South Gippsland Hospital

Trust. Excellence. Accountability. Mutual respect.

Annual Report

2016-2017

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Overview

Establishment & Relevant Ministers

South Gippsland Hospital, 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 inpatient maternity suite and two day procedure beds, a maternity suite, 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. 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. 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.

South Gippsland Hospital is a Public Hospital and is an incorporated body listed under Schedule 1 of the *Health Services Act* 1988.

During the reporting period the responsible ministers were:

- The Honourable Jill Hennessy MLA, Minister for Health, Minister for Ambulance Services
- Martin Foley MLA, Minister for Housing, Disability and Ageing, Minister for Mental Health

Vision, Mission, Strategic Directions and Values

Vision

South Gippsland Hospital will demonstrate excellence in community focused rural healthcare

Mission

To deliver the highest quality health care services that are equitable and accessible to all; that meets the current and changing needs of our community; and collaborate with our strategic partners to provide innovative models of care that reflect best practice.

Strategic Directions

- Develop a health service which is responsive to community needs
- Improving status of our community's health status and health experiences
- Expanding our workforce and build system capacity
- Increase financial sustainability and productivity
- Implementing improvement and innovation
- Increase accountability and transparency

Core Values

- Trust: We act with integrity and can rely on each other.
- Excellence: We do our best at all times and look for ways to improve.
- Accountability: We accept responsibility for our actions, attitudes, and actions.
- Mutual respect: We treat others the way we want to be treated.

Overview (continued)

Overview of Services

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 has approximately 5600 people.

The Hospital offers services on an in -patient basis, outreach clinics, through its Community Health Centre and in -home care.

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

Continuing Care 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

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 2016.

Eric Neil Roussac – Chair, Board of Management 2016-2017

Overview (continued)

Chair's Report

This year, as with last year and probably most preceding years, produced its share of highs and lows. The financial and operational performances of the hospital will be dealt with elsewhere in this annual report.

From a Board perspective, perhaps the most significant event to occur this year - one with potentially far-reaching consequences for SGH - was the appointment by DHHS of a consultant to develop a service plan for our sub-region.

The sub-regional health services are Bass Coast Health in Wonthaggi, Gippsland Southern Health Service in Leongatha and Korumburra, and SGH. Service planning within the sub-region has a long antecedence, going back at least ten years to the South Coast Area-Based Plan report.

The latest report identified a low level of self-sufficiency within the south coast area, indicating that much of the service demand from within the sub-region is not being met locally. From our Board's perspective the way ahead is clear: build up the capability of the larger services to capture leakage out of the area, and improve co-operation between services to retain patients within the sub-region. The role of a 'small rural' like SGH will be to provide a range of less complex acute care and a wider range of community based care for our local community.

Throughout the consultation phase, the SGH Board concentrated its effort on ensuring any draft report focused more on expansion and capability-building than redistribution of services within the sub-region. After considerable discussion at both Board and Executive levels, a report was produced and agreed to by the three health services. It will be a challenge to the Boards and Executives of all three services to achieve the outcomes detailed in the plan.

A second significant initiative was the appointment of external consultants Dr Rupert Sherwood and Susan Gannon to report to the Board on the maternity service offered at SGH. The last external maternity review was conducted in 2011. The Board needed assurance that our maternity service was both safe and of the highest quality, particularly in view of the events that led to the recent Duckett Report. Sherwood and Gannon in their overall assessment six years later were able to report that:

"The Board, Executive, staff and the community have more than risen to - and met - the challenges of providing a safe, high-quality, consumer-focused service for the region that depends on SGH for antenatal and birthing services."

While the Board is pleased to have this assurance, it is also conscious that continuous effort is required to ensure maintenance and improvement of all services, including maternity.

In January of this year, Chris Trotman, who comes from a health and community services background and has considerable board experience, was appointed to the position of CEO. Chris succeeded Peter Rushen, who had been at SGH for six years.

On behalf of the hospital and wider community, I would like to thank Peter for his contribution and wish both him and Liz well for the future. The transition to a new CEO can be a time of uncertainty for any organisation, so it is pleasing to see the ease with which Chris has settled into the CEO role and become part of the hospital community.

Chair's Report cont.

Cont...

Board Membership Changes

2016 saw the departure of Mohya Davies and the appointment of Graeme Baxter, who brings with him a depth of public sector administrative experience. Mohya joined the Board in 1986, and over the intervening 30 years has made an enormous contribution to SGH. On behalf of the Board, I would like to thank Mohya and welcome Graeme.

Acknowledgements

No Chair's report would be complete without an expression of appreciation for the contribution made by so many to the operation of the hospital. In no particular order, I would like to thank:

Our executive staff: CEO Chris Trotman, DON Anna Stefani, DoCH Samantha Park and DMS Craig Winter;

The staff for their dedication and the quality of care provided;
All our contractors, particularly the Foster Medical Group and South Gippsland Radiology;

The Corner Inlet community and beyond for its support as volunteers and donors, both as individuals and through service organisations;

The members of the Hospital Auxiliary, who, as they have over a long period of time, worked tirelessly and productively, raising a considerable amount of money for the purchase of hospital equipment;

The members of the Board, for their dedication and hard work in support of the Hospital. Here I must also include David Pollard and Rod Lomax, independent members of the Audit and Risk Management Committee.

Thanks also to Ralph Gallagher, who resigned as an independent member of the ARM Committee during the year;

The members and the Board of Prom Country Aged Care for the spirit of co -operation and support given to SGH throughout the year.

Looking Forward

Mention has been made earlier in this report of the sub-regional service plan: this will be of continuing interest to both the Board and the Executive into the future.

Another change that is likely to have an impact on Board composition - and consequently Board function - is the emphasis now being placed on skills mix within boards. In small rural communities particularly, the range of skills available does not always meet requirements. The solution - importing skills to fill identified gaps - has the potential for local representation to be supplemented by specialised expertise.

This will be my last Chair's report, so I'd like to take this opportunity to thank community members, staff members and Board members, both past and present, for their help and consideration over the last four years.

Neil Roussac

Overview (continued)

CEO's Report

When I joined the team at South Gippsland Hospital in January 2017, I was impressed by the high quality of service delivery throughout the organisation in both clinical and non -clinical areas. My sincere thanks go to my predecessor, Peter Rushen. When he retired, he left a strong organisation with highly skilled and professional staff – which made my job easier!

Key performance indicators. Our Quality and Safety indicators met or exceeded the targets set by the Department of Health and Human Services again this year. In particular, our results for patient experience and patient safety culture were well above targets, indicating that both in-patients and out-patients have a high quality and safe experience when receiving services at SGH. While the health service met most of our key performance indicators, the financial result showed an operating deficit of over $64,000 – due largely to higher than usual employee sick leave and the clearing of some accounts for projects that will not be proceeding. We also scored very highly in the accreditation surveillance audit in March this year and numerous internal and external audits in clinical areas and corporate services.
SGH successfully achieved deliverables for our Statement of Priorities. Key areas include improved practice in End of Life Care, Foetal Surveillance, Health Promotion and Mental Health. We also commenced Telehealth consultations, in partnership with our Regional Hospital, to assist in patient care after hours.

Our work with other Gippsland hospitals. As mentioned in the Chair's Report, the South Gippsland Coast Clinical Services plan development progressed this year and was endorsed by the Boards of the three hospitals – SGH, Gippsland Southern Health Service and Bass Coast Health. The consultant's report identified the need for SGH to continue offering all current services, including surgery and obstetrics. It also showed a number of clinical areas where SGH is currently not satisfying local demand. Historically, our level of self-sufficiency is 45% - which means 55% of people in our catchment are travelling out of the area for health services. Ideally SGH should aim for a self-sufficiency rate of nearer to 75%. While implementation of the plan is yet to commence, we have examined areas in which we can improve our efficiency and increase self-sufficiency, within our current funding model. Notably, an improvement to our theatre facilities will enable more surgical procedures to be conducted in each theatre list. SGH will apply for funding for this purpose in the next round of capital works funding. In the meantime, the CEO's of the three hospitals continue to work together to improve the available services for the South Gippsland Coast catchment.
In addition, SGH has become a member of the newly-formed Rural and Regional partnership which links us closely with all the public hospitals in Gippsland, including Latrobe Regional Hospital. This partnership ensures consistency of practice and improves clinical pathways across the region.
A number of projects are underway which will improve our collective clinical governance, increase our access to skilled medical specialists and provide cost-saving opportunities.

Community Support. We appreciate the support of many organisations and individuals for their financial and in-kind support. The tireless work from the members of the SGH Auxiliary enabled the purchase of many essential items including a podiatry chair, ECG machine, and a significant contribution to the purchase of new endoscopes. We have also been supported by the SGH Community Foundation, Foster Rotary Club, Foster RSL, the Toora and District Community Bank, Esso Australia, the Mirror newspaper and the many people in our community who supported the Murray to Moyne Event and donated to the Annual Appeal. Your assistance to our hospital enables us to provide additional services to our local community.

My thanks go to all staff of SGH for their professional attitude to their work and their commitment to our patients. Our community can be confident of excellent quality of care and kindness from staff, when they need to access our health service Special thanks to the Management Executive Group and Executive Assistant for their assistance and patience in my first six months in the role.

Finally, I wish to thank the Board for their support and guidance this year. The local community is privileged to have such passionate and skilled volunteers on the Board of their local health service.

Chris Trotman

Governance and Management

Board of Governance

The Board oversees the strategic direction and management of South Gippsland Hospital and ensures that all services provided are consistent with the health service's by-laws, the *Health Services Act 1998* and any applicable Victorian and Commonwealth legislation.

Board Members

(as at 30 June 2017)

Neil Roussac, B.Sc , **President**
appointed 2006

Susan Pilkington, Vice President
appointed 2014

Iain Vernon, BBS, MBA, Dip.BA, CPA**, Treasurer**
appointed 2015

Clive White, B.Juris, LL.B
appointed 1986

Matthew Marriott, BVSc (Hons)
appointed 2009

Bruce Lester
appointed 2010

Paul Ahern
appointed 2011

Lisa Barham-Lomax, B.Ed. Grad. Dip. Leadership and O.D, Exec Masters in Public Administration
appointed 2012

Janyce Bull
appointed 2014

Dr Priscilla Robinson, PhD, MPH, MHSc (PHP)
appointed 2014

Graeme Baxter, MoE, Dip.Bus, Dip.Tourism
appointed 2016

Dr Peter Longmore, MB.BS (Monash), MRACOG, FRANZCOG, Grad. Dip Health Econ. (USyd), Master Health Serv. Management (Monash), Aust. Cert. Aviation Med. (Monash), DAME, AFRACMA, CertH.P. Educ. (USQ)
appointed 2017

Audit and Risk Management Committee

(as at 30 June 2017)

Susan Pilkington

Matthew Marriott

Bruce Lester

Neil Roussac

Ralph Gallagher (Independent member resigned 30 November 2016)

Rod Lomax (Independent Member)

Executive Management

(as at 30 June 2017)

Chief Executive Officer
Chris Trotman
MoE, B.Bus (Acc), Grad Dip Ed (Health), Cert Gen Nursing (Div1), GAICD

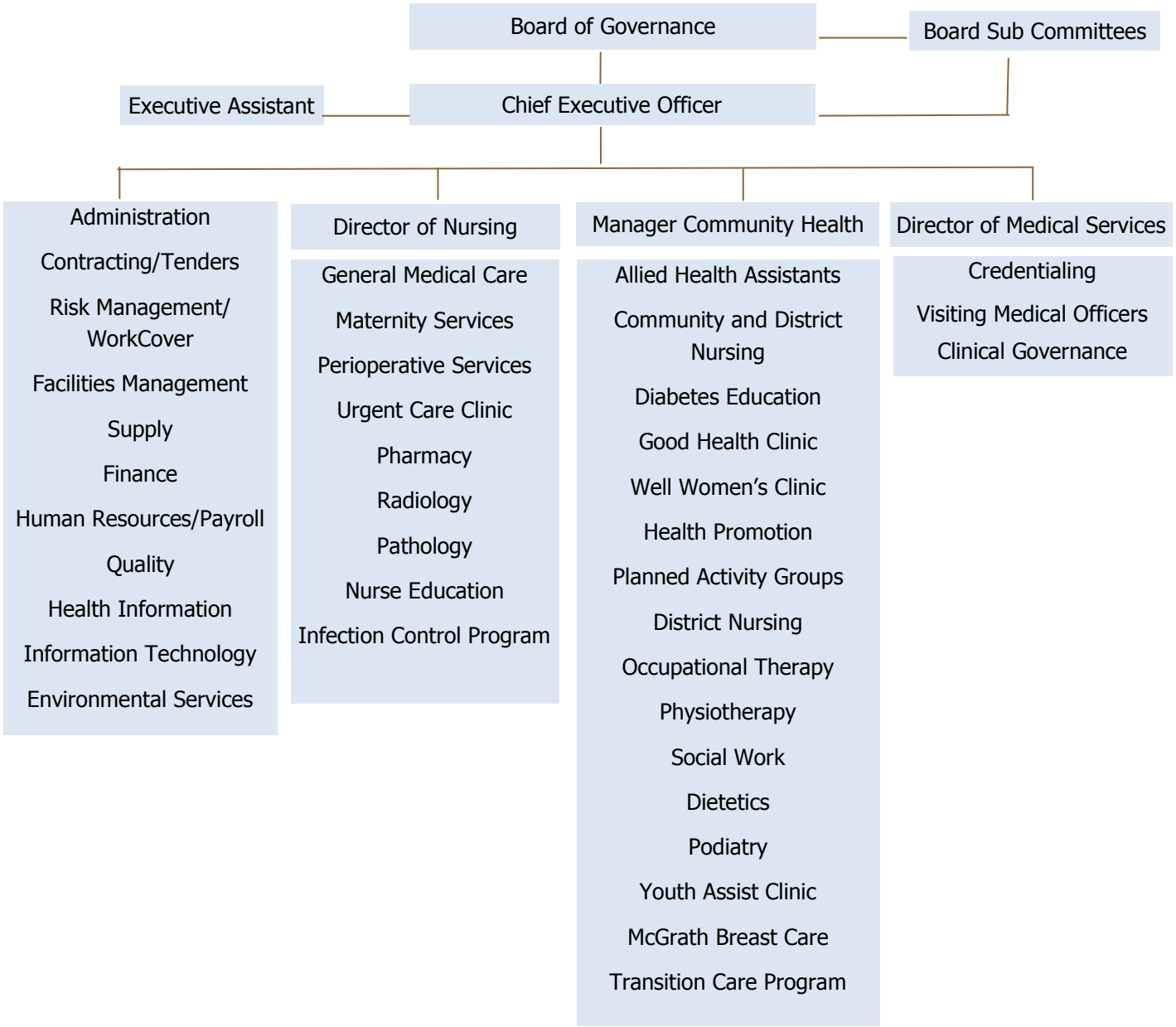
Director of Medical Services
Dr Craig Winter, MB.BS, MBA, GMA, FACEM

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

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

Governance and Management (continued)

Organisational structure



Report of Operations

Statement of priorities Part A – Strategic Priorities

The Victorian Government's priorities and policy directions are outlined in the *Victorian Health Priorities Framework 2012–2022*. In 2016.2017South Gippsland Hospital will contribute to the achievement of these priorities by:

Domain	Action	Deliverables	Outcomes
Quality and safety	Implement systems and processes to recognise and support person-centred end of life care in all settings, with a focus on providing support for people who chose to die at home.	South Gippsland Hospital will implement current best practice end of life management principles in line with the Victorian End of Life and Palliative Care Framework. South Gippsland Hospital will partner with Latrobe Regional Hospital as the new regionally based specialist palliative care service commences in South Gippsland from January 2017 to support person centred care for the community.	Victorian End of Life Program resources have been developed in line with the framework by the Regional Palliative Care Consortia, led by Latrobe Regional Hospital (LRH) with contributions from the SGH Director of Nursing (DON). Implementation is in progress. SGH has partnered with LRH to facilitate credentialing of medical specialists from LRH to provide service to SGH palliative care clients. These medical specialists are now working with the doctors from Foster Medical Centre (FMC) to support person-centred care for our community.
	Advance care planning is included as a parameter in an assessment of outcomes including: mortality and morbidity review reports, patient experience, and routine data collection.	South Gippsland Hospital will conduct documentation audits for the presence of Advance Care Plans in medical records.	All deaths are reviewed iin line with the SGH Mortality and Morbidity policy. All expected deaths and Advance Care Plans (ACP) are reviewed and comments included in Riskman quality entry.
	Progress implementation of a whole-of-hospital model for responding to family violence	South Gippsland Hospital will adopt the principles outlined in the Women's Hospital Strengthening Hospital Responses to Family Violence (SHRFV) toolkit and resources for clinical staff to strengthen knowledge and awareness of family violence in hospital and community services.	SGH is working in partnership with Bass Coast Health (BCH) and Gippsland Southern Health Service (GSHS) to implement the SHRFV toolkit in a sub-regional model. While there has been a delay in the release of the toolkit, policy updates have been

Part A – Strategic Priorities cont.

Domain	Action	Deliverables	Outcomes
Quality and safety			undertaken locally and full implementation will be completed in the next 12 months.
	Develop a regional leadership culture that fosters multidisciplinary and multi organisational collaboration to promote learning and the provision of safe, quality care across rural and regional Victoria.	South Gippsland Hospital will actively participate in the development of and implementation of the South Gippsland Coast - South Gippsland Health Services Plan in partnership with Bass Coast Health, Gippsland Southern Health Service and Latrobe Regional Hospital. South Gippsland Hospital maternity staff will participate on the regional Perinatal Mortality and Morbidity Committee.	SGH has worked in partnership with BCH and GSHS to finalise the South Gippsland Coast Clinical Services Plan, which has been endorsed by the SGH Board. The CEOs of the three hospitals have developed an implementation plan. SGH DON has participated on the regional Perinatal Mortality and Morbidity Committee.
	Establish a foetal surveillance competency policy and associated procedures for all staff providing maternity care that includes the minimum training requirements, safe staffing arrangements and ongoing compliance monitoring arrangements.	South Gippsland Hospital aim to achieve a 90% level of compliance for all clinical workforce associated with maternity care including midwifes and GP obstetricians. The policy outlines the expectation that each clinician attends Foetal Surveillance Education Program full day training every three years with annual update or online training undertaken.	SGH received a grant of $10,000 in January 2017 to develop this policy. A clinical midwife consultant was engaged and provided: • Audit of 30 histories • Review of cardiotocography (CTG) current practice • Development of policy • Implementation of policy • Evaluation of policy • Recommendations and action plan on workforce development. Ongoing staff training in compliance requirements will be embedded in the next 12 months.

Part A – Strategic Priorities cont.

Domain	Action	Deliverables	Outcomes
	Use patient feedback, including the Victorian Healthcare Experience Survey to drive improved health outcomes and experiences through a strong focus on person and family centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first.	Victorian Health Experience Survey data utilised along with the consumer representatives on Quality Systems Review Committee to identify improvement opportunities and monitor implementation.	Currently VHES data is reported to the Board Clinical Governance and Quality Committee (CGQC) and Management Executive Group (MEG) to identify improvement opportunities. Consumer representation and consultation process has been assessed and a consumer representation on the Quality Systems Review Committee is in place.
Access and timeliness	Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine).	Complete Bettercare Victoria business plan in conjunction with Gippsland Southern Health Service, Yarram and District Health Service and Latrobe Regional Hospital for the introduction of a tele-health program for after-hours urgent care consultation. South Gippsland Hospital will develop and implement a public education/information strategy to ensure effective use of urgent care to reduce the number of primary care type presentations.	SGH Telehealth program commenced in June 2017 which has facilitated enhanced out of hours health care available to the local community. A strategic media campaign of the changes to after-hours services in Urgent Care Centre (UCC) was implemented and has resulted in increased community understanding of the services available.
	Develop and implement a strategy to ensure the preparedness of the organisation for the NDIS and HACC transition and reform, with particular consideration to service access, service expectations, workforce and financial management.	Review the 'South Gippsland Options and Pathways for transition of HACC services' 2016 report.	SGH reviewed the HACC options and determined it was not feasible for SGH to be a sole provider of these services. South Gippsland Shire HACC services are to be transferred to GSHS. SGH liaised with HACC providers in the catchment and will provide sub-contracted services.

Part A – Strategic Priorities cont.

Domain	Action	Deliverables	Outcomes
		Develop a '2017-2019 HACC Services Action Plan' to address service access, service expectations, workforce and financial management in consultation with Gippsland Southern Health Service and South Gippsland Shire Council by July 2017.	SGH has also investigated the service delivery options under the NDIS. The cost-benefit analysis showed that it is only feasible to provide a limited number of allied health services to NDIS clients at this time.
		Meet all requirements of both the Commonwealth Community Home Support Program requirements and Home and Community Care Program for Younger People over 2016/17.	Currently met.
		Appoint internal lead by December 2016 to champion the National Disability Insurance Scheme roll out from October 2017.	Not progressed as no longer required.
Supporting healthy populations	Health services support shared population health and wellbeing planning at a local level - aligning with the Local Government Municipal Public Health and Wellbeing plan and working with other local agencies and Primary Health Networks.	Participate in the planning cycle for the new 2017-21 South Gippsland Shire Public Health and Wellbeing Plan	The Health Promotion Officer (HPO) and the Director of Community Health (DCH) participated in the working group to develop the plan which is currently in draft.
		Align Integrated Health Promotion to the South Gippsland Shire Municipal Public Health and Wellbeing Plan	Work is currently underway in partnership with the South Coast Primary Care Partnership to finalise the 2017-2021 integrated health promotion plan. This plan will be closely aligned with both the South Gippsland Shire and Bass Coast Shire Municipal Public Health and Wellbeing Plans. The alignment of the integrated health promotion plan will be reviewed when the final plan is released.

Part A – Strategic Priorities cont.

Domain	Action	Deliverables	Outcomes
Supporting healthy populations	That health services focus on primary prevention, including suicide prevention activities, and aim to impact on large numbers of people in the places where they spend their time adopting a place based, whole of population approach to tackle the multiple risk factors of poor health.	South Gippsland Hospital to develop a policy to promote a wellness model via health promotion and service provision ideals within existing programs. E.g. Youth Assist Clinic. Implement Community Health programs, and a new population based approach to Health Promotion partnerships. Register for the Healthy Together Achievements Program and work with one external agency to reach recognition point 2 in two priority areas.	Two new policies have been developed to support a wellness model via health promotion and service provisions ideals—the Health and Wellbeing at SGH policy and the Health and Wellbeing Charter. Both these policies have been endorsed at Executive level. HPO has developed partnerships with 4 agencies—3 schools and Parks Victoria. SGH has achieved recognition in two priority areas (smoke free environment and healthy eating) in the Achievements program.
	Develop and implement strategies that encourage a culturally diverse environment such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.	Identify barriers to Cultural and Linguistically Diverse members accessing the health service. Work with the regional Diversity Advisor to engage community members to assist the health service to be more culturally sensitive and appropriate.	Catchment has very low CALD population. SGH has accessed some resources to promote access to SGH amongst this cohort. SGH Diversity Plan is completed and outlines key strategies to improve health outcomes for people from a CALD background.

Part A – Strategic Priorities cont.

Domain	Action	Deliverables	Outcomes
	Improve the health outcomes of Aboriginal and Torres Strait Islander people by establishing culturally safe practices which recognise and respect their cultural identities and safely meets their needs, expectations and rights.	To support local Aboriginal youth access the Youth Clinic the health service will; • ensure all staff and volunteers at the Youth Clinic complete cultural awareness training, and • complete a review of the clinic's resources and processes to ensure culturally appropriate. Work with regional Aboriginal Regional Development Officer to implement the Gippsland Aboriginal Health Cultural Competence Framework and Quality Improvement Tool	DCH and Aboriginal Regional Development Officer have developed a basic tool to audit our current position and identify areas for improvement. It was identified that there is a very low number of Aboriginal and Torres Strait Islander people in the catchment. After completing the audit, SGH scored in the category "*your organisation and practices have made a start and show potential to providing more inclusive care.* The next step is to complete the larger Cultural Competency Tool. DCH has made contact with the CEO of Rumyhuuck Morwell and is aiming to develop a referral pathway into this organisation.
	Drive improvements to Victoria's mental health system through focus and engagement in activity delivering on the 10 Year Plan for Mental Health and active input into consultations on the Design, Service and infrastructure Plan for Victoria's Clinical mental health system.	Develop stronger partnerships with Gippsland Primary Health Network, relevant referral agencies and higher level service providers for mental health assessment and care. Increased staff education to be provided in relation to mental health assessment and care.	SGH is further developing its strong relationship with GPHN as fund-holders for the ATAPS program which includes regular liaison meetings. SGH is continuing to manage GP referrals to external agencies including the ATAPS program. The SGH Youth Assist Clinic (YAC) has a role in intake, assessment and referrals.

Part A – Strategic Priorities cont.

Domain	Action	Deliverables	Outcomes
Governance and leadership	Using the Government's Rainbow eQuality Guide, identify and adopt 'actions for inclusive practices' and be more responsive to the health and wellbeing of lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals and communities.	Undertake a gap analysis against the Rainbow eQuality Guide and develop an Action Plan to address identified gaps.	The DCH has undertaken the gap analysis and the action plan is under development.
	Demonstrate implementation of the Victorian Clinical Governance Policy Framework: Governance for the provision of safe, quality healthcare at each level of the organisation, with clearly documented and understood roles and responsibilities. Ensure effective integrated systems, processes, leadership are in place to support the provision of safe, quality, accountable and person centred healthcare. It is an expectation that health services implement to best meet their employees' and community's needs, and that clinical governance arrangements undergo frequent and formal review, evaluation and amendment to drive continuous improvement.	Review South Gippsland Hospital's Clinical Governance Framework against the revised Victorian Clinical Governance Framework when released to ensure the health service's systems and process align with the revised framework.	Since the release of the Victorian Clinical Governance Framework in June 2017, a review has commenced and clear clinical governance roles and responsibilities are being embedded in the revised organisational quality management system.

Part A – Strategic Priorities cont.

Domain	Action	Deliverables	Outcomes
	Contribute to the development and implementation of Local Region Action Plans under the series of statewide design, service and infrastructure plans being progressively released from 2016-17. This will require partnerships and active collaboration across regions to ensure plans meet both regional and local service needs.	South Gippsland Hospital will continue to actively contribute and implement the outcomes of the Gippsland Maternity Services Implementation Working Party.	The DON and Acute Care Manager (ACM) are members of the Regional Maternity Working Group and have contributed to the development of the following policies: • Regional BMI policy • Referral Pathway policy
	Ensure that an anti-bullying and harassment policy exists and includes the identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal and the policy specifies a regular review schedule.	Implement South Gippsland Hospital policies and procedures and undertake necessary training to ensure appropriate management of bullying and harassment.	SGH online learning platform eREHSEN has been extended to include this learning module as part of the mandatory training for all SGH staff. Awareness and understanding has increased as a result of external facilitation of a team workshop and the work of a project team in the Clinician to Manager course.
	Board and senior management ensure that an organisational wide occupational health and safety risk management approach is in place which includes: A focus on prevention and the strategies used to manage risks, including the regular review of these controls; and Strategies to improve reporting of OHS incidents, risks and controls, with a particular focus on prevention of occupational violence and bullying and harassment, throughout all levels of the organisation, including to the board;	Ensure the South Gippsland Hospital Risk Management Framework reflects the organisational commitment to risk control and reporting and to occupational health and safety management focusing on prevention. Implement recommendations of an independent safety audit to reduce the risk of and prevent occupational violence.	Risk Management Framework reviewed. Implementation in progress. A second submission to the health Service Violence Prevention Fund has been lodged.

Part A – Strategic Priorities cont.

Domain	Action	Deliverables	Outcomes
	and mechanisms for consulting with, debriefing and communicating with all staff regarding outcomes of investigations and controls following occupational violence and bullying and harassment incidents.	Regular reporting all quality and safety to staff.	Quality Co-ordinator regularly reports all quality and safety issues to staff through scheduled meetings and monthly quality reports in staff newsletters and refers to Executive for follow-up where necessary.
	Implement and monitor workforce plans that: improve industrial relations; promote a learning culture; align with the Best Practice Clinical Learning Environment Framework; promote effective succession planning; increase employment opportunities for Aboriginal and Torres Strait Islander people; ensure the workforce is appropriately qualified and skilled; and support the delivery of high- quality and safe person-centred care.	Implement a training plan to enhance leadership skills throughout the organisation to provide for succession planning.	BPCLE indicators have been reported. Professional supervision has been introduced at Executive level and will be extended throughout the organisation. Four managers have self-funded a six-month leadership course via the Academy of Clinical Leadership.
	Create a workforce culture that: includes staff in decision making; promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and includes consumers and the community.	Ensure mechanisms for communication with staff through team meetings, newsletter. All staff performance reviews to encourage the maintenance of a strong and committed workplace culture to embed the South Gippsland Hospital values.	Monthly staff newsletters are well received by staff and viewed as an important communication tool. All work areas hold regular team meetings with open discussion to enable staff input into decision-making. An external consultant worked with one work group to develop the workforce culture with good outcomes. SGH values are embedded in the performance review process. The SGH performance review form has been reviewed by the Executive and the improved format is in draft form.

Part A – Strategic Priorities cont.

Domain	Action	Deliverables	Outcomes
		Develop and implement a leadership program for team leaders and supervisors to be conducted over the next 12 months.	Four managers have self-funded a six-month leadership course with the Academy of Clinical Leadership.
	Ensure that the Victorian Child Safe Standards are embedded in everyday thinking and practice to better protect children from abuse, which includes the implementation of: strategies to embed an organisational culture of child safety; a code of conduct that establishes clear expectations for appropriate behaviour with children; screening, supervision, training and other human resources practices that reduce the risk of child abuse; processes for responding to and reporting suspected abuse to children; strategies to identify and reduce or remove the risk of abuse and strategies to promote the participation and empowerment of children.	South Gippsland Hospital will undertake an audit of its processes and staff awareness of the South Gippsland Hospital policies related to the Child Safe Standards.	Policies have been developed and staff awareness program implemented. This includes discussion at recruitment, orientation and at performance reviews.
	Implement policies and procedures to ensure clinical staff have access to vaccination programs and are appropriately vaccinated and/or immunised to protect staff and prevent the transmission of infection to susceptible patients or people in their care.	Ensure all South Gippsland Hospital clinical staff has access to the Influenza vaccination whilst maternity staff also has access to Boostrix vaccination.	Excellent 2016 influenza immunisation result (SRHS monitor shows 97%).
Financial sustainability	Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	Adhere to the high standards of financial management to ensure the viability of the health service within the agreed budget.	Final budget position is almost unchanged from the first half year. Budget preparation for FY18 addressing subsidised programs.

Part A – Strategic Priorities cont.

Domain	Action	Deliverables	Outcomes
	Actively contribute to the development of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measureable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling.	Continue to seek opportunities to implement low carbon opportunities with key annual target.	Post operative theatre team commenced local recycling program and commenced participation in recycling 'little blue towels'. Facilities team has driven efficiencies in waste management and environmental sustainability.

Report of Operations (continued)

Statement of priorities - Part B: Performance priorities

The *Victorian health agency monitoring and intervention* describes the Department of Health and Human Services' approach to monitoring and assessing the performance of health agencies and detecting, actively responding and intervening in relation to performance concerns and risk. This document aligns with the measuring and monitoring element of the *Victorian health services performance framework*.

Changes to the key performance measures in 2016-17 strengthen the focus on quality and safety, in particular maternity and newborn, and access and timeliness in line with ministerial and departmental priorities.

Further information is available at https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability

Quality and safety

Key performance indicator	Target	2016-2017 Result
Accreditation		
Compliance with NSQHS Standards accreditation	Full compliance	Full compliance
Cleaning Standards		
Overall compliance with standards	Full compliance	Achieved
Very high risk (Category A)	90 points	Achieved
High risk (Category B)	85 points	Achieved
Moderate risk (Category C)	85 points	Achieved
Infection prevention and control		
Submission of infection surveillance data to VICNISS1	Full compliance	Full compliance
Compliance with the Hand Hygiene Australia program	80%	Achieved
Percentage of healthcare workers immunised for influenza	75%	Achieved
Patient experience		
Victorian Healthcare Experience Survey - data submission	Full compliance	Full compliance
Victorian Healthcare Experience Survey – patient experience Q1	95% positive experience	Full compliance*
Victorian Healthcare Experience Survey—patient experience Q2	95% positive experience	96% achieved
Victorian Healthcare Experience Survey—patient experience Q3	95% positive experience	Full Compliance*
Victorian Healthcare Experience Survey –discharge care Q1	75% very positive response	Full compliance*
Victorian Healthcare Experience Survey – discharge care Q2	75% very positive response	94% achieved
Victorian healthcare Experience Survey –discharge care Q3	75% very positive response	Full compliance*

* Less than 42 responses were received for the period due to relative size of the Health Service

Statement of priorities - Part B: Performance priorities (cont)

Quality and safety

Key performance indicator	Target	2016-2017 Result
Maternity and newborn		
Percentage of women with prearranged postnatal home care	100%	100%
Rate of singleton term infants without birth anomalies with APGAR score <7 to 5 minutes	≤1.6%	1%
Rate of severe fetal growth restriction in singleton pregnancy undelivered by 40 weeks	≤28.6%	0%
Perinatal Service Performance Indicator (PSPI) reports should be consulted for a description on the utility and business rules for these indicators. Note that data for 2016 and 2017 is provisional.		

Governance and leadership

Key performance indicator	Target	Actual
People Matter Survey - percentage of staff with a positive response to safety culture questions	80%	96%

Financial sustainability

Key performance indicator	Target	Actual
Finance		
Operating result ($m)	0.00	-0.05
Trade creditors	60 days	46
Patient fee debtors	60 days	74
Adjusted current asset ratio	0.7	1.4
Number of days with available cash	14 days	81.3
Asset management		
Basic asset management plan	Full compliance	Full compliance

Report of Operations (continued)

Statement of priorities - Part C: Activity and Funding

The performance and financial framework within which state government-funded organisations operate is described in 'Volume 2: Health operations 2016-17' of the Department of Health and Human Services' *Policy and funding guidelines.*

The *Policy and funding guidelines* are available at https://www2.health.vic.gov.au/about/policy-and- funding-guidelines.

Funding type	Budget ($'000)	2016-2017 Activity Achievement
Small Rural		
Other specified funding	259	
Small Rural Acute	4956	
Small Rural HACC	45	628
Small Rural Primary Health	136	2486
Health Workforce	52	0
Total	**5448**	
Service		**Activity 2016-2017 (specify unit of activity ie. occasions of services/ hours of service etc)**
Acute bed days		3850
Births		49
Urgent Care Presentations		1980
Transition Care Program—residential bed hours		1122
Transition Care Program—home based bed hours		1239

Further information about the Department of Health and Human Services' approach to funding and price setting for specific clinical activities, and funding policy changes is also available at https://www2.health.vic.gov.au/hospitals-and-

Attestations

Attestation Ministerial Standing Direction 3.7.1. Risk Management Framework and Processes.

I, CHRIS TROTMAN, certify that South Gippsland Hospital has complied with Ministerial Direction 3.7.1 - Risk Management Framework and Processes. The South Gippsland Hospital Audit and Risk Management

Chris Trotman
Accountable Officer

Foster
2017

Attestation on Compliance with Health Purchasing Victoria (HPV) Health Purchasing Policies

I, CHRIS TROTMAN, certify that South Gippsland Hospital has put in place appropriate internal controls and processes to ensure that it has complied with all requirements set out in the *HPV Health Purchasing Policies* including mandatory HPV collective agreements as required by the *Health Services Act 1988* (Vic) and has critically reviewed these controls and processes during the year.

Chris Trotman
Accountable Officer

Foster
2017

Workforce

Workforce data

Labour Category	JUNE Current		JUNE YTD FTE	
	2016	2017	2016	2017
Nursing	27.9	31.56	29.2	31.17
Administration and Clerical	10.1	11.64	10.4	11.83
Medical Support	5.1	1.33	4.1	1.10
Hotel and Allied Services	8.8	10.27	10.0	10.29
Sessional Clinicians	0	0.05	0	0.07
Ancillary Staff (Allied Health)	3.9	6.39	4.8	5.22
Total	56.2	61.18	59.0	60.12

Occupational violence statistics

	2016-2017
WorkCover accepted claims with an occupational violence cause per 100 FTE	0
Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	0
Number of occupational violence incidents reported	0
Number of occupational violence incidents reported per 100 FTE	0
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	0

For the purposes of the above statistics the following definitions apply:

Occupational violence - any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment.

Incident – an event or circumstance that could have resulted in, or did result in, harm to an employee. Incidents of all severity rating must be included. Code Grey reporting is not included, however, if an incident occurs during the course of a planned or unplanned Code Grey, the incident must be included.

Accepted WorkCover claims – Accepted WorkCover claims that were lodged in 2016-17.

Lost time – is defined as greater than one day.

Injury, illness or condition – This includes all reported harm as a result of the incident, regardless of whether the employee required time off work or submitted a claim.

FTE figures required in the above table should be calculated consistent with the Workforce information FTE calculation (refer to page 16 of the Health Service Model Annual Report guidelines). These do not include contracted staff (e.g. Agency nurses, Fee-for-Service Visiting Medical Officers) who are not regarded as employees for this purpose. The above data should be consistent with the information provided in the Minimum Employee Data Set.

Workforce (continued)

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. South Gippsland Hospital staff are also expected to embrace and work in accordance with the Code of Conduct for Victorian Public Sector Employees.

Occupational health and safety

South Gippsland Hospital meets all certification performance indicators in relation to Occupational Health and Safety requirements. It maintains an Occupational Health and Safety framework to manage a safe work environment, roles and responsibilities, the OH&S Committee, incident management and return to work programs.

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 2016-2017 financial year.

Summary of Financial Results

Summary of operational and budgetary objectives

In 2016-2017, SGH achieved the targets established under the Statement of Priorities. The hospital recorded a deficit of $64,952 before capital purpose income and depreciation. Capital purpose income of $51,675 was received during the financial year with depreciation write-offs totalling $405,410.

Summary of factors affecting operations

The results for the year have been affected by the following:

- Additional government funding
- Negative variance in in-patient fees
- Higher than anticipated level of sick leave, despite 97% of staff having flu vaccinations
- Higher utility charges
- Clearing of accounts for projects that will no longer proceed

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.

Summary of financial results

	2017 $	2016 $	2015 $	2014 $	2013 $
Total Revenue	7,861,216	7,796,448	7,260,336	7,296,084	6,895,865
Total Expenses	7,926,168	8,024,174	7,898,864	7,480,281	6,960,739
Net Result for the Year	(195,495)	(227,726)	(638,528)	(184,197)	(64,874)
Net Increase in Asset Revaluation Reserve	-	-	-	561,624	-
Accumulated Surpluses (Accumulated Deficits)	79,352	274,847	502,572	1,141,100	1,325,297
Contributed Capital	3,086,756	3,086,756	3,086,756	3,086,756	3,086,756
Asset Revaluation Reserve	2,857,560	2,057,560	2,857,560	2,857,560	2,295,936
Total Equity	6,023,668	6,219,163	6,446,888	7,085,416	6,707,989
Total Assets	8,170,685	8,316,368	8,496,127	8,836,792	8,649,412
Total Liabilities	2,147,017	2,097,209	2,049,240	1,751,316	1,941,423
Net Assets	6,023,668	6,219,163	6,446,888	7,085,416	6,707,989

Other information and disclosures

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.

Freedom of Information

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 no requests under the Act in the reporting period.

Compliance with DataVic Access Policy

Consistent with the DataVic Access Policy issued by the Victorian Government in 2012, the information included in this Annual Report will be available at http://www.data.vic.gov.au/ in machine readable format.

Ex-gratia payments

There were no ex-gratia payments made in 2016-2017.

Consultancies

In 2016-2017 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.

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'.

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.

Building Act 1993

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

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.

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.

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.

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 Participation Act 2003

Freedom of Information Act 1982

Safe Patient Care Act 2015

Other information and disclosures (continued)

Availability of additional information (FRD 22H)

In compliance with the requirements of FRD 22H *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 South Gippsland Hospital 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 South Gippsland Hospital;

(e) Details of any major external reviews carried out on South Gippsland Hospital;

(f) Details of major research and development activities undertaken by South Gippsland Hospital that are not otherwise covered either in the Report of Operations or in a document that contains the financial statements and Report of Operations;

(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 South Gippsland Hospital 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 South Gippsland Hospital and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the Report of Operations;

(k) A list of major committees sponsored by South Gippsland Hospital the purposes of each committee and the extent to which those purposes have been achieved;

(l) Details of all consultancies and contractors including consultants/ contractors engaged, services provided, and expenditure committed for each engagement.

Other information and disclosures (continued)

Disclosure Index

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 Department's compliance with statutory disclosure requirements.

Legislation	Requirement	Page Reference
Ministerial Directions		
Report of Operations		
Charter and purpose		
FRD 22G	Manner of establishment and the relevant Ministers	2
FRD 22G	Purpose, functions, powers and duties	2
FRD 22G	Initiatives and key achievements	2
FRD 22G	Nature and range of services provided	3
Management and structure		
FRD 22G	Organisational structure	8
Financial and other information		
FRD 10A	Disclosure index	30
FRD 11A	Disclosure of ex-gratia expenses	28
FRD 21B	Responsible person and executive officer disclosures	FR 65
FRD 22G	Application and operation of *Protected Disclosure 2012*	28
FRD 22G	Application and operation of *Carers Recognition Act 2012*	28
FRD 22G	Application and operation of *Freedom of Information Act 1982*	28
FRD 22G	Compliance with building and maintenance provisions of *Building Act 1993*	28
FRD 22G	Details of consultancies over $10,000	28
FRD 22G	Details of consultancies under $10,000	28
FRD 22G	Employment and conduct principles	26
FRD 22H	Information and Communication Technology Expenditure	N/A
FRD 22G	Major changes or factors affecting performance	27
FRD 22G	Occupational health and safety	26
FRD 22G	Operational and budgetary objectives and performance against objectives	27
FRD 24C	Reporting of office-based environmental impacts	28
FRD 22G	Significant changes in financial position during the year	27
FRD 22G	Statement on National Competition Policy	28
FRD 22G	Subsequent events	27

Other information and disclosures (continued)

Disclosure Index cont.

Legislation	Requirement	Page Reference
FRD 22G	Summary of the financial results for the year	27
FRD 22G	Workforce Data Disclosures including a statement on the application of employment and conduct principles	25
FRD 25B	Victorian Industry Participation Policy disclosures	28
FRD 29A	Workforce Data disclosures	25
SD 3.4.13	Attestation on data integrity	24
FRD 103F	Non-Financial Physical Assets	FR26
FRD 110A	Cash flow Statements	FR8
FRD 112D	Defined Benefit Superannuation Obligations	FR21
SD 5.2.3	Declaration in report of operations	FR2
SD 3.7.1	Risk management framework and processes.	24
Other requirements under Standing Directions 5.2		
SD 5.2.2	Declaration in Financial statements	FR2
SD 5.2.1(a)	Compliance with Australian accounting standards and other authoritative pronouncements	FR10
SD 5.2.1(a)	Compliance with Ministerial Directions	FR10
Legislation		
Freedom of Information Act 1982		28
Protected Disclosure Act 2001		28
Carers Recognition Act 2012		28
Victorian Industry Participation Policy Act *2003*		28
Building Act 1993		28
Financial Management Act 1994		28
Safe Patient Care Act 2015		28

Financial Statements for the year ended 30 June 2017

Financial Statements for the year ended 30 June 2017

South Gippsland Hospital Board member's, accountable officer's and chief finance & accounting officer's declaration

The attached financial statements for South Gippsland Hospital have been prepared in accordance with Standing Directions 4.2 of the *Financial Management Act 1994,* applicable Financial Reporting Directions, Australian Accounting Standards including 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 accompanying notes, presents fairly the financial transactions during the year ended 30 June 2017 and the financial position of South Gippsland Hospital at 30 June 2017.

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.

Susan Pilkington
Board Member

Foster
31 August 2017

Chris Trotman
Accountable Officer

Foster
31 August 2017

Peter Tilley
Chief Finance & Accounting Officer

Foster
31 August 2017

Financial Statements for the year ended 30 June 2017

South Gippsland Hospital Board member's, accountable officer's and chief finance & accounting officer's declaration

The attached financial statements for South Gippsland Hospital have been prepared in accordance with Standing Directions 4.2 of the *Financial Management Act 1994,* applicable Financial Reporting Directions, Australian Accounting Standards including 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 accompanying notes, presents fairly the financial transactions during the year ended 30 June 2017 and the financial position of South Gippsland Hospital at 30 June 2017.

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.

Susan Pilkington
Board Member

Foster
31 August 2017

Chris Trotman
Accountable Officer

Foster
31 August 2017

Peter Tilley
Chief Finance & Accounting Officer

Foster
31 August 2017

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of South Gippsland Hospital

Opinion

I have audited the financial report of South Gippsland Hospital (the health service) which comprises the:

- balance sheet as at 30 June 2017
- comprehensive operating statement for the year then ended
- statement of changes in equity for the year then ended
- cash flow statement for the year then ended
- notes to the financial statements, including a summary of significant accounting policies
- board member's, accountable officer's and chief finance & accounting officer's declaration.

In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2017 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.

Basis for Opinion

I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. My responsibilities under the Act are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report.

My independence is established by the *Constitution Act 1975*. My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Australia. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code.

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

Board's responsibilities for the financial report

The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Financial Management Act 1994*, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error.

In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, and using the going concern basis of accounting unless it is inappropriate to do so.

Auditor's responsibilities for the audit of the financial report

As required by the *Audit Act 1994,* my responsibility is to express an opinion on the financial report based on the audit. My objectives for the audit are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

As part of an audit in accordance with the Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit 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 health service's internal control
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board
- conclude on the appropriateness of the Board's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the health service's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the health service to cease to continue as a going concern.
- evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

MELBOURNE
31 August 2017

Ron Mak
as delegate for the Auditor-General of Victoria

South Gippsland Hospital
Comprehensive Operating Statement
For the Year Ended 30 June 2017

	Note	2017	2016
Revenue from operating activities	2.1	7,619,703	7,467,315
Revenue from non-operating activities	2.1	241,513	184,752
Employee expenses	3.1	(5,692,359)	(5,393,172)
Non salary labour costs	3.1	(238,259)	(250,880)
Supplies and consumables	3.1	(460,988)	(422,618)
Other expenses	3.1	(1,534,562)	(1,508,929)
Net result before capital and specific items		**(64,952)**	**76,468**
Capital purpose income	2.1	270,778	236,204
Depreciation and Amortisation	4.4	(362,305)	(366,565)
Impairment of non-financial assets	3.1	(43,105)	-
Net Result after capital and specific items		**(199,584)**	**(53,893)**
Other economic flows included in net result			
Net gain/(loss) on non-financial assets	7.2	4,089	(173,833)
		4,089	**(173,833)**
Net result from continuing operations		**(195,495)**	**(227,726)**
NET RESULT FOR THE YEAR		**(195,495)**	**(227,726)**
Comprehensive result		**(195,495)**	**(227,726)**

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

South Gippsland Hospital
Balance Sheet
As at 30 June 2017

	Note	2017	2016
Current assets			
Cash and cash equivalents	6.1	530,484	317,792
Receivables	5.1	299,813	303,808
Investments and other financial assets	4.1	1,104,283	1,458,707
Inventories	5.2	72,822	73,113
Prepayments	5.4	10,250	-
Other assets	5.6	76,867	26,986
Total current assets		**2,094,519**	**2,180,406**
Non-current assets			
Receivables	5.1	433,297	377,605
Property, plant & equipment	4.3	5,642,869	5,814,443
Total non-current assets		**6,076,166**	**6,192,048**
TOTAL ASSETS		**8,170,685**	**8,372,454**
Current liabilities			
Payables	5.5	179,209	226,850
Provisions	3.2	1,710,197	1,648,884
Other current liabilities	5.3	34,887	31,570
Total current liabilities		**1,924,293**	**1,907,304**
Non-current liabilities			
Provisions	3.2	222,724	245,987
Total non-current liabilities		**222,724**	**245,987**
TOTAL LIABILITIES		**2,147,017**	**2,153,291**
NET ASSETS		**6,023,668**	**6,219,163**
EQUITY			
Property, plant & equipment revaluation surplus	8.1a	2,857,560	2,857,560
Contributed capital	8.1b	3,086,756	3,086,756
Accumulated surpluses/(deficits)	8.1c	79,352	274,847
TOTAL EQUITY	8.1c	**6,023,668**	**6,219,163**

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

South Gippsland Hospital
Statement of Changes in Equity
For the Year Ended 30 June 2017

	Note	Property, Plant & Equipment Revaluation Surplus	Contributions by Owners	Accumulated Surpluses/ (Deficits)	Total
Balance at 1 July 2015		**2,857,560**	**3,086,756**	**502,573**	**6,446,889**
Net result for the year		-	-	(227,726)	(227,726)
Balance at 30 June 2016		**2,857,560**	**3,086,756**	**274,847**	**6,219,163**
Net result for the year		-	-	(195,495)	(195,495)
Balance at 30 June 2017		**2,857,560**	**3,086,756**	**79,352**	**6,023,668**

South Gippsland Hospital
Cash Flow Statement
For the Year Ended 30 June 2017

	Note	2017	2016
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating grants from government		6,101,188	5,780,576
Capital grants from government		51,675	83,676
Patient and resident fees received		438,138	467,758
Donations and bequests received		162,106	100,282
GST received from/(paid to) ATO		143,095	161,501
Recoupment from private practice for use of hospital facilities		39,369	43,195
Interest received		44,241	49,744
Capital donations and bequests received		85,543	152,528
Other receipts		1,105,976	992,687
Total receipts		***8,171,331***	***7,831,947***
Employee expenses paid		(5,654,309)	(5,272,713)
Fees for Service of Medical Officers		(243,259)	(252,562)
Payments for supplies & consumables		(471,964)	(412,018)
Other payments		(1,799,464)	(1,610,162)
Total payments		***(8,168,996)***	***(7,547,455)***
NET CASH FLOW FROM/(USED IN) OPERATING ACTIVITIES	8.2	**2,335**	**284,492**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for non-financial assets		(275,859)	(204,464)
Proceeds from sale of non-financial assets		46,113	18,205
Proceeds from sale of investments		354,424	(13,569)
NET CASH FLOW FROM/(USED IN) INVESTING ACTIVITIES		**124,678**	**(199,828)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		**127,013**	**84,664**
Cash and cash equivalents at beginning of financial year		**234,175**	**149,511**
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.1	**361,188**	**234,175**

This Statement should be read in conjunction with the accompanying notes

Basis of presentation

These financial statements are presented in Australian dollars and the historical cost convention is used unless a different measurement basis is specifically disclosed in the note associated with the item measured on a different basis.

The accrual basis of accounting has been applied in the preparation of these financial statements whereby assets, liabilities, equity, income and expenses are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

Consistent with the requirements of AASB 1004 Contributions (that is contributed capital and its repayment) are treated as equity transactions and, therefore, do not form part of the income and expenses of the hospital.

Additions to net assets which have been designated as contributions by owners are recognised as contributed capital. Other transfers that are in the nature of contributions to or distributions by owners have also been designated as contributions by owners.

Transfers of net assets arising from administrative restructurings are treated as distributions to or contribution by owners. Transfer of net liabilities arising from administrative restructurings are treated as distribution to owners.

Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements made in the preparation of these financial statements are disclosed in the notes where amounts affected by those judgements are disclosed. 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.

Revisions to accounting estimates are recognised in the period in which the estimate is revised and also future periods that are affected by the revision. Judgements and assumptions made by management in applying the application of AASB that have significant effect on the financial statements and estimates are disclosed in the notes under the heading: 'Significant judgement or estimates'.

Note 1: Statement of Significant Accounting Policies

These annual financial statements represent the audited general purpose financial statements for South Gippsland Hospital ("the Health Service") for the period ending 30 June 2017. The report provides 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 31 August 2016.

[b] 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.

[c] 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 2017, and the comparative information presented in these financial statements for the year ended 30 June 2016.

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 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 when new indices are published by the Valuer General 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.

Judgements, estimates and assumptions are required to be made about the carrying amounts 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.

[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 4.2 Jointly Controlled Assets.

Note 2: Funding delivery of our services

The hospital's overall objective is to deliver programs and services that support and enhance the wellbeing of all Victorians.

To enable the hospital to fulfil its objective it receives income based on parliamentary appropriations. The hospital also receives income from the supply of services.

Structure
2.1 Analysis of revenue by source
2.2 Assets received free of charge or for nominal consideration

Note 2.1: Analysis of Revenue by Source

	Admitted Patients 2017	Non-Admitted 2017	Primary Health 2017	Other 2017	Total 2017
Government Grant	5,367,424	522,450	159,140	-	6,049,014
Indirect contributions by Department of Health and Human Services	62,851	-	-	-	62,851
Patient Fees	280,580	146,009	-	-	426,589
Catering	-	-	-	33,206	33,206
Transitional Care Program	393,921	-	-	-	393,921
Other revenue from operating activities	-	-	-	654,122	654,122
Total Revenue from Operating Activities	**6,104,776**	**668,459**	**159,140**	**687,328**	**7,619,703**
Interest	-	-	-	45,928	45,928
Donations & bequests				162,106	162,106
Profit on disposal of non-current assets	-	-	-	4,089	4,089
Other Revenue from Non-Operating Activities	-	-	-	33,479	33,479
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**245,602**	**245,602**
Capital Donations	-	-	-	50,204	50,204
Capital Grants	-	-	-	51,675	51,675
Assets Received Free or Charge	-	-	-	35,339	35,339
Other capital income	-	-	-	133,560	133,560
Total Capital Purpose Income	**-**	**-**	**-**	**270,778**	**270,778**
Total Revenue	**6,104,776**	**668,459**	**159,140**	**1,203,708**	**8,136,083**

	Admitted Patients 2016	Non-Admitted 2016	Primary Health 2016	Other 2016	Total 2016
Government Grant	5,204,202	495,727	130,809	-	5,830,738
Indirect contributions by Department of Health and Human Services	76,096	-	-	-	76,096
Patient Fees	335,920	137,482	-	-	473,402
Catering				49,261	49,261
Transitional Care Program	404,235	-	-	-	404,235
Other revenue from operating activities	-	-	-	633,583	633,583
Total Revenue from Operating Activities	**6,020,453**	**633,209**	**130,809**	**682,844**	**7,467,315**
Interest	-	-	-	49,798	49,798
Donations & bequests	-	-	-	100,282	100,282
Other Revenue from Non-Operating Activities	-	-	-	34,672	34,672
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**184,752**	**184,752**
Capital Donations	-	-	-	152,528	152,528
Capital Grants	-	-	-	83,676	83,676
Total Capital Purpose Income	**-**	**-**	**-**	**236,204**	**236,204**
Total Revenue	**6,020,453**	**633,209**	**130,809**	**1,103,800**	**7,888,271**

Department of Health and Human Services makes certain payments on behalf of the Health Service (List). These amounts have been brought to account in determining

* The intent is to classify commercial activities (previously reported as "Hospital and Community Initiatives") revenue into the "Other" program column.

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 and Human Services.
- 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 04/2017.

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 surplus, 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 amount. Contributions in the form of services are only recognised when a fair value can be reliably determined and the service would have been purchased if not received as a donation.

Other income
Other income includes radiology facility rental, project and educations funding.

Note 2.2: Assets received free of charge or for nominal consideration

	2017	2016
During the reporting period, the fair value of assets received free of charge, was as follows:		
Plant and Equipment	35,339	-
TOTAL	**35,339**	**-**

Note 3: The cost of delivering services

This section provides an account of the expenses incurred by the hospital in delivering services and outputs. In Section 2, the funds that enable the provision of services were disclosed and in this note the cost associated with provision of services are recorded.

Structure
3.1 Analysis of expenses by source
3.2 Provisions
3.3 Superannuation

Note 3.1: Analysis of Expenses by Source

	Admitted Patients 2017	Non-Admitted 2017	Primary Health 2017	Other 2017	Total 2017
Employee Expenses	4,743,697	519,424	123,660	305,578	5,692,359
Other Operating Expenses					
Non Salary Labour Costs	198,552	21,741	5,176	12,790	238,259
Supplies & Consumables	384,162	42,065	10,014	24,747	460,988
Other Expenses	768,009	84,095	20,021	662,437	1,534,562
Total Expenditure from Operating Activities	**6,094,420**	**667,325**	**158,871**	**1,005,552**	**7,926,168**
Other Non-Operating Expenses					
Impairment of Non-Financial Assets				43,105	43,105
Depreciation & Amortisation (refer note 4.4)	-	-	-	362,305	362,305
Total other expenses	**-**	**-**	**-**	**405,410**	**405,410**
Total Expenses	**6,094,420**	**667,325**	**158,871**	**1,410,962**	**8,331,578**

	Admitted Patients 2016	Non-Admitted 2016	Primary Health 2016	Other 2016	Total 2016
Employee Expenses	4,297,278	451,946	93,299	550,649	5,393,172
Other Operating Expenses					
Non Salary Labour Costs	250,880	-	-	-	250,880
Supplies & Consumables	387,949	21,784	4,497	8,388	422,618
Other Expenses	1,119,977	113,871	23,507	251,573	1,508,928
Total Expenditure from Operating Activities	**6,056,084**	**587,601**	**121,303**	**810,610**	**7,575,599**
Other Non-Operating Expenses					
Impairment of Non-Financial Assets	-	-	-	-	-
Loss on disposal of non-current assets	-	-	-	173,833	173,833
Depreciation & Amortisation (refer note 4.4)	-	-	-	366,565	366,565
Total other expenses	**-**	**-**	**-**	**540,398**	**540,398**
Total Expenses	**6,056,084**	**587,601**	**121,303**	**1,351,008**	**8,115,997**

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;
- Fringe benefits tax;
- Leave entitlements;
- Termination payments;
- Workcover premiums;
- Superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

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

Finance costs include:
– interest on bank overdrafts and short-term and long-term borrowings (Interest expense is recognised in the period in which it is 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.

Bad and doubtful debts
Refer to Note 4.1 Investments and other 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 amount.
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.

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 a 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.

Financial guarantee
Payments that are contingent under financial guarantee contracts are recognised as a liability at the time the guarantee is issued. The liability is initially measured at fair value, and if there is a material increase in the likelihood that the guarantee may have to be exercised, then it is measured at the higher of the amount determined in accordance with AASB 137 Provisions, Contingent Liabilities and Contingent Assets and the amount initially recognised less cumulative amortisation, where appropriate.
In the determination of fair value, consideration is given to factors including the overall capital management/prudential supervision framework in operation, the protection provided by the State Government by way of funding should the probability of default increase, probability of default by the guaranteed party and the likely loss to the Health Service in the event of default.

Note 3.2: Employee benefits in the balance sheet

	2017	2016
Current Provisions		
Employee Benefits [(i)]		
Annual leave		
- Unconditional and expected to be settled wholly within 12 months [(ii)]	293,554	145,766
- Unconditional and expected to be settled wholly after 12 months [(iii)]	293,554	437,298
Long service leave		
- Unconditional and expected to be settled wholly within 12 months [(ii)]	178,903	170,229
- Unconditional and expected to be settled wholly after 12 months [(iii)]	536,710	510,687
	1,302,721	1,263,980
Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months [(ii)]	51,862	55,791
- Unconditional and expected to be settled after 12 months [(iii)]	92,115	80,005
Other		
- Accrued salaries and wages	252,627	234,190
- Accrued days off	10,872	14,918
Total Current Provisions	**1,710,197**	**1,648,884**
Non-Current Provisions		
Employee Benefits [(i)]	201,162	222,476
Provisions related to Employee Benefit On-Costs	21,562	23,511
Total Non-Current Provisions	**222,724**	**245,987**
Total Provisions	**1,932,921**	**1,894,871**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Unconditional LSL Entitlement	796,121	755,304
Annual Leave Entitlements	650,577	644,472
Accrued Wages and Salaries	252,627	234,190
Accrued Days Off	10,872	14,918
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements [(ii)]	222,724	245,987
Other	-	-
Total Employee Benefits and Related On-Costs	**1,932,921**	**1,894,871**

Notes:
(i) Provisions for employee benefits consist of amounts for annual leave and long service leave accrued by employees, not including on-costs.
(ii) The amounts disclosed are nominal amounts
(iii) The amounts disclosed are discounted to present values

Movements in provisions	2017	2016
Movement in Long Service Leave:		
Balance at start of year	**1,001,291**	**900,839**
Provision made during the year		
- Revaluations	(1,308)	8,724
- Expense recognising Employee Service	184,568	178,809
Settlement made during the year	(165,706)	(87,081)
Balance at end of year	**1,018,845**	**1,001,291**

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 of the 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 accumulating sick leave are all recognised in the provision for employee benefits as 'current liabilities', because the health service does not have an unconditional right to defer settlements of these liabilities.
Depending on the expectation of the timing of settlement, liabilities for wages and salaries, annual leave and sick leave are measured at:
- Undiscounted value – if the health service expects to wholly settle within 12 months; or
- Present value – if the health service does not expect to wholly settle within 12 months.

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

Unconditional LSL 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. An unconditional right arises after a qualifying period.

The components of this current LSL liability are measured at:
- Undiscounted value – if the health service expects to wholly settle within 12 months; and
- Present value – if the health service does not expect to wholly settle within 12 months.

Conditional LSL 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. This non-current LSL liability is measured at present value.

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

Note 3.3: Superannuation

	Paid Contribution for the Year		Contribution Outstanding at Year End	
	2017	**2016**	**2017**	**2016**
Defined contribution plans:				
First Super	365,623	330,988	13,359	10,379
Hesta Super	106,282	105,366	3,883	3,285
Total	471,905	436,354	17,242	13,664

Employees of the Hospital are entitled to receive superannuation benefits and the Hospital contributes to both defined benefit and defined contribution plans. The defined benefit plan(s) provides benefits based on years of service and final average salary.

The Hospital does not recognise any defined benefit liability in respect of the plan(s) 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. The Department of Treasury & Finance discloses the State's defined benefits liabilities in its disclosure for administered items.

However superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the comprehensive operating statement of the Hospital.
The name, details and amounts expense in relation to the major employee superannuation funds and contributions made by the Hospital are listed above.

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 plans in respect of the 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 upon 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(s) 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 Note 3.3: Superannuation.

Superannuation liabilities
The Health Service does not recognise any unfunded defined benefit liability in respect of the superannuation plans because the Health Service 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.

Note 4: Key assets to support delivery

The hospital controls infrastructure and other investments that are utilised in fulfilling its objectives and conducting its activities. They represent the key resources that have been entrusted to the hospital to be utilised for delivery of those outputs.

Structure
4.1 Investments and other financial assets
4.2 Jointly controlled operations
4.3 Property, plant & equipment
4.4 Depreciation and amortisation

Note 4.1: Investments and other financial assets

	Operating Fund		Specific Purpose Fund		Capital Fund		Total	
	2017	2016	2017	2016	2017	2016	2017	2016
CURRENT								
Loans and receivables								
Term Deposits								
Aust. Dollar Term Deposits > 3 months (i)								
Term Deposit #1 (Capital Development)	-	-	-	-	326,575	321,962	326,575	321,962
Term Deposit #2 (Leave Liabilities)	-	-	-	380,916	-	-	-	380,916
Term Deposit #3 (Leave Liabilities)	-	-	777,708	755,829	-	-	777,708	755,829
Total Current	-	-	777,708	1,136,745	326,575	321,962	1,104,283	1,458,707
NON CURRENT								
Loans and receivables								
Term Deposit								
Aust. Dollar Term Deposits > 12 months	-	-	-	-	-	-	-	-
Total Non Current	-	-	-	-	-	-	-	-
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**-**	**-**	**777,708**	**1,136,745**	**326,575**	**321,962**	**1,104,283**	**1,458,707**
Represented by:								
Health Service Investments	-	-	777,708	1,136,745	326,575	321,962	1,104,283	1,458,707
Monies Held in Trust								
Patient Monies	-	-	-	-	-	-	-	-
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**-**	**-**	**777,708**	**1,136,745**	**326,575**	**321,962**	**1,104,283**	**1,458,707**

Notes:
(i) Term deposits under 'investments and other financial assets' class include only term deposits with maturity greater than 90 days.

(a) Ageing analysis of investments and other financial assets
Please refer to Note 7.1 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 7.1 for the nature and extent of credit risk arising from investments and other financial assets

Investments and Other Financial Assets
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 recognition.

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

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

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 instrument assets, except those measured at fair value through profit or loss, are subject to annual review for impairment.

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. 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 AAASB 136 Impairment of Assets.

Doubtful debts
Receivables are assessed for bad and doubtful debts on a regular basis. Those bad debts considered as written off by mutual consent are classified as a transaction expense. Bad Debts not written off by mutual consent are the allowance for doubtful debts are classified as other economic flows in the net result.

Note 4.2: Jointly Controlled Operation

Summarised financial information in respect of the agency's jointly controlled operation is set below. The amounts are included in the financial statements under their respective categories.

		2017	2016
Name of entity	**Principle Activity**	**Ownership Interest**	
Gippsland Health Alliance	Information Technology	**3.36%**	**3.36%**
Summarised Financial Information of Joint Venture:			
Summarised balance sheet:			
Current assets			
Cash and cash equivalents		169,296	83,617
Other current assets		113,526	67,407
Total current assets		282,822	151,024
Non-current assets			
Other non current assets		5,312	4,028
Total non-current assets		5,312	4,028
Total Assets		**288,134**	**155,052**
Current Liabilities			
Other non-financial liabilities (including payables, provisions)		34,884	31,570
Total current liabilities		34,884	31,570
Non-Current Liabilities		-	-
Total Liabilities		**34,884**	**31,570**
Share of Joint Venture's Net Assets		**253,250**	**123,482**
Operating Revenue			
GHA Revenue		345,748	332,148
		345,748	332,148
Operating Expense			
GHA Expense		(349,540)	(339,380)
		(349,540)	(339,380)
Net result from operating		(3,792)	(7,232)
Capital Revenue			
GHA Revenue		133,560	-
		133,560	-
Net result from continuing operation		**129,768**	**(7,232)**
Share of Joint Venture's Net Result After Income Tax		**129,768**	**(7,232)**

Note 4.3: Property, plant & equipment

(a) Gross carrying amount and accumulated depreciation

	2017	2016
Land [(i)]		
Land at Fair Value	360,000	360,000
Less Impairment	-	-
Total Land	**360,000**	**360,000**
Buildings		
Buildings at Fair Value	4,898,792	4,898,792
Less Acc'd Depreciation	(519,118)	(346,078)
Buildings - Work in Progress	-	27,194
Total Buildings	**4,379,674**	**4,579,908**
Plant and Equipment		
Plant and Equipment at Fair Value	214,298	212,098
Less Acc'd Depreciation	(132,698)	(113,932)
Total Plant and Equipment	**81,600**	**98,166**
Medical Equipment		
Medical Equipment at Fair Value	1,409,731	1,335,265
Less Acc'd Depreciation	(1,005,088)	(1,007,418)
Total Medical Equipment	**404,643**	**327,847**
Furniture and Fittings		
Furniture and Fittings at Fair Value	202,534	189,129
Less Acc'd Depreciation	(93,889)	(76,469)
Total Furniture and Fittings	**108,645**	**112,660**
Other Equipment		
Other Equipment at Fair Value	478,915	469,037
Less Acc'd Depreciation	(373,379)	(349,263)
Other Equipment - Work in Progress	-	5,059
Total Other Equipment	**105,536**	**124,833**
GHA Plant and Equipment		
GHA Plant and Equipment at Fair Value	5,312	4,028
Total GHA Plant and Equipment	**5,312**	**4,028**
Motor Vehicles		
Motor Vehicles at Fair Value	286,974	290,521
Less Acc'd Depreciation	(89,515)	(83,518)
Total Motor Vehicles	**197,459**	**207,003**
TOTAL	**5,642,869**	**5,814,443**

Note 4.3: Property, plant & equipment (continued)

(b) Reconciliations of the carrying amounts of each class of asset

	Land	Buildings	Plant & Equipment	Medical Equipment	Furniture & Fittings	Other Equipment	GHA Plant & Equipment	Motor Vehicles	Total
Balance at 1 July 2015	**360,000**	**4,733,853**	**116,895**	**551,936**	**24,473**	**145,988**	**4,068**	**231,369**	**6,168,582**
Additions	-	19,094	-	51,993	101,967	7,186		24,224	204,464
Disposals	-	-	-	(178,376)	-	-	-	(13,662)	(192,038)
Depreciation (Note 4.4)	-	(173,039)	(18,729)	(97,706)	(13,780)	(28,343)	(40)	(34,928)	(366,565)
Balance at 1 July 2016	**360,000**	**4,579,908**	**98,166**	**327,847**	**112,660**	**124,832**	**4,028**	**207,003**	**5,814,443**
Additions	-	15,910	2,200	166,192	13,404	11,769	1,392	64,992	275,859
Disposals	-	-	-	(1,091)	-	(1,294)	-	(39,638)	(42,023)
Impairment Loss	-	(43,105)	-	-	-	-	-	-	(43,105)
Depreciation (Note 4.4)	-	(173,039)	(18,766)	(88,305)	(17,419)	(29,770)	(108)	(34,898)	(362,305)
Balance at 30 June 2017	**360,000**	**4,379,674**	**81,600**	**404,643**	**108,645**	**105,536**	**5,312**	**197,459**	**5,642,869**

Land and buildings carried at valuation

An independent valuation of the Health Service's land and buildings was performed by *the Valuer-General Victoria* to determine the fair value of the land and buildings. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments.

The effective date of the valuation is *30 June 2014*

Note 4.3: Property, plant & equipment (continued)

(c) Fair value measurement hierarchy for assets

	Carrying amount as at 30 June 2017	Fair value measurement at end of reporting period using: Level 1 (1)	Level 2 (1)	Level 3 (1)
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	4,379,674			4,379,674
Total of building at fair value	4,379,674	-	-	4,379,674
Plant and equipment at fair value				
Plant equipment and vehicles at fair value	-	-	-	-
- Vehicles (ii)	197,459	-	-	197,459
- Plant and equipment	81,600	-	-	81,600
Total of plant, equipment and vehicles at fair value	279,059	-	-	279,059
Medical equipment at fair value				
Medical equipment at fair value	404,643	-	-	404,643
Total medical equipment at fair value	404,643	-	-	404,643
Furniture and fittings at fair value				-
Furniture and fittings at fair value	108,645	-	-	108,645
Total Furniture and fittings at fair value	108,645	-	-	108,645
Other equipment at fair value				-
Other equipment at fair value	105,536	-	-	105,536
Total other equipment at fair value	105,536	-	-	105,536
GHA plant and equipment at fair value				-
GHA plant and equipment at fair value	5,312	-	-	5,312
Total GHA plant and equipment at fair value	5,312	-	-	5,312
	5,642,869	**-**	**-**	**5,642,869**

Note

(i) Classified in accordance with the fair value hierarchy,

(ii) Vehicles are categorised to Level 3 assets if the depreciated replacement cost is used in estimating the fair value. However, entities should consult with an independent valuer in determining whether a market approach is appropriate for vehicles with an active resale market available. If yes, a Level 2 categorisation for such vehicles would be appropriate.

There have been no transfers between levels during the period.

Note 4.3: Property, plant & equipment (continued)

	Carrying amount as at 30 June 2016	Fair value measurement at end of reporting period using: Level 1 (1)	Level 2 (1)	Level 3 (1)
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	4,579,908	-	-	4,579,908
- Station Road, Foster	4,579,908	-	-	4,579,908
Total of building at fair value				
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	207,003	-	-	207,003
- Plant and equipment	98,166	-	-	98,166
Total of plant, equipment and vehicles at fair value	305,169	-	-	305,169
Medical equipment at fair value				-
Medical equipment at fair value	327,847	-	-	327,847
Total medical equipment at fair value	327,847	-	-	327,847
Furniture and fittings at fair value				-
Furniture and fittings at fair value	112,660	-	-	112,660
Total Furniture and fittings at fair value	112,660	-	-	112,660
Other equipment at fair value				-
Other equipment at fair value	124,831	-	-	124,831
Total other equipment at fair value	124,831	-	-	124,831
GHA plant and equipment at fair value				-
GHA plant and equipment at fair value	4,028	-	-	4,028
Total GHA plant and equipment at fair value	4,028	-	-	4,028
	5,814,443	**-**	**-**	**5,814,443**

Note

(i) Classified in accordance with the fair value hierarchy,

(ii) Vehicles are categorised to Level 3 assets if the depreciated replacement cost is used in estimating the fair value. However, entities should consult with an independent valuer in determining whether a market approach is appropriate for vehicles with an active resale market available. If yes, a Level 2 categorisation for such vehicles would be appropriate.

There have been no transfers between levels during the period.

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 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, the Health Service 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.

In addition, the Health Service determines whether transfers have occurred between levels in the hierarchy by re-assessing categorisation (based on the lowest level input that is significant to the fair value measurement as a whole) at the end of each reporting period.

The Valuer-General Victoria (VGV) is the Health Service's independent valuation agency.

The Health Service, 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.

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 and assumptions 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 land, buildings, infrastructure, plant and equipment (refer to Note 7.1);
• superannuation expense (refer to note 3.3); 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 3.2).

Fair value measurement
Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.
The fair value measurement is based on the following assumptions:
• that the transaction to sell the asset or transfer the liability takes place either in the principal market (or the most advantageous market, in the absence of the principal market), either of which must be accessible to the Health Service at the measurement date;
• that the Health Service uses the same valuation assumptions that market participants would use when pricing the asset or liability, assuming that market participants act in their economic best interest.

The fair value measurement of a non-financial asset takes into account a market participant's ability to generate economic benefits by using the asset in its highest and best use or by selling it to another market participant that would use the asset in its highest and best use.

Consideration of highest and best use (HBU) for non-financial physical assets
Judgements about highest and best use must take into account the characteristics of the assets concerned, including restrictions on the use and disposal of assets arising from the asset's physical nature and any applicable legislative/contractual arrangements.

In considering the HBU for non-financial physical assets, valuers are probably best placed to determine highest and best use (HBU) in consultation with Health Services. Health Services and their valuers therefore need to have a shared understanding of the circumstances of the assets. A Health Service has to form its own view about a valuer's determination, as it is ultimately responsible for what is presented in its audited financial statements.

In accordance with paragraph AASB 13.29, Health Services can assume the current use of a non-financial physical asset is its HBU unless market or other factors suggest that a different use by market participants would maximise the value of the asset.

Therefore, an assessment of the HBU will be required when the indicators are triggered within a reporting period, which suggest the market participants would have perceived an alternative use of an asset that can generate maximum value. Once identified, Health Services are required to engage with VGV or other independent valuers for formal HBU assessment.
These indicators, as a minimum, include:
External factors:
• Changed acts, regulations, local law or such instrument which affects or may affect the use or development of the asset;
• Changes in planning scheme, including zones, reservations, overlays that would affect or remove the restrictions imposed on the asset's use from its past use;
• Evidence that suggest the current use of an asset is no longer core to requirements to deliver a Health Service's service obligation;
• Evidence that suggests that the asset might be sold or demolished at reaching the late stage of an asset's life cycle.

In addition, Health Services need to assess the HBU as part of the 5-year review of fair value of non-financial physical assets. This is consistent with the current requirements on FRD 103F Non-financial physical assets and FRD 107B Investment properties.

Valuation hierarchy
Health Services need to use valuation techniques that are appropriate for the circumstances and where there is sufficient data available to measure fair value, maximising the use of relevant observable inputs and minimising the use of unobservable inputs.
All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy. It is 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.

Note 4.3: Property, plant & equipment (continued)

(d) Reconciliation of Level 3 fair value

30 June 2017	Land	Buildings	Plant and equipment	Medical equipment	Furniture and fittings	Other equipment	GHA equipment	Motor vehicles
Opening Balance	**360,000**	**4,579,908**	**98,166**	**327,847**	**112,660**	**124,832**	**4,028**	**207,003**
Purchases (sales)	-	15,910	2,200	165,101	13,404	10,475	1,392	25,354
Transfers in (out) of Level 3	-	-	-	-	-	-	-	-
Gains or losses recognised in net result	-	-	-	-	-	-	-	-
- Depreciation	-	(173,039)	(18,766)	(88,305)	(17,419)	(29,770)	(108)	(34,898)
- Impairment	-	(43,105)	-	-	-	-	-	-
Subtotal	360,000	4,379,674	81,600	404,643	108,645	105,536	5,312	197,459
	360,000	**4,379,674**	**81,600**	**404,643**	**108,645**	**105,536**	**5,312**	**197,459**

30 June 2016	Land	Buildings	Plant and equipment	Medical equipment	Furniture and fittings	Other equipment	GHA equipment	Motor vehicles
Opening Balance	360,000	4,733,853	116,895	551,936	24,473	145,988	4,068	231,369
Purchases (sales)	-	19,094	-	(126,383)	101,967	7,186	-	10,562
Transfers in (out) of Level 3	-	-	-	-	-	-	-	-
Gains or losses recognised in net result	-	-	-	-	-	-	-	-
- Depreciation	-	(173,039)	(18,729)	(97,706)	(13,780)	(28,343)	(40)	(34,928)
Subtotal	360,000	4,579,908	98,166	327,847	112,660	124,832	4,028	207,003
	360,000	**4,579,908**	**98,166**	**327,847**	**112,660**	**124,832**	**4,028**	**207,003**

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.

For non-specialised land and non-specialised buildings, an independent valuation was performed by independent valuers (Westernport Property Consultants) to determine the fair value using the market approach. Valuation of the assets was determined by analysing comparable sales and allowing for share, size, topography, location and other relevant factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30 June 2014.

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 Hospital 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 Hospital 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 2017.

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

Note 4.3: Property, plant & equipment (continued)

(e) Description of significant unobservable inputs to Level 3 valuations:

	Valuation technique [(i)]	Significant unobservable inputs [(i)]
Specialised land		
- Station Road, Foster	Market approach	Community Service Obligation (CSO) adjustment
Specialised buildings		
- Station Road, Foster	Depreciated replacement cost	Direct cost per square metre Useful life of specialised buildings
Plant and equipment at fair value		
-Plant and equipment	Depreciated replacement cost	Cost per unit Useful life of PPE
Vehicles		
-Vehicles	Depreciated replacement cost	Cost per unit Useful life of vehicles
Medical equipment at fair value		
-Medical equipment	Depreciated replacement cost	Cost per unit Useful life of medical equipment

(i) [Illustrations on the valuation techniques, significant unobservable inputs and the related quantitative range of those inputs are indicative and should not be directly used without consultation with entities' independent valuer. Please note that AASB 2015-7 Fair Value Disclosures of Not-for-Profit Public Sector Entities, which is operative from 1 July 2016 provides an exemption for not-for-profit public sector entities from disclosing the shaded columns relating to the quantitative information of 'significant unobservable inputs' and the 'sensitivity analysis' if the assets are held primarily for their current service potential rather than to generate net cash inflows. Please note that the State early adopted AASB 2015-7 in the 2014-15 reporting period and gave not-for-profit entities the option to early adopt this amending standard last year. As a result, all not-for-profit entities must now comply with this amending standard for the current financial year. This amending standard is not applicable for assets that are held for cash generating purposes. Not-for-profit entities that have assets generating net cash inflows will still need to disclose the information in the shaded columns.]

(ii) 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.

The significant unobservable inputs have remain unchanged from 2016.

Property, Plant and Equipment
All non-current physical assets are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and accumulated impairment loss. 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 4.3 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 accumulated impairment loss. 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 103F 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 amount and fair value.

Revaluation increments are recognised in 'other comprehensive income' and are credited directly in equity 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 normally transferred to accumulated funds on derecognition of the relevant asset.

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

Note 4.4: Depreciation and amortisation

	2017	2016
Depreciation		
Buildings	173,039	173,039
Plant & Equipment	18,766	18,729
Medical Equipment	88,305	97,706
Motor Vehicles	34,898	34,928
Furniture & Fittings	17,419	13,780
Other Equipment	29,878	28,383
Total Depreciation	**362,305**	**366,565**

All buildings, plant and equipment and other non-financial physical assets that have finite useful lives are depreciated (i.e. excludes land assets held for sale, and investment properties). 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.

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, residual value 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 and Human Services. 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.

	2017	2016
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

Note 5: Other assets and liabilities

This section sets out those assets and liabilities that arose from the hospital's operations.

Structure
5.1 Receivables
5.2 Inventories
5.3 Other liabilities
5.4 Prepayments
5.5 Payables
5.6 Other non-financial assets

Note 5.1: Receivables

	2017	2016
CURRENT		
Contractual		
Inter Hospital Debtors	90,029	1,407
Trade Debtors	73,760	103,265
Patient Fees	72,861	84,410
Accrued Investment Income	9,896	8,209
Department of Health and Human Services		
WIES Recall	3,908	56,082
GHA Receivables	36,659	40,421
Less Allowance for Doubtful Debts		
Patient Fees	(5,348)	(9,126)
	281,765	**284,668**
Statutory		
GST Receivable	18,048	19,140
	18,048	**19,140**
TOTAL CURRENT RECEIVABLES	**299,813**	**303,808**
NON CURRENT		
Statutory		
Long Service Leave - Department of Health / Department of Health and Human Services	433,297	377,605
	433,297	**377,605**
TOTAL NON-CURRENT RECEIVABLES	**433,297**	**377,605**
TOTAL RECEIVABLES	**733,110**	**681,413**

(a) Movement in the Allowance for doubtful debts

Balance at beginning of year	9,126	13,412
Increase/(decrease) in allowance recognised in net result	(3,778)	(4,286)
Balance at end of year	**5,348**	**9,126**

(b) Ageing analysis of receivables
Please refer to Note 7.1 for the ageing analysis of contractual receivables

(c) Nature and extent of risk arising from receivables
Please refer to Note 7.1 for the nature and extent of credit risk arising from contractual receivables

Receivables consist of:
- contractual receivables, which includes mainly debtors in relation to goods and services, loans to third parties, accrued investment income, and finance lease receivables; and
- statutory receivables, which includes predominantly amounts owing from the Victorian Government and Goods and Services Tax ("GST") input tax credits recoverable.

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.

Note 5.2: Inventories

	2017	2016
Pharmaceuticals		
At cost	15,506	14,532
Catering Supplies		
At cost	5,752	5,391
Medical and Surgical Lines		
At cost	47,812	49,674
Engineering Stores		
At Cost	3,752	3,516
TOTAL INVENTORIES	**72,822**	**73,113**

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

Note 5.3: Other liabilities

	2017	2016
CURRENT		
GHA Other current liabilities	34,887	31,570
TOTAL CURRENT OTHER ASSETS	**34,887**	**31,570**
TOTAL OTHER ASSETS	**34,887**	**31,570**

Note 5.4: Prepayments and other non-financial assets

	2017	2016
CURRENT		
Prepayments	10,250	-
TOTAL CURRENT OTHER ASSETS	**10,250**	**-**
TOTAL OTHER ASSETS	**10,250**	**-**

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

Note 5.5: Payables

	2017	2016
CURRENT		
Contractual		
Trade Creditors [(i)]	117,816	207,023
Accrued Expenses	61,393	19,827
	179,209	**226,850**
TOTAL PAYABLES	**179,209**	**226,850**

(i) The average credit period is 30 days. No interest is charged on the other payables for the first 30 days from the date of the invoice.

(a) Maturity analysis of payables
Please refer to Note 7.1 for the ageing analysis of contractual payables

(b) Nature and extent of risk arising from payables
Please refer to note 7.1 for the nature and extent of risks arising from contractual 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 those 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.

Note 5.6: Other non-financial assets

	2017	2016
CURRENT		
GHA Other current assets	76,867	26,986
TOTAL CURRENT OTHER ASSETS	**76,867**	**26,986**
TOTAL OTHER ASSETS	**76,867**	**26,986**

Note 6: Other assets and liabilities

This section provides information on the sources of finance utilised by the hospital during its operations, along with interest expenses (the cost of borrowings) and other information related to financing activities of the hospital.

This section includes disclosures of balances that are financial instruments (such as borrowings and cash balances). Note: 7.1 provides additional, specific financial instrument disclosures.

Structure
6.1 Cash and cash equivalents
6.2 Commitments for expenditure

Note 6.1: Cash and Cash Equivalents

For the purposes 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.

	2017	2016
Cash on hand	400	400
Cash at bank	530,084	317,392
Total Cash and Cash Equivalents	**530,484**	**317,792**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	361,188	234,175
GHA Cash at Bank	169,296	83,617
Total Cash and Cash Equivalents	**530,484**	**317,792**

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 with an insignificant risk of changes in value.

Note 6.2: Commitments for expenditure

The Hosptial does not have any capital or lease commitments for expenditure as at 30 June 2017. (2016: Nil)

Note 7: Risks, contingencies & valuation uncertainties

Introduction

The hospital is exposed to risk from its activities and outside factors. In addition, it is often necessary to make judgements and estimates associated with recognition and measurement of items in the financial statements. This section sets out financial instrument specific information, (including exposures to financial risks) as well as those items that are contingent in nature or require a higher level of judgement to be applied, which for the hospital is related mainly to fair value determination.

Structure
7.1 Financial instruments
7.2 Net gain/ (loss) on disposal of non-financial assets
7.3 Contingent assets and contingent liabilities
7.4 Fair value determination

Note 7.1: Financial Instruments

Financial risk management objectives and policies

The South Gippsland Hospital's 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 the financial statements.

The Health Service's main financial risks include credit risk, liquidity risk, interest rate risk and equity price risk. The Health Service manages these financial risks in accordance with its financial risk management policy.

The Health Service uses different methods to measure and manage the different risks to which it is exposed. Primary responsibility for the identification and management of financial risks rests with the financial risk management committee of the Health Service.

The main purpose in holding financial instruments is to prudentially manage South Gippsland Hospital financial risks within the government policy parameters.

Note 7.1: Financial Instruments (Continued)

2017	Contractual financial assets - loans and receivables	Contractual financial liabilities at amortised cost	Total
Contractual Financial Assets			
Cash and cash equivalents	530,484	-	530,484
Receivables			
- Trade Debtors	281,765	-	281,765
Other Financial Assets			
- Term Deposit	1,104,283	-	1,104,283
Total Financial Assets [(i)]	**1,916,532**	**-**	**1,916,532**
Financial Liabilities			
Payables	-	179,209	179,209
Total Financial Liabilities [(ii)]	**-**	**179,209**	**179,209**

2016	Contractual financial assets - loans and receivables	Contractual financial liabilities at amortised cost	Total
Contractual Financial Assets			
Cash and cash equivalents	317,792	-	317,792
Receivables			
- Trade Debtors	284,668	-	284,668
Other Financial Assets			
- Term Deposit	1,458,707	-	1,458,707
Total Financial Assets [(i)]	**2,061,167**	**-**	**2,061,167**
Financial Liabilities			
Payables	-	226,850	226,850
Total Financial Liabilities [(ii)]	**-**	**226,850**	**226,850**

(i) The total amount of financial assets disclosed here excludes statutory receivables
(ii) The total amount of financial liabilities disclosed here excludes statutory payables (i.e. Taxes payable)

Note 7.1 Financial Instruments (Continued)

(b) Net holding gain/(loss) on financial instruments by category

	Net holding gain/(loss)	Total interest income / (expense)	Fee income / (expense)	Impairment loss	Total
2017					
Financial Assets					
Cash and Cash Equivalents [(i)]	-	45,928	-	-	45,928
Loans and Receivables [(i)]	-	-	-	-	-
Total Financial Assets	**-**	**45,928**	**-**	**-**	**45,928**
2016					
Financial Assets					
Cash and Cash Equivalents [(i)]	-	49,798	-	-	49,798
Loans and Receivables [(i)]		-	-	-	-
Total Financial Assets	**-**	**49,798**	**-**	**-**	**49,798**

(i) For cash and cash equivalents, loans or receivables and available-for-sale financial assets, the net gain or loss is calculated by taking the movement in the fair value of the asset, interest revenue, plus or minus foreign exchange gains or losses arising from revaluation of the financial assets, and minus any impairment recognised in the net result; and

Note 7.1: Financial Instruments (continued)

(c) 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 the 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. For debtors other than the Government, it is the Health Service's policy to only deal with entities with high credit ratings of a minimum Triple-B rating and to obtain sufficient collateral or credit enhancements, where appropriate.

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. As with the policy for debtors, 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 South Gippsland Hospital'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

2017	Financial institutions (AA credit rating)	Government agencies (AA credit rating)	Government agencies (BBB credit rating)	Other (min BBB credit rating)	Total
Financial Assets					
Cash and Cash Equivalents	530,084	-	-	400	530,484
Loans and Receivables					
- Trade Debtors	-	-	-	281,765	281,765
- Term Deposit	1,104,283	-	-	-	1,104,283
Total Financial Assets	**1,634,367**	**-**	**-**	**282,165**	**1,916,532**
2016					
Financial Assets					
Cash and Cash Equivalents	317,392	-	-	400	317,792
Loans and Receivables					
- Trade Debtors	-	-	-	284,668	284,668
- Term Deposit	1,458,707	-	-	-	1,458,707
Total Financial Assets	**1,776,099**	**-**	**-**	**285,068**	**2,061,167**

(i) The total amounts disclosed here exclude statutory amounts (e.g. amounts owing from Victorian Government and GST input tax credit recoverable).

Note 7.1: Financial Instruments (continued)

(c) Credit Risk (continued)

Ageing analysis of Financial Assets 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	
2017							
Financial Assets							
Cash and Cash Equivalents	530,484	530,484	-	-	-	-	-
Loans and Receivables							
- Trade Debtors	281,765	205,193	28,179	48,393	-	-	(5,348)
- Term Deposit	1,104,283	1,104,283	-	-	-	-	-
Total Financial Assets	**1,916,532**	**1,839,960**	**28,179**	**48,393**	**-**	**-**	**(5,348)**
2016							
Financial Assets							
Cash and Cash Equivalents	317,792	317,792	-	-	-	-	-
Loans and Receivables							
- Trade Debtors	284,668	272,609	381	11,678	-	-	(9,126)
- Term Deposit	1,458,707	1,458,707	-	-	-	-	-
Total Financial Assets	**2,061,167**	**2,049,108**	**381**	**11,678**	**-**	**-**	**(9,126)**

(i) Ageing analysis of financial assets must exclude the types of statutory financial assets (i.e GST input tax credit)

Contractual financial assets that are either past due or impaired
There are no material financial assets which are individually determined to be impaired. Currently the Hospital does not hold any collateral as security nor credit enhancements relating to its financial assets.

There are no financial assets that have had their terms renegotiated so as to prevent them from being past due or impaired, and they are stated at their carrying amounts as indicated. The ageing analysis table above discloses the ageing only of contractual financial assets that are past due but not impaired.

Note 7.1: Financial Instruments (continued)

(d) 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 Services operates under the Government's fair payments policy of settling financial obligations within 30 days and in the event of a dispute, making payments within 30 days from the date of resolution.

The Health Service's maximum exposure to liquidity risk is the carrying amounts of financial liabilities as disclosed in the face of the balance sheet. The Health Service manages its liquidity risk as follows:
- ongoing reivew of cashflow requirements
- staggered maturities on term deposits
- active monitoring and collection of debtors

The following table discloses the contractual maturity analysis for South Gippsland 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 as at 30 June

			Maturity Dates			
2017	**Carrying Amount**	**Nominal Amount**	**Less than 1 Month**	**1-3 Months**	**3 months - 1 Year**	**1-5 Years**
Financial Liabilities						
At amortised cost						
Payables	179,209	179,209	169,851	9,358	-	-
Total Financial Liabilities	**179,209**	**179,209**	**169,851**	**9,358**	**-**	**-**
2016						
Financial Liabilities						
At amortised cost						
Payables	226,850	226,850	226,850	-	-	-
Total Financial Liabilities	**226,850**	**226,850**	**226,850**	**-**	**-**	**-**

(i) Ageing analysis of financial liabilities excludes the types of statutory financial liabilities (i.e GST payable)

Note 7.1: Financial Instruments (continued)

(e) Market risk

The South Gippsland Hospital's 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 South Gippsland 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 South Gippsland Hospital's interest bearing liabilities. Minimisation of risk is achieved by mainly undertaking fixed rate or non-interest bearing financial instruments. For financial liabilities, the health service mainly undertake financial liabilities with relatively even maturity profiles.

Cash flow interest rate risk is the risk that the future cash flows of a financial instrument will fluctuate because of changes in market interest rates.

The Health Service has minimal exposure to cash flow interest rate risks through its cash and deposits, term deposits and bank overdrafts that are at floating rate.

The Health Service manages this risk by mainly undertaking fixed rate or non-interest bearing financial instruments with relatively even maturity profiles, with only insignificant amounts of financial instruments at floating rate. Management has concluded for cash at bank and bank overdraft, as financial assets that can be left at floating rate without necessarily exposing the Health Service to significant bad risk, management monitors movement in interest rates on a daily basis.

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
2017					
Financial Assets					
Cash and Cash Equivalents	1.41	530,484	-	530,084	400
Loans and Receivables [(i)]					
- Receivables		281,765	-	-	281,765
- Term Deposit	2.51	1,104,283	1,104,283	-	-
		1,916,532	**1,104,283**	**530,084**	**282,165**
Financial Liabilities					
At amortised cost					
Payables[(i)]		179,209	-	-	179,209
		179,209	**-**	**-**	**179,209**
2016					
Financial Assets					
Cash and Cash Equivalents	0.54	317,792	-	317,392	400
Loans and Receivables [(i)]					
- Receivables		284,668	-	-	284,668
- Term Deposit	2.94	1,458,707	1,458,707	-	-
		2,061,167	**1,458,707**	**317,392**	**285,068**
Financial Liabilities					
At amortised cost					
Payables[(i)]		226,850	-	-	226,850
		226,850	**-**	**-**	**226,850**

(i) The carrying amount must exclude types of statutory financial assets and liabilities (i.e. GST input tax credit and GST payable)

Note 7.1: Financial Instruments (continued)

(e) 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 South Gippsland Hospital believes the following movements are 'reasonably possible' over the next 12 months (Base rates are sourced from the Reserve Bank of Australia)

- A parallel shift of +1% and -1% in market interest rates (AUD) from year-end rates of 1.5%

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

	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-1%		+1%		-1%		+1%	
2017		**Profit**	**Equity**	**Profit**	**Equity**	**Profit**	**Equity**	**Profit**	**Equity**
Financial Assets									
Cash and Cash Equivalents [(i)]	530,484	(5,305)	(5,305)	5,305	5,305	-	-	-	-
Loans and Receivables [(i)]									
- Trade Debtors	281,765	-	-	-	-	-	-	-	-
- Term Deposit	1,104,283	(11,043)	(11,043)	11,043	11,043	-	-	-	-
Financial Liabilities									
At amortised cost									
Payables	179,209	-	-	-	-	-	-	-	-
		(16,348)	**(16,348)**	**16,348**	**16,348**	**-**	**-**	**-**	**-**
2016									
Financial Assets									
Cash and Cash Equivalents [(i)]	317,792	(3,178)	(3,178)	3,178	3,178	-	-	-	-
Loans and Receivables [(i)]									
- Trade Debtors	284,668	-	-	-	-	-	-	-	-
- Term Deposit	1,458,707	(14,587)	(14,587)	14,587	14,587	-	-	-	-
Financial Liabilities									
At amortised cost									
Payables	226,850	-	-	-	-	-	-	-	-
		(17,765)	**(17,765)**	**17,765**	**17,765**	**-**	**-**	**-**	**-**

(i) e.g.. Sensitivity of cash and cash equivalents to a +1% movement in interest rates: [$22,403k*0.07]-[$22,403k*0.06] = $224k. Similar for a -1% movement in interest rate, impact = $(224k).

(ii) The carrying amount must exclude types of statutory financial assets and liabilities (i.e. GST input tax credit and GST payable).

Note 7.1: Financial Instruments (continued)

(f) 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 statements 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.

Comparison between carrying amount and fair value

	Carrying Amount 2017	Fair value 2017	Carrying Amount 2016	Fair value 2016
Financial Assets				
Cash and Cash Equivalents	530,484	530,484	317,792	317,792
Loans and Receivables [(i)]				
- Trade Debtors	281,765	281,765	284,668	284,668
- Term Deposit	1,104,283	1,104,283	1,458,707	1,458,707
Total Financial Assets	**1,916,532**	**1,916,532**	**2,061,167**	**2,061,167**
Financial Liabilities				
At amortised cost				
Payables	179,209	179,209	226,850	226,850
Total Financial Liabilities	**179,209**	**179,209**	**226,850**	**226,850**

(i) The carrying amount must exclude types of statutory financial assets and liabilities (i.e. GST input tax credit and GST payable).

Note 7.1: Financial Instruments (continued)

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of the Health Service's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial 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 category includes cash and deposits (refer to Note 6.1), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

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 cost 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 reclassified as available for sale. The Health Service would also be prevented from classifying investment securities as held to maturity for the current and the 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 or 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 or loss.

Note 7.2: Net gain/(loss) on disposal of non-financial assets

	2017	2016
Proceeds from Disposals of Non-Current Assets		
Plant and Equipment	50	5,000
Medical Equipment	7,273	-
Motor Vehicles	38,788	13,205
Total Proceeds from Disposal of Non-Current Assets	**46,111**	**18,205**
Less: Written Down Value of Non-Current Assets Sold		
Plant and Equipment	1,293	178,376
Medical Equipment	1,091	-
Motor Vehicles	39,638	13,662
Total Written Down Value of Non-Current Assets Sold	**42,022**	**192,038**
Net gain/(loss) on Disposal of Non-Financial Assets	**4,089**	**(173,833)**

Disposal of Non-Financial Assets
Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement.

Impairment of Non-Financial Assets
All non-financial assets are assessed annually for indications of impairment, except for:
- inventories;
- investment properties that are measured at fair value;
- non-current physical assets held for sale; and

If there is an indication of impairment, the assets concerned are tested as to whether their carrying amount exceeds their possible recoverable amount. Where an asset's carrying amount 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 reversal 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 or 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 of disposal. 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 of disposal.

Note 7.3: Contingent assets and contingent liabilities

There were no contingent assets or contingent liabilities at 30 June 2017. (2016: Nil)

Note 7.4 Fair value determination

Asset class	Examples of types of assets	Expected fair value level	Likely valuation approach	Significant inputs (Level 3 only)
Specialised land - Station Road, Foster	Land subject to restrictions as to use and/or sale Land in areas where there is not an active market	Level 3	Market approach	CSO adjustments
Specialised buildings [(i)]	Specialised buildings with limited alternative uses and/or substantial customisation e.g. prisons, hospitals, and schools	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Plant and equipment [(i)]	Specialised items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Vehicles	If there is an active resale market available;	Level 2	Market approach	N/A
Medical Equipment	If there is no active resale market available	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life

[(i)] Newly built / acquired assets could be categorised as Level 2 assets as depreciation would not be a significant unobservable input (based on the 10% materiality threshold)

Note 8: Other Disclosures

This section includes additional material disclosures required by accounting standards or otherwise, for the understanding of this financial report.

Structure
8.1 Equity
8.2 Reconciliation of net result for the year to net cash inflow/(outflow) from operating activities
8.3 Operating Segments
8.4 Responsible persons disclosures
8.5 Executive officer disclosures
8.6 Related parties
8.7 Remuneration of auditors
8.8 AASBs issued that are not yet effective
8.9 Events occurring after the balance sheet date
8.10 Alternative presentation of comprehensive operating statement
8.11 Glossary of terms and style conventions

Note 8.1: Equity

	2017	2016
(a) Surpluses		
Property, Plant & Equipment Revaluation Surplus [1]		
Balance at the beginning of the reporting period	2,857,560	2,857,560
Balance at the end of the reporting period*	**2,857,560**	**2,857,560**
* Represented by:		
- Land	146,586	146,586
- Buildings	2,710,974	2,710,974
- Plant and Equipment	-	-
	2,857,560	**2,857,560**

(1) The property, plant & equipment asset revaluation surplus arises on the revaluation of property, plant & equipment.

(b) Contributed Capital		
Balance at the beginning of the reporting period	3,086,756	3,086,756
Balance at the end of the reporting period	**3,086,756**	**3,086,756**
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	274,847	502,573
Net Result for the Year	(195,495)	(227,726)
Balance at the end of the reporting period	**79,352**	**274,847**
Total Equity at end of financial year	**6,023,668**	**6,219,163**

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 to or distributions by owners 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.

Note 8.2: Reconciliation of Net Result for the Year to Net Cash Inflow/(Outflow) from Operating Activities

	2017	2016
Net result for the period	(195,495)	(227,726)
Non-cash movements:		
Depreciation and amortisation	362,305	366,565
Net (Profit)/loss from Sale of Plant & Equipment	(4,089)	173,833
Impairement of non-financial assets	43,105	-
Movements in assets and liabilities:		
Change in operating assets and liabilities		
(Increase)/decrease in receivables	(51,697)	(130,309)
(Increase)/decrease in other assets	(135,561)	(818)
Increase/(decrease) in employee entitlements	38,050	120,459
Increase/(decrease) in payables	(47,641)	1,365
Increase/(decrease) in other liabilities	3,317	(17,773)
(Increase)/decrease in Prepayments	(10,250)	-
(Increase)/decrease in inventories	291	(1,104)
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**2,335**	**284,492**

Note 8.3: Segment Reporting

South Gippsland Hospital 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.

Geographical Segment

South Gippsland Hospital operates in Foster, Victoria. 100% of revenue, net surplus from ordinary activities and assets relate to operations in Foster, Victoria.

Note 8.4: Responsible persons disclosures

In accordance with the Ministerial Directions issued by the Minister for Finance under the *Financial Management Act 1994* , the following disclosures are made regarding responsible persons for the reporting period.

	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	1/7/2016 - 30/6/2017
Governing Boards	
Mr. Neil Roussac (Chair) (appointed 2006)	1/7/2016 - 30/6/2017
Mr. Clive White (appointed 1986)	1/7/2016 - 30/6/2017
Dr. Matthew Marriott (appointed 2009)	1/7/2016 - 30/6/2017
Mr. Bruce Lester (appointed 2010)	1/7/2016 - 30/6/2017
Mr. Paul Ahern (appointed 2011)	1/7/2016 - 30/6/2017
Mrs. Lisa Barham-Lomax (appointed 2012)	1/7/2016 - 30/6/2017
Dr. Priscilla Robinson (appointed 2014)	1/7/2016 - 30/6/2017
Ms. Janyce Bull (appointed 2014)	1/7/2016 - 30/6/2017
Ms. Susan Pilkington (appointed 2014)	1/7/2016 - 30/6/2017
Mr. Iain Vernon (appointed 2015)	1/7/2016 - 30/6/2017
Mr. Graeme Baxter (appointed 2016)	1/7/2016 - 30/6/2017
Accountable Officers & Key Management Personnel	
Mr. Peter Rushen	01/07/2016 - 13/01/2017
Ms. Anna Stefani	14/01/2017 - 22/01/2017
Ms. Christine Trotman	23/01/2017 - 30/6/2017

Remuneration

Remuneration received or receivable by responsible persons was in the range: $160,000 - $170,000 ($190,000 - $200,000 in 2015-16)

	2017	2016
Other Transactions of Responsible Persons and their Related Parties.		
Mr. Paul Ahern as trustee in Aherns Fruit Market was in receipt of payment for fruit and vegetable supplies on normal commercial terms and conditions to the Hospital and not for his role on the Board.	10,807	8,679

Note 8.5: Executive officer disclosures

Remuneration of executives
The number of executive officers, other than Ministers and Accountable Officers, and their total remuneration during the reporting period are shown in the table below. Total annualised employee equivalent provides a measure of full time equivalent executive officers over the reporting period.

Remuneration comprises employee benefits in all forms of consideration paid, payable or provided in exchange for services rendered, and is disclosed in the following categories

Short-term employee benefits include amounts such as wages, salaries, annual leave or sick leave that are usually paid or payable on a regular basis, as well as non-monetary benefits such as allowances and free or subsidised goods or services.

Post-employment benefits include pensions and other retirement benefits paid or payable on a discrete basis when employment has ceased.

Other long-term benefits include long service leave, other long-service benefit or deferred compensation.

Termination benefits include termination of employment payments, such as severance packages.

Share-based payments are cash or other assets paid or payable as agreed between the health service and the employee, provided specific vesting conditions, if any, are met.

Remuneration of executive officers (including Key Management Personnel disclosed in Note 8.6)	**2017**	**2016 (a)**
Short-term employee benefits	96,953	-
Post-employment benefits	12,056	-
Termination benefits	-	-
Total remuneration (b)	**109,009**	**-**
Total number of executives (c)	**1**	**-**
Total annualised employee equivalent (AEE) (d)	**1**	**-**

(a) No comparatives have been reported because remuneration in the prior year was determined in line with the basis and definition under FDR 21B. Remuneration previously excluded non-monetary benefits and comprised any money, consideration or benefit received or receivable, excluding reimbursement of out-of-pocket expenses, including any amount received or receivable from a related party transaction. Refer to the prior year's financial statements for executive remuneration for the 2015/16 reporting period.
(b) The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of the entity under AASB 124 Related Party Disclosures and are also reported within the related parties note disclosure (Note 8.6).

(c) Annualised employee equivalent is based on the time fraction worked over the reporting period.

Note 8.6: Related parties

The hospital is a wholly owned and controlled entity of the State of Victoria. Related parties of the hospital include:

- all key management personnel and their close family members;
- all cabinet ministers ad their close family members; and
- all hospitals and public sector entities that are controlled and consolidated into the whole of state consolidated financial statements.

All related party transactions have been entered into on an arm's length basis.

Key management personnel during the year for South Gippsland Hospital were:

Mr Peter Rushen	01/07/2016 - 13/01/2017
Ms Anna Stefani	01/07/2016 - 30/06/2017
Ms Christine Trotman	23/01/2017 - 30/06/2017

Key management personnel (KMP) of the hospital include the Portfolio Ministers and Cabinet Ministers and KMP as determined by the hospital. The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The Minister's remuneration and allowances is set by the Parliamentary Salaries and Superannuation Act 1968, and is reported within the Department of Parliamentary Services' Financial Report.

Compensation	**2017**
Short-term employee benefits	220,756
Post-employment benefits	53,366
Termination benefits	-
Total remuneration	**274,122**
Total number of executives	**3**
Total annualised employee equivalent (AEE)	**2**

Transactions with key management personnel and other related parties
Given the breadth and depth of State government activities, related parties transact with the Victorian public sector in a manner consistent with other members of the public e.g. stamp duty and other government fees and charges. Further employment of processes within the Victorian public sector occur on terms and conditions consistent with the Public Administration Act 2004 and Codes of Conduct and Standards issued by the Victorian Public Sector Commission. Procurement processes occur on terms and conditions consistent with the Victorian Government Procurement Board requirements. Outside of normal citizen type transactions with the department, there were no significant related party transactions that involved key management personnel and their close family members. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

Significant transactions with government-related entities
The South Gippsland Hospital received funding from the Department of Health and Human Services of $5,677,673 (2016: $5,810,374).

The South Gippsland Hospital received funding from the Latrobe Regional Hospital of $393,921 (2016: $404,235) for the Transitional Care Program.

Note 8.7. Remuneration of auditors

	2017	2016
Victorian Auditor-General's Office		
Audit of financial statement	21,500	21,000
Total expenses (exclusive of GST)	**21,500**	**21,000**

Note 8.8. AASBs issued that are not yet effective

The table below is provided to assist entities in updating their disclosure in relation to the Australian accounting standards that are issued but not yet effective for 2016-17 in accordance with paragraph 30 of AASB 108. This disclosure should be included in the Summary of Significant Accounting Policies note of entities' financial reports. Entities are expected to review the relevance of the proposed disclosure based on their own circumstances.

Standard/Interpretation	*Summary*	*Applicable for annual reporting periods beginning on*	*Impact on public sector entity financial statements*
AASB 9 Financial Instruments	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	01-Jan-18	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. While there will be no significant impact arising from AASB 9, there will be a change to the way financial instruments are disclosed.
AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)	The requirements for classifying and measuring financial liabilities were added to AASB 9. The existing requirements for the classification of financial liabilities and the ability to use the fair value option have been retained. However, where the fair value option is used for financial liabilities the change in fair value is accounted for as follows: • The change in fair value attributable to changes in credit risk is presented in other comprehensive income (OCI); and • Other fair value changes are presented in profit and loss. If this approach creates or enlarges an accounting mismatch in the profit or loss, the effect of the changes in credit risk are also presented in profit or loss.	01-Jan-18	The assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss. Changes in own credit risk in respect of liabilities designated at fair value through profit and loss will now be presented within other comprehensive income (OCI). Hedge accounting will be more closely aligned with common risk management practices making it easier to have an effective hedge. For entities with significant lending activities, an overhaul of related systems and processes may be needed.
AASB 2014-1 Amendments to Australian Accounting Standards [Part E Financial Instruments]	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	01-Jan-18	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	01-Jan-18	The assessment has indicated that there will be no significant impact for the public sector.

Note 8.8. AASBs issued that are not yet effective (cont)

Standard/Interpretation	*Summary*	*Applicable for annual reporting periods beginning on*	*Impact on public sector entity financial statements*
AASB 15 Revenue from Contracts with Customers	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	01-Jan-18	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications.
AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15	Amends the measurement of trade receivables and the recognition of dividends. Trade receivables, that do not have a significant financing component, are to be measured at their transaction price, at initial recognition. Dividends are recognised in the profit and loss only when: • the entity's right to receive payment of the dividend is established; • it is probable that the economic benefits associated with the dividend will flow to the entity; and • the amount can be measured reliably.	1 Jan 2017, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.
AASB 2015-8 Amendments to Australian Accounting Standards – Effective Date of AASB 15	This Standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	01-Jan-18	This amending standard will defer the application period of AASB 15 for for-profit entities to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2016-3 Amendments to Australian Accounting Standards – Clarifications to AASB 15	This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: • A promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation; • For items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer; and • For licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access).	01-Jan-18	The assessment has indicated that there will be no significant impact for the public sector, other than the impact identified for AASB 15 above.
AASB 2016-7 Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities	This Standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019.	01-Jan-19	This amending standard will defer the application period of AASB 15 for not-for-profit entities to the 2019-20 reporting period.

Note 8.8. AASBs issued that are not yet effective (cont)

Standard/Interpretation	*Summary*	*Applicable for annual reporting periods beginning on*	*Impact on public sector entity financial statements*
AASB 2016-8 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities	This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events. The amendments: • require non-contractual receivables arising from statutory requirements (i.e. taxes, rates and fines) to be initially measured and recognised in accordance with AASB 9 as if those receivables are financial instruments; and • clarifies circumstances when a contract with a customer is within the scope of AASB 15.	01-Jan-19	The assessment has indicated that there will be no significant impact for the public sector, other than the impacts identified for AASB 9 and AASB 15 above.
AASB 16 Leases	The key changes introduced by AASB 16 include the recognition of most operating leases (which are current not recognised) on balance sheet.	01-Jan-19	The assessment has indicated that as most operating leases will come on balance sheet, recognition of the right-of-use assets and lease liabilities will cause net debt to increase. Rather than expensing the lease payments, depreciation of right-of-use assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. No change for lessors.
AASB 2016-4 Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities	The standard amends AASB 136 Impairment of Assets to remove references to using depreciated replacement cost (DRC) as a measure of value in use for not-for-profit entities.	01-Jan-17	The assessment has indicated that there is minimal impact. Given the specialised nature and restrictions of public sector assets, the existing use is presumed to be the highest and best use (HBU), hence current replacement cost under AASB 13 Fair Value Measurement is the same as the depreciated replacement cost concept under AASB 136.
AASB 1058 Income of Not-for-Profit Entities	This standard replaces AASB 1004 Contributions and establishes revenue recognition principles for transactions where the consideration to acquire an asset is significantly less than fair value to enable to not-for-profit entity to further its objectives.	01-Jan-19	The assessment has indicated that revenue from capital grants that are provided under an enforceable agreement that have sufficiently specific obligations, will now be deferred and recognised as performance obligations are satisfied. As a result, the timing recognition of revenue will change.

Note 8.9. Events occurring after the balance sheet date

There have been no events since balance date which have had a material effect on these financial statements. (2016: Nil)

Note 8.10: Alternate Presentation of Comprehensive operating
For the Year Ended 30 June 2017

	Note	2017	2016
Grants			
Operating	2.1	6,111,865	5,906,834
Capital	2.1	51,675	83,676
Interest and Dividends	2.1	45,928	49,798
Other income	2.1	1,922,526	1,756,140
Revenue from Transactions		**8,131,994**	**7,796,448**
Employee Expenses	3.1	(5,692,359)	(5,393,172)
Other Operating Expenses	3.1	(2,233,809)	(2,090,604)
Non-Operating Expenses			
Impairment of non-financial assets	3.1	(43,105)	-
Depreciation and Amortisation	4.5	(362,305)	(366,565)
Expenses from Transactions		**(8,331,578)**	**(7,850,341)**
Net Result from Transactions		**(199,584)**	**(53,893)**
Other economic flows included in net result			
Net gain/(loss) on non-financial assets	2.1	4,089	(173,833)
Total other economic flows included in net result		4,089	(173,833)
Net result from continuing operations		**(195,495)**	**(227,726)**
NET RESULT FOR THE YEAR		**(195,495)**	**(227,726)**
Comprehensive result		**(195,495)**	**(227,726)**

This statement should be read in Conjunction with the accompanying notes

Note 8.11: Glossary of terms and style conventions
For the Year Ended 30 June 2017

Actuarial gains or losses on superannuation defined benefit plans
Actuarial gains or losses are changes in the present value of the superannuation defined benefit liability resulting from
(a) experience adjustments (the effects of differences between the previous actuarial assumptions and what has actually occurred); and
(b) the effects of changes in actuarial assumptions.

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

Associates
Associates are all entities over which an entity has significant influence but not control, generally accompanying a shareholding and voting rights of between 20 per cent and 50 per cent.

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 comprehensive income.

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 expenses
Ex-gratia expenses mean the voluntary payment of money or other non-monetary benefit (e.g. a write off) that is not made either to acquire goods, services or other benefits for the entity or to meet a legal liability, or to settle or resolve a possible legal liability, or claim against the entity.

Note 8.11: Glossary of terms and style conventions (cont.)
For the Year Ended 30 June 2017

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 favorable 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 unfavorable 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
A complete set of financial statements comprises:
(a) Balance sheet as at the end of the period;
(b) Comprehensive operating statement for the period;
(c) A statement of changes in equity for the period;
(d) Cash flow statement for the period;
(e) Notes, comprising a summary of significant accounting policies and other explanatory information;
(f) Comparative information in respect of the preceding period as specified in paragraph 38 of AASB 101 Presentation of Financial Statements; and
(g) A statement of financial position at the beginning of the preceding period when an entity applies an accounting policy retrospectively or makes a retrospective restatement of items in its financial statements, or when it reclassifies items in its financial statements in accordance with paragraphs 41 of AASB 101.

Note 8.11: Glossary of terms and style conventions (cont.)
For the Year Ended 30 June 2017

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.

Investment properties
Investment properties represent properties held to earn rentals or for capital appreciation or both. Investment properties exclude properties held to meet service delivery objectives of the State of Victoria.

Joint Arrangements
A joint arrangement is an arrangement of which two or more parties have joint control. A joint arrangement has the following characteristics:
(a) The parties are bound by a contractual arrangement.
(b) The contractual arrangement gives two or more of those parties joint control of the arrangement
A joint arrangement is either a joint operation or a joint venture.

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.

Note 8.11: Glossary of terms and style conventions (cont.)
For the Year Ended 30 June 2017

Net acquisition of non-financial assets (from transactions)
Purchases (and other acquisitions) of non-financial assets less sales (or disposals) of non-financial assets less depreciation plus changes in inventories and other movements in non-financial assets. It includes only those increases or decreases in non-financial assets resulting from transactions and therefore excludes write-offs, impairment write-downs and revaluations.

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.

Non-produced assets
Non-produced assets are assets needed for production that have not themselves been produced. They include land, subsoil assets, and certain intangible assets. Non-produced intangibles are intangible assets needed for production that have not themselves been produced. They include constructs of society such as patents.

Non-profit institution
A legal or social entity that is created for the purpose of producing or distributing goods and services but is not permitted to be a source of income, profit or other financial gain for the units that establish, control or finance it.

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 startup costs associated with capital projects).

Public financial corporation sector
Public financial corporations (PFCs) are bodies primarily engaged in the provision of financial intermediation services or auxiliary financial services. They are able to incur financial liabilities on their own account (e.g. taking deposits, issuing securities or providing insurance services). Estimates are not published for the public financial corporation sector.

Public non-financial corporation sector
The public non-financial corporation (PNFC) sector comprises bodies mainly engaged in the production of goods and services (of a non-financial nature) for sale in the market place at prices that aim to recover most of the costs involved (e.g. water and port authorities). In general, PNFCs are legally distinguishable from the governments which own them.

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.

Note 8.11: Glossary of terms and style conventions (cont.)
For the Year Ended 30 June 2017

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.

Taxation income
Taxation income represents income received from the State's taxpayers and includes:
- payroll tax; land tax; duties levied principally on conveyances and land transfers;
- gambling taxes levied mainly on private lotteries, electronic gaming machines, casino operations and racing;
- insurance duty relating to compulsory third party, life and non-life policies;
- insurance company contributions to fire brigades;
- motor vehicle taxes, including registration fees and duty on registrations and transfers;
- levies (including the environmental levy) on statutory corporations in other sectors of government; and
- other taxes, including landfill levies, license and concession fees.

Transactions
Revised Transactions are those economic flows that are considered to arise as a result of policy decisions, usually an interaction between two entities by mutual agreement. They also include flows in an entity such as depreciation where the owner is simultaneously acting as the owner of the depreciating asset and as the consumer of the service provided by the asset.

Taxation is regarded as mutually agreed interactions between the government and taxpayers. Transactions can be in kind (e.g. assets provided/given free of charge or for nominal consideration) or where the final consideration is cash.

Style conventions
Figures in the tables and in the text have been rounded. Discrepancies in tables between totals and sums of components reflect rounding. Percentage variations in all tables are based on the underlying unrounded amounts.

The notation used in the tables is as follows:
zero, or rounded to zero
(xxx.x) negative numbers
201x year period
201x-1x year period