Australian Government
Department of Health and Aged Care

Quarterly Financial Report

Frequently Asked Questions

agedcareengagement.health.gov.au

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Contents

Section 1

General

General

Timeframes

1.1 What is the timeframe of Quarterly Financial Report (QFR) submission?

Financial Year Quarters	Dates of submission	Number of days
Quarter One (July to September)	**04 November**	35 days
Quarter Two (October to December)	**14 February**	45 days
Quarter Three (January to March)	**05 May**	35 days
Quarter Four (April to June)	**04 August**	35 days

The above submission due dates are legislated. Submission of the QFR is due to the Department within 35 days after the end of each quarter. Providers have 45 days to submit the quarter two reports to accommodate Christmas and New Year's holidays.

Support and Resources

1.2 What support is available to assist providers to complete the QFR?

A helpdesk function is available to providers to answer technical/accounting queries by phone and email. Definitions, guides, and frequently asked questions documents are published on the department's website.

1.3 Is there a helpdesk phone number for providers to contact if they have questions?

Please contact Forms Administration's helpdesk at (02) 4403 0640 or email health@formsadministration.com.au for questions relating to ACFR and QFR.

Helpdesk queries relating to the balance sheet and income statement which require further support, will be referred to QFRACFRHelp@health.com.au by Forms administration. QFRACFRHelp@health.com.au will provide technical and accounting advice to support providers as required.

1.4 Where can providers access the QFR template and definitions?

QFR reporting resources, including the templates and definitions, are available on the department's website.

1.5 Where can we access the QFR webinar materials?

QFR webinar recordings, slides and transcripts are available on the department's website.

QFR vs ACFR

1.6 Does the QFR replace the ACFR?

No, the QFR is in addition to the ACFR.

1.7 Is there reconciliation between the QFR and ACFR?

No reconciliation is required between the QFR and ACFR. Not all sections of the QFR line up to the ACFR. For example, the 'Quarterly Financial Statement' section is collected at the approved provider level in the QFR but at the parent entity level in the ACFR.

1.8 Is the reporting format of the QFR along the same lines as the ACFR or is there something extra?

The residential and home care 'Care Labour Costs and Hours' section is designed to resemble the ACFR (with minor differences). Key differences include:

- Allied health is broken up into specific professions in the QFR but not the ACFR
- 'Other direct care expenses', such as work cover, are not reported in the 'Quarterly Financial Statement' section
- Providers are not required to report on detailed residential expenses relating to hotel services, administration, or accommodation in the QFR.

Not all sections of the QFR replicate the ACFR. For example, the 'Quarterly Financial Statement' is collected at the approved provider level in the QFR but at the parent entity level in the ACFR. The 'Viability' and the 'Food and Nutrition' sections are not collected in the annual ACFR.

1.9 Does the QFR still require breakdown by facility?

Yes. The QFR requires facility level breakdown for the residential expenses/hours and 'Food and Nutrition' sections.

1.10 Does the General Purpose Financial Report (GPFR) need to be prepared for approved providers as an entity or just the approved provider only?

GPFRs need to be prepared at the approved provider level and are only required as a part of the annual ACFR submission. A GPFR is not required for the QFR.

Provider requirements

1.11 Which sections are government providers required to complete?

Government providers are required to complete the 'Labour Costs and Hours' and 'Food and Nutrition' sections of QFR. Similar to the ACFR, they are not required to fill approved provider level information in the Quarterly Financial Statements section.

1.12 Does government include local government?

Yes (same as the ACFR).

1.13 Do government providers include public hospital/health services?

Government providers that deliver aged care through a public hospital/health service (Multi-Purpose Services) only need to complete the 'Food and Nutrition' section.

1.14 Which sections are Multi-Purpose Services (MPS) and National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) providers required to complete?

From 1 Oct 2022, all MPS providers are required to complete the 'Food and Nutrition' section of the QFR. This replaces the quarterly Basic Daily Fee (BDF) supplementary reporting form. NATSIFACP providers need to complete the 'Food and Nutrition' section of the QFR.

1.15 Is the QFR required for providers who have more than one location/company offering services (but not consolidated for tax)?

The QFR is required to be submitted by all approved providers (similar to the ACFR).

1.16 How long is the quarterly reporting requirement anticipated to last?

The QFR will be an ongoing requirement for providers.

Completing the QFR

1.19 Can the QFR be completed and submitted by ABN instead of approved provider (NAPS ID)?

No, the QFR must be completed and submitted at the approved provider (NAPS ID) level, consistent with the ACFR.

1.20 When you refer to an organisation, do you answer for the whole organisation or just the part of the organisation that provides residential/home care services?

Approved providers (the organisation) are required to submit information based on their NAPS ID (same as the ACFR).

1.21 Is the QFR a cumulative report?

Quarterly Financial Statements are reported on a year-to-date basis. The 'Viability' section is point in time, reflecting the viability situation at the time of reporting. All other sections should be completed for respective quarters only.

1.22 Does the QFR have an upload function instead of manual entry?

Yes, an upload function is available to upload service level data (similar to the ACFR).

1.23 Will the upload file have to be manually completed each quarter? This means it will not be possible to have a template linked to supporting data, as a new file will be provided each quarter?

The upload files will need to be completed each quarter, as the services attached to each approved provider could change from quarter to quarter. If you can generate a template from your internal systems, a possible solution would be to add a macro to

your template which would populate your data into the QFR template. Then you would just need to change the name of the file reference to re-populate into a new QFR template each quarter.

1.24 Will there be an upload portal to load excel files for large providers rather than loading individual files?

The portal will have a separate upload page for each section of the QFR for each provider. This means that there would be four excel files which would need to be uploaded into the portal (services/planning regions are listed as columns within the excel sheet). There is no difference in the number of files which need to be uploaded for a small or large provider.

1.25 Is there a suggested chart of account structure for MYOB users to make this reporting easier?

It is recommended that the chart of accounts includes a set of GL accounts for wages, superannuation, entitlements and agency wages split by the roles as set out in the QFR and ACFR. For example, under wages there would be Wages RN, Wages EN, Wages PCW etc. The same is required for agency staff.

The Department via (QFRACFRHelp@health.com.au) can provide a chart of accounts template to assist if requested.

1.26 Given the administrative cost of compliance and the reporting demand when preparing the QFR and the annual ACFR, are there additional funding/grants available to assist providers who may have a lack of resources?

The Australian National Aged Care Classification (AN-ACC) funding model aims to make funding fairer and more equitable across the aged care sector. The AN-ACC assessment process reduces administrative burden so providers can spend more time providing residents with safe and effective care.

1.27 Is there information on exemptions?

Similar to the ACFR, it is a legislative requirement for providers to submit the QFR by the due date for each quarter. There is no legislative authority to grant an extension to the due dates.

1.28 What is the interface for QFR data collection?

Data has historically been collected through the Forms Administration data collection portal. From 2023-24 Q2, providers will submit their QFR through the department's new form submission system.

1.29 Is the QFR for each NAPS ID or RAC ID?

Each approved provider (NAPS ID) is required to complete one QFR every quarter. In the QFR, various sections are required to be completed at the service level (RACS ID). This is the same approach as the ACFR.

Signing the QFR

1.30 Who is required to sign the QFR?

If the approved provider is not a State, a Territory, an authority of a State or Territory or a local government authority, the QFR must be signed by:

if the provider is a body corporate that is incorporated, or taken to be incorporated, under the *Corporations Act 2001*—a director of the body corporate for the purposes of that Act;

otherwise—a member of the provider's governing body.

If the approved provider is a State, a Territory, an authority of a State or Territory or a local government authority, the QFR must be signed by one of the approved provider's key personnel who is authorised by the provider to sign the report.

1.31 Can a CEO sign the QFR on behalf of a director?

If the provider is a body corporate that is incorporated, or taken to be incorporated, under the *Corporations Act 2001*, the QFR needs to be signed by the director, or in other cases a member of the governing board, for all non-government providers. It cannot be signed off by any other personnel.

Submitting the QFR

1.32 Quarter 2 submissions are due before listed providers lodge half year results with the ASX. This poses a challenge for these providers regarding the security of the information before it is released to the market.

Any financial data that is provided to the department is 'protected information' under the *Aged Care Act*. The department has measures in place to ensure that only authorised personnel can access to financial information reported to the department through the QFR or other mechanisms. Departmental officials provided with access to such information are subject to strict confidentiality requirements including using information obtained as part of their duties for personal gain.

1.33 If an error has been detected after report submission, should a correction be added to the following quarter?

As the data in ‘Quarterly Financial Statements’ section is year to date, any error will be self- corrected in the next QFR. However, as data in the ‘Labour Costs and Hours’ and ‘Food and Nutrition’ sections is for the quarter only, providers should notify the helpdesk of any changes.

Compliance

1.34 Are there penalties for late submission of the QFR?

Any QFRs submitted after the due date may not be included in the star ratings process. This is likely to result in a 1 star rating for the Staffing sub-category.

The ACQSC actively monitors compliance with lodgement timeframes and will take formal compliance action where other regulatory approaches, such as reminders and cautioning does not result in a timely lodgement.

Sector consultation and feedback

1.35 Will there be feedback to providers regarding industry trends?

Every quarter, the department publishes a quarterly financial snapshot that provides analysis of the financial performance of the Australian aged care sector (specifically on residential aged care and home care) and includes:

- Financial performance indicators
- Food and nutrition (for residential care)
- Labour costs
- Care minutes

1.36 Is it possible to extend the QFR submission period?

In response to sector feedback, the department extended the due date for the QFR from the initially advised 21 days after the quarter ends to 35 days after the quarter ends for quarters 1, 3 and 4, and 45 days after the quarter ends for quarter 2. It is important that providers meet these timeframes to ensure their data feeds into the quarterly star ratings process. Submission due dates have been legislated.

Section 2

Viability and Prudential

Viability and Prudential

2.1 If the answer to Refundable Accommodation Deposits (Q8 in the ‘Residential Viability and Prudential Questions’ section) is 'Yes', are providers required to upload the instances (similar to the ACFR)?

If providers answer ‘Yes’, they need to provide additional information as to why the RADs are unable to be refunded.

2.2 Does "unable to refund RADs in the statutory timeframe" include RADs not refunded due to clerical oversight/error, or just RADs not refunded due to liquidity issues?

Yes, include all instances of being unable to refund RADs in the statutory timeframe and include an explanation in the comments. The comments provide context to help the department understand whether there are viability concerns, or if it was due to error.

2.3 Under the residential care questions, how is the minimum liquidity amount calculated?

Minimum liquidity is not calculated as part of the ’Viability’ section. The ‘Viability’ section asks if minimum liquidity has fallen below the level that you have previously reported in the Annual Prudential Compliance Statement, which is submitted as part of the ACFR. Your minimum liquidity amount is included in your Liquidity Management Strategy.

2.3 Please explain the process where a provider is identified as being in financial trouble.

The data reported to the department including through the ACFR and QFR provides insights into the financial performance and viability of aged care providers. The department considers several risk factors and contacts providers that may be facing high risk or financial stress to understand their current financial position and may connect them to programs that suit their specific circumstances.

2.4 We are a provider of both residential and community services, is a group position on financial viability considered?

If you provide both residential and home care services, you need to complete both Q&A worksheets. Yes, we look at the viability concerns at the segment level (residential and home care separately) as well as at the provider/group level.

2.5 If home Care or even aged care is facing financial stress but the parent is not, are we expected to confirm difficulty even though solvency is not an issue?

We consider financial stress at the service level and the provider level. Additional comments could be added in the end column to indicate that solvency is not a concern at the provider level.

2.6 Define operational loss.

We look at EBITDA results as they exclude non-cash items like depreciation and amortisation.

Section 3

Quarterly Financial Statements

Quarterly Financial Statements

3.1 Will the layout of the Quarterly Financial Statements' section in the QFR be the same as the ACFR?

It will be consistent to the ACFR. However, the QFR needs to be completed at the approved provider level, unlike the ACFR which is at the ultimate parent entity level.

3.2 What level of data is required in the 'Quarterly Financial Statements' section?

The Quarterly Financial Statement section in the QFR is at the approved provider level.

3.3 Should residential aged care ratios be calculated at the entity level or should they be answered at the consolidated organisational level?

Ratios in the Quarterly Financial Statement section are automatically calculated by the system.

3.4 Why do providers need to submit a balance sheet every quarter?

The information in the balance sheet is used by the department for more timely analysis of risk and the financial position of aged care providers. Analysis will also be made available to consumers to improve transparency of the overall performance of the aged care sector.

3.5 What is the purpose of doing the allocation between the various business segments at the balance sheet level?

Both residential aged care and home care providers are required to segment their income statement and balance sheet to complete the 'Quarterly Financial Statement' section of the QFR. The department acknowledges that some providers may need to make reasonable estimations for some data items. This requirement is similar to what providers have already done in the 'Consolidated Segment Note' in the ACFR, however, at the approved provider Level. Feedback from prior consultations has resulted in items such as cash, financial assets and equity not needing to be segmented.

Segmenting assets and liabilities in the balance sheet helps the department to understand the financial position and risks associated with particular business segments. This informs policy planning and funding for the sector.

3.6 Where do providers allocate retirement village assets/liabilities and profit and loss on the QFR?

Retirement village financial information should be allocated under the 'Retirement' category in the Quarterly Financial Statement section.

3.7 Is there a set liquidity ratio or capital adequacy ratio that must be maintained?

The Royal Commission into Aged Care Quality and Safety (Royal Commission) recommended that the Government introduce liquidity and capital adequacy requirements. The department will consult with the sector on this matter before introducing such requirements.

3.8 Are all resident liabilities classified as current liabilities for the purpose of calculating ratios?

The QFR does not differentiate between current and non-current liabilities.

3.9 Does the Veteran's Supplement need to be included in the community column of the Quarterly Financial Statements section in the QFR?

If the Veteran's Supplement is provided in residential care settings, then it should be reported in the residential column. If support for Veterans is provided through other Department of Veteran Affairs (DVA) support programs outside residential care, it should be reported in community.

3.10 Define 'Community'.

'Community' includes Commonwealth Home Support Program (CHSP), DVA and other non-aged care community services including National Disability Insurance Scheme (NDIS), children services and other community services.

3.11 Where should providers report financial information relating to the provision of mental health services in the QFR?

Mental health services provided under the umbrella of the residential nursing home should be reported in the Residential column. However, if mental health services are provided in isolation outside residential or home care, they should be reported in the 'Community' column.

3.12 Are Transitional Care Programme (TCP) services and Short-Term Restorative Care (STRC) included in community care or home care?

TCP and STRC are reported in the 'Community' column in Quarterly Financial Statements.

3.13 For providers of Home Care Packages (HCP), CHSP and NDIS, is a profit and loss statement required for CHSP and NDIS?

Residential aged care and home care providers that also provide CHSP and/or other community services such as the NDIS are required to include financial information relating to their CHSP/NDIS operations in the 'Community' column of the Quarterly Financial Statements section of the QFR.

3.14 If NDIS services are provided by the aged care provider through the same legal entity, do they need to be reported in the community column of the Quarterly Financial Statements section in the QFR?

Yes.

3.15 How are central corporate recharges treated when reporting at the approved provider level?

In the Quarterly Financial Statements section of the QFR, management fees should include corporate recharges (the apportionment of administration costs from the organisation's shared administration services and/or corporate head office).

Section 4

Residential Labour Costs and Hours

Residential Labour Costs and Hours

Care minutes obligations and targets

4.1 Will the minimum care minutes requirement start from 01 October 2023?

Yes. The national care minutes standard of 200 care minutes that providers need to meet will become mandatory from 1 October 2023.

The care minutes standard will increase to 215 care minutes, including 44 minutes of registered nurse time from 1 October 2024.

4.2 Is the QFR used to create care minute targets for services?

No, care minute targets are set through AN-ACC classifications of residents in a service for the previous quarter. The QFR is used to report against this target.

4.3 Are care minutes static throughout the quarter, and not dependent on day-to-day occupancy in the quarter as reported in the QFR?

Yes, the average per resident per day care minutes targets are static throughout the quarter, even if the service's resident case mix changes. The care minutes targets for a service are only updated at the start of a new quarter.

4.4 What is the purpose of the direct care minutes (worked) per occupied bed day section?

This is to measure whether providers are meeting their care minute targets which contribute to their Star Ratings.

4.5 Is the QFR used to determine if providers have met their case mix adjusted care minute targets?

Yes.

4.6 Does the QFR track and identify unpaid overtime for staff?

No, the purpose of the QFR is to report and monitor against set care minute targets. Care minute targets are set through AN-ACC classifications of residents in a facility for the previous

Reporting and definitions

4.7 Should ‘occupied bed days’ be as provided in the monthly Medicare payment summary, or actual figures as recorded by the residential aged care facility?

It should be consistent with the monthly Medicare payment summary.

Do the residential costs and hours include both respite and permanent beds?

Yes, it includes costs of delivering care to both respite and permanent residents.

4.8 Many payroll systems have labour hour data based on pay periods, which do not fully align to calendar quarters. Should labour hours data be extrapolated to adjust for the difference?

Yes, the labour costs and hours data are required to be adjusted to align with QFR reporting quarters. Hours must be accrued based on the three full months in the quarter and not pay runs that straddle the quarter. The rationale for this is that care minutes are based on occupied bed days for the full quarter. If hours are not accrued until the end of the month there will be a misalignment between occupied bed days and care minutes.

4.9 With reporting of hours, does the provider need to accrue hours when fortnights do not line up in the quarter?

You need to accrue the hours because your care minutes are based on occupied bed days for the full month. If hours are not accrued until the end of the month there will be a misalignment between occupied bed days and care minutes.

4.10 The QFR questions assume you can extract data from systems (e.g., percentage of services provided by external providers). If this is not attainable, how should we answer?

In regard to services provided by external providers such as agency and allied health staff, we suggest adjusting your general ledger systems to separately account for these

expenses. For example, implementing a new natural account for ‘Allied Health Professional - Podiatrist’ to account for the requirements for the expanded collection requirements around allied health.

4.11 What should be included in average hourly pay rates?

The average hourly rate is calculated by working out the average hourly rate of direct care staff employed by an organisation as per employee award/agreement/contract. This average does not include any on-costs. The average hourly rate should not include penalty rates/casual loading.

4.12 How should average hourly rate to be calculated?

As the QFR must accommodate for a range of a providers with differing systems and system capabilities, a provider may calculate the average rate of pay using award rates based on the number of people in the organisation at each award level. For example - If you have employed 3 RNs at hourly rates of $50/hr, $50/hr and $65/hr the average will be [($50+$50+$65)]/3 = $55/hr. The total number of hours worked by each employee will not impact this calculation. It is also fine if providers with more sophisticated systems can calculate a base rate of pay based on work hours. This method should include the weighting of hours worked for each category of nurse.

4.13 How should worked hours be recorded in a general ledger accounting system?

Some general ledger accounting systems have an area where non-financial information such as quantities can be recorded. If a time recording function is not available in your accounting system, use a facility level rostering record instead.

4.14 Why are workers’ compensation and payroll tax costs excluded?

Only the costs that can be directly attributable to employees are included.

4.15 If your total expenses include all costs but your average hourly rate does not include super, overtime or allowances, would it not correspond with total hours worked?

The data is not intended to reconcile. Total cost is required to show the department the total cost of care. The average hourly rate informs the department of the average hourly rates paid to employees before any additional overtime or allowances.

4.16 Why are leave entitlements included in labour costs but excluded in care minutes calculations?

The cost of employees includes all on-costs and leave entitlements. The department is interested in the full cost of an employee. In relation to hours worked, the department is interested in worked hours only.

4.17 Why does contract labour does not have categories?

The department understands that it may not be easy to capture these costs. We will seek to understand which organisations contract out their services and work with them to ensure they meet reporting requirements in the future.

4.18 Do average hours include agency data?

Providers should record the hours of agency staff to ensure that they report all the direct care hours provided to their residents.

4.19 Does rate of pay apply to internal labour only or does it also include agency?

As per the definition this includes only staff employed by your organisation as per your employee award/agreements/contracts. This would not include agency staff.

4.20 As agency hours are hard to obtain, are there options for transitional arrangements if systems are not easily able to extract labour hours from a submitted invoice?

Please speak to your provider to issue invoices that can easily determine the staff that worked including role and the hours that were worked.

4.21 What happens if the provider is unable to split the allied health components from agency staff?

Please speak to you provider to issue invoices that split the allied health components by profession.

4.22 What happens if the allied health charges per resident or service, rather than by time?

Please speak to your provider about adding the time per service to their invoice.

4.23 Are travel and accommodation costs associated with agency staff or visiting professionals included?

Yes, as this is the real cost of using the agency staff. Accommodation costs should be included in agency staff costs as that is the true cost of having an agency staff member.

4.24 For RN shift coverage (AM/PM), should this include shifts worked by agency staff?

Shifts worked by agency staff are included. There is a specific section titled 'Agency Staff Worked Hours' under the section 'Labour Worked Hours - Direct Care'.

4.25 Can position descriptions be used to allocate direct care hours?

Providers can use position descriptions to allocate direct care hours for staff members with multiple roles.

4.26 Define 'Direct Care Minutes'.

Direct care minutes are actual worked hours by registered nurses (RN), enrolled nurses (EN), and personal care workers (PCW) or assistants in nursing (AIN) who are performing direct 'clinical care' and 'personal care' activities. This excludes staff leave time and training. Where a registered nurse, enrolled nurse or personal care worker/assistant in nursing is employed in a hybrid role, for example providing both personal care and other activities such as catering and laundry, the portion of the worker's time spent on personal care can count towards care minutes.

Please refer to the QFR definitions published on the department's website.

4.27 Define 'non-worked hours'.

The QFR captures the amount of time staff spend performing their employable duties as 'worked hours' (for example a registered nurse working a 6-hour shift, is reported/counted as 6 'worked' hours). 'Worked' hours does not mean 'paid' hours of work, but rather the number of hours a staff member actually provided a service/performed their respective duties. 'Non-worked' hours, however, refers to staff leave time and training (for example if a registered nurse takes a day of leave, this is not considered a 'worked' shift, but they are still paid; similarly, if a registered nurse participates in a day of training, this is not considered a 'worked' shift for the purposes of QFR reporting).

Please refer to the QFR definitions published on the department's website.

4.28 Does direct care cost include superannuation?

Yes, direct care cost includes superannuation.

4.29 Are allied health labour costs and hours replicated across other segments of the QFR or are they only inputted into one of the tabs?

Speech pathologist and dietetic care are collected in the both the Residential Care Labour Cost/Hours and the Food and Nutrition sections. Definitions provided for each section make the data presented different and relevant in each section. For example, Speech Pathologist will only include food, nutrition, and dining experience in the 'Food and Nutrition' section, whereas in the Residential Care Labour Cost/Hours section, it will include food, nutrition, dining experience and communications.

4.30 What is best practice for reporting the hours of care provided by third party allied health contactors (e.g., podiatry)?

Best practice is to receive an itemised invoice from the allied health professional that shows the hours spent and amount charged.

4.31 Does labour cost include long service leave?

Yes.

4.32 How do we report if we have two RAC numbers under one roof and the services are managed as one facility? Can we report as one consolidated report?

Residential aged care providers must report information in the QFR at the service level, even if it operates as part of one larger facility. Care hours reported in the QFR are measured against each service's case mix adjusted care minutes targets, which directly inform the Staffing Star Rating for each residential care service.

4.33 Why are head office costs not allocated in care labour costs?

The QFR focuses on the reporting of care expenses and care hours. Administration and non-care related costs are not directly related to the provision of care. They also do not have any weighting on providers' star ratings.

4.34 What if an approved provider has direct labour costs across a number of facilities? Should these costs be allocated based on time or another method?

For a nurse or other direct care staff working across several facilities, the costs and hours should be apportioned based on the time they are allocated to each facility.

4.35 Where should we capture care advisor expenses? Care management?

Care management expenses are recorded in row 8 of the Residential Care Labour Cost and Hours section. Care management hours are recorded in row 47 of the Residential Care Labour Cost and Hours Section.

4.36 For registered nurses, are the morning/afternoon shift categories set? Where do we allocate overnight hours?

There is a category in the QFR for overnight shifts (11pm-7am). Allocate to the categories based on where the most time is spent if there is overlap. For example, if a nurse works from 9pm-5am, allocate these hours to the overnight shift. Note that the shift times provided in the QFR template are only a guide.

4.37 If a shift goes across a morning and an afternoon shift, where should the hours be reflected?

Providers can allocate the staff to the shifts based on where the majority of their time is spent. For example, if a registered nurse works from 8am to 4pm, they spend the majority of their time in the morning and should be allocated to the morning shift.

4.38 Some of our systems cannot report RN hours by shift, do we apply a proportional allocation of hours?

The reason for the categories of hours is that the department is interested in the impact of 24/7 nursing on staff. This is based on worked hours and not paid hours. It is therefore recommended that providers use rosters where possible rather than payroll for calculating this.

4.39 Do worked hours include shifts where a facility is unable to cover a shift with available staff (unfilled shifts)?

Worked hours are hours worked by staff (employee or agency) in their designated position. It does not include unfilled shifts.

4.40 Do casual staff have non-worked hours?

As per the QFR definitions, casual staff are captured under agency staff and both their worked and non-worked hours are accounted for. Only ‘worked hours’ of registered nurses, enrolled nurses and personal care workers/assistants in nursing can be counted towards care minutes. If RN, EN and PCW are casual/agency staff their direct care time is still counted towards care minutes and captured in the QFR.

4.41 If staff spend, for example, 10% of their time providing direct care, how should their leave hours be reported in the "non-worked hours" category? Should all of their non- worked hours be reported, or just a partial amount as well?

If a staff member's hours are proportioned based on their role, then their non-worked hours also need to be proportioned to match their worked hours. For example, if 10% of their time goes to direct care and they are on leave for the 10% that they are usually providing direct care, please record the 10% as non-worked hours.

4.42 Define ‘available bed days’.

‘Available’ refers to a bed being physically available to be occupied. If a provider has been approved for a bed but that bed was not physically available, it should not be included in the available bed days amount. In summary, available bed days are the number of beds that are actually available for a resident and exclude off-line beds.

4.43 Do occupied bed days include days a permanent resident is in hospital or on social leave?

Permanent aged care residents’ care time will be counted towards your service’s case mix-adjusted care minutes target during periods of hospital leave. This is because funding for residents on hospital leave will continue up to a maximum of 29 days at 100% and reduce to funding from the Base Care Tariff component of AN-ACC, only if the hospital stay exceeds 29 days. Also, residents who are on leave are considered to be in care and are included in the calculation.

4.44 Is it correct that direct care with clients is counted as worked hours, but paid hours would now include broken shift allowances, training, annual leave, and sick leave?

Yes, that is correct. Staff worked hours are the number of hours a staff member actually provided a service/performed their respective duties. For example, a staff member rostered for an 8-hour shift who attended 1 hour of training will be paid for the full 8 hours, however their ‘worked hours’ in terms of the QFR are 7 hours.

4.45 Is there a benchmark on the average RN care minutes across the morning, afternoon and overnight shifts?

As information has not previously been collected at this granular level, benchmarks have not yet been set across the different shifts. It is however expected that the majority of RN time is spent on the morning and afternoon shifts. An important outcome from the collection of this data is to allow the government to assess the levels of 24/7 RN care provided by the sector.

4.46 Will 'other allied health' be required to be specified anywhere?

'Other allied health' expenditure and care minutes are required to be reported by providers in the Residential Care Labour Costs and Hours section of the QFR.

4.47 Given there are no allied health care minute targets, what does this mean for allied health?

While there are no care targets for allied health, allied health is an important element of quality of care in the aged care sector. Information collected in the QFR will help the department effectively target those providers at greatest risk of potential non-compliance or where there may be emerging viability problems that may have the potential to cause quality and safety issues.

4.48 What are the reported minutes and costs of allied health categories used for and how does it relate to the role of the ACQSC? Are allied health assistants delineated by type of profession assisted? Is 'other allied health' disaggregated somewhere?

QFR data provides visibility of the use of allied health and lifestyle services during and following the transition to AN-ACC. Information on the provision of allied health services under AN-ACC is also shared with the ACQSC to ensure that providers are meeting their responsibilities under the Quality Standards. Delineation of allied health assistant data by type of profession assisted or de-aggregation of other allied health data is not currently required.

4.49 What are some examples of best practice care minutes monitoring to ensure we provide accurate data based on the resident's needs?

Further information and worked examples of reporting care minutes are available in the care minutes and 24/7 registered nurse responsibility guide.

4.50 Occupied bed days are used to calculate care minutes. How does this work when occupied bed days include respite residents and unassessed residents without care minute requirements?

As outlined in the care minutes and 24/7 registered nurse responsibility guide, respite residents that have a classification (Class 101, 102 or 103) contribute to the care minutes targets. Table 2 in the guide linked above provides information on the minutes associated with each of the respite classes.

Unassessed residents (i.e., those with a default AN-ACC classification) do not contribute to the service-level average care minutes target calculation (which is set based on the resident case mix from the previous quarter). This target is the minutes per resident per day that providers can view in the provider portal, and is calculated by multiplying the number of care days delivered in each class by the class minutes targets (outlined in Table 1 and Table 2 of the guide), summing these together and dividing by the total number of care days delivered over the month (to residents with an AN-ACC or respite classification).

The service-level average care minutes targets assigned are used for the following quarter, irrespective of whether residents' AN-ACC classes change or residents enter or exit care. The target applies to all resident care days (occupied bed days) delivered over the quarter, including for residential respite care, and care days delivered to residents with default classifications.

Care workers

4.51 Is there a definitive list of what roles constitute care minutes?

Yes, in line with the recommendations of the Royal Commission, only the following types of care can be included in care minutes calculations:

- Registered nurses,
- Enrolled nurses and licensed nurses (registered with the Nursing and Midwifery Board of Australia) and
- Personal care workers or assistants in nursing.

Note this only applies to 'Worked hours' of registered nurse, enrolled nurse, and personal care worker or assistant in nursing staff and does not include staff leave time and training.

For example, direct care would include a personal care worker sitting with a resident and helping them eat or helping them with toileting. However, if the personal care

worker attends training for one day or a few hours, this is not considered direct care as it doesn't involve working directly with the resident. For more examples of direct care please see the care minutes and 24/7 registered nurse responsibility guide.

4.52 Do care minutes include registered nurses completing care plans and documenting assessment or just the time they spend assessing residents?

The portion of time that registered nurses spend on care planning for residents can be included in care minutes. This may include identifying and documenting changes to a resident's health status, care planning, liaising with residents and families and engaging with health providers including arranging appointments to ensure residents' needs are met.

4.53 Where do providers record information on wages of registered nurses who provide clinical care to clients and manage/coordinate their packages?

If the registered nurse is providing clinical care, their wages will need to be split between client care and care management to ensure accurate allocation of costs. This data assists the department in reviewing the appropriate funding subsidy overall and by service.

4.54 Can you include any hybrid roles under AIN if they do direct care but are not actually AINs? I.e., lifestyle staff who do these functions.

Only direct 'clinical care' and 'personal care' activities provided by specified workers (RB), enrolled nurse or personal care worker/assistant in nursing) can be counted towards care minutes.

An assistant in nursing employed under the Nurses Award 2020 is a specified worker and may deliver care minutes. Lifestyle staff who are not specified workers may not deliver care minutes.

Where a specified worker is employed in a hybrid role, for example, performing both personal and/or clinical care activities and non-care activities, only the portion of the worker's time on 'direct care' activities counts towards care minutes.

Direct care activities

4.55 Is supervision of staff providing direct care counted towards care minutes?

Supervision of staff who are performing direct care is not counted towards care minutes (only the time spent by the staff member performing the direct care would count, if they are a nurse or personal care worker). Supervisory duties can however be captured as a part of care management staff costs.

4.56 Education/training of care staff is often done on the job as part of day-to-day activities (e.g., short, targeted info sessions). Are these hours to be excluded from care minutes?

Yes, only 'worked hours' of registered nurse, enrolled nurse, and personal care worker staff will count towards care minutes. This excludes staff leave time and training.

4.57 Are training hours excluded from the QFR costs and included under non-worked hours?

Training and leave hours constitute non-worked hours.

4.58 Where care management staff have time allocated to 'direct care' for purposes of calculating care minutes, should costs be allocated to the registered nurse section?

The portion of time that care management staff spend on the care of residents can also be included in care minutes if they are a registered nurse, enrolled nurse or personal care worker/assistant in nursing. For example:

- managing the care of individual residents through tasks such as providing advice about or performing wound management, diabetes management, behavioural management, medication management, nutrition and hydration management, pressure care management and incontinence management.
- identifying and documenting changes to a resident's health status, care planning and liaising with residents and families, engaging with health providers including arranging appointments to ensure residents' needs are met.

4.59 Should CEO, DON and Clinical Manager be included as Care Management Staff?

Whilst these staff members would fall under the broader definition of care management staff in terms of oversight duties, care management staff activities that are

administrative or not related directly to the care of individual residents, such as staff rostering, recruitment, and facility level planning and reporting, can't be counted towards care minutes. Only the portion of time that care management staff and staff in hybrid roles spend on the care of residents can be included in care minutes.

4.60 Does Care Management include administration staff as well?

Care Management does not include administration staff. As per the definitions care management staff include Director of Nursing/Nurse Manager/Facility Manager. Hours worked for any staff that fit outside of the care category are not included.

Care management staff activities that are administrative or not related directly to the care of individual residents, such as staff rostering, recruitment, and facility level planning and reporting, cannot be counted towards care minutes.

4.61 Where a provider splits care managers for direct labour hours, does this need to be reflected in expenditure?

Where a care manager is employed in a hybrid role, for example providing both clinical care and other activities, only the portion of the worker's time spent on clinical care counts towards RN labour costs. The rest will remain as Care Management.

4.62 If a facility manager is a registered nurse, does time spent with residents/ resident's families count towards care minutes?

Where a registered nurse, enrolled nurse or personal care worker/assistant in nursing is employed in a hybrid role, for example providing both personal care and performing other duties, the portion of the worker's time spent on personal care can count towards care minutes.

Care management staff activities that are administrative or not related directly to the care of individual residents, such as staff rostering, recruitment, and facility level planning and reporting, cannot be counted towards care minutes.

4.63 Where do providers record back-office expenses e.g., corporate services, senior management, audit, legal and other operational costs in the QFR?

This information is collected in the Quarterly Financial Statement, under 'Other Expenses' in the Expense section. Although not reported at the facility level, the department requires this information to be reported at the approved provider level. This information is also collected in the administration section of the ACFR.

4.64 Should providers include lifestyle staff providing direct care?

The Government acknowledges the contribution of lifestyle staff in providing services to older Australians, including in residential aged care settings. However, in line with the recommendations of the Royal Commission, only the following types of care staff can be included in care minutes calculations: registered nurses, enrolled nurses and licensed nurses (registered with the Nursing and Midwifery Board of Australia) and personal care workers/assistants in nursing.

The QFR collects data on labour costs (direct care) including labour hours worked by lifestyle staff. Where lifestyle staff take on additional roles, their hours worked should be split/apportioned based on the times that are allocated to each role. Where lifestyle staff work across separate facilities, hours worked should be split/apportioned based on the time they are allocated to each facility.

4.65 Are domestic services included in personal care minutes?

Domestic services are not counted as direct care and are reported as relevant labour costs in the ACFR.

Where a personal care worker is employed in a hybrid role, for example providing both personal care and other activities such as catering and laundry, only the portion of the worker's time spent on personal care can count towards care minutes.

4.66 Are care staff who also prepare and serve meals to residents counted as direct care for the purposes of care minutes?

Only registered nurses, enrolled nurses and licensed nurses (registered with the Nursing and Midwifery Board of Australia) and personal care workers/assistants in nursing can be included in care minutes calculations.

In terms of QFR reporting, if a registered nurse, enrolled nurse or personal care worker/assistant in nursing is sitting with a resident and feeding them or assisting them to eat, then this is considered direct care and is counted towards care minutes. Catering services are not counted as direct care and will be reported as labour costs in the QFR under catering expenses.

Where a registered nurse, enrolled nurse or personal care worker is employed in a hybrid role, for example providing both personal care and other activities such as catering and laundry, the portion of the worker's time spent on personal care such as assistance with feeding can count towards care minutes.

4.67 Where AN-ACC is funded for allied health and direct care, why are allied health care hours not identified and counted as direct care?

Only registered nurses, enrolled nurses and licensed nurses (registered with the Nursing and Midwifery Board of Australia) and personal care workers can be included in care minutes calculations. It is the responsibility of approved providers to determine how best to meet the care needs of their residents in accordance with their obligations under the Aged Care Act 1997 and the associated Quality Standards.

There are a range of services that providers are required to make available (or to assist with access) to all residents who need them that are detailed under Schedule 1 of the Quality of Care Principles 2014. This includes access to allied health services as part of an individual therapy program aimed at maintaining or restoring a resident's ability to perform daily tasks. ACFI funding, which included allied health care, was rolled into the AN-ACC funding allocation, with providers still funded for and required to provide allied health services to residents.

4.68 Is diversional therapy counted towards direct care minutes?

The Government acknowledges the contribution of diversional therapy staff in providing services to older Australians, including in residential aged care settings. However, in line with the recommendations of the Royal Commission, only the following types of care staff can be included in care minutes calculations: registered nurses, enrolled nurses and licensed nurses (registered with the Nursing and Midwifery Board of Australia) and personal care workers/assistants in nursing.

The QFR collects data on labour costs (direct care) including labour hours worked by diversional therapy staff (not including leave and training hours). Where staff take on additional roles, their hours worked should be split/apportioned based on the time allocated to each role. Where diversional therapy staff work across separate facilities, hours worked should be split/apportioned based on the time they are allocated to each facility.

4.69 Is pastoral or spiritual care included under care minutes?

In line with the recommendations of the Royal Commission, only the following types of care staff can be included in care minutes calculations: registered nurses, enrolled nurses and licensed nurses (registered with the Nursing and Midwifery Board of Australia) and personal care workers/assistants in nursing.

4.70 Should a buddy shift be considered training?

If a new employee/trainee is shadowing/being trained by another staff member then this is not considered direct care and is not counted towards care minutes. Only ‘worked hours’ of registered nurses, enrolled nurses and personal care workers/assistants in nursing can be counted towards care minutes. This excludes staff leave time and training and does not include activities that are administrative or not related directly to the care of individual residents.

4.71 Why is training excluded when this is a requirement for staff to be able to provide care safely and effectively?

AN-ACC funding is about providing more equitable care funding to providers that better matches resident needs with the costs of delivering care. The aim of care minutes is to raise the quality of care delivered to residents in residential aged care. As per the Royal Commission recommendations, activities that are administrative or not related directly to the care of individual residents such as staff leave time and training, cannot be counted towards care minutes. Only ‘worked hours’ of registered nurses, enrolled nurses and personal care workers/assistants in nursing can be counted towards care minutes.

4.72 Why can social and emotional support provided by a PCW be counted in the care minutes target, but it cannot be counted if a lifestyle assistant provides the same social and emotional support?

Consistent with the Royal Commission recommendations the government is introducing new care minutes requirements, requiring the delivery of an average of 200 care minutes, including 40 minutes of registered nurse time per resident per day. These care minutes can be delivered by personal care workers/assistants in nursing , enrolled nurses or registered nurses and do not include allied health, lifestyle workers and other aged care staff (e.g., catering, hotel services, facility and room cleaning, maintenance and gardening).

Social and emotional support is a vital part of residential aged care. It is important to note that while lifestyle services are excluded from care minutes, these are funded separately under AN-ACC. Funding under AN-ACC is sufficient to provide residents with lifestyle services consistent with their individual care plans. The QFR collects information on lifestyle services – this will help continue to inform policy and the AN-ACC model.

4.73 What level of analysis should be done to arrive at the care minutes for hybrid roles?

For hybrid roles, the QFR requires an apportionment based on the time allocated to each role. Providers must have a methodology for this apportionment that is supportable if asked or required.

4.74 Are interdisciplinary care planning and case review considered direct care?

Yes, interdisciplinary care planning and care review are considered direct care and counted towards care minutes if provided by a registered nurse, enrolled nurse or personal care worker including care management staff (Director of Nursing, Nurse Manager or Facility Manager). In line with the recommendations of the Royal Commission, direct care is care provided by only the following types of care staff: registered nurses, enrolled nurses and personal care workers/assistants in nursing. This excludes staff leave time and training and does not include activities that are administrative or not related directly to the care of individual residents (such as staff rostering, recruitment, and facility level planning and reporting).

4.75 Are average pay rates for care managers entered?

No, average pay rates are only entered for registered nurses, enrolled and licensed nurses and personal care workers/assistants in nursing. If a care manager also provides services as an RN, the rate of their pay will be included in the average pay rates. Pay rates for care managers who are also RNs may be higher than the dedicated RN rates.

4.76 Can we include volunteer hours in care minutes?

Volunteer hours cannot be included in care minutes. Only ‘worked hours’ of registered nurses, enrolled nurses and personal care workers/assistants in nursing can be included in care minutes, as per the Royal Commission recommendations. Worked hours refer to the number of hours an employee is paid/compensated to provide services at a residential aged care facility. It does not include staff leave and training and voluntary hours.

4.77 Do the average hourly rates of pay of registered nurses include casual loading?

No, casual loading is not included.

4.78 Does the average rate of pay include penalty rates or is it the base rate?

The average rate is the base rate of direct care at your organisation.

4.79 There is no allocation of head office costs in the Care Labour costs. Why are they not allocated?

The QFR focuses on the reporting of care expenses and care hours. Administration and non-care costs are not directly related in the provision of care.

Section 5

Home Care

5.2 Is home care only defined as HCP or does it also include other services such as CHSP?

Home care only includes HCP, which is the same as the Home Care section in the ACFR. CHSP should be reported in the Community Column of the Quarterly Financial Statements section of the QFR.

5.3 Does the QFR apply to CHSP providers and HCP providers?

All home care providers are required to complete the QFR. CHSP providers who do not provide residential and/or home care are not required to complete the QFR.

5.4 Will the QFR be required for the new Support at Home program and how will it be differentiated from the CHSP and HCP equivalents?

The financial reporting requirements for home care providers will be updated as required to align with the new Support at Home program that is planned to commence on 1 July 2025.

5.5 If you are a home care provider only and do not provide residential care services, do you need to complete the QFR?

Yes. The QFR is to be completed by all residential aged care, home care, MPS and NATSIFACP providers. However, as not all sections of the QFR are applicable to all providers, providers only see the sections of the QFR that they are required to complete. In this case, you only see and complete the sections applicable to home care if you are a home care provider who does not provide residential care.

5.6 If home care packages are a component of the business and don’t have a separate balance sheet, do providers report on the organisation's balance as a whole or estimate the components which are home care related only?

Both residential aged care and home care providers are required to segment their income statement and balance sheet to complete the ‘Quarterly Financial Statement’ section of the QFR. The department acknowledges that some providers may need to make reasonable estimations for some data items.

5.7 Does the QFR require information on income and expenditure on services brokered to other providers as well as self-funded (private) clients? Is this information reported under the home care segment?

Home care income and expenditure should cover HCP clients, private clients that meet the age requirements for home care (persons 65 years of age or older (50 years or older for those who identify as an Aboriginal or Torres Strait Islander person)) and brokered services for HCP clients and age eligible private clients with other providers. This

information should be reported under the home care segment. Income and expenditure relating to services provided to clients on other government programs such as the NDIS/CHSP should be excluded. This is consistent with the way in which the Home Care Income and Expenditure Statement within the ACFR is completed.

5.8 Are there different requirements (items) for completion by home care providers?

Home care providers are required to complete the 'Viability' section, 'Quarterly Financial Statements' and the 'Home Care Labour Costs and Hours' sections in the QFR. Please refer to table 1 in the QFR guide for further details.

5.9 Are home care providers required to submit by government planning region, or use internal business structures to define planning area?

The Home Care 'Labour Costs and Hours' section of the QFR should be completed at the aged care planning region level. The QFR has a separate, labelled column for each provider's planning region(s). This is consistent with the Home Care Income and Expenditure statement in the ACFR.

5.10 For home care providers, do labour costs include care workers providing home cleaning or just clinical and personal care?

Labour costs include care workers providing gardening, cleaning and domestic assistance. Depending on how the worker was engaged, they should be included in 'Labour Cost - Internal Direct Care - Employee' or 'Sub-contracted or Brokered Client Services - External Direct Care Service Cost'. They should be categorised as personal care staff.

5.11 Does the brokerage agency need to complete the 'direct cost' section for home care providers who use third party organisations to provide direct care services?

Providers need to collect adequate information from brokering agencies to enable the completion of the relevant sections of the QFR. All costs need to be split into the relevant categories in the form.

5.12 If home care providers receive and process invoices for physio and podiatry (which are recorded directly against the HCP funds account in the balance sheet with no income or expense posting in the income statement), should this be considered as sub-contracted direct care?

In accordance with the AASB standards, the reporting requirements in the ACFR and QFR ask all income and expenses to be recognised through the income statement. If a provider has previously processed this transaction through the balance sheet, this needs to be corrected and recognised in income statements moving forward.

5.13 How are the hours and costs for management and admin staff in home care (including CEO) captured in the QFR?

Definitions for ‘Admin and Support Costs’ have been updated. Advice to exclude the management fee has been replaced with advice to exclude the corporate recharge. Corporate recharge is not collected in the QFR but is collected in the ACFR.

The provision of administrative work relating to home care consumers (including senior management and directors fees) should be included in ‘Admin and Support Costs’ even if provided by centralised head office staff under the ‘Centrally Held’ column.

The apportionment of administration costs from the organisation's administration cost centre and/or corporate head office which cannot be allocated to ‘Admin and Support Costs’ should be included in corporate recharge in the ACFR.

5.14 If labour hours are actual hours and not paid hours, how can home care providers match payments in the QFR with hours?

The home care ‘Care Labour Costs and Hours’ has an additional item called ‘Non-worked Hours’ at the bottom of the home care hours section to allow for paid (non-worked) hours to be completed. This should be used to provide leave and training hours. All other labour hours reported should be actual worked hours.

5.15 Should the Agency Staff section include details of third party providers (e.g., a client has a physio session with an outside therapist and charges it to their package)?

The expenditure should be disclosed in the ‘Sub-Contracted or Brokered Services – External Direct Care Service Cost’ section as the service has been brokered by the provider for the person receiving care.

5.16 What is required to be shown on the ‘Sub-contracted or Brokered Client Services - External Direct Care Service Cost’ lines?

This includes the total amount paid to sub-contractors/brokered agencies for the delivery of services. For labour worked hours, include total worked hours and does not include leave and training hours.

5.17 Do HCP providers need to ask agencies to break down their invoices to determine hours worked vs fees?

When an agency sends an invoice to providers, the agency fee is generally already reflected in the cost of each labour cost item. It does not need to be provided separately. In terms of hours, it should not be impacted by the agency's fee, as it is the hours worked.

5.18 Do HCP providers code case managers by their discipline?

'Wages and Salaries - Care Management Staff' should include salaries and superannuation paid to care management staff (employee involved in managing care for the care recipients). If it is a hybrid role, where direct care is also being provided by the care manager, it should be apportioned to the relevant roles (RN, EN. etc).

5.19 What's the difference between franchise and brokerage?

A franchise is a business arrangement where an entity (the franchisee) enters an agreement to pay an established aged care provider (the franchisor) for the use of their brand name and other intangibles to gain better access to new packages and entry into the market. The franchisor usually has no direct involvement with the package service delivery and is simply paid a royalty for their brand reputation.

Brokerage is an arrangement where the provider responsible for servicing packages selects someone external to their business to deliver specific services, however the provider is still usually in control of the care management and administration of the packages.

5.20 What's the difference between agency and brokerage?

Agency is a short-term solution to seek external provision of services that are usually delivered internally. Brokerage is where a formal agreement is in place for an external firm to routinely deliver services for an agreed term or continuously.

5.21 Do we insert the balance of unspent funds per balance sheet?

For the QFR, the balance held on your balance sheet (funds held by provider) is entered into the Quarterly Financial Statements section. The ACFR requires more detailed reporting on unspent balances.

5.22 Why is there no Care Management under Direct Care for home care providers as there is for residential?

There is a separate section for Care Management in home care as it is a much larger portion of the overall operation and is charged separately for each package holder.

5.23 When we broker services from an approved provider, they report care minutes and we report care minutes. Is there be a duplication of reporting? How is this managed?

Care minutes must be reported by the approved provider who has received the funding on behalf of their clients. If the approved provider is not directly providing the care, it is expected that the broker service that is providing the care reports the correct hours back to the approved provider.

Section 6

Food and Nutrition

Food and Nutrition

6.1 Is food and nutrition information reported at the facility level or approved provider level?

Information is reported at the facility level.

6.2 Does food and nutrition reporting only relate to residential care services or do providers need to report on food and nutrition delivered under home care packages?

Food and nutrition reporting is only required for residential services, MPS and NATSIFACP services.

6.3 Will there be a reconciliation between the BDF Supplement report and the 'Food and Nutrition' section of the QFR report?

6.4 The basic content of the BDF supplement report has been rolled into the QFR, which replaced BDF reporting requirements. Why is there an expectation for providers to spend the total amount of $10?

An additional BDF supplement of $10 per resident per day was provided to services based on their undertaking to the department to improve daily living services with a focus on food and nutrition. This funding was provided at the recommendation of the Royal Commission in the context that the average expenditure on food was below what could provide adequate meals to residents.

6.5 Will definitions of line items required in the nutrition reporting tab be provided?

Yes, definitions for each line item are already available on the Forms Admin: https://health.formsadministration.com.au/dss.nsf/DSSForms.xsp.

The department has also released explanatory notes to assist providers with the transition to reporting through the QFR.

6.6 Is the $10 per day per resident BDF going to be increased to account for the additional recording and reporting requirements?

There will be no increase in the BDF supplement amount to account for reporting, as the reporting was a condition of receiving the supplement as outlined in the

undertaking providers signed with the department. This funding uplift was part of the $3.2 billion investment by Government into residential aged care.

As of 1 October 2021 supplement has been rolled into the AN-ACC funding for residential aged care services. In line with the Government's commitment to improve accountability in aged care, food and nutrition reporting is now mandatory for all residential, MPS and NATSIFACP services. For information regarding funding allowances and changes you can contact the AN-ACC team at ACFR.FacilityReporting.Help@Health.gov.au.

6.8 How should speech pathologist costs be split to be reported in the Food & Nutrition Costs and Residential Care Labour Cost & Hours sections? Similarly, how should dietetic care be reported?

Speech pathologist costs should be split to be reported in the Food & Nutrition Costs section if they relate to food, nutrition and dining experience. The total speech pathologist cost and hours, including food, nutrition, dining as well as communication, etc, needs to be reported in the Residential Care Labour Cost & Hours section.

Dietetic care should be the same across both the Residential & Food & Nutrition sections. However, if you believe there might be any exception, please provide an example to us for further consideration.

6.9 Internal delivery costs are not external supplier delivery charges?

No, they are different. Internal delivery costs are related to internal catering, such as the cost of delivery for food and ingredients to the facility to be used for internal catering. It is anticipated that external supplier delivery charges i.e., delivery charges associated with external contracts, will be included within the external contract cost and they will be unable to be separated.

6.10 Are Regional Hospitality Managers hours/wages included in the report?

If the hours for the Regional Hospitality Manager relates to food, nutrition and/or dining then they should be recorded in the QFR. If they relate to multiple services, then the hours should be split accordingly across the services.

6.11 Does 'Food and cooking ingredients – other' exclude catering non-edible costs?

Non-edible costs, such as cutlery, are not reported through food and nutrition reporting in the QFR. 'Food and cooking ingredients – other' refers to edible cooking ingredients which are pre-prepared or processed. This differentiation is made using

the GST classification. For more information, please see the Food and Nutrition reporting ‘Explanatory Notes’ available on the department’s website.

Section 7

Star Ratings

Star Ratings

7.1 How does the data reported in the QFR impact facilities/services' Star Ratings?

Star Ratings are published for all residential aged care services on My Aged Care. Star Ratings support senior Australians to compare services and make informed choices by providing simple 'at-a-glance' information, based on an overall rating and four sub-categories:

- Residents' Experience.
- Compliance.
- Staffing.
- Quality Measures.

The residential care labour cost and hours reporting section of the QFR captures the care hours delivered by specified care workers to residents who were in care at a service during the relevant quarter. This information directly informs the performance of services against their minimum care minute targets for the Staffing Rating.

7.2 Does the Star Ratings system apply to home care providers?

No. Star ratings currently apply to residential aged care providers.

7.3 What are the components of the Star Ratings design and how does the department work out the rating?

The star rating design is a rules-based system with clear specification of requirements to attain each level of rating. Weighting of each data source within the overall Star Rating is based on importance and maturity, with Residents' Experience Ratings being the highest (33%), followed by Service Compliance (30%), Staff Care Minutes (22%), and the five Quality Indicators (15%). The Star ratings of 1-5 stars represent inadequate (1), average (3) to outstanding (5) care respectively. New services receive a Star Rating only once data is available.

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