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Transcript
Fresenius Helios Capital Markets Day 2018

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AGENDA & SPEAKERS

PRESENTATION: Welcome – Markus Georgi

Markus Georgi: So good morning, all. Welcome, all of you, to our Capital Markets Day here in Berlin today. I think, as you can tell, full house of more than 90 participants in the audience, and this is record participation in the history of our CMDs. And we really appreciate you guys being here and your interest in Fresenius Helios.

As you can see, we start today with presentations of our Group CEO Stephan Sturm, followed by Francesco De Meo. He will give you a broad overview of Helios.health or Helios Group. After these two presentations, we'll get an impressive scope of various aspects of Fresenius Helios in another 10 sessions. The range goes from a medical view, cost synergies up to some deep dive into the Spanish hospital market.

We planned four Q&A sessions for today, two in the morning, two in the afternoon. And the presentations of Helios Germany business overview and Helios Germany efficiency are held in German. And to follow these presentations, I would like to ask you to use the headphones in front of you.

Some more housekeeping items, try to keep it quick. These little devices, I would like to ask you to put them on mute for today. Maybe the most important housekeeping item, lunch will be served at 12:00 in the garden lounge. This is this direction.

And finally, I would like to thank -- to take the opportunity to thank all the people from the project team from Helios, the group and all people who made it happen to have this Capital Markets Day today. It's always a big organization behind such a CMD and lots of stuff to do that typically nobody sees. So thank you, once again, to make it happen today.

One last remark, would like to draw your attention to our mobile event app. That's first time such an app is supporting our CMD, which provides you with the latest updates for today. And we would appreciate if you could provide us with your feedback of this Capital Markets Day, yesterday and today, via the app.

And with that, it's my pleasure to hand over to our Group CEO. Stephan, the floor is all yours.

PRESENTATION: Introduction – Stephan Sturm

Stephan Sturm: Good morning, all. Happy to see you all here in the room and also good morning to those of you participating, unfortunately, only via the Web. It's a pleasure to have you all participate. We appreciate your interest in Fresenius, as always. It is a big investment of your time. We most certainly acknowledge that. We will try to make it worth your while.

For those of you, in particular those who can only join us via the Web, what you did miss yesterday afternoon was a trip to one of our finest hospitals at Fresenius Helios here in Germany on the outskirts of Berlin. I believe what you missed is a set of medical professionals who have conveyed a sense of passion about what they do, a sense of pride of what they do.

And content wise, what you missed is a few pieces of tangible evidence that, in our business, size matters, scale matters, the ability to invest matters. The ability to leverage investments across a variety of individual hospital locations matters and that, overall, obviously passion for what you do is a critical success factor.

I hope those who were able to attend last night's dinner also over and above some good food had something to take home content wise. I was asked by a few participants after the event whether we had actually paid for our dinner speaker's work. And the answer is

very obviously no. It was hot from the press. It is a neutral piece of work that Mr. Augurzky presented yesterday afternoon here in Berlin. He just did us the favor to repeat this to all of you at the dinner event last night. This is, to the best of my knowledge, a neutral piece of work which, however, I will readily admit, so I appreciate the question, is very much down the line of our strategy and what we plan to do.

Over the course of today, we would like you to be a bit more acquainted with the dynamics that determine our business. When we announced the acquisition of Quirónsalud in September 2016, we at that time already promised you that we would get you more of a deep dive on our Spanish business at the appropriate point in time, which is now.

A lot of things have happened also to our German business in the meantime. And therefore, there will be a quite extensive session on the dynamics that determine and that also that we do anticipate going forward in our and for our German business.

So next to these two building blocks, the German business and also Quirónsalud, what the majority of the day is going to be spent on is what we called and continue to call the Rainbow of Happiness, the areas where we do believe and increasingly believe synergy potentials does exist.

You will see the initial projects that we have gone about and where initial synergy benefits have materialized already, but you will also hear about future plans, where we have an increasing hope, anticipation, belief that further synergy benefits can be had.

Over and above a purely quantitative economic view of the world, we also want to make you a bit more acquainted with what is really at the core of our business, what is driving it all. And that is quality of medicine. So you will also hear views from our chief medical officers for Helios.health, but also for Helios in Germany and for Quirónsalud, how they go about medicine and how we increasingly try to align our thinking in that regard.

Our colleagues that you're going to hear and meet over the course of the day are true and passionate experts in their fields. What in order to master the challenges and the opportunities in their area, at least until the recent past, has not been a requirement is a very good command of the English language. So I would ask you to -- for your patience and also for the understanding that some of the speeches are going to be held in German and in Spanish. And I would also like to ask you not to misinterpret maybe a not ideal yet command of the English language with a lack of expertise in the actual area of what our colleagues are doing.

This is a rare occasion, a Fresenius Capital Markets Day. Our last Capital Markets Day dates back to 2012. It somehow feels that all of our Capital Markets Days coincide with major football tournaments, a true coincidence because, as it happens, the last Capital Markets Day before that 2012 as Kabi, was 2008. 2008 was a joint Capital Markets Day for the, at that time, still newly acquired Fresenius Helios and Fresenius Vamed. It also happened here in Berlin. I would -- and that is not a threat, Francesco, to you and your colleagues. I would expect that it won't take another 10 years until we have the next Helios Capital Markets Day.

Look, many of you, when we made the various announcements over the course of last year were asking me, "When are we going to learn more about Fresenius Kabi and all the fascinating things more or less that you have initiated there?" And the plan was already at that time that we would do a Helios/Quirónsalud Capital Markets Day first to get you more acquainted with those dynamics because, in particular, when it comes to our biosimilars business, we believe we need to get a bit more of actual real-life ownership experience before we have something to show for ourselves. At the time when we formulated that plan, we didn't know that Akorn wouldn't go 100% the way we had originally planned it to be, but that is a different story.

Talking about a different story, do me a favor, please. It's very rarely that I ask a favor, but this is meant to be a Fresenius Helios/Quirónsalud Capital Markets Day. Many of you used the opportunity already yesterday and over dinner to ask all the appropriate questions about Kabi and Akorn in particular. I would really want to make sure, also as a matter of courtesy to our Helios colleagues, who have spent days and nights burning the midnight oil to prepare for today's event, that also in the Q&A session we at least today keep it reserved to questions surrounding our hospital business. Thank you.

Having said all that, I want to hand it over to Francesco, who is going to give you a bit of an overview also of the day. And he's going to make you more familiar with and remind you of the Rainbow of Happiness. You will see more of Francesco, also of Rachel and myself, in the intermittent Q&A sessions, and I will also try to give a fair wrap up of the day later this afternoon.

Thank you for now. I'm looking forward to an interesting day full of content surrounding our hospital business.

PRESENTATION: Fresenius Helios Business Overview - Francesco De Meo

Francesco De Meo: Thanks, Stephan. And a warm welcome also from my side. I got five minutes in plus now, Stephan, because you were really good in time. But I will try to make it in my 30 minutes.

To give an overview at the beginning of such a day is not an easy thing because I have to touch all topics you will hear later on more concrete. I don't want to bore you, but I want to give you an impression what's the idea. We talked a lot yesterday with some of your colleagues on my table being there on Fresenius Helios, on the hospital business. We had no questions on Akorn. That's fine.

And the most important thing was a kind of easy mathematics because we started to think about, what is one plus one, if you talk on integration. And as you know, integrations being then two are usually good integrations because a lot of integrations are less than two. However, what we want to show you today is not only one plus one is two. At the end of the day, we would appreciate you being convinced that we are able to make one plus one to more than two, three, or even more.

So I start, and my colleagues will continue. I take my machine here. You will see me running. Oh, it's not here. It's not here. Where is it? I look for the pointing here. So it's not here. So I take the five minutes to get it. Here it comes.

And it's here. Thank you very much. So you see, it is very important to be supported by adequate technic. You will hear about that also during the sessions. As my starting point, it's always the key takeaways I want to address. So you will see on any session following now some key takeaways for that session.

And you may verify yourself if we met the key takeaways or not. So what I want to show you is that we are successful across different healthcare markets, that we learn from each other and we learn from the best. That's sometimes the Spanish colleagues and sometimes the German colleagues.

We have a best practice transfer that drives the national transformation. There will be a lot of that in examples in the next sessions. And we are prepared for further regional expansion. I discussed with Markus what is regional. What is meant is the international expansion has begun. So there are next regions to be addressed for further international expansion. So the key takeaways, and feel free at the end of that day to send to me any email or something like that saying you did it or not.

The overview, to understand Helios means to understand the milestones of Helios. Therefore, I take some minutes on that, even if many of you know the history of Helios. When I joined Helios in 2000, Helios was a change management machine. Why that? Our business model at that time was privatization.

What is privatization in German context? It is buying state hospitals, badly managed and near to insolvency, and making them better, better in quality and efficiency. That is and was the business from the beginning.

It is a big difference to the Spanish market approach because, there, you cannot buy public hospitals. And Héctor will talk about the different system, the different approach in Spain, which for us seems not worse, but different, and to some extent more flexible than the German approach saying all public or privatized.

As you know, the time of privatizations were driven by three aspects. First, there was a change in remuneration. So in former times, there was a payment on cash cost payment. So the management of the hospitals in Germany, they came usually from administration. And the only thing they had to do is to write a check to the state, paying the costs they got in the hospitals, 12-14 days inpatient stay, extremely inefficient structures, processes. The real manager at that time were the chief doctors, thinking on quality, yes, but also on quality of their own money.

That changed with the DRG system coming in Germany. And as you also know, now we get a payment in a lump sum. And being more efficient means making profit for investments.

Why do we need profit in Germany? In former times, investments were paid by the state, by the regions. But a lot of regions didn't pay that any longer since the last 12, 15, 20 years even. And therefore, as a lack of investment, the lack of medical equipment, there's no presenter even there, and therefore, it was a big issue for some of the state hospitals to find by privatization an investor to make it better.

You saw that yesterday in Berlin Buch, for example. And who has been to Berlin Buch the last Capital Markets Day 10 years ago will have felt that it is still today one of the best and modern hospitals. Built some more than 10 years ago, it's 12 years ago. So privatization was our business, and it is our business. However, as you heard from Boris yesterday, there are two factors that make privatization at the moment near to not happen in Germany. Why that?

Germany is a rich, rich nation. And the state hospitals get deficit payments from the public. So there is no pressure on making happen what we call a more selective competition in German market. That means closing about 300 to 400 hospitals in Germany. The need, anybody you ask, is seen on all what we see of the market. It will be Ralf Kuhlen talking on that. It will be Franzel Simon talking on that, Ralf as the medical anesthetist looking from the medical side and Franzel Simon, the new CEO in Germany, on the management perpective on that.

So it was a situation in Germany making privatization happen. That situation has changed. And we tried to claim to forbid the public to make that deficit spending. I don't know whether you followed that claim and actions. We put even to the European Court. At the end, we lost. The European Court stated that, in Germany, it is allowed to give that kind of subsidies to public hospitals.

So there is no pressure coming from that for further privatization at the moment. And I don't say a lot about the political situation. You know politicians fear about elections, and you don't win elections in Germany if you name or do privatizations at the moment.

As that effect was coming up in 2005, we focused more on consolidation. So you know about the big deals. It was Wittgensteiner coming from Fresenius together with the Fresenius deal, we being now Fresenius. It is done. It was the best known Rhön transaction. And all of that contributed to a consolidation on the German market and brought us to more size and to scale opportunities.

However, what about growth in Germany if there is no further privatization and if there is no consolidation? There is growth on an organic level and on a stable level. Franzel Simon will talk about that. But it is not that much we knew from that past.

And we felt also prepared to be better English speaking going international. When I joined Helios, it was clear that Helios should be only a German company for all time. And suddenly the world is different. So we thought it could and it would be a good idea to go international. And we started with Quirónsalud.

We're happy that our first step going international is a successful one. And we will explain you during the next sessions why. That are the milestones. So I hope you understand what is Helios Germany, what is Helios Spain, and why we do that.

Stephan talked about passion, not coming from the organization side, coming from the medical side. It is passion driving our business, passion of the doctors and the nurses and all the people surrounding that business. And what's driving us can be explained with that numbers. It's more than 200 babies, Helios babies every day born in Europe. There's a lot of opportunities taken on big numbers, for example, in gloves or in energy.

We are proud to invest per day more than €1.2 million from our earned money in our hospitals. And we are proud to have all those employees summed up at the end to more than 106,000 in Fresenius Helios Europe.

So the passion is very important. So the people must be motivated, even if the system at the moment in Germany is not very motivating. It's something you will hear from the colleagues -- the regulations make us thinking about how to motivate our people.

The normal KPIs. You know a lot of hospitals, a lot of beds, employees, inpatients, outpatients, medical centers, and the revenue. For me, the most important thing on that slide are the colors. You see the nice green. It's the traditional Helios green. You see the red. In the preparation of that Capital Markets Day, we discussed with Investor Relations whether it is a good idea to put something in red on the slides. They told me our colleagues don't like red because it's a bad sign. I can say the Quirónsalud red is a nice red. It is a good sign, and therefore, we remained with the traditional red to make a difference. I will come back to differences.

What you can see here is a big difference in the outpatient sector. Have a look on red and green. Have a look on red and green in revenues. And have a look on red and green in medical centers, outpatients. The red is far more bigger than the green. And that's the system that is different in Spain and Germany. We will come to that point, being one of the most important differences between Spain and Germany during all sessions because that's a driving factor for process, for efficiency, and for growth opportunities. So have a look on that, and you will see what makes the difference and why it is important to be different.

However, if all is different, what about one plus one? I will come back to that. More important for me at the moment is we took not only different colors. We remained on the brand Quirónsalud, Helios.

When I talk to Héctor and Victor and the negotiations, there was always thinking about, is there risk of German tanks coming to Spain to make all the same? And I said, "No,

because you can see I'm also different, being half Italian and half German. So to live as a half-half is very important to take the difference as an opportunity."

Therefore, why should we change locally really the best brands we have in Spain and in Germany only because we go international and we are asked about integration? It is the better way to hold on the existing brands because the patients are orientated on that, and the patients love those brands. It doesn't matter for me to see a red and a green and to talk about Helios Germany and about Quirónsalud in Spain. But it does matter for the patient going in Spain to a Quirónsalud hospital or a Quirónsalud hospital with another brand. So it is very important to take the difference and the chance of the differences.

So is all different? No. There's a common value approach. When we discussed with Quirónsalud their approach, we saw that we are thinking the same way. And I want to explain you the approach you will see also during the sessions later on.

We want to provide high-quality and cost-efficient healthcare. So the most important things must be value driven, high quality, and cost efficiency. What do we need for that? We need good market access. We have it, number one in Spain, number one in Germany.

And we need efficient processes for that. We have them in different ranges. And you will hear about that from Enrico and Pedro later. And you will hear about that from Olaf and Corinna on the German view.

We need an infrastructure and the financing of that. So we must make profits. We must have the opportunity to make profits. So yesterday, I was asked for next steps in internationalization. That are the most important things we are looking for before we decide to go in next targets or markets.

We need the controlling and a permanent readjustment. And as you heard yesterday also from Boris, we need the qualified and specialized doctors and caretakers, especially nurses. The battle may be lost there if we are not able to take with us the most important qualified people.

But in Germany, as you heard, there are not enough of them. So if we talk about personnel, we also have to talk about innovation and processes, about digitalization because we must change the working plans as we don't have all the staff in future we need to make the work. Therefore, we will talk also about digitalization in a session done by Jörg Reschke and Adolfo. And you will see the different approaches in a yin and yang situation, Germany and Spain.

So what makes the difference? In short, the regulation density is completely different between Spain and Germany. We have a high national wide regulation in Germany. We have a medium and local variable regulation in Spain. The growth opportunities are completely different.

We have a largely saturated market in Germany. You heard it also yesterday what will happen in Germany. The best of that, it will take some time. Privatization's coming back. As you heard yesterday from Boris, he expects in 2022, '23, '24 or some years later the next boost on privatization. So it's fine also for the German colleagues to work on efficiency at that time period and to come back with an organic growth in privatizations then later on.

In the Spanish market, it's more dynamic. We have opportunities even in consolidations there. Héctor will talk about that and greenfield and ORPs. And he will talk also together with Adolfo at the end on digitalization for services and growth.

The financing systems are different. We have in Germany the separate financing models between outpatient and inpatient. And you will hear about that a lot this day because that's the most difficult situation to be met in Germany for good quality and for efficiency.

In Spain, it is different. As you saw from the red and the green at the beginning, in Spain, we are able to make the outpatient services in our hospitals. So Spain may be a pattern for the changes that must come logically in Germany. We'll talk about that also later on.

The insurance system you know is also completely different in one important point. Health is financed in Spain with taxes. In Germany, you know it is covered by payments of the people. So the insurance system in Germany is very closed, meaning you can only go into a private insurance at a certain income level. And it is an either or decision.

In Spain a private insurance is not instead, but the private insurance is additional to the public insurance. And that's a big point if you think about growing in Germany or in Spain. It is Franzel Simon and Héctor coming to that point.

So if there's a difference, it makes no sense to think about making it all the same. You must follow a strategy country by country. And see the three points here. You will hear about growth, and you will hear in Germany about a growth perspective by portfolio sharpening, by clustering, building centers, minimum quantities, and integrated outpatient care. You will hear, in Spain, it is more dynamic, continuing the focus on growth areas Héctor will report on in his presentation.

In Spain, we have a model on outpatient services, on check-up centers, ORPs, and outpatient activities that could be transferred to Germany to a certain extent. Therefore, in Germany, it is to develop outpatient activities. In Spain, it is to make them growing.

Innovation. There is a different approach in innovation. If you, for example, look on the medical equipment, in Spain, we have some medical equipment we do not have in our German hospitals. Why that? For example, Da Vinci system. From a medical quality view, it is not something that brings you to better quality. The studies all saying that. However, in Spain, being a hospital with Da Vinci brings you the patients. And you get it financed. In Germany, both not at the moment. So in Germany, we try to meet also then the financing challenges by thinking about different investments related to what we see in Spain.

If we talk to the German colleagues and after Quirónsalud coming in, the doctors being passionate doctors, as you heard, all asked, "Okay. But why don't we have now all in our hospitals also Da Vincis?" And we could explain that, and we had to explain that. And we can also explain it to the German market.

The processes are similar, but also different. We will see that, in Spain, it is a matter to increase cost efficiency, while the service leadership should be maintained. In Germany, we are cost leader, but it is not enough. It will be Olaf Jedersberger talking about the next step that we come nearer to an industrial level, while increasing also the service level. It is a bad word in Germany to talk about industrial level when you talk about healthcare. But frankly said, to make it more professional, and that means industrial, is good for patients and good for the system.

So we benefit from the experience of offering in our business model high quality, high efficiency in different markets with different conditions, challenges and opportunities on both sides.

I will talk now about two steps -- that means one plus one is two -- and perhaps at the end of this day about step three to make then one plus one more than two. What is it

what we can learn? We discussed a lot on that slide because, on a first view, I think you cannot understand it. You see red and green. It's Spain and Germany. You see gray. It's Helios.health. It's the holding structure we installed. The slide shows a clear pathway of best practice transfer on a high market system level.

If you see in red the patient experience on the Spanish side, they are very, very successful on that. You see on the German side the clustering and the minimum we have to meet in Germany on the DRG system. So the Spanish colleagues can learn from us if in Spain there will come up the clustering needs as in Germany, and they will come in the future. We started with some clustering activities also in Spain. And the Germans have to learn and can learn on the patient experiences taken in Spain. So that's a good way. We have a local approach, and we have experience that could be transported to the other land.

A big point, length of stay, we'll hear a lot of that this day. The Spanish colleagues are very good in length of stay. It will be explained by Ralf and the colleagues why that's the fact. The Germans started to go also there, even if we know that we will not be there at the end as long as the system is as it is with the boundaries between outpatient and inpatient.

But we can learn from the Spanish colleagues what to do. Jörg Reschke will show you, for example, an approach showing the waiting times in our emergency rooms and units.

The Spanish colleagues asked for peer reviews we know from Germany that help to make quality, medical quality better. So it is the Spanish colleagues trying to get our experience on SOPs and peer reviews. And it is the German colleagues trying to get the experience on lengths of stays.

The same if you think about reimbursements. The German system is very closed. But in a closed system, you have a lot of activities to change the DRG system. It is to be expected that some of those things we see now in Germany will be taken also to other European states. So if you talk about the Fixkostendegressionsabschlag, it's a very German word. I don't know how it would be spelled then in Spain. But maybe something similar will come also to Spain if they fear that there are too much patients treated as inpatients in the system.

We know how to deal with that from the German experience the last 10, 15 years. And that's an experience we can give to the Spanish colleagues. The Spanish colleagues then know how to work with different flexible reimbursement systems. You will hear from Héctor that there are PPP models, that there is private insurance, that there are the ORPs, and that you have also an outsourcing DRG system that you are paid on activity on capital, so a lot of modern new additional reimbursement systems and also the opportunities on that.

And we believe that, in Germany, there will be a change in some years latest, also on reimbursement systems. And if that comes, we have the pattern for that. We even can go to the politicians, show what happened in Spain with Quirónsalud, making them to be convinced that something of that could be also tested in Germany. The legal framework is there in Germany. It is only the heads not thinking that way at the moment. And at least you will hear a lot about health activities, Helios.health activities on synergies and on medical quality given by Ralf Kuhlen and by the colleagues.

So I need the last five minutes, Stephan. We are the best in class with different strategies to address different healthcare markets. We have different growth strategies, and we focus on synergy potentials. That will be followed in the next sessions. We have a mutual best practice exchange, and we benefit from global healthcare trends, while adopting to local needs. That's to be best in class.

And what about the next step? You heard from Stephan about the portfolio sharpening we called it now. It is that we gave under the Fresenius umbrella the post-acute care portfolio from Helios to Vamed. And he explained that it makes a lot of sense and that we are convinced in Germany about that to make that because so we can focus on the next steps in Germany, being acute care and related outpatient care to our acute care.

And there's a big chance also for the rehab clinics and the portfolio we gave to Vamed because Vamed itself is internationally positioned on that. And Vamed may drive that business then more international as it could have been done from Helios Germany because it was not a corrective of Helios Germany the last 15, 20 years. So there are new growth prospects then driven by portfolio sharpening. And I will talk at the end from a smart approach, but let's hear and see what that will be at the end of my last session.

Step one, we learned by integration. It will be Enrico and Pedro talking a lot about that and the different synergies we took from that, step one. Step two, the Rainbow of Happiness, we had a lot of topics to be dealt with in an interaction. The integration from the beginning was not an integration by German tanks. It was integration by interaction on defined topics. And you see all those topics on the Rainbow of Happiness we dealt with the last year. And the colleagues will touch any of that point, showing you what happened. And most of that what happened made us happy and hopefully also you in your view on Fresenius Helios and the Quirónsalud integration and international opportunities. So we'll always come back to that Rainbow of Happiness.

And it's me to give it over now to Ralf Kuhlen, being the next presenter with a view on medical healthcare. And he will touch some of those topics of the Rainbow of Happiness for you in the next session. Thank you very much.

PRESENTATION: A Medical View Across Borders – Ralf Kuhlen

Ralf Kuhlen: Thank you, Franco. Good morning to everybody. After having a wonderful evening yesterday at the teahouse, we can share some thoughts on the medical view across border, thank you, which are pretty good based on what Boris Augurzky yesterday gave us from an external view on the German market and our company.

Yesterday evening, I promised that I would find the proper translation for Fixkostendegressionsabschlag. I talked to Rachel about it. It simply doesn't exist. The meaning is that you have to give a discount once you are doing more, for whatever reasons, but finally, you don't get the full reimbursement. That's what it means, and that is what impeding our gains in volumes.

Okay. Going into this, we start with the Rainbow. And within the next 20 minutes, I'm trying to give a somewhat broad overview on the medical items, such as length of stay, waiting times, or quality, peer reviewing, something we do about quality medicine in Germany and meanwhile as well in Spain. And while it's me to give a more general perspective on that, later on in the day, it will be Leticia from Quirónsalud and Andreas from Helios Germany to go into some specific examples.

General view with once again the key messages. The first and I guess the most important key message is the patient is in the center of whatever we're doing here. And whatever we're thinking about, methods, structures, processes, how to come to results, the patient is our focus. And I guess this was -- Franco talked about the value approach. That was very, very similar for Quirónsalud and Helios Germany. That was the reason why all our discussions went so open and completely along the same line.

And with two slides, I'm trying to give you some insight of what that could mean to medical system or to medical treatments. The Spanish healthcare system has an excellent quality, and it is very efficient. And actually, astonishingly, we will look into some OECD data. Boris began that comparison yesterday evening. Astonishingly, it's

even more efficient than the German system. And at least me wouldn't have thought that before, to be honest. But it is true.

The third part, obviously, medicine has no borders. Disease is the same all over the world, and treatment is more or less comparable all over the world, no question about it. But good medicine might have some borders. There might be structures, there might be systems which are opposing hindrance to really provide good medicine. And we will have some thoughts on those structures and systems which are helpful or not so helpful.

And at the end, I guess, for this audience, no big news. Good medicine, we would consider good medicine and economic success going along one line and fitting together. However, no news for you probably, but we in the business are confronted with discussions on that issue every -- actually every day because we are in Germany, as well as I guess in Spain, we are accused for thinking about money and nothing else but money and don't really care about the medical outcomes. And I hope that I will be able to show you with a couple of slides that everybody who's accusing us is simply wrong because both of it is the result of optimal process, optimal treatment, optimal way of providing care.

So let's begin with the patient-centered vision. Maybe the easiest way to get there is imagine yourself being a patient. Imagine yourself being somebody who has to go to the hospital. What would be your expectation in the system? For me, for us, pretty easy. You want to be diagnosed. You want to know what's wrong with you. From your symptoms, the proper diagnosis should've been established. That has been discussed with you.

You had the room to answer questions, and they were answered. And you know what's that all about. And all this is documented. And all this is put into a system where the data which has been gathered during the diagnostic process are not lost. They're transferred to the hospital. And t best, they're available to you. They're on your smartphone. You can show them to your doctor, to your family doctor, to your friends, if you want to.

Once you have that, you can go into the hospital and would expect that, in the hospital, everything is planned in advance. So all the steps of treatment, all your timelines are given before you actually enter the hospital. Once again, at best, you have them on your smartphone. You know all your appointments. You're meeting the radiologist on day one. You're meeting the anesthetist in the evening. You're doing the operation the next day. You're having your first rehab session on the afternoon after the operation. And all this is on your smartphone, all this available to everybody in the treatment team.

No waiting times would result out of this because everything which is in your system is in the hospital information system as well. Jörg and Adolfo will comment on the challenges for this. But that would be actually the expectation.

Enhanced recovery. We have learned over the years that we used to think about the hospital patient as a patient being in bed. To be honest, you would expect that you have to go to bedrest once you go in a hospital. That was true for many, many, many conditions. And to make it easy, it's virtually always wrong because bedrest per se has so many negative side effects that you simply should get rid of immobilization.

So we were thinking about remobilizing the patient. But what is taught from literature from really a huge body of evidence is, if you get rid of the immobilization, you don't need to remobilize. What does that mean? Apply the most noninvasive, most modern technology. Do the less trauma possible to the patient, and don't get immobilized.

I had an operation on my left knee. It was a simple operations, but still two hours. I had my first physiotherapy session on the afternoon after the operation, two hours after I went off the recovery room. I was off the hospital the next day. That may be an

expectation which we would all share because, for us, time is important issue, and we want to be home. We want to be back to work, our normal life immediately.

For my parents, 83, completely different. They find it very calm and relaxing to be in the hospital, have a bell, and once you hit the knob, somebody's coming and taking care of you. That is changing over generations, over time. But I guess the expectation of all of us and definitely the expectation of younger people is to get out of there as soon as possible.

This chart, actually the same is true as for admission. You want all your treatment, all your data be available to, A, you and, B, all the treatment team afterwards, rehab, family doctor, whoever it is. Now that's pretty easy in terms of that could be something like the optimal way through your disease hospital stay.

And Franco has already highlighted some obstacles to this because, in Germany, for example, we have the complete separation between outpatient, inpatient, rehab, different reimbursement, different budget, different dataset, different technology in terms of software. That is hard to facilitate a journey through all this when you're having three different systems which are completely separated from each other.

That's different in Spain. That's the reason why some of the gains we are seeing over time today are easier to be achieved in Spain, not necessarily meaning that we are not getting there in Germany, but it's easier.

Patient expectations, talking about getting out of the hospital as soon as possible, being remobilized as soon as possible, having a physiotherapy session on the day of your operation, this is something my parents would not expect from the hospital. That is something I would expect meanwhile.

To be honest, we have trained our patients over the last 30, 40 years that immobilization, bedrest, be calm and easy is something good in the hospital. So we have both. The traditions and attitude of the care providers of the years created an atmosphere where patients would expect something from you. And we have to change this when we want to go for the enhanced recovery. This is not happening like this. You cannot say, "We change it," and then it's changed tomorrow. This really takes time because you really have to convince people.

The reason for that is that the risk of complication is clearly time dependent. And it's decreasing. So the reason for discharging patients earlier from the hospital is very easy. They are better off. They have less complications. So the length of stay for us, thinking about economics as well, is good when it decreases. But it is really not the goal. It's simply the result of an optimal medical treatment process. That's the reason why we are looking into this as well in Spain as in Germany pretty much.

That was flow. Now content wise, what are we actually doing in medicine? It is something which I would say meanwhile has become pretty easy because we have the concept of evidence-based medicine, which in fact is a global concept. And I guess you heard the word before.

What does that mean? Assess your patient. Ask the right clinical question. That is something which is of eager importance that you think about what is the condition, and then you ask the appropriate question, and now don't rely on your own experience. Try to get the best evidence to answer that question, state of the art. Best evidence is coming from randomized controlled trials, meta-analysis, research in any way, coming from data, from big data analysis, coming from your own experience.

Appraise that evidence to the situation of the individual patient, and apply it, five easy steps actually. For a hospital group, maybe easier than for a standalone hospital because

we have such a huge amount of data that, for virtually any condition, we have the evidence what we actually should do. And we are pretty sure about the outcomes.

At Helios Germany, we are measuring outcomes actually since the beginning, since the implementation of the DRG system in 2000. So if you would look into what we are doing there, just an example, acute myocardial infarction is a disease which is having a relevant fatality rate, in-hospital mortality rate around 10% couple of years ago.

In Germany, the green light bars, the light green bars, it came down to approximately 8.5%. At Helios, we are 30% better. We save thousands of lives compared to the German average. That is a clear sign of something good there. I don't want to take it as a scientific proof that we are really better. Okay. But I don't want to hear the accusation that we don't care about quality. That is simply wrong. And that is not only true for acute myocardial infarction. That is true for many, many, many conditions. Altogether, we have 46 well-defined outcomes which are counting on all our hospitals. And in 85% of all those goals in all our hospitals in Germany, more than 2,800 individual goals, we are better than German average. That is good.

In Spain, we took this method of analyzing data, which is a little bit tricky to do because the Spanish healthcare system is not having a DRG system all over the place. They have something what they call the minimal dataset, where the ICD codes, the diagnosis codes, and the procedure codes are to be found and to be analyzed. And we did that. And the Spanish group as good as the German group, tremendously well above average, in terms of quality, perfect for all of us.

Well, there is in Germany 15% left. In 15% of the conditions, we are below average. We are not bad, but we are below average. And here, we invented a method over the last 15 years actually, which we call peer review, pretty easy. In the condition where you are below average, a group of reviewers is coming to your hospital. And those reviewers are specialists in the fields coming from other hospitals. And they are looking into concrete patient charts. And they are reviewing what happened to the patient in the respective indicator, in the respective condition.

And then they are discussing their results and observations with the clinical team. And they're writing a protocol. If we would do the same thing tomorrow, we should do that and that and that and that different. And this is really something which gives you a very, very concrete template for improvement.

And it is effective, as we have shown in the meanwhile in a couple of retrospective analyses. Look at a standardized mortality rate, difficult word, easy to understand. If the observed mortality rate is higher than the expected mortality rate, then this ratio is above one. So 1.45 means the observed mortality rate in those conditions was 45% above average, which is not good, definitely. So that was the reason for doing the peer review there. More than 4,000 patients were in this analysis. This is one of the most powerful analyses ever on this issue.

One year after the review, it came down. That is, to my knowledge, one of the most effective methods in medicine - maybe not only in medicine - to improve quality. We received a prize for that paper. Meanwhile, we are doing the biggest prospective examination and study on that issue together with 270 hospitals from the Initiative of Quality Medicine. We are prospectively proving that peer review is really increasing quality and outcomes.

Is it only medicine? All of us implemented it pretty much at Helios in Germany. Quirónsalud might be thinking about it as well. Meanwhile, we do reviews for management as well. And peer review in management is kind of a funny thing because all the discussions we had in medicine 15 years ago, like there are no mistakes. If there is a mistake, somebody is simply guilty, and then we don't need to talk about that. This

is happening in management today. So we have to develop that culture. Think that is something where learning from the best could mean that management could learn something from medicine here. And personally, I foresee something like evidence-based medicine and evidence-based management in the near future.

If you want to do something about quality, you need to measure. You need to have a plan. You need to check whether you are on your plan or below. And you need to be able to do something about it. I've shown you that we are able to do this in terms of medical quality.

This are outcomes. And outcomes are probably the most important. But still, there is structure and process. And let's look into structure and process a little bit for the comparison of systems and how systems might support or hinder those outcomes.

Question to you, what do you think? How many days does the average German spend in a hospital every year, 1.8, 0.9, 0.7, 0.6? What do you think? Who's in favor of 0.7? Nobody. Who doesn't want to play that game with me? Who's in favor of 0.9? Good. That's Switzerland. Who is in favor of 1.8? Good. That's true. 0.6 is Spain. 0.7 by the way is Canada.

So if we think about it, it's three times more, and this might now be explained by couple of aspects. One has been named by Boris Augurzky yesterday. If you remember the amount of beds per capita, that is pretty much the same as this.

Now is it reasonable to assume that Germans are going more into the hospital because they are more ill? Because treatment is somehow more difficult and takes longer or more hospitalization? That is not very reasonable. It is reasonable to think about whether this is a consequence of structure, of the system.

And if you look into the pure number of hospital discharges, how many people are going to the hospital every year, Boris has shown this yesterday evening as well. It is 25% of the German population making an inpatient case every year, 18 million inhabitants, 19 million hospital cases, unbelievable, the highest number in the world, apart from Austria, which is pretty much the same in the systematical approach as in Germany. In Spain, it's 11%, obvious difference.

Now one point could be, you know what, when people are being more in a hospital, they are healthier afterwards, and they are better off. That would be a reasonable point, unfortunately wrong because it simply doesn't happen. And the OECD, where much of those comparisons is coming from, gave us a pretty good framework to assess the respective impact. Why is the health status, the outcome of health the way it is?

First, and the layer for everything is there is epidemiological differences, demographic differences, economical and social differences in different systems. And clearly, the German population is one of the oldest on the earth. So this is clearly something which was the health status at the end will have an impact.

The healthcare system per se has an impact on health outcomes, no question. But the risk factors are having an impact on outcomes as well. How many people are smoking? How many people are drinking? How many people don't move? How many people do not have healthy food and whatsoever?

Now if you look into the respective impact of healthcare system to health status, it would be reasonable for Germany if all this hospitalization rates would finally result into perfect health status. What is the data coming from the OECD? That is health status measured as life expectancy, cure rate from defined diseases, some mortality range, whatever it is, outcomes. Those outcomes on Germany are on OECD average. Perfect, it's on average.

Spain, always better. Spain is having a better health status, a higher life expectancy, higher cure rates from very many diseases. That is really hard to take for the German healthcare system.

Look into resources. We are spending way above average resources in our healthcare system. And that is definitely true for money, money as percentage of the gross domestic product, per capita, however you count it. And the most astonishingly, that is true for nurses, doctors. If you would count them per capita, we have rather good ratios of nurses and doctors per capita. In fact, it is very comparable to Scandinavia.

But we have so many beds that, if you would take beds as the denominator, we have a tremendous lack of doctors and nurses per bed. The reason is not the lack in nurses. The reason is that we have way too much beds. And that is something which clearly is moving Helios in Germany because they are going away here, which clearly is moving our system, and which clearly is something we can learn from the Spanish colleagues who with less beds are able to do very much the same because the outpatient/inpatient relation is very different.

So interesting to look into those data and finally ending up with a very provocative analysis not coming from us or the OECD. It was from the Lancet paper on the assessment of healthcare efficiency.

If you look into the preventable mortality rates on the X axis, the lower the preventable mortality rate, the better is the system, I think understandable. And the resource utilization on the Y axis, you see that, although Germany is putting more resources in it than Spain, they have lower preventable mortality rates. They are simply more efficient.

The Spanish system, in general more efficient than the German system in general, Quirónsalud much more efficient than the Spanish system, Helios Germany much more efficient than the German system. Good for both respective groups, very good. And now learning from each other begins. Really learning from the best is an opportunity here.

Take length of stay, I'm sorry, process. The German average is around 7.4 days. And it came down over the last years. And Helios is way below for acute care, 1.-something days below. That is good. But if you would compare the German average length of stay to the OECD data, and the difference here is that's not only acute care. This number reflects all inpatients, including mental disease. That's the reason why there's a 9 for the length of stay in days.

But it's way above the OECD. It's way above Spain. So for Helios Germany, the benchmark cannot be the German average because the German average is not good. For Helios, the benchmark must be something else. And that's the reason why, in this length of stay business, we are really trying to learn from each other. Some examples, and I guess Leticia and Andreas are going somewhat more into detail there.

For acute care, they are 1.5 days below Germany. Cholecystectomy, length of stay is half as long. Hip replacement, half as long. Knee replacement, half as long. Prostate operation, half as long. Tonsillectomies, the very few which are done on an inpatient basis, because most of them are done ambulatory, one-third as long.

Turn it around and imagine how many beds we could save. Same quality is coming out there, no question about that. Imagine how many beds we could save if we would come there. There again is an obstacle to that process because we have the German DRG system with a minimal length of stay. Once you go below that minimal length of stay, your reimbursement decreases.

That is an obstacle by concept, by system. We need to talk to our regulators about that. We need to show those examples to move that over here. That is not going to happen

within the next two weeks, but maybe we are able to move that over the years. Very impressive, something to learn from.

Last slide. The economic success and the medical success for us are going along one line, without any question. Franco has shown you this circle here, our conditions, where we look into markets, where we can be successful. And improving efficiency is one of the key issues. That is the CEO of Helios.health, his vision.

This is WHO. They don't care about money that much. They definitely don't care about EBIT or something like this. They define improved efficiency as a key quality aspect of healthcare systems. So it's not only talking about money. Worldwide, it's mainly talking about access. We need to be efficient to enable access for many people to the healthcare system. That's the worldwide issue.

But both are completely clear about the following: Improving efficiency is a key aspect of healthcare systems and a provision of medicine. And I think this is something where we really can learn from each other. We are doing it on a pretty good basis, and we're going in some examples in the following section I guess in the afternoon with Leticia and Andreas.

So far, thank you very much. And who's next? Franzel.

PRESENTATION: Helios Germany Overview – Franzel Simon

Franzel Simon: (interpreted) Yes, good morning from my part as well. And now because we're going to be focusing on Germany, I'm going to change perspectives and move over to this podium to speak from. So I'd like to welcome all very cordially here to Berlin. And I would like to tell you a little bit about Germany and a little bit about the Helios business in Germany, where we're headed for, what our challenge is, what we -- how we want to counteract these challenges.

And I would also like to begin with our Rainbow, as you can see. And I would like to focus on the right-hand side, where we're talking about Helios Germany.

So what are my key takeaways? Well, in Germany, the hospital business is a very attractive business. However, there are very high entry barriers. So nobody can just come up and say, "I want to build a hospital, and I want to start treating patients." You can do that, but then you can only treat private patients. And if you listen to what Franco said, then you know there are only about 10% to 11% of the patients are private patients.

Other than that, if you want to enter the system, you have to become a member of the hospital plan, so to speak. So it's a very attractive business with high entry barriers. The regulatory framework in Germany is something I will discuss in more detail later on. But this framework offers risk on the one hand and -- but it does allow for a number of opportunities, even though there are certain barriers to entrepreneurial ideas.

Helios Germany, as you have seen from Francesco's presentation, has an ideal structure. And so we see ourselves as the ideal partner for the new ideas coming up ahead, namely cross-sectoral care that we can already see at Quirónsalud. And we have set ourselves up for this change in the business due to the size that we have to our regional allocation and to our structures.

In many, many areas, we were also the pioneers with regard to new care models. Ralf Kuhlen has already showed you some of these aspects. We began very early with regard to introducing new care models, with regard to advanced trading for employees, and also with regard to new skills mixes. Do all of the same tasks have to be done by the modern nurses of today as were done in the past, or can we change this as well? This is a subject

that we are focusing on, but I'll talk about this a little bit later on. And last but not least, I believe that we in Germany are excellently prepared for the future.

So who is Helios Germany, and how are we set up within Helios Germany? You can see that we have six managing directors who work together as a team. And we're all based here in Berlin at our headquarters. And we manage Helios centrally.

In terms of our philosophy, we've always said that we wanted lean hierarchies, that we continue to have, even though we have become even bigger over the course of time with many, many different hospitals.

Well, what has happened to us is that, due to the fact that we have these lean hierarchies, we are able to talk to each other much more quickly, reach decisions much more quickly, and this is something that is less possible if you have a very complex structure with many levels of hierarchy.

And we have introduced local responsibility at the hospitals locally because we have a number of different German federal states, and thus, you have a number of different hospitals and sizes of hospitals. So it's very, very important to make sure that you have local responsibility so that decisions can be made at a local level. But we provide company-wide networking services, and where we're talking about also bundling our capacities, for example, with regard to procurement or for other infrastructure services.

Below the top level of management, we have this extended management team plus the rehabilitation part of our business. We have seven regional managing directors at this lower level. And they have to make their own decisions and implement the decisions taken centrally here in Berlin and implement them in the various regions, as you can see this with regard to their technical operations. And we provide support, and they have to implement this decision.

We also recognized at a very early stage how important it was to incorporate medicine into our daily business. And that is why we've created a medical advisory board. And these are the members of the medical advisory board at Helios. They are all senior physicians and specialists at the various hospitals in Helios. And they support the hospitals, but also the management with all issues related to medicine. And so they discuss, what is an innovation, or as you heard Ralf speak about quality, how can we improve the quality? And they support and organize the peer reviews.

And in addition to our medical advisory board, we also have so-called specialist groups. That is groups of specialists which provide support to all of our chief physicians. And all of our chief physicians are active in a specialist group. And they discuss all medical issues, where they develop standards and medical concepts and where they're also going to make recommendations for actions, namely, what are innovations, and should these innovations be implemented? And all of this is then discussed with the advisory board and then with the management.

We have four strategic objectives against which we measure all of our efforts. As Ralf has already said this as well, we do not see this as a role where the medical success is contrary to economic success. No, it's the other way around. We try to promote both, and then we tend to see them as supplementary and as complementary factors. And this is something that we also began relatively early in Germany.

With regard to quality, Ralf Kuhlen has already spoken about this subject. And Andreas Meier-Hellmann will also discuss a number of these other objectives. One of our objectives is the subject of knowledge. Here, too, we have 74,000 employees in Germany. And we recognized at a very early stage how important it is to obtain and retain good employees in order to provide good care.

And we also recognized very early that we have to look after our employees. And thus, we began at an early stage with trying to improve the work-life balance. And so we now provide 32 kindergartens in our company. And we even have 24-hour kindergartens, where our employees can also leave children overnight, for example. We have a number of flexible working-hour schemes and job sharing offers.

But we also spend €30 million for training and development for employees because, if you want to provide good medical care, you need well-trained employees. And so we also provide a number of training sessions at three simulation centers where employees can come to learn about new technologies and to increase their knowledge and improve their skills.

And we have also focused on the subject of health management issues, such as employee healthcare. And so our employees receive a card so they can be treated almost like a private patient at hospitals so that they would always go into the wards for private patients or would receive the additional voluntary services if they wish to make use of this.

Yes, so economic efficiency is a subject that has already been raised. And so this applies to us not only with regard to the increased number of hospitals that we've acquired, but we've also continued to grow steadily with regard to our sales and with regard to the development of our EBIT margin.

And you can see that we have the highest margin for the private operators of hospitals. And I would, of course, also like to emphasize that many of our profits are reinvested in our enterprise. As you can see, this red line shows you how much we invest into our hospitals in order to be able to keep up with technical advances, while maintaining high medical quality for our patients. But I'll talk about this again later.

Before I turn to the regulatory framework, I would like to briefly show you what the acute care hospital market in Germany looks like in general. You can see that we have three groups of operators. We have the so-called public hospitals. We have the nonprofit hospitals, which are usually run by churches or other charitable organizations. Then we have the private hospitals. And you can see that that's also shifted. You can see that, as a percentage Helios runs 4.5% of the hospitals.

But if you then take a look at the inpatient cases and the beds, the situation changes a bit. We can say that the private sector has a high number of beds and we have,approximatelyone-third of these beds. And we've also seen an increase here. And I believe that there will be a different situation in future.

Helios has a share of beds of 6%. Why is it that, if we looked at the beds and inpatient caseswhere does this change come from? Well, you've seen, in the last couple of years in the course of a number of privatizations, it was the smaller hospitals that went into the red. And they were the first to be privatized. And that's why, initially, the private hospital operators were only able to take over a number of smaller hospitals. And we were one of the first that began to focus on taking over maximum care hospitals and other specialized hospitals.

So what does the trend look like in the German hospital market? You can see, as Ralf Kuhlen has already said, with regard to length of stay, we've reduced the average length of stay from 14 days to approximately 6.7 days today. But this is primarily due to the fact that we had the change in remuneration to the DRGs. That's what led to the increased pressure to reduce the average length of stay.

But we are still far, far away from what our European neighbors have been able to achieve, as Ralf Kuhlen has shown you. So I believe that, here, too, we have an awful lot to do in the future. And we will be able to achieve the one or the other success.

But you can see that, in the last 20 years, there are 200 hospitals fewer in Germany than there used to be. And that means, because some hospitals have no longer been able to comply with the regulatory framework, or they waited too long to privatize. So that was no longer worthwhile from either a medical or economic point of view to take over certain hospitals. And that's why some hospitals were completely shut down and completely disappeared from the market. But as you saw in Ralf Kuhlen's presentation, in Germany, we still have too many hospitals when compared internationally. And with us, we have too many beds, as you've already seen.

So what is the allocation within Germany? What types of hospitals do we have in Germany? And we distinguish between three types of hospitals. First of all, we have the general hospitals with more than 1,097 hospitals. And then we have the so-called major regional hospitals , the brackets show you the figures for Helios. They cover some additional rdepartments.

And in Germany, we have 77 maximum care hospitals. There are a number of differences of opinion as to when is a hospital really considered to be a maximum care hospital? Well, basically, they are defined as hospitals with approximately more than 800 beds.

So you can see that we have seven out of 77 maximum care hospitals. So we are well set up to meet the future. We have the biggest share in terms of other private hospital operators. None of them have any maximum care hospitals so that, again, we are well equipped to face the future and to face the challenges that lie ahead. And of course, we are well set up to meet the new regulatory changes that lie ahead of it. And so we have 19 major regional hospitals, and we have seven maximum care hospitals. And we are big enough, therefore, to cope with the challenges.

And you've already heard this as well with regard to the financing situation in Germany. The situation in Germany is completely different from Spain. I've already said, in Germany, if you want to treat public healthcare patients, then you have to become part of the so-called German hospital plan, where we have a so-called dual-financing system. So we have two pots, a big pot and a small pot.

The big pot are the operating costs. That is, you're getting your money because the money to cover the running cost is some of money that you negotiate with the public healthcare schemes. And once a year, this is set up. And then the billed DRGs should cover the operating costs, personnel, medicines, and so on.

The smaller pot is designed for investments. And that used to come from the public purse. Well, basically the law says 100% of the investments have to be paid by the respective German federal state for the investments in hospital. But many German federal states no longer do this. And in fact, they are earmarking less money each and every year to finance investments in hospitals.

So if you want to invest, you're only getting 35%. And then you frequently have the problem that you're being told, "Yes, we're going to be promoting your measure, but you're not going to be getting your money for this measure in 2018, but only in 2023." So then you have to decide whether you want to wait that long in order to get the public money, or can you make your own investments until that time? So we have to generate earnings. And at the end of the day, this will allow us to continue to invest in our hospitals.

So the smaller part keeps getting smaller over the course of time. But in the meantime, with the new regulatory framework, the legislator is also trying to interfere with the so-called bigger pot. And I'll come back to this later on. And what they're trying to do now is come up with minimum staffing ratios. And they're also trying to take out some of the money from this big pot.

So how is a budget created in Germany? We've already heard this. It's the sum of relative cost weights. Every diagnosis is based on a certain case mix index. And if you then multiply the case mix index with the admissions, then you get the sum of relative cost weights. And they are then multiplied by a so-called base rate per case, which then allows you to create your overall budget.

This base rate varies in Germany. For example, if you take an average of all of the German federal states, then you come up with a base rate of €3,500. So if you have a patient who has to enter the hospital, leaves the hospital after three days and with a relative cost weight of 1.0, and then you have a base rate of €3,500, and that is multiplied by this 1.0. That gives a payment of €3,500. And that's the budget. And there are quarters both upwardly and downwardly.

That is, you keep the patient in the hospital for three days. Then you would get the €3,500. But if your patient has to stay in the hospital for five days, you're still only getting €3,500. So in addition to the medical reasonableness, you also need to take a look at the economic efficiency in order to see how can we work on the length of stay.

On the right-hand side, all of the cases, all of the relative cost weights are added together. And that comes up with the hospital budget of 10,000 admissions, so times €3,500, and that would lead to proceeds of €35 million from the public healthcare schemes.

So what's going to be changing? And what are our opportunities? And again, what are the opportunities for Helios Germany in the future? We have a structural fund that is going to be extended. And this allows hospitals to receive monies from the German federal government in order to merge hospitals or to close hospitals. So for us, this means that, if hospitals are uneconomic or are in the red or cannot be operated from a medical or an economic standpoint, then you can close this hospital with a little help from the structural fund.

That gives us the opportunity for growth because we take a look at our environment, and if hospitals disappear from the landscape, the patients aren't going to disappear. This will give us an opportunity to treat these patients in our own hospitals. And thus, we can generate some growth.

Another change is that, in the future, the collective wage rates are going to change. And every hospital, every group of workers negotiates collective pay scales. And they're no longer going to be reimbursed on a one-to-one basis, but through an average wage through Germany. And thus, you have to have a budget for increases in the payroll, whereas if you've -- even if you're paying a higher collective wage rate, then that would be at the expense of the hospital operator, who has to see how he's going to finance this. This will change in the future. And namely, what you've negotiated with the trade unions with regard to increases will then be incorporated one to one in the hospital budgets.

And then the formation of clusters and centers is an opportunity for growth, as Ralf Kuhlen has already announced. And here, we see one of our biggest opportunities to generate growth, first of all, with regard to the numbers of admissions because we will be concentrating on forming centers where we'd be able to provide even better medical quality and thus be able to attract even more patients to our hospitals.

And the second point is that the government has also provided for such centers if these centers have been registered as such and if they have been incorporated into the hospital and that they are supposed to be receiving a surcharge in the future for maintaining the center in order to, again, obtain better quality.

Another opportunity that we have, and once again, the legislature through the so-called joint federal committee has made a requirement with regard to emergency services. To date, there is no formal structure. Every hospital could decide to hold its own or to maintain its own emergency room or not. And now the legislature is intervening in this situation. And at the moment, we're assuming that between 400 to 600 hospitals will no longer provide emergency services in the future because they will no longer be able to comply with the basic requirements.

This is a real chance for us to grow because, in our environment, this means that other hospitals will not be able to participate in emergency room services, emergency care services. So the ambulance services will not be taking the patients to these hospitals. So we have the opportunity to receive more patients via ambulance and thus be able to receive more patients and treat them as well.

So you're surely going to be asking yourself, " how is this going to affect Helios?" We've conducted an initial survey in our hospitals. We have 80 acute care hospitals; 11 of those have never participated in providing emergency room services. Either they were specialized clinics, or they had clinics that provided beds to affiliated physicians, where they never had to take in any patients on emergency basis.

Sixty clinics already meet these new structural requirements and nine smaller clinics, which could possibly have to be dropped for the provision of emergency services. But once again, four of those have a large potential for complementing what is missing in order to fulfill these new structural requirements.

So you can see that, here, too, we have a real chance; 400 to 600 hospitals will be affected by this change. And I believe that we, again, are very well equipped to deal with this change and thus be able to achieve more growth due to the fact that the ambulance services will be bringing us more patients.

Other opportunities that we have, and we'll be hearing other presentations. The subject of digitization offers us a huge opportunity to improve our processes and structures to attract patients by facing the challenges posed by digitization, but also provides an opportunity for increasing economic efficiency, as you will hear later on during the course of the day, namely by leveraging potentials due to the collaboration with Vamed, but also with our colleagues in Spain with regard to procurement, technology, medical services, medical devices, and so on. And you'll be hearing more about this later on.

We see this as a huge opportunity for us, so despite the changes in the regulatory environment to create even better structures, to improve our economic efficiency, and to leverage the potentials that we have in collaboration with our sister companies and our affiliate hospitals.

So of course, there are risks that we're going to have to face. And this has already been mentioned. For example, the introduction of minimum nursing staff levels.This subject was raised yesterday that is going to be a requirement with regard to the wards, namely how many nurses will have to work in a ward. And the legislature is not saying, "If you don't have these minimum nursing staff levels, you can can no longer admit these patients.” No, we have to continue to provide treatment to these patients. But then we would have to expect a discount in the payment.

So I think we are well equipped to face this risk because we have certain structures due to our case mix. What's going to count here is whether everything can be implemented. And the law already provides for certain opportunities with regard to neonatology and so on. And so we'll have to take a look to see to what extent a skill mix will allow us to improve the ratios. But I believe that this will give us the opportunity to become even better.

But this is a big risk for Germany as a whole because there is going to be a major run for qualified nursing staff. I believe that we are trying to do as much as possible to encourage our employees to stay with us by offering them opportunities. And so we have a real chance here.

So in addition to the introduction of minimum nursing staff levels, there are also some thoughts concerning removing the nursing care cost from the DRG catalog. And so of course, in this case, those hospitals who have very good structures and processes would be penalized. And so we'll have to wait and see what possible negative effects might be introduced because, if due to illness or losses of employees, then you don't have the one nurse, then you might have to face a discount on your DRGs.

And then you quickly find yourself in a situation where you can no longer have your costs reimbursed. But you also don't have the nurses working in the wards and so on. And the situation could become difficult. But again, I think that we are well prepared to meet this situation.

Another risk is the subject of adaptations to the calculation for the individual DRGs. That is that those DRGs that involve a lot of material costs are going to be depreciated because due to the bundling of procurement possibilities, the devices that are being used for implantations are becoming cheaper,

So we are seeing that certain DRGs are going to be downgraded, so to speak. So even if you're offering the same service as in the previous year, you will be receiving less money in the future. And this is something we will also have to cope with. And even though this is a risk, we see an opportunity here to benefit from the collaboration with our Spanish colleagues in procurement in order to achieve better negotiation results in order to counteract such negative catalog effects, but which we would then be able to compensate for with better structures. But then of course, the whole subject of administration plays a role because an unfilled bed, of course, also generates cost.

Okay. And then this,the negative word of the year, the German phrase Fixkostendegressionsabschlag, for which there is no real translation.This would be a discount on the so-called fixed cost. And there are all sorts of discussions as, should this be completely eliminated, which all of the hospitals in Germany would be arguing in favor of because it can't be that you're going to be penalized if you're treating more patients and especially if you're also providing better medical quality to these patients. So why should you have to expect and accept discounts?

But there are also thoughts to increase this amount, from a current average of 25% to 35% to 50%, which of course would also counteract growth because, again, if you want to treat more patients, in the first three years, you have to accept certain discounts, which from our point of view is definitely the wrong path to take. But that is a risk, of course.

And that is why, in view of all of these regulatory changes that we see in our future, we have to try to counteract these effects by forming centers, not only because we're saying the medical care will become better if we form such centers and we're able to prove this because, if you have centers where you have -- where you're treating certain patients for certain diseases more frequently, then you're providing better care.

And that is why, from a medical point of view, there's a lot of sense to forming centers. And of course, there's also -- this also makes economic sense. And this is going to be a change in the future. The politicians are in favor of this. I believe that we've acted as a pioneer in the last couple of years because we began forming centers.

And I believe that we've really set ourselves up well. We start off with regional centers. And we've also bundled certain services at our maximum care hospitals after many,

many discussions with our chief physicians. But the initial results show us that it is possible to provide good service to patients, and thus, you can also treat patients in a way that is medically good and that makes economic sense.

We're also thinking that perhaps the regional centers might not be the right solution for the future. It might make more sense to build real lighthouse projects. You'll be hearing more about this from my colleague Andreas, where we say we don't want to form regional centers, but where does it make sense for which disease?

For example, pancreatic diseases, could we come up with one center nationwide in order to have a real lighthouse center, in order to improve medical quality, but also to promote patient growth because we would then assume that we would be able to draw patients from across Germany to such lighthouse centers?

As I've said, this is going to be a path that we have started. I believe we were the pioneer in this area as well. And the politicians have recognized that there is a need for this change. And we are, again, in the forefront of this new trend.

So in summary, where do we see our biggest growth factors? One, through the formation of centers for single services, as I've already said. A decrease in the number of emergency service providers because they will no longer be able to provide these services by law, and that would lead to a growing number of cases for the remaining providers. And there's going to be a cleansing of the market due to this because hospitals will be closed due to the requirements of the structural fund, which will lead to continued market consolidation and therefore fewer hospitals competing with Helios. And that means we will be treating more patients.

A fourth point is -- that I haven't even mentioned to date -- is a subject that we've learned from our Spanish colleagues, namely the idea of service, increasing service quality, in addition to medical quality that we're also going to have to focus more on increasing service quality for patients and for their families as well. And we've started developing the first models along this line in order to provide better service quality to patients and their families and thus generate patient loyalty.

We can learn an awful lot from our Spanish colleagues, particularly with regard to waiting times, which has led to huge discussions in Germany because a lot of patients complain about the long waiting times for certain operations, for example. And I believe that we can really make a lot of improvements.

But of course, service quality also means that with digitization, we also believe that we can improve the service in our clinics. And you will be hearing more about this later on from Jörg Reschke.

So development of new business areas is an important growth factor for us in the future as well. I believe we are going to try to become and remain pioneers in this area because we are going to be trying to establish cooperations between our larger hospitals with smaller hospitals to provide services with regard to on-call services, but also to provide support to smaller hospitals with our specialists when we're talking about certain catheter treatments and measurements and so on, and then if they have severely ill patients that are then admitted to our maximum care hospitals that we can see that we are able to see that there's a market for us. And that's why we've come up with some first positive initial results from our collaboration with third-party hospitals. And thus, we have developed some very good models for attracting more patients.

And of course, cross-sectoral care, you've already heard this term from Franco -- Francesco. It's much easier in Spain than it is in Germany. In Germany, it was impossible because we have two different areas, so to speak. We have the inpatients treated in hospitals. And then we have the ambulatory patient care, outpatient care.

But in the future, we are going to need good models because we're already seeing that, particularly in rural regions, there aren't enough physicians and that the physicians in these areas are getting older. And so that means we can no longer provide good care to our patients in rural regions. And so we also will need new models and good models in order to continue to provide good care to our patients.

Despite all of the tailwinds that we're enjoying and the headwinds that we're facing, we are trying to come up with new models. And one model that we are trying to introduce together with the politicians in order to provide better care for patients, where we want to take over rural practices, not only by sending one physician, who will then be spending the next 20 years in that town, but where we want to introduce a rotation concept, for example, in Schwerin in northern Germany, where they could then provide medical care for pediatrics, cardiology, or even just perfectly normal general practitioners. The public healthcare schemes are fighting this idea, but the politicians are willing to support our efforts along these lines. And I believe that this will also be a good growth market for us.

And of course, at the end of the day, there will be continued privatization. And as you saw yesterday evening, right now, there isn't any privatization going on. But once the regulatory framework changes, we will be able to continue to grow by engaging in the selective acquisition of other hospitals.

So in summary, the anticipated political regulations will definitely have an impact on our hospitals and on our financial performance in Germany. We are confident that we have taken the decisive measures to counteract such regulatory challenges, namely in order to come out of this battle in a positive way.

We have superior medical quality. We have digitization. We are in the process of developing new care models. We're focusing on clustering, cross-sectoral care. And we've talked about the sharpening of our hospital portfolio. So we believe that we're excellently prepared for the future. And once again, I believe that this sharpening of our portfolio has been one of our growth factors by passing on the rehab sector to our sister company Fresenius Vamed. And so I believe that we are well prepared to meet the future. And we are going to continue to be prepared for the future. Thank you.

Q&A SESSION

Markus Georgi Thank you very much for your update on the the German hospital market and the challenges we're expecting due to the regulatory changes in German hospital business. With that, I would like to run the first Q&A session for today, followed by a 15 minutes' break. And we will start again with Héctor's presentation with a deep dive in the Spanish hospital market at 11:00. So we're happy to take your first questions. Hans Boström from Credit Suisse..

Hans Boström: Hello, Hans Boström from Credit Suisse. Two questions if I may. First, on the idea of taking out the nursing costs from the DRG, could you give us a sense of how disadvantaged you would be in profit terms from such a measure in margins or otherwise?

And secondly, the presentation about the average length of stay and how, well, first of all, the private operators generally have higher length of stay, I'm very curious to understand why that is generally in Germany, obviously, Helios much lower. But the second point of that is, how far lower could you go before you actually start getting penalized in terms of going below the minimum stay requirements for maximum reimbursement? Thank you.

Francesco De Meo: Yeah, I take it. I think I take the first nursing topic. And Ralf then taking length of stay. I cannot give you a figure at the moment on the nursing issue. It's

not because we are not able to calculate anything, but any calculation is determined by the fact that there is no law on that yet.

So the only thing we can say is that it may reflect our margin if the law is taken as it is written in the coalition contract at the moment. We know from the past that making a coalition agreement is one side. And transferring this into law is another side. So we expect that there will be a time schedule to make the law and to give the hospitals room for meeting the points.

Therefore, we will be prepared on the one side, but we will also be really challenged because we are more profitable on that way. Our problem is more the structural problem.

If you look at our staffing, and Boris talked about that, we use less nurses because we have a skill mix doing our work in the hospitals. And therefore, we get the money for a DRG structure that will be over.

And then if we are forced by the new structure and by law to use fully qualified nurses, that will be a problem, what about our skill mix? Shall we fire all the people doing the work at the moment, for example, in services, and using then nurses that should be hired? And what about nurses not being there? What will the law be saying on that situation if there is no nurse that can be hired? Therefore, we thought about some ideas and ranges. But we expect our calculation and our statement on that if and when the law is really written. And we can have a look on what happens then.

Ralf Kuhlen: Maybe if I may, before going into your second question on, is there a natural end to all this, one comment on the nursing aspect. What actually is a nurse? By law and by all the discussions, we are saying a nurse is a nurse. That would be the same as saying a doctor is a doctor. But we know that all the medical aspects in a hospital are driven by specialists. So nursing has specialized very much over the last 20 years. And actually saying and citing a nurse is a defined workforce doing the same all over the hospital is simply wrong.

And in the systems where we're looking into very, very good process, into very, very low lengths of stay, very good outcomes, nurses do pretty much of the job because they are highly specialized and they are highly trained on different items of what they're actually doing there.

Having one reimbursement for everybody there, hard to imagine. But the imagination in Germany simply is that the nurse is a general nurse, and that's what it is. But that is not at all reflecting day-to-day reality and not at all reflecting what actually should be. And I guess this is something they have not even thought about, to be honest.

Back to your second question, natural end of length of stay, just a story from my own training, a hip replacement was an operation taking approximately two weeks when I was trained as an anesthesiologist / intensivist. Everybody was lying on the intensive care. And it made sense because everybody was coming completely cold out of the operating theater, and blood loss was tremendous.

Today, due to technical improvements, due to new ways of doing the operation and due to new ways of preparing the patient, there are people in Scandinavia and the US doing it on an outpatient basis, not because they're completely away from what should be done, because you simply can do it. And on average, it's around four to five days in really good systems because everything is prepared. And the invasiveness of the operation came pretty much down.

So, whether there is a natural end, yes or no, I don't know where it really is. I cannot imagine that a liver transplantation will be done within two days. But once again, when I

started, it was like four weeks. Now it's down to 10 days in really good institutions. So there's really improvement.

Systematic hindrances and systematic obstacles are there when we're having the lower lengths of stay, the lower limit for the lengths of stay in Germany, and the reimbursement is decreased, pretty much decreased below that. Take tonsillectomy. You can easily do it on an ambulatory basis. The peak complication rate of tonsillectomies is anyway six days after the operation. So it doesn't make any sense to keep the kids for two days in the hospital because, if they're having a complication, it's happening six days afterwards.

But on the ambulatory basis, your reimbursement is tremendously low in Germany compared to inpatient. So here, the systematic approach is really giving you an end to this process optimization. And we have to talk about that to all the regulators. In Spain, you do very, very many cases on an ambulatory basis without any risk.

Markus Georgi: Thank you, Ralf and Francesco. Next one -- Michael.

Michael Jüngling, Morgan Stanley: Thank you and good morning. I have a few questions, firstly on the, Spain privatization hospital trend. When you bought this asset in Q4 of 2016, we really have seen no consolidation. And I'm curious on a few fronts. Firstly, how would you describe the consolidation in the Spanish market today? Are you missing out on assets, or is it just the market's very, very quiet? And how would you view your pipeline over the next 12 months?

Then also on Spain, during the financial crisis, we saw a really big uptick in insured patients, which helped Quirónsalud. Now that the Spanish economy is improving, would you expect there to be a reduction in the insured lives as the government has more money and reinvests money into the public system?

And question number three is in relation to the comments made about geographic expansion. Can you comment on what you are looking for geographically, but also what you're looking for in terms of the types of assets? Are we talking here about primary care as well? Is it only secondary care? Is it controlled by the borders of Europe, or would you also go beyond Europe?

Stephan Sturm: Good old Michael, always ahead of the curve. So I take it everything that was discussed about Germany is entirely clear to you, hence only questions about Spain, trying to preempt what Héctor is going to say in a few minutes. Make it short, please, okay, because much of it's going to be covered in your presentation.

Héctor Ciria: Okay. So first question out, opportunities in Spain, the market, especially in the private segment was very fragmented several years ago. But I'm going to show later that it's still quite fragmented. So there's still significant opportunities to grow, in particular in some areas of Spain. And I will show that later. And actually, we are working on that. And we have a solid pipeline of potential acquisitions. So the first question.

Second one, in terms of how the financial crisis could have affected more people going into the private segment. There is a piece of data that I'll share with you that basically shows that, over the last 10 years, and this throughout different business cycles, the private healthcare segment has been growing at about 4%. That's top line growth market. And we continue to expect the same growth rate of 3%, 4% for the next years.

So I think it could be affected in a positive way that that crisis you're talking about. But I think the growth in the private segment has been quite solid throughout different cycles. And we expect that to continue at least for the next coming years. I'm going to show you some figures on that as well.

Stephan Sturm: Thank you, Héctor.

Francesco De Meo: And I take over your question on the next regional steps.. I will come back to that at the end of this day, showing you our criteria to select targets and markets. So I think you can then think about from your best known targets and markets whether they could fit to our criteria. I will not talk about our status in that thinking today. But I will show you the criteria. So I think you will get, let's say, an impression, some kind of touchpoint to think about what could be the next steps.

Markus Georgi: Thank you, Francesco. Given the fact that we'd like to enter the 15 minutes' break and another three Q&A sessions following over the day, one last for this round. It's Lisa Clive?

Lisa Clive, Bernstein: Hi, thanks. Two questions. There was one mention in all those slides about the Helios Plus Card. I remember when this was introduced a few years ago. There was a lot of excitement, hopes that it could bring more patients, increase volumes. How has that program rolled out? And what should we expect in the future?

And then second question, Francesco mentioned at one point Da Vinci and how purchases of capital equipment like that, there's some sort of funding from the state. Can you just explain that system a bit more and how we should think about adoption of new technology? Robotics is obviously a very big and growing field. And so just thinking about how you view those technologies and your ability to buy them within the next few years.

Stephan Sturm: HeliosPlus is for you, Francesco?

Francesco De Meo: Yes and also the technology question.

Stephan Sturm: Yeah, well, Ralf's going to help you on technology.

Francesco De Meo: Yeah, because it's a big point, really, because the decision on technology is not made only on management level, looking on the economic view. For us, it's more important to make a difference between a real innovation and a nice-to-have thing for doctors.

And if nice-to-have -- Héctor will talk about that later on -- is paid, okay, it's nice-to-have for the doctors and paid. But if nice-to-have is not paid, it makes no sense to do that. So I will come back to that also later.

So therefore, my example on that was, for example, Da Vinci. We were the first with Da Vincis in Leipzig, for example, the heart clinic. Some 15 years ago, they started with that. They tested whether it takes to better quality in heart surgery. And at the end, they saw it does not bring more quality. And so they gave Da Vinci back because, as said, it makes no sense on the quality level.

However, Héctor will tell you that, on the Spanish market, it is very important to be in there because it's a real competitive advantage in making patients come to your hospitals. And it is financed by that because you get the payment for the patients coming in. And that's a different situation.

So it will be I believe on the same track. We'll have the technology progress and innovation. But we will be discussing it more from a medical point of view, whether something is no innovation but nice to have. An example from Ralf, and then I continue with HeliosPlus.

Ralf Kuhlen: Maybe a good example to apply the principles of evidence-based medicine. If you would go through this, then you would ask the question whether the technology,

take the Da Vinci, is doing something better or more effective than any comparison. And all those data are so far not really positive.

Now here, probably the different system approaches come into play because we were thinking very much about evidence base. Is it better? Do we have to have it? Is it gaining some new insights, some new benefits, some new outcomes? If the answer was no, we were saying, "Okay. Then we don't use it." There is no evidence that you should not use it. So all the data are very comparable to conventional approaches.

Now in a market where marketing issues come into play and where you can really do marketing with that technology, it's not by any means worse than the conventional technology, fine. If this is even refinanced, even better.

In Germany, with all those aspects you've seen in the last slides,we are pretty much saturated in general terms, the marketing issue was not that pronounced during the last years. That might change now because, if the size of hospitals is becoming bigger, if the number of hospitals is decreasing, marketing might play a role to steer the patient to go into the one or the other hospital. And we really need to assess this.

So far, it has been based on evidence. And evidence for, in general, not only Da Vinci, robot-assisted surgery is not that strong. So there's not really a reason that you have to have it. And I think, in Spain, that was always different because they have the marketing aspect. And we do it because then we attract patients to come here was much more pronounced. And once again, there is no evidence against it. And the concept of non-inferiority is something we never took very serious, but you can take it serious.

Stephan Sturm: Thank you, Ralf.

Francesco De Meo: On HeliosPlus in short, HeliosPlus started as a program for our employees in Germany. So it was to give them something that, if they have some needs as inpatient, they are treated at the highest service level in our own hospitals. That is the idea, and that works very well. It is appreciated by our employees.

And for us, it brought more patients coming from our employees because, sometimes, in former times, they thought to go to another hospital, not because of quality, but as you can imagine, if you go to your own hospital, the question of, "What are my colleagues thinking about that, and who knows about me being ill, and who knows about my inpatient status?" was often a question. So that's running fine and well because it's very important to offer such things as a service for the employees.

We thought that that could be also a good idea going outside with that idea and making people coming into our hospitals or even the Rhön and Asklepios hospitals in that kind of "Wir für Gesundheit" networking. And there we saw that that's not so much convincing. It is okay. There are some companies using it, but it is only convincing if you can offer the outpatient services also in the system.

So we started then to go from Helios Plus -- that's an inpatient service approach – more to an approach including outpatient service. So we used our opportunities also in the outpatient services because, for the Germans who don’t work at Helios, it is very important to bring their employees very fast to the doctors in the outpatient world.

So that works very well. But to make more patients come in, you see we must follow the strategy to go into the outpatient sector. Only if we are very present there and can offer that with our capacities, and that is to really try to overcome the boundaries, then we are able to attract even more patients with that concept.

At the moment, only focusing on inpatients and offering some to the extent with our outpatient centers [Medizinische Versorgungszentren - MVZ], that's okay, but that's not

the growth perspective we expect if we were able to go more to the outpatient sector. And that's what we learned also from our colleagues in Spain because they are already there. And therefore Franzel mentioned it on one point. Therefore, we started to think about outpatient concepts and offering such services on the outpatient level also in Germany.

And we started with digitalization to be attractive to that level to the outside world. But the most important thing is we must go with that concept to the outpatient world because that's the most important thing also for other companies that the people are soon treated in the outpatient world and come back to work.

Markus Georgi: Thank you, Francesco. Let's go for a 15 minutes' break. We'll be back here at 11:00 for the deep dive into the Spanish hospital market, which is followed by the next Q&A session. Thank you.

BREAK

Markus Georgi: Thanks being back, and now I'm proud to hand over to Héctor Ciria, CEO of Quirónsalud. He will provide us with a promised deep dive on the Spanish hospital market. Héctor, the stage is yours.

PRESENTATION: Quirónsalud Overview

Héctor Ciria: Okay. So it's a great pleasure to be here with you today. Thank you very much for your interest in Quirónsalud. So you already know this Rainbow. So today, we are going to be talking about Quirónsalud.

So starting with the takeaways, Quirónsalud is a leading Spanish hospital group. We'll explain that hopefully the leading group not only by size, also by other features. The Spanish market, as Francesco was explaining, has many different financing models. And actually, at Quirónsalud, we work with basically all of them, which I think is an interesting feature that you will understand later.

We have many different opportunities for growth. I think, in all the three main growth avenues, organic growth, inorganic growth, and also new openings, we will discuss that. And for management, there are three areas that are absolutely top priorities. One of them is guaranteeing always the maximum medical quality, also making sure that we continue to improve day by day our patient experience, and thirdly, digital transformation. Also, this will be covered in the presentation.

So since this is the first time that we are presenting Quirónsalud to you, we will start introducing the management team. Then we'll give an overview of both the Spanish hospital market and also the Quirónsalud group. And finally, we'll share with you some of the growth avenues that we expect for the next years.

So going to management team, our Nonexecutive Chairman is Mr. Victor Madera. He's the Founder of the company. He's been in the group for 20 years. He's chairing the Spanish Quirónsalud board. And obviously, he's the person who has done the most to build and shape what Quirónsalud is today.

Myself, Héctor Ciria, I am the CEO. I joined the company six years ago, back then as CFO and also head of strategy and corporate development, have been very involved over the last years in the intense amount of activity that the company has gone through, especially in the consolidation of the private hospital market.

In the team, we have five support areas and three operating areas. The support areas is: Finance and Control is led by Miguel Mascaró. Then IT and Digital Transformation is

responsibility of Adolfo. You will know him today. He's there. He's an engineer. He's been in the company for seven years. HR Talent and Organization, this is the responsibility of Juan Carlos. Juan Carlos has been for 20 years in the company in many different positions. Communication by Julio Fernandez, Julio also in the sector for three years. And then Leticia Moral, she's here. She will be presenting a section on Quality. And you've been in the sector your entire career. She's a doctor.

Then we have three operating areas or three COOs. First one, the COO for Private Hospitals, in charge of 40 hospitals is Pedro Rico. He will be presenting to you today also. He's a doctor in internal medicine. Then four large public hospitals are the responsibility of Juan Antonio Álvaro. He's been in the company for 15 years. And then we have a new business unit, Occupational Risk Prevention. This is something which has started three years ago. And this is led by Fernando Camino, who's been for more than 20 years in the prevention sector industry. So overall, this is some a pretty experienced management team with many years working in the sector.

So let's now move to the Spanish hospital market. So starting with just some macro figures, if we compare Spain versus our European peers, in terms of total healthcare expenditure, in Spain, we're spending 9% of total GDP on healthcare, which is basically in line with our European peers. But if we look at healthcare expenditure on a per capita basis, which is the next figure, you can see that we are significantly below, which could indicate that there is some growth potential.

If we then look at physicians, how many physicians we have, it's basically in line with the average in Spain. So, so far, there is no scarcity of physicians or scarcity of nurses. Maybe in the future, there could be a bit of scarcity in doctors. But as of now, this is not the case.

And then in terms of bed density, the figure we have already discussed, clearly, there is no overcapacity of beds in the Spanish market. We have three beds per 1,000 inhabitants, which is significantly below the average and significantly below some of our European peers.

Moving onto the Spanish healthcare system, this is -- we call it a duplicative model or a dual system because we have -- on the one hand, we have the public system, and on the other hand, the private system.

And as pointed out before by Francesco, those systems are additional. There's not one instead of the other one. So the public system covers the entire Spanish population, 100% coverage of our population, which is 47 million in Spain, is basically for free for the Spanish patients. There are basically no copayments and is financed through taxes. (inaudible) percent out of the total 9% of GDP expenditure, 70% of that expenditure is covered or paid or financed by the public system.

Then on top of it, and that's an additional system, we have the private system. The private system accounts in total for 30% of total expenditure. And in the private system, we have 10 million people, so 20% of the Spanish population that have a private insurance that goes on top of the public system. This private insurance is paid by users, who decide to pay themselves. Sometimes also the companies they work for, they pay for the private insurance.

And when compared with some other countries, the expenditure in private insurance is quite affordable. So on average, it's €770 per year per user the amount you have to pay to get your private insurance to have access to the private system.

Why do people decide to pay a private insurance by themselves if they can go to the public system for free? So basically, for the reasons that we are sharing on the slide. In the private system, you have shorter waiting times. You have direct access to the

specialist doctor. You don't need to go through the GP. You can go straight. You have freedom to choose the doctor you want to be seen by. And generally, you have more comfortable hotel services.

So in a way, the private system is actually supporting the public system by releasing resources. So people who decide to pay in order to go to the private system are actually not using the public system while they still pay for it through their taxes. So it's a way of supporting that -- the public system.

I'm going to spend a bit of time on this slide. Just to give you some big numbers about the size of the market, the Spanish GDP is €1.2 trillion. We've said that 9% of the Spanish GDP is spent on healthcare. So total healthcare expenditure is about €100 billion.

If we then try to segment how much of this size -- how much of this market is what we call care delivery, the care delivery market, and care delivery meaning medical services, hospitals, and leaving out pharmacy, leaving out elderly care, leaving out home therapists, so the care delivery market is about €60 billion. These are ballpark numbers.

And we can split this in the two systems I just mentioned. So the public network, which is about €45 billion, the public network is where basically patients go as a public patient, and they don't need to pay and consists of primary care centers, all the GPs, and also 286 public acute hospitals. I'm leaving out psychiatric hospitals and other kind of specialized hospitals. Actually, out of those 286 public hospitals, there are some PPP models among which we at Quirónsalud are managing five hospitals under different PPP structures that are integrated within that public system.

On top of the public network, you also have as a parallel system the private network. The size of that network is about -- of that market is of €14 billion. And there, you have outpatient medical centers. And we have 290 acute hospitals in the private network, out of which we own and manage 39.

So if I now -- if we now do assume of this €14 billion -- and I'm talking about this because, obviously, it's our largest portion. It's the area we're most interested in. In this €14 billion market, there are basically three types of players. You have on one hand medical centers, outpatient medical centers. It's 27% of this market, about €4 billion. And these players actually compete with us because, as it has been explained, we at Quirónsalud do a lot of outpatient activity. Actually, about 50% of our activity is outpatient. We also have in this market not-for-profit hospitals, hospitals that are by charitable organizations, by the charge by foundations, and they also compete with us.

And then finally, €6 billion consists of for-profit private hospitals, like it is the case of Quirónsalud. If we look in these for-profit hospitals which are the payers, in all the hospitals, there are three types of payers. The most important ones are health insurance companies. It represents two-thirds of the market. Second type of payer is patients that decide to pay by themselves out of pocket, so self-pay patients. And also, you can have income in the private network coming from the public administration because, when the public administration cannot cope with all of this demand in the public network, they tend to outsource and send some patients to the private providers. So at the end of the day, there are these three types of payers in the private system, health insurance companies, people that pay out of pocket, and then some outsourcing from the public administration.

So in summary, where are we in Quirónsalud? So we have five PPPs in this large €45 billion-plus market in the public network. We have another 39 hospitals in this €14 billion market. And then we also have a business unit which is the ORPs, the risk prevention, which is not on this slide because it's a different market. I will address it later.

Let me now focus on this soft segment, the for-profit hospitals. I'm focusing on this one because, obviously, it's the most important one for us, but also because it's the subsegment where we have more data. There are three main messages I would like to share with you. And I come back to one of the questions that was raised before.

First message is that this subsegment, the for-profit private hospital market, has been growing over the last 12 years at a rate of 4%, so very solid growth. And it is expected to continue growing at at least 3%, 4%. Actually, in Q1 figures, the market grew 5%. So we continue to think that there is significant growth there.

Second important message is that this sector is growing -- is outgrowing the GDP growth in Spain, no matter what economic cycle you look at. So here, you have three different economic cycles. In all cases, the hospital, private hospital market grew more than the GDP in Spain.

And the third important message is that, who is driving this growth? So out of the three types of payers, the one that is growing the most is the health insurance companies. And health insurance companies have been growing at 5%, and they continue to grow at this rate. Okay. So these are the three main messages I wanted to convey.

So with that, let's move to an overview of Quirónsalud. Quirónsalud is the largest hospital group in Spain in a market that is still quite fragmented. As you can see -- sorry, as you can see on the right-hand side of the slide, we are the largest hospital group, but there are still many others, many other players in the country.

In 2017, total sales were about €2.8 billion, representing 10% growth, out of which 6% was organic. We have more than 100 healthcare centers in Spain, out of which 45 are hospitals with a bed capacity installed of 7,000 beds. We have 40,000 professionals working in our centers. We'll talk about that later. And through our ORP unit, Occupational Risk Prevention unit, we have more than 300 centers distributed across the Spanish geography that allow us to have direct access to 5 million workers.

We have a strong commitment with quality, with education, and with innovation and research. Actually, when mentioning education, out of our 45 hospitals, we have eight that are university hospitals. And we are also present in Latin America through an acquisition we did last year in Peru. We have one hospital in Lima that so far is giving very good results.

It has been already discussed in several presentations that the Spanish system is quite different to the German system. And one of the main differences is that, obviously, in Spain, there is a continuum between the inpatient sector and the outpatient. We do all of them in the same setting, in the same hospitals.

And you can see that in the slide that, when we look at some important KPIs, some volume KPIs, for instance, in 2017, we had 8.6 million of outpatient consultations. We had 2.6 million of emergencies. All of those are outpatient cases. Obviously, we also have inpatients, 1.5 million of patient days, and average length of stay of 4.3 days, which is below the average in Spain. So the main point I wanted to raise here is that these are big volumes, and the outpatient volumes represent about 50% in total of our revenues, which is significant different and a structural difference versus the Germany system.

If we look at the history of Quirónsalud, we can say that it's a history of growth. And actually, growth is in our DNA. If we look, for instance, from 2000 until today, the company has passed from four hospitals to 45, from €30 million revenue to close to €2.8 billion. And this growth has come from all the different growth sources we have. So growth has come from organic growth, typically above market growth, also because we have been expanding our hospital base by opening new hospitals, new greenfields, we

did 10 of those during this period, and also through acquisitions. We have done more than 25 acquisitions over the last 17 years.

Actually, if you look at the last four years, you can see that there was a significant expansion in these four years. We more than tripled the size of the company. And this growth was mainly driven by -- actually by acquisitions. We did 20 acquisitions in that period, basically by being the leaders in the consolidation of the Spanish hospital private market. Let me explain a bit about these four years because it's important to understand what we did also to try to see what we are going to do in the future.

So what happened over the last four years? Well, as mentioned, M&A played a transformational role. And we did 20 acquisitions in about four years. If we try to put them in -- to structure the conversation, if we try to put it like in three buckets, there is one important type of acquisition that happened was the combination of idcsalud and Grupo Quirón. This basically was the merger of the two leaders in Spain, idcsalud and Quirón, and the resulting company was Quirónsalud. That happened in 2014. And really, that was transformational for us as a company.

On top of that, we did many acquisitions, where what we were trying to do was to acquire the best possible hospital, the most prestigious hospitals in their respective local markets. This industry is an industry that it has a lot of economies of scale, but also, it's quite local. So it's important to have the best possible doctors and the best possible hospitals in every city, if possible, of course. So we did many of those acquisitions to improve our position in some local markets. In particular, we acquired Grupo Ruber in Madrid, Clinica Rotger in Mallorca, or Policlinica Gipuzcoa in San Sebastián, just to mention a few.

The other thing we did in 2015 was we entered into a new market, which is the risk-prevention market, and we acquired four companies and later on another two. And by acquiring these six companies, we created the leader in the prevention sector in Spain, and we named it Quirónprevencion.

So all of this is what happened over the last four years. When doing that, we created quite a lot of value. And we achieved about €100 million of annual synergies. Most of these synergies have already been realized, and they are in a steady state. And obviously, the synergies came from many different sources. The main was procurement. Also, we internalized many services in the acquired hospitals that used to be outsourced to third parties. We internalized that with our in-house resources. And with that, we got many savings. We also got savings in headquarters. And obviously, the integration of six ORP companies gave us the opportunity to rationalize the network and get some savings there as well.

It's important to mention that, even if most of these synergies have already been realized, not all of them have hit our accounting yet. But also, the most important thing is that, after all of these acquisitions, the company has developed a culture of looking continuously for improvements and looking continuously for efficiencies. And we actually have a team that is just dedicated to that, which is the team that used to be searching for those synergies when we made the acquisitions.

So after all this growth, we are left with a company that we really can say that it is a people company. And it's a people company because we have more than 40,000 professionals working in our centers. Out of those, 32,000 are employees, and about 8,000 are mercantile doctors or freelance doctors that come to work to our hospitals.

75% of our employees are female, and 74%, so three-quarters, have indefinite contracts. This for us is very important because having indefinite contracts means that we have stability in our workforce. And given that we spent significant resources to train

our people and to try to explain the culture we want, it's important to have stability in that workforce.

We are among the top 10 employers in Spain. And a challenge that we are addressing right now that is not sorted is that, obviously, after this significant growth, in the company, we have still many different cultures. We have people coming from many different backgrounds, and we are making a significant effort to try to build one company and not be just a conglomerate of different hospitals.

This is the reason why, three years ago, we developed our internal corporate university. We call it Quirónsalud. And in this corporate university, what we are doing is we are trying -- we are putting together people from all of our hospitals. They come from different backgrounds because they used to belong to different companies. We are training them. We are identifying leaders. We are trying to make sure that we exchange best practices. And at the end of the day, what we also want is that people know each other because that makes things much simpler. And it's a way to try to have one single culture in the company.

For those of you that don't know Quirónsalud much, let me tell you that we have prestigious hospitals in almost every large Spanish city. Actually, if we look at the top 10 Spanish provinces, and I talk about provinces because, typically, the catchment area of a hospital is not just the city, it's the province. In the top 10 Spanish provinces, we are in all of them. So obviously, we're in Madrid, Barcelona, Valencia, Seville, Málaga, (inaudible), but we are also in Zaragoza, in Mallorca. So we basically are in all of them.

And as a result of this presence and as a result of the prestige of many of these hospitals, we often have in our hospitals many celebrities that you might recognize some of them from the pictures. So maybe you recognize Cristiano Ronaldo, Messi, the royal family, Fernando Alonso or Rafael Nadal, all of these guys. We often find them as patients in our hospitals.

We've mentioned that there are three areas that are top priorities for us as management. One of them is top quality, medicine quality. Second one is patient experience. And the third one is digital transformation.

In terms of healthcare quality, it has already been discussed, and I think there is a session by Leticia and Andreas that will talk about that. So I don't want to spend much time on this. But just to maybe share an example that we are very proud of, only three weeks ago, we received at one of our largest hospitals in Madrid, Fundación Jiménez Díaz, we received a very prestigious international award for its excellence that was given by the European Foundation for Quality Management.

The hospital received the five-star recognition for excellence with a score of 650 points, which means that, in Spain, and I think also in Europe is the maximum score of a hospital of the category of FJD. So obviously, this makes us very proud. And we have to say that this doesn't happen by chance. This team has been working for more than 15 years to try to improve day by day the quality and the processes. Similarly, we have a joint commission recognition in some hospitals.

And in terms of patient experience, similar idea, we also work on a daily basis to try to improve our patient experience. When we talk about patient experience, this means many different things. This means, at the end of the day, that our patients are happy. But in order to get there, we need to work on many different areas, which means caring for them and treating them in the right way, which means smiling to them, offering them all the information they need to feel at ease in our hospitals, making sure they don't wait too long when they come to our hospitals, making sure that the food is right at the right time, that everything is clean. So there are many different things to try to get satisfaction in our patients.

We recently collaborated with Cleveland Clinic. You know Cleveland from the US. They are experts in patient experience. They came to our hospitals to try to identify areas of improvement. We are also monitoring on a daily basis the NPS, net promotion score, for our hospitals. We benchmark our hospitals to see how well they do. And we incorporate the NPS as part of the incentives of our managers because we want to make sure that our patients are happy. And well, these are just some of the few initiatives that we are doing to try to continuously improve on patient experience.

And I said that the third important priority is digital transformation. Digital transformation is a must. This will be explained later by Jörg and Adolfo. If we don't do it, someone else will do it. And this is not something about IT. This is a corporate project. We better make -- we better take advantage of the new opportunities we have with the digital tools to improve our operations, or otherwise, we will be left behind.

I don't want to spend much time on this because there will be a session. But just let me tell you that we are trying to get many benefits from digital transformation. First of all, it should allow us to standardize and to automate many processes. And standardization means not only improvements in efficiency, but also improvements in quality because clinical outcomes are much more homogeneous once we are sure that we are making the processes in the best possible way.

Also: improved patient experience because we have a direct connection with the patient through, for instance, our portal patient application. It also mean growth opportunities because there are new business models that we can develop. And also very important, again, human talent. People like -- if we want to attract people, if we want to retain people, we need to show that we are a modern organization that is embracing the new digital world. If we don't do that, many talents won't like to be with us, and they will go somewhere else. So even for a human factor, it's important as well to work on digital.

Talking about equipment, and there have been some discussions about this as well. We invest a significant amount of money in our hospitals to make sure we have the latest available technology. And why is that? Well, obviously because it is in the benefit of our patients, but also, and this is also very important, because the patients want to be treated by the best doctors. And the best doctors want to have the best technology.

So for instance, talking about the Da Vinci robot, it's not only marketing. It's also that the best doctors want to have that technology available for them. At least in Spain that's the case. So it's a way also of retaining the best physicians.

Just to give you an example, we have all kind -- we have 86 MRIs, out of which we have many of them being (inaudible), all sort of multi-sliced CT scans, linear accelerators, five Da Vinci robots. We have one gamma knife, one cyber knife to treat cancer.

And actually, the most important investment we are going to make over the next months in medical technology is the -- we are going to open the first proton beam therapy in Spain. Hopefully, it will be open by Q4 2019. And this is the most advanced technology to treat cancer. We are very proud of this project because this should allow us to bring to Spain a technology that is not available today. And obviously, we are putting a lot of effort to make this happen.

Rather than me explaining what proton therapy means, I would like to share with you a video talking about this technology.

[Video plays]

Male Voice: Cancer continues to be one of the most pressing challenges facing the scientific community worldwide. However, research, technological innovation, and the

efforts of medical professionals are creating increasingly safe, effective, and personalized treatment options.

This is the case with proton therapy. This treatment, currently available in only 23 centers throughout Europe, will be available for the first time in Spain in 2019, offered by Quirónsalud.

The new Quirónsalud proton therapy center located in Madrid will meet the growing demand of patients who require safer radiotherapy treatment with fewer side effects.

A new and modern center, equipped with cutting-edge medical technology and created with painstaking attention to detail, will offer each patient utmost comfort during their treatment.

The facility features all the necessary technology for tumor treatments, all in a single multifunctional room. The proton therapy system, called Proteus 1, allows oncologists to deliver the most precise dose of radiation exactly where the patient needs it.

This system utilizes the most advanced equipment for imaging and treatment planning and can also rotate around the patient to direct the proton beam from any angle. Thanks to the physical properties of protons, proton therapy is currently the most advanced and safe radiotherapy technique for the treatment of certain types of cancer.

Some of its benefits include minimal or no radiation around or near the tumor, a lower total dose of radiation per treatment, a significant reduction in secondary tumors, and an improvement in quality of life.

Applied in specific doses, the protons can act with precision inside tissues, achieving greater anti-tumor activity and causing less damage to healthy tissues. That is what makes this therapy especially indicated in pediatric patients and for certain types of tumors.

With this new proton therapy center, Quirónsalud is moving to the forefront of oncology, offering the widest array of cancer treatments in all of Spain. This is yet another example of the company's continued commitment to research, quality of care, innovation, and above all, its commitment to people's health. Quirónsalud, health person by person.

[Video ends]

Héctor Ciria: Okay. Hope you liked it. Let's now move to the next section, talking about the different business units we have at Quirónsalud. So if we simplify a bit the world of Quirónsalud, we have three sorts of business units. The most important one, obviously, is the hospitals, is our healthcare services. 88% of our revenues come from hospitals.

Second division is the prevention, the ORP division. It's 12% of total revenue. And the third one, which is quite important, but in the interest of time, I won't explain it in depth, is what we call the transversal units. Transversal units for us are subsidiaries of Quirónsalud 100% owned by us that provide services internally to our hospitals and to our ORP network. So for instance, in these transversal units, we have health diagnostics. This is our internal laboratory. We do the laboratory in house. And just with our volumes, we are the largest laboratory in Spain.

Similarly for bepers, bepers is a company that is doing the non-healthcare services for our hospitals, like cleaning, maintenance, cafeteria, kitchen. All of those services are done by bepers. We also have there our central purchasing unit, our corporate call center, etc.

So if we now go to -- if we spend a bit of time on the hospitals and the ORP, what you can see is that the largest contributor in terms of revenues is the private segment, just health insurance companies plus the self-pay represent about 60% of total sales, while the sales that are coming from the regional government, so the public administrations, is about 30%. I'm going to go now to each of these building blocks.

So starting with the private activity, in the hospital private activity, we have two sources of income or two types of payers, the most important one being the health insurance companies. We have agreement with them all. We work with all of them. 90% of those are domestic Spanish health insurance companies, but we also work with international health insurance companies, particularly to cope with international tourism and with the travel segment. And as mentioned, we have one hospital in Peru. So that also fits into this 10% of international health insurance companies.

If we talk about the Spanish health insurance companies, they have been growing, I explained that at the beginning of the presentation, historically at 4%, 5%, and they continue to do that. The top five, you have them on the screen, Adeslas, Sanitas, asisa, DKV, and Mapfre. They control about 80% of the markets here of the health insurance companies in Spain. And today, we have established a win-win relationship with them. We actually need them, but they also need us. And we are really working together to try to improve the quality of service we offer to our private patients in order to increase the pie for everyone for the health insurance companies and for ourselves.

We also have about 11% of our revenues coming from self-pay, people paying out of pocket. Why do people come to our hospitals and they pay by themselves? Typically three reasons. Some cases is because they don't have a health insurance plan. And obviously, if they come to the private network, they need to pay. Second reason is because sometimes the health insurance plans don't cover all the different treatments and also because there are some doctors that are only looking at private patients.

Having this percentage of private self-pay patients means that our hospitals are seen -- are highly regarded by the Spanish populations. Otherwise, they would not come to us because they have other ways to go to the hospital sector without the need to pay out of pocket.

If we now move to -- and this represents, as mentioned, 60% of our sales. If we now move to the public activity, in the public activity, we should distinguish between two different worlds. The first one is long-term contracts. And long-term contracts are related to hospitals that operate or are integrated within the public network. This is where we have the PPPs. And also, there are short-term contracts I will address later.

So if we first talk about the long-term contracts, as we have mentioned, we have five hospitals, four in Madrid, one in Catalonia, that are integrated in the public network. By that, what we mean is that they have a reference area and that the public patients can go there for free. These contracts are different. There are some of them that the reimbursement is based on capitation. In some other cases, it's based on activity or on DRGs.

The length of the contracts is also different between Spain and Catalonia -- sorry, between Madrid and Catalonia. In Madrid, these are typically 30-year contracts. In Catalonia, it's 10 years. And the ones in Madrid which are the largest ones, the expiration dates are between 2036 and 2041. So they are quite long, and they won't expire until the next 20 years or so.

Another important difference between Madrid and the one in Catalonia is that, in Madrid, there is a free choice system, which means that any public patient can decide to what hospital they want to go. They can decide to come to our hospitals or go to another hospital.

We also have short-term contracts. And this basically means that the public administration, when in their hospitals they cannot cope with all the activity and they have very high waiting list, typically, they outsource some activity to the private network. This happens in many of our hospitals. We work with many different regional governments. And typically here, the contracts are shorter in time. They are two to five years. But this is also an important source of income that all private players have.

Something that is of the utmost importance is that we always do our best to offer to our patients and, in particular now that we are talking about public patients, that we offer to our public patients the best possible medical quality and also the best possible patient experience. We discussed that.

This -- and I wanted to share with you some figures that are publicly available that are not done by us where our four PPP hospitals in Madrid are compared with the rest of the Madrid hospitals in the public network. And what we can see is that, year after year in the surveys that are done by the regional government of Madrid asking the patients, the public patients how happy they are with the hospital network in Madrid, our four PPP hospitals, they are always leading the rankings in terms of user satisfaction. For us, this is something we put a lot of effort, and it's very important.

So to show you the latest figures from 2017, these were published only a couple of months ago, for instance, in -- sorry, in Madrid, the public hospitals, they are distributed in three different groups, depending on complexity. Group 3 is the most complex one. There are eight hospitals in the Madrid region. We have one hospital, FJD, which belongs to this Group 3, maximum complexity. And it's ranked number one by users in terms of user satisfaction.

Group 2, 13 hospitals in the region, we have two in that group. They have been ranked number one and number three. And in Group 1, the minimum level of complexity, our Hospital Infanta Elena is also ranked number one. And as you can see over the last years, this is not something that happened only in 2017, but this has been the result that we typically achieved over the last years.

Moving onto the final section, which is the ORP unit, this is a unit that we created recently in 2015 by acquiring different companies, putting them together, and creating Quirónprevencion, which is the leader today in a market of a size of €1.3 billion.

This segment, the ORP segment, is interesting for us because it offers growth opportunities. First of all, we think the sector -- so we think the prevention sector is a sector that is growing. And it is growing because there are some macro tailwinds. So the Spanish GDP is growing, and also the unemployment rate is being reduced. The more people that are in the workforce, more risk prevention we have to do through our ORP unit. So just the unit itself is growing.

But for us, what is also very important is the opportunities, the synergies we have between the ORP unit and our hospitals. Why is that? Well, because through our ORP, we are covering the health and safety of 5 million workers in Spain, which is about 25% of the total workforce in Spain of 19 million I believe. We are doing 2 million medical checkups per year to those workers. And obviously, when that happens, we found in some cases that there is the need for some medical, additional medical treatment. And obviously, we can do some cross-referral to our hospital network.

Some of these medical services in the ORP are provided by Quirónsalud, by the hospital segment. And the last point I want to raise is that the clients of the ORP business are corporates. And for instance, among the top 35 companies in Spain, the Ibex 35, we work with many of them through our ORP unit. And this opens us the door as Quirónsalud to go directly to the large corporates in Spain, like Telefonica, Inditex,

Iberia, Endesa, to go there and offer them also a hospital or medical services. So that's an interesting division for us that has many synergies with our hospital network.

This has been discussed. My only sentence here in terms of the integration with Fresenius Helios is that we are happy. I think integration is on track. The German tanks have not come. And I would say this has been a promising start, where I think we are both trying to find the right equilibrium between the differences, but also trying to find what the opportunities are and trying to exchange best practices. So there will be a lot to be talked about this area. I won't say anything else that I think it has been a very promising start.

So moving onto the last chapter about growth opportunities. As it happened in the past, we continue to think that we have growth opportunities both organically, inorganically, and through new openings. Talking about organically, well, first of all, we think we will continue to grow. And we are growing because Spain is growing as an economy. So obviously, those are tailwinds we have.

Spain is growing at 3% in the past. It's expected to grow 2.7% this year. And as I mentioned at the beginning of the presentation, the private hospital market, the market we are in, is also growing at 3%, 4% -- it has been growing at 4% and is expected to continue growing 3%, 4%. So just by macro reasons, we have some positive drivers.

We think we can grow in all the business units. In the public segment, a bit more moderate growth, but the growth will come thanks to the quality of services and also thanks to the free choice in Madrid. In the private segment, we expect to continue growing our market. And this is thanks to our relationships with the main health insurance companies and also because we are doing some expansion projects in some of our hospitals. We are increasing capacity in some of our hospitals.

And in the ORP division, as mentioned, there is a positive cycle that we are running now in Spain. There is less unemployment or more employment. We can also do some referrals with our hospitals. And there are still some opportunities that we have not fully exploited when combining the six companies we acquired. This is in terms of top line.

In terms of bottom line, I won't go into details, but there are also many opportunities that we can still do. Just to give you an example, after all the M&A we did, we still have I think, Adolfo, 12 different ERP systems coming. These are legacy systems. So we are working on integrating them. Obviously, this is not efficient to have 12 different systems. So we are working also on having some shared services centers to be more optimal in the back office.

We continue to internalize some services into our transversal units. This would be for further efficiencies. And as mentioned, we have a team that is just working continuously for more improvements. So this should help us also in increasing the -- in growing the bottom line.

In terms of new openings, there are five new openings that we expect for the next three years. The most imminent one is the opening of a completely brand new hospital in Cordoba. We just announced it last week that we are going to open this hospital in September. And we are very happy about it. And we hope to do it really well because it will be our first hospital in that city.

We just discussed about the proton therapy center, which should be available for the public by the end of 2019. We are also planning on building a new hospital in the area of Alcala de Henares by 2020. We're expanding our largest hospital in -- our largest private hospital in Madrid portfolio. We are making a large expansion.

And also, there's another project that is quite interesting, Torre Vida, which should see light in 2020, which is in the financial district of Madrid. In Madrid, there are four large towers or four skyscrapers. And a fifth one is being built. And in that fifth skyscraper, we are going to open a large outpatient center focused on wellness and focused on sports medicine. That will happen in 2020. And we are also quite excited about this opportunity.

And last slide, coming back to one of the questions that was raised in the prior session, inorganic opportunities. We still think that there are significant growth opportunities by acquisitions in Spain because the private market is still fragmented.

And just to give you some figures, we mentioned at the beginning of the presentation that there are 290 private hospitals in the private network. We own and operate 39, but you see here the figures. Other hospital groups, they operate another 133. And then there are more than 100 independent hospitals. So we have a solid pipeline of additional opportunities. Obviously, a significant portion was done already, but there are still some more opportunities to come. And we are looking at some of them.

Finally, Latin America, last year, we did our first entrance in the market by acquiring one hospital Peru in the city of Lima. It's a large hospital, more than 200 beds. We are very happy about it. In the first year of operations, we have a performance that is above our expectations. And this could be something that we could continue to look at. In particular, there are some markets in Latin America that are serious markets that have improved regulatory conditions that are quite fragmented.

So in those markets, there are the possibility also to continue growing and that are markets that have a significant growth because the middle class is accessing healthcare. And therefore, they will be demanding more and more healthcare services. So that's an additional opportunity that we could look at.

So with that, this is everything I wanted to share with you, and then open for questions. Thank you very much.

Markus Georgi: Thank you, Héctor, for your presentation and the impressive movie.

Héctor Ciria: Thank you.

Q&A SESSION

Stephan Sturm: Before entering the second Q&A session, I've got some good news. All three coffee machines are working again. And therefore, I would like to ask you to be back after lunch on time. Next presentation slot starts at 1:00 p.m. And with that, I would like to open a second Q&A session. Hassan.

Hassan Al-Wakeel: Thank you. Hassan Al-Wakeel from Barclays. I have a couple of questions, please. So firstly, on length of stay, are there only structural reasons driving the difference in length of stay, such as the average age being higher in Germany relative to Spain, or do you see no reason for -- in five years' time, say, the length of stay to be similar in both countries?

Secondly, how likely is it to your mind that you'll get full reimbursement for minimum staffing? And in this case, could you recoup some of the costs that you've already invested in Q1?

And then one final question in terms of the pricing dynamics in Spain. Given the concentrated insurer landscape, what kind of pricing growth have you been able to achieve? Thanks.

Héctor Ciria: Maybe I can say something on length of stay. I think there is something that is structurally different, which is the inpatient/outpatient difference. In Spain, there's a full continuum. And obviously, the Spanish system has always worked like that. And the system is not only us. It's not only Quirónsalud. It's the entire system.

Whenever the patient is ready, sorry, to be sent home, it is sent home because it's not good to stay in the hospital just for the sake of it. Obviously, we can send the patient home as an outpatient. We continue to monitor his health while at home. And that patient can come in one or two days for follow checkups, for follow ups. So this is embedded in the culture of the Spanish system. And that is a very important tool that we can do. And I think our German colleagues, it's not possible because you don't have that continuum of care.

Ralf Kuhlen: Maybe one more comment. If you would compare the populations in general, there's quite differences. For example, in Germany, we have approximately 92% of all our patients through all German hospitals are statutory insured, 8% private. That's completely different in Spain. And there's an obvious difference between the privately insured patient and the statutory insured patient, even in Germany, lengths of stay being below for the privately insured patient for I guess obvious reason.

But if you would compare, as on one of the slides, cholecystectomy versus cholecystectomy, so one operation with one operation like-for-like, then population is really the same. So this is really mostly the systematic difference between the two systems.

Stephan Sturm: Hassan, on minimum staffing, appreciate the question, appreciate the interest. (Inaudible). Yeah, that's better. I'll do it the traditional style. Hate to be Brittany Spears anyway. Appreciate -- would you leave the stage, please? Appreciate the question, but as Franzel said, the legislation, in particular the implementation of the legislation, the fine print, that is still in flux, as you would expect for trying to influence it. But at the same time, we're preparing ourselves for the worst.

With regard to the CapEx to the investment that we're doing in order to prepare ourselves, as you know, we're working on the assumptions and have already done so that we need to carry this through the P&L. A glimpse of it you have already seen in Q1. It is also reflected in our guidance for the full year.

However, as you also have seen from Franzel's presentation, one of the core measures to offset that and to prepare ourselves for what's going to come is clustering in a larger concentration. And arguably, at least I would argue that this is something that should happen anyway, yeah? And it's going to drive medical quality. It's going to have us, I would argue, stand out even more in an increasingly consolidated German hospital market. And therefore, we're not working on the assumption that anything like this is going to come back to us, at least not directly from those who inflict the damage, but indirectly by incremental revenues and hopefully earnings in the outer years. Francesco, you want to add to that?

Francesco De Meo: Yeah, I don't take that, but I make you some three examples so that you can understand, Hassan, as we discussed also outside, that it's very important that it's not a minimum staff issue. It's the question about structuring organizational pathways in our hospitals.

So three examples, what's the investment we talk about? The investment is that we don't take a lot of money investing, as you know, from investments in builds or something like that. We invest in digitalization, okay, but the biggest investment is to have a look on the structures.

One example, intensive care units is an example. It makes you understand what happens with minimum staffing. As Franzel said, there was and is a minimum staff requirement regulated in Germany on the intensive care units. We knew about that some years ago. And then we had a look on the intensive care units and the beds being there. With that look, we saw that, if we had to fill the staff requirements with all the beds standing there, we would never be able to do that, and it will cost a lot of money.

However, we saw from quality reports and from studies that we are far away from the normal standard of intensive unit care beds because the traditional way was in Germany you got the money for that in former times. So you built that bed.

We started a project to reduce intensive care unit beds. And at the end, I think Andreas will take some of that, we saw we get a better quality with less beds. And now we meet with the same staff, being there some years ago, the requirements for the new staff. So the approach is not so easy digital. The approach is very, very structural thinking. And therefore, we prepare all to make an intelligent structure.

Second example, when we start to make the clustering, we have the discussions with doctors, with the very important doctors. If you say the doctor in Spain, you don't get something to play with on medical equipment. In Germany, you don't get the patient to play with because you make only three or four or five cases a year.

However, the doctor is educated that he is the doctor for that. And in his personal reputation, he thinks he should do that even if he is in a hospital not being prepared in future for such requirements. We started to make it, the pioneers doing it. They will lose doctors.

So our problem is that, at the beginning with that, we invest in loosing some kind of sales even because we are in controversial discussions with doctors, and doctors leave us going to other hospitals not being that kind of pioneer because, there, they can make the three or four cases, even at bad quality at the moment. So being pioneer means we invest in future, knowing that that may be negative with a negative impact today, second example.

Third example, lengths of stay, Ralf, a big, big, big thing. If we reduce length of stay, usually, we thought that, at beginning, we will get a lot of cost effectiveness and more, let's say, not efficiency only, but also EBIT.

At the moment, we see reducing length of stay does only bring that effect if we can close some departments. So only if we get the lengths of stay down structured to enable us to close departments in some hospitals, we would get the EBIT effect. If not, we have less length of stay, but the same cost structure.

And as we don't know exactly what will be regulated on the minimum staff in future, we try to prepare all what makes sense, but we cannot say at the moment what will be the real investment to meet at the moment not concrete known regulations. But that's the approach. And therefore, we lose some of that. We thought about the sales and the EBIT. But we think, to be pioneer, it's worth to do that because it's worth to do that on quality and on efficiency, as just explained.

Ralf Kuhlen: If I may add one aspect which I think generally is very important to understanding the system as it is in Germany, since any complication would increase the degree of severity, and the increase in the degree of severity is being reimbursed, you are in fact reimbursed for complication in the German system.

So when we are talking about pay for performance or nonpayment for nonperformance, in fact, we are having a system where complication rates are being reimbursed. Talking about lengths of stay, Andreas has just told me that, when we would really carefully

analyze what happened at Helios Germany with the length of stay during the last year, where we do see a tremendous decrease, most of it has been taken place by the patients who are over the upper limit of lengths of stay within the DRG catalog.

And for those patients, you receive an additional per diem honorarium, if you want to. So if you would decrease this because you decrease the amount of complications, making this long lying necessary, you decrease the length of stay, but you even lose money. And this is something, when people are hesitating to talk about pay for performance, we should be fair enough to say that the system we are having today is actually paying for nonperformance.

And this is something you really have to take into account that some process optimization, which is not going along the reimbursement system, decreasing the need for mechanical ventilation, intensive care, whatsoever, can decrease sales through the decrease of the CMI, the case mix index.

And I think all agree that our primary goal really is best possible medicine. So we never want to ventilate somebody who's not necessarily on a ventilator. But the simple truth is that this happens in Germany. And that is something we have to be aware of that we do it, although we cut our sales a little bit. And I guess that is completely different in Spain for the moment, but this is one of the consequences coming out of the DRG system with upper and lower limits of lengths of stay.

Francesco De Meo: But, Ralf, we believe that that will come back or even more. That's the same with the center building. At the moment, we don't know, or we are not able to bring all the patients to the centers. But if there is that kind of center built and the quality there, there will come more patients, not today, but tomorrow. And we hope in the near tomorrow that's what also Andreas will show you that we are convinced that, at the end, quality will lead to patients on that.

Stephan Sturm: Hence, we called it an investment with a payback. Hassan?

Héctor Ciria: Yeah, maybe very short answer on your question on pricing dynamics. So in Spain is the tradition -- this has been for a long time that basically pricing is typically adjusted by CPI. And this happens in the public setting, but it also happens when negotiating tariffs with the health insurance companies.

Over the last four, five years, you know that, given the economic situation of Spain, CPI was basically zero. So the consumer price index was basically stagnant. Now CPI is increasing a bit. So we should be some price inflation in terms of the tariffs we'll get, but not -- I wouldn't say more -- not more than basically CPI.

So when we are showing you the growth rates, especially the historical growth rates, you can imagine that, given that basically CPI was at zero, close to zero, most of the growth that we got was volume growth. And it's the same when we are projecting forward some growth. Most of it is coming from volumes and only a small portion in terms of pricing.

Hassan Al-Wakeel: Thank you very much.

Markus Georgi: Okay. Thank you. And next question comes from Veronica.

Veronica Dubajova: Thank you. Veronica Dubajova, Goldman Sachs. I have two questions, please. One is for Héctor on Quirónsalud. If I look at your business, you've been growing faster than the private market organically over the last few years. Can you give us some insight into which part of the portfolio's driven that 5%, 6% growth for you versus the 3% to 4% for the market? And how sustainable you think this current momentum from an organic perspective is for your business, that would be helpful.

And my second question is a conceptual question. I know we've circled around this Germany inefficiency issue, if you will, for a while. But ultimately, this will come down to the government wanting to implement change. And it'd be great to get some insights into the types of conversations that you're having about that and whether you think that's likely. Are there going to be new incentives put into place that will drive a lower length of stay and better spending of the German healthcare spend, or is this just something you hope for, but there's no political implication that it happens? Thank you.

Héctor Ciria: Okay. So coming to the first question, I would say it's a combination of different factors. First of all, many of our hospitals are very well recognized by the Spanish patients. When we mentioned that we were doing acquisitions on local markets, trying to acquire the best possible hospitals, it's because we wanted not only to be larger, but to be better. And if you have the hospitals that are seen better than the average by patients, typically, you receive more patients than the average of the market. So this is one of the reasons.

The other important reason I would say is that we keep on also investing in our hospitals. Over the last years and also going forward, we have many expansion projects within our network. We call that expansion organic because it is not the opening of new hospitals. And obviously, that is also helping. That capacity increase, it is also helping to basically get more patients, while many of our competitors are not doing that because of CapEx constraints or for other reasons.

And then I would say finally also, coming back maybe to the last slide, where you could see still how fragmented the market is in the private segment, you could see there were more than 100 hospitals that were independent hospitals. Those ones are typically owned by families or by doctors. And also, there are other hospital groups that own two or three hospitals.

Obviously, this is a business of economics of scale. If you don't have enough economies of scale, it is complicated to get some savings in procurement or in other cost areas. And if you don't get those savings and you have pricing pressure from the health insurance companies, it is obviously more complicated to continue investing in the best technology. And if they don't do that, obviously, we become more attractive because we do invest. We become more attractive for other patients.

So those are the main reasons why we got, I would say, more growth in the private segment than what the average did. And we continue seeing this at least for the foreseeable future. It's tough to say in 10 years, 15 years, but at least in the next four, five years, we continue to think that that will be the case.

Francesco De Meo: Let's talk me about hope in short, and then I will explain why it is a hope, but in good faith. Why? We have an experience in Germany what it means to go against traditions because that's the battle we have to do. And in former times, we thought that, to change that by making it could be very dangerous.

However, we saw being pioneers and doing the right things brings on your side step by step other people and, at the end, also some institutions and some politicians. So our approach is that, by doing that, we change the world because we have some size in Germany, and we are heard by the politicians what we are thinking about that.

And if that part is done and they see that there is one going forward, there will be the followers. And the biggest argument that therefore I believe that it will be something that will come, that must come is the quality aspect.

If you talk to politicians, they are not so in favor of that at the moment because they fear for their elections. If you talk on institutions, they are more of them because they are

oriented on the studies and on the quality aspect. And they are on our side in thinking at the moment. They are not on our side in doing. So we do and believe in good faith that they, thinking the same, will do it then also.

It will take in Germany some time, more time, but not that time as, for example, we saw in Switzerland. So the Germans are faster than the Swiss colleagues. However, they are not so fast as we saw from the Spanish colleagues because their world outside has been with more pressure. And in Germany, we don't have that economical pressure.

Stephan Sturm: Thank you, all. Very much unlike ourselves, we are 20 minutes behind schedule. I am acutely aware that many of us have flights to catch at the end of a fully packed afternoon. So my suggestion is that we go for the lunchbreak now. I promise all of us will be available out there for additional and more individual Q&A. My request is that we be back here at 1:00 p.m. sharp. And I can promise that there is much more interesting content in the afternoon sessions.

For those of you whose questions have already been answered, particularly those of you, I would like to encourage you to pay a visit to our colleagues from Berlin Buch, who are out there and have a virtual reality show for the operating theater of the future, but also virtual reality on magnetic resonance on the heart muscle, the one to the right, the other to the end of the atrium. I can really recommend you going there. And again, very much for being back here at 1:00 sharp. Thank you.

LUNCH BREAK

Markus Georgi: So welcome back. Thank you being back on time, and happy to open the afternoon sessions. And with that, I would like to hand over to Leticia and Andreas. Stage is yours. Welcome. Ralf is doing some introduction.

Ralf Kuhlen: Thank you very much, Markus. So as promised from the general overview, we had discussed now a couple of examples on what we discussed in the medical bubbles, if I might say so. The animation is not working. There it is. From Leticia -- I do it the other way around. Leticia Moral, who is the Chief Medical Officer at Quirónsalud, and Andreas Meier-Hellmann, who is the Chief Medical Officer in Germany. I guess, Andreas, you are beginning. Andreas is going to do it in German with translation. So put your headphones, and Leticia is doing it in English. Andreas?

PRESENTATION: Views on Health Care Germany & Spain – Andreas Meier-Hellmann & Leticia Moral Iglesias

Andreas Meier-Hellmann: (interpreted) Dear ladies and gentlemen, I have been permitted to give you a brief view of the German market. And the subjects that I'm going to be addressing can be seen here. They've been emphasized in this chart. And my two most important takeaways are that we see a very good opportunity in being able to increase our efficiency and thus being able to continue to grow.

And nevertheless, we will always continue to maintain our superior quality levels. And as part of the efforts to increase our efficiency, we will hope to improve our medical quality. And I will provide you with one example.

And a second point that has always been raised several times is the subject of centralization. We have exceeded a critical size, which has given us the opportunity to think about what we can use from this scale. And I'm going to give you an example on that, too.

So if we first take a look at the German hospital market, we can quickly gain the impression that we have a whole series of problems that are totally unsuitable for

allowing any further growth. We have fixed prices due to our DRG system so that, if at all, we can only try to make some improvements with regard to cutting costs.

But then we're going to have a new challenge, namely when we're talking about nurse-to-patient ratios in the near future, which will be stipulated. That will also tie our hands. And basically, you've already heard that we have way too many hospitals here in Germany. Now these are all points that we cannot directly influence. But there are a whole series of other problems where one also could think that perhaps they would tend to be an impediment to further growth, but where we definitely do see opportunities for us.

First of all, the length of stay, which has repeatedly been raised today, and I'm going to show you what we're able to do in this area. And this was also briefly raised before the break. We have way too many intensive care beds. For every 100,000 inhabitants, we have 27 ICU beds. In Switzerland, you only have 11 beds for the same number of residents. And there's absolutely no indication whatsoever to say that, when providing care to critically ill patients that anything is better.

So we simply have to admit and see that, with the very expensive resource of intensive care medicine that it's not properly being managed in Germany because it surely does not contribute to any efficiency in medical quality or improvement in medical quality.

And as already mentioned, when we're talking about intensive care medicine, if we are going to have a requirement of one nurse for two beds, we've already got the nurses. We only have to reduce every second bed. And then we will be able to comply with the nurse-to-patient ratio that is going to be stipulated by law in the future.

And what has also repeatedly been mentioned is the strict separation in Germany of outpatient/inpatient care. We can't simply tell our patients simply come back if we've discharged them. So we're simply -- we're letting them into a different world if we discharge them from the hospital too early and very poor interfaces between the two worlds. And that's why there is a difference between Germany, between the stationary and the inpatient care and outpatient care.

We're offering almost all services at all hospitals, and we don't really need any data to think about the possibility that could not be a good idea. If you're using common sense that the experience that we have in hospitals, even though they only have a very few patients, are going to be able to provide the same quality.

And of course, you're all familiar with the standard proverb here in Germany. The more you practice, the better you become. And this is something that also needs to be taken into consideration that, if hospitals provide services or surgeries for which they have very few patients, then they can't be quite as good as a center where they do this type of operation each and every day.

So where do we stand? Well, you've already seen this length of stay. We're definitely on the right track to trying to reduce the length of stay and compared to the average in Germany and what -- particularly when you look at the various averages for the various patients.

But we've also addressed the issue of intensive care unit usage, where we said, "Yes, of course, we do have to manage this resource a little bit more reasonably, not only to save this resource, but simply because we know that a patient who is lying in an intensive care unit, even though he doesn't really belong there, in case of doubt, will not have any benefits. If at all, he will only experience a drawback."

And since we've decided to address this issue, you can see in the chart in the middle and the chart on the right-hand side that the number of intensive care beds that we are

operating have been reduced. But the probability that a patient will have contact with an intensive care unit will be decreased. And the number of days that we treat patients in ICU units has also clearly been reduced. So we are on the right track. What else can we do to become more effective?

We are working with so-called SOPs, standard operating procedures, that is with a clear setting of patient pathways to improve patient outcome. And we've noticed that structuring medicine alone will also lead to better outcomes, simply ensuring that everyone knows exactly what he or she should be doing and when.

And then in a second round, we went ahead and said, "Okay. We are going to establish SOPs, which explicitly will lead to a decrease in the length of stay." So that says, "What are we going to be doing on the first and second or third day? And when are we going to be discharging our patients in order to provide clarity, in order to ensure clear pathways and clear structures?"

These SOPs are highly effective, as I can show you with this chart. In the upper curves on the left-hand side, you can see the effect of these SOPs with patients who've suffered myocardial infarction, and you can see this decrease in 2000 -- between 2016 and 2018. You can see there's been an increase. So we're able to be faster than the average German length of stay so that these SOPs which are focused explicitly on length of stay have led to decreases.

And the same thing with the hip replacement interventions on the right-hand side. This does not mean that we are sending our patient off on a five-day journey and that we're ending the journey after three days, no. These SOPs mean that a journey that used to take five days but now only needs three days because we are faster and because certain byways that we used to have no longer take place, or no detours are necessary.

So after three days, the patient is a little bit more relaxed and so on. And nevertheless, the outcome is better. In other words, I want to emphasize the fact that the reduction of the length of stay is not in any way worsening the quality of the care that we are providing to our patients. So you can see everything is under the value of one, means that we're better than what we were able to expect. And you can see on the left-hand side, the bottom chart, SMR patients with -- that there are no significant changes, at least no worsening under these measures.

And on the right-hand side, you can see the values for the hip replacements. And you can again see a clearly positive effect due to a couple of other measures that we also took. So we are able to prove that these SOPs are not only effective and work, but we've also been able to increase the quality of care that we are providing to our patients.

Another issue is the strict separation of outpatient/inpatient market. This has repeatedly been mentioned. And that is surely one of the reasons why the length of stay has been so long in Germany. So what can we learn from Spain? And when you look at the figures, this is something you'll see once again from -- in my colleague Leticia's presentation.

You can see that we've saved 125,000 days simply by moving patients that we tend to do in hospitals as a matter of routine in Germany, moving them to an outpatient setting that creates more capacities and thus allows us to save 125,000 saved days. And thus, this is where we can learn from Spain.

We're also going to start thinking about how we can provide this type of care in an outpatient setting. And that can happen very quickly because we have the opportunity to show -- have our Spanish colleagues show us what they've done. And that is a highly efficient way to learn from this, and that's how we can implement this fairly quickly.

Secondly, we're going to seize each and every opportunity to penetrate the outpatient market. My colleague Franzel Simon gave you an example. In a region which is structurally weak, where we do not have enough GPs and can no longer really provide enough care to the patients, we are going to try to close the gap there and by extending the services that we provide to outpatient medicine.

And a third point is the formation of centers. So the question is, in such a highly competitive market, like in Germany, how can you assume that a patient would be willing to drive two or three times as long to get the service that he needs, even though it would be offered near his residence? And why would he be willing to travel in order to go to a medical center that is 300 kilometers away and would be able to treat him much more quickly?

And the reason for this is surely not that, in those hospitals, where we're no longer offering these services means that we're going to be able to save a lot of money. That's not the case because the effect of that would be negligible. But one reason could be that the patient would be willing to travel this long distance in order to get what he would not have been able to get elsewhere. That can always be the quality of the medical care.

And that that really is the case is what you can see here in these graphs. These are routine data that have been collected over five years. They then show you the routine situation in Germany. You can clearly see that there is a correlation between the case numbers and the outcome of the various services on the left-hand side.

You can see esophageal surgery on the right-hand side. And on the left-hand side at the bottom, we have pancreatic resections and so on, where -- and in both cases, you need a highly experienced surgeon in order to provide this type of treatment. And then you can see at the top the transcatheter aortic valve replacement.

And you can see that we've been to almost cut in half the mortality by forming the center. That is, again, there is a clear correlation between the volumes that would be provided at a center. And that is where the surgeons have really become very proficient in this type of operation. And that would be one reason why patients would be willing to travel to these centers because patients could expect much better quality of care. And we really expect that people will do so.

I would like to give you one example. If you take a look at the situation in Germany, where for example esophagectomies are offered at Germany university hospitals, then you can see the university hospitals in Germany that play in the upper-level markets. And you can see that most of the university hospitals have approximately between 50 to approximately 185 cases.

And those are the people at the top of the scale. But you can also see there's one hospital that has 185 interventions. That is almost like a lighthouse project. And that shows us that the principle of having lighthouses really works because it doesn't mean that the University Hospital in Cologne is the only one that provides this type of surgery, but actually that they are offering better quality.

If we look at our houses in Germany, and then you see lots of green dots on the map of Germany, and you can see the figures are very far removed from being a lighthouse, far removed from being a lighthouse like Cologne and having 180. But due to our size, we are able to try to bundle these patients and thus build up a lighthouse, for example, in the North Sea in order to then be able to achieve an average total of patients of 172, not in the North Sea because that would be a good idea, but primarily because it's so nicely to see that this nice green point that you can see in the -- against the blue, we're going to build this hospital somewhere else.

But due to our size, we have the potential to even build up a lighthouse in order to offer this quality, which is not possible elsewhere, and thus to generate lighthouses, so to speak, so that we can convince our own patients to go there. But what is more important but also will mean that we will be attracting other patients who are not being treated in our hospitals to think about coming to such a center in order to be treated there.

So we are firmly convinced that the time is ripe, that this is going to work, both in order to convince the patients that we already have, but also other patients as well. And of all of the other entities, we are capable of building up lighthouses that would have the size in order to keep up with the major providers in Germany.

And you can see this for pancreas surgery. The biggest university hospital has 543 interventions. And all of the Helios hospitals have a total of 632 interventions. And cystectomies, the largest number of cases is at the Munich University Hospital of 126. And at all Helios hospitals, we treat at total of 437 patients, and thus, we have the opportunity to become one of the biggest providers of certain types of surgery.

So in summary, we're assuming that we will continue to be able to decrease the length of stay through clever and better processes while maintaining or even improving our quality. And thus, we see an opportunity for growth.

And secondly, by focusing on the buildup of centers, we would then have the opportunity to build lighthouses because we've achieved and exceeded the critical size. And these houses would then become lighthouses. So that was a brief view of the German market. And as the next speaker, you will hear from Leticia Moral about the Spanish market. So thank you very much from my part.

Leticia Moral Iglesias: Thank you. Okay. Good afternoon, ladies and gentlemen. It's a great pleasure to be here and to have the opportunity to explain you some of the topics where Quirónsalud and Helios are working together.

Sorry, as Ralf and the rest of the speakers said before, we are trying to achieve the best of both worlds. And the main topics of my presentation will be three. We will continue to speak about efficiency and how the integration of the healthcare market, the inpatient and the outpatient healthcare market, can improve efficiency. We will continue to speak about patient experience as a key driver of Quirónsalud growth. And finally, but not most important -- not less important, sorry, we will speak about how we are transferring best practices between Helios and Quirónsalud in order to improve clinical practice.

Talking about efficiency, you have here two different data. For the beginning, on the left, you can see the average length of stay of Quirónsalud from the past year and the year before. But also, at the same time, with the length of stay, another index that we are working very hard on it is that the percentage of ambulatory surgery. We speak a lot about length of stay, but sometimes, we forget that the ambulatory surgery is a way to increase the efficiency.

As you can see, the results of Quirónsalud were not very different between one year and another. But if you go deep down to this result, you can see that we have opportunities and we are improving our operational efficiency. As you can see, we continue with hip replacement. Past year, we operate 10% more patients on this procedure than the year before. And at the same time, we reduced the length of stay in this procedure 9%.

With this improvement, what happened is, with more or less the same days, we operate 10% more patients. Okay. And we save every day around eight beds. Sorry because my English is not perfect. When this morning Stephan told you that some speakers don't speak perfect English, it's my case, but I try to do my best in order to speak in English. Sorry.

Sorry, sorry. When we speak about ambulatory surgery, you can see that we have very different performance in some of the DRGs. Look at the first DRG we want to talk about. This is one, the surgery from cataracts. Now in Spain, 98% of the procedures are performed as an ambulatory base.

Twenty years ago when I start to work as a manager, it was just the opposite. 98% of the cases were performed as an inpatient. And as you can see, in 20 years, things changed completely. But this is 98%, and you can see more other DRGs with also a high rate of surgery as outpatient.

But we have opportunities to improve because, in some other DRGs, for example, the surgery for hernia, as you can see, in this case, our percentage of ambulatory activity -- thank you -- is only 39%. And we can improve a lot because the benchmark is around 70% in UK and in other countries.

In my case, we will forget by now efficiency, and we will talk from the second topic. That is patient experience. This morning, before lunch, Héctor talked about how patient experience is one of the key drivers of Quirónsalud growth.

What we are doing with this? First, we think what patients want and what patients expect, and we try to offer what the patients want and what the patients expect. We offer center care for patients. And we have three strategies, three managed strategies. One is to organize focus group with patients, trying to know what they expect for our services. The second one is our care and caring program. It was a program implemented by IDC, the former company, but a successful program. And what we are doing is to teach our employees how to treat patients.

Also, we have a daily monitoring. Héctor told you we have a daily monitoring of NPS in order to know what patients think about our services. But here, around 200,000 people give us their opinion. This year, the number of patients that are giving their opinion increased more than 30% each month.

Also, we work hard with good accessibility because we know it's one of the most valerate thing for patients. And we have two targets. In the emergency department, our target is thus: one patient should wait less than 30 minutes in order to be seen by a doctor. And in the outpatient area, we have two targets. The first one is that a patient should be at 10, 15 days at the most. And the other is that patients should not wait in the waiting list -- sorry, in the waiting room more than 15 minutes because we know it's another important thing for patients.

Okay. Now you will see how our model by now, and we are very proud of this, is a success, and we continue to be a success for sure. Here, you have the results of the four hospitals that work in the public market in the community of Madrid. And in all of them, these are the rate of complaints, the average time in surgical waiting list, and the average time in outpatient waiting list. Do you remember out two targets? And you can see, in the three indicators, the Quirónsalud hospitals performed the best and very far from the worst in each group.

Why these two hospitals, Ray Juan Carlos tends to perform worse to the other? The only reason is that they were in the same group, and one is the first and one other is the second. And in this part of the slide, you can see preliminary data. This study was performed some weeks ago, and the result will be presented next Tuesday in Madrid. And these are the results in NPS in private market hospitals. And you can see the results from Quirónsalud and from our competitors. Both in emergency department and in outpatient clinics, our performance is more than 20 points up of our competitors. We are proud of these results, and they are the results of a big work year by year.

Talking about medical practice and patient safety, in my slide, I tried to separate two different states of our working. The first one is before Helios. This morning, Héctor told you that the new company started only three years ago. Of course, the hospitals worked very hard before in order to give the best quality to the patients, but they work most of the times in an individual way.

What we do the first years of the new company is to implement a benchmark, an internal benchmark. As we have so many hospitals, we compare one hospital to the others. And also, we use external benchmark with hospital data from Spain and from international standard, mostly the standard for the Agency of Healthcare Research of Quality in the States.

This was our work two years -- one year and a half ago. But when we joined Helios, we start to work with Ralf and his team. Our team worked very, very hard. And by November -- no, sorry, by October, we had the first results of the comparison between Quirónsalud and Helios in 46 quality indicators. I will show you some of the data. These are some of the graphics that, each three months, our hospital have this information. And we are comparing our results and Helios results.

Here, you have two indicators. In one of then the Quirónsalud performance is slightly, slightly better. I think we are the similar performance than Helios. And in another indicator, it's the opposite. The performance of Helios is much better -- not better, no not -- sorry, it's my English -- of Quirónsalud average. These are our three group of hospital. These are the reference hospital. These are medium hospital and the small hospitals. And you can see we have difference between hospital, what we are doing with this. We work with hospital. At the beginning, we said, "Please analyze your own data." We will discuss with you, but if this will not improve, we can do the other thing is to start with peer review. Okay?

Maybe some of you can recognize the man on this picture. This picture was taken in the first peer review in Quirónsalud. It was in December past year in Teknon. And we decided to start -- after a long discussion with Ralf and his team, we start to decide with a soft process, not with mortality, but the beginning with a soft process that is the hip fracture in people older than 65.

What happened with this peer review? Just not yesterday, the day before yesterday was the fourth peer review in Spain. And we are very happy to show you how this strategy at Quirónsalud to improve a good result, but to a better result. Why I said here you have the results in the past year by group of hospital and the global data of Quirónsalud. And in this picture, these are the official data.

The last one, you can see that Spain, okay, is under the median of these countries, but the Quirónsalud rates are really better than the Spanish -- the global Spanish rate. But our rates are lower than the German, than the top of the countries, which is Norway. And we would like to improve our results for sure, and we will do.

And what we'll do next year and the year after, we will continue to work with peer review. Next month, we have this meeting in Madrid in order to discuss how to continue with peer review, if continue with the same procedures in more hospital or to add more procedures. For sure, we will add more procedures. And a good thing is that we convince other private Spanish hospital. And for next year, we will have not only the benchmark from Helios and the other countries which use this methodology. Also, we can compare our hospitals with the rest of Spanish healthcare market.

And finally, the last topic I would like to present to you is our strategy to manage complex cases. As you know now, the Spanish healthcare system is more prone to accessibility than to concentrate complex cases. Our politicians many years before started to plan one hospital very close to every big city in our country. Not only big city,

also small and medium city now have a hospital. That's why accessibility is also that people like a lot.

Okay. What we are doing, we are continuous monitoring the complication and the mortality rate in our hospitals, as I told you. Also, we adopt a strategy that Pedro and his team also work very hard is to use multi-hospital teams. What does it mean? The same group of doctors work in more than one hospital. With this, we can assure that the medical quality is the same, although the number of cases can be lower in one hospital than another.

Another strategy we are using to promoting best quality is to promoting Quirónsalud's network. What is this? The same that, in a way, the same that Andreas told you before. We are trying to refer patients from a small-medium hospital to another. But as we are very ambitious, past year, we decided to adopt one more strategy. And we are working in concentrating complex services in cities where we have more than one hospital. The first project is to create a big heart department in Barcelona in Centro Médico Teknon. That will be operating by the end of this year.

This is all I wanted to tell to you. Thank you for your attention. I know that Quirónsalud and Helios started a journey together. And I think we have a lot of -- [to done] for the next year. Thank you very much.

Francesco De Meo: So, Héctor, I'm missing you. We make a short introduction. It's actually me introducing the next session, which will be done by Enrico and by Pedro. And I think it's for you one of the most interesting sessions, hopefully, because it's a session on cost synergies. So the only thing, Héctor, I wanted to ask you, what about -- German tanks didn't come. That's fine. But what about your impression on integration process and how our colleagues worked together?

Héctor Ciria: Sure. I think, as mentioned before, I think we have found a very good equilibrium to try to, obviously, understand the differences between the markets and the differences also between the groups. But also, should -- that should not be an impediment to get benefits, right?

And actually, one of the most important ones -- I'm going to talk about that, so I actually shouldn't be talking, but we have already started with three, four sources of synergies that we have working together with teams from both Germany and Spain. And so far, I would say the results are quite promising. Some of the results, we already saw the benefits this year. And there's much -- hopefully, much more to come.

Francesco De Meo: You believe in that. And you see in the Rainbow of Happiness what are the big points that will be treated now in the session. And I give it to Enrico and Pedro. Thanks a lot. And make your show.

Héctor Ciria: Thank you.

PRESENTATION: Cost Synergies by Integration – Enrico Jensch & Pedro Rico Pérez

Enrico Jensch: Thank you. Thank you, Francesco. Thank you, Héctor. Ladies and gentlemen, at first, we have a small problem because Stephan Sturm yesterday announced the Pedro and Enrico show. That makes a lot of pressure for us. And so we decided to say it's our aim to give you only a small overview about our daily, the most of time, successful business. So let's start.

Pedro and I have been working closely together to generate the first synergies since I remember the end of 2016. Our joint objective is to achieve the best of both worlds. We described that. You have heard already a lot about the Rainbow of Happiness, the

platform idea, the integration through interaction. As Francesco and Héctor introduced, we will focus on cost synergies, especially procurement, laboratory outsourcing, and cooperations.

So before we do that, we would like to give you some key takeaways. In our presentation, we will explain to you how we can improve as a group. That is the most important message for us. First of all, we are two leading hospital providers active in two different markets. We are aware that the local healthcare needs in Spain and Germany are different and will remain different.

The second, therefore, we adapt the standard of care to the national markets. Third, size matters. Higher procurement volumes, patient experience, and cross-border learning, new opportunities arise. Both of us can benefit.

Fourth, the efficient processes help us to realize synergies while, at the same time, we are increasing the quality of services. However, standardization does not work everywhere. Much is possible, but markets have their limits. Again, different markets have different requirements. We will give some examples a little bit later. However, by working together, we can be more efficient and cost effective.

So before we talk about opportunities, we have to get a better understanding of important market drivers and limits. Just a quick reminder of some of the major differences between the Spanish and the Germany healthcare market. For example, with regard to hospital admissions, Spain, for example, has a low hospital admission rate of only 11%. Germany, on the contrary, has much higher admission rate of 25% as well as much higher lengths of stay. Ralf mentioned it a little bit earlier. The German healthcare market is more situated than the Spanish one.

Pedro, would you like to tell us a little bit more Spain, please?

Pedro Rico Pérez: Yes, thank you, Enrico. As you have seen in the previous presentation, the Spanish healthcare market is a competitive market with a good growth potential. The main drivers you see also in the previous presentation are we don't have boundaries between inpatient and outpatient market. It's a big difference to Germany. Héctor explained and other speakers explained about this issue.

The private health insurance market is growing approximately 4% p.a., and the new Quirónsalud agreements with these insurance companies give us more penetration rate and better situation in the market.

Further, the potential of consolidation is an opportunity. Héctor talked about this opportunity of consolidation in the market. And additional growth is possible by greenfield projects, especially in the private hospitals, and also in the public sector with the free-choice model of the Madrid Hospital. Héctor explained also this opportunity for growing.

Enrico, please, can you explain something more about the drivers in the German market?

Enrico Jensch: Of course, Pedro. As discussed already, the German markets is more regulated and saturated. The regulatory framework limits grow potential in German. On the other hand, it comes along with a high price stability. Franzel told this. It is a high barrier for new market entrants. Unfortunately, the pricing system is also very inflexible, which is clearly a limit. Additional revenues are restricted. We may increase revenue with specialized services. We call it Wahlleistung or sometimes premium quality.

So let us now talk about the limits, Pedro.

Pedro Rico Pérez: Yes, in Spain, some limits are the elevated DSO/DPO, and it's a national issue. And another national issue is the state of construction for -- of the hospitals. We need more CapEx in Spain than Germany. This is not only for Quirónsalud. We have limits also for greenfields in the public sector. And another limit is the -- in some Spanish regions, the insurance market is -- has a high penetration, and the potential for growing is below the average.

Enrico, the limits in Germany?

Enrico Jensch: So I will describe that. I try to describe it. In Germany, there is a clear separation between the in and outpatient. You have heard it before. And I will come back to that with some examples. It's -- I think that it's better for understanding further. The hospitals are reliant on general practitioner's referrals. In addition, new regulation is coming into force, for example, the minimum staffing, which will have an impact on cost structure. Regulation also prohibits greenfield projects in the public sector.

Let's come back to the sector boundaries between in and outpatient and how they prevent us from realizing further ideas, some examples. In order to align processes between the sectors and increase the quality of treatments, the introduction of hybrid DRGs would make sense.

That means one DRG to cover the whole Medicare treatment, including outpatient and inpatient services. That would allow to generally reduce cost, for example, by avoiding double clinical reports or double prescriptions. At the same time, the quality increase. Separate financing and separate regulation for the inpatient and outpatient sectors in Germany hinder the providers to introduce such innovations until now.

So besides the growth potential, it is important to constantly look for possible synergies at the cost level or even across countries. Therefore, let's have a look at the cost structure in both countries. You will see that the cost ratios are different, but the cost drivers are very similar.

Pedro Rico Pérez: And you can see in the slide, in both countries, the personnel expenses is the major part of the cost and can be seen as a fixed cost in general. Further, the relatively variable cost blocks are procurement and cost for additional service. Lease payment for infrastructure and medical equipment are rather fixed also.

In Spain, the personnel cost is lower than in Germany. In Germany, the average wage is higher than in Spain. But it's not only a problem with the average wage. In Spain, only the 45% of our doctor are employed for us. Fifty-five of our doctors are freelance doctors and as they are self-employers. And in hospitals and private hospitals, the freelance doctor is a variable cost of approximately 20% of sales. We have also some doctors, some freelance doctors that bill directly the fees to their patients. In this case, we have neither the cost, neither the income.

Enrico Jensch: So relatively fixed cost blocks in Germany are the personnel costs, investments in owned infrastructure, and also the cost for medical equipment, whereas relatively variable cost blocks are also procurement costs and additional services, for example, laboratory and maintenance of medical equipment, too.

In the end, we can summarize. The cost drivers are comparable. The cost ratios are different. It makes sense to address the issue across countries. We identified cost synergies especially in the areas of procurement, additional services, laboratory, and medical technology. What is our goal? Our goal is to combine the existing strengths.

So let's talk about the efficiency supports quality. First of all, we are convinced that internationalization creates new opportunities. We started with single projects and are developing common strategies. And to be successful, we learned to follow certain rules.

First of all, be clear on your goals. Quality and price should be the common driver. The second, practice cross-group thinking beyond country borders and on basis of the whole for Fresenius platform. The third, accept that there are different approaches to success.

One example, Pedro, do you still remember our negotiations for the laboratory services? I wanted to push and finalize the negotiations. You wanted to wait even longer and continue to negotiate, although the German deadlines had expired. What did you tell me?

Pedro Rico Pérez: Yes, I remember. I told you, "Enrico, please don't pressure us with timelines." Spanish and German way of negotiation is different. I convinced you for the Spanish way. That was our first joint success.

Enrico Jensch: Yes, that was our first joint success. It was a nice experience for me, be sure. So what we promised in September 2016, let's briefly recap on the synergies that we presented at announcement of the Quirónsalud acquisition. At that time, we estimated to achieve midterm pretax synergies of approximately €50 million per annum total. During the integration process, we even identified additional areas for best practice exchange.

Today, we can confirm that identified cost synergies are contributing significantly to total synergies. Further, synergies are realized on the revenue side as well as via increased efficiency, and processes, and quality improvement. This was already or will be part of some of the other presentations, for example, digitalization and efficiency.

So, wait. Do you remember? In this presentation, we focus on the cost synergies, especially procurement, laboratory services, as well as outsourcing of services via cooperations. Let's come to the midterm cost synergies.

First of all, let's talk about one of our main joint projects, the procurement including future strategy. What was the starting point? Both of us had different suppliers with contracts to be renegotiated. What were the challenges in our project? First of all, to coordinate the lead. The second, to reconcile different negotiation cultures. The third, to define and bundle the first product groups to be jointly negotiated.

The focus was on medical consumables as first step. Our goal here also -- that's important -- highest quality and best prices for both of us. We achieved that by acting with one face to the market. The project started with selected group products first.

Further procurement strategy has to be introduced step by step. That includes: expanding it to further product groups, further bundling of volumes, the harmonization of contracts, and contracting better prices on a European level also by fostering long-term supplier relationships. The major part, the strategic procurement in Germany, has already been centralized and standardized.

We are in the process of further consolidating and expanding our negotiation power through this strategic purchasing department of Helios Germany for Spain as well as for the cooperation with Vamed. This project will have further effects in the years 2020 and beyond. The procurement project is typical for us, a typical example for transferring the German best practice to Spain where possible, and also to benefit from combined cost synergies.

Pedro, what were the challenges on your side?

Pedro Rico Pérez: The main challenge in Spain is the standardization of products. Purchasing in Spain is different than in Germany. In Germany, the standardization of products is driven by the decision of medical group experts we don't have in Spain. Our relation with the doctors is difficult to achieve this standardization.

But we are advancing in the standardization levels. The current market situation, the relation with the medical, professional, and some cultural factors, make a sudden change in this issue difficult in Spain. But we are advancing in this area.

Price difference can be explained by logistics cost. That could be different in Spain and Germany. We estimate to achieve midterm pretax cost synergies of about -- in procurement of about €10 million p.a., and most of them will be in Spain.

Enrico Jensch: Fine, Pedro. Let's speak about our favorite, our laboratory project. Let's look at our first proper joint project. So from the acquisition phase, we knew that Quirónsalud had already decided to limit external supply services in Germany. We have already minimized these costs by insourcing laboratory services.

Pedro, what was the starting point?

Pedro Rico Pérez: Yes, at the time of acquisition, Quirónsalud was in the position to negotiate a new contract with a standard provider for laboratory service. Helios has just a standard supply agreement with the -- before the acquisition with this laboratory service. Helios is the operator of the labs in your hospitals. But the technology and the consumables are provided by an external party.

What was the goal in Spain? First time, we want to have the best, the state-of-art technology in our laboratories for managing the growing demand on the laboratory tests after the acquisition of OEPs and to support the general growth of the company. The second time, we need to ensure the laboratory service of 18 hospitals. And in summary, we want to get the best technology, the best service, and the best price.

What was your goal in Germany?

Enrico Jensch: What was our goal? To increase the negotiation power with the existing supplier by bundling the volumes with Spain, that was the most important thing. What was our challenge? To renegotiate the contract with the existing supplier in Germany many years before and of contract duration while improving the conditions, and to overcome cultural and language barriers as well as local interests.

That was our really first successfully project. With one face to the market, we successfully renegotiated laboratory services in both countries and raised first cost synergies this year. So far, we have not yet insourced all laboratory services in Germany. Further insourcing and restructuring in Germany are the next steps for the laboratory project, with effects starting midterm. We estimate to achieve midterm pretax cost synergies from the laboratory projects of approximately €10 million per annum.

Sorry. So let's come to the outsourcing and cooperations part. Under the headline outsourcing and cooperation, we sum up further cost synergies. This includes several projects for outsourcing medical engineering in both countries and technical services and sterilization currently only in Germany, and cooperation with Fresenius Vamed.

Pedro Rico Pérez: Yes, so let's talk about the medical engineering project in Spain first. What was our starting point? So far, Quirónsalud has direct and previous contract for the medical technology with different providers for medical -- for maintenance service.

What was our goal in Spain? To consolidate these contracts and to standardize the service levels. Fresenius Vamed was chosen as the best provider based on a firm offer that promised cost savings from the beginning. Maintenance service for medical device is one of Vamed's core competence. The project started with the high technology medical device in all the hospitals and low/mid complex medical device in Catalonia regions and will be followed by the expansion of low/mid medical device to all the hospital in the next month.

Enrico Jensch: Okay. And based on that positive experience, in Germany, we are currently also in talks with Vamed to outsource the medical engineering, considering the same approach as in Spain. In addition, merging the in-house technical services at Helios Germany with Vamed's businesses and outsourcing sterilization services to Vamed will create further cost synergies. We estimate to achieve midterm pretax cost synergies from outsourcing and cooperation projects of approximately €10 million per annum.

Do we have an idea for further cost synergies 2020 and beyond? Of course. We identified further cost synergies of approximately €10 million per annum for the years 2020 and beyond. Let me give some examples.

First, improvement in logistics, what are we speaking about here? First, centralization of warehouses in Germany to reduce excess capacity, digitalization in the warehouses, and optimization of fleet management. The second, strategic procurement, further bundling of volumes in both countries and for Vamed, one face to the market concept, and also increase negotiation power. Third, the additional concentration of laboratories in Germany that goes along with the formation of clusters.

Pedro, please elaborate on some of the additional ideas for Spain.

Pedro Rico Pérez: Yes, as Héctor comment in his presentation, we are working in some other areas for synergies. First of them is we plan to establish the shared service center in Spain. Service currently provides in hospitals, and we want to concentrate to optimize the service. And this includes, for example, call center service, billing centers, accountability, bad debt collection, for example. We are confident that this approach will leave us to significant synergies for both cost and revenues.

And the second project that Héctor told about it also in his presentation is the revenue assurance project that will introduce the optimization of the billing process and generate the incorporate synergies.

Enrico Jensch: Okay. So do you remember? We spoke about the Fresenius platform approach. Beyond integration of Helios Germany and Quirónsalud, we evaluated further potential service synergies and improvements of efficiency and quality within the Fresenius Group. The idea is that each business unit focuses on its core business.

Many of the cost synergies we have shown are realized together with Fresenius Vamed, our platform export for technical services, and the construction of healthcare facilities. Technical services include the maintenance of medical technology in both countries, further technical services and the outsourcing of sterilization in Germany. These are joint projects with Vamed. Further, our approach to generate savings relies on economies of scale, bundling of expertise, efficient use of resources.

So best practice, next steps. As you see, we have a lot of additional ideas, just to name a few. The supply of sterile goods, that will mean no more investment needed from Helios, pay per use, and further standardization of the service and operation of the sterilization machines by Vamed and third-party provider, merging the in-house construction and project management department with Vamed.

If the projects like sterilization and logistics in Germany will be successfully implemented, these would be potential ideas also for our Spanish colleagues.

So let me make -- let us make some closing remarks. You have seen, during our integration process and closely working together, we have identified substantial synergies. However, we have also learned that the transformation has its limits. Different markets need different approaches.

An example for easy transformation, digital pathology. The physical presence of a specialist, in this case the pathologist, is not required. The issue sample can be scanned and examined digitally somewhere else.

A contrary example, benchmarking, to improve allocation and optimization of staff was very successful in Germany. This was even more necessary with the introduction of the DRG system, which increased cost pressure. Transferring that to Spain at the moment would not succeed. Additional services guarantee the patient go as Spanish patients choose their hospital considering services. Again, different markets need different approaches.

Pedro, one final comment from you about cultural differences and their importance. We discussed that over a glass wine. I remember it was a glass white wine.

Pedro Rico Pérez: Yes, in Mallorca I think.

Enrico Jensch: In Mallorca.

Pedro Rico Pérez: Yes, Enrico. Cultural difference sometimes force us to choose a different approach and is a challenge for all of us. At the same time, it offers a great opportunity. I think we have achieved a lot. We can achieve more, especially when we work together.

Enrico Jensch: I fully agree with you, Pedro. It is important to learn from each other and use best practice. However, we have to be more or less, más o menos, sensitive not to standardize everything, but accept the respective cultures and different approaches.

In addition, you have seen that, by closely working together during our integration process, we have identified substantial synergies. And we have spotted further areas to work on in the next years, enough to update you on the next Capital Market Day. Thank you.

PRESENTATION: Helios Germany Efficiency – Olaf Jedersberger & Corinna Glenz

Olaf Jedersberger: (interpreted) Yes, my colleague and I, my colleague Corinna Glenz and I are going to be reporting to you about the subject of efficiency. And here, you can see our famous Rainbow of Happiness once again. And in terms of standardization, you can see what we are going to do with this.

I'm going to have to reduce my speech a little bit because we're running the danger of overwhelm you with duplications. So we haven't changed everything, but we do believe that the key takeaways continue to be important.

So what are the key takeaways for you? Well, the cost-cutting measures have already almost been fully exploited. Process optimization is the key to increasing productivity going forward. And we are the first to measure productivity. And when I talk about productivity, I'm talking about economic productivity in medicine. And that's a completely new approach, contrary to what you've already heard from our colleagues.

And then of course, there's a fourth measure. And of course, if you're measuring something, then you also have to do something with the results of what you've measured. And we will be presenting you some results as well.

Yes, of course, we are cost leaders, and we want to continue to be cost leaders. Cost efficiency continues to be very, very important and will always be one focus of our activities. And that's nothing special, I admit. But increasing productivity does play a role because, if you take a look at the cost structure of our 88 acute care hospitals show us that, of course, the most of these costs come from medical expenses. Three-quarters of

our expenses are medical expenses. And the rest can be broken down into personnel costs and material costs and so on.

But the biggest block here for these costs are, of course, our medical personnel. So merely trying to cut costs with regard to medical costs when utilizing the benchmarks that we use that we keep running into more and more limits because, just to give you an example here, it could possibly lead to the fact that we simply try to reduce the nursing staff.

Then in the midterm, that could be harmful for the quality, on the one hand, but also for our productivity, on the other hand. And that is why another and more important approach is necessary in order to increase productivity and cost efficiency that we are now looking for a new approach, that we need more efficient internal processes related to medicine.

And just -- and this tool is benchmarking. And this is a tool that we've been using for many years now. And that's our day-to-day business so to speak, namely these benchmarks can be found on our Intranet and the so called toolbox. And all 88 acute care hospitals have access to this each and every day. And you will find benchmarks on personnel and staffing and medical, nonmedical material costs, and so on. And they will be updated regularly on a monthly or quarterly basis.

And on the right-hand side, you can see what they really look like, ranking lists with the benchmark values where you're breaking down by clinics and by locations and with clear names so everyone can really understand what's going on. Those that are in the red can then turn to their colleagues and who have been listed in green, and they can work together with their colleagues to try to improve their own ratings.

So productivity is one of the buzzwords. And now we want to talk about productivity in hospitals. We heard a little bit about this yesterday from Boris, and I believe we've heard a lot about this from some of our colleagues. But there's only two aspects that I wish to focus on.

We're all saying, of course, we have to be -- think about the future, but of course, we have to be more efficient. But some of these terms, using terms such as like productivity, cost leadership, economization, or administration in the public leads all of you to certain reflexes in Germany, at least if you come from Germany, negative reflex, of course, which necessarily doesn't always make our life any easier.

Secondly, some time ago, I wrote an article, and I dared to make a comparison with the German automotive industry and with the idea of talking about production process management concept, products, and so on in order to try to illuminate what is really different, what might be similar, and what is actually the same.

And at the end of the day, you simply have to ascertain that there are one or two significant differences that stand out. First of all, the complexity in the product of health, and that is the biggest difference. And secondly, we have 88 protection facilities. That is hospitals. And one of the -- and at the end of the day, when we're talking about health, then we always have a patient, a human being that is receiving our product. And that is very important to keep in mind.

So how can we increase productivity? The only way to do this is through standardization. I think all of you have become more and more aware of this. But to make this implementable for us, then we started measuring our productivity. And how do we do this? We have a so-called productivity factor in medicine that we've developed and worked out for ourselves.

And what does it say? It's relatively simple. How many medical euros of proceeds are receiving with the amount of money that I'm using for our cost? And I'm focusing on medical costs and not on all of the hospital costs. That's a new approach, and here, you can see in these curves at the top of this chart, you can see the development of this productivity factor from the year 2015 until today.

And what you're seeing is the median and then the lower quartile and the higher quartile at 75%. All of the units, all 88 units, and you can see that there is a lateral movement here. So that surprised us a little bit in the beginning, but it's also a reflection of the fact that you have reached certain limits by only thinking about cutting costs. So it kind of confirms us that we have to take a different approach.

So what can we do? How can we remain productive or become even more productive? We've already heard lots of examples. The idea is or the approach that we're taking is we're going to try to come up with the optimal patient path and in order to avoid wastage.

And so there are four approaches, four activities, SOPs. As my colleague Meier-Hellmann has already explained in detail, the SOPs will help us, even though the idea is good, but that this will lead to streamline processes and more efficiency in the utilization of our resources.

This is going to take up quite a bit of our time because this is just a process that we've just begun. The second point is that we are now going to be clustering our more productive and less productive facilities in order to be able to compare them directly and to learn where the best practices are, and how can we roll them out to the other facilities?

The third aspect is innovation. So we observe the market with regard to medical technology. You've already heard about the Da Vinci robots here. But we're not only taking a look at the medical technology to see whether they are going to be sustainable, but also whether they're really going to be able to help us to optimize our processes.

Digitalization is also going to play a role. And we'll be hearing more about this subject in the two following speeches. And last but not least, we have to keep in mind that we are working on our building structures, but also our medical processes and contents. And what that means in detail will be presented to you by my colleague Corinna Glenz using the Dr. Horst Schmidt Kliniken in Wiesbaden as her example.

And last but not least, we not only believe in lean management and administrative processes, but of course, we also have to ensure that we're also tackling the administrative processes as well and become more efficient there.

So thank you very much, and I'm now going to pass the mic to Corinna.

Corinna Glenz: (interpreted) Thank you very much, Olaf. Yes, I would now like to use the Dr. Horst Schmidt Kliniken in Wiesbaden how we are changing building structures to improve our processes, but how we're adapting our medical structures as well to improve our processes and the outcomes for the patient.

Just a little bit of background about HSK, this hospital, the maximum care provider for the state capital in Wiesbaden, State of Hesse, they have 32 medical departments and institutes. And it's an academic teaching hospital of the University of Mainz. Approximately a 1,000 beds have been set up. And so we have 45,000 inpatients per year and more than 100,000 outpatients per year.

So what else do we have now? Well, HSK, well, it used to be a municipal hospital. It was located within the city of Wiesbaden, was rebuilt in 1982. And even then, it was already a

loss-making business. They had certain medical departments that were flagships. But this hospital was never an economic success. And that means that there were no investments in maintenance and that the hospital was unable to engage in major investments. But there was never any money to make these investments.

And most recently, so much money would've had to be invested that the city decided not to. So there were a number of attempts to rehabilitate the hospital. They worked with consultants. They negotiated a contract with the trade unions, but really, none of this was really a big success.

So in 2011, the time had come. The decision was made to partly privatize the hospital. And so they looked for minority shareholder who would assume full accountability for the business operations and the financial success. In 2012, they found a partner. At that time, it was the Rhön Kliniken AG. And in 2014, Helios acquired a large number of the Rhön clinics, including HSK in Wiesbaden. So that's a picture of the hospital itself.

So this is what we found in 2014. There were chief physician vacancies that existed. We had a staffing surplus, monthly losses, lack of investment, and very critical public and critical local politics, primarily because they hadn't really decided to adopt the idea of privatization.

What you need to know is HSK is not on the only hospital in the region. We have two other clinics in Wiesbaden, Deutsche Clinic for Diagnostic that does -- has -- treats a lot of outpatients. And then we have another hospital, and then we have some other smaller facilities that also belong to us.

And the competitive environment is very strong. We have three other acute care hospitals. And on the other side of the Rhine River, we have the University Hospital in Mainz. And in Frankfurt, there's the next university hospital. And then we also have a couple of other competitors nearby as well. So if you take a close look at the map, you can see highly competitive situation.

So what have we done since 2014? Well, we tried to take all of our classic earnings improvement measures as you had -- we've kind of expanded our medical areas. We've beautified three awards and so on, improved our service. And we have to say that, well, because these rooms were in demand in Wiesbaden then, we replaced the vacancies for chief physicians, and we came up with two new positions in immunology and pulmonary diagnostics. And then we also merged a couple of departments.

At a different number of places, we had ICUs. And under our Chief Physician [Dr. Bengold], we merged them. And we also reduced the size of the beds because we didn't have the staffing to operate all of the beds, but also because we noticed that these beds were not being filled by the right patients, that some patients really belonged on a normal ward, but were being placed in these beds just to fill them for the time being.

So what did we do? We reduced the staff, and we also reduced other costs where it made sense. And you'll hear more about that later.

So the next step was the new hospital building. We had the opportunity to build a modern building that is going to be compact and that is attractive for employees and patients. We wanted to come up with an architecture that optimizes our workflows and processes, reduces the legwork, so to speak, for patients and employees, concentrates and centralizes core areas, such as operating rooms and ICUs, for example, and that we're going to be expanding the range of services on offer. And we want to provide attractive accommodations and evolve the HSK to a center of excellence in a regional network.

So what does this new building look like? Well, you can see a photo of the front view at the top. And this is a bird's eye perspective. It will have a total of area of almost 100,000 square meters, which would be approximately the space required for 630 family homes. And it will cost more than €263 million. We've already heard a little bit about financing. €68 million will be coming from public funds. So this is -- we really had to make a major investment on our own here.

You can see the building here at the bottom. And this is the area where the current hospital is, and that's going to be torn down. And the smaller buildings will remain. And there will have different centers.

And we hope to be -- have everything finished by the year 2020. And I was asked a little bit about a helipad here. That is here. It's directly on the roof of the first part of the building. And below that, we have operating room and emergency departments and so on so that the patients will be -- automatically be able to move very quickly to where they need to go.

So we're building quite a lot at Helios. And we have our own construction team. And we're trying to utilize the experience that we've gained from all of our projects and bring this all together. And thus, we are developing construction standards and recommendations for future projects.

And that has been the case here as well. We've ascertained that, currently, at HSK, just to -- that goods are being transported by people from one area to the other in the hospital or that, in other clinics, we have better systems and that they have certain systems that would move materials and so on that work 24 hours a day. And therefore, they need fewer staff, and they are much more effective and more efficient.

The second example that I've already referred to and which you probably also saw in Berlin Buch yesterday, and that was the centralization and merger of OP, operating room use services. We have four areas in which operations are performed and that are blinking. And they lie on different floors. And they have certain unsterile areas and so that we really can't -- it's not an optimal situation.

In the new building, you can see what's blue. This was the old house. There's going to be a sterile OP area. And that's where we're going to integrate all of our OP services, but also other areas. And then we will be able to generate synergies, such as we will have fewer storage places. We will have better access to operating rooms, better possibilities for our teams to work together and share a space when changing clothes, and so on.

So and now we want to talk about the medical structures as well. So we have decided to -- we have set up an abdominal center at the HSK. And it comprises three departments, first of all, general and abdominal surgery and then gastroenterology. And then we have -- we will be having a joint reception organizational structure. We'll simply have a reception desk instead of separate because they are going to be sharing these organizational structures.

And we will also have a joint clinical unit and ambulatory care unit. And they will also have a joint ward. So let's assume patient comes to you with -- to the abdominal center. And as somebody looks at him in the emergency department, and it later was decided, well, he might have to have an operation. So he might go to abdominal surgery, or he might want to go for a conservative treatment. But so could be that the patient is moved to the less suitable department. He has to have -- undergo additional tests and so on in order to finally receive the optimal patient.

This is what we want to avoid by jointly looking at this patient right from the very beginning and then jointly decide what kind of treatment the patient needs. And thus,

you can avoid the duplication of tests and other examinations and so on, save time, save money, and save tests for the patients.

And we're going to have smaller clinics. If in these smaller hospitals that are also to be found in this region, where patients show up with a tumor, for example, then the chief physicians of all these clinics are going to be brought together. And they're going to form a so-called tumor board in order to decide, what is the best treatment for the patient? Are these treatments that perhaps have lots of complications and more difficult? Then a decision might be made to move the patient to HSK for an operation.

But smaller interventions could take place at the smaller clinics, for example. And thus, we're also trying to increase the quality, the medical quality as well. And that's the second clinic that we have in Wiesbaden. DKD can play a role that would take over post-care aspects. And they have -- and they work very closely with lots of physicians who have their own practices who send their patients to DKD.

So another example is Helios HSK and DKD used to work completely separated from one another and absolutely did not have a network at all. We looked at the situation and said, "What a shame," because we have all sorts of experts in both hospitals, but they weren't working together. The only thing that worked together was neuroradiology.

So we said, "Okay. We're going to come up with a new hub, and the HSK is going to be the hospital for the inpatients, and DKD is going to be for those patients where they're going to treat outpatients." And then we have a couple of areas where HSK is very strong and where they can provide special service neurooncology, neuropediatrics, and neurosurgery. And DKD has specialists such as headaches, pain management, neuromuscular diseases, and so on. And in some areas, both are active, for example, treatment of stroke patients or neuroimmunology, such as multiple sclerosis, or movement disorders, such as Parkinson.

So what are we doing here? The patient who was constantly treated for multiple sclerosis on outpatient basis might suddenly turn for the worst. And then he would be treated with -- in the future with the same physician. That is the physician who knows this patient very well would then continue to look after the patient when he moves into the HSK. On the other hand, that certain patients could first show up at HSK, and then from the physicians that they are treated by and attended by there could then continue to treat them when they become outpatients at DKD. And we can talk about medical plans, and both experts from both areas can work together on future treatments for the patients.

Third and last example is you can see our new building here. In this area at the top, we are going to be building our new so-called woman and child center. These are areas that work very closely together anyway. And so pediatrics and so on and obstetrics and all belong together in one hospital. And it's going to be on the ground floor where we'll have outpatient care, where we have a day hospital, somewhere we'll also provide C sections and then also neonatology. That is you have a prematurely born baby that can be driven into the next room and looked after very intensively. And other children would be on higher stations and so on.

And then we have a gynecology and obstetrics ward, then the pediatric ward, and then as we said, the private patient ward pediatrics and obstetrics so that we have better synergies. The physicians can exchange their thoughts much more quickly. And we're creating a much more pleasant atmosphere for our patients because everything is all under one roof.

Yes, well, sorry, that was one too quick. Okay. And so I hope we can now turn on the video to show you this video. It worked yesterday when we practiced. I don't know if we can work it. This is a shame. Oh, here we go. Okay.

We've talked a lot about passion. And I think this is a pediatric physician. And he's dancing for a patient who is severely ill. And he was feeling so bad that the physician promised him that, if you want to get better, then I will dance for you. And so this video was clicked on the Internet for millions of times. And so I wanted to show that we have such motivated physicians. And you'll feel much better. So thank you very much for listening.

Q&A SESSION

Markus Georgi: -- Corinna. Thank you, Olaf. That brings us to the next Q&A session. We have to make up some time. And therefore, my recommendation would be let's do a 10 minutes Q&A session followed by a 10 minutes break. So the next session would start then at 3:00 p.m. Any questions? Oliver.

Oliver Metzger: Hi, it's Oliver from Commerzbank with one question. It's about the impact of a case mix also with regards to your over total growth. So on one hand, we see the number of patients which increased by more than 1% with a price component of a budget DRG as a little bit too high, but even taking into account some discounts, we are at north of then 2% and some organic growth which you have reported over last quarters is a little bit north than 3%, so below -- more at the lower end of your midterm guidance.

So basically, there's one component, the case mix, which might explain potentially the gap between number growth and the price component. And potentially, you can give us some idea why in the sum the organic growth is laying a little behind the overall input matrix which are observable. So if there are any changes in the case mix which might explain that.

Francesco De Meo: Ralf, we make it together. I repeat the question as I understood the question. That's my -- and I give you an answer to a certain extent. The rest may be done by Ralf. If you come from 3% organic growth and you think about the price effects you know from the Veränderungsrate in Germany, you ask why isn't it that? Why is it low? Why is it lower? Maybe it's the case mix index making that lower than being that 2.9%.

It is also the case mix index, but what you didn't consider is the catalog effect also Franzel talked about. So there are some diagnoses not paid the same as paid last year. So even if we get, for example, 3% price effect, in reality, it is less than 3% if the catalog effect doesn't give the same reimbursement, for example, cardiology or Endoprothetik. So usually, we lose between 0.3 to 0.6 on that effect. It depends on our total portfolio.

That's something you didn't mention, but indeed, it's also the case mix index. We have the fact that we see that we get in our hospitals mainly people now with a lower case mix. And it depends on the length of stay discussion and the case mix index. Therefore, I said that's something that Ralf can explain for you.

Ralf Kuhlen: We are -- I'm sorry. We are probably coming back to the Fixkostendegressionsabschlag. But that's going to be the second argument. The first is we -- there is actually -- the DRG is calculated from real-world costs. There are 270-something calculation hospitals in Germany, where all the prices and all the reimbursement costs are really calculated and then coming up to DRG, that theory because, afterwards, the DRG are modulated a little bit.

And for example, whenever there is the fear of overuse, like for example, in cardiology and orthopedics or in spinal surgery, the InEK, which is the institute who finally is defining the DRG and the reimbursement, is decreasing the reimbursement from this respective condition.

Just giving you an example from the so-called catalog effect in the last year, the mix of cardiology we were having, which is pretty strong -- we have with Leipzig one of the biggest heart centers in the world actually. The mix of cardiology we're having there was decreased by 8% on average, the same performance, the same operations, the same patients, the same numbers, 8% less reimbursed. So that is the first thing. So case mix index is reflecting severity of disease but not really only reflecting severity of disease. It is adjusted over the years.

And the second one is Fixkostendegressionsabschlag because, if you are doing something above your budget because you are terribly good and patients are coming to your hospital and you have to give that discount approximately of 35%, that will return into a decrease sales although you're doing actually the performance. And that's the other one.

Markus Georgi: Julian.

Julien Dormois, Exane BNP Paribas: Yeah, just coming back on Quirónsalud for a second, you had a very successful growth trajectory in the company and especially on inorganic growth. I'm at the back. And last year, I think you delivered like 4% in organic growth at Quirónsalud. Is that the kind of level that you are targeting for the next few years, or do you have the ambition and the capacity to absorb more over time?
And the second question relates to the profitability or the profit structures of the private hospitals that you buy in Spain. Are they typically pretty profitable? And do they come to a higher price that what Helios in Germany has been used to pay? And typically, I think it was like 10 or 12 times EBITDA that you've been paying for loss-making German hospitals. Do they come at a higher price tag?

Héctor Ciria: Okay. So in terms of acquisitions, it is very complicated to say how many you're going to have every year because that does not only depend on us. That depends also obviously on the opportunities. We are ready to complete those opportunities whenever we find the right targets. But that could be a good number.

Last year, we actually did -- I think it was six small acquisitions, a couple of them in the ORP segment and also in the hospital segments. And we are also looking at others over the coming years, but it's -- I think I would be speculating if I say a number because that also obviously depends on the opportunities.

And also, we only want to do acquisitions whenever that brings us some value. I mentioned that before. We just don't want to be greater or be larger. We want to be better. So if that -- the target doesn't add anything to what we have, why do we need it, right? So but that could be a good number, looking at four, five small acquisitions every year. That could be an option, but really depends on market dynamics. And we have to find opportunity.

Stephan Sturm: Julian's question was actually about organic growth. And he said 4% last year from recollection.

Héctor Ciria: Okay. Sorry, I --

Stephan Sturm: I think it's five. And you said whether that was a good proxy for --

Héctor Ciria: Okay. Sorry, I understood you were talking about acquisitions. The organic growth, yeah, last year was a bit more, was 6%, 6% organic. That's a number that we are kind of targeting. I think the range is about 4% to 6%. We expect to be in the upper range of organic growth, this 4% to 6%. And hopefully, if things go well, we would even be a bit above that number. But 6% was last year, and we are trying to work on something similar for the future.

Then you were asking also about the acquisitions on pricing, right? So that's why I thought the four or five was the acquisitions. So at the end of the day, to my acquisitions in Spain, you need to be competitive because we are not the only buyers. There are other buyers. And it is true that, typically, when you buy a good asset, you need to pay typically those figures, right? You mentioned 10, 12 times. It depends on the different acquisitions. But if you want to get a good asset, you need to pay market pricings. And those are the kind of valuations that are the reference in Spain.

Having said that, typically, thanks to our scale, we are able to find synergies pretty quickly in the cost base. So the most obvious one is procurement. In procurement, it was discussed before about 20% plus of the total cost structure is procurement. And in procurement, we are typically 10% to 20% cheaper than many of the targets we acquire. And that's a synergy that we get almost immediately, once we introduce the new targeting to our buying platform.

So those are the kind of quick synergies. Something similar happens sometimes when we do in house our laboratory or the non-healthcare services, we take those in house. And those are pretty quick synergies that affect the cost but doesn't affect the way the hospital works. So we are not talking about personnel. We are just talking about being more efficient in the procurement, right? By doing that, this allows us pretty quickly to be below the 10 times multiple just because of those synergies that are achieved 12 months -- in 12 months' time, more or less.

So short answer is we need to pay those kind of levels typically, but we are below 10 times pretty quickly in most of the cases.

Stephan Sturm: And I think -- correct me if I'm wrong -- geographical presence does play a role. If we can form or even complete a geographical cluster, we may even be prepared to pay up because of near-term synergies. If it is a so far - all right - untapped region within Spain, we're going to be more conservative.

Héctor Ciria: Yeah, that's exactly the case. Actually, I've been asked many times. When you see the map of Spain, there are like some holes, right? It's, "Why you are not there?" Well, simply because we didn't find good targets, or the ones we liked were not actionable. We just didn't want to go there for the sake of, let's say, conquering territory, right? That doesn't make sense.

In our acquisition strategy, we are not only acquiring some hospitals. As I mentioned, we are also doing some M&A in the ORP business. And also, within the healthcare service, remember that we have a very important outpatient volume as well. So we are also acquiring medical centers that are outpatient centers that, as Stephan is pointing out, they are very helpful to actually act as satellites to around our hospitals. They look -- they work as feeders. And they capture patients that can be sent to our hospitals.

This approach is quite helpful because it was also discussed before that having proximity is very good in Spain. People like to have a contact point very close to their homes. So you can offer them those medical centers. And then if they need more complex treatments, we can send them to our hospitals. So we are also growing in making acquisitions in medical center, which is even a farther fragmenting market.

Markus Georgi: One more question from Michael.

Michael Jüngling: Thank you. The first question is it's very helpful to highlight the differences in inpatient days between Spain and Germany. I think what's missing here is a timeframe that we can work with of how long it may take to reduce it by day. Are we talking about a two-year period or a three-year period?

Question number two is, in terms of the headwinds of reducing inpatient days for Germany, could you highlight maybe the top three headwinds that you are facing? Is it physician compliance, whatever it may be?

And question number three is -- I'm just curious. What actually is one hospital day worth? Are we talking here about €300 a day or €200 a day, some sort of guidance? I know you're probably going to say it depends, but some sort of range of €200 to €400 or whatever it is would be helpful.

Markus Georgi: Didn't we say one? Okay. Who would like to start?

Ralf Kuhlen: Question number two, it's in between €200 to €300 a day but depends very much on what day you actually are looking at. The first day, where you do all the diagnostics and all the interventions and everything which has to be done, is definitely much more expensive. And day 10, where the patient is simply being in hospital for whatever reason, just lying there, is definitely much more inexpensive.

So in some calculations the German colleagues did during the last weeks and months actually, it came up to be in between €200 to €400 a day. But here, it becomes really complex. And I gave a little comment on this before.

If you -- once you are above the upper limit of length of stay, you are reimbursed additionally to the DRG reimbursement. So it's a per diem honorarium which is paid to the hospital there. If you decrease this, then you decrease your cost but as well your reimbursement. Therefore, it really becomes complex, and it really -- there is no easy answer to that because it really depends on the actual day we are looking at that.

And the other one, how long does it take until we achieve the reduction of length of stay, if I got you correctly -- it's hard to hear from here.

Michael Jüngling: Yes, that was right.

Ralf Kuhlen: Yeah, changing attitudes and habits is really an issue in -- I guess in general terms and in medicine definitely. So the -- what we achieved within the last year was approximately 0.8 days. That is tremendous, being below the average that much. And I think we can go further on. And I think we really can learn from the partners here. But I wouldn't give one, two, or three years. It takes really time to change habits on a day-to-day basis. So we will come there, but it's a lasting process.

Michael Jüngling: And is it physician compliance that's the most challenging? Maybe you could rank the top three challenges that you face in reducing inpatient days from here.

Francesco De Meo: When we talk about that changes, we have to talk with doctors and the nurses because we have to change the process. But the most important thing is that they often fear the same what is told in the outside world. They think, if you make it faster, maybe it will be not accepted from the outside world, and the patients will not come any longer.

So we started to make that discussion on the Spanish experiences, saying our doctors and nurses. But the patients accept it if you explain it. And that takes some time also because they must be educated to explain to the patient. The patients come to them and say, "It's not possible. I must go out of the hospital two days earlier than I'm accustomed to, and I go to the next hospital and be there two days longer." That's the problem to make it.

And to say to the €200, €300, already know about our discussion in the budget process. In the first step, we thought that such kind of calculation was very intelligent to show on

this lengths of stay and to calculate the stays, the days we don't have multiple -- and that take a multiple on €200 or €300, something like that.

At the end, we saw that that calculation is not valid because it's too complex. So you cannot have a calculation saying it's that day. It's in all 100, 20, 30, 50,000 days, and you make the multiple €200, €300. That doesn't work because, in reality, we saw that we cannot get the money as it is calculated.

Why not? It is the attitude, okay, but it's also the costs are not gone. They are there. They will only go, the fixed costs, if you can close departments or close beds. So that's the situation we found. And therefore, we are very cautious about the calculation on such an issue.

There will be something coming. And we will see it after the time what will come. But it depends on a situation in the hospitals and on closing scenario of certain departments, for example.

Stephan Sturm: Okay. Michael, out of one question, there were three. I want to wrap up this answer by complementing Francesco, though. And, Francesco, it is fair to say that whilst throughout the year we have a capacity utilization of below 80%, as we all know, as you have seen from our quarterly earnings profile, there is also a certain seasonality in the German business. More pronounced in Spain, but there is also seasonality in the German business.

From my perspective, one of the key benefits of shortening the length of stay is that we have in high season a higher probability of accepting additional cases, yeah, with the given and installed capacity.

So I fully agree with Francesco. It is a very complex calculation with a lot of variables. Maybe over time, we get a bit closer to it. I do agree that the €200 to €300 of variable cost doesn't capture the entire picture because some of it is fixed cost that won't go away. But on the other hand, we will see an effect also on the revenue side.

For the time being, I'm afraid I can't give you more than an answer than it is most certainly a positive effect on our profitability if we bring down the average length of stay. Directionally, that's absolutely without a question.

And secondly, with a bit more education, it will most certainly also have an effect on patient numbers and the revenue and subsequent EBIT.

Hope that was instructive. Let's remeet at five past 3:00, please, and let's grab a cup of coffee. Thank you.

BREAK

Markus Georgi: Okay. As we announced before, we would start on time. The next session is presented by Adolfo and Jörg. They will give you an overview where we currently stands when it comes to digitalization and innovation. And hopefully, that's more interesting for you than grab a cup of coffee.

PRESENTATION: Quirónsalud Digital Transformation –
Adolfo Fernández Valmayor
PRESENTATION: Helios Germany Innovation & Digitalization – Jörg Reschke

Thanks for all being back on time. Once again, happy to introduce Adolfo and Jörg. And they will give you a short overview where we stand today from a combined business perspective when it comes to digitalization and innovation. I think short introduction by you, Francesco.

Francesco De Meo: By Héctor and me. I will start because I promised a yin and yang, Héctor. You know the Rainbow of Happiness here. And you know where digitalization has to be reflected on that Rainbow. So it touches a lot of those points. It is me now to start the yin and yang. And it's Héctor then to continue with his part on the yin and yang and with the key takeaways. And then we give over to the colleagues being here.

So oops, where's my yin and yang? Oh, here's yin and yang. Okay. So we go to the yin and yang, and then we go back to the key takeaways.

It's a nice picture. I believe you understand it. I hope you understand it. You know the colors, the German green and the Quirónsalud red. And if we talk about digitalization in both worlds, it has highest priority. However, you will see on the presentations that, in Germany, we did the first steps and the big things thinking digitalization being a driver on efficiency. And we did not aim so much to the patient. Therefore, you see the green that way.

And in Spain, we found it vice versa. The Spanish colleagues started to think about digitalization coming from the patient and his needs, as you saw and you will see even in Adolfo's presentation later on. And then they learned about digitalization helping to make things more efficient. So the most important thing on that would be and will be that Adolfo and Jörg then at the end will put together the yin and yang in our digitalizations.

And what's the key takeaways? For you now, Héctor.

Héctor Ciria: Okay. So Francesco was saying, actually for us, when we started on any digital opportunities, we had the patient in our mindset and tried to offer everything that was good for the patient, not only from a medicine point of view, but also from a service point of view. And this is how all of our solutions started with patient first in our mindset.

And key takeaways, we think that digital is going to change basically everything. It could change the relationship with the patients, but also, it will change the relationship between doctor and patient and also between nurses, between porters. Everyone in the organization is going to be changed the way they work by introducing new digital opportunities. And Adolfo will talk about that.

Digital is not optional. We've discussed that. We'd rather do it, or otherwise, someone else will do it. And not only that is digital offering us so many new tools that why not using them if we can use them to improve our outcomes, we can use it to improve our patient experience, we can use them to improve our efficiency?

Digitalization is also a way to basically connect with all the stakeholders. And that will be discussed. It's not only patients. It's also doctors. It's also our clients. It's also the health insurance companies. It's also the community.

And then it is very important, and I think, Jörg, you will talk about that, that we have standardized data, that the data has good quality, that it is well controlled, that it is well protected. This is very important in today's world. And obviously, you have been focusing a lot on that. We are learning from you as well. And that's the only way that we can continue working in digital. We need to protect the data of our patients. That's paramount for us. And obviously, we're spending time to make sure that we comply with not only with the regulation, but also that we do things as we should do from our high ethical standards. So we talk about all of that.

Francesco De Meo: Let's hear yin and yang of digitalization, please.

Adolfo Fernández Valmayor: Okay. Thank you very much. We know that you were waiting for us, for the digital moment. So here we are. Well, you know the Rainbow. We are only concentrating in more or less these areas of the Rainbow.

And some key takeaways, digital is not optional. It's mandatory. If we don't do this, probably we will be out of the market in -- I don't know -- 10, 15 years. But for us, it's not just mandatory. It's the big opportunity. It's the big opportunity to change the doctor-patient relationship from paternalism to a person-to-person relationship.

And with three new features that are absolutely demanded in this new era, which is real time, which is transparency, and personalization. Nowadays, everything has to be in real time, and it has to be for us, just for us. And transparency is mandatory because it helps us to improve our procedures.

I would like to start with a video, with a short video for future.

[Video plays]

Female Voice: [Spoken in Spanish]

[Video ends]

Adolfo Fernández Valmayor: Okay. This is not really future. It's present in some of our hospital. We are working in all these things. And well, it's just an idea. How are we working in this digital transformation? We are working along four transformation axes, which first one is with our external partners. We are working with our external partners. Two, among our centers, we are connecting our centers for doing a lot of things inside our hospitals, changing the way many of the professionals that are inside the hospitals are working and for sure with our patient in the middle and doing everything with our patient in our mind.

I'm just going to give you some small samples of any of these four axes. The first one, working with external partners, at this moment, we have 57 primary care centers connected and 140 nursing homes connecting with our hospital. These allow us to have direct relationships because -- between doctors, between the doctor of the primary care center or the doctors of the nurse home can connect directly to a specialist in one of our hospitals and together take the decision if they have to send the patient to the emergency department or not. We have avoid along of movements of patients for these centers to our hospitals, which is good for the patient. And in some of hospital, it's also good for us.

Also, and the other example is the ambulances. We were the pioneer in Spain who were able to connect the ambulance to our emergency department. So the person with a heart attack is monitored inside the ambulance. We are managing the ambulance like if it were another box of our emergency department. And as soon as the patient gets into the hospital, we can move him directly to the intensive care unit or to a critical box or whatever is necessary.

We are doing -- some of these practices we are transferred to the private sector also. And we are working with external partners in some medical centers which doesn't belong to Quirónsalud. And also, we are working with insurance companies to do electronic consultation of the patients' treatments.

And the second axis is working in our centers. Before in one -- before presentation, Leticia told that we are working in multi-hospital medical doctors, medical teams. We are using technology for this. And this allow us to have some medical specialties in some small hospitals that it couldn't be possible to have if we don't have this hospital connected.

Examples of this are, for example, brain stroke emergency that we can have brain stroke emergency using telemedicine in some small hospitals. And we are also able to have remote intensive care units in Catalonia between some hospital because we have one team monitoring the small one from another.

In the third axis, I will have some examples of mobility. We have mobility apps for doctors, for nurses, for the cleaning and maintenance team, in which they can do their job more efficiently and advise when the room is clean so we can put another patient in the room, and especially for the porters. The porters has an application in which they receive -- it's like a Uber application, something like that. They receive all the tasks that they have to do. The get the task. They capture the task. And they can go and move the patient.

This has allowed us to improve the productivity over 30%. And more important, it reduced the movement of the patients in about 25% of the time. And well, they're happy. They're happy because now they have a smartphone. We have give all of them a smartphone that they haven't in the past. So this is another important thing.

And also, we are working in this efficiency by productivity, sorry. But also, as we told you before, we are thinking about patients because we are at this moment working with tablets in an arm in the bed. And these tablets is -- they are not also -- they are not only entertainment systems. They are also clinical devices in which we can put the medical treatment of the patient. And as it was this morning before, the patient know when the doctor is going to come to the room to visit him or if he has to go to a test or whatever. The person now -- when a porter is going to come and to take them to test. So this is the most important part of this area. We are changing the way we work.

Another two examples for the patients in this axis is the kiosks. We are working with a lot of kiosks in our centers in which the patient can tell us when he arrives to the hospital so we can start to take time. This is very important for us for the program that Leticia told you before, which is called 15 minutes plus 15 days.

For the 15 minutes waiting time for the patients, we start taking time when the patient arrives. Now we are moving this to the patient mobile so he can advise us when he's in the hospital using the mobile. And also, we are signing the consents using the fingerprint in their mobile.

And also, we are using bracelets. We are using bracelets for the families, taking -- tracking the patients when they are in the surgical circuit, when they're in the operating rooms, and also for the fragile patients. Many times, patients, when they arrive to the hospital, we immobilize them. They are in the bed. And at the end of their stay in the hospital, they are in a worse mobility position that they were when they entered. Using this program, we are improving this. Ralf talked about this in his presentation also. And it's very important because we apply them to step -- to walk every day 900 step. And this is good for their health.

And the fourth axis is our patients in the middle, our portal patient. And I have another short video.

[Video plays]

Male Voice: [Spoken in Spanish]

[Video ends]

Adolfo Fernández Valmayor: Okay. I'm finishing. Nowadays, at this moment, we have over 700,000 patients in the patient portal. And 50% of these are active user in the last

six months. We also -- they also have access to over 5 million accesses to their electronical medical record and over 1 million appointments done in the portal. This million appointments on the portal is also a way of give efficiency to our system because this million of appointment are free compared to our call center personnel or the admission of the hospitals.

And the new application in which we are working now is this one here on the right, which we are working in medication application, a drug track adherence in which we can remind the patient when he has to take the pill.

And the last message, just I would like to give, we have this Web portal, Web application portal in an APP, but also in an app, but also in a Web model. And the only message that I wanted to give you in the Web version is that this is a family portal. It's not just a patient portal because, as you can see here, here is Daniel. He is the father of Adrian. And he can using this application, work with all the family electronical medical records. And really we are thinking not only the patient, but all in their families. Thank you. That's all.

Jörg Reschke: So thank you, Adolfo. So I think we heard and feel the beat, the heartbeat, and also the passion in your digital solutions at Quirónsalud. And for us at Helios, we also have some slides -- no films, but some slides.

So for us, it gave us an orientation to keep on track and to be much more patient orientated than we have been before. We were very focused on the organization in our hospitals. We were very focused on giving support to the production in our hospitals.

And we've also the Rainbow of Happiness. And we are here. And with the cooperation and with the knowledge of each other, we focused on patient orientation. And the key messages I want to give you are smart solution are keeping in touch with patients, supporting the diagnostic and treatment process.

Digitalization fosters the connection with our partners, not only the patients, also the other partners, like insurance companies and so on. And a standardized data bridge is the way for exchange between these partners. And data security is the frame for all of that.

Now we have also some solutions. We have a patient portal. We have something like OPFIT to give an education module after a surgery. And we have something that we call GUIDE ME we developed with Fresenius Kabi that's a platform we launched end of year to give a portal for a disease management program.

We have waiting time displays, and we developed them after we saw what's possible in Spain, as Francesco told today in the morning. We have a lot of documentation things, not to be part of the process. We started to have a lot of apps for photo documentation and for process documentation.

At the base of -- basically, we started to determine our status of digitalization in our 88 acute care hospitals and evaluated all clinical processes. And there is a standard from Himss Analytics. It's a system called EMR, electronic medical record level. This is something we analyzed with our digitalization cockpit and gives us an orientation where we are with our strategy.

And the green bubble shows the Helios clinics. And you see level seven is the highest level. Everything is digitalized. And level zero is like you do everything in paperwork. And with Helios, we have some clinics in level six. And in the average, we are at 3.5. In Europe, we are with a 3.1. And we are more than one level ahead of the German average with our status of digitalization.

And this is very important to develop data to our partners. And we developed what we call the Helios Bridge. It's based on IHE's HL7 FHIR technology. And it gives us the opportunity to send and get data from our partners. And we don't have a one-on-one cooperation strategy. We have a one-on-N cooperation strategy so that we are absolutely open to receive and send data to all of your devices you have in your arm, in your bag, and so on, and to get in touch with insurance companies to exchange data, patient data, and also to exchange data in the Fresenius family.

This is also the base for our patient portal to send data to the patients, not only to the insurance companies and get data from the mobile devices, also to send data to the patient portal and not only to the Helios patient portal, to other portals like one from Apple health records. Maybe a lot of you knows about that. We are able to send our data to these record portals. And also, via this technology, it's possible to make appointments and to check in, in our hospitals.

What are we doing with all this data? We collect data. As typical Germans, we collect them, and give some reports, BI reports, KPIs, fill some dashboards, and so on. But the idea is to develop something like a case predictor to identify duty schedules, to have an idea for staff requirements, to have an overview in our stocks, and to be prepared with our equipment. That's what we're working on just to get more productive to increase medical quality and efficiency.

What's the frame? The frame is security. It's very, very important not only in Germany. It's always very, very important. And we are part of the local -- the German Security Council, Cybersecurity Council. We have some things done with the German TÜV. We built up an own cyber defense center to protect our and the very important patient data. And that gives us the security which is the frame for all this mobile technology.

And we met several times. And what we learned from the Spanish colleagues is your heartbeat and the passion for mobile applications. Your patient portal, thanks a lot, gives us a very, very good impression and ideas. And maybe there -- in the future, there can be some apps developed together.

Adolfo Fernández Valmayor: For sure. For sure. Really, it has been very profitable for us also. We have been learning a lot about the way you manage your data. You said Germans collect data all the time. It's true. And we are working with you with the healthcare outcomes benchmark, which is very important for us. We have also learned a lot about cybersecurity. When there was that WannaCry issue in Europe, we weren't attacked. But we improved a lot after working with you after that problem. And also, we are working on several things about procurement because not only Helios, but also your Fresenius Netcare is helping us with some of the things that we have to buy in our department also.

Jörg Reschke: So we'd like to thank you, and it's your decision who is yin and who's yang.

Adolfo Fernández Valmayor: Thank you.

PRESENTATION: CFO Update – Daniela Hommel

Daniela Hommel: A warm welcome also from my side at the end of a long day. And thanks for being so passionate to stay with us here, to listen to me, and when we look now at our financial statements.

I also start with the Rainbow as my colleagues before me. And the question that I had to answer often yesterday night was, what does the CFO at Helios.health do actually the whole day? Is it pulling budgets together, controlling numbers? And no, it's not. And that's what I told you last night already.

It's looking at -- also at that Rainbow and finding new ideas that drive business in the future. And that's why my presentation is not only on this Rainbow and the initiatives that were already implemented, but already -- but also on the part what we can do next and then be prepared for the future. So it's on integration through interaction.

What should be the key takeaways? We start with the financials as with our current financial statements. And they were determined by local structures actually. You have heard today many times that sales and EBIT growth is expected from combining the best of both worlds. But growth will also be supported by a sharpened portfolio and investment into the future. Now let's start.

Where do we stand currently? And if I put this in an equation that reads one plus one equals two, please do not forget the tremendous efforts that the colleagues do locally in implementing so many synergies already on local level. On top of this, we look then for synergies from Helios.health level. But that is special about our business. A lot of work is done already in the local financial statements.

So how do they look like? We want to look at the income statement, at operating cash flow and CapEx, and our employees just to set an anchor for the following presentation. And we look at sales, EBIT, EBIT margin, and net income.

Last year, we made sales of €8.6 billion. The EBIT was about €1 billion, resulting in an EBIT margin of 12.1%. Now think back what you heard about the EBIT margin in the healthcare business and hospital business in general.

Net income amounted to €728 million. Our operating cash flow was €733 million. We invested €415 million into capital projects. And you heard about them today already. Think about the greenfield projects in Madrid and the proton therapy centers and also what Corinna told you about investments into our German hospitals. So that are the current projects. More than 100,000 employees contributed to those great results.

In the following part of my presentation, I want to explain you how we look at our financial statements. But your questions today showed me already it seems to be a little bit difficult how to interpret the numbers and what messages you can take away from those presentations. And that's why I want to start with a quote first. And please do not forget, "Not everything that counts can be counted, and not everything that can be counted counts."

And probably, at that time of the day, you have the same impression that I had when I looked the first time at all the numbers in the healthcare sector. To me, it looked like a train map, and you were never sure what route or what train you should take to come home from one end to the other end.

But then if you move a little bit up, one thing is sure. All the healthcare systems in the world, they look differently. And maybe they take different routes through the network of trains. But they have one thing in common. They want to make sure that patients get healthy by the treatment.

And that's why, if we want to think about KPIs, financial KPIs that enable us to look at our financial statements and to identify the further growth potentials, we need KPIs that use standardization where possible, but that also allow for the differences where necessary, and most important, allow for the inherent limitation that we have set for our business. That is the patient is the first thing we think about. And with that thought in mind, please, let's continue and look at two slides of financial statement information a little bit deeper.

And the question that we want to answer, how can we one plus one be more than two also in the future, and on this slide for sales. We look at our business now from three perspectives. That's Helios Germany, Helios Spain, and Helios.health. And what I want to explain you, where there's additional potential for growth at Helios.health.

And if you look at the sales side, we want to look at sales, inpatients and outpatients numbers, DRG-alike revenues, DSO, and the bad debt expense ratio because that has impact on the EBIT. At Helios Germany, we achieved sales of €6.1 billion. We treated 1.3 million inpatients and 4 million outpatients. DRG-alike revenues amounted to 81%, and we had a DSO of 52 days. Our bad debt expense ratio was 0.2%.

The picture, as you have heard today, is completely different in Spain. So we treat -- we achieved sales of €2.6 billion, treated 400,000 inpatients only, but 11.2 million outpatients. DRG-alike revenues, meaning fixed payments per treatment, amounted to 17%. DSO is higher. It's 138 days. But our bad debt expense ratio is also 0.2%.

So what can we learn from looking at the numbers in that way? The patient number and the payer structure differs. However, the impact on our EBIT is comparable, by losing money by payers that do not pay.

And what you've also seen today that we have renowned experiences and specialists in our clinics. And the idea that comes from health is that we can use that knowledge to treat international patients even better. So if we could market those capacities, those specialists on a broader scale to patients, those clinics may be attractive then also for patients from internationally. And that helps us to increase the amount of patients that we can treat. And that drives our sales.

Now over to the cost side. And you've heard -- also have heard a little bit about this already. So again, three dimensions, and we look at personnel expense ratios, which is adjusted for Spain, medical expense ratio, other operating expense ratio, and then finally EBIT. In Spain, we have the specialty that not all the doctors are employed, but we adjusted this for this presentation.

The personnel expense ratio in Germany is 61%. The medical expense ratio taken from the financial statements, roughly 20%. Other operating expense ratio is about 4%. The EBIT amounted to €725 million.

Helios Spain has a personnel expense ratio of 51%. The medical expense ratio is about the same, is 21%. And the other operating expense ratio is about 9%, resulting in an EBIT of €327 million.

That means and comparable is that 80% to 85% of our sales are made up by operating expenses. That's not dramatic. However, those operating expenses are basically fixed expenses. So they cannot be scaled easily when sales go up or down. And that's why all the initiatives that you've heard today are so important so that we can manage our expenses in the best way.

So what can we add at Helios.health to all the stuff that you have heard already today? And for instance, there's a project on digital pathology. You heard about this what the colleagues in Spain do already. And there may be thoughts to transfer such knowhow also to Germany in the future. It takes some time, but the last weeks I spent, for instance, to discuss business plans with my colleagues from Helios.health how that can be done and how -- whether that brings synergies also in the future in addition to the ones we have heard today. So we are looking at additional synergies already in a very early stage.

So that means we can still learn from the best practices in both countries, not only that we try to be a market leader in both countries. There's always knowledge that you can transfer between those countries.

And I'm deeply convinced from this best practice learning and also from the idea of peer review. I started my own career in a profession that invented the peer review already in 1975, the year when I was born basically. And that gives us or gives me the confidence that there is something to the story that you can learn from best practices and be even better if look with a fresh mindset on what is there already in addition to the great work that our colleagues do.

So what can be -- what else can be done? You've heard already that we sharpened our portfolio now a bit two days ago. And we look at our portfolio from time to time. Why do we do this? We want to focus what we can do best and our core competencies because only focus allows us also to grow further.

Now from a financial side, what is the effect? You see here the reported financials for 2017 for Fresenius Helios. And then the effect of the portfolio sharpening is about €440 million in sales and €36 million in EBIT for the financials 2017. So the new -- the pro forma financials -- these are called pro forma financials -- would look as follows. And you see that the portfolio sharpening effect has an effect on Helios already.

The last piece of my presentation is on the future. How can be one plus one be more than two by investing in the future? And there is the idea in our heads that we can use the Helios.health platform for investments into further growth to drive sales and EBIT and to increase them.

How do we determine what investments are the right investments from our side? And we think that the value approach that Francesco introduced today this morning to you is the best anchor to determine where to invest and how to invest. And the investment fields are good market access, efficient processes, infrastructure, controlling readjustment, and qualified medicine, specialized personnel.

What do I mean with good market access? For instance, to define the structures how we can treat international patients. How do we get grip in the countries where we do not have investments? How can we be attractive for patients there and use the structures that we have? Do we need additional structures? What types of investments do we need to make to gain this market access? That are the questions that we are currently thinking of.

Efficient processes, and Enrico and Pedro and also Olaf, Franzel Simon, and Corinna talked to you about this. So that's why no further examples from my side. But you surely agree also that comes along with more investments.

Infrastructure, that's not investment into brick and buildings. I think you've heard today we have a lot of them. But we want to also be ready for the future. And that means investing into the other technologies that we see in other industries. So from time to time, we look in the automotive industry. We look at transportation. We look at logistics, so industries that are comparable to what we do, but do this as a specialized industry, while in our business, all comes together in the hospital business. And that means that we could invest into Logistics 4.0, but also pursue further digital initiatives, like the digital pathology I just told you about.

Controlling and readjustments doesn't mean financial controlling. It refers to the point that Ralf made this morning and also Leticia and Andreas. It means that we could define structures to further use our SOPs and peer reviews that made us so strong. So maybe include other hospitals in there that do not belong to us, but to see how we can increase synergies also by making that thought available to third parties.

And last but not least, we need qualified specialized personnel. That point was mentioned so often yesterday and also today. And that's why one of our major investment fields is also to create an attractive and future-oriented work environment for our people.

To sum it up, a balanced investment into all of those five fields, that enables us to grow further. It's not a single field. It's a combination of those five fields that makes us strong for the future. And that brings me to the end of my presentation. Thank you very much.

PRESENTATION: Summary & Outlook – Francesco De Meo

Francesco De Meo: So I will not make it in five, but I try to make it in 10 minutes. Let's go. You know it, the Rainbow. You know it, key takeaways Germany and key takeaways Spain. We did it. You can read it. I think we met that key takeaways with all represented. But I talked about step one, best practice transfer integration. I talked about step two, taking experiences out of systems and learning in systems to make the second step in the approach. But what is the more international approach?

We are looking Helios to be a healthcare provider for defined patient segment in any given market. So it's a complete different approach to the approach we started in Germany or even in Spain, thinking about acquiring other hospitals or groups.

So if we look on markets being future markets or targets, that's the aim, to establish us as that kind of provider. What does it mean? When you look abroad Germany and Spain, analyze and define the segments that could be provided with such services, we determine a service portfolio and deliver the organization if there are. If not, it's no market. It's no target.

We calculate the costs. You know they are different, same drivers, different costs as in Spain -- between Spain and Germany. We decide on a payment and financing model, if it's adequate or not. And we love payment and financing models being flexible, as you know from Spain, more flexible as it is in Germany.

And we specify the medical quality and service benchmarks. Medical quality is important. And you should not go in markets or you should not go with targets not able to deliver that medical quality we believe to be our value. And it's the same for service. So that's what we want to do. That's where we look for.

And I don't know whether you find some targets there or some markets there. In former times, we discussed it on markets. And we would have started to look on the different landscapes and maps and thinking about different nations being interesting market.

We changed that view, latest with and after Quirónsalud. The market is important. But the first step to think about the market is the target. So we changed the process in analyzing the situation where we could or should go furthermore in the next regions in our internationalization.

So it's Helios.health starting with Germany and Spain. And you will not find now other colors on that map. But you will find that there is a target evaluation. And that's work in process. We do it every day, every week, every month. And our focus is on acute care and outpatient care. That's also -- you know about our portfolio sharpening with given rehab clinics or post-acute to Vamed.

We need a market size. That means we also need a platform in size of targets. Usually, we discussed roundabout €500 million in sales to make a platform. That may be an orientation. It is not given, but it is an orientation we take for us because we know from the past that that's a size that may be relevant to build up a platform or even to come to that size fast after consolidation in a market.

We want a stable political environment. As you know, when we invested in Spain, there was no government. So it's not important where there is the government or not. It's the system that is very important. And therefore, that's a stable political environment. So the system that there will be a government elected, that there will be a government able to make something for our market view.

And we want a favorable reimbursement scheme. If we don't get it, we will not go to that market at the end.

So that's the target evaluation. We will look on all those targets you may find there on that map. And we believe that best practice transfer will drive the international transformation and that, with that, we will be able to establish Helios as the provider of high-quality and high-efficient medicine anywhere on that map.

That's all. Or is it not? We talk about hospitals. We talk about structures. We talk about workspace. We talk about emotions in a world that has been completely changed by the smart transformation you all know. So why don't we talk about a smart transformation also on the healthcare and Helios and Fresenius level? What does it mean?

We know the five megatrends in healthcare. It's the changes in demographics. It's the focus on customer experience. You know about Internet of Things. You know about the big data. And you know about the precision replacing intuition. We cannot ignore those five megatrends. And we believe that we are best positioned to think about a smart transformation also in healthcare services in future.

Therefore, however, you need a new business model. A digital transformation and smart solution does not need a hospital everywhere. If you think about the platforms guiding patients, if you think about Uber, MyTaxi, Airbnb, all those smart colleagues don't need the taxis, the hotels.

So perhaps it can be also delivered a smart service for smart patients with our hospitals but even over them in other regions. Perhaps in future, we don't have to buy targets in another nation. We only have to use hospitals being there and sent with our smart solutions to patients to that hospitals. That would be a completely different way of healthcare services.

We are far away from that. But we are prepared. Why? What are the advantages of such kind of platform? And why is Fresenius very, very near to build such a platform? Because we are able to do such things.

Take for example cancer, bowel cancer, high prevalence and intensive costs. You have a lifelong challenge. You have a frequent comorbidity and strong emotional impact. And you have a complex treatment.

We know that all. And there is -- for all of that, we have a place in the world where we make it in reality, in real world. That's the difference between us and the Apples and the Googles. They don't have those places at the moment. As you know, they try, or they start to think about building up such places in the United States, for example. We have all those places. We have all those knowledge. So why not building that kind of platform and having a smart patient within such a Fresenius platform?

That's nothing for today, to be extended, but maybe something for the next Capital Markets Day to be reported.

Thank you very much. I'm below the 10 minutes. And it's the final remark I think now to be done after the Q&A from you, Stephan. Thank you very much.

Q&A SESSION

Markus Georgi: And thanks to our colleagues for all the presentation we heard before today. One presentation still missing, closing remarks by Stephan. And before that, would like to open the last Q&A session for today. So, Ed, would you like to start?

Ed Ridley-Day: Thank you and thank you for the presentations. If we could talk about potential M&A, and thank you for those slides you put up there. Can we talk specifically about the UK and France? They have the scale and obviously the opportunity to perform. But equally, whether they have sustainable and favorable reimbursement is a matter of great discussion. So could you rule out moving into, for example, the UK, a market that we -- some of us know very well? That'd be my first question.

Francesco De Meo: I think, if you go through the criteria, there are some targets in France and in UK, but there are also some targets elsewhere in the world. So maybe it is France and UK. Maybe also it is another point of the world. It depends on the discussion with targets and the view on the targets.

Ed Ridley-Day: So you wouldn't --

Stephan Sturm: You are a very smart communicator, Francesco, and a fast learner because I was already concerned that the next one would ask you about Italy and Portugal and -- okay. Well done. So it's --

Ed Ridley-Day: Okay. So not ruled out. But also, and this is actually more a question for Héctor, could you just in terms of the acquisitions, first of all, there was sort of return on capital targets that you're assuming for your new investments with Quirón in Spain. And just give us an idea of the sort of returns we could see on those five projects that you're handling at the moment.

Héctor Ciria: Okay. So I kind of explained a bit about that. The first thing we look at is the positioning of the targets, if they help to be better for our platform. Obviously, the acquisition prices is important. If you pay a very high price, then it makes your return more complicated.

But basically, what we look at is what kind of savings, not touching personnel because, for us, people is very important, and it's a very sensitive market. So typically, what are the quick savings that we can get? We look at those when we do the due diligence. We do very detailed due diligence.

We have our database of, for instance, every single product of procurement, how much we are paying. We know how much the target is paying for the same bottle of water, for instance, or the same brand of gloves. And then we do that before making the acquisition. And we make sure we target that the synergies we have preidentified, we get them later. We do that for procurement. We do that for external services, laboratory, cleaning, etc., etc.

And sometimes, there are a bit of revenue synergies as well. And basically what we do is we identify all of them. We assume we can't get them. And if by getting those numbers, our DCF figures meet the requirement that we are asked for, then obviously we go ahead.

Rachel Empey: Am I live? Okay. Thank you, Héctor. That probably opens the door perfectly for me in terms of what is asked for, no? I'm not going to answer your question very directly, but I'd like to talk a little bit about how we evaluate the various options and allocation of capital options that we have at a group level and how that relates particularly to Héctor and also to the rest of the Helios Group.

Clearly, as a business with a lot of opportunity and a lot of options in terms of investments, both organic and inorganic, we clearly have a relatively -- how can I say this -- diligent and robust evaluation model in terms of how we choose to invest.

We look at the things you would expect us to. We look particularly at detailed discounted cash flows, as Héctor said. We've very careful in terms of evaluation project-related risk and appropriate WACCs so that, when we are comparing a hospital acquisition in Spain versus an investment into, let's say, a manufacturing portfolio somewhere in China, we are clearly evaluating that as we see it appropriately risk weighted in terms of the certainty of the returns that we will see from that.

We're also looking at the payback that we're likely to see and looking at some of the other metrics in terms of the return on the absolute capital we put in. You clearly know very well the metrics that we're able to deliver on each of the subsidiary levels and a group level. And there isn't an easy answer to say, for this particular type of project, this is the answer. But we have a very robust process that goes around that that enables us to give you very consistent return on capital numbers and also deliver the combination of organic and inorganic growth that you've seen.

Markus Georgi: Veronica.

Veronica Dubajova: Thank you. I have two questions, please. My first one is on this idea that you can get revenue synergies from combining the two businesses. And I'd love to -- I think, if I go back to when you announced Quirónsalud, the discussion was really only about cost synergies. And I'd love to understand how quickly you think you can get to those revenue synergies and maybe quantify them for us so we can think about that.

And then my second question is on the international expansion. And what do you see as a realistic timeline for that? And if we look at Helios in five years' time, is this going to be a question of you add one new country every two years? Could you enter multiple countries in a single year? How should we think about that? Thanks.

Stephan Sturm: Okay. Francesco, you may, but you don't have to answer.

Francesco De Meo: On the revenue side, it was mentioned one project we are in a more concrete status now. It is the international patient approach. We saw that we do not take all we could take on that international approach. And combining that, we believe that that will lead to real combined revenue.

I think the process now is soon to be decided and closed so that, beginning from next year, you will find also some, let's say, kind of structure and then approach that makes really clear that the combined strategy brings more patients to Germany or even to Spain. A lot of people like to travel more to Spain. That's the one reason. But also in Spain, some kind of cost structures are not as it is in Germany.

So maybe it will be even more revenue driven towards Spain from international patients than towards Germany. But on the health perspective, it doesn't matter. The most important thing is to get the revenue.

And that's really something. It's not big, big numbers. But we had a look on that and even identifying some groups we saw and we do not take. We talk always about 20 million or 30 million. And that's something we discussed in the integration transaction process. So I see -- and that will be something that may come soon on that level.

It is more difficult to make revenues whereby transferring systems. All we talked about on the outpatient sector, for example, Germany tries to make that approach also now in Germany. So learning from Spain and being successful in Germany will bring us more revenue in Germany. But that's not that easy transformation as we see it on international

patient level. That's more complicated and more complex. But if we are successful, that will bring really stable new revenue against the pressure we get in Germany, for example, from the other things. That's longer, and the first step I think is a very step we can take.

And about, when I started to think about a family, I did not plan to make in certain time the next babies. However, now at the moment, I'm at a status of number eight. So if you would have asked me 10 years ago, I never had said anything about that. So take it -- it may be as babies come. And that may be fast and soon, but it may be also later.

Stephan Sturm: Rachel and I are in charge of birth control.

Veronica Dubajova: Can I ask the question slightly differently? If you say, "We used to think about markets that we want to go into, and then we look at the targets in those markets," now you're saying, "We're looking at targets first." That would suggest to me that it's much more likely that you'll end up with more countries over time than under the previous plan. Is that a correct interpretation?

Francesco De Meo: Yes, that may be. It depends, but it depends on targets being at that level I mentioned. So that's not that they're a mass of targets fulfilling that all. But real -- we're looking for different countries because there is not a selection on country. It's a selection on target, the first step. Indeed, there, you're right.

Veronica Dubajova: Okay. Thank you very much.

Markus Georgi: Hans.

Hans Böström: So two questions for Héctor, if I may. So obviously, on Spain, first, could you elaborate or give us a sense of the change in government? The very recent change in government has changed the outlook particularly for any growth in the PPP business. Obviously, there've been cancelations of contracts in the Valencia region, not -- with a competitor of you in not too distant past. So that was my first question. And obviously, one assumes this has no impact on your existing business, but just give a sense of how this political change might change the climate overall.

And secondly, you mentioned in your presentation early on before lunch I think even that you're talking about going direct to corporates in your risk prevention business. Is this with a view of circumventing the insurance companies? I'm not really quite clear how that would work with the insured market. Thank you.

Héctor Ciria: Okay. So well, in terms of the changing government, we don't have the crystal ball. So it's really come -- they just started right now. They haven't explained what their political problem is going to be. So we don't think we should be giving an opinion what is going to happen.

But having said all that, you have to also bear in mind that, in Spain, healthcare was -- long time ago, it was decentralized into the 17 different regions. And actually, the health policy and the day-to-day interaction that we have with the communities or with the regions is not with the central government. It is with the governments at the regional level. And there has been basically no change on that. Our main relation with the public administrations in Madrid, basically, there has been no change there.

You were talking about PPPs, about our contracts. We have -- especially in Madrid, where is -- where we are more present, the contracts have a long time until they expire. We mentioned they expire -- there are four of them -- between 2036-2041. So that's 18 to 22 years.

And there has been no case in Spain of early terminations. The only cases that have happened actually in other regions is that, when the contracts came to the end of their life, then in some cases, they were not extended. So we are far away from that situation. The legal framework is quite solid for all of those concessions. And therefore, it's not something that is on the table as of now.

Then coming to the second question, we don't really see that as a way of bypassing the health insurance companies. It's actually a way to increase our relationship that we never did before with corporates because you have to bear in mind that, in many of these large corporates we are talking about, like the IBEX 35 companies, many of these companies are offering for their employees, as a benefit, they are offering health plans, which are health insurance plans.

So actually, what we are trying to do is to get closer to these large employers and try to offer them services that could be helpful for their employees that they could implement in their HR policy. And actually, the corporates don't need to pay for that because it is already the health insurance companies who are covering that. So --

Francesco De Meo: If you think on the history, he didn't tell about that, but the ORPs in former times were part of the state insurance scheme. So in reality, the ORPs were in that state insurance system. And in Spain, there is the obligation for the companies, the big companies he mentioned, to give that service for their employees. So to make that, in Spain, it's really an open way to do that without being themselves an insurance or something like that. But it's really the normal way in Spain. It's more complicated in Germany. But in Spain, it's really a normal way to make the business there.

Héctor Ciria: Let me give you some examples. So for instance, there are large corporates that they have headquarters with thousands of employees. And something that is important for them is to offer good healthcare services to the employees. So in some cases, we are even having medical centers in the headquarters, right? That's something that the corporates like, the employees love as well. And in many cases, these employees are insured with their health insurance. So we are actually offering something that was not there before.

And the ORPs, what is helping us is that, before, those large corporates were not our clients. And now that they are through our ORP division, it is much simpler to basically contact them and offer them services that they find interesting. So this is one of the examples where we are thinking about many other opportunities.

Markus Georgi: Cool. Thank you. The very last question for today goes to Gunnar.

Gunnar Romer: Thank you. First question, coming back onto cost synergies, thanks for confirming those. I'm still not sure how much you have achieved by the end of 2017 and how much is outstanding.

Secondly, I think you talked a lot today about best practice sharing. And I can see that there's a lot of benefits in the medium to long term certainly. When do you think you would be in a position to quantify the benefits? And how do you think we should look at them in between?

And lastly, Stephan, I think, in one of your earlier comments, you said that, with regard to Helios Germany, you're preparing for the worst. I was just wondering whether you can help us understand what the worst case is for next year in terms of margin. Thank you.

Stephan Sturm: Gunnar, we're not going to give you a precise number. But what we have accomplished so far is a number, say, in the high single digits or make it up to €10 million.

And look, we I believe have painted in true Fresenius style a pretty conservative picture on Helios Germany today because, again, in good old Fresenius and also Fresenius Helios style, no surprises, at least no nasty surprises. And we better alert you to dark clouds on the horizon when also we see them. And while we alert you to them, we prepare for them and try to deal with them.

And so as I alluded to some of you over the dinner table last night, from my perspective, maybe not the worst-case scenario, but a bad-case scenario is that we're going to see that segregated DRG reimbursement for nursing and for everything else, that we, like many others, will find it difficult to come up to the required minimum nursing levels, that therefore we will forgo in many -- some -- many instances that nursing DRG reimbursement. And that will be the very same, given the nursing shortage across the country for -- also for all of our competitors.

But given the continuously good state of the economy, that the politicians will find a way to make the public hospitals whole via subsidies through the back door. That from my perspective is a bad-case scenario where we're trying to prepare ourselves for by going about the various initiatives that we were talking about.

There was a lot of time spent, maybe a bit too much time spent, on challenges and risks. But I want to make sure that we also do see the opportunities in that business. And what is a minimum nursing ratio compared to the -- I'm making a joke now, careful -- compared to the inevitable price pressure in injectable generics in the US?

Héctor Ciria: If I may add without going into details of the synergies, just one point I want to mention is that there were three main buckets that were discussed, procurement, laboratory, and outsourcing. In all three, true savings have already happened in all of them, so obviously at different levels. But this is not something that is only for the future. That's why we said that we are into a good start because tangible efficiencies have already happened in all three buckets.

Markus Georgi: Okay. Thank you. Like in the beginning of today, the stage is all yours, Stephan.

PRESENTATION: Closing Remarks – Stephan Sturm

Stephan Sturm: Thank you. I want to briefly wrap up. And I'm not sure whether it's good or bad news, but it's at least a piece of news. My presentation does not contain the Rainbow of Happiness.

Thank you for being here. As I said this morning, we do know it's a huge investment of your time. And I hope -- I have the cautious belief that we were able to make it worth your while. At this point in time, allow me one comment with regard to my colleagues involved. And I hope that what has come across is how much all of us do care about what we do, how passionate we are about furthering the wellbeing of our patients.

And therefore, I am very proud of my colleagues who have been involved because they have been doing things that clearly are not what they are used to, clearly outside their area of otherwise excellent expertise. And I believe they have done a very good job to convey that message. And therefore, again, I'm very proud of you. Thank you very much.
Thank you. This may easily not have been your typical Capital Markets Day these days. We were not bombarding you with tons of numbers. We were also not giving you a new midterm target or other intermittent targets.

You know, old Fresenius style, you have a midterm target explicitly in terms of the growth rates that we have been talking about, implicitly in the group medium-term

targets. And we at Fresenius tend to set ourselves new targets only when we have accomplished the old ones.

But what we wanted to do is to get you a bit more of a qualitative look at our business at the underlying drivers of the business. And we also wanted to make sure you get a glimpse at least of what we're doing in further alignment between Fresenius Helios and Quirónsalud.

So from my perspective, takeaway number one, and I hope we managed to bring that across, Helios across the two countries that we're currently active in is a highly attractive, not only, but in particular because of its stability, highly attractive business, but particularly because of its stability and the lack of meaningful volatility.

And therefore, it is a perfect fit into the Fresenius Group structure. And therefore, we at the group level as well as at the Helios, larger Helios level, are keen to grow the business further.

As I just alluded to, each business whether in or outside Fresenius has its challenges but also its opportunities. Maybe it is Fresenius style to focus more on the challenges ahead. Maybe that is driven by the fact that we are spending a meaningful amount of time on thinking about and putting in place mitigation measures.

In Germany, there are a few challenges also in the near term. And again, we were alluding to those from the end of last year. We were sharing more information on that in February. And we got you more information as to where we stand and what also we want to do about those challenges over the course of today.

I also do see, and think about our dinner speaker last night, very meaningful opportunities ahead. This is about critical mass, the ability to invest, to leverage these investments. This is about being able to focus on quality because, at the end of the day, and I think that is not -- in the not too distant future, quality will be paid for.

I hope what has also come across is that, dear shareholders, forgive us, but at the forefront of anything that we do is our patients. And we can wholeheartedly and with a clean conscience say that because we're also acutely aware that whatever is good for our patients is going to be good for our shareholders.

There may be a little bit of a time lag. Hence, we're going through some of these investments that have to be taken through the P&L right now and in the coming quarters. If our shareholders have a bit of patience, they will be nicely rewarded. There is little doubt in my mind.

But let's also be clear. This is not an ailing business at all. What we're talking about is just that the stellar growth rates, EBIT growth rates that we have seen in the past, are not sustainable. What we have seen, though, is that we have in time detected a wonderful opportunity to broaden our geographic footprint by going into Spain and that we have ample growth opportunities also there and that, therefore, for the combination of the two businesses, this continues to be, from our perspective, a highly attractive package.

Héctor was talking about organic growth. Héctor was taking about nonorganic growth. Héctor was talking about the acute care business, the ambulatory business, but also the ORP business. So and that all against the backdrop of remarkable stability as far as the political and regulatory backdrop is concerned.

I have to very many of you right from the beginning openly admitted that I have been a skeptic of international expansion. I -- when looking at the other cross-border moves, I

felt whatever other people were talking about in terms of cross-border synergies, that was just a shambles.

But in this particular instance that we are looking at now, I am increasingly converted. My skepticism -- well, look, I'm a former CFO. So I have always got to be a bit skeptical. But my skepticism is fading, fading substantially. And it is fading even more when I see on the stage here today living examples of cross-border synergies and personalized synergy potentials.

Enrico, Pedro, thank you very much. I think it was a living example of -- careful how I choose my words -- cultural differences, but mutual respect, and an overarching shared goal and ambition that has led and will continue to lead to very good results.

When I think about our technology presentation, I think it was another classic, where Jörg, we were very much in true German style focused on the technical implementation of what we want to do and where the Spanish way was playing much more with emotions. And I had a little tear in my eye when I was looking at those videos. So also here, I believe it is a wonderful synergy where very much we can learn from each other and learning from the best.

And by the way, those often quoted German tanks, I haven't seen any. I don't think they exist. And German tanks these days don't work, as far as I know.

So what I have told very many of you is that, with fading skepticism, we should increasingly prepare ourselves for a potential third country. The message that we wanted to convey today is, yes, we do believe that cross-border synergies do exist. Yes, we believe that they even exist in a meaningful potential. And on that basis, not because we have to but because we can and we should, we should embrace the idea of further internationalization.

What we told you in February is that we had created the first preparatory step by founding the Helios.health international holding. There, we have the institutionalized oversight over synergy creation. And it's also meant to be the harbor for any further addition on the Helios side of things.

What we informed you about on Wednesday is another preparatory step. It is the separation of the post-acute clinics from Helios and the transfer within Fresenius to Vamed. I believe you should look at this from two angles. One is the Vamed angle, where we also believe that cross-border synergies do exist and where Vamed, where they are the market leader in post-acute care in Austria already, in Switzerland already, are a top three operator in the Czech Republic, and now a top three operator in Germany, and hence a top three operator in Europe. They will further drive cross-border synergies in that post-acute care business.

And you should look at it also from the Helios angle, where we want to make sure that, at Helios, there is a sharpened focus, as Francesco and Daniela alluded to, and more management capacity available for a further potential international expansion.

Now many of you have heard me say before that, in an ideal world, I would like to see more synergy benefits in '18. I would like to see a bit more Spanish market, intra-Spanish market consolidation in '18 and '19. And on that basis, I would very much like to start looking at a third country in '19 and go about execution in 2020.

That is the ideal world. And very rarely opportunities do present themselves the way you're wishing for them. So on the one hand, I don't want to whet your appetite overly, yeah? There is nothing that we're working on right now. But at the same time, it would be a shame if, along our way and whilst we continue to be more open and more

optimistic about further internationalization, we didn't have all our ducks in a row and would be able to shoot when a target comes our way.

And therefore, yes, in an ideal world, from my perspective, that would be the timetable, the right target coming along. It may be later. It may be earlier.

I think I covered most of this maybe with the exception of the growing importance of Vamed in the group. And for about an hour, Markus, we were toying with the idea whether we should give Vamed a separate slot at this Capital Markets Day. We then decided against it. We felt it was then more of a distraction in a very complex overall timetable anyway.

But what you should have -- what is very obvious is that we're strengthening the Vamed business with the post-acute clinics. But what you also have heard in various presentations, but maybe in the most pronounced fashion in the Enrico-Pedro show, is that Vamed is increasingly playing a role for the Helios acute care clinics, be it in Germany or in Spain.

And there, maybe using the Quirónsalud acquisition as a catalyst, we're seeing more openness, more -- much more of a drive to look at Vamed as a potential outsourcing partner. At the end, you heard and saw Francesco talking about the overall Fresenius platform that bodes well for a further internationalization step.

At the very end, I need to be technical for a brief period of time. Those are, and you will have seen it from our press release, that's the scope of this internal transaction that we've done. We're looking at approximately €460 million of sales. It is -- the transaction value is strictly at arm's length. And the EBIT that we're shifting is an annualized €37 million.

Against that backdrop, what you need to reflect in your models -- got the picture, Veronica? What you should -- what you need to reflect in your models is absolutely zero as far as Fresenius Kabi is concerned.

But given that we expect closing of the transaction on July 1st, the second half of the post-acute revenue and EBIT is going to go to Fresenius Vamed. And therefore, we need to adjust EBIT growth at Helios from 7% to 10% so far to 5% to 8%. We're talking about, in round numbers, €20 million in the second half of this year that will accrue at Vamed rather than at Helios. Given that we had only given an organic sales growth guidance, that remains unchanged.

For Vamed, magic of the small numbers, when Helios is losing 2 percentage points, Vamed is gaining more than 25. So out of 5% to 10%, we're taking a guidance taking into account the very same approximately €20 million from 5% to 10% to 32% to 37%.

What that means is that it is truly only a shift from Helios to Vamed. Look, what you've got to bear in mind is that, initially, we do expect this to be EBIT neutral on the group level. Many of you will know we at Fresenius are 100% owners of Helios, 77% owners at Fresenius Vamed. So EBIT neutrality, cash flow neutrality will still result in an initial ever so slight earnings after tax dilution.

It is an investment, also here, that we very gladly do because we do believe -- no offense, Francesco and team, we do believe that Vamed is going to do an even better job at the post-acute hospitals and that, in the not too distant future, couple of years, this is going to be EBIT and cash flow and earnings accretive at the group level.

Hence, no reason whatsoever to tinker with the group guidance for this year. Sales, no, and the very small hardly measureable earnings dilution, that is very well covered by our net income growth target that remains at 6% to 9%.

There are a few good and maybe, a few pretty much good things going on at the moment. And I'm very glad that I don't have to talk about the Akorn transaction today. I did all or most of that over the course of last night. But also in that regard, you will have followed what we had to say about this. And there is no reason to be downbeat on this at all, from my perspective.

And therefore, the next data point where I would like to give you an update on together with Rachel is our Q2 communication on July 31st. And there, we will in particular then also give you an update as to how we see the lay of the land for Fresenius Kabi.

Once again, thank you very much for being here today. I hope it was worth your while. And have a safe trip home. Thank you very much.