



STEWART BROWN
Business Solutions

**AGED CARE
FINANCIAL PERFORMANCE SURVEY**

**YEAR ENDED
30 JUNE 2009**

HEADLINES AND HIGHLIGHTS

OVERVIEW

The Aged Care Financial Performance survey for the year ended 30 June 2009 includes data from a total of 333 residential aged care facilities (RACF's) and 148 community care programs. This is the highest participation level to date and makes this the largest survey of its kind in Australia. The good news - it is only going to get bigger and better. Already there are a total of 426 RACF's and 223 community care programs registered to participate in the 2010 series of surveys.

The Results at a Glance

Our survey defines high care as those facilities comprising our income bands 1 & 2. This means that they have operating income (daily care subsidies and daily care fees) in excess of \$153 per bed day. Facilities with operating income less than \$153 per bed day have been classified as low care for the purposes of this survey.

Facilities sorted by high and low care Summary of Stewart, Brown & Co aged care financial survey for residential aged care facilities for the year ended 30 June 2009. All amounts shown are measured in Dollars Per Bed Day.	Low Care (Bands 3 to 5)	
	Year Ended 30 June 2009 \$	Year Ended 30 June 2008 \$
Income	120.31	112.05
Care Costs	67.24	60.41
<i>Care costs as % of income</i>	55.89%	53.92%
Operational Costs	59.04	53.65
Total Costs	126.28	114.06
Net Operating Result	(\$ 5.97)	(\$ 2.01)
Total Facility Result	\$ 1.90	\$ 6.07
EBITDA per bed per annum	\$ 2,851	\$ 4,308

Table 2

Table 2 summarises the results for low care facilities. While these facilities are not making losses as high as their high care counterparts, they are making significant losses. This deterioration in results is evident in which ever measure of profitability is used – operating result, total facility result or EBITDA. The good news for low care facilities is that the total facility result remains in the black. The question is – for how long?

Some Facts and Figures

Below are some statistics to assist in understanding the gravity of what aged care providers are dealing with.

- Only 24 of 110 high care facilities achieved an operating profit (21.8%)
- 35 of 110 high care facilities had a negative EBITDA (31.8%)
- The average operating results of low care facilities declined throughout the year. Since June 2008 they declined by \$3.95 per bed day
- 88 of 223 low care facilities achieved an operating profit (39.5%)
- 68 of the 223 low care facilities had a negative EBITDA (30.5%)
- Only 33.6% of all facilities in the survey made an operating profit for the 2009 financial year
- 167 of the 333 facilities in this survey (50.2%) are making an overall profit taking into account all sources of income and expenditure. This is down from 59.8% at March 2009 and 63.5% at June 2008

Facilities sorted by high and low care Summary of Stewart, Brown & Co aged care financial survey for residential aged care facilities for the year ended 30 June 2009. All amounts shown are measured in Dollars Per Bed Day.	High Care (Bands 1 & 2)	
	Year Ended 30 June 2009 \$	Year Ended 30 June 2008 \$
Income	172.34	164.83
Care Costs	114.53	111.41
<i>Care costs as % of income</i>	66.46%	67.59%
Operational Costs	67.49	60.50
Total Costs	182.02	171.91
Net Operating Result	(\$ 9.68)	(\$ 7.08)
Total Facility Result	(\$ 5.16)	\$ 1.68
EBITDA per bed per annum	\$ 1,434	\$ 3,444

Table 1

Table 1 summarises the results for high care facilities and compares them with the results from the previous financial year. The results are not good viewing. There has been a further deterioration in the results of high care facilities since last financial year.

Even when taking into account other sources of income and expenditure (capital income including accommodation charges, retentions, interest on investments, accommodation supplements) the average result for these facilities is a loss of \$5.16 per bed day. This was a surplus of \$1.68 per bed day in the 2008 financial year.

Deterioration of Results over Time

This trend of deteriorating operating results has not occurred overnight. As Figure 1 (below) shows results have been trending downward for some 5 years in high care and for the past 3 years in low care.

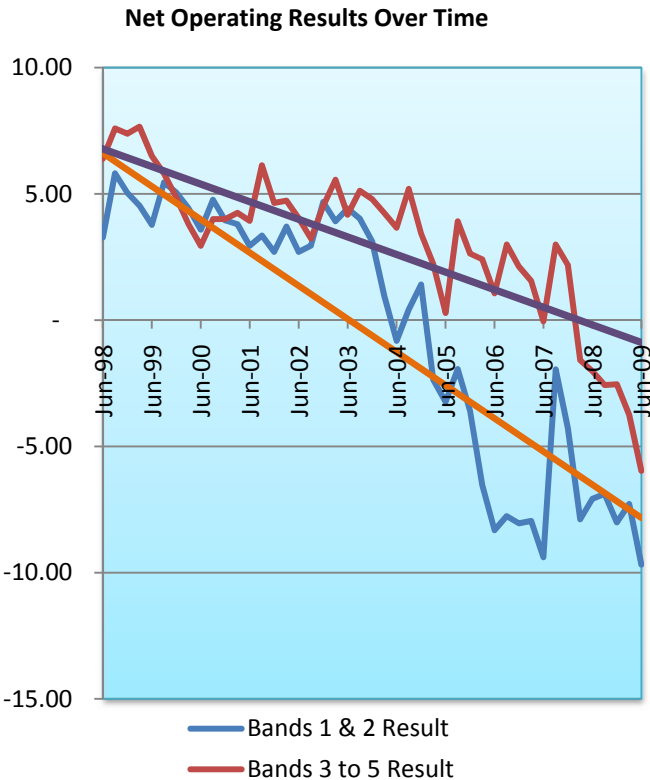


Figure 1

There have been peaks and troughs in the results as governments have injected funds from time to time however the peaks have not been sustainable. There are also annual peaks as subsidy increases flow through in the first quarter of the year. Unfortunately by the end of the year these subsidy increases have been eaten away by rises in expenses.

It can be argued that funding is at a record high and there is no doubt that is correct. What is also true is that funding is a function of the number of places being funded. Funding has not kept pace with rising costs as demonstrated in Figure 2.

Both income and costs have risen at rates above the movement in the CPI however the sector is suffering because the rate of increase in costs has outstripped the rate of increase in income.

Income & Care Costs Cumulative Movement Compared to CPI - All Facilities

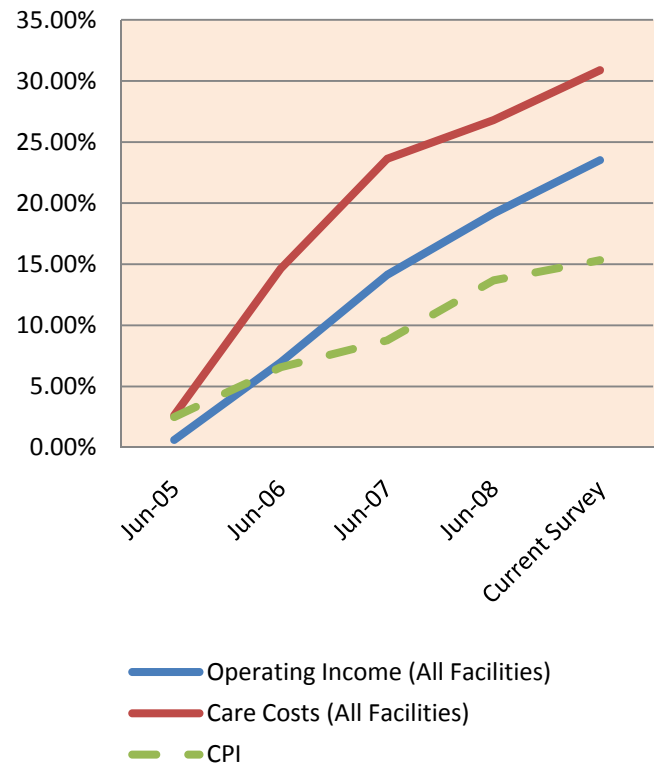


Figure 2

Narrowing the Focus

Over time we have changed our focus on how facilities are grouped for benchmarking purposes. They used to be grouped based on the mix of residents in the facility as measured by the average RCS of the facility. With the changing of the funding of resident care to the ACFI model this is no longer possible. However, there remains a direct relationship between the resident classification under ACFI and the amount of income received.

As a result we now group facilities based on their operating income stream. They are grouped into 5 bands as shown in Table 3 (below)

	This Survey	June 2008 Survey
Band 1	Over \$173	Over \$163
Band 2	\$153 to \$173	\$150 to \$163
Band 3	\$122 to \$153	\$120 to \$150
Band 4	\$97 to \$122	\$95 to \$120
Band 5	Under \$97	Under \$95

Table 3

Results by Income Band	Operating Income				
	Band 1	Band 2	Band 3	Band 4	Band 5
Extracts from Stewart, Brown & Co aged care financial survey for the year ended 30 June 2009.	\$	\$	\$	\$	\$
Total of Facilities 333					
Income	178.29	161.48	138.51	110.29	88.25
Care Costs	119.45	105.52	84.42	56.30	41.59
Care costs as % of income	67.00%	65.35%	60.95%	51.05%	47.13%
Operational Costs	68.19	66.22	62.58	57.01	52.93
Total Costs	187.64	171.74	147.00	113.31	94.52
Net Operating Result	(\$ 9.35)	(\$10.26)	(\$ 8.49)	(\$ 3.02)	(\$ 6.27)
Total Facility Result	(\$ 3.99)	(\$ 7.22)	(\$ 0.92)	\$ 4.74	\$ 2.88
EBITDA per bed per annum	\$1,829	\$ 741	\$1,957	\$4,036	\$2,307

Table 4

Given that only 34% of all facilities in the survey made an operating profit, it is not surprising that no single group of facilities made an operating profit on average. Two groups did have an average total facility profit. These two groups are at the lower end of low care – Bands 4 and 5. Indeed Band 4 was the better performing band overall.

The results summarised in Table 4 are survey averages. We do not use these as benchmarks. Instead we recommend the use of the average of the top quartile (top 25%) of facilities in each group as a benchmark. The results of these facilities are summarised in Table 5 (below).

Top 25% by Income Band	Operating Income – Top 25% facilities in each Group				
	Band 1	Band 2	Band 3	Band 4	Band 5
Extracts from Stewart, Brown & Co aged care financial survey for the year ended 30 June 2009.	\$	\$	\$	\$	\$
Total of Facilities 84					
Income	182.18	160.35	140.06	108.50	90.60
Care Costs	112.44	94.25	73.76	40.55	35.05
Care costs as % of income	61.72%	58.78%	52.66%	37.37%	38.69%
Operational Costs	58.17	61.70	56.09	49.96	47.19
Total Costs	170.61	155.95	129.85	90.51	82.24
Net Operating Result	\$ 11.57	\$ 4.40	\$ 10.21	\$ 17.99	\$ 8.36
Total Facility Result	\$ 12.90	\$ 3.80	\$ 3.23	\$ 18.27	\$ 13.95
EBITDA per bed per annum	\$ 8,122	\$ 4,590	\$ 7,705	\$ 9,823	\$ 6,364

Table 5

Each of these groups are averaging a profit result at all levels – operating, total facility and EBITDA. This is the good news. The bad news part of this story is that this group is not representative of the facilities in the survey and the gap between this group and the survey average is vast. Taking Band 1 as an example, the gap in operating profit between the survey average and the top quartile is \$20.92 per bed day. To put that into context, for a 60 bed facility in this group, that difference equates to almost \$460,000 per annum.

So what does that mean for facility managers and operators? It means that it is possible to make a profit at the operational level. It also means that for many of those managers and operators there is a long way to go to reach that goal.

Results Across Income Bands

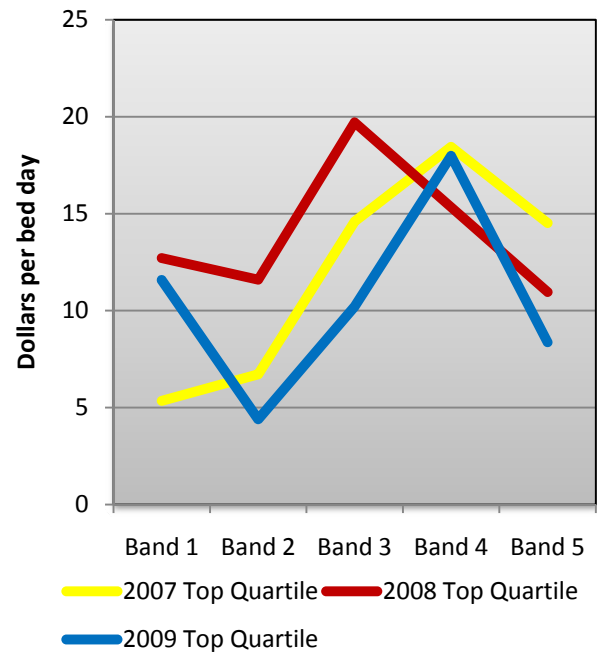


Figure 3

The graph above (Figure 3) shows the way the operating results shift across the various income bands for the facilities in the top quartile for the past 3 years. The general trends for each year are much the same. Sadly, the only group to outperform the 2008 results were those in Band 4. Not surprisingly, the shapes and results for the survey average is very similar to that displayed in Figure 3. The results dip from Band 1 to Band 2 and then climb until they reach a peak in Band 4 and then fall away sharply to Band 5. The other interesting aspect to this is that the change in funding appears to have shifted the peak from Band 3 to Band 4.

Drivers of profit

Up to this point we have spoken mainly about the results themselves rather than what might be causing these results. The aim of these surveys, and the analysis that we provide is to examine the drivers of profitability – to ask the questions on why one group is outperforming another and to answer those questions by using the data available.

The first point of difference between the facilities in the top quartile and the survey average is the care cost to income ratio. These care costs are predominantly made up of staff costs as well as items such as continence supplies, medication, therapy supplies and other minor direct care costs.

We used Band 1 as an example earlier and will do so again now. The survey average care cost to income ratio for band 1 is 67% and the average for the top quartile is 61.72% - a difference of 5.28% of income. This equates to \$9.41 per bed day (based on survey average income) or \$3,436 per bed per annum. For a 60 bed facility in this group that would be \$206,160 in additional care costs.

The other interesting point is that there is also a difference of \$10.02 per bed day in other operating costs. These costs include catering, cleaning, laundry, property and maintenance, utilities and administration.

Comparison of Band 1 Extracts from Stewart, Brown & Co aged care financial survey for the year ended 30 June 2009.	Band 1 Results		
	Top Quartile \$	Survey Average \$	Variance \$
Operational Costs			
Catering	19.81	21.94	2.13
Cleaning	5.93	6.56	0.63
Laundry	3.46	4.59	1.13
Property & maintenance	9.24	10.35	1.11
Utilities	3.25	3.64	0.39
Administration	16.48	21.11	4.63
Total Operational costs	58.17	68.19	10.02
Total Costs	170.61	187.64	17.03
Net Operating Result	\$ 11.57	(\$ 9.35)	\$ 20.92
Total Facility Result	\$ 12.90	(\$ 3.99)	\$ 16.89
EBITDA per bed per annum	\$ 8,122	\$ 1,829	\$ 6,293
Net Operating Result – June 2008	\$ 12.71	(\$ 5.80)	\$ 18.51
Net Operating Result – June 2007	\$ 5.35	(\$ 9.53)	\$ 14.88

Table 6

Table 6 summarises the differences in these operating costs for these two groups of facilities in Band 1. It is clear that not only are care costs managed differently, but so to are the other operating costs in each major area of operation. What is not made clear by this data is how much of the difference is due to better management and how much of it is due to other factors – largely outside of the control of facility managers.

In recent surveys we found that there had been a significant rise in administration costs. In March 2009 we decided to do a special questionnaire on administration costs and it provided some interesting results.

The respondents were divided into two groups. The first can be described as using the “Corporate Office” model whereby the organisation typically operates multiple services and has a centralised administration. Administration costs are generally allocated across the services and some of these services will also have some direct administration costs in addition to “Corporate Office” costs. The other group we called the “facility” model. This group often operates a single stand alone facility or site and allocates administration costs at the transaction level. The majority of respondents fell into the corporate office group.

Our findings were that there did not appear to be any direct relationship between the number of clients being serviced and the administration cost per client. Instead the main relationship was between the number of services across which administration costs could be allocated. This relationship is shown in Figure 4 (below).

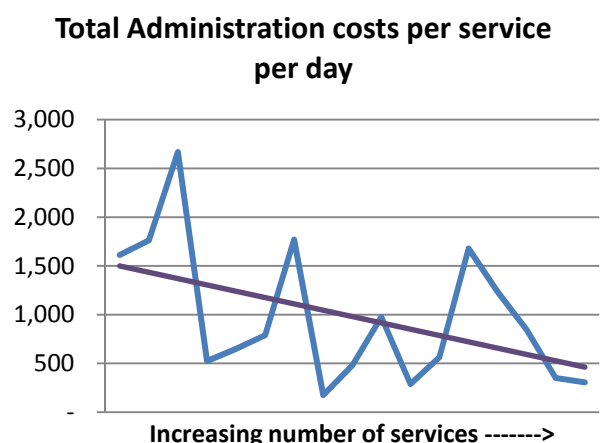


Figure 4

The other interesting aspect to the survey was the relationship that appeared to exist between the use of computer systems and the level of increase in administration costs. Just over 70% of those organisations adopting the corporate model have

implemented one or more new computer systems in the finance, payroll, rostering or clinical areas during the past 2 years. Their administration costs per client per day have risen only \$0.55 during that same period. In contrast, only 28% of the organisations adopting the facility model have implemented new computer systems during that period and their administration costs have risen by \$6.55 per client per day. The main difference is in the increases in wages and associated costs for those two groups. There was an average increase in wages in the corporate group of \$0.14 per available client day compared with \$4.62 for the facility model. This would appear to indicate that the investment in these systems has brought some benefit to the organisations. It would appear that they have been better able to cope with an increasing administration burden compared to those that have not made a similar investment.

Lastly we asked respondents to provide us with their perceptions as to why administration costs have risen. There were varied responses but there appeared to be a common theme as demonstrated by the following examples.

“Cost of compliance with all legislative requests i.e. Police checks, ACFI reporting, recruitment costs, quarterly Commonwealth reporting, keeping up with new technologies and changes to legislation”

“Need to have in-house accounting and admin due to the growing complexity of industry compliance requirements”

“Increased level of compliance, complaints system is causing us to spend more time justifying our service provision rather than providing a service to the aged”

Building Design

There are several aspects of building design that may have a bearing on profitability. There have been indications in the past that single bed high care facilities are less likely to make a profit than multi bed rooms. There has been anecdotal evidence that it is more difficult to make a profit in multi-level facilities than single level facilities. Our data has shown that the number of places in a facility may also have some bearing on how likely or not an operating profit can be achieved. Does the existence of a dementia unit affect profitability?

In the June 2008 survey we gathered some data in respect of these questions and we did so again in this survey.

The response this time around was better than in 2008 and we were able to perform more detailed analysis on the data received with interesting results. The results of this survey appears to have confirmed the results of our 2008 survey in most respects.

With respect to high care facilities, those that have a majority of single bed rooms do not appear to achieve average operating results as high as facilities that have a majority of multi bed rooms. This is illustrated in Figure 5 below.

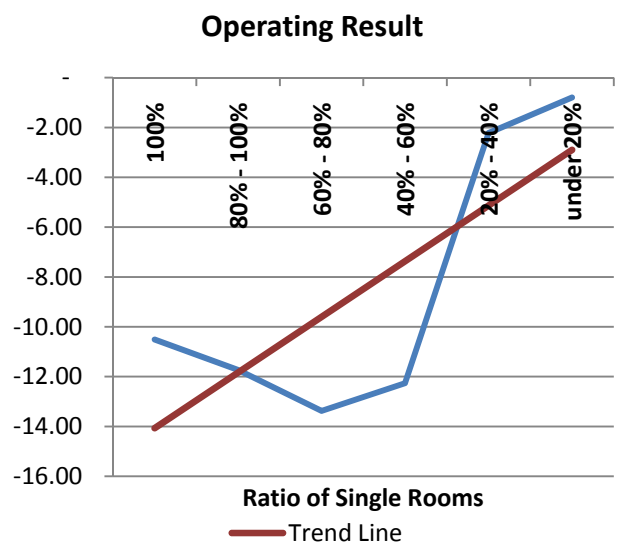


Figure 5

Further analysis shows a more complex trend. It would appear that there is also some synergy between profit and whether there is an overwhelming majority of one type of room or the other. The group of facilities that have 100% of single bed rooms perform better on average than the groups where there is between 40% and 80% of single rooms. The best performing results occur within those facilities with fewer than 40% of the rooms being single bed rooms.

The age of the facility may also have some influence over profitability as Figure 6 (next page) shows. When we analysed this relationship we saw that property and maintenance costs appeared to decline during the period between 15 and 30 years of age. Drilling down further we found that this was predominantly caused by movements in the depreciation charge on plant and equipment during that period. However, we do not believe that is the end of the matter. We also found that care costs to income ratio also declined during this period. Could it have something to do with how facilities were designed during that period? At this point we will have to defer to further research on the matter.

All Facilities - Operating Result by age of facility

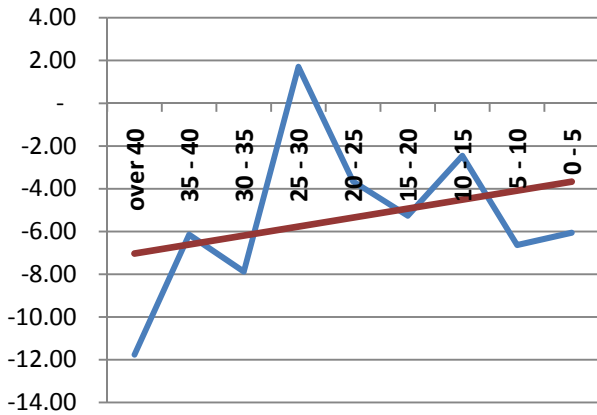


Figure 6

The other aspect to building design that has often been used to offer a reason for lower profitability is whether or not it is a single level facility. Is there truth to the myth? There appears to be some truth to it as shown by Figure 7 (below).

Operating Result

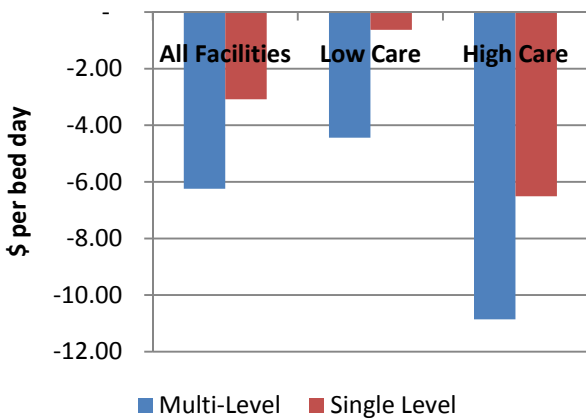


Figure 7

These results were also confirmed using the total facility result and EBITDA as profit measurements. We drilled down to see whether this was a staffing issue and it does not appear to be with very little difference between the care cost to income ratio between the two groups. We will be performing some ongoing analysis of this relationship and will include the results in future reports.

In 2008 we looked at how the existence of a dementia unit or wing affected profitability. We found that it appeared to have an adverse affect. In contrast, the 2009 survey has found that results appear to have improved under ACFI.

The operating profit of facilities with a dementia unit is now higher on average than if it does not have a dementia unit. The results for high care facilities are shown below in Figure 8.

High Care - Effect of Dementia Unit

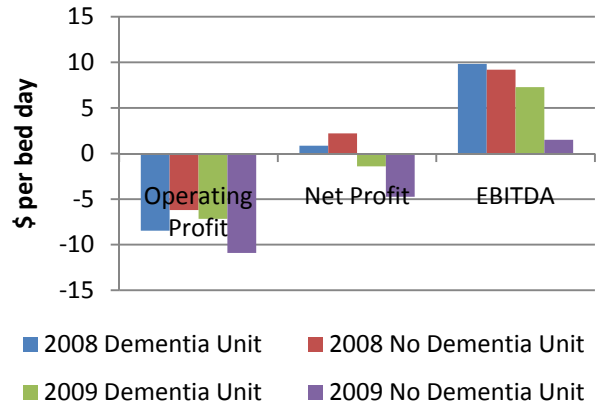


Figure 8

The results for low care facilities display a similar pattern. It also should be the case that if a specific area is designated to provide a specific type of care and designed for that purpose then it should be more efficient (read profitable) than having residents with dementia scattered throughout a facility. Unfortunately in the past this aspect of care provision was not recognised in the way facilities were funded. ACFI would appear to have gone some way to rectifying that situation.

Wages Data

Our survey collects data on employee hours worked and the results are summarised in Table 7 below. Differences in hours worked per resident per day between the survey average and the top quartile are only marginal however these fractions of hours add up over the course of a year and over a full facility.

For example, the 0.04 hrs difference in registered nursing hours for bands 1 & 2 equates to 2.4 minutes per client per day. In a 60 bed facility that is 2.4 hrs of a registered nurse per day. Using the average cost of a registered nurse (as per our survey) 2.4 hours per day equates to almost \$40K over a full year. We understand that it is not as simple as that, however it demonstrates that small changes can have a significant affect on the bottom line. It also demonstrates why the facilities that are doing well usually have a more cost effect staff mix than those that are not performing as well.

Table 11	Bands 1 & 2 Average	Bands 1 & 2 TOP 25%	Bands 3 to 5 Average	Bands 3 to 5 TOP 25%
Registered Nurses	0.53	0.49	0.20	0.11
Other care staff	2.34	2.16	1.63	1.24
Therapists	0.13	0.14	0.09	0.10
Total care Hours	3.00	2.79	1.92	1.46
Hotel services	0.54	0.60	0.48	0.42
Maintenance	0.05	0.06	0.06	0.04
Administration	0.16	0.13	0.15	0.13
Total Hours	3.75	3.58	2.61	2.06

Table 7

Community Care

Community care is the growth area and is also more profitable than residential care. It is also cheaper to fund from a government viewpoint. This survey included 148 community care programs and we have 223 programs registered for the 2010 series of surveys.

The significant area of growth is in the Extended Aged Care at Home (EACH) and EACH Dementia programs. One of the challenges facing the industry is how these programs will affect the vacancy rates of low care facilities.

As more and more people choose to take up a community care program, the entry into residential care will be delayed and a higher proportion of people will enter as high care residents rather than as low care residents.

Table 8 (below) summarises the results of the various types of community care programs as well as the hours worked per client per week. The hours for the CACP programs are very similar to those worked in a low care residential facility and similarly those hours worked in EACH programs are similar to the number of care hours provided in a high care residential facility.

The big advantage to providing care in a community setting in contrast to a residential care facility is that in community care there are no costs associated with operating the building. There are no property and maintenance costs, utility or cleaning expenses. This means that these costs do not have to be funded and it also means that whatever funding is provided primarily goes to the client's care needs.

	CACP	EACH	EACH Dem
Operating Result (\$ per available client days)	\$ 3.50	\$ 10.54	\$ 19.88
Average staff hours per week per client package			
Direct client care staff	5.09	12.87	13.78
Coordinators/Case managers	0.84	3.69	3.03
Administration	0.51	1.21	1.20
	6.45	17.78	18.01

Table 8

The recent Health Reform Commission Report into health and ageing included recommendations to expand the use of community care so we expect that current growth trends in this area will continue and we will watch with interest the affect that this growth has on residential care.

If you have a question regarding this report or our benchmarking service please contact Max Hopkins or David Sinclair on (02) 9412 3033 or visit our website at www.sbbsolutions.com.au.

This report, including all data and analysis contained therein does not express or purport to express any opinion on the level of care provided to the residents or clients of the facilities and community care programs participating in the survey. This report is concerned only with the analysis of the financial performance of those participating facilities and community care programs.

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