Encompass Health

May 19, 2020

Whit Mayo: Okay, great. I think we're going to go ahead and get started. It's 10:00 A.M. This is Whit Mayo, UBS's Healthcare Facilities and Managed Care Analyst. It's my pleasure to have the management team from Encompass Healthcare with us today. Joining the company we have Doug Coltharp, the Chief Financial Officer, Mark Tarr, the Chief Executive Officer and, of course, Crissy Carlisle that runs the Investor Relations effort. Maybe just to get started guys, I think you put out an 8-K this morning giving a real-time update on some of the business trends; maybe Doug or Mark if you care to elaborate on some of the numbers that you've put out this morning, that might be just a good place to start.

Mark Tarr: Yeah, good morning and welcome everyone. This is Mark, I'll take a first shot at this and yeah, we filed the 8-K this morning that shows our volume trends and our operating segments and I think if you have had a chance to take a look at it you'd see that where we certainly ended February strong, went into March strong, second half of March started to decline. We saw a bottoming of the downward trend in both of our segments in April and then we've had a nice trajectory coming back up through April and then so far into May. So, we feel very positive about the way the trends are going now and the fundamentals of our business going forward.

Whit Mayo: Great, I was trying to hit my mute button. Helpful. Let's just start also on the CARES Act. You -- you certainly have had a different view on some of the terms and conditions of the program. I think that we all sensed that you were a little bit hesitant to take the funds; you've now returned the funds. Just maybe walk us through some of the elements of the program that left you just a little uncomfortable with the program in general?

Mark Tarr: Well, once again, this is Mark and first of all we want to make sure and recognize the fact that we're very appreciative of HHS and Congress wanting to make sure to help support the providers out there. Certainly it's been a challenging time for everyone in the healthcare segment. But we did some due diligence on it. We receive $237 million that was quickly itemized in accounts and not spent or dispersed in any way. We used the next two to three weeks after receipt to these funds to do a fair amount of due diligence on the terms and conditions and whatever information we could gather on that and at the end of the day we just felt as a well capitalized company, we had access to a variety of funding resources, we just though it was the best decision for Encompass Health to return the funds.

Doug Coltharp: And let -- this is Doug, let me give you some more specifics on things that were specific to us. And so the first was the allocation methodologies. So as you know, the $237 million, $238 million that we received came in two tranches. The first tranche was substantially larger than the second but the allocation methodology that was utilized by HHS to distribute those funds to various providers differed from the first tranche to the

second tranche and it was language in the second distribution that led us to believe that it was the methodology for the second tranche that should be applied to both. When we applied the methodology from the second tranche, it suggested that the amount that we should have been due was closer to $80 million then it was the $237 million.

The second was an issue of aggregation. We received the funds at 209 separate legal entities under the Encompass Health corporate umbrella. And as we researched this and even as we tried to seek clarification from HHS, we could not get any assurances that there would not be a continuing requirement to utilize the funds, report on the funds, be audited on the funds, etc., at that entity level at which it was received. And hat would have both limited our ability to fully utilize the now $80 million because not every one of those entities was equally impacted by COVID-19 and it also would have imposed a very significant administrative burden and potential risk on us.

Third thing is our interpretation was that any utilization of the funds would be subject to federal income taxes. And so that would also reduce the amount of dollars that was really available to us. Fourth, was the concept of alternative reimbursement sources that's embedded in the language. And so we believed that at least a portion of the damage that we have suffered from COVID-19 might be subject to a business interruption insurance claim. Now, that's going to be a controversial topic and likely will take years to process a claim like that but if -- to the extent that we were pursuing any such claim, that would preclude us from using at least the portion of whatever funds we have retained. And the last one is an item that we've talked about before and that is attestation and that is the form of the attestation associated with the acceptance of these funds remains very open-ended and includes provisions that allows HHS and other governmental entities and committees of Congress to add terms and conditions unilaterally post the acceptance of these funds and we found that aspect to be problematic. Beyond that, we also believed that once the COVID-19 pandemic passes that there is potentially going to be substantial congressional remorse about how various aid programs were distributed to various companies and you may find yourself as a publically traded company with, as Mark stated, access to other sources of capital to be on a public shaming list. And that was just a risk that given an out, substantially whittled down allocation of the CARE funds that we did not believe was in the best interest of our shareholders.

Whit Mayo: Yeah, no. All helpful. I think saved yourself a trip to D.C. for a congressional hearing for sure. Maybe just back to just the impact on the business from COVID-19. I mean, when you look at your different patient categories across both the inpatient rehab and the home health businesses, I mean, does anything stand out as being, you know, a type of patient that was more impacted? Obviously, I think the elective orthopedic musculoskeletal businesses is one, stroke business, neuro -- just kind of curious if you've seen any meaningful impact in different patient categories?

Mark Tarr: Whit, in general, if you looked at it just from a broad brushstroke, it was the lower acuity patients that we saw a decline in and that would include orthopedic patients; hip fractures, lower extremity joint replacements, that was consistent, even though it's not a large portion of our discharges on our hospital side, it does make up a material amount on the home health side through the -- particularly the elective procedures, about 20% of our overall business on the home health side. We saw actual increase of the percentage of discharges from our hospitals falling in the stroke category. So, we maintained the patients that were of the higher acuity levels which would include stroke and we saw a

decrease in any of those that could be either elective or termed as being low acuity in nature.

Doug Coltharp: But the other thing that we have observed is that we took a bigger volume hit on the in-patient rehabilitation side and Medicare fee-for-service patients than we did in Medicare Advantage. As a matter of fact, we saw a tremendous surge in Medicare Advantage patients and we think that that has something to do with both the average age and the relative health of that population of patients versus the fee-for-service [which skews] older and tends to have a different array of [abilities]. It also, no doubt, was positively influenced by the waiver of most of the managed care plans post-acute preauthorization requirements beginning in April.

Whit Mayo: Yeah, so just to be clear, it's not that you saw an overall increase in your Medicare Advantage Volumes but as a percentage of your total, it went up as the fee-for-service volumes went down, correct?

Doug Coltharp: Actually, in more recent weeks, it's been both. It's been year-over-year growth in the Medicare Advantage discharges and as a result, it is increasing as a percentage of our payer mix.

Whit Mayo: CMS, as you alluded to, well, you really were alluding more towards the payers and the response efforts to try to keep the pipe slowing, but CMS came out and made a number of modifications to a lot of the rules around post-acute, you know, for inpatient rehab eliminating the three-hour therapy rule, I think, waiving the 60% rule, home health, there's a number of modifications. Can you maybe speak a little bit to some of those changes and how that's been helpful and do you think there are any longer-term implications from those relief efforts just on the rules?

Mark Tarr: Well, I think that they have been helpful; certainly in terms of our ability to work with referral sources as they were looking to place patients into post acute from the acute care hospitals. It gave us an opportunity to accept some patients that -- into our [ERP] that were still rehab patients but maybe in the past would not have been able to tolerate the three hours a day of therapy or would have been restricted by the 60% rule. So both of those opportunities gave us a chance to, what I would consider to be, better service our acute care referring sources at a time that, quite frankly, they were looking for opportunities to reduce their capacity to prepare for this influx of COVID patients, in some cases, it never eventually happened.

You had the telemedicine that was also impactful in both of our segments. I think that that, while not impactful in a material way, I do think that telemedicine, in general, is going to be something that CMS is going to be trying to implement as a complimentary component of care going forward. And then I think just the enhanced use of nurse practitioners and PA, particularly on the home health side, gives us an additional opportunity to go out and market and have our sales force communicate and market to the nurse practitioners and PA's that are out there too.

So, overall, I think it's been helpful. I don’t think it's been a huge influence but I think it has been helpful.

Doug Coltharp: I would say, specifically, just add to Mark's comments, the impact on the ERP business

related to the relaxation of the regulations regarding both patient criteria and requirements of care, just taking a little bit of time to work its way through the system. It requires broad-based communication by us to all of our hospitals and they have been communication to our clinical marketing liaisons about what those new criteria mean, what is and what is not acceptable and how that might be applied to the patient flow from the acute care hospitals. And although we have great partnerships with the acute care hospitals, recognize that they have had a tremendous amount thrown at them in terms of regulatory changes and payment model changes and everything. They've very, very preoccupied right now with some of those and at the end of the day only about 3.5% of the patients who flow though an acute care hospital, in a normalized environment, ultimately wind up in an in-patient rehabilitation facility. So, it took us a little while to get the retention. Those things are now completely in place and not only are they helping with the recovery of volume, but an important component of this is those changes allow us now to treat patients who are recovering from COVID-19 because if you've got an elderly patient who spent a period of time in an ICU and an acute care hospital, particularly if a portion of that time was on intubation, they really need the kind of post acute care that we can provide in our facilities but they don't come after that kind of experience, they don't come into one of our facilities able to tolerate the normal therapy regime that we're required by law to administer.

Whit Mayo: Yeah, I mean, your model is unique in a sense that you have true partnerships with acute care hospitals, I think, across what may be 30% of your inpatient rehab hospitals and I'm just sort of curious how you're engaging with those -- I mean, you sort of alluded to this, but that you're engaging with your hospital partners to work around what post-acute solutions they need. Does this, in some ways, strengthen the relationships that you think you have and provide you an opportunity to reengage about a full post-acute solution across rehab and home health? Is this something that you're pursuing at this point. Wasn't sure exactly how that conversation is evolving?

Mark Tarr: With -- it absolutely -- this period has absolutely given us a chance to strengthen our relationship; not only with our JV partners but also just as -- just referring partners, maybe where we don't even have a JV partnership, they -- all the acute care hospitals are looking for post-acute providers that can provide great care that have a smooth transition from the discharge at acute care hospitals to the admission in the post-acute facility or into the home health agency and so I think this period has really given us an opportunity to strengthen our relationships.

As I mentioned earlier, we were certainly trying to make sure we were a positive influence when it came to working with hospitals as they were trying to discharge and open up their beds for the COVID patients. Throughout this period we admitted COVID patients into our hospitals. We had 80 of our hospitals admitted COVID patients where we could successfully treat these patients in our settings in a very positive manner.

So, I think we have continued to strengthen our relationship, share the fact that we are a quality provider in the marketplace, get great outcomes and can truly be a post-acute partner in a larger continuum.

Doug Coltharp: I think this is an opportunity and we're taking full advantage of it to really highlight the clinical efficacy of both of our business segments and to do that with key constituencies that range from the acute care hospitals to the Medicare Advantage plans that we

referenced before to attending physicians and so forth. And they're really understanding just how differentiated we are and how helpful we can be in terms of treating patients more effectively if they're in need of post-acute in-patient care in an ERP versus a SNF, we're being able to bypass the SNF visit altogether when coming out of the acute care hospital for the lower acuity patients and receive high quality and effective care in the home setting.

Whit Mayo: Yeah, maybe just to stay on this point, I mean, as I reflect back on the analyst day that you had in early March, you had a slide where you, I think, provided some empirical data around, let's call it, the low cost advantage of in-patient rehab versus other post-acute alternatives. I think you cited some 90-day episodic costs that were materially lower than skilled nursing. Doug, can you maybe revisit some of those numbers and that analysis and how you've been, obviously, engaging with a lot of hospitals to drive home that message?

Doug Coltharp: Yeah, I'll start. I know Mark's going to want to add some on this, but first as you attempt to compare across the sites of care, it's important to recognize that the results are going to market, provider and DRG specific and then it's important to evaluate these on a episodic basis to capture both the stay in the [PAC] setting and some reasonable period post-discharge from that inpatient PAC setting. So, we've focused in the Investor Day, and we focus internally, on 60 and 90-day episodes and that was the specific methodology we used with examples that we shared as part of our Investor Day materials.

And so generally speaking, when you look at higher acuity more medically complex patients who are eligible for care in either a SNF or an ERP, our company outperforms the SNF in both outcomes and cost effectiveness primarily due to shorter length of stay and lower acute care readmissions. And so many times our ERP's are more costly on the frontend compared to a SNF if you're just comparing them on a per diem basis. And also then if you look at kind of that even times a typical length of stay.

But you might, for instance, have an example where a stay in an ERP was $15,000 for an episode as compared to say $12,000 for a SNF but then when you add in the very costly impact of the readmission that would occur within a 60 or 90-day period, it flip-flops dramatically and creates a pretty wide delta between the episodic costs.

Mark Tarr: I think it also goes to show how the clinical collaborations is working for us. So we have 89 markets now where we have both an ERP and home health service in those marketplaces and you start to look at some of the quality metrics that come out in the -- in these overlap markets and it's clearly showing that we have an opportunity in our overlap markets to return a higher percentage of patients back to the community and also have an opportunity to score higher on the patient satisfaction with regard to the overall satisfaction with care as well as satisfaction with the discharge process. So, it's just something that healthcare in general, whenever you have a discharge in transition from one healthcare setting to the next, it's imperative that there's strong communication, a collaboration and it's difficult to do that unless you're vested in the process and having these overlap markets where we have both a facility-based presence and a home-based presence we're able to provide that level of care in a more collaborative manner that ultimately responds and results in higher quality of care.

Doug Coltharp: One of the specific examples we used demonstrating the results from one of the larger

acute care hospital networks within our marketplace was around [stropes] and in that Investor Day material we showed that the 90-day average spend for a patient that went into our ERP and then stayed with us through home health was just about $60,000. And, on average, the same 90-day spend for one of those acute care patients who went into a SNF setting instead, was almost $94,000 so that was about a 37% differential right there and we have numerous other examples like that.

Whit Mayo: Super helpful. I want to transition a second to the [FIM] to care tool change this past year. It started, I believe, in the fourth quarter of last year and how has that transition been relative to your initial expectation? My impression is that you are tracking better than I expected to see. It felt like you were overcoming it by a pretty wide margin, but I may be off. So, just any early comments around that transition would be helpful.

Mark Tarr: Yeah, you're right. That transition has gone well. We're very pleased with the way our hospitals have responded to that. As you point out, it did start in the fourth quarter of 2019. That was after over a year of preparation, actually a couple of years of preparation. In 2019 I think we spent some $5 million in overall education as part of this and it's shown that that was money well spent, our hospitals transitioned very smoothly into the care tool. The level of differentiation between one hospital and another, as you recall, we're trying to have a portfolio that was consistent across the same types of patients in one hospital with another hospital in terms of the score. So we've not seen a lot of variation across our portfolio which is good. That was the whole intent of the overall education with our staff and nurses and so we've been very pleased with the transition.

Doug Coltharp: And what you may recall that we began providing estimates of the potential impact of the full transition to care tool that would take place on October 1 of 2019 in the first quarter of last year. And then we updated that on a quarterly basis by looking at the prior three months and we were essentially running the care tool against the FIM that was still in place at that time. And through the course of last year, we kept bringing in the estimated impact starting initially with an anticipation that we would have a negative pricing impact in Fiscal Year 2020 to by the time we actually entered the fiscal year and dropped FIM and focused solely on care, our estimate of the 2020 impact was flat to up 50 basis points. We did outperform that marginally in the first quarter of the transition which was Q4 of last year and so as we entered calendar year 2020, we raised the estimate for the first three quarters to flat to up 75 basis points. And as we said in the first quarter, we believe that we landed right smack in the middle of it when you adjust out some of the prior period pricing implications.

It's going to be increasingly difficult as we move forward to try to isolate the impact of this transition versus FIM because we no longer are running FIM simultaneously and so it's all these other factors that are impacting it but generally we feel like, as Mark has suggested, we have successfully made the transition across our hospital portfolio to the care tool. We'll continue to reinforce training and look for the consistent application but we feel like we've landed in the middle, if not to the high end of the range that we previously provided.

Whit Mayo: Got it. So if you just isolate the revenue headwind from the care tool, I think originally we had sort of estimated it around $55 million, give or take, is there a way to frame how you look at just the care tool revenue impact versus netting it against all the market basket factors and everything else?

Doug Coltharp: Well, I think what you would need to do is pick your point in terms of where we land in that 0 to 75 basis points and then compare that to what would have been a beginning rate of 2.4% and it's the delta between the two. What becomes difficult is you have to apply that against some kind of volume and patient mix and one of the reasons that we withdrew our guidance in April is that those two things, although they're recovering nicely as indicated in our 8-K, remain very much influx.

Whit Mayo: Yeah, I'll figure something out.

Doug Coltharp: I knew you would.

Whit Mayo: I've got a question here -- yeah. Let's just talk about the recession for a second and the impact on your overall business and I think it's generally a topic that we get a lot of inbound questions on and your business is certainly over indexed towards Medicare and generally, historically, we think about these being more recession resistant-like businesses. Does anything change going forward? You know, how do you think about demand, how do you think about your cost structure? I mean, presumably with unemployment going up, that might create a little bit of, not deflation, but something like that on your clinical cost structure. So, I don't know, just any thoughts would be great.

Mark Tarr: If you look back, recession has not really impacted our business at all. As you noted, I mean, there might be certain pockets where you might see a little bit of benefit on the labor side, really kind of put your finger just on that. Certainly easier to hire particularly the support staff in marketplaces that maybe have a little bit more pressure from a recession standpoint on jobs than others but it's not been much, if any, of an influence on our overall business. I think we're well positioned going forward as we always try to note and point towards the demographic trends and aging population and the fact that as the population grows older, the likelihood of needing our services increases. I think that positions us very well for whether it's a recession or a non-recession marketplace.

Doug Coltharp: And it's a -- we don't want this to sound in any way morbid, but to the extent that COVID-19 stays with us, perhaps, indefinitely, albeit substantially reduced rate, the likelihood that it is still disproportionally impacting the elderly population, as the flu does today, I think is high and there are going to be a percentage of those patients who are not only going to survive it but are going to require the services that we provide both in the inpatient setting and at home so there's another factor that I think would contribute to demand.

And as a result, we're not pulling back on any of our capacity expansion plans, to the contrary, we're plowing forward with those.

Whit Mayo: Yeah, that's helpful. And maybe thinking longer term, I mean, another sort of inbound question that I received from a number of investors is thinking about certain asset classes that may benefit long-term from COVID-19 and there seems to be sort of this, I don't know, this inertia towards the home model, home infusion, home dialysis, home health of course, do you -- how do you think long-term this may impact how the delivery system, the ecosystem sort of looks at home health?

Mark Tarr: I think it's going to continue to increase the demand. I think more and more people

already had chosen the home setting as a preferred setting to receive care if available to them so I think this only -- this COVID-19 only pushes that trend forward and so I think it's very sound for home health and the outlook there.

Doug Coltharp: Albeit subject to the continued reduction and anxiety and we're seeing progress in this but it's not resolved yet with regard to both patient anxiety and caregiver anxiety.

Whit Mayo: Yeah, while why don't we just transition there? I think this is a good segue to talk about PDGM and what the pre-COVID experience was, how you were tracking versus your original plans. You had a much different view, I think, of the slope of the curve coming into this to maybe some of your peers and then obviously COVID has created a lot of missed visits and some challenges around LUPA.

So any initial impressions of how your operators have responded, you know, pre-COVID and post-COVID in light of the transition in PDGM?

Doug Coltharp: Unfortunately there just wasn't really an opportunity o get a read on that. If you think about it, we had a hybrid pricing model coming into the year because we were implementing PDGM effective January 1 but you still had many episodes that started in the second half of December that were carrying over and being priced into the old system that really carried through until February, almost to March. So we had about maybe two weeks to start to get a view on the PDGM impact and that's not even enough to cover an initial 30-day payment period. What we can say, and something that we talked about quite a bit on the first quarter call is that for us, the impact of COVID-19 was spreading gasoline on a fire that already existed. We knew that we were going to have challenges based on our referral source mix and our patient mix given the negative impact of PDGM based on the program design for reimbursements related to patients that come out of the community, for therapy patients versus nursing patients and for the LUPA designation. And things that are directly attributable to the COVID-19 negatively impacted the progress that we were making on getting more patients referred to us out of an institutional setting so that was a negative in terms of a pricing impact and they had a pretty substantial increase in the number of payment periods that were falling under the LUPA threshold. We've started to see that mitigate to some extent and we think the trend line is positive but that's what led to that really significant decline in revenue per episode that we had in the first quarter and it made it very difficult for us to get a real assessment as to how PDGM was tracking. We feel good about all of the training that we've done, about the programs that we have in place, the systems capabilities that we have in place; we're just going to need a more normalized operating environment, whatever that may be moving forward, to truly assess the impact of PDGM on our business.

Mark Tarr: As you know, our home health team has a very strong track record of making whatever adjustments and adaptability to regulatory changes and have really done well in the past so we're very confident that we'll have that same trend going forward.

Whit Mayo: That's great. Something I wanted to talk about that I've been thinking a lot about lately is Medicare Advantage and you've noted more recently that you've successfully narrowed the payment gap between MA and fee-for-service on inpatient rehab. You know, I don't think you've had the same experience with home health and obviously MA is going to continue to grow, we presume, as a percent of the overall Medicare population and maybe just talk about the experience on inpatient rehab, how you narrowed that gap, what

the gap is, what the gap was and any comments on home health or hospice?

Doug Coltharp: Yeah, so we're -- this is Doug. In terms of on the ERP side, if you roll the clock back probably five years ago, the payment gap between fee-for-service and Medicare Advantage would have been as high as 25% and that was due to the fact that a large percentage of our contracts remained on a per diem basis and were managed very aggressively by the Medicare Advantage plans such that the length of stay was lower. Over time we were able to demonstrate through our value proposition our ability to effectively treat a higher acuity patient ultimately reducing the cost of an episode but it was important, as we explained to the MA plans there, that our clinicians be able to manage the plan of care including the length of stay and to not have this aggressive management of the per diem rate.

And so the primary way that we did that was we converted the contracts from a per diem to a case rate basis so that we were sharing effectively in some of the risk and those rates were very much tied to fee-for-service. At the same time, where we really demonstrated our efficacy, was around the more medically complex higher acuity patients. We've talked about before, when you look at our Medicare Advantage book of business, it skews very highly into those categories. We were up at around 35% in a more normalized environment of our MA book of business, our stroke patients, and those carry a higher reimbursement. So it's both the conversion of contracts from a per diem to a case rate basis and the higher acuity overall; it's founded in MA population for our patients versus fee-for-service that has narrowed the rate differential and in the first quarter that was at its lowest level ever at 6%.

Mark Tarr: I think this is where the increased amount of outcomes data plays to our advantage and it's one of the things that we've really used on the ERP side with this value proposition and starting to have the MA plans start thinking longer-term and not just short-term in terms of overall cost. I think that too will also resonate eventually in the home health sector as well and that ultimately the value and the outcomes will matter and not all providers are the same.

Doug Coltharp: And we really believe that for both of our business segments, the MA plans have been enormously constructive to work with through this pandemic and we're hopeful that we're going to be able to demonstrate during this period of time, just how differentiated we are from our peers and that the value proposition for both of our business segments is really there and that that will change the nature of the relationship in a favorable way with the MA plans for both business segments as ultimately we overcome the pandemic.

Whit Mayo: Yeah, I think they're certainly looking for ways to spend money right now. On the stroke opportunity, since you referenced the patient population a little bit earlier. You've -- the American Stroke and Heart Associations came out endorsing a patient rehab as the preferred setting of treatment for stroke. But where do we go with the next campaign, you know, do you think about a national branding campaign? I'm just trying to think about like what the internal initiatives are to continue to keep the momentum building around the awareness of stroke and how to treat it?

Mark Tarr: We have continued with the American Heart, America Stroke Association on our national branding opportunity. We felt like the first year and a half of that had nice results in terms of just getting exposure to portions of the public or the referring clinicians that we

did not have access to or a chance to get exposure to in the past so we continued to move forward with that. We continued to publish our outcomes. We think this pandemic has given an even clearer insight in terms of the separation of the settings of care, ERP versus SNF and we'll take full advantage of that going forward to continue to make sure that the outcomes that we're able to get with the stroke population are paramount when compared to the other settings. So, we've got a nice foothold into that. We think that there continues to be opportunities for growth in the future. I think overall we're just a little bit over 5% of overall market share of the stroke opportunity so we hope to continue to build that platform.

Doug Coltharp: I think there's going to be both an opportunity and a need as we work through this pandemic to engage in those kinds of awareness campaigns. In addition to the factors that Mark just cited, there have been widespread reports, granted this is anecdotal but I'm sure you've read some of the same articles about patients who have simply elected not to go to an acute care hospital, not to go to an emergency room when they're having clear symptoms of a stroke. And the impact that it is having, particularly within the elderly population in these instances, is pretty catastrophic and I think it's going to become much more widely known as we continue to move through the pandemic and I think it's going to be incumbent upon providers and care givers to really reinforce the need within the elderly population to seek treatment for stroke in the most efficient setting as possible. I really believe that there's an opportunity for us to increase the education and awareness and to fully demonstrate our effectiveness at treating stroke patients.

Mark Tarr: It will take a couple of years to play out in terms of the data but this deferred care that has occurred over the last couple of months, it's going to have some longer-term impacts.

Whit Mayo: Certainly. Well, with that, I think we are just out of time. So, why don’t we leave it there. Doug, Mark, thanks -- and Crissy, thanks for joining us, really appreciate your time and insight; incredibly helpful. As always, if anyone has questions, please reach out to myself, my team, we'll get back to you as soon as we can. I think we've got Acadia presenting in about ten minutes so we'll take a quick break. Thanks again guys, enjoy that and we will hopefully see you soon, talk soon. Bye.

Mark Tarr: Thanks, Whit.

Doug Coltharp: Thank you, Whit.