RSM Bird Cameron

RSM health+
Aged Care

Factors Influencing the Financial Performance of Residential Aged Care Providers

Contents

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

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Introduction

31 March, 2015

The Aged Care Financing Authority (ACFA) 2013 and 2014 reports on funding and financing in the aged care sector (the ACFA reports) highlight the variability of the financial performance of different residential aged care providers (providers) based on earnings before interest, tax, depreciation and amortisation (EBITDA).

Current Department of Social Services (DSS) data suggests that this variation is not specifically determined by factors such as the provider's ownership category – including for-profit (FP), not-for-profit (NFP) and government run – size or location.

In February 2014, Senator The Hon. Mitch Fifield, Assistant Minister for Social Services, requested that ACFA include in its current work program a detailed study into the factors that influence providers' financial performance. The study needed to focus on identifying what drives some providers to perform better and leads others to record a lower financial performance, and what could be done to improve the financial performance of those providers that don't perform as well. The study would first examine residential providers and later home care providers, and would consider issues affecting rural, regional and remote providers.

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Glossary

Term	Definition
accommodation bond	An amount paid as a lump sum by a care recipient for their accommodation costs in a residential aged care facility, payable by a pre-1 July 2014 resident.
Accreditation Standards	The standards for quality of care and quality of life for the provision of residential aged care under the *Quality of Care Principles 2014*.
Aged Care Approvals Round (ACAR)	An annual competitive tender process for releasing and allocating aged care places to approved aged care providers. The number of places released is governed by the Commonwealth's population-based target ratio for aged care service provision.
Aged Care Financing Authority	Provides independent advice to the Australian Government on funding and financing issues, informed by consultation with consumers and the aged care and finance sectors.
Aged Care Funding Instrument (ACFI)	Used to determine care subsidies for residents in aged care homes based on the assessed care needs of each individual. The ACFI replaced the Residential Classification Scheme on 20 March 2008 as the means of allocating Australian Government funding to residential aged care providers on behalf of residents.
agency staff	A temporary, externally sourced workforce, usually engaged through a recruitment company.
approval in principle (AIP)	Describes beds applied for and approved through the ACAR rounds but not yet brought online.
approved provider	A person or organisation approved under Part 2.1 of the *Aged Care Act 1997* (Cth) a provider of care for the purpose of payment of subsidy (a provider approved since the commencement of this Act must be a corporation).
capital grants	Government funding allocated through the ACAR to approved providers to undertake necessary capital works to establish, upgrade or expand residential aged care services.
city and regional providers	City refers to providers operating in locations as classified by the Australian Bureau of Statistics (ABS) Major Cities Classification, and regional providers are those in all other locations. In determining city (only) or regional (only) providers, at least 70 per cent of the subsidy days must be provided in that geographic classification, otherwise the provider is classified as city & regional.
City (only) providers	City providers operate in locations classified as Major Cities by the Australian Bureau of Statistics. In determining city (only) providers, at least 70 per cent of subsidy days must be provided in that geographic classification.
Community Aged Care Package (CACP)	Care consisting of a package of services provided to a person who lives in their own home and is not in residential care.
daily accommodation payment (DAP)	An amount that a care recipient pays towards their accommodation costs in a residential aged care facility, calculated on a daily basis.
deemed accommodation charge	The result of multiplying a bond pool calculated as at 30 June 2013, by the average FY13 Maximum Permissible Interest Rate (MPIR). This charge is used to normalise operating financial performance across providers with varying bond pools.
Department of Social Services (DSS)	Administers the *Aged Care Act 1997* (Cth) and regulates the aged care industry on behalf of the Australian Government.
earnings before interest, taxes, depreciation and amortisation (EBITDA)	Net profit after tax with interest, taxes, depreciation and amortisation added back to it. This can be used to analyse and compare the profitability companies and industries as it eliminates the effects of financing and accounting decisions.
extra service	Services approved under the *Aged Care Act 1997* (Cth) to offer extra services to recipients of residential aged care. This can apply to the whole service or a distinct parts of service where a significantly higher standard of accommodation services and food is provided.
financial assets	Assets shown on the Statement of Financial Position that generate financial income.
financial liabilities	Liabilities shown on the Statement of Financial Position that require finance expenses to be paid.
for-profit provider	An approved provider with a constituent document that allows it to distribute profits to its owners.
general-purpose financial report (GPFR)	A financial report prepared for users who are unable to prepare a report of their own.
high care	Over 70% of care days delivered with an ACFI classification of 'high'.

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Term	Definition
home and community care (HACC)	A programme of basic maintenance and support services for frail older people, younger people with disabilities and the carers of these people to prevent premature admission to residential care services. It includes home nursing, home help, respite care and assistance with meals and transport.
home care	Income-tested home-based care and support to help older Australians remain in their own homes. Services are co-ordinated by a home care provider and funded by the Australian Government.
liquidity management strategy (LMS)	A document that identifies: the amount (expressed as whole dollars) required to ensure that an approved provider has sufficient liquidity to refund accommodation bonds balances and refundable deposits (including entry contributions) as they fall due (expressed as whole dollars), and the factors that the approved provider considered in determining the minimum level of liquidity the form in which the approved provider will maintain the minimum level of liquidity (see section 44(1), *Fees and Payments Principles (No.2)* 2014).
logistic regression models	Used in multivariate analysis to predict the probability of a provider sitting within a certain group, based on a number of variables.
low care	Over 70% of care days delivered with an ACFI classification of 'low'.
maximum permissible interest rate (MPIR)	The rate used to calculate the equivalent daily payment of a refundable deposit – that is, the refundable deposit is multiplied by the MPIR and divided by 365 days. The MPIR is determined in accordance with section 6 of the *Fees and Payments Principles (No.2)* 2014.
mixed care	High care and low care classifications are based on over 70% of care days delivered having an ACFI classification of 'high' or 'low' respectively, otherwise the classification is mixed care.
multivariate analysis	Weighs a range of drivers or factors to determine their relative importance in driving financial performance.
net borrowing cost before tax (NBCBT)	Interest expenses – including deemed interest on lump sum accommodation payments – less interest income.
net financial liabilities (NFL)	Financial assets less financial liabilities.
net financing expense before tax (NFEBT)	Financial income less financial expenses.
net operating profit margin (NOPM)	OEBITDA divided by operating revenue.
net operating profit before tax (NOPBT)	OEBITDA less depreciation and amortisation.
net profit before tax (NPBT)	NOPBT plus NFEBT.
not-for-profit (NFP) provider	An approved provider with a constituent document that does not allow it to distribute profits to its owners.
Group 4	The group of providers who did not generate sufficient cash flow to pay for $3,000 prpa of building repairs and maintenance, and equipment replacement.
operating asset	Balance sheet assets required to maintain the operation of a residential aged care facility.
operating asset turnover (OATO)	Operating revenues divided by net operating assets.
operating EBITDA (OEBITDA)	Operating revenues less operating expenses.
operating liabilities	Liabilities shown on the Statement of Financial Position that support the working capital of residential aged care operations.
private home care	Care provided in the recipient's home, independent of a government subsidy.
per resident per annum (prpa)	A value divided by the number of residents in a facility, expressed as resident days divided by 365.
refundable accommodation deposit (RAD)	A lump-sum amount a care recipient pays for their accommodation costs in a residential aged care facility.
residential aged care	A program that provides various supported accommodation services for older people who are unable to continue living independently in their own homes.
return on equity (ROE)	NPBT divided by net equity.
return on net operating assets (RNOA)	OEBITDA divided by net operating assets.
rural, regional and remote providers	Providers who operate more than 70 per cent of their facilities in regions outside a city, as defined by the Australian Bureau of Statistics (ABS) Major Cities classification.

Term	Definition
significant refurbishment	As defined by Division 5, subdivision A–Accommodation Supplement of the *Subsidy Principles 2014*.
size	Refers to the number of facilities a provider operates. Size is defined as a single facility, 2–6 facilities, 7–20 facilities, 20 or more facilities.
supported residents	Those who entered care for the first time on or after 20 March 2008 or who re-entered care on or after 20 March 2008 after a break of more than 28 days and have assets equal to or less than an amount determined by the Secretary [DSS] to be the maximum asset threshold for supported resident status. These residents received government-subsidised accommodation.
viability supplement	A payment made under the Act to assist aged care services in rural and remote areas with the cost of delivering services in those areas. The residential viability supplement is payable for care recipients in residential care homes that meet specific criteria, such as the location of the service and number of allocated places. Eligible services are generally those with fewer than 45 places in less accessible locations. The Australian Government also provides a viability supplement to provide additional practical support to eligible Multi-Purpose Services (MPS), and services funded under the National Aboriginal and Torres Strait Islander (NATSI) Flexible Aged Care Program and home care services in rural and remote areas. The viability supplement is also available for aged care services with greater than 50 per cent of their residents meeting the homeless criterion.
weighted average cost of capital (WACC)	The cost of capital sourced from equity and debt investments, divided by the ratio of debt to equity in the capital structure.

Executive Summary

In June 2014, ACFA engaged RSM Bird Cameron (RSM), in association with PricewaterhouseCoopers (PwC), to study the qualitative and quantitative factors influencing and associated with the variable financial performance of different residential aged care providers.

In undertaking this project we considered the industry through the lenses of ownership, location, size and level of care (resident care profile), then overlayed these factors with an analysis of financial and other metrics.

We were particularly mindful that industry input was essential to the study's results and findings, so we designed the qualitative survey in collaboration with DSS, ACFA, residential aged care providers, and industry peak bodies including Aged and Community Services Australia (ACSA) and Leading Aged Services Australia (LASA).

ACFA established the Finance and Accounting Advisory Group to enhance our analytics approach and provide feedback on the reporting process.

The study and this report both focus specifically on factors influencing providers' financial performance. RSM and PwC acknowledge that the aged care industry is very diverse and different providers deliver very distinct financial outcomes. Providers make implicit and explicit choices and trade-offs regarding the care and services they provide – including where and to whom they provide care and services, how much they charge residents (permitted within legislation) and how they participate in and contribute to their local communities. As such, financial performance is only one of a number of measures we can use to assess providers' overall performance and outcomes. There is no doubt that providers would rank differently if measured by other, non-financial metrics.

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ACFA Findings in Relation to Financial Performance

The analysis of the financial performance of the industry contained in the ACFA reports relevant to this report comprises the quartile analysis of EBITDA based on:

- ownership – not-for-profit (NFP), for-profit (FP) or government
- location – city, regional or both; noting that where 70% or more places are located in either city or regional centres, a provider is classified as either city or regional, and in other circumstances they are classified as located in both
- size – the number of facilities operated by an approved provider
- care (resident care profile) a provider is classified as providing high care when more than 70% of care days are delivered with an ACFI classification of 'high'.

Table 1 shows the spread of financial performance (measured by EBITDA) of residential aged care providers, broken down by ownership, location, size and resident care profile of for the year ended 30 June 2013.

Table 1: Financial performance by location, ownership, size and care profile[1]

	Top quartile (average)	Bottom quartile (average)
Ownership		
NFP	$19,125	-$2,556
FP	$20,203	-$8,157
Government	$18,023	-$11,958
Location		
City	$19,327	-$6,144
City and Regional	$16,129	-$4,522
Regional	$27,343	-$4,480
Size		
Single-facility providers	$22,796	-$6,309
2-6 facilities	$19,851	-$6,722
7-19 facilities	$18,661	-$1,950
20 or more facilities	$16,620	N/A[1]
Resident care profile		
High care	$19,612	-$5,624
Mixed care	$22,950	-$4,653
Low care	$17,111	-$5,759

Based on this limited information it would appear that:

- NFP and FP providers in the top quartile achieve similar levels of EBITDA per resident per annum (prpa)
- FP providers in the bottom quartile struggle more than NFP providers in the bottom quartile, as measured by EBITDA prpa
- reduced EBITDA prpa can occur in both city and regional locations
- an EBITDA prpa of circa $20,000 can be generated in both city and regional locations
- single-facility providers achieve the highest level of EBITDA prpa

[1] EBITDA for the bottom quartile of providers with 20 or more facilities is not presented in the ACFA 2013 report.

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- larger groups appear more able to avoid lower EBITDA prpa
- no particular resident care profile is associated with reduced EBITDA prpa
- a mixed resident care profile is associated with the highest EBITDA.

The ACFA analysis was based on information contained in the general purpose financial report (GPFR) of providers for the year ended 30 June 2013.

Building on the ACFA Analysis

Before extending the analysis in the ACFA report, we considered four key issues, as outlined below.

EBITDA as the basis of measuring financial performance

EBITDA is defined as net profit after tax with interest, taxes, depreciation and amortisation added back to it. EBITDA is used to analyse and compare the profitability between companies and industries, as it eliminates the effects of financing and accounting decisions. Our analysis indicated that unless EBITDA was standardised, individual provider financial performance could be distorted by non-recurring or non-operating income and expense items, and the inconsistent treatment of other items. To prevent this we have used operating earnings before interest, tax, depreciation and amortisation (OEBITDA) as the primary measure of financial performance.

Definition of OEBITDA

OEBITDA is EBITDA adjusted for the distorting influence of non-operating income and expense items such as:

- investment returns
- changes in the valuation of fixed assets and investments
- capital grants
- distributions to and from related parties.

OEBITDA was also normalised to address the following issues:

- the treatment of lump sum accommodation payments in relation to daily accommodation payments. To facilitate a 'like for like' comparison of providers' OEBITDA, our OEBITDA calculations excluded all interest expense and income, and included a deemed daily accommodation charge, factoring in lump sums held by providers and the average 2013 maximum permissible interest rate (MPIR)
- rental expenses are incurred by a minority of providers. Where this occurs it is either because a related entity to the approved provider holds the physical assets, or there is a third party arrangement. In either case, as it distorts comparative financial performance, we have excluded rental expense from our OEBITDA calculation.

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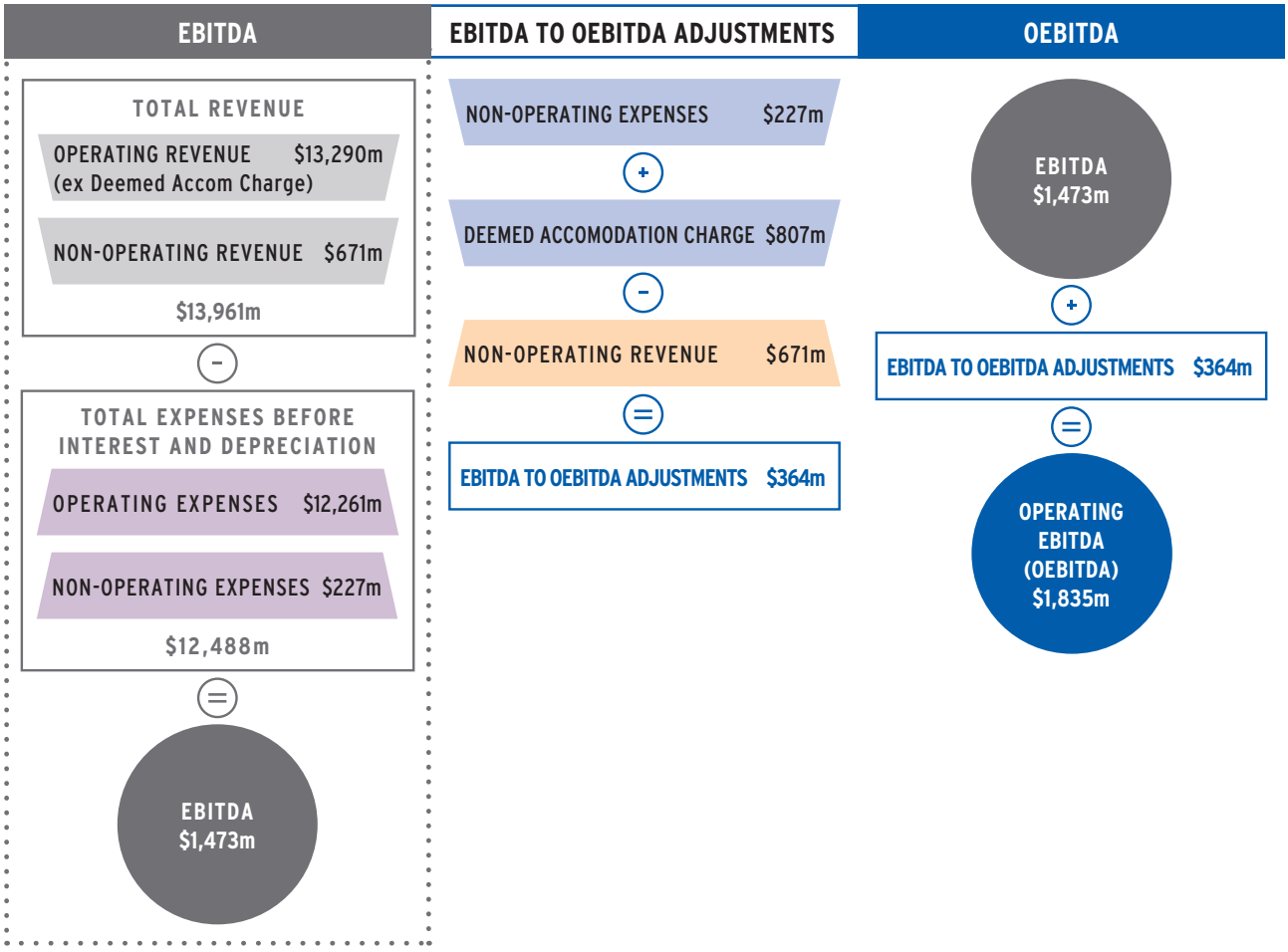
OEBITDA enables a deeper analysis of what drives different levels of operating financial performance. Figure 1 provides a reconciliation of the ACFA definition of EBITDA to OEBITDA, as well as the net impact of removing the non-operating items from EBITDA and including the deemed accommodation charge. In aggregate, an additional $364 million of operating earnings is recognised in OEBITDA relative to EBITDA. Figure 6 in Appendix 1 provides a more detailed breakdown of how OEBITDA and related measures used in our analysis are reconciled to terms and measures used in the ACFA report.

Figure 1: Summarises the relationship between EBITDA and OEBITDA (numbers are in $m)



Grouping of providers

We worked with ACFA's Finance and Accounting Advisory Group to categorise providers' financial performance. As our study seeks to understand financial performance along a continuum, categories were created based on performance, rather than grouping the industry by provider numbers on a quartile or other basis.

For the purpose of our study we categorised financial performance as:

a. **Financial performance group 1 (Group 1)** – providers whose OEBITDA placed them in the top 20% (quintile) of all providers

b. **Financial performance group 2 (Group 2)** – providers whose OEBITDA placed them in the next 20% (quintile) of all providers

c. **Financial performance group 4 (Group 4)** – As ACFA is particularly interested in providers with the lowest financial performance, we defined 'low financial performance' as that where the net operating cash flow – adjusted by removing actual building repair and maintenance – is below a notional level of repairs and maintenance considered necessary to maintain a facility in good order and repair. Net operating cash flow adjusted for actual building repair and maintenance is represented in Figure 2 below.

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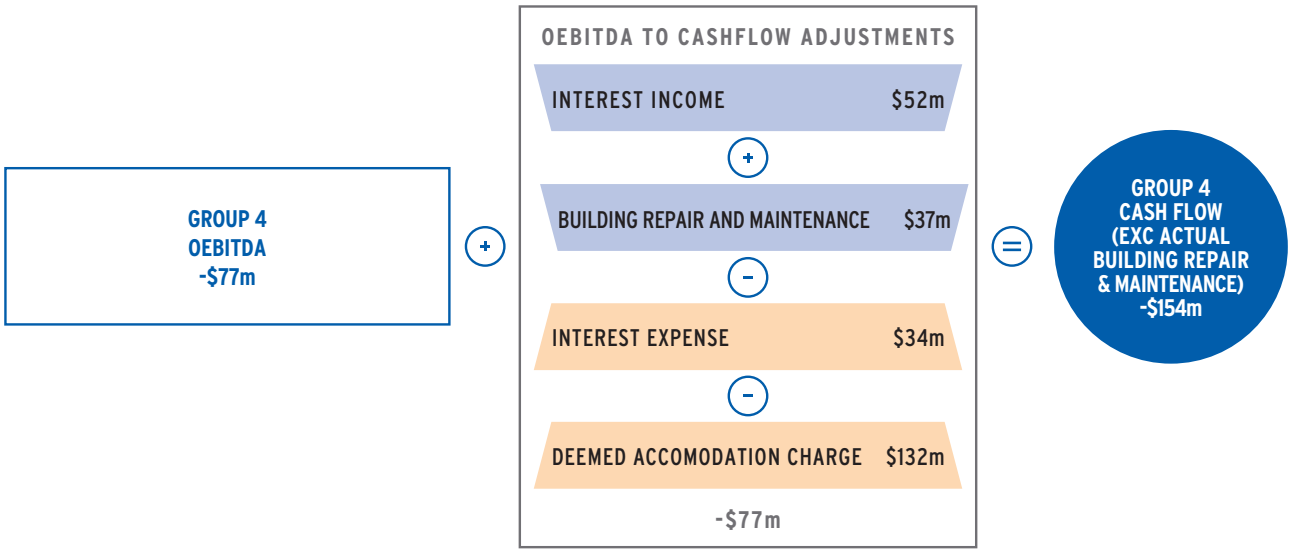
Figure 2: Net operating cash flow adjusted for repairs and maintenance (numbers are in $m)



A Group 4 classification does not mean a provider is at risk of failure. In fact, our analysis showed that providers in this group have developed alternative income streams so they can continue to operate despite the operational challenges they face.

d. **Financial performance group 3 (Group 3)** – providers whose OEBITDA prpa is below that of providers in the second quintile not including providers who are in Group 4.

Our quantitative analysis is based on a single year's financial data. We examined the consistency of providers' quartile performance using EBITDA and OEBITDA. While measuring financial performance by OEBITDA results in greater consistency, provider financial performance rankings do change over time. The results of providers with better financial performance tend to exhibit more consistency relative to those of providers with lower financial performance when measured by OEBITDA.

A detailed explanation of the characteristics of providers we considered when grouping the sector is contained in section 2 of this report.

Table 2 summarises the OEBITDA, operating revenue and operating expenses of each group of providers.

Table 2: OEBITDA, operating revenue and operating expenses, and composition of groups

	Group 1 (prpa)	Group 2 (prpa)	Group 3 (prpa)	Group 4 (prpa)
Average OEBITDA	$25,731	$15,250	$7,263	-$2,072
Average operating revenue	$93,875	$84,372	$78,577	$76,837
Average operating expenses	$68,144	$69,123	$71,314	$78,909

The influence of non-financial factors on financial outcomes

To understand the impact of non-financial factors on the financial outcomes of providers, PwC and RSM conducted a qualitative survey of 164 respondents. We consulted LASA, ACSA and other industry representatives to develop the survey questions. Appendix 2 details the methodology and survey background, while Appendix 4 contains a complete analysis of the survey questions and responses. The qualitative analysis included a multivariate analysis to isolate co-existing factors, the methodology of which is explained in Appendix 3.

The Impact of Ownership, Location and Size on Financial Performance

This section considers the relative concentration of providers based on the attributes of ownership location and size in the four groups.

Ownership

Table 3 shows the distribution of providers by ownership across the four groups. NFP providers are over-represented in groups 3 and 4 and slightly under-represented in Group 2. NFP providers are significantly under-represented in Group 1, which contains 32 NFP providers or 16% of the group.

Table 3: The number of providers in group, by ownership

	Group 1 (prpa)	Group 2 (prpa)	Group 3 (prpa)	Group 4 (prpa)	Total
FP	162 (80.6%)	94 (48.7%)	53 (18.3%)	63 (18.5%)	372 (36.3%)
NFP	32 (15.9%)	94 (48.7%)	212 (73.1%)	206 (60.6%)	544 (53.2%)
Government	7 (3.5%)	5 (2.6%)	25 (8.6%)	71 (20.9%)	108 (10.5%)
Total providers, by group	201	193	290	340	1024

Location

Table 4 shows the distribution of providers by location across the four groups. City-based providers are over-represented in groups 1 and 2. While some regional providers do achieve Group 1 and Group 2 outcomes, they are under-represented in these groups.

Table 4: Number of providers in group, by location

	Group 1 (prpa)	Group 2 (prpa)	Group 3 (prpa)	Group 4 (prpa)	Total
City	160 (79.6%)	142 (73.7%)	147 (50.7%)	141 (41.5%)	590 (57.6%)
Regional	35 (17.4%)	39 (20.2%)	132 (45.5%)	189 (55.6%)	395 (38.6%)
City and Regional	6 (3%)	12 (6.3%)	11 (3.8%)	10 (2.9%)	39 (3.8%)
Total providers, by group	201	193	290	340	1024

Size

Tables 5 shows the distribution of providers based on size across the four groups, i.e. the number of facilities under common ownership. With the exception of providers operating 7–19 facilities, providers are generally found in proportion to their representation within the industry in each group. The small number of providers with more than 20 facilities does not enable robust conclusions to be drawn. There does not appear to be economies of scale, based on the number of facilities owned.

Table 5: Number of providers in group, by size

	Group 1 (prpa)	Group 2 (prpa)	Group 3 (prpa)	Group 4 (prpa)	Total
Single facility	139 (69.2%)	116 (60.1%)	192 (66.2%)	199 (58.5%)	646 (63.1%)
2–6 facilities	54 (26.9%)	54 (28.0%)	68 (23.4%)	124 (36.5%)	300 (29.3%)
7–19 facilities	5 (2.5%)	18 (9.3%)	25 (4.5%)	15 (4.4%)	63 (6.2%)
20 or more facilities	3 (1.5%)	5 (2.6%)	5 (5.9%)	2 (0.6%)	15 (1.4%)
Total providers, by group	201	193	290	340	1024

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We also considered whether the average number of beds within a facility correlated with financial performance. Table 6 shows the average OEBITDA compared to the average number of beds within a facility in the four groups. There is a strong relationship between the average number of beds in a facility and the financial performance group to which a provider belongs. The higher the average numbers of beds per facility the better the financial performance.

Table 6: Overall industry composition by average number of beds in a facility

	Average number of beds per facility	Average OEBITDA (prpa)
Group 1	80	$25,731
Group 2	74	$15,250
Group 3	70	$7,263
Group 4	55	-$2,072

Summary

Based on our grouping, it appears that:

- providers operating on a FP basis in a city location are more likely to fall into Group 1 or Group 2 compared to providers with other forms of ownership in regional locations. However, a significant number (35%) of providers with other forms of ownership, and 23.4% of providers not exclusively providing city-based services, also achieved Group 1 or Group 2 financial outcomes
- providers operating a greater number of facilities do not achieve economies of scale and, consequently, better financial performance. However, there is a significant advantage in operating facilities with higher numbers of beds.

These findings suggest other internal operational factors in addition to ownership, location and size help some providers achieve better financial performance. We identified a number of key qualitative and quantitative factors that correlate with better financial performance.

Key Factors Influencing Financial Performance

Table 7 shows the key factors we found to be associated with providers' relative financial performance. These factors were derived from the results of our quantitative review of the providers' 2013 GPFR and qualitative multivariate analysis of survey data.

Table 7: Key factors associated with better financial performance

Operating revenue management	Providers in Group 1 have higher levels of operating revenue from both residents and government subsidies. In particular, Groups 1 and 2 have more accurate management of their ACFI.
Operating expense management	Providers with lower OEBITDA have higher absolute operating costs and higher costs relative to their operating income. This creates a squeeze on their OEBITDA.
Capital management	The better financially performing providers maintain lower liquidity, use more debt and manage it better.
Process management	The better financially performing providers have stronger business processes, particularly around budgeting, planning and outsourcing.
Governance and strategy	Better financially performing providers exhibit some specific governance practices and attributes including a narrower business focus. They are more inclined to provide residential care services only, and are more consistent in reviewing plans and progress and asset management.

Multivariate Analysis

The multivariate analysis, conducted in relation to survey respondents and individual responses, showed the following factors as represented in Table 8 were correlated with better financial performance. The results from the multivariate analysis were considered in the process of compiling the key factors associated with the drivers of financial performance in Table 7.

Where multiple factors were found to correlate to better financial performance, the multivariate analysis sought to identify the significance of individual factors. This analysis does not explain how or why identified factors influence the outcome. The methodology used in the multivariate analysis is explained in Appendix 3.

Table 8 – Multivariate Analysis Results

Question/factor	Description	Strength
Ownership	Having an ownership type of FP positively impacts operational financial performance.	✓✓✓
Accreditation	Successfully meeting accreditation requirements positively influences operational financial performance.	✓✓✓
Services offered	Providers with better operational financial performance are more targeted in their service offering and more likely to focus on residential aged care.	✓✓✓
Finance/debt facilities	Providers with better operational financial performance are more likely to have dedicated finance/debt facilities.	✓✓✓
Location	Being based in the city positively impacts operational financial performance.	✓✓
Shared services	Providers with better operational financial performance and with more than one facility share a higher proportion of their corporate services.	✓✓
Bond management	Providers with better operational financial performance target a lower bond percentage held in cash.	✓✓
ACFI management	Providers with better operational financial performance are more likely to have a dedicated internal ACFI resource.	✓✓
Outsourcing	Providers with better operational financial performance are more likely to outsource functions such as laundry, payroll and IT	✓

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Other Factors Related to Financial Performance

We also identified a number of other factors that, while not appearing to be key to differing financial performance, provides further insight into differing business models and financial performance outcomes. These are described below:

- occupancy rates across all groups were consistently high, averaging 93.1% and varying from 91.5% for Group 1 to 92.0% for Group 4
- notwithstanding the percentage of providers for whom returns derived are modest, only 3.0% of providers indicated an intention to leave the industry
- survey responses suggest there is broad intention to continue to invest in providing additional places
- a number of Group 4 providers have indicated an intention to use debt to expand operations. Their current financial performance may restrict their capacity to implement expansion plans.

Considerations for Specific Types and Groups of Providers

Group 4 providers

When we compared the operational characteristics of providers in Group 4 to the better financial performers (comprised of groups 1, 2 and 3) we found that:

- the OEBITDA of these providers is impacted by both lower revenue and higher costs
- their focus may not be on achieving financial performance outcomes
- lower number of beds per facility is linked to lower OEBITDA, and this group averages 55 beds per facility compared to better financial performers with an average of 73 beds per facility
- they have conservative liquidity management strategies
- they are less likely to rely on specialist internal skills to assess residents' ACFI classification
- as care levels increase, OEBITDA declines.

Group 1 providers

Group 1 providers were typified by their focus at both a strategic and operational level. We found that:

- group 1 providers overwhelmingly focused on one service offering, being residential aged care
- their resident mix and location resulted in higher government subsidies (care subsidies) and resident income (resident-contributed care fees and accommodation bonds/the deemed accommodation charge)
- the number of beds per facility – averaging 80 beds per facility – contributed to their efficiency
- these providers were distinguished by their capital and liquidity management.

Government providers

When we looked specifically at government providers we found:

- they have significantly smaller facilities by number of beds per facility: averaging 37 beds compared to 72 for providers of other ownership types
- their average operating expenses are 1.4 times the average of all other providers
- this difference in average operating expenses is accounted for by higher staffing costs, though we could not determine if this is total staff or unit cost of labour
- government providers appear to generate more revenue per resident, and for state government services this is likely to reflect additional sources of funding.

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Regional providers

Key characteristics of these regional providers are:

- they have a significant disadvantage due to the number of beds within a facility: 49 places compared to 74 for city and mixed providers
- providers across all ownership groups in regional locations receive lower government subsidies than providers in other locations
- providers across all ownership groups in regional locations are able to offset some of this lower operating revenue through lower average operating expenses – which is particularly pronounced for government providers in regional locations as compared to the government providers in city and mixed locations.

The Impact of the Supported Resident Ratio

Supported residents determine a significant portion of government funding for providers. If the 40% ratio is not met, the accommodation supplement is scaled back by 25%. We found that the dispersion of the supported ratio tended towards a normal distribution centred at 40–45%. Of particular interest was that:

- OEBITDA prpa for FP providers was highest at the two ends of the supported ratio distribution
- providers at the lower end of the supported ratio spectrum partly supplemented their income with extra services fees.

Viability Supplement

We analysed the impact of the viability supplement to assess if providers would shift between the financial performance groups if the supplement was not included in the OEBITDA calculation. In the 2013 financial year, 119 providers in Group 4 received the supplement.

When we removed the supplement from the OEBITDA calculation we found that 18 providers that were not in Group 4 but which received the supplement, would have been in Group 4 in the absence of the supplement.

Future Expansion Plans

As part of our survey, we asked providers a series of questions regarding their growth plans over the coming two years. We found that:

- 31 providers (15.7%) intended to bring approved in principle (AIP) places online
- 61 providers (31.0%) intended to expand and apply for new places
- providers from all groups have plans to expand, with the providers in groups 1 and 2 more likely to apply for new places.

We found that in the survey results for ACAR participation, participation increased from 1.1% to 29.9% of respondents from 2009 to 2013.

Of those providers planning to expand, 176 providers (82.6%) plan to redevelop existing buildings or develop on existing land. Providers are planning to fund their expansion plans primarily through bank loans (42.3%) and refundable accommodation deposits (41.3%).

Only 3% of surveyed providers indicated plans to exit the industry, with no particular group being more inclined to exit.

Additional Observations for ACFA to Consider

Based on work already undertaken , we submit the following further observations for ACFA to consider:

Observation 1: The quality of future research into the drivers of financial performance will be enhanced by adopting recommendations in ACFA's report to the Minister *'Improving the Collection of Financial Data from Aged Care Providers'*.

Observation 2: Increased governance and management capacity for Group 4 providers could enhance their financial performance, and it may be worthwhile to explore how Group 4 providers should go about achieving this outcome.

Observation 3: Given the impact of excess liquidity on net profit before tax, ACFA should continue to monitor trends in liquidity relative to net profit before tax.

Observation 4: Our analysis was conducted with reference to only one year's financial data (2013). As we found that providers move between groups, it would be worthwhile to repeat some or all of the analysis at regular intervals to gain deeper insight into any emerging trend.

1. About This Report

The Aged Care Financing Authority (ACFA) commissioned RSM and PwC to assist with its study into the factors that influence aged care providers' financial performance. We were asked to:

- identify the different approaches to business and financial management being used in the industry, including the short- and long-term impacts of these approaches on providers' financial performance, capital investment, sustainability, quality and cultural outcomes
- compare types of providers – including for-profit (FP), not-for-profit (NFP) and government – their location and market share (number and size of facilities), considering their varying business strategies and determining the extent to which some providers do not have a clear business strategy
- conduct qualitative and quantitative analysis of higher-performing providers relative to those not performing as well
- identify the financial, management, strategic and cultural factors that differentiate the better financial performers from those not performing as well
- provide commentary on what could be done to improve the financial performance of the lower-financially performing providers
- separately consider what factors affect provider financial performance in rural, regional and remote areas, including the impact of the viability supplement on rural, regional and remote providers.

ACFA also requested an analysis of the impact of providers':

- governance and strategy approaches
- management and administration policies
- organisation and personnel management
- market-facing and resident-related factors
- capital management practices.

1.1. Approach Overview

RSM and PwC submitted a joint proposal to undertake this project. The proposal combined RSM's deep understanding of the industry – at the operator and policy level – with PwC's expertise in the area of qualitative analysis.

In undertaking this project we considered the mainstream residential aged care providers through the lenses of ownership, location, size and level of care (resident care profile), then overlayed these factors with an analysis of financial and other metrics. Multi-Purpose Service (MPS) providers, have different operating and funding models compared to mainstream residential aged care providers, so were not included in the financial performance analysis.

The primary sources of data available to us included:

- the general purpose financial report (GPFR) data provided to Department of Social Services (DSS)
- other financial information held by DSS
- information provided by providers who participated in the PwC-managed qualitative survey.

We were particularly mindful that the industry needed to support the study's results and findings, so we designed the qualitative survey in collaboration with DSS, ACFA, residential aged care providers and industry peak bodies (ACSA and LASA).

ACFA established the Finance and Accounting Advisory Group to enhance our analytics approach and provide feedback on the reporting process.

As ACFA has produced two annual reports that include financial analysis of industry performance, we based our approach on this existing knowledge. We considered ACFA's analytical approach to developing its annual report, in particular its use of quartiles to compare and contrast performance, and the use of EBITDA as the primary measure of financial performance. In some instances we used common measures; at other times we refined ACFA's measures of performance to gain a deeper level of analysis.

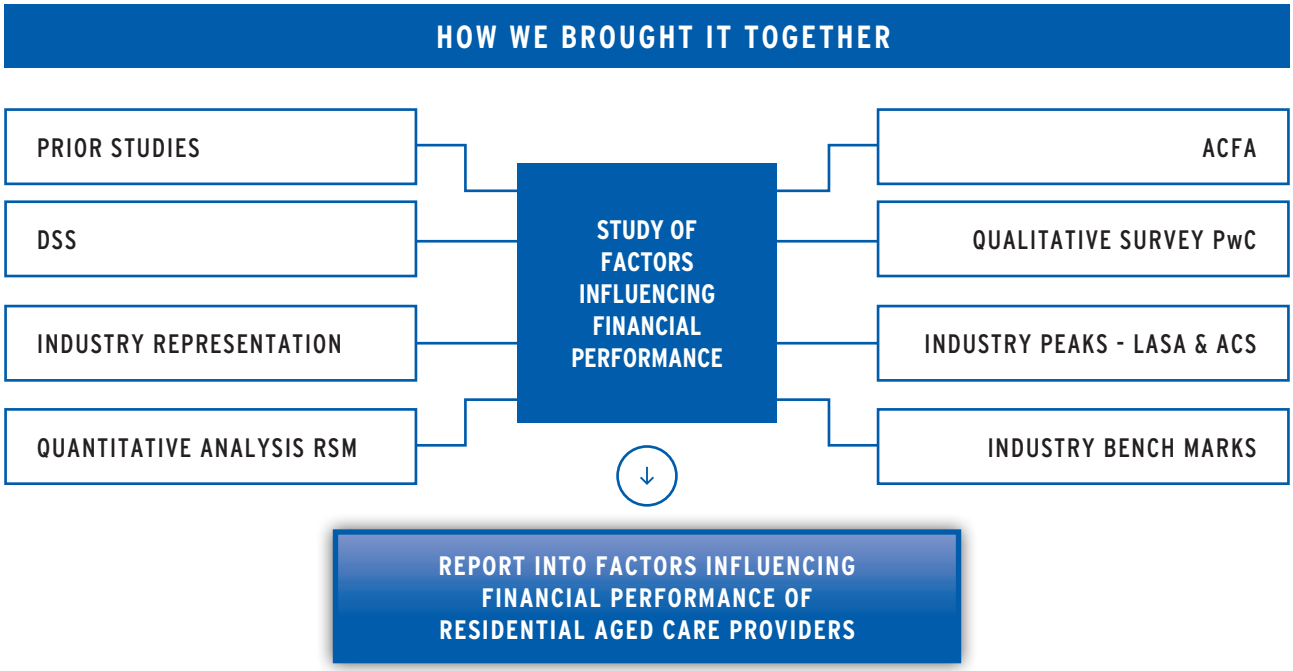
This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

We also considered the findings and processes from the following prior studies:

- *'Impact of financing arrangements on access to quality care'*, KPMG, 2013
- *'The viability of residential aged care providers'*, Deloitte Access Economics, 2011
- *'Australian Cost of Residential Aged Care Research'*, Grant Thornton, 2012.

Figure 3 shows how our approach drew on input from multiple sources, which enabled us to form a unified view of the factors driving and differentiating the financial performance of residential aged care providers.

Figure 3



1.2. Analytics Approach

1.2.1. Quantitative analysis

Our approach to the quantitative analysis was designed to ensure that, within the constraints of the data available, we compared like for like financial performance. To achieve this we isolated all non-operating income and expense items and sought to remove the impact of corporate structures on operating financial performance. We only included providers in our analysis where we could be confident that the item being analysed could be isolated within their GPFR or other appropriate data. In some instances this resulted in our analysis being based on a subset of the population. Where this occurs, it is noted.

In 2013, not all providers had access to lump sum accommodation payments. Those who did take a lump sum incurred an opportunity cost, being a daily accommodation charge. To remove this impact we calculated a deemed accommodation charge based on the aggregate lump sums held by these providers and the maximum permissible interest rate.

Appendix 1 sets out in detail the approaches and processes we went through to ensure appropriate analysis of financial factors.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

1.2.2. Qualitative survey

The qualitative survey questions were designed in consultation with the industry. We analysed the attributes (size, location, ownership and resident care profile) of participants to ensure they were representative of the population. Table 9 sets out a summary of the factors addressed in the survey questions.

Table 9: Factors addressed in the survey questions

Question type	Questions
General information	1-2
Governance/strategy	3-11
Capital management	12-17
Finance	18-29
Operations	30-38
Workforce	39-41
Resident/marketing	42-48
Facility level	49-60

Appendix 2 sets out in detail how the survey was constructed and administered. Appendix 4 sets out all the results of the survey questions.

1.2.3. Multivariate analysis

Multivariate analysis looks at a range of factors to try to understand their relative importance in driving operational financial performance. Our analysis identified nine key factors which appeared to differentiate financial performance. By modelling these factors simultaneously, we were able to identify the strength of impact of each of these factors on financial performance of providers.

Appendix 3 sets out in detail our approach in conducting the multivariate analysis.

1.3. Key Measures of Financial Performance

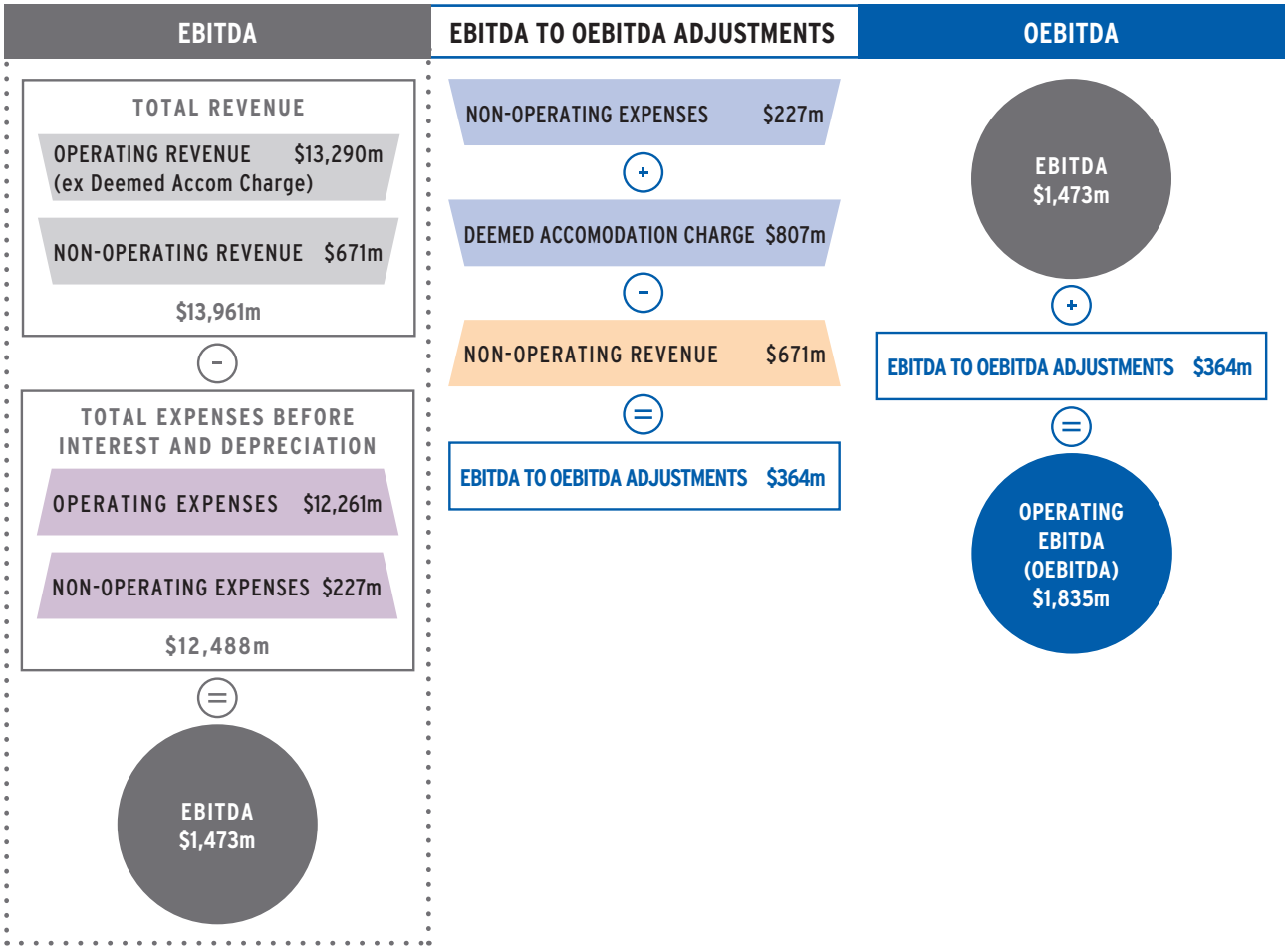
For the purpose of this study we defined 'financial performance' in terms of:

- operating earnings before interest, tax, depreciation and amortisation (OEBITDA). OEBITDA is EBITDA excluding non-operating income items and interest income, and includes a deemed daily accommodation charge, factoring in lump sums held by providers and the 2013 maximum permissible interest rate (MPIR). To ensure consistency we also excluded related party rent charges. We used OEBITDA as a measure as it significantly increased the consistency and comparability of provider performance figures
- net operating profit before tax (NOPBT), which is OEBITDA less depreciation and amortisation
- adjusted net operating cash flow, which is OEBITDA less net interest expense and after adding back actual repairs
- operating revenue is revenue directly related to running a residential aged care facility, excluding related party income, investment income, donations and capital grants
- operating expenses excluding finance expenses, related party charges and similar charges to profit
- equity, which includes debts to related parties.

OEBITDA enables a deeper analysis of what drives variations in operating financial performance. In Figure 4, we have provided a reconciliation of the ACFA definition of EBITDA to OEBITDA. Figure 4 shows the net impact of removing the non-operating items from EBITDA and the inclusion of the deemed accommodation charge. In aggregate, an additional $364m of operating earnings are recognised in OEBITDA relative to EBITDA. Figure 6 in Appendix 1 provides a more detailed breakdown of how OEBITDA and related measures used in our analysis are reconciled to terms and measures used in the ACFA report.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Figure 4: Summarises the relationship between EBITDA and OEBITDA (numbers are in $m)



1.4. Grouping

We worked with ACFA's Finance and Accounting Advisory Group to categorise providers' financial performance. As our study sought to understand financial performance along a continuum, categories were created based on performance, rather than grouping the industry by provider numbers on a quartile or other basis.

For the purpose of this study we categorised financial performance into:

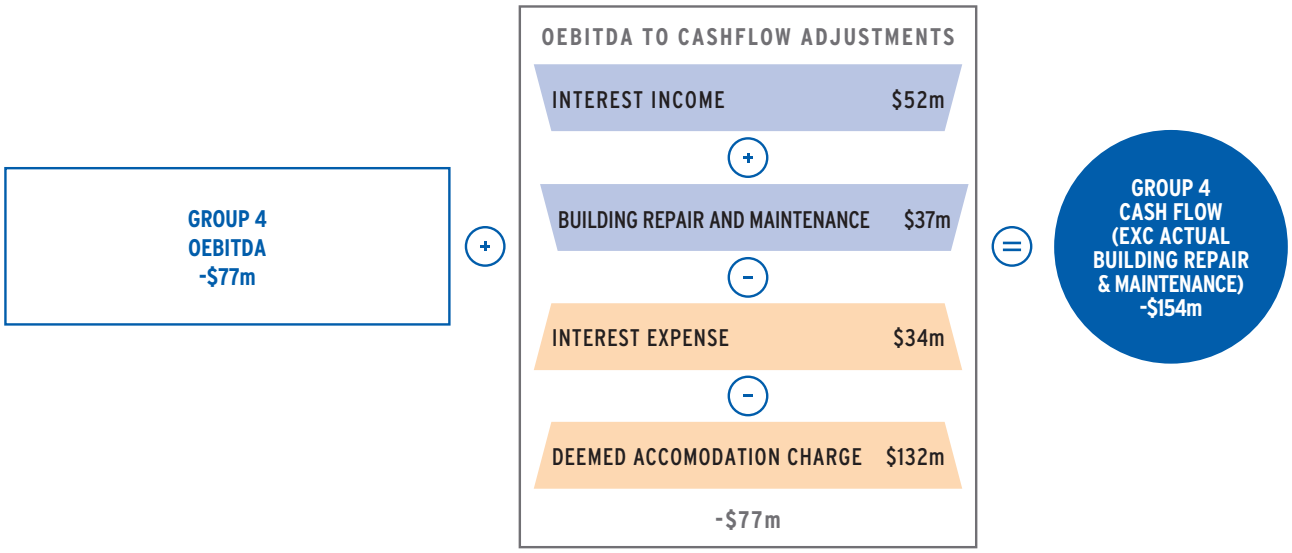
a. **Financial performance group 1 (Group 1)** – providers whose OEBITDA placed them in the top 20% (quintile) of all providers

b. **Financial performance group 2 (Group 2)** – providers whose OEBITDA placed them in the next (quintile) of all providers,

c. **Financial performance group 4 (Group 4)** – As ACFA is particularly interested in providers with the lowest financial performance we defined 'low financial performance' as that where net operating cash flow adjusted by removing actual building repair and maintenance is below a notional level of repairs and maintenance considered necessary to maintain a facility in good order and repair.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Figure 5: Net operating cash flow adjusted for repairs and maintenance (numbers are in $m)



Group 4 classification does not mean a provider is at risk of failure. In fact, our analysis showed that providers in this group have developed alternative income streams so they can continue to operate despite the operational challenges they face.

d. **Financial performance group 3 (Group 3)** – providers whose OEBITDA prpa is below that of providers in the second quintile not including providers who are in Group 4.

Section 2 of this report sets out how we established the measures of financial performance and approached grouping. Appendix 1 includes further detail of these terms and reconciliation with the related terms used in the AFCA reports.

Based on the above segmentation, we conducted a detailed quantitative analysis of the FY2013 GPFR data and other financial information held by DSS, to identify and understand the variations and similarities in key financial measures of providers.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

1.5. Structure of this Report

The study looked at the attributes of ownership, location and size together with many quantitative and qualitative factors and variables associated with operating a residential aged care facility. To assist readers in better understanding the findings, the report has been structured as follows:

Table 10: Structure of Report

Section	Title	Subject matter
1	About this report	Provides a context and background for the report and the methodology used in the analysis
2	Grouping of providers	Sets out how providers were placed into the four performance groups
3	Impact of ownership, location and size Other key quantitative and qualitative factors impacting financial performance	Considers the impact of these key attributes on financial performance Considers other factors (qualitative and quantitative) that are considered key in explaining differing financial performance
4	Other factors related to financial performance	Looks at factors not considered key to financial performance which provide further insight into providers in the four financial performance groups
5	More about Group 4 providers	An in-depth look at the characteristics of Group 4 providers compared to better financial performers (Groups 1, 2 and 3)
6	More about Group 1 providers	Highlights the key features that assist providers in this group achieve their better financial performance
7	More about other groups of providers	Considers factors contributing to or associated with other groups of providers: • government • regional influences • recipients of viability supplement • impact of supported resident ratio • remote Aboriginal and Torres Strait Islander (ATSI) and Multi-Purpose Services (MPS) providers
8	Recent changes on financial performance	Outlines the funding and financing changes since 2013 that are expected to have an impact on future operating financial performance
9	Providers' expansion plans	Analyses the feedback from survey respondents on their future plans
10	Earnings lost on surplus liquidity	Provides an overview of the impact on OEBITDA of relatively high liquidity attributable to lump sum accommodation liabilities held in liquid investments
Appendix 1	Details of the quantitative analysis	Details the basis of and limitations to our quantitative analysis
Appendix 2	Details of the qualitative analysis	Background on how the qualitative survey was developed and administered, including an analysis of the participants
Appendix 3	Results of the multivariate analysis	Provides background on the analysis and findings
Appendix 4	Qualitative survey	Contains a complete list of survey questions and an analysis of the responses

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

1.6. Limitations of Our Analysis

The quantitative analysis relies extensively on data held by DSS. This data includes:

- de-identified GPFR data provided by approved providers
- service-level information pertaining to location, ownership and care
- subsidy-related information
- information about approved places being allocated and brought online.

Our quantitative analysis is based on a single year's data. We examined the consistency of providers' quartile performance using EBITDA and OEBITDA. While financial performance measured by OEBITDA results in greater consistency of ranking, providers' financial performance rankings do change over time. Providers with better financial performance tend to exhibit more consistency relative to providers with lower financial performance as measured by OEBITDA.

ACFA recently completed a detailed review of financial data that DSS had collected through GPFRs. Among other things, ACFA noted the limited quality and usability of the GPFR data. As our quantitative analysis was primarily based on this GPFR data, our work is also constrained by the limitations of this data. Throughout this report we have identified where these limitations affected our analysis and where we adapted the available data to undertake our analysis.

The PwC-managed survey was voluntary and self-reported, and asked respondents to recall past events. Surveys of this type have inherent weaknesses and limitations when asking participants to consider causes, or where multiple contributing factors co-exist. The multivariate analysis PwC conducted seeks to analyse the results in a way that addresses these co-existent factors and the limitations of the survey methodology.

This report is based on qualitative and quantitative analysis undertaken by RSM and PwC for the specific purpose of assisting ACFA to prepare its final report to the minister. While the report is compiled from information we derived from individual approved providers, it is not intended to be used by individual providers as a basis for developing individual operating models. Neither RSM nor PwC accept any responsibility to any person other than ACFA for the contents of this report.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

2. Grouping of Providers

2.1. Financial Grouping of Providers

Our primary measure of financial performance to rank and group providers was operating earnings before interest, tax, depreciation and amortisation (OEBITDA) per resident per annum (prpa).

OEBITDA differs from EBITDA in that it excludes non-operating income and expenses. This approach helps to compare and group providers using a consistent financial performance measure. The calculation of OEBITDA and its reconciliation to EBITDA as defined by ACFA in its annual report is contained in Appendix 1.

The aged care industry is diverse and its providers have diverse financial outcomes. Providers make implicit and explicit choices and trade-offs regarding the care and services provided, where and to whom they provide them, and how much they charge. There is no doubt that providers would rank differently if measured by other, non financial metrics.

We defined four groups of providers, which we labelled financial performance Groups 1 through 4.

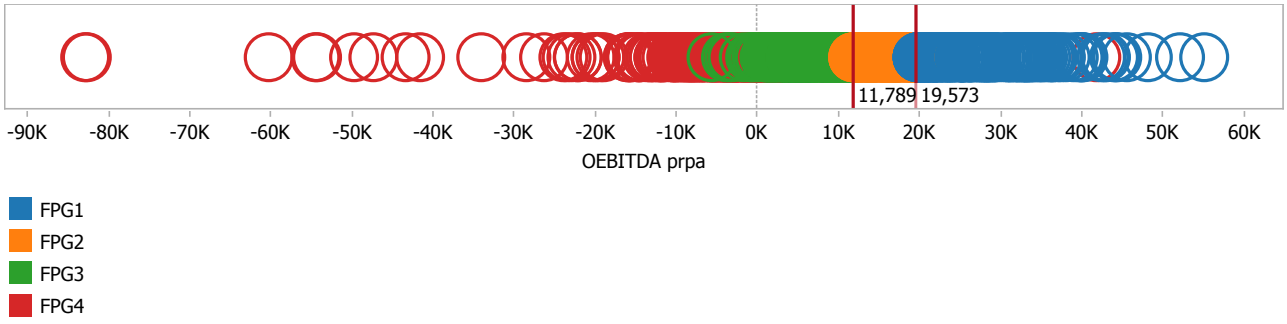
In ranking the 1,034 providers, we concluded that the analyses would benefit from the removal of 10 outliers: five from the top and five from the bottom. While we could not determine what was impacting the results of these outliers, their OEBITDA prpa was so divergent from the average OEBITDA prpa, it called into question the accuracy and validity of the GPFR information they reported. These outliers were mostly but not exclusively FP providers classified as high care, at one location, in a city. This left 1,024 providers.

2.1.1. Group 1 and Group 2 providers

Group 1 was defined as the top quintile of providers, or the top 20%, adjusted for outliers and ranked by OEBITDA prpa. The lowest-ranked operator in this group had OEBITDA prpa of $19,573 in FY13. The average OEBITDA of providers in this group was $25,731.

Group 2 was defined as the second quintile, or those in the next 20% of providers by OEBITDA. The top-ranked providers in this group had OEBITDA prpa of $19,572 while the lowest-ranked operator in this group had OEBITDA prpa of $11,789. The average OEBITDA of providers in this group was $15,250.

Chart 001: Financial Performance Group (FPG) 1 and Financial Performance Group (FPG) 2 OEBITDA Cutoff



2.1.2. Group 4 providers

Irrespective of mission, all providers seek to deliver a financial outcome allowing continued provision of care to their residents. Based on consultation with the industry there was agreement that a provider would be classified as Group 4, for the purposes of this study, if they did not generate sufficient cash flow to pay for $3,000 prpa of building repairs and maintenance and equipment replacement. This amount reflects the average cost of repairs for providers of $2,280 prpa, as identified in the survey and reported in section 3.5.2, together with an allowance to pay for the cost of replacing $10,000 prpa of consumable plant and equipment over an anticipated life of 10 years. Together these allowances recognise that maintaining a facility in good order and repair is essential to the provision of quality care.

Cash flow was calculated as OEBITDA prpa plus interest income, less interest expense and the deemed accommodation

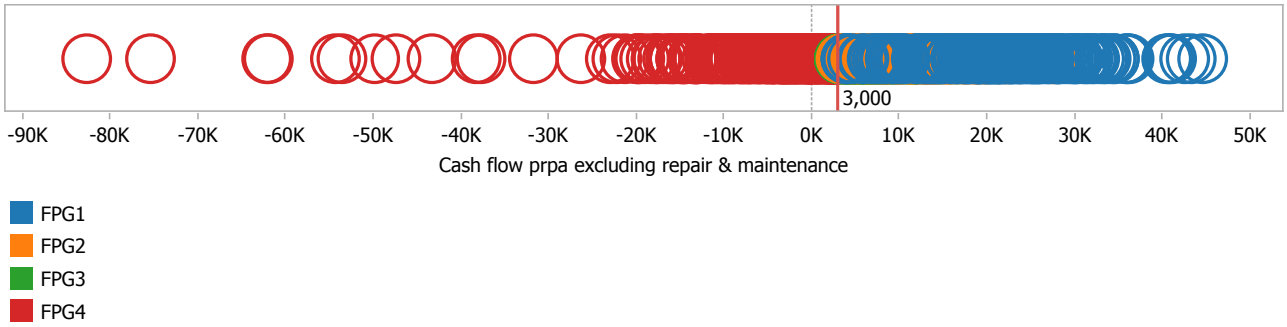
charge. Actual building repairs and maintenance expenses were added back to the result, to accommodate providers who had an unusual year in this respect in FY13.

The highest OEBITDA prpa of providers in this group was $41,651. When the cash flow adjustments were made to the OEBITDA prpa of this provider, the resulting cash flow prpa was -$44. Extreme results like this underpin our approach.

The average OEBITDA prpa of this group was -$2,072.

Classification in Group 4 does not suggest that these providers are at imminent risk of failure or have no future in the industry. Many providers, particularly those in regional or rural and remote locations, are known to be in Group 4. Providers in this group have developed solutions or obtain support to allow them to provide equity of access to those who need the services they provide. Furthermore, providers' financial performance changes over time, which means they tend to change groups. The degree to which providers change groups is set out in Appendix 1. In section 5, we have considered how these providers have adapted to their financial circumstances.

Chart 002: Financial Performance Group (FPG) 4



One third of the industry, (340 providers), was classified as Group 4.

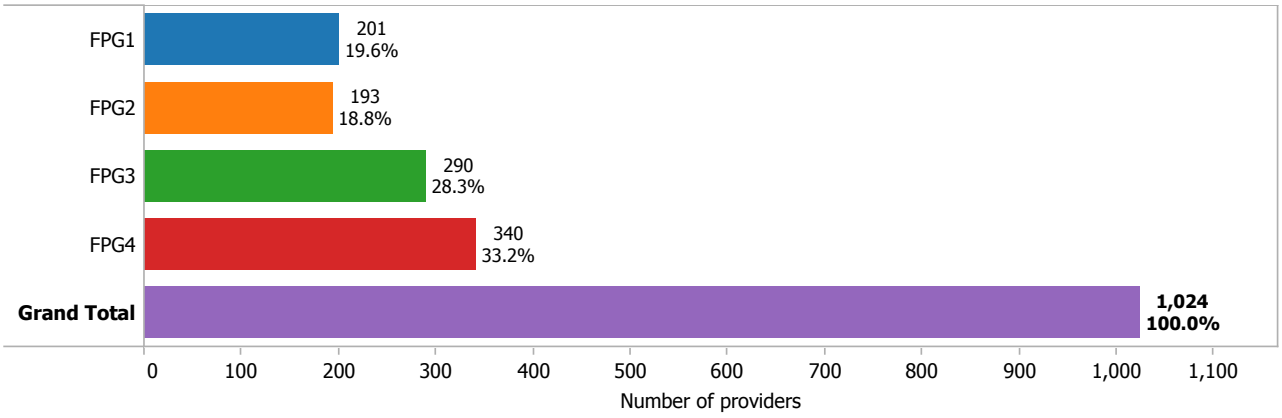
2.1.3. Group 3 providers

This group contained providers whose OEBITDA prpa was below that of providers in the second quintile while excluding providers who were in Group 4. There were 290 providers (28.3%) classified as Group 3. The highest OEBITDA of this group was $11,761 while the lowest OEBITDA was -$5,801. The average OEBITDA of this group was $7,263.

2.1.4. Number of providers in each group

Chart 003 shows the number of providers in each group.

Chart 003: Providers in Financial Performance Group (FPG)

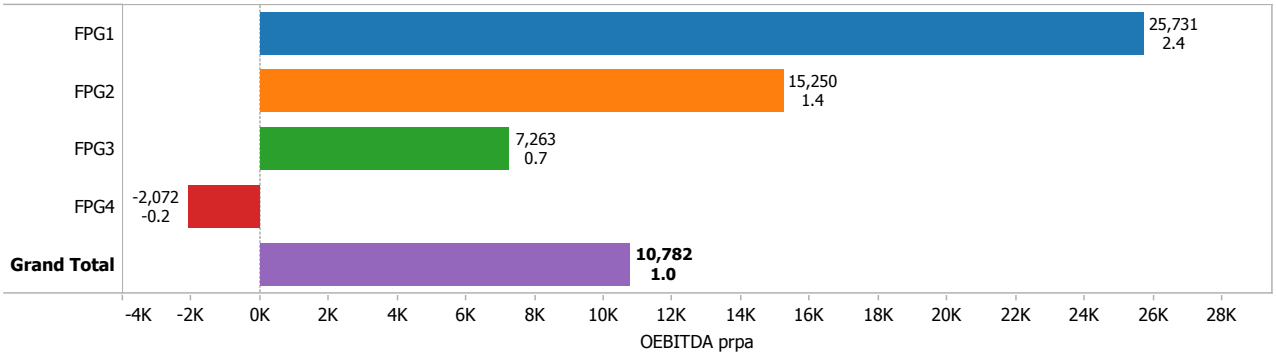


As we calculated Group 4 using cash flow, this caused a small amount of overlap with Group 1 and Group 2, which were grouped using OEBITDA prpa. This overlap resulted from the deemed accommodation charge and net interest adjustment from OEBITDA prpa to cash flow. Overlapping providers were classified as Group 4. This reduced the number of providers in Group 1 and Group 2 from 205 (20%), to 201 (19.6%) and 193 (18.8%) respectively.

2.1.5. OEBITDA prpa of each group

Chart 004 shows the average OEBITDA of each group and the industry average OEBITDA.

Chart 004: OEBITDA prpa per Financial Performance Group (FPG)



2.1.6. Key aggregate financial metrics of each group

Table 11: Key aggregate financial metrics

	Group 1 ($m)	Group 2 ($m)	Group 3 ($m)	Group 4 ($m)	Aggregate ($m)
Operating revenue	3,066 (21.9%)	3,599 (25.6%)	4,518 (32.2%)	2,849 (20.3%)	14,032
Operating expenses	-2,226 (18.2%)	-2,949 (24.2%)	-4,100 (33.6%)	-2,926 (24.0%)	-12,201
OEBITDA	840 (45.9%)	651 (35.5%)	418 (22.8%)	-77 (-4.2%)	1,832
NOPBT	731 (65.5%)	478 (42.9%)	141 (12.6%)	-235 (-21.0%)	1,115

2.2. Ownership, Location, Size and Resident Care Profile

ACFA has produced two annual reports that include financial analyses of industry performance. These analyses look at the industry across the four dimensions of ownership, location, size (also called services or facilities) and resident care profile. We have used the same ACFA dimensions and definitions.

The industry composition viewed by these dimensions is shown in charts 005, 006, 007 and 008.

When inviting providers to participate in the survey, we mapped the invitations according to these four dimensions to ensure the representativeness of the conclusions drawn from the survey responses.

Chart 005: Ownership

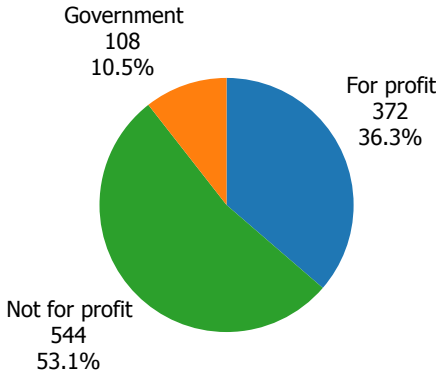


Chart 006: Location

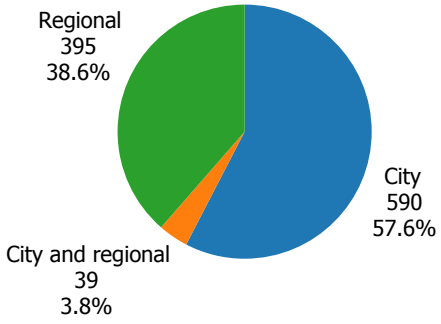


Chart 007: Size

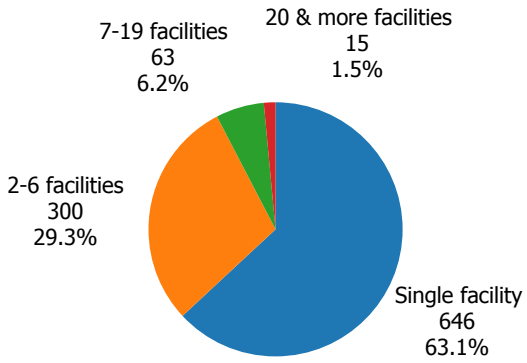
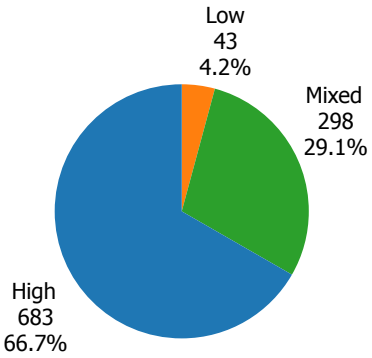


Chart 008: Resident Care Profile



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

2.2.1. Providers in financial groups by ownership

Chart 009 shows that just over half of the providers (544 or 53.1%) operated on a NFP basis.

Group 1 was dominated by 162 FP providers (80.6%). However, 32 NFP providers (15.9%) delivered Group 1 performance. There were as many NFP providers –94 (48.7%) – as FP[2] providers in Group 2.

Notably, 63 FP providers (18.5%) were in Group 4.

Chart 009: Providers in Financial Performance Group (FPG) by Ownership

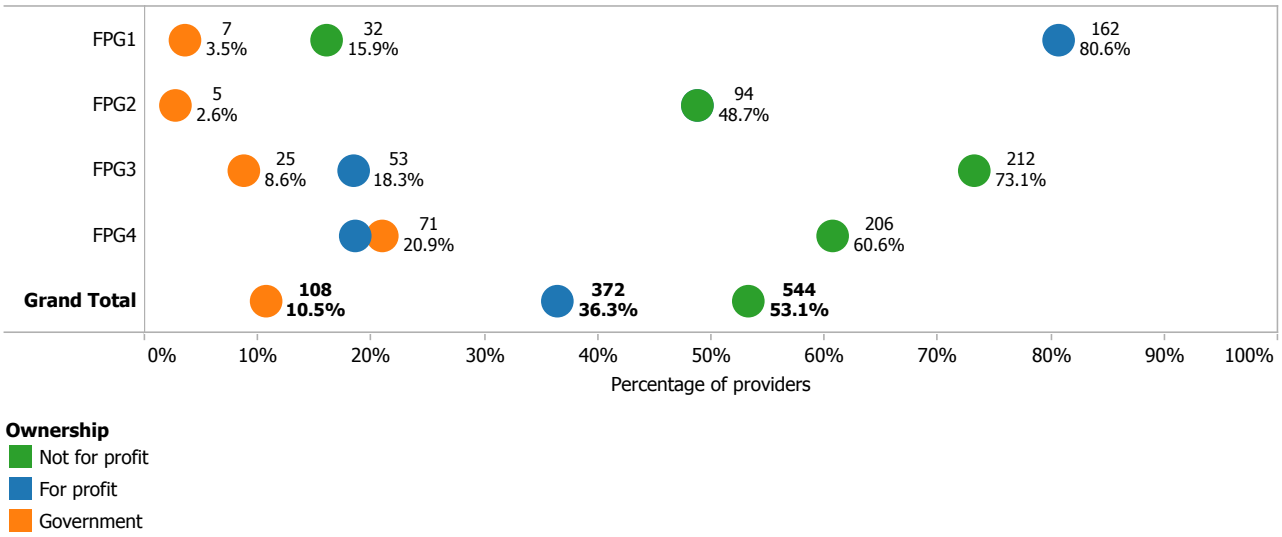
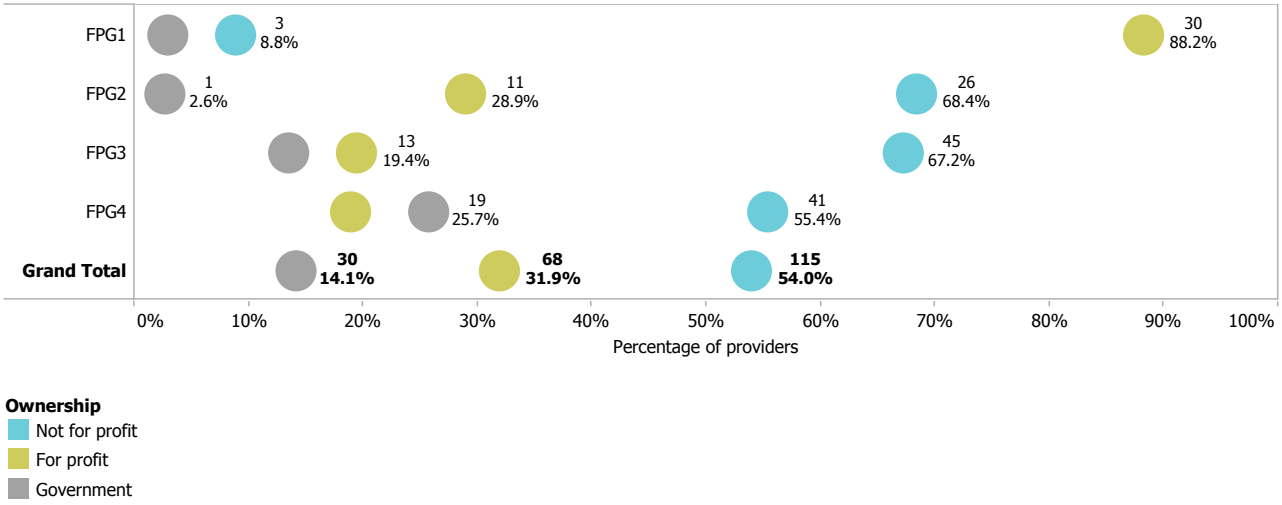


Chart 010 shows that the distribution of survey respondents was generally representative of the population. This provided confidence with respect to the survey findings.

Chart 010: Survey Responses by Ownership



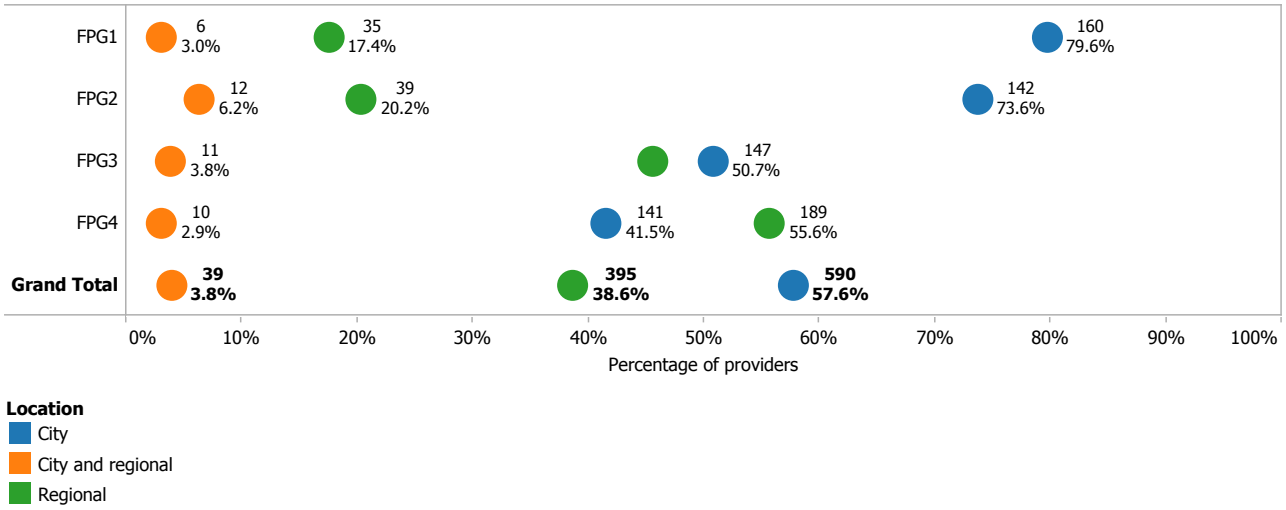
[2] In Chart 009, as the numbers of FP and NFP providers are the same in FPG2, the green dot representing the NFP providers has overlapped the blue dot representing FP providers.

2.2.2. Providers in financial groups by location

Chart 011 shows that providers in cities dominated Group 1 and Group 2, with 160 (79.6%) and 142 (73.6%) providers respectively.

There was a bias towards regional providers in Group 4.

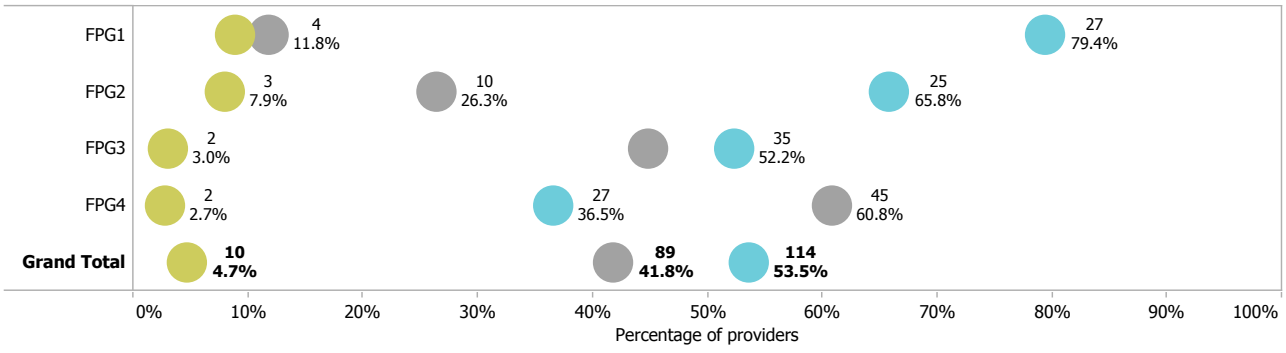
Chart 011: Providers in Financial Performance Group (FPG) by Location



Location
- City
- City and regional
- Regional

Chart 012 shows that the distribution of survey respondents was generally representative of the population.

Chart 012: Survey Responses by Location



Location
- City
- City and regional
- Regional

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

2.2.3. Providers in financial groups by size and beds per facility

Almost two-thirds (646 or 63.1%) of providers operate a single facility and 946 (92.4%) operate six or fewer facilities. By this measure, there is little differentiation across the groups, as chart 013 shows.

Chart 013: Providers in Financial Performance Group (FPG) by Size

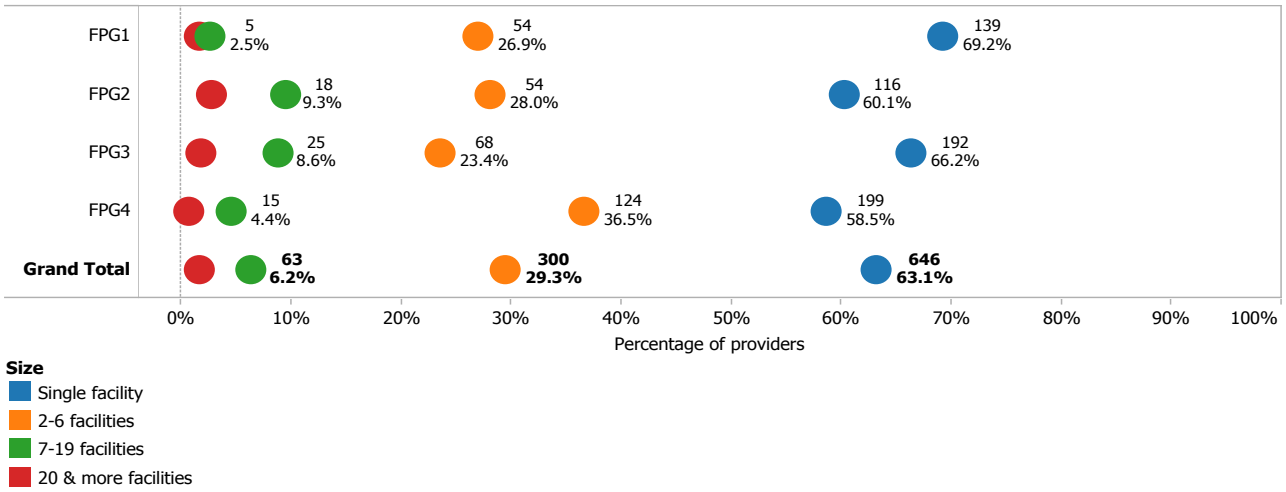
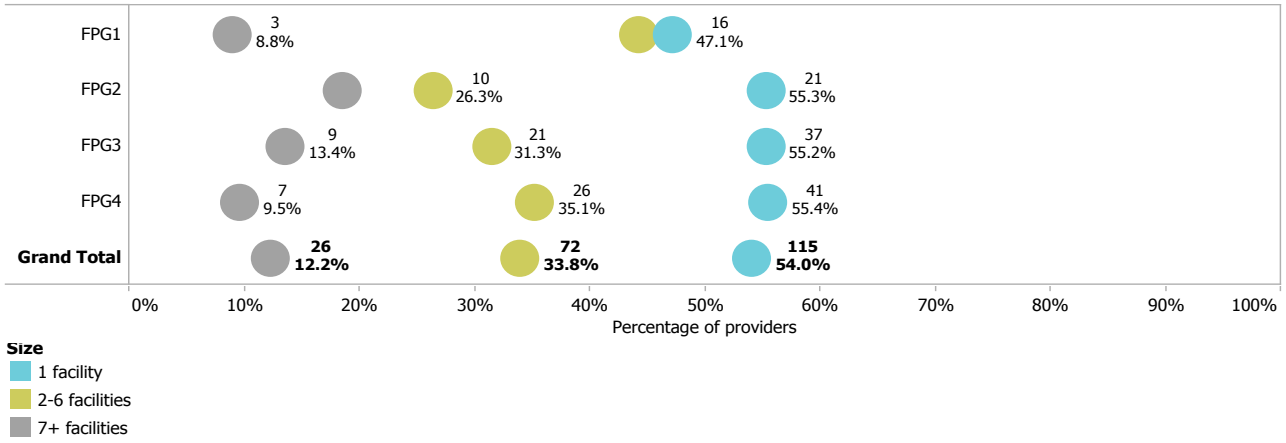


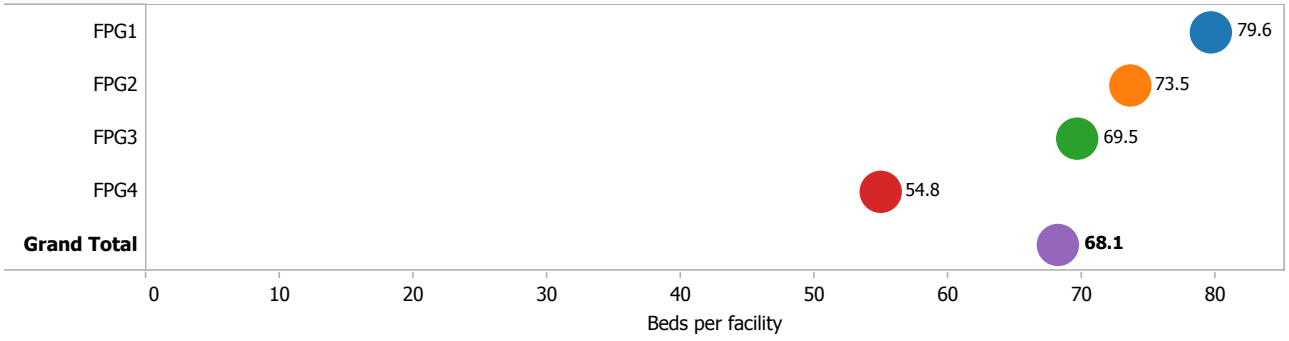
Chart 014 shows that the distribution of survey respondents was generally representative of the population. Due to the small sample of respondents with 20 or more facilities, they have been grouped with the providers with 7-19 facilities.

Chart 014: Survey Responses by Size



Another aspect of size is the average number of beds available in a facility. Chart 015 shows a clear relationship between the average number of beds in a facility and the grouping of providers. Financial performance increases as the average number of beds per facility increases.

Chart 015: Average Beds per Facility for Providers Across Group



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

2.2.4. Providers in financial groups by resident care profile

Two-thirds of the industry, 683 (66.7%) provided high care[3] services.

A high proportion, 177 (88.1%), of Group 1 were classified as high care services and this group provided no low care only services.

Group 4 had the lowest concentration of high care providers, 172 (50.6%), and the highest concentration of low care[4] providers, 26 (7.6%).

Chart 016: Providers in Financial Performance Group (FPG) by Resident Care Profile

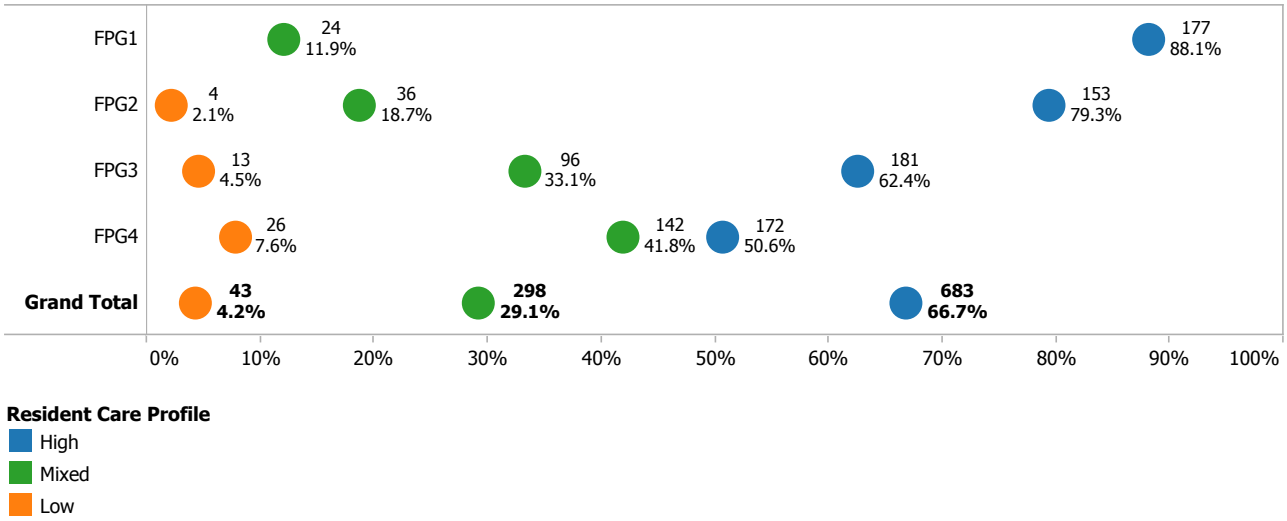
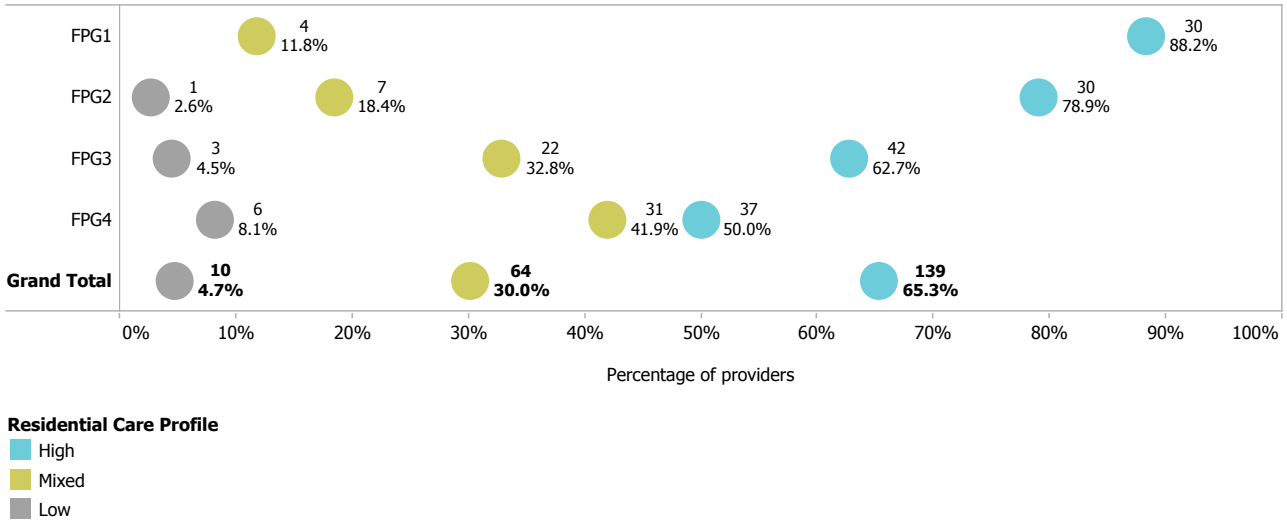


Chart 017 shows that the distribution of survey respondents was generally representative of the population.

Chart 017: Survey Respondents by Residential Care Profile



[3] Providers are classified as high care when over 70% of care days delivered have an ACFI classification of 'high'.
[4] Providers are classified as low care when over 70% of care days delivered have an ACFI classification of 'low'.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

3. Key Findings

3.1. Summary

The following table summarises the impact of key attributes and the qualitative and quantitative factors associated with varying levels of financial performance. These factors are examined in further detail in this section of the report.

Table 12: Summary of key findings

Key findings	Section in report	Impact on financial performance
Attributes	**3.2**	
Ownership	3.2.1	Ownership is relevant but not determinative of financial performance. FP providers perform better financially, as measured by OEBITDA
Location	3.2.2	Location provides a stronger guide to expected financial performance, However, being located regionally is not determinative of financial performance. A significant number of providers in city locations are in Group 4 and a significant number of providers in Group 1 operate in regional locations.
Size	3.2.3	While increasing the size of an organisation (that is, the number of facilities operated) does not correlate with better financial performance, increasing the number of beds within a facility does correlate strongly with improved financial performance.
Financial management	**3.3**	
Operating revenue management	3.3.1	Providers with higher OEBITDA receive more operating revenue from all sources and are less reliant on government income. They receive more government subsidies (mainly ACFI) and more deemed accommodation charges from residents.
Operating expense management	3.3.2	Providers with lower OEBITDA have higher absolute operating expenses and higher costs relative to their operating revenue. This creates a squeeze on OEBITDA.
Capital management	3.3.3	The better financially performing providers maintain lower liquidity and have more experience managing debt levels.
Process management	**3.4**	The better financially performing providers have stronger business processes, particularly regarding budgeting, planning, and outsourcing.
Governance and strategy	**3.5**	
Board attributes	3.5.1	The better financially performing providers have stronger and more focused governance capabilities – for instance, regarding their approach to and monitoring of risk.
Asset management	3.5.2	The better financially performing providers spend appropriately on infrastructure. They keep their facilities fresh through refurbishment programs.
Business focus	3.5.3	The better financially performing providers are very clear about their business focus. They tend to deliver residential care only, and have more targeted marketing and resident profiles.
Strategy and planning	3.5.4	Better financially performing providers monitor plans more regularly and anticipate change.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

3.2. Ownership, Location, Size and Resident Care Profile

3.2.1. OEBITDA and ownership

As already discussed, there were NFP, FP and government-run providers in all four financial groups.

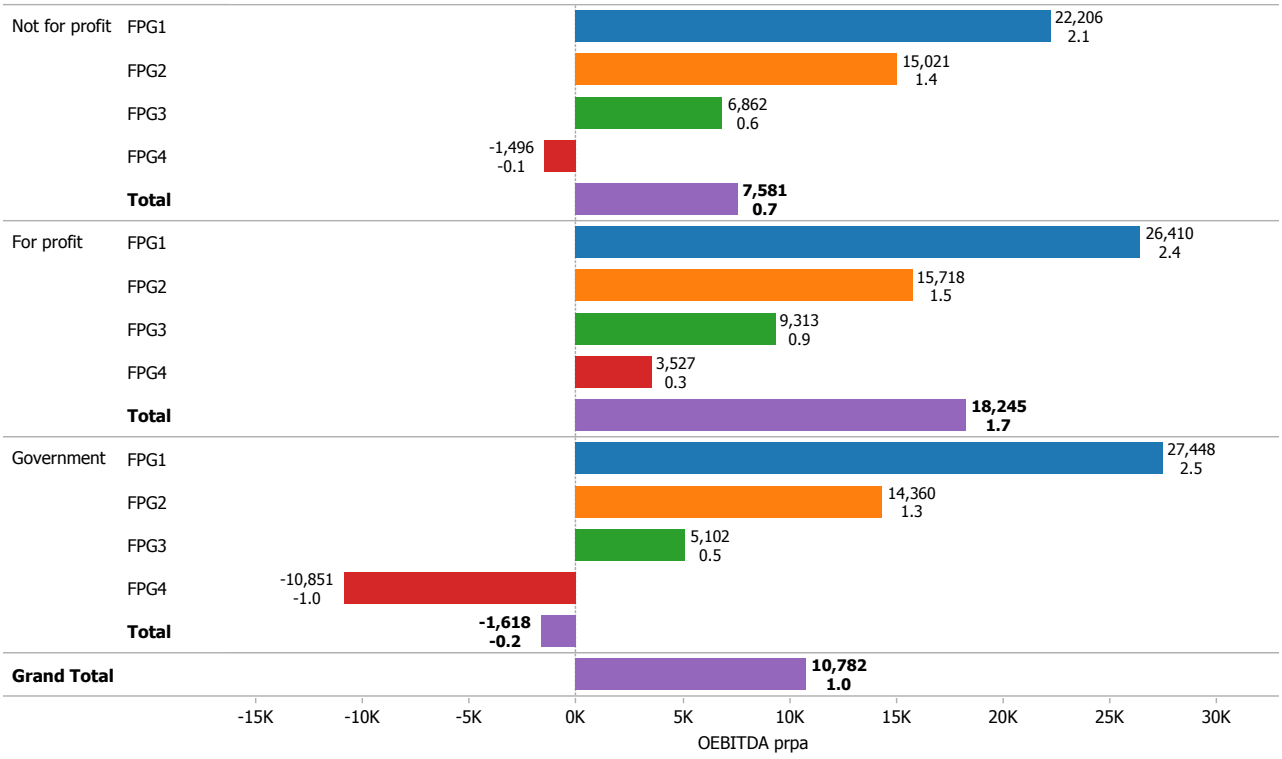
Chart 018 shows that FP providers earned higher OEBITDA prpa than NFP and government providers in all groups except for Group 1.

On average, FP providers earned $18,245 OEBITDA prpa. This is 1.7 times the industry average of $10,782 OEBITDA prpa.

NFP providers earned an average of $7,581 OEBITDA prpa, or 0.7 times the industry average and less than half the average of the FP group.

Given the over-representation of government providers in Group 4 and the basis on which they operate, the financial performance of government providers in Group 1 may warrant further analysis with additional data.

Chart 018: OEBITDA prpa by Ownership and Financial Performance Group (FPG)

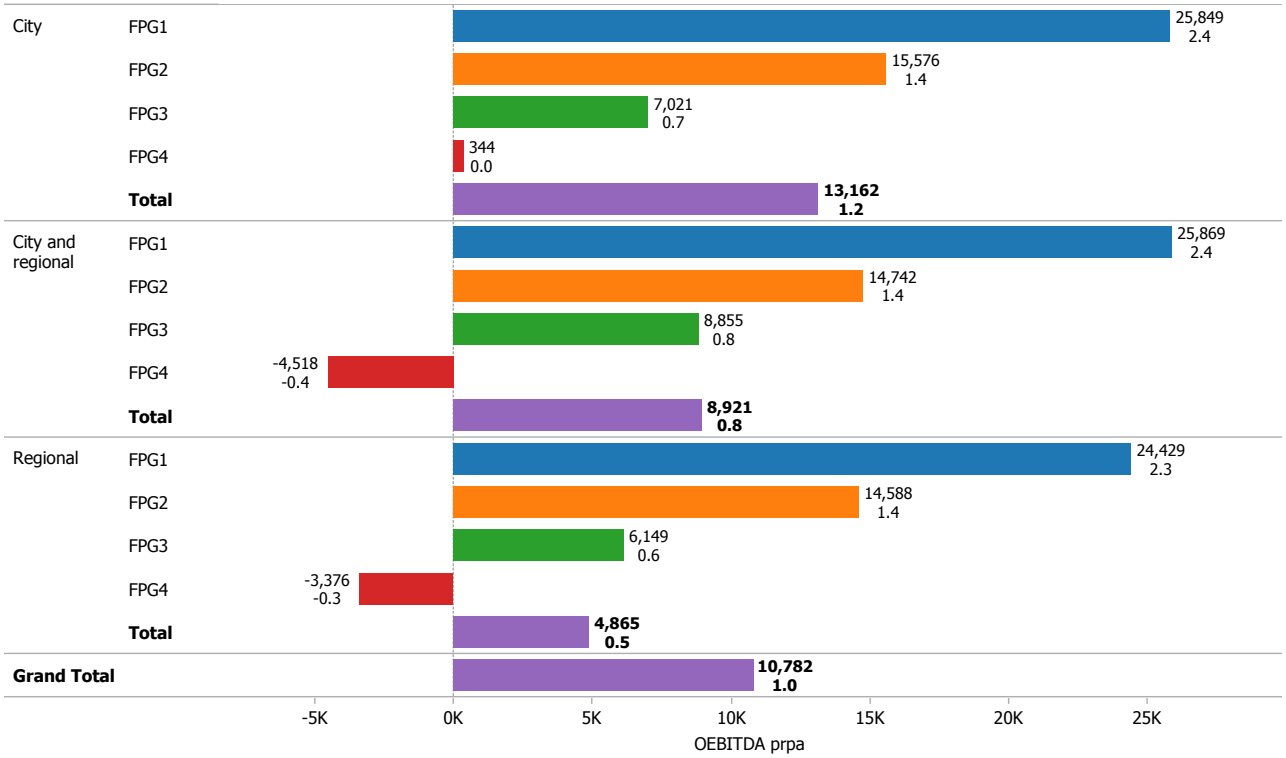


This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

3.2.2. OEBITDA and location

Chart 019 shows that location is linked to financial performance. City providers generated higher average OEBITDA prpa than regional providers, at $13,162 (1.2 times average) compared with $4,865 (0.5 times average).

Chart 019: OEBITDA prpa by Location and Financial Performance Group (FPG)



Providers in Group 1 and Group 2 achieved better results wherever they operated. The average OEBITDA prpa of Group 1 providers ranged narrowly between $25,849 (2.4 times average) and $24,429 (2.3 times average), and the financial performance of Group 2 providers mirrored this pattern.

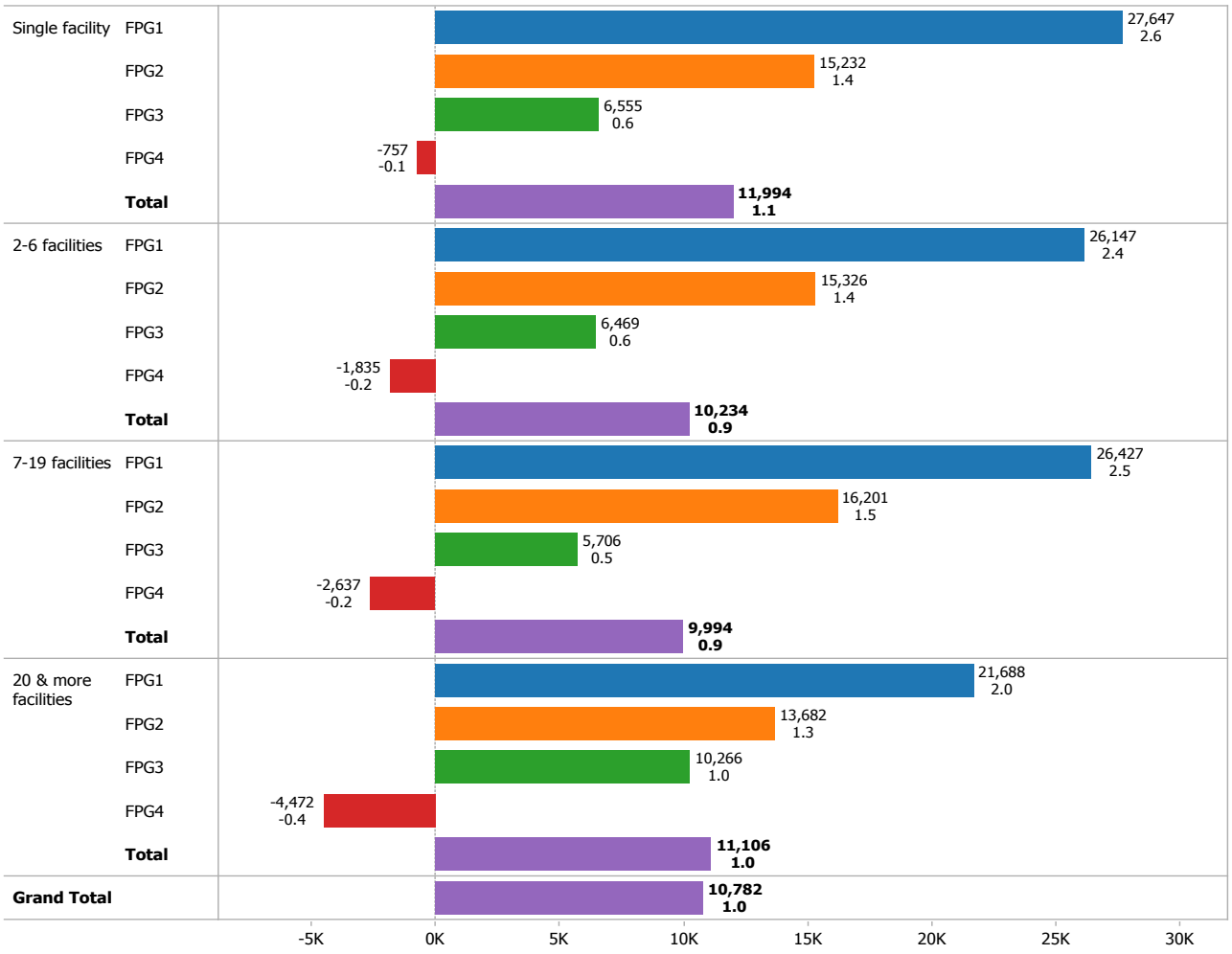
Contrast these results with those of Group 4 providers, which earned $344 OEBITDA prpa on average in cities and lost $3,376 OEBITDA prpa (-0.3 times average) in regional locations. Providers in Group 4 operating in both city and regional locations tended to achieve the lowest financial outcome.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

3.2.3. OEBITDA and size

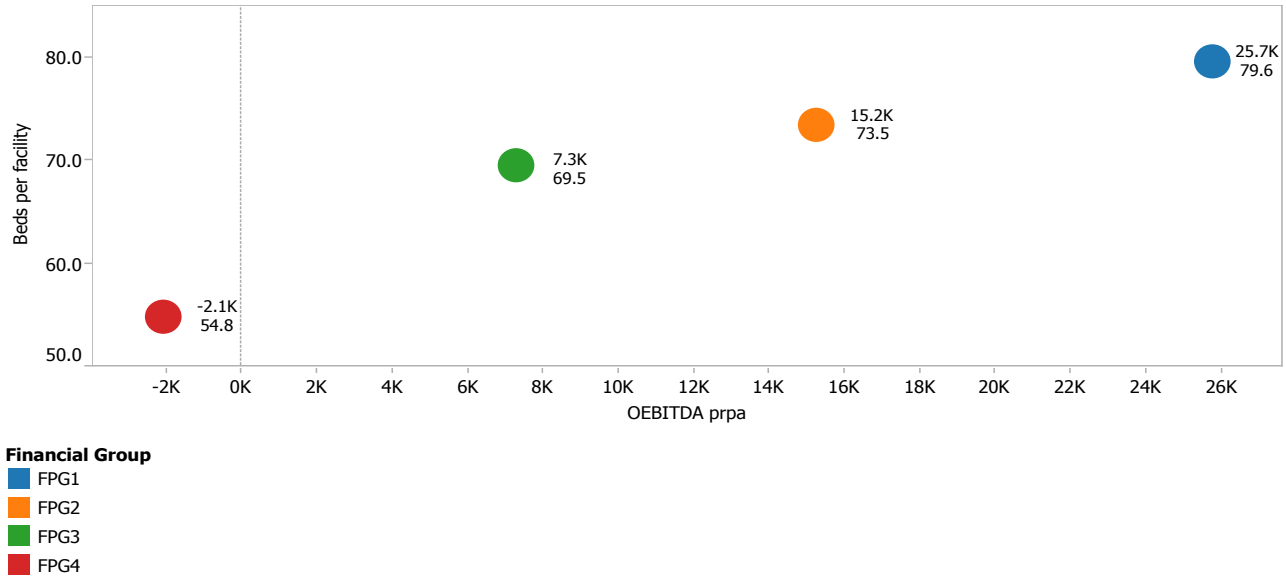
In Group 1, it is only at the largest size grouping that financial performance declines. In Group 4, there is an inverse relationship between size and OEBITDA prpa. The impact of size varies for the remaining two groups.

Chart 020: OEBITDA prpa by Size and Financial Performance Group (FPG)



As shown in Chart 021 there was a strong link between bed numbers per facility and OEBITDA. As bed numbers per facility increase, so does OEBITDA.

Chart 021: OEBITDA prpa as Compared to Beds per Facility



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

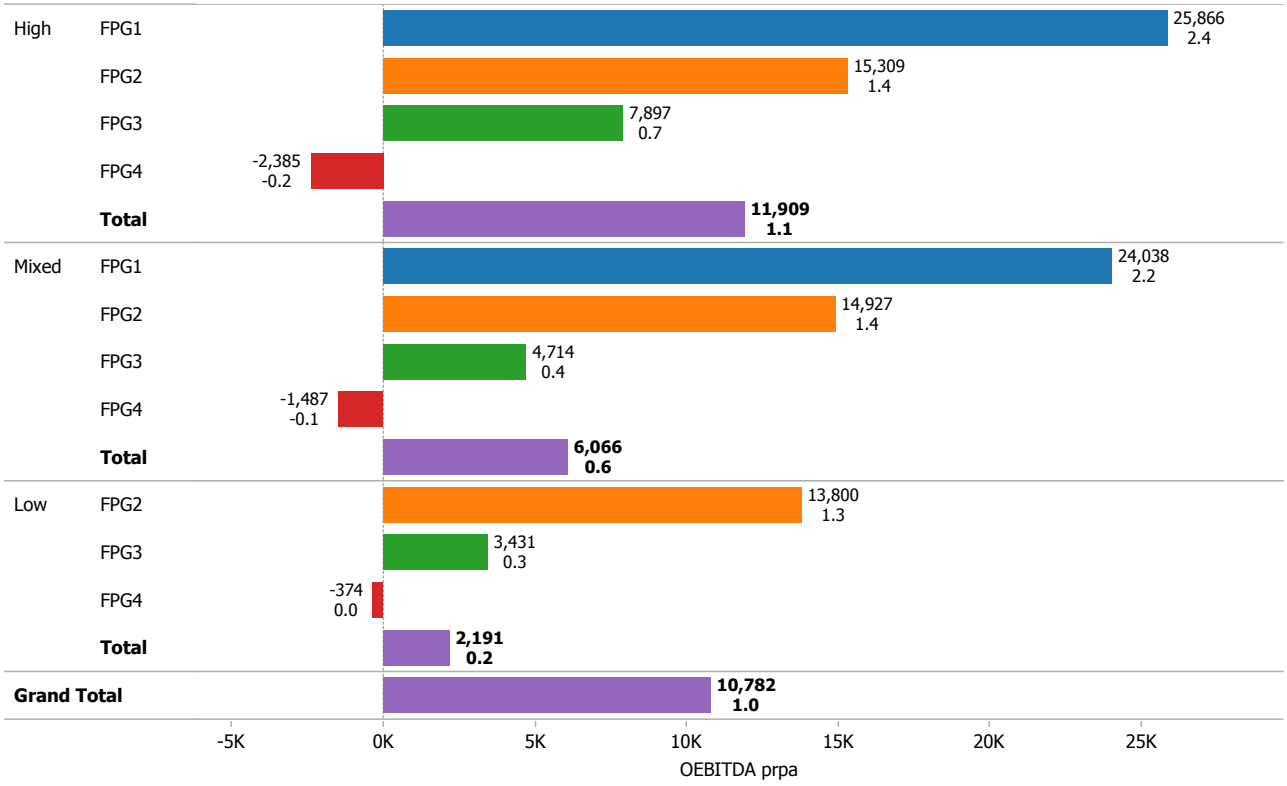
3.2.4. OEBITDA and resident care profile

Chart 016 in section 2.2.4 showed that only a small number of providers were classified as low care services and none of them were in Group 1.

Chart 022 shows that high care[2] services are much more profitable than low care[3] services, delivering $11,909 OEBITDA prpa (1.1 times average) compared with $2,191 OEBITDA prpa (0.2 times average) achieved by low care services.

In contrast to the other groups, Group 4 loses more money with increasing acuity of the resident care profile. This begs the question: do Group 4 providers have difficulties managing revenues or expenses as care needs increase? This is considered further in the sections of this report where we examine operating revenue and operating expenses.

Chart 022: OEBITDA prpa by Resident Care Profile and Financial Performance Group (FPG)



3.2.5. Summary of the effects of ownership, location, size and resident care profile

Providers that perform better financially tend to be located in the city and operate on a FP basis. This finding is supported by the multivariate analysis detailed in Appendix 3.

The analysis also shows that a significant number of providers (35%) with other forms of ownership, and 23.4% of providers not exclusively providing city-based services, also achieve Group 1 or Group 2 financial outcomes.

There appear to be no economies of scale based on the number of facilities owned. However, there is a strong relationship between financial performance and the number of beds in a facility.

The provision of higher levels of care produces marginal OEBITDA for all groups other than Group 4.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

3.3. Financial Management

In this section we examine the management of operating revenue and operating expenses, and the investment in operating assets.

3.3.1. Operating revenue management

We have examined the effects of the following in respect of operating revenue management:

- total operating revenue
- government revenue comprising care subsidies (mainly ACFI) and accommodation supplements
- resident revenue comprising income-tested care fees as well as accommodation charges including bond retentions and deemed (notional) accommodation charges.

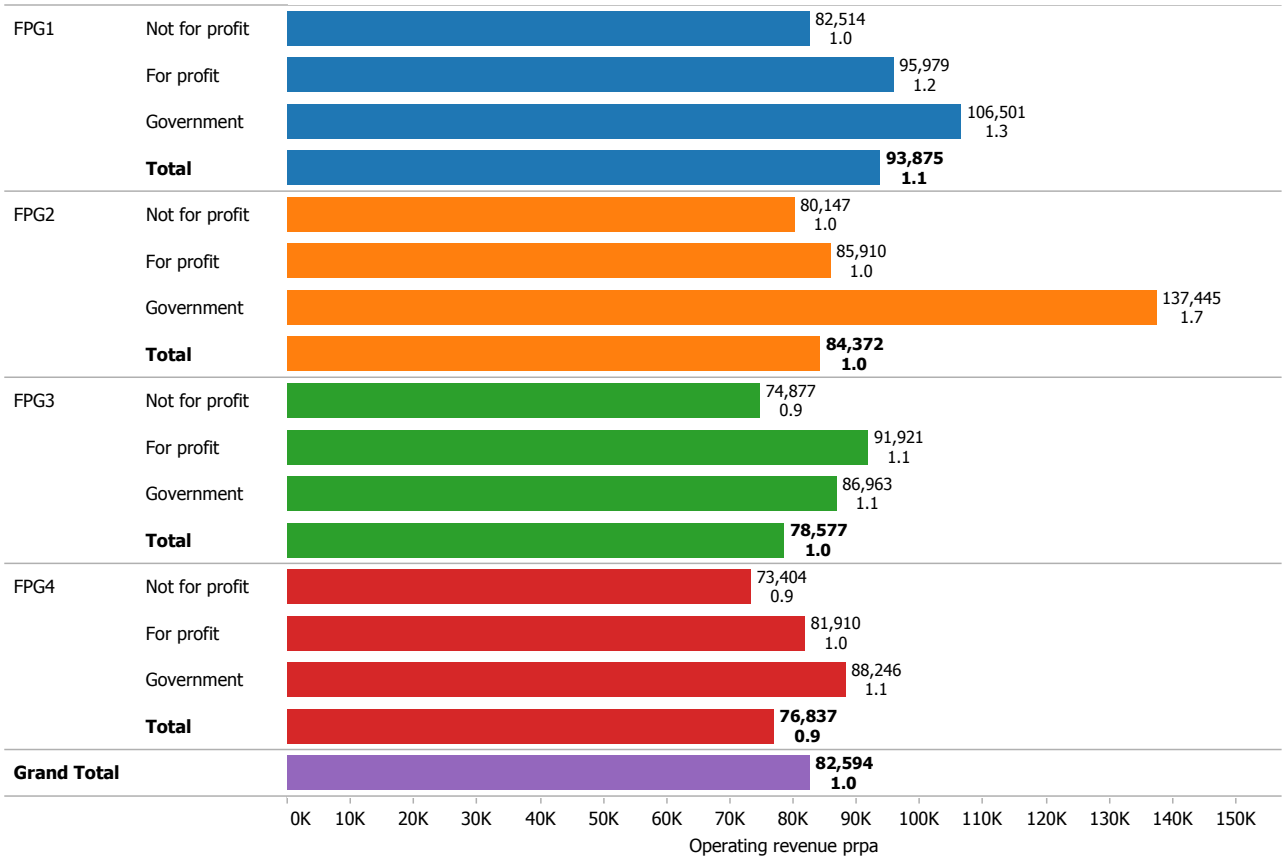
Total operating revenue

Chart 023 shows the gradual increase in average operating revenue from the better financially performing providers to those lower financially performing groups. Providers in Group 4 generated an average of $76,837 prpa in operating revenue (0.9 times average) while those in Group 1 generated $93,875 average operating revenue prpa (1.1 times average).

FP providers consistently generated more revenue than NFP providers.

We were unable to analyse the extent of additional funding received by government providers.

Chart 023: Operating Revenue prpa by Financial Performance Group (FPG) and Ownership



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

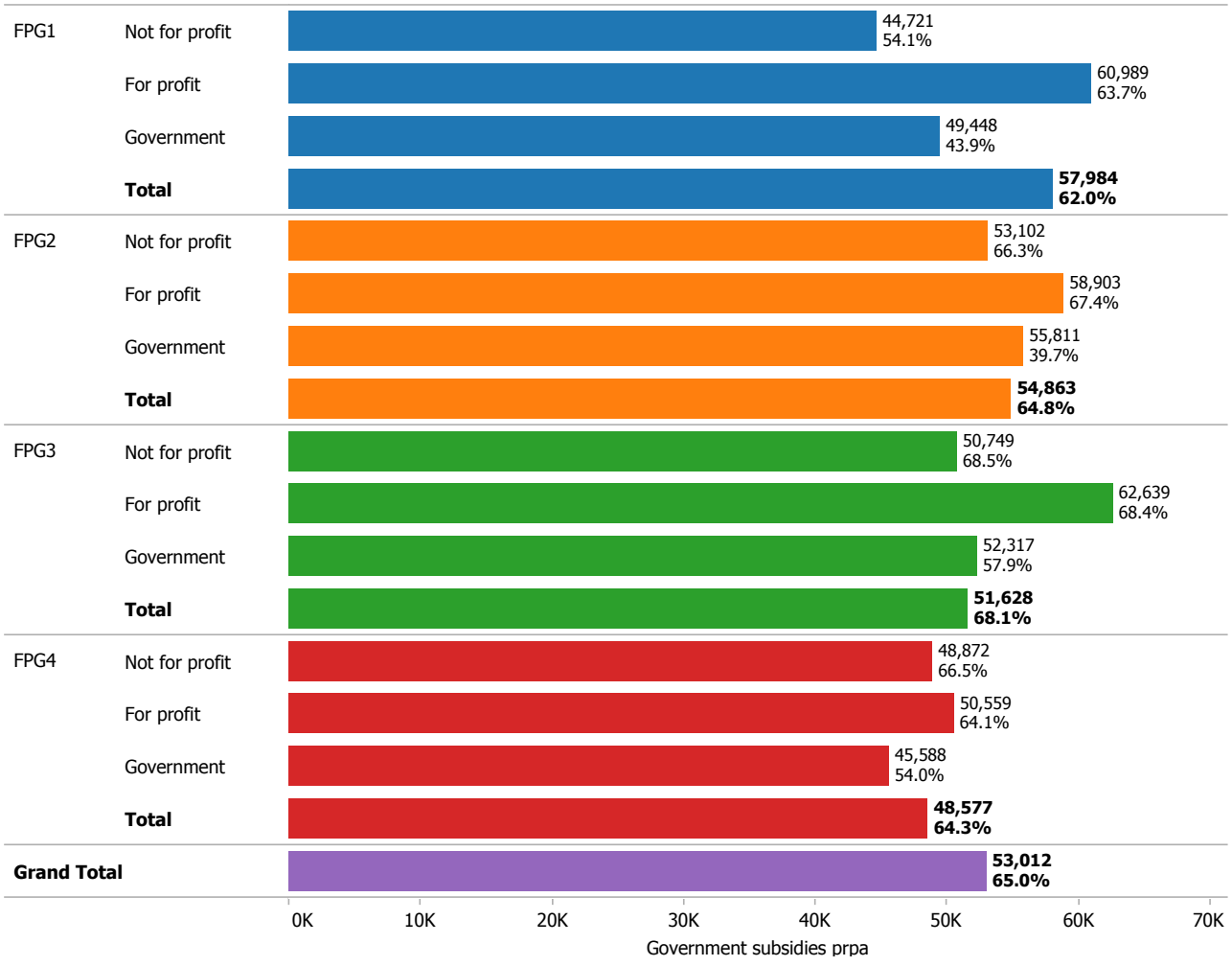
Government subsidies

Government subsidies were reported as a line item in the GPFR by 846 (82.6%) providers. Chart 024 shows that, for these providers, government subsidies were on average $53,012 prpa and comprised 65% of operating revenue.

Chart 024 also shows:

- government subsidies prpa step up as we move up through the groups
- on average, better financially performing providers receive more subsidies
- in every group, FP providers receive more subsidies than NFP providers
- government subsidies represent 62% of the revenues of Group 1 providers, which is the lowest proportion of any group and reflects the higher level of resident income derived by this group.

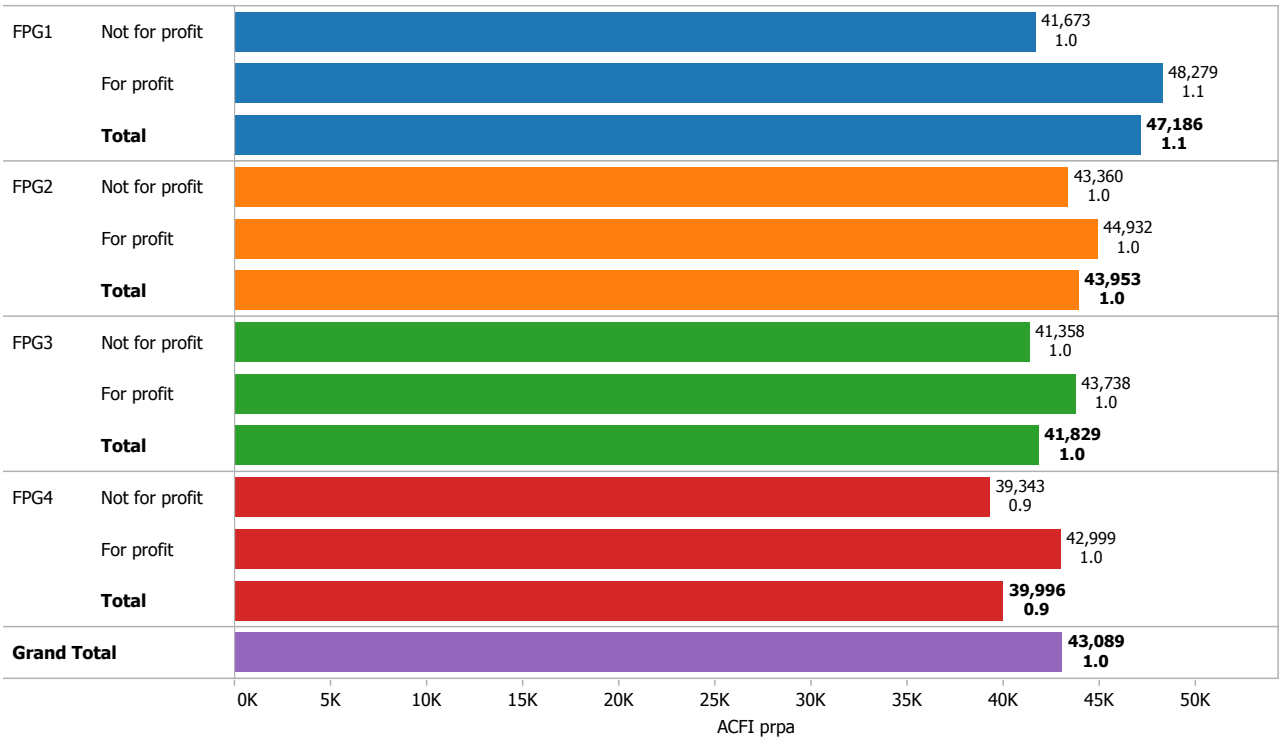
Chart 024: Government Subsidies prpa by Financial Performance Group (FPG) and Ownership



ACFI management

When we analysed the amount of ACFI received by providers, based on grouping and ownership, we saw a direct correlation between the average level of ACFI and the group to which a provider belonged. This is particularly pronounced in Group 1. We also found that in all cases, FP providers received higher average ACFI than NFP providers. FP providers in Group 4 received relatively high ACFI subsidy compared to the other groups.

Chart 025: ACFI prpa by Financial Performance Group (FPG) and Ownership

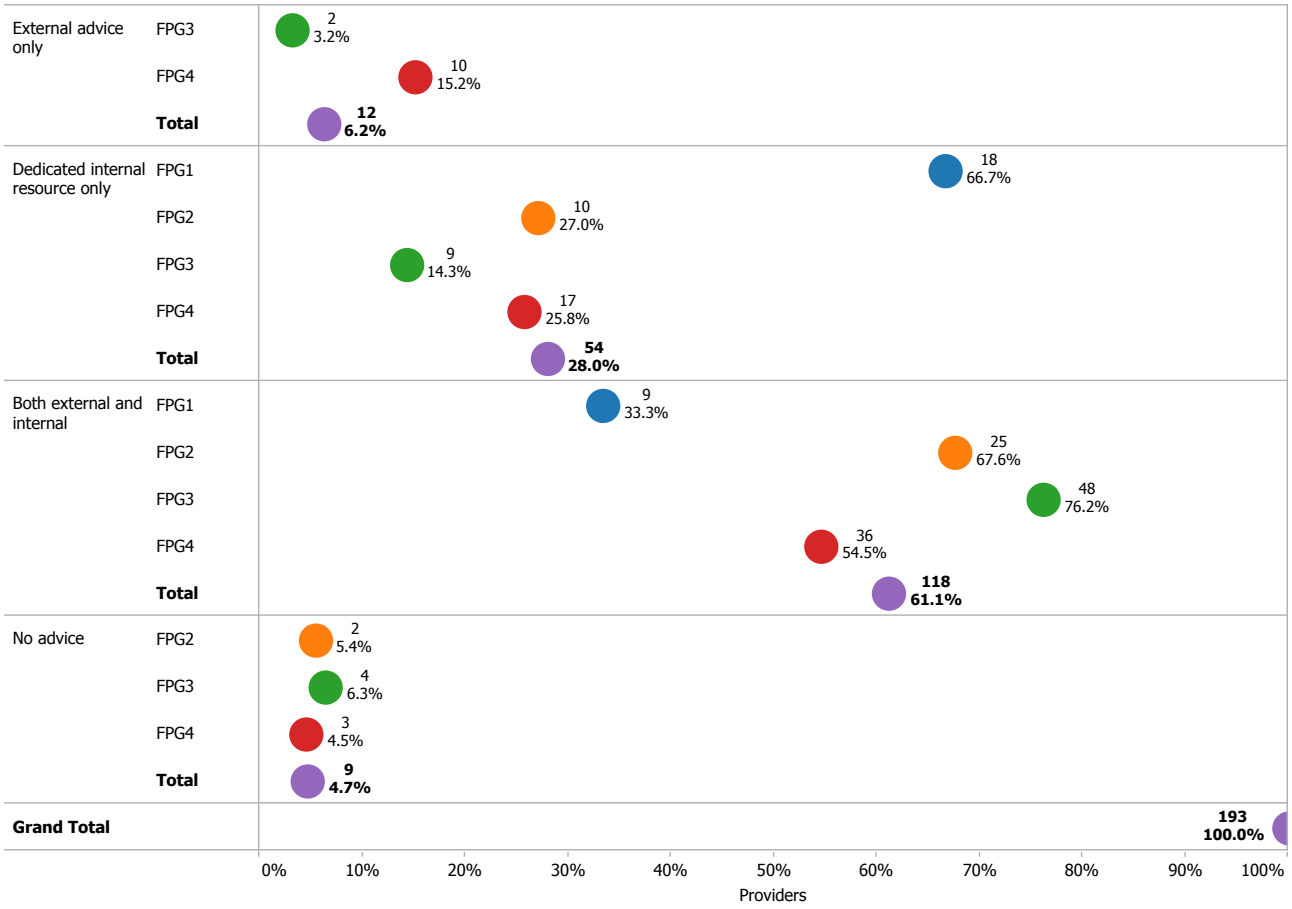


This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Survey respondents were asked about their approach to managing ACFI. Chart 026 shows that providers are likely to obtain external advice and, in particular, FP providers in Group 1 are more likely to have a dedicated internal resource managing claims under ACFI.

Chart 026: ACFI Management by Financial Performance Group (FPG)

31. Have you obtained external advice and/or have dedicated internal resources to manage claims under ACFI?



"Null" and "Unknown" responses are excluded.

Resident income

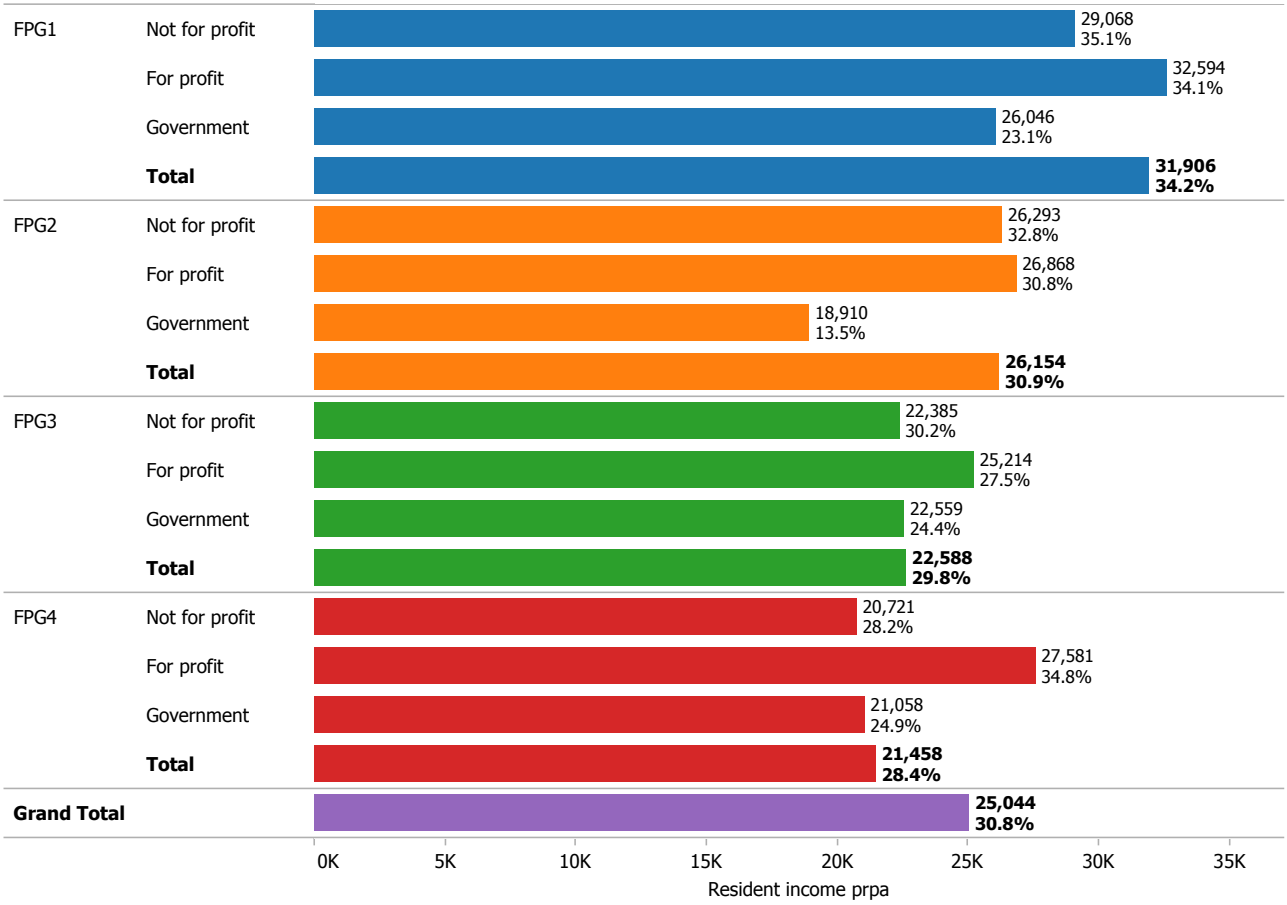
Resident income includes the basic daily fee and income-tested care fee, which were reported as the line item; Resident Client Charges in the GPFR by 836 providers, and deemed accommodation income as calculated for this study[5].

Chart 027 shows that, on average, resident income was $25,044 prpa and comprised 30.8% of operating revenue prpa.

Chart 027 also shows:

- Resident income steps up as we move up through the groups. Better financially performing providers generated more resident income.
- Resident income represents a higher proportion of revenues as we move up through the groups.
- In every group, the FP providers generate more resident income than NFP providers.

Chart 027: Resident Income prpa by Financial Performance Group (FPG) and Ownership



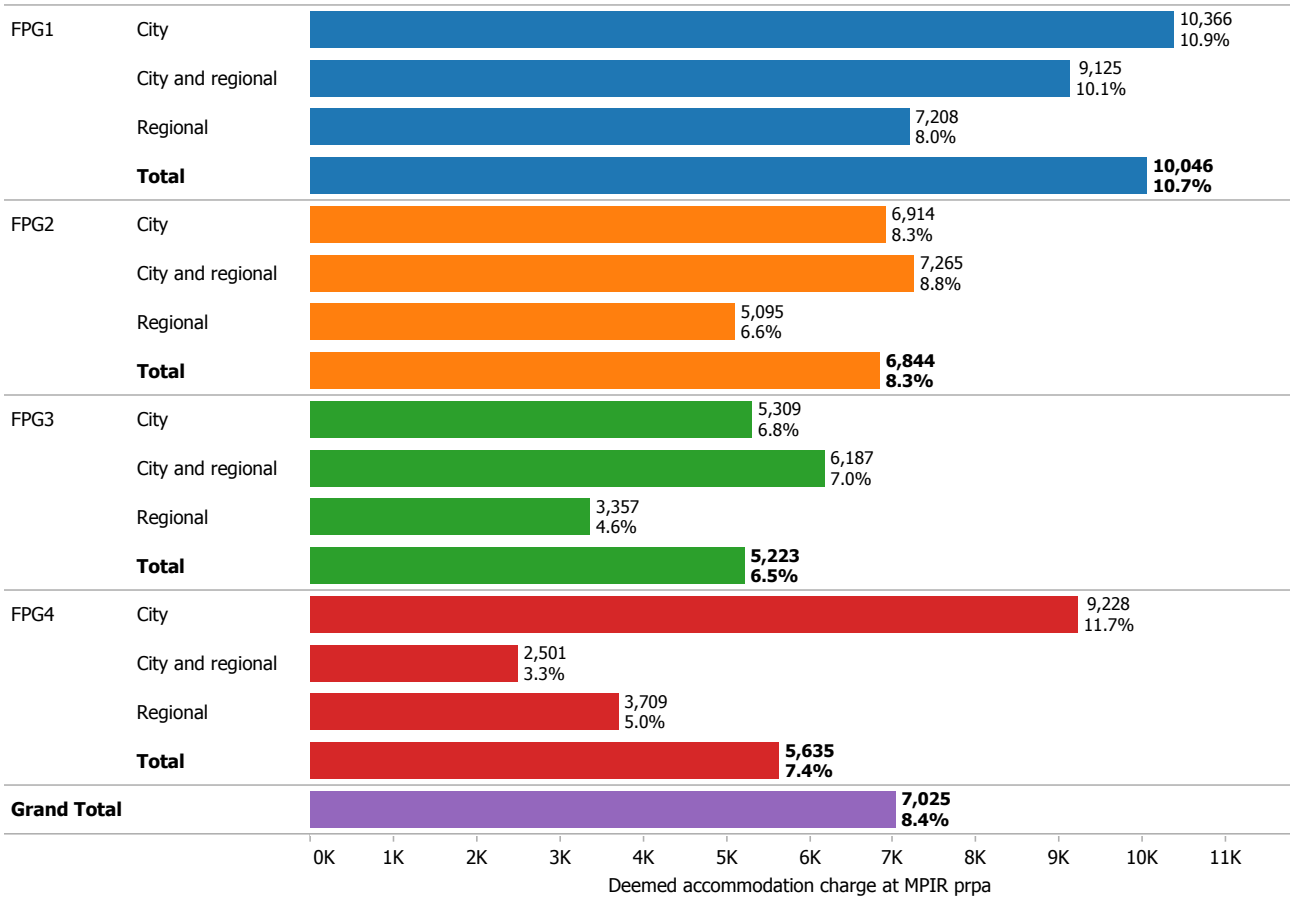
[5] Refer to Appendix 1.

Deemed accommodation income

In providing accommodation services, providers received either a daily accommodation charge or an accommodation bond. This variation limits the comparability of provider operating results. To facilitate comparability, we have imputed interest on bond balances at the average MPIR rate for 2013 and added this to OEBITDA as a deemed accommodation charge.

The deemed accommodation charge prpa tended to increase in step with increased financial performance. One key reason, as Chart 028 indicates, is that city locations, where the better financially performing providers are more likely to be found, receive larger accommodation bonds. The results shown in Chart 028 relate to the 650 providers who reported accommodation bond liabilities in their GPFR.

Chart 028: Deemed Accommodation Charge prpa by Financial Performance Group (FPG) and Location



Summary of capacity to generate operating revenue

A provider's capacity to generate operating revenue is a key determinant of its OEBITDA. Providers with better financial performance:

- accurately manage their ACFI
- generate higher deemed and actual accommodation charges, reflecting higher average accommodation bonds
- have the ability to earn more revenue from residents, which makes them less dependent on government subsidies.

Where providers achieve lower levels of operating revenue, this may reflect non financial choices, in particular by NFP and government providers, or the socio-economic status of residents. Providers who are culturally and structurally more focused on financial outcomes derive more income from all sources.

3.3.2. Operating expense management

The data available only allowed us to examine the impact of operating expense management at the level of total operating expenses and wages.

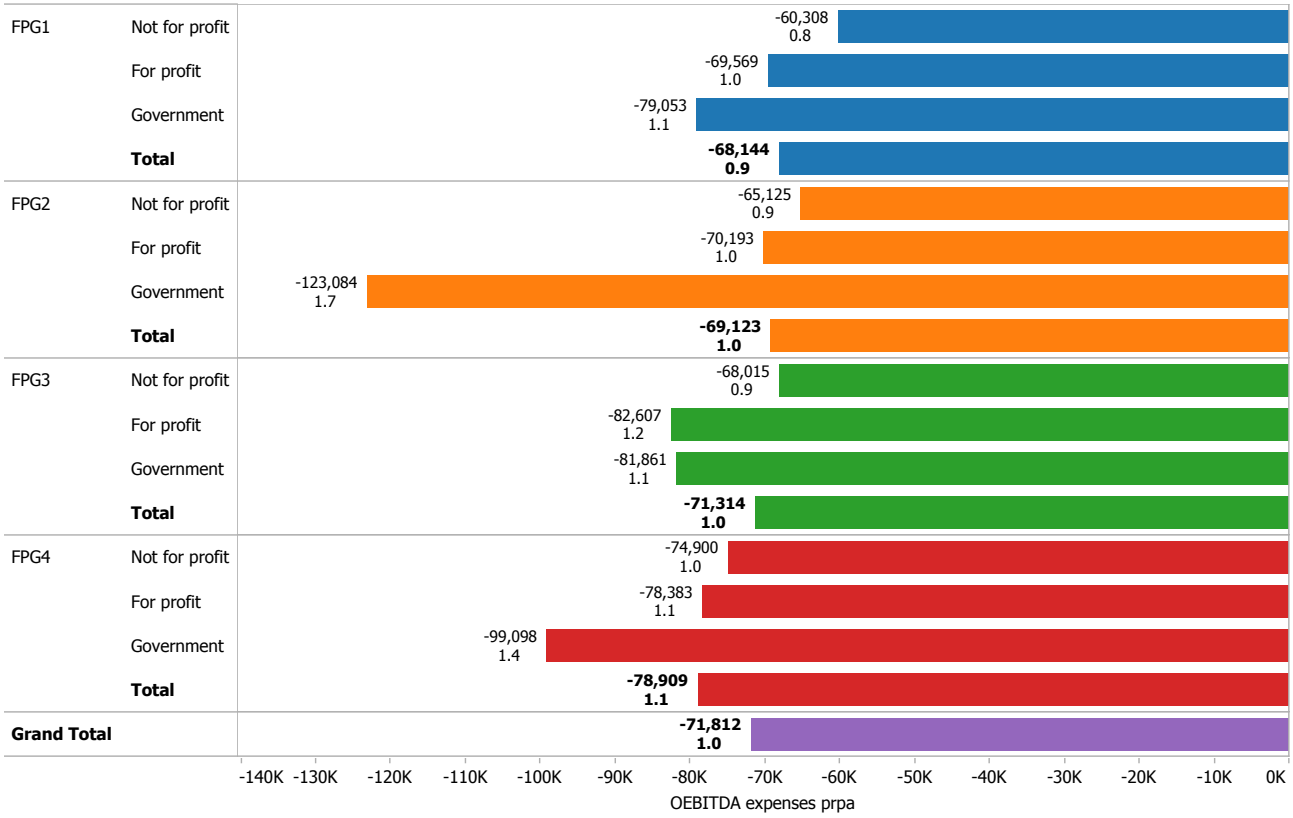
Total operating expenses

Group 1 operated with lower average costs than the other groups. As can be seen in Chart 029, there is a direct correlation between operating expense prpa and better financial performance by group. However, the differences were reasonably modest for all groups other than Group 4, ranging from $68,144 OEBITDA expenses prpa for Group 1 to $71,314 for Group 3. Group 4 had operating expenses prpa of $78,909.

Group 4 is the only group with above-average expenses. OEBITDA expenses prpa were $78,909. Further insight into this is provided in section 5 of this report.

In every group, the NFP providers had lower expenses than the FP providers yet they generate lower OEBITDA irrespective of operating model. This suggests that focusing on expenses alone does not necessarily lead to better financial performance.

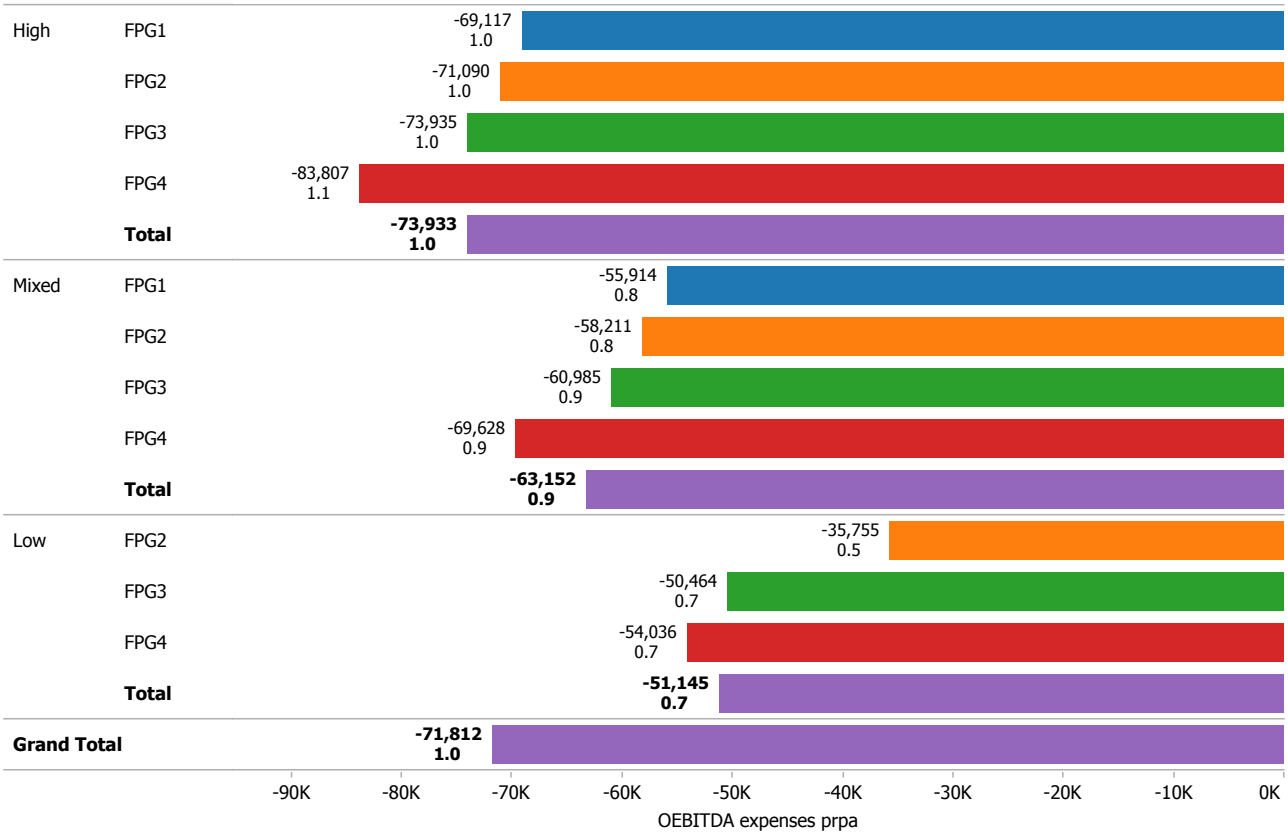
Chart 029: Operating Expenses prpa by Financial Performance Group (FPG) and Ownership



Resident care profile and operating expense management

In section 3.2.4 it was noted that Group 4 providers generate less OEBITDA prpa with increasing levels of care. Chart 030 shows that this group also has relatively higher operating expenses prpa for all care levels.

Chart 030: Operating Expenses prpa by Resident Care Profile and Financial Performance Group (FPG)



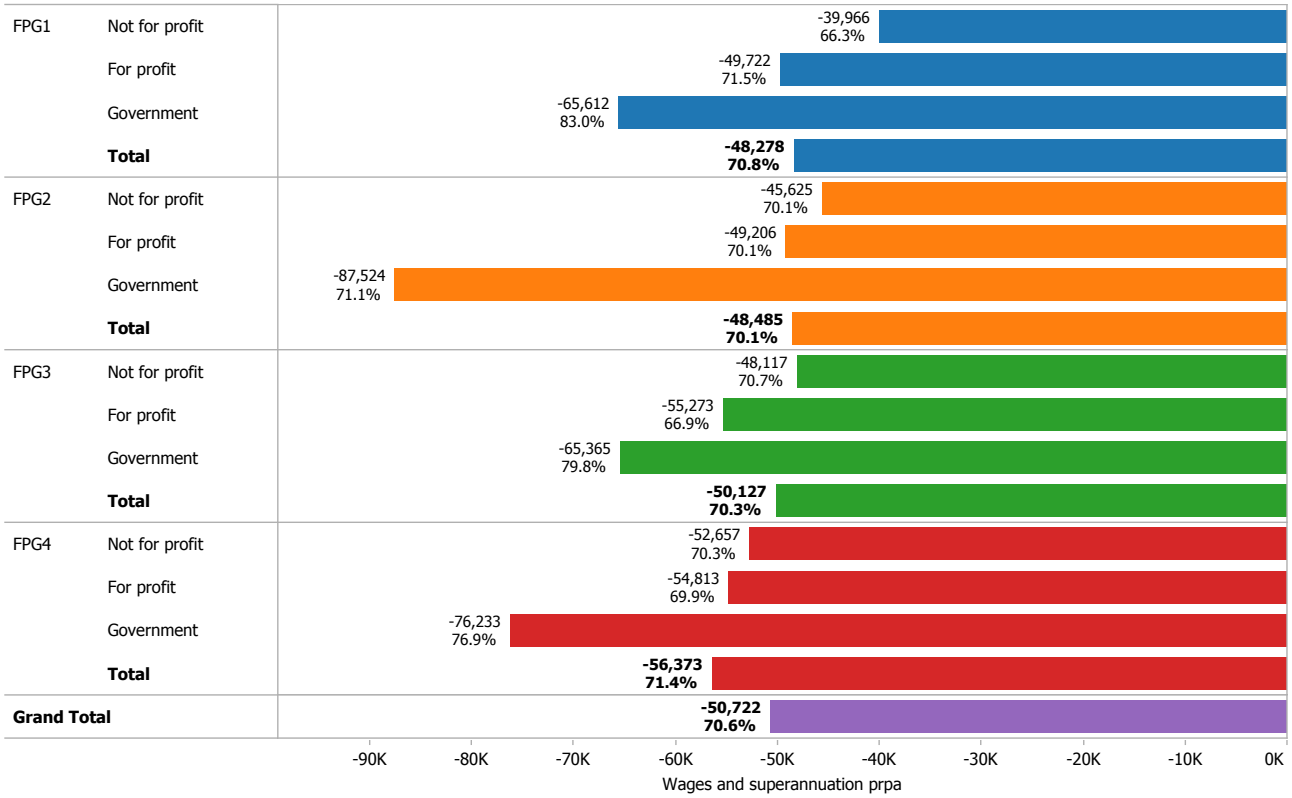
This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Wages and superannuation

Chart 031 shows:

- on average, wages and superannuation were $50,722 prpa and they comprised 70.6% of OEBITDA expenses prpa
- FP providers paid higher wages prpa than NFP providers in all groups. We were unable to determine whether this relates to wage rates or staffing levels
- wages and superannuation expense were above average in dollar amounts for Group 4 providers, as well as higher than average in proportion to OEBITDA expenses prpa (71.4%). The cost management of Group 4 providers relative to their available operating revenue was not as effective as that of other providers
- the relatively high cost of labour for government providers is evident.

Chart 031: Wages and Superannuation prpa by Financial Performance Group (FPG) and Ownership



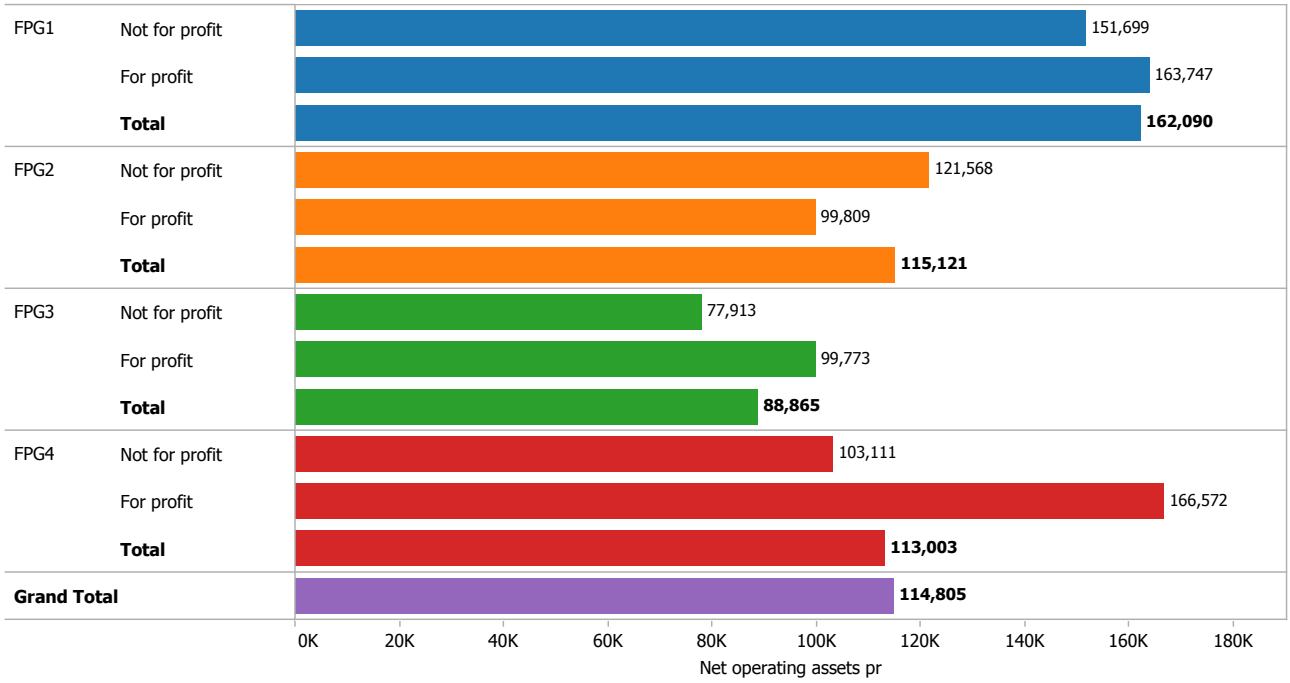
3.3.3. Capital management

OEBITDA provides a measure of operating profitability. The return a provider achieves on operating investments depends on how well the operating assets portfolio is managed. How the investments are financed – the mix of debt and equity – determines the provider's return on equity.

Operating assets financed

Chart 032 shows the net operating assets (NOA) pr (operating assets pr less operating liabilities pr) of each group by ownership. The balances ranged from $166,572 pr to $77,913 pr. It is important to bear in mind that NOA is expressed at written-down value and, accordingly, newer facilities will have higher NOA values.

Chart 032: Net Operating Assets pr by Financial Performance Group (FPG) and Ownership



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Gearing

Providers fund their investments in NOA using a combination of:

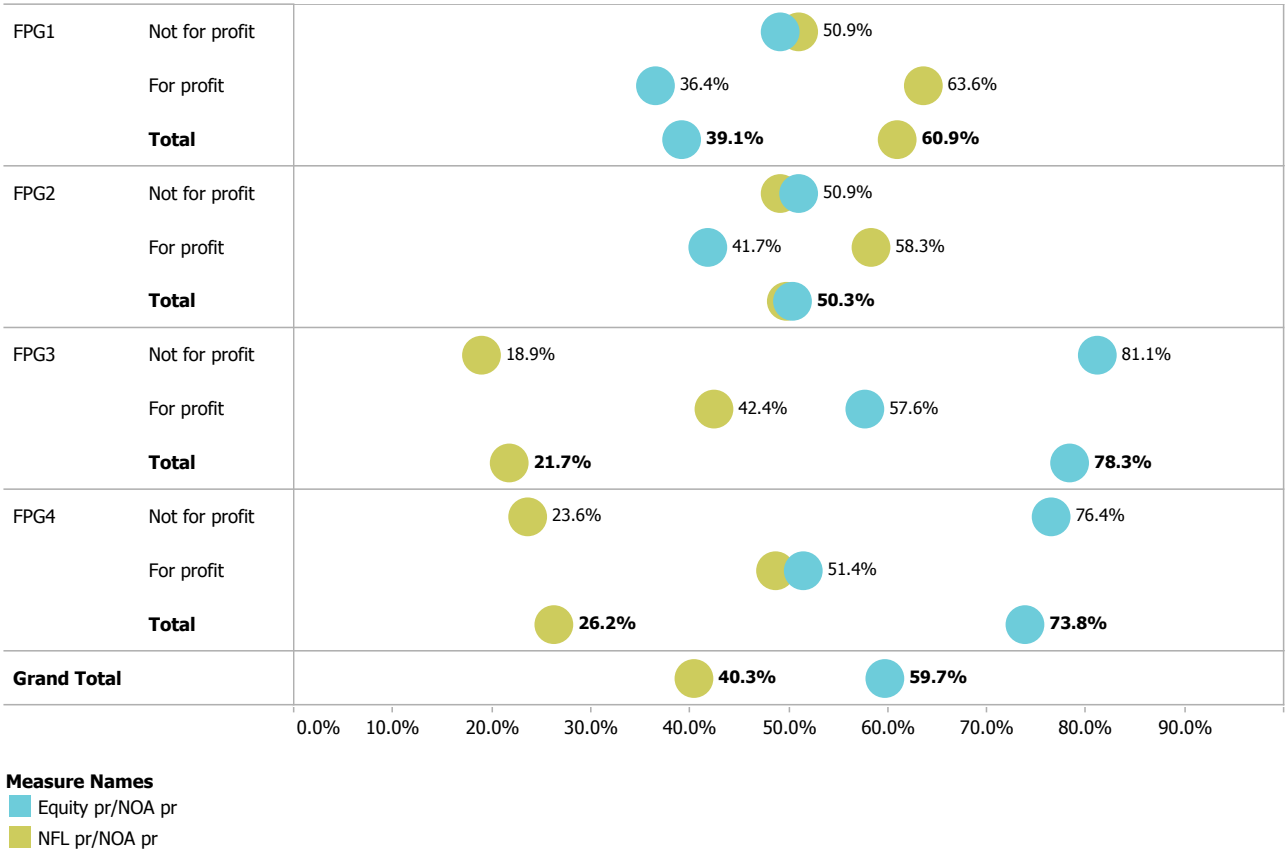
- bank debt and loans from residents, in the form of accommodation bonds, from which we subtract cash and liquid assets to calculate net financial liabilities (NFL)
- equity which comprises contributed funds and accumulated profits or surpluses, and within which we have included related party loans.

These calculations are discussed in more detail in Appendix 1.

Chart 033 shows the percentage of gearing for each group. The gearing ratio (shown in yellow) is the percentage of NOA that is funded by NFL. Providers in Group 1 used proportionately more debt (60.9% overall) than providers in Group 2 (50.3% overall) and the industry in general (40.3% overall). As a broad comment, the top two groups used approximately twice as much debt as the bottom two.

In every group, FP providers used a higher proportion of debt than NFP providers.

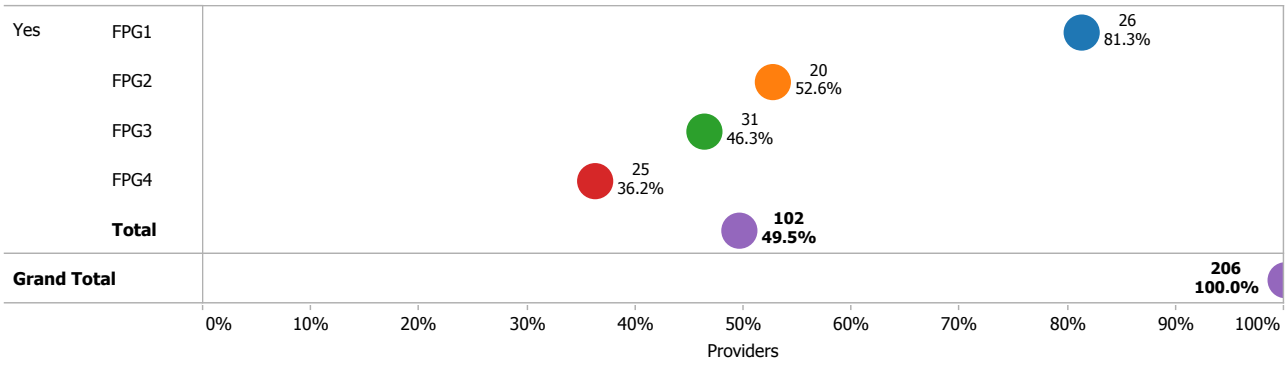
Chart 033: Gearing



The survey findings were consistent with the GPFR data. Chart 034 shows the better financially performing groups were more inclined to use debt, and Chart 035 shows they were more inclined to use longer-term facilities.

Chart 034: Capital Management by Financial Performance Group (FPG)

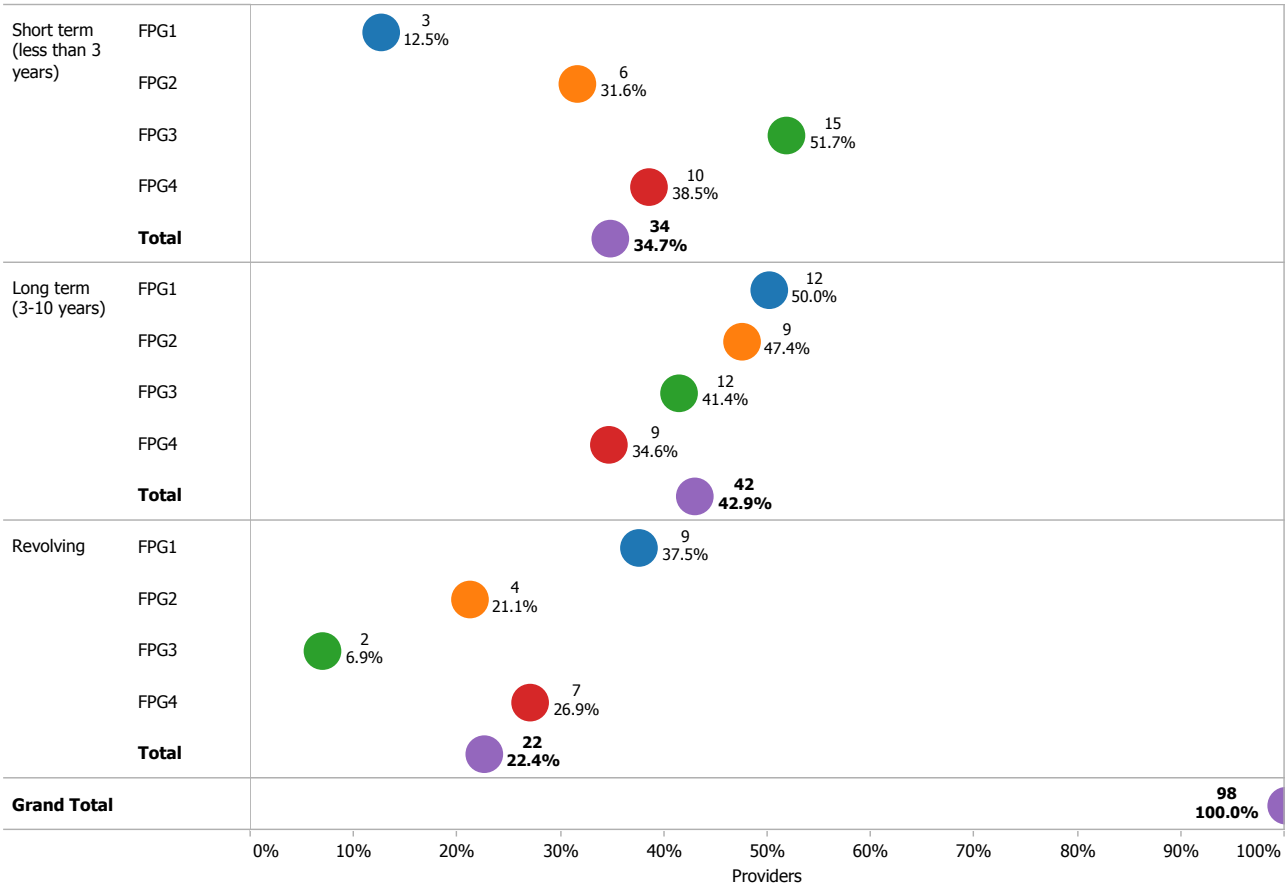
12. As a residential aged care provider, do you use bank finance?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Chart 035: Debt Financing by Financial Performance Group (FPG)

13. If yes, what is your preferred approach to debt financing?



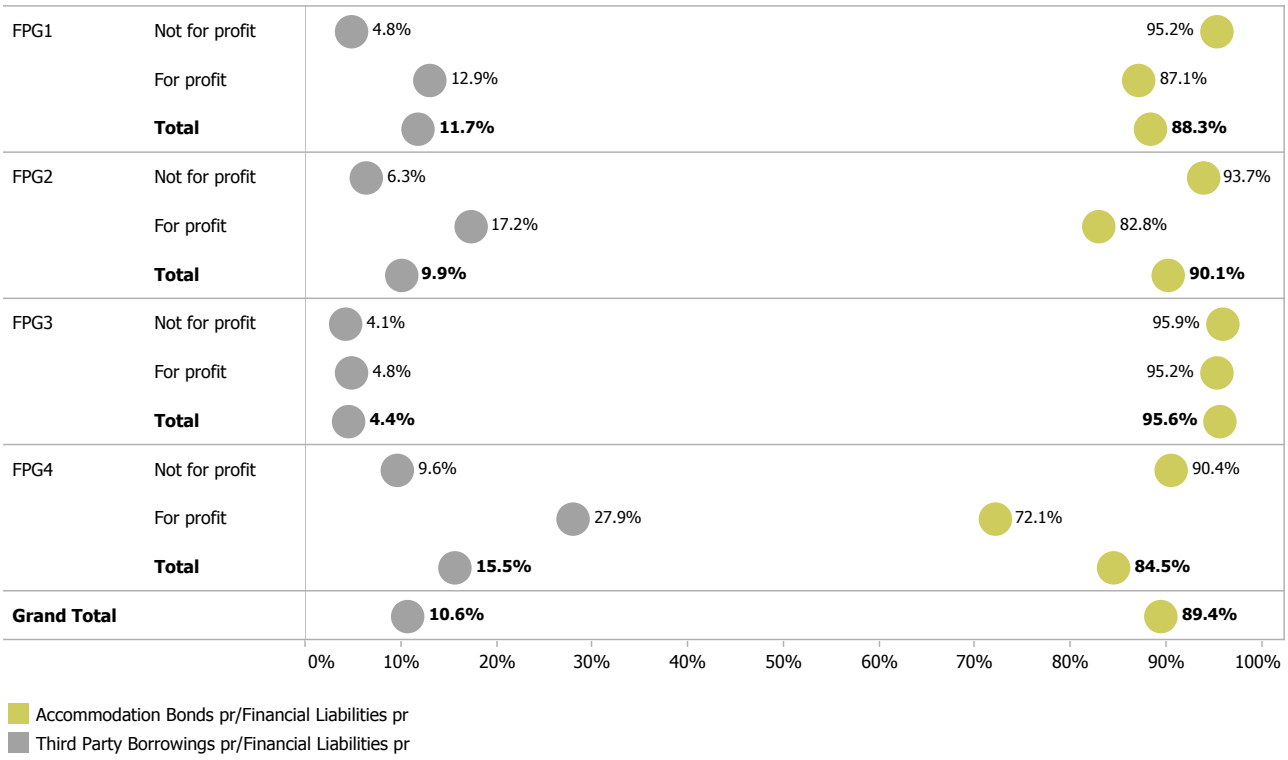
"Null" and "Unknown" responses are excluded.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

The mix of accommodation bonds and third party debt

Net financial liabilities comprise accommodation bond liabilities and third party debt, offset by financial assets such as cash and interest-bearing deposits. Chart 036 shows that liabilities are dominated by accommodation bonds. On average, bonds account for 89.4% of liabilities and the proportion doesn't vary much by group or ownership.

Chart 036: Composition of Financial Liabilities



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

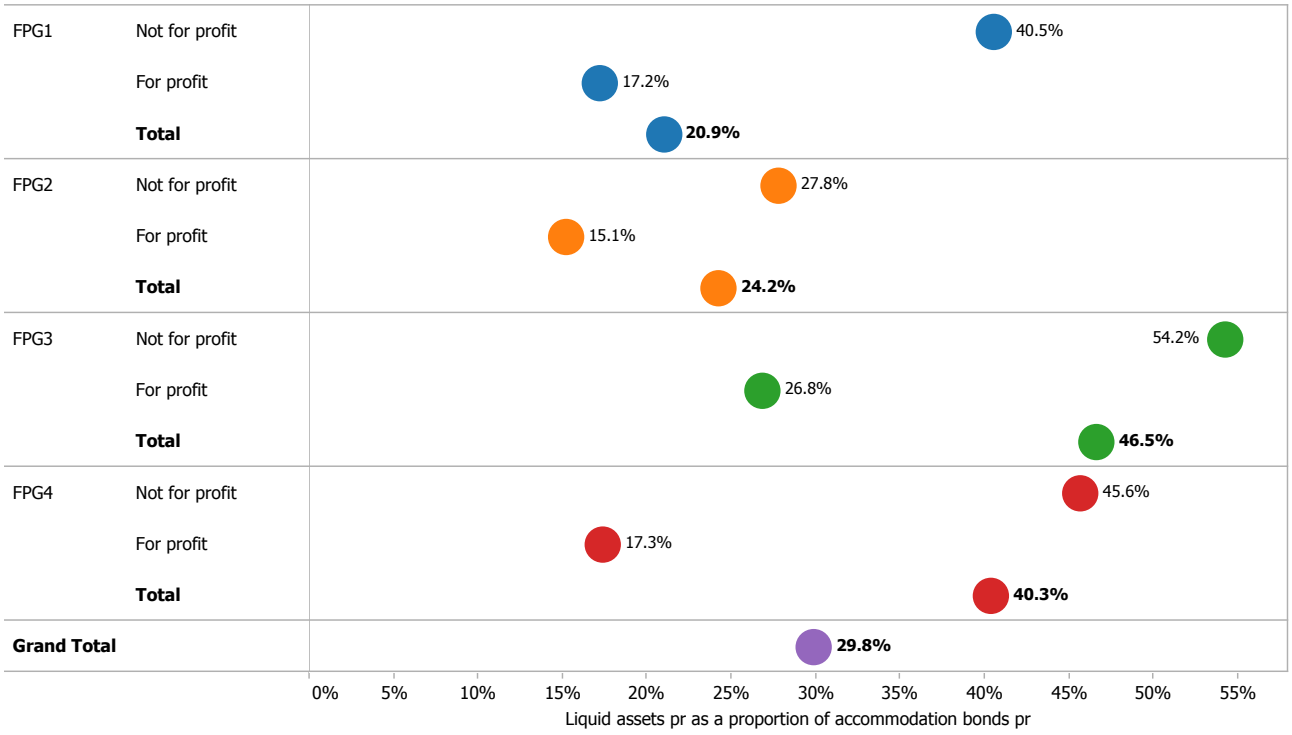
Liquid assets compared with accommodation bonds

Providers are required to hold liquid assets in accordance with their liquidity management strategy to ensure repayment of accommodation bonds when required.

Chart 037 shows liquid assets as a proportion of accommodation bonds. The industry average was 29.8%. The chart also shows that Group 1 had the lowest level of liquid assets (20.9%). FP providers in this group averaged 17.2%. As a broad observation, the top two groups held approximately half the proportionate liquid asset balance of the bottom two groups. Providers in Group 4 hold, on average, 40.3% liquidity.

FP providers always held proportionately lower liquid asset balances than NFP providers. While providers can earn interest on liquid assets, it is most unlikely that providers are able to earn interest at a rate approaching the MPIR on accommodation bonds, or the interest paid on third party debt. While it is appropriate and prudent to hold a reasonable balance of liquid assets against accommodation bond liabilities, an unnecessarily high balance will dilute net profit before tax (NPBT). However, it won't impact the measurement of OEBITDA – which excludes interest revenues and expenses – and impact overall viability.

Chart 037: Liquid Assets pr as a Proportion of Accommodation Bonds pr by Group and Ownership

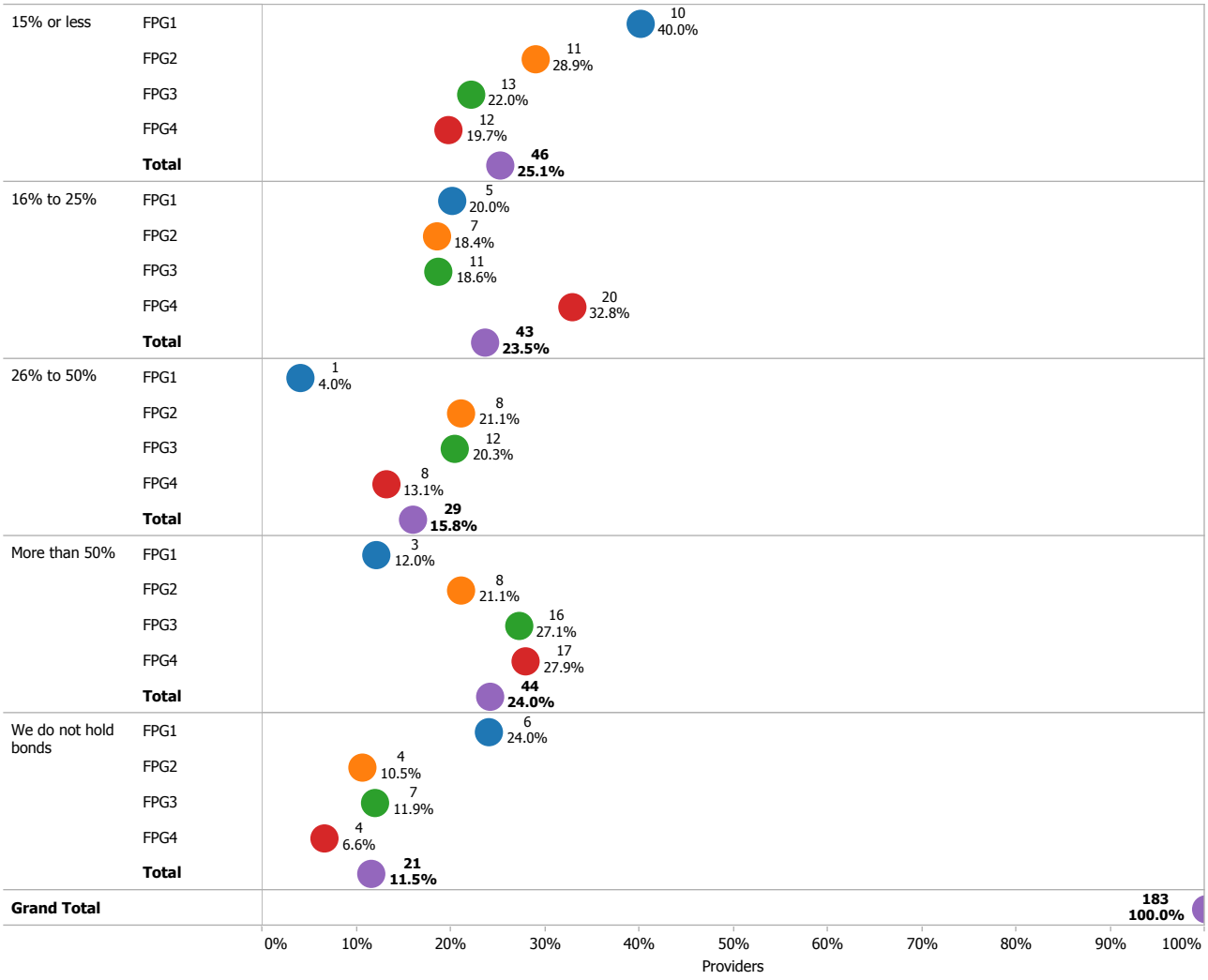


Bond liquidity target

We asked survey respondents who held accommodation bonds about their target proportion of liquid assets to accommodation bond liabilities. Chart 038 is generally consistent with Chart 037 in that the better financially performing groups target lower liquidity. Conversely, the actual liquidity percentage of the providers with lower OEBITDA is not as closely linked to their policy. This may suggest a reduced focus on this aspect of financial performance by these providers.

Chart 038: Bond Management by Financial Performance Group (FPG)

27. As per your liquidity management strategy, what is your targeted accommodation bond percentage level held in cash, cash equivalents or on call?



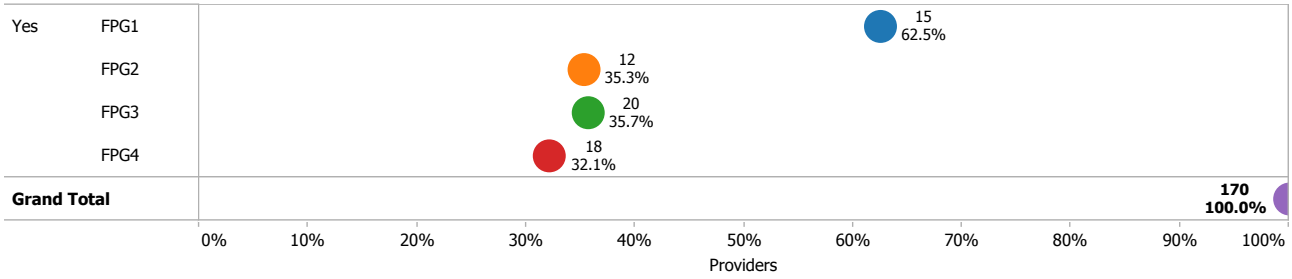
"Null" and "Unknown" responses are excluded.

Dedicated finance to support bond liquidity

Maintaining sufficient bond liquidity can be achieved by either holding liquid assets or through the use of finance facilities.

We asked if providers had dedicated finance facilities available to support bond liquidity. Chart 039 shows that providers in Group 1 supplement their lower levels of cash liquidity with dedicated finance facilities. In this way they maintain high liquidity without compromising income.

Chart 039: Finance/Debt Facilities by Financial Performance Group (FPG)
28. Do you have dedicated finance/debt facilities to supplement bond liquidity?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

3.3.4. Summary of observations on financial management

Better financially performing providers manage all aspects of finances including operating revenue, operating expenses and capital investment, whereas those with reduced OEBITDA tend to have a narrower focus on cost management and a more conservative approach to financial matters, in particular liquidity management. In section 10 we consider the impact of excessive liquidity on NPBT.

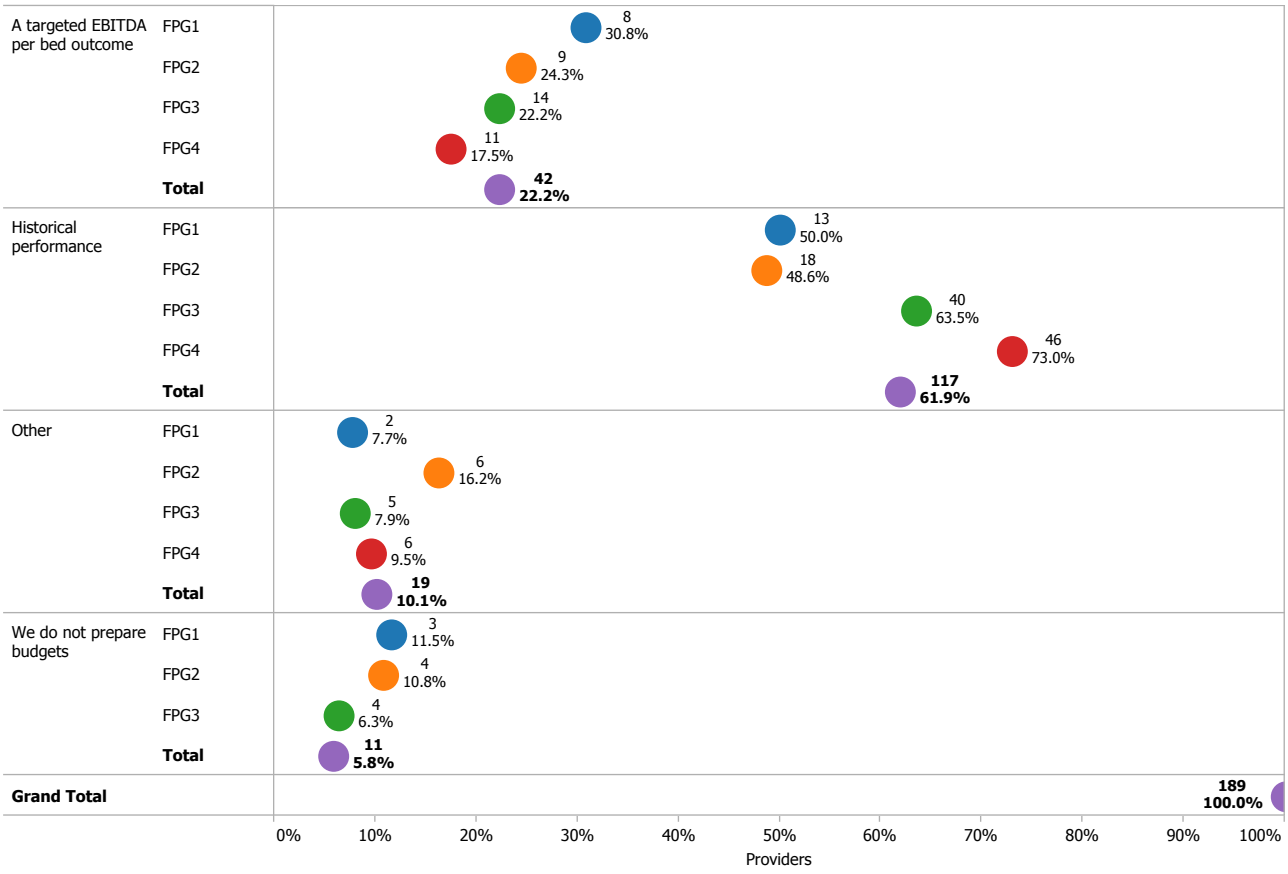
3.4. Process Management

The survey indicated a number of interesting differences between the groups in how various processes are managed. There were also a number of similarities.

3.4.1. Budgeting

Chart 040 shows that most respondents prepare budgets and focus on historical financial performance. However, the top two groups are more inclined to also focus on a target EBITDA per resident.

Chart 040: Budget Preparation by Financial Performance Group (FPG)
24. On what basis were your FY13 budgets prepared?



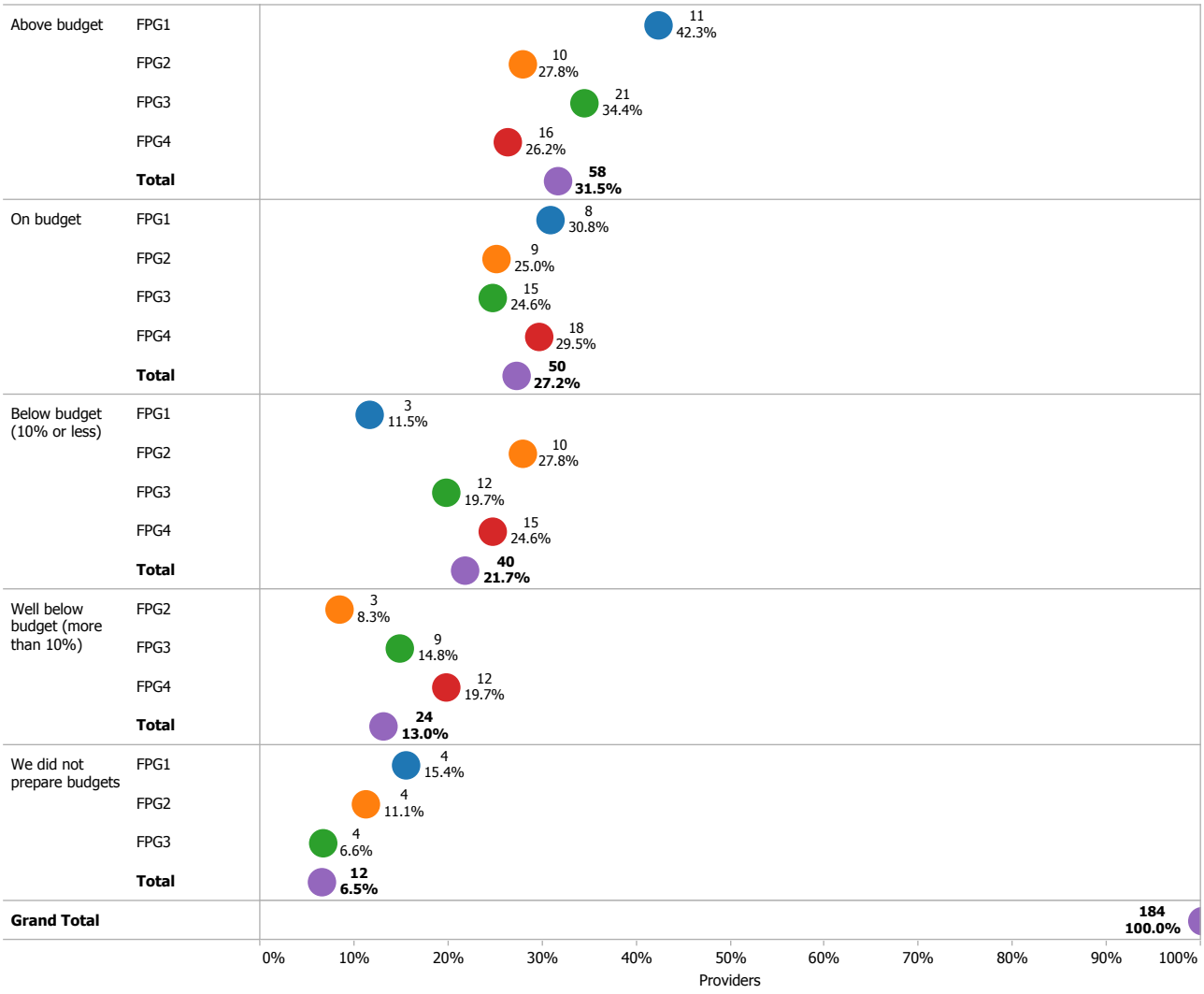
"Null" and "Unknown" responses are excluded.

We asked respondents about actual financial performance compared to budget. Chart 041 shows that of those providers that had budgets, Group 1 was more inclined to be at or above budget in FY 2013.

Providers tend to deliver results that are consistent with their budgets. This means that the better financially performing providers generally budget to deliver better financial performance.

A particularly interesting finding, shown in Chart 041, is that Group 1 providers are more likely to deliver a result above budget and less likely to deliver a result below budget. Conversely, groups with a lower OEBITDA are a little more likely to deliver a result well below budget.

Chart 041: FY13 Results by Financial Performance Group (FPG)
25. Was your FY13 provider actual EBITDA result in line with your budget?

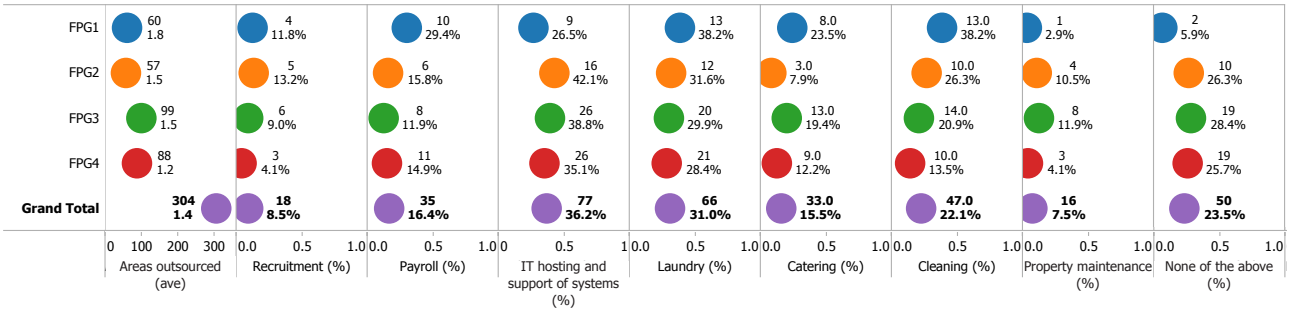


"Null" and "Unknown" responses are excluded.

3.4.2. Outsourcing

Providers were asked about outsourcing in the survey. Chart 042 shows that Group 1 is more inclined to outsource business functions. Chart 042 also shows the business functions outsourced. The top three areas that Group 1 providers outsource are laundry (38.2%), cleaning (38.2%) and payroll (29.4%). Other groups favour outsourcing IT hosting and system support.

Chart 042: Outsourcing Areas by Financial Performance Group (FPG)
36. In FY13, which of the following areas did you outsource to an external provider?



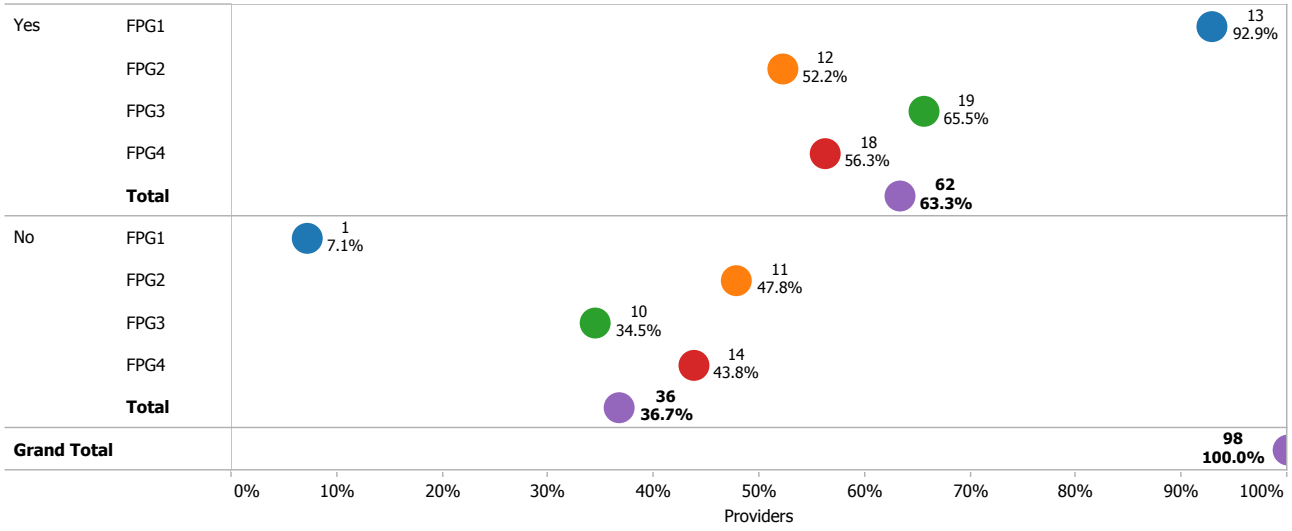
"Null" and "Unknown" responses are excluded.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

3.4.3. Success in ACAR participation

As new places are allocated in a competitive tender, success in applying for places is considered to reflect the strength of operational management. We asked survey respondents about their success in the Aged Care Approvals Round (ACAR). Chart 043 shows Group 1 providers were clearly more successful than those in other groups when applying for places.

Chart 043: Success in ACAR Round by Financial Performance Group (FPG)
34. If you participated in an ACAR round in the last 5 years (ie. 2009-2013) were you successful in your most recent attempt?

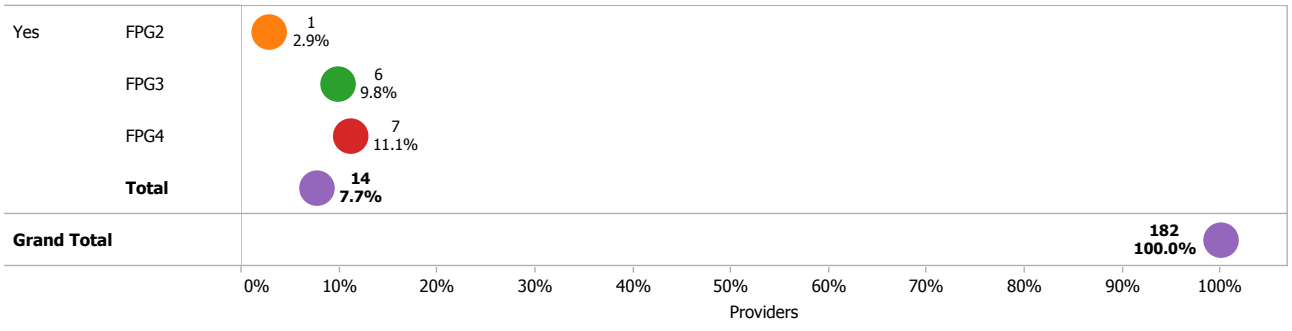


"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

3.4.4. Accreditation

Chart 044 shows the number of providers in each group that had unmet outcomes from their last accreditation visit relative to respondent providers by group. While overall the likelihood of unmet outcomes is low, it increases as we step down the financial groups. This may be a further indicator of how better financially performing providers are better at managing processes.

Chart 044: Unmet Outcomes from Accreditation
41. In FY13, did you have any unmet outcomes from an accreditation visit?

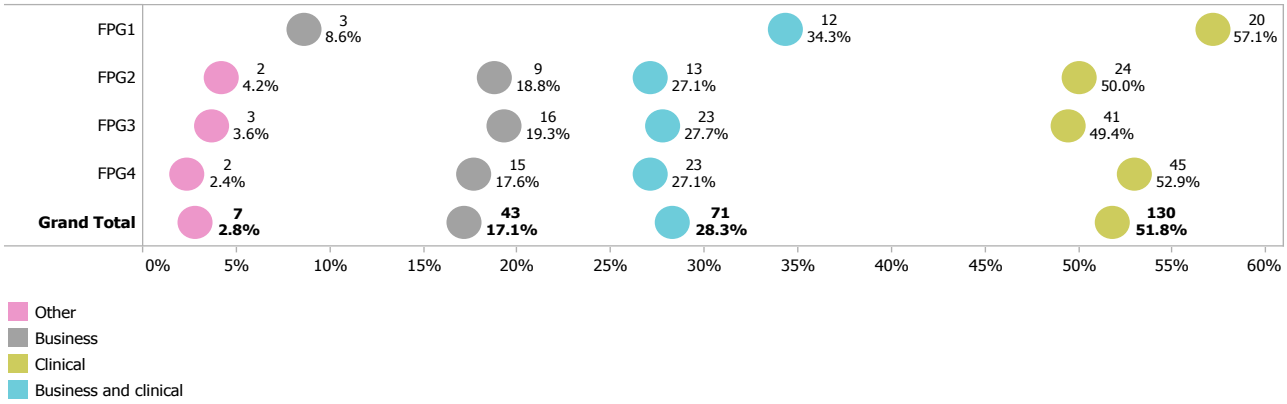


"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

3.4.5. Background of facility manager

Chart 045 shows a clear preference at the senior operational management level for staff with clinical experience and business experience, especially from providers in Group 1.

Chart 045: Background of Facility Manager or DoN
53. In FY13, did your Facility Manager or DoN who had overall management responsibility of your facility have a background in:



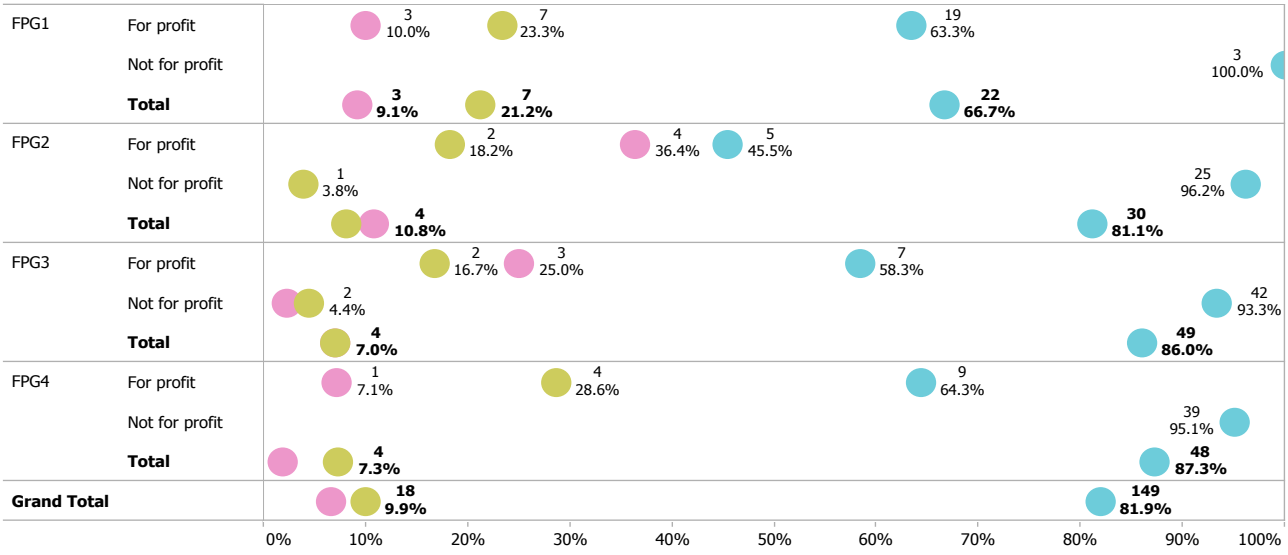
3.5. Governance and Strategy

Boards or governing bodies have overall responsibility for governance and strategy, which are impacted by a number of factors that ultimately influence the relative financial performance of providers.

As Chart 046 shows, 81.9% of providers overall have a board of directors, with a further 9.9% having some other form of governance.

The only notable variation was Group 1, with its tilt towards other forms of governance. Other forms of governance could relate to privately owned facilities that do not have a formal board and some local government providers that have management committee structures.

Chart 046: Board of Directors by Financial Performance Group (FPG)
3. In FY13, did you have a board of directors in place?



The Government segment is hidden but shown in the totals.

Board of directors
Yes
Other governance
No

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

3.5.1. Board attributes

We found the following board attributes were associated with differing levels of financial performance.

Skill sets of board members

There are variations when it comes to the skill sets of board members, as shown in Chart 047. Overall, community representation is less evident than other skills, particularly in Group 1, with only 11.8% of boards having community representation. As Chart 048 shows, community representation is very much a regional phenomenon.

The boards of Group 4 providers are less likely to have expertise specific to the aged care sector.

Chart 047: Skill Sets of the Board of Directors by Financial Performance Group (FPG)
4. Please indicate the skills represented by your board of directors in FY13.

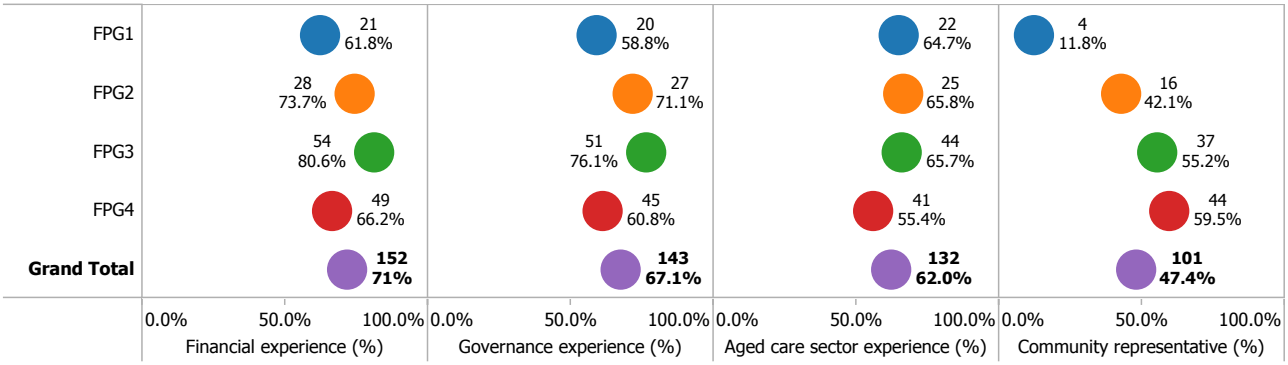
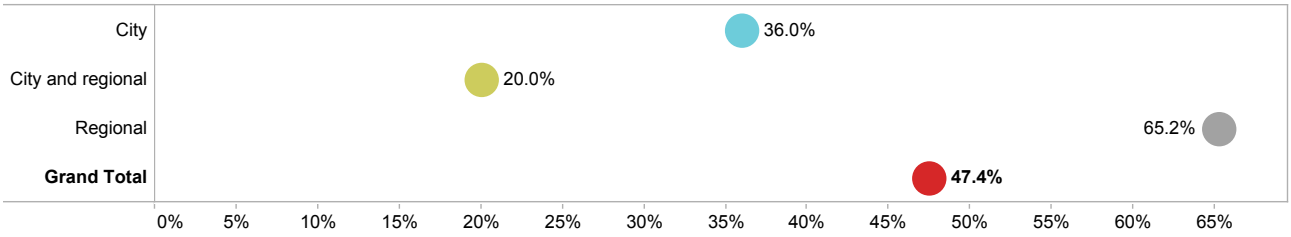


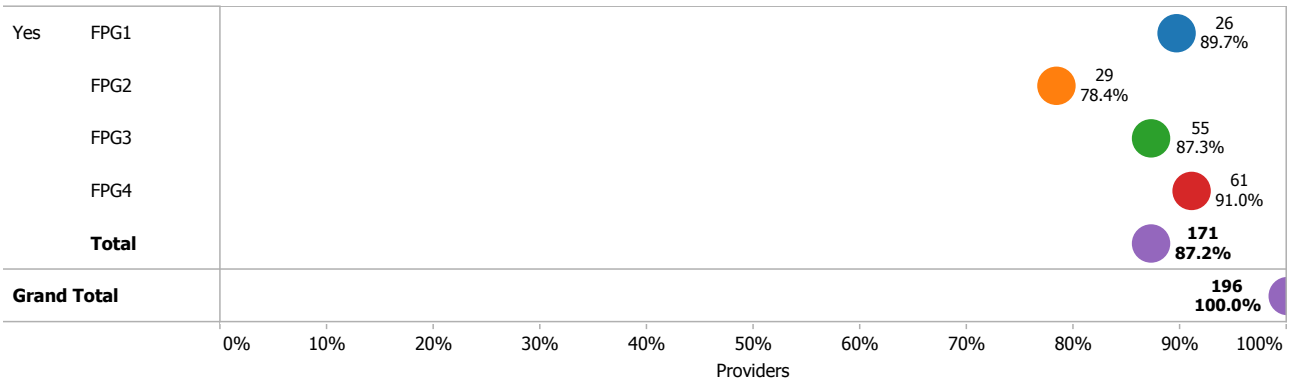
Chart 048: Community Representation by Location
4. Please indicate the skills represented by your board of directors in FY13



Risk management

The survey showed that most providers have a risk management policy and there is little difference across the groups. See Chart 049.

Chart 049: Risk Management Policy by Financial Performance Group (FPG)
9. In FY13, did you have a risk management policy in place?

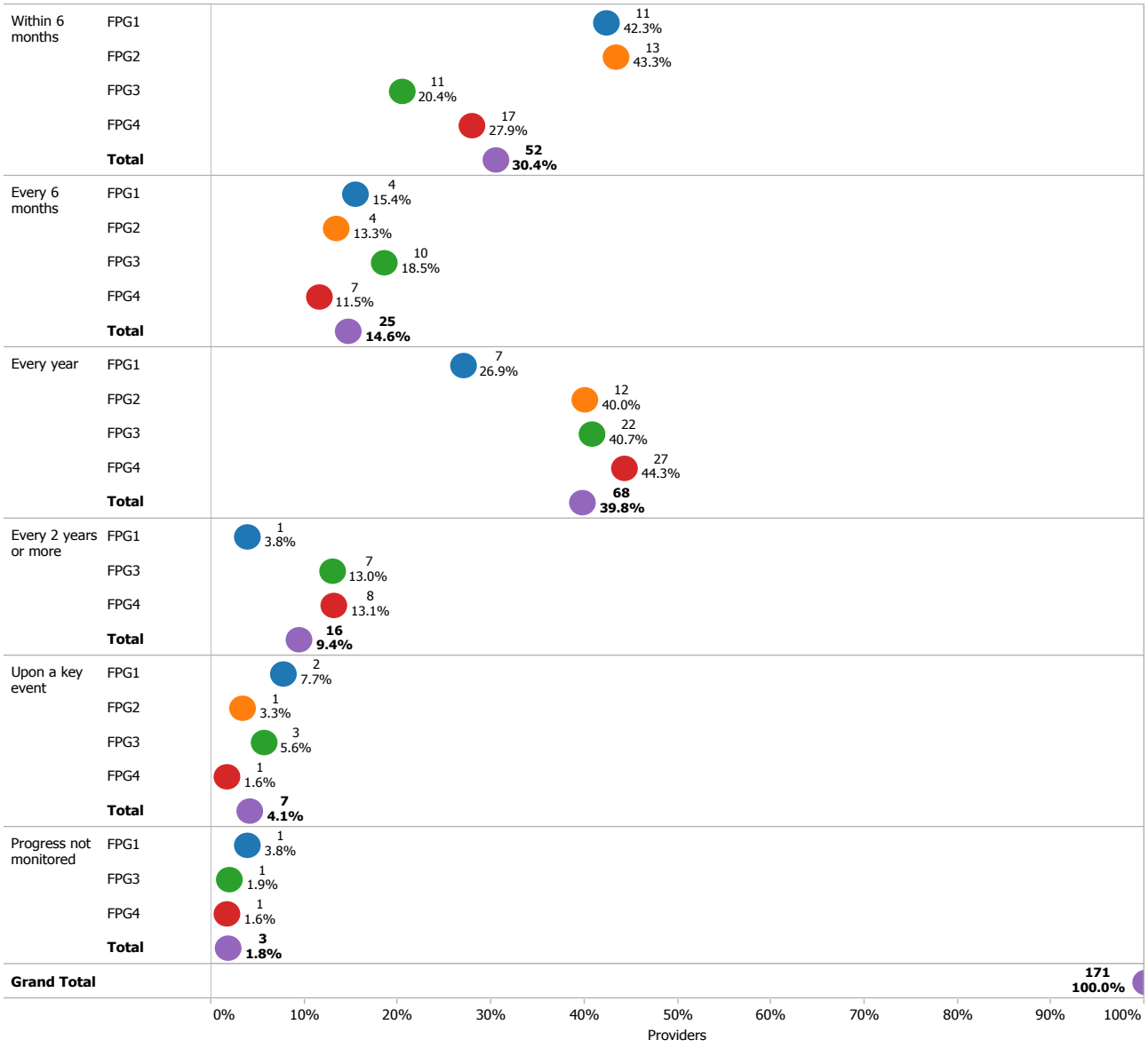


"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

However, we found that the better financially performing groups monitor their risk management plan more often. See Chart 050.

Chart 050: Timely Review of Risk Management Policy by Financial Performance Group (FPG)
10. How frequently do senior management and/or the board monitor progress of the risk management policy?



"Null" and "Unknown" responses are excluded.

3.5.2. Asset management

Asset management relates to the rate of refurbishment or currency of a facility and to its room configuration.

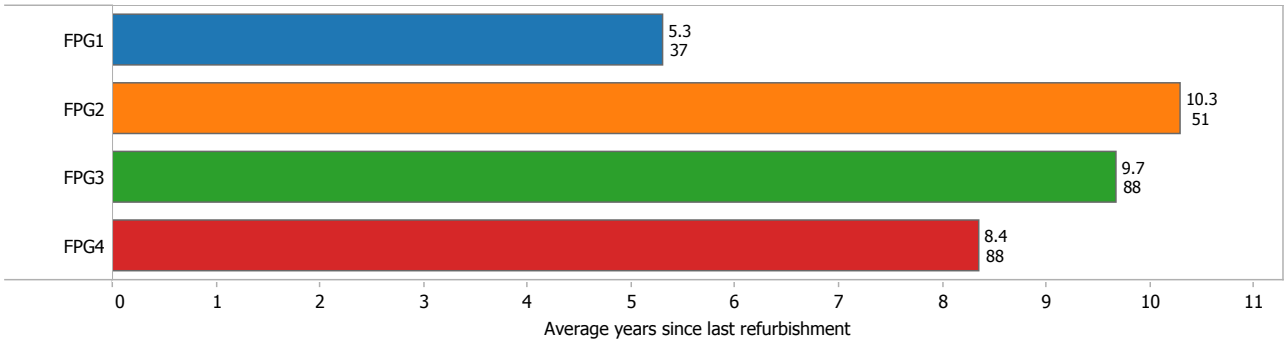
Average years since last refurbishment

Aged care facilities need to meet the changing expectations of residents. This translates to them having a finite life. We were interested to see if there was a relationship between the currency of a facility, measured by the time since last refurbishment, and financial performance.

Chart 051 shows that providers in Group 1 group have more up-to-date premises than the other groups, with the last refurbishment taking place on average 5.3 years ago. By comparison Group 4 refurbished on average 8.4 years ago.

Curiously, Group 2 providers have premises most in need of refurbishment, with the last refurbishment taking place on average 10.3 years ago.

Chart 051: Years Since Last Refurbishment
50. When did you last undertake a significant refurbishment of your facility?

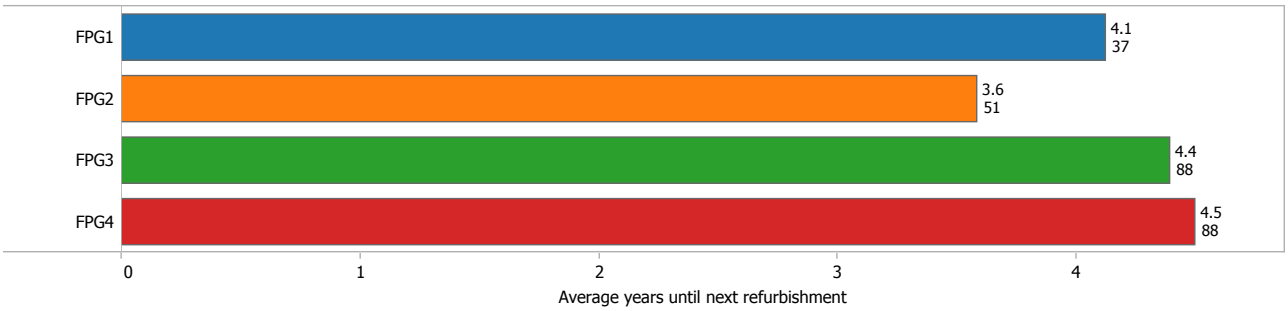


Time to next refurbishment

We then looked at the planned time to the next refurbishment. Chart 052 shows that the time until the next proposed refurbishment of facilities is broadly consistent.

Consistent with Chart 051, Group 2 providers plan to refurbish a little sooner than those in other groups.

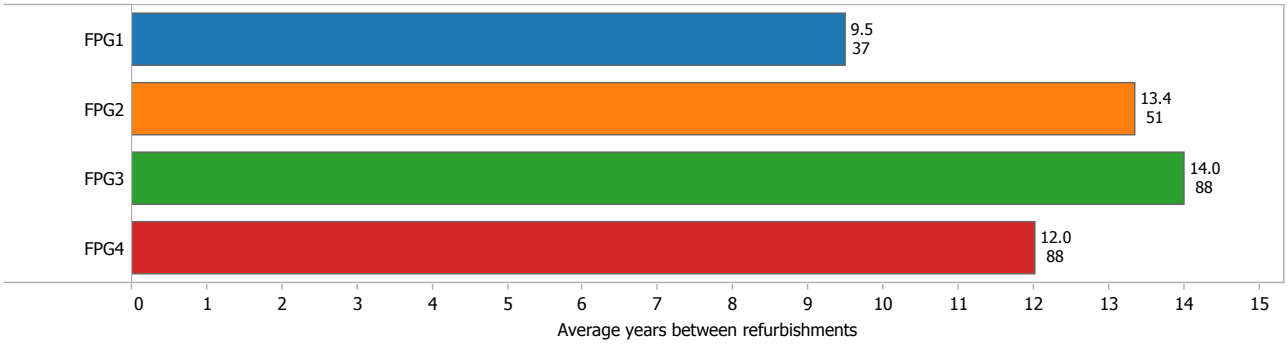
Chart 052: Years to Next Refurbishment
51. When do you expect to refurbish again in the future?



Life cycle of facilities

When the 'time since last refurbishment' is added to the 'intention to refurbish' we can determine the life cycle of facilities. On average, Group 1 providers appear to refurbish more frequently (every 9.5 years) than those in other groups. Group 3 providers are the slowest to refurbish, doing so on average every 14 years.

Chart 053: Years Between Refurbishments



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

The life cycle of facilities has two significant implications:

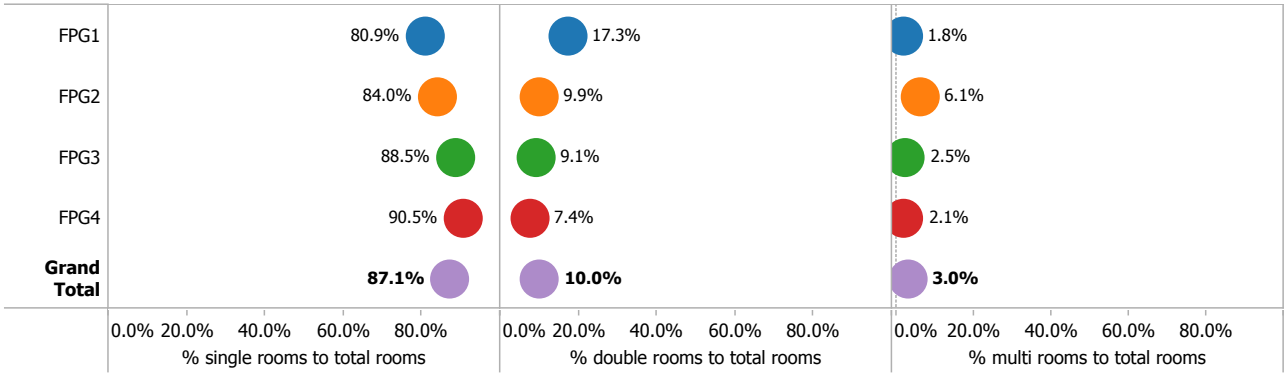
- in a competitive market, older facilities may command lower accommodation income, which may impact OEBITDA
- unless the cost of updating facilities (for which depreciation is a surrogate) is taken into account, the relative financial performance of providers may be distorted. Analysing return on net operating assets (RNOA) using net operating profit before tax (NOPBT) is a way of achieving more consistent analysis at this level

Room configuration

We asked providers to provide details of room configuration (beds per room). As Chart 054 shows, room configuration is associated with financial performance. While single rooms dominate the industry, providers in Group 1 have more double rooms and fewer multi-bed rooms than providers in other groups. This study did not look at return on investment in relation to bed numbers. However, a higher average number of beds per room, subject to the legislative limit of 1.5, may reduce construction costs and impact operational efficiency. This result suggests that providers should critically consider the room configuration when planning new facilities.

Chart 054: Multi-Bed Rooms

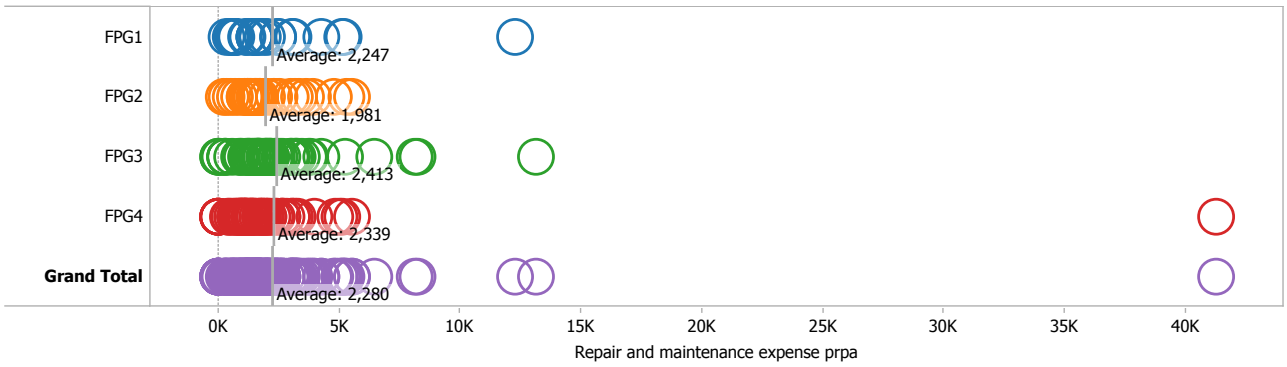
60. Please complete the following table about your facility as at 30 June 2013?



Repairs and maintenance

While it might be considered that older buildings may result in higher repairs costs, particularly if last refurbished longer ago than newer facilities, this was not borne out in the data. Chart 055 shows that all groups spent similar amounts on maintaining their properties.

Chart 055: Repair and Maintenance Expense prpa



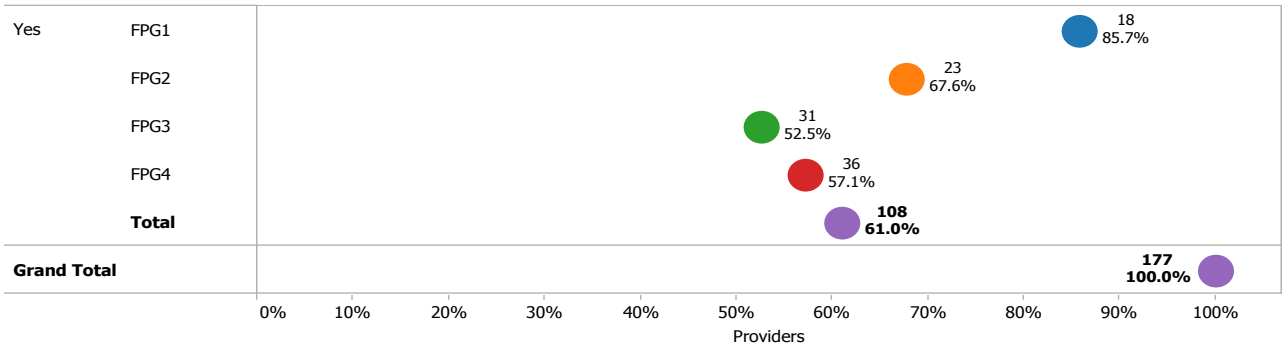
This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

3.5.3. Marketing

Market positioning

We asked survey respondents whether they have a clear market positioning or resident profile. Chart 056 shows that the top two groups, especially Group 1, are clearer on their positioning than the bottom two groups.

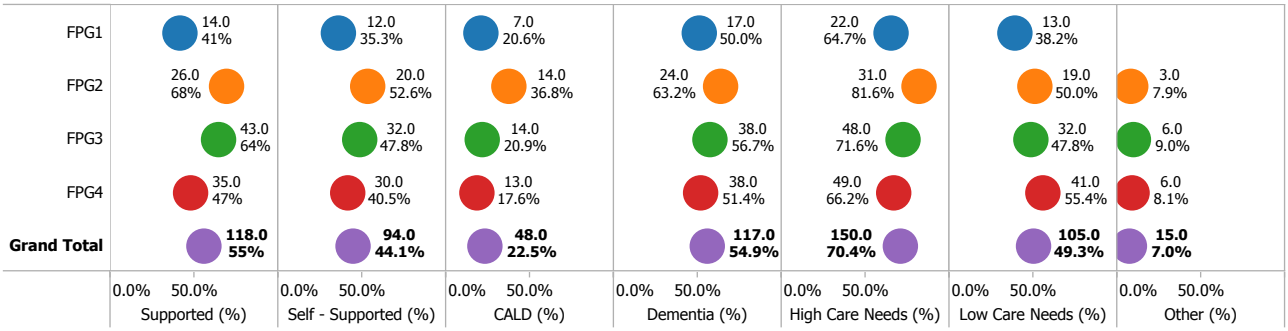
Chart 056: Clear Market Position/Target Resident Profile
42. Did you have a clear market position/target resident profile in FY13



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

We asked which resident types providers targeted. The clearest difference is that those in Group 1 plan to avoid low care relative to those in other groups.

Chart 057: Resident Types
48. Please tell us the types of residents you focused on in FY13

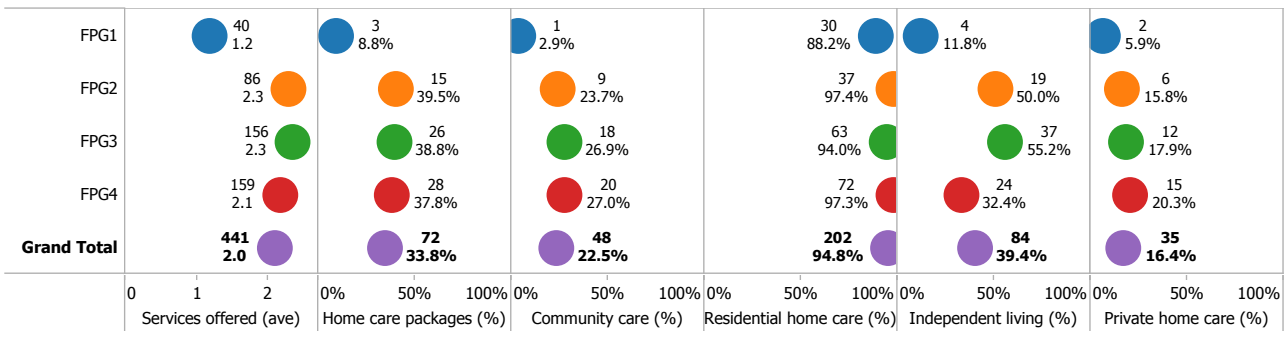


"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Services offered

We asked providers about the variety of services offered. Multiple selections were permitted in the survey. Chart 058 shows that Group 1 offers 1.2 services on average compared to an overall average of 2.0. This shows that providers in this group have a clearer focus.

Chart 058: Services Offered by Financial Performance Group (FPG)
1. Which of the following services do you offer?

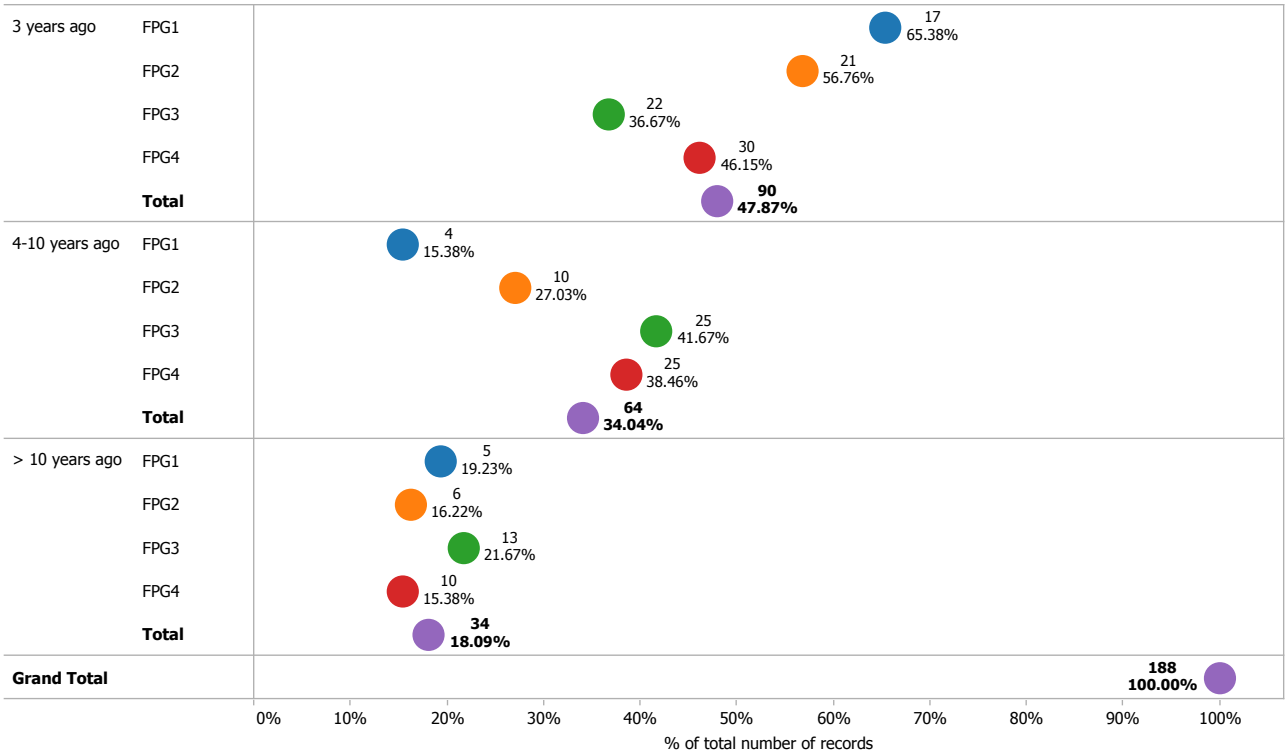


This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Branding

There is a very clear relationship between currency of brand and better financial performance, as shown in Chart 059.

Chart 059: Brand/Logo
45. When was your company logo and branding last updated?

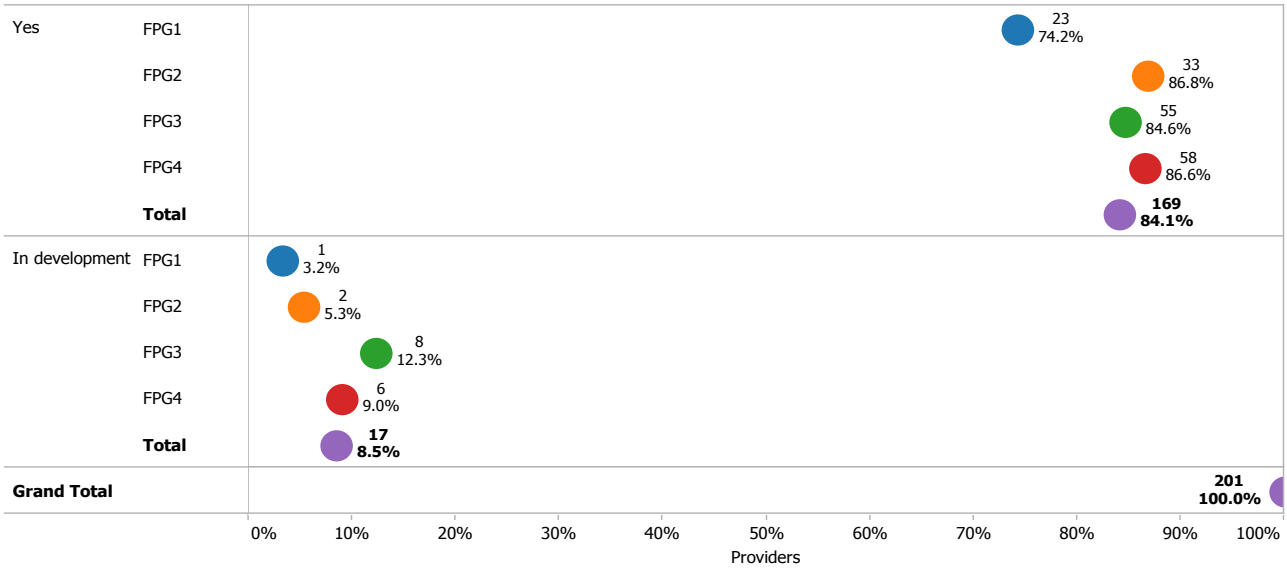


"Null" and "Unknown" responses are excluded.

3.5.4. Strategy and planning

We asked providers whether they had a strategic plan in place. There was high consistency across all groups, as shown in chart 060, with a curious finding that Group 1 providers were the least likely to have a strategic plan. This suggests that a strategic plan is not a differentiating factor in financial performance.

Chart 060: Strategic Plan by Financial Performance Group (FPG)
6. FY13, did you have a strategic plan in place?

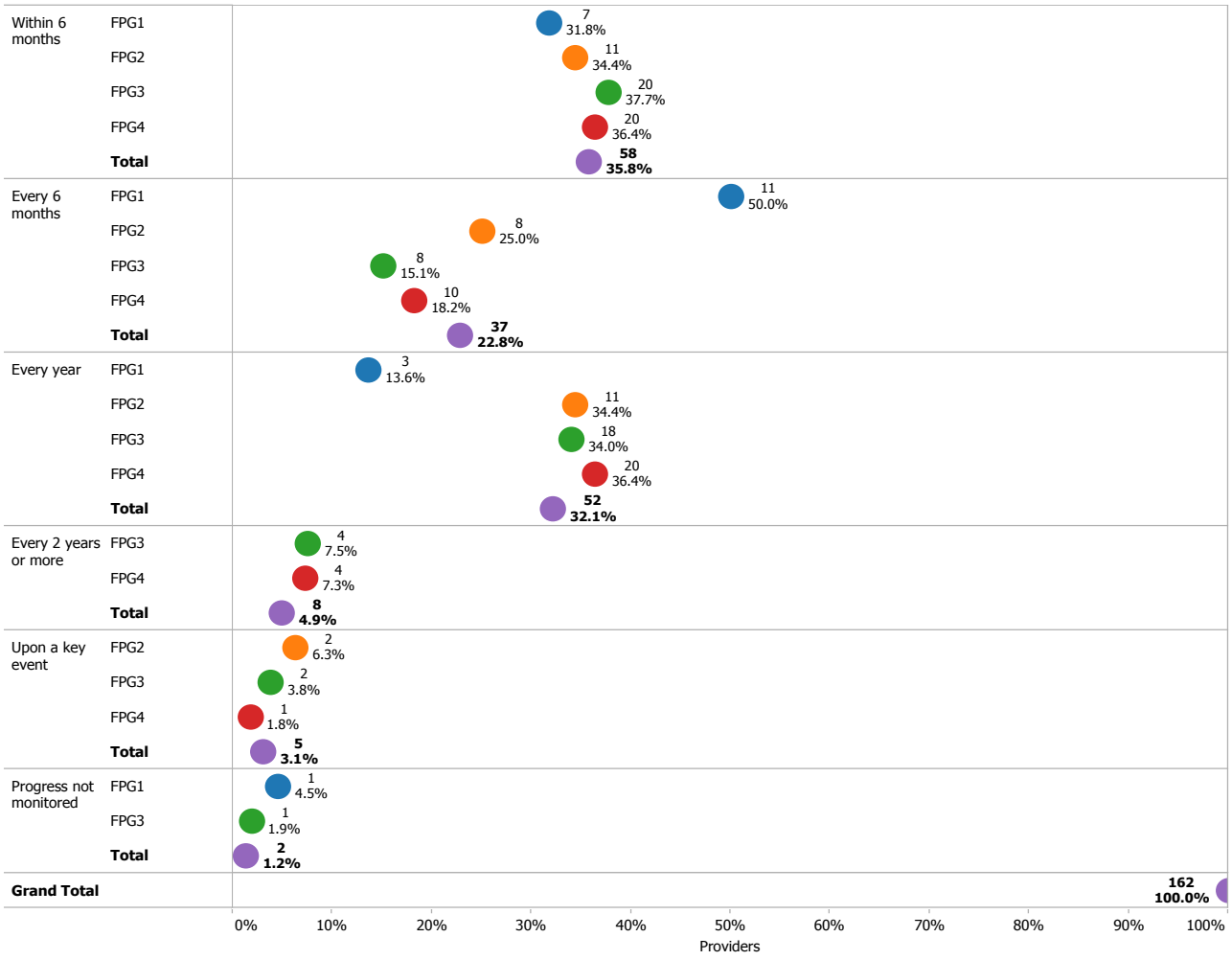


"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Chart 061 provides greater insight and shows that those providers who constantly review progress in light of their strategic plan achieve better financial results, none more so than providers in Group 1.

Chart 061: Monitoring Progress of Strategic Plan by Financial Performance Group (FPG)
7. How frequently do senior management and/or the board monitor progress of the strategic plan?

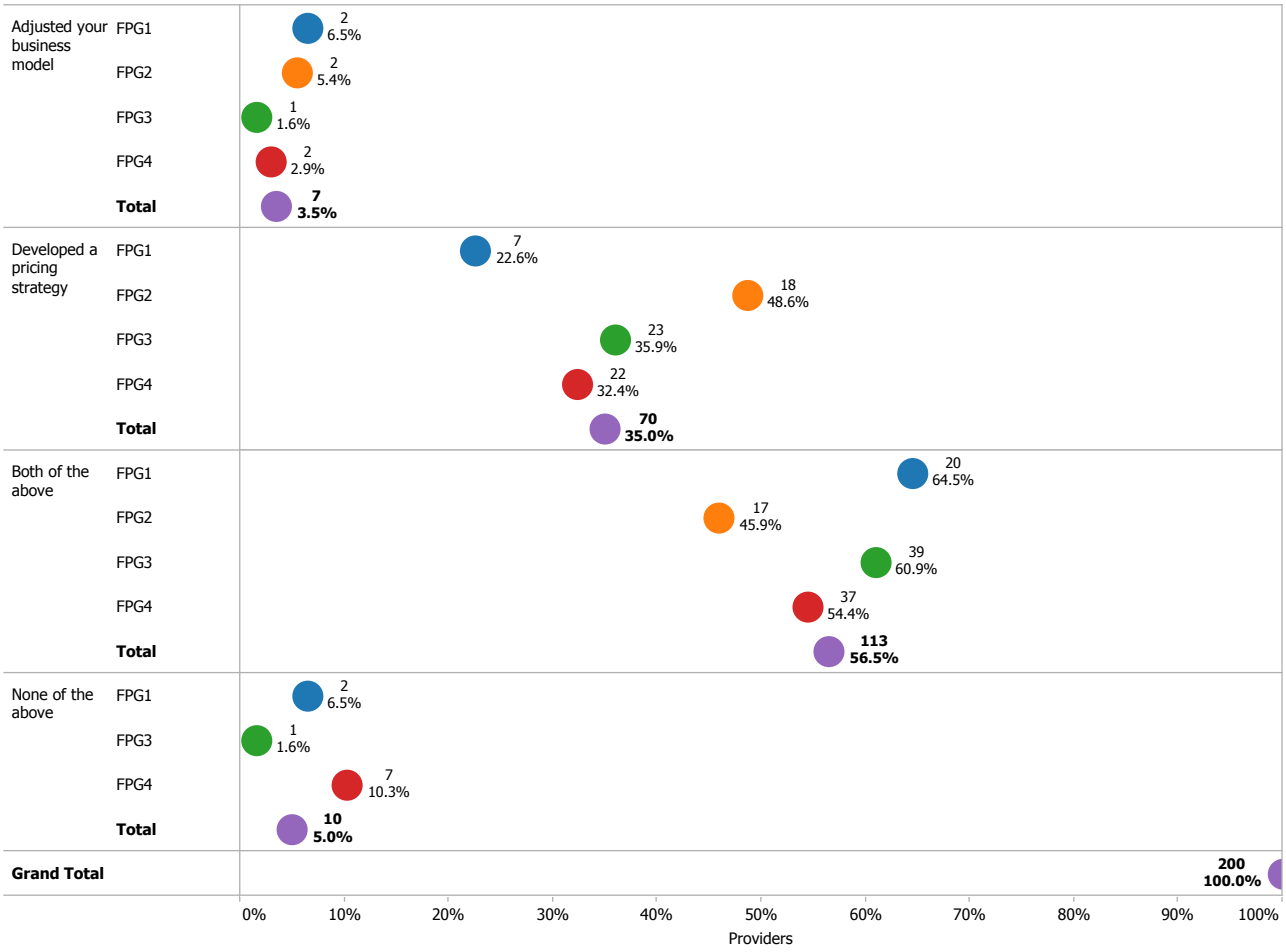


"Null" and "Unknown" responses are excluded.

Dealing with change

We asked respondents how they dealt with the 1 July 2014 changes. Chart 062 shows that most providers adjusted to the changes via their pricing strategy, and to a lesser extent via their business model. Most providers adjusted via both.

Chart 062: Aged Care Reform by Financial Performance Group (FPG)
8. As a result of the 1 July 2014 aged care reforms, have you?



"Null" and "Unknown" responses are excluded.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

4. Other Factors Related to Financial Performance

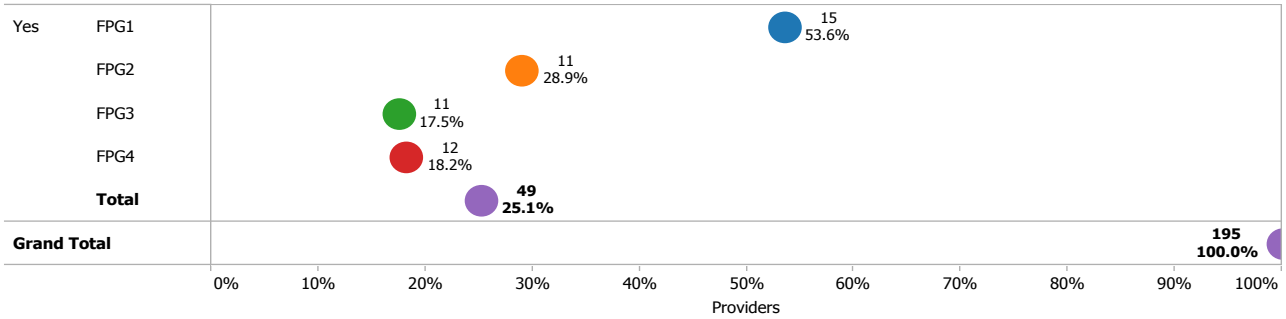
This section examines other findings that, while less relevant to the differentiation of financial performance of providers, give further insights into provider characteristics.

4.1. Corporate Structure

We asked providers if they held land and buildings in an entity separate to their operating entity. The use of multiple structures may have taxation benefits for FP providers, as well as affecting payment of related party rents. Appendix 1 explains how we have handled the impact of related party rent.

Chart 063 shows that providers in Group 1 were likely to use multiple structures.

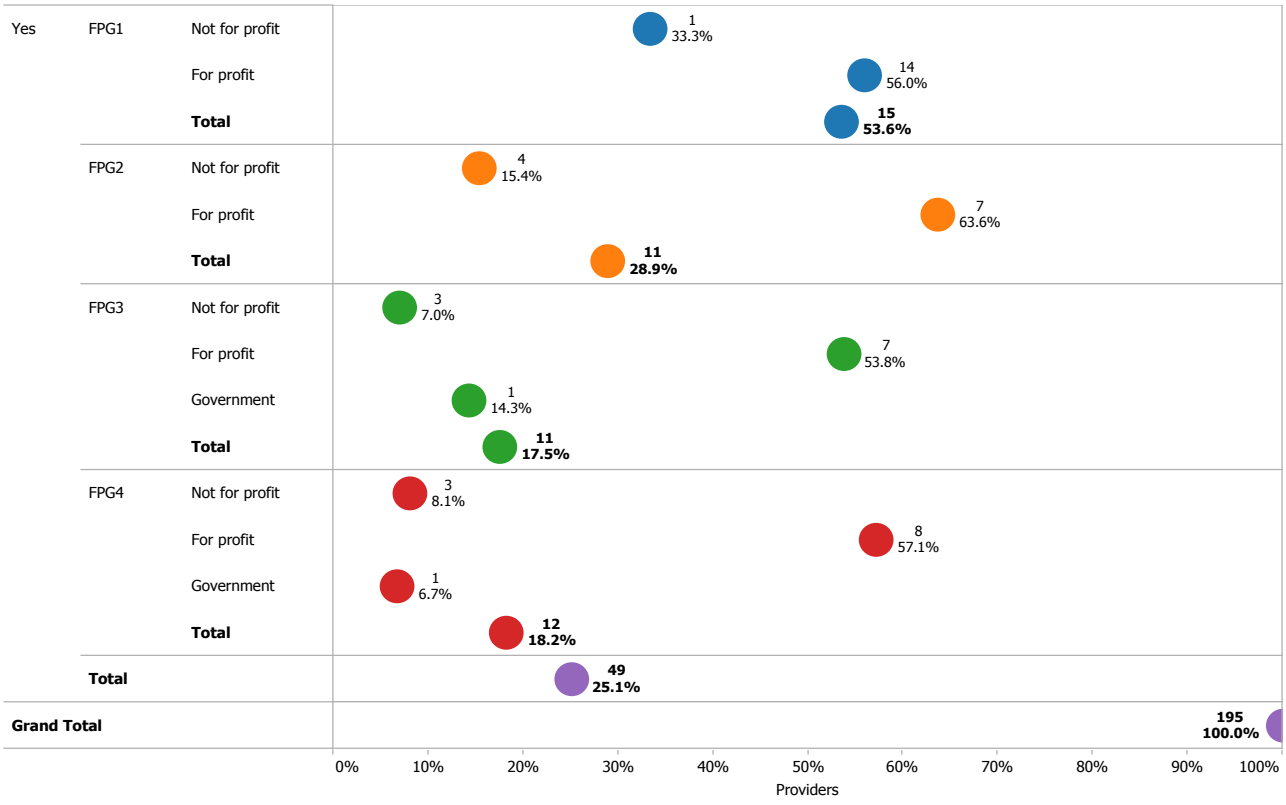
Chart 063: Corporate Structure by Financial Performance Group (FPG)
19. In FY13, did you hold your land and buildings in a related entity separate to your operating entity



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

As Chart 064 shows, the use of these structures is a FP phenomenon.

Chart 064: Corporate Structure by Financial Performance Group (FPG)
19. In FY13, did you hold your land and buildings in a related entity separate to your operating entity?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

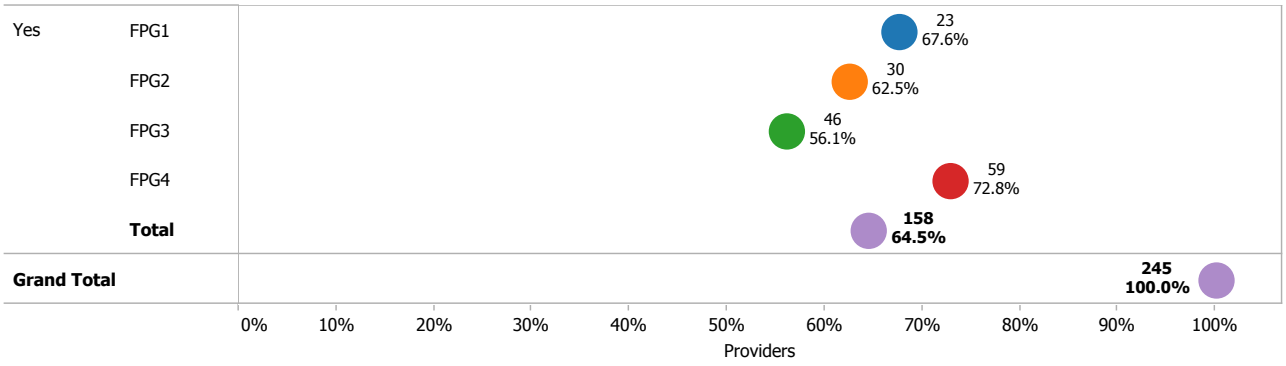
4.2. Admission Management

Admissions staff

The survey shows that the better financially performing providers were more likely to have dedicated admission staff, with the exception of providers in Group 4, which was the most likely (see Chart 065). A deeper insight into the functions of admission staff – for instance, whether they help to assess a potential resident's fit with the target market profile – may be beneficial should ACFA undertake future studies.

Chart 065: Admissions Staff

57. In FY13, did you have dedicated admissions staff?



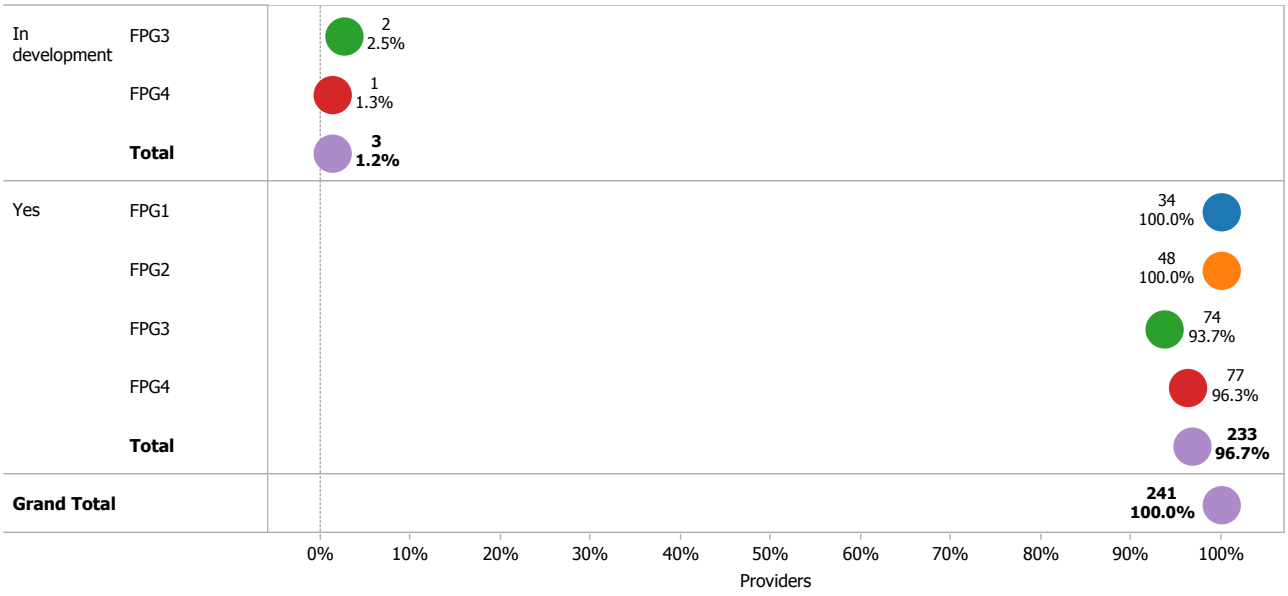
"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Admission process

Chart 066 shows that nearly all providers have a formal admissions process. Having an admissions process was therefore not significant in differentiating providers' financial performance.

Chart 066: Admissions Process

58. In FY13, did you have a formal admissions process?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

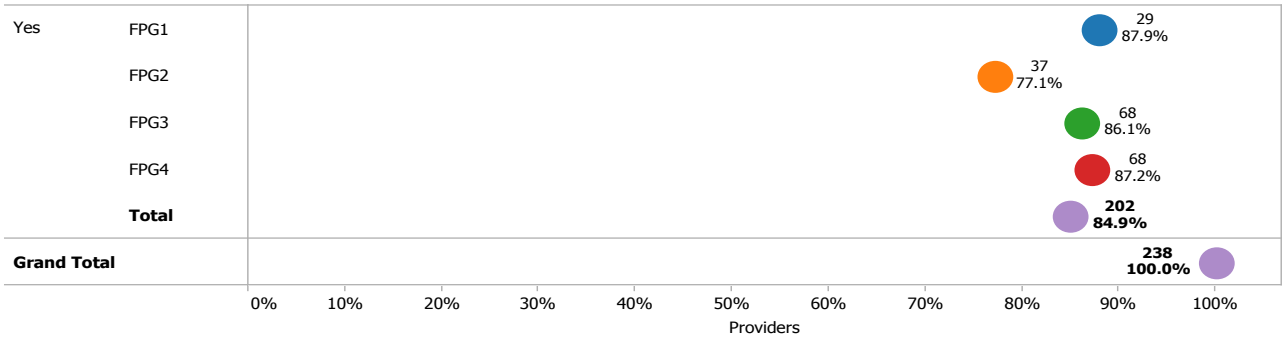
This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Waitlist

Most providers noted that they had a waitlist. Chart 067 shows a curious dip in the number of potential residents on the waitlists of providers in Group 2.

Chart 067: Waitlist

59. In FY13, did you maintain a waitlist at your facility?



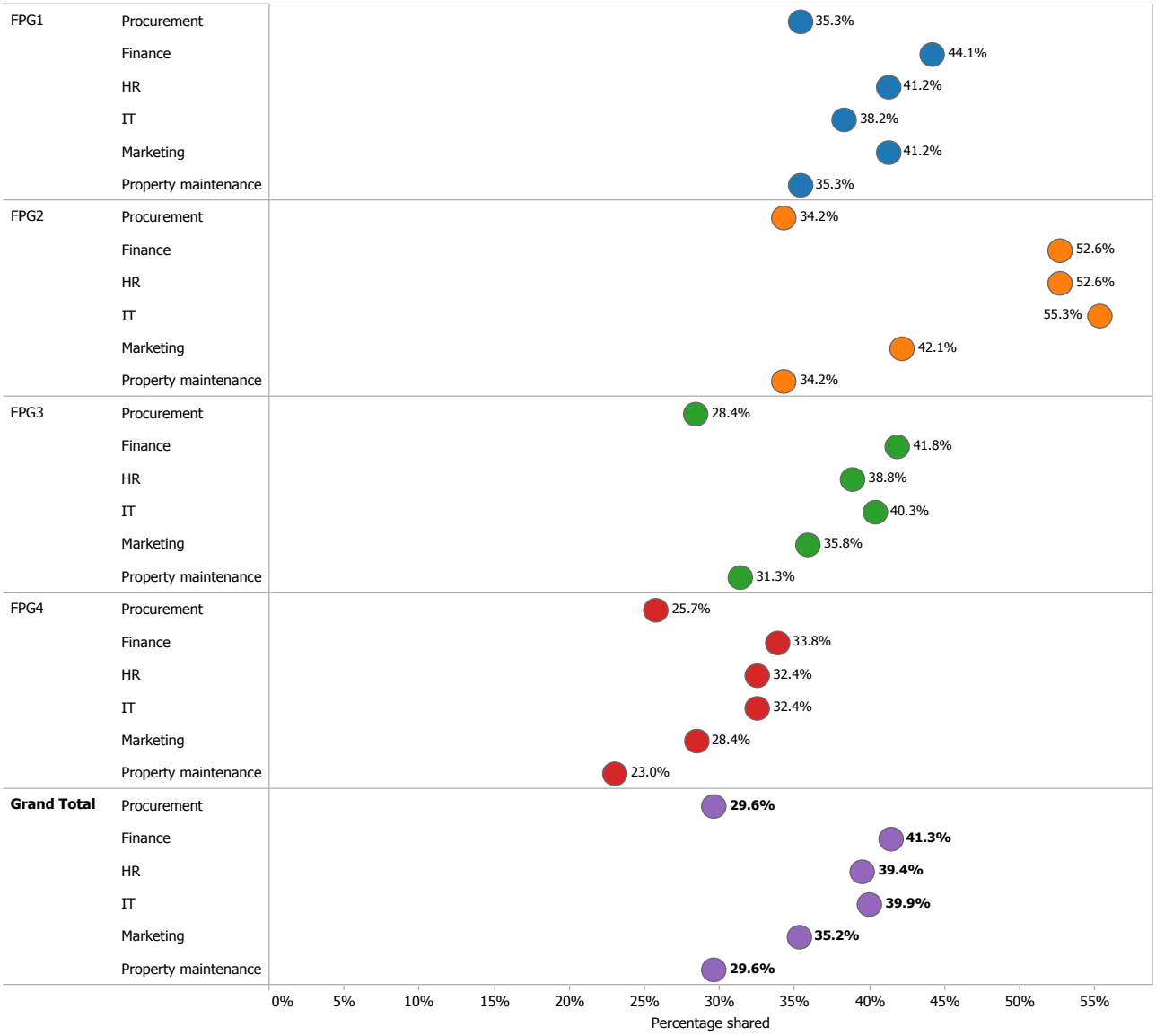
"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

4.3. Shared Services

The survey showed that providers with multiple locations use a shared service model. Chart 068 shows that providers in Group 2 were a little more inclined to share services in the area of procurement. Providers in Group 4 embrace shared services to a lesser degree than all other groups.

Chart 068: Shared Services Across Multiple Facilities

37. If you have more than one facility, do you run shared services in the following areas across all your facilities?

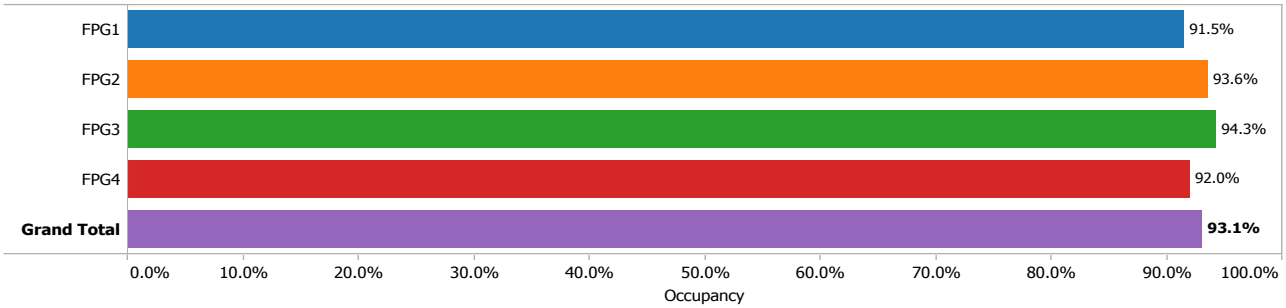


This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

4.4. Occupancy

Chart 069 shows that providers in all groups achieve very similar average occupancy rates. This is not to say that relatively low occupancy rates have no impact on financial performance. This outcome is a reflection of the regional service provision targets which govern the allocation of new places.

Chart 069: Occupancy Rate

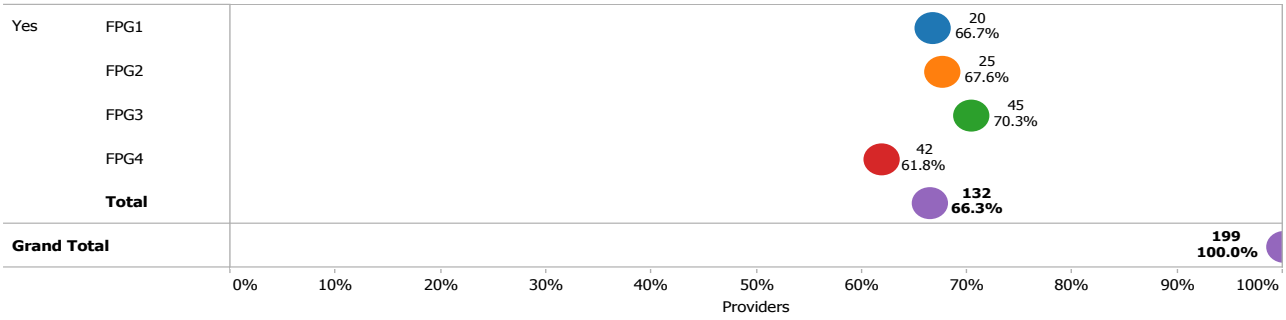


4.5. Seeking External Advice

We asked providers whether they used external advice in relation to growth and operational strategies. There was a consistent approach to this across all groups, with between 60% and 69% of providers seeking external advice on these matters. Group 3 providers were most likely to do so. Due to the consistency across all groups, it would seem that seeking external advice is not a differentiating factor in financial performance.

Chart 070: Seeking External Advice by Financial Performance Group (FPG)

14. Do you seek external advice on growth and operational strategies?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

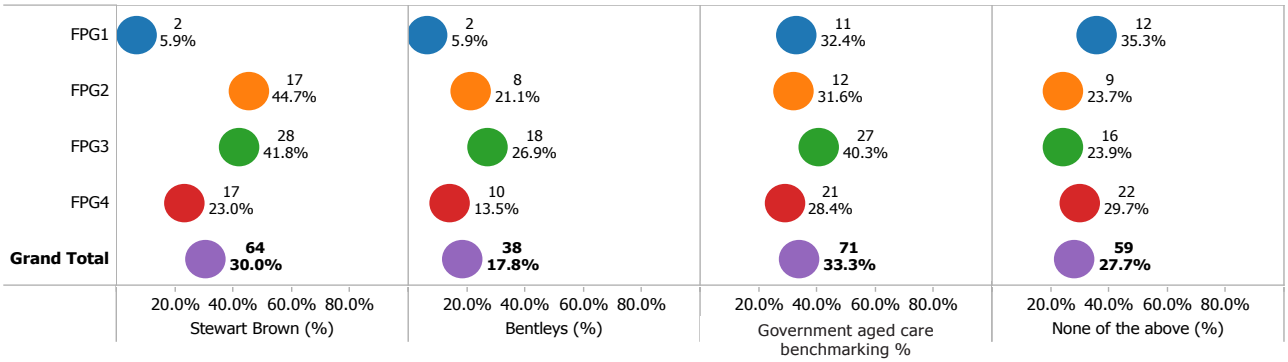
This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

4.6. Participation in Benchmarking

Chart 071 indicates that providers in groups 2 and 3 tend to participate in commercial benchmarking to a much greater degree than those in groups 1 or 4. We also found that participation was skewed towards NFP providers.

Chart 071: Benchmarking by Financial Performance Group (FPG)

32. Which of the following financial benchmarking studies do you regularly participate in

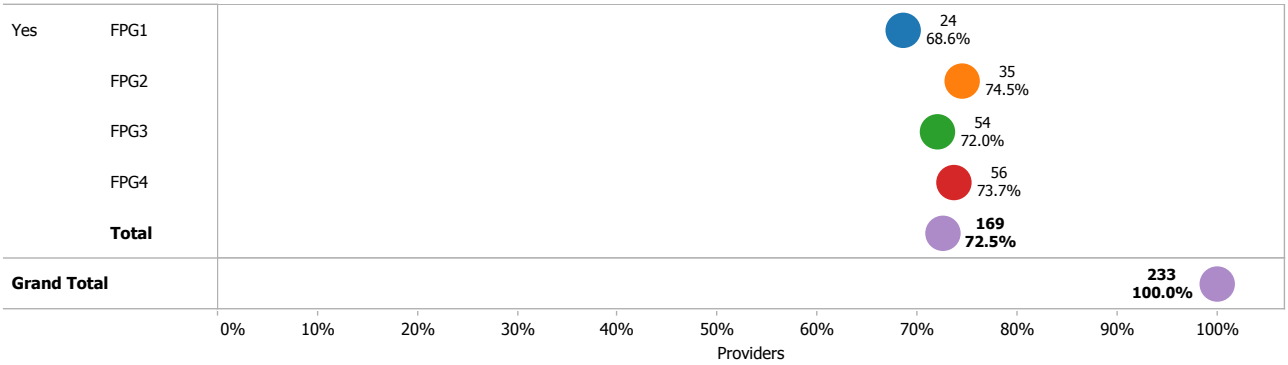


4.7. Local Community Alliances

The majority of providers form alliances and links with their local community, with a similar proportion doing so across all groups (between 66% and 73%).

Chart 072: Local Community Alliances

56. In FY13, did your facility form alliances and links to your local community eg.child care centres, schools?

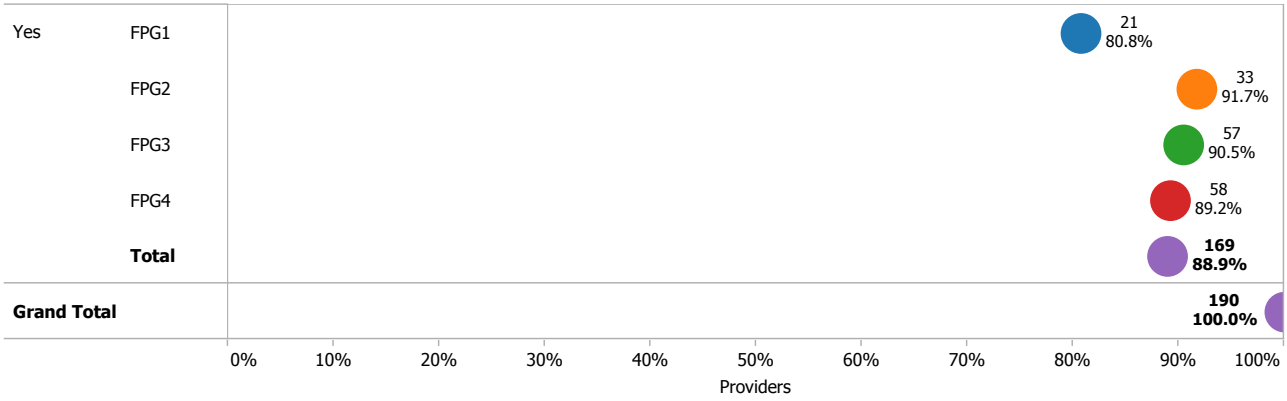


"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

4.8. Use of Volunteers

The responses to a question on the use of volunteers showed high consistency across all groups, ranging from 80.8% in Group 1 to 91.7% in Group 2. In future surveys, ACFA may wish to question providers regarding the average number of volunteers that a provider uses. This can be compared to average staff count to gain greater insight into the wages expense.

Chart 073: Volunteer Staff by Financial Performance Group (FPG)
39. In FY13, did you have volunteer staff

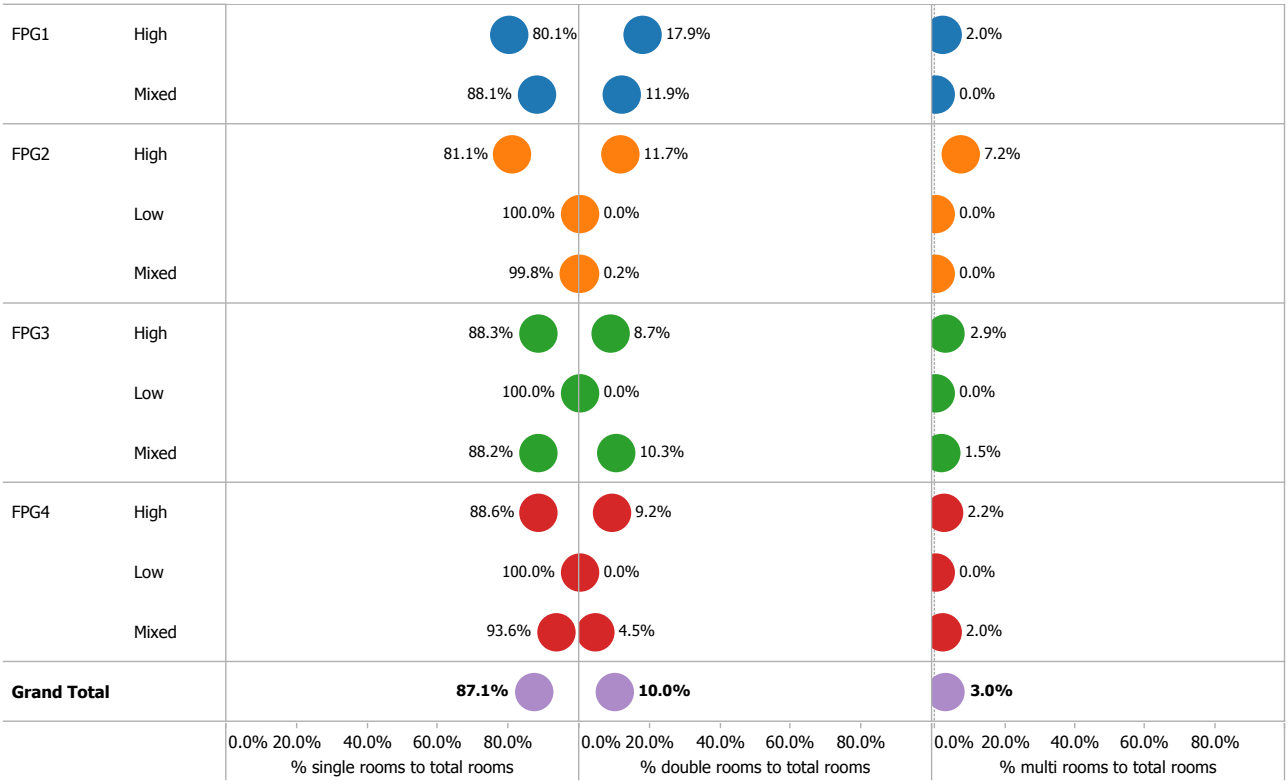


"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

4.9. Room Configuration

In addition to the impact of the general use of two-bed rooms, as identified in the 'Key findings' section, Chart 074 shows that room configuration by resident care profile is in line with the overall trend. Performers with higher OEBITDA tend to use more two-bed rooms across all resident care profiles.

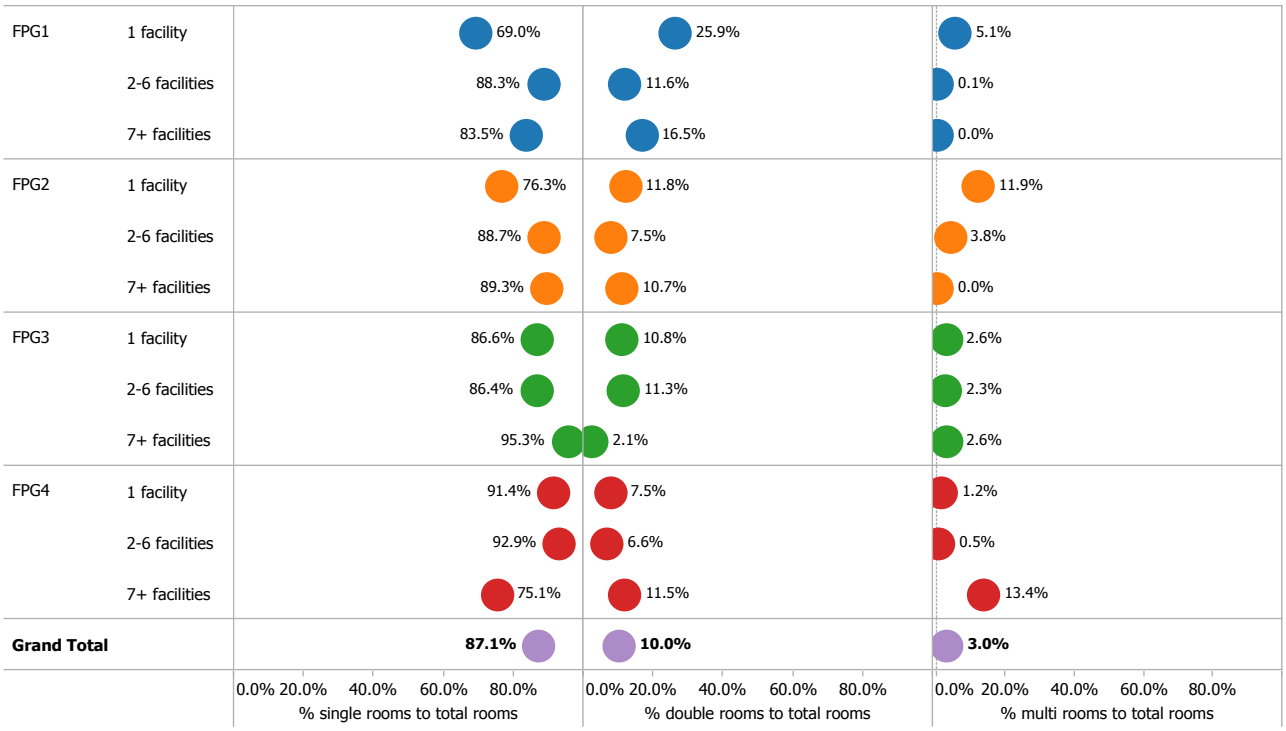
Chart 074: Multi-Bed Rooms by Financial Performance Group (FPG) and Residential Care Profile
60. Please complete the following table about your facility as at 30 June 2013?



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

We also considered room configuration according to provider size and found that providers operating a single facility use more two-bed rooms.

Chart 075: Multi-Bed Rooms by Financial Performance Group (FPG) and Size
60. Please complete the following table about your facility as at 30 June 2013?

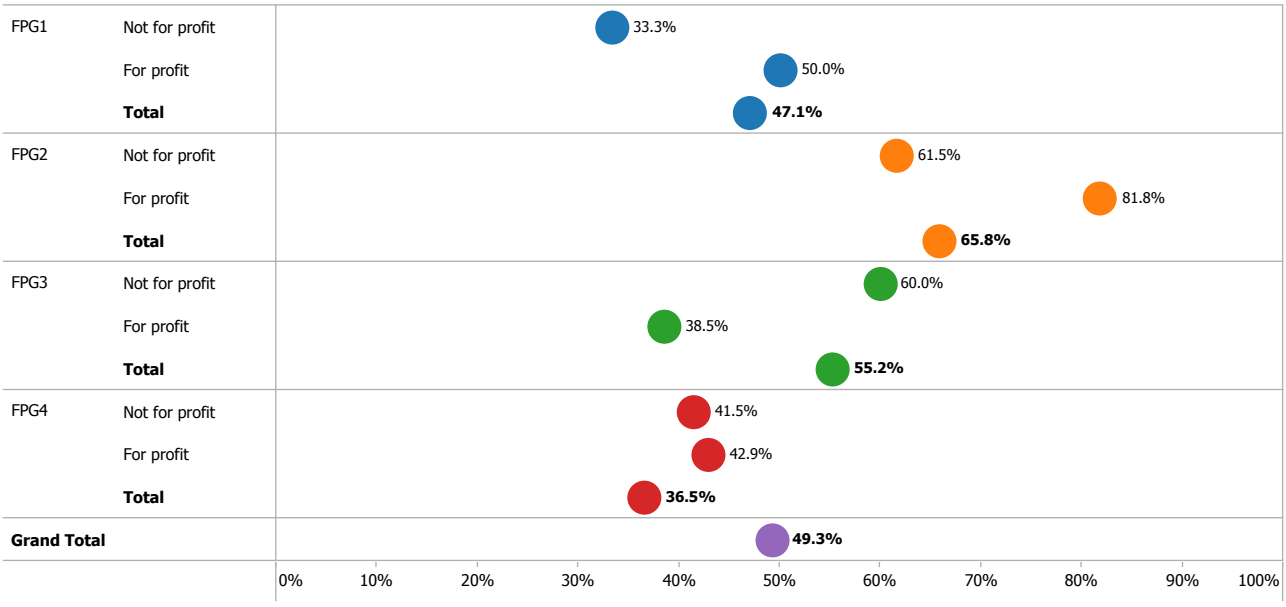


4.10. Staff Management Practices

Agency staffing

The survey examined the propensity to use agency staffing. Chart 076 shows that, on average, 49.3% of the industry use agency staffing, but the usage was quite mixed across the groups and by both ownership and group.

Chart 076: Providers Using Agency Staff

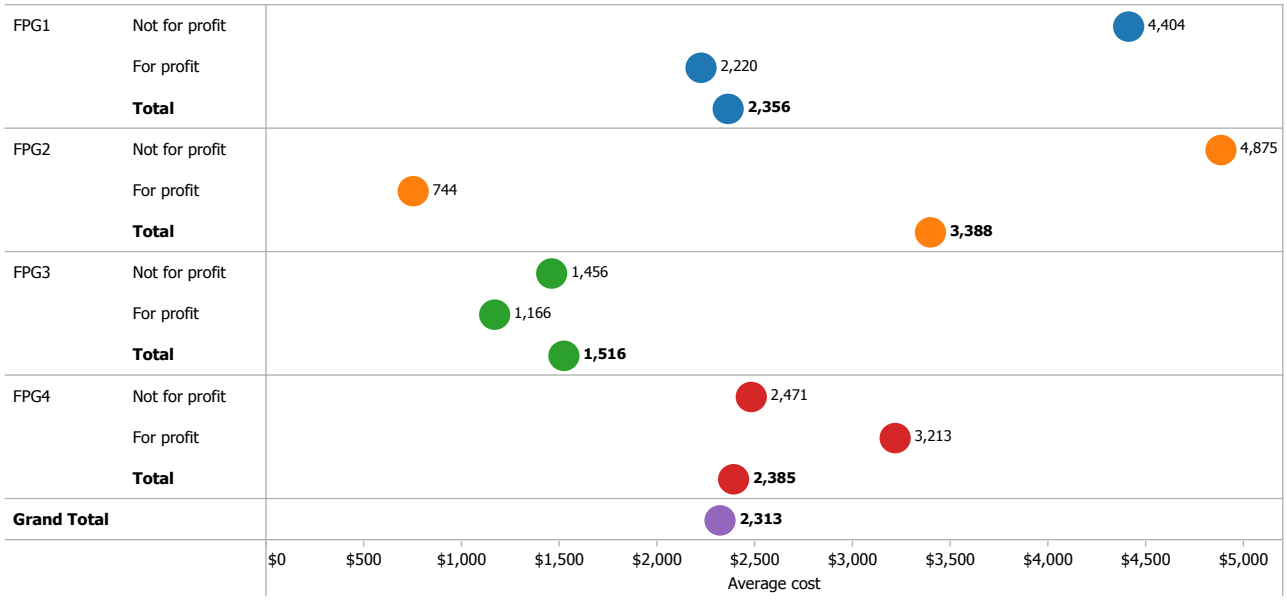


To gain greater insight, we analysed the cost of agency staff on a per bed basis. Chart 077, again, shows quite mixed results.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Chart 077: Average Agency Staff Cost Per Bed

18. Agency staff cost $ in FY13

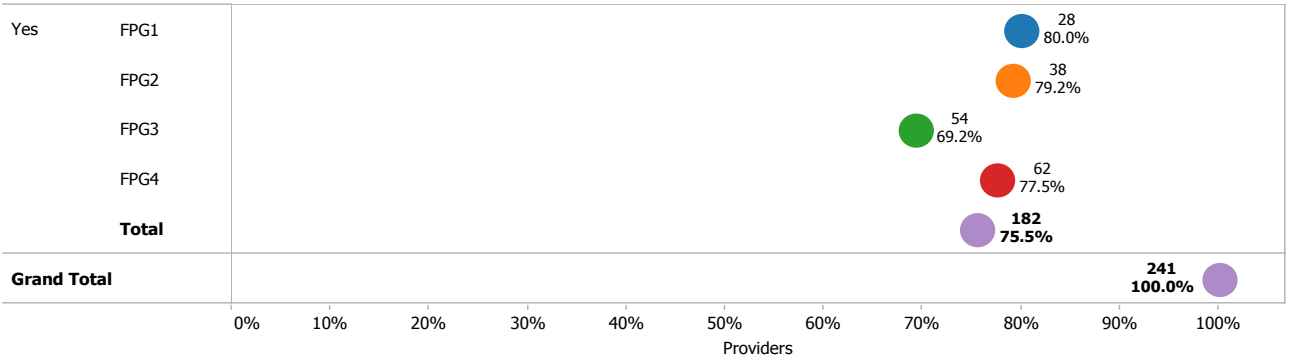


Management Development Training

As Chart 078 shows, with the exception of Group 3 providers, there was a consistent approach to providing management development training in FY2013.

Chart 078: Training

55. In FY13, did you invest in management development training programs for your Facility Manager or DoN?



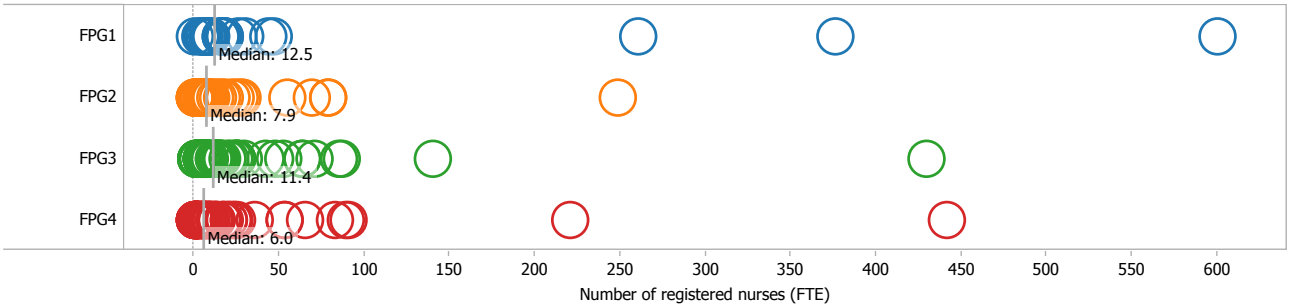
"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Registered nurses

We were interested to see if the relative use of registered nurses was linked to financial performance. Chart 079 shows the findings are inconclusive.

Chart 079: Provider Financial Data

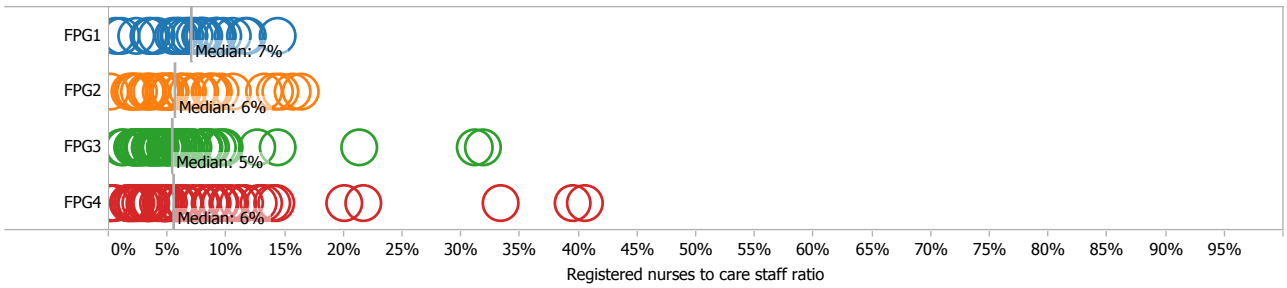
18e. Registered nurses (FTE) at 30/06/2013



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Chart 080 shows there is a high degree of consistency in the ratio of registered nurses to other care staff across all groups.

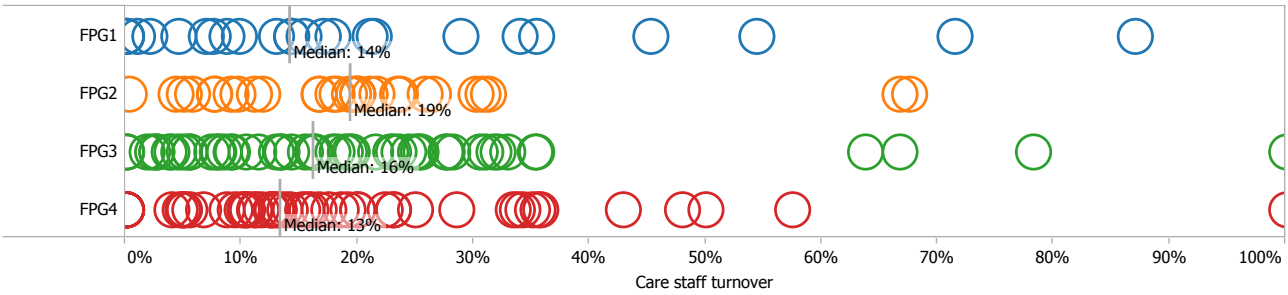
Chart 080: RN to Care Staff Ratio Distribution



Staff turnover

Staff turnover figures can be distorted depending on how providers answered the survey question. Notwithstanding this, while staff turnover rates varied across the groups, there wasn't any clear relationship with financial performance (see Chart 081).

Chart 081: Care Staff Turnover



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

5. About Group 4 Providers

Providers in Group 4 represent 33% of all providers and generate an aggregate OEBITDA of -$77 million at an average of -$2,072 prpa, compared to the aggregate OEBITDA of $1,909m at an average of $14,370 prpa of the better financially performing providers in groups 1, 2 and 3.

In light of the representation of Group 4 providers in the industry, and their collective financial performance, it is important to understand the challenges and opportunities of this group. To provide this insight we compared the characteristics of Group 4 providers to those of better financially performing providers. This allowed us to focus on identifying what drives some providers to perform better financially and leads others to not perform as well, and what could be done to improve the financial performance of Group 4 providers, which was a specific requirement of the Assistant Minister for Social Services, the Hon. Mitch Fifield.

Group 4 providers, which are weighted to the NFP and government providers, place a high emphasis on non-financial measures of performance. This can be seen in a number of areas:

- they gravitate to the least financially attractive locations; regional, rural and remote
- they tend to operate smaller facilities.
- they are more dependent on capital grants.
- despite their relatively low OEBITDA as a group, these providers have developed additional revenue sources to ensure their ongoing viability.
- while some rely on additional government (state and federal) support, many rely on their communities (for donations), past surpluses or the benevolence of the larger groups to which they belong.

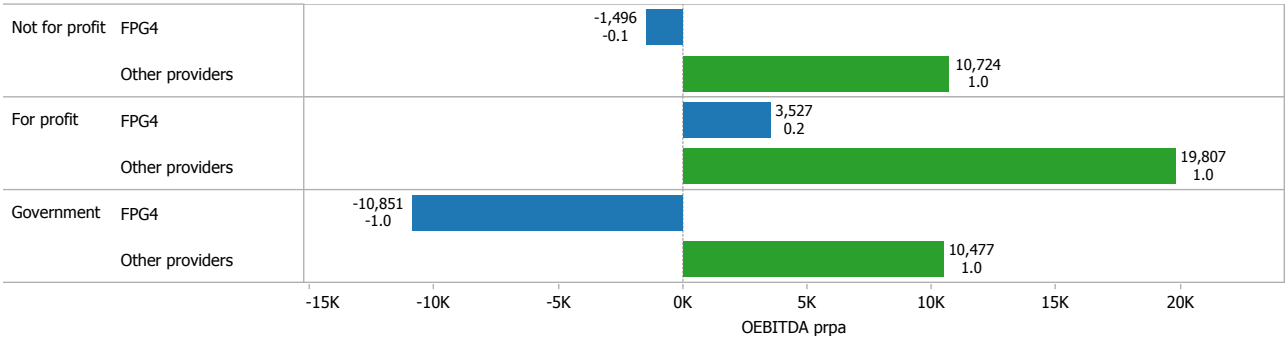
Notwithstanding the above, our findings suggest that there are areas which this group could consider to improve their financial performance.

5.1. Impact of Ownership, Location, Size and Resident Care Profile

5.1.1. Ownership

When considering ownership of aged care providers, the government sector is over-represented in Group 4 (21%) compared to an overall industry average of 10%. NFP providers are over-represented to a lesser extent in Group 4 at 61%, compared to an overall average of 53%. Relative performance at the OEBITDA prpa level of Group 4 by ownership is represented in Chart 082 and shows the gap is greatest for government providers.

Chart 082: OEBITDA prpa by Financial Performance Group (FPG) 4 Providers Compared With all Other Providers



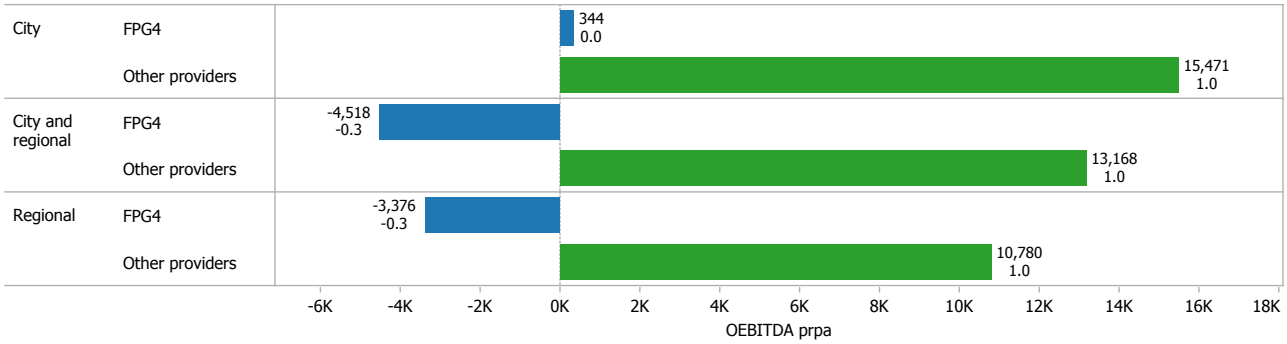
This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

5.1.2. Location

Group 4 is heavily dominated by regional providers –56% are regional compared to only 17% of Group 1 providers. When analysing the location of survey participants by state, Queensland is more likely to have providers in this group.

The relative OEBITDA prpa gap is greatest for those operating a combination of city and regional facilities.

Chart 083: OEBITDA prpa by Location, for Financial Performance Group (FPG) 4 Compared With all Other Providers

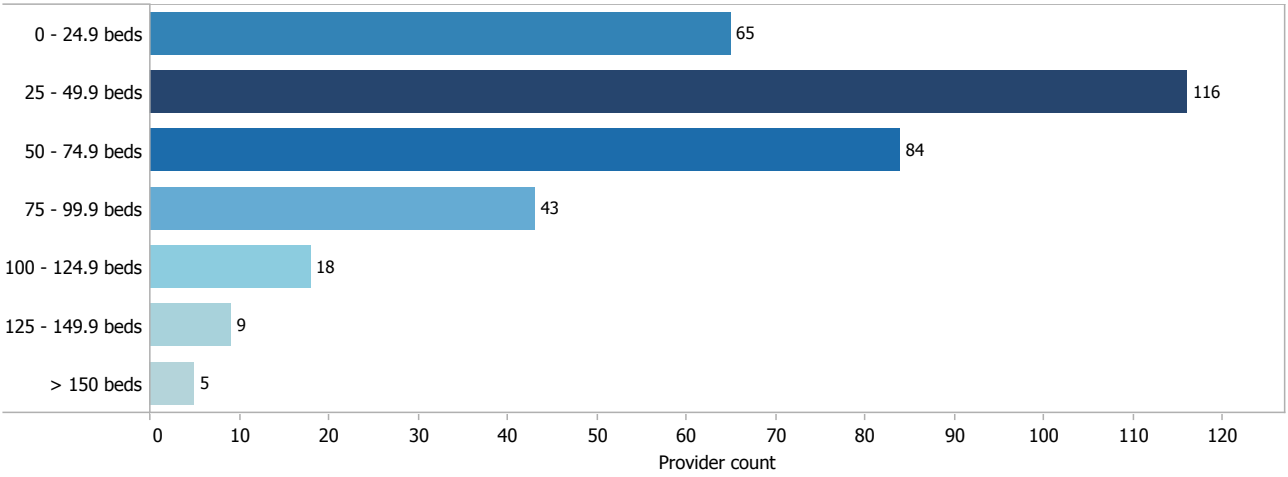


5.1.3. Size and beds per facility

Group 4 providers have the highest proportion of providers operating 2–6 facilities, compared to the better financially performing providers, at 36.5%. Only 58.5% of Group 4 providers operate single facilities, the lowest proportion of all provider groups.

Group 4 has a much lower average number of beds per facility – averaging 55 beds – compared to Group 1 providers, which average 80 beds. Chart 084 shows the variation in bed numbers in a facility for providers in Group 4.

Chart 084: Beds per Facility Distribution for Financial Performance Group (FPG) 4



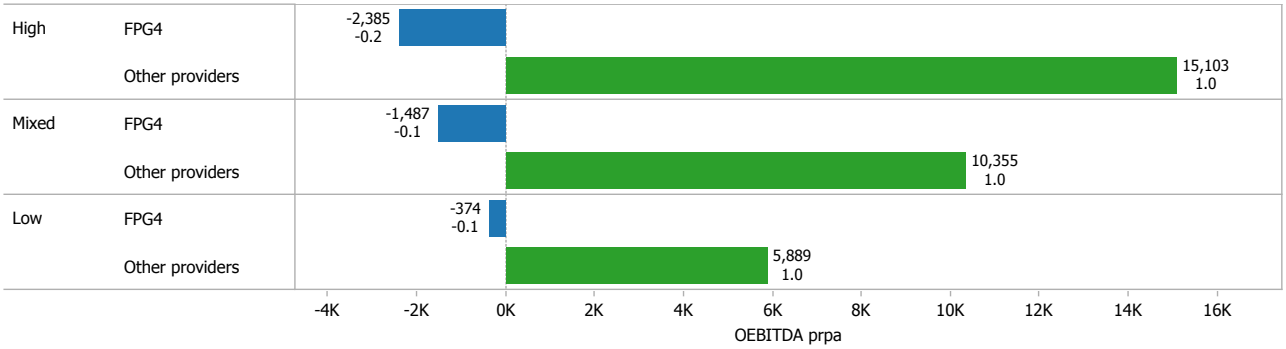
5.1.4. Resident care profile

Group 4 had the lowest proportion of providers classified as 'high care'[6], at 50.6%. It also had the highest proportion of providers classified as 'low care'[7], at 7.6%.

When OEBITDA is considered with resident care profile, the gap is widest with high care facilities, confirming that Group 4 providers face additional challenges when managing more complex operating environments. Section 3.2.5 shows that as the level of care increases, Group 4 providers exhibit higher operating expenses prpa as compared to the better financially performing providers.

[6] Providers are classified as high care when over 70% of care days delivered have an ACFI classification of 'high'.
[7] Providers are classified as low care when over 70% of care days delivered have an ACFI classification of 'low'.

Chart 085: OEBITDA prpa by Resident Care Profile for Financial Performance Group (FPG) 4 Compared With all Other Provider



5.1.5. Summary of the impact of ownership, location, size and resident care profile

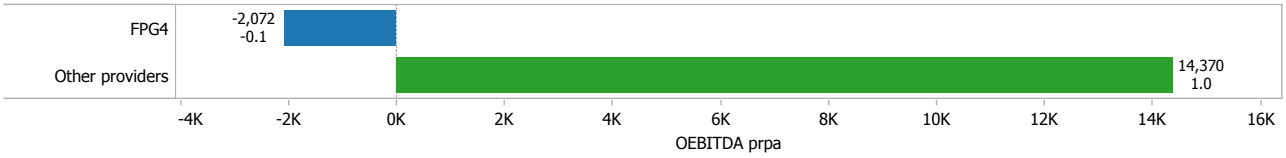
NFP and government providers operating in regional locations are over-represented in Group 4. This suggests that the primary motivation for these providers is less likely to be financial performance.

Where feasible, Group 4 providers should give careful consideration to increasing the number of beds in their facilities, as this report has shown that economies of scale is achieved from having more beds in a facility.

5.2. Provider Financial Performance

The gap in OEBITDA performance between Group 4 providers and the better financially performing providers is $16,442 prpa.

Chart 086: OEBITDA prpa for Financial Performance Group (FPG) 4 Providers Compared With all Other Providers



To provide insight into causes of the OEBITDA gap, we examined the management of operating revenue, and the operating expenses of the Group 4 providers compared to the better financially performing providers.

5.2.1 Operating revenue management

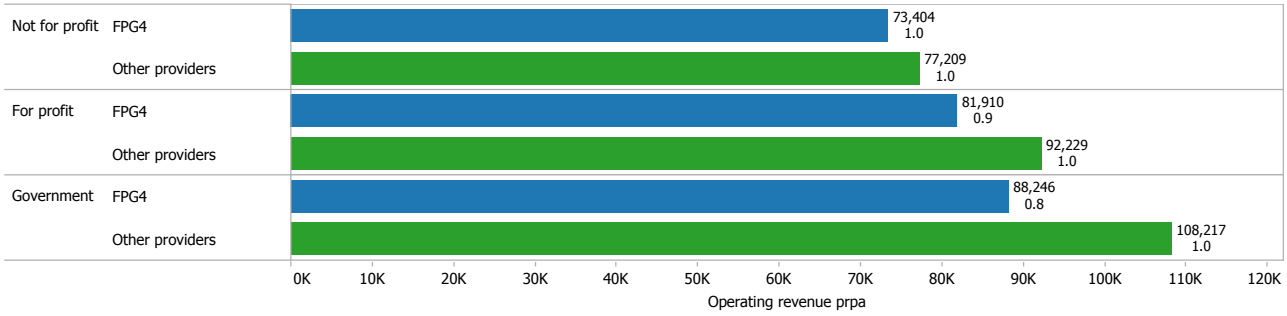
We have examined the effects of the following in respect of operating revenue management:

- operating revenue prpa
- government revenue comprising care subsidies (mainly ACFI) and accommodation supplements
- resident income comprising of income-tested resident-contributed care fees and accommodation charges, including bond retentions and deemed (notional) accommodation bonds.

Operating revenue prpa

Chart 087 shows the varying capacity of providers in Group 4 to generate operating revenues by ownership. As differences in revenue would mostly result in similar differences in OEBITDA, the differences in all ownership categories are significant. The difference in the FP and government sectors, of $10,300 and $20,000 prpa respectively, is particularly striking.

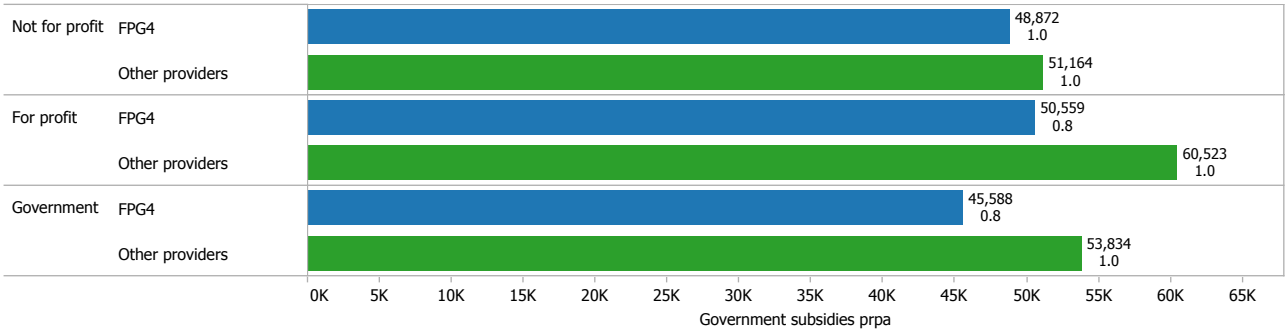
Chart 087: Operating Revenue prpa by Ownership for Financial Performance Group (FPG) 4 Compared With all Other Providers



Government subsidies

Government subsidies were reported by 846 providers as a separate line item in their GPFR. Chart 088 shows revenue from government subsidies for Group 4 providers compared to the better performing providers. While, overall, NFP providers receive similar subsidies – $48,872 prpa compared to $51,164 prpa – there is a significant difference in the government subsidies of FP and government providers of $9,964 and $8,246 respectively.

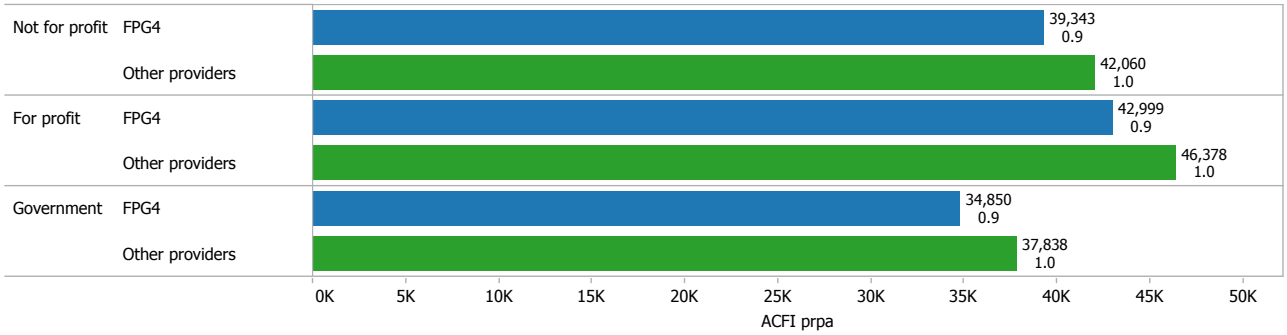
Chart 088: Government Subsidies prpa by Ownership for Financial Performance Group (FPG) 4 Compared With all Other Providers



ACFI management

Government subsidy includes ACFI. Chart 089 shows that NFP providers in Group 4 receive $2,717 prpa less than better financially performing NFP providers, while FP providers receive $3,379 and government providers receive $2,988 less.

Chart 089: ACFI revenue prpa by Ownership for Financial Performance Group (FPG) 4 Compared With all Other Providers



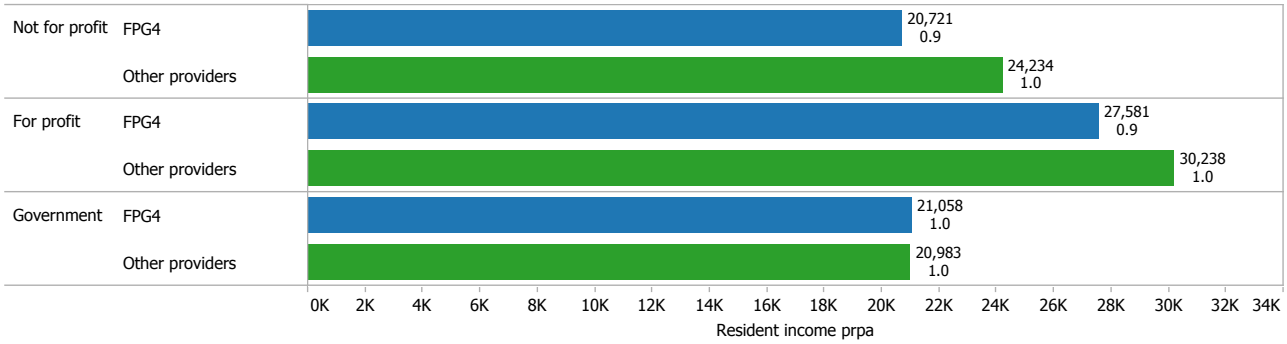
The difference in total government subsidies received by NFP providers is less than the difference in the ACFI they receive because the majority of Group 4 providers receive other government subsidies, including the viability supplement for eligible providers.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Resident income

Chart 090 shows the extent to which revenue differences related to resident income. The difference between FP and NFP providers operating in the same financial performance group is a material contributor to their differing OEBITDA outcomes. To the extent that providers have some control over these charges – for instance, by using accommodation bonds in low care and high care extra service there may be some scope for the NFP sector to increase financial returns in this area. The results in the graph relate to the 836 providers who reported resident client charges as a line item in their GPFRs.

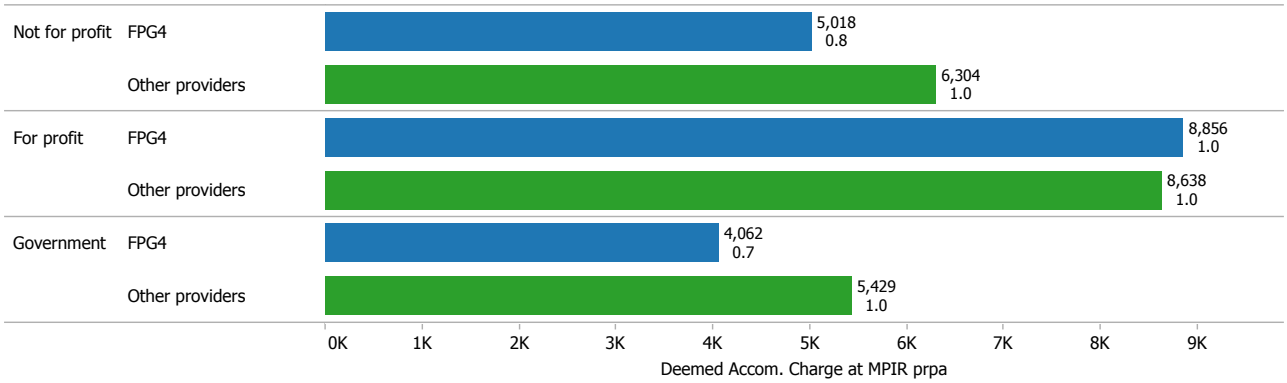
Chart 090: Resident Income prpa by Ownership for Financial Performance Group (FPG) 4 Compared With all Other Providers



Deemed accommodation charge

Chart 091 highlights the difference in deemed accommodation charges, which are a component of the resident income in Chart 090. Of particular interest is how the FP providers appear to be able to manage this more effectively. The results of the graph are shown for the 650 providers who reported accommodation bond liabilities as a line item in their GPFR. The impact of reduced resident charges is greatest for NFP providers.

Chart 091: Deemed Accommodation Charge prpa by Ownership for Financial Performance Group (FPG) 4 Compared With all Other Providers



Summary of the capacity to generate operating revenue

Group 4 providers receive less operating revenue prpa – including deemed accommodation income from both government and residents – compared to the better financially performing providers. The consideration of operating revenue prpa must be seen in context. Our analysis of resident care profiles shows that Group 4 providers are more likely to provide more low care than high care as compared to the better financial performers. This directly impacts upon the level of ACFI received.

As discussed in section 5.4, we see that Group 4 providers have developed additional non-operating revenue sources to offset their lower levels of operating revenue.

5.2.2. Operating expense management

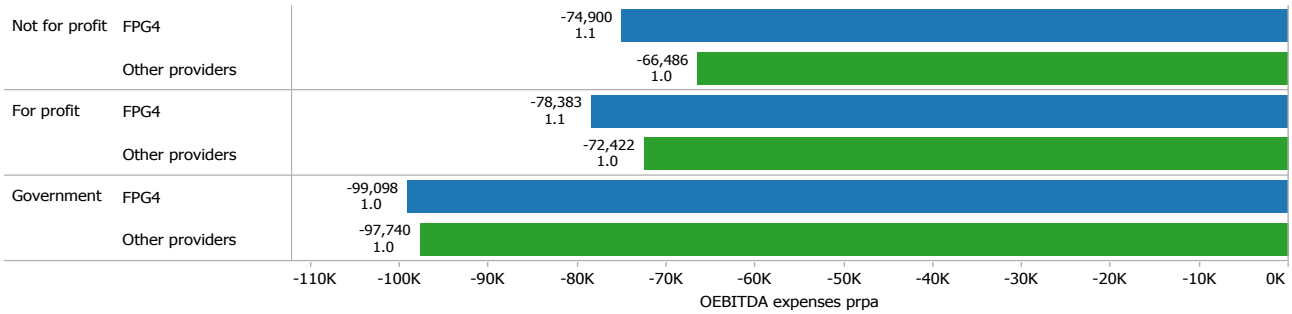
The available GPFR data allowed us to examine the effects of the following in respect of operating expense management:

- operating expenses prpa
- wages and superannuation prpa.

Operating expenses prpa

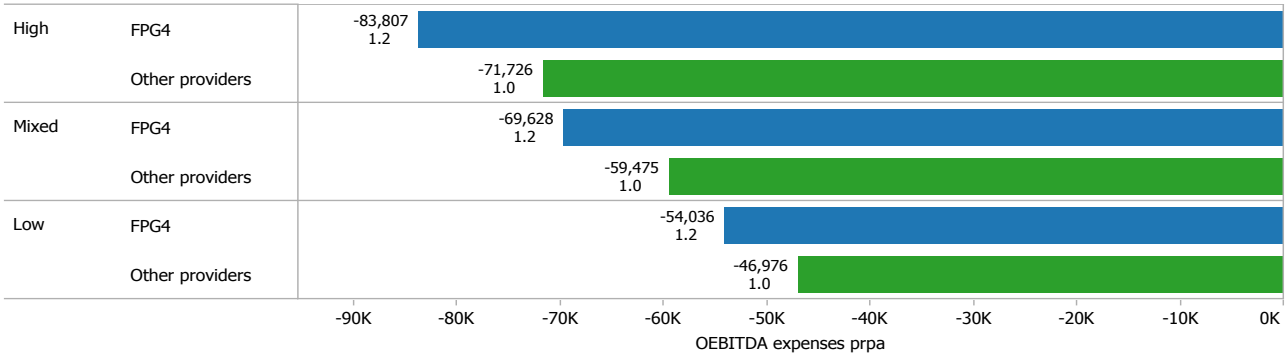
As with our analysis of operating revenue prpa, Chart 092 shows operating expenses varied significantly by ownership.

Chart 092: Operating Expenses prpa by Ownership for Financial Performance Group (FPG) 4 Compared With all Other Providers



The differences in operating expenses relative to resident care profile, as seen in Chart 093, confirms that Group 4 providers are challenged by the increasing complexity of care.

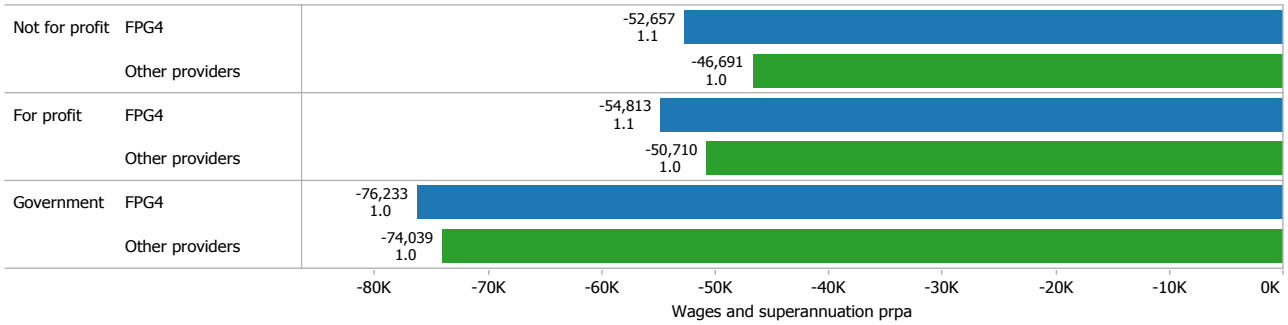
Chart 093: Operating Expenses prpa by Resident Profile, for Financial Performance Group (FPG) 4 Compared with all Other Providers



Wages and superannuation

Wages contribute significantly to higher operating expenses. The effect of this can be seen in Chart 094, in which the wages and conditions applicable to government providers are clearly evident. The cost differential for providers in Group 4 compared to the better financially performing providers is significant, contributing to their lower OEBTIDA outcome.

Chart 094: Wages and Superannuation prpa by Ownership for Financial Performance Group (FPG) 4 Compared With all Other Providers



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

5.2.3. Summary of financial performance

The above analysis shows that the OEBITDA prpa differential between Group 4 providers and the better financially performing providers is driven by a squeeze in both operating revenue prpa and operating expenses prpa.

In the following section, we analyse how Group 4 providers have compensated for this squeeze through a number of non-operating revenue streams.

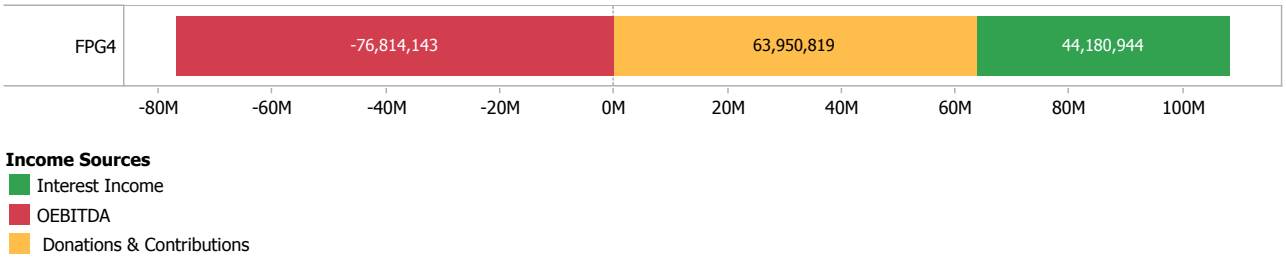
5.3. How They Offset Low OEBITDA

We identified four possible sources of non-operating revenue that will likely allow Group 4 providers to continue to operate despite generating a negative OEBITDA of -$2,072. These include:

- donations
- investment income
- draw-down on reserves
- cross-subsidies within ownership groups.

The relative impact of these non-operating revenue sources can be seen in Chart 095.

Chart 095: Aggregate Impact of Donations and Investment Income for Financial Performance Group (FPG) 4 Providers



Donations

Donation income was reported as a GPFR line item by 334 providers. Of these, 135 were Group 4 providers, which equates to 39% of the group.

The average donation reported by Group 4 providers was $3,894 prpa. This was almost four times the reported industry average of $1,338.

Investment income

Group 4 providers exhibit high liquidity, which provides them with investment income to supplement operating performance. On average, investment income contributes $1,405 prpa.

Draw-down on reserves

Because our data set was limited to FY 2013, we were unable to analyse draw-down on reserves.

Cross-subsidy

Around 41% of Group 4 providers have more than one facility, compared to 37% across the industry. This suggests a slightly greater capacity for cross-subsidy by multiple site owners.

5.4. Additional Considerations

In addition to increasing non-operating revenue sources, Group 4 providers could consider a number of other ways to improve financial performance, as outlined below.

Outsourcing

Outsourcing functions such as laundry, payroll and IT works very well for Group 1 providers in increasing financial performance, but Group 4 providers do not appear to benefit financially from outsourcing. It may be prudent for Group 4 providers to reconsider their outsourcing operations with a view toward best practice.

Setting performance expectations and monitoring progress of strategic plan

Performance to budget, which would include non-operating revenue, suggests that providers in this group understand their circumstances and have adapted to them. Establishing operating financial expectations that target better financial outcomes and increased monitoring of progress towards these expectations may benefit Group 4 providers. Participation in benchmarks would provide some context of where to set these financial performance expectations.

Services offered

Group 4 providers offer multiple services including residential care, as shown in section 3.5.3. This is broadly reflected in other provider groups except in Group 1, where providers only offer an average of 1.2 services.

Bond liquidity

At forty per cent, Group 4 providers have high liquidity, which affects their NPBT. Group 4 providers should cautiously consider expansion where there is a market and need for increased scale.

Chart 096: Gearing by Ownership for Financial Performance Group (FPG) 4 Compared With all Other Providers

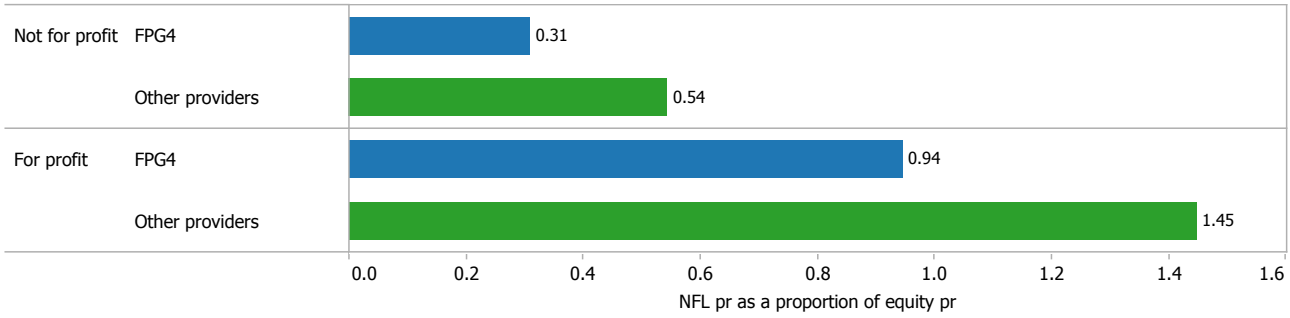
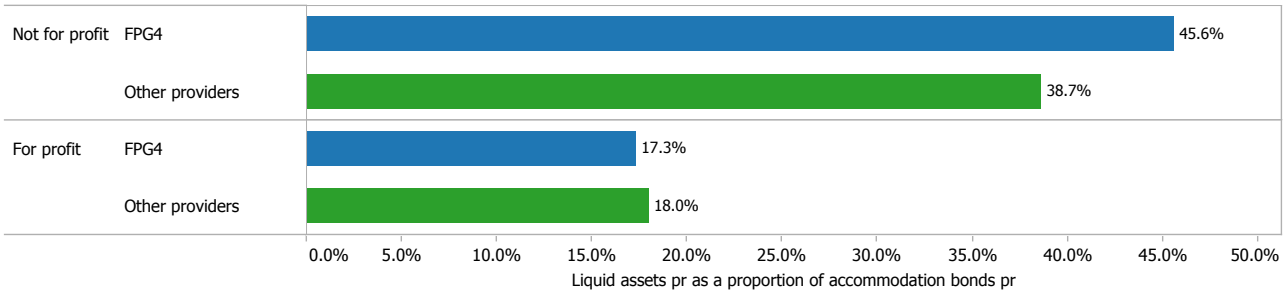


Chart 097: Liquid Assets pr as a proportion of Accommodation Bonds pr, for Financial Performance Group (FPG) 4 Compared With all Other Providers



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Summary

It appears that Group 4 providers place a high emphasis on non-financial measures of performance. They have offset their comparatively lower financial performance through non-operating income sources.

Furthermore providers in this group have indicated a desire to:

- stay in the industry
- expand in either size or number of beds per facility.

Notwithstanding the above, our findings suggest that Group 4 providers could improve their financial performance by:

- framing their budgets so as to strive to achieve higher OEBITDA and note the factors this report found to achieve these higher budget expectations
- more closely monitor their strategic plan
- networking, including participating in commercial benchmarking to understand what other providers do in specific areas
- upskilling would be beneficial in relation to understanding revenue opportunities and gain a greater understanding of the opportunity cost of high liquidity and management of claims under ACFI improving governance and strategy by examining policies on outsourcing, asset management, and reviewing plans and progress.

6. More About Group 1 Providers

Group 1 represents the top 20% of providers based on financial performance. Performing at a high level requires focus on a business model and business processes. Group 1 providers:

- focus on their customers across the dimensions of location, resident care profile and socio-economic status far more than providers in other groups
- focus more on residential aged care than any other group
- focus on maximising income from all sources
- operate business models where costs and revenues are aligned
- distinguish themselves in their approach to capital (liquidity) management
- consistently apply disciplined processes within their businesses
- operate facilities at a scale and in locations that maximise their opportunity for financial success, such as cities.

Other interesting aspects of the Group 1 business approach include:

- size: Group 1 includes a slightly higher proportion of providers with a single facility – 69% compared to an industry average of 63%
- number of beds: On average, Group 1 providers operate 80 beds per facility compared to an industry average of 68 beds
- currency of a facility: They keep their facilities fresh and appealing. They are five years from their last refurbishment and are 4.1 years from their next planned refurbishment. This is consistent with their market focus. Relatively high revenue prpa from residents would suggest that this translates to higher resident charges
- outsourcing success: This group has the highest level of outsourcing and, based on overall operating costs, they manage it well and therefore extract value from it
- bond liquidity: Consistent with their high operational management skill, Group 1 providers manage bond liquidity well. While the group's overall liquidity is 21%, its FP provides achieve 17%.

Summary

While a focus on the business was evident in Group 1, it is clear that these providers do not do this at the cost of focusing on their residents. Like providers in all other groups, Group 1 providers appear optimistic about the future of the industry.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

7. More About Other Provider Groups

7.1. Government Providers

Government providers, both state and local, account for only 10.5% of the industry. By ownership they are over-represented in Group 4 (21%) and are mostly found in regional locations.

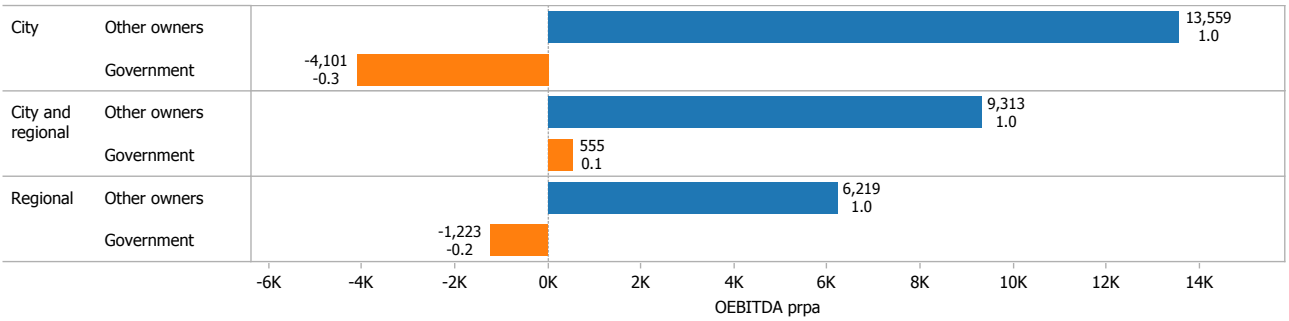
To the extent that the government sector exists where there is a market failure (evidenced by lower average number of beds per facility) losses may be inevitable. However, our analysis shows that the employment practices of these providers independently contribute substantially to financial performance. This topic is explored further in the following analysis where we compare the financial performance of government providers to that of NFP and FP providers.

7.1.1. Impact of location, size and resident care profile

Location

Eighty per cent of government providers operate in regional locations. Chart 098 shows that the largest gap in OEBITDA prpa between government-owned and other providers is in city locations, at $17,660.

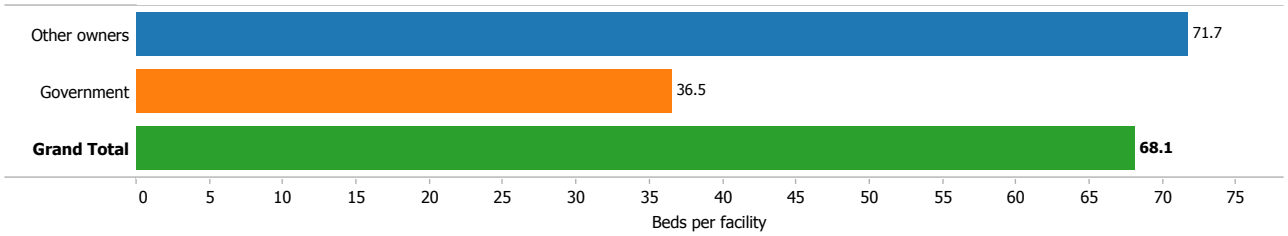
Chart 098: OEBITDA prpa by Location for Government Owned Providers Compared With all Other Providers



Size – average number of beds per facility

When examining size, we focused on the average number of beds per facility. As Chart 099 shows, government providers have a materially lower average number of beds per facility compared to NFP and FP providers. This may reflect that these providers operate facilities in remote locations with smaller populations.

Chart 099: Average Number of Beds for Government Owned Providers Compared With all Other Providers



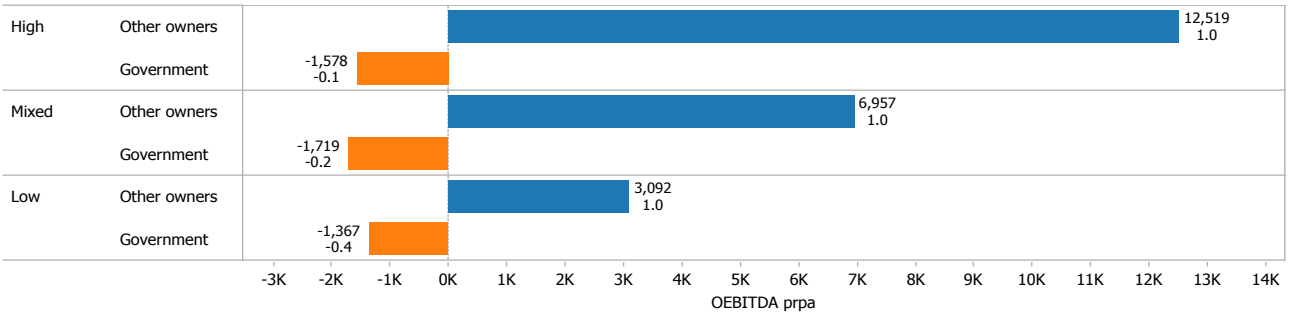
This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Resident care profile

Of government providers, 6.5% are classified as 'low care'[8] and 43% are classified as 'mixed care'[9]. In the remainder of the industry, 4.2% and 29.1% of providers are classified as providing low or mixed care respectively.

From Chart 100, it is evident that government providers generate similar negative results across all resident care profiles. So increasing complexity of care is as much a factor as it is for Group 4 providers overall.

Chart 100: OEBITDA prpa by Resident Care Profile for Government Owned Providers Compared With all Other Providers



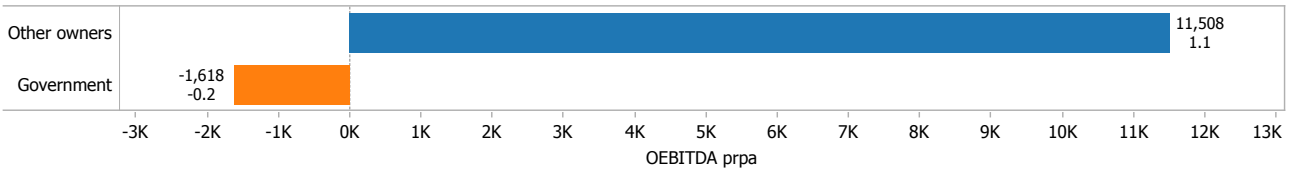
Summary of the impact of location, size and resident care profile

Government providers operate facilities with a lower average number of beds compared to NFP and FP providers, which affects financial performance. Generally, regionally located facilities have lower average bed numbers. Interestingly for government providers, their OEBITDA prpa is lowest in city locations.

7.1.2. Provider financial performance

The OEBITDA prpa gap between government providers and providers of other ownership types is $13,126.

Chart 101: OEBITDA prpa by Ownership for Government Owned Providers Compared With all Other Providers

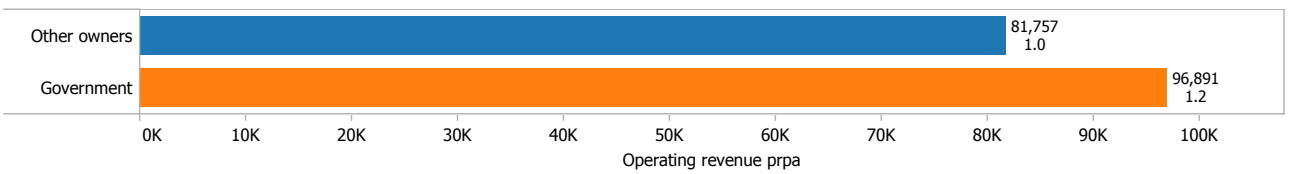


To understand the drivers of this gap, we have compared operating revenue prpa and operating expenses prpa across ownership types.

Operating revenue management

Chart 102 shows that the government providers generate more operating revenue prpa compared to providers of other ownership types. This in part may reflect additional state and local government funding.

Chart 102: Operating Revenue prpa by Ownership for Government Owned Providers Compared with all Other Providers



[8] Providers are classified as Low care when over 70% of care days delivered have an ACFI classification of 'Low'
[9] High and low care classifications are based on over 70% of care days delivered having an ACFI classification of high or low respectively, otherwise the classification is mixed care.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Operating expense management

As shown in Chart 103, government providers operate under a significant disadvantage to manage expenses compared to providers of other ownership types. The difference in expenses for government providers compared to other ownership types is $28,261 prpa.

Chart 103: OEBITDA Expenses prpa for Government Owned Providers Compared with all Other Providers

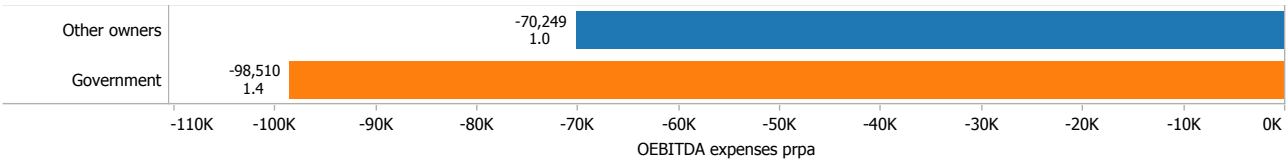
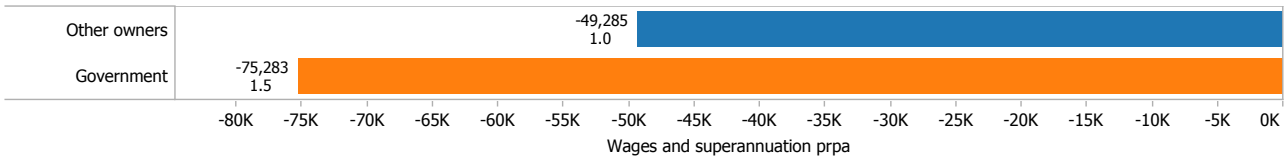


Chart 104 depicts the primary driver for the differences in operating expenses prpa. Higher wages and superannuation account for $25,998 prpa of the $28,261 prpa difference in expenses shown in Chart 103. Our study did not allow us to distinguish this expense from higher pay or higher staffing levels.

Chart 104: Wages and Superannuation prpa for Government Owned Providers Compared with all Other Providers



7.1.3. Summary of government providers

The majority of government providers operate in regional locations. It may be the case that a number of these providers operate in an environment where there is market failure. Losses in these operations may be inevitable. However, it has also been shown that the employment practices of government providers contribute significantly to their financial performance.

7.2. Regional Influences and the Viability Supplement

In our examination of regional providers, the following findings were of particular interest:

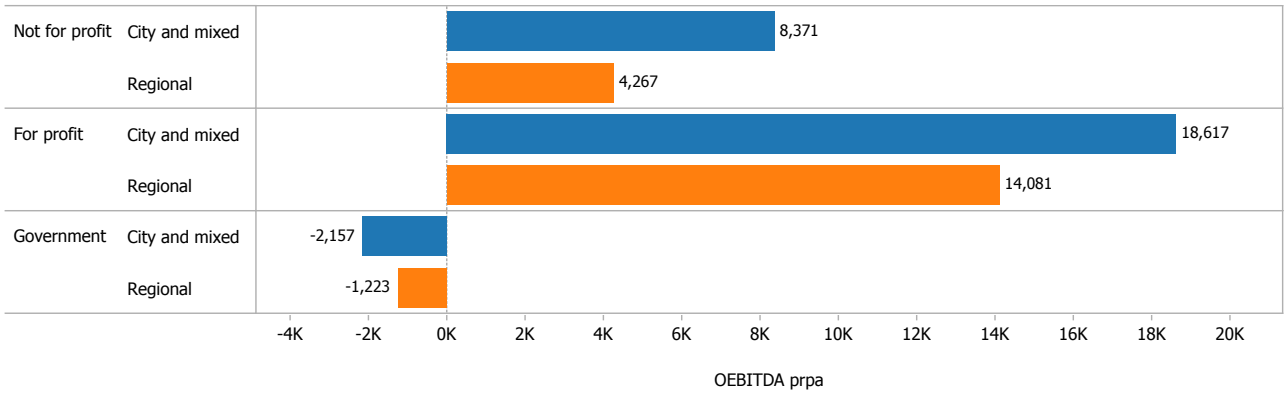
- on average, regional providers operate facilities with substantially lower average bed numbers as compared to providers in city and mixed locations. This phenomenon was also significant for Group 4 and government providers
- while regional providers represent 38.6% of all providers, they account for 56% of Group 4 providers and 80% of government providers
- regional providers achieved lower operating revenues prpa across all ownership groups
- FP and NFP providers operating regionally incur less operating expenses prpa as compared to FP and NFP providers operating in city and mixed locations
- government regional providers have substantially higher operating expenses prpa compared to other regionally based providers.

7.2.1. The impact of ownership, size and resident care profile

Ownership

NFP and government providers together represent 85.3% of regionally based providers. As Chart 105 shows, there is a gap of approximately $4,000 in OEBITDA prpa between regionally based FP and NFP providers as compared to their counterparts in city and mixed locations. Notwithstanding the relative financial performance of government providers, their OEBTDA prpa is much lower than other regionally based providers.

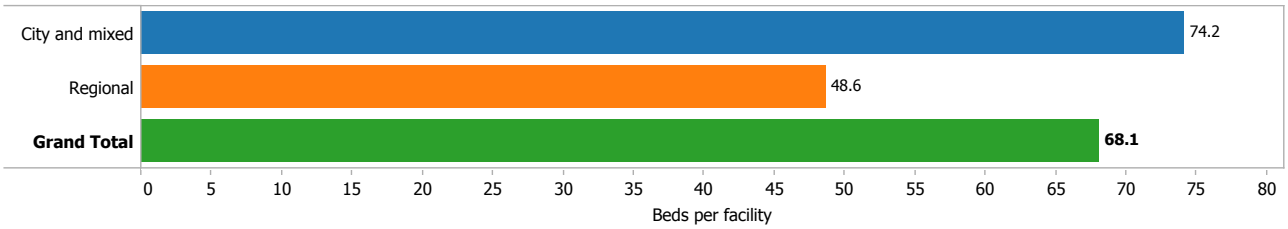
Chart 105: OEBITDA prpa by Ownership and Location



Size – average number of beds per facility

When considering size, our analysis focused on the average number of beds per facility. Regionally based providers operate smaller facilities with an average of 49 beds compared to city and mixed location providers, which average 74 beds.

Chart 106: Average Beds per Facility by Location

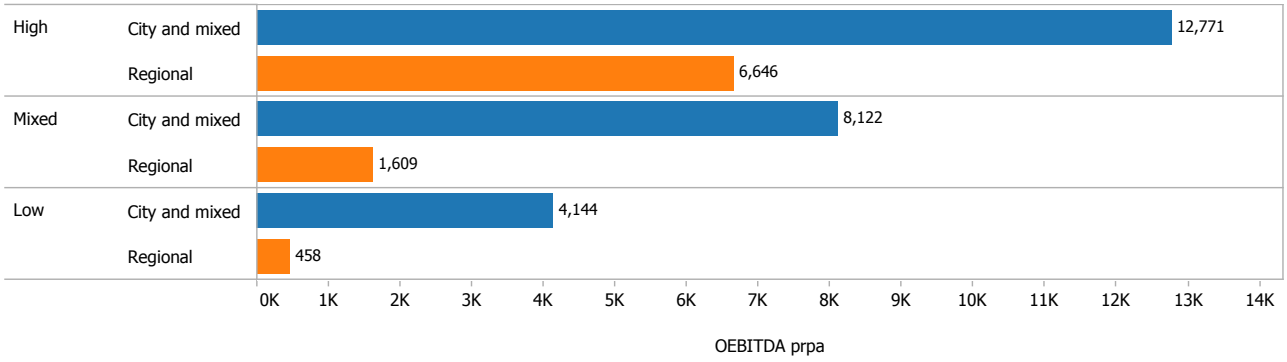


This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Resident care profile

Consistent with the findings in relation to ownership and size, operating outcome as measured by OEBITDA prpa shows that regionally based providers achieve significantly lower OEBITDA prpa relative to city and mixed-location providers across all resident care profiles.

Chart 107: OEBITDA prpa by Resident Care Profile and Location



Summary of the impact of ownership, size and resident care profile

As reported in section 3, we found that the number of beds within a facility is strongly linked to a provider's OEBITDA prpa. As such, average bed numbers within a facility is a key determining factor of financial performance in regional locations.

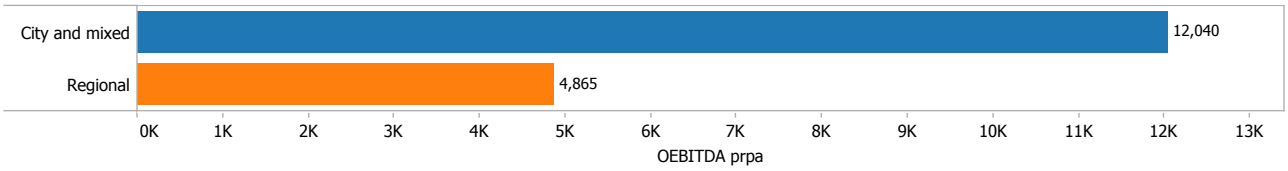
There is a lower propensity for FP providers to operate in regional locations. NFP and government providers provide the majority of services required by regional communities. The NFP and government providers are over-represented in the lower financial performance group. This may be due to the fact that financial performance is not the key focus of these providers.

7.2.2. Provider financial performance

Chart 108 shows a variation in OEBITDA prpa of $7,175 between regionally located, and city and mixed providers. Regionally based providers achieve only 40% of the OEBITDA prpa of city and mixed location providers.

As the following sections show, this lower OEBITDA prpa is primarily due to lower operating revenue. From section 2.2.2 we know that regional providers are over-represented in the groups with the lowest financial performance (321 or 81% of regional providers are in groups 3 or 4, while combined these groups represent 61.5% of all providers).

Chart 108: OEBITDA prpa by Location



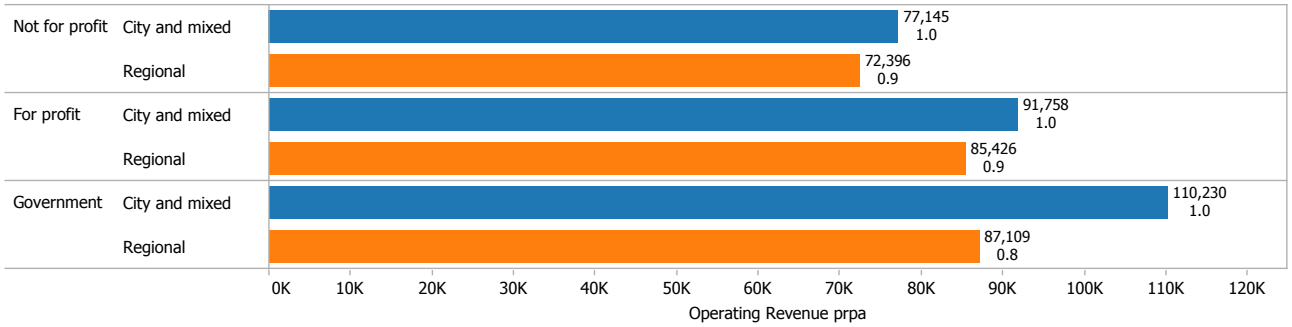
Operating revenue management

When considering operating revenue for regionally based providers, we analysed revenue sources from both government and residents. Regionally based providers may also be eligible to receive the viability supplement which is examined in detail in section 7.2.6.

Operating Revenue prpa

Regional providers generate less operating revenue prpa ($4,749 for NFP and $6,332 for FP providers) than providers in all other locations. This is evident across both government and resident revenue sources.

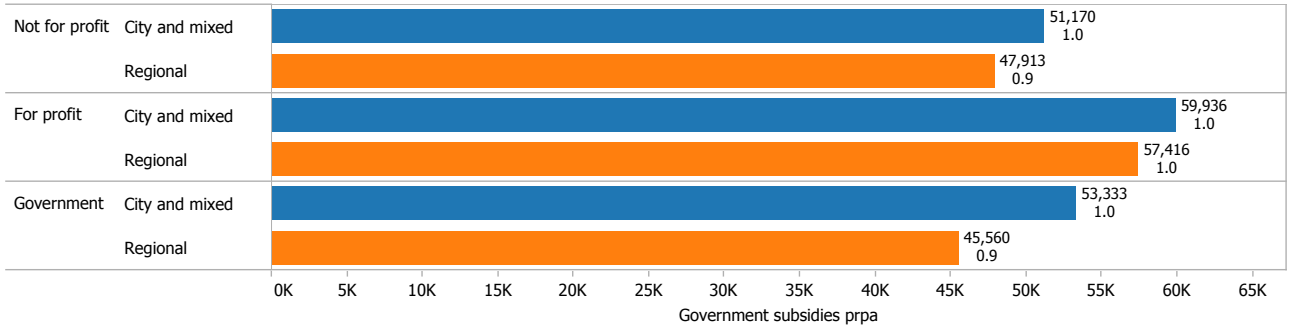
Chart 109: Operating Revenue prpa by Ownership and Location



Government Subsidies

Regional providers earn less in government subsidies than other providers, notwithstanding that this sector includes those receiving the viability supplement. Government subsidies have been examined for the 846 providers who reported this as a GPFR line item (see Chart 110).

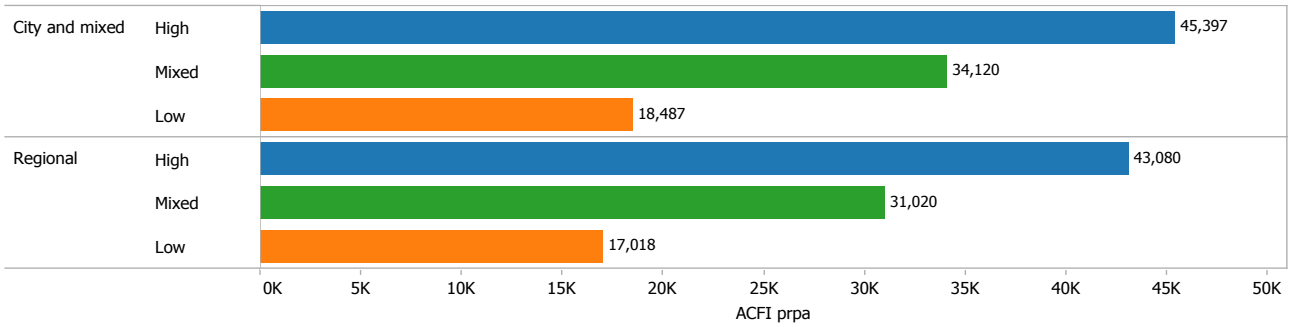
Chart 110: Government Subsidies by Ownership and Location



ACFI management

The lower government subsidies for regional providers across ownership is partly explained by the lower levels of ACFI received across all resident care profiles and reflects the fact that this group operates more facilities classified as 'low care'[10] compared to other groups operating in city and mixed locations.

Chart 111: ACFI prpa Grouped by Location and Residential Care Profile

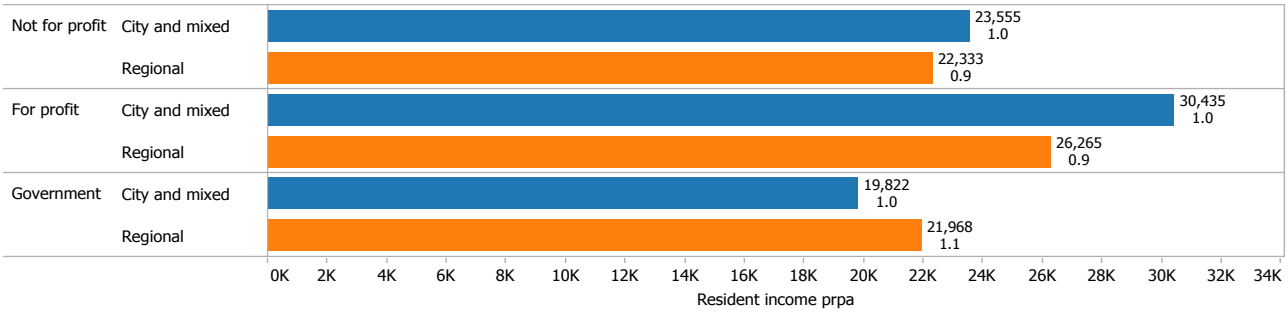


[10] Providers are classified as 'low care' when over 70% of care days delivered have an ACFI classification of 'low'.

Resident income

Providers in regional locations receive significantly less resident income, including deemed accommodation income, than other providers, particularly FP providers. We examined resident income for the 836 providers who reported resident client charges, as shown in Chart 112.

Chart 112: Resident Income by Ownership and Location



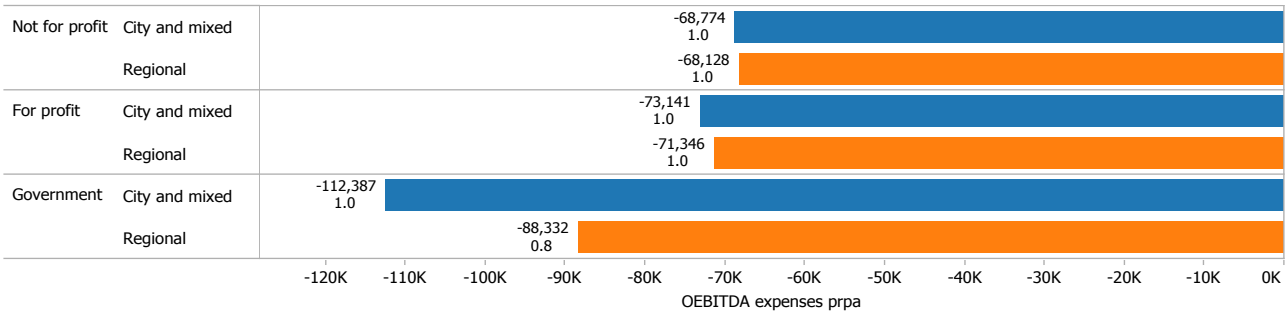
7.2.3. Operating expense management

There is no material difference in the operating expenses prpa of NFP providers based on location, with all providers recording approximately $68,000 prpa irrespective of location.

FP regional providers have a cost advantage of $1,800 prpa over city and regional-location providers that helps to offset their lower revenue.

Government providers operating regionally incur substantially fewer operating expenses prpa compared to their city counterparts; however, their costs are significantly more when compared to both FP and NFP providers in all locations.

Chart 113: Operating Expenses by Ownership and Location



7.2.4. Summary of regional influences

The cumulative effect of several factors causes regional operators to achieve lower average OEBITDA prpa compared to providers operating in city and regional locations, including that:

- facilities in these locations are smaller, with lower average bed numbers per facility, which limits their capacity to gain efficiencies at the facility level
- FP providers tend to not operate in regional locations
- government and NFP providers ensure services are provided to regional communities and in doing so are over-represented in the lower financial performance groups
- government providers in particular have higher operating expenses.

7.2.5. Multi-purpose services and aboriginal and torres strait islander providers

PwC contacted all providers in this group launching this survey on 1 December 2014 with an initial aim to keep it open for two weeks. At the outset, we established that we required at least 15 - 20 providers to submit fully completed surveys to be able to perform analysis allowing us to draw conclusions that were representative of the 51 providers within this sector.

By 15 December 2014, there were only six submissions. As a result, we kept the survey open until 9 January 2015, with a reminder email sent to the remaining 44 providers. In addition, further reminders were sent to providers during the week commencing 5 January 2015.

When the survey was closed we had received 13 submitted surveys (five ATSI and eight MPS). As we did not meet the threshold of 15 - 20 providers, we have not included analysis of the responses in this report. The data pertaining to these providers was given to ACFA.

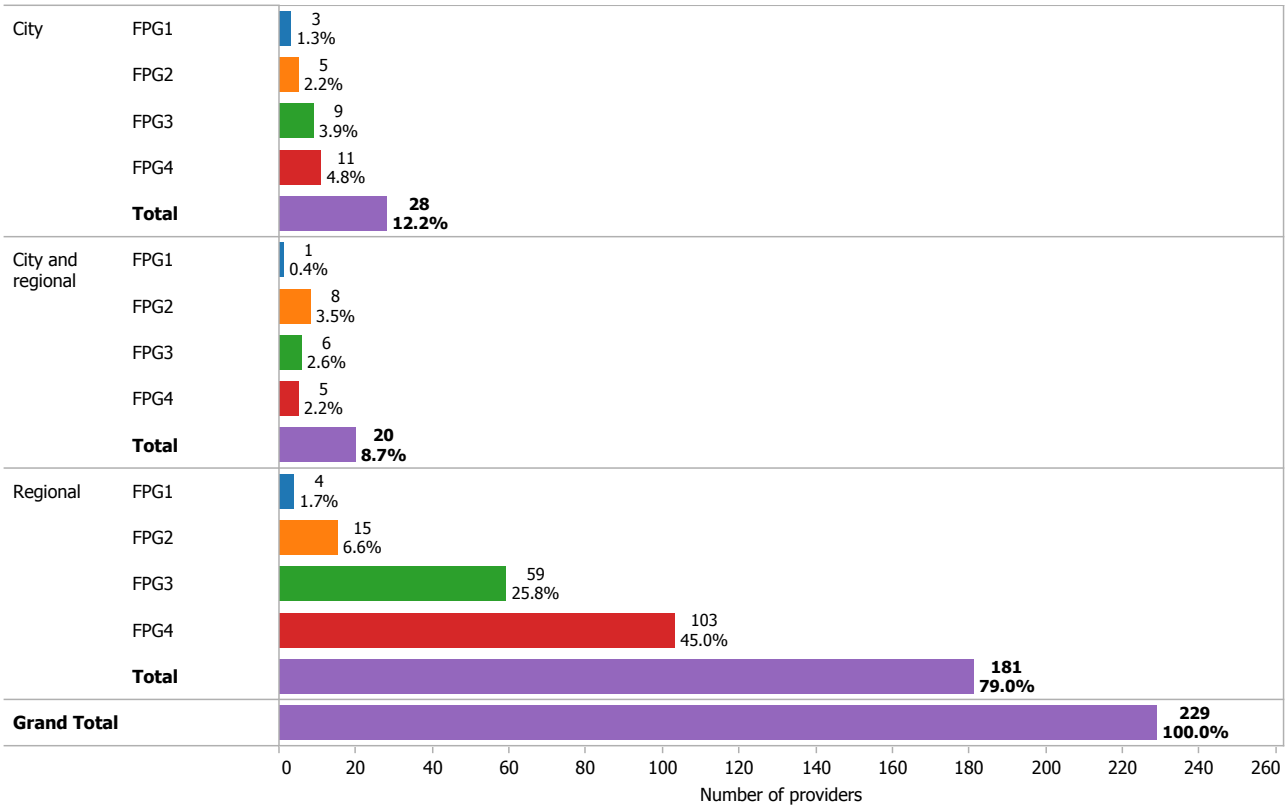
7.2.6. Recipients of the viability supplement

The viability supplement is an additional government subsidy payable to certain providers. It is aimed at improving the viability of smaller rural and remote operators whose location imposes additional costs on service provision or to providers whose residents are particularly disadvantaged, such as homeless.

This targeted approach is reflected in Chart 114, which shows only 28 (12.2%) of recipients of the viability supplement are city-based. The majority (181 or 79.0%) are in regional areas. Chart 114 also shows that the viability supplement targets those providers most in need well, with only 36 recipients (15.7%) in groups 1 and 2.

This analysis combines GPFR data relating to providers with viability supplement data relating to service locations. There may be some small anomalies in the location analysis below.

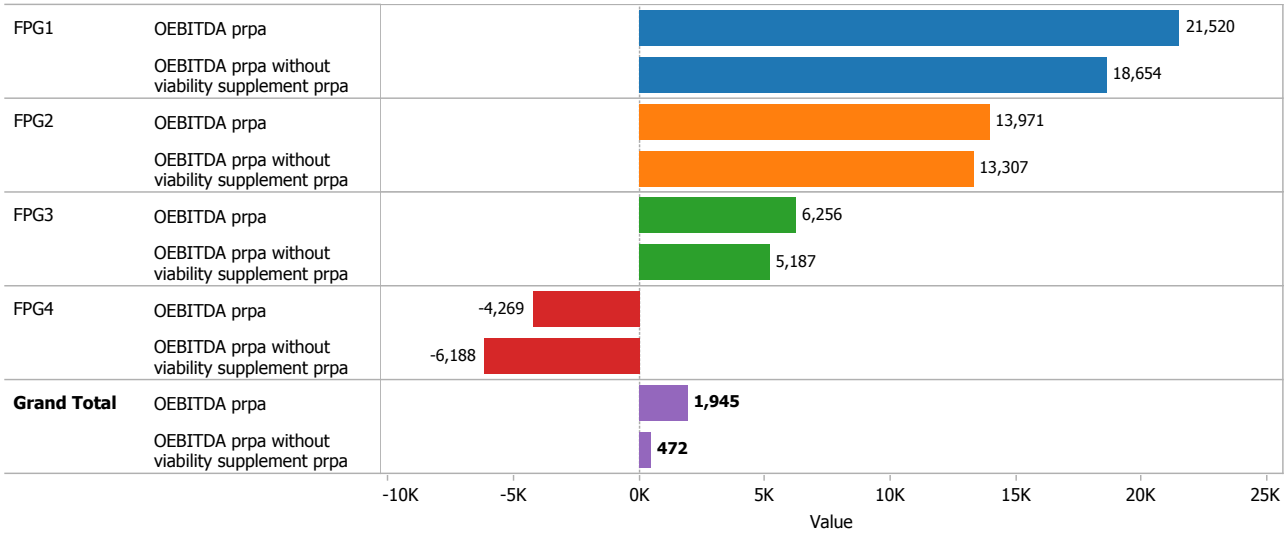
Chart 114: Providers Receiving Viability Supplement by Location and Financial Performance Group (FPG)



We have focused on regional providers when analysing the supplement's contribution to financial performance. Chart 115 shows the average OEBITDA of regional providers receiving the subsidy by financial group. We observed that:

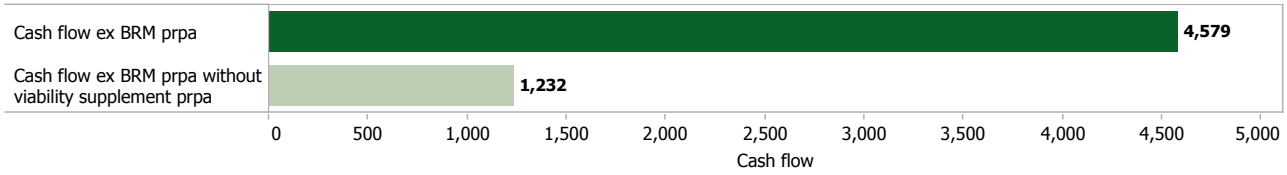
- the viability supplement added $1,919 to the OEBITDA prpa of the regional providers in Group 4. However, a gap of $4,269 prpa still remained for these providers before reaching a break-even position
- interestingly, the four regional providers in Group 1 received the most financial benefit from the supplement, at an average of $2,866 prpa

Chart 115: Effect of Viability Supplement on OEBITDA of Regional Providers by Financial Performance Group (FPG)



We also sought to understand the extent to which the supplement has kept providers out of Group 4. The supplement prevented 18 providers from being classified in Group 4. These providers were classified as Group 3 and all but one was located regionally. The collective impact of the supplement for these 18 providers is depicted in Chart 116.

Chart 116: Effect of Viability Supplement on Cash Flow of Providers that Would be Financial Performance Group (FPG) 4 Without it



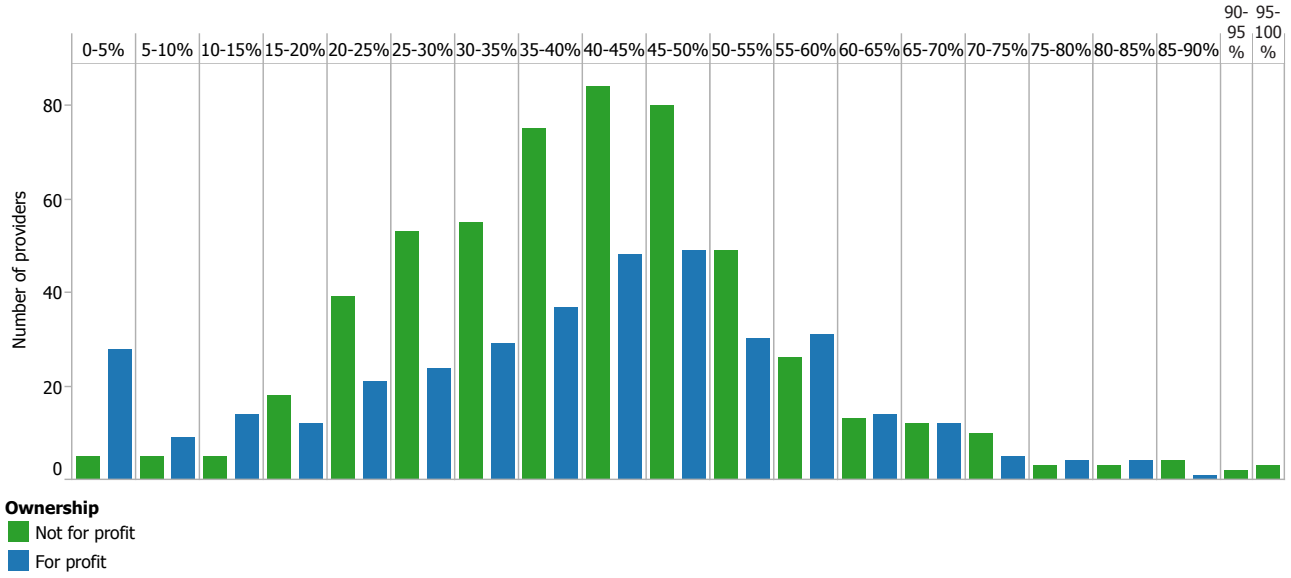
7.3. Supported Resident Ratio

Significant government funding is dependent on the supported resident ratio. To receive the full accommodation subsidy, providers are required to meet a supported ratio of more than 40%. If a provider's supported ratio does not exceed 40%, the accommodation subsidy is scaled back by 25%. We analysed how providers build business models around the 40% supported resident ratio.

Dispersion

Chart 117 shows that, across the industry the supported ratio tends towards a normal distribution centred at 40% to 45%.

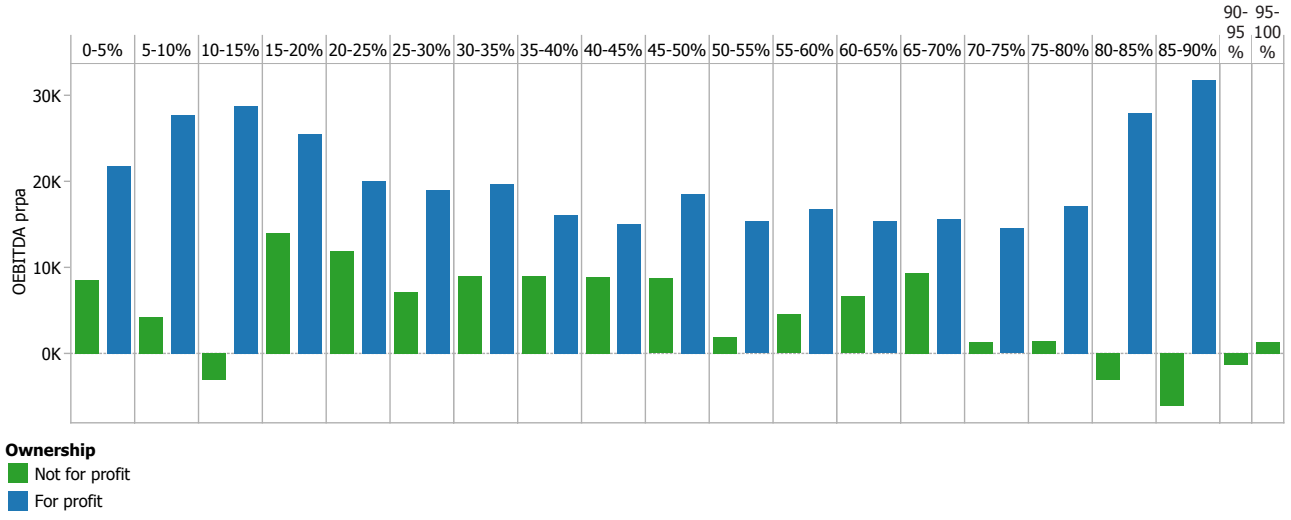
Chart 117: Dispersion of Supported Ratio by Ownership



OEBITDA and supported ratio

When OEBITDA is mapped across the supported ratio bands, as in Chart 118, the trend for the FP providers is distinctive. This suggests that FP providers in particular have developed approaches to manage the loss of revenue at both higher and lower supported resident ratios.

Chart 118: OEBITDA prpa Across Supported Ratio Bands

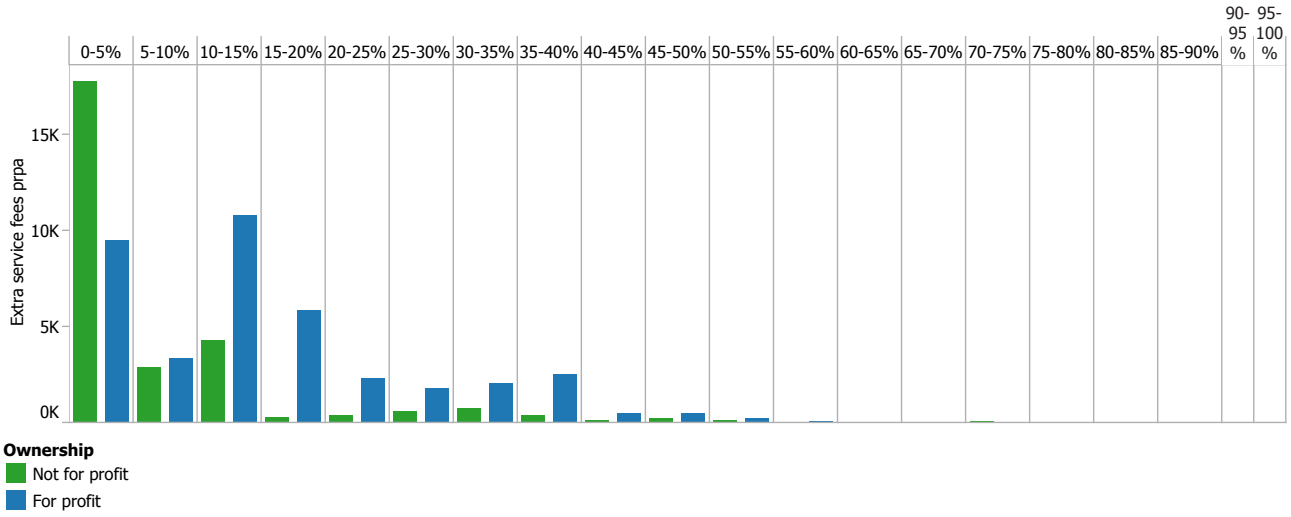


This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Extra service fees

Chart 119 suggests FP providers with low supported resident ratios, especially those in the 0% to 20% range, are supplementing their income through the provision of extra services.

Chart 119: Extra Service prpa Across Supported Ratio bands



8. Recent Changes On Future Financial Performance

Our study is based on the latest available financial data, which relates to FY 2013. As of 1 July 2014, the following key financial performance drivers have changed:

1. With the removal of the high/low distinction, providers have expanded access to refundable accommodation deposits (RAD). Consumers also have more choice regarding the method they use to pay for their accommodation costs, either a RAD, daily accommodation payment (DAP) or a combination. Providers now have greater access to different revenue streams.
2. If providers undertake 'significant refurbishments' and meet all of the eligibility criteria, they may receive the higher accommodation supplement.
3. The removal of the payroll tax supplement will negatively impact FP providers' OEBITDA and NPBT.
4. Removal of the cap on daily accommodation charges in high care should have a positive impact on revenue.
5. The workforce supplement has been redirected into general funding for the sector, resulting in a funding increase of 2.4%.

Assessing the impact of these changes on the financial performance of providers is outside the scope of this study.

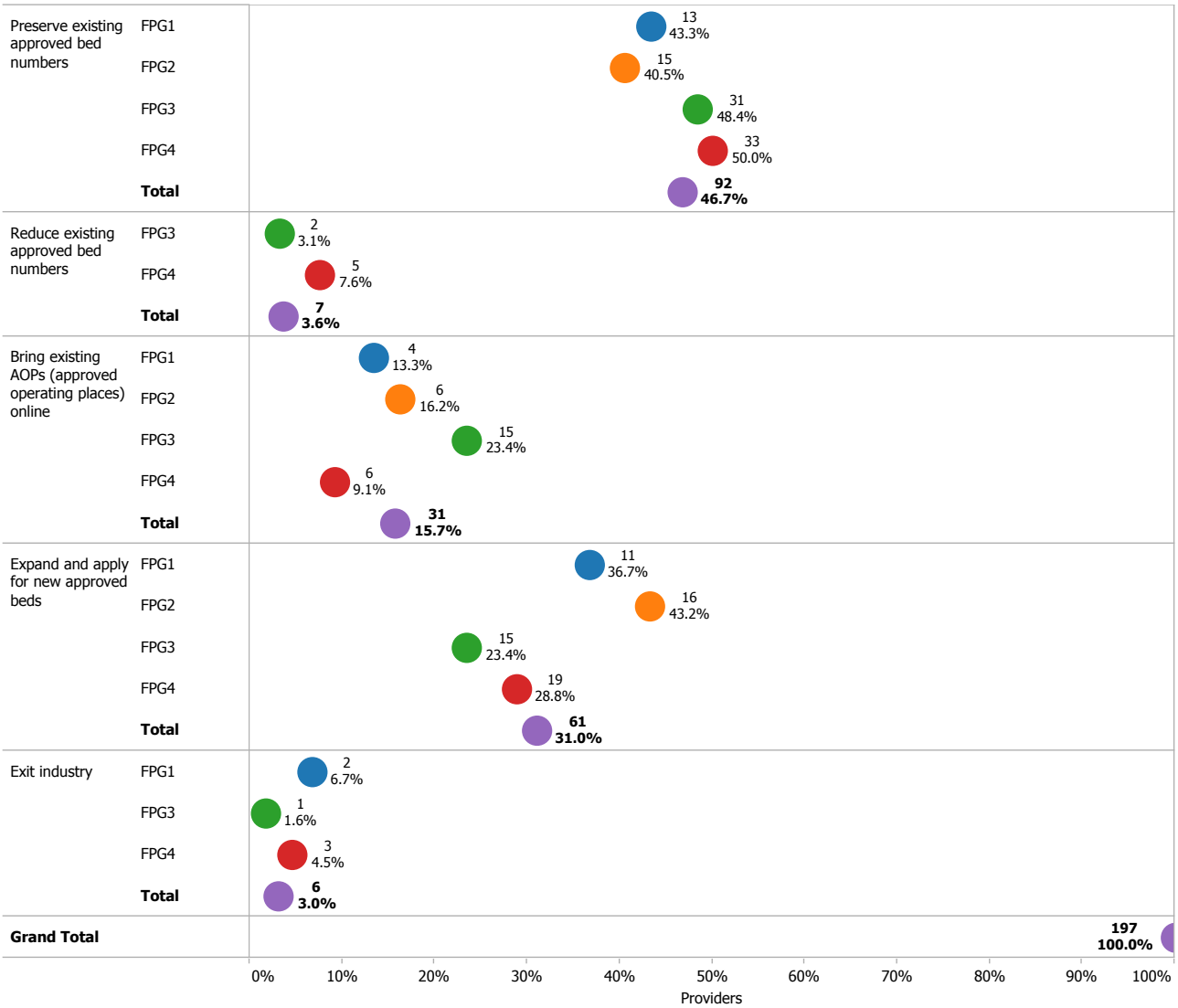
This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

9. Providers' Expansion Plans

We asked providers a series of questions about their growth plans over the next two years. Providers' intentions are shown in Chart 120:

- a small number (13 or 6.6%) propose to shrink operations or exit the industry
- almost half (92 or 46.7%) plan to maintain the status quo
- almost half (92 or 46.7%) plan to expand operations: 31 (15.7%) already have beds approved and 61 (31.0%) aim to apply for new beds.

Chart 120: Residential Aged Care Strategy by Financial Performance Group (FPG)
11. In regards to residential aged care, in the next 2 years do you have definite plans to...?



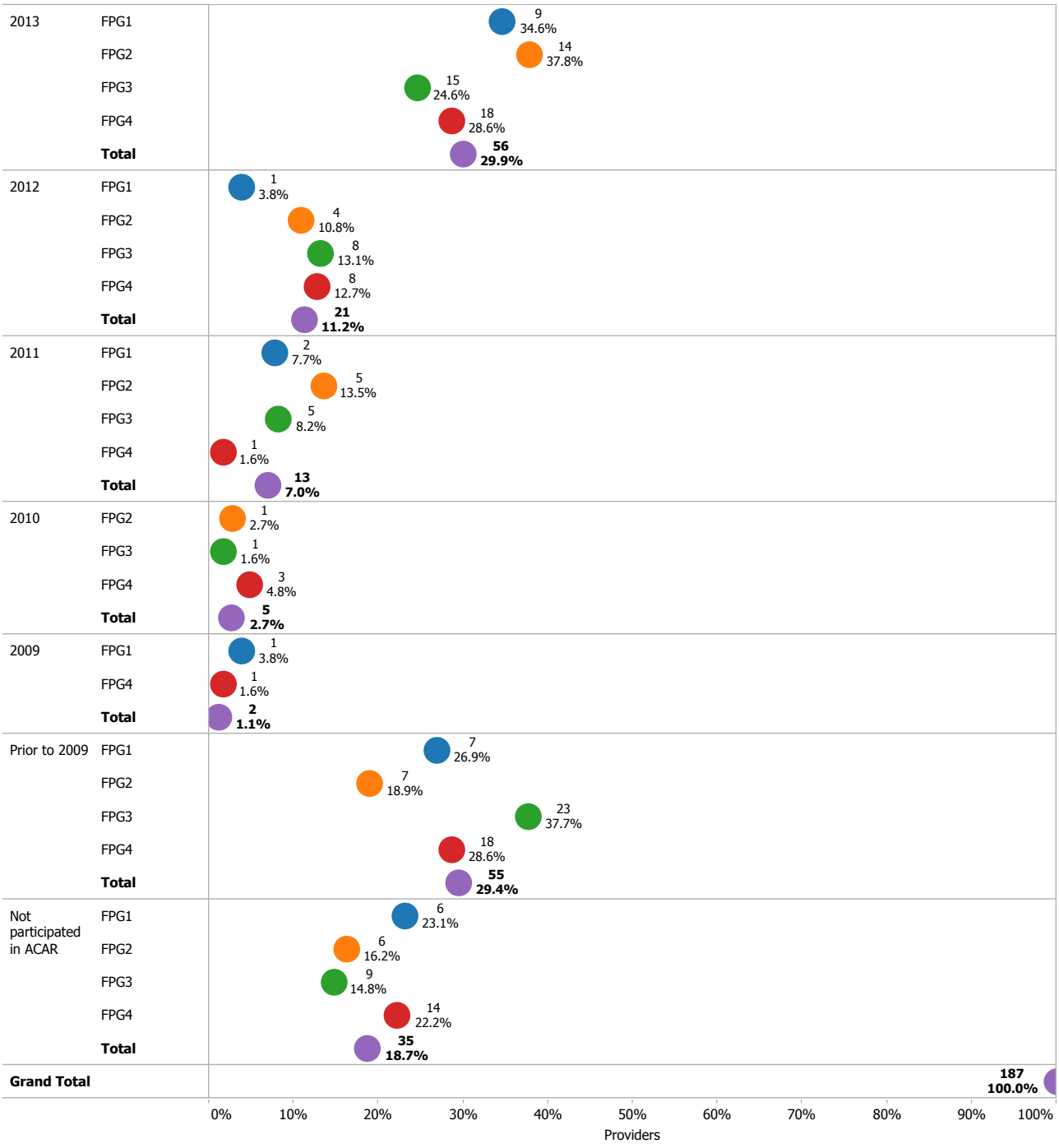
"Null" and "Unknown" responses are excluded.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

9.1. Participation in ACAR Rounds

Chart 121 shows the survey's findings regarding providers' participation in recent ACAR rounds. While participation was subdued in the period 2009-2012, it bounced back in 2013 to 2009 levels. This is consistent with the findings in relation to how providers plan to expand in section 9.4.

Chart 121: Participation in ACAR Round by Financial Performance Group (FPG)
33. When did you last participate in an ACAR round for residential aged care (excluding 2014)?



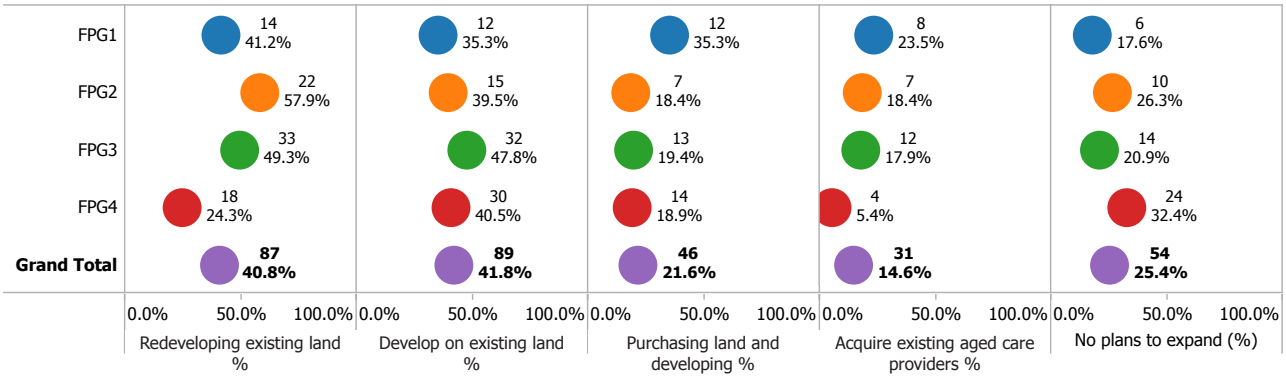
Null and Unknown responses are excluded.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

9.2. Expansion Methods

Chart 122 shows that, of those providers planning to expand, most (176 or 82.6%) plan to redevelop existing buildings or develop on existing land. Purchasing land for development is also a popular option for 46 providers (21.6%), and 31 providers (14.6%) plan to purchase existing facilities.

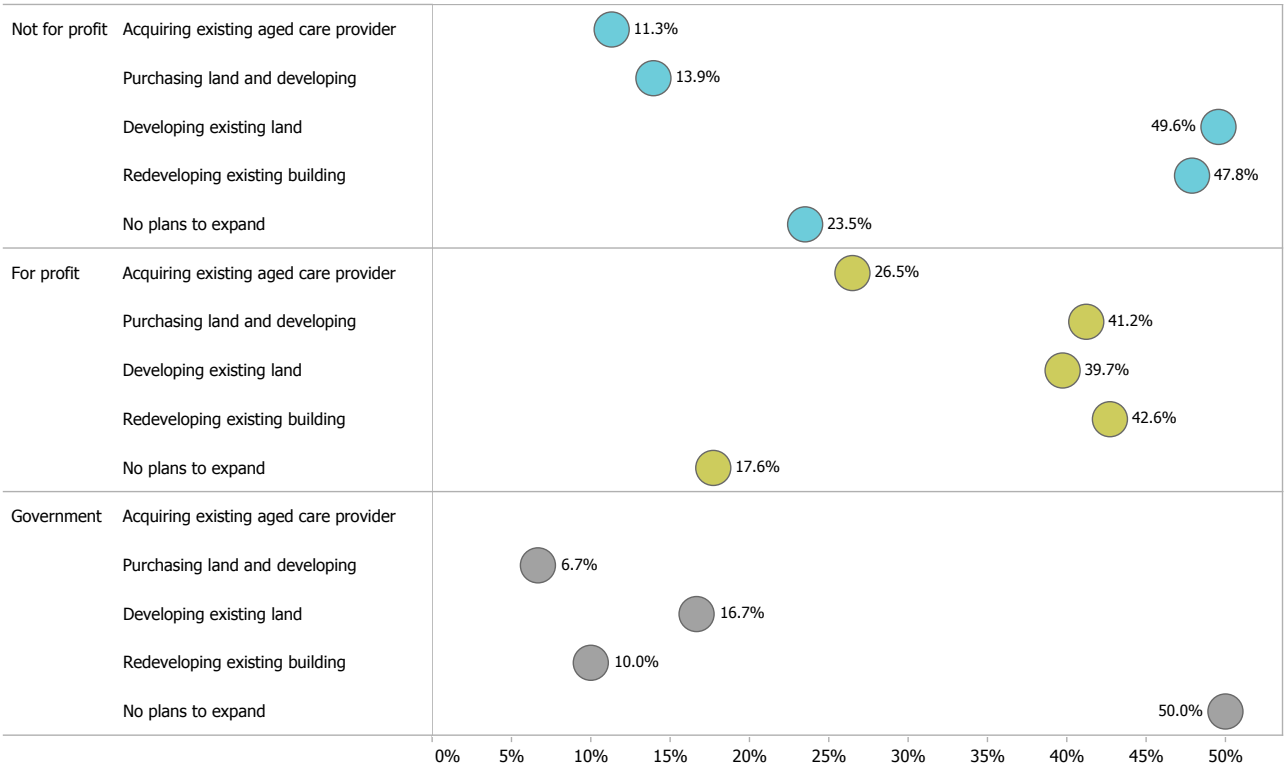
Chart 122: Expansion Plans by Financial Performance Group (FPG)
16. In regard to residential aged care, do you have plans to expand by ...?



9.3. Effect of Ownership on Expansion Plans

Chart 123 indicates a tendency for NFP providers to expand using existing land and buildings, whereas FP providers have broader options and are more likely to consider purchasing existing facilities or land.

Chart 123: Provider Expansion Plans by Ownership



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

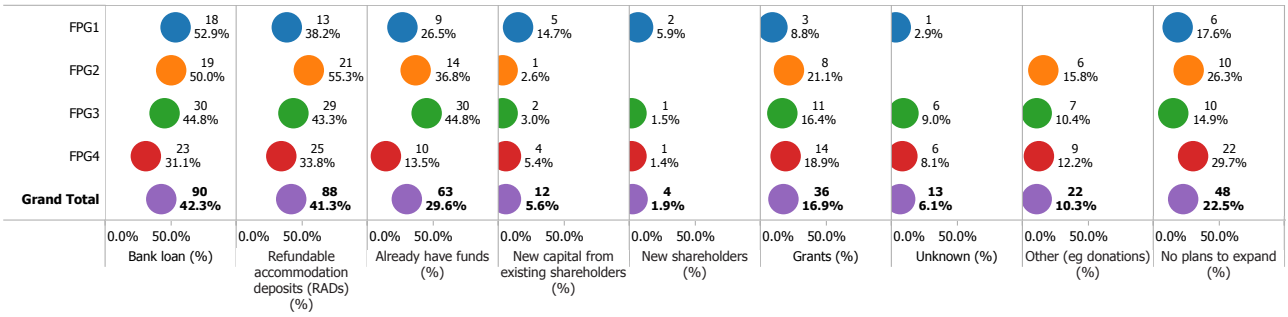
9.4. How Expansion Will be Funded

Chart 124 indicates providers' intended funding sources for expansion. According to the survey:

- more than a quarter of providers (63 or 29.6%) already have funds to expand, though the proportion varies substantially across financial groups
- bank loans combined with accommodation bonds will provide most of the funding
- together, these sources of debt will account for 83.6% of funding
- very little equity capital will be raised
- capital grants and donations are seen as substantial sources of funds for the bottom two financial groups.

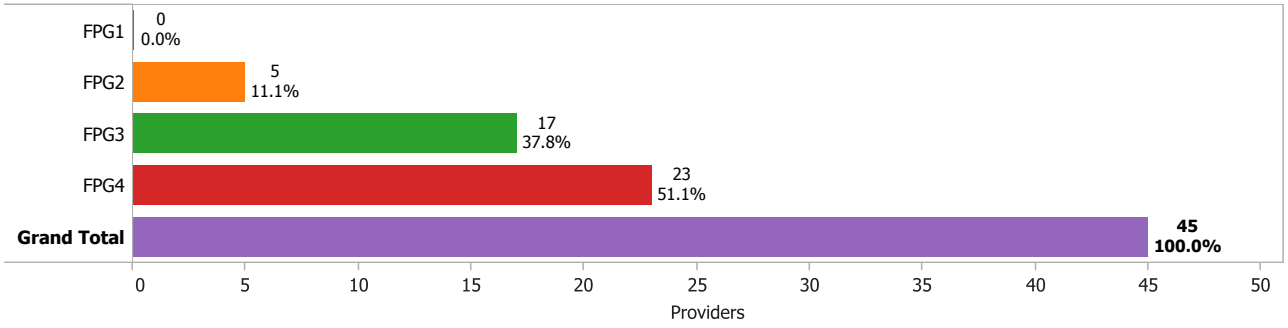
Chart 124: Funding Expansion by Financial Performance Group (FPG)

17. How do you plan to fund expansion?



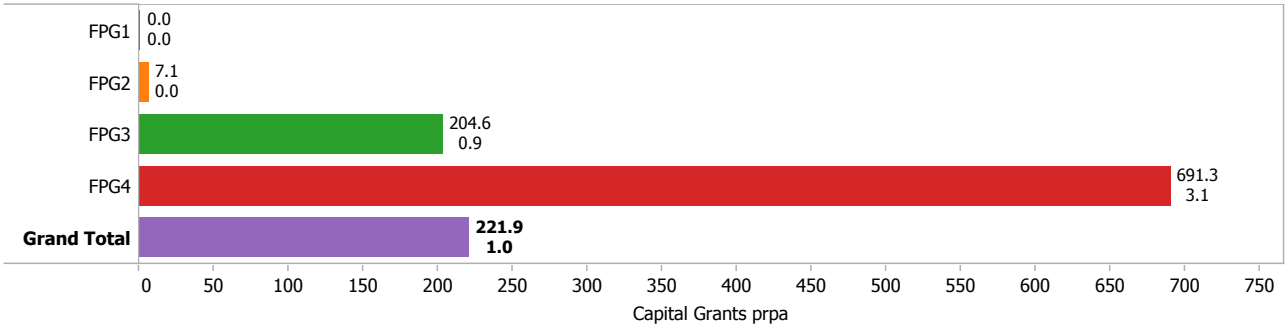
Given that grants featured as a proposed source of funding, we examined which providers received capital grants in FY 2013. Chart 125 shows that providers in groups 3 and 4 receive the highest number of capital grants (88.9%).

Chart 125: Capital Grants Recipients by Financial Performance Group (FPG)



As shown in Chart 126, Group 4 providers also receive the most capital grants from a prpa perspective.

Chart 126: Capital Grants prpa by Financial Performance Group (FPG)



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

10. Earnings Lost on Surplus Liquidity

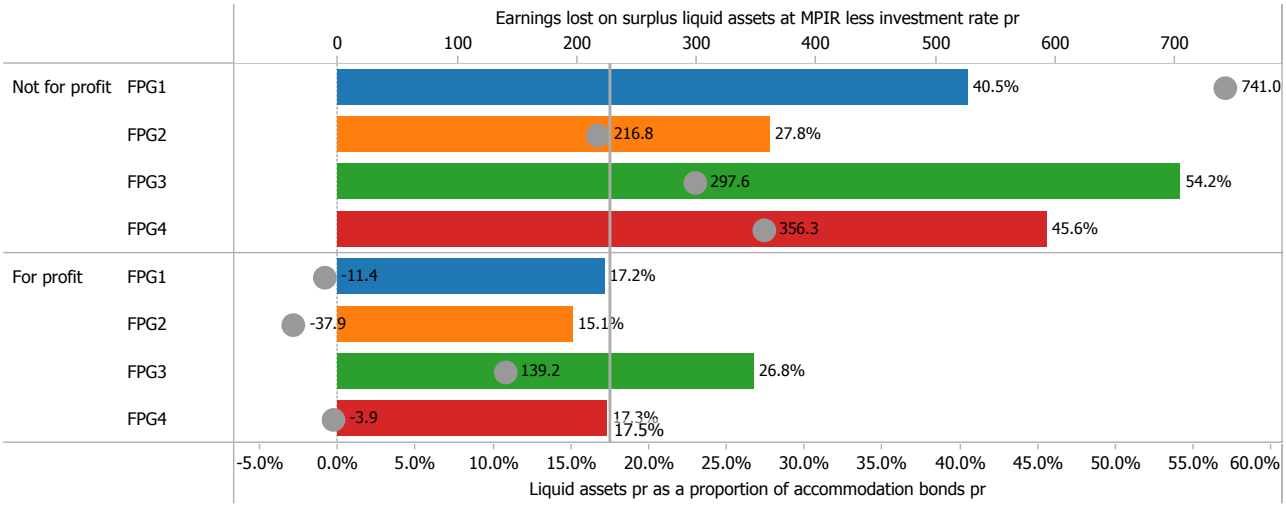
In section 3.3.3, we highlighted the different approaches to liquidity management among providers in the different groups. This analysis showed that FP providers generally maintained lower liquidity levels (cash reserves). Our analytical approach removed the effect of varying levels of lump sum and daily accommodation payments and varying levels of liquidity on OEBITDA. However, providers' overall financial performance, as measured by NPBT, is impacted by liquidity levels attributable to lump sum accommodation payments.

Chart 127 shows the level of liquidity, measured as liquid assets, divided by the accommodation bond liability. This varies from 54.2% for Group 3 NFP providers to 15.1% for Group 2 FP providers.

Using a threshold liquidity level of 17.5% (the liquidity of the FP providers in Group 1) we calculated the lost revenue from holding excess liquidity. The circles in Chart 127 represent the lost revenue prpa from this excess liquidity. For example, Group 4 NFP providers could have improved profitability by $356 prpa if they had held a lower level of bond liquidity.

While currently modest, the impact of excess liquidity is likely to increase under the new accommodation payment regime.

Chart 127: Earnings Lost on Surplus Liqudity



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Appendix 1 – Financial Calculations Assumptions and Approach

As explained in section 1, the quantitative analysis is based on specific information held by DSS. DSS has identified certain limitations in this information. In Appendix 1, we explain our approach to analysing and adjusting the financial information on which the analysis is based.

Data Used

The quantitative analysis is based on the de-identified GPFR data set for FY2013 that was used to inform that year's ACFA Annual Report. We also considered the following data supplied by the DSS:

- ACFI payment data
- viability supplement data.

Selection of Suitable Financial Measures for Analysis

Financial performance can be interpreted in many ways using various measures. Arguably the most commonly cited comparative measure of financial performance in aged care is earnings before interest, taxes, depreciation and amortisation (EBITDA). To a lesser extent, net profit before tax (NPBT) and return on equity (ROE) are also used.

Although in common use, EBITDA is not a defined accounting term and, as such, there is no standard approach to calculating it. The calculation ACFA generally uses includes some revenue and expense items that do not appear to relate to the day-to-day provision of aged care services or that are applied inconsistently between providers.

We gave careful consideration to the following matters in determining which measure to use. In particular we considered:

- potentially distorting items within EBITDA, as used in the ACFA report
- the importance of separating the analysis of investment and financing decisions from an analysis of operating financial performance
- the need for consistent treatment of accommodation charges.

Items excluded from EBITDA

As noted above, a number of potentially distorting revenue and expense items are included in the calculation of EBITDA. For the purposes of this study we have removed the items shown in Table 13 from the calculation of EBITDA that was used in the ACFA Annual Report.

For clarity, we have called the revised calculation operating earnings before interest, tax, depreciation and amortisation (OEBITDA).

Table 13: Items excluded from OEBITDA

Excluded item	Rationale for exclusion	FY13 Value
Trust distributions	Trust distributions are not generated from the aged care operations of the reporting entity and should be excluded.	$12m
Interest income	This is a financing item and should be considered below the EBITDA line.	$233m
Donations and contributions	Although a legitimate source of income, donations and contributions are not derived from aged care operations and are distorting because not all providers seek these.	$75m
Capital grants	This non-operating revenue item is used for capital works. It is included in earnings under accounting standards.	$39m
Insurance claims	These are irregular items and may be operating or capital in nature.	$7m
Profits or losses on sale of assets	These are non-operating items and are distorting for comparison purposes.	Net $40m
Revaluation increases or decreases	Non-operating item accounted for below EBITDA line.	Net ($6m)
Contributions to parent entities	Non-operating item and distorting for comparative purposes.	($5m)
Rent	Rent is inconsistently charged depending on how providers have set up their corporate structures.	($186m)

Consistent treatment of accommodation charges and bonds

In FY2013, providers offering low care and high care with extra services received accommodation bonds as opposed to daily accommodation charges for high care. Traditionally, the impact of taking a bond has not been fully recognised in the calculation of EBITDA.

Providers can use accommodation bonds to reduce bank debt balances and interest expense. Alternatively, bonds can earn interest income, presumably at a lower rate than charged on bank debt. It can be readily argued that bond interest earned belongs with financing activities, not operating activities.

We have sought to overcome any distortion in comparing the OEBITDA of providers by including a deemed accommodation charge in OEBITDA. We used the average MPIR applying in FY2013 to calculate the notional income earned on accommodation bonds. In aggregate, the deemed accommodation income was $807 million.

To offset this deemed income and balance the books, we have included deemed bond interest of the same amount as a financing expense.

Through this process, our analyses and conclusions are agnostic to whether a provider had access to accommodation bonds.

In future studies of this type, it may be worthwhile examining the actual interest earned on bonds, or saved by offsetting bonds against bank debt, rather than assuming that the MPIR applies in practice.

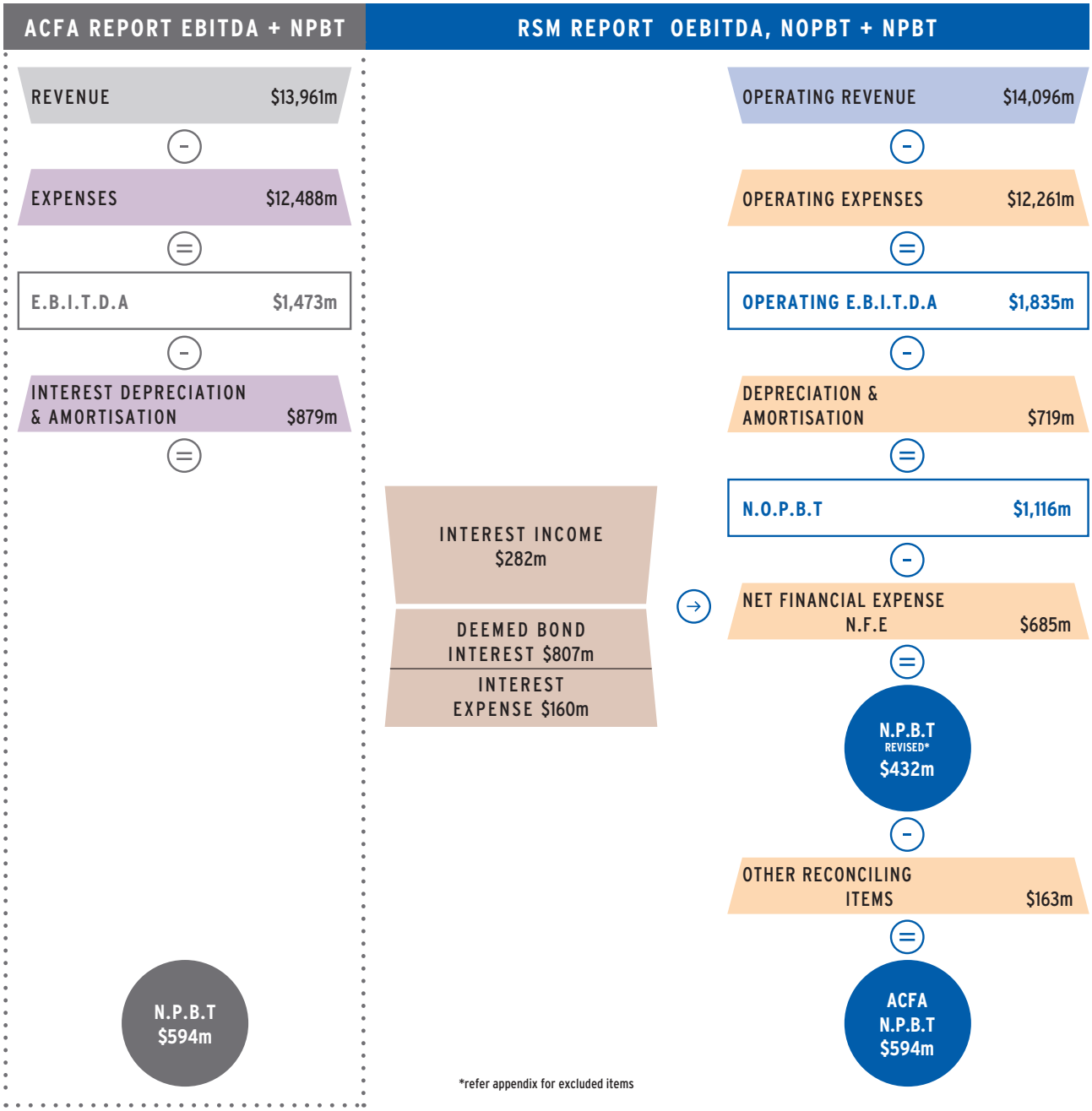
Net operating profit before tax

Depreciation and amortisation is a charge on the use of operating assets. The expense also acts as a surrogate for the savings required to replace physical stock. We have applied depreciation and amortisation against OEBITDA to derive net operating profit tax (NOPBT), which allows for a more well-rounded understanding of operating financial performance.

Revised income statement

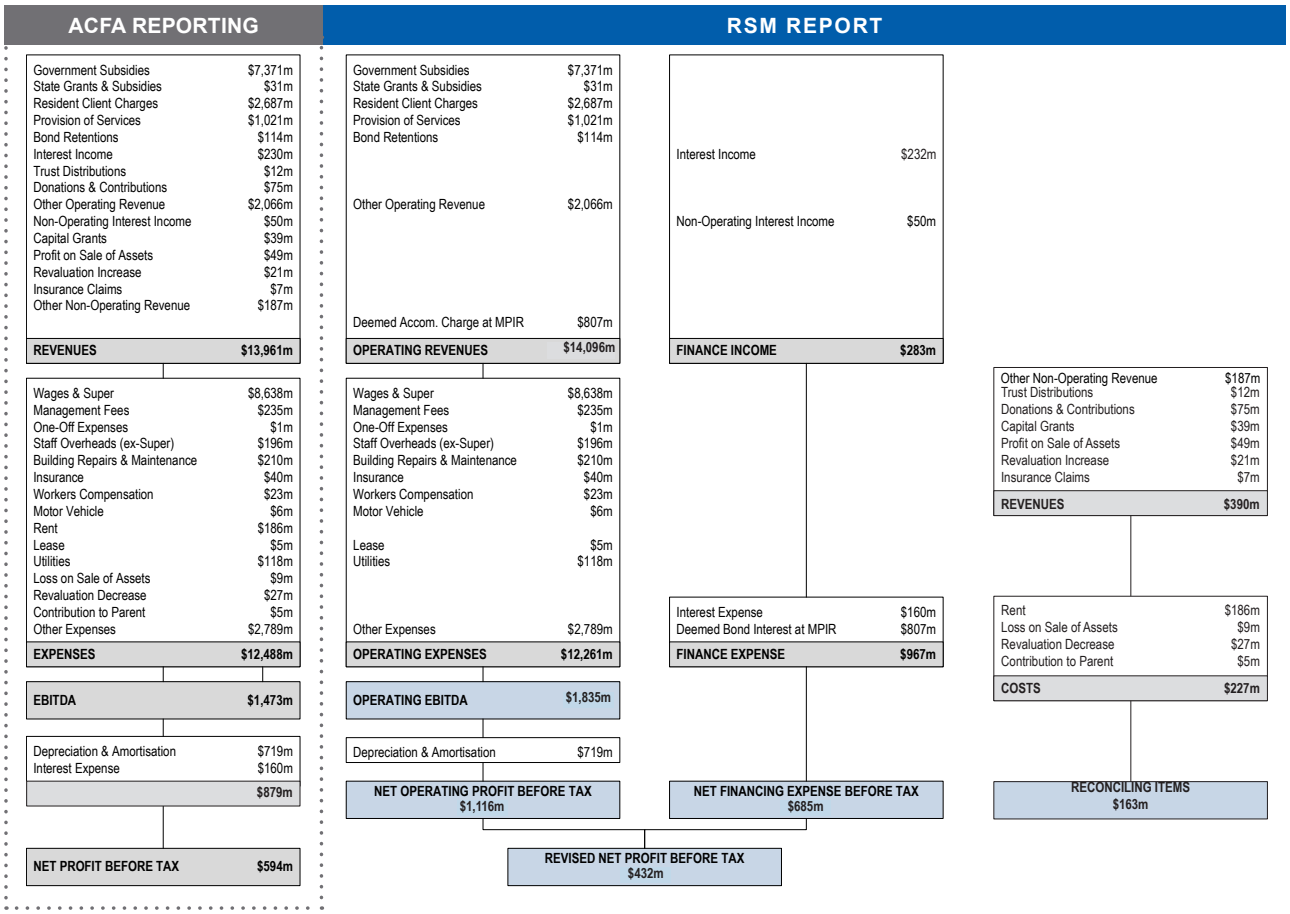
Figure 6 shows how EBITDA as calculated for the ACFA annual reports reconciles with OEBITDA as used in this report and introduces NOPBT. A more detailed version of the items in each calculation is contained in Figure 7.

Figure 6: Reconciliation of ACFA EBITDA to OEBITDA (numbers are in $m)



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Figure 7



Effect of income statement revisions on EBITDA and NPBT

The revised income statement introduces net operating profit before tax (NOPBT) and net financing expense before tax (NFE) measures. It shows that the revised NPBT is NOPBT less NFE. NPBT and the revised NPBT differ by the exclusion of the non-operating revenues and expenses as set out above.

Table 14 demonstrates the impact on reported EBITDA and NPBT when non-operating income and expense items are removed and notional accommodation revenue and interest in relation to accommodation bonds is included.

Table 14: ACFA EBITDA and NPBT compared to OEBITDA and revised NPBT

	2013	2012	2011
ACFA-reported EBITDA	$1,472,944,608	$1,544,313,578	$1,333,533,112
OEBITDA	$1,835,411,544	$1,946,479,969	$1,950,623,584
Change	$363,000,000	$402,000,000	$617,000,000
Percentage change	+25%	+26%	+46%
ACFA-reported NPBT	$593,890,824	$726,104,548	$525,750,507
Revised NPBT	$432,160,725	$581,311,709	$548,885,436
Change	$162,000,000	$145,000,000	$23,000,000
Percentage change	-27%	-20%	+4%

The inclusion of deemed accommodation income significantly impacts EBITDA.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Separating Investment and Financing

It is important and conventional to separate the analysis of an investment in operating assets from the analysis of how that investment is financed. Just as we have separated operating and financing revenues and expenses in the income statement, we have separated operating and financial assets and liabilities in the statement of financial position.

To facilitate this analysis we have re-organised the balance sheet into net operating assets (NOA) and net financial liabilities (NFL), as per Figure 8.

Financial assets and financial liabilities

Financial liabilities include interest-bearing debts and accommodation bonds. Financial assets are those that generate interest income or could generate interest income or offset interest-bearing liabilities.

We have treated cash as a financial asset. While there is generally a need to keep a small amount of cash available for operational purposes, it is conventional to treat cash as a financial asset if it earns or could earn interest or if banking arrangements enable it to be offset against loan balances in calculating loan interest.

Related party liabilities

There are several circumstances in which a provider's statement of financial position may show related party liabilities. These include when:

- operations are conducted via an operating company (OpCo) and property company (PropCo), or other multi-entity structures
- the rules governing the permitted use of accommodation bonds encourage the use of related party debt rather than equity
- providers using trust structures that accumulate rather than distribute operating surpluses, do so through the creation of related party liabilities in the operating entity.

In each of these cases equity as traditionally understood can be inconsistently stated when comparing providers. To avoid any distortion caused by the structural preferences of providers we have treated related party liabilities as equity. This is consistent with the calculation of operating outcome (OEBITDA and NOPBT).

Revised statement of financial position

Using the distinction of operating and financial assets and liabilities, and our restatement of related party loans, the statement of financial position is restated in Figure 8. A more detailed version is shown in Figure 9.

Figure 8

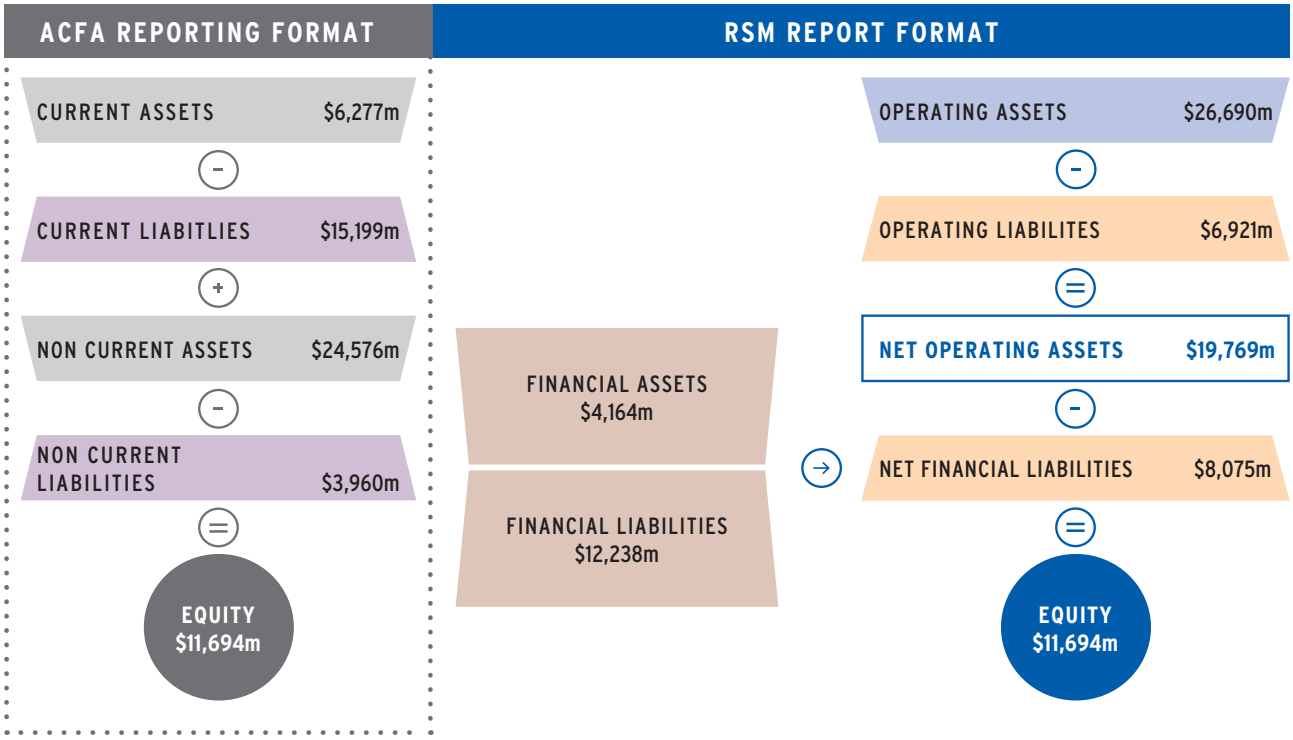
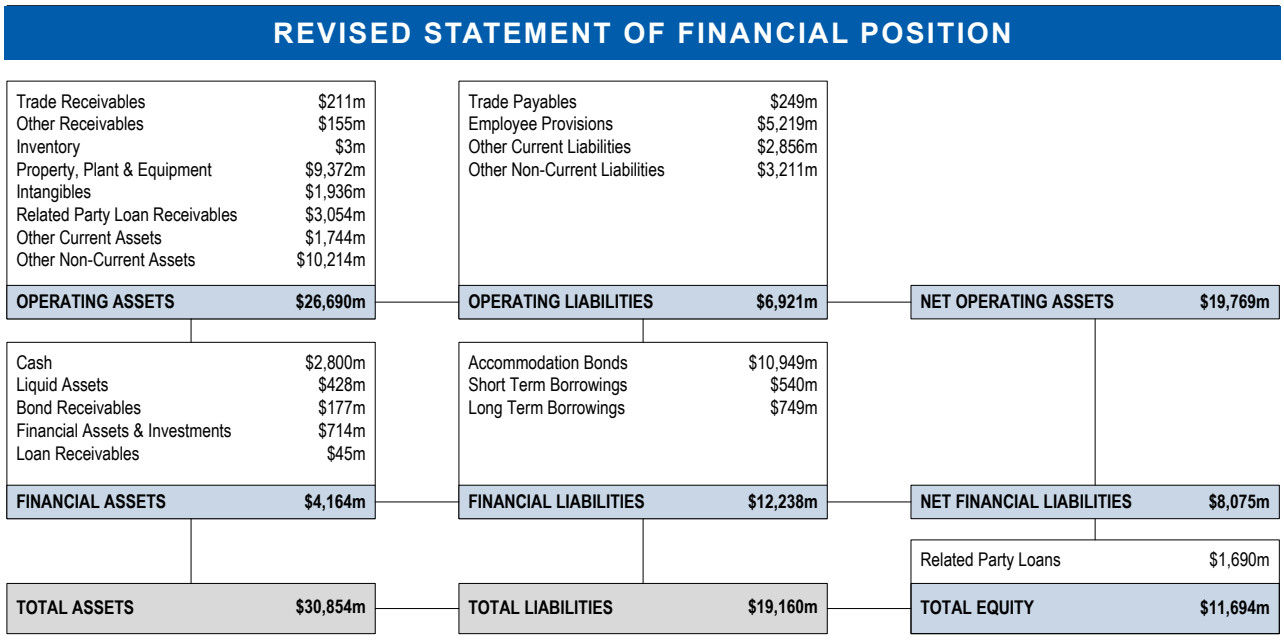


Figure 9



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Relationship Between the Revised Income Statement and the Revised Statement of Financial Position

The revised statement of financial performance and statement of financial position enable us to compare NOPBT and NOA to calculate the return on net operating assets (RNOA).This is a clean measure of operating investment performance, unaffected by how the operating investments are financed or how accommodation payments by residents are acquitted.

Investors in this industry have diverse access to debt and equity, depending in particular on whether they are FP or NFP and their size. Regardless of their funding circumstances investors can compare an investment's forecast RNOA with their weighted average cost of capital (WACC) to decide if the investment is worthwhile.

NFE could be compared with NFL to calculate the net borrowing cost before tax (NBCBT). We haven't done this because we only have year-end NFL data and this calculation is best made using average balances.

NPBT can be compared with equity to calculate ROE.

Consistency of Provider Performance

As our quantitative analysis is based on a single year's data it was important to understand whether a provider's relative operating financial performance in FY13 was indicative of its longer-term performance. This was achieved by tracking the consistency of providers' quartile performance using ACFA EBITDA and OEBITDA.

Table 12 compares the consistency of performance over a three-year period from 2010–11 to 2012–13 using ACFA EBITDA and the OEBITDA used in this report.

Table 15: ACFA EBITDA compared to OEBITDA

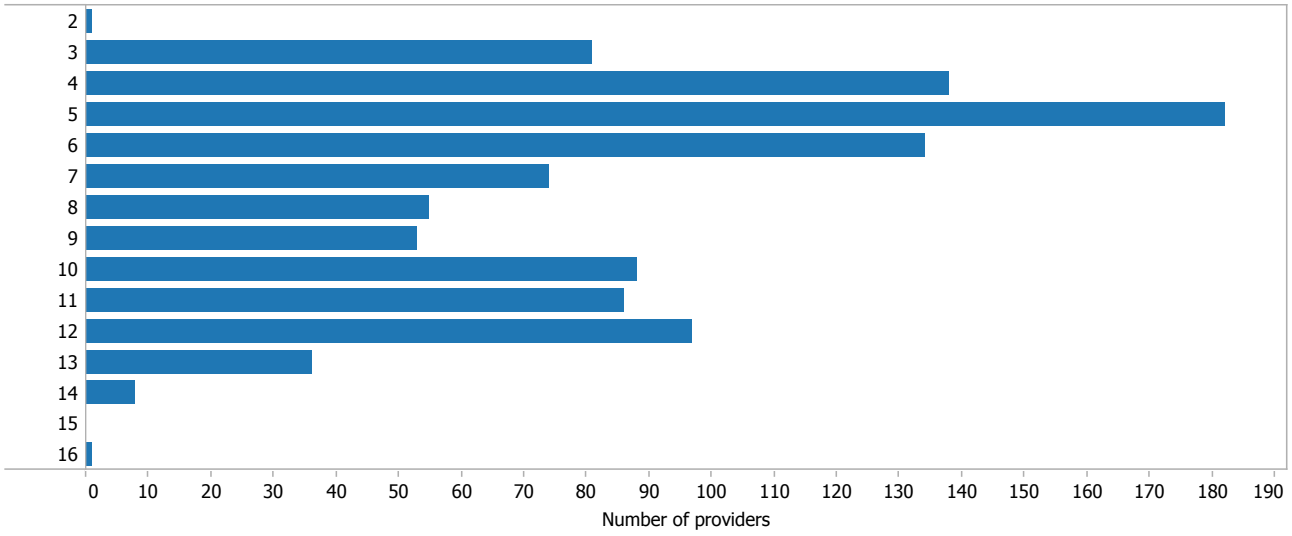
	First quartile	Second quartile	Third quartile	Fourth quartile
Based on ACFA EBITDA				
Providers in the same quartile in all three years	129	69	57	113
Percentage of total	11.4%	6.1%	5.0%	10.0%
Consistency	52.7%	27.6%	22.4%	46.3%
Based on OEBITDA				
Providers in the same quartile in all three years	153	82	76	113
Percentage of total	13.6%	7.3%	6.7%	10.0%
Consistency	61.9%	32.8%	30.2%	46.1%

With the exception of the bottom quartile, removing the impact of non-operating income and expenses improves the consistency of a provider's placing within quartile bands over three years. Excluding non-operating items adds confidence to the classification of providers based on financial performance.

Line-Level Analyses

ACFA has expressed interest in understanding the impact of specific revenue and cost elements on performance. The degree of line-level reporting in the GPFR data varied substantially across the industry. Chart 128 shows the number of providers that reported specific numbers of line items in the income statement and the statement of financial position counted together. The peak of 5–6 reported line items reflects that providers only reported key income statement and statement of financial position totals.

Chart 128: Number of OEBITDA Line Items Reported



This low level of line item data left us with an unanswerable question: If a provider did not report a line-level item, did that mean there was nothing to report or did it mean it was reported in another or the 'other' category? The second option is likely – the 'other revenues' and 'other expenses' categories show quite large amounts. This has limited our ability to analyse the accounts at the line level.

Normalisation

In this report most income statement figures for individual providers have been normalised for size by conversion to a per resident per annum (prpa) figure. Most statement of financial position figures have been converted to a per resident (pr) figure.

Exclusion of Outliers

In ranking the 1,034 providers we concluded that the analyses would benefit from removing10 outliers: five from the top and five from the bottom. While we could not determine what was impacting the results of these outliers, their OEBITDA prpa were so divergent from the average OEBITDA prpa, it called into question the accuracy and validity of the GPFR information they reported. These outliers were mostly but not exclusively FP providers classified as 'high care' at one location in a city. This left 1,024 providers.

Appendix 2 – Qualitative Study Background

PwC designed and managed the survey of the qualitative aspects of aged care financial performance used in this study. The following approach was used in designing, managing and analysing the results of the qualitative survey.

Questionnaire Topics and Design

The questionnaire was jointly designed by PwC and RSM. A survey committee comprising three ACFA board members provided guidance and industry knowledge. In addition, the survey was tested with representatives from both small and large aged care providers, as well as industry peak body leaders.

At the conclusion of this process we settled on 60 qualitative and three quantitative questions. The survey addressed the following areas of operation:

- governance and strategy
- capital management
- finance and refurbishment
- operations
- workforce
- residents and marketing.

The questionnaire was delivered online and took participants around 20 minutes to complete. Participants could save and complete the survey in stages. Most questions were answered using check boxes.

Most questions were designed to be answered at the provider level, with 13 directed at the facility level. To accommodate these facility-level questions, PwC randomly selected two facilities among providers operating more than five facilities. If a respondent had facilities in city and in regional, rural or remote areas, one metropolitan and one regional, rural or remote facility were selected. Respondents were directed to answer the facility-level questions for each of their nominated facilities.

The responses to the questionnaire are shown in Appendix 4.

Recruitment

The survey was targeted at CEOs or other C-level executives. Participants were identified from ACFA data, augmented by RSM, PwC and Stewart Brown contact lists.

Survey participants were recruited through an email invitation accompanied by a letter from Lynda O'Grady, Chairman of ACFA to demonstrate ACFA's support and endorsement.

We supplemented recruitment with follow-up emails, phone calls and promotion at the LASAconference in October 2014.

Survey Participants

The survey sample was stratified by location and ownership to make sure it was representative of the industry. We calculated that at least 117 responses were needed for some of the advanced analyses, so to be safe we set a target of 200 responses.

We received 164 completed surveys. Another 55 surveys were partially completed. Chart 129 provides a breakdown of the survey responses. We received only four completed surveys for government providers in a city location, compared with a target of 7.

Chart 129: Survery Participation by Ownership and Location

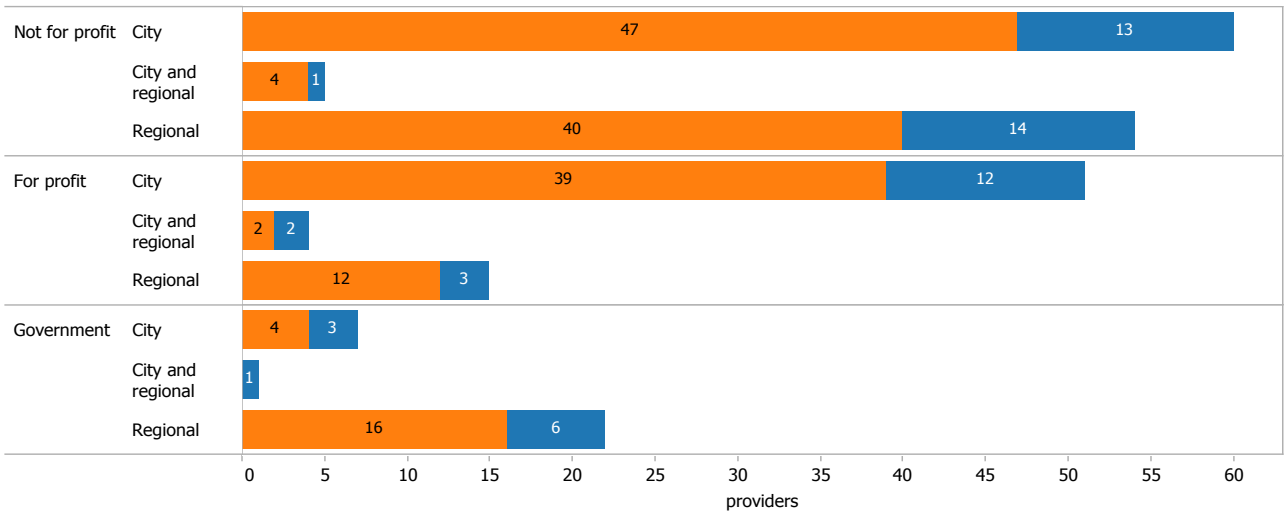
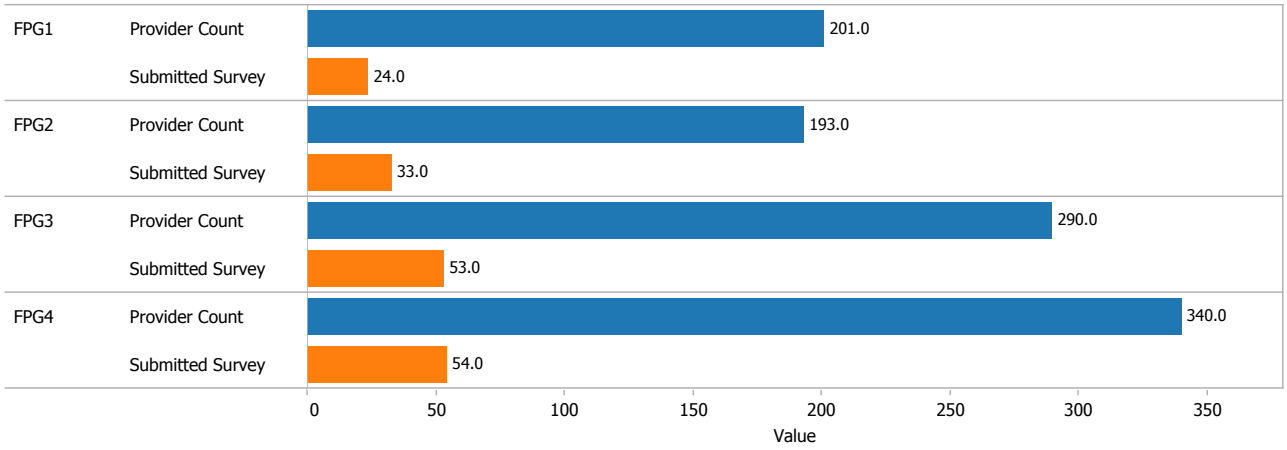


Chart 130: Distribution of Completed Survey Respondents Across Financial Performance Group (FPG)



The 164 complete surveys provided us with a distribution across ownership, location and financial groups that aligns well with the nature and shape of the broader industry. In other words, we achieved a representative sample. Chart 129 above shows the split of the survey population against the industry population.

Of the 55 incomplete surveys:

- nine providers had completed but not submitted the survey
- 17 providers had completed more than 50% of the survey
- 29 providers had completed less than 50% of the survey.

To bolster numbers and use all the survey data collected, we included these responses in our analysis.

Timing

The survey was open for completion online from 25 September 2014 until 6 November 2014.

Confidentiality

Each participant's identity and responses have been kept confidential. Only aggregated results have been made available to DSS.

Appendix 3 – Multivariate Analysis

Multivariate analysis looks at a range of factors to try to understand their relative importance in driving operational financial performance.

Nine key factors were modelled together to explain the difference between the better performing and lower performing provider groups. By modelling them simultaneously we were able to identify the separate impact of each.

The model was built by adding each factor incrementally to test its individual significance. This means that for each additional factor added to the model, we were able to test and verify that the incremental improvement in accuracy was not coincidental.

For example, the model started with the FP variable, and each variable was added on top of this, testing that the new variable significantly improved the accuracy of the results rather than being coincidentally important. As we added each additional variable, the model became more accurate.

Although FP providers have a high tendency to fall in the better financially performing groups, some fall into groups 3 and 4, indicating that operating FP is not the only driver of performance. We also saw that the other ownership types are spread across the four groups, so there are definitely other factors at play in driving operational financial performance.

Approach to Multivariate Analysis

We used a set of logistic regression models to identify the important factors driving operational financial performance. This type of model helps to predict the probability that a provider will fall in a certain group based on a number of factors and variables.

We used a series of models to test for the best combinations of factors and check for stability across the sample. The models attempt to tease out the important factors across the following splits:

- Group 1 compared to groups 2, 3 and 4
- Groups 1 and 2 compared to groups 3 and 4
- Groups 1, 2 and 3 compared to Group 4

These models allowed us to discover the factors that contribute to a provider qualifying as Group 1 as well as characteristics shared by Group 4 providers. Some factors were common across all three models listed above, and some were more important to the Group 1 or Group 4 model. We removed any factors that did not align across all three models as the inconsistency indicated a potential for instability.

Table 16: Top findings from multivariate analysis

Question/factor	Domain	Description	Strength
Ownership	Strategy/governance	Having an ownership type of FP positively impacts operational financial performance.	✓✓✓
Accreditation	Process application	Successfully meeting accreditation requirements positively influences operational financial performance.	✓✓✓
Services offered	Strategic focus	Providers with better operational financial performance are more targeted in their service offering and more likely to focus on residential aged care.	✓✓✓
Finance/debt facilities	Strategy/governance	Providers with better operational financial performance are more likely to have dedicated finance/debt facilities.	✓✓✓
Location	Location/strategy	Being based in the city positively impacts operational financial performance.	✓✓
Shared services	Process application	Providers with better operational financial performance and with more than one facility share a higher proportion of their corporate services.	✓✓
Bond management	Strategy/governance	Providers with better operational financial performance target a lower bond % held in cash.	✓✓
ACFI management	People management	Providers with better operational financial performance are more likely to have a dedicated internal ACFI resource.	✓✓
Outsourcing	Process application	Providers with better operational financial performance are more likely to outsource functions such as laundry, payroll and IT	✓

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Appendix 4 – Complete Qualitative Survey Responses

Table 17: Index to survey questions

Question type	Questions	Key finding (section)	Other finding (section)	Provider expansion plans (section)
General information	Questions 1-2			
	1. Which of the following services do you offer?	3.5.3 Marketing		
	2. you provide home care packages (e.g. EACH, EACHD, CACP), would you be interested in participating in a future home care-related survey in 2015?			
Governance/strategy	Questions 3-11			
	3. In FY13, did you have a board of directors in place?	3.5 Governance and Strategy		
	4. Please indicate the skills represented by your board of directors in FY13.	3.5.1 Board attributes		
	6. In FY13, did you have a strategic plan in place?			
	7. How frequently do senior management and/or the board monitor progress of the strategic plan?	3.5.4 Strategy and planning		
	8. As a result of the 1 July 2014 aged care reforms, have you ...?	3.5.4 Strategy and planning		
	9. In FY13, did you have a risk management policy in place?	3.5.1 Board attributes		
	10. How frequently do senior management and/or the board monitor progress of the risk management policy?	3.5.1 Board Attributes		
	11. In regard to residential aged care, in the next two years do you have definite plans?			9. Provider Expansion Plans
Capital management	Questions 12-17			
	12. As a residential aged care provider, do you use bank finance?	3.3.3 Capital management		
	13. If yes, what is your preferred approach to debt financing?	3.3.3 Capital management		
	14. Do you seek external advice on growth and operational strategies?		4.5 Seeking External Advice	
	15. In FY13, did you have a master plan in place to determine your building improvements in the long term?			
	16. In regard to residential aged care, do you have plans to expand by ...?			9.2 Expansion Methods
	17. How do you plan to fund expansion?			9.4 How Expansion Will be Funded
Finance	Questions 18-29			
	18a. Repairs and maintenance expense in FY13			
	18b. Total care staff leavers in FY13			
	18c. Opening care staff headcount at 01/07/2012			
	18d. Closing care staff headcount at 30/06/2013			

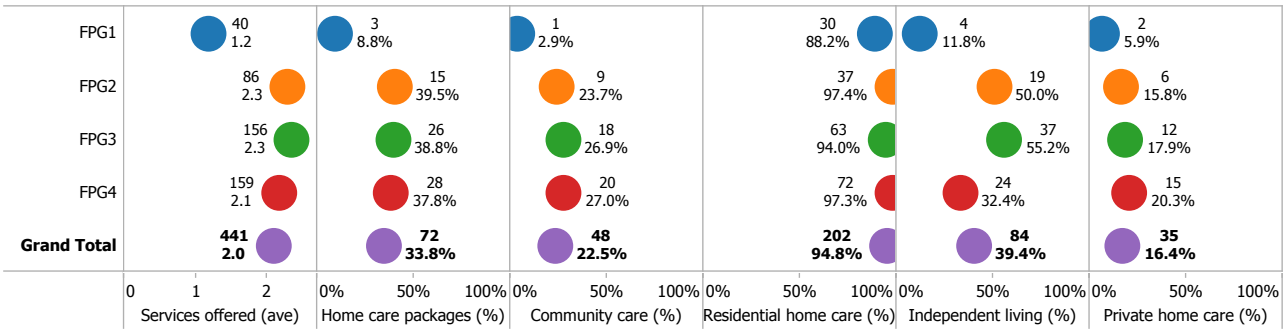
Question type	Questions	Key finding (section)	Other finding (section)	Provider expansion plans (section)
	18e. Registered nurses (FTE) at 30/06/2013		4.10. Staff Management Practices	
	18f. Agency staff cost ($) in FY13		4.10. Staff Management Practices	
	19. In FY13, did you hold your land and buildings in a related entity separate to your operating entity?		4.1 Corporate Structure	
	20. If yes, what was the FY13 rent expense in the operating entity?			
	21. How much was the management fee that you paid to a related party entity?			
	22. In FY 13, how did you manage your accounting requirements?			
	23. If you use a bookkeeper, how often are your accounts reviewed by an external accountant?			
	24. On what basis were your FY13 budgets prepared?	3.4.1 Budgeting		
	25. Was your FY13 provider EBITDA result in line with your budget?	3.4.1 Budgeting		
	26. In FY13, how frequently did you prepare financial forecasts?	3.3.3 Capital management		
	27. As per your liquidity management strategy, what is your targeted accommodation bond percentage level held in cash, cash equivalents or on call?	3.3.3 Capital management		
	28. Do you have dedicated finance/debt facilities to supplement bond liquidity?			
	29. In FY13, did you have a formal dividend policy?			
Operations	Questions 30-38			
	30. In FY13, did all of your facilities use a central IT system to support clinical care delivery?			
	31. Have you obtained external advice and/or have dedicated internal resources to manage claims under ACFI?	3.3.1 Operating Revenue Management		
	32. Which of the following financial benchmarking studies do you regularly participate in?		4.6 Participation in Benchmarking	
	33. When did you last participate in an ACAR round for residential aged care (excluding 2014)?			9.1 Participation in ACAR Rounds
	34. If you participated in an ACAR round in the last five years (i.e. 2009-13) were you successful in your most recent attempt?	3.4.3 ACAR Participation		
	35. As a result of your success in applying for extra beds, are your beds currently online?			
	36. In FY13, which of the following areas did you outsource to an external provider?	3.4.2 Outsourcing		
	37. If you have more than one facility, do you run shared services in the following areas across all your facilities?		4.3 Shared Services	
	38. If you operate more than one facility, please select the statement that best describes your management structure.			
Workforce	Qs. 39-41			
	39. In FY13, did you have volunteer staff?		4.8 Use of Volunteers	

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Question type	Questions	Key finding (section)	Other finding (section)	Provider expansion plans (section)
	40. Which of the following initiatives did you have in place in FY13 to upskill your care staff?			
	41. In FY13, did you have any unmet outcomes from an accreditation visit?	3.4.4 Accreditation		
Resident/marketing	Questions 42–48			
	42. Did you have a clear market position/target resident profile in FY13?	3.5.3 Marketing		
	43. In FY13, where did most of your residents come from? (Rank 1 source)			
	44. How often is your website reviewed and updated?			
	45. When was your company logo and branding last updated?	3.5.3 Marketing		
	46. Do you regularly meet with other aged care providers to discuss resident needs, reforms, staff needs, operational structure efficiencies, ACFI etc.?			
	47. Do you perform research on what the demographic requirements may be in each of your facilities' local area in the next 10/20 years?			
	48. Please tell us the types of residents you focused on in FY13.	3.5.3 Marketing		
Facility level	Questions 49–60			
	49. When did you last undertake a significant refurbishment of your facility?			
	50. When do you expect to refurbish again in the future?	3.5.2 Asset management		
	51. How do you plan to fund refurbishment in the future?	3.5.2 Asset management		
	52. In FY13, did your facility manager or DoN review financial/management reports on a monthly basis?			
	53. In FY13, did your facility measure and monitor staffing costs to operational income a regular basis?	3.4.5 Background of facility manager		
	54. In FY13, did your facility manager or DoN who had overall management responsibility of your facility have a: ...?			
	55. In FY13, did you invest in management development training programs for your facility manager or DoN?		4.10. Staff Management Practices	
	56. In FY13, did your facility form alliances and links to your local community, e.g.childcare centres, schools?		4.7 Local Community Alliances	
	57. In FY13, did you have dedicated admissions staff?		4.2 Admission Management	
	58. In FY13, did you have a formal admissions process?		4.2 Admission Management	
	59. In FY13, did you maintain a waitlist at your facility?		4.2 Admission management	
	60. Please complete the following table about your facility as at 30 June 2013: room configuration	3.5.2 Asset management		

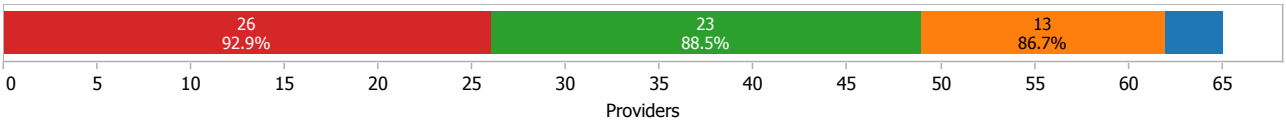
Survey Question 01: Services Offered by Financial Performance Group (FPG)

1. Which of the following services do you offer?



Survey Question 02: Register Interest by Financial Performance Group (FPG)

2. If you do provide home care packages (eg. EACH, EACHD, CACP), would you be interested in participating in a future home care related survey in 2015?



Includes only providers who offer home care services

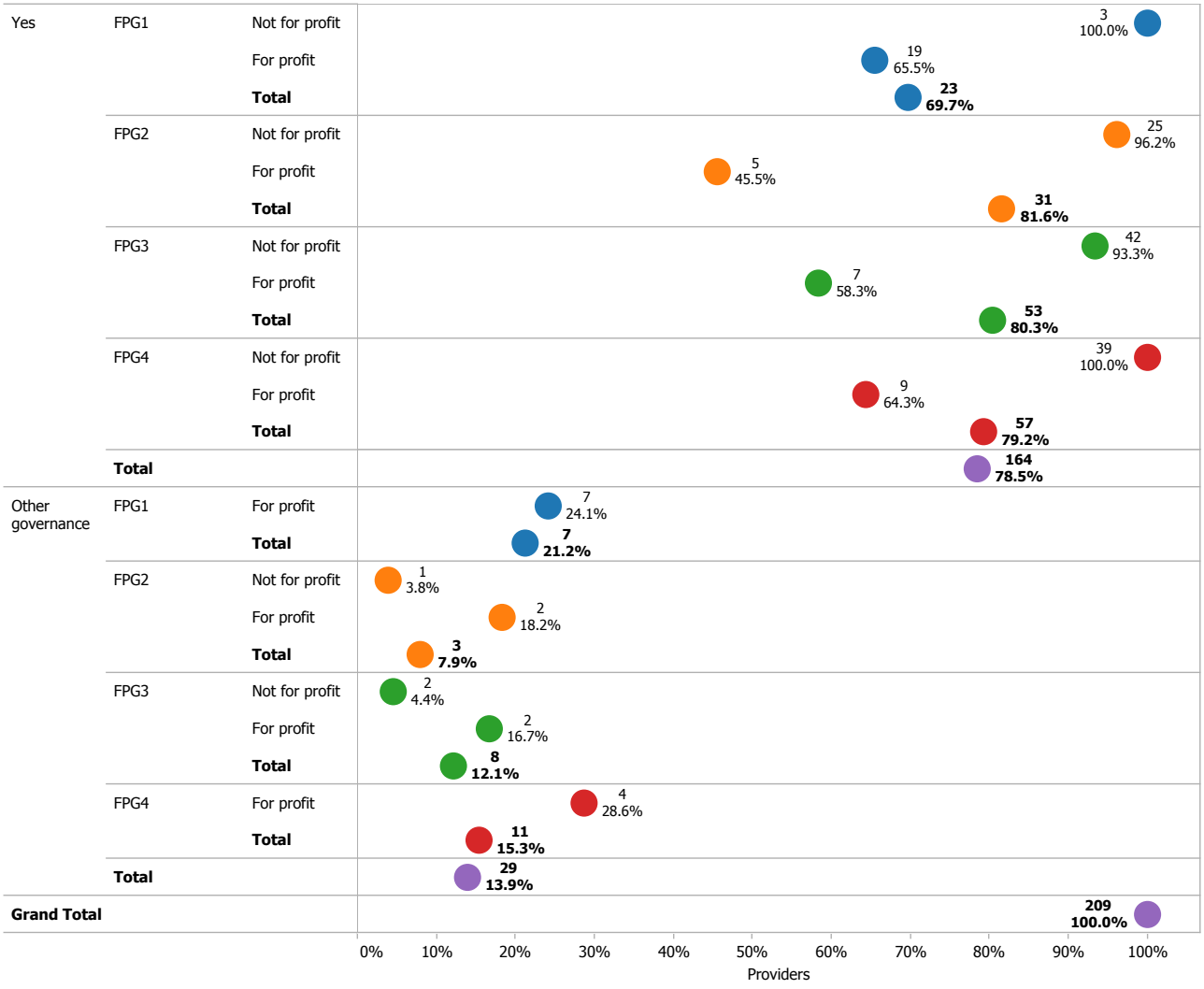
Group

- FPG1
- FPG2
- FPG3
- FPG4

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

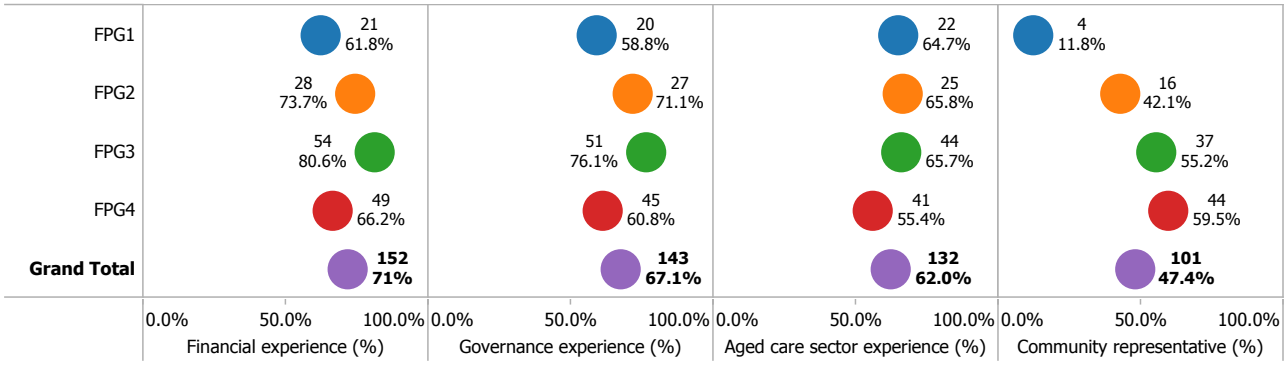
Survey Question 03: Board of Directors by Financial Performance Group (FPG)

3. In FY13, did you have a board of directors in place?



Survey Question 04: Skill Sets of the Board of Directors by Financial Performance Group (FPG)

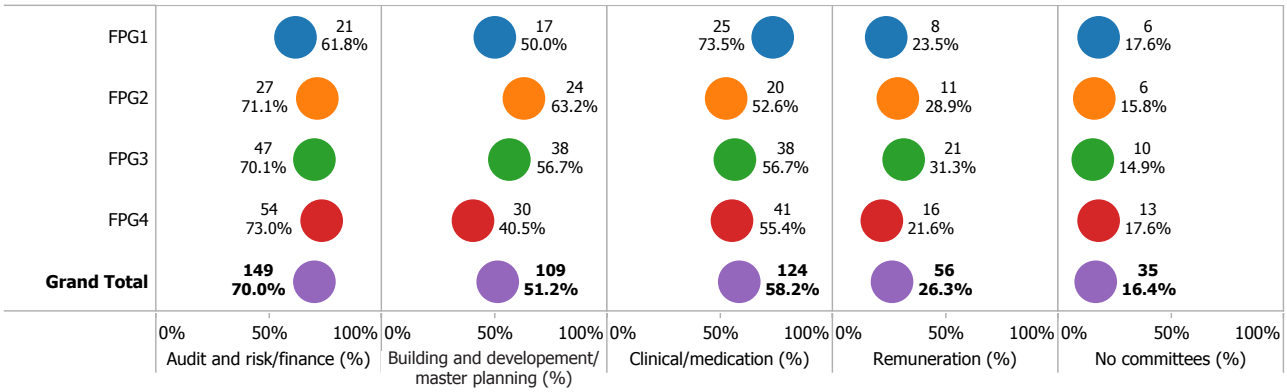
4. Please indicate the skills represented by your board of directors in FY13.



This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

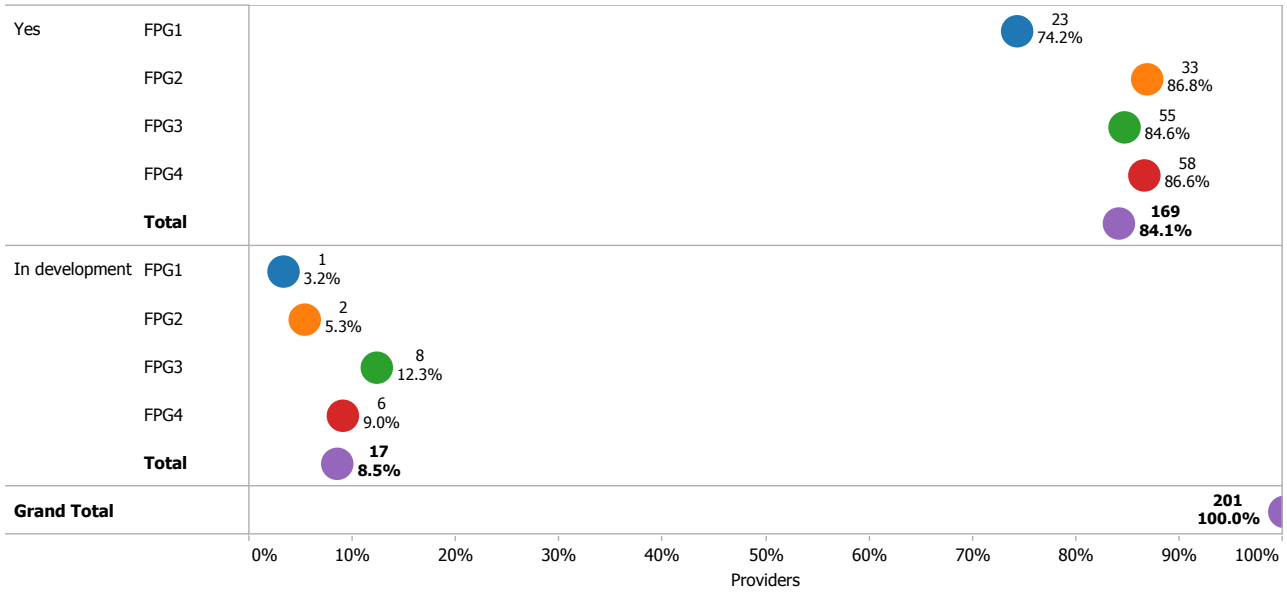
Survey Question 05: Types of Committees by Financial Performance Group (FPG)

5. In FY13, which of the following committees did you have in place?



Survey Question 06: Strategic Plan by Financial Performance Group (FPG)

6. FY13, did you have a strategic plan in place?

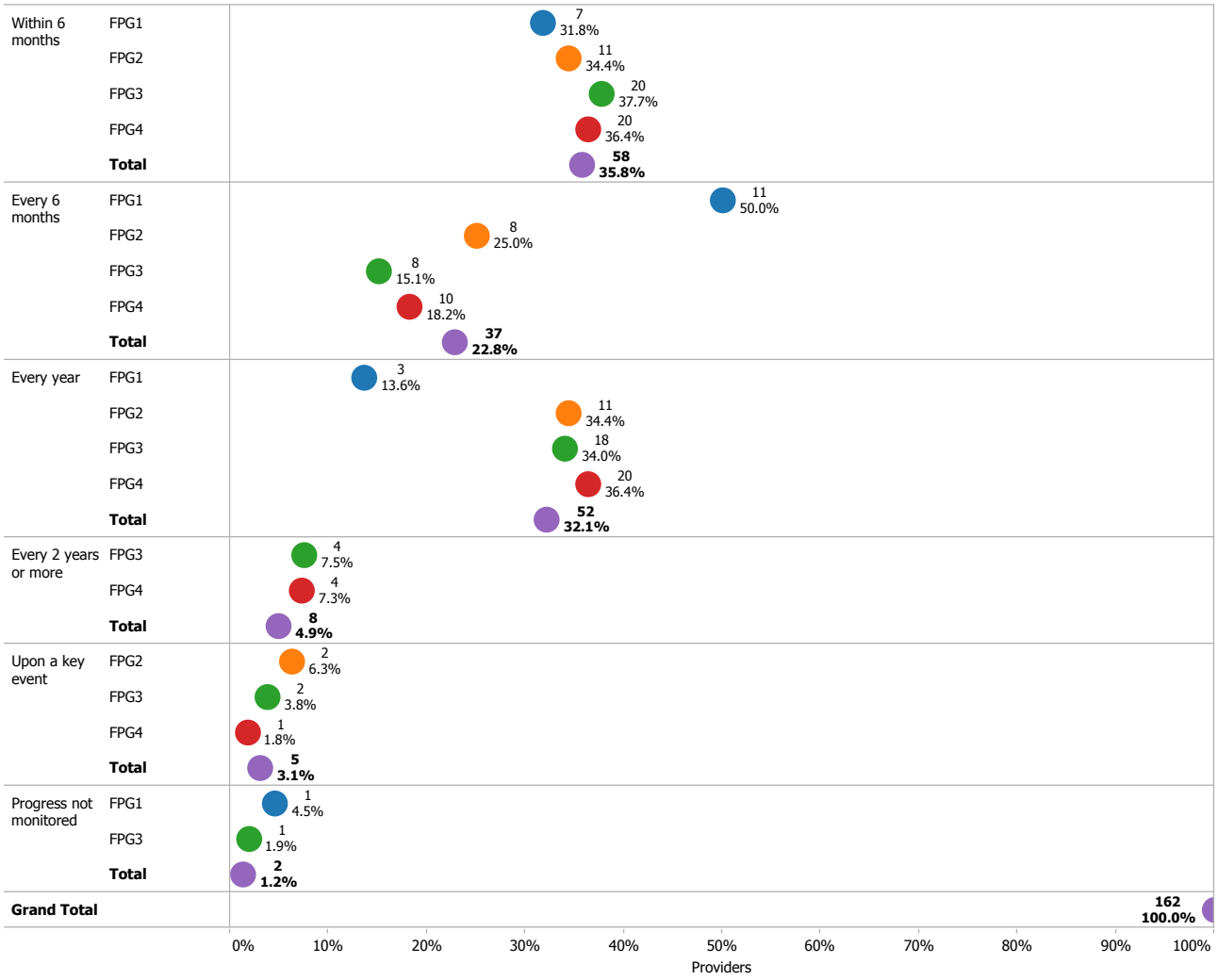


"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Survey Question 07: Monitoring Progress of Strategic Plan by Financial Performance Group (FPG)

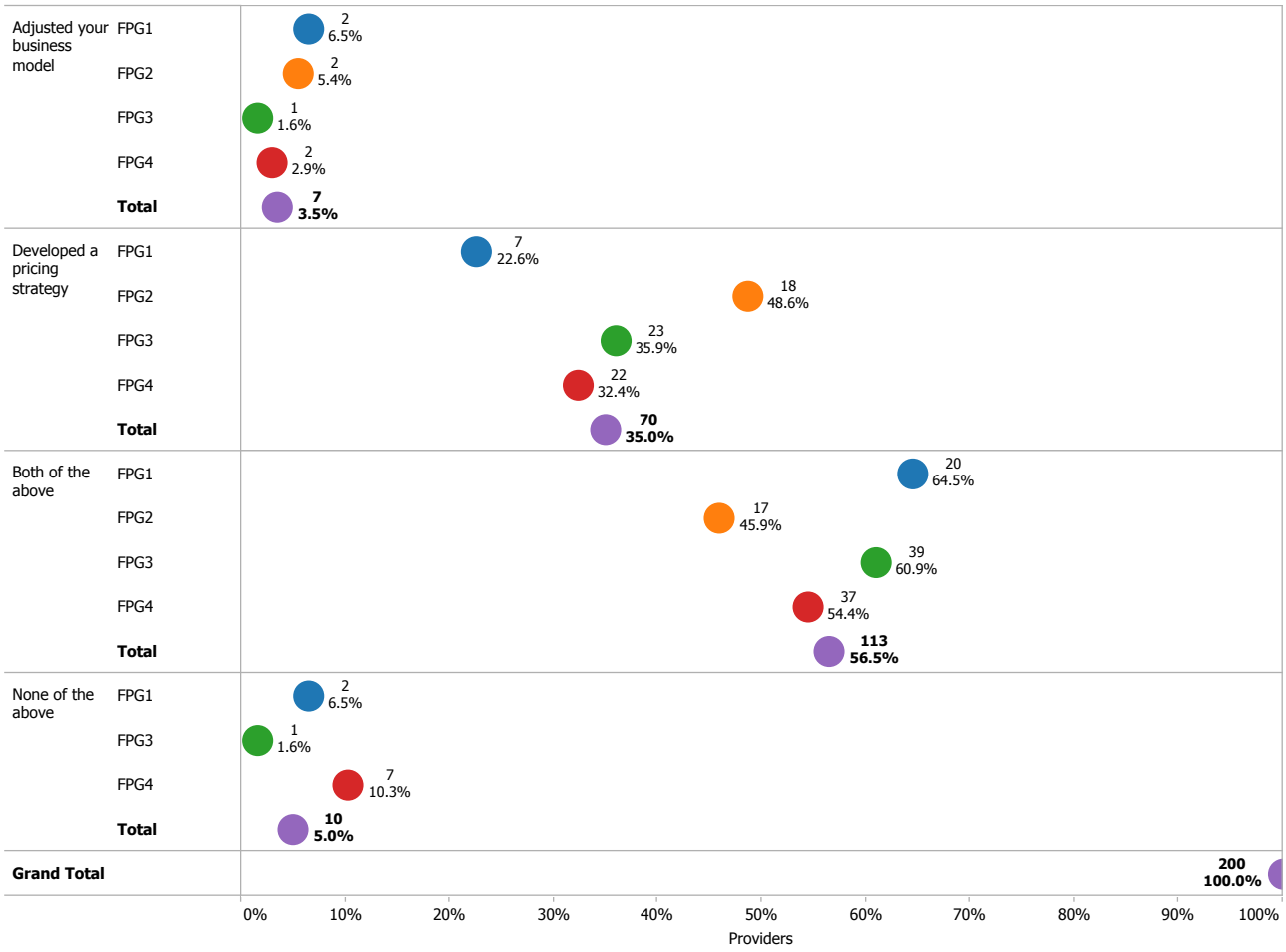
7. How frequently do senior management and/or the board monitor progress of the strategic plan?



"Null" and "Unknown" responses are excluded.

Survey Question 08: Aged Care Reform by Financial Performance Group (FPG)

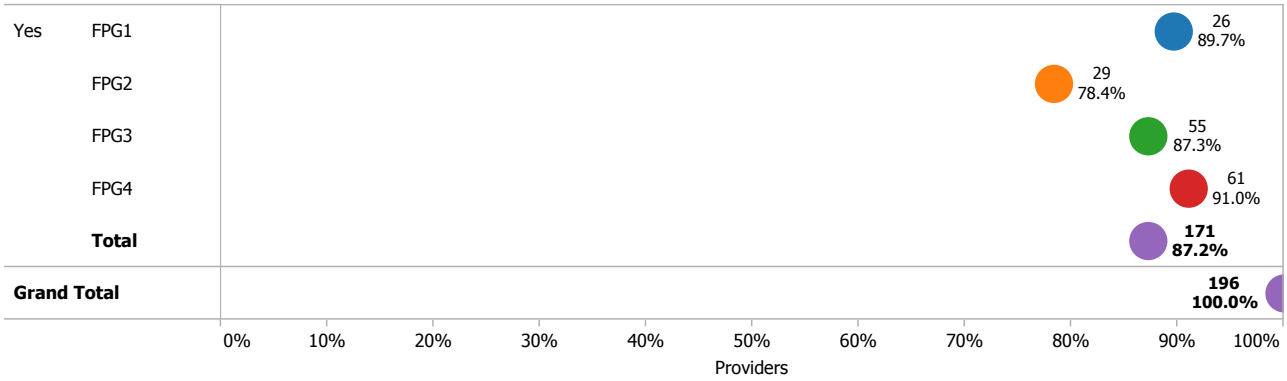
8. As a result of the 1 July 2014 aged care reforms, have you?



"Null" and "Unknown" responses are excluded.

Survey Question 09: Risk Management Policy by Financial Performance Group (FPG)

9. In FY13, did you have a risk management policy in place?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

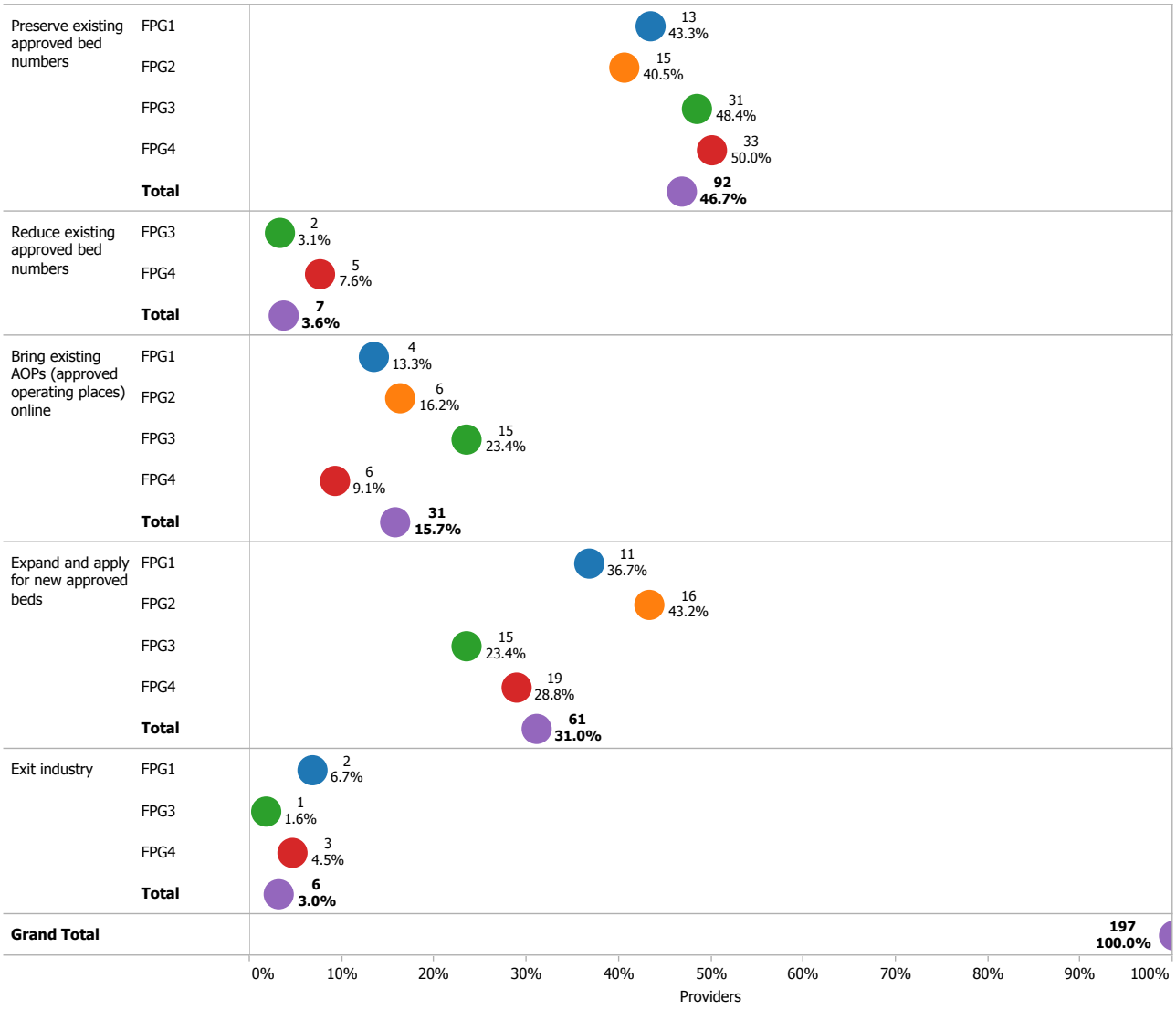
Survey Question 10: Timely Review of Risk Management Policy by Financial Performance Group (FPG)

10. How frequently do senior management and/or the board monitor progress of the risk management policy?

"Null" and "Unknown" responses are excluded.

Survey Question 11: Residential Aged Care Strategy by Financial Performance Group (FPG)

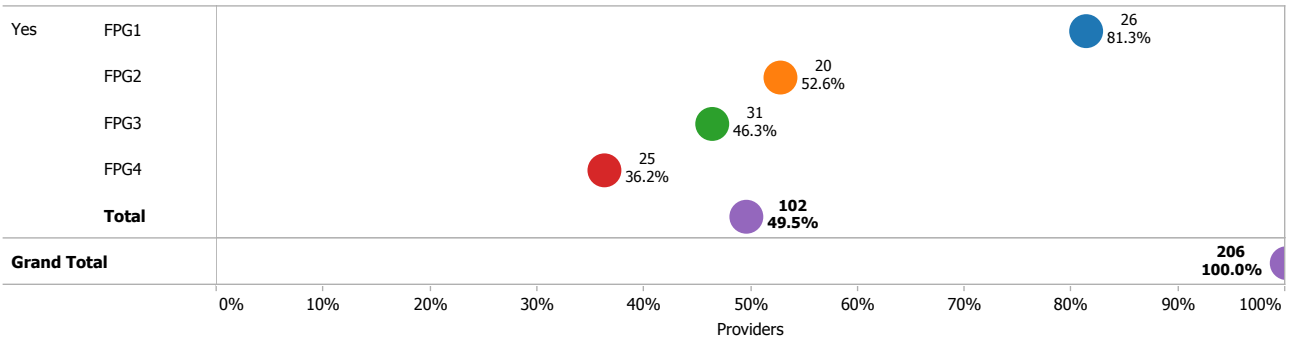
11. In regards to residential aged care, in the next 2 years do you have definite plans to...?



"Null" and "Unknown" responses are excluded.

Survey Question 12: Capital Management by Financial Performance Group (FPG)

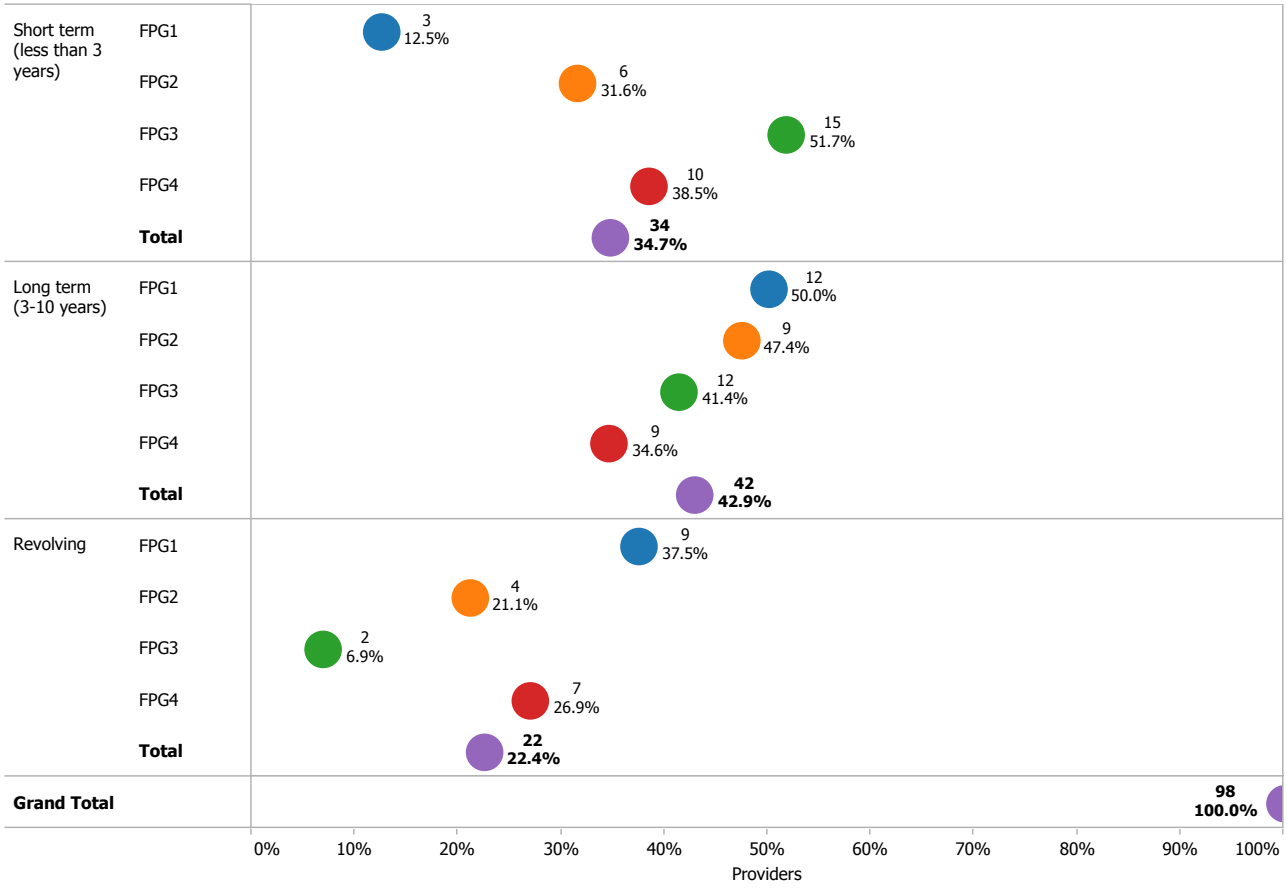
12. As a residential aged care provider, do you use bank finance?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 13: Debt Financing by Financial Performance Group (FPG)

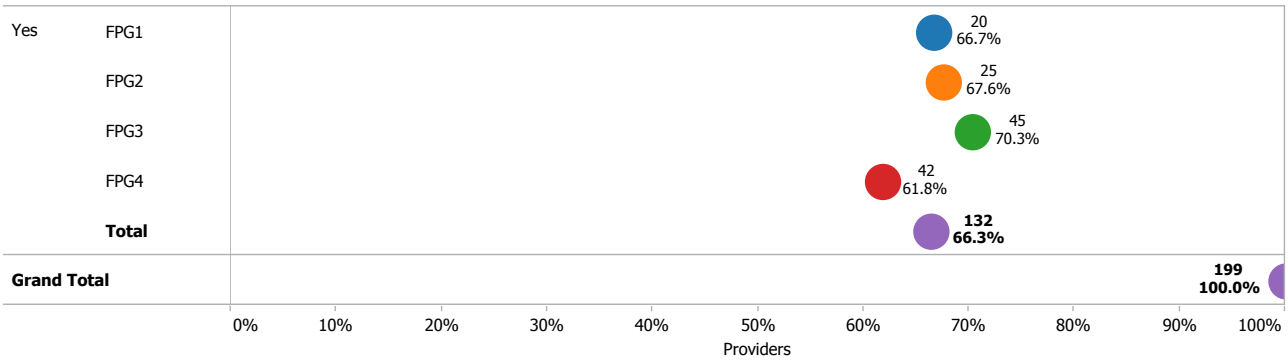
13. If yes, what is your preferred approach to debt financing?



"Null" and "Unknown" responses are excluded.

Survey Question 14: Seeking External Advice by Financial Performance Group (FPG)

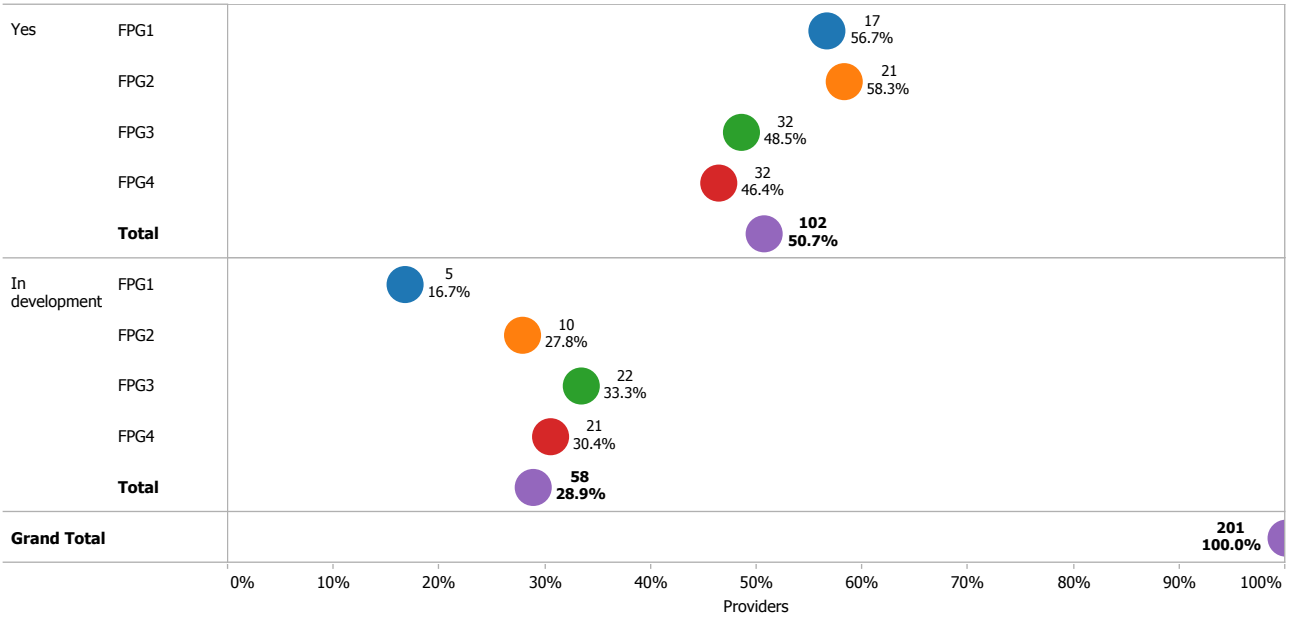
14. Do you seek external advice on growth and operational strategies?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 15: Master Plan by Financial Performance Group (FPG)

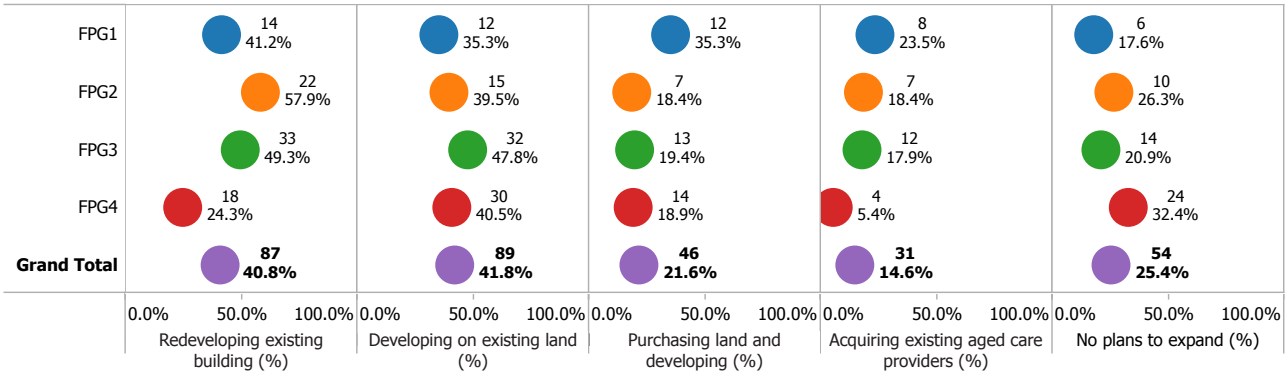
15. In FY13, did you have a master plan in place to determine your building improvements in the long term?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

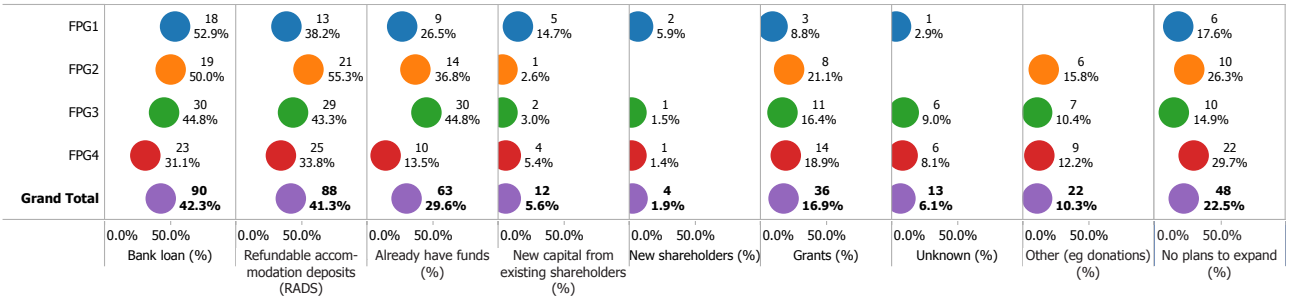
Survey Question 16: Expansion Plans by Financial Performance Group (FPG)

16. In regard to residential aged care, do you have plans to expand by ...?



Survey Question 17: Funding Expansion by Financial Performance Group (FPG)

17. How do you plan to fund expansion?



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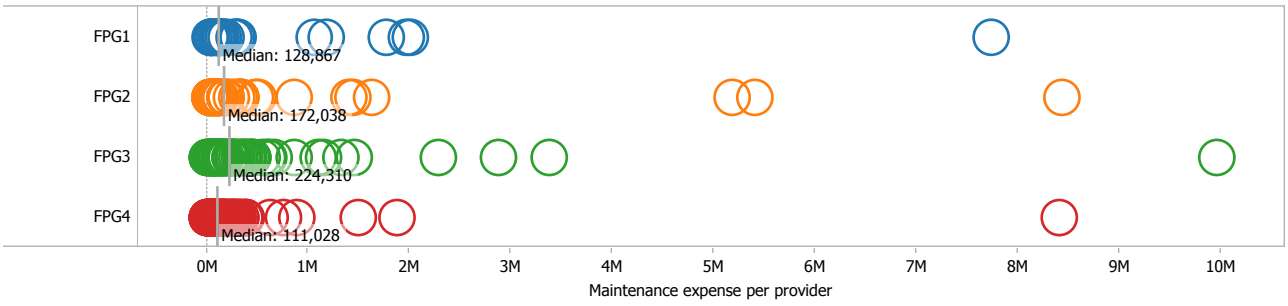
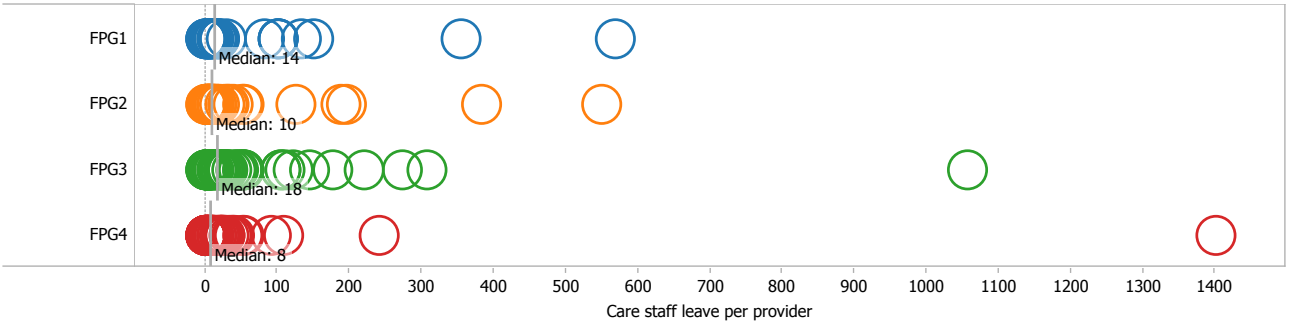
Survey Question 18a: Provider Financial Data

18a. Repairs and maintenance expense in FY13



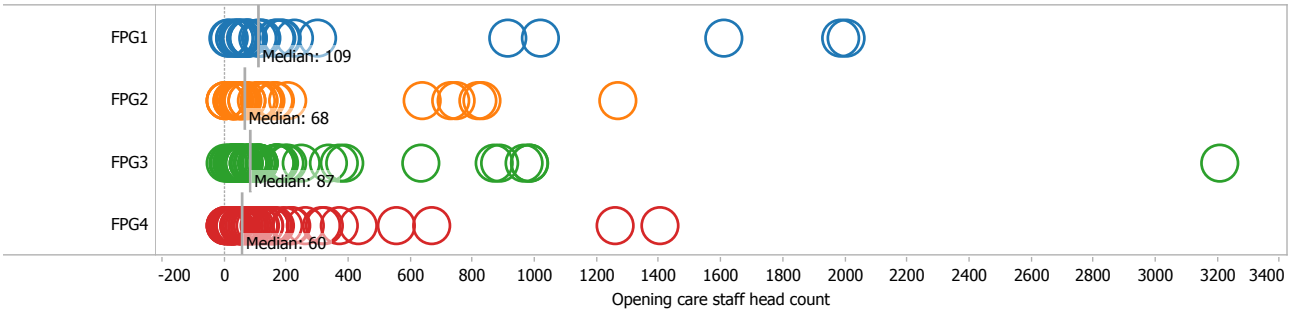
Survey Question 18b: Provider Financial Data

18b. Total care staff leavers in FY13



Survey Question 18c: Provider Financial Data

18c. Opening care staff headcount 01/07/2012



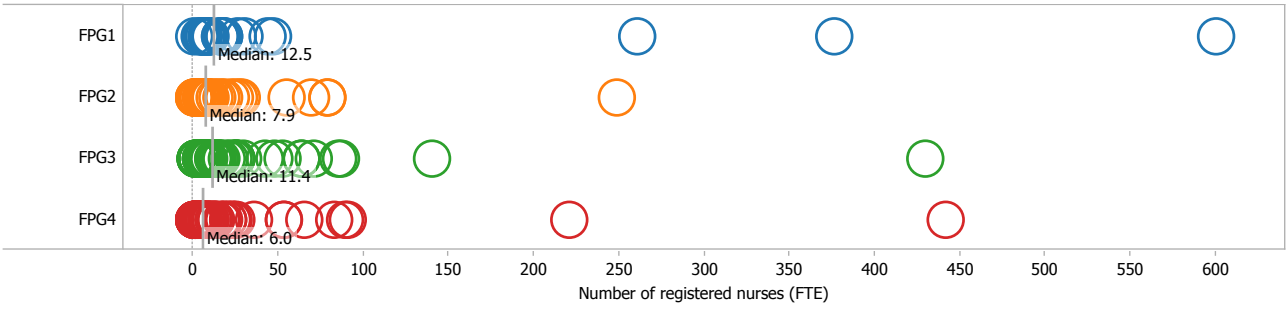
Survey Question 18d: Provider Financial Data

18d. Closing care staff headcount 30/06/2013

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

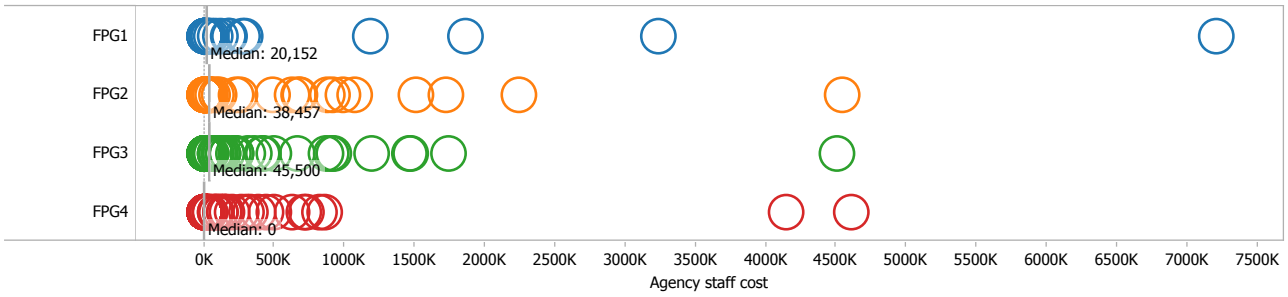
Survey Question 18e: Provider Financial Data

18e. Registered nurses (FTE) at 30/06/2013



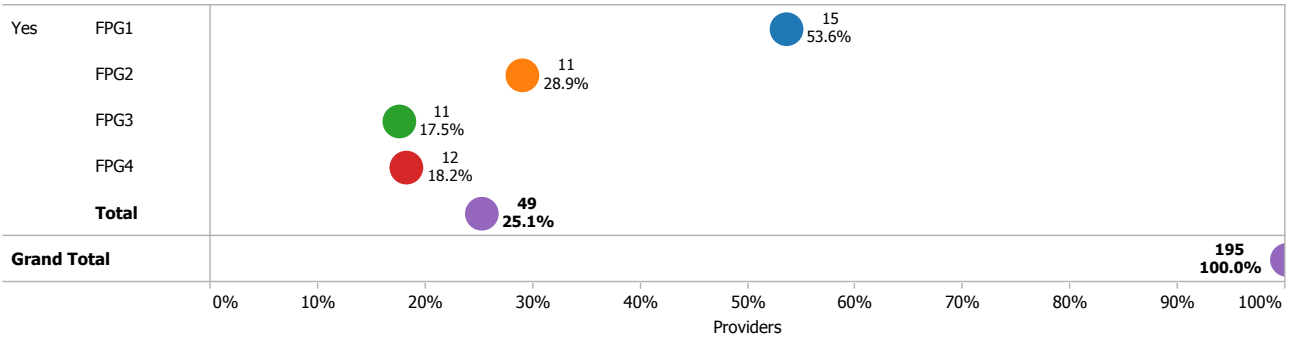
Survey Question 18f: Provider Financial Data

18f. Agency staff cost $ in FY13



Survey Question 19: Corporate Structure by Financial Performance Group (FPG)

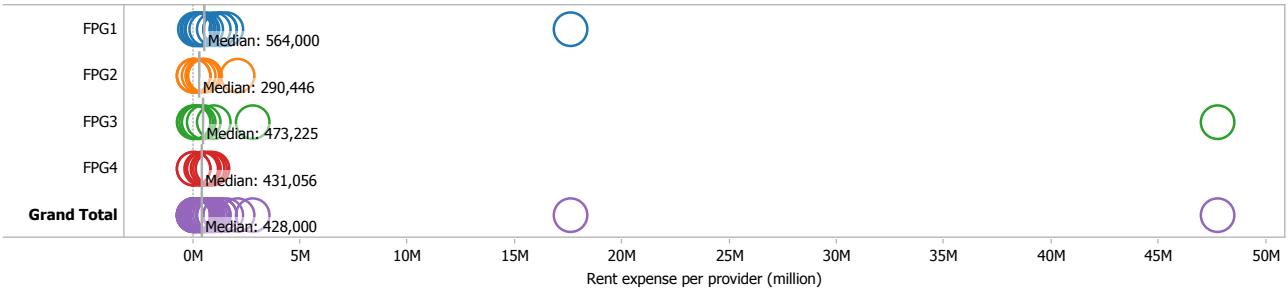
19. In FY13, did you hold your land and buildings in a related entity separate to your operating entity?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 20: Rent Expense per Provider by Financial Performance Group (FPG)

20. If yes, what was the FY13 rent expense in the operating entity?



The chart shows rent for those providers that paid rent.

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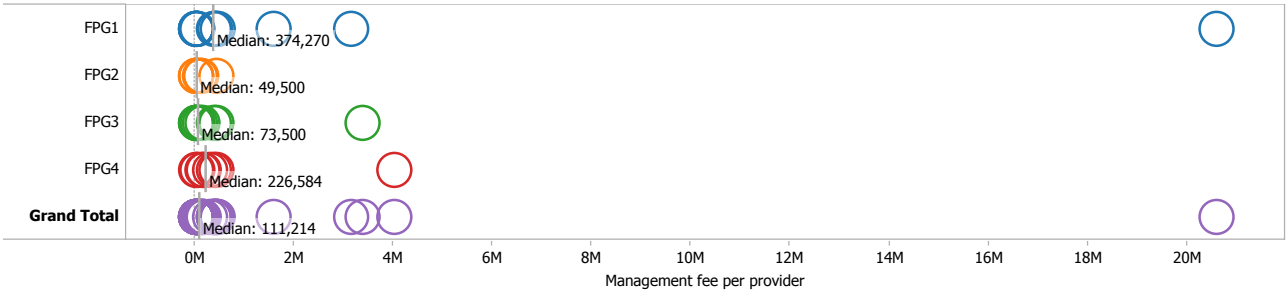
Survey Question 21: Management Fee per Provider by Financial Performance Group (FPG)

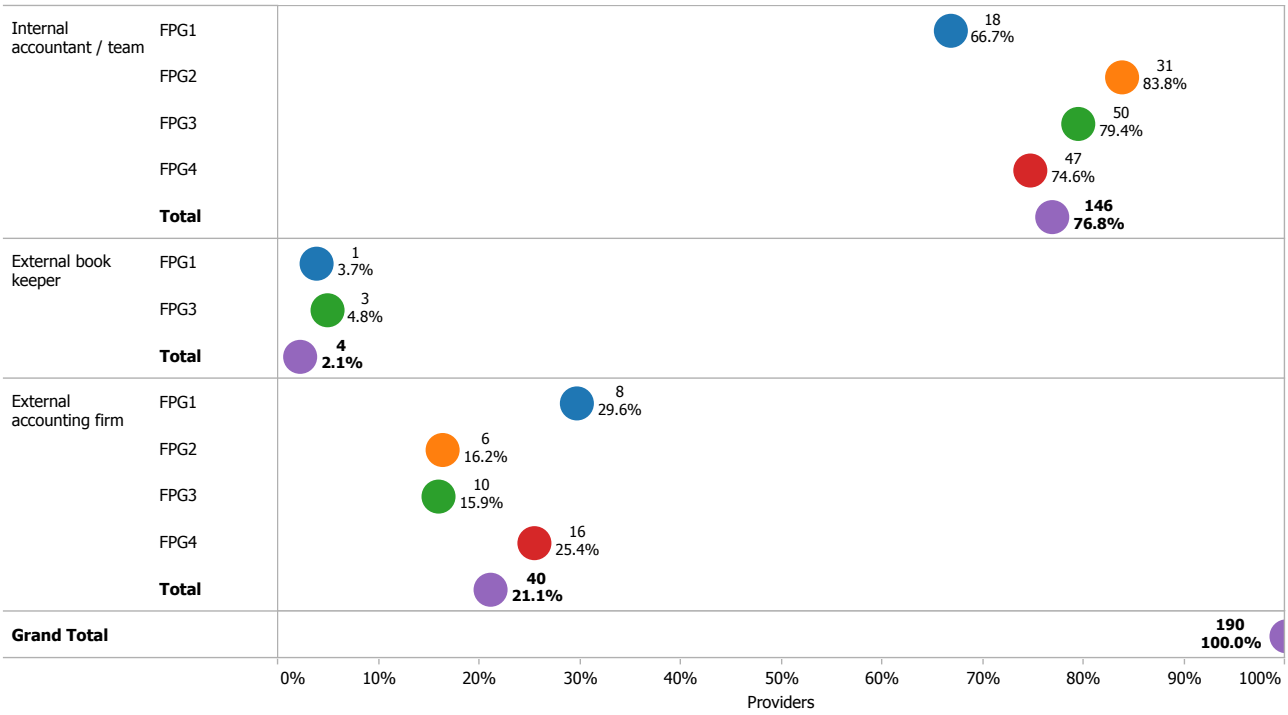
21. How much was the management fee that you paid to a related party entity?



The chart shows fees for those providers that paid a fee.

Survey Question 22: Finance Team by Financial Performance Group (FPG)

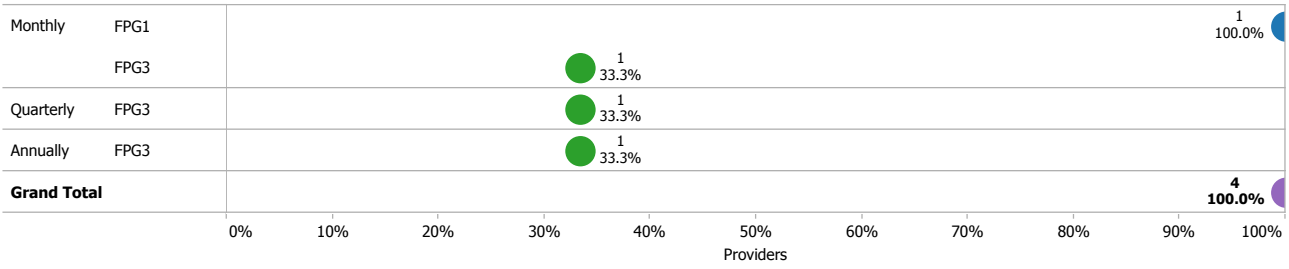
22. In FY 13, how did you manage your accounting requirements?



"Null" and "Unknown" responses are excluded.

Survey Question 23: Bookkeeper by Financial Performance Group (FPG)

23. If you use a bookkeeper, how often are your accounts reviewed by an external accountant?

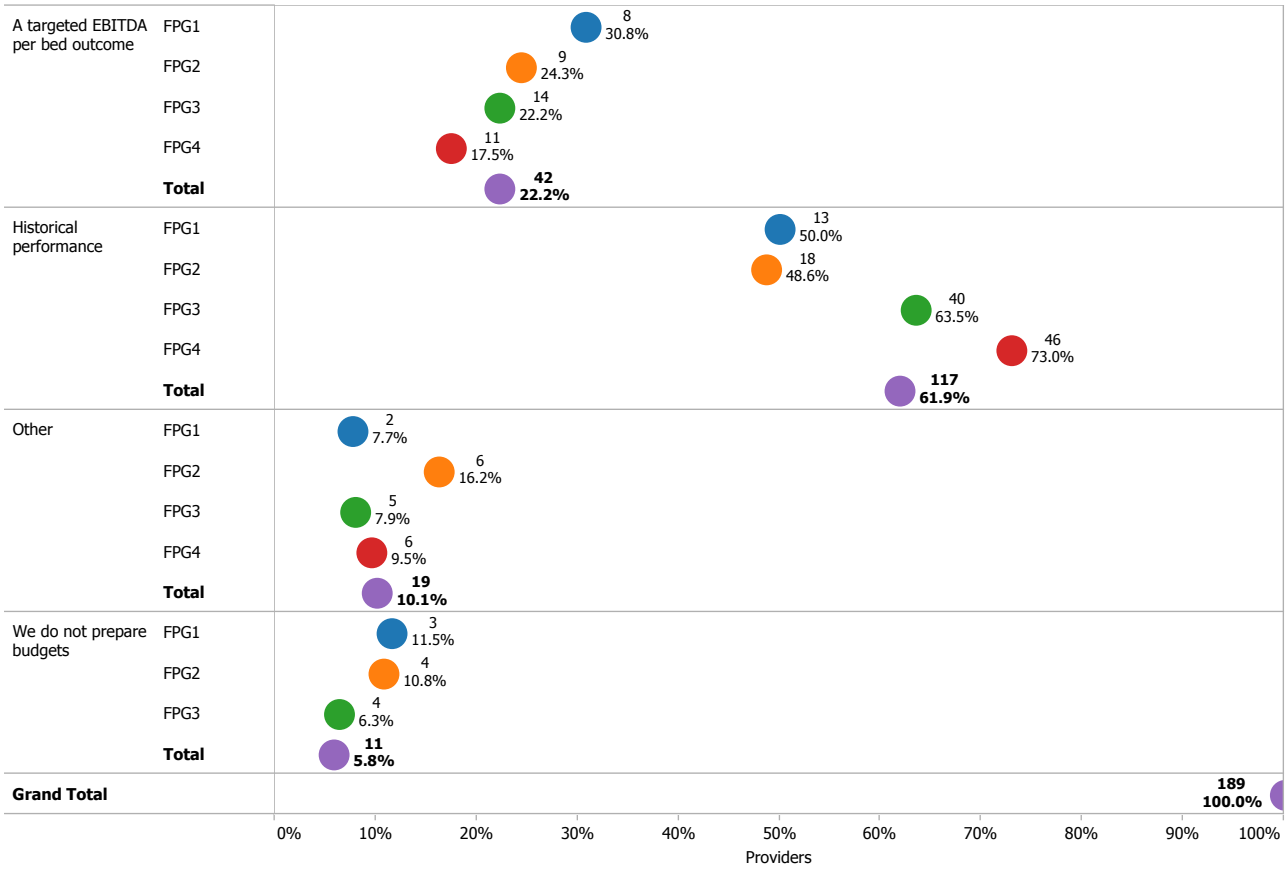


"Null" and "Unknown" responses are excluded.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Survey Question 24: Budget Preparation by Financial Performance Group (FPG)

24. On what basis were your FY13 budgets prepared?

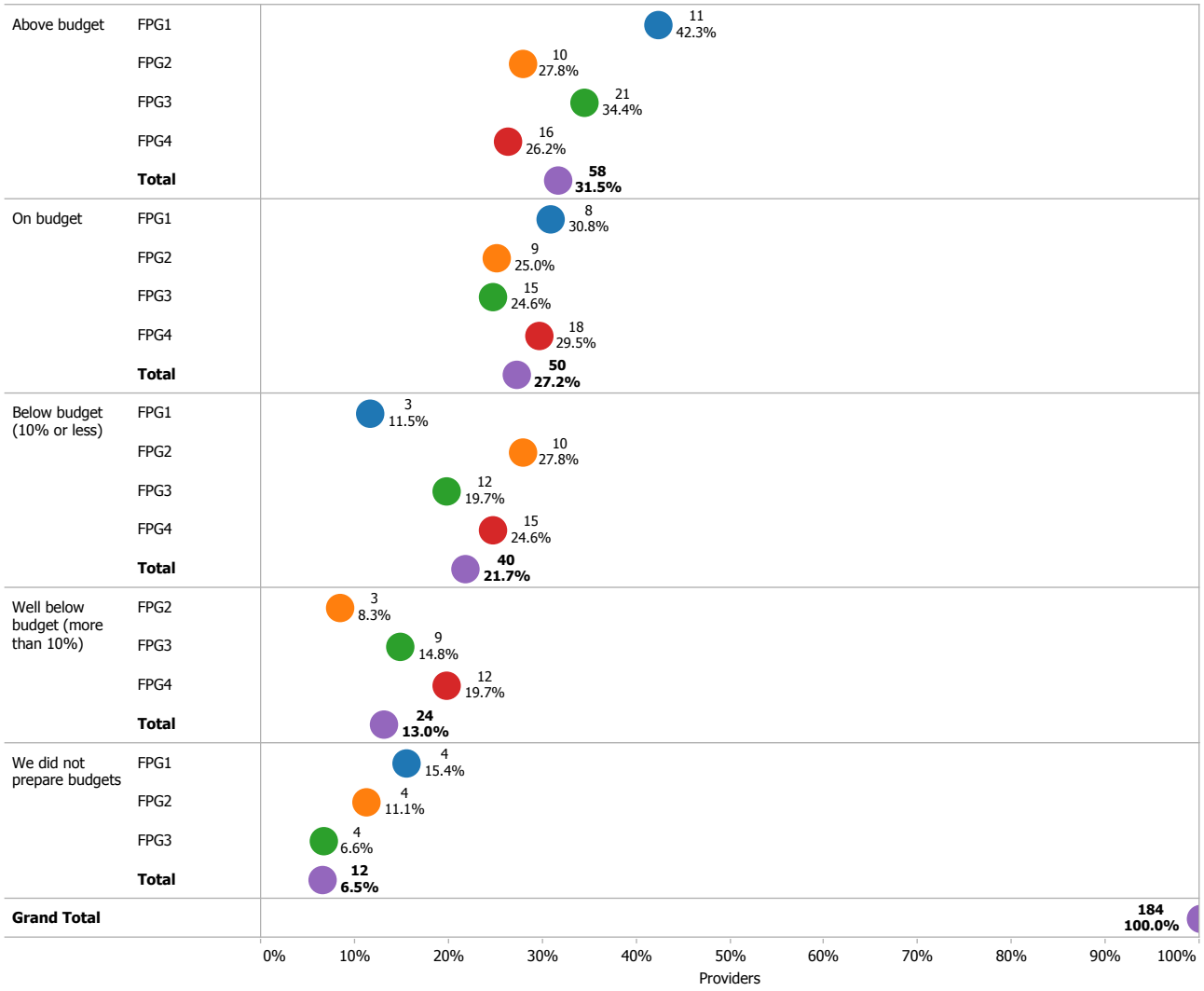


"Null" and "Unknown" responses are excluded.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Survey Question 25: FY13 Results by Financial Performance Group (FPG)

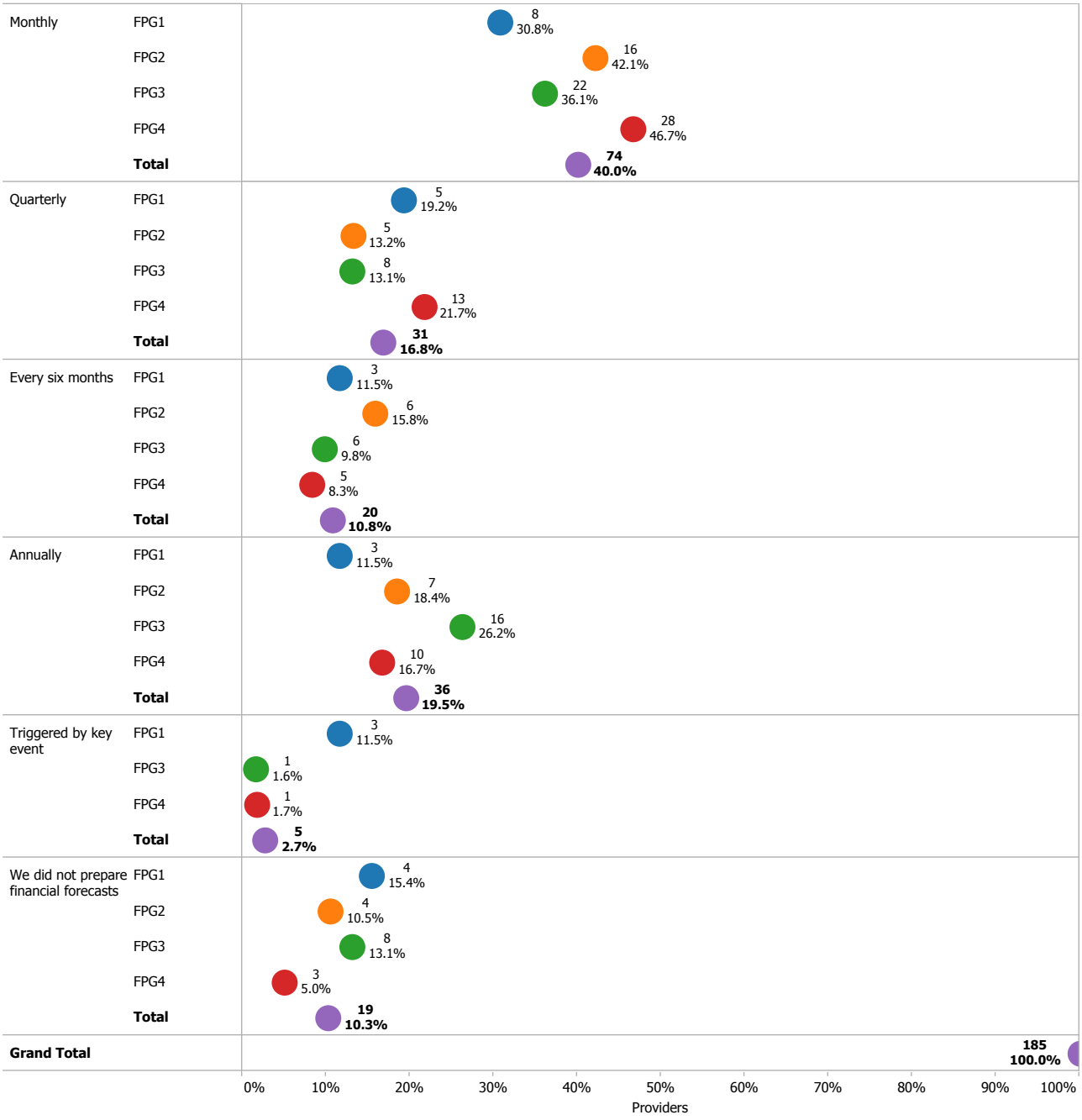
25. Was your FY13 provider actual EBITDA result in line with your budget?



"Null" and "Unknown" responses are excluded.

Survey Question 26: Forecasting Preparation by Financial Performance Group (FPG)

26. In FY13, how frequently did you prepare financial forecasts

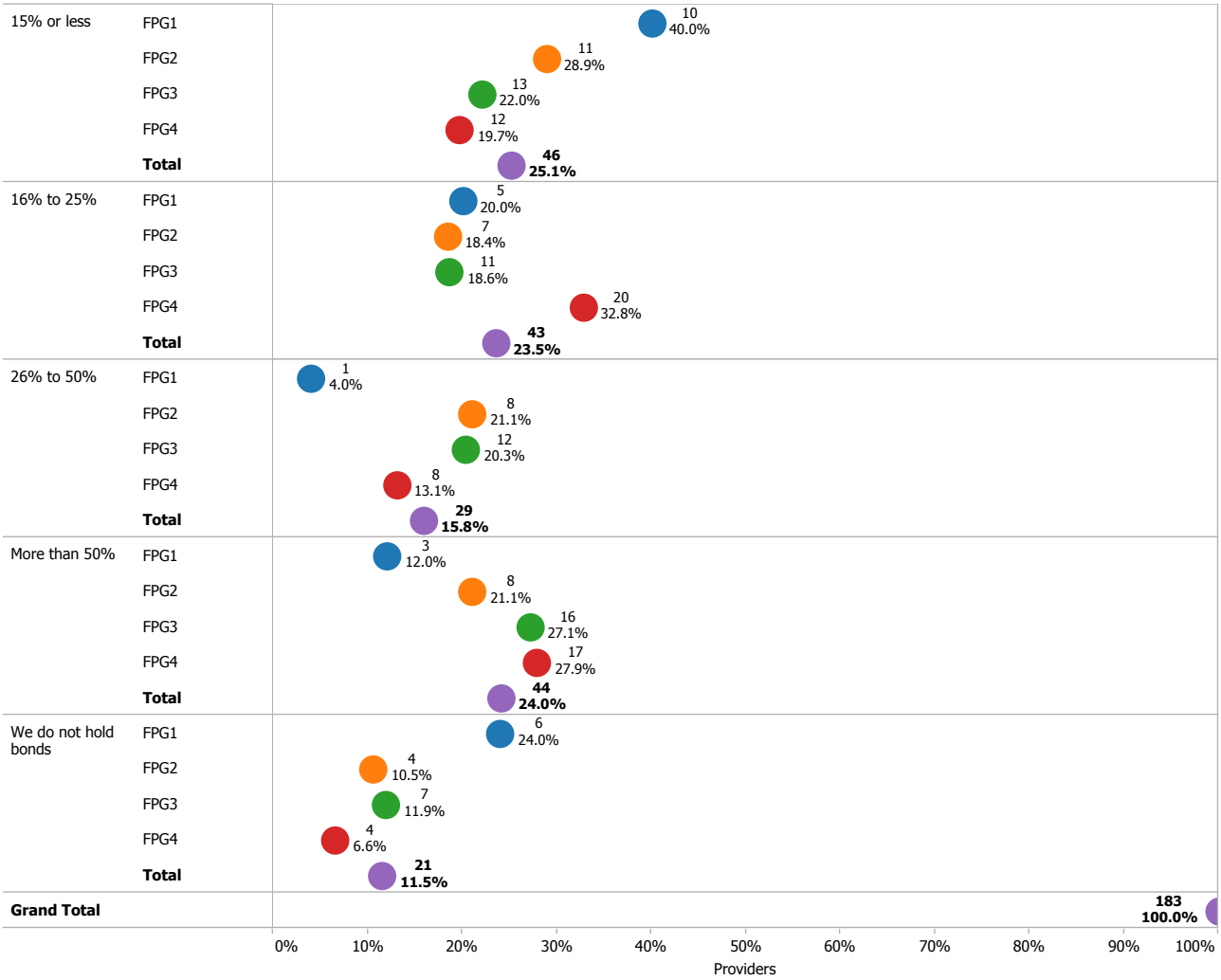


"Null" and "Unknown" responses are excluded.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Survey Question 27: Bond Management by Financial Performance Group (FPG)

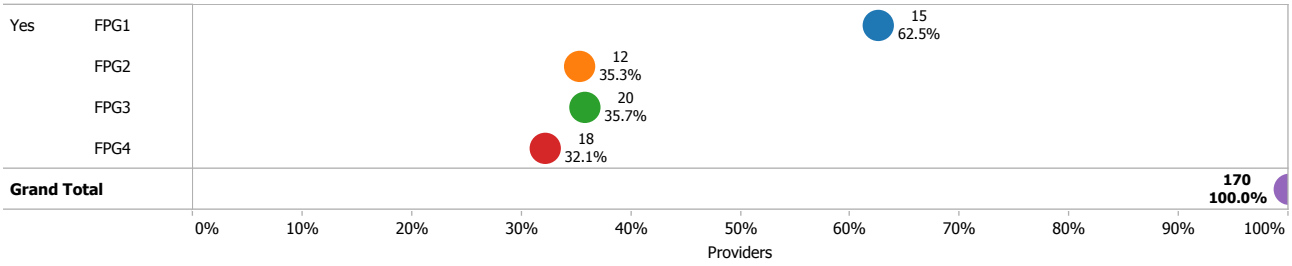
27. As per your liquidity management strategy, what is your targeted accommodation bond percentage level held in cash, cash equivalents or on call?



"Null" and "Unknown" responses are excluded.

Survey Question 28: Finance/Debt Facilities by Financial Performance Group (FPG)

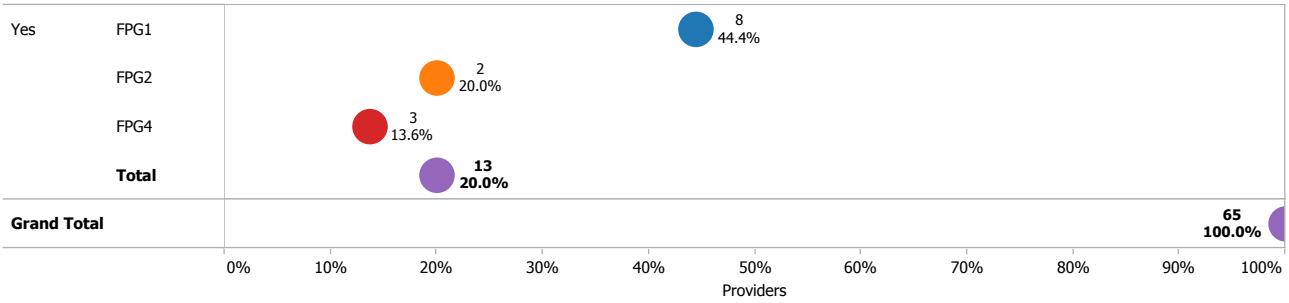
28. Do you have dedicated finance/debt facilities to supplement bond liquidity?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 29: Dividend Policy by Financial Performance Group (FPG)

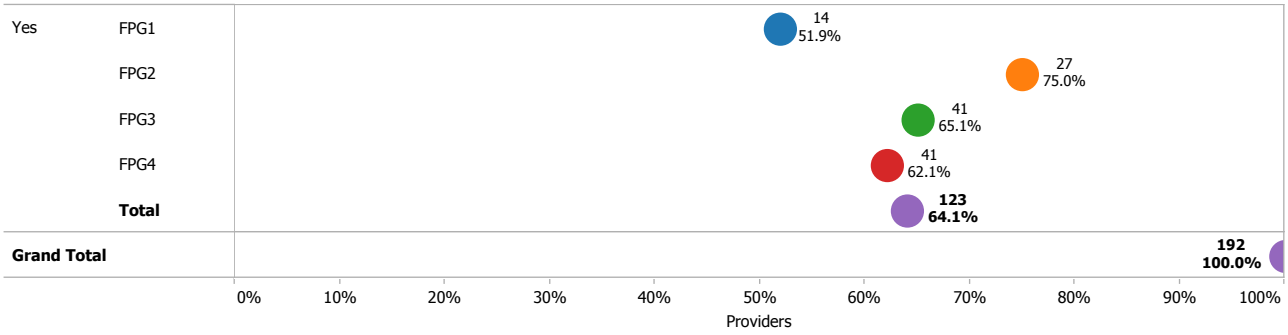
29. In FY13, did you have a formal dividend policy?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 30: Electronic Clinical System by Financial Performance Group (FPG)

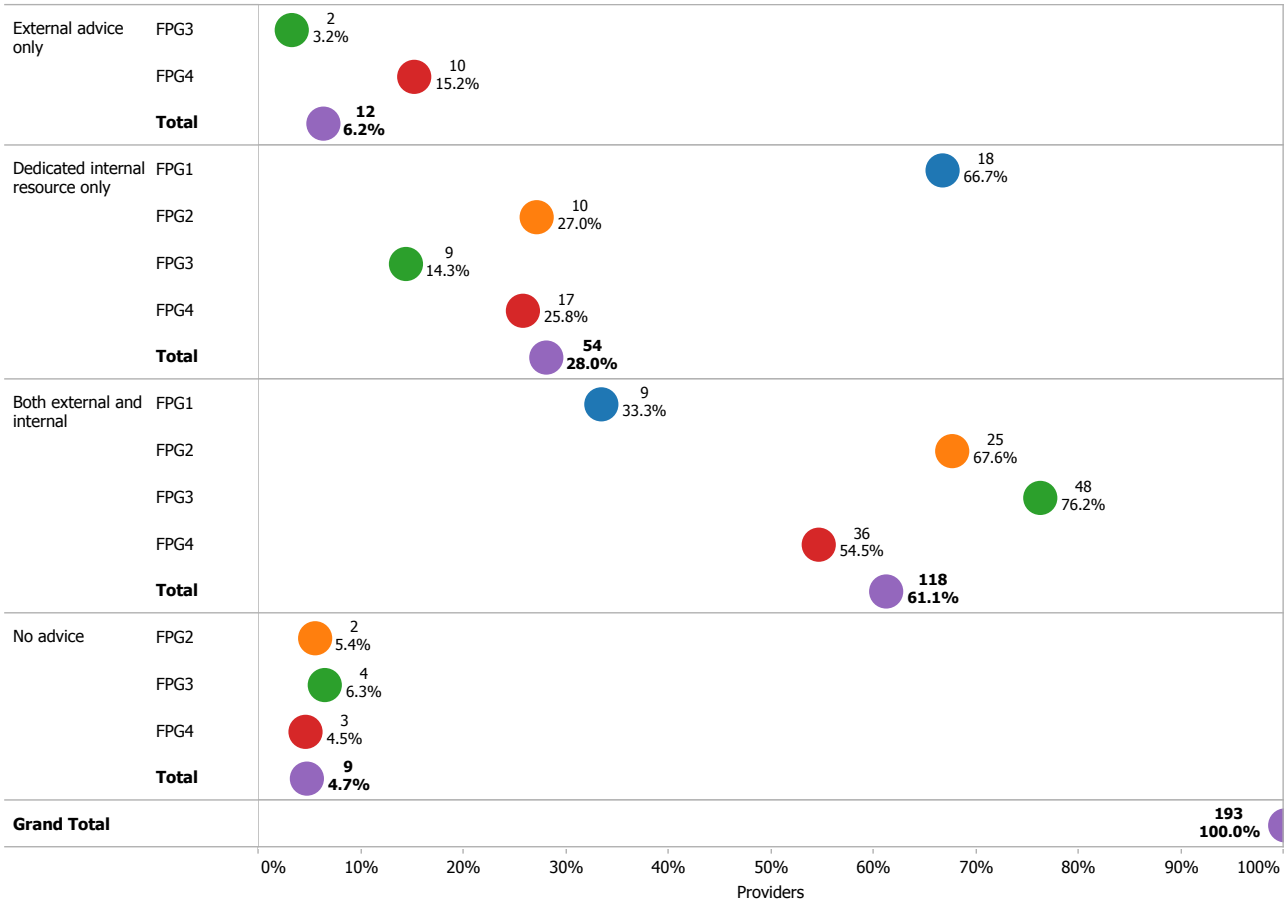
30. In FY13, did all of your facilities use a central IT system to suport clinical care delivery?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 31: ACFI Management by Financial Performance Group (FPG)

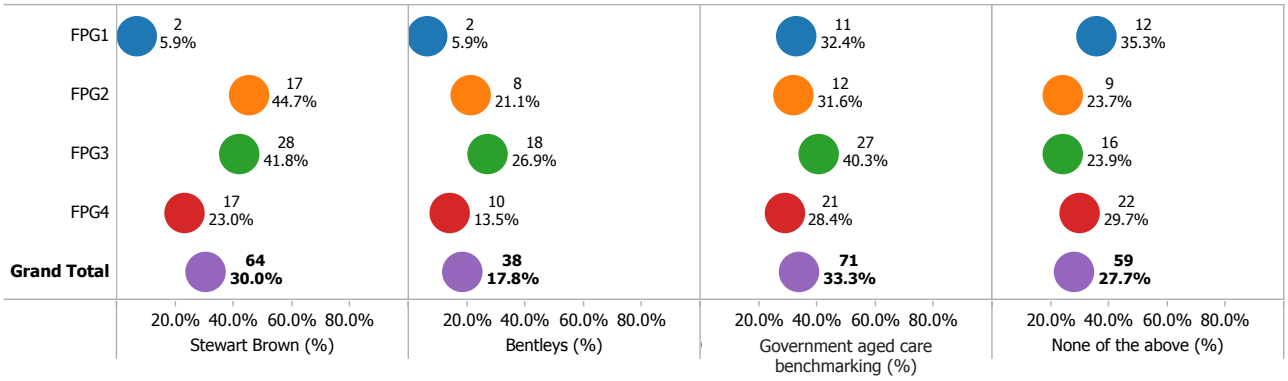
31. Have you obtained external advice and/or have dedicated internal resources to manage claims under ACFI?



"Null" and "Unknown" responses are excluded.

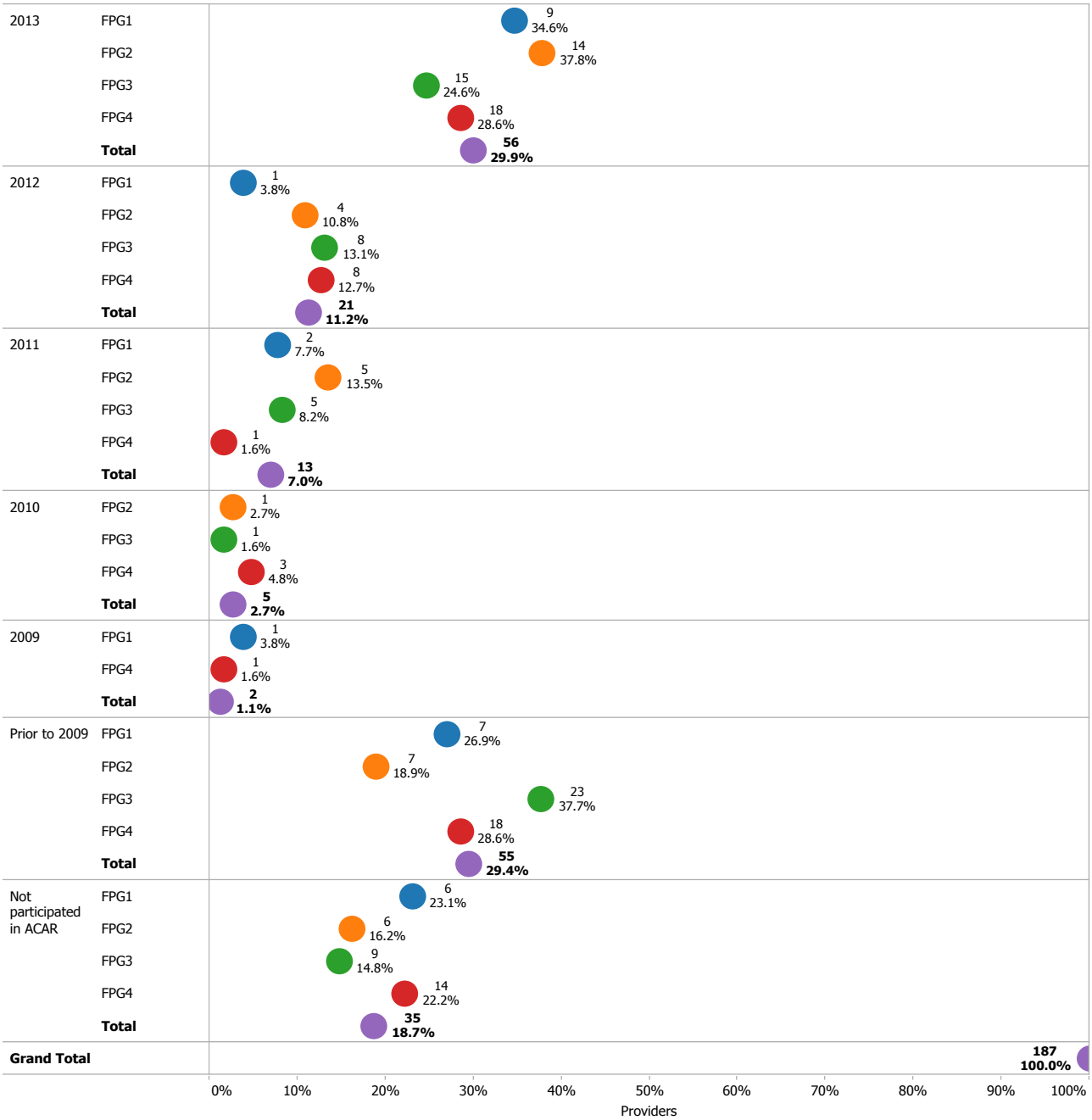
Survey Question 32: Benchmarking by Financial Performance Group (FPG)

32. Which of the following financial benchmarking studies do you regularly participate in?



Survey Question 33: Participation in ACAR Round by Financial Performance Group (FPG)

33. When did you last participate in an ACAR round for residential aged care (excluding 2014)?

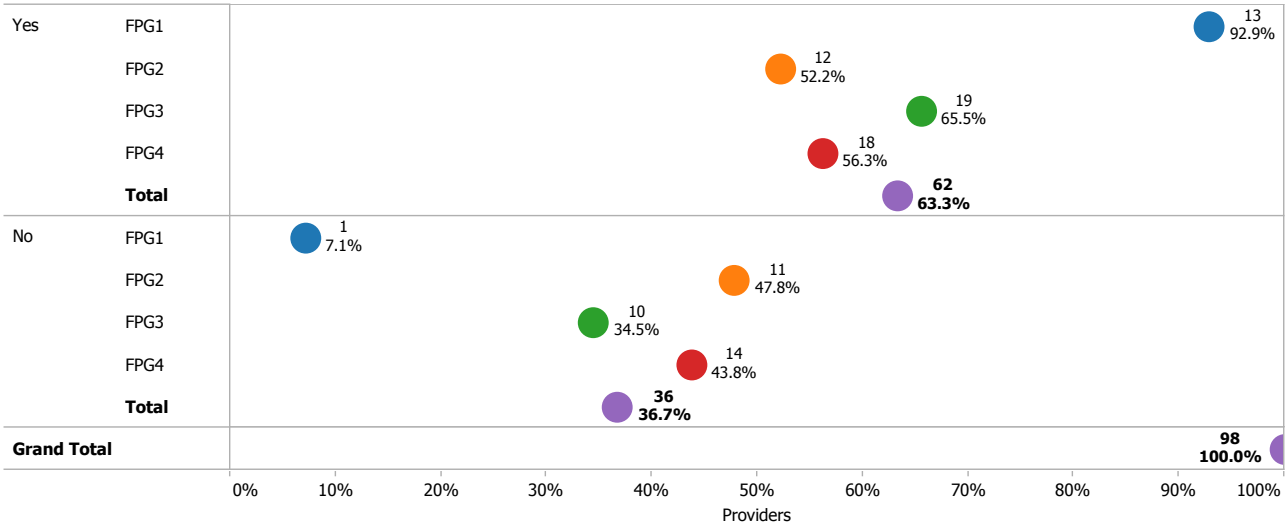


Null and Unknown responses are excluded.

This study considers financial performance only. Issues of choice, access and quality of care, while important, are not part of this study.

Survey Question 34: Success in ACAR Round by Financial Performance Group (FPG)

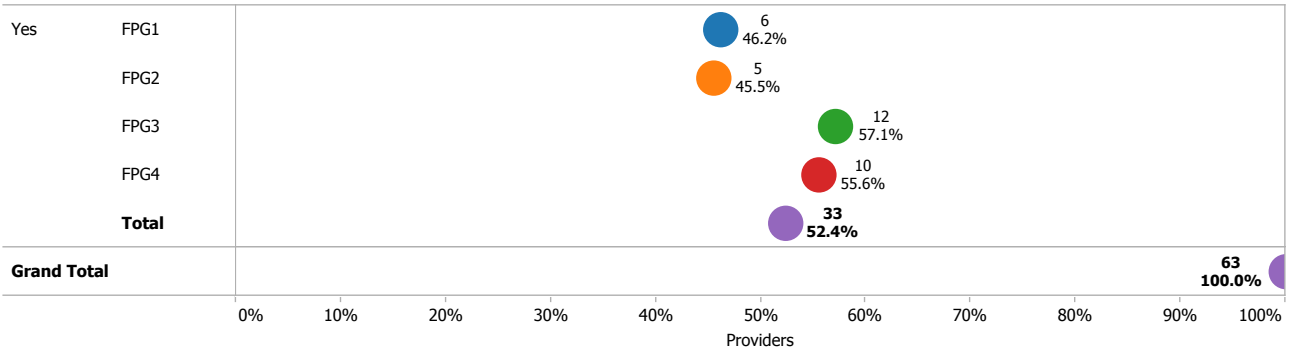
34. If you participated in an ACAR round in the last 5 years (ie. 2009-2013) were you successful in your most recent attempt?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 35: Beds Online by Financial Performance Group (FPG)

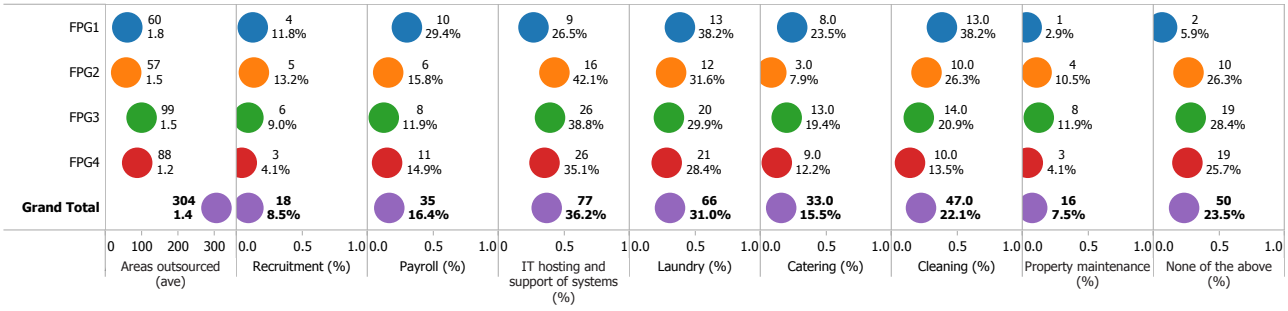
35. As a result of your success in applying for extra beds, are your beds currently online?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 36: Outsourcing Areas by Financial Performance Group (FPG)

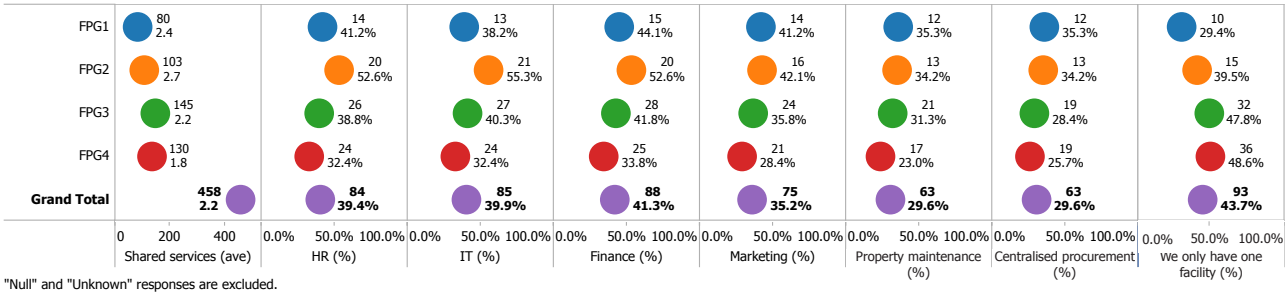
36. In FY13, which of the following areas did you outsource to an external provider?



"Null" and "Unknown" responses are excluded.

Survey Question 37: Shared Services by Financial Performance Group (FPG)

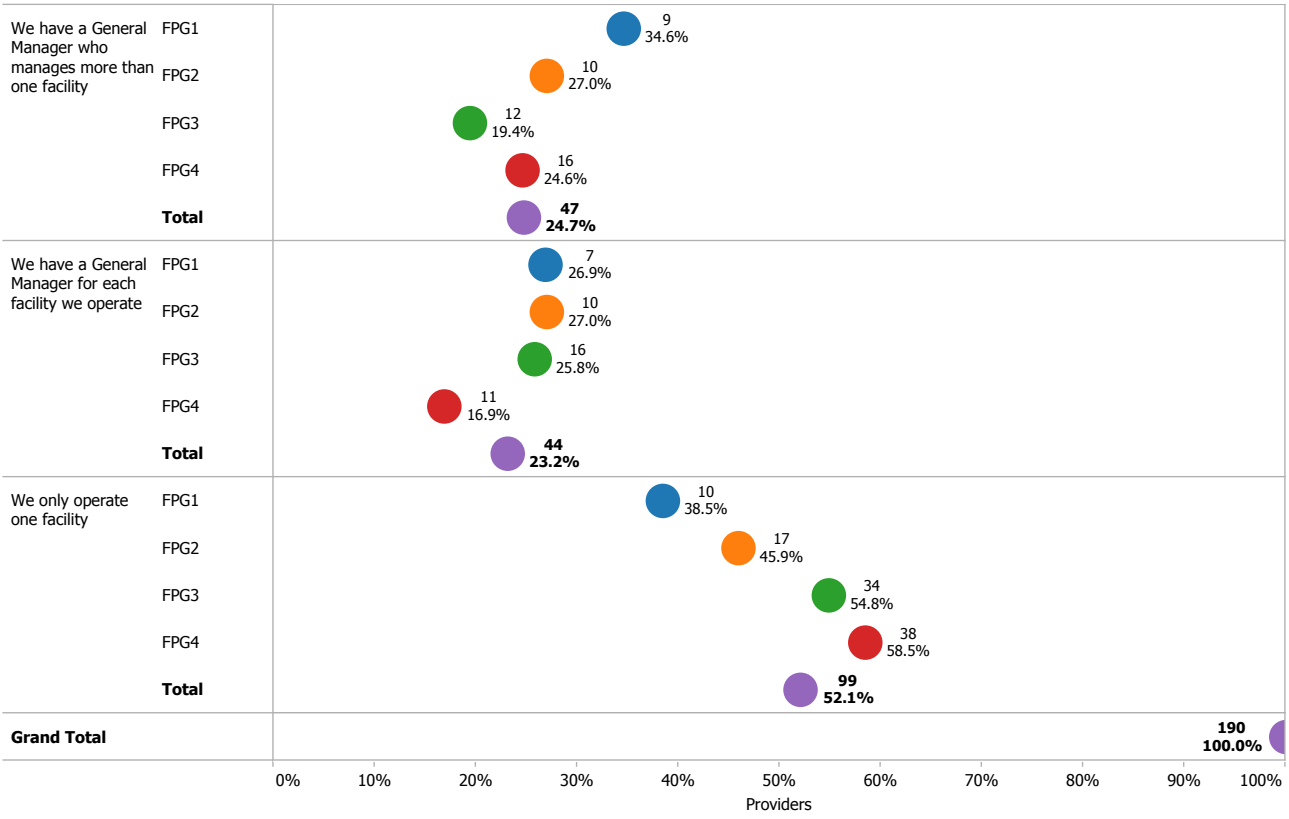
37. If you have more than one facility, do you run shared services in the following areas across all your facilities?



"Null" and "Unknown" responses are excluded.

Survey Question 38: Multi-Facility Management by Financial Performance Group (FPG)

38. If you operate more than one facility, please select the statement that best describes your management structure.



"Null" and "Unknown" responses are excluded.

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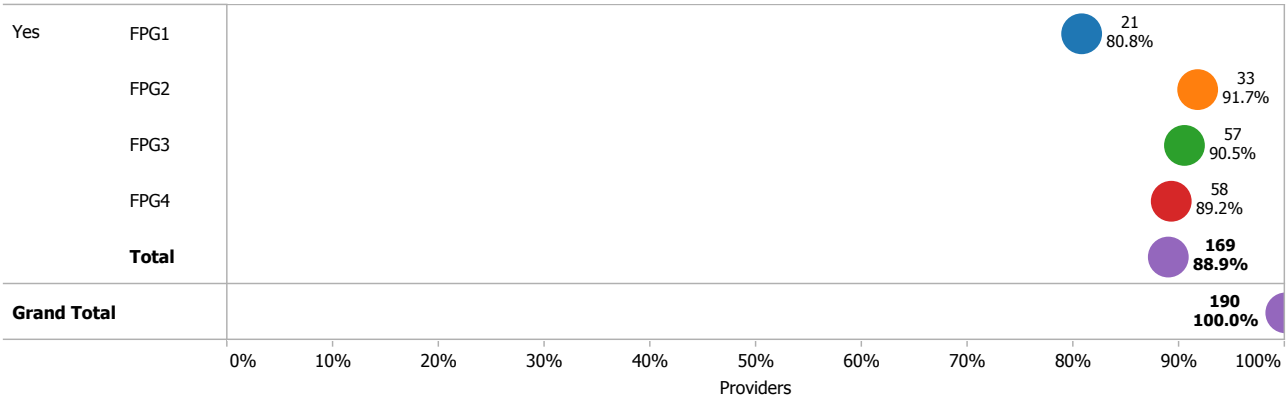
Survey Question 39: Volunteer Staff by Financial Performance Group (FPG)

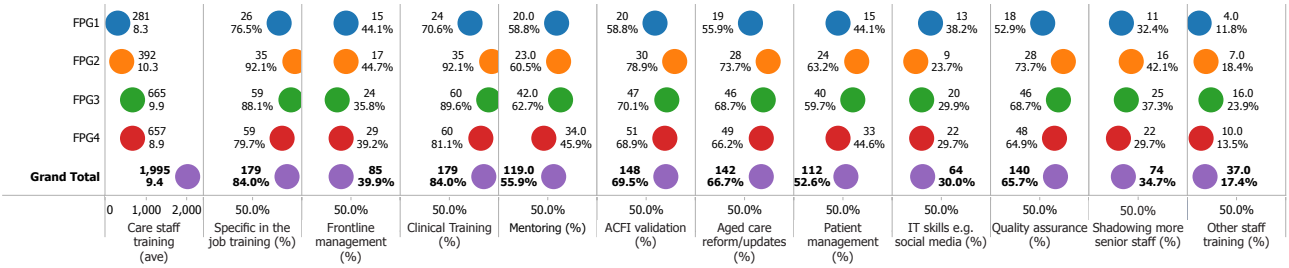
39. In FY13, did you have volunteer staff?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

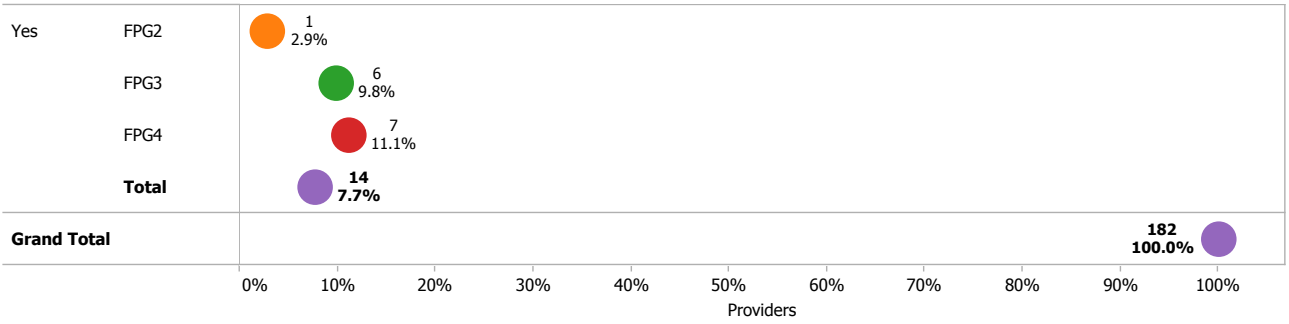
Survey Question 40: Care Staff Training by Financial Performance Group (FPG)

40. Which of the following initiatives did you have in place in FY13 to upskill your care staff?



Survey Question 41: Unmet Outcomes from Accreditation

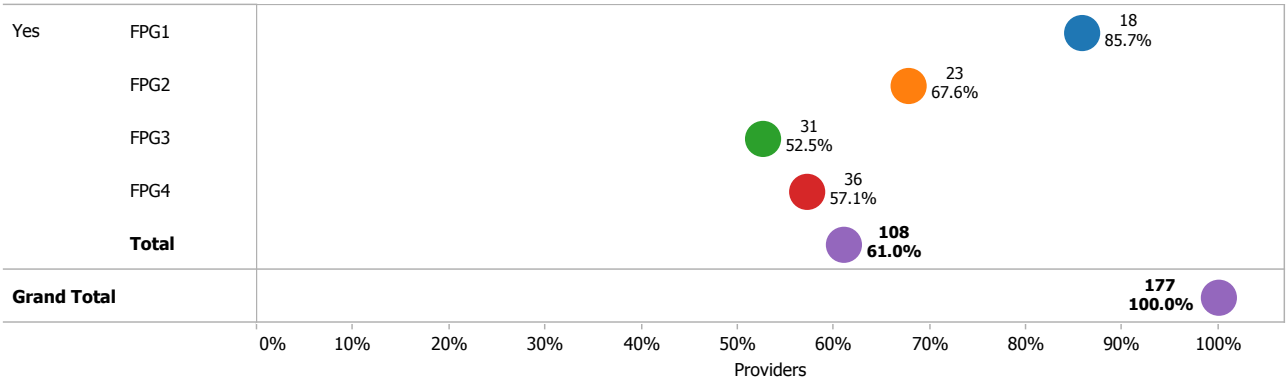
41. In FY13, did you have any unmet outcomes from an accreditation visit?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

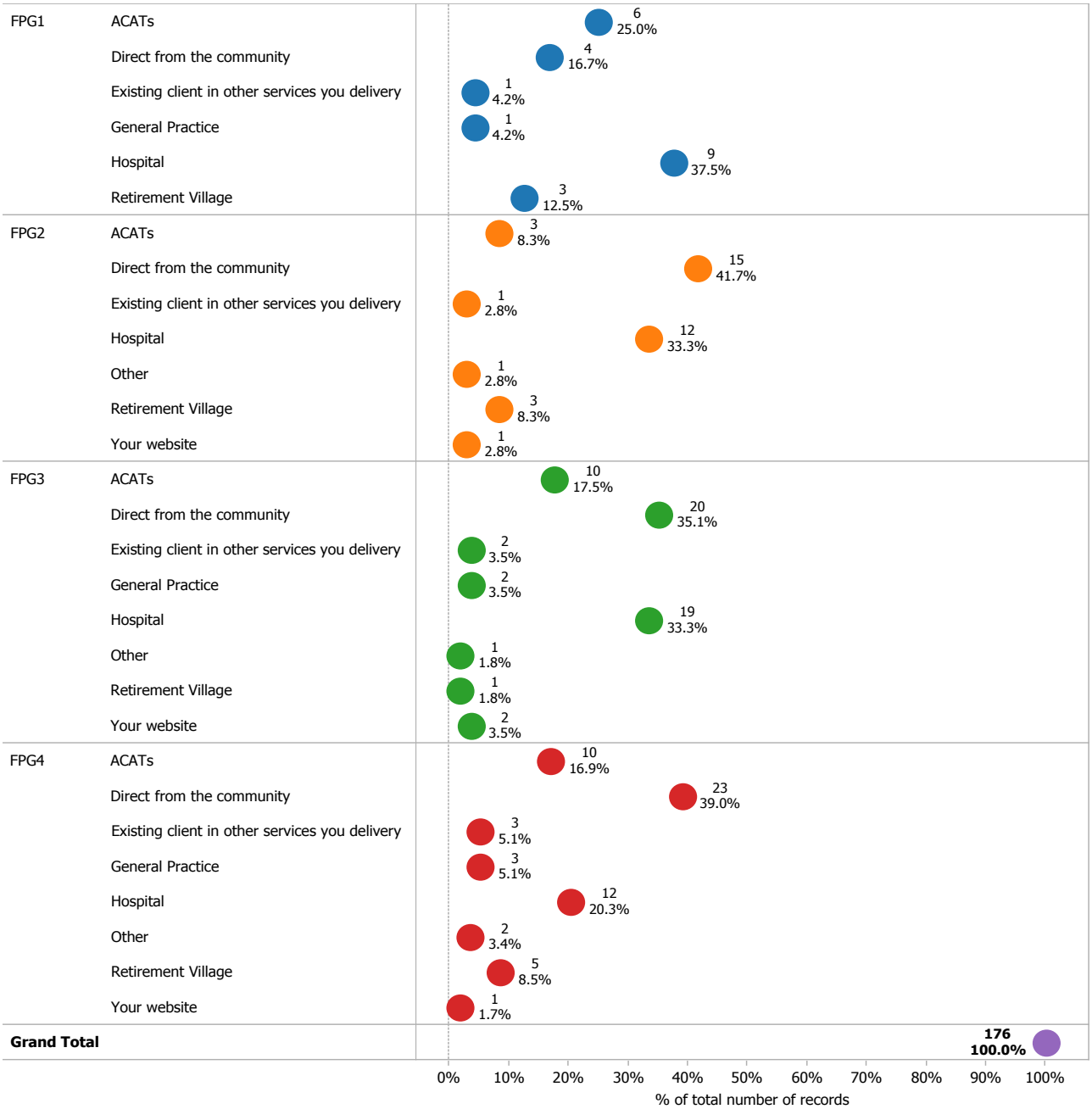
Survey Question 42: Clear Market Position/Target Resident Profile

42. Did you have a clear market position/target resident profile in FY13



Survey Question 43: Resident Source

43. In FY 13, where did most of your residents come from? (Rank 1 source)



"Null" and "Unknown" responses are excluded.

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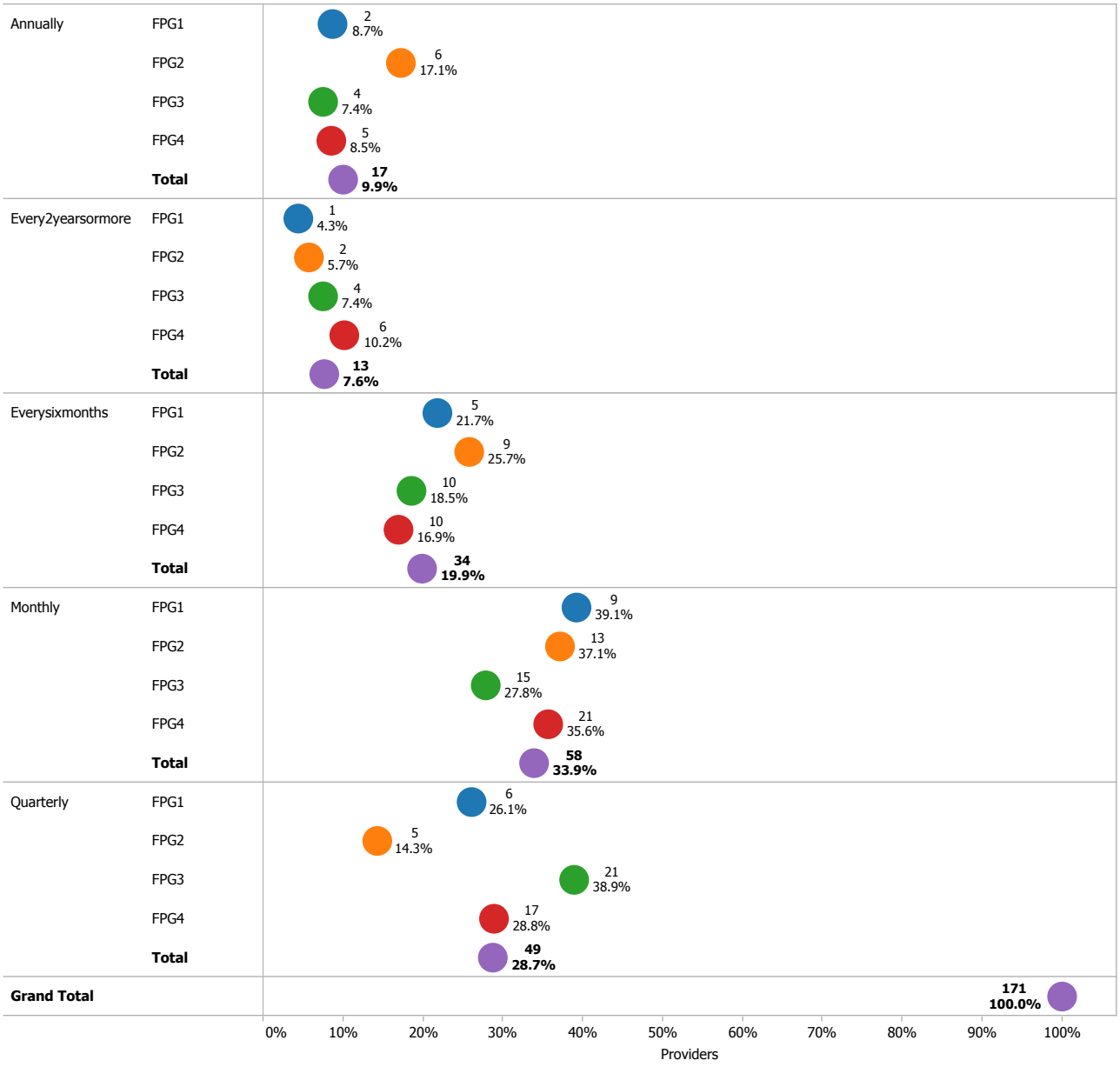
Survey Question 44: Website Update

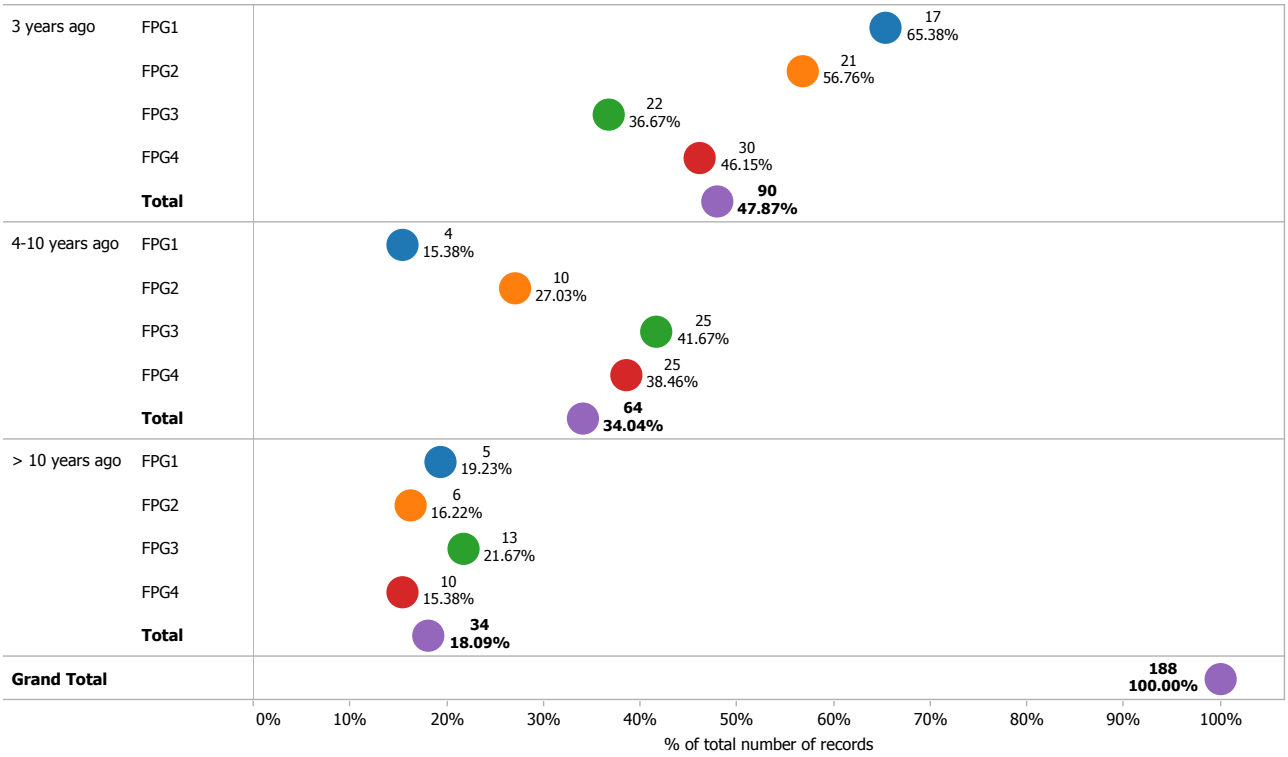
44. How often is your Website reviewed and updated?



"Null" and "Unknown" responses are excluded.

Survey Question 45: Brand/Logo

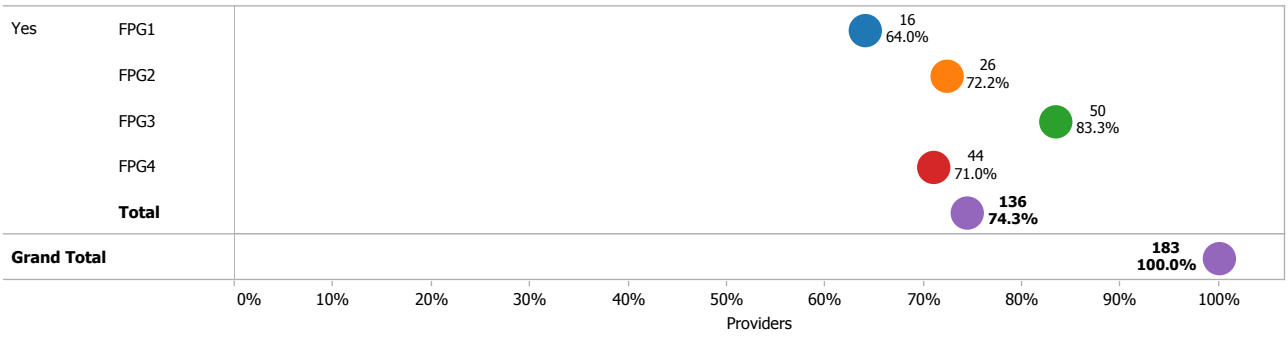
45. When was your company logo and branding last updated?



"Null" and "Unknown" responses are excluded.

Survey Question 46: Engagement with Other Providers

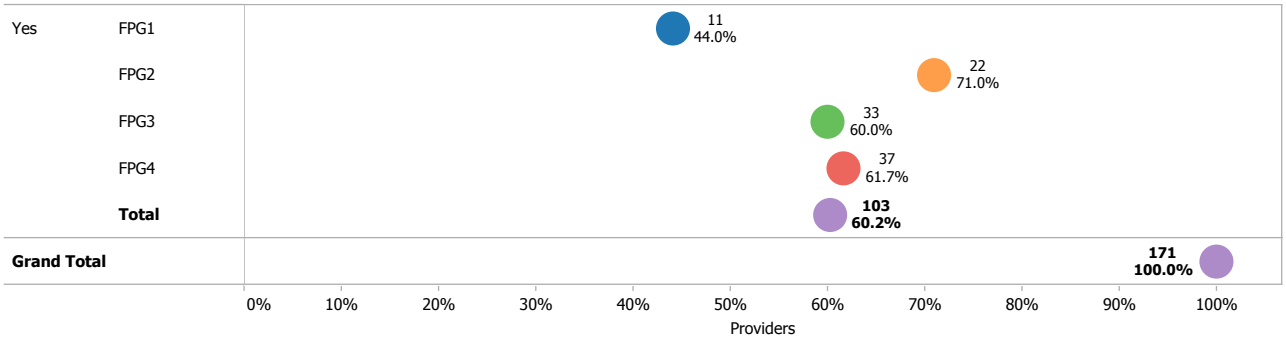
46. Do you regularly meet with other aged care providers to discuss resident needs, reforms, staff needs, operational structure efficiencies, ACFI etc.?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 47: Demographic Research

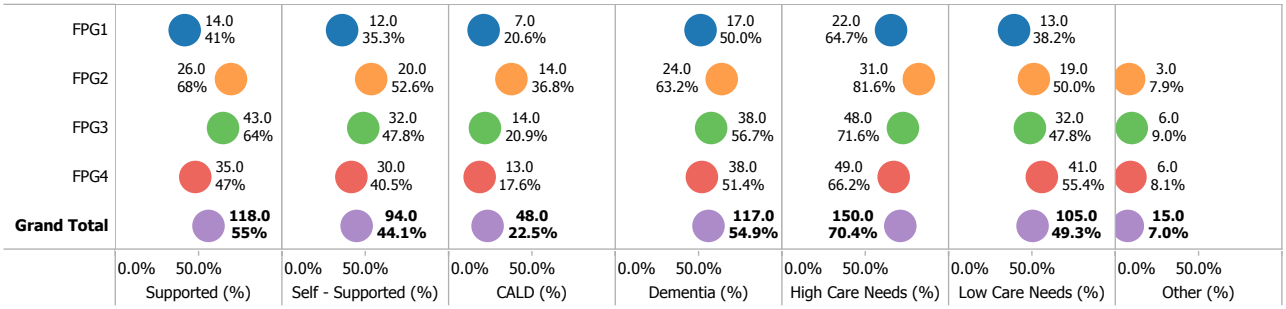
47. Do you perform research on what the demographic requirements may be in each of your facility's local area in the next 10/20 years?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 48: Resident Types

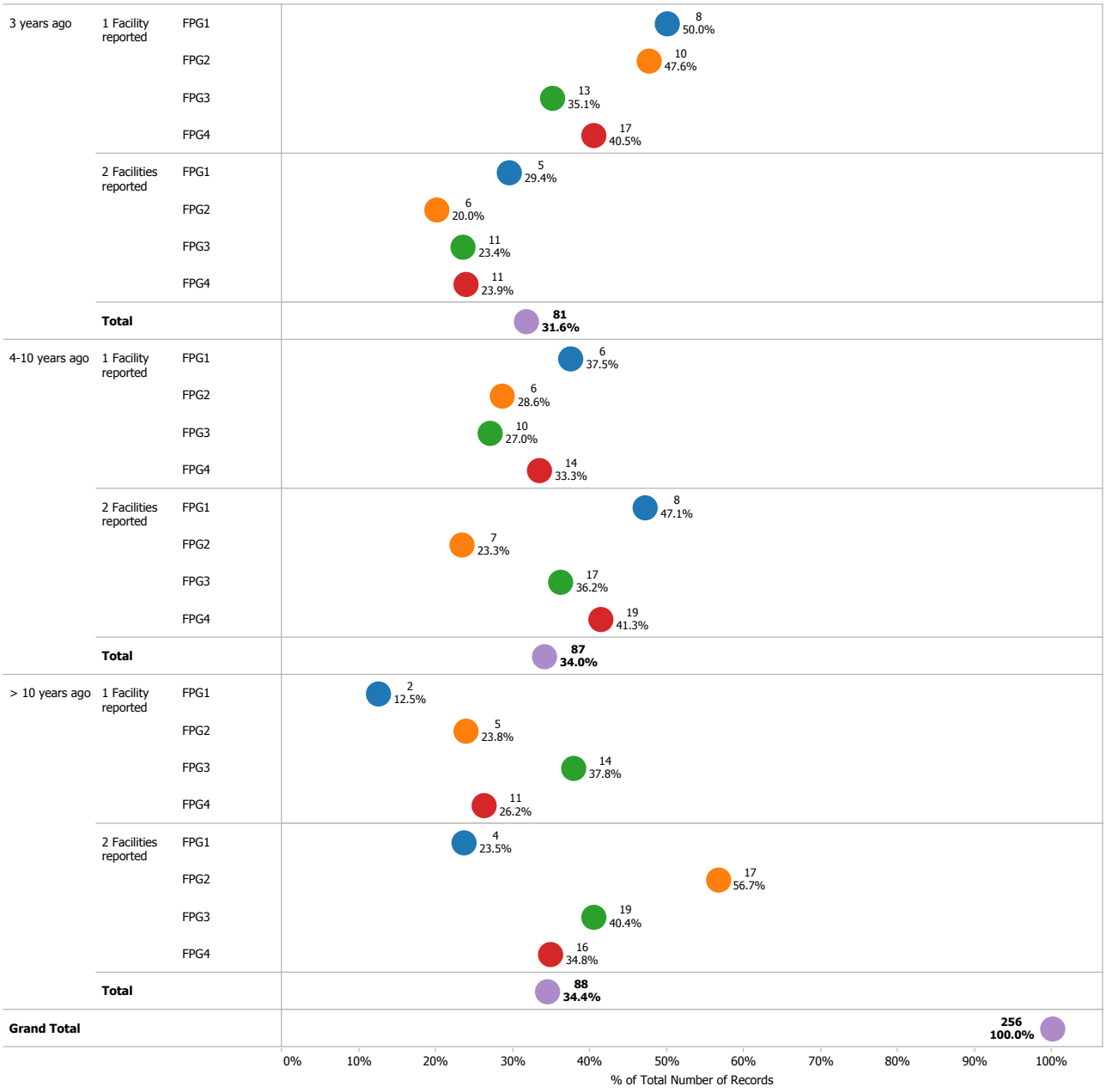
48. Please tell us the types of residents you focused on in FY13



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 49: Last Refurbishment

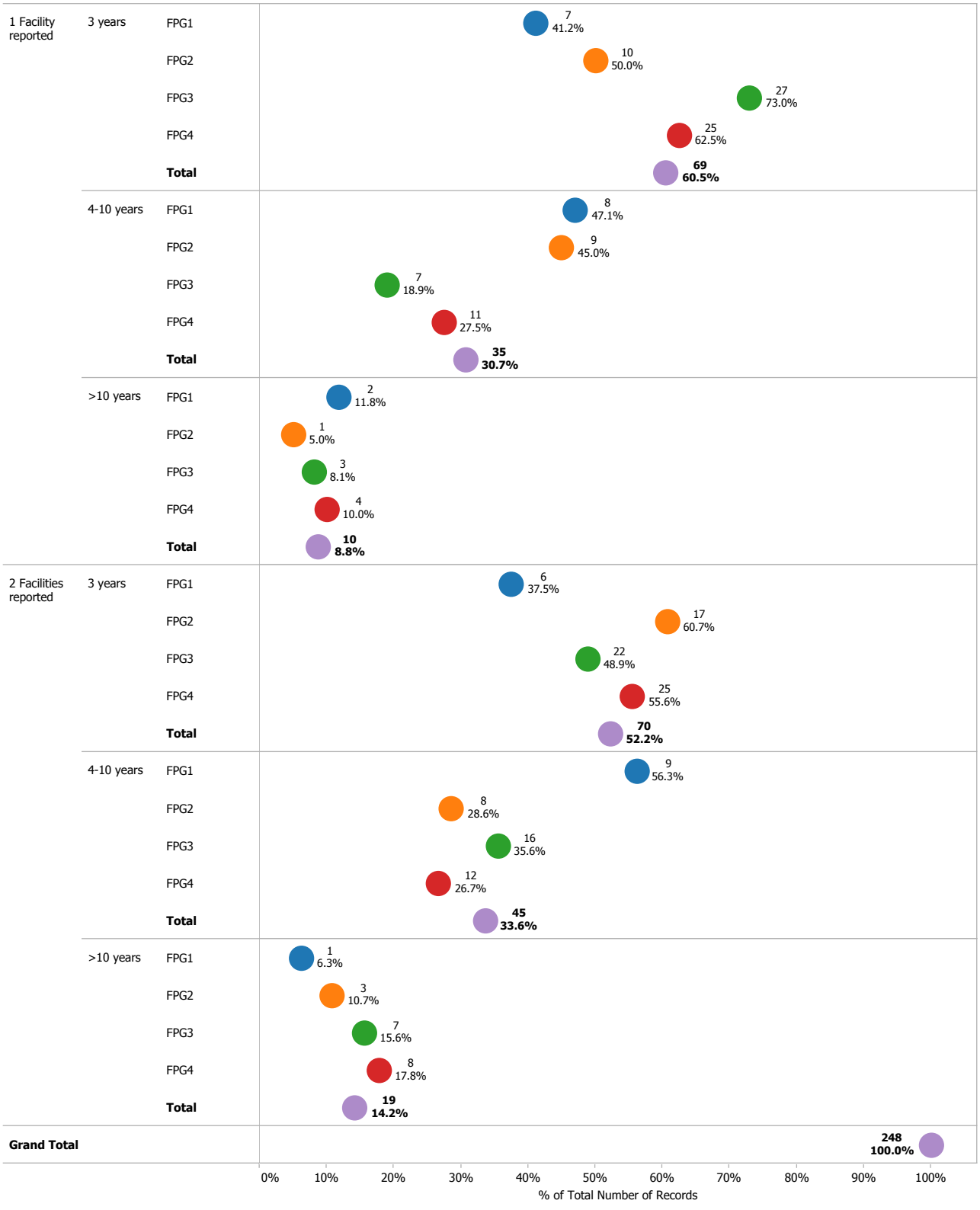
49. When did you last undertake a significant refurbishment of your facility?



"Null" and "Unknown" responses are excluded.

Survey Question 50: Next Planned Refurbishment

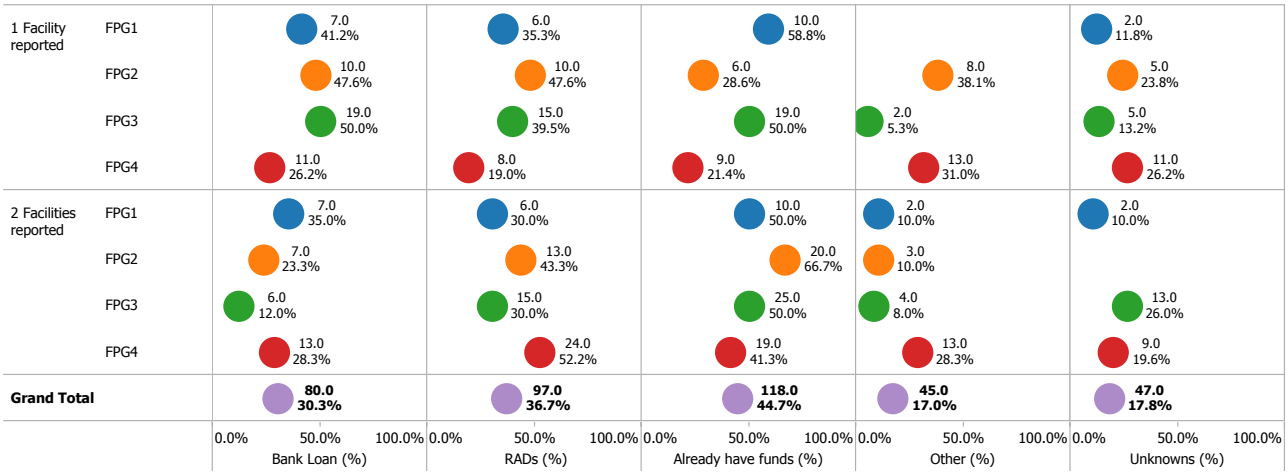
50. When do you expect to refurbish again in the future?



"Null" and "Unknown" responses are excluded.

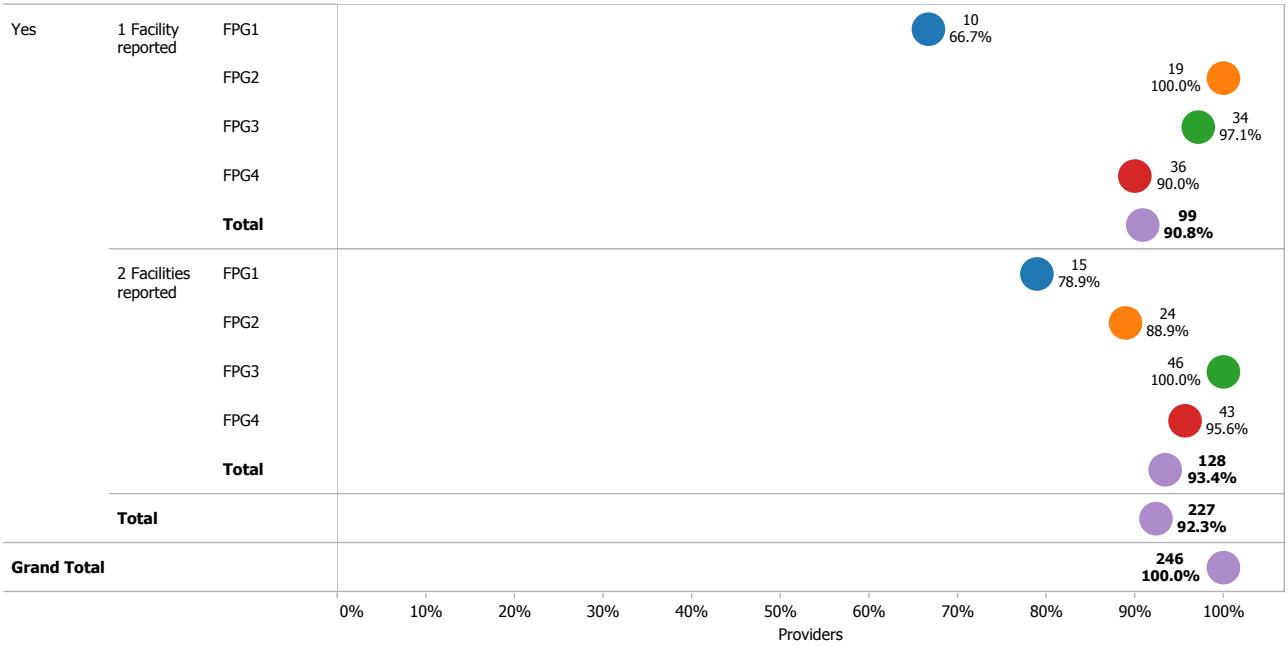
Survey Question 51: Funding Refurbishment

51. How do you plan to fund refurbishment in the future?



Survey Question 52: Review of Financial Information

52. In FY13, did your Facility Manager or DoN review financial/management reports on a monthly basis?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

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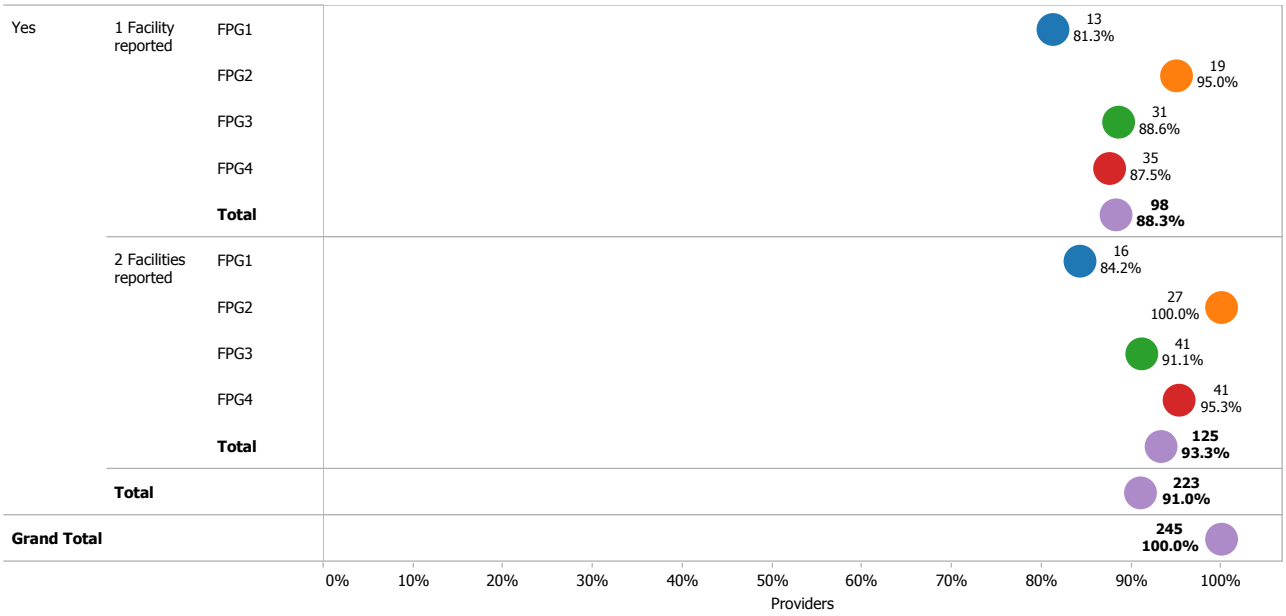
Survey Question 53: Measurement of Staffing Cost

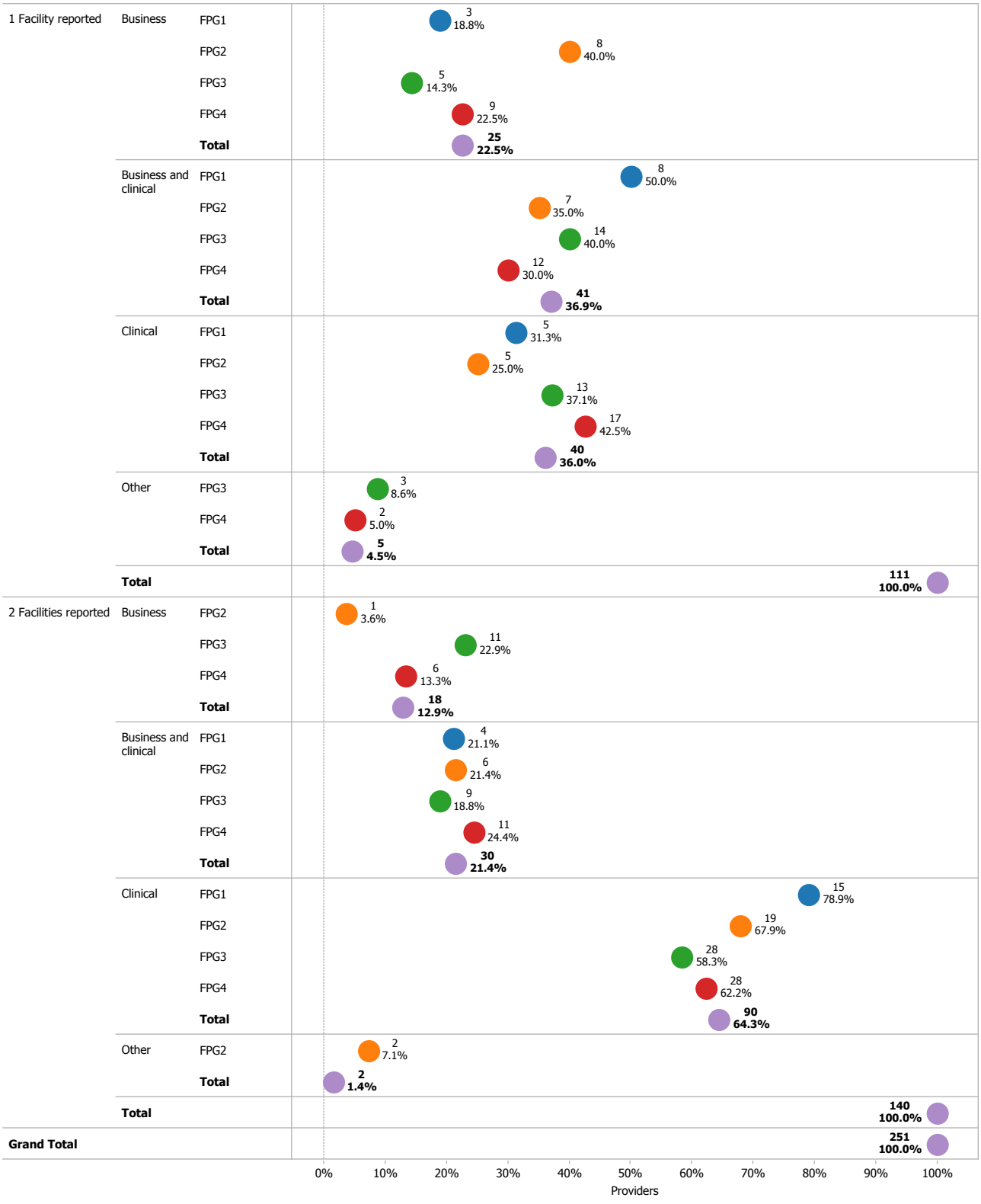
53. In FY13, did your facility measure and monitor staffing costs to operational income on a regular basis?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 54: Facility Management

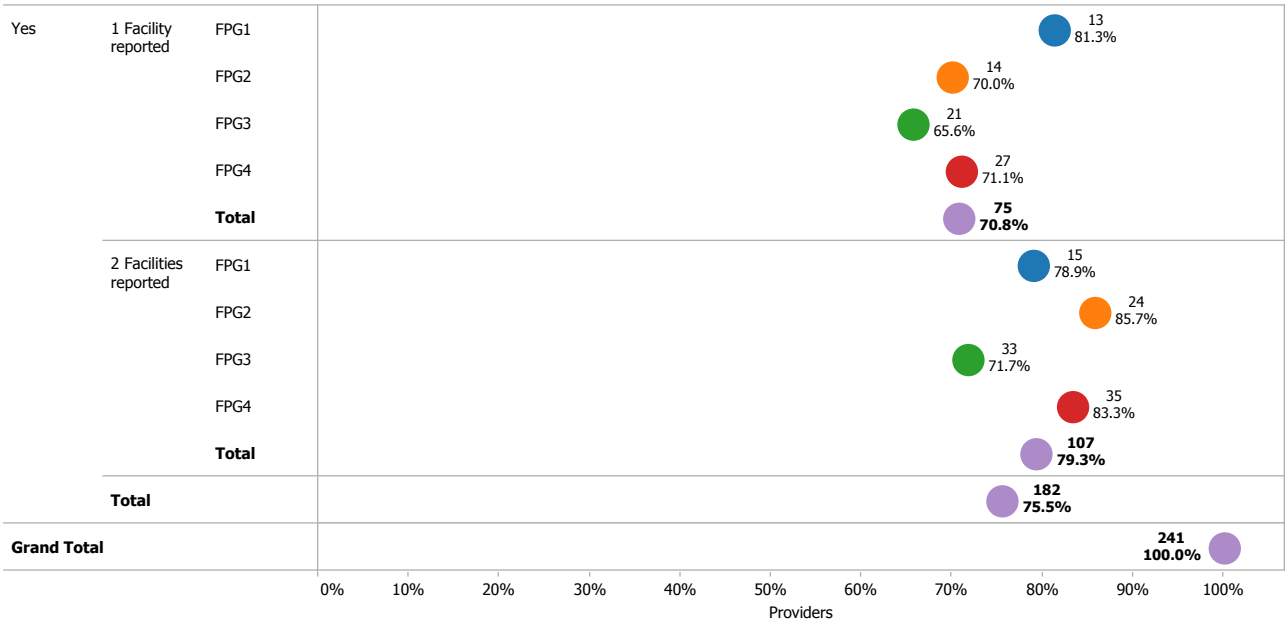
54. In FY13, did your Facility Manager or DoN who had overall management responsibility of your facility have a:



"Null" and "Unknown" responses are excluded.

Survey Question 55: Training

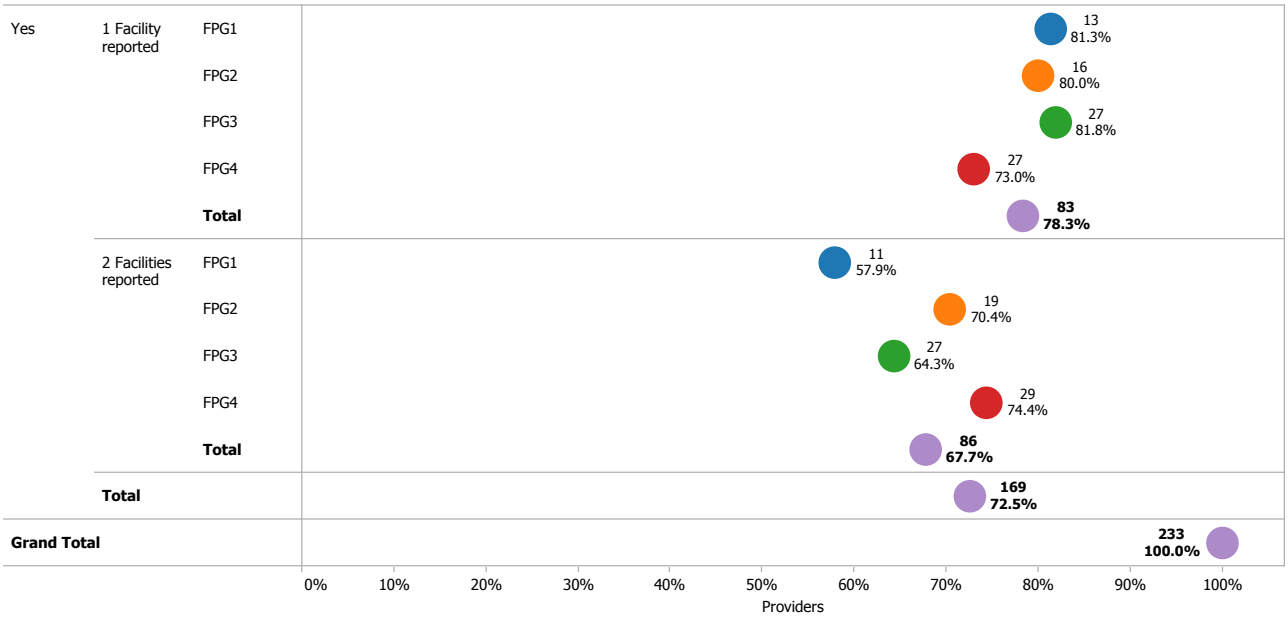
55. In FY13, did you invest in management development training programs for your Facility Manager or DoN?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 56: Local Community Alliances

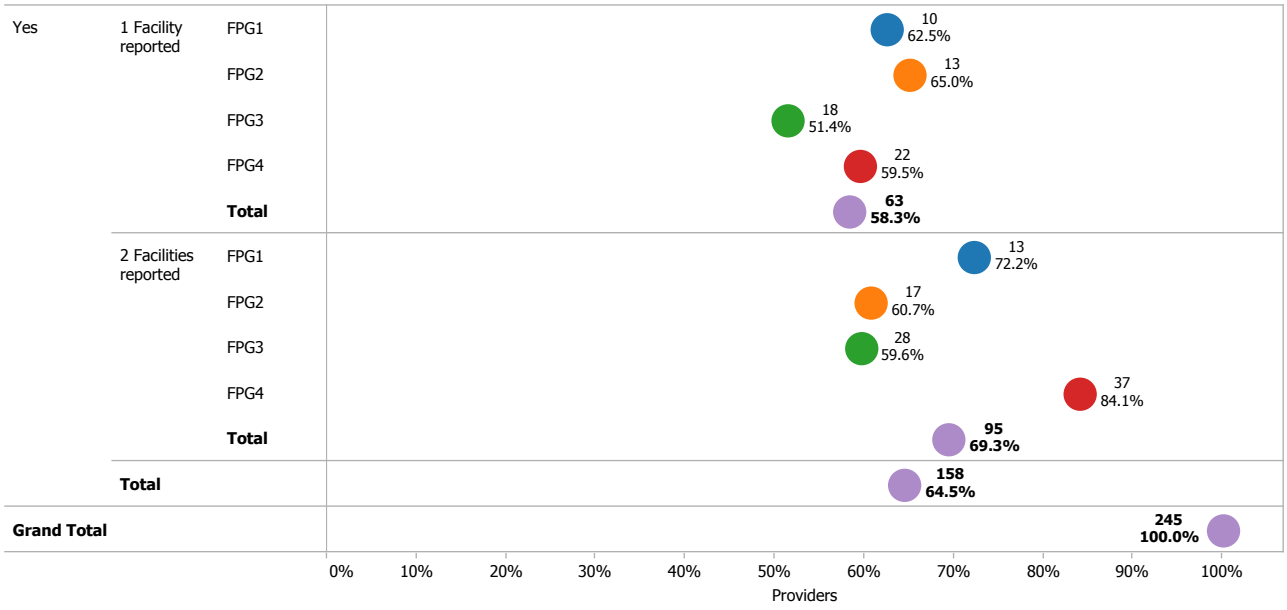
56. In FY13, did your facility form alliances and links to your local community eg.child care centres, schools?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 57: Admissions Staff

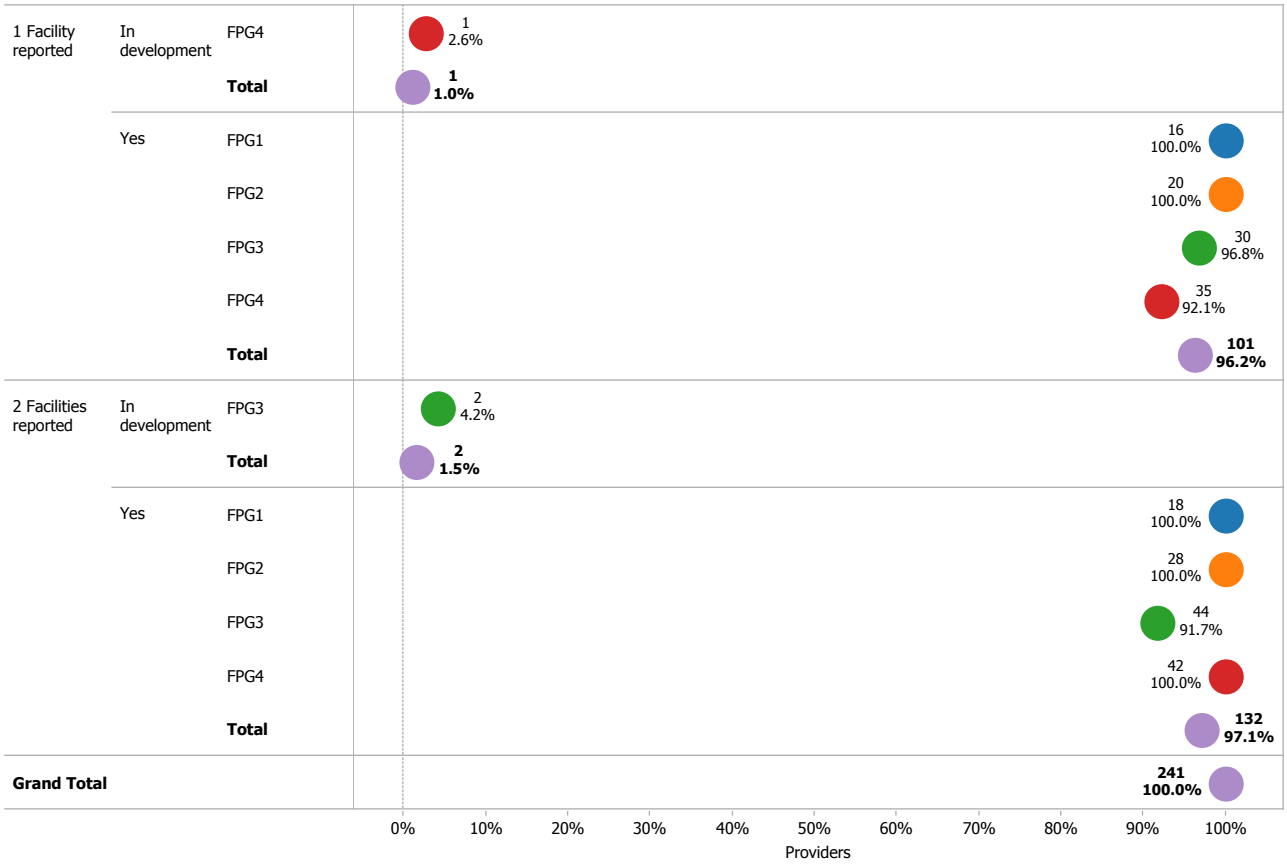
57. In FY13, did you have dedicated admissions staff?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 58: Admissions Process

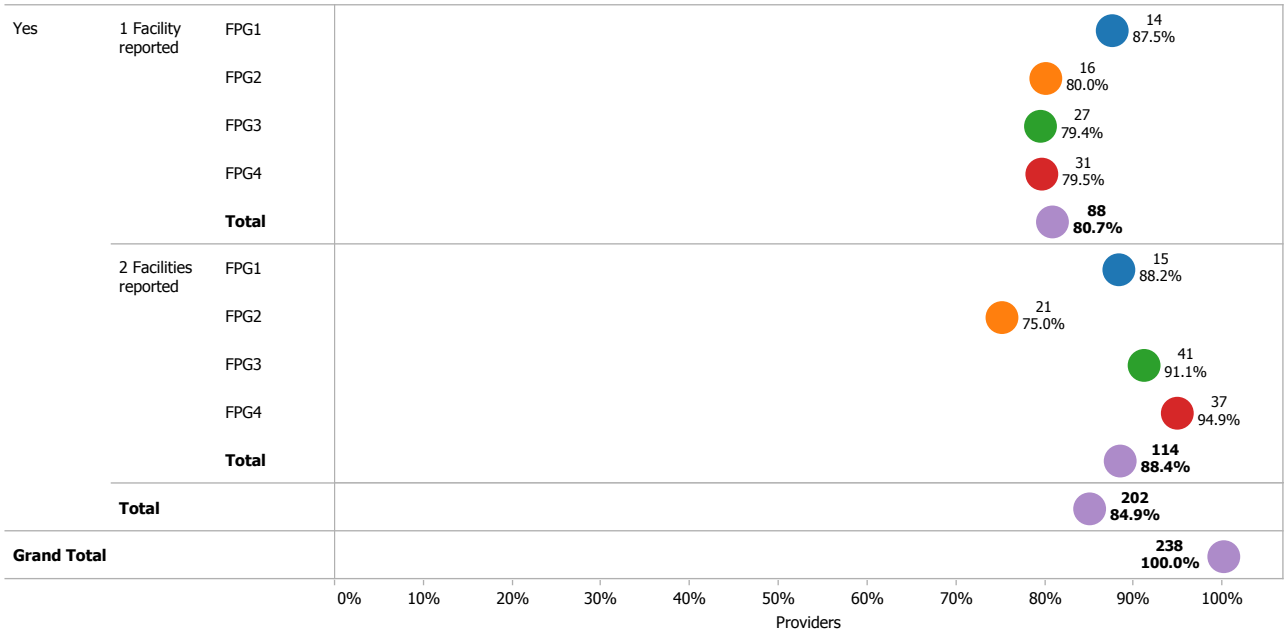
58. In FY13, did you have a formal admissions process?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 59: Waitlist

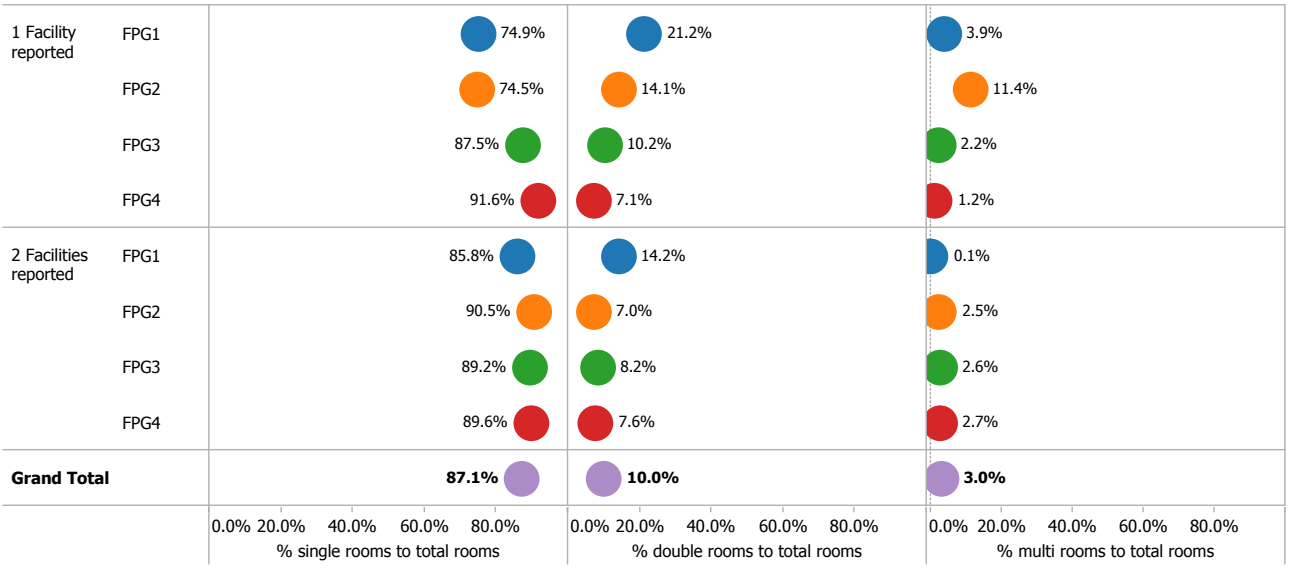
59. In FY13, did you maintain a waitlist at your facility?



"Null" and "Unknown" responses are excluded. "No" responses are hidden but form part of the grand total.

Survey Question 60: Multi-Bed Rooms

60. Please complete the following table about your facility as at 30 June 2013?



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