**Ramsay Healthcare**

**Event: Analyst & Institutional Investor Briefing – Full Year 2020**

**Date: Thursday, 27th August 2020**

**Speakers: Craig McNally and Martyn Roberts**

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**Craig McNally:** Welcome to this full year's results briefing for the year ended 30th June, 2020. I'm Craig McNally, managing director and CEO of Ramsay Healthcare, and I'm joined for the first time by our newly appointed group financial officer, Martyn Roberts.

This morning, we have released our earnings report for the full year, which demonstrates our resilience in a time of crisis and our strong balance sheet, which supports our growth strategy into the future. This past June quarter, which is possibly one of the most remarkable periods I've experienced in my 33 years with the company, and the performance of our teams during those challenging times demonstrated what an incredible and resilient organization Ramsay Healthcare is. We have accomplished a lot over the period, including an equity raising, and we are well positioned for the long-term. I refer to our standard disclaimer, on slide two and I'll move on to slide three.

Before we go through the results this morning, I want to take the opportunity to talk about the circumstances we're working in and how effectively our teams are responding around the world. While the business had been tracking well until February 2020, the circumstances posed by the COVID-19 pandemic on the company's operations had a significant impact on our full year result. With the onset of the pandemic in March 2020, business sustainability and ensuring that we protected the wellbeing of our patients, staff and doctors was our overwhelming primary focus. Elective surgery restrictions were imposed in most regions from March, creating a significant level of uncertainty. Ramsay led the discussions with all levels of government in our major regions, being Australia, UK, and France, to make our facilities available to national efforts. As I will detail later in the presentation, Ramsay Hospitals in France and UK remain under national agreements until later in the year, and Victoria is also again under elective surgery restrictions and we remain heavily involved in assisting with the COVID-19 crisis there.

Let's move on to **slide four**. I'm extremely proud of our global teams and how they've responded to the crisis, delivering for each other and delivering for our patients, all the while strengthening our culture of people caring for people. Our main goal has been to protect the wellbeing of our patients, staff and doctors, and to ensure that our facilities are serving their communities. The period has been filled with example after example of our hospitals, doctors and staff going above and beyond to assist in this crisis. Some examples are in France, our Ramsay Santé hospitals cared for over 7,000 coronavirus victims and our staff suffered with the families of the patients who died of COVID-19. Most of Ramsay's UK facilities were made available to the national effort and we performed 13,000 urgent operations for the NHS until the end of June, which was about a third of the total independent sector NHS activity. In Asia, we've treated many hundreds of COVID-19 patients, particularly so in Indonesia. Our flagship hospital in Sweden, which is Saint Göran, and our Omegna Hospital in Northern Italy, were heavily involved in the crisis as both these regions were significantly impacted by the virus.

In Australia, Joondalup Health Campus was one of the first facilities in the country to treat a large cohort of COVID-19 patients. With very little notice and over one weekend Joondalup took in over 30 patients suffering with coronavirus from the Artania cruise ship and cared for these patients without any cross infection to staff, doctors, or other patients, demonstrating their amazing expertise and ability to manage in a crisis and they received much praise from those patients. Through July and August, our hospitals in Victoria have been caring for hundreds of COVID-19 patients, assisting public hospitals with urgent surgery work, and our staff are currently providing up to 60 shifts a day in affected aged care facilities.

Moving on to **slide five**, I'm pleased to say that no Ramsay employees were stood down because of the pandemic. However, we do not underestimate the impact of COVID-19 on our staff and doctors, and have taken into account the high transmission rate to healthcare workers. We implemented stringent new safety and clinical quality protocols, guidelines on social distancing and PPE use, and adopted patient and visitor screening and visitor restrictions to ensure maximum safety for our staff, patients and doctors. All of which will come at increased costs but protecting our staff and doctors was our overriding priority. Ramsay has also developed some practical tools and support programs on mental health, wellbeing, and resilience and we've adopted virtual technologies to assist with communications both in country and across the world.

Moving on to **slide six**, the strategic location of our facilities across regions meant that they played a key role in supporting governments with national response efforts and this work is ongoing. We've also been assisting off campus at nursing homes and our nurses have volunteered in the public sector as well and additionally, we've been lining critical equipment to the public sector across our regions. We also threw support into our communities, supporting local businesses struggling for survival. For example, our hospitals in Australia have purchased many thousands of meals for our staff from local restaurants and cafes during the pandemic.

Onto **slide seven**, our global supply chain and management systems were well leveraged through the pandemic and were able to limit shortfalls in equipment, PPE and medicines. In Sweden, patient use of our Capio Flow digital consultation platform in the proximity care business expanded almost threefold to over 33,000 consultations per month. In addition to Sweden, we're agile in terms of our technology response to delivering programs and consultations virtually, for example, delivering antenatal care and mental health programs via telehealth platforms.

In summary, our response during this pandemic has demonstrated what an incredible and sustainable organization we are, and one that is driven to do the right thing for our patients, staff, doctors, and the general community. It has been an extremely challenging time for our staff and doctors as we've pivoted to support national efforts during this crisis. COVID-19 has impacted our financial results this year, which I'll outline shortly, but importantly, it has cemented and reinforced our role as a leading healthcare and hospital provider in our major regions and I couldn't be more proud of our efforts in that regard.

Moving on to **slide eight**, I'll just outline our agenda for today. We'll provide an overview of our group performance for the financial year 2020, a breakdown of our performance by segment, an update on group financials, including cash flow and liquidity, and an overview of strategy, before outlining our outlook.

Moving on to **slide 10**. Today Ramsay Healthcare reports a group core net profit after tax, core NPAT, of $336.9 million for the year ended 30th June 2020, which is a decrease of 43% on the previous corresponding period. On a like for like basis under the old lease accounting standard, AASB 117 leases, this was a decrease of 34.4% on the previous corresponding period. Core NPAT delivered core EPS of 155.9 cents for the year, a decrease of 44.5% on the previous corresponding period. On a like for like basis, this was a decrease of 35.9% on the previous corresponding period. The company's statutory net profit after tax of $284 million was down 47.9% on the previous corresponding period. On a like for like basis, this was a decrease of 40% on the previous corresponding period. Just to remind you, at the end of February, we reaffirmed our FY20 guidance of core EPS growth on a like for like basis of 2% to 4%. The extraordinary circumstances posed by the COVID-19 pandemic on the company's operations and around the world resulted in us withdrawing guidance in March 2020, and had a significant impact on the full year result.

For the full year, Ramsay's Australian operations revenue decreased by 2.2% and EBITDAR decreased by 23.2%. Ramsay UK revenue was down 4.9% and EBITDAR was down 10.6% on the previous corresponding period. Ramsay Santé's results includes consolidating the extra four months of Capio, which was acquired in November 2018, hence revenues were up 14.3% and EBITDAR up 8.5%. And finally, for Ramsay Sime Darby, our equity accounted share of the JV net profits were down 18.2%.

As previously announced, the company will not be paying a final dividend on ordinary shares for FY20. The Cares dividend due for payment on 20th October 2020 will be paid.

Moving on to **slide 12**. Before the pandemic, Ramsay's Australian division was on track to make full year targets, but was significantly impacted by elective surgery restrictions from March 2020. We entered partnership agreements with governments in New South Wales, Queensland, Victoria and Western Australia to maintain full capacity and make our facilities available to assist with the COVID-19 response. In return, Ramsay received net recoverable costs, hence the business was broadly breakeven at the EBIT level for the four-month period between March and June 2020.

Most agreements were paused or ceased on 30th June 2020 as elective surgery restrictions eased. However, elective surgery restrictions were re-introduced in Victoria in late July and we recommenced the agreement with the Victorian government on 23rd July 2020. We are very proud of how our teams in Australia have delivered for our patients during this crisis.

Our overall net promoter score, NPS, for the fourth quarter was 77.8, the highest we've ever achieved, which is world-class result. For the full year FY20 our NPS was 75 and in an outstanding achievement, Ramsay Australia recorded zero sentinel events during the haul of FY20.

Year to date with the exception of Victoria, Ramsay Australian hospitals have experienced increasing surgical demand, which has tracked above last year, but the rapid escalation of the crisis in Victoria demonstrates that it is too early to make any conclusive statements about the near term. We are experiencing additional costs associated with increased PPE usage, more costly PPE on a per-unit basis and staff involved in screening visitors to our facilities and cleaning regimes. Despite the current situation, we are positive about the longer term. The relationships we have developed with governments have put us in a strong position to continue to support the public sector in dealing with the backlog of work into the future.

Moving on to **slide 13**, the Company remains committed to investment in brownfields and to this end, in FY20, Ramsay Australia completed 11 projects totalling $255 million, consisting of 295 gross bids, which was a net 222, 11 theatres and 85 consulting suites. Towards the end of the financial year, two major projects were completed earlier than anticipated at North West Private in Brisbane, which has pitched on the slide and the development at John Flynn Private on the Gold Coast. Both these projects were previously expected to complete in early FY21. During the last financial year, the board approved a further $196 million in projects, including 209 net beds, seven theatres, 13 consulting suites and a new emergency department.

Moving on to **slide 14** on continental Europe. For the first half of FY20 Ramsay Santé's revenues were up 44.3% and EBITDAR was up 38% due to consolidating an extra four months of Capio earnings, remembering that Capio was acquired on 7th November 2018. However, the second half of 2020 was negatively impacted by COVID-19, with revenues down 5.3% and EBITDAR down 10.5%. Ramsay Santé was on track to meet full year targets before COVID-19 hit Europe and was recording strong activity to that point. Ramsay Santé received a revenue guarantee from the French government, which applies from 1st March until 31st December 2020. Sweden also received government support during the period, specifically in relation to Saint Göran's in Stockholm.

Surgical activity in France and the Nordics has been ramping up since June, although it is now in summer vacation time. There remain concerns of a second wave in Europe, and while our business has performed well at the start of this year, there are still many uncertainties and it is too early to make any predictions about FY21. Ramsay Santé continues to make good progress on the integration of the Capio business. We expect to achieve identified synergies, but the timing of the realization of these synergies has been impacted by the COVID-19 pandemic and will be pushed back until normal activity resumes.

Moving on to the UK on slide 15. On the back of the strong first half, Ramsay UK continued to perform well at the start of the third quarter. However, like other regions, Ramsay UK was heavily impacted by COVID-19 and elective surgery restrictions. Ramsay UK led the industry discussions on making hospitals available to the NHS and an agreement was reached with NHS England for the COVID-19 period, where Ramsay received net cost recovery for its services and capacity, meaning the business was broadly breakeven at the EBIT level for March to June 2020. Importantly, the crisis has seen many new services and doctors move into our hospitals and the engagement built with NHS trusts has positioned Ramsay UK well for the future.

Uncertainties still remain in relation to the pandemic in the UK and the duration of the current agreement with NHS England, which remains on foot. We are in negotiations with NHS England to extend and vary this agreement with a possible December 2020 end date. The NHS has recently launched a tender to identify operators to assist with reducing waiting lists over the next four years and Ramsay UK will

participate in this process. More than 50,000 patients have now waited at least a year for treatment and waiting lists are predicted to hit 10 million patients by December 2020.

Moving on to **slide 16** on Asia. There were no restrictions imposed on elective surgery during the pandemic in either Malaysia or Indonesia, which meant there was no government support as had been achieved in other regions. However, movement control orders in these countries impacted patient volumes during the period. Our hospitals in Asia contributed to the care of COVID-19 patients. We are starting to see patient volumes in those regions gradually increase, but some areas will take some time to recover.

I'll now hand over to Martyn to go through the group financials in more detail.

**Martyn Roberts:** Thanks, Craig. It's great to be with everyone this morning. Moving on to **slide 18**. In terms of our overall group performance, Craig has covered this at a high level, however, some points are worth noting. Firstly, effective 1st July 2019 Ramsay adopted the new lease accounting standard AASB 16, which removed the accounting distinction between operating and finance leases and brings all leases on balance sheet with consequential impact on the income statement. From a technical perspective, Ramsay applied the modified retrospective method of adoption of the standard effective from 1st July 2019, whereby FY19 comparative year accounts are not being restated. The table on the left hand of the slide therefore shows the as-reported numbers under the new lease standard for FY20 compared to the numbers reported under the old lease standard for FY19. The table on the right shows the like for like comparison for the full year results under the old lease standard. The only line items that are comparable under both the old and new lease standards are revenue and EBITDAR.

Ramsay Santé has consolidated the earnings of Capio since the acquisition in November, 2018. FY20 therefore includes 12 months' worth of Capio of earnings whereas the FY19 included eight months of Capio earnings. The impact of the adoption of the new lease standard on the profit and loss line items for the year has been a decrease in operating lease expense of $486 million, an increase in depreciation of $345.8 million and an increased interest expense of $231.7 million. Finance costs include a $12 million break fee on an interest rate cost associated with one of the credit facilities repaid with proceeds from the equity raising. Core NPAT was down 43% for the year and on a like for like basis, core NPAT under the old lease accounting standard was down 34.4%.

As Craig stated earlier, no final dividend has been declared this year. I'd like to also state that it is our intention to no longer separate our profit between core and non-core going forward. We will however provide details of any material, one off items within our commentary.

Turning now to **slide 19**. Capital employed increased by $4.5 billion in right of use assets as a result of the adoption of AASB 16. There was a positive impact on FY20 working capital due to revenue guarantee payments received by Ramsay Santé being in excess of revenue guarantee accruals recognized in the period. Property plant and equipment reduced due to a $368 million transferred to right of use asset. Other assets and liabilities increased due to the AASB 16-related derecognition of the deferred lease provision of $294 million. Return on capital employed decreased by 6.9 percentage points to 9.4% due to the reduction in EBIT in FY20, the acquisition of Capio in FY19 and the adoption of AASB 16. Return on capital employed will become an increased focus in future years with a disciplined approach to the allocation of capital.

Turning now to cash flow on **slide 20**. Free cash flow was $1 billion for the year, up $691 million on the prior year. This was due to the cash received as part of government guarantee programs, particularly in France, where payments received from the revenue guarantee scheme were in excess of the amounts accrued as revenue. The proceeds of the $1.5 billion equity raising in the second half of FY20 has been partially used to pay down debt.

Turning now to leverage and capital management on **slide 21**. As a result of the $1.5 billion equity raise in half two and positive cash flows from government guarantee schemes, net debt reduced to $2.8 billion as defined in previous years. However, it increased by $5.3 billion of capitalized leases this year. Consolidated balance sheet leverage reduced to two times as measured under the old lease standard

methodology. Our next debt maturity is not until October 2022 and we now have the equivalent of approximately $3 billion in undrawn debt capacity and cash headroom to allow us to fund future growth activities in the coming years.

And on that I'll now hand back to Craig to talk about strategy and our outlook. Thank you.

**Craig McNally:** Thanks Martyn. We'll move on to **slide 23**. Yes, this financial headroom does put us in a better position to continue to execute on our growth strategy, which includes growing from the core including brownfields and pursuing improved public-private collaborations, continuing to investigate healthcare acquisitions both in Australia and internationally in and out of hospital, where they make sense and meet our investment criteria, continue to strengthen our operating performance and developing our digital and data strategies, which leveraged from our global reach, and pursuing innovation, clinical excellence, a better customer experience and developing our talent. During COVID-19, we did not stop in terms of delivering on this strategy. We continue to invest in brownfields, both here and overseas, and we've also been driving new healthcare solutions out of hospital in France and in Australia, progressing our hospital-in-the-home business, as well as expanding our mental health business beyond the hospital walls.

Finally, I'll move on to our outlook on slide 25. FY20 has been an extraordinary year and one that has highlighted the strength and depth of Ramsay Healthcare. Many uncertainties remain with respect to the impact the pandemic will have. As a result, Ramsay is unable to provide guidance for FY21. Notwithstanding the significant near-term uncertainties, over the longer term strong industry fundamentals remain. In addition to the increased demand for healthcare generally created by aging populations with increased incidents of chronic disease, there are also now longer public waiting lists in each of our markets. We expect to play an enhanced role in relieving pressure on public waiting lists into the future. Following our recent $1.5 billion equity raising, Ramsay is also committed to expanding our business both in Australia and overseas. As highlighted, we have a strong balance sheet to support this growth strategy.

Thank you for attending and we're happy to take any questions.

**Chris Cooper (Goldman Sachs):** Hi, morning. Thank you. On Australia, can I just confirm my understanding of these – of the viability agreements? So, because they're not currently active outside of the state of Victoria, you are currently receiving a sort of pre-COVID level of reimbursement on all surgical procedures in all other states, is that correct?

**Craig McNally:** That's correct. If the agreements aren't active, then it's normal trading. So the only active agreement, or agreement that's been reactivated, is Victoria.

**Chris Cooper (Goldman Sachs):** Got it. And in Victoria, you're basically being managed to a sort of a cost recovery, sort of 0% margin sort of basis?

**Craig McNally:** Yes it's the original agreement that's been reactivated.

**Chris Cooper (Goldman Sachs):** Understood. Thank you. And just a couple of quickly on the backlog if you don't mind. I mean, obviously we note your commentary, surgical volumes are above the prior year levels outside of Victoria. I know previously you've spoken to one of the biggest uncertainties through all this being just, you know, the psychology of patients, I guess, and their willingness and ability to undergo procedures, which weren't necessarily deferred through the depth of the pandemic. Now we're a couple of months in to the reduction of the restrictions in most states. What's your latest thinking there in terms of how patients are proceeding with rescheduling? And I guess just part B, if that would be, again, given you've got a bit more visibility than you had a couple of months ago, what's your latest thinking in terms of how long it might take to get through the backlog of work that did build up in that period sort of April to June?

**Craig McNally:** Thanks Chris. Whilst the surgical activity has been above the same period last year for July, August, it's really difficult to draw a longer term or medium term trend from that, because there's a pent up, backlog from procedures that were deferred really from March and what we need more time to see

is what's happening across the systems. So, what's happening with people accessing primary care to then get referred to specialists and onto hospitals? So, the shape of the recovery I don't anticipate to be linear and I expect it will be a longer timeframe. In answer to the second part of your question, no, absolutely still uncertain and will depend very much on the way that the public sector addresses its increased waiting lists, and so to bring it back to individual behaviours, too early to tell.

**Chris Cooper (Goldman Sachs):** Okay, but on the deferral piece, I mean, I know previously you've commented that you'd expected greater than 80% of those procedures which were deferred to come back at some point. Is that a number you're still confident of today?

**Craig McNally:** Yes, I think so, absolutely. But, it's our best guess given the types of procedures that need to be undertaken and the timeframe is uncertain as I say.

**Chris Cooper (Goldman Sachs):** Got it. Thanks a lot.

**David Low (JP Morgan):** Thanks very much and thanks for taking my questions. Just on the same topic, Craig, I mean, I noticed in the commentary there was a comment made that specialties were ramping up more slowly even though activity was above previous years. Just wondering what you meant by that?

**Craig McNally:** With the procedural activity where, there was a backlog that has ramped up and that's really in all of our markets, but what we've seen slow down or not recover as quickly is for example medical admissions. So, respiratory conditions with a low incidence of flu for all the obvious reasons, I think, related to lockdown, we're not seeing the same volume of medical admissions as we saw last year. Mental health and rehab it's the same, just slower to recover than the surgical admissions.

**David Low (JP Morgan):** Okay and just an overview on that, is the mix likely to be positive or negative?

**Craig McNally:** Too early to tell in terms of the surgical mix, it's likely to be slightly negative, I think, you know, given the high margin businesses are slower to recover, but that's too general a statement, David, you know, because the acute surgical work, the urgent work, was being done anyway. So, you know, the restrictions weren't on acute surgical work in the first instance, but, we just need more time to see what develops.

**David Low (JP Morgan):** And along the same vein again, I mean, you've commented on high costs from PPE, et cetera, I know you're not giving guidance, but how material are these increased costs? I mean, I presume they're not affecting throughput of an operating theatre but they are adding staff in other parts of the hospital?

**Martyn Roberts:** David it's Martyn. So yes, we're not giving guidance on costs. What we can say is that July is pretty much the only month that we've experienced of back to normal-ish activity and what we've seen there is about $6 million of extra costs in the month of July in relation to additional COVID costs. So, about $2 million in PPE, which is more than double what it was last year, about $2 million in additional staff costs involved in screening people when they're presenting to the hospital, taking temperatures, et cetera. And then another $2 million in terms of other various costs that we've had associated with COVID-related activities over and above. That's just Australia. So, you know, other factors in other markets, obviously it's still under government arrangements there. So yes, about $6 million in July, but we'd be loath to try and extrapolate that over the rest of the year because we just don't know what's going to happen.

**David Low (JP Morgan):** Thanks. And one question for you, Martyn, actually just one follow up on that. I mean, does Victoria influence that a lot? I mean, is that sort of an ex-Victoria number, which is, I guess what we'd like to understand? And while I've got you, just working capital. That big movement in working capital, I see France called out, could that kind of reverse? Could you talk a little bit about what to expect going forward on that one, please?

**Martyn Roberts:** Those costs were ex-Victoria. Now working capital, so in France, the way that the arrangement is happening there is we're getting cash advances every month from the government, which

are essentially equivalent of, you know, one month's worth of government payments from the prior year. We make some claims against that, but that cash that we're getting is way in excess of what we're actually going to be entitled to when we come to settle that back in March 2021. And so what you've got there is quite a large creditor balance owing back to the French government, which will just sit with us and probably get bigger during the first half of 2021 as well until it's all reconciled in March 2021 for the March to December period.

**David Low (JP Morgan):** Right, so it does reverse out.

**Martyn Roberts:** It does reverse out, yes.

**David Low (JP Morgan):** And you've not really sort of – I mean, it would be useful to get some clarity on how much – I mean, I don't know if it's at your fingertips, but perhaps at some point some clarity on how much that is and how much is going to reverse out, just for our modelling. But I'll leave it at that. Thank you.

**Martyn Roberts:** Okay. Thanks.

**Lyanne Harrison (BAML):** Good morning all. Thank you for taking my question. Just to follow up on Chris's comment on activity level, you mentioned you're seeing higher surgical activity in Australia. Is that also increased activity above prior corresponding period, does that also apply to your French operations and your Nordic operations?

**Craig McNally:** Yes, it does. I mean, France in particular. So, France's recovery on surgical procedures has been stronger than we had anticipated a few months ago, particularly given the quantum of COVID patients that the French business had to deal with, and so the recovery is pleasing. Nordics, we are still coming out of the summer holidays and surgical restrictions in Sweden were only eased a couple of weeks ago. So, we're optimistic we'll see those surgical volumes come back into the business in the Nordics and the same for the UK. And the UK, as I flagged, the NHS is looking to actively address the long waiting lists through the tender process and with a four-year cycle to do that. So, I fully expect volumes to increase there as well.

**Lyanne Harrison (BAML):** Okay. On those long waiting lists, whether it's the UK also in Australia, we know the waiting list are getting longer, are you seeing any material transfers of volume from the public to the private sector currently or is that, you know, like the UK, it's waiting on the tender process to come through?

**Craig McNally:** There's two aspects of that. There's the public sector activity we're doing, and that's more localized. So, in various states there'll be local arrangements not necessarily on a state-wide basis, but on a regional basis to deal with addressing public hospital waiting lists. But overall, there's no question that the waiting list has increased.

And the other thing we'll see, I mean, people do get focused on waiting lists because that is the sort of bigger part of the picture, but what we're also seeing is we've seen people are not entering the system, like I alluded to before. Not entering the system at a primary care level. So, things like cancer rates, we'll see people returning for treatment and diagnosis and treatment of cancer, and the real risk – and I think there's a message to send out there is people have to access the healthcare system. They need to enter, you know, the way they would normally enter and see their primary care clinicians so that appropriate diagnosis will occur and the risk is – well, this is off the track a little bit, but one of the reasons we have great cancer outcomes in Australia particularly is access and that's because of early diagnosis and treatment. The risk is, and there's plenty of other people with more expertise that will talk about it, but the risk is that people are deferring accessing the system and with consequences that can be avoided.

**Lyanne Harrison (BAML):** Okay. And just one final question on government support in both France and Sweden. With the French revenue guarantee, does that work out to be EBIT neutral for Ramsay Santé or

is it a slight EBIT positive? And then for Sweden, can you provide some colour on the government support you received and is this ongoing?

**Craig McNally:** So Lyanne, in France it does vary month to month depending on the level of billings we're actually doing, because the guarantee is a revenue guarantee, it's not a cost recovery. So it does depend. During the period of March to June we have a slight positive EBIT amount, but then to cover rental costs, which now under AASB 16 we have some of that down in interest, so, you know, it did cover some of those interest costs. So, if you looked at it on the old accounting basis, it was pretty much close to break even, but a bit different now under the new accounting.

And in Sweden, we just had a one-off payment in June that was not huge but helpful in terms of what we were doing with our hospital activity there.

**Lyanne Harrison (BAML):** Okay, great. Thank you very much.

**Andrew Goodsell (MST):** Thanks very much for taking my questions. You talked to lower medical specialty growth, and you've got a pretty big commitment to mental health in Australia and France. I was just wondering if you've had any early indications of the recovery of that particular specialty and perhaps any views you've got on sort of outlook there. Sounds like it would fit a lot of the, you know, pent up demand that you've been talking about.

**Craig McNally:** It's an interesting one, mental health. There's lots of speculation about, you know, the increase – potential for the mental health issues in the community and I think that's real. We're not seeing that come back to inpatient volumes as quickly as we've seen the surgical recovery, and I think part of that is people still not accessing the system. And we're also seeing other – which is, you know, in mental health it's a very fragmented part of the industry and we're seeing other services that – and we're providing other services as well in terms of using virtual technology to be able to provide consultations.

So, but we anticipate – and then the other issue is the starting issue. Mental health facilities aren't geared up as much to deal with, you know, infectious patients, and so I think there's a reluctance it reflects that community behaviour aspect we've talked about. So, despite all the training that we've put in and fortunately for our business both here and in Australia, the significant mental health business, we've got, you know, clinical resources to leverage off in our acute business, to make sure that those environments are as safe as they possibly can be. But I think there's still a perception out there that if you can avoid going to, an institution, you do.

**Andrew Goodsell (MST):** I guess the picture we're getting here is just with some of this, you know, recovery back-end weighted and potentially the public sector inertia, I guess, in getting some of those contracts up and running and turning the tap on. Is it more of a second half weighted recovery, you know, all things being – all things being quite difficult to predict. Is that just your sense of, you know, we are going to be a lot further down the track by February next year? Is that going to be when we talk to you then?

**Craig McNally:** Andrew, I wish I did have that crystal ball. I mean, I think what is clear is that – and if we reflect back to where we were in February, March, April, really, and from an Australian perspective, you know, the incidence of the virus wasn't as great as was modelled and so the impact on the system wasn't as great, but we still went into lock down in Europe, France, UK, the Nordics, the impact was much more significant and the volumes of COVID-positive patients and the consequences of that were much greater in Australia. We did anticipate the first half of FY21 still would be unpredictable and even despite the level of infection in Australia, it's still uncertain. So, I agree with you. I think it's more back-ended than people might have initially thought, because we've still got that uncertainty and that uncertainty is right in front of us and obviously as we move forward, we'll understand more about the implications of second, third waves and what lockdown does, et cetera.

**Andrew Goodsell (MST):** Got it. And just a quick one, Martyn you've touched on this, the GDS accounts didn't come out and won't come out, from what they say, until October, but just in terms of the way in which you've booked the revenue to your P&L, and obviously you've put excess revenue into the working capital,

but, yeah, just your confidence around how your forecast and so on or, you know, how you've come about those numbers.

**Martyn Roberts:** Good question. I mean, you know, Santé's accounts don't normally come out until October, but you're right, they normally put out a press release at this time. The reason they haven't is that the revenue that we've booked is really based on estimates on a hospital by hospital basis. So, the revenue guarantee scheme works at a hospital level not at a national level, and so, because it's for the period March to December, we've had to make estimates for each hospital of what our billings might be in the second half of calendar 2020 to basically work out what our accruals should be. If those estimates change between now and when they issue their accounts and October, then the assessment of how much to accrue at the end of June may well change as well. So, you may see some slightly different numbers being released by Santé in October than what we've included in our accounts. It's the best estimate we've got at the moment. It's been audited and everybody kind of agrees that it's where we are today and what we can estimate, but that's essentially it.

You'll see in our accounts, if you go through, that we have actually called out the amount we did receive or have booked rather, with regard to that. It's $235 million. And that essentially takes us between what we bill to the government and what we were getting in terms of the cash advances from the government in each month that we operated.

So, yes if you were estimating that you were going to have very, very strong trading in the second half, you may not accrue as much at this stage. So, it is really going to depend on the second wave and how much profit we'll make in the second half of this calendar year.

**Andrew Goodsell (MST):** Got it. That's great. Thank you very much. Thanks guys.

**Saul Hadassin (UBS):** Good morning Craig, good morning, Martyn. Craig, just a quick one on Australian hospitals and taking into consideration what you've said regarding activity and also the higher costs, if those costs sort of remain in place for the rest of the fiscal year and assuming activity remains as it is, just any comments on the ability to preserve margins in that segment.

**Craig McNally:** Well, I think preservation of margins is a difficult task. There's no question there's cost increases, some of which will be temporary, and we'll manage those down over time. Some of them will I think be permanent and so, an example will be the unit cost of PPE and the usage of PPE will result in a permanent increase in PPE costs. Where it settles, as we go forward, it won't be at the peak levels that – pricing that we were paying back in April, but it will settle it at a level higher than it has been historically. So, maintaining margins will be extremely difficult, but margin is a function of revenue and cost and so where we are on the revenue side, we get more efficiency with greater volume, so the recovery of volumes will be critical to that. Pricing, we're in an environment with health funds – I'll pre-empt the question on where we are in negotiations – we've still got one negotiation to finalise. And so, short answer is maintaining margin is going to be difficult, Saul.

**Saul Hadassin (UBS):** Thanks Craig. And just for Martyn, a comment on the slide 19, which talks about ROCE becoming an increased focus as it relates to allocation of capital. I mean, I had historically thought Ramsay had been fairly disciplined, particularly as it relates to brownfield deployments. Can you just give some colour as to what that refers to?

**Martyn Roberts:** It's really internally becoming a greater focus. You are right, it has been an excellent discipline going forward, and we want to make sure that we maintain that discipline and we're really making that comment to make sure people aren't thinking that we've now got $1.5 billion dollars in the bank that we're going to sort of start to soften that discipline. We're going to be as focused as we were before, if not more so going forward, so.

**Saul Hadassin (UBS):** Sure. And then Martyn so, just very finally, the move to include non-core items going forward on the basis that the dollar value of those items was netted to sort of $40 to $50 million last year, is that a reasonable estimate going into FY21?

**Martyn Roberts:** I think by their very nature, we wouldn't be able to give you guidance on non-core items. So, you know, we just felt that it was an appropriate time to start moving away from that concept and report on statutory profit going forward and that's what we'll do, but if there are any, you know, material one-off items in nature, we will highlight them in our commentary so that you can still sort of normalize your earnings if you wish to do so. But yeah, by their very nature it'd be very hard for me to forecast those.

**Craig McNally:** And I think the point there is about transparency. Where there was the old way, we tried to be as transparent as we could be in calling out what those items were and that will be the case going forward.

**Saul Hadassin:** Great. Thank you guys, that's all I have.

**David Bailey (Macquarie): G**ood morning. Hi guys. Just to follow up on Chris's earlier question about the agreements with the states. I saw the determination with Western Australia, but is 30th June the correct assumption for New South Wales and Queensland in terms of when those agreement were paused?

**Craig McNally:** Yes.

**David Bailey (Macquarie):** Okay. That's helpful. Thank you.

**Craig McNally:** Just a technical response, New South Wales isn't technically paused, we're just not – it's not active.

**David Bailey (Macquarie):** Yes, okay. In terms of brownfields, you've given some numbers there for FY21, just wondering if there's been any impacts that have occurred to date when you're out of FY20 year, whether those numbers have changed and then, you know, more just the commentary around the broader private sector. You know, some of the issues in relation to funding, has that changed in expectations for some operators that you're aware of?

**Craig McNally:** Maybe I'll answer the second one first. I mean, I'd like to get a share of the $1 billion plus that the health funds saved in the June quarter. That would be handy, and there's – however you account for that, the numbers are the numbers and the APRA data says that health funds saved over $1 billion in claims cost for that quarter. So, how that rolls into funding for, you know various groups, I can't comment on other operators and where their agreements and negotiations are at.

In terms of brownfields, you know, the brownfield numbers for us, we've sort of been transparent about those numbers. The increased brownfield spend or capacity that came online in FY20 was increased because we brought a couple of projects forward. We finished them before the end of June, where we anticipated finishing them after the end of June, so that's why it's $255 million for FY20. As outlined in the presentation, the board approved $196 million in FY 20 for future brownfields. So, we're still absolutely committed to the brownfield agenda. It's still – the fundamentals of growth are still there in the system despite, you know, the COVID situation. And so you need capacity to service growth whatever that growth number will be. It's always lumpy, it's not linear.

**David Bailey (Macquarie):** Then just one final one from me just on those NHS tenders and the two plus two contracts, just if you give us a bit of a sense as to how material they could be? And then some of the considerations that need to be taken into account for a provider to be successful in winning those tenders?

**Craig McNally: W**ithout going into the specifics of it because that's still unfolding, it was really as much an expression of interest and capability statement in this first stage. And it really is about capability, having the capacity and the expertise and the relationships to be able to service that increased demand. A broader case mix will result, but then I think one of the positive – if there are positive things to come out of this situation – is that the assistance that we gave the NHS in the UK in our portfolio of hospitals demonstrated to the NHS that we had the capacity and capability to do a lot more work and a lot more complex work. And, you know, I've called out that we've done an initial 13,000 urgent cases for the NHS, which were the

sorts of things that we wouldn't otherwise have done traditionally. So, I think that puts us in good stead for whatever the process delivers in terms of dealing with the waiting list issue in the UK.

**David Bailey (Macquarie):** That's great. Thank you.

**Gretel Janu (Credit Suisse):** Thanks. Good morning. So firstly, just on the UK contract just to be clear with the renegotiations underway with possible December 2020 end date, I guess, do you anticipate to be EBIT neutral for that whole period or will there be opportunities for profit or additional incentives for exceeding certain volume levels?

**Craig McNally:** I won't go into the detail too much, Gretel, other than to say there is a – because the agreement hasn't been executed, you know. The negotiations are really at the end stage of the way that agreement will look and there will be a concept of moving away from an absolute EBIT neutral to be able to make a margin on private revenue, but there is an underwriting of the volume of that private revenue potentially. So, it's a little too early to be specific about it, but it will be - to all intents and purposes, it's likely to be slightly different from the agreement that we had before.

**Gretel Janu (Credit Suisse):** Okay. And then just in terms of Victoria, are you able to give us some indication in terms of the revenue and earnings contribution of that in pre-COVID world for the Australian business?

**Craig McNally:** Oh, no, we don't normally break it down by state, Gretel, so we won't do that.

**Gretel Janu (Credit Suisse):** Okay. Fair enough. I guess, it's probably too early to say at this time, but I guess what are your expectations on timing of exiting – reporting that contract after restrictions are eased? Like how much after, you know, things return back to stage three or earlier do you think you could kind of look to exit that contract?

**Craig McNally:** That's a really difficult one to call, because the speed at which we exited or the other agreements were either paused or terminated was really a result of the perception at the time about what the implications of COVID would be. I would suggest there's probably a more conservative position that we take and going forward and it's really hard to quantify, you know, what timeframe that would be, but I think the experience will be a sobering one.

**Gretel Janu (Credit Suisse):** Okay. Thanks very much, that's all I have.

**Steve Wheen (Evans & Partners): T**hanks very much. Good morning, Craig. I just wanted to go back to your comments on renegotiations with the insurers. As I understand it, you came off contract or the termination of the Medibank contract was August last year. Have you been without indexation that entire time from Medibank, what's your confidence in your ability to claw that back and how would it you be able to be, I guess, compensated for that from last year into this year? If we could just start there. I also just had a follow-up is what sort of responsibility does Medibank have to reimbursing or at least helping cover the costs or the inflated costs around PPE going forward? Thanks.

**Craig McNally:** Okay. Thanks, Steve. So, the agreement with Medibank, did – it didn't expire, but its end date under the existing – under the previous or the existing terms and conditions was 31st August. And so what's happened since then is that it has continued on foot on the same basis. So you are correct, there has been no indexation from 1st September 2019. Medibank has no obligation to – none of the funds have an obligation, and there's no mechanism that says as our PPE costs increase, you have to pay us more money. So, that's a negotiation we have, well, you know, that we'll have with the funds as the agreements come to their negotiating – negotiation stage. For Medibank, I won't specifically comment on what will happen retrospectively or what the terms and conditions will be other than to say that we are continuing the negotiation with Medibank. So, there's a focus back on that, and I will say that the focus on that did drop through that critical COVID period because our priority was what we were going to do for our patients and our staff then. So, we are back at the table and let's see how we go. Nice to get it resolved quickly.

**Steve Wheen (Evans & Partners):** But your starting point would be for a recoupment of that. It's not like we're just starting with the new financial year and that's ancient history now?

**Craig McNally:** Nice try, Steve, but I won't go there.

**Steve Wheen (Evans & Partners):** Okay. Alright, let's move on. It's clear that to try and look our way forward there's a lot of focus on the backlog of surgeries. Maybe I could ask in a different way, do you have any sort of feel or line of sight as to what the extent of the backlog is and how long that might take to clear through the private system? And the public system, I guess?

**Craig McNally:** My view on that hasn't changed from some months ago that it will certainly take longer to deal with the backlog than it did to create the backlog. So, I think we've got some time ahead of us as a system, and this is the same in other countries as well, to deal with the backlog of work. How long it will take, again, you know, I've said before that I'm not sure how long it will take and it's a function of capacity. So, the capacity issue for us specifically is physical capacity and we've got that because we can work the assets harder, but in order to work the assets harder, you have to resource them and that's staff and our staff and doctors wanting to do more work. And so there will be, I imagine there will be sort of a wave of that, but it's – on a sustainable basis, we'll have to look at how we resource that and at what level. So I'm not dodging it because there's something other than what the obvious is, it's just really hard to predict.

**Steve Wheen (Evans & Partners):** I mean, I guess you can understand from our perspective that just saying it's bigger than last year, that's not the biggest of hurdles for July. Is there any other commentary that you could give around those volumes just to give us an indication as to – is one month deferrals presenting as one month within July? That's the part that's the hardest to determine your way forward.

**Craig McNally:** The hardest piece to determine. I mean, we could just do some projections based on, the numbers of procedures that we didn't do from March through June and anticipate what that would be. And take a line off that and say, we're going to get 80% or 90% of those coming back and we'll forecast to treat them in a particular time. The unknown factor is the consumer behaviour piece. Are people going to take time off work in this environment to have their procedure done if they can defer it for six months? So, previously they would have gone, 'Yeah, I'll have it done in two weeks' time. Fantastic.' Now they'll think, 'I just might delay it.' So, that's the real unknown piece.

**Steve Wheen (Evans & Partners):** Yup, okay. Two Final questions for me for Martyn. Firstly, just again, wanted to pick up on that return on capital employed comment in the slides. Just wanted to understand whether or not that's potentially a reference or an investigation into sale and leaseback type arrangements because I've noticed in your history that you have undertaken that style of approach. Can you just give some comments as your initial thoughts on that approach within the Ramsay context?

**Martyn Roberts: W**e've got quite a naturally balanced portfolio by sort of, you know, history if you like, where in Australia we own all our assets and in Europe and the UK, we lease them. So, it's quite a nice mix currently. Looking at sale and leasebacks in Australia is definitely not on my to-do list at the moment. You know, we're always looking at capital management initiatives and – but, you know, with the equity raise, we certainly don't need the money. And, you know, we'll continue to have it on a back burner in terms of watch, but it's definitely not in my short term to-do list, that's for sure.

**Steve Wheen (Evans & Partners):** Fantastic. And then just lastly, I just noticed in your accounts a creditor balance of $555 million in other creditors. I'm just wondering what that provision for?

**Martyn Roberts:** That's pretty much mostly associated with the balance in relation to the monies that we've received in France as part of the revenue guarantee scheme. So, as I was saying before, we are receiving the whole amount of what we would have got, let's say on average on a monthly basis from government payments last year, but obviously we're only booking a small part of that as revenue, which is a difference between what we're billing and what the total was last year. So, we're actually – the French government's giving us a lot of cash, we owe that money back to the French government and that's what that creditor is.

**Steve Wheen (Evans & Partners):** Got it. Thanks very much.

**Operator:** Thank you very much. Your next question is from the line of Sean Laaman from Morgan Stanley. Please go ahead, sir. Thank you.

**Sean Laaman (Morgan Stanley):** Thank you. Good morning, Craig. Good morning, Martyn. I hope you're both well. At the risk of labouring the point on capacity, Craig, if overnight, for example, you were to get back to pre-COVID levels, and just talking to Australia and normal level levels of activity was the outlook, what kind of headroom do you have in terms of capacity to cope with the private backlog assuming that 100% of surgeries were called up?

**Craig McNally: T**hat's a good question, Sean. From a staffing and physical capacity, we're okay. I mean, we – theatre utilization is sort of an interesting concept because you don't assume that the theatres are available 24 hours a day, seven days a week. So, when you're calculating the utilization, you're using a restricted number of hours to do that. So, you can expand the hours you've got. You can increase the staff. Now we've got a flexible workforce, we can increase the hours that staff work. There would be cost to that because we use overtime and agency staff to deal with peaks. I think that one of the bigger constraining issues is the doctors and how much extra work will the doctors want to do and can they do, you know, reasonably.

So, there is the potential for significant capacity. So, we shouldn't be capacity constrained from an operating theatre perspective. And as most of the procedural work in our business is done on a day-only basis, it's just making sure that we get that part of the process efficient and we'd have to lengthen the hours to do that. So, you know, capacity I don't think is a concern from constraint.

**Sean Laaman (Morgan Stanley):** Well, thank you, Craig. And then following on from that and this question might be a little premature, but is there any longer term implications from the pandemic in terms of reduction in natural headroom of capacity, you know, so pushing beds further apart, no four bed wards, that type of thing that point naturally reduce headroom within your portfolio?

**Craig McNally: I**t's a good pickup, Sean. So, we have got small – and it's particularly multi-bedrooms. So if you've got a portfolio that has small multi-bedrooms where you're not going to comply with social distancing, and France is an example of that, that you are going to reduce capacity on that basis.

**Sean Laaman (Morgan Stanley):** Great. Thank you, Craig. And final question, if I may, is there any more detail you can provide on how much of the public wait list that you think could go through the private system or again, is it probably too premature?

**Craig McNally:** Too premature and it will vary across different geographies, both in country and across other markets. So, you know, Western Australia won't call on the private sector as much as other states, I would imagine. They'll push that through the public hospitals, of which we operate two of them. So, you know, we would certainly expect to see more volume there.

**Sean Laaman (Morgan Stanley):** Great. Thank you, gentlemen. That's all I have.

**John Deakin-Bell (Citi Group):** Well, thanks very much. Two quick questions, one was just trying to understand the difference in the leverage between Australia and the UK, for example. So, you see – and I know we're just looking at the full year here, but in Australia, the revenue fell $114 million, the EBITDAR fell $235 million, so it was kind of twice the leverage, but in the UK it's the opposite. It fell $25 million and EBITDAR was down $10 million. In fact, if I look at the second half margin in the UK, it didn't change that much. Why was the UK so much better off than Australia?

**Craig McNally:** John the answer to that question is that in the UK, the rent and depreciation is significantly higher in proportion to operating expenses than it is in Australia, by virtue of the fact that I was talking before that we rent most of our hospitals in Australia, you've got fully depreciated hospitals, et cetera. So, if you think about a world where your revenue is there just to cover all your costs, so operating expenses,

rent, and depreciation, you need a much higher margin at an EBITDAR level in the UK to cover that rent and depreciation than you do in Australia. And so therefore at an EBITDAR level, you've seen that much bigger reduction in Australia than in the UK.

**John Deakin-Bell (Citi Group):** Great. Thank you. And then –

**Craig McNally:** It will be that. So what we've said is that, you know, in both countries we were broadly breakeven at an EBIT level. It's just that we've got much higher rent and depreciation proportionally in the UK than we do in Australia.

**John Deakin-Bell (Citi Group):** In the fourth quarter, yeah. And just, just to clarify back to Craig's comment around margin, when you said you – the margins would decline. I'm assuming that was across the year, not – I mean, the second-half margin in Australia, if we think back, was 10.8% EBITDAR. So, you're talking about the FY21 versus FY20 margin rather than the second half, correct?

**Craig McNally:** Absolutely John, and it really just, across what they would normally have been rather than what they have been for FY20, is the point, yeah.

**John Deakin-Bell (Citi Group):** Right. Thanks very much.

**Craig McNally:** Thanks for your time this morning. I'd just probably like to finish the way I started and that's just I'm extremely proud of our organization in terms of what we've done in all of our markets, to step up to the plate, and our focus has been on our patients and our staff. It obviously has financial implications, but what we do is we provide healthcare services and we've done a fantastic job of doing that. So, I'd like to thank all of our staff and doctors for what they've done through this period. It's been amazing.