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ALL THINGS REAL ESTATE WITH TRISHA TALBOT

David Mandell:

Hello, this is David Mandell, host of the podcast. Very excited about today's discussion, about our guest today. We're going to be talking about a topic that is close to the heart of many docs --- which is real estate. So, let me introduce Trisha Talbot. We'll have her bio that I'm going to read plus a link to her LinkedIn, which I'll refer to in the show notes, so you can read all about her and let me give you her brief bio, bring her on.

So, Trisha Talbot advises physician owners and investors with opportunities in the healthcare real estate asset class. Her track record in investment sales, landlord representation, corporate representation, and tenant representation offers clients trusted experience with comprehensive strategies with pricing, market fluctuations, and problem-solving solutions that result in successfully closed transactions. Aligning the real estate investment requirements of property owners and physician investors together with the corporate goals of the healthcare companies that occupy medical facilities has made Trisha a leader in the healthcare real estate brokerage community. Her performance and production achievements are recognized annually. Trisha lives in Scottsdale, Arizona with her wonderfully patient husband, and two gracious children that support her drive to make an impact helping clinicians share their gift to heal others. So, with that, Trisha, welcome to the program.

Trisha Talbot:

Thank you.

David Mandell:

Excellent. So, I read your bio, which is about you and what you do, but I also want to link to your LinkedIn profile, which gets into some of your degrees and experience, and we'll talk about that. But one of the things, or two of the things I saw on that profile that were interesting to me, because I hadn't heard of them before, and I think the docs will be interested, are two certifications that you have. One is called a master's of corporate real estate, MCR, and the other is a Certified Commercial Investment Member, CCIM. Can you give us a little background on both of these and what they mean?

Trisha Talbot:

Absolutely. So, CCIM, a Certified Commercial Investment Member, it's an organization that you go through four different classes and then a capstone, where you focus just on positioning properties as income generating real estate and how to value them and how to underwrite them. It starts with just some general discount cash flow analysis. Then it goes through user decision analysis, which is you can get three properties, but you don't necessarily want to take the cheapest one, because it could be in a really poor area. Then it gets into underwriting in a lot more detail. So, people that have this designation, like myself, they have specifically gone through this training and have a background in how to make sure that a property is properly underwritten and helps on the sell side, properly underwritten in, on the buy side, how to analyze it for a client. Then also how to help them decide financially on a piece of real estate, along with the qualitative aspects of the property as well in order to either purchase or sell a property that makes sense for them.

David Mandell:

So, it's a lot of understanding cash flows, modeling and getting a sense of the financial model of a property. Would that be accurate?

Trisha Talbot:

Exactly right.

David Mandell:

Yeah. Then what about the master's of corporate real estate? Well, how's that different or what did you learn going through?

Trisha Talbot:

So, that one is different. So, that's taking a look at real estate as a function of a company. So, for instance, I had a client that had 150-plus sites across the country. That has to be aggregated in order for somebody somewhere to be able to make some decisions without it being incredibly painful. So, this is taking real estate as a function of a company, again, financially modeling it, but being able to also have key indicators saying, "Hey, what is your annual run rate? Which is what is the cost of all your leases and the operating expenses to you, as the person using the real estate. If you own real estate, what is the value of your assets under management?" Obviously, that drills down into to what those mean.

But, as a company, we, as real estate professionals, on my side, it's easy for us to understand how real estate works. But if you are selling widgets, your real estate is a function of you being

able to sell more widgets. It's not necessarily a function of the real estate per se. I mean, obviously nobody wants to overpay, but sometimes for companies you need to be in a specific location. That location, when you run the numbers of what it will generate for your business, it makes sense for you to pay the rent that's in that location. Is it the cheapest rent in town? No. Do you want somebody like myself to represent you in that negotiation, because there's a lot of other things that can be negotiated? Absolutely. But it takes the financial analysis of the real estate and then applies the company's business on top of it. Then real estate, you deploy the real estate as a function of what the company objectives are.

David Mandell:

Interesting. So, it sounds like the CCIM is more looking at a property or a group of properties in isolation and the master's of corporate real estate is more how it fits in with the rest of the business.

Trisha Talbot:

Exactly.

David Mandell:

... depending on what kind of business. In here, we're talking about healthcare, right?

Trisha Talbot:

Right.

David Mandell:

So, we'll get to that in a couple minutes. So, you've been in the real estate in industry for a long time. Tell us a little bit about your career path. Where'd you go first and how'd you move through that industry?

Trisha Talbot:

I started as an in-house leasing department for a healthcare developer. They just developed medical office properties and healthcare properties. So, I started there and then moved into third-party brokerage and did a ton of landlord leasing. Then from there, started doing investments. From there, I've just continued to do more on the investment side. I actually don't

have any more landlord listings. But I like all of the experience, because I can really understand when I'm putting a property on the market, how to underwrite it, read the leases, see some of the clauses that are in there and understand that you can't just throw a lease rate out there. It has to actually fit within the market dynamics and the other terms of the market fundamentals, which, I would say, are tenant improvements.

If there's any renewals, annual increases and how all of that fits together. A lot of real estate professionals sometimes can do this, but sometimes you have people that just grew up in the investment side and people that just grew up doing landlord leasing. I think the benefit I have is a really extensive experience in both leasing and sales. So, I really can, I think, take a very deep dive, look into these properties and help organize them, if they are not organized, and be able to get some standard lease terms and conditions and forms in place together with some attorneys, and really clean up a property and put it on the market.

If you put a property that's not cleaned up on the market to investors, this is where people don't get the value of the property for themselves. Because investors, they'll take a property in whatever form and clean it up, but they're not going to pay you for that. They're going to discount it to you. Then they're going to, because they typically have to hire people and spend money. So, they will get the economic benefit of them cleaning it up rather than somebody else cleaning up the property.

That's what I find a lot with that some of these physician-owned properties is sometimes they have a lease on it for themselves. Sometimes they haven't had a lease, they're just like, "Well, I just pay the mortgage." And that's fine. So, either they don't have a lease or they have tenants in place and the tenants aren't even paying market lease rates. So, that's problematic. Sometimes, what happens is when I see some physician owners come to me is they're tired of managing the property, they're tired of dealing with leasing the property, because, in some cases, and not all, they'll be a group of physicians that get together and then they decide that they want to own instead of lease. But then they don't really discuss who's going to be the one to manage it.

Then someone raises their hand, because they don't feel that they want to pay management fees or anything like that. Then that person ends up, as a part-time job, managing the building, because it is, I mean, it takes time and expertise in doing that. So, then someone just gets tired, and is like, "You know what, let's cash out of this." But it hasn't been professionally managed or leased. So, everything's in different places and some things have been taken care of and some haven't. So, I can come in and grab all of that and organize it for them to hopefully be able to get their property to the value that they are expecting.

David Mandell:

How did you end up launching DOCPROPERTIES? You worked for a landlord, you did some investing on your own? What caused you or what motivated you or what did you see in the marketplace that got you to launch DOCPROPERTIES? And tell us what you do for physicians in that.

Trisha Talbot:

Sure. So, I was at a national firm and when you're at a national firm, medical office or healthcare is underneath office. So, the food groups of commercial real estate are office, industrial, retail, multifamily and land. So, healthcare gets sort of pushed under office and it's not its own. That sometimes would be, I would hit a lot of walls, because they would be like, well, we have all these resources for the office and you have to figure out how to get those resources to help you. But it's different than office. I can't just go and say, "Hey, I need the market report, the quarterly market report for office properties. I need you to help me do some research on this market for medical." You have to take office and you have to parse out all of the non-medical properties.

Because not every property will qualify as office. In Arizona, a lot of the municipalities are five per thousand parking. I think in a lot... I see this across the board. I do deals in other markets with a network of brokers that I have. But the parking is pretty much consistent. It's five per thousand, plus or minus. Some are grandfathered in, some are going even higher, up to six per thousand. So, first of all, the parking has to accommodate medical. It has to be high enough. Not every building has that.

David Mandell:

So, you're saying, just to make sure, because this is kind of important.t You're saying that, if I was looking to buy, if I'm a physician and I was looking at offices, there may be some offices that they just don't qualify for medical, because they don't have enough parking?

Trisha Talbot:

Right. That's exactly right.

David Mandell:

They wouldn't work, essentially.

Trisha Talbot:

Yeah.

David Mandell:

Because there's people coming all day long to a medical office versus a financial office, and we have some people come by, but really it's just not that many people. So, is that kind of a difference when someone's looking, they have to really understand they need something that would fit a medical environment, which has a lot more traffic?

Trisha Talbot:

So, right now, there might be some office landlords, owners, thinking, "Hey, since my office building is vacant, I might want to try and make it medical." Well, some might be able to do it, but others may not, some will be able to do a portion, but then as soon as they lease up enough in medical to absorb, as the maximum amount of parking to allow for the rest of it to be office, they have to stop leasing to medical. Plus, typically, when they've bought it, they have not bought it with underwriting in mind to do medical tenant improvements. So, building out an office for financial services or an attorney is a lot less than building out an office for a medical provider that requires typically sinks and exam rooms, probably more than one bathroom, because they probably have separate staff.

Then there's also requirements by the city for certain amount of square footage. You have to have more bathrooms. But if you're an OB-GYN, you're going to definitely want to have a staff bathroom and then a patient bathroom, because every time somebody has to come in for an OB appointment, they have to leave a urine sample. So, just things like that. There's functionally different uses for an office user versus a medical user. The medical user requires more TIs. Now, with that, the owner gets longer lease terms. So, you could probably go in and, as a general office user, maybe negotiate a three-year lease. That typically doesn't happen in medical, because they need tenant improvements. So, in order for the landlord to offer those tenant improvements, it needs a longer lease term to amortize those costs.

David Mandell:

Got it, makes sense.

Trisha Talbot:

So, there's different financial strategies when you're purchasing a building to make it medical and different ones if you're going to do general office.

David Mandell:

It makes total sense to me. It sounds like, in big picture, I mean, again, high level, medical's more involved, it's more involved in terms of what you need inside, the parking, I wouldn't even have thought of, but it makes sense. So, because of that, if I'm on the owner's side, I need longer lease terms because I need to, like you said, amortize those costs over time. If I'm

on the physician buyer's side, I got to really understand that, "Hey, I may want to buy this building so I can have my office in there. My idea is to have all these other medical offices in there, but I may not be able to do that, because based on the office, I may be able to get one or two medical in there and the rest can't be, because I'll bump up against these requirements." So, yeah, that's interesting. I wouldn't have thought about that.

Trisha Talbot:

Well, there's also some patient dignity. Really, patients, you don't want to have an oncology center or a dialysis center or something where patients are really, really sick coming through a general office lobby, where there's attorneys and lawyer, it just doesn't make sense. So, there's that.

David Mandell:

I see.

Trisha Talbot:

You know what I mean?

David Mandell:

There is a marketing or image element to it. I mean, different for maybe a plastic surgeon or dermatologist or something like that.

Trisha Talbot:

I think it's more for the patients. You don't want to have to have... Like sick patients, they're already feeling horrible and they're obviously not looking their best and they don't necessarily want to be driven through this main lobby where people are coming and doing white collar job stuff, they're all dressed in their suits and then you're sick and being wheeled through a lobby.

David Mandell:

It's a good point that I don't really think about. Fortunately, I'm pretty healthy so far, so I haven't had to really deal with that. But I'm thinking of even orthopedics, crutches, all these people in crutches and then there's a medical office. I know where we have our offices, none of them, I think, have medical in it. I'm in an office tower down here in South Florida. I don't think there's medical on any of that. So, I never really thought of it that way, but I guess that's true.

So, I want to explore some questions to keep us on track, time-wise, the kind of questions that physicians would ask you. Right? So, first of all, what is a healthcare real estate advisor? And if I was a doc, why would I consider that?

Trisha Talbot:

So, one, a healthcare real estate advisor, they really do or should know the medical office market. So, if you're saying, "Hey, I want to open up a site here or in these three markets." They either know people to interview that can help you, if it's not in your local market, or they know the inventory. Now, you can go on the databases and click through a bunch of stuff, but you know the landlords based on what you are going to need or your client's investment in tenant improvements are going to require. I think you can save your client a lot of time of spinning wheels and negotiating deals in properties where the landlord has had it for so long that it's a lot of second generation space, they're not interested in redoing a ton of tenant improvements. They just want to sort of backfill, do carpet paint, and maybe something here or there. But they're not interested in doing much else.

Then if you're a tenant that's like, if your client's like, "Hey, I'll do a 10-year lease, but I really want the landlord to fund a majority of the tenant improvements." You know the landlords that are willing to do that. Because otherwise you spend a lot of time chasing and negotiating deals that they don't make sense for your client based on what their needs are going to be.

You know where cap rates are for medical buildings, you know where lease rates are, lease terms, where different places in the lease that a client should negotiate based on their goals. Just for example, death and disability is a big one in healthcare because if the doctor is disabled or is deceased, then sometimes they are the practice, so they need to be able to not have their estate have to deal with a lease if that's the case. So, that's just one clause, but there's several that are sensitive to healthcare providers and that they should be aware of depending on if they're a group or a sole practitioner.

David Mandell:

So, a follow-up question on that. So, let's say I got a doc listening to this right now and they're, "Hey, Trisha sounds like she... She's talking about, she's got experience in this, she's in Scottsdale, I'm in fill in whatever city it is, let's just call it Atlanta." Is that something that you, with your knowledge, do you have a network? Like, "I have somebody in Atlanta who would know the local and I can give the national expertise," or would that be something you would refer out? Or is that somebody that you could work with? How does that work in terms of a national audience that's listening to this, let's say.

Trisha Talbot:

Sure. I have an extensive broker network that I've developed over the years and I have a lot of states covered. For example, it depends, if someone was buying something in Atlanta or wanting to lease something in Atlanta, I would just refer it to somebody that I know there. If they want to sell something that's in Atlanta, I would still go through a local broker, but I would do a lot of the upfront work. Then, with the local broker, we would put it on the market. So, it depends. But I do have a pretty extensive broker network and if I can't help them at all, and it really just requires a person in the local municipality. I'd make the introduction and then get out of the way.

David Mandell:

That makes sense. So, doing this for a long time, you've got networks around the country, which makes sense, similar to OJM and estate planning attorneys, we know a lot of good ones, we know some firms that can cover nationally a lot of states, where they're licensed and have done work. So, we can cover most places if a client needs it. If I'm a doc, I've got, let's say, a building already, where my practice is, or I've got a surgery center, that has real estate. If I was whether thinking about selling it or just wanted to understand the value maybe to refinance or what have you, how would I go about that? Is that something that you typically help with then? What's the process there?

Trisha Talbot:

So, definitely on the sell side, I mean, valuating for refinance, that would just be a consulting gig, doing a market analysis for them. Then they would take it to some lenders, it's called a broker opinion of value. But the selling is something that I can do. I'm actually doing a pretty big portfolio right now and it's in a variety of different markets. So, along with my broker network, I've been able to get that teed up and off the ground.

David Mandell:

Got it. Okay. Then the process, you were talking a little bit about purchasing or a lease. It sounds like, to me, it's a big enough decision and I've been at conferences, especially like aesthetic conferences where they talk about build out and actually figuring out architectural plans and all this. It's like, which do you do first? Do you figure out what you need from an architect point of view and then do you go to somebody like you to say, "Okay, now I want to find this somewhere." Or do they work with someone like you first to say, "Okay, financially, what I should be doing?" Then build around that with a budget, because some people may want to build the Taj Mahal and doesn't really make sense. So, how do you see that working out often in your experience? What's the best step first?

Trisha Talbot:

I go back to, first of all, a company deciding what is their budget for a new site? What do they want their lease expense to be? That includes rate plus the operating expenses. Because different business lines or whatever they're trying to accomplish, they might have different revenue streams. So, what the revenue stream that's going to be in that site, really figuring out what your budget can be for overhead for your office space. Then from there, figuring out, if it's their first office, I feel like the first office is really hard because they don't necessarily know what they need.

But, for example, I have a client that's a women's center and they have an idea of what they're looking at and then they're doing now their own internal analysis. But if you're an orthopedic or family practice or something like that, and I can ask the questions of how many exam rooms are you looking for? How many bathrooms do you want in there for patients and then for staff? How many people do you want your waiting room to hold? How many people do you want in your front office? Do you want to have a break room? Do you want to have private physician offices? Then whatever, if they need a lab or something else.

So, I can sort of sketch out that, and based on my experience, have a little bit of an idea of how much space they're going to need within a target range. Then with their budget go and be able to find buildings that are that size. And when they start to buy a building, do they want it just for that size? Do they want to be able to have expansion abilities? Do they want to lease out some space? So, those questions come in. So, I can help them in that regard. If they don't have architects, I can recommend some. But if they do have a relationship with an architect, I try to get plans to send over to the architect to be able to do some conceptual plans for their clients.

So, I guess the answer to your question is, it depends, but you can have some things running somewhat parallel. I can be looking for buildings, find some, get the plans, send it over to the architect, have them do some sketches, see if it's going to work for them, physically. Then start getting into a short list of properties, because I'm sure there's probably a few properties that something can work in. Then from there, I can just try to negotiate. If they like all the properties the same and they all will functionally fit, then I can just negotiate on terms and try to get them the best deal. It is nice.

So, with general contractors as well, it kind of depends on the size of the project, but somebody like me, I can refer some. Or if they have a relationship with them, once they do get that conceptual plan from the architect, they could have their general contractor do what's called budget numbers just to give them an idea of what the numbers would be. Because I'm sure they have their own models that they can say, "Oh, this, this and this, tweak a few things." "Here's an estimated amount of what it would cost." So, some of these things can all be

running parallel. When I'm working with a client's team like that, try to make it as seamless as possible.

David Mandell:

That makes sense. Yeah. Sometimes you have to run these things in parallel. So, a couple related questions, we're coming to the end of the time, but I want to get these two together. So, let's just say, I'm thinking about, and I'm sure a lot of docs have thought about this maybe in the last year or so as real estate values have gone up a lot. I don't know so much in the medical office space, certainly, we all know about homes. How would I position a medical office for its highest valuation, A, and B, when should I consider selling? I mean, a lot of docs, if they're solo practice, would be like, "Okay, when I'm about to retire." But in a group practice, would they ever sell? I mean, why would they, practice is going to continue, they need to be somewhere. So, if you can talk about positioning for valuation and then when you would even think about selling.

Trisha Talbot:

So, positioning, so a lot with income real estate, it has a lot to do with the tenants inside. So, if they're the only tenant, I would say they need to get a lease, a market lease in place. If they have other tenants, you have to look and see what is going on there. If they don't have market leases, then you can try to work through them if they're expiring and renew them. But it's depending on where... This is the problem if they've been negotiating below market rents and then they want to, all of a sudden, do market rents, what most likely happen is they'll have to clean out the tenants that are in there, because jumping a tenant up too much, just everyone gets upset.

But let's assume we have market leases in place. So, that's great. The common area, making sure that common area is in its best look and feel, maybe a fresh coat of paint. I don't know that anyone has carpet anymore, but if they did have carpet, I'd recommend that they remove it. Then landscaping, make sure that the landscaping is taken care of, the exterior. If the building needs to be painted, just like a house, in some ways, if the exterior of the building needs to be painted, if the roof is at... I don't necessarily recommend replacing a roof of a building you're going to sell, but definitely make sure that it's in good working order, patch it, repair it. Definitely do not have a lot of deferred maintenance on the property, just make sure that's-

David Mandell:

If you don't want to have a headache, yeah.

Trisha Talbot:

Exactly.

David Mandell:

Then what about the other piece of it, which is, when would I consider selling? What would you say would be an indicator that, "Hey, this might be a time to sell, either because of the market or because of your circumstances." Or when do you see practices selling?

Trisha Talbot:

So, if you're looking to sell, just in general, right now, cap rates are pretty low and they stay pretty low on medical office for the most part, provided that the lease terms are strong and the tenants are strong. There's a lot of capital that has migrated over to medical office, because of the thought that it is recession proof. It's not recession proof. I mean, it's recession resilient. I mean, everyone gets affected when there's a recession. But it is the fact that it is a purpose-driven property. I mean, there's reasons for these tenants to be in there during COVID. Even during COVID, the physicians had to go in, I mean, those essential businesses. Physicians had to go in, I mean, there were some elective procedures that were paused for some time. But they went back pretty quickly. In Arizona, I think it was maybe five or six weeks.

David Mandell:

Yes.

Trisha Talbot:

So, these people cannot work out of their offices, I mean, or out of their homes, patients can't go... So, there's a reason for them to be there and they have a mission critical demand-driven. So, that's one reason to do it. Now, when somebody should cash out? So, sale leasebacks are pretty popular with physician-owned real estate. That's because the value of the property is at its highest when you have the longest lease in it. So, let's say, 10 years. So, if you're going to want to sell it, I would say, look and be aware of maybe your retirement age and maybe 10, 12 years before then, maybe think about putting a 10-year lease on your property and then selling it to an investor, because that's where you're going to get your highest invest use.

If you wait until you retire and then you move out, then you're selling a vacant building. Then it's on a price per square foot. If you bought it, of course, 30 years ago, you're going to make money on it. But the highest amount, the highest value you will receive is with a tenant in place. So, either you have to move out and find a tenant, or you cash out about 10 years before you are about to retire. Now, practices with multiple providers, there are people out

there that can put some structures in place where people that are looking to retire can cash out and people that are young and coming into the practice can buy in. So, they can structure it that way, where you don't actually have to sell the real estate. You can exchange ownership.

David Mandell:

Cash out your own.

Trisha Talbot:

Great. Exactly.

David Mandell:

Financing, have the young docs buy you out on some kind of rolling process, just like you might do for the practice value. Now, it was interesting when you said there, a 10 year timeframe might be the perfect time. So, those of you listening, who are approaching retirement, or you see it out there, especially solo practices... Now, I guess some clients may say they'd rather hold onto it and then try to find someone to take over the practice and then have a rental stream.

We had a doc on the podcast, Dr. Yanoff, last season who talked about that as something that he did as he exited. But at least it should be thought through and sounds like even 10 years out, because you want to make smart decisions. If you say, "Listen, I don't want to be a landlord, I'd rather get out." If the value of the timing is good, where there's an upcycle, then maybe makes sense to sell and lease it back. I guess you're saying there are investors out there who would buy the property. It may actually value it more favorably with knowing that your practice is going to be paying rent for 10 years in there.

Trisha Talbot:

Exactly. I think once you decide that, once you make that choice... So, with physician-owned real estate, sometimes there's still an emotional connection to the building. Some of these practices have built these buildings from the ground up, they've put their heart and soul into it and that's why they typically want to hang onto it for the income stream. But what you have to decide, you have to really take the emotion out of it. I don't mean to sound cold. But you need to analyze it from a purely financial perspective and say, "The benefit that I will receive on a monthly basis from this income stream versus this lump sum of capital, and then go employing that capital and other investment real estate, where there's already tenants and I don't have to fill it."

And then there's passive ways that you can invest in real estate and active ways that you can invest in real estate and you can still get tax advantages in both. So, from there, you just have to decide how involved, hands-on do I want to be? And what can I do with this lump sum of capital, because maybe you go in and then diversify into two different rental properties instead of one. You never know.

David Mandell:

Or even diversify in other asset classes, as we help docs with at OJM -- balance out their portfolio, say, "Listen, let's have some things that are more balanced." Especially if they're not balanced already. That would be something we recommend. So, yeah. Excellent. So, let's just, last thing, what's one takeaway or one broad idea you would give docs listening to this about real estate in their practice?

Trisha:

Yeah. So, with medical office real estate, the value of the real estate is really the tenants in there. So, as a tenant or as an owner, the value is you as a tenant in the building, if you own it, or if you're a tenant in a landlord's building, it's the tenants that make the value of that building. So, I guess when you're negotiating a lease or looking to buy or sell a property, just think about that, that you are the value of the property. A medical office building built out in the middle of nowhere is a value of zero, because nobody will occupy space there versus a medical property that is built serving a community or in a lot of mental buildings are built with pre-leasing. So, they have to have a certain amount of pre-leasing before they'll actually start going vertical. It's because the value of a medical building is the tenants that are in it.

David Mandell:

Yeah. That's a good thing to remember for those of you who don't own, who you are lessees, that you have some negotiation power because the value is in what your lease and you're continue to pay. So, that's a great point. Trisha, thank you so much for being on. This was great. I learned a lot. And I know a lot of our clients and docs out there listening, this is something that we get asked about and questions. So, thanks again for being on.

Trisha Talbot:

You're welcome. Hopefully, I didn't get too in the weeds. If so, someone can just ping me.

David Mandell:

Absolutely. Well, we're going to have your bio in there and the LinkedIn. So, if people have questions and there may be people who are in a decision place right now and could use your help. I wouldn't be surprised. You know docs like I do, a lot of them want to get in the weeds more than sometimes they should, actually. So, that's fine. But thanks again for being on.

Trisha Talbot:

You bet.

David Mandell:

Thanks for all you folks out there listening. Again, we'll have another episode in a couple weeks and if you are a physician and you think you have some interesting story to tell or some insights or something that you think your colleagues would appreciate hearing, feel free to contact me. I'm always looking for new guests and would love to hear from you. So, with that, thank you very much. And look for our next episode in a couple weeks.