

New Busselton District/Sub-Regional Hospital and Community Health Centre

Financial Evaluation Report

07 July 2006

PRICEWATERHOUSECOOPERS 

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This Report is for the sole use of Aurora to assist in the preparation of the Site Selection Evaluation Report. The Site Selection Evaluation Report will be used by the Evaluation Steering Committee as part of the report for the WA Country Health Service – South West.

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Executive Summary

Introduction

PricewaterhouseCoopers has prepared this report as the third component of a Site Selection Evaluation Report in relation to the proposed new facility to replace the existing District / Sub-Regional Hospital and Community Health Centre in the Shire of Busselton, Western Australia. An assessment is underway to review potential options to deliver the requisite facilities including sites to locate the new facilities. In order to evaluate the potential options, it is understood that the Department will consider technical aspects, the outcome of community consultation and cost implications in delivering the options.

Four potential site locations for the facilities are examined in this report. Aurora Projects is preparing a Site Selection Evaluation Report, on behalf of the WA Country Health Service – South West which includes the following components:

- Part 1 – Technical Evaluation of Site Options;
- Part 2 – Feedback from Community Consultation Program;
- Part 3 – Indicative Analysis of Capital, Recurrent and Site Costs; and

PricewaterhouseCoopers has been asked by Aurora Projects to prepare this report as the basis of the third component of the Site Selection Evaluation Report to be prepared by Aurora Projects.

Sites and Physical Delivery Options

The sites and build options are summarised as follows:

Site A1: Vasse Newton

Site A1 is located in Vasse on the western side of Bussell Highway bypass, east of the Buayanyup drain. The site is defined at the southern extent by properties along Dowell Road and is currently used for pastoral farming.

The site would need to be acquired for an estimated \$18 million. Hanson Property Marketing and Management Pty Limited (“Hanson” or “Developer”), acting on behalf of the site owner, understood to be Saracen Group Pty Limited (“Saracen”), proposes the State build a public hospital on the land and the Developer offers to make additional land available to provide opportunity for co-located facilities. The Developer submitted a concept plan which includes the following co-located private facilities¹:

- a public hospital;
- a private hospital;
- medical consulting suites; and
- a major aged care and retirement complex.

¹ Source: Potential Private Sector Participation Demand/Supply Analysis, Australian Health Services Group. P.8

The proposal at Site A1 would involve locating the public hospital facilities close to the centre of the Vasse CBD on a 2.2 hectares site, which will necessitate a multi-storey development. The developer has suggested that infrastructure and operational costs may be shared between the public and private sector resulting in a more cost efficient arrangement for all the parties concerned. The exact nature of any sharing has yet to be defined.

The proposed build options include:

- Construction of a complete new build multi storey 75 bed public hospital without a laundry and kitchen where the respective services would be provided by a co-located aged care operator (Option A1-1)
- Construction of a complete new build multi storey with kitchen and laundry containing 75 public beds (Option A1-2).
- Construction of a complete new build multi storey with kitchen and laundry containing 65 public beds with the opportunity to purchase an average of 10 sub acute beds and related services from a co-located Aged Care operator (Option A1-3).
- Construction of a complete new build multi storey hospital without a kitchen and laundry where the respective services would be provided by a co-located aged care operator. Contains 65 public beds with the opportunity to purchase an average of 10 sub acute beds and related services from a co-located Aged Care operator (Option A1-4).

Site A2: Vasse Newton

Hanson, on behalf of Saracen, has only recently put forward a proposal for development of the public hospital on a second site, referred to as Site A2. Site A2 is located to the north of the future Vasse-Dunsborough Road, approximately 300m north east of Site A1. Of a bigger site approximately 7 hectares have been set aside for the hospital precinct. It is understood that 4 hectares would be made available for the public hospital.

As with Site A1, Hanson proposes the State build a public hospital and offers to make additional 3 hectares of land available to provide opportunity for co-located facilities. The Developer submitted a concept plan which includes the following co-located private facilities:²

- a public hospital;
- a private hospital;
- medical consulting suites; and
- a major aged care and retirement complex.

In contrast to Site A1 it is understood that this Site A2 will be made available to the State free of charge. As with the Site A1 proposal, Hanson has suggested that infrastructure and operational costs may be shared between the public and private sector resulting in a more cost efficient arrangement for all the parties concerned. The exact nature of any sharing has yet to be defined.

The concept plan proposes the following build options:

² Busselton Hospital Site Technical Evaluation, Sinclair Knight Merz, 8 June 2006

- Construction of a complete new build multi storey 75 bed public hospital without a laundry and kitchen where the respective services would be provided by a co-located aged care operator (Option A2-1)
- Construction of a complete new build multi storey with kitchen and laundry containing 75 public beds (Option A2-2).
- Construction of a complete new build multi storey with kitchen and laundry containing 65 public beds with the opportunity to purchase an average of 10 sub acute beds and related services from a co-located Aged Care operator (Option A2-3).
- Construction of a complete new build multi storey hospital without a kitchen and laundry where the respective services would be provided by a co-located aged care operator. Contains 65 public beds with the opportunity to purchase an average of 10 sub acute beds and related services from a co-located Aged Care operator (Option A2-4).

It will be necessary to rezone Site A2 to accommodate the proposed developments, which is likely to take up to 12 months and would involve community consultation.

Site B: the existing public hospital site

The existing Busselton District Hospital is situated at the junction of Mill Street and Bussell Highway, 3km from the centre of Busselton and is owned by the State. The hospital site contains the existing hospital buildings including a health centre, a hospice, the main hospital building and an ambulance station, car parking and surrounding landscaping. This site has potential to cater for the new facilities, but the project will involve refurbishment or demolition of some existing buildings.

The considered construction options include:

- A mixture of refurbishment and new build across the Site, with kitchen and laundry, involving a staged construction program to ensure continuity of the clinical services throughout construction. The completed facilities will reflect a single story design containing 75 public beds (Option B1);
- A complete new build, with kitchen and laundry, involving demolition of the existing hospital and a staged construction program to ensure continuity of the clinical services throughout construction. The completed facilities will reflect a single story design containing 75 public beds (Option B2); and
- A complete new build, with kitchen and laundry, involving demolition of the existing hospital and a staged construction program to ensure continuity of the clinical services throughout construction. The completed facilities will reflect a multi story design containing 75 public beds (Option B3)

Site C: Abattoir Site

Site C encompasses the site of a former abattoir and is situated between Bussell Highway bypass to the north and Kookaburra Way to the south, 3km south of Busselton Town centre. The site is currently privately owned and would need to be acquired from the current owner at what is estimated to be around \$30 million. The land use within the site currently comprises pastoral land with occasional mature trees and requires rezoning to accommodate the proposed development. It is likely that the site will eventually be bordered by residential properties. Currently several rural properties are located to the south of the site. The land is privately owned and the owners have

indicated that they are willing to consider the sale of land to allow for a public hospital. Development on this Site assumes the construction of a complete new build with a single storey design on a Greenfield site, with kitchen and laundry containing 75 public beds (Option C).

The key risks associated with the site comprise rezoning and approval risks as well as latent ground conditions and are discussed in more detail in section 4.6.5.

Private Sector Involvement

The private sector could add value to the Project in a number of ways. The private sector could, for example:

- provide public sector infrastructure and associated non-clinical services such as maintenance, cleaning and catering or combined provision of such services under an arrangement such as a public private partnership;
- undertake commercial activities such as provision of residential aged care, private hospitals, diagnostic services or retail opportunities.

Based on an initial assessment, AHSG predicts an increase in demand for public inpatient and day only beds to 75 beds and for only 13 private inpatient and day only beds in 2016. According to AHSG, the bed base required for a viable private hospital is generally around 60-80 beds. While AHSG indicates that further demand analysis is required, a private hospital does not seem to be viable. Although according to AHSG potential for operational synergies might be limited, the consultant indicates that potential value could be added with the co-location of an aged care facility where the public sector purchase beds from the aged care operator for sub-acute and specialist aged care services.

It is understood that there have been initial discussions with potential operators to determine the feasibility of the proposed co-location model proposed by Hanson. However, based on the research conducted by AHSG, a private hospital does not appear to be a viable proposition at least over the medium term, particularly given the apparent lack of demand for the private patient services. However, potential opportunities may exist for co-located consulting suites or an aged care and retirement village.

Risk Assessment

Based on the risks associated with the Sites as identified by Sinclair Knight Merz ("SKM") a risk assessment workshop was held to identify further risks and to assess and quantify these. General risks applicable to all sites include public consultation risk, the risk of changes in the underlying cost assumptions and the availability of a local workforce.

Key risks associated with Site A1 include flooding and hydrology, site access and public transport risk as well as planning risk. The approval process could also be affected by potential indigenous cultural sites.

Apart from the rezoning and approval risks, SKM identified various risks associated with Site A2 including access and public transport constraints, natural disaster and hydrology risk and potential heritage issues associated with indigenous cultural sites. Given that Site A2 was proposed only

recently, SKM has indicated that further assessment is necessary to fully analyse the risks associated with this Site A2.

Key risks associated with Site B include a lengthy environmental approval process due to identified endangered species on the site, latent ground conditions and the potential for construction disruptions as well as the risk of natural disaster which includes flooding and tidal surges. Additionally, there is decanting and staging risk because the new hospital would be built on the existing site.

The key risks associated with the Site C comprise rezoning and approval risks as well as latent ground conditions.

Financial Assessment

Each of the build options have been costed by RBB. In Net Present Cost (“NPC”) terms they rank between \$49 million for Option A2-4 and B1 and \$78 million for Option C, the latter including site acquisition costs which do not apply for any Site A2 or B options.

AHSG has identified potential operating cost differentials between the different options and a base case. The most significant differential, approximately \$9.3 million for \$9.8 in NPC terms, may exist for Option A1-3 and A2-3 respectively as both benefit from the opportunity to purchase an average of 10 sub acute beds and related services from a co-located Aged Care operator. This is based on the assumption that the Aged Care operator could provide these services significantly cheaper. The same differentials are expected for the combination option 4.

It should be noted, that we have not reviewed the Developer’s proposal. Any operating cost differential would be conditional upon arrangements with an Aged Care operator. Furthermore, no assessment has been made regarding similar arrangements on site B or C at this stage. Opportunities for private sector involvement may exist for these sites and it is recommended that these are assessed further.

Summary Results of Report

The table below shows the total cost for each Option (excluding any GST). It is important to note that the figures do not represent an overall project costing. Only operating cost differentials but no operating costs have been assessed at this stage. Significant further analysis would be required for a full project costing. The figures rather provide an indicative comparison for site selection purposes. Both SKM and AHSG have indicated that further assessment is necessary in order to validate the following figures:

Build Option	Site Acquisition cost (\$m NPC)	Capital Build Cost including Site Acquisition (\$m NPC)	Operating Cost Differentials (\$m NPC)	Total Costs (\$m NPC)	Risk Adjustment (\$m NPC)	Risk Adjusted Costs (excluding Site Realisation Funds, \$m NPC)
Option A1-1	16.6	68.4	0.5	68.9	10.6	79.5
Option A1-2	16.6	69.7	0.5	70.2	10.3	80.5

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Build Option	Site Acquisition cost (\$m NPC)	Capital Build Cost including Site Acquisition (\$m NPC)	Operating Cost Differentials (\$m NPC)	Total Costs (\$m NPC)	Risk Adjustment (\$m NPC)	Risk Adjusted Costs (excluding Site Realisation Funds, \$m NPC)
Option A1-3	16.6	67.4	(9.3)	58.1	10.6	68.7
Option A1-4	16.6	66.0	(9.3)	56.7	10.6	67.3
Option A2-1	0.0	51.4	0.0	51.4	10.8	62.2
Option A2-2	0.0	52.6	0.0	52.6	10.5	63.1
Option A2-3	0.0	50.4	(9.8)	40.6	10.8	51.4
Option A2-4	0.0	49.2	(9.8)	39.4	10.8	50.2
Option B1	0.0	49.3	0.7	50.0	7.6	57.6
Option B2	0.0	52.1	0.0	52.1	7.1	59.2
Option B3	0.0	53.9	0.5	54.4	6.6	61.0
Option C	27.6	77.7	0.0	77.7	9.5	87.2

Option C involves the hospital development on the site of a former abattoir which is privately owned. This option is considered the least cost effective option primarily due to the estimated site acquisition costs of nominal \$30m as discussed in section 5.3.

Similarly, although some favourable cost differentials may exist with option A1-3 and A1-4, the options associated with site A1 are not cost efficient because the State would be required to acquire the site for an estimated \$18 million in nominal terms.

Despite a relatively high risk adjustment, the most cost efficient option would be Option A2-4. This is because of the comparably low capital cost as the hospital would be built without a kitchen and laundry and only 65 as opposed to 75 beds. Furthermore, no site acquisition cost would be incurred. Option A2-4 benefits from no incremental operating cost differential associated with purchasing linen and catering services outside of the hospital but an estimated \$9.8 million

operating cost differential from purchasing an average of 10 sub acute beds and related services from a co-located Aged Care operator.

In the capital cost assessment no proceeds from the sale of the existing hospital site have been considered as the achievable proceeds from the sale of Site B are at this stage subjective and it is understood that the decision with regard to a sale of the Site B has not been made. However, if proceeds from the sale of the existing site were available to the project, these would offset the cost incurred for the construction on any other site. Therefore, realisation of Site B may have a significant impact on the site selection process and it is recommended that the risk adjusted potential value of the existing hospital site is assessed in more detail.

When considering the concept plan for Site A1 and A2, it is strongly recommended to assess the ability and capacity of a private developer to progress and implement the proposed development including co-located facilities. The information available to date indicate a lack of demand for a private hospital which would impact on the feasibility of such a development and the potential realisation of indicative savings in operating costs. Options A1-4 and A2-4 in particular rely on cost saving to be achieved on the basis of development of co-located facilities by the private sector, particularly an Aged Care Facility. These savings would not be achieved if the co-located facilities were not developed.

Furthermore, no assessment has been made regarding the potential for private sector involvement for any site B option or for Option C at this stage. Opportunities for similar co-located private sector involvement may exist for these sites and it is recommended that these are assessed further before a Site or delivery option is selected.

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1 Introduction

1.1 Background

The Western Australian Department of Health (the “Department”) is responsible for the delivery of health care in Western Australia. In doing so, it is responsible for ensuring that its sub-regional and community health care facilities are located in an appropriate geographical position and provided in a manner which provides value for money (“VfM”) over the long term.

The Shire of Busselton is expected to face a significant population growth over the next 25 years and a key component of the population growth is the increase in the aging population.³ To support the population growth, there is a requirement to provide for modern public hospital facilities. A new facility is therefore proposed to replace the existing District / Sub-Regional Hospital and Community Health Centre in the Shire of Busselton, Western Australia.⁴

An assessment is underway to review potential options to deliver the requisite facilities including sites to locate the new facilities. In order to evaluate the potential options, it is understood that the Department will consider the outcomes of:

Initially eight sites were identified as potential locations for the facilities. Subsequent to the Busselton Site Selection Steering Committee Workshop held 28 April 2006 only three sites were considered viable and they are examined in this report.

1.2 Purpose of this Report and Terms of Reference

1.2.1 Purpose of this Report

Aurora Projects is preparing a Site Selection Evaluation Report, on behalf of the WA Country Health Service – South West which includes the following components:

- Part 1 – Technical Evaluation of Site Options;
- Part 2 – Feedback from Community Consultation Program;
- Part 3 – Indicative Analysis of Capital, Recurrent and Site Costs; and

Part 1 considers the technical issues associated with the different locations of the proposed replacement hospital. This report was prepared by SKM and each of the eight sites were assessed in relation to a range of criteria relating to:

- accessibility;
- site area;
- infrastructure issues;
- local environment;
- social issues;

³ Busselton Hospital Site Technical Evaluation, Sinclair Knight Merz, Appendix G, Busselton Hospital – Demographic Profile, 30 June 2006

⁴ Busselton Hospital Site Technical Evaluation, Sinclair Knight Merz, 30 June 2006

- potential for private sector involvement; and
- consistency with local/state planning strategies.

The report provided a qualitative and quantitative assessment of all eight sites, highlighting best and worst performing sites against each of the abovementioned criteria.

Part 2 considers the outcomes of the community consultation process, including the feedback received, potential issues identified and the level of support indicated by the community for the potential sites. This report was prepared by Estill & Associates.

PricewaterhouseCoopers has been asked by Aurora Projects to prepare this report as the basis of the third component of the Site Selection Evaluation Report to be prepared by Aurora Projects.

1.2.2 Terms of Reference

The terms of reference for this Financial Evaluation Report, forming Part 3 (Terms of Reference) are to prepare an evaluation of:

- The cost of developing the new hospital facilities at the respective sites, including site acquisition costs;
- The cost of operating the facilities on the respective sites;
- Any cost benefits from the realisation of the Existing Site;
- Articulate the cost differentials between the sites in respect of capital, recurrent and site acquisition costs; and,
- The possible involvement of the private sector in the total project and development of the public hospital facilities.

1.3 Report Structure

The structure of this Report is as follows.

Section 2: The Sites and physical delivery options

This section contains an analysis of each of the sites and physical delivery options. The analysis includes an outline of each site and potential build option suitable for each site.

Section 3: Involvement of private sector across the sites

An overview of potential involvement of the private sector at the site of the proposed hospital development. In particular the overview considers:

- the scope for private sector involvement in the delivery of a private hospital adjacent to the new public hospital development;
- review of market interest in provision of private health care services; and
- the potential opportunity for private aged care facilities.

An overview of delivery options and extent to which the private sector could assist in the delivery of the public hospital development based on the following:

- a consideration of the scope for private sector involvement in the delivery of the Project;
- a qualitative comparative analysis of the potential to deliver the project using a PPP; and
- a comparison of the Project with other projects around Australia

Section 4: Risk assessment

This section contains a risk assessment for each build option. The analysis includes:

- an outline of the risk assessment process;
- an identification of key risks and suggested risk mitigation strategies; and
- an outline of the process for risk quantification utilised in the financial assessment for each build option.

Section 5: Financial assessment

This section contains the comparative analysis of the Project for each proposed build option. The analysis includes:

- the presentation of capital costs to develop the project at each of the different sites;
- a preliminary assessment of the site acquisition costs and realisation of any benefits from land sales;
- the comparative operating cost differentials between the different options required to assess the options on a like for like basis; and
- an indicative impact that the realisation of the risks outlined in Section 4 is likely to have on the comparative costs across the different options.

2 The Sites and Physical Delivery Options

2.1 Introduction

This chapter describes each of the proposed sites.

2.1.1 Vasse Newtown Sites

Vasse is approximately 240km southwest of Perth and 11km southwest of Busselton with the town being master planned for 5,500 people. The two Vasse Newtown Sites considered are privately owned and are predominately pastoral lands.

Site A1

The Vasse Newton Site A1 is located in Vasse on the western side of Bussell Highway bypass, east of the Buayanyup drain. The site is defined at the southern extent by properties along Dowell Road and is currently used for pastoral farming.

The site would need to be acquired for an estimated \$18 million. Hanson, acting on behalf of the site owner, understood to be Saracen, proposes the State build a public hospital on the land and the Developer offers to make additional land available to provide opportunity for co-located facilities. The Developer submitted a concept plan which includes the following co-located private facilities⁵:

- a public hospital;
- a private hospital;
- medical consulting suites; and
- a major aged care and retirement complex.

The proposal at the Vasse Newtown Site A1 would involve locating the health facilities close to the centre of the Vasse CBD on a 6.0 hectare of which only 2.2 hectares are made available by the Developer to accommodate the hospital. This will necessitate a multi-storey development. The developer has suggested that infrastructure and operational costs may be shared between the public and private sector resulting in a more cost efficient arrangement for all the parties concerned. The exact nature of any sharing has yet to be defined by the developer.

Key risks associated with site include flooding and site access risk as well as planning risk. The risks are discussed in more detail in section 4.6.2.

Site A2

Hanson, on behalf of Saracen, has only recently put forward a proposal for a second site, referred to as the Vasse Newton Site A2. Site A2 is located to the north of the future Vasse-Dunsborough Road, approximately 300m north east of Site A1. The size of A2 is approximately 18 hectares, within which approximately 7 hectares have been set aside for the hospital precinct. It is

⁵ Source: Potential Private Sector Participation Demand/Supply Analysis, Australian Health Services Group. P.8

understood that 4 hectares would be made available for the public hospital. The available 4 hectares are expected to be sufficient to accommodate a single story design hospital.

As with Site A1, Hanson proposes the State build a public hospital and offers to make additional 3 hectares of land available to provide opportunity for co-located facilities. The Developer submitted a concept plan which includes the following co-located private facilities⁶

- a public hospital;
- a private hospital;
- medical consulting suites; and
- a major aged care and retirement complex.

In contrast to Site A1 it is understood that this Site A2 will be made available to the State free of charge. As with the Site A1 proposal, the Developer has suggested that infrastructure and operational costs may be shared between the public and private sector resulting in a more cost efficient arrangement for all the parties concerned. The exact nature of any sharing has yet to be defined by the developer.

An assessment of the zoning of the site (currently "Agriculture") by RobertsDay has indicated that while both "hospital" and "aged persons" uses would be allowed within the "Agriculture" zone, it does not allow for medical consulting sites on the site.⁷ The Shire of Busselton has indicated that, given the scale of the proposed development, the land should be appropriately rezoned to allow for these types of projects. Therefore, it is currently envisaged to rezone the site to accommodate the proposed developments. A rezoning is likely to take up to 12 months and would involve community consultation. According to SKM, a Development Guide Plan will not be required for Site A2. The cost plans currently account for 18 month of rezoning, approval, design and development of a business case to happen simultaneously. SKM has indicated that further work is necessary to fully assess the risks associated with this Site A2. Potential risks include access constraints and natural disaster, i.e. flooding risk. The risks are discussed in more detail in section 4.6.3.

2.1.2 Site B: Existing Hospital Site

The existing Busselton District Hospital is situated at the junction of Mill Street and Bussell Highway, 3km from the centre of Busselton. The hospital site contains the existing hospital buildings including a health centre, a hospice, the main hospital building and an ambulance station, car parking and surrounding landscaping. This site has potential to cater for the new facilities, but the project will involve refurbishment or demolition of some existing buildings.

Key risks include the environmental approval process due to identified endangered species on the site, latent ground conditions and the potential for construction disruptions as well as the risk of natural disaster which includes flooding and tidal surges associated with this site. Additionally, there is decanting and staging risk because the new hospital would be built on the existing site. The risks are discussed in more detail in section 0

2.1.3 Site C: Abattoir Site

⁶ Source: Potential Private Sector Participation Demand/Supply Analysis, Australian Health Services Group. P.8

⁷ Source: RobertsDay – Town Planners, Correspondence Dated 16 May 2006.

Site C encompasses the site of a former abattoir and is situated between Bussell Highway bypass to the north and Kookaburra Way to the south, 3km south of Busselton Town centre. The land use within the site currently comprises pastoral land with occasional mature trees and requires rezoning to accommodate the proposed development. The site will eventually be bordered by residential properties. Currently several rural properties are located to the south of the site. The land is privately owned and the owners have indicated that they are willing to consider the sale of land to allow for a public hospital.

The key risks associated with the site comprise rezoning and approval risks as well as latent ground conditions and are discussed in more detail in section 4.6.5.

2.2 Site Ownership

The following table summarises the current ownership of each of the sites and identifies whether or not there is support for the associated use of the land for a public hospital. Information in this table is from Part 1 Technical Evaluation of Site Options as prepared by SKM.

Site	Current Owner	Support Use of Land for Public Hospital
Site A1	Commercial - Property Developer	Yes
Site A2	Commercial - Property Developer	Yes
Site B	State - WA Government	Yes
Site C	Commercial Group	Yes

The SKM Technical Evaluation (Part 1) highlighted that the owners of the Sites A, B and C would consider allowing a public hospital on their land and were willing to discuss the proposal further.

Compulsory acquisition of a site has not as yet been assessed as a potential course of action. The process for compulsory acquisition is expected to take 12 months. We understand the State currently owns the land upon which all other public hospital facilities in WA are located. Legal advice should be sought around the legal imperatives for the State to own land, however from a commercial perspective it is important that the State can have long term tenure at the site and can not be injuncted against providing critical health services.

2.3 Build Options Under Assessment

2.3.1 Description of build options

It has been determined that there are seven potential build options. The table below provides an overview of these options:

Option	Description	Site
Option A1-1	Development on this Site assuming a complete new build with a multi storey design, but without a kitchen and laundry. Food and linen services are assumed to be provided by a co-located Aged Care Facility. Contains 75 public beds.	Site A1
Option A1-2	Development on this Site assuming a complete new build with a multi storey design, with kitchen and laundry. Contains 75 public beds.	Site A1
Option A1-3	Development on this Site assuming a complete new build with a multi storey design, with kitchen and laundry. Contains 65 public beds with the opportunity to purchase an average of 10 sub acute beds and related services from a co-located Aged Care operator.	Site A1
Option A1-4	Development on this Site assuming a complete new build with a multi storey design, but without a kitchen and laundry. Food and linen services are assumed to be provided by a co-located Aged Care Facility. Contains 65 public beds with the opportunity to purchase an average of 10 sub acute beds and related services from a co-located Aged Care operator. This option is a combination of Option A1-1 and A1-3.	Site A1
Option A2-1	Development on this Site assuming a complete new build with a single storey design, but without a kitchen and laundry. Food and linen services are assumed to be provided by a co-located Aged Care Facility. Contains 75 public beds.	Site A2
Option A2-2	Development on this Site assuming a complete new build with a single storey design, with kitchen and laundry. Contains 75 public beds.	Site A2
Option A2-3	Development on this Site assuming a complete new build with a single storey design, with kitchen and laundry. Contains 65 public beds with the opportunity to purchase an average of 10 sub acute beds and related services from a co-located Aged Care operator.	Site A2

Option	Description	Site
Option A2-4	Development on this Site assuming a complete new build with a single storey design, but without a kitchen and laundry. Food and linen services are assumed to be provided by a co-located Aged Care Facility. Contains 65 public beds with the opportunity to purchase an average of 10 sub acute beds and related services from a co-located Aged Care operator. This option is a combination of Option A2-1 and A2-3.	Site A2
Option B1	Development on this Site assuming a mixture of refurbishment and new build across the Site, with kitchen and laundry. This will involve a staged construction program to ensure continuity of the clinical services throughout construction. The completed facilities will reflect a single story design. Contains 75 public beds.	Site B
Option B2	Development on this Site assuming a complete new build with a single storey design, with kitchen and laundry. This will involve demolition of the existing hospital and a staged construction program to ensure continuity of the clinical services throughout construction. The completed facilities will reflect a single story design. Contains 75 public beds.	Site B
Option B3	Development on this Site assuming a complete new build with a multi storey design, with kitchen and laundry. This will involve demolition of the existing hospital and a staged construction program to ensure continuity of the clinical services throughout construction. Contains 75 public beds.	Site B
Option C	Development on this Site assuming a complete new build with a single storey design on a Greenfield site, with kitchen and laundry. Contains 75 public beds.	Site C

2.3.2 Private sector involvement on the Vase Newtown sites

Options 1, 3 or a combination of them on both Sites A1 and A2 are reliant on a co-location model in particular an Aged Care facility, as proposed by the Developer of the Sites. Information regarding the co-location model is provided in Appendix B: ‘Potential Private Sector Participation & Demand / Supply Analysis’ prepared by Australian Health Services Group (AHSB) (the “AHSB Report”).

As highlighted in Section 3.2, the AHSB Report indicates that there is not likely to be sufficient demand for private sector hospital services. However, the AHSB Report does identify private aged care facilities (nursing and hostel beds) as potentially viable development opportunities. Further demand studies would need to be conducted to ascertain whether or not Options 1, 3 or a combination of both would be viable.

The operating cost differentials of the proposed options with private sector involvement have been assessed in a report prepared by the AHSB, attached as Appendix F. These differentials have been quantified in Section 5.4 of this report.

It should be noted that no analysis has been made regarding similar structures on site B or C at this stage. Opportunities for private sector involvement may exist for these sites and it is recommended that these are assessed further. The following section discusses potential private sector involvement in general.

3 Involvement of the Private Sector across the Sites

3.1 Introduction

The private sector could add value to the Project in a number of ways. The private sector could, for example:

- provide public sector infrastructure and associated non-clinical services such as maintenance, cleaning and catering or combined provision of such services under an arrangement such as a public private partnership;
- undertake commercial activities such as provision of residential aged care, private hospitals, diagnostic services or retail opportunities.

Any involvement of the private sector should, however, provide VfM to the State. VfM could be achieved by either a reduction of costs or the transfer of risks associated with the delivery of the public hospital or commercial opportunities to the private sector.

This section considers these different ways in which the private sector could be involved in the project and the likelihood/feasibility of such involvement.

3.2 Commercial Activities

Information in this section of the report has been sourced primarily from the AHSG Report.

3.2.1 Private Hospital

The projected bed numbers required for public and private sector hospitals are shown in the table below:

Year	Public Inpatient and Day Only Beds	Private Inpatient and Day Only Beds	Total Inpatient and Day Only Beds
2006	54	10	64
2011	64	11	75
2016	75	13	88

Source: *Potential Private Sector Participation Demand/Supply Analysis*, Australian Health Services Group. P.6

The table shows that the demand for public and private services is around 90 beds in 2016. Of this, it is estimated that there will only be demand for 13 private beds.

According to the AHSG Report, the bed base required for a viable private hospital is generally around 60-80 beds. It is not surprising therefore, that the AHSG Report considers appetite for private sector involvement in the development of further private hospital facilities to be low. In forming this opinion, the likely operators considered by ASHG were:

- St John of God Health Care
- Ramsay Health Care
- Healthscope
- Little Company of Mary Health Care (Calvary Group)
- Sisters of Charity
- Mater Health Care
- Mercy Health Care
- Uniting Care
- A range of smaller or independent operators

St John of God Health Care currently operates a major private hospital (130 beds) in Bunbury and appears unlikely to be willing to enter the Busselton market. Ramsay Health Care has previously indicated that it did not wish to participate in such a development in Busselton, other operators had alternative geographic focuses and the smaller independent operators who may have been interested but were not considered likely to be because of the small population base and low projected demand.

3.2.2 Consulting Centre

Co-location of a consulting centre may be a possible opportunity for any Site. A Consulting Centre could include medical suites for specialists, diagnostics, a range of allied health and pharmacy services. It could also include retail outlets or cafes.

AHSG indicate that it is typical for the private sector when developing a private hospital to consider also a medical consulting centre to attract specialist practitioners to the hospital. Medical practitioners usually want suites to be strata title or will purchase suites via their superannuation funds. Any structure for development of the hospital facilities would need to consider these investment preferences.

The report found that very few medical practitioners are based in Busselton. The majority of the specialist practitioners operate rooms from Bunbury and given that the referral and medical practices are well established it may take some time for change.⁸

3.2.3 Aged Care Facility

It may be possible to locate an aged care facility (nursing and hostel beds) and a retirement complex (independent living units adjacent to an acute care complex and potentially consulting complex). Whilst AHSG indicate that this model has been growing in popularity in recent years around Australia, it is not common given that the potential for operational synergies between the two is limited.

Generally the private sector prefers separate facilities to the public sector. We understand that, in part, this stems from a desire to have a separate identity and also the ability to control their own

⁸ Source: Potential Private Sector Participation Demand/Supply Analysis, Australian Health Services Group. P.[3]

destiny in terms of access to facilities and tenure. Some aged care/retirement village developers will share catering, hotel and maintenance services; however, requirements do tend to vary.

An area where there could be potential for added value with co-location of an aged care facility, however, is where the public sector purchase beds from the aged care operator for sub-acute and specialist aged care services.

To ensure the private sector business tenure, any structure would, however, need to consider the need for an aged care operator to either own land or have a long term ground lease for the land upon which the aged care facility would be built.

3.2.4 The Vasse Health Precinct Development

It is understood that the owner of the two Vasse Sites has provided a development proposition for the State. The development concept includes the development of the following facilities:⁹

- Public hospital
- Private hospital
- Medical consulting suites
- Aged care and retirement village

It is understood that the Developer has asserted capital and operational cost savings to both the public and private sector through shared infrastructure.¹⁰ It is understood that there have been initial discussions with potential operators to determine the feasibility of the proposed co-location model, however, based on the research conducted by AHSG, it does not appear to be a viable proposition at least over the medium term. However, potential opportunities may exist for co-located consulting suites or an aged care and retirement village.

Although the AHSG Report indicates that there could be structural issues (in terms of land ownership and investment) these should be capable of being addressed by a developer. There remains, however, the primary issue of an apparent lack of demand for the private patient services.

In saying this, it may be possible to structure the development in such a way as to ensure the public sector receives a public hospital at a pre-agreed cost (including pre-agreed savings) whilst the private sector developer assumes the risks of achieving the pre-defined savings. It is also important to consider that any savings achieved here may also be achieved with feasible developments across other the Sites.

As highlighted in section 2.2, it may not be appropriate for the public sector to build a public hospital on land that it does not own or have access via long term lease. Legal advice should be sought in this regard.

⁹ Source: Potential Private Sector Participation Demand/Supply Analysis, Australian Health Services Group, P.8

¹⁰ Source: Potential Private Sector Participation Demand/Supply Analysis, Australian Health Services Group, P.8

3.3 Private Sector Involvement in Delivery of the Services

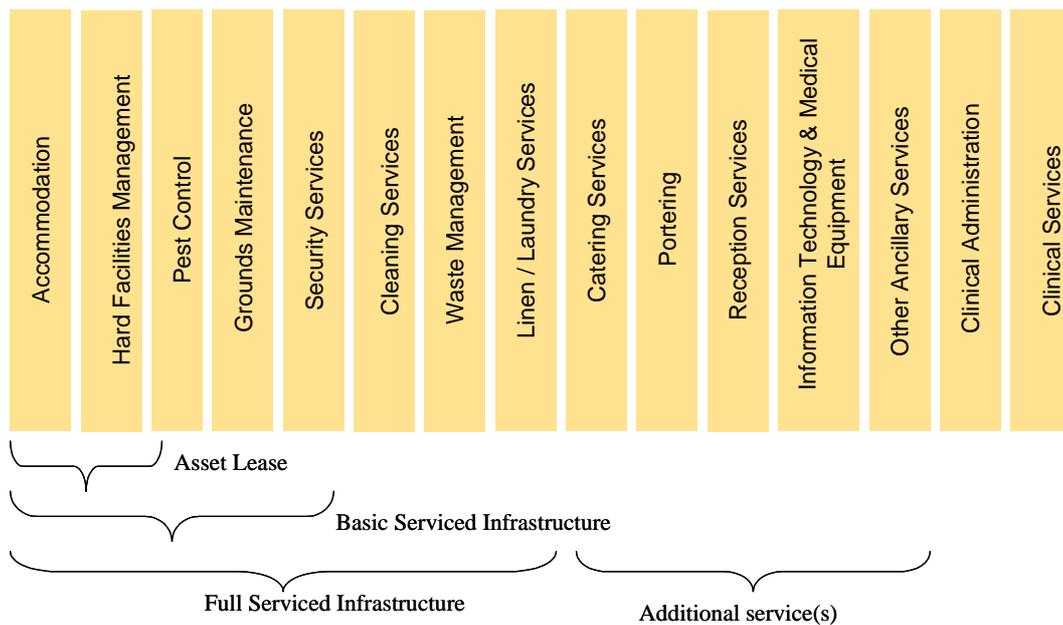
3.3.1 Service Provision

It is understood that the services required to complete a new or refurbished public hospital development would include all the services related to the accommodation, care and treatment of patients from the point at which they arrive for treatment through to their release.

The private sector could deliver non-clinical services at the public hospital either individually or as a combined project. The private sector could also add value via provision of some or all aspects of the non-clinical, services using the WA Government policy, Partnerships for Growth. Partnerships for Growth is a policy which governs the use and structure of public private partnerships (“PPPs”). It results in a contract for a single private party to deliver public infrastructure-based services. PPPs of some form have been successfully used to deliver public hospital infrastructure across Australia.

PPPs can involve the private sector providing accommodation and maintenance only through to providing all services apart from clinical and clinical administrative services. Some potential structures of a PPP are illustrated in the diagram below.

Diagram 3.2.1: Scope of Services required for the Busselton public hospital development



The Asset Lease model allows for limited investment by the private sector whilst the Full Services Infrastructure Model presents a more substantial investment. A fully privatised model has not been considered as it does not comply with the Partnerships for Growth policy.

The categorisation of a number of individual services at this stage is preliminary and would need to be finalised as part of any further investigation should the public sector wish to progress with private sector involvement in the delivery of the Project. An important element in choosing the scope of services to be delivered under a PPP arrangements will be the extent to which the PPP services can be effectively integrated with the services which are delivered by the WA Country

Health Service – South West. Effective integration of the Project as a whole with the other parts of the WA Country Health Service – South West operations will also be important.

The need to maintain “flexible” working and contractual arrangements will also be important for a site which is likely to continue to evolve with population growth.

Provision of some services should also be considered in the context of their impact upon the delivery of other services before the scope of a PPP arrangement is finalised. For example:

- It may be argued that cleaning may effect the need for maintenance, and where there are different providers of these services, dysfunctional interface arrangements may follow.
- Provision of internal and perimeter security services provides the provider of Accommodation Services with incentive and flexibility to better manage the risk of damage to the facility, equipment or landscaping.
- Provision of portering services by the provider of Accommodation Services provides a seamless line of accountability to the extent that there is any damage to the facilities resulting from the portering services.

Additional revenue potential may exist with the provision of car parking. This service could be provided by the private sector which may add value to the project and provide VfM to the State. Provision of car parking as well as other ancillary services might be considered further in the next stage of the project’s development once a decision regarding the preferred Site has been made.

3.3.2 Partnerships for Growth

Partnerships for Growth identifies six characteristics for Projects that are appropriate for delivery as a PPP. An initial assessment of the project against these characteristics indicates the potential for the project to be delivered under Partnerships for Growth. A detailed assessment of this project against each characteristic is contained in Appendix G.

It should be noted that whilst the size of the project and States previous experience in PPPs are favourable characteristics, further work will need to be done to assess whether there is sufficient market demand and capacity to assist in delivery of this project as a PPP.

The key findings of the AHSG report as outlined in Section 3.2 dictates that a market assessment should be done first before the project is delivered to the market for procurement as a PPP, to ascertain more clearly the private sector appetite and the ability of the construction industry in WA to undertake a project of this size.

3.4 Conclusion

The AHSG report indicates that further demand analysis needs to be conducted before any venture regarding commercial activities with the private sector is agreed to.

Whilst initial findings of the report indicate probable insufficient demand and lack of willing operators for stand alone private hospital facilities there does appear to be potential value that could arise through the sharing of beds between the public sector hospital and private sector aged care facility operator.

In relation to the proposed involvement of the private sector with the delivery of infrastructure and/or services further market assessment needs to be conducted before any venture is approved. There does appear, at this initial stage, some value of the private sector involvement in the provision of public sector infrastructure and associated non-clinical services and that arrangements such as PPPs may be viable options for procurement.

4 Risk Assessment

4.1 Introduction

It is important to critically review the risks inherent in each of the site options in order to quantifiably compare each option. At this stage in the evaluation process and given the information available it has not been possible to undertake a detailed risk quantification process, however, attempt has been made to quantify the magnitude of material risks associated with the sites.

Risks are inherent in all projects no matter what the size of the project. For project management, the most serious consequences of risk can be broadly summarised as follows:

- failure to keep within the cost estimate
- failure to achieve completion date
- failure to achieve the required quality and operational requirements.

Risk analysis can be qualitative and quantitative. In analysing and attempting to quantify the effect of risk on a project, the sources of risk must first be identified and secondly their effects must be assessed and analysed.

The objectives of a qualitative risk analysis are:

- risk identification
- initial risk analysis.

This initial qualitative assessment brings considerable benefits in terms of understanding the project and its problems, as well as provoking thought about the appropriate management response to risks.

Initial focus has been on risks with differential impact on each sites but allowance has been made for all material risks noted at this early stage of the project.

This risk assessment process is discussed as part of this report.

4.2 Risk assessment process

This Section contains an outline of the risk assessment process and the methodology adopted for the quantification of risks.

The risk information for the Project was gathered and refined in four phases:

- Phase One - Risk Identification by SKM
- Phase Two - Risk Refinement and Quantification
- Phase Three - Further Risk Refinement

4.2.1 Phase One – Risk identification by SKM

SKM identified a number of risks in their Part 1 – Technical Evaluation report. RBB prepared the capital costings for each build option. The costings quantify some but not all risks identified by the SKM Part 1 Technical Evaluation Report.

Phase One also involved preparation of a preliminary risk register identifying residual material risks at each site.

4.2.2 Phase Two – Risk Refinement and Quantification

A structured Risk Refinement and Quantification Workshop (“Risk Workshop”) was held on 12 May 2006, the primary purpose of which was to review and quantify the risks identified in Phase One and to identify any further risks that related to the Project. The workshop was facilitated by PricewaterhouseCoopers. All build options were evaluated.

The following representatives attended the Risk Workshop from their respective organisations.

Name	Organisation
Nadine Lennie (Chair)	PricewaterhouseCoopers
Michael Da Gama Pinto	PricewaterhouseCoopers
Ian Southwell	Aurora Projects
Len Dockrill	Aurora Projects
Ian Smith	WA Country Health Service - South West
David Naughton	WA Country Health Service - South West
Rory Stemp	WA Country Health Service - South West
Sam Petricevic	Department of Housing and Works (WA)
Ian McDonald	Australian Health Services Group
Hugh Cunningham	Sinclair Knight Merz
Marie Verschuer	Estill & Associates
Vivian Garde	Estill & Associates
John Stranger	John Stranger Partnership

During the Risk Workshop the participants were asked to determine the likelihood and consequences of risks occurring and quantify the risks identified in Phases One and Two.

The overall objectives of Phase Three were:

- Update the Project Risk Register to reflect the Project’s development
- Quantify the risks within a pre defined framework
- Develop / refine risk management and mitigation strategies

The workshop covered both capital (design and construction) and recurrent (hospital operations, facilities maintenance, whole of life and service delivery risks) aspects of the Project.

Each participant was asked to confirm the following (within a pre-defined range):

- probability of occurrence expressed as a percentage
- most likely impact expressed as cost (for capital and operating costs) in today's dollars

The results of these estimates were then recorded on the risk register to enable development of the risk quantification model and results and to enable further refinement during Phase Four.

4.2.3 Phase Three – Further risk refinement

Phase Four provides an opportunity to further refine the risk analysis in terms of description, consequence and management and mitigation strategies as identified in the Risk Register, and to reflect the Project as it had developed since the initial Risk Workshop.

4.3 Risk Management

The key outcome of the Project risk assessment process has been the formulation of a risk register, discussed below, which records all of the data from the risk workshop and risk analysis including risk management strategies and the further analysis conducted by the Project Team.

Risk management requires management responses and policies to reduce and control the identified risks. Risk management involves the formulation of management responses to the main risks. Risk management will not remove all risk from a project as its principle aim is to ensure that risks are efficiently managed.

From a risk management perspective it is also important to remember that overall project risk remains unchanged, unless:

- risks are removed
- risks are reduced
- risks are created.

4.4 Risk register

A Project Risk Register was developed during the risk assessment process, a copy of which is provided at Appendix C. The Risk Register is a risk management tool that captures all the risks identified and discussed during the Risk Assessment Process and includes details of the likely consequences if the risk occurs. The risk register also identifies whether the risk is quantifiable and if it is, the quantification assumptions.

The risk register reflects the Project as at 27 June 2006 and will need to be updated through the risk refinement process to reflect the revised Project scope. This will include further risk identification and update of quantification results.

The risks identified and captured in the risk register were then quantified, applying the methodology described in the following section.

4.5 Risk Quantification

4.5.1 Risk Quantification Methodology

Risk Quantification Technique

As the Project is still in its early stages of development, a simple probability valuation technique has been utilised to provide a single estimate for risk which is based on analysing risks

independently of each other. The weighted effects of each risk are accumulated to provide the most likely outcome risk adjusted costing for each option.

Risk Quantification Framework

For risk quantification, the aim was to identify the “material” risks that have a significant cost impact when considering the risk probability in combination with the likely cost of occurrence and primarily in the context of building a public hospital as one particular site versus another.

The Risk Workshop Participants were asked to provide estimates based on historical evidence and professional judgement and applying 90% confidence test to their estimates. In other words, one could reasonably expect the estimates provided to be within the final outcome for each risk but there is still some chance that the outcome will fall outside of the range estimated.

The approach outlined below was utilised for establishing the probability and impact estimates that rate the risks in the first place using a risk framework and secondly by refining this information to get to more solid data tailored for each risk.

Some risks were difficult to quantify due to the high level of uncertainty in terms of variables or the inherent nature of the risk. These risks were classified as qualitative and recorded as such. To assist the process we set parameters around subjective descriptions of probability and impact. The following were agreed at the workshop:

	Capital Risks		Recurrent Risks	
	Probability	Capital Risks ¹	Probability	Recurrent Risk ²
High	More than likely >40%	Large cost increase > \$4m	More than likely >40%	Large cost increase > \$500k
Medium	Quite likely 10 – 40%	Significant increase \$2m - \$4m	Quite likely 10 – 40%	Significant increase \$250k - \$500k
Low	Unlikely <10%	Small cost increase < \$2m	Unlikely <10%	Small cost increase < \$250k

1. Impact on Capital Cost as single cost estimate (also applicable to lifecycle refurbishment)
2. Impact as per annum estimate

4.6 Key risks identified

The following section describes the risks identified during the assessment process.

4.6.1 General risk applicable to all sites

Input Costs

Input cost risk is the risk that construction cost estimates may materially change due to changes in underlying costs of labour and materials. This risk is applicable to all options.

The escalation profile utilised by RBB Partnerships when compiling the cost plans for all options is as follows:

Year	Annual Escalation Rate
2006	12.0%
2007	8.0%

2008	5.5%
2009 onwards	4.0%

Source: Western Australia Office of Housing and Works

These rates reflect fluctuations in the cost of non-residential building in the Perth metropolitan area and have been calculated using the cost index system operated by the Department of Housing & Works.

Using the figures in the above table, the cost of escalation for a month can be between 0.7% - 1% for the first two years of the project. Based on capital costs of around \$100 million a one month delay to construction could therefore cost between \$700,000 and \$1million respectively.

The risk that construction costs estimates change for each build has been rated as high probability for all options but assessed as having a low impact. The impact was considered low as only small deviations in costs above the annual escalation rates above were expected.

Community Consultation

The risk that community expectations do not match project design, scope or timing has been identified as a risk for all options.

The detailed study forming Part 2 - Feedback from Community Consultation Program provides a foundation for understanding the expectations of the community, being the key stakeholders of the proposed development. Strategies to mitigate this risk include continual consultation with the community, a targeted media campaign and a review of experiences on similar projects is conducted.

Availability of Local workforce

There is a risk that sufficient local workforce is not available to support the construction of the hospital. This risk has been deemed to have a medium probability associated with a low impact. Occurrence of this risk would likely result in higher salary costs so there is a link with inflationary aspects. This risk is exclusive to assessment of inflation.

4.6.2 Site A 1

Planning and approval risks

Planning and approvals risk is the risk associated with achieving correct zoning as well as required approvals, which includes environmental and heritage approvals where necessary. Site A1 is appropriately zoned. However, a Development Guide Plan and Detailed Area Plans need to be developed as part of the approval process which is expected to take up to 6 months to be completed.¹¹ There is a risk that community objection to the approval process may increase the anticipated time frame resulting in additional delays and costs. The approval risk has been assessed as having a low probability with a low impact.

The Site has been approved by the EPA for development and delays relating to environmental approvals are deemed to unlikely.¹²

According to the Department of Indigenous Affairs ("DIA) database a sacred site (Site ID 676 – Busselton Fringe Camp) encompasses the eastern portion of Site A1. As the level of inaccuracy

¹¹ Busselton Hospital Site Technical Evaluation, Sinclair Knight Merz, 30 June 2006

¹² Busselton Hospital Site Technical Evaluation, Sinclair Knight Merz, 30 June 2006

associated with the original recording of this site was high, it is difficult to ascertain its exact location. The location of this site should be confirmed through a full ethnographic and archaeological field survey. Several ethnographic and archaeological surveys have been conducted in the vicinity of Sites A1 and A2, however, none are specific to the area. The potential issues associated with this sacred site could result in delays to the approval timetable without a full ethnographic and archaeological field survey to confirm the absence of this site or finds within the site boundary.¹³ This risk has been assessed as having a low probability after the review of the Aboriginal Heritage Inquiry System but with a high impact. It is recommended that the heritage studies are undertaken to ensure sites are known and recorded and to enable construction programs and the design to reflect potential discoveries.

The cost plan currently allows a time frame of 18 months for the creation of a Development Guide Plan and to get all necessary approvals. In preparing the cost plan it has been assumed that the detailed business case and the design work will be done in parallel during this period.

Construction Disruption

The Site is located in close proximity to rural residential properties to the south and east. There is a risk that residential neighbours disrupted by construction may lodge complaints with the Council. Depending on the severity of the disruption and validity of the complaint in a worse case scenario delays in construction may occur. Furthermore, some land surrounding the site is not yet developed but is proposed for commercial and residential development. Therefore, there is a risk that construction on surrounding properties may potentially impact on the construction of the hospital, for example creating dust etc which will need to be managed. While the risk during the construction period has been assessed as being low, the recurrent risk with respect to construction disruption has been assessed to have a high probability of occurrence but with a low impact.

Site Access

WA Health and SKM advised, the site would require new public transport capacity for a new hospital. The risk that the transport provisions are insufficient has been assessed as having a high probability with a medium impact. The impact of risk has been obtained by quantifying the cost to improve access to public transport.

Flooding Risk

The site is relatively low lying and would be affected by 1 in 100 year floods which would consequentially impact on access and structure. There is a risk that capital costs may increase due to construction delays caused by flooding and flood mitigation strategies such as the construction of drainage systems. The cost plans however reflect Hospital facilities which are elevated to mitigate against the impact of 1 in 100 year flood. There is a remaining risk that the Site is affected by floods larger than the 1 in 100 year flood. The risk is deemed to be of medium probability with a high impact.

The Department of Water has recommended that 1 in 500 year flood protection should be provided and that access to the site should not be compromised during such an event.¹⁴ SKM advise that the Department of Water has not provided any specific interpretation of this recommendation in terms of its likely impact on the site or construction. A detailed hydrological study would be required to define the 1 in 500 year flood level and to determine its impacts on the Busselton area. This study has not taken place. It should therefore be noted that there is no guarantee that the 1 in

¹³ Information provided by SKM on the 22 June 2006

¹⁴ Busselton Hospital Site Technical Evaluation, Sinclair Knight Merz, 30 June 2006

100 year flood is a good predictor of how suitable the sites would be for the 1 in 500 year event. SKM recommends to undertake further analysis in this respect.

Interface Risk

The risk that the effectiveness of the private sector interfaces during the operating period of the project is lower than expected. Option A1-1 involves privately provided linen and catering services and Option A1-3 involves the provision of 10 sub-acute beds by a private aged care operator. Option A1-4 represents a combination of Option A1-1 and Option A1-3. There is a risk that services are not received to the quality or price expected over the term of the assessment. Adequate contract management is a mitigant of sorts, in particular for adequate quality and the risk associated with the need to find alternative supply based on quality aspects was deemed to be low with low impact

However, the risk that operating cost differentials are different from the expectations is considered having a low probability with a medium impact.

Future Proofing

This Site has less available space compared to other options. Whilst there may appear to be risk around under provision of land for future development such requirements are not known. However, the exact size of the allocated site still needs to be clarified. Due to its nature, it is difficult to quantify the risk impact for this type of risk.

4.6.3 Site A2

Planning and approval risks

The site is likely to require rezoning to accommodate the proposed development which is expected to take up to 12 months to complete.¹⁵ There is a risk that community objection to the proposed rezoning and the approval process may increase the anticipated time frame resulting in additional delays and costs. The rezoning risk has been assessed as having a medium probability with a low impact.

Additionally, environmental approval would need to be obtained for Site A2. The approval may be delayed to assess the impact of the potential removal of woodland habitat in the north of the site which may support habitat for the endangered Western ringtailed possum. The overall environmental approval risk has been assessed as having a low probability and medium impact.

According to the DIA database the above sacred site (Site ID 676 – Busselton Fringe Camp) encompasses the southern portion of Site A2. As the level of inaccuracy associated with the original recording of this site was high, it is difficult to ascertain its exact location. The location of this site should be confirmed through a full ethnographic and archaeological field survey. Several ethnographic and archaeological surveys have been conducted in the vicinity of Sites A1 and A2, however, none are specific to the area. The potential issues associated with this sacred site could result in delays to the approval timetable without a full ethnographic and archaeological field survey to confirm the absence of this site or finds within the site boundary.¹⁶

The cost plan currently allows a time frame of 18 months to undertake the rezoning and to achieve all necessary approvals. In preparing the cost plan it has been assumed that the detailed business case and the design work will be done simultaneously during this period.

¹⁵ Busselton Hospital Site Technical Evaluation, Sinclair Knight Merz, 30 June 2006

¹⁶ Information provided by SKM on the 22 June 2006

Construction Disruption

The Site is located in close proximity to some rural residential properties to the east. There is a risk that residential neighbours disrupted by construction may lodge complaints with council. Depending on the severity of the disruption and validity of the complaint in a worse case delays in construction may occur. Furthermore, some land surrounding the site is not yet developed but is proposed for commercial and residential development. Therefore there is a further risk that construction on surrounding properties may potentially impact on the construction of the hospital, for example creating dust etc which will need to be managed. While the risk during the construction period has been assessed as having a low probability and a low impact, the recurrent risk with respect to construction disruption has been assessed to have a high probability of occurrence but a low impact.

Site Access

The concept plan currently envisages that the main access to the Site would be from the Bussell Highway. Without major modifications to the highway access to the Site for ambulance vehicles, staff, visitors and public transport would be restricted. Limited accessibility may result in reduced levels of patients and staff/visitors inconvenience. Therefore, the site is likely to require costly modifications to the Bussell Highway. According to a preliminary estimate by SKM the cost associated with the necessary modification would in the order of \$1.0 million.

Additionally, the site would require new public transport capacity to handle the hospitals transport requirements. The risk that the transport provisions are insufficient has been assessed as having a high probability with a medium impact. The impact of risk has been obtained by quantifying the cost to improve public transport access.

The site access risk has been assessed as having a high probability of occurrence associated with a medium impact

Flooding Risk

The site is relatively low lying and would be affected by 1 in 100 year floods which would consequentially impact on access and structure. There is a risk that capital costs may increase due to construction delays caused by flooding and flood mitigation strategies such as the construction of drainage systems. The cost plans however reflect Hospital facilities which are elevated to mitigate against the impact of 1 in 100 year flood. There is a remaining risk that the Site is affected by floods larger than the 1 in 100 year flood. The risk is deemed to be of medium probability with a high impact.

The Department of Water has recommended that 1 in 500 year flood protection should be provided and that access to the site should not be compromised during such an event.¹⁷ SKM advise that the Department of Water has not provided any specific interpretation of this recommendation in terms of its likely impact on the site or construction. A detailed hydrological study would be required to define the 1 in 500 year flood level and to determine its impacts on the Busselton area. This study has not taken place. It should therefore be noted that there is no guarantee that the 1 in 100 year flood is a good predictor of how suitable the sites would be for the 1 in 500 year event. SKM recommends to undertake further analysis in this respect.

Interface Risk

¹⁷ Busselton Hospital Site Technical Evaluation, Sinclair Knight Merz, 30 June 2006

The risk that the effectiveness of the private sector interfaces during the operating period of the project is lower than expected. Option A2-1 involves privately provided linen and catering services and Option A2-3 involves the provision of 10 sub-acute beds by a private aged care operator. Option A2-4 represents a combination of Option A2-1 and Option A2-3. There is a risk that services are not received to the quality or price expected over the term of the assessment. Adequate contract management is a mitigant of sorts, in particular for adequate quality and the risk associated with the need to find alternative supply based on quality aspects was deemed to be low with low impact

However, the risk that operating cost differentials are different from the expectations is considered having a low probability with a medium impact.

Future Proofing

This Site has less available space compared to other options. Whilst it may appear to be risk around under provision of land for future development such requirements are not known. However, the exact size of the allocated site still needs to be clarified. Due to its nature, it is difficult to quantify the risk impact for this type of risk.

4.6.4 Site B

Planning and approval risks

Site B does not require rezoning. Planning approval risk for Site B is therefore mostly associated with environmental approvals as the endangered Western Ringtail Possum is known to inhabit this Site and the requirement for the removal of peppermint trees may have to be referred to the Commonwealth Department of Environment and Heritage (DEH) for consideration under the Environment Protection and Biodiversity Conservation Act 1999. The time and cost associated with the process for achieving the requisite environmental approvals can be included in construction costs, however, there is a risk that community objection increases the likely approval timeframe resulting in additional delay costs or at worst, cost to change the proposed site plans. Additionally, whilst no specific sites have been identified, the Site could be impacted by Heritage issues according to SKM.

As with the Sites A1 and A 2, the cost plan allows a time frame of 18 months to achieve the necessary approvals. In preparing the cost plan it has been assumed that the detailed business case and the design work will be done in parallel during this period. The risk has been assessed to be of low impact with a low probability of occurrence.

Further investigation is required to ascertain whether or not the above timeframes are appropriate and if there are measures that could be taken to reduce any delays to construction. It is also appropriate to consult experiences on similar projects.

Latent ground conditions

This site has areas of potential contamination. In preparing cost assumptions allowances have been made for contaminants associated with the sites currently in use. The risk is deemed to have a low probability with a low impact.

Construction Disruption

The Site is located in close proximity to residential property owners. There is a risk that residential neighbours disrupted by construction may lodge complaints with council. Depending on the severity of the disruption and validity of the complaint in a worse case delays in construction may occur.

Flooding and Tidal Surge Risk

The site is relatively low lying and would be affected by 1 in 100 year floods which would consequentially impact on access and structure. Additionally, the site may be impacted by tidal surge. There is a risk that capital costs may increase due to construction delays caused by flooding and flood mitigation strategies such as the construction of drainage systems. The cost plans however reflect Hospital facilities which are elevated to mitigate against the impact of 1 in 100 year flood. There is a remaining risk that the Site is affected by floods larger than the 1 in 100 year flood, although the risk is deemed to be of low probability with a high impact.

Latent defects

The risk of latent defects is mostly associated with Option B1 as it comprises refurbishment of parts of the existing buildings. This may cause defects and poor quality construction and exhibits the risk of increased maintenance cost during the operational phase. The impact has been assessed to be medium while the probability is deemed to be medium during the construction phase and low during the operational phase.

Decanting & Staging

The construction of a new hospital on the existing site may cause disruption for the hospital operations during the decanting phase. There is a risk that the allowances for staging and decanting are inadequate, which has been assessed as having a high probability of occurrence and low impact for Option B2 and a medium probability for the Options B1 and B3.

4.6.5 Site C

Planning and approval risks

Site C would require rezoning, which is expected to take approximately 9-12 months in order to accommodate a medical centre and consulting suits. The site requires clearance by the EPA which is expected to be done in conjunction with the above mentioned zoning approvals. The environmental approval risk is deemed to have a low probability with a low impact.

The cost plan currently allows a time frame of 18 months to undertake the rezoning and to get all necessary approvals. It is assumed that the detailed business case and the design work will be done in parallel during this period. The risk of the total timeframe of 18 month being inadequate has been assessed as a low probability but with a high impact if there is a delay.

Latent ground conditions

This site has areas of potential contamination. In preparing cost assumptions allowances have been made for contaminants associated with the sites current use.

Construction Disruption

As with Site B, this site is located in close proximity to some residential property owners. There is a risk that residential neighbours disrupted by construction may lodge a complaint. Depending on the severity of the disruption and validity of the complaint delays in construction may occur.

There is a further risk that construction on surrounding properties may potentially impact on the construction of the hospital, delaying its progress. Given the area consists of primarily residential construction the level of risk is deemed to be low.

Site Access

Furthermore, the site would require new public transport capacity to handle the hospitals transport requirements. The risk that the transport provisions are insufficient has been assessed as having a high probability with a medium impact. The impact of risk has been obtained by quantifying the cost to improve public transport access.

4.7 Risk Results

The following preliminary risk results for each option were calculated based on the methodology described in section 4.5.1 considering the risks associated with the sites:

Build Option	Raw Capital Risk Adjustment (NPC \$m)	Raw Recurrent Risk Adjustment (NPC \$m)	Total Raw Risk Adjustment (NPC \$m)	Total Raw Risk Adjustment as a % of Total Capital NPC Costs (excluding Site Acquisition)
Option A1-1	3.5	7.1	10.6	20.3%
Option A1-2	3.5	6.8	10.3	19.2%
Option A1-3	3.5	7.1	10.6	25.5%
Option A1-4	3.5	7.1	10.6	26.4%
Option A2-1	3.7	7.1	10.8	21.0%
Option A2-2	3.7	6.8	10.5	20.0%
Option A2-3	3.7	7.1	10.8	26.6%
Option A2-4	3.7	7.1	10.8	27.4%
Option B1	4.9	2.7	7.6	15.2%
Option B2	4.7	2.4	7.1	13.6%
Option B3	4.2	2.4	6.6	12.1%
Option C	3.9	5.6	9.5	19.0%

All options reliant on both Vasse-Newton sites exhibit greater risk than the other options and therefore require greater risk adjustments. The adjustments reflect risks associated with a potentially lengthy approval and rezoning process, limited site access or public transport constraints, natural disaster and third party disruption. The adjustment for Option 1 and Option 3 and the combination of these on both Sites A1 and A2 are slightly higher because of the risk associated with the interface with the private sector during the operation of the hospital and the risk that operational cost differentials are different from the expectations. Option B1 has greater risks than the other Options located on Site B due to the refurbished element of the proposed option.

5 Financial Assessment

5.1 Introduction

This section analyses the cost of each of the build options. The analysis focuses on the capital costs, the site acquisition and site realisation values. The capital cost for each of the build options have been costed by RBB. The costing information is contained at Appendix D with assumptions outlined behind it. Additionally, the analysis draws upon information regarding the incremental effects of the proposed hospital solutions provided by AHSG, attached as appendix F. The analysis also highlights the impact of the risk quantification for each build options outlined in Section 2.1.

5.2 Capital Cost Analysis

5.2.1 Capital Cost

The table below shows the capital cost for each build option. The capital costs presented below include allowances for external works, standard contingencies and escalation to tender for each option. As expected, the cost plans contain some exclusions considering the early stage of the project and they have been highlighted in Section 5.2.2. The NPC is calculated in 30 June 2006 terms utilising a nominal S-curve as provided by RBB and a standard discount rate associated with a project of this nature of 5.65% nominal¹⁸.

Build Option	Site Acquisition Cost (nominal \$m)	Total Capital Build Cost including site acquisition costs (nominal \$m)	Site Acquisition Cost (NPC \$m)	Total Capital Build Cost including site acquisition costs (NPC \$m)
Option A1-1	18	79.7	16.6	68.4
Option A1-2	18	81.3	16.6	69.7
Option A1-3	18	78.5	16.6	67.4
Option A1-4	18	76.8	16.6	66.0
Option A2-1	0.0	61.0	0.0	51.4
Option A2-2	0.0	62.5	0.0	52.6
Option A2-3	0.0	59.8	0.0	50.4
Option A2-4	0.0	58.3	0.0	49.2

¹⁸ 10 year bond rate on the 8 June was 5.70 and on 15 June it was 5.68%. End of May the bond rate was 5.65.

Build Option	Site Acquisition Cost (nominal \$m)	Total Capital Build Cost including site acquisition costs (nominal \$m)	Site Acquisition Cost (NPC \$m)	Total Capital Build Cost including site acquisition costs (NPC \$m)
Option B1	0.0	58.4	0.0	49.3
Option B2	0.0	61.7	0.0	52.1
Option B3	0.0	64.1	0.0	53.9
Option C	30	89.4	27.6	77.7

Overall, Site C appears to be the most expensive option from a capital cost perspective as the Site needs to be acquired before construction can begin. The site acquisition costs that have been utilised by the quantity surveyor are \$30 million. Site A1 would need to be acquired for \$18 million, which makes the Site the second most expensive site in capital cost terms.

5.2.2 Cost Plan Comments

The following notes have also been included as part of the cost plan:

- Major services infrastructure upgrade are indicative (desktop costings)
- Areas allocated to departments are inclusive of internal circulation to those departments

Due to the preliminary nature of the costings at this stage of the project the above comments are considered reasonable and will be refined in more detail upon master planning of the preferred option. At this stage the above comments would not appear to affect one site more than another and have not been quantified for the purposes of selecting a preferred site.

5.3 Site Acquisition and Realisation

The site acquisition and realisation value assumptions of the respective sites were derived from the AHSG Indicative Land Values Memo (13 April 2006), attached as Appendix E.

Site acquisition NPC have been calculated as part of total construction costs as provided by RBB.

It is understood that Site A2 can be obtained free of charge from the owner, Saracen, in return for which Saracen would like to receive development rights for the development proposal as described in section 3.2.4. No acquisition cost has therefore been included for Site A2, however, we are not aware of the extent of any approval expected from Saracen in return for the offer.

No site acquisition cost would be incurred for any development on Site B, as the current hospital site is owned by the State.

Site C would need to be acquired from the current owner. According to information provided by AHSG the value of the land today is estimated to be in the order of \$30 million (nominal).

The proceeds from the sale of the current hospital Site B (Site Realisation) are based on the following assumptions:

- The current site is 12HA in size
- Assuming average lot sizes of 660 sqm
- 15% allowance for roads
- \$40k per block development fee
- developer margin of 35%
- Sales being 17 Beach front lots at \$650,000; 16 First St back lots at \$400,000; 11 Highway backing lots at \$150,000, and 116 general lots at \$400,000 this would total Gross Sales of \$53m. Net Sales after allowing for development costs of \$53,000 per block is \$45m based on 160 lots.
- If the price was determined before any developer fee (of say 35%) would give a price of \$30m for the undeveloped land.
- The above figures assume normal development ratios and no extensive set backs from the water or highway boundaries
- Reduction of \$3m (10%) to the price of \$30m for the undeveloped land as per the AHSG Indicative Land Values memo the area is currently experiencing reductions in sales prices of up to 10%, resulting in an estimated value of nominal \$27.0 million (NPC \$19.96 million, based on discount rate of 5.65%).

However, the value of the land of the existing hospital is likely to be affected by possible development approval constraints or a lengthy approval process for any subsequent development, e.g. caused by environmental issues associated with the identified peppermint trees or the endangered Western Ringtail Possum. Additionally, according to Aurora Projects it is expected that Site B would be sold without demolition of the existing hospital. A potential buyer is likely to include the cost of undertaking the demolition and assuming the risks associated with it in any purchase price. In order to quantify the risks associated with the site realisation, further detailed assessment of the risks is required. Furthermore, it is understood that the decision with regard to a sale of the Site B has not been made by WA Health.

Therefore, as the likely proceeds from the sale of the existing site are currently unknown are subject to risk, no realisation value has been considered at this stage.

Site	Estimated Acquisition Cost nominal \$m	Details of Assumption regarding the Estimated Acquisition Costs
A1	18	Per proposal from Hanson
A2	0	Per proposal from Hanson the Site has been offered for nil consideration. The expected cost of the land, based on the AHSG land values memo was \$18 million for 100 lots in that area.
B	0.0	Already owned by the State.

C	30.0	<p>Currently being developed by owner and a sub division has been lodged. Based on a R5 Ratio of development the value would be approximately \$280,000 to \$300,000 per standard lot.</p> <p>Per SKM (Part 1) Technical report minimum 5hectares required for project. Therefore 50,000sqm required = 100 lots required. 100 lots at \$300,000 = 30.0m.</p>
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5.4 Operating Cost Differentials

Aurora projects engaged AHSG to estimate potential operational cost differentials between the different options. Each of the sites A2-2, B2 and C contain a new build single storey 75 bed hospital including laundry and kitchen, are regarded as the base case operational model. The remaining options provide for different capital solutions affecting the operating costs. Based on information provided by Aurora Projects, it is understood that operating cost differentials would be cumulative.¹⁹ The estimates and the assumptions and methodology behind them can be found in Appendix F.

Option	Differential per annum (Nominal \$m)	Differential over 25 years of operations (NPC \$m)	Summary of Assumption regarding the Operating Cost Differential Estimates
Option A1-1	0.03	0.5	<p>Catering and linen services to be purchased from aged care operator</p> <p>Benchmark costs for a catering service is usually around \$35 per day inclusive of all costs and laundry costs vary but a cost of \$15 per patient per day would be reasonable for the expected case mix</p> <p>Based on 100% occupancy of 75 beds as estimated by AHSG demand study.</p> <p>AHSG expects that the public sector, if it were to provide the services internally, would face similar costs. Therefore, AHSG assumes the cost differential to be nil.</p> <p>However, no actual cost data from the existing hospital are currently available to substantiate this view. Further analysis would need to be conducted before a decision regarding the cost effectiveness could be made.</p> <p>Additionally, maintenance cost of lifts for the building would be incurred. These are estimated at \$10,000 per lift per year. Assuming there are three lifts (two for patients and visitors and one for services) an expected additional cost of up to \$30,000 per annum may be incurred.</p>

¹⁹ Correspondence with Ian Southwell, Aurora Projects, 23 June 2006

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Option	Differential per annum (Nominal \$m)	Differential over 25 years of operations (NPC \$m)	Summary of Assumption regarding the Operating Cost Differential Estimates
Option A1-2	0.03	0.5	Maintenance cost of lifts for the building would be incurred. These are estimated at \$10,000 per lift per year. Assuming there are three lifts (two for patients and visitors and one for services) an expected additional cost of up to \$30,000 per annum may be incurred.
Option A1-3	(0.63)	(9.3)	Purchase approximately 10 beds of activity per day on average for sub acute services from the aged care operator If it is assumed that a reasonable saving would be \$180 per day, allowing for some levels of medical, diagnostic and allied health support and a margin for the operator, an annual reduction in costs of \$558,000 may be achieved (10 patients for 365 days at \$180 per day), based on an occupancy rate of 85%. Additionally, maintenance cost of lifts for the building would be incurred. These are estimated at \$10,000 per lift per year. Assuming there are three lifts (two for patients and visitors and one for services) an expected additional cost of up to \$30,000 per annum may be incurred.
Option A1-4	(0.63)	(9.3)	A combination of Option A1-1 and Option A1-2. Purchase of an average of 10 beds and associated services per day for sub acute services as well as linen and catering services from the aged care operator
Option A2-1	0.0	0.0	See Option A1-1. However, no maintenance cost for lifts would be incurred
Option A2-3	(0.66)	(9.8)	See Option A1-3. However, no maintenance cost for lifts would be incurred
Option A2-4	(0.66)	(9.8)	See Option A1-4. However, no maintenance cost for lifts would be incurred
Option B1	0.04	0.7	The most obvious cost differential in this option is the additional cost of maintenance of the refurbished buildings versus an all new option One may expect to have maintenance and energy costs of approximately \$40,000 to \$60,000 per annum additional to a new facility from around year 4 onwards. Therefore $(\$40,000 + \$60,000)/2 = \$50,000 / 25 \text{ years} * 21 \text{ years} = \$42,000$ additional average cost each year.
Option B3	0.03	0.5	There is generally little to differentiate the costs of a single versus two storey facility outside of the initial construction costs. The only obvious costs differences would be in the maintenance of lifts for the building. This may be estimated at

Option	Differential per annum (Nominal \$m)	Differential over 25 years of operations (NPC \$m)	Summary of Assumption regarding the Operating Cost Differential Estimates
			\$10,000 per lift per year. Assuming there are three lifts (two for patients and visitors and one for services) an expected additional cost of up to \$30,000 per annum may be incurred.

The most significant differential, approximately \$9.3 million for \$9.8 in NPC terms, may exist for Option A1-3 and A2-3 respectively as both benefit from the opportunity to purchase an average of 10 sub acute beds and related services from a co-located Aged Care operator. This is based on the assumption that the public Hospital could purchase the services for \$180 per day and patient compared to \$400 if the Hospital were to provide these services. The same differentials are expected for the combination option 4.

It should be noted, that we have not reviewed the Developer's proposal. Any operating cost differential would be conditional upon arrangements with an Aged Care operator. Furthermore, no assessment has been made regarding similar arrangements on site B or C at this stage. Opportunities for private sector involvement may exist for these sites and it is recommended that these are assessed further.

5.5 Summary and conclusion

The table below shows the total cost for each Option (excluding any GST). It is important to note that the figures do not represent an overall project costing. Only operating cost differentials but no operating costs have been assessed at this stage. Significant further analysis would be required for a full project costing. The figures rather provide an indicative comparison for site selection purposes. Both SKM and AHSG have indicated that further assessment is necessary in order to validate the following figures:

Build Option	Site Acquisition cost (\$m NPC)	Capital Build Cost including Site Acquisition (\$m NPC)	Operating Cost Differentials (\$m NPC)	Total Costs (\$m NPC)	Risk Adjustment (\$m NPC)	Risk Adjusted Costs (excluding Site Realisation Funds, \$m NPC)
Option A1-1	16.6	68.4	0.5	68.9	10.6	79.5
Option A1-2	16.6	69.7	0.5	70.2	10.3	80.5
Option A1-3	16.6	67.4	(9.3)	58.1	10.6	68.7

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Build Option	Site Acquisition cost (\$m NPC)	Capital Build Cost including Site Acquisition (\$m NPC)	Operating Cost Differentials (\$m NPC)	Total Costs (\$m NPC)	Risk Adjustment (\$m NPC)	Risk Adjusted Costs (excluding Site Realisation Funds, \$m NPC)
Option A1-4	16.6	66.0	(9.3)	56.7	10.6	67.3
Option A2-1	0.0	51.4	0.0	51.4	10.8	62.2
Option A2-2	0.0	52.6	0.0	52.6	10.5	63.1
Option A2-3	0.0	50.4	(9.8)	40.6	10.8	51.4
Option A2-4	0.0	49.2	(9.8)	39.4	10.8	50.2
Option B1	0.0	49.3	0.7	50.0	7.6	57.6
Option B2	0.0	52.1	0.0	52.1	7.1	59.2
Option B3	0.0	53.9	0.5	54.4	6.6	61.0
Option C	27.6	77.7	0.0	77.7	9.5	87.2

Option C involves the hospital development on the site of a former abattoir which is privately owned. This option is considered the least cost effective option primarily due to the estimated site acquisition costs of nominal \$30m as discussed in section 5.3.

Similarly, although some favourable cost differentials may exist with option A1-3 and A1-4, the options associated with site A1 are not cost efficient because the State would be required to acquire the site for an estimated \$18 million in nominal terms.

Despite a relatively high risk adjustment, the most cost efficient option would be Option A2-4. This is because of the comparably low capital cost as the hospital would be built without a kitchen and laundry and only 65 as opposed to 75 beds. Furthermore, no site acquisition cost would be incurred. Option A2-4 benefits from no incremental operating cost differential associated with purchasing linen and catering services outside of the hospital. An estimated \$9.8 million operating cost saving is assumed to be obtainable from purchasing an average of 10 sub acute beds and related services from a co-located Aged Care operator, but the ability to realise this saving has not been adequately substantiated and is dependent on private interest which may not be forthcoming.

In the capital cost assessment no proceeds from the sale of the existing hospital site have been considered as the achievable proceeds from the sale of Site B are at this stage subjective and it is understood that the decision with regard to a sale of the Site B has not been made. However, if proceeds from the sale of the existing site were available to the project, these would offset the cost incurred for the construction on any other site. Therefore, realisation of Site B may have a significant impact on the site selection process and it is recommended that the risk adjusted potential value of the existing hospital site is assessed in more detail. Moreover, the potential savings in operating costs from a co-located Aged Care operator may be similarly achievable for this site.

When considering the concept plan for Site A1 and A2, it is strongly recommended to assess the ability and capacity of a private developer to progress and implement the proposed development including co-located facilities. The information available to date indicate a lack of demand for a private hospital which would impact on the feasibility of such a development and the potential realisation of indicative savings in operating costs. Options A1-4 and A2-4 in particular rely on cost saving to be achieved on the basis of development of co-located facilities by the private sector, particularly an Aged Care Facility. These savings would not be achieved if the co-located facilities were not developed.

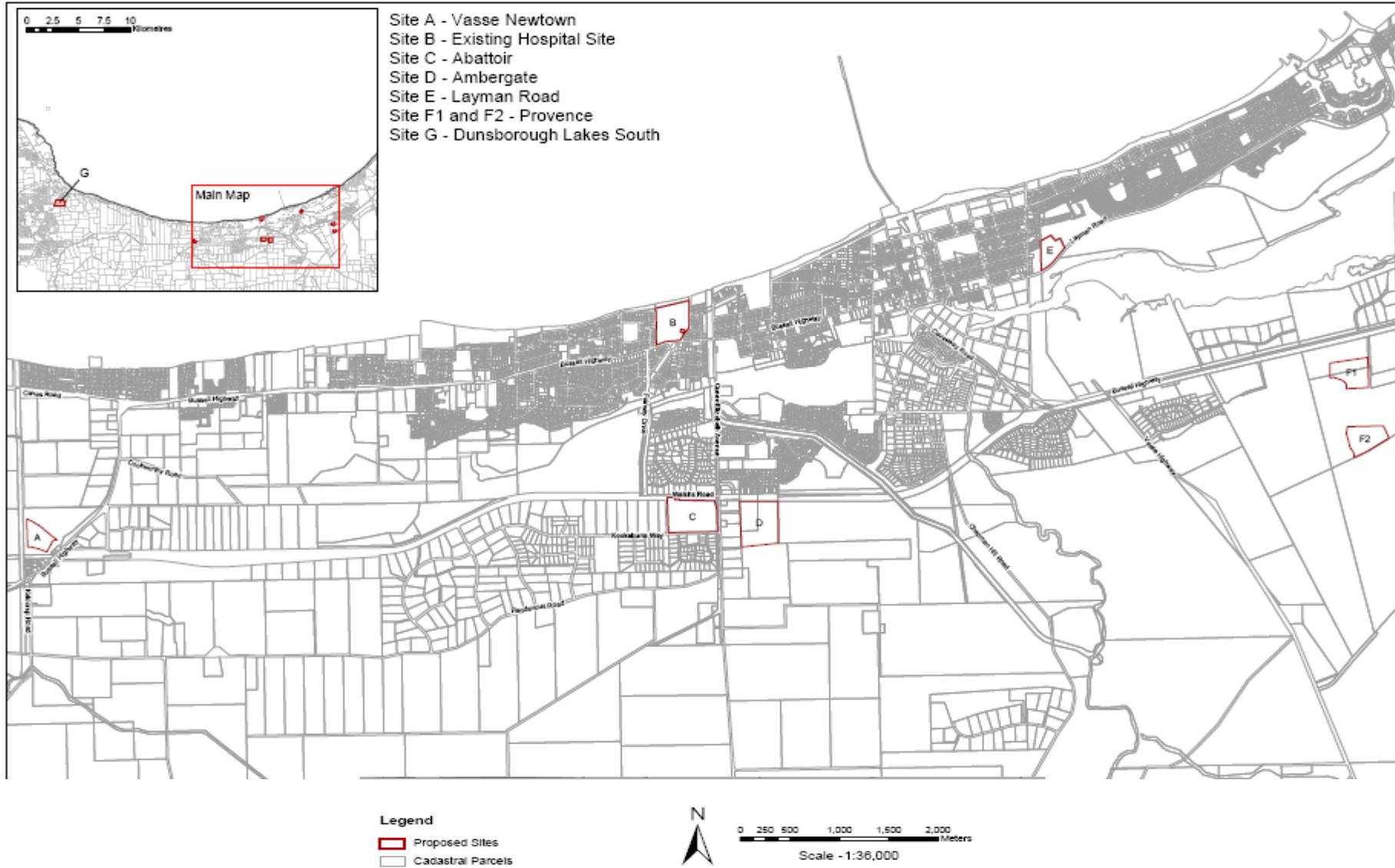
Furthermore, no assessment has been made regarding the potential for private sector involvement for any site B option or for Option C at this stage. Opportunities for private sector involvement may exist for these sites and it is recommended that these are assessed further before a Site or delivery option is selected.

Glossary

In this Report, unless the context otherwise requires, the following words and expressions have the meanings set out below:

Aurora Projects	Aurora Projects Pty Limited
AHSG	Australian Health Services Group
The Department	Western Australian Department of Health
Estil	Estill and Associates Pty Ltd
NPC	Net present cost as at 30 June 2006
PPP	Public, Private Partnership
Project	The New Busselton District/Sub-Regional Hospital and Community Health Centre Site Selection Project.
PwC	PricewaterhouseCoopers
Report	The Indicative Capital, Recurrent and Site Costs Financial Evaluation Report prepared by PwC.
SKM	Sinclair Knight Merz
State	Western Australia Government
SWAHS	South West Area Health Service

Appendix A – Site Map and Plan



Appendix B – Private Sector Healthcare Model

**New Busselton District/Sub-Regional
Hospital
Site Selection Evaluation**

**Potential Private Sector Participation &
Demand / Supply Analysis**

13th April 2006

Disclaimer

This Report is a confidential document that has been prepared by the Australian Health Services Group (AHSB) at the request of Aurora Projects Pty Limited (Aurora).

This Report has been prepared to provide advice to Aurora and Price Waterhouse Coopers (PwC) in relation to the preparation of the Site Selection Evaluation Process in relation to potential private sector participation.

This Report is for the sole use of Aurora and PwC to assist in the preparation of the Site Selection Evaluation Report.

The information, statements, budgets, forecasts and opinions (together Information) contained in this Report have been prepared by AHSB from the indicative capital, recurrent and site costs provided by PAC Construction Consultants. Supply and Demand data has been provided by South West Area Health Service. No verification of the Information has been carried out by AHSB or any of their respective agents, directors, officers or employees.

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Brief

Australian Health Services Group (AHSG) has been asked by Aurora Projects in their role as Project Director for the Busselton Site Selection Project to provide advice and assess the potential of private sector participation in this project.

AHSG was asked to:

1. Review the relevant data to determine the likely supply and demand for services and quantify the likely bed requirements for the delivery of private patient services
2. Assess the potential private sector participation in any new development inclusive of a co-location model of service delivery
3. Identify likely Operators of a private service
4. Assess the viability of a private hospital within the proposed development

This report, together with a range of other information has been provided to Price Waterhouse Coopers (PwC) to assist them in undertaking a Financial Evaluation of the various site options currently under consideration.

Healthcare Model

It has been proposed that with the development of a new health service for the Busselton region that the private sector may be involved in the provision of a range of health and aged care services.

In previous considerations to the current site selection process, a private sector health service developer has put forward a model of private sector participation in relation to the Vasse Site.

In determining the potential involvement of the private sector in any future development a number of factors need to be considered;

- potential demand for private hospital services;
- financing of private health care facilities; and
- structure of health care facilities.

This report provides a discussion of the key factors used to determine the potential viability of a private hospital development and private sector participation, ownership and or funding issues of such arrangements.

Demand and Supply Analysis for Private Hospital Services

An analysis of the current and future demand and potential supply for private patient services has been completed. Source data was provided by the South West Area Health Service (“SWAHS”) covering detailed demand and supply data. Two reports have been prepared by SWAHS being;

- ‘SWAHS Busselton Hospital Business Case September 2005 – Draft for Discussion’;
- In addition, an internal SWAHS documented ‘Inpatient Activity Forecasting Overview Busselton Hospital Replacement’.

The AHSG considered this source data, the reports provided and assumptions presented to inform analysis on the likely demand for private patient services in the proposed development of new hospital healthcare facilities.

This analysis of the likely potential demand for private patient services is based on a number of factors and assumptions. These include:

- Recognition of the current status of the market where private patient services are currently provided from either the City of Perth or from Bunbury, most notably by St John of God Health Care (SJGHC);
- The majority of specialist medical practitioners operate their rooms from Bunbury;
- Specialist medical practitioners visit Busselton to provide consultation services;
- The current medical referral and treatment patterns are well established and will be difficult to change unless a comprehensive provision of services was provided in Busselton;
- Overall demand for all hospital services, public and private;
- The overall view of service delivery configurations articulated by SWAHS in terms of role delineations and service planning where in Bunbury will remain the provider of regional services;

- It is recognised that where possible Busselton will treat the majority of patients from its catchment area, including the South West area from Busselton, within its role delineation and that there is a desire to reduce the number of patients flowing to Bunbury for this lower level secondary case mix;
- Forward projections for inpatient and day only activity levels have been based on current age / gender utilisation²⁰ and adjusted for population growth for the relevant statistical local areas of the South West through to 2016²¹;
- Current levels of private health insurance membership; and
- Recognition that the range of potential services that could be offered in a private hospital would be generally in line with the scope and role delineation of the public hospital

Based on the data sources and above factors, projections have then been made for the overall anticipated demand for hospital services and the likely demand for private patient services.

Demand Analysis

Demand for services, public and private is projected to be approximately 80 to 90 beds at 2016.

Projected activity levels 2006 to 2016

Activity	Projected activity levels		
	2006	2011	2016
Separations	6,147	7,273	8,487
Over Night Bed Days	18,681	22,103	25,793
Day Only Bed Days	1,076	1,273	1,486
Bed Equivalents Over Night at 85%	71.24	71.24	83.14
Bed Equivalents Day Only at 120%	3.45	4.08	4.76
Total	63.66	75.32	87.90

²⁰ Hospital Morbidity Data System - Department of Health WA

²¹ Department of Planning and Infrastructure – Western Australia Tomorrow Population Projections Report No. 4

The split of public and private demand is shown in the following table for the years 2006 to 2016.

Projected Bed Numbers for public and private sectors

Year	Public Inpatient & Day Only Beds	Private Inpatient & Day Only Beds	Total Inpatient & Day Only Beds
2006	54	10	64
2011	64	11	75
2016	75	13	88

The analysis is based on the following key underlying assumptions:

- Inpatient occupancy of 85%;
- Day Only occupancy at 120%;
- Average length of stay is at current level of 3.77 days for inpatients and 1 day for Day Only;
- National private health insurance levels are approximately 40% and have been discounted by two thirds to allow for the current strong outflows, competition of the existing private provider at Bunbury, the location of the current specialist medical practitioner workforce in either Bunbury or Perth and the expected scope of lower to mid level secondary services;
- Overall volumes recognise the desired reversal of flows from Bunbury back to Busselton in light of providing an anticipated broader service base; and
- Day Chemotherapy and Renal Dialysis services are excluded from these projections being Day based ambulatory services.

The outcome of this analysis is that the demand for private patient services is low at only 10 to 13 beds only.

Potential Private Sector/Market Interest Operators

A review of the potential private sector operators of a private hospital in Busselton has been considered. The likely operators may include:

- St John of God Health Care;
- Ramsay Health Care;
- Healthscope;
- Little Company of Mary Health Care (Calvary Group);
- Sisters of Charity;
- Mater Health Care;
- Mercy Health Care;
- Uniting Care; and
- A range of small or independent operators.

Based on the above list of potential operators:

- Ramsay Health Care has already stated they are not willing to participate in such a development²²;
- Little Company of Mary, Mater Health Care, Sisters of Charity, Mercy Health Care, Uniting Care and most small or independent operators have no base in Western Australia;
- Healthscope has only one facility in Perth being the Mount Private Hospital and has focused its growth across the Eastern sea board;
- St John of God Health Care currently operates a major private hospital in Bunbury (130 beds), which it has recently expanded, and would be unlikely to willingly enter the Busselton market if it put the viability of its current facility at risk and or split its current specialist medical workforce. However, it may consider entering the market to stop an alternative player entering; and
- A range of small or independent operators may consider this opportunity but due to its location outside of a major City and in light of the services offered in Bunbury and the location of the specialist medical practitioners it would generally be seen as a difficult proposition.

In light of the projected demand for private patient services and the characteristics of the likely operators the Busselton development it is not considered to be seen as an attractive or feasible opportunity. It is likely that many operators would not even consider this proposition due the small population base, low demand and incumbent private hospital in Bunbury.

Viability of a Private Hospital

For a private hospital to be viable there needs to be;

- sufficient population base;
- reasonable opportunity in the market place in terms of competition;
- sufficient demand for services to create an economically viable and sustainable business; and
- a willing and available specialist medical workforce.

As noted above, the population base is relatively small, the demand for private patient services is small, there is an established successful competitor in Bunbury and there are few medical practitioners based in Busselton.

In general terms the bed base required for a viable private hospital is approximately 60 to 80 beds. The opportunity presented at Busselton does not meet the generally accepted key criteria for success for establishing a sustainable private hospital.

Private Sector Co-location Model

²² Ramsay Healthcare acquired Affinity Healthcare who had been assessing the potential for a private hospital development in Busselton. On the acquisition Ramsay assessed the project and has declined to proceed.

As part of the considerations of the potential participation of the private sector in providing health services we have considered the development of a Co-Located Model of Health Services (“Co-location Model”). Further we were asked to consider the practicalities of such an arrangement.

A co-location of health services would generally include public and private hospital services and a medical consulting centre. The consulting centre would typically include consulting suites for specialists, diagnostic providers namely pathology and imaging services, a range of allied health providers, pharmacy services and may also include commercial opportunities such as a cafe or retail.

In addition to this it is possible to also co-locate an aged care facility (nursing and hostel beds) and a retirement village complex (independent living units) adjacent to an acute care hospital and consulting complex. Whilst this model has been growing in popularity in recent years around Australia it is still uncommon due to the lack of operational relationships and synergies between acute and aged care.

A co-location model is a proposition put forward by the private sector developer of the Vasse site. It is understood that the proposal would include:

- a public hospital;
- a private hospital;
- medical consulting suites; and
- a major aged care and retirement complex.

The proposal at Vasse would involve locating the health facilities close to the centre of the CBD over a smaller site resulting in a multi-storey development. The developer has suggested that through such an arrangement that infrastructure and operational costs may be shared between the public and private sector resulting in a more cost efficient arrangement for all the parties concerned.

In general terms, a co-location model of facilities and service delivery is possible on all of the seven sites under consideration.

It is our understanding that the same design (the standard design) can be applied to all of the sites except Vasse. Based on this commonality, the base capital costs excluding capital infrastructure and service issues separately addressed in the site evaluation are approximately the same.

Separate costings have been prepared by P.A.C. Constructions for the standard versus Vasse options and have been provided to PwC for their consideration.

Co-Location Structure

The development of appropriate structure for co-location models is often difficult with issues arising from the various participants perspectives. Generally speaking the public and private sectors each prefer to own their facilities. This is due to the ability to exercise control over the asset and because the financial costs are generally less than paying lease terms. Notwithstanding this, a number of co-location models exist in Australia, but the predominant model is for each party to

own and fund their own buildings, have one land owner (normally the public sector) and have a range of service sharing activities between the parties governed by service agreements.

It is also typical for the private sector when developing the private hospital to develop a medical consulting centre predominately aimed at the specialist medical practitioners who would use the hospital. In most situations the medical practitioners wish to have the consulting suites strata titled and the medical practitioner often purchase the suites via their superannuation funds.

The other tenants of the medical centres being diagnostic, allied health professionals and retail tenants usually prefer to rent space over a range of lease terms and periods.

Based on this typical scenario it is common to have one land owner, two hospital assets owned and funded by the respective operators, medical practitioners owning their consulting suites and the balance of tenants renting space.

The diagnostic tenants, being pathology and imaging services, would typically want 10 year terms with a number of options. They view these centres as long term propositions and don't want other providers coming into a centre where they have established and serviced a market.

If an aged care development is added to this co-location model this would add another party who would typically wish to own and fund their own facilities. As aged care is predominately an asset investment, aged care operators usually also seek to own their land. This is normally required to secure funding from banks and other financial institutions.

As noted above there is little synergy between acute care and aged care / retirement village developments. Generally there is an ability to share common service infrastructure for green field developments and road ways. At an operational level some operators are willing to share catering, hotel and maintenance services; however the requirements of each party do vary. The area for biggest potential is where the public hospital would like to purchase beds from the aged care operator for sub acute and specialist aged care services. This can allow the public hospital to free up acute beds for the delivery of acute services.

Under co-location models there is also commonly a range of service agreements for the sharing of services which may include everything from catering and hotel services through to clinical support services like pathology, imaging, allied health, etc. The public hospital may also purchase a range of defined direct clinical services eg elective surgery by speciality or procedure or sub acute medical care.

Each co-location requires a range of discussions to determine the best mix of service purchasing and provision.

Potential Issues for Private Participants under a Co-location Model

As has been noted above there are a range of issues for consideration in the development of a co-location model. These may include:

- Single or multiple land owners;

- Single or multiple asset owners;
- Potential conflict of interests in land and asset ownership between all potential parties eg hospitals (public and private), medical practitioners, aged care and retirement village operators, the developer if separate to the primary service providers, the retail, diagnostic and allied health tenants;
- Ability to gain funding for developments linked to asset ownership;
- Level of synergies for service sharing between each facility; and
- The ability to expand and or vary service agreements as circumstances change due to original agreements at the time of development.

Vasse Co-location Model

As part of this assessment we have been asked to comment on the co-location model that has been put forward for the Vasse site.

As has been outlined above, the developer of this site has proposed a co-location of public and private hospitals, a medical centre and an aged care and retirement village complex. The developer intends to own the land and undertake the facility development with all operators entering into lease terms for their respective requirements and seeks to have a variety of costs shared across all potential participants.

This development on the terms as put forward by the developer has a number of issues which include:

- Lack of volume to make a private hospital viable;
- Issues of ownership of land and facilities as outlined above;
- Desire of medical practitioners to own their consulting suites versus lease; and
- Limited capital and service synergies between acute and aged care services.

It is our understanding that to date there has not been any discussions with potential operators to secure the terms and conditions of a co-location model and the success or otherwise of this proposal is unable to be determined. Based on the information currently to hand it is unlikely that the currently proposed model would be successful in relation to a Private Hospital but opportunities may exist for synergies with an Aged Care operator in relation to hotel services and the provision of some sub acute services at both capital and operational levels.

Likelihood of Private sector participation

There are a number of constraints and issues that present to any potential private sector participant in the development of private health services for the Busselton area.

The primary issue is the lack of demand for private patient hospital services. This is a corner stone to enable a viable and vibrant involvement of medical practitioners, diagnostic providers and the allied health personnel.

Combined with the existing private hospital, located in Bunbury, it is considered that there is little likelihood of a private hospital being developed in the Busselton area.

The involvement of medical practitioners in consulting suites and the participation of other diagnostic and allied health professionals is possible dependant on the terms of any involvement.

Opportunities with an Aged Care operator may exist and discussions would need to be held with potential operators to define the potential service and business models and synergies available.

Ian MacDonald
Managing Director

Appendix C – Risk Register

Appendix D - Capital Cost Details

Appendix E – Indicative Land Values

Indicative Land Values Busselton Site Selection Project

Confidential Discussion with:

Kevin Cross
Director
LJ Hooker Busselton

13th April 2006

I had an extensive discussion with Kevin Cross of LJ Hooker Busselton today to discuss the typical land values within the Region.

Based on the sale being for developed land to be put to the market the following is an indicative range of land sale prices currently being achieved.

The values are based on land being approximately 600 to 650 sq m blocks.

Development costs per block range in the \$40,000 to \$55,000 range dependant on the site and the level of existing services eg deep sewer, roads, etc.

A Developer margin of approximately 35% has been added.

If the land was not being developed by a developer for sale the extent of the development fee and developer margin may vary.

Based on the assumption of the land being developed ready for sale the following information is given as a guide.

Indicative Land Values:

Current Hospital Site

- The current site is 12HA in size
- Assuming average lot sizes of 660 sqm
- 15% allowance for roads
- \$40k per block development fee
- developer margin of 35%
- Sales being 17 Beach front lots at \$650,000; 16 First St back lots at \$400,000; 11 Highway backing lots at \$150,000, and 116 general lots at \$400,000 this would total Gross Sales of \$53m

- Net Sales after allowing for development costs of \$53,000 per block is \$45m based on 160 lots.
- If the price was determined before any developer fee of 35% this would give a price of \$30m for the undeveloped land.
- The above figures assume normal development ratios and no extensive set backs from the water or highway boundaries

Old Abattoir Site

- Currently being developed by owner and a sub division has been lodged
- Based on a R5 Ratio of development the value would be approximately \$280,000 to \$300,000 per standard lot

Ambergate Area

- Value around \$240,000 to \$250,000 per lot
- There is no deep sewage currently

Vasse Newtown Area

- Current asking price per lot of 500 to 600 sqm is \$170,000 to \$180,000
- Currently not achieving this and selling for up to 8% to 10% less.

Updated Information as at 28th April 2006

I spoke with Kevin Cross again today, 28th April and sought his estimation of Values for the three further sites currently being considered.

Layman Road

- Site adjacent was subject to an offer by a developer at \$11.5m which was rejected by the owner. The site under consideration is 80% of this size, being approximately 5.6214 Hectares for which a value of \$9.2m is considered fair.
- Based on lot sizes of 600 sqm the value once developed would be around \$140,000 to \$150,000 per lot.

Provence – Sites 1 & 2

- These sites are already well into development by the Developer and are highly unlikely to be available
- Lots range from \$175,000 for 300 sqm to \$500,000 for 2000 sqm
- 1700 lots in the development
- Standard lot size of 600 sqm would be around \$350,000

Dunsborough – Commonage Road

- For a standard lot size of 600 sqm the price range is \$220,000 to \$240,000

Ian MacDonald

Managing Director

Appendix F – Operating Cost Analysis

DRAFT**Busselton Hospital Site Selection****Operational Cost Differential Estimates**

AHSG has been asked to assess if there are any significant operational cost differentials under the various Site options currently being considered.

Outlined below are our comments and approximate costings. These are best estimates based on our knowledge of the project and anticipated designs.

For the 3 sites under consideration there are 7 options for the development and configuration of services. Site Options A2, B2 and C1 are traditional “public” hospital models and will be considered as the “Base” for comparison purposes. These options see the public hospital developed and operated as a fully self contained service in the traditional manner.

Options A1, A3, B1 and B3 all have variations away from this base model. Each of these 4 options is considered here.

Option A1 – Vasse, 75 beds No Kitchen & Laundry, Buy from collocated Aged Care Provider

- Catering and linen services to be purchased from aged care operator
- Lower capital costs – refer to capital costings
- Aged care operator will need to offer a hospital level catering and linen service which is different to an aged care service.
- Will the operator in fact operate a laundry or not build any laundry facility and seek the service through a large scale laundry service
- Benchmark costs for a catering service is usually around \$35 per day inclusive of all costs
- Laundry costs vary but a cost of \$15 per patient per day would be reasonable for the expected casemix. Most Laundry’s charge through a combination of items and weight
- Replacement capital / equipment costs will be eliminated
- Service contracts will effect the impact of price rises or falls over time and the terms of any agreement will influence the outcomes
- Allowing for the operator to generate a small margin on the service agreements there will be little in difference in the annual operating costs. Generally the Aged and Private sectors are more efficient than a public facility if large economies of scale are not available, as exist in this case.
- Savings are really only evident in the upfront capital costs and recurrent equipment replacement and maintenance agreements.

Option A3 – Vasse, 65 beds buy Sub Acute Services from collocated Aged Care Provider

- All services are in house except some sub acute
- Purchase approximately 10 beds of activity per day on average for subacute services from the aged care operator
- Lower capital costs – refer to capital costings
- Should achieve a lower cost of service provision dependant on the service specification agreed with an operator
- Assuming limited or no medical support and true sub acute care levels the expected costs per day should be approximately \$160 to \$180 per day. This would place it at around a \$10 to \$30 premium over the current average care costs for Hi Care (Nursing Homes) residents (September 2005).
- Average hospital costs for acute patients, if the case weight was approximately \$2900 for a weight of one, would equate to a cost of \$483 per day for an average 6 day stay. It is assumed that the average subacute patient would have a case weight of no more than one.
- Private health fund step down rates for medical patients would see daily payments of no more than approximately \$340 per day excluding medical and diagnostic services.
- On this basis, for sub acute patients one would expect that the cost per patient per day in a public facility may be around \$400 per day.
- Based on the above criteria the expected savings per day for sub acute patients would be approximately \$ 220 per day (subject to the level of medical and diagnostic & allied health support required)
- If it is assumed that a reasonable saving would be \$180 per day, allowing for some levels of medical, diagnostic and allied health support and a margin for the operator, an annual reduction in costs of \$657,000 may be achieved (10 patients for 365 days at \$180 per day)
- This potential is very much subject to the service requirements and negotiations yet to be determined by either party.

Option B1 – Busselton Existing, 75 beds Part refurbished and part new facility

- The most obvious cost differential in this option is the additional cost of maintenance of the refurbished buildings versus an all new option
- The life cycle for a refurbished building for maintenance is generally shorter than an all new facility
- Energy costs of older buildings are generally higher
- On this basis one may expect to have maintenance and energy costs of approximately \$40,000 to \$60,000 per annum additional to a new facility from around year 4 onwards
- The actual cost differentials will be dependant on the amount of buildings refurbished and the usage of these buildings

Option B3 – Busselton Existing, 75 beds Multi Storey new facility

- There is generally little to differentiate the costs of a single versus two storey facility outside of the initial construction costs

- If the designs of the wards and units can be contained in functional units with the correct relationships between services there is expected to be little in the way of differential costs.
- The only obvious costs differences would be in the maintenance of lifts for the building. This may be estimated at \$10 per lift per year. Assuming there are three lifts (two for patients and visitors and one for services) an expected additional cost of up to \$30,000 per annum may be incurred.

In summary, outside of option A3 there is not a differential of any real significance. Option A3 is subject to service scope and negotiations by the respective parties and what they are or are not willing to enter into.

Ian MacDonald
Managing Director

19th May 2006

Appendix G – Partnerships for Growth Assessment

The following table assesses the potential to achieve value in the delivery of the project under the WA governments Partnerships for Growth arrangements, when listed against the six criteria.

	Characteristic	Explanation of the Characteristic ²³	Assessment of Project Against Characteristic
1	Business opportunity	The arrangement should provide an opportunity for the private sector to achieve a reasonable return on its investment.	<p>The private sector will have the opportunity to earn a reasonable return on its investment subject to the delivery of the project providing value for money when assessed against the proposed cost of the investment were the public sector to deliver the project itself.</p> <p>The ability of the project to provide value for money should be considered against the key findings of the AHSG report as outlined in section 3.2.</p>
2	Private sector capability	The Government must ensure that available and suitable players exist in the market with a proven capability and track record. The market must also have the capacity to provide an alternative private partner in the event of a contract failure.	<p>A market sounding has not been conducted at this stage of the Project, however there are precedents for the delivery of public hospital infrastructure via a PPP in NSW and Victoria and other accommodation infrastructure such as courts, convention centers, prisons, TAFE's and schools have been delivered around all states in Australia including WA.</p> <p>That said, an issues in the procurement of the WA Courts Project (which was successfully procured as a PPP and reached financial close in July 2005) was the lack of construction companies in the WA market with the requisite financial capacity to undertake large scale PPP projects. The capital cost of this project may be such that sufficient players can be identified, however, this should be thoroughly tested as part of a market sounding process before any project is delivered to the market for procurement as a PPP.</p>
3	Private sector skills and innovation	The private sector can add value by bringing their skills to the project, which improves cost efficiencies for the Government.	The scope of services included within the PPP delivery would determine the extent of innovation available to the private sector. Where there are limited services included in a PPP Model, there may be limited scope for innovation, but inclusion of additional services with consideration of including services such as cleaning, portering, catering and security there may provide scope for greater benefits to WA Country Health Service – South West from innovation solutions from a private sector service provider.

²³ All explanations are from Partnerships For Growth

	Characteristic	Explanation of the Characteristic ²³	Assessment of Project Against Characteristic
4	Risk allocation	Risks are shared such that each party takes responsibility for risks they are best to manage	There is potential for risk transfer, the scope of which will depend on the allocation of services within the PPP arrangement.
5	Cost as compared to the PSC	The risk adjusted whole of life cost should be favourable when compared with the PSC	Appears based on other drivers that this could be the case and is therefore worthwhile pursuing. It depends on other issues being presented.
6	Size	The transaction costs from entering into a PPP should not erode the value that the PPP can deliver	While the size of the Project depends on the elements of the Project included within a PPP Project scope, the capital cost of the Project is expected to be in the order of \$100m.