



Quarterly Financial Report – Residential Care Labour Costs and Hours reporting

Frequently Asked Questions (FAQs)

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This FAQ document contains Quarterly Financial Report (QFR) information specific to Residential Care Labour Costs and Hours. The broader QFR FAQ document can be accessed [here](#) and includes:

- General information about completing the QFR
- Viability and Prudential
- Year to date Financial Statements
- Hourly wage rates
- Home Care
- Food and nutrition
- Outbreak Management Expenses

Care minutes responsibility and targets

1. Is the QFR used to calculate care minutes targets for services?

No, care minutes targets are calculated from the Australian National Aged Care Classification (AN-ACC) classifications of permanent residents (including palliative care residents) and respite residents that were in care during the target calculation period. For more information on care minutes targets see Section 4 of the [Care minutes and 24/7 registered nurse responsibility guide](#).

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

Yes, each service's care minutes targets are static throughout the quarter once they have been calculated, even if the service's resident case mix changes. For more information see Section 4 of the [Care minutes and 24/7 registered nurse responsibility guide](#).

3. Is the QFR used to determine if providers have met their care minute targets?

Yes.

Labour hour reporting and what counts as care minutes

4. What are 'direct care minutes'?

Direct care minutes are the actual worked time by registered nurses (RNs), enrolled nurses (ENs), and/or personal care workers/assistants in nursing (PCWs/AINs) who perform direct clinical care and personal care activities on-site. It may include both direct (i.e., in person assistance) and those that are not face to face (for example writing up care plans or organising a referral).

This excludes staff leave time, training, on-call and virtual telehealth arrangements which do not contribute towards care minutes. Where a RN, EN or PCW/AIN is

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

Refer to Section 3 in the [Care minutes and 24/7 registered nurse responsibility guide](#) for a list of activities that are counted as direct care time when delivered by a RN, EN or PCW/AIN, and a list of activities that are not counted as direct care.

5. Why is 'Aged Care employee – Direct care Level 6' excluded from the PCW/AIN definition?

According to the Aged Care Award 2010 (under Schedule B – Classifications) Aged Care employees are separated into 'general' Levels 1 to 7 (e.g., general and administrative services, food services, gardeners, cleaners, receptionists etc.) and 'direct care'. For the purposes of care minutes reporting, a PCW is considered an Aged Care Employee – Direct Care. PCWs are covered specifically under Schedule B.2, which states Levels 2-5 and 7 are inclusive of personal care tasks. Levels 1 and 6 are not inclusive of personal care tasks.

6. Is supervision of staff who are providing direct care counted towards care minutes?

Recognising that aged care is delivered within a team environment, day-to-day supervision, provided by RNs, ENs and PCWs/AINs in direct care roles of other direct care staff while they are providing care to residents can be counted as care minutes.

Management and administrative tasks, such as rostering and recruitment, are not counted as care minutes.

7. Are interdisciplinary care planning and case review activities considered as direct care?

Yes, interdisciplinary care planning and care review activities are considered direct care and count towards care minutes, but only if provided by a RN, EN or PCW/AIN on-site.

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

Only 'worked hours' of RNs, ENs and PCWs/AINs will count towards care minutes. This does **not** include staff leave time and training (such as training sessions).

Buddy shift* arrangements can be counted as care minutes, if both staff working in the buddy shift arrangement are either RNs, ENs or PCWs/AINs providing direct care to residents.

*A buddy shift is when a less experienced worker accompanies an experienced worker on one or more shifts. This allows the less experienced worker to understand more about resident needs and preferences, get to know the work routine and apply learnings.

See [QFR data definitions](#) for definitions of RN, EN or PCW/AIN. Importantly, students (such as unpaid undergraduate nursing student placements), staff leave time, training, or volunteer hours should not be included in care minutes reporting in the QFR.

9. How should hours for a Registered Undergraduate Student of Nursing (RUSON) be recorded in the QFR and do they count towards care minutes?

Worked direct care hours of Registered Undergraduate Students of Nursing (RUSON) should be reported as PCWs/AINs in the QFR (and count towards care minutes) if they have registered as a student nurse with the Australian Health Practitioner Regulation Agency and:

- successfully completed not less than 12 months of the Bachelor of Nursing degree
- are supervised by RNs at all times.

Unpaid placement hours **cannot** be reported and do not count towards care minutes.

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

Catering services including preparing and serving meals are not counted as direct care and should be reported as labour costs in the QFR under the Food and Nutrition section.

Where a RN, EN or PCW/AIN is employed in a hybrid role, for example, providing both personal care and other activities such as catering, only the portion of the worker's time spent on direct care (such as assistance with feeding) on-site can count towards care minutes.

11. What should not be reported as care minutes?

Things that should not be reported as care minutes include (but are not limited to):

- domestic services
- diversional therapy
- pastoral or spiritual care
- volunteer hours
- telehealth
- shifts that are unfilled, for example, if the staff member scheduled for that shift has called in sick

- care provided to non-subsidised residents.

Only care time to government-subsidised residential aged care residents (including those receiving residential respite) funded under the AN-ACC model should be reported as care minutes. Care time for private residents or residents funded under other programs such as the Transition Care Programme is not counted in care minutes reporting.

12. How should hours provided by surge staff or staff funded by additional financial assistance be reported in the QFR?

Surge workforce and other financial assistance provided by the department should be included in the reported hours of care delivery.

As there will be no corresponding expenditure (as costs are covered by the department), this will likely result in a data validation query from the QFR and Aged Care Financial Report (ACFR) Helpdesk during the data validation period. Providers should respond to that email query in the given time, confirming the use of surge workforce/financial assistance in the quarter.

13. What should be included in 'non-worked' hours?

'Non-worked' hours refer to staff leave time and training.

For example, if a RN takes 7.5 hours of leave or training, then those 7.5 hours should be recorded as non-worked hours even if they are paid for this period.

14. Are 'worked hours' the same as Full Time Equivalent (FTE)?

No, worked hours are different to FTE. Worked hours capture all the hours worked by staff while FTE is a unit to measure employed people in a way that makes them comparable. Worked hours for the purposes of the ACFR and QFR reporting exclude all staff leave, training and unpaid breaks. The roster or payroll system should be used to collect hours worked.

15. For RN shift coverage, are the morning/afternoon/overnight shift categories set and should agency staff be included?

Allocate to the shift 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 (e.g., 11pm-7am). Note that the shift times provided in the QFR template are only a guide.

Apportioning expenses/hours in the QFR

16. What if a provider has direct care staff working across several services? Should these costs be allocated based on time or another method?

For direct care staff working across several services, the costs and hours should be apportioned based on the time they are allocated to each service.

17. 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 their non-worked hours be reported, or just a partial amount as well?

All non-worked hours are to be reported. This is consistent with the definitions of non-worked hours which include all forms of leave (including leave and training) for all job categories reported in the QFR.

Although a staff member's direct care hours are apportioned based on their role, their non-worked hours are not apportioned and are to be reported in full. For example, if a Care Manager spends 10% of their worked hours as an RN providing direct care and works 1,000 hours and takes 200 hours of leave within a specified period, they would report:

- 100 hours RN direct care
- 900 hours Care Management work
- 200 hours recorded under non-worked hours.

18. Where staff work in hybrid roles, can position descriptions be used to allocate direct care hours?

Position descriptions may be indicative of the work performed by staff, but care hours reported must reflect their actual activities and worked hours providing direct care on-site, not just their duty statement. If a staff member's job description only includes care work, but they also perform non-care work, then their time must be apportioned in line with the guidance for hybrid roles.

For hybrid roles, the QFR requires an apportionment based on the time allocated to each role. For example, where a specified worker is employed in a hybrid role such as performing both personal and/or clinical care activities and non-care activities (e.g., catering, laundry or cleaning), costs should be split/apportioned based on the time they are allocated to each role. Providers must have a methodology for this apportionment that can be verified if asked or required. Some providers have procured time-in-motion studies to support the applied apportionment rates.

19. How do providers report when they have recently consolidated 2+ services?

If services have been consolidated, the submitted data will need to reflect this from the day they merged as accurately as possible based on allocation of resources. For example, if Service A merged into Service B's SRV ID one month into the quarter, then the provider is expected to report:

- Service A: Initial month of data where it was a separate SRV ID
- Service B: 2 months of Service A for when the consolidation occurred as well as the 3 months for Service B.

Allied Health

20. What is the allied health reporting in the QFR used for and how does it relate to the role of the Aged Care Quality and Safety Commission (ACQSC)?

Allied health reporting in the QFR provides visibility of the use of allied health care in residential aged care. Information on the provision of allied health services provided is shared with the ACQSC to ensure that providers are meeting their responsibilities under Schedule 1 of the Quality of Care Principles 2014. Allied health expenses reported in the QFR are also published for each service on the My Aged Care website [Find a Provider](#) tool.

21. Are allied health assistants described by type of profession they assist? Is 'other allied health' disaggregated?

Description of allied health assistant data by type of profession they assist, or de-aggregation of other allied health data is not currently required. [See QFR data definitions for definitions of 'allied health assistant' and 'other allied health'](#).

22. 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 both the Residential Care Labour Cost/Hours and the Food and Nutrition sections. In the Food and Nutrition section, speech pathologist entries mainly cover chewing/swallowing therapy. In the Residential Care Labour Cost/Hours section, speech pathologist entries incorporate many types of services. These entries have been made separate based on feedback from Speech Pathology Australia.

Labour costs and hours entered for dietetic care in the Food and Nutrition section will prefill the Residential Care Labour Cost/Hours section.

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

Providers should speak to their agency provider to issue invoices that split the allied health components by profession so that they show the hours spent and amount charged. Hours that contractors spend delivering care should be included in Agency staff worked hours - direct care.

Only hours worked by agency or staff on external contracts relating to caring for government-subsidised residential aged care residents (including those receiving residential respite) funded under the AN-ACC model should be included.

The hours for a podiatrist, etc. would be captured under allied health.

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

Providers should speak to their allied health provider about adding the time per service to their invoice to allow accurate reporting to the department. It may also be an option to record the time when the allied health provider enters and exits the service for purposes of reporting care hours delivered. It is important to note that allied health data from the QFR is provided to the ACQSC to support their compliance activities.

25. Should I report services that fall outside of AN-ACC funding as part of care time e.g., chronic disease management allied health services funded by the Medicare Benefits Schedule (MBS)?

No, only services which are funded by AN-ACC should be reported within the QFR. Allied health services funded by the MBS should not be reported as part of allied health care time or expenses.

26. Should I report allied health delivered via telehealth in the QFR?

Yes, telehealth services delivered by allied health professionals should be reported in the QFR.

Occupied Bed Days

27. Should 'occupied bed days' be as provided in the monthly Services Australia payment summary, or actual figures as recorded by the residential aged care service?

The total occupied beds should reflect the total number of days of subsidised care delivered in the period (not the number of beds). This should be consistent with claims submitted to Services Australia and reflect the AN-ACC resident classification funding days.

Only days of care for government-subsidised residential aged care residents (including those receiving residential respite) funded under the AN-ACC model should be included. This should not include days of care provided to private residents or residents funded under other programs such as the Transition Care Programme.

Residents on leave (e.g., social or in hospital) are also counted as an occupied bed day for the purposes of QFR reporting except where the resident is on hospital leave for 29 consecutive days. In this instance, the first 28 days of leave are included, but not the 29th and subsequent days. Whilst hospital leave which is greater than 28 days may appear as paid days in the Services Australia report, it does not have a funded amount and should not be included in occupied bed days.

Expenses Reporting

28. Why are workers' compensation and payroll tax costs reported in the ACFR but excluded in the QFR?

The QFR was designed to be a timely and smaller scale report than the ACFR. Only the labour costs that can be directly attributable to employees are included in the QFR.

29. Are travel and accommodation costs associated with agency staff or visiting professionals to be included in labour costs?

Yes, if this is in the agreement with the agency to include or reimburse such costs then include the costs. Refer to the [QFR data definitions](#).

30. Does direct care cost include superannuation and leave provisions, such as annual leave and long service leave?

Yes, as per the [ACFR](#) and [QFR data definitions](#) direct care cost includes superannuation and leave provisions.

31. 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.

The total Administration expenses percentage allocation for the residential segment by categories: care, hotel, accommodation and COVID-19 are collected in the ACFR but not in the QFR.

32. Where do providers record internal 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 service 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.

33. Should providers report any retainer payments e.g., RN Retainer payments?

The RN Retainer Bonus **should not** be included as expenditure with the QFR. However, it should be reported as income in the ACFR under the subsidies and Supplements (Commonwealth) income. The expenses component should be reported under other administration costs.

Reporting issues

34. 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 just the pay periods included within the quarter. If a pay period has days that cover on either side of the reporting period, ensure to include the appropriate number of working days in the relevant reporting period.

For example, the reporting dates for Quarter 4 are 1 April to 30 June. If a service has fortnightly pay periods ending 4 April and 27 June, they will need to:

- Exclude the hours between associated with pay period prior to 1 April
- Accrue an additional three working days i.e., 28 – 30 June, to complete the full reporting period.

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.

35. How do providers report agency costs when invoices are not billed in the required quarter?

The department understands that hours are generally derived from rostering systems, whilst expenditure is derived from finance systems and there can be discrepancies between the two systems. For example, if an invoice is paid after quarter end, the hours will be recognised within the quarter, however the expenditure may have been recorded in the following quarters. As per standard accounting practices, invoices and expenditure should be recorded in the same period that labour services were delivered. It is important to ensure that the hours worked, and expenditure reported are applicable to the reporting quarter by allocating the invoice to the period it was incurred in.

Accruals ensure that expenditure are matched in the period in which they are incurred, even though internal pay cycles may not match with the QFR dates. Providers must accrue hours or expenditure based on the required period only and

not based on previous quarters (i.e., do not accrue hours for the sole purpose of reconciling previous quarters).

Reporting incomplete or misleading care hours data may affect the calculation of a service's Staffing Rating and overall Star Rating.

Keep a record of the information on which you based your submission, as this may be required as part of the [Care time reporting assessments](#) process.

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

Care time delivered by agency staff should be included in the information reported in the QFR as this will be counted towards the delivery of care minutes.

Providers should speak to their agency/external provider to request they issue invoices that can easily determine the staff that worked, including role and the hours that were worked.

For services provided by external providers such as agency and allied health staff, the department suggests adjusting general ledger systems to separately account for these expenses. For example, implement a new natural account for 'Allied Health Professional - Podiatrist' to account for the expanded collection requirements around allied health.

RN hours for directly employed and agency staff must be reported separately across the three shifts which are then totalled into total direct care RN or total agency RN worked hours.

37. How do providers ensure accurate reporting of care hours for hybrid staff whose time is apportioned between direct and non-direct care?

It is a provider's responsibility to ensure that hybrid direct care staff have their time correctly apportioned between direct care and non-direct care hours. Providers must establish a methodology for apportioning the time of their hybrid direct care workers. This must be accurately reflected in the reported direct care hours. See [QFR data definitions](#) for further details.

During a care time reporting assessment an assessor may review the apportionment methodology to assess its validity. This may involve examining duty statements and role descriptions to determine the reasonableness of the apportionment rates. Assessors will also review the application of these rates in relation to the reported care hours to ensure accuracy.

38. How do providers ensure accurate measurement of reported shifts?

Providers can ensure accurate measurement of reported shifts by ensuring that the data aligns with your organisation's rostering system, timesheets and/or any other

accounting system that records hours. Providers should avoid common pitfalls such as double-counted overtime or reporting errors related to incorrect time periods. This often occurs when providers attempt to align their payroll reports based on payroll cycles to the QFR reporting periods.

It is important for providers to maintain an accurate record that documents direct care worker minutes. This practice ensures that all reported shifts accurately reflect the actual time worked within the QFR reporting period, enhancing overall accuracy in care time reporting. You can find [QFR reporting guidance materials](#) on our website.

39. Should providers report hours of direct care staff who are off-site?

Providers should only report hours of direct care staff towards care minutes targets when they are providing care on-site.

40. How should providers categorise staff who provide care but are not a RN, EN, or PCW/AIN?

Providers are responsible for accurately categorising staff for reporting purposes. Staff members such as lifestyle officers or managers who perform care-related activities (but are not RNs, ENs, or PCW/AINs should be categorised accordingly(see [QFR data definitions](#)).

Only direct care activities performed by RNs, ENs, or PCWs/AINs can count towards a service's care minutes target.



Phone **1800 200 422**
(My Aged Care's freecall phone line)



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For technical accounting advice or validation responses, please contact the QFR & ACFR Helpdesk via QFRACFRHelp@health.gov.au

For translating and interpreting services, call **131 450** and ask for My Aged Care on **1800 200 422**.

To use the National Relay Service, visit nrschat.nrscall.gov.au/nrs or call **1800 555 660**.