Residential Aged Care Cost Collection (RACCC) 2024–25

Final Report

Version 1.3
20 February 2026

IHACPA

Acknowledgement of Country

We acknowledge the Traditional Owners and Custodians of Country throughout Australia, and recognise their continuing connection to land, sky, waters and culture. We pay our respects to them, and to Elders both past and present.

Artwork by Chern'ee Sutton

Residential Aged Care Cost Collection (RACCC) 2024–25: Final Report — 20 February 2026

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Abbreviations

ACFR	Aged Care Financial Report
ACFI	Aged Care Funding Instrument
AC-ID	Aged Care Identifier
AH	Allied Health
AHA	Allied Health Assistant
AHP	Allied Health Professional
AN-ACC	Australian National Aged Care Classification
BCT	Base Care Tariff
CI	Confidence interval
CPI	Consumer Price Index
CRID	Care Recipient Identifier
DHDA	Department of Health, Disability and Ageing
DRS	Data Request Specification
EHR	Electronic Health Record
EN	Enrolled Nurse
EOI	Expression of Interest
IHACPA	Independent Health and Aged Care Pricing Authority
LO	Lifestyle Officer
MMM	Modified Monash Model
PPM	PowerPerformance Manager
PHS	PowerHealth Solutions
OBD	Occupied Bed Days
QFR	Quarterly Financial Report
RACCPS	Residential Aged Care Costing Pilot Study
RACCS	Residential Aged Care Costing Study
RACCC	Residential Aged Care Cost Collection
RACH	Residential Aged Care Home
RgBD	Registered Bed Days
RM	Relationship Manager
RN	Registered Nurse
RBD	Resident Bed Day
RUCS	Resource Utilisation and Classification Study
RVU	Relative Value Unit
SDMS	Secure Data Management System
WPI	Wage Price Index

Executive Summary

Background

The Independent Health and Aged Care Pricing Authority (IHACPA) commissioned the Residential Aged Care Cost Collection (RACCC) 2024–25 to improve understanding of the cost of delivering residential aged care services in Australia. Conducted by a consortium led by HealthConsult with PowerHealth (now Telstra Health) and Venndelta, the cost collection builds on previous IHACPA projects including the Residential Aged Care Costing Study (RACCS) 2023, the Residential Aged Care Costing Pilot Study (RACCPS) 2021–22 and the Residential Aged Care Data Improvement Project (RACDIP) 2022.

Residential aged care cost collections provide an important evidence base for IHACPA's advice on efficient prices under the Australian National Aged Care Classification (AN-ACC) funding model, enabling a more transparent and activity-linked understanding of aged care service costs. The RACCC 2024–25 provides the most comprehensive dataset to date on the costs and time involved in delivering residential aged care. It will inform both IHACPA's pricing advice to the Australian Government, as well as the future development and refinement of aged care costing standards and business rules.

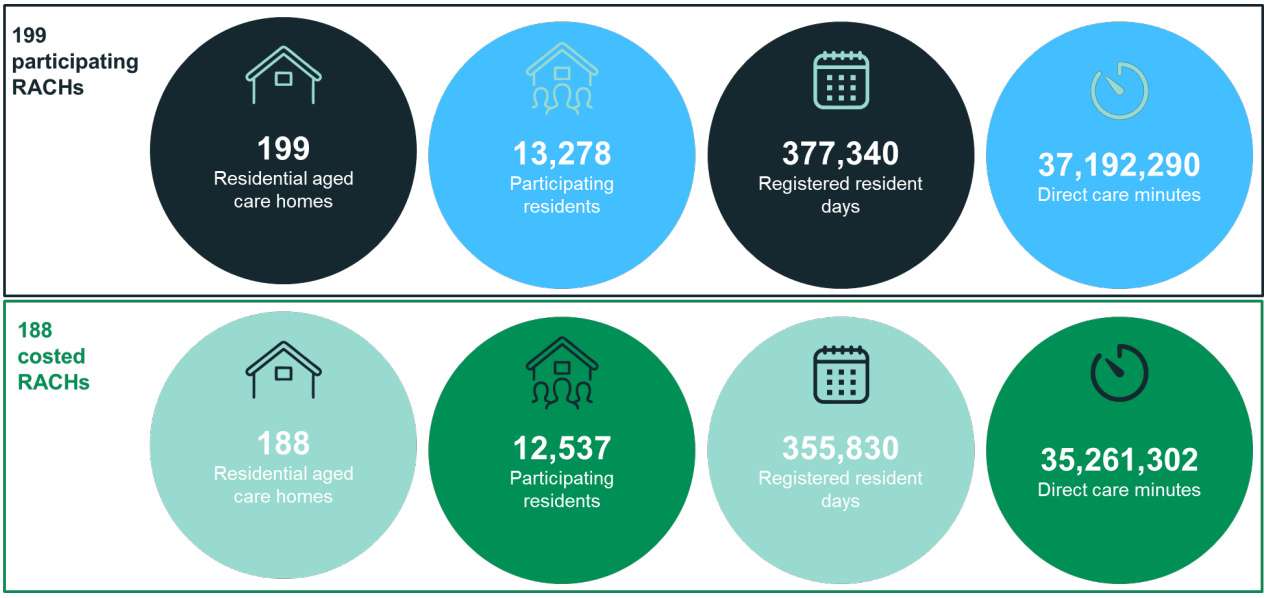
Cost collection overview

RACCC 2024–25 involved data collection from 200 residential aged care homes (RACHs) and was undertaken in 2 phases between July 2024 and September 2025. Data collection combined real-time measurement of direct care time using Bluetooth-enabled devices with supplementary workforce, resident and activity data to ensure accurate attribution of time and context for care delivery. Financial data from the Quarterly Financial Report (QFR), Aged Care Financial Report (ACFR) and a subset of RACH-level templates were also collected to support adjustments and detailed analysis.

Of the 200 RACHs recruited, costed data was completed for 199 homes. Following validation, 188 homes (94%) were included in the final costed dataset, representing 12,537 residents and 355,830 days of care (**Figure 1**). One home was excluded prior to costing due to unresolved data quality issues, and a further 11 were excluded because their financial data in their ACFR and QFR could not be reliably aligned to the cost collection period.

The sample was designed to be nationally representative by size, ownership and location. It included metropolitan, regional and remote RACHs, government, not-for-profit and for-profit operators, and services specialising in Aboriginal and Torres Strait Islander Peoples, dementia and homelessness care.

Figure 1: Overview of data collected through the RACCC 2024–25



Care minutes

RACCC 2024–25 involved the collection of operational data from participating RACHs. Throughout this report, the term 'care minutes' refers to both 'direct care minutes' (the time residents spent in close proximity to staff members) and 'indirect care minutes' (the difference between worked hours and direct care minutes). These care minutes cover all roles providing direct care to residents, such as nurses, personal care workers, allied health staff/assistants, lifestyle officers and others.

In contrast, the mandated care minute responsibility introduced by the Department of Health, Disability and Ageing (DHDA) in October 2023 only capture care provided by registered nurses, enrolled nurses, assistants in nursing and personal care workers.

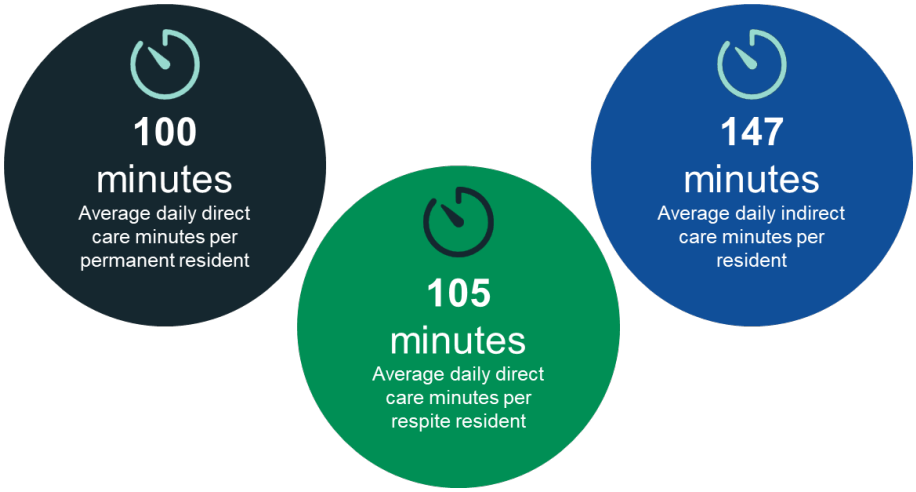
Therefore, the report's findings around care minutes should not be directly compared with the DHDA's mandated care minute targets as the workforce categories were not aligned.

Direct care time

Care time data were collected for permanent and respite residents across all AN-ACC Classes. On average:

- Permanent residents received an average of 100 minutes of direct care per day, ranging from 50 minutes for Class 2 to 135 minutes for Class 13.
- Respite residents received an average of 105 minutes per day, ranging from 65 minutes for Class 101 to 130 minutes for Class 103.
- Care workers provided the majority of care minutes, followed by Registered Nurses (RNs), Enrolled Nurses (ENs), lifestyle officers (LOs) and allied health (AH) staff.
- Average care minutes increased across higher numbered AN-ACC classes and were slightly higher in small and government-operated RACHs.
- Care minutes for new residents were higher for some AN-ACC Classes in the first 28 days, however, by 90 days, they were comparable to ongoing residents, suggesting that transition activities are largely integrated into routine care.

Figure 2: Average daily direct and indirect care minutes per resident



Cost findings

The costing analysis combined QFR and ACFR data indexed to 2024–25 values. Costs were calculated per registered bed day (RgBD), which includes both occupied and leave days. Some costs, such as cleaning and accommodation, continue to be incurred when residents are absent.

Average daily costs increased with care complexity and were broadly consistent with direct care time patterns:

- The average daily cost for permanent residents was $430, ranging from $354 for Class 2 to $489 for Class 13.
- For respite residents, average daily costs ranged from $381 for Class 101 to $498 for Class 103.
- Direct care labour accounted for 50–60% of total expenditure and remained the primary cost driver, followed by Hotel, Accommodation and other non-labour expenses.
- Higher average costs were observed in smaller and remote RACHs and in government-operated services, with residents in MM 6–7 locations recording average daily costs of $768, compared with $419–$460 in MM 1–5 locations.

Compared with RACCS 2023, RACCC 2024–25 recorded higher average daily costs across all AN-ACC Classes. This increase reflects both methodological improvements, including enhanced data capture, validation and completeness, and structural changes in the sector driven by workforce, wage and quality reforms introduced since 2023. In both studies, respite residents incurred slightly higher average costs than permanent residents.

The RACCC 2024–25 dataset was also used to produce a set of AN-ACC cost weights, indexed to the average cost per RgBD. While these weights are not directly comparable with the price weights used in the AN-ACC funding model, given the different cost components included, they show a clear narrowing in the cost range between the lowest and highest AN-ACC classes compared with the current price weights. This shift likely reflects changes in cost structures following significant sector reforms since the AN-ACC classification was developed in 2018. A definitive explanation, however, would require a comprehensive review of the AN-ACC classification and its underlying cost relativities.

Deep dive analysis

4 deep-dive analyses were undertaken to explore areas identified by IHACPA for further investigation: indirect care time, AH service delivery, residential respite care and overhead allocation methods. These analyses provide insights into non-direct care activities, the composition and utilisation of AH services, and the distribution of overhead and administrative costs, informing the refinement of future costing standards and activity drivers.

Collectively, the deep dives confirm that:

- **Indirect care** represents a substantial component of staff workload and warrants explicit treatment within the costing methodology through role- and shift-based parameters.
- **AH utilisation** remains limited and supply-driven, with physiotherapy dominating provision. Provider-funded AH data should continue to be collected and linked with financial data to capture both direct and indirect activity. Any available beacon data on indirect AH time was excluded from analysis due to low coverage. Future collections should expand measurement of indirect and group-based AH activity by supplementing wearable-device data with HRMS or survey information and by exploring technologies capable of detecting multiple simultaneous Bluetooth signals.
- **Respite care** incurs higher and more variable daily costs, reflecting turnover frequency and episodic workload. Comparison of RACCC-measured costs with official AN-ACC weights shows that on average respite residents are funded approximately 16% above the permanent resident average, while their measured costs are about 5% higher, indicating current weights already recognise, and may slightly over-recognise, respite care cost differentials.
- **Overhead allocation** significantly affects stream-level cost attribution, warranting further investigation in future cost collections.

These insights provide an evidence base for future refinement of the aged-care costing methodology and pricing advice.

Data quality and sector engagement

RACCC 2024–25 introduced several improvements to data quality and sector experience:

- replacement of AC-IDs with Care Recipient IDs (CRIDs) to reduce burden on homes
- streamlined use of IHACPA's Secure Data Management System (SDMS)
- enhanced trimming and validation rules to standardise time data and financial alignment
- dedicated Relationship Managers (RMs) to support on-home implementation and issue resolution.

High compliance was achieved across participating homes, supported by proactive RM engagement, clear communication and robust privacy protections. Only minor breaches were recorded (either no risk of serious harm or no breach occurred), and all were resolved promptly without risk of harm.

The sector responded positively to these enhancements, resulting in high participation, fewer data issues and greater confidence in IHACPA's costing processes based on participant feedback provided at the end of the data collection.

Conclusion and next steps

The RACCC 2024–25 has provided IHACPA with a comprehensive and representative dataset on the costs of delivering residential aged care in Australia. The collection successfully expanded participation and strengthened data quality.

Results confirm a strong relationship between higher AN-ACC classes, direct care time and cost, with direct labour remaining the primary cost driver. Higher average costs compared with RACCS 2023 reflect methodological changes, price inflation and structural sector changes.

Successive reforms, including the 24/7 RN requirement, care-minute targets and Fair Work wage increases, have significantly reshaped the sector's cost structure, increasing labour intensity, compliance requirements and fixed costs. These shifts reinforce the importance of regular review of AN-ACC weights and BCT settings to ensure pricing advice reflects contemporary care delivery conditions.

RACCC 2024–25 also highlights the need for an ongoing, rolling costing roadmap to progressively strengthen IHACPA's aged care costing capability and for consideration of additional assistance and support for RACHs to encourage greater participation, particularly among for-profit providers.

RACCC 2024–25 represents a major step forward in developing a sustainable, activity-based costing framework for residential aged care. By expanding provider representation, improving data linkages, refining costing standards and strengthening sector capability, IHACPA will be better positioned to continue to deliver robust, transparent and evidence-based pricing advice that supports efficient, high-quality aged care across Australia.

Recommendations

Findings from the RACCC 2024–25 confirm that the collection provides a strong foundation for developing a nationally representative, activity-based costing framework for residential aged care. However, several technical and structural refinements are required to strengthen data reliability, improve alignment between time and financial datasets, and build sector readiness for future cost-collection cycles.

Table 1 includes 10 recommendation areas for future cost collections.

Table 1: Recommendations for consideration in future cost collections

Recommendation focus	Description / Action for future collections
1. Expand participation and representativeness	**R1.** Broaden participation in future collections, with targeted engagement of underrepresented cohorts such as for-profit, remote, Aboriginal and Torres Strait Islander Peoples and homelessness-focused services to improve precision and ensure efficient prices reflect diverse care contexts. **R2.** Consider whether additional incentives could increase participation.
2. Strengthen care-time measurement and analysis	**R3.** Continue and enhance direct time measurement. Continue the use of direct time-measurement technology to maintain a robust, objective basis for estimating care minutes and labour cost in future RACCC cycles. Pending the outcomes of the Phase 3 HRMS feasibility study, which is testing the extraction of care-plan data from RACH systems, progressively assess opportunities to integrate validated HRMS data sources alongside wearable-based measurement to improve efficiency, scalability and accuracy.
3. Review and refine AN-ACC Classes and weights	**R4.** Periodic review of AN-ACC class definitions should continue using RACCC evidence to ensure the classification minimises within-class cost variation and maximises across-class variation, supporting close alignment between funding and the observed resource intensity of care delivery. **R5.** Analyse AN-ACC cost relativities using RACCC 2024–25 findings, including the observed narrowing of cost differences across classes. Reassess the proportionality between measured cost differentials (by class and cohort) and the weighted-average AN-ACC price weights (including BCT settings). Where evidence demonstrates under- or over-recognition of relative cost, for example, for respite residents or high numbered classes, update cost weights and/or BCT settings to reflect the efficient cost of care following recent sector reforms.
4. Strengthen data alignment and integration	**R6.** Develop a timing-reconciliation framework, drawing on matching principles from IHACPA's hospital costing standards, to manage reporting lags and/or automate linkages, where possible, between ACFR, QFR and care activity datasets. Future collections could also explore obtaining General Ledger data from selected RACHs to enable more precise financial to activity data matching and validation while balancing provider burden.
5. Establish a rolling costing roadmap and strengthen sector capability	**R7.** Implement a multi-year roadmap for continuous improvement of business rules, cost models and provider guidance, supporting transition to a steady-state national collection. **R8.** Continue targeted training, communication and feedback mechanisms to strengthen provider understanding of costing and data-validation processes and reinforce confidence in IHACPA's pricing advice.
6. Refine measurement of indirect care (deep dive)	**R9a.** Introduce role and shift specific indirect time factors to more accurately represent non-resident-facing activities such as documentation and coordination. **R9b.** Standardise activity definitions and codes across all RACHs and progressively integrate electronic health record (EHR) data to improve measurement accuracy.

Recommendation focus	Description / Action for future collections
	R9c. Validate night shift differentials through targeted time-and-motion studies to confirm higher indirect care loads overnight.
7. Improve visibility and measurement of allied health services (deep dive)	**R10a.** Strengthen AH measurement by continuing discipline-level data collection and linking time, rostering and financial data. **R10b.** Expand participation across AH disciplines and provider types to improve representativeness. **R10c.** Capture indirect (documentation, case discussions, multidisciplinary meetings) and group-based AH activity to complement direct measurement. **R10d.** Analyse workforce, contracting and funding influences on access and extend future RACCC cycles to include externally/self-funded AH services.
8. Enhance representation and costing of respite care (deep dive)	**R11a.** Formalise episode-level identification in the RACCC DRS (admission, discharge, duration) and expand participation; maintain confidence intervals (CIs)/sensitivity analyses. **R11b.** Quantify turnover frequency (admissions per bed per year) and its impact on per-day cost; test a modest flag-fall/per-episode component if warranted. **R11c.** Compare RACCC-measured respite costs with weighted average AN-ACC cost weights to test alignment and identify any under-recognised episodic effect. **R11d.** Liaise with the Department to evaluate whether turnover workload is recognised in funding; if not, consider a short-stay/turnover adjustment.
9. Optimise overhead allocation methods (deep dive)	**R12.** Further validate and refine allocation percentages as participation expands, testing stability across provider type/size/location.
10. Maintain transparency and continuous improvement	**R13.** Maintain public reporting of confidence intervals, sensitivity analyses and methodological updates to promote transparency and sector confidence in future cost-collection cycles. Integrate feedback from participants and deep-dive findings into ongoing refinement of the aged-care costing framework.

Together, these actions will consolidate data quality, streamline reporting, and position IHACPA to deliver a sustainable, routine national cost collection that strengthens the evidence base for aged-care pricing and funding reform.

Interpretation of graphs

Box-and-whisker plots

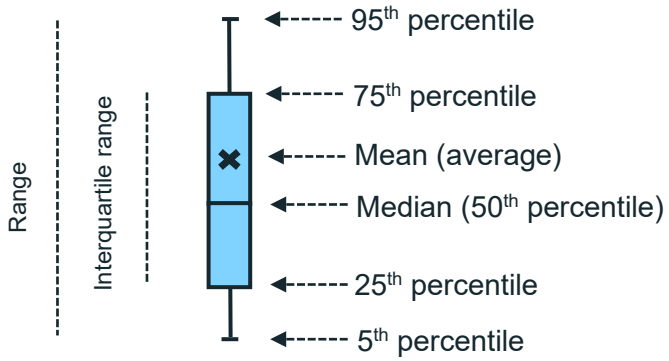
Box-and-whisker plots are used throughout this report to show the distribution of a dataset.

The definitions for interpreting the box plots are:

- **5th percentile**: The value below which 5% of the data fall.
- **25th percentile (first quartile)**: The value below which 25% of data fall.
- **Median (50th percentile)**: The mid-point of the data, represented by the line which divides the interquartile range. Half the data values are greater than or equal to this value and the other half are below it.
- **Mean (average)**: The sum of all data values divided by the number of values. It represents the central or typical value of the data set and is shown by the cross on the plot.
- **75th percentile**: **(third quartile)**: The value below which 75% of data fall.
- **95th percentile**: The value below which 95% of data fall.

Figure 3 illustrates how to read the box-and-whisker plots used in this report.

Figure 3: Interpretation of a box-and-whisker plot



Confidence intervals

Confidence intervals (CIs) used in this report indicate the margin of error for the RACCC 2024–25 sample. The **black error bars** at the top of each bar represent 95% CIs, adjusted to account for clustering in the sample (i.e. multiple bed days were costed for the same resident).

Differences between groups are interpreted descriptively. Non-overlapping CIs indicate greater separation between groups; however, formal statistical hypothesis testing was not undertaken.

Introduction and objectives

On 14 May 2024, the Independent Health and Aged Care Pricing Authority (IHACPA) engaged a consortium led by HealthConsult to deliver the Residential Aged Care Cost Collection 2024–25 (RACCC 2024–25). This report presents the consolidated findings of the RACCC 2024–25, produced by the HealthConsult-led consortium with PowerHealth (now Telstra Health) and Venndelta.

Introduction

IHACPA commissioned the RACCC 2024–25 to improve understanding of the costs associated with delivering residential aged care services in Australia. The cost collection costed a representative sample of residential aged care services to inform the pricing and funding models aligned with the Australian National Aged Care Classification (AN-ACC).

RACCC 2024–25 builds on previous IHACPA projects, including the Residential Aged Care Costing Pilot Study 2021–22 (RACCPS 2021–22)[1], the Residential Aged Care Data Improvement Project 2022 (RACDIP 2022) and the Residential Aged Care Costing Study 2023 (RACCS 2023).[2] While the methodologies have evolved over time, each study has progressively refined IHACPA's understanding of residential aged care costs and strengthened the capacity for longitudinal analysis of cost structures.

Using a combination of top-down and bottom-up costing techniques, supported by operational and financial data, RACCC 2024–25 provides robust cost estimates to inform IHACPA's classification and pricing advice and strengthens the evidence base for future costing studies.

RACCC 2024–25 was delivered in 2 phases:

1. **Phase 1 (May 2024 and December 2024):** Data collection from 71 residential aged care homes (RACHs).
2. **Phase 2 (January 2025 to September 2025):** Data collection from an additional 129 RACHs.

The data collection occurred between July 2024 and September 2025. In total, 200 RACHs participated (with one home excluded prior to costing).

Aged care funding reform

The AN-ACC and associated funding model were implemented nationally on 1 October 2022. AN-ACC links government subsidies to the characteristics of aged care services and resident care needs, both of which are the main drivers of service delivery costs.[3]

[1] Independent Health and Aged Care Pricing Authority. Residential Aged Care Costing Pilot Study Report. Sydney: IHACPA; 2022 Aug. Available from: https://www.ihacpa.gov.au/sites/default/files/2022-11/residential_aged_care_costing_pilot_study_-_2022_-_final_report.pdf

[2] Independent Health and Aged Care Pricing Authority. *2023 Residential Aged Care Costing Study Final Report*. Sydney: IHACPA; 2024 Jan. Available from: https://www.ihacpa.gov.au/resources/2023-residential-aged-care-costing-study-final-report

[3] Independent Health and Aged Care Pricing Authority. *Australian National Aged Care Classification*. Sydney: IHACPA; 2022 Dec. Available from: https://www.ihacpa.gov.au/aged-care/background/australian-national-aged-care-classification

Developed from the 2019 Resource Utilisation and Classification Study (RUCS),[4] AN-ACC replaced the Aged Care Funding Instrument (ACFI)[5] to provide a more transparent, clinically informed, and evidence-based funding approach.

The AN-ACC funding model comprises 2 main components:

- **Variable subsidy:** Based on a resident's AN-ACC Class and reflects individual resident characteristics and care needs, with separate arrangements for permanent and respite residents.[6]
- **Base Care Tariff (BCT):** A fixed payment covering stable care costs across all residents within a RACH.

Since August 2022, IHACPA has been responsible for providing aged care costing and pricing advice to the Australian Government.[7] This role requires a detailed understanding of the provider cost structures to inform both AN-ACC components and support an adaptive, evidence-based funding system.

Objectives

The specific objectives of the cost collection were to:

- develop a costed dataset to enable IHACPA to provide informed costing and pricing advice to the Australian Government
- further enhance and refine data collection systems, processes and sector capabilities to support the ongoing costing of residential aged care services
- provide recommendations to support the continued development of aged care costing methodologies, including the introduction of relative value units (RVUs), service weights and business rules.

Integrating RACCS 2023 recommendations into RACCC 2024–25

RACCS 2023 made several recommendations to refine future costing studies. **Table 2** summarises how each was addressed in RACCC 2024–25.

Table 2: Integrating RACCS 20203 recommendations into RACCC 2024–25

RACCS 2023 recommendation	RACCC 2024–25 approach
Expand the sample size	Increased to 200 RACHs (82 additional homes from RACCS 2023) using a stratified sampling framework with adaptive recruitment. Strata were defined in advance (including geography, service size and provider type), with homes admitted within strata from Expressions of Interest (EOIs). Targeted recruitment was undertaken where required (e.g. Aboriginal and Torres Strait Islander–specific services) and pragmatic adjustments were made where strata were undersubscribed, to preserve overall representativeness.
Flexible approach to engaging with specialised service populations	Purposeful recruitment of specialised services (including Aboriginal and Torres Strait Islander services, specialist dementia services and specialised homelessness services) within the broader stratified sampling framework,

[4] Eagar K, McNamee J, Gordon R, Snoek M, Duncan C, Samsa P, Loggie C. *The Australian National Aged Care Classification (AN-ACC): The Resource Utilisation and Classification Study: Report 1*. Wollongong: Australian Health Services Research Institute, University of Wollongong; 2019.

[5] Independent Health and Aged Care Pricing Authority. *Australian National Aged Care Classification*. Sydney: IHACPA; 2022 Dec. Available from: https://www.ihacpa.gov.au/aged-care/background/australian-national-aged-care-classification

[6] Department of Health, Disability and Ageing. *The Australian National Aged Care Classification (AN-ACC) funding guide*. Canberra: Commonwealth of Australia; 2025 Sep 12. Available from: https://www.health.gov.au/resources/publications/the-australian-national-aged-care-classification-an-acc-funding-guide?language=en

[7] Independent Health and Aged Care Pricing Authority. *Royal Commission into Aged Care Quality and Safety*. Sydney: IHACPA; 2025. Available from: https://www.ihacpa.gov.au/aged-care/background/royal-commission-aged-care-quality-and-safety (IHACPA)

RACCS 2023 recommendation	RACCC 2024–25 approach
	supported by tailored engagement strategies to ensure representation of smaller and priority cohorts.
Continue to investigate the allocation of indirect care time	Deep dive using location beacons and a survey of 30 homes.
Targeted study for new versus long term resident costs	Analysed a resident's first 28 and 90 days of care relative to other residents.
Align treatment of co-located homes to operating structure	7 co-located services participated. Data collection was adapted to operational realities rather than NAPS IDs.
Explore alternative avenues for the collection of resident AC-IDs	Introduced Care Recipient IDs (CRIDs) as a practical alternative to AC-IDs, supported by mapping within the Secure Data Management System (SDMS). CRIDs were typically much easier for RACHs to obtain and provide.
Streamline the secure data transfer process	Data submitted directly into the SDMS with hands-on training and support by HealthConsult Relationship Managers (RMs). Homes reported ongoing access and security (i.e. one time password process) challenges.
Proactively manage data breaches	RMs proactively mitigated data breaches through ongoing data security discussions and training on SDMS use and document de-identification, with only 19 Category 4 and 6 Category 3 breaches recorded during RACCC 2024–25.

IHACPA identified several priority areas for deeper investigation in RACCC 2024–25, based on recommendations from RACCS 2023. In response, focused analyses were undertaken on allied health service delivery, direct and non-direct care activities, residential respite services and overhead expenditure, including the allocation of administrative costs. Summary findings from these analyses are included in this Final Report.

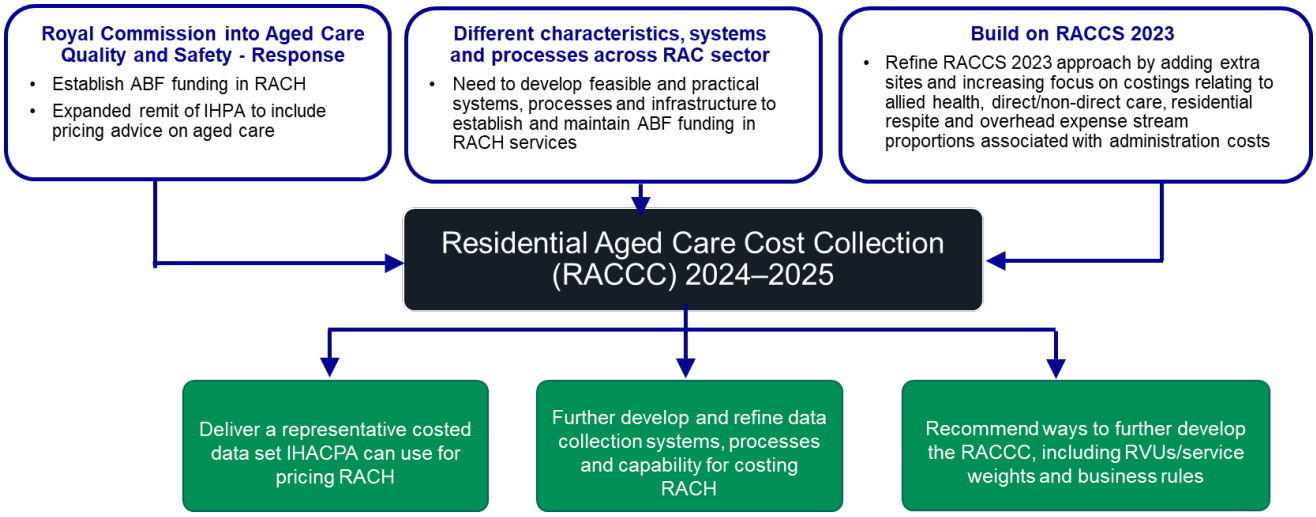
About RACCC

This Chapter outlines the design, governance and implementation of the RACCC 2024–25. It describes the project's objectives, governance and engagement arrangements, sampling approach, consent processes, and data collection methods. It also summarises the technology, infrastructure and security measures used to ensure high-quality, reliable and secure data capture across participating residential aged care homes.

Overview of RACCC 2024–25

RACCC 2024–25 applied established activity-based costing techniques, capturing care time data via low-intrusion technologies and sourcing financial data from central datasets where possible. Building on the RACCS 2023 approach, refinements were introduced to improve data quality and efficiency through the use of advanced technologies, streamlined data collection and stronger sector engagement. **Figure 4** outlines the overarching framework for RACCC 2024–25.

Figure 4: Overarching framework for RACCC 2024–25



Source: IHACPA RFQ and HealthConsult (2024–25)[8]

Project governance

RACCC 2024–25 was delivered under a jointly agreed governance framework between IHACPA and the HealthConsult-led Consortium. The framework defined roles, responsibilities, sector engagement processes and documentation to support transparent oversight and collaboration. Weekly project management meetings between IHACPA and consortium members ensured shared visibility, continuous feedback, and timely, evidence-based decision-making throughout the project.

Stakeholder engagement

Effective stakeholder engagement underpinned the success of RACCC 2024–25. A jointly developed Stakeholder Engagement Plan between IHACPA and the HealthConsult-led consortium established clear principles of transparency, partnership and a 'no surprises' approach. Engagement was structured across 3 levels:

[8] Royal Commission into Aged Care Quality and Safety. Final Report: Volume 3A – The New System. Canberra: Commonwealth of Australia; 2021. Available from: https://www.royalcommission.gov.au/system/files/2021-03/final-report-volume-3a.pdf

1. **Sector engagement:** Periodic national webinars formed the core of communications, supported by IHACPA emails to relevant mailing lists, promotion in the DHDA aged care newsletter, conference presentations and an Expression of Interest (EOI) form on the IHACPA website.
2. **Home engagement:** HealthConsult RMs provided pre-home briefings, online training and technology setup support, with ongoing check-ins and daily monitoring to address issues quickly.
3. **System engagement:** IHACPA and consortium representatives shared project updates and insights at national forums and conferences to maintain transparency and build sector confidence.

This collaborative approach ensured strong alignment between IHACPA, the Consortium and participating providers, fostering trust and active participation. Refer to the Sector engagement chapter for detailed sector engagement and recruitment activities.

Sampling strategy

RACCC 2024–25 employed a stratified sampling approach to ensure participation by a nationally representative sample of RACHs. Primary selection criteria included:

- **geographic location:** metropolitan (MM 1–2), regional (MM 3–5), remote (MM 6–7)
- **ownership type:** government, not-for-profit, for-profit
- **size:** small (up to 30 beds), medium (31–89 beds), large (90 beds or more).

Sampling rules were developed to ensure a representative sample of RACHs were included in each sampling cell. These rules were applied based on the population size of each stratum, with target sample proportions and minimum participation thresholds summarised in **Table 3**.

Table 3: Sampling rules by RACH stratum population size

RACHs stratum population	Target sample	Minimum RACHs
<5	100%	N/A
5 to 9	50%	4
10 to 19	25%	4
>19	Probability proportional to size	4

Secondary selection criterion considered Base Care Tariff (BCT) Classification to purposely include specialised services for Aboriginal and Torres Strait Islander Peoples or residents experiencing or at risk of homelessness.

The sampling strategy was initially designed for 100 RACHs in Phase 1 and was updated in January 2025 to reflect the expanded target of 200 RACHs across both phases. **Table 4** shows the national distribution and target numbers by stratum.

Table 4: RACCC 2024–25 sampling framework

Stratum	RACH size category	Geographic location	Provider type	No. of RACHs in Australia	Target no. of RACHs	No. of participating RACHs	% participating RACHs	National proportion
1	Small	Metro	For profit	8	4	1	0.5%	0.3%
2	Small	Regional	For profit	4	4	0	0.0%	0.2%
3	Small	Remote	For profit	0	0	0	0.0%	0.0%
4	Small	Metro	Government	9	1	0	0.0%	0.3%
5	Small	Regional	Government	103	5	5	2.5%	4.0%
6	Small	Remote	Government	6	1	6	3.0%	0.2%
7	Small	Metro	Not for profit	23	8	2	1.0%	0.9%

Stratum	RACH size category	Geographic location	Provider type	No. of RACHs in Australia	Target no. of RACHs	No. of participating RACHs	% participating RACHs	National proportion
8	Small	Regional	Not for profit	71	8	8	4.0%	2.7%
9	Small	Remote	Not for profit	9	5	2	1.0%	0.3%
10	Medium	Metro	For profit	273	18	13	6.5%	10.6%
11	Medium	Regional	For profit	68	8	3	1.5%	2.6%
12	Medium	Remote	For profit	14	4	0	0.0%	0.5%
13	Medium	Metro	Government	5	1	2	1.0%	0.2%
14	Medium	Regional	Government	62	3	1	0.5%	2.4%
15	Medium	Remote	Government	2	1	0	0.0%	0.1%
16	Medium	Metro	Not for profit	440	28	50	25.1%	17.0%
17	Medium	Regional	Not for profit	317	20	21	10.6%	12.3%
18	Medium	Remote	Not for profit	11	4	1	0.5%	0.4%
19	Large	Metro	For profit	453	29	15	7.5%	17.5%
20	Large	Regional	For profit	97	8	3	1.5%	3.7%
21	Large	Remote	For profit	0	0	0	0.0%	0.0%
22	Large	Metro	Government	8	1	1	0.5%	0.3%
23	Large	Regional	Government	7	1	0	0.0%	0.3%
24	Large	Remote	Government	0	0	0	0.0%	0.0%
25	Large	Metro	Not for profit	415	27	48	24.1%	16.0%
26	Large	Regional	Not for profit	161	10	17	8.5%	7.0%
27	Large	Remote	Not for profit	1	1	0	0.0%	0.0%
Total				**2,567**		**199**	**100%**	**100%**

Consent processes

RACCC 2024–25 was conducted as part of IHACPA's routine operational activities and did not constitute human research under the *National Statement on Ethical Conduct in Human Research*. Therefore, written consent from individual residents and staff was not required.

To ensure transparency and choice, IHACPA and the Consortium implemented clear communication and opt-out processes:

- **Residents/families** received letters and other resources explaining the cost collection purpose, data collection using wearable devices and privacy protections with the right to opt out at any time (Appendix D.1). Data for residents who opted out were excluded from the cost collection dataset.
- **Staff** received similar information (Appendix D.2) with resources for union representatives (Appendix D.3) and were supported through local RACH communication and project team training.
- **RACH participation** was confirmed through a signed form (Appendix D.4) verifying that residents or their representatives and staff had been informed about the cost collection and that residents or their representatives had been given the opportunity to opt out.

Data collection technology

RACCC 2024–25 used Bluetooth-enabled technology to record time interactions between residents and staff. Residents wore small cards (used almost universally) or bracelets that emitted Bluetooth signals. These signals were detected by staff cards. Once a staff card came within 1.5 metres of a resident card for a continuous period of at least 30 seconds, it would begin capturing a de-identified resident identifier (ID), a de-identified staff ID, staff role, date, time and duration of interaction. At the end of each shift, the data captured on the staff member's card was transferred automatically to a secure server. Data were collected

from direct care staff (e.g. nurses, personal care workers, lifestyle officers and allied health staff) but not from non-care staff such as kitchen, cleaning or administrative personnel.

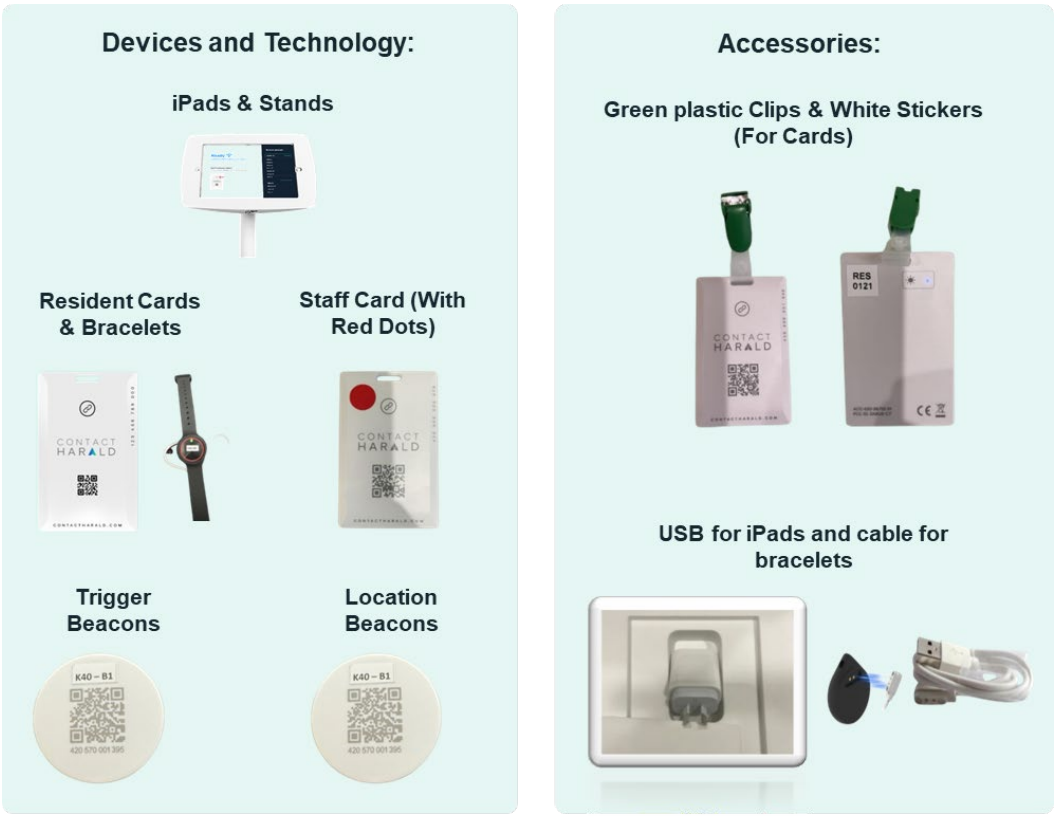
Some homes also had location beacons operating using the same Bluetooth principle, placed in strategic areas to capture data on indirect care time (e.g. documentation).

A key feature of the technology used in RACCC 2024–25 was its simplicity. Devices were pre-programmed, required no charging, and did not require extensive setup or training. Staff wore the cards like standard ID badges, while residents used lightweight bracelets or cards assigned to their room or bed number. Importantly, no personally identifiable information was collected – only role (e.g. RN, care worker) and interaction-based information, which remained anonymous. Resident data also remained anonymous.

Each participating RACH received a data collection technology pack (**Figure 5**) that included:

- **Resident bracelets/cards**: Assigned to a room or bed number to protect privacy. Emitted Bluetooth signals detected by staff cards. Bracelets had a 30-day battery life (rechargeable), while card batteries lasted 10-12 month and did not require recharging.
- **Staff cards**: Colour coded by staff role. Automatically recorded interactions with resident cards and location beacons. No manual data entry was required.
- **Location beacons**: Captured indirect care time when staff were in rooms where the beacons were located.
- **iPads and trigger beacons**: Served as data gateways for secure, automated data transfer from staff cards to the cost collection portal.

Figure 5: RACCC 2024–25 technology



Data infrastructure and security

IHACPA's Secure Data Management System

IHACPAs Secure Data Management System (SDMS) was the central platform for secure data exchange between RACHs, the Consortium and IHACPA. Individual SDMS accounts were established for all users, enabling encrypted upload and retrieval of project templates and datasets, including:

- resident and financial Data Request Specification (DRS) templates
- resident absence DRS templates
- centralised sources such as the Aged Care Financial Report (ACFR), Quarterly Financial Report (QFR) and resident-level information files (containing AC-IDs only).

The SDMS supported secure data submission, quality assurance monitoring and coordination between IHACPA and the project team. However, participants frequently cited usability challenges which occasionally slowed data submission, particularly delays in access, one-time password issues and mobile verification requirements.

Data management

RACCC 2024–25 involved an extensive collection of resident and home level data, managed in line with IHACPA's stringent data security requirements. Key safeguards included:

- No personally identifiable data (e.g. names) were collected.
- All data outside of the SDMS were de-identified using randomised 5-digit codes assigned to each RACH.
- The mapping process is performed exclusively within the SDMS.
- All transfer of sensitive data between RACHs, IHACPA and the broader project team occurred via the SDMS upload portal to prevent transmission by insecure methods (such as email).
- Participants were regularly briefed on de-identification and secure data handling.

There were 6 data breaches classified as Category 3 (No risk of serious harm, i.e. privacy incident contained) and 19 incidents classified as Category 4 (No further action required, i.e. no breach occurred, notification unnecessary). Each data breach is assessed against the IHACPA data breach response plan, which includes the following categories:

- Category 1 – Urgent response required (most serious)
- Category 2 – Further information required – the Executive Director, Legal and Corporate will investigate
- Category 3 – No risk of serious harm
- Category 4 – No further action required (least serious).

The data breaches recorded typically involving trivial inclusions in data being uploaded by RACHs (e.g. a therapy animal's name or reference to a holiday). RMs promptly notified RACHs, provided remediation advice, and IHACPA formally confirmed each notification.

Sector engagement

This Chapter outlines the sector engagement, recruitment and data collection processes for the RACCC 2024–25. It describes the national recruitment strategy, stakeholder engagement mechanisms and the sequencing of data collection. It also summarises the structured processes used for onboarding homes, capturing live direct care time data and collecting supplementary operational information to support accurate costing and analysis.

Data collection timeline

RACCC 2024–25 was conducted between May 2024 and November 2025. The 30-day[9] live data-collection periods for the 200 participating RACHs occurred between July 2024 and September 2025. The data for one home was excluded prior to the costing process due to data quality issues, resulting in 199 homes being costed. The data collection process was structured in 6 tranches as shown in **Table 5** to coordinate resources and accommodate home preferences.

Table 5: Summary of RACCC 2024–25 data collection periods

Phase	Tranche	Start date	End date	No. of RACHs
1	1	22 July 2024	10 September 2024	25
1	2	23 September 2024	5 November 2024	28
1	3	11 November 2024	24 December 2024	17
2	4	13 January 2025	8 April 2025	22
2	5	31 March 2025	8 July 2025	50
2	6	16 June 2025	5 September 2025	57

Sector-wide engagement and recruitment

A comprehensive, joint recruitment strategy was delivered by IHACPA and HealthConsult to engage the residential aged care sector. The program combined large-scale promotion with targeted outreach to achieve representation across provider types, locations and sizes.

Core engagement activities included:

- **National webinars:** Periodic interactive sessions co-hosted by IHACPA and HealthConsult formed the primary engagement mechanism, outlining project objectives, participation requirements and benefits.
- **Weekly recruitment sessions:** Drop-in sessions enabled RACHs to ask questions, confirm participation and discuss logistics.
- **Targeted outreach:** Direct emails and phone calls to providers, including follow-ups with under-represented cohorts such as government-operated, regional and specialist homelessness services.

[9] 30 days of data was collected for the majority of homes. However, in some cases this may have been reduced for several reasons due to COVID outbreaks, logistics and unexpected events at a home impacting key staffing availability.

- **Collaborative networks:** Presentations at state and national provider group meetings and use of existing IHACPA and/or HealthConsult relationships to encourage participation.
- **IHACPA-led promotion:** Open EOI on the IHACPA website; conference presentations and exhibition booths; and inclusion in the Department of Health, Disability and Ageing's aged-care newsletter, linking to EOIs and webinar registrations.
- **Social-media and digital materials:** Short promotional videos, posters and an information pack distributed via LinkedIn and sector channels to explain the cost collection and highlight ease of participation.

Recruitment progress was tracked by the Consortium and summarised in weekly reports showing the number of homes recruited, remaining targets and any sampling gaps. When gaps were identified, targeted campaigns were undertaken, most notably in March 2025, when direct engagement with more than 150 provider representatives secured the final homes required for Phase 2.

Initial engagement

After an EOI for RACCC 2024–25 was received, HealthConsult scheduled an initial meeting within 3 business days. Homes were provided with an Information Pack outlining the cost collection objectives, anticipated benefits, participant responsibilities and key timelines. These meetings introduced RACCC 2024–25, clarified participation requirements and discussed preferred data collection periods.

Because the RACCC methodology relied on operational data and required active involvement from home staff to support live data collection, participation needed strong engagement from operational teams. However, the inclusion of the word "costing" in the cost collection title often led to EOIs being submitted by finance teams. This often required follow-up meetings with home managers and clinical leaders to explain the practical aspects of participation and confirm home readiness for data collection.

Larger provider organisations typically coordinated participation through their head office, often with the aim of involving multiple services. In contrast, standalone RACHs committed more quickly due to simpler internal processes. Government-operated services typically required extended lead times to accommodate internal discussions and formal approval processes.

Once a RACH confirmed participation, a home sponsor (usually the home manager or clinical care manager) was appointed as the primary contact. A HealthConsult RM was then assigned to provide ongoing support, respond to queries and coordinate home readiness. Recruitment typically took several weeks from the initial EOI to confirmation.

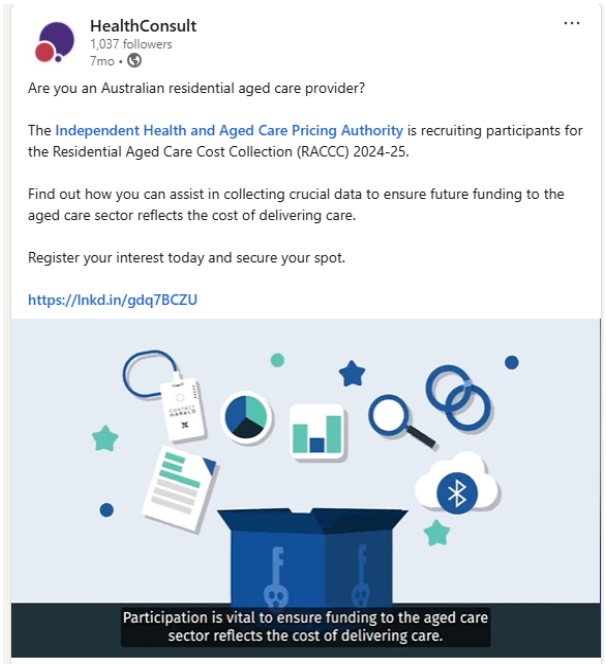
Recruitment materials

Recruitment was supported by a suite of coordinated materials and digital resources. Examples of the promotional material are shown in **Figure 6** and Appendix D. Key recruitment materials included:

- **Short promotional videos** designed to inform staff and residents about the purpose and process of RACCC 2024–25, with a focus on the simplicity of participation and the importance of getting involved.[10]
- **Information packs** designed to provide RACHs with a concise overview of the cost collection requirements and timelines tailored for RACH leadership teams.
- **Posters and flyers** for display in participating RACHs to promote awareness among residents, families and staff.

[10] Example promotional videos are publicly accessible online: staff video – https://healthconsult86.sharepoint.com/:v:/s/HealthConsult/ETyayUY25yxMubiHXTx1WikB3IPRauNGTPF5rsfr6xoCwg?e=AiusnN; residents video – https://healthconsult86.sharepoint.com/:v:/s/HealthConsult/EV_XUDPDfetDusOh3liuyFgBtc2q7Kjncek4ab2-n4u5mA?e=vyy5BA

Figure 6: Example promotional materials



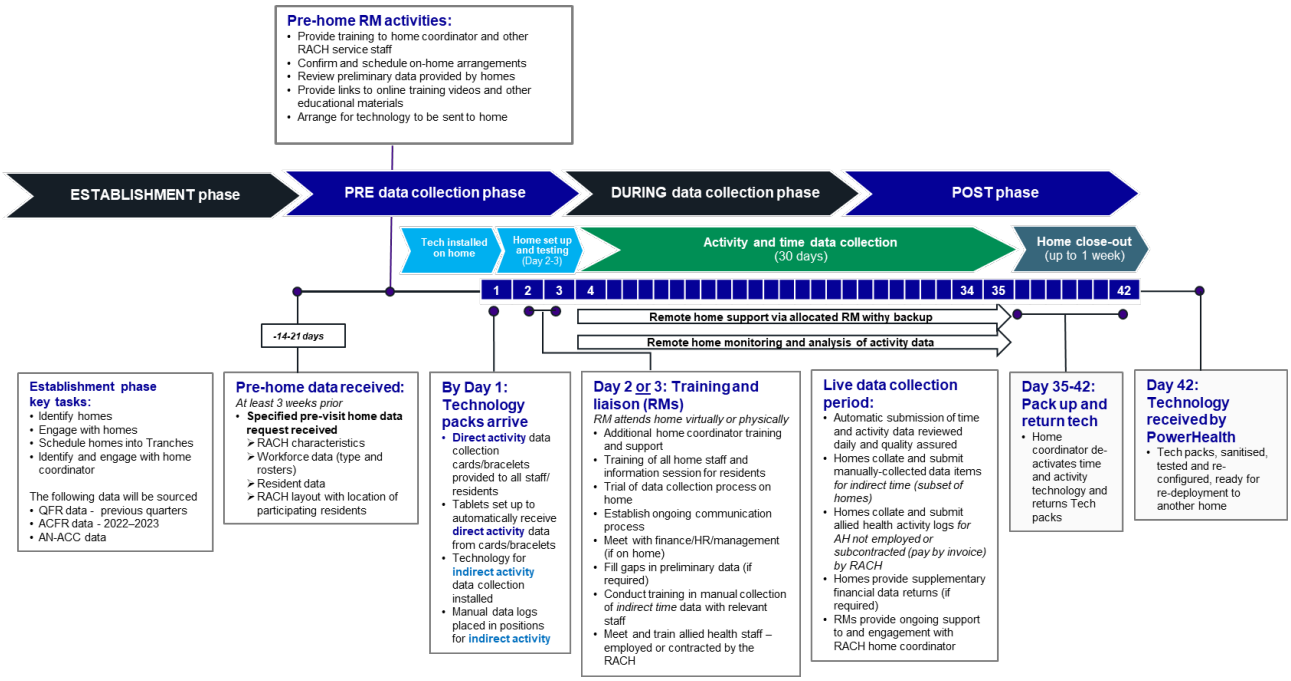
Source: RACCC 2024–25

Upon recruitment, each home received a **Participant Pack** containing a detailed implementation plan, communication materials for staff and residents, and short explainer videos about cost collection procedures and technology use.

Direct time data collection

Figure 7 summarises key steps involved in data collection from onboarding through to data submission and technology return, as well as the ongoing engagement with RACHs.

Figure 7: Overview of RACCC 2024–25 stakeholder engagement and data collection



Source: RACCC 2024–25

Pre-data collection phase

Following confirmation of participation, RMs proactively contacted each home sponsor to initiate implementation, review the Implementation Plan and finalise preparatory steps. Activities included confirming communication requirements, collecting home-specific details (e.g. number of beds and rooms, physical layout), verifying technical and non-time data needs, and agreeing on key dates (e.g. start of data collection).

RMs visited most homes (183 of the 199 RACHs) to install technology, train staff and residents, and ensure that all supplementary data were received. The remaining homes were supported through remote setup and training, either at the request of the home or where on-home access was challenging due to location, timing or other logistical constraints. The in-person setups proved essential for real-time troubleshooting and building staff confidence. Final readiness checks with each RACH were completed before data collection began.

Live data collection phase

During the 30-day collection period, RMs maintained close contact with homes through weekly check-ins and ad hoc support. Discussions focused on data completeness, anomalies (e.g. missing or damaged cards), resident movements and operational issues (e.g. staff shortages or outbreaks).

RMs also monitored de-identified time-data dashboards to identify irregularities and support data integrity, though detailed data could not be shared with homes due to confidentiality requirements. Toward the end of each collection period, RMs initiated close-out planning and equipment return arrangements.

Post-data collection phase

Within one week of completion, RMs held formal close-out meetings with each RACH to review experiences, validate data and arrange pack-up logistics. Key topics included feedback on participation, data quality checks, identification of missing staff or resident data and confirmation of equipment return.

Remote RACHs generally managed pack-up independently, while others preferred in-person support. Close-out meetings also outlined next steps, including reporting timelines and delivery of cost collection outputs.

Operational data collection

Building on and improving the robustness of the RACCS 2023 infrastructure, detailed DRS and business rules (Appendix A) were developed for RACCC 2024–25 and made available through the SDMS. The DRS templates (Appendix F) were completed collaboratively by home staff and the RMs to ensure accuracy and minimise the burden on participating RACHs. Some templates were submitted once, while others were collected multiple times throughout the cost collection period in response to changes.

In addition to the DRS files, supplementary data were collected and entered into the SDMS using the same approach as the core DRS files. These included:

- **Asset log**: A catalogue of all devices (resident and staff) and their allocation to specific resident rooms or staff roles. This log was essential for accurately coding the Bluetooth time-monitoring data and linking device movements to the correct resident or staff member.
- **Unit information:** Details of each unit within the RACH, including the number of beds within each unit and identification of any memory support areas or other specialised areas.
- **De-identified staff roster**: Shift schedules for the 30-day data collection period, transposed by the RM into a structured data collection template, capturing shift start and end times, staff role, and unit allocation.

A summary of the direct care time and the home operational data requirements is provided in Appendix G.

Data collection feedback processes

Data limitations

Overall, the quality and completeness of the RACCC 2024–25 dataset were considered high. Most participating RACHs achieved strong compliance with the cost collection protocols, and the data collected were sufficient for robust analysis across all key variables. One home was excluded prior to costing due to unresolved data quality issues, and a further 11 were excluded during validation because their financial data could not be reliably aligned to the cost collection period. These exclusions were unrelated to the general data quality issues described below.

The main factors influencing data quality were:

- **Card use and compliance:** Data accuracy relied on staff consistently wearing their assigned cards. Instances of non-compliance or card loss were infrequent but, where they occurred, resulted in minor under-representation of direct care time.
- **Home engagement and quality assurance:** Engagement was generally strong; however, a small number of homes had limited capacity for real-time feedback, which occasionally constrained the ability to identify and correct issues during data collection.
- **Technical constraints:** The wearable technology could detect proximity to only one resident at a time, requiring group activities to be recorded manually. Care provided outside the 1.5-metre detection range, such as during infection control measures, may not have been captured, leading to modest under-counting of legitimate care interactions in some cases.

Despite these minor limitations, the dataset was deemed reliable and representative of RACHs, providing a robust evidence base for the analyses presented in this report.

RACCC 2024–25 home feedback

HealthConsult maintained regular communication with RACH staff throughout the cost collection. Feedback indicated strong engagement and generally positive experiences with the data collection process. Key themes included:

- **Staff engagement:** Participation was high and improved over the data collection period.
- **Process adaptation:** Early challenges were common but quickly resolved.
- **Home differences:** Smaller RACHs found participation easier, while larger or more complex care RACHs faced greater logistical challenges.
- **Resident identification:** Collecting AC-IDs was burdensome but eased significantly with the introduction of CRIDs collection instead.
- **Support effectiveness:** RMs were widely commended for their responsiveness and ongoing support throughout the cost collection.
- **Logistical ease:** Technology setup and pack-down were generally straightforward, though some homes suggested longer setup times or RM presence on the first day of data collection, while a minority of homes requested significantly higher physical presence to ‘go live’.
- **System usability:** The SDMS platform was frequently described as difficult to use, with some staff viewing certain breach alerts (e.g. pet names, religious references) as unnecessary.

Each participating RACH received 2 reports as part of the formal feedback mechanisms:

- A descriptive feedback report that provided RACH level de-identified care time data by staff role and AN-ACC Class.
- A more detailed Insights Report that provided de-identified aggregated care time and cost data across all participating RACCC 2024–25 RACHs.

Data preparation and costing methodology

This Chapter describes the data preparation and costing methodology applied in the RACCC 2024–25. It outlines the business rules, data sources and processes used to convert time and financial data into cost estimates aligned with the AN-ACC funding model. It summarises the key inputs, cost streams and overhead allocation methods, and explains how data was standardised, validated and indexed to ensure comparability across homes and consistency with the approved Business Rules.

Costing framework and business rules

The RACCC 2024–25 costing methodology was governed by a comprehensive set of Business Rules (refer to Appendix A). These rules guided dataset preparation, expenditure allocation and cost calculation. Key features included:

- a costing structure consisting of 4 expense streams: Care (labour and other resident expenses), Hotel, Accommodation and other expenses, including administration
- defined cost type/categories for reporting and analysis
- allocation methodology for each cost type, including the required metrics used to allocate expenditures to each cost bucket ('products').

The costing was undertaken using PowerHealth Solutions (PHS) costing engine PowerPerformance Manager (PPM). **Figure 8** shows the end-to-end process from input data to final cost outputs.

Inputs for the costing process

2 main data sources informed the costing process:

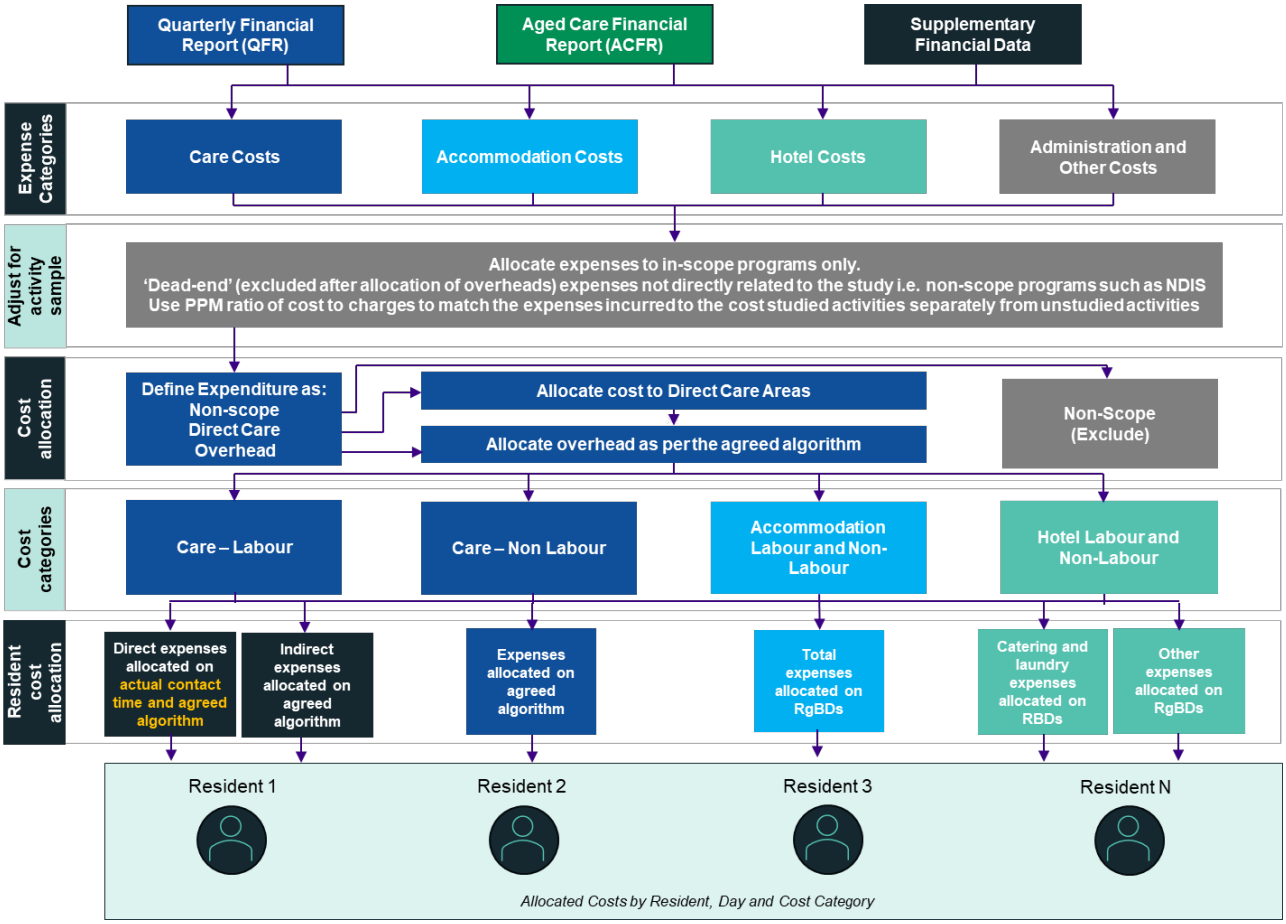
1. **time data** collected in real-time from Bluetooth enabled cards and beacons
2. **financial data** from the QFR and the ACFR.

Time data from homes

4 categories of time data were included:

- **Direct time**, which was a combination of 2 components:
  - *Card time:* captured by in-scope staff resources using the Bluetooth enabled cards (i.e. data collected by staff wearing cards when interacting with residents who participated in the data collection and were also wearing cards) at each home.
  - *Group activities:* data provided by homes on group activities provided to residents.
- **Indirect time,** which was a combination of:
  - *Location beacons:* staff time collected by beacons placed in areas where staff undertook activities relating to residents (e.g. clinical notes, booking appointments), but the resident was not present. Location beacons were not used at all homes.
  - *Unallocated time:* the difference between the adjusted roster time (adjusted to reflect residents who opted out or were excluded due to data quality) and the sum of direct and indirect time.

Figure 8: High level flow diagram of the costing methodology



Source: RACCC 2024–25 Business Rules to Support the Costing Process, dated 16 May 2025 (Appendix A)

Financial data

Financial inputs were sourced from the QFR and the ACFR submitted by RACHs to the Department of Health, Disability and Ageing (DHDA) and provided to the Consortium by IHACPA. These datasets formed the foundation of the financial ledger used for the RACCC 2024–25 costing process.

- **QFR:** The QFR provided quarterly information on direct care labour costs and worked hours by workforce category. For RACCC 2024–25, QFR quarter 2 (Q2) 2024–25 (1 October – 31 December 2024) was used. Only one quarter's data was used to fully reflect the changes in requirements on the residential aged care sector that applied from 1 October 2024, especially for minutes of care. No indexation was applied to QFR data as it already reflected 2024–25 financial year values.
- **ACFR:** The ACFR 2023–24 supplied broader financial information, including non-labour and overhead expenses (e.g. Accommodation, Hotel and Administration costs) required to complete the cost base. While the ACFR reporting period did not coincide with the cost data collection period, it was the most recent full-year dataset that had been quality assured by the DHDA and provided to IHACPA. To approximate alignment with QFR Q2 2024–25, ACFR data were indexed to current-year dollar values using a 3.03% Wage Price Index (WPI) for labour components and a 2.31% Consumer Price Index (CPI) for non-labour components, consistent with the approved Business Rules.

The 2 datasets were combined in line with IHACPA's principle of only using finalised, quality-assured financial data. Linear scaling by resident bed days (RBDs) and application of indexation adjustments were undertaken to approximate alignment with each home's cost collection period. Although the ACFR period was not time-matched to the data collection window, this approach provided a consistent basis for estimating total costs during the costing period.

Misalignment between activity data and the QFR and ACFR data was unavoidable. After consideration, some adjustments were not applied for 2 reasons:

1. corrective adjustments risked introducing greater error given the limited evidence available within the cost collection scope.
2. data anomalies were mainly evident at detailed levels, while aggregate results remained robust. In cases where timing or structural differences could not be reliably reconciled, 11 RACHs were excluded from the final dataset analysed and presented in this report to preserve data integrity and comparability across the collection.

Defined cost streams

The costing methodology was based on the need to understand cost structures associated with the AN-ACC funding model, particularly the need to identify the following categories of expenditure at the registered bed day (RgBD) level:

- **Care costs:** includes labour (split between direct care, provided by staff in contact with a resident; and indirect care, such as capturing clinical notes and phoning family members) and resident expenses. COVID-related costs were included in Care costs.
- **Hotel costs:** includes expenses such as cleaning, catering, laundry, etc.
- **Accommodation costs:** includes expenses such as labour, depreciation and maintenance related to the physical home.
- **Administration expenses:** includes corporate recharges, insurance, quality, etc. These were classed as overheads and allocated across the 3 streams (Care, Hotel and Accommodation) via the agreed basis of allocation as outlined in Section 4.4.

Care costs, especially labour, represent the highest proportional spend in the aged care sector. Therefore, for presentation purposes, Care costs have been subdivided into the 2 following categories:

- **Care – Labour costs:** relating only to the labour component of Care costs.
- **Care – Non-labour costs:** relating to all other Care costs that are not labour.

Allocation of overhead costs

Overhead allocation followed the RACCS 2023 approach for comparability:

- Corporate recharges were apportioned to Care, Hotel and Accommodation streams based on total General Ledger spend within the stream.
- Remaining administrative expenses were evenly split: 50% to Hotel and 50% to Accommodation.

Application of the business rules

The RACCC 2024–25 Business Rules (Appendix A) detailed how data were standardised and indexed to align financial values with the data collection periods. Key steps included:

- **Indexing financial data:** applying the WPI to labour costs and the CPI to non-labour costs (ACFR 2022–23). No indexation was applied to QFR Q2 2024–25 data.
- **Scaling costs:** adjusting to match each home's data-collection days (i.e. RBDs).
- **Preparing time data:** cleaning resident and staff records, allocating indirect, group and unallocated time, adjusting for opt-outs, and applying day/night splits.
- **Applying cost allocations:** matching expenditure to time data and distributing overheads as per agreed methods.

Data suppression and exclusions

Suppression: Consistent with IHACPA policy, data for any category with fewer than 5 residents or homes (e.g. AN-ACC Class, Modified Monash Model (MMM), BCT group) were excluded to maintain anonymity and therefore are not presented in this report.

Exclusions: A total of 12 homes were excluded from analysis: one RACH prior to costing due to unresolved data quality issues and 11 RACHs following validation because their financial data (available ACFR and QFR) could not be reliably aligned to the cost collection period.

Interpretation of data included in this report

Dataset overview

The final costed dataset comprised data from 188 homes, 12,537 unique residents and 355,830 days of care. During the data collection period, 256 residents (2.0%) changed AN-ACC Classification, resulting in 12,794 unique care encounters across the 188 homes.

Throughout this report, references to residents exclude those who opted out of data collection or were excluded due to data quality issues.

Key definitions

- **Encounter:** A record for each unique resident and AN-ACC Classification combination. If a resident's AN-ACC Classification remained consistent throughout the data collection period, they have one encounter; if it changed, they may have 2 or more encounters recorded.
- **Resident Bed Days (RBDs):** The total number of days a participating resident was present at the RACH during the data collection period. Days when the resident was on leave (for example, in hospital, on social leave or other absences) are excluded.
- **Registered Bed Days (RgBDs):** The total number of days a bed was registered as occupied, including both days when the resident was present and days when they were temporarily on leave. This measure reflects the period during which Accommodation and Hotel costs continue to be incurred.

Attribution of bed days

Where a resident changed AN-ACC Classification during the data collection period, their bed days were attributed to the relevant AN-ACC Class for each day. This ensures that both time and cost analyses accurately reflect changes in resident expected daily resource use.

Analytic conventions

- For care time analyses, results are expressed per RBD, representing only days when the resident was present at the RACH.
- For cost analyses, results are expressed per RgBD, which includes both occupied and leave days as Accommodation and Hotel costs continue to be incurred during resident absences.
- When calculating the average daily cost per RgBD by AN-ACC Class, the applicable RgBDs for each resident within each Class were applied to determine Class-specific averages.

Overview of participating RACHs

This Chapter presents the characteristics of the RACCC 2024–25 sample.

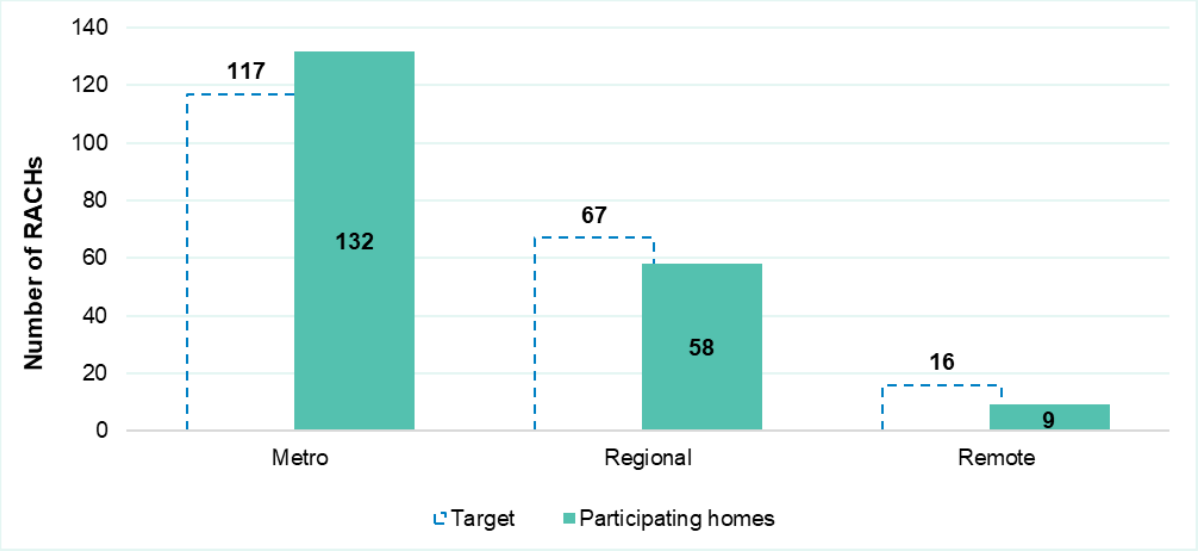
The data presented in this Chapter relates to 199 RACHs and reflects the total number of RACHs from which data were collected during RACCC 2024–25.

Location of participating RACHs

Location was a primary selection criterion with homes grouped into 3 geographical location categories: *'metropolitan', 'regional' and 'remote'*. Location was further grouped by remoteness using the Modified Monash Model (MMM). While widely used, the MMM has recognised limitations and some locations may receive classifications that do not fully reflect their local geographic or service access characteristics.[11]

Figure 9 shows the breakdown of RACHs by location. Although the number of remote homes fell short of the target, over-sampling ensured the dataset remained representative. A breakdown is provided in **Table 4** (Chapter 2). Further analysis is provided in Appendix H.

Figure 9: Number of RACHs by location



Source: HealthConsult sampling framework (2024-2025); RACCC 2024–25 Final dataset

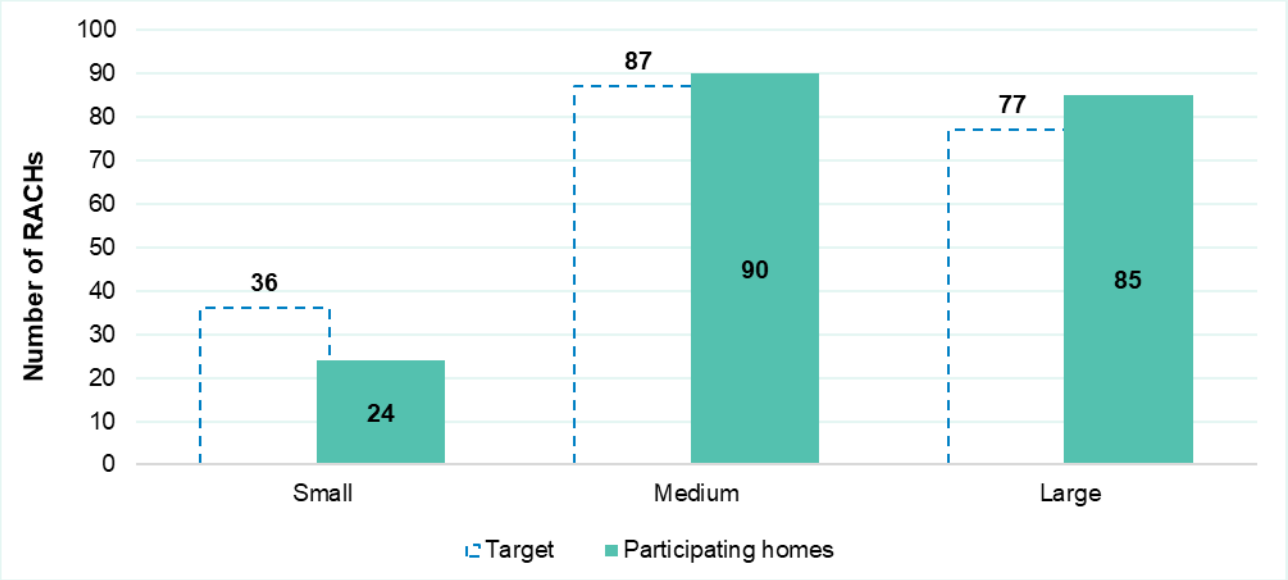
Size of participating RACHs

RACH size was a primary selection criterion, with 3 groups based on the number of operational beds: small (up to 30 beds), medium (31-89 beds) and large (90 beds or more). These size categories are applied consistently throughout this report. **Figure 10** shows that the number of medium and large RACHs exceeded the sample target. Although the number of small RACHs was below the target, the intentional over-sampling

[11] Department of Health, Disability and Ageing. Review of the Remoteness Classification System for Aged Care – Consultation Summary Report. Available from: https://www.health.gov.au/sites/default/files/2025-09/review-of-the-remoteness-classification-system-for-aged-care-consultation-summary-report.pdf

of smaller strata ensured that the proportion of small homes in the sample (12%) exceeded the proportion nationally (9%) (subtotal of all small RACHs in **Table 4**).

Figure 10: Number of RACHs by size

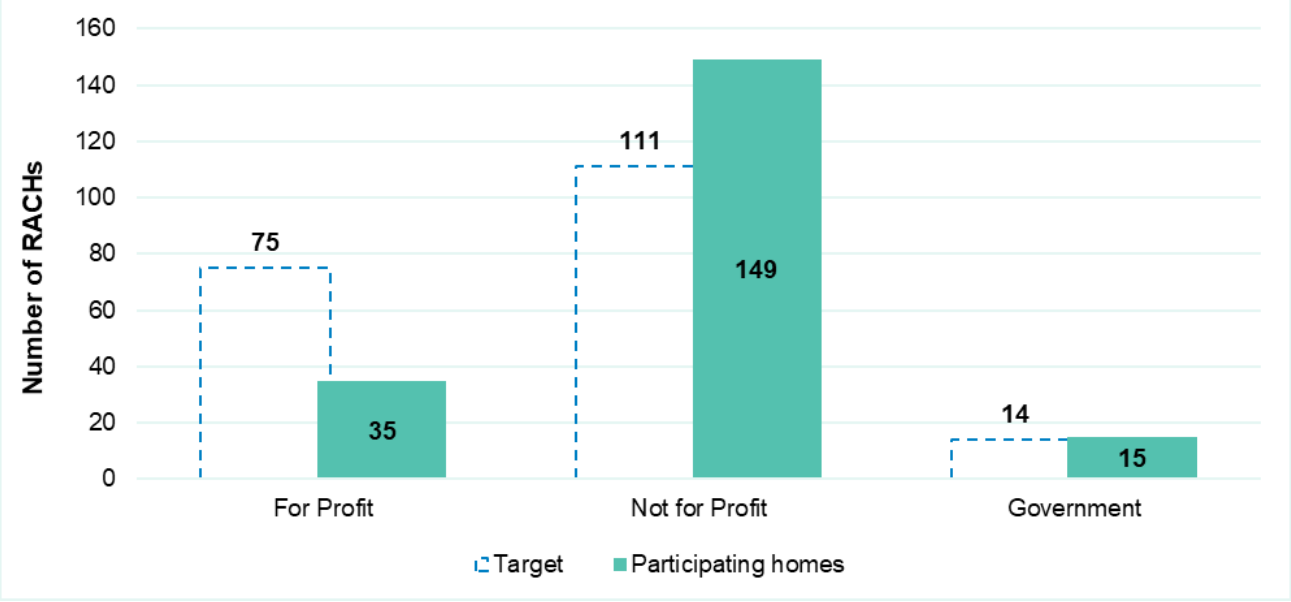


Source: HealthConsult sampling framework (2024-2025); RACCC 2024–25 Final dataset
Note: size groups are defined as: small (up to 30 beds), medium (31-89 beds) and large (90 beds or more).

Ownership type

The final primary selection criterion was ownership type, namely for-profit, not-for-profit and government. **Figure 11** shows that the number of RACHs in the latter 2 categories exceeded the target. The number of for-profit homes was more challenging, with 35 recruited relative to the target of 75. Despite ongoing recruitment efforts and a heavy investment in RMs providing tailored support, resource limitations within for-profit providers appear to have constrained participation.

Figure 11: Number of RACHs by ownership type



Source: HealthConsult sampling framework (2024-2025); RACCC 2024-25 Final dataset

Base Care Tariff

There are 7 Base Care Tariff (BCT) categories under the AN-ACC funding model. The BCT categories current at the time of RACCC 2024–25 are shown in **Table 6**.

Table 6: Base Care Tariffs as 1 November 2025

BCT Category #	BCT category description
BCT 1	Specialised Indigenous, located in MM 7
BCT 2	Specialised Indigenous, located in MM 6
BCT 3	Standard MM 6–7
BCT 4	Standard MM 2–3
BCT 5	Specialised Homelessness Service
BCT 6	Standard MM 1
BCT 7	Standard MM 4-5

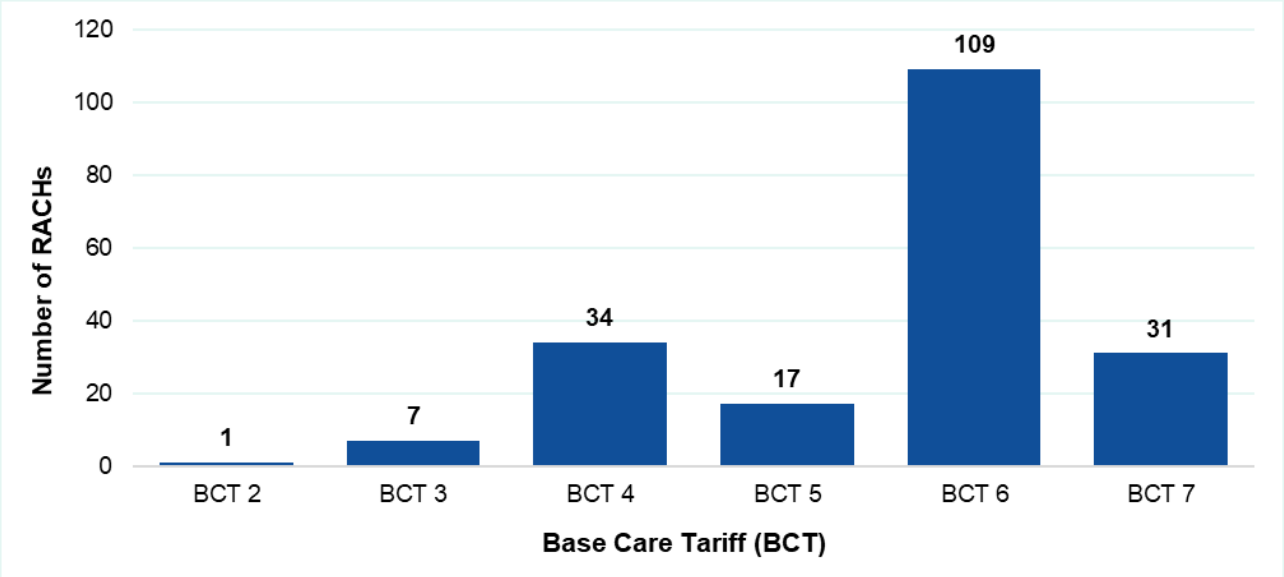
The BCT categories are based on a RACH's Modified Monash (MM) location, MM category and/or specialisation (homeless, remote, very remote, Aboriginal and Torres Strait Islander). RACHs automatically receive a BCT category based on their MM location but must seek DHDA approval to access specialised BCT categories.[12]

Figure 12 shows the number of participating RACHs by BCT. The 199 RACHs represented all BCTs expect BCT 1 (specialised Indigenous, located in MM 7). The most represented group was BCT 6 (standard MM 1) with 109 RACHs (55% of all participating RACHs). Of the categories participating, the least represented was BCT 2 (specialised Indigenous, located in MM 6).

In practice, homes may meet the eligibility criteria for more than one BCT category. A number of homes in RACCC 2024–25 supported a high proportion of Aboriginal and Torres Strait Islander Peoples residents but were classified under the Homelessness BCT category, reflecting shared resident social and demographic characteristics. This overlap illustrates the complexity and intersection of needs within the residential aged care sector rather than misclassification. Similar classification challenges have also been noted in the MMM, where some locations have been identified as receiving classifications that do not always align with local geographic or service access characteristics.[11] The lack of mutual exclusivity between BCT categories suggests a potential for revision or a classification hierarchy to guide allocation when a RACH qualifies for more than one category. Such an approach could also inform future revisions of BCT tariffs.

[12] Australian National Aged Care Classification (AN-ACC) Funding Guide – V1.21, November 2025

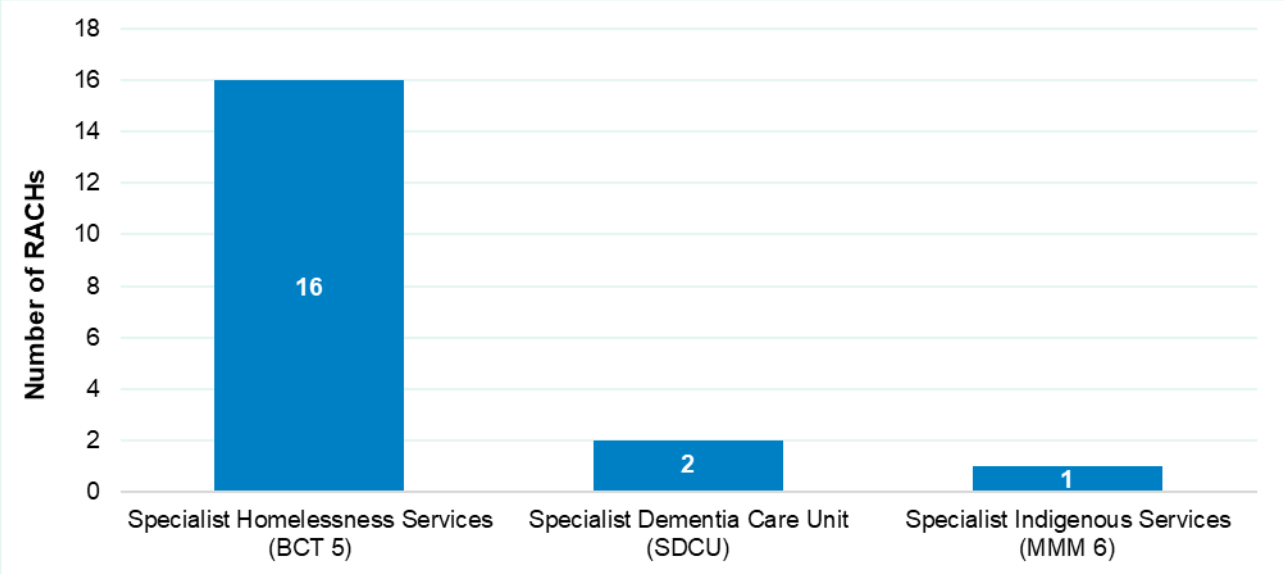
Figure 12: Number of participating RACHs by BCT



Source: HealthConsult sampling framework (2024-2025); RACCC 2024–25 Final dataset
Note: BCT 2 = Specialised Indigenous, located in MM 6; BCT 3 = Standard MM 6–7; BCT 4 = Standard MM 2–3; BCT 5 = Specialised Homeless; BCT 6 = Standard MM 1; BCT 7 = Standard MM 4–5; the final dataset did not include any homes classified as BCT 1 (Specialised Indigenous, located in MM 7).

The **secondary selection criterion** supported representation across all BCT groups, with targeted inclusion of specialised services for Aboriginal and Torres Strait Islander Peoples residents and those experiencing or at risk of homelessness. In total, 19 RACHs (10% of all participating RACHs) belonged to a specialised BCT category (**Figure 13**).

Figure 13: Number of RACHs by specialist category



Source: HealthConsult sampling framework (2024-2025); RACCC 2024–25 Final dataset

Direct care time analysis

This Chapter presents an analysis of direct care time data across key RACH characteristics.

The data in this Chapter is based on:

- 188 RACHs: excluded one RACH prior to costing due to unresolved data quality issues and excluded 11 RACHs during validation because their financial data could not be reliably aligned to the cost collection period.
- **Average care minutes were calculated using resident bed days (RBD) as the denominator**, or days the resident was in care at the RACH (i.e. days of leave were excluded).
- Results in this section reflect measured direct care time from the RACCC 2024–25 data collection and are not equivalent to AN-ACC care-minute targets.

Average direct care minutes by AN-ACC Class

AN-ACC Class data was available for 12,352 of the 12,794 care encounters (96.5%) in the costed dataset. For residents who changed AN-ACC Class during the collection period, care time was apportioned to the days spent in each Class.

AN-ACC[13] classifies residents based on clinical characteristics, including mobility, function, cognitive impairment, pressure sore risk and other compounding factors. Mobility is the first splitting variable producing 3 main Class groups that are further divided based on the other clinical characteristics. As such, care minutes generally increase across Classes 2 to 3, 4 to 7, and 8 to 13. Class 1 is separately assigned to residents admitted specifically for palliative care.

The 3 respite AN-ACC Classes (101, 102, and 103) are differentiated only by residents' mobility levels. In these Classes, average care minutes increase in line with decreasing mobility.

Figure 14 shows average daily care minutes by AN-ACC Class by staff type.

Key observations include:

- For permanent residents (AN-ACC Classes 2 to 13), average daily care time was **100 minutes**[14], ranging from 50 minutes in Class 2 to 135 minutes in Class 13.
- For respite residents (AN-ACC Classes 101 to 103), average daily care time was **105 minutes**, ranging from 65 minutes in Class 101 to 130 minutes in Class 103.
- Care workers consistently provided the largest share of total care minutes, followed by RNs, lifestyle staff, ENs and AH staff.
- Average daily minutes generally increased with higher numbered AN-ACC Classes, driven mainly by greater care worker time. For example, care worker minutes rose more than threefold from Class 2 (30 minutes) to Class 13 (103 minutes), while nursing minutes changed only marginally. Class 1 was the exception, reflecting its small sample size (n=14) and distinct palliative care profile.
- AH and other staff accounted for a small proportion of the total minutes for all AN-ACC Classes.

[13] Australian Government Department of Health. Australian National Aged Care Classification (AN-ACC) Reference Manual including AN-ACC Assessment Tool. Publication date: 1 April 2021

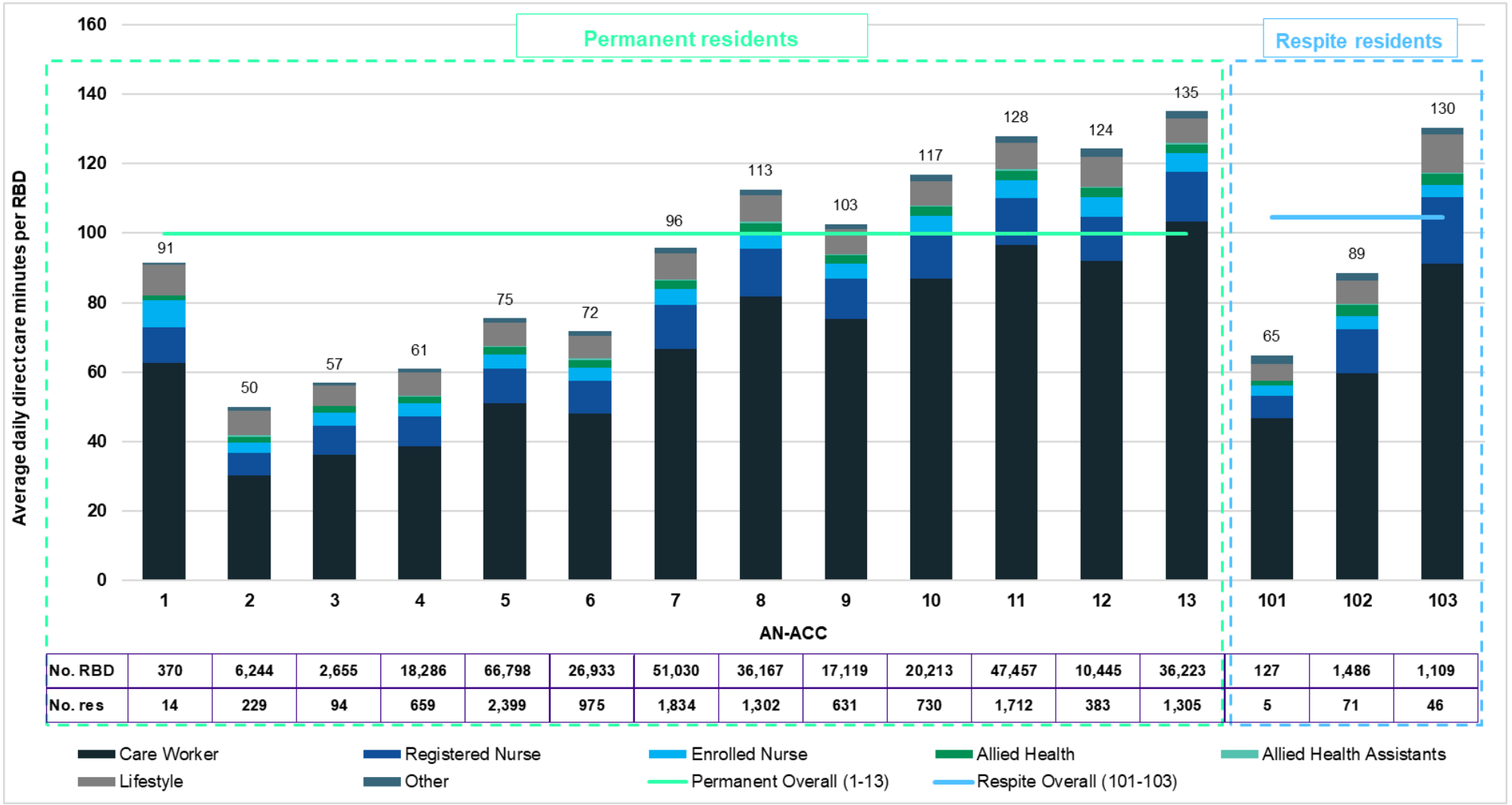
[14] These care minutes are not comparable to the mandatory care minute targets introduced by the Department of Health, Disability and Aged Care on 1 October 2023 as the workforce categories and method of calculating minutes are not aligned.

Figure 15 shows the distribution of average daily minutes across AN-ACC Classes using a box and whisker plot.

Key observations include:

- For both permanent and respite residents, the mean, median, 25th and 75th percentiles of direct daily care minutes generally increase with higher AN-ACC Classes, with Class 1 again the exception.
- Despite the upward trend, there remains a high degree of overlap between Classes, indicating variation in care needs within each level.
- Among permanent residents, Class 8 had the widest range of average daily minutes, while Class 1 had the narrowest.
- Among respite residents, Class 103 had the widest range of average daily minutes, while Class 101 had the narrowest.
- In most Classes, the upper whisker is noticeably longer than the bottom whisker, indicating a substantial number of residents with very high care minutes (far above the Class average).
- Consequently, the mean exceeds the median in all Classes, as a small number of residents with very high care needs lift the average without affecting the median time per RBD.

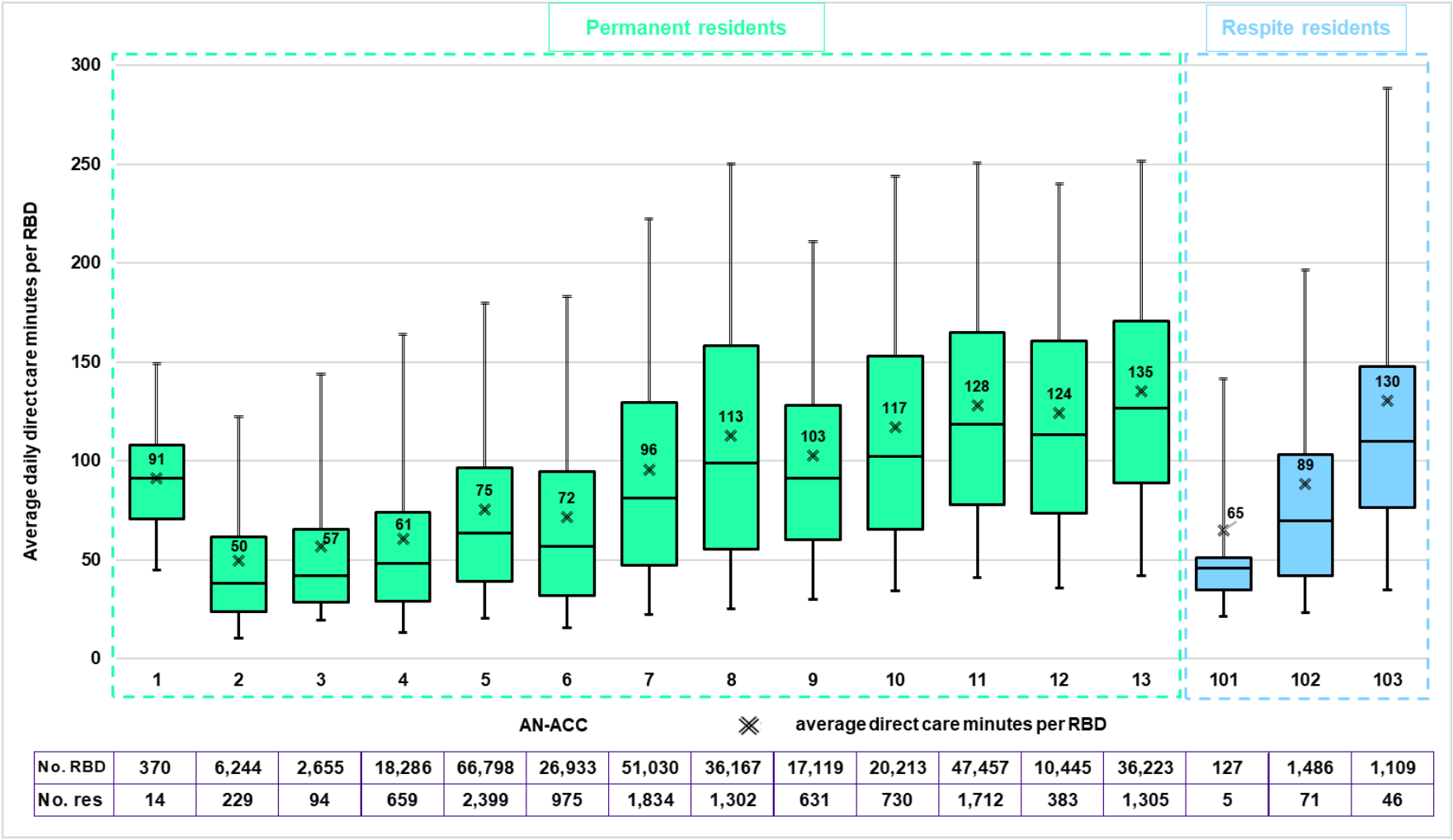
Figure 14: Average direct care minutes per RBD by AN-ACC Class



Source: RACCC 2024–25 Final dataset

Note: Avg Mins = average direct care minutes per resident per day; No. RBD = number of resident bed days; No. res = number of residents; 256 residents (2% of all residents in the final dataset) changed AN-ACC Class at least once during the data collection period; outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity; not classified residents (i.e. did not have an AN-ACC Class) have been excluded.

Figure 15: Box and whisker plot of direct care minutes per RBD by AN-ACC Class



No. RBD	370	6,244	2,655	18,286	66,798	26,933	51,030	36,167	17,119	20,213	47,457	10,445	36,223	127	1,486	1,109
No. res	14	229	94	659	2,399	975	1,834	1,302	631	730	1,712	383	1,305	5	71	46

Source: RACCC 2024–25 Final dataset

Note: No. RBD = number of resident bed days; No. res = number of residents; 256 residents (2% of all residents in the final dataset) changed AN-ACC Class at least once during the data collection period; outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity; not classified residents (i.e. did not have an AN-ACC Class) have been excluded.

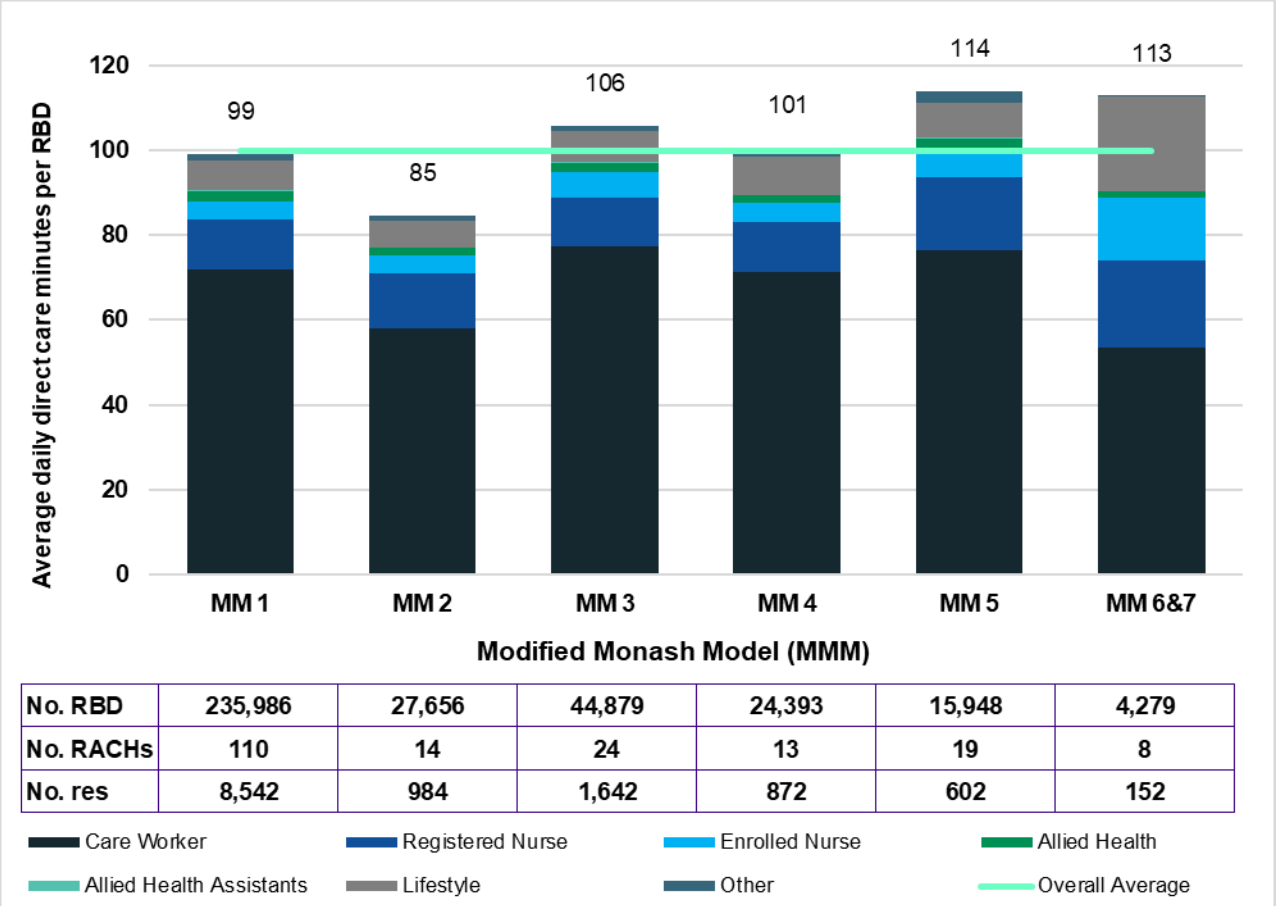
Average direct care minutes by MMM

Figure 16 shows the average number of daily direct care minutes by MMM, by staff category. MM 6 and 7 have been combined due to the small number of homes in these categories.

Key observations include:

- There is no consistent trend in average daily direct care minutes across MMM categories.
- The averages range from 85 minutes in MM 2 locations to 114 minutes in MM 5 locations.
- Regional centres (MM 2) have somewhat lower direct care minutes than the average.
- The composition of direct care minutes by staff category varies by MMM. The proportion of care minutes delivered by nurses and LOs is considerably higher in MM 6 and 7 locations, while the proportion of care minutes delivered by care workers is lower. This may reflect differences in resident profiles or operational practices within RACHs in more remote areas.

Figure 16: Direct care minutes per RBD by MMM and staff role



	MM 1	MM 2	MM 3	MM 4	MM 5	MM 6&7
No. RBD	235,986	27,656	44,879	24,393	15,948	4,279
No. RACHs	110	14	24	13	19	8
No. res	8,542	984	1,642	872	602	152

Source: RACCC 2024–25 Final dataset

Note: Avg Mins = average direct care minutes per resident per day; MM 1 = Metropolitan areas; MM 2 = Regional centres; MM 3 = Large rural towns; MM 4 = Medium rural towns; MM 5 = Small rural towns; MM 6 = Remote communities; MM 7 = Very remote communities; No. RBD = number of resident bed days; No. RACHs = number of residential aged care homes; No. res = number of residents; Outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACH and resident anonymity.

Average direct care minutes by jurisdiction

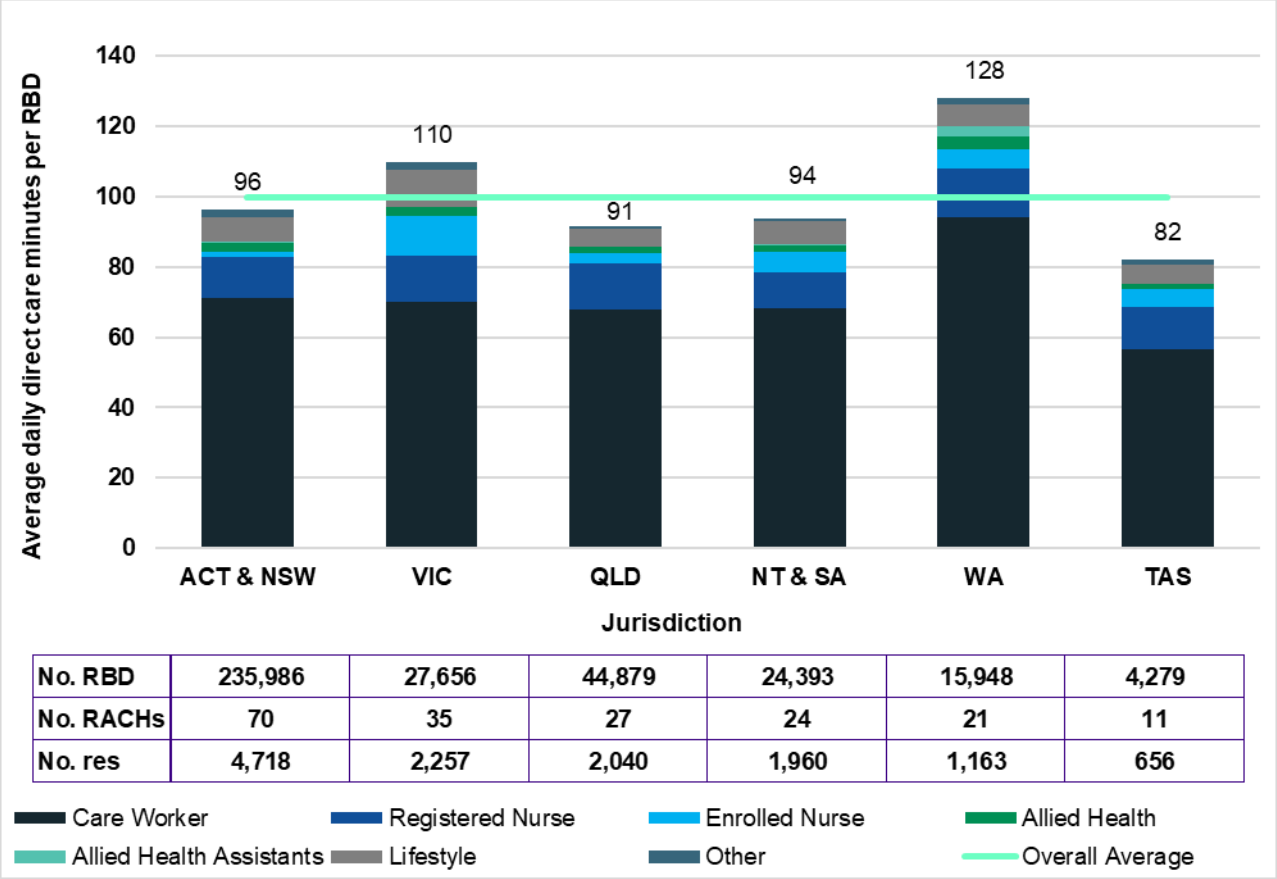
Figure 17 shows the average number of daily direct care minutes by jurisdiction, by staff category. Due to the smaller jurisdiction sample sizes, the ACT has been combined with NSW and the NT with SA.

Key observations include:

- Average daily direct care minutes vary across jurisdictions, ranging from 83 minutes in Tasmania to 128 minutes in Western Australia.
- The average direct care minutes in Western Australia is around 43% higher than the average for Tasmania.
- No consistent pattern is evident across other jurisdictions, with most falling within a relatively narrow range.
- The distribution of staff delivering care minutes is broadly similar across most jurisdictions.

Victoria records a higher proportion of care minutes delivered by ENs compared with other states, reflecting its larger EN workforce.[15] Western Australia was the only jurisdiction with a notable contribution of minutes delivered by allied health assistants.

Figure 17: Direct care minutes per RBD by jurisdiction and staff role



Source: RACCC 2024–25 Final dataset

Note: Avg Mins = average direct care minutes per resident per day; No. RBD = number of resident bed days; No. RACHs = number of residential aged care homes; No. res = number of residents; Outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACH and resident anonymity.

[15] Nursing and Midwifery Board of Australia. 'Nursing and Midwifery Board of Australia Registrant data (April 2025 - June 2025). AHRPA: 2025. Available from: https://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx

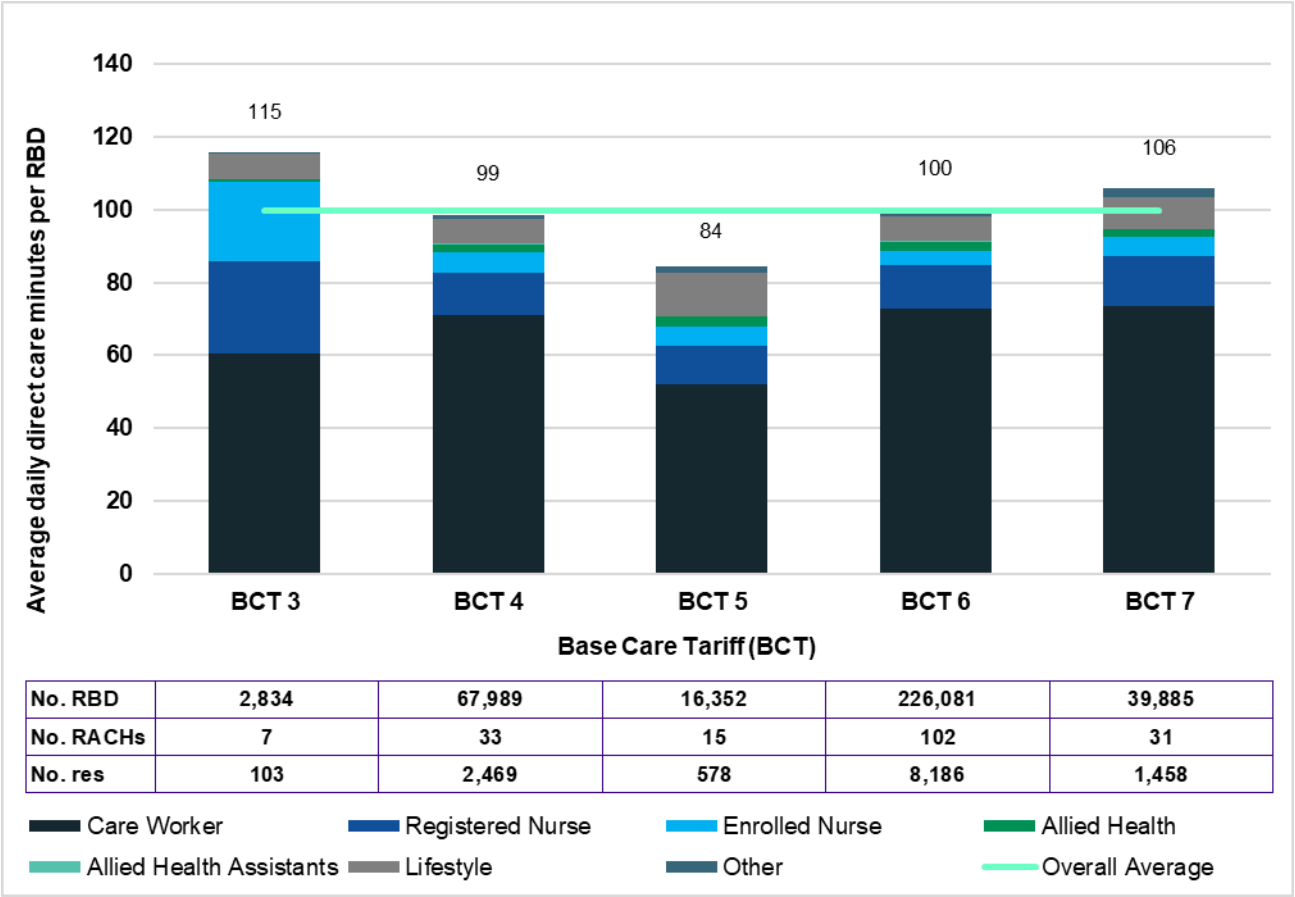
Average direct care minutes by BCT category

Figure 18 presents the average number of daily direct care minutes by BCT, by staff category.

Key observations include:

- Average daily care minutes were broadly consistent across BCT categories, although BCT 5 RACHs had slightly lower averages while BCT 3 RACHs were slightly above the average.
- The lower average at BCT 5 RACHs was mainly due to reduced care worker time.
- The mix of staff delivering care varied by BCT category. BCT 3 RACHs had a higher proportion of care minutes delivered by RNs and ENs, reflecting a greater reliance on clinical staff.
- The higher proportion of nursing time in BCT 3 explains the elevated average daily minutes, as BCT care worker minutes were similar to other categories.

Figure 18: Direct care minutes per RBD by BCT and staff role



	BCT 3	BCT 4	BCT 5	BCT 6	BCT 7
No. RBD	2,834	67,989	16,352	226,081	39,885
No. RACHs	7	33	15	102	31
No. res	103	2,469	578	8,186	1,458

Source: RACCC 2024–25 Final dataset

Note: Avg Mins = average direct care minutes per resident per day; Base Care Tariff (BCT) 3 = Standard MM 6–7; BCT 4 = Standard MM 2–3; BCT 5 = Specialised Homelessness; BCT 6 = Standard MM 1; BCT 7 = Standard MM 4–5; No. RBD = number of resident bed days; No. RACHs = number of residential aged care homes; No. res = number of residents; the final dataset with 188 RACHs did not include any homes classified as BCT 1 (Specialised Indigenous, located in MM 7) or BCT 2 (Specialised Indigenous, located in MM 6); Outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACH and resident anonymity.

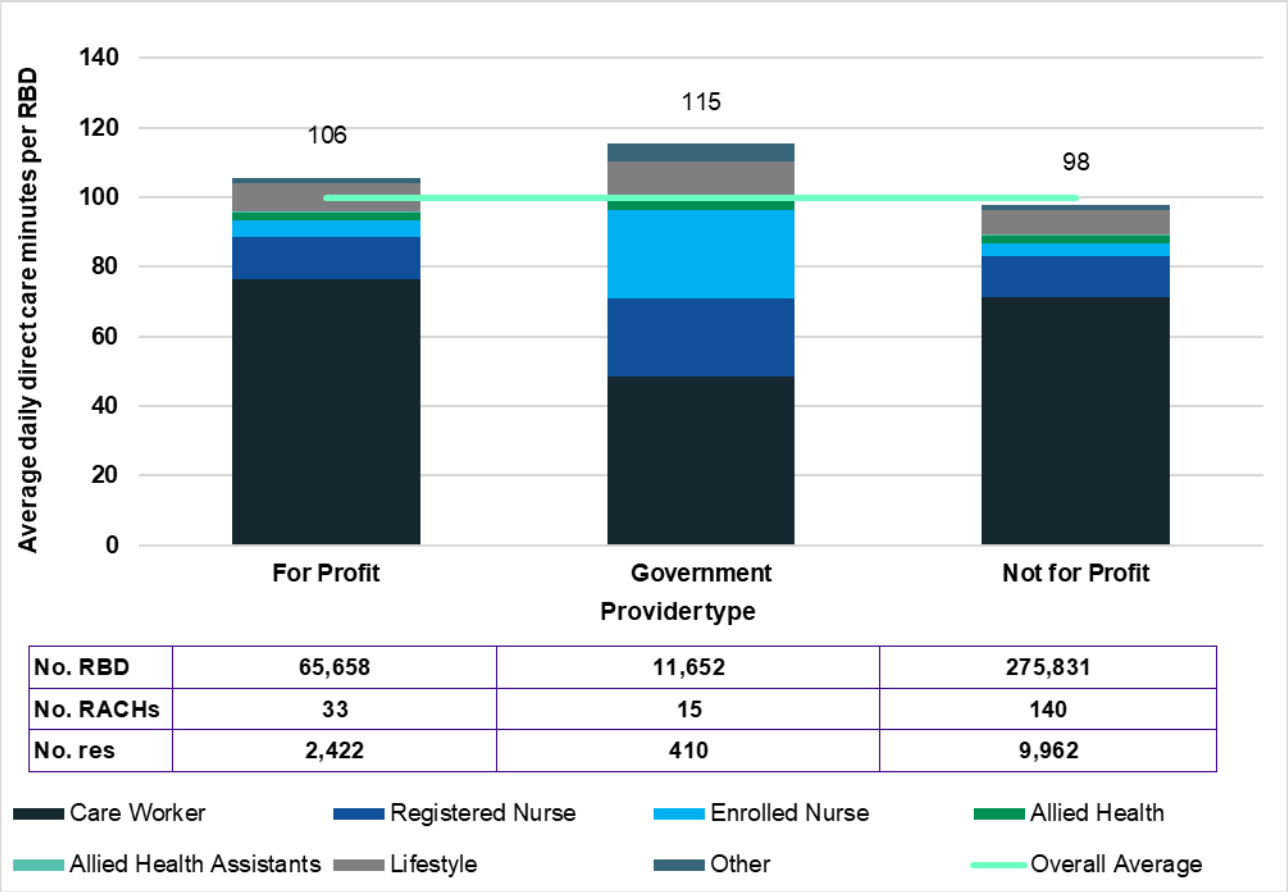
Average direct care minutes by provider type

Figure 19 shows the average number of daily direct care minutes by provider type (for-profit, not-for-profit and government) by staff category.

Key observations include:

- Average daily care minutes ranged from 98 minutes in not-for-profit homes, to 115 minutes in government homes, with 106 minutes in for-profit homes.
- Government providers recorded higher average daily care minutes, while differences between for-profit and not-for-profit homes were small. This likely reflects known differences in the care needs of residents in government RACHs.
- The composition of staff delivering care varied considerably by provider type. In government RACHs, a larger proportion of care minutes was delivered by RNs, ENs and LOs.
- In contrast, for-profit and not-for-profit homes relied more heavily on care workers, with small contributions by nurses and lifestyle staff.
- These differences reflect variations in workforce models, resident profiles and/or operational priorities across provider types.

Figure 19: Direct care minutes per RBD by provider type and staff role



Source: RACCC 2024–25 Final dataset

Note: Avg Mins = average direct care minutes per resident per day; No. RACHs = number of homes; No. RBD = number of resident bed days; No. RACHs = number of residential aged care homes; No. res = number of residents; Outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity.

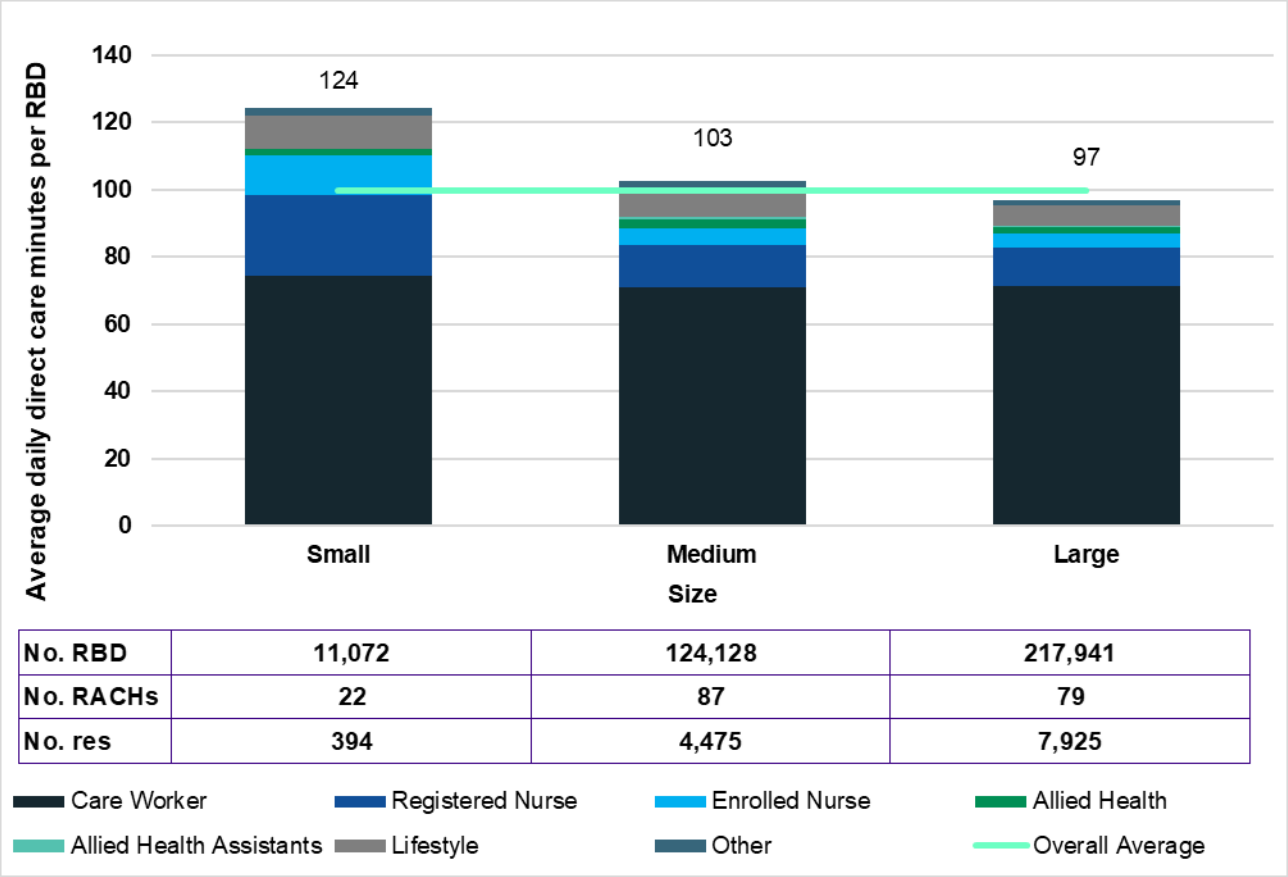
Average direct care minutes by RACH size

Figure 20 shows the average number of daily direct care minutes by RACH size by staff type.

Key observations include:

- Small RACHs provide an average of 124 daily direct care minutes which is substantially higher than medium and large RACHs.
- The amount of care minutes delivered by care workers is very similar regardless of size.
- Generally, small RACHs allocate a marginally greater proportion of care minutes to RNs and ENs compared with medium and large RACHs.
- The remaining staff types make up a small proportion of daily care minutes across all size categories, with most of this time delivered by lifestyle staff.

Figure 20: Daily direct care minutes per RBD by RACH size and staff role



No. RBD	11,072	124,128	217,941
No. RACHs	22	87	79
No. res	394	4,475	7,925

Source: RACCC 2024–25 Final dataset

Note: Avg Mins = average direct care minutes per resident per day; Small = 30 or less operational places; Medium = 31 to 89 operational places; Large = 90 or more operational places; No. RACHs = number of homes; No. RBD = number of resident bed days; No. RACHs = number of residential aged care homes; No. res = number of residents; Outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity.

Average direct care minutes by new residents

Under the AN-ACC funding model, RACHs receive a one-off transition payment from the Australian Government when a new resident enters permanent care. This payment is to meet the initial costs associated with transitioning a new resident into care.[16]

This analysis examined variations in the average number of direct care minutes delivered to residents during their first 28 days and 90 days of care, compared with average care time provided to established residents.

Where a resident moved from being in their first 28 or 90 days of care during the data collection period, the days from the respective phase are used to calculate each average.

Residents in first 28 days of care

Figure 21 shows the average daily direct care minutes for residents during their first 28 days of care compared with those who had been in care for a longer period, by AN-ACC Class.

Key observations include:

- Across most AN-ACC Classes, there was minimal variation in average daily direct care minutes between new residents (first 28 days) and longer-term residents.
- Where small differences were observed, such as in Class 10, the overlap in CIs suggests no clear separation between groups.
- Clearer differences were observed in a small number of Classes: 4, 12 and 102 received slightly more direct care minutes in their first 28 days, while those in Class 8 and Class 103 received slightly fewer care minutes.
- Although most variations were small, a general pattern was evident. Higher numbered (need) AN-ACC Classes tended to require more direct care minutes above the average for ongoing care during their first 28 days.

Residents in first 90 days of care

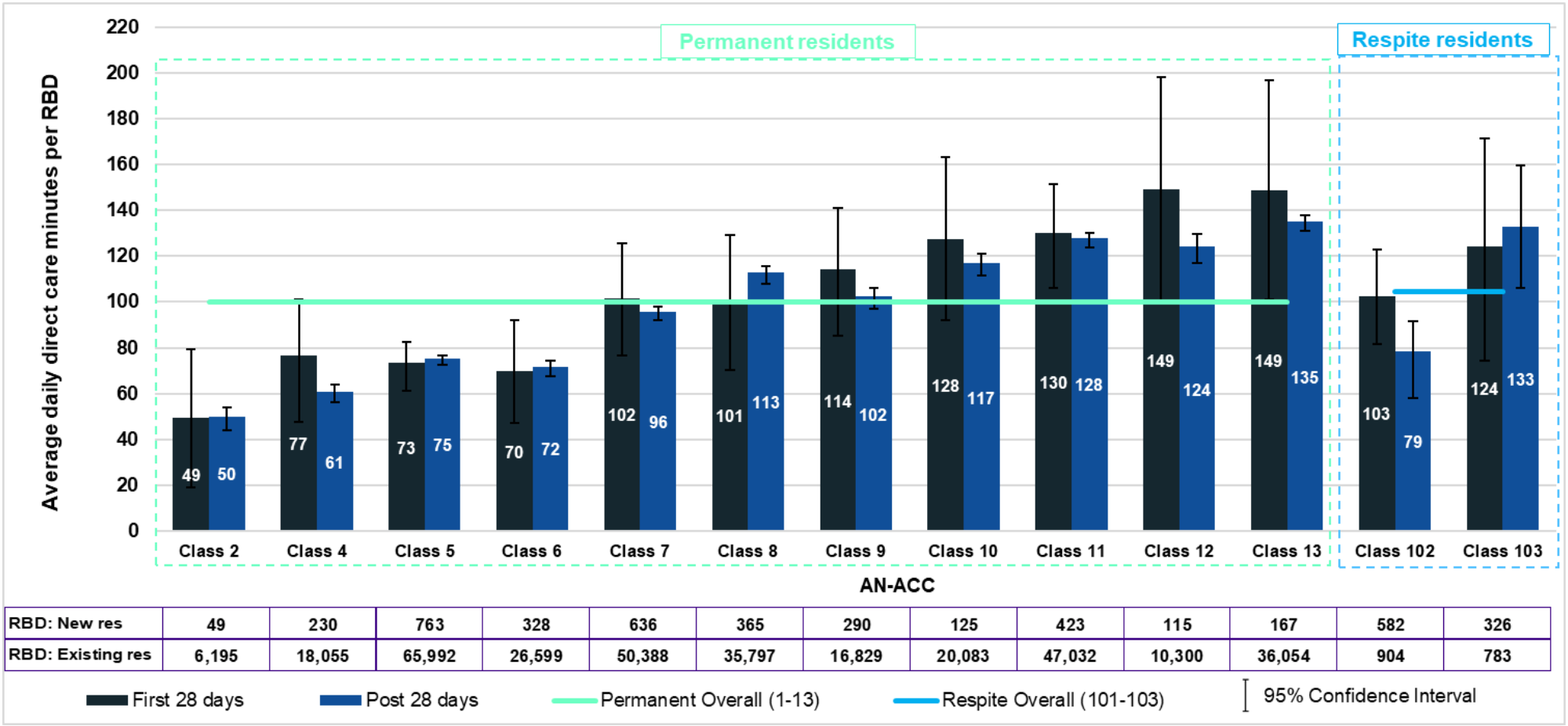
Figure 22 shows the average daily direct care minutes for residents during their first 90 days of care compared with those who had been in care for a longer period, by AN-ACC Class.

Key observations include:

- Consistent with the 28-day analysis, there is minimal variation in average daily direct care minutes between residents in their first 90 days and longer-term residents.
- Where differences are observed, such as in Class 3, these were small and associated with overlapping CIs, indicating no clear separation between groups. Overall, the additional care minutes required above the Class average were more pronounced in the first 28 days of care than in the first 90 days. By 90 days, average daily minutes closely aligned with those of longer-stay residents, indicating that care levels stabilise relatively early after admission. This pattern suggests that transition-related activities are largely incorporated into routine care rather than provided as distinct additional tasks.

[16] Department of Health, Disability and Ageing. 'Subsidy for residential aged care'. Available from: https://www.health.gov.au/our-work/residential-aged-care/funding/subsidy

Figure 21: Direct care minutes per RBD for residents in first 28 days and the post 28 days periods

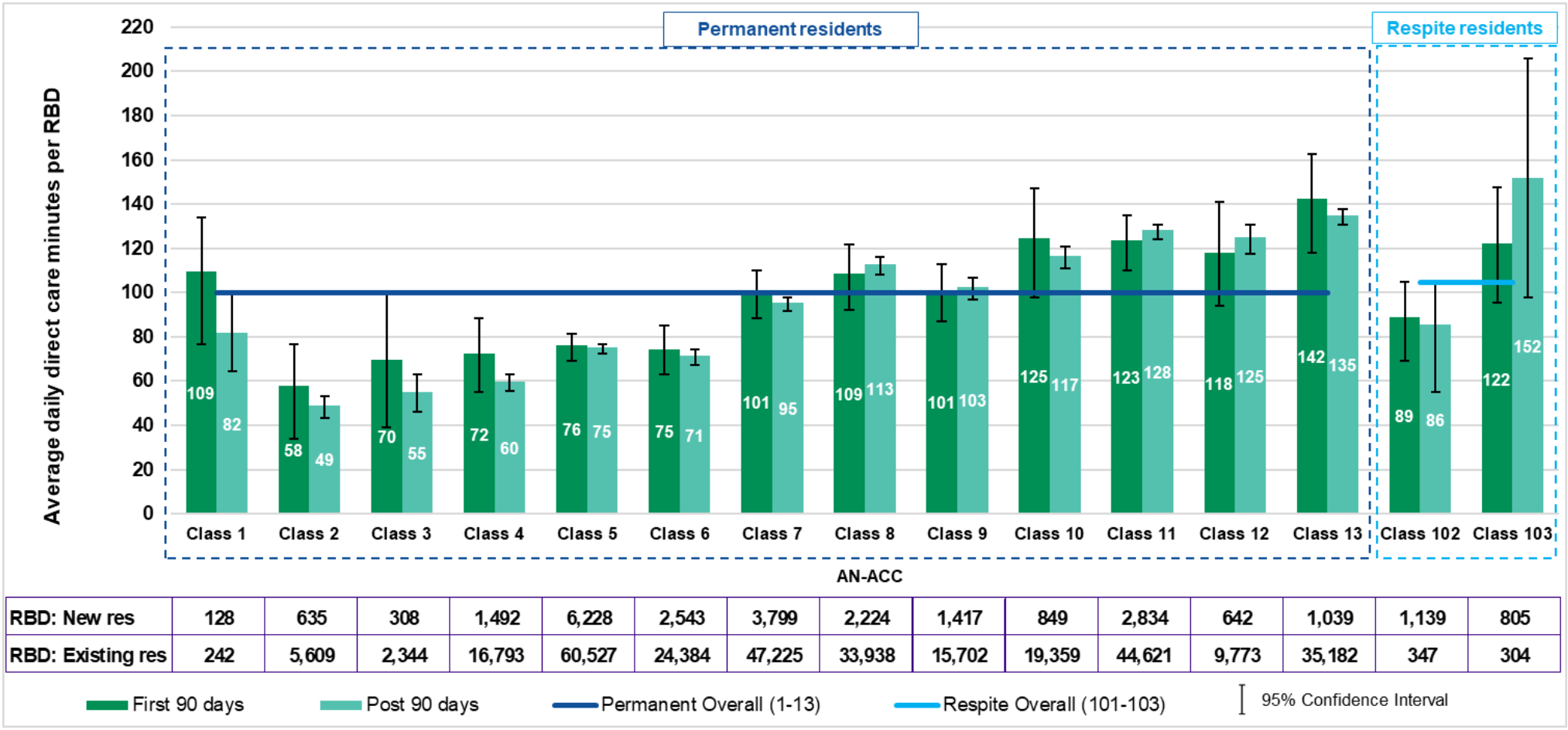


RBD: New res	49	230	763	328	636	365	290	125	423	115	167	582	326
RBD: Existing res	6,195	18,055	65,992	26,599	50,388	35,797	16,829	20,083	47,032	10,300	36,054	904	783

Source: RACCC 2024–25 Final dataset

Note: RBD = registered bed days; RBD: New res refers to the number of bed days for residents within their first 28 days of admission, while RBD: Existing res refers to the number of bed days for residents beyond 28 days, For example, in Class 2, RBD: New residents (RBD New res) = 49 and RBD: Existing residents (RBD: Existing res)= 6,195; AN-ACC Classes with less than 5 residents have been suppressed; however, all residents are included in the overall average cost per RBD presented; 256 residents (2% of all residents in the final dataset) changed AN-ACC Classification at least once during the data collection period; outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity; not classified residents (i.e. did not have an AN-ACC Class) have been excluded.

Figure 22: Direct care minutes for residents in first 90 days and the post 90 days periods



	Class 1	Class 2	Class 3	Class 4	Class 5	Class 6	Class 7	Class 8	Class 9	Class 10	Class 11	Class 12	Class 13	Class 102	Class 103
RBD: New res	128	635	308	1,492	6,228	2,543	3,799	2,224	1,417	849	2,834	642	1,039	1,139	805
RBD: Existing res	242	5,609	2,344	16,793	60,527	24,384	47,225	33,938	15,702	19,359	44,621	9,773	35,182	347	304

Source: RACCC 2024–25 Final dataset

Note: RBD = registered bed days; RBD: New res refers to the number of bed days for residents within their first 90 days of admission, while RBD: Existing res refers to the number of bed days for residents beyond 90 days, For example, in Class 1, RBD: New residents (RBD New res) = 128 and RBD: Existing residents (RBD: Existing res)= 242; AN-ACC Classes with less than 5 residents have been suppressed; however, all residents are included in the overall average cost per RBD presented; 256 residents (2% of all residents in the final dataset) changed AN-ACC Classification at least once during the data collection period; outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity; not classified residents (i.e. did not have an AN-ACC Class) have been excluded.

Cost analysis

This Chapter presents an analysis of RACH costs by key RACH characteristics. The data presented in this chapter is based on:

- 188 RACHs: excluded one home prior to costing due to unresolved data quality issues and 11 RACHs during validation because their financial data could not be reliably aligned to the cost collection period.
- **Cost per bed day is calculated using registered bed days (RgBDs) as the denominator.** This measure includes both occupied and leave days, as some costs (e.g. cleaning, accommodation) continue to be incurred when residents are temporarily absent.

Average daily cost by AN-ACC Class

Overview of costs by AN-ACC Class

Figure 23 shows the average daily cost per RgBD by AN-ACC Class and cost type.

Key observations include:

- Direct costs account for the majority of total expenditure, while overheads represent a comparatively small share.
- Average daily costs increase consistently across the higher numbered AN-ACC classes, reflecting higher resource requirements for residents with greater care needs. Costs range from $354 in Class 2 to $489 in Class 13.
- A similar pattern is observed for respite classes, with average daily costs rising from $381 in Class 101 to $498 in Class 103.
- The 95% CIs reflect uncertainty around the mean estimates and have been calculated using variance estimation that adjusts for clustering of RgBDs within individuals.

Cost composition by expense stream

Figure 24 shows the average daily cost per RgBD by AN-ACC Class and expense stream.

Key observations include:

- Direct care labour is the dominant cost component, representing more than half of total expenditure across all AN-ACC classes.
- Direct care labour costs rise steadily across AN-ACC classes from $170 in Class 2 to $300 in Class 13. This is the primary driver of overall cost differences.
- Hotel costs are the next largest cost and remain broadly consistent across AN-ACC classes, ranging from $86 to $100.
- Accommodation and direct care non-labour costs form a smaller, stable share of total expenditure across classes.
- The average cost for respite classes ($454) is slightly higher than for permanent residents ($430) as shown by the blue and green horizontal reference lines, respectively.

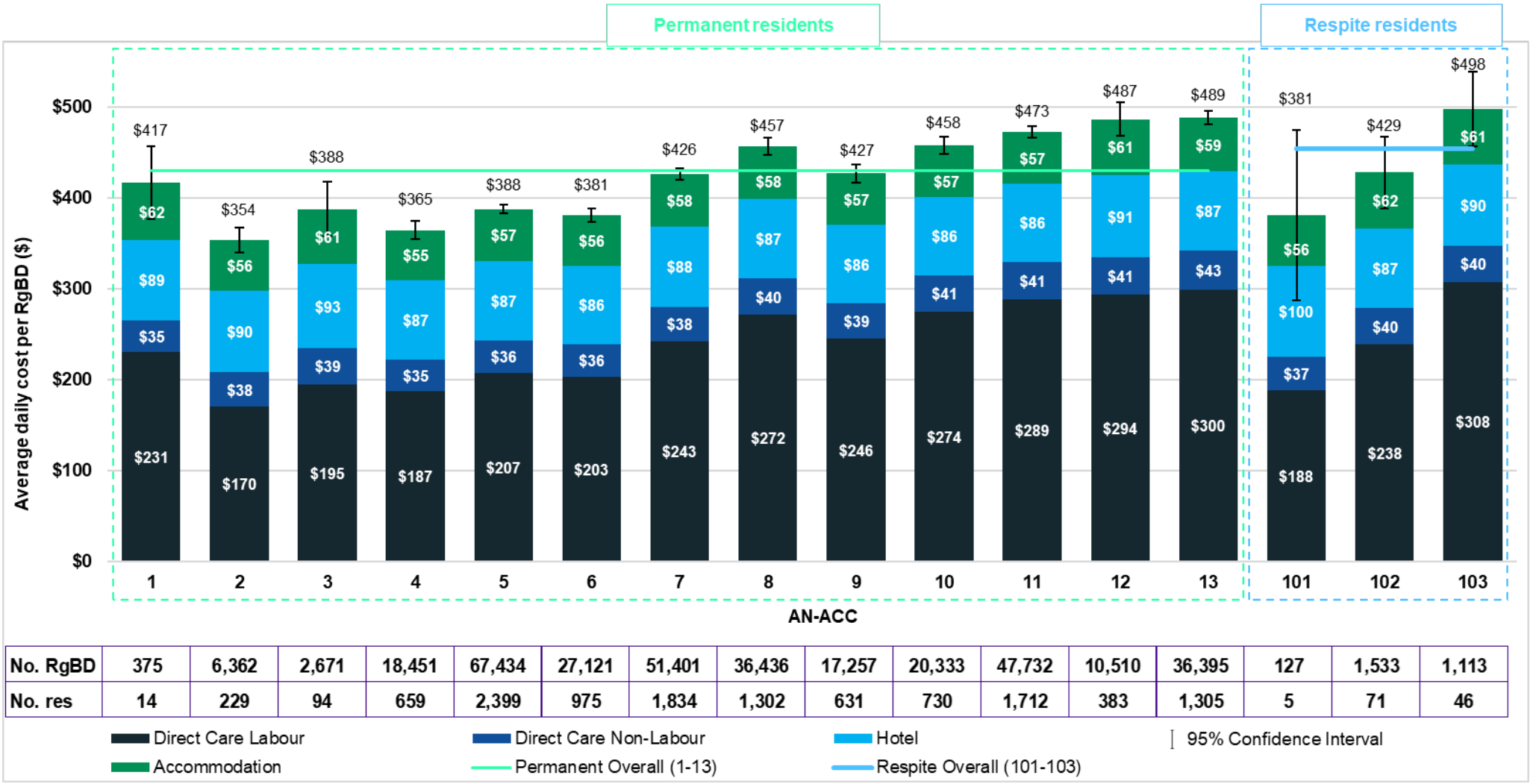
Comparison with RACCS 2023 results by AN-ACC Class

Figure 25 compares the average daily costs by AN-ACC Class between RACCC 2024–25 and RACCS 2023 (using index numbers based on measured cost in each AN-ACC Class divided by the weighted average across all AN-ACC classes to remove the effect of cost escalation).

Key observations include:

- For permanent residents, the spread of the results was narrower in RACCC 2024–25 (0.82 to 1.16, range 0.34) than in RACCS 2023 (0.74 to 1.12, range 0.38), indicating less differentiation across AN-ACC classes in the 2024–25 results.
- RACCC 2024–25 shows a more linear trend of rising costs across the AN-ACC classes, whereas RACCS 2023 exhibited greater fluctuations between classes, particularly Class 3.
- Variation between the studies differ by Class. For example, Classes 8 and 9 show minimal change; while Classes 7 and below showed a relative decrease, and Class 10 and above show an increase in cost per bed day in 2024–25 compared to 2023.
- For respite residents, RACCC 2024–25 shows a significant increase in the relative cost per bed day from 1.00 for Class 102 to 1.16 for Class 103, while RACCS 2023 shows a slight decrease from 1.07 for Class 102 to 1.04 for Class 103.
- Overall, the 2024–25 results demonstrate a stronger and more consistent relationship between AN-ACC Class number and cost (as is intended in the classification design), probably reflecting a larger sample size, improved data quality and greater representation of higher needs residents compared with the smaller RACCS 2023 sample.

Figure 23: Average cost per RgBD by cost type

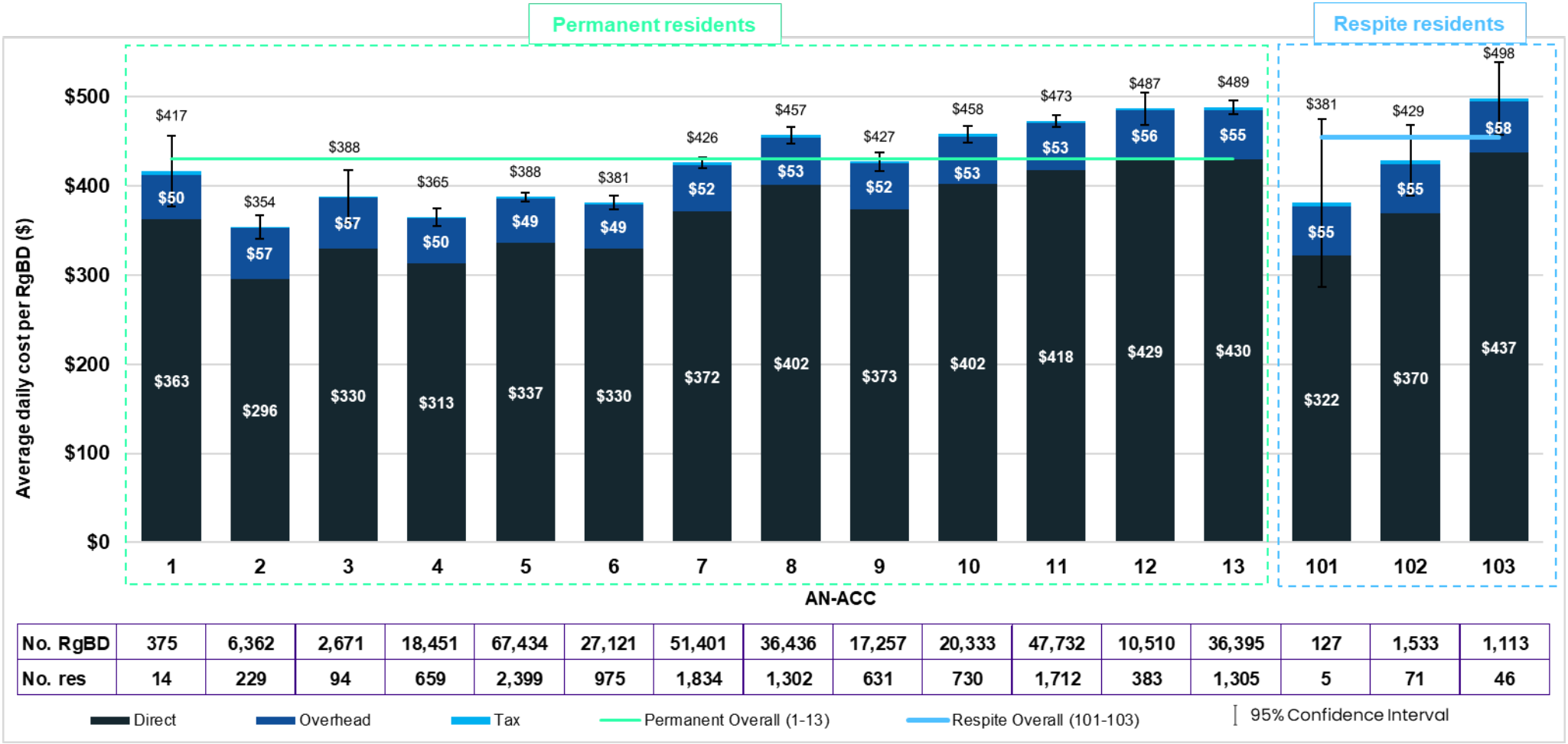


No. RgBD	375	6,362	2,671	18,451	67,434	27,121	51,401	36,436	17,257	20,333	47,732	10,510	36,395	127	1,533	1,113
No. res	14	229	94	659	2,399	975	1,834	1,302	631	730	1,712	383	1,305	5	71	46

Source: RACCC 2024–25 Final dataset

Note: Total = Total average cost per registered bed day (RgBD); No. res = number of residents; some numbers in the above graph may not add due to rounding; 256 residents (2% of all residents in the final dataset) changed AN-ACC Class at least once during the data collection period; outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity; not classified residents (i.e. did not have an AN-ACC Class) have been excluded.

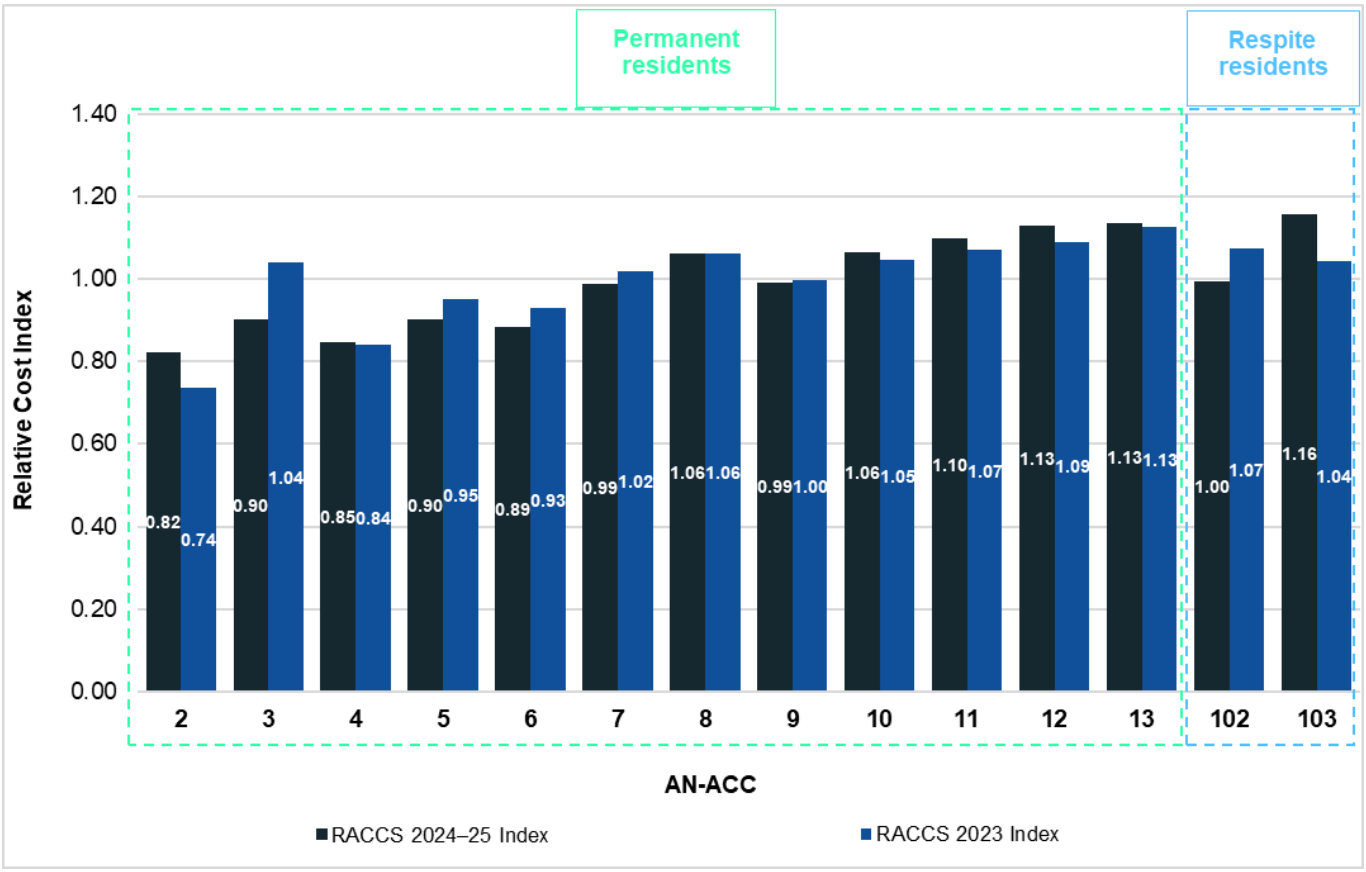
Figure 24: Average cost per RgBD by expense stream



Source: RACCC 2024–25 Final dataset

Note: Total = Total average cost per registered bed day (RgBD); No. res = number of residents; some numbers in the above graph may not add due to rounding; 256 residents (2% of all residents in the final dataset) changed AN-ACC Class at least once during the data collection period; outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity; not classified residents (i.e. did not have an AN-ACC Class) have been excluded.

Figure 25: Cost comparison based on relative index of RACCS 2023 and RACCC 2024–25 by AN-ACC Class



Sources: RACCC 2024–25 Final dataset; RACCS 2023 Final Report
Note: Index values were calculated as Cost ÷ Weighted average for each AN-ACC Class; Weighted averages were calculated as Σ (Cost × Residents) ÷ Σ Residents

Comparison of permanent and respite resident component costs

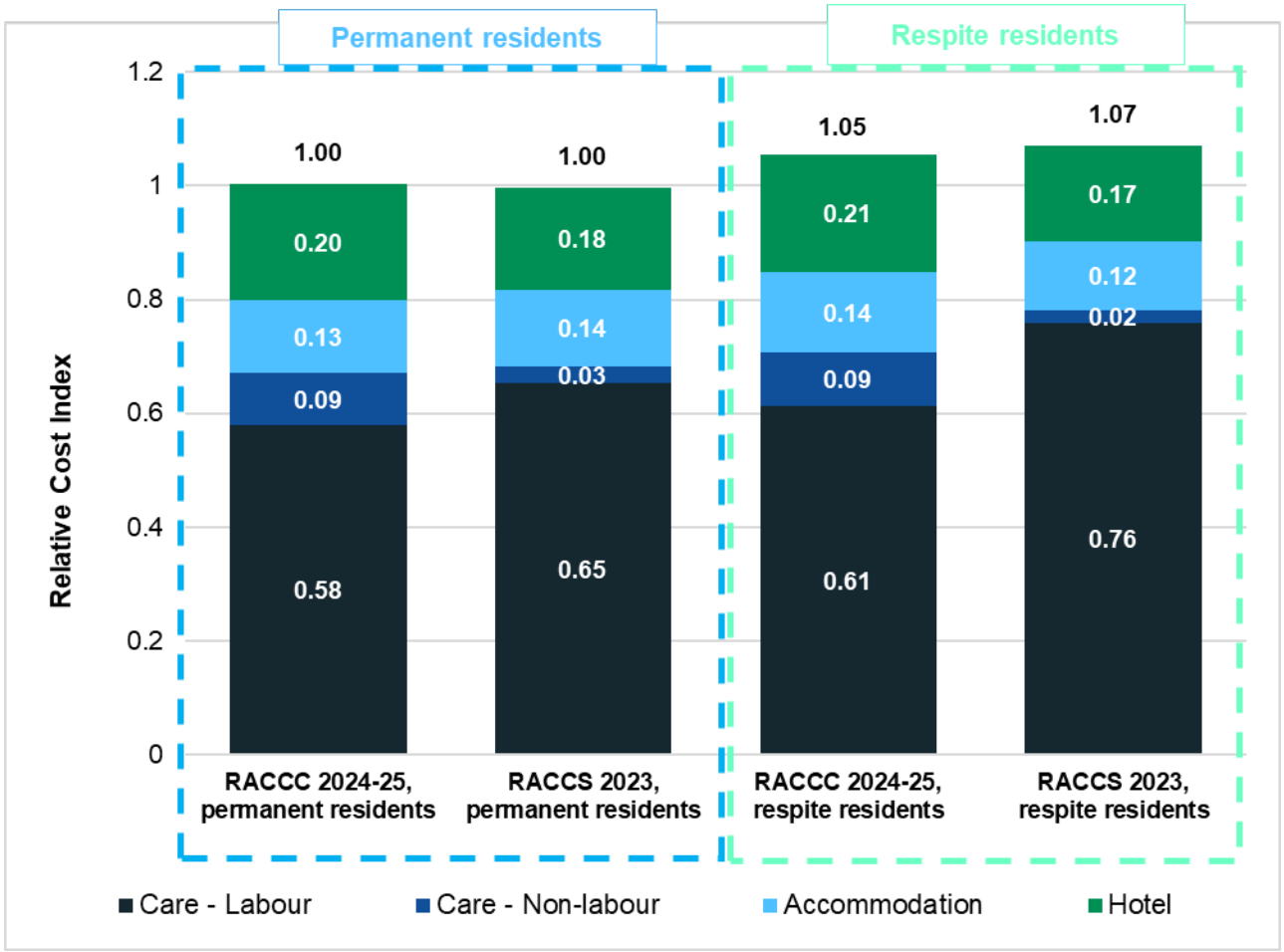
Figure 26 shows a relative index comparison of average daily costs between RACCC 2024–25 and RACCS 2023 by cost component for permanent and respite residents.

Key observations include:

- For **permanent residents,** the care component constituted the highest proportion of costs for both RACCC 2024–25 and RACCS 2023:
  - In 2024–25, care labour accounted for 58% of the cost per bed day, which was lower than the 65% for 2023. When comparing both care components (labour and non-labour) combined, this represents 67% of total bed day cost in 2024–25 and 68% in 2023, which shows a reduction in variation between the 2 datasets. However, the analysis still indicates that care costs were slightly proportionally higher in 2023 than in 2024–25.
  - There is a notable movement in the care non-labour costs between the 2 datasets (3% in 2023 to 9% in 2024–25). This likely reflects a different approach to measuring care labour and care non-labour across the 2 data collections, as when the 2 components are aggregated the variation in care costs as a proportion of total bed day cost is reduced.
  - The proportion of total costs for Accommodation was relatively consistent at 13% for 2024–25 and 14% in 2023.
  - Hotel costs at 20% represented a higher proportion of per bed days cost in 2024–25 than in 2023 (18%).

- Consistently, for **respite residents,** care costs were the highest component of total bed day cost:
  - Care labour represented 58% in 2024–25, which was significantly lower than in 2023 at 71%. When both care components are combined, the variation between the 2 datasets reduces, but care costs still constitute a higher proportion of total bed day costs in 2023 (73%) than in 2024–25 (67%).
  - Again, there is the presence of a notable difference in the non-care labour component (9% in 2024–25 to 2% in 2023), which most likely reflects different approaches to measuring care labour and care non-labour across the 2 datasets.
  - Both Hotel and Accommodation costs were a higher proportion of total bed day cost in 2024–25 (20% and 13% respectively) compared to 2023 (16% and 11% respectively) for respite residents.
- The relativity of permanent (index value of 1.0) to respite (1.07) cost per bed in 2023 was more noticeable than in 2024–25 (1.00 permanent to 1.05 respite residents).

Figure 26: Cost comparison based on relative index between RACCS 2023 and RACCC 2024–25



Sources: RACCC 2024–25 Final dataset, RACCS 2023 report

Note: Index values were calculated as Cost ÷ Weighted average for each AN-ACC Class; each stacked segment (cost stream) was calculated as Cost stream ÷ Weighted average; Weighted averages were calculated as Σ (Cost × Residents) ÷ Σ Residents; Some numbers in the above graph may not add due to rounding; residents not classified have been excluded

Average daily costs by RACH location

This section provides a breakdown of average daily cost based on the following RACH location characteristics: MMM category; Metropolitan, regional, remote; BCT category and jurisdiction.

The sample size for MM 6 and 7 homes was relatively small (n = 8). Within this small cohort, several homes reported disproportionately high levels of expenditure. This has substantially increased the average costs for categories that are influenced by RACH location (MMM[17], BCT, size and ownership) as reported in Sections 7.3 to 7.5. While there may be other contributing factors, it is likely that this cost differential would be less if the sample included additional MM 6 and 7 homes.

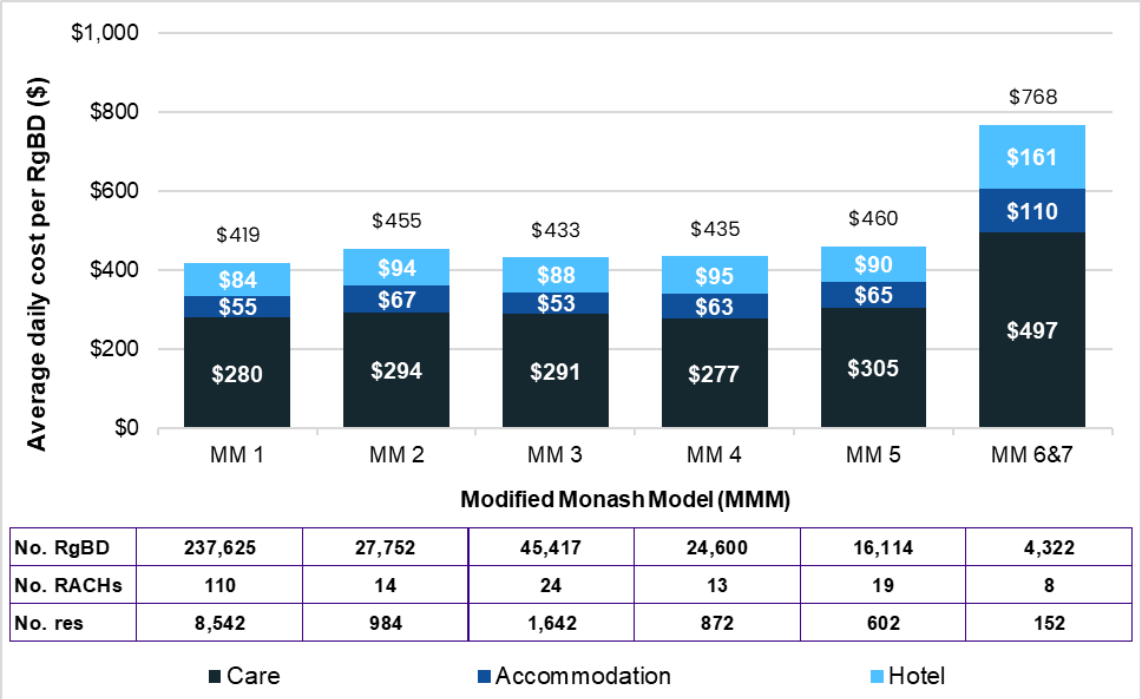
Average daily costs by MMM category

Figure 27 shows the average daily cost by MMM category.

Key observations include:

- The average daily cost ranged from $419 per day in MM 1 to $768 per day in MM 6–7.
- There is less than 10% variation in average daily cost between MM 1 and MM 5 (range from $419 to $460).
- In contrast, average daily costs in MM 6 and 7 ($768) are significantly higher than all other MMM categories.

Figure 27: Cost per RgBD by MMM



	MM 1	MM 2	MM 3	MM 4	MM 5	MM 6&7
No. RgBD	237,625	27,752	45,417	24,600	16,114	4,322
No. RACHs	110	14	24	13	19	8
No. res	8,542	984	1,642	872	602	152

Source: RACCC 2024–25 Final dataset

Note due to the limited spread of the data, confidence intervals are not included in this figure, please refer to Appendix C for full tables MM 1 = Metropolitan areas; MM 2 = Regional centres; MM 3 = Large rural towns; MM 4 = Medium rural towns; MM 5 = Small rural towns; MM 6 = Remote communities; MM 7 = Very remote communities; No. RgBD = number of registered bed days; No. RACHs = number of residential aged care homes; No. res = number of residents. Outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity.

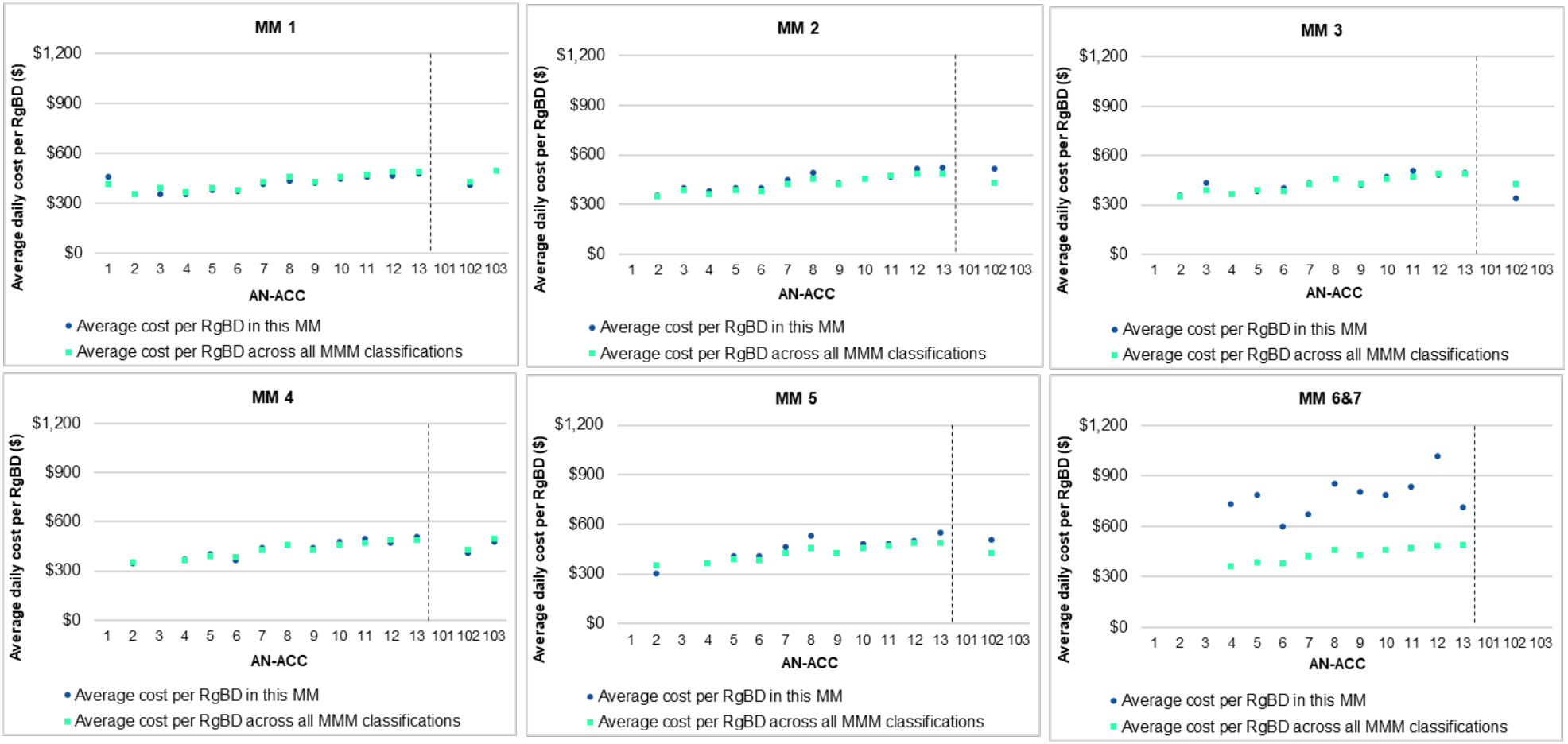
[17] For sampling purposes, MM1–MM2 were classified as metropolitan, MM3–MM5 were classified as regional, and MM6–MM7 were classified as remote.

Figure 28 shows average daily costs by AN-ACC Class and MMM category. The red line in each box shows the cost across all MMM categories, while the second line shows the cost for the specific MMM category.

Key observations include:

- For MM 1 to MM 5, the average costs generally aligns closely with the overall average, ranging across AN-ACC classes from $300 to $600.
- The pattern of average daily cost by AN-ACC Class is very similar across MM 1 to MM 5 locations.
- The pattern of average daily cost by AN-ACC Class in MM 6 is noticeably more volatile.

Figure 28: Average daily cost per RgBD by AN-ACC Class and MMM



Source: RACCC 2024–25 Final Dataset

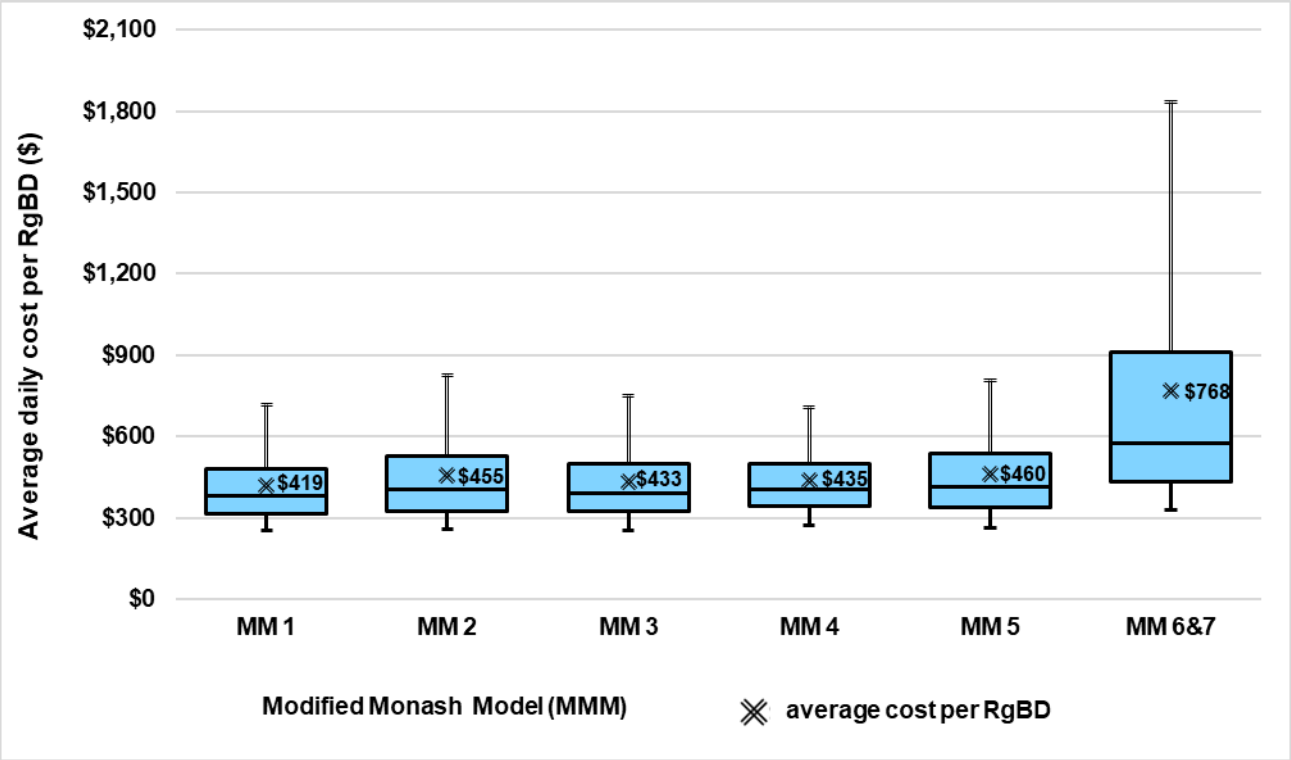
Note: MM 1 = Metropolitan areas; MM 2 = Regional centres; MM 3 = Large rural towns; MM 4 = Medium rural towns; MM 5 = Small rural towns; MM 6 = Remote communities; MM 7 = Very remote communities; Vertical dotted line separates permanent (1–13) and respite (101–103) residents; AN-ACC Classes with fewer than 5 residents in the corresponding MM category have been suppressed; Outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity.

Figure 29 shows the distribution of average daily costs by MMM category.

Key observations include:

- The variation in cost across MM 1 to MM 5 is relatively tight (as indicated by the smaller boxes), indicating consistent cost structures across metropolitan, regional and rural towns.
- In contrast, MM 6 and 7 had extremely high cost variability with a daily cost of more than $1,800 at the 95th percentile.

Figure 29: Distribution of average cost per RgBD by MMM category



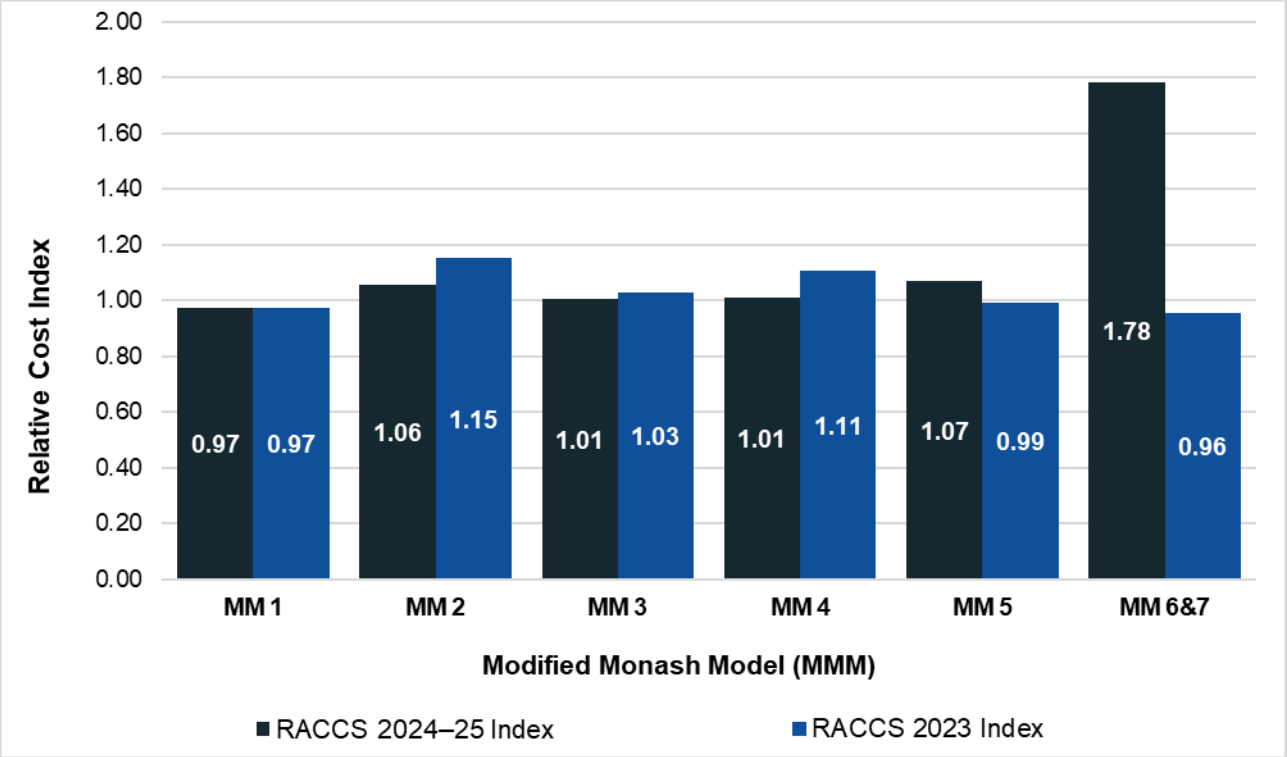
Source: RACCC 2024–25 Final Dataset
Note: MM 1 = Metropolitan areas; MM 2 = Regional centres; MM 3 = Large rural towns; MM 4 = Medium rural towns; MM 5 = Small rural towns; MM 6 = Remote communities; MM 7 = Very remote communities; Number of RACHs: MM 1 n=110; MM 2 n=14; MM 3 n=24; MM 4 n=13; MM 5 n=19; MM 6&7 n=8; outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity.

Figure 30 shows a comparison based on relative index of average daily costs in each MMM category between RACCC 2024–25 and RACCS 2023.

Key observations include:

- For MM 1 and 3, the costs are relative between the 2 datasets. There was a relative decrease in costs for MM 2 and 4 in 2024–25 compared to 2023. Costs showed an increase in MM 5 and MM 6&7.
- The significant increase in MM 6&7 (0.96 in 2023 to 1.78 in 2024–25) reflects the impact of the atypically high cost RACHs in this category (refer to Section Average daily costs by RACH location).

Figure 30: Comparison based on relative index of RACCS 2023 and RACCC 2024–25 by MMM



Sources: RACCC 2024–25 Final dataset; RACCS 2023 Final Report

Note: Index values were calculated as Cost ÷ Weighted average; Weighted averages were calculated as Σ (Cost × Residents) ÷ Σ Residents; MM 1 = Metropolitan areas; MM 2 = Regional centres; MM 3 = Large rural towns; MM 4 = Medium rural towns; MM 5 = Small rural towns; MM 6 = Remote communities; MM 7 = Very remote communities; Number of RACHs (2024-25 data): MM 1 n=110, MM 2 n=14, MM 3 n=24, MM 4 n=13, MM 5 n=19, MM 6&7 n=8; Number of RACHs (2023 data): MM 1 n=69, MM 2 n=12, MM 3 n=6, MM 4 n=7, MM 5 n=14, MM 6&7 n=3

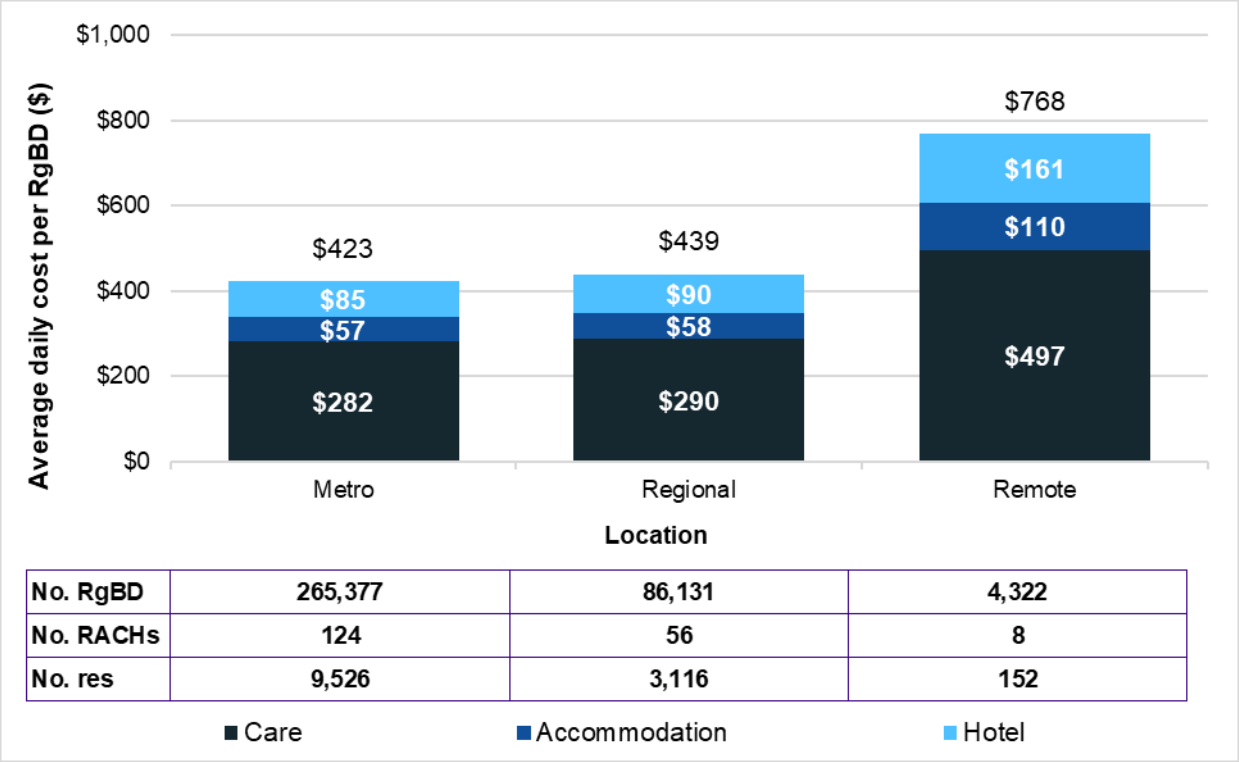
Average daily costs by metropolitan, regional remote location

Figure 31 shows the average daily cost by RACHs in metropolitan, regional and remote locations.

Key observations include:

- While metropolitan and regional homes have very similar average daily costs $423 and $439 respectively, homes in remote locations have a substantially higher average daily cost of $768.
- Again, the significantly higher costs in remote locations reflects the impact of the small group of atypically high costs homes in this category.

Figure 31: Cost per RgBD by location



Source: RACCC 2024–25 Final dataset
Note: due to the limited spread of the data, confidence intervals are not included in this figure, please refer to Appendix C for full tables
No. RgBD = number of registered bed days; No. RACHs = number of residential aged care homes; No. res = number of residents;.
Outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity.

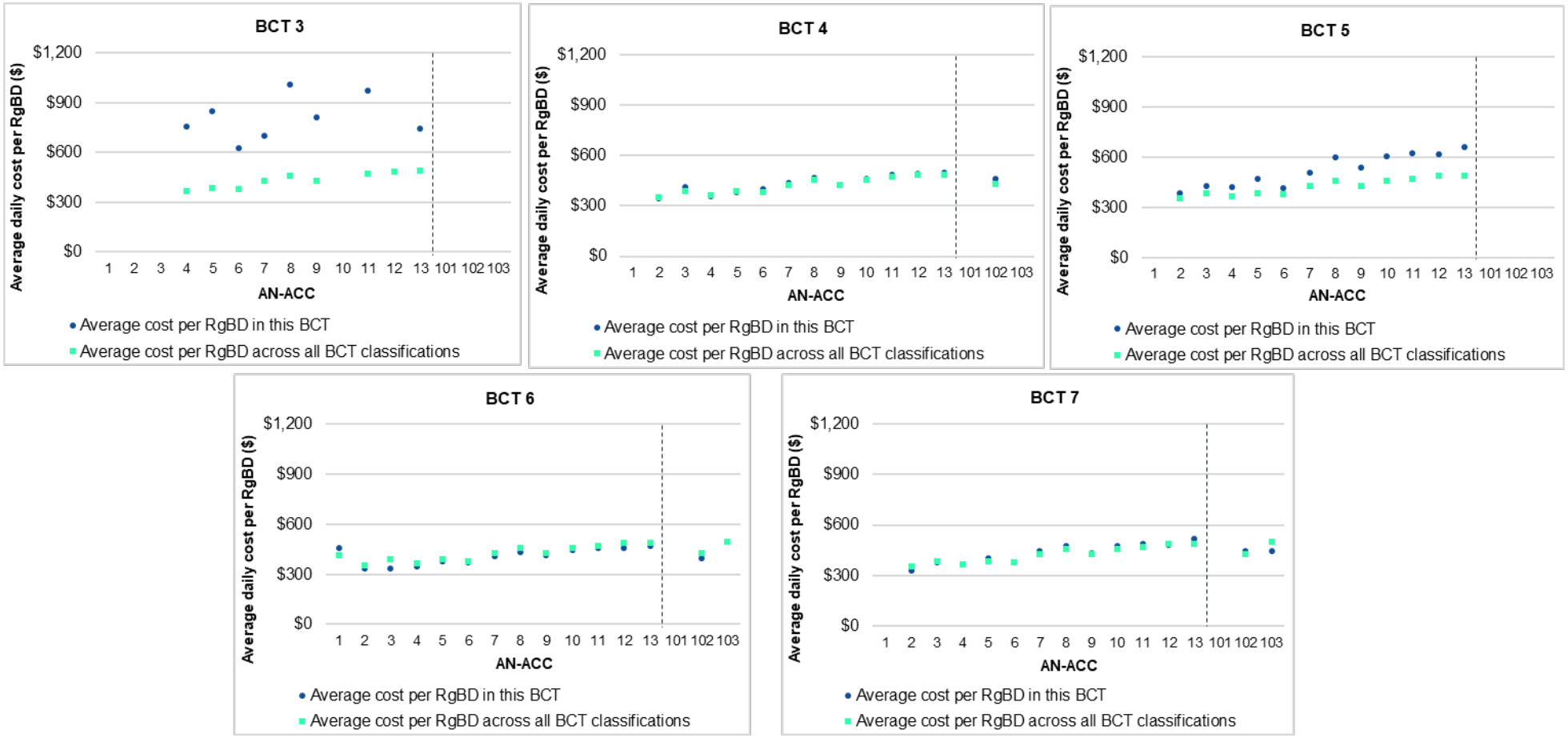
Average daily costs by BCT category

Figure 32 shows the average daily cost by AN-ACC Class and BCT category.

Key observations include:

- BCT categories 4, 6 and 7 are stable and closely aligned with overall averages across AN-ACC Classes.
- BCT 5 shows more variability across AN-ACC Classes and is generally above the overall average.
- BCT 3 shows very high and variable average costs relative to other BCT categories, reaching more than $1,200 per day for AN-ACC Classes 11 and 12. There were 3 homes in BCT 3 that had significantly higher costs per RgBD than other RACHs, which impacted the overall outcome for this BCT.

Figure 32: Average daily cost per RgBD by AN-ACC Class and BCT



Source: RACCC 2024–25 Final Dataset

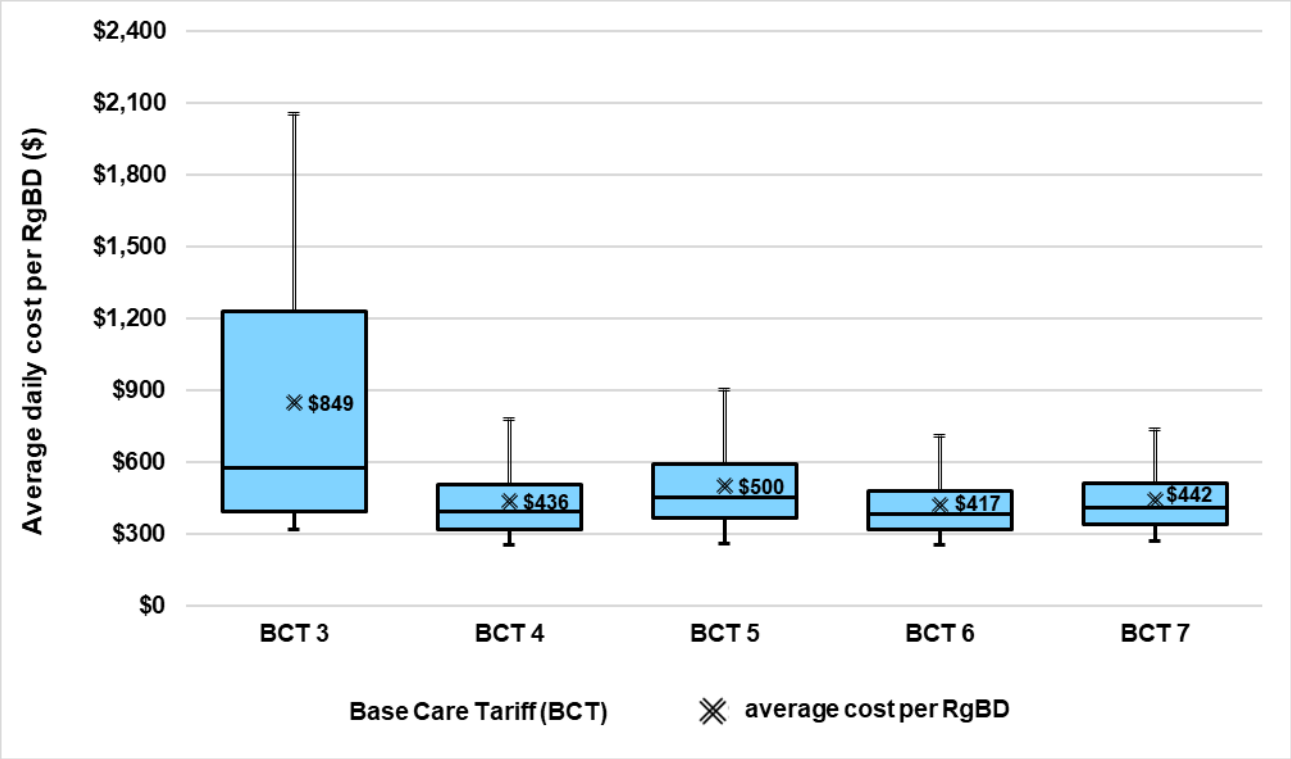
Note: BCT 3 = Standard MM 6–7; BCT 4 = Standard MM 2–3; BCT 5 = Specialised Homeless; BCT 6 = Standard MM 1; BCT 7 = Standard MM 4–5; Vertical dotted line separates permanent (1–13) and respite (101–103) residents; the final dataset with 188 RACHs did not include any homes classified as BCT 1 (Specialised Indigenous, located in MM 7) or BCT 2 (Specialised Indigenous, located in MM 6); AN-ACC Classes with fewer than 5 residents in the corresponding BCT category have been suppressed; Outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity.

Figure 33 shows the distribution of average daily cost by BCT category.

Key observations include:

- The cost distribution across BCT categories 4, 5, 6 and 7 shows low variability, averaging between $417 and $500.
- BCT 3 shows the highest average daily cost and the greatest variability, with daily costs of approximately $2,000.

Figure 33: Distribution of average cost per RgBD by BCT category



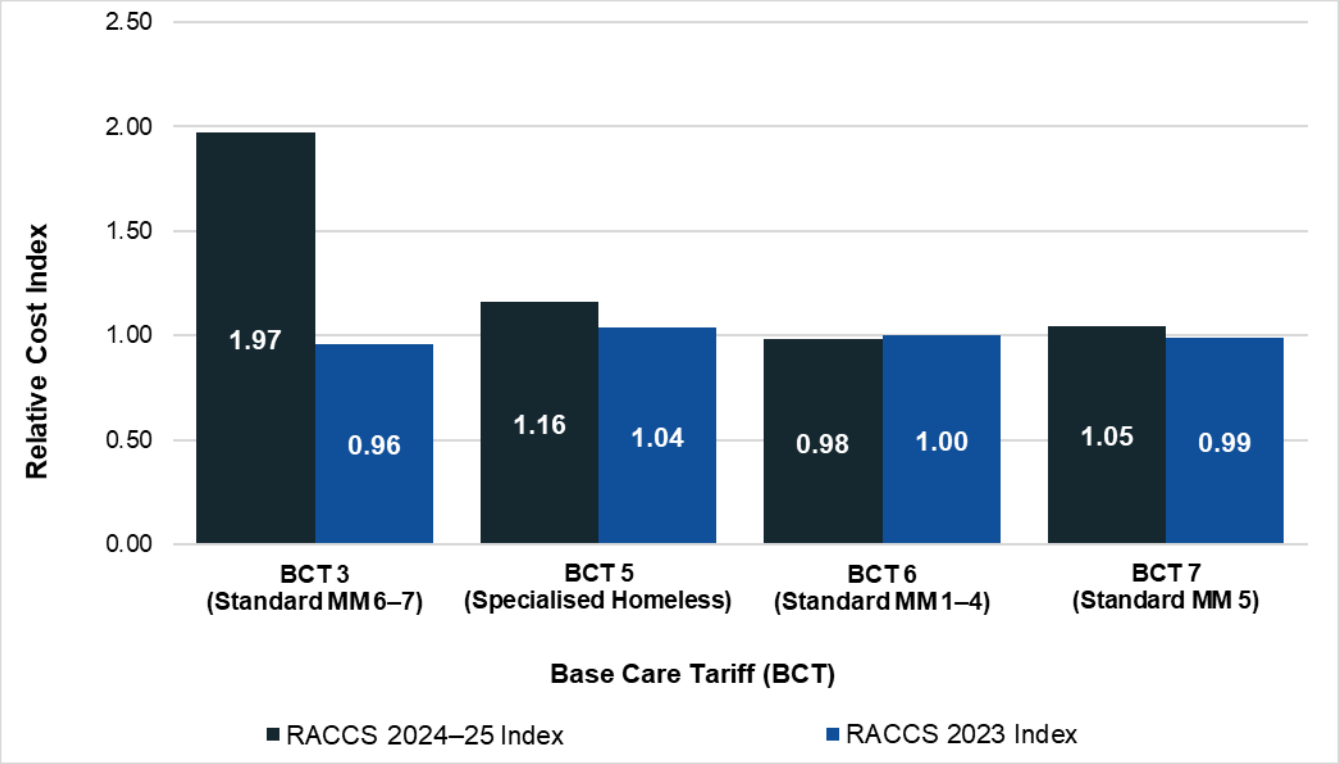
Source: RACCC 2024–25 Final Dataset
Note: BCT 3 = Standard MM 6–7; BCT 4 = Standard MM 2–3; BCT 5 = Specialised Homeless; BCT 6 = Standard MM 1; BCT 7 = Standard MM 4–5; Number of RACHs: BCT 3 n=7; BCT 4 n=33; BCT 5 n=15; BCT 6 n=102; BCT 7 n=31; the final dataset with 188 RACHs did not include any homes classified as BCT 1 (Specialised Indigenous, located in MM 7) or BCT 2 (Specialised Indigenous, located in MM 6); outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity.

Figure 34 shows a comparison based on relative index of the average daily costs by BCT category between RACCC 2024–25 and RACCS 2023.

Key observations include:

- RACCC 2024–25 recorded a relatively higher average daily cost than RACCS 2023 in BCT 3, 5 and 7. BCT 6 costs are relatively similar. The changes may have been the result of a more robust costing processing reflecting enhancements in the 2024–25 cost collection methodology, such as improved home compliance, better monitoring of care-time data, and more accurate financial validation.
- The significant increase for BCT 3, which includes RACHs located in MM 6 and 7, reflects the impact of the atypically high cost RACHs in this category (refer to Section Average daily costs by RACH location).

Figure 34: Comparison based on relative index of RACCS 2023 and RACCC 2024–25 by BCT



Sources: RACCC 2024–25 Final dataset; RACCS 2023 Final Report

Note: Index values were calculated as Cost ÷ Weighted average; Weighted averages were calculated as Σ (Cost × Residents) ÷ Σ Residents; BCT categories used in the RACCS 2023 report have been used in the above graph to ensure comparability (i.e. BCT 6 represents Standard MM 1–4 homes) despite new BCT categories coming into effect on 1 October 2024; BCT 3 = Standard MM 6–7; BCT 5 = Specialised Homeless; BCT 6 = Standard MM 1–4; BCT 7 = Standard MM 5; Number of RACHs (2024–25 data): BCT 3 n=7, BCT 5 n=15, BCT 6 n=148, BCT 7 n=18; Number of RACHs (2023 data): BCT 3 n=3, BCT 5 n=8, BCT 6 n=86, BCT 7 n=14; BCT categories with less than 5 residents have been suppressed.

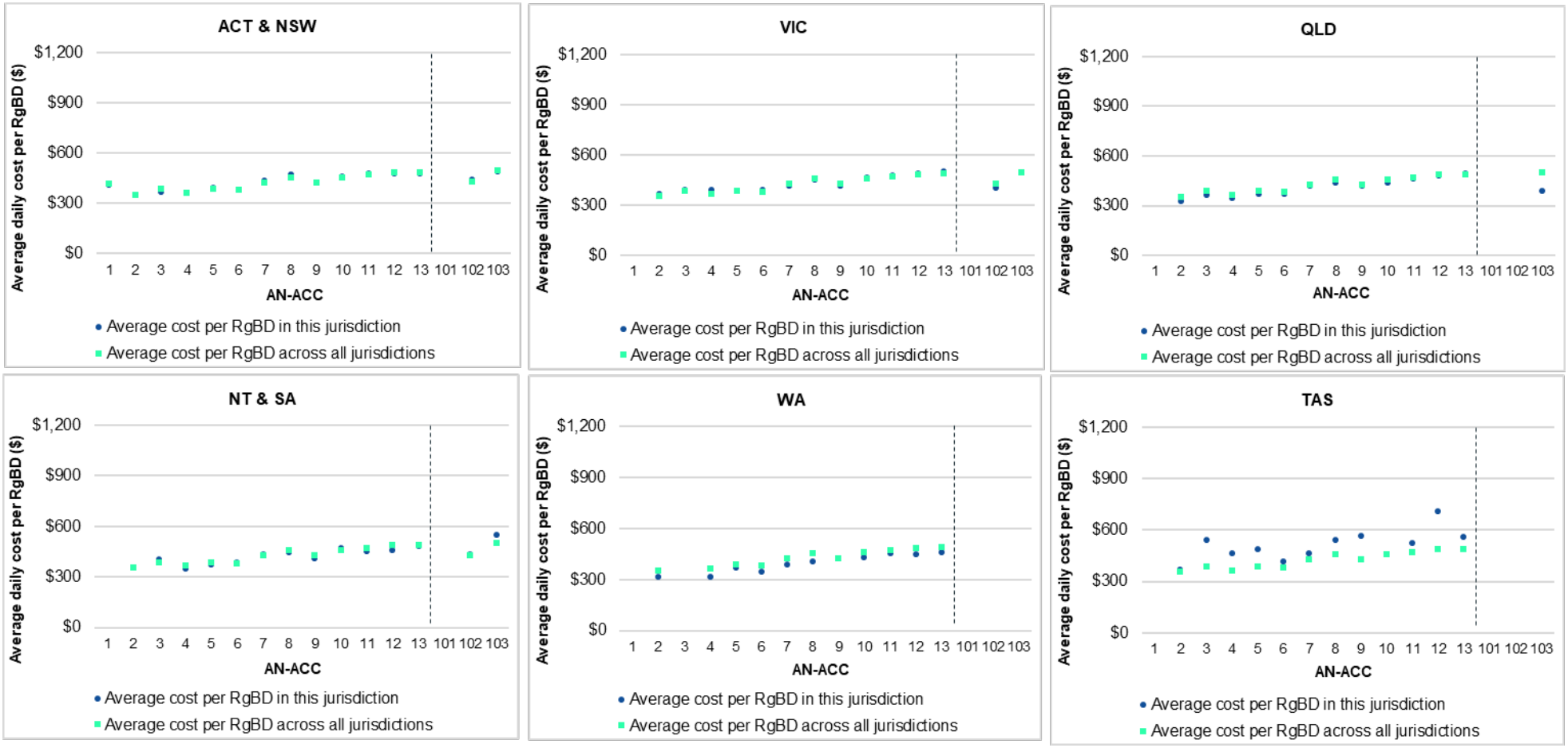
Average daily cost by jurisdiction

Figure 35 shows the average daily cost by AN-ACC Class and jurisdiction.

Key observations include:

- Across most jurisdictions, costs are fairly stable and closely track the national average across AN-ACC classes.
- WA and NT & SA show slightly lower but consistent costs and are closely aligned with the overall average.
- Tasmania stands out with greater fluctuation and higher peaks for some AN-ACC classes. This was due to 3 homes that had significantly higher costs per RgBD than other RACHs, which impacted the overall outcome for Tasmania.

Figure 35: Average daily cost per RgBD by AN-ACC Class and jurisdiction



Source: RACCC 2024–25 Final Dataset

Note: Vertical dotted line separates permanent (1–13) and respite (101–103) residents; AN-ACC Classes with fewer than 5 residents in the corresponding jurisdiction category have been suppressed; Outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity.

Figure 36 shows the distribution of average daily cost by jurisdiction.

Key observations include:

- Costs are consistent across most jurisdictions, averaging between $422 and $435 per day.
- The exceptions are Western Australia, where the average daily cost is lowest at $402 and Tasmania, where the average daily cost is highest $504.
- There is noticeable variability in cost within jurisdictions even though the average daily costs are broadly similar across most jurisdictions.
- Tasmania displays the highest variability with a much wider interquartile range and long whiskers extending close to $1,200.

Figure 36: Distribution of average cost per RgBD by jurisdiction

Source: RACCC 2024–25 Final Dataset

Note: Number of RACHs: ACT&NSW n=70; VIC n=35; QLD n=27; NT&SA n=24; WA n=21; TAS n=11; outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity.

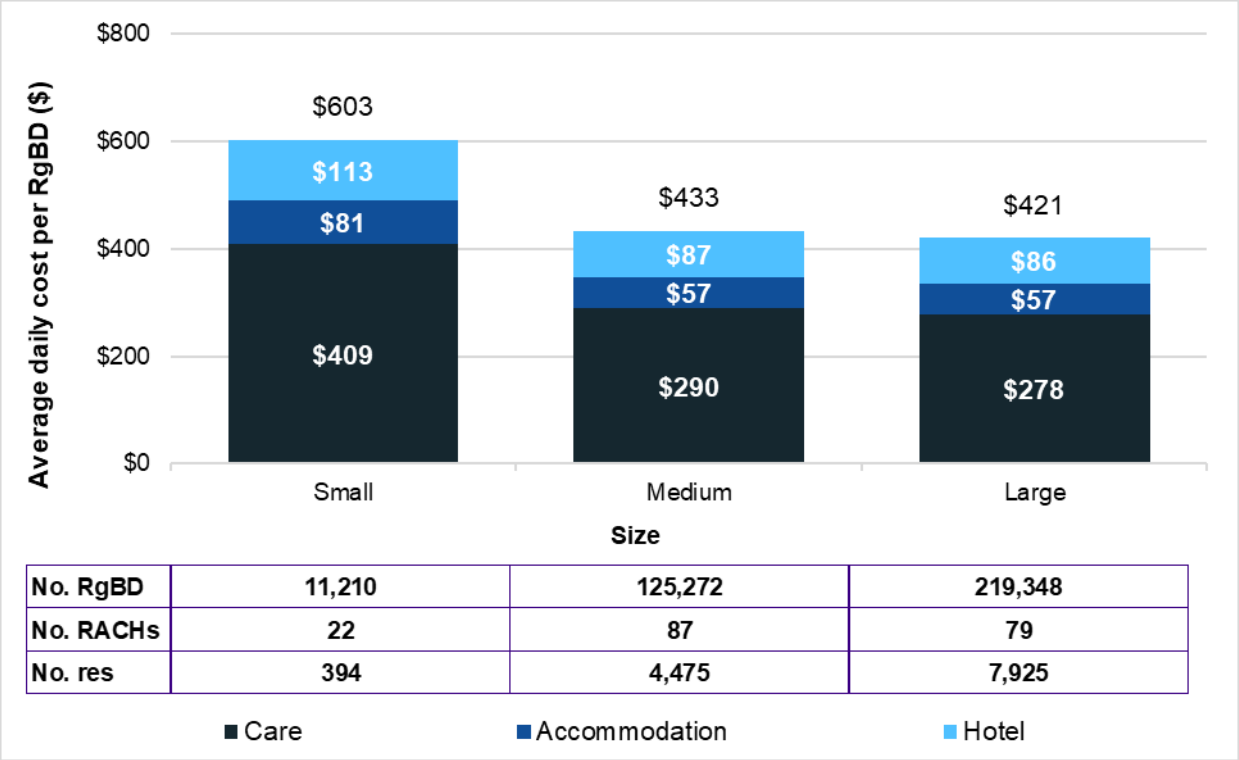
Average daily cost by RACH size

Figure 37 shows the average daily cost by RACH size.

Key observations include:

- Residents in small RACHs have an average cost of $603 compared with medium and large RACHs ($434 and $421 respectively).
- The higher average cost per bed day of small RACHs reflects the impact of the atypically high cost for RACHs in this category (refer to Section Average daily costs by RACH location).

Figure 37: Cost per RgBD by size



	Small	Medium	Large
No. RgBD	11,210	125,272	219,348
No. RACHs	22	87	79
No. res	394	4,475	7,925

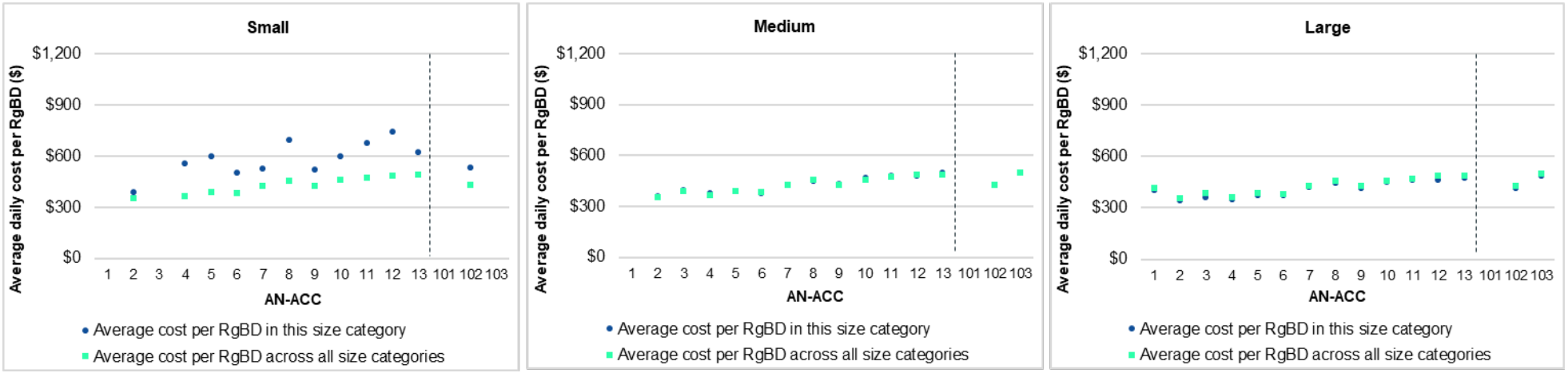
Source: RACCC 2024–25 Final dataset

Note: due to the limited spread of the data, confidence intervals are not included in this figure, please refer to Appendix C for full tables No. RgBD = number of registered bed days; No. RACHs = number of residential aged care homes; No. res = number of residents;. Outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity.

Figure 38 shows the average daily cost by AN-ACC Class and RACH size. Key observations include:

- Small RACHs have substantially higher than average costs across all AN-ACC Classes.
- Medium and large sized RACHs are very closely aligned with the overall average costs across all AN-ACC Classes.

Figure 38: Distribution of average cost by AN-ACC Class and RACH size



Source: RACCC 2024–25 Final Dataset

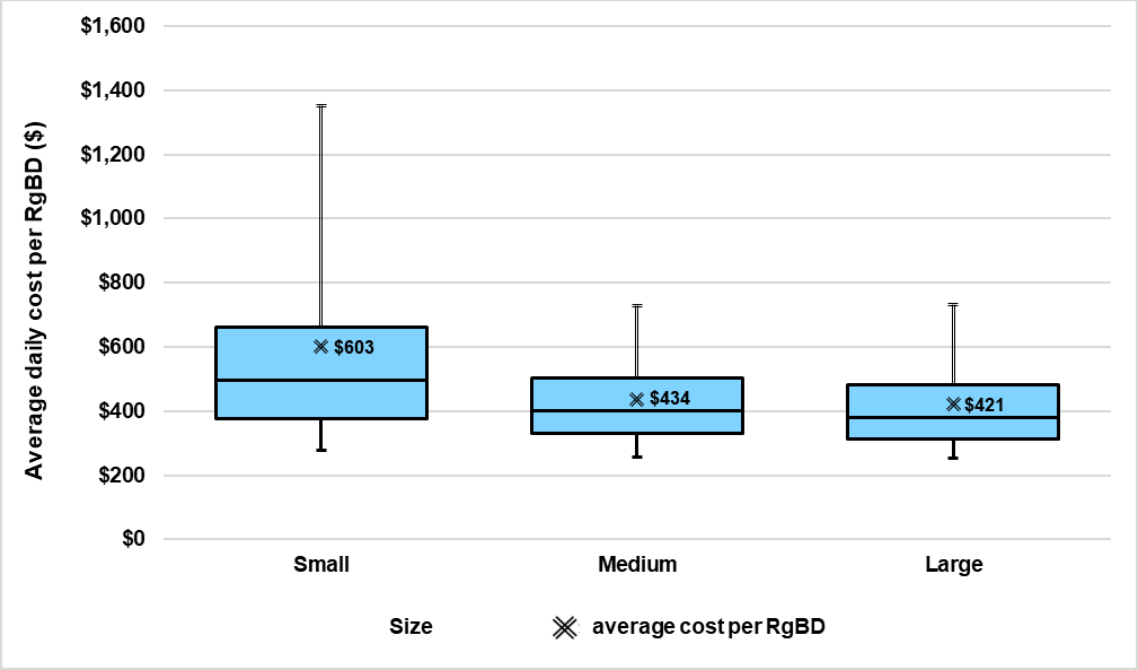
Note: Small = 30 or less operational places; Medium = 31 to 89 operational places; Large = 90 or more operational places; Vertical dotted line separates permanent (1–13) and respite (101–103) residents; AN-ACC Classes with fewer than 5 residents in the corresponding size category have been suppressed; Outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity.

Figure 39 shows the distribution of average daily cost by RACH size.

Key observations include:

- Medium and large RACHs have lower and more consistent costs, averaging $434 and $421 respectively.
- Small RACHs have the highest average daily cost ($603) and the greatest variability with costs ranging widely up to about $1,400.
- The median cost for small RACHs is considerably higher than for medium and large RACHs, and their interquartile range is much wider. That is, small homes are both more expensive and their costs are more variable.

Figure 39: Distribution of average cost per RgBD by RACH size



Source: RACCC 2024–25 Final Dataset

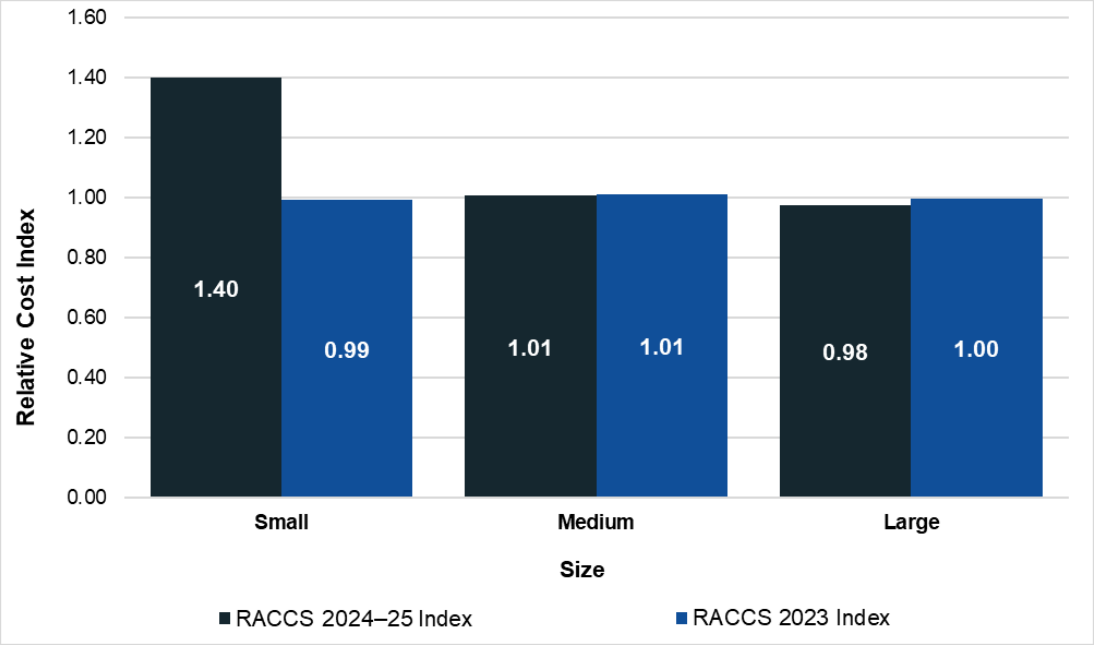
Note: Small = 30 or less operational places; Medium = 31 to 89 operational places; Large = 90 or more operational places; Number of RACHs: Small n=22, Medium n=87, Large n=79; outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity.

Figure 40 shows a comparison based on relative index of average daily costs by RACH size between RACCC 2024–25 and RACCS 2023.

Key observations include:

- The relative cost of medium and large RACHs is consistent across the 2 datasets.
- The per bed day cost of small RACHs shows a significant increase in RACCC 2024–25 over RACC 2023, reflecting the impact of the atypically high cost for RACHs in this category (refer to Section Average daily costs by RACH location).

Figure 40: Cost comparison based on relative index of RACCS 2023 and RACCC 2024–25 by RACH size



Source: RACCC 2024–25 Final dataset; RACCS 2023 Final Report

Note: Index values were calculated as Cost ÷ Weighted average; Weighted averages were calculated as Σ (Cost × Residents) ÷ Σ Residents; Small = 30 or less operational places; Medium = 31 to 89 operational places; Large = 90 or more operational places; Number of RACHs (2024-25 data): Small n=22, Medium n=87, Large n=79; Number of RACHs (2023 data): Small n=12, Medium n=58, Large n=41

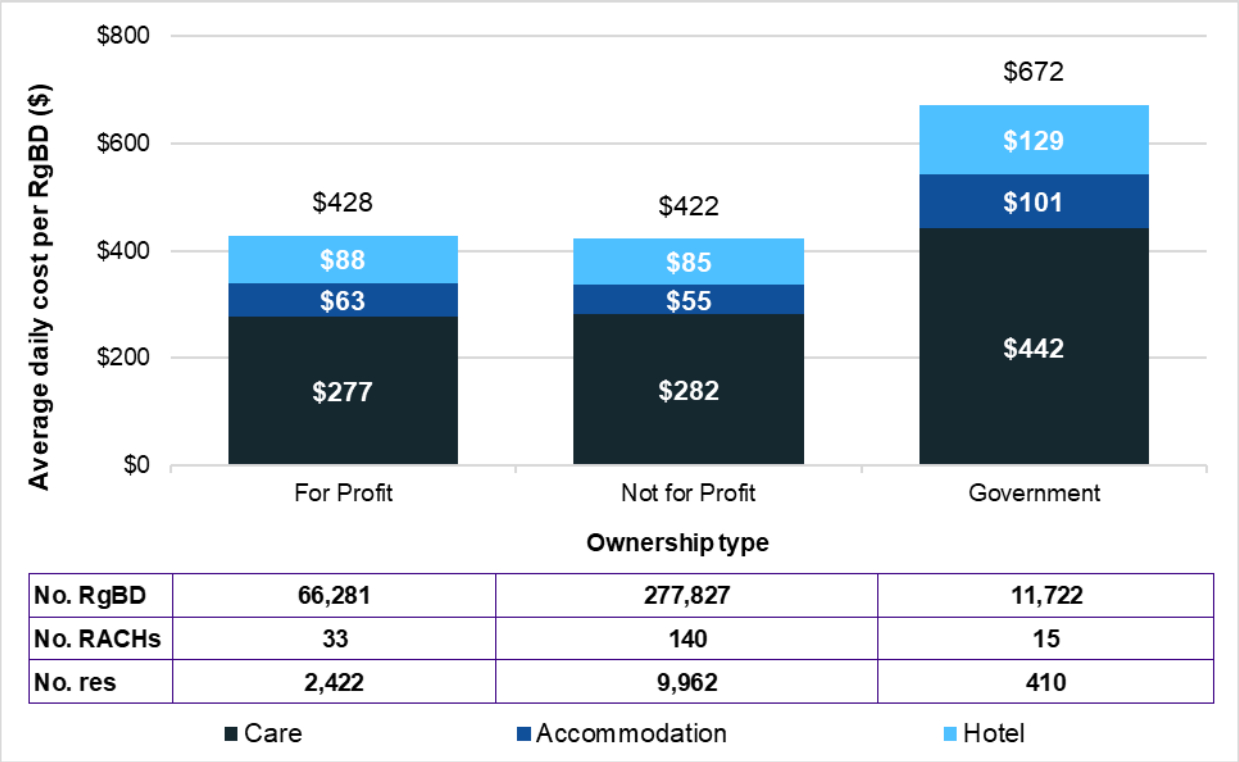
Average daily cost by RACH ownership

Figure 41 shows the average daily cost broken down by ownership.

Key observations include:

- Government providers have substantially higher average daily cost ($672) than for-profit ($428) and not-for-profit ($422) RACHs. There was not an equivalent difference in the average number of minutes at these homes (**Figure 19**).
- The higher costs at government homes may be associated with higher resident care needs in these RACHs. It may also be influenced by these homes often being located in remote areas or differences in the composition of staff roles in these RACHs.

Figure 41: Cost per RgBD by ownership



No. RgBD	**66,281**	**277,827**	**11,722**
No. RACHs	**33**	**140**	**15**
No. res	**2,422**	**9,962**	**410**

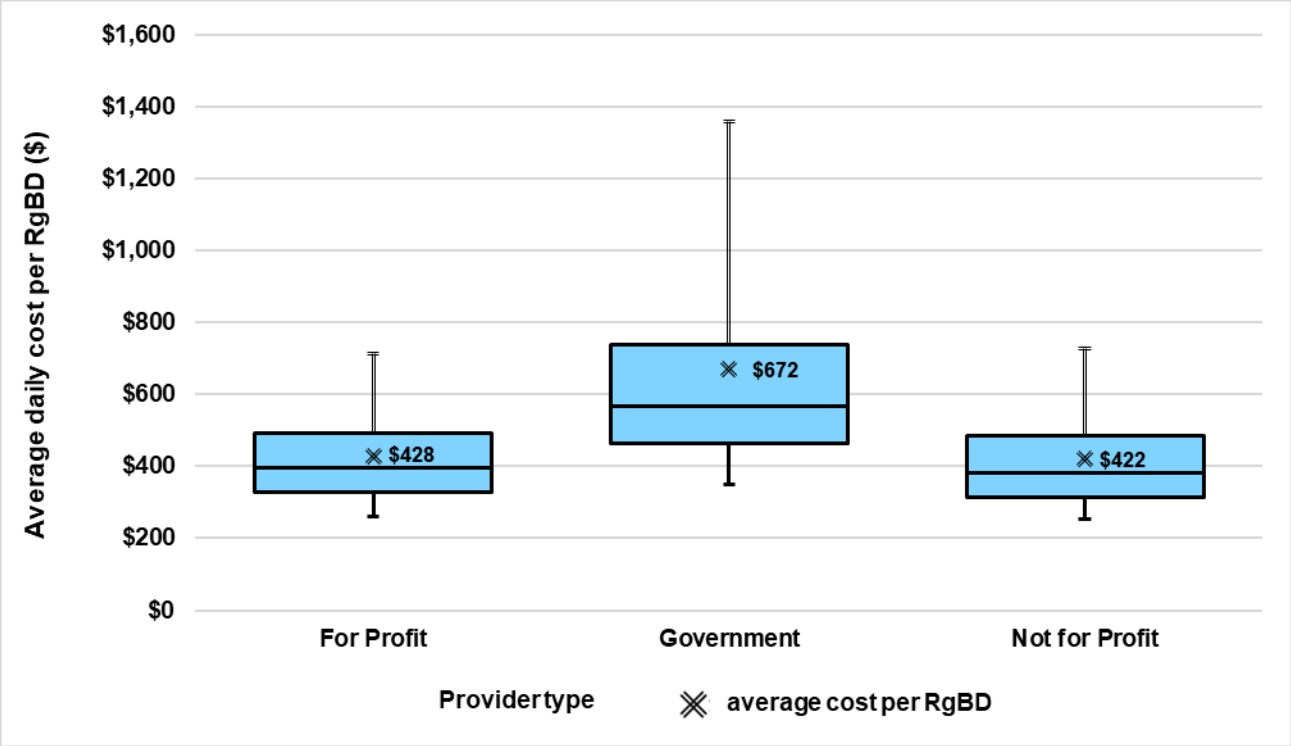
Source: RACCC 2024–25 Final dataset
Note: due to the limited spread of the data, confidence intervals are not included in this figure, please refer to Appendix C for full tables
No. RgBD = number of registered bed days; No. RACHs = number of residential aged care homes; No. res = number of residents;.
Outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity.

Figure 42 shows the distribution of average daily cost by RACH ownership.

Key observations include:

- For-profit and not-for-profit RACHs have similar average daily costs ($428 and $422 respectively), and each has a narrow cost range.
- In contrast, government owned RACHs have both substantially higher costs and a far wider cost distribution.

Figure 42: Distribution of daily cost per RgBD by RACH ownership



Source: RACCC 2024–25 Final Dataset

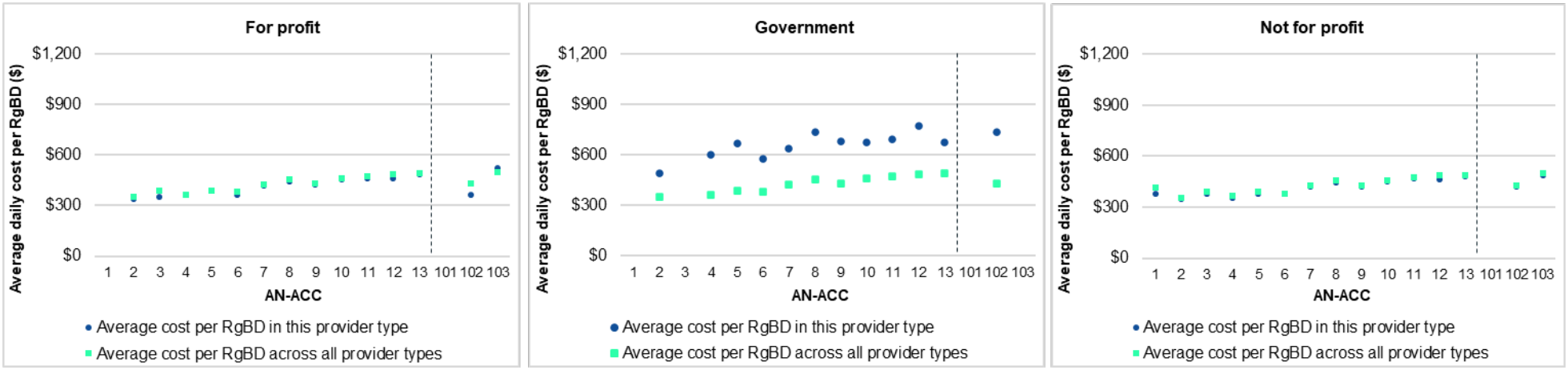
Note: Number of RACHs: For profit n=33; Government n=15; Not-for-profit n=140; outliers (including residents who were on leave during the entire data collection period) in each category have been excluded to maintain RACHs and resident anonymity.

Figure 43 shows the average daily cost by AN-ACC Class and provider type.

Key observations include:

- For-profit and not-for-profit RACHs have average daily costs that very closely align with overall average costs across AN-ACC classes.
- In contrast, government owned RACHs have consistently higher and more variable costs across all AN-ACC classes.

Figure 43: Distribution of average cost by AN-ACC Class and provider type



Source: RACCC 2024–25 Final Dataset

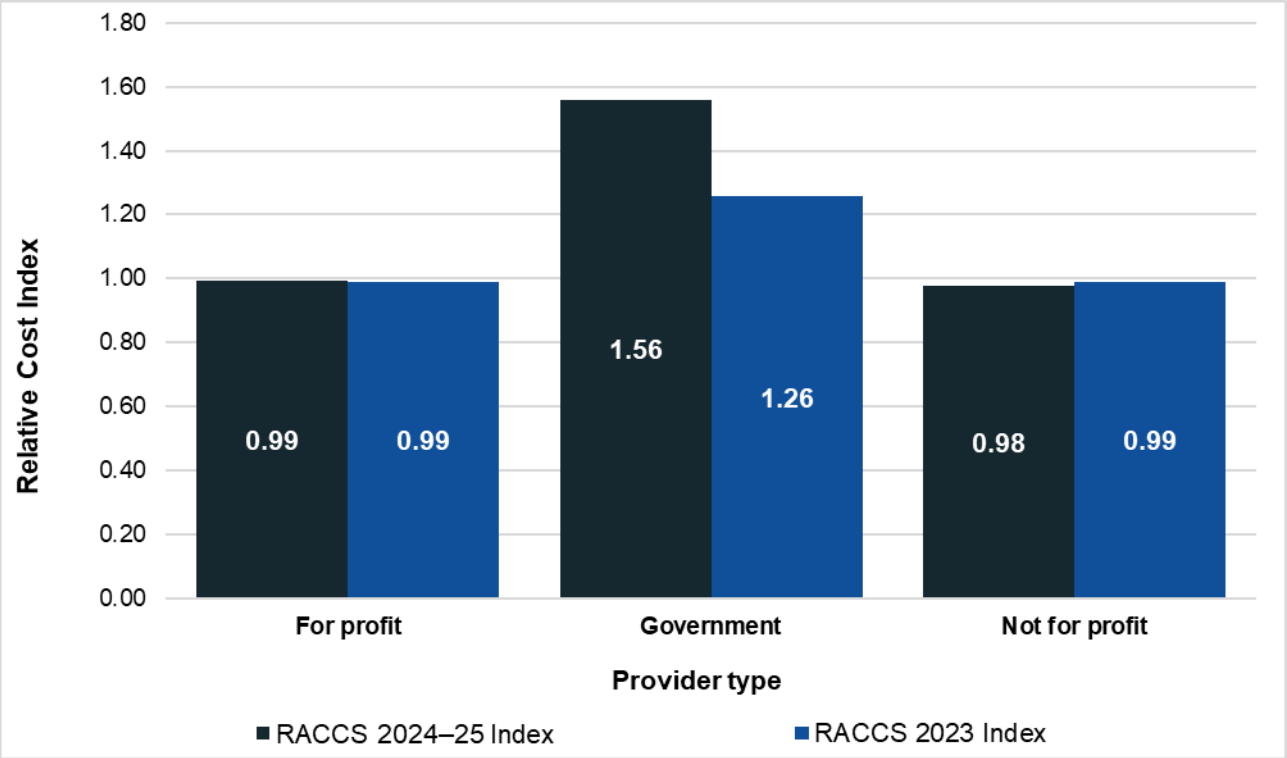
Note: Vertical dotted line separates permanent (1–13) and respite (101–103) residents; AN-ACC Classes with fewer than 5 residents in the corresponding provider type category have been suppressed; Outliers in each category (including residents who were on leave during the entire data collection period) have been excluded to maintain RACHs and resident anonymity.

Figure 44 shows a comparison based on a relative index of the average daily costs by RACH provider type between RACCC 2024–25 and RACCS 2023.

Key observations include:

- For-profit and not-for-profit RACHs show that relative costs per day are similar across the 2 datasets.
- In contrast, government owned RACHs have considerably higher costs, increasing from 1.26 in RACCC 2023 to 1.56 in RACCC 2024–25. This reflects the impact of the atypically high cost for RACHs in this category (refer to Section Average daily costs by RACH location).

Figure 44: Cost comparison based on relative index of RACCS 2023 and RACCC 2024–25 by provider type



Source: RACCC 2024-25 Final dataset; RACCS 2023 Final Report

Note: Index values were calculated as Cost ÷ Weighted average; Weighted averages were calculated as Σ (Cost × Residents) ÷ Σ Residents; Number of RACHs (2024-25 data): For profit n=33; Government n=15; Not for profit n=140; Number of RACHs (2023 data): For profit n=38, Government n=12, Not for profit n=61

AN-ACC weights

Weights reflect the relative cost of providing care across residents. The final RACCC 2024–25 dataset was used to produce a set of weights for the AN-ACC classification comparable to the AN-ACC price weights. The calculations used only fully absorbed care costs (i.e. hotel and accommodation costs were excluded) to ensure comparability with AN-ACC price weights. The average AN-ACC (or the National Weighted Activity Unit (NWAU)) price weight was calculated for the resident cohort in the data collection, and both cost weight and price weights were normalised by dividing by their respective averages to allow direct comparison (i.e. a weight of 1 represents the average for the sample cohort). The outcomes are shown in **Table 7**.

Table 7: AN-ACC weights

AN-ACC Class	Description	Cost collection derived weights (Care costs only)[a]	Normalised to the average NWAU[b]
1	Admit for palliative care	0.93	1.35
2	Independent without compounding factors	0.73	0.39
3	Independent with compounding factors	0.82	0.74
4	Assisted mobility, high cognition, without compounding factors	0.78	0.54
5	Assisted mobility, high cognition, with compounding factors	0.85	0.80
6	Assisted mobility, medium cognition, without compounding factors	0.84	0.72
7	Assisted mobility, medium cognition, with compounding factors	0.98	1.00
8	Assisted mobility, low cognition	1.09	1.11
9	Not mobile, higher function, without compounding factors	0.99	0.98
10	Not mobile, higher function, with compounding factors	1.10	1.09
11	Not mobile, lower function, lower pressure sore risk	1.15	1.26
12	Not mobile, lower function, higher pressure sore risk, without compounding factors	1.17	1.22
13	Not mobile, lower function, higher pressure sore risk, with compounding factors	1.20	1.35
101	Respite, independent mobility	0.79	0.75
102	Respite, assisted mobility	0.98	1.07
103	Respite, not mobile	1.22	1.32

Source: RACCC 2024–25 Final dataset
Note: NWAU = National Weighted Activity Unit
a: derived from the final dataset based on fully absorbed care costs only (i.e. does not include hotel or accommodation costs)
b: derived from: *The Australian National Aged Care Classification (AN-ACC) Funding Guide (Department of Health, Disability and Ageing); version 1.21; 1 November 2025* normalised to the average for the sample cohort

There is a clear difference between the relativities by Class within the 2 sets of weights, with the normalised numbers showing a greater spread in the NWAU weights than the weights derived from the fully absorbed care costs. Specifically, a narrowing of the difference between the lowest and highest weighted cost data (0.73 to 1.22) compared to the relative range within the AN-ACC price weights (0.39 to 1.35).

The significant reforms undertaken in the residential aged care sector since the development of the AN-ACC classification in 2018 may have impacted on this shift in cost structures. However, the cause and effect of the observed change is unlikely to be fully understood without a comprehensive review of the AN-ACC classification.

Deep dive analysis

This Chapter presents the results of the 4 deep-dive analyses undertaken as part of the RACCC 2024–25 program. These targeted investigations were designed to strengthen the evidence base supporting IHACPA's aged care costing methodology and to address data and methodological gaps identified in earlier cost collections.

Overview

As part of RACCC 2024–25, 4 focused deep-dive analyses were undertaken to explore:

1. **Indirect care time,** to improve understanding of non-resident-facing care activities and their treatment within the costing model.
2. **Allied health (AH) service delivery,** to quantify provider-funded AH time and cost and assess variation by discipline and resident characteristics.
3. **Respite care costs,** to compare short-stay and permanent resident costs and explore factors contributing to variation.
4. **Overhead allocation methods,** to test alternative approaches for distributing overhead and administrative costs across the Care, Hotel and Accommodation expense streams.

Each analysis used a defined sub-sample of participating RACHs, supported by supplementary data collection and validation processes, to provide detailed insights into specific cost drivers. Together, they extend the core RACCC dataset and offer practical refinements for improving data representativeness, cost attribution and alignment between measured resource use and AN-ACC funding relativities.

Key findings and implications are summarised and consolidated in Chapter below.

Indirect care time

This section presents the results of the indirect care time analysis, which examined how non-resident-facing activities such as documentation, coordination and communication contribute to staff workload and how these activities should be reflected in IHACPA's costing methodology.

Scope and dataset

30 RACHs across 6 jurisdictions participated in a structured survey supported by beacon and wearable device data to validate reported patterns. Most homes were not-for-profit (87%) and located in metropolitan or regional areas.

Key findings

The analysis provided a clearer picture of how indirect activities contribute to total workload across roles and shifts. The main findings were as follows:

- **Indirect care is substantial.** It accounts for a large share of staff workload, highest for RNs (≈45%), then ENs (≈29%) and personal care workers (PCWs)/assistants in nursing (AINs) (≈16%).
- **Documentation dominates.** Documentation and care management represented about 54% of indirect time on day shifts and 70% at night. Internal communication was the next most frequent activity (≈9–15%).
- **Role-specific variation.** Clinical staff focused on documentation and coordination, while lifestyle and allied health assistants focused on preparation and activity planning.

- **Night shift effect.** Indirect time increased markedly overnight, particularly for RNs.
- **Drivers of variation.** Dementia, behavioural issues, palliative and acute care, compliance requirements, family engagement and outbreaks all increased indirect workload.
- **Digital systems matter.** Mobile, integrated documentation systems improved efficiency, while fragmented systems increased administrative burden.

Implications for future costing cycles

The results confirm that indirect care is a measurable and material component of aged care workload. Future RACCC cycles could explicitly incorporate role- and shift-based indirect time factors (e.g. standardised ratios of direct to indirect time by staff type), supported by standardised activity definitions, clearer classification of "other indirect" tasks and progressive integration of electronic data sources. Strengthening the representativeness of the indirect time analysis through wider home participation will enhance the robustness of future estimates.

Allied health services

This section presents the results of the deep dive AH analysis, which explored provider-funded AH activity and cost to better understand how therapy services are delivered and resourced in residential aged care.

Scope and dataset

Data were drawn from 66 RACHs (time period with matched QFR data) covering physiotherapy, occupational therapy, podiatry, dietetics, speech pathology and allied health assistants (AHAs). The dataset included 4,096 resident encounters, 113,666 registered bed days and 6,655 hours of AH care. Only provider-funded services were in scope; externally funded or self-funded services were excluded.

Time and activity data were captured using PPM wearable devices assigned to allied health professionals (AHPs) or allied health assistants (AHAs) to measure direct resident contact. Beacon data on indirect time collected at a small number of homes was excluded due to low coverage and inconsistent signal quality.

Key findings

The analysis revealed marked differences in how AH services are structured and accessed across homes and professions.

- **Physiotherapy is the most prevalent.** Physiotherapy was offered in about 80% of RACHs; other disciplines were available in less than half of the 66 RACHs.
- **Weekday-dominant service pattern**. Most AH activity occurred Monday to Thursday, likely reflecting workforce availability rather than resident need.
- **Utilisation rises in higher numbered AN-ACC Classes.** Residents in higher numbered AN-ACC Classes (10, 11 and 102) received more AH time per day.
- **Availability drives use.** Residents in RACHs offering multiple AH disciplines accessed a broader mix of services, confirming supply-driven patterns.
- **Measured vs reported hours.** Time data aligned with QFR hours for most disciplines except physiotherapy, where direct care time represented only ≈30% of paid hours, suggesting substantial unmeasured indirect work (e.g. documentation, care planning, multidisciplinary meetings). Although some indirect AH activity was captured in RACCC 2024–25 via beacons, it was excluded from the analysis due to data limitations. Consequently, measured direct care time underestimates total AH workload and the associated cost.
- **Group-based activity not captured by current technology**. The wearable devices used in RACCC 2024–25 could only detect proximity to one resident at a time, meaning group-based sessions, particularly common in physiotherapy and lifestyle-related therapy, were not recorded.

- **Service use is episodic.** Most residents accessed AH on one to 5 days during the 30-day period. Ongoing sessions were rare and mainly supported by AHAs.

Implications

AH services are an essential component of resident care but remain uneven and dependent on workforce supply. Future costing cycles should continue discipline-level data collection, expand participation to improve representativeness and supplement wearable device data with HRMS or short survey information to estimate indirect activity. Consideration should also be given to exploring technologies capable of detecting multiple simultaneous signals to better measure group-based therapy. These improvements will ensure both direct and indirect AH contributions are more accurately reflected in the Care stream and provide a stronger basis for testing cost relativities for residents with higher or more complex therapy needs.

Respite care

This section presents the results of the deep dive into respite care analysis, which compared the cost profile of respite residents with permanent residents to assess variation by AN-ACC Class, provider type and location.

Scope and dataset

The dataset included 122 respite residents across 72 RACHs (2,773 RgBDs) classified into the 3 AN-ACC respite classes:

- **Class 101:** For residents who are independently mobile (127 RgBD, 5 residents).
- **Class 102:** For residents who require assisted mobility (1,533 RgBD, 71 residents).
- **Class 103:** For residents who have limited mobility (1,113 RgBD, 46 residents).

Key findings

The analysis shows that respite residents have higher and more variable daily costs than permanent residents, largely due to their short-stay nature and high turnover.

- **Higher average daily cost.** Respite residents averaged $454 per RgBD, about 5% higher than permanent residents ($430).
- **Mobility drives cost.** Average daily costs increased from $381 (Class 101) to $498 (Class 103); reflecting higher direct care labour requirements as mobility needs increase.
- **Wide variability.** Most costs ranged $320 to $520 per RgBD, with a small number of high-cost residents (>$800).
- **Structural and geographic influences.** Highest costs were observed in remote (MM 6&7) and specialised (BCT 5) services and in smaller RACHs. Government-operated homes recorded the highest median cost per RgBD ($680).
- **Episodic workload.** Frequent admissions, discharges and room preparation add to the per-day workload and are not fully captured by current costing methods.
- **Alignment of costs and AN-ACC weights.** Relative comparison of RACCC 2024–25 results with AN-ACC Class weights (standardised for the RACCC 2024–25 sample volumes) shows that respite residents incurred average daily costs that were on average about 5% higher than permanent residents, while their weighted average AN-ACC price weights were on average 16% higher. This difference suggests that the existing AN-ACC weights already recognise, and may modestly over-recognise, the additional cost associated with respite care.

Implications

Respite care is more resource-intensive and variable than permanent care, primarily due to turnover-related effort. The comparison between measured RACCC costs and AN-ACC weights suggests that current relativities may slightly overstate the efficient cost of respite care. IHACPA should review the balance between respite and permanent class weights in future pricing cycles to confirm alignment between funding and observed efficient costs. Future costing cycles should include consistent episode identifiers, measure turnover frequency and continue to compare RACCC-measured costs with weighted average AN-ACC weights to test alignment and identify any unrecognised cost differentials.

Overhead allocation methods

This section presents the results of the deep dive analysis into overhead allocation.

Scope and dataset

Overhead and administrative costs constitute a substantial portion of total expenditure in residential aged care. 4 alternative methods for allocating overhead costs across Care, Accommodation and Hotel streams are under ongoing consideration. Each method applied a different rule while holding the underlying cost base constant.

- **Method 1 (StewartBrown methodology):** *NB: This is the method that has been applied to sites within the final dataset.* Corporate recharges apportioned by general ledger (GL) spend; remaining overheads split 50:50 between Hotel and Accommodation.
- **Method 2 (Fixed StewartBrown percentages):** Care 37%, Accommodation 29.4%, Hotel 33.6%.
- **Method 3 (GL proportional):** Overheads distributed according to each stream's proportion of GL expenditure at that home.
- **Method 4 (Provider-determined percentages):** Adjusted median proportions based on self-reported home-specific estimates by providers (Care 65%, Accommodation 10%, Hotel 25%).

Key findings

The 4 methods produced markedly different results, demonstrating the sensitivity of stream costs to allocation assumptions.

- **Allocation assumptions matter.** Care's share of overhead costs varied from 37% (Method 2) to 73% (Method 3), materially affecting reported costs.

Implications

Overhead allocation strongly influences reported cost composition, with variation in the output of the 4 options explored. Further analysis with a larger sample of providers should be undertaken prior to implementing any changes to cost allocations.

Conclusion and recommendations

This Chapter summarises the key findings from the RACCC 2024–25 and the implications for future aged care costing work. It also includes evidence-based recommendations to guide future collections, strengthen data quality and participation, and ensure AN-ACC pricing advice reflects the efficient cost of high quality care.

Overview

The RACCC 2024–25 achieved its objectives of producing a robust, representative and methodologically consistent costed dataset to inform IHACPA's aged care pricing advice. The collection expanded participation to 200 RACHs and delivered significant methodological advances, improved data quality and stronger analytical rigour than previous studies.

The final dataset provides the most detailed picture to date of how care time, staffing models and costs interact in residential aged care. Findings confirm a strong and consistent relationship between resident characteristics, care minutes and daily cost, with predictable variation by provider type, size and location.

Representativeness and participation

RACCC 2024–25 achieved a nationally representative sample of RACHs across location, size and ownership type. The proportion of homes in each location category (metropolitan, regional, remote), MMM category (MM 1–7) and size category (small, medium, large) closely reflects the national distribution of RACHs.

While recruitment targets were exceeded for most strata, particularly large metropolitan and medium regional not-for-profit RACHs, participation among for-profit RACHs remained below target. IHACPA invested heavily in RMs to provide tailored support and reduce participation burden, which strengthened data quality and home engagement. However, resource limitations within for-profit providers appear to have constrained participation.

Future collections could test whether additional incentives to assist providers during the data collection process increases recruitment among for-profit and underrepresented service types.

R1. **Expand participation and representativeness**. Broaden participation in future collections, with targeted engagement of underrepresented cohorts such as for-profit, remote, Aboriginal and Torres Strait Islander Peoples and homelessness-focused services to improve precision and ensure efficient prices reflect diverse care contexts.

R2. **Test participation incentives**. Consider whether additional incentives to assist providers in participating in the live data collection could increase recruitment.

Care time findings

The care time analysis, based on data from wearable Bluetooth devices, revealed consistent patterns across resident, provider and service characteristics:

- **Relationship with AN-ACC Classes:** Average daily minutes increased across AN-ACC Classes (permanent and respite), with Class 1 the notable exception given its palliative focus and small sample.
- **Staff composition:** Care workers delivered the majority of care minutes, followed by RNs, ENs and lifestyle staff. AH staff contributed a smaller proportion of total care time.

- **Provider and location effects**: Government-operated, small and remote RACHs recorded higher average care minutes and a greater share of nurse-delivered care, reflecting different workforce models and operational realities.
- **Transition patterns:** New residents required slightly more direct care in their first 28 days, particularly in higher-numbered AN-ACC Classes, but by 90 days their average care time aligned with ongoing residents, suggesting that admission activities are generally embedded within routine care.
- **Variation within Classes:** The distribution of minutes was right-skewed, with some residents requiring substantially higher levels of care, reinforcing the need for periodic review of Class definitions and weights.

R3. **Continue and enhance direct time measurement**. Continue the use of direct time measurement technology to maintain a robust, objective basis for estimating care minutes and labour cost in future RACCC cycles. Pending the outcomes of the Phase 3 HRMS feasibility study, which is testing the extraction of care plan data from RACH systems, progressively assess opportunities to integrate validated HRMS data sources alongside wearable-based measurement to improve efficiency, scalability and accuracy.

Cost findings

Cost analysis demonstrated clear and consistent relationships between care requirements, staffing models and total expenditure:

- **Direct labour drives cost:** Labour accounted for 50–60% of total expenditure and was the main source of variation across RACHs.
- **Costs rise across higher numbered AN-ACC Classes:** Average daily costs increased from $354 in Class 2 to $489 in Class 13.
- **Respite residents are costlier per day:** Average costs ranged from $381 (Class 101) to $498 (Class 103), reflecting greater turnover and staffing intensity.
- **Structural cost drivers:** Higher unit costs were recorded in smaller, government-operated and remote RACHs, primarily due to scale limitations and workforce costs.
- **Consistency in cost composition:** The proportion of expenditure across cost components remained broadly stable, suggesting a consistent cost structure nationally.
- **Comparison with RACCS 2023:** Relative indexed comparison of the cost components generally showed that care costs constituted a higher proportion of the total cost per bed day in 2023 than in 2024–25, while both Accommodation and Hotel costs were proportionally higher in 2024–25.
- **Convergence across AN-ACC classes:** The narrowing in cost relativities between the lowest to highest AN-ACC classes, coupled with significant overlap in cost distribution, suggests the need to reassess whether the current AN-ACC classification and weights continue to reflect observed cost patterns.

R4. **Review AN-ACC Class definitions**. Periodic review of AN-ACC Class definitions should be undertaken using data generated via the RACCC to ensure they minimise cost variation within classes while maximising cost variation across classes (i.e. they allow funding to be closely aligned to measure resource use).

R5. **Review AN-ACC cost weights and BCT settings**. The RACCC 2024–25 findings, particularly the narrowing of relativities across AN-ACC classes, indicate the need to reassess existing AN-ACC price weights (with or without a review of class definitions as per R4) and BCT settings. This review should ensure that funding continues to reflect the efficient cost of delivering residential aged care following recent sector and workforce reforms.

Methodological progress, data quality and sector capability

High levels of compliance, engagement and completeness were achieved across almost all participating homes, supported by clear governance arrangements, dedicated RMs, and improved systems such as CRIDs and streamlined SDMS workflows. Only one home was excluded due to unresolved data quality issues, while a further 11 were removed during validation because their ACFR/QFR data could not be reliably aligned to the cost collection period. The final sample of 188 homes remained nationally representative by ownership, size and geography, providing a robust evidence base for future cost modelling.

RACCC 2024–25 demonstrated significant methodological advances, including better defined business rules, consistent trimming logic, enhanced financial alignment protocols and comprehensive quality assurance at all stages. These refinements strengthened the accuracy, comparability and transparency of the final dataset. Sector feedback confirmed strong acceptance of these improvements and growing confidence in IHACPA's costing and data collection framework.

RACCC 2024–25 also demonstrated strong provider capability and engagement, with many homes showing improved understanding of data quality requirements over time. Continued investment in relationship management, communication and technical guidance will be critical to maintaining sector confidence and sustaining high participation in future cycles.

R6. **Strengthen data alignment and linkages**. Develop a timing-reconciliation framework, drawing on matching principles from IHACPA's hospital costing standards, to manage reporting lags and/or automate linkages, where possible, between ACFR, QFR and care activity datasets. Future collections could also explore obtaining General Ledger data from selected RACHs to enable more precise financial to activity data matching and validation while balancing provider burden.

R7. **Implement a rolling aged care costing roadmap**. Establish a multi-year roadmap for continuous improvement in business rules, cost models and provider guidance, supporting a transition to a steady-state national aged care cost collection.

R8. **Continue building sector capability and confidence**. Continue targeted training, communication and feedback mechanisms to strengthen provider understanding of costing and data validation processes and to reinforce confidence in IHACPA's pricing advice.

Deep dive analysis

The 4 deep-dive analyses undertaken as part of RACCC 2024–25 have strengthened the evidence base for residential aged care costing methodology. Together they provide a more complete picture of cost formation across key elements of care delivery: indirect care workforce activity, AH utilisation, respite care and overhead distribution.

The deep dives confirmed that:

- **Indirect care** represents a substantial and measurable share of total staff workload. Documentation and coordination activities account for a large proportion of nursing and personal care workers time, particularly overnight. Explicit role- and shift-based parameters are needed to ensure these activities are accurately reflected in the costing model.
- **AH services** make an important contribution to resident outcomes but remain unevenly delivered and heavily influenced by workforce availability. Physiotherapy dominates provision, while other AH disciplines are under-represented. Current Bluetooth technology captures only 1:1 resident contact, meaning indirect and group-based AH activities are not fully measured. Future collections should enhance data capture and linkage with financial records by supplementing wearable device data with HRMS or short survey information and exploring technologies capable of detecting multiple simultaneous signals. These improvements will ensure both direct, indirect and group-based therapy contributions are more accurately reflected within the Care stream.

- **Respite care is more resource-intensive and variable than permanent care.** The higher daily cost is largely attributable to turnover-related admission and discharge activities. Comparison of RACCC 2024–25 results with official AN-ACC Class weights shows that respite residents incur about 5% higher daily costs than permanent residents, while their weighted-average AN-ACC price weights are 16% higher. This indicates that existing AN-ACC relativities already recognise, and may modestly over-recognise, the additional cost associated with respite care, warranting review of these relativities in future pricing cycles.
- **Overhead allocation** has a significant effect on stream-level cost attribution. Further analysis with a larger sample of providers should be undertaken prior to implementing any changes to cost allocations.

Collectively, the deep dive findings reinforce the importance of continuous improvement in data capture, validation and integration. Implementing the suggested actions will:

- improve the accuracy and comparability of labour and overhead attribution across homes and service types
- strengthen the visibility of allied health and respite care contributions to total cost
- support the periodic review and, where necessary, recalibration of AN-ACC weights and funding relativities to ensure they remain proportionate to observed efficient costs
- enhance the transparency and credibility of IHACPA's annual aged care pricing advice.

These analyses represent a significant step forward in the maturity of the RACCC dataset and provide the foundation for ongoing methodological refinement and evidence-based policy development in Australia's residential aged care sector.

The following summarised recommendations consolidate key findings by topic.

R9. **Indirect care time**. Refine how indirect care is recognised within the costing model by introducing role- and shift-specific indirect time factors, standardising activity definitions and progressively integrating beacon or EHR data to improve measurement accuracy.

R10. **AH services**. Strengthen visibility of AH activity by continuing discipline-level data collection, expanding provider participation and linking time, rostering and financial data to capture direct, indirect and group-based therapy. Future cycles should supplement wearable device data with HRMS or short survey information and explore technologies capable of detecting multiple simultaneous Bluetooth signals to improve measurement of group-based sessions.

R11. **Respite care**. Refine how short-stay and high-turnover respite episodes are represented in costing and review how these costs are reflected in AN-ACC relativities. Incorporate consistent episode identifiers, measure turnover frequency and compare RACCC-measured costs with AN-ACC weights to confirm proportionality between funding and observed efficient costs, adjusting relativities if future evidence indicates over- or under-recognition.

R12. **Overhead allocation**. Further validate and refine allocation percentages in future cost collections.

Taken together, these deep dive recommendations provide IHACPA with clear, evidence-based pathways to further refine its aged care costing methodology and support the transition toward a steady-state national collection in future years.

Conclusion and next steps

The results of the RACCC 2024–25 should be interpreted within the context of the major reforms that are reshaping residential aged care since the inaugural RUCS in 2018. At that time, sector reform was in its early stages. The Tune Review of Aged Care and the Aged Care Workforce Taskforce had begun identifying structural and workforce challenges, but the Royal Commission into Aged Care Quality and Safety (announced in 2018) and the subsequent reform agenda had not yet commenced. RUCS therefore provides a pre-reform benchmark, capturing the cost structure of residential aged care before the major policy, workforce and quality changes that have since taken place.

Since 2018, successive reforms have fundamentally altered the cost structure and delivery model of residential aged care, raising labour intensity, expanding compliance requirements and increasing fixed cost pressures. **Table 8** summarises the main structural cost drivers associated with these reforms and indicates where the impacts are observed within the RACCC 2024–25 dataset.

Table 8: Key structural cost drivers influencing RACCC 2024–25 results

Cost driver	Key reforms and developments	Observed cost impacts *(with source attribution noted in brackets)*
Workforce and labour costs	• 24/7 Registered Nurse requirement (from July 2023) • mandatory care minute targets (200 minutes incl. 40 RN, rising to 215/44 from Oct 2024) • Fair Work Commission wage increases (15% uplift for direct-care roles, 2022–24) • expanded clinical governance and supervision requirements • post-COVID workforce shortages and higher agency reliance.	• labour remains the dominant cost driver *(evidenced by 50–60% of total expenditure)* • higher staffing levels and hourly wage rates *(evidenced)* • growth in indirect labour time due to documentation and coordination requirements *(partially evidenced – seen in indirect labour cost growth)* • average cost per paid care minute up 7–10% since 2023.
Quality and compliance costs (administrative and indirect labour)	• Royal Commission reforms expanded governance, reporting and accountability requirements • Quality Indicator Program broadened from 3 to 11 indicators (2023) • Star Ratings introduced (Dec 2022) • new Aged Care Quality Standards and new Aged Care Act to commence 1 Nov 2025 *(no impact on RACCC 2024–25 but expected to affect RACCC 2026).*	• increased demand for quality, compliance and data management staff *(evidenced as growth in administrative and indirect labour streams)* • higher administrative overheads *(evidenced by growth in Admin/Other expense streams)* • ongoing investment in clinical and reporting systems *(contextual – not directly captured).*
Hotel and non-clinical costs	• enhanced nutrition and food standards • permanent infection control protocols post-COVID • rising energy and utility prices (2022–24).	• higher Hotel and consumable costs per resident day *(evidenced by ~6% increase)* • increased staffing and consumables for food service and infection control *(partially evidenced; reflected in higher Hotel cost components)* • capital upgrades to kitchens / HVAC / environmental systems *(contextual; not directly captured in the dataset).*
Capital, maintenance and accommodation	• evolving design and accommodation standards emphasising single room, dementia friendly and infection resilient layouts • expanded safety, fire and compliance obligations • higher insurance and accreditation related costs.	• greater capital intensity and fixed overhead per RBD *(partially evidenced – variation across providers)* • moderate year-on-year growth in depreciation and maintenance expenses *(evidenced by moderate increase in Accommodation cost share).*

Together, these developments have redefined the cost profile of residential aged care. The differences observed between the RACCS 2023 and RACCC 2024–25 datasets reflect a structural adjustment as the sector adapts to the reformed funding and regulatory environment, rather than short-term variation.

Given the scale and pace of reform, both AN-ACC Class weights and BCT settings are expected to evolve to reflect contemporary service delivery conditions and the efficient cost of providing high quality care.

As the sector continues to develop, ongoing review and adjustments to AN-ACC Class weights and the BCT will remain essential to ensure IHACPA's annual pricing advice reflects current evidence of efficient and sustainable care delivery.

The RACCC 2024–25 represents a significant advance in IHACPA's evidence base for residential aged care pricing. It demonstrates the sector's growing capacity to provide high quality, time- and cost-linked data and confirms the feasibility of transitioning toward a national, activity-based costing framework.

Implementing the recommended actions: expanding provider representation, improving data alignment, refining costing standards, and strengthening costing capability will enable IHACPA to produce progressively more granular and defensible pricing advice that better reflects service diversity and support a sustainable, efficient aged care system.

Appendix A Business rules to support costing process

RACCC 2024-25

Business rules to support the costing processes for the final dataset

OFFICIAL

16 May 2025

IHACPA

RACCC 2024-25 Business rules to support costing process for final dataset — 16 May 2025

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A.1. Potential combination of financial data sources

The following outlines the potential data sources for financial data that could be used to support in deriving the costing ledger for the RACCC 2024-25 study.

1.1. Guiding principles for the use of financial data

The following principles will guide the use of financial data as inputs into the costing process:

- Any data submitted to the Department of Health, Disability and Ageing or Independent Hospital and Aged Care Pricing Authority (IHACPA) for official purposes, such as the Quarterly Financial Report (QFR) and Aged Care Financial Report (ACFR), will only be used once finalised (i.e. draft versions will not be used).
- Any data collected for the primary purpose of RACCC 2024-25 (excluding drafts of data to be subsequently submitted for other official purposes) can be used. It will be the responsibility of the HealthConsult Consortium to review the data to ensure that it is fit for purpose before use.
- Misalignment of activity and costs data under the agreed methodology could result from:
  - Use of data from different time periods, e.g. the period in which the timing data is collected from participating sites differs to the period of the financial data being used
  - Staff inadvertently using a card assigned to a different staff designation (and not being aware of doing so) or forgetting to wear a staff card altogether.

These issues may, in some instances, generate implausible analysis results due to the misalignment of data (e.g. calculated hourly rates for some staff designations are unrealistic). After consideration, no adjustments will be made to deal with misaligned data. This decision was taken for two reasons. First, corrective action is likely to lead to greater errors as there is no solid evidence base within the scope of RACCC 2024–25 on which to adjust the financial data. Second, the implausible data generally occurs when drilling down into the results, whereas the results at the aggregate level are more robust.

1.2. Options for financial data combinations

QFR and ACFR data will be used for all sites as the principal sources of the financial data. The time periods for these reports are defined as:

- **QFR data**: Finalised QFR 2 2024-25 (second quarter data 1 October to 31 December 2024), available in the SDMS. ***Note that the decision to use only one quarter's data was taken to fully reflect the changes in requirements on the residential aged care sector that applied from 1 October 2024, especially for minutes of care.***
- **ACFR data**: Finalised ACFR 2023-24, available in the SDMS.

1.3. Summary of the indexation adjustments

The approach adopted for indexation adjustments is as follows:

- **Wage increases**
  - No indexation applied to labour costs within the QFR data for Wage Price Index (WPI), as the QFR is based in 2024-25 financial year.
  - Labour costs not within the QFR but in the ACFR (e.g. labour costs for catering, cleaning, hotel, accommodation, etc.) are indexed at the WPI rate of indexation (for the midpoint of 2023-24

ACFR = 31 Dec 2023 to midpoint of Q2 2024-25 QFR = 15 Nov 2024), not the Consumer Price Index (CPI) rate of indexation used for non-labour costs.

- **Price increases for non-salary and wage expenses**
  - The rate of indexation applied to the 2023-24 ACFR non-labour data will represent the movement in CPI for midpoint of 2023-24 ACFR = 31 Dec 2023 to midpoint of Q2 2024-25 QFR = 15 Nov 2024.

Table 9 presents a summary of the rate of indexation required to align the financial data to the data collection period.

Table 9: Rate of indexation adjustment to be applied to all sites

	Rate of indexation
WPI[a] (for labour costs within QFR)	n/a
CPI[b] (for non-labour costs within the ACFR)	2.31%
WPI[c] (for labour costs within ACFR)	3.03%

a: No indexation applied to 24-25 values

b: For 2023-24 ACFR: Consumer Price Index (CPI) Index Numbers; All groups CPI; Australia; Difference between December 2023 (136.1) and average of the index values from September 2024 to December 2024 (139.3) = 3.150 express as a percentage 2.313%)

c: Movement in the Wage Price Index (WPI) Quarterly Index; Total hourly rates of pay excluding bonuses; Australia; Private and Public; Health care and social assistance; Difference between December 2023 (160.1) and average of the index values from September 2024 to December 2024 (160.1) = 3.950 express as a percentage 2.53%); plus 0.5% to represent the increase in the superannuation guarantee levy from 11.0% to 11.5% effective from 1 July 2024, noting superannuation is excluded from the WPI equates to 3.03%

A.2. Steps to transition data

The steps required to transition the data from the existing sources to present dollar terms and to align the data to the number of days within the study period are summarised below. A simple linear process is used to transition the raw data to the inputs required as part of the costing process.

2.1. Aligning the source financial data to the study period

The following steps outline the process to align the financial input data to the study period for a site. The study period for each site is targeted to reflect 30 days within the 2024-25 financial year, dependent upon the Tranche and Sprint they participate in[18].

Indexation of QFR data

1) **Identify QFR data period**. QFR 2 (2024-25) data for each site.
2) **Value of adjustment to QFR data**. No indexation is required to the QFR data as it relates to the 2024-25 financial year.

Indexation of ACFR data

3) **Identify the ACFR data**. 2023-24 ACFR data (submitted to IHACPA).
4) **Value of the adjustment to ACFR data**. To reflect the value in current dollar terms, the amounts need to be indexed.
    - Each line item within the ACFR data, excluding data that is being extracted from the QFR (i.e. care expenses employee, care expenses agency costs and total direct care labour costs), needs to be indexed.
    - As 2023-24 data will be used the rate of indexation to be applied is:
        - **2.31%**[19] CPI rate of indexation for non-labour costs
        - **3.03%**[20] WPI rate of indexation for any labour components (e.g. labour costs for catering, cleaning, hotel, accommodation etc.).
5) **Identify the number of actual study days for the study period for the site**. Note that the target is 30 days but may vary depending on local circumstances.
    - Refer to the site's start and end dates to determine the number of full study days.
    - Review the first and last days of data capture to ensure they reflect full days and are not representative of partial data collection. If either is partial, subtract the day(s) from the number of study days for a site.
    - Review the data for days that are clear outliers, e.g. time collected is significantly lower or higher (plus or minus 50% total daily hours for a site) than other days during the study period. Subtract the number

[18] Please refer to project progress reports for the specific start and end date of each Tranche and Sprint

[19] For 2023-24 ACFR: Consumer Price Index (CPI) Index Numbers; All groups CPI; Australia; Difference between December 2023 (136.1) and average of the index values from September 2024 to December 2024 (139.3) = 3.150 express as a percentage 2.31%)

[20] Movement in the Wage Price Index (WPI) Quarterly Index; Total hourly rates of pay excluding bonuses; Australia; Private and Public; Health care and social assistance; Difference between December 2023 (160.1) and average of the index values from September 2024 to December 2024 (160.1) = 3.950 express as a percentage 2.53%); plus 0.5% to represent the increase in the superannuation guarantee levy from 11.0% to 11.5% effective from 1 July 2024, noting superannuation is excluded from the WPI equates to 3.03%

of impacted day(s) from the study period. Note that the treatment of outliers for individual staff and resident cards is discussed in Step 8).

6) **Scaling the QFR data**. Using the indexed QFR data from Step 1), scale the data to reflect the number of bed days in the study period for the site, as outlined below:

- Scaled QFR data = QFR data (/) QFR resident bed days (*) the number of resident bed days for the site during the data collection period.

7) **Scaling the ACFR data**. Using the indexed ACFR data from Step 4), scale the data to reflect the number of bed days in the study period for the site, as outlined below:

- Scaled ACFR data = ACFR data (/) ACFR resident bed days (*) the number of resident bed days for the site during the data collection period.

2.2. Preparation of time data

The timing data collected from each site during the data collection period needs to be prepared for use in the costing process. The steps required are outlined below.

8) **Data cleansing**. The raw time data collected needs to undergo a data cleansing process, including:

- Any data captured before or after the data collection period for a site should be removed to ensure that the time data only reflects the days in the study period.
- Any data collected by an individual resident's card interacting with staff cards during the data collection period that is clearly an error (e.g. excessive hours collected for an individual resident due to the resident card being located too close to the basket containing all staff cards) should be adjusted as follows:
  - **Resident time data**:
    - Direct time data cleansing uses the 'adjusted daily average', calculated as the arithmetic mean of the total direct time recorded for each resident bed day but excluding from the numerator and denominator:
      - days where direct time is less than 5 mins and
      - days where direct time is more than 9 hours.
    - Where the total direct time for a day is less than one-quarter (L4, lower trim point) of the adjusted daily average for a resident without adequate explanation from the site, the time recorded is removed and replaced by the adjusted daily average for that resident.
    - Where the total direct time for a day is more than 3 times (H3, upper trim point) the adjusted daily average for a resident without adequate explanation from the site, the time recorded is removed and replaced by the adjusted daily average for that resident.
  - **Staff time data:**
    - Where the total time collected by a staff card exceeds 24 hours (i.e. 1,440 mins) within a day, the data is removed from the direct data collected.

9) **Determining occupied bed days**. The process to determine the occupied beds for a site during the study period is outlined below:

- Use the list of all residents (*File No. 2*), including those who have opted out, with an admission date before the commencement of the study period.
- Multiply the number of residents by the number of study days (as per Step 5).

- Subtract the number of days a resident is absent (*File No. 4*) (including Leave/holidays, Hospital/other care appointments, Deceased, if a Discharge Date is provided (*File No.2*), the days left in the study period, and Other).
- For any new admissions (*File No. 2*) (i.e. any resident with an admission date after the commencement of the study period), add the number of remaining days in the study period from the date of admission (excluding any days during the study period that may have been excluded for that site or excluded for a resident, e.g. leave days).

10) **Indirect time captured**. For indirect time captured by staff cards interacting with the beacons placed in staff common areas during the data collection period, a hierarchical approach to the allocation of this time is outlined below. This step relates only to the allocation of time captured during the study period that is not directly attributable to a resident; unallocated time is addressed separately in Step 12).

- ***Indirect*** time captured but not supported by additional information on indirect time[21]:
  - 44% of costs associated with indirect care time should be treated as attributable to specific residents and allocated in line with direct care minutes for residents captured by the staff cards, as adjusted for the trimming rules in Step 8 for that day (i.e. across all hours of the day).
  - 56% of costs associated with indirect care time should be allocated evenly across all residents based on occupied bed days for that day (i.e. across all hours of the day).

11) **Group activity time**: Time recorded for staff providing group activities for residents. The process to allocate time that aligns with the Group Activity data provided by sites is to:

- Allocate time indicated as relating to group activities equally across all residents based on resident bed days (RBD) (limited to within a unit where applicable) for the specified time and staff designation(s) provided.
- Remove this time from the 'direct time for those staff designations.

12) **Unallocated time**: The difference between total time captured (time data collected via the staff cards interacting with beacons and group activity time during the study period) and the adjusted roster time (adjusted to reflect residents who opted out or were excluded due to data quality). Total hours worked is based on the adjusted roster time, which is calculated for a site by:

- ***Roster data***: Taking the roster for the days corresponding to the data collection period and calculating the hours represented for each staff designation, adjusting for any days that have been excluded (e.g. excluding any days during the study period that may have been removed for that site (as per Step 5)).
- ***Adjusting for staff meal times***: For carers, nursing staff and allied health assistants (AHAs) the following adjustments are required:
  - For staff working more than 5hrs, deduct 30mins (representing the unpaid meal break).
  - For staff that work less than 5hrs, no adjustment is required.
- No meal breaks adjustment is required for allied health staff, as they generally work casually.
- ***Adjusting for residents who opt or are excluded due to data quality***: Calculate the proportion of roster time that relates to residents who opted out or were excluded due to data quality reasons and remove this from the total roster time.

The above changes result in the adjusted roster time.

- Total captured time**:** Total captured time = direct time (card time and group activities) (+) indirect time captured (from interactions with location beacons) (-) time data relating to any days that have been excluded (as per Step 5).

[21] The 44%:56% ratio being applied was prescribed by IHACPA, as derived in RACCS 2023

- **Allocation of unallocated time**: Where unallocated time is the adjusted roster time less (-) total captured time[22].
  - 44% of costs associated with unallocated time should be treated as attributable to specific residents and allocated in line with direct care minutes for residents captured by the proximity devices (i.e. staff cards) for that day (i.e. across all hours of the day).
  - 56% of costs associated with unallocated time should be allocated evenly across all residents based on occupied bed days for that day (i.e. across all hours of the day).

13) **Separate the resident time between day hours and night hours**. Separate time data (direct, indirect) for each resident for each day into day and night hours, defined as:
    - ***Day hours***: the hours between 6am to 9.59pm
    - ***Night hours***: the hours between 10.00pm to 5.59am.
14) **Residents who have opted out of the study**. For residents who opt out, they are considered as having opted out for the whole study and not just from the opt out date to the end of the data collection period.
15) **Basis of allocation**. For costs other than those based on time allocation, the basis for allocation is summarised in **Table 10**. Residents that are on leave (including going to hospital) are not allocated variable costs (i.e. those allocated on resident bed days) but are allocated fixed costs (i.e. those allocated on registered bed days).

Table 10: Basis of allocation

Expense category	Basis of allocation
Resident Supplies	Resident Bed Days
Other Direct Care Expenses	Registered Bed Days
Catering	Resident Bed Days
Cleaning	Registered Bed Days
Laundry	Resident Bed Days
Maintenance	Registered Bed Days
Energy	Registered Bed Days
Other Hotel	Registered Bed Days
Accommodation	Registered Bed Days
COVID 19 Expense	Resident Bed Days

[22] The 44%:56% ratio being applied was prescribed by IHACPA, as derived in RACCS 2023

2.3 Summary of all trimming rules

A summary of all trimming rules is provided in **Table 11**.

Table 11: Summary of trimming rules (for interim dataset)

Rule No.		Rule	Description
Raw dataset			
(-)	Rule 1	Sites for exclusion	Sites removed due to data quality issues (generally due a large proportion of days with very low or insufficient direct time records); the site is removed if the proportion is >50% without clear reason
(-)	Rule 2	Bad direct time data is 50% or more resident days are greater than 9 hours	Residents with excessive volume of very high direct time days are treated as opted out residents (an error in collection is assumed)
(-)	Rule 3	Data outside data collection start and end dates	Judgement is used where it is evident that a site started later than anticipated
(-)	Rule 4	Adjust all data for opted out residents	All direct, indirect, group and delta time removed (in proportion to resident bed days), residents 'count' retained for bed numbers, scaling financials, receive overhead costs
(-)	Rule 5	Data after resident's death	Any direct time data from the day following a resident's death is removed
(-)	Rule 6	Data during other absences	Any direct time data collected during a resident's hospital (or other type of leave) stay removed
(-)	Rule 7	Data pre-admission date for residents admitted during study period	Any direct time data occurring before the date of admission are removed
(-)	Rule 8	Interactions belonging to invalid resident IDs (spare devices)	Any time relating to devices not allocated to residents is removed
(-)	Rule 9	Interactions comprising multiple cards with a duration of precisely 30 minutes starting at exactly the same time	These records are removed as they are overwhelmingly likely to be a result of resident cards being temporarily stored with staff cards
=		**Cleansed dataset**	
Cleansed dataset			
(-)	Rule 10	Data outside selected 30 consecutive costing days	Trimming at beginning and end of 30 day period where data is considerably lower than mid-study norms
(-)	Rule 11	Bad days mid-study with very low record counts (rule applied at 'site' level)^	Days with data issues removed from consecutive sequence (rare), all residents opted out on those days. Site specific application only if required
(-)	Rule 12	Residents with a low number of days (<25% of all days) with associated wearable records	These residents are treated as opt out if low volumes are not explained through absence or card swaps
(-)	Rule 13	Judicious application of manual trimming	For example, where trimming algorithms result in rare costing anomalies (unrealistic delta times (Rule 14) circumstances vary
=		**Business rules applied dataset**	

Rule No.		Rule	Description
Business rules applied dataset			
(+)	Rule 14	Backfilling days outside threshold range with resident study period average (excluding values outside threshold)	Thresholds are L4 (25%) of resident norm, H3 (300%) of resident norm, considered per staff designation, per day (base on the adjusted daily average as per *Section 2.2 point 8*)
(+)	Rule 15*	Back filling days over 9 hours	For resident bed days where the measured direct time is >9 hours, the measured time for each staff designation will be replaced with the adjusted daily average direct time for that resident (even if it complies with the H3 (upper trim point) rule).
(+)	Rule 16*	Back filling days below set AN-ACC minimum threshold	Measured direct time is replaced with the adjusted average direct time for each staff designation for resident bed days with measured direct time less than the pre-determined AN-ACC class threshold time (even if it complies with the L4 (lower trim point) rule). The AN-ACC class thresholds are defined as follows: • AN-ACC class 2: no minimum • AN-ACC classes 4 and 6: 5 minutes • AN-ACC classes 3, 5, 7, 8 and 9: 10 minutes • AN-ACC classes 11, 12 and 13: 15 minutes
(-)	Rule 17*	Exclude residents with more than 75% days below AN-ACC minimum threshold	The entire record is excluded for a resident if more than 75% of their days fell below the pre-determined AN-ACC class threshold time defined as: • AN-ACC class 2: no minimum • AN-ACC classes 4 and 6: 5 minutes • AN-ACC classes 3, 5, 7, 8 and 9: 10 minutes • AN-ACC classes 11, 12 and 13: 15 minutes
(+)	Rule 18	Delta records are created where rostered hours exceed wearable hours recorded	Delta hours are also created where staff designation costs exist in the ACFR expenditure data and no corresponding wearable hours are recorded
(+)	Rule 19	Adjustment for unmatched ACFR/QFR S&W costs	Where the ledger file contains costs for S&W categories without corresponding roster/wearable data, the staff designation is switched to the best-fit adjacent staff designation with the 'most' cost. E.g. EN -> RN, LSO -> PCW
=		**Backfilled dataset**	

^Clarence Estate experienced an electrical storm which wiped time data from wearables cards on the 3rd and 4th of August 2024.

*These rules are introduced for the purpose of aligning to the RACCS 2023 trimming rules.

A.3. Adjustments required during the costing process

3.1. Allocation of overhead costs

Preparation of input files for allocation of overhead costs:

16) **Allocation method for overhead expenses**. Administrative expenses (including corporate recharges, insurance, quality, etc. and consistent with items included as administrative expenses within the ACFR) have been classed as overheads. Only administrative expenses constitute overhead costs for this study. Several options for allocating overhead expenses were considered. Ultimately, IHACPA requested that the following approach be used.

- **Step 1: Allocation of overhead costs to streams**
  - ***Allocation of corporate recharges to streams***: Split the site's corporate recharge expenses across the three streams; namely, care, accommodation and hotel. This allocation is based on:
    - *Care stream*: care expenditure as a proportion of total expenditure (noting that COVID expenses are included within care stream)
    - *Accommodation stream*: accommodation expenditure as a proportion of total expenditure
    - *Hotel stream*: hotel expenditure as a proportion of total expenditure.
  - ***Split remaining administrative costs between accommodation and hotel streams***:
    - *Accommodation stream*: 50% of remaining administrative expenses allocated to accommodation overhead costs
    - *Hotel stream*: 50% of remaining administrative expenses allocated to hotel overhead costs
- **Step 2: Allocation of overhead expenses for each stream to individual residents**. Once the pool of overhead expenses has been determined for each of the three streams, these expenses then need to be allocated to each resident per day per stream. Some costs will not be allocated if the resident is on leave for a given day. Different allocation methods are used between the three streams:
  - ***Care Stream***: Three (3) different methods to allocate corporate recharges (the only type of overhead expenses allocated to the care stream) to individual residents:
    - *Direct time* collected by cards to allocate direct labour cost components to individual residents, using the actual time for all staff designations, which includes individual disciplines within allied health
    - *Prescribed 44%:56% split* to allocate indirect and unallocated cost components to individual residents
    - *RBDs* to allocate group activity cost components to individual residents.

    This means that the amount of corporate recharge expenses incurred by a resident will likely vary day by day, based on the care time they have received.
  - ***Accommodation Stream***: Registered bed days are used to allocate the accommodation stream proportion of overhead expenses to individual residents. Using registered bed days will result in a consistent amount being allocated to each resident. The use of registered bed days will also result in costs being incurred by a resident even when they are on leave.
  - ***Hotel Stream***: Two (2) different methods to allocate overhead expenses to individual residents:
    - *Registered bed days* to allocate cleaning, energy and other hotel cost components to individual residents
    - *RBDs* to allocate catering and laundry cost components to individual residents.

    Expenses allocated on registered bed days will result in costs being incurred by a resident even when they are on leave. Expenses allocated on RBDs will not be incurred when the resident is on leave.

3.2. Adjustments that may be required during the costing process

Table 12 provides an overview of the adjustments that may need to be made as part of the costing process.

Table 12: Adjustments required during the costing process

No.	Adjustment	Rationale
1	**Residents who opt out**	• Adjust the data for the number of days that a resident opts out of the study, where it is assumed that any resident who opts out does so for the complete study. • Use the proportion of bed days provided to residents who opt out to adjust the expenditure data (i.e. if 5% of the beds days are attributable to residents who opt out, then 5% of the reported expenditure is removed from the costing process). • Use the same proportion of opt out bed days as the basis to adjust the staff time captured during the study period, by staff designation (total time combination of direct and indirect time).
2	**If allied health (AH) is not captured by designation**	• Data captured to an AH card (e.g. where the 'AH other' staff category is used) not linked to a specific designation (i.e. not specifically allocated to a physio, OT, etc.) or where the site has indicated that the card has been used by more than one type of allied health staff • Use the reference data (i.e. QFR data) broken down by designation to allocate the undesignated AH time in the same proportions and disciplines as per the QFR data for the site with the application of per Trimming Rule 19 where required.

Appendix B Mapping of additional administrative expense categories to ACFR administrative lines

Table 13 shows the mapping of the additional administrative expenses (category and subcategory) in the '*Additional Admin data*' tab in *File No. 7 Financial data* to the corresponding line items in the administrative category in the ACFR.

Table 13: Mapping of administrative expenses to ACFR categories

Additional admin expense items	Sub-category (Additional admin expenses)	ACFR
Labour costs - Administration staff - Employees and Agency	Allocate Administration staff labour costs against the following business areas:	Employee and Agency labour costs
	CEO, Executive staff	
	Business Support (ICT Management, HR, People & Culture, Finance and business services)	
	Quality & Risk/Compliance	
	Other - Sales, Marketing and business development	
Quality, compliance and training external costs - Administration staff	Accreditation expenses	Quality, compliance and training external costs
	Other quality, compliance and training external expenses	
Insurances	WorkCover premium	WorkCover premium (aged care home admin employee labour)
	Professional Indemnity	Insurances
	Volunteers	
	Public liability	
	Rental properties	
	General contents	
	Building and contents	
	Motor vehicles	
Other administration costs	IT expenses	Other administrative costs
	Consulting fees	
	Marketing	
	Recruitment expenses	
	Accounting fees	
	Legal fees	
	Audit fees	
	Finance expenses	
	Safety management (OH&S)	
	Travel	
	Sundry expenses	
Corporate recharges	Corporate recharges	Corporate Recharges
Taxes	Payroll Tax	Payroll tax (aged care home admin employee labour)
	FBT	Fringe benefits tax

Appendix C Confidence interval and standard error tables

Table 14: Average cost per RgBD by Modified Monash Model (MMM) classification, with 95% CIs and standard error

Modified Monash Model (MMM)	95% CI	Standard Error
MM 1	$417 - $422	1.33
MM 2	$445 - $464	4.81
MM 3	$426 - $439	3.38
MM 4	$428 - $442	3.68
MM 5	$447 - $473	6.59
MM 6–7	$689 - $847	40.36

Source: RACCC 2024–25 Final dataset

Note: MM 1 = Metropolitan areas; MM 2 = Regional centres; MM 3 = Large rural towns; MM 4 = Medium rural towns; MM 5 = Small rural towns; MM 6 = Remote communities; MM 7 = Very remote communities

Table 15: Average cost per RgBD by location, with 95% CIs and standard error

Location	95% CI	Standard Error
Metro	$421 - $426	1.30
Regional	$434 - $443	2.42
Remote	$689 - $847	40.36

Source: RACCC 2024–25 Final dataset

Table 16: Average cost per RgBD by size, with 95% confidence intervals and standard error

Size	95% CI	Standard Error
Small	$567 - $439	18.51
Medium	$431 - $438	1.89
Large	$418 - $423	1.43

Source: RACCC 2024–25 Final dataset

Note: Small = 30 or less operational places; Medium = 31 to 89 operational places; Large = 90 or more operational places

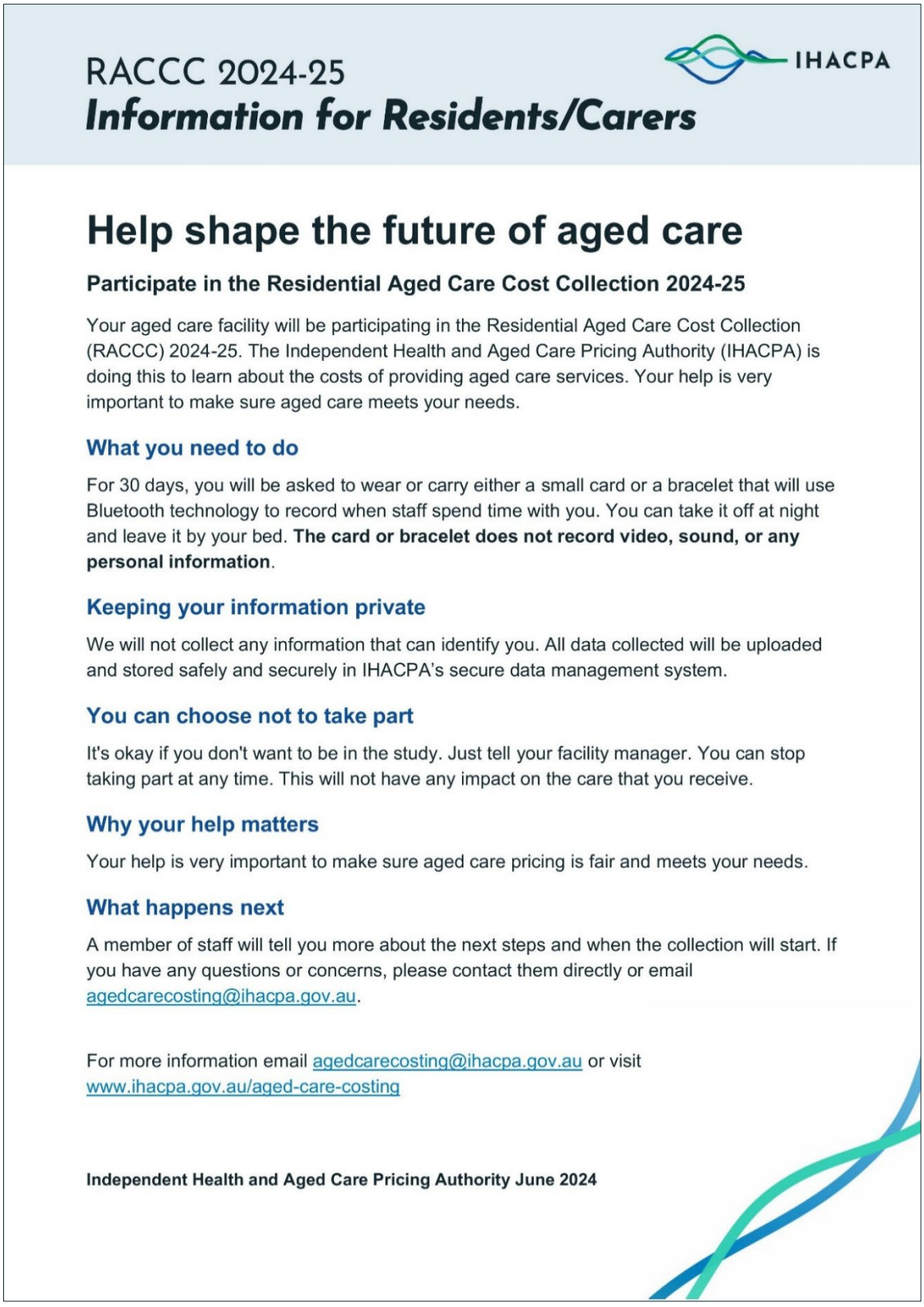
Table 17: Average cost per RgBD by ownership, with 95% confidence intervals and standard error

Ownership	95% CI	Standard Error
For Profit	$423 - $433	2.38
Not for Profit	$419 - $424	1.27
Government	$639 - $704	16.62

Source: RACCC 2024–25 Final dataset

Appendix D Participant information letters

D.1. Letter for residents and family carers



RACCC 2024-25

Information for Residents/Carers

IHACPA

Help shape the future of aged care

Participate in the Residential Aged Care Cost Collection 2024-25

Your aged care facility will be participating in the Residential Aged Care Cost Collection (RACCC) 2024-25. The Independent Health and Aged Care Pricing Authority (IHACPA) is doing this to learn about the costs of providing aged care services. Your help is very important to make sure aged care meets your needs.

What you need to do

For 30 days, you will be asked to wear or carry either a small card or a bracelet that will use Bluetooth technology to record when staff spend time with you. You can take it off at night and leave it by your bed. **The card or bracelet does not record video, sound, or any personal information**.

Keeping your information private

We will not collect any information that can identify you. All data collected will be uploaded and stored safely and securely in IHACPA's secure data management system.

You can choose not to take part

It's okay if you don't want to be in the study. Just tell your facility manager. You can stop taking part at any time. This will not have any impact on the care that you receive.

Why your help matters

Your help is very important to make sure aged care pricing is fair and meets your needs.

What happens next

A member of staff will tell you more about the next steps and when the collection will start. If you have any questions or concerns, please contact them directly or email agedcarecosting@ihacpa.gov.au.

For more information email agedcarecosting@ihacpa.gov.au or visit www.ihacpa.gov.au/aged-care-costing

Independent Health and Aged Care Pricing Authority June 2024

D.2. Letter for staff

RACCC 2024-25
Information for Staff

IHACPA

Help shape the future of aged care

Participate in the Residential Aged Care Cost Collection 2024-25

Your aged care facility will be participating in the Residential Aged Care Cost Collection (RACCC) 2024-25. The Independent Health and Aged Care Pricing Authority (IHACPA) is doing this to learn about the costs of providing aged care services. Your help is very important to ensuring that residential aged care is appropriately funded.

What you need to do

For 30 days, staff will be asked to wear special cards or bracelets during each shift. These will record the amount of time you spend with individual residents using Bluetooth technology. At the start of each shift, you will simply pick up a card or bracelet that will have your job title on it (e.g. RN, care worker etc.) At the end of your shift, you simply return the card or bracelet to the collection box. You will not need to charge the devices.

Training and help

HealthConsult's team will be there to help you during the collection. They will provide training on how to use the devices. They will also provide information packs, posters and a short video explaining the data collection.

Keeping your information private

Your identity will remain anonymous as no personally identifiable data will be collected. Data will be securely uploaded to IHACPA's Secure Management Data System, ensuring that employers cannot access it. This process guarantees that participating in the cost collection will not result in any negative consequences for you. You will also have the choice to opt out of the study without facing any penalties.

Why your help matters

Your help is very important to make sure aged care pricing is fair and evidence-based.

What happens next

A Site Sponsor will be appointed at each facility. They will tell you more about the next steps and when the collection will start. If you have any questions or concerns, please contact them directly or email agedcarecosting@ihacpa.gov.au.

For more information email agedcarecosting@ihacpa.gov.au or visit www.ihacpa.gov.au/aged-care-costing

Independent Health and Aged Care Pricing Authority June 2024

D.3. Letter for union representatives

RACCC 2024-25
Information for Union representatives

IHACPA

Residential Aged Care Cost Collection 2024-25

The Independent Health and Aged Care Pricing Authority (IHACPA) is currently recruiting residential aged care providers to participate in the residential aged care cost collection (RACCC) 2024-25. The RACCC 2024-25 will occur in about 200 facilities with data collection occurring progressively between July 2024 and August 2025. The RACCC 2024-25 aims to increase the number of participants from the Residential Aged Care Costing Study 2023 and to improve IHACPA's understanding of areas such as care related administration costs, allied health, indirect care time and respite services. The data collected will be used to inform IHACPA's aged care price advice to the Minister for Health and Aged Care.

IHACPA has consulted with the Health Services Union (HSU) on this matter. Staff with questions or concerns can contact HSU at 1300 478 670 or info@hsu.asn.au, or can speak to their appropriate union.

What it involves

For 30 days, staff will wear special cards or bracelets during their shifts. These will record the time that staff spend with residents using Bluetooth technology. At the start of each shift, staff will pick up a card or bracelet with their job title on it (e.g. RN, care worker etc.). After their shift, they will return the card or bracelet to the collection box. Staff won't need to charge the devices. There will also be an option for staff to choose not to participate in the study. If staff choose not to participate, there will be no penalties. Similarly, staff will not receive additional payment for their involvement in the collection. De-identified organisational level information will also be collected from each study site.

Keeping information private

No data will be collected that can identify individual staff members. All data will be uploaded and stored securely in IHACPA's secure data management system. Employers will not be able to see data that could identify individual staff members. This means staff cannot be assessed or penalised based on the data collected.

Training and help

Staff will be trained on how to use the devices and HealthConsult's team will provide ongoing support throughout the data collection. They will also give staff information packs, posters and a short video explaining the data collection.

Independent Health and Aged Care Pricing Authority June 2024

D.4. RACH confirmation

RACCC 2024-25
Resident Consent Confirmation

IHACPA

Residential Aged Care Costing Collection (RACCC) 2024-25

I hereby confirm that the resident information for the Residential Aged Care Costing Collection 2024-25, provided by the Independent Health and Aged Care Pricing Authority (IHACPA), has been distributed to residents/relatives at the below facility prior to the commencement of data collection. I attest that the residents/families are fully informed of their option to opt out of RACCC 2024-25 at any time before or during the data collection process.

I confirm that the wishes of those who opt out of the RACCC 2024-25 will be fully respected. No resident who has opted out of the study will be included in the data collection process. On the day of roll out, we will verbally confirm with all residents their willingness to be part of the data collection process prior to the beacons are distributed.

This document serves as a formal acknowledgment of the above-mentioned matters, and it is my commitment to ensure that they are upheld throughout the duration of the Costing Study.

Facility Representative Confirmation

Facility Name:

Name of Representative:

Signature of Representative:

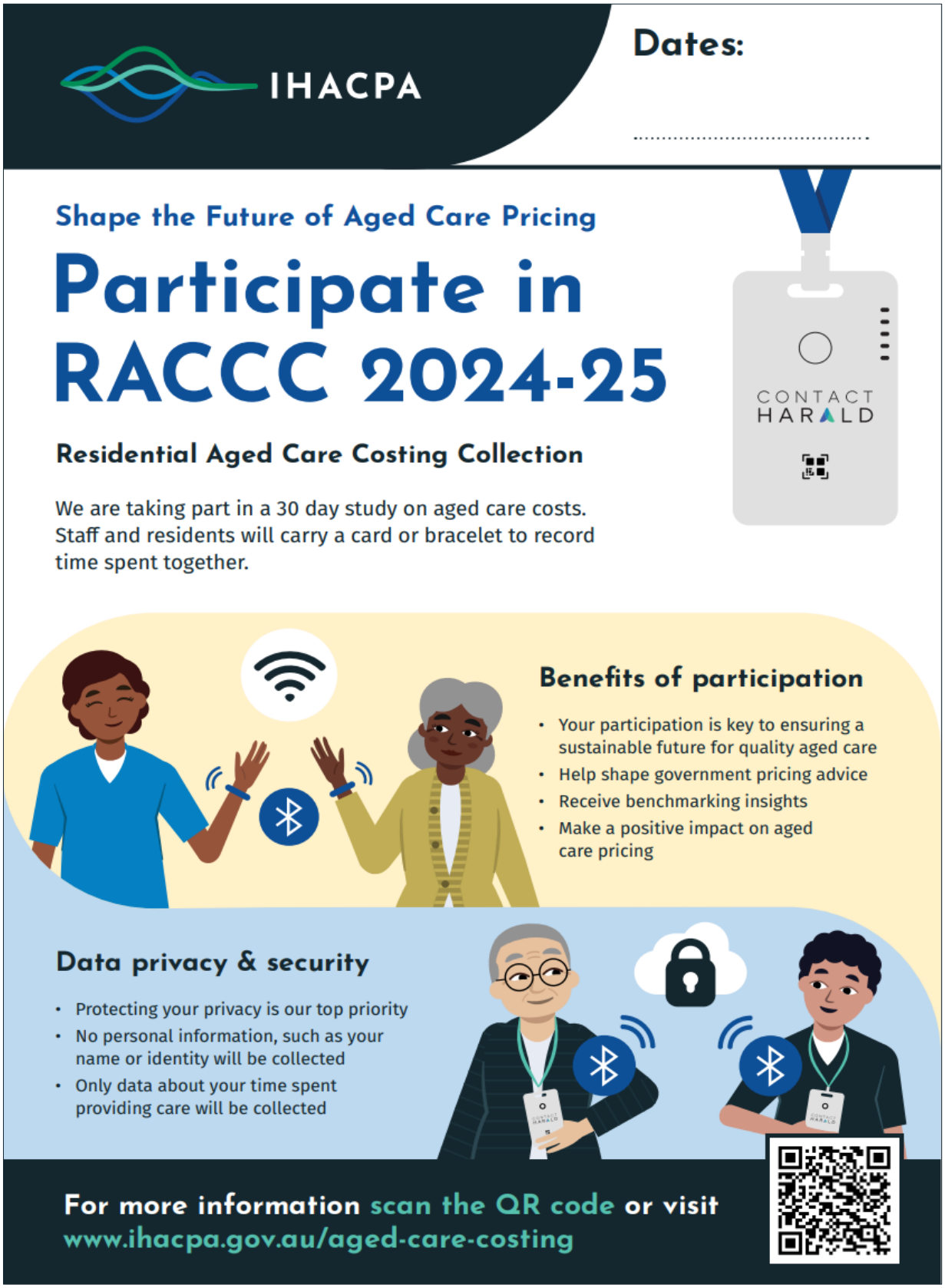
Date:

More information

For more information email agedcarecosting@ihacpa.gov.au or visit www.ihacpa.gov.au/aged-care-costing

Independent Health and Aged Care Pricing Authority June 2024

Appendix E RACH recruitment materials



Appendix F RACCC 2024–25 DRS files

Table 18: DRS files used for data collection for RACCC 2024–25

File (DRS)	Purpose	Contents/Key Data	Frequency	Notes
File 1: Workforce data	Provides a profile of the workforce at a given home to support analysis of time data	List of de-identified staff members by staff type and unit including work patters	Submitted once prior to data collection	Not used beyond Phase 1 - file was burdensome for homes to complete and didn't provide significant additional insights from the de-identified roster
File 2: Resident details and movements	Establishes the resident population and tracks unit/room movements, allowing time data from Bluetooth devices to be correctly attributed to residents and interactions	Resident list with: • AC-ID or CRID identifier • admission and discharge dates • room, bed, and unit allocation • device number assigned to each resident • residents who moved units, rooms, or beds during the collection period (only completed if required) • identification of residents who opted out of the cost collection.	Submitted prior to data collection and updated as needed throughout (i.e. to capture discharges or additional opt outs)	
File 3: Group activities	• captures structured group activities and staff involvement • accounts for device limitations: staff cards can only register one resident at a time • ensures time data from Bluetooth devices can be correctly interpreted for group care settings	• date/time of activity • short activity description • staff type • staff card ID • unit/s participating (if applicable).	Submitted as often as required during data collection	

File (DRS)	Purpose	Contents/Key Data	Frequency	Notes
File 4: Resident absences	Identifies periods when residents are not in the RACH, ensuring Bluetooth-collected care time is not incorrectly attributed to absent residents	• resident identifier (AC-ID and/or room number) • dates/duration of leave • category of leave (i.e. social, hospital, deceased).	As needed, only if leave occurs during the cost collection period	
File 5: Resident Change in status	Identifies cognitive or functional changes in residents that may affect care needs, helping to validate variations observed in recorded time data	• resident identifier (AC-ID and/or room number) • date of change • brief description of change.	As needed, only if changes occur during the cost collection period	
File 6: Indirect care time	Documents non-direct care activities performed by staff in staff areas, supporting a complete understanding of total staff time allocation beyond direct resident care	• date/time of indirect activity • staff type • description of tasks performed in staff areas.	Submitted as often as required during data collection	Trialled by a subset of homes in Phase 1 and discontinued due to burden on the homes to complete and reliability of results (refer Section 8)
File 7: Financial data* **Subset of 50 homes completed only*	Provides home level costs to combine with time data and resident activity, enabling robust cost-per-care analysis and allocation of overheads	• home costs • administrative overhead composition.	Submitted once no later than 7 days after data collection	Updated after Phase 1 to reduce the amount of work required for homes

Appendix G RACCC 2024–25 Data sources and data collection timing

Table 19: Tables in the DRS, data source and timing of data collection

Data Table descriptor	Data item examples	Nature of data	Source	Timing of data collection	Number of RACH	File No.
RACH service characteristics and staffing						
RACH organisation characteristics data	• organisational type, number of places, location, specialised focus (if applicable)	Non-sensitive	RACH coordinator enters into SDMS	PRE data collection phase	All	Supplementary data during initial contact
	• type of unit (e.g., dementia care units), type of rooms within the unit (single/shared) and usual staff support for the unit.	Non-sensitive	RACH coordinator enters into SDMS	PRE data collection phase	All	Supplementary data *List of Units* and *Roster*
Workforce data	• workforce by staff type, during the month in which the cost collection occurred	Non-sensitive	RACH coordinator enters into SDMS	PRE data collection phase	All	Supplementary data *Roster*
	• staff rosters for the days in the cost collection period and any deviations from rostered staff.	Non-sensitive	RACH coordinator upload to SDMS	DURING data collection phase	All	Supplementary data *Roster*
Resident data						
Resident characteristics data[23]	• Aged Care ID (AC-ID) • demographic characteristics • resident AN-ACC end Class • date of assessment for resident AN-ACC end Class • Items from the assessment profile held by the RACH	Sensitive data	IHACPA and RACH coordinator upload to SDMS	PRE data collection phase	All	*File 2: Resident details and movements* linked to data in SDMS
	• AC-ID • resident's card identifier (for timing data) • residents' room.	Sensitive data	RACH coordinator enters into SDMS	PRE data collection phase	All	*File 2: Resident details and movements*
Resident movement data	• AC- ID • date of movement • origin and destination • reason from movement (e.g., admission to RACH, movements between sub-unit within RACH, admission to	Sensitive data	RACH coordinator enters into SDMS	DURING data collection phase	All	*File 2: Resident details and movements* and *File 4: Resident absence*

[23] A request will also be made to the Department of Health, Disability and Ageing for an extract of data related to the most recent assessment of the resident and associated AN-ACC data, and equivalent of resident movements. Using the AC-ID, these data will be linked to the cost collection data within the SDMS solely for the purpose of analysis for this cost collection. This will provide independent verification of the AN-ACC Class assigned to the resident and additional assessment information.

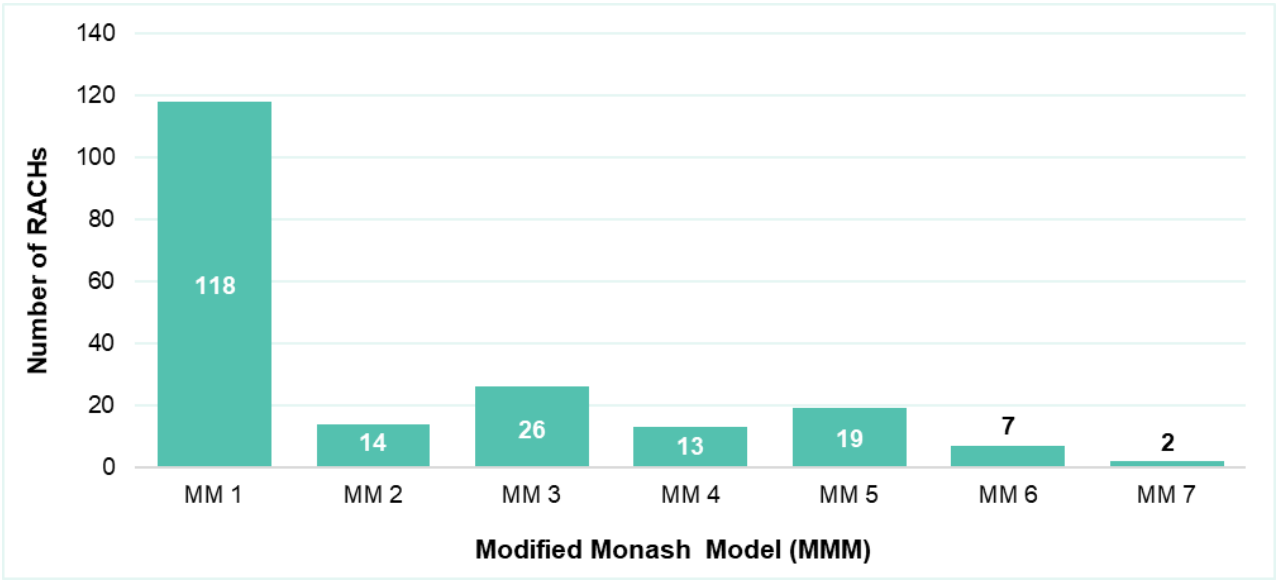
Data Table descriptor	Data item examples	Nature of data	Source	Timing of data collection	Number of RACH	File No.
	hospital, discharge, death).					
Resident time varying characteristics	• AC-ID • data items on how relative needs for the resident have changed over time, such as, periods of illness, onset/progression of conditions, admissions to hospital, short- or long-term changes in mobility.	Sensitive data	RACH coordinator enters into SDMS	DURING data collection phase	All	*File 5: Resident change in status*
Time and activity data						
DIRECT Time and activity data primary[α]	• staff wearable identifier • resident wearable identifier • interaction start time and end time.	Non-sensitive data	Bluetooth wearable automatically transferred to secure cloud then to SDMS	DURING data collection phase	All	n/a collected via devices during the cost collection
INDIRECT Time and activity data	• fixed beacon identifier • staff wearable identifier • interaction start time and end time • activity log capturing time staff spend on resident and non-resident activities in location where residents are not present.	Non-sensitive data	Bluetooth wearable automatically transferred to secure cloud then to SDMS plus manual activity log uploaded into SDMS	DURING data collection phase	**At least (n=24) 20% of RACH**	Collected via devices during the cost collection *File 6: Indirect time*
Financial data						
Secondary Financial data	• QFR data – last 2 quarters • ACFR data – last completed financial year • Stewart Brown financial data (if home participants).	Commercially sensitive data	Via home and IHACPA uploaded into SDMS	ESTABLISHMENT Phase	All**	QFR and ACFR in SDMS *File 7: Financial data* (optional)
Primary Financial Data	• supplementary financial data (e.g. administration/overhead cost data; Care expenses; Hotel service expenses, Administration expenses, Accommodation expenses, Infection prevention and COVID-19 expenses, other data that helps align expenditure to the in-scope services delivered in the costing period (e.g., overhead allocation statistics, product fractions, etc.).	Commercially sensitive data	RACH coordinator collects and enters into survey and uploads into SDMS	DURING data collection phase	RACH that cannot provide Stewart Brown financial data	*File 7: Financial data* (optional)

[α] Inclusive of allied health professional employed or subcontracted by the home ** ACFR and QFR data of all RACH will be sought from IHACPA to ensure that as soon as RACH are recruited ACFR and QFR data can be cleaned, loaded and validated into PPM engine for the home

Appendix H RACH by MMM and jurisdiction

Figure 45 shows the breakdown of homes based on MMM category. While the MMM was not a specific sampling selection criterion, the number of homes in each MMM category aligns with the national distribution of RACHs. For example, 59% of sampled RACHs are from MM 1, compared to 64% nationally, and 7% are from MM 4 compared to 7% nationally.

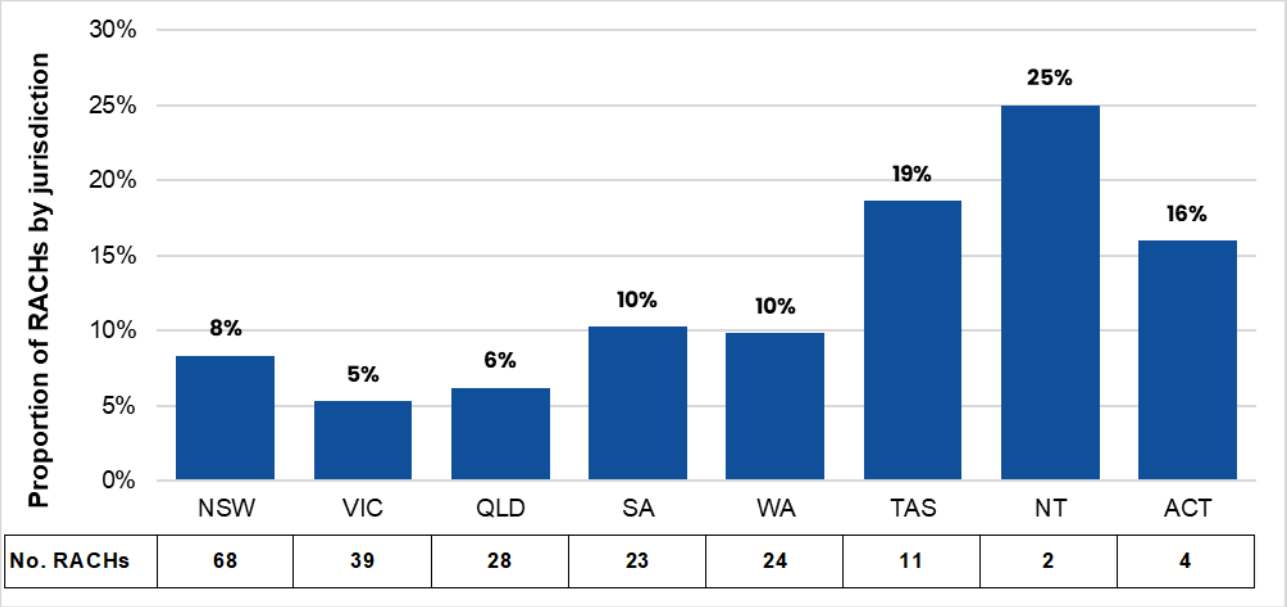
Figure 45: Number of RACHs by MMM category



Source: HealthConsult sampling framework (2024-2025) and RACCC 2024–25 Final dataset
Note: MM 1 = Metropolitan areas; MM 2 = Regional centres; MM 3 = Large rural towns; MM 4 = Medium rural towns; MM 5 = Small rural towns; MM 6 = Remote communities; MM 7 = Very remote communities.

Figure 46 shows the breakdown of RACHs based on jurisdiction. While jurisdiction was not a sampling selection criterion, the sample aligns with the national distribution of RACHs by jurisdiction, reflecting the population density and geographic concentration of RACHs in the eastern states.

Figure 46: Proportion of total participating RACHs across Australia, by jurisdiction



No. RACHs	68	39	28	23	24	11	2	4

Source: HealthConsult sampling framework (2024-2025) and RACCC 2024–25 Final dataset
Note: represents the proportion of the total number of participating RACHs within each jurisdiction; No. RACHs = number of RACHs in the cost collection.

Independent Health and Aged Care Pricing Authority

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