# Medical Facilities Corporation (TSX: DR) Initial Screen

**High-quality, specialty surgery hospital operator trading at <5.3x P/FCF & <3.5x '26 FCF**

**Aryann Gupta**

## Key Ratio and Statistics (in CAD)

| | | | |
|---|---|---|---|
| **Recommendation** | **Strong Buy** | P/B | 2.20x |
| Market Cap | 223.2 | LTM P/E | 10.97x |
| 52-Week Low | 7.50 | EV/EBIT | 4.70x |
| 52-Week High | 9.80 | Net Debt/LTM EBITDA | 1.40x |
| Share Price | 8.98 | Date | 12/31/2023 |

Before starting, I would like to thank everyone who has done existing work on MFC. Your research has been invaluable to me and has helped me understand the business to a greater extent.

I would consult whoever is reading this to go and read the original write-ups first. They are as follows:

- https://ausram.substack.com/p/medical-facilities-corp
- https://www.greystonevalue.com/_files/ugd/47fd79_ffc6d148e7b74658b2eb702a7e2d5047.pdf
- https://drive.google.com/file/d/1ayHB7SqEpJ7Dwqhws1JpoBU3QNp-52Ra/view
- https://tridentopportunities.com/en/medical-facilities-corp-share-non-cyclical-share-at/

I also want to preface that this is the first time I am looking at a healthcare asset like MFC, so this write-up is perhaps longer than it needs to be.

## Company Overview:

Current Analyst Coverage:
RBC Capital Markets: Douglas Miehm/Sahil Dhingra & Leede Jones Gable: Douglas Loe Douglas

Current Shareholders:

**Top Investors**

| Investor Rank | Investor Name | % O/S | Position (M) | Position Change (M) | Value ($, M) | Latest Filing Date |
|---|---|---|---|---|---|---|
| 1 | Tarpon Investimentos SA | 9.64% | 2.40 | +2.40 | 16.28 | 30-Jun-2022 |
| 2 | Dimensional Fund Advisors, L.P. | 1.62% | 0.40 | 0 | 2.74 | 31-Dec-2023 |
| 3 | APG Asset Management N.V. | 0.61% | 0.15 | +0.15 | 1.06 | 30-Sep-2023 |
| 4 | Jarislowsky Fraser, Ltd. | 0.57% | 0.14 | +0.14 | 0.89 | 30-Jun-2023 |
| 5 | Connor, Clark & Lunn Investment | 0.52% | 0.13 | +0.00 | 0.84 | 30-Nov-2023 |
| 6 | Blanchard, Yanick | 0.40% | 0.10 | 0 | 0.59 | 27-Mar-2023 |
| 7 | Empiricus Gestao de Recursos Ltda | 0.28% | 0.07 | 0 | 0.41 | 31-Mar-2023 |
| 8 | Baillie Gifford & Co. | 0.26% | 0.06 | 0 | 0.41 | 31-Jul-2023 |
| 9 | Dimensional Fund Advisors, Ltd. | 0.20% | 0.05 | 0 | 0.32 | 30-Nov-2023 |
| 10 | 1832 Asset Management L.P. | 0.15% | 0.04 | +0.01 | 0.26 | 31-Aug-2023 |
| 11 | Vestcor Inc | 0.15% | 0.04 | +0.04 | 0.22 | 31-Dec-2022 |
| 12 | LSV Asset Management | 0.13% | 0.03 | +0.03 | 0.21 | 30-Jun-2023 |
| 13 | Laurus Investment Counsel | 0.12% | 0.03 | 0 | 0.20 | 30-Nov-2023 |
| 14 | SEI Investments Canada | 0.09% | 0.02 | +0.01 | 0.16 | 30-Sep-2023 |
| 15 | BlackRock Institutional Trust Company, | 0.07% | 0.02 | +0.00 | 0.12 | 31-Dec-2023 |
| 16 | Manulife Investment Management (North | 0.03% | 0.01 | +0.01 | 0.05 | 30-Jun-2023 |
| 17 | Watson (David Nathaniel Tait) | 0.03% | 0.01 | +0.01 | 0.05 | 18-May-2022 |
| 18 | Hotchkis and Wiley Capital Management, | 0.02% | 0.01 | +0.01 | 0.03 | 30-Nov-2023 |
| 19 | DFA Australia Ltd. | 0.01% | 0.00 | +0.00 | 0.02 | 31-Oct-2023 |
| 20 | Allspring Global Investments, LLC | 0.01% | 0.00 | 0 | 0.02 | 30-Sep-2022 |
| **Total** | | **14.94%** | **3.71** | **2.81** | **24.88** | |

**Figure 1: MFC Shareholding**

When pulling MFC's largest shareholder data, both CapitalIQ and Refinitv had out-of-date data. Some of the holdings were last updated over a year and three months ago. I am not sure where I can pull more up-to-date data from, but once I find it, I will accordingly update this table.

**Business Overview:**

Medical Facilities Corporation (MFC), in partnership with physicians, owns a diverse portfolio of highly rated, high-quality surgical facilities in the United States through its wholly owned US-based subsidiaries. MFC's ownership includes controlling interest in four specialty surgical hospitals (SSH) in Arkansas, Oklahoma, and South Dakota and an ambulatory surgery center (ASC) in California.

| Summary of Facility Information as of September 30, 2023 | Arkansas Surgical Hospital (ASH) | Oklahoma Spine Hospital (OSH) | Black Hills Surgical Hospital (BHSH) | Sioux Falls Specialty Hospital (SFSH) | Surgery Center of Newport Coast (SCNC) |
|---|---|---|---|---|---|
| Location | North Little Rock | Oklahoma City | Rapid City | Sioux Falls | Newport Beach |
| Year Opened | 2005 | 1999 | 1997 | 1985 | 2004 |
| Year Acquired by the Corporation | 2012 | 2005 | 2004 | 2004 | 2008 |
| Ownership Interest | 51.00% | 64.00% | 54.20% | 51.00% | 51.00% |
| Non-controlling Interest | 49.00% | 36.00% | 45.80% | 49.00% | 49.00% |
| Exchangeable Interest | 5.00% | 1.00% | 10.80% | 14.00% | - |
| Size (sq ft) | 126000 | 61000 | 86000 | 76000 | 7000 |
| Operating/Procedure Rooms | 13/2 | 7/2 | 11/1 | 15/1 | 2/1 |
| Overnight Rooms | 41 | 25 | 26 | 33 | - |

**Figure 2: Summary of MFC Facilities**

Non-controlling interests in the facilities are indirectly owned, primarily by physicians practicing at the facilities. Upon MFC's acquisition of indirect controlling interests in the SSHs located in Arkansas, Oklahoma, and South Dakota, the non-controlling interest shareholders were granted the right to exchange between 1.00% to 14.00% of the ownership interest in their respective facilities for common shares of the corporation. The liability associated with this derivative instrument is recorded on the consolidated balance sheet.

Figure 2 below provides a more comprehensive breakdown of the revenue contribution by facility.

| Revenue Contribution By Facility (In thousands of U.S. dollars) | Nine Months Ended September 30, | | | | % of revenue |
|---|---|---|---|---|---|
| | 2023 | 2022 | $ Change | % Change | (2023) |
| ASH | 66,623 | 56,240 | 10,383 | 18.46% | 20.61% |
| OSH | 58,461 | 56,319 | 2,142 | 3.80% | 18.08% |
| BHSH | 75,825 | 71,308 | 4,517 | 6.33% | 23.45% |
| SFSH | 103,537 | 96,963 | 6,574 | 6.78% | 32.02% |
| SCNC | 7,223 | 8,226 | (1,003) | -12.19% | 2.23% |
| MFC Nueterra ASCs | 11,648 | 18,234 | (6,586) | -36.12% | 3.60% |
| **Total revenue and other income** | **323,317** | **307,290** | **16,027** | **5.22%** | |

**Figure 3: Revenue Contribution by Facility FY2022 – FY2023 (9M)**

| Summary of Exited Assets as of Septmeber 30, 2023 | Date Exited | C.O.I (%) Prior to Sale | Sale Proceeds ($, mm) | Pre-tax Gain on Sale | Notes |
|---|---|---|---|---|---|
| Eastwind Surgical | 5/5/23 | N/A | - | - | Permanently Closed |
| Riverview Ambulatory Surgical Center | 6/30/23 | N/A | - | - | Permanently Closed |
| City Place Surgery & St. Luke's Surgery Center | 7/1/23 | 30.30% | 1.40 | 1.10 | Buyer Assumed debt of $5mm |
| Miracle Hills Surgery Center | 7/31/23 | 58.70% | 1 | 0.6 | - |
| Brookside Surgery Center | 8/25/23 | 49.60% | 1.1 | 0.8 | - |

**Figure 4: Summary of Exited MFC Facilities**

In addition, through a partnership with NueHealth LLC MFC used to own controlling interest in four ASCs located in Michigan, Missouri, Nebraska, and Pennsylvania. This has been part of a strategy to divest non-core assets that were not efficiently run and profitable. Figure 2 summarizes the assets that were divested during FY2023.

The SSHs perform scheduled surgical, imaging, diagnostic, and other procedures, including primary and urgent care, and derive their revenue from the fees charged for the use of their facilities. The ASCs specialize in outpatient surgical procedures, with patient stays of less than 24 hours, whereas SSHs are licensed for both inpatient and outpatient surgeries. The facilities mainly focus on limited clinical specialties, such as orthopedics, neurosurgery, pain management, and other non-emergency elective procedures. In addition to this, two of the SSHs provide urgent care services.

Payor Mix

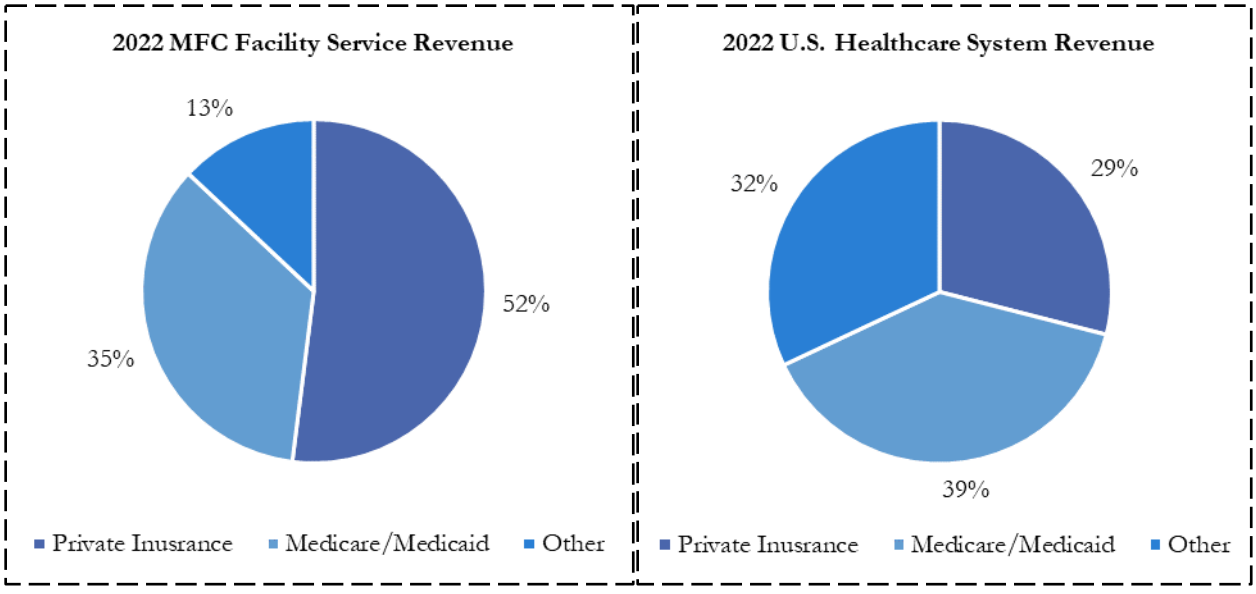


**Figure 5: MFC vs. US Healthcare System Payor Mix**

Payor mix is very important to consider and take into account when looking at the facilities that MFC owns. Structurally private insurance patients are higher margin patients for hospitals, so having a mix that skews towards private insurance patents is a favorable tailwind that would make MFC hospitals more attractive acquisition targets. I will dive more into this in a later update.

**What Went Wrong at MFC?**

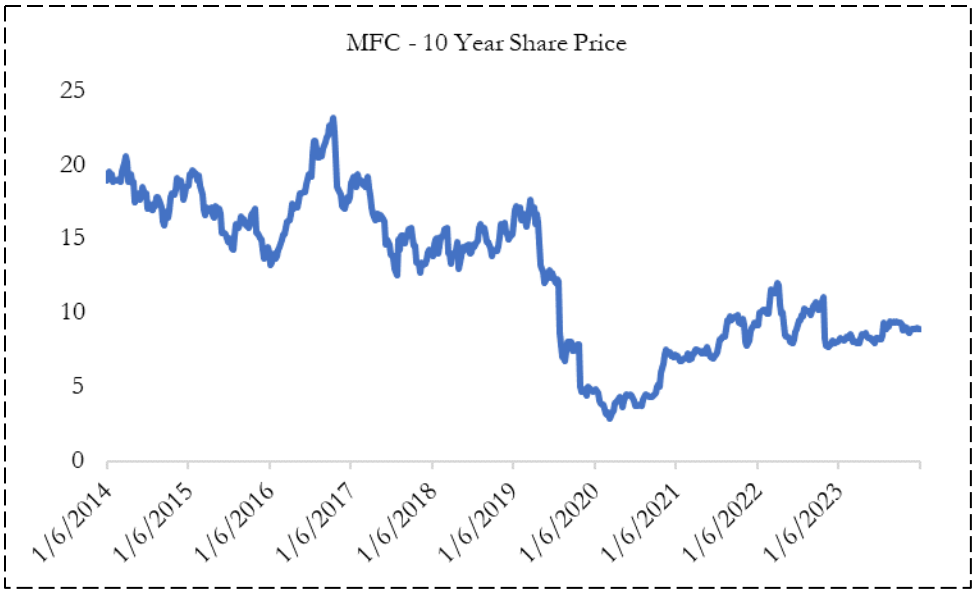


**Figure 6: MFC 10 Year Share Price**

To better understand MFC's lackluster performance over the last ten years, where the share price has slumped over 50%, it is very important to understand MFC's history to explain what has led to such immense value destruction for shareholders, in what has been otherwise a great time for equities and value creation.

MFC was listed on the 29th of March 2004. They did not do a vanilla equity issuance; rather, they issued income-participating (IPS) securities. So, when investors bought one IPS, they bought both one common share and a C$5.90 aggregate principal amount of 12.5% subordinated notes. Only in May of 2011 did MFC convert to the traditional common share structure from the original IPS structure.

MFC's historical strategy has been to use debt to fund acquisitions of both ASCs and SSHs. Everything was going relatively smoothly for the company until Q1 of 2019. This is where we start to see the first issues with their strategy.

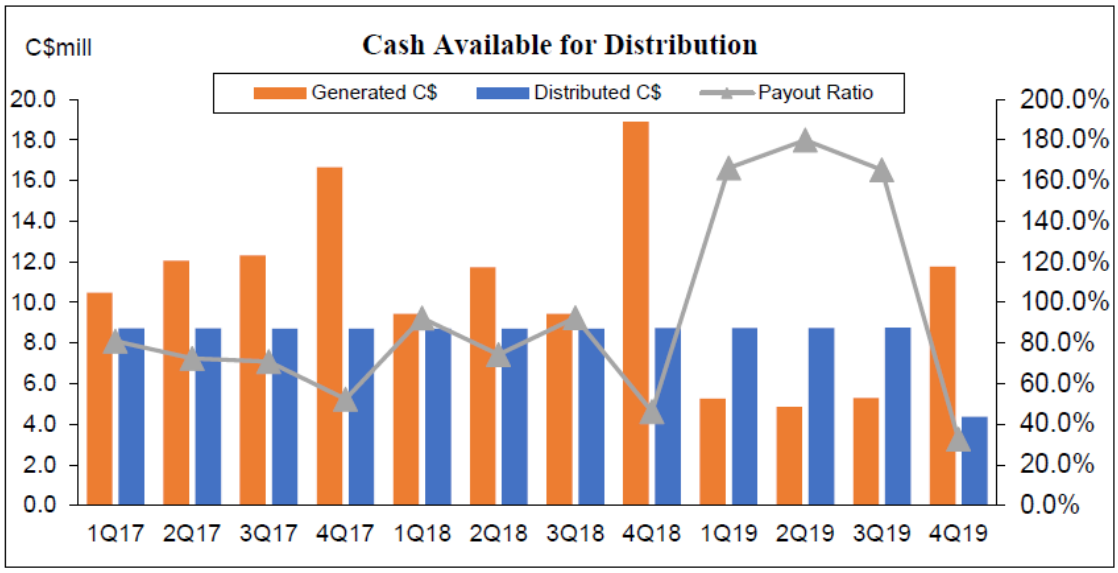


**Figure 7: MFC CAFD 1Q2017 – 4Q2019 from 2020 MDA**

*Also, in regard to the graph above, which shows 'CAFD.' This is a non-GAAP/non-IFRS measure, and I explain this more in my section on covering MFC's financials.*

This was brought up in MFC's Q1 2019 call, where management mentioned that income from operations was down 14.1mm from Q1 of 2018 to 10.2mm in Q1 of 2019. They associated the decrease with the lower EBITDA from a few facilities, but most notably from Unity Medical and Surgical Hospital (UMASH). They associated the lower EBITDA as being primarily a result of a payor mix with a higher proportion of governmental payors as well as an increased proportion of lower-acuity cases.

This also marked the first quarter, where MFC's cash available for distribution was less than the payout that they had made. This resulted in a payout ratio of 166.3% for 1Q2019 compared to 92.2% for 1Q2018. This can be seen in Figure 5. Management then went on to say that going back as far as 2013, the first quarter has typically been MFC's weakest quarter.

I also think it's worth highlighting some of the most poignant questions from the 1Q2019 Earnings Call that analysts asked, as it serves to provide a clearer picture of effectively what went wrong and how management was so blindsided by what was to come.

| | |
|---|---|
| **Question 1:** Regarding UMASH, is there any demographic or any other sort of structural changes in UMASH's markets that might explain the increase we saw in the government pay on the quarter. Also leading on from that as you look at the payor mix that we saw in the quarter, is that indicative of what we may see in coming quarters? | **Answer 1:** We saw overall volume growth at Unity. The issue is that we had a lower acuity of those surgeries. And what we see from fourth quarter to first quarter, we generally have a higher commercial payor mix in the fourth quarter of the year so that we typically see more governmental payors in the first quarter as a result of those compressions. |
| **Question 2:** Did what we see in the quarter in terms of lower-acuity cases is that indicative of what we might see in additional quarters? | **Answer 2:** Well, we think it's more of an anomaly when we are talking about a higher case mix. Higher level of acute surgeries, those take a while to source, to preauthorize through insurance and so forth. So we think there has been no trend, no demographic change, nothing that would indicate that it would be a continuing issue. |
| **Question 3:** Just from everything you have been talking about, it sounds like there's really nothing to be read into the activities, the payor mix, the case volume, that would necessarily reflect any kind of changes through the rest of this year or into next year from normal patterns. | **Answer 3:** I would think that's correct. There is nothing. We are not seeing anything in any of our markets that would show a change to just kind of the normal progression. So I think, the first quarter we have a lot more Medicare patients than we do in the fourth quarter, and that trend every year in US health care continues to kind of keep going that way. |
| **Question 4:** Are there going to be any changes in the position of the dividend going forward? | **Answer 4:** We have no plans to change the dividend. |

Something that I learned here is that government payors are structurally less profitable than privately insured payors. This is something that I will cover in more detail in a later update. The second thing is that inpatient cases are more profitable than outpatient cases, which does make sense rationally, given that one would expect having a patient stay overnight to be significantly more profitable than just having a treatment that does not require hospitalization. I will also cover this in greater detail in a later update.

Between Q1 and Q2 of 2019, MFC's CFO changed from Tyler Murphy to David Watson, and MFC's poor performance continued into 2Q2019. The issues mentioned in the 1Q2019 call continued, and management had no reasonable answers other than that they were disappointed.

By 3Q2019, Management realized that the monthly dividend that they had been paying out historically was no longer sustainable. So, in 3Q2019, it was announced that the dividend payment schedule had been changed from monthly to quarterly, at an annual rate of C$0.28 per share versus the prior annual rate of C$1.125 per share. Then CEO Robert Horrar

said, "The challenges we have been facing this year at Unity Medical and Surgical Hospital, or UMASH, continued to affect our results in the third quarter. We are disappointed in the results over the past few quarters, which has resulted in a payout ratio in excess of 100%."

Alongside this, MFC recorded a $22mm goodwill impairment charge related to the MFC Nueterra ASCs. The impairment charge was largely due to challenges at one of the larger ASCs in the group.

The dividend that was paid monthly was something that was core to MFC's shareholder base. Once the monthly dividend was gone, a lot of retail dividend investors left, meaning MFC had no natural shareholder base.

In 2020, MFC's financial situation was worsened by the COVID pandemic, which led to MFC's share price hitting a low of C$2.86. Alongside this, in February 2020, it was announced that MFC had sold the majority of its interest in UMASH, and its ownership interest decreased from 87.6% to 31.7%. MFC received $1.1mm in cash consideration for its equity interests. Furthermore, UMASH's debt obligation to MFC was reduced by $3mm, with the remaining $20mm being structured on a five-year term. MFC also announced that they would also be selling the real estate assets underlying UMASH, consisting of both land and buildings, for approximately $25mm.

**What has changed?**

Since the divestiture of UMASH, MFC has adopted a change in corporate strategy. This was announced in a press release that was shared on the 13th of September, 2022. They announced that they were in constructive discussions with Converium Capital, a shareholder of the company, and other shareholders to gather feedback on MFC's strategic direction.

As part of this change in corporate strategy, it was announced that the following would be done:

- MFC would suspend all acquisitions
- Divest all non-core assets
- Pursue overhead cost reductions
- Evaluate and implement strategies to return capital to its shareholders

As part of this change in strategy, MFC added Adina Storch and Yanick Blanchard as independent directors of the company, which replaced Stephen Dineley and Lois Cormack, who resigned from the board. Alongside changes in the board, Jason Redman was appointed as interim CEO and since has become the permanent CEO.

As was mentioned in the Business Overview section at the start of the report, MFC disposed of five of their ASCs throughout FY2023, which were all non-core assets.

MFC has also aggressively bought back its shares since September of 2022. MFC did this via a modified Dutch auction for up to $34.5mm that was announced alongside the change in corporate strategy.

| QoQ Change in DSO | | | | | | |
|---|---|---|---|---|---|---|
| | Q2 2022 | Q3 2022 | Q4 2022 | Q1 2023 | Q2 2023 | Q3 2023 |
| **DSO** | **30,196,779** | **29,554,010** | **29,366,985** | **25,702,096** | **25,345,146** | **25,066,567** |
| Nominal Change | | (642,769) | (187,025) | (3,664,889) | (356,950) | (278,579) |
| *%change YoY* | | *-2.13%* | *-0.63%* | *-12.48%* | *-1.39%* | *-1.10%* |

**Figure 8: MFC Common Shares Outstanding Table & YoY Change**

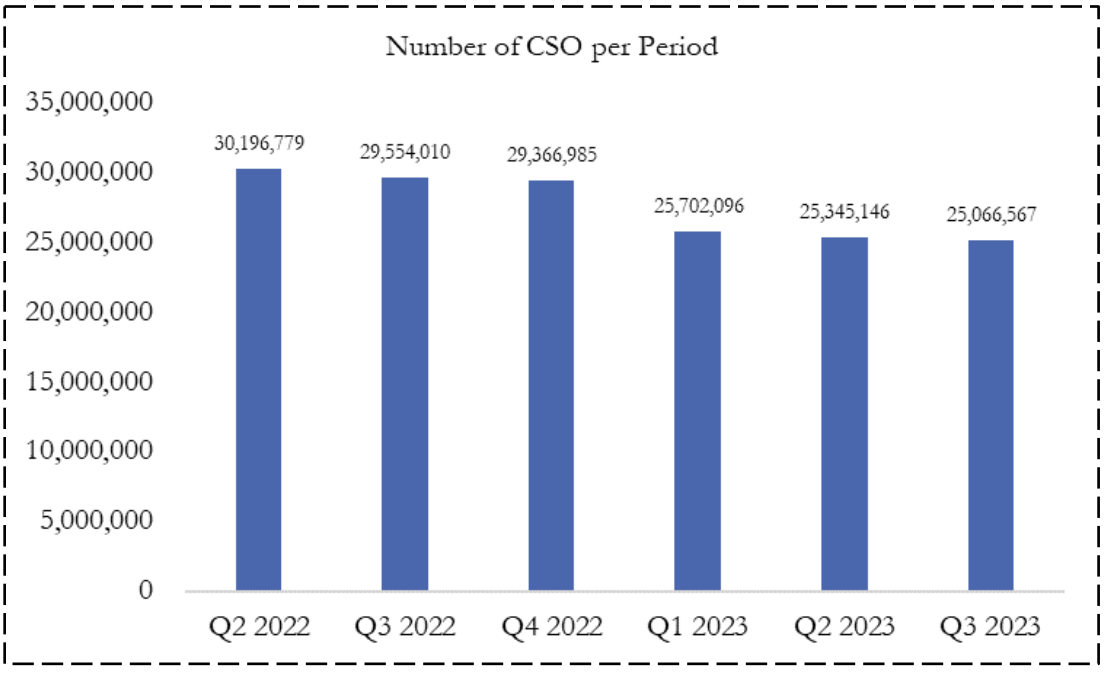


**Figure 9: MFC Common Shares Outstanding Per Period**

Since then, they have continued to buy back shares and pay off debt. During FY2023, $12mm of repayments were made against their corporate credit facility.

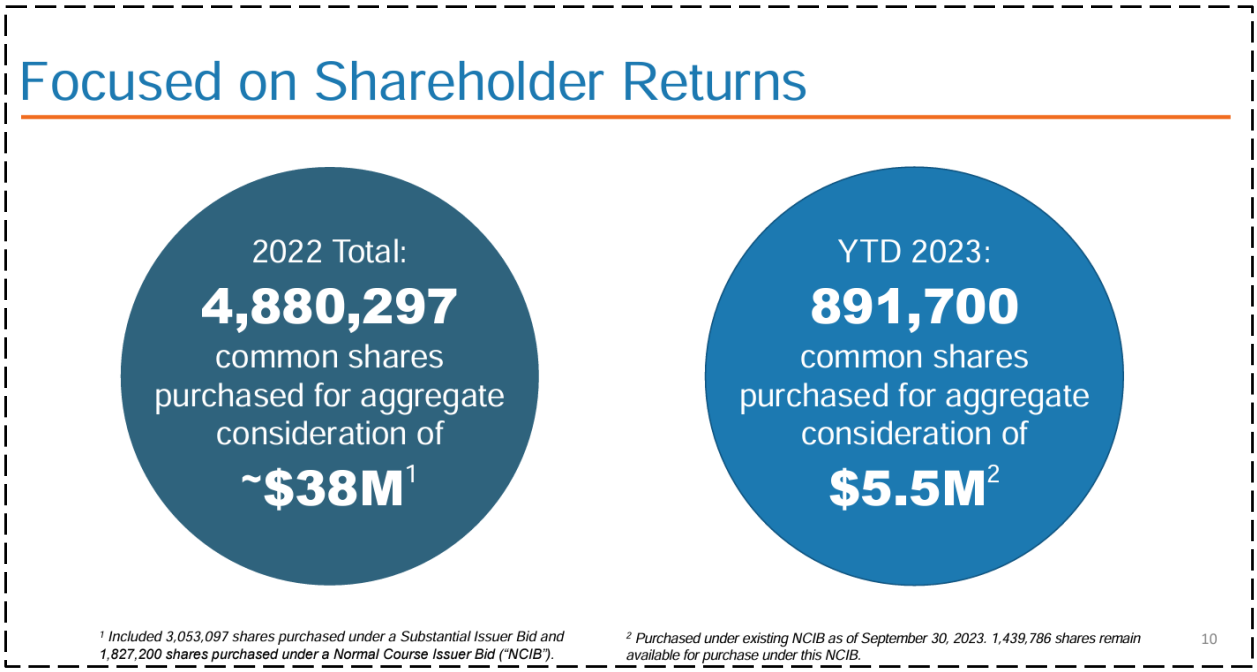


**Figure 10: MFC Investor Relations Presentation from December 2023**

It is also extremely important to focus on the reduction in corporate overheads at the MFC Canada level of the structure. Prior to Jason Redman having come on, corporate costs had been on an upward trajectory for a couple of years and had doubled from just under $6mm to over $12mm. On top of this, prior management had granted themselves significant stock options.

$12mm in corporate expenses is somewhat unacceptable, and it just looks like management was looking to line their pockets instead of having the shareholder's best interest at heart. Since Jason has come in as the CEO, management has made multiple decisions to help reduce corporate overheads. For example, last year, they replaced KPMG with Grant Thornton as their auditor, which brought significant cost savings. Management has guided that overall, their strategy of cutting overhead costs should increase the cashflows attributable to shareholders in the range of $5mm.

| Cash Available for Distribution<br>(In thousands of U.S. dollars) | 2022 | 2021 |
|---|---|---|
| Cash available for distribution at Facility level | 70,195 | 85,576 |
| Non-controlling interest in cash available for distribution at Facility level | (33,110) | (40,489) |
| **Corporation's share of cash available for distribution at Facility level** | **37,085** | **45,087** |
| Corporate expenses | (12,054) | (12,021) |
| *%of corporation's share of CAFH @ Facility level* | *32.50%* | *26.66%* |
| Interest on corporate credit facility | (789) | (568) |
| Recovers of (provision for) current income taxes | (3,082) | (2,623) |
| **Cash available for distribution** | **21,160** | **29,875** |

**Figure 11: Cash Available for Distribution: Corporate Expenses**

**Notes From Call with Converium Capital:**

*I really want to thank Michael for taking time out of his very busy schedule to chat. His thoughts on activism generally and also on MFC were very particularly insightful and helped me better frame the pitch.*

**What initially attracted you to MFC, and why did you initiate your position?**

- Got involved in the summer/fall of 2021
- Their view frankly was that:
    a) The company was really cheap, trading at sub 6x EBITDA. All the peers at the time were trading at 12, 13, 14, and 15x EBITDA
    b) At the same time, they had very little leverage, which was different from their peers
    c) Thought the management team had built up an overhead cost structure that was unnecessary
- It took them a year to make those changes, but in September of 2022, Converium replaced almost the full board, 4 out of 6 directors
- They also replaced the CEO and set out a strategy to:
    a) Cut down the overhead
    b) Sell off all the facilities
    c) Use the proceeds as if it were going to be a piecemeal sale and buyback stock
- Converium's view is that if MFC is trading at 5.5x EBITDA, and you can sell assets at 9, 10, 11x EBITDA, MFC should be doing that, and if MFC uses that to buy back shares, you end up with a lot more value on a per share basis
- That is long-term what's happening, except that the larger hospitals have not yet been sold
- Converium is hopeful that this is the year at least two of those get sold

**What tends to make an activism campaign successful? I went through some of your other past positions, such as Foxtons, and saw you had issued a letter to the Chairman recommending the sale of the company. That did not end up going through, but at MFC, obviously, your campaign worked. So, I just want to know what the key ingredients are that make an activist campaign successful.**

- They look for companies that are:
    a) Inexpensive
    b) Not very levered
    c) Have multiple paths where Converium can win
- Sometimes, there are structures in companies that don't really have a place in public markets
- If you look at Foxtons, it is a decent business, a very good brand name in the London market, with no leverage at all, and in an industry that has consolidated
- So, Converium felt the management team was bad. They felt there was a lot of upside to the performance organically. Converium thought they could win by just growing and building up their rental business/lettings business or by selling the whole company
- At the end of the day, they felt it was just logical for the company to be sold
- It was just today that Converium sent a letter to the board telling them that they are going to force the issue at the AGM if Foxtons doesn't put the company up for sale before then
- There, too, Converium participated with several other shareholders to change the board, and you can't have a controlling shareholding. They then issued that public letter, which resulted in the CEO getting fired and he got replaced with a new CEO who was far better
- That new CEO has done a lot of good things, including thinning the cost structure, growing the lettings book

**What has your experience with Jason Redman been like? What do you think of him? How exactly were you involved in his appointment?**

- Converium replaced 4 of the 7 directors, and then when the old CEO left, the board just dropped down to 6
- Michael has known Jason for a long time and is a great turnaround guy
- They also brought on Yanick Blanchard, who ran corporate banking for National Bank of Canada, so has a capital allocation background

- Michael Gisser ran Asia M&A for a large international law firm, so he has a legal, regulatory, and M&A background
- Adina Storch was also added, who is still the general counsel of a large industrial distribution business that is publicly listed, to sort of round it out
- Once Jason was on the board in May of 2022, he had experience, and he was a natural to slot into the CEO position

**How do you think about the competitive threats for the existing SSHs? For example, Sanford is opening up a new orthopedics segment.**

- This is always something that is brought up. Each market is different, but Converium does not see a significant amount of threat in either Oklahoma or Arkansas. Both these hospitals are fine, but they are not the greatest hospitals out there
- In South Dakota, those two hospitals do 65% of all orthopedic surgeries in the state, and they are owned by the doctors. So, the real competitive threat is one of two things. Either the doctors leave their equity on the table and go somewhere else, or Avera and Sanford build orthopedic hospitals and attract better doctors and use their referral networks to do that
- From anyone's perspective, you would not want to go to an okay doctor. I would want to go to the best doctor, which happens to be the Medical Facilities doctor, and so Converium thinks the competitive threat in those markets is a little lower than people perceive because no one is going to use a bad lawyer if you can use a good one
- No one will just go to a bad hip replacement guy if they can go to a good one
- SFSH is the number one orthopedic hospital in the US
- Yes, it is possible that someone adds competition. It is possible that some of the younger doctors, who don't own as much of the hospital, jump ship to a rival
- Converium doesn't think the number one orthopedic surgery hospital in the country is going to all of a sudden lose all of its business
- The way the partnership is structured, the doctors own half of the hospital. A doctor can leave the partnership and request their equity in the partnership back. No more than 6% of the equity can be paid out in any one-year
- The real risk is a rainmaker, a very good surgeon, decides to leave the partnership. But if that happens, there are two consequences
- The first is they can only get 6% out in a year, and if they own more than 6%, they are going to get that out in a subsequent year, which depends on the hospital continuing to perform in order to pay them out
- The second consequence if a rainmaker leaves is that all the doctors that are smaller and own 1-2% are going to leave as well. In which case, there is going to be no value to distribute to the guy who now owns 5, 10, or 15% of this hospital
- Each of the hospitals has 2 to 3 rainmakers that under the 50% own, those 2 or 3 guys own 25-30%. These doctors have to stay there. Converium sees it as sort of a prisoner's dilemma. They have to stay there in order for there to be value

**Also, it seems like a lot of variables that clearly drive the CAFD metric that management uses are somewhat unpredictable, like physician availability or case mix, other than the obvious seasonal trends. How did you think about these variables?**

- Converium does not focus on these drivers at all. Converium does not care about the case mixes. It is all irrelevant. If MFC can sell the assets, Converium can make a lot of money, and if MFC can't, Converium won't lose money, but it won't make a lot either
- Over time, more hip pain, etc., but they don't look at it
- The strategy is about selling all assets, and it just comes down to being able to do it

<u>My thoughts after the call:</u>
I thought it was reassuring to know that Converium is also aligned in disposing of assets and effectively winding up the business. Management is aligned to do this, and so are shareholders, given the financial incentives. Thus, creating a setup where there is the potential for us to win and achieve a substantial return within the next 18-24 months is possible. This left me with two very important questions to answer: 1) understanding what multiples the assets MFC holds transact at and 2) understanding business quality more to ensure I am happy owning these assets in case the sales do not come to fruition.

*I want to preface my discussion of MFC's finances by saying that I typically would not include such an in-depth financial overview in a write-up. Still, I think it is somewhat necessary given the complicated and opaque nature of MFC's financials, which hopefully is one of the reasons this opportunity exists today.*

| Income Statement (In thousands of U.S. dollars) | 9M 2023 | 2022 | 2021 |
|---|---|---|---|
| **Revenue and other income** | | | |
| Facility service revenue | 323,317 | 424,551 | 398,633 |
| Government stimulus income (costs) | - | (10,162) | 13,099 |
| | **323,317** | **414,389** | **411,732** |
| **Operating expenses** | | | |
| Salaries and benefits | 99,098 | 127,352 | 119,901 |
| Drugs and supplies | 109,441 | 143,925 | 130,027 |
| General and administrative expenses | 56,666 | 70,861 | 57,677 |
| Impairment of goodwill, other intangibles and equipment | - | 16,549 | - |
| Depreciation of property and equipment | 7,227 | 9,288 | 9,366 |
| Depreciation of right-of-use assets | 8,114 | 10,837 | 10,172 |
| Amortization of other intangibles | 1,172 | 638 | 7,231 |
| | **281,718** | **379,450** | **334,374** |
| **Income from operations** | **41,599** | **34,939** | **77,358** |
| **Finance costs** | | | |
| Change in value of exchangeable interest liability | 4,010 | (8,224) | 11,539 |
| Interest expense on exchangeable interest liability | 5,226 | 7,362 | 8,707 |
| Interest expense, net of interest income | 4,651 | 5,731 | 6,064 |
| Impairment loss on loan receivable | 786 | 11,990 | - |
| Loss on foreign currency | 42 | 3 | 34 |
| | **14,715** | **16,862** | **26,344** |
| Share of equity loss in associates | -2167 | 574 | 125 |
| **Income before income taxes** | **29,051** | **17,503** | **50,889** |
| Income tax expense | 5,363 | 5,208 | 4,396 |
| **Net income and comprehensive income for the period** | **23,688** | **12,295** | **46,493** |
| **Attributable to:** | | | |
| Owners of the Corporation | 7,621 | (4,405) | 15,500 |
| Non-controlling interest | 16,067 | 16,700 | 30,993 |
| | **23,688** | **12,295** | **46,493** |

**Figure 12: MFC Income Statement for FY2021 - FY2023**

**MFC Topline:**

Understanding MFC's financials is somewhat complicated because there are so many NCIs in their operating assets. But to better understand why this opportunity exists, understanding the financials of MFC is essential. The first thing to note is that even though MFC is listed in Canada, all their earnings are reported in US Dollars. Therefore, any financials used throughout this report will all be in US Dollars.

The third line item in Figure 12, 'Government Stimulus income (costs),' oscillates between positive in FY2020, then negative in FY2021, and completely disappears in FY2023. To clarify this, one must understand the litany of COVID-19 relief programs run by the government. The Coronavirus Aid, Relief and Economic Security (CARES) Act was signed into law on March 7th, 2020. The CARES Act included provisions for financial assistance to hospitals, surgery centers, and healthcare providers. These funds were made available via the Public Health and Social Services Emergency Fund (PHSSEF), the Paycheck Protection Program (PPP), and the Employee Retention Credit (ERC).

The PHSSEF was administered by the Department of Health and Human Services (HHS) to provide eligible healthcare providers with relief funds to cover non-reimbursable expenses, including lost revenue, attributable to COVID-19. Funds not utilized for eligible costs and not applied to lost revenues must be returned.

MFC recognized income for the loans received under the PPP during prior periods based on management's assumption that they had met the requirements for forgiveness. However, given the denial and additional review of certain loan forgiveness applications by the SBA in 2022, MFC management no longer had reasonable assurance of meeting the forgiveness requirements for loans of $12.34mm. This $12.34mm is made up of all PPP loan balances for facilities whose forgiveness applications have been denied or are under review. It is for that reason we see the reversal of $12.34mm from FY2022's revenue. Management is still trying to pursue loan forgiveness, and if this does occur in the future, there will be a recognition of income. All these expenses and income are one-time effects as a result of COVID-19, and thus, as Christian from Trident Opportunities suggests, it makes more sense to deduct the positive stimulus income from 2021, and the negative income from 2022 should be added back on top of revenues. This effectively smoothens out the revenue and somewhat adjusts for the impacts of COVID-19. Figure 4 below shows this.

| (In thousands of U.S. dollars) | Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2021 | 2020 |
| HHS | 1,434 | 9,724 | 11,514 |
| PPP | (12,335) | 1,479 | 12,226 |
| ERC | 608 | 192 | - |
| FFCRA | - | 52 | 1,288 |
| Other | 131 | 1,652 | 980 |
| **Government Stimulus Income (Costs)** | **(10,162)** | **13,099** | **26,008** |

**Figure 13: Government Stimulus Income Impact on I/S for FY2021 - FY2022**

| Revenues Without Adjustment (In thousands of U.S. dollars) | | | |
|---|---|---|---|
| | 9M 2023 | 2022 | 2021 |
| Facility service revenue | 323,317 | 424,551 | 398,633 |
| Government stimulus income (costs) | - | (10,162) | 13,099 |
| **Total Revenue** | **323,317** | **414,389** | **411,732** |
| *YoY Growth %* | | *0.65%* | |
| **Revenues With Adjustment (In thousands of U.S. dollars)** | | | |
| | 9M 2023 | 2022 | 2021 |
| Facility service revenue | 323,317 | 424,551 | 398,633 |
| Government stimulus income (costs) | - | 10,162 | (13,099) |
| **Total Revenue** | **323,317** | **434,713** | **385,534** |
| *YoY Growth %* | | *12.76%* | |

**Figure 14: Revenue With & Without Adjustments for FY2021 – 9M2023**

**MFC EBIT:**

Perhaps somewhat more concerning is that even though we see adjusted revenue growth of 12.76% there is a 54.8% decline in EBIT. This is shown below in Figure 5. The important thing to note here is that there was a one-time noncash expense in the 'Impairment of goodwill, other intangibles and equipment' line item, which was a $16.55mm drag on EBIT. MFC recorded an impairment loss in the MFC Nueterra ASCs cash-generating unit (CGU). These were the ASCs that were divested of in FY2023. While I am always weary of adjusting as management and investors too often classify otherwise recurring expenditures as one-time expenditures, I think here it is fair to make this adjustment. Thus, we can see below in Figure 5 that once we make this adjustment, the actual decline in EBIT improves from 54.5% to only 4%. While a 4% decline in EBIT is not great, it is significantly better than a 54.8% decline. Furthermore, I think there is a strong case to be made that the decline in EBIT is due to transitory issues, which I do not believe will last.

| EBIT | | | |
|---|---|---|---|
| | 9M 2023 | 2022 | 2021 |
| Facility service revenue | 323,317 | 424,551 | 398,633 |
| Government stimulus income (costs) | - | (10,162) | 13,099 |
| **Total Revenue** | **323,317** | **414,389** | **411,732** |
| | | | |
| **EBIT** | **41,599** | **34,939** | **77,358** |
| *YoY Growth %* | | *-54.83%* | |
| Adjusted EBIT | | | |
| | 9M 2023 | 2022 | 2021 |
| Facility service revenue | 323,317 | 424,551 | 398,633 |
| Government stimulus income (costs) | - | 10,162 | (13,099) |
| **Total Revenue** | **323,317** | **434,713** | **385,534** |
| | | | |
| **EBIT** | **41,599** | **45,101** | **64,259** |
| + Impairment of goodwill, other intangibles and equipment | | 16,549 | |
| **Adjusted EBIT** | **41,599** | **61,650** | **64,259** |
| *YoY Growth %* | | *-4.06%* | |

**Figure 15: Adjusted EBIT for FY2021 – 9M2023**

**Exchangeable Interest Liability:**

On the income statement, we see that in the 'Finance costs' segment, there is this change in the value of exchangeable interest liability, which crops up somewhat randomly, either having a positive or negative impact on MFC's bottom line. There is also the line item underneath, which is the interest expense on exchangeable interest liability. Both of these are shown in the figure below.

| | 9M 2023 | 2022 | 2021 |
|---|---|---|---|
| **Finance costs** | | | |
| Change in value of exchangeable interest liability | 4,010 | (8,224) | 11,539 |
| Interest expense on exchangeable interest liability | 5,226 | 7,362 | 8,707 |
| Interest expense, net of interest income | 4,651 | 5,731 | 6,064 |
| Impairment loss on loan receivable | 786 | 11,990 | - |
| Loss on foreign currency | 42 | 3 | 34 |
| | **14,715** | **16,862** | **26,344** |

**Figure 16: Finance Costs on MFC Income Statement**

As a result of MFC's acquisition of its interests in ASH, BHSH, SFSH, and OSH, MFC entered into exchange agreements with the owners who originally retained a 49% non-controlling interest in these facilities. The terms that MFC agreed to allow the non-controlling interest holders in each of these facilities the right to exchange a portion of their interest in their respective facilities for common shares of MFC. The outstanding exchangeable interest for each facility is detailed below.

| Summary of Facility Information as of September 30, 2023 | Arkansas Surgical Hospital (ASH) | Oklahoma Spine Hospital (OSH) | Black Hills Surgical Hospital (BHSH) | Sioux Falls Specialty Hospital (SFSH) | Surgery Center of Newport Coast (SCNC) |
|---|---|---|---|---|---|
| Exchangeable Interest | 5.00% | 1.00% | 10.80% | 14.00% | - |

**Figure 17: Exchangeable Interest by Facility**

The exchangeable interests are subject to certain limitations, such as the exchange can only take place quarterly, and the NCIs are not allowed to exchange more than 3% per quarter. The exchangeable interest liability is carried at fair value and is determined at each reporting date by multiplying the closing share price by the total number of common shares issuable under the exchangeable interest. The distributions that each facility makes in excess of what the company does not own but would own if the interest exchange was effective are recorded as interest expense. These distributions that each facility makes are treated as interest expenses but are fundamentally non-cash expenses.

| EIL Maths (In thousands of U.S. dollars) | September 30, 2023 | June 30, 2023 | Change |
|---|---|---|---|
| Shares to be issued for EIL | 5,937,372 | 6,082,735 | (145,363) |
| MFC's closing share price | CAD 9.46 | CAD 8.29 | CAD 1.17 |
| Closing USD/CAD exchange rate | $1.3579 | $1.3247 | $0.0332 |
| **Exchangeable Interest Liability** | **41,364** | **38,066** | **3,298** |

**Figure 18: Change in Value of EIL Exemplified**

The figure above demonstrates the change in the value of the exchangeable interest liability. If MFC's share price increases in any given period, then the EIL on MFC's balance sheet increases and thus has a negative impact on MFC's bottom line, but given that it is a non-cash expense, it is added back in the cash-flow statement under finance income.

**Hospital Quality:**

*Also, I want to preface this section by saying that the research on the quality of the hospitals will be improved once I do site visits for the two hospitals in SD.*

Black Hills Surgical Hospital

Year after year, BHSH has consistently ranked among the top 1% of hospitals in the nation for providing quality care and service out of nearly 5,000 hospitals.

| Medical Excellence 2021-2022 (CareChex by Quantros) | | |
|---|---|---|
| **#1 in State** | **#1 in Market** | **Top 100 in Nation** |
| Overall Hospital Care | Overall Hospital Care | Overall Hospital Care |
| Overall Surgical Care | Overall Surgical Care | Overall Surgical Care |
| Joint Replacement | General Surgery | Joint Replacement |
| Neurological Care | Joint Replacement | Major Orthopedic Surgery |
| Major Orthopedic Surgery | Neurological Care | Spinal Fusion |
| | Major Orthopedic Surgery | Spinal Surgery |

**Figure 20: CareChex Medical Excellence Ranking 2021-2022**

| Patient Safety 2021-2022 (CareChex by Quantros) | | |
|---|---|---|
| **#1 in State** | **#1 in Market** | **Top 100 in Nation** |
| Overall Hospital Care | Overall Hospital Care | Overall Hospital Care |
| Overall Surgical Care | Overall Surgical Care | Overall Surgical Care |
| Joint Replacement | Joint Replacement | Joint Replacement |
| Major Orthopedic Surgery | Neurological Care | Major Orthopedic Surgery |
| | Major Orthopedic Surgery | |

**Figure 21: CareChex Patient Safety Ranking 2021-2022**

BHSH also won the award from CareChex for the best hospital overall in South Dakota in 2022.

BHSH has also received numerous awards from Healthgrades, which is another site that ranks hospitals. Based on their surveys, they have found that 93% of patients would recommend BHSH, which is 23% higher than the national average. From 2017 through 2019, patients treated in hospitals receiving the America's 100 Best Hospitals for Joint Replacement Award have, an average, a 64.5 percent lower risk of experiencing a complication while in the hospital than if they were treated in hospitals that did not receive the award. Additionally, patients treated at hospitals that did not receive the award were 2.82 times more likely to experience a complication in the hospital than if they were treated at hospitals that received the award.


**Figure 22: Healthgrades Awards for BHSH**

BHSH was also ranked among the top 10 hospitals in the nation for orthopedic and spine care based on HCAHPS patient survey data. HCAHPS is the Hospital Consumer Assessment of Healthcare Providers and Systems. HCAHPS is the first national, standardized, publicly reported survey of patients' perspectives of hospital care that is administered by the government. These results are available for patients to check at http://www.medicare.gov/care-compare. And are frequently checked.


**Figure 23: HCAHPS Survey Results for BHSH**

I also think that Google Reviews are worth looking at, given that these would probably be some of the first things that customers look at when considering a hospital.

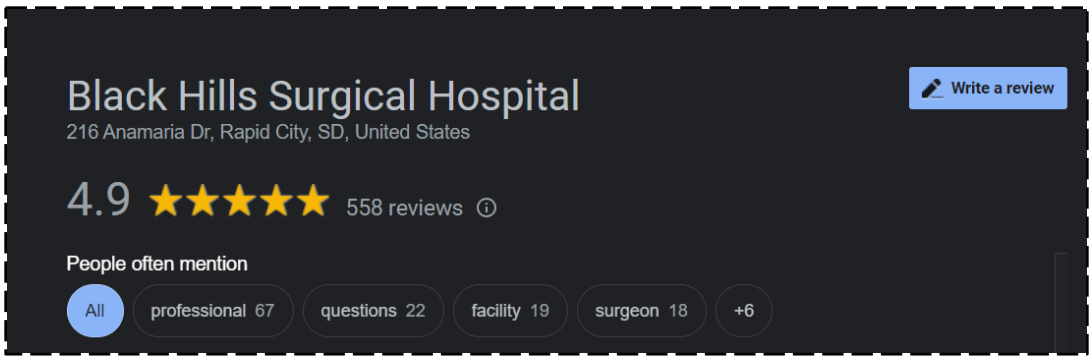


**Figure 24: Google Reviews of BHSH**

*For all the following hospitals, I will include the same metrics as BHSH but will not give as detailed an explanation because I don't think it is actually needed. It is just important to get across the message that these hospitals are great hospitals and only reaffirm what Michael at Converium was telling me.*

Sioux Falls Specialty Hospital


**Figure 25: Healthgrades Awards for SFSH**


**Figure 26: HCAHPS Survey Results for SFSH**

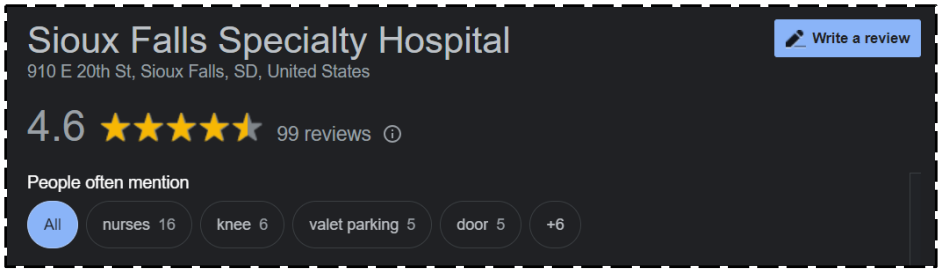


**Figure 27: Google Reviews of SFSH**

Arkansas Surgical Hospital


**Figure 28: Healthgrades Awards for ASH**

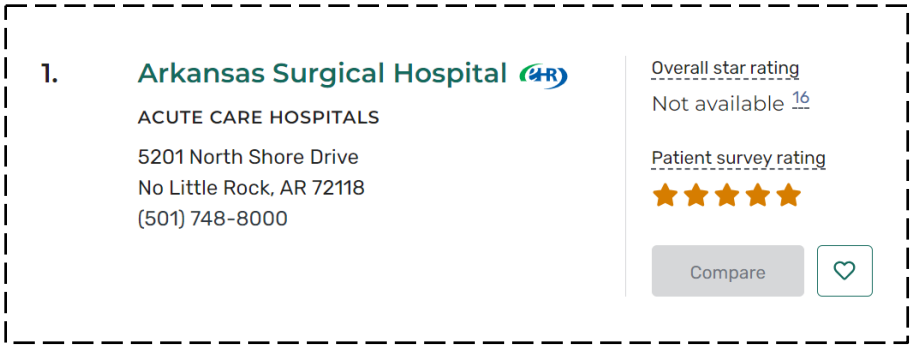


**Figure 29: HCAHPS Survey Results for ASH**

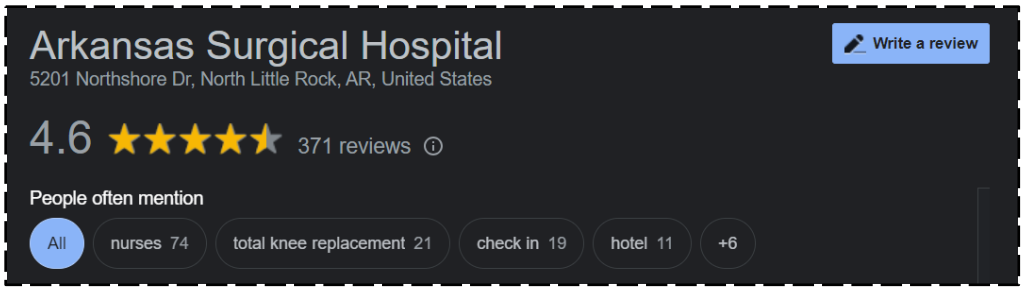


**Figure 30: Google Reviews of ASH**

Oklahoma Spine Hospital

Of all the specialty surgical hospitals that MFC owns, I think that the lowest quality one is the Oklahoma Spine Hospital.

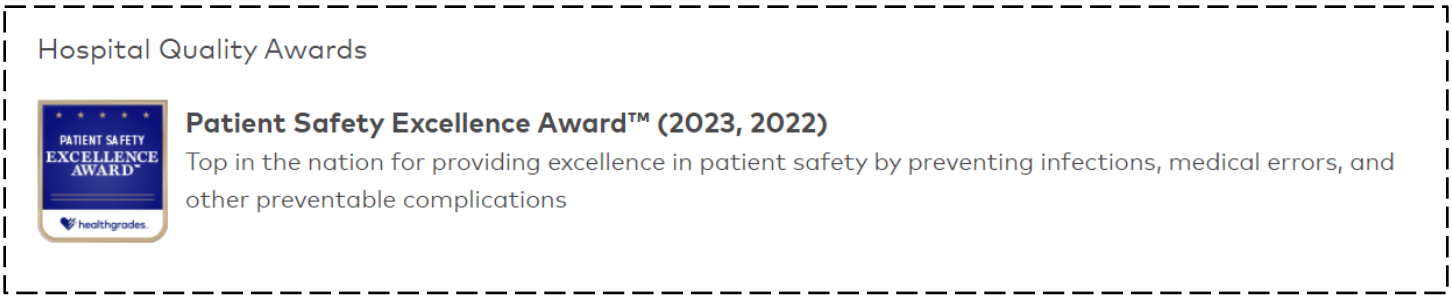


**Figure 31: Healthgrades Awards for OSH**


**Figure 32: HCAHPS Survey Results for OSH**

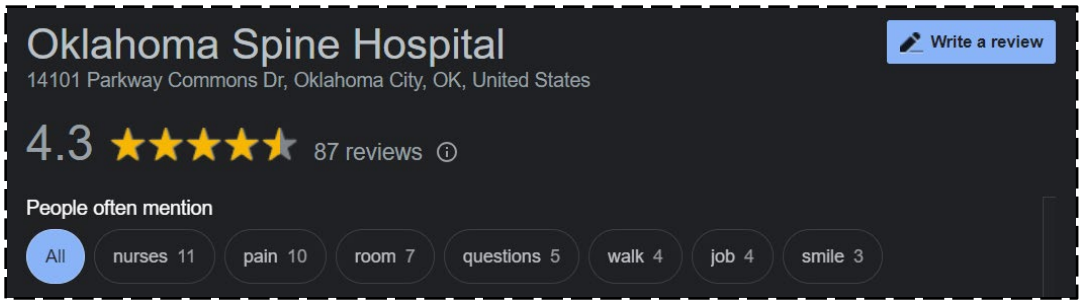


**Figure 33: Google Reviews of OSH**

## Quick & Dirty Valuation:

This valuation is by no means comprehensive. It is just to give a brief idea of how undervalued I think MFC is today. I feel like the more time I have spent investing, the less useful I have realized complex DCFs and operating builds are. I will in a future post (after my visit to South Dakota and Oklahoma), I will update this model to make it more comprehensive, but for the time being, I think this does the job.

| Operating Build | 21A | 22A | 23E | 24E | 25E | 26E | 27E | 28E |
|---|---|---|---|---|---|---|---|---|
| Facility Service Revenue | 398,633.0 | 424,551.0 | 445,778.55 | 459,151.91 | 472,926.46 | 487,114.26 | 501,727.69 | 516,779.52 |
| *%growth YoY* | | *6.50%* | *5.00%* | *3.00%* | *3.00%* | *3.00%* | *3.00%* | *3.00%* |
| Government Stimulus Income | 13,099.0 | (10,162.0) | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Revenue** | **411,732.0** | **414,389.1** | **445,778.6** | **459,151.9** | **472,926.5** | **487,114.3** | **501,727.7** | **516,779.5** |
| | | | | | | | | |
| **EBIT** | **77,358.0** | **34,939.0** | **66,866.8** | **75,760.1** | **78,032.9** | **80,373.9** | **82,785.1** | **85,268.6** |
| *%operating margin* | *19.41%* | *8.23%* | *15.00%* | *16.50%* | *16.50%* | *16.50%* | *16.50%* | *16.50%* |

| DCF | 21A | 22A | 23E | 24E | 25E | 26E | 27E | 28E |
|---|---|---|---|---|---|---|---|---|
| Period | | | | 1 | 2 | 3 | 4 | 5 |
| **EBIT** | **77,358.0** | **34,939.0** | **66,866.8** | **77,047.3** | **80,707.0** | **84,540.6** | **88,556.3** | **92,762.7** |
| Tax Rate | 20% | 20% | 20% | 20% | 20% | 20% | 20% | 20% |
| **EBIAT** | **61,886.40** | **27,951.20** | **53,493.43** | **60,608.06** | **62,426.30** | **64,299.09** | **66,228.06** | **68,214.90** |
| | | | | | | | | |
| D&A | | | | 9,500.00 | 9,500.00 | 9,500.00 | 9,500.00 | 9,500.00 |
| Change in Net Working Capital | | | | 350.00 | 344.36 | 354.69 | 365.34 | 376.30 |
| *%of Sales* | | | | *2.50%* | *2.50%* | *2.50%* | *2.50%* | *2.50%* |
| CAPEX | | | | 8,500.00 | 8,500.00 | 8,500.00 | 8,500.00 | 8,500.00 |
| Minority Interest Deduction | | | | 21,440.32 | 22,078.68 | 22,730.54 | 23,401.95 | 24,093.51 |
| | | | | | | | | |
| **Unlevered Free Cash Flows** | | | | **39,817.74** | **41,003.26** | **42,213.85** | **43,460.77** | **44,745.09** |
| Discount Rate | | | | 9.50% | 9.50% | 9.50% | 9.50% | 9.50% |
| PV of FCF | | | | 36,363.23 | 34,197.17 | 32,152.34 | 30,230.19 | 28,423.32 |
| **PV of Stage 1** | **161,366.25** | | | | | | | |

| EV to EQ Bridge | |
|---|---|
| Final-Year FCF | 44,745.09 |
| Exit Multiple | 8x |
| Terminal Value | 357,960.74 |
| **PV of TV** | **227,386.57** |
| | |
| Enterprise Value | 388,752.82 |
| less Debt | 52,603.00 |
| plus Cash & Cash Equivalents | 26,979.00 |
| Equity Value | 363,128.82 |
| DSO | 25,066,567.00 |
| | |
| Equity Value per Share (USD) | 14.49 |
| **Equity Value per Share (CAD)** | **19.56** |
| **Upside** | **112.81%** |

| Assumptions for DCF | |
|---|---|
| Discount Rate | 9.50% |
| Share Price | 9.19 |
| DSO | 25,066,567 |

**Risks:**

Limits on the Expansion of Physician-Owned Hospitals:
Section 6001(a)(3) of the Affordable Care Act amended the rural provider exception and the whole hospital exception to provide that a hospital with physician ownership or investment may not increase the number of operating rooms, procedure rooms, and beds beyond that for which the hospital was licensed on March 23, 2010. However, in certain cases, the Secretary may grant an exception from the prohibition on facility expansion if a hospital with physician ownership qualifies as an applicable hospital or high Medicaid facility.

To qualify as an applicable hospital, the hospital must meet the following criteria:

- Located in a county in which the percentage increase in the population during the most recent 5-year period is at least 150% of the percentage increase in the population growth of the State in which the hospital is located
- Annual percent of total inpatient admissions under Medicaid is equal to or greater than the average percent with respect to such admissions for all hospitals in the county in which the hospital is located
- Does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries
- Located in a state in which the average bed capacity in the state is less than the national average bed capacity
- Has an average bed occupancy rate that is greater than the average bed occupancy rate in the state in which the hospital is located

To qualify as a high Medicaid facility, the hospital must meet the following criteria:

- Not the sole hospital in a county
- For the last twelve months, has an annual percent of total inpatient admissions under Medicaid that is estimated to be greater than such percent with respect to such admissions for any other hospital in the country in which the hospital is located
- Does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries

In the case of MFC, I do not see this to be a major risk or threat given that all of MFC's hospitals only operate during the weekdays during business hours. It is hard to see full utilization rates of beds at MFC's hospitals, given that this is something that they do not break out. I hope I can get more clarity on this specifically when I speak to management. Otherwise, just based on what management has mentioned on earnings calls where they discuss a decline in revenue at a particular facility due to physician ability, it also reaffirms the view that there is likely no constraint of supply of beds; rather, currently, MFC is not utilizing their facilities to their full capacity. Any acquirer would also see this.

Conflicts of Interest in Physician-Owned Hospitals:
Also, generally, physician-owned hospitals tend to be associated with significant conflicts of interest. This is because physicians self-refer their patients to facilities and services they own.

The Government Accountability Office & Medicare Payment Advisory Commission have shown that physician-owned hospitals tend to:

- Cherry-pick patients by avoiding the less profitable Medicaid and insured patients
- Treat fewer medical complex patients
- Provide fewer emergency services and often rely on publicly funded 911 services and acute care, community hospitals for these services for their own patients

I think there is generally a split view on this in Congress. Many members of Congress are proposing to weaken Medicare's prohibition on physician self-referral to new physician-owned hospitals and loosen restrictions on the growth of grandfathered hospitals.

Competitive Threats:
This is something that is consistently brought up and asked by a bank analyst on almost every single earnings call. It was most recently, during the Q3 earnings call, that Sahil Dhingra brought up if there was any increase in competition. While I think this is probably true, I think the main thing to keep in mind is that MFC's facilities are all top-of-the-line, as shown both by independent assessment agencies and the HCAHPS survey. Also, given the demographic tailwinds, there is more likely than not to be a shortage of orthopedic and spinal surgery than a lack of demand. I will also provide more on this in my second update.

Weakening of M&A Environment:
I will look more into this for the second update.

**Catalysts:**

Continued Accretive Purchases of Shares at Current Prices:
The current buybacks that management is pursuing are extremely accretive to today's equity holders.

**Further Research For 2nd Update:**

- Talk to management, either Jason or David
- Have visited South Dakota: BHSH and SFSH, Oklahoma: OSH
- Better understanding of the acquisition landscape, who are the key players, and what are things players like Surgery Partners are looking for in acquisition targets. Talk to their IR and also better understand their strategy.
- I also want to understand competitive dynamics better. Not yet sure who the best person to talk about this would be.

**Appendix:**

**Exhibit 1: Definitions**
In-Patient: If you go to a hospital for an overnight stay, you're an inpatient.
Out-Patient: A consultation or treatment does not require hospital admission. This could be check-ups or aftercare following treatment.

**Exhibit 2: VIC Link**

- https://valueinvestorsclub.com/idea/MEDICAL_FACILITIES_CORP/4207429070

**Exhibit 3: MFC Investor Relations Website**

- https://www.medicalfacilitiescorp.ca/

**Exhibit 4: MFC Substack/Fund Letter Links**

- https://ausram.substack.com/p/medical-facilities-corp
- https://www.greystonevalue.com/_files/ugd/47fd79_ffc6d148e7b74658b2eb702a7e2d5047.pdf
- https://drive.google.com/file/d/1ayHB7SqEpJ7Dwqhws1JpoBU3QNp-52Ra/view
- https://tridentopportunities.com/en/medical-facilities-corp-share-non-cyclical-share-at/