

Bairnsdale Regional
Health Service

...focusing on you

Bairnsdale Regional Health Service

Annual Report

2012 - 2013

Focusing on you

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PRESIDENT AND CEO REPORT

On behalf of the Board of Management (BOM), management and staff we are pleased to present the 2012 -2013 Annual Report of Bairnsdale Regional Health (BRHS).

This is the third year that we have had a formal agreement with the Department of Health called a Statement of Priority which sets out the expectations of our performance for the 2012-13 financial year. We are pleased to report that we have made substantive achievements against these expectations and targets as outlined within this Annual Report.



It has been a year of change and many achievements for BRHS. The CEO has now been in the role for 12 months and we have undertaken an inclusive and consultative process to develop our new Strategic Plan which will be formally launched at our Annual General Meeting. This process to develop the new Strategic Plan has created objectives to guide the organisation over the next five years. This plan is also the foundation for the development of robust departmental Work Plans which are created annually to ensure we are all working together to achieve these five year objectives.

We have been successful in recruiting some key specialist medical staff to join our team. Craig Clarke, a Gerontologist, commenced working with us in March and will take a key role in enhancing our sub-acute services. Lee Van Schoor commenced as a full time General Surgeon and will add to the current surgical team to help ensure we have a sustainable surgical service. Marcel van der Heiden an experienced Physician commenced and will assist us in achieving our aspiration to increase the level of care we can provide at BRHS. We have also been successful in having a second Oncologist join our team and he will commence providing service in September 2013.

We have developed a number of frameworks which will enhance our governance in the key areas of enterprise risk management, clinical governance and workforce planning. These Frameworks include a number of performance indicators and measurements that will be reported to the Board as part of a newly developed Board Reporting Dashboard. This reporting system creates a different dialogue between the Board and the organisation and helps us to understand the true health of the organisation. These indicators measure the, quality and safety of the care we provide to our consumers, the health of our finances, our ability to meet funder and community expectations and the wellbeing and capability of our staff.

There have been a number of changes at a Board level. Peter Crick resigned in June after 20 years on the Board and a number of years as the Chair during a time of growth and change. Charme Sedunary served for one term and retired at the end of this financial year. We thank them both for their commitment to BRHS. The Board will have three new members join us for the 2013-14 and beyond. Dr John Urie is on the Board representing the VMOs and takes an active part in decision making.

We are pleased to report that we have made significant progress in the implementation of the recommendations from the DLA Piper Review and in most cases the recommendations have already been fully implemented. This positive progress has been confirmed by a formal review of progress undertaken by Dr Heather Wellington from DLA Piper. This follow up was part of a commitment that the Board made to get an external assessment about the overall health of the organisation. This follow up review was overwhelmingly positive and a summary of the findings will be found on our website.

We would also like to take this opportunity to thank our volunteers and fundraising auxiliaries for their generosity, time and effort on behalf of the health service and the East Gippsland community.

As Board Chair and CEO we would like to sincerely thank the Board, management, volunteers and staff for their support and unwavering commitment to BRHS and to the community of East Gippsland for their support through a period of significant internal change. We look forward to the continuing development of the organisation and enhancement of the services we provide. We also look forward to exciting new models of integrated care and capital works projects that will commence during the 2013-14 financial year to continue the improvement of the environment for both our consumers and staff.



Angela Hutson
President, Board of Management



Therese Tierney
Chief Executive Officer

CHARTER AND PURPOSE

Establishment

The Bairnsdale Regional Health Service (BRHS) is established under the Health Services Act 1988. The responsible Minister during the reporting period is the Hon David Davis MP.

Strategic Plan – Mission, Vision, Values and our Motto

Mission

Leading, shaping and delivering quality health care services to East Gippsland.

Vision

To be a key provider of healthcare services in East Gippsland through:

- Innovation in the delivery of health care services
- Recognition by its clients as being committed to quality care
- Working in partnership with other healthcare providers
- Responsiveness to community needs
- Recognition by its staff as an employer who values their contributions; and
- Delivery of cost effective services

Values

- Customer Service
- Respect
- Teamwork
- Efficiency

Our motto

...focusing on you



Summary of Key Achievements

This has been a year of great change, the development of new initiatives at BRHS listed below are a number of the highlights and achievements:

- A new Strategic Plan has been developed through a highly consultative process involving staff and the community. This process has added value to the development of objectives that are relevant and significant to BRHS.
- We were successful in delivering on the expectations as described in the 2012-13 Statement of Priorities.
- The completion of the Junior and Senior Medical Workforce Plans and the successful recruitment of a Surgeon, a Physician a Geriatrician and a second Oncologist.
- Finalisation of the executive team structure with three dedicated Directors: Director of Medical Service, Director of Nursing, Midwifery and Aged Care and the Director of Allied, Community and Support Services and the appointment of a Chief Financial Officer.
- Dr John Urie appointed as the Visiting Medical Officer attendee to Board of Management meetings.
- A Clinical Governance Framework was developed and is being implemented. This includes the establishment of indicators and the successful implementation of a new clinical governance committee structure.
- A Risk Management Framework was developed and implemented. This also includes the development of a revised OH&S Plan and policy and the recruitment of a skilled OH&S and Risk Manager.
- Successful accreditation of the Aged Care Services was achieved and significantly successful outcomes were noted with the subsequent unannounced inspections.
- A successful Postgraduate Medical Council Victoria (PMCV) accreditation was maintained and junior medical staff satisfaction improved.
- A significant reduction in our unplanned readmissions to 2.5% of our total admissions.
- The successful implementation of the DLA Piper recommendations as confirmed by Dr Heather Wellington's subsequent DLA Piper progress report.
- A staff Positive Health and Wellbeing Action Plan has been developed and is currently being implemented.
- Our participation and leadership in partnership activities were expanded with other health services in the sub region and more broadly.
- A new Instrument of Delegation has been developed to provide clarity and authority to the organisation
- An Aboriginal Employment Plan was developed and we were successful in recruiting six aboriginal trainees in nursing, dental and allied health roles.
- The reconfiguration of many of our services has improved the coordination and integration of these services and met the current targets and reporting requirements.
- The design and funding of a \$1 million capital works program to reconfigure the triage area in the Emergency Department and to develop a Short Stay Unit was undertaken. The design includes some modifications in the wards to improve the environment for both our consumers and staff.
- The Team Leader of our My Midwife program Angela Kellock was nominated by a consumer and awarded the Victorian Midwife of the Year. This award has significant recognition in the industry.
- BRHS Chief Pharmacist, Margie Griffiths, has been appointed to the Palliative Care Clinical Network representing the pharmacy aspects palliative care and influencing state-wide policy.

Functions, Powers and Duties

BRHS provides healthcare services to more than 40,000 people across the East Gippsland Shire covering an area of 21,000 square kilometres. Towns to benefit from the services of BRHS include Bairnsdale, Benambra, Bruthen, Buchan, Ensay, Lakes Entrance, Lindenow, Mallacoota, Metung, Omeo, Orbost, Paynesville, Swan Reach and Swifts Creek.

- Hospital services operate from the main campus in Day Street, Bairnsdale and include emergency services, acute and post-acute services, specialist consulting rooms, dialysis and oncology outpatient services, allied health outpatient services, radiology, pathology and residential aged care facilities.
- Community health services are located in both Bairnsdale and Paynesville providing outpatient allied health services, Planned Activity Group, and dental services in Bairnsdale. Outreach Planned Activity Groups are also located in Metung, Buchan, Bruthen, Lindenow and Paynesville.
- Outreach healthcare and education services are also provided throughout the region including allied health services at the Lake Tyers Aboriginal Trust and the Gippsland and East Gippsland Aboriginal Co-operative (GEGAC); outreach midwifery and maternal health, district nursing and in-home palliative care.

BRHS work is in partnership and its services are complimented by other East Gippsland health services such as Gippsland Lakes Community Health, Omeo District Health, Orbost Regional Health and our Bush Nursing Centre colleagues.



NATURE AND RANGE OF SERVICES PROVIDED

Services

Acute & Sub Acute Health

Dialysis
Emergency Services
Geriatric Evaluation and Management
Hospital in the Home (HITH)
Medical
Medical Imaging
Obstetrics
Oncology
Paediatrics
Palliative Care Pathology (through Gippsland Pathology)
Pharmacy
Rehabilitation
Stomal Therapy
Surgical Care
Theatre
Non – Emergency Patient Transport

Aged Care

Residential Dementia
Residential High Care
Residential Low Care
Respite Care

Allied Health

Allied Health Assistants
Cardiac Rehabilitation Group
Diabetes Exercise Group
Dietetics
Falls Prevention Group
Koori Hospital Liaison
Mobility Group
Occupational Therapy (including Hand Therapy and Lymphedema Management)
Orthopaedic Rehabilitation Group
Physiotherapy
Pulmonary Rehabilitation Group
Podiatry
Social Work
Speech Pathology

Ancillary

Medical Library
Mental Health (through Latrobe Regional Hospital)

Community Health

Adolescent Health
Breast Care

Cardiac Rehabilitation
Community Dental Health Program
Continence Advisory Service
Dental
Diabetes Education
Home Based Nursing Service (District Nursing)
Hospital Admission Risk Program (HARP)
Hospital in the Home (HITH)
Needle Exchange Program
Palliative Care
Planned Activity Group (PAG)
Post-Acute Care (PAC)
Pulmonary Rehabilitation
QUIT program – smoking cessation
Women's Health

Visiting Specialists

Audiology
Cardiology
Cognitive, Dementia and Memory Service
Dietetics
Gastroenterology
General Physician
General Surgeon
Geriatric Medicine
Gynaecology
Ear, Nose and Throat Surgeon
Infusion Nurse
Low Fertility Clinic
Low-Vision Clinic
Neuropsychology
Nephrology
Oncologist
Ophthalmologist
Orthopaedics
Outreach Polio Clinic (bi-annual)
Paediatric Surgeon
Paediatrician
Physician
Physiotherapy (Women's Health)
Psychology
Rehabilitation Cardiologist
Renal Physician
Rheumatologist
Urologist
Vascular Surgeon
Women's Health

Visiting Specialists and Medical Officers

Cardiologists

Dr David Bertovic
Dr Justin Mariani
Dr Meroula Richardson
Dr James Shaw
Mr Andrew Taylor

Head, Neck, Nose & Throat

Prof Andrew Sizeland
Mr Guillermo Hurtado

Gastroenterologists

Dr David Iser
Dr Jeremy Ryan

General Surgeons

Mr Adrian Aitken
Mr Anamitra Sarkar
Mr Clem Smith
Mr Servaise de Kock

Gynaecologists

Dr Robert McKimm
Dr Michael Sedgley
Dr Gareth Weston

Nephrologists

Dr. David Hooke
Prof David Power

Oncologists

Dr John Scarlett

Ophthalmologist

Dr Pradeep Madhok

Orthopaedic / Legal

Dr Stan O'Loughlin

Orthopaedic Surgeons

Mr Andries DeVilliers
Mr Peter Rehfisch
Mr Warwick Wright

Paediatricians

Dr Peter Goss
Dr Jo McCubbin
Dr Austen Erasmus
Dr Sylvia Welgemoed

Paediatric Surgeons

Mr Chris Kimber
Mr Neil McMullen

Physician

Dr Krishna Mandaleson

Rehabilitation Physician

Dr David McConachy

Rheumatologists

Assoc Prof Peter Ryan

Urologists

Prof Mark Frydenberg
Dr Jeremy Grummet

Vascular Surgeon

Mr Peter Milne

Visiting Medical Officers

Dr Andrew Rutherford
Dr Daniel Otuonye
Dr Daryl Smith
Dr David McConville
Dr Elizabeth Boyd
Dr Graham Bromwich
Dr John Urie
Dr Poh Ng
Dr Myles Chapman (Field Emergency Medical Officer)
Dr Naveen Joshi
Dr Peter Lindstedt
Dr Peter Worboys
Dr Phillip Sewell
Dr Ross de Steiger
Dr Sema Yilmaz
Dr Sue George
Dr Tomasz Grabinski
Dr Wanda Wysocka-Grabinska

Senior Medical Officers

Dr Scott Deller
Dr Mark Pritchard
Dr Hulme Hay

Director of Medical Services

Dr Ka Chun Tse

Gippsland Lakes Community Health
District Medical Officers serving the
Hospital in the Home Program.

Cunninghame Arm Medical Centre District
Medical Officers serving the Hospital in the
Home Program.

BOARD OF MANAGEMENT

President

Angela Hutson

Appointed 2000

Bachelor of Arts; Dip Ed; Masters in Organisational Leadership; Graduate Dip Business in Entrepreneurship and Innovation; Grad Cert Enterprise Management; Diploma of Frontline Management.

Extensive experience in senior executive management and governance in the public sector. Up until May 2011 was CEO of East Gippsland TAFE. Currently working as a Management and Education Consultant.

Vice President

Doug Vickers

Appointed July 2011

Dip Edu & Grad Dip Edu

Principal, Bairnsdale West Primary School for over 10 years. East Gippsland Schools Network chair for past 6 years.

Public Service Medal in 2007 for working with the indigenous community and children with special needs

Active member of a number of community and sporting groups

Treasurer

John Websdale

Appointed July 2011

Dip Management

Director Development, East Gippsland Shire with over 30 year experience specialising in corporate services, governance functions and regional development.

Philippa deVoil

Appointed 2001

BA (Admin); Dip App Sc.(Nursing)

Former Executive Director of Nursing, Served on various government advisory committees. Extensive health service experience including aged care services in public and private sectors at management and board levels. Rotarian and local volunteer.

Dr David Formby

Appointed 2008

MB BS.DCH; FRACP; FRCP; FRACMA; MHA.

Former Medical Director Princess Margaret Hospital for Children, Perth, Wangaratta Regional Hospital and Latrobe Regional Hospital. Previous Treasurer and Chairman of the Federal Assembly of the AMA. Former surveyor with the Australian Council of Health Care Standards. Formerly Consultant Paediatrician at Princess Margaret Hospital, Latrobe Regional Hospital and Bairnsdale Regional Hospital. Past President of the Bairnsdale Golf/Bowls Club.

Lindley Jones

Appointed July 2011

DipB(FLM); Grad.Dip. Emergency Health(MICA); AdvDip MICA Paramedics; Grad.Dip.VET UniMelb; BNursing.

Extensive experience in medical emergencies and is an active community member.

Charme Sedunary

Appointed July 2010

Retired 30 June 2013

Former office manager at Slap Architects. Treasurer of the Pelicans community fundraising committee. Area of expertise is Human Resource management.

Peter Crick

Appointed to Board in 1992.

Retired 30 June 2013

Held various bank management positions in the Gippsland region and Tasmania over a 23 year period from 1979 – 2002. Board President in 2001 – 2003 and 2010 – 2012. Significant association with Freemasons Victoria over 46 years and currently Deputy First Grand Principal of the Supreme Grand Chapter. Keen gardener and walker.

Dr Michael Taffy Jones

Delegate to the Board of Management

Attendance 2012/13. Appointed by the Minister April 2012 for a term of 1 year. Term which was completed in April 2013

Board of Management Attendance 2012/13

For the 2012/13 period there were 10 meetings held. No meeting was held in January, due to annual Board break or in July, due to a change in the scheduling of Board meetings.

Angela Hutson	9/10
Doug Vickers	8/10
John Websdale	9/10
Philippa deVoil	9/10
Dr David Formby	9/10
Lindley Jones	8/10
Charme Sedunary	6/10
Peter Crick	7/10

Audit and Risk Committee

The Audit and Risk Committee is a sub-committee of the Board of Management. The committee assists the Board in fulfilling its governance responsibilities relating to and including, the accounting and financial reporting process, external and internal audit functions, the risk management system and legal and regulatory requirements. The committee meets a minimum of 6 times each year.

Committees member during 2012/13 were;

John Websdale
Doug Vickers
Peter Crick

Clinical Credentialing Committee

The Clinical Credentialing committee is a sub-committee of the Board of Management. The committee is responsible for assessing the professional expertise, competence, reputation and authenticity of the qualifications of medical staff seeking appointment or re-appointment to the medical staff of BRHS. The committee meets as required.

Committees member during 2012/13 were;

Peter Crick
Doug Vickers
Lindley Jones

Quality Committee

The Quality Committee is a sub-committee of the Board of Management. The committee oversees each dimension of quality, safety, effectiveness and appropriateness to ensure an organisational wide quality program and culture exists. The committee meets every second month (6 times per year).

Committees member during 2012/13 were;

Philippa deVoil
David Formby
Lindley Jones
Charme Sedunary



Back row L-R: Lindley Jones; Philippa deVoil; Doug Vickers (Vice Chair)
Front row L-R: David Formby; John Websdale (Treasurer); Angela Hutson (Chair); John Urie (VMO invitee)
Absent: Charme Sedunary and Peter Crick

CHIEF EXECUTIVE OFFICER, DIRECTORS AND CHIEF FINANCIAL OFFICER

Therese Tierney

Chief Executive Officer

RN, CRRN (USA), Grad Dip Bus, FIPPA

The Chief Executive Officer (CEO) is responsible for the effective operation of BRHS for the integration of services to provide a seamless continuum of care to the community, for the general direction of all business and affairs of the BRHS as a whole, and for advising and making recommendations to the Board of Management with respect to these activities.

The CEO BRHS is also CEO of (MDHSS) via consent by the Committee of Management MDHSS and agreement by the Board of Management BRHS.

Ka Chun Tse

Director of Medical Services

MBBS, MHM, MPH, AFACHSM

The Medical Services Directorate at BRHS supports the operation and development of the medical workforce, pharmacy, radiology services, health information services, elective surgery access coordination, and health sciences library.

It also oversees the clinical and research governance of the health service, and works collaboratively with the East Gippsland Regional Clinical School to support medical student placements at BRHS.

Bernadette Hammond

Director of Nursing, Midwifery and Aged Care

RN, RM, CCN, BNrsg, MHSM (Monash)

The Nursing, Midwifery and Aged Care Directorate at BRHS incorporate a range of clinical, nursing, community and residential aged care services. This covers the services provided by the Emergency Department, general surgical, maternity, medical inpatient care, District Nursing, health independence programs, transition from hospital to home (discharge) and follow-up care, high and low level residential care for older people, renal dialysis and the oncology and medical ambulatory day unit for those requiring chemotherapy or other treatment on a day stay basis. The Directorate also incorporates and manages patient liaison and volunteer services, palliative care and infection prevention across the organisation.

Brendan Coulton

Director of Allied, Community and Support Services

B.A Science, Dip Education, M.B.A, Hon Bail Justice.

The Allied Health, Community and Support Services Directorate at BRHS provides leadership to the planning and operation of allied health services both inpatient and outpatients. The role provides management support to the Community nursing services (including Diabetes, Continence, Women's and family health), Dental service and Planned Activity Groups based at the Ross Street Campus. The Directorate includes the Post-Acute Care program and Consulting Suites in addition to Infrastructure and Hotel Service areas of Food, Environmental and Facilities. Risk Management, Occupational Health and Safety, Executive Projects, Supply and Emergency Management provide great diversity to the role.

Tania Donaldson

Chief Financial Officer

CA, B.Bus, Grad Cert Computing

The Finance section is responsible for the provision of main reception, finance and supply services. It ensures the operational practices are consistent with the Financial Management Act 1998. Responsible for producing financial reports, monitoring, evaluating and reporting on organisational performance. Provides leadership in financial analysis and interpretation of financial results. Responsible for annual financial statement and budget compilation. Currently developing the clinical costing area and coordinating the implementation of systems to ensure readiness for Activity Based Funding. Ensure compliance with Hospital Purchasing Victoria and Victorian Industry Participation Policy in purchasing. Coordinate annual Securing Our Health System submission and maintain the fixed asset register and capital plan.

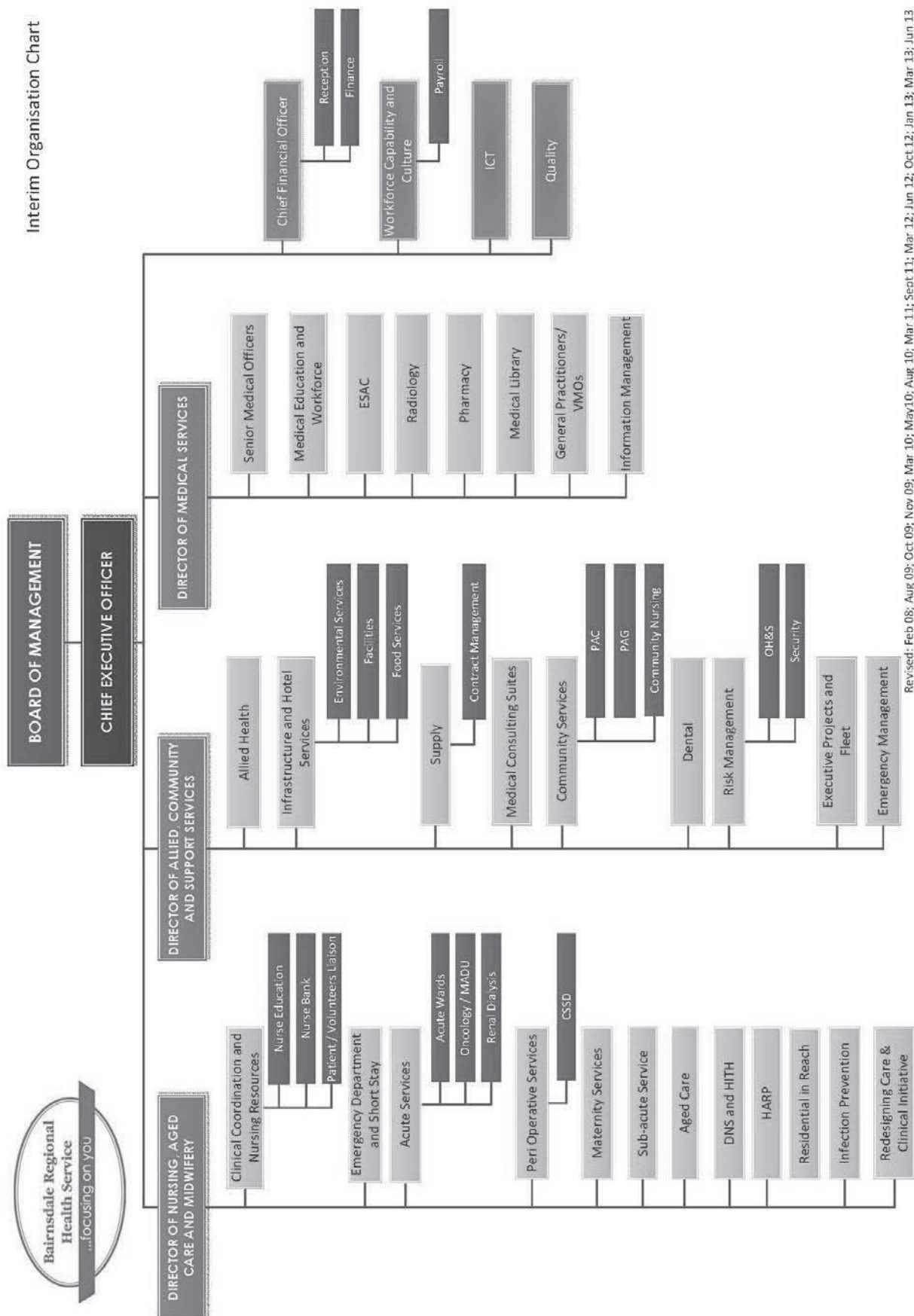
Michele Gardner

Former Director Clinical (Nursing) & Corporate Service. Acting Chief Executive Officer February 2012 - July 2012

Resigned February 2013

Organisational Structure

Interim Organisation Chart



WORKFORCE

Labour Category – Full Time Equivalent

Labour Category	JUNE Current Month FTE*		JUNE YTD FTE**	
	2012	2013	2012	2013
Nursing	193.55	206.41	189.63	197.94
Administration and Clerical	73.75	74.21	70.81	75.74
Medical Support	30.36	32.28	30.60	30.38
Hotel and Allied Services	111.59	114.48	107.50	115.97
Medical Officers	3.29	3.05	2.45	2.83
Hospital Medical Officers	12.82	12.52	13.29	16.30
Sessional Clinicians	0.00	0.00	0.00	0.00
Ancillary Staff (Allied Health)	29.78	31.01	32.69	31.09
Total	455.14	473.96	446.97	470.25

Employment Principles

BRHS ensures that the employment processes are designed to assess applicants against the selection criteria to appoint the most suitable applicant.

The employment principles are open to all without systemic, hidden or apparent bias on the grounds of gender, race, disability, sexuality, age, marital status, pregnancy, potential pregnancy, breastfeeding, religious belief, medical record, irrelevant criminal record or trade union activity and reflect best practice.

Code of Conduct

BRHS is committed to the Public Sector values and workplace equity principles. This includes equal opportunity, freedom from all forms of discrimination and creating and maintaining a work environment where all employees are treated with dignity and respect. The integrity of the organisation is based on embracing diversity and valuing human rights.

As a public health service, BRHS employees are required to abide by the 'Code of Conduct for Victorian Public Sector Employees' (Code of Conduct).

Certain professionals within the health service may be subject to professional codes of conduct that establish specific behaviours relevant to their profession. Where this is the case individuals are expected to read the 'Code of Conduct for Victorian Public Sector Employees' in conjunction with any professional codes of conduct.

BRHS and its employees will abide by the Public Sector Values; Responsiveness, Integrity, Impartiality, Accountability, Respect, Leadership, Human Rights.



REPORT OF OPERATIONS

Responsible Bodies Declaration

In accordance with the Financial Management Act 1994, I am pleased to present the Report of Operations for BRHS for the year ending 30 June 2013.



Angela Hutson
President, Board of Management

BRHS
30 July 2013

Financial Year Summary

	2013 \$000	2012 \$000	2011 \$000	2010 \$000	2009 \$000
Total Revenue	64,819	62,108	59,120	54,816	53,356
Total Expenses	67,091	61,870	59,655	56,371	51,971
Overall Surplus / (deficit)	(2,273)	238	(535)	(1,555)	1,385
Retained Surplus / (deficit)	7,615	9,896	9,633	8,170	9,245
Total Assets	69,040	68,027	67,918	65,521	66,902
Total Liabilities	20,494	20,657	20,787	17,854	17,679
Net Assets	48,546	47,369	47,132	47,667	49,222
Total Equity	48,546	47,369	47,132	47,667	49,222

Changes in Prices, Fees, Charges, Rates and Levies

The Service charges fees for services it provides to: Aged Care Residents, Allied Health Clients accessing services through HACC and CACPs and District Nursing, as well as private patients in our main hospital. On all of these occasions BRHS charges according to schedules of fees published by the appropriate federal authority, and fees are only increased when advice is received from the appropriate Commonwealth Department.

Significant changes in financial position

There were no significant changes in BRHS's financial position during the 2012/13 Financial Year.

Major Changes affecting achievement of Operational Objectives

There were no major changes affecting achievement of Operational Objectives for BRHS during the 2012/13 Financial Year.

Events subsequent to balance data

There were no events subsequent to balance data for BRHS during the 2012/13 Financial Year.

Consultancies

There were 17 consultancies in this financial year. These consultancies cost \$151,957, with no consultancy costing more than \$100,000.

Consultancy Details <\$10,000		
Number of Consultancies		12
Total \$ of Consultancies (ex GST)		\$36,192
Consultancy Details >\$10,000 and <\$100,000		
North Arm Consulting	\$55,000	Review of residential aged care quality systems, preparation for residential aged care accreditation.
DLA Piper	\$27,540	Progress report of recommendations of governance and management review.
MR Jones	\$20,475	Ministerial delegate to BRHS Board.
Workwell Consulting Pty Ltd	\$16,000	Strategic planning for Board and executive.
Carfi Psychological & Rehab Services	\$13,250	Support services.
Total \$ of Consultancies (ex GST)		\$132,265
Number of Consultancies >\$100,000		0

Occupational Health and Safety (OH&S)

BRHS is committed to providing a safe environment for all staff, volunteers, residents, patients and visitors. To support this commitment, BRHS complies with its obligations under the OH&S Act 2004 and Occupational Health and Safety Regulations 2007.

The BRHS OH&S Committee is made up of management representatives and trained staff health and safety representatives, and meets monthly to address matters relating to workplace safety. The OH&S Committee reviews information about OH&S incidents and hazards so that trends are identified and corrective actions can be put in place to increase workplace safety.

As part of the BRHS Risk Management Governance Framework, indicators have been adopted to monitor OH&S performance including the number and severity of workplace incidents, the number of injuries resulting in lost time and comparison of work-cover claims ratio against an industry benchmark average.

Building and Maintenance compliance

BRHS complies with the building and maintenance provisions of the Building Act 1993

Freedom of Information (FOI)

The FOI Act 1982 gives people the right of access to information held by Bairnsdale Regional Health Service 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 Director of Medical Services.

Health Services charge a fee for FOI requests in accordance with the guidelines set by the Department of Justice. Fees for Medico-Legal requests are also received. The revenue for this financial year is \$3,942.44. The FOI Application fee is waived for those applicants holding a health care card or who demonstrate financial hardship.

Type of request	Number Processed
Freedom of Information	115
Medico-Legal	75
Total	190

National Competition Policy

In accordance with the national competition principles agreed by the Federal and State Governments in April 1995, BRHS has implemented policies and programs to ensure compliance with the National Competition Policy.

Statement of availability of additional information

In compliance with the requirements of FRD 22C Standard Disclosures in the Report of Operations, details in respect of the items listed below have been retained by BRHS and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements, if applicable):

- (a) A statement of pecuniary interest has been completed;
- (b) Details of shares held by senior officers as nominee or held beneficially;
- (c) Details of publications produced by the Department about the activities of the Health Service and where they can be obtained;
- (d) Details of changes in prices, fees, charges, rates and levies charged by the Health Service;
- (e) Details of any major external reviews carried out on the Health Service;
- (f) Details of major research and development activities undertaken by the Health Service 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 the Health Service to develop community awareness of the Health Service and its services;
- (i) Details of assessments and measures undertaken to improve the occupational health and safety of employees;
- (j) General statement on industrial relations within the Health Service and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the Report of Operations;
- (k) A list of major committees sponsored by the Health Service, 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.

Victorian Industry Participation

BRHS did not commence or complete any contracts to which the VIPP Act 2003 would apply.

Disclosure of ex-gratia payments

BRHS discloses that there were no ex-gratia payments incurred or written off during the reporting period.

Financial Donations to BRHS 2012/13

Bequests & Estates

DN Noble & BF Noble	\$20.00
Estate of Arthur Martin	\$19,747.00
Estate of DW Aubrey	\$10,000.00
Estate of Erica Cromwell	\$5,117.18
Estate of Joffre Gilchrist	\$2,000.00
Estate of Ruth M Aubrey	\$5,000.00
In Memory of Leone Pheeney	\$10.00
Matthew & Melissa Davies	\$100.00
Maurice Harper	\$379.00

BRHS Fundraising Auxiliary

Bower Birds	\$37,068.52
Chocolate Sales	\$27.27

Community Group

Bairnsdale Club	\$15,000.00
Criminal Justice Diversion	\$250.00
East Gippsland Newspapers	\$631.70
Engel & Partners	\$10,000.00
Kennedy Trailers	\$110,000.00
LEFCOL	\$50.00
NEN Elearning Package	\$500.00
Ritchies	\$1,512.18
Westpac Bank	\$3,429.26
Yarram Apex Club	\$50.00

Business Sector

Apex Bairnsdale	\$250.00
Ass. of Woolworths Employees	\$50.00
B&D Palliative Care Volunteers	\$17,775.00
Eagers Services Pty Ltd	\$50.00
East Gippsland Makery	\$131.00
La Viva Voce Choir	\$1,010.00
Lions Ladies Club of Orbost	\$200.00
Metung Bloodhounds	\$6,500.00
Noamunga Pty Ltd	\$200.00
Paynesville Bowling Club	\$200.00
Paynesville Pelicans	\$6,835.00
Salaried Consultants	\$76,217.57
Paynesville Uniting Church	\$500.00
Twin Hearts Meditation Group	\$100.00
Urban Funk Dance	\$500.00

Individual

A Dickinson	\$20.00
A Pomeroy	\$50.00
Alison Fathers	\$45.00
Anonymous	\$925.00
B E Fitzpatrick	\$25.00
Bev & Clyde Weir	\$50.00
Bill Roberts	\$70.00
Brendon Croucher	\$2,000.00
Bruce Hailey	\$1,000.00
D & C McArthur	\$20.00
D & J Benjamin	\$25.00
DL & TL Roderick	\$50.00
Don & Noel Robinson	\$20.00
Donald Robinson	\$20.00
Douglas & Margaret Harper	\$49.13
Eileen Gregg	\$18.95

Fiona Woolen	\$10.00
FM & SM Garden	\$200.00
Fred Cannington	\$1,000.00
G & R Davies	\$100.00
Gascoignes	\$50.00
Gill Douglas & Celia Flynn	\$24.57
GP & JM Connley	\$20.00
Graham & Anne Webb	\$60.00
Guido & Filomena Maglione	\$20.00
Gus & Jenny Sperti	\$800.00
Gweneth Cooper	\$1,600.00
Heather Gissing	\$25.00
Ian, Bruce, Margaret & Brian Dean	\$50.00
Ida Weeks	\$20.00
IM & JR Cook	\$50.00
J & M Zagami	\$50.00
Jean Anderson	\$500.00
Jean Butcher & Isobel Ough	\$40.00
Jean Philpot	\$50.00
Jennie Prout	\$100.00
Jenny Radovrich	\$20.00
K E Childs	\$5.00
KC & J A Eckhardt	\$400.00
Ken White - Whites ATS	\$500.00
Kerrie Ferguson	\$50.00
Lana Prout	\$50.00
Lillian Smith	\$15.00
Lina & Joe Minniti	\$20.00
Lorna MacFarlane	\$30.00
Lorraine Davies	\$15.00
M Greenwood	\$5.00
Magistrates Court of Victoria	\$100.00
Margorie Dooley	\$100.00
Marie & Terry Wilson	\$50.00
Marjorie Edsall	\$1,000.00
Maurice Harper	\$20.00
Merle McRae	\$1,500.00
MJ Ray	\$50.00
David M Hull	\$2,000.00
Murray Mitchell	\$25.00
ND & BC Paine	\$50.00
Noel & Barbara Croft	\$20.00
Norma Ward	\$50.00
P F Bills	\$25.00
Robyn Brunt	\$45.00
Roger Johnson	\$400.00
S Avery	\$50.00
Samantha Robinson	\$50.00
Sheila D'Lasselle	\$20.00
Stan Collins	\$20.00
Stephen Lang	\$250.00
T Coucoulas	\$50.00
Terry Semmens	\$20.00
Tess McGreevy	\$50.00
The Hooper Family	\$100.00
Timothy Nicholls	\$10.00
VO & BJ Davies	\$50.00
WR & BM Whitehead	\$50.00
Y & V Voysey	\$200.00

Grand Total **\$348,033.33**

STATEMENT OF PRIORITIES

Statement of Priorities Part A

Priority	Action	Deliverable	Outcome
Developing a system that is responsive to people's needs	In partnership with other providers within the local area apply existing service capability frameworks to maximise the use of available resources across the local area.	Partner with East Gippsland health services to develop an agreed framework for an East Gippsland Health Services Plan, and maximise the use of resources in the sub-region and improve care pathways.	The primary partners have been meeting regularly and are in agreement on the need for a Service/Strategic Plan for the subregion which includes patient pathway development, respects local governance but ensures we act as one system to serve the East Gippsland. The elements of the Plan are now being discussed and the Plan to commence development in early 2014.
	Explore opportunities to develop strategies that support greater service responsiveness for diverse populations.	Aboriginal Health Plan developed in partnership with Gippsland and East Gippsland Aboriginal Cooperative (GEGAC) based on Koolin Balit strategies. Completed Aboriginal Employment Plan.	BRHS has a draft Plan and work on a joint Plan is being developed. Regular meetings between both agencies have been ongoing to improve clinical pathways and referrals. The Aboriginal Employment Plan is completed. BRHS exceeds the public sector employment target and we have commenced a trainee program in nursing allied health and oral health.
Improving every Victorian's health status and experiences	Collaborate with key partners such as members of local PCP, the newly formed Medicare Locals, community health services and Aboriginal health service providers to support local implementation of relevant components of the Victorian Health and Wellbeing Plan 2011–2015.	Collaborate with the East Gippsland Shire Council process to develop an East Gippsland Public Health and Wellbeing Plan 2013-17 that tackles Gippsland's health promotion priorities (Physical Activity, Healthy Eating and Mental Health Promotion).	BRHS has participated actively in the development of the Municipal Health and Wellbeing Plan as a member of the PCP and as an individual agency through the participation in working groups, submission, advice and feedback.

Priority	Action	Deliverable	Outcome
	Consider new models of care and more coordinated services to respond to the specific needs of people with priority clinical conditions.	<p>New emergency model of care and workforce models (e.g., Nurse Practitioner) documented and plan developed for implementation.</p> <p>Review of the Rehabilitation and Geriatric Evaluation and Management Model of Care completed.</p> <p>Evaluation of newly implemented aged care structure completed.</p>	<p>A new workforce model has been implemented successfully and evaluated. The Nurse Practitioner role is about to commence and a candidate identified.</p> <p>As we were successful in recruiting a Geriatrician we delayed the review until he commenced. This review will be undertaken in 2013-14 as part of a formally funded Redesign Project.</p> <p>New structure evaluated with significant improvements in clinical measures and residents satisfaction. Highly commended for the care and quality improvement plan in a recent unannounced inspection by the Aged Care Accreditation Agency</p>
Expanding service, workforce and system capacity	Identify opportunities to address workforce gaps by optimising workforce capability and capacity, and exploring alternative workforce models.	<p>Senior Medical Workforce Plan completed, endorsed by the Board of Management and implementation commenced.</p> <p>Develop strategy to work with the community to resolve the issue of GP shortages with the aim of reducing the impact on the health service and health outcomes.</p>	<p>This work has been completed through a consultative process with the medical staff and VMO's and three of the key role filled – Geriatrician, Surgeon and Physician.</p> <p>BRHS was instrumental in setting up a community taskforce to understand the issues, determine the actions required, and improve community awareness of the issues.</p> <p>There are some early indicators that the GP numbers will improve over time. The success of some aspects of the Medical Workforce Plan has helped to reduce the impact on the health service.</p>
Increasing the system's financial sustainability and productivity	Identify opportunities for efficiency and better value service delivery.	<p>Elective Surgery Access Coordination Service implemented to improve the management of and access to elective surgery.</p> <p>Creation of a data/clinical costing unit to better understand costs of providing inpatient services.</p>	<p>ESAC service have been introduced and current surgical activity and wait lists prioritised</p> <p>Reviewed our existing clinical costing data and extended the initiative to our outpatient and community based services. This initiative is being supported by technology enablers which has made it possible to have this work led and monitored by a Working Group.</p>
	Examine and reduce variation in administrative overheads	Create a formal process for BRHS and other East Gippsland Health Services to work in partnership in recruiting, sharing of services and reducing our administrative costs.	The health services in East Gippsland have been meeting regularly to address a number of areas of collaboration and partnership. This includes joint recruitment and realignment of some services.

Priority	Action	Deliverable	Outcome
	Develop and support alternative arrangements that drive greater financial productivity and sustainability through more efficient purchasing of non- clinical services.	Strategic Financial Plan created to address efficiency generally, capital forecasting and strategies addressing the changing funding environment.	This was deferred to October 2013 as it was determined we needed to understand our current financial drivers better prior to commencing the Planning. Systems have been introduced to predict WIES activity, budget guidelines, the impact of the federal reform, templates to guide the development of business cases and processes for capital planning and forecasting.
Implementing continuous improvements and innovation	Develop and implement improvement strategies that better support patient flow and the quality and safety of hospital services.	Investigate the cause of, and subsequently reduce, unplanned readmissions.	A Working Party was created and data analysed to understand the cause of our unplanned readmissions. Strategies were created for the patient groups identified. Readmission rate reduced from 4% to 2%
	Develop and implement strategies that support service innovation and redesign.	Develop a prioritised Service Improvement Plan and redesign activities integrated into the health services quality system to ensure sustainability of initiatives	Developed a systematic Plan for the review of corporate services and models of care. These reviews have been integrated into the newly introduced departmental Work plans and resourced as part of this process. This has resulted in a number of system changes and quality initiatives monitored through the recent implementation of RiskmanQ and formal project evaluation processes.
Increasing accountability & transparency	Implement systems that support streamlined approaches to clinical governance at all levels of the organisation.	Clinical Governance Framework completed.	This has been completed and implemented. The new indicators identified are now being collected and measured and the new clinical governance committee structures implemented. A number of these indicators are part of the newly developed Board Reporting Dashboard.
	Continue to strengthen the capability of rural health service boards and senior management to ensure that ongoing stewardship obligations of rural and regional health services can be met.	Complete implementation of the Wellington Review. Complete follow-up assessment by DLA Piper.	The recommendations from the DLA Piper review have been implemented. The follow up assessment has also been completed and confirms the positive progress and renewal of the organisation.

Priority	Action	Deliverable	Outcome
Improving utilisation of e-health and Improving communications technology.	Maximise the use of health ICT infrastructure to better connect a broad range of health care and other health – related workforces.	Infrastructure in place for the Telemedicine Plan and the list of participating doctors and specialists available. Work with Monash University to share technology for workforce development and networking.	Installed telemedicine and video conferencing infrastructure in the Day Street site and the Ross Street site to enable an increased number of telemedicine interventions and to enable workforce development. BRHS has an agreement with Monash and is a high level user of their facilities and simulation centre. Monash has also joined the BRHS Clinical Education Committee
	Trial, implement and evaluate strategies that use ICT as an enabler of better patient care.	Development of an electronic system for improving the integration of care and information sharing in the health service.	Reviewed the current systems and rationalised the number of clinical platforms. Increased the use of the Service to Service (S2S) referral system internally and externally. Implementing the reporting and discharge communication components of Bosnet.



Statement of Priorities Part B

Operating Result	Target	2012-13 actuals
Annual Operating result (\$m)	0.000	0.642

WIES activity performance	Target	2012-13 actuals
Percentage of WIES (public and private) performance to target	100	102
Cash management	Target	2012-13 actuals
Creditors	<60 days	42 days
Debtors	<60 days	23 days

Access performance

Emergency Care	Target	2012-13 actuals
Percentage of ambulance transfers within 40 minutes	90	91%
NEAT – Percentage of emergency presentations to physically leave the emergency department for admissions to hospital, be referred to another hospital for treatment, or be discharged within four hours (July – December 2012)	70	76
NEAT – Percentage of emergency presentations to physically leave the emergency department for admissions to hospital, be referred to another hospital for treatment, or be discharged within four hours (January – June 2013)	75	78
Number of patients with length of stay in the emergency department greater than 24 hours	0	6
Percentage of Triage Category 1 emergency patients seen immediately	100%	100%
Percentage of Triage Category 1 to 5 emergency patients seen within clinically recommended times	80%	76

Service Performance

Quality and Safety	Target	2012-13 actuals
Health service accreditation	Full compliance	Compliant
Residential aged care accreditation	Full compliance	Compliant
Cleaning standards	Full compliance	Compliant
Submission of data to VICNISS	Full compliance	Compliant
Hand Hygiene (rate)	70	73.2
Victorian Patient Satisfaction Monitor (OCI)	73	79
Consumer Participation Indicator	75	80
People Matter Survey	Full compliance	Compliant

Maternity	Target	2012-13 actuals
Percentage of women with prearranged postnatal home care	100	92

Statement of Priorities Part C

Funding type Acute Admitted	2012-13 Activity Achievement
WIES Public	4,802
WIES Private	986
Total PPWIES (Public and Private)	5,788
WIES Renal	545
WIES DVA	271
WIES TAC	19
WIES TOTAL	6,624
Subacute Admitted	
Rehab L2 Public	2,565
Rehab L2 Private	587
Rehab L2 DVA	201
GEM Public	840
GEM Private	445
GEM DVA	79
Palliative Care Public	188
Palliative Care Private	51
Palliative Care DVA	37
Subacute non-admitted	
SACS	8,120
SACS DVA	347
Post-Acute Care	743
Post-Acute Care DVA	38
Aged Care	
Aged Care Assessment Service	32,068
Residential Aged Care	61,206
Primary Health	
Community Health / Primary Care Programs	1,825

ATTESTATION OF DATA INTEGRITY

I, Therese Tierney, certify that the BRHS has put in place appropriate internal controls and processes to ensure that reported data reasonably reflects actual performance. The BRHS has critically reviewed these controls and processes during the year.



Therese Tierney
Chief Executive Officer

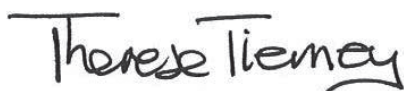
BRHS
30 July 2013

ATTESTATION FOR COMPLIANCE WITH THE MINISTERIAL STANDING DIRECTION 4.5.5.1 - INSURANCE

I, Therese Tierney, certify that the Bairnsdale Regional Health Service has complied with Ministerial Direction 4.5.5.1 – Insurance, except for:

- Maintaining a current register of all insurance and indemnities and making this available to the Victorian Managed Insurance Agency on request, and
- Recording the valuation and basis for valuation of self-insured retained losses.

These items will form actions as part of an overall Strategic Insurance Review having established a year one baseline understanding.

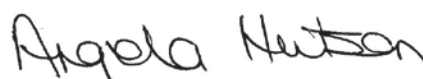


Therese Tierney
Chief Executive Officer

BRHS
30 July 2013

ATTESTATION OF COMPLIANCE WITH AUSTRALIA/NEW ZEALAND RISK MANAGEMENT STANDARD

I, Angela Hutson, certify that the BRHS has risk management processes in place consistent with the AS/NZS ISO 31000:2009 (or an equivalent designated standard) and an internal control system is in place that enables the executive to understand, manage and satisfactorily control risk exposures. The Audit and Risk Committee verifies this assurance and that the risk profile of the BRHS has been critically reviewed within the last 12 months.



Angela Hutson
President, Board of Management

BRHS
30 July 2013



GLOSSARY OF TERMS

Accreditation

To audit and give credentials to.

Acute Care

Care that is generally provided for a short period of time to treat a certain illness or condition.

Cardiac

Relating to, situated near, or acting on the heart.

Chemotherapy

A type of pharmacotherapy used in the treatment or control of disease, particularly cancer.

Dementia

A usually progressive condition marked by the development of multiple cognitive deficits.

Dialysis

The process of removing blood from an artery (as of a kidney patient), purifying it by dialysis, adding vital substances, and returning it to a vein – also called haemodialysis.

Dietetics

The science of diet and nutrition.

DVA

Department of Veterans' Affairs.

Gastroenterology

A branch of medicine concerned with the structure, functions, diseases, and pathology of the stomach and intestines.

Geriatric

A branch of medicine that deals with the problems and diseases of old age and aging people.

Governance

The way in which decisions important for the future of organisations are taken, communicated, monitored and assessed. It includes the processes an organisation has for holding managers accountable and measuring performance.

HACC

Home and Community Care

HARP

Hospital Admission Risk Program that enhances and develops preventive models of care focused on people with chronic and complex conditions to prevent inappropriate emergency presentations or admissions.

HiTH

Hospital in the Home. The provision of hospital care in the comfort of the persons own home.

Intern

A physician gaining supervised practical experience in a hospital after graduating from medical school.

LAOS

Limited Adverse Occurrence Screening is a program that provides rural hospitals with a cost effective way of improving systems and quality of care. It does this by providing anonymous, non-confrontational general practitioner (GP) peer review of selected patient records with the involvement of the treating GP. This independent medical review may be otherwise difficult to obtain the small hospital of a rural community.

Midwifery

The act of assisting at childbirth.

Nosocomial (as in VICNISS)

Acquired or occurring in a hospital

Obstetric

Relating to, or associated with, pregnancy and childbirth.

Occupational Therapy

Treatment aimed at assisting people overcome limitations caused by injury or illness, enabling people to participate in the activities that have meaning to them.

Oncology

A branch of medicine concerned with the investigation, diagnosis and management of people with cancer.

Ophthalmology

A branch of medical science dealing with the structure, functions, and diseases of the eye.

Orthopaedic

A branch of medicine concerned with the treatment of the musculoskeletal system.

Paediatrics

A branch of medicine dealing with the development, care, and diseases of children.

PAG

Planned Activity Group

Palliative

A concept of care which provides coordinated medical, nursing and allied services for people who are terminally ill, delivered where possible in the environment of the person's choice, and which provides physical, psychological, emotional and spiritual support for patients and for patients' families and friends.

Pathway

Clinical pathways are standardised, evidence-based multidisciplinary management plans, which identify an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a homogenous group of patients.

Physiotherapy

The treatment of disease by physical and mechanical means such as massage, regulated exercise, water, light, heat and electricity.

Podiatry

The medical care and treatment of the human foot.

Pressure Ulcer/Area

An area of skin that has been damaged due to unrelieved pressure.

Radiology

A branch of medicine concerned with the use of radiant energy (as X-rays or ultrasound) in the diagnosis and treatment of disease.

Registrar

An admitting officer at a hospital

Renal

Of or relating to the kidneys or the surrounding area

Social Work

Social work is committed to the pursuit of social Justice and addresses situations of personal distress and crisis. Social work is informed by an understanding of human development and behaviour and of complex social structures and processes.

Speech Pathology

The study and treatment of human communication disorders including disorders of speech, language and swallowing.

Stoma

An artificial permanent opening especially in the abdominal wall made in surgical procedures.

Sub-acute care

Goal-oriented interventions aimed at assessing and managing often complex conditions to maximise independence and quality of life for people with disabling conditions.

TAC

Transport Accident Commission

VICNISS

Victorian Nosocomial Infection Surveillance System

VWA

Victorian Workcover Authority (now known as WorkSafe Victoria)

WIES

Weighted Inlier Equivalent Separations – Unit of payment for acute admitted care.

WorkSafe Victoria

Formally Victorian Workcover Authority

Source: Merriam Webster Medical Dictionary (online); Pocket Macquarie Dictionary; Stedman's Medical Dictionary

Bairnsdale Regional Health Service

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


The attached financial statements for Bairnsdale Regional Health Service have been prepared in accordance with Standing Direction 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 2013 and the financial position of Bairnsdale Regional Health Service at 30 June 2013.

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

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

Angela Hutson
Board President



Bairnsdale
28 August 2013

Therese Tierney
Accountable Officer



Bairnsdale
28 August 2013

Tania Donaldson
Chief Financial Officer



Bairnsdale
28 August 2013

INDEPENDENT AUDITOR'S REPORT

To the Board Members, Bairnsdale Regional Health Service

The Financial Report

The accompanying financial report for the year ended 30 June 2013 of Bairnsdale Regional Health Service which comprises the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement, notes comprising a summary of significant accounting policies and other explanatory information, and the Board Member's, Accountable Officer's and Chief Finance and Accounting Officer's declaration has been audited.

The Board Members' Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

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

Independent Auditor's Report (continued)

Independence

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


Opinion

In my opinion, the financial report presents fairly, in all material respects, the financial position of Bairnsdale Regional Health Service as at 30 June 2013 and of its financial performance and its cash flows for the year then ended in accordance with applicable Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*.

Matters Relating to the Electronic Publication of the Audited Financial Report

This auditor's report relates to the financial report of Bairnsdale Regional Health Service for the year ended 30 June 2013 included both in Bairnsdale Regional Health Service's annual report and on the website. The Board Members of Bairnsdale Regional Health Service are responsible for the integrity of Bairnsdale Regional Health Service's website. I have not been engaged to report on the integrity of Bairnsdale Regional Health Service's website. The auditor's report refers only to the subject matter described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these statements. If users of the financial report are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial report to confirm the information contained in the website version of the financial report.

MELBOURNE
28 August 2013


for John Doyle
Auditor-General

Bairnsdale Regional Health Service
Comprehensive Operating Statement
For the financial year ended 30 June 2013

	Note	2013 \$'000	2012 \$'000
Revenue from operating activities	2	62,722	59,236
Revenue from non-operating activities	2	652	787
Employee expenses	3	(40,199)	(36,668)
Non salary labour costs	3	(3,650)	(3,538)
Supplies & consumables	3	(9,006)	(8,015)
Other expenses	3	(9,878)	(9,477)
Net result before capital & specific items		642	2,325
Capital purpose income	2(a)	1,444	2,085
Depreciation	4	(4,307)	(4,123)
Finance costs	5	(51)	(50)
NET RESULT FOR THE YEAR		(2,273)	238
Other comprehensive income			
Items that will not be reclassified to net result			
Changes in property, plant & equipment revaluation surplus	15	3,449	-
Total other comprehensive income		3,449	-
Comprehensive result		1,177	238

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

Bairnsdale Regional Health Service

Balance Sheet

As at 30 June 2013

	Note	2013 \$'000	2012 \$'000
Current assets			
Cash and cash equivalents	6	22,293	22,822
Receivables	7	2,216	2,440
Inventories	8	369	426
Other assets	9	275	153
Total current assets		25,153	25,841
Non-current assets			
Receivables	7	361	86
Property, plant & equipment	10	43,526	42,099
Total non-current assets		43,887	42,185
TOTAL ASSETS		69,040	68,027
Current liabilities			
Payables	11	3,904	5,487
Interest bearing liabilities	12	59	55
Provisions	13	8,318	7,183
Other current liabilities	14	6,051	6,003
Total current liabilities		18,332	18,728
Non-current liabilities			
Interest bearing liabilities	12	785	840
Provisions	13	1,377	1,089
Total non-current liabilities		2,162	1,929
TOTAL LIABILITIES		20,494	20,657
NET ASSETS		48,546	47,369
EQUITY			
Property, plant & equipment revaluation surplus	15a	21,379	17,930
Restricted specific purpose surplus	15a	89	81
Contributed capital	15b	19,463	19,463
Accumulated surpluses/(deficits)	15c	7,615	9,896
TOTAL EQUITY		48,546	47,369
Contingent assets and contingent liabilities	19		
Commitments	18		

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

Bairnsdale Regional Health Service

Statement of changes in equity for the financial year ended 30 June 2013

	Note	Property, Plant & Equipment Revaluation Surplus	Restricted Specific Purpose Surplus	Contributions by Owners	Accumulated Surpluses/ (Deficits)	Total
		\$'000	\$'000	\$'000	\$'000	\$'000
Balance at 1 July 2011		17,930	106	19,463	9,633	47,132
Net result for the year	15a,c	-	-	-	238	238
Transfer from accumulated surplus		-	(25)	-	25	-
Balance at 30 June 2012		17,930	81	19,463	9,896	47,369
Net result for the year		-	-	-	(2,273)	(2,273)
Other comprehensive income for the year	15a	3,449	-	-	-	3,449
Transfer to accumulated surplus	15c	-	7	-	(7)	-
Balance at 30 June 2013		21,379	89	19,463	7,615	48,546

This Statement should be read in conjunction with the accompanying notes

Bairnsdale Regional Health Service

Cash Flow Statement

For the financial year ended 30 June 2013

	Note	2013 \$'000	2012 \$'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating grants from government		48,059	45,549
Patient and resident fees received		11,778	11,489
Donations and bequests received		102	168
GST received from/(paid to) ATO		(221)	25
Interest received		652	787
Other receipts		1,843	1,636
Total receipts		62,213	59,654
Employee expenses paid		(38,897)	(36,246)
Non salary labour costs		(3,619)	(3,538)
Payments for supplies & consumables		(9,006)	(8,015)
Finance costs		(51)	(50)
Other payments		(10,325)	(7,861)
Total payments		(61,898)	(55,709)
Cash generated from operations		315	3,945
Capital grants from government		1,215	168
Capital donations and bequests received		248	1,928
NET CASH FLOW FROM OPERATING ACTIVITIES	16	1,777	6,041
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for non-financial assets		(2,450)	(3,174)
Proceeds from sale of non-financial assets		148	3
NET CASH FLOW USED IN INVESTING ACTIVITIES		(2,303)	(3,172)
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of borrowings		(51)	(69)
NET CASH FLOW USED IN FINANCING ACTIVITIES		(51)	(69)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		(576)	2,799
Cash and cash equivalents at beginning of financial year		16,819	14,019
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6	16,242	16,819

This Statement should be read in conjunction with the accompanying notes

Note 1: Summary of Significant Accounting Policies

These annual financial statements represent the audited general purpose financial statements for Bairnsdale Regional Health Service for the period ending 30 June 2013. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

These financial statements are a general purpose financial statements which have been prepared in accordance with the *Financial Management Act 1994* and applicable Australian Accounting Standards (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 Bairnsdale Regional Health Service on 28 August 2013.

(b) Basis of accounting preparation and measurement

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

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2013, and the comparative information presented in these financial statements for the year ended 30 June 2012.

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

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

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

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

- non-current physical assets, which subsequent to acquisition, are measured at a revalued amount being their fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent losses. Revaluations are made and are reassessed with sufficient regularity to ensure that the carrying amounts do not materially differ from their fair values;
- derivative financial instruments, managed investment schemes, certain debt securities, and investment properties after initial recognition, which are measured at fair value with changes

reflected in the comprehensive operating statement through (fair value through profit and loss); and

- available-for-sale investments which are measured at fair value with movements reflected in equity until the asset is derecognised (i.e. other comprehensive income – items that may be reclassified subsequent to net result);
- the fair value of assets other than land is generally based on their depreciated replacement value.

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

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

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

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

(c) Reporting entity

The financial statements include all the controlled activities of Bairnsdale Regional Health Service.

Its principal address is:

122 Day Street

Bairnsdale

Victoria 3875.

A description of the nature of Bairnsdale Regional Health Service'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

Bairnsdale Regional Health Service's overall objective is to lead and delivering quality health care services to East Gippsland, as well as improves the quality of life to Victorians.

Bairnsdale Regional Health Service is predominantly funded by accrual based grant funding for the provision of outputs.

(d) Scope and presentation of financial statements

Fund accounting

Bairnsdale Regional Health Service operates on a fund accounting basis and maintains three funds: Operating, Specific Purpose and Capital Funds. Bairnsdale Regional Health Service's Capital and Specific Purpose Funds include unspent capital donations and receipts from fund-raising activities conducted solely in respect of these funds.

Services supported by health services agreement and services supported by hospital and community initiatives

Activities classified as *Services Supported by Health Services Agreement* (HSA) are substantially funded by the Department of Health and includes Residential Aged Care Services (RACS) and are also funded from other sources such as the Commonwealth, patients and residents, while *Services Supported by Hospital and Community Initiatives* (H&CI) are funded by the Health Service's own activities or local initiatives and/or the Commonwealth.

Residential aged care service

The Bairnsdale Regional Health Service Residential Aged Care operations are an integral part of Bairnsdale Regional Health Service and share its resources. An apportionment of land and buildings has been made based on floor space. The results of the two operations have been segregated based on actual revenue earned and expenditure incurred by each operation in Note 2b to the financial statements.

The Bairnsdale Regional Health Service Residential Aged Care is substantially funded from Commonwealth bed-day subsidies.

Comprehensive operating statement

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

Capital and specific items, which are excluded from this sub-total, comprise:

- ❖ capital purpose income, which comprises all tied grants, donations and bequests received for the purpose of acquiring non-current assets, such as capital works, plant and equipment or intangible assets. It also includes donations of plant and equipment (refer Note 1(e)). Consequently the recognition of revenue as capital purpose income is based on the intention of the provider of the revenue at the time the revenue is provided.

- ❖ specific income/expense, comprises the following items, where material:
 - Voluntary departure packages
 - Write-down of inventories
 - Non-current asset revaluation increments/decrements
 - Diminution/impairment of investments
 - Restructuring of operations (disaggregation/aggregation of Health Services)
 - Litigation settlements
 - Non-current assets lost or found
 - Forgiveness of loans
 - Reversals of provisions
 - Voluntary changes in accounting policies (which are not required by an accounting standard or other authoritative pronouncement of the Australian Accounting Standards Board)
- ❖ impairment of financial and non-financial assets, includes all impairment losses (and reversal of previous impairment losses), which have been recognised in accordance with Note 1 (i)
- ❖ depreciation and amortisation, as described in Note 1 (f)
- ❖ assets provided or received free of charge (refer to Note 1 (e) and (f))
- ❖ expenditure using capital purpose income, comprises expenditure which either falls below the asset capitalisation threshold or doesn't meet asset recognition criteria and therefore does not result in the recognition of an asset in the balance sheet, where funding for that expenditure is from capital purpose income.

Balance sheet

Assets and liabilities are categorised either as current or non-current, are disclosed in the notes where relevant

Statement of changes in equity

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

Cash flow statement

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

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

Rounding

All amounts shown in the financial statements are expressed to the nearest \$1,000 unless otherwise stated.

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

(e) Income from transactions

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

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

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

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

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

Indirect contributions from the Department of Health

- Insurance is recognised as revenue following advice from the Department of Health.
- Long Service Leave (LSL) – Revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Metropolitan Health and Aged Care Services Division Hospital Circular 05/2013 (update for 2012-13)

Patient and resident Fees

Patient fees are recognised as revenue at the time 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 diagnostic imaging is recognised at the time invoices are 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 reserve, such as the specific restricted purpose reserve.

Interest revenue

Interest revenue is recognised on a time proportionate basis that takes in account the effective yield of the financial asset.

Sale of investments

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

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

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

Other income

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

(f) Expenses recognition

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

Cost of goods sold

Costs of goods sold are recognised when the sale of an item occurs by transferring the cost or value of the item/s from inventories.

Employee expenses

Employee expenses include:

- wages and salaries;
- annual leave;
- sick leave;
- long service leave; and
- superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

Defined contribution superannuation plans

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

Defined benefit superannuation plans

The amount charged to the comprehensive operating statement in respect of defined benefit superannuation plans represents the contributions made by the Health Service to the superannuation 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 Bairnsdale Regional Health Service are entitled to receive superannuation benefits and Bairnsdale Regional 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 bases for determining the level of contributions is determined by the various actuaries of the defined benefit superannuation plans.

The Health Service 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 and 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 Health Service. The name, details and amounts expense in relation to the major employee superannuation funds and contributions made by the Health Services are as follows:

The name and details of the major employee superannuation funds and contributions made by Bairnsdale Regional Health Service are as follows:

Fund	Contributions Paid or Payable for the year	
	2013	2012
	\$'000	\$'000
Defined benefit plans:		
First State Super	80	90
Defined contribution plans:		
First State Super	2,265	2,053
H.E.S.T. Australia Ltd	785	670
Total	3,130	2,813

Depreciation

All infrastructure assets, buildings, plant and equipment and other non-financial physical assets that have finite useful lives are depreciated (i.e. exclude 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 and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health. Assets with a cost in excess of \$1,000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

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

	2013	2012
Buildings		
- Structures	38 to 50 years	38 to 50 years
- Other	23 to 45 years	23 to 45 years
Plant & Equipment	10 years	10 years
Medical Equipment	6 to 7 years	6 to 7 years
Computers and Communication	4 years	4 years
Furniture and Fittings	10 to 14 years	10 to 14 years
Motor Vehicles	8 years	8 years

Please note: the estimated useful lives, residual values and depreciation method are reviewed at the end of each annual reporting period, and adjustment made where appropriate.

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);
- amortisation of discounts or premiums relating to borrowings;
- amortisation of ancillary costs incurred in connection with the arrangement of borrowings; and
- finance charges in respect of finance leases recognised in accordance with AASB 117 Leases.

Grants and other transfers

Grants and other transfer 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 consumable

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 1 (i) Impairment of financial assets.

Fair value of assets, services and resources provided free of charge or for nominal consideration

Contribution 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 Health Service or agency as a consequence of a restructuring of administrative arrangements. In the latter case, such transfer will be recognised at carrying value.

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

Borrowing costs of qualifying assets

In accordance with the paragraphs of AASB 123 *Borrowing Costs* applicable to not-for-profit public sector entities, the Health Services continues to recognise borrowing costs immediately as an expense, to the extent that they are directly attributable to the acquisition, construction or production of a qualifying asset.

(g) Other comprehensive income

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

Net gain/ (loss) on non-financial assets

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

Revaluation gains/ (losses) of non-financial physical assets

Refer to Note 1 (i) Revaluations of non-financial physical assets.

Disposal of non-financial assets

Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal and is determined after deducting from proceeds the carrying value of the asset at that time.

Revaluations of financial instruments at fair value

Refer to Note 1 (h) Financial instruments

Net gain/ (loss) on financial instruments

Net gain/ (loss) on financial instruments includes:

- realised and unrealised gains and losses from revaluations of financial instruments at fair value;
- impairment and reversal of impairment for financial instruments at amortised cost (refer to Note 1 (i)); and

Other gain/ (losses) from other comprehensive income

Other gains/ (losses) include:

- the revaluation of the present value of the long service leave liability due to changes in the bond interest rates; and
- transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

(h) Financial instruments

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 Bairnsdale Regional Health Service's activities, certain financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 Financial Instruments: Presentation. For example, statutory receivable 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 deposits (refer to Note 1 (h)), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

Financial liabilities at amortised cost

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

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

(i) Assets

Cash and Cash Equivalents

Cash and cash equivalents comprise cash on hand and cash at bank, deposits at call and highly liquid investments with an original maturity of 3 months or less, which are held for the purpose of meeting short term cash commitments rather than for investment purposes, which are readily convertible to known amounts of cash and are subject to insignificant risk of changes in value.

Receivables

Receivables consist of:

- contractual receivables, which includes of 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 GST input tax credits recoverable.

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

Receivables are recognised initially at fair value and subsequently measured at amortised cost, using the effective interest method, less any accumulated impairment.

Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition. Collectability of debts is reviewed on an ongoing basis, and debts which are known to be uncollectible are written off. A provision for doubtful debts is recognised when there is objective evidence that the debts may not be collected and bad debts are written off when identified.

Investments and other financial assets

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

Investments are classified in the following categories:

- financial assets at fair value through profit or loss;
- loans and receivables; and
- available-for-sale financial assets.

The Bairnsdale Regional 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.

Bairnsdale Regional 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.

Inventories

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

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

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

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

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

Property, Plant and Equipment

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

The initial cost for non-financial physical assets under finance lease (Refer Note 1 (k)) is measured at amounts equal to the fair value of the leased asset or, if lower, the present value of the minimum lease payments, each determined at the inception of the lease.

Crown land is measured at fair value with regard to the property's highest and best use after due consideration is made for any legal or constructive restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset. Theoretical opportunities that may be available in relation to the asset(s) are not taken into account until it is virtually certain that any restrictions will no longer apply.

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

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

Revaluations of non-current physical assets

Non-current physical assets are measured at fair value and are revalued in accordance with FRD 103D Non-current physical assets. This revaluation process normally occurs at least every five years, based upon the asset's Government Purpose Classification, but may occur more frequently if fair value assessments indicate material changes in values. Independent valuers are used to conduct these scheduled revaluations and any interim revaluations are determined in accordance with the

requirements of the FRDs. Revaluation increments or decrements arise from differences between an asset's carrying value and fair value.

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

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

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

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

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

Prepayments

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.

Disposal of non-financial assets

Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement. Refer to Note 1(g).

Impairment of non-financial assets

All non-financial assets are assessed annually for indications of impairment, except for:

- inventories;
- assets arising from construction contracts.

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

If there is an indication that there has been a change in the estimate of an asset's recoverable amount since the last impairment loss was recognised, the carrying amount shall be increased to its recoverable amount. This reversal of the impairment loss occurs only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation 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 to sell. Recoverable amount for assets held primarily to

generate net cash inflows is measured at the higher of the present value of future cash flows expected to be obtained from the asset and fair value less costs to sell.

Investments in jointly controlled assets and operations

In respect of any interest in jointly controlled assets, Bairnsdale Regional Health Service recognises in the financial statements:

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

For jointly controlled operations Bairnsdale Regional Health Service recognises:

- the assets that it controls;
- the liabilities that it incurs
- expenses that it incurs; and
- the share of income that it earns from selling outputs of the joint venture

Derecognition of financial assets

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

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

Where the Health Service has neither transferred nor 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 Bairnsdale Regional Health Service assesses whether there is objective evidence that a financial asset or group of financial asset is impaired. All financial instruments assets, except those measured at fair value through profit or loss, are subject to annual review for impairment.

Receivables are assessed for bad and doubtful debts on a regular basis. Bad debts considered as written off and allowance for doubtful receivables are expensed.

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

Where the fair value of an investment in an equity instrument at balance date has reduced by 20 per cent or more than its cost price or where its fair value has been less than its cost price for a period of 12 or more months, the financial instrument is treated as impaired.

In order to determine an appropriate fair value as at 30 June 2013 for its portfolio of financial assets, the value was compared against valuation methodologies provided by the issuer as at 30 June 2013. These methodologies were critiqued and considered to be consistent with standard market valuation techniques.

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

Net gain/ (loss) on financial instruments

Net gain/ (loss) on financial instruments includes:

- realised and unrealised gains and losses from revaluations of financial instruments that are designated at fair value through profit or loss or held-for-trading;
- impairment and reversal of impairment for financial instruments at amortised cost; and
- disposals of financial assets and derecognition of financial liabilities.

Revaluations of financial instruments at fair value

The revaluation gain/(loss) on financial instruments at fair value excludes dividends or interest earned on financial assets.

(j) Liabilities

Payables

Payables consist of:

- contractual payables which consist predominantly of accounts payable representing liabilities for goods and services provided to the health service prior to the end of the financial year that are unpaid, and arise when the health service becomes obliged to make future payments in respect of 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 payables.

Contractual payable 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 are not included in the category of financial liabilities at amortised cost, because they do not arise from a contract.

Borrowings

Borrowings are initially recognised at fair value of the consideration received, less directly attributable transaction costs (refer also to note 1 (k)). The measurement basis subsequent to initial recognition depends on, whether the Health Service has categorised its borrowings as either, financial liabilities designated at fair value through profit or loss, or financial liabilities at amortised cost. Any difference between the initial recognised amount and the redemption value is recognised in net result over the period of the borrowing using the effective interest method.

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 provision 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

Wages and salaries, annual leave, sick leave and accrued days off

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

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

Long service leave

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

Current Liability – unconditional LSL (representing 10 or more years of continuous service) is disclosed in the notes to the financial statements as a current liability even where Bairnsdale Regional Health Service does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months.

The components of this current LSL liability are measured at:

- present value – component that Bairnsdale Regional Health Service does not expect to settle within 12 months; and
- nominal value – component that Bairnsdale Regional Health Service expects to settle within 12 months.

Non-current liability – conditional LSL (representing less than 10 years of continuous service) is disclosed as a non-current liability. There is an unconditional right to defer the settlement of the entitlement until the employee has completed the requisite years of service. Conditional LSL is required to be measured at present value.

Consideration is given to expected future wage and salary levels, experience of employee departures and periods of service. Expected future payments are discounted using interest rates of Commonwealth Government guaranteed securities in Australia.

Termination benefits

Termination benefits are payable when employment is terminated before the normal retirement date or when an employee accepts voluntary redundancy in exchange for these benefits.

Liabilities for termination benefits are recognised when a detailed plan for the termination has been developed and a valid expectation has been raised with those employees affected that the terminations will be carried out. The liabilities for termination benefits are recognised in other creditors unless the amount or timing of the payments is uncertain, in which case they are recognised as a provision.

On-costs

Employee benefit on-costs, such as workers compensation, superannuation are recognised together with provisions for employee benefits.

Superannuation liabilities

Bairnsdale Regional 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. The Department of Treasury and Finance administers and discloses the State's defined benefit liabilities in its financial statements.

(k) Leases

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

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

Operating leases – entity as lessee

Operating lease payments, including any contingent rentals, are recognised as an expense in the comprehensive operating statement on a straight line basis over the lease term, except where another systematic basis is more representative of the time pattern of the benefits derived from the use of the leased asset. The leased asset is not recognised in the balance sheet.

(l) Equity

Property, plant & equipment revaluation surplus

The asset revaluation surplus is used to record increments and decrements on the revaluation of non-current physical assets.

Specific restricted purpose reserve

A specific restricted purpose reserve is established where the Health Service has possession or title to the funds but has no discretion to amend or vary the restriction and/or condition underlying the funds received.

Contributed capital

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

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

(m) Commitments

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed by way of a note (refer note 19) at their nominal value and are inclusive of the goods and services tax ("GST") payable. In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant individual projects are stated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

(n) Contingent assets and contingent liabilities

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

(o) Goods and services tax ("GST")

Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the taxation authority. In this case it is recognised as part of the cost of acquisition of the asset or as part of the expense.

Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the taxation authority is included with other receivables or payables in the balance sheet.

Cash flows are presented on a gross basis. The GST components of cash flows arising from investing or financing activities which are recoverable from, or payable to the taxation authority are presented as an operating cash flow.

Commitments for expenditure and contingent assets and liabilities are presented on a gross basis.

(p) Events after the reporting period

Assets, liabilities, income or expenses arise from past transactions or from other past events. Adjustments are made to amounts recognised in the financial statements for events which occur after the reporting period and before the date the financial statements are authorised for issue, where those events provide information about conditions which existed in the reporting period. Note disclosure is made about events between the end of the reporting period and the date the financial statements are authorised for issue where the events relate to conditions which arose after the end of the reporting period and which may have a material impact on the results of subsequent reporting periods.

(q) AASs issued that are not yet effective

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2013 reporting period. DFT assesses the impact of all these new standards and advises the Health Service of their applicability and early adoption where applicable. As at 30 June 2013, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting period commencing after the stated operative dates as detailed in the table below.

Bairnsdale Regional Health Service has not and does not intend to adopt these standards early.

Standard/ Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on public sector entity financial statements
AASB 9 <i>Financial instruments</i>	This Standard simplifies requirements for the classification and measurement of financial assets resulting from Phase 1 of the IASB's project to replace IAS 39 <i>Financial Instruments: Recognition and Measurement</i> (AASB 139 <i>Financial Instruments: Recognition and Measurement</i>).	1 January 2015	Subject to AASB's further modifications to AASB 9, together with the anticipated changes resulting from the staged projects on impairments and hedge accounting, details of impacts will be assessed.
AASB 11 <i>Joint Arrangements</i>	This Standard deals with the concept of joint control, and sets out a new principles-based approach for determining the type of joint arrangement that exists and the corresponding accounting treatment. The new categories of joint arrangements under AASB 11 are more aligned to the actual rights and obligations of the parties to the arrangement.	1 January 2014	<p>Not-for-profit entities are not permitted to apply this Standard prior to the mandatory application date.</p> <p>Subject to AASB's final deliberations and any modifications made to AASB 11 for not-for-profit entities, the entity will need to assess the nature of arrangements with other entities in determining whether a joint arrangement exists in light of AASB 11.</p>
AASB 12 <i>Disclosure of Interests in Other Entities</i>	This Standard requires disclosure of information that enables users of financial statements to evaluate the nature of, and risks associated with, interest in other entities and the effects of those interests on the financial statements. This Standard replaces the disclosure requirements in AASB 127 <i>Separate Financial Statements</i> and AASB 131 <i>Interests in Joint Ventures</i> . The exposure draft ED 238 proposes to add some implementation guidance to AASB 12, explaining and illustrating the definition of a 'structured entity' from a not-for-profit perspective.	1 January 2014	<p>Not-for-profit entities are not permitted to apply this Standard prior to the mandatory application date.</p> <p>Impacts on the level and nature of the disclosures will be assessed based on the eventual implications arising from AASB 10, AASB 11 and AASB 128 <i>Investments in Associates and Joint Ventures</i>.</p>

AASB 13 <i>Fair Value Measurement</i>	This Standard outlines the requirements for measuring the fair value of assets and liabilities and replaces the existing fair value definition and guidance in other Australian accounting standards. AASB 13 includes a 'fair value hierarchy' which ranks the valuation technique inputs into three levels using unadjusted quoted prices in active markets for identical assets or liabilities; other observable inputs; and unobservable inputs.	1 January 2013	Disclosure for fair value measurements using unobservable inputs are relatively detailed compared to disclosure for fair value measurements using observable inputs. Consequently, the Standard may increase the disclosures for required assets measured using depreciated replacement cost.
AASB 119 <i>Employee Benefits</i>	In this revised Standard for defined benefit superannuation plans, there is a change to the methodology in the calculation of superannuation expenses, in particular there is now a change in the split between superannuation interest expense (classified as transactions) and actuarial gains and losses (classified as 'Other economic flows – other movements in equity') reported on the comprehensive operating statement.	1 January 2013	Not-for-profit entities are not permitted to apply this Standard prior to the mandatory application date. While the total superannuation expense is unchanged, the revised methodology is expected to have a negative impact on the net result from transactions a few Victorian public sector entities that report superannuation defined benefit plans.
AASB 127 <i>Separate Financial Statements</i>	This revised Standard prescribes the accounting and disclosure requirements for investments in subsidiaries, joint ventures and associates when an entity prepares separate financial statements.	1 January 2014	Not-for-profit entities are not permitted to apply this Standard prior to the mandatory application date. The AASB is assessing the applicability of principles in AASB 127 in a not-for-profit context. As such, impact will be assessed after the AASB's deliberation.
AASB 1053 <i>Application of Tiers of Australian Accounting Standards</i>	This Standard establishes a differential financial reporting framework consisting of two tiers of reporting requirements for preparing general purpose financial statements.	1 July 2013	The Victorian Government is currently considering the impacts of Reduced Disclosure Requirements (RDRs) for certain public sector entities, and has not decided if RDRs will be implemented to the Victorian public sector.

AASB 1055 Budgetary Reporting	AASB 1055 extends the scope of budgetary reporting that is currently applicable for the whole of government and general government sector (GGS) to NFP entities within the GGS, provided that these entities present separate budget to the parliament	1 January 2014	<p>[If separate budget is presented to the parliament]:</p> <ul style="list-style-type: none"> • The entity will be required to restate in the financial statements the budgetary information in accordance with the presentation format prescribed in Australian Accounting Standards and explain the significant variances from the original budget. <p>[If separate budget is not presented to the parliament]:</p> <ul style="list-style-type: none"> • This Standard is not applicable as no budget disclosure is required.
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(r) Category Groups

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

Admitted patient services (admitted patients) comprises all recurrent health revenue/expenditure on admitted patient services, where services are delivered in public hospitals, or free standing day hospital facilities, or alcohol and drug treatment units or hospitals specialising in dental services, hearing and ophthalmic aids.

Outpatient services (outpatients) comprises all recurrent health revenue/expenditure on public hospital type outpatient services, where services are delivered in public hospital outpatient clinics, or free standing day hospital facilities, or rehabilitation facilities, or alcohol and drug treatment units, or outpatient clinics specialising in ophthalmic aids or palliative care.

Emergency department services (EDS) comprises all recurrent health revenue/expenditure on emergency department services that are available free of charge to public patients.

Aged care comprises revenue/expenditure from Home and Community Care (HACC) programs, Allied Health, Aged Care Assessment and support services.

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

Off campus, ambulatory services (ambulatory) comprises all recurrent health revenue/expenditure on public hospital type services including palliative care facilities and rehabilitation facilities, as well as services provided under the following agreements: Services that are provided or received by hospitals (or area health services) but are delivered/received outside a hospital campus, services which have moved from a hospital to a community setting since June 1998, services which fall within the agreed scope of inclusions under the new system, which have been delivered within hospital's i.e. in rural/remote areas.

Residential aged care including mental health (RAC incl. mental health) referred to in the past as psychogeriatric residential services, comprises those Commonwealth-licensed residential aged care services in receipt of supplementary funding from DH under the mental health program. It excludes all other residential services funded under the mental health program, such as mental health funded community care units (CCUs) and secure extended care units (SECs).

Other services excluded from Australian Health Care Agreement (AHCA) (other) comprises revenue/expenditure for services not separately classified above, including: Public Health Services including Laboratory testing, Blood Borne Viruses / Sexually Transmitted Infections clinical services, Kooris liaison officers, immunisation and screening services, Drugs services including drug withdrawal, counselling and the needle and syringe program, Dental Health services including general and specialist dental care, school dental services and clinical education, Disability services including aids and equipment and flexible support packages to people with a disability, Community Care programs including sexual assault support, early parenting services, parenting assessment and skills development, and various support services. Health and Community Initiatives also falls in this category group.

Note 2: Revenue

Revenue from Operating Activities

Government Grants

- Department of Health
- Victorian Health Funding Pool
- Department of Human Services
- Dental Health Services Victoria
- State Government - Other
- Equipment and Infrastructure Maintenance
- Commonwealth Government
- Residential Aged Care Subsidy
- Other

Total Government Grants

Indirect Contributions by Department of Health

- Insurance
- Long Service Leave

Total Indirect Contributions by Department of Health

Patient and Resident Fees

- Patient and Resident Fees (refer note 2b)
- Residential Aged Care (refer note 2b)

Total Patient & Resident Fees

Business units

- Diagnostic Imaging

Commercial Activities & Specific Purpose Funds

- Private Consulting Suites
- Pharmacy Services

Total Commercial Activities & Specific Purpose Funds

Donations & Bequests

Other Revenue from Operating Activities

Total Revenue from Operating Activities

Revenue from Non-Operating Activities

Interest & Dividends

Other Revenue from Non-Operating Activities

Total Revenue from Non-Operating Activities

Capital Purpose Income

State Government Capital Grants

- Targeted Capital Works and Equipment
- Other

Commonwealth Government Capital Grants

Assets Received Free of Charge (refer note 2d)

Net Gain/(Loss) on Disposal of Non-Financial Assets (refer note 2c)

Donations & Bequests

Total Capital Purpose Income

Total Revenue (refer to note 2a)

HSA 2013 \$'000	HSA 2012 \$'000	H&CI 2013 \$'000	H&CI 2012 \$'000	Total 2013 \$'000	Total 2012 \$'000
20,741	42,850			20,741	42,850
24,737				24,737	-
65	69			65	69
935	806			935	806
	203			-	203
3,691	3,535			3,691	3,535
1,903	2,033			1,903	2,033
52,073	49,497	-	-	52,073	49,497
74	134			74	134
352	(120)			352	(120)
426	14	-	-	426	14
2,735	2,338			2,735	2,338
2,085	2,192			2,085	2,192
4,820	4,530	-	-	4,820	4,530
		3,252	3,220	3,252	3,220
		137		137	-
		185	170	185	170
-	-	3,575	3,390	3,575	3,390
102	168			102	168
1,727	1,636			1,727	1,636
59,147	55,846	3,575	3,390	62,722	59,236
652	787			652	787
				-	-
652	787	-	-	652	787
1,179	123			1,179	123
	45			-	45
36				36	-
		18	15	18	15
		(18)	(11)	(18)	(11)
		230	1,913	230	1,913
1,215	168	230	1,917	1,444	2,085
61,014	56,801	3,805	5,307	64,819	62,108

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

This note relates to revenues above the net result line only, and does not reconcile to comprehensive income

Note 2a: Analysis of Revenue by Source

	Admitted Patients 2013 \$'000	Outpatients 2013 \$'000	EDS 2013 \$'000	Ambulatory 2013 \$'000	RAC 2013 \$'000	Aged Care 2013 \$'000	Primary Health 2013 \$'000	Other 2013 \$'000	Total 2013 \$'000
Revenue from Services Supported by Health Services Agreement									
Government Grants	28,668	3,272	3,619	5,445	4,354	1,918	489	4,309	52,073
Indirect contributions by Department of Health	77							349	426
Patient & Resident Fees (refer note 2b)	1,111	429	51	528	2,085	170	22	423	4,820
Donations & Bequests (non capital)	89	0	1	0	7	1	0	3	102
Other Revenue from Operating Activities	116	1	6	32	17	36	103	1,417	1,727
Interest & Dividends					0			652	652
Capital Purpose Income (refer note 2)								1,215	1,215
Total Revenue from Services Supported by Health Services Agreement	30,061	3,702	3,677	6,006	6,462	2,125	614	8,368	61,014
Revenue from Services Supported by Hospital and Community Initiatives									
Donations & Bequests (non capital)								248	248
Commercial Activities and Specific Purpose Funds								3,575	3,575
Capital Purpose Income (refer note 2)								(18)	(18)
Total Revenue from Services Supported by Hospital and Community Initiatives	-	-	-	-	-	-	-	3,805	3,805
Total Revenue	30,061	3,702	3,677	6,006	6,462	2,125	614	12,173	64,819

Indirect contributions by Department of Health:

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

Note 2a: Analysis of revenue by source (continued)

	Admitted Patients 2012 \$'000	Outpatients 2012 \$'000	EDS 2012 \$'000	Ambulatory 2012 \$'000	RAC 2012 \$'000	Aged Care 2012 \$'000	Primary Health 2012 \$'000	Other 2012 \$'000	Total 2012 \$'000
Revenue from Services Supported by Health Services Agreement									
Government Grants	26,459	3,068	2,620	4,541	4,460	1,452	629	6,268	49,497
Indirect contributions by Department of Health Patient & Resident Fees (refer note 2b)	938	416	28	366	2,192	165	40	14	4,530
Donations & Bequests (non capital)	49	111	3	1		2	1	386	1,681
Other Revenue from Operating Activities	94	121	1	14	11	18	135	1,242	1,636
Interest & Dividends					1			786	787
Capital Purpose Income (refer note 2)								2,096	2,096
Total Revenue from Services Supported by Health Services Agreement	27,539	3,715	2,653	4,922	6,665	1,637	805	10,792	58,728
Revenue from Services Supported by Hospital and Community Initiatives									
Commercial Activities & Specific Purpose Funds								3,390	3,390
Capital Purpose Income (refer note 2)								(11)	(11)
Total Revenue from Services Supported by Hospital and Community Initiatives	-	-	-	-	-	-	-	3,379	3,379
Total Revenue	27,539	3,715	2,653	4,922	6,665	1,637	805	14,172	62,108

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

Note 2b: Private and Resident Fees

Patient and Resident Fees

Acute (incl rehabilitation, GEM and other acute care types)

- Inpatients
- Outpatients

Residential Aged Care

- Generic
- Residential Accommodation Payments

Total Patient and Resident Fees

2013 \$'000	2012 \$'000
1,637	1,302
1,098	1,037
1,522	1,486
563	706
4,820	4,530

Note 2c: Net Loss on Disposal of Non-Financial Assets

Proceeds from Disposals of Non-Current Assets

Medical Equipment

Motor Vehicles

Computers & Communication

Total Proceeds from Disposal of Non-Current Assets

Less: Written Down Value of Non-Current Assets Sold

Medical Equipment

Motor Vehicles

Computers & Communication

Total Written Down Value of Non-Current Assets Sold

Net Loss on Disposal of Non-Financial Assets

2013 \$'000	2012 \$'000
-	3
148	-
-	-
148	3
15	13
150	1
1	-
165	13
(18)	(11)

Note 2d: Assets Received Free of Charge or For Nominal Consideration

During the reporting period, the fair value of assets received free of charge, was as follows:

Plant and Equipment - Public Donations

TOTAL

2013 \$'000	2012 \$'000
18	15
18	15

Note 3: Expenses

	HSA 2013 \$'000	HSA 2012 \$'000	H&CI 2013 \$'000	H&CI 2012 \$'000	Total 2013 \$'000	Total 2012 \$'000
Employee Expenses						
Salaries & Wages	33,743	31,454	1,278	1,075	35,021	32,529
WorkCover Premium	590	388	20	16	610	404
Departure Packages	348	190	-	-	348	190
Long Service Leave	1,034	727	56	6	1,090	732
Superannuation	3,047	2,733	83	80	3,130	2,813
Total Employee Expenses	38,762	35,493	1,437	1,176	40,199	36,668
Non Salary Labour Costs						
Fees for Visiting Medical Officers	2,989	3,128	3	-	2,993	3,128
Agency Costs - Other	587	393	70	17	658	409
Total Non Salary Labour Costs	3,577	3,521	74	17	3,650	3,538
Supplies & Consumables						
Drug Supplies	2,809	2,947	-	-	2,809	2,947
\$100 Drugs	-	192	-	-	-	192
Medical, Surgical Supplies and Prosthesis	3,704	2,654	961	837	4,665	3,491
Pathology Supplies	618	542	1	1	620	543
Food Supplies	913	842	-	-	913	842
Total Supplies & Consumables	8,044	7,177	962	838	9,006	8,015
Other Expenses						
Domestic Services & Supplies	1,004	742	14	19	1,018	761
Fuel, Light, Power and Water	729	588	-	-	729	588
Insurance costs funded by the Department of Health	74	835	-	-	74	835
Motor Vehicle Expenses	138	122	14	11	152	133
Repairs & Maintenance	867	1,013	46	47	913	1,060
Maintenance Contracts	270	288	42	30	312	318
Patient Transport	2,243	2,229	-	-	2,243	2,229
Bad & Doubtful Debts	121	110	-	-	121	110
Lease Expenses	143	104	180	220	323	324
Advertising Expenses	54	54	-	0	54	54
Other Administrative Expenses	3,636	2,828	188	177	3,824	3,006
Audit Fees						
- VAGO - Audit of Financial Statements	33	33	-	-	33	33
- Other	81	26	-	-	81	26
Total Other Expenses	9,394	8,971	484	505	9,878	9,477
Impairment of Assets						
Depreciation & Amortisation			4,307	4,123	4,307	4,123
Finance Costs (refer note 5)			51	50	51	50
Total Impairment of Assets	-	-	4,359	4,172	4,359	4,172
Total Expenses	59,776	55,162	7,315	6,708	67,091	61,870

Note 3a: Analysis of Expenses by Source

	Admitted Patients 2013 \$'000	Outpatients 2013 \$'000	EDS 2013 \$'000	Ambulatory 2013 \$'000	RAC 2013 \$'000	Aged Care 2013 \$'000	Primary Health 2013 \$'000	Other 2013 \$'000	Total 2013 \$'000
Services Supported by Health Services Agreement									
Employee Expenses	10,183	448	2,351	2,161	5,300	1,264	325	16,730	38,762
Non Salary Labour Costs	2,872	3	173	110	-	-	223	197	3,577
Supplies & Consumables	3,076	326	1,752	360	152	63	106	2,209	8,044
Other Expenses from Continuing Operations	12,418	363	3,820	2,565	1,513	547	167	(11,998)	9,394
Total Expenses from Services Supported by Health Services Agreement	28,548	1,140	8,096	5,196	6,964	1,874	821	7,137	59,776
Services Supported by Hospital and Community Initiatives									
Employee Expenses								1,437	1,437
Non Salary Labour Costs								74	74
Supplies & Consumables								962	962
Other Expenses from Continuing Operations								484	484
Total Expenses from Services Supported by Hospital and Community Initiatives	-	-	-	-	-	-	-	2,956	2,956
Depreciation & Amortisation (refer note 4)								4,307	4,307
Finance Costs (refer note 5)								51	51
Total Expenditure from Services supported by Health Services Agreement and by Hospital and Community Initiatives	-	-	-	-	-	-	-	4,359	4,359
Total Expenses	28,548	1,140	8,096	5,196	6,964	1,874	821	14,452	67,091

Note 3a: Analysis of expenses by source (continued)

	Admitted Patients 2012 \$'000	Outpatients 2012 \$'000	EDS 2012 \$'000	Ambulatory 2012 \$'000	RAC 2012 \$'000	Aged Care 2012 \$'000	Primary Health 2012 \$'000	Other 2012 \$'000	Total 2012 \$'000
Services Supported by Health Services Agreement									
Employee Expenses	8,948	1,321	2,140	2,143	4,082	1,146	297	15,415	35,493
Non Salary Labour Costs	2,722	225	274	105			272	(78)	3,521
Supplies & Consumables	6,344	299	394	262	129	46	51	4,732	12,258
Other Expenses from Continuing Operations	6,213	147	4,659	1,929	1,799	208	231	(11,304)	3,883
Total Expenses from Services Supported by Health Services Agreement	24,227	1,992	7,468	4,440	6,010	1,400	853	8,765	55,154
Services Supported by Hospital and Community Initiatives									
Employee Expenses	-	-	-	-	-	-	-	1,176	1,176
Non Salary Labour Costs	-	-	-	-	-	-	-	17	17
Supplies & Consumables	-	-	-	-	-	-	-	838	838
Other Expenses from Continuing Operations	-	-	-	-	-	-	-	513	513
Total Expense from Services Supported by Hospital and Community Initiatives	-	-	-	-	-	-	-	2,543	2,543
Depreciation & Amortisation (refer note 4)	-	-	-	-	-	-	-	4,123	4,123
Finance Costs (refer note 5)	-	-	-	-	-	-	-	50	50
Total Expenditure from Services supported by Health Services Agreement and by Hospital and Community Initiatives	-	-	-	-	-	-	-	4,172	4,172
Total Expenses	24,227	1,992	7,468	4,440	6,010	1,400	853	15,481	61,870

Note 3b: Analysis of Expenses by Internally Managed and Restricted Specific Purpose Funds for Services Supported by Hospital and Community Initiatives

	2013 \$'000	2012 \$'000
Commercial Activities		
Diagnostic Imaging	2,818	2,629
Non-Emergency Patient Transport	(84)	(94)
TOTAL	2,734	2,535

Note 4: Depreciation and Amortisation

	2013 \$'000	2012 \$'000
Depreciation		
Buildings	3,141	3,105
Plant & Equipment	126	112
Medical Equipment	679	554
Motor Vehicles	148	156
Computers & Communication	174	176
Furniture & Fittings	40	19
Total Depreciation	4,307	4,123

Note 5: Finance Costs

	2013 \$'000	2012 \$'000
Interest on Long Term Borrowings	51	50
Total Finance Costs	51	50

Note 6: 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.

	2013 \$'000	2012 \$'000
Cash on hand	6	6
Cash at bank	1,556	1,244
Term Deposits	17,000	15,000
Deposits at Call	3,731	6,572
Total Cash and Cash Equivalents	22,293	22,822
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	16,242	16,819
Cash for Monies Held in Trust		
- Cash at Bank	183	139
- Term Deposits	5,000	5,000
- Deposits at Call	868	864
Total Cash for Monies Held in Trust	6,051	6,003
Total Cash and Cash Equivalents	22,293	22,822

Note 9: Other Assets

CURRENT

Prepayments
GHA Other Current Assets (refer Note 21)
Rental Property Bonds Paid

TOTAL OTHER ASSETS

2013 \$'000	2012 \$'000
226	116
45	36
4	2
275	153

Note 10: Property, Plant & Equipment

Land

Land at Fair Value

Total Land

2013 \$'000	2012 \$'000
2,185	2,185
2,185	2,185

Buildings

Buildings Under Construction at cost

Buildings at Fair Value

Less Acc'd Depreciation

Total Buildings

163	21
36,027	88,240
1	52,690
36,189	35,571

Plant and Equipment

Plant and Equipment at Fair Value

Less Acc'd Depreciation

Total Plant and Equipment

2,395	1,827
1,313	1,225
1,081	602

Medical Equipment

Medical Equipment at Fair Value

Less Acc'd Depreciation

Total Medical Equipment

6,178	5,448
3,420	3,023
2,758	2,425

Motor Vehicles

Motor Vehicles at Fair Value

Less Acc'd Depreciation

Total Motor Vehicles

912	883
350	305
561	578

Computers & Communication

Computers & Communication at Fair Value

Less Acc'd Depreciation

Total Computers & Communication

1,559	1,535
1,139	1,107
421	429

Furniture & Fittings

Furniture & Fittings at Fair Value

Less Acc'd Depreciation

Total Furniture & Fittings

530	474
200	163
330	310

TOTAL PROPERTY, PLANT & EQUIPMENT

43,526	42,099
---------------	---------------

Note 10: Property, plant & equipment (continued)

Reconciliations of the carrying amounts of each class of asset for the entity at the beginning and end of the previous and current financial year are set out below.

	Land \$'000	Buildings \$'000	Plant & Equipment \$'000	Medical Equipment \$'000	Motor Vehicles \$'000	Computers \$'000	Furniture & Fittings \$'000	Total \$'000
Balance at 1 July 2011	2,185	37,147	641	2,029	641	299	119	43,061
Additions		1,529	72	963	92	306	212	3,174
Disposals				(13)			(1)	(13)
Depreciation and Amortisation (note 4)		(3,105)	(112)	(554)	(156)	(176)	(19)	(4,123)
Balance at 1 July 2012	2,185	35,571	602	2,425	578	429	310	42,099
Additions		310	605	1,026	281	166	61	2,450
Disposals				(15)	(150)	(1)	(1)	(165)
Revaluation Increments		3,449						3,449
Depreciation and Amortisation (note 4)		(3,141)	(126)	(679)	(148)	(174)	(40)	(4,307)
Balance at 30 June 2013	2,185	36,189	1,081	2,758	561	421	330	43,526

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 2009

A managerial valuation of the Health Service's buildings was performed by management to determine the fair value of the buildings, based on indices provided by the Valuer-General Victoria.

The effective date of the valuation is 30 June 2013

Note 11: Payables

	2013 \$'000	2012 \$'000
CURRENT		
Contractual		
Trade Creditors	2,577	1,912
Accrued Expenses	603	1,730
Salary Packaging	25	36
PPI Medical Payable	5	1
Income in Advance	144	304
Consultants Payable	2	6
	3,356	3,989
Statutory		
GST Payable	20	31
Department of Health	528	1,466
	548	1,498
TOTAL CURRENT	3,904	5,487
TOTAL PAYABLES	3,904	5,487

(a) Maturity analysis of payables

Please refer to Note 17(c) for the ageing analysis of contractual payables

(b) Nature and extent of risk arising from payables

Please refer to note 17(c) for the nature and extent of risks arising from contractual payables

Note 12: Liabilities

	2013 \$'000	2012 \$'000
CURRENT		
Australian Dollar Borrowings		
– TCV Loan	59	55
Total Current	59	55
NON CURRENT		
Australian Dollar Borrowings		
– TCV Loan	785	840
Total Non-Current	785	840
Total Borrowings	844	895

Finance costs of the Health Service incurred during the year are accounted for as follows:

Amount of finance costs recognised as expenses	51	50
--	----	----

(a) Maturity analysis of borrowings

Please refer to note 17(c) for the ageing analysis of borrowings.

(b) Nature and extent of risk arising from borrowings

Please refer to note 17(c) for the nature and extent of risks arising from borrowings.

(c) Defaults and breaches

During the current and prior year, there were no defaults and breaches of any of the borrowings.

Note 13: Provisions

	2013 \$'000	2012 \$'000
Current Provisions		
Employee Benefits		
- Unconditional and expected to be settled within 12 months	4,545	3,929
- Unconditional and expected to be settled after 12 months	3,111	2,661
	7,656	6,590
Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months	319	301
- Unconditional and expected to be settled after 12 months	342	293
	661	593
Total Current Provisions	8,318	7,183
Non-Current Provisions		
Employee Benefits	1,240	981
Provisions related to Employee Benefit On-Costs	136	108
Total Non-Current Provisions	1,377	1,089
Total Provisions	9,695	8,272
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Unconditional LSL Entitlement	3,557	3,239
Annual Leave Entitlements	2,456	2,155
Accrued Wages and Salaries	1,561	1,125
Accrued Days Off	82	70
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements	1,240	981
Total Employee Benefits	8,897	7,571
On-Costs		
Current On-Costs	661	593
Non-Current On-Costs	136	108
Total On-Costs	798	701
Total Employee Benefits and Related On-Costs	9,695	8,272

	2013 \$'000	2012 \$'000
(b) Movements in provisions		
Movement in Long Service Leave:		
Balance at start of year	4,685	4,590
Provision made during the year		
- Revaluations	211	(76)
- Expense recognising Employee Service	880	808
Settlement made during the year	(451)	(638)
Balance at end of year	5,325	4,685

Note 14: Other Liabilities

	2013 \$'000	2012 \$'000
CURRENT		
Monies Held in Trust		
- Patient Monies Held in Trust	383	339
- Accommodation Bonds (Refundable Entrance Fees)	5,668	5,664
Total Other Liabilities	6,051	6,003
Total Monies Held in Trust		
Represented by the following assets:		
Cash Assets (refer to Note 6)	6,051	6,003
TOTAL	6,051	6,003

Note 15: Equity

(a) Surpluses

Property, Plant & Equipment Revaluation Surplus

Balance at the beginning of the reporting period

Revaluation Increments

- Buildings

Balance at the end of the reporting period*

* Represented by:

- Land

- Buildings

Restricted Specific Purpose Surplus

Balance at the beginning of the reporting period

Transfer to and from Restricted Specific Purpose Surplus

- Medical Fund

- Donations

Balance at the end of the reporting period

Total Surpluses

(b) Contributed Capital

Balance at the beginning of the reporting period

Balance at the end of the reporting period

(c) Accumulated Surpluses/(Deficits)

Balance at the beginning of the reporting period

Net Result for the Year

Transfers to and from Surplus

Balance at the end of the reporting period

Total Equity at end of financial year

2013 \$'000	2012 \$'000
17,930	17,930
3,449	-
21,379	17,930
905	905
20,474	17,025
21,379	17,930
81	106
(7)	(25)
14	-
89	81
21,468	18,011
19,463	19,463
19,463	19,463
9,896	9,633
(2,273)	238
(7)	25
7,615	9,896
48,546	47,369

Note 16: Reconciliation of Net Result for the Year to Net Cash Inflow from Operating Activities

Net result for the period

Non-cash movements:

Depreciation and amortisation

Provision for doubtful debts

Movements included in investing and financing activities

Net loss from disposal of non financial physical assets

Movements in assets and liabilities:

Change in operating assets and liabilities

(Increase)/decrease in receivables

Decrease in inventories

(Increase)/decrease in other assets

Decrease in payables

Increase in provisions

NET CASH INFLOW FROM OPERATING ACTIVITIES

2013 \$'000	2012 \$'000
(2,273)	238
4,307	4,123
3	1
18	11
(53)	1,282
58	87
(122)	17
(1,582)	(140)
1,422	422
1,777	6,041

Note 17: Financial Instruments

(a) Financial risk management objectives and policies

Bairnsdale Regional Health Service's principal financial instruments comprise of:

- cash assets
- term deposits
- receivables (excluding statutory receivables)
- payables (excluding statutory payables)
- accommodation bonds

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

The Health Service's main financial risks include credit risk, liquidity risk and interest rate 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 Audit & Risk Committee of the Health Service.

The main purpose in holding financial instruments is to prudentially manage Bairnsdale Regional Health Service's financial risks within the government policy parameters.

Categorisation of financial instruments

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

	Carrying Amount 2013 \$'000	Carrying Amount 2012 \$'000
Financial Assets		
Cash and cash equivalents	22,293	22,822
Loans and Receivables	1,136	1,105
Total Financial Assets ⁽ⁱ⁾	23,429	23,927
Financial Liabilities		
At Amortised Cost	10,251	10,887
Total Financial Liabilities ⁽ⁱⁱ⁾	10,251	10,887

(i) The total amount of financial assets disclosed here excludes statutory receivables (i.e. GST input tax credit recoverable)

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

Net holding gain on financial instruments by category

	Net holding gain 2013 \$'000	Net holding gain 2012 \$'000
Financial Assets		
Cash and Cash Equivalents ⁽ⁱ⁾	652	787
Total Financial Assets	652	787
Financial Liabilities		
At Amortised Cost ⁽ⁱⁱ⁾	51	50
Total Financial Liabilities	51	50

(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

(ii) For financial liabilities measured at amortised cost, the net gain or loss is calculated by taking the interest expense, plus or minus foreign exchange gains or losses arising from the revaluation of financial liabilities measured at amortised cost.

Note 17: Financial Instruments (continued)

(b) Credit risk

Credit risk arises from the contractual financial assets of the Health Service, which comprise cash and deposits, non-statutory receivables and available for sale contractual financial assets. The Health Service's exposure to credit risk arises from 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 Bairnsdale Regional Health Service's maximum exposure to credit risk without taking account of the value of any collateral obtained.

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

	Financial institutions (AAA credit rating) \$'000	Government agencies (AAA credit rating) \$'000	Government agencies (BBB credit rating) \$'000	Other (min BBB credit rating) \$'000	Total \$'000
2013					
Financial Assets					
Cash and Cash Equivalents	22,293				22,293
Receivables					
- Trade Debtors				341	341
- Other Receivables (i)				795	795
Total Financial Assets	22,293	-	-	1,136	23,429
2012					
Financial Assets					
Cash and Cash Equivalents	22,822				22,822
Receivables					
- Trade Debtors				485	485
- Other Receivables				620	620
Total Financial Assets	22,822	-	-	1,105	23,927

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

Note 17: Financial Instruments (continued)

(b) Credit risk (continued)

Ageing analysis of Financial Assets as at 30 June

	Consolidated 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	
2013	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Financial Assets							
Cash and Cash Equivalents	22,293	22,293					
Receivables (i)							
- Trade Debtors	341	334		2	5		
- Other Receivables	795	687	72	9	26		
Total Financial Assets	23,429	23,315	72	11	31	-	-
2012							
Financial Assets							
Cash and Cash Equivalents	22,822	22,822					
Receivables (i)							
- Trade Debtors	485	485					
- Other Receivables	620	526	68	13	14		
Total Financial Assets	23,927	23,832	68	13	14	-	-

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

There are no material financial assets which are individually determined to be impaired. Currently Bairnsdale Regional Health Service does not hold any collateral as security nor credit enhancements relating to any of 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 the 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 17: Financial Instruments (continued)

(c) Liquidity risk

Liquidity risk is the risk that the Health Service would be unable to meet its financial obligations as and when they fall due. The Health 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:

Interest Bearing Liabilities is a fixed interest rate loan with Treasury Corporation Victoria. Payables are all due within the next three months. Other Financial Liabilities relate to aged care resident trust funds and accommodation bonds, which may be required to be paid out at any time. We have estimated the usual time frame in which payments have been made.

The following table discloses the contractual maturity analysis for Bairnsdale Regional Health Service'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

	Carrying Amount \$'000	Nominal Amount \$'000	Maturity Dates			
			Less than 1 Month \$'000	1-3 Months \$'000	3 months - 1 Year \$'000	1-5 Years \$'000
2013						
Financial Liabilities						
Payables	3,356	3,356	3,356			
Borrowings	844	844	9	9	41	785
Other Financial Liabilities (i)						
- Accommodation Bonds	5,668	5,668			1,424	4,243
- Other	383	383			383	
Total Financial Liabilities	10,251	10,251	3,365	9	1,848	5,029
2012						
Financial Liabilities						
Payables	3,989	3,989	3,989			
Borrowings	895	895	8	8	39	840
Other Financial Liabilities (i)						
- Accommodation Bonds	5,664	5,664			1,976	3,688
- Other	339	339			339	
Total Financial Liabilities	10,887	10,887	3,997	8	2,354	4,527

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

Note 17: Financial Instruments (continued)

(d) Market risk

Bairnsdale Regional Health Service'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

Bairnsdale Regional Health Service 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 Bairnsdale Regional Health Service'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.

Other price risk

Bairnsdale Regional Health Service has the risk that increasing inflation will increase prices from suppliers for payables.

Interest rate exposure of financial assets and liabilities as at 30 June

	Weighted Average Effective Interest Rate (%)	Carrying Amount \$'000	Interest Rate Exposure		
			Fixed Interest Rate \$'000	Variable Interest Rate \$'000	Non- Interest Bearing \$'000
2013					
Financial Assets					
Cash and Cash Equivalents	4.24	22,293	17,000	5,287	6
Receivables					
- Trade Debtors		341			341
- Other Receivables		795			795
		23,429	17,000	5,287	1,142
Financial Liabilities					
Payables		3,356			3,356
Borrowings	5.88	844	844		
Other Financial Liabilities					
- Accommodation Bonds		5,668			5,668
- Other		383			383
		10,251	844	-	9,407
2012					
Financial Assets					
Cash and Cash Equivalents	5.17	22,822	15,000	7,815	6
Receivables					
- Trade Debtors		485			485
- Other Receivables		620			620
		23,927	15,000	7,815	1,111
Financial Liabilities					
Payables		3,989			3,989
Borrowings	5.88	895	895		
Other Financial Liabilities					
- Accommodation Bonds		5,664			5,664
- Other		339			339
		10,887	895	-	9,992

Note 17: Financial Instruments (continued)

(d) Market risk (continued)

Sensitivity disclosure analysis

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

- A shift of +0.50% and -0.25% in market interest rates (AUD) from year-end rates of 4.34%;
- A parallel shift of +10.0% and -10.0% in inflation rate from year-end rates of 2%

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

	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-0.25%		+0.5%		-10%		+10%	
		Profit \$'000	Equity \$'000	Profit \$'000	Equity \$'000	Profit \$'000	Equity \$'000	Profit \$'000	Equity \$'000
2013									
Financial Assets									
Cash and Cash Equivalents	22,293	(56)	(56)	111	111	-	-	-	-
Receivables									
- Trade Debtors	341	-	-	-	-	-	-	-	-
- Other Receivables	795	-	-	-	-	-	-	-	-
Financial Liabilities									
Payables	3,356	-	-	-	-	-	-	-	-
Borrowings	844	-	-	-	-	-	-	-	-
Other Financial Liabilities	-	-	-	-	-	-	-	-	-
- Accommodation Bonds	5,668	-	-	-	-	-	-	-	-
- Other	383	-	-	-	-	-	-	-	-
		(56)	(56)	111	111	-	-	-	-
2012									
Financial Assets									
Cash and Cash Equivalents	22,822	(57)	(57)	114	114	-	-	-	-
Receivables									
- Trade Debtors	485	-	-	-	-	-	-	-	-
- Other Receivables	620	-	-	-	-	-	-	-	-
Financial Liabilities									
Payables	3,989	-	-	-	-	-	-	-	-
Borrowings	895	-	-	-	-	-	-	-	-
Other Financial Liabilities									
- Accommodation Bonds	5,664	-	-	-	-	-	-	-	-
- Other	339	-	-	-	-	-	-	-	-
		(57)	(57)	114	114	-	-	-	-

Note 17: Financial Instruments (continued)

(e) Fair value

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

- Level 1 - the fair value of financial instrument with standard terms and conditions and traded in active liquid markets are determined with reference to quoted market prices;
- Level 2 - the fair value is determined using inputs other than quoted prices that are observable for the financial asset or liability, either directly or indirectly; and
- Level 3 - the fair value is determined in accordance with generally accepted pricing models based on discounted cash flow analysis using unobservable market inputs.

The Health Services considers that the carrying amount of financial instrument assets and liabilities recorded in the financial 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

	Consol'd Carrying Amount	Fair value	Consol'd Carrying Amount	Fair value
	2013 \$'000	2013 \$'000	2012 \$'000	2012 \$'000
Financial Assets				
Cash and Cash Equivalents	22,293	22,293	22,822	22,822
Receivables				
- Trade Debtors	341	341	485	485
- Other Receivables	795	795	620	620
Total Financial Assets	23,429	23,429	23,927	23,927
Financial Liabilities				
Payables	3,356	3,356	3,989	3,989
Borrowings	844	844	895	895
Other Financial Liabilities				
- Accommodation Bonds	5,668	5,668	5,664	5,664
- Other	383	383	339	339
Total Financial Liabilities	10,251	10,251	10,887	10,887

Note 18: Commitments

	2013 \$'000	2012 \$'000
Capital expenditure commitments		
Payable:		
Land and Buildings	-	55
Total capital expenditure commitments	-	55
Land and Buildings		
Not later than one year	-	55
Total	-	55
Lease commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating Leases	405	752
Total lease commitments	405	752
Operating Leases		
CT scanner and two ultrasound leases payable as follows:		
<i>Cancellable</i>		
Not later than one year	347	347
Later than 1 year and not later than 5 years	58	405
Sub Total	405	752
TOTAL LEASE COMMITMENTS	405	752
Total Commitments (inclusive of GST)	405	807
Less GST recoverable from the Australian Tax Office	(37)	(73)
Total Commitments (exclusive of GST)	368	734

All amounts shown in the commitments note are nominal amounts inclusive of GST.

Note 19: Contingent Assets and Contingent Liabilities

No contingent assets or contingent liabilities as at 30 June 2013 (2012: nil).

Note 20: Operating Segments

REVENUE
External Segment Revenue
Intersegment Revenue
Total Revenue

EXPENSES
External Segment Expenses
Intersegment Expenses
Total Expenses
Net Result from ordinary activities

Interest Expense
Interest Income
Net Result for Year

OTHER INFORMATION

Segment Assets

Total Assets

Segment Liabilities

Total Liabilities

Acquisition of Property, Plant and Equipment
Depreciation Expense

The major products/services from which the above segments derive revenue are:

Business Segments

Residential Aged Care Services (RAC)

Radiology

NEPT

Rest of Health Service (Other)

Services

Provider of Residential Aged Care

Provider of Diagnostic Imaging

Provider of Non Emergency Patient Transport

Admitted, Outpatients, Emergency, HACCC, Sub-Acute, Primary Health.

Pricing from the Radiology Segment is at 85% of CMBS scheduled fee.

Geographical Segment

Bairnsdale Regional Health Service operates predominantly in East Gippsland, Victoria. More than 90% of revenue, net surplus from ordinary activities and segment assets relate to operations in East Gippsland, Victoria.

	RAC		Radiology		NEPT		Other		Eliminations		Consol'd	
	2013 \$'000	2012 \$'000	2013 \$'000	2012 \$'000	2013 \$'000	2012 \$'000	2013 \$'000	2012 \$'000	2013 \$'000	2012 \$'000	2013 \$'000	2012 \$'000
External Segment Revenue	6,462	6,663	3,252	3,238	-	-	54,617	51,432			64,332	61,334
Intersegment Revenue	-	-	1,300	1,111	304	298	1,687	1,742	(3,292)	(3,151)	-	-
Total Revenue	6,462	6,663	4,553	4,350	304	298	56,305	53,175	(3,292)	(3,151)	64,332	61,334
External Segment Expenses	(6,650)	(5,616)	(3,916)	(3,475)	(270)	(270)	(56,369)	(52,473)			(67,205)	(61,834)
Intersegment Expenses	(1,220)	(1,284)	(467)	(458)	(0)	-	(1,605)	(1,409)	3,292	3,151	-	-
Total Expenses	(7,870)	(6,900)	(4,383)	(3,933)	(270)	(270)	(57,974)	(53,882)	3,292	3,151	(67,205)	(61,834)
Net Result from ordinary activities	(1,408)	(236)	170	416	34	28	(1,669)	(707)	-	-	(2,874)	(499)
Interest Expense	-	-	-	-	-	-	(51)	(50)	-	-	(51)	(50)
Interest Income	0	1	-	-	-	-	652	786	-	-	652	787
Net Result for Year	(1,408)	(235)	170	416	34	28	(1,069)	29	-	-	(2,273)	238
OTHER INFORMATION												
Segment Assets	20,290	21,699	1,197	981	1	51	47,552	45,296	-	-	69,040	68,027
Total Assets	20,290	21,699	1,197	981	1	51	47,552	45,296	-	-	69,040	68,027
Segment Liabilities	7,077	6,995	560	511	54	43	12,803	13,107	-	-	20,494	20,657
Total Liabilities	7,077	6,995	560	511	54	43	12,803	13,107	-	-	20,494	20,657
Acquisition of Property, Plant and Equipment	125	130	340	750	-	120	1,985	2,174	-	-	2,450	3,174
Depreciation Expense	889	889	167	167	66	66	3,186	3,001	-	-	4,307	4,123

Note 21: Jointly Controlled Operations and Assets

Name of Entity	Principal Activity	Ownership Interest	
		2013 %	2012 %
Gippsland Health Alliance	Information Systems	11.99	11.77

Bairnsdale Regional Health Service's interest in assets employed in the above jointly controlled operations and assets is detailed below. The amounts are included in the financial statements under their respective asset categories:

	2013 \$'000	2012 \$'000
Current Assets		
Cash and Cash Equivalents	479	431
Receivables	197	177
Other Current Assets	45	36
Total Current Assets	720	644
Non Current Assets		
Property, Plant and Equipment	8	9
Total Non Current Assets	8	9
Total Assets	728	652
Current Liabilities		
Other Current Liabilities	316	213
Total Current Liabilities	316	213

Bairnsdale Regional Health Service's interest in revenues and expenses resulting from jointly controlled operations and assets is detailed below:

	2013 \$'000	2012 \$'000
Revenues		
Gippsland Health Alliance Income	215	207
Total Revenue	215	207
Expenses		
Information Technology and Administrative Expenses	1,075	961
Depreciation	1	6
Total Expenses	1,076	967
Net result	(861)	(760)

Note 22a: 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.

Responsible Ministers:

The Honourable David Davis, MLC, Minister for Health and Ageing
The Honourable Mary Woodridge, MLA, Minister for Mental Health

Governing Boards

A. Hutson
D. Vickers
J. Websdale
D. Formby
P. deVoil
L. Jones
P. Crick
C. Sedunary

Accountable Officers

Mrs Therese Tierney

Period
1/7/2012 - 30/6/2013
1/7/2012 - 30/6/2013
1/7/2012 - 30/6/2013
1/7/2012 - 30/6/2013
1/7/2012 - 30/6/2013
1/7/2012 - 30/6/2013
1/7/2012 - 30/6/2013
1/7/2012 - 30/6/2013
1/7/2012 - 30/6/2013
1/7/2012 - 30/6/2013

Remuneration of Responsible Persons

The number of Responsible Persons are shown in their relevant income bands;

Income Band

\$0 - \$9,999
\$70,000 - \$79,999
\$240,000 - \$249,999
\$450,000 - \$459,999

Total Numbers

Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:

2013 No.	2012 No.
8	10
1	1
1	1
9	12
\$240,985	\$531,752

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

Other Transactions of Responsible Persons and their Related Parties.

Other transactions of responsible persons and their related parties requiring disclosure under the Directions of the Minister for Finance have been considered and there are no matters to report.

Note 22b: Executive Officer Disclosures

Executive Officers' Remuneration

The numbers of executive officers, other than Ministers and Accountable Officers, and their total remuneration during the reporting period are shown in the first two columns in the table below in their relevant income bands. The base remuneration of executive officers is shown in the third and fourth columns. Base remuneration is exclusive of bonus payments, long-service leave payments, redundancy payments and retirement benefits.

A number of executive officers retired, resigned or were retrenched in the past year. This has had a significant impact on total remuneration figures due to the inclusion of annual leave, long-service leave and retrenchment payments.

\$40,000 - \$49,999
\$50,000 - \$59,999
\$70,000 - \$79,999
\$90,000 - \$99,999
\$100,000 - \$109,999
\$110,000 - \$119,999
\$120,000 - \$129,999
\$130,000 - \$139,999
\$140,000 - \$149,999
\$210,000 - \$219,999
\$230,000 - \$239,999

Total

Total annualised employee equivalents (AEE) ⁽ⁱ⁾

Total Remuneration

Total Remuneration 2013 No.	2012 No.	Base Remuneration 2013 No.	2012 No.
	1		1
	1		1
	1		1
1		1	
		1	
	1		1
1	1		1
1		2	
1		1	
1			
5	5	5	5
4.3	3.5	4.3	3.5
\$ 812,982	\$ 427,575	\$ 712,724	\$ 427,575

(i) Annualised employee equivalent is based on paid working hours of 38 ordinary hours per week over the 52 weeks for a reporting period.

Note 23: Events Occurring after the Balance Sheet Date

No events occurred after the balance sheet date to effect this report. (2012: Nil)

Note 24: Economic Dependency

Bairnsdale Regional Health Service being a public hospital is dependent substantially upon funds from the Department of Health.

Changes to the Department of Health funding streams could have a substantial effect upon the viability of Bairnsdale Regional Health Service.

Bairnsdale Regional Health Service's Aged Care is funded substantially from the Department of Health and Ageing, a change in funding of aged care beds could also have a substantial effect on the viability of our aged care facility.

Note 25. Remuneration of Auditors

Victorian Auditor-General's Office

Audit or review of financial statement

2013 \$'000	2012 \$'000
33	33

Disclosure Index

The annual report of the Bairnsdale Regional Health Service 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.

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Maddocks Gardens, McKean Street, Bairnsdale VIC
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Sutherland Lodge, McKean Street, Bairnsdale VIC 3875

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Auditor General, Victoria

Internal Auditors

Grant Thornton



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