SOUTH GIPPSLAND
HOSPITAL

73rd Annual Report 2013-2014

Table of Contents

History

South Gippsland Hospital (SGH) is located in the small town of Foster at the gateway to Wilson's Promontory and Tarra Bulga National Parks. The town of Foster has a population of approximately 1700 people however the official catchment area of the Hospital boasts 5600 people.

The organisation, classified as a small rural health service (SRHS), is an integrated hospital and community health service providing a broad range of acute and primary care services. It is closely associated with the Foster and Toora Medical Centres which provide the medical practitioner services. The combined experience and skills of the doctors and hospital staff and the range of services provided by the organisation, especially the obstetrics care, has led to a significant number of people accessing the services of South Gippsland Hospital from outside the recognised catchment boundaries.

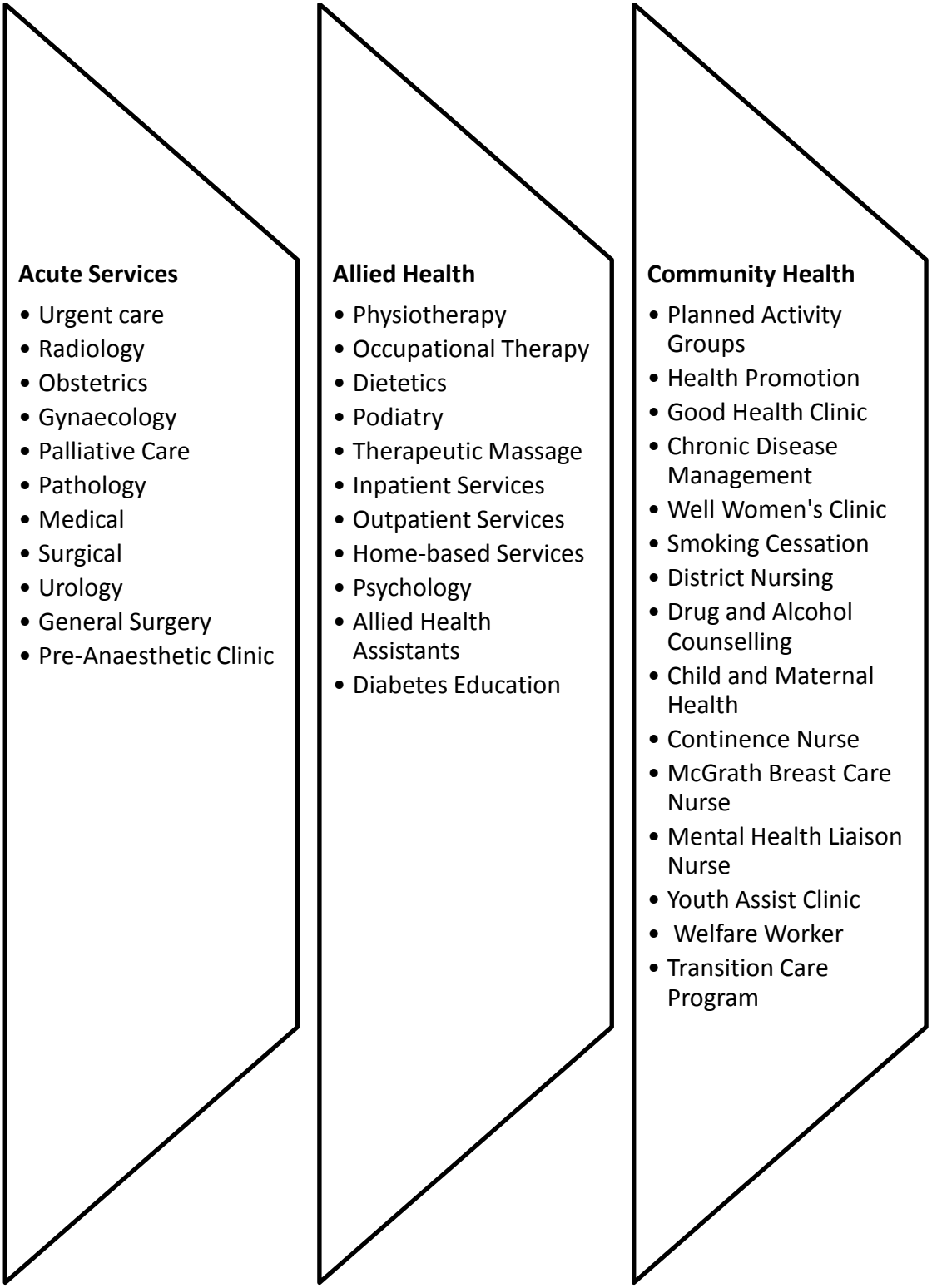
South Gippsland Hospital was established in 1907 as a private institution and continued as such until 1937 when it was taken over by the community as a local hospital. It gained public hospital status in 1941, when it was incorporated under the *Hospital and Charities Act*. The hospital building is more than 60 years old. It has 16 in-patient and two day-procedure beds, an operating theatre, ambulance bay, radiology facilities and an Urgent Care Clinic.

A Community Health Centre, co-located on the hospital site, was opened in June 2001 at a cost of almost $400,000. This money was made available largely from hospital reserves and community fund raising. Growing demand for primary care services saw this building quickly reach full capacity and late in 2007 the Board approved the construction of an extension to allow the organisation to meet the current and future needs of the community. Once again, the works, completed in November 2008, were fully funded through the Hospital's reserves and the generous donations received from the community.

In recent years, the hospital has expanded services to meet community needs with the addition of a CT scanner and the establishment of a radiography centre. At the same time, outpatient urgent care facilities were upgraded and necessary maintenance and refurbishment of the nurses' station and passageways was undertaken.

Greater awareness of community health has necessitated expansion of primary health care services and the development of a community supported Youth Assistance Program. We continue to offer urology, gastroenterology and general surgery. These services continue to grow and have been well received by the community.

Services


Acute Services
• Urgent care
• Radiology
• Obstetrics
• Gynaecology
• Palliative Care
• Pathology
• Medical
• Surgical
• Urology
• General Surgery
• Pre-Anaesthetic Clinic
Allied Health
• Physiotherapy
• Occupational Therapy
• Dietetics
• Podiatry
• Therapeutic Massage
• Inpatient Services
• Outpatient Services
• Home-based Services
• Psychology
• Allied Health Assistants
• Diabetes Education
Community Health
• Planned Activity Groups
• Health Promotion
• Good Health Clinic
• Chronic Disease Management
• Well Women's Clinic
• Smoking Cessation
• District Nursing
• Drug and Alcohol Counselling
• Child and Maternal Health
• Continence Nurse
• McGrath Breast Care Nurse
• Mental Health Liaison Nurse
• Youth Assist Clinic
• Welfare Worker
• Transition Care Program

Board Report

The year ended June 2014 has been a period of consolidation and planning for the future rather than of new undertakings. Our Executive team – Chief Executive Officer, Peter Rushen, Director of Nursing, Anna Stefani, and Community Health Manager Samantha Park – continued unchanged. I take this opportunity on behalf of the Board to thank them sincerely for their untiring efforts.

Perhaps the most significant event to occur this year was the opening of Prom Country House on land purchased from SGH, adjacent to the Hospital and the Medical Centre. In the short term, space has become available in Banksia Lodge, part of which has been rented by South Gippsland Hospital for hospital use. Longer term, the close physical proximity of the Hospital and Prom Country House should allow even closer co-operation and sharing of resources between the two institutions.

Also of significance for the future were the changes made to the way medical services are funded. The Board believes these changes will make it easier for our major medical service provider, Foster Medical Group, to attract and retain doctors.

The extraordinary activity in urgent and maternity care in previous years was rewarded by the provision of growth funding from the Department of Health. More detail of this is contained in the Treasurer's Report and the accounts.

As outlined in last year's Chair's Report, SGH was again a party to a Statement of Priorities (SoP) agreement with the Department of Health. It is pleasing to report that, as was the case last year, all the strategic priorities and KPIs contained in the SoP have been met.

While no new major initiatives have been undertaken during the year, significant work by staff and the Board in service and strategic planning has been done. This work has helped the Board better understand its client base and their service requirements and gain a better understanding of the role of SGH in its community. This knowledge is essential for the provision of services and infrastructure into the future.

There has also been considerable staff resources engaged in the implementation of National Safety and Quality Service Standards which focuses on the level of care patients and clients can expect from our health service. This work will continue in coming years and in 2015 the hospital will be accredited against new national standards of consumer care.

Board Membership

Vacancies created by the retirement of Lee-Anne Van Dyke and Rodney Delbridge were filled by Bernadette Thomson and Jeffry White. Bernadette brings wide clinical experience, particularly in the area of mental health, to the Board, while Jeff's accountancy background extended the range of skills available to members.

I thank all Committee Chairs and members of the Board for their dedication, commitment and support throughout the year.

Acknowledgements

While the Board concerns itself with policy-setting and oversight, the "doing" part of the provision of a health service falls to a number of groups to whom we must express our appreciation.

- The staff of the Hospital and Community Health Centre for their dedication and the quality of care provided
- The Corner Inlet Community for its support as donors and volunteers, both as individuals and through service and commercial organisations
- Our many contractors, particularly Foster Medical Group and South Gippsland Radiology
- The Hospital Auxiliary, whose members have been tireless and productive in their efforts towards fund-raising for the purchase of hospital equipment
- Finally, Rod Lomax and Ralph Gallagher, who serve as independent members of the Audit and Risk Management Committee.

Outlook

It seems that while each year brings its own particular challenges due to the intervention of the unexpected, some things remain unchanged. Looking ahead, 2015 will again be a year of financial restraint set against a background of increasing demand for the services we provide. In the medium term, some uncertainty exists as to the sources of funding for health services. Let us hope that when this uncertainty is finally resolved it will not disadvantage those in our community who have a need for hospital services.

In conclusion, it is apparent that at SGH we enjoy an outstanding health service due to the dedication of the staff and support of the community. As long as this continues, we have every reason for optimism.

Neil Roussac, Board President

Responsible bodies' declaration

In accordance with the *Financial Management Act* 1994, I am pleased to present the Report of Operations for South Gippsland Hospital for the year ending 30 June 2014.

Eric Neil Roussac – Chair, Board of Management
Date - 28 August 2014

Statement of Priorities

Part A – Strategic Priorities

Priority	Action	Deliverable	Outcome
Developing a system that is responsive to people's needs	• Implement formal advance care planning structures and processes that provide patients with opportunities to develop, review and have their expressed preferences for future treatment and care enacted. • Contribute to area based planning initiatives that consider health care across the care continuum. • Configure and distribute services to address the health needs of the local population. • In partnership with other local providers, apply existing service capability frameworks to maximise the use of available resources across the catchment. • Work and plan with key partners and service providers to respond to issues of distance and travel time experienced by some rural and regional Victorians.	• Develop a policy framework and commence implementation of an advanced care planning system. • Collaborate with sub-regional health services to implement strategies from the Gippsland South Coast Service Plan and Model of Care. • Update SGH service plan to assist with determining future service delivery. • Contribute to implementation of system improvements, partnerships and collaboration within Gippsland. • In co-operation with Foster Medical Group, attract ongoing specialist services to respond to community need and reduce patient need to travel to Melbourne or Latrobe Regional Hospital.	Consultations with local clinical practice in establishing standard format and access to information .Formal policy yet to be developed. Re- connection with sub regional partners established and early planning undertaken. Service Plan completed September 2013. Actively involved in implementation of acute pathways project and Gippsland Regional Maternity and Newborn Planning. Appointment of new specialist practitioners to maintain service levels. Succession planning in place for Endocrinologist.
Improving every Victorian's health status and experiences	Improve thirty-day unplanned readmission rates.	Finalise development of discharge policies and processes to ensure patients are appropriately referred to primary and community health services.	Discharge Planning Support Policy completed and active discharge meeting process in place

Priority	Action	Deliverable	Outcome
Expanding service, workforce and system capability	• Build workforce capability and sustainability by supporting formal clinical education and training for staff and health students, in particular inter-professional learning. • Work collaboratively with the department on service and capital planning to develop service and system capacity.	• Implement the Inter-Professional Clinical Supervision Framework developed through the South Coast Inter-Professional Clinical Supervision Project. • Complete business plan for the refurbishment of post-operative recovery facilities.	Active participant in this program. Design work in progress prior to preparation of plan.
Increasing the system's financial sustainability and productivity.	• Reduce variation in health service administrative costs. • Identify opportunities for efficiency and better value service delivery.	• In partnership with Foster Medical Group and Prom Country Aged Care investigate opportunities for sharing support services across the three facilities. • Implement a new Visiting Medical Officer payment system.	Active co-operation through establishment of a Precinct Management Group representing all parties. Fully implemented and post audit review completed.
Implementing continuous improvements and innovation	Develop and implement improvement strategies that optimise access, patient flow, system	Take action to ensure quality and safety management and key person strategies are in place to ensure business continuity.	Embedded all management processes and reviewed by Board of Management
Increasing accountability and transparency	Prepare for the National Safety and Quality Health Service Standards as applicable.	Develop an action plan to ensure accreditation is maintained.	Clear plan in place to ensure requirements for accreditation are met.
Improving utilisation of e-health and communications technology	Work with partners to better connect service providers and deliver appropriate and timely services to rural and regional Victorians.	Investigate opportunities in partnership with Foster Medical Group for tele-health.	No progress at this point.

Part B – Performance Priorities

Financial Performance

Key performance indicator	Target	2013-2014 Actuals
Operating result		
Annual operating result ($m)	0.005	0.190
Cash management		
Creditors	< 60 days	61 days
Debtors	< 60 days	59 days

Service Performance

Key performance indicator	Target	2012-2013 Actuals
Quality and safety		
Health service accreditation	Full compliance	Fully compliant
Cleaning standards	90	99.1
Submission of data to VICNISS	Full compliance	Fully compliant
Healthcare worker immunization - influenza	60	81
Hand Hygiene (rate)	70	87
Victorian Patient Satisfaction Monitor: (OCI) July-December 2013	73	N/A
Victorian Hospital Experience Measurement Instrument (January to June 2014)	Full compliance	N/A
People Matter Survey	Full compliance	Fully compliant
Maternity		
Percentage of women with prearranged postnatal home care	100	100

Chief Executive Officer's Report

This year was marked by a number of operational challenges but from a health delivery perspective there was no impact on the quality of health services and the feedback from patients and clients was very positive. Overall it was a busier year in maternity, urgent care services and community health, resulting in welcome additional growth funding and a confidence in the service expressed by Department of Health, in an economic environment where Government funding has been constrained.

The successes and challenges of the year can be measured in many ways but are generally reflected in the following areas:

Upgrade of Physical Facilities
The project to expand the radiology facility and upgrade the Nurses' Station and Urgent Care Clinic were completed and included a general upgrade of passageways and repainting of wards. While there was considerable disruption to services, staff managed in difficult circumstances and the quality of care was not compromised. This work has enabled the installation of the CT scanner and a new co-operative relationship with Sullivan Imaging (South Gippsland Radiology Services). At a total cost of $590,000 for all works, this represents very good value when compared to the earlier plans.

Business Viability
A very healthy operating result was achieved in 2013/14 as a result of additional income streams. There have been service development initiatives in the period including additional nursing staff on day and evening shifts being trialled and staffing for the preparation of National Standards accreditation was allocated to meet this workload. Additional case management staff in Community Health has alleviated workload pressures in Good Health Clinic and Transition Care Program.

An additional 6.5% or $210,000 in recurrent funding has been provided to support growth in maternity services and acute health. This is a very positive signal from the Department of Health that they support the service program offered by SGH. Much of this has been allocated to additional nursing staff costs.

Staffing
The results from the People Matter Survey confirmed that the workforce is well settled and committed to achievement of the hospital's objectives. We achieved an exceptionally positive result with over 65 of possible 90 factors ranking in the top quartile of comparable health services. This result has been acknowledged by the Health Services Commission (formerly State Services Authority) as an exceptional outcome.

While we have a healthy and vibrant workplace, the impact of staff absenteeism has been challenging to ensure there are sufficient staff numbers for rosters. The engagement of additional graduate nurses and now midwifery graduates has provided the additional workforce to meet immediate needs and also likely longer term workforce requirements.

Business Planning/Operations
As part of the overall strategic review of the hospital operation we have recently published a technical paper to support a new service plan to meet future community needs. A number of recommendations are pending the completion of a Board Strategic Review which will

provide a vision for the hospital in the next three years. In each quarter of the year a review of operations was provided to the Board on key performance indicators and targets achieved in meeting the strategic objectives. All targets have been met for the year.

Since the review of mortality data conducted by the Director of Medical Services an ongoing review of all significant clinical events has been conducted and, where necessary, followed up and reported to the Board. This reflects a core accountability of the Board for clinical governance.

Communications/Stakeholders
The ongoing collaboration with Prom Country Aged Care and Foster Medical Clinic has ensured that there is a good working relationship with our precinct partners. Resolution of the subdivision of land was a lengthy process requiring frequent follow up. SGH in consultation with the precinct partners initiated the consultation with South Gippsland Shire Council on the development of the car park and we are looking forward to ongoing Council support in progressing this project.

The availability of space in Banksia Lodge has provided accommodation for some community health functions and further planned use is well advanced. The existing shared service agreement with Prom Country Aged Care for provision of stores supplies and maintenance support has been renewed.

Community and Public Relations
Opportunities to engage with the community have been an important part of the year's activities. Presentations were made to Rotary and other community groups and a reasonably high profile for the hospital has been maintained in the community. The Quality of Care Report continues to receive positive community comment. A close working relationship with the Hospital Auxiliary has been maintained, with a number of staff presenting at their meetings and supporting their administrative effort. We thank them for their continued financial support in the provision of much needed medical equipment.

Active involvement in fund raising and added staffing benefits of the Murray to Moyne bike ride event has been important in building a strong team environment in the hospital and providing welcome donated funding.

Summary
The improvements to the physical environment of the hospital and Community Health Centre have been significant in enhancing working conditions and further expansion into Banksia Lodge will provide better working conditions for staff, clients and patients. Furthermore, a stable financial state has enabled greater focus on services rather than financial administration and there is strong support from Department of Health for the work that we do.

There are plans in place for further enhancement of facilities and we are working well with our stakeholders and service providers.

The support received from the Board of Management and their contribution is greatly appreciated.

Treasurer's Report

I am very pleased to report that in the year ended 30 June 2014 the hospital exceeded budget expectations and achieved an operating surplus of $189,680 and after allowance for capital items and depreciation a net overall deficit of $134,703.

The total operating revenue was $7,204,830, an increase of 9% on the previous year. This increase was due to special growth funding in State Government grants and a significant increase in income derived from self-generated sources such as private patient fees, undergraduate nurse training fees and the Transition Care Program. Expenditure was $7,015,149, an increase of 7% and was mainly applied to additional salary costs, while all other costs were contained within budget expectations.

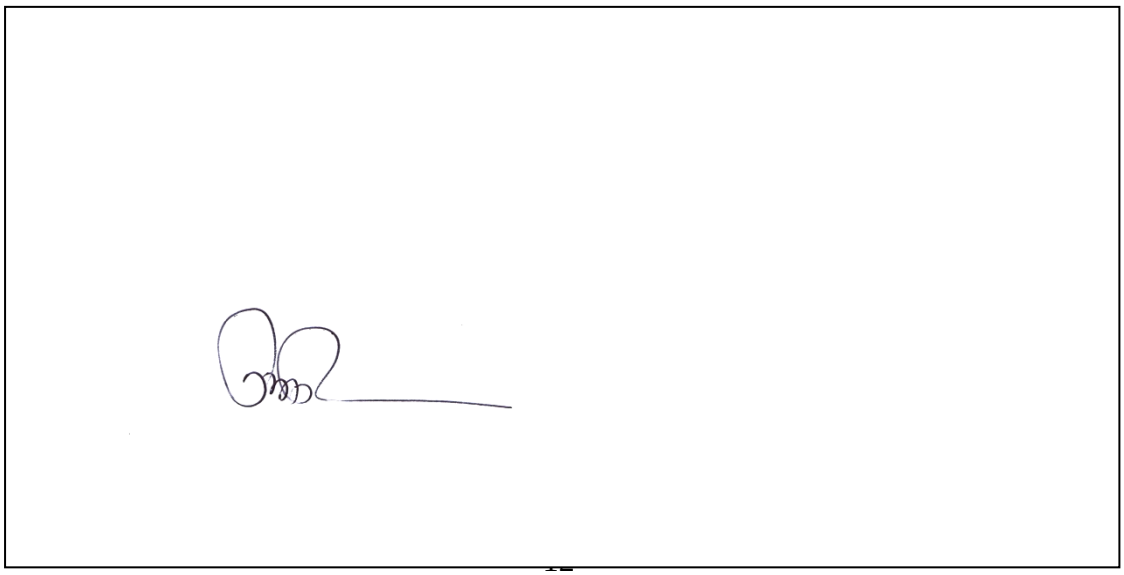
It is encouraging that at a time when Government funding is constrained that we have received growth funding in recognition of the increased activity at the hospital and also achieved a healthy operating surplus. Considerable staff resources have been committed to implementing the new accreditation standards established by the Australian Commission on Safety and Quality in Healthcare and this work is likely to continue for some time. The management and staff are to be complimented on their effort in dealing with these changes, the increase in service provision and maintaining operating efficiency. There were no significant capital works during the period but plans are currently being prepared for facility developments in the coming year.

A statutory revaluation of land and buildings was undertaken during the year resulting in an increase in the Asset Revaluation Reserve of $561,624.

The hospital is in a very sound financial position and currently holds adequate reserves to cover all of its commitments including statutory employee obligations.

We are fortunate in having strong leadership and dedicated staff and we thank them for their contribution to this year's result. The commitment of the Board, Hospital Auxiliary and community in their support for our hospital is also noted.

Bruce Lester
Treasurer



Summary of Financial Results

	2014 $	2013 $	2012 $	2011 $	2010 $
Total Revenue		6,895,865	6,668,214	5,877,600	5,648,883
Total Expenses		6,960,739	6,466,169	6,139,903	6,059,294
Net Result for the Year		(64,874)	202,045	(261,300)	(410,411)
Net Increase in Asset Revaluation Reserve		-	-	-	-
Accumulated Surpluses (Accumulated Deficits)		1,325,297	1,390,171	1,188,126	1,449,426
Contributed Capital		3,086,756	3,086,756	3,086,756	3,086,756
Asset Revaluation Reserve		2,295,936	2,295,936	2,295,936	2,295,936
Total Equity		6,707,989	6,772,863	6,570,818	6,832,118
Total Assets		8,649,412	8,940,375	8,196,736	8,410,488
Total Liabilities		1,941,423	1,717,514	1,625,918	1,578,370
Net Assets		6,707,989	6,772,863	6,570,818	6,832,118

Attestation for compliance with the Ministerial Standing Direction 4.5.5.1 – Insurance

I, PETER RUSHEN, certify that South Gippsland Hospital has complied with Ministerial Direction 4.5.5.1 – Insurance

Peter Rushen – Chief Executive Officer, Foster, 28 August 2014

Revenue Indicators

	Average Collection Days	
	2014	**2013**
Private	57	56
TAC	60	95
VWA	137	22

Debtors Outstanding as at 30 June 2014

	Under 30 days	**31-60 days**	**61-90 days**	**Over 90 days**	**Total 30/6/14**	**Total 30/6/13**
Private	**33077**	**16848**	**4977**		**54902**	**53249**
TAC	**237**	**81**		**81**	**399**	**327**
VWA						**3423**
Other Compensable	**8497**	**5519**	**729**	**3016**	**17761**	**19874**
TOTAL					**73063**	**76873**

ABBREVIATIONS:

TAC Transport Accident Commission

VWA Victorian WorkCover Authority

Workforce Data

Labour Category	**JUNE Current Month FTE**		**JUNE YTD FTE**	
	2013	**2014**	**2013**	**2014**
Nursing	52.5	49.0	53.4	50.4
Administration and Clerical	21.0	17.0	22.2	24.1
Medical Support	11.1	10.0	11.7	11.5
Hotel and Allied Services	25.3	23.0	25.3	23.6
Medical Officers	0.08	0.08	0.3	0.08
Hospital Medical Officers	0	0	0	0
Sessional Clinicians	0	0	0	0
Ancillary Staff (Allied Health)	3.4	1.7	1.9	2.2

Board of Management

Neil Roussac, B.Sc – appointed 2006
President
I was born at South Gippsland Hospital and educated in Foster and Melbourne University. I am married and a partner in a family farming business. My Board appointment continues a long family involvement with the hospital, both as clients and with voluntary work.

Clive White, B.Juris, LL.B – appointed 1986
Vice President
I am a practising lawyer, married with three children. I have been a member of the Board for 27 years, have prior service as President for two years and Treasurer for three years and continue to be a member of other sub-committees.

Bruce Lester – appointed 2010
Treasurer
I have spent most of my life in the Foster area where I ran a sheep and cattle grazing property. I have sat on local school councils, was a local shire councillor and served on several beef industry boards. I recently retired and plan to devote more time to family, golf and travel. I believe strongly in promoting and fostering the strength of the local community particularly in the provision of health services.

Megan Knight, T.P.T.C, GradDip BusTech – appointed 2004
Assistant Treasurer/Immediate Past President
With husband, Robert, I operate a small beef property. Prior to retirement I held senior roles in lending, strategic planning and human resource management in the Rural Finance Corporation of Victoria.

Bill Fuller – appointed 2000
I am married to Barb and have three children. I was a pilot in general aviation and a farmer in the Dumbalk district before retiring to Foster. I have taken an active interest in a variety of community activities for many years. I have previously held the positions of President and Treasurer and am currently serving on several sub-committees.

Mohya Davies, Dip.Ed – appointed 1986
I am a long term member of the board who has seen enormous change in our health service. I am dedicated to the progression of our unique health service and the development of a health precinct. I take a special interest in the development of Community Health and the planning committee. I am a Coastal Promontory Ward Councillor on South Gippsland Shire. My husband and I are partners in a couple of small businesses.

Matthew Marriott BVSc (Hons) – appointed 2009
My wife Kate and I have three small children. I grew up in the area and attended Foster Primary School. After a short stint as a practising veterinarian, I returned to the family beef farm near Foster 15 years ago. I like making a contribution to our treasured local hospital.

Paul Ahern - appointed 2011
My wife Mary-Ann and I are retail and wholesale fruiterers in Foster. We have three children - born and educated in Foster- one of whom is working with us. We have operated our business for nearly

30 years. I have sat on a number of boards within our industry and within our community and enjoy the opportunities given to me to be involved.

Lisa Barham-Lomax B.Ed. Grad. Dip. Leadership and O.D, Exec Masters in Public Administration – appointed 2012
I live in Foster with my husband and three children, currently working at Bass Coast Shire Council as Social and Community Planning Co-ordinator. I was raised in Foster and attended both the primary and secondary colleges, before moving away to study and work for 17 years. My family and I returned to live here in 2010.

Bernadette Thomson BA, Grad. Dip. Psych, MAPsS, MVAPP – appointed 2013
I am married with three children and live in Melbourne. I am a psychologist and psychoanalytic psychotherapist working in private practice in Richmond. I have also trained as a double certificate nurse, no longer practising. My family and I have owned property in the area for many years and have established strong friendships and an affinity for the Foster community and its values. I am pleased to be contributing to the South Gippsland Hospital which is such a valuable resource for the residents of the region.

Jeffry White, Masters of Business - Accounting, B.Bus (BIS), Ass.Dip.Acc – appointed 2013, resigned December 2013
Worked as an accountant, business systems manager and chief financial officer throughout a more than 25 year career in private enterprise.

Board Member Attendance

Board Member	Number of Meetings Held	Number of Meetings Attended
Neil Roussac	11	10
Mohya Davies	11	7
Bill Fuller	11	9
Megan Knight	11	9
Matthew Marriott	11	11
Bruce Lester	11	5
Clive White	11	7
Paul Ahern	11	8
Lisa Barham-Lomax	11	10
Bernadette Thomson	11	11
Jeffry White	6	3

Board Committees

During the year, the Board reviewed the Charter of each of its Committees. The Charters provide:

Audit and Risk Management Committee
The Audit Committee considers recommendations relating to internal audit reports, monitors statutory compliance and ensures compliance to matters raised by the Victorian Auditor-General's Office. The Audit Committee met five times during 2013-2014. Members are: Matthew Marriott (Chair), Bill Fuller, Bruce Lester, Neil Roussac, Mohya Davies and independent community representatives Rod Lomax and Ralph Gallagher.

Finance Committee
Monitors accounting and reporting requirements, examines budgets, reviews staffing levels and internal audit programs. The Finance Committee met 11 times during 2013-2014. Members are: Bruce Lester (Chair), Bill Fuller, Clive White, Megan Knight, Matthew Marriott and Neil Roussac.

Planning Committee
Identifies and reviews existing hospital services which require upgrading or modification and recommends establishment, delivery and financing of future services. The Planning Committee met five times during 2013-2014. Planning also monitors the maintenance program for buildings, grounds and equipment and recommends budget inclusions for major and minor works and replacements. Members are: Lisa Barham-Lomax (Chair), Mohya Davies, Megan Knight, Paul Ahern and Neil Roussac.

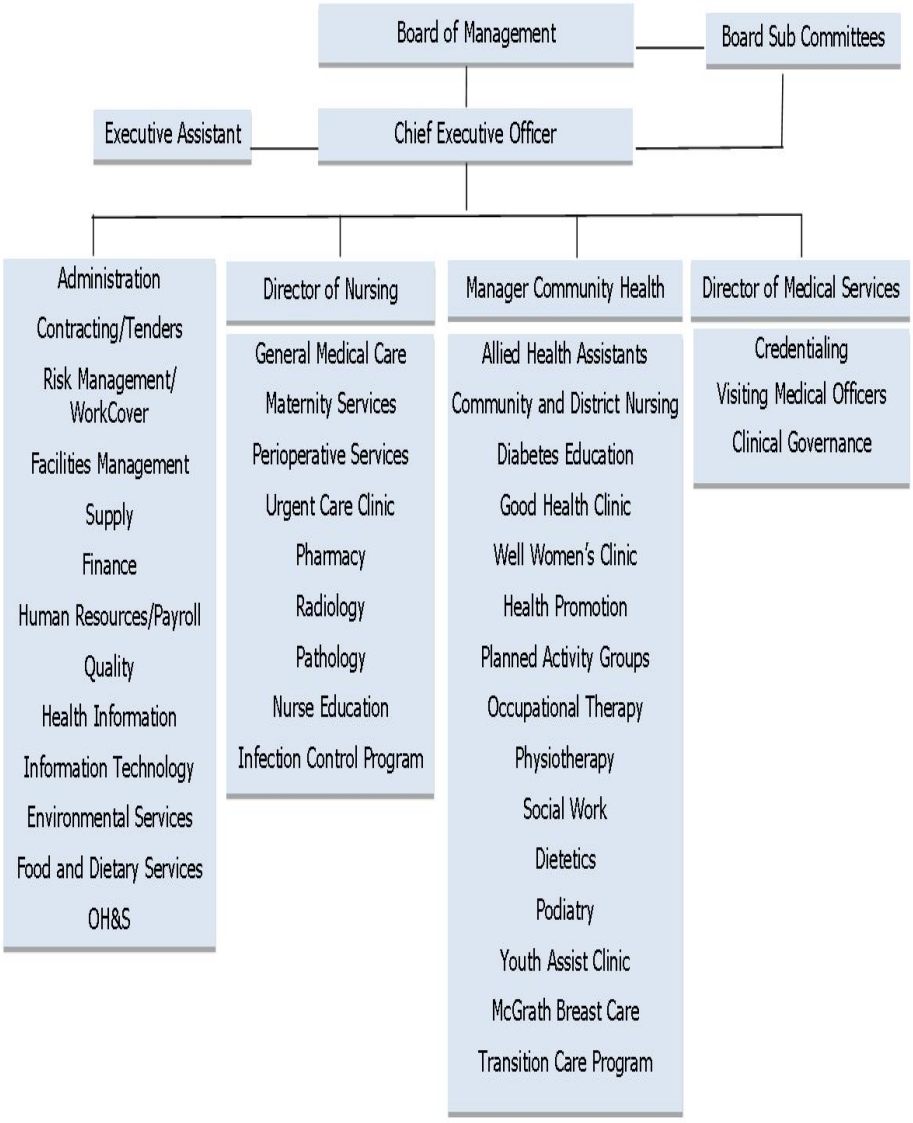
Quality Systems Review Committee
Monitors and provides direction for continuous quality improvement and performance monitoring. The Committee met five times during 2013-2014.
Members are: Megan Knight (Chair), Clive White, Matthew Marriott, Lisa Barham-Lomax and Neil Roussac.

Executive Committee
Members are: Neil Roussac, Megan Knight and Bruce Lester.

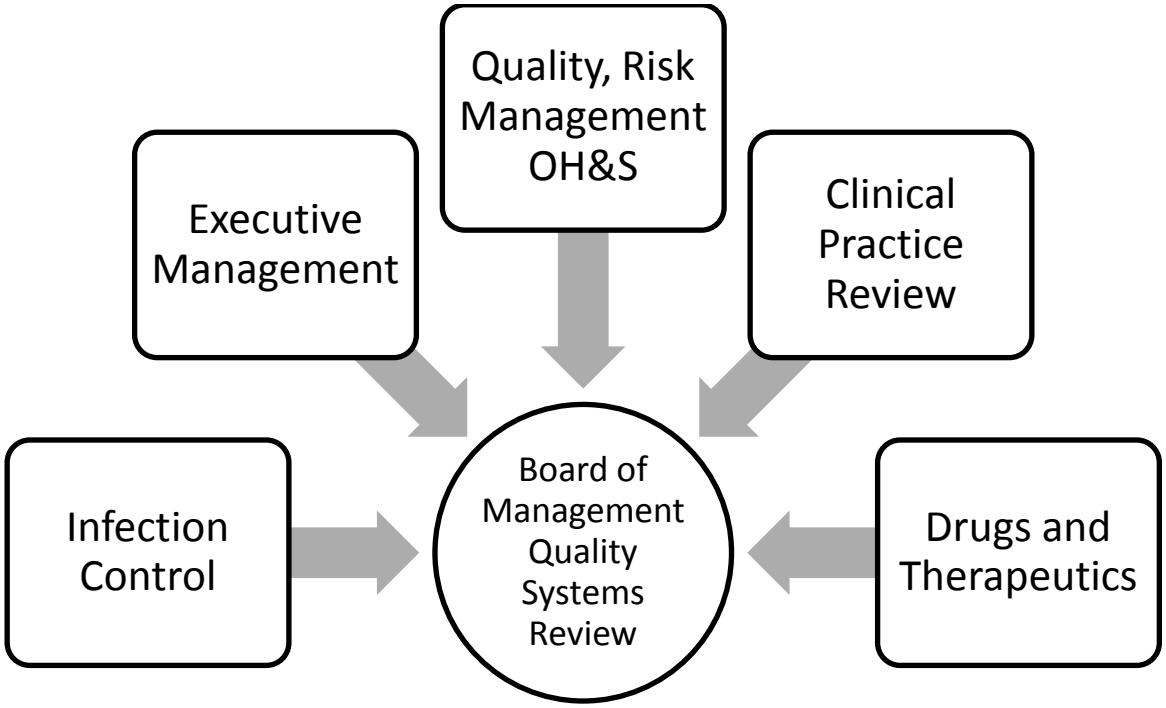
Medical Appointments Advisory Committee
This committee monitors Visiting Medical Officer (VMO) contractual arrangements and makes recommendations to the Board on clinical scope of practice and credentialing following the VMO reviews performed by the Sub-Regional Credentialing Committee. Members are: Bill Fuller (Chair) and Megan Knight.

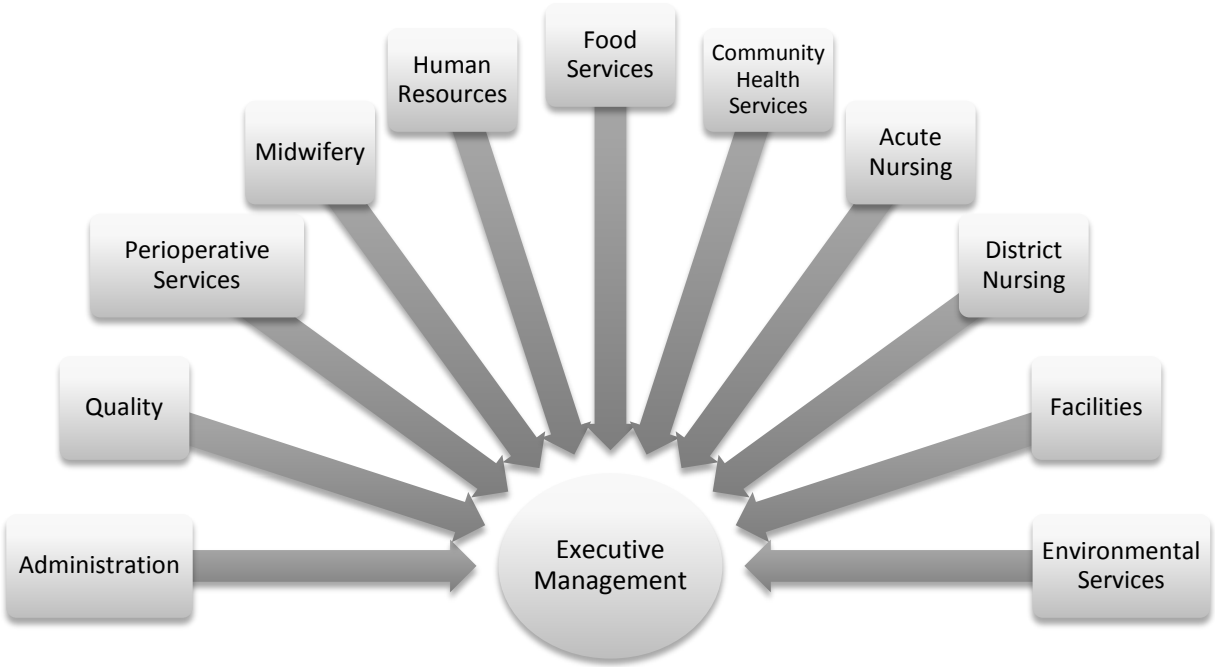
Remuneration Committee
The role of this Committee is to review and revise the remuneration position for Executive staff along the guidelines of the Government Sector Executive Remuneration Panel. Members are: Clive White (Chair) and Bill Fuller.

South Gippsland Hospital Organisational Chart



Organisational Committee Structure





Executive Team

Peter Rushen, Chief Executive Officer
B.Econ, CPA

As Chief Executive Officer, Peter brings more than 30 years commercial experience in the oil industry, together with a further period in the health and welfare sector. Peter also held a number of Board positions - in education and at South Gippsland Hospital (SGH).

Dr Craig Winter, Director of Medical Services
MB.BS, MBA, GMA, FACEM

Craig has been Director of Medical Services (DMS) at SGH for 11 years and is DMS for a number of other regional Health Services. Craig is also an emergency physician at St Vincent's Hospital in Melbourne.

Anna Stefani, Director of Nursing
RN, RM, GCDE, IBCLC

Anna has been nursing for 25 years and as a midwife for 20 years. Prior working roles, aside from working at SGH for 20 years, have included the Maternity Support Program, Secondary School Nursing and Maternity Unit Manager.

Samantha Park, Manager Community Health
BSc, MS (Prelim), Grad Dip Adolescent Health and Welfare

Samantha was appointed to her current role in May 2011 and held the positions of Quality and Risk Co-ordinator and Administrative Support Officer when she joined the hospital in September 2009. She has previously worked in the field of clinical research and has undertaken considerable voluntary work in the community.

Visiting Medical Officers

Dr David Iser, MBBS, FRACGP, Dip Obs, RACOG
Dr Philip Worboys, MBBS, FRACGP, Dip Obs, RACOG
Dr Frances Grimes, MBBS, Dip Obs, RACOG
Dr David Polmear, MBBS (Hons), BSc, Dip Obs, RCOG, FRACGP
Dr Owen Casson, MBBS, FRACGP
Dr Michael Fitzgerald MBBS, FRACGP
Dr Stanley Rajasooriar, MBBS, BSc
Dr Trevor Andrews, MBBS
Dr Deidre Bentley, MBBS
Dr Ruyu Yao, MBBS
Dr Kaveh Haghighi, MBBS, (Iran)
Dr Syam Navuru, MBBS (India)
Dr Alison Wilde, MBBS, Dip Pall Med
Dr Claire Langford, MBBS, DCH
Dr John-Paul Kennedy, BA, MB, BaO, BCH
Dr Tania Morgan, MBBS, Dip Obs, FACOG, MPH
Dr Claire Rayner, MBBS, DRANZCOG
Dr Lisa Mathews, MBBS, BMS
Dr Jamal Moussa, MBBS Lithuania
Dr Peter Cullen-Byrne, MBBS, BaO

Visiting Specialists

Mr David Luiz, MB, BCH, FCOG (SA), MRCOG, FRANZCOG
Mr Andrew Jamieson, BSc, MBBS, FRACS, FRCS (England)
Mr John Iser, MBBS, FRACP
Dr Ranjit Rao, MBBS, FRACS
Dr Kristina Cvach, MBBS, MPH&PM, FRANZCOG

Director of Nursing

Acute Care continues to remain a dynamic and diverse environment in both admission and urgent care presentations and appreciation is given to the whole care team involved with co-ordinating and providing the best available care to our community.

Acute Department

More than 1000 admissions for the year20 13/14 has kept the Acute Ward busy with the complex nature of our ageing community reflected in our patient profile. In addition to inpatients, around 200 urgent care presentations occur each month with more in the summer months when our coastal community population increases.

Highlights from each department are as follows:

Peri Operative and Sterilising Unit

Activity

Surgical Services

- Provided 107 operating sessions for general, urology, obstetrics and gynaecology and gastroenterology surgery compared to 105 sessions the previous year;
- Provided 719 procedures from the elective waiting lists, compared to 672 the year before; and
- Provided 7 emergency caesarean procedures compared with 8 emergency caesareans being performed in the 2012/13 period.

Quality and safety

- Improvements in drug storage have been made to comply with National Standard 4.
- Administration of appropriate medicines to comply with SGH Antimicrobial Stewardship guidelines
- Improvements in procedures relating to the identification of patients and matching their identity with the correct treatment in compliance with National Standard 5.
- Installation of pipeline suction system throughout the hospital has greatly improved safety of anaesthetics delivery.
- 99% compliance with sterilising risk assessment audits of AS/NZ 4187:2003 Standards.

Workforce

We farewelled Dr David Luiz, who has been skilfully providing gynaecological surgical services and consultation for 17 years at SGH, at a luncheon in December. We have been fortunate to secure the services of Dr Kristina Cvach who specialises in urogynaecology to continue this service.

Congratulations to Dr Owen Casson on qualifying and commencing operative obstetrics, providing surgical births along with Dr David Iser. We welcomed Dr Claire Rayner, who also offers obstetrics and supervised surgical births, strengthening our surgical team. The co-operation of Gippsland Southern Health Service anaesthetists in providing relief anaesthetics has been greatly appreciated.

Infection Prevention and Control

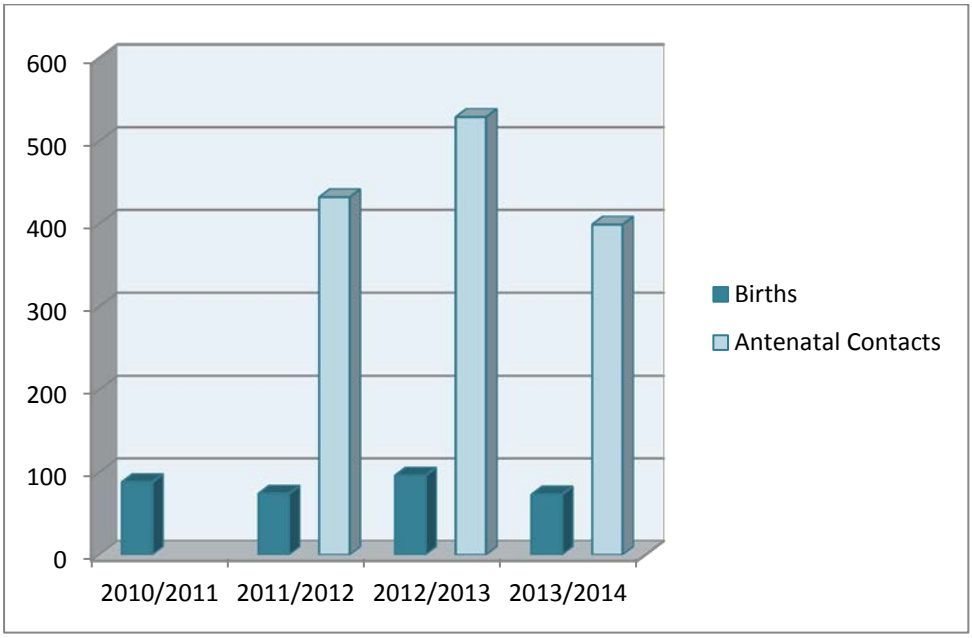
- Continued and improved systems and strategies to maintain prevention of infection of patients meeting National Standard 3.
- Effective management of infectious patients when they are admitted to minimise cross infection.
- Hand Hygiene 87% compliance average for 2013-14 exceeding national target of 70% compliance.
- External cleaning audits meeting National targets in all areas.
- 2013 staff uptake of Influenza vaccine 68% above the state target of 60% .
- All surveillance submitted to VICNISS.

Maternity Services

Maternity clinical activity is highlighted in the following graph. The antenatal contacts are provided via the Shared Care midwifery model – a collaborative system of care involving Foster Medical Centre and SGH midwives.

Birth Numbers and Antenatal Contacts 2010- 2014

Figure 1 Yearly Birth numbers South Gippsland Hospital



Maternity workforce

The hospital has 12 midwives employed with an additional two midwives who work in the antenatal clinic. We were very fortunate to secure the services of experienced midwife Jennie Teskey, who has made a sea change and settled in Gippsland. Jennie works in the antenatal clinic in addition to working in the birthing suite.

Currently we have four Division 1 nurses undertaking the Post Graduate Diploma of Midwifery: Sheralee Jones in her second year and Mirinda Hoffert, Jade Shoobert and Liz Purtell in first year.

Figure 2 Midwifery workforce by years of experience

Education

Mandatory training requirements have increased this year with the introduction of the National Standards. Nursing staff have been required to attend additional sessions to meet these standards, including patient centred care, quality and infection control.

The Post Graduate Diploma of Midwifery program has continued in conjunction with Monash University and now Federation University. We currently have three first year students and one second year student in the program. This has proved to be a great program to 'grow our own' midwives over the past 12 years with five midwives already completing the program, four of whom have stayed on staff.

We have continued to increase our undergraduate student numbers and have also hosted a number of year 10 students from local secondary colleges on their work experience placements.

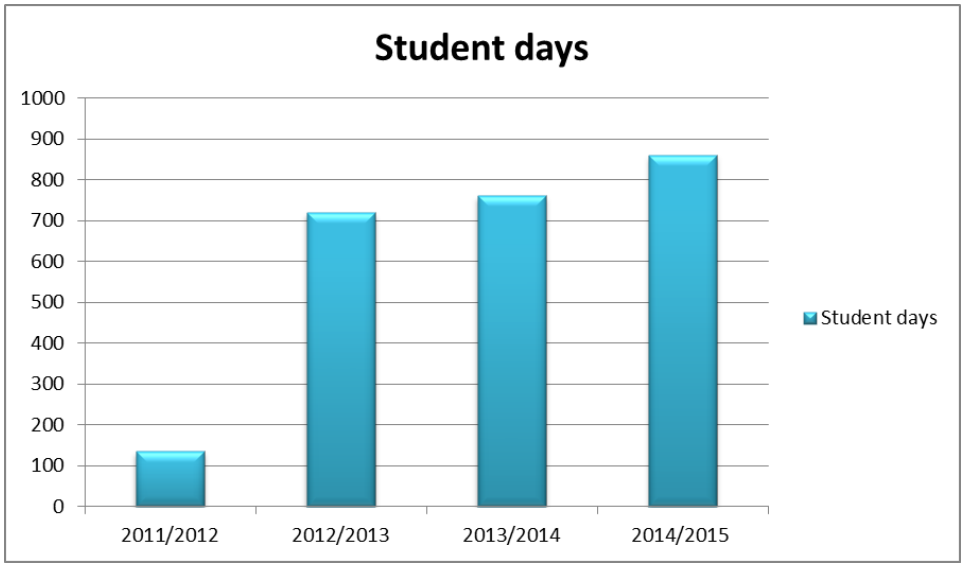


Figure 3 Student days by year

Facilitating students from 10 tertiary level educational providers has allowed our nursing staff to increase their scope of practice to include mentoring undergraduate students. Our patients benefit from having enthusiastic students under supervised care for them both in the hospital and community setting.

This enables our nursing staff to share their knowledge and expertise and in turn learn from the students about current practices being taught and the students gain a unique perspective of working in a rural health setting. Financial remuneration from the educational providers and the Department of Health provides funds towards our educational programs.

Best Practice Clinical Learning Environment

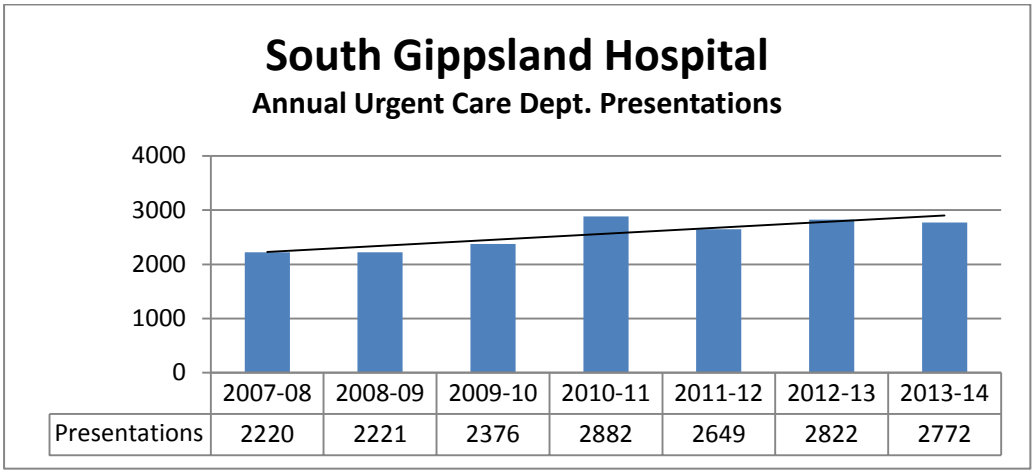
The Best Practice Clinical Learning Environment (BPCLE) project is a Victorian State Government initiative aiming at improving the education of clinicians in the public health service. The Department of Health has funded the appointment of BPCLE facilitators to implement the project with a focus on improving the clinical placement experience of students in all health professions. The BPCLE project commenced in January 2014 with the appointment of a BPCLE facilitator who has undertaken the process of assessment, planning and evaluation of education services at SGH utilising the BPCLE framework.

This process initially involved an assessment of 265 criteria and from this assessment an action plan with 20 goals and 60 tasks has been developed. In addition, 20 indicators have been identified for continuing monitoring by the health service. Currently a number of tasks in the action plan are in the process of being implemented and it is anticipated that reporting against the selected indicators will begin early in 2015.

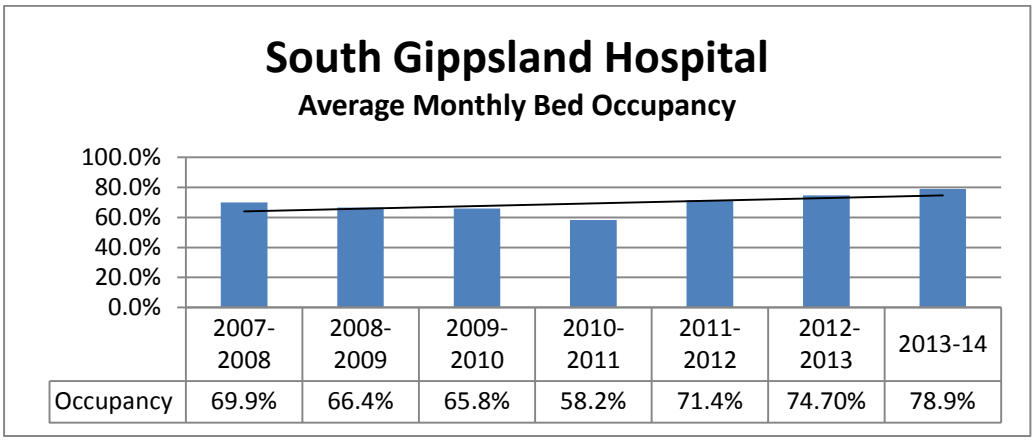
In conclusion, it is gratifying to see the ten National Standards and related requirements are now becoming firmly embedded within our core clinical practice at SGH, exciting to be building on our learning culture with increased student throughput and adherence to the values of the BPCLE and as a small rural health service, that we continue to provide a diverse range of services to our local community and be recognised as a valuable and sustainable health care facility.

I wish to conclude this report by thanking all the tireless caring health care professionals at SGH who provide excellent care to our community.

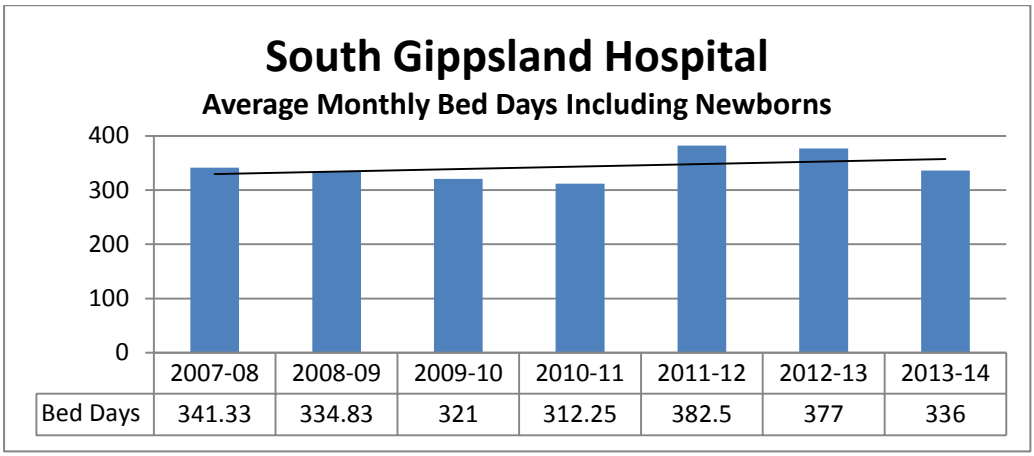
Performance Indicators



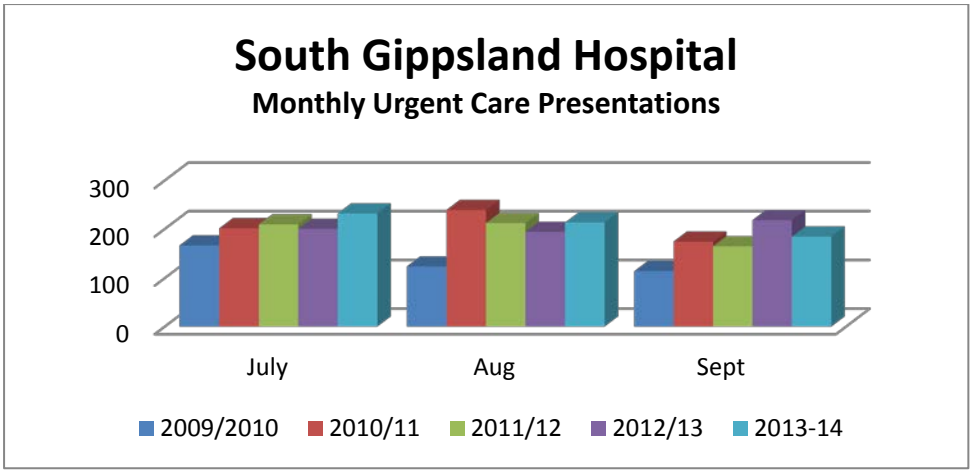
	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Presentations	2220	2221	2376	2882	2649	2822	2772

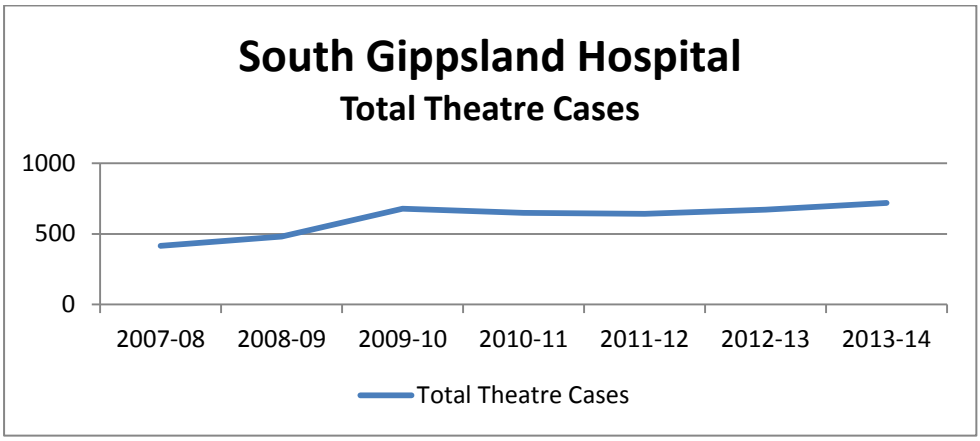


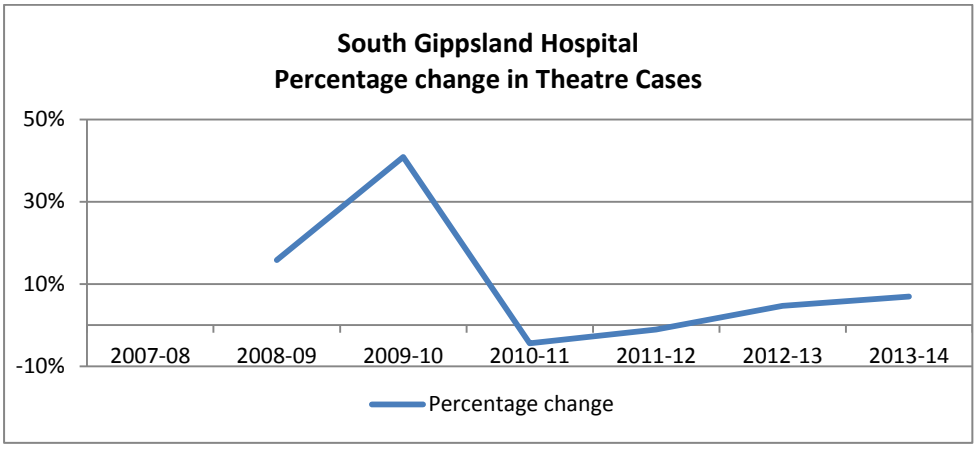
	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-14
Occupancy	69.9%	66.4%	65.8%	58.2%	71.4%	74.70%	78.9%



	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Bed Days	341.33	334.83	321	312.25	382.5	377	336


South Gippsland Hospital
Monthly Urgent Care Presentations
300
200
100
0
July
Aug
Sept
2009/2010
2010/11
2011/12
2012/13
2013-14


South Gippsland Hospital
Total Theatre Cases
1000
500
0
2007-08
2008-09
2009-10
2010-11
2011-12
2012-13
2013-14
Total Theatre Cases


South Gippsland Hospital
Percentage change in Theatre Cases
50%
30%
10%
-10%
2007-08
2008-09
2009-10
2010-11
2011-12
2012-13
2013-14
Percentage change

Community Health Centre Report

South Gippsland Hospital's Community Health Centre provides community focused nursing, allied health services and other health and chronic disease management programs.
Community Health:

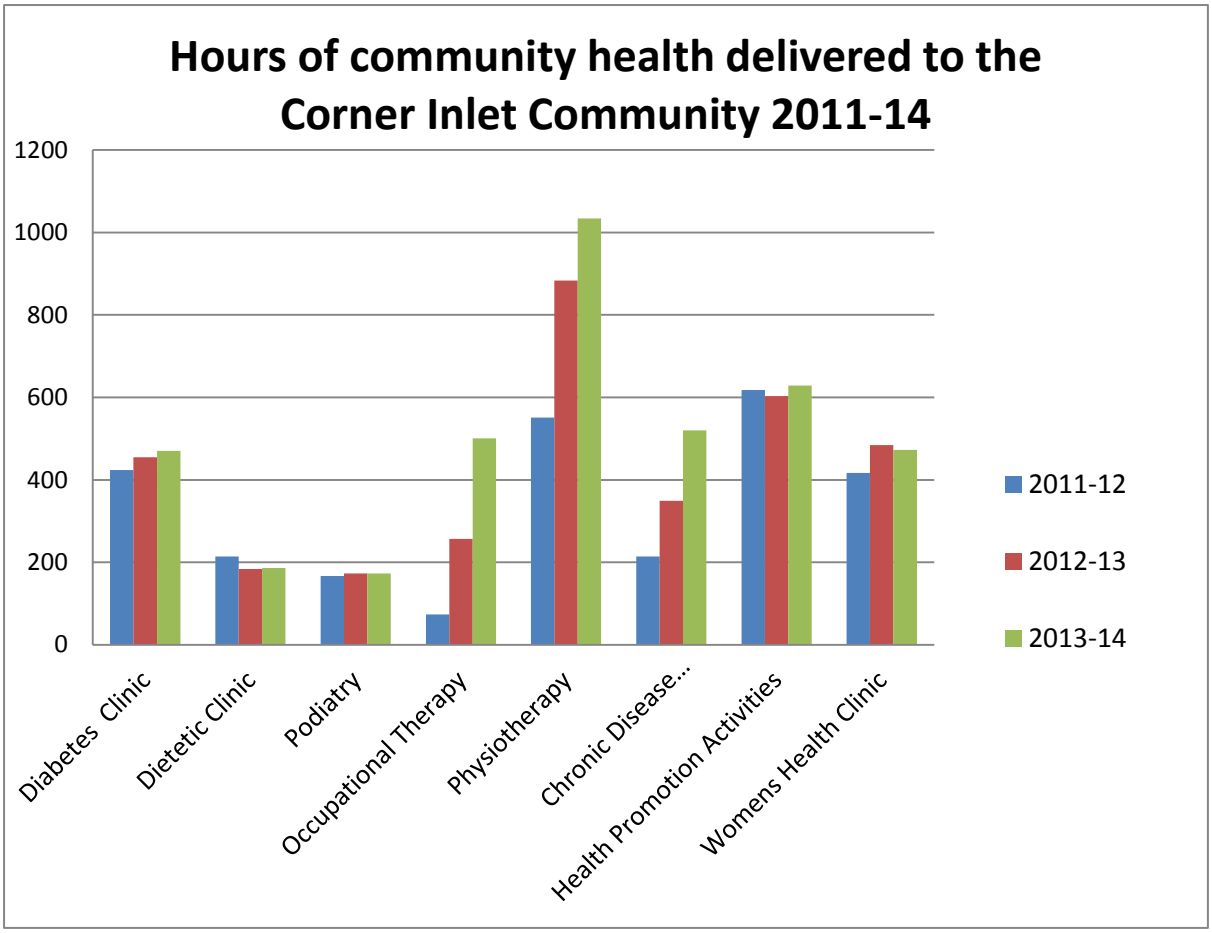
- delivers a range of service delivery methods to reach a wide range of clients
- offers an extensive mix of services
- ensures low cost or fully funded service provision and
- provides meeting rooms and facilities that can be utilised at low or no cost to the community

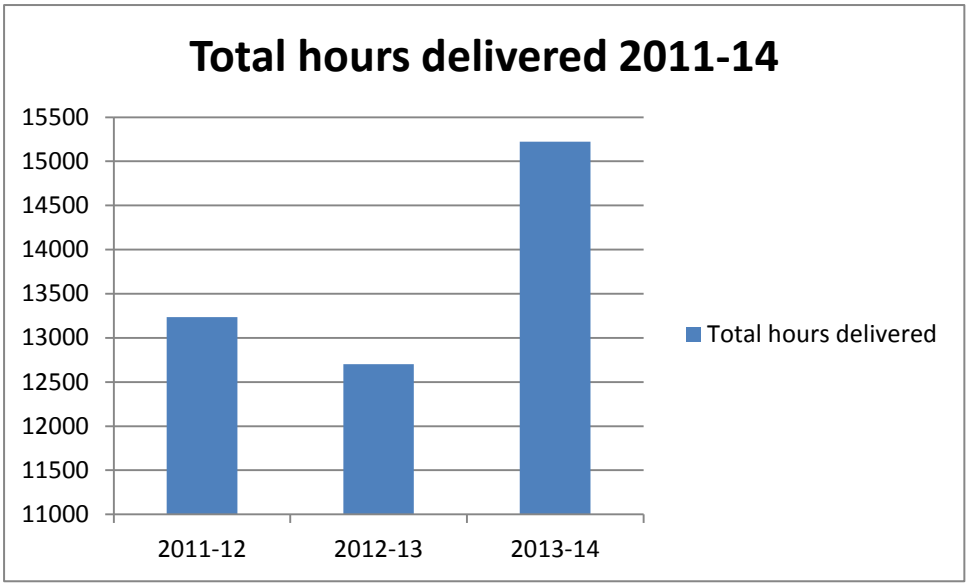
Services available:

South Gippsland Hospital was supported over 2013-14 by the Department of Health to provide services to the community sector via Home and Community Care (HACC)funding and Small Rural Health Service (SRHS) flexible funding. By forming partnerships with other primary health organisations South Gippsland Hospital is also able to offer a wider range of services to the community.

Funding stream	Services provided in 2013-14
Home and Community Care (HACC) service funding	• Occupational Therapy • Physiotherapy • Dietetics • Podiatry • District Nursing Service • Planned Activity Groups • Stoma, Wound care, Foot care & Continence Clinics
Small Rural Health Services flexible funding	• Diabetes Clinic • Chronic Disease Management • Dietetics • Physiotherapy • Health Promotion (including Lifestyle and Exercise Programs) • Women's Health Service
Other Community partnerships	• Youth Assist Clinic • Breast Care Clinic • Infant Hearing screening • Life! Taking action on Diabetes-a preventive program • Massage Therapy • Pilates and yoga • Psychology / Counseling • Gippscare Housing support • Transport to services • Drug and Alcohol counselling

Hours of service provided by Community Health





Community Health Services highlights 2013-14

- The introduction of a quarterly Fall Prevention Program 'Stepping On' coordinated and facilitated by our Occupational Therapist. To educate those most at risk of a fall the program addresses diet, vision, environment, medication, exercise and mobility techniques.

- Recruitment of a salaried Physiotherapist enabling a significant increase in Physiotherapy EFT.

- Introduction of a pulmonary rehabilitation group and increased individual and home based physiotherapy assessment.

- Introduction of nutritional menu planning and nutritional screening for acute patients and those with chronic wounds.

- Introduction of comprehensive care planning across all services.

- Monthly wound care clinics delivered by the regional wound care specialist.

- Delivering the Foodcents program, an innovative program to assist vulnerable clients learn to shop, budget for and cook low cost healthy meals

- Rapid increase of weekly client contact with the Youth Assist Clinic and the introduction of care coordination for youth with complex needs.

- Invitations to present at the Victorian Youth Council Hey Day event and at the Latrobe regional Youth conference

- Successful grant applications to the Toora and District Community Bank, Gippsland Medicare Local, Department of Health and the South Gippsland Shire Council Community Foundation.

- Purchase of a dedicated Allied Health car to assist with home based assessment, outreach clinics, travel to regional meetings and to support clients with transport into centre based programs when required.

Quality

Quality Management System

The 2013-2014 financial year saw significant changes for the hospital's Quality Management System as we incorporated the requirements of the first three National Safety and Quality Health Service Standards into our existing framework. Preparation for compliance involved a comprehensive gap analysis and subsequent updating of existing policies and procedures, education systems and auditing processes. This included a thorough review of all policies relating to the Quality Management System and the expansion of the current system to include standalone policies for:

- Clinical Governance Framework
- Morbidity and Mortality Review – Clinical Risk Management (CRM) Process
- Policies and Procedures guidelines
- Diversity Policy Statement
- Medical Records Content and Documentation
- Medical Record Management

The annual surveillance audit in November 2013 assessed compliance with NSQHS Standards 1, 2 and 3, the JAS-ANZ Core Standards for Safety and Quality in Healthcare, and AS/NZS ISO 9001:2008. It identified a few areas needing further refinement and this resulted in the implementation of:

- revised education and competency-based training for invasive devices
- revised protocols, auditing, education and training for aseptic technique
- an antimicrobial stewardship program

Full accreditation against all requirements was maintained after a follow up audit in February 2014. The auditor's overall comments reflected the hospital's commitment to quality outcomes:

> *'Top management is committed to ensuring continual improvement of the system's effectiveness. There appears to be a keen focus on system and process controls, organizational activities, reviews, continuously improving service delivery and developing reporting framework as the services evolved. The quality management system is effective in establishing sound and thorough processes to provide good outcomes……. and is appropriate and effectively implemented, monitored and measured. SGH continues to mature the system which has been evident at each audit. The staff embrace and takes ownership of the system and continue to develop and improve their service delivery.'*

The continued focus on patient safety and quality of care saw the establishment of a new monthly meeting of the Management Executive Group specifically focusing on the Quality Management System. A detailed monthly report is considered and reviewed by the group and recommendations are made as required to ensure ongoing compliance with accreditation standards.

The non-compliance policy was expanded to specifically include preventive action and a new non-compliance action plan process was developed. This includes more involvement from

Department Heads in determining appropriate quality improvement strategies and evaluation of their effectiveness.

Documentation of quality improvements was expanded to include the use of the RiskMan software Quality Activity component. This included entries for Clinical Risk Management. The utilisation of the Riskman Incident Reporting module was expanded and new requirements for further training were introduced for staff in relation to specific incidents as required.

The ongoing program of monitoring, evaluation and review continued. Once more, this was informed by the regular program of internal audits, contracted audits, external audits, incident management system, complaints and compliments system, and patient satisfaction surveys. The results continued to be reported to the Management Executive Group as well as the Quality Systems Review, Clinical Practice, Drugs and Therapeutics, and Occupational Health and Safety committees for their consideration, review and feedback. Staff continued to be informed of the results and analysis via departmental meetings, monthly quality reports, memos and organisational newsletters. The local community was informed via the Quality of Care report published in the local newspaper.

Patient Satisfaction

The results of the new Victorian Health Experience Survey for the last quarter of 2013-14 have not been released at the time of writing, but we look forward to utilising this new system for monitoring patient satisfaction in the future. In the meantime, as we transition from the old Victorian Patient Satisfaction Monitor (that ceased at the beginning of this financial year), SGH has continued to implement its own post discharge phone survey.

Ten monthly surveys were conducted, each with ten patients participating. The average score was 98.2%. The survey covered the admission process, clinical care, hotel services and discharge planning. It specifically asked patients about information provided on rights, the complaints process and patients involvement in decisions made about their care. All results were presented to the staff, Management Executive Group and Board for their consideration and follow up as required. The overall response was a high level of satisfaction with the services, treatment and care provided.

The satisfaction of patients was also reflected in the 109 unsolicited compliments received. Once again, patients expressed their appreciation of the level of care provided and the friendly, supportive, helpful, professional and caring attitude of staff.

Eleven complaints from patients or carers were received during the twelve month period. 3 related to nature/timing of care provided, 2 related to services from external providers, 2 related to communication style, 2 to perceived 'attitude' of staff and 2 to 'hotel' services. All were fully investigated with action plans developed, discussion with relevant staff, any necessary changes implemented and issues resolved to the satisfactions of those making the complaints. Each complaint was considered by the Management Executive Group before being finalised as well as being reported to the Board's Quality Systems Review Committee.

Audits

The regular schedule of documentation audits continued to provide a mechanism for maintaining sound documentation practice. The average score for compliance of Acute Clinical Documentation was 94% (up from an average of 90% in 2012-13). All results were reviewed by the Management Executive Group on a monthly basis, referred to appropriate clinical staff for further discussion and specific actions as required. They were also referred

to the Clinical Practice Review Committee, Drugs and Therapeutics Committee and Quality System Review Committee for their consideration. The more in depth corrective action process required Department Heads to identify actions needed within two weeks of audit results and to report back on outcomes and evaluation of actions taken four weeks later.

This year's annual external cleaning audit achieved a score of 98.1% compared to the 2013 result of 89.2%.
The audit commented:

> *'All aspects of the internal cleaning audit program at South Gippsland Hospital are compliant to the Cleaning Standards for Victorian Health Facilities. A lot of effort is apparent in a very organized and effective cleaning audit program with staff clearly dedicated to ensuring a high standard of cleaning is maintained and compliance requirements are met……..'*

The annual external Food Safety audit again scored 100%. The auditor's summarised his comments as follows:

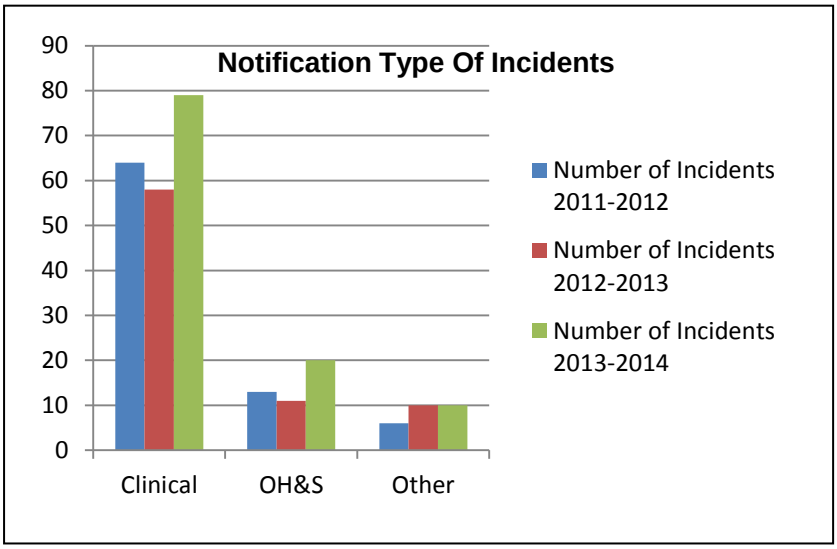
> *'In all areas of food safety operation there is a good level of compliance with competent staff managing a safe and excellent quality food service to the residents under their care. The catering facilities were spotless and are a credit to the dedication of the Catering Manager and the whole kitchen team! Congratulations on achieving a positive audit outcome'.*

Regular observational audits were carried out by OH&S representatives across the spectrum of hospital environments with an average score of 99%. An expanded mandatory training program was implemented helping to ensure the provision of a safe work environment and a high level of patient safety and quality of care.

Incident Reports
Reporting of incidents continued using the "RiskMan" software as part of the Victorian Hospital Incident Management System, as did the individual investigation of incidents by the designated line manager. All results were reviewed at monthly Management Executive Group meetings and referred, as appropriate, to the DON, Acute Care/Maternity Manager, NUM Perioperative Services and Nursing Meetings for further discussion and action as required. Incidents were also considered by the Clinical Practice Review Committee (clinical), Drugs and Therapeutics Committee (medication incidents), and OH&S Committee (OH&S incidents). A summary of these considerations was reported on a quarterly basis to the Board's Quality Systems Review Committee. Where applicable, appropriate controls and education systems were put in place.

A culture of ensuring any incidents (including potential for harm) are recorded in the incident management system has continued to be encouraged over the twelve month period. In part, this has been responsible for a higher number of incidents (109) being recorded this year. With the shift of emphasis away from pressure ulcers to pressure injuries, we are now recording early stage pressure injuries in the system, including those identified on admission. The reminder to include 'slips' as well as 'falls' has been partly responsible for the increase in the number of 'slip/trip/falls being recorded.

The total number of incidents for the 2013-14 financial year was 109 compared to 79 for 2012-13 and 83 for 2011-2012. These are broken down by notification type, severity and primary incident type below:



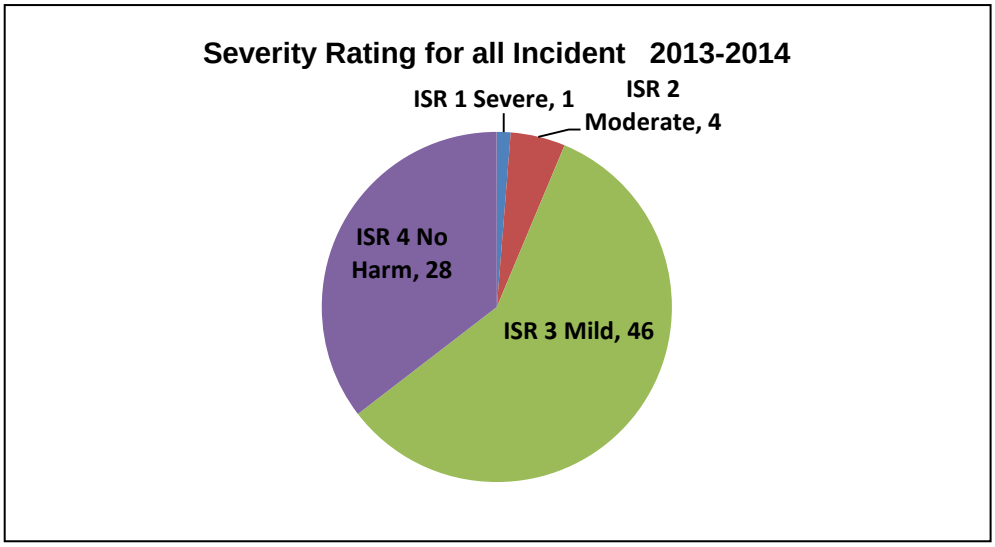
Severity Ratings

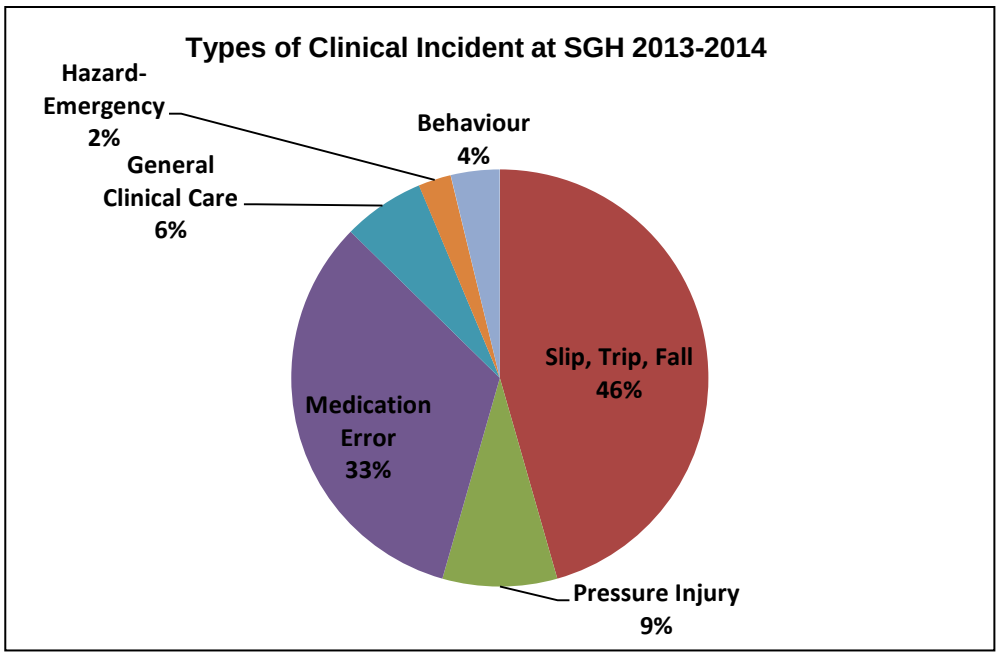
ISR 1 Severe- An event that resulting in death or a severe injury

ISR 2 Moderate- An event resulting in a moderate injury and increased levels of care

ISR 3 Mild- An event resulting in minimal injury and/or additional care

ISR 4 No Harm/Near Miss- An event resulting in no harm but having the potential to do so





The number of clinical incidents for 2013-14 involving slip/trip/falls was 36, representing 45% of the total 79 clinical incidents. This compares to 21 (39% of 64) in 2012-2013 and 36 (56% of 58) in 2011-2012. In 2013-14 78% of falls had either physical or psychological functioning identified as a contributing factor, this compares to 43% in 2012-13 and 68% in 2011-12. In 2013-14 33% of falls had the natural course of disease identified as a contributing factor, compared to 22% in 2012-13 and 21% in 2011-12. Whilst by no means conclusive, the last two sets of data may indicate a more vulnerable client group in 2013-14 than 2011-12. None the less, all reasonable efforts were made to reduce the incidents of slips, trips or falls. Minimisation strategies put in place included, assessment of each incident by the physiotherapist, implementation of recommendations for continued care, regular reporting to nursing meetings and discussion of falls assessments for patients at discharge planning meetings.

The number of clinical incidents for 2013-14 involving medication was 26, representing 33% of total clinical incidents. This compares to 21(36%) in 2012-2013 and 8 (13%) in 2011-2012 - the lower figure for 2011-12 is primarily a reflection of the less developed medication incident documentation practice at the time). Medication errors were followed up with the new requirement that nursing staff complete medication education packages and competency assessments as required. Staff were reminded of specific practices that reduce the risk of future errors through ongoing communications.

The number of clinical incidents for 2013-14 involving pressure injuries was 7, representing 9% of the total clinical incidents. These were not recorded in previous years and in part account for the increase in total incidents for 2013-14.

Of the total 79 clinical incidents, 67 involved no harm, or loss/reduction in functioning; 11 involved temporary loss or reduction in functioning; and one involved an unexpected death unrelated to the care provided.

The 20 OHS incidents involved 9 identification of potential hazards, 4 slip/trip/falls, 2 abuses of staff by patients, 2 minor impacts with objects, 1 minor burn, 1 minor strain and 1 needle stick injury. None of the incidents involved significant harm and all were referred to the OH&S committee for further follow up and remediation as required.

Additional Information

Quality and Safety	Target	2013-14 actuals
Health service accreditation	**Full compliance**	Achieved
Residential aged care accreditation	**Full compliance**	Not Relevant
Cleaning standards (Overall)	**Full compliance**	Achieved
Cleaning standards (AQL-A)	**90**	99.1%
Cleaning standards (AQL-B)	**85**	97.2%
Cleaning standards (AQL-C)	**85**	98.0%
Health care worker immunisation - influenza	**75**	Achieved
Submission of data to VICNISS	**Full compliance**	Achieved
Hand Hygiene (rate)	**70**	87%
Victorian Patient Satisfaction Monitor (OCI) (patients discharged from January-June 2013)	**73**	Achieved
Consumer Participation Indicator (patients discharged from January-June 2013)	**75**	Achieved
Victorian Hospital Experience Measurement Instrument (January – June 2014)	**Full compliance**	No data currently available
People Matter Survey	**Full compliance**	Achieved

Donations

South Gippsland Hospital is fortunate to have ongoing support from many organisations and individual members of the community. Donations are a vital part of our fund-raising activities and we would like to thank the following, who have generously contributed during the 2013-2014 financial year to assist continuation of our quality patient care.

Organisations	Individuals	In memory of a loved one
Esso Australia Foster Golf Club QR Construction (Gippsland) Pty Ltd Prom Meats Pier Port Hotel Social Club Toora and District Community Bank Atoll Travel Fish Creek Quarries South Gippsland Radiology South Gippsland Drafting Service Southern Stock Feeds Zodiac Knights Masters Group Oakleys White Lawyers Baflis Pty Ltd Paragreen Real Estate Foster Tyres and Service Centre Bromleys Café on Main O'Connell Motors Rotary Club of Foster Yarram Motor Garage Peter Stoitse Transport AP Business Services Kaedem Dairies Yanakie Campdraft Association Toora Lions Club South Gippsland Indoor Bias Bowls Association	R Martin C Pearson K Nicholas K Beattie P and C Slack H and R Marriott G and J Wallis W and T Saunders N Hanna P and R Woulfe K Brown M Napier P Findlay L Grant R McPherson N and M McIntosh L Marshall I Atkins R Bland A Turner R and J Mortlock J Minty S Wilson R Gabrielle E Windisch J Mitchell J and R McKenzie T Murphy V Lester D and J Allison S Musinskas M Neilson M Fitzgerald N Poletti P Hepples	**In memory of Eileen Dorling** Fish Creek CFA Ladies Auxiliary A Peace Campbell Family W O'Neill Tori Family B Duffus OK Café D and P Abernethy M Wilde Griebenow Family R Cody D and J Piggin R and S Tibballs L Howell **In memory of Mary Adler** R and C Desmyth **In memory of Fiona Bird** S Sheron J and J Nairn **In memory of Kevin Knowles** E Jolley **In memory of Olive Mangan** Corner Inlet Legacy Widows' Club F and M Van Neer R Spokes P Heldens J Swincer P Madge V Riddell J De Marchi

Requirements

The Annual Report of South Gippsland Hospital is prepared in accordance with Victorian legislation. A summary of the legislative obligations and required disclosures of South Gippsland Hospital is detailed below.

South Gippsland Hospital is a Public Hospital and is an incorporated body listed under Schedule 1 of the *Health Services Act* 1988. The responsible Minister during the reporting period was the Honourable David Davis MLA. The Annual Report is a public document and a copy may be obtained on request.

Summary of Operational and Budgetary Objectives
In 2013-2014, South Gippsland Hospital has achieved the targets established in the Health Service Agreement. The hospital recorded a $140,183 operating surplus before capital purpose income and depreciation. Capital purpose income of $47,428 was received during the financial year, with depreciation write-offs totalling $371,884 being applied.

Summary of Factors affecting Operations
The results of the service during the reporting period have been affected by the following factors:

- An increase in revenue due to the addition of growth funding in Government grants and significant non-grant revenue.
- Additional employee expenses due to the engagement of Visiting Medical Officers as employed staff and reducing non-salary labour costs.
- Significant increase in professional indemnity insurance due to new methodology used by Victorian Managed Insurance Authority.
- Additional unplanned equipment maintenance costs and relocation costs to new premises.
- General increases in administrative costs due to inflation.

Events subsequent to Balance Date
At the date of this report, management is not aware of any events that have occurred subsequent to balance date that may have material impact on the results of the next reporting period.

Competitive Neutrality
South Gippsland Hospital complies with all Government policies regarding competitive neutrality requirements and has implemented policies and programs to ensure compliance with the National Competition Policy and the requirements of the Competitive Neutrality Policy Victoria and any subsequent reforms.

Building Act 1993
All buildings and maintenance provisions of South Gippsland Hospital comply with the *Building Act* 1993, which encompasses the Building Code.

Protected Disclosure Act 2012
South Gippsland Hospital endorses the provisions of the Protected Disclosure Act 2012 which encourages and facilitates disclosure of improper conduct by public officers, public bodies and protects persons who make these disclosures.

Carers' Recognition Act 2012
South Gippsland Hospital endorses the Carers Recognition Act which recognises, promotes and values the role of carers. Staff are encouraged to consider and promote the care relationship principles and the supporting document 'Victorian Charter Supporting People in Care Relationships'.

Occupational Health and Safety
South Gippsland Hospital meets all certification performance indicators in relation to Occupational Health and Safety requirements.

Contracts Commenced and/or Completed
There were no contracts commenced but not completed during the financial year which require disclosure under *the Victorian Industry Participation Policy (VIPP) Act* 2003.

Consultancies
In 2013-2014 there were no consultancies where the total fees payable to the consultants were $10,000 or greater nor were there any consultancies where the total fees payable to the consultants were less than $10,000.

Industrial Relations
South Gippsland Hospital continues to maintain a good working relationship with the Unions representing its staff members. There were zero days lost to industrial action in the 2013-2014 financial year.

Ex-Gratia Payments
There were no ex-gratia payments made in 2013-2014.

Comments and Complaints
Comments, suggestions and complaints are valued as they provide feedback on whether our services are meeting community needs or action is required to improve or extend services. Our patients and clients are encouraged to discuss issues with the senior staff member on duty or complete a Comments and Suggestions Form. The designated Complaints Officer is the Quality Co-ordinator. The Hospital follows strict guidelines to resolve all complaints. Unresolved complaints may be directed to the Health Services Commissioner on 8601 5200 or toll free 1800 136 066.

Legislation
South Gippsland Hospital complies with the requirements of the following legislation:
Financial Management Act 1994
Protected Disclosure Act 2012
Carers Recognition Act 2012
Victorian Industry Protection Act 2003
Directions of the Minister for Finance, including Financial Reporting Directions
Health Services Act 1988

Freedom of Information Act 1982
The Freedom of Information Act 1982 (the FOI Act) gives people right of access to information held by South Gippsland Hospital and applications for access to information and records are processed in accordance with the FOI Act by the Health Information Manager under delegation from the Chief Executive Officer. Health Services charge a fee for FOI and medico-legal requests. In some instances where hardship can be proven, the fee may be waived. SGH has in place a corporate policy and procedure which complies with the Act.

Disclosures made under this policy will be investigated swiftly, professionally and discreetly. A copy of the Act and the policy and procedure is available to staff in the hospital library and a copy is also held in the Human Resource Department. There were two requests under the Act in the reporting period.

Professional Development
South Gippsland Hospital has in place a supportive professional development model, assisting with the cost of education fees for any member of staff who has a commitment to both their profession and the hospital.

Statement of Merit and Equity
South Gippsland Hospital is subject to the provisions of the *Public Authorities (Equal Employment Opportunity) Act* 1990 and is committed to equality in the workplace. The hospital bases its employment practices on the principles of fairness and merit and seeks to provide a welcoming work environment that is free from discrimination and harassment.

Environmental Performance
South Gippsland Hospital has an active Environmental Program and monitors the usage of energy and water to avoid unnecessary waste. The environmental impact of all proposed developments is reviewed to ensure that they meet key performance standards.

Auditors
Audits for South Gippsland Hospital are conducted on behalf of the Victorian Auditor-General's Office by its authorised agent, Crowe Horwath. Internal auditors are RSM Bird Cameron.

Accountancy Services
Accountancy services are provided to South Gippsland Hospital by Duesburys Gippsland, Foster.

Solicitor
Legal services are provided by the Victorian Hospitals' Industrial Association.

Bankers
Bankers for South Gippsland Hospital are ANZ Banking Group, Bendigo and Adelaide Bank, Westpac, Commonwealth Bank and National Australia Bank.

Additional Information Available on Request
In compliance with the requirements of FRD 22E Standard Disclosures in the Report of Operations, details in respect of the items listed below have been retained by South Gippsland Hospital and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the Freedom of Information requirements, if applicable).

a. A statement of pecuniary interest has been completed.

b. Details of shares held by senior officers as nominee or held beneficially.

c. Details of publications produced by the Department about the activities of the health service and where they can be obtained.

d. Details of changes in prices, fees, charges, rates and levies charged by the health service.

e. Details of any major external reviews carried out by the health service.

f. Details of major research and development activities undertaken by the health service.

g. Details of overseas visits undertaken including a summary of the objectives and outcomes of each visit.

h. Details of major promotional, public relations and marketing activities undertaken by the health service to develop community awareness of the health service and its services.

i. Details of assessments and measures undertaken to improve the occupational health and safety of employees.

j. General statement on industrial relations within the health service and details of time lost through industrial accidents and disputes.

k. A list of major committees sponsored by the health service, the purpose of each committee and the extent to which the purposes have been achieved.

l. Details of all consultancies and contractors including:

- consultants/contractors engaged;
- services provided; and
- expenditure committed to for each engagement.

Disclosure Index – Appendix A

The Annual Report of the South Gippsland Hospital is prepared in accordance with all relevant Victorian legislation. This index has been prepared to facilitate identification of the Hospital's compliance with statutory disclosure requirements.

Legislation	Requirement	Page Reference
Ministerial Directions		
Report of Operations		
Charter and Purpose		
FRD 22D	Manner of establishment and the relevant Ministers	
FRD 22D	Objectives, functions, powers and duties	Cover
FRD 22D	Nature and range of services provided	4
Management and structure		
FRD 22D	Organisational structure	15
Financial and other information		
FRD 10	Disclosure index	37, 38
FRD 11A	Disclosure of ex-gratia payments	34
FRD 12A	Disclosure of major contracts	
FRD 21B	Responsible person and executive officer disclosures	FS46
FRD 22E	Application and operation of *Protected Disclosure Act* 2012	
FRD 22E	Application and operation of *Carers Recognition Act* 2012	
FRD 22E	Application and operation of *Freedom of Information Act* 1982	35
FRD 22E	Compliance with building and maintenance provisions of *Building Act* 1993	33
FRD 22E	Details of consultancies over $10,000	34
FRD 22E	Details of consultancies under $10,000	34
FRD 22E	Employment and conduct principles	
FRD 22E	Major changes or factors affecting performance	33
FRD 22E	Occupational health and safety	33
FRD 22C	Operational and budgetary objectives and performance against objectives	33
FRD 24C	Reporting of office-based environmental impacts	
FRD 22E	Significant changes in financial position during the year	32
FRD 22E	Statement of availability of other information	35
FRD 22E	Statement on National Competition Policy	33
FRD 22E	Subsequent events	33
FRD 22E	Summary of the financial results for the year	10
FRD 22E	Workforce data disclosures including a statement on the application of employment and conduct principles	11
FRD 25B	Victorian Industry Participation Policy disclosures	33
FRD 29	Workforce data disclosures	
SD 4.2(g)	Specific information requirements	
SD 4.2(j)	Sign-off requirements	FS2

SD 4.5.5.1	Compliance attestation	11
SD 4.5.5	Risk management compliance attestation	10

Financial statements required under Part 7 of the FMA

SD 4.2(a)	Statement of Changes in Equity	FS7
SD 4.2(b)	Comprehensive operating Statement	FS5
SD 4.2(b)	Balance Sheet	FS6
SD 4.2(b)	Cash Flow Statement	FS8

Other requirements under Standing Directions 4.2

SD 4.2(a)	Compliance with Australian accounting standards and other authoritative pronouncements	FS9
SD 4.2(c)	Accountable Officer's declaration	FS2
SD 4.2(c)	Compliance with Ministerial Directions	FS9
SD 4.2(d)	Rounding of amounts	FS20

Legislation

Freedom of Information Act 1982
Protected Disclosure Act 2012
Carers Recognition Act 2012
Victorian Industry Protection Act 2003
Building Act 1993
Financial Management Act 1994

SOUTH GIPPSLAND
HOSPITAL

Financial Statements

for year ended
30 June 2014

SOUTH GIPPSLAND HOSPITAL
Board Member's
Accountable Officer's and
Chief Finance and Accounting Officer's Declaration

We certify that the attached financial statements for South Gippsland Hospital have been prepared in accordance with Standing Direction 4.2 of the *Financial Management Act* 1994, applicable Financial Reporting Directions, Australian Accounting Standards, Australian Accounting Interpretations and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and notes to and forming part of the financial report presents fairly the financial transactions during the year ended 30 June 2014 and the financial position of South Gippsland Hospital as at 30 June 2014.

At the time of signing, we are not aware of any circumstance which would render any particulars included in the financial statements to be misleading or inaccurate.

We authorise the attached financial statements for issue on this day.

Mr Neil Roussac	Mr Peter Rushen	Mr Peter Tilley
Board President	Accountable Officer	Chief Finance and Accounting Officer
Foster	Foster	Foster
Date: 28 August 2014	Date: 28 August 2014	Date: 28 August 2014

VAGO
Victorian Auditor-General's Office

Level 24, 35 Collins Street
Melbourne VIC 3000
Telephone 61 3 8601 7000
Facsimile 61 3 8601 7010
Email comments@audit.vic.gov.au
Website www.audit.vic.gov.au

INDEPENDENT AUDITOR'S REPORT

To the Board Members, South Gippsland Hospital

The Financial Report

The accompanying financial report for the year ended 30 June 2014 of the South Gippsland Hospital which comprises comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement, notes comprising a summary of significant accounting policies and other explanatory information, and the Board Member's, Accountable Officer's and Chief Finance and Accounting Officer's Declaration has been audited.

The Board Members' Responsibility for the Financial Report

The Board Members of the South Gippsland Hospital are responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*, and for such internal control as the Board Members determine is necessary to enable the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

As required by the *Audit Act 1994*, my responsibility is to express an opinion on the financial report based on the audit, which has been conducted in accordance with Australian Auditing Standards. Those standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The audit procedures selected depend on judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, consideration is given to the internal control relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Board Members, as well as evaluating the overall presentation of the financial report.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Independent Auditor's Report (continued)

Independence

The Auditor-General's independence is established by the *Constitution Act 1975*. The Auditor-General is not subject to direction by any person about the way in which his powers and responsibilities are to be exercised. In conducting the audit, the Auditor-General, his staff and delegates complied with all applicable independence requirements of the Australian accounting profession.

Opinion

In my opinion, the financial report presents fairly, in all material respects, the financial position of the South Gippsland Hospital as at 30 June 2014 and of its financial performance and its cash flows for the year then ended in accordance with applicable Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*.

Matters Relating to the Electronic Publication of the Audited Financial Report

This auditor's report relates to the financial report of the South Gippsland Hospital for the year ended 30 June 2014 included both in the South Gippsland Hospital's annual report and on the website. The Board Members of the South Gippsland Hospital are responsible for the integrity of the South Gippsland Hospital's website. I have not been engaged to report on the integrity of the South Gippsland Hospital's website. The auditor's report refers only to the subject matter described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these statements. If users of the financial report are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial report to confirm the information contained in the website version of the financial report.

MELBOURNE
29 August 2014

John Doyle
Auditor-General

SOUTH GIPPSLAND HOSPITAL

Comprehensive Operating Statement
for the finanical year ended 30 June 2014

	Note	2014 $	2013 $
Revenue from Operating Activities	2	7,145,439	6,477,549
Revenue from Non-Operating Activities	2	103,217	129,525
Employee Expenses	3a	(4,952,555)	(4,508,495)
Non Salary Labour Costs	3a	(436,882)	(528,614)
Supplies and Consumables	3a	(572,909)	(548,159)
Other Expenses	3a	(1,146,051)	(1,018,376)
NET RESULT BEFORE CAPITAL & SPECIFIC ITEMS		140,259	3,430
CAPITAL & SPECIFIC ITEMS			
Capital Purpose Income	2	47,428	288,791
Depreciation and Amortisation	4	(371,884)	(357,095)
NET RESULT FOR THE YEAR		**(184,197)**	**(64,874)**
OTHER COMPREHENSIVE INCOME			
Net fair value revaluation of Non Financial Assets	11	561,624	-
TOTAL OTHER COMPREHENSIVE INCOME		561,624	-
			-
COMPREHENSIVE RESULT FOR THE YEAR		377,427	(64,874)

This Statement should be read in conjunction with the accompanying notes.

SOUTH GIPPSLAND HOSPITAL

P.O. Box 104
87 Station Road
Foster, Vic., 3960
A.B.N. 35 364 836 505

ERRATUM

SOUTH GIPPSLAND HOSPITAL
ANNUAL REPORT 2013-2014

In page 6 of the Financial Statements, in the Balance Sheet Assets table, in the Current Assets section, create an additional line at line 4 and insert:

'Inventory' under the current assets column
'8' under the Note column
'$76,530' under the 2014 column
'$67,651' under the 2013 column

Clive White
Acting Board President

Date: 9 September 2014

Peter Rushen
Chief Executive Officer

Date: 9 September 2014

Peter Tilley
Chief Financial Officer

Date: 9 September 2014

TELEPHONE: (03) 5683 9777 — FAX No.: (03) 5682 2178 — E-mail: sghosp@sghs.com.au

SOUTH GIPPSLAND HOSPITAL

Balance Sheet
as at 30 June 2014

	Note	2014 $	2013 $
ASSETS			
Current Assets			
Cash and Cash Equivalents	5	219,088	267,980
Receivables	6	257,231	279,879
Investments and Other Financial Assets	7	1,545,245	1,698,488
Non-Financial Assets Classified as Held For Sale	9	-	-
Other Current Assets	10	13,153	14,662
Total Current Assets		2,111,248	2,328,660
Non-Current Assets			
Receivables	6	256,287	236,532
Property, Plant & Equipment	11	6,469,257	6,084,220
Intangible Assets	12	-	-
Total Non-Current Assets		6,725,544	6,320,752
TOTAL ASSETS		**8,836,792**	**8,649,412**
LIABILITIES			
Current Liabilities			
Payables	13	147,186	504,726
Provisions	14	1,376,704	1,180,418
Other Current Liabilities	16	36,782	81,137
Total Current Liabilities		1,560,672	1,766,281
Non-Current Liabilities			
Provisions	14	190,704	175,142
Total Non-Current Liabilities		190,704	175,142
TOTAL LIABILITIES		**1,751,376**	**1,941,423**
NET ASSETS		**7,085,416**	**6,707,989**
EQUITY			
Property, Plant & Equipment Revaluation Surplus	17a	2,857,560	2,295,936
Contributed Capital	17b	3,086,756	3,086,756
Accumulated Surpluses	17c	1,141,100	1,325,297
TOTAL EQUITY	17c	**7,085,416**	**6,707,989**
Contingent Assets and Contingent Liabilities	22		
Commitments	20		

This Statement should be read in conjunction with the accompanying notes.

SOUTH GIPPSLAND HOSPITAL

Statement Of Changes in Equity
for the finanical year ended 30 June 2014

	Note	Property, Plant & Equipment Revaluation Surplus	Contributed Capital	Accumulated Surpluses/ (Deficits)	Total
Balance at 30 June 2012	17a	2,295,936	3,086,756	1,390,171	6,772,863
Net Result for Year	17c	-	-	(64,874)	(64,874)
Balance at 30 June 2013		**2,295,936**	**3,086,756**	**1,325,297**	**6,707,989**
Net Result for Year	17c	-	-	(184,197)	(184,197)
Other Comprehensive income for year	11	561,624	-	-	561,624
Balance at 30 June 2014		**2,857,560**	**3,086,756**	**1,141,100**	**7,085,416**

This Statement should be read in conjunction with the accompanying notes.

SOUTH GIPPSLAND HOSPITAL

Cash Flow Statement

for the finanical year ended 30 June 2014

	Note	2014 $ Inflows/ (Outflows)	2013 $ Inflows/ (Outflows)
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts			
Operating Grants from Government		5,833,115	5,221,048
Patient Fees Received		469,356	400,894
Donations & Bequests Received		43,723	20,185
GST Received from / (paid to) ATO		(77,497)	(49,605)
Recoupment from private practice for use of hospital facilities		41,180	44,608
Interest Received		67,289	109,284
Other Receipts		1,013,448	921,448
Total Receipts		7,390,614	6,667,862
Payments			
Employee Expenses Paid		(4,740,707)	(4,415,142)
Fees for Service of Medical Officers		(462,683)	(537,868)
Payments for Supplies & Consumables		(567,656)	(599,561)
Other Payments		(1,673,832)	(1,005,021)
Total Payments		(7,444,878)	(6,557,592)
Cash Generated from Operations		(54,264)	110,270
Capital Grants from Government		27,757	69,120
Capital Donations and Bequests Received		22,485	67,327
NET CASH INFLOWS / (OUTFLOWS) FROM OPERATING ACTIVITIES	18	(4,022)	246,717
CASH FLOWS FROM INVESTING ACTIVITIES			
Payment for Non-Financial Assets		(223,022)	(1,132,639)
Proceeds from Land for Resale	2c	-	376,206
Proceeds from Sale of Non-Financial Assets	2c	24,910	32,110
Proceeds on sale investments		153,242	151,741
NET CASH FLOW USED IN INVESTING ACTIVITIES		(44,870)	(572,582)
NET DECREASE IN CASH AND CASH EQUIVALENTS HELD		(48,892)	(325,865)
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR		267,980	593,845
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	5	219,088	267,980

Note 1: Statement of Significant Accounting Policies

These annual financial statements represent the audited general purpose financial statements for South Gippsland Hospital for the period ending 30 June 2014. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

[a] Statement of Compliance

These financial statements are general purpose financial statements which have been prepared in accordance with the Financial Management Act 1994 and applicable AASs, which include interpretations issued by the Australian Accounting Standards Board (AASB). They are presented in a manner consistent with the requirements of AASB 101 Presentation of Financial Statements.

The financial statements also comply with relevant Financial Reporting Directions (FRDs) issued by the Department of Treasury and Finance and relevant Standing Directions (SDs) authorised by the Minister for Finance.

The Health Service is a "not for profit" entity and therefore applies the additional Aus paragraphs applicable to "not for profit" Health Services under the AASs.

The annual financial statements were authorised for issue by the Board of South Gippsland Hospital on 28/08/2014.

[b] Basis of Accounting Preparation and Measurement

Accounting policies are selected and applied in a manner which ensures that the resulting financial information satisfies the concepts of relevance and reliability, thereby ensuring that the substance of the underlying transactions or other events is reported.

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2014 and the comparative information presented in these financial statements for the year ended 30 June 2013.

The going concern basis was used to prepare the financial statements.

These financial statements are presented in Australian dollars, the functional and presentation currency of the Health Service.

The financial statements, except for cash flow information, have been prepared using the accrual basis of accounting. Under the accrual basis, items are recognised as assets, liabilities, equity, income or expenses when they satisfy the definitions and recognition criteria for those items, that is they are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

The financial statements are prepared in accordance with the historical cost convention, except for;

- Non-current physical assets, which subsequent to acquisition, are measured at a revalued amount, being their fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made and are re-assessed with sufficient regularity to ensure that the carrying amounts do not materially differ from their fair values;
- The fair value of assets other than land is generally based on their depreciated replacement value.

Historical cost is based on the fair values of the consideration given in exchange for assets.

In the application of AASs management is required to make judgments, estimates and assumptions about carrying values of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods. Judgements made by management in the application of AASs that have significant effects on the financial statements and estimates, with a risk of material adjustments in the subsequent reporting period, relate to:

- the fair value of the land, buildings, infrastructure, plant and equipment (refer to Note 1(k));
- superannuation expense (refer to note 1(h)); and
- actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 1(l)).

Consistent with AASB 13 Fair Value Measurement, The Health Service determines the policies and procedures for both recurring fair value measurements such as property, plant and equipment, investment properties and financial instruments, and for non-recurring fair value measurements such as non-financial physical assets held for sale, in accordance with the requirements of AASB 13 and the relevant FRDs.

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy, described as follows, based on the lowest level input that is significant to the fair value measurement as a whole:

· Level 1 – Quoted (unadjusted) market prices in active markets for identical assets or liabilities

· Level 2 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable

· Level 3 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

For the purpose of fair value disclosures, South Gippsland Hospital has determined classes of assets and liabilities on the basis of the nature, characteristics and risks of the asset or liability and the level of the fair value hierarchy as explained above.

The Valuer-General Victoria (VGV) is South Gippsland Hospital's independent valuation agency.

South Gippsland Hospital, in conjunction with VGV monitors the changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required.

[c] Reporting Entity

The financial statements includes all the controlled activities of the Health Service.
Its principal address is:
87 Station Road
Foster
Victoria 3960

A description of the nature of the South Gippsland Hospital's operations and its principal activities is included in the report of operations, which does not form part of these financial statements.

Objectives and funding
South Gippsland Hospital's overall objective is to be a healthcare provider delivering exceptional performance in provision of healthcare services, as well as improve the quality of life to Victorians.

South Gippsland Hospital is predominantly funded by accrual based grant funding for the provision of outputs.

[d] Principles of Consolidation

Jointly Controlled Assets
Interests in jointly controlled assets or operations are not consolidated by the Health Service, but are accounted for in accordance with the policy outlined in Note 1(k) Assets.

[e] Scope and presentation of financial statements

Fund Accounting
The Health Service operates on a fund accounting basis and maintains two funds, being an Operating Fund and a Specific Purpose Fund. The Health Service's Specific Purpose Fund includes unspent donations and receipts from fund-raising activities conducted solely in respect of these funds.

Services Supported by Health Services Agreement and Services Supported by Hospital and Community Initiatives
Activities classified as *Services Supported by Health Services Agreement [HSA]* are substantially funded by the Department of Health while Services Supported by *Hospital and Community Initiatives* [H&CI] are funded by the Health Service's own activities or local initiatives.

Comprehensive operating statement
The Comprehensive operating statement includes the subtotal titled 'Net Result Before Capital & Specific Items' to enhance the understanding of the financial performance of the Health Service. This subtotal reports the result excluding items such as capital grants, assets received or provided free of charge, depreciation, expenditure using capital purpose income and items of an unusual nature and amount such as specific income and expenses. The exclusion of these items is made to enhance matching of income and expenses so as to facilitate the comparability and consistency of results between years and Victorian Public Health Services. The 'Net Result Before Capital & Specific Items' is used by the management of the Health Service, the Department of Health and the Victorian Government to measure the ongoing performance of Health Services.

Capital & specific items, which are excluded from this sub-total, comprise:
- Capital purpose income, which comprises all tied grants, donations and bequests received for the purpose of acquiring non-current assets, such as capital works, plant and equipment or intangible assets. It also includes donations of plant and equipment (refer to Note 1(g)). Consequently the recognition of revenue as capital purpose income is based on the intention of the provider of the revenue at the time the revenue is provided.
- Depreciation, amortisation and impairment, as described in Note 1 (h).

Balance Sheet
Assets and liabilities are categorised either as current or non-current (non-current being those assets or liabilities expected to be recovered/settled more than 12 months after reporting period), are disclosed in the notes where relevant.

Statement of changes in equity
The statement of changes in equity presents reconciliations of each non-owner and owner changes in equity from opening balance at the beginning of the reporting period to the closing balance at the end of the reporting period. It also shows separately changes due to amounts recognised in the comprehensive result and amounts recognised in other comprehensive income.

Cash flow statement
Cash flows are classified according to whether or not they arise from operating activities, investing activities, or financing activities. This classification is consistent with requirements under AASB 107 *Statement of Cash Flows.*

For the cash flow statement presentation purposes, cash & cash equivalents includes bank overdrafts, which are included as current borrowings in the balance sheet.

Rounding
All amounts shown in the financial statements are expressed to the nearest dollar unless otherwise stated.

Minor discrepancies in tables between totals and sum of components are due to rounding.

Comparative Information
Where necessary the previous year's figures have been reclassified to facilitate comparisons.

[f] Change in accounting policies

AASB 13 Fair Value Measurement

AASB 13 establishes a single source of guidance for all fair value measurements. AASB 13 does not change when a health service is required to use fair value, but rather provides guidance on how to measure fair value under Australian Accounting Standards when fair value is required or permitted. The health service has considered the specific requirements relating to highest and best use, valuation premise, and principal (or most advantageous) market. The methods, assumptions, processes and procedures for determining fair value were revised and adjusted where applicable. In light of AASB 13, the health service has reviewed the fair value principles as well as its current valuation methodologies in assessing the fair value, and the assessment has not materially changed the fair values recognised.

AASB 13 has predominantly impacted the disclosures of the health service. It requires specific disclosures about fair value measurements and disclosures of fair values, some of which replace existing disclosure requirements in other standards, including AASB 7 Financial Instruments: Disclosures.

The disclosure requirements of AASB 13 apply prospectively and need not to be provided for comparative periods, before initial application. Consequently, comparatives of these disclosures have not been provided for 2012-13, except for financial instruments, of which the fair value disclosures are required under AASB 7 Financial Instruments Disclosures.

AASB 119 Employee Benefits

In 2013-14, the health service has applied AASB 119 Employee Benefits (Sep 2011, as amended), and related consequential amendments for the first time.

The revised AASB 119 changes the accounting for defined benefit plans and termination benefits. The most significant change relates to the accounting for changes in defined benefit obligation and plan assets. As the current accounting policy is for the Department of Treasury and Finance to recognise and disclose the State's defined benefit liabilities in its financial statements, changes in defined benefit obligations and plan assets will have limited impact on the health service.

The revised standard also changes the definition of short-term employee benefits. These were previously benefits that were expected to be settled within 12 months after the end of the reporting period in which the employees render the related service, however, short-term employee benefits are now defined as benefits expected to be settled wholly within 12 months after the end of the reporting period in which the employees render the related service. As a result, accrued annual leave balances which were previously classified as short-term employee benefits no longer meet this definition and are now classified as long-term employee benefits. This has resulted in a change of measurement for the annual leave provision from an undiscounted to discounted basis.

As the impact of applying the AASB 19 to the 2013 figures is immaterial there has therefore been no correcting adjustment to the figures for 2013.

[g] Income from transactions

Income is recognised in accordance with AASB 118 *Revenue* and is recognised as to the extent that it is probable that the economic benefits will flow to the Health Service and the income can be reliably measured at fair value. Unearned income at reporting date is reported as income received in advance.

Amounts disclosed as revenue are, where applicable, net of returns, allowances, duties and taxes.

Government Grants and other transfers of income (other than contributions by owners)

In accordance with AASB 1004 *Contributions,* government grants and other transfers of income (other than contributions by owners) are recognised as income when the Health Service gains control of the underlying assets irrespective of whether conditions are imposed on the Health Service's use of the contributions.

Contributions are deferred as income in advance when the Health Service has a present obligation to repay them and the present obligation can be reliably measured.

Indirect Contributions from the Department of Health

- Insurance is recognised as revenue following advice from the Department of Health.
- Long Service Leave (LSL) - Revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Metropolitan Health and Aged Care Services Division Hospital Circular 05/2014.

Patient Fees

Patient fees are recognised as revenue at the time the invoices are raised.

Private Practice Fees

Private practice fees are recognised as revenue at the time invoices are raised.

Revenue from commercial activities

Revenue from commercial activities such as catering & property income are recognised at the time the invoice is raised.

Donations and Other Bequests

Donations and bequests are recognised as revenue when received. If donations are for a special purpose, they may be appropriated to a fund, such as the specific restricted purpose surplus.

Interest Revenue

Interest revenue is recognised on a time proportionate basis that takes into account the effective yield of the financial asset, which allocates interest over the relevant period.

Sale of Investments

The gain/loss on the sale of investments is recognised when the investment is realised.

Fair value of assets and services received free of charge or for nominal consideration

Resources received free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them, irrespective of whether restrictions or conditions are imposed over the use of the contributions, unless received from another Health Service or agency as a consequence of a restructuring of administrative arrangements. In the latter case, such transfer will be recognised at carrying value. Contributions in the form of services are only recognised when a fair value can be reliably determined and the services would have been purchased if not received as a donation.

Other income

Other income includes non-property rental, dividends, forgiveness of liabilities, and bad debt reversals.

[h] Expense Recognition

Expenses are recognised as they are incurred and reported in the financial year to which they relate.

Employee expenses

Employee expenses include:

- Wages and salaries;
- Annual leave;
- Sick leave;
- Long service leave;
- Superannuation expenses which are reported differently depending on whether employees are members of defined benefit or defined contribution plans.

Defined contribution superannuation plans

In relation to defined contribution (i.e accumulation) superannuation plans, the associated expense is simply the employer contributions that are paid or payable in respect of employees who are members of these plans during the reporting period. Contributions to defined contribution superannuation plans are expensed when incurred.

Defined benefit superannuation plans
The amount charged to the Comprehensive Operating Statement in respect of defined benefit superannuation plans represents the contributions made by the Health Service to the superannuation plan in respect of the current services of current Health Service staff during the reporting period. Superannuation contributions are made to the plans based on the relevant rules of each plan, and are based on actuarial advice.

Employees of the Health Service are entitled to receive superannuation benefits and the Health Service contributes to both the defined benefit and defined contribution plans. The defined benefit plan provide benefits based on years of service and final average salary.

The name and details of the major employee superannuation funds and contributions made by the Health Service are disclosed in Note15: Superannuation.

Depreciation
All infrastructure assets, buildings, plant and equipment and other non-financial physical assets that have finite useful lives are depreciated. Depreciation begins when the asset is available for use, which is when it is in the location and condition necessary for it to be capable of operating in a manner intended by management.

Intangible produced assets with finite lives are depreciated as an expense on a systematic basis over the asset's useful life. Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health. Assets with a cost in excess of $1,000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

The following table indicates the expected useful lives of non-current assets on which the depreciation charges are based.

	2014	2013
Buildings	Up to 40 years	Up to 40 years
Plant & Equipment	Up to 20 years	Up to 20 years
Motor Vehicles	Up to 10 years	Up to 10 years

The estimated useful lives, residual values and depreciation method are reviewed at the end of each annual reporting period, and adjustments made where appropriate.

As part of the buildings valuation, buildings values were componentised and each component assessed for its useful life which is represented above.

Intangible produced assets with finite lives are depreciated as an expense on a systematic basis over the asset's useful life.

Amortisation
Amortisation is allocated to intangible non-produced assets with finite useful lives on a systematic (typically straight-line) basis over the asset's useful life. Amortisation begins when the asset is available for use, that is, when it is in the location and condition necessary for it to be capable of operating in the manner intended by management.

The amortisation period and the amortisation method for an intangible asset with a finite useful life are reviewed at least at the end of each annual reporting period. In addition, an assessment is made at each reporting date to determine whether there are indicators that the intangible asset concerned is impaired. If so, the assets concerned are tested as to whether their carrying value exceeds their recoverable amount.

Intangible assets with finite useful lives are amortised over a 10-15 year period (2013: 10-15 years).

Finance Costs
Finance costs are recognised as expenses in the period in which they are incurred.

Grants & other transfers
Grants and other transfers to third parties (other than contribution to owners) are recognised as an expense in the reporting period in which they are paid or payable. They include transactions such as grants, subsidies and personal benefit payments made in cash to individuals.

Other operating expenses
Other operating expenses generally represent the day-to-day running costs incurred in normal operations and include:

Supplies and consumables
Supplies and services costs which are recognised as an expense in the reporting period in which they are incurred. The carrying amounts of any inventories held for distribution are expensed when distributed from inventory stores.

Bad and doubtful debts
Refer to Note 1 (k) Impairment of financial assets.

Fair value of assets, services and resources provided free of charge or for nominal consideration
Contributions of resources provided free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them, irrespective of whether restrictions or conditions are imposed over the use of the contributions, unless received from another agency as a consequence of a restructuring of administrative arrangements. In the latter case, such a transfer will be recognised at its carrying value.

Contributions in the form of services are only recognised when a fair value can be reliably determined and the services would have been purchased if not donated.

[i] Other comprehensive income

Other comprehensive income measures the change in volume or value of assets or liabilities that do not result from transactions.

Net gains/(losses) of non-financial physical assets
Net gain/(loss) on non-financial assets and liabilities includes realised and unrealised gains and losses as follows:

Revaluation gains/(losses) of non-financial physical assets
Refer to Note 1(k) Revaluations of non-financial physical assets.

Net gain/ (loss) on disposal of non-financial assets
Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal and is the difference between the proceeds and the carrying value of the asset at the time.

Net gain/(loss) on financial instruments
Net gain/(loss) on financial instruments includes:
- impairment and reversal of impairment for financial instruments at amortised cost (refer to Note 1 (k)); and
- disposals of financial assets and derecognition of financial liabilities

Revaluations of financial instrument at fair value
Refer to Note 1 (j) Financial instruments.

Share of net profits/(losses) of associates and joint entities, excluding dividends
Refer to Note 1 (e) Basis of consolidation.

Other gains/(losses) from other comprehensive income
Other gains/(losses) include:
- the revaluation of the present value of the long service leave liability due to changes in the bond interest rates.

[j] Financial Instruments

Financial instruments arise out of contractual agreements that give rise to a financial asset of one Health Service and a financial liability or equity instrument of another Health Service. Due to the nature of the Health Service's activities, certain financial instruments and financial liabilities arise under statute rather than contract. Such financial assets and liabilities do not meet the definition of financial instruments in AASB 132 Financial Instruments: Presentation. For example, statutory receivables arising from taxes, fines and penalties do not meet the definition of financial instruments as they do not arise under contract.

Where relevant, for note disclosure purposes, a distinction is made between those financial assets and financial liabilities that meet the definition of financial instruments in accordance with AASB 132 and those that do not.

The following refers to financial instruments unless otherwise stated.

Categories of non-derivative financial instruments

Loans and Receivables

Loans and receivables are financial instrument assets with fixed and determinable payments that are not quoted on an active market. These assets are initially recognised at fair value plus any directly attributable transaction costs. Subsequent to initial measurement, loans and receivables are measured at amortised cost using the effective interest method, less any impairment.

Loans and receivables categories includes cash and deposits (refer to Note 1(k)), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

The effective interest method is a method of calculating the amortised cost of a financial asset and of allocating interest income over the relevant period. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, or, where appropriate, a shorter period.

Held-to-maturity investments

If the Health Service has the positive intent and ability to hold nominated investments to maturity, then such financial assets may be classified as held-to-maturity. Held-to-maturity financial assets are recognised initially at fair value plus any directly attributable transaction costs. Subsequent to initial recognition held-to-maturity financial assets are measured at amortised costs using the effective interest method, less any impairment losses.

The Health Service makes limited use of this classification because any sale or reclassification of more than an insignificant amount of held-to-maturity investments not close to their maturity, would result in the whole category being classified as available-for-sale. The Health Service would also be prevented from classifying investment securities as held-to-maturity for the current and following two financial years.

The held-to-maturity category includes certain term deposits and debt securities for which the Health Service concerned intends to hold to maturity.

Financial liabilities at amortised cost

Financial instrument liabilities are initially recognised on the date they are originated. They are initially measured at fair value plus any directly attributable transaction costs. Subsequent to initial recognition, these financial instruments are measured at amortised cost with any difference between the initial recognised amount and the redemption value being recognised in profit and loss over the period of the interest-bearing liability, using the effective interest rate method.

Financial instrument liabilities measured at amortised cost include all of the Health Service's contractual payables, deposits held and advances received, and interest-bearing arrangements other than those designated at fair value through profit and loss.

[k] Assets

Cash and cash equivalents

Cash and cash equivalents recognised on the balance sheet comprise cash on hand and cash at bank, deposits at call and highly liquid investments with an original maturity of three months or less, which are held for the purpose of meeting short term cash commitments rather than for investment purposes, which are readily convertible to known amounts of cash and are subject to insignificant risk of changes in value.

For cash flow statement presentation purposes, cash and cash equivalents include bank overdrafts, which are included as liabilities on the balance sheet.

Receivables

Receivables consist of:

- Contractual receivables, which includes mainly debtors in relation to goods and services and accrued investment income.
- Statutory receivables, which include predominately amounts owing from the Victorian Government and Goods and Services Tax "GST" input tax credits recoverable.

Receivables that are contractual are classified as financial instruments and classified as loans and receivables. Statutory receivables are recognised and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments because they do not arise from a contract.

Receivables are recognised initially at fair value and subsequently measured at amortised cost, using the effective interest method, less any accumulated impairment. Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition. Collectability of debts is reviewed on an ongoing basis and debts which are known to be uncollectible are written off. A provision for doubtful debts is recognised when there is objective evidence that the debts may not be collected and bad debts are written off when identified.

Investments and Other Financial Assets

Investments are recognised and derecognised on trade date where purchase or sale of an investment is under a contract whose terms require delivery of the investment within the timeframe established by the market concerned and are initially measured at fair value, net of transaction costs.

Investments are classified in the following categories:

- Held to maturity; and
- Loans and receivables.

The Health Service classifies its other financial assets between current and non-current assets based on the purpose for which the assets were acquired. Management determines the classification of its other financial assets at initial

The Health Service assesses at each balance sheet date whether a financial asset or group of financial assets are impaired.

All financial assets, except those measured at fair value through profit and loss are subject to an annual review of impairment.

Inventories

Inventories include goods and other property held either for sale, consumption or for distribution at no or nominal cost in the ordinary course of business operations. It excludes depreciable assets.

Inventories held for distribution are measured at cost, adjusted for any loss of service potential. All other inventories are measured at the lower of cost and net realisable value.

Inventories acquired for no cost or nominal considerations are measured at current replacement cost at the date of acquisition.

The bases used in assessing loss of service potential for inventories held for distribution include current replacement cost and technical or functional obsolescence. Technical obsolescence occurs when an item still functions for some or all of the tasks it was originally acquired to do, but no longer matches existing technologies. Functional obsolescence occurs when an item no longer functions the way it did when it was first acquired.

Cost is assigned to land for sale (undeveloped, under development and developed), if applicable, and to other high value, low volume inventory items on a specific identification of cost basis.

Cost for all other inventory is measured on the basis of weighted average cost.

Property, Plant and Equipment
All non-current physical assets are measured initially at cost and subsequently valued at fair value less accumulated depreciation and impairment. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. Assets transferred as part of a merger/machinery of government are transferred at their carrying amount.

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 11 Property, plant and equipment.

Land and Buildings are recognised initially at cost and subsequently measured at fair value less accumulated depreciation and impairment.

Plant, equipment and vehicles are recognised initially at cost and subsequently measured at fair value less accumulated depreciation and impairment. Depreciated historical cost is generally a reasonable proxy for fair value because of the short lives of the assets concerned.

Revaluation of Non-current Physical Assets
Non-current physical assets are measured at fair value and are revalued in accordance with FRD 103E Non-current physical assets. This revaluation process normally occurs at least every five years, based upon the asset's Government Purpose Classification, but may occur more frequently if fair value assessments indicate material changes in values. Independent valuers are used to conduct these scheduled revaluations and any interim revaluations are determined in accordance with the requirements of the FRDs. Revaluation increments or decrements arise from differences between an asset's carrying value and fair value.

Revaluation increments are recognised in 'other comprehensive income' and are credited directly to the asset revaluation surplus, except that, to the extent that an increment reverses a revaluation decrement in respect of that same class of asset previously recognised as an expense in net result, the increment is recognised as income in the net result.

Revaluation decrements are recognised in 'other comprehensive income' to the extent that a credit balance exists in the asset revaluation surplus in respect of the same class of property, plant and equipment.

Revaluation increases and revaluation decreases relating to individual assets within an asset class are offset against one another within that class but are not offset in respect of assets in different classes.

Revaluation surplus is not transferred to accumulated funds on derecognition of the relevant asset.

In accordance with FRD 103E, the Health Service's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

Intangible assets
Intangible assets represent identifiable non-monetary assets without physical substance such as computer software and development costs, where applicable.

Intangible assets are initially recognised at cost. Subsequently, intangible assets with finite useful lives are carried at cost less accumulated amortisation and accumulated impairment losses. Costs incurred subsequent to initial acquisition are capitalised when it is expected that additional future economic benefits will flow to the Health Service.

Expenditure on research activities is recognised as an expense in the period on which it is incurred.

An internally-generated intangible asset arising from development (or from the development phase of an internal project) is recognised if, and only if, all of the following are demonstrated:

a) the technical feasibility of completing the intangible asset so that it will be available for use or sale;
b) an intention to complete the intangible asset and use or sell it;
c) the ability to use or sell the intangible asset;
d) the intangible asset will generate probable future economic benefits;
e) the availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset; and
f) the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Prepayments

Other non-financial assets include prepayments which represent payments in advance of receipt of goods and services or that part of expenditure made in one accounting period covering a term extending beyond that period.

Disposal of Non-Financial Assets

Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement. Refer to note 1(l) – 'other comprehensive income'.

Impairment of Non-Financial Assets

Apart from intangible assets with indefinite useful lives, all other assets are assessed annually for indications of impairment, except for inventories and financial assets.

If there is an indication of impairment, the assets concerned are tested as to whether their carrying value exceeds their possible recoverable amount. Where an asset's carrying value exceeds its recoverable amount, the difference is written-off as an expense except to the extent that the write-down can be debited to an asset revaluation surplus amount applicable to that same class of asset.

If there is an indication that there has been a change in the estimate of an asset's recoverable amount since the last impairment loss was recognised, the carrying amount shall be increased to its recoverable amount. This reversal of the impairment loss occurs only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation and amortisation, if no impairment loss had been recognised in prior years.

It is deemed that, in the event of the loss or destruction of an asset, the future economic benefits arising from the use of the asset will be replaced unless a specific decision to the contrary has been made. The recoverable amount for most assets is measured at the higher of depreciated replacement cost and fair value less costs to sell. Recoverable amount for assets held primarily to generate net cash inflows is measured at the higher of the present value of future cash flows expected to be obtained from the asset and fair value, less costs to sell.

Investments in jointly controlled assets and operations

In respect of any interest in jointly controlled assets, the health service recognises in the financial statements:

- its share of jointly controlled assets;
- any liabilities that it had incurred;
- its share of liabilities incurred jointly by the joint venture;
- any income earned from the selling or using of its share of the output from the joint venture; and
- any expenses incurred in relation to being an investor in the joint venture.

Derecognition of financial assets

A financial asset (or, where applicable, a part of a financial asset or part of a group of similar financial assets) is derecognised when:

- the rights to receive cash flows from the asset have expired; or
- the Health Service retains the right to receive cash flows from the asset, but has assumed an obligation to pay them in full without material delay to a third party under a 'pass through' arrangement; or
- the Health Service has transferred its rights to receive cash flows from the asset and either:
  (a) has transferred substantially all the risks and rewards of the asset; or
  (b) has neither transferred nor retained substantially all the risks and rewards of the asset, but has transferred control of the asset.

Where the Health Service has neither transferred not retained substantially all the risks and rewards or transferred control, the asset is recognised to the extent of the Health Service's continuing involvement in the asset.

Impairment of Financial Assets
At the end of each reporting period the Health Service assesses whether there is objective evidence that a financial asset or group of financial asset is impaired. All financial instruments assets, except those measured at fair value through profit or loss, are subject to annual review for impairment.

The amount of the allowance is the difference between the financial asset's carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate.

Receivables are assessed for bad and doubtful debts on a regular basis. Bad debts considered as written off and allowance for doubtful receivables are expensed. Bad debt written off by mutual consent and the allowance for doubtful debts are classified as 'other comprehensive income' in the net result.

In assessing impairment of statutory (non-contractual) financial assets, which are not financial instruments, professional judgement is applied in assessing materiality using estimates, averages and other computational methods in accordance with AASB 136 Impairment of Assets.

Net Gain / (Loss) on Financial Instruments
Net gain / (loss) on financial instruments includes:
- impairment and reversal of impairment for financial instruments at amortised cost; and
- disposals of financial assets and derecognition of financial liabilities.

[I] Liabilities

Payables
Payables consist of:
- contractual payables which consist predominantly of accounts payable representing liabilities for goods and services provided to the Health Service prior to the end of the financial year that are unpaid, and arise when the Health Service becomes obliged to make future payments in respect of the purchase of the goods and services. The normal credit terms for accounts payable are usually Nett 30 days.
- statutory payables, such as goods and services tax and fringe benefits tax payable.

Contractual payables are classified as financial instruments and are initially recognised at fair value, and then subsequently carried at amortised cost. Statutory payables are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from a contract.

Provisions
Provisions are recognised when the Health Service has a present obligation, the future sacrifice of economic benefits is probable, and the amount of the provision can be measured reliably.

The amount recognised as a liability is the best estimate of the consideration required to settle the present obligation at reporting date, taking into account the risks and uncertainties surrounding the obligation. Where a provision is measured using the cash flows estimated to settle the present obligation, its carrying amount is the present value of those cash flows, using a discount rate that reflects the time value of money and risks specific to the provision.

When some or all of the economic benefits required to settle a provision are expected to be received from a third party, the receivable is recognised as an asset if it is virtually certain that recovery will be received and the amount receivable can be measured reliably.

Employee Benefits
This provision arises for benefits accruing to employees in respect of wages and salaries, annual leave and long service leave for services rendered to the reporting date.

Wages and Salaries, Annual Leave and Accrued Days Off
Liabilities for wages and salaries, including non-monetary benefits, annual leave and accrued days off expected to be settled within 12 months of the reporting date are recognised in the provision for employee benefits in respect of employee's services up to the reporting date, classified as current liabilities and measured at nominal values.

Those liabilities that are not expected to be settled within 12 months are recognised in the provision for employee benefits as current liabilities, but are measured at the present value of the amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

Long Service Leave
The liability for long service leave (LSL) is recognised in the provision for employee benefits.

Current Liability - unconditional LSL (representing 10 or more years of continuous service) is disclosed in the notes to the financial statements as a current liability even where the Health Service does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months.
The components of this current LSL liability are measured at:
- present value on the component that the Health Service does not expect to settle within 12 months; and
- nominal value on the component that the Health Service expects to settle within 12 months.

Non-Current Liability - conditional LSL (representing less than 10 years of continuous service) is disclosed as a non-current liability. There is an unconditional right to defer the settlement of the entitlement until the employee has completed the requisite years of service. Conditional LSL is required to be measured at present value. Consideration is given to expected future wage and salary levels, experience of employee departures and periods of service. Expected future payments are discounted using interest rates of Commonwealth Government guaranteed securities in Australia.

Termination Benefits
Termination benefits are payable when employment is terminated before the normal retirement date or when an employee decides to accept an offer of benefits in exchange for the termination of employment.

The health service recognises termination benefits when it is demonstrably committed to either terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

On-Costs
Employee benefit on-costs such as payroll tax, workers compensation and superannuation are recognised separately in the expense for employee benefits.

Superannuation liabilities
The Health Service does not recognise any unfunded defined benefit liability in respect of the superannuation plans because the entity has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due.

Derecognition of financial liabilities
A financial liability is derecognised when the obligation under the liability is discharged, cancelled or expires.

When an existing financial liability is replaced by another from the same lender on substantially different terms, or the terms of an existing liability are substantially modified, such an exchange or modification is treated as derecognition of the original liability and the recognition of a new liability. The difference in the respective carrying amounts is recognised as an expense in the consolidated comprehensive operating statement.

[m] Leases

A lease is a right to use an asset for an agreed period of time in exchange for payment. Leases are classified at their inception as either operating or finance leases based on the economic substance of the agreement so as to reflect the risks and rewards incidental to ownership.

Leases of property, plant and equipment are classified as finance leases whenever the terms of the lease transfer substantially all the risks and rewards of ownership to the lessee. All other leases are classified as operating leases.

Finance Leases
The Health Service does not hold any finance lease arrangements with other parties.

Operating Leases
Rental income from an operating lease is recognised on a straight-line basis over the term of the relevant lease.

[n] Equity

Contributed Capital
Consistent with Australian Accounting Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities* and FRD 119A *Contributions by Owners*, appropriations for additions to the net asset base have been designated as contributed capital. Other transfers that are in the nature of contributions or distributions, that have been designated as contributed capital are also treated as contributed capital.

Transfers of net assets arising from administrative restructurings are treated as contributions by owners. Transfers of net liabilities arising from administrative restructures are to go through the comprehensive operating statement.

Property, Plant & Equipment Revaluation Surplus
The asset revaluation surplus is used to record increments and decrements on the revaluation of non-current physical assets.

[o] Commitments

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed by way of note (refer to note 20) at their nominal value and are inclusive of the GST payable. In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant individual projects are stated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

[p] Contingent assets and contingent liabilities

Contingent assets and contingent liabilities are not recognised in the Balance Sheet, but are disclosed by way of note and if quantifiable, are measured at nominal value. Contingent assets and contingent liabilities are presented inclusive of GST receivable or payable respectively.

[q] Service concession arrangements

The Health Service sometimes enters into certain arrangement with private sector participants to design and construct or upgrade assets used to provide public services. These arrangements are typically complex and usually include the provision of operational and maintenance services for a specified period of time. These arrangements are often referred to as either public private partnerships or service concession arrangements (SCAs).

These SCAs usually take one of two main forms. In the more common form, the Health Service pays the operator over the period of the arrangement, subject to specified performance criteria being met. At the date of commitment to the principal provisions of the arrangement, these estimated periodic payments are allocated between a component related to the design and construction or upgrading of the asset and components related to the ongoing operation and maintenance of the asset. The former component is accounted for as a lease payment in accordance with the lease policy (see Note 1(m)). The remaining components are accounted for as commitments (see Note 1(o)) for operating costs which are expensed in the comprehensive operating statement as they are incurred.

The other less common form of SCA, is one in which the Health Service grants to an operator for a specified period of time, the right to collect fees from users of the SCA asset, in return for which the operator constructs the asset and has the obligation to supply agreed upon services, including maintenance of the asset for the period of the concession. These private sector entities typically lease land, and sometimes state works, from the Health Service and construct infrastructure. At the end of the concession period, the land and state works, together with the constructed facilities, will be returned to the grantor Health Agency.

[r] Goods and Service Tax

Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the taxation authority. In this case it is recognised as part of the cost of acquisition of an asset or part of the expense. Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the taxation authority is included with other receivables or payables in the balance sheet. Cash flows are presented on a gross basis. The GST component of cash flows arising from investing or financing activities which are recoverable from, or payable to the taxation authority, are presented as operating cash flow. Commitments for expenditure and contingent assets and liabilities are presented on a gross basis.

[s] Events after the reporting period

Assets, liabilities, income or expenses arise from past transactions or other past events. Where the transactions result from an agreement between the Health Service and other parties, the transactions are only recognised when the agreement is irrevocable at or before the end of the reporting period.

Adjustments are made to amounts recognised in the financial statements for the events which occur after reporting date and before the date the financial statements are authorised for issue, where those events provide information about conditions which exist in the reporting period. Note disclosure is made about events between the end of the reporting period and the date the financial statements are authorised for issue where the events relate to conditions which arose after the end of the reporting period and which have a material impact of the results on subsequent reporting periods.

[t] Foreign Currency

The Health Service had no foreign currency transactions in the reporting period.

[u] AASs issued that are not yet effective

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2014 reporting period. DTF assesses the impact of all these new standards and advises the Hospital of their applicability and early adoption where applicable.

As at 30 June 2014, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. The Hospital has not and does not intend to adopt these standards early.

Standard/ Interpretation	Summary	Applicable for Annual reporting periods beginning on	reporting periods beginning on Impact on financial Statements
AASB 9 Financial instruments	This standard simplifies requirements for the classification and measurement of financial assets resulting from Phase 1 of the IASB's project to replace IAS 39 Financial Instruments: Recognition and Measurement (AASB 139 Financial Instruments: Recognition and Measurement).	1 Jan 2017	Subject to AASB's further modifications to AASB 9, together with the anticipated changes resulting from the staged projects on impairments and hedge accounting, details of impacts will be assessed
AASB 12 Disclosure of Interests in Other Entities	This Standard requires disclosure of information that enables users of financial statements to evaluate the nature of, and risks associated with, interests in other entities and the effects of those interests on the financial statements. This Standard replaces the disclosure requirements in AASB 127 Separate Financial Statements and AASB 131 Interests in Joint Ventures. The exposure draft ED 238 proposes to add some implementation guidance to AASB 12, explaining and illustrating the definition of a 'structured entity' from a not-for-profit perspective.	1 Jan 2014	Not-for-profit entities are not permitted to apply this Standard prior to the mandatory application date. Impacts on the level and nature of the disclosures will be assessed based on the eventual implications arising from AASB 10, AASB 11 and AASB 128 Investments in Associates and Joint Ventures.

AASB 128 Investments in Associates and Joint Ventures	This revised Standard sets out the requirements for the application of the equity method when accounting for investments in associates and joint ventures.	1 Jan 2014	Not-for-profit entities are not permitted to apply this Standard prior to the mandatory application date. The AASB is assessing the applicability of principles in AASB 128 in a not-for-profit context. As such, the impact will be assessed after the AASB's deliberation.

[v] Category Groups

The Health Service has used the following category groups for reporting purposes for the current and previous financial years.

Admitted Patient Services (Admitted Patients)
Comprises all recurrent health revenue and expenditure on admitted patient services, where services are delivered in public hospitals.

Aged Care
Comprises revenue and expenditure from Home and Community Care (HACC) programs, Allied Health and support services.

Primary Health
Comprises revenue and expenditure for Community Health Services including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy.

Other Services excluded from Australian Health Care Agreement (Other)
Comprises revenue and expenditure for services not separately classified above. Health and Community Initiatives also fall into this category group.

SOUTH GIPPSLAND HOSPITAL

Notes to the Financial Statements
for the year ended 30 June 2014

Note 2: Revenue

	Note	HSA 2014 $	HSA 2013 $	H&CI 2014 $	H&CI 2013 $	Total 2014 $	Total 2013 $
Revenue from Operating Activities							
Government Grants							
- Department of Health		5,846,264	5,156,979	-	-	5,846,264	5,156,979
Indirect Contributions by Dept Health*							
- Insurance		6,440	113,239	-	-	6,440	113,239
- Long Service Leave		19,755	21,946	-	-	19,755	21,946
Patient Fees	2b	467,586	419,139	-	-	467,586	419,139
Donations & Bequests		-	-	43,723	20,185	43,723	20,185
Recoupment from Private Practices for Use of Hospital Facilities		-	-	41,180	44,608	41,180	44,608
Other Revenue from Operating Activities		-	-	720,491	701,453	720,491	701,453
Total Revenue from Operating Activities		6,340,045	5,711,303	805,394	766,246	7,145,439	6,477,549
Revenue from Non-Operating Activities							
Interest		-	-	64,534	94,213	64,534	94,213
Property Income		-	-	38,683	35,312	38,683	35,312
Revenue from Non-Operating Activities		-	-	103,217	129,525	103,217	129,525
Capital Purpose Income							
State Government Capital Grants							
- Department of Health		27,757	69,120	-	-	27,757	69,120
Donations & Bequests		-	-	22,485	67,327	22,485	67,327
Net Gain/(Loss) from Sale of Non Current Assets	2c	-	-	(2,814)	152,344	(2,814)	152,344
Total Capital Purpose Income		27,757	69,120	19,671	219,671	47,428	288,791
Total Revenue	2a	6,367,802	5,780,423	928,282	1,115,442	7,296,084	6,895,865

*Indirect contributions by Department of Health
Department of Health makes certain payments on behalf of the Health Service. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

SOUTH GIPPSLAND HOSPITAL

Notes to the Financial Statements
for the year ended 30 June 2014

Note 2a: Analysis of Revenue by Source

	Note	Admitted Patients	Aged Care	Primary Health	Other	Total
		2014 $	2014 $	2014 $	2014 $	2014 $
Revenue from Services Supported by Health Services Agreement						
Government Grants						
- Department of Health		5,129,646	487,649	118,688	-	5,735,983
Indirect Contributions by Dept Health*						
- Insurance		144,478	-	-	-	144,478
- Long Service Leave		19,755	-	-	-	19,755
Patient Fees	2b	319,821	147,765	-	-	467,586
Other Revenue from Operating Activities		-	-	-	85,469	85,469
Total Revenue from Services Supported by Health Services Agreement		5,613,700	635,414	118,688	85,469	6,453,271
Revenue from Services Supported by Hospital and Community Initiatives						
Business Units						
Catering		-	-	-	51,539	51,539
Property Income		-	-	-	38,683	38,683
Other Activities						
Net Gain from Sale of Non Current Assets	2c	-	-	-	(2,815)	(2,815)
Recoupment from private practices for use of Hospital facilities		-	-	-	41,180	41,180
Interest		-	-	-	64,534	64,534
Donations & Bequests		-	-	-	66,208	66,208
Transitional Care Program		350,748	-	-	-	350,748
Other		-	-	-	232,735	232,735
Total Revenue from Services Supported by Hospital and Community Initiatives		350,748	-	-	492,064	842,812
Total Revenue		5,964,448	635,414	118,688	577,533	7,296,083

*Indirect contributions by Department of Health
Department of Human Services makes certain payments on behalf of the Hospital. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

SOUTH GIPPSLAND HOSPITAL

Notes to the Financial Statements
for the year ended 30 June 2014

Note 2a: Analysis of Revenue by Source

	Note	Admitted Patients	Aged Care	Primary Health	Other	Total
		2013 $	2013 $	2013 $	2013 $	2013 $
Revenue from Services Supported by Health Services Agreement						
Government Grants						
- Department of Health		4,588,515	522,998	114,586	-	5,226,099
Indirect Contributions by Dept Health*						
- Insurance		113,239	-	-	-	113,239
- Long Service Leave		21,946	-	-	-	21,946
Patient Fees	2b	282,015	137,125	-	-	419,140
Other Revenue from Operating Activities		-	-	-	47,209	47,209
Total Revenue from Services Supported by Health Services Agreement		5,005,715	660,123	114,586	47,209	5,827,633
Revenue from Services Supported by Hospital and Community Initiatives						
Business Units						
Catering		-	-	-	54,109	54,109
Property Income		-	-	-	35,312	35,312
Other Activities						
Net Gain from Sale of Non Current Assets	2c	-	-	-	152,343	152,343
Recoupment from private practices for use of Hospital facilities		-	-	-	44,608	44,608
Interest		-	-	-	94,213	94,213
Donations & Bequests		-	-	-	87,512	87,512
Transitional Care Program		352,402	-	-	-	352,402
Other		-	-	-	247,733	247,733
Total Revenue from Services Supported by Hospital and Community Initiatives		352,402	-	-	715,830	1,068,232
Total Revenue		5,358,117	660,123	114,586	763,039	6,895,865

*Indirect contributions by Department of Health
Department of Human Services makes certain payments on behalf of the Hospital. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

Note 2b: Patient Fees

	2014 $	2013 $
Patient Fees Raised		
Acute		
- Inpatients	319,821	282,015
Aged Care & Primary Health		
- Visiting Nursing	138,032	127,145
- Other	9,733	9,979
TOTAL PATIENT FEES	467,586	419,139

Note 2c: Net Gain on Disposal of Non-Current Assets

Proceeds from Disposal of Non-Current Assets		
Land	-	376,206
Plant and Equipment	847	136
Motor Vehicles	24,063	31,974
Total Proceeds from Disposal of Non-Current Assets	24,910	408,316
Less: Written Down Value of Non-Current Assets Sold		
Land	-	(211,402)
Plant and Equipment	(1,486)	(26,708)
Motor Vehicles	(26,238)	(17,862)
Total Written Down Value of Non-Current Assets Sold	(27,724)	(255,972)
NET GAIN ON DISPOSAL OF NON-CURRENT ASSETS	(2,814)	152,344

SOUTH GIPPSLAND HOSPITAL

Notes to the Financial Statements
for the year ended 30 June 2014

Note 3: Expenses

	HSA 2014 $	HSA 2013 $	H&CI 2014 $	H&CI 2013 $	Total 2014 $	Total 2013 $
Employee Expenses						
Salaries & Wages	4,028,492	3,881,980	345,551	104,855	4,374,043	3,986,835
Workcover	44,180	35,105	3,791	950	47,971	36,055
Long Service Leave	118,111	117,729	10,133	3,182	128,244	120,911
Superannuation	370,513	355,101	31,784	9,593	402,297	364,694
Total Employee Expenses	4,561,296	4,389,915	391,259	118,580	4,952,555	4,508,495
Non Salary Labour Costs						
Fees for Service Medical Officers	436,882	528,614	-	-	436,882	528,614
Total Non Salary Labour Costs	436,882	528,614	-	-	436,882	528,614
Supplies & Consumables						
Drug Supplies	85,221	90,083	-	-	85,221	90,083
Medical & Surgical Supplies	193,985	165,540	-	-	193,985	165,540
Pathology Supplies	43,904	52,164	-	-	43,904	52,164
Food Supplies	74,433	82,557	6,386	2,231	80,819	84,788
Inpatient Services	168,980	155,584	-	-	168,980	155,584
Total Supplies & Consumables	566,523	545,928	6,386	2,231	572,909	548,159
Other Expenses						
Domestic Services & Supplies	82,607	82,046	7,087	2,218	89,694	84,264
Fuel, Light, Power & Water	84,168	65,841	7,221	1,780	91,389	67,621
Indirect Contributions by DH - Insurance	133,063	110,259	11,416	2,980	144,479	113,239
Motor Vehicle Expenses	34,845	36,143	2,990	978	37,835	37,121
Repairs & Maintenance	105,805	100,839	9,077	2,726	114,882	103,565
Patient Transport	60,485	51,750	-	-	60,485	51,750
Medical Records	10,574	9,449	-	-	10,574	9,449
Bad & Doubtful Debts	-	445	-	-	-	445
Other Administrative Expenses	531,149	518,029	45,562	13,993	576,711	532,022
Auditor General's Fees (Note 26)	20,000	18,900	-	-	20,000	18,900
Total Other Expenses	1,062,696	993,701	83,353	24,675	1,146,049	1,018,376
Depreciation and Amortisation (Note 4)	-	-	371,885	357,095	371,885	357,095
Total	-	-	371,885	357,095	371,885	357,095
Total Expenses	6,627,397	6,458,158	852,883	502,581	7,480,280	6,960,739

SOUTH GIPPSLAND HOSPITAL

Notes to the Financial Statements
for the year ended 30 June 2014

Note 3a: Analysis of Expenses by Source

	Acute Care 2014 $	Acute Care 2013 $	Aged Care 2014 $	Aged Care 2013 $	Primary Health 2014 $	Primary Health 2013 $	Other 2014 $	Other 2013 $	Total 2014 $	Total 2013 $
Services Supported by Health Services Agreement										
Employee Benefits										
Salaries & Wages	3,577,967	3,391,600	380,541	417,820	69,984	72,560	-	-	4,028,492	3,881,980
Workcover	39,240	30,671	4,173	3,778	767	656	-	-	44,180	35,105
Long Service Leave	104,903	102,858	11,157	12,671	2,051	2,200	-	-	118,111	117,729
Superannuation	329,078	310,245	34,999	38,219	6,436	6,637	-	-	370,513	355,101
Fees for Service Medical Officers	436,882	528,614	-	-	-	-	-	-	436,882	528,614
Supplies & Consumables										
Drug Supplies	85,221	90,083	-	-	-	-	-	-	85,221	90,083
Medical & Surgical Supplies	174,006	145,180	16,876	17,348	3,103	3,012	-	-	193,985	165,540
Pathology Supplies	43,904	52,164	-	-	-	-	-	-	43,904	52,164
Food Supplies	66,109	72,129	7,031	8,885	1,293	1,543	-	-	74,433	82,557
Inpatient Services	168,980	155,584	-	-	-	-	-	-	168,980	155,584
Other Expenses										
Domestic Services & Supplies	73,369	71,683	7,803	8,830	1,435	1,533	-	-	82,607	82,046
Fuel, Light, Power & Water	74,756	57,525	7,950	7,086	1,462	1,230	-	-	84,168	65,841
Indirect Contributions by DH - Insurance	118,183	96,332	12,569	11,867	2,311	2,060	-	-	133,063	110,259
Motor Vehicle Expenses	30,949	31,578	3,291	3,890	605	675	-	-	34,845	36,143
Repairs & Maintenance	93,973	88,102	9,994	10,853	1,838	1,884	-	-	105,805	100,839
Patient Transport	60,485	51,750	-	-	-	-	-	-	60,485	51,750
Medical Records	10,574	9,449	-	-	-	-	-	-	10,574	9,449
Bad & Doubtful Debts	-	445	-	-	-	-	-	-	-	445
Other Administrative Expenses	471,750	452,592	50,173	55,756	9,227	9,682	-	-	531,150	518,030
Total Expenses from Services Supported by Health Services Agreement	5,960,329	5,738,584	546,557	597,003	100,512	103,672	-	-	6,607,398	6,439,259
Services Supported by Hospital and Community Initiatives										
Employee Benefits										
Salaries & Wages	-	-	-	-	-	-	345,551	104,855	345,551	104,855
Workcover	-	-	-	-	-	-	3,791	950	3,791	950
Long Service Leave	-	-	-	-	-	-	10,133	3,182	10,133	3,182
Superannuation	-	-	-	-	-	-	31,784	9,593	31,784	9,593

SOUTH GIPPSLAND HOSPITAL

Notes to the Financial Statements
for the year ended 30 June 2014

Note 3a: Analysis of Expenses by Source (continued)

Supplies & Consumables										
Drug Supplies	-	-	-	-	-	-	-	-	-	-
Medical & Surgical Supplies	-	-	-	-	-	-	-	-	-	-
Food Supplies	-	-	-	-	-	-	6,386	2,231	6,386	2,231
Other Expenses										
Domestic Services	-	-	-	-	-	-	7,087	2,218	7,087	2,218
Fuel, Light, Power & Water	-	-	-	-	-	-	7,221	1,780	7,221	1,780
Indirect Contributions by DH - Insurance	-	-	-	-	-	-	11,416	2,980	11,416	2,980
Motor Vehicle Expenses	-	-	-	-	-	-	2,990	978	2,990	978
Repairs & Maintenance	-	-	-	-	-	-	9,077	2,726	9,077	2,726
Other Administrative Expenses	-	-	-	-	-	-	45,562	13,993	45,562	13,993
Total Expenses from Services Supported by Hospital and Community Initiatives	-	-	-	-	-	-	480,998	145,486	480,998	145,486
Depreciation and Amortisation (Note 4)	-	-	-	-	-	-	371,885	357,095	371,885	357,095
Auditor General's Fees (Note 26)	20,000	18,900	-	-	-	-	-	-	20,000	18,900
Total Expenses	5,980,329	5,757,484	546,557	597,003	100,512	103,672	852,883	502,581	7,480,281	6,960,740

Due to the nature of the services and the manner in which the services are provided by the Health Service, the above expenses have been apportioned where applicable on the basis of the Revenue from Services, being 81.8% Acute Care, 8.7% Aged Care, 1.6% Primary Health and 7.9% Other.

Note 4: Depreciation, Amortisation & Impairment

	2014 $	2013 $
Depreciation		
Buildings	147,095	130,729
Plant & Equipment	21,698	17,874
Motor Vehicles	31,878	29,070
Medical Equipment	145,470	152,094
Furniture & Fittings	7,403	8,124
Other Equipment	18,340	18,954
Total Depreciation	371,884	356,845
Amortisation		
Computer Software	-	250
Total Amortisation	-	250
TOTAL DEPRECIATION AND AMORTISATION	371,884	357,095

Note 5: Cash and Cash Equivalents

For the purpose of the Cash Flow Statement, cash assets includes cash on hand and in banks, and short-term deposits which are readily convertible to cash on hand and are subject to an insignificant risk of change in value, net of outstanding bank overdrafts.

	2014 $	2013 $
Cash on Hand	400	400
Cash at Bank	218,688	267,580
TOTAL CASH AND CASH EQUIVALENTS	219,088	267,980
Represented by:		
Cash for Health Service Operations	94,569	143,848
GHA Cash at Bank	124,519	124,132
TOTAL CASH AND CASH EQUIVALENTS	219,088	267,980

Note 6: Receivables

Current		
Contractual		
- Sundry Debtors	163,694	156,247
- Patient Fees	54,902	56,672
- Accrued Investment Income	11,556	14,311
- GHA Receivables	20,197	56,366
Less Allowance for Doubtful Debts		
- Patient Fees	(2,095)	(2,095)
	248,254	281,501
Statutory		
- GST Refund Due	8,977	(1,622)
	8,977	(1,622)
Total Current	257,231	279,879

Note 6: Receivables (continued)

Non-Current	2014	2013
Statutory	$	$
- Accrued Revenue		
Department of Health Long Service Leave	256,287	236,532
Total Non-Current	256,287	236,532
TOTAL RECEIVABLES	513,518	516,411

(a) Movement in the Allowance for doubtful debts

Balance at beginning of year	2,095	1,650
Amounts recovered during the year	-	-
Increase/(Decrease) in allowance recognised in net result	-	445
Balance at end of year	2,095	2,095

(b) Ageing analysis of receivables

Please refer to note 19b for the ageing analysis of receivables.

(c) Nature and extent of risk arising from receivables

Please refer to note 19b for the nature and extent of credit risk arising from receivables.

Note 7: Investments and Other Financial Assets

	Operating Fund 2014 $	Operating Fund 2013 $	Total 2014 $	Total 2013 $
Current				
Term Deposits				
- Term Deposit # 1 (Capital Development)	398,309	579,047	398,309	579,047
- Term Deposit # 4 (Leave Liabilities)	355,000	354,176	355,000	354,176
- Term Deposit # 5 (Leave Liabilities)	707,936	681,265	707,936	681,265
- Term Deposit # 6 (Contingencies)	84,000	84,000	84,000	84,000
TOTAL OTHER FINANCIAL ASSETS	1,545,245	1,698,488	1,545,245	1,698,488

(a) Ageing analysis of investments and other financial assets

Please refer to note 19(b) for the ageing analysis of investments and other financial assets.

(b) Nature and extent of risk arising from investments and other financial assets

Please refer to note 19(b) for the nature and extent of credit risk arising from investments and other financial assets.

Note 8: Inventories

	2014 $	2013 $
Pharmaceuticals At Cost	14,541	12,854
Catering Supplies At Cost	5,357	4,736
Medical & Surgical Lines At Cost	52,806	46,598
Engineering Stores At Cost	3,827	3,463
TOTAL INVENTORIES	76,530	67,651

Note 9: Non-Financial Assets Classified as Held For Sale

	2014 $	2013 $
Freehold Land - At Fair Value	-	-
Freehold Land - At Cost	-	-
TOTAL NON-FINANCIAL ASSETS CLASSIFIED AS HELD FOR SALE	-	-

Note 10: Other Current Assets

	2014 $	2013 $
GHA Other Current Assets	13,153	13,541
Rental Property Bonds	-	1,121
TOTAL OTHER CURRENT ASSETS	13,153	14,662

Note 11: Property, Plant & Equipment

	2014 $	2013 $
Land		
- Land at fair value	360,000	189,950
- Land at Cost	-	262,945
Total Land	360,000	452,895
Buildings		
- Buildings at fair value	4,898,792	4,048,606
- Buildings at Cost	-	850,410
Less Accumulated Depreciation	-	(511,164)
- Buildings - Work in Progress	2,290	2,290
Total Buildings	4,901,082	4,390,141
Plant and Equipment		
- Plant & Equipment at fair value	204,284	196,252
Less Accumulated Depreciation	(76,856)	(75,894)
	127,428	120,358
- Motor Vehicles at fair value	290,977	257,313
Less Accumulated Depreciation	(50,235)	(52,578)
	240,742	204,735
- Medical Equipment at fair value	1,522,597	1,472,264
Less Accumulated Depreciation	(853,827)	(742,215)
	668,770	730,049
- Furniture & Fittings at fair value	87,162	86,062
Less Accumulated Depreciation	(55,286)	(47,883)
	31,876	38,179
- Other Equipment at fair value	410,578	415,642
Less Accumulated Depreciation	(284,897)	(272,033)
- Other Equipment - Work in Progress	9,500	-
	135,181	143,609
- GHA Plant & Equipment	4,178	4,254
	4,178	4,254
Total Plant & Equipment	1,208,175	1,241,184
TOTAL PROPERTY, PLANT & EQUIPMENT	6,469,257	6,084,220

Note 11: Property, Plant & Equipment (continued)

All land and buildings were valued at the 30th June, 2014 by Mr. J Kilgour (A.A.P.I.) of Westernport Property Consultants under contract by Valuer-General Victoria. Reconciliation of the carrying amounts of each class of asset at the beginning and end of the previous and current financial years are set out below.

Fair value, where applicable is calculated in accordance with Note 1(b).

	Freehold Land	Buildings	Plant & Equipment	Transport	Total
	$	$	$	$	$
Balance at 1st July 2012	189,950	3,907,065	1,121,450	134,531	5,352,996
Additions	262,945	613,805	138,753	117,136	1,132,639
Disposals	-	-	(26,708)	(17,862)	(44,570)
Depreciation/amortisation expense (Note 4)	-	(130,729)	(197,046)	(29,070)	(356,845)
Building WIP write-down	-	-	-	-	-
Balance at 1st July 2013	452,895	4,390,141	1,036,449	204,735	6,084,220
Additions	-	3,517	125,381	94,123	223,021
Disposals	-	-	(1,486)	(26,238)	(27,724)
Revaluation increments / (decrements)	(92,895)	654,519	-	-	561,624
Depreciation/amortisation expense (Note 4)	-	(147,095)	(192,911)	(31,878)	(371,884)
Balance at 30th June 2014	360,000	4,901,082	967,433	240,742	6,469,257

(a) Fair value measurement hierarchy for assets as at 30 June 2014

	Carrying amount as at 30 June 2014	Level 1	Level 2	Level 3
Land at fair value				
Non-specialised land				
Specialised land				
- Station Road - Foster	360,000	-	-	360,000
Total of land at fair value	360,000	-	-	360,000
Buildings at fair value				
Non-specialised buildings				
Specialised buildings				
- Station Road, Foster	4,901,082	-	-	4,901,082
Total of building at fair value	4,901,082	-	-	4,901,082
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	240,742	-	-	240,742
- Plant and equipment	298,663	-	-	298,663
Total of plant, equipment and vehicles at fair value	539,405	-	-	539,405
Medical equipment at fair value				
- Medical Equipment	668,770	-	-	668,770
Total medical equipment at fair value	668,770	-	-	668,770
Total Assets at fair value	6,469,257	-	-	6,469,257

There have been no transfers between levels during the period.

Non-specialised land and non-specialised buildings

Non-specialised land and non-specialised buildings are valued using the market approach. Under this valuation method, the assets are compared to recent comparable sales or sales of comparable assets which are considered to have nominal or no added improvement value.

Non-specialised land and non-specialised buildings are valued using the market approach. Under this valuation method, the assets are compared to recent comparable sales or sales of comparable assets which are considered to have nominal or no added improvement value.

To the extent that non-specialised land and non-specialised buildings do not contain significant, unobservable adjustments, these assets are classified as Level 2 under the market approach.

Specialised land and specialised buildings

The market approach is also used for specialised land and specialised buildings although is adjusted for the community service obligation (CSO) to reflect the specialised nature of the assets being valued. Specialised assets contain significant, unobservable adjustments; therefore these assets are classified as Level 3 under the market based direct comparison approach.

The CSO adjustment is a reflection of the valuer's assessment of the impact of restrictions associated with an asset to the extent that is also equally applicable to market participants. This approach is in light of the highest and best use consideration required for fair value measurement, and takes into account the use of the asset that is physically possible, legally permissible and financially feasible. As adjustments of CSO are considered as significant unobservable inputs, specialised land would be classified as Level 3 assets.

For the health services, the depreciated replacement cost method is used for the majority of specialised buildings, adjusting for the associated depreciation. As depreciation adjustments are considered as significant and unobservable inputs in nature, specialised buildings are classified as Level 3 for fair value measurements.

An independent valuation of the Hospital's specialised land and specialised buildings was performed by the Valuer-General Victoria. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation is 30 June 2014.

Vehicles

The Health Service acquires new vehicles and at times disposes of them before completion of their economic life. The process of acquisition, use and disposal in the market is managed by the Health Service who set relevant depreciation rates during use to reflect the consumption of the vehicles. As a result, the fair value of vehicles does not differ materially from the carrying value (depreciated cost).

Plant and equipment

Plant and equipment is held at carrying value (depreciated cost). When plant and equipment is specialised in use, such that it is rarely sold other than as part of a going concern, the depreciated replacement cost is used to estimate the fair value. Unless there is market evidence that current replacement costs are significantly different from the original acquisition cost, it is considered unlikely that depreciated replacement cost will be materially different from the existing carrying value.

There were no changes in valuation techniques throughout the period to 30 June 2014.

For all assets measured at fair value, the current use is considered the highest and best use.

(b) Reconciliation of Level 3 fair value

	Land	Buildings	Plant and equipment	Medical equipment
Opening Balance	452,895	4,393,659	560,634	780,383
Purchases (sales)				
Transfers in (out) of Level 3				
Gains or losses recognised in net result				
- Depreciation	-	(147,095)	(21,229)	(111,613)
Subtotal	452,895	4,246,564	539,405	668,770
Items recognised in other comprehensive income				
- Revaluation	(92,895)	654,519	-	-
Subtotal	(92,895)	654,519	-	-
Closing Balance	360,000	4,901,083	539,405	668,770

	Valuation technique	Significant unobservable inputs	Range (weighted average)	Sensitivity of fair value measurement to changes in significant unobservable inputs
Specialised land - Station Road, Foster	Market Approach	Community Service Obligation (CSO) adjustment	20% (20%)(i)	A significant increase or decrease in the CSO adjustment would result in a significantly lower (higher) fair value
Specialised Buildings - Station Road, Foster	Depreciated replacement cost	Direct cost per square meter	$350 - $1825/m2	A significant increase or decrease in direct cost per square metre adjustment would result in higher or lower fair value.
		Useful life of building	1-50 years	A significant increase or decrease in the estimated useful life of the asset would result in significantly higher or lower valuation.
Plant & Equipment at fair value - Plant & Equipment	Depreciated replacement cost	Cost per unit	$0 - $64,000 ($2,160)	A significant increase or decrease in cost per unit would result in higher or lower fair value.
		Useful life of asset	5-10 years (7years)	A significant increase or decrease in the estimated useful like of asset would result in significantly higher or lower value.
Vehicles at fair value - Vehicles	Depreciated replacement cost	Cost per unit	$15,000 - $50,000 ($26,750)	A significant increase or decrease in cost per unit would result in higher or lower fair value.
		Useful life of asset	8-10 years (9years)	A significant increase or decrease in the estimated useful like of asset would result in significantly higher or lower value.
Medical equipment at fair value - Medical Expenses	Depreciated replacement cost	Cost per unit	$0 - $190,000 ($4,100)	A significant increase or decrease in cost per unit would result in higher or lower fair value.
		Useful life of asset	8-10 years (9years)	A significant increase or decrease in the estimated useful like of asset would result in significantly higher or lower value.

(i) CSO adjustments ranging from 50% to 70% were applied to reduce the market approach value for the Department's specialised land, with the weighted average 60% reduction applied.

SOUTH GIPPSLAND HOSPITAL

Notes to the Financial Statements
for the year ended 30 June 2014

Note 12: Intangible Assets

	2014 $	2013 $
Intangible Assets at Cost		
- Computer Software	11,250	11,250
Less Accumulated Amortisation	(11,250)	(11,250)
Total Intangible Assets	-	-

	Computer Software $	Computer Software $
Balance at 1st July 2012	250	499
Additions	-	-
Disposals	-	-
Amortisation expense (Note 4)	(250)	(250)
Balance at 1st July 2013	-	249
Additions	-	-
Disposals	-	-
Amortisation expense (Note 4)	-	(250)
Balance at 30th June 2014	-	-

Note 13: Payables

	2014 $	2013 $
Current		
Contractual		
- Trade Creditors	180,263	442,008
- GHA Payables	-	-
- Accrued Expenses	28,046	82,237
	208,309	524,245
Statutory		
- Department of Health Recall - WIES	(61,123)	(19,520)
TOTAL PAYABLES	**147,186**	**504,725**

Note 13a: Maturity Analysis of Payables

Please refer to note 19c for the ageing analysis of contractual payables.

Note 13b: Nature and extent of risk arising from Payables

Please refer to note 19c for the nature and extent of risks arising from contractual payables.

Note 14: Provisions

CURRENT (refer note 1 (l))		
Long Service Leave		
- Unconditional and expected to be settled wholly within 12 months	159,194	154,934
- Unconditional and expected to be settled wholly after 12 months	477,581	464,802
Annual Leave		
- Unconditional and expected to be settled wholly within 12 months	414,288	349,043
- Unconditional and expected to be settled wholly after 12 months	145,560	122,637
Accrued Wages & Salaries	167,424	79,219
Accrued Days Off	12,658	9,783
TOTAL CURRENT EMPLOYEE BENEFITS	1,376,704	1,180,418
NON-CURRENT (refer note 1 (l))		
Long Service Leave	190,704	175,142
TOTAL NON-CURRENT EMPLOYEE BENEFITS	190,704	175,142
Movement in Long Service Leave:		
Balance at start of year	794,879	771,017
Provision made during the year	128,244	120,911
Settlements made during the year	(95,643)	(97,049)
Balance at end of year	827,480	794,879

Note 15: Superannuation

	2014	2013
	$	$
Defined Contribtion plans:		
- Health Super	312,212	-
- Hesta Super	89,245	66,909
- First State Super	-	296,774
- Other	840	1,011
TOTAL SUPERANNUATION	402,297	364,694

Note 16: Other Current Liabilities

Current		
GHA Other Current Liabilities	36,782	81,137
TOTAL OTHER CURRENT LIABILITIES	**36,782**	**81,137**

Note 17: Equity

	2014 $	2013 $
(a) Surpluses		
Property, Plant & Equipment Revaluation Surplus		
Balance at the beginning of the reporting period	2,295,936	2,295,936
Revaluation Increments / (Decrements)		
- Land	(92,895)	-
- Buildings	654,519	-
Balance at end of Reporting Period	2,857,560	2,295,936
Represented by;		
- Land	146,586	239,481
- Buildings	2,710,974	2,056,455
Total Reserves	2,857,560	2,295,936
(b) Contributed Capital		
Balance at the beginning of the reporting period	3,086,756	3,086,756
Balance at the end of reporting period	3,086,756	3,086,756
(c) Accumulated Surpluses		
Balance at the beginning of the reporting period	1,325,297	1,390,171
Net Result for year	(184,197)	(64,874)
Balance at the end of reporting period	1,141,100	1,325,297
Total Equity at the Reporting Date	7,085,416	6,707,989

Note 18: Reconciliation of Net Result for the Year to Net Cash Inflow / (Outflow) from Operating Activities

Net Result for the Year	(184,197)	(64,874)
Depreciation and Amortisation	371,884	357,095
Net Gain from Sale of Plant & Equipment	2,814	(152,344)
Change in Operating Assets and Liabilities		
Increase/(Decrease) in Payables	(357,539)	84,702
Increase/(Decrease) in Employee Entitlements	211,848	93,351
(Increase)/Decrease in Inventories	(8,879)	(38,607)
(Increase)/Decrease in Receivables	2,893	(76,449)
Increase/(Decrease) in Other Assets	1,509	(2,014)
(Increase)/Decrease in Other Liabilities	(44,355)	45,857
Net Cash Inflow / (Outflow) from Operating Activities	(4,022)	246,717

Note 19: Financial Instruments

(a) Financial Risk Management Objectives and Policies

The Health Services principal financial instruments comprise of:
- Cash Assets
- Term Deposits
- Receivables (excluding statutory receivables)
- Payables (excluding statutory payables)

Details of the significant accounting policies and methods adopted, including the criteria for recognition, the basis of measurement and the basis on which income and expenses are recognised, with respect to each class of financial asset, financial liability and equity instrument are disclosed in note 1 to the financial statements.

Categorisation of financial instruments

Details of each categories in accordance with AASB 139, shall be disclosed either on the face of the balance sheet or in the notes.

	Note	Carrying Amount 2014 $	Carrying Amount 2013 $
Financial Assets			
Cash and cash equivalents	5	219,088	267,980
Receivables	6	250,349	283,596
Term Deposits	7	1,545,245	1,698,488
Total Financial Assets		2,014,682	2,250,064
Financial Liabilities			
Payables at amortised cost	13	208,309	524,245
Total Financial Liabilities		208,309	524,245
Holding Gains from Interest Earned	2	64,534	94,213

Note 19: Financial Instruments (continued)

(b) Credit Risk

Credit risk arises from the contractual financial assets of the Health Service, which comprise cash and deposits, non-statutory receivables and available for sale contractual financial assets. The Health Service's exposure to credit risk arises from potential default of a counter party on their contractual obligations resulting in financial loss to the Health Service. Credit risk is measured at fair value and is monitored on a regular basis.

Credit risk associated with the Health Service's contractual financial assets is minimal because the main debtor is the Victorian Government.

In addition, the Health Service does not engage in hedging for its contractual financial assets and mainly obtains contractual financial assets that are on fixed interest, except for cash assets, which are mainly cash at bank. The Health Service's policy is to only deal with banks with high credit ratings.

Provision of impairment for contractual financial assets is recognised when there is objective evidence that the Health Service will not be able to collect a receivable. Objective evidence includes financial difficulties of the debtor, default payments, debts which are more than 60 days overdue, and changes in debtor credit ratings.

Except as otherwise detailed in the following table, the carrying amount of contractual financial assets recorded in the financial statements, net of any allowances for losses, represents the Health Service's maximum exposure to credit risk without taking account of the value of any collateral obtained.

Credit quality of contractual financial assets that are neither past due nor impaired

	Financial Institutions AAA Rating	Other	Total
	$	$	$
2014			
Financial Assets			
Cash and Cash Equivalents	218,688	400	219,088
Receivables	-	248,254	248,254
Other financial assets	1,545,245	-	1,545,245
Total Financial Assets	1,763,933	248,654	2,012,587
2013			
Financial Assets			
Cash and Cash Equivalents	267,580	400	267,980
Receivables	-	281,501	281,501
Other financial assets	1,698,488	-	1,698,488
Total Financial Assets	1,966,068	281,901	2,247,969

Note 19: Financial Instruments (continued)

(b) Credit Risk

The Hospital's exposure to credit risk and the effective weighted average interest rate by ageing periods is set out in the following table. For interest rates applicable to each class of asset refer to individual notes to the financial statements.

Ageing analysis of Financial Asset as at 30 June

	Carrying Amount	Not Past Due and not Impaired	Past Due But Not Impaired				Impaired Financial Assets
			Less than 1 Month	1 - 3 Months	3 Months - 1 Year	1 - 5 Years	
	$	$	$	$	$	$	$
2014							
Financial Assets							
Cash and Cash Equivalents	219,088	219,088	-	-	-	-	-
Receivables	250,349	175,133	22,512	52,704	-	-	-
Other financial assets	1,545,245	1,545,245	-	-	-	-	-
Total Financial Assets	2,014,682	1,939,466	22,512	52,704	-	-	-
2013							
Financial Assets							
Cash and Cash Equivalents	267,980	267,980	-	-	-	-	-
Receivables	281,501	207,543	39,272	34,686	-	-	-
Other financial assets	1,698,488	1,698,488	-	-	-	-	-
Total Financial Assets	2,247,969	2,174,011	39,272	34,686	-	-	-

Ageing analysis of financial assets excludes the types of statutory financial assets (i.e. GST input tax credits)

(c) Liquidity Risk

Liquidity risk is the risk that the Health Service would be unable to meet its financial obligations as and when they fall due. The Health Service's maximum exposure to liquidity risk is the carrying amounts of financial liabilities as disclosed on the face of the balance sheet. Financial liabilties comprise only of payables, being the monthly trading accounts and sufficient funds are held in the trading bank account to cover these liabilities as and when they fall due.

The following table discloses the contractual maturity analysis for the Hospital's financial liabilities. For interest rates applicable to each class of liability refer to individual notes to the financial statements.

Maturity analysis of financial liabilities

	Carrying Amount	Contractual Cash Flows	Maturity Dates			
			Less than 1 Month	1 - 3 Months	3 Months - 1 Year	1 - 5 Years
2014	$	$	$	$	$	$
Payables						
Trade creditors & accruals	208,309	208,309	208,309	-	-	-
Total Financial Liabilities	208,309	208,309	208,309	-	-	-
2013						
Payables						
Trade creditors & accruals	524,245	524,245	524,245	-	-	-
Total Financial Liabilities	524,245	524,245	524,245	-	-	-

Note 19: Financial Instruments (continued)

(d) Market Risk

The Hospital exposures to market risk are primarily through interest rate risk with only insignificant exposure to foreign currency and other price risks. Objectives, policies and processes used to manage each of these risks are disclosed in the paragraph below.

Currency Risk

The Hospital is exposed to insignificant foreign currency risk through its payables relating to purchases of supplies and consumables from overseas. This is because of a limited amount of purchases denominated in foreign currencies and a short timeframe between commitment and settlement.

Interest Rate Risk

Exposure to interest rate risk might arise primarily through the Hospital's financial assets and liabilities. Minimisation of risk is achieved by spreading the terms on our fixed deposits.

Interest Rate Exposure of Financial Assets and Liabilities as at 30 June

	Weighted Average Effective Interest Rate	Carrying Amount	Interest Rate Exposure		
			Fixed Interest Rate	Variable Interest Rate	Non-Interest Bearing
	%	$	$	$	$
2014					
Financial Assets					
Cash and Cash Equivalents	0.84%	219,088	-	218,688	400
Receivables					
- Trade Debtors	-	228,057	-	-	228,057
- Other Receivables	-	22,292	-	-	22,292
Other financial assets					
- Term Deposits	3.64%	1,545,245	1,545,245	-	-
		2,014,682	1,545,245	218,688	250,749
Financial Liabilities					
Payables	-	208,309	-	-	208,309
	-	208,309	-	-	208,309
2013					
Financial Assets					
Cash and Cash Equivalents	0.92%	267,980	-	267,580	400
Receivables					
- Trade Debtors	-	225,135	-	-	225,135
- Other Receivables	-	56,366	-	-	56,366
Other financial assets					
- Term Deposits	4.20%	1,698,488	1,698,488	-	-
		2,247,969	1,698,488	267,580	281,901
Financial Liabilities					
Payables	-	524,245	-	-	524,245
	-	524,245	-	-	524,245

Note 19d: Financial Instruments (continued)

(d) Market Risk (continued)

Sensitivity Disclosure Analysis

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, the Hospital believes the following movements are "reasonably possible" over the next 12 months (Base rates are sourced from the Australia and New Zealand Bank)

- A parallel shift of + 1% and - 1% in market interest rates (AUD) from year-end rates of 3.5%;

The following table discloses the impact on net operating result and equity for each category of financial instrument held by the Hospital at year end as presented to key management personnel, if changes in the relevant risk occur.

	Carrying	Interest Rate Risk			
	Amount	- 1%		+ 1%	
		Profit	Equity	Profit	Equity
	$	$	$	$	$
2014					
Financial Assets					
Cash and Cash Equivalents	218,688	(2,187)	(2,187)	2,187	2,187
Cash on hand	400	-	-	-	-
Receivables					
- Trade Debtors	228,057	-	-	-	-
- Other Receivables	22,292	-	-	-	-
Other financial assets					
- Term Deposits	1,545,245	(15,452)	(15,452)	15,452	15,452
Financial Liabilities					
Payables	208,309	-	-	-	-
		(17,639)	(17,639)	17,639	17,639
2013					
Financial Assets					
Cash and Cash Equivalents	267,580	(2,676)	(2,676)	2,676	2,676
Cash on hand	400	-	-	-	-
Receivables					
- Trade Debtors	225,135	-	-	-	-
- Other Receivables	56,366	-	-	-	-
Other financial assets					
- Term Deposits	1,698,488	(16,985)	(16,985)	16,985	16,985
Financial Liabilities					
Payables	524,245	-	-	-	-
		(19,661)	(19,661)	19,661	19,661

Note 19: Financial Instruments (continued)

(e) Fair Value

The fair values and net fair values of financial instrument assets and liabilities are determined as follows:

Level 1- the fair value of financial instrument with standard terms and conditions and traded in active liquid markets are determined with reference to quoted market prices.

Level 2 - the fair value is determined using inputs other than quoted prices that are observable for the financial asset or liability, either directly or indirectly; and

Level 3 - the fair value is determined in accordance with generally accepted pricing models based on discounted cash flow analysis using unobservable market inputs.

The Health Services considers that the carrying amount of financial instrument assets and liabilities recorded in the financial statement to be a fair approximation of their fair values, because of the short-term nature of the financial instruments and the expectation that they will be paid in full.

The following table shows that the fair values of most of the contractual financial assets and liabilities are the same as the carrying amounts.

	Carrying Amount 2014 $	Fair Value 2014 $	Carrying Amount 2013 $	Fair Value 2013 $
Financial Assets				
Cash and Cash Equivalents	219,088	219,088	267,980	267,980
Receivables				
- Trade Debtors	228,057	228,057	225,135	225,135
- Other Receivables	22,292	22,292	56,366	56,366
Other financial assets				
- Term Deposits	1,545,245	1,545,245	1,698,488	1,698,488
Total Financial Assets	2,014,682	2,014,682	2,247,969	2,247,969
Financial Liabilities				
Payables	208,309	208,309	524,245	524,245
Total Financial Liabilities	208,309	208,309	524,245	524,245

Note 20: Commitments for expenditure

The Health Service does not have any capital or lease commitments for expenditure as at 30 June 2014. (2013: Nil)

Note 21: Segment Reporting

The Health Service does not have any significant income earning activities other than the provision of health services. Residential aged care services are provided by a separate legal entity.

Note 22: Contingent Assets and Contingent Liabilities

There were no contingent assets or contingent liabilities at 30 June 2014. (2013: Nil)

Note 23: Jointly Controlled Assets

Name of Entity	Principal Activity	Ownership Interest 2014 %	Ownership Interest 2013 %
Gippsland Health Alliance	Information Technology	2.97	2.63

The Health Service interest in assets employed in the above jointly controlled operations and assets is detailed below.

	2014 $	2013 $
Current Assets		
Cash and Cash Equivalents	124,519	124,132
Receivables	20,197	56,366
Other Current Assets	13,153	13,541
Total Current Assets	157,869	194,039
Non-Current Assets		
Property, Plant & Equipment	4,178	4,254
Total Non-Current Assets	4,178	4,254
Share of Total Assets	162,047	198,293
Current Liabilities		
Payables	-	-
Other Current Liabilities	36,782	81,137
Total Current Liabilities	36,782	81,137
Share of Total Liabilities	36,782	81,137
Net Assets	125,265	117,156
Reconciliation of jointly controlled assets:		
Share of funds at beginning of the reporting period	117,156	123,164
Contributions made in current reporting period	198,213	183,061
Share of current year Surplus/(Deficit)	(190,104)	(189,069)
Share of funds at end of reporting period	125,265	117,156
Operating Revenue		
GHA Revenue	85,469	47,209
Total Operating Revenue	85,469	47,209
Operating Expenses		
GHA Expenses	275,497	236,156
Total Operating Expenses	275,497	236,156
Capital Expenditure		
Depreciation	76	122
Total Capital Expenditure	76	122
Net Result	(190,104)	(189,069)

Note 24: Responsible Persons Disclosures

	Period	
Responsible Ministers:		
The Honourable David Davis, MLC, Minister for Health and Ageing	01/07/2013	30/06/2014
Governing Board:		
Mr. Neil Roussac (Chair) (appointed 2006)	01/07/2013	30/06/2014
Mrs. Megan Knight (appointed 2004)	01/07/2013	30/06/2014
Mr. Bill Fuller (appointed 2000)	01/07/2013	30/06/2014
Mrs. Mohya Davies (appointed 1986)	01/07/2013	30/06/2014
Mr. Clive White (appointed 1986)	01/07/2013	30/06/2014
Dr. Matthew Marriott (appointed 2009)	01/07/2013	30/06/2014
Mr. Bruce Lester (appointed 2010)	01/07/2013	30/06/2014
Mr. Paul Ahern (appointed 2011)	01/07/2013	30/06/2014
Mrs. Lisa Barham-Lomax (appointed 2012)	01/07/2013	30/06/2014
Mr. Jeffry White (appointed 2013, resigned 2014)	01/07/2013	28/02/2014
Ms. Bernadette Thomson (appointed 2013)	01/07/2013	30/06/2014
Accountable Officer		
Mr. Peter Rushen	01/07/2013	30/06/2014

	2014	**2013**
Remuneration of Responsible Persons		
The number of Responsible Persons are shown in their relevant income bands:		
Income Band		
$120,000 - $129,999	0	1
$140,000 - $149,999	1	0

Amounts relating to Responsible Ministers are reported in the financial statements of the Department of Premier and Cabinet.

There was no remuneration paid to any Board Member in respect of their role as a Board Member.

Other Transactions of Responsible Persons and their Related Parties.

Mrs. Mohya Davies as a partner in Foster Butchery was in receipt of payment for meat supplies provided to the Hospital and not for her role on the Board. The total paid to Foster Butchery for the period 1st July 2013 to 30th June 2014 was $12,911 (2013 $11,176)

Mr. Paul Ahern as a partner in Aherns Fruit Market was in receipt of payment for food supplies provided to the Hospital and not for his role on the Board. The total paid to Aherns Fruit Market for the period 1st July 2013 to 30th June 2014 was $8,541 (2013 $9,032)

There were no other transactions with responsible persons or their related parties.

Note 25: Executive Officer Disclosures

The numbers of executive officers, other than Ministers and Accountable Officers, due in 2013/14 remuneration during the reporting period are shown below.	2014	2013
The number of Executive Officers whose total remuneration exceeded $100,000 amounted to:	1	Nil

Note 26: Remuneration of Auditors

	2014 $	2014 $
Audit fees paid or payable to the Victorian Auditor- General's Office for audit of the Hospital's current financial report	20,000	18,900
	20,000	**18,900**

Note 27: Events Occurring After Reporting Date

There have been no events since balance date which have had a material effect on these financial statements (2013:Nil)

Note 28: Economic Dependency

South Gippsland Hospital is wholly dependent upon the continued financial support of the State Government and in particular, the Department of Health.

Note 29: Glossary of terms and style conventions

Actuarial gains or losses on superannuation defined benefit plans
Actuarial gains or losses reflect movements in the superannuation liability resulting from differences between the assumptions used to calculate the superannuation expense and actual experience.

Amortisation
Amortisation is the expense which results from the consumption, extraction or use over time of a non-produced physical or intangible asset.

Comprehensive result
The net result of all items of income and expense recognised for the period. It is the aggregate of operating result and other non-owner movements in equity.

Commitments
Commitments include those operating, capital and other outsourcing commitments arising from non-cancellable contractual or statutory sources.

Current grants
Amounts payable or receivable for current purposes for which no economic benefits of equal value are receivable or payable in return.

Depreciation
Depreciation is an expense that arises from the consumption through wear or time of a produced physical or intangible asset. This expense reduces the 'net result for the year'.

Effective interest method
The effective interest method is used to calculate the amortised cost of a financial asset or liability and of allocating interest income over the relevant period. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial instrument, or, where appropriate, a shorter period

Employee benefits expenses
Employee benefits expenses include all costs related to employment including wages and salaries, fringe benefits tax, leave entitlements, redundancy payments, defined benefits superannuation plans, and defined contribution superannuation plans.

Ex gratia payments
Ex gratia payment is the gratuitous payment of money where no legal obligation exists.

Financial asset
A financial asset is any asset that is:
(a) cash;
(b) an equity instrument of another entity;
(c) a contractual or statutory right:
- to receive cash or another financial asset from another entity; or
- to exchange financial assets or financial liabilities with another entity under conditions that are potentially favourable to the entity; or

(d) a contract that will or may be settled in the entity's own equity instruments and is:
- a non-derivative for which the entity is or may be obliged to receive a variable number of the entity's own equity instruments; or
- a derivative that will or may be settled other than by the exchange of a fixed amount of cash or another financial asset for a fixed number of the entity's own equity instruments.

Financial instrument
A financial instrument is any contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Financial assets or liabilities that are not contractual (such as statutory receivables or payables that arise as a result of statutory requirements imposed by governments) are not financial instruments.

Financial liability
A financial liability is any liability that is:
(a) A contractual obligation:
(i) to deliver cash or another financial asset to another entity; or
(ii) to exchange financial assets or financial liabilities with another entity under conditions that are potentially unfavourable to the entity; or
(b) A contract that will or may be settled in the entity's own equity instruments and is:
(i) a non-derivative for which the entity is or may be obliged to deliver a variable number of the entity's own equity instruments; or
(ii) a derivative that will or may be settled other than by the exchange of a fixed amount of cash or another financial asset for a fixed number of the entity's own equity instruments. For this purpose the entity's own equity instruments do not include instruments that are themselves contracts for the future receipt or delivery of the entity's own equity instruments.

Financial statements
Depending on the context of the sentence where the term 'financial statements' is used, it may include only the main financial statements (i.e. comprehensive operating statement, balance sheet, cash flow statements, and statement of changes in equity); or it may also be used to replace the old term 'financial report' under the revised AASB 101 (September 2007), which means it may include the main financial statements and the notes.

Grants and other transfers
Transactions in which one unit provides goods, services, assets (or extinguishes a liability) or labour to another unit without receiving approximately equal value in return. Grants can either be operating or capital in nature.

While grants to governments may result in the provision of some goods or services to the transferor, they do not give the transferor a claim to receive directly benefits of approximately equal value. For this reason, grants are referred to by the AASB as involuntary transfers and are termed non-reciprocal transfers. Receipt and sacrifice of approximately equal value may occur, but only by coincidence. For example, governments are not obliged to provide commensurate benefits, in the form of goods or services, to particular taxpayers in return for their taxes. Grants can be paid as general purpose grants which refer to grants that are not subject to conditions regarding their use. Alternatively, they may be paid as specific purpose grants which are paid for a particular purpose and/or have conditions attached regarding their use.

General government sector
The general government sector comprises all government departments, offices and other bodies engaged in providing services free of charge or at prices significantly below their cost of production. General government services include those which are mainly non-market in nature, those which are largely for collective consumption by the community and those which involve the transfer or redistribution of income. These services are financed mainly through taxes, or other compulsory levies and user charges.

Intangible produced assets
Refer to produced assets in this glossary.

Intangible non-produced assets
Refer to non-produced asset in this glossary.

Interest expense
Costs incurred in connection with the borrowing of funds includes interest on bank overdrafts and short-term and long-term liabilities, amortisation of discounts or premiums relating to liabilities, interest component of finance leases repayments, and the increase in financial liabilities and non-employee provisions due to the unwinding of discounts to reflect the passage of time.

Interest income
Interest income includes unwinding over time of discounts on financial assets and interest received on bank term deposits and other investments.

Liabilities
Liabilities refers to interest-bearing liabilities mainly raised from public liabilities raised through the Treasury Corporation of Victoria, finance leases and other interest-bearing arrangements. Liabilities also include non-interest-bearing advances from government that are acquired for policy purposes.

Net result
Net result is a measure of financial performance of the operations for the period. It is the net result of items of income, gains and expenses (including losses) recognised for the period, excluding those that are classified as 'other comprehensive income'. Net result from transactions/net operating balance Net result from transactions or net operating balance is a key fiscal aggregate and is income from transactions minus expenses from transactions. It is a summary measure of the ongoing sustainability of operations. It excludes gains and losses resulting from changes in price levels and other changes in the volume of assets.

Net worth
Assets less liabilities, which is an economic measure of wealth.

Non-financial assets
Non-financial assets are all assets that are not 'financial assets'. It includes inventories, land, buildings, infrastructure, road networks, land under roads, plant and equipment, investment properties, cultural and heritage assets, intangible and biological assets.

Payables
Includes short and long term trade debt and accounts payable, grants, taxes and interest payable.

Produced assets
Produced assets include buildings, plant and equipment, inventories, cultivated assets and certain intangible assets. Intangible produced assets may include computer software, motion picture films, and research and development costs (which does not include the start up costs associated with capital projects).

Receivables
Includes amounts owing from government through appropriation receivable, short and long term trade credit and accounts receivable, accrued investment income, grants, taxes and interest receivable.

Sales of goods and services
Refers to income from the direct provision of goods and services and includes fees and charges for services rendered, sales of goods and services, fees from regulatory services and work done as an agent for private enterprises. It also includes rental income under operating leases and on
produced assets such as buildings and entertainment, but excludes rent income from the use of non-produced assets such as land. User charges includes sale of goods and services income.

Supplies and services
Supplies and services generally represent cost of goods sold and the day-to-day running costs, including maintenance costs, incurred in the normal operations of the Department.