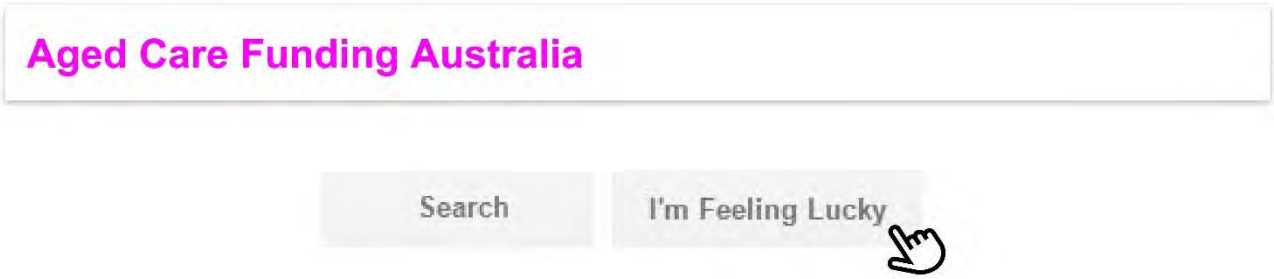
StewartBrown

Integrity + Quality + Clarity

AGED CARE FINANCIAL PERFORMANCE SURVEY



RESIDENTIAL CARE REPORT - MARCH 2017

The StewartBrown *Aged Care Financial Performance Survey* (ACFPS) incorporates detailed financial and supporting data from over 869 residential aged care facilities and 479 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 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 440 home care programs.

"Advice using your language, supporting your goals"

AGED CARE FINANCIAL PERFORMANCE SURVEY

855+ RESIDENTIAL CARE FACILITIES

480+ 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

CONTENTS

HIGHLIGHTS
OPERATING RESULTS

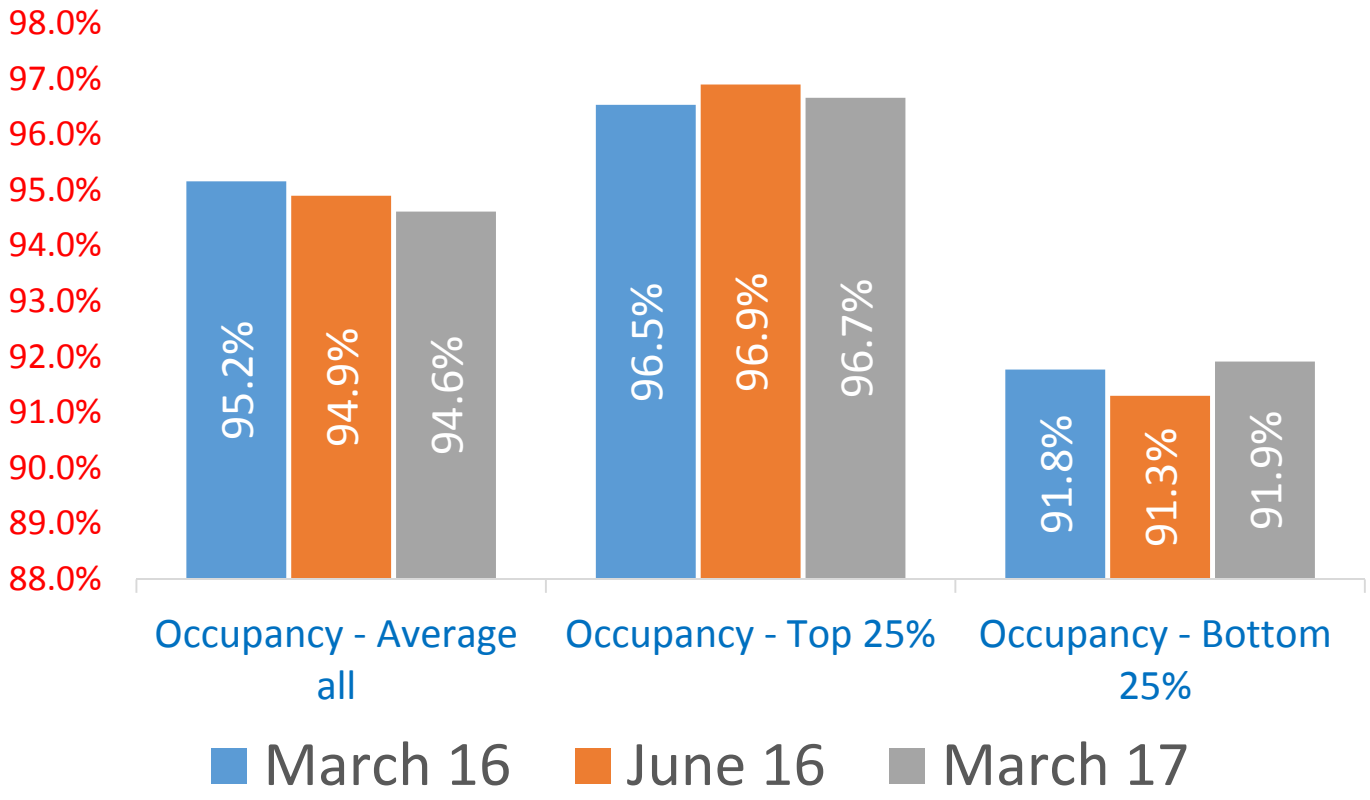
$9.93 Average Care Result of $9.93 per resident per day a decrease of $0.85 from June 2016 at $10.78 and a decrease of $0.50 cents from March 2016 at $10.43

$38.29 Average Care Result of the top 25% was $38.29 per resident per day a decrease of $0.13 from June 2016 at $38.42 and a decrease of $1.02 from March 2016 at $39.31

$8,616 Average facility EBITDA of $8,616 per bed per annum a decrease of $325 from June 2016 at $8,941 and a decrease of $211 from March 2016 at $8,828

$18,526 Average facility EBITDA of the top 25% $18,526 per bed per annum an increase of $405 from June 2016 at $18,121 and an increase of $102 from March 2016 at $18,425

HIGHLIGHTS
OCCUPANCY



HIGHLIGHTS
ANALYSIS

71.8% positive overall result

Down 3.9% from December 2016: 75.7%
Down 4.1% from June 2016: 75.9%

117 facilities had a negative EBITDA

Up 31% from December 2016: 89
Up 41% from June 2016: 83

Average Care Result of bottom 75% was $1.27 per bed day

Average Care Result of bottom 75% was ($1.24) cents worse at $1.27 than June 2016 at $2.51 and was $0.06 cents worse than March 2016 at $1.33

Average Care Result of bottom 50% ($7.44) per bed day

Average Care Result of bottom 50% was ($1.82) worse at ($7.44) than June 2016 at ($5.62) and ($0.83) cents worse than March 2016 at ($6.61)

Average Care Result of bottom 25% ($18.67) per bed day

Average Care Result of bottom 25% was ($1.13) worse at ($18.67) than June 2016 at ($17.54) and ($0.21) cents worse than March 2016 at ($18.46)

HIGHLIGHTS
ANALYSIS

$273,214

Average Refundable Deposit held in the 12 months to March 2017 was $273,214 a 10% increase on March 2016 of $247,416

December 2016 - $268,149

June 2016 - $252,319

$312,607

Average Refundable Deposit taken in the 12 months to March 2017 was $312,607 a 9% increase on March 2016 of $285,529

December 2016 - $311,297

June 2016 - $298,712

$27.13

Top 50% Average Care Result was $27.13 per bed day an increase of $0.12 cents on June 2016 at $27.01 and a 1% decrease of $0.21 cents on March 2016 at $27.34

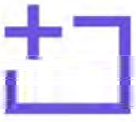
December 2016 - $28.16

$14.96

Care Result varies across States and Territories with the highest being New South Wales with an average Care Result of $14.96 per bed day

($1.44)

Care Result varies across States and Territories with the lowest being the Australian Capital Territory with an average Care Result of ($1.44) per bed day



67.3%

of facilities had a positive facility result (care result + accommodation result) down 4.2% from June 2016 at 71.5%

December 2016 - 71.6%

HIGHLIGHTS
ANALYSIS

Care Result <40 places - $2.37 pbd

Average Care Result for facilities under 40 beds was $2.37 per bed per day a 46% decrease of ($2.03) from June 2016 of $4.40
December 2016 - $5.99
March 2016 - $0.33

Care Result 40-60 places - $14.31 pbd

Average Care Result for facilities 40-60 beds was $14.31 per bed per day a 1% increase of $0.18 from June 2016 of $14.13
December 2016 - $16.29
March 2016 - $13.86

Care Result 60-80 places - $10.97 pbd

Average Care Result for facilities 60-80 beds was $10.97 per bed per day a 2% decrease of ($0.22) from June 2016 of $11.19
December 2016 - $12.13
March 2016 - $9.81

Care Result 80-100 places - $9.79 pbd

Average Care Result for facilities 80-100 beds was $9.79 per bed per day a 16% decrease of ($1.90) from June 2016 of $11.69
December 2016 - $11.95
March 2016 - $10.29

Care Result 100-120 places - $8.06 pbd

Average Care Result for facilities100-120 beds was $8.06 per bed per day a 2% increase of $0.14 from June 2016 of $7.92
December 2016 - $9.94
March 2016 - $8.41

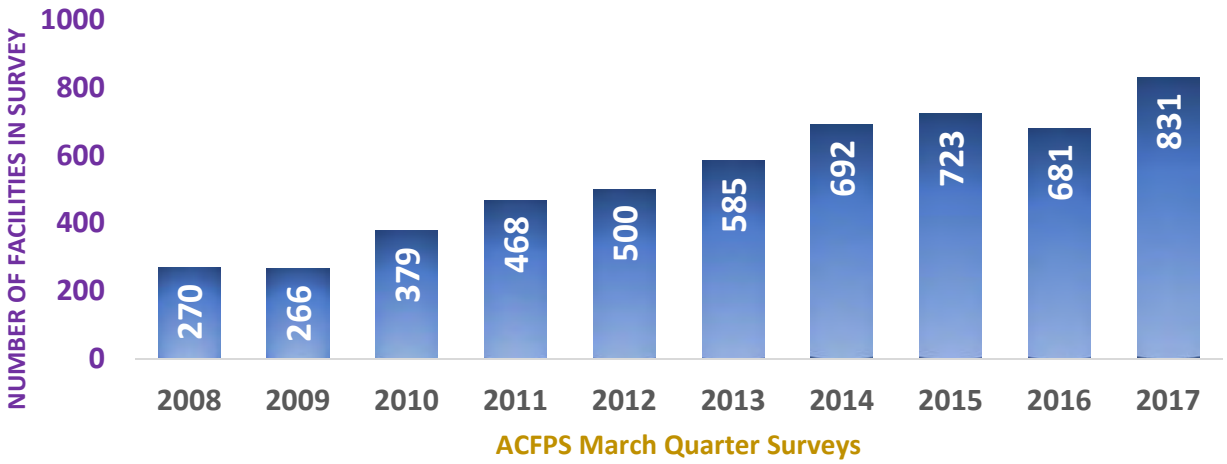
Care Result >120 places - $9.03 pbd

Average Care Result for facilities >120 beds was $9.03 per bed per day a 14% decrease of ($1.52) from June 2016 of $10.55
December 2016 - $11.15
March 2016 - $11.70

INTRODUCTION

The StewartBrown *Aged Care Financial Performance Survey* (ACFPS) March 2017 Residential Care Report continues to increase in participation numbers to now include 869 facilities, with 831 providing validated data with the specified range, comprising than 66,000 beds.

Figure 1: Growth of ACFPS March quarter participation numbers



The ACFPS benchmarking 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 March 2017 survey report contains the summary analysis of more than 24 *million* operational 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

EXECUTIVE SUMMARY

This report indicates the impact from the first nine months of the Aged Care Funding Instrument (ACFI) subsidy changes and the initial effect of the planned ACFI funding changes on 1 January 2017. During the first part of the 2017, the Australian Health Services Research Institute (AHSRI University of Wollongong) was commissioned by the Australian Government Department of Health (DOH) to develop options and recommendations for a funding toolset to replace ACFI in residential aged care. StewartBrown has made some observations of the paper that will be distributed as a supplemental newsletter in late June and would appreciate participant views on the options articulated within the paper.

What we do know is the Department released over 14,000 home care packages in March 2017. There was a vast increase in the activity of ACATs before the changes as providers and clients wanted to fill vacant packages, leading to a subsequent increase in waiting times for ACAT assessments in the aftermath - exacerbated by the new packages being released as people also sought priority changes. This intense activity during the first part of the year, coupled with advertising about provider capability to maintain consumers at home, may have contributed to the softening in residential occupancy.

A summary of the key results and comparisons for the year-to-date March 2017:

- ACFI subsidy has increased to an *average* of $170.39 pbd (increase of 2.53% since June 2016)
- Direct care costs have increased to an *average* of $129.91 pbd (increase of 3.3% since June 2016)
- Every-day-living expenses have increased to an *average* of $80.60 pbd (increase of 3.36% since June 2016)
- *Top quartile* Care Result is $38.29 pbd (decrease of $0.13 pbd from June 2016)
- *Average* Care Result is $9.93 pbd (decrease of $0.85 pbd from June 2016)
- *Top quartile* EBITDA is $18,526 pbpa (increase of $405 pbpa from June 2016)
- *Average* EBITDA is $8,616 pbpa (decrease of $325 pbpa from June 2016)
- *Bottom quartile* EBITDA is a loss of $776 pbpa
- *Top quartile* Accommodation Result is a loss of $0.63 pbd (loss of $0.40 pbd June 2016)
- *Average* Accommodation Result is a loss of $0.11 pbd (surplus of $0.97 pbd June 2016)

The results for March 2017 point to the expected tightening of funding that will speed up reductions in operating surpluses unless directed action is taken to offset these revenue losses. Residential care providers will require more focus on increasing revenue streams, particularly through offering additional optional services and maximising accommodation pricing.

The June 2017 ACFPS report will provide a more comprehensive overview of the initial impact of these measures and hopefully indicate that providers have acted on shoring up both their revenue options and minimising their costs.

CARE RESULT

The Care Result is the net result of providing care to the residents including **Direct Care Costs**, **Hotel Services**, **Utilities** and **Administration** and **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 March 2017 survey collected data from over 869 facilities. In keeping with our pursuit of excellence we do exclude some data sets to ensure consistency of data. The March 2017 data set encompasses information from 831 facilities representing a total of over 65,900 beds and 24 million care days.

The breakdown of included facilities was :

Band	Number
Band 1	176 RACF
Band 2	251 RACF
Band 3	214 RACF
Band 4	108 RACF
Band 5	82 RACF

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 Care Results for the last five Quarters

Care Result ($ per bed day)					
	Mar-17	**Dec-16**	**Sep-16**	**Jun-16**	**Mar-16**
Average	9.93	11.87	12.00	10.78	10.43
Top Quartile	38.29	40.14	41.25	38.42	39.31
Cumulative difference from quarter result to March 2017					
Average		(1.94)	(2.07)	(0.85)	(0.51)
Top Quartile		(1.85)	(2.96)	(0.13)	(1.02)

Care Result

The *average* Care Result has decreased from $10.78 pbd at June 2016 to $9.93 pbd as at March 2017.

The *top quartile* Care Result (25%) has decreased by $0.13 to $38.29 pbd compared to the June 2016 result of $38.42 pbd. The same period analysis also shows a decline in the Care result by $1.02 in the 12 months since March 2016 at $39.31 pbd. This has validated the sector expectation of a downward trend through the calendar year that was originally considered an indication of the initial tightening of some of the ACFI rules, more particularly in the higher care domains of ACFI which the *top quartile* providers may be overly represented.

Importance of cost management in facility results

The combination of the Care and Accommodation Expenses indicates that cost management remains a key focus item for providers and is the key differentiator between the *top quartile* and the remaining 75% of the sector. Although both segments saw upward pressure on expenses during the 12 months to March 2017 we will explore what this looks like across the year in terms on Revenue and Expense result in our June Aged Care Financial Performance Survey report.

Table 2: Impact of cost management on Care Result Top Quartile and Bottom 75%

	Top Quartile Average Mar-17	**Bottom Quartile Average Mar-17**	**Top Quartile Average Mar-16**	**Bottom Quartile Average Mar-16**
Facility Care Revenue	$221.78	$220.02	$214.04	$213.16
Facility Care Expenses	$183.49	$218.75	$174.73	$211.83
Difference	+$38.29	+$1.27	+$39.31	+$1.33

Table 2 highlights that the *top quartile* performs significantly more efficiently in managing their cost base and provides the engine room for the strength of their consolidated result. To underscore this point for the residential segment, we can see that the Care Revenue for both the *top quartile* and *bottom quartile* is almost line ball in terms of quantum with only expenses being the differentiator.

In both Home Care and Residential Care the importance of understanding our cost drivers is critical to the sustainability of aged care businesses as a whole.

Facility EBITDA

The *average* Facility EBITDA (Care + Accommodation), which takes into account the Care Result and Accommodation Result but excludes all investment and fundraising revenue, is the **true operational result** that should be benchmarked (especially in relation to EBITDA).

Table 3: Summary of Facility EBITDAs for the last five Quarters

Facility EBITDA ($ per bed per annum)					
	Mar-17	Dec-16	Sep-16	Jun-16	Mar-16
Average	8,616	9,404	9,401	8,941	8,828
Top Quartile	18,526	18,943	19,278	18,121	18,425
Cumulative difference from quarter result to March 2017					
Average		(788)	(785)	(325)	-211
Top Quartile		(416)	(752)	405	102

The *average* Facility EBITDA is showing a slightly worse result in in the March 2017 quarter of $8,616 per bed per annum which is a $325 per bed per annum decrease on the June 2016 results at $8,941 pbpa.

The *top quartile* Facility EDITDA of $18,526 pbpa has increased in the 9 months to March 2017 by $405 per bed per annum from the June 2016 amount of $18,121 pbpa.

Organisation EBITDA

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.

Table 4: Summary of Organisational EBITDAs for the last five Quarters

EBITDA ($ per bed per annum)					
	Mar-17	Dec-16	Sep-16	Jun-16	Mar-16
Average	8,890	9,734	9,773	9,539	9,197
Top Quartile	18,772	19,134	19,499	18,466	18,584
Cumulative difference from quarter result to March 2017					
Average	-	(844)	(883)	(649)	(307)
Top Quartile	-	(362)	(727)	306	188

The *average* organisational EBITDA is showing a strong decline in the March 2017 quarter of $8,890 per bed per annum which is a $649 per bed per annum decrease on the June 2016 results at $9,539 pbpa.

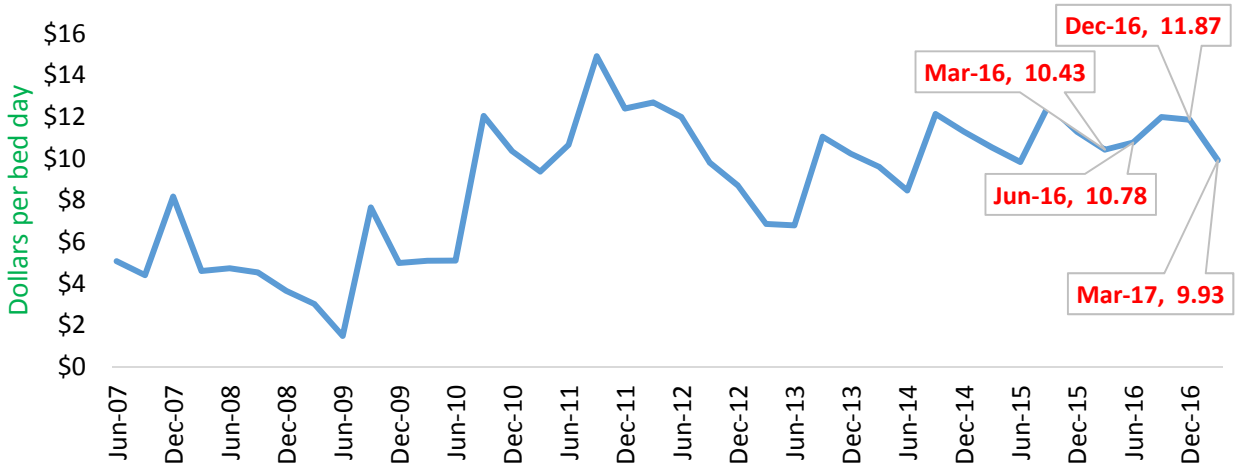
The *top quartile* organisational EDITDA is showing a slightly improved result in in the March 2017 quarter of $18,772 per bed per annum which is a $306 per bed per annum increase on the June 2016 results at $18,466 pbpa.

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 2016 care result spike that was present in 2013, 2014 and 2015 may be the initial impact of the current ACFI changes.

In the original muting of the Care Result for September 2016 we suggested that the results for June 2017 would trend lower against previous years as the subsidy changes begin to bite with the March 2017 result declining $1.94 pbd from December 2016 and $0.50 pbd in the 12 months from March 2016.

Figure 2: Care Result - Survey average over time (June 2007 to March 2017) ($ per bed day)



RESULT IN DETAIL

Overall Results

As mentioned earlier, during the 12 and 6 months to March 2017 there have been slippage in the Care Result for both the overall Survey *Average* and the *Average* for the *top quartile* of facilities when compared to June 2016 and March 2016.

Table 5: Survey Averages and Top Quartile for the half year ended 31 March 2017, 30 June 2016 and 30 December 2015 (all amounts represent $ per bed day unless otherwise stated)

	Survey Average Mar-17	Survey Average Jun-16	Survey Average Mar-16	Top Quartile Average Mar-17	Top Quartile Average Jun-16	Top Quartile Average Mar-16
Care Revenue	220.44	214.55	213.37	221.78	214.95	214.04
Expenditure						
Direct care costs	129.91	125.78	125.20	110.82	105.83	105.80
Catering	27.83	27.02	26.81	26.57	25.85	25.68
Cleaning	7.63	7.24	7.37	6.77	6.37	6.22
Laundry	3.80	3.75	3.64	3.27	3.27	3.05
Utilities	6.22	5.93	5.92	6.01	5.76	5.71
Administration & support	35.12	34.04	34.01	30.06	29.45	28.27
Total expenditure	210.51	203.77	202.94	183.49	176.53	174.73
Care Result for the year	**$9.93**	**$10.78**	**$10.43**	**$38.29**	**$38.42**	**$39.31**
Accommodation revenue	27.33	27.18	26.99	25.57	24.05	24.13
Accommodation expenses	27.44	26.21	25.61	26.20	24.46	24.47
Accommodation Result	**($0.11)**	**$0.97**	**$1.39**	**($0.63)**	**($0.40)**	**($0.34)**
Facility Result	**$9.81**	**$11.75**	**$11.82**	**$37.66**	**$38.02**	**$38.97**
Facility EBITDA per bed per annum	**$8,616**	**$8,941**	**$8,828**	**$18,526**	**$18,121**	**$18,425**
Provider revenue	3.69	4.27	3.58	2.27	2.61	2.31
Provider expenses	1.11	1.19	1.23	1.16	0.55	0.48
Provider Result	**$2.59**	**$3.08**	**$2.35**	**$1.11**	**$2.06**	**$1.83**
Total Result for the year	**$12.40**	**$14.83**	**$14.17**	**$38.77**	**$40.07**	**$40.80**
EBITDA per bed per annum	**$8,890**	**$9,539**	**$9,197**	**$18,772**	**$18,466**	**$18,584**
KPIs						
Occupancy	*94.61%*	*94.90%*	*95.16%*	*96.66%*	*96.90%*	*96.53%*
Care costs as % of care revenue	*58.93%*	*58.60%*	*58.68%*	*49.97%*	*49.20%*	*49.43%*
Care Result - return on care revenue	*4.50%*	*5.00%*	*4.89%*	*17.26%*	*17.90%*	*18.37%*
Supported ratio	*46.40%*	*46.00%*	*48.57%*	*45.18%*	*43.50%*	*45.46%*

StewartBrown and the sector generally expressed concerns in both the June 2016 and December 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 slowed in response to the ACFI Changes to be marginally worse than the March 2016 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, stabilise and preferably growth Care Revenue beyond the statutory funding.

Table 6: Comparison of various groups of facilities against Top Quartile for year ended 31 March 2017 (all amounts represent $ per bed day unless otherwise stated)

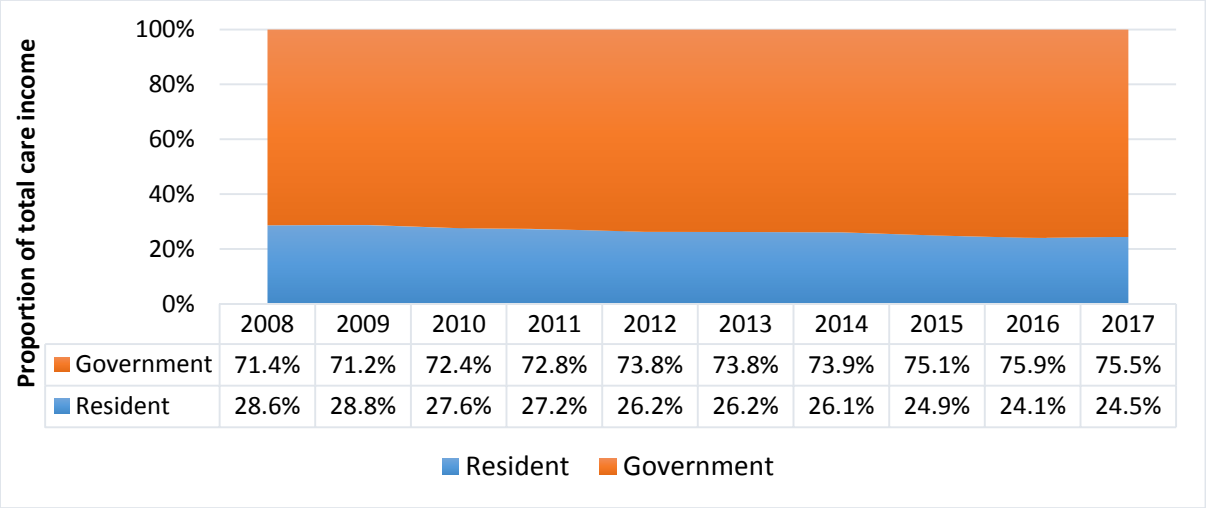
	Top Quartile Average Mar-17	Bottom 75% Average Mar-17	Bottom 50% Average Mar-17	Bottom 25% Average Mar-17
Care Revenue	**221.78**	**220.02**	**219.72**	**217.33**
Expenditure				
Direct care costs	110.82	135.74	141.14	146.36
Hotel services	36.61	40.07	40.85	42.33
Utilities	6.01	6.29	6.41	6.72
Administration & support	30.06	36.66	38.75	40.59
Total expenditure	183.49	218.75	227.16	236.01
Care Result for the year	**$38.29**	**$1.27**	**($7.44)**	**($18.67)**
Accommodation revenue	25.57	27.86	28.44	28.51
Accommodation expenses	26.20	27.82	28.03	27.65
Accommodation Result	**($0.63)**	**$0.04**	**$0.40**	**$0.86**
Facility Result	**$37.66**	**$1.31**	**($7.03)**	**($17.81)**
Facility EBITDA per bed per annum	**$18,526**	**$5,675**	**$2,917**	**($776)**
Provider revenue	2.27	4.13	4.31	5.21
Provider expenses	1.16	1.09	1.22	1.32
Provider Result	**$1.11**	**$3.04**	**$3.09**	**$3.89**
Total Result for the year	**$38.77**	**$4.35**	**($3.94)**	**($13.92)**
EBITDA per bed per annum	**$18,772**	**$5,958**	**$3,222**	**($394)**
KPIs				
Occupancy	*96.66%*	*94.01%*	*93.59%*	*91.92%*
Care costs as % of care revenue	*49.97%*	*61.69%*	*64.24%*	*67.34%*
Care result - return on care revenue	*17.26%*	*0.58%*	*(3.38%)*	*(8.59%)*
Supported ratio	*45.18%*	*46.81%*	*47.12%*	*45.75%*

As shown in ***Table 6*** above, the *average* Care Result for a facility outside the top quartile is only $1.27 pbd. For the same quarter in 2016 the *average* was $1.33 pbd. The *average* for the bottom 50% and bottom quartile has eroded further to become a loss of $7.44 pbd and a loss of $17.81 pbd 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.

Share of Care Revenue

As with the December 2016 ACFPS we have analysed the share of Care Revenue to ascertain if the movement to a "user pays" system is flowing through on the revenue side of aged care funding. Commonwealth share of Care Revenue had increased in the 10 years since the inception of ACFI and has moderated down in the March 2017 Survey by 0.4% to a Commonwealth share of 75.5% and Consumer share of 24.5%. As the sector moves forward, growing the revenue on both sides of the graph will be crucial to sustainability and the share percentages should flow with capacity to pay.

Figure 3: Share of Care Revenue at March YTD each year

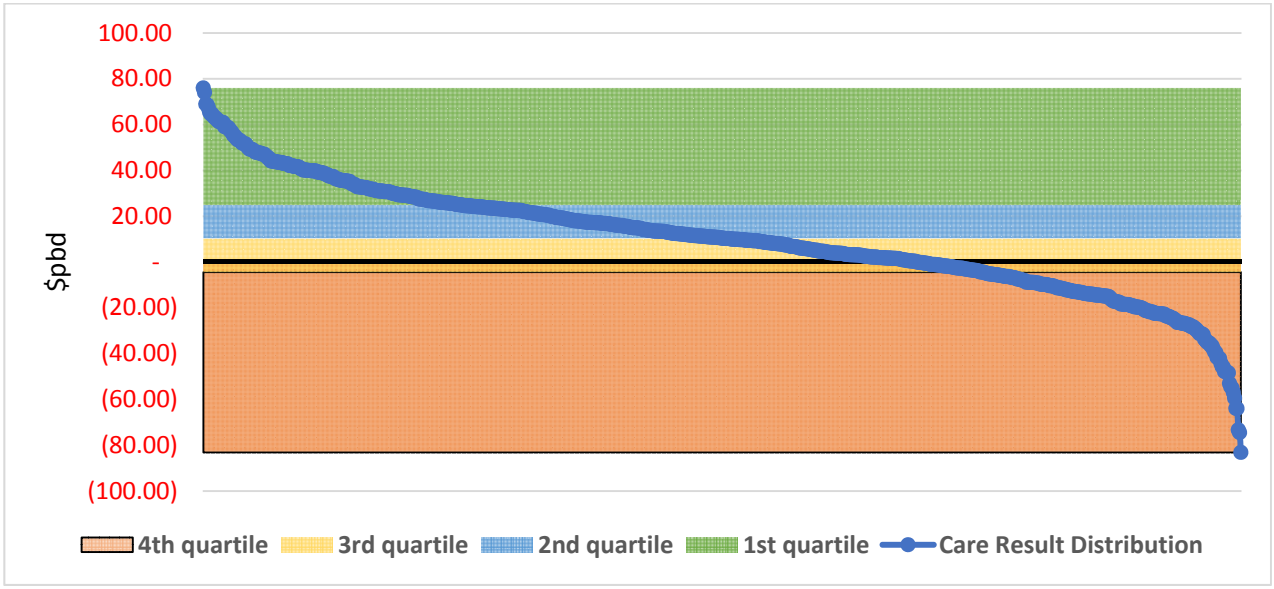


	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Government	71.4%	71.2%	72.4%	72.8%	73.8%	73.8%	73.9%	75.1%	75.9%	75.5%
Resident	28.6%	28.8%	27.6%	27.2%	26.2%	26.2%	26.1%	24.9%	24.1%	24.5%

Care Result Distribution Analysis

The distribution of the Care Results for the complete data set is as follows in ***Figure 4***:

Figure 4: Care Result distribution for March 2017



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

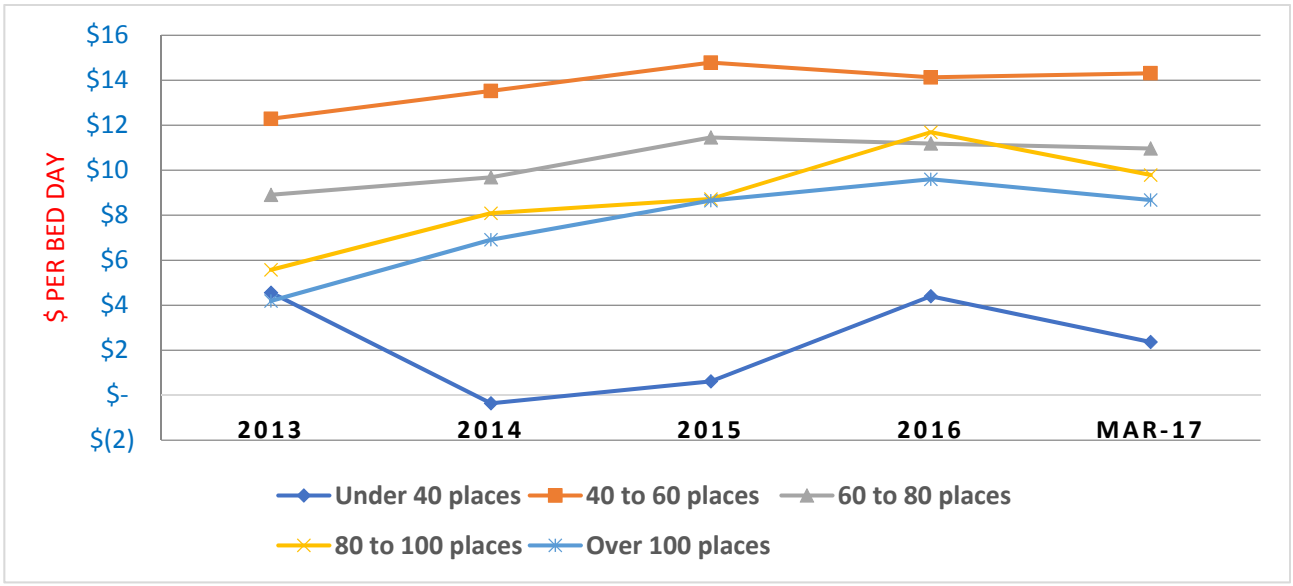
Quartile	Bottom Range	Top Range	Number of facilities
1st	$24.86	$75.99	208
2nd	$10.41	$24.86	208
3rd	$(4.42)	$10.41	207
4th	$(83.16)	$(4.42)	208

Average Care Result by size

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.

The group of facilities with between 40 and 60 places remains highest Care Result on *average*. The second highest surplus group in the March 2017 survey is that with between 60 and 80 beds, closely followed by the group with between 80 and 100 places. 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 although as noted in December 2016 their results may well be limited depending on their ability to improve performance within the limitations of their size and design.

Figure 5: Average Care Result by Size

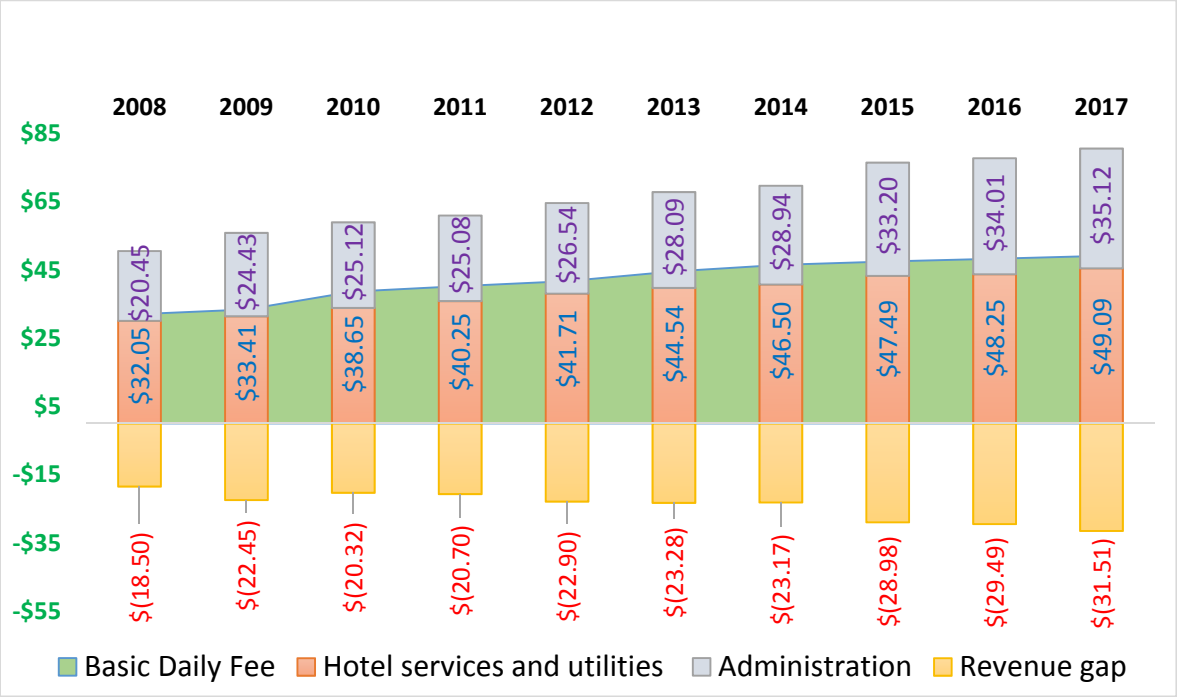


Basic Daily Fee and Everyday Living Costs

The figure below indicates that almost the entire amount of administration and support costs are now recovered from ACFI revenue as the revenue is diverted 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".

The revenue gap between a resident's daily living expenses and the revenue received from the basic daily fee was $31.51 per bed day as at March 2017. This gap continues to grow with a 7% increase from the March 2016 figure of $29.49 per bed day further highlighting that the combination of ACFI changes and escalating 'living expenses' has accelerated the leakage of ACFI revenue towards meeting these costs.

Figure 6: Everyday living expenses compared to basic daily fee (March 2007 to March 2017)

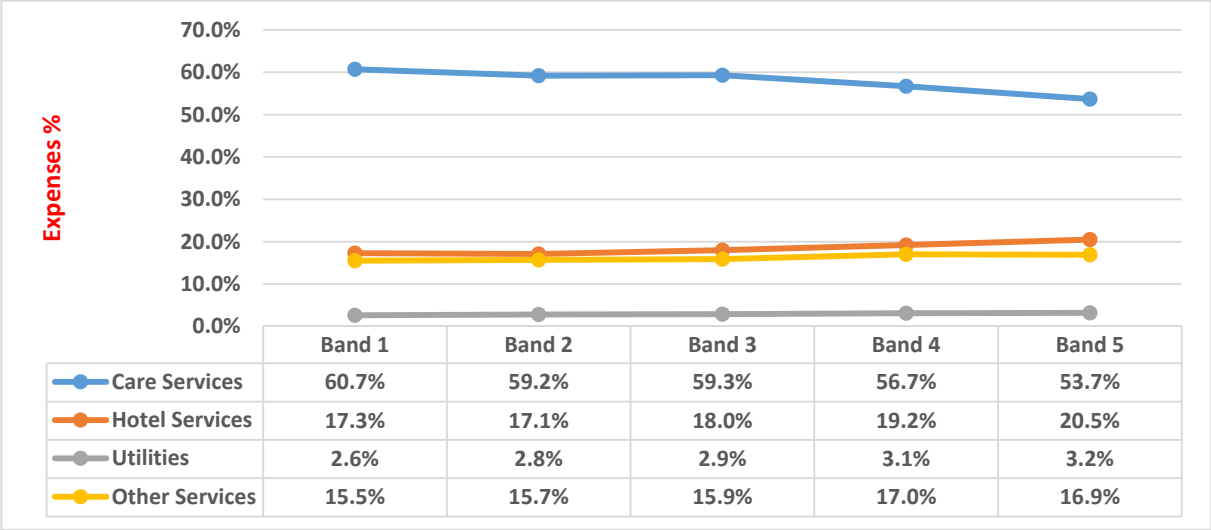


What we do know is that from 2007 until today the *cumulative* increase in resident revenue has been 33.6% while the cost of utilities has risen in the same period by 86.7%. The cost of providing Hotel Services has also outstripped resident revenue at 46.7%. Perhaps indicating that the complexity is rising for both managing a facility and residents is that Administration has risen 71.7% cumulatively over this time as well, all contributing to the deficit we see in the revenue gap for the daily fee.

Direct Care Costs and Care Hours worked per resident

Direct Care Costs as a percentage of Care Revenue grew to 58.9% from 58.6% in the June 2016 result. Care Revenue has increased by $5.89 with the *average* March 2017 Care Revenue reaching $220.44 pbd (June 2016: $214.55 pbd), the additional revenue has been matched and exceeded by additional Care Expenditure with March *average* expenditure of $210.51 pbd growing by $6.74 pbd, $0.85 pbd more than the revenue received affecting the surplus line.

Figure 7: Expenses as % of Care income

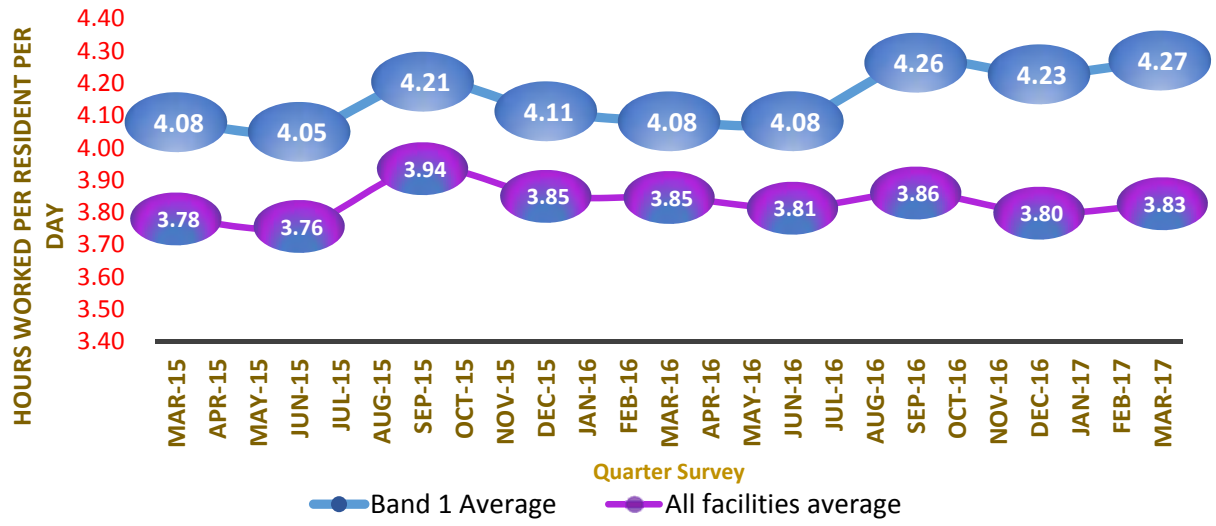


	Band 1	Band 2	Band 3	Band 4	Band 5
Care Services	60.7%	59.2%	59.3%	56.7%	53.7%
Hotel Services	17.3%	17.1%	18.0%	19.2%	20.5%
Utilities	2.6%	2.8%	2.9%	3.1%	3.2%
Other Services	15.5%	15.7%	15.9%	17.0%	16.9%

When viewed in line with the *average* total care hours worked per resident per day in ***Figure 8*** below, we start to see a trend across all bands where the care hours have stabilised after steadily increasing across the sector. The *top quartile* total hours worked per client per day remains stable at 4.27 hours while the survey *average* has settled at 3.83 hours.

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 seniors housing as staff become more mobile across organisations.

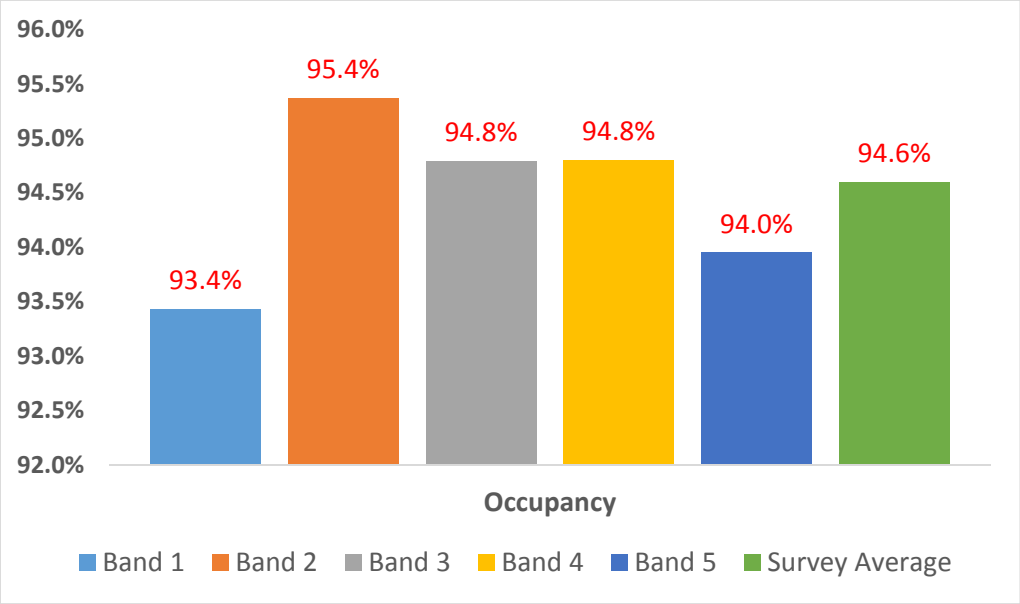
Figure 8: Average total care hours worked per resident per day



Occupancy

In conversations with the sector during the first part of the year a number of providers had signalled that their occupancy had eased off but had bounced back during April/May. The March 2017 occupancy figures may indicate this easing of beds as the *average* occupancy declined marginally by 0.3% with the survey *Average* settling at 94.6%.

Figure 9: Average Occupancy in bands and Survey



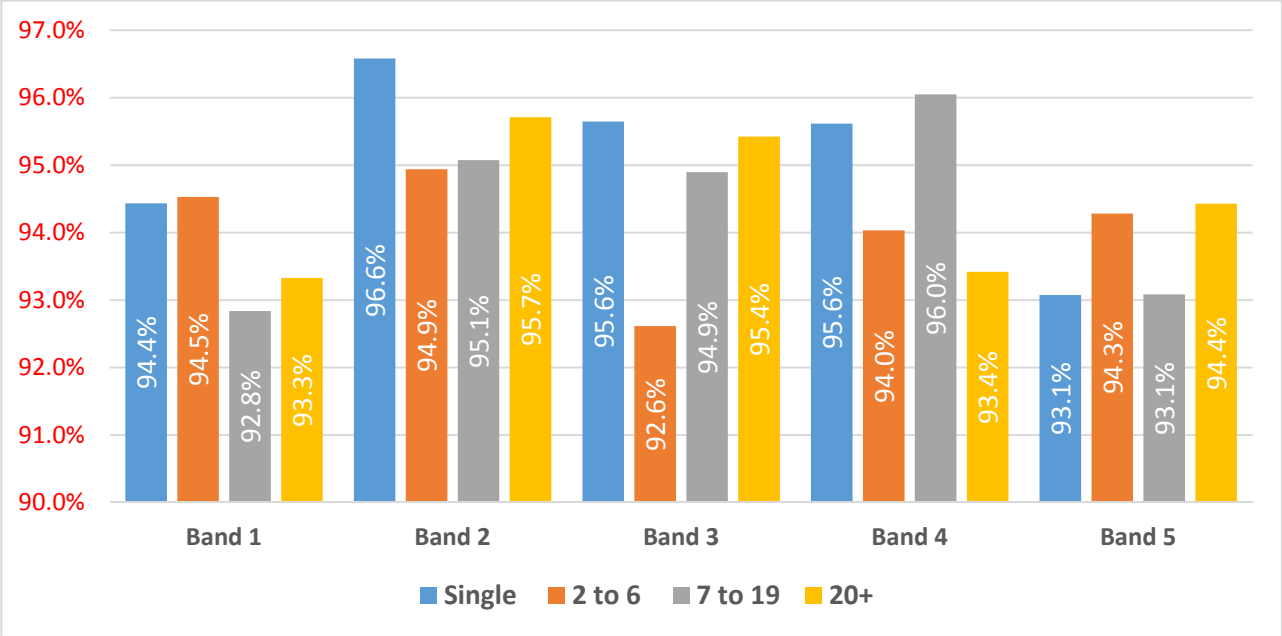
The Department released over 14,000 home care packages in March 2017. The release also assigned packages to consumers who were currently in care but were awaiting a package at their approved level. The Department of Health approved 76 new providers to enter the market in addition to the 504 providers already in the market. In the lead up to the 27 February reform, the Home Care sector saw quite a lot of activity across the board in relation to the pending change.

There was a vast increase in the activity of ACATs before the changes as providers and clients wanted to fill vacant packages, leading to a subsequent increase in waiting times for ACAT assessments in the aftermath - exacerbated by the new packages being released as people also sought priority changes. This intense activity during the first part of the year, coupled with advertising about provider capability to maintain consumers at home, may have contributed to the softening in residential occupancy.

Past analysis of occupancy and organisation size had shown that stand-alone facilities and those with less than 6 facilities exhibited a strong focus on keeping occupancy high. Interestingly the March 2017 analysis indicates that the past general rule that the larger and more complex an organisation is, its occupancy rate is sub-optimal appears to be changing with large organisations performing better in 4 of the 5 bands compared to mid-sized organisations.

While acknowledging that many large organisations also operate in rural or remote locations where occupancy may be depressed by local conditions, it appears that the latent capability to "systemise" maintenance of occupancy by larger organisations may be gaining traction.

Figure 10: Occupancy Rate By Number of Facilities



Results by State

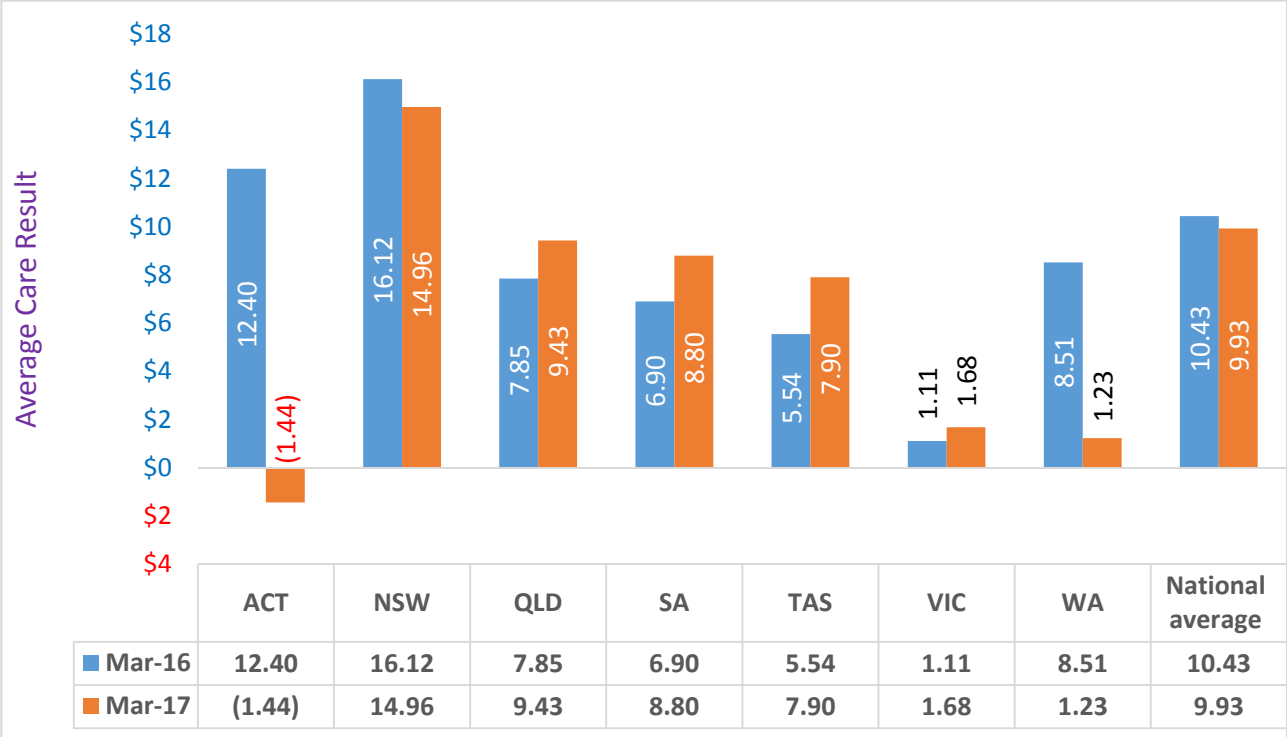
There continues to be disparity in the results of facilities across State borders. Western Australian facilities continue to decline. The March 2017 WA *average* Care Result is $1.23 pbd compared to $8.51 pbd in March 2016 which was close to the National *average* at June 2016 ($10.14 pbd). The ACT has shown a similar rapid drop off in *average* Care Result with the March 2016 result of $12.40 pbd dropping sharply in to $1.44 pbd as at March 2017.

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 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 end of financial year results. 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* Care Results for New South Wales facilities have eased but remain the highest nationally at $14.96 pbd which is a decline on the March 2016 results of $16.12 pbd and June 2016 results for that State of $15.32 pbd. NSW results remain an *average* of $5.03 pbd higher than the National *average*. With the exception of Western Australia and the ACT, the *average* results for each *individual* State continued to improve slightly in the March quarter compared to both March 2016 and June 2016, but overall when combined there has been a decline in *average* Care Result nationally.

Figure 11: Average Care Result by State and Territory – March 2017 compared with March 2016



	ACT	NSW	QLD	SA	TAS	VIC	WA	National average
Mar-16	12.40	16.12	7.85	6.90	5.54	1.11	8.51	10.43
Mar-17	(1.44)	14.96	9.43	8.80	7.90	1.68	1.23	9.93

ACCOMMODATION ANALYTICS

Summary of Accommodation Result

As would be expected the Accommodation Revenue has been far less volatile than Care Revenue and as such in the 12 months to March 2017 *average* Accommodation Revenue grew marginally by $0.34 pbd to $27.33 pbd up from March 2016 at $26.99 pbd and $0.15 pbd up on June 2016 at $27.18. The *bottom quartile* of the sector retracted in the March 2016 to March 2017 period by $0.04 pbd from $27.90 pbd to $27.86 pbd.

In line with the Care Result we have seen a strong uplift in Accommodation Expenses in the same period rising $1.83 pbd to $27.44 pbd for March 2017 from the March figure of $25.61 pbd and $1.23 pbd higher than June 2016. The *bottom quartile* of the sector saw an increase in *average* Accommodation Expenses by $1.85 pbd from $25.97 pbd in March 2016 to $27.82 pbd in March 2017.

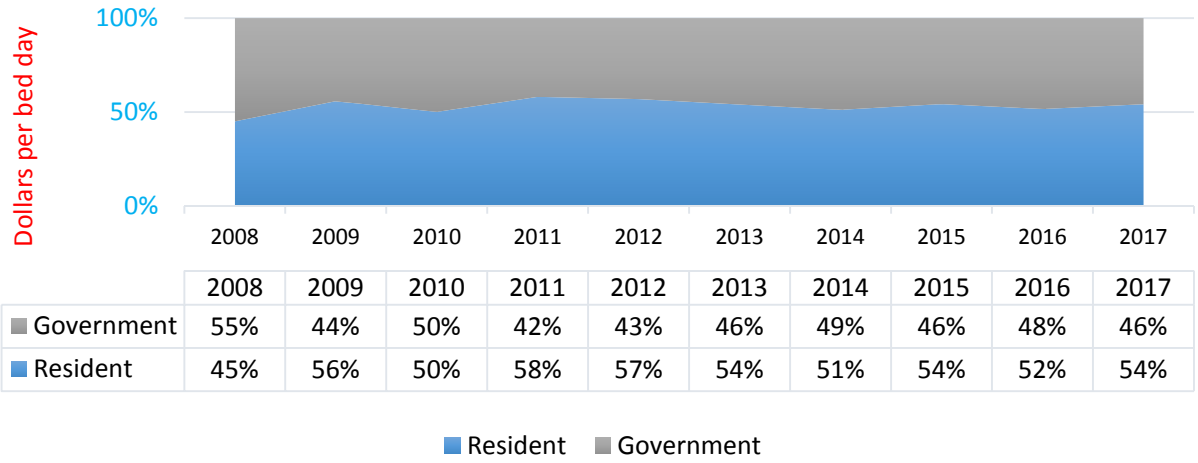
The *top quartile* saw a slight increase in their *average* Accommodation Revenue of $1.44 pbd to $25.57 pbd in March 2017 compared to $24.13 pbd in March 2017, and a $1.52 pbd increase from the June 2016 amount of $24.05 pbd. *Top quartile* Accommodation Expenses in March 2016 were $24.47 pbd increasing in the 12 months by $1.73 pbd to a March 2017 amount of $26.20 pbd, and by $1.74 pbd from the June 2016 amount of $24.46 pbd.

The combination of the Care and Accommodation Expenses indicates that cost management remains a key focus item for providers and is they key differentiator between the *top quartile* and the remaining 75% of the sector. Although both segments saw upward pressure on expenses during the 12 months to March 2017 we will explore what this looks like across the year in terms on Revenue and Expense result in our June ACFPS report. In both Home Care and Residential Care the importance of understanding our cost drivers is critical to the sustainability of aged care businesses as a whole.

Share of Accommodation Revenue

During 2015/16 we saw the share of revenue tip back towards the Commonwealth but in the year to 2017 this trend reversed with a 2.0% shift back towards the resident contributing the larger share of accommodation income, with Government share of 46% and consumer at 54%. 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 may be overstating the government's accommodation contribution relative to the aged care sector as a whole.

Figure 12: Share of Accommodation Revenue as at March each year to March 2017



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Government	55%	44%	50%	42%	43%	46%	49%	46%	48%	46%
Resident	45%	56%	50%	58%	57%	54%	51%	54%	52%	54%

Aged Care Approval Round (ACAR) result analysis

On 26 May 2017, Minister Wyatt announced the allocation of 9,911 residential aged care places and $64 million in capital grants in addition to the allocation of 475 new Short Term Restorative Care (STRC) places on February 27 2017. For the 2016-17 ACAR, the Australian Government did not create an indicative distribution of places by Aged Care Planning Region, instead opting to advertise the availability of places in state- and territory-wide pools.

StewartBrown conducted an analysis in the ACAR result and used the organisation type to determine the profit/not-for-profit as this was the easiest way to map the provider type. Not for profit therefore includes charitable, religious, community based and state government. For profit includes private incorporated body.

Overall our analysis indicates that twice as many places allocated are going to private providers compared to not-for-profit with 63% of allocations being placed with private providers.

Figure 13: Raw allocation for ACAR result 2017

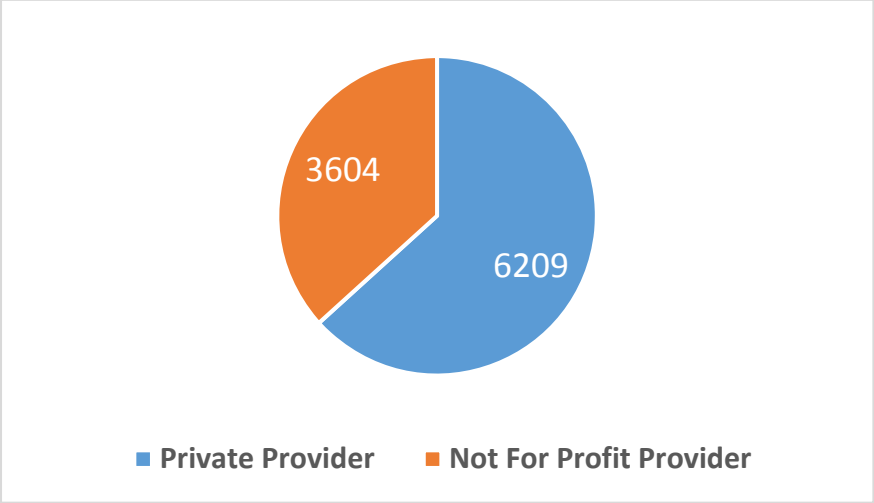
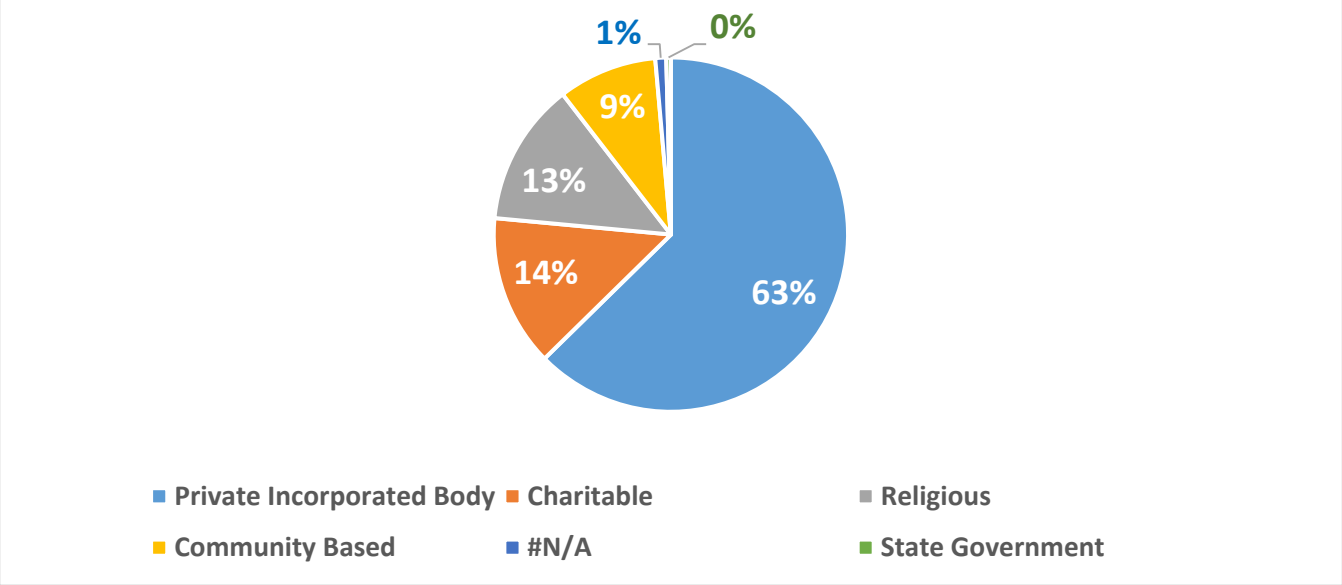


Figure 124: ACAR allocation by organisation type



Average Accommodation pricing

Although the current housing market growth phase is expected to soften, the rate of growth actually accelerated over the first quarter of 2017 with combined capital city dwelling values 12.9% over the 12 months to March 2017[1]. For some time StewartBrown has been highlighting the growing differential between the *average* aged care Accommodation Price (Retirement, Independent Living and Residential care) in Australia against the rapid growth in dwelling values in all states. With an *average* national house price greater than **$660,000** it is relevant that providers need to be more strategic and more courageous in setting their Accommodation Pricing.

At March 2017, the *average* Residential Accommodation Deposit (RAD) taken during the period was $312,607, an increase of $1,310 above the December 2016 figure of $311,297 and an increase of $13,894 above the June 2016 figure of $298.712.

Table 7: Movement in RAD/RAC currently held or taken 12 months to march 2017

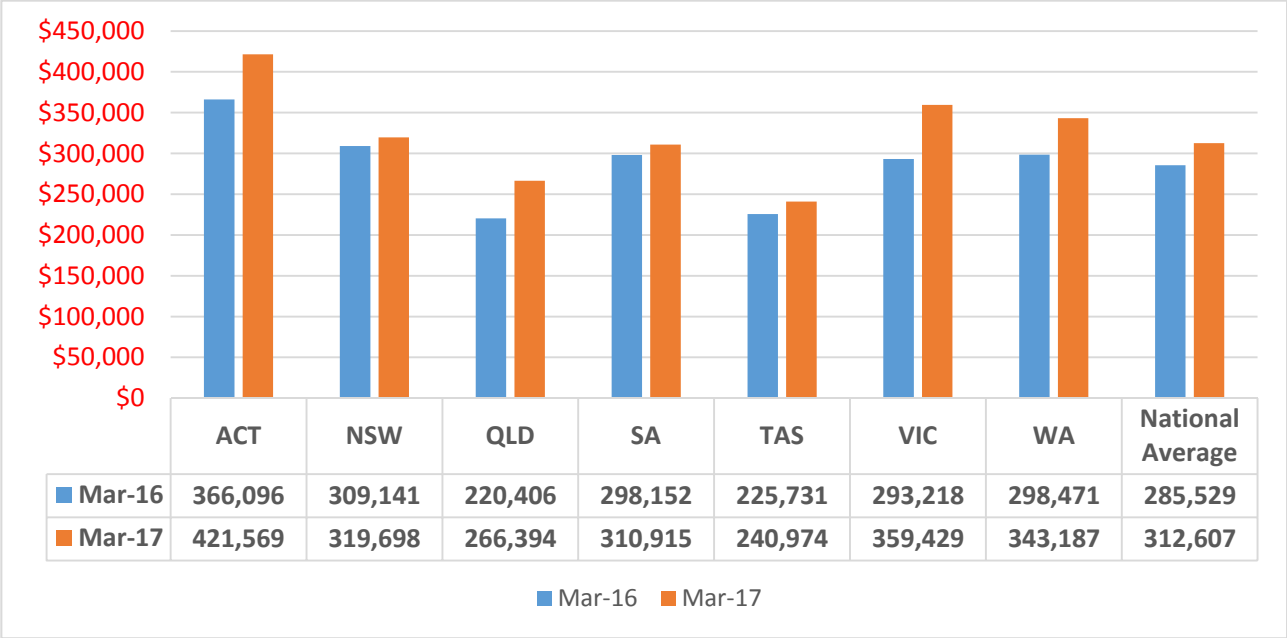
	Mar-16	Jun-16	Sep-16	Dec-16	Mar-17
Average bond/refundable deposit held	247,416	252,319	261,488	268,149	273,214
Average refundable deposit taken	285,529	298,712	287,992	311,297	312,607

It appears that stability in the overall occupancy of RACF has provided some comfort for the sector to test the market around uplifting accommodation prices, with all states and territories showing growth in the RAD taken lifting by an *average* $27,078 in the 12 months to March 2017.

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.

[1] March 2017 CoreLogic report

Figure 13: Average RAD taken by State and Territory



	ACT	NSW	QLD	SA	TAS	VIC	WA	National Average
Mar-16	366,096	309,141	220,406	298,152	225,731	293,218	298,471	285,529
Mar-17	421,569	319,698	266,394	310,915	240,974	359,429	343,187	312,607

Accommodation result distribution

As with the Care Result distribution in Figure 4 (page 14), the graph in ***Figure 16*** indicates that the Accommodation Result appears to be fairly normally distributed across the 831 facilities included and that the sector can rely upon data across the bands as being representative. The quartile range is set out below.

Figure 14: Accommodation Result distribution

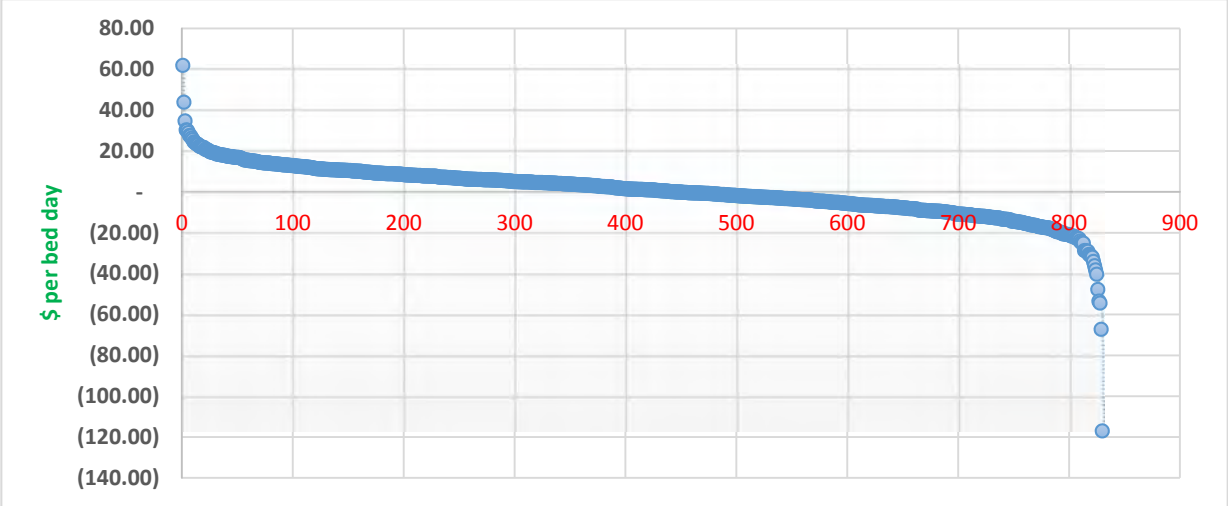


Table 8: Accommodation Result Distribution

Quartile	Bottom range	Top range	Number
1st	8.15	74.52	207
2nd	1.12	8.15	208
3rd	(6.72)	1.12	208
4th	(74.50)	(6.72)	208

Side by Side Profiling of Provider Distribution

When analysing the sector results from the *Aged Care Financial Performance Survey* we are always investigating what might be different or similar in the performance of providers. The March survey has allowed us to consider a side by side analysis of the participants, providing a profile of the sector that throws up some surprising and not so surprising results.

Table 9: Side by side analysis of facility elements

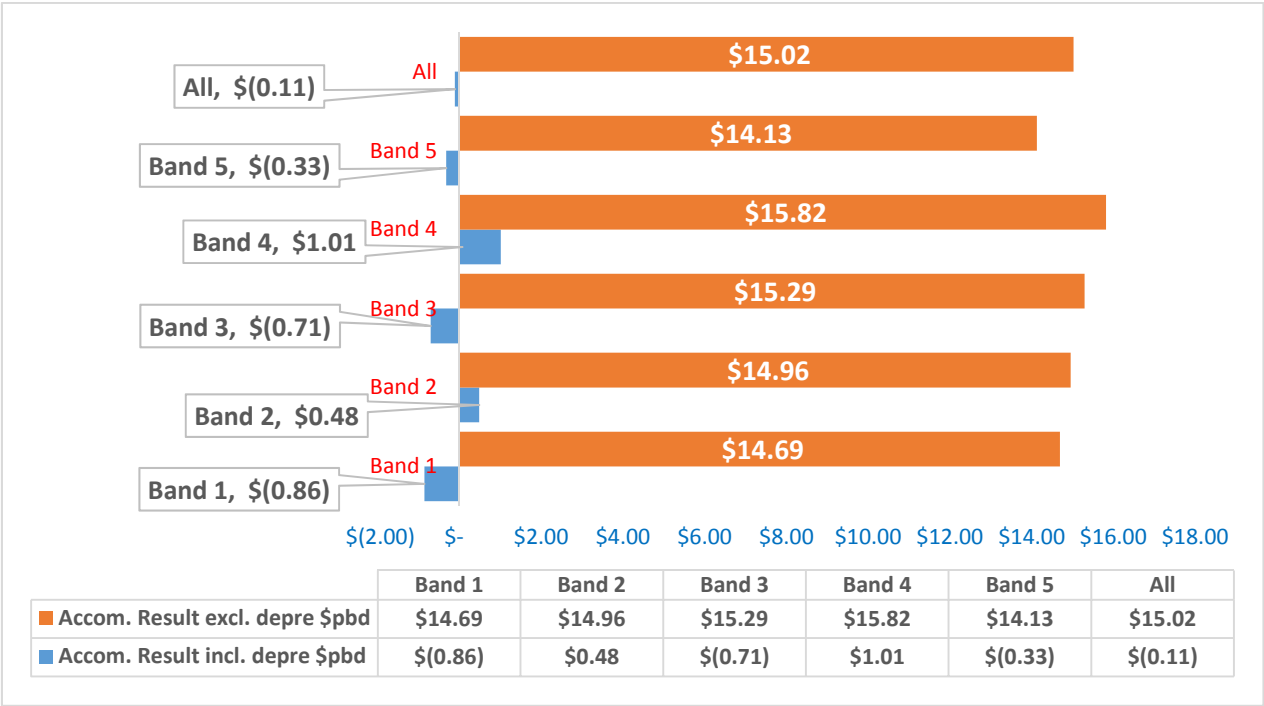
Profile	Survey Average	Top Quartile	Bottom Quartile	Negative EBITDA
Characteristics				
Dementia Wing	61.4%	52.9%	60.1%	58.1%
Multi storey	44.3%	51.9%	39.4%	41.0%
Supported Ratio > = 40%	71.6%	65.9%	73.1%	65.0%
Major City	64.5%	72.1%	51.9%	58.1%
Regional & Remote	35.5%	27.9%	48.1%	41.9%
Standalone Provider	7.8%	6.3%	10.6%	7.7%
Larger Provider	92.2%	93.8%	89.4%	92.3%
Less than 40 places	9.7%	7.2%	14.9%	19.7%
Between 60 to 80 places	24.7%	34.6%	21.6%	21.4%
Between 80 to 100 places	22.9%	22.6%	20.7%	21.4%
Greater than 100 places	25.0%	20.2%	25.5%	24.8%

- The most unsurprising result is that larger providers have facilities that are represented in both the *top* and *bottom quartiles* of the survey. With 92.3% of larger providers having a facility with a negative EDITDA further underscoring that there is strong cross subsidy of facilities within a larger providers network. Many larger Not-For-Profit providers are now routinely costing Mission to ensure that the operations remain viable to support that mission to the level desired. As operating conditions tighten these providers will need to ensure that those facilities with a negative EDITDA are contributing to either the strategic or mission imperative of the organisation in order to be maintained.
- 65.0% of providers with a negative EBITDA also have a supported ratio higher than 40% with the *bottom quartile* having a higher density of supported residents at 73.1%
- In a similar vein perhaps the most surprising statistic is that 58.2% of facilities with a negative EBITDA are located in a major city. Often when the sector talks of providers doing it tough it is in relation to the rural or remote cohort who comprise 41.9% of the negative EBITDA cohort. However, almost half the cohort of *bottom quartile* facilities are located in the rural or remote areas at 48.1%
- Providers who have facilities with less than 40 beds have double the representation in the *bottom quartile* than the top.
- The analysis confirms that the majority of *top quartile* facilities are located in major cities with 72.1% and 27.9% located in regional, rural or remote centres.

Accommodation Result and 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 15: Accommodation Result including and excluding depreciation



	Band 1	Band 2	Band 3	Band 4	Band 5	All
Accom. Result excl. depre $pbd	$14.69	$14.96	$15.29	$15.82	$14.13	$15.02
Accom. Result incl. depre $pbd	$(0.86)	$0.48	$(0.71)	$1.01	$(0.33)	$(0.11)

StewartBrown has commented previously on the emergence of a "retail" environment for aged care and the importance of ensuring that amenity and utility of a facility meets the consumer demand. Although depreciation affects the current surplus of a provider it may be considered as a future investment that estimates the net present value of cash higher than taking the surplus out in lower depreciation.

Figure 17 above shows this impact of depreciation on provider surpluses and 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.

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.

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 7*** (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 10: 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 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 Quartile 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 (including investment income), taxation, depreciation and amortisation. The calculation excludes interest (and investment) revenue as well as interest expense on borrowings.

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

EBIT

Earnings before interest (including investment income) 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 Health 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 Health in their listing of aged care services. Those that were designated as being an "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

Senior Manager | Business Analyst 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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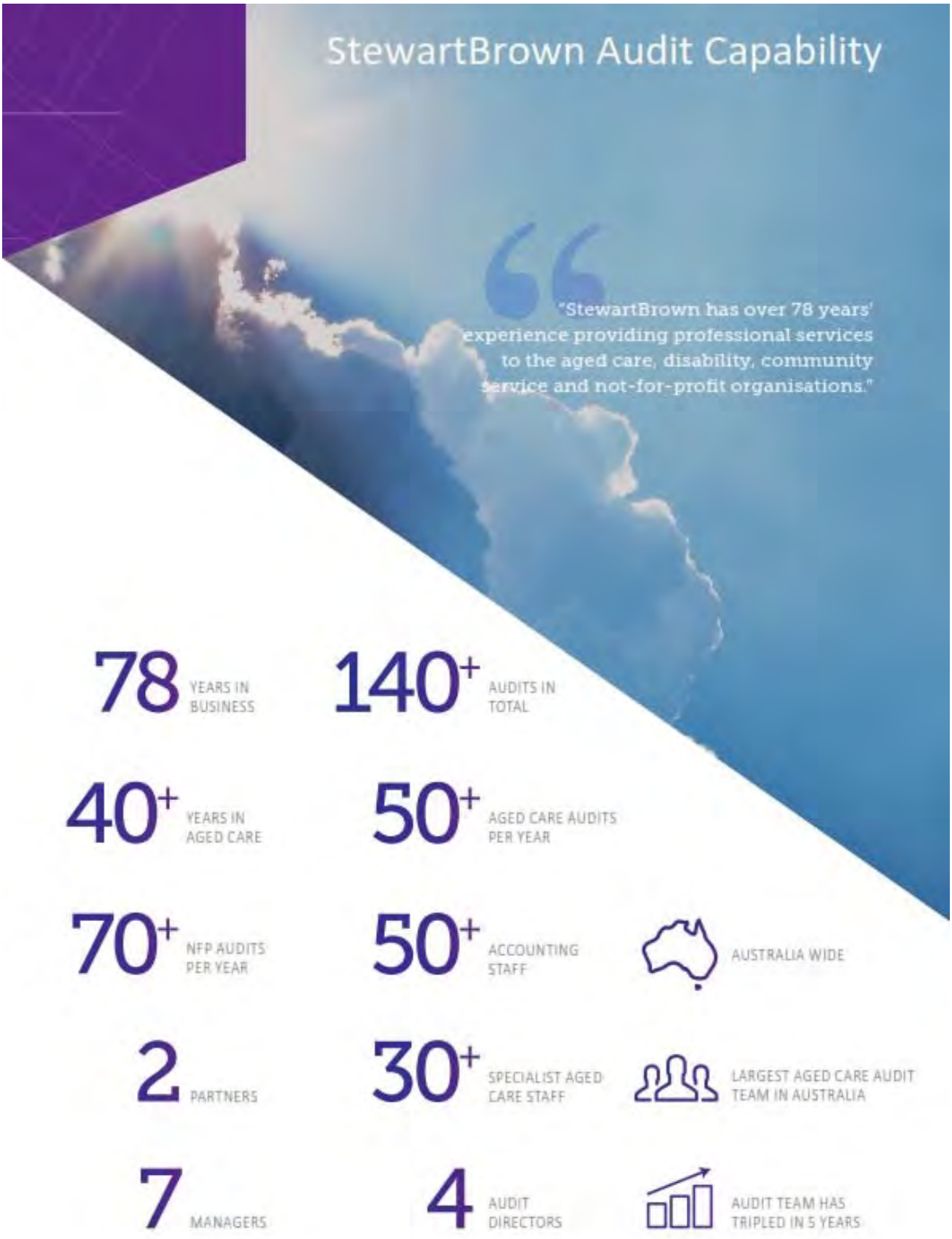
StewartBrown Audit Capability
"StewartBrown has over 78 years' experience providing professional services to the aged care, disability, community service and not-for-profit organisations."
78 YEARS IN BUSINESS
140+ AUDITS IN TOTAL
40+ YEARS IN AGED CARE
50+ AGED CARE AUDITS PER YEAR
70+ NFP AUDITS PER 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