StewartBrown

Integrity + Quality + Clarity

AGED CARE FINANCIAL PERFORMANCE SURVEY

RESIDENTIAL CARE REPORT - DECEMBER 2016

The StewartBrown *Aged Care Financial Performance Survey* incorporates detailed financial and supporting data from over 830 residential aged care facilities and 445 home care programs across Australia. The quarterly survey is the largest benchmark within the aged care sector and provides an invaluable insight into the trends and drivers of financial performance at the sector level and at the facility or program level.

Significant aged care knowledge

If you work in aged care, disability or community services you have likely have heard our name; StewartBrown is trusted by industry experts, providers and government to provide analysis and insights.

We are recognised nationally as the leading provider of audit, accounting and consulting services to the aged care sector in Australia.

We also run Australia's largest aged and community care financial benchmarking survey. Our data is recognised in the industry, by government and the finance sector, as the leading information source and performance monitor for aged care.

We have over 180 providers participating, including 830 residential aged care facilities and 450 home care programs.

"Advice using your language, supporting your goals"

AGED CARE FINANCIAL PERFORMANCE SURVEY

830+ RESIDENTIAL CARE PROVIDERS

450+ HOME CARE PROVIDERS

23 MILLION CARE DAYS OF DATA

6 ANNUAL ROADSHOWS TO 600 ATTENDEES

30+ PRESENTATIONS TO INDUSTRY

6+ CONFERENCE KEYNOTES

PUBLIC REPORTING BACK TO 2007

QUARTERLY REPORTING

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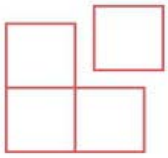
HIGHLIGHTS
OPERATING RESULTS

$11.87 *Average* Care Result of $11.87 per resident per day an increase of $1.09 from June 2016 at $10.78 and an increase of $0.57 cents from December 2015 at $11.30

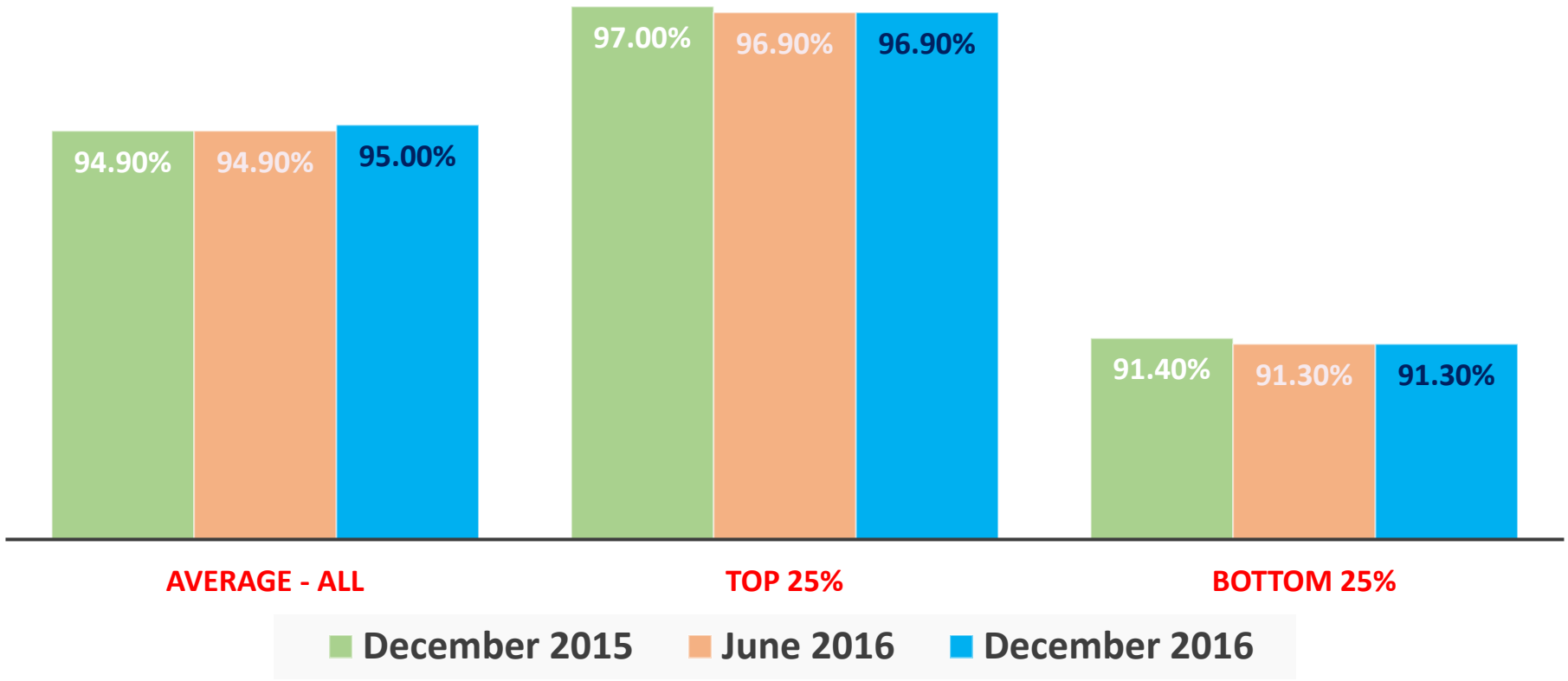


$40.14 *Average* Care Result of the top 25% was $40.14 per resident per day an increase of $1.72 from June 2016 at $38.42 and an increase of $0.93 cents from December 2015 at $39.21

$9,404 *Average* facility EBITDA of $9,404 per bed per annum an increase of $462 from June 2016 at $8,941 and an increase of $359 from December 2015 at $9,044

$18,943 *Average* facility EBITDA of the top 25% $18,943 per bed per annum an increase of $821 from June 2016 at $18,121 and an increase of $564 from December 2015 at $18,378

HIGHLIGHTS
OCCUPANCY



HIGHLIGHTS
ANALYSIS

76% positive overall result

Up 0.1% from June 2016: 75.9%

89 facilities (11%) had a negative EBITDA

Up 0.8% from June 2016: 10.2%

Average Care Result of bottom 75% was $3.35 per bed day

Average Care Result of bottom 75% was $0.84 cents better than June 2016 at $2.51 and was $0.52 cents more than December 2015 at $2.83

Average Care Result of bottom 50% $(5.11) per bed day

Average Care Result of bottom 50% was $0.51 cents better than June 2016 at $(5.62) and $0.30 cents worse than December 2015 at $(4.80)

Average Care Result of bottom 25% $(16.04) per bed day

Average Care Result of bottom 25% was $1.50 better than June 2016 at $(17.54) and $0.76 cents better than December 2015 at $(16.80)

HIGHLIGHTS ANALYSIS

$268,149 *Average* Refundable Deposit held at December 2016 was $268,149 an 11% increase of $26,597 from December 2015 at $241,552

$311,297 *Average* Refundable Deposit taken in the 6 months to December 2016 a 10% increase of $28,764 from December 2015

$28.61 Top 50% *average* Care Result was $28.61 per bed day a 6% increase of $1.60 on June 2016 at $27.01 and a 3% increase of $0.95 cents on December 2015 at $27.66

$16.69 Care Result varies across States and Territories with the highest being New South Wales with an *average* Care Result of $16.69 per bed day

$3.71 Care Result varies across States and Territories with the lowest being Victoria with an *average* Care Result of $3.71 per bed day

72% of facilities had a positive facility result (care result + accommodation result) up 1.3% from June 2016 at 70.7%

HIGHLIGHTS
ANALYSIS

47% Government share of Accommodation Revenue 47% falling 1% from 48% December 2015

53% Consumer share of Accommodation Revenue 53% rising 1% from 52% December 2015

$365,000 During the year to December 2016 the *average* accommodation price was $365,000

16% Number of providers who increased their prices above $550,000 during the year to December 2016

$22.70 Depreciation expense for buildings less than 5 years was $22.70, $16.54 for buildings 6 to 15 years and $13.65 for buildings over 16 years

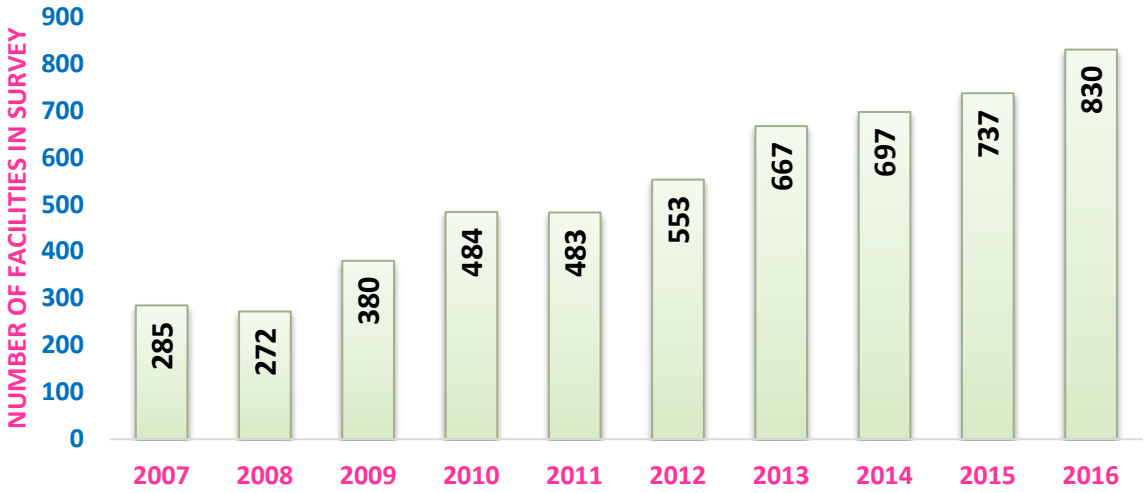
35% Percentage of facilities who ***increased*** their minimum or maximum Accommodation Price in the year to December 2016

6% Percentage of facilities who ***decreased*** their minimum or maximum Accommodation Price in the year to December 2016

INTRODUCTION

The StewartBrown Aged Care Financial Performance Survey half year report provides another milestone for the Aged Care sector with us growing with you to now include more than 830 facilities providing residential aged care data for more than 66,000 beds.

Figure 1: Growth of ACFPS December surveys



The Aged Care Financial Performance Benchmark is a tool that has been shaped by the sector itself to ensure that we provide data that you can read today and use tomorrow through an analysis that is customised to your facility and organisation. Should you wish to understand how to use the benchmark more effectively for your organisation please let us know.

This December 2016 survey report contains the summary analysis of more than 23.7 *million* care days of data to derive insights and assistance to:

- ✓ Determine and understand sector trends
- ✓ Drive improvements in financial and operational performance
- ✓ Measure and compare your operations against various organisations
- ✓ Assess your productivity
- ✓ Set goals and make informed decisions

We continue to encourage providers to talk to us about how we can assist you to use the survey to better understand the strategic and tactical trends within the sector, drive your business performance or prepare your organisation for change. Our services are targeted to provide you with usable information, guidance and insights derived from more than 10 years of survey data.

StewartBrown will be bringing a number of changes to the *Aged Care Financial Performance Survey* over the course of the year as we continually enhance our service to providers. These will include:

- Significant enhancements to the interactive web site as we progress with the redevelopment of the site to allow better usage of the contemporary and historical data
- Ability of providers to request a detailed accommodation pricing and competitor analysis for each of their facilities *(simply contact our office)*
- Presentations of your results and a sector update upon request (via webinar or in person)
- Additional analysis on specific areas of interest and regular newsletters based on this analysis
- There will be further details on these and other enhancements our service offering in coming weeks.

EXECUTIVE SUMMARY

Quite possibly the most talked about issue within aged care today is the impact that the first 6 months of Aged Care Funding Instrument (ACFI) subsidy changes and the potential effect of the planned ACFI funding changes effective from 1 January 2017 has wrought on the sector. Talk of significant reductions in revenue for the coming budget planning period will tax the minds of most executives and Boards within the sector, many looking to consolidate changes made in response to the reform process, while navigating the headwinds of funding changes.

The return on Care Revenue has been trending upwards slightly, but while Care Revenue keeps increasing at relatively healthy rates, most of the additional revenue has been matched by additional Care Costs rather than falling to the surplus line. So, there is still concern around the growth of expenditure items outpacing revenue growth, more particularly the progression of direct Care Costs which now rests at **$128.47** per bed day up **$2.69** from June 2016 ($125.78 pbd) and up **$5.16** per bed day from December 2015 ($123.31 pbd).

Initial indications through the 2016 calendar year was that the 2017 financial year will see *Average* results decline compared to the 2016 financial year on the back of the ACFI changes, but the December results have marginally defied this trend, but still appear to be pointing to a low growth future.

The *Average* Care Result has increased to **$11.87** pbd for the December 2016 quarter from $10.78 per bed day (pbd) for the year to June 2016. Comparing this to the same period last year there has been an increase in the *Average* Care Result of **$0.56** per bed day. The *Average* Care Result of the top quartile have risen by **$0.93** cents per bed day compared to the December Quarter 2015. This result is slightly contrary to the downward trend through the calendar year that was originally considered an indication of the initial tightening of some of the ACFI rules.

Hopefully this points to a growing acknowledgement by providers that the down regulation of ACFI rates will speed up decline in surplus unless directed action is taken to offset these changes and consolidate opportunities offered through the reforms.

We will also briefly look at what the *Aged Care Financial Performance Survey* data is telling us about the lowest performing 50% of providers in the sector. It is clearly becoming tougher to operate an aged care facility profitably, but for this group we pull apart some of the characteristics of those that comprise this cohort. The overall performance of the sector is critical but more so how the whole sector is advancing the care and accommodation of our seniors when segments of the market are distressed.

We take some time to review Accommodation Results from the survey noting that at December 2016 the *Average* accommodation price was $365,000. The *Average* Residential Accommodation Deposit (RAD) taken during the same period was $311,434 - an increase of $15,830 above the June 2015 figure and $28,764 above the December 2015 *average* RAD. This tracks significantly below the national median house price of $660,000[1] by $295,000 further highlighting that accommodation pricing is an area of revenue that remains to be fully explored.

Explanations of how we structure the bands for analysis within the Aged Care Financial Performance Survey and an appendix of terms used in this report on pages 34 and 35 respectively.

[1] RPLogic data 2016

CARE RESULT

The Care Result is the net result of providing care to the residents including **direct Care Costs**, H**otel Services**, **utilities** and **administration** and other **support services** costs.

With the exception of corporate recharges that form part of the administration costs of some facilities, and to a lesser degree, utility costs, these costs associated with the care and daily living expenses of the residents could be considered to be "controllable costs" for management at a facility level.

Several factors might influence the Care Result including number of beds, building design and location of the facility. However, the survey shows that there are facilities performing well even with these factors working against them. In most cases, such factors do not preclude a facility from making a good surplus, however they may make it more difficult to do so.

We will examine the influence that these other factors might have on obtaining a surplus over the course of the year as special focus points.

The December 2016 survey collected data from over 830 facilities with the final data set representing a total of over 65,000 beds and 23 million care days. The breakdown of facilities was

Band	Number
Band 1	182 RACF
Band 2	253 RACF
Band 3	202 RACF
Band 4	105 RACF
Band 5	88 RACF

The December 2016 survey collected data from over 830 facilities with the final data set representing a total of over 65,000 beds and 23 million care days.

RESULTS IN BRIEF

Initial indications through the 2016 calendar year was that the 2017 financial year will see *average* results decline compared to the 2016 financial year, so hopefully this points to a growing acknowledgement by providers that the down regulation of ACFI rates will speed up decline in surplus unless directed action is taken to offset these changes and consolidate opportunities offered through the reforms.

Table 1: Summary of Results for the Quarters ended 31 December 2016 and 31 December 2015 and year ended 30 June 2016

Care Result ($pbd)						
	December 16	December 15	Change		June 2016	Change
Average	11.87	11.30	↑	0.56	10.78	↑ 1.09
Top 25%	40.14	39.21	↑	0.93	38.42	↑ 1.72

Facility EBITDA ($ per bed pa)						
	December 16	December 15	Change		June 2016	Change
Average	9,404	9,044	↑	359	8,941	↑ 463
Top 25%	18,943	18,378	↑	565	18,121	↑ 822

EBITDA ($ per bed pa)						
	December 16	December 15	Change		June 2016	Change
Average	9,734	9,307	↑	427	9,539	↑ 195
Top 25%	19,134	18,539	↑	595	18,466	↑ 668

Care Result

The *Average* Care Result has increased to **$11.87** per bed per day (pbd) for the December 2016 quarter from $10.78 pbd for the year to June 2016. Comparing this to the same period last year there has been an increase in the *Average* Care Result of **$0.56** per bed day from December 2016 ($11.30 pbd).

The *Average* Care Result of the top quartile (25%) have risen by **$0.93** cents per bed day compared to the December Quarter 2015. This has defied a downward trend through the calendar year that was originally considered an indication of the initial tightening of some of the ACFI rules.

Facility EBITDA

The *Average* Facility EBITDA (Care + Accommodation), which takes into account the Accommodation Result and Care Result but excludes all investment and fundraising revenue, is the true operational result that should be benchmarked (especially in relation to EBITDA). Facility EBITDA is showing a slightly better result in in the December 2016 quarter of **$9,404** per bed per annum which is a $463 per bed per annum improvement on the June 2016 results ($8,941 pbpa). Facility EBITDA also increased to $359 more than the *Average* Facility EBITDA for the December 2015 quarter ($9,044 pbpa).

Total EBITDA

The *Average* Total EBITDA (Facility + Provider) may include all investment and fundraising revenue for the organisation (if allocated at facility level), and therefore for clarity is only for information and should not be used specifically to benchmark performance. The *Average* Total EBITDA is showing a slightly better result for the December 2016 quarter of **$9,734** per bed per annum which is a $195 per bed per annum improvement from the June 2016 results ($9,539 pbpa) and an increase of **$427** from December 2015 results ($9,307 pbpa).

Commentary on Total EBITDA

Our analysis of the impact of non-operational revenue - such as donations, bequests, fundraising or investments - indicates that approximately 27% of the survey respondents allocated revenue of this type at facility level (rather than organisation level). The remaining 73% of survey participants had allocated little or no "non-operating" revenue. As a performance indicator we also included the providers within the Top Quartile to observe what affect, if any, non-operational revenue might play. The result is in Table 2 below.

Table 2: Effect of Non-operational revenue on EBITDA

	Survey *Average*			Top Quartile	
	ALL Participants (100%)	**Non-operational income *included*** (27%)	**Non-operational income *excluded*** (73%)	**Non-operational income *included*** (7%)	**Non-operational income *excluded*** (18%)
TOTAL EBITDA PER BED PER ANNUM	**$9,734**	**$ 8,700**	**$ 10,093**	**$ 17,888**	**$ 19,300**
FACILITY EBITDA PER BED PER ANNUM	**$ 9,404**	**$ 7,491**	**$ 10,093**	**$ 16,984**	**$ 19,300**

Survey *Average*: We can see the impact that non-operational revenue has on the survey *Average* EBITDA skewing it upwards by **$303** pbpa (to $9,734 pbpa) as the non-operational funds received in **27%** of the participants is then spread among the whole data set. Please refer to the yellow shaded area where the total EBITDA has been only calculated for these 27% of providers, resulting in an increase pf **$1,209** pbpa higher (to $8,700 pbpa) than their facility EBITDA. The remaining **73%** of the participants (refer grey shaded area) sows both Total EBITDA and Facility EBITDA as identical as you would expect.

Top Quartile: The same analytics occur in the Top Quartile. It is worth noting however that the difference between the Total EBITDA and Facility EBITDA in this quartile is not as pronounced being - 1/3 the magnitude of the yellow shaded column result (16% versus 5%). Once again for those not receiving this non-operational revenue in the purple column the EBITDA result is the same at Total and Facility level.

Takeaways from EBITDA analysis

- The *Average and Top 25%* Total EBITDA Result (Facility + Provider) may include all investment and fundraising revenue for some facilities (being a minority), and therefore is not appropriate for facility level benchmark comparison.
- Those providers who are not in the top quartile that receive non-operational revenue would appear to rely more on this revenue stream than those within the top quartile. This was also an outcome observed in the Aged Care Financing Authority paper *"Factors Influencing the Financial Performance of Residential Aged Care Providers"*
- Overall analysis of the residential sector performance on an operating level should be directed at the Facility EBITDA result per bed per annum and not the Total EBITDA result

EBITDA Benchmark Comparison between NFP and For-Profit providers

When analysing the results from the *Aged Care Financial Performance Survey,* StewartBrown strives to ensure that the outcomes reflected are able to be utilised for the whole sector. Often, we hear private providers who do not participate in the benchmark suggest that our analysis is not directly attributable to their operations, particularly in the for-profit (FP) segment. One of the most common justifications for this statement is that Not-For-Profit (NFP) providers often receive non-operational revenue in the form of donations, bequests, fundraising or other investments.

On an operational level, the core differences are around payroll tax and fringe benefit concessions. These can readily be determined, and therefore excluded from the overall benchmark comparison.

Consideration of actual makeup of the residential sector derived from 2016 Service List shows that there is a mix of approximately 56% Not-For-Profit, 38% Private and 6% Government provider beds within Australia.

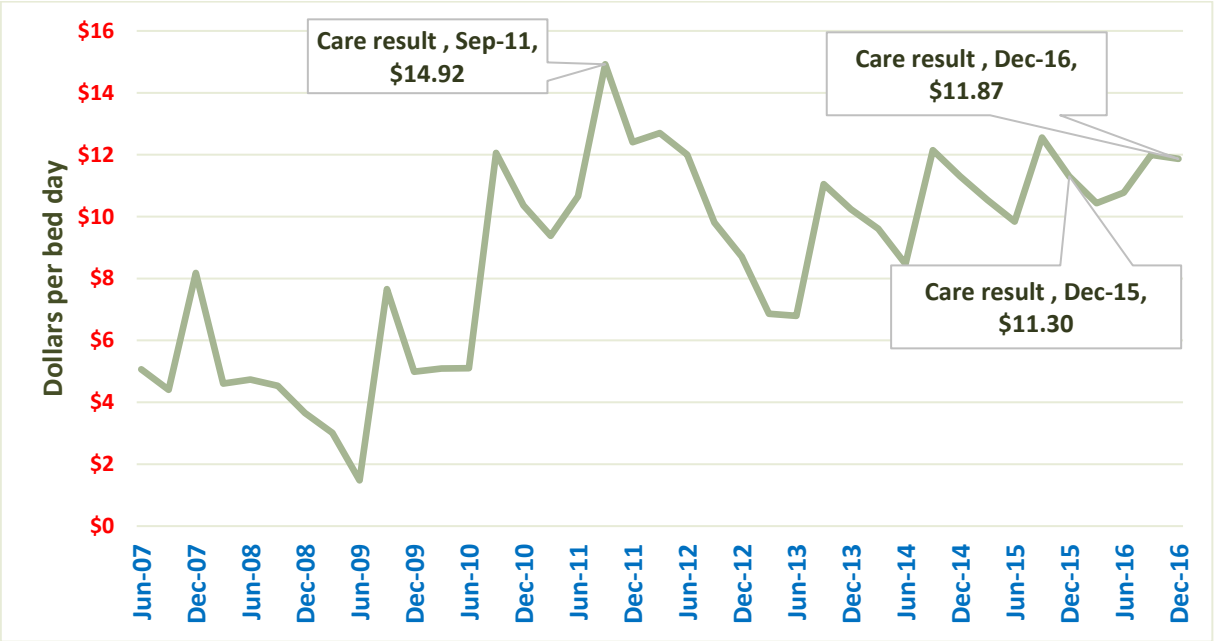
The *Aged Care Financial Performance Survey* includes granular data at the facility level to ensure that, regardless of the organisation size, structure and complexity, there was a common baseline for comparison including operational revenue and expense, staffing hours (by category) per resident per day, accommodation pricing, facility size and regional analysis. During our analysis phase, we excise outliers and moderate any "head office" information that does not pertain to operational revenue and expenses to bring the result to being a true facility level performance.

This approach ensures that the data presented is applicable to all providers to utilise in their operational KPIs and planning. Given the revenue and expenditure items within aged care are highly correlated regardless of operating structure, except as noted above, we believe it is relevant for detailed comparison between the NFP and FP segments.

ACFI Changes

The first tranche of the ACFI reductions started July 1 with changes to the scoring matrix and halving of indexation in the CHC domain. Although there has been an increasing surplus trend since 2013 after the initial fiscal cliff of the first ACFI subsidy rates freeze in 2012, so by looking at the graph below, it is apparent that the lack of a September care result spike that we have seen in 2013, 2014 and 2015 may be the initial impact of the current ACFI changes. This muting of the September 2016 result would suggest that the results for June 2017 will trend lower against previous years as the subsidy changes begin to bite. StewartBrown is releasing a newsletter alongside this December survey report that includes a provider case study on how they approached the ACFI changes.

Figure 2: Care Result - Survey Average over time (June 2007 to December 2016) ($ per bed day)



Share of Care Revenue

In the preamble to the Aged Care Roadmap, David Tune OA PSM suggest that an aspiration of the roadmap for consumer choice will be underpinned by: ***"A fiscally sustainable aged care system that requires consumers to contribute to their Care costs where they can afford to do so means that there will be increased consumer expectations for greater choice and control. "***

Therefore, it will be concerning to aged care stakeholders to consider Figure 3 below showing that survey data in December 2016 indicates that the majority funder of the Care Revenue component of the aged care system is still the Commonwealth at **76%**, actually **4%** greater than at the commencement of the ACFI in 2007. These figures may be slightly skewed by the survey sample being comprised of providers who have a propensity to accept clients with a higher acuity but less ability to pay.

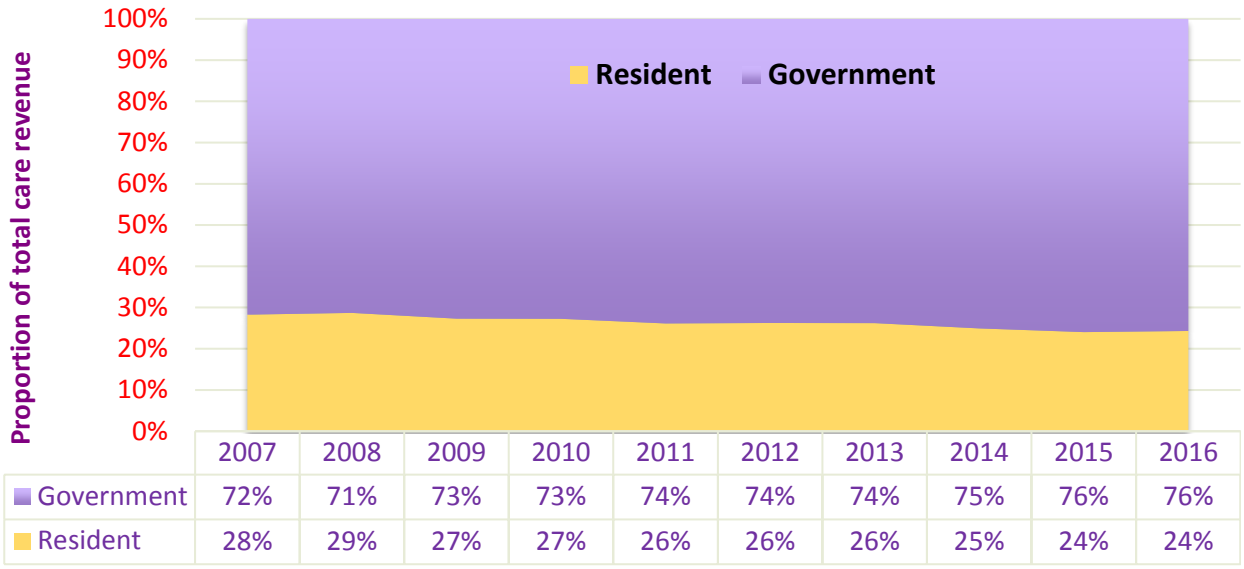
The 2016 ACFA Report on the *Funding and Financing of the Aged Care Industry* showed that the share of Care Revenue for 2014/15 was 73% Commonwealth and 27% consumer, slightly lower than our figure. This data is more than a year in arrears so we will have to wait and see what the next ACFA report shows to fully explore if there is a real difference.

While changes to Home Care flow through keeping clients in their homes longer, we expect to see providers continue to move away from catering for residents with lower care needs and towards residents with high care needs. Despite the means-tested care fee starting on 1 July 2014, the government's share of the cost of care is static rather than declining and has not materially changed the resident revenue proportion. Given that the trajectory of aged care costs is rising, it may be that in a net present value of cash basis, the trend to stasis may be a win from the government's point of view (ie their share of revenue has not grown to match spending on aged care).

As we discuss later in the report the supported resident ratio has grown marginally to a national figure of **47%**[2], correlating to our survey result, at a time where the acuity of the clients is also growing in complexity. So, it is not unexpected that there would be fewer residents paying a means-tested care fee, however given almost three years of means tested fees it would be expected that almost all residents entering residential care may have been assessed and any fee applied - but it appears to be less than the modelling of government intended.

There is also a case to suggest that the quantum of revenue offset to consumers by the means-tested care fee has been subsumed and overtaken by the increase in ACFI revenue due to their assessed needs.

Figure 3: Share of Care Revenue at December each year



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Government	72%	71%	73%	73%	74%	74%	74%	75%	76%	76%
Resident	28%	29%	27%	27%	26%	26%	26%	25%	24%	24%

[2] Aged Care Financing Authority Report January 2017

RESULT IN DETAIL

Overall Results

As mentioned earlier, during the 12 and 6 months to December there have been improvements in the Care Result for both the overall Survey *Average* and the *Average* for the Top 25% of facilities when compared to June 2016 and December 2015.

Table 3: Survey Averages and Top Quartile for the half year ended 31 December 2016, 30 June 2016 and 30 December 2015 (all amounts represent $ per bed day unless otherwise stated)

	Survey *Average* Dec-16	Survey *Average* Jun-16	Survey *Average* Dec-15	Top 25% *Average* Dec-16	Top 25% *Average* Jun-16	Top 25% *Average* Dec-15
	$ pbd	$ pbd	$ pbd	$ pbd	$ pbd	$ pbd
Care Revenue	**220.44**	**214.55**	**212.76**	**222.59**	**214.95**	**213.29**
Care Expenditure						
Direct care costs	128.47	125.78	123.31	109.91	105.83	104.73
Catering	27.58	27.02	27.17	26.60	25.85	25.66
Cleaning	7.52	7.24	7.20	6.80	6.37	6.09
Laundry	3.76	3.75	3.66	3.26	3.27	3.19
Utilities	6.08	5.93	6.06	5.78	5.76	5.70
Administration & support	35.17	34.04	34.06	30.11	29.45	28.70
Total Care expenditure	**208.58**	**203.77**	**201.46**	**182.46**	**176.53**	**174.08**
Care Result	**$11.87**	**$10.78**	**$11.30**	**$40.14**	**$38.42**	**$39.21**
Accommodation revenue	27.38	27.18	26.65	25.18	24.05	24.08
Accommodation expenses	26.83	26.21	25.23	25.46	24.46	23.95
Accommodation Result	**$0.55**	**$0.97**	**$1.43**	**$(0.28)**	**$ (0.40)**	**$0.13**
Facility Result	**$12.42**	**$11.75**	**$12.73**	**$39.86**	**$38.02**	**$39.34**
Facility EBITDA per bed per annum	**$9,404**	**$8,941**	**$9,044**	**$18,943**	**$18,121**	**$18,378**
Additional Data						
Provider revenue	3.36	4.27	3.41	2.10	2.61	1.95
Provider expenses	0.89	1.19	1.25	1.08	0.55	0.56
Provider Result	**$2.47**	**$3.08**	**$2.16**	**$1.02**	**$2.06**	**1.39**
Total Result for the year	**$14.89**	**$14.83**	**$14.89**	**$40.88**	**$40.07**	**$40.73**
EBITDA per bed per annum	**$9,734**	**$9,539**	**$9,307**	**$19,134**	**$18,466**	**$18,539**
KPIs						
Occupancy	*95.05%*	*94.90%*	*94.91%*	*96.90%*	*96.90%*	*96.97%*
Care costs as % of Care Revenue	*58.28%*	*58.60%*	*57.96%*	*49.38%*	*49.20%*	*49.10%*
Care Result - return on Care Revenue	*5.38%*	*5.00%*	*5.31%*	*18.03%*	*17.90%*	*18.38%*
Supported ratio	*46.03%*	*46.00%*	*48.57%*	*44.30%*	*43.50%*	*45.46%*
Average bond/RAD held	$268,149	$252,319	$241,552	$275,876	$259,177	$246,206
Average RAD taken during period	$311,297	$298,627	$282,533	$347,571	$311,888	$302,282

We expressed concerns in both the June 2016 and September 2016 surveys about a decline in the operating performance of providers across the sector that may continue to gather pace into the new calendar year spurred by the ACFI changes. Care Revenue has rallied somewhat to be marginally better than the December 2015 result indicating that the sector has invested significant effort into stabilising their revenue, but as the fiscal environmental continues to deteriorate out to 2019 more work will be required by providers and government to shore up and stabilise Care Revenue.

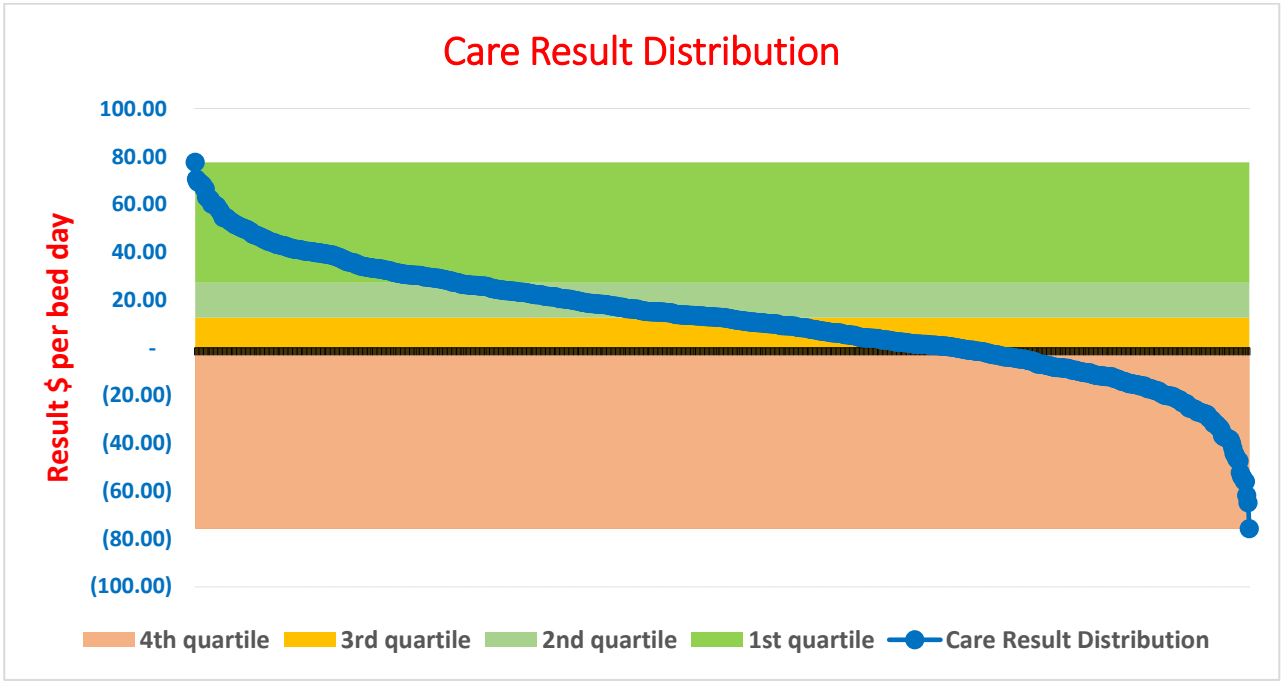
Table 4: Comparison of various groups of facilities against Top 25% for year ended 31 December 2016 (all amounts represent $ per bed day unless otherwise stated)

	Top 25% *Average* Dec-16	**Bottom 75% *Average* Dec-16**	**Bottom 50% *Average* Dec-16**	**Bottom 25% *Average* Dec-16**
	$ pbd	**$ pbd**	**$ pbd**	**$ pbd**
Care Revenue	**222.59**	**219.80**	**219.39**	**217.37**
Care Expenditure				
Direct Care costs	109.91	134.07	139.45	144.67
Hotel services	36.65	39.52	40.37	41.84
Utilities	5.78	6.17	6.29	6.62
Administration & support	30.11	36.70	38.39	40.28
Total expenditure	**182.46**	**216.45**	**224.50**	**233.41**
Care Result	**$40.14**	**$3.35**	**$(5.11)**	**$(16.04)**
Accommodation **revenue**	25.18	28.05	28.39	28.42
Accommodation expenses	25.46	27.24	26.95	26.19
Accommodation Result	**$(0.28)**	**$0.81**	**$1.43**	**$2.23**
Facility Result	**$39.86**	**$4.16**	**$(3.67)**	**$(13.81)**
Facility EBITDA per bed per annum	**$18,943**	**$6,595**	**$3,895**	**$306**
Additional Data				
Provider revenue	2.10	3.73	3.78	4.36
Provider expenses	1.08	0.83	0.88	0.69
Provider Result	**$1.02**	**$2.91**	**$2.89**	**$3.67**
Total Result for the year	**$40.88**	**$7.06**	**$(0.78)**	**$(10.14)**
EBITDA per bed per annum	**$19,134**	**$6,967**	**$4,317**	**$921**
KPIs				
Occupancy	*96.90%*	*94.33%*	*93.68%*	*91.30%*
Care costs as % of Care Revenue	*49.38%*	*61.00%*	*63.56%*	*66.55%*
Care result - return on Care Revenue	*18.03%*	*1.52%*	*-2.33%*	*-7.38%*
Supported ratio	*44.30%*	*46.61%*	*46.72%*	*46.50%*
Average bond/RAD held	$ 275,876	$ 197,768	$ 158,354	$ 264,599
Average RAD taken during year	$ 347,571	$ 211,475	$ 160,421	$ 311,607

As shown in Table 4 above, the *Average* Care Result for a facility outside the top quartile is only **$3.35** per bed day. For the same quarter in 2015 the *Average* was **$2.83** per bed day. The *Average* for the bottom 50% and bottom quartile has eroded further to become a loss of **$(5.11)** and a loss of **$(16.04)** per bed day respectively, strengthening concerns that unless such facilities is being supported by a larger organisation or significant non-operating revenue streams, it will not be sustainable. Cross subsidy of facilities by larger organisations will increasingly be framed in both mission and operational terms to understand the true picture of overall survival of these facilities into the future.

Care Result Distribution Analysis

The distribution of the Care Results for the complete data set is as follows:-



The Care Result appears to be fairly normally distributed. The quartile range is set out below.

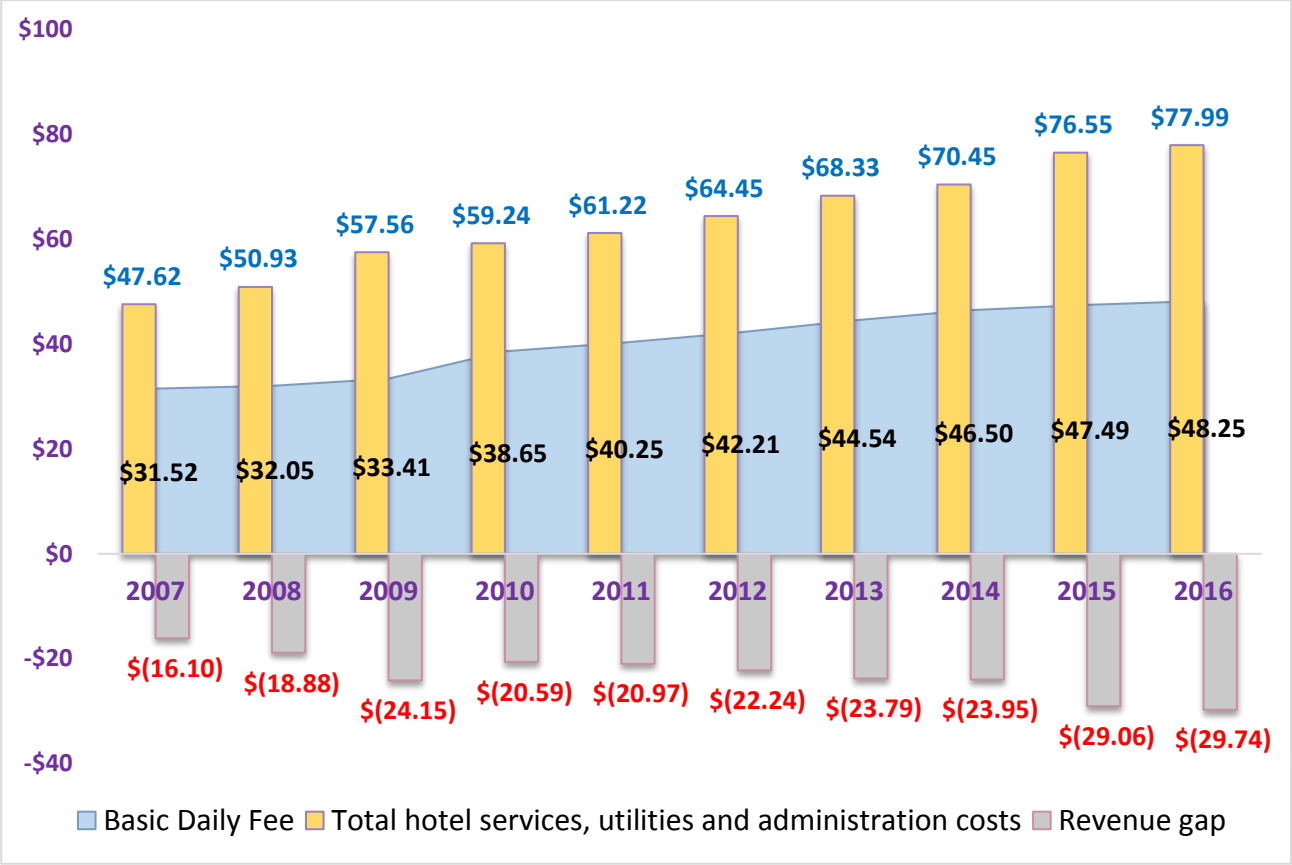
Quartile	Bottom range $ pbd	Top range $ pbd	Number of facilities
1st	27.26	77.69	208
2nd	12.60	27.26	207
3rd	(2.23)	12.60	208
4th	(75.88)	(2.23)	207

Basic Daily Fee and Everyday Living Costs

One area where ACFI revenue is being diverted is to supplement the basic daily fee which contributes towards the day-to-day living costs of an aged care resident such as meals, cleaning, laundry, heating and cooling, rather than "direct care". Figure 4 shows that at 2007 the revenue gap between a client's daily living expenses and the revenue received from the basic daily fee was **$16.10** per day. Some 10 years later that gap has almost doubled to **$29.74** per day further highlighting that an increasing proportion of ACFI revenue is going towards meeting these costs rather than the "direct care" costs. This means that the basic daily fee is not enough to cover the total hotel services costs and utility costs combined.

Almost the entire amount of administration and support costs are now recovered from ACFI revenue.

Figure 4: Everyday living expenses compared to basic daily fee (December 2007 to December 2016)

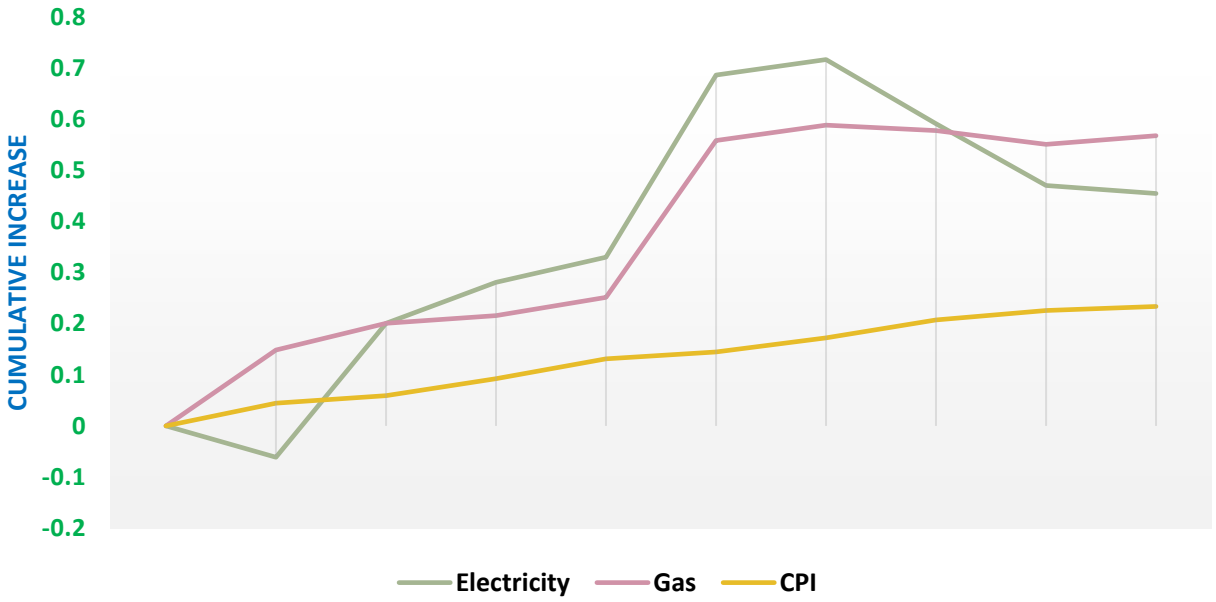


Although inflation has been at historical lows there is still an environment where utility and living costs are rising. Energy usage fluctuates in response to demand and peaks such as hot or cold weather, but aged care providers will see energy price hikes in the key aged care expenditure items such as gas and electricity into the foreseeable future. In real terms - that is, taking into account the general increase in prices across all goods and services - prices for utilities increased on *average* by **72%** for electricity and **54%** for gas in the 10 years to June 2013[3]. Victoria and South Australian businesses have it worse, facing about a 170 per cent increase between 2015 and 2017, while Queensland customers got off relatively lightly with 106 per cent[4].

[3] Source: Australian Bureau of Statistics

[4] https://goo.gl/EXwSOS

Figure 5: Electricity and Gas cumulative increase 2007-2016



As the sector begins to take up efficiencies through solar or other energy cost moderations it is likely that a more immediate and material action must be taken by the sector to float the daily care fee. The concept of floating the basic daily fee is one where the fee value is allowed to fluctuate in response to the client's ability to pay and any market mechanisms that might create competition or price tension. An important context for this approach would be to ensure a floor price remains at 85% of the single pension to ensure that those without means, undertaking respite or enduring hardship have a suitable safety net to fall back on.

Obviously, the sector, particularly Government, has viewed a fixed fee as preferable for its greater stability and certainty. However, as basic living costs continue to rise floating the fee may dampen the impact of sector sovereign revenue shocks (such as ACFI changes) and business cycles (such as deregulation), while enabling a more equitable proportion of funding to be returned to direct care. Freeing up this portion of ACFI funding would also potentially underwrite the ability of providers to offer different models of care and differentiate themselves based on their "standard" service offering.

It will be important in any review of ACFI that the level of contribution to these other costs will need to be taken into consideration.

Direct Care Costs and Care Hours worked per resident

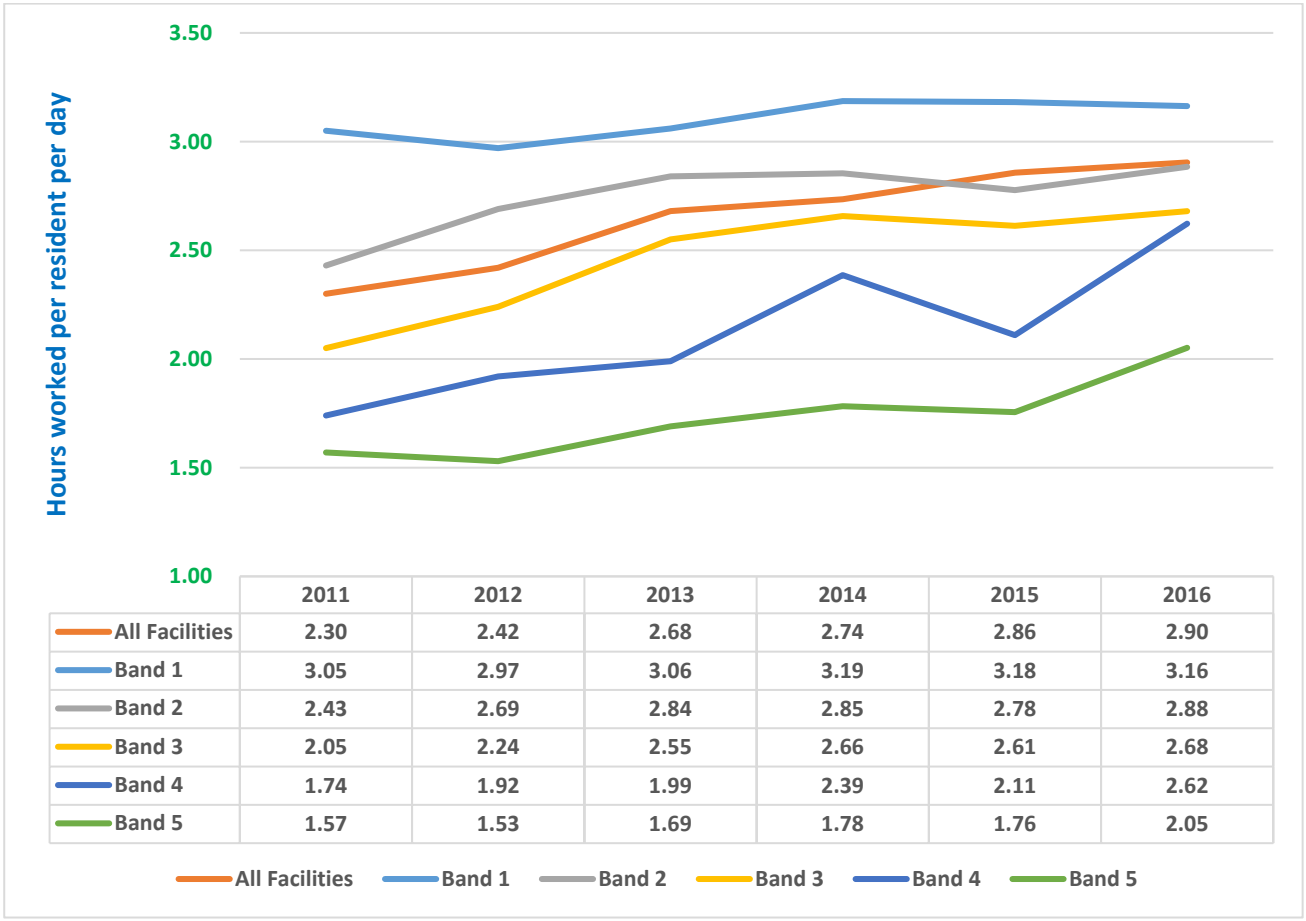
The return on Care Revenue has been trending upwards slightly, but while Care Revenue keeps increasing at relatively healthy rates, most of the additional revenue has been matched by additional Care Costs rather than falling to the surplus line.

There is still concern around the growth of expenditure items outpacing revenue growth, more particularly the progression of Direct Care Costs which now rests at **$128.47** per client per day against June 2016 ($125.78 pbd) and December 2015 ($123.31 pbd**)**. In the past, we have reflected that this may be a proxy for the rising acuity of residential care clients and as such points to this item growing further against the backdrop of increasing lengths of stay in home care before entering RACF with higher complexity, co-morbidity and frailty.

Care costs as a percentage of Care Revenue **grew to 58.28%** which along with an improvement in operational performance has seen the *Average* return on Care Revenue grow slightly to 5.38% in the December quarter.

When viewed in line with the Average total care hours worked per resident per day in Figure 6 below, we start to see a trend across all bands where the care hours is steadily increasing across the sector. There has been an erosion in the growth in care hours worked per resident in Band 1 from a historical peak of 3.19 hours in 2014. Although there has been some volatility in the hours, since 2012 the trend has been for direct care hours to increase across the board so it will be interesting to observe the progression towards June 2017 results to see if facilities are amending their rosters in response to ACFI and other revenue challenges.

Figure 6: Average total care hours worked per resident per day



	2011	2012	2013	2014	2015	2016
All Facilities	2.30	2.42	2.68	2.74	2.86	2.90
Band 1	3.05	2.97	3.06	3.19	3.18	3.16
Band 2	2.43	2.69	2.84	2.85	2.78	2.88
Band 3	2.05	2.24	2.55	2.66	2.61	2.68
Band 4	1.74	1.92	1.99	2.39	2.11	2.62
Band 5	1.57	1.53	1.69	1.78	1.76	2.05

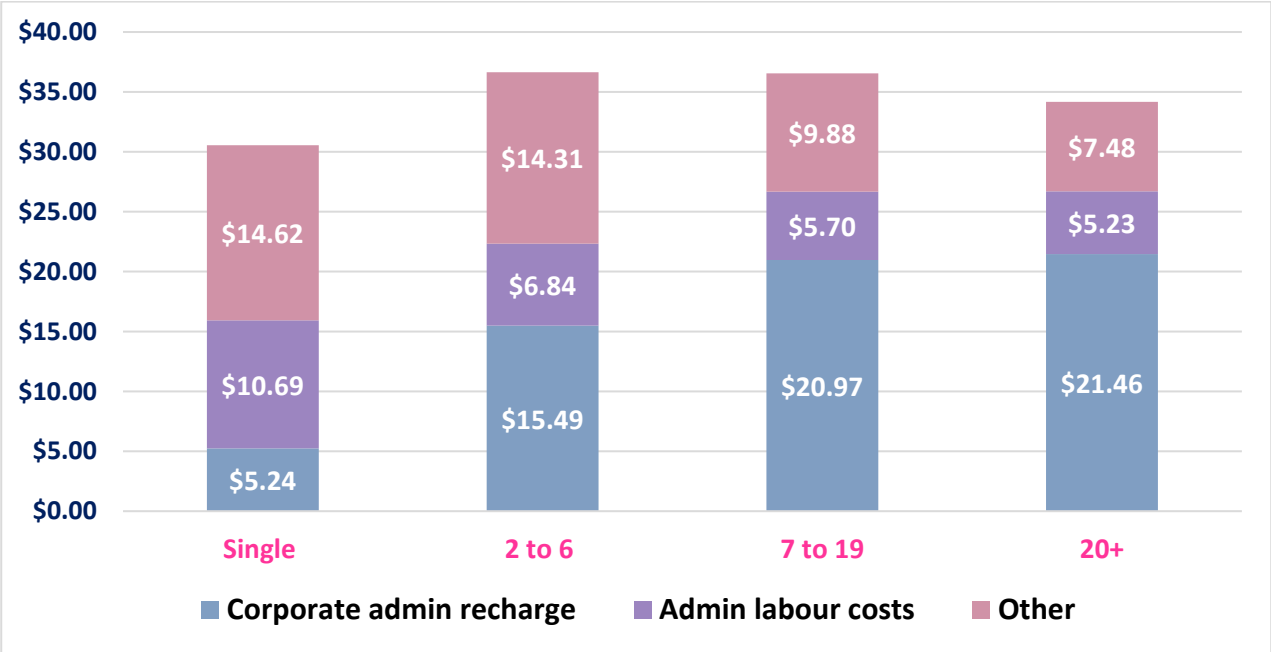
Of course, the debate continues to rage within the sector concerning Care Revenue not matching client acuity growth and how this is impinging on the Cost of Care. As we have seen and heard from numerous discussions with clients and providers there is an ongoing discussion about the growing magnitude of clinical/care intensity required for each facility client mix and how this will shape staffing, not only in RACF but also home care and ILU as staff become more mobile across organisations.

Administration and Support Services

The December half year report is also an opportunity to consider how providers are coping with the administration of providing care and accommodation. Resulting from the December survey, StewartBrown undertakes a deeper dive on what comprises the critical inputs and outputs of administration to understand how changes to aged care policy, client acuity or demographics and the influence of size/complexity of organisations impacts upon the running of residential aged care. We break down the survey analysis into specific areas to enable a better understanding of what affects corporate administration such as ownership type, location and organisation size.

What we do know is that the cost of administration continues to rise faster than CPI and in line with revenue growth, with little to no reduction in the pace of administration growth, for larger organisations who should be showing some benefit from economies of scale. StewartBrown will be working through the data to provide a Corporate Administration Survey report during the month of May so please keep an eye out for this special report.

Figure 7: Composition of administration & support services costs by size groupings



Occupancy and Supported Ratio

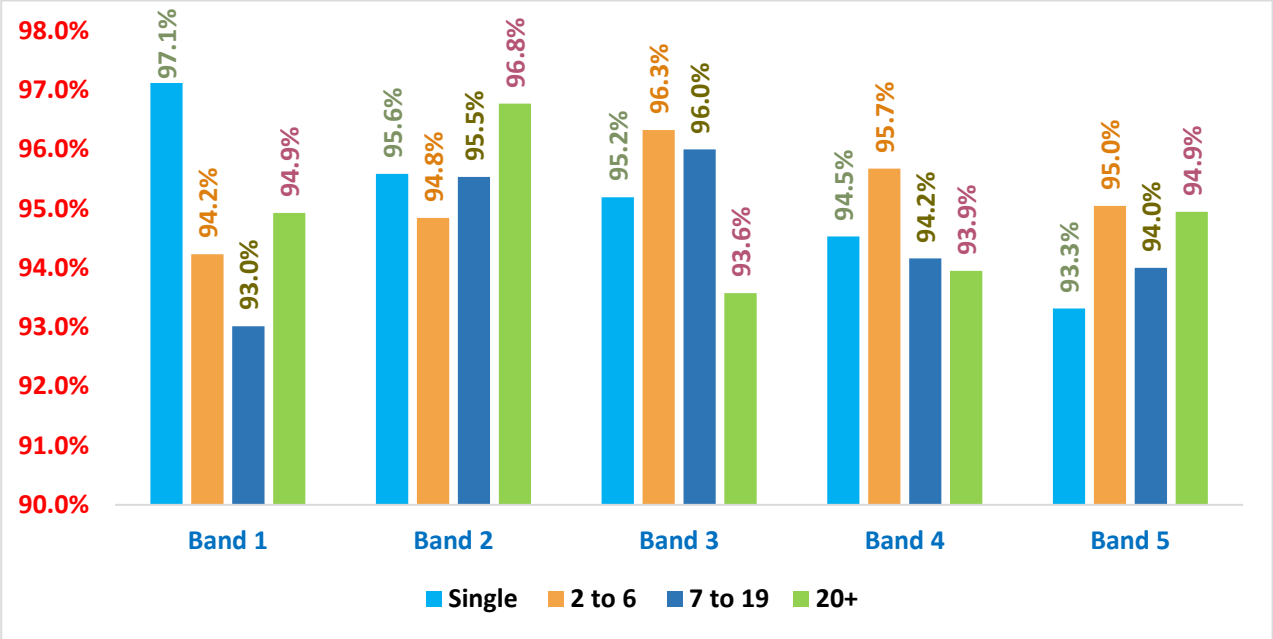
Occupancy remains stable with the survey *Average* remaining at a functional **94.9%** with stand-alone facilities and those with less than 6 facilities in the group continuing to exhibit a strong focus on keeping occupancy high. While acknowledging that many large organisations also operate in rural or remote locations where occupancy may be depressed by local conditions, as with corporate administration, we might expect that larger providers may have more capability to "systemise" maintenance of occupancy.
For those organisations that have between 2-6 or 7-19 facilities there appears to be a strong geographic co-location of services that allows better co-ordination. Reference to Figure 8 below, as a general rule we see that the larger and more complex an organisation is, its occupancy rate is sub-optimal.

While there were concerns throughout the reform process that supported client ratios may decline or that some providers were showing a preference for non-supported residents, the national supported ratio has actually increased in the NFP cohort to now rest at **over 46%.** In January of this year Aged Care Financing Authority released its report to Government on cost neutral mechanisms to ensure access to care for supported residents. The Aged Care Financing Authority report found or recommended that:

- there is not a strong case for the continuation of the regional ratios
- it is unlikely the ratios are significantly affecting provider behaviour.
- clear financial incentive of the separate 40 per cent ratio seems to be more effective in influencing provider behaviour
- the 40 per cent target ratio remains appropriate noting that supported residents make up around 47 per cent of all residents nationally.
- the calculation of the 40 per cent ratio be moved to a monthly rather than daily basis to improve administration

One of the risks within the ACFA recommendations may be through a "transfer of the burden" of supported residents to the not-for-profit sector. Albeit an assumption based on historical government data we may be seeing from Figure 3 on page 11 the data showing that the survey participants might already be carrying a larger proportion of supported clients with higher needs. While there may not be a global risk to the maintenance of the overall supported ratio at current levels, an unintended consequence for the sector may be a hidden drift of clients to the NFP sector if adequate monitoring does not occur. This risk will revolve around the access to future capital and income for those providers who, under their mission, take up the 'drifting supported residents' that some providers will decide not to take. The effects of this will not be felt immediately but this should be closely monitored as the risk will be that there will be a two-paced sector - one with little access to capital and lower income streams from accommodation and the other with a greater access to income and capital.

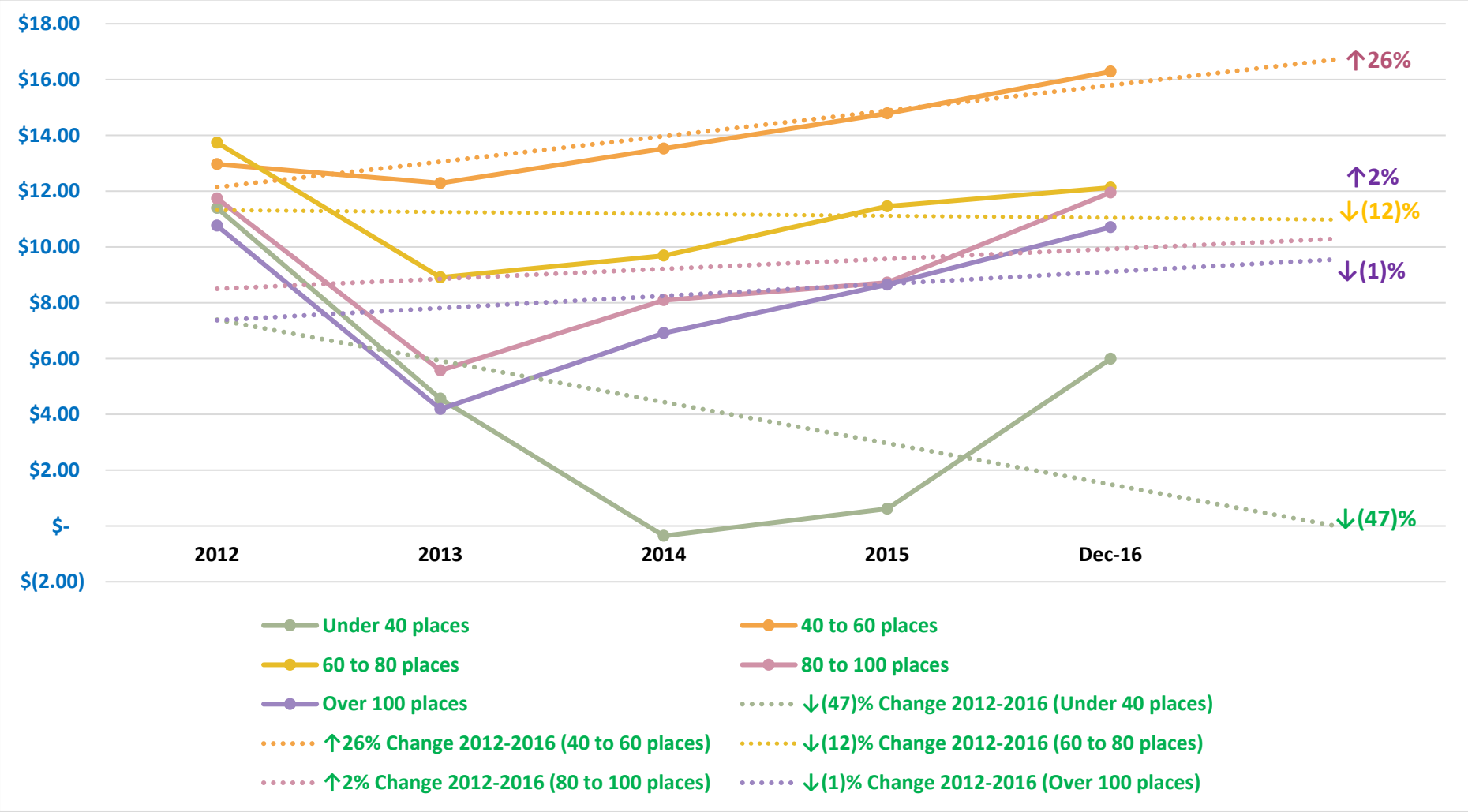
Figure 8: Occupancy by number of facilities



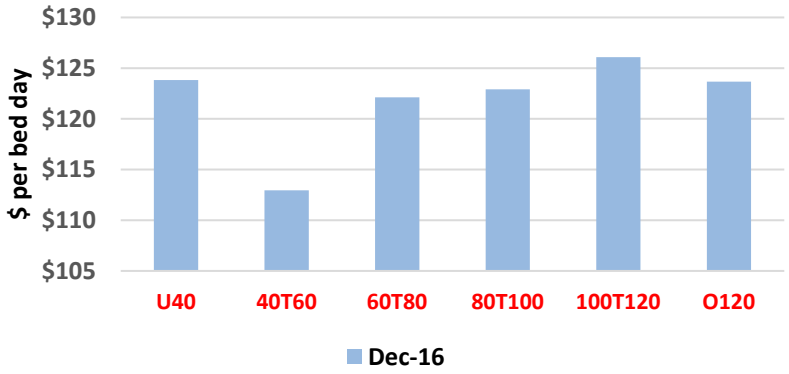
The Influence of Size and Location

The survey data has already shown that location and size of the facility may have an influence on the *Average* results of a residential aged care facility. When we consider size, we group the data by the number of places (beds) in the facility.

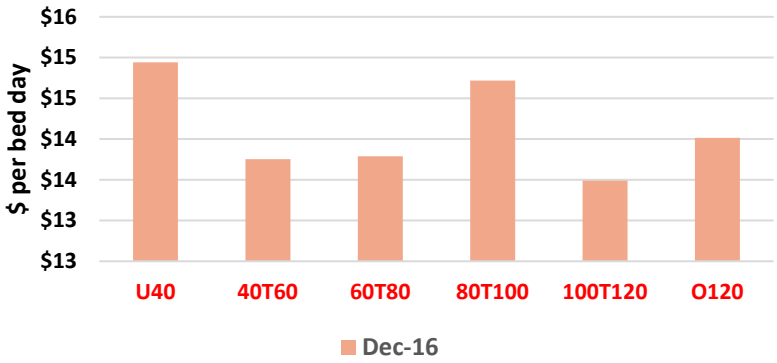
Figure 9: Trend of the Average Care Result by facility size (bed numbers) including growth change from 2012 until now



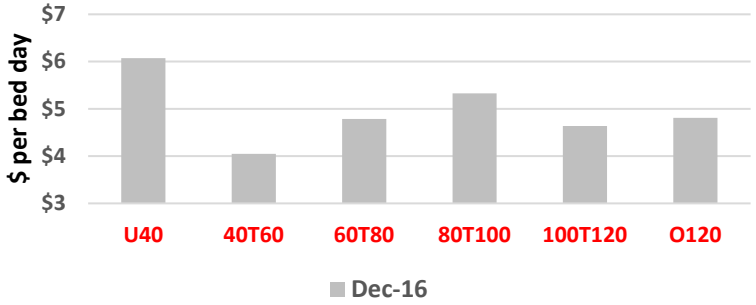
Total care labour costs and size



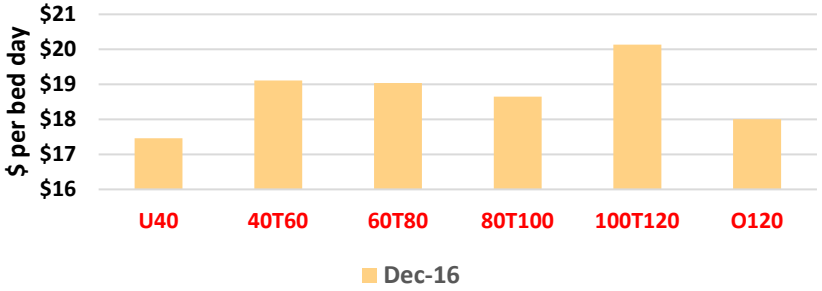
Catering labour costs



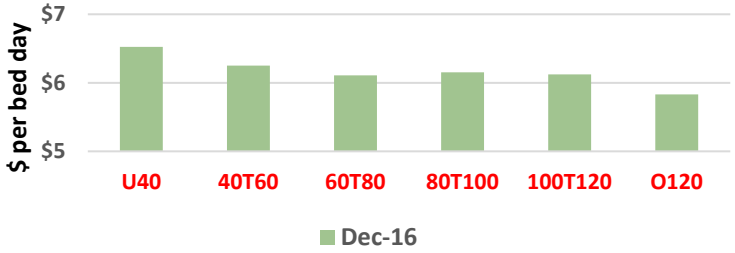
Cleaning labour costs



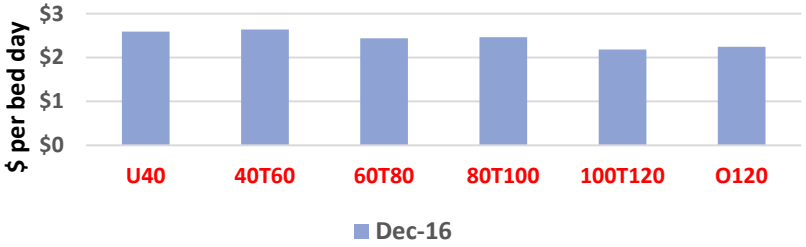
Admin labour costs



Utilities



Maintenance labour costs



The group of facilities with between 40 and 60 places remains highest surplus on *Average*. The second highest surplus group in the 2016 survey is that with between 60 and 80 beds, closely followed by the group with between 80 and 100 places. In fact, there is only **$0.61 per bed day** separating the groups between 60 beds and over.

Those facilities under 40 places have rebounded strongly from the lows of 2014 and may be exhibiting a response to low care residents moving on and being replaced by higher acuity clients. While the apparent turnaround of smaller facilities is welcomed there is a propensity for these locations to have previously been hostel style and they may well be limited in their ability to improve performance further due to:

- Building design affecting clinical and care workflow
- Location
- Facility size constraints
- Workforce issues and clinical capacity as resident acuity rises
- Level of demand for services in an older style residence (occupancy)

Thus, quite obviously, the financial performance generally comes down to how well a facility is managed but there are quite a few mitigating factors that will need to be considered by this group as time goes on and client acuity rises alongside demands for updated amenity and accommodation.

The chart above also shows that the results have been relatively consistent over a number of years. The improvement in the results of the larger facilities has also continued to move in an upward trajectory, although this is at a far slower rate of growth. We would expect that the larger facilities may begin to improve at a faster rate as providers better manage staff and other costs in multiple story facilities.

Analysis of Lowest 50% of Facility Results

The aged care sector has been through almost 4 years of active reform with an analysis of the process now in progress with the Tune Review. During the year to December 2016 we know that **72%** of the survey participants obtained a positive Facility Result (Care plus Accommodation Result) which was up **1.3%** on June 2016. Of course, this means that **28%** of the sector had a negative Facility Result pointing to almost 30% of the aged care facilities not being viable in the longer term unless their performance improves. In the interests of understanding this cohort of facilities better we have done some analysis of the characteristics that these facilities exhibit against the remainder of the sector.

So, what do we see when we do a side by side comparison of the facilities?

- Single facility providers are **1.35** times more likely to be in the lowest 50%
- Groups less than 20 facilities are **1.75** times more likely to be in the lowest 50%
- Outer regional facilities are **1.41** times more likely to be in the lowest 50%
- Remote facilities are **1.6** times more likely to be in the lowest 50%
- Very remote facilities are **1.33** times more likely to be in the lowest 50% *(noting they receive greater non-operational assistance/revenue than the others in the regional remote group)*
- These facilities as a whole carry a larger percentage of supported residents at **74.2%** against the top quartile who carry a supported ratio of **64.4%**
- Almost all of these facilities are operated by large providers who are carrying their losses as a part of the overall organisational performance. StewartBrown always recommends that these organisations fully cost their mission to ensure that mission remains sustainable and delivers on outcomes.
- Facilities represented in the negative EBITDA group are often smaller, often 40 beds or below, but all facility sizes are represented in this group.

There is nothing startling in these results and most providers could have guessed the main themes. However, it does point to some larger considerations for those operating facilities in these at-risk areas:

- Single facilities and small groups will need to consider consolidation or alliances in order to become functionally larger and obtain better economies of scale
- Management and staff capability will be critical to ongoing viability and survival pointing to strategies around attraction, recruitment and retention of staff and/or management
- Boards will need to be well versed in sector reforms, their impacts and mitigations required to improve facility performance or more likely manage risks that these represent.
- Boards may also be faced with a "Sophie's Choice" decision as to whether to continue or close a facility
- Governments at both a state and federal level will need to consider how best to support facilities in rural and remote locations in order to service their communities. We have seen some steps to this with changes to the viability supplement, but there will need to be more consideration of supportive action.
- Governments and Providers will need to carefully consider whether some of these facilities are unviable and therefore may need to be de-commissioned or risk dragging the financial performance of the whole organisation or community down. This has wide ranging public health and support impacts for rural and remote communities to be considered.

Results By State

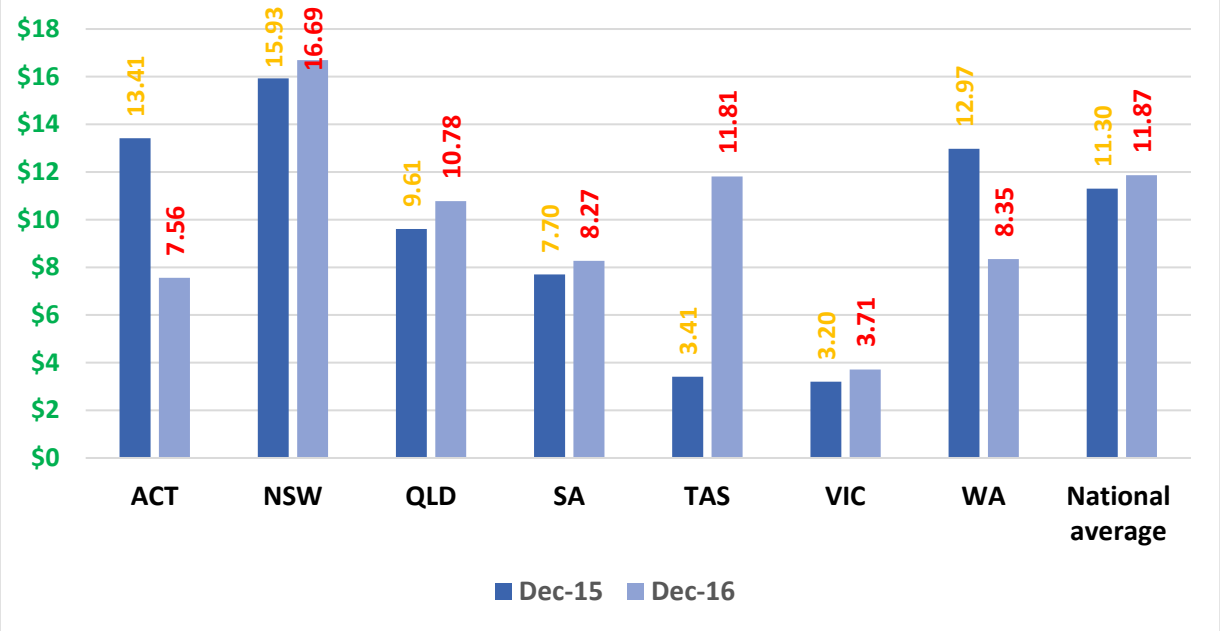
There continues to be disparity in the results of facilities across State borders. Western Australian facilities continue to decline against the December 2016 results further retreating from $12.97 in December 2015 to what was close to the National *Average* at June 2016 ($10.14 per bed day) to an *Average* of **$8.35** per bed day for the December 2016 quarter. Interestingly their 2016 results were lower than the 2015 financial year.

Given the large change in Care Result for both Western Australia and the ACT we checked to see if there was a significant activity or variance that impacted either state. For Western Australia, particularly it appears that all bands (band determined as at Dec-16) are struggling, and Band 4 in particular has decreased significantly.

On analysis, we know the decrease was not due to any outliers as such and our clients in Western Australia have signalled that operations have been tougher, so this may signal changes at the state level. Naturally we will follow this change closely through the remainder of the 2016/17 financial year. For the ACT, there is also no evidence of a single issue that is primarily affecting the results and is also signalling tougher operating conditions as with Western Australia.

The *Average* results for New South Wales facilities remain the highest nationally at **$16.69** per bed day which is an improvement on the December 2015 results **($15.93** pbd) and June 2016 results for that State **($15.32** per bed day). NSW results are now an *Average* of **$4.82** per bed day higher than the National *Average*. With the exception of Western Australia and the ACT, the *Average* results for each State continued their improvement in the December quarter compared to both December 2015 and June 2016.

Figure 10: Average Care Result by State and Territory – December 2016 compared with December 2015

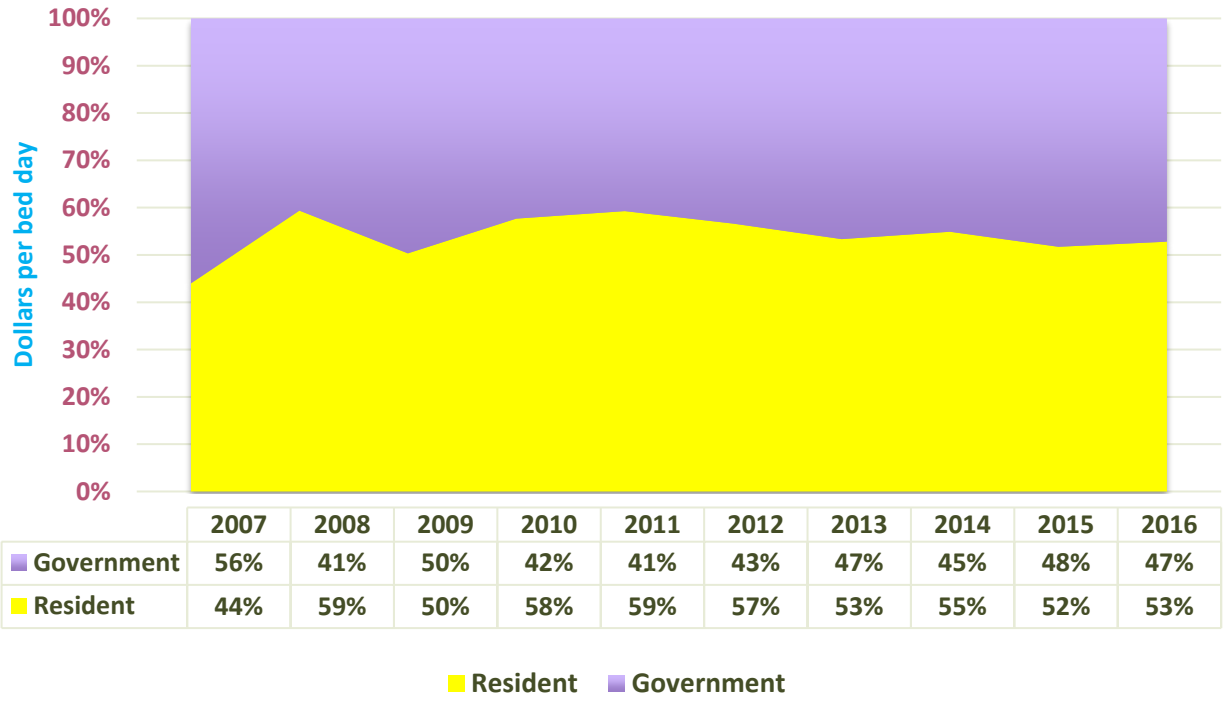


ACCOMMODATION ANALYTICS

Share of Accommodation Revenue

During 2015 we saw the share of revenue tip back towards the Commonwealth but in 2016 this trend reversed with a shift back towards the resident contributing the larger share of accommodation income, almost being a mirror image of 2007 with Government share of **47%** and consumer at **53%**. As with the Care Revenue share earlier we would expect that, due to the high supported resident ratios across this survey population that, the figures would be overstating the government's contribution relative to the aged care sector as a whole.

Figure 11: Share of accommodation Revenue as at December



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Government	56%	41%	50%	42%	41%	43%	47%	45%	48%	47%
Resident	44%	59%	50%	58%	59%	57%	53%	55%	52%	53%

Average Accommodation Pricing

For some time StewartBrown has been highlighting the growing differential between the *Average* accommodations price in Australia against the rapid growth in dwelling values in all states. With an *Average* national house price of **$660,000** it is relevant that providers need to be more strategic and a little more courageous in setting their Accommodation Pricing. We also note the Department's guidelines on levying additional charges such as the Asset Replacement Charges.

At December 2016, the *Average* Accommodation Price was **$365,000** (The *Average* Residential Accommodation Deposit (RAD) taken during the same period was **$311,434** an increase of **$15,830** above the June 2015 figure and **$28,764** above the December 2015 *average* RAD).

This tracks significantly below the national median house price of $660,000[5] by $295,000 further highlighting that accommodation pricing is an area of revenue that remains to be fully explored.

[5] RPLogic data 2016

Hobart has the lowest median house price of $382,500 which is still higher than the *average* accommodation price within Australia. Providers should take heart that with a compound growth rate of 5.98% in in RAD pricing since the reforms allowed RADs in high care - occupancy remains stable at 94.9% across the nation.

During 2016 of the half a million dwellings sold only 33% of the nation's homes and 40% of apartments sold for less than $400,000[3], indicating that 60% of the real estate market currently is valued well above the *average* accommodation price. Of course, there are exceptions at both ends of the market, but generally there is scope for a more progressive accommodation price growth.

Movements in Accommodation Pricing

Taking data from the *Pricing Commissioners Annual Report 15/16*[6], during the 2015/16 year 4,142 beds had RAD prices approved that were above the maximum amount determined by the Minister, equating to less than **1.8%** of the beds in the sector being re-priced above the $550,000 mark. Looking at the sector pricing movements for 2016 we can see that:

- **16%** increased their minimum and maximum price (but only 1.8% of these above $550,000)
- **4%** decreased their minimum and maximum price
- **62%** did not change pricing at all

While it is interesting to note the **4%** who decreased their pricing, most likely to shore up occupancy in ageing stock, it is lower than the discounting seen in the real estate market which sits at about 6%.

Table 5: Published Accommodation Prices by State

	Min Published Accommodation Price ($)	Max Published Accommodation Price ($)	Median Published Accommodation Price ($)	*Average* RAD Taken ($)
National	34,000	2,740,602	365,000	311,434
NSW	50,000	2,740,602	357,000	313,152
QLD	100,000	913,500	360,000	257,961
VIC	34,000	1,835,000	380,000	330,047
NT	114,000	550,000	320,000	540,145
SA	45,000	825,000	350,000	352,997
WA	120,000	1,250,000	365,000	291,069
ACT	220,000	950,000	505,000	452,984
TAS	175,000	650,000	325,000	216,476

[6] https://goo.gl/QixzdC

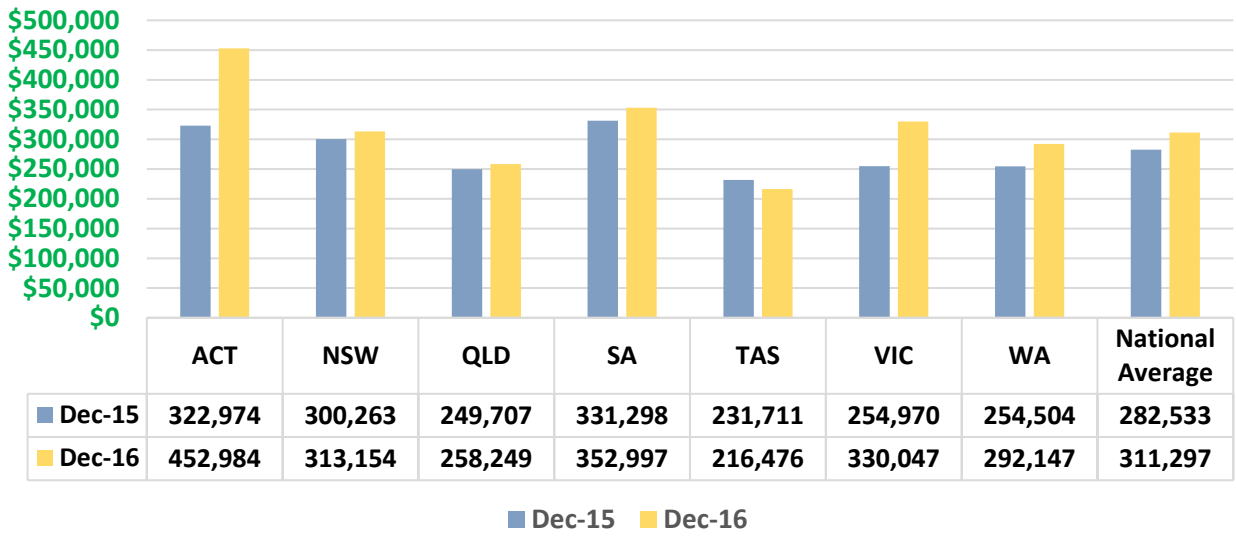
In real terms, it could be said that aged care accommodation is too low, leading to pressure on other parts of the business where costs outstrip revenue, which should push management and boards towards a re-pricing of their accommodation to match market conditions.

As with our hypothesis of floating the basic daily fee, accommodation pricing should not be seen as static but one where the price is allowed to fluctuate in response to the client's ability to pay and any market mechanisms that create price headroom.

Stability in the overall occupancy of RACF should provide comfort to the sector that there is scope to at least test the market around uplifting accommodation prices, in fact those with a higher Accommodation Price often have higher occupancies than their competitors.

StewartBrown has built a range of tools that can assist providers with identifying not only their competitor positioning but also comparators to the real estate market wherever their service is, providing strong analysis and guidance for their pricing strategies.

Figure 12: Average RAD taken by State and Territory



	ACT	NSW	QLD	SA	TAS	VIC	WA	National Average
Dec-15	322,974	300,263	249,707	331,298	231,711	254,970	254,504	282,533
Dec-16	452,984	313,154	258,249	352,997	216,476	330,047	292,147	311,297

Importance of Realistic Depreciation Expense

Given the dependence on built environment for residential care it is important that the sector continues to observe the importance of providing a realistic and robust depreciation expense. At a time where Australia requires 76,000 beds in the next 10 years perhaps the most important role for depreciation is that it allows providers to set aside part of their revenue as funds for future asset replacement and refurbishment. Of course, the converse is that without charges of depreciation expense, that portion of revenue might have been inappropriately used for other purposes.

Figure 13: Age distribution of residential age care building stock

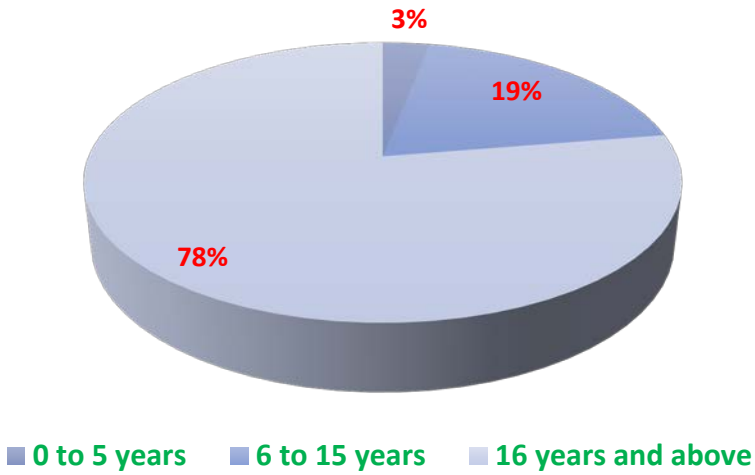
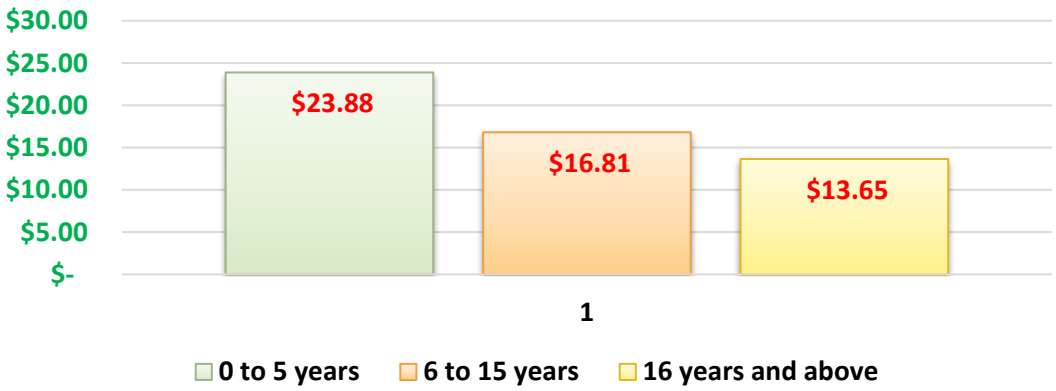


Figure 14 below confirms that the newer builds have a higher cost and therefore greater depreciation, because the average depreciation rate is similar across the building sizes there has not been a lot of new builds in recent years as per the Figure 13 above, hence the effect of an estimated growth in facilities 0-5 years in Figure 14 has not (yet) greatly affected the overall results.

Figure 14: Depreciation expense versus aged of residential aged care building stock



We then looked at the basic sufficiency of Accommodation Surpluses, quantifying it in the Table 6 below. This rudimentary analysis suggests that providers need to be delivering an Accommodation Surplus before depreciation of a minimum of **$17.12 pbd** to provide for a full replacement cost and also a further minimum surplus of **$4.57 pbd** for future refurbishment cost (i.e. **$21.69 pbd** total Accommodation Surplus before depreciation as a minimum). The rationale is included Table 6.

Table 6: Depreciation requirement for building replacement or refurbishment

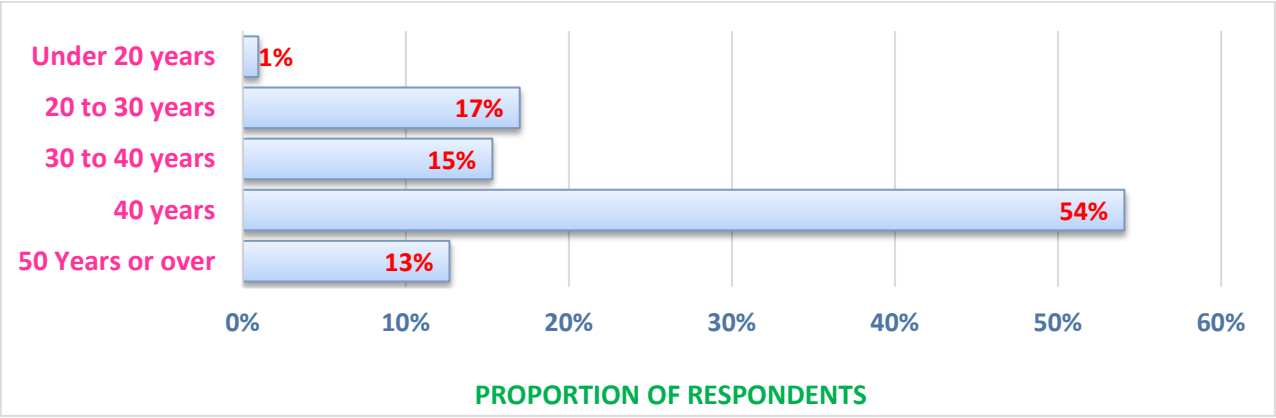
Building Replacement Cost ($ per bed)	**$ 250,000**	**$ 275,000**	**$ 300,000**	**$ 325,000**
Depreciation rate (%) *(40 years)*	2.5%	2.5%	2.5%	2.5%
Depreciation charge ($pa)	$ 6,250	$ 6,875	$ 7,500	$ 8,125
Depreciation charge ($pbd)	**$ 17.12**	**$ 18.84**	**$ 20.55**	**$ 22.26**
Depreciation rate (%) *(25 years)*	4%	4%	4%	4%
Depreciation charge ($pa)	$ 10,000	$ 11,000	$ 12,000	$ 13,000
Depreciation charge ($pbd)	**$ 27.40**	**$ 30.14**	**$ 32.88**	**$ 35.62**

Refurbishment Cost ($ per bed)	**$ 25,000**	**$ 35,000**	**$ 50,000**	**$60,000**
Depreciation rate (%) *(15 years)*	6.67%	6.67%	6.67%	6.67%
Depreciation charge ($pa)	$ 1,668	$ 2,335	$ 3,335	$ 4,002
Depreciation charge ($pbd)	**$ 4.57**	**$ 6.40**	**$ 9.14**	**$ 10.96**
Depreciation rate (%) *(10 years)*	10%	10%	10%	10%
Depreciation charge ($pa)	$ 2,500	$ 3,500	$ 5,000	$ 6,000
Depreciation charge ($pbd)	**$ 6.85**	**$ 9.59**	**$ 13.70**	**$ 16.44**

There is an accounting quandary in that depreciation is based on historical cost (not replacement cost), however it could be argued that to ensure that buildings can be eventually replaced, and, in the interim will require internal refurbishment every 10-15 years they should adjust their depreciation rates accordingly on existing buildings (maybe in the order of 5% - 6% pa). This in turn would presumably drive providers to improve their Accommodation Result as the higher depreciation charge needs to be recovered.

The depreciation policy of many providers does not appear to match their policy on refurbishment. Given that close to half of the providers indicated that their renewal policy is to undertake a major refurbishment of a facility in under 15 years, then it could be expected that the *Average* depreciation rate would be closer to *20 or 30 years* rather than 40 years and over.

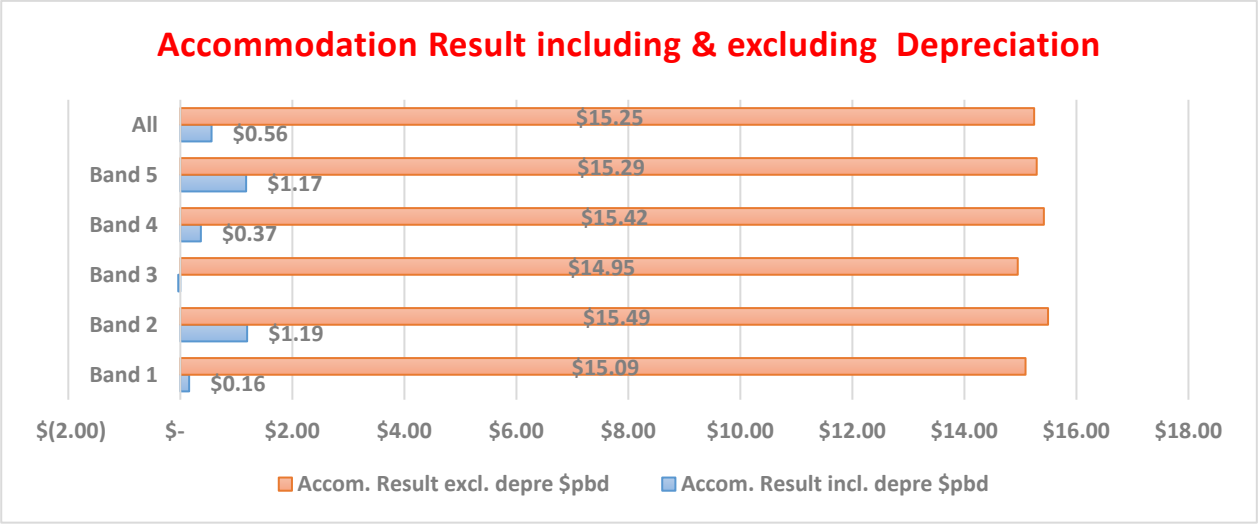
Figure 15: Depreciation Policy - distribution of policy on estimated useful life of residential aged care facilities for the purpose of depreciation



If it is the policy to refurbish a facility in say 15 years, then you would expect at least half of the value of the building to have been depreciated by that time. The other half you might continue to depreciate over say 40 or 50 years. The effective depreciation rate in this case would be closer to 4.5% than the 2.5% which appears to be a sector standard.

Figure 16 below shows the impact of depreciation on provider surpluses, this is a reflection of the size of the surplus and cash flows the entity needs to generate to refurbish or redevelop the facility when the need arises. To underestimate the level of depreciation means that sufficient surpluses and cash flows will not be generated for that purpose.

Figure 16: Accommodation result including and excluding depreciation



Having said that, it would appear that the NFP sector is generally more aggressive in its depreciation policies than the listed entities. The *Average* depreciation charge across all the facilities in the StewartBrown survey was **$13.99** per bed day in the 2016 financial year (2015: $13.83 per bed day). This is in contrast to the *average* across the three listed entities of just **$8.84** per bed day (2015: $8.53 per bed day). In fact, the listed entities have depreciation policies for buildings based on estimated useful lives that range between 50 and 60 years.

Appropriate use of depreciation may in time become a competitive advantage for those that eschew surplus in the short term through inadequate depreciation rates and invest in the upkeep, refurbishment and replacement of their assets to meet the changing mores and requirements the Boomer generation will expect from the provider of the future.

Sector Change in Accommodation Pricing

During the year to December 2016 we have seen approximately 35-36% of providers increase both their minimum and maximum prices. It would be expected that for any sector a change in pricing to more than 30% of the market is significant and further underscores that providers are actively responding to their changing environment.

Another interesting change is those providers who have reduced their pricing over the year. A decrease in minimum and maximum price has occurred in **approximately 5-6%** of the sector and may be in response to occupancy, amenity or other competitive forces.

As stated previously the compound growth rate of accommodation pricing since the start of reforms has been 5.98% and during this year those providers that have adjusted their pricing upwards have done so by an average 14%, again highlighting that providers are moving strongly to price their offer more appropriately in response to conditions.

Although price elasticity would be expected in any market, it is our contention that unless providers are certain that price is their only competitive lever remaining to be pulled, then they should consider very strongly assessing the competitor environment more closely before changing their pricing downwards. Providers that decreased their minimum price did so by a significant factor of 25% and decreased their maximum price by 17%. Discounting works in the retail space so well, because brands can limit supply (or at least make it look like supply is limited), and therefore create a sense of urgency in the eyes of the consumer. However, in a sector like aged care where supply is functionally limited by regulation and availability there are many other avenues that management or a board can investigate before reducing price.

Discounting is a slippery slope and if we use the average accommodation result, with depreciation added back, the *Average* Accommodation Result has a thin 38% gross margin. If a provider drops their prices by 20%, they will have to triple the number of beds occupied to have the same gross surplus dollars which is unlikely.

Figure 17: Changes in Minimum Price

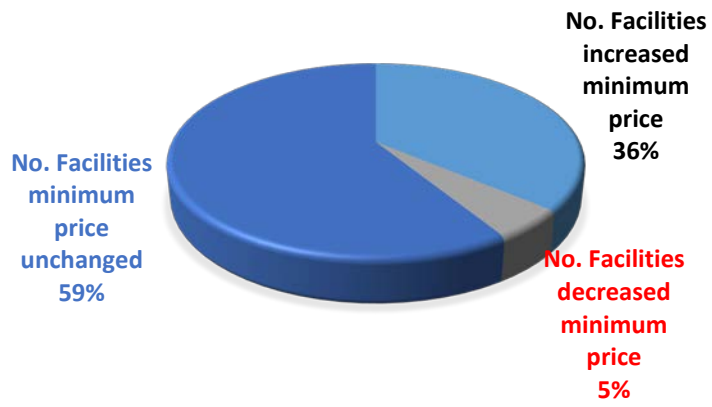
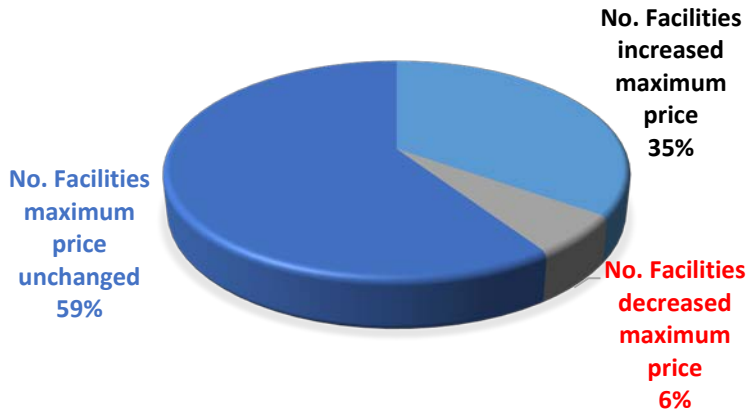


Figure 18: Changes in Maximum Price



BENCHMARK BANDS

For the purpose of benchmarking facilities against each other we sort facilities into "benchmark groups" based on the levels of **care subsidies** + **resident daily fees**_+ **extra service fees** received. These revenue types should then group facilities based on their "care" revenue streams and as such they should have comparable cost profiles as well. We reassess the parameters of these bands each year to allow for increases in subsidy and fee rates as well as the creep in revenue due to the practice of ageing in place. The bands used for the current and past financial years are shown in table 12 (below).

In 2017 we have reassessed band parameters to take into account the increase in subsidy rates, and the change in overall Care Revenue of many of the facilities in the survey.

As a result, we looked at a number of alternatives including both increasing and reducing the number of bands. The reason that we looked at reducing the number of bands was due to a number of participating facilities that move backwards and forwards between bands as a result of shifting revenue.

However, even if we were to reduce the number of bands there will still be facilities that that sit on the threshold between bands and will move backwards and forwards. Unfortunately, this cannot be totally avoided.

Ultimately, and after some experimentation, we decided on increasing threshold of each of the bands by $15. This has evened the distribution of facilities across the bands somewhat as well as providing a greater focus on those facilities with higher Care Revenue. Band 1 had become the largest band and that has now been redistributed somewhat so that Band 1 now truly represents high care facilities again.

Table 7: Benchmark bands 2012 until today

	2017 Surveys	2016 Surveys	2015 Surveys	2014 Surveys	2012 & 2013 Surveys
Band 1	**Over $235**	Over $220	Over $210	Over $210	Over $195
Band 2	**$220 to $235**	$205 to $220	$190 to $210	$190 to $210	$175 to $195
Band 3	**$205 to $220**	$190 to $205	$170 to $190	$170 to $190	$155 to $175
Band 4	**$190 to $205**	$175 to $190	$150 to $170	$150 to $170	$135 to $155
Band 5	**Under $190**	Under $175	Under $150	Under $150	Under $135

GLOSSARY OF TERMS

Averages

All *averages* are calculated using the total of the raw data submitted for any one line item and then dividing that total by the total occupied bed days for the facilities in the group. For example, the *average* for contract catering across all facilities would be the total amount submitted for that line item divided by the total occupied bed days for all facilities in the survey.

***Average* by line item**

This measure is *averaged* across only those facilities that provide data for that line item. All other measures are *averaged* across all the facilities in the particular group. The *average* by line item is particularly useful for line items such as contract catering, cleaning and laundry, property rental, extra service revenue and administration fees as these items are not included by everyone

Benchmark

We consider the benchmark to be the *average* of the top 25% (or 1st Quartile) in the group of facilities being examined. For example, if we are examining the results for facilities in Band 1, then the benchmark would be the *average* of the top 25% of the facilities in Band 1.

Dollars per bed day

This is the common measure used to compare items across facilities. The denominator used in this measure is the number of occupied bed days for any particular facility or group of facilities.

EBITDA

This measure represents earnings before interest, taxation, depreciation and amortisation. The calculation excludes interest revenue on investments as well as interest expense on borrowings.

The main reason for this is to achieve some consistency in the calculation. Different organisations allocate interest differently at the "facility level". To ensure that the measure is consistent across all organisations we exclude interest revenue.

EBIT

Earnings before interest and taxation. This is a measure that excludes those variables relating to the tax status and financial position of an entity but recognises the consumption of capital in the form of depreciation and amortisation.

Facility EBITDA

The starting point for this calculation is the Facility Result which is a combination of the Care and Accommodation results. It excludes all "provider revenue and expenditure" including fundraising revenue, investment revenue from other than interest, capital grants and sundry revenue. It also excludes those items excluded from the EBITDA calculation above. This measure is considered to be more consistent across the facilities because it excludes all those items which are generally allocated at the facility level on an inconsistent and arbitrary basis depending on the policies of the individual provider.

Facility Result

Combination of the Care and Accommodation results. It excludes revenue from fundraising, investments, sundry revenue and fair value adjustments.

Location - City

Facilities have been designated as being city based according to the designation by the Department of Social Services (formerly Department of Health and Ageing) in their listing of aged care services. Those that were designated as being a "Major City of Australia" have been designated City.

Location - Regional

Facilities have been designated as being regionally based according to the designation by the Department of Social Services (formerly Department of Health and Ageing) in their listing of aged care services. Those that were designated as being a "Inner Regional", "Outer Regional" or "Remote" have been designated as Regional.

StewartBrown Aged Care Executive Team

Stuart Hutcheon

Managing Partner

Stuart Hutcheon is the firm's Managing Partner and the head of our Audit & Assurance Division, and also provides consulting services to a diverse client base. He has had considerable experience with both commercial and not-for-surplus organisations. This experience covers all areas of professional services including auditing, management accounting, budgeting, salary packaging and FBT advice. Stuart has been involved in providing professional services to the aged care and community care sector sectors for over 20 years.

Grant Corderoy

Senior Partner

Grant Corderoy is the head of the Aged and Community Care and Business Consulting Division. Grant first established the *Aged Care Financial Performance Survey* in 1995. He specialises in a range of services for his clients including undertaking complex accounting assignments, business performance reviews, organisation and governance reviews, system reviews, management consulting, strategic planning and general business advice. He also has considerable experience in advising clients on the sale and purchases of businesses, business valuations and due diligence.

Patrick Reid

Director

Patrick has recently joined StewartBrown in the position of Director - Aged Care, Community and Disability after serving as CEO of LASA. As an experienced CEO, board director, business owner and executive with more than 20 years' success in business, association management and lobbying, Patrick possesses a proven track record in business, leadership, change management and advocacy. Patrick has highly developed financial, commercial, negotiation and management skills.

David Sinclair

Director

David Sinclair has been with the firm for over 20 years and has been involved in the *Aged Care Financial Performance Survey* for the duration of that service and now heads the team undertaking the survey. David is also heavily involved in consulting assignments for aged care and community service clients including strategic planning, financial modelling, budgeting and governance reviews.

Tracy Thomas

Manager - Analyst and Consulting Division

Tracy is a Chartered Accountant with six years post qualification experience. She has a diverse background having worked in audit and assurance, for the regulator of private health insurance and for a private health insurance company. Since joining StewartBrown she has worked with several providers of residential aged care and home care and produced the *Aged Care Financial Performance Survey* Corporate Administration Report and Listed Providers Analysis for year ended June 2016. She specialises in data analysis and financial modelling.

StewartBrown - Our Knowledge is your success

StewartBrown, Chartered Accountants, was established in 1939 and is one of the leading boutique accountancy firms in Australia combining a full range of professional services with varied corporate assignments. Our professional mission statement is "*we deliver service beyond numbers*", which reflects the commitment to helping our extensive range of clients to achieve their financial goals.

We offer a depth of technical knowledge and varied professional experience, with many of our senior staff now having well over 10 years' of service with the firm, resulting in our clients benefitting from continuity and accountants who really understand their business.

What a boutique firm offers

Whilst StewartBrown provides a range of professional services, our "point of difference" is our ability to engage in assignments of a complex nature by providing a varied mix of experience and corporate skills. Examples of recent consulting assignments include:-

- Contract accounting
- Payroll processing and billing processing
- Financial modelling and unit costing analysis
- Strategic planning facilitation
- ITSC Project management
- Governance reviews
- Organisation restructures
- Risk management reviews
- Due diligence
- Work-flow building design
- FBT and GST reviews
- Detailed forecasting modelling

Audit and assurance services

Complementing our consulting services is our dynamic Audit division. StewartBrown adopts a risk based audit approach which is performed strictly in accordance with Australian Auditing Standards. Our engagements involve a detailed analysis of the client's business and systems of internal control to ensure we fully understand how the client operates and identify areas that pose the greatest risk of being materially misstated in the financial statements. Our detailed testing procedures are then tailored to meet the risks identified and also ensure an efficient and effective audit is performed. What we offer our audit clients are a mix of experience and knowledge well beyond that of most other firms. Our audit staff all have regular exposure to consulting and secondment assignments which significantly enhances the "value add" we bring to our audit clients.

Specialty in the aged care, community and disability sectors

StewartBrown is widely regarded as being a leading specialist within the aged care, community and disability sectors. Our client base includes many large national providers in addition to independent stand-alone providers, faith-based and community providers, culturally specific providers, as well as government and statutory bodies.

Our commitment to these important social sectors each year involve 30+ plus speaking engagements at Conferences, sector briefings, workshops, department briefings, organisation presentations and community consultations.

Integrity + Quality + Clarity

These terms which appear on our logo are more than aspirations, they appear for a very important reason - they encapsulate the professional standards that we strive to continually maintain and ensure best practice

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StewartBrown Audit Capability
"StewartBrown has over 78 years' experience providing professional services to the aged care, disability, community service and not-for-profit organisations."
78 YEARS IN BUSINESS
140+ AUDITS IN TOTAL
40+ YEARS IN AGED CARE
50+ AGED CARE AUDITS PER YEAR
70+ NFP AUDITS PER YEAR
50+ ACCOUNTING STAFF
AUSTRALIA WIDE
2 PARTNERS
30+ SPECIALIST AGED CARE STAFF
LARGEST AGED CARE AUDIT TEAM IN AUSTRALIA
7 MANAGERS
4 AUDIT DIRECTORS
AUDIT TEAM HAS TRIPLED IN 5 YEARS