Queensland Government

Queensland Health

Enquiries to: Helen Rees
Director
Private Health Regulation Unit
Healthcare Regulation Branch
Telephone: s.73 - Irrelevant information
File Ref: C-HFA-1491-006

Mr David Kippin
Weststate Private Hospital Pty Ltd
PO Box 1434
Townsville Qld 4810

Email: s.73 - Irrelevant @weststate.com.au

Dear Mr Kippin

Application for approval of Weststate Private Hospital –Approval with additional conditions

Thank you for your application for an approval to be an authority holder for a new private health facility.

Decision

I am pleased to grant an approval, with conditions, under section 19 of the *Private Health Facilities Act 1999* (**Act**), to Weststate Private Hospital Limited (**WPH**) to be an authority holder for the proposed private health facility to be located on Cnr Ingham Rd and Sturt St, Townsville, and to be known as Weststate Private Hospital.

The proposed private health facility will be licenced as a 26 inpatient bed private hospital to provide the following types and levels of services as per the Clinical Services Capability Framework:

- Anaesthetic Services Level 3
- Anaesthetic Services - Children's > 1 Years Level 3
- Close Observation Services Level 3
- Medical Imaging Services Level 4
- Medical Services Level 4
- Medication Services Level 4
- Nuclear Medicine Services Level 4
- Pathology Services Level 4
- Perioperative Services - Day Surgery Services Level 4
- Perioperative Services - Endoscopy Services Level 4
- Perioperative Services - Operating Suite Services Level 3
- Perioperative Services - Post-Anaesthetic Care Services Level 3
- Surgical Services Level 3
- Surgical Services - Children's > 1 years Level 3

The conditions of the approval are:

1. The approval holder must notify the Chief Health Officer of a prescribed change within 21 days of the prescribed change in accordance with section 23(4) of the Act (see also section 5 of the *Private Health Facilities Regulation 2016*).

2. Only the type and level of health services stated on the approval will be provided at the proposed private health facility.
3. The approval holder must provide the following to the Chief Health Officer, to allow the Chief Health Officer to determine whether the holder remains suitable to hold the authority:
    a. Current financial reports, and any other information the authority holder may wish to provide, in January and July of each year for the duration of this approval or such other period notified by the Chief Health Officer in writing.
    b. Information which indicates that the authority holder may be affected by bankruptcy action (see s 80(3) of the Act or by control action (see s 80(4) of the Act) under the *Corporations Act 2001*, within 7 days of the authority holder becoming aware of the information.

Please find enclosed Approval No 2312/22 that has been issued on 22 December 2022, expiry 30 September 2024.

Reasons for the decision to impose conditions 2 and 3

Material relied upon

In making my decision, I had regard to the following:

- Application form and supporting documentation
- Certified statutory declaration from the Directors of WPH
- WPH's business case and corporate structure
- WPH's and Weststate Hospital Holdings' financial statements for 2021 and 2022
- Liquidator reports including reports to creditors and statutory reports to creditors
- Two (2) Equifax Australasia Credit Ratings Pty Ltd (**Equifax**) reports including Comprehensive Credit Rating of WPH and Advanced Financial Assessment of WPH utilising your response to the Comprehensive Credit Rating report
- NAB funding correspondence
- Centuria Capital Group leasing agreement
- *Private Health Facilities Act 1999*

Findings on material questions of fact

In relation to condition 2, I made the following findings:

1. WPH has submitted documentation as part of its application which seeks approval of particular types and levels of health services.
2. The application has been assessed on the basis that the specified types and levels of health services are those which will be provided at the proposed private health facility.
3. The suitability of the holder and proposed private health facility have not been assessed in relation to other types and levels of health services.

In relation to condition 3, I made the following findings:

1. Weststate Private Pty Ltd was the holder of an approval for a private health facility, being Weststate Private Hospital. Weststate Private Pty Ltd went into liquidation while it held the approval.
2. In considering the suitability of WPH to hold an authority for a private health facility, under s 13(2)(g) of the Act I may have regard to WPH's current financial position and financial background.
3. As each of the directors of WPH was a director of Weststate Private Pty Ltd immediately prior to its liquidation, I considered the circumstances giving rise to the liquidation to be relevant to the financial background of WPH.
4. As part of its application, WPH submitted information about how it intended to raise funds to provide health services at the proposed facility. I considered the proposed funding arrangement to be relevant to the current financial position of WPH.

5. To assist me in assessing the current financial position and financial background of WPH, I sought a report from Equifax.
6. Equifax provided an initial report on 26 August 2022 (**Initial Report**). In accordance with the recommendations of the Initial Report, and consistent with the rules of natural justice, I sought further information from WPH under s 18 of the Act.
7. Upon receipt of the further information, I considered it desirable to obtain a further report from Equifax, to assist in assessing the current financial position and financial background of WPH.
8. Equifax provided a further report on 8 November 2022 (**Second Report**). In accordance with the recommendations of the Second Report, and consistent with the rules of natural justice, I sought further submissions from WPH on the Second Report.
9. The Second Report recommended:
    a. That I obtain satisfactory evidence that WPH will obtain the proposed capital investment and debt financing.
    b. That I consider imposing conditions on this authority providing for ongoing financial monitoring.
10. On 25 November 2022, WPH made submissions providing further information about funding and noting that WPH's directors have no objection to the imposition of reporting covenants requiring WPH to participate in ongoing financial monitoring, including provision of the financial and other information to facilitate regular reviews of WPH's credit quality.
11. Having considered the relevant documents and further information, and noting the financial background of WPH, I consider that ongoing financial monitoring is desirable, so that I can be satisfied that WPH remains a suitable person to hold the authority.

Reasons for the Decision

In relation to condition 2, I consider that the inclusion of a requirement that only the assessed types and levels of health services are being offered by the facility is desirable for the proper operation of the proposed private health facility, and the health and wellbeing of patients who may receive health services at the proposed facility.

In relation to condition 3, I consider that the inclusion of a requirement for ongoing financial monitoring is appropriate for the proper operation of the proposed facility, enabling me to be satisfied that WPH remains financially stable and a suitable person to hold the authority.

Review of decision

You may seek a review of the decision to impose conditions 2 and 3 within 28 days of receiving this notice under part 9, division 1 of the Act.

A review application must, at first instance, be made to me, in writing, and state the grounds of the review. The application can be sent to s.73 - Irrelevant information@health.qld.gov.au.

If you are dissatisfied with the internal review decision, you may apply to QCAT under part 9, division 2 of the Act.

Please contact Helen Rees, Director, Private Health Regulation Unit, Department of Health by telephone on s.73 - Irrelevant information or by email at s.73 - Irrelevant information@health.qld.gov.au should you require any clarification or further time to apply for review.

Yours sincerely

Dr John Gerrard
Chief Health Officer
21 December 2022

APPROVAL NUMBER: 2312/22

Queensland Government

Private Health Facilities Act 1999
Private Health Facilities Regulation 2016

Department of Health

APPROVAL FOR A PRIVATE HEALTH FACILITY

for

Weststate Private Hospital Limited

proposed licensee of

WESTSTATE PRIVATE HOSPITAL

located at
29-37 Ingham Road TOWNSVILLE QLD 4810

The proposed health facility is to be a private hospital licensed for **26 beds**.

Services	CSCF Level	Services	CSCF Level
Anaesthetic Services - Children's > 1 Years	Lvl 3	Pathology Services	Lvl 4
Anaesthetic Services	Lvl 3	Perioperative Services - Day Surgery Services	Lvl 4
Close Observation Services	Lvl 3	Perioperative Services - Endoscopy Services	Lvl 4
Medical Imaging Services	Lvl 4	Perioperative Services - Operating Suite Services	Lvl 3
Medical Services	Lvl 4	Perioperative Services - Post-Anaesthetic Care Services	Lvl 3
Medication Services	Lvl 4	Surgical Services - Children's > 1 years	Lvl 3
Nuclear Medicine Services	Lvl 4	Surgical Services	Lvl 3

The approval is issued subject to compliance with the Private Health Facilities Act 1999 and the following conditions:

1. The approval holder must notify the chief health officer of a prescribed change within 21 days of the prescribed change in accordance with section 23(4) of the *Private Health Facilities Act 1999* (see also section 5 of the *Private Health Facilities Regulation 2016*).
2. Only the type and level of health services stated on the approval will be provided at the proposed private health facility.
3. The approval holder must provide the following to the Chief Health Officer, to allow the Chief Health Officer to determine whether the holder remains suitable to hold the authority:
   (a) Current financial reports, and any other information the authority holder may wish to provide, in January and July of each year for the duration of this approval or such other period notified by the Chief Health Officer in writing.
   (b) Information which indicates that the authority holder may be affected by bankruptcy action (see s 80(3) of the *Private Health Facilities Act 1999*) or by control action (see s 80(4) of the *Private Health Facilities Act 1999*) under the *Corporations Act 2001*, within 7 days of the authority holder becoming aware of the information.

This approval shall commence on the **22 December 2022**
The approval shall, unless sooner cancelled, suspended or surrendered, expire on the **30 September 2024**

Dated at Brisbane this 21st day of December 2022

Chief Health Officer

Queensland Government

Queensland Health

Enquiries to: Helen Rees
Director
Private Health Regulation Unit
Healthcare Regulation Branch
Telephone: s.73 - Irrelevant information
File Ref: C-HFA-1491-006

Mr David Kippin
Weststate Private Hospital Pty Ltd
PO Box 1434
Townsville Qld 4810

Email: s.73 - Irrelevant @weststate.com.au

Dear Mr Kippin

Application for approval of Weststate Private Hospital – Written notice requesting further information

I refer to the further information and documents provided by Weststate Private Hospital Limited (**WPH**) on 17 October 2022.

To assist me in deciding WPH's application, the further information and documents were provided to Equifax Australasia Credit Ratings Pty Ltd (**Equifax**). Equifax has provided an advanced financial assessment on WPH dated 8 November 2022 (Attachment 1. Second Equifax Report).

Before deciding WPH's application I would like to afford WPH with an opportunity to provide the following, in light of the Second Equifax Report:

1. The matters set out under the "Recommendations" heading of the Second Equifax Report, being:
   a) evidence of the ability of WPH's directors to fund capital requirements to operate the proposed hospital, including $s.73 - Irrelevant information in capital investment for WPH and $s.73 - Irrelevant information in debt financing;
   b) an undertaking from the directors of WPH stating that I will be updated of any material changes to the independently verified five-year financial forecast, version "Revised July 2022", or any circumstances that may affect the forecast utilised for the Second Equifax Report; and
   c) any submissions on the recommendation that consideration be given to imposing reporting covenants that require WPH to participate in an ongoing financial monitoring regime including provision of financial and other information to facilitate regular reviews of WPH's credit quality (at my request).

2. Any submissions on the Second Equifax Report.

Under s 21(b) of the *Private Health Facilities Act 1999*, I must decide WPH's application by **13 December 2022**, or the application is taken to be refused (unless I consider that further time is required under s 20).

I request that WPH provide its response by **4pm on 28 November 2022**. If WPH fails to provide its response within the stated time, I may proceed to decide the application based on the material available at that time.

Please provide the information or documents by email to s.73 - Irrelevant information @health.qld.gov.au.

Please contact Helen Rees, Director, Private Health Regulation Unit, Department of Health by telephone on s.73 - Irrelevant information or by email at s.73 - Irrelevant information @health.qld.gov.au should you require any clarification or further time to respond to this request.

Yours sincerely

Dr John Gerrard
Queensland Chief Health Officer
Deputy Director-General
16 November 2022

Queensland Government

Queensland Health

Enquiries to: Helen Rees
Director
Private Health Regulation Unit
Telephone: 0417 726 763
File Ref: C-HFA-1491-004

Mr David Kippin
Weststate Private Hospital Pty Ltd
PO Box 1434
TOWNSVILLE QLD 4810

Email: s.73 - Irrelevant information **@weststate.com.au**

Dear Mr Kippen

Application for approval of Weststate Private Hospital – Written notice requiring further information or a document

This is a notice under s 18 of the *Private Health Facilities Act 1999* (Act) requiring further information or a document to help me to decide the application by Weststate Private Hospital Limited (WPH) for an approval for the proposed Weststate Private Hospital under part 5 of the Act made on 2 August 2022 (Application).

I consider the further information or documents set out in Attachment 1 to be necessary and reasonable to help me decide the Application.

The information or documents required to be given under this notice must be provided by 4pm on **17 October 2022**. If WPH fails to comply with this notice within the stated time, WPH is taken to have withdrawn the Application.

Please provide the information or documents by email to s.73 - Irrelevant information @health.qld.gov.au.

Please contact Helen Rees, Director, Private Health Regulation Unit, Department of Health, on telephone s.73 - Irrelevant information or via email at s.73 - Irrelevant information @health.qld.gov.au should you require any clarification or further time to respond to this notice.

Yours sincerely

Dr John Gerrard
Queensland Chief Health Officer
Deputy Director-General
15 September 2022

Attachments:

- Attachment 1: Details of further information or documents
- Attachment 2: Equifax report

Attachment 1: Details of further information or documents

Item	Description of information or document	Relevant statutory function
1	Further information about the conduct of the directors of WPH in their capacity as directors of Weststate Consortium Pty Ltd (**Consortium**) in relation to payments made by Consortium to Weststate Private Pty Ltd, particularly those made on 11 August 2020 (s.73 - Irrelevant information and 3 September 2020 s.73 - Irrelevant information Where the further information relates to the conduct of a director of WPH, the further information must be verified by a statutory declaration.	Act, s 13(2)(b) Act, s 13(2)(g)
2	Any submissions that WPH may wish to make on the contents of the reports of Consortium's administrator and liquidators submitted as part of the Application, particularly the liquidator's report dated 22 April 2022. Where the submissions relate to the conduct of a director of WPH, the submissions must be verified by a statutory declaration.	Act, s 13(2)(b)
3	Any submissions that WPH may wish to make on its directors' responsibility for the circumstances leading to Consortium entering voluntary administration and, subsequently, liquidation. Where the submissions relate to the conduct of a director of WPH, the submissions must be verified by a statutory declaration.	Act, s 13(2)(g)
4	Justification from a suitably qualified expert on the validity and appropriateness of the key operating and non-operating assumptions used to derive the five year financial forecast previously provided by WPH as part of the Application.	Act, s 13(2)(h)
5	Evidence of WPH's ability to raise the proposed funding, including the shareholder investment of $ s.73 - Irrelevant information and s.73 - Irrelevant information n debt funding. Where the evidence relates to the conduct of a director of WPH, the evidence must be verified by a statutory declaration.	Act, s 13(2)(h)
6	Any submissions that WPH may wish to make on the credit assessment report prepared by Equifax Australasia Credit Ratings Pty Ltd on WPH. A copy of this report is provided in Attachment 2. Where the submissions relate to the conduct of a director of WPH, the submissions must be verified by a statutory declaration.	Act, s 13(2)(h)

List of Services and Levels

Clinical services capability framework (CSCF)

Facility name:	WESTSTATE PRIVATE HOSPITAL
Date of submission	21 July 2022

Indicate all services and capability levels you offer/intend to offer by entering level numbers against the relevant services. The minimum requirements you will need to meet to offer each service are outlined in the relevant CSCF module.

CSCF services	Level
Alcohol and Other Drug Services–Ambulatory	
Alcohol and Other Drug Services–Emergency	
Alcohol and Other Drug Services–Inpatient Adult	
Alcohol and Other Drug Services–Inpatient Child and Youth	
Anaesthetic Services	3
Anaesthetic Services–Children's	3
Cancer Services–Children's	
Cancer Services–Haematological Malignancy	
Cancer Services–Medical Oncology	
Cancer Services–Radiation Oncology	
Cancer Services–Radiation Oncology – Children's	
Cardiac Services–Cardiac (Coronary) Care Unit Services	
Cardiac Services–Cardiac Diagnostic & Interventional Services	

CSCF services	Level
Cardiac Services–Cardiac Medicine Services	
Cardiac Services–Cardiac Rehabilitation–Inpatient	
Cardiac Services–Cardiac Rehabilitation–Outpatient	
Cardiac Services–Ongoing prevention and maintenance	
Cardiac Services–Cardiac Surgery Services	
Cardiac Services–Cardiac Outreach Services	
Close Observation Services	3
Close Observation Services - Children's	
Emergency Services	
Emergency Services–Children's	
Geriatric Services–Emergency geriatric care	
Geriatric Services–Geriatric Acute Inpatient	
Geriatric Services–Ambulatory	
Geriatric Services–Cognitive Impairment	
Geriatric Services–Consultation Liaison	
Geriatric Services–Geriatric Evaluation and Management	
Geriatric Services–Interim Care	
Geriatric Services–Geriatric Rehabilitation	
Geriatric Services–Ortho-geriatric	
Hyperbaric Oxygen Therapy Services	
Intensive Care Services	
Intensive Care Services–Children's	

CSCF services	Level
Maternity Services	
Medical Services	
Medical Services–Children's	
Medication Services	4
Medical Imaging Services	4
Mental Health Services–Adult Ambulatory	
Mental Health Services–Adult Acute Inpatient	
Mental Health Services–Adult Non-Acute Inpatient	
Mental Health Services–Child & Youth Ambulatory	
Mental Health Services–Child & Youth Acute Inpatient	
Mental Health Services–Child & Youth Non-Acute Inpatient	
Mental Health Services–Older Persons Ambulatory	
Mental Health Services–Older Persons Acute Inpatient	
Mental Health Services–Statewide & Other Targeted Services–Eating Disorder	
Mental Health Services–Statewide & Other Targeted Services–Perinatal & Infant	
Neonatal Services	
Nuclear Medicine Services	4
Palliative Care Services	
Pathology Services	4
Perioperative Services–Acute Pain Services	
Perioperative Services–Day Surgery Services	4
Perioperative Services–Endoscopy Services	4

CSCF services	Level
Perioperative Services–Operating Suite Services	3
Perioperative Services–Post-Anaesthetic Care Services including Children's Post-Anaesthetic Care	3
Persistent Pain Management Services	
Rehabilitation Services	
Renal Services	
Sleep Disorder Services	
Surgical Services, including Surgical Oncology Services	3
Surgical Services–Children's	3
Termination of Pregnancy Services	

Health services within private hospital facilities – third party providers
Third party details are required for the following in-hospital services

CSCF services	Name of third party provider
Medical Imaging Services	Permira - I-Med
Medication Services	Icon Group – Slade Pharmacy
Nuclear Medicines Services	
Pathology Services	Sonic Health Care - S&N

Refer to Section 10(3) and section 40 of the Act

Weststate Private Hospital

Business Case

Revised July 2022

WESTSTATE
PRIVATE HOSPITAL
Leading Your Healthcare Journey

E³ Vision: Experience, Engagement, Efficiency

Contents

Glossary of Abbreviations

ALOS
Average Length of Stay for a hospital inpatient, measured in days.

BAF

Queensland Government Building Accelerated Fund (interest free loans for up to $15m over 15 years)

CCU
Coronary Care Unit. Higher dependency staffing and monitoring for cardiac patients.

CEO
Chief Executive Officer

CMO
Career Medical Officer. Employed by a hospital, typically to manage patients on behalf of specialists

CSSD
Central Sterile Supply Department (sterilisation of theatre instruments)

DA
Development Approval. Council town planning approval for a project to proceed.

EBITDA
Earnings Before Interest, Tax, Depreciation, Amortisation. Recent sales of private hospitals have been based around 11-12 x EBITDA

EBITDAR
as above after rent.

EMR
Electronic Medical Record (digital, paperless system)

HDU
High Dependency Unit – For patients that require a higher level of monitoring, typically after surgery for a limited time until returned to the ward.

HSPC
Health Sciences Planning Consultants. Leading hospital architects.

ICU
Intensive Care Unit. Specially designed and licensed area for high acuity patients, typically with 1:1 or 1:2 nurse to patient ratios. Funded at higher rate by Health funds and subject to separate reporting.

Mater
The Mater Private Hospital Townsville

NAIF

Northern Australia Infrastructure Facility fund, providing low interest loans for infrastructure projects to stimulate investment. This project has been formally supported by the Federal member.

PAS
Patient Administration System, a standard component of medical record and EMR systems.

PPD
Per patient day – used to calculate the cost of keeping a patient in hospital for one day

TASY

The selected Electronic Medical Record (fully digital) system, provided by Philips

TUH
Townsville University Hospital, the main public hospital in Townsville, affiliated with James Cook University.

WPH
Weststate Private Hospital

Executive Summary

Note:

This version reflects Stage 1 only and assumes Bank finance for most of the required equipment procurement. A proposal is planned for submission with the Northern Australia Infrastructure Facility (NAIF) fund for loans at concessional interest rates and deferred principal repayments (5 years deferral) for:

- s.73 - Irrelevant information ***contribution to building construction***

This will have the effect of reducing rent payments by s.73 - Irreleva nt ***pa. It is uncertain whether any loan will be approved by NAIF, and whether for the full amount or part thereof.***

These are not reflected in this Business Case nor in the detailed companion financial model.

It assumes Bank funding for equipment for Stage 1 of $ s.73 - Irrelevant informatio ***(of $*** s.73 - Irrelevan t ***total equipment procurement) repayable with interest and principal over 7 years. Only a loan for Stage 1 is sought now until the timing for the Stage 2 DA is determined after the hospital has established a sustained period of profitable trading.***

The financial model has been reviewed in detail, and some conservative changes made as part of a continuing review process.

Overview

Weststate Private Hospital (WPH) will be a new modern hospital, uniquely owned by surgical specialists in Townsville. The core founding shareholders are leaders in their fields in Townsville and have already invested in excess of $ s.73 - Irrelev ant in their personal capacities since project inception.

The project is the development of a private hospital in Townsville, owned by three local specialists, with the plan to broaden shareholding to other specialists in Townsville, i.e., to be a doctor owned facility.

The development sites are the old Townsville West State School and an adjacent clear site, at the North East intersection of Ingham Rd and Sturt St, a major and busy intersection at the edge of the CBD. The specific adjoining site locations are 763 Sturt Street West End, 2 Wilson Street West End and 2A Lamington Road West End. The project involves refurbishment of the school for consulting and non-clinical services, and construction of a hospital on an adjacent site with connecting links.

It is also planned to create a Medical Suites building on another adjacent site to complement consulting rooms established in the school renovation.

Services will be restricted to surgical only – the highest revenue services with the shortest lengths of stay and therefore rapid turnover, and a high revenue per sqm of footprint, relevant for earnings to rent cost ratios.

The founding shareholders are committed to high quality patient care, supported with industry leading services and processes. This is embodied in the three (3) 'E' Values, expressed as E³:

- **Experience of the Patient and Provider**
- **Efficiency of the Hospital**
- **Engagement of all Stakeholders**

E³ Vision: Experience, Engagement, Efficiency

Current Scope – Stage 1

The scope of the hospital is consistent with the approved DA and Queensland Health guidelines.

The hospital will consist of **4** Operating Theatres; **1** Procedure Room/Operating Theatre; **26** Overnight Beds; **19** Recovery/Day Beds (consisting of **2** x Stage 1 Recovery Beds; **16** x Stage 2 Recovery Beds; **1** x Isolation Room Bed) and is classified as **a Surgical Level 3 - Complexity IV Hospital.** This classification includes major surgical procedures with low to medium anaesthetic risk, and a close observation, High Dependency Unit (HDU). The intended medical procedures would meet the 'major surgical procedure' requirement.

This will provide the Hospital with a license approval to undertake a range of high-volume surgical procedures such as major orthopaedic (hips and knees), bariatric surgery, urology procedures such as TURPS (Prostate) and other general surgeries.

Future Proofing – Potential Stage 2 Scope

It is expected that the demand for theatre time from prospective surgeons will exceed initial estimates. Within the footprint of the existing DA, it is possible to accommodate the development of 7 theatres, 1 procedure room, 21 day beds and 54 overnight beds (including 6 ICU / HDU). Should this **Stage 2** expansion proceed, at an appropriate time in the future, an amendment to the Council DA will be required.

Stage 1 - Project Financing Components	Projected Cost
Land and buildings Rent at 6% pa (after 15 month "honeymoon scale up")	s.73 - Irrelevant information
Equipment	
Equity - Working Capital Reserve	
Equity - Equipment Reserve	
Bank Loan – Equipment financing	

In summary, a major hospital property fund (Centuria Capital Group) is the substantive owner of the land and buildings. WPH will own the business and be responsible for furniture, fittings, equipment (FFE), and operational outlays. Separation of ownership of the operating business from the land and buildings is a common structure in the private hospital sector under the OpCo – PropCo model.

Key drivers underpinning success of the hospital include:

- Doctor-owned shareholding underwriting the service quality and exceptional patient experience ethos.
- The surgical case commitment from the 3 founding surgeons/principal shareholders, will significantly underpin the surgical revenues of the hospital.
- Provide a quality competitive alternative to Townsville's only other private overnight hospital, the Mater Private Hospital Townsville.
- Absolute commitment from the organisation to deliver quality and efficiency for patients, doctors and health insurance funds to address current high dissatisfaction levels in the private health sector. This is expressed through Weststate's E³ vision – *Experience of the Patient and Provider, Efficiency of the Hospital, Engagement of all Stakeholders*.

- Engagement of an experienced interim consulting CEO to drive the development stage through to the commissioning of the hospital, at which stage a permanent CEO will be appointed (CEO has been appointed but will not commence for 9 months).
- Involvement of health architect firm HSPC, considered to be best-practice architects in the health and hospital sector. HSPC has been contractually engaged by the builder, Woollam Constructions.
- A growing population in Townsville, with demonstrated strong future demand as ascertained by demand forecasts in the health sector. Hospital admissions are forecast to double over the next 15 years *(Ref: Hardes and Associates, see graph on page 16).*
- Specialising in higher fee surgical procedures, avoiding lower fee, lower acuity rehabilitation, mental health and complex medical patients, as well as excluding high risk obstetrics services.
- Offering a solution for the current problem of an over-burdened public hospital system with extraordinarily high admissions of privately insured patients.
- Development property will sit within Centuria Property Fund – CHPF South Bunbury Pty Ltd as trustee for CCHPF Hobart Sub Trust
- Development approval for Stage 1 obtained from Townsville City Council. A design and development plan has also been proposed for Stage 2 which readily facilitates viable expansion for additional theatres and beds within the DA approved footprint, which is proposed at an appropriate time in the future.
- A complementary and adjacent development, comprising medical suites, is to be available on strata and lease basis which will complement the existing consulting facilities available within the core project development (albeit, on limited scale).
- The use of an Electronic Medical Record system (will be only the third private EMR in Australia) will hallmark the hospital by providing a paperless fully digital operation, enabling efficiencies and quality to be at optimum levels and set new benchmarks.
- Integrating the very latest in medical technology, more advanced than public and private health providers in North Queensland. This will include orthopaedic robots, theatre air quality systems to virtually eliminate infection and a reverse osmosis water treatment system for the Central Sterile Services Department (CSSD) to ensure infection-free sterilising.
- A significant feature of the Business Case viability assessment is that the 3 founding surgeons will contribute some s.73 - Irrelevant information in hospital revenue, being 50% of the year 1 target.
- A relatively small sample of other surgeons verbally committed to a number of sessions each. To be conservative, this indicated number of sessions was halved.
- The combined revenue on the foregoing basis is 70% of year 1 target revenue, per following table:

Founding Surgeon Hospital Revenue				
	Sess pw	Cases / sess.	Rev. per case	Rev pa 46 weeks
Peter McEwan	s.73 - Irrelevant information			
Kaushik Hazratwala				
Kiran Hazratwals				
Add Other verbal commitments discounted by 50%				
s.73 - Irrelevant information	s.73 - Irrelevant information			
Founders Plus Sample (discounted)				s.73 - Irrelevant information
Year 1 Revenue target				
% of Target				

A full-scale surgeon recruitment program has been curtailed during the core construction phase to enable surgeons to gain comfort with the development as it rises. The recruitment program will spell out incentives including shareholding; discounted rent for consulting rooms; participation in the decision making with the hospital thereby providing clinical autonomy; selection of their own dedicated theatre teams; higher patient satisfaction due to a concentrated focus on quality and patient amenity. When the CEO is announced, it is expected that there will be widespread endorsement of the appointment among surgeons and within the local business community.

Finance

- Total financing requirement sought from Nab is s.73 - Irrelevant information of a total of s.73 - Irrelevant information for Stage 1 equipment. The current DA is for Stage 1 which already incorporates the required construction to accommodate an additional 3 theatres and 30 beds for a future stage 2 expansion.
- Five-year forecasts for Profit & Loss and Balance Sheet have been prepared by an experienced hospital finance specialist and are annexed as part of this Business Case, together with a summary 5-year cash flow. The forecasts have been revised to accommodate predicted rises in interest rates as advised by Nab's Treasury Division.
- A summary of projected results is as follows:

	Year 1	Year 2	Year 3	Year 4	Year 5
Revenue	s.73 - Irrelevant information				
Expenditure					
EBITDAR					
Margin					
Rent					
EBITDA					

- An aggressive (by industry standards) length of stay target will be effected by careful patient selection controlled by surgeons and best practice pre-admission and treatment standards. A higher than usual number of day beds has been provided resulting in a higher-than-average revenue per patient, and a high yield per square metre of footprint; (i.e., higher earnings per rent).
- The case volumes of all surgeons expressing strong interest in becoming a shareholder have been tabulated and discounted to remain conservative. These case volumes, at conservative revenue rate assumptions, drive the revenue projections above.

Improved financial performance, reflected in higher EBITDA margins from managing ALOS, more efficient patient processes and avoidance of lower yielding medical patients will be complemented by:

  - more attractive procurement terms for prostheses and consumables and ensuring high compliance with negotiated terms.
  - a relatively smaller footprint through effective design and ALOS management, thereby delivering a higher yield per square metre.
  - the efficiency and quality outcomes afforded by an EMR digital system.
  - a preparedness to proactively work with health funds to achieve mutually beneficial reforms, to which initial engagement has been positive.

- The planned activity levels include relocation of some surgical only activity from the Mater Private Hospital Townsville, from same day surgeries, and from private patients admitted to the public system, noting that the participating doctors also have appointments at the public hospital. This will be achieved by participating doctors redirecting patients to Weststate Private Hospital, which will offer a higher level of technology, more modern facilities and patient-centred care than currently experienced at other providers.
- The rent to EBITDAR ratio falls comfortably within industry benchmarks after year 2 ramp up.
- Declining levels of health insurance membership in Australia is receiving significant media coverage and appears to pose a risk. Over the past seven years, Queensland has seen a reduction in hospital insurance from 45% of the population to 40.5%, although the number of health insurance

policies has slightly increased over the past 12 months, reversing previous trends. The population growth in Townsville was 1.74% pa over the same period. Therefore, it is likely that the number of people with private health insurance has actually increased in absolute terms. Moreover, it is planned to negotiate reduced, or eliminated out-of-pocket costs for patients attending WPH, another advantage in the marketplace and a significant development that will make health insurance a far more attractive product.

Background to Project Development

The development site at 29 Ingham Road, West End, is the former location of the Townsville West State School, with the heritage-listed three-storey red brick building opening in 1939. In 1991, the school moved to premises behind the site, in Wilson St, having outgrown the original space. The site was then subsequently used as a multi-use education centre, before being acquired by Lautaret Pty Ltd – a Geon Property joint venture entity – in 2014 for the original purposes of developing the site into offices.

It was suggested the site would be an ideal private hospital site. At the same time, many medical specialists at the Mater Private Hospital Townsville were dissatisfied with the performance of a monopoly provider in the region, and a small group decided to build their own hospital, and subsequently settled on the old school site with adjacent land available to construct a new private facility.

The original property owner, Lautaret Pty Ltd, is the developer of the site and has completed a development agreement with Centuria Capital Limited and has sold the land to a Centuria health property trust on a fund-through basis.

Since the project was established:

- WPH has expended considerable resources in the initial appointment of an interim CEO, a Chairman, and a nurse consultant to document policies and clinical pathways, initial concept designs, services planning, sizing and configuration. The Chair interim CEO and nurse consultant will manage the development phase, pending the appointment of a long-term operational CEO, at least 6 months prior to commissioning the hospital, and then become a director.
- The Associate Director Clinical Services – Performance Manager has been appointed and commenced in April 2022 to provide critical clinical advice and support throughout the establishment phase.
- Design plans were completed and lodged with Townsville City Council who subsequently awarded a Development Approval (DA).
- The Mater private hospital objected to the Council's decision and lodged an appeal, with the appeal hearing held in the Queensland Planning Court in November and December 2018.
- At the major hospital property fund suggestion, Neil Henderson, (now the current interim CEO) was nominated to be the Lautaret expert witness in hospital demand and financial areas. Other consultants were appointed to cover town planning, acoustics, heritage etc areas.
- The Court decision was finally handed down in October 2019, dismissing the appeal and confirming the DA. The Court allowed up to 18 November 2019 for any subsequent appeal, and in the judgement sought some minor planning issues to be addressed. The Mater Private Hospital Townsville did not appeal the court decision.
- Both the incumbent hospital property fund and the interim CEO found the initial design did not meet the required standards in terms of workflow efficiencies, capital cost, flexibility for future expansion, patient amenity, operational efficiencies etc. It was agreed an experienced private architect, specialising in the health industry, was needed to redesign the hospital. Accordingly, Health Sciences Planning (HSPC) were appointed to undertake the redesign, which was completed in November 2019, and subsequently appointed as project architect. The redesign has created workflow efficiencies with operational cost savings and futureproofing for expansion.
- In lodging amended Court mandated design changes, albeit minor, it is critical that the original parameters of the approved DA be retained, at least initially. Thus, the redesign retains the external shape and size, overall sqm, number of theatres and beds, etc. This has been achieved with built-in capacity to add another 2 theatres and 30 beds for an amended DA in due course and futureproofing to extend another level. Within this design constraint, the amended service

configuration has been accommodated, so the amended DA will not be required to address external dimensions or mass, rather internal configuration.

- WPH has continued with, inter alia: the redesign; development of financial forecasts; selection of an EMR / PAS; financial forecasting and equipment procurement negotiations with various major suppliers.

Proposed service ethos

The founding shareholders of WPH are committed to delivering exemplary quality and efficiency for the hospital's major stakeholders: its patients, doctors, and contributing health funds.

This is expressed through the company's *E³ vision*:

- Experience of the patient and provider
- Efficiency of the hospital
- Engagement of all stakeholders.

The intention of the *E³ vision* is to ensure patients have demonstrated better outcomes (perceived and clinically measured), resulting from:

- Improved efficiency and clinical pathways.
- Measured quality outcomes against benchmarks for all doctors.
- Measured patient outcomes (not currently adequately done within the industry).
- Negotiating innovative health contracts delivering mutual benefits for participating health funds, fund members and WPH; thereby establishing a new direction for health funds and provider contractual relationships.

Achieving these goals requires sophisticated hospital systems which capture data pre-, during- and post-hospitalisation, with the ability to tailor reports to a specific application. This will be a critical mandatory feature of the selected EMR/PAS.

Weststate has executed a procurement agreement to purchase the Phillips-TASY EMR system which will provide industry leading, fully integrated technologies to support the Hospital's Vision, Mission and objectives.

Overall, the core shareholders are seeking to enshrine the above ethos by making it a condition of engagement and credentialing for all specialists at WPH.

A key goal is to establish WPH as a benchmark market leader in the implementation of the foregoing ethos.

This ethos, coupled with other aspects including state-of-the-art robotic technology, outstanding consumer amenities and the benefits of the ownership model, will enable the market and funders to see WPH as a differentiator, a constructive disrupter and the model for future hospital development and ownership.

The Greater Townsville hospital market

Economic status

Townsville is the 13th largest city in Australia and has the largest population base in northern Australia. The Townsville region has one of the most diverse economies in regional Australia, is widely recognised as the commercial hub of Northern Australia.

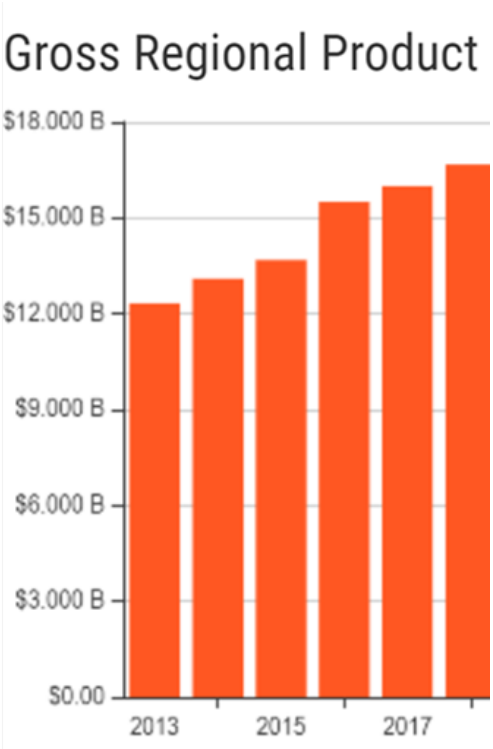
The region is founded on a strong base of agriculture and mining resources, Australia's largest military base and strategic RAAF base, a port boasting a broad-based trade profile, and a world-class university. To this foundation, the region continues to add growing strengths in industries including mining services, defence services, professional services, renewable energy, tourism, research and development, and the addition of a second university.

Townsville supports **103,546 jobs** and has an annual economic output of **$32.409 billion**. The average annual personal income in the Townsville local government area is higher than the Queensland average. Townsville has a higher average income per capita than any other regional centre within Australia's 20 largest cities.

The theme promoted by the Federal Government's 'White Paper on Developing Northern Australia', is to transform the nation's top-end into an economic powerhouse. The Townsville region encompasses five regional centres: Townsville, Charters Towers, Burdekin, Palm Island and Hinchinbrook.

The local economy has been boosted through projects such as the $250M North Queensland Stadium, $225M Haughton water pipeline and the Port of Townsville's $1.6B expansion project. Additionally, the resources sector is returning to strength, investment from the private sector increasing and Government policy agreements including the landmark Townsville City Deal and the Australia and Singapore Comprehensive Strategic Partnership are providing momentum and funding for future developments.

Over the past 4 years, over $400 million worth of commitments have been secured for the region, including stage two of the Haughton water pipeline, the Port's channel widening, Hells Gates dam, DriveIt motorsport and driver training precinct and improvements to Palm Island's water supply.

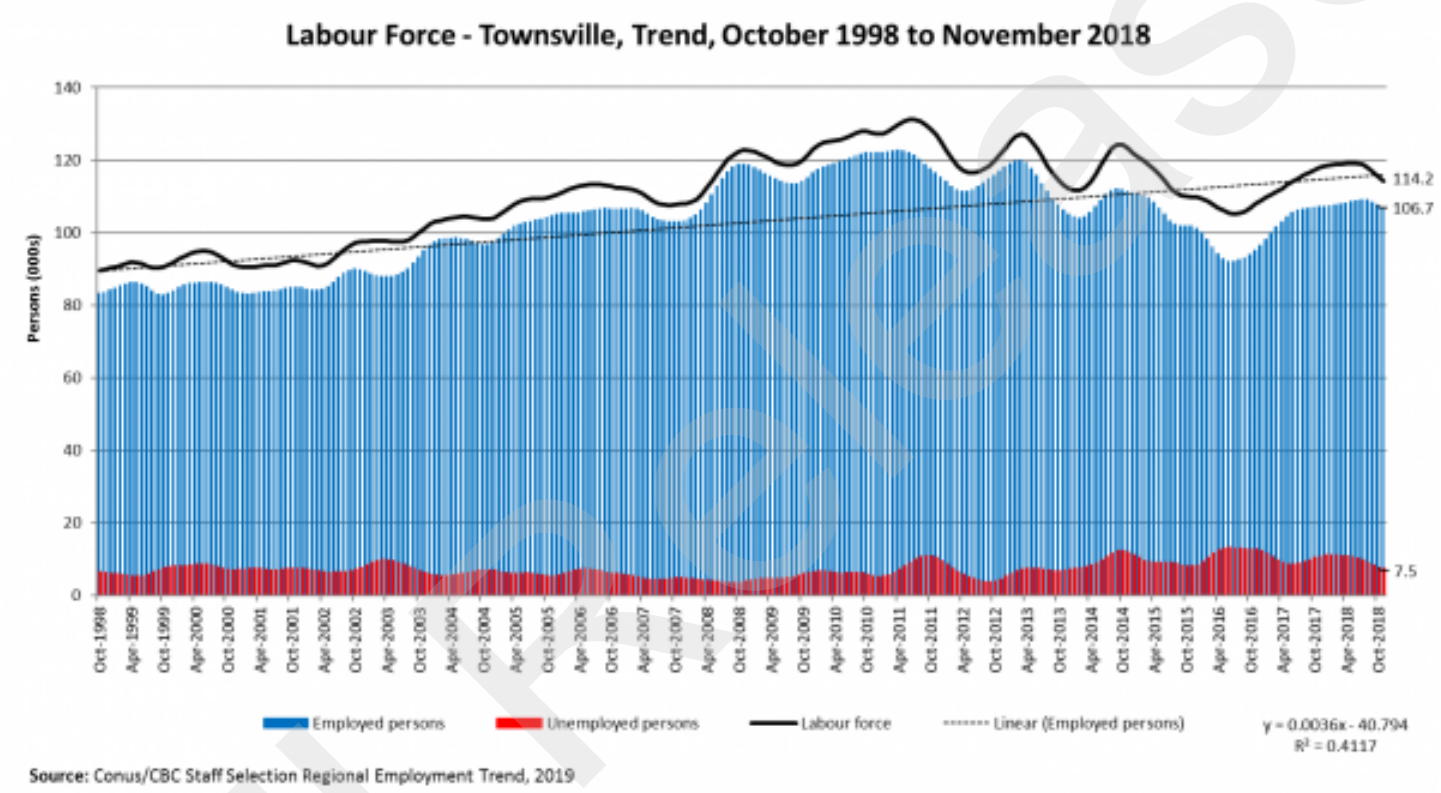


Other major projects underway include:

- The $2 billion Adani Carmichael Coal Mine and Rail Project. An open cut and underground coal mine initially producing 25 million tonnes per annum to be transported over a multi-user open access 388km railway line and exported via the Abbot Point Coal Terminal. The mine, rail and port project will entail investment of $16.5B and contribute thousands of jobs to the Queensland economy.
- Singapore Military Training Base. The Singapore Armed Forces will have access to military training areas located at the Townsville Field Training Area and the Shoalwater Bay Training Area, bringing 14,000 soldiers for up to 18 weeks of the year.
- A '*Memorandum of Understanding Concerning Military Training and Training Area Development in Australia'* was signed in October 2016 which will be in effect for 25 years. It is estimated that $2.25B will be invested in the Townsville and Rockhampton regions from 2016 to 2026. This capital infrastructure will supply vast opportunities to local suppliers and contractors.

- Korea Zinc Company ($300m project) has announced plans to expand its Australian subsidiary, Sun Metals Corporation which is expected to create about 350 construction jobs, and 100 ongoing positions in Townsville.

To support the general population, particularly during these forecasted periods of expansion and increased investment, a considerable health and support workforce is required. This is already inherent in the Townsville region, with Conus Industry Employment Trend statistics for November estimating the largest employment division in the Townsville region in November 2018 was Health Care and Social Assistance (20%).



Source: Conus/CBC Staff Selection Regional Employment Trend, 2019

Population

Reference to the latest population forecasts by the Queensland Government (Dec 2018) https://www.qgso.qld.gov.au/statistics/theme/population/population-projections/regions show that the Townsville catchment population (see map), is forecast to grow from 235,037 in 2016 (Census) to 324,317 by 2041, an increase of 38%.

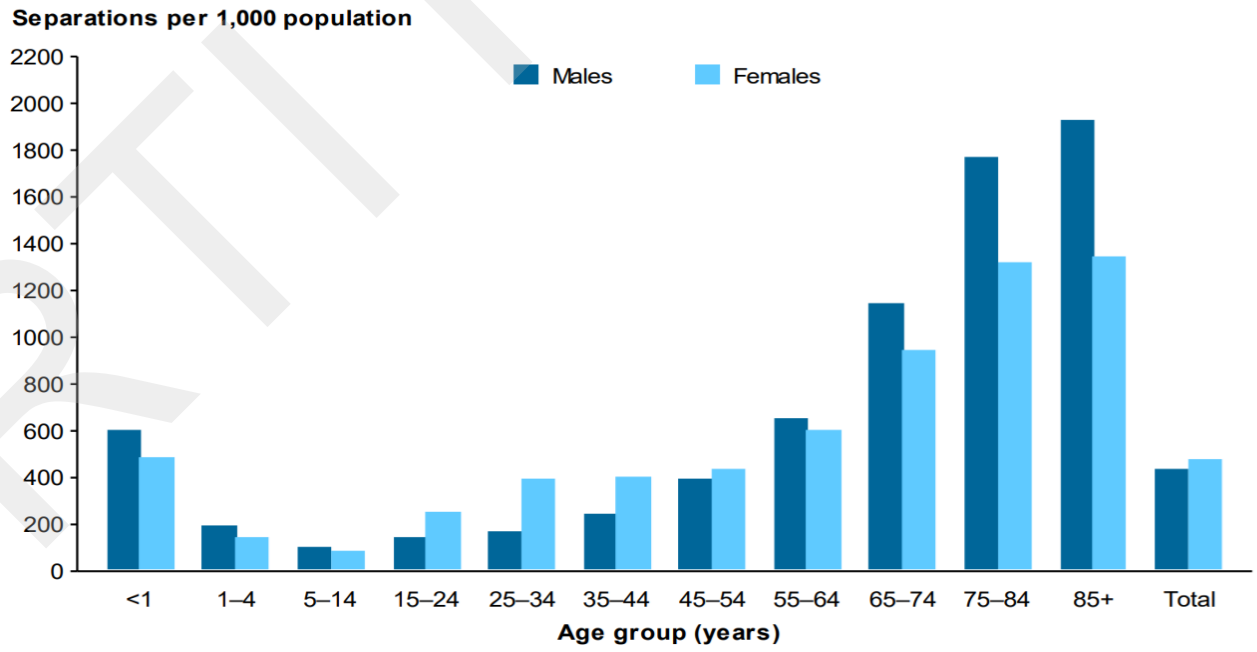
Queensland Statistical Areas, Level 4 (SA4), 2016 - Townsville (ASGS Code 318)

There is a direct and measurable relationship between age and sex; and utilisation of hospital services, as documented in the graph below from the Australian Institute of Health and Welfare, Admitted patient care 2017/18. The sharp increase in utilisation rates for people aged 65+ is notable.

The age group with the largest expected increase is the group over 65 years of age, which is expected to double (increase by 99.7% or 30,822) between 2016 and 2041 The change in population profile indicates health services will need to cater for a growing demand from families and an ageing population. The growth in demand for private hospital admissions can be quantified in the *Region hospitals and service demand* section.

Of further note and consideration is that Townsville's only overnight private hospital is a Catholic-aligned provider, with 72% of Townsville's population identifying as non-Catholic in the most recent census.

Figure 3.2: Separations per 1,000 population by age group and sex, all hospitals, 2017–18



Note: See Box 1.1 and appendixes A and B for notes on data limitations and methods.

Region hospitals and service demand

The main public hospital in greater north Queensland is the Townsville University Hospital (TUH), comprising 624 beds, supported by six smaller public hospitals in the region comprising 130 beds – a total of 754 public hospital beds for the area.

In addition to three-day surgery centres, there is one only overnight hospital – the Mater Private Hospital Townsville, comprising 200 beds across two campuses, with a daily inpatient average of only 123 beds, approximately the same as the number of beds used by private patients at TUH (see below).

Included in the public hospital bed numbers and patient activity, is chargeable patients (privately insured and third-party payers) electing to be treated in a public hospital rather than a private hospital.
Based only on known private patients, there were 11,583 private chargeable separations (vast majority privately insured) at TUH.

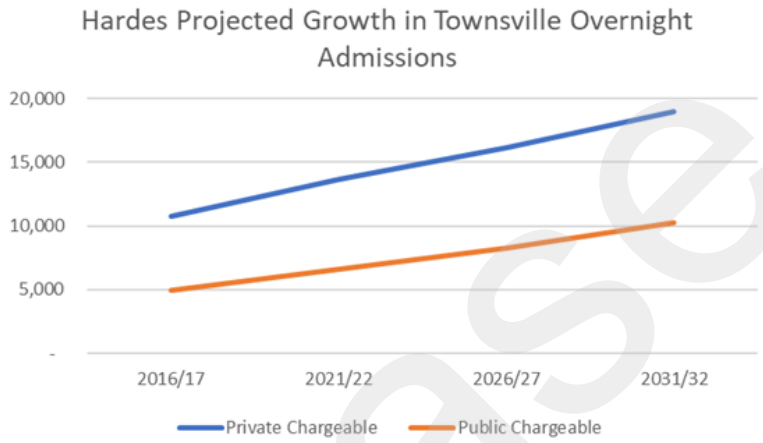
At an ALOS of 3.3 days at TUH, this equates to 123 beds at 85% occupancy. This ALOS is approximately the same at the Mater Private Hospital Townsville, so approximately 50% of overnight private inpatients choose not to be admitted to the Mater. This represents a major source of potential patient admissions for WPH.
The Townsville hospital market and demand characteristics can be described as:

- A large and rapidly growing population, extending further north and west into regional Queensland.
- Over 1,000 public and private hospital beds.
- Above state average socio-economic index.
- A public hospital (TUH) “at or near breaking point”. Recent reports attributable to the hospital board calls for a doubling in size and capacity over the next 10 years.
- A sole provider of private hospital overnight beds; the Mater, a not-for-profit Catholic provider with two campuses, with relatively low occupancy of its 201 overnight beds.
- Excessive and abnormally high use of public hospital beds for overnight private / chargeable patients at extraordinary levels, i.e. 43.7% above state average. For overnight beds, there are no private choices for patients on religious or amenity grounds, for doctors or for health funds.

The major increase in demand in the public and private hospital market is driven by a growing and ageing population (growth of 3.8% pa).

There is strong demonstrable demand for private hospital services in the region.

The number of patients who have elected not to be admitted at the Mater equal patients who did elect admission – an extraordinary situation. Using data from Hardes - a national expert in hospital demand data - the number of private hospitals in demand and available to a new entrant (i.e. includes growth plus relevant beds for WPH by excluding those beds where services will not be provided), is at least double the number of overnight beds planned for WPH.



The clear conclusion is that there is growing demand for an additional overnight private hospital in Townsville, a conclusion consistent with previous studies.

Hardes Table I
Projected overnight locally-based private hospital requirements - Residents of Townsville and Charters Towers/Ayr/Ingham

	2015/16	*2021/22*	*2026/27*	*2031/32*
Admissions	*10,758*	*13,374*	*15,706*	*18,350*
Bed days	*40,086*	*49,329*	*58,263*	*68,549*
Beds Required at 85% Occupancy	*129*	*159*	*188*	*221*

This method simply indexes base actual overnight separations and bed days for the primary catchment. It does not take into account existing (and growing), private patients in public hospitals, a market available to Mater and a new entrant.

Therefore, the following adjustments are appropriate:

Table 4 Adjustments to Hardes Bed Requirements

	2015/16	2021/22	2026/27	2031/32
Add 63% adj. Private / Chargeable in public hospitals (NH Table 1)	77	105	130	161
Adjusted Total	206	264	318	382
Less Mater Actual Daily inpatient average indexed by 3.8% pa	119	149	180	217
Available to New Entrant or Mater	87	115	138	165

True opportunity for WPH

(*Hardes and Associates use publicly available databases and produce hospital demand data for clients and are recognized as a leading source of this analysis*)

Proposed services and rationale

WPH's primary service focus will be surgical cases. This area has the highest revenue per patient day (PPD), apart from Cardiology, at around $2,000+ per bed day (excluding prosthetic costs reimbursed at cost, which nets out at $0.). Orthopedics is a key service where new techniques and home based rehabilitation can reduce length of stay significantly and therefore revenue per patient days where episodically funded (Medibank and BUPA)

This provides higher revenue per bed day, per occupied bed and per rented sqm than medical, rehabilitation and mental health services.

The biggest surgical sub-specialty will be orthopedics. Other significant sub-specialties will be urology, ophthalmology, endoscopy, general surgery, gynecology, oral, ENT, neurosurgery, hepatobiliary, vascular and bariatric.

A key to profitability will be high volume, short stay patients. This is because health fund rates are structured to provide (for those services deemed to be overnight status) 100% for first few days, then it drops markedly for periods beyond pre-determined lengths of stay according to the type of diagnosis. At very long lengths of stay the revenue is below cost. Selection of short stay patients will also reduce the average time per operation and therefore enable a higher volume of patients through the same theatre capacity.

Excluded from WPH's service mix are:

- **Rehabilitation** – with an average of $600 PPD. Additionally, health funds are increasingly working to eliminate most overnight inpatient rehabilitation.
- **Mental Health (psychiatric)** – with an average of $600 PPD. Additionally, there is an existing private hospital in Townsville (Townsville Private Clinic) providing this service.
- **Obstetrics** – despite attracting similar average revenue PPD as surgical cases, requires scale to safely and economically deliver (about 800 cases pa), interrupts theatres for emergency caesareans, and carries a very high insurance premium for medical malpractice claims. Mater provide this service.
- **Medical** (respiratory, rheumatology, etc) – with an average of $700-$800 PPD. Cases are older patients with co-morbidities, carries a high risk of long ALOS at low revenue rates, high use of pharmaceuticals, and cases are often difficult to discharge.
- **Paediatric medical** – requires higher nurse-to-patient ratios and therefore lower margins.
- **Cardiothoracic surgery** – despite carrying high revenue, also requires very high-cost support and minimum numbers for viability and staff skills to be maintained.

Ownership structures

Land and Buildings

The property is owned by CHPF South Bunbury Pty Ltd as trustee for CCHPF Hobart Sub Trust, a trustee entity of Centuria Capital Group, as lessor under a 30-year lease to WPH. Lautaret Pty Ltd, a joint venture company within the Geon Property Group, will develop the site with Geon Property Group managing the project.

The lease contains provisions for a potential NAIF funding scenario, with the landlord agreeing for WPH to own specified parts of the building subject to NAIF approval and agreement on the specified ownership provisions. Also, the landlord has agreed that upon WPH exit, it will buy back the WPH owned part of the building at its written down value or agree for the new business buyer to acquire that part of the building

The Lease and Agreement for Lease were executed by all parties mid-September 2021.

Neil Henderson, Interim CEO, has extensive experience in working with major hospital property funds while managing hospitals. These include The Valley (now Mulgrave) Private Hospital, owned by Australian Unity, and Southeastern Private hospital, owned by Vital (now North West) Healthcare Property Trust. He is therefore familiar with the relationship with a hospital property fund.

Hospital Operating Business

The ownership of Weststate Private Hospital is summarised below. Key points to note are as follows-

1. The hospital operations are conducted in the entity Weststate Private Hospital Limited.

2. Weststate Private Hospital Limited is 100% owned by Weststate Hospital Holdings Limited. Weststate Hospital Holdings Limited is a holding company, it has no operations. Its sole purpose is to separate the equity interests from the equipment financing and operational business at the Weststate Private Hospital Limited level.

Founding Surgeons have funded development costs to date by way of a shareholder loan to Weststate Hospital Holdings Limited. This has been capitalised by way of equity into Weststate Private Hospital Limited

Executive employees may be able to acquire shares under a share trust to ensure commitment to the hospital's vision and ethos, and as a strategy to attract and retain the best employees.

Capital investment required

Land and Buildings

No investment is required, as it is funded progressively by the hospital property fund and capitalised at an industry standard rate.

The current estimate of land, buildings, renovation to school, development profit and financing is approximately s.73 - Irrelevant information including Stage 2, increasing to s.73 - Irrelevant information when integral fixtures are included. (*Under NAIF proposal, WPH has an option to contribute $20m towards the building cost by way of specified items.*)

Medical Equipment / Furnishings / Fit out

Current estimate is s.73 - Irrelevant information based on schedule of items quoted by major suppliers and preliminary estimates from other equipment vendors.

This amount is proposed to be financed by loan from National Australia Bank (Nab) under terms proposed, being s.73 - Irrelevant information for Stage 1.

Rent Guarantee

Typically, a hospital property fund requires a rent guarantee covering the first year. The Directors have provided the s.73 - Irrelevant information Guarantee via. Nab, secured with cash from the founders' personal resources.

Under NAIF, if approved, the amount of the rent guarantee will be proportionally reduced.

Working Capital

This requirement has been calculated at s.73 - Irrelevant information and includes stocking up and pre-commissioning costs (hiring of CEO, Director of Nursing, CFO, consultants) prior to opening and net outlays in the first few months as the hospital ramps up and health funds payments lag by 30 days. This is funded from equity.

Equity Reserve

A separate equity reserve of s.73 - Irrelevant information capital will be used as contribution to equipment procurement.

Shareholder contributions

Surgeons and anaesthetists will be invited to take an optional shareholding, deliberately set at a low level, as part of an incentive package to commit their engagement to the operational performance ethos of the Hospital. The option is deliberately set at a low level to make the 'cost to exit' multiple enticing for surgeons. Therefore, the revenue top line is underwritten from this strategy.

In addition, there is the option to seek a further equity partner where that partner will add value to the business and mutual benefits ensue.

Construction Process and Timelines

Current Status

The amended design (previously in Stages 1 and 2 before the now consolidated design) had been submitted to the Planning and Environment Court to comply with decision conditions. These are minor and did not affect the integrity of the proposed design. However, the design submitted by the initial project architects was found to have inadequacies in terms of efficiencies and impact on operational costs, sizing and height. A WPH initiative was to select an architect with proven performance in the private (commercial for-profit) hospital field; i.e. HSPC Architects, used exclusively by Healthe Care Australia, and supported by the landlord, and renowned for quality design at optimal cost and efficiency in workflows. HSPC were asked to redesign the plans submitted to Council, retaining key elements of the approved DA – external size and footprint, number of beds, theatres etc.

This was completed late November 2019 and presented to the WPH Board. Of note, there were major efficiencies in workflow and staffing achieved, and future proofed to accommodate another two theatres and 30 beds, all within the approved footprint. This outcome has been endorsed by the WPH Board, Geon and Centuria.

Geon have subsequently received legal advice that it is not necessary to alter previously submitted plans, given that the Court conditions were minor in nature. Rather, an explanation of how the Court conditions will be met has sufficed.

The Court assessed advice from Geon about conforming to the Court's conditions, and advice was received that the changes were approved, and an amended DA issued.

HSPC has taken over as project architects and has proceeded to detailed mechanical, civil, electrical and civil detailed drawings.

A builder has been selected – Woollams, who have experience in hospitals and in Townsville.

The project will proceed on a "Design and Construct" basis with Woollams and selected sub-contractors.

An experienced Project Manager has been appointed to oversee Weststate's obligations and responsibilities for Tenant's works.

Construction fencing and bunting are erected with groundworks well advanced.

Timeline

It is expected that the hospital will be ready for commissioning in Qtr. three 2023.

Projected financial performance – P&L

The financial model is developed in detail and is attached. It has been prepared using industry benchmarks by a consultant, who is still actively engaged in the private hospital industry in a senior finance role, using proven and professionally validated modelling methodologies and under the direction of the WPH Principal Consultant / Interim CEO.

Projected activity indicators and KPIs follow.

The assumptions and key elements of the model are:

- Theatre volumes is the key driver of activity. These volumes are based on verbal feedback and signed EOIs given by surgeons interviewed, noting that the process is being curtailed during the construction phase so that surgeons could visibly evidence the hospital coming out of the ground..
- These interviews confirmed what the founding Director surgeons knew from past experience; viz
    - That there was major dissatisfaction with the current private health services provider
    - It had been an unresponsive monopoly for too long
    - That a new hospital would be strongly supported as a positive competitive alternative for the growing and progressive community of Townsville and North Queensland
    - That a surgeon-owned hospital would represent a new paradigm in private hospital ownership and service reform
    - Only a surgeon-owned hospital could deliver the full suite of much sought-after reforms that the private health insurance industry and the general public are seeking
    - That the majority of surgeons at the Mater, currently housed in the consulting building, face an uncertain future in that building as it has been proposed for conversion to a hospital ward, causing further discontent.

A number of significant events and opportunities emerged since the original Business Case was prepared late 2019 that have resulted in the revised position now presented.

A. Surgeon Interest Confirmed at Higher Levels (which requires more theatres)

We have signed Expressions of Interest for nominated number of theatre operating sessions from surgeons who collectively underwrite $40m revenue. This equates to Year 3 revenue and 95% of Year 5 revenue. We will be presenting these, and other surgeons not yet listed (such as gynaecology, neurosurgery etc), with:

- An offer to provide consulting rooms at very attractive rental rates (fitted-out), and
- An optional invitation to invest in WPH, as part of an incentive package to engage with the operational performance ethos of the hospital

The vast majority of surgeons (if not all) will be (and have been) immediately attracted to the opportunity of being able to participate in a private hospital that-

- has a new more efficient operating model in which they can positively input
- Provides for a significantly reduced risk of infection
- Has efficiencies and convenience associated with an EMR
- develops a culture which results in a better hospital experience for all stakeholders

- provides cost effective access to co-located consulting rooms, and
- aligns interest by enabling surgeons to have an ownership interest in the hospital.

It is important that the right mix of surgeons commit to the hospital. The optimal combination relates to the mix of disciplines and types and profitability of operations. The surgeons that are the highest priority for the hospital to secure are those that:

- subscribe to high quality standards in their field of expertise
- perform case types that are appropriate for the quality and financial goals of the hospital, and
- share the vision of the Founders in implementing an improved operating model.

In order to secure commitment from surgeons to underpin the financial model the following commercial arrangements will be offered to surgeons:

- surgeons will commit to a minimum level of capacity under a *capacity reservation arrangement,* for their operations in the hospital. If they do not ulitise the capacity, the surgeon will forfeit the shares offered in total or proportional to the shortfall.
- surgeons will have the option of subscribing for shares in the entity that will own the Weststate Private Hospital business
- surgeons will also have the option of leasing consulting rooms at a location adjacent to the new hospital at very low rental rates (or no charge).

These benefits and how the program will be implemented will be presented to surgeons as the hospital is being constructed.

It is significant to note that revenue from the 3 founding surgeons alone comprises 50% of year 1 revenue:

Founding Surgeon Hospital Revenue				
	Sess pw	Cases / sess.	Rev. per case	Rev pa 46 weeks
Peter McEwan	s.73 - Irrelevant information			
Kaushik Hazratwala				
Kiran Hazratwals				
Year 1 Revenue target				
% of Target				

This increases to 72% when commitments from a relatively small sample of other surgeons was taken into account, and then discounted by 50%.

Add Other verbal commitments discounted by 50%			
s.73 - Irrelevant information	73 - Irrelevant information		
Founders Plus Sample (discounted)			s.73 - Irrelevant information
Year 1 Revenue target			
% of Target			

When the first level of the hospital emerges from the ground, a comprehensive surgeon recruitment program will be undertaken, offering incentives including shareholding in the Operating Company; discounted consulting rooms; world leading infection management technologies; information on improved patient amenities, far superior to the competitor (the community will be targeted directly on this feature); improved efficiencies and patient outcome measures.

It is also intended to actively source public hospital surgical contracts and initial discussions are promising. A discounted rate will be offered to TUH. A submission has been lodged for 250 orthopaedic cases as follows together with some other specialities to be submitted.

Surgery Connect	Vol. pa	Gross Fee	Discounted	Prosth	Surgeon	Anaesth	Net	Hosp Rev.	Sess pw
Ortho.	250	s.73 - Irrelevant information							
Urology	75								
Gen Surg	75								
Gastro	100								

Awarding of a Public Hospital contract would necessitate commissioning of a 5th theatre (available in shell form and only requiring a fit out).

B. Cardiology Not Viable (more than offset by surgical demand)

Enquiries with cardiologists included looking at establishing a joint venture which has proven to be a most effective market penetration strategy elsewhere. However, the cardiologists when consulted did not inspire confidence that a viable service would be established. Given that the equipment cost for a cath lab is in the order of $2m, it was decided to focus on meeting the high surgical demand, and to consider cardiology as a subsequent stage.

C. Government Funding Available at Concessional Rates

In addition to the major Australian Banks, WP has applied to the Northern Australia Infrastructure Fund (NAIF) for funding. NAIF is a Commonwealth Government initiative to stimulate investment in Northern Australia that has demonstrable public benefit.

An application will be lodged with NAIF for $20m building contribution. NAIF loans are at concessional rates to traditional Bank rates in Australia. A term of 15 years will be sought from NAIF.

Net Impact – Financial Forecast

	Year 1	Year 2	Year 3	Year 4	Year 5
	Projected	Projected	Projected	Projected	Projected
	s.73 - Irrelevant information				
Revenue					
Total Patient Revenue					
Other Revenue (CMO Billing & Rental)					
Total Revenue					
Variable Costs					
Labour					
Productive Personnel Costs					
Indirect Personnel Costs					
Total Labour					
Labour as a % of Revenue					
Labour as a % of Revenue excl Prostheses					
Total Contract Services					
Supplies					
Medical / Surgical Supplies					
Pharmacy Supplies					
Non-Medical Supplies					
Total Supplies					
Supplies as a % of Revenue					
Supplies as a % of Revenue excl Prostheses					
Total Variable Costs					
Variable Costs as % of Revenue					
Variable Costs as % of Revenue excl Prostheses					
Variable Costs as % of Total Costs					
Fixed Costs					
Property & Equipment					
Utilities					
Other Expenses					
Total Fixed Costs					
Fixed Expenses as % of Revenue					
Total Hospital Expenses					
EBITDAR					
EBITDAR Margin					
Operating Leases / Rent					
EBITDA					
EBITDA Margin					

Projected financial performance – activity indicators

Assumptions

- In this context, beds are not a measure of size or capacity – theatre volumes of good-higher yielding cases will be the generator of high revenue with a relatively small number of beds. There will be no medical or sub-acute patients, nor acute patients with complex co-morbidities that require significantly long ALOS.
- Theatres, as productive assets, will be worked harder than industry norms, recognising that ROI is improved the longer theatres are utilised
- 4 theatres will be fully utilised assuming an average operating time of 55 minutes. It is planned to improve efficiency in theatres to reduce this time – see Attachment 2
- Overnight beds will be fully utilised by year 5, however the average LOS used for overnight stays of 1.7 days is expected to be further reduced significantly, thereby freeing up bed capacity (it is noted that only patients suitable for a short stay hospital will be admitted, thereby skewing length of stay to the lower range)
- 5-hour sessions will be implemented in line with many hospitals
- A Saturday am session is planned
- The ratio of day cases to total cases is 58%, slightly higher than industry norms but reflecting more aggressive length of stay – for example, many joints will be discharged same day or 1 day overnight) stay, with supervised and monitored home rehabilitation (See Attachment 2)
- Work hours per patient day improve with scale increase

Extract of KPIs

	Year 1	Year 2	Year 3	Year 4	Year 5
Statistics (Whole Numbers)	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
Inpatient Days	s.73 - Irrelevant information				
Days Only Days					
Total Patient Days					
Number of Admissions					
Number of Operations					
Number of Workhours					
Available Inpatient Beds					
Available Day Beds					
Theatres					
Days in Month					
Number of Operations - Overnight					
Number of Operations - DAY					
Endoscopy					
Key Performance Indicators					
Inpatient Occupancy					
Total Occupancy					
Patients per day					
ALOS					
Total Revenue Per Patient Day (RPPD)					
Patient Revenue PPD (Excl Prosth Margin)					
WHPPD					
Labour Cost PPD (Incl on-costs)					
Labour Cost per Hr (Incl on-costs)					
Pharmacy Cost PPD					
Supply Cost PPD					
Supply Cost Per Admission					
Theatre minutes					
Ave time / op					
Utilisation					
ALOS - o/night only					

Projected cashflows

Cash flows are based on the following assumptions:

- Accounts receivable, mainly health funds, is initially 30-45 days lag, reducing to 25 days on average.
- Inventories – initial stocking up, initially 45 days holding lag, reducing to 35-30 days after seven months.
- Accounts payable – mainly salaries and other creditors; initially 45 days payment term for suppliers but reducing to 30 days after three months.

- Equipment leased
- Capital Expenditure – 2% of total revenue allocated to CAPEX each year with a seven-year useful life (except year 1).
- Working capital requirement (soft asset bank)

It is also noted that the tax treatment for accelerated tax depreciation allowances has not been included.

At present the tax regime provides for accelerated write-offs. It is likely that this will be retained or enhanced in the future with announcements expected in October this year. In addition, it is expected that a 10% investment allowance will be announced. The current depreciation regime provides for a 50% write-off in the year that plant and equipment is installed ready for use, plus the normal depreciation on the remaining 50% balance.

For the equipment alone the write-off in year one would be in the order of $14m being:

- $8m being 50% of $16m (this is the accelerated write off)
- plus $0.8m being 10% of $8m (this is conservative estimate of normal depreciation rate applied to the 50% that is not immediately written off)
- plus $1.6m being 10% of $16m (this is the investment allowance which is likely to be introduced).

Note that this is a very high-level analysis and treatment will vary across asset classes.

The tax deductions that will be available will exceed the level of taxable income of the hospital in the early years, meaning that the hospital will not pay tax for some years, thereby optimising cash flow in the early years.

Key to working capital requirements will be the timing of staff during the commissioning / pre-opening phase, and the speed of ramp up. This will become clearer closer to the event as surgeons start booking theatre lists.

A summary of equipment and working capital sources and applications is a s follows:

		INFLOWS		
Summary	**Outlay**	**Bank**	**Equity**	**Surplus**
Equip	s.73 - Irrelevant information			
W/Cap prior open				
W/cap Mth 1-1+Ban				

	July	August	September	October	November	December	January	February	March	April	May	June	Yr
Per Model	s.73 - Irrelevant information												
Total operating activities													
Principle Only Debt (Bank)													
Interest Only Equipment													
Interest Only Working Capital													
Interest Only Bank Loan													
Principle Only Debt (Working capital)													
Total financing activities													
Net cash flow													
Beginning cash balance													
Ending cash balance													

Total project cash flows follow, with the detailed model extending these out to 5 years.

WESTSTATE PRIVATE HOSPITAL
Leading Your Healthcare Journey

CASH FLOW PROJECTION $'000	Before Dividends					
Cash Flow From Operating activities	s.73 - Irrelevant information					
EBITDA						
(BreakDown of the EBITDA Cost of Year 0)						
(Display purposes only as it driven from P&L Year 0)						
Tasy Fit Gap Completion						
Consultants / Staff (3)						
Pre commissioning staff						
(Increase) Accounts receivable						
Inventory Central						
Inventory Impress						
(Decrease) Accounts payable						
Total operating activities						
Investing activities						
Capital expenditures						
Rent Guarantee						
Rental Reserve						
Total investing activities						
Financing activities						
Principal Only Working Capital						
Principal Only NAB Bank						
Interest Only Working Capital						
Interest Only NAB Bank Loan						
Cornerstone Investors convertible note 8% $4M Start and						
Tranche 2 Founders Equity $5m($3M now $2M in Mar22)						
Owner funding Equipment						
Pay of FFE using equity						
Dividend Scheme A (Equity)						
Total financing activities						
Net cash flow						
Beginning cash balance						
Ending cash balance						

.

Competitive advantages and risks

Competitive Advantages

New and modern facility – in contrast to the Mater Private Hospital Townsville, WPH will be new with all single rooms with ensuites.

Electronic Medical Record – The procurement of the Phillips-TASY EMR System will provide a fully digital / paperless hospital, the first in north Queensland, where patients and doctors alike will be attracted to the benefits. For doctors, access to information from mobile phones with full medical information will be an attraction to using the hospital. For patients, bedside access to ordering meals directly, and selected information, and reduced requests for admission details will be an advantage. The EMR will also be conducive to recruiting staff from the public and Mater hospitals, as well as providing the vehicle to demonstrate superior outcomes to health funds.

Model of care – the directors are very strong about quality of care, measuring it at all levels. Reducing length of stay through pre-determined clinical pathways will reduce the time patients are hospitalised, and at the same time, delivering better patient satisfaction and clinical outcomes.

Research –Two WPH directors founded the ORIQL (Orthopaedic Research Institute of Queensland) in 2013. It conducts high quality clinical and laboratory orthopaedic research and has links with James Cook University. In addition to practical outcomes from the research, it adds to not only the perception of quality, but an actual improvement in quality.

Robots – an orthopaedic robot is planned to be purchased. This will be an attraction for orthopaedic surgeons. For patients, the higher accuracy of a robot will be attractive. Medtronic will be releasing a urology / general surgery robot named Hugo, which will be far more financially attractive than the da Vinci robot.

Doctor shareholders – doctors owning their own hospital means, when faced with a choice, they will use their own facility, underwriting volumes and revenue. In addition, because most hold senior posts in the public hospital, for private patients in the public hospital (a very significant volume) the doctors now have an incentive to refer those patients to WPH. The experiences with hospital relationships with doctors, and the opportunity for doctors to own their hospital and thus better control their destiny, will be strong drivers for preferring WPH to treat their patients. See Section following.

Patient amenity – in addition to planned high patient amenity, patients will enjoy large screen TVs, Foxtel and Netflix, WIFI, bedside ordering of food / beverages – these are all patient “perceptions” of quality. In reality, the model of care will demonstrate a higher clinical quality of care.

Patient out-of-pocket costs – This has emerged as an industry-wide issue and may partly explain the high use of public hospital services by insured patients. Because a significant portion of surgeons will be shareholders of WPH, there is the unique ability to either significantly reduce or eliminate out-of-pocket gaps. This will increase the attractiveness of privately insured patients to WPH over Mater or TUH.

Medical Suites Building – An associated development will offer a dedicated medical suite building available on attractive lease terms and conditions as part of incentive packages for participating surgeons and practitioners.

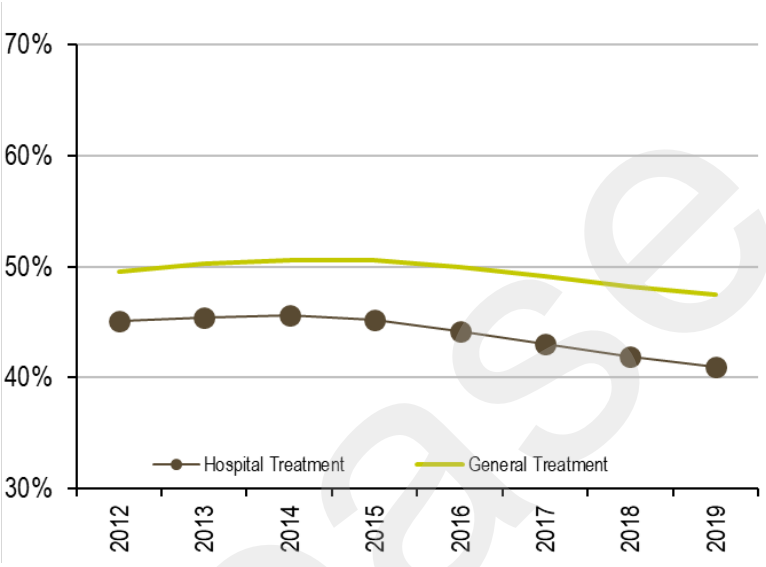
Other technology – all equipment will be new with the latest technology – theatres, bedrooms. Other market leading technologies in relation to air handling in theatres and water treatment in CSSD offer lower infection risk.

Risks and Mitigation

Health Insurance – The percentage of the population with hospital insurance is declining slightly due to costs associated with private hospital stays – primarily “out-of-pocket” costs compared to “free” public hospital stays

In Qld this has seen a reduction in hospital insurance from 45% of the population to 40.5%, a fall of 4.5 percentage points over 7 years. The population growth in Townsville has been 1.74% pa over the same period.

Therefore, it is likely that the number of people with private health insurance has actually increased in absolute terms. Moreover, APHRA Quarterly Health Insurance Statistics (Sept 2019) show an increase of insured persons from 11.24m to 11.25m over the preceding 12 months.



Queensland percentage with Health Insurance Sept 2019 Qtr

Rather than seeing this as competing for a declining market, it is likely, in reality, to be a steady or slightly growing market. Patients will, for the first time, have an opportunity to compare hospital and clinical outcomes and experiences with the Mater's long-term legacy and thus have comparative choice with the WPH proposition. The growing and large pool of private patients in TUH is an attractive target for WPH, better placed to infiltrate due to shareholder doctors having senior appointments at TUH.

WPH is in a stronger position to mitigate against this trend:

- Because doctors are shareholders, they are likely to agree to little or no out-of-pocket cost in order to drive volume.
- WPH will be driving innovative deals with Health funds to provide better value for insured patients. This includes home-based support services as part of the admission package for appropriate cases.

Non-denominational – as WPH's only competitor is a Catholic hospital, for some of the 74% of Townsville's non-Catholic population this option may not be attractive. It is not known to what extent private patients elect to be treated at TUH over Mater for this reason. In any event, WPH will be able to offer services not available at the Mater.

Health fund contracts – The current contract negotiating environment is very tight with hospitals being price takers with little choice other than to accept offers of 1-2% price increase.

The major hospital groups have an adversarial relationship with health funds. On the other hand, health funds are welcoming new and innovative approaches to funding. WPH has what is believed to be an approach that health funds would embrace – shorter stays with lower cost home support where appropriate, and better clinical outcomes. WPH is well-positioned to establish new funding models of care.

To be conservative, Year 1 revenue rates reflect 85% of industry rates under Tier Two, with Tier One from Year 2. The rate has been kept conservative.

Mater competitive response – would be to persuade surgeons to return. There is nothing tangible that can be offered. Inducements are illegal under the HIC Act, so it would need to be service based. Given the local private hospital environment, it would be difficult for the Mater to significantly disrupt WPH's entry. A mutually beneficial market collaboration is not only possible but will be encouraged.

Doctors not attracted - it is possible that some surgeons will not be attracted to WPH. One reason would be that they don't like supporting a doctor owned facility where they are not shareholders – i.e. they don't want to make profits for another doctor. Of course, in this case they have the opportunity to be shareholders. If that offering is not attractive, then some will elect to maintain their status quo.

Proposed shareholder structure

We see five classes of shareholders:

1. Founding Directors
2. Cornerstone Investors - on a converting note basis (convertible after 3 years at 20% discount)
3. Introduced Investors – on a straight shareholding basis
4. Key Clinical Specialists : Participating Surgeons, Anaesthetists etc.- by invitation and based on their contribution to the hospital's operational performance.
5. Executive and Key Employees – subject to qualifying criteria

Surgeons and anaesthetists will be invited to take space under attractive lease arrangements in the medical consulting building, being attracted to what we expect will be the major medical precinct in Townsville.

Attachment 1 - Profiles of Directors

Director: Dr Kaushik (Kosh) Hazratwala

Kosh is a Specialist Lower Limb Orthopaedic Surgeon with an interest in Adult Hip and Knee Reconstruction, Sports Injury Surgery and General Limb Trauma.

In January 2009, Dr Hazratwala formed the Townsville Lower Limb Clinic as a specialist center for Orthopaedic Surgery, offering super-specialised orthopaedic services for conditions of the lower limb.

Director: Dr Kiran Hazratwala

Dr Kiran Hazratwala is a private Consultant Urologist at the Northern Urology Clinic, located at the Mater Private Hospital Townsville in Pimlico.

He gained expertise in both the surgical and non-surgical management of Prostate cancer.

This included Nerve Sparing Radical Prostatectomy as well as Low Dose Rate (LDR) and High Dose Rate (HDR) Brachytherapy. Dr Hazratwala's other areas of special interest and expertise are in Laparoscopic Renal Surgery, Urological Oncology (bladder/prostate/testis), Laser Stone Surgery, minimally invasive treatments for BPH (Benign Prostatic Hyperplasia) and Vasectomy with reversal thereof.

Director: Dr. Peter McEwen M.B.B.S. F.R.A.C.S. F. A.Orth.A. Dip Mod Lang

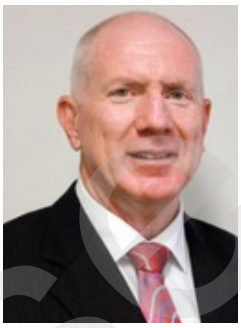
Orthopaedic Surgeon, specialising in surgery of the knee

Visiting Specialist Orthopaedic Surgeon Mater Misericordiae Hospital Townsville, and Senior Visiting Specialist Orthopaedic Surgeon The Townsville University Hospital. Founding member and Chairman, Board of Directors Orthopaedic Research Institute of Queensland. Senior Adjunct Clinical Lecturer James Cook University. Nationally and internationally recognised clinician and researcher. Expert in advanced technologies and rapid recovery. Committee member National Joint Replacement Registry.

Fellow of the:

- Royal Australasian College of Surgeons
- Australian Orthopaedic Association
- Australian Knee Society
- International Society of Arthroscopy Knee Surgery and Orthopaedic Sports Medicine (ISAKOS)
- Asia Pacific Orthopaedic Association

Chairman: David Kippin



Experienced Director and consultant with a demonstrated history of working in the management consulting and business advisory industry, spanning a diverse breadth of commercial, business and not-for-profit experience. Skilled in People and Culture Leadership and Management, Negotiation, Strategic and Business Planning, Strategy Implementation.

Career overview:

- Extensive career with National Australia Bank including roles in Marketing and Distribution - International Trade, Head Office; NAB secondment to McKinsey Consulting; Regional Business Manager-Melbourne CBD; Regional Executive-Townsville and North Queensland
- 2006-2009 CEO of Moore Stephens (Qld) Limited, a large mid-tier Accounting and Financial Services company.
- 2011-2014 CEO of Townsville Enterprise Limited - Engaged in activities to develop, market and enhance the economic prosperity and sustainability of the North Queensland region.
- 2016-2018 Consulting Chief Executive to Jobtrain (part of *selectability* Group), inspiring people to achieve self-development, employability and self-worth.
- Current and ongoing - Kippinvest Pty Ltd, private consulting business assisting and supporting business and providing directional insight.

Interim CEO / Principal Consultant Advisor: Neil Henderson

More than 30 years in healthcare, including 10 years as Business Development at Healthscope, with a focus on acquisitions and business growth strategies, contributing to a growth in market cap of the company from $30m in 1999 to $2.6b upon delisting to private equity in 2011.

Five years at Healthe Care (HeC) as both CEO at The Valley and South Eastern private hospitals, and national executive HeC. Played a key role in increasing HeC value from $250m in 2011 to $950m in 2016.

1987-1996 as co-founder, owner and manager of a successful private health management consultancy company, with 30 staff world-wide in markets including Australia, UK, Middle East, Hong Kong, Malaysia.

In 1995, Executive Director of the Kennett Government's Metropolitan Hospitals Planning Board which transformed Melbourne's 30 public hospitals into major networks, still essentially intact today.

1980-87 as senior finance officer in Victorian Health Department, including representing Finance in the development of Diagnosis Related Groups (DRGs) in Australia, and Resource Manager for North East Metropolitan Region.

Many years' experience working with Property Companies as landlord / property owner, and HSPC as architects, and numerous major brown fielding projects at Healthscope and Healthe Care.

Attachment 2 – Weststate Efficiency Plan

Weststate Private Hospital OR Efficiency Plan.

The Efficiency Playbook.

Value based bundling by health payers in the U.S. has driven a great deal of work in the areas of hospital efficiency, patient optimisation and reduction of length of stay. The value component ensures that improvements in the above parameters are not at the expense of patient outcome and experience.

There are consistent drivers of efficiency identified in the literature.

These include:

1. Hospital Electronic Medical Record (EMR). The EMR is an essential tool for standardising best practice hospital process from before admission, throughout the hospital stay and after discharge. An EMR configured is such a way embeds critical care pathways at an institutional level. This in turn reduces variability (the enemy of quality) and ensures that at every point in an episode of care, best practice is being employed by all involved. The EMR is also the means by which data is acquired to measure performance so that a continual cycle of improvement is executed.

WPH will be the first fully digital greenfield private hospital in Australia. WPH has purchased the Tasy EMR from Philips. Tasy is an intuitive cloud-based HTML EMR and is the single largest investment of the build which is an indicator of it's critical importance. Both Philips and WPH have dedicated enormous resource to ensuring Tasy is configured to drive efficiency, minimise variation and allow near instantaneous benchmarking if individual surgeons, anaesthetists and operating theatre teams. A detailed performance matrix (Appendix 1) has been developed and tested on real data to ensure that it has sufficient sensitivity to differentiate clinically relevant levels of performance. Benchmark ranking on the performance matrix will be used to reward exemplar practitioners and teams. Learnings from performance matrix analysis will be fed back at specialty levels so that "everyone learns from everyone'. Every parameter in the matrix will be routinely recorded in the EMR and customised queries configured so that extracting data is essentially instantaneous.

2. Process Mapping. Maximising efficiency requires a knowledge of physical space, human resource and digital infrastructure so that barriers to efficient process can be identified and rectified. Methodologies such as Lean and Six Sigma can be applied to each process to eliminate non- value-add steps. Each process is analysed in multiple domains, ie, personnel, information processed, and time. Work streams are then optimised to increase value at each step: minimizing volume variation; streamlining the preoperative process; reducing nonoperative time; eliminating redundant information; and promoting employee engagement.

Zimmer-Biomet is the preferred supplier of orthopaedic implants to WPH. Accelero is a subsidiary company of Zimmer-Biomet that specialises in process optimisation using methodologies outline above. WPH has engaged Accelero to ensure optimised process from day 1. An example of the processes involved is included in Appendix 2. Zimmer-Biomet through Accelero will provide a range of technologies to WPH that will deliver a digital continuum that will automatically feed back into the EMR and the performance Matrix. This includes the My Mobility digital patient engagement platform, the ROSA orthopaedic robotic system (x2), and Orthointel data analytics. WPH has negotiated access to MyMobility and Orthointel data analytics for all hip, knee and shoulder replacements, not just for those with Zimmer-Biomet prostheses. It is worth noting that Weststate Director Dr Peter McEwen, is an expert user of My Mobility.

3. Accountable Operating Room Teams. An operating room team is comprised of five members – surgeon, anaesthetist, anaesthetic nurse, scout nurse and scrub nurse. An accountable operating room team is an operationally efficient team composed of all involved stakeholders, who mutually collaborate to deliver safe, high-quality care that optimizes clinical and financial outcomes. Most hospitals do not run accountable OR teams as the nursing members are generally treated as interchangeable components. Accountability is therefore lost, as is the ability to recognise and reward exemplar teams. When accountable OR teams are set, virtually every metric is driven in the correct direction. On time start, changeover time, operative time all improve. Costs reduce as disposables are not opened unnecessarily. Conflict is all but eliminated as is nursing sick leave. There is a huge evidence base to support this, some of which is summarised in Appendix C

WPH will be running each OR team as an accountable pod. Each pod will have it's own performance matrix as per individual practitioners. One of the critical elements of keeping good staff is to make it clear that their efforts are making a difference. The performance matrix embedded into the EMR ensures that good staff are fed back real data, rewarded for excellence and retained as employees

4. Enhanced Recovery After Surgery (ERAS). ERAS is an evidence-based best practice perioperative protocol applied to a surgical event. This involves preoperative optimisation and education, critical protocols instituted at a hospital level and post discharge contact and monitoring. Configuring the EMR essentially involves embedding these protocols into the hospital pathways. ERAS underpins rapid recovery and short stay surgery. Digital platforms such as My Mobility are powerful tools for education and post discharge contact. ERAS protocols should be embedded at an institutional rather than at an individual practitioner level. This involves the hospital taking ownership of much of the process. Examples of this are the nurse optimiser and nurse navigator roles which underpin many of the processes that Accelero will assist the hospital to put in place.

It is worth noting that WPH Directors, Dr Peter McEwen and DR Kaushik Hazratwala have successfully employed ERAS protocols in their practice despite the facility in which they work actively resisting the change. Dr McEwen has a national reputation as an expert on the subject. It is absolutely not a case of forcing momentous change on unprepared practitioners but rather, streamlining the institution to assist the practitioner in achieving maximum efficiency and best possible outcomes

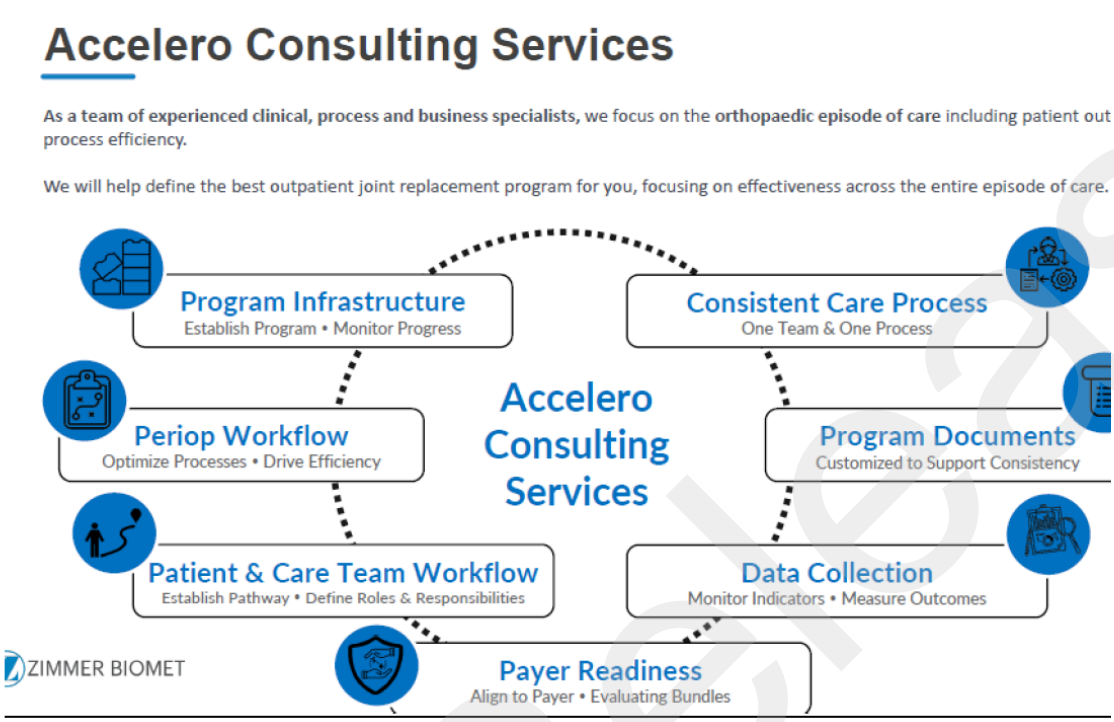
Summary.

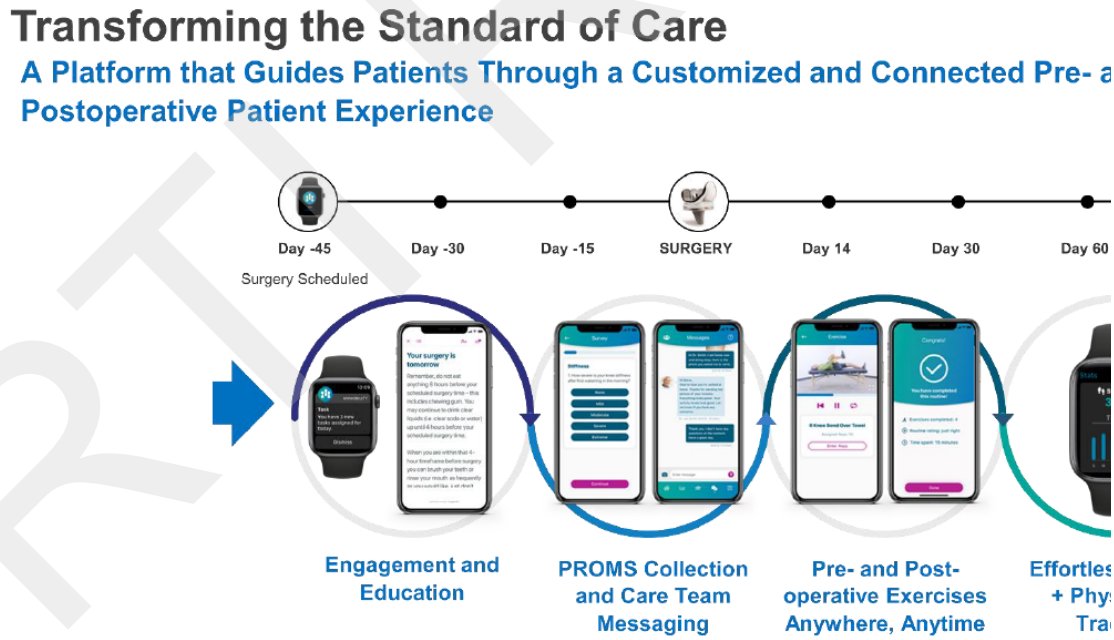
WPH has already committed enormous resource to ensuring all the necessary elements to achieve maximum hospital efficiency and world-class outcomes are in place. The Director – surgeon cohort already has vast clinical experience in the field. It can be seen from the results detailed in appendix 3 that enormous improvements in efficiency can be achieved by exactly the systems and processes that WPH will have in place. Conservatively, considering time savings alone, OR output will be 20% in excess of what is traditionally achieved with outdated models of care. When these saving are compounded by shortened length of stay WPH will not only benefit from more funding bundles but from an increased profit margin on each bundle.

Appendix 1 (Orthopaedic Surgeon)

Domain	Identifier	Metric	Definition
	A	Smoking status	Non or Ex (zero tolerance
	B	BMI	<40 (zero tolerance)
Fit for Surgery Compliance	C	Anaemia	Age / gender lower limit
	D	Staphlococcal screen	tested / treated (zero tol
	E	Diabetes	HbA1c (<8.0) / Fructosan
	F	On-time Start	Knife to skin within 15 m
	G	On-time Finish	Closure within 45 min of
	H	Total Sessions	Half day sessions in 6 mo
	I	Cancelled Lists	Sessions not used per 6 r
	J	Minutes per Session	Time used per session
	K	Session Utilisation Ratio	Minutes per session/ Sch
Operating Theatres	L	Total Utilisation Ratio	(Total sessions-cancelled
	M	Turnover Time	Closure to knife to skin
	N	Operative Time	Skin to skin
	O	Total Consumable Costs	$ Total Consumable Cost
	P	Wasted Disposable Costs	$ Total Wasted Consuma
	Q	Complaints	From OT staff per 6 mont
	R	Total Revenue	$ OT Revenue per 6 mon
	S	OT Efficiency	(Total Revenue-Total Cor
	T	Mean Length of Stay Single Arthroplasty	hrs (Rank Surgeons) Best
	U	Mean Length of Stay Double Arthroplasty	hrs (Rank Surgeons) Best
Wards	V	Mean Length of Stay Non-Arthroplasty	hrs (Rank Surgeons) Best
	W	Discharge Disposition (Home / HIH)	Home/Total x100 (%) (Ra
	X	Planned ICU / HDU	Number in 6 month perio
	Y	Unplanned ICU / HDU	Number in 6 month period
	Z	Consumable Costs (pharmacy) Single Arthroplasty	Total Pharmacy Cost / Num
	AA	Consumable Costs (pharmacy) Double Arthroplasty	Total Pharmacy Cost / Num
	AB	Consumable Costs (pharmacy) Non-Arthroplasty	Total Pharmacy Cost / Num
	AC	Complaints	Rank surgeons (Best is 0)
	AD	Ward Efficiency	20-T-V-Z-AB
	AE	Readmissions	30 day (number)
	AF	Readmissions	90 day (number)
	AG	Return to theatre	number
	AH	SWI	number
	AI	DWI	number
Complications	AJ	PJI	number
	AK	DVT	number
	AL	PE	number
	AM	fall	number
	AN	transfusion	number
	AO	Complcations total	AEx2 + AF + AGx2 + AH + Ax
	AP	Complcations Ratio	Total Cases - Complication T
	AQ	PROM (Hip Arthroplasty) 12 months	Oxford (0-48, 0=worst and 4
	AR	PROM (Hip Arthroplasty) 12 months	Oxford (0-48, 0=worst and 4
Outcomes	AS	PROM Average	AN+AO/2 (Rank Surgeons)
	AT	PROM Score	20-Rank- Penalty (5 if PROM
	AU	PREM	NORPEQ (8 questions, 1-5 s
Total	AV		

Appendix 2. Accelero





Appendix 3. Evidence Base.

Scale of the intervention	Author	Method	Study design	Outcome
Small	Attarian	Process redesign	Time interrupted cohort. Level of evidence II	Number of cases increased by
	Bender	Six sigma	Nonrandomized trial, 24,193 cases over 2 y; level of evidence II	Number of cases increased by decreased by 3%, 19% increase
	Casaletto	Process mapping/ redesign	Nonrandomized trial. Eight cases. Level of evidence II	Reduced operative time by 20% the number of surgical steps fr eight carpal tunnel decompres
	Cassera	Team familiarity	Cohort; 360 cases. Level of evidence III	Addition of 1 team member in procedure time by predicted 1
	Chalian	Pathway redesign	Nonrandomized trial; 21 cases. Level of evidence II	12% operative time decrease
	Chin	Tool reduction	Cross-sectional study: 226 instrument trays, level of evidence II	Average instrument utilization be 27.8%, able to reduce instru by 57%
	Engelmann	Standardized breaks	Randomized controlled trial; 51 cases. Level of evidence I	Frequent intraoperative breaks half hour did not increase oper decreased adverse outcomes a surgeon cortisol levels.
	Farrokhi	Lean methodology, 5s tool reduction	Nonrandomized controlled trial; 2766 cases. Level of evidence II	Reduction of surgical trays for invasive spine surgery by 70% (and decrease operative time by
	He	Team familiarity	Retrospective cohort; 1900 cases. Level of evidence III	Addition of one team member procedure time by predicted 3
	Krasner	Parallel processing and standardization	Cohort; 549 cases. Level of evidence III	22-min surgical time saved; 10 anesthesia time

	Lain	IHI collaborative improvement, standardization, tool reduction, cycle time reduction	Cohort; 805 cardiac surgeries. Level of evidence III	26% cost reduction in coro
	Lee	Process mapping/ redesign	Nonrandomized controlled trial; 150 patients, 100 before intervention. Level of evidence II	Unilateral group cost decr decreases of 1.3 h; bilatera decreases of 2.2 h
	Lunardini	Tool reduction	Cross-sectional study: 38 instrument trays, level of evidence II	42% of instruments unuse from tray with projected s per year
	Morris	Root cost analysis, process mapping	Retrospective cohort; 419 cases. Level of evidence III	Decreased instruments by OR non-operating time by
	Ngu	Planning, streamlined supply chain and instrument trays, team building	Nonrandomized controlled trial; one surgical team. Level of evidence II.	Instrumentation reduced doubling surgical volume
	Nundy	Checklists	Nonrandomized controlled trial; 422 survey respondents. Level of evidence II	11% decrease in intraoper decrease in communicatio
	Porta	Checklists (team assessment)	Cross-sectional survey; 11,342 cases. Level of evidence IV	9% decrease in mean dela wasted time
	Stockert	Tool reduction	Cross-sectional study: 49 procedures, 237 instrument trays, level of evidence II	Utilization rate for instrun
	Zheng	Team familiarity	Retrospective cohort; 587 cases. Level of evidence III	Addition of 1 team membe procedure time by predict
Medium	Al-Hakim	Tracking delay	Cross-sectional study; 31 cases. Level of evidence IV	Approximately 25% of the spent on preventable disru that preventable disruptio added activities