Royal Commission

Into Aged Care Quality and Safety

Grant Corderoy

Witness Statement *(20 April 2020)*

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1. Qualifications and Research

Grant Corderoy

Current Occupation

Senior Partner, StewartBrown, Chartered Accountants

Relevant Past Occupations

Commenced with StewartBrown in July 1977. In the intervening period, I have had several relevant secondments:-

- Management Consultant - six months secondment to Uniting*Care* NSW.ACT to manage the rationalisation and integration of each business segment, including aged care, children's services, property, and corporate
- Chief Financial Officer - lengthy secondment to manage the expansion of large private company having operating locations in each mainland State, New Zealand, Malaysia and Japan

Qualifications

- Bachelor of Commerce (Accounting)
- Diploma of Journalism

Experience and Involvement in the Aged Care Sector

With over 42 years' experience within the profession, my client portfolio includes numerous consulting projects for the Department of Health, with specific focus on financial sustainability at government, provider and consumer levels as well as policy development including extensive stakeholder consultations.

I have an ongoing professional relationship with in excess of 190 aged care providers, the Department of Health, aged care peak bodies, consumers and sector panels. My professional involvement within the sector includes audit and risk, financial modelling and analysis, governance reviews, systems reviews and implementations, financial statements preparation and analysis, Board and management workshops, facilitations and presentations, and numerous sector conference and forum presentations.

I have been a Board member of three aged care provider organisations, and member of Finance, Risk & Audit Committees for several provider organisations.

I established the StewartBrown *Aged Care Financial Performance Survey* in 1995 and am still the lead manager in relation to the Survey.

StewartBrown

A significant amount of the responses in this Witness Statement will include extracts of tables, graphs and commentary sourced from the StewartBrown *Aged Care Financial Performance Survey Sector Report (December 2019)* (Survey) of which I was the primary report author, as well as from my ongoing professional involvement with stakeholders in the aged care sector.

Accordingly, it is relevant to provide a brief résumé of StewartBrown and the Survey

StewartBrown is a Chartered Accounting firm principally located in Chatswood, Sydney. The firm currently consists of 7 Partners and over 70 employees providing professional services including Audit, Consulting, Business Services, Taxation and Financial Planning. StewartBrown provides these professional services nationally to a range of clients, however, we have a speciality expertise in aged care and community services, social services, independent schools, children's services and disability services.

With respect to aged care and community services, StewartBrown have more than 40 professional staff actively providing significant professional services to the sector nationally including:-

- Audit and assurance
- Preparation of general purpose financial statements
- Annual Prudential Compliance audits
- Community Acquittals
- Governance reviews (including Board and Executive)
- Finance systems and process reviews
- Financial modelling and forecast assignments
- Secondments
- Conference presentations and sector workshops
- Briefings to Department of Health and the Aged Care Financing Authority
- Aged Care Financial Performance Survey *(December 2019: 193 providers comprising 1,125 residential facilities; 512 community programmes incorporating 36,529 HCP packages)*

Aged Care Financial Performance Survey

StewartBrown undertakes the largest financial performance benchmarking survey covering the aged and community care sector in Australia. This survey includes detailed operational, equity and staffing data on a quarterly basis for residential aged care facilities and home care packages.

The *Aged Care Financial Performance Survey* (ACFPS) commenced in 1995 and has grown exponentially due to the requirement for Boards and executive management to be able to compare their operations to that of other facilities and programmes within the sector.

Over the years, the format of the results of the Survey has become more granular in content and has become an integral part of the strategic, budgeting, forecasting and review processes within the participant provider organisations.

Subscribers to the Survey include some of the largest providers nationally, independent stand-alone providers, faith-based and community providers, for-profit providers, culturally specific providers, as well as government bodies, including the Department of Health (DoH), Aged Care Financing Authority (ACFA), aged services sector peak bodies, consumer bodies and other service providers.

The Survey provides quarterly financial and non-financial data for residential (by aged care home) and home care (by program) at a granular level. In addition, the Survey obtains specific segment information and key balance sheet information at organisation (approved provider) level every six months.

StewartBrown's involvement in the aged care sector over many years has provided a unique and comprehensive knowledge of the financial performance of providers and of the financial performance and viability of the aged care sector.

StewartBrown, through both the Survey and other related publications or presentations is not an advocate for any stakeholder in the sector and has professional relationships with the Department, Aged Care Financing Authority, peak bodies, provider organisations, aged care staff and aged care residents and clients.

The primary agenda of StewartBrown is that all financial policy and related public commentary should be evidenced based, objective and supported by accurate data.

2. Financial State of the Sector

Financial Performance Overview

To ensure more clarity to the specific responses requested, it is beneficial to provide a snapshot of the financial performance of the sector for the six months ended 31 December 2019.

The financial impact of COVID-19 has not impacted on the December 2019 results, but will heavily influence the results for the March and subsequent quarters until the virus has stabilised and the economy returned to some normality. The Government has provided additional funding to primarily ensure staff retention, however the additional operational and regulatory burden to ensure that aged care homes and community care recipients are protected as far as possible from the impacts of the virus may not be sufficiently covered by this additional funding.

Approved Provider - Aggregate Results

- Operating surplus* reduced to an average loss of $1,104k for the six months, a decrease of $363k
- Operating EBITDA (cash flow from operations surplus) reduced by $205k to $791k surplus
- Operating surplus expressed as a return on assets employed has further reduced to negative 1.03%
- Operating EBITDA return on assets has reduced to 0.74% (Dec-18: 0.97%)
- Liquid cash and financial assets as a percentage of debt (refundable loans, borrowings and CDC liability) has reduced by 3.5% to 34.2% (Dec-18: 37.7%). The listed entity ratio was 2.05% (after dividend)

**Operating profit/loss excludes non-recurrent revenues and expenses – grants/revaluations/donations/impairment*

Residential Care

- 56% of aged care homes recorded an operating loss for the December six month period
- 29% of aged care homes recorded an EBITDAR loss (operating cash loss) for the December period
- Average ACFI per bed day (pbd) for Survey participants increased by $2.63 pbd to $180.30 pbd *(1.4% pa)*
- ACFI direct care services costs increased to $154.48 pbd *(6.8% pa)*
- Occupancy levels for survey participants decreased to 93.9% average occupancy (94.9% Dec-18)
- Total care hours worked per resident per day increased by 0.09 hours to 3.25 hours (Dec-18: 3.16 hours)
- Costs for providing everyday living services exceeded revenue by $8.13 pbd *(excluding administration)*
- Average Net Profit Before Tax (NPBT) for aged care homes (the overall Operating Result) reduced by $3,319 per bed per annum (pbpa) to a loss of $2,120 pbpa *(year-on-year comparison)*
- Average EBITDAR for aged care homes reduced by $3,146 pbpa to $4,245 pbpa *(year-on-year comparison)*
- Supported ratio remained constant at 46.9%
- Average full RADs taken in the December six months increased to $424,209 (nationally) an increase of $31,017 in the year from Dec-18

Home Care Packages

- Revenue per client per day (pcpd) average for Survey participants decreased by 6.1% (being $4.66 pcpd)
- The average operating profit per client day increased by $1.40 pcpd to $4.73 pcpd ($3.33 Dec-18; $3.65 FY19)
- Direct service costs decreased by $4.29 pcpd (59.04% of total revenue)
- Revenue utilisation has declined by 3.5% to 85.4%
- The average unspent funds per client has increased by $1,078 per client (to average $7,904 per client)
- Staff hours worked per client per week *reduced* by 0.90 hours (average 5.79 hours per week)

Are Aged Care Providers Adequately Funded to Provide Quality Care?

Residential Care

Residential Care is a significant and urgent concern in relation to financial viability and ongoing sustainability. The December six months period showed a decrease in occupancy levels, the first overall decline over a period of time for at least five years. Occupancy and financial result are significantly inter-related, and accordingly any decline in occupancy has a direct negative impact on the operating performance of providers.

The ACFI revenue increase of just under 1.5% pa is primarily as a result of the COPE inflation increase and indicates that the average acuity of residents has plateaued to a large extent. However, the costs of providing direct care has increased by 6.8% pa and this differential is not supportable under the current funding envelope.

Direct care staff costs represented 80.9% of the ACFI (direct care) subsidy, and the ongoing disparity between the subsidy COPE increase and staff cost increases continues to cause considerable concern.

A significant issue in relation to residential care is the unsustainable loss in providing everyday living (indirect care) services. The cost of providing these essential services exceeds the revenue (largely the Basic Daily Fee) by an average of $8.13 per resident per day without any allowance for the administration costs. If the administration costs specifically related to these services was included, the **loss is $20.93 per resident per day.** This has a direct consequence in the ability to utilise the ACFI subsidy for providing direct care services.

Outer regional, rural and remote homes continue to deteriorate in their financial performance and viability. These homes have an **average operating loss of $4,719 per bed per annum** ($14.06 loss per resident per day). This has resulted in 71% of these homes having an operating loss and 44% having a cash operating loss. These percentages will likely further deteriorate over the next six months.

A major cause for the financial concern in relation to the residential aged care sector is the operating results for the Bottom 75% of aged care homes *(based on financial performance and not on clinical care delivery)*. This is a very large cohort and the average result is an **operating loss of $15.94 per resident per day**. Given the number of homes this represents, this confirms that there is an urgent requirement for additional funding and a sustainable funding model going forward.

Investment in the residential aged care sector, be it new builds or major refurbishment and improvements to existing homes, has seen a significant downturn. Much of this is due to the regulatory uncertainty and the poor financial performance of the sector which is a major disincentive to investment confidence.

Home Care Packages

Home Care has experienced an improved operating performance for the Dec-19 six months, with an overall increase of $1.40 per client per day in comparison to the Dec-18 six months. A possible concerning point is that that the improved performance was not as a result of increased revenue, but due to reduced costs, and particularly staff costs (and resultant staffing hours). Whether this is sustainable is open to conjecture.

It also needs to be noted that the financial performance for the December quarter (three months) was a loss of $1.62 per client per day ($570 per client per annum) which indicates financial volatility in this segment as well.

The biggest single issue in relation to Home Care Packages remains in relation to the level of Unspent Funds. The quantum of unspent funds has kept rising each quarter, and now averages $7,904 per client (care recipient). In aggregate, this represents in excess of $800 million of funding that is not being utilised.

This continued growth in Unspent Funds, and many probable instances of their use for capital-related expenditure for care recipients (probably for a short-term benefit in many instances) is not sustainable.

The recently announced changes to the subsidy payment arrangements (being in arrears rather than in advance) and the potential further reforms for providers to be reimbursed for actual services provided rather than for the funding package by care recipient may largely address the unspent funds concerns in this regard *(please note that the commencement date for the implementation of the funding payments cycle has been deferred due to the Covid-19 financial concerns).*

The cash flow implications to providers of the proposed reforms need to be considered and monitored. I understand that it is proposed that the current unspent funds will only be remitted back to the Government over a reasonable time period, and this should ease much of the initial cash flow concerns.

In summary, unlike residential care, home care packages can be considered to be over-funded from a consumer (client) perspective as the level of unspent (unutilised) subsidy funding is increasing. To improve the financial performance, approved providers should increase their pricing to a commensurate level to their operating costs. This will have some impact of the level of unspent funds, however there would be significant benefit in having the majority of the unspent funds redistributed to provide more packages for consumers.

Key Challenges Experienced Under the Current Aged Care System

I will address the key challenges from my experience and perspective by each segment.

Approved Provider (Organisation Level)

The major challenge at the approved provider level is to remain financially viable. There has been a steady and consistent decline in the operating and EBITDA results over a number of years and this has had the following effects:

- Declining investment into existing infrastructure (particularly property) and new developments and innovative approaches to the delivery of care
- Poor and inappropriate financial returns for stakeholders
- Increased liquidity concerns for a significant proportion of providers with prudential implications
- Required consolidation of the residential and home care sectors has stagnated due to risk and poor financial performance
- Drift of senior and middle management staff with required leadership, skills and experience away from the sector creating a significant void

A snapshot of the organisation results for the period to December 2019 is in included the below graph.

Organisations sorted by Total Assets

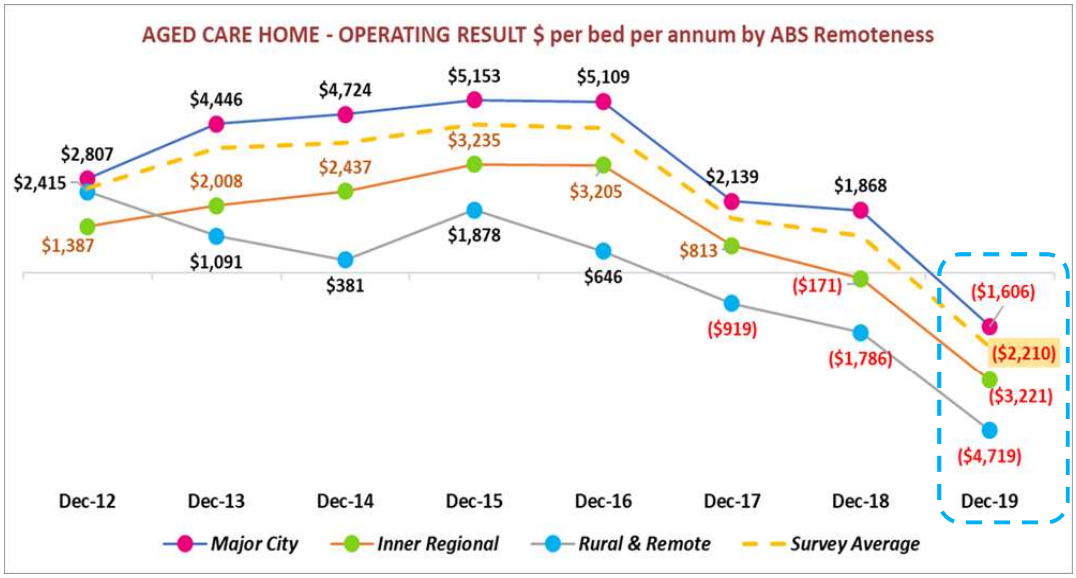
	Total Assets >$150M $'000s	Total Assets $50M - $150M $'000s	Total Assets $25M - $50M $'000s	Total Assets <$25M $'000s
Operating Surplus / (Deficit)	($2,879)	($294)	($138)	($119)
Average NPBT	($1,701)	($131)	($65)	($9)
Operating EBITDA	$2,210	$113	$57	$12
EBITDA	$3,388	$276	$131	$122
NPBT Return on Assets	(0.65%)	(0.32%)	(0.36%)	(0.11%)
Operating Surplus Return on Assets	(1.10%)	(0.71%)	(0.76%)	(1.45%)
Cash & Financial Assets % of Debt	29.10%	57.43%	67.40%	73.52%

Residential Care

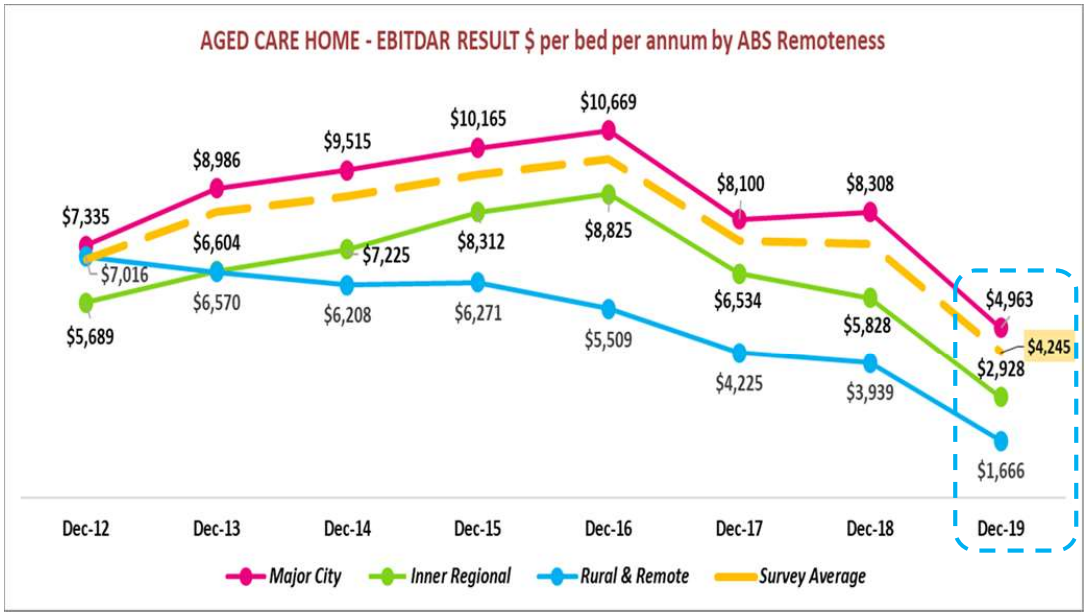
Current Financial Performance

As noted earlier, residential care has significant financial viability concerns and these involve all ownership types, geographic regions, size of homes and resident acuity mix. The following charts show the decline in operating result (loss) and EBITDAR result for the period December 2012 to December 2019.

Operating Result Trends by geographic region



EBITDAR Results Trends (Earnings before Interest, Taxation, Depreciation, Amortisation and Rent)



Factors that Exacerbate the Key Challenges

Briefly, there are several major factors that influence the declining financial performance:-

- ACFI subsidy criteria is not adequately meeting the cost of direct care service delivery for certain domains (particularly in relation to the complex health and behaviour domains)
- COPE (inflation) increase not matching the actual cost increases of staff costs

- Outer regional, rural and remote aged care homes requiring a variance to the funding model due to specific characteristics that impact on their operations, which include staff shortages, higher costs of goods and services (including labour), lower accommodation prices and lower occupancy rates
- Hotel services delivery (catering/cleaning/laundry/utilities/maintenance/local administration) being delivered at a cost significantly less that the resident fees received (being 85% of the single pension for all residents)
- Guidelines for the delivery and pricing of additional services being inadequate, contradictory and subject to differing interpretations by the various regulatory bodies
- Costs for increased training and development of staff (and particularly clinical and care staff) not being appropriately funded
- Accommodation pricing model is no longer appropriate for a capital intensive sector as residential aged care
- Requirement for substantial increase in community education as to the cost of delivery care, cost of accommodation and complexities of residential aged care

Areas that the Challenges can be Mitigated or Addressed

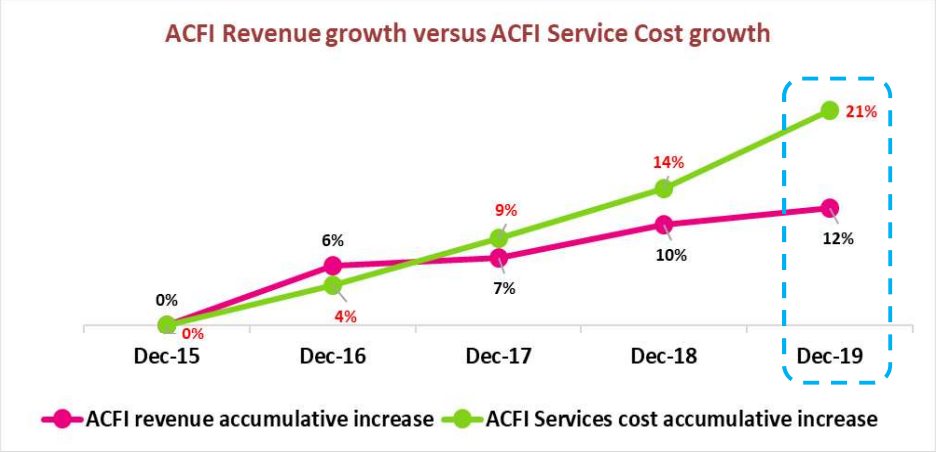
Some specific reforms to assist in mitigating certain of the factors noted above include:-

Direct Care (ACFI) Funding

The components of the ACFI (direct care) funding and expenditure are as follows:

The average ACFI subsidy is currently $180.30 per resident per day. The direct staff costs associated with providing direct care services averages $145.90 per resident day (80.9% of ACFI) with other direct care costs totalling $8.57 per resident day. No allowance in the ACFI funding model is for an administration component.

The below graph shows the trend of ACFI revenue (including COPE increases) and ACFI costs (staff/medical).



FUNDING REFORM CONSIDERATION

COPE (inflation) subsidy to be calculated based on annual ABS Wage Price Index plus 1% (additional 1% to allow for award/EA increases for aged care workers) *(staff costs represent over 80% of ACFI revenue)*
(Estimated additional annual subsidy - $240 m)

Indirect Care (Everyday Living) Funding

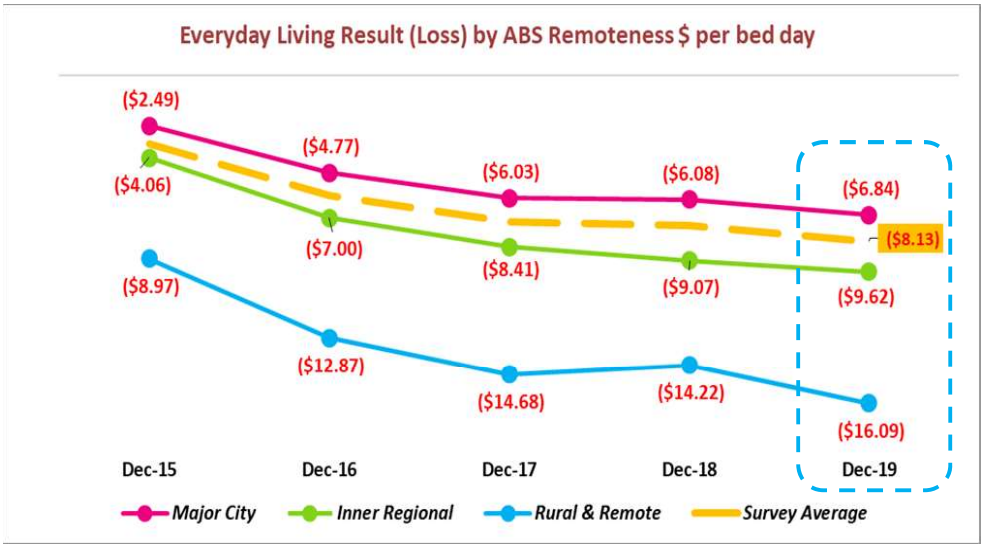
The components of the ACFI (direct care) funding and expenditure are as follows:

The recoupment of everyday living costs is a key reason for the poor financial performance in residential care. Whilst opportunities exist to charge additional optional services to residents, several challenges exist in this regard. A major issue is in relation to supported residents who, by majority, do not have the financial means to pay for additional services, or indeed pay a higher Basic Daily Fee (85% of the single pension).

With a supported resident ratio averaging in excess of 47.6% across all aged care homes will continue to be an issue for providers in addressing the introduction of additional services.

For the Dec-19 six month period the direct costs of providing everyday living services exceeded the revenue by $8.13 pbd (Dec-18 $7.38 pbd). However, with the inclusion of normal administration costs (including procurement, payroll, rosters, accounts, quality control, insurances, human resources and corporate costs) the loss increases to be $20.93 per bed day.

The below graph highlights the continued decline in recoupment of costs through the Basic Daily Fee and additional/extra services for those providers who levy this. The graph excludes any administration recoupment.



FUNDING REFORM CONSIDERATION

Increase the base amount for the Basic Daily Fee (which relates to Everyday Living costs) by $10 per bed per day - government subsidy to compensate for all residents in the interim (first 2-3 years) and then progressively means-tested. A further recommendation is to enact the full deregulation of the Basic Daily Fee in line with the Tune Legislative Review recommendation

(Estimated additional annual subsidy - $700 m)

Direct Care Staffing

Residential aged care, by its very nature, requires a high degree of direct staffing with appropriate skills and supported by an expansive professional development and training program. There is little doubt that being an aged care professional, at all levels, is extremely demanding and requires significant improvements in pay rates and conditions.

The current funding envelope does not provide sufficient opportunity to develop and enhance the aged care workforce. Much of the required strategic actions are as outlined in the report "*A Matter of Care: Australia's Aged Care Workforce Strategy*" (June 2018) which provides an extensive evidenced based guide for the aged care sector to enact.

Direct care staffing hours have shown a gradual and progressive rise over the last decade, mirroring the increased acuity levels and care needs of residents, however it is not being supported by the funding which is not sufficient to allow for more staffing hours to deliver care.

The lack of additional funding has potentially compromised the ability of providers to ensure there is additional training to support the required strategic actions.

FUNDING REFORM CONSIDERATION

Ongoing 2.5% training subsidy (based on ACFI revenue) to finance staff skill and training (subsidy includes costs of staff to attend training). Recommend that the training subsidy be on an acquittal basis to ensure that it is properly directed to training purposes

(Estimated additional annual subsidy - $315 m)

Regional, Rural and Remote Homes

Regional, rural and remote residential care financial viability is at a critical juncture. As at December 2019 the number of residential care homes in these geographic locations operating at a loss was 71% and indications are that this will increase to around 80% by June 2020.

This concern is further exacerbated when considering that 44% of these homes are experiencing a cash operating loss, and this will potentially increase to close to 50% by June 2020.

Residential aged care funding draws no distinction as to location with the exception of some rural and remote homes receiving a viability supplement to assist. However, given the number of homes operating at a loss, it appears that the supplement is not sufficient and, additionally, that there are homes who do not qualify for the supplement.

As the residential care homes who operate in remote locations have a number of characteristics that are not prevalent with inner regional and metropolitan locations, there should be a differentiation in respect to the funding principles.

FUNDING REFORM CONSIDERATION

Regional aged care homes to be fully funded for ACFI based on 100% occupancy *(subject to financial viability analysis for vulnerable homes)*

(Estimated additional annual subsidy - $140 m)

Accommodation Pricing

An area of constant feedback from both providers and consumers is that within the community there is still a lack of understanding about the pricing (and cost) of residential care accommodation. The concept of paying a RAD or a DAP or a combination of both is confusing to potential residents (and their family) and this decision is often made in the short time frame before a resident enters an aged care home.

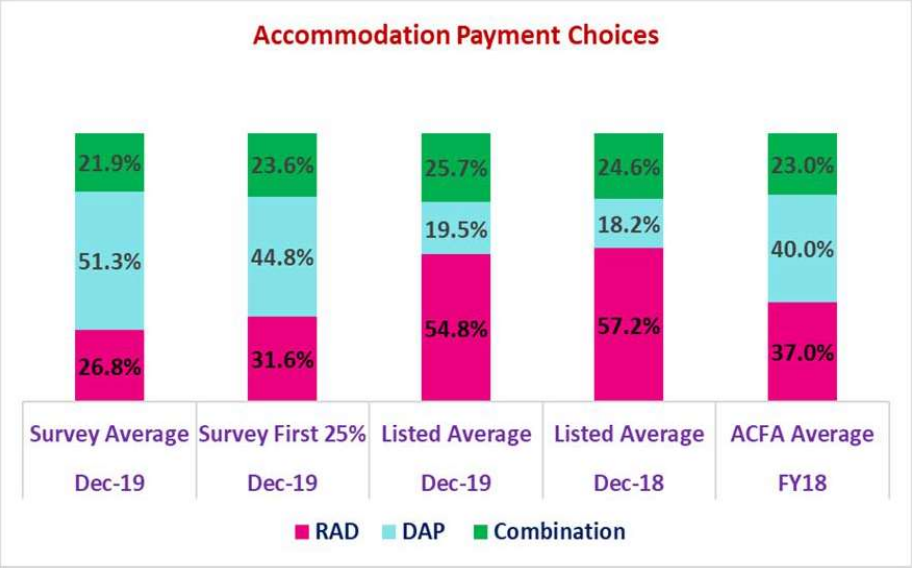
There is often conflicting advice provided to the family by financial planners as their role is to minimise any effect on the pension or tax status, and also to protect any future inheritance. The complexities further arise with financially supported or semi-supported residents and how to calculate the RAC or DAC (or combination).

This has had an overall effect of some providers not having an effective strategy for accommodation pricing and incoming residents making decisions not based on the standard of care that should be provided but on the standard and cost of the accommodation.

The acuity (care needs) of a resident is directly related to the ACFI funding and expenditure. Everyday living (indirect care) expenses are offset against the Basic Daily Fee and additional services (if charged). Accommodation pricing, however, is not assessed on care needs but on the standard of accommodation and the financial ability of an incoming resident to meet the price through either a RAD, DAP or a combination of both. Any consumer or community expectation that the standard of accommodation, and accordingly the accommodation pricing, is relative to direct care provided is somewhat misconstrued.

The receipt of RADs is intended to assist in the repayment of external borrowing and to provide capital for providers to rebuild. It is arguable as to whether the use of RADs (which are in effect unsecured debt and requires ultimate repayment) for refurbishment of existing buildings is desirable as it will eventually negatively distort the debt to equity ratio. Refurbishment funds should be derived from the accommodation surplus where possible.

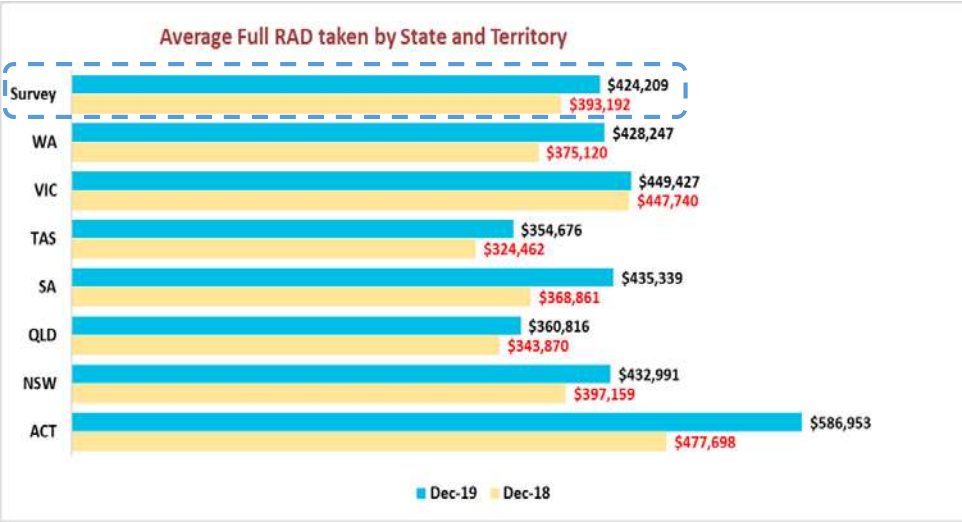
There has also been a steady movement towards more DAPs as a percentage of accommodation pricing preference, which is creating cash flow uncertainty for providers as they replace an outgoing RAD with a DAP (refer below table for the trend).



The current RAD/DAP model needs to be reassessed. When a RAD is received and if fully invested in the current interest rate environment, it may yield an effective interest rate of 1.005 to 1.5%. Assuming the RAD is $424,000 (being the average full RAD taken for the period to 31 December 2019 - refer following table) the investment income will be $5,300 per annum using a median interest rate of 1.25%.

However, the RAD coverage to liquid cash and financial assets is around 25%, hence the effective interest rate return would be $1,325 per annum which is clearly an insufficient return.

By way of comparison, the DAP is calculated at the Maximum, Permissible Interest Rate (MPIR) which is currently 4.89%. Therefore, if a DAP was received on the $424,000 accommodation price, this would equate to a daily amount payable by the resident of $56.80 per day ($398.72 per week).



Therefore, for a full RAD paying resident, the maximum return is in the range of $1,325 pa ($25.48 per week) to $5,300 pa ($101.92 per week) which is significantly less than property rentals which are around $436 per week (Australian average) and the equivalent DAP of $398.72 per week.

Supported residents represent over 45% of the resident population, and accordingly neither a full RAD/DAP/Combination will be received. The current accommodation supplement subsidy paid for supported residents is $37.93 per day ($266.24 per week) and would represent a full RAD of $283,118.

This analysis excludes the significant refurbishment supplement as this relates to capital expenditure to improve the accommodation of a home and is more of a capital revenue item.

FUNDING REFORM CONSIDERATION

1. The accommodation pricing model be amended to include a form of effective rent payment for full RADs and Combination RADs/DAPs

2. The deferred fee calculation be based on the MPIR less the 2 year government bond rate (the bond rate representing the potential interest forgone by a resident paying a RAD)

3. The MPIR be set at a minimum of 5%

4. The accommodation supplement be calculated as being 85% of the average Australian RAD taken multiplied by the MPIR

(Estimated additional annual subsidy with respect to the accommodation supplement - $350 m)

Impact of Caps on what can be charged for Daily Living Costs and Care

Annual and lifetime caps apply to income-tested care fees paid by home care recipients and the means-tested care fees paid by residential care residents. Any cap paid from a recipient in home care extends to the period if they enter residential care. The current caps are $28,087 per year and $67,409 in a lifetime.

Recommendation 15 included in the *Legislated Review of Aged Care 2017* (Tune Review) recommended the abolition of both the annual and lifetime caps. We note that the Government rejected this recommendation at the time. The continuation of the caps results in the government (taxpayer) paying these amounts as soon as the caps are reached, and accordingly this reduces the recurrent subsidies available through the budgetary process.

If the caps are not abolished, an alternative would be to increase the amounts of the cap ceilings by a significantly larger amount annually - as an example, by $5,000 for the annual cap and $15,000 for the lifetime cap.

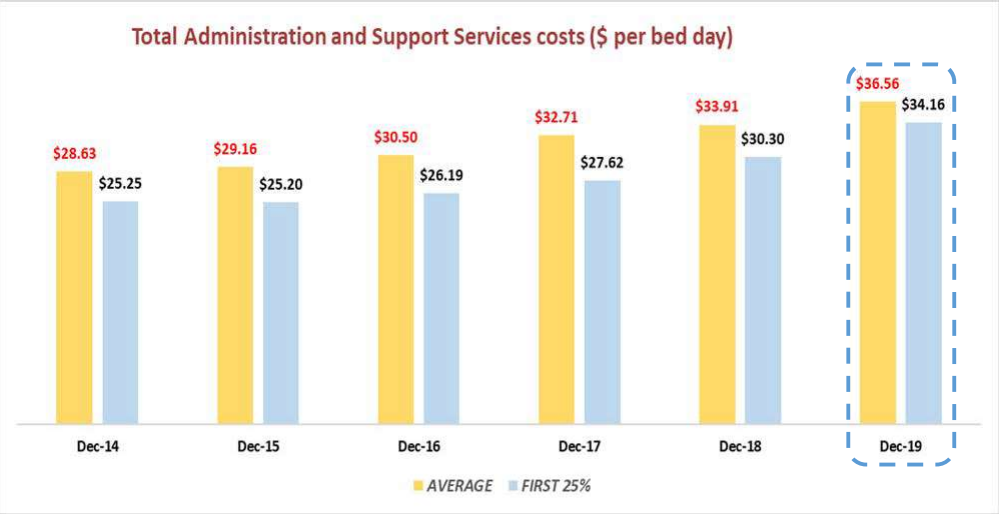
The Role of Potential Variation of the Levels of Accommodation Pricing

The overall role of the Pricing Commissioner is very important, and should be expanded (further explanation is included later). The Tune Review recommendations 19 (a) and 19 (b) are still relevant and should be implemented from my perspective.

The Pricing Commissioner has not rejected many (if any) applications for an accommodation price above $550,000 (though often requesting additional supporting information) and accordingly the current application levels are too low and incur additional cost for the provider to make applications for pricing above $550,000 to $750,000 with no feasible benefit for the consumer.

Administration and Overhead Costs Recognition in Subsidies

Administration costs have continued to increase at a rate higher than CPI. One of the main drivers for this is the increasing compliance requirements and this has now been exacerbated by costs associated with fulfilling information requests, making submissions and attending hearings in relation to the Royal Commission.



It is likely that administration costs will continue to increase for the remainder of this financial year due to increased compliance costs in relation to the new quality standards and greater scrutiny on direct care staffing costs and care service delivery by consumers and stakeholders. *The increased cost associated with the effects of the bushfires and COVID-19 virus will also severely impact administration costs.*

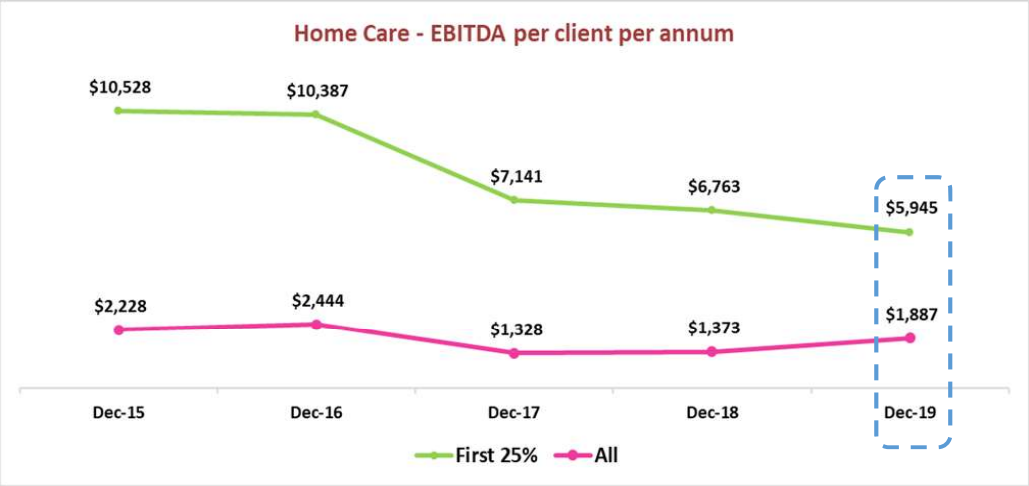
Administration costs do not have a separate revenue stream in residential aged care. Item 1.1 *Administration* of Schedule 1 *Quality and Care Principles (2014)* state administration as being "General operation of the residential care service, including documentation relating to care recipients" which appears to be directed at administration costs provided directly at the aged care home, and not including the corporate administration and related functions, such as finance, payroll, rosters, human resources, procurement, property, quality and training amongst other important functions.

Item 1.1 is included in Part 1 - Hotel services of *Schedule 1* and as noted earlier, hotel services (everyday living) incur an average cost above revenue of $8.13 per resident per day before any allowance for administration.

Home Care Packages

Current Financial Performance

The financial performance trend for home care packages (HCP) for the periods 2015 to 2019 is summarised in the following graph (*First 25% refers to operating results not necessarily to quality of services provided*).



The December quarter (October to December) was a loss of $520 per client per annum (*First 25%* was a loss of $2,006 per client per annum) which suggest that the results to June 2020 will be lower than the previous year comparatives.

Factors that Exacerbate the Key Challenges

There are several factors that are influencing the financial performance of home care package providers:-

- The level of unspent funds (revenue utilisation). Many of the costs are fixed in nature (as distinct from variable being dependent upon actual service delivery) and the inability to utilise the recurrent funding for each care recipient results in these costs being spread over lower revenue
- Guidelines for the delivery and pricing of packaged (bundled) services to care recipients are inadequate, contradictory and subject to differing interpretations by the various regulatory bodies
- Costs for increased training and development of staff (and particularly clinical and care staff) not being appropriately funded
- Requirement for substantial increase in community education as to the cost of delivery of home care
- Client contribution (Basic Daily Fee) is not being fully charged in many instances as it essentially adds to the unspent funds balance and is an administration cost to charge the client and collect the basic daily fee, especially if it does not benefit the overall operating result
- Having only four package subsidy levels (rates) has resulted in a significant gap for a consumer to move to a higher level of funding to meet their care needs and difficult for providers to fully utilise each respective package level
- Service pricing revenue has declined in actual terms per client per day, likely as a result of competition. However, there is little transparency as to the quality and assessment of the service provision
- There is no funding allowance for improvement and innovation for technology, particularly including tele-health and social communication for care recipients
- The funding model for regional, rural and remote home care package delivery should be cognisant of the impact of distance between care recipients and providers, technology, additional costs of consumables and the issues around staffing availability

Areas that the Challenges can be Mitigated or Addressed

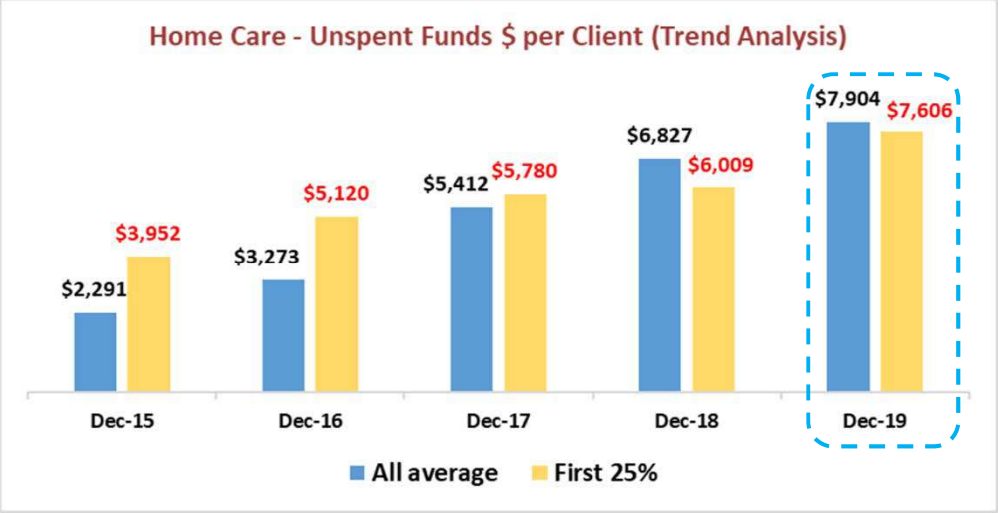
Some specific reforms to assist in mitigating certain of the factors noted above include:-

Unspent Funds

The aggregate and increasing level of unspent funds continue to remain the most significant issue, from both a service delivery and financial performance perspective.

From a care recipient's perspective, large unspent funds could be a result of not fully utilising the subsidy for the overall package of care and support that it is intended to provide based on the ACAT assessment. We still note that the estimate of only between 8% - 12% of unspent funds are later utilised by a care recipient. Approximately 3% of unspent funds are capital items on average with the majority returned to the government because the consumer moves out of in-home care.

The trend growth of unspent funds is as follows:



One of the possible contributory reasons for unspent funds increasing may be due to the care assessment being compromised due to only having four package levels. The subsidy gap between the four levels is quite significant - Level 1 (low care needs) is currently $8,786 pa; Level 2 is $15,458 pa; Level 3 is $33,638 pa; and Level 4 is $50,991 pa *(all amounts excluding the 1.2% temporary Covid-19 supplement).*

Assessments may be based on future care needs rather than current care needs, and accordingly the care recipients funding is for a higher level (package) and this is unable to be properly utilised for many months. Having more levels between the lowest funding level ($8,786) and the highest level ($50,991) may assist in addressing some of this inequity. The ability for consumers to move to a different package level (particularly a lower level) without having to go back to the prioritisation queue would also be beneficial.

The proposed reform to funding in arrears and further to reimbursing the actual service amount charged to residents (in arrears) will also very likely reduce the level of unspent funds. Whilst there may be some short-term cash flow implications, sound business management and having appropriate levels of equity and working capital will alleviate this issue to a great extent. However, as with many aspects in relation to funding, the impact on rural and remote providers must be separately assessed and required funding assured.

FUNDING REFORM CONSIDERATION

1. The proposed reforms in relation to funding in arrears should be implemented as soon as practicable

2. The funding package levels be increased from the current 4 levels to between 6 and 8 levels

3. Capital purchases over a maximum limit (say $5,000) within any individual package to require greater scrutiny and approval

(Estimated additional annual subsidy with respect to the unspent funds initiatives - $0 m)

Package Bundling

Due to the increased levels of unspent funds (care recipients not utilising the full extent of their funding) a number of alternate service delivery programs have been initiated or considered by providers. Package bundling is one method of providing the care recipient a more inclusive program of services and increasing the utilisation of the subsidy and client contribution.

There exists a number of regulatory guidelines around package bundling and in particular:

- Australian Competition & Consumer Commission (June 2018), *Home Care Report*
- Australian Competition & Consumer Commission (June 2018), *Home Care - a Guide to Consumer Rights*
- The Hon Ken Wyatt AM MP, Minister for Aged Care (June 2018), *Correspondence to Home Care Providers*
- MyAgedCare, *Your guide to home care package services*

Whilst each of the guidelines confirms the guiding principle that a care recipient should not be charged for services not provided, there is no singular source of clarity as to how a bundled package can be administered to ensure that both the care recipient and provider are not disadvantaged.

This has caused a number of interpretations, with some leading to challenges by the Aged Care Quality and Safety Commission (and its predecessor) as to how some providers have delivered and accounted for packaged services. Effective package bundling can have a number of advantages to the care recipient in certain instances and also provide a mechanism for utilising the funding package in an effective manner.

FUNDING REFORM CONSIDERATION

The Government, through the various agencies being The Department of Health, Aged Care Quality and Safety Commission, and Australian Competition & Consumer Commission develop and issue a comprehensive set of guidelines in relation to home care package bundling that provides equal benefit and equity to both care recipients and approved providers

(Estimated additional annual subsidy - $0 m)

Basic Daily Fee

Recommendation 12 of the Tune Review includes a number of recommendations in relation to the basic daily fee as well as the income-tested care fee. These recommendations should be enacted, in my opinion, and further expanded.

As noted, many providers do not levy the full (or in many cases, any) of the basic daily fee for home care packages. This negates the principle that there is a responsibility for recipients to co-contribute to receiving age care services. Having a non-refundable basic daily fee will ensure more equity between consumer and taxpayer funded care, and is also consistent with the principle and charging of the residential aged care basic daily fee.

To move to a non-refundable basic daily fee will also have the likely benefit of reducing the subsidy funding utilised for home care packages and this surplus can be used to fund additional and required packages to more consumers.

FUNDING REFORM CONSIDERATION

The basic daily fee to be a non-refundable compulsorily charge to care recipients receiving home care package services

(Estimated additional annual subsidy - $0 m)

Impact of Caps on what can be charged for Daily Living Costs and Care

The response to this point is in accord with that included with residential care previously.

Administration and Overhead Costs Recognition in Subsidies

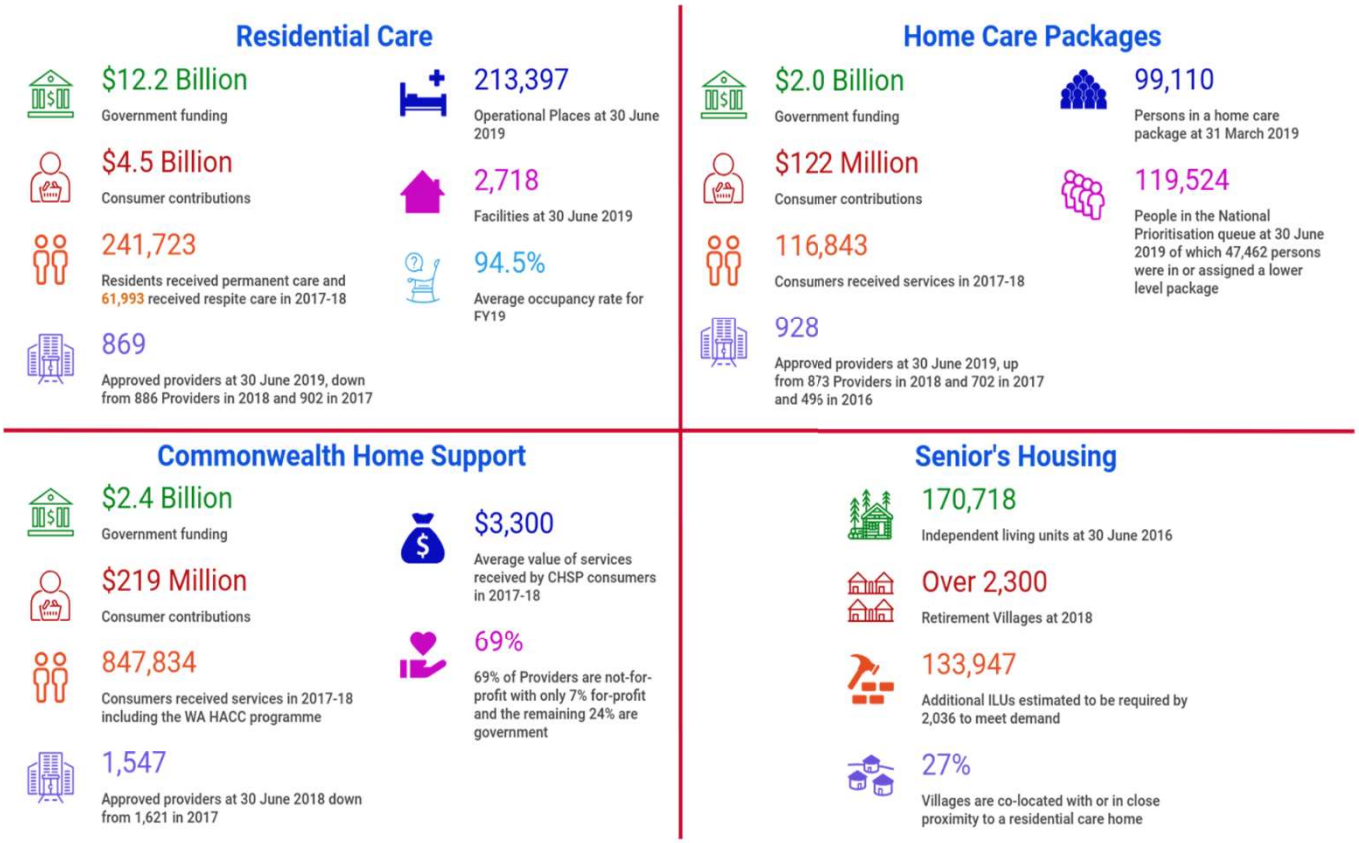
Effective from 1 July 2019 all administration costs, including overhead costs, are required to not be charged as a separate item and therefore included in the price charged for each service delivery. A twelve month transition period was allowed to transition existing care recipients as at 30 June 2019 who were being charged administration fees on the previous method to the new pricing arrangements.

A disadvantage of the new administration fee regime is that previously a provider had a fixed administration recoupment (ie all care recipients were charged a stipulated administration fee irrespective of how much of the package they utilised) whereas the current administration recoupment is totally dependent upon the services fees actually charged.

Features that Could Impact on Care Services Being Delivered Cost Efficiently

Ideal Characteristics of Efficient Delivery of Aged Care

The aged care sector can be encapsulated by the below diagram which include the respective segments. Whilst some of the data is not the most recent (and not always available) it is still very relevant.



A feature of the sector is that whilst each segment has an inter-relationship, there is still quite a siloed approach from the Department through to the providers, consumers, workforce and other stakeholders. Whilst "continuum of care" is often quoted as being the strategic direction of aged care, it should be noted that less than 50% of elderly persons transition from senior living to residential aged care.

In this sense, the primary ideal characteristic of efficient delivery of aged care must have the overarching objective of delivering care based on the actual assessed need of each care recipient, and then ensuring a smooth transition to higher care needs if, and when, required.

Many of the characteristics as included in the *Aged Care Roadmap* (March 2016) prepared by the Aged Care Sector Committee are still very relevant in the current aged care climate. The Roadmap followed much of the guiding principles as contained in the Productivity Commission report *Caring for Older Australians* (August 2011).

In relation to workforce and the efficient delivery of aged care, the previously noted report "*A Matter of Care: Australia's Aged Care Workforce Strategy*" (June 2018) has equal relevance.

The *Legislated Review of Aged Care 2017* included recommendations and related commentary that would support an efficient delivery of aged care services.

Does the Current Design and Operations of the Aged Care System Align with the Characteristics?

The aged care sector has characteristics associated with other taxpayer funded system that requires significant controlled regulation and is directly involved with vulnerable persons.

The sector has the following primary characteristics:-

- Consumer cohort are elderly with many having health conditions associated with old age in addition to other medical conditions
- A very high capital cost associated with residential aged care and seniors housing (retirement living)
- The requirement for significant staffing levels (represents nearly of 70% of the total revenue)
- Government subsidy funding constitutes nearly 75% of care related revenue flows (except for seniors housing)
- Regulatory environment is demanding
- Investment returns are poor compared to other commercial sectors
- Lack of community understanding in relation to the complexities of aged care or in planning to enter the aged care system as a consumer (recipient)
- Diverse workforce
- Similar to the health sector, aged care services are required in all geographic locations and communities throughout Australia

To design a robust and inclusive system to meet the above characteristics and abide by the principles of the Aged Care Roadmap and Workforce Strategy is probably more aspirational rather than achievable. My experience and qualification in regard to the clinical, social, regulatory and workforce requirements of the sector is not in any respects of a sufficient level to be able to provide any reasonable commentary.

A summary of certain observations that I consider do not align with or incentivise the ideal design characteristics as described in the reports noted above include:

- The current funding envelope for residential aged care is not sufficient to maintain nor grow this segment in a manner to meet the future requirements
- The sector does not operate within nor have a proper integration between the various segments (residential/HCP/CHSP) from a policy or regulatory perspective and this inhibits the efficient delivery of care by providers
- The funding model needs to be consistent and seamless through each of the segments rather than the current situation where each segment is separate and distinct
- Seniors housing (retirement living) sits outside of aged care in the current legislative, operational and funding environment despite being very much a part of the sector in relation to the age and care requirements of the majority of residents
- Innovation is often stifled by lack of clarity within the regulatory framework and associated guidelines
- The governance of the sector at all levels (government/provider/consumer) is sporadic and inconsistent in many instances and requires more clarity as to guiding principles required

- Innovative technology is not funded nor prioritised which has limited the ability to enhance the delivery of care
- Consumers need to have a greater financial co-contribution to aged care, which will also lead to having a greater understanding and influence in the delivery of aged care services

Residential Aged Care: Cross-Subsidising Funding Streams

Financial Extent of Cross-Subsidising

Residential aged care revenue streams are:

- ACFI (direct care) - government subsidy funded based on resident acuity and care needs
- Everyday Living (indirect care) - resident funded to meet the costs of hotel and related services
- Accommodation - government and resident funded based on affordability

The below graph details the financial results for each of the above revenue streams as sourced from the StewartBrown Survey for the six months ended 31 December 2019.

This graph shows that the ACFI (direct care) subsidy and associated costs result in a surplus of $16.68 per resident per day (after inclusion of administration overhead costs). However, this surplus is absorbed by the losses incurred with Everyday Living ($20.93 per resident per day) and Accommodation ($2.18 per resident per day).

The overall result is an average operating loss of $6.43 per resident per day for each aged care home. For this reason such cross-subsidisation occurs and is necessary to maintain financial viability of an aged care home if possible.

Issues Due to Cross-Subsidisation

It is not appropriate to absolutely isolate each of the respective revenue streams as they are all inter-related in the overall operation and management of an aged care home. However, each revenue stream has specific associated costs and not meeting these costs will significantly impact the efficiency, quality and safety of residential aged care.

There has been much evidenced based discussion and speculation with respect to direct care staffing levels required to deliver aged care services from a clinical and allied health perspective. I cannot make comment in this regard other than to confirm that the present (ACFI) funding model has a surplus that is not being directed toward more staffing hours, but to the other cost requirements of the daily operations that need to be met.

Whether a surplus of $16.68 per resident per day will meet the additional staffing requirements is a further discussion point. Consideration is also required as to where a provider is entitled to make a surplus - is it only from accommodation (as an example), or should it come from each revenue stream? From a practical perspective, an overall (and necessary) operating surplus must be sourced from each revenue stream, so this needs to be factored when considering the direct care revenue surplus.

This submission has included reform considerations in relation to Everyday Living and Accommodation revenue streams, and should these (or alternate) reforms be enacted this would relieve much of the issues around the direct care funding cross-subsidisation that currently exist.

Can Cross-Subsidisation be Avoided in a New Funding System?

Any funding system for residential aged care must recognise that each operating segment within an aged care home must have sufficient revenue, with the additional requirement for surplus funds to be accumulated to maintain the standard of accommodation for future residents, rather than rely on RAD growth to fund major refurbishment and rebuilds. It is arguable as to whether the accommodation pricing regime is a long term sustainable system in any case.

It is therefore likely that a level of cross-subsidisation will exist in any new funding system. Due to the sizeable geographic, social, demographic, cultural and environmental extremes associated with residential aged care, a new, robust and progressive funding system will, by its nature, be required to be significantly more flexible and less prescriptive than today's funding model. A "one size fits all" funding system is no longer appropriate in my opinion.

Input Costs in Delivering Aged Care

Input Costs

The input cost associated with the delivery of care and accommodation vary between the different segments, with payroll and related costs, resident/client expenses and administration overheads being common. Included in *Appendix B* is a definition and description of the respective input revenue and expenses line items.

How these Costs are Expressed and Measured

The measurement of these costs should be in accordance with the recognition and measurement requirements specified by all Australian Accounting Standards and Interpretations, and the disclosure requirements that are mandatory under the Australian Accounting Standards applicable to the provider entity and as required by the *Aged Care Act 1997* and *Accountability Principles 2014.*

When expressing the input cost at the operation level for comparison and analysis purposes the actual dollar cost can be expressed as follows:

- Residential aged care - $ per bed day (per resident per day) based on actual occupancy
- Home care packages - $ per client (care recipient) per day based on actual client numbers
- CHSP - $ per program (and $ per clients if possible) based on actual program activity

Variation in Costs due to Services, Location and Demographics

As is the case with all business, essential services, support services, health and social services there is considerable variations in the costs of providing those services dependent upon geographic location, demographic and cultural diversity and specific individual requirements. Aged care services are particularly influenced by these factors and variables.

Physical Location for Service Delivery

The cost of service delivery is influenced by the physical location and specific requirements. A governing factor is in regard to the aged care needs required by the recipient. Residential aged care services are required as a result of high acuity, health and fragility of the recipient and is provided in a fixed accommodation environment that allows the provision of 24 hour care. It is unlikely that this level of care can be provided in an in-home location.

Community care is reliant on travel, distance to the care recipient and ability to provide the required service delivery in various living environments. This has some distinct difficulties when compared to residential aged care and accordingly requires a different cost structure.

Geographic Location of the Service

All aged care service delivery is influenced by the geographic location of the service and associated costs as a result of the location. The operating performance for outer regional, rural and remote residential aged care homes has been noted earlier in this submission, whereby over 71% of aged care homes are operating at a loss, with this loss being significantly higher than aged care homes in inner regional and metropolitan areas.

Similarly, home care providers have additional costs associated with geographic location, particularly around consumable and travel related costs.

In respect to residential aged care, the StewartBrown Survey highlighted that direct and indirect care costs did vary across regions due to remoteness when comparing in dollar terms, but when considered in relation to ACFI revenue levels, there was considerably less percentage variance. This is an important factor to consider in any future funding model - that direct care costs, which mainly consist of labour, are likely to vary depending on the overall care needs of the residents in the aged care home. The ACFI subsidy declines, on average, the more remote an aged care home is.

This can be due to a more remote home being less discerning on the level of care required by a prospective resident when they are admitted into care - they may not have as much choice in who to admit to their home. However, direct costs are, in general directly proportional to the care needs of the residents.

In summary, regional and remote geographic locations have lower occupancy levels, a lower resident cohort (number of residents) and lower acuity levels in aged care homes (based on average ACFI per resident). Therefore the input costs, of which many are fixed costs by nature, are spread over a lower revenue base with the resultant effect of poorer financial performance.

Home care is to a much lesser extent affected by geographic location outside of the additional cost noted above. The lower size of the care recipient cohort will be an influencing factor as is the case with residential aged care.

Cultural and Demographic Considerations

The data set for services delivered in very remote communities or specific CALD or lower socio-economic communities is not sufficient to make an absolute analysis. It is apparent that the costs are greater in the very remote locations, obtaining the right skills and staffing numbers is challenging and the revenue base is much lower. This can significantly affect the service delivery and the financial capacity of providers to adequately service the aged care needs.

The same analysis restrictions apply in assessing the input costs for the respective CALD and lower socio-economic demographic cohort.

Mechanisms to Assist in Meeting these Costs

This has been addressed in previous sections of this submission to a large extent. In summary, an effective aged care system needs to be able to differentiate between the specific requirements that affect some sectors of the community and ensure that equity and balance is maintained for all care recipients.

3. Current Prudential Regulation and Financial Oversight

Regulatory Framework

Current Regulatory Framework

Currently, the regulatory framework for the financial oversight and prudential management in residential aged care (primarily) and home care packages is contained in the following legislation:

- *Aged Care Act 1997 (Act)*
- *Fees and Payments Principles 2014 (No 2) (Principles)*
- *Aged Care (Accommodation Payment Security) Act 2006*
- *Aged Care (Accommodation Payment Security) Levy Act 2006*
- *Sanctions Principles 2014 (Sanctions)*
- *Accountability Principles 2014*
- *Approved Provider Principles 2014*
- *User Rights Principles 2014*

Prudential Standards (Residential Aged Care)

The Prudential Standards (Standards) are in place to provide for the prudential management of RADs and their stated purpose is to provide a mechanism to:

- Protect RADs (*Liquidity Standard*)
- Provide sound financial management (*Records Standard*)
- Set out governance systems for managing RADs (*Governance Standard*)
- Providing information about the financial management of Approved Providers and the management of RADs (Disclosure Standard)

While the onus is on approved providers to comply with these standards, it is a requirement that the Department is in a position to both monitor compliance but additionally have the added ability to monitor the financial viability of approved providers and be able to take action to safeguard resident RADs, and minimise the cost to the taxpayer, in a more effective and timely manner than is currently possible.

Ideally, the Department should have the ability to foreshadow, using robust risk assessment models, if an approved provider is at risk of financial failure. The Department can then take appropriate action to minimise the cost to the taxpayer and the upheaval and concern that this type of event can cause to residents and their families as well as to staff and other key stakeholders. Failures in the system can also diminish confidence in the overall residential aged care sector and in the Department's ability to adequately administer it.

Financial Reporting Requirements

Division 2 of the *Accountability Principles 2014* requires approved providers to submit to Department the following:

- Aged Care Financial Report (ACFR) *(which includes the Annual Prudential Compliance Statement)*
- General Purpose Financial Report *(residential aged care providers only)*

No additional reporting requirements are applicable for home care providers (HCP or CHSP).

Adequacy of Current Reporting Requirements

The adequacy of the current arrangements for financial oversight and prudential management are restricted due to the following:

- Limited extent of compulsory reporting that is submitted to the Department by providers
- Quality and consistency of information submitted
- Variations in legal and ownership structures of providers resulting in access to required information being difficult to obtain
- Timeliness of receiving financial and related information from providers
- Insufficient specialist financial and analytical resources available within the Department
- Lack of clarity within the Department organisation structure as to where specific responsibilities for financial oversight and assessment are held
- Inconsistent and overlapping of responsibilities within the Department and the Quality Commission in regards to financial oversight and compliance activities

Reviews

To assist in this submission and to support the commentary included above, included as ***Appendix C*** and ***Appendix D*** are the following reports:-

- StewartBrown *Peer Review of ACFA's Data Collection and Reporting Activities* (June 2017) *(as available under Freedom of Information)*
- StewartBrown *Managing Prudential Risk in Residential Aged Care* (March 2019) submission paper to Department of Health

4. Improving Prudential Regulation in Aged Care

Which Areas of the Australian Government should be Responsible

There is always a combination of competing and complementary accountabilities and responsibilities for any financial assessment and prudential management within Government departments.

In relation to aged care, it is very important that the relationship, communication and transparency between all stakeholders is enhanced and appropriately managed. For this reason, the financial and prudential management for aged care must remain within the auspices of the Department of Health (Aged Care division) and the Aged Care Quality and Safety Commission.

Policy and financial oversight, amongst other important areas, should be within the jurisdiction of the Department whilst compliance and the quality regulatory compliance should reside with the Quality Agency.

Of equal importance is that both the Department and the Quality Agency are properly resourced from a personnel, technology, legislative information systems and data collection perspectives to fulfil their respective roles and functions and maintain a strong communication and information flow to all stakeholders.

Relationship Between Financial Oversight and Safety Regulation

The relationship between these important functions must be a priority. From a financial oversight viewpoint, the Department needs to take a stronger pivotal position than is currently the case. In conjunction with the collection of financial and related information and providing analysis for ACFA, ROACA and the Minister, the relationship with the provider should be strengthened.

The Department should be a valuable source of information and advice for providers to utilise, and an increased and regular communication with providers will also allow the Department to be better informed of any issues, particularly financial, that may affect the provider in continuing to provide the levels of care required.

This is where the Quality Agency has a substantive role - the compliance regulation and to engage with providers that are referred to them by the Department where the financial viability is under threat and may lead to quality of care delivery issues or concerns.

Role of Prudential Regulator where Approved Provider is Transitioning from the Sector

In such a circumstance as an approved provider transitioning out of the aged care sector, the specific circumstances as to the reasons for this need to be established.

If the reasons are due to financial viability leading to a potential administration or receivership, the Department should have the legislative capacity to appoint a receiver in the first instance to protect as far as possible the RAD debt exposure and staff entitlements.

The Quality Agency need to be involved as soon as practicable to ensure resident and staff quality and compliance is maintained.

Once both the Department and Agency are satisfied that appropriate mechanisms and mitigations are in place, the normal commercial and regulatory process should then occur in consultation with the Department and the Quality Agency.

For reasons of transition that are not driven by potential financial collapse, it should still be incumbent on the provider to communicate with the Department and Quality Agency prior to progressing to a commercial transaction, with both the Department and the Quality Agency required to act expediently to ensure a smooth and timely transition.

Recommendations for Strengthening the Prudential and Reporting Framework

Governance Standard

1. The current Governance Standard be amended so that it is more closely aligned with Standard 8 (the Governance Standard) contained in the *Quality of Care Principles* insofar as:
    (i) Ensuring that the Directors (or equivalent) of an Approved Provider are responsible for maintaining the prudential compliance of the Approved Provider.
    (ii) There are appropriate risk management systems in place to monitor and minimise risk of non-compliance.
    (iii) The risk systems are designed to minimise the possibility of the Approved Provider becoming financially unviable and putting in jeopardy the ability to refund RADs and accommodation bonds as and when they fall due.
2. The amended Governance Standard be supplemented by detailed guidance material as is the case for the Quality Standards.

Risk Assessment

3. Assessment of liquidity should be made at the Approved Provider level (rather than at the residential segment level).
4. A minimal level of liquidity be adopted, and that this level of liquidity be determined by the Department along with the financial asset classes in which the liquidity must be held.
5. The minimum liquidity ratio be set at 15%.
6. Capital adequacy levels be built into the risk assessment process for the purpose of reviewing whether an Approved Provider is at risk of being financially unviable.
7. The Aged Care Group Funding Policy & Prudential Branch (or new compliance team) should be responsible for the financial assessment approval of any transfer of aged care homes (RACs) between Approved Providers (via a merger and/or acquisition) and the financial assessment approval of a new Approved Provider application, to ensure all confirmation of equity, financial resources, capital requirements, legal structure and prudential compliance is taken into appropriate consideration.

General Purpose Financial Statements

8. General Purpose Financial Statements (GPFS) should be a legislative requirement for all aged care Approved Providers (including residential, HCP and CHSP providers) and these must be furnished to the Department within the specified time frame.
9. It is not recommended that there be changes to the level of reporting (Tier 1 or Tier 2) currently being made within the GPFS structure.
10. The GPFS include a Declaration by the Directors that the Approved Provider has complied with *Part 5 of the Fees and Payments Principles 2014 (No.2)*. The Declaration would attest to the information contained in the Annual Prudential Compliance Statement (APCS) and in relation to the permitted use of RAD's as well as other matters contained in the APCS.
11. The Audit Opinion as included in the GPFS be required to include an additional Assurance Opinion on the Approved Provider's compliance with *Part 5 of the Fees and Payments Principles 2014 (No.2).*

External Auditors

12. All external auditors appointed to audit the financial statements and other information as required by the *Aged Care Act* and *Principles*:
    (i) Be registered with the Department of Health.
    (ii) Be a Registered Company Auditor *(this is already in the legislation and there are some exemptions for regional and remote areas).*
    (iii) Attest that they are sufficiently experienced to audit an aged care Approved Provider.
    (iv) Attest that they understand their obligations, and those of the Approved Provider in relation to financial reporting under the *Act* and *Principles* and they understand the reporting obligations and obligations of an aged care Approved Provider under the Prudential Standards.
    (v) Undertake at least 10 hours of CPD annually in relation to aged care legislation, policy and reporting.

Aged Care Financial Report

13. It is recommended that the ACFR become the primary source of financial information from Approved Providers for the Department. It will include the following additional information to supplement the disclosures already contained in the ACFR:
    (i) A detailed income and expenditure statement breakdown by each segment (as currently the case for residential and HCP *but not* CHSP).

(ii) A segment note, including balance sheet, for each operating segment in a format designed by the Department to meet its information needs for prudential compliance activities including risk assessment and monitoring of financial viability of providers.
(iii) A variety of key ratios such as liquidity, capital adequacy and RAD coverage.
(iv) Details of the category and amounts held in each class of financial asset.
(v) Details of any securities held by another party over the assets of the Approved Provider.
(vi) Additional related party disclosures including:
  (a) Changes to corporate structure including changes in ownership of the Approved Provider or group of entities (new outline of corporate structure to be provided as an Appendix should changes occur in a prescribed format).
  (b) Details of valued securities over loans (related party and external).
  (c) Consolidated financial statement incorporating the parent entity and related parties, including details of permitted use assets, encumbrances and liquid financial assets.
  (d) Details of the amount and nature of related party transactions that occurred during the financial year, and of balances at the end of the financial year.
  (e) Loans to related parties to be split between loans made for permitted uses and other loans.

14. The ACFR should apply to all Approved Providers including providers of Home Care Packages (currently the case in relation to income and expenditure) and In-Home Support (CHSP) services. The ACFR will be required to be completed for all Approved Provider (consolidated) financial statements.
15. The design of the ACFR, including format and inclusions should be undertaken by the Department as a dedicated separate project. This will include provision for the ACFR to be accompanied by an Audit Report, probably being an expansion on the current APCS Audit Report and a declaration signed on behalf of the Approved Provider entity Directors (or governing body).
16. A modified Permitted Use reconciliation statement be inserted in the APCS to replace the existing permitted use reconciliation statement. The current tick-box statement as to what permitted uses RADs had been used for in the fiscal year will remain.

Annual Prudential Compliance Statement

17. Additional questions will be included in the APCS that are linked to meeting minimum mandated liquidity ratios:
  (i) Has the Approved Provider maintained the liquidity at or above the mandated minimum level throughout the financial year?
  (ii) If it has not, did they report that breach as required and, if so, what was the date of the breach and the date reported to the Department.
  (iii) Has the Approved Provider maintained a positive capital adequacy ratio throughout the financial year?
  (iv) If it has not, did they report that fact as required and, if so, what was the date of the breach and the date reported to the Department.
  (v) Are there any events, known at the time of signing the APCS that would cause the Approved Provider to become financially unviable, breach mandated liquidity levels or to move into a position of having a negative capital adequacy ratio? If yes, please provide appropriate details and supporting documentation.
  (vi) Asset classes in which liquid cash assets are held.
  (vii) Existence of lines of credit or other financing facilities to support prudential management including details of covenants and encumbrances.
18. A member of the Governing body (a Director or equivalent) of the Approved Provider, along with a responsible official (member of the executive) sign an appropriate Declaration attesting to the accuracy and completeness of the information contained in the APCS.

Reporting to the Department

19. The following matters must be reported to the Department within 14 days of them having occurred or upon the request of the Department:
    (i) Approved Providers who are assessed as being in the in the "Very High" and "High" risk category must provide all information as requested on a continuous basis.
    (ii) Breaches in relation to RAD refunds not being paid in accordance with the timeframes set out in legislation.
    (iii) Moving below mandated (or agreed) minimum liquidity levels.
    (iv) Moving into a negative capital adequacy ratio position.
    (v) Material adverse change in financial position *(within the tolerance levels as defined in section 9).*
    (vi) Breach of Permitted Use rules.
    (vii) Significant change in the structure of the Approved Provider entity or parent entity (ownership, entities, related party loans).
    (viii) If there is knowledge of an event that is likely to occur that will adversely affect the financial viability of the Approved Provider, provide appropriate details of that event.

Corporate Structures and Related Party Transactions

20. Legislation to be modified to give clarity to what constitutes a loan being on a "commercial basis". At a minimum it should include that:
    (i) The loan is secured over the asset to which it relates (if it relates to a residential or flexible aged care service) or if it relates to the repayment of RADs then it must be secured by some other means and have the backing of tangible, unsecured assets.
    (ii) The loan is for a specific period of time and that it includes a review period or terms of repayment.
    (iii) That interest is charged at commercial rates.
21. Any material changes to the group or ownership structure needs to be reported within 28 days of it occurring and annually in the ACFR
22. Audited group financial statements (consolidated at parent entity level), or authorised extracts, are required to be provided as part of the ACFR.
23. Upon request from the Department, the Approved Provider furnishes the requested information regarding the loan to the related party. The information would include, but may not be limited to:
    (i) A copy of the signed loan agreement between the related parties.
    (ii) Details of the security provided under the loan agreement.
    (iii) Audited financial statements of the related party(s) subject to the loan agreement or security arrangement.
    (iv) Evidence that the loaned funds have been used for permitted uses as required under the *Act* and *Principles.*
24. Should funds be loaned to a related party for the purpose of refunding a RAD, or to repay debt in relation to refunding RADs, that this arrangement should be reported to the Department within 28 days of it occurring unless an agreed arrangement has been previously approved by the Department for this to occur.
25. Should liquid cash assets be held in an entity on behalf of an Approved Provider, as is the case in a number of faith based NFP entities, then an audit certificate from the entity holding the cash assets will need to be provided at least annually to the Department attesting to the fact that the amounts held are unencumbered and they are being held on behalf of the Approved Provider and that they are available at call.

Permitted Uses

26. Restrictions be placed on the type of liquid financial investments that can be made in relation to securities and that the following types of securities be excluded:
    (i) Interests or securities in entities located in jurisdictions outside Australia.
27. Restricting the ability to lend funds to a related party or another approved provider for the purpose of refunding RAD balances unless prior approval has been obtained from the Department.
28. The following additional disclosures be made to residents with an accommodation deposit upon request and within 7 days of entering into an accommodation agreement:
    (i) The classes of financial products for which the Approved Provider are allowed to invest under their current Investment Management Strategy (IMS).
    (ii) The classes of assets in which the Approved Provider has invested refundable deposits during the previous financial year and the proportion of the total financial asset for each class of financial products.
    (iii) A summary of permitted uses for which refundable deposits and accommodation bonds have been used by the Approved Provider in the previous financial year.
29. The APCS be modified to include the same level of disclosure. Alternatively, this detail could be provided as part of the ACFR extended reporting regime.
30. The permitted use statement be amended to reflect the following:
    (i) State what permitted use categories that expenditure has been made from any source (currently only from RADs and Bonds).
    (ii) Provide greater clarity around qualifying capital expenditure.
    (iii) Make allowance for change of purpose for expenditure previously deemed permitted use. This should be disclosed by way of an adjusted return (similar to an amended tax return).
    (iv) Make allowance for sales/transfers of residential aged care services and the related effect on cumulative permitted uses.
31. A revised permitted use reconciliation be inserted in the ACFR forming part of the APCS to establish the permitted use asset backing for the current balance of refundable accommodation deposits and accommodation bonds.
32. The permitted use reconciliation should form the basis for the ongoing risk assessment for prioritising Approved Providers for compliance action including requests for additional information and compliance audits.
33. The permitted uses reconciliation should be pre-populated by the Department from data previously submitted by the Approved Provider.
34. In the first instance the pre-populated permitted uses reconciliation should be furnished to all Approved Providers who will have to attest to its accuracy. If the Approved Provider notes incorrect data relating to what had previously been lodged, based on error or a misunderstanding of the permitted use statement, then they will be required to communicate those adjustments to the Department. This will enhance the accuracy of the permitted uses data upon which compliance will be assessed.
35. Additional Department resources need be employed to undertake compliance auditing and monitoring with respect to Approved Providers complying with the permitted use rules.

Other Sectors that Provide a Good Model of Financial Oversight

Whilst this submission has detailed a number of proposed recommendations for improved financial oversight and compliance, my general view is that aged care has in many aspects a reporting model that when further developed and enhanced will compared favourably to other community based sectors and even the services sector. There is no evidence that the Australian Prudential and Regulatory Authority (APRA) or the Australian Securities and Investment Commission (ASIC) has maintained an effective higher level of compliance for other sectors.

TOPICS TO BE ADDRESSED IN WITNESS STATEMENT

[Note: Where applicable, identify the basis of your opinion, including with reference to your research. Include appropriate citations when citing any statistics or other research. Unless otherwise specified, the term "aged care services" refers to both residential aged care services and aged care services provided in the home.]

Qualifications and research

1. Provide an overview of:
    a. your current occupation
    b. any relevant past occupations you have held
    c. your qualifications
    d. your experience working in aged care
    e. your involvement in the aged care system either in Australia or internationally.

Financial state of the sector and cost of care and accommodation

2. Are aged care providers adequately funded to provide quality care?
3. Identify and explain the key financial challenges that aged care providers experience under the current aged care system. Without limitation of the matters you wish to address, your statement should cover:
    a. the factors that exacerbate the key challenges
    b. how the challenges can be addressed, ameliorated or mitigated against
    c. the impact of caps on what can be charged for daily living costs and care
    d. the role of potential variation of the levels of Refundable Accommodation Deposits (RADs) and Daily Accommodation Payments (DAPs) via application for determination by the pricing commissioner
    e. the extent to which care and accommodation subsidy levels appropriately recognise the administrative and overhead costs of delivering those services
    f. any evidence for your response
4. Are there features of the aged care system that impact on aged care services being delivered in a cost-efficient manner? Without limitation of the matters you wish to address, your statement should describe:
    a. the ideal characteristics of efficient delivery of aged care
    b. whether and how the design and operation of the current system aligns or does not align with or incentivise these characteristics

c. any evidence for your responses

5. Are residential aged care services (that is, the operations of approved providers by which aged care is provided to residents of residential aged care facilities) cross-subsidising the provision of personal and clinical care through funding obtained for accommodation and hotel services? If so, include in your statement, if possible:

    a. any evidence for your response

    b. your views as to the reasons why cross-subsidising is occurring

    c. your views as to whether this presents problems affecting the efficiency, quality or safety of aged care

    d. your views as whether and how this could be avoided under a new system?

6. At a general level, what are the input costs that providers face in delivering aged care services (both residential and home care services)? In your answer describe:

    a. how these costs can be expressed and measured

    b. whether these costs vary by reference to:

        i. the location in which the aged care service is being delivered (i.e. collective living as against living in the community)

        ii. the geographic location of the service (i.e. metro, regional, remote services)

        iii. the population served (e.g. socio-economic status, CALD, indigenous etc)

    If these costs do vary, how do they vary?

    c. What can be done to meet these costs?

Current arrangements for prudential regulation and financial oversight

7. How adequate are the current arrangements for financial oversight and prudential regulation of residential aged care providers? To what extent do you consider that they would allow the Department of Health and/or the Aged Care Quality and Safety Commission to:

    a. accurately assess the financial performance and viability of the sector to inform decisions about funding and financing, planning and market development

    b. identify providers that may be at risk of financial failure in a timely manner, to enable any risk to disruption of care to be managed

    c. provide sufficient protection against the risk (to the Australian Government) that providers will not be able to cover the value of bonds and other liabilities from realisable assets

    d. manage the Australian Government's risk as insurer of last resort of residential accommodation deposits

    e. inform quality and safety risk assessment.

8. How adequate are the current arrangements for financial oversight and prudential regulation of home care providers? To what extent do you consider that they would allow the Department of Health and/or the Aged Care Quality and Safety Commission to:

    a. accurately assess the financial performance and viability of the sector to inform decisions about funding and financing, planning and market development

    b. identify providers that may be at risk of financial failure in a timely manner, to enable any risk to disruption of care to be managed

    c. inform quality and safety risk assessment.

9. How adequate is the information currently collected by the Department of Health regarding:

    a. the financial performance of or financial risks associated with approved providers

    b. the use and security of RADs?

10. Are the reporting structures sufficient and, in particular, do they provide sufficient transparency around the location of funds available to approved providers?

11. To what extent do complex structures of aged care businesses (including the potential use of discretionary trusts) reduce the effectiveness of the existing financial reporting arrangements? How could this be addressed?

12. How transparent are the existing prudential regulation and financial oversight processes to approved providers of aged care, and to the public?

Improving prudential regulation in aged care

13. Which area(s) of the Australian Government should be responsible for prudential regulation, including assessing and responding to financial risk and setting prudential standards? In your response, provide any comments you may have on improving the capability of the aged care regulators.

14. What is the relationship between financial oversight and quality and safety regulation?

15. What should be the role of the prudential regulator in relation to an approved provider that is transitioning out of the aged care sector?

16. How could the prudential framework be strengthened? In your response, address:

    a. the prudential standards set out in the *Fees and Payments Principles 2014 (No 2)* (Cth)

    b. financial reporting requirements, including those set out in the *Accountability Principles 2014* (Cth) as well as the potential use of Special Purpose Financial Reports

    c. oversight and sanctions

    d. ring fencing and the extent to which ring fencing in the aged care sector would strengthen the prudential framework

    e. transparency.

17. Are there other sectors that could provide a good model of financial oversight? If so, briefly describe the key features of those arrangements.

AGED CARE FINANCIAL REPORT (ACFR)
DATA INPUT DEFINITIONS

APPENDIX B

Residential Aged Care	Definition and Description Inclusions	Exclusions
INCOME		
Care Income		
Subsidies and supplements (Commonwealth)	Care related government subsidies and supplements. Please refer to **Appendix A tab** for detailed listing of subsidy and supplements to be included	All accommodation subsidies
Subsidies and supplements (State/Territory)	State/Territory care related subsidies and supplements	
Resident Fees: Means-tested care fee	Income and means tested fees charged to residents (offset against ACFI subsidy)	Excludes income and means tested fees reductions, these are to be included in the subsidies and supplements (Government)
Resident Fees: Other	Other care related fees including occasional care services like consultation, therapy, medication, treatment or procedure; insurance funding of younger persons	
Everyday Living Income		
Basic daily fee	Includes basic daily fee and/or respite fees paid by the resident	Excludes accommodation charges (which are in lieu of RADs); means-tested care fee; extra/optional services charges
Extra services fees	Additional daily fees charged to residents in an approved extra services place	Additional services fees
Additional services fees	Additional daily fees charged to residents for additional services purchased by the resident	Extra services fees
Accommodation Income		
Subsidies and supplements (Commonwealth)	Accommodation related government supplements. Please refer to **Appendix A tab** for full listing of accommodation related supplements (includes the means-tested accommodation supplement)	If it is a significantly refurbished facility then the accommodation supplement amount and all Government accommodation supplement amounts are entered in the significant refurbishment supplement line below
Subsidies and supplements (State/Territory)	State/Territory accommodation related government supplements	
Significant refurbishment supplement	If the facility is classed as significantly refurbished this is full amount received for the accommodation supplement and all Government accommodation supplements	
Resident accommodation payments and charges	Daily Accommodation Payments; Daily Accommodation Contribution; Accommodation Charges; interest on outstanding accommodation bonds	Interest on outstanding RADs (include this with DAPs or DACs above)
Interest received - accommodation bonds	Interest received/accrued on outstanding accommodation bonds	Excludes income received via DAPs or DACs
Financing Income		
Interest and investment income	Interest and distributions on investments that can be attributable to the aged care home. If it is the practice to allocate interest to home then please include it. This income will be excluded from the EBITDA calculation.	Interest charged on late bonds; DAPs or DACs

AGED CARE FINANCIAL REPORT (ACFR)
DATA INPUT DEFINITIONS

APPENDIX B

Residential Aged Care	Definition and Description Inclusions	Exclusions
EXPENDITURE		
Care Expenses		
Labour costs	Employment costs relating to direct care staff (nursing administration/registered nurses/enrolled and licenced nurses/other unlicensed nurses/personal care staff/allied health and lifestyle) Includes salaries and superannuation; allowances; accrued leave entitlements; workers compensation; termination payments; fringe benefits paid; payroll tax; and any other direct labour costs	Staff training; staff amenities; staff recruitment; agency staff
Contract labour costs	Agency and staff on external contracts with an unrelated organisation	Staff directly employed in any capacity by the aged care home
Resident expenses	Cost of incontinence systems and supplies and cost of medication and other medical supplies such as bandages, ointments, as well as the cost of packaging and distributing the medication such as Webster or similar system. Includes costs of nutritional supplements. Also include cost of medical gases and enteral feeding costs.	
Other expenses	Other items relating to direct resident care - include chaplaincy/pastoral, cost of therapy supplies, activity costs, unrecovered cost of bus hire, public telephone cost, entertainment etc.	
Everyday Living Expenses		
Labour costs - hotel services	Employment costs relating to hotel services staff (catering/cleaning/laundry) Includes salaries and superannuation; allowances; accrued leave entitlements; workers compensation; termination payments; fringe benefits paid; payroll tax; and any other direct labour costs	Staff training; staff amenities; staff recruitment; agency staff
Contract hotel services - external	Contract services paid to an external (unrelated) organisation for catering/cleaning/laundry services	
Contract hotel services - internal	Contract services paid through an internal shared services style arrangement within the organisation for catering, cleaning and laundry services	
Other hotel expenses	Cost of all consumable supplies used for catering/cleaning/laundry Includes food and supplements; crockery and cutlery; cooking utensils; cleaning and laundry materials; toiletry and sanitary materials; bedding linen	
Utilities	Electricity; gas; council rates (land and water); rubbish removal expenses relating directly to an aged care home	Medical gases such as oxygen
Motor vehicle expenses	All costs associated with operating, maintaining and repairing motor vehicles associated with resident care (eg bus)	
Administration Expenses		
Labour costs	Employment costs relating to administration staff at the aged care home level Includes salaries and superannuation; allowances; accrued leave entitlements; workers compensation; termination payments; fringe benefits paid; payroll tax; and any other direct labour costs	Staff training; staff amenities; staff recruitment; agency staff
Administration recharge	Apportionment of administration costs from the organisations administration shared services and/or corporate head office	
Management fees	Fees paid to an external organisation to provide operational and clinical management services Include related party and external (non-related party) management fees paid	
Staff training and education	Specialist aged care training costs, including conferences and attendance, internal training materials, travel to training	
Other administration costs	Includes all other administration items including, advertising for staff; accounting fees; accreditation costs; audit fees ÍT expenses including maintenance contracts on hardware and software; consulting fees; general expenses; legal fees; postage & courier; printing & stationery; recruitment costs; safety management (OH&S); subscription & library costs; telephone; travel & accommodation; insurances	Administration recharges, workers compensation premiums.

AGED CARE FINANCIAL REPORT (ACFR)
DATA INPUT DEFINITIONS

APPENDIX B

Residential Aged Care	Definition and Description Inclusions	Exclusions
Accommodation Expenses		
Labour costs	Employment costs relating to maintenance staff at the aged care home level Includes salaries and superannuation; allowances; accrued leave entitlements; workers compensation; termination payments; fringe benefits paid; payroll tax; and any other direct labour costs	Staff training; staff amenities; staff recruitment; agency staff
Depreciation - building	Building and leasehold improvements depreciation	
Depreciation - other assets	Depreciation and amortisation expense relating to plant and equipment; furniture and fittings; motor vehicles; IT equipment; IT software	Depreciation of buildings, leasehold improvements; refurbishments costs not capitalised
Property repairs and maintenance	Materials and other third party costs in maintaining and repairing the operating assets of the aged care home Includes contract labour for repairs and maintenance; long term maintenance contracts; fire protection pest control; grounds maintenance; security; minor asset purchases; minor capital works or replacements	Refurbishment costs
Refurbishment	Costs associated with maintenance of building and common areas (which have not been capitalised) Room changeover costs when a resident leaves (re-painting, some carpet replacement, replacement of light fittings and other minor replacements)	Major upgrades of resident rooms, bathrooms or other structural changes should generally be capitalised (not expensed)
Rent - buildings	Rent of aged care home (if owned by another entity); rent of offices or other buildings utilised by the home	
Other accommodation expenses	Other expenses directly relating to accommodation not included above	
Finance Expenses		
Interest expense	Interest paid to outgoing residents or their estates in compliance with the *Aged Care Act* with respect to the regulated delay in paying out their RAD's/bonds Interest on borrowings than can be attributable to the aged care home (if it is the normal practice to allocate interest). This expense will be excluded from the EBITDA calculation.	Interest paid on borrowings is normally not allocated to a specific aged care home (organisation expense)
NON-RECURRENT INCOME & EXPENSES		
Donations, bequests and fundraising	Donations, bequests and fundraising income (net of expenses)	
Fair value gains (losses) on financial assets	Fair value (unrealised) movements on all financial assets	Non realised movements
Fair value gains (losses) on non-current assets	Fair value (unrealised) movements on other non-current assets (including investment property)	Property, plant and equipment (movement disclosed through Comprehensive Income)
Grants received	Grants received (including government grants and specific purpose grants) for capital purposes	Grants that are related to operating expenses (include with operating income)
Impairment loss (gain)	Impairment of non-current asset or loan receivable (related party and non-related party)	Doubtful debts and bad debts
Realised gains (loss) on disposal of assets	Actual (realised) gain (loss) on disposal of any asset (current or non-current asset)	Non realised movements
Net effect of adoption of AASB 16 Leases	Net income and expense effect as a result of the adoption of AASB 16 Leases	
Other non-recurrent income & expenses	Any other non-recurrent income and expenses *All material amounts to be separately disclosed in note 1*	

APPENDIX B

AGED CARE FINANCIAL REPORT (ACFR)
DATA INPUT DEFINITIONS

Home Care Package (HCP)	Definition and Description Inclusions	Exclusions
INCOME		
Direct care services	Income from services supplied directly by the provider to the client	
Sub-contracted services	Income from services provided to the client by third parties	
Care management fees	Income derived from care management where this is invoiced separately to the clients	
Package administration fees	Income derived from package administration where this is invoiced separately to the clients	
Exit amounts deducted	Amount of exit amounts deducted when clients have departed	
Other income	Any other income relating to home care client service delivery not included above	Organisation other income (not client related)
EXPENDITURE		
Wages and salaries - care staff	Employment costs relating to direct care staff Includes salaries and superannuation; allowances; accrued leave entitlements; workers compensation; termination payments; fringe benefits paid; payroll tax; and any other direct labour costs	
Wages and salaries - administration and non-care staff	Employment costs relating to all staff not directly providing services to clients Includes salaries and superannuation; allowances; accrued leave entitlements; workers compensation; termination payments; fringe benefits paid; payroll tax; and any other direct labour costs	
Administration costs and management fees	Includes all other administration items including, advertising for staff; accounting fees; accreditation costs; audit fees ÍT expenses including maintenance contracts on hardware and software; consulting fees; general expenses; legal fees; postage & courier; printing & stationery; recruitment costs; rent; safety management (OH&S); subscription & library costs; telephone; travel & accommodation; insurances; utilities	
Care related expenses	All consumables used in providing services to clients Includes medications; incontinence aids; food costs; cleaning and maintenance costs; travel expenses (relating to care delivery); interpreting/translation expenses	Items purchased for clients to be included in sub-contracted costs
Sub-contracting or brokered client services	Total expenditure of sub-contracted services for provision of direct client services including items purchased for the client	Exclude any organisation capital purchases (equipment; motor vehicles)
Depreciation expense	Depreciation & amortisation of any property, plant & equipment used in the conduct of providing home care packages	Organisation depreciation expense (building; IT equipment; IT software)
Other expenses	All other expenses not included above	

APPENDIX B

AGED CARE FINANCIAL REPORT (ACFR)
DATA INPUT DEFINITIONS

Commonwealth Home Support Programme (CHSP)	Definition and Description Inclusions	Exclusions
INCOME		
CHSP grants	Government CHSP grant funds received	
Fees charged to clients	Client contributions and fees received	
Other income	Any other income relating to CHSP service delivery not included above	Organisation other income (not client related)
EXPENDITURE		
Wages and salaries - service delivery staff	Employment costs relating to direct CHSP client service delivery Includes salaries and superannuation; allowances; accrued leave entitlements; workers compensation; termination payments; fringe benefits paid; payroll tax; and any other direct labour costs	
Wages and salaries - administration and other staff	Employment costs relating to all staff not directly providing CHSP services to clients Includes salaries and superannuation; allowances; accrued leave entitlements; workers compensation; termination payments; fringe benefits paid; payroll tax; and any other direct labour costs	
Administration costs and management fees	Includes all other administration items including, advertising for staff; accounting fees; accreditation costs; audit fees ÍT expenses including maintenance contracts on hardware and software; consulting fees; general expenses; legal fees; postage & courier; printing & stationery; recruitment costs; rent; safety management (OH&S); subscription & library costs; telephone; travel & accommodation; insurances; utilities	
Service delivery related expenses	All consumables used in providing CHSP services to clients Includes medications; food costs; cleaning and maintenance costs; travel expenses (relating to service delivery); interpreting/translation expenses	Items purchased for clients to be included in sub-contracted costs
Sub-contracting or brokered client services	Total expenditure of sub-contracted services for provision of direct CHSP client services including items purchased for the client	Exclude any organisation capital purchases (equipment; motor vehicles)
Depreciation expense	Depreciation & amortisation of any property, plant & equipment used in the conduct of providing CHSP services	Organisation depreciation expense (building; IT equipment; IT software)
Other expenses	All other expenses not included above	

APPENDIX C

Peer Review of ACFA's Data Collection and Reporting Activities

June 2017

CONTENTS

1. Executive Summary

1.1 Abstract

StewartBrown were engaged by the Department of Health (Department) to undertake a peer review of the Department's data collection and reporting activities with a view to enhancing current processes and future report content.

The Scope and Methodology of the peer review are detailed in ***Chapter 2*** of this report, and each subsequent Chapter includes the Outline of Current Processes and Practices, commentary, Key Findings and Recommendations in relation to that specific review area.

1.2 Summary of findings and overall assessment

Benchmarking Services

Benchmarking Services involves Forms Administration and the Financial Analysis & Reporting team within Financial Performance Section of the Department. Elements of the process that work well relate to the accuracy of the data input and related quality control measures administered by Forms Administration. However, the Department does not have any quality control or review protocols and procedures relating to the collection, collation and analysis of data in regards to its benchmarking service.

In addition, there exist many elements that frustrate the process, resulting in workarounds and impacting negatively on the data quality, relevance and use of the benchmarking services. These elements are discussed further in Section 3 of this report and include the following:

- GPFR interpretation and disclosure issues affecting the quality and comparability of the residential data and trends
- The unreliability of the Residential Segment data – it is not timely and has inconsistent data definitions
- Timing of reporting
- The lack of functionality (including insufficient depth of granular data quality and quantum) of the "cost centre" Department benchmark

The Aged Care Financial Report (ACFR) will assist in improving the Income & Expenditure data gathered by the Department in relation to providing "absolute" residential and home care financial information, but issues remain in relation to the utility of this data due to the delay in collection, processing and reporting on it. Due to the high rates of non-disclosure and/or lack of item allocation the Residential Balance Sheet in the ACFR does not provide any reliable information for the Department and should be discontinued.

Overall assessment

The data management and analysis process should be improved by establishing a central data warehouse and having the Financial Analysis & Reporting team be responsible for all data analysis.

The Department benchmark website should be discontinued.

Departmental and ACFA Reports - ROACA and ACFA's Annual Report

The processes for relating to the *Report on the Operation of the Aged Care Act (ROACA)* and *Aged Care Financing Authority (ACFA) Annual Report* were reviewed as part of the engagement. Weaknesses were found to exist in the protocols and procedures relating to the collection, collation and analysis of statistical trends and data used for the reports. Often data comes from disparate sources and has not been reviewed or verified prior to inclusion in the reports.

Furthermore, the timing of the reports (especially the ACFA report) and the size of the reports (particularly the ACFA report) may limit the value and utility to stakeholders. Consideration of more use of technology (emails/web hyper-links) and a quarterly reporting process will be more beneficial and timely.

Overall assessment

The data management and analysis process should be improved by establishing a central data warehouse and having the Financial Analysis & Reporting team be responsible for all data analysis. This will improve the consistency and accuracy of reported data and allow for additional and more relevant financial analysis.

ROACA overlaps considerably with the ACFA report. A review should be conducted to ensure it reports only on items required, with the ACFA reporting being supplemental or supporting information for ROACA.

Financial Performance and Reporting Function

The review of the Financial Performance and Reporting function covered several areas including current data collection, storage and manipulation methods, differences between StewartBrown data and Department data, documentation of practices, resourcing and potential for additional sector analysis.

The data analysis functions currently in operation are cumbersome, inadequately documented and limited in analysis. A significant amount of time is involved in data preparation and manipulation and data analytics performed have flaws in relation to the accuracy and relevance. Having a central data warehouse would result in efficiencies in data preparation allowing for improved data analysis and a focus on understanding trends and movements.

Weaknesses exist in the documenting of protocols and procedures relating to the collection, collation, analysis and reporting of the Department information. This may partly be due to having long-standing, highly experienced staff performing these functions, however there is a need to refresh the logic and functionality of processes at regular intervals

The skill level of staff involved in the Financial Analysis & Reporting team is not well matched to the work being performed. Two assistant directors spend a significant amount on time on data integrity, preparation and manual manipulation and would be better suited to review, analysis and commentary. An experienced business analyst with aged care background would be a more appropriate solution and would allow for the team to perform all types of financial analysis including for prudential as well as any additional sector analysis.

Overall assessment

The data management and analysis process should be improved by establishing a central data warehouse and having the Financial Analysis & Reporting team be responsible for all data analysis. This will improve the consistency and accuracy of reported data and allow for additional and more relevant financial analysis.

The data software and technology needs to be upgraded and enriched. As a starting point, this could be achieved by using a data warehouse and not relying solely on excel spreadsheets. Full documentation of process, functionality and outputs is required so that the team can be better structured to meet the skill level of tasks performed.

Administrative Impacts of Regulation / Compliance

There has been a steady increase in the provider administration and compliance costs since 2011. The Department compliance activities (and associated costs) need to be reviewed with greater focus on analytical review. Approved Provider administration and support costs are increasing at unsustainable levels as a result of ensuring both clinical and financial compliance.

Overall assessment

The ACFR will improve the quality and consistency of data obtained, but will likely increase costs to the provider in preparing and submitting the ACFR.

Governance and Structure - Funding Policy Branch

In reviewing the above areas, it was observed that the strategic information (data, information analysis and decision support) structure is not contemporary and the linkage between key divisions and agencies needs to be strengthened. The internal reporting structures need to be clarified to ensure consistency of data, analysis and commentary.

Statistical data and related commentary is often relayed without rigorous scrutiny and review. This may present some risk, particularly external, given the breadth of reporting and the sector's reliance upon information from the Department.

Overall assessment

Better clarity around responsibilities, review procedures and improved communication between all sections (Financial Performance Section, Prudential Risk and Compliance Section and Aged Care Reporting Sections) are required in order to streamline the processes.

The data management and analysis process should be improved by establishing a central data warehouse with the Aged Care Reporting Section responsible for the receiving, cleansing and checking of all financial and non-financial data received by the Department from Providers.

The Financial Analysis & Reporting team should be responsible for all data analysis. This will improve the consistency and accuracy of reported data and allow for additional and more relevant financial analysis.

1.3 Recommendations

The following rating system has been used to prioritise the recommendation and to give some guidance as to the timeline for rectifying the current weakness in the system or implementing a new system. In the following list of recommendations, similar recommendations have been grouped together.

Extreme		Action should be taken as soon as possible – within three to six months. Is likely to provide efficiencies and flow-on cost benefits. Is likely to involve a change in a current process or role or modification to existing systems
High		Action should commence within six to twelve months. Is likely to involve implementing new systems or software, or is currently in progress. May also involve redeployment of staff or responsibilities
Moderate		Action should be taken in the longer term but steps should be taken to implement the action within the next twelve months. Is likely to be reliant on other high or extreme recommendations having been implemented. For example, the second or third stages of a current or planned software change or implementation process. May involve the redeployment of staff or responsibilities.
Low		Benefits from implementing the recommendation will be minor should be actioned as resources and systems allow

No	Ref	Section/s	Recommendation	Priority
1	3.5.1 5.5.1	Benchmarking services Financial Performance and Reporting Function	A central data warehouse be established that is responsible for the ACFR and GPFR data inputs (in addition to other sources). Financial Performance is then able to extract data from this data warehouse for analysis purposes	
2	3.5.2 5.5.2	Benchmarking services Financial Performance and Reporting Function Administrative Impacts of Regulation / Compliance	The Aged Care Reporting Section be responsible for the receiving, cleansing and checking of all financial and related non-financial data received by the Department	
3	3.5.3 5.5.7	Benchmarking services Financial Performance and Administrative Impacts of Regulation / Compliance	All data analysis (financial, prudential Approved Provider and risk analysis) to be performed by the Financial Analysis & Reporting Section. If any data quality issues are found this should be fed back to the Aged Care Reporting Section through an established process and the data updated in the data warehouse accordingly by the Aged Care Reporting Section.	
4	3.5.4	Benchmarking services	The GPFR data (Statement of Income & Expenditure (AP), Financial Position (AP), Statement of Cash Flow (AP), Notes) should be used for providing "absolute" financial data at Approved Provider level	
5	3.5.5	Benchmarking services	Data to be collected from one source for specific trend analysis (i.e. reliance on ACFR for Income and Expenditure only rather than subsidy information from DHS)	
6	3.5.6	Benchmarking services	The Department benchmark website be discontinued	
7	3.5.7	Benchmarking services	The Department consider restructuring the approach taken to obtain and use December year-end reporting Approved Providers with the aim of reducing the time taken to issue the report by utilising a fiscal year-end basis	
8	4.5.1	Departmental and ACFA Reports	ACFA reporting be more streamlined and timely with quarterly trend analysis reporting	
9	4.5.2	Departmental and ACFA Reports	ACFA quarterly reports to be more readily structured to enable distribution by email with links to detailed reports and supporting information	
10	4.5.3	Departmental and ACFA Reports	ACFA quarterly reports to focus more on demographic analysis including the linkage with the funding	
11	4.5.4	Departmental and ACFA Reports	The annual ACFA report provide "absolute" historical financial and non-financial data (with commentary directed at future policy initiatives)	
12	4.5.5	Departmental and ACFA Reports	ROACA report should not overlap with ACFA report on key financial data and analysis	

No	Ref	Section/s	Recommendation	Priority
13	5.5.3	Financial Performance and Reporting Function	The Department consider the method of comparison of different data sources	●
14	5.5.4	Financial Performance and Reporting Function	Data is to be collected from one source for trend analysis (i.e. reliance on ACFR for Income and Expenditure only rather than subsidy information from DHS).	●
15	5.5.5	Financial Performance and Reporting Function	The Department increase the use of contemporary analysis tools and software (such as Excel TCM; XLSTAT)	●
16	5.5.6	Financial Performance and Reporting Function Administrative Impacts of Regulation / Compliance	Additional resources and utilisation of analytics staff is required.	●
17	5.5.8	Financial Performance and Reporting Function	Full documentation of processes, functionality and outputs is required	●
18	6.5.3	Administrative Impacts of Regulation / Compliance	Financial Analysis & Reporting Section redesign processes to have greater focus on analytical functionality	●
26	6.5.5	Administrative Impacts of Regulation / Compliance	Aged Care Financial Report to remove the Statement of Financial Position (residential segment) data input requirement	●
27	6.5.6	Administrative Impacts of Regulation / Compliance	Aged Care Financial Report to be amended to require the Statement of Income & Expenses by Home Care Service to be at consolidated level only	●

2. Terms of Reference

2.1 Scope and Objective of Peer Review

StewartBrown were engaged by the Department of Health (Department) to undertake a peer review of the Department's data collection and reporting activities with a view to enhancing current processes and future report content. The services that have been provided are as detailed in the *Health RFQ 2016/02* and are listed in the relevant chapters of the report.

Included in the Peer Review and in consultation with the Department, discussions with the Prudential Risk and Compliance team were held to gain further insight into the data analysis undertaken and the related processes.

2.2 Definitions

A comprehensive listing of definitions and abbreviations is included as ***Appendix A***.

2.3 Methodology and Approach

The detailed methodology and approach for each Scope area is set out in the relevant Chapter. The approach involved interviews and discussion with key staff, desktop review of the applicable data provided by the Department, review of relevant current systems and processes, and comparisons with StewartBrown financial and non-financial data as included in the *Aged Care Financial Performance Survey* (ACFPS) database and analysis reporting.

StewartBrown conducted several interviews with the key staff involved in the Department's aged care financial reporting, benchmarking service, and prudential assessment.

StewartBrown also obtained and used the following resources from the Department to inform the review findings and recommendations:

- Data collection forms and methods used by the Department and/or Forms Administration
- Sample of de-identified data collected at both GPFR and service level
- Line item definitions used by Forms Administration for service level data collection
- Calculation logic used in analysis and development of KPI's and trend reporting
- Excel workbooks which contained the extracted 2015 GPFR final data
- Extract from CASPER as provided by the Aged Care Reporting Section for residential and home care

2.4 Report Structure

In accordance with the requirements as detailed in the *Health RFQ 2016/02* that each Chapter of the report refers to the specific Scope area with each Chapter including:-

1. Scope;
2. Methodology and Approach for each activity undertaken;
3. Outline of Current Practices and Processes;
4. Key findings from the peer review conducted; and
5. Recommendations.

2.5 Confidentiality

This report, and the information contained therein, including any recommendations made, is confidential and should only be used for the purpose for which the report was commissioned.

2.6 Report Disclaimer

This report has been prepared under instructions from and for the sole use by the Department of Health (Department) as part of the peer review undertaken by StewartBrown. This report, including any analysis and opinions expressed therein is based on information provided to StewartBrown by the Department Health staff. For the purposes of this review, StewartBrown has not performed an audit on the financial data, accounts process flows or systems of internal control and accordingly has solely relied on the information provided by the Department and interviews and discussions with the relevant staff. This report should not be relied upon by any party other than the Department or for any purpose other than for which it has been written.

2.7 Independence Declaration

There are no matters in relation to this assignment that StewartBrown or any of the engagement staff are aware of that would constitute a real or perceived conflict of interest.

3. Benchmarking Services

3.1 Scope

Perform a review of the Department's benchmarking methodology and reporting activities including:

- Reviewing the Department's current benchmarking approach to understand the data items being collected, compare and contrast this with StewartBrown's survey template and identify any additional items that may be beneficial for the Department to include in the survey template;
- Reviewing the methodology being used by both the Department and StewartBrown to analyse the data collected and prepare benchmarking reports with the aim of:
    - Seeking to understand the differences between the Department's GPFR analysis and reported results, to the results reported by StewartBrown;
    - Identify changes and/or enhancements to the Department's analysis and reporting methodology so that it may better align the Department's and StewartBrown results; and
    - Identify any additional analysis that may be beneficial for the Department to include.

3.2 Methodology and Approach

As part of the review of the benchmarking processes and results, StewartBrown has performed the following tasks:

- Review of data collection methods (GPFR and service level)
- Review of data line item definitions (GPFR and service level)
- Consideration of the level at which data is collected (GPFR v service level)
- Review of the calculations for various measures such as EBITDA
- Detailed analysis and review of a sample selection of providers at line item level and comparison of results using Department data and StewartBrown data

In order to perform the above tasks, StewartBrown conducted several interviews with the key staff involved in the benchmarking services. These included staff from the below sections:-

- Financial Performance
- Aged Care Reporting (ROACA)
- ACFA Secretariat & Aged Care Supplements

StewartBrown also obtained and used the following resources from the Department to inform the review findings and recommendations:

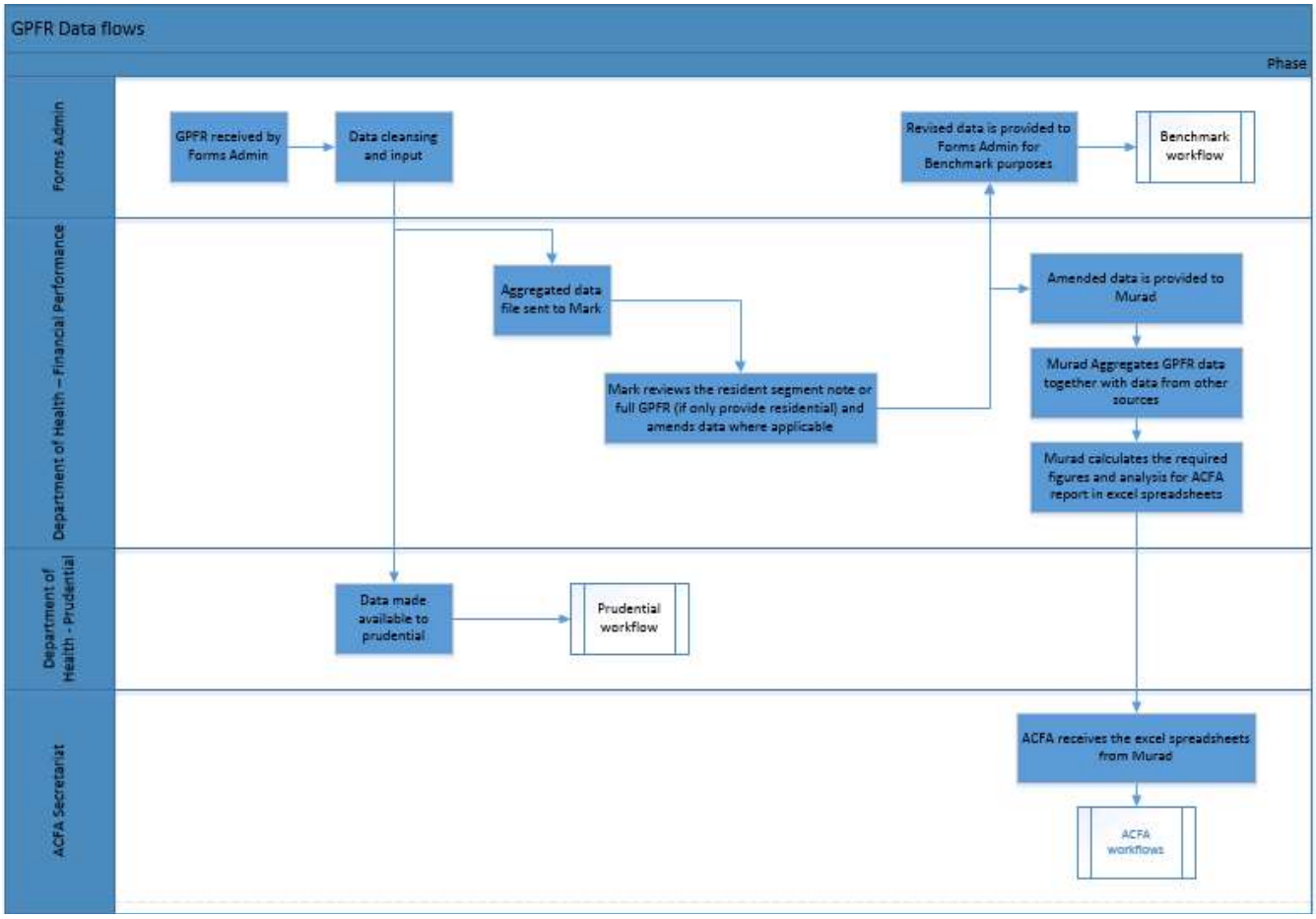
- Data collection forms and methods used by the Department and/or Forms Administration
- Sample of de-identified data collected at both GPFR and service level
- Line item definitions used by Forms administration for service level data collection
- Calculation logic used in analysis and development of KPI's and trend reporting
- Excel workbooks which contained the extracted 2015 GPFR final data
- Extract from CASPER as provided by the Aged Care Reporting Section for residential and home care

From the above interviews and documents, the differences between the StewartBrown *Aged Care Financial Performance Survey* (ACFPS) data and analysis and that of the Departments, as well as recommendations were determined.

3.3 Outline of Current Practices and Processes

The overall workflows relating to the residential GPFR reports and their role in the ACFA and Department Benchmarking are illustrated in the figure below:-

Figure 1: General Purpose Financial Report data flows



Forms Administration

The General Purpose Financial Reports for all residential approved providers with a 30 June year-end are due by the 31 October each year. The 31 December year-end submissions are due by 31 March the following year.

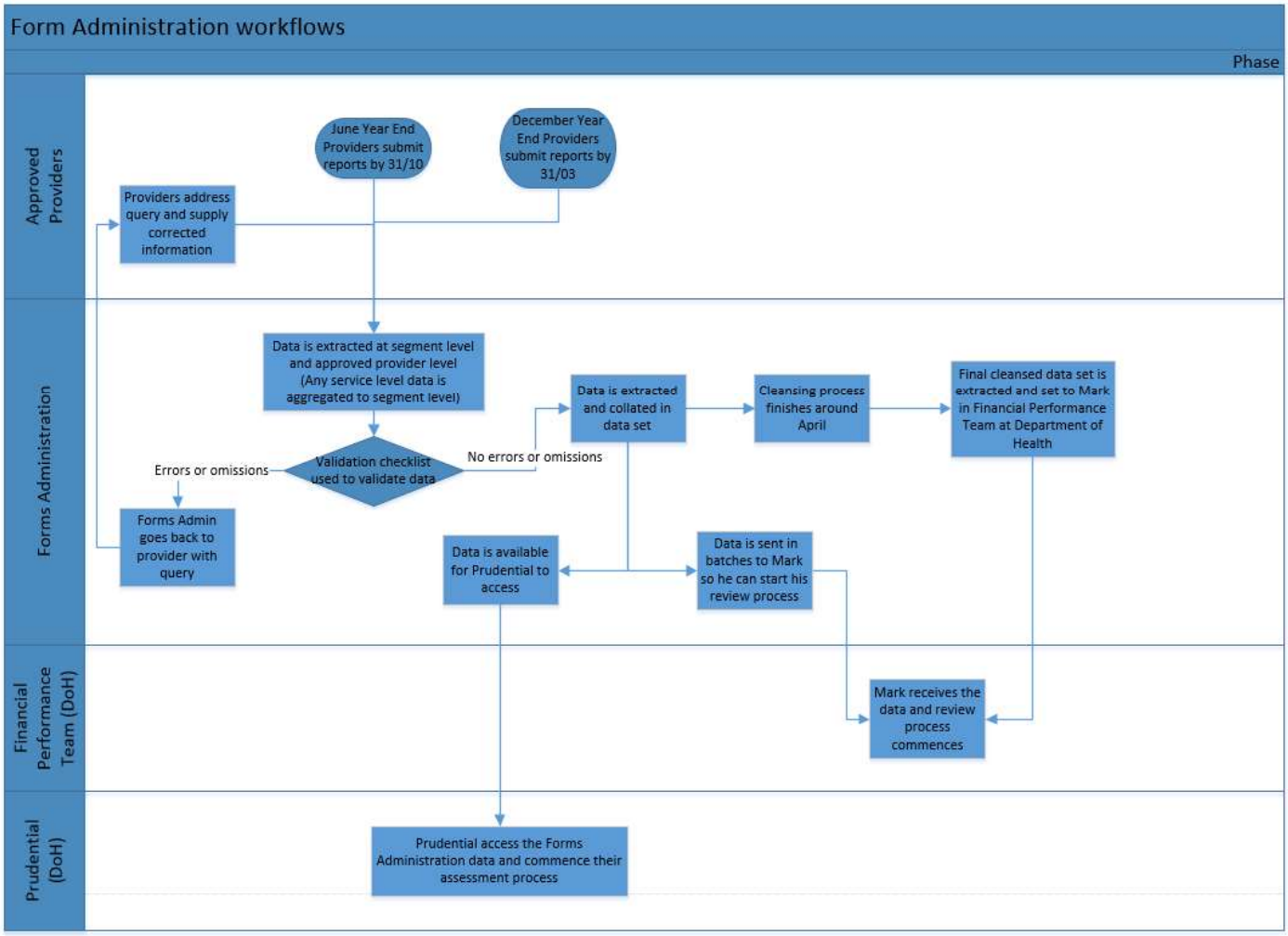
Forms Administration receives the GPFRs and inputs the data and the final cleansed data for the 30 June Approved Providers is available in April.

The validation checklist ensures that all the information received meets all the requirements of the Act, all relevant disclosures are included, that key financial data correctly adds and balances.

Forms Administration do not conduct any data analysis but are tasked with and focused on preparing the data extraction files for the Department. There are two different extraction files. Prudential receives one feed of information and Financial Performance receives the other feed of information independently.

The role of Forms Administration is summarised in the workflow below.

Figure 2: Forms Administration data flows



We randomly selected a sample of the residential aged care providers GPFRs and compared them to the data obtained in the Financial Performance GPFR data set which is based on the extracted data sent across by Forms Administration. This together with discussions with Forms Administration and the Financial Performance Section is the basis for our observation that the accuracy of the data input and related quality control measures administered by Forms Administration is appropriate and reliable.

GPFR data quality

The role of the Financial Analysis & Reporting Section within the Financial Performance Section is depicted earlier in *Figure 1*. This Chapter restricts itself to observations around the GPFR data quality. Observations about the role of Financial Performance in relation to other sources of data, data aggregation, analysis and comparison process are set out in ***Chapter 5***.

Residential segment data

Residential Segment data collected is not reliable. Reliance on the GPFR as the main source for residential data and trends is inadequate and inconsistent. GRFRs are prepared as per Accounting Standards and there can be various interpretations of these Standards by each provider.

As a result, there is no one-size-fits-all standard GPFR and there is a wide mix of different levels of disclosure which means that the data classification is not like for like. Furthermore, the quality of the GPFRs varies. In some cases, the segment data may only be four items - Total Revenue, Total Expenses, Total Assets, and Total Liabilities.

A review of the 2014/15 GPFR data extraction confirmed that 5% of Approved Providers do not provide any breakdown for revenue and 15% of Approved Providers do not provide a breakdown for expenses, but rather the total revenue and total expenses are disclosed as Other Revenue and Other Expenses respectively.

This means that the value of the other revenue and other expenses are overstated and the value of the other classifications such as wages, depreciation and interest expense are understated. A similar issue exists for the split of assets and liabilities.

Percentage of Total Approved Providers	Percentage Value of $ Total
• **5%** of Approved Providers do not provide a breakdown for *revenue*	• **4%** of total revenue is not broken down into the separate revenue components - only disclosed as *other revenue*
• **15%** of Approved Providers do not provide a breakdown for *expenses*	• **10%** of total expenses is not broken down into separate expense components - only disclosed as *other expenses*
• **28%** of Approved Providers do not provide a breakdown for *total current assets*	• **32%** of total current assets is not broken down into the separate components - only disclosed as *other current assets*
• **26%** of Approved Providers do not provide a breakdown for *total non-current assets*	• **34%** of total non-current assets is not broken down into separate components - only disclosed as *other non-current assets*
• **22%** of Approved Providers do not provide a breakdown for *total current liabilities*	• **26%** of total current liabilities is not broken down into the separate components - only disclosed as *other current liabilities*
• **37%** of Approved Providers do not provide a breakdown for *total non-current liabilities*	• **24%** of total non-current liabilities is not broken down into separate components - only disclosed as *other non-current liabilities*

Accordingly, we recommend that the GPFR be used only for *organisation analysis* and not for residential segment analysis. The Aged Care Financial Report should be the vehicle used for specific residential income and expenditure analysis.

Revenue and expense segment data

A number of Approved Providers do not present the allocation as per the line items in the Financial Performance GPFR data collection sheet. This is illustrated in ***Appendix B Table B.1*** which sets out the line item analysis for the residential profit and loss items. Where the number of approved providers that DID NOT provide information for the line item is greater than 50%, the figure has been shaded in **light red**.

A senior member of the Financial Performance Section determines the methodology to allocate wages, interest and depreciation for those providers that do not provide this data dissected in their GPFR.

The initial approach is to apply the same split as per the Approved Provider *Statement of Comprehensive Income* and related notes. If this is unable to be performed due to inconsistent data then the allocation is based on the industry average across those providers that did provide the breakdown of their data.

However, a further complication which cannot be resolved is the definition of Staff Costs (salaries and wages). Some providers include on-costs, workers compensation, fringe benefits, superannuation, leave accruals and agency costs as Staff Costs whilst others only include direct salary and wages or a combination of the former.

Of the line items listed below only those highlighted in **orange** are used in the determination of figures for the ACFA report. As a result, much of the financial information gathered is not used in any capacity for Departmental reporting. *The data granularity of the input does not match that of the output.*

Some of the data is used to populate the Departmental Benchmark (refer to further discussion on the following page). However, given the limitations mentioned above in addition to the small number of users of the Departmental Benchmark, the continuance of the service is questionable.

Balance sheet segment data

Appendix B Table B.2 sets out the line item analysis for the residential segment balance sheet. Where the number of approved providers that DID NOT provide information for the line item is greater than 50%, the figure has been shaded in **light red.** Of the line items listed below only those highlighted in **orange** are used in the determination of figures for the ACFA report. As a result, a lot of the information gathered is not used. *The data granularity of the input does not match that of the output.*

December Approved Providers

Residential Segment data collected is not timely. One of the reasons given for the late publication and release of the ACFA report is that there are a number of Approved Providers with a December financial year-end. In order to include their residential operating segment results in the ACFA report, the complete GPFR data set is only available at the end of March at the earliest.

Timeliness is not the only issue that arises from including the December Approved Providers in the ACFA report. Another issue is comparability. There is the possibility that the operating environment for the year ended December may be significantly different from the year ended June and inclusion of the December year end could skew the resulting figures and analysis. For this reason, we have examined the composition of the December year end Approved Providers.

There are eight Approved Providers that have a December year end. Four of which are part of the same group. They comprise less than 1% (0.8%) of the total number of Approved Providers (966) for the 2015 year. However, in terms of the net result and EBITDA they comprise around 5%. They also comprise 5.6% of the total bonds/ RADs held.

Appendix B Table B.3 compares the December Approved Providers to the Total to determine the level of significance these providers have on the total results. In terms of facility EBITDA, they comprise 6.5% of the total.

However, when the key ratios are compared in ***Appendix B Table B.4***, there is no significant difference between the ratios of all Approved Providers and the ratios of those providers excluding the December year-end aged care providers.

It is recommended that the Department consider the approach taken to the December Approved Providers with the aim of reducing the time taken to issue the report. Options available include:-

- Excluding the December Approved Provider results (as illustrated above did not significantly impact the key ratios/ analysis for 2015 year)
- Working with the December providers so that they report to the Department based on the fiscal year (management reporting) in addition to their December year-end results
- Changing the grouping of the time periods - the aggregated data could include the prior year December data with the current year June data. For example, this would mean combining the December 2015 with June 2016 data instead of December 2016 with June 2016 data
- It is also noted that the Bonds/RADs liability disclosed in the GPFR differs from that as disclosed in the Annual Prudential Compliance Statement (refer to ***Appendix B Table B3*** items highlighted with "**"). It would appear that the Bonds/RADs are disclosed in some GPFR residential segments as Other Current Liabilities, however it is likely that there is a considerable imbalance. This difference is currently not reconciled by the Department.

Departmental Benchmark

The revised final GPFR data is provided to Forms Administration for the Departmental Benchmark. Beyond this, the Department does not implement any quality control or review functions in relation to the Department benchmarking service.

There are two (2) Department (Forms Administration) benchmark types for residential aged care:

- **Basic** - which includes information derived from the GPFR Residential Segment (i.e. consolidated Approved Provider residential data)
- **Cost Centre** - which is on a "facility" basis (either by input directly into Forms Administration portal or using StewartBrown and/or Bentley's input sheets)

Basic Benchmarking

The Basic benchmark presents the aggregated (consolidated) results of all facilities combined - at an approved provider level. Users are able to access online ratios and charts in addition to a downloadable excel report which summarises these results in a printable format.

- Profitability ratios include EBITDA per subsidy day and net profit per subsidy day
- Investment includes balance sheet ratios such as EBITDA return on Equity, EBITDA return on assets, current ratio, bond liquidity ratio, debt to equity ratio, net worth per resident per year
- Care subsidy ratios show the average care subsidy per subsidy day and the care subsidy breakdown
- Service profile ratios include the occupancy rate, supported resident ratio and high care resident percentage
- Bond analysis shows the average value of total bonds and the average value of new bonds.

This information has **limited utility** in an operational sense for residential aged care facilities and home care providers.

The timing of the benchmark (June 2015 data is only available in May/ June 2016) further reduces the utility and benefits of the benchmark to approved providers.

Furthermore, as mentioned earlier in this report, the Residential Segment data collected is not reliable. Reliance on the GPFR as the main source for residential data and trends is inadequate and inconsistent. Much of the financial information gathered is not used in any capacity for Departmental reporting apart from the items highlighted in orange in ***Appendix B Tables B1 and B2***. However, some of this data is used to populate the Departmental Benchmark. Given the limitations of this data addition to the small number of users of the Departmental Benchmark, the continuance of the service is questionable.

As a result, it is not surprising that the majority of providers (69%) do not use the benchmarking data. For the 2014/15 year, the number of services completing and engaged in Benchmarking was 1,457 comprised of 459 unique providers. Given the scale of the industry (972 residential aged care providers, 504 home care providers), this is a relatively small cohort (31%). These statistics on the specific use by providers of the benchmarking website are limited due to the limitations imposed by the security governance and protocols of the website. Often the total numbers are all that is available and this will include Prudential, Home Care, ACFR trial and Benchmarking.

- Access to the website is on a total basis and includes Home Care, Prudential, ACFR and so on
- The total number of "hits" for the year was 1.2 million not including internet search robots
- Unique Authenticated users during the year was 1,083
- The site is also available to the general public, clouding the usage statistics

Advanced Cost-Centre Benchmarking

The Cost Centre data does show more relevant information at a facility level. This includes wages ratios, other profitability, revenue analysis, expense analysis and operational ratios. However, there are insufficient providers that supply this information.

The Advance Cost-Centre Benchmark participation only includes **37 Approved Providers** (388 facilities in total). Of these 37 Approved Providers, 23 providers (345 facilities which is **89%** of the total number of facilities in the Cost Centre Benchmark) are also participants of the StewartBrown *Aged Care Financial Performance Survey*s.

	Number of providers	Number of facilities
StewartBrown Survey Participants	23	345
Non StewartBrown Survey Participants	14	43
Total	37	388

Furthermore, the functionality (including insufficient depth of granular data quality and quantum) of the "cost centre" Department benchmark makes continuance of this service doubtful. Refer to the prior commentary discussing GPFR data quality.

Commentary

The significance of this analysis is that the providers who also participate in the StewartBrown *ACFPS* have merely supplied Forms Administration with the same input sheets that is used for the *ACFPS* (as requested by Forms Administration) and a summary of this input is included on the Cost Centre Benchmark. As those providers will have already received the significantly larger database, more detailed and granular benchmark reporting from the StewartBrown *ACFP* the previous September (the Department Benchmark is available around March the following year) it is very unlikely that these approved providers utilise the Department Benchmark in any beneficial manner.

Comparison of StewartBrown and Department Benchmarks

Appendix B Table C.5 summarises the similarities and differences between the StewartBrown *Aged Care Financial Performance Survey* benchmarking and the Department's GPFR data and benchmarking.

Aged Care Financial Report

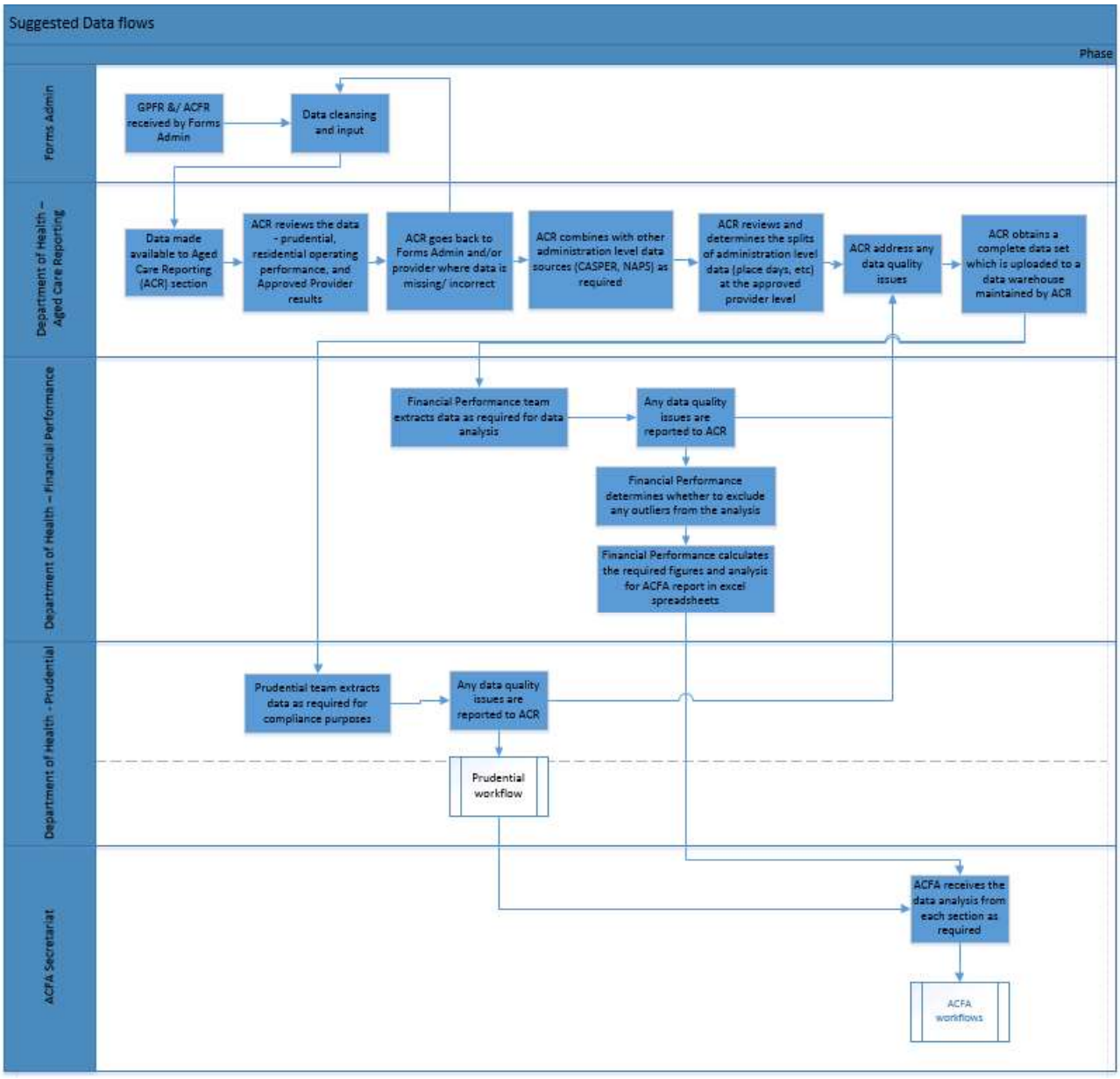
The ACFR will assist in improving the Income & Expenditure data gathered by the Department in relation to providing "absolute" residential and home care financial information, but issues remain in relation to the utility of this data due to the residential data being at consolidated provider level (rather than facility level), delays in the collection, processing and reporting on finalised data.

The Residential Balance Sheet in the ACFR will not provide any reliable information for the Department and should be discontinued. All balance sheet analysis and ratios should be performed at provider level (consolidated) rather than at segment level. Further analysis of the ACFR is included in ***Chapter 7***.

Recommended Data Flow

The following data flow illustrates a more streamlined process segregating the responsibilities of data management (creation and maintenance of the GPFR data set) and data analysis which can be carried out by the Financial Analysis & Reporting Section.

Figure 3: Recommended data flows



3.4 Key findings

- The accuracy of the data input and related quality control measures administered by Forms Administration are fit for purpose
- Due to interpretation variability, variable data and disclosure issues the reliance on the GPFR as the main source for residential data and trends is unreliable
- Due to interpretation variability, variable data and disclosure issues the Residential Segment data collected is not reliable, not timely and has inconsistent data definitions
- The lack of functionality (including insufficient depth of granular data quality and quantum) of the "cost centre" Department benchmark makes continuance of this service doubtful
- The Department does not have any quality control or review protocols and procedures relating to the collection, collation and analysis of data in regards to its benchmarking service

- The ACFR will assist in improving the Income & Expenditure data gathered by the Department in relation to providing "absolute" residential and home care financial information, but issues remain in relation to the utility of this data due to the delay in collection, processing and reporting on it
- Due to the high rates of non-disclosure and/or lack of item allocation the Residential Balance Sheet in the ACFR does not provide any reliable information for the Department and should be discontinued
- This gap analysis highlights the differences in reported results stemming from the sample populations of the StewartBrown Survey and Departmental data sets. The Department data sets combine data derived from different sources which are inconsistent and makes direct comparison incomplete

3.5 Recommendations

A summary of recommendations in relation to **Chapter 3 - *Benchmarking*:**

3.5.1 A central data warehouse be established that is responsible for the ACFR and GPFR data inputs (in addition to data from other internal sources).

3.5.2 The Aged Care Reporting Section be responsible for the receiving, cleansing and checking of all financial and related non-financial data received by the Department

3.5.3 The data analysis to be performed by the Financial Analysis & Reporting Section. If any data quality issues are found this should be fed back to the Aged Care Reporting Section through an established process and the data updated in the data warehouse accordingly by the Aged Care Reporting Section

3.5.4 The GPFR data (Statement of Income & Expenditure (AP), Financial Position (AP), Statement of Cash Flow (AP), Notes) should be used for providing "absolute" financial data at Approved Provider level

3.5.5 Data to be collected from one source for specific trend analysis (i.e. reliance on ACFR for Income and Expenditure only rather than subsidy information from DHS)

3.5.6 The Department benchmark website be discontinued

3.5.7 The Department consider restructuring the approach taken to obtain and use December year-end reporting Approved Providers with the aim of reducing the time taken to issue the report by utilising a fiscal year-end basis

4. ROACA and ACFA Annual Reports

4.1 Scope

Perform a review of Departmental and ACFA reports, analysis and reporting activities including:

- Review the methodology being used to analyse and report the data collected with the aim of:
  - Providing insights into the StewartBrown data collected at facility / service level and the results reported;
  - Identifying changes and/or enhancements to ACFA and the Department's analysis and reporting methodology;
  - Identifying any additional qualitative and quantitative sector analysis that may be of benefit to ACFA and the Department to perform;
  - Identifying areas / topics for future one-off reports;
  - Undertaking a gap analysis and identify opportunities to enhance ACFA's report with the addition of relevant qualitative and quantitative sector observations; and
  - Performing sector analysis of provider balance sheets and rates of capital return.

4.2 Methodology and Approach

There were a number of aspects to this part of the review and they are listed with the work performed below:

Literature Review

- Reviewed and critiqued the last two annual reports by ACFA and the Department
- Reviewed other ACFA reports to assess what one-off reports have already been released and may be ongoing areas of focus

Process Review

- Reviewed the processes for report development

Ascertaining areas of focus

- Interviewed key members of ACFA and the Department to discuss methodologies and areas of focus from the point of view of Government
- Assessed implications of the Aged Care Roadmap for future reporting and how this might affect the types of data and analysis that might need to be provided to stakeholders

StewartBrown held several interviews with the key stakeholders from the Department and ACFA and discussed:

- Past areas of focus and the logic behind the analysis being undertaken by the Department and ACFA
- Any legislative requirements or guidelines that the annual or one-off reports must meet
- Actual or aspirational goals that ACFA or the Department wish to achieve through these published reports
- Any internal goals or reporting that the Department would like to meet through the data gathering and analysis process

4.3 Outline of Current Practices and Processes

ROACA

The drafting and preparation of the ROACA is a process that starts soon after the end of the financial year and concludes with the tabling of the report in Parliament no later than the last day of November. A variety of Branches within the Department provide input into the report but in many cases the Aged Care Reporting (Aged Care Policy Branch (ACPB)) input data on behalf of the program areas. In respect to other processes involved with compiling the report:

- The Aged Care Policy Branch managed the outflow and returns of input requests
- A writer/editor contracted to the Department, working with Aged Care Policy Branch, collated the input, provided editorial services, and authored text to fill gaps
- The writer/editor and ACPB together managed version control
- Departmental executives (SES) and the Minister's Office received, provided input into, and approved draft manuscripts at multiple stages in the process.

The various branches of the Department that have input into the process and report is shown in the following tables:

Table 1: ROACA report chapters and input

Chapter	Title	Input From
1	Overview of the Australian Aged Care System	Aged Care Policy Branch
2	Informed Access to Aged Care	Access Reform Branch My Aged Care Operations Branch Ageing and Sector Support Branch
3	Home Support	Home Support Branch
4	Home Care	Home Care Reform Branch Funding Policy Branch
5	Respite Care	Home Support Branch Residential and Flexible Care Branch Funding Policy Branch
6	Residential Care	Residential and Flexible Care Branch Funding Policy Branch
7	Flexible Care	Residential and Flexible Care Branch
8	Support for People with Special Needs	Aged Care Policy Branch Ageing and Sector Support Branch
9	Aged Care Workforce Sector and Support	Ageing and Sector Support Branch
10	Quality and Regulation	Quality Reform Branch Prudential and Approved Provider Regulation Branch

This information can also be shown in the form of a matrix to more clearly see what contributions were made by the various Branches of the Department.

Table 2: ROACA report matrix of input and chapters

Input received from:	Report Chapters									
	1	2	3	4	5	6	7	8	9	10
Aged Care Policy Branch	X							X		
Access Reform Branch		X								
My Aged Care Operations Branch		X								
Ageing and Sector Support Branch		X						X	X	
Home Support Branch			X		X					
Home Care Reform Branch				X						
Funding Policy Branch				X	X	X				
Residential and Flexible Care Branch					X	X	X			
Quality Reform Branch										X
Prudential and Approved Provider Regulation Branch										X

Legislative framework for the report

The ROACA is required by *Section 63-2* of the *Aged Care Act 1997* (the *Act*) and must be laid before each House of Parliament no later than 30 November in each year reporting on the preceding year ended on 30 June. The Act prescribes a limited number of matters for which information ***must*** be included in the report but it does not limit the report to those matters.

The matters that must be included are:

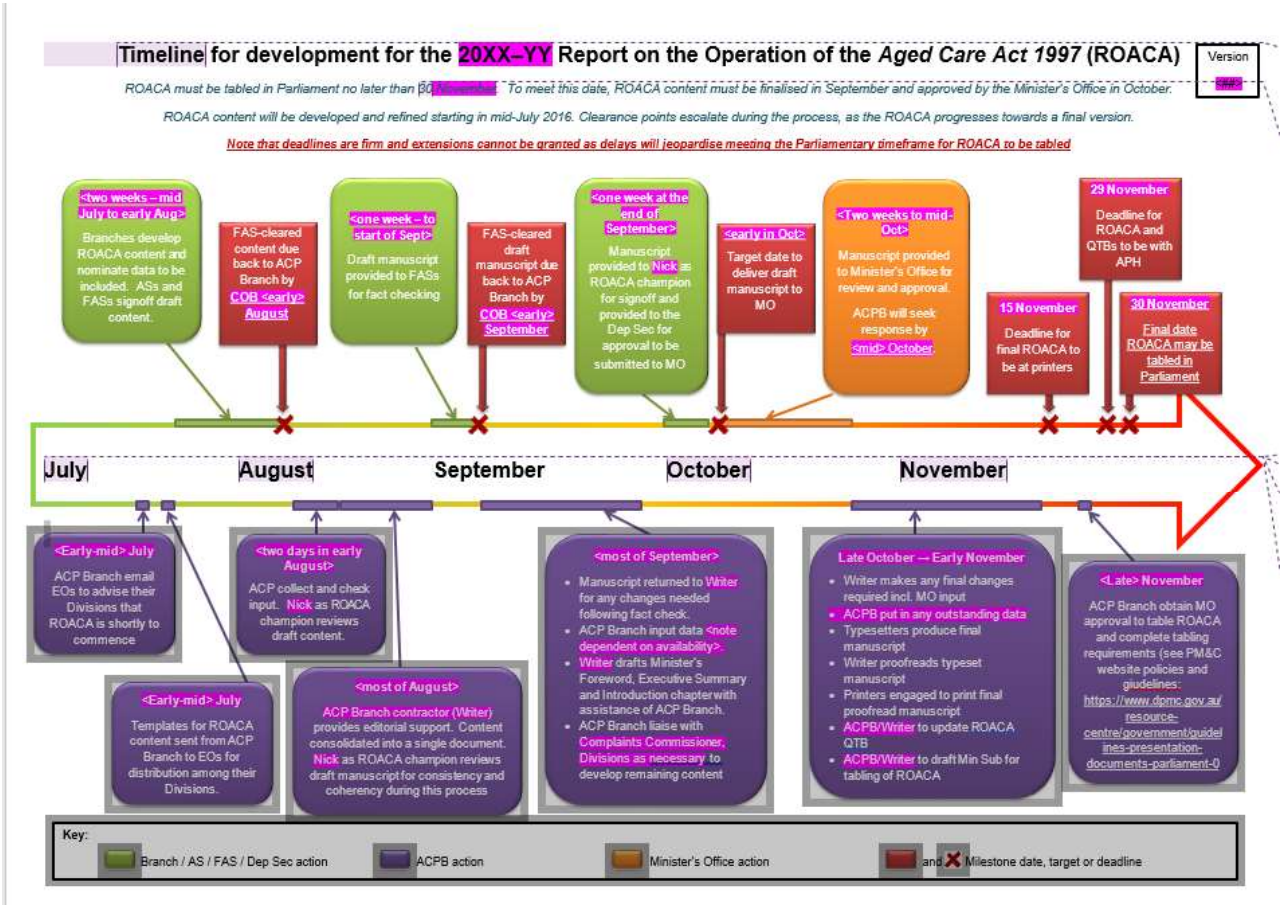
- the extent of unmet demand for places; and
- the adequacy of the Commonwealth subsidies provided to meet the care needs of residents; and
- the extent to which providers are complying with their responsibilities under this Act and the *Aged Care (Transitional Provisions) Act 1997*; and
- the amounts of accommodation payments and accommodation contributions paid; and
- the amounts of those accommodation payments and accommodation contributions paid as refundable deposits and daily payments; and
- the amounts of accommodation bonds and accommodation charges charged; and
- the duration of waiting periods for entry to residential care; and
- the extent of building, upgrading and refurbishment of aged care facilities; and
- the imposition of any sanctions for non-compliance under Part 4.4, including details of the nature of the non-compliance and the sanctions imposed;

As stated in the report, it *"also provides additional information to aid an understanding of aged care programmes and policies"*. Our review of the report would indicate that this has become the primary purpose of the report rather than to meet its strict obligations under the Act. It is a report that is mainly focused on the past - a *historical report* rather than reporting on what future trends.

Timeline for reporting

The timeline for the preparation and consideration of the ROACA report is relatively short given the process (as outlined below) for report approval. Eliminating the overlaps with the ACFA reporting will assist meeting the timeline.

Figure 4: ROACA report timeline



It is the timing of the report, and more specifically the timing of when the data is available, that causes the most issues for the Department in preparing the report. The data for inclusion in the report is generally is not available for input and analysis until late September to early October each year. The issues encountered because of the timeline for preparation and the lack of timely data include:

- Data for aged care assessments is lagged for a year - means the data being reported may change after the report is published
- The time lag for Home Care data is longer than some other sources due to issues with source system
- Data from Medicare and other sources may change as adjustments are made to it over time causing inconsistencies in what is published in the ROACA report and what may be published or made publicly available at a later date
- There may be insufficient time to properly validate the data being used in the report

One way to minimise data changes, particularly where it may relate to information that does not have to be reported on in ROACA would be to issue supplementary reports from time to time to time once the data has been properly validated and assurances received that it is final. It might be possible in the ROACA to concentrate predominantly on those matters that it must report on to meet the legislative requirements.

Further reports could be issued over the course of the year to meet the objectives of providing additional information to aid an understanding of aged care programmes and policies. This may allow the supplementary reports to be more focused so that readers do not get lost in the detail as they are likely to do now.

Overlap with ACFA reporting

There is some overlap with reporting from ACFA, and one of the more confusing aspects to this is that the ACFA report is using data that is a year older than that reported in ROACA. This means that where the same issue is being reported upon, the data being presented will be different as it will relate to different years.

A simple example of this is a comparison of a small passage from each of the 2016 reports with respect to the average age of entry into aged care.

From the 2016 ROACA Report (based on 2015-16 year) released in November 2016:

- The average age at admission into a home care package was 79.5 years for men and 80.6 years for women
- The average age for new admissions to permanent residential aged care was 82.0 years for men and 84.5 years for women

From the 2016 ACFA report (based on 2014-15 year) released on 29 July 2016:

- "In home care the average age of consumers was 82.3 years compared with 84.6 years in residential care, while the proportion of people aged 85 and over in residential care was 60 per cent compared with 43 per cent in home care."

These passages are not wildly different and the information being presented in the ACFA report is for the 2014-15 year and the information in the ROACA report is for the 2015-16 year so a difference in the numbers might be expected. However, from a reader's perspective these inconsistencies are confusing, particularly when the reports are only released 4 months apart. It would be more beneficial if there were less overlap between the two reports, and where there was the information presented be the same. However, to achieve synchronisation between the two reports they would require the same reporting timeframe, or at least be reporting on the same period.

Aged Care Financing Authority (ACFA) report on the funding and financing of the aged care sector

The Aged Care Financing Authority (ACFA) is an independent statutory committee, charged with the role of providing independent and transparent advice to the Australian Government on the sustainability and viability of the aged care sector.

ACFA is required to provide an annual report on the impact of funding and financing arrangements on the viability and sustainability of the sector, taking into account impacts on access to care and the aged care workforce.

Legislative Framework for the Annual Report

ACFA was established as a committee under S96-3 of the Act under a Legislative Instrument titled the *Committee Principles 2014* (the *Principles*). Section 6 of the Principles sets out the functions of the Aged Care Financing Authority, one of which is:

- To provide advice to the Minister, by 30 June each year, on the impact of the funding and financing arrangements on:
  - The viability and sustainability of the aged care sector; and;
  - The ability of care recipients to access quality aged care; and
  - The aged care workforce

The Report on the Funding and Financing of the Aged Care Sector is the report that ACFA issues annually fulfil its obligations under the Principles. The 2016 report was provided to Government on 29 July 2016.

Independently of that report, Section 8 of the Principles prescribes that ACFA must, as soon as practicable after the end of each financial year, prepare and give to the Minister a report on the operations of the Authority during that year. This report for the 2015-16 financial year was titled "*2015-16 Operations Report of the Aged Care Financing Authority*".

Our review and this report does not include a review of the Operations Report however it is mentioned from a contextual point of view.

With respect to the ACFA Report on the Funding and Financing of the Aged Care Sector (The ACFA report), our review has found a variety of issues that affect the effectiveness and validity of the information being presented in the report as well finding data and analysis which is very helpful in understanding the viability and sustainability of the sector as well as issues affecting the aged care workforce.

These issues can broadly be categorised into four (4) categories:

- Data sources
- Timing of the report
- Workflows
- Report content

Data sources

The timing of the report will be discussed in more detail, but it has to be noted from the outset that the data that is presented in the ACFA report, by its nature, is mainly out of date and this is a significant impediment to the relevance of the data and message being presented by the report. The report issued in July 2016 was primarily based on data for the 2014-15 financial year which means that the analysis of viability and sustainability is somewhat dated by the time it is published.

Certainly, ACFA does, wherever possible supplement the data presented with more up-to-date data. In some cases, this is used to validate analysis and conclusions based on the older data set. However, the problem with the time relativity of most the data set remains a significant issue.

Another issue is the consistency of the data being presented within the report. This is due primarily to the different sources used and no or little reconciliation between sources. In the 2016 ACFA report, the primary sources of data was financial and administrative data collected by the Commonwealth and included:

- From *residential aged care providers*:
  - General Purpose Financial Reports (GPFRs)
  - Annual Survey of Aged Care Homes (SACH)
  - Published aged care accommodation prices (My Aged Care Website)
- From *home care providers*:
  - Home Care Packages Programme Financial Reports
  - Home and Community Care Minimum Data Set
- Other *general data*:
  - ACFA's survey of aged care providers as part of its reform monitoring up to 31 December 2015;
  - The 2012 National Aged Care Workforce Census and Survey; and
  - The 2014-15 Report on the Operation of the Aged Care Act (ROACA);

One of the problems is that while all of this data comes from the Commonwealth, it is often from different data sets and there appears to be a certain disconnect between the Branches supplying the data. This leads to different figures being quoted in different sections of the report and different time sets being used.

Below are several examples of this:

Example 1 - In 6.2.1 of the report it states that *"At 30 June 2015, there were 192,370 operational residential care places in Australia"* whereas in a detailed data Table D-1 in Appendix B, the total operational residential aged care places is shown as 195,953.

Example 2 - Chart 3.1 displays the changes in the quantum of the pool of lump sum accommodation bonds over time. Below the graph is the following qualification and explanation:

"Note: The overall pool of lump sum accommodation amounts presented in Chart 3.1 have been derived from a regular survey of service providers. Less than half of all service providers participated in the December 2015 survey. To adjust for non-response, survey data have been weighted to estimate total lump sum payments for the entire sector. The June 2015 figure of $19.84 billion differs from lump sum payment pool amount of $18.2 billion presented elsewhere in the report. This latter figure is sourced from the Approved Provider Compliance Statement returns of those providers who submitted their GPFRs and does not include accommodation payments receivable."

This includes the data for June 2015 and June 2014. For both periods, the Department should have data from their APCS relating to 100% of the bond pool as this amount must be provided in the APCS. Rather than use estimates for these two periods it may have been better to use the actual amounts. We understand that there is also the issue of one figure including bonds receivable and one figure not, but the more confusing issue for the reader is that there are different figures in the report being quoted for the same thing.

The disclaimers provided in the ACFA report are not immediately obvious and users may misinterpret the results**. It is recommended that within each section of the report a paragraph of data limitations and use is provided. It is also recommended that the data sources of any tables and charts are acknowledged in footnotes.**

One of the other major factors relating to the data set is the quality of the data itself. Much of the financial information used in Chapters 5 and 7 of the report for the analysis of the financial performance and position of the aged care providers is sources from the General Purpose Financial Reports, and the Residential Care

Segment note that approved providers are asked to include. The quality and consistency of this information can be affected by several factors including:

- Level of detail provided can vary significantly between approved providers
- Accounting Standards are open to interpretation and it is probable that there will be different applications of these standards across the sector
- Data in the segment note may not be complete
- Data at the segment level is subject to the allocation methods used by individual approved providers and there is likely to be inconsistency in those methods
- The methods used for allocations between business segments are not disclosed in the GPFR
- Inconsistency of the treatment of items in the balance sheet such as how lump sum accommodation deposits are classified between current and non-current can impact the liquidity metrics and other metrics used to measure sustainability
- The data used in the financial analysis is a mixture of information from the GPFRs and other sources but this all goes into the one "melting pot" and is analysed as if it was from a single source.
- There is no apparent attempt to reconcile these sources of data

It is likely that the ACFR will provide a greater level of consistency the format in which the financial information is received but many of the other issues will remain. For example, the balance sheets of some aged care providers will show property, plant and equipment at valuation whereas others will show these assets at cost less depreciation. This can have a significant effect on the balance sheet ratios used by the Department in its sustainability analysis. The ACFR will still be subject to allocation issues between operating segments, particularly in respect of the balance sheet. We would contend that from a sustainability point of view, examining the sustainability of the balance sheet at a segment level is not appropriate.

One of the advantages of the GPFR or ACFR data is that it should be "absolute" in that it should be based on data from 100% of aged care providers with little need to interpret or re-engineer the data set. The goal of the ACFA and through the Financial Reporting branch should be to ensure that the data set is indeed absolute.

There are a number of ways that this can be achieved including:

- Performing a greater level of analysis at the approved provider level rather than at the segment level. If the aim of the report is to assess the viability and sustainability of the sector then the focus should be on the overall viability of those organisations within the sector, rather than just on the residential or community care segments. If an aged care provider fails financially, it may be a result of other parts of the business not the residential aged care part, but if the business as a whole is not healthy then it will affect the aged care segments.

- Enforce the full application of the segment reporting accounting standard (*AASB Operating Segments*) and provide a template for providers to use. As we understand this the legislative framework is in place and if a template is provided to approved providers there is likely to be far more consistency in both format an approach. It also ensures that this information is audited.

- Either through Forms Administration or the Financial Reporting Branch perform more integrity checks on the data or provide the sector with accounting policy guidelines for some of the major contentious areas of how accounting standards are interpreted or items are allocated between

segments. This might mean contacting more providers and making adjustments to the financial data submitted to ensure more consistency on how common items are treated in the financial analysis.

The other factors affecting the data including the methods used to analyse it and the general workflows in collecting it are discussed in ***Chapter 3***. Benchmarking Services and ***Chapter 5***. Financial Performance and Reporting.

Timing of the report

We understand that because of the legislative framework, ACFA is tasked with providing advice to the Minister, by 30 June each year, on the impact of the funding and financing arrangements on:

- The viability and sustainability of the aged care sector; and;
- The ability of care recipients to access quality aged care; and
- The aged care workforce

Currently this advice is being provided in the form of the annual ACFA Report on the *Funding and Financing of the Aged Care Sector*. As stated earlier, the timing of the report means that most the analysis is being performed on data that is not relating to the year in which the report is being issued. For the 2016 report, most of the data being analysed was for the 2014-15 financial year. From a reader's point of view, it means that the analysis of the financial data is interesting - but is out of date. In comparison, the ROACA report which is released only 4 months later, is reporting on data from the immediate financial year just past and is seen to be more relevant.

We understand some of the reasons for the timing of the report and the length of time taken to compile a full data set including:

- GPFR (and now ACFR) are not required to be submitted until October 31 each year for most approved providers
- Several (approximately ten) large approved providers have December reporting dates and do not have to submit data until April 30
- The full data set is not available for analysis until after April each year

However, a lot of the other information contained in the ACFA Report is available well before the data sourced from the submissions from approved providers. A great deal of the data is available by the time the ROACA is published.

A better method of reporting to the Minister, and to the public, could be to issue several reports over the course of the year. This could be half yearly or possibly quarterly. Each of these reports could have common items being reported upon as they come to hand such as and then each report may have a particular focus based around when information is released.

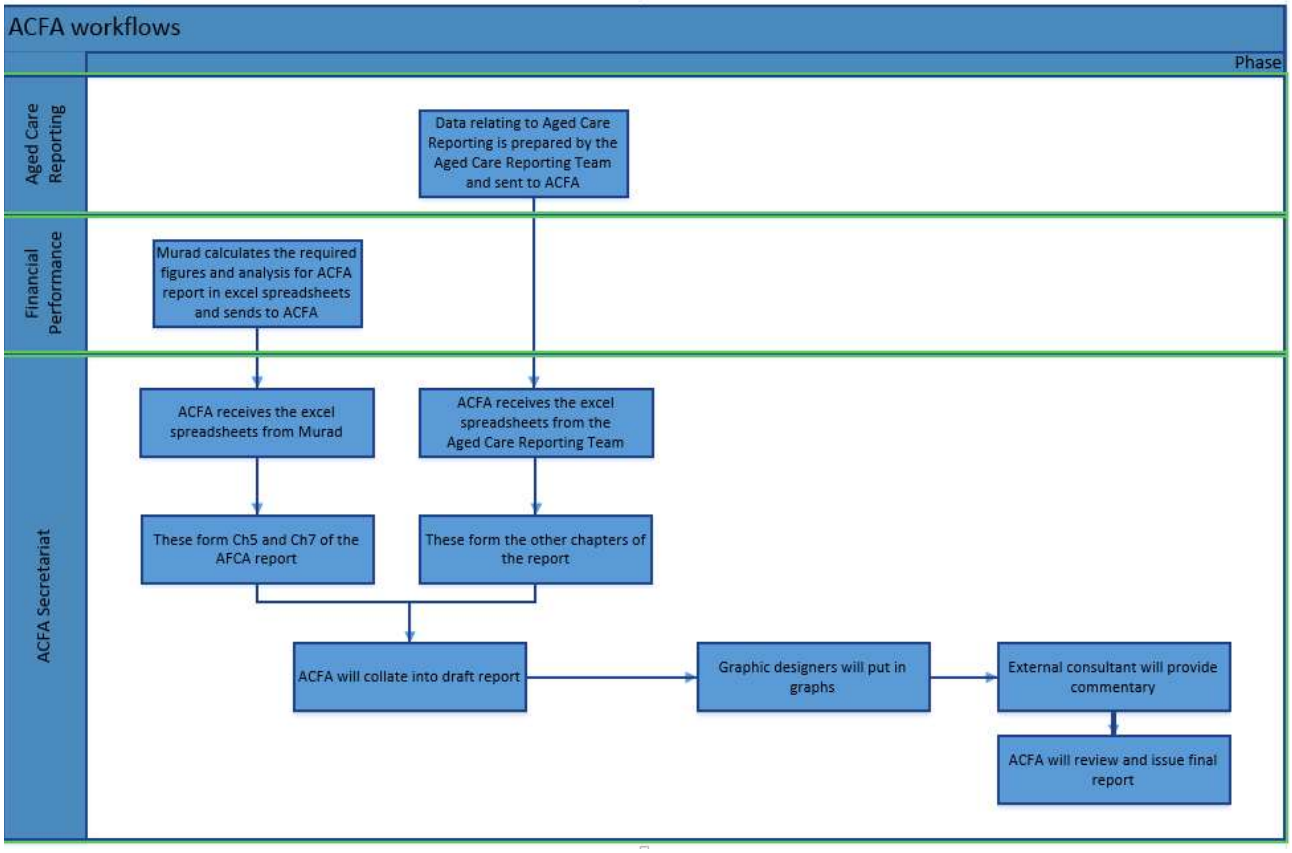
More timely reports reporting on more up-to-date information is going to be far more relevant to stakeholder than is currently the case.

Workflows

The majority of the analysis of the financial data is performed by the Financial Performance Section of the Funding Policy Branch. ACFA process the analysis provided to them, collate that data and analysis and enter it into the draft report. The workflows are summarised in the diagram below.

ACFA Secretariat

Figure 5: ACFA workflows



In essence, ACFA does little, if any, analysis of the data, and nor does it provide the commentary on the data which is currently outsourced to the various Department Sections and external consultants.

The Financial Analysis and Reporting Section within the Financial Performance Section currently includes two assistant directors who are heavily involved in the GPFR data preparation process. It is recommended this work could be performed by an experienced business analyst employed at a more appropriate (lower) level. The role of the assistant director/s would then be to review the data analysis and focus on explaining trends and movements.

We feel that enhancing the business analytical skills within the Financial Performance Section would assist the Department in a number of areas, not least with providing assistance in the compilation of the ACFA report, providing prudential data analysis and being able to provide assistance with analysing financial statements from a prudential viewpoint.

It is our opinion that these additional skills can be achieved within the current staffing within the FPS.

Also, while the ACFA report is providing analysis on the viability and sustainability of the sector, there does not appear to be any interaction or information sharing with the PRCS whose remit it is to assess the financial risk associated with approved providers. Having more information sharing between the two branches is also likely to be useful.

Report content

Providers often ask us for information and we often point them in the direction of the ACFA report. The same people had said they had "looked at the report" but did not realise that information was included. Other comments made to us on a regular basis can be summarised as follows:

- Report was too lengthy in size and content
- Financial Information is not current
- Very good and beneficial demographic data is included
- Gives a good insight into the composition of the sector
- Report is a bit confusing

As mentioned earlier, we feel that the reporting could benefit breaking the Annual Report down into several smaller reports with a greater focus and more up-to-date information. As a result of the reforms there are going to be areas of interest and concern that ACFA will be in a position to provide up-to-date statistics and relevant analysis on. This will be of benefit to both the sector as well as to the Minister. Providing the report in this way will continue to satisfy, we believe, the remit to provide advice by 30 June each year. It just means this advice is being provided over the course of the year rather than in a single report as is currently the case.

Quarterly reports could include regular data updates on subjects such as:

- Residential aged care and home care claiming rates
- Respite utilisation
- Transition utilisation
- Residential care occupancy rates
- Home care package allocations by planning regions (*this will be of extreme interest*)
- Approved provider numbers by planning region (*this will be of interest to the home care sector*)
- ACFI statistics (*this will be of great interest to the sector*)
- Accommodation pricing statistics (*this will be of growing interest*)
- Sub-edited commentary form the likes of the Pricing Commissioner

From a financial performance point of view, quarterly data can be obtained from StewartBrown and other sources to provide some qualified commentary at a facility, home care package and provider level.

Other sources of data may also be sourced such as from My Aged Care website and portal around accommodation pricing, home care referrals, home care exit fee pricing and proportion of packages available for services. All of this data should be available on a regular basis.

As the financial performance data becomes available then a report can be published that focusses on that area. An interim report may be able to be produced when most information is available and the data from the prior year can be used for the non-30 June providers. The level of analysis in this interim report will not be extensive as the final report but it can give a snapshot of the health of the sector.

The full data set from the ACFR/GPFR can be used to issue a final report with a greater depth of analysis when the December year end providers are added to it.

We would **recommend** a greater use of trend analysis on the financial performance of aged care providers and other aspects of the sector where possible. Analysis at a point in time can be useful but it can also be misleading unless it is put into context with the trends over time.

We also **recommend** that there is more financial analysis performed at the approved provider level rather than at the segment level for residential care and home care. The sustainability and viability of the sector is not reliant solely on the profitability of the residential or home care segments. It is important to recognise and assess the viability of those organisations that are participating in the aged care sector.

The demographic analysis that is currently in the report should also be the focus of a special report rather than be lost in the detail of some of the other aspects. This is one of the most valuable aspects of the current report, yet many providers do not know this information is available to them.

It should also be reiterated that the report would benefit from having access to an experienced business analyst, and particularly one that knows the aged care sector. This gives ACFA, but the Branch in general, a resource to provide a reality check on some of the commentary and analysis that is being provided in the various reports.

4.4 Key Findings

- The timing of the main report (July the following year for the ACFA report) may limit the value and utility to stakeholders
- Weaknesses exist in the protocols and procedures relating to the collection, collation and analysis of statistical trends and data used for the reports, and such data has not been reviewed or verified prior to inclusion in the reports (and often comes from disparate sources)
- ROACA overlaps considerably with the ACFA report and may require a review to ensure it reports only on items required, with the ACFA reporting being supplemental or supporting information for ROACA
- All reports should reference information sources on the pages where said data is utilised as footnotes or citations rather than appendices or end notes
- The size of the reports (and particularly the ACFA report) is too large and cumbersome. Consideration of more use of technology (emails/web hyper-links) and regular reporting will be more beneficial and timely
- Some of the key financial statistical data (and trend analysis) is inconsistent and inaccurate
- Additional and more relevant financial analysis is required

4.5 Recommendations

A summary of recommendations in relation to Chapter 4 - *ROACA and ACFA Annual Reports*:

4.5.1 ACFA reporting be more streamlined and timely with quarterly trend analysis reporting

4.5.2 ACFA quarterly reports to be more readily structured to enable distribution by email with links to detailed reports and supporting information

4.5.3 ACFA quarterly reports to focus more on demographic analysis including the linkage with the funding

4.5.4 The annual ACFA report provide "absolute" historical financial and non-financial data (with commentary directed at future policy initiatives)

4.5.5 ROACA report should not overlap with ACFA report on key financial data and analysis

5. Financial Performance and Reporting Function

5.1 Scope

With respect to the benchmarking and reporting activities, perform a review of the current performance reporting function within the branch including:

- Analysis of data differences and similarities between StewartBrown and Departmental data collection activities, providing a platform for greater future comparison;
- Consideration of current outputs with a view to finding new informational insights. Consider the potential for additional sector analysis, including rates of return with respect to analysing sector balance sheets;
- Performing a review of current data storage and manipulation practices, noting any areas for improvement;
- Performing a review of the current benchmark tools and technology use with a view to streamlining and optimising current processes;
- Development of documentation of the current practices and processes, providing a basis for ongoing process continuity; and
- Providing a better understanding of the ongoing resource and workload compliment.

5.2 Methodology and Approach

The methodology and approach for this part of the review is similar to that for ***Chapters 2 and 3***.

When interviewing staff and making information requests in relation to the benchmarking and reporting activities, StewartBrown also enquired about the financial performance and reporting functions.

StewartBrown made use of their ITC staff and data analysts (who are primarily responsible for manipulating and storing the StewartBrown data and analysing that data) in order to assist in the assessment of the practices used by the Department or its agent (Forms Administration).

This section of the report sets out the observations and findings in relation to the following:

- Current data collection, storage and manipulation methods and the potential for streamlining or improving these operations
- Differences between StewartBrown and Department data
- The development of documentation of the current practices, protocols and processes that will provide the Department with a basis for ongoing process continuity
- Current analysis tools and potential for new tools or technologies that could be used to make this practice more efficient and to maximise the use of available data
- An assessment of the current and likely needs to resource this area in relation to potential workloads
- The potential for additional sector analysis

5.3 Outline of Current Practices and Processes

Current data collection, storage and manipulation methods - GPFR data

Aggregation of GPFR data with other data

The aggregation of GPFR data with other data sources is not consistent in comparing like with like. Other data sources are used together with the GPFR data. In order to correctly combine the data a sorting process is used which involves matching the provider level reporting with the service level data and addressing areas where services have moved during the financial year.

The data sources used include:

Data extracted from National Approved Provider Systems (NAPS)

- Service association dates
- Ownership types of providers
- Location of services by ABS remoteness structure definition

Data extracted from CASPER

Data is extracted from CASPER at service level (as opposed to approved provider level). Government payments and administrative data and each of their components are extracted.

Payment Data

- ACFI &RCS payments
- Respite payments
- Other basic subsidies
- Accommodation supplements
- Other supplements
- Subsidy reduction
- Total government payments

Administrative Data

- Number of services
- Number of permanent residents
- Number of respite residents
- Number of places
- Subsidy days (or claim days)
- Resident days (or recipient days)
- Place days (or bed days)

Data extracted from Survey of Aged Care Homes (SACH)

- Charges/ DAPS
- Retentions
- Other deductions

Data extracted from SAS – sourced from multiple data sets

- Extra service fee amounts (resident level)

Data extracted from Prudential (collected under the Approved Provider Compliance Statement submission)

- Number of RADs/bonds
- Amount of RADs/bonds

Commentary on data sources and methodology

Claim, recipient and place days (occupied bed days) data are all across the financial year. Places and recipients data are as at 30 June 2015. Correspondingly, providers may have data for days but not places/recipients if the provider's services closed during the financial year. This data is shown as a point-in-time - i.e. any provider-service associations are snapshotted as at 30 June 2015 and any prior or subsequent changes are not represented.

Therefore, a senior staff member of the Financial Performance Section compares the service listing from CASPER to the services from NAPS system (which contains the dates of association of services with their current providers) and combines these lists together into a single list of services showing total government payments and service association dates. For those services that have moved the total government payments for the 12-month period are split between the two records by the number of months associated with the respective providers.

Variances between sources

StewartBrown obtained the GPFR final dataset from the Financial Performance Section (FPS) and compared the administrative data to a dataset obtained from the Aged Care Reporting Section (ACRS).

The data set obtained from the ACRT was from the 30 June 2015 snapshot and included the following:

Residential Care

Provider ID	Provider Name	State /Territory	Organisation Type	Sum of Claim Days	Sum of Recipient Days	Sum of Place Days	Operational places at 30 June 2015	Permanent residents in care at 30 June 2015	Respite residents in care at 30 June 2015

Home Care

Provider ID	Provider Name	State /Territory	Organisation Type	Sum of Claim Days	Sum of Consumer Days	Sum of Package Days	Operational packages at 30 June 2015	Consumers in care at 30 June 2015

Comparison of data in Financial Performance Section's GPFR excel spreadsheet to data obtained from Aged Care Reporting Section shows variances between the sources. The data from the Aged Care Reporting Section agrees with the data presented in the *2016 Report on the Funding and Financing of the Aged Care Industry* (*Chapter 3*). A summary of these variances is set out below:-

1) Reconciliation of Approved Providers (NAPS)

The reconciliation of Approved Providers in the table below shows that there are some differences between the data sets.

	ACRS data	FPS data
Total Approved Providers	1030	998
Approved Providers with 0 places as per ACRT data	58	26
Reported Approved Providers	972	972

The CASPER data has 1030 unique NAPS IDs for June 2015 (includes those that closed during the financial year ended 20 June 2015 - that had 0 places as at 30 June 2015). Excluding those with zero places as at 30 June 2015 results in 972 Approved Providers - this is the figure quoted in the ACFA report.

The Financial Performance data however only has 998 unique NAPs for June 2015 and if those with zero places (as per ACR data) are exclude this results in 972 as well. At first glance seems to reconcile, however, there is in fact a mismatch of four providers.

- Two NAPS IDS are included in the GPFR spreadsheet but not included in the data from ACRT
- A different two NAPs IDS are included in the ACRT data but not in the GPFR data.
- This difference is shown below

NAPS	Included in ACRT data	Included in FPT data
277	Yes	No
3431	Yes	No
2485	No	Yes
6987	No	Yes

More importantly, the number of Approved Providers with GPFR data is only 966 compared to the reported 972 providers. Therefore, there are 6 providers that did not provider GPFR data.

2) **Unexplained differences in the total number of claim days, resident days, place days as well as places and total residents**

When the totals for the administrative level data (claim days, resident days, place days, operational places and number of residents) are compared, there exist unexplained differences between the Financial Performance Section (FPS) data and the Aged Care Reporting Section (ACRS) data.

The differences are shown below, and as illustrated, result in differences in the calculated occupancy ratios.

	Total ACRS data	Total FPS data	Difference
Claim days	64,422,473	64,542,279	-119,806
Resident days	64,527,155	63,742,071	785,084
Place days	69,650,009	68,836,653	813,356
Occupancy*	92.5%	93.8%	-1.3%

** Occupancy is calculated as claim days/place days*

It is understandable that at an Approved Provider level there would be differences as the FPS undertakes work to ensure that the administrative figures are allocated and split to the relevant providers in cases where services have changed providers. However, the total amounts for the sector should still reconcile.

3) **Differences in the value of RADs and accommodation bonds**

The values of RADS and accommodation bonds as per the GPFR at both the Approved Provider level and at the total sector level are different to the values for RADS and bonds as extracted from Prudential Section. As a result, the GPFR values are ignored and the data used for reporting is the Prudential Section data.

Theoretically, however, the values should be equivalent. *This further illustrates the redundancy of the residential balance sheet residential segment information.*

Prudential collects the value of RADs and bond through the Annual Prudential Compliance Statement submission and since any missing or incorrect submissions result in compliance issues, they will be followed up by Forms Administration in the first instance or Prudential if unresolved.

In the GPFR, this is not the case with roughly 34% of providers not providing data for current bonds/RADs.

	From GPFR	From Prudential
Total Bonds/RADs of all approved providers	$14,203,187,815	$18,213,677,448

Comparison and analysis using different sources

Due to the different sources of data, it appears that often analysis is made when the data is not comparable. For example, the composition breakdown of revenue is not on a like-for-like basis. The Commonwealth funding component is based on the CASPER data (DSS Medicare payments) which are on a *cash* accounting basis. The total revenue as reported by the Approved Provider in the GPFR is on an *accrual* accounting basis.

Commonwealth funding	Source
ACFI	CASPER - DSS payment database
Respite and other supplements	CASPER - DSS payment database
Reductions & adjustments	CASPER - DSS payment database
Accommodation supplements	CASPER - DSS payment database
Resident payments	
MTCF	Equals the reductions & adjustments item above
Accommodation payments	SACH
BDF	Product of the basic daily fee of $47.10 and the number of claim days for the year ended 30 June 2015
Extra services fee	Extract from SAS - sourced from multiple data sets
Total residential service income	Sum of above items
Other income	Balancing item
Total revenue	GPFR residential segment information

Current data collection, storage and manipulation methods - Home Care Data

The Home Care financial data is collected at Aged Care Planning Region (ACPR) level for each provider and contains all the income and expenses information. This is through the Home Care Financial Report (HCFR) which all approved providers are required to submit. Forms Administration collects these and aggregates the data before sending it across to the Financial Performance Section within the Department.

Additional Home Care data is then obtained (at service level and at the total of all 4 package levels) from:-

Aged Care Reporting Section	CASPER	NAPS
Total government payments ○ Subsidy payments ○ Supplements ○ Subsidy reduction	Administrative data ○ Number of services ○ Number of clients (total of all 4 levels) ○ Number of packages ○ Subsidy days ○ Client data ○ Place days	○ Ownership type of providers ○ Location of services by ABS remoteness ○ Age Care Planning regions of all the services

The Financial Performance Section then combines the list of services from CASPER to list of services from NAPS and aggregates this with the financial data by provider at ACPR level. Differences between the reported Home Care Financial data and the government payments as per CASPER at service level are then found. The Financial Performance Section attempts to reconcile and apportion splits where necessary.

Aggregation of Home Care data with other data

There are significant cases in which the revenue that was reported for current year also contained previous year receipts. Such providers of ACPRs are flagged as outliers.

Fundamentally, the issue arises due to the different nature of the source data. The comparison is not on a like-for-like basis. The total government payments in the form of subsidy payments, supplements and subsidy reductions are on a cash basis and will have significant timing differences due to the lag in claiming. The reported government revenue as per the Approved Provider is on an accrual basis.

The Home Care Financial Report allows for items to be classified as centrally held or unallocated items. Any figures in this category are excluded from the Financial Performance Section data even though they are included in the Total Home Care Results for the Provider.

When comparing the individual provider results submitted to the Department to those received by StewartBrown this is one of the main areas of difference, as the StewartBrown data has a stronger cleansing and review process.

The actual number of providers included in the financial reporting data (435) is *lower* than the sector total number as published in the ACFA report (504). The submitted financial performance reports are reviewed by senior members in the Financial Performance Section and only those whose financial reports were submitted in a useable form are included. The rest are excluded together with their results, which also means that the financial performance of the Home care sector is not absolute in nature.

For the 2014/15 financial year, the data used consisted of 89% of all home care providers and 11% are excluded. However, there are 16 unreconciled providers when we compare the ACFA sector total to the Financial Performance Section total: -

Number of Providers	Percentage of total
435	86%
53	11%
16	3%
504	100%

Similarly, to residential care, the different data sources result in different figures and unexplained variances. The Sector Total as per ACRT was provided to StewartBrown and is based on the 2014/15 snapshot. It is expected that this would be the same as the sector total as published in the ACFA report, however there are some variances as shown in the following table.

Table 3: Comparison of Home Care data sources

	Sector Total as per ACRT	Sector Total as per FPT	Sector Total as per ACFA
Number of providers	496	435	504
Number of services	n/a	n/a	2,292
Number of packages	72,247	60,796	72,702
Claim days	20,829,744	17,376,512	20,883,073
Package days	24,289,153	20,370,804	24,686,497
Occupancy	85.8%	85.3%	85.8%

Occupancy is measured as the total number of days a package was actually being used by a consumer (occupied place) as a proportion of the number of days a package was available to be offered to a consumer by a provider (available/operational place). It is calculated as claim days divided by package days.

In addition, although there may be 435 providers, at the service level a number of services may have been excluded by the FPT for a number of reasons which are not always clearly identified.

For example, NAPS 5826 has total packages of 669 as per the Financial Performance Section data but has 1899 as per the Aged Care Reporting Section data. This is due to some ACPR services being excluded.

Table 4: Example of how the provider total may exclude some ACPR services in the Financial Data

		ACRS	FPS
NAPS5826	ACT	134	0
NAPS5826	NSW	689	0
NAPS5826	QLD	344	0
NAPS5826	SA	63	0
NAPS5826	TAS	43	43
NAPS5826	VIC	88	88
NAPS5826	WA	538	538
NAPS5826	**Provider total**	**1,899**	**669**

These differences are further highlighted by a comparison of the revenue by planning region as per the Home Care Financial Report and that as disclosed by the FPT data extraction which is the source used for the ACFA report.

The planning region Western Sydney, highlighted in **orange** in the following table, is the only one that is included in the Home Care data tables for the ACFA report.

Table 5: Comparison of revenue as per Home Care Financial Report and as included in ACFA report

Planning region	Total revenue as per HCFR	Total revenue as per FPT data
ACT	3,988,459	0
Brisbane South	392,976	0
Eastern Metro	1,153,264	0
Logan River Valley	2,229,538	0
Metro East	631,332	0
Metro South East	13,438,221	0
Mid North Coast	1,035,696	0
North western	272,288	0
Southern	570,953	0
Sunshine Coast	1,981,061	0
Western Sydney	14,037,807	14,037,807
Total	**39,731,603**	**14,037,807**

Differences between StewartBrown data and Department data

Calculation of Occupancy Ratios

The occupancy rate is defined as the number of days of claims as a proportion of operational place days. Occupancy is calculated to include both permanent and respite residents.

The place days (occupied bed days) data are reliant on the number of operational places the provider has and the duration of time for which they were operational, as recorded in NAPS. Data may be impacted by the promptness with which providers inform the Department of the operationalization of their places. Given that some providers do not notify the Department of the decision to take beds offline due to redevelopment or other strategic decisions, this results in the number of available places as stated by the Department being higher than the actual number of available places in the industry.

In contrast, the StewartBrown survey asks participants for the *actual* available number of places and as a result there are differences between the StewartBrown occupancy rate and the occupancy rate as determined by the Department. The occupancy rate as determined by the Department will be lower due to the higher number of place days.

Example

A provider has 120 operational places which is 43,800 operational place days for the year to 30 June 2015. This is the data the Department has for the number of place days for this provider. However due to refurbishment of one wing only 100 places (36,500 place days) were actually available to residents during the year to 30 June 2015. This is the figure that is obtained in the StewartBrown ACFPS. The number of claim days is 35,770 and both the Department and StewartBrown have this information. The occupancy ratio will differ due to the difference in operational place days - 98.0% as per StewartBrown calculation and 81.7% as per the Department calculation.

Calculation of EBITDA

The calculation of EBITDA differs between the StewartBrown approach and the Department's approach. Interest/Investment income is *excluded* from the StewartBrown calculation of EBITDA. However, under the Department's method, EBITDA is calculated by starting with net profit before tax and adding back in interest expense, depreciation and amortisation. Using this calculation, earnings includes any additional income from investments or secondary operations as well as one-time payments for the sale of assets.

Another consideration is that the StewartBrown survey focuses on **Facility EBITDA**. This is based on the operational profit of the facility (or if aggregated the sum of all facilities) plus the adjustment for interest expense and depreciations allocated at a facility level.

This excludes "provider level" revenue and expenses such as:

Provider level Revenue items

- Interest Income
- Trust distributions
- Donations and contributions
- Non-operating interest
- Capital grants
- Profit on sale of assets
- Revaluation increase
- Insurance claims
- Other non-operating revenue

Provider level Expense items

- Interest expense
- One off expenses
- Loss on sale of assets
- Revaluation decrement
- Contribution/Expense from external entity (parent)

This means that the EBITDA as per the Department's calculation should be interpreted carefully. It is not the EBITDA as a result of residential aged care operations but rather EBITDA related to both residential aged care operations and other provider level operations such as investment income, donations and contributions, etc.

An example of how a provider's results may differ is illustrated in the following table.

Table 6: Example of difference between facility results and provider result

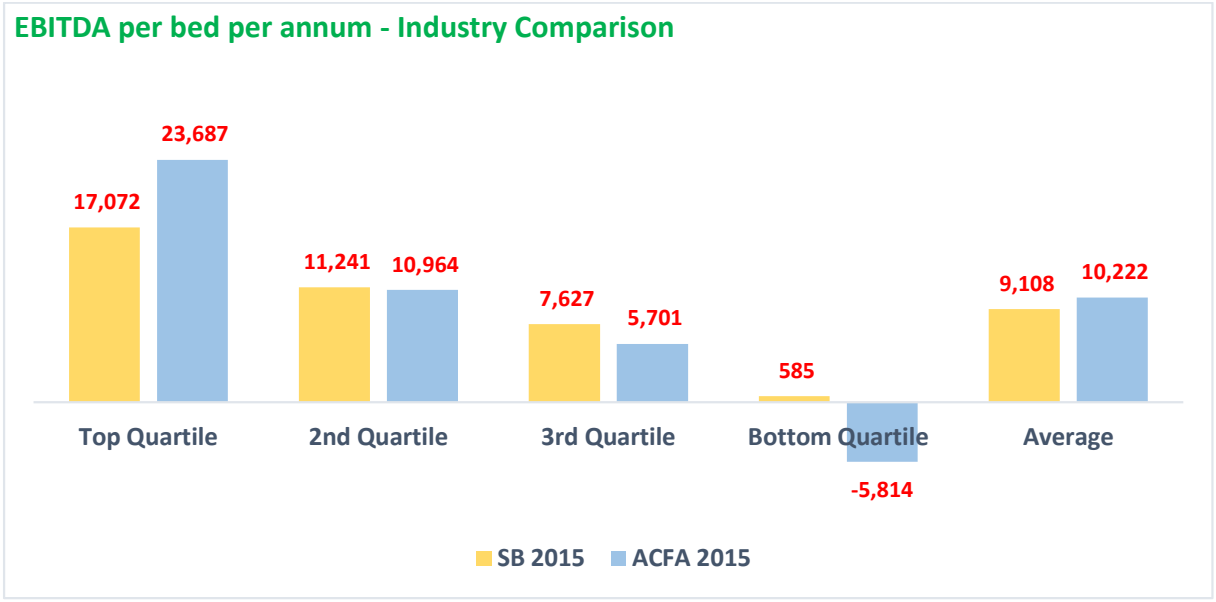
	Total	Provider level items	Total less provider level items*
	$	$	$
Revenue	116,194,000	2,435,000	113,759,000
Facility expenses	107,532,000	632,000	106,900,000
Facility result	8,662,000	1,803,000	6,859,000
EBITDA (excluding investment income)	15,125,000	420,000	14,705,000
Provider EBITDA including investment income	16,525,000	n/a	n/a

**This is the implied aggregated facility level data*

Calculation of Quartiles

Quartiles are stratified by Facility Care Result in the StewartBrown survey. However, they are stratified by Approved Provider EBITDA by the Department. This together with the differences in the EBITDA calculation results in the differences as illustrated in the following figure. The ACFA results have a greater range than the StewartBrown results.

Figure 6: Comparison of June 2015 ACFA EBITDA Quartiles with StewartBrown ACFPS EBITDA Quartiles



Calculation of Profile by Location

With the Department analysis, the providers are also classified by location using a 70:30 ratio of "Financials given" subsidy days in City and Regional areas. For example, if 70% or more subsidy days are recorded in the city (metropolitan) area, then the provider will be classified as City based provider.

However, the location of the facilities in the StewartBrown ACFPS is based on the actual physical location of each respective facility, thereby the profile by location will be more accurate.

When comparing the performance of metro and regional areas, this difference in methodology could understate the performance of metro areas or overstate the performance of regional areas.

Documentation of the current practices and processes

The documentation of the current practices and processes is limited and as a result the knowledge is restricted to the staff members performing the tasks. Thus, there exists a risk that the specific knowledge could be lost if the staff member/s were to leave the Department. Of equal importance, it means that the methodology adopted is not subject to review, amendment or quality assurance.

The existing GPFR process documentation obtained by StewartBrown comprises of two word documents around the residential aged care data methodology and home care data methodology which outline the general approach taken in creating these data sets. There are no step-by-step instructions, reference to documents, allocation of responsibilities nor internal review procedures included.

Current benchmark tools and potential for new tools or technologies

Due to the limited relevance and usefulness of the Department Benchmark (in terms of the quantum and quality of data, timing of reporting and number of participants), it is recommended that the Department Benchmark service be discontinued.

The reporting and trend tools available on the Department Benchmark site are basic in nature. As a result, any further analysis and recommendations relating to enhancing the tools and technologies of the Department Benchmark have not been considered.

Resourcing

The majority of the work in relation to financial performance (GPFR analysis and reporting) is reliant on two key members of the team. Much of their function revolves around the reviewing of data submitted to Forms Administration by providers and making decisions as to the treatment of material outliers in this data.

It is rare that clarifications or confirmation of specific data that is regarded as being an outlier is referred back to the provider. This essentially means that any adjustments made are on the basis of a “value judgement” and no review of those judgements is made. This is a major internal control and process deficiency.

It is our opinion that the current functions performed by the Financial Performance Section in this regard are not appropriate and duplicate the reviewing and checking processes performed by Forms Administration.

We have recommended in this report that the Department have one data collection point (Aged Care Reporting Section) which would reduce this requirement in both the Financial Analysis & Reporting Section and Prudential Risk and Compliance Section.

This change in the data collection and reviewing process would then allow the Financial Analysis & Reporting Section to focus specifically on analytical reviews and trend analysis, which are more appropriate and relevant.

Potential for additional sector analysis

There is always potential for additional sector analysis. This will be (and should be) constrained by the relevant purpose and purview of the Department in relation to ROACA and ACFA reporting.

With this in mind there are still potential areas for further data analysis. These have been discussed earlier in this report (refer to ***Chapter 4*** in relation to the commentary on ACFA report content).

It is recommended that additional sector and approved provider analysis conducted by the Financial Performance Section additionally focuses on risk assessment and that they work closely with Prudential in relation to advising on potential financial viability and compliance issues.

5.4 Key Findings

- The Department analytical functionality needs to be enhanced - more efficiency in data preparation in order to allow for improved data analysis and a focus on understanding trends and movements. An experienced business analyst with aged care background could assist with this, however we consider that an enhancement of certain specific skills within the current staffing would also suffice
- Weaknesses exist in the documenting of protocols and procedures relating to the collection, collation, analysis and reporting of the Department information
- Data collected needs to be verified, reviewed, cleansed and maintained in one Department database
- The data analysis functions currently in operation are cumbersome, inadequately documented and limited in analysis
- The data software and technology needs to be upgraded and enriched
- Data analytics performed have flaws in relation to the accuracy and relevance

5.5 Recommendations

5.5.1 A central data warehouse be established that is responsible for the ACFR and GPFR data inputs. Financial Performance is then able to extract data from this data warehouse for analysis purposes

5.5.2 Data is collected, cleansed and maintained by Aged Care Reporting Section

5.5.3 The Department consider the method of comparison of different data sources

5.5.4 Data is to be collected from one source for trend analysis (i.e. reliance on ACFR for Income and Expenditure only rather than subsidy information from DHS).

5.5.5 The Department increase the use of contemporary analysis tools and software (such as Excel TCM; XLSTAT)

5.5.6 Additional resources and utilisation of analytics staff is required

5.5.7 Any additional sector analysis conducted by the Financial Performance Section concentrates on risk and that they work closely with the Prudential Risk and Compliance Section to reduce duplication of analysis and assessment and improve the efficiency and effectiveness of the work performed

5.5.8 Full documentation of processes, functionality and outputs is required

6. Administrative Impacts of Regulation/Compliance

6.1 Scope

Consider the practical impact and costs associated with regulation and compliance monitoring activities conducted within the branch. Consider if there are opportunities to design better policy outcomes with respect to sector administrative activities/overheads.

6.2 Methodology and Approach

The methodology and approach for this part of the review is similar to that for above Chapters. It involved a combination of interviews and desktop reviews of documentation.

In particular, in these interviews StewartBrown considered:

- Policy development
- Compliance practices and monitoring activities
- Statistics on compliance activity carried out by the Department and its agencies
- Any data supplied by providers in relation to the time taken to provide data for the purpose of compliance activities

StewartBrown has examined the cost of regulation and compliance monitoring from a number of viewpoints:

- Internal Departmental activity - what is being monitored and how is that process being achieved?
- The point of view of the aged care provider - what additional data is required by the Department that is not normally collected as part of normal business practices? StewartBrown used its own experiences with assisting clients in this regard
- Policy development practices - how does the Department assess the potential administrative burden on providers when developing policy and compliance practices?

Based on the information collected, we reported on the following:

- An assessment of the cost of compliance from the points of view of the Department and service providers
- Observations about current and planned compliance processes and recommendations where we believe these could be more efficient or streamlined or indeed better targeted
- Observations and recommendations in relation of the way the Department assesses the potential cost or saving in regards to the administrative burden of service providers when developing policy and compliance practices.

6.3 Outline of Current Practices and Processes

Department Compliance Activities

The Scope of the Peer Review was directed on the Department's data collection and reporting activities with specific reference to the Financial Analysis & Reporting Section and secondary reference to the ACFA Secretariat Section and Aged Care Reporting Section.

The brief additionally involved an assessment of the financial analysis and reporting functionality of the Prudential Risk and Compliance Section.

Accordingly, much of the review and analysis of the current practices and processes of these Sections are contained in the relevant specific areas within this report (***Chapters 3 to 6***).

Financial Performance

A major focus on the Financial Performance Section relates to the data collection from approved providers that form part of the financial reporting for ACFA and ROACA. Data is sourced from various sources, with the major data source being from Forms Administration who are contracted to receive and process financial information from approved providers, with this largely being from GPFR's.

As noted previously in this report, the data collection is from several disparate sources, and whilst there is a review process of this data, this review is performed in isolation (being no comparison is made of the data from different sources to ensure completeness and accuracy). The Financial Performance Section is also responsible for the analysis and reporting in relation to current projects and ad-hoc requests, and this often involves the use of existing data collected or the sourcing of appropriate data from other internal sources.

From a value perspective, it is our opinion that the Financial Performance Section has too much time resource allocated to reviewing data collected (with duplication of this process) and a more productive utilisation should be directed to the analysis of the data, including incorporation of the prudential financial analysis. Much of the time resource is dedicated to the year-end analysis of the GPFR supplied by the approved providers and Forms Administration, and this only peaks over several months.

On the basis of our review, it is our opinion that the FP team has sufficient additional capacity within its current staffing FTE's to perform the revised functions and meet the timeline requirements.

In relation to compliance, there is little opportunity for the Financial Analysis & Reporting Section to have influence in this regard at the present time. Their reviews of the residential segment reporting taken directly from GPFR, the Survey of Aged Care Homes, Statement of Income and Expenses by Home Care Service and certain data provided from SAS and Prudential are all confined to reasonableness and identifying any outlier data. No specific analysis of the financial information obtained is provided in a formal sense unless specifically requested by other Branches or Sections.

Prudential Risk and Compliance

The Prudential Risk and Compliance Section also receives GPFR data directly via Forms Administration. A separate review of the GPFR's is also conducted and the risk profile matrix attached to each approved provider. Given the lack of visibility that the current process has over non-residential aged care activities and related financial exposure of approved providers, this review is limited in scope and more likely to be reactive rather than being proactive which is the more preferable approach.

We have **recommended** that the financial analysis of approved providers be transferred to be under the purview of the Financial Analysis & Reporting Section. This would then mean that the Prudential Risk and Compliance Section is primarily focused on compliance, which will involve analysis provided from the Financial Performance Section and from direct contact with approved providers.

Aged Care Reporting

This report includes our clear recommendation that the Aged Care Reporting Section be the recipient of all financial and certain non-financial data relational to the aged care sector. The Aged Care Reporting would be tasked with ensuring the accuracy, timeliness and cleansing of the data collection and managing the data in Data Warehouse so that the users of the data can receive it in a consistent and useable form to allow the appropriate analysis as required.

Outcomes

It is our opinion that the changes to the structure as summarised below would be at worst cost neutral and potentially cost positive. Significantly, it will improve the data collection process and subsequent analysis activities which will enhance both internal reporting, compliance activities and reporting back to the sector.

In summary, we **recommend** the following:

- The consolidation of the financial data collection to be with the Aged Care Reporting Section
- The transfer of the financial analysis and risk assessment from Prudential to the Financial Analysis & Reporting Section within the Financial Performance team under the Funding Policy Branch
- The restructure of resources and processes within the Financial Analysis & Reporting Section to cease the review and checking of data collection (and related activities as detailed in ***Chapters 3 and 5*** of this report) and enhance the analytical functionality

There will also be a significant cost saving by discontinuing the Department Benchmark service.

Provider Compliance Costs

There has been a steady increase in the provider administration and compliance costs since 2011. Whilst it is difficult to separate the cost of compliance from the overall administration and support costs, the below table shows the $ cost and *accumulated* percentage increase for residential aged care providers in this period. As a comparison, we have also included the relative costs for the other Everyday Living Expenses (catering/cleaning/laundry/utilities) for the same period.

The figures are expressed in $ per bed day terms and in $ per bed per annum terms, and are sourced from the StewartBrown *ACFPS*.

Table 7: Accumulated cost comparison for Administration/Support services and Every Day Living

Year	Administration/Support			Every Day Living		
	$ per bed day	$ per bed pa	% increase	$ per bed day	$ per bed pa	% increase
2011	24.64	8,994		36.58	13,352	
2012	26.38	9,629	7.06%	38.07	13,896	4.07%
2013	27.41	10,005	11.24%	40.92	14,936	11.86%
2014	27.64	10,088	12.16%	42.81	15,626	17.03%
2015	33.71	12,304	36.80%	42.84	15,636	17.11%
2016	34.06	12,432	38.23%	43.93	16,034	20.09%
December 2016	35.17	12,837	**42.73%**	44.94	16,403	**22.85%**
CPI % (2011 - Dec 2016)			*10.88%*			*10.88%*

Aged Care Financial Report

Existing Reporting Framework

The *Aged Care Act 1997* requires approved providers to submit annually:

- Survey of Aged Care Homes *(unaudited)*
- Home Care Financial Reporting *(unaudited)*
- General Purpose Financial Report *(audited)*
- Annual Prudential Compliance Statement *(audited)*

New Reporting Framework

For 2017 fiscal year, a new reporting framework commences:

Objectives:

- ✓ Reduce the complexity of reporting arrangements
- ✓ Improve consistency and quality of data collected
- ✓ Improve the analysis of financial data collected
- ✓ Streamline reporting to be submitted

Outputs:

New reporting framework includes:

- General Purpose Financial Report *(audited)*
- Aged Care Financial Report (ACFR)
  - Statement of Income & Expenses *(by residential segment)*
  - Statement of Income & Expenses *(by home care service)*
  - Statement of Financial Position *(residential segment)*
  - Statutory Reports *(Approved Provider)*
  - Prudential Reporting *(Approved Provider)*
  - Building Activity by Residential Aged Care Service

Commentary

General Purpose Financial Report and Aged Care Financial Report

The ACFR has *4 tabs* relational to Approved Provider GPFR:

- Statement of Income and Expenses
- Statement of Financial Position
- Cash Flow Statement
- Notes

The ACFR is not required to be completed for Approved Provider tabs if GPFR is submitted and the mandated lines ***are included*** in the GPFR

The ACFR defined reporting (tabs) that relate to the GPFR should not create much additional burden to providers on the assumption that the GPFR includes all mandated lines as required by the ACFR. If this is not the case, then the approved provider will be required to complete the respective portal input for the ACFR which will be additional to the current practice.

There will be no process benefit for either Forms Administration or the Financial Analysis & Reporting Section as the GPFR's will still require to be reviewed to ensure compliance and inclusion of all mandated lines. We expect that this will, in reality, create additional (but necessary) cost to the Department.

Statement of Income & Expenses (residential segment)
There will be a clear benefit to the Department in relation to the consistency of data obtained through having specific data definitions. The data input required is an abbreviated form of the data submitted by providers to the StewartBrown *ACFPS*, so participants in the *ACFPS* will have no issue in completing this input.

For other providers (being approximately 70% in number), however, there will be an additional compliance cost to perform this input, including mapping of their chart of accounts to match the ACFR input and increased account dissections required.

As this input is at consolidated level (not by individual facility) it will not provide any benchmark or comparison functionality for providers, so the benefits will be to identify on an "absolute" basis the respective components of residential income and expenses and perform historical trend analysis on that basis.

We **recommend** the exclusion of all components of non-operating revenue and expense items (interest/investments/donations/revaluations) when reporting on the financial performance of residential aged care. The non-operating items can be separately reported for certain trend analysis.

Statement of Income & Expenses (home care service)
The ACFR includes exactly the same reporting requirements as previously, and accordingly there is no additional burden to providers.

Unlike the residential segment income and expenditure which is at consolidated level, the home care reporting is at service level input. Increasingly, home care providers report internally by geographic location rather than by service level so there will be inconsistency in data input, or it will require additional cost and effort for providers.

We **recommend** that the Statement of Income & Expenses by Home Care be required at consolidated level rather than service level. We are unaware of the specific benefits that the Department would obtain by continuing to receive this input at service level.

Statement of Financial Position (residential segment)
We **recommend** that this reporting obligation be ceased. As discussed in ***Chapters 3 to 5***, approved providers do not segment their balance sheet as it serves no specific purpose in managing their operational activities. Many providers have shared assets (including property assets) which results in determining the residential component being based on arbitrary allocation.

Similarly, cash and liquid assets are not quarantined by segment, and we note that the ACFR does not require this disclosure as it is (seemingly) grouped in the line item "Other current assets" which, in reality, will be purely the balancing item for the residential balance sheet. Any financial analysis based on the residential balance sheet data is incomplete, inaccurate and misleading.

Annual Prudential Compliance Statement
We have made reference to the APCS requirements and functionality in ***Chapter 6***.

Building Activity by Residential Aged Care Service
We have made no specific comment on this report other than we recommend the Department seek provider input as to the value of providing this information in its current format.

6.4 Key Findings

- Financial Performance Section has too much focus on reviewing and checking data as provided by Forms Administration. There is a duplication and overlap of the data integrity checking already performed by Forms Administration. FPS should primarily focus on the analytical review not the data integrity
- Forms Administration increase their scope to include identifying data outliers and seeking clarification from providers as required
- Financial data is captured from a variety of sources but there is no consistent process for reviewing the accuracy and quality of the data
- The Aged Care Reporting Section is responsible for some, but not all, of the financial data collection
- There is no specific financial analysis performed on the financial information provided to the ACFA Secretariat for inclusion in the ACFA reporting
- The financial analysis performed by the Prudential Risk and Compliance Section is performed in isolation to that performed by the Financial Performance Section
- The Department compliance activities (and associated costs) need to be reviewed with greater focus on analytical review
- Provider administration and support costs are increasing at unsustainable levels concluding ensuring both clinical and financial compliance
- The Aged Care Financial Report will improve the quality and consistency of data obtained, but will likely increase the provider cost in preparing and submitting the ACFR
- The Aged Care Financial Report includes some non-essential data input, especially in regards to the residential segment balance sheet and the income and expenses by home care service level

6.5 Recommendations

A summary of our recommendations relation to the Administrative Impacts of Regulation/Compliance are:

6.5.1 The Aged Care Reporting Section be responsible for the receiving, cleansing and checking of all financial and related non-financial data received by the Department

6.5.2 Transfer the financial analysis and risk assessment from Prudential and Risk Compliance Section to Financial Analysis & Reporting Section

6.5.3 Financial Analysis & Reporting Section redesign processes to have greater focus on analytical functionality

6.5.4 Financial Analysis & Reporting Section to realign staffing resources to reduce the requirement for checking and input of financial data received and increase the requirement for analytical skills

6.5.5 Aged Care Financial Report to remove the Statement of Financial Position (residential segment) data input requirement

6.5.6 Aged Care Financial Report to be amended to require the Statement of Income & Expenses by Home Care Service to be at consolidated level only

Appendix A - Glossary

The following table sets out the definitions for a number of acronyms used throughout this report.

Acronym	Term
AACG	Ageing and Aged Care Group
ACFA	Aged Care Financing Authority
ACFI	Aged Care Funding Instrument
ACFPS	Aged Care Financial Performance Survey
ACFR	Aged Care Financial Report
ACPB	Aged Care Policy Branch
ACRS	Aged Care Reporting Section
APCS	Annual Prudential Compliance Statement
BOND	Accommodation Bond
CASPER	Department's CASPER database
DAP	Daily Accommodation Payment
DHS	Department of Human Services
DSS	Department of Social Services
EBITDA	Earnings before interest, tax, depreciation and amortisation
EY	Ernst & Young
FPS	Financial Performance Section
GPFR	General Purpose Financial Report
HCFR	Home Care Financial Report
HCP	Home Care Package
ICT	Information and communication technologies
IMS	Investment Management Strategy
NAPS	National Approved Provider Systems
PRCS	Prudential Risk and Compliance Section
RAD	Refundable Accommodation Deposit
RCS	Resident Classification Scale
RESIDENTIAL	Residential Aged Care
ROACA	Report on the Operation of the Aged Care Act
SACH	Survey of Aged Care Homes
SAS	SAS analytics software & solutions
SES	Senior Executive Service

Appendix B - Tables

Table B1: Line item analysis for revenue and expense components in the GPFR

Line item	$ Value	Number of providers *with* line item data	Number of providers *without* line item data	% not provided
Revenue components				
Government Subsidies	9,041,029,367	828	138	14%
State Grants/ Subsidies	82,815,578	45	921	95%
Resident Client Charges	3,375,293,514	823	143	15%
Provision of Services	744,469,095	75	891	92%
Bond Retentions	94,469,381	428	538	56%
Interest Income	262,446,466	685	281	29%
Trust Distributions	17,213,046	33	933	97%
Donations & Contributions	33,337,883	305	661	68%
Other Operating Revenue	1,909,447,117	734	232	24%
Non-Operating Interest	21,231,440	59	907	94%
Capital Grants	25,433,588	62	904	94%
Profit on Sale of Assets	55,391,721	56	910	94%
Revaluation Increase	58,652,667	33	933	97%
Insurance Claims	1,261,188	69	897	93%
Other Non-Operating Revenue	87,593,958	312	654	68%
Total Revenue	**15,810,086,007**	**966**	**0**	**0%**
Expense components				
Wages & Super Care	2,837,646,330	324	642	66%
Wages & Super Admin	130,676,844	177	789	82%
Wages & Super Other	6,697,475,377	920	46	5%
Management Fees	331,750,938	172	794	82%
Depreciation & Amortisation	728,379,377	919	47	5%
Interest	140,347,715	591	375	39%
One Off Expenses	2,522,057	9	957	99%
Staff Overheads (excluding super)	226,105,244	401	565	58%
Building Repairs & Maintenance	197,575,692	497	469	49%
Insurance	36,293,128	369	597	62%
Workers Compensation	18,984,698	126	840	87%
Motor Vehicle	5,154,723	251	715	74%
Building Rent	217,549,662	186	780	81%
Other Rent	1,268,228	55	911	94%
Lease	3,160,073	20	946	98%
Utilities	123,250,786	483	483	50%
Loss on Sale	3,074,839	120	846	88%
Revaluation Decrement	20,428,032	22	944	98%
Contrib/Exp from External Entity (Parent)	15,505,738	9	957	99%
Other Expenses	3,165,932,943	960	6	1%
Total Expenses	**14,903,082,425**	**966**	**0**	**0%**

Table B2: Line item analysis for asset and liability components in the GPFR

Line item	$ Value	Number of providers *with* line item data	Number of providers *without* line item data	% not provided
Asset components				
Cash	3,593,016,677	680	286	30%
Liquid Assets (non-cash)	602,155,593	78	888	92%
Trade Receivables	491,633,704	410	556	58%
Other Receivables	235,555,329	499	467	48%
Accommodation Bonds Receivables	201,545,106	86	880	91%
Related Party Loans Receivable	1,619,469,962	141	825	85%
Inventory	4,692,795	95	871	90%
Other Current Assets	3,572,120,715	757	209	22%
Total Current Assets	10,320,189,882	952	14	1%
Loans	78,854,913	11	955	99%
Related Party Loans	1,655,088,100	141	825	85%
Property, Plant & Equipment	10,674,157,130	697	269	28%
Financial Assets / Investments	975,399,079	94	872	90%
Intangibles	3,186,877,602	360	606	63%
Other Non-Current Assets	9,695,843,502	433	533	55%
Total Non-Current Assets	26,266,220,326	956	10	1%
TOTAL ASSETS	**36,586,410,208**	**963**	**3**	**0%**
Liability components				
Short Term Borrowings	360,833,228	198	768	80%
Short Term Related Party Loans	1,037,248,243	169	797	83%
Trade Payables	244,580,850	461	505	52%
Employee Provisions	617,525,883	627	339	35%
Accommodation Bonds (RADs)	12,563,959,113	638	328	34%
Other Current Liabilities	6,602,137,859	899	67	7%
Total Current Liabilities	21,426,285,176	957	9	1%
Long Term Borrowings	812,136,349	167	799	83%
Long Term Related Party Loans	395,064,927	77	889	92%
Employee Provisions	111,566,499	522	444	46%
Accommodation Bonds (RADs)	1,639,228,702	120	846	88%
Other Non-Current Liabilities	1,301,219,810	352	614	64%
Total Non-Current Liabilities	4,259,216,287	843	123	13%
TOTAL LIABILITIES	25,685,501,463	957	9	1%
NET ASSETS	**10,900,908,745**	**960**	**6**	**1%**

Table B3: Residential Aged Care December Approved Providers compared to total Approved Providers for the 2015 year

	December APs Total	All APs Total	December APs as a % of total AP
Operational data			
Providers	*8*	*966*	*0.8%*
Subsidy days	4,101,550	63,404,343	6.5%
Resident days	4,110,125	62,790,911	6.5%
Bed days	4,444,185	67,774,012	6.6%
Occupancy	92.3%	93.6%	
Profit and Loss			
Government Subsidies	383,728,727	9,041,029,367	4.2%
Resident Client Charges	107,496,794	3,375,293,514	3.2%
Bond Retentions	333,797	94,469,381	0.4%
Other operating income	588,356,934	2,736,731,790	21.5%
Facility revenue	1,079,916,252	15,247,524,051	7.1%
Interest Income	26,548,675	262,446,466	10.1%
Other non-operating income	150,866	300,115,490	0.1%
Provider revenue	26,699,541	562,561,956	4.7%
Total revenue	1,106,615,793	15,810,086,007	7.0%
Employee expenses***	724,865,600	9,997,549,489	7.3%
Depreciation	27,710,981	728,379,377	3.8%
Other operating expenses	290,409,659	3,995,275,178	7.3%
Facility expenses	1,042,986,240	14,721,204,044	7.1%
Interest expenses	13,208,280	140,347,715	9.4%
Other non-operating expenses	650,000	41,530,666	1.6%
Provider expenses	13,858,280	181,878,381	7.6%
Total expenses	1,056,844,520	14,903,082,425	7.1%
Net result	49,771,272	907,003,583	5.5%
EBITDA	90,690,533	1,775,730,674	5.1%
EBITDA SB Calculation*	64,141,859	1,513,284,208	4.2%
Facility EBITDA	64,640,993	992,252,919	6.5%
Segment Balance sheet			
Cash	51,328,387	3,593,016,677	1.4%
Liquid Assets (non-cash)	-	602,155,593	0.0%
Other current assets	1,134,030,131	6,125,017,612	18.5%
Total Current Assets	1,185,358,518	10,320,189,882	11.5%
Property, Plant & Equipment	66,669,706	10,674,157,130	0.6%
Financial Assets / Investments	-	975,399,079	0.0%
Intangibles	252,216,447	3,186,877,602	7.9%
Other non-current assets	911,171,213	11,429,786,515	8.0%
Total non-current assets	1,230,057,367	26,266,220,326	4.7%
TOTAL ASSETS	2,415,415,884	36,586,410,208	6.6%
Short Term Borrowings	4,500,000	360,833,228	1.2%
Accommodation Bonds (RADs) **	671,791,256	12,563,959,113	5.3%
Other current liabilities	1,225,431,603	8,501,492,835	14.4%
Total current liabilities	1,901,722,859	21,426,285,176	8.9%
Long Term Borrowings	-	812,136,349	0.0%
Accommodation Bonds (RADs) **	-	1,639,228,702	0.0%
Other non-current liabilities	269,545,620	1,807,851,236	14.9%
Total non-current liabilities	269,545,620	4,259,216,287	6.3%
TOTAL LIABILITIES	2,171,268,479	25,685,501,463	8.5%
NET ASSETS	**244,147,405**	**10,900,908,745**	**2.2%**
Bonds/RADs held (per Prudential Compliance Statement) **	1,014,611,502	18,213,677,448	5.6%

Table B4: Comparison of key ratios including and excluding the December Residential Aged Care December Approved Providers for the 2015 year

Ratios/ Analysis	All APs Total	All APs less December Total	Difference
EBITDA margin	11.2%	11.5%	(0.2%)
NPBT margin	5.7%	5.8%	(0.1%)
Average profit (EBITDA) per consumer ($) per annum	10,222	10,371	(149)
NPBT per resident per annum	5,221	5,276	(55)
Interest coverage	12.65	13.25	(0.60)
Average return on equity	16.3%	15.8%	0.5%
Average return on assets	4.9%	4.9%	(0.1%)
Average debt ratio	70.2%	68.8%	1.4%
Current ratio	0.48	0.47	0.01
% EBITDA to total assets	4.9%	4.9%	(0.1%)
% EBITDA to equity	16.3%	15.8%	0.5%
Accommodation deposits as % of total assets	50%	50%	(0.5%)
Other liabilities as % of total assets	20%	18%	1.9%
Net worth/ equity as % of total assets	30%	31%	(1.4%)
Per resident per day ($)			
Care subsidies & supplements	151.41	149.86	1.55
Accommodation supplements	13.05	13.08	(0.03)
MTCF	5.89	5.82	0.07
Accommodation payments	10.74	10.96	(0.23)
BDF	47.10	47.10	-
Extra services fee	2.89	2.74	0.15
Total residential service income	231.08	229.56	1.52
Other income	18.28	18.38	(0.10)
Total revenue	249.35	247.94	1.41

Table B5: Comparison of StewartBrown and Department Benchmarks

	StewartBrown	Department	Notes
Revenue and expenses			
Regularity	Quarterly	Annual	
Segments	Residential Home Care (HCP)	Residential	
Timing of issue	Two months after quarter end	6 months after December year-end (12 months after June year-end)	
Data source	Survey form submission with granular Facility/HCP level data. Strict data definitions	GPFR submission with residential segment level data. No strict data definitions	
Data fields and usage	Expanded - revenue is split into Care and Accommodation and expenses include labour, catering, cleaning, laundry, utilities and support	Limited - focus is on splitting revenue into government and resident sources, expenses include wages, depreciation, interest expense and other expenses	Refer to ***Appendix B*** Table D1 and D2 for format of *ACFPS* Refer to Table C1 for list of GPFR revenue and expense line items
Balance Sheet			
Regularity	Bi-annual	Annual	
Timing of issue	Two months after bi-annual end	6 months after December year-end (12 months after June year-end)	
Data source	Survey form submission at provider level data and cross referenced to GPFR	GPFR submission with residential segment level data	
Data fields and usage	Expanded - includes AP level balance sheet data and supporting schedules. Strict data definitions	Limited - extracted from residential segment note. No strict data definitions	Refer to ***Appendix D*** Table D3 for format of ACFPS Refer to Table C2 for list of GPFR balance sheet line items
Data processing			
Data cleansing	In-house	Forms Administration	
Data quality checks prior to data entry/processing	Strict variance control - all unusual items or variances referred back to provider	Financial Performance Section - will only make obvious amendments	
Data analytics	Other non-operating revenue and expenses (at Facility/HCP level) is not used in determining the Facility EBITDA	Other non-operating revenue and expenses (at approved provider level) is used in determining EBITDA	
EBITDA	Interest/Investment income is not used in determining EBITDA	Interest/Investment income is used in determining EBITDA	
Non-Financial Data	Staff hours (by category) per resident day. Accommodation pricing analytics	None included	

APPENDIX D

StewartBrown

Integrity + Quality + Clarity

Australian Government

Department of Health

Managing Prudential Risk in Residential Aged Care

Submission *(March 2019)*

APPENDIX D

CONTENTS

1. Executive Summary

1.1 Managing Prudential Risk in Residential Aged Care

In February 2019, The Australian Department of Health (the Department) released the discussion paper "*Managing Prudential Risk in Residential Aged Care"* in consultation with the residential aged care sector and the broader community on the issue of managing prudential risk in residential aged care.

The existing framework in place under the *Aged Care Act 1997* (*the Act*) supports this objective however two recent reviews have recommended that the prudential framework be strengthened (*Ernst and Young* and the *Tune Review*).

The Department has invited submissions from all interested stakeholders to gather the sector's views on the options for better managing prudential risk in residential aged care.

1.2 StewartBrown Chartered Accountants

StewartBrown is a Chartered Accounting firm located in Chatswood, Sydney with an Adelaide branch office. The firm currently consists of 6 Partners and over 70 employees providing services including Audit, Consulting, Business Services, Taxation and Financial Planning. StewartBrown provides these professional services nationally to a range of clients, however, we have a speciality expertise in aged care and community services, social services, independent schools, children's services and disability services.

With respect to aged care and community services, StewartBrown have more than 35 professional staff actively providing significant professional services to the sector nationally including: -

- Audit and assurance
- Preparation of General Purpose Financial Reports
- Annual Prudential Compliance Statement audits
- Community Acquittals
- Governance reviews (including Board and Executive)
- Finance systems and process reviews
- Financial modelling and forecast assignments
- Secondments
- Conference presentations and sector workshops
- Briefings to Department of Health and the Aged Care Financing Authority
- Aged Care Financial Performance Survey *(2018: 192 providers comprising 974 residential facilities; 512 community programmes incorporating 24,952 HCP packages)*

1.3 Background

Prudential Risk

As noted in the Department discussion paper, residential providers currently hold in excess of $25 billion of refundable accommodation payments (RADs and Accommodation Bonds) and there has been a significant increase since the July 2014 when the new accommodation payments structure was introduced. The amount of RADs held are projected to increase to $36 billion by 2025.

In 2016 at the request of the Minister for Health, Aged Care and Sport the Aged Care Financing Authority (ACFA) prepared a report *"The Protection of Residential Aged Care Lump Sum Accommodation Payments"* to examine the existing Accommodation Payment Guarantee Scheme (Bond Guarantee Scheme) and any potential alternatives.

This report considered a range of alternate options and concluded, in principle, that the continuation of the existing Bond Guarantee Scheme is a viable option, and the Scheme's beneficiaries should contribute to the cost of the guarantee.

In May 2018 after consideration of the Tune Review, the Government announced as part of the Federal Budget the "Better Quality of Care - managing prudential risk in residential care" a strengthening of standards in relation to RADs by:

- introducing a compulsory retrospective levy on residential aged care service providers where defaults exceed $3 million in any fiscal year;
- developing stronger prudential standards applied to accommodation payments held by residential service providers; and
- raising the Government's prudential regulatory capability to better protect the growing pool of accommodation payments

The review made two key recommendations for the strengthening of the protection of accommodation payments:

- A strengthening of the Prudential Standards and their oversight including consideration of the findings and recommendations of the EY review
- Mandating the recoupment of the Bond Guarantee Scheme costs

Accommodation Payment Guarantee Scheme 2006

The legislative authority for the Bond Guarantee Scheme is the *Aged Care (Accommodation Payment Security) Act 2006*. Since its inception the Bond Guarantee Scheme has been triggered 11 times, paying approximately 260 RAD refunds amounting to $41.7 million (plus accrued interest of $1.8 million).

The reforms to the Bond Guarantee Scheme are to improve certainty to providers and consumers as to how the levy will operate. In summary, the compulsory retrospective levy is being legislated to be enacted where the default cost exceeds $3 million in any fiscal year.

Whilst such a levy has existed for a number of years, the proposed legislation is to make it enforceable effective from 1 July 2019, with the calculation period for defaults commencing from July 2018.

Our understanding of the proposed legislation is that should there be a default of greater than $3 million in any one fiscal year, the levy will be calculated on the basis of the respective Approved Providers RAD balance as a percentage of the total RAD balance. Should there be a significant default, it is likely that the levy will be administered over a number of years.

Prudential Standards

The Prudential Standards as set out in the *Fees and Payments Principles 2014 (No 2)* (the *Principles*) outline the regulatory requirements of providers in respect of their prudential management of refundable accommodation deposits, accommodation bonds and entry contributions (collectively known as accommodation deposits).

The *Aged Care Act 1997* requires that all Approved Providers must comply with the Prudential Standards as set out in the *Fees and Payments Principles 2014 (No.2)*.

There are four Prudential Standards being:

- Liquidity Standard
- Records Standard
- Governance Standard; and
- Disclosure Standard

One of the requirements contained in the Disclosure Standard is the disclosure each year of certain information to the Department. The Approved Provider must submit to the Secretary a statement in the form specified disclosing matters relating to the compliance with the Prudential Standards during the year and disclose instances or periods of non-compliance with those Standards (included with the Annual Prudential Compliance Statement).

Permitted Uses

Division 52N of the *Aged Care Act 1997* defines permitted uses. The use of refundable accommodation deposits (RADs) is regulated by *Part 6* of the *Principles.*

An Approved Provider is permitted to use RADs for the following:

a) Capital expenditure for residential or flexible aged care purposes
b) Invest in certain financial products
c) To make a loan (with certain conditions to be satisfied)
d) To refund or repay debt accrued for the purposes of refunding accommodation deposits
e) To repay debt accrued for the purposes of capital expenditure as referred to in (a) above
f) To repay debt accrued before 1 October 2011 (the application date for the current permitted use rules) if the debt is accrued for the purposes of providing aged care to care recipients

Annual Prudential Compliance Statement

Approved Providers that hold refundable accommodation deposits are required by 52N-1 of the *Aged Care Act 1997* to comply with the Prudential Standards. The Disclosure Standard requires to complete and submit the Annual Prudential Compliance Statement (APCS) to the secretary of the Department within four months of the end of their financial year.

The APCS acts to demonstrate the compliance with the four Prudential Standards. The APCS must be audited by an independent external auditor.

The APCS contains questions about the number and value of the accommodation deposits held, whether refunds were paid on time, and whether they complied with Prudential Standards. Approved Providers are also required to provide information to support their compliance with permitted uses for accommodation deposits.

Financial Reporting Requirements

Division 2 of the *Accountability Principles 2014* requires Approved Providers to submit to Department the following:

- Aged Care Financial Report (ACFR) *(which includes the Annual Prudential Compliance Statement)*
- General Purpose Financial Report

Corporate Governance

Governance refers to the systems that are in place to "govern" or control an organisation. Each organisation must consider how this is best achieved for their organisation which can depend on for example, the size and complexity of the organisation as a whole.

Those charged with governance - such as the Board of Directors, Responsible Entities, Management Committee or similar (Directors) are the primary stakeholders influencing corporate governance of the organisation and have the ultimate responsibility and accountability of ensuring strategic goals are met, financial sustainability is maintained, as well as to comply with obligations as set by the regulatory environment in which the organisation operates.

For Approved Providers, with regards to financial reporting and prudential compliance, the Directors must ensure compliance with the following (depending on the type of organisation):

- *Corporations Act 2001* (for listed companies, and for-profit companies)
- *Australian Charities and Not-for-Profits Commission Act 2012* (for registered not-for-profit entities)
- *Income Tax Assessment Act 1997*
- *Aged Care Act 1997*
- *Fees and Payments Principles 2014 (No 2)*
- *Accountability Principles 2014*

The Directors must ensure appropriate mechanisms have been implemented to ensure compliance with the above regulatory environment in addition to a significant number of other legislative and statutory obligations. This includes the responsibilities relevant to managing prudential risk within the organisation and ensuring compliance with the current Standards as set out in the respective *Principles.*

With particular reference to the Governance Standard, the Directors must ensure that the organisation only uses RADs for permitted uses and that RADs are refunded to residents or their estates within the specified timeframe. The Governance Standard also sets out the minimum governance system that should be adopted by an Approved Provider including those in relation to reporting and delegation. An important component is the requirement to enable a robust risk management environment.

Liquidity and Capital Adequacy Management

Part 5, division 2, section 43 of the *Fees and Payments Principles 2014 (No 2)* states *"If an approved provider holds one or more refundable deposit balances, accommodation bond balances or entry contribution balances, the approved provider must maintain sufficient liquidity to ensure that the approved provider can refund, in accordance with the Act and these principles, any of those balances that can be expected to fall due in the following 12 months."*

Approved Providers are required to implement a written Liquidity Management Strategy which satisfies the following:

a) The amount (expressed as an amount of whole dollars) required to ensure that the Approved Provider has sufficient liquidity for the purposes of *section 43*;
b) The factors that the Approved Provider has regard to in determining the minimum level of liquidity;
c) The form in which the Approved Provider will maintain the minimum level of liquidity.

EY have made the recommendation that Approved Providers must maintain a prescribed percentage of liquid assets, for example, 10% of the value of lump sum accommodation payments held.

EY have also recommended Introducing a specific Capital Adequacy requirement so that a provider must maintain a prescribed percentage of net assets, for example, assets must exceed liabilities by an amount exceeding 20% of total assets.

We agree with EY's recommendations (*B1* and *C1*) on minimum liquidity levels and capital adequacy requirements, however before setting any mandated minimum ratios the Department will need to assess the impacts to Approved Providers and the residential aged care sector as a whole.

1.4 Ernst and Young (EY) Review

Included as *Appendix "A"* is a summary of the EY recommendations as included in the *Review of Aged Care legislation which provides for the regulation and protection of Refundable Accommodation Payments in Residential Aged Care* (*EY Review*), and our respective commentary.

As an overarching comment, EY have recommended that Approved Providers should establish a sound risk management framework to support their Liquidity Strategy and Investment Management Strategy and periodically review the effectiveness of the framework.

This includes recommendations that the Disclosure Standard should be amended to include an obligation on Approved Providers to disclose material events or information. *We agree with these recommendations.*

In addition to this, we **recommend** that the Disclosure Standard be amended so that the Approved Provider should disclose the classes of assets which investments were made during the financial year, including the amount invested. This disclosure should be mandatory for all prospective care recipients as well as annually to all existing residents. This could be provided in a simple disclosure statement along with some of the existing mandatory disclosures.

EY have recommended the introduction of minimum liquidity and capital adequacy ratios over a reasonable transition period. Without knowledge as to the potential effect to some Approved Providers that this might have, we can see certain merit in this approach which could have subsidiary benefit in regards to governance at provider level.

We **recommend** that only 50% of accessible funds through an unrestricted bank facility (overdraft or line of credit) be included in the minimum liquidity level calculation, as the use of such a line of credit could be used by the Approved Provider for non-permitted use purposes. If the liquidity facilities are only provided for RAD liquidity purposes (purpose utilisation restricted) then the full 100% should be included in the calculation.

1.5 Governance and Disclosure

Abstract

The EY recommendation around governance (*EY Proposal "F"*) is in our opinion the primary consideration in managing prudential risk. The Governance Standard is the appropriate mechanism to implement further enhancements to the governance requirements.

The Prudential Standards should provide the authority and guidance for managing prudential risk in residential aged care. A key component of the Prudential Standards relates to "governance" and this is where the primary focus should be directed - in ensuring that the Approved Provider has a strong and robust governance structure, including a risk management framework, that is supported by appropriate legislative requirements.

This is an area where many Boards will require guidance in establishing an appropriate risk management framework for their organisation. Any legislative requirement for a robust risk management framework should be accompanied by resources for providers to assist them. This is likely to be in the form of education and guidance materials for those responsible for the governance of the provider organisations.

The enhancement of the General Purpose Financial Report (GPFR) requirements and compliance will provide the best and easiest method for the Department to ensure proper governance. It is our **recommendation** the GPFR should include Declarations that when signed by the Directors and Auditors will have statutory authority.

General Purpose Financial Reports

With the exception of the listed entity Approved Providers (Estia Health/Regis Aged Care/Japara Healthcare) and State, Territory and Local Government Approved Providers, all residential aged care providers can be categorised as Tier 2 reporting entities but have the option to prepare Tier 1 GPFR's.

Tier 2 reporting entities are required to adopt Australian Accounting Standards AASB 1053: *Application of Tiers of Australian Accounting Standards* and AASB 2010-2: *Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirement* in the preparation of their GPFR.

In accordance with the Reduced Disclosure Requirements, Tier 2 entities are not required to apply or fully disclose the following Australian Accounting Standards applicable to aged care providers:

AASB 7 Financial Instruments: Disclosures
AASB 8 Operating Segments
AASB 9 Financial Instruments
AASB 11 Joint Arrangements
AASB 12 Disclosure of Interests in Other Entities
AASB 124 Related Party Disclosures

AASB 8 Operating Segments

Before the introduction of the Aged Care Financial Report and amendment to the Accountability Principles 2014, providers were required to "*treat residential aged care as a reportable segment within the meaning of the Accounting Standard relating to segment reporting that applies to the relevant financial year*".

This requirement resulted in providers including a residential aged care segment disclosure in the audited GPFR, however, with the introduction of the ACFR from 2016/17 financial year which includes the residential aged care segment information, the residential aged care segment can now be excluded from the GPFR.

As many Approved Providers have operating and capital activities beyond those governed by the *Aged Care Act*, for the Department to make a reasonable assessment of the provider's overall financial viability they require full visibility over the other operating segments. To this extent, we **recommend** that the compulsory requirement to adopt *AASB 8 Operating Segments* be implemented.

Other Accounting Standards

In addition to Tier 2 entities not having to comply with *AASB 8 Operating Segments*, these entities also do not have to comply with a number of other Australian Accounting Standards as already noted above.

Where Approved Providers have transactions or activities that would otherwise have to be reported on under these Accounting Standards but for the fact that they are Tier 2 entities, we **recommend** that when the applicable Accounting Standard applies to their entity, then the provider should report in accordance with the Accounting Standard. For example, if an Approved Provider entity had related party transactions then it would need to report these transactions in accordance with *AASB 124 Related Party Disclosures*.

For the *Financial Instruments* standards, we **recommend** that the Approved Provider limit their application to only having to compulsorily disclose where entities have investments in financial instruments other than cash and term deposits or external borrowings other than residents' borrowings.

The application of these Accounting Standards, where applicable, to all Approved Providers will ensure a greater level of disclosure and transparency and a greater level of consistency in those disclosures. Guidance may have to be provided in the format that is preferred by the Department, and consultation with the Accounting bodies in creating a legislative framework would also be encouraged.

The fact that these disclosures will be included in the GPFR also means that they will be subject to audit which will provide further assurance to users of the GPFR including the Department, residents and their families.

The other aspect to having a greater level of disclosure in the GPFR is that the ACFR becomes an instrument for collecting supplementary data for analysis by the Department, rather than being the primary source of data for assessing whether an entity is at risk of financial failure. This role will now be primarily filled by the GPFR as it will provide information on the whole of the entity which will be a better guide as to its future viability and other risk factors.

Directors' Declarations

Currently, the ACFR and APCS does not require a Declaration by those charged with governance (Directors) stating that the information provided is true and correct. A Key Person, being an executive member of management, can lodge and sign the minimalist Declaration that now exists.

We **recommend** that included in the GPFR is a Declaration by the Directors that the entity has complied with Part 5 of the *Fees and Payments Principles 2014 (No.2)*. The Declaration would attest to the information contained in the APCS and in relation to the permitted use of RAD's as well as other matters contained in the APCS.

Such a Declaration would be in addition to the existing Directors Declaration in relation to the financial statements which includes the ability to "pay debts as and when they become due and payable". Similar Declarations are required for other legislation which may affect an Approved Provider such as the NSW *Charitable Fundraising Act 1991* or similar state-based Acts.

Audit Opinions

Currently, the GPFR and the APCS requires an audit opinion whilst the ACFR does not require an audit opinion.

We **recommend** that the Audit Opinion as included in the GPFR be required to include another Assurance Opinion on the Approved Provider's compliance with Part 5 of the *Fees and Payments Principles 2014 (No.2).*

The Audit Opinion would be based on an audit conducted in accordance with the applicable Standards on Assurance Engagements (*ASAE 3100 Compliance Engagements)*, issued by the Auditing and Assurance Standards Board and with the Approved Provider's Compliance with the Prudential Requirements.

Continuous Disclosure

Currently, if there are breaches of prudential rules they are not disclosed to the Department until the APCS is lodged each year by the due date of 31 October, which can be up to 16 months after the event has occurred.

We **recommend** that a continuous disclosure regime operate whereby Approved Providers will be required to notify the Department of certain breaches within a set timeframe. It is not suggested that this will involve all breaches, rather it be restricted to breaches that may signal that the Approved Provider is under financial stress. These would include:

- Not meeting minimum liquidity levels (mandatory levels if introduced or those as stipulated by the current Liquidity Management Strategy)
- Repayment of Refundable Accommodation Deposits being outside the specified timeframe (possibly within certain thresholds - one late payment may not signify an issue but several late payments over a short period may do so)
- Not meeting the Capital Adequacy ratio

These would provide the Department with early warning signs that an Approved Provider is in financial difficulty and may help to prevent an eventual financial failure.

We **recommend** that the APCS include specific questions in relation to whether the Approved Provider has had any of the above breaches during the fiscal year and accordingly, if they were notified to the Department within the set timeframe.

This would then have further legislative authority due to the Declarations noted above requiring to be signed by the Directors and the Auditors.

Proposal	**Recommendation**	**Priority**	**StewartBrown Comments**
A. Introduce transparent reporting on Approved Provider corporate structures and inter-party transactions	**A1.** Require Approved Providers to report their corporate structures including identity of ultimate shareholders and any significant changes to their ownership	High	This may be problematic from the point of view of many private providers. A compromise position maybe to disclose ultimate ownership. Corporate structure may be able to be limited to the type of entity (company, trust, partnership etc). Even with NFP's there can be some complexities in relation to Property Trusts in some of the faith-based institutions. Changes to ownership might be covered anyway in cases where the purchaser has to gain accreditation.
	A2. Allow Approved Providers to report on a single entity or consolidated group basis	High	From a prudential point of view the single entity basis might be counter-productive from collecting sufficient data about the financial position of the consolidated entity. The consolidated basis provides the best information as a single entity may reply on support from the overall group.
	A3. Where an Approved Provider or Approved Provider group wishes to transfer assets outside the group: ▸ The loan to value ratio of the asset to the liabilities should not exceed 80% of the value of the underlying asset ▸ The use must be secured by appropriate security, such as a mortgage (ranking below bank secured debt)	High	These would appear to be reasonable constraints. Ensuring proper security over assets would be worthwhile - may have to mandate a valuation of the assets over which security is held.

Proposal	Recommendation	Priority	StewartBrown Comments
B. Redefine the Liquidity Standard	**B1.** Set a liquidity threshold as a defined percentage of Accommodation Payment money held by the Approved Provider Group, such as the higher of 10%, where an Approved Provider is a single site, single facility operation with a smaller Accommodation Payment pool and low resident turnover, a higher threshold	High	This could be an issue from time to time in the business cycle of an approved provider. It may curb investment for smaller providers and in regional and remote areas, particularly regional and remote areas where the first round of RADs may be used to pay off construction debt. EY are suggesting a higher ratio for smaller providers - this may force some providers out of business. EY's own evaluation said that the exit of some providers is a risk. This may be an issue in regional and remote areas where no alternate provider is wishing to enter. This may be more a matter of providing guidance on liquidity rather than setting firm thresholds. If any requirement along these lines was introduced it would need a transition period and caveats to manage the burden on operations.
	B2. Phase in the threshold over a 5-10 year period. For example, require 5% within 5 years; 7.5% within 7.5 years and 10% within 10 years	Extreme	This will absolutely be necessary. May be some compromise on the phase in ratios - need some data in relation to how many providers are in each bracket now and what they will need to do to move to the required thresholds. This could affect the listed entities as much as anyone as their cash to bond ratios are very low. For most not-for-profits that were around in the capital grant era, and for those mature organisations this should not be an issue, but if organisations have largely been relying on external debt and have been on a continuous growth strategy it may be an issue.
	B3. Define the form of liquidity as real liquid or accessible funds being a combination of unpledged/unencumbered cash in the bank; a bank facility (such as an overdraft or line of credit) or money that can otherwise be accessed immediately	Extreme	This is reasonable - it is the way that most funds would be held now. The unencumbered cash could be an issue as most security arrangements with banks etc. are to have security over all the assets of an entity. It needs to be clear that these ratios will be based on the total cash or liquid assets of an organisation and that we are not stepping back into the realm of having cash quarantined as "RAD cash". We recommend that unrestricted bank facilities (overdraft or line of credit) be calculated on the basis of 50% of the limit (rather than the full limit or available borrowings) as the use of such a line of credit could be utilised for a non-Permitted Use purposes.

	Proposal	Recommendation	Priority	StewartBrown Comments
C.	***Introduce Capital Adequacy requirement***	**C1.** Introduce a capital adequacy metric, such as, 20% equity on the balance sheet[1]	High	From a for-profit point of view this will be the ratio of share capital or owners equity as a proportion of the defined assets of the company. For NFPs this will be the members funds as a proportion of the defined assets. From a NFP point of view the only way to inject capital to increase the ratio will be to increase retained earnings. From a FP perspective there will be some issues around the organisational/group structures. Reference to *APS 110* which is APRAs *Prudential Standard on Capital Adequacy* is worth considering. If a capital adequacy measure is introduced, given some of the exiting bank covenants , new construction may stall in the first instance. This recommendation may be modified if there is also more clarity and a minimum standard for liquidity.
		C2. Define quality of capital to include tangible assets such as land and buildings; and intangible assets which are able to be valued, such as, bed licences	High	This makes sense should the capital adequacy ratio be adopted. However, according to ASIC and the Accounting Standards bed licences can't be valued, and they are likely to lose their value should there be a deregulation of residential places. We recommend that this be restricted to tangible assets - may cause issues for listed entities and some private providers who are more likely to have values attached to bed licences.

[1] This is equivalent to what is required by financiers when lending against real property. Where a borrower is more highly geared, a financier will require them to take out insurance to secure the balance of the value of the property.

Proposal	Recommendation	Priority	StewartBrown Comments
D. Improve the disclosure Standard to provide better transparency of Approved Providers' businesses and how they are using Accommodation Payments	**D1.** Amend section 9(1) of the Act to require notification "*as soon as it happens and in no event more than 14 days after it happens*"	High	Currently 28 days notification period of "a change of circumstances that materially affects the approved provider's suitability to be a provider of aged care". This is moving toward continuous disclosure and there will need to be some clarity about what type of events will require a notification. Currently defined under S8.3 which is very broad and somewhat subjective.
	D2. Require the prior consent of the Department to be given to material changes in the legal ownership or control of an Approved Provider	High	Would have thought this was required as it stands as part of the approval of key personnel - but again will need clarity around "material changes". For example, Boards of NFPs and CEOs as well as for-profits change and evolve on a regular basis - practicality around getting prior consent for these changes are not tenable. If the recommendation relates to situations such as the sale or transfer of an approved provider entity, then that may be tenable – similar to ACCC rules - but will need to have minimum approval times in any regulations.
	D3. Require Approved Providers to adopt an industry standard such as APS330 or Direct2APRA (D2A) reporting. Approved Providers would be obligated to disclose the following to the Department: ▸ Changes in corporate structure ▸ Significant related party transactions, which are required to be reported in the GPFR ▸ Cash flow in accordance with the Accounting Standards to show the financial position of the Approved Provider ▸ Compliance with the liquidity standard (including any period of non-compliance and how it was rectified ▸ Compliance with the capital adequacy metric (including any period of non-compliance and how it was rectified)	Extreme	With the exception of the first and last dot points the other matters currently have to be reported to the Department via GPFR, ACFR or APCS. Adoption of *APS330* would require capital adequacy ratios and possibly minimum liquidity amount quarterly. Would not be necessary if capital adequacy ratio is not adopted - preferred option. All other information is currently disclosed.

	Proposal	Recommendation	Priority	StewartBrown Comments
E.	***Retain requirement for an Independent Auditor to sign-off the APCS***	**E1.** Reinstate / Do not remove the requirement for an independent auditor to sign-off the APCS	High	Agreed, this has already been actioned. Currently the APCS is signed by a Key Person rather than the Directors. We recommend that it be a requirement for the Directors to sign the APCS.
F.	***Enhance Governance Standard – Introduce: Part 1 Corporate Governance***	**F1.** Develop the Governance Standard to adopt generally accepted corporate governance principles (such as those adopted by ASIC, APRA, ASX and the ACNC). This includes (leveraging ASX corporate governance principles 3rd ed.): ▸ Lay foundations for the management and oversight of the organisation ▸ To act ethically and responsibly ▸ Safe guard reporting ▸ Prepare a code of conduct for "key personnel" to improve industry practices to operate in accordance with recipients of care's best interests Impose an obligation for Approved Providers to produce a corporate governance statement which describes the extent to which they have complied with the code of practice and principles	Moderate	We agree that increased governance is a primary consideration, and the Governance Standard is the appropriate mechanism. Code of Conduct, etc could be incorporated into the Governance Standard.
G.	***Enhance Governance Standard - Part 2: Introduce a Financial Risk Management Framework***	**G1.** Incorporate a financial risk management standard into the Governance Standard	Moderate	This is a reasonable suggestion.

	Proposal	Recommendation	Priority	StewartBrown Comments
H.	***Enhance the disclosure to recipients of care and their families on how Accommodation Payment funds will be treated, including for the Permitted Uses and on a winding-up of an Approved Provider***	**H1.** Require Approved Providers to disclose to recipients of care and their families how Accommodation Payment money will be held, when it will be refunded and how recipients of care rank on a winding up of an Approved Provider	Moderate	*S 15d* of *Fees and Payment Principles 2014 no 2* would cover this as far as refunding arrangements. Ranking upon winding up is problematic as they would currently rank as unsecured creditors. This may cause confusion for consumers (residents and family) with the main requirement to clearly disclose that RADs are guaranteed by the Government (and the limits around this guarantee). How the deposit funds would be held is also problematic as this can change on a daily basis and is counter-intuitive to the Permitted Use rules and how accommodation funds can be used. This implies that all deposits are 'held' in some liquid form which is not the case. Suggest this be modified to disclose in what form minimum liquidity amount is held.
I.	***Limit or phase out discretionary trusts***	**I1.** Allow no new discretionary trusts in Approved Provider group structures	High	TBA - This will affect private providers and may have tax implications. It would be beneficial to know how many providers would be affected and in what way. We would imagine that structures such as tax would mainly be used for tax minimisation purposes rather than to strip assets.
		I2. Phase out discretionary trust structures in a 5-10 year period	Extreme	EY evaluate benefits as: • More financially robust Approved Providers • Reduce incidence of those • Approved Providers using corporate structures to move assets away from liabilities • Increased ability to track Accommodation Payment money and Permitted Uses more easily

	Proposal	**Recommendation**	**Priority**	**StewartBrown Comments**
J.	***Where Approved Providers do not comply with the Liquidity and Capital Adequacy requirements either:*** ***• Restrict their ability to charge new Accommodation Payments; or*** ***• Require them to provide additional security in place until they comply with those thresholds***	**J1.** If the Approved Provider capital falls below the liquidity or capital adequacy thresholds: ▸ Require the Approved Provider to make up the shortfall; such as by injecting additional capital or by entering into a subordinated loan with shareholders[2] ▸ Restrict the charging of new Accommodation Payments until the capital metric is achieved. This may also require an amendment to the Sanctions Principles accordingly	High	Will only be an issue if the minimum capital adequacy ratio recommendation is adopted. This should be determined in conjunction with the minimum liquidity amount prescribed. Need to consider the implications for NFPs - what mechanisms do they have to inject additional capital. Sanctions of any type should be a last resort rather than a first response.
K.	***Compliance education and training***	**K1.** The Department create a communication and engagement strategy for engaging with Approved Providers and other stakeholders in the Aged Care industry	Extreme	Agreed Part of that engagement should include funding for education of key personnel including Boards, setting up guidelines and templates to assist providers to understand the prudential regulations and any new risk management framework

[2] There is a limit to how much equity can be injected via subordinated debt under tax legislation.

Proposal	Recommendation	Priority	StewartBrown Comments
L. Overarching systematic risk management framework	**L1.** To support the revised Prudential Standards, the Department will need to recalibrate its current risk assessment methodology and model to reflect the new compliance requirements. We recommend that the Department adopt a probability and impact rating system (PAIRS) - type model adopting a qualitative and quantitative assessment criteria of Approved Providers. The revised model will reflect the criteria in the Prudential Standards should be risk-based and commensurate with the size and sophistication of the Approved Provider. The framework should focus towards higher risk entities. Considerations of what the model would include are: ▸ Risk management ▸ Financial management metric ▸ Capital management (as redefined in the Prudential Standards) ▸ Liquidity management (as redefined in the Prudential Standards) ▸ Management and corporate governance practices (as redefined in the Prudential Standards)		Agreed
	L2. Introduce an internal risk management strategy document for the Department to assess the inherent risks of Approved Providers' non-compliance which may mean that an Approved Provider is not financially viable or that the Scheme is called on		Agreed

	Proposal	Recommendations	Priority	StewartBrown Comments
	Overarching systematic risk management framework (continued)	**L3.** Introduction of measures to assess threshold requirements		Agreed
		L4. Consideration to be given to determine appropriate segmentation and classification of Approved Providers		Agreed
M.	***New operating model for PRCS to Administer Prudential Standards***	**M1.** Assess demands and develop target operating model to support the new regulatory framework		Agreed
N.	***Strengthen tools, resources and capability in PRCS to improve compliance function***	**N1.** Collect data and enhance the analytics capability within PRCS to assess and understand risk profile of Approved Providers in light of the revised the Prudential Standards		Agreed
		N2. Enhance number of resources and the use of more sophisticated tools in the PRCS to conduct compliance activities		Agreed
O.	***Enhance the end-to-end processes and collaboration with respect to the compliance of approved Providers***	**O1.** Consider developing and socialising a holistic end-to-end business process across the Department, including (i) identifying who is collecting or accessing prudential data about Approved Providers and for what purpose and (ii) escalation pathways. This should ideally be done in collaboration with other teams in the Department that are involved in the compliance pathways		Agreed

FURTHER OPTIONS (DEPARTMENT OF HEALTH)

Issue: *Risk/Response*	Recommendations	Priority	StewartBrown Comments
10. Assessment of financial liability	**AA1.** Create legislative authority to support the assessment of the financial viability of Approved Providers: ▸ Allow independent review by the Commonwealth of provider's current financial information (audited and unaudited) ▸ Allow the Department to require the provision of current financial information where there are concerns of provider's financial viability when warranted ▸ Allow the Department to require the provision of relevant supporting information including current financial reports for the provider and/or related entities where there are concerns relating to a provider's financial viability, prudential compliance and/or permitted use		Agreed. We suggest that these recommendations be integrated with enhancing the Governance Standard to ensure more accountability by the Directors. The requirement for Directors to include the Prudential Disclosures in the GPFR and the Auditors Report to be also included will assist in the governance accountability. If a approved provider fails to meet the required capital adequacy or liquidity threshold, the responsibility should be for the organisation to advise the Department in the first instance (and the APCS include a question as to whether such an circumstance occurred). The places the accountability firmly with the Directors who could be held personally liable if there was a deliberate default.
	AA2. Require Approved Providers to inform the Secretary (under Section 9(1) of the Act) of concerns relating to financial viability		Agreed (refer above).
	AA3. Support the migration of all providers to Tier 1 financial reporting		We believe this will be very onerous on a number of providers. We suggest that the Principles be amended to include compulsory adoption of certain Accounting Standards if applicable.