HealthSouth Corporation

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ED: Good to see such a nice turnout. Thank you all for being here. As I said to the first session, thank you for making it through to the last day, and now, at least, the last health care presentation.

We're very happy to have HealthSouth. We have a good contingent from the company. Doug Coltharp is Chief Financial Officer, Ed Fay, Treasurer, and also in the audience is Crissy Carlisle, so thank you all for making the commitment to travel and be with us.

DOUG COLTHARP: Thank you and good morning, everybody. Thanks for your turnout earlier this morning, overcoming the temptations of the Miami nightlife and the Super Tuesday hangover. It's great to see such a full crowd this morning.

We'll start with a brief overview of HealthSouth for those of you who might not be as familiar with our business, and then I'm going to go through some of the strategic accomplishments we had during 2015. It was a big year for us, strategically. We completed, over the span of 12 months, three acquisitions with a value of about $1.6 billion.

Then I want to set the stage for 2016, talk a little bit about our corporate strategic priorities in 2016. I'll remind you of the guidance that we issued last week, and then talk about some of the decisions we'll be making regarding the allocation of free cash flow to an array of the alternatives that are available to us.

To begin with, HealthSouth is a leading provider of post-acute services in the US, and we do so operating in two of the post-acute sectors -- inpatient rehabilitation facilities, and home health. The acronym for inpatient rehabilitation facilities is IRFs. That is embedded in my mind, so as much as I might try to avoid the use of any kind of jargon, I'm going to say IRFs frequently, and when I do, that again is shorthand for the inpatient rehab business.

We have the largest, and our core business, the business segment that we operated in prior to 16 months ago is the IRF business, and there, we enjoyed the leading market share in the US. We have about 20 percent of all of the inpatient rehab beds that are operated in the US, and we serve a similar percentage of the Medicare patients.

As many of you know, the inpatient rehab business is predominantly focused on the Medicare

beneficiary population, and that is due to the CMS regulations that govern patient criteria for admission into that sector.

There are two types of IRFs in the US. There are free-standing hospitals, and there are designated units within an acute care hospital. We operate solely in the free-standing hospital business.

There are roughly 250 or so freestanding hospitals in the US, inclusive of Puerto Rico, and we operate 121 of those. We believe that the next largest aggregation in any single competitor is less than 20, so below us it becomes a highly fragmented business. The bulk of the units in the United States are those that are housed within an acute care hospital, there are probably about 950 of those.

They tend to be much smaller than the freestanding hospitals, on average probably closer to 20 beds, and in a freestanding hospital about 60, and generally you see this show up in the MedPAC reports frequently, they operate less efficiently as a result. Our hospitals span 29 states and about a third of our hospitals are operated in a JV partnership with a local acute care partner.

We do that because by virtue of the definition of being in post-acute, about 95 percent of the patients who get admitted into one of our hospitals come to us from an acute care hospital, and we find that it is very beneficial to have that kind of collaborative relationship with a local acute care partner.

Again, about a third of our hospitals are in those types of joint venture relationships. That's the strategy that we had embarked upon beginning more than two decades ago.

We think it is particularly on point as we continue the progression towards more integrated care delivery and payment models. About 16 months ago we entered into a second post-acute business segment, and that is home health. We did that via the acquisition of Encompass Home Health and Hospice, I'm going to talk more about that acquisition in just a moment.

As of the end of the year, Encompass had about 180 locations for adult home health and part of our strategy, and again I'll cover this more in just a few moments, is to create overlap between our IRF markets and home health. As of the end of the year, we had an Encompass Home Health location in about 60 percent of the markets in which we operate a HealthSouth IRF.

I mentioned about 16 months ago we moved into a second business segment, home health, and we did that in order to position ourselves more favorably for the advent of integrated care, and integrated payment delivery models. About 55 percent of the patients who are discharged from a HealthSouth IRF ultimately require home health services.

If you think about it, that's off of a base of about 150,000 discharges, and again just a brief set back for those who are not familiar with the IRF business, we measure our volume by patients discharged, versus patients admitted. We had about 150,000 discharges in 2015 and about 55 percent of those require some level of home health following the exit from our hospital.

Prior to 2015, we were capturing only a very small percentage of that. We were doing so with 25 hospital-based home health agencies.

When I say hospital-based, they were HealthSouth home health agencies, they were based in 25 of our IRFs and they were trying to capture a portion of those discharges. But it really wasn't a big focus for us, the business was doing less than $25 million in annual revenue, and about $4 million in EBITDA, so it was almost kind of an afterthought. We wanted to be able to provide a continuum of care for that portion of our patients that are exiting the IRF.

We thought that that would position us to provide higher quality outcomes and to do things like reduce hospital readmissions for those patients and also felt that we could apply the same level of cost effectiveness across that longer continuum of care that was evident in our IRF business and then as we acquired Encompass was also evident in their business. Encompass had a reputation for being the highest quality, most cost-effective home health company out there.

It was started by a woman and continues to be run by a woman named April Anthony, who's a very impressive operator. It was owned by the private equity firm Cressey, what we saw in the Encompass business, and this is a business that we had monitored closely and had spent time getting to know April and her team over about a four year period prior to acquisition, is that they had the same commitment to patient quality and cost effectiveness that we had in our RF business.

They had the same commitment to technology-enabled business processes that was a hallmark of our IRF business, and we felt that the team and the infrastructure were highly scalable and that was important to us because as I mentioned at the outset, part of our strategy in entering this business was to expand the home health footprint across to all of our IRF markets so that continuum can be provided in every market in which we operate.

We acquired the Encompass business at the beginning of the year. We were able to put to test the concept that the team was scalable on November 2nd we acquired a second home health business, a company called CareSouth, that was about $175 million acquisition that gave us 44 incremental locations, about 35 of those were in CON states, which is important, because that speaks to the scarcity value associated with this property. It gave us about 14 incremental overlap markets with the HealthSouth IRFs.

Importantly, CareSouth already operated on the Homecare Hombase IT platform. That platform is utilized by more than 50 percent of the home health agencies in the US. That platform was designed by April Anthony, the CEO of Encompass, ultimately it has been spun off into a separate company and that was sold to the Hearst Corporation, but obviously it's a system that April knows very well, and because the Encompass runs on that platform it's making the integration substantially easier.

Through the course of the year we also had an opportunity to continue to grow our home health presence to what I'll call the regular weight development activities. The home health business is highly fragmented, and I mentioned to some of you at dinner last night, this data may be a little bit stale, but there are approximately 12,500 home health agencies in the US, and about 95 percent of them have less than $5 million in annual revenue.

We have a strategy of going out there and acquiring these one-off businesses that don't have a large ticket price, in many instances you're really just buying a license in a particular market, and then we quickly convert those over to the Encompass platform and we're now prioritizing that pipeline so that we're picking up incremental markets where we have a HealthSouth IRF.

We were able to open on a de novo basis for additional locations through the course of 2015, and then also to acquire 10 other locations through the course of the year. Then we took those legacy home health agencies that were housed in the HealthSouth hospitals that I mentioned previously, and we integrated 23 of those over to the home health platform, so it was a big year for us in home health.

It's also a big year for us in the IRF space.

We were able to grow the total number of beds that we operate by 18 percent, and we were able to grow the number of hospitals that we operate by 13 percent further solidifying our position as the leading player in the IRF market. We did this in two ways, one is we had two significant acquisitions in the IRF space that occurred in 2015.

The first was we acquired 158 bed, and that's large, remember I mentioned to you at the outset, if you look at the units within an acute care facility is typically about 20 beds, freestanding closer to 60 beds, this was a 158-bed hospital located in Lexington, Kentucky. It had an array of other services that were running through there as well.

Interestingly enough, it is the only IRF in the statistical market area for Lexington, which is a great market. We were able to pick up this facility. It does require some repositioning. That repositioning is going very well. We operate a combination of both IRF beds and some SNF beds. Not our typical operating model, but one that we think accommodates this market. That's going to be a

very successful part of our franchise on a go-forward basis.

I also mentioned to you in the opening remarks that there is a high disaggregation factor in the IRF sector once you move beyond our portfolio of free-standing hospitals, and so there's a scarcity value that's assigned to any portfolios of free-standing IRFs that might become available.

There was a company called Reliant Hospital Partners. Again, it had a private equity sponsor. It was a set of assets that we had been monitoring for a long period of time. The sponsor elected to monetize that business in 2015, and we were a natural buyer.

We acquired Reliant Hospital Partners in a transaction that closed on October 1st. It was about a $730 million deal, and it gave us 11 new hospitals, 8 of those in the Texas market, where we already have a very large market share, giving us the opportunity to rationalize our position in markets like Houston in Texas, and expand in some ancillary markets -- a couple of locations in Massachusetts, and then one in Ohio as well.

Along with that, we also continued our regular-weight development activity in the IRF sector. I mentioned our joint venture strategy to you previously. We made progress on seven incremental joint ventures, including some exciting new locations, and then we were able to add approximately 85 new beds. I guess not approximately -- 85 new beds through bed expansions, which is where we actually add capacity to an existing hospital.

That, by the way, is a phenomenal use of capital, because you're adding onto an existing infrastructure, so you're leveraging that infrastructure, and you're adding that capacity into a market where you know the demand already exists, and where you're already well established.

Why do we think it's the right strategy to keep investing in the IRFs, and now to invest in home health? There are two things that I would point to immediately. First is the demographic trend that exists in this country. The growth curve, the [inaudible 13:12] , if you will, for the demographic cohort of the population that is in excess of age 65, kinked up in about 2011, and is suspected to run at a rate higher than the national average for the next 10 to 15 years.

That's the patient population that both of our businesses address. Both of our businesses are focused on the Medicare beneficiary population. What's driving that increased growth curve are two things.

One, it's the vanguard of the Baby Boomer generation pushed over age 65, and now they'll continue to fuel that demographic, again, for the next 10 to 15 years, and then on the opposite end of the spectrum, life expectancy continues to increase, and so we're getting that demographic cohort expanded on both ends, and that again plays into the demand for our services increasing.

It's also the case, and any of you who cover health care hear this ad nauseum, that there is a real focus on moving towards more integrated care and more integrated payment delivery systems, and more value-based payment options that really focus on tying payments, not just to a service being done, but to the quality of the service being done.

CMS has set some ambitious goals regarding the percentage of payments that will be tied to a value base, to a quality metric, and that will be part of a collaborative model. Frankly, it's going to be a little tough for them to get to the levels they have established for 2016. By 2018, maybe.

The timeframe here is less important. What is important is that we believe, and our strategy is designed to say the movement towards these types of models is inevitable, and we think that we are positioned to be a beneficiary as these new models come into play, because both of our business segments operate at the highest quality point for the patients in terms of patient outcomes, and at the most cost-effective point as well.

When you move through this kind of transition to integrated payment and integrated care, ultimately what that portends is that the silos that exist today that define patient criteria very narrowly between the various sectors of post-acute, particularly on the inpatient side, should break down.

If you are paying for an episode of care, just once, you become agnostic as to whether or not that patient spends some time in an IRF, in an L-TAC, or a SNF and then goes home. You become agnostic regarding length of stay. It's a single payment, so what you want to know is that you get an outcome for the single payment that you've agreed to pay as the payor, and then it's the responsibility of the providers to maximize the profitability within that spectrum.

Last week, we reported our results for Q4 and for fiscal year 2015. We finished the year with a strong quarter. It was characterized by strong volume growth in both of our business segments. Obviously that volume growth was aided by the acquisitions that we made in the fourth quarter -- again, Reliant right at the beginning of the quarter, CareSouth on November 2nd.

We also saw strong organic growth in both of our business segments. If you look at the key volume statistics for the home health business -- and we're not allowed to say "same store" there, because we didn't own Encompass in 2014, but it's essentially the same store equivalent of looking at the performance of those agencies that were owned in all of 2014 against '15.

The key volume statistics up there were up double digits. In the IRF space, we had another quarter of three percent same store growth bringing the year in. That three percent, that's higher than the market is growing, so it indicates that we continue to take market share even in our same store base.

We also saw impressive growth in our EBITDA. For the quarter, EBITDA was up about 36 percent. Again, that was aided by the two acquisitions that we made, and on the year we were up 18 percent.

Perhaps most importantly is we demonstrated again in 2015 the consistent and high level of free cash flow that our business generates, and so for 2015, we generated adjusted free cash flow of $389 million. That was a 25 percent increase over 2014.

What are our priorities as we shift now into 2016? First -- and again, I had the opportunity to discuss this with many of you at dinner last night, we're taking a hiatus from major acquisitions. Again, three significant acquisitions in a 12-month period was more than we had initially anticipated embarking upon.

All three of the businesses that we bought -- Encompass, Reliant, and CareSouth -- had private equity sponsors, and for many reasons, last year was an active year in terms of private equity sponsors electing to monetize those businesses.

Those were all businesses that we had monitored for a long period of time, and importantly, over the preceding four to five years, we had put our balance sheet in a position where we could capitalize on these opportunities when they arose.

We had driven our leverage down to by far the lowest in the post-acute provider space. We had maintained a strategy of owning the bulk of our real estate, which we think adds strength to the balance sheet and provides additional flexibility into our operating model. The debt markets were very favorable last year, thanks to all of you. We accessed the high-yield market on four separate occasions during 2015 to fund these acquisitions.

Now it's time for us to take a step back and really concentrate on integrating these businesses and continuing to refine our operating model across our entire business segment in both IRF and home health to ensure that we're maintaining that position as the highest quality provider of patient outcomes in the most cost effective manner.

And continuing to enhance our position in these integrated care and payment models.

Although we are taking a break from major acquisitions we will continue, again not a very articulate term, but we're going to continue what I referred to previously as the regular way development opportunities in both of our business segments. What does that mean?

That means that we anticipate opening four to six new IRF units through the course of the year. Most of those this year are going to be de novo's. You may see us make a one off acquisition. It won't be the size of Cardinal Hill because those aren't available out there previously, but probably

more like a 50 or 60 bed freestanding unit.

No visibility on any of those right now, again, but targeting four to six new units to open this year.

In home health, we'll continue to pick off these smaller agencies with desire to fill in some of those markets where we operate in IRF but don't have a home health presences. We've suggested that there's about 30 to 40 million dollars to be spent in that way.

By the way, that can be covered by the free cash flow that's being generated solely out of our home health care business.

I mentioned to you that we enjoyed access to the debt capital markets last year but it increased our leverage. Clearly we had the capacity and the balance sheet to do that but we ended the year with leverage of 4.6 times. If you pro forma that for the full year contribution in EBITDA of the assets that we acquired in the fourth quarter it was 4.2 times.

That's not alarming to us because, as we'll talk about in just a few moments, we look at both the absolute level of leverage and then, also, the composition of our debt capital. It's higher than we'd like as a run rate.

We would like to see that drift below four times by the end of 2016. We don't think that that represents an overly ambitious goal. If you take the midpoint of our EBITDA guidance, we're going to get to that in just a moment for 2016, it suggests that if we hit that level of EBITDA then funded debt from year end 2015 would need to come down about $70 million to get below four times.

I think I'll be able to demonstrate to you in just a moment that we have a high degree of confidence that there well be sufficient free cash flow available to get to that level.

We will continue, as we are, reducing the financial leverage our strategy of shareholder distributions. We've got a dividend that we put in place about three years ago. It's 23 cents per share.

That was designed, frankly, to try to provide a reason for shareholders to stick around when we get whipsawed by unfounded rumors regarding what's going to happen to the post acute delivery system. I don't know if it's worked but it's out there right now. We do think it's an important part of the shareholder value proposition. Right now it's about $85 million annually.

On the operations side, we use the moniker TeamWorks to describe our best practices that we deploy across our business segments. In the past, we've used a TeamWorks module for sales and marketing. We've used a TeamWorks module for cost rationalization.

This year the TeamWorks module is going to be focused on enhancing the clinical collaboration between our IRFs and home health, again to the benefit of our patient population. Seeking to drive better outcomes across the board.

We'll also continue our focus on participating in some of the bundled payment and other integrated payment delivery models and pilots that are ongoing. CJR starts in April. BPCI will be getting some momentum this summer. We will be participating in both of those.

Last week, as part of our earnings, we did reiterate some components of the guidance that we had initially issued at the JP Morgan Equity Conference back in January. That was we reiterated our guidance on both revenue and EBITDA, both of which represent 12 to 15 percent growth over 2015 actual.

We increased our EPS guidance. We did that for two reasons. The most significant one is that as we finished our purchase price allocation for the Reliant and CareSouth acquisitions we had changed estimates regarding depreciation and amortization. Secondly, we did have some share repurchase activity in the fourth quarter. We adjusted the share count down to reflect that. That was not in hand when we initially issued the guidance at the JP Morgan conference.

Some of the considerations underlying our 2016 guidance, I won't go through each of these in the interest of time. But just to point to one that we have talked about since we announced entering into a definitive agreement with Reliant.

That is the Reliant business was very attractive to us because of the scarcity of being able to acquire a portfolio of the ability to rationalize some of those key markets and to add capacity where we otherwise don't have the opportunity to do it in some key Texas markets.

Operationally it was run differently than ours. It was focused on a lower acuity patient. They were, if you will, to use a restaurant parlance, they were turning the tables faster. They had a shorter length of stay. They had lower staffing requirements in their hospitals than we do.

What we will be doing through the course of 2016 is repositioning those acquired assets to the HealthSouth operating model. Ultimately, the objective there is to position those businesses to treat a higher acuity patient and to position those businesses better to participate in the integrated delivery networks.

To treat a higher acuity patient, first they have to be staffed like HealthSouth hospitals. That includes increasing both the nursing and the therapy component. To be able to better positioned to participate in integrated models they need the implementation of our clinical information system.

Those things will happen through the course of 2016. As a result, we expect those facilities to take a step back from their fourth quarter run rate in terms of EBITDA contribution. We've suggested that through the course of 2016 those facilities will contribute about two to three million dollars less per quarter than the fourth quarter run rate would have indicated.

As they emerge from 2016 they'll be positioned operationally like our other HealthSouth hospitals. We will see strong revenue growth. Ultimately those are going to be highly accredited to our business model.

On the home health side, less integration to be done with CareSouth. It's a smaller business. Again, it was already operating on a compatible IT platform. There is some integration to be done, particularly in the area of sales and marketing and the approach to collaborating with our IRFs.

As a result, we don't see much growth coming from that business in the first half of '16 but would expect their growth trajectory to resume in the second half of '16. All of that is incorporated into the guidance we reviewed on the previous slide.

How do you think about free cash flow in 2016? This is designed to give our investors some view as to what items are going to be required to be covered from operating cash before we get to free cash flow. We've provided estimates for cash interest expense, for maintenance CapEx, etc. This gets you down the midpoint of the range down in the bottom in the blue bar for adjusted free cash flow.

This is, again, coming off of the EBITDA guidance. Deduct these items. You get to the blue bar down at the bottom. Suggests that we should have about $400 million in adjusted free cash flow in 2016. That money can be used to support our growth initiatives in both business segments, so the discretionary portion of our CapEx, to repay debt, and to fund shareholder distributions.

Let's look at how we might allocate it across those buckets.

Up at the top you see that our first priority is continuing to grow through that regular way development activity I mentioned in both business segments. These are some numbers that I had cited for your previously in terms of four to six new IRFs per year, which suggests spending of 70 to 90 million dollars.

We'll spend about 30 to 40 million dollars on home health agencies. I mentioned to you previously the high return that we get on bed expansions because of our ability to leverage the demand and the infrastructure in those units. We'd like to spend about 20 to 30 million dollars there, adding between 80 and 100 beds in that manner.

That gets you to about 120 to 180 million dollars. Pick $150 million off of that as the midpoint.

You've got about $250 million left that can then be used to either repay debt. Off of that has to come the common dividend which is already in place. That's about $85 million or so, but it still leaves, then, roughly 150 to 165 million dollars for debt repayment and other activities.

Again, that's something that gives us the confidence that if we are just able to post something at the midpoint of our EBITDA guidance range, bringing the leverage down below four times by the end of the year, not the height of our aspirations but a good starting point, is certainly readily achievable.

This is the maturity stack of our current debt structure. Again, I mentioned previously that when we think about leverage we think it's very important to think not only about the absolute level of leverage, that is an important number to us, but also what's the composition of our debt capital?

We have been very deliberate over the course of the last several years to design a debt capital structure that is bifurcated between our bank debt on the front end and then layered maturities of senior unsecured notes. You see the nearest maturity that we face is in mid 2020. That is our bank facility.

We've got a $600 million revolving credit facility. We maintain very sufficient unfunded availability under that facility. That's part of our strategy. The layered maturities of senior notes beyond that.

In terms of where we might focus our debt repayment activity, it's not going to be a secret to anybody because we've made two partial calls on it. Our 7 3/4 percent notes due 2022 became initially callable in September of 2016. We called $50 million of those notes in the fourth quarter. Last week we issued the call notice on an incremental $50 million.

That's the most expensive piece of debt capital that we have out there. Because it's callable it makes it easy to target that in terms of our debt reduction.

I'll conclude with this slide, leaving a few minutes for questions. This summarizes why we think HealthSouth is an attractive company to invest in and to apply an allocation of your debt capital to.

Attractive sector, good demographics, nondiscretionary ailments that we treat. We approach both of our industry segments with a leading market share. I note here we've got our home health business identified as the fifth largest Medicare provider. At year end we actually moved up to fourth. We need to update this slide.

We operate in a very cost effective manner. We do have that portfolio. Almost 65 percent of our real estate is owned, which is unique to the post acute provider sector. We believe we operate from a position of financial strength given our EBITDA margins and the adjusted free cash flow

that we generate.

We continue to have good growth opportunities in both of our business segments.

With that, Ed and I will be happy to open it up for any questions.

I'm going to bring the mic up. Right here in the front row.

AUDIENCE MEMBER 1: I know it's hard to do this but could you give us a sense of what you would view as the top two or three reimbursement risks that you view going forward, either from the customer's perspective because they're growing way too fast, or just because of your caseload dependency in a certain area?

DOUG: I think everybody heard the question but what are the top two or three reimbursement risks we see?

Let me start by saying one that we don't view as a significant risk. That's any of the bundled payment initiatives, the CJR initiative, or any discussion around site neutral. We do not view those as significant risk.

A, they're complicated and they're going to come in very slowly. B, we think that our assets are extremely well positioned to succeed in those types of environments and that, ultimately, those would increase the addressable market for us and still allow us to earn a sufficient return for our capital providers.

What you fear most is kind of the arbitrary cut, and there are two things out there that I would point to as just potential risks, and I don't think they're very high risks.

One is if you looked at some of the recent MedPAC discussion out there in the IRF space, they've now focused on the distinction between the profit margins of freestanding units and of hospital-based units, and they've tried to say what are some of the reasons for that, they acknowledge that scale is one of those.

But they're also trying to look at it and say is there anything that suggests that there's a coding differential between them, or anything of that nature.

We have provided some information to MedPAC, this was referenced in our earnings call last year. It's a report called the Doffs-Devonza report, and we have actually now made that available along with the letter that was sent MedPAC on our website, so I encourage you to access that report that really supports the contention that the difference in the margin is all attributable to cost.

MedPAC has said one potential solution to this, and it's really absurd when you think about it, is to expand the outlier pool and to then make more redistributions from the high-margins IRFs to the low-paying IRFs. So they want to create a program that incents inefficiency and rewards you for being inefficient. It's within CMS's power to expand without any further approval, to expand the outlier pool from three percent to five percent.

We don't get any outpayer payments back, we get less than one half of one percent, so if that happens that's something that just looks like sequestration to us. We think the probability of that happening is very remote, but it's out there. The second is if you get a new administration and they come in and they just say, "It's time to cut costs across the board," and everybody's getting hit with another sequestration.

Again, I think the probability of either one of those is low, but those are out there. I think we've got time for probably one more question. Right here?

AUDIENCE MEMBER 2: You mentioned that 55 percent of your patients require home health care, I don't know if I missed it, but did you mention how much you're currently capturing right now, and how much you expect to capture, and is there a way to think about how much additional margin you make on that patient once you're providing both services to them?

DOUG: Thank you, because I was supposed to mention that, and I did not. I'll give you a proxy on that, and that is in 2014 before we owned Encompass, for the month of December Encompass captured 35 discharges from HealthSouth IRFs. In December '15, they captured over 900, so that's the kind of progress that we're making. We're probably at a capture rate of somewhere around 12 percent.

We don't have a specific goal in mind, we want to continue to advance it, but actually the capture rate is the result of the strategy and not a means to itself. That is what we're attempting to do is to enhance the outcomes for the Medicare beneficiary population and provide a greater value to the Medicare program by engaging in clinical collaboration between our IRFs and our home health units.

Ultimately that will result in a higher capture rate, and in terms of what it might mean for the revenue perspective, I think a couple of ways that you can think about it is probably on average a typical patient discharged from a rehab hospital will require 1.5 to 2 episodes of care. The typical revenue per episode is about $3,100 and Encompass runs at a 17 percent EBITDA margin.

So you can pick your own level of discharges and kind of do the math around that. I believe that we are out of time, again I want to thank you all for your attendance and your attention today.

[applause]

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