

BUSINESS VALUATION REPORT · ILLUSTRATIVE EXAMPLE

Ashcombe Family Medical Pty Ltd

A fictional general practice in Heidelberg, Victoria · Market value of the business and 100% of the shares

Guided by **APES 225 Valuation Services** · Built on public data for the real Heidelberg catchment

Not a valuation of any real practice. The practice, its doctors and its financial figures are invented. The location data, Medicare settings, tax rules and market evidence are real and sourced.

PREPARED FOR

Illustrative example; no client

REFERENCE

HPNA-EXAMPLE-GP-HEIDELBERG

VALUATION DATE

30 June 2026 (illustrative)

REPORT DATE

September 2026

MELBOURNE

Level 7, 55 Collins Street
Melbourne VIC 3000

SYDNEY

377 New South Head Road
Double Bay NSW 2028

BRISBANE

Level 11, 458 Brunswick Street
Fortitude Valley QLD 4006

PERTH

Meetings by appointment

About this example

This report shows how HPNA values a general practice in Melbourne: what we look at, how the numbers connect and what a purchaser is really paying for. It is laid out as an HPNA valuation report would be, section by section, and it goes further than most: it tests the practice against its real catchment, the Medicare settings in force at the valuation date, Victoria's payroll tax rules and the market for GP practices.

What is real and what is invented. Ashcombe Family Medical Pty Ltd does not exist. Its doctors, patients, billings, costs, results and debts are invented, and every figure reconciles so that each step from GP billings to equity value can be followed. The setting is real: population, bulk billing and fee statistics for Banyule, Medicare fees and incentives, the Victorian payroll tax exemption, award wages, rents and the legal rules are taken from public sources, listed in Appendix B. None of the invented figures is a benchmark or an estimate of what any real practice is worth.

What we checked for this example

QUESTION	WHERE THE ANSWER CAME FROM
Who lives in the catchment, and how is it changing?	ABS population and Census data, Victoria in Future 2023, SEIFA 2021, DSS concession card counts [abs, vif, dss]
How much of local GP work is bulk billed, and at what fee?	Medicare quarterly statistics for the Banyule SA3 and comparison areas to June 2026 [sa3, phn, aihw]
What does Medicare pay, and what changed in FY2026?	MBS fees at 1 July 2025 and 2026; bulk billing incentive expansion and the new practice incentive program from 1 November 2025 [mbs, bbi, bbpip]
Can the practice recruit overseas-trained GPs?	Distribution Priority Area rules and classification [dpa]
What does payroll tax cost a mixed-billing Victorian practice?	Payroll Tax Act 2007 Sch 2 cl 19B, SRO guidance and rulings [pt, cases]
Are the costs, rent and service fee at market?	Award pay guides, salary surveys, GP job advertisements, local lease listings [wages, ops, rent]
What do buyers pay, and how do deals work?	Listed-company transactions, adviser commentary, deal terms [market]
What has to be checked when a Victorian practice changes hands?	Health Records Act, MyMedicare and PIP rules, Retail Leases Act, restraint cases [legal, mymed, pip]

How this report follows APES 225

HPNA reports are guided by APES 225 *Valuation Services*, issued by the Accounting Professional & Ethical Standards Board. APES 225 is the standard Australia's accounting bodies set for valuation work. We are an independent valuation practice, not an accounting firm, and we follow its guidelines in every report we sign. Paragraph 5.2 of the Standard lists what a written Valuation Report should clearly communicate. The table shows where each item is found in this example.

5.2	ITEM	WHERE
(a)	The name of the party engaging the valuer	Section 2
(b)	A description of the business ownership interest, business, asset or liability being valued	Sections 2 and 4
(c)	The date at which the value has been determined	Cover; section 2
(d)	The date on which the report is issued	Cover; section 2
(e)	The purpose for which the report has been prepared	Section 2
(f)	The name and qualifications of the valuer responsible	Sections 2 and 20
(g)	The scope of the Valuation, including any limitations or restrictions	Sections 2 and 19
(h)	The standard of value and its definition	Section 2
(i)	The Premise of Value adopted	Section 2
(j)	Whether the valuer acted independently	Sections 2 and 20
(k)	The Valuation Approaches, Methods and Procedures adopted and how they were applied	Sections 11 to 14
(l)	The specific information relied on and the extent to which it was reviewed	Section 19; Appendix B
(m)	The material assumptions and their basis	Section 19
(n)	A Conclusion of Value	Sections 1 and 14
(o)	All qualifications that materially affect the Conclusion of Value	Section 19
(p)	For a Limited Scope Valuation Engagement, the statement it calls for	Not applicable; see section 2
(q)	For a Calculation Engagement, the statement it calls for	Not applicable
(r)	That the valuer's fee is not contingent on the conclusion, content or use of the report	Sections 2 and 20
(s)	A statement of the standard the Valuation Service followed	Section 20

1. Executive summary

This illustrative report states an opinion of the market value of Ashcombe Family Medical Pty Ltd ("the practice"), a single-site, mixed-billing general practice in the Heidelberg activity centre in Melbourne's north-east, and of 100% of its shares, at 30 June 2026. The owner, the principal GP, is considering a sale.

CONCLUSION OF VALUE · ILLUSTRATIVE

\$1,197,000

Enterprise value of the business, adopted within a range of \$1,112,000 to \$1,368,000: 3.5x maintainable EBITDA of \$342,000.

Equity value of 100% of the shares: **\$1,034,000** after \$165,000 of borrowings, \$38,000 of accrued long service leave and \$40,000 of surplus cash (range \$949,000 to \$1,205,000).

	AMOUNT
GP billings collected through the practice, FY2026	\$3,672,000
Practice revenue in the company's accounts	\$1,599,926
Reported EBITDA	\$258,426 (16.2%)
Normalised EBITDA	\$346,876 (21.7%)
Maintainable EBITDA (run-rate billing mix, rounded)	\$342,000 (21.4%)
Enterprise value range	\$1,112,000 to \$1,368,000 (3.25x to 4.0x)
Adopted enterprise value	\$1,197,000 (3.5x)
Less borrowings and accrued long service leave	(\$203,000)
Plus surplus cash	\$40,000
Indicative equity value	\$1,034,000

What the figure rests on. The GPs billed \$3.67m through the practice, but most of it is theirs. The company's revenue is the \$1.23m of service fees it keeps plus \$371k of income of its own, mostly government incentives (sections 4 to 6). Reported EBITDA of \$258,426 becomes \$346,876 once the principal pays the same 35% as the other GPs, the unpaid clinical lead role is priced in, the related-party rent is set to market, and one-off and private items are removed (section 8). Restating the year on the billing mix the practice settled into after the 1 November 2025 Medicare changes gives maintainable EBITDA of \$342,000.

Why Heidelberg matters. Of the four settings we tested, Banyule leaves the most room for private fees (Boroondara, shown only for comparison, leaves more): its residents were bulk billed for 72.0% of GP services in FY2026 against 82.5% across Victoria, and the average fee per GP service was \$78.26 against \$68.91 ^[sa3]. That is what makes a mixed-billing practice viable here. It is inner metropolitan, so it is not a Distribution Priority Area, and GP recruitment relies on doctors free of Medicare's location restrictions (section 3).

What would change the figure. GP retention moves value most: if GP A left, only 30% of that doctor's billings stayed and the rest were not replaced, enterprise value would fall by about \$505k (section 7). Victoria's payroll tax costs the practice \$38,500 a year, and would be \$108,000 without the bulk-billing exemption (section 9). Switching to bulk billing every patient would lift the practice's own result but, at the same volume, cut its GPs' incomes by about 6% (section 10). The owner's role alone can separate two practices with this revenue and profit by about \$691k (section 15).

2. Engagement, scope and independence

Engaging party (5.2(a)). In this example, the principal GP, who is the sole shareholder and director of the practice company and is considering a sale. In an actual engagement the engaging party is named here and in the engagement letter.

Purpose (5.2(e)). To inform the owner's decisions about a potential sale: whether, when and on what terms. The report explains what the practice is worth, why, and which factors a purchaser is likely to focus on. It is not a fairness opinion, expert evidence or tax

advice.

Subject (5.2(b)). The business operated by Ashcombe Family Medical Pty Ltd (enterprise value) and 100% of the ordinary shares in the company (equity value). The premises, owned by the principal's family trust, are not part of the valuation.

Standard and premise of value (5.2(h), (i)). Market value: the price that would be agreed between a willing but not anxious buyer and a willing but not anxious seller, acting at arm's length and each informed of the relevant facts, in the sense described in *Spencer v Commonwealth* (1907) 5 CLR 418. The premise is a going concern.

Valuation date and report date (5.2(c), (d)). 30 June 2026, the end of the last completed financial year; report dated September 2026. Statistics published after the valuation date are used only where they describe the period up to it, such as the June quarter 2026 Medicare data. Listings observed in September 2026, such as rents and nearby GP services, are used as evidence of conditions at the valuation date. Later events, such as the RACGP Standards 6th edition (26 August 2026) and the federal exposure draft on non-compete clauses (7 September 2026), are noted but not reflected in the value.

Scope (5.2(g)). A Valuation Engagement as APES 225 defines it, with no limitation on the valuer's choice of approaches or on the information that could be requested.

Independence and fee (5.2(j), (r)). The fee is fixed and not contingent on the conclusion, content or use of the report. HPNA is not a business broker and earns no commission from any party to a transaction. The valuer is Jackson Wilson, Director (section 20).

3. Location and catchment

The practice sits in the Heidelberg activity centre (Heidelberg to Rosanna SA2, postcode 3084), in the City of Banyule, the Banyule SA3 and the Eastern Melbourne Primary Health Network. Its patients come mainly from Heidelberg, Ivanhoe, Rosanna, Viewbank and Heidelberg West. The Austin Hospital, the Mercy Hospital for Women, the Heidelberg Repatriation Hospital and Warringal Private Hospital are nearby, and Heidelberg station is on the Hurstbridge line.

CATCHMENT MEASURE	BANYULE	COMPARISON	SOURCE
Population, 30 June 2025	132,770 (+1.0% in the year)		[abs]
Projected population, 2026 to 2036	133,020 to 148,860 (+11.9%)		[vif]
Residents aged 65+, 2026 to 2036	19.3% to 21.0%	Victoria 17.1% to 18.3%	[vif]
Residents aged 75+, 2026 to 2036	9.7% to 11.5%		[vif]
Median age; median weekly household income (2021)	40; \$2,027		[abs]
SEIFA advantage and disadvantage (IRSAD)	LGA decile 10; Heidelberg to Rosanna 9; Heidelberg West 5		[abs]
Primary concession card holders, June 2026	About 21.8% of residents	Victoria about 23.5%	[dss]
Private health insurance (adults)	51.7%		[emphn]
GP services per 100 people, 2024-25	635	Metropolitan areas 613	[aihw]
GP bulk billing rate, FY2026 (services)	72.0%	Victoria 82.5%; Australia 80.9%	[sa3]
Average fee charged per GP service, FY2026	\$78.26	Victoria \$68.91	[sa3]
Average patient contribution, privately billed service	\$55.85	Victoria \$54.93	[sa3]
Share of GP fee dollars that were bulk billed, FY2026	57.2%	Victoria 71.1%	[sa3]
General practices in the LGA	39		[emphn]
Distribution Priority Area (GP)	No: inner metropolitan MM1		[dpa]

Medicare statistics by SA3 count GP attendances by the patient's home address, not the practice's location, and exclude the bulk billing incentive items. Projections are from Victoria in Future 2023, Release 2 (December 2023).

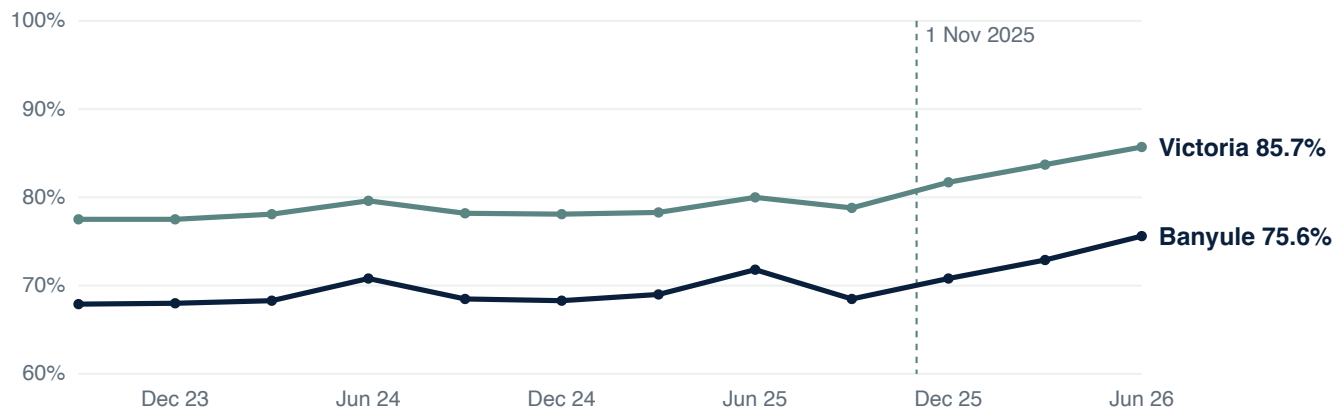


Figure 1. GP bulk billing rate by quarter, share of services, FY2024 to FY2026. Source: Medicare quarterly statistics by SA3 [sa3].

A local market that is moving. Banyule's GP bulk billing rate sat near 68% to 72% for two years. After bulk billing incentives were extended to all Medicare-eligible patients on 1 November 2025 it rose each quarter, reaching 75.6% in the June quarter 2026 against 71.8% a year earlier [sa3, bbi]. Across Victoria, 935 practices had registered for the new Bulk Billing Practice Incentive Program by 31 January 2026, about half of the practices registered in MyMedicare [phn]. A mixed-billing practice in Heidelberg is still normal, but the ground under its private fees shifted during the year being valued.

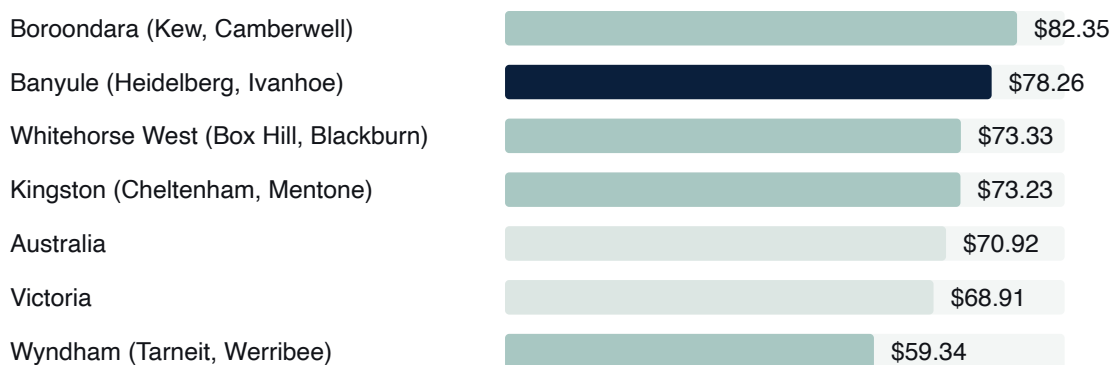


Figure 2. Average fee charged per GP service, FY2026 (bulk billed and privately billed together) [sa3].

Why this catchment supports private fees. Banyule is advantaged overall, older than Victoria and ageing faster, with about half of adults privately insured. Its residents are bulk billed less often than most Victorians, and its fee per GP service is second only to Boroondara among the areas compared. The gap paid when a patient is privately billed, \$55.85, is close to the state average of \$54.93: what differs is how often a gap is charged, not its size. The area is also mixed: Heidelberg West is in the middle of the national SEIFA range, and about a fifth of residents hold a concession card. A practice here can bulk bill children, pensioners and concession card holders and charge a gap to working-age adults, which is what this practice does.

Competition. A healthdirect search in September 2026, centred on Ivanhoe next to the Heidelberg activity centre, returned at least 30 GP services within 5 km (the finder's display limit). Of the ten nearest, seven showed that fees apply, two were mixed billing and one bulk billed only [hd]. Corporate groups operate in the area, but the nearest ten were mostly independent.

Workforce. Distribution Priority Areas decide where doctors subject to the ten-year moratorium in s 19AB of the Health Insurance Act 1973, including many overseas-trained GPs, can bill Medicare. Inner metropolitan MM1 areas are not Distribution Priority Areas, and the last annual update was March 2025 [dpa]. The practice therefore recruits only from GPs free of those restrictions. The fast-track registration pathway for UK, Irish and New Zealand GPs, opened in October 2024, does not change this: GPs covered by the moratorium, such as most UK- and Irish-trained doctors, still need a Distribution Priority Area or an exemption to bill Medicare [ops].

Premises market. Medical and consulting suites advertised in Heidelberg and Ivanhoe in 2026 asked about \$270 to \$300 per square metre a year, net of outgoings, and up to about \$340 in nearby Kew East. Newer purpose-built medical buildings elsewhere in suburban Melbourne, a GP clinic at Mickleham and an imaging centre at Bundoora, carry passing net rents of about \$490 to \$500 [rent]. The practice's building is established rather than new, so the local range is the better guide (section 8).

4. The practice and what is being valued

PROFILE	
Established	2011
Location	Heidelberg activity centre, Banyule; one site
Premises	About 560 sqm: 12 consulting rooms (9 used by GPs, 3 licensed to allied health), 2 treatment rooms, a pathology collection room
Lease	From the principal's family trust; six years left plus a five-year option
Operating model	Service-fee model: GPs are independent contractors billing under their own provider numbers
GPs	9: the principal plus 8 contracted GPs; 6.9 FTE on a consulting-hours basis
Practice nurses	3 employed, 2.4 FTE
Management and reception	Practice manager plus 5.0 FTE of reception and administration
Hours	Weekdays 8am to 8pm; Saturday mornings
Billing	Mixed: 62% of services bulk billed in FY2026 (children, concession card holders, plans and assessments)
Patients	About 9,400 active (three visits in two years); 3,300 registered through MyMedicare
Accreditation	Accredited against the RACGP Standards (5th edition)
Owner involvement	Principal GP (0.7 FTE) and unpaid clinical lead

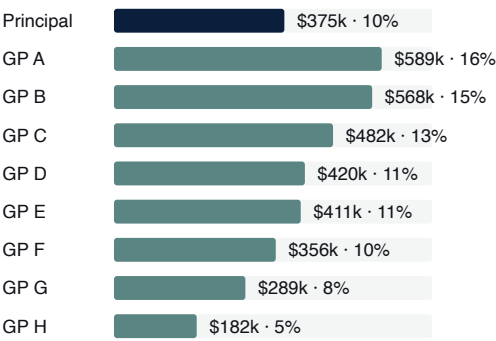


Figure 3. GP billings by doctor, FY2026.

The largest biller, GP A, accounts for 16% of the total and the principal for 10%. The concentration that matters is GP A and GP B together: 32% of billings and 25% of the practice's revenue.

GP billings are not the practice's revenue

In a service-fee practice the GPs bill patients and Medicare under their own provider numbers. The practice collects the money on their behalf, keeps a service fee for rooms, nurses, reception, systems and administration, and pays the rest to the GP. The company's revenue is the service fee plus income that is its own. Some practices record gross billings as revenue and the GPs' share as a cost; the profit is the same, but the revenue line is very different, so we always state which figure we are using. The distinction also decides which revenue band a practice falls into for most fee scales, including ours.

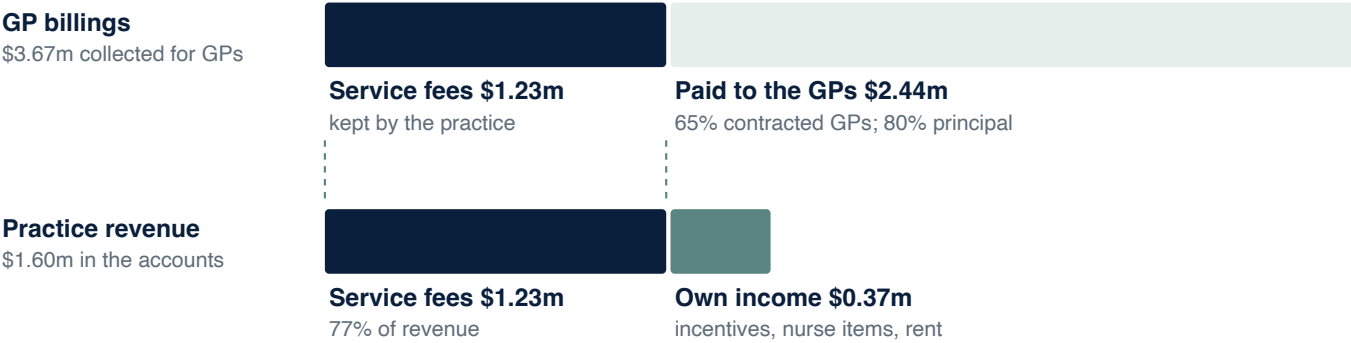


Figure 4. Where \$3.67m of GP billings went, FY2026. The service-fee segment is the same \$1.23m in both bars.

Revenue is not value

A practice with \$1.60m of revenue is not worth \$1.60m. Revenue pays the nurses, reception, rent and systems; a buyer pays for what is left over, and for how confident they can be that it will keep coming. **Enterprise value** is the value of the operating practice before debt and cash. **Equity value** is what the shareholder receives: enterprise value less interest-bearing debt and debt-like items, plus surplus cash.

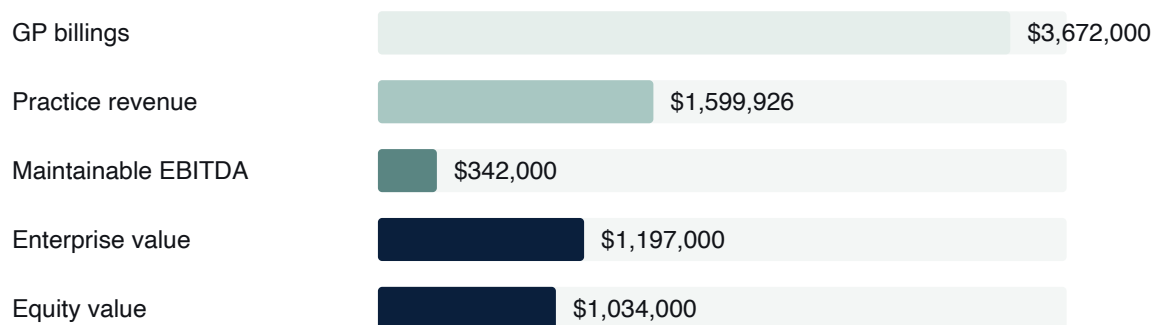


Figure 5. From GP billings to equity value, FY2026.

Share sale or business sale. In a share sale the buyer acquires the company with its GP agreements, employees, registrations, liabilities and history, and the price is the equity value. In a business sale the seller keeps the company and sells the goodwill, equipment and contracts; registrations, records and incentive eligibility then have to move, which takes time and paperwork (section 16). Either way, each GP must choose to stay, because provider numbers belong to the doctor and the location, not to the practice.

5. How the GPs' billings are built

Every dollar of GP billings starts as a Medicare item, a bulk billing incentive or a private fee. We rebuild the GPs' billings from the item mix, Medicare fees at 1 July 2025 and the practice's billing policy, and test the result against local statistics.

SERVICE	SHARE	PER GP FTE A YEAR	MEDICARE BENEFIT FY2026	GAP IF PRIVATELY BILLED
Level A (item 3)	3%	159	\$20.05	bulk billed
Level B (item 23)	60%	3,180	\$43.90	\$50
Level C (item 36)	22%	1,166	\$84.90	\$70
Level D (item 44)	5%	265	\$125.10	\$90
Level E (item 123)	1%	53	\$202.65	\$120
Chronic condition plan (965/967)	4%	212	\$156.55	bulk billed
Mental health plan (2715)	2%	106	\$106.20	bulk billed
Health assessment (705)	2%	106	\$222.00	bulk billed
Procedures and other items	1%	53	\$60.00	bulk billed

Illustrative. 5,300 services per GP FTE a year, where one FTE is 34 consulting hours a week for 46 weeks (1,564 hours), about 3.4 services per consulting hour. GP items are paid at 100% of the schedule fee; fees are those in force from 1 July 2025 [mbs]. The item mix and gaps are assumptions; the gaps average \$58.07 per privately billed consult, against \$55.85 across Banyule [sa3].

PER GP FTE, FY2026	AMOUNT	PER SERVICE
Medicare benefits (100% of schedule fee)	\$356,833	\$67.33
Bulk billing incentives: item 75870 (\$21.85) on consults, 10990 (\$7.35) on other items	\$62,217	\$11.74
Patient gaps on privately billed consults	\$116,457	\$21.97
GP billings per FTE	\$535,507	\$101.04

The 1 November 2025 change, inside the year. Until 31 October 2025 the bulk billing incentive items applied only to children under 16 and concession card holders. From 1 November they applied to every Medicare-eligible patient, and the new Bulk Billing Practice Incentive Program began [bbi, bbpip]. The model claims them before November only for those groups: on the bulk-billed consults, which went to them, and on about 65% of other bulk-billed services. The practice kept its mixed model but bulk billed more working-age adults: 47% of consults were privately billed from July to October and 41% from November to June, so the share of all services bulk billed rose from 58.6% to 63.9%. Banyule as a whole moved the same way: 75.6% of its residents' GP services were bulk billed in the June quarter 2026, against 71.8% a year earlier [sa3].

Testing the build against the data. The model gives GP billings of about \$536k per FTE. Practice analytics put average GP billings at \$308 per consulting hour nationally in 2022, about \$480,000 a year at 34 hours a week for 46 weeks; after Medicare indexation and private fee rises since then, \$500,000 to \$560,000 per full-time mixed-billing GP is a reasonable range [ops]. The model's \$342 per consulting hour is at the upper end, and its average fee per service before incentives, \$89.30, is above Banyule's \$78.26,

because this practice privately bills more often than its area and its mix leans to longer consults and care plans. Its bulk-billed share of fee dollars, 55.6%, sits close to Banyule's 57.2% [sa3]: a useful benchmark, because Victoria's payroll tax exemption uses a similar dollar ratio for the practice's own GP work (section 9).

6. Practice revenue and incentives



Figure 6. Practice revenue by source, FY2026.

YEAR	GP BILLINGS	GROWTH	GP FTE	BILLINGS PER FTE	PRACTICE REVENUE	REPORTED EBITDA	SERVICES BULK BILLED
FY2024	\$3,092,000	-	6.0	\$515,000	\$1,397,000	\$207,000	57%
FY2025	\$3,360,000	8.7%	6.4	\$525,000	\$1,496,000	\$233,000	58%
FY2026	\$3,672,000	9.3%	6.9	\$532,000	\$1,599,926	\$258,426	62%

Growth came from doctors and fees, not volume per doctor. GP FTE rose from 6.0 to 6.9. Billings per FTE also rose, with Medicare indexation of 2.4% on 1 July 2025 and higher private fees, partly offset by the move to more bulk billing after November [mbs].

Income that is the practice's own

INCOME	FY2026	WHAT IT DEPENDS ON	HOW SECURE
Workforce Incentive Program, practice stream	\$137,376	Accreditation and enough employed nurse hours per 1,000 SWPE; the maximum was \$137,375.60 a year from July 2025 and \$140,947.36 from August 2026 [wip]	MODERATE
PIP quality improvement	\$37,000	\$5 per SWPE a year, capped at \$12,500 a quarter; accreditation and quarterly data to the PHN. SWPE assumed 7,400 [pip]	MODERATE
PIP eHealth	\$48,100	\$6.50 per SWPE a year, capped at \$12,500 a quarter; digital health requirements [pip]	MODERATE
Nurse items	\$50,000	Item 10997 (\$14.00 plus a \$7.35 incentive when bulk billed) for patients on a chronic condition plan, up to 5 a year; about 2,360 services [mbs]	STRONG
Allied health room licences	\$52,500	Three practitioners' licences; renewals	MODERATE
Pathology collection room	\$24,000	Rent must not differ from market value by more than 20%, benchmarked against nearby collection centres [legal]	LOW
Private vaccines, medicals, reports	\$22,000	Demand; non-Medicare fees	MODERATE

Incentives are real income, with conditions. Government incentives are 14% of the practice's revenue. They belong to the company and continue on a share sale if accreditation and registrations are maintained, but they are clawed back if eligibility lapses. On a change of ownership, PIP and WIP payments are held until form IP010 is lodged, while MyMedicare payments continue to the previous owner until the new owner's documents arrive (section 16) [pip, mymed]. The Workforce Incentive Program in effect funds more than half of the nurses' cost; without the nurses, both the payment and the nurse items would go.

Pathology rent is lower-quality income. Rent for an approved collection centre is a prohibited practice under the Health Insurance Act 1973 if it differs from market value by more than 20%, and the first civil penalty for above-market rents, \$1.65 million, was

imposed in 2023 [legal]. Pathology providers are also under margin pressure. We value this line at market and give it less weight than service fees.

7. GP economics and retention

A GP practice is valued on the doctors who will keep consulting there after a sale. What matters is how much each GP bills, what the practice keeps, and how long they stay.

GP	FTE	BILLINGS	PER FTE	SHARE	SERVICE FEE	FEE TO PRACTICE	JOINED
Principal GP (owner)	0.7	\$375,000	\$535,714	10%	20%	\$75,000	2011
GP A	1.0	\$589,000	\$589,000	16%	35%	\$206,150	2013
GP B	1.0	\$568,000	\$568,000	15%	35%	\$198,800	2015
GP C	0.9	\$482,000	\$535,556	13%	35%	\$168,700	2018
GP D	0.8	\$420,000	\$525,000	11%	35%	\$147,000	2019
GP E	0.8	\$411,000	\$513,750	11%	35%	\$143,850	2021
GP F	0.7	\$356,000	\$508,571	10%	35%	\$124,600	2022
GP G	0.6	\$289,000	\$481,667	8%	35%	\$101,150	2024
GP H	0.4	\$182,000	\$455,000	5%	35%	\$63,700	2025
All GPs	6.9	\$3,672,000	\$532,174	100%	33.5%	\$1,228,950	

Illustrative. Billings are gross patient fees, Medicare benefits and incentives billed under each GP's provider number at this practice, FY2026. The principal's 20% is an owner's arrangement and is normalised to 35% in section 8.

The service fee. Metropolitan Melbourne GP job advertisements in 2026 mostly offer GPs 70% of billings, within a range of 65% to 75%; the practice's 35% is at the top of that range (its GPs keep 65%) and rests on the nurses, reception and allied health it provides [ops]. Each percentage point of service fee is worth about \$37k of EBITDA a year. Many practices tier the fee, with lower rates on care-plan items or after hours. A buyer will test whether 35% holds when GP agreements are renewed.

Each GP is a stream of service fees. One more GP FTE at the practice average of \$532k brings about \$186k of service fees; after about \$45,000 of extra reception and nurse time, most of it reaches EBITDA, because rent and systems are already paid. The 9 GP rooms are used for about 41% of opening hours, so there is room to grow. A buyer pays for that growth only once it has been achieved.

What happens when a GP leaves

IF GP A LEFT	BILLINGS KEPT BY OTHER GPs	SERVICE FEES LOST A YEAR	EFFECT ON ENTERPRISE VALUE AT 3.5X
Most patients stay with the practice	60%	\$82,460	(\$289,000)
Most patients follow the GP	30%	\$144,305	(\$505,000)

GP A pays \$206,150 of service fees a year. Costs barely move when a GP leaves, so lost fees fall almost straight to EBITDA until the GP is replaced. How many patients stay depends on whether they know other doctors at the practice, whether other GPs have capacity, and whether the agreement's notice and non-solicitation terms are reasonable. Patients remain free to choose their doctor. Replacing a GP typically takes three to six months, sometimes six to twelve, and a placement fee in the tens of thousands of dollars [ops].

GP AGREEMENT TERM	WHY A BUYER READS IT	IN THIS EXAMPLE
Notice period	Time to recruit and hand over patients	Three months on either side
Restraint and non-solicitation	Protects the patient base, if reasonable in time and area	Cascading 5 km, 12 months; non-solicitation of patients and staff
Service fee and what it covers	Sets the practice's share and the GP's reason to stay	35% of billings; rooms, nurses, reception, systems
Fee collection	How money flows affects payroll tax and contractor status	Practice collects as agent and remits fortnightly
Records and patient data	Who holds the records and how continuity of care is arranged	Held by the practice; access for the GP as the law requires
Change of control	Whether the agreement continues after a sale	Continues on a share sale

8. Financial performance and normalisation

Buyers do not pay for last year's accounts. They pay for what the practice will earn under normal ownership: every GP paying the market service fee, the owner's roles paid at market, rent at market, and private and one-off items removed.

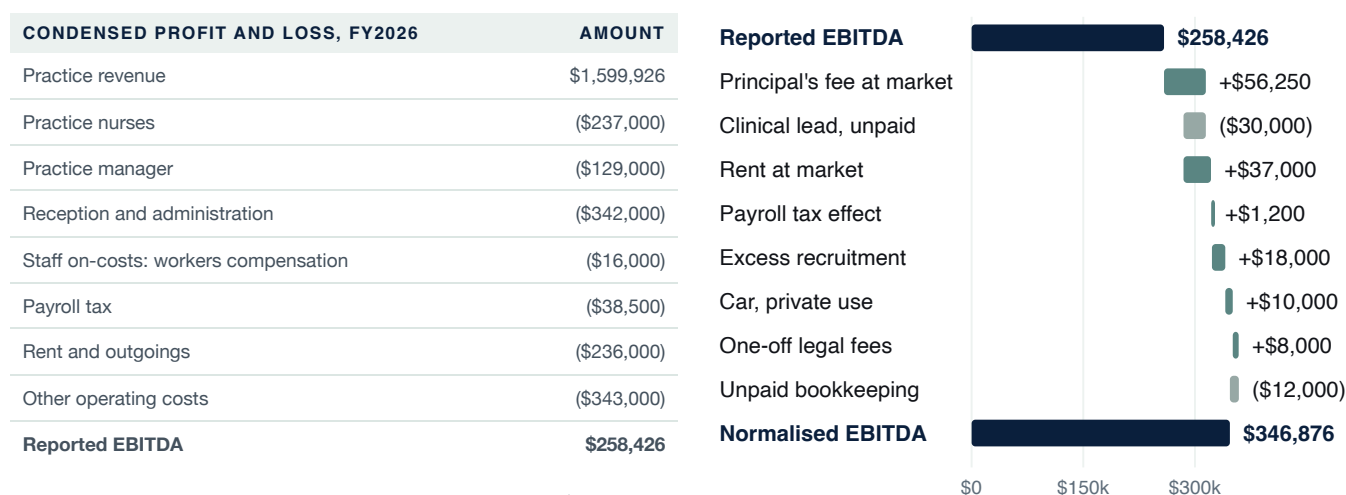


Figure 7. Normalisation bridge, FY2026.

Testing the costs against the market

COST	IN THE ACCOUNTS	BENCHMARK	SOURCE
Practice nurses	\$88,000 a year per FTE plus super	Market about \$80,000 to \$90,000 (national; Victorian averages near \$80,000); award RN level 1 \$1,164.20 a week from 1 July 2025	[wages]
Practice manager	\$115,000 plus super	Melbourne mid-level \$98,000 to \$120,000	[wages]
Reception and administration	\$61,000 a year per FTE plus super	Award support services level 3 \$1,056.00 a week (\$54,912 a year); many clinics pay about \$30 to \$33 an hour	[wages]
Superannuation	12% of wages	Superannuation guarantee 12% from 1 July 2025	[wages]
Rent and outgoings	\$236,000 (\$421 per sqm)	Market \$199,000: \$300 net plus \$55 outgoings per sqm	[rent]
Practice software	Within IT costs	Leading practice software licence about \$1,418 a year per full-time GP (FY2026)	[ops]
Maintainable EBITDA margin	21.4%	An adviser reports adjusted EBITDA margins of about 13% to 17% of practice revenue; this practice is above that because of its 35% fee and its incentive income	[market]

Worked example: the principal's two roles and the family trust lease

THE PRINCIPAL	AMOUNT
Service fee paid on own billings of \$375,000, at 20%	\$75,000
Service fee at the 35% every other GP pays	\$131,250
Added back: fee a buyer would receive	+\$56,250
Less: clinical lead allowance a buyer would pay	(\$30,000)
Rent, outgoings and land tax above market	+\$37,000
Net effect on EBITDA, including payroll tax	+\$64,450

Normalisation cuts both ways. As a doctor, the principal pays the practice less than the market rate; as clinical lead, the principal works unpaid. A buyer would collect 35% from any GP in those rooms and would pay someone to lead clinically, so both are priced at market. The principal's family trust charges \$236,000, including a land tax recharge of \$11,500. If, as is likely for a medical practice serving the public, the lease is a retail lease under the Retail Leases Act 2003 (Vic), a clause passing on the landlord's land tax is void [legal]. A buyer will require a new arm's-length lease at market.

Why maintainable earnings differ from FY2026. Four months of FY2026 came before the 1 November Medicare changes. The practice then bulk billed more patients: fewer gaps, more incentives, a larger payroll tax exemption. Restating the whole year on the November to June mix changes service fees by (\$7,000) and payroll tax by +\$2,400, so maintainable EBITDA is \$342,000. The local shift had not finished by June 2026, so a buyer may run the latest quarter's mix, which would lower maintainable EBITDA a little further; that risk is reflected in the multiple.

Known changes from 1 July 2026, considered and not adjusted. Medicare fees rose 2.6% on 1 July 2026, worth about \$22k a year in service fees; award wages rose 4.75%, about \$34k if passed on to all staff [mbs, wages]. A rise in private gaps of about 4%, in line with recent increases, would close the difference, so no adjustment is made. From 1 July 2026 super must also reach the fund within seven business days of each payday, which affects cash flow but not EBITDA.

9. Payroll tax in Victoria

The SRO's view, in Revenue Ruling PTA-041 (11 August 2023), is that a medical centre's service-fee arrangement with a GP will often be a "relevant contract" unless an exclusion applies. Where it is, the GP's share of patient fees that the centre pays out is taxable as wages; whether it applies depends on the agreement and how it operates in practice. The Victorian Court of Appeal's decision in *Optical Superstore* [2019] VSCA 197 and the New South Wales *Thomas and Naaz* decisions support that treatment [pt, cases].

Relief and the exemption. Relief announced on 22 May 2024, given under the Treasurer's ex gratia powers, covers unpaid or future assessments on payments to contractor GPs up to 30 June 2024 for all GP businesses, and up to 30 June 2025 for businesses that by that date had not been advised, by the SRO, a lawyer or an accountant, that payroll tax was payable and had not begun paying it. From 1 July 2025, clause 19B of Schedule 2 to the Payroll Tax Act 2007 exempts the part of GP wages that relates to fully funded (bulk billed) GP work, for employee and contractor GPs alike. It has no sunset clause [pt].

CLAUSE 19B APPLIED TO FY2026	AMOUNT
A: wages paid for GP work (GPs' share of billings)	\$2,443,050
B / C: fully funded GP fees as a share of all GP fees (dollars, not services)	55.6%
E = A x B / C: exempt GP wages	\$1,357,600
Taxable GP wages	\$1,085,450
Ordinary wages: nurses, practice manager, reception (including super)	\$708,000
Total taxable wages	\$1,793,450
Less annual deduction (full \$1,000,000 below \$3 million of wages)	(\$1,000,000)
Payroll tax at 4.85%	\$38,500

Measure the ratio in dollars. The exemption uses fee dollars, not the number of services. The practice bulk billed 62% of its services, but those were the lower-fee services: only 55.6% of GP fee dollars were fully funded. Using the service count would understate the tax at \$30,700 instead of \$38,500. Each percentage point of fully funded billings is worth about \$1,180 of tax a year.

SCENARIO	PAYROLL TAX FY2026	EFFECT ON VALUE AT 3.5X
The exemption applied as legislated (base case)	\$38,500	Included in the value
No relevant contract at all (a genuine exclusion applies)	\$0	+\$135k
Relevant contract and no exemption	\$108,000	(\$243k)

What a buyer checks. Registration with the SRO; any SRO correspondence or professional advice received before 22 May 2024, which could remove FY2025 relief; the FY2026 annual reconciliation with the A, B and C workings reconciled to billing reports; and the GP agreements and how money actually flows. If the principal controls other businesses, grouping can share one deduction across them and raise the tax. Unresolved historical exposure is usually handled by a specific indemnity backed by a retention from the price, not by a lower multiple.

10. The billing decision: mixed billing or the practice incentive program

From 1 November 2025 a practice where every GP bulk bills every eligible service for every Medicare-eligible patient receives an extra 12.5% of the Medicare benefits for those services, paid quarterly and split equally between the GP and the practice. It is all or nothing: a practice that privately bills even a small share of eligible services to Medicare-eligible patients receives no program payment for that quarter, although it keeps the bulk billing incentives; services outside the eligible list may still be privately billed [bbpip]. About half of Victorian MyMedicare practices had registered by January 2026 [phn]. A buyer of a mixed-billing practice will model both options.

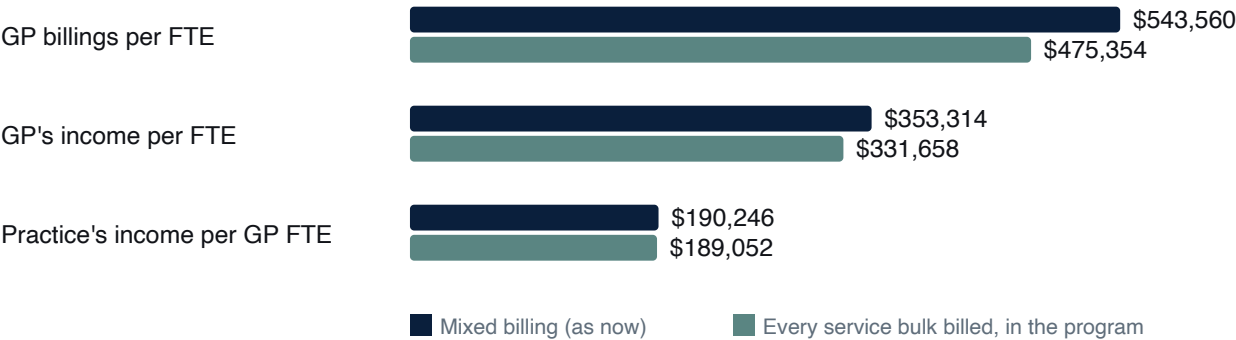


Figure 8. Mixed billing against bulk billing every service in the program, per GP FTE, at 1 July 2026 fees. Same volume and item mix.

The comparison holds volume and item mix constant, applies the 12.5% to eligible items only (procedures excluded), keeps ordinary wages at FY2026 in both columns, and charges no service fee on the GP's half of the program payment. Practices that move to full bulk billing often see more, shorter consults, which could narrow or reverse the GPs' loss.

WHOLE PRACTICE, A YEAR AT FY2027 FEES	MIXED BILLING	EVERY SERVICE BULK BILLED	DIFFERENCE
GP billings	\$3,751,000	\$3,280,000	(\$471,000)
Service fees at 35%	\$1,313,000	\$1,148,000	(\$165,000)
Program payment, practice half	nil	\$156,000	+\$156,000
Payroll tax	(\$35,800)	\$0	+\$35,800
Practice result from these lines	\$1,277,000	\$1,304,000	+\$28,000
Each GP's income per FTE	\$353,000	\$332,000	(\$22,000)

Better for the practice, worse for its GPs. Bulk billing everyone removes the gaps, adds incentive income and the program payment, and makes all GP wages fully funded, so payroll tax on GP payments disappears. For the practice the result is about \$28k better. For the GPs it is about \$22k worse per FTE, because the patient gaps they lose are larger than the incentives they gain. To hold GP incomes level the practice would have to cut its service fee to about 30.4%, and it would then be about \$122k worse off than it is now.

The break-even gap. For the GPs, mixed billing pays more only while the average gap stays above about \$41 per privately billed consult; for GPs and practice together, about \$46 before payroll tax and \$49 after it, provided private patients do not leave. The model's gaps average \$58; Banyule's privately billed patients paid \$55.85 on average in FY2026 [sa3]. For the practice alone, full bulk billing is already ahead at today's gaps. The margin is thin either way, which is why billing policy appears among the risks in the multiple (section 13). The valuation is struck on the model in place; a change of billing model belongs in a buyer's forecast, not in maintainable earnings.

11. Valuation approaches, methods and procedures

Selection of approaches. APES 225 recognises three valuation approaches: income, market and cost. For a profitable, established general practice, maintainable earnings will commonly be central, but the appropriate approach depends on the facts. Here the capitalisation of maintainable earnings is primary, with market and cost cross-checks.

METHOD	WHAT IT DOES	ROLE IN THIS EXAMPLE
Capitalisation of maintainable EBITDA	Applies a multiple, reflecting risk and growth, to maintainable EBITDA	Primary. 3.5x on \$342,000
Maintainable earnings assessment	Normalised, run-rate earnings tested against history, capacity and the local market	Sets \$342,000 (sections 5 to 9)
Market cross-check	Tests the implied multiple against transactions and published commentary, weighed for comparability	Implied 0.75x practice revenue and 3.5x EBITDA (section 12)
Asset-based	Values the net tangible assets that could be sold or replaced	Floor only: fit-out and equipment about \$225k

Why not a rule of thumb. Rules of thumb for GP practices, whether a multiple of profit, a percentage of billings or an amount per doctor, hide the decisions that matter: which revenue, which profit, and how likely the GPs are to stay. Two practices with the same billings can differ widely in value if one keeps a 35% fee from a settled team and the other depends on its owner's own consulting.

When other methods come in. Where earnings are expected to change materially, for example after a switch to full bulk billing, a new site or the loss of a senior GP, a discounted cash flow can capture the path of earnings better than a single multiple.

12. Market evidence

There are two markets for general practices in Australia, and evidence from one should not be applied to the other.

EVIDENCE	WHAT IT SHOWS	WEIGHT HERE
Single practices: adviser and broker commentary, 2024 to 2026	Indicative ranges of about 1x to 6x adjusted earnings across advisers; one sets 2.5x to 3.5x for internal succession, 3x to 4x for GP groups and 4x to 6x for listed or private-equity backed buyers; multi-doctor practices with GPs under contract sit toward the upper end [market]	Relevant, but commentary rather than data
A Melbourne listing, 2026	An accredited mixed-billing practice in the eastern suburbs asking about 2.5x adjusted profit [market]	One asking price, not a sale
Platform deals: Healius medical centres to BGH Capital, 2020	\$500 million enterprise value, reported at about 13x FY2019 earnings [market]	Not comparable: scale and strategic value
Platform deals: Medibank and Better Medical, 2025	About \$159 million for 61 clinics; about 13x, doubling Medibank's expected EBITDA of about \$6 million for the half-year to 30 June 2026 (a forecast) [market]	Not comparable; the EBITDA basis is not stated

Who the buyers are. Group operators run about a quarter of Australian practice sites and employ about a third of GPs; 532 group sites are in Victoria. The largest include Amplar Health (Medibank: Myhealth and Better Medical), IPN (Sonic), ForHealth, Family Doctor and Partnered Health (being acquired by Bupa) [market]. Corporate buyers generally prefer larger multi-doctor practices with GPs under contract.

How deals are structured. Buyers pay for value they can keep, so a sale usually needs signed agreements with the associate GPs running 12 to 24 months past completion, a stay-on period for the vendor GP of 6 to 24 months with a restraint, and often part of the price deferred or tied to GP retention and billings over one to three years. A higher headline multiple with an aggressive earn-out can be worth less than a lower clean price. Market value, as defined in section 2, is the value of the practice as a whole before those terms; the terms decide how and when it is paid.

Claims we do not rely on. Some marketing material quotes 5x to 8x for single practices or 10x to 15x "platform" multiples. These are unsupported or relate to groups of practices, and are given no weight.

13. The earnings multiple

The multiple is how much a buyer pays for each dollar of maintainable earnings. It rises with durability and transferability and falls with risk.

POSITIVE FACTOR	IN THIS EXAMPLE	STRENGTH
Established trading history	Trading since 2011; GP billings up 19% in two years	STRONG
Depth of the GP team	Nine GPs, 6.9 FTE; the principal bills 10% of the total	STRONG
GP tenure	Five of eight contracted GPs have been at the practice five years or more	STRONG
Catchment	Older, ageing and advantaged; the lowest bulk billing rate of the four settings tested	STRONG
Accreditation and incentives	Accredited; \$222k of PIP and WIP income a year	MODERATE
Registered patient base	About 9,400 active patients; 3,300 registered through MyMedicare	MODERATE
Spare consulting capacity	GP rooms used for about 41% of opening hours	MODERATE
Premises	Six years left on the lease plus an option, at a rent that can be reset to market	MODERATE
FACTOR POTENTIALLY REDUCING VALUE	IN THIS EXAMPLE	PRESENT
Concentration in two GPs	GP A and GP B bill 32% of the practice total	MODERATE
Service fee at the top of the market	35% against a typical 30% in 2026 advertisements; each point is about \$37k of EBITDA a year	MODERATE
Recruitment pool	Inner metropolitan, so not a Distribution Priority Area: no Medicare billing by doctors under the s19AB moratorium	MODERATE
Payroll tax	About 44% of GP payments are taxable under Victoria's formula	MODERATE
Billing policy	Eastern Melbourne bulk billing rose from 75.2% to 82.9% of GP services between the September 2025 and June 2026 quarters; private fees face pressure	MODERATE
Patients choose their GP	Restraints are reasonable, but a departing GP's patients may follow	MODERATE
Incentive dependence	PIP and WIP depend on accreditation and continuity through a change of owner	LOW
Principal's roles	Clinical lead, a tenth of billings, and the landlord's family trust	LOW

MULTIPLE	ENTERPRISE VALUE
3.25x	\$1,112,000
3.5x	\$1,197,000 Adopted
3.75x	\$1,282,000
4.0x	\$1,368,000

Why 3.5x. The strengths are structural: fifteen years of trading, a nine-GP team with long tenure, a catchment that supports private fees, and income the practice earns in its own right. The risks are moderate but several: two GPs carry close to a third of billings, recruitment is limited to unrestricted doctors, about 44% of GP payments are taxable, the 35% service fee is at the top of the market, and the local shift to bulk billing puts pressure on the private fees the model depends on. On balance the practice sits in the lower half of the 3.25x to 4.0x range, consistent with the 3x to 4x commentary for GP group buyers (section 12).

Practice-specific, not sector-wide. This range comes from the factors above for this fictional practice. It is not a market rate for GP clinics and should not be applied to any other business.

14. Conclusion of value and sensitivity

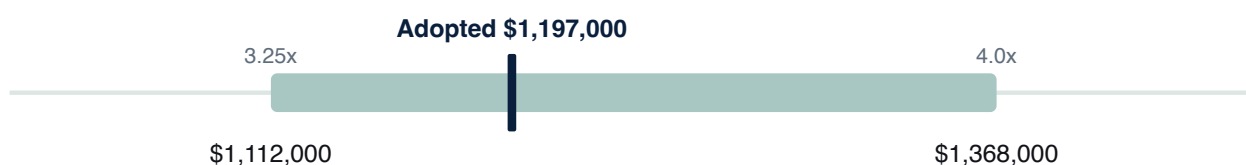


Figure 9. Enterprise value range and adopted value.

ENTERPRISE VALUE TO EQUITY VALUE	AMOUNT
Adopted enterprise value	\$1,197,000
Less bank loan (fit-out)	(\$120,000)
Less equipment finance	(\$45,000)
Less accrued long service leave (debt-like)	(\$38,000)
Plus surplus cash (below)	\$40,000
Working capital (normal level at completion)	nil
Indicative equity value	\$1,034,000

CASH IN A GP PRACTICE IS NOT ALL SURPLUS	AMOUNT
Cash at bank, 30 June 2026	\$200,000
Less fees collected and owed to the GPs	(\$95,000)
Less working cash the practice needs	(\$65,000)
Surplus cash	\$40,000

The practice remits GP fees fortnightly, so much of its bank balance at any time belongs to the doctors. In a share sale the company keeps its employees, and under the Long Service Leave Act 2018 (Vic) their service is continuous, so accrued long service leave for the practice manager and a long-serving nurse is treated as debt-like [legal]. Annual leave sits within normal working capital. Company income tax on the FY2026 profit, net of instalments, is assumed settled or within normal working capital at completion; any balance would be deducted as debt-like.

CROSS-CHECK	RESULT
Enterprise value to practice revenue	0.75x
Enterprise value to GP billings	0.33x
Enterprise value per GP FTE	\$173k
Post-tax return to a debt-free buyer, after \$40k maintenance capital expenditure and 25% tax	18.9%
Net tangible assets (floor)	\$225k

Sensitivity of enterprise value

MAINTAINABLE EBITDA	3.0X	3.25X	3.5X	3.75X	4.0X
\$282,000	\$846,000	\$916,500	\$987,000	\$1,057,500	\$1,128,000
\$312,000	\$936,000	\$1,014,000	\$1,092,000	\$1,170,000	\$1,248,000
\$342,000	\$1,026,000	\$1,111,500	\$1,197,000	\$1,282,500	\$1,368,000
\$372,000	\$1,116,000	\$1,209,000	\$1,302,000	\$1,395,000	\$1,488,000
\$402,000	\$1,206,000	\$1,306,500	\$1,407,000	\$1,507,500	\$1,608,000

Shaded: the assessed range, \$342,000 at 3.25x to 4.0x. The adopted \$1,197,000 sits in the 3.5x column.

Reading the matrix. Each \$30,000 of maintainable EBITDA moves value by about \$105k at the adopted multiple; each quarter-turn of multiple moves it by \$86k. The departure of GP A alone could move maintainable EBITDA by \$82k to \$144k, and payroll tax without the exemption by about \$69k. The corners are not predictions: they show the value if the evidence supported different earnings or a different risk assessment.

15. Owner dependence

Owner dependence is one of the most common reasons a practice is worth less than its profit suggests. A buyer is paying for earnings that continue after the principal steps back.

QUESTION	WHY A BUYER ASKS	IN THIS EXAMPLE
How much does the principal personally bill?	Patients may follow the doctor, not the practice	\$375,000, 10% of GP billings (0.7 FTE)
Who leads the practice clinically?	A buyer must replace clinical governance and supervision	The principal, unpaid; priced in at market (section 8)
Who manages the practice day to day?	Management that leaves with the owner must be rebuilt	An experienced practice manager, nine years in the role
Who recruits and keeps the GPs?	GP retention is the value driver	The practice manager recruits; the principal holds the senior relationships
Who owns the premises?	The buyer needs secure tenure at market rent	The principal's family trust; a new market lease on sale
Will the principal keep consulting after a sale?	Sets the handover and the risk to the principal's patients	Assumed: at least 18 months at the market service fee

Same revenue, same profit, different value

	PRACTICE A: THIS EXAMPLE	PRACTICE B
Practice revenue	\$1,599,926	\$1,599,926
Reported EBITDA	\$258,426	\$258,426
Principal's role	0.7 FTE GP and clinical lead; practice manager employed	Full-time GP and the largest biller (about 15% of billings, with the longest-standing patients), clinical lead; runs the practice with a senior receptionist
Principal's own fee and rent	Below and above market; both normalised	Already at market
Market cost of the principal's unpaid roles	\$30,000	\$94,000 (part-time manager plus clinical lead)
Owner adjustments	+\$64,450	(\$94,000)
Other adjustments and run-rate	+\$19,400	+\$19,400
Maintainable EBITDA (rounded)	\$342,000	\$184,000
Multiple	3.5x	2.75x
Enterprise value	\$1,197,000	\$506,000

Practice B's principal does two jobs for nothing, so maintainable earnings fall once a buyer prices in replacements; and because the practice's largest biller, its clinical lead and its manager are the same person, a buyer also applies a lower multiple. The two effects compound: about **\$691k** of difference on identical revenue and profit.

16. Goodwill, transfer and legal diligence



Figure 10. Composition of the adopted enterprise value of \$1,197,000.

Goodwill only has economic value to the extent it is transferable to a purchaser. Once fit-out and equipment (\$225,000) are counted, 81% of the enterprise value is goodwill. In law a business has one goodwill; what differs is its sources. Goodwill that rests on one doctor's personal following may not survive that doctor's departure. Goodwill that sits in the practice, its name, records, team, systems and registered patients, is what a buyer can hold onto. Medicare provider numbers are issued to an individual doctor for a location and cannot be sold [legal].

INTANGIBLE	HAS VALUE TO A BUYER WHEN
Practice name and brand	Owned by the company and known locally, not tied to one doctor
Patient records	Held or controlled by the practice, subject to privacy, professional and contractual obligations
Active patient base	Patients see more than one GP, so the relationship is with the practice
MyMedicare registrations	Patients registered with the practice; some items and incentives depend on it
GP agreements	Current, continuing on a share sale, with reasonable notice and restraint terms
Accreditation	Current and held by the company, keeping PIP, WIP and MyMedicare eligibility
Nurse and allied health team	Chronic disease and preventive care that does not depend on one GP
Website, phone numbers, booking listings	Registered to the company and kept on a share sale
Systems and procedures	Billing, recalls, triage and infection control written down and used

Why a share sale is simpler for a Victorian practice

ITEM	SHARE SALE (THIS EXAMPLE)	BUSINESS SALE
Health records	Stay in the company; no transfer of personal information	Health Records Act 2001 (Vic) HPP 10: newspaper notice, then at least 21 days before records move; in-practice notice and letters to current patients [legal]
MyMedicare registration	Stays; notify within 7 days if control changes	New owner is a continuing entity only if accreditation is kept; otherwise re-register and accredit within 12 months [mymed]
PIP and WIP	Continue with the company; notify the change of ownership within 7 days	Form IP010 with evidence of sale and the accreditation certificate; payments held until lodged [pip]
Accreditation	Continues; the agency may review a change of ownership	Must be transferred or re-obtained
Immunisation register provider number, healthcare identifiers	Unchanged	A new ABN needs a new immunisation register provider number
Employees	Stay employed; entitlements and long service leave continue	Offered new employment; long service leave continuity if re-employed within 12 weeks
Lease	Stays, subject to any change-of-control clause	Assignment needs landlord consent
Historical liabilities	Stay in the company: payroll tax, Medicare compliance, employment	Stay with the seller

Restraints in Victoria. Victoria has no restraints of trade statute, so restraints are tested at common law for reasonableness. The Supreme Court granted an interlocutory injunction enforcing a 10 km restraint against a GP who had sold his Epping practice and begun practising about 800 metres away (*Idameneo (No 123) v Deady* [2013] VSC 727), and enforced a 10 km zone for about four months against a contracted GP with cascading terms (*Epichealth v Yang* [2015] VSC 516) [cases]. The federal exposure draft released on 7 September 2026 would ban non-competes for employees earning up to \$190,100 from 2027; as drafted it does not reach contractor GPs or restraints given on a sale of business. It was not law at the valuation date [legal].

Contractor status. The same GP agreements face three tests at once: superannuation (contractors paid mainly for their labour are employees for super), the Fair Work Act whole-of-relationship test in force since 26 August 2024, and payroll tax (section 9). A

properly run service-fee model lowers the risk, but documents and actual practice must match [legal].

17. What a purchaser will investigate

AREA	ITEMS	WHY IT MATTERS
Financial	Three years of accounts; year-to-date results; billings and service fees by GP; owner remuneration; related-party rent; debt	The earnings trend, its quality, and what comes off enterprise value
GPs	Every GP agreement; tenure; notice and restraint terms; intentions after a sale; AHPRA registration and provider numbers at the address	Whether the service fees keep coming
Payroll tax and employment	SRO registration and correspondence; the cl 19B workings; contractor status; payroll, super and entitlements	Exposures a buyer would inherit
Medicare and incentives	Billing model; MBS item mix and documentation; any compliance reviews; PIP, WIP and MyMedicare records and payment history for eight quarters	Income that depends on compliance and eligibility
Patients and demand	Active patients; MyMedicare registrations; new-patient trends; appointment availability	Evidence the patient base belongs to the practice
Premises and contracts	Lease terms and option; allied health licences; pathology rent assessment; software and equipment contracts	Tenure and income that continue after completion
Privacy	Compliance with the Privacy Act and the Health Records Act; due diligence uses aggregated data, not patient identifiers	Records are the practice's most sensitive asset

After-tax proceeds are a separate question. What an owner keeps depends on the sale structure and on tax, including the small business CGT concessions and the changes to the CGT discount legislated to apply from 1 July 2027. That is a matter for the owner's accountant, and timing can matter.

18. Preparing for a sale

These steps reduce the uncertainties a purchaser would otherwise price in. None guarantees a higher price: the effect depends on the practice, the buyer and the market at the time.

ACTION	WHAT IT GIVES A PURCHASER
Put every GP on a current written agreement	Clear service fees, notice periods and reasonable restraints
Bring the principal's own arrangements to market	Service fee, rent and unpaid roles that need no argument
Document the payroll tax position and keep the A, B and C workings	An exposure that is measured, not guessed
Decide the billing model deliberately	A stable private-fee base, or a planned move into the incentive program
Keep accreditation, MyMedicare and incentive eligibility current	Income the practice earns in its own right
Report billings and service fees by GP every month	Earnings that can be verified quickly
Grant a market lease with an option	Tenure that outlasts the buyer's payback period
Spread patients across GPs and appoint a clinical lead	A practice that runs without the owner
Plan the handover	A principal who stays long enough for patients to move to other GPs

19. Information, assumptions and limitations

Information relied on (5.2(l)). For the practice itself, none: every practice figure is constructed. For the setting, the public sources in Appendix B, as at the dates stated. In an actual engagement HPNA would initially request the items below. Nothing is needed before a first conversation.

ITEM	USUALLY COMES FROM
FY2024 to FY2026 financial statements	The accountant
Year-to-date accounts	Accounting software
Billings and service fees by GP, by year; billing mix	Practice-management software
GP list: FTE, start date, service fee rate; the GP agreement template	The practice manager

ITEM	USUALLY COMES FROM
PIP, WIP and MyMedicare statements; accreditation certificate	Practice manager; Services Australia
Payroll tax returns and any SRO correspondence or advice	The tax adviser
Owner role, remuneration and related-party rent	A short conversation
Lease, loans and finance, room licences	The owner's files

Material assumptions (5.2(m)). The practice continues as a going concern; the GPs continue under their current agreements; the principal keeps consulting through a handover of at least 18 months at the market service fee; a new lease is granted at market rent; payroll tax is paid as clause 19B provides and no liability arises for periods before 1 July 2025; accreditation, MyMedicare and incentive eligibility continue; Medicare arrangements continue under the settings in force at 30 June 2026 with no change to the billing model; and normal working capital is delivered at completion.

Qualifications (5.2(o)). A report relies on information provided by the practice and its advisers, which the valuer does not audit. Public statistics are used as published; some were extracted or derived by HPNA, as Appendix B notes. The report is not tax, legal or financial product advice, not a recommendation to buy or sell, and not expert evidence. A draft is issued for factual review before the report is finalised; that review corrects facts, not the opinion.

20. Valuer responsible

An HPNA report is signed by Jackson Wilson, Director, for Valuation Group Pty Ltd trading as HPNA. Mr Wilson holds a Bachelor of Business (Finance) and a Diploma of Financial Services, and is RG146 compliant. He has valued privately held Australian businesses since 2013, including healthcare and allied-health practices.

SPECIMEN DECLARATION OF THE VALUER RESPONSIBLE

In a signed report, the valuer declares that:

- the Valuation Service has been conducted, and the report prepared, following the guidelines of APES 225 *Valuation Services*, including the content of a Valuation Report set out in paragraph 5.2;
- the engagement is a Valuation Engagement as APES 225 defines it;
- the valuer has acted independently and not as an advocate for the client or any other person, and neither the valuer nor HPNA holds any interest in the practice or in the outcome of a sale;
- the fee is fixed and not contingent on the conclusion, content or future use of the report;
- where matters outside the valuer's expertise arose, the valuer did not purport to resolve them, and the extent of reliance on others is disclosed;
- the evidence gathered is sufficient, in the valuer's professional judgement, to support the conclusion, subject to the qualifications stated; and
- the opinions expressed are the valuer's own, formed independently and held honestly.

[SPECIMEN · ILLUSTRATIVE EXAMPLE · NOT SIGNED]

Jackson Wilson · Director · B.Bus (Finance), Diploma of Financial Services, RG146

HPNA · Level 7, 55 Collins Street, Melbourne VIC 3000 · 0433 475 518 · valuations@olivergroup.com.au

Appendix A. The same practice in four places

Location changes the valuation before a single number in the accounts changes. We tested three established middle-ring areas and one growth corridor before setting this example in Heidelberg.

LOCAL AREA (SA3)	BANYULE	KINGSTON	WHITEHORSE WEST	WYNDHAM
GP bulk billing rate, FY2026	72.0%	75.5%	78.3%	92.8%
Average fee per GP service, FY2026	\$78.26	\$73.23	\$73.33	\$59.34
Bulk-billed share of fee dollars	57.2%	62.1%	67.4%	87.9%
Distribution Priority Area	No	No	No	Yes
Population trend	+11.9% to 2036; ageing	Growth with a Suburban Rail Loop station due 2035	Ageing share flat	Wyndham SA3 +3.7% in 2024-25
What it means for this model	Private fees viable; recruitment from unrestricted GPs only	Fees a little lower; corporate competition	Leans to bulk billing; 41% of Whitehorse LGA residents speak a language other than English at home	Near-universal bulk billing; about nine-tenths of GP payments exempt from payroll tax; overseas-trained GPs can bill Medicare

Sources: Medicare quarterly statistics by SA3 to June 2026, extracted by HPNA [sa3]; Distribution Priority Area classification and address checks [dpa]; ABS, Victoria in Future 2023 and EMPHN summaries [abs, vif, emphn].

What changes. In Heidelberg, the practice's value rests on private fees and on keeping its GPs, and about 44% of GP payments are taxable. In Tarneit, the same model would be unusual: nearly every GP service in Wyndham is bulk billed, so fees per service are lower, about nine-tenths of GP payments would be exempt from payroll tax, and overseas-trained GPs can bill Medicare, which eases recruitment but makes the workforce depend on a classification reviewed each year. Growth there is faster, and so is new competition. A valuer who applied a Heidelberg multiple to a Tarneit practice, or the reverse, would be wrong in both directions.

Appendix B. Sources and diligence log

Public sources consulted between 25 and 29 September 2026 for this example. Where a source was a secondary summary, or where HPNA extracted or derived a figure, the text says so. Government websites sometimes block automated access; where a primary page could not be read, the fact was confirmed from a second source or is described in general terms.

KEY	SOURCE	WHERE
[mbs]	MBS Online item descriptors and fees (items 3, 23, 36, 44, 123, 965, 967, 2715, 705, 10997, 75870, 10990); MBS news, 1 July 2026 (indexation 2.6%); 1 July 2025 values from an MM1 quick reference guide (July 2025).	mbsonline.gov.au; www9.health.gov.au/mbs
[bbi]	Bulk billing incentives: changes to eligibility from 1 November 2025 (factsheet).	mbsonline.gov.au
[bbpip]	Bulk Billing Practice Incentive Program: Program Guidelines (3 March 2026) and FAQ for practices (7 April 2026); Services Australia program page.	health.gov.au; servicesaustralia.gov.au
[sa3]	Medicare quarterly statistics, GP non-referred attendances by SA3, to the June quarter 2025-26 (workbook published August 2026). Figures for Banyule, Kingston, Whitehorse, Wyndham, Boroondara, Victoria and Australia were extracted by HPNA. Counts are by patient residence and exclude bulk billing incentive items.	health.gov.au
[phn]	Medicare quarterly statistics by Primary Health Network, June quarter 2025-26; per-patient bulk billing dashboard 2025-26; national bulk billing snapshot, 1 November 2025 to 31 January 2026.	health.gov.au
[aihw]	AIHW, Medicare-subsidised GP, allied health and specialist health care across local areas, 2024-25 (released 26 March 2026).	aihw.gov.au
[abs]	ABS Regional population 2024-25 (ERP 30 June 2025); 2021 Census QuickStats (Banyule LGA and SA2s); SEIFA 2021.	abs.gov.au
[vif]	Victoria in Future 2023 (Release 2, December 2023), LGA population and age projections to 2036.	planning.vic.gov.au

KEY	SOURCE	WHERE
[dss]	Department of Social Services, benefit and payment recipient demographics, June 2026 quarter (concession cards by LGA).	data.gov.au
[emphn]	Eastern Melbourne PHN, Health Needs Assessment LGA summaries 2024 (published November 2025).	emphn.org.au
[hd]	healthdirect service finder, GP services near Ivanhoe VIC 3079 (snapshot 29 September 2026).	healthdirect.gov.au
[dpa]	Department of Health, Disability and Ageing, Distribution Priority Area classification (latest annual update March 2025); Health Workforce Locator (address checks 29 September 2026).	health.gov.au
[rent]	Advertised medical and consulting suites for lease, Heidelberg and Ivanhoe (September 2026); purpose-built medical centre leases in suburban Melbourne (2024 to 2025).	commercialrealestate.com.au; agents' releases
[pt]	State Revenue Office Victoria: medical industry page (updated 18 May 2026), current rates, threshold and phase-out, grouping; Revenue Ruling PTA-041 (11 August 2023); State Taxation Further Amendment Act 2024 (No. 50 of 2024) s 43, inserting cl 19B of Schedule 2 to the Payroll Tax Act 2007; Premier's release, 22 May 2024.	sro.vic.gov.au; legislation.vic.gov.au
[cases]	Commissioner of State Revenue v The Optical Superstore Pty Ltd [2019] VSCA 197; Thomas and Naaz Pty Ltd [2021] NSWCATAD 259, [2022] NSWCATAP 220, [2023] NSWCA 40; Idameneo (No 123) Pty Ltd v Deady [2013] VSC 727; Epichealth Pty Ltd v Yang [2015] VSC 516.	court and tribunal reports
[pip]	Services Australia, Practice Incentives Program payment types (QI and eHealth rates and caps); updating practice details on a change of ownership (form IP010).	servicesaustralia.gov.au
[wip]	Workforce Incentive Program, Practice Stream guidelines (effective 1 July 2026) and Practice Stream incentive payments page (maximum \$137,375.60 from July 2025).	health.gov.au
[mymed]	MyMedicare Program Guidelines (July 2026): sale of a practice, continuing entity, notification within 7 days.	health.gov.au
[wages]	Fair Work pay guides: Nurses Award 2020 and Health Professionals and Support Services Award 2020 (1 July 2025 rates); Annual Wage Review 2026 (4.75% from 1 July 2026); superannuation guarantee 12% (ATO); practice manager and practice nurse market pay (2026 salary guides and job boards).	fairwork.gov.au; ato.gov.au
[ops]	Service fee ranges in 2026 Melbourne GP job advertisements; consulting-hours FTE and billings per consulting hour (Cubiko); RACGP Health of the Nation 2025; practice software licence fees (2026).	various, secondary
[market]	ASX releases: Healius sale of medical centres to BGH Capital (15 June 2020); Medibank acquisition of Better Medical (5 November 2025) and of a further 41% of Myhealth, taking its stake from 49% to 90% (7 December 2023). Adviser and broker commentary on GP practice multiples (2024 to 2026); group operator counts (GP Zoo, July 2026).	asx.com.au; advisers' publications
[legal]	Health Records Act 2001 (Vic), HPP 4 and HPP 10, and HCC guidance; OAIC, selling a business; Health Insurance Act 1973 Part IIBA (prohibited practices, pathology rent) and Department of Health compliance page; Retail Leases Act 2003 (Vic) ss 4 and 50; Long Service Leave Act 2018 (Vic); Treasury exposure draft on non-compete clauses (7 September 2026).	legislation and regulators' guidance

Derived figures. The Banyule bulk-billed share of fee dollars (bulk billed fee charged over total fee charged, FY2026 quarters summed); the average patient contribution for Banyule (patient-billed fees less patient-billed benefits, over patient-billed services); the Better Medical multiple (price over twice Medibank's expected half-year EBITDA).

How HPNA approaches a GP practice valuation

For an established general practice considering a potential sale, HPNA would typically:

1. **Understand the catchment:** who the patients are, how the local market bills, and whether the location helps or limits recruitment.
2. **Separate GP billings from practice revenue:** what the doctors bill, what the practice keeps, and what is its own income.
3. **Rebuild the billings** from the item mix, Medicare settings and billing policy, and test them against local data.
4. **Reconstruct maintainable earnings:** the principal's fee and roles, related-party rent, one-off items and the run-rate after any change in settings.
5. **Measure payroll tax** under the state's rules, on the right basis, relying on the practice's tax advice.
6. **Assess GP retention and owner dependence:** billings and tenure by doctor, agreement terms, concentration and the cost of a departure.
7. **Test the billing model** against the alternatives a buyer will consider.
8. **Consider whether goodwill and registrations would transfer**, and what a buyer's lawyer will check.
9. **Weigh the market evidence** for comparability, and determine a range and an adopted value, for enterprise value and equity value.

The objective is not simply to produce a number. It is to explain what the practice is worth, why it is worth that amount, and which factors a purchaser is likely to focus on.

Thinking about selling your general practice?

A valuation can be useful before commencing a sale process because it allows an owner to understand the likely value range, identify issues that may affect a purchaser's assessment, and determine whether it is the right time to proceed.

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CONTACT

Jackson Wilson

Director

0433 475 518 · valuations@olivergroup.com.au

ILLUSTRATIVE EXAMPLE: NOT A VALUATION OF ANY REAL PRACTICE

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