Australian Government
Department of Health, Disability and Ageing

Audit requirements for Care Minutes Performance Statement

Guidance for Auditors

February 2026

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Audit Requirements for Care Time Reporting

The Australian Government is changing the way it funds residential aged care to strengthen the link between care funding and the delivery of care. These changes include new reporting and audit requirements to help maintain the integrity of the funding arrangements and protect consumers from misreporting and poor performance.

Introduction

The Royal Commission into Aged Care Quality and Safety released its final report in 2021. Their report highlighted systemic issues in the aged care system, in particular, underfunding, understaffing, and a lack of transparency on how care time was delivered.

Recommendation 86 of the Royal Commission recommended a minimum care time standard for registered residential aged care providers (providers). This included:

- From 1 July 2022, providers must engage registered nurses, enrolled nurses, and personal care workers for at least 200 minutes per day, per resident. At least 40 minutes of this care should be delivered by a registered nurse (RN).
- From 1 July 2024, providers be required to always have at least one registered nurse on site (24/7 RN requirement).

In response to the same Royal Commission recommendation, the Australian Parliament passed the Aged Care Legislation Amendment (Care Minutes Responsibilities) Principles 2023. This Amendment required aged care facilities, to meet minimum average care time minutes per resident per day from 1 October 2023. From 1 October 2024, the sector-wide average target is 215 minutes per day, including 44 minutes provided by a registered nurse.[1]

The aged care reforms also include a new funding model known as the Australian National Aged Care Classification (AN-ACC). Under AN-ACC, each resident is assigned to a class based on an independent assessment of their care needs. These classes are used to calculate the care minutes target for services. Services targets

[1] The department's guidance on the care minutes obligation is available here: https://www.health.gov.au/our-work/care-minutes-registered-nurses-aged-care/care-minutes

are set quarterly, based on the provider's case-mix during the reference period for the quarter. The reference period is the three-month period commencing four months prior to the quarter (i.e. the reference period for the April-June quarter is December to February).

These care time obligations are now outlined under Sections 175 and 176 of the *Aged Care Act 2024* (the Act) and through associated provisions in the *Aged Care Rules 2025* (the Rules), including Section 176-15 which sets out the obligation to provide required amounts of direct care.

Since the inception of these obligations, providers have been required to report on their performance against them. Providers are required to report on their performance against the Care Minutes Obligation in their Quarterly Financial Report, in line with the form approved under Section 166-340 of the Rules. Providers are required to report on their performance against the Registered Nurse 24/7 Obligation, under Section 166-885 of the Rules.

In the Mid-year Economic and Fiscal Outlook 2024-25, the government announced the introduction of a new care minutes supplement. Non-specialised providers[2] in MM1 regions (metropolitan areas) saw their Base Care Tariff decrease, substituted with funding provided through a performance-based supplement, depending on their performance against their care minutes targets. Entitlement to this supplement is calculated using providers' reporting.

With the introduction of the care minutes supplement, all residential aged care providers are also required to prepare and submit a Care Minutes Performance Statement (CMPS) as part of their annual Aged Care Financial Report (ACFR). This requirement is described in Section 166-335 of the Rules. Providers are required to engage an external auditor to complete an audit of the CMPS. This requirement applies to all registered providers of residential care and all residential care homes, including specialised and non-specialised services, provided at all locations. Providers will be required to submit their first CMPS and audit report as part of their ACFR for 2025-26.

Under Section 154 of the Act, and Section 154-1300 of the Rules, providers are responsible for maintaining records that enable proper assessment of performance against the care time and 24/7 RN obligations. These records support verification of care delivery and subsidy claims and must be sufficient to demonstrate compliance with obligations under Chapter 3 of the Act.

[2] Providers may apply for specialised status, under section 243 of the Act. The only form of specialised status available to MM1 providers is specialised homeless status.

Objectives of this Guide

This guide is designed to assist the external auditors (auditors) engaged by an aged care provider in conducting their audit of the provider's CMPS. It includes information that auditors are expected to consider when conducting their audit.

This guide is general in nature and does not constitute legal advice. In cases of discrepancy between the guide and the legislation, Sections 175 and 176 of the Act, and Sections 176-15 and 166-855 of the Rules, are the primary source documents setting out care time and 24/7 RN onsite attendance reporting requirements.

In line with the Rules, the audit should be performed in accordance with Standard on Assurance Engagements **ASAE 3000** ***Assurance Engagements Other than Audits or Reviews of Historical Financial Information*** **(ASAE 3000)** issued by the Auditing and Assurance Standards Board.[3]

What is the Care Minutes Performance Statement?

The CMPS captures detailed information on direct care minutes delivered, associated labour costs, RN coverage, and occupancy. The first CMPS will cover the 2025-26 financial year.[4] An example of a template for the CMPS is available on the Department of Health, Disability and Ageing's (the department) website for providers to review.

The following information will be included in the CMPS prepared by the aged care provider:

1. Quarterly Labour Costs - Direct Care (Employee and Agency)
2. Quarterly Labour worked hours Direct Care (Employee and Agency)
3. Monthly Registered Nurse Coverage Percentage
4. Quarterly Occupied Bed Days
5. Quarterly Direct Care minutes (worked) per occupied bed day.

Providers will provide this information for each aged care home they operate, within one CMPS. This information should be provided to the auditors, noting that this information has been reported to the department, either in Quarterly Financial

[3] This guidance is based on ASAE 3000 Assurance Engagement Other than Audits or Reviews of Historical Financial Information (ASAE 3000) published 6 September 2022 and is operative for financial reporting periods beginning on or after 15 December 2022. This Standard on Assurance Engagements represents the Australian equivalent of revised ISAE 3000 *Assurance Engagements Other than Audits or Reviews of Historical Financial Information*.

[4] For the first year of reporting, providers will only be required to prepare a CMPS for the period following 1 November 2025 (the commencement of the *Aged Care Act 2024*). This means that providers will need to include RN coverage from 1 November 2025, and performance against care minutes from 1 January 2026.

Reports, the monthly Registered Nurse report, or is available through the provider portal. The auditors will provide one audit report over the provider's CMPS.

Who may conduct the audit?

In line with Section 166-335 of the *Aged Care Rules 2025*, the audit must be performed by a registered company auditor. The audit may be performed by the auditor who is conducting the audit of the provider's financial statements or may be performed by another external auditor under a separate engagement. It is a provider's responsibility to ensure that the auditor is a registered company auditor.

As a registered company auditor, the auditor must comply with the independence and ethical requirements relating to audit engagements, including those contained in APES 110 *Code of Ethics for Professional Accountants (including Independence Standards)*, which is founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

Alternative Auditors

In line with Section 166-335 of the Rules, the Secretary of the Department of Health, Disability and Ageing (the System Governor) may approve an alternative auditor, who is not a registered company auditor, at the request of the aged care provider. Auditors who are not a registered company auditors should ensure that the aged care provider has obtained approval from the System Governor to engage you prior to commencement of the audit.

Section 1

Audit Objective and Requirements

1. Audit Objective and Requirements

1.1. Audit objective and requirements

The auditor will conduct the engagement with the objective to express an opinion on whether the Care Minutes Performance Statement (CMPS) is prepared, in all material respects, in accordance with the requirements set out in paragraph 166.335(5) of the Aged Care Rules 2025 (the Rules). This includes whether the CMPS fairly presents the total care minutes, care minute expenses, 24/7 RN coverage, and required explanations for variances as specified in the Rules.

The auditor will issue a report including this opinion in accordance with Standard on Assurance Engagements **ASAE 3000** ***Assurance Engagements Other than Audits or Reviews of Historical Financial Information*** **(ASAE 3000)** issued by the Auditing and Assurance Standards Board.

The level of assurance required is reasonable assurance, the highest level of assurance that can be obtained in an audit. In a reasonable assurance engagement, the auditor designs and performs procedures to reduce engagement risk to an acceptably low level, allowing them to form a opinion about whether the subject matter is free from material misstatement. While it is not possible to eliminate all risk or detect every inaccuracy, more extensive evidence gathering and detailed testing are typically required to support this opinion.

Procedures and evidence gathering should consider the materiality of risks identified in Section 2.2. and Table 1 of this guide. The auditor's opinion is expressed in a form that conveys their opinion on the outcome of the evaluation of the preparation of the provider's CMPS against the audit criteria (see ASAE 3000:12(a)(i)(a)).

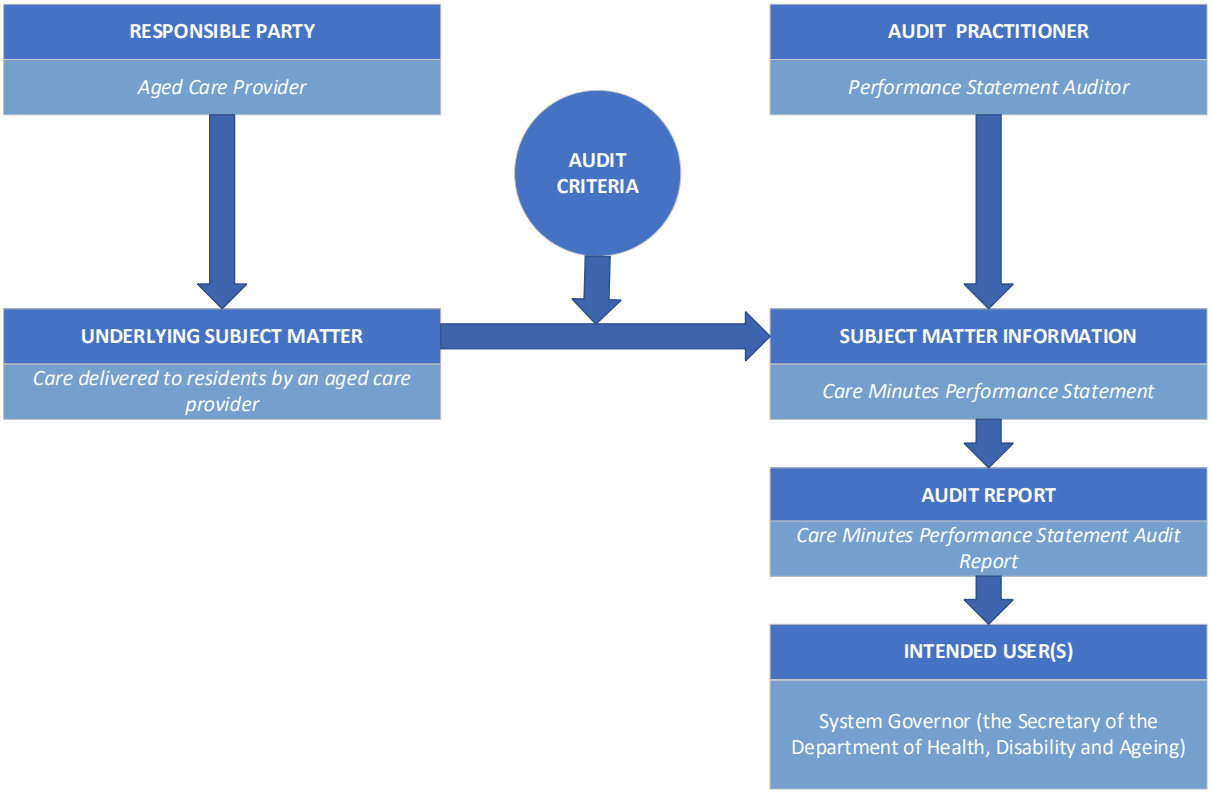
1.2. Intended users of the Care Minutes Performance Statement audit report

Figure 1 identifies the parties involved in the CMPS audit. The department is an intended user of the CMPS audit report, as the report will be used to consider and assess the accuracy of an provider's reported care time and 24/7 RN responsibilities under the Act and the Rules.

The aged care registered provider remains the engaging party for the purpose of the CMPS audit. The audit report is required to be addressed to both the provider and

the **System Governor** (i.e., the Secretary).[5] The auditor must ensure that the terms of the audit engagement reflect these roles and enable the audit report to be both addressed and distributed to the department.

Figure 1. Parties relevant to the Care Minutes Performance Statement audit and audit report



1.3. Consequences of failing to comply with audit requirements

Providers will be required to submit their first assured CMPS as part of the ACFR for 2025-26. Auditors should plan for the audit process and report to be completed within an appropriate time that enables an aged care provider to meet these requirements.

Failing to comply with this audit requirement is a breach of section 166-335 of the *Aged Care Rules 2025*, and the provider may attract a civil penalty under section 166 (6) of the *Aged Care Act 2024*.

[5] See Section 41(3) of the Accountability Principles 2014 – Provision of further information and documents to Secretary.

Section 2

Audit Planning and Design

2. Audit Planning and Design

Auditors are required to use their professional judgement in planning and performing the audit to determine the nature, timing and extent of audit testing required to form and express an opinion. The auditor will design and perform procedures to enable an opinion to be formed as to whether in all material respects the CMPS fairly presents the provider's performance against the Care Minutes and 24/7 Registered Nurse obligations outlined in the *Aged Care Act 2024* and the *Aged Care Rules 2025*.

Given that this is a new reporting requirement, it is essential that audit procedures are effectively planned and fit for purpose. Effective engagement with the audit process begins with clear and transparent communication between the auditor (or audit team) and the provider. Where possible, the auditor should integrate planning and reporting with the financial statement audit to create an efficient audit process and reduce the administrative burden placed on providers (see section 2.4.1).

2.1. Understanding the ASAE 3000 and applicable regulations

A clear understanding of ASAE 3000, the requirements of the *Aged Care Act 2024,* and the *Aged Care Rules 2025,* will assist the auditor in designing and performing audit procedures required to assure the CMPS.

Paragraph 5, Section 166-335 of the *Aged Care Rules 2025*, outlines the CMPS reporting obligations. A CMPS must:

- be in a form approved by the system governor
- not contain false or misleading information
- disclose the amounts of care minutes delivered, by quarter and staff category
- disclose the cost of care minutes delivered, by quarter and staff category
- disclose the 24/7 nursing coverage across the reporting period by calendar month expressed as a percentage
- if the provider has previously reported a different amount of performance for a period in the CMPS through a QFR or RN24/7 report, they must explain this difference; and
- include a signed audit report.

2.2. Engagement risk

Engagement risk is the risk of an auditor expressing an inappropriate opinion when the subject matter information (care time reporting) is materially misstated (ASAE 3000: 12(f), A11-A14). This may include evidence that is inaccurate or incomplete because of ineffective record keeping and internal controls, and/or inadequate

evidence gathering, misrepresentation or fraud. The audit plan should be prepared in line with ASAE 3000 so that the risk of not detecting a material misstatement is reduced to an acceptably low level (see ASAE 3000: A12(b)).

The risk of material misstatement includes risks that the auditor does not directly influence. These include:

- **Inherent risk:** The risk of a material misstatement of care time reporting before consideration and application of internal controls (see ASAE 3000: A12(a)(i)). For example, CMPS reporting may be susceptible to bias or manipulation.
- **Control risk:** The risk that a material misstatement occurs in care time reporting and is not prevented, or detected and corrected on a timely basis (see ASAE 3000: A12(a)(ii)). For example, CMPS reporting is a new reporting requirement, and appropriate internal controls may not yet be implemented and/or operating effectively which may result in failure to prevent, detect and correct misstatement on a timely basis.

Professional judgement should be applied when considering the materiality of these engagement risks (see ASAE 3000: A81). Refer to Appendix B for an Engagement Risk Assessment example template.

2.2.1. Fraud risk

Providers' performance against the Care Minutes and 24/7 Registered Nurse obligations impacts their entitlement to subsidies and supplements from the Australian Government. Responsibilities to detect and manage fraud risk associated with care time and 24/7 RN reporting requirements is held by the aged care provider, not the auditor. However, the auditor should consider and assess the risk of fraud or suspected fraud in the preparation of the CMPS as part of the audit engagement.

For example, fraud can occur where entitlement to subsidies or supplements is calculated based on misreported information. This could include:

- misstating the volume of on-site staff attendance that occurred;
- misattributing non-care activities such as administrative work as care time; and/or
- allocating care time against an incorrect category of employee.

The auditor should assess the provider's ability to prevent, detect, respond, monitor and report on fraud relevant to the CMPS, as it relates to the accuracy of the reported Care Minutes and registered nurse attendance. This may include reviewing providers' fraud control plans, and their systems and procedures relating to fraud prevention, investigations, and reporting.

The benefit obtained from misstatement is largely in favour of the organisation making the disclosures, rather than individual employees. As a result, the fraud risk assessment should consider the organisation's internal policies for recording the care

minutes. This may include assessing how the organisation identifies how much of relevant staff members' time is spent delivering direct care.

The Department of Health, Disability and Ageing undertakes assurance activities over providers' reporting against the Care Minutes and Registered Nurse 24/7 obligations. Auditors should ask their clients for any correspondence from the department regarding concerns it has regarding their clients' historical reporting. Auditors should pay particular regard to any issues identified and confirm they do not persist.

Organisations engaging in fraud to obtain a higher rate for the care minutes supplement are likely to alter duty statements, to support allocating more of an employee's time to care minutes. It may be necessary to directly interview staff members about what work they perform, to understand if their duty statements provide an appropriate evidence base for the care minutes calculation. If duty statements do not align with the work employees perform, and no other sufficient appropriate evidence exists as to how employees spend their time, it may be necessary to disclaim in the audit report.

2.3. Auditor responsibilities

There should be a common understanding between the auditor, the aged care provider and the department on the standards against which the provider's CMPS will be assured.

The auditor should obtain reasonable assurance about whether an aged care provider's CMPS is prepared, in all material respects, in accordance with paragraph 166.335(5) of the Rules.

The auditor should review the reporting criteria to determine whether they are appropriately qualified and confident they can provide this audit service.

In designing an appropriate audit criterion, regard should be given to the achieving the audit objective, and should be clearly presented in the CMPS audit report. Criteria should be relevant, complete, reliable, neutral and understandable (see 'Applicable Criteria', ASAE 3000: A45–A52).

2.4. Understanding the entity, subject matter and other reporting requirements

Understanding the entity, subject matter and other engagement circumstances provides the auditor with a frame of reference for exercising professional judgment throughout the Audit engagement and to understand the risk of material misstatement (ASAE 3000: A103, A106). The aged care sector is made up of not-for-profit, for-profit and government providers that vary in size, maturity and complexity

of operating systems. The auditor will apply professional judgment in considering the characteristics of the aged care provider in the context of the CMPS audit.

In particular, the auditor should ensure they understand the Care Minutes and 24/7 Registered Nurse obligations. The care minutes and 24/7 registered nurse guides for registered providers of residential aged care are essential to the auditor developing this understanding, and should be used as reference materials for the auditor in completing the engagement. In particular, the care minutes guide provides guidance about what work counts toward the care minutes responsibility. This is essential to the completion of the engagement.

2.4.1. Use of another auditor's work who is engaged for annual reporting requirements

Engaging the same auditor(s) or same audit firm for both the annual financial statement and CMPS reporting can provide an efficient audit and reporting process for providers. Where possible, planning and substantive testing procedures can occur simultaneously.

If the work of the annual financial statement audit is relevant and can be used in the CMPS audit, the auditor should be satisfied it can be appropriately applied. When the annual financial statements audit is conducted by another engagement team, the auditor should be satisfied that their involvement is such that they can accept responsibility for the audit opinion drawn (see ASAE 3000: 32(b)(ii)). If the auditor decides to use evidence collected and used by another auditor, they should consider whether the other auditor is suitably qualified, understands and complies with ethical requirements, and is independent (see ASAE3000: A72).

2.4.2. Aged Care Providers system of internal control

Central to understanding the entity and the risk of material misstatement is an understanding of the design and implementation of internal control systems over the preparation of the CMPS (see ASAE3000: A106). An auditor should use their professional judgement to determine the relevant controls.

Auditors should understand, evaluate and consider the limitations of controls they may rely on in their audit of the CMPS and document this in the audit plan. This may include the provider's procedures and processes for allocating and measuring care time, assessing on-site attendance and the controls that support these processes. Controls can be either preventive or detective and may include information technology general controls (ITGCs). Auditors should determine whether relevant controls have been effectively designed and implemented. This would include making enquiries to the personnel responsible for preparing information that is incorporated into the CMPS.

A misstatement arising from a breakdown in internal control(s) may indicate the existence of other misstatements, increasing the engagement risk. As outlined in

section 2.4.1., the auditor may consider the broader audit work program and findings. This includes considering the connectivity between systems. For example, timesheet and care minute information may be impacted by payroll information or systems which are within the scope of financial statement audit.

Other risks relevant to these internal controls are outlined in Table 1 below.

2.4.3. Substantive testing

In addition to understanding and testing internal controls, the auditor can use substantive testing to address the engagement criteria.

Substantive testing can directly assure the information reported in the CMPS. Examples of substantive testing for accuracy and completeness over the information reported, is detailed below:

- Trace care time reporting against information logged by personnel in the provider's reporting systems,
- Recalculate and compare recorded care hours to the care system,
- Vouch care minutes reported to source documentation such as to signed timesheets or electronic verification logs,
- Perform a payroll reconciliation which compares paid hours against reported hours,
- Perform cut-off testing.

The auditor should use their professional judgement to determine the requirement and scope of substantive testing and outline this in the audit plan.

Where substantive testing is used, the auditor will use their professional judgement to determine the sample size, with consideration to the risk, materiality and size of the aged care provider they are engaged to assure. Materiality is further discussed in section 2.5.1. The auditor should firstly rely on the audit firms' standard approach to sampling. However, ***ASA 530 Audit Sampling*** provides guidance and outlines sample design, size and selection requirements (see ASA 530: 6-8; A4-A13).[6]

2.4.4. Aged Care providers risk environment

In line with Engagement Risk (see section 2.2), the following table outlines a non-exhaustive list of potential risks related to the provision of care time and associated reporting.

Table 1: Source and summary of risks that may impact care time delivery and reporting

[6] ASA 530 Assurance Sampling was published 3 March 2020 and is operative for financial reporting periods beginning on or after 15 December 2021.

Source of engagement risk	Summary of risk
Subject matter characteristics	The nature, timing, size, volume and complexity of care time reporting and targets.
Internal factors	Residential aged care providers previous actions regarding care time targets and requirements.
	Residential aged care providers actions regarding previous audit and compliance requirements.
	The complexity, quantity and quality of care time data and information.
	The integrity, quality and extent of residential aged care providers' measuring and recording processes and systems, including how this aligns with reporting periods.
	The effectiveness of internal controls of the above processes and systems.
	The nature and degree of change experienced by the residential aged care entity due to new care time reporting requirements.
Internal IT factors	Reliance on systems or programs that inaccurately process data and/or process inaccurate data.
	Unauthorised access to data or common databases that have multiple users.
	A breakdown of segregation of duties where personnel gain access privileges beyond those necessary to perform their assigned duties.
	Unauthorised changes to data in master files.
	Failure to make necessary changes to programs or systems; inappropriate manual intervention.
	Potential loss of data or inability to access data as required.
External factors	The impact of major events, such as pandemics or natural disasters impacting ability of staff to attend work.
	Changes in the regulatory environment that are not appropriately considered and captured by the providers' systems and processes.

The following case studies may assist the auditor in considering the different types of engagement risks in the context of care time reporting.

CASE STUDY 1: HYBRID ROLE

A personal care worker (PCW) is employed in a hybrid role at an aged care provider. This means they split their time between providing direct care for residents and performing other tasks, such as serving meals at lunch and dinner. This type of work is beyond the scope of direct care and should not be recorded as care time. The PCW currently spends around 70 percent of their time providing direct care activities and 30 per cent completing lifestyle tasks, however, their lifestyle workload has recently increased.

The auditor should consider the **engagement risk** of lifestyle tasks being misreporting as care time. This includes understanding:

- The differences between tasks related to direct care (activities included in care minutes) and non-direct care.
- How these tasks are allocated.
- The existence of controls related to accurately measuring hybrid roles.

CASE STUDY 2: REPORTING PERIODS AND SYSTEM PERMISSIONS

An aged care provider uses a centralised software system for task allocation and reporting (including direct care time, lifestyle tasks and administrative tasks), timesheets, leave and payroll. The intention of this system is to help staff keep track of their reporting, duties, and identify where additional staff may be required for the provider to meet care time targets and 24/7 RN requirements. Access permissions vary across the provider and are dependent on the staff members role.

The auditor requests access to this information and identifies that the systems' reporting period is based on fortnightly payroll cycles and differs to the quarterly and monthly reporting periods the CMPS is based on. The auditor should consider the **engagement risk** of misalignment in reporting periods on the preparation of information contained within the CMPS.

The auditor should also consider controls regarding the access permissions which may allow staff to alter their reporting, whether through rectifying errors or backdating. Specific control activities that could be performed by the auditor, may include review of internal reporting processes, review of approval mechanisms and reconciliation procedures.

2.4.5. Care time reporting information

Auditors should familiarise themselves with the department's available guidance and seek further information from providers through targeted information requests.

Care Minutes Responsibility guide includes information regarding:

- care worker types
- direct care activities
- care minute targets
- existing reporting and quality audit targets
- previous care minute reporting requirements (prior to implementation of this audit requirement).

24/7 registered nurse responsibility guide includes information regarding:

- 24/7 RN responsibilities across different locations and working arrangements, including hybrid or dual roles
- current reporting requirements
- the interaction with the care time reporting assessment program.

2.5. Developing the audit plan

The auditor should design and perform audit procedures to reduce engagement risk to an acceptably low level (in the circumstances of the engagement) as the basis for providing their opinion (see ASAE 3000:12(a)(i)). The lead auditor, together with any team members should develop an audit plan that includes a detailed approach for the nature, timing and extent of procedures to be performed, and the justification for selecting them (see ASAE 3000: 40, A86).

The audit plan should be shared with the aged care provider and include:

- the audit objective and criteria
- consideration of materiality
- risk assessment (includes considering fraud and risk management)
- planned audit procedures and tests (including timing and extent)
- the types and expected sources of audit evidence, including substantive and controls-based procedures
- planned evidence gathering techniques
- the estimated cost and resourcing requirements to perform the audit within the required timeframe.

In planning the audit, auditors should consider how an aged care provider:

- Conducts task allocation to determine if only care-related hours are reported, not time dedicated to general administration.

- Detects and explains any variance between care minute reporting and specific care activities, including what constitutes an acceptable variance and how this is documented.
- Determines the integrity and verification of data sources including verifying reported bed days against actual patient occupancy, and the approvals of shift logs, timesheets, and other staffing records.
- Has implemented procedures for allocating care activities in line with care type and staffing levels, including any check and balances such as a supervisory review.

An audit plan mitigates the risk of material misstatement and the operational engagement risk that an audit will not be completed in accordance with the approved budget and timeframe, and to the required level of reasonable assurance.

2.5.1. Materiality considerations

The auditor's consideration of materiality should reflect how the information within the CMPS will be used. The department uses the information to validate a provider's subsidy entitlements and informs consumers when making a choice on aged care services through the My Aged Care website. As such, materiality should be set to support the use of the information in this manner.

Materiality determines the significance of an amount, transaction or discrepancy and it is a matter of the auditor's professional judgement. An issue in the CMPS is considered material if it has the potential to adversely affect the department and/or consumers using that information to make decisions.

The care minutes supplement is linked to the delivery of total care minutes and RN care minutes. This information is reported quarterly in the QFR and annually in the CMPS and is used to calculate the supplement per bed, per day. Providers will receive more funding the closer they were to delivering their care minute targets in the previous quarter. Providers who are not meeting their care minute targets will see their care funding reduce. Further guidance on the care minutes supplement can be found on the department's website. Quarterly payments made by the department are based on the performance reported in the QFR. The department then reconciles this against the CMPS annually to ensure that payments accurately reflect providers' actual performance. The level of materiality selected for the audit must support this reliance on both the quarterly data and the annual reconciliation process.

The Star Ratings system assists consumers to make an informed choice about aged care facilities. The rating system includes a 'Staffing' subcategory that measures the average amount of care time that residents at each aged care home received, compared with the minimum average care targets. These are initially reported using the QFR and will be validated against the assured CMPS.

Section 3

Audit Implementation

3. Audit Implementation

The CMPS audit is likely to be occurring alongside the annual audit of the financial statements. To minimise disruption and create an efficient process for the auditor and aged care provider, the audit of the CMPS should be integrated and/or timed to work effectively with the financial statement audit process where possible.

3.1. Engagement timing

The timing of an audit will depend on the size and complexity of the aged care entity. The aged care provider must provide a copy of the CMPS and the audit report to the department as part of their ACFR. These are typically due on 31 October each year, but some providers prepare reports using a different financial year. The audit plan should outline the proposed timeline of events to assist the aged care provider in meeting their ACFR reporting obligations. As mentioned above, ideally the audit of the CMPS should be completed during the financial audit process. See Appendix C for an Engagement Planning and Implementation Checklist – Template Example.

3.2. Communication with provider

The auditor should prepare and communicate the list of information required from the provider to efficiently gather sufficient and appropriate evidence. Ongoing communication between the auditor and the provider will help to minimise delays when addressing the audit related questions and setting clear expectations with the management. Findings should be discussed with providers on timely basis to facilitate the auditor to evaluate and conclude using the evidence gathered in accordance with the ASAE 3000.

3.3. Gathering audit evidence

The auditor should evaluate the sufficiency and appropriateness of the evidence obtained in the context of the audit review and, if necessary, obtain further evidence. The audit is an iterative process which can require the auditors to change the nature, timing or extent of other planned procedures based on the evidence obtained and their professional judgement (see ASAE 3000: 65, A154-A155). All relevant evidence should be considered regardless of whether it corroborates or contradicts the audit report findings. The auditor should consider the effect on their opinion if they cannot obtain any further evidence that is necessary (see ASAE 3000: A147-155).

3.4. Other considerations

Where separate or the same audit firms have been engaged to complete the audit of financial statements and the audit of the CMPS, the auditor should work with the provider to coordinate common audit activities across the separate engagements.

3.5. Forming an opinion

The auditor should form an opinion about whether the CMPS is free of material misstatement. In forming that opinion, the auditor should consider whether they have obtained reasonable audit to address the risk of material misstatement (see ASAE 3000: 64-66). The opinion is based on the auditor's professional judgement.

3.5.1. Types of Opinions

The auditor will provide an **unmodified opinion** when:

- In their professional judgement, the CMPS is prepared, in all material respects, in accordance with the reporting requirements of paragraph 166-335(5) of the Aged Care Rules 2025.
- Emphasis of Matter and Other Matter paragraphs may be included in this opinion (see ASAE 300: 73).
- This is the most common audit opinion and is also known as an unqualified or 'clean' opinion. The opinion does not contain adverse findings or disclaimers about the audit process or report (see ASAE 3000: 72(a)).

The auditor will provide a **modified opinion** when, in their professional judgement:

- a scope limitation exists and the effect of the matter could be material (see ASAE 3000: 66, 74, A156-158); and/or
- the CMPS is materially misstated (see ASAE 3000: 74).

If the auditor expresses a modified opinion because of a scope limitation but is also aware that the CMPS has been materially misstated, the auditor should include a clear description of both the scope limitation and the reason(s) for the material misstatement in the report (ASAE 3000: 74-77). The materiality and significance of the finding will determine the type of modified opinion made.

The auditor will provide a **qualified opinion** when:

- In their professional judgement, the effect or possible effects of a matter are not material enough to require an adverse opinion or a disclaimer of opinion. (see ASAE 3000: 75, A189-190).
- For example, if one service operated by a multi-service provider excessively attributed their PCW's time to direct care, this may attract qualification. The audit opinion drawn could then be expressed as:

Based on the procedures performed and the evidence obtained, except for the effect of the matter described in the Basis for Qualified Opinion section of our report, nothing has come to our attention that causes us to believe that the [appropriate party's] Care Minutes Performance Statement was not prepared, in all material respects, in accordance with paragraph 166.335(5) of the Rules.

The auditor will provide a **disclaimer of opinion** when:

- In their professional judgement, the auditor is unable to form an opinion at all based on insufficient evidence (see ASAE 3000: A191).
- A disclaimer of opinion is issued where the auditor cannot form a opinion due to significant limitations in the evidence available. The limitation must be both material and pervasive.
- For example, if a registered provider has multiple instances of not keeping appropriate records outlining the duties of staff, this may attract a disclaimer of opinion. The audit opinion drawn could then be expressed as:

  We do not express any opinion on the Provider's Performance Statement for the year ended [insert year end] in accordance with the reporting requirements of paragraph 166-335(5) of the Aged Care Rules 2025 ("the Rules") because of the significance of the matter described in the Basis for Disclaimer of Opinion section of our report. Accordingly, we do not express an opinion on the Performance Statement.

The auditor will provide an **adverse opinion** when:

- In their professional judgement, the auditor detects a material misstatement of such significance that the CMPS is not prepared in accordance with paragraph 166.335(5) of the Rules (see ASAE 3000: A191).
- An adverse opinion is expressed when the auditor detects material and pervasive issues.
- For example, if a registered provider has not kept appropriate records outlining the duties of staff, and interview evidence from staff conflicts with the documented duty statements, then the auditor may issue an adverse opinion. This may be expressed as:

  In conducting the engagement, we reviewed the duty statements for staff that were presented as delivering direct care and interviewed these staff about their day-to-day responsibilities. In undertaking these interviews, significant differences were identified between the responsibilities set out in duty statements, and the responsibilities outlined by staff in interviews. No further evidence was able to be obtained about the nature of the work performed by staff.
  Because of the significance of the matter described in the Basis for Adverse Opinion section of our report, the [appropriate party's] statement is not prepared, in all material respects, in accordance with paragraph 166.335(5) of the Rules.

For more information, refer to Appendix A for an audit report template.

3.5.2. Emphasis of Matter

An auditor can include an Emphasis of Matter paragraph to draw attention to a matter the auditor considers to be important to the provider and department's understanding of the CMPS but does not change the auditor's opinion (see ASAE 3000: 73).

Section 4

Audit Reporting

4. Audit Reporting

4.1. Audit Report

At the completion of the audit, the auditor will issue an audit report to the provider and the System Governor. The audit will provide reasonable assurance to the department on whether the provider's care time reporting is presented, in all material respects, in accordance with paragraph 166.355(5) of the Rules. The provider is responsible for sharing this with the department as part of their annual ACFR.

Refer to Appendix A for an audit opinion report template.

4.2. Inherent limitations

Because of the inherent limitations of an audit engagement, together with the inherent limitations of any system of internal control, there is an unavoidable risk that fraud, error, non-compliance with laws and regulations or misstatements may occur and not be detected. An audit is not designed to detect all instances of misreporting as this would require absolute assurance. Seeking absolute assurance would be too complex, time consuming and costly due to the nature and amount of evidence that would be required to be examined.

Where appropriate, auditors should provide a description in the report of any significant inherent limitations associated with their evaluation of care time reporting against the criteria (see ASAE 3000: 69(e), A166).

4.3. Audit distribution

As outlined in guidance for residential aged care providers, providers will provide a copy of the CMPS to the department as part of their ACFR reports. The auditor should ensure as a condition of their engagement that a copy of the audit report can be provided to department (see section 1.2 of this guidance).

Section 5

5. Glossary

Glossary

Term	Definition
24/7 registered nurse (RN) responsibility	All approved providers must meet this responsibility by having at least one registered nurse (RN) onsite and on duty at all times at the residential facility, or facilities, they operate, unless an exemption is in place.
Aged Care Financial Report (ACFR)	All approved providers must meet this responsibility by having at least one registered nurse (RN) onsite and on duty at all times at the residential facility, or facilities, they operate, unless an exemption is in place.
Aged care provider	See provider (organisation).
Aged Care Quality and Safety Commission (ACQSC or the Commission)	The Commission is the national end-to-end regulator of aged care services, and the primary point of contact for care recipients and providers in relation to quality and safety. This is undertaken in accordance with the Commission Act and the Commission Rules, or through contractual arrangements.
assessment	This can refer to either: • Assessment of eligibility for subsidised aged care by an Aged Care Assessment Team. • Assessment of care needs in permanent residential aged care using the AN-ACC assessment.
Australian National Aged Care Classification (AN-ACC) funding model	The funding model used by the Government to fund providers to deliver care, including delivering their care minutes.
AN-ACC classes	The 13 different classes for permanent residents that determines the amount of variable subsidy the aged care provider will be paid for the resident.
care minutes	A mandatory (legislated) responsibility on providers that commenced on 1 October 2023 and is

Term	Definition
	regulated by the ACQSC. Only direct and personal care activities provided by aged care providers can be counted toward the purposes of meeting the care minute responsibility.
care minutes target	The target for total care minutes and registered nurse (RN) minutes that the registered provider must meet on average over the quarter.
care recipient	Care recipient means a person to whom an approved provider provides, or is to provide, care through an aged care service (see also recipient).
care worker	See direct care staff member.
co-located services	Generally, one residential care service aligns to one residential facility. However, for the purpose of the 24/7 RN responsibility, co-located services may form a single residential facility if there are two or more services operated by the same approved provider and the services are operating from the same building or complex of buildings inclusive of their immediate surrounds that effectively form a single location.
counted care recipient	A care recipient receiving care through a residential care service. This excludes care recipients who are on extended hospital leave and the day is on or after the 29th day of the recipient's leave.
direct care activities	Also known as direct clinical care activities, these activities include treatments and procedures, such as medication, nutrition and pressure management, assistance in obtaining health practitioner services, such as arranging and supporting residents to attend appointments; assistance in obtaining access to specialised therapy services, such as engaging with allied health services, or nursing services, such as geriatric assessments and assessing resident's clinical care needs.

Term	Definition
enrolled nurse	A person who is registered under the National Law in the nursing profession as an enrolled nurse.
exit	In the context of aged care, this is leaving an aged care service. Also known as ‘discharge’. The discharge reason is recorded. When a person leaves aged care services, the time that they had spent receiving that type of care is added up to calculate the length of stay.
Government Provider Management System (GPMS)	An online system used by providers to access and report information to the government.
medical practitioners	doctors who are responsible for diagnosing and treating physical and mental illness, disorders and injuries; recommending preventative action; and referring patients to specialists, other health care workers, and social, welfare and support workers.
nurse practitioners	A nurse practitioner is an RN registered with the Nursing and Midwifery Board of Australia (NMBA) who has completed approved education to be recognised as a nurse practitioner by Services Australia. Aged care staff who are nurse practitioners can count towards the 24/7 RN responsibility if they are onsite and on duty.
occupancy rate	Total number of days that all people spent in a type of aged care over a year, divided by the total number of places that were available in that type of care over the year.
on duty	The RN must be available to provide care to care recipients and oversight of the care provided by other care staff as needed. An RN is also considered to be ‘on duty’ when taking mandated breaks during a continuous period of work if those breaks are prescribed in their employment conditions. However, this exclude mandated breaks that are taken offsite (meaning beyond the

Term	Definition
	building or complex of buildings including its surrounds).
onsite	The RN must be within the confines of the residential facility or the immediate surrounds.
organisation type	The ownership structure of the provider organisation that manages a residential aged care facility. These are classified as not-for-profit (includes charities, religious organisations and community-based organisations), government (includes state government, territory government and local government organisations) and private (includes publicly listed companies and organisations that are registered as private companies).
permanent residential aged care	An Australian Government-funded aged care program which provides round-the-clock personal care and nursing services to people living long-term in a residential aged care facility.
personal care services	Assisting with daily living activities, attending to personal hygiene, physical, administrative and cognitive needs and assisting with clinical care and provision of medical treatments and procedures where qualified to do so. This includes tasks such as bathing and getting dressed, assistance with eating, going to the toilet, grooming, getting in and out of bed, and moving about.
personal care worker	An employee who is classified under Schedule B.2 in the Aged Care Award 2010 as an aged care employee – direct care level 1 to level 6 (or in an equivalent role in an equivalent award or enterprise agreement or individual contract/agreement). Their primary responsibility is to provide personal care services to residents under the supervision of an RN or an EN.
places	Each Australian Government-funded aged care facility has a certain number of operational places

Term	Definition
	(sometimes called ‘beds’) that are either occupied, or available to be occupied.
program type (aged care)	The program under which a place in aged care is funded (home support, home care, residential care, transition care, short-term restorative care, Multi-Purpose Service, the National Aboriginal and Torres Strait Islander Aged Care Program, and Innovative pool).
provider (organisation)	These are the organisations that own and operate aged care services (outlets or facilities).
provider responsibilities	The set of responsibilities approved providers have in relation to the aged care they provide through their services to aged care consumers/care recipients. These responsibilities, under the Aged Care Act 1997 relate to the quality of care they provide, user rights for the people to whom the care is provided, accountability for the care that is provided, and the basic suitability of their key personnel.
recipient	Any person who receives care and support, either in their own home or in a residential aged care facility
registered nurse (RN)	A person who is registered under the Health Practitioner Regulation National Law in the nursing profession as an RN. An approved provider cannot meet the 24/7 RN responsibility though, or report coverage provided by, other care staff such as enrolled nurse, personal care workers, assistants in nursing or a person that was previously registered as an RN.
residential aged care facility	Facilities that provide Australian Government-funded residential aged care either on a permanent or short-term (respite) basis to people. The service must meet specified standards in the quality of the built environment, care, and staffing levels in

Term	Definition
	accordance with the Aged Care Act 1997. Some people refer to these services as ‘nursing homes.’
residential care	A program that provides personal and/or nursing care to people in a residential aged care facility. As part of the service, people are also provided with meals and accommodation, including cleaning services, furniture and equipment.
Registered nurse (RN) care minutes	The number of care minutes delivered by an RN.
services	A care facility that provides aged care, such as a residential aged care service or an outlet that delivers home care. The Australian government provides funding for those services that it has approved as set out in the Aged Care Act 1997. Services are owned by provider organisations (or providers), and one provider can operate more than one service.
specified care workers	Care minutes can only be delivered by the following specified care workers: • registered nurses (RN) • enrolled nurse (EN) • personal care workers and assistants in nursing (PCW/AIN).
Star Ratings	Aged care homes receive an Overall Star Rating of between 1 and 5 stars, and a rating across each of the 4 sub-categories (resident experience, compliance, staffing and quality measures). The more Star Ratings an aged care home receives, the better the quality of care.

Section 6

6. Appendices

Appendix A: Audit report templates

We have prepared audit report templates for auditors to apply in auditing Care Minutes Performance Statements for providers. This includes:

- Unmodified Opinion Template
- Unmodified Opinion Template – Emphasis of Matter
- Modified Opinion - Qualified Opinion Template
- Modified Opinion - Disclaimer of Opinion Template
- Modified Opinion - Adverse Opinion Template.

These audit report templates are available on the department's website.

Appendix B: Engagement Risk Assessment – Example Template

The purpose of this Engagement Risk Assessment example template is to provide auditors with additional guidance in identifying and managing risks related to the audit of the Care Minutes Performance Statement.

Auditors may use this optional template for further guidance in audit planning and implementation.

However, this template is not intended to be prescriptive. Auditors are still required to use their own methodology, in line with the AUASB Standards and their firm's established audit quality management system, to plan and implement an audit.

Appendix B is available on the department's website.

Appendix C: Engagement Planning and Implementation Checklist – Example Template

The purpose of this Engagement Planning and Implementation Checklist example template is to provide auditors with additional guidance in the planning and implementation of the Care Minutes Performance Statement audit.

This includes identifying key requirements, sequencing and timing considerations, to facilitate an effective audit process and enable providers to meet their reporting obligations. This template may be used to communicate the CMPS audit process with providers unfamiliar with the process.

This template is not intended to be prescriptive. Auditors are still required to use their own methodology, in line with the AUASB Standards and their firm's established audit quality management system, to plan and implement an audit.

Appendix C is available on the department's website.