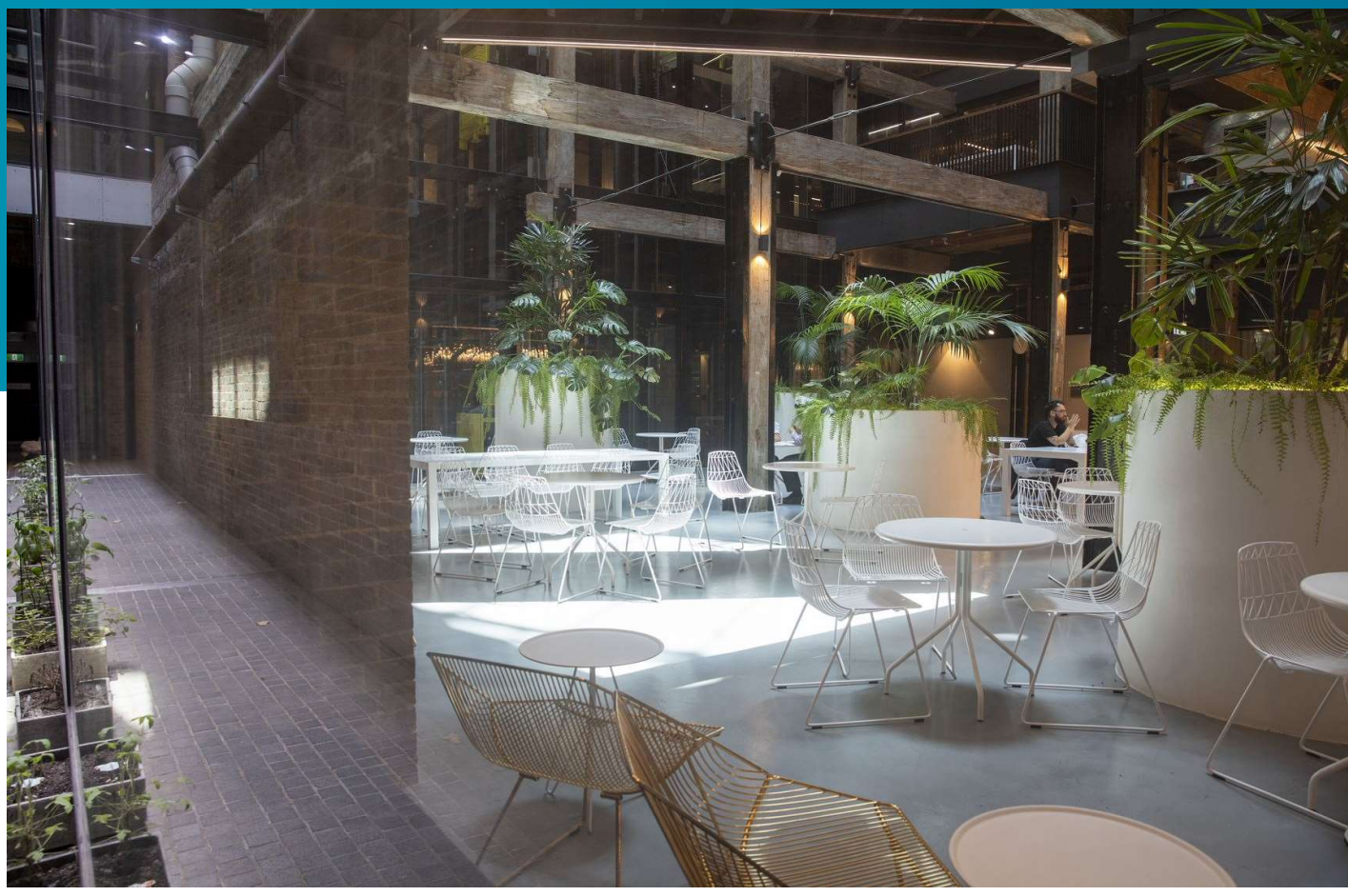
NABERS

The Rules

Energy and Water for Hospitals

Version 2.0 — December 2022



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1 Introduction

1.1 General

The National Australian Built Environment Rating System (NABERS) is a performance-based rating system managed by the **National Administrator.**

NABERS ratings are expressed as a number of stars, for example:

NABERS rating	Performance comparison
6 stars ★★★★★★	Market leading building performance
5 stars ★★★★★	Excellent building performance
3 stars ★★★	Market average building performance

An accredited NABERS Energy or Water rating is awarded when the **National Administrator** certifies a rating completed by an **Assessor**. The **National Administrator** may independently audit the rating and assist in resolving complex technical issues.

The objective of this document is to provide an independent method to benchmark the environmental performance of a hospital to provide asset specific information on energy and water use, and to compare performance with other hospitals. NABERS hospital ratings will be managed by state and territory **health departments**. The hospital ratings will be undertaken by the **health department** for a given state.

These **Rules** will supersede the following documents:

a) *NABERS Energy and Water for hospitals — Rules for collecting and using data*, v1.0, January 2017.

b) *NABERS Energy and Water for hospitals — Support Document: Rules for collecting and using data*, v1.0, January 2017.

The purpose of these **Rules** is to ensure ratings are conducted in a consistent and robust manner. Consistency is important to ensure ratings are comparable and accurately reflect the performance parameters.

In addition to the **Rules**, an **Assessor** is to make use of relevant **rulings** and the **NABERS rating assessment form**. A list of the documentation required in relation to this document is given in Chapter 9.

Note: **Rules** texts are amended as required by additional **Rulings** which are published on the NABERS website at www.nabers.gov.au.

1.2 Interpretations of the Rules and Rulings

Assessments for an accredited rating must comply with the version of the **Rules,** as well as any relevant **Rulings,** current on the day the rating application is lodged to NABERS, unless one of the following occurs:

a) The **National Administrator** has specifically approved otherwise in writing.

b) The assessment is conducted under the terms of a NABERS Commitment Agreement which specifies an earlier version of the **Rules**.

A **Ruling** takes precedence if there is any conflict with the **Rules**. If there is a conflict between **Rulings**, the most recent takes precedence.

1.3 Situations not covered by the Rules

These **Rules** are intended to cover most ratings. If an exceptional situation is encountered and the **Rules** are not easily applicable, the **Assessor** must contact the **National Administrator** for assistance.

Where an **Assessor** is unsure how to apply the **Rules**, the **National Administrator** may resolve the issue by making an interpretation of the **Rules** or by advising the use of a specific procedure that aligns with the intention of the **Rules**. Written correspondence from the **National Administrator** is required as evidence if this occurs.

Procedures not contained within these **Rules** may only be used for a particular rating with prior written approval from the **National Administrator**. Approval to use the same procedure must be sought from the **National Administrator** each time it is proposed to be used. Approval is entirely at the discretion of the **National Administrator**.

1.4 How to use this document

The term '**Rules**' refers to a body of works produced by NABERS that specify what must be examined, tested and documented when an **Assessor** conducts a rating. Wherever the term is used in this document from Chapter 3 onwards, it refers to this document, NABERS The Rules — Energy and Water for Hospitals. Other **Rules** documents mentioned in the text are distinguished from the present document by the inclusion of their title.

Text appearing **dark green** and **bold** is a defined term. Defined terms can be found in Section 2 of these **Rules** or in the terms and definitions chapter of the respective **Rules** document.

The following formatting conventions may appear in this text:

⚠ Important requirements and/or instructions are highlighted by an information callout box.

Note: Text appearing with a grey background is explanatory text only and is not to be read as part of the **Ruling** or is otherwise not essential for the purposes of this document.

Example: Text appearing with a green background is intended to demonstrate a worked example of the respective **Rules** section or **Ruling** section.

1.5 What is new in this version

A list of the main changes between version 2.0 and the version 1.0 is given in Appendix C.

1.6 Related documents

NABERS The Rules – Metering and Consumption, v1.3, 2022

Australian hospital peer groups, Australian Institute of Health and Welfare, Nov 2015

2 Terms and definitions

This chapter lists the key terms and their definitions that are integral to the proper use of this document.

Term	Definition
acceptable data	Data which meets the applicable accuracy and validity requirements of these **Rules**.
acceptable estimate	The values derived from an estimation method permitted by these **Rules** in place of incomplete or uncertain data. **Estimates** that do not satisfy the above specifications are deemed unacceptable and cannot be used in the rating.
activity metrics	The metrics used to adjust/normalise the operating performance of the hospitals in the rating tool. This includes the following: a) Occupied bed days. b) Separations. c) Aged care beds.
Assessor(s)	An accredited person authorised by the **National Administrator** to conduct NABERS ratings.
Aged care beds (ACBs)	Beds for the treatment for aged care patients in public hospitals. The count of these will include: a) Commonwealth funded beds b) Beds funded by other sources
end use(s)	A purpose or activity (or a group of related purposes and activities) that water or energy is used for. Where several instances of very similar individual **end uses** occur together so as to form a single collection (e.g. luminaires in a lighting grid) then the collection is to be regarded as a single **end use**.
estimate(s)(d)	Information relying on an **Assessor's** subjective judgement of the values to be used in place of incomplete or uncertain data.

Term	Definition
Gross Building Area (GBA)	The area of the building at all building levels, measured between the normal outside face of any enclosing walls (or the centre line of common walls between different properties), balustrades and supports. It includes the following: a) Basements (except unexcavated portions). b) Floored roof spaces and attics. c) Car parks. d) Enclosed porches and attached enclosed covered ways alongside buildings. e) Plant and equipment rooms. f) Lift shafts, vertical ducts, staircases and any other fully enclosed spaces and usable areas of the building. g) Roofed balconies, open verandas, porches and porticos. h) Attached open covered ways alongside buildings. i) Undercrofts and usable space under buildings. j) It excludes the following: k) Open courts and light wells. l) Connecting or isolated covered ways and net open areas of upper portions of rooms, lobbies, halls interstitial spaces and the like, which extend through the storey. m) Eaves overhangs, sun shading, awnings.
health department(s)	The relevant state authority involved in the maintenance and operation of the state health infrastructure.
major refurbishments	Characterised on a state-by-state basis. Any refurbishment, renovation or restoration that has a significant impact on day-to-day operations of the hospital.
metering system(s)	Device(s) providing an individual measurement which includes all of the following: a) The meter. b) The processes that convert the initial meter signal into an energy reading, e.g. current transformers and K factors for electricity meters and pressure correction factors for gas meters. c) The interface through which the meter reading is taken, e.g. manual readings, utility software or a building management system.

Term	Definition
Multi purpose health service (MPHS)	Reporting of a type of bed days for care provided in some states. Bed days for MPHS beds can be included in either a) Total **OBD** count; or b) **ACB Days**
NABERS Rating Assessment Form	The spreadsheet provided by NABERS for inputting all hospital operational and consumption data. This spreadsheet assists in data collation, validation and calculation of NABERS rating outcomes.
National Administrator	The body responsible for administering NABERS, in particular the following: a) Establishing and maintaining the standards and procedures to be followed in all aspects of the operation of the system. b) Determining issues that arise during the operation of the system and the making of ratings. c) Accrediting **Assessors** and awarding accredited ratings in accordance with NABERS standards and procedures. d) The functions of the **National Administrator** are undertaken by the NSW Government through the Department of Treasury
occupied bed days (OBDs)	The total number of bed days for all admitted patients accommodated during the **reporting period**. It is taken from the count of the number of inpatients at midnight (approximately) each day. Details for same day patients are also recorded as **OBDs** where one **OBD** is counted for each same day patient. The total OBD count for rating assessment uses OBD, MPHS and ACB data combined.
offsite	Located outside the physical boundaries of the building being rated and/or its grounds (as per the title of the building).
onsite	Located within the physical boundaries of the building being rated and/or its grounds (as per the title of the building). If located in a shared plant room, it is considered **onsite** for all buildings that share the plant room.
patient days	The total number of days for all patients who were admitted for an episode of care and who separated during a specified reference period. Patient days are non-compliant and should only to be used in situations where OBD data is not available. Assessors must note any hospitals where patient days data is used.

Term	Definition
rating period	The 12-month base period for the rating, requiring at least 12 continuous months of **acceptable data** upon which the rating is based.
Rules	Authoritative document produced by the **National Administrator** that specifies what must be covered by an **Assessor** in order to produce a rating.
Ruling(s)	An authoritative decision by the **National Administrator** which acts as an addition or amendment to this document.
separation(s)	The process by which an episode of care for an admitted patient stops. A **separation** may be formal or statistical, as follows: a) *Formal **separation***: The administrative process by which a hospital records the stopping of treatment and/or care and/or accommodation of a patient. b) *Statistical **separation***: The administrative process by which a hospital records the stopping of an episode of care for a patient within the one hospital stay.
source(s)(d)	For NABERS energy ratings: An individual fuel or energy **source** type such as gas, electricity or diesel fuel. For NABERS water ratings: An individual water **source** type such as mains water, bore water, externally reticulated grey water or river water.

Term	Definition
specialised hospital facilities	These facilities include the following: a) Accident and emergency. b) Anaesthetics. c) Breast screening. d) Cardiology. e) Chaplaincy. f) Critical care. g) Diagnostic imaging. h) Discharge lounge. i) Ear nose and throat (ENT). j) Elderly services department. k) Gastroenterology. l) Endoscopy. m) General surgery. n) Gynaecology. o) Haematology. p) Hospital pharmacy. q) Maternity departments. r) Microbiology.

Term	Definition
	s) Neonatal unit. t) Nephrology. u) Neurology. v) Nutrition and dietetics. w) Obstetrics and gynaecology units. x) Occupational therapy. y) Oncology. z) Ophthalmology. aa) Orthopaedics. bb) Pain management clinics. cc) Physiotherapy. dd) Radiotherapy. ee) Renal unit. ff) Rheumatology. gg) Sexual health. hh) Urology. ii) Other relevant departments as applicable.
utility	A company recognised and regulated under legislation for the supply of energy or water to a building and its occupants.
utility meter(s)(ing)	A meter measuring supplies of energy or water to a building, operated by a **utility** as the basis for billing its customer(s).

3 Key concepts and procedures

3.1 General

This chapter covers the following elements required for obtaining a hospital rating:

a) Rating process.

b) **Rating period**.

c) Documentation and record keeping.

d) **Acceptable data** and **estimates**.

e) Peer group eligibility.

3.2 Rating process

An accredited NABERS rating is awarded when the NABERS **National Administrator** certifies a rating lodged and completed by an **Assessor**. The **National Administrator** may independently audit the rating and assist in resolving complex technical issues.

The main documents and tools used in preparing a rating application are as follows:

Document or tool	Description
Rules for collecting and using data (including additional **Rulings**)	The quality standard for accredited ratings that specifies the information required and how it is used to prepare a rating application.
Support documents for the **Rules**	Additional information provided for the **Assessor**, that supplements the **Rules**.
NABERS Hospitals **Rating Assessment Form**	A spreadsheet template distributed by the **National Administrator** which allows **Assessors** to input data in order to obtain rating results.

The following steps must be completed:

a) Collect relevant data for the assessment through published reports, central hospital database, etc.

b) Perform data validation/verification where required.

c) Enter data into NABERS Hospital **Rating Assessment Form**.

d) Determine the final star rating.

e) Submit NABERS Hospital **Rating Assessment Form** to the **National Administrator** for certification.

f) **National Administrator** conducts quality assurance checks and certifies the ratings.

g) Collate and maintain all documentation and evidence for at least seven (7) years for audit purposes.

The stages to complete a NABERS hospital rating are shown in Figure 3.2.

Figure 3.2: Overview of the assessment process

3.3 Rating period

A NABERS rating is based on a 12-month **rating period**. Once certified, the rating is valid for a further 12 months after the **rating period**. This is called the **validity period**.

The **Assessor** must respond to all questions from the **National Administrator** within 10 working days to avoid impacting the validity of the rating.

More information on the **rating period**, **validity period** and time limits for submission can be found in Appendix B.

3.4 Acceptable data and estimates

3.4.1 Principles

An assessment for an accredited NABERS energy or water for hospitals rating must be based on the data or **estimates** specified in the **Rules** (including applicable **Rulings**).

3.4.2 Standards for acceptable data and estimates

3.4.2.1 Data

If accurate and verifiable data is available, it must be used. Where a section of the **Rules** allows more than one type of data **source** to be used and no particular priority is given, the **Assessor** must determine the most accurate **source** and use the corresponding data in the rating assessment. The data can be obtained, but not limited to, the following **sources**:

a) Data obtained through externally published documents.

b) Data obtained through internally published documents.

c) Data obtained through a central hospital database system, managed by the **health department**.

d) Data obtained from individual hospitals and/or site inspections.

3.4.2.2 Site inspections

Assessors may be required to inspect the premises during the rating assessment, for the following reasons:

a) Confirm that documentation provided for the assessment is accurate.

b) Check for inclusions and exclusions from the energy and water coverage (as appropriate).

c) Visit plant rooms to ensure that all relevant equipment is covered under the meters included in the rating.

d) Resolve any other issues that arise.

The site inspection is only required if the **Assessor** deems it necessary to undertake the above-mentioned tasks or if directed by the **National Administrator**.

The site inspection must take place either within the **rating period** or within a reasonable period of time at the end of the **rating period**. This is to ensure the inspection is relevant to the rating.

If the **Assessor** cannot physically conduct the site inspection, they may delegate this task to another **Assessor**. The **Assessor** submitting the rating is responsible for the accuracy of the data and must make sure that the inspection is conducted in agreement with this section. The **Assessor** must obtain and retain all the evidence required to prove their assumptions for auditing purposes.

3.4.2.3 Estimates

If **acceptable data** is not available, or where these **Rules** permit otherwise, **estimates** (including assumptions, approximations and un-validated data) can only be used if the following occurs:

a) The **estimates** satisfy the specific requirements of the **Rules**.

b) Specific approval is granted by the National Administrator

3.4.3 Data validation — Random sample selection

Where applicable, a random sample of 10 % of the hospitals are required for the data validation of all the following metrics:

a) **Occupied bed days**.

b) **Separations**.

c) **Aged care beds**.

d) Energy and water coverage.

e) Consumption data.

Where feasible, the **Assessor** must ensure that the sample dataset is the same for the validation of all the different metrics.

3.5 Documentation and record keeping

3.5.1 Documentation required

An assessment may be based on copies of original documents such as **utility** bills and other records as long as the **Assessor** is satisfied that they are, or can be, verified to be true and complete records of the original documents or files.

For a detailed checklist of the documentation required for performing the rating, see Chapter 9.

3.5.2 Records to be kept seven (7) years for audit

The **health department** must keep all records on which an assessment is based for audit purposes. This includes records of assumptions and all information and calculations used as the basis for **estimates**. Records must be kept for seven (7) years from the date the rating application was lodged with the **National Administrator**.

3.5.3 Records to be kept by health department

The records kept must be the actual documents used for the assessment or verifiable copies. The records kept by **health departments** must be to such a standard that it would be possible for another **Assessor** or an auditor to accurately repeat the rating from only the documents provided.

3.6 Peer group eligibility

The hospitals under the peer groups presented below, are eligible for a NABERS Rating. The eligibility of the peer groups has been determined through statistical validation, type of service provided and peer group data analysis.

Note: Hospitals that do not belong to any of the peer groups listed, can be rated under the 'Other hospitals' category in the NABERS rating assessment form, however, the rating will not be recognised by NABERS and it should not be publicly advertised.

The list of peer groups will be periodically reviewed and updated. A detailed description of the peer group classification has been provided in Appendix A, Hospital peer groups.

Eligible hospital peer groups are as follows:

a) Acute psychiatric hospitals.

b) Children's hospitals.

c) Drug and alcohol hospitals.

d) Early parenting centres.

e) Forensic psychiatric hospitals.

f) Mixed subacute and non-acute hospitals.

g) Non-acute psychiatric hospitals.

h) Other acute specialised hospitals.

i) Other day procedure hospitals.

j) Outpatient hospitals.

k) Principal referral hospitals.

l) Psychiatric hospitals.

m) Public acute Group A hospitals.

n) Public acute Group B hospitals.

o) Public acute Group C hospitals.

p) Public acute Group D hospitals.

q) Public rehabilitation hospitals.

r) Same day hospitals.

s) Unpeered hospitals.

t) Very small hospitals.

u) Women's hospitals.

4 Occupied bed days

4.1 Summary

The **occupied bed days (OBDs)** are used to adjust the energy and water consumption, along with other factors, to ensure a fair comparison between hospitals. The total **OBDs** must be counted and reported consistently and accurately.

4.2 Process overview

Table 4.1: Determining the number of occupied bed days

	Step	Reference
1	Determine the number of occupied bed days for each hospital	4.3
2	Confirm if the OBD count includes days from aged care beds	6.3.3
3	Enter data into the **NABERS rating assessment form**.	

4.3 Determining the number of occupied bed days

4.3.1 Principle and definition

The **OBDs** are the total number of bed days of all admitted patients accommodated during the **rating period**. **Occupied bed days** are used to adjust for the activity level within a hospital.

The **OBD** count associated with **aged care beds (ACBs)** contributes to the total OBD count for the hospital, but is usually considered separately in hospital records. There are specific considerations for treating ACB data and this is covered in Chapter 6.

The OBD count associated with **multi purpose health service (MPHS)** beds contributes to the total OBD count for the hospital, but is usually considered separately in hospital records. The bed days can be treated similarly to ACBs, or can be included in the general OBD count

For documentation requirements, see Section 9.2.1

4.3.2 Counting OBDs

Assessors should calculate the total number of **OBDs** for hospitals in the **rating period** based on whether a patient occupies a bed any time between 00:00 h and 23:59 h, as one **OBD**.

The following show examples of **OBD** counts:

a) The day the patient is admitted, count as one **OBD**.

b) If the patient remains in hospital from midnight to 23:59 h, count as one **OBD**.

c) The day a patient goes on leave or is separated, count as one **OBD**.

d) If the patient is admitted and separated or goes on leave on the same date (same-day patients), count as one **OBD**.

e) If the patient returns from leave and goes on leave or is separated on the same date, count as one **OBD**.

f) The day a patient goes on leave or is separated, and another patient is admitted in the same bed, count as two (2) **OBDs**.

As a guide, the **Assessor** should ensure that the **OBD** count per bed does not exceed 365 days (366 days for a leap year). In the event that days do exceed a year, the **Assessor** should further investigate and obtain adequate reasoning and supporting evidence for the same.

The **Assessor** will also have to undertake the data validation of the **OBD** data collected as described in Chapter 7.

Where the **Assessor** is unable to obtain the **OBDs** for a given hospital, the associated **patient days** can be used instead, for the rating assessment.

Note: This option is considered as not being in compliance with the **Rules** and therefore the **Assessor** must state this in the **Rating Assessment Form** ('Assessor Info' tab). The **patient days** are subjected to all the requirements as that of **OBDs** as specified under the **Rules**.

For documentation requirements, see Section 9.2.1.

5 Separations

5.1 Summary

Like **OBDs**, **separations** are used to adjust the energy and water consumption, along with other factors, to ensure a fair comparison between hospitals. The **separations** must be counted and reported consistently and accurately.

5.2 Process overview

Table 5.1: Determining the number of separations

	Step	Reference
1	Determine the number of separations for each hospital	5.3
2	Enter data into the **NABERS rating assessment form**.	

5.3 Determining the number of separations

5.3.1 Principle and definition

Based on the meteor data registry (Australian Institute of Health and Welfare (AIHW)), the NABERS rating assessment accounts for the formal **separation** in hospitals which is defined as the administrative process by which a hospital records the stopping of treatment and/or care and/or accommodation of a patient. This forms the underlining principle of counting **separations**.

5.3.2 Counting separations

The following show examples of **separation** counts:

a) The event of a patient being discharged from the hospital, count as a **separation**.

b) The event of a patient transferring from one type of treatment to another, count as a **separation**.

c) The event of a patient transferring from one type of care to another, count as a **separation**.

d) The event where an episode of care ceases followed by the patient being discharged by the hospital, count as a **separation**.

e) The event where an episode of care ceases within the one hospital stay, count as a **separation**.

f) The event of a patient going on leave from the hospital, is not counted as a **separation**.

The **Assessor** will also have to undertake the data validation of the **separations** data collected as described in Chapter 7.

For documentation requirements, see Section 9.3.1

6 Aged care beds

6.1 Summary

The number of **Aged Care Beds** is used to determine the total **OBD** count, which is used to adjust the energy and water consumption. This ensures that fair comparisons can be made between hospitals even though the number of funded aged care beds vary. The number of **ACBs** must be counted and reported consistently and accurately, including whether they are included in the base OBD count.

In some states, such as Queensland, MPHS (Multi Purpose Health Service) beds are also provided and operated in a similar fashion to ACB. The OBDs for these beds can be entered in the ACB Day count or the normal OBD count.

6.2 Process overview

Table 6.1: Determining the number of aged care beds

	Step	Reference
1	Determine the number of aged care beds and aged care bed days for each hospital	6.3.2
2	Confirm if the aged care bed days are already included in OBD count	6.3.3
3	Confirm funding type for aged care beds	6.3.4
4	Enter data into the **NABERS rating assessment form**.	

6.3 Determining the number of aged care beds

6.3.1 Principle and definition

The **ACBs** are for the treatment of aged care patients in public hospitals and are predominantly funded by the Commonwealth, but there are a number of other funding sources. These beds are typically not included in the base **OBD** count and can be entered separately in the **NABERS Rating Assessment form**.

6.3.2 Counting ACBs

The **Assessor** must report the total number of aged care beds from all funding sources.

The **ACBs** must provide the following types of care:

a) Residential care.

b) Transitional care.

For documentation requirements, see Section 9.4.1

6.3.3 Counting ACB Days

In a typical rating assessment, the number of **ACBs** are converted to an associated bed-day metric by multiplying it by a default value of 300 days.

For increased accuracy, where available the **Assessor** should provide the actual **ACB Days**

For hospitals where the **ACBs** equivalent bed-days are included in the base **OBD** count, the Assessor should note this on the Rating Assessment tab of the **NABERS Rating Assessment form** to avoid double counting.

Note: Even if the **OBD** count includes **ACB Days**, assessors should still include **ACB** and ACB Day data in the **NABERS Rating Assessment form**, as this will help future benchmark improvement if required.

For documentation requirements, see Section 9.4.2; 9.4.3

6.3.4 Funding types for aged care beds

Assessor must include the total number of aged care beds with the **ACBs**, regardless of funding type. In cases where aged care beds are funded by other organisations, the Assessor should note the data source on the Data Validation tab of the NABERS Rating Assessment form.

The number of beds funded by the following types of organisations may be included:

a) Commonwealth Government.

b) State Government.

c) Community-based organisation.

The **Assessor** will also have to undertake the data validation of the **ACB** data collected as described in Chapter 7.

For documentation requirements, see Section 9.4.4

7 Data validation

7.1 Summary

The **Assessor** is required to validate a sample of the operational **activity metrics** data and of the consumption data collected for the rating assessment. Data validation ensures that the data provided is accurate and assists in eliminating incorrect data. The steps for validating each data type are provided in the following sections.

The following different **activity metrics** collected for the assessment, are required to undergo the data validation procedures separately:

a) **Occupied bed days**.

b) **Separations**.

c) **Aged care beds**.

The following different consumption data are required to be validated from utility bills:

a) Electricity consumption

b) Gas consumption

c) Water consumption

Note: LPG, diesel nor renewable energy consumption and/or production are not required to be validated from utility and non-utility sources.

7.2 Process overview

Table 7.1: Validating data

	Step	Reference
1	Randomly select sample of hospitals and validate operations data	7.3
2	Randomly select sample of hospitals and validate consumption data	7.4
3	Enter validation results into the **NABERS rating assessment form**.	

7.3 Operational Data validation

7.3.1 Step 1: Random sample

From the entire dataset, select a random sample of hospitals consisting of at least 10 % of the hospitals. The hospitals randomly selected for operational data validation may overlap with the hospitals randomly selected (Section 7.4.1) for consumption data validation.

Note: The **Assessor** must ensure that a different set of randomly selected hospitals, as long as feasible, are selected for the subsequent ratings.

7.3.2 Step 2: Data source

For the sample dataset, perform the following validation. See Section 7.7, for diagrammatic representation of the process.

If the primary **source** of the activity metric data belongs to the following categories, no further validation will be required:

a) Externally published reports.

b) Internally published reports.

For the remaining hospitals in the sample dataset, if the activity metric data obtained through the central database, or other sources, which is not published, it will have to undergo the following data validation procedures.

7.3.3 Step 3: Validation A — Check internal procedures

To validate the activity metric data obtained from the central database, or other sources the **Assessor** must:

a) Obtain the verification/confirmation procedures used by the **health department** to verify the data, prior to internal/external reporting.

b) Verify the data through confirmation procedures obtained above.

If Step 3 is not feasible, the **Assessor** must perform the Step 4 validations, see Section 7.3.4

7.3.4 Step 4: Validation B — Check with hospital

To validate the activity metric data obtained from the central database, or other sources the **Assessor** must complete the following:

a) Obtain activity metric data directly from individual hospitals covering the **rating period** in the sample dataset, where applicable.

b) Perform validation for the selected hospitals, i.e. verify and confirm the activity metric data obtained from the central database system.

c) Verify the accuracy of all activity metric data for the randomly selected hospitals so the rating can proceed.

However, where the activity metric data for one or more of the randomly selected hospitals is found to be inaccurate the following must be completed:

1) The **Assessor** must, following confirmation that the data is correct, rectify the corresponding incorrect figures in the data.
2) Repeat Step 3 for a separate set of randomly selected hospitals, for the given activity metric.

For documentation, see Section 9.5.1

7.4 Consumption data validation

7.4.1 Step 1: Select a random sample of hospitals

From the entire dataset, select a random sample of hospitals consisting of at least 10 % of the hospitals. The hospitals randomly selected for operational data validation may overlap with the hospitals randomly selected (Section 7.3.1) for consumption data validation.

To validate the **utility** data obtained, the **Assessor** must obtain monthly/quarterly **utility** bills (electronic formats are acceptable) covering the **rating period** for at least 10 % of the randomly selected hospitals for which operational data has been validated.

Note: The **Assessor** must ensure that a different set of randomly selected hospitals, as long as feasible, are selected for the subsequent ratings.

7.4.2 Step 2: Data validation

For those randomly selected hospitals, verify the **utility** bill information with the **utility** data obtained from the central database system.

The **Assessor** must review the data and ensure that it complies with expectation, e.g. usage patterns. Investigate any anomalies in the data and find explanations for them. If there is no reason for the anomaly, treat anomalous data as **estimated**.

7.4.3 Step 3: Results of validation

Where all the **utility** data for the randomly selected hospitals are verified to be accurate the rating can proceed.

Note: The **Assessor** must ensure that a different set of randomly selected hospitals, if applicable, are selected for the subsequent ratings.

However, where **utility** data for one or more of the randomly selected hospitals are found to be inaccurate, the **Assessor** must perform the following:

a) Confirm and rectify the corresponding incorrect figures in the data.
b) Repeat Step 1 and randomly select a different set of 10 % of the hospitals. Then obtain monthly/quarterly **utility** bills (electronic formats are acceptable) covering the **rating period** for those hospital.
c) Repeat Step 2 for the new set of hospitals to ensure that the validation requirements are met.

For documentation requirements, see Section 9.5.2

7.5 Data discrepancies

For the different **activity metrics**, where discrepancies are found between site-reported and Commonwealth-reported figures, the **Assessor** must consider the most recent data and ensure that the rules of counting the metrics have been conformed to.

7.6 Data modification

If the **activity metrics** are revised after the ratings have been processed, the **Assessor** must complete the following:

a) Notify the **National Administrator** of the modification.

b) Update the rating data in the **Rating Assessment Form**.

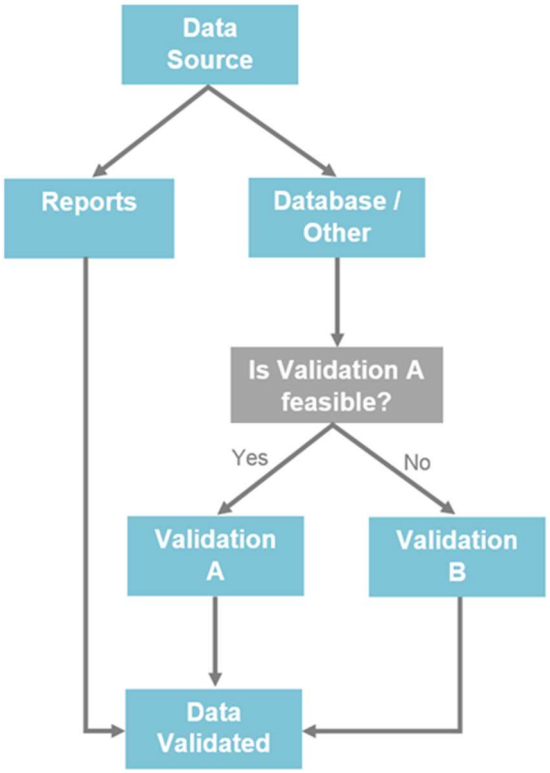
c) Lodge updated ratings with the **National Administrator**.

The **National Administrator**, following the applicable quality assurance procedures, will certify the rating. The validity of the certification will be the same as that of the previous rating (the rating that has been modified).

7.7 Data validation — Process flow

Figure 7.7-1 shows the process flow for the data validation of **activity metrics**.

Figure 7.7-1: Overview of the activity metric data validation process



8 Minimum energy & water coverage

8.1 Summary

Correctly interpreting the scope of energy supply and consumption data is essential to the accuracy of a NABERS energy for hospitals rating. The key principles are as follows:

a) An assessment for an accredited rating must include all **sources** of external energy supplied to the rated premises, and must cover all of the energy **end uses** specified for the rating type in Section

b) **Utility** and **non-utility meters** that meet the requirements of *NABERS The Rules – Metering and Consumption* may be used in any combination to achieve the required coverage, subject to the accuracy requirements of Section 3.4.

This Chapter is to be read in conjunction with Chapter 3 of *NABERS The Rules – Metering and Consumption*.

For documentation requirements, see Section 9.6.

Note: Where several instances of very similar individual **end uses** occur together so as to form a single collection (e.g. luminaires in hallways, taps in rooms, or emergency lighting in a stairwell) then the collection is to be regarded as a single **end uses**.

8.2 Minimum energy coverage

8.2.1 General

Once the energy sources and their supply points have been determined, **Assessors** must ensure that all the required energy **end uses** as listed in this chapter are covered by the sources and supply points identified in accordance with Chapter 3 of *NABERS The Rules – Metering and Consumption*.

If an end use is required to be included in the rating but is not covered by one of the supply points identified, then the **Assessor** must use one of the alternative allowable methods listed in Chapter 7 of *NABERS The Rules – Metering and Consumption* to ensure the minimum energy coverage requirements can be met.

8.2.2 Energy coverage

The minimum energy coverage includes energy consumed in the hospital during the **rating period**, such as the following:

a) **Specialised hospital facilities** and associated equipment.

b) Research facilities and associated equipment.

c) Back of house (staff office) space.

d) Lighting and power.

e) Lifts and escalators.

f) Air conditioning and ventilation.

g) Exterior lighting and exterior signage.

h) Generator fuel.

i) Car park ventilation and lighting where car parking is **onsite** and provided for hospital staff, patients and visitors.

j) On-site kitchens, cafeterias and restaurants servicing staff, patients and visitors.

k) Any on-site laundries.

The **Assessor** may examine available single-line diagrams and electrical circuit schedules and visit the plant rooms to ensure that all relevant equipment is covered under the meters included in the rating.

For documentation requirements, see Section 9.6.3.

For more information on on-site renewable systems, refer to NABERS Ruling – On-site Renewable Electricity Generation (OREG) Systems.

For more information on GreenPower™, refer to Section 4.5 of *NABERS The Rules – Metering and Consumption*.

8.2.3 Car parks

8.2.3.1 General

Energy use associated with hospital car parks is included within the coverage of the rating except where it can be demonstrated that the car park is not for hospital use; or is owned and operated by a third party.

Note: Where parking is provided to the hospital by a third party (e.g. a public car park owner/operator) that controls the operation of the car park, then the car park energy is not included in the rating. The car park energy is still included if the hospital leases their car park to a third-party provider to operate

8.2.3.2 Total exclusion

The energy use of lighting and ventilation in car parks used by the hospital may be totally excluded from the rating where—

a) The car park is not located on the site of the hospital; or

b) both—

1) The ownership and management of the car park are independent of the ownership and management of the hospital to be rated.

2) There is a separate meter (or group of meters) that covers the entire energy use associated with the car park but does not cover any other aspect of the building's central services energy use that must be included in the assessment.

Note: There is no total exclusion simply on the grounds that the car park is leased to, or otherwise operated by, a manager independent from the hospital owner or operator.

8.2.3.3 Proportional exclusion of energy use

Where the hospital does not have use of all the building's car park, then a proportion of the energy use associated with the non-hospital car spaces may be excluded from the rating in accordance with the following requirements:

a) Proportional exclusion of car park energy use is only permitted where there is a separate meter (or group of meters) that covers the entire energy use associated with the car park but does not cover any other aspect of the hospital's energy use that must be included in the assessment.

   For example, it is not common for car park metering to include other basement services such as hydraulic pumping — in such cases, proportioning is not permitted.

b) Where a commercial agreement with one or more third party assigns a proportion of the measured car park energy use, then the share(s) specified in the documentation must be used in the assessment.

c) If no specific allocation of the energy use is given in third party commercial agreements, the relevant proportion is calculated by dividing the number of parking spaces allocated to the hospital by the total number of parking spaces.

   Where pass cards or keys have been issued to the hospital, the number of parking spaces allocated to the hospital is the greater of the following:

   1) The number of physically dedicated parking spaces.

   2) The number of pass cards or keys issued (to a limit of the total number of parking spaces).

   Dedicated parking space, pass or key allocation data must be **sourced** from third party commercial agreements.

d) If there are no third-party commercial agreements available, then it is acceptable to determine the proportions by obtaining documentation signed by third parties that identifies the proportion of allocation.

e) If there is no documentation and no third parties are able or willing to identify proportions, then all of the energy use associated with the car park must be included in the assessment.

f) Regardless of the method used to proportion the energy use, the maximum that can be excluded is 100 % of the measured car park energy usage.

The **Assessor** must fully document both the method and all data used to proportion car park energy usage.

8.2.4 Electric vehicle charging points

The energy associated with electric vehicle charging points does not form part of the minimum energy coverage and is not required to be included. Emissions associated with moving vehicles are not included in the scope of ratings.

8.3 Minimum water coverage

8.3.1 General

Once the water sources and their supply points have been determined, **Assessors** must ensure that all the required water end uses as listed in this chapter are covered by the sources and supply points identified in accordance with Chapter 3 of *NABERS The Rules – Metering and Consumption*.

If an end use is required to be included in the rating but is not covered by one of the supply points identified, then the Assessor must use one of the alternative allowable methods listed in Chapter 7 of *NABERS The Rules – Metering and Consumption* to ensure the minimum water coverage requirements can be met.

8.3.2 Water coverage

The minimum water coverage includes water used in the hospital during the **rating period**, such as for the following:

a) **Specialised hospital facilities** and research facilities.

b) Air-conditioning, evaporative cooling and other building services, e.g. general cleaning, facade cleaning, etc.

c) Taps and sinks, both front and back of house.

d) Toilets.

e) Fire services if metered.

f) On-site laundries.

g) On-site kitchens, cafes and restaurants servicing staff, patients and visitors.

h) Water features and irrigation associated with the hospital, including those areas outside the building, but within site boundaries.

Water consumption for non-hospital applications may be excluded. These may only be excluded on the basis of meter readings specific to the application concerned.

For documentation requirements, see Section 9.6.4.

Note: In the absence of meter readings, no exclusions are permitted. **Estimates** are not permitted for exclusions.

8.3.2.1 Fire system consumption

Water consumption from the operation of a building's fire system, whether consumed in an emergency or during testing, is considered a cost of operating a building and must be included in the calculation of water consumption if it is metered. If it is not metered, fire system consumption need not be included.

8.3.2.2 On-site capture and recycling

On-site water collection and recycling are not included in the external **sources** covered by a NABERS water for hospitals rating and will therefore improve the rating. In effect this means that supplier billing data must be used without modification.

Where water is collected or recycled at the premises to be rated (e.g. by rainwater harvesting, treatment of on-site waste water or recycled reject reverse osmosis water) and is either:

a) connected on the user side of the meter which records the relevant external water supply to the premises; or

b) used on site independently of **utility**-supplied systems,

then it will reduce the amount of externally supplied water needed. On-site water capture and recycling are efficient mechanisms to reduce external water consumption which is why the corresponding usage is not included in the rating assessment. No adjustment is therefore required which means that supplier billing data must be used without modification.

Note: No discount of on-site water use is allowed against water exported from the site, under any circumstances.

8.3.2.3 Treatment of externally supplied recycled water

The **Assessor** must provide the quantity of the total externally supplied recycled water in the rating assessment tab of the **NABERS rating Assessment form** 'rating assessment tab', where applicable. The recycled water is deducted from the total water consumption in the rating assessment.

8.4 Unoccupied spaces

The energy and water use (within the scope of the minimum energy and/or coverage) of unoccupied hospital spaces must always be included.

8.5 Exclusions

Energy or water use may only be excluded from a rating if:

a) The energy or water is not part of the minimum energy or water coverage of the rating; and

b) There is a methodology within the **Rules** that permits exclusion; and

c) The accuracy and **validation** requirements for the metering of the exclusion are met.

The metering for any exclusion must not include any end uses that are required under the minimum energy or water coverage.

8.6 Energy & water coverage verification

8.6.1 General

The **Assessor** is required to validate a sample of the hospitals to ensure requirements for the minimum coverage of energy and water have been met. Coverage validation ensures that the data provided is accurate and assists in eliminating incorrect data. The same steps are used for validating both energy coverage and water coverage and are provided in the following sections.

8.6.2 Step 1: Select a random sample of hospitals

From the entire dataset, select a random sample of hospitals consisting of at least 10 % of the hospitals. The hospitals randomly selected for energy coverage or water coverage validation may overlap with each other or the hospitals randomly selected (Section 7.3.1 and Section 7.4.1) for operational data or consumption data validation.

Note: The **Assessor** must ensure that a different set of randomly selected hospitals, as long as feasible, are selected for the subsequent ratings.

8.6.3 Step 2: Data validation

For those randomly selected hospitals, verify energy or water coverage meets the minimum coverage requirements (Section 8.2 and 8.3).

To validate the coverage the **Assessor** must obtain the following from the hospital facility managers:

a) Written confirmation that the list of energy/water sources obtained is accurate.

b) Written confirmation of the inclusion of all the associated water consumption data for all the meters available onsite.

For documentation requirements, see Section 9.6.3 and Section 9.6.4

9 Documentation Required

9.1 Summary

9.1.1 Information and documentation requirements

The information in the tables below is required for a rating. Information may be contained in many different formats. The purpose of the documentation is to provide an acceptable, credible source of the required information. In some instances, specific document types may be unnecessary for an individual rating. Or, under different rating circumstances, the specific document types may carry multiple items of information required for the rating. The qualifying factor is not the type of document but that the documentation contains the required information in an acceptable format.

The tables in Section 9.2 onwards are organised based on the divisions of previous chapters (Chapter 3 through to Chapter 12). All the required information should be obtained from the owner/manager of the premises before a site visit, and then confirmed during the site visit and subsequent assessment. A site inspection helps to verify that the information provided is accurate, current and complete.

Individual ratings may require additional information or documentation depending on the individual circumstances of the **rated premises**. **Table 9.1** provides an overview of the documentation required for energy and water ratings according to **data type**.

Table 9.1: Overview of documentation required for energy and water ratings

Data Type	Information Required	NABERS Energy	NABERS Water
Climate	The building's postcode	☑	☑
Number of **occupied bed days**	The number of **occupied bed days**	☑	☑
Number of **separations**	The number of **separations**	☑	☑
Number of **aged care beds**	The number of **aged care beds**, from all funding sources	☑	☑

Peer group	The **peer group** of the hospital from the Australian institute of Health and Welfare (AIHW) website	☑	☑
Energy user	12 months of continuous data for all energy supplied to the hospital	☑	
Water use	12 months of continuous data for all external water supplied to the hospital		☑

9.1.2 Documentation retention

Assessors must keep copies of the documentation that contains information on which an assessment is based, including any specific guidance or approvals given by the **National Administrator**.

All data retained for audit must be in a form which facilitates reviews and makes anomalies easily apparent.

Access to original documents is highly desirable if they are available. Copies of original documents may be used as evidence as long as the **Assessor** is satisfied that they are, or can be verified to be, true and complete records of the original documents or files

9.2 Documentation required for Chapter 4: Occupied bed days

Topic	Requirements	Documentation
9.2.1 Count of occupied bed days	Section 4.3.2	Required information **Assessors** must retain evidence of the total occupi whichever source is used Documentation Examples Documentation that can be used as evidence includes a) Hospital reports b) Hospital database extracts c) Other data sources

9.3 Documentation required for Chapter 5: Separations

Topic	Requirements	Documentation
9.3.1 Count of separations	Section 5.3.2	Required information **Assessors** must retain evidence of the total separatio source is used Documentation Examples Documentation that can be used as evidence includes a) Hospital reports b) Hospital database extracts c) Other data sources

9.4 Documentation required for Chapter 6: Aged care beds

Topic	Requirements	Documentation
9.4.1 Count of Aged Care Beds	Section 6.3.2	Required information **Assessors** must retain evidence of the total aged care beds, for each hospital, from whichever source is used Documentation Examples Documentation that can be used as evidence includes: a) Hospital reports b) Hospital database extracts c) Other data sources
9.4.2 Count of Aged Care Bed Days	Section 6.3.3	Required information **Assessors** must retain evidence of the total aged care bed days, for each hospital, from whichever source is used Documentation Examples Documentation that can be used as evidence includes: a) Hospital reports b) Hospital database extracts c) Other data sources

9.4.3 Inclusion of ACB Days in OBD count	Section 6.3.3	Required information **Assessors** must retain evidence of the whether or not aged care bed days were included in the OBD count, for each hospital, from whichever source is used Documentation Examples Documentation that can be used as evidence includes: a) Hospital reports b) Hospital database extracts c) Other data sources
9.4.4 Source of Aged Care bed funding	Section 6.3.4	Required information **Assessors** must retain evidence of the aged care bed days, for each hospital, from whichever source is used Documentation Examples Documentation that can be used as evidence includes: a) Hospital reports b) Hospital database extracts c) Other data sources

9.5 Documentation required for Chapter 7: Data validation

Topic	Requirements	Documentation
9.5.1 Validation of operational data	Section 7.3	Required information **Assessors** must retain evidence that validates each operational metric (OBDs, Separations, Aged Care Beds, MPHS Bed Days) for each hospital in the randomly selected sample. Documentation Examples Documentation that can be used as evidence includes: a) Externally or internally published reports; or

		b) Identification of validation method used; and i. Evidence confirming procedures used by health department to verify data prior to reporting; or ii. Metric data provided directly by the hospital
9.5.2 Validation of consumption data	Section 7.4	Required information The **Assessor** must retain the monthly/quarterly **utility** bills (electronic formats are acceptable) covering the **rating period** for each hospital in the randomly selected sample. Documentation Examples Documentation provided must comply with Chapter 9 of *NABERS The Rules – Metering and Consumption*.

9.6 Documentation required for Chapter 8: Minimum energy & water coverage

Topic	Requirements	Documentation
9.6.1 List of energy sources	Section 8.1	Required Information **Assessors** must retain the following for each hospital being rated: a) The different NMIs for electricity supply. b) The different MIRNs and meter number for gas supply. c) The different account numbers for LPG supply. d) Other applicable account numbers for energy (electricity, gas and/or LPG) supply **sources**.
9.6.2 List of water sources	Section 8.1	Required Information **Assessors** must retain the following for each hospital being rated: a) a list of the different account numbers and water meter numbers for water supply used by the hospital.

9.6.3 Minimum energy coverage	Section 8.6	Required Information **Assessors** must retain evidence that validates the energy coverage for each hospital in the randomly selected sample. The following must be obtained through hospital facility managers: a) Written confirmation that the list of energy **sources** obtained is accurate. b) Written confirmation of the inclusion of all the associated energy consumption data for all the meters available **onsite**.
9.6.4 Minimum water coverage	Section 8.6	Required Information **Assessors** must retain evidence that validates the energy coverage for each hospital in the randomly selected sample. The following must be obtained through hospital facility managers: a) Written confirmation that the list of water **sources** obtained is accurate. b) Written confirmation of the inclusion of all the associated water consumption data for all the meters available **onsite**.

Appendices

Summary

Appendix A Hospital peer groups

This appendix provides descriptions of the different hospital peer group classifications. The classifications are based on the publication by the AIHW, found at https://www.aihw.gov.au/reports/hospitals/australian-hospital-peer-groups/summary

The list of current peer groups is found in Table 3.1 of the report, on page 26. The current peer group for all hospitals is found in Appendix C of the report, page 84.

Group	Description
Acute psychiatric hospitals	Provide acute psychiatric treatment.
Children's hospitals	Specialise in the treatment and care of children.
Drug and alcohol hospitals	Specialises in the treatment of disorders relating to drug or alcohol use.
Early parenting centres	Specialise in care and assistance for mothers and their very young children.
Forensic psychiatric hospitals	Provide assessment and treatment of people with a mental disorder and a history of criminal offending, or those who are at risk of offending.

Group	Description
Mixed subacute and non-acute hospitals	Primarily provide a mixture of subacute (rehabilitation, palliative care, geriatric evaluation and management, psychogeriatric care) and non-acute (maintenance) care that is not covered by the hospitals in the rehabilitation and geriatric evaluation and management hospital peer group.
Non-acute psychiatric hospitals	Provide non-acute psychiatric treatment — mainly to the general adult population.
Other acute specialised hospitals	Specialise in a particular form of acute care, not grouped elsewhere. This group is too diverse to be considered a peer group for comparison purposes. It includes hospitals that specialise in the treatment of cancer, rheumatology, eye, ear and dental disorders.
Other day procedure hospitals	Provide a variety of specialised services on a same day basis.
Outpatient hospitals	Provide a range of non-admitted patient services. Generally, these hospitals do not admit patients.
Principal referral hospitals	Provide a very broad range of services, including some very sophisticated services, and have very large patient volumes. Most include an intensive care unit, a cardiac surgery unit, a neurosurgery unit, an infectious diseases unit and a 24-hour emergency department.
Psychiatric hospitals	Specialise in providing psychiatric care and/or treatment for people with a mental disorder or psychiatric disability

Group	Description
Public acute Group A hospitals	Provide a wide range of services to a large number of patients and are usually situated in metropolitan centres or inner regional areas. Most have an intensive care unit and a 24-hour emergency department. They are among the largest hospitals but provide a narrower range of services than the principal referral group. They have a range of specialist units, potentially including bone marrow transplant, coronary care and oncology units.
Public acute Group B hospitals	Most have a 24-hour emergency department and perform elective surgery. They provide a narrower range of services than the principal referral and public acute Group A hospitals. They have a range of specialist units, potentially including obstetrics, paediatrics, psychiatric and oncology units.
Public acute Group C hospitals	These hospitals usually provide an obstetric unit, surgical services and some form of emergency facility. Generally smaller than the public acute Group B hospitals.
Public acute Group D hospitals	Often situated in regional and remote areas and offer a smaller range of services relative to the other public acute hospital groups. Hospitals in this group tend to have a greater proportion of non-acute **separations** compared with other public acute hospitals.
Public rehabilitation hospital	Primarily provide rehabilitation and/or geriatric evaluation and management in which the clinical purpose or treatment goal is improvement in the functioning of a patient.
Same day hospitals	Treat patients on a same-day basis. The hospitals in the same day hospital peer groups tend to be highly specialised.

Group	Description
Unpeered hospitals	Could not be placed in one of the other peer groups.
Very small hospitals	Generally provide less than 200 admitted patient **separations** each year.
Women's hospitals	Specialise in treatment and care of women.

Appendix B The rating period

B.1. Data must cover same period

The **rating period** covers the continuous 12-month use indicated for the period (e.g. March 2015 to February 2016), the NABERS energy and water rating applies to. For each hospital, data from all **sources** used in a rating application for a NABERS energy or water rating must be one of the following:

a) Cover the same timeframe as the **rating period**.

b) Meet the specific requirements of the *NABERS The Rules – Metering and Consumption*.

B.2. Newly built or major refurbishments

New hospitals or hospitals subject to major refurbishment can begin the **rating period** for a NABERS assessment once the hospital has been commissioned.

B.3. Allowance for lodgement

A NABERS rating is based on 12 months of **acceptable data**, called the **rating period**. Once certified, the rating is valid for up to 12 months, called the **validity period**.

It takes time for the **Assessor** to complete a rating, so 120 days is given to lodge the rating after the end of the **rating period**. Ratings lodged after the 120 days will have a reduced **validity period** to ensure all ratings are based on current data.

The following scenarios illustrate this principle.

Scenario 1

A NABERS Rating is lodged with the **National Administrator** within 120 days of the end of the **rating period**. It will be valid for 365 days from the date of certification. See **Figure 9.6-1**.

Example:

a) The **rating period** is 1 January 2021 to 31 December 2021. The due date is therefore 30 April 2022.

b) The **Assessor** lodges the rating on 1 June 2022, and the **National Administrator** certifies it on 6 June 2018. This is after the due date.

c) The rating will therefore be valid for 365 days from the end of the **rating period** (31 December 2021).

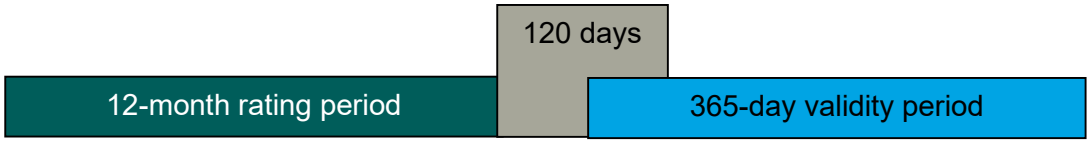


Figure 9.6-1: Rating lodged within 120 days of the end of rating period

Scenario 2

A NABERS rating is lodged with the **National Administrator** more than 120 calendar days after the end of the **rating period**. It will be valid for 365 days from the end of the **rating period**, see **Figure 9.6-2**.

Example:

The **rating period** is 1 January 20121 to 31 December 20121. The due date is therefore 30 April 2022.

The **Assessor** lodges the rating on 1 June 2022, and the **National Administrator** certifies it on 6 June 2022. This is after the due date.

The rating will therefore be valid for 365 days from the end of the **rating period** (31 December 20121).

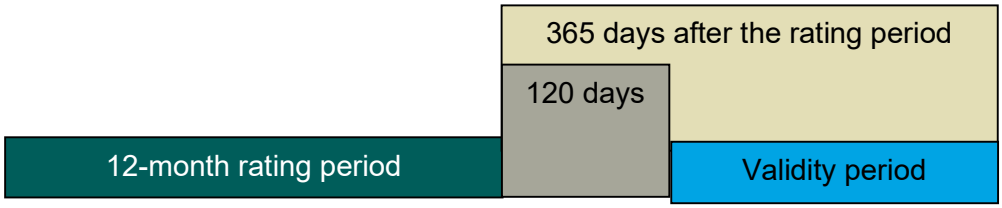


Figure 9.6-2: Rating lodged after 120 days from the end of rating period

B.4. Allowance for responses

Assessor are given 120 days after the **rating period** to lodge ratings with the **National Administrator**. The **Assessor** should allow 10 working days within this 120-day period for a response from the **National Administrator.** The **National Administrator** then allows a further 10 working days for the **Assessor** to respond to any queries that arise from quality assurance checks before certification.

When the **Assessor** is required to provide clarification multiple times, this must be done within the allowable 10 working days period.

If the **Assessor** has not responded adequately to all queries and the rating has not been certified within 120 days of the end of the **rating period** + 10 working days, the rating will only be valid for up to 365 days from the end of the **rating period**. This does not include the time taken by the **National Administrator**.

The following scenario illustrates this principle.

Scenario 3

A NABERS rating is lodged with the **National Administrator** one day before the lodgement due date (120 days from the end of the **rating period**). Depending on how quickly the **Assessor** responds to clarifications, the rating will either be valid for 365 days from the date of certification or 365 days from the end of the **rating period**.

Example:

a) The **rating period** is 1 January 2021 to 31 December 2021. The due date is therefore 30 April 2022.

b) The **Assessor** lodges the rating on 29 April 2022, 119 days after the end of the **rating period**.

c) The **National Administrator** responds on 3 May 2022 requesting further clarification. The **Assessor** must provide adequate clarification by 14 May 2022 (120 days from the end of the rating period plus 10 working days) for the rating to be valid for 365 days from the date of certification.

d) If the **Assessor** responds on the 8 May 2022, the rating will be certified and valid until the 8 May 2023.

e) If the **Assessor** does not respond with clarification until the 30 May 2022, the rating will only be valid until 365 days from the end of the **rating period** and therefore will expire on the 31 December 2022.

Appendix C List of changes

The following tables document the history of the content of *NABERS The Rules – Energy and Water for Hospitals* v1.0 in order to produce version 2.0.

Energy and Water for Hospitals – Chapter 1 – Introduction		
The structure and contents of Chapter 1 has been revised and updated. Several new sections were added, including *Formatting conventions and referencing*. Purpose of this document and relationship to new *Metering and Consumption Rules* document explained.		
Version 1.0 (old location	**Version 2.0** (new location)	**Changes made**
1.1	1.1 and 1.4	Edited for clarity and brought into line with NABERS Style Guide Additional sections which are standard text in Rules documents now appear as *1.2 Interpretation of the Rules* and *1.3 Situations not covered by the Rules*.
1.2	1.5 and 1.6	Table of main changes updated. Related documents section expanded to list secondary material referenced in the text: • ***NABERS The Rules – Metering and Consumption***, v1.0, 2020 • ***NABERS Ruling – On-site Renewable Generation Systems,* v1.0, 2020** • AS 1668.4-2012, The use of ventilation and air conditioning in buildings, Part 4: Natural ventilation of buildings
Chapter 1	Chapter 1	

		New structure: • Summary • Interpretation of the Rules • Situations not covered by the Rules • How to use this document • What is new in this version? • Related documents

Energy and Water for Hospitals – Chapter 2 – Terms and definitions		
Chapter 2 has undergone considerable editing and has had a title change from 'Key concepts' to 'Terms and definitions'. Most of its content moved to other chapters (or documents). Chapter 2 in v2.0 contains solely the terms and definitions integral to the proper understanding and use of the document.		
Version 1.0 (old location	**Version 2.0** (new location)	**Changes made**
-	Chapter 2	The following definitions have been updated: ▪ end use ▪ metering system ▪ Rules ▪ utility The following have been added: ▪ Multi purpose health service (MPHS) ▪ NABERS rating assessment form ▪ ruling ▪ validity period The following have been deleted: ▪ Alternative method ▪ Assumption

		▪ Data ▪ Data type ▪ Estimate ▪ metering systems requiring validation ▪ non-utility meter ▪ potential error ▪ source ▪ un-validated metering systems ▪ utility meter ▪ verification
-	1.2 and 1.3	Integrated into the Introductory chapter.
2.3	3.5	Content incorporated into new Chapter 9
2.2	3.3 and Appendix B	Most of the content incorporated into new Appendix B.
2.4	NABERS The Rules – Metering and Consumption	Separated and incorporated into NABERS The Rules – Metering and Consumption

Energy and Water for Hospitals – Chapter 3 – Key concepts and procedures

Chapter 3 contains the remainder of the former Chapter 2, the content of which has been reviewed and restructured to align with the new Rules format.

Version 1.0 (old location	**Version 2.0** (new location)	**Changes made**
2.1	3.2	Edited for clarity but content the same.

2.2	3.3 and Appendix B	Content reduced and simplified as most information can now be found in Appendix B.
2.4	3.4	Section reviewed and simplified for clarity.
2.3	3.5	Edited for clarity but content the same.
2.5	3.7	Minor editorial changes.

Energy and Water for Hospitals – Chapter 4 – Occupied bed days		
Chapter 3 of v1.0 has become Chapter 4 Occupied bed days in v2.0. All standards for acceptable data have been moved to Section 3.4. All the documentation requirements have been moved to Chapter 9. All figures have been reviewed and updated.		
Version 1.0 (old location	**Version 2.0** (new location)	**Changes made**
3.1	4.1	Slightly reworded for clarity.
-	4.2	Section added
3.2	4.3	Content the same, just reformatted. Note on MPHS add

Energy and Water for Hospitals – Chapter 5 –:Separations		
Chapter 4 of v1.0 has become Chapter 5 Separations Occupied bed days in v2.0. All standards for acceptable data have been moved to Section 3.4. All the documentation requirements have been moved to Chapter 9. All figures have been reviewed and updated.		
Version 1.0 (old location	**Version 2.0** (new location)	**Changes made**
4.1	5.1	Slightly reworded for clarity.
-	5.2	Section added
4.2	5.3	Slightly reworded for clarity.
-	5.3.5	Content added to clarify requirement to confirm laundry availability

Energy and Water for Hospitals – Chapter 6 – Aged care beds		
Chapter 5 of v1.0 has become Chapter 6 Aged care beds in v2.0. Wording has been clarified throughout to remove 'Commonwealth Funded' and just use the term 'Aged Care Beds'. All standards for acceptable data have been moved to Section 3.4. All the documentation requirements have been moved to Chapter 9. All figures have been reviewed and updated.		
Version 1.0 (old location	**Version 2.0** (new location)	**Changes made**
5.1	6.1	Reworded for clarity. Added section on MPHS beds days.
-	5.2	Section added

5.2	6.3	Slightly reworded for clarity.
5.2.2	6.3.4	Section added to separate funding types for clarity.

Energy and Water for Hospitals – Chapter 7 – Data validation		
Chapter 6 of v1.0 has become Chapter 7 Data validation in v2.0. All the documentation requirements have been moved to Chapter 9.		
Version 1.0 (old location	**Version 2.0** (new location)	**Changes made**
6.1	7.1	Reworded for clarity. Consumption data validation included.
-	7.2	Section added
6.2	7.3	Content the same, just reformatted.
-	7.4	Consumption data validation section added
6.3	7.5	Content the same, just reformatted.
6.4	7.6	Content the same, just reformatted.
6.5	7.7	Content the same, just reformatted.

Energy and Water for Hospitals – Chapter 8 – Minimum energy & water coveragea		
Former Chapter 7 on energy coverage has been combined with former Chapter 8 on water coverage to form this new chapter. These chapters have been reviewed and restructured to align with the new Rules format. Some content has been removed as it belongs in the *Metering and Consumption Rules*. Where possible, content has been simplified for clarity.		
Version 1.0 (old location	**Version 2.0** (new location)	**Changes made**
7.1	9.1 and 9.2	The summary section of 8.1 combines content drawn from Sections 8.1 and 9.1 of the previous version. Link to Chapter 3 of *NABERS The Rules – Metering and Consumption* added in 9.1.
7.1.6	9.2.5	Section on energy exclusions re-written. Section on electric vehicle charging points added.
7.2	–	On-site generation section removed and link to *NABERS Ruling – On-site Renewable Electricity Generation (OREG) Systems* for more information on on-site renewable systems added.
7.3	–	Greenpower removed section as content features in *NABERS Rules – Metering and Consumption*.
7.4	10.7	Documentation removed to Chapter 10.
8.1	9.1 and 9.3	Introductory content about water combined with energy in 9.1. Some paragraphs moved around for improve flow of sections, such as on-site capture and recycling, which was moved up to 9.3.
8.2	10.7	Documentation removed to Chapter 10.

Energy and Water for Hospitals – Chapter 9 of v1.0		
Former Chapter 9 of v1.0 has been separated, with part being moved to the new document published in 2020, *NABERS The Rules – Metering and Consumption- v1.2* to align with the requirements of other building types. The other part has been added to Chapter 7 Data validation.		
Version 1.0 (old location	**NABERS The Rules – Metering and Consumption** (new location)	**Changes made**
Chapter 9 Consumption data	Much of this chapter has been incorporated into *NABERS The Rules – Metering and Consumption* as it relates to consumption of energy and water in a variety of building types, not just in Hospitals.	
9.1 Summary	–	Removed – no longer applicable due to restructure
9.2 Measuring consumption	3.2	• 'Measuring consumption' – title changed to 'Energy and water sources and supply points' • All information revised and separate energy and water sections merged together
9.3 Consumption Data Validation	7.4	Consumption data validation moved to Chapter 7, with other data validation requirements.
9.4 Documentation required	Chapter 9	All documentation requirements revised and moved to Chapter 9.

Energy and Water for Hospitals – Chapter 9 – Documentation Required
Appendix A in v1.0 has become Chapter 9 in v2.0. All documentation requirements within the document have been consolidated into the new Chapter 9 which goes through the document by section and outlines information required and (where applicable) documentation examples. **The content has been reviewed and simplified for clarity.**

Version 1.0 (old location	**Version 1.0** (new location)	**Changes made**
10.1	9.1	Content removed due to removal of Appendix A – Information checklist for accredited ratings
10.1	9.2.1	Added content for occupied bed days
	9.3.1	Added content for separations
	9.4.1	Added content for aged care beds
	9.4.2	Added content for aged care bed days
	9.4.3	Added content for inclusion of ACB Days in OBD count
	9.4.4	Added content for source of funding of aged care beds
	9.5.1	Added content for validation of operational data
	9.5.2	Added content for validation of consumption data
	9.6.1	Added content for list of energy sources
	9.6.2	Added content for list of water sources
	9.6.3	Added content for minimum energy coverage
	9.6.4	Added content for minimum water coverage

Energy and Water for Hospitals – Appendices		
The appendices are no longer numbered but stand-alone sections of the text. The previous Appendix A has been added to Chapter 9; the previous Appendix B has been added to chapter 2. An appendix on the rating period has been added.		
Version 1.0 (old location	**Version 2.0** (new location)	**Changes made**
Appendix A	Chapter 9	Appendix A removed as deemed unnecessary step for Assessors to have to complete as it is not required in the Rating Assessment form. All the example documentation in this checklist is now covered in Chapter 9.
Appendix C	Appendix A	Reference to source of peer group classifications added.
–	Appendix B	Appendix added to describe, in detail, the rating period. It is foreseen that this information about the rating period might be better added to the suite of documents as a ruling, rather than remain as repeated information in several documents. This will be amended in future updates to these texts.

Contact us

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