FINAL TRANSCRIPT

Medical Facilities Corporation

2016 Fourth Quarter Results Conference Call

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PRESENTATION

Operator

Good morning, ladies and gentlemen. Welcome to the Medical Facilities Corporation's 2016 fourth quarter results conference call.

Before the call is turned over to management, listeners are cautioned that today's presentation and the responses to questions may contain forward-looking statements within the meaning of the safe harbor provisions of Canadian provincial securities law. Forward-looking statements involve risks and uncertainties, and undue reliance should not be placed on such statements.

Certain material factors or assumptions are applied in making forward-looking statements, and actual results may differ materially from those expressed or implied in such statements.

For additional information about factors that may cause actual results to differ materially from expectations, and about material factors or assumptions applied in making forward-looking statements, please consult the MD&A for this quarter, the Risk Factor section of the Annual Information Form, and Medical Facilities' other filings with Canadian securities regulators.

Medical Facilities does not undertake to update any forward-looking statements. Such statements speak only as of the date made.

Listeners are also reminded that today's call is being recorded for the benefit of individual shareholders, the media, and other interested parties who may want to review the call at a later time.

I would now like to turn the meeting over to Mr. Britt Reynolds, President and CEO of Medical Facilities. Please go ahead Mr. Reynolds.

Britt Reynolds — President and Chief Executive Officer, Medical Facilities Corporation

Thank you, Operator, and good morning, everyone. Joining me today is Tyler Murphy, our Chief Financial Officer, and Jim Rolfe, our Chief Development Officer.

Prior to the market opening today, we released our 2016 fourth quarter financial results. Our new release, financial statements, and MD&A may be accessed through our corporate website at www.medicalfacilitiescorp.ca. These were also released to SEDAR today.

I'll start by discussing the progress we made in the last quarter, and then discuss 2016. Tyler will review our financial results. Following, Jim will then describe our strategy for growth. At the conclusion of our comments, we will then open the call for questions.

2016 was an instrumental year for Medical Facilities Corporation. In the year we had a complete change in our senior management team, we added and expanded facilities, and we put in place a detailed strategy for long-term growth. These changes began at the board level early in 2016 when they added me to join MFC.

Along with that, they made the decision to leverage the progress of a solid company that was founded 12 years earlier on a reputation of delivering stable distributions. Toward one of those deliveries, we have growth and accentuated distributions.

I joined MFC late May with the objective of growing our organization. In 2016, we built the team, learned about our facilities and communities, and identified potential acquisitions.

Jim Rolfe joined us in the new role of Chief Development Officer in September. He added immediate value through his expertise in evaluating, acquiring, and integrating health care assets of all types. These include physician, joint ventures, and outpatient facilities.

At the end of 2016, Michael Salter, our Chief Financial Officer since the inception, retired. Michael was instrumental on founding of MFC and in underscoring our IPO. Under his direction he established our reputation for focused financial management and consistent distributions.

Tyler Murphy joined us in November of 2016 and succeeded Michael as CFO at the beginning of this year. I worked with Tyler previously. He has a strong financial acumen in all areas of operations, asset management, and public markets. His skill at integrating acquisition assets is also.

In 2016, we made progress both in acquisitions and organic growth. As you are aware, in September we completed the acquisition of Unity Hospital in Mishawaka, Indiana. This is exactly the type of asset we are targeting.

Unity is a 29-bed Medicare-certified facility with four surgical and two special procedure suites. They are focused on providing neurosurgical, orthopaedic surgery, as well as ophthalmology, podiatry, and pain management. We purchased a 62 percent interest in Unity for $27.8 million.

This is an important acquisition. It added another physician-owned surgical hospital to our roster. Unity delivers very high-quality care being five-star rated by the Centers for Medicare & Medicaid Services. This is important in maximizing patient outcomes and in attracting physicians.

Another important acquisition in 2016 was Prairie States Surgical Centre, an ambulatory surgical centre located in Sioux Falls, South Dakota. It was acquired by our hospital in Sioux Falls and immediately merged into the hospital as an outpatient department. This merger increased the day surgery capacity at Sioux Falls and provided overnight stay options for the procedures conducted at Prairies States.

As well, the Prairie States physicians became part of the Sioux Falls medical staff. This helped expand capacity at the newly combined facility.

In 2016, our centre at Black Hills continued to increase its presence in the community and add incremental revenue specifically with the addition of an urgent care centre in Spearfish, South Dakota located in an adjacent market. This is the third urgent care centre that Black Hills has added.

We believe building a strong regional preference like this will also help drive case volume at Black Hills.

The success we had in 2016 is an introduction to the progress that we have targeted for going forward. To ensure that this growth culture is embedded in our organization, the management team has made this a priority focus.

Tyler will provide a review of our financial results for the fourth quarter and also for 2016, followed by Jim, who will expand further on our growth strategies.

Tyler?

Tyler Murphy — Chief Financial Offer, Medical Facilities Corporation

Thanks, Britt. As on our previous calls, I would like to note that all of the dollar amounts expressed in today's call are in US dollars, unless otherwise stated.

In 2016, MFC had revenue of $339.5 million, a 10 percent increase over $308.8 million in 2015. Driving this growth is the increase in case volume at all of our centres along with additions from our acquisitions.

We have had growth in cases every year since inception, which is a testament to the quality of our facilities and their teams.

Strong momentum in case volume will continue to be a key feature of MFC that will help as we execute on our growth strategy, both to serve as a model for physician-owned facilities to join our network and to recruit physicians.

On a quarterly basis revenue was $108 million, up 20 percent from Q4 2015. Again, the increase was driven by case growth and contributions from acquired facilities. Of note was an 11.9 percent increase in the revenue at Black Hills, reflecting the addition of the new urgent care centre and a new ear, nose, and throat clinic.

The fourth quarter also demonstrated a cyclicality we experience when patients with private insurance elect to have their surgeries at the end of the year after their deductibles are expended. Q4 revenue was up 37 percent over Q3 and represented 32 percent of 2016 annual revenue.

Payor mix continued to have an impact on annual revenue as we performed a higher proportion of cases paid for by Medicare. This was particularly the case at Oklahoma Spine Hospital and Sioux Falls Specialty Hospital. Government payors pay less for procedures than private payors. As a result, income from operations declined by 8.9 percent year over year.

With fourth quarter case growth consisting of a higher proportion of private payors, we saw a less negative impact from payor mix in the quarter. When accounting for a noncash reversal of an accrued rent liability in Q4 2015, income from operations was up slightly year over year at 25.3 million.

Cash available for distribution in 2016 was C$50.7 million, a 10.5 percent increase from a year earlier. On a quarterly basis, cash available for distribution was C$17.8 million in Q4 2016, a 41.8 percent increase over Q4 2015. For both annual and quarterly results the reason for the difference is that no losses on foreign exchange forward contracts were realized in 2016.

On a per share basis, our cash available for distribution was C$1.63 in 2016 compared to C$1.47 per share in 2015. For the fourth quarter this was $0.57 compared C$0.40 in Q4 2015.

The resulting payout ratio was 69 percent for the year and 49 percent for the quarter compared to a 76.7 and 69.7 percent, respectively, for the previous year. At the end of 2016 with cash

and cash equivalents of $67.6 million and about US$32 million available on our credit facility, we believe we are well positioned to execute on our growth strategy.

For additional detail on the specific results for each centre, please refer to our MD&A.

Now Jim will talk to you about our growth strategy. Jim?

Jim Rolfe — Chief Development Officer, Medical Facilities Corporation

All right. Thanks, Tyler. As Britt mentioned earlier, the MFC management team focus for the end of 2016 and early 2017 was on creating a detailed strategy for growth that would guide the Company for the next few years. It was brought to the board, revised with their input, and ratified this past February.

Our strategy for growth has two parts: making accretive acquisitions and expanding revenue and improving efficiencies at our existing facilities.

In terms of growth acquisitions, we currently have a robust pipeline. As you know, MFC was very active in 2016. We looked at several opportunities, closed on two, and passed on several more.

Local reimbursement pressure continues to provide opportunities in the US M&A health care market. There were 940 transactions totalling $175 billion in 2015, more than double the average rate for the previous decade. This increased in 2016, and the trend is expected to continue in 2017.

Britt, Tyler, and I have considerable experience in identifying; evaluating; acquiring; and integrating medical facilities, and we have been active in our networks to look for new opportunities.

When we consider facilities for acquisitions we look for the following attributes that are adjacent to our current portfolio.

First, the facility must have high-quality with optimum clinical outcomes. Next, they must have physician alignment and affiliation. Our focus is to acquire majority control and to only acquire facilities where practising physicians are our partners. Lastly, it must be accretive with strong earnings and growth available from a local strong position base, demographics, and operating enhancements.

We expect early opportunities will be with the ambulatory surgical centres like our Newport Beach and our Prairie States facilities.

There are around 5,000 ASCs in the US, and they have grown into a key health care delivery platform and are offering more varied and complex services.

We will continue to consider physician-owned specialty surgical hospitals when they become available, and act as we did with Unity Hospital in 2016. These, however, are currently restricted under the Affordable Care Act, which limits their numbers and will mean fewer will be available to acquire.

The next component of our growth strategy is organic growth. Organic growth drivers at our current facilities will be achieved through physician development; expanding service offerings; end-market acquisitions; capacity utilization; and operational efficiencies.

Since joining MFC, I have been closely involved with our local leadership teams to develop individual strategies for physician development, as the recruitment and retention of highly qualified physicians is important to the continued success of our hospitals.

We are looking at opportunities for them to join MFC as accredited physicians or a physician investor. In either case, the new physicians benefit from working in a highly rated facility with high-quality service, improved time management, and optimum patient outcomes.

Expanding service offerings is also an important organic growth initiative. As we address the decreasing reimbursement and the increase in consumerism, such as quality, price, and access, we are focused on expansion of our local footprint and service offerings. Examples of these services are surgical diversity; hospice services; cardiac care; oncology; and urgent care. These will deliver immediate results in terms of growth and case volumes and utilization.

The new urgent care centres established by Black Hills and Spearfish that Britt mentioned earlier, and their addition of an ENT clinic, illustrates the recent success we've had with this initiative.

Consistent with our expansion of service lines mentioned earlier, we are also focused on end-market complementary acquisitions, such as ASCs and imaging centres. Adding these will expand our local market area for services offered and access, enabling continued high patient and provider satisfaction, and importantly, expanding our patient base.

In addition to physician development, expansion of services, and end-market acquisitions, MFC will continue to focus to improve efficiencies and margins. Given that a large portion of MFC

facility procedures provide orthopaedic services, there are opportunities to realize cost improvements through a streamlined procurement of implants and related supplies.

We have also initiated communication across our organization to facilitate sharing of best practices in management and patient care. This multifaceted approach to growth is one that we feel will deliver both near-term results and build long-term shareholder value.

On behalf of the whole executive team, I'd like to say we are dedicated to this strategy, and we are looking forward to reporting on our progress throughout the rest of 2017.

We will now open the call up to questions.

Q&A

Operator

If you would like to ask a question at this time, please press *, then the number 1 on your telephone keypad. If you would like to withdraw your question press the # key. We will pause for just a moment to compile the Q&A roster.

Your first question comes from Lennox Gibbs from TD Securities. Your line is open.

Lennox Gibbs — TD Securities

Good morning. Thank you. Just with respect to the margins, what were the relative contributions of payor mix and case mix to the year-on-year margin trend?

Britt Reynolds

Hey, Lennox. This is Britt. As we reported earlier, the case mix volume we're really excited about the year of strong volume growth pretty much across the board, and so that was a positive for us.

From a payor mix standpoint and especially in markets when you acquire new facilities it takes a little while to really reach to the physicians in that marketplace that they're joining, as well as refining the processes, which takes a little time out of the gate. And we spent a lot of time focusing on learning about those centres not only through diligence, but afterwards.

So a little bit of margin downside on some of the acquisitions, but not to be unexpected in a situation like that in the very short term. So that's pretty consistent with what we would expect, and not consistent with what we would expect to see long term.

Lennox Gibbs

Okay. And then if you look at the base business, so to speak, what are some of the case mix issues in the base business? Which facilities, which procedures, where do you think you have the greatest opportunities to improve case mix in the base business?

Britt Reynolds

Well, I would tell you from a case mix standpoint, and I think I should tell you, we see the opportunity to improve that pretty much across the board. Now it's going to be extremely variable, so I don't want to be coy about that.

There's obviously opportunity, which is the second part of your question, but clearly in both of the newly acquired facilities there's a case mix opportunity, as Jim mentioned, both from recruiting new service lines in and bringing them under the fold, as well as implementing some strategies that we've seen in some of our other markets.

And then in our existing portfolio from an opportunity to improve, I think there are a couple of select facilities, and probably don't really want to call them out necessarily individually, but that have some opportunity or have good opportunities to improve it, again, based on the same rationale.

We really haven't been on a large physician recruitment initiative historically, or at least in the most recent history. And as we do that that gives us good opportunity to focus on case mix.

Lennox Gibbs

Okay. And then if you don't want to call out facilities per se can you speak more specifically to procedures, to the kinds of procedures that you would like to boost volumes on?

Britt Reynolds

Oh, absolutely; be glad to do that for you. In the neurosurgical arena, clearly that's our bread and butter, and we're going to continue to grow that. We have a lot of interest not only in existing markets for new additions, we had an obvious one in the acquisition of Prairie States, which was a group of neurosurgeons and orthopedics. And orthopedics would be the second area we see good margin growth in and continued services.

And then as Jim alluded to, we are exploring very heavily and have some active interest in areas that are not typical that you would hear us talk about like cardiology and some other areas, and those services have nice margins. So to really get back to your main question, Lennox, it's that kind of margin opportunity that maybe we haven't historically had that's the real focus of what drives Jim's opportunities as we're seeking them out.

So your question's spot on with where our directive is on opportunity.

Lennox Gibbs

Thanks very much.

Operator

Your next question comes from Endri Leno from National Bank. Your line is open.

Endri Leno — National Bank

Hi. Good morning, and thank you for taking my question. First one is it's just a bit specific on Arkansas Hospital. I was wondering even after adjusting for a noncash charge for last year there seemed a bit of a margin contraction. I was wondering if you can expand on what drove the higher expense and how transient were these factors?

Tyler Murphy

Yeah. This is Tyler. Good morning. Yeah. Arkansas had … They did have lower case volumes, so they were down a bit. They also had higher Medicare volumes than in the past, which obviously as we've discussed, are much lower reimbursement on the private pay side.

Jim's been doing some work down there to help them recruit some new physicians that I think will help bring back in some of these managed care cases and some of the higher-margin business. So it's something that we are definitely concentrated on.

Britt Reynolds

Yeah. This is Britt. I would tell you I'm not sure that I've had this commentary in my shorter tenure here with you, but that marketplace is one that is probably the most competitive on a higher number of patients on a lower reimbursement compared to some of our other facilities.

So actually when you dig down in the details and look at some of the comparables across our organization, they're one of the more efficient utilizers of the cost-side equation. And that's in a must-be kind of situation in order to yield the stronger results that they have historically.

So we're going to continue to have some challenges there, but those challenges have not translated into something where we're not bullish on the market. In fact, this is one of the markets where Jim, as Tyler alluded, has spent a lot of time. And there's a lot of opportunity, again much like I said earlier, of adding services and provisions that have not been historically there that will have a natural uptick on margin.

So margin selection is essentially what I think you're asking, and that is core to us going forward.

Endri Leno

Great. Thank you very much. And one other question that I have, Britt, you mentioned in your opening comments about possible joint ventures. And I was wondering—I mean as part of a growth strategy—and I was wondering if you could please expand on what could these entail, please?

Britt Reynolds

Well, I think the obvious piece of the joint venture is the continuation of the model with our medical staff partners, and that would include in if we were to acquire a specialty surgical facility much like UMASH, or in an ambulatory surgery setting we would have physician partnership in that as well and other sources.

But we're also open to partnerships with other entities if that makes sense in a given market. Clearly we will maintain our majority position, so it's not going to dilute that in any way. But sometimes partnerships with even local providers where we could provide the service either better or differently that's not something we're averse to.

Endri Leno

Great. Thank you very much. That's all the questions I had.

Britt Reynolds

Okay.

Operator

Your next question comes from Neil Linsdell from Industrial Alliance. Your line is open.

Neil Linsdell — Industrial Alliance

First of all, obviously you're getting some great revenue growth; a lot of traffic coming through your hospitals. On the expense side, I know the margins are going to vary quarter to quarter quite significantly based on case and payor mix, but you've got these ongoing programs to try and take costs and work inefficiencies and synergies. Can you give us any idea of dollar value we might be able to expect from the current operations that you can save?

Tyler Murphy

I don't believe—we haven't really put out any kind of forecast on a dollar savings. Obviously, the two of the three main categories we're looking at is SWB. I mean we do have some competitive markets on the wage side. And then obviously drugs and supplies. And that's a big project we're undertaking right now as we're trying to aggregate all of our facilities' data so we can go to a GPO or go to a distributor and show what we're buying across the board as a company as opposed to it being a one-by-one facility basis, and hope to help drive some savings to these facilities.

You're not going to be able to stop increases in SWB, you're not going to be able to stop increases in drugs and supplies, but we hope to be able to keep that going at not as an increased of a level, and so that's a lot of what we're working on right now.

Britt Reynolds

Yeah. This is Britt, Neil. One of the opportunities that Tyler was speaking to, I think, is on the SWB side of the equation. Part of the strength we talk about almost every time we're on a call or a discussion with you is the quality that we deliver there. And I'm never going to say we're going to do

quality at the expense of operating prudently, but on our SWB we're competitive in our marketplaces; it's an attractive place for people to work.

And we staff those typically a little bit richer than you might at a general acute care hospital. I don't see us switching wildly away from that because a five-star rating is both impressive from a continued reimbursement opportunity for pick-ups but also from a place where physicians want to go.

So it's a ginger balance on that, but there is opportunity and I'm not going to sidestep that. There is opportunity to address that, and we're working with our facilities to do it.

As Tyler mentioned on the supply side of the equation, it's a little bit longer of a run—and not trying to stall at all—but the real solution is what he said, which is being part of a large consortium where we can purchase not only from our own book of business, but also with other partners in the health care space, and all of us having been part of that in the past that that's going to be the solution.

And it just takes time to get into the some of those big provider networks, but it is, as he said, a clear focus. We know we have to control the costs. I am extremely pleased with this volume growth compared to most in the industry, in our industry, in the ASC industry, in the hospital industry as well. I think our opportunity, as you aptly put it, is in the cost-side equation.

Neil Linsdell

Yeah. Okay. And let me ask the question that I don't think you thought you were going to be able to avoid on this conference call. But with the changes in the government regulations that

seem to be proposed right now, do you see any impact to the way you've been operating the business, or any new opportunities perhaps if the ACA is repealed and it gives you a chance to expand with your current surgical hospitals? Is there any positive or negatives that you're seeing so far with the proposals coming out?

Britt Reynolds

Yeah. One, we did anticipate the call, as you said. But actually, Neil, I welcome the call because I've had this statement again with many of you, and I want to continue to make sure that we're having this centre and forefront. In our area of the business—and oftentimes we get lumped with other providers in the health care space, and again I'm speaking more specifically to the general acute care hospital provider space—where we're distinctly different is our cases, be among the surgery centre side or on the hospital side of the equation, are scheduled elective procedures that the physician is controlling into our facilities, meaning making the selection to come to our hospital.

We are not operating full-service 24/7 emergency departments, critical intensive care units, areas where the cost is exorbitant, and you have no control whatsoever on who comes through the door. You don't have it as an operator; doctor really doesn't have it as a provider.

So regardless of really what direction the ACA goes in, that's not going to change. So it's not something that we're really focused a lot on because it really doesn't look to be something that's going to focus our attention, and nor should it really. And we have a low percentage of those patients who really fall into any kind of low subsidy kind of paying or no-pay kind of pay.

So we view it, frankly, as neutral at worse. And quite candidly, and you alluded to this in the second part of your question, we have been a part of PJ and others saying we welcome the opportunity to get back full force in the business of being able to continue doing this.

So from Jim's job standpoint, I don't think you can make him happier than the opportunity to be able to get back into the business again if it shouldn't be repealed, and puts us into a much more robust opportunity in markets not to even walk away from a de novo opportunity if it made sense.

So we see it neutral on the day-to-day operations, and we see it opportunistic on the ability to affect our acquisition pipeline.

Neil Linsdell

Okay. Great. And then just as a follow-up to that, I mean you've been doing this a long time as far as looking for acquisition opportunities. Has the current administrative changes changed the attitude of the potential sellers out there?

Britt Reynolds

I'm going to—I'll take one stab, and then I want Jim to really delve in. I would tell you on a sort of top aerial view, yeah, I think it's made some folks a little skittish, and they're looking for partnerships and looking for economies of being part of something bigger. And I would couch that as being an opinion, not an absolute statement by someone.

But I feel comfortable enough to share it in that I think it offers opportunity for the reasons I shared a few minutes ago for partnership with us.

But, Jim, if you want to share some insights.

Jim Rolfe

Yeah. Morning, Neil. Yeah. No, I think Britt's exactly right. I think that—and we're seeing this as well—with the continued decrease in reimbursement, competition has gotten pretty robust in a lot of areas. And so not—I mean the same with acute care hospitals.

So I think a lot of these specialty hospitals—there's 245 out there, so there's not a lot of them—but I think they're starting to feel the pressures of what the acute care, to some degree—not near as large as the acute care—but I think they're seeing some financial pressure.

And like Britt alluded to, scalability and being with somebody with the size that actually has capital to help them grow their local footprint, like we mentioned earlier today, I think they're looking for that, so.

Yeah. And the same on the ASC side I think that they're seeing this same pressure, and one's ability to grow it and expand their footprint as well.

Neil Linsdell

Okay. Great colour. And then just in parting, Tyler, maybe you talked about the dry powder with 68 million in cash, 32 million in available credit facilities, I think you said. So that'll give you $100 million. But you're still like pretty low on the leverage side compared to some of your competitors. I mean what's your comfort level as far as leveraging that up when you're looking at acquisitions?

Tyler Murphy

Yeah. We haven't set a target leverage. I think the comfort level's going to come as we start to look at these opportunities, we get closer to things that we can actually close, and kind of the size of those. I mean we do have a couple of opportunities to monetize some real estate that would give us some additional dry powder and other ways.

I mean obviously we're not going to jump from where we are as a low-leverage company all the way up to where our peers are. I mean that would just be … It would have to be a stepped approach, but it's obviously going to be based on opportunity. And I think we'll talk more about actual leverage targets and levels as we start to realize are we getting more surgical hospitals in the loop? Are we going to get more ASCs? And just kind of what the capital's going to be required to take care of those.

Britt Reynolds

If I could add slightly to that; I think acquisitions, like we've demonstrated by the ones clearly vetted, were within that wheelhouse that we described and comfort zone. If you saw us want to ever contemplate a leverage piece, it would be on an opportunity where Jim was able to find a pretty significant-sized multi-facility acquisition.

And at that point in time we'd be very clear about our diligence and what any opportunity might be. But even so, as Tyler mentioned, it's still not going to be some radical departure.

Neil Linsdell

Okay. Great. Thanks a lot, guys.

Tyler Murphy

Sure.

Britt Reynolds

Yep.

Operator

Your next question comes from Matt Bottomley from Canaccord Genuity. Your line is open.

Matt Bottomley — Canaccord Genuity

Good morning.

Britt Reynolds

Good morning.

Tyler Murphy

Morning.

Matt Bottomley

Just a couple quick questions on Unity just going back to the margins there; so first full quarter in it's one of the lower contributors compared to some of your other facilities. So I'm just wondering if there's any integration costs or nonrecurring items that hit OpEx that we should consider going forward? Or what some initiatives might be in terms of how we look at the margins in that facility over the next few quarters?

Britt Reynolds

Yeah. This is Britt. Yes. You're dead on. There are always going to be integration opportunities, and my experience has been you're going to see those in the first three to six months typically as the most intensive as you both sort of weed out what you kind of learned through the diligence process and as you learn a facility even greater.

But also, and Jim alluded to this in his earlier comments, we're actually looking for opportunities where there's some differences and abilities to move that margin up. I mean obviously that's the role of an acquisition. And so it's not surprising to us, either in a level or in the fact that it existed in the relatively short period that we've owned them.

So clearly some start-up costs, clearly some integration costs, and just the sheer process of doing the diligence from legal fees to folks that have to make sure we put all the appropriate pieces and documentation together. So again, far shot from saying hang on for a long period of time, but this was somewhat anticipated.

I think in particular because you're asking about Unity—and I might ask Jim to give some colour on this—one of the things that made it attractive to us is we knew this would happen, but we also knew the opportunity for expansion was about as rapid as you could see in terms of what was open on the market. So our ability to sort of flip to growth side of the equation as we're normalizing and stabilizing is real.

Jim, just a few colour on that?

Jim Rolfe

Yeah. Matt, UMASH has a chassis to be substantially larger than it is now. Their quality is definitely off the charts. It's a five-star hospital. So with that has a fixed expense from their nursing side and from their patient care side. So they do have a chassis.

So yeah, so it's my—not my job—it's our job to work with local management to bring in new physicians to grow service line, and so it's a little bit of a component that by having nice, well-run, high-quality chassis let's add to that chassis and grow that margin.

Britt Reynolds

And from our diligence—it's Britt again—from our diligence, as well as our boots on the ground, there is solid, solid interest in physician and other services joining and becoming part of this new direction at Unity, both in terms of same-type procedural case, as well as a whole host of incremental cases that they've never done before that we find extremely exciting. So it really rolls back into the we're working to get our house in order in the short-term, short-short term, but our upside potential is not just theoretical. I mean these are real doctors having real conversations with us about becoming a part of this organization.

Matt Bottomley

Okay. Great. Thanks. So then maybe just on the—and I think you've answered this within that question—but maybe just on the revenue side then for Unity. If you normalize for the fact that your Q4 is about 30 percent of your revenues, do you think Unity's run rate for the quarter after that normalization is appropriate looking into the current fiscal year?

Tyler Murphy

Yeah. As you alluded to, I mean obviously the fourth quarter is going to be a little bit higher on a percentage basis. I have not broken that one out quarter by quarter from last year, as obviously I just came on board right before the fourth quarter. But I think it is safe to say obviously that first quarter's not going to be nearly like the fourth quarter.

And then as you build through the year you have the second quarter that's usually better than the first, and the third quarter just it really depends a lot on vacations and other things as you kind of move through it. So I think once we get another quarter or two under our belt on Unity as part of our consolidated financials we'll have a much better picture, and be able to articulate it a lot better as far as how it's going to break down comparative to the rest of our facilities.

Matt Bottomley

Okay. Great. Thanks. And just last question on my end, just your payout ratio of 69 percent came down nicely this year. We've seen a full fiscal year now where you're FX isn't impacted from the hedges from 2015. So do you think sub-70 percent is a good way to look at it going forward?

Tyler Murphy

Yes. I think that's right.

Matt Bottomley

Okay. Great. Thank you.

Operator

Your next question comes from Doug Miehm from RBC Capital Markets. Your line is open.

Doug Miehm — RBC Capital Markets

Morning. A couple questions with respect to operations at the individual hospitals and those sorts of things. Perhaps you can tell us about referral mix of owners versus nonowners at the moment? And then if you could just talk to us about layoffs and turnovers, or turnover at the facilities; anything unusual? Or is it business as anticipated?

Britt Reynolds

Sure. Let me address maybe in reverse order. So layoffs and turnover we really haven't seen—let me address it on a couple different levels—from a physician standpoint we've not seen any kind of loss of significant physician group or significant physician individual that's been historically with our existing core business.

And quite the contrary on our two acquisitions which we've added physicians, frankly, even in the short term who have been not only that are currently practising, but that are in line to practise in the very, very near term.

So from a turnover standpoint, we're not really experiencing that. Specifically in one of our markets in the Midwest we had some I would call it a run on trying to take away some of our core nursing staff that have been long-term folks, and we were able to actually avoid that and maintain our folks. And there were some costs associated with that, obviously, but we felt like it was the right

thing to do from the five-star rating that facility has enjoyed for a long time, as well as just the consistency. And it's a top operator for us in Black Hills.

So that is going to in the short term increase our costs. But again, it's our job to make sure that we're driving more revenue there to offset that increase. That's really the only market where we've seen that kind of competitive force, either on the physician or on the staff side of the equation that would contribute to that.

And then the first part of your question, again, if you don't mind, Doug?

Doug Miehm

Just referral mix, owners; physician-owners versus nonowners.

Britt Reynolds

Well, a large part of our markets are pretty much right at that exact threshold of a 49 percent ownership stake in partnership with our 51, so vast majority of our case load from a historical organic standpoint is coming from that existing pool.

As Jim alluded to earlier, our view on opportunity—and we're really bullish on this—is the attractiveness of physicians that aren't currently on our medical staffs or have historically not used us. And the interest level for a variety of reasons, be that either quality, efficiency, more fluidness for their own personal practices, we're getting a lot of interest individually from physicians both to our local leadership, as well as to us individually.

So I think there's a lot of upside potential in attracting a greater percentage of folks that currently don't use us now and particularly in our organic markets.

Doug Miehm

Perfect. And then maybe one for Jim and then maybe another one; acquisition multiples you're seeing? And if you were to go after like a cardiac care, would it be in an existing market? Or would this be something new? So just multiples and give us an example of what the strategy would be around a cardiac care facility?

Jim Rolfe

Yeah. Doug, the cardiac care, we're not going to get into the cardiac care as a platform. So location by location from our organic centres that we currently have if we want to add that service line, we'll definitely look at that. But no, we're not going to get into the cardiac business for sure, as a platform.

Britt Reynolds

And I may have confused you, Doug, in the opening discussion or in part of the Q&A. This, as Jim mentioned, is a very local situational dynamic where this is a large group with a large cardiac platform, and that's an opportunistic situation.

As Jim alluded, we're not going to go out and blanket cardiac services at every one of our hospitals. So it's much a case by case, and you could substitute any other specialty that you wanted to other than cardiac in that same vein.

So what we're trying to reflect openly to you guys is we're looking at additional service lines, but they very likely to differ from facility to facility and circumstance to circumstance, not necessarily that we are going to move from something to something else at every one of our facilities. It's going to be very situationally crafted.

Doug Miehm

Okay. And then just finally on these related party transactions, when we talk about orthopaedic surgeons and orthopaedic groups at Sioux Falls, I'm just trying to figure out how much are they earning of that $7.5 million that was paid out this year? And why don't you have these types of agreements at some of the other facilities?

Britt Reynolds

Again, if it's okay, I'll take it sort of in reverse order. From a why would we not have it at other facilities, again—not again, excuse me, sort of potentially in contrast to what I just said that we don't have an absolute on cardiology in a marketplace, orthopaedics would be a stalwart for us in pretty much every one of our centres and every one of an ASC that we either currently operate or might acquire. And so orthopaedics—to I think the question you're absolutely delving at—orthopaedics is a service line that does well for us.

And let me quantify that for you. It does well for us in terms of it's margin versus other types of service; it does well for us in terms of the complexity; it does well for us in terms of we've had good

outcomes in our locations. So it would be one, along with neurosurgical, various aspects of general surgery, and the like that we already offer, or that in new markets if it's not offered we'd look to do.

So that's a little bit of a contrast to what I was discussing on cardiology and Jim was discussing on cardiology, orthopaedics would be right in our wheelhouse.

Jim Rolfe

Yeah. And just keep in mind too that that's not just professional fees. That includes up and down the board and a fee to services, physical therapy, medical product implants. It's just it's all listed under related party, but it's not just a professional fee that's being paid to the doctors.

Doug Miehm

Yeah. I'm just trying to figure out why that's even necessary. Like even this billing one with Unity, why do you need to pay for billing?

Jim Rolfe

It's just an outsource. They've outsourced their billing services, much like many people do; much like we have IMD doing one of our hospitals, one of our competitor hospitals, and it was something that was already in place when the acquisition was taken over. Those are the type of things that are opportunities for us to look at going forward if we want to internalize that, if we want to do it through IMD, or something else that we already own; that again is future opportunity for us to look at margin savings.

Doug Miehm

Perfect. Okay. Thanks very much.

Operator

Once again, if you would like to ask a question, press *, then the number 1 on your telephone keypad.

Your next question comes from Ryan Lee from CIBC. Your line is open.

Ryan Lee — CIBC

Good morning, guys. I'm calling in for Prakash Gowd; a couple of questions here. My first question's relating to the private payor mix as a percentage of the facility services. We see that 2016's about 28 percent, and the year before that it's around 27.5. Where do you see this trend going in 2017 and beyond?

Britt Reynolds

We had a little bit of trouble hearing you on the very beginning, and if it's not too much of a inconvenience, could we hear that question again, please?

Ryan Lee

Yeah. No problem. I'm just asking about the payor mix. Looking back in 2015 it's around 27.5 for the public payors and 28.7 percent for 2016. We'd just like to know where this is going to go in 2017 and beyond.

Tyler Murphy

Well, I mean we haven't put out any kind of target synergies. And as we said, I think if you listen back through all of Jim's comments and kind of the whole management team's comments, we are trying to help facilities where they need it recruit new physicians. Obviously these bring in more managed care, Blue Cross-type reimbursement.

In a lot of cases these are younger physicians, they have a little bit younger patient base, so you're not as worried about the Medicare mix. So I mean that's kind of one of our jobs is to try to help these facilities bring in these cases to keep the highest percentage of managed care, Blue Cross, that type of thing coming in the door.

Ryan Lee

Okay. And in terms of the acquisitions now, you mentioned you have a robust pipeline. When do we see like the fruits of your labour coming in? Would it be in the second half of the year? Or would we see something sooner?

Jim Rolfe

No, no. It's definitely going to be on at least the second half of the year. We spend a lot of time with our current centres. I've been visiting all of our current centres to talk about organic growth, which is the second component of what I do.

But yeah, we have several conversations right now, and as you well know, these things take time to bear fruit, so yeah, definitely in the second half.

Ryan Lee

Okay. Thanks.

Operator

At this time, I will turn the call over to Mr. Reynolds.

Britt Reynolds

Yes. Thank you, Operator. We thank you, all, for your time today, your questions, and the opportunity to share our direction with you.

And we appreciate your interest in Medical Facilities, and we wish you a great day.

Operator

This concludes today's conference call. You may now disconnect.

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