

BRHS Annual Report

2016 - 2017

# BRHS Bairnsdale Regional Health Service

## 2016 - 2017 ANNUAL REPORT



Improving the health & wellbeing of the East Gippsland Community by providing accessible, high quality & sustainable healthcare.

**BRHS** Bairnsdale Regional Health Service

**CBD Campus**

183 Main Street  
Bairnsdale VIC 3875  
P (03) 5150 3300

**Day Street Campus**

122 Day Street  
Bairnsdale VIC 3875  
P (03) 5150 3333

**Ross Street Campus**

Ross Street  
Bairnsdale VIC 3875  
P (03) 5152 0222

**PO Box 474**

Bairnsdale VIC 3875  
E [email@brhs.com.au](mailto:email@brhs.com.au)  
[www.brhs.com.au](http://www.brhs.com.au)

*Your Health  
Our Priority.*



We acknowledge that  
Bairnsdale Regional Health Service  
is located on the traditional land of the  
Gunaikurnai people and we pay our  
respects to elders both past and present  
and thank them for their contribution  
to the development of our service.



President and CEO Report .....	2
Report of Operations .....	3
Responsible Bodies Declaration .....	3
Establishment .....	3
Objectives, Functions, Powers and Duties .....	3
Nature and range of services provided .....	4
Visiting Specialists and Medical Officers .....	6
Board of Management .....	8
Chief Executive Officer, Directors and Chief Financial Officer .....	10
Organisation Chart .....	12
Key Initiatives and Projects, Changes and Future Plans .....	13
Workforce .....	14
Financial Year Summary .....	15
Donations to BRHS 2016-2017 .....	22
Statement of Priorities Part A .....	23
Statement of Priorities Part B .....	33
Statement of Priorities Part C .....	35
Attestation for Compliance with the Ministerial Standing Direction 3.7.1 – Risk Management Framework and Processes .....	37
Attestation on Compliance with Health Purchasing Victoria (HPV) Health Purchasing Policies .....	37
Compliance with Datavic Access Policy .....	37
Victorian Auditor General's Office Independent Auditor's Report .....	38
Board Member's, Accountable Officer's and Chief Finance & Accounting Officer's Declaration .....	40
Financial Statements .....	41
Disclosure Index .....	111

## PRESIDENT AND CEO REPORT

It gives us great pleasure to present the 2016-17 Bairnsdale Regional Health Annual Report. This year was the fifth and last year of our five year Strategic Plan 2012-17 so this year we have developed a new Strategic Plan 2017-22 which will be launched shortly. We are pleased to report that due to the efforts over the last five years we substantively met our five year strategic goals and will be entering a new planning period in a good position.

We have ended the year with a small deficit which relates to the unique challenges we face responding to the growth in demand for our services. The highlights of this activity for 2016-17 can be found in this report.

As we do each year at this time we would like to acknowledge with pride the efforts and dedication of our very committed staff. What we have achieved in terms of patient care and the services provided to our community over the last year is due to the professionalism of our 850+ staff.

We would also like to acknowledge the significant contribution of our dedicated volunteers. The impact of their cheerful and helpful presence around the health service should not be underestimated as they make a significant contribution to the patient and visitor experience at BRHS. Our volunteers contribute in many ways such as supporting the Kiosk, tending the patient flowers, assisting in the daily activities across the organisation in supporting our patients and residents. The Kiosk Auxiliary this year has been working hard to accumulate the funds to support the fit out of the new High Dependency Unit which will open in early 2018. This forward planning is of great help to BRHS as we continue to grow.

We welcomed a new Board member to the team this year Julie Small and farewelled Lindley Jones after more than 5 years on the Board. We would like to thank Lindley for her significant contribution to the Board and governance of BRHS. We would like to take this opportunity to ask community members who feel they have the skills to be part of the Board of BRHS in the future to seriously consider making this contribution and become part of our growing and dynamic organisation.



Angela Hutson

**Angela Hutson**  
President, Board of Management



Therese Tierney

**Therese Tierney**  
Chief Executive Officer

# REPORT OF OPERATIONS

## Responsible Bodies Declaration

In accordance with the Financial Management Act 1994, I am pleased to present the report of operations for Bairnsdale Regional Health Service for the year ending 30 June 2017.



### **Douglas Vickers**

Acting President, Board of Management  
Bairnsdale Regional Health Service  
23 August 2017

## Establishment

Bairnsdale Regional Health Service (BRHS) was established under the Health Services Act 1988. The responsible Ministers from 1 July 2016 to 30 June 2017 were The Honourable Jill Hennessy MLA, Minister for Health, Minister for Ambulance Services and The Honourable Martin Foley, Minister for Housing, Disability, Aged Care and Minister for Mental Health.

## Objectives, Functions, Powers and Duties

Bairnsdale Regional Health Service operates under a guiding Strategic Plan which outlines a clear Vision, Role Statement and a set of Strategic Objectives, Organisational Principles and Trademark Behaviours that define our organisation. Bairnsdale Regional Health Service is a sub-regional hospital within the Victorian Health system with a duty to improve the health and wellbeing of the East Gippsland community by providing accessible, high quality and sustainable health care. This year sees the conclusion of the five year Strategic Plan 2013-2017.

## Vision

Respected leader of outstanding health care.

## Strategic Objectives

- High quality, effective care
- Skilled, motivated and valued workforce
- Accountability, sustainability and governance
- Leadership and partnership

## Our Principles

### **Progressive**

BRHS will pursue contemporary models of care which allows for innovation and leadership in rural health care.

### **Accountable**

BRHS acknowledges our obligations through a culture of honesty, trust and absolute responsibility for its actions.

### **Competent**

BRHS will demonstrate proficiency and knowledge as a sub-regional health service provider and continue to develop its expertise.

### **Person Centred**

BRHS works in partnership with patients, families and carers to enable them to make informed decisions about their own health.

### **Collaborative**

BRHS will establish relationships that enhance the delivery of safe and high quality health services in East Gippsland.

## Nature and range of services provided

BRHS provides a range of multi-disciplinary health services to a growing population over the East Gippsland Shire which is located in eastern Victoria, between 280 and 550 kilometres from Melbourne.

The East Gippsland Shire Estimated Resident Population for 2016 is 44,542, with a population density of 0.02 persons per hectare.

<b>Statistics</b>	<b>Population</b> 44,542 ABS ERP 2016	<b>Land area</b> 2,093,144 hectares (20,931 Km <sup>2</sup> )	<b>Population density</b> 0.02 Persons per hectare
-------------------	---	--	--

BRHS regularly reviews its models of care, workforce sustainability and capital infrastructure to improve the care experience of the consumers we serve and to ensure we are positioned to respond to community growth, health needs and service demand.

BRHS incorporates a long established acute hospital, providing sub-acute inpatient services, a well-established modern theatre suite (two operating theatres), an emergency department and short stay unit, maternity services and a purpose built Oncology and Dialysis Unit. A modern Medical Imaging (x-ray) and Pathology (outsourced) service alongside the pharmacy department.

In addition to acute care, BRHS also operates Maddock Gardens; a highly regarded 90 bed Aged Care facility, a full range of Allied Health Services, Dental, Community and District Nursing. The medical consulting suites offer patients local access to visiting medical specialists supported by the BRHS team.

BRHS provides services not just within the walls of the Hospital but also in the community and in consumers' homes.

**@Hospital** services are delivered in or at hospital. Consumers will typically be admitted as an inpatient, which may include day services or an overnight stay.

**@Community** services are delivered in a structured venue or centre that our consumers will attend. These consumers are outpatients.

**@Home** services are delivered to consumers in their home, including residential aged care and other group home situations. @Home services may include some short term services and support or acute/high levels of clinical service as a substitute to care in the hospital.

BRHS is the largest employer in the region with over 800 staff and an operating budget of \$82M. It is governed by a Board of Management of 10 people. The diversity of the services and the importance of the role BRHS has in the community creates a need for a well-defined system of good governance to ensure we meet the health needs of the community today and in the future. We need to ensure we have the community's confidence by working towards a robust future through sustainable growth and advocacy and continuing to ensure an environment that is progressive, safe and dynamic.

## BRHS

@Home

- Allied Health Services (see full details in @Community)
- Residential Aged Care
  - Dementia Care
  - Respite Care
- Residential In Reach Service
- Hospital in the Home (HITH)
- Falls Prevention Group
- Palliative Care
- Post-Acute Care (PAC)
- Home Based Nursing Services
- Community Palliative Care
- Complex Care Co-ordination
- Rehabilitation in the Home

## BRHS

@Community

- Visiting Medical Specialists
- Community Health Nursing
  - Women's Health
  - Adolescent Health
  - Breast Care Services
  - District Nursing
  - Community Palliative Care
  - Prostate Cancer Specialist Nurse
- Cardiac Rehabilitation
- Continence Service
- Dental Services
- Diabetes Education
- Planned Activity Group (PAG)
- Pulmonary Rehabilitation
- Allied Health Services
  - Physiotherapy
  - Occupational Therapy
  - Speech Pathology
  - Social Work
  - Dietetics
  - Podiatry
- Lymphedema Clinic
- Needle Exchange Program
- Complex Care

## BRHS

@Hospital

- Dialysis
- Emergency Services
- Geriatric Evaluation and Management (GEM)
- Inpatient Rehabilitation
- Transition Care Program
- Medical Admitted Day Unit (MADU)
- General Medicine
- Medical Imaging
- Obstetrics & Gynecology
- Oncology
- Pediatrics
- Pathology (Provider: Gippsland Pathology)
- Pharmacy
- Stomal Therapy
- Surgical Care
- Maternity Services
- Inpatient Palliative Care
- Short Stay Unit (SSU)
- Allied Health Services
- Aboriginal Health
- Visiting Medical Specialists

## BRHS

inSupport

- Executive Team and Support
- Volunteer Programs
- Risk & Safety
- Health Information Services
- Facilities
- Food Services
- ICT
- Medical Library
- Finance
- Business Intelligence
- Communications
- Quality & Service Improvement
- Medical Workforce & Education
- Environmental Services
- People and Culture
- Administration

## Visiting Specialists and Medical Officers

### Anaesthetist

Dr Ben Turner

### Cardiologists

Dr David Bertovic

Dr Justin Mariani

Dr James Shaw

Dr Anthony White

### FACRRM

Dr Andre Wannenburg

### Head, Neck, Nose & Throat

Mr Guillermo Hurtado

### Gastroenterologists

Dr David Iser

Dr Matthew Kitson

Dr Jeremy Ryan

### General Surgeons

Mr Gordon Arthur

Mr Adrian Aitken

Mr Servaise de Kock

Mr Anamitra Sarkar

### Gynaecologists

Dr Sarah Roberts

Dr Gareth Weston

Dr Alex Bonner

Dr David Simon

Dr Anu Sarkar

### Hospital in the Home (HITH)

#### Visiting Medical Officers

Dr Tom Alwyn

Dr Maria Bodenstein

Dr Ian Broom

Dr David Campbell

Dr Jane Greacen

Dr Greg Hayes

Dr Patrick Kinsella

Dr Elizabeth Wearne

### Medical Administration

Dr Kaushik Banerjee

Dr Catherina de Muelenaere

### Nephrologists

Dr David Hooke

Prof David Power

### Neuropsychologist

Dr Helen Clausen

### Oncologists

Dr Sachin Joshi

### Ophthalmologist

Dr Pradeep Madhok

### Orthopaedic Surgeon

Mr Andries DeVilliers

### Orthopaedic / Legal

Dr Stan O'Loughlin

### Paediatricians

Dr Peter Goss

Dr Jo McCubbin

Dr Saba Subramanian

Dr Sylvia Welgemoed

### Paediatric Surgeon

Mr Chris Kimber

### Occupational Physician

Dr Jane Greacen

### General Physicians

Dr Marcel van der Heiden

Dr Kushantha Gunarathne

### Geriatrician

Dr Craig Clarke

### Haematologist

Dr Amanda Ormerod

### Rehabilitation Physician

Dr David McConachy

### Rheumatologists

Assoc Prof Peter Ryan

Dr Timothy Bennett

### Urologists

Prof Mark Frydenberg

Assoc Prof Jeremy Grummet

Mr Adam Landau

### Senior Medical Officers

Dr Mark Pritchard

### Subcontracted Services

Pathologists from Gippsland Pathology

Radiologists from IMED Radiology

Echocardiogram/Stress Echocardiogram Service

### Vascular Surgeon

Mr Peter Milne



**Visiting Medical Officers (General Practitioners)**

Dr Daniel Otuonye  
Dr Daryl Smith  
Dr David McConville  
Dr Elizabeth Boyd (retired 1 May 2017)  
Dr John Urie  
Dr Poh Ng  
Dr Myles Chapman (Field Emergency Medical Officer – East Gippsland) (retired 1 May 2017)  
Dr Greg Ivanoff (Field Emergency Medical Officer – Central Gippsland)  
Dr Sara Renwick-Lau (Field Emergency Medical Officer – Mallacoota)

Dr Antoinette Mowbray  
Dr Hulme Hay  
Dr Naveen Joshi  
Dr Peter Worboys  
Dr Phillip Sewell  
Dr Ross de Steiger  
Dr Sema Yilmaz  
Dr Laura Linden  
Dr Romilly Hawter  
Dr Sarah Wilmot  
Dr Jarrod Miles  
Dr Rob Phair  
Dr Claire Rayner

**Bairnsdale Regional Health Service Board of Management 2016-2017**

(L-R) Chris Barry, Brendon Moar, Julie Small, Angela Hutson, Peter Murphy,  
Mendy Urie, Doug Vickers and Dr Tim Watford

## Board of Management

### Angela Hutson - President

Appointed 2000

Angela was the CEO of East Gippsland Institute of TAFE from 2004 – 2011. Angela is a member of the Regional Development Australia Gippsland Committee. She is a member of the Gunai Kurnai Traditional Owner Land Management Board; a Board member of East Gippsland Water, Federation Training and Workways Australia.

Angela is a Fellow and Graduate of the Australian Institute of Company Directors. Her qualifications include a Bachelor of Arts, Diploma of Education, Masters in Organisational Leadership and a Graduate Diploma of Business in Entrepreneurship.

### Doug Vickers - Vice President

Appointed July 2011

Dip Ed & Grad Dip Ed

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.

### Peter Murphy

Appointed July 2013

B.A., LL.B

Director of WG&M, has been practising law in East Gippsland for over 25 years, former Member of the Gippsland Law Association. Active member of a number of community and sporting organisations.

### Mendy Urie

Appointed July 2013

MBA, Master of Strategic Foresight, Dip Management

Past Div 1 Nurse and Midwife

7 years as Councillor with East Gippsland Shire including 3 years as Mayor. Currently on COM of BRE Inc., President of Women4Evolution and consultant in individual and collective transformational practice.

### Lindley Jones

Appointed July 2011. (Retired August 2016)

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.

### Chris Barry

Appointed July 2015

BSci

Chris is currently the Gippsland Emergency Management Leader for the Dept. Environment, Land & Water. He is a former CEO of several State Government, Statutory Authorities and Ministerial Taskforces.

He is currently a Director of Noweyung Inc. and Yoga Association Victoria and has previously been strongly involved in School Councils and Community Colleges. Chris is a graduate of the Australian Institute of Company Directors.

### Brendon Moar

Appointed July 2015

BPHARM MPS

Brendon is a local business owner and community pharmacist in East Gippsland for 11 years. Brendon is a member of Gippsland Primary Healthcare Network Clinical Advisory Council and is a member of Pharmacy Board of Australia notifications committee.

Brendon is passionate about the health and wellbeing of his local community.

### Julie Small

Appointed July 2016

Julie is passionate about people, health and community and has strong personal and professional ties to the community in which she lives and works. Julie has been involved in numerous fundraising and community projects and is an active member of Bairnsdale Sunrise Rotary Club.

Julie has expertise in the areas of human resources management, occupational health and safety, reporting, and office management.

### Tim Watford

Appointed July 2015

MBBS D.Obst RCOG DA, MRCS(Eng) LRCP(Lond)Tim has been a General Medical Practitioner in Bairnsdale since 1977 and is a former Director of Anaesthetics at Bairnsdale Regional Health Service.

## Board of Management Attendance 2016-2017

For the 2016/17 period there were 11 meetings held. No meeting was held in January, due to the annual Board break.

Angela Hutson	10/11
Doug Vickers	9/11
Julie Small	11/11
Lindley Jones	1/2
Mendy Urie	10/11
Peter Murphy	9/11
Chris Barry	8/11
Brendon Moar	9/11
Tim Watford	10/11

## Board of Management Sub-Committees

### 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.

Committee members during 2016/17:

Jessica Cane (external contract member)  
Ernie Metcalf (external contract member)  
Brendon Moar  
Doug Vickers  
Chris Barry  
Tim Watford  
Peter Murphy (interim member)  
Mendy Urie (interim member)

### 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.

Committee members during 2016/2017:

Angela Hutson

### Clinical Quality and Performance Committee

The Clinical Quality and Performance Committee is a sub-committee of the Board of Management. The committee works closely with the operational executive and management group to ensure clinical

performance and quality achieve the strategic goals of the organisation and meet consumer needs. The committee sets the foundations for an organisational culture that provides safe clinical practice and improved health outcomes for consumers. The committee's work is guided by an organisational Clinical Governance Framework that includes specific clinical targets and KPIs that monitor clinical safety, risk and care provision. The committee also oversees the clinical requirements of a number of expected Standards including the National Safety and Quality in Healthcare Standards to achieve Australian Council of Healthcare Standards Accreditation and accreditation by other bodies such as the Common Care (Home Care) Standards. The committee meets every second month (6 times per year.)

Committee members during 2016/17:

Peter Murphy (Chair)  
Tim Watford  
Brendon Moar  
Mendy Urie

### Community Advisory Committee

The Community Advisory Committee is a sub-committee of the Board of Management.

Consumer Representatives during 2016/17:

Patricia Bryce (Co-Vice Chair)  
Kerri Easton (Co-Vice Chair)  
Peter Bryant  
Jill Ellis  
Rob Wilson  
Denice Spence  
Anna Cook  
Board Members during 2016/2017 were:  
Julie Small (Chair)  
Chris Barry  
Angela Hutson

The committee provides a structured partnership between consumer, community and the health service, creating a system that is responsive to patient, carer and consumer input to improve the safety and quality of care delivered. The committee has met bi-monthly and participated in the following as an example of the activities involved.

- Health Literacy Workgroup meetings
- Review of Accreditation requirements
- Reviewed and assessed health information brochures
- Monitoring Consumer Feedback, including the Victorian Hospital Experience Survey outcomes

## **Chief Executive Officer, Directors and Chief Financial Officer**

### **Therese Tierney**

Chief Executive Officer

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

### **Kaushik Banerjea**

Director of Medical Services

MBBS, DM (Emergency Medicine), MHM, AFCHSM

Adjunct Senior Lecturer Monash University

Adjunct A/Professor Emergency Medicine, George Washington University

The Medical Services Directorate at BRHS supports the operation and development of the Medical Workforce, Pharmacy, Medical Imaging services and Infection Prevention. 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. The directorate is also responsible for the training and development of Interns.

### **Bernadette Hammond**

Director of Nursing, Midwifery and Aged Care

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

The Nursing, Midwifery and Aged Care Directorate at BRHS incorporates a range of clinical, nursing, community and residential aged care services and provides the leadership, and has operational responsibility, for peri-operative and surgical services, maternity services, medical inpatient care, rehabilitation and sub-acute inpatient unit, home based nursing services including hospital in the home, health independence programs - Residential In Reach and Complex Care programs, Maddocks Gardens residential aged care facility, renal dialysis and oncology units, patient liaison services, palliative care, nursing and midwifery education including undergraduate, graduate and post-graduate programs.

### **Brendan Coulton**

Director of Allied, Community and Support Services

B.A Science, Dip Edu, M.B.A.

The Director of Allied, Community and Support Services provides leadership and operational management to Allied Health inpatient and outpatient services aimed at meeting client centred goals. Community Services includes community based nursing services (including Diabetes, Continence, Women's, Men's and family health), Dental services and Planned Activity Groups all based at the Ross Street Campus. The directorate includes the Central Intake, Post-Acute Care program and Medical Consulting Suites. The Support Services include the areas of Food, Environmental, Facilities/Maintenance, Risk Management, Occupational Health and Safety, Environmental Sustainability and Emergency Management as well as the role of Chief Procurement Officer.

### **Deb Ellks**

Director of Innovation and Strategy

RN, BN, MBL, AFACHSM

The Director, Innovation & Strategy is operationally responsible for the Aboriginal Health Unit, Alcohol & Other Drugs Program, Health Information Services, Quality, Risk and Safety Program, and building Service Improvement capability to drive continuous improvement in the care of our community. The Directorate's brief includes the design and implementation of the mechanisms and systems that



produce innovative solutions to complex problems whilst building capability and sustainability across BRHS, recognising that people are our greatest asset. These strategic projects ensure sustainable organisational integration of BRHS' vision and strategy across BRHS.

### **Tania Donaldson**

Chief Financial Officer (CFO)

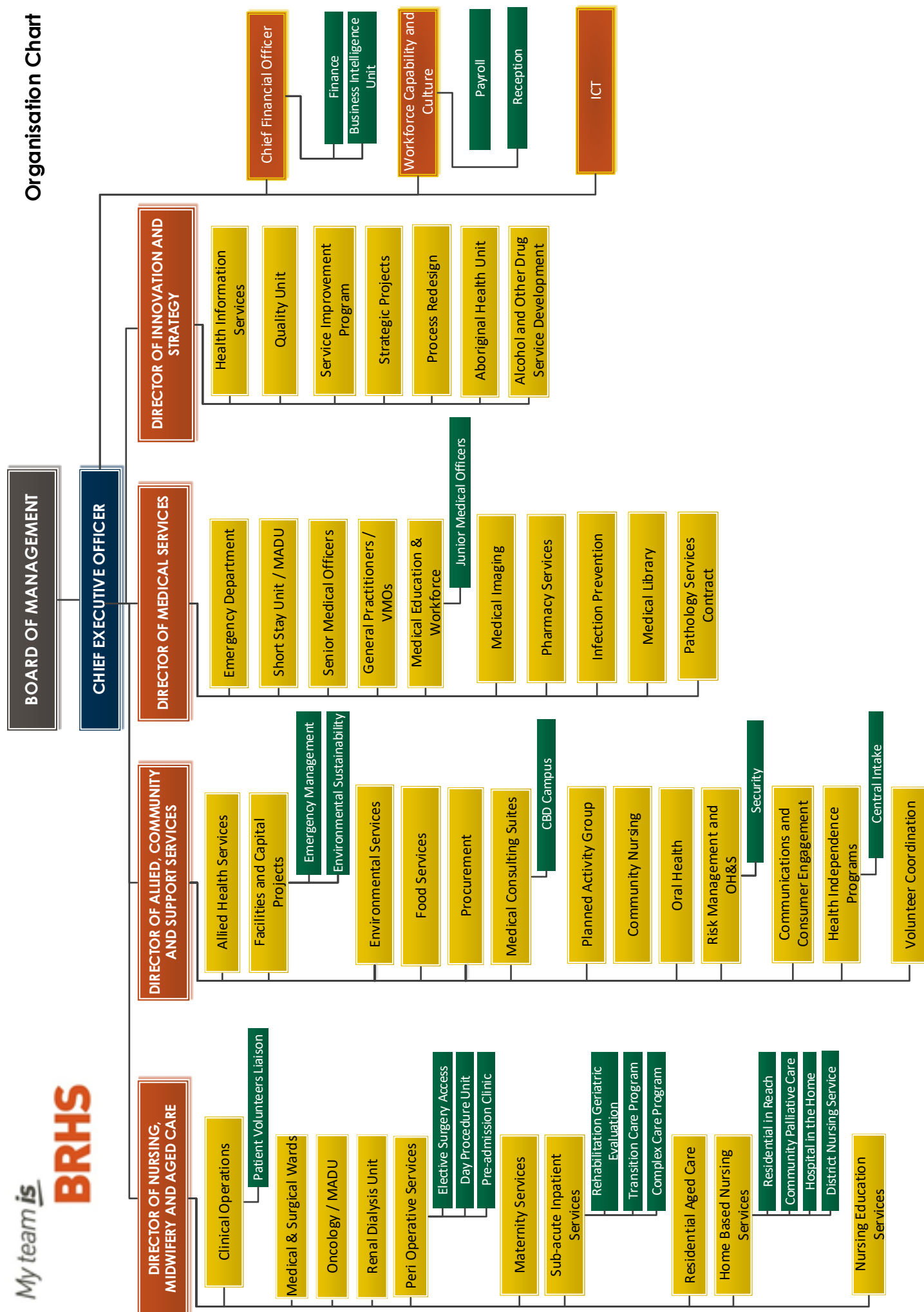
CA, B.Bus, Grad Cert Computing

The Director is responsible for the provision of finance services, business intelligence and accommodation coordination. It ensures the operational practices are consistent with the Financial Management Act 1994. The CFO provides support and assistance to the Executive and Department Heads in maintaining and developing the BRHS finance and information management systems. The position also coordinates the preparation of annual operating and capital budgets and monthly reporting of managers regarding their variances. The position is responsible for the provision of all costing, including clinical costing, and costing of proposed business cases. The position chairs the Information Management Committee and sets the strategic direction for BRHS for Finance, Information Management and Asset Management.



### **The BRHS Executive Team (L-R)**

Bernadette Hammond, Kaushik Banerjee, Deb Ellks,  
Therese Tierney (CEO) and Brendan Coulton



## Key Initiatives and Projects, Changes and Future Plans

There are a number of key initiatives and projects implemented by BRHS during the 2016-2017 year has highlighted below. In addition BRHS has responded as required to significant changes from previous year's plans to ensure we meet the objectives of our future plans, these are disclosed below.

### Key Initiatives and Projects include:

- Development and publication of the new Strategic Plan 2017-2021 and the creative involvement of the Futurist and the population health data to create the Plan.
- The completion of the East Gippsland Capability Framework and Service Plan and the joint board sign off of the Plan. As part of this process BRHS now has its own Strategic Service Plan.
- The creation of the Patient Experience Framework provides a key strategic focus on ensuring the consumer is at the centre of our care and quality improvement initiatives focus on patient experience.
- The development of the Clinical Governance Framework in response to the Victorian Government Targeting Zero policy implementation.
- The completion of the Operating Theatre review to ensure we continue to meet demands for surgical requirements of our community.
- The maturity of our Risk Management Framework and risk culture (external assessment)
- The Lighthouse Research Project which been concluded has now been funded again (Phase 3) and BRHS has received two years of funding to continue with the project. Phase 1&2 resulted in significant improvement in Aboriginal access and identification and a raised awareness of cultural safety. This included the creation of the Aboriginal Resource Group.
- The review and creation of the new Aboriginal Employment Plan
- Joining the Advisory Board to understand what worldwide best practice is and adapt it to our environment.
- The continued development of the Board Reporting Dashboard.

### Changes and Future Plans

BRHS has plans in place to merge two smaller wards, Fraser and Gabo into one larger ward in early 2018 with a capital building project known as the "One Ward" currently underway. This includes plans for a purpose built High Dependency Unit which will provide for providing higher acuity care at BRHS.

BRHS will continue to apply a Risk Management focus to ensure we are well positioned to navigate the changing health environment and ensure we meet our objectives and needs of the community we serve. This year will be the year the first of actions implemented towards achieving the new strategic plan 2017-2022 objectives.

BRHS is continuing to work on the transition to the National Disability Insurance Scheme (NDIS) with a focus on minimising any impact on consumer and service delivery.

The operating result for 2016-2017 was a deficit of \$357,000, this is referred to on the Comprehensive Operating Statement as Net result before capital and specific items. The net result was a surplus of \$9,000. The difference between the operating and net results are capital items and leave revaluations. Capital purpose income includes: capital grants; capital donations and bequests; and net result of asset disposals. Capital Expenses include: depreciation of assets; and interest on borrowings (finance costs). Under accounting standards we are required to revalue long term leave liabilities. The resulting transaction is also only included in the net result, not the operating result.

## WORKFORCE

### Labour Category – Full Time Equivalent

Labour Category	JUNE Current Month FTE		JUNE YTD FTE	
	2016	2017	2016	2017
<b>Nursing</b>	216.27	221.04	211.15	214.00
<b>Administration and Clerical</b>	96.54	98.48	93.06	94.70
<b>Medical Support</b>	44.44	48.16	43.62	47.42
<b>Hotel and Allied Services</b>	111.98	109.99	110.08	112.37
<b>Medical Officers</b>	5.32	6.28	5.32	5.63
<b>Hospital Medical Officers</b>	20.19	23.67	19.05	21.60
<b>Sessional Clinicians</b>	0.56	1.18	0.45	1.08
<b>Ancillary Staff (Allied Health)</b>	33.15	36.15	33.42	33.63
<b>Total</b>	<b>528.45</b>	<b>544.95</b>	<b>516.15</b>	<b>530.43</b>

### Employment Principles

BRHS ensures that all employment processes are designed to assess applicants against pre-determined key selection criteria in order to appoint the most suitable applicant for the role.

Employment to BRHS is open to all applicants 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 reflects best practice. Appointments and employee classifications are made according to the relevant and applicable Enterprise Agreement.

### 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 are subject to professional codes of conduct that establish specific behaviours relevant to their profession. Where this is the case individuals are expected to abide with 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.

BRHS has also established a set of Trademark Behaviours by which employees are contracted under the employment arrangements to demonstrate.

### Trademark Behaviours

- Display trust & mutual respect
- Courage to change
- Step up & take responsibility
- Be positive & support others
- Learn & apply knowledge



## Financial Year Summary

	2017 \$000	2016 \$000	2015 \$000	2014 \$000	2013 \$000
<b>Total Revenue</b>	88,615	80,797	74,504	71,307	64,819
<b>Total Expenses</b>	88,606	83,681	76,525	71,473	67,091
<b>Net Result for the Year (inc. Capital and Specific Items)</b>	9	(2,883)	(2,022)	(166)	(2,273)
<b>Retained Surplus / (Accumulated Deficit)</b>	360	1,886	5,135	7,223	7,615
<b>Total Assets</b>	74,324	74,387	74,752	73,042	69,040
<b>Total Liabilities</b>	26,070	26,143	24,047	21,823	20,494
<b>Net Assets</b>	47,254	48,245	50,705	51,219	48,546
<b>Total Equity</b>	47,254	48,245	50,705	51,219	48,546

### Significant changes in financial position

There were no significant changes in BRHS's financial position during the 2016-17 Financial Year.

### Operational and budgetary objectives, performance, significant activities and achievements

Bairnsdale Regional Health Service strives to meet the objectives as set out in our Strategic Plan and annual deliverables and those set out in government policy in the Statement of Priorities and related policies.

To achieve our objectives we need to have a comprehensive understanding of our resources and what the major influences are impacting those resources. We do this by working within the parameters of our Strategic Financial Plan and monitor and manage our resources to ensure the organisation can meet its obligations and grow the business.

The major influences on our business from a financial planning context are: Demographics and East Gippsland Population Growth; Infrastructure and Asset Management; Capital Works Requirements; Service Provision Needs; Government Funding and Reform; Employee Entitlements; Technology; and Community and Consumer Opinion.

Bairnsdale Regional Health Service has achieved its annual deliverables for 2016-2017 including activity levels required by funding and policy guidelines, although did post a deficit result.

### The particular highlights of the year include:

#### Our Care

- The pain and mobility program at Maddocks Gardens has been in operation for two years and the average daily bed revenue has been maintained at the target.
- The AOD withdrawal bed is meeting all of its targets and embedded and respected in community. This service won the VHA award this year as an outstanding example of collaboration.
- The delivery of the telemedicine project was a great outcome for us and for our smaller neighbours. Our telemedicine and the Victorian Stroke Telemedicine and more recently the acute paediatric assessment from CGHS and the Eye Telehealth are operational.

#### Capital Works

- The One Ward project is on target to be completed in early 2018 with a substantial building extension and renovation will see two small wards become one with modern

facilities, more single rooms and a space for a High Dependency Unit to be established.

- The work to refurbish the old mental health facility for the relocation of the home based nursing services, complex care and the intake team is close to completion
- Commissioning of the new sterilisers and tracking system in the operating theatres. We will also meet the new standards as a result of this project.
- Successful funding submission for capital projects:
  - \$800,000 funding for the replacement of the generator – work to commence in 2017-18
  - \$274,000 for the chillers as part of the One Ward Project.

#### People and Financial Management

- The continued implementation of the Information Management and Information Technology Strategy which has resulted in the selection of Tech-One and its recent implementation.
- The embedding of the Business Intelligence Unit and their activities in turning data into knowledge and improving decision making.
- A total of 162 managers and associate managers/team leaders have now completed the Trademark Management and Leadership program since 2014. A further 21 managers and team leaders have undertaken the program in 2016
- The People Matter Survey has become an annual feedback tool for staff to provide feedback and assess the satisfaction and culture of the organisation. 47% of staff responded the survey, an action plan has been developed to address the key priorities

#### Partnerships

- The four East Gippsland health services, namely Bairnsdale Regional Health Service, Omeo District Health, Gippsland Lakes Community Health and Orbost Regional Health have finalised a Strategic Capability and Service Plan. The plan encompasses the development of the full range of health services including acute, sub-acute, emergency care, maternity, mental health, primary health and community-based services. The plan is intended to consider service developments over the next five to 10 years, and provides the basis for more strategic service development over the next 20 years.
- BRHS has collaborated with a number of local businesses and agencies to consider Interagency Risks, or risks that impact or could impact on our ability to provide services, this has help to plan for Business Continuity contingencies.

#### **Major changes or factors affecting performance**

There were no major changes or factors affecting the performance of Bairnsdale Regional Health Service during the 2016-17 financial year.

#### **Events subsequent to balance date**

There were no events subsequent to balance date for BRHS relating to the 2016-17 Financial Year.

#### **Consultancies**

There were 20 consultancies in this financial year. These consultancies cost \$148,168.

<b>Consultancy Details &lt;\$10,000</b>	
Number of Consultancies	16
Total \$ of Consultancies (ex GST)	\$56,970
<b>Consultancy Details &gt;\$10,000</b>	
Clocktower Medical Centre Community Based Internship Agreement	\$25,750

Greymitt Pty Ltd Keynote Board Meeting and Facilitation Health Strategy	\$15,448
Finity Consulting Health Data Analytics	\$25,000
Macleod St Medical Centre Community Based Internship Agreement	\$25,000

### Government Advertising

BRHS did not undertake any government advertising with total media buy of \$100,000 or greater (exclusive of GST).

### Information and Communications Technology (ICT) expenditure

ICT expenditure represents an entity's costs in providing business-enabling ICT services and consists of the following costs elements:

- Operating and capital expenditure (including depreciation);
- ICT services- internally and externally sourced;
- Cost in providing ICT services (including personnel & facilities) across the agency, whether funded through a central ICT budget or through other budgets; and
- Cost in providing ICT services to other organisations.

Non-Business As Usual (Non- BAU) expenditure- is a subset of ICT expenditure that relates to extending or enhancing current ICT capabilities and are usually run as projects.

Business As Usual (BAU) expenditure- includes all remaining ICT expenditure other than Non-BAU ICT expenditure and typically relates to ongoing activities to operate and maintain the current ICT capability.

The total Information and Communication Technology (ICT) expenditure incurred during 2016-17 is \$2,593,043 (excluding GST) with the details shown below:

Business As Usual (BAU)	\$1,745,878
ICT expenditure Total (excluding GST)	
Non-Business As Usual (non-BAU) ICT expenditure (Total= Operational Expenditure and Capital Expenditure) (excluding GST)	\$847,165
Non BAU Operational expenditure (excluding GST)	\$0
Non BAU Capital expenditure (excluding GST)	\$847,165

### Car parking fees

Bairnsdale Regional Health Service does not have a fee based car parking facility. All parking is provided free for patients, visitors and staff.

### Occupational Violence

Health services are required to monitor and publicly report incidents of occupational violence which follows the Victorian Government's commitment to address occupational violence in healthcare.

<b>BRHS Occupational violence statistics</b>	<b>2016-17</b>
1. Workcover accepted claims with an occupational violence cause per 100 FTE	0
2. Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	0
3. Number of occupational violence incidents reported	86
4. Number of occupational violence incidents reported per 100 FTE	16.21
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition	8.2 %

#### Definitions

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

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

Incident - occupational health and safety incidents reported in the health service incident reporting system.

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

Lost time – is defined as greater than one day.

#### **Occupational Health and Safety (OH&S)**

Bairnsdale Regional Health Service is committed to providing a safe environment for everyone and therefore complies with obligations under the Occupational Health and Safety Act 2004, Occupational Health and Safety Regulations 2007 and other legislation and standards that support safety. Risk assessments, audits and workplace inspections are conducted to ensure the workplace environment is safe and records are retained by BRHS in line with archiving requirements. The BRHS Occupational Health & Safety Plan is an organisational framework based on AS/NZ 4804:2001 that describes how BRHS complies with the principles of occupational health & safety.

BRHS has an active OH&S committee made up of 16 trained Health & Safety Representatives and a number of additional staff in key roles that support workplace safety. Ongoing continuous improvement in workplace safety is implemented within the Risk & Safety work plan. BRHS has been successful in funding applications for additional CCTV and equipment and training aimed at reducing manual handling risk this year.

#### **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 \$4,891.90. The FOI application fee is waived for those applicants holding a health care card or who demonstrate financial hardship.

In accordance with Part II of the Freedom of Information (FOI) Act 1982, Bairnsdale Regional Health Service (BRHS) is required to publish certain statements relating to its functions, processes and documents held. This is contained in the Freedom of Information Statement II Publication of Information, which is available on the BRHS website.

Type of request	Number Processed
Freedom of Information	98
Medico-Legal	118
<b>Total</b>	<b>216</b>

### **Protected Disclosures Act 2012**

Bairnsdale Regional Health Service was not required to disclose any issues under the Protected Disclosure Act 2012 (the Act) in the financial year 2016-17.

### **Carers Recognition Act 2012**

Bairnsdale Regional Health Service is aware of and complies with the requirements of the Carers Recognition Act 2012 (the Act) and was not required to make any disclosures during the reporting period. As a care support organisation, Bairnsdale Regional Health Service:

- takes all practicable measures to ensure that its employees and agents have an awareness and understanding of the care relationship principles
- takes all practicable measures to ensure that persons who are in care relationships and who are receiving services in relation to the care relationship from BRHS have an awareness and understanding of the care relationship principles
- takes all practicable measures to ensure that BRHS and its employees and agents reflect the care relationship principles in developing, providing or evaluating support and assistance for persons in care relationships.

### **National Competition Policy**

Bairnsdale Regional Health Service complied with relevant policies with respect to the National Competition Policy, including:

- i. the requirements of the Government policy statement, Competitive Neutrality Policy Victoria; and
- ii. Subsequent reforms.

### **Environmental Performance**

Bairnsdale Regional Health Service Environmental Sustainability Committee has met bi-monthly during the 2016-17 financial year and worked on achieving activity and targets as set out in the Environmental Management Plan 2014-16 and Terms of Reference. The Environmental Sustainability Policy and Plan have both been reviewed and updated to 2017-2020.

BRHS recognises that environmental sustainability is one of the important issues for our global community and strives to maintain a high standard of environmental care in conducting our activities. Some key initiatives and achievements of the previous plan include:

- Food scrap composting
- Remember to switch off lights campaign and education to staff
- PVC recovery in Hospitals which includes recycling of plastic tubing in dialysis

- Second hand mobile phones are being recycled
- Recycling of our printer cartridges
- Replacement program of LED lights
- Install timer switches on domestic hot water units
- Installation of flow restrictors on all taps
- BRHS has prioritised two key areas of waste management and leadership with the Global Green and Healthy Hospitals membership. This will see a complete review of our waste management systems and improvements to recycling across the organisation with subsequent result of reducing landfill.

#### BRHS Energy Consumption

Financial Year	Total energy consumed (Gj)	CHG Emissions (tonnes CO2-e)
<b>2013-2014</b>	23,448	3,975
<b>2014-2015</b>	24,796	4,234
<b>2015-2016</b>	26,374	4,486
<b>2016-2017</b>	25,428	4,291

BRHS' energy consumption has decreased slightly during the last year despite the expanded and introduced new services, extended buildings (floor space) and increased the total size of the organisation. In particular the introduction of the MRI has substantially increased our energy consumption to deliver this service. This has been offset with the introduction and focus of our environmental sustainability actions as identified above. NB: The last quarter of 2016-2017 is estimated using seasonal adjusted calculations.

#### **Statement of availability of additional information**

Consistent with FRD 22H (Section 6.19) the Report of Operations should confirm the 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) Declarations of pecuniary interests have been duly completed by all relevant officers
- b) Details of shares held by senior officers as nominee or held beneficially;
- c) Details of publications produced by the entity about itself, and how these 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 are 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.

#### **Local Jobs First- Victorian Industry Participation Policy (VIPP)**

BRHS is required to provide the following information for contracts commenced and/or completed in the financial under the Victorian Industry Participation Policy (VIPP) Act 2003.

- a) Bairnsdale Regional Health Service had one contract for Capital Building works to the value of \$3,608,238.85 that commenced in the 2016-17 financial year for which the VIPP Plan was required. This project has not been completed with a January 2018 completion time frame.
- b) BRHS has one contract where 88.7 percent of 'local content' was committed under the contract that commenced in the reporting period to which a VIPP Plan was required for the regionally based project.
- c) For the one contract commenced, the below table describes the total VIPP Plan outcomes (local content, employment, engagement of apprentices/trainees and skills/technology transfer outcomes) achieved as a result of the contract.

Outcomes achieved					
Local content achieved (%)	New local jobs created	Existing jobs retained	New apprenticeships created	Existing apprenticeships retained	Skills technology transfer outcomes
88.7%	2	16	1	3	Apprentices received training on different tasks as the project progressed

- d) BRHS had one contract commence from September 2016 where the minimum formal weighting was applied for local content in the tendering evaluation of the VIPP Plan.
- e) Reporting on grants provided and design contracts. BRHS had a total of six conversations with the Industry Capability Network with respect to the registration and issue of an Interaction Reference Number.

The objectives of the Local Jobs First - VIPP are:

- promoting employment and business growth by expanding market opportunities for local industry;
- providing contractors with increased access to, and raised awareness of, local industry capability;
- exposing local industry to world's best practice in workplace innovation, e-commerce and use of new technologies and materials; and
- developing local industry's international competitiveness and flexibility in responding to changing global markets by giving local industry a fair opportunity to compete against foreign suppliers.

## Donations to BRHS 2016-2017

### Bequests & Estates

Estate of Brian & Valerie Denton	\$2,500.00
Estate of Carol Irene Edgell	\$591,265.55
Estate of Erica Cromwell	\$5,427.34
Estate of George & Phyllis Simpson	\$216,750.00
Estate of Philip Hostnick	\$4,650.00

### BRHS Fundraising Auxiliary

Bower Birds	\$57,951.73
-------------	-------------

### Business Sector

Bairnsdale Power Station	\$998.34
Gippsland Lakes Community Health	\$7,000.00
Gippsland Saddlery and Gascoignes	\$50.00
Karls Mega Sports	\$32.00
Noamunga Pty Ltd	\$200.00
Ritchies	\$2,465.44
Roche Products	\$3,203.55
Simon Ellis - Entertainment	
Gippsland	\$3,000.00
Spotlight Bairnsdale	\$292.00

### Community Group

Bairnsdale Bowls Club	\$350.00
Bairnsdale Golf and Bowls Club	\$6,230.00
Bairnsdale Int Women's Group	\$638.00
Bdale & Dist Old Time Dance Group Inc	\$1,000.00
Lakes Entrance Sec College VCAL students	\$450.95
Metung Bloodhounds	\$5,000.00
Parkridge Village Social Committee	\$700.00
Paynesville Bowls Club	\$2,040.00
Paynesville Hospital Auxiliary	\$9,000.00
Paynesville Mens Shed	\$175.00
Paynesville Opportunity Shop	\$6,200.00
Paynesville Uniting Church Op Shop (The Shed)	\$4,140.40
Raymond Island Tai Chi Group	\$1,500.00
St. Johns Anglican Opportunity Shop	\$4,500.00
The Male Bag Foundation	\$35,000.00
The Silt Jetty Girls	\$362.70
The United Grand Lodge Victoria	\$15,000.00
Tour De Cure	\$10,000.00

### Individual

Alan & Mary Rowe	\$50.00
Anonymous	\$6,444.90
Antonio Di Palma	\$1,000.00
Barbara Barke	\$50.00
Barry Bills	\$10.00
Brenden & Barbara	\$20.00
Carolyn Wyld	\$20.00
Cindy Lumley	\$50.00

Dennis Saxton	\$100.00
Don & Judy Emanuel	\$50.00
Elizabeth Kenyon	\$20.00
Elle Davies	\$250.00
F Garden	\$200.00
Faye & Kevin Eckhardt	\$1,000.00
Graham Bennett	\$100.00
Gus & Jennifer Sperti	\$1,000.00
Harry Donelly	\$130.00
Heather W	\$10.00
In Memory of Philip Charles Answer	\$40.00
Jackie Vanpolen	\$20.00
JE Gibson	\$100.00
Jennifer Visser	\$200.00
Jim Voysey	\$100.00
Judith B Ward	\$50.00
June Hopkins	\$50.00
Karen Dimarco	\$2,000.00
L McKenzie & R Mares	\$100.00
Les & Esme Mills	\$20.00
Mary & Alan Rowe	\$20.00
Merle McRae	\$1,000.00
Mia Pitzner	\$100.00
Nancy & Max Hodder	\$50.00
Peter Millard & Lynden Dean	\$155.00
Robert "Bob" Hoenger (Gideons Bibles)	\$0.00
Rod Cusack	\$10.00
Russell Buck	\$50.00
Salaried Staff CDBS	\$112,542.55
Salaried Staff MBS	\$193,818.48
Sam Dipalma	\$60.00
Sandra Holland	\$20.00
Shamis Law	\$250.00
Tristesse De Visser	\$10,000.00
	<b>\$1,329,333.93</b>



## STATEMENT OF PRIORITIES

The Statement of Priorities (SoP) is the formal funding and monitoring agreement between Victorian sub-regional and local health services and the Secretary for Health, and is in accordance with section 26 of the Health Services Act 1988 (Vic). The annual agreement facilitates delivery of or substantial progress towards the key shared objectives of financial viability, improved access and quality of service provision.

### Statement of Priorities Part A

#### Strategic priorities

Bairnsdale Regional Health Service Statement of Priorities outcomes for 2016-2017 are provided below:

Domain	Action	Deliverable	Outcomes
	Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine).	Service improvement project to be undertaken September to December 2016 of Central Intake to improve access to HLP and care in the community. Smiles4Miles program to be recommenced and the Outreach Dental Service (Aboriginal and Child Screening programs) commenced by August 2016. Increase access to telemedicine in the Medical Consulting Suites.	All actions complete. Smiles for Miles education and planning completed and roll out to the early years setting commenced. Outreach Van service to ACCO's in place and child screening program continuing. Have increased the access to specialists via telemedicine.

Domain	Action	Deliverable	Outcomes
Access and timeliness (Continued)	<p>Ensure the implementation of a range of strategies in specialist clinics to:</p> <ul style="list-style-type: none"> <li>Optimise referral management processes and improve patient flow through to ensure patients are seen in turn and within time.</li> <li>Ensure patient data is recorded in a timely, accurate manner and is working toward meeting the requirements of the Victorian Integrated Non Admitted (VINAH) dataset.</li> </ul>	<p>Wait time analysis and failure to attend data being captured and actions to reduce FTA with SMS messaging being introduced by February 2017.</p> <p>Project to improve the access to the Haematology and Oncology Specialist Clinic commencing August 2016 and completed November 2016.</p> <p>The newly created Business Intelligence Unit and Information Management and Information Technology Committee to be charged with overseeing the integrity of data transition to VINAH.</p>	<p>Analysis has been done and changed the timeframes of the SMS.</p> <p>A redesign project was completed to improve access and flow for consumers of the Haematology and Oncology service, including appointment scheduling.</p> <p>Upgrades completed and data integrity tested and resource allocated so on track.</p>
	<p>Ensure the implementation of a range of strategies (including processes and service models) to improve patient flow, transfer times and efficiency in the emergency department, with particular focus on patients did not wait for treatment and/or patients that re-presented within 48 hours.</p>	<p>Continue the patient flow project with data analysis to be completed with time of discharge and length of stay to be the priorities in 2016-17.</p>	<p>Continuing. Discharge by 1200 increasing and LOS reducing. Health Roundtable data indicates we have regained 300 bed days in six months.</p>
	<p>Develop and implement a strategy to ensure the preparedness of the organisation for the NDIS and HACC transition and reform, with particular consideration to service access, service expectations, workforce and financial management.</p>	<p>Transition Working Group established to minimise disruption and reduce access barriers for consumers.</p> <p>Workforce and financial matters addressed in the service work plans with clear service targets. KPI's to be established by March 2017.</p>	<p>Work being undertaken within the HACC workgroup. We have a process in place to support consumer access.</p> <p>Project established to develop KPI's and close to completion.</p>

Domain	Action	Deliverable	Outcomes
<b>Governance and leadership</b>	Demonstrate implementation of the Victorian Clinical Governance Policy Framework: Governance for the provision of safe, quality healthcare at each level of the organisation, with clearly documented and understood roles and responsibilities. Ensure effective integrated systems, processes, leadership are in place to support the provision of safe, quality, accountable and person centred healthcare. It is an expectation that health services implement to best meet their employees' and community's needs, and that clinical governance arrangements undergo frequent and formal review, evaluation and amendment to drive continuous improvement.	The existing Clinical Governance Framework will be reviewed after the release of the new state-wide clinical governance framework and the review of the Victorian hospital safety and quality assurance report.	The Framework is completed and presented to the July BOM and committee structure and terms of reference reviewed and adjusted as required. Dashboards designed to match the data requirement for accountability at each level in the organisation. Clinical Governance Framework modelled on the newly release DHHS guidelines and action plan to respond to "Targeting Zero" recommendations.
	Contribute to the development and implementation of Local Region Action Plans under the series of state-wide design, service and infrastructure plans being progressively released from 2016-17. This will require partnerships and active collaboration across regions to ensure plans meet both regional and local service needs.	To actively participate and implement outcomes of the Gippsland Maternity Services Implementation Group Review. The East Gippsland Capability Framework and Service Plan will be completed in October. Continue to participate in the regional clinical pathway development in partnership with the PHN.	Participate in regional M&M and pathway. Local M&M created with specialist support. Completed and endorsed by the East Gippsland Health Boards of Management. MoU in the process of being developed for the oversight of the implementation plan. Actively involved in the clinical pathway development with the PHN.

Domain	Action	Deliverable	Outcomes
<b>Governance and leadership (continued)</b>	<p>Ensure that an anti-bullying and harassment policy exists and includes the identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal and the policy specifies a regular review schedule.</p>	<p>Utilise 2016 People Matter Survey (PMS) results to identify issues with current culture and implement strategies to respond to any issues.</p>	<p>People Matter Survey completed in 2016. Whilst the results were good the opportunity was taken to refresh bullying and harassment awareness and reporting training in 2017.</p> <p>PMS completed in May 2017 with 47% participation. Results expected July.</p>
	<p>Board and senior management ensure that an organisational wide occupational health and safety risk management approach is in place which includes: A focus on prevention and the strategies used to manage risks, including the regular review of these controls; and strategies to improve reporting of OHS incidents, risks and controls, with a particular focus on prevention of occupational violence and bullying and harassment, throughout all levels of the organisation, including to the board; and</p> <p>Mechanisms for consulting with, debriefing and communicating with all staff regarding outcomes of investigations and controls following occupational violence and bullying and harassment incidents.</p>	<p>Annual Plan and Awareness Campaign developed. In line with organisations Risk Management and Safety Framework the focus is to roll-out education in occupational violence/aggression and bullying with a particular focus on awareness to all staff.</p>	<p>Education held in early 2017. Grievances followed up promptly and we scan the environment regularly to ensure that there is not unreported bullying or harassment.</p> <p>Aggression management training system in place.</p>

Domain	Action	Deliverable	Outcomes
	Implement and monitor workforce plans that improve industrial relations; promote a learning culture; align with the Best Practice Clinical Learning Environment Framework; promote effective succession planning; increase employment opportunities for Aboriginal and Torres Strait Islander people; ensure the workforce is appropriately qualified and skilled; and support the delivery of high quality and safe person centred care.	Review existing plans and develop a new Medical Workforce Plan by November 2016 and Aboriginal Employment Plan by August 2016. Conduct further Trademark Leadership Program for managers. Organisation wide education and professional development plan to be developed. Under the auspice of the Health Literacy Working Group staff will be provided education on person-centred care.	Medical Workforce Plan developed and consultation completed. To be finalised. Aboriginal Employment Plan completed and presented to the BOM. Traineeships continue Trademark program 2016 completed and further program in 2017. Education plan on track for non-clinical staff. Not commenced at this stage as will be part of the roll out of the Patient Experience Framework 2017-18.
	Create a workforce culture that includes staff in decision making; promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and includes consumers and the community.	BRHS will evaluate the impact of strategies to embed organisational principles and trademark behaviours across the organisation and the delivery of management and leadership programs utilising the People Matter Survey results.	People Matter Survey results received and actions to further improve developed. Trademark principles and behaviours embedded and staff elected to keep in the next five year strategic plan. Senior Manager Training - Having Difficult conversations completed.
	Ensure that the Victorian Child Safe Standards are embedded in everyday thinking and practice to better protect children from abuse, which includes the implementation of strategies to embed an organisational culture of child safety; a child safe policy or statement of commitment to child safety; a code of conduct that establishes clear expectations for appropriate behaviour	BRHS will continue to implement strategies identified by the Child Safe Standards Working Party with a particular focus on delivery of further education to key staff in ED, Paediatrics maternity program staff in the first instance on the identification of children at risk.	On track and compliant. Attended the forums provided by the Good Beginnings initiative and using that knowledge to improve our response.



Domain	Action	Deliverable	Outcomes
Governance and leadership (continued)	with children; screening, supervision, training and other human resources practices that reduce the risk of child abuse; processes for responding to and reporting suspected abuse to children; strategies to identify and reduce or remove the risk of abuse and strategies to promote the participation and empowerment of children.		
	Implement policies and procedures to ensure clinical staff have access to vaccination programs and are appropriately vaccinated and/or immunised to protect staff and prevent the transmission of infection to susceptible patients or people in their care.	100% of new employees vaccinated prior to commencement of employment. Flu vaccination targets achieved.	We have a program and ensure that the appropriate immunisation record is in place. At the end of the flu vaccination program we had an 80% immunisation (state wide target 75%) and a 97% return of the consent forms.
	Implement systems and processes to recognise and support person-centred end of life care in all settings, with a focus on providing support for people who choose to die at home.	Palliative Care Working Group use the Care Plan for the Dying Person - Victoria supported through the Centre for Palliative Care at SVH. BRHS will use the tools and guidance and support centre for its implementation. The BRHS Working Group will implement the directions in the End of Life and Palliative Care Framework by developing the processes to ensure support for dying in a place of choice.	Active working group and implementing directions.
	Advance care planning is included as a parameter in an assessment of outcomes including mortality and morbidity review reports, patient experience, and routine data collection.	Complete an audit to ensure compliance with policy for all aged care residents to have an ACP on admission and ACP were complied with during M&M review processes.	Currently all of our residents have an ACP in place as part of the normal processes. Audit of M&M has just been undertaken.

Domain	Action	Deliverable	Outcomes
Quality and Safety (continued)	Progress implementation of a whole-of-hospital model for responding to family violence	Improve screening processes in the Emergency Department and then extend processes across the organisation. The Women's and Bendigo Health model will be implemented to create a whole of health service approach.	Improving the screening as this stage has focused on Emergency Department, Alcohol and Other Drug Service, Maternity and Aboriginal Health Unit. Will be rolled out further for whole of health service response as agreed 2017-18.
	Develop a regional leadership culture that fosters multidisciplinary and multi organisational collaboration to promote learning and the provision of safe, quality care across rural and regional Victoria.	Lead the completion of the East Gippsland Capability Framework and Service Plan by October 2016. Active participation of maternity clinical staff on regional maternity M&M committee.	Final draft completed in November and endorsed by the four East Gippsland Boards of Management. BRHS actively participates in regional process and has improved/created the local M&M to feed into the regional committee.
	Establish a foetal surveillance competency policy and associated procedures for all staff providing maternity care that includes the minimum training requirements, safe staffing arrangements and ongoing compliance monitoring arrangements.	Policy in place. Requirements are a part of the professional development and training program and online assessment in place. Random audits undertaken by the Educator. Target: 80% compliance for each workforce group by June 30th 2017.	Education completed and compliant.
	Use patient feedback, including the Victorian Healthcare Experience Survey to drive improved health outcomes and experiences through a strong focus on person and family centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first.	Develop a new Patient Experience Framework by November 2016.	Document completed and presented to the November BOM meeting. Action Plan (implementation plan) to be further developed and staged. Some elements such as bedside boards and patient initiated MET calls etc. in place.

Domain	Action	Deliverable	Outcomes
	Develop a whole of hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint.	Complete an audit to ensure compliance with health service policy in Emergency Department".	Compliant.
	Health services support shared population health and wellbeing planning at a local level - aligning with the Local Government Municipal Public Health and Wellbeing Plan and working with other local agencies and Primary Health Networks.	Active participation on East Gippsland Primary Care Partnership to ensure alignment with the East Gippsland Municipal Public Health and Wellbeing Plan. Work with the PHN on their planning initiatives and clinical pathway project. Complete report aimed at creating a profile of small neighbourhoods to identify emerging risks in the community for future planning by October 2016.	BRHS are very active in supporting the EGSC in the creation of the Municipal Public Health and Wellbeing Plan. Working with the PHN on the clinical pathway development. Worked with Finity on the creation of the neighbourhood demographics. This has been completed and used in the development of the Strategic Plan 2017-22.
	That health services focus on primary prevention, including suicide prevention activities, and aim to impact on large numbers of people in the places where they spend their time adopting a place based, whole of population approach to tackle the multiple risk factors of poor health.	The Positive Health Employee Wellbeing (PHEW) program will build on the work already undertaken when the Healthy Together Achievement Program in mental wellbeing was achieved in 2015-16. The additional focus is on sleep deprivation and suicide awareness. BRHS will monitor utilisation and trends in the Employee Assistance Program.	The sleep deprivation component has been addressed and program completed. Suicide awareness to be completed. In addition PHEW is undertaking an initiative dealing with the family violence issues and impact on staff.
	Develop and implement strategies that encourage a culturally diverse environment such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.	In line with the Bairnsdale Regional Health Service Diversity Plan 2016-17 action plans implement an education program for Central Intake to raise awareness and evaluate the effectiveness and appropriateness of intake process.	Training has been completed and cultural requirements are collected as part of the intake information. Also includes other aspects of diversity such as dementia and financial hardship. "Asking the question" training completed.

Domain	Action	Deliverable	Outcomes
Supporting healthy populations (continued)	Improve the health outcomes of Aboriginal and Torres Strait Islander people by establishing culturally safe practices which recognise and respect their cultural identities and safely meets their needs, expectations and rights.	The Bairnsdale Regional Health Services' Aboriginal Health Unit will oversee the implementation of actions to improve access and referral pathways through continued community engagement.	On track. This work is being further enhanced as a site for the Phase 3 of the Lighthouse project for the next two years.
	Drive improvements to Victoria's mental health system through focus and engagement in activity delivering on the 10 Year Plan for Mental Health and active input into consultations on the Design, Service and Infrastructure Plan for Victoria's Clinical mental health system.	Bairnsdale Regional Health Service will review the mental health pathway in the context of the release of the 10 year mental health plan and the suicide prevention framework 2016-25.	The local Mental Health Pathway is well used and activated as required.
	Using the Government's Rainbow Equality Guide, identify and adopt 'actions for inclusive practices' and be more responsive to the health and wellbeing of lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals and communities.	Complete a LGBTI gap analysis and identify opportunities to improve access and inclusiveness of services.	LGBTIQ workgroup established. Gap analysis undertaken and priority actions identified to achieve Rainbow Tick.

Domain	Action	Deliverable	Outcomes
	Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	Complete annual review of the Strategic Financial Management Plan and update the three year rolling capital plan and cash flow forecast by September 2016.	Completed and endorsed by the Board in September. Due for review for 2017-18. The financial challenges of this year will be addressed in the Plan.
	Actively contribute to the development of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measurable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling.	Review the current BRHS Environmental Sustainability Plan by March 2017. Join the Greening Hospitals and select two areas of focus by September.	<p>Review Complete. Joined Greening Hospitals The two areas of focus are:</p> <ul style="list-style-type: none"> <li>• Waste minimisation and</li> <li>• Increasing staff knowledge.</li> </ul> <p>Solar Panel feasibility project commenced.</p>



## Statement of Priorities Part B

### Quality and safety

Key performance indicator	Target	2016-2017 Actuals
<b>Accreditation</b>		
Compliance with NSQHS Standards accreditation	Full compliance	Compliant
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Compliant
<b>Infection prevention and control</b>		
Compliance with cleaning standards	Full compliance	Achieved
Very High Risk (Category A)	90 points	Achieved
High Risk (Category B)	85 points	Achieved
Moderate Risk (Category C)	85 points	Achieved
Submission of infection surveillance data to VICNISS <sup>(1)</sup>	Full compliance	Compliant
Compliance with the Hand Hygiene Australia program	80%	Compliant 88.1%
Percentage of healthcare workers immunised for influenza	75%	80
<b>Patient experience</b>		
Victorian Healthcare Experience Survey – data submission	Full compliance	Achieved
Victorian Healthcare Experience Survey -patient experience Quarter 1	95% positive experience	97.4% - Achieved (July to September result taken from Q2 Monitor)
Victorian Healthcare Experience Survey – patient experience Quarter 2	95% positive experience	94.4% Not Achieved (October to December Result -Taken from Q3 Monitor)
Victorian Healthcare Experience Survey – patient experience Quarter 3	95% positive experience	93.8% Not Achieved (Jan to March Result - Taken from Q4 Monitor)
Victorian Healthcare Experience Survey - discharge care Quarter 1	75% very positive experience	81.4% - Achieved (July to Sep result taken from Q2 monitor)
Victorian Healthcare Experience Survey - discharge care Quarter 2	75% very positive experience	77.6% - Achieved (October to December result taken from Q3 monitor)
Victorian Healthcare Experience Survey - discharge care Quarter 3	75% very positive experience	76.9% - Achieved (Jan to March result taken from Q4 monitor)
<b>Maternity and newborn<sup>(2)</sup></b>		
Percentage of women with prearranged postnatal home care	100%	100%
Rate of singleton term infants without birth anomalies with APGAR score <7 to 5 minutes	≤ 1.6%	0%
Rate of severe foetal growth restriction in singleton pregnancy undelivered by 40 weeks	≤ 28.6%	0%

Continuing care		
Functional independence gain from admission to discharge, relative to length of stay	≥ 0.39 (GEM) ≥ 0.645 (rehab)	0.61 0.80

<sup>(1)</sup> VICNISS is the Victorian Healthcare Associated Infection Surveillance.

<sup>(2)</sup> Perinatal Service Performance Indicator (PSPi) reports should be consulted for a description on the utility and business rules for these indicators. Note that data for 2016 and 2017 is provisional.

## Governance and leadership

Key performance indicator	Target	2016-2017 Actuals
People Matter Survey – percentage of staff with a positive response to safety culture questions	80%	92%

## Access and timeliness

Key performance indicator	Target	2016-2017 Actuals
Emergency care		
Percentage of ambulance patients transferred within 40 minutes	90%	94%
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%	81%
Percentage of emergency patients with a length of stay less than four hours	81%	77%
Number of patients with a length of stay in the emergency department greater than 24 hours	0	4

## Financial sustainability

Key performance indicator	Target	2016-2017 Actuals
Finance		
Operating result (\$m)	0.15	(0.36)
Trade creditors	60 days	33 days
Patient fee debtors	60 days	26 days
Public & private WIES <sup>(3)</sup> performance to target	100%	102%
Adjusted current asset ratio	0.7	1.35
Number of days with available cash	14 days	45 days
Asset management		
Basic asset management plan	Full compliance	Compliant

<sup>(3)</sup> WIES is a Weighted Inlier Equivalent Separation.

## Statement of Priorities Part C

Funding type	2016-17 Activity Achievement
<b>Acute Admitted</b>	
WIES DVA	248
WIES Private	941
WIES Public	6,379
WIES TAC	32
<b>Acute Non-Admitted</b>	
Home Enteral Nutrition	118
<b>Aged Care</b>	
HACC	12,860
Residential Aged Care	32,630
<b>Subacute and Non-Acute Admitted</b>	
Subacute WIES – GEM Private	28
Subacute WIES – GEM Public	61
Subacute WIES – Palliative Care Private	9
Subacute WIES – Palliative Care Public	42
Subacute WIES – Rehabilitation Private	38
Subacute WIES – Rehabilitation Public	163
Subacute WIES - DVA	23
<b>Subacute Non-Admitted</b>	
Health Independence Program - Public	20,424
<b>Primary Health</b>	
Community Health / Primary Care Programs	1,458
<b>Other</b>	
Health Workforce	32

## Data sources and definitions

Admitted patient data is sourced from the Victorian Admitted Episode Dataset (VAED), and definitions are in accordance with the standards in the VAED Manual. It is acknowledged that preparation of the data for the above table will be occurring before the final consolidation, and therefore the data published in the Report of Operations will not be final.

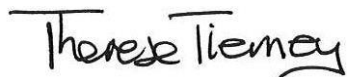
Non-admitted patient data is in accordance with the definitions in the Victorian Emergency Minimum Dataset (VEMD) and AIMS manuals. The data published in the Report of Operations may not be final.



### **ATTESTATION FOR COMPLIANCE WITH THE MINISTERIAL STANDING DIRECTION 3.7.1 – RISK MANAGEMENT FRAMEWORK AND PROCESSES**

I, Therese Tierney, certify that Bairnsdale Regional Health Service has complied with the Ministerial Standing Direction 3.7.1 – Risk management framework and processes.

The BRHS Audit & Risk Committee has verified this.



Therese Tierney  
Chief Executive Officer  
BRHS  
23 August 2017

### **ATTESTATION ON COMPLIANCE WITH HEALTH PURCHASING VICTORIA (HPV) HEALTH PURCHASING POLICIES**

I, Therese Tierney, certify that Bairnsdale Regional Health Service has put in place appropriate internal controls and processes to ensure that it has complied with all requirements set out in the *HPV Health Purchasing Policies* including mandatory HPV collective agreements as required by the *Health Services Act 1988 (Vic)* and has critically reviewed these controls and processed during this year.



Therese Tierney  
Chief Executive Officer  
BRHS  
23 August 2017

### **COMPLIANCE WITH DATAVIC ACCESS POLICY**

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



# Independent Auditor's Report

## To the Board of Bairnsdale Regional Health Service

<b>Opinion</b>	<p>I have audited the financial report of Bairnsdale Regional Health Service (the health service) which comprises the:</p> <ul style="list-style-type: none"><li>• balance sheet as at 30 June 2017</li><li>• comprehensive operating statement for the year then ended</li><li>• statement of changes in equity for the year then ended</li><li>• cash flow statement for the year then ended</li><li>• notes to the financial statements, including a summary of significant accounting policies</li><li>• board member's, accountable officer's and chief finance &amp; accounting officer's declaration.</li></ul> <p>In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2017 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the <i>Financial Management Act 1994</i> and applicable Australian Accounting Standards.</p>
<b>Basis for Opinion</b>	<p>I have conducted my audit in accordance with the <i>Audit Act 1994</i> which incorporates the Australian Auditing Standards. My responsibilities under the Act are further described in the <i>Auditor's Responsibilities for the Audit of the Financial Report</i> section of my report.</p> <p>My independence is established by the <i>Constitution Act 1975</i>. My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 <i>Code of Ethics for Professional Accountants</i> (the Code) that are relevant to my audit of the financial report in Australia. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code.</p> <p>I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.</p>
<b>Board's responsibilities for the financial report</b>	<p>The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the <i>Financial Management Act 1994</i>, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error.</p> <p>In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, and using the going concern basis of accounting unless it is inappropriate to do so.</p>

**Auditor's responsibilities for the audit of the financial report**

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

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

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

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



MELBOURNE  
24 August 2017

Ron Mak  
*as delegate for the Auditor-General of Victoria*

## 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 5.2 of the Standing Directions of the Minister for Finance under the *Financial Management Act 1994*, applicable Financial Reporting Directions, Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2017 and the financial position of *Bairnsdale Regional Health Service* at 30 June 2017.

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


We authorise the attached financial statements for issue on 23<sup>rd</sup> August 2017.



Doug Vickers  
Acting Board President

Bairnsdale Regional  
Health Service

23/08/2017



Therese Tierney  
Accountable Officer

Bairnsdale Regional  
Health Service

23/08/2017



Tania Donaldson  
Chief Finance &  
Accounting Officer

Bairnsdale Regional  
Health Service

23/08/2017

**Bairnsdale Regional Health Service**  
**Comprehensive Operating Statement**  
**For the Year Ended 30 June 2017**

	Note	2017 \$'000	2016 \$'000
Revenue from operating activities	2.1	83,521	79,225
Revenue from non-operating activities	2.1	575	671
Employee expenses	3.1	(48,320)	(44,911)
Non salary labour costs	3.1	(7,891)	(6,844)
Supplies & consumables	3.1	(9,930)	(10,700)
Patient transport	3.1	(2,899)	(2,643)
Insurance	3.1	(1,110)	(1,049)
Commercial activities	3.1	(6,185)	(5,406)
Other expenses	3.1	(8,117)	(7,995)
<b>Net result before capital &amp; specific items</b>		<b>(357)</b>	<b>349</b>
Capital purpose income	2.1	4,519	901
Depreciation	4.4	(4,291)	(4,110)
Finance costs	3.3	(37)	(41)
<b>Net result after capital &amp; specific items</b>		<b>(165)</b>	<b>(2,902)</b>
<b>Other economic flows included in net result</b>			
Revaluation of long service leave		175	18
<b>Total other economic flows included in net result</b>		<b>175</b>	<b>18</b>
<b>NET RESULT FOR THE YEAR</b>		<b>9</b>	<b>(2,883)</b>
<b>Other comprehensive income</b>			
<b>Items that will not be reclassified to net result</b>			
Changes in physical assets revaluation surplus	8.1	-	-
<b>Total other comprehensive income</b>		<b>-</b>	<b>-</b>
<b>COMPREHENSIVE RESULT</b>		<b>9</b>	<b>(2,883)</b>

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

**Bairnsdale Regional Health Service**  
**Balance Sheet**  
**As at 30 June 2017**

	Note	2017 \$'000	2016 \$'000
<b>Current assets</b>			
Cash and cash equivalents	6.2	24,403	22,619
Receivables	5.1	2,315	2,621
Inventories	5.2	490	463
Other assets	5.4	533	1,478
<b>Total current assets</b>		<b>27,742</b>	<b>27,181</b>
<b>Non-current assets</b>			
Receivables	5.1	719	442
Property, plant & equipment	4.3	45,862	46,765
<b>Total non-current assets</b>		<b>46,581</b>	<b>47,206</b>
<b>TOTAL ASSETS</b>		<b>74,324</b>	<b>74,387</b>
<b>Current liabilities</b>			
Payables	5.5	1,918	3,895
Borrowings	6.1	69	65
Provisions	3.4	9,916	9,105
Other current liabilities	5.3	11,673	10,637
<b>Total current liabilities</b>		<b>23,576</b>	<b>23,701</b>
<b>Non-current liabilities</b>			
Borrowings	6.1	533	602
Provisions	3.4	1,960	1,839
<b>Total non-current liabilities</b>		<b>2,494</b>	<b>2,441</b>
<b>TOTAL LIABILITIES</b>		<b>26,070</b>	<b>26,143</b>
<b>NET ASSETS</b>		<b>48,254</b>	<b>48,245</b>
<b>Equity</b>			
Physical assets revaluation surplus	8.1a	24,218	24,218
Restricted specific purpose surplus	8.1a	2,283	747
Contributed capital	8.1b	21,394	21,394
Accumulated surpluses	8.1c	360	1,886
<b>TOTAL EQUITY</b>		<b>48,254</b>	<b>48,245</b>
Contingent assets and contingent liabilities	7.3		
Commitments	6.3		

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



# Bairnsdale Regional Health Service

## Statement of Changes in Equity

### For the Year Ended 30 June 2017

	Note	Physical Assets Revaluation Surplus	Restricted Specific Purpose Surplus	Contributions by Owners	Accumulated Surpluses/ (Deficits)	Total
		\$'000	\$'000	\$'000	\$'000	\$'000
<b>Balance at 1 July 2015</b>		<b>24,218</b>	<b>381</b>	<b>20,971</b>	<b>5,135</b>	<b>50,705</b>
Net result for the year		-	-	-	(2,883)	(2,883)
Other comprehensive income for the year	8.1a	-	-	-	-	-
Transfer to accumulated surplus	8.1c	-	366	-	(366)	-
Transfer to / returned from contributed capital	8.1b	-	-	423	-	423
<b>Balance at 30 June 2016</b>		<b>24,218</b>	<b>747</b>	<b>21,394</b>	<b>1,886</b>	<b>48,245</b>
Net result for the year		-	-	-	9	9
Other comprehensive income for the year	8.1a	-	-	-	-	-
Transfer to accumulated surplus	8.1c	-	1,536	-	(1,536)	-
Transfer to / returned from contributed capital	8.1b	-	-	-	-	-
<b>Balance at 30 June 2017</b>		<b>24,218</b>	<b>2,283</b>	<b>21,394</b>	<b>360</b>	<b>48,254</b>

This Statement should be read in conjunction with the accompanying notes

**Bairnsdale Regional Health Service**  
**Cash Flow Statement**  
**For the Year Ended 30 June 2017**

	Note	2017 \$'000	2016 \$'000
<b>CASH FLOWS FROM OPERATING ACTIVITIES</b>			
Operating grants from government		63,330	59,537
Capital grants from government		3,152	524
Patient and resident fees received		15,968	15,555
Donations and bequests received		322	343
GST received from/(paid to) ATO		110	(25)
Interest received		575	671
Capital donations and bequests received		1,007	402
Other receipts		3,961	2,204
<b>Total receipts</b>		<b>88,427</b>	<b>79,212</b>
Employee expenses paid		(50,230)	(46,346)
Non salary labour costs		(8,058)	(6,985)
Payments for supplies & consumables		(12,018)	(12,675)
Finance costs		(37)	(41)
Other payments		(13,832)	(13,289)
<b>Total payments</b>		<b>(84,175)</b>	<b>(79,336)</b>
<b>NET CASH FLOW FROM OPERATING ACTIVITIES</b>	8.2	<b>4,252</b>	<b>(123)</b>
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>			
Payments for non-financial assets		(3,505)	(5,474)
Proceeds from sale of non-financial assets		65	75
<b>NET CASH FLOW USED IN INVESTING ACTIVITIES</b>		<b>(3,440)</b>	<b>(5,399)</b>
<b>CASH FLOWS FROM FINANCING ACTIVITIES</b>			
Repayment of borrowings		(65)	(61)
Contributed capital from government		-	423
<b>NET CASH FLOW FROM/(USED IN) FINANCING ACTIVITIES</b>		<b>(65)</b>	<b>362</b>
<b>NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD</b>		<b>748</b>	<b>(5,161)</b>
Cash and cash equivalents at beginning of financial year		<b>11,982</b>	<b>17,143</b>
<b>CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR</b>	6.2	<b>12,730</b>	<b>11,982</b>

*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 2017. This report provides users with information about the Health Service's stewardship of resources entrusted to it.

### (a) Statement of compliance

These financial statements are general purpose financial statements which have been prepared in accordance with the *Financial Management Act 1994* and applicable 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 AASBs.

The annual financial statements were authorised for issue by the Board of Bairnsdale Regional Health Service on 23 August 2017.

### (b) 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 be a respected leader of outstanding health care, and to improve the health and wellbeing of the East Gippsland community by providing accessible, high quality and sustainable health care.

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

### (c) Basis of accounting preparation and measurement

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

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2017, and the comparative information presented in these financial statements for the year ended 30 June 2016.

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

## **Note 1: Summary of Significant Accounting Policies (cont'd)**

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

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

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

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

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

### **(d) Principles of consolidation**

#### **Intersegment Transactions**

Transactions between segments within Bairnsdale Regional Health Service have been eliminated to reflect the extent of Bairnsdale Regional Health Service's operations as a group.

#### **Jointly controlled assets or operations**

Interests in jointly controlled assets or operations are not consolidated by Bairnsdale Regional Health Service, but are accounted for in accordance with the policy outlined in Note 4.2 Investments Accounted for Using the Equity Method.

## Note 2: Funding Delivery of Our Services

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

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

### Structure

2.1 Analysis of revenue by source

2.2 Assets received free of charge or for nominal consideration



## Note 2.1: Analysis of Revenue by Source

Admitted Patients 2017 \$'000	Non-Admitted 2017 \$'000	ED 2017 \$'000	RAC 2017 \$'000	Aged Care 2017 \$'000	Primary Health 2017 \$'000	Other 2017 \$'000	Total 2017 \$'000
48,971	3,601	5,967	6,014	2,116	206	1,597	68,472
320	-	-	-	-	-	-	320
2,053	753	83	2,139	409	8	110	5,554
-	-	-	-	-	-	5,777	5,777
1,327	126	377	797	402	123	246	3,399
<b>52,671</b>	<b>4,479</b>	<b>6,427</b>	<b>8,950</b>	<b>2,928</b>	<b>336</b>	<b>7,730</b>	<b>83,521</b>
347	-	-	228	-	-	-	575
<b>347</b>	<b>-</b>	<b>-</b>	<b>228</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>575</b>
						4,519	4,519
-	-	-	-	-	-	<b>4,519</b>	<b>4,519</b>
<b>53,018</b>	<b>4,479</b>	<b>6,427</b>	<b>9,178</b>	<b>2,928</b>	<b>336</b>	<b>12,250</b>	<b>88,616</b>

Government Grants  
Indirect contributions by Department of Health & Human Services  
Patient & Resident Fees  
Commercial Activities  
Other Revenue from Operating Activities  
**Total Revenue from Operating Activities**

Interest  
**Total Revenue from Non-Operating Activities**

Capital Purpose Income  
**Total Capital Purpose Income**  
**Total Revenue**

Department of Health and Human Services 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.

## Note 2.1: Analysis of revenue by source (continued)

	Admitted Patients 2016 \$'000	Non-Admitted 2016 \$'000	ED 2016 \$'000	RAC 2016 \$'000	Aged Care 2016 \$'000	Primary Health 2016 \$'000	Other 2016 \$'000	Total 2016 \$'000
Government Grants	47,407	3,518	4,738	6,087	2,105	202	1,111	65,168
Indirect contributions by Department of Health & Human Services	(89)	-	-	-	-	-	-	(89)
Patient & Resident Fees	2,180	771	64	2,081	360	7	70	5,532
Commercial Activities	-	-	-	-	-	-	5,160	5,160
Other Revenue from Operating Activities	2,361	48	107	350	245	125	218	3,453
<b>Total Revenue from Operating Activities</b>	<b>51,859</b>	<b>4,337</b>	<b>4,908</b>	<b>8,518</b>	<b>2,710</b>	<b>334</b>	<b>6,559</b>	<b>79,225</b>
Interest	377	-	-	295	-	-	-	671
<b>Total Revenue from Non-Operating Activities</b>	<b>377</b>	<b>-</b>	<b>-</b>	<b>295</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>671</b>
Capital Purpose Income	-	-	-	-	-	-	901	901
<b>Total Capital Purpose Income</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>901</b>	<b>901</b>
<b>Total Revenue</b>	<b>52,235</b>	<b>4,337</b>	<b>4,908</b>	<b>8,813</b>	<b>2,710</b>	<b>334</b>	<b>7,460</b>	<b>80,797</b>

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.

Income is recognised in accordance with AASB 118 Revenue and is recognised 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 at fair value. Unearned income at reporting date is reported as income received in advance.

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

## Note 2.1: Analysis of revenue by source (continued)

### Indirect contributions from the Department of Health and Human Services

- Insurance is recognised as revenue following advice from the Department of Health and Human Services.
- Long Service Leave (LSL) – Revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Metropolitan Health and Aged Care Services Division Hospital Circular 04/2017 (update for 2016-17).

### 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 surplus, such as the specific restricted purpose surplus.

### Interest revenue

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

### Other income

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

## Note 2.1: Analysis of revenue by source (continued)

### 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 acute and subacute admitted patient services, where services are delivered in public hospitals.

**Non Admitted Services** comprises acute and subacute non admitted services, where services are delivered in public hospital clinics and provide models of integrated community care, which significantly reduces the demand for hospital beds and supports the transition from hospital to home in a safe and timely manner.

**Emergency Department Services (ED)** comprises all emergency department services.

**Aged Care** comprises a range of in home, specialist geriatric, residential care and community based programs and support services, such as Home and Community Care (HACC) that are targeted to older people, people with a disability, and their carers.

**Primary, Community and Dental Health** comprises a range of home based, community based, community, primary health and dental services including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy and a range of dental health services.

**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 the department 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 and secure extended care units.

**Other Services** not reported elsewhere - (Other) comprises services not separately classified above, 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, 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 2.2: 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**

2017 \$'000	2016 \$'000
1	-
<b>1</b>	<b>-</b>

### **Note 3: The Cost of Delivery of Our Services**

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

#### Structure

3.1 Analysis of expenses by source

3.2 Analysis of expense and revenue by internally managed and restricted specific purpose funds

3.3 Finance costs

3.4 Provisions

3.5 Superannuation



### Note 3.1: Analysis of Expenses by Source

	Admitted Patients 2017 \$'000	Non-Admitted 2017 \$'000	ED 2017 \$'000	RAC 2017 \$'000	Aged Care 2017 \$'000	Primary Health 2017 \$'000	Other 2017 \$'000	Total 2017 \$'000
Employee Expenses	24,463	2,028	7,384	9,770	2,918	423	1,334	48,320
Non Salary Labour Costs	4,966	14	2,502	361	-	0	48	7,891
Supplies & Consumables	6,656	331	1,659	916	105	4	260	9,930
Patient Transport	2,899	-	-	1	-	-	-	2,899
Insurance	1,110	-	-	-	-	-	-	1,110
Commercial Activities	-	-	-	-	-	-	6,185	6,185
Other Expenses	6,816	63	492	343	318	11	73	8,117
<b>Total Expenditure from Operating Activities</b>	<b>46,911</b>	<b>2,435</b>	<b>12,037</b>	<b>11,391</b>	<b>3,341</b>	<b>438</b>	<b>7,899</b>	<b>84,453</b>
Depreciation & Amortisation (refer note 4.4)							4,291	4,291
Finance Costs (refer note 3.3)							37	37
<b>Total Other Expenses</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>4,328</b>	<b>4,328</b>
<b>Total Expenses</b>	<b>46,911</b>	<b>2,435</b>	<b>12,037</b>	<b>11,391</b>	<b>3,341</b>	<b>438</b>	<b>12,228</b>	<b>88,781</b>

### Note 3.1.1: Analysis of expenses by source (continued)

	Admitted Patients 2016 \$'000	Non- Admitted 2016 \$'000	ED 2016 \$'000	RAC 2016 \$'000	Aged Care 2016 \$'000	Primary Health 2016 \$'000	Other 2016 \$'000	Total 2016 \$'000
Employee Expenses	24,481	2,038	5,783	8,528	2,613	374	1,095	44,911
Non Salary Labour Costs	4,968	22	1,431	399	-	0	25	6,844
Supplies & Consumables	6,884	329	2,236	845	89	6	310	10,700
Patient Transport	1,172	4	1,466	-	-	-	-	2,643
Insurance	1,047	-	-	-	-	-	2	1,049
Commercial Activities	-	-	-	-	-	-	5,406	5,406
Other Expenses	6,768	66	321	415	321	55	49	7,995
<b>Total Expenditure from Operating Activities</b>	<b>45,319</b>	<b>2,459</b>	<b>11,238</b>	<b>10,187</b>	<b>3,024</b>	<b>435</b>	<b>6,887</b>	<b>79,548</b>
Depreciation & Amortisation (refer note 4.2)	-	-	-	-	-	-	4,110	4,110
Finance Costs (refer note 3.3)	-	-	-	-	-	-	41	41
<b>Total Other Expenses</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>4,151</b>	<b>4,151</b>
<b>Total Expenses</b>	<b>45,319</b>	<b>2,459</b>	<b>11,238</b>	<b>10,187</b>	<b>3,024</b>	<b>435</b>	<b>11,038</b>	<b>83,699</b>

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

#### Employee expenses

Employee expenses include:

- wages and salaries;
- fringe benefits tax;
- sick leave;
- leave entitlements;
- termination payments;
- workcover premiums; and
- superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

#### 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.

### **Note 3.1.1: Analysis of expenses by source (continued)**

#### **Other operating expenses**

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

#### **Supplies and consumables**

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

#### **Bad and doubtful debts**

Refer to Note 4.1 Investments and other financial assets.

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

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 Service 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.

#### **Other economic flows included in net result**

Other economic flows are the changes 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 4.3 Property plant and equipment.

#### **Net gain/ (loss) on disposal of non-financial assets**

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

#### **Net gain/ (loss) on financial instruments**

Net gain/ (loss) on financial instruments includes:

a. impairment and reversal of impairment for financial instruments at amortised cost refer to Note 4.1 Investments and other financial assets;

#### **Revaluations of financial instruments at fair value**

Refer to Note 7.1 Financial instruments.

#### **Share of net profits/ (losses) of associates and jointly controlled entities, excluding dividends.**

Refer to Note 1 (d) Basis of consolidation.

#### **Other gains/ (losses) from other economic flows**

Other gains/ (losses) include:

- a. the revaluation of the present value of the long service leave liability due to changes in the bond rate movements, inflation rate movements and the impact of changes in probability factors; and
- b. transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

### **Note 3.1.1: Analysis of expenses by source (continued)**

#### **Derecognition of financial liabilities**

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

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

#### **Financial guarantee**

Payments that are contingent under financial guarantee contracts are recognised as a liability at the time the guarantee is issued. The liability is initially measured at fair value, and if there is a material increase in the likelihood that the guarantee may have to be exercised, then it is measured at the higher of the amount determined in accordance with AASB 137 Provisions, Contingent Liabilities and Contingent Assets and the amount initially recognised less cumulative amortisation, where appropriate.

In the determination of fair value, consideration is given to factors including the overall capital management/prudential supervision framework in operation, the protection provided by the State Government by way of funding should the probability of default increase, probability of default by the guaranteed party and the likely loss to the Health Service in the event of default.

### Note 3.2: Analysis of Expense and Revenue by Internally Managed and Restricted Specific Purpose Funds for Services Supported by Hospital and Community Initiatives

	Expense		Revenue	
	2017 \$'000	2016 \$'000	2017 \$'000	2016 \$'000
<b>Commercial Activities</b>				
Diagnostic Imaging	5,296	4,563	5,429	4,815
Cafeteria	310	248	191	190
Central Business District	232	299	22	18
Donations SPFI	48	5	16	14
Private Consulting Suites	299	292	120	123
<b>TOTAL</b>	<b>6,185</b>	<b>5,406</b>	<b>5,777</b>	<b>5,160</b>

### Note 3.3: Finance Costs

	2017 \$'000	2016 \$'000
Interest on Long Term Borrowings	37	41
<b>Total Finance Costs</b>	<b>37</b>	<b>41</b>

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.

### Note 3.4: Employee Benefits in the Balance Sheet

	2017 \$'000	2016 \$'000
<b>Current Provisions</b>		
Employee Benefits (i)		
Annual Leave		
- Unconditional and expected to be settled within 12 months (ii)	3,181	3,321
- Unconditional and expected to be settled after 12 months (ii)	522	-
Long Service Leave		
- Unconditional and expected to be settled within 12 months (ii)	613	520
- Unconditional and expected to be settled after 12 months (ii)	3,931	3,562
Other		
- Accrued Wages	669	789
- Accrued Day Off	91	99
	9,008	8,290
Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months (ii)	418	422
- Unconditional and expected to be settled after 12 months (ii)	490	392
	908	814
<b>Total Current Provisions</b>	<b>9,916</b>	<b>9,105</b>
<b>Non-Current Provisions</b>		
Employee Benefits (i)	1,766	1,657
Provisions related to Employee Benefit On-Costs	194	182
<b>Total Non-Current Provisions</b>	<b>1,960</b>	<b>1,839</b>
<b>Total Provisions</b>	<b>11,877</b>	<b>10,944</b>
<b>(a) Employee Benefits and Related On-Costs</b>		
<b>Current Employee Benefits and related on-costs</b>		
Unconditional LSL Entitlement	4,545	4,081
Annual Leave Entitlements	3,703	3,321
Accrued Wages and Salaries	669	789
Accrued Days Off	91	99
<b>Non-Current Employee Benefits and related on-costs</b>		
Conditional Long Service Leave Entitlements	1,766	1,657
<b>Total Employee Benefits</b>	<b>10,774</b>	<b>9,947</b>
<b>On-Costs</b>		
Current On-Costs	908	814
Non-Current On-Costs	194	182
<b>Total On-Costs</b>	<b>1,102</b>	<b>997</b>
<b>Total Employee Benefits and Related On-Costs</b>	<b>11,877</b>	<b>10,944</b>

**Notes:**

(i) Provision for employee benefits consists of amounts for annual leave and long service leave accrued by employees. On-costs such as payroll tax and worker's compensation insurance are not employee benefits and are reflected as a separate provision.

(ii) The amounts disclosed are at present values.

#### (b) Movements in provisions

##### Movement in Long Service Leave:

##### Balance at start of year

Provision made during the year

- Revaluations

- Expense recognising Employee Service

Settlement made during the year

##### Balance at end of year

2017 \$'000	2016 \$'000
6,369	6,161
(175)	18
1,422	787
(611)	(597)
<b>7,005</b>	<b>6,369</b>



## Note 3.4: Employee Benefits in the Balance Sheet

### Provisions

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

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

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

### Employee benefits

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

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

Liabilities for wages and salaries, including non-monetary benefits, annual leave, and accumulating sick leave are all recognised in the provision for employee benefits as 'current liabilities', because the health service does not have an unconditional right to defer settlements of these liabilities.

Depending on the expectation of the timing of settlement, liabilities for wages and salaries, annual leave and sick leave are measured at:

- Undiscounted value – if the health service expects to wholly settle within 12 months; or
- Present value – if the health service does not expect to wholly settle within 12 months.

#### Long service leave (LSL)

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

Unconditional LSL is disclosed in the notes to the financial statements as a current liability even where the health service does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months. An unconditional right arises after a qualifying period.

The components of this current LSL liability are measured at:

- Undiscounted value – if the health service expects to wholly settle within 12 months; and
- Present value – if the health service does not expect to wholly settle within 12 months.

Conditional LSL is disclosed as a non-current liability. There is an unconditional right to defer the settlement of the entitlement until the employee has completed the requisite years of service. This non-current LSL liability is measured at present value.

Any gain or loss followed revaluation of the present value of non-current LSL liability is recognised as a transaction, except to the extent that a gain or loss arises due to changes in estimations e.g. bond rate movements, inflation rate movements and changes in probability factors which are then recognised as other economic flow.

### Termination benefits

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

The health service recognises termination benefits when it is demonstrably committed to either terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy.

### On-costs related to employee expenses

Provisions for on-costs, such as payroll tax, workers compensation and superannuation are recognised together with provisions for employee benefits.

## Note 3.5: Superannuation

	Paid Contribution for the year		Contribution Outstanding at	
	2017 \$'000	2016 \$'000	2017 \$'000	2016 \$'000
<b>(i) Defined benefit plans:</b>				
First State Super	62	66	-	-
<b>Defined contribution plans:</b>				
First State Super	2,746	2,604	-	-
H.E.S.T. Australia Ltd	1,303	1,150	-	-
<b>Total</b>	<b>4,112</b>	<b>3,821</b>	<b>-</b>	<b>-</b>

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

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

### 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 the Bairnsdale Regional Health Service contributes to both the defined benefit and defined contribution plans. The defined benefit plans provide benefits based on years of service and final average salary.

The name and details of the major employee superannuation funds and contributions made by the Bairnsdale Regional Health Service are disclosed in Note 3.5: Superannuation.

### 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.

## **Note 4: Key Assets to Support Service Delivery**

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

### Structure

- 4.1 Investments and other financial assets
- 4.2 Investments accounted for using the equity method
- 4.3 Property, plant & equipment
- 4.4 Depreciation and amortisation

## **Note 4.1: Investments and Other Financial Assets**

### **Investments and other financial assets**

Hospital investments must be in accordance in Standing Direction 4.5.6 – Treasury Risk Management. 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;
- held to maturity;
- 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.

### **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.

The allowance is the difference between the financial asset's carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate. In assessing impairment of statutory (non-contractual) financial assets, which are not financial instruments, professional judgement is applied in assessing materiality using estimates, averages and other computational methods in accordance with AASB 136 Impairment of Assets.

### **Doubtful debts**

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

## Note 4.2: Investments Accounted for Using the Equity Method

Name of Entity	Principal Activity	Country of Incorporation	Ownership Interest		Published Fair Value	
			2017 %	2016 %	2017 \$'000	2016 \$'000
Jointly Controlled Entity						
Gippsland Health Alliance	Information Systems	Australia	12.04	12.01	893	440

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:

### Summarised Balance Sheet:

	2017 \$'000	2016 \$'000
<b>Current Assets</b>		
Cash and Cash Equivalents	633	334
Receivables	115	128
Other Current Assets	270	96
<b>Total Current Assets</b>	<b>1,018</b>	<b>558</b>
<b>Non Current Assets</b>		
Property, Plant and Equipment	12	7
<b>Total Non Current Assets</b>	<b>12</b>	<b>7</b>
<b>Total Assets</b>	<b>1,030</b>	<b>565</b>
<b>Current Liabilities</b>		
Accrued Expenses	107	76
Other Current Liabilities	30	50
<b>Total Current Liabilities</b>	<b>137</b>	<b>125</b>

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

### Summarised Operating Statement:

	2017 \$'000	2016 \$'000
<b>Revenues</b>		
Gippsland Health Alliance Income	1,673	1,158
<b>Total Revenue</b>	<b>1,673</b>	<b>1,158</b>
<b>Expenses</b>		
Information Technology and Administrative Expenses	1,220	1,183
Depreciation	0	0
<b>Total Expenses</b>	<b>1,220</b>	<b>1,183</b>
<b>Share of Jointly Controlled Entity's Net Result After Tax</b>	<b>453</b>	<b>(25)</b>

### Movements in carrying amount of interests in the Jointly Controlled Entity

	2017 \$'000	2016 \$'000
Carrying amount at the beginning of the year	440	465
Share of the joint venture's net result after tax	453	(25)
Share of the joint venture's other comprehensive income	-	-
Dividends received/receivable from the joint venture	-	-
<b>Carrying amount at end of the year</b>	<b>893</b>	<b>440</b>

### Contingent Liabilities and Capital Commitments

No contingent liabilities and capital commitments as at 30 June 2017.

## **Note 4.2: Investments Accounted for Using the Equity Method (Continued)**

### **Jointly controlled assets and operations**

Interests in jointly controlled assets or operations are not consolidated by Bairnsdale Regional Health Service, but are accounted for in accordance with the policy outlined in Section 4.

### **Investments accounted for using the equity method**

Joint control is the contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control. Joint ventures are joint arrangements whereby Bairnsdale Regional Health Service, via its joint control of the arrangement, has rights to the net assets of the arrangements.

### **Investments in joint operations**

In respect of any interest in joint operations, Bairnsdale Regional Health Service recognises in the financial statements:

- its assets, including its share of any assets held jointly;
- any liabilities including its share of liabilities that it had incurred;
- its revenue from the sale of its share of the output from the joint operation;
- its share of the revenue from the sale of the output by the operation; and
- its expenses, including its share of any expenses incurred jointly.



## Note 4.3: Property, Plant & Equipment

### (a) Gross carrying amount and accumulated depreciation

	2017 \$'000	2016 \$'000
<b>Land</b>		
Land at Fair Value	2,677	2,677
Crown Land - Other at Fair Value	590	590
<b>Total Land</b>	<b>3,267</b>	<b>3,267</b>
<b>Buildings</b>		
Buildings Under Construction at cost	2,119	217
Buildings at Fair Value	40,969	40,577
Less Acc'd Depreciation	8,101	5,373
<b>Total Buildings</b>	<b>34,987</b>	<b>35,421</b>
<b>Plant and Equipment</b>		
Plant and Equipment at Fair Value	3,257	3,347
Less Acc'd Depreciation	1,828	1,781
<b>Total Plant and Equipment</b>	<b>1,429</b>	<b>1,566</b>
<b>Medical Equipment</b>		
Medical Equipment at Fair Value	7,839	8,169
Less Acc'd Depreciation	4,855	4,479
<b>Total Medical Equipment</b>	<b>2,985</b>	<b>3,690</b>
<b>Motor Vehicles</b>		
Motor Vehicles at Fair Value	931	894
Less Acc'd Depreciation	442	357
<b>Total Motor Vehicles</b>	<b>489</b>	<b>537</b>
<b>Computers &amp; Communication</b>		
Computers & Communication at Fair Value	3,618	2,597
Less Acc'd Depreciation	1,529	1,206
<b>Total Computers &amp; Communication</b>	<b>2,089</b>	<b>1,391</b>
<b>Furniture &amp; Fittings</b>		
Furniture & Fittings at Fair Value	916	1,148
Less Acc'd Depreciation	299	255
<b>Total Furniture &amp; Fittings</b>	<b>617</b>	<b>893</b>
<b>TOTAL PROPERTY, PLANT &amp; EQUIPMENT</b>	<b>45,862</b>	<b>46,765</b>

## Note 4.3: Property, plant & equipment (continued)

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

	Land	Buildings	Plant & Equipment	Medical Equipment	Motor Vehicles	Computers	Furniture & Fittings	Total
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
<b>Balance at 1 July 2015</b>	<b>3,267</b>	<b>36,025</b>	<b>1,217</b>	<b>2,993</b>	<b>549</b>	<b>953</b>	<b>497</b>	<b>45,501</b>
Additions	-	2,062	575	1,512	131	716	479	5,474
Disposals	-	-	(3)	(23)	(49)	(2)	(23)	(100)
Revaluation Increments	-	-	-	-	-	-	-	-
Depreciation and Amortisation (note 4.4)	-	(2,666)	(223)	(792)	(93)	(276)	(60)	(4,110)
<b>Balance at 1 July 2016</b>	<b>3,267</b>	<b>35,421</b>	<b>1,566</b>	<b>3,690</b>	<b>537</b>	<b>1,391</b>	<b>893</b>	<b>46,765</b>
Additions	-	2,033	121	116	102	1,062	70	3,505
Disposals	-	-	(28)	(16)	(53)	(6)	(14)	(116)
Net Transfers Between Classes	-	260	-	-	-	-	(260)	-
Revaluation Increments	-	-	-	-	-	-	-	-
Depreciation and Amortisation (note 4.4)	-	(2,727)	(230)	(806)	(98)	(358)	(72)	(4,291)
<b>Balance at 30 June 2017</b>	<b>3,267</b>	<b>34,987</b>	<b>1,429</b>	<b>2,985</b>	<b>489</b>	<b>2,089</b>	<b>617</b>	<b>45,862</b>

### Land and buildings carried at valuation

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

The effective date of the valuation is 30 June 2014.

## Note 4.3: Property, plant & equipment (continued)

### (c) Fair value measurement hierarchy for assets as at 30 June 2017

	Carrying amount as at 30 June 2017	Fair value measurement at end of reporting period using:		
		Level 1 <sup>(1)</sup>	Level 2 <sup>(1)</sup>	Level 3 <sup>(1)</sup>
<b>Land at fair value</b>				
Non-specialised land	2,677		2,677	
Specialised land	590			590
Total of land at fair value	3,267	-	2,677	590
<b>Buildings at fair value</b>				
Non-specialised buildings	4,663		4,663	
Specialised buildings	30,324			30,324
Total of building at fair value	34,987	-	4,663	30,324
<b>Plant and equipment at fair value</b>				
Plant equipment and vehicles at fair value				
- Vehicles	489		489	
- Furniture & fittings	617		617	
- Computers & communication	2,089		2,089	
- Plant and equipment	1,429		1,429	
Total of plant, equipment and vehicles at fair value	4,624	-	4,624	-
<b>Medical equipment at fair value</b>				
Total medical equipment at fair value	2,985	-	2,985	-
	<b>45,862</b>	<b>-</b>	<b>14,949</b>	<b>30,914</b>

#### Note

<sup>1</sup> Classified in accordance with the fair value hierarchy, described as follows, based on the lowest level input that is significant to the fair value measurement as a whole:

Level 1 - quoted (unadjusted) mark prices in active market for identical assets;

Level 2 - valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable; and

Level 3 - valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

There have been no transfers between levels during the period.

## Note 4.3: Property, plant & equipment (continued)

### (c) Fair value measurement hierarchy for assets as at 30 June 2016

	Carrying amount as at 30 June 2016	Fair value measurement at end of reporting period using:		
		Level 1 <sup>(1)</sup>	Level 2 <sup>(1)</sup>	Level 3 <sup>(1)</sup>
<b>Land at fair value</b>				
Non-specialised land	2,677		2,677	
Specialised land	590			590
Total of land at fair value	3,267	-	2,677	590
<b>Buildings at fair value</b>				
Non-specialised buildings	4,547		4,547	
Specialised buildings	30,874			30,874
Total of building at fair value	35,421	-	4,547	30,874
<b>Plant and equipment at fair value</b>				
Plant equipment and vehicles at fair value				
- Vehicles	537		537	
- Furniture & fittings	893		893	
- Computers & communication	1,391		1,391	
- Plant and equipment	1,566		1,566	
Total of plant, equipment and vehicles at fair value	4,386	-	4,386	-
<b>Medical equipment at fair value</b>				
Total medical equipment at fair value	3,690	-	3,690	-
	<b>46,765</b>	<b>-</b>	<b>15,301</b>	<b>31,464</b>

#### Note

1. Classified in accordance with the fair value hierarchy, described as follows, based on the lowest level input that is significant to the fair value measurement as a whole:

Level 1 - quoted (unadjusted) mark prices in active market for identical assets;

Level 2 - valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable; and

Level 3 - valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

There have been no transfers between levels during the period.

## Note 4.3: Property, plant & equipment (continued)

Revisions to accounting estimates are recognised in the period in which the estimate is revised and also in future periods that are affected by the revision. Judgements and assumptions made by management in the application of AASBs that have significant effects on the financial statements and estimates relate to:

- the fair value of land, buildings, infrastructure, plant and equipment, (refer to Note 7.1);
- superannuation expense (refer to Note 3.5);
- actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.4); and
- equities and management investment schemes classified at level 3 of the fair value hierarchy

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

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

- Level 1 – Quoted (unadjusted) market prices in active markets for identical assets or liabilities
- Level 2 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable
- Level 3 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

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

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

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

Bairnsdale Regional Health Service, in conjunction with VGV monitors the changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required.

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

- the fair value of land, buildings, infrastructure, plant and equipment (refer to Note 7.1);
- superannuation expense (refer to note 3.5); and
- actuarial assumptions for employee benefit provision based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.4).

## Note 4.3: Property, plant & equipment (continued)

### Fair value measurement

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

The fair value measurement is based on the following assumptions:

- that the transaction to sell the asset or transfer the liability takes place either in the principal market (or the most advantageous market, in the absence of the principal market), either of which must be accessible to the Health Service at the measurement date;
- that the Health Service uses the same valuation assumptions that market participants would use when pricing the asset or liability, assuming that market participants act in their economic best interest.

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

### Consideration of highest and best use (HBU) for non-financial physical assets

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

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

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

Therefore, an assessment of the HBU will be required when the indicators are triggered within a reporting period, which suggest the market participants would have perceived an alternative use of an asset that can generate maximum value. Once identified, Health Services are required to engage with VGV or other independent valuers for formal HBU assessment.

These indicators, as a minimum, include:

External factors:

- Changed acts, regulations, local law or such instrument which affects or may affect the use or development of the asset;
- Changes in planning scheme, including zones, reservations, overlays that would affect or remove the restrictions imposed on the asset's use from its past use;
- Evidence that suggest the current use of an asset is no longer core to requirements to deliver a Health Service's service obligation;
- Evidence that suggests that the asset might be sold or demolished at reaching the late stage of an asset's life cycle.

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

## **Note 4.3: Property, plant & equipment (continued)**

### **Valuation hierarchy**

Health Services need to use valuation techniques that are appropriate for the circumstances and where there is sufficient data available to measure fair value, maximising the use of relevant observable inputs and minimising the use of unobservable inputs.

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

- Level 1 – Quoted (unadjusted) market prices in active markets for identical assets or liabilities;
- Level 2 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable;
- Level 3 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.



## Note 4.3: Property, plant & equipment (continued)

### (d) Reconciliation of Level 3 fair value

30 June 2017	Land	Buildings
<b>Opening Balance</b>	590	30,874
<b>Purchases</b>	-	1,918
Gains or losses recognised in net result		
- Depreciation	-	(2,468)
<b>Subtotal</b>	590	30,324
Items recognised in other comprehensive income		
- Revaluation	-	-
<b>Subtotal</b>	-	-
<b>Closing Balance</b>	<b>590</b>	<b>30,324</b>

There have been no transfers between levels during the period.

30 June 2016	Land	Buildings
<b>Opening Balance</b>	590	30,878
<b>Purchases</b>	-	2,496
Gains or losses recognised in net result		
- Depreciation	-	(2,501)
<b>Subtotal</b>	590	30,874
Items recognised in other comprehensive income		
- Revaluation	-	-
<b>Subtotal</b>	-	-
<b>Closing Balance</b>	<b>590</b>	<b>30,874</b>

## **Note 4.3: Property, plant & equipment (continued)**

### **Identifying unobservable inputs (level 3) fair value measurements**

Level 3 fair value inputs are unobservable valuation inputs for an asset or liability. These inputs require significant judgement and assumptions in deriving fair value for both financial and non-financial assets.

Unobservable inputs shall be used to measure fair value to the extent that relevant observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity for the asset or liability at the measurement date. However, the fair value measurement objective remains the same, i.e., an exit price at the measurement date from the perspective of a market participant that holds the asset or owes the liability. Therefore, unobservable inputs shall reflect the assumptions that market participants would use when pricing the asset or liability, including assumptions about risk.

Assumptions about risk include the inherent risk in a particular valuation technique used to measure fair value (such as a pricing risk model) and the risk inherent in the inputs to the valuation technique. A measurement that does not include an adjustment for risk would not represent a fair value measurement if market participants would include one when pricing the asset or liability i.e., it might be necessary to include a risk adjustment when there is significant measurement uncertainty. For example, when there has been a significant decrease in the volume or level of activity when compared with normal market activity for the asset or liability or similar assets or liabilities, and the Health Service has determined that the transaction price or quoted price does not represent fair value.

A Health Service shall develop unobservable inputs using the best information available in the circumstances, which might include the Health Service's own data. In developing unobservable inputs, a Health Service may begin with its own data, but it shall adjust this data if reasonably available information indicates that other market participants would use different data or there is something particular to the Health Service that is not available to other market participants. A Health Service need not undertake exhaustive efforts to obtain information about other market participant assumptions. However, a Health Service shall take into account all information about market participant assumptions that is reasonably available. Unobservable inputs developed in the manner described above are considered market participant assumptions and meet the object of a fair value measurement.

### **Non-specialised land and non-specialised building**

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

For non-specialised land and non-specialised buildings, an independent valuation was performed by independent valuers (Opteon) to determine the fair value using the market approach.

Valuation of the assets was determined by analysing comparable sales and allowing for share, size, topography, location and other relevant factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30 June 2014.

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

### **Specialised land and specialised building**

The market approach is also used for specialised land and specialised building although is adjusted for the community service obligation (CSO) to reflect the specialised nature of the assets being valued.

Specialised assets contain significant, unobserved adjustments; therefore these assets are classified as Level 3 under the market based direct comparison approach.

## **Note 4.3: Property, plant & equipment (continued)**

### **Specialised land and specialised buiding**

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

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

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

### **Vehicles**

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

### **Plant and equipment**

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

There were no changes in valuation techniques throughout the period to 30 June 2017.

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

### Note 4.3: Property, plant & equipment (continued)

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

	Valuation technique	Significant unobservable inputs
<b>Specialised land</b> Crown Land - 54 Moroney St & 38 McKean St	Market approach	Community Service Obligation (CSO) adjustment
<b>Specialised buildings</b> 122 Day Street Main Hospital Building	Depreciated replacement cost	Direct cost per square metre
121-125 McKean Street Maddocks Garden		Useful life of specialised buildings

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

## Note 4.3: Property, plant & equipment (continued)

### Property, plant and equipment

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

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 4.1 Property, plant and equipment.

The initial cost for non-financial physical assets under finance lease 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 physical 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. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best uses.

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

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

### Revaluations of non-current physical assets

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

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

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

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

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

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

## Note 4.4: Depreciation and Amortisation

### Depreciation

Buildings
Plant & Equipment
Medical Equipment
Motor Vehicles
Computers & Communication
Furniture & Fittings
<b>Total Depreciation</b>

2016 \$'000	2015 \$'000
2,727	2,666
230	223
806	792
98	93
358	276
72	60
<b>4,291</b>	<b>4,110</b>

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

Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives, residual value and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health and Human Services. Assets with a cost in excess of \$3,000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

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

	2017	2016
Buildings		
- Structure Shell Building Fabric	38 to 50 years	38 to 50 years
- Site Engineering Services and Central Plant	23 to 45 years	23 to 45 years
Central Plant		
- Fit Out		
- Trunk Reticulated Building Systems		
Plant & Equipment	5 to 15 years	5 to 15 years
Medical Equipment	5 to 10 years	5 to 10 years
Computers and Communication	3 to 10 years	3 to 10 years
Furniture and Fitting	10 to 14 years	10 to 14 years
Motor Vehicles	8 to 15 years	8 to 15 years

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

## Note 5: Other Assets and Liabilities

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

Structure

5.1 Receivables

5.2 Inventories

5.3 Other liabilities

5.4 Prepayments and other assets

5.5 Payables



## Note 5.1: Receivables

	2017 \$'000	2016 \$'000
<b>CURRENT</b>		
<b>Contractual</b>		
Trade Debtors	412	398
Patient Fees	764	757
Accrued Investment Income	76	66
Accrued Revenue	124	316
Less: Allowance for Doubtful Debts		
Trade Debtors	(3)	(1)
Patient Fees	(23)	(20)
	<b>1,349</b>	<b>1,516</b>
<b>Statutory</b>		
GST Receivable	302	409
Accrued Revenue - Department of Health & Human Services	664	697
	<b>966</b>	<b>1,106</b>
<b>TOTAL CURRENT RECEIVABLES</b>	<b>2,315</b>	<b>2,621</b>
<b>NON CURRENT</b>		
<b>Statutory</b>		
Long Service Leave - Department of Health & Human Services	719	442
<b>TOTAL NON-CURRENT RECEIVABLES</b>	<b>719</b>	<b>442</b>
<b>TOTAL RECEIVABLES</b>	<b>3,034</b>	<b>3,063</b>

### (a) Movement in the Allowance for doubtful debts

	2,017 \$'000	2,016 \$'000
Balance at beginning of year	21	40
(Decrease)/Increase in allowance recognised in net result	5	(19)
<b>Balance at end of year</b>	<b>26</b>	<b>21</b>

### (b) Ageing analysis of receivables

Please refer to note 7.1 (c) for the ageing analysis of contractual receivables

### (c) Nature and extent of risk arising from receivables

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

Receivables consist of:

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

Receivables 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.

## Note 5.2: Inventories

	2017 \$'000	2016 \$'000
<b>Pharmaceuticals</b>		
At cost	274	285
<b>Medical and Surgical Lines</b>		
At cost	217	178
<b>TOTAL INVENTORIES</b>	<b>490</b>	<b>463</b>

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

Inventories held for distribution are measured at cost, adjusted for any loss of service potential. All other inventories, 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.

## Note 5.3: Other Liabilities

	2017 \$'000	2016 \$'000
<b>CURRENT</b>		
Monies Held in Trust		
- Resident Monies Held in Trust	533	753
- Accommodation Deposits	11,140	9,884
<b>Total Other Liabilities</b>	<b>11,673</b>	<b>10,637</b>
<b>Total Monies Held in Trust</b>		
<b>Represented by the following assets:</b>		
Cash Assets (refer to Note 6.2)	11,673	10,637
<b>TOTAL</b>	<b>11,673</b>	<b>10,637</b>

## Note 5.4: Prepayment and Other Non-Financial Assets

	2017 \$'000	2016 \$'000
<b>CURRENT</b>		
Prepayments	256	1,375
GHA Other Current Assets (refer Note 4.2)	270	96
Rental Property Bonds Paid	8	8
<b>TOTAL OTHER ASSETS</b>	<b>533</b>	<b>1,478</b>

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

## Note 5.5: Payables

	2017 \$'000	2016 \$'000
<b>CURRENT</b>		
<b>Contractual</b>		
Trade Creditors <sup>(i)</sup>	39	2,659
Accrued Expenses	1,624	1,112
Salary Packaging	12	16
PPI Medical Payable	1	4
Income in Advance	75	66
Consultants Payable	-	7
	<b>1,751</b>	<b>3,863</b>
<b>Statutory</b>		
GST Payable	24	21
Department of Health and Human Services	142	12
	<b>167</b>	<b>33</b>
<b>TOTAL CURRENT</b>	<b>1,918</b>	<b>3,895</b>
<b>TOTAL PAYABLES</b>	<b>1,918</b>	<b>3,895</b>

(i) The average credit period is 40 days. No interest is charged on the other payables.

### (a) Maturity analysis of payables

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

### (b) Nature and extent of risk arising from payables

Please refer to note 7.1 (d) for the nature and extent of risks arising from contractual payables

Payables consist of:

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

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

## Note 6: How We Finance Our Operations

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

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

### Structure

6.1 Borrowings

6.2 Cash and cash equivalents

6.3 Commitments for expenditure

## Note 6.1: Borrowings

	2017 \$'000	2016 \$'000
<b>CURRENT</b>		
Australian Dollar Borrowings		
– TCV Loan	69	65
<b>Total Current</b>	<b>69</b>	<b>65</b>
<b>NON CURRENT</b>		
Australian Dollar Borrowings		
– TCV Loan	533	602
<b>Total Non-Current</b>	<b>533</b>	<b>602</b>
<b>Total Borrowings</b>	<b>602</b>	<b>667</b>

The loan is unsecured with a fixed rate of 5.88% over a total period of 20 years, ending in September 2024.

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

Amount of finance costs recognised as expenses	37	41
--	----	----

### (a) Maturity analysis of payables

Please refer to note 18(c) for the ageing analysis of borrowings

### (b) Nature and extent of risk arising from borrowings

Please refer to note 18(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

### Borrowings

All borrowings are initially recognised at fair value of the consideration received, less directly attributable transaction costs. 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 borrowings using the effective interest method.

The classification depends on the nature and purpose of the borrowing. The Health Service determines the classification of its borrowing at initial recognition.

### Leases

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

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

All other leases are classified as operating leases.

## Note 6.1: Borrowings (continued)

### 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.

### Leasing arrangements

Operating leases relate to the investment property owned by the Health Service with lease terms between five to ten years. All operating lease contracts contain market review clauses in the event that the lessee exercises its option to renew. The lessor does not have an option to purchase the property at the expiry of the lease period.

#### Non-cancellable operating lease payable

Not longer than one year

Longer than one year but not longer than five years

Longer than five years

2017 \$'000	2016 \$'000
642	642
1,091	1,733
-	-
<b>1,733</b>	<b>2,375</b>

## Note 6.2: Cash and Cash Equivalents

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

	2017 \$'000	2016 \$'000
Cash on hand	7	7
Cash at bank	1,392	1,321
Term Deposits	23,000	21,000
Deposits at Call	5	290
<b>Total Cash and Cash Equivalents</b>	<b>24,403</b>	<b>22,619</b>
<b>Represented by:</b>		
Cash for Health Service Operations (as per Cash Flow Statement)	12,730	11,982
Cash for Monies Held in Trust		
- Cash at Bank	133	353
- Term Deposits	11,540	10,284
- Deposits at Call	-	-
Total Cash for Monies Held in Trust	11,673	10,637
<b>Total Cash and Cash Equivalents</b>	<b>24,403</b>	<b>22,619</b>

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

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

## Note 6.3: Commitments for Expenditure

	2017 \$'000	2016 \$'000
<b>(a)</b>		
<b>Capital expenditure commitments</b>		
Payable:		
Buildings	1,718	-
Computers & Communication	330	-
<b>Total capital expenditure commitments</b>	<b>2,048</b>	<b>-</b>
<b>Lease commitments</b>		
Commitments in relation to leases contracted for at the reporting date:		
Operating Leases	1,733	2,375
<b>Total lease commitments</b>	<b>1,733</b>	<b>2,375</b>
<b>Operating Leases</b>		
CT scanner and five ultrasound leases payable as follows:		
<i>Cancellable</i>	-	-
<b>Sub Total</b>	<b>-</b>	<b>-</b>
<i>Non-Cancellable</i>	1,733	2,375
<b>Sub Total</b>	<b>1,733</b>	<b>2,375</b>
<b>Total Commitments (inclusive of GST)</b>	<b>3,781</b>	<b>2,375</b>
<b>(b) Commitments payable</b>		
<b>Capital expenditure commitments payable</b>		
Not later than one year		
Land and Buildings	2,048	-
Computers & Communication	-	-
<b>Total capital expenditure commitments</b>	<b>2,048</b>	<b>-</b>
<b>Lease commitments payable</b>		
Not later than one year	642	642
Later than 1 year and not later than 5 years	1,091	1,733
<b>Total lease commitments</b>	<b>1,733</b>	<b>2,375</b>
<b>Total Commitments (inclusive of GST)</b>	<b>3,781</b>	<b>2,375</b>

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

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



## **Note 7: Risks, Contingencies and Valuation Uncertainties**

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

### **Structure**

#### **7.1 Financial instruments**

#### **7.2 Net gain/ (loss) on disposal of non-financial assets**

#### **7.3 Contingent assets and contingent liabilities**

#### **7.4 Fair value determination**

## Note 7.1: Financial Instruments

### (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 deposits

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

	Contractual financial assets - loans and receivables	Contractual financial liabilities at amortised cost	Total
2017	\$'000	\$'000	\$'000
<b>Contractual Financial Assets</b>			
Cash and cash equivalents	24,403	-	24,403
Receivables			
- Other Receivables	1,349	-	1,349
<b>Total Financial Assets <sup>(i)</sup></b>	<b>25,753</b>	<b>-</b>	<b>25,753</b>
<b>Financial Liabilities</b>			
Payables	-	1,751	1,751
Borrowings	-	602	602
Other Financial Liabilities			
- Accommodation Deposits	-	11,140	11,140
- Resident Monies Held in Trust	-	533	533
<b>Total Financial Liabilities <sup>(ii)</sup></b>	<b>-</b>	<b>14,026</b>	<b>14,026</b>

	Contractual financial assets - loans and receivables	Contractual financial liabilities at amortised cost	Total
2016	\$'000	\$'000	\$'000
<b>Contractual Financial Assets</b>			
Cash and cash equivalents	22,619	-	22,619
Receivables			
- Other Receivables	1,516	-	1,516
<b>Total Financial Assets <sup>(i)</sup></b>	<b>24,134</b>	<b>-</b>	<b>24,134</b>
<b>Financial Liabilities</b>			
Payables	-	3,863	3,863
Borrowings	-	667	667
Other Financial Liabilities			
- Accommodation Deposits	-	9,884	9,884
- Residents Monies Held in Trust	-	753	753
<b>Total Financial Liabilities <sup>(ii)</sup></b>	<b>-</b>	<b>15,166</b>	<b>15,166</b>

## Note 7.1: Financial Instruments (continued)

### (b) Net holding gain on financial instruments by category

	Net holding gain/(loss) \$'000	Total interest income / (expense) \$'000	Fee income / (expense) \$'000	Impairment loss \$'000	Total \$'000
<b>2017</b>					
<b>Financial Assets</b>					
Cash and Cash Equivalents <sup>(i)</sup>	-	575	-	-	575
<b>Total Financial Assets</b>	-	<b>575</b>	-	-	<b>575</b>
<b>Financial Liabilities</b>					
At Amortised Cost <sup>(ii)</sup>	-	37	-	-	37
<b>Total Financial Liabilities</b>	-	<b>37</b>	-	-	<b>37</b>
<b>2016</b>					
<b>Financial Assets</b>					
Cash and Cash Equivalents <sup>(i)</sup>	-	671	-	-	671
<b>Total Financial Assets</b>	-	<b>671</b>	-	-	<b>671</b>
<b>Financial Liabilities</b>					
At Amortised Cost <sup>(ii)</sup>	-	41	-	-	41
<b>Total Financial Liabilities</b>	-	<b>41</b>	-	-	<b>41</b>

(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.

(iii) For financial assets and liabilities that are held-for-trading or designated at fair value through profit or loss, the net gain or loss is calculated by taking the movement in the fair value of the financial asset or liability.

## Note 7.1: Financial Instruments (continued)

### (c) Credit risk

Credit risk arises from the contractual financial assets of the Health Service, which comprise cash and deposits and non-statutory receivables. 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
<b>2017</b>					
<b>Financial Assets</b>					
Cash and Cash Equivalents	-	12,004	-	12,399	24,403
Receivables					
- Trade Debtors	-	-	-	409	409
- Other Receivables (i)	-	-	-	941	941
<b>Total Financial Assets</b>	<b>-</b>	<b>12,004</b>	<b>-</b>	<b>13,748</b>	<b>25,753</b>
<b>2016</b>					
<b>Financial Assets</b>					
Cash and Cash Equivalents	-	12,286	-	10,333	22,619
Receivables					
- Trade Debtors	-	-	-	397	397
- Other Receivables	-	-	-	1,119	1,119
<b>Total Financial Assets</b>	<b>-</b>	<b>12,286</b>	<b>-</b>	<b>11,849</b>	<b>24,134</b>

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

## Note 7.1: Financial Instruments (continued)

### (c) Credit risk (continued)

#### Ageing analysis of Financial Assets as at 30 June

	Consol'd 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	
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
<b>2017</b>							
<b>Financial Assets</b>							
Cash and Cash Equivalents	24,403	24,403	-	-	-	-	-
Receivables (i)							
- Trade Debtors	409	320	11	66	11	-	-
- Other Receivables	941	771	121	21	27	-	-
<b>Total Financial Assets</b>	<b>25,753</b>	<b>25,495</b>	<b>133</b>	<b>88</b>	<b>38</b>	<b>-</b>	<b>-</b>
<b>2016</b>							
<b>Financial Assets</b>							
Cash and Cash Equivalents	22,619	22,619	-	-	-	-	-
Receivables (i)							
- Trade Debtors	397	314	63	15	5	-	-
- Other Receivables	1,119	877	110	94	39	-	-
<b>Total Financial Assets</b>	<b>24,134</b>	<b>23,810</b>	<b>172</b>	<b>109</b>	<b>44</b>	<b>-</b>	<b>-</b>

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

#### Contractual financial assets that are either past due or impaired

There are no material financial assets which are individually determined to be impaired. Currently 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 7.1: Financial Instruments (continued)

### (d) Liquidity risk

Liquidity risk is the risk that the Health Service would be unable to meet its financial obligations as and when they fall due. The Health Services operates under the Government's fair payments policy of settling financial obligations within 30 days and in the event of a dispute, making payments within 30 days from the date of resolution.

The Health Service's maximum exposure to liquidity risk is the carrying amounts of financial liabilities as disclosed in the face of the balance sheet. The Health Service manages its liquidity risk as follows:

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
<b>2017</b>						
<b>Financial Liabilities</b>						
Payables	1,751	1,751	1,751	-	-	-
Borrowings	602	602	6	11	52	533
Other Financial Liabilities (i)						
- Accommodation Deposits	11,140	11,140	-	-	2,228	8,912
- Other	533	533	-	-	533	-
<b>Total Financial Liabilities</b>	<b>14,026</b>	<b>14,026</b>	<b>1,757</b>	<b>11</b>	<b>2,813</b>	<b>9,446</b>
<b>2016</b>						
<b>Financial Liabilities</b>						
Payables	3,863	3,863	3,863	-	-	-
Borrowings	667	667	5	11	49	602
Other Financial Liabilities (i)						
- Accommodation Deposits	9,884	9,884	-	-	1,878	8,006
- Other	753	753	-	-	753	-
<b>Total Financial Liabilities</b>	<b>15,166</b>	<b>15,166</b>	<b>3,868</b>	<b>11</b>	<b>2,680</b>	<b>8,608</b>

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

## Note 7.1: Financial Instruments (continued)

### (e) Market risk

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
<b>2017</b>					
<b>Financial Assets</b>					
Cash and Cash Equivalents	2.04	24,403	21,000	3,403	-
Receivables					
- Trade Debtors		409	-	-	409
- Other Receivables		941	-	-	941
		<b>25,753</b>	<b>21,000</b>	<b>3,403</b>	<b>1,349</b>
<b>Financial Liabilities</b>					
Payables		1,751	-	-	1,751
Borrowings	5.88	602	602	-	-
Other Financial Liabilities					
- Accommodation Deposits		11,140	-	-	11,140
- Other		533	-	-	533
		<b>14,026</b>	<b>602</b>	<b>-</b>	<b>13,424</b>
<b>2016</b>					
<b>Financial Assets</b>					
Cash and Cash Equivalents	2.37	22,619	21,000	1,619	-
Receivables					
- Trade Debtors		397	-	-	397
- Other Receivables		1,119	-	-	1,119
		<b>24,134</b>	<b>21,000</b>	<b>1,619</b>	<b>1,516</b>
<b>Financial Liabilities</b>					
Payables		3,863	-	-	3,863
Borrowings	5.88	667	667	-	-
Other Financial Liabilities					
- Accommodation Deposits		9,884	-	-	9,884
- Other		753	-	-	753
		<b>15,166</b>	<b>667</b>	<b>-</b>	<b>14,499</b>

## Note 7.1: Financial Instruments (continued)

### (e) Market risk (continued)

#### Sensitivity disclosure analysis

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, 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 +0.25% and -0.25% in market interest rates (AUD) from year-end rates of 1.95%;

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 \$'000	Interest Rate Risk			
		-0.25% Profit \$'000	-0.25% Equity \$'000	+0.25% Profit \$'000	+0.25% Equity \$'000
<b>2017</b>					
<b>Financial Assets</b>					
Cash and Cash Equivalents	24,403	(61)	(61)	61	61
Receivables					
- Trade Debtors	409	-	-	-	-
- Other Receivables	941	-	-	-	-
<b>Financial Liabilities</b>					
Payables	1,751	-	-	-	-
Borrowings	602	-	-	-	-
Other Financial Liabilities	-	-	-	-	-
- Accommodation Deposits	11,140	-	-	-	-
- Other	533	-	-	-	-
		<b>(61)</b>	<b>(61)</b>	<b>61</b>	<b>61</b>
<b>2016</b>					
<b>Financial Assets</b>					
Cash and Cash Equivalents	22,619	(57)	(57)	57	57
Receivables					
- Trade Debtors	397	-	-	-	-
- Other Receivables	1,119	-	-	-	-
<b>Financial Liabilities</b>					
Payables	3,863	-	-	-	-
Borrowings	667	-	-	-	-
Other Financial Liabilities					
- Accommodation Deposits	9,884	-	-	-	-
- Other	753	-	-	-	-
		<b>(57)</b>	<b>(57)</b>	<b>57</b>	<b>57</b>



## Note 7.1: Financial Instruments (continued)

### (f) Fair value

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

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

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

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

### Comparison between carrying amount and fair value

	Consol'd Carrying Amount	Fair value	Consol'd Carrying Amount	Fair value
	2017 \$'000	2017 \$'000	2016 \$'000	2016 \$'000
<b>Financial Assets</b>				
Cash and Cash Equivalents	24,403	24,403	22,619	22,619
Receivables				
- Trade Debtors	409	409	397	397
- Other Receivables	941	941	1,119	1,119
<b>Total Financial Assets</b>	<b>25,753</b>	<b>25,753</b>	<b>24,134</b>	<b>24,134</b>
<b>Financial Liabilities</b>				
Payables	1,751	1,751	3,863	3,863
Borrowings	602	602	667	667
Other Financial Liabilities				
- Accommodation Deposits	11,140	11,140	9,884	9,884
- Other	533	533	753	753
<b>Total Financial Liabilities</b>	<b>14,026</b>	<b>14,026</b>	<b>15,166</b>	<b>15,166</b>

## **Note 7.1: Financial Instruments (continued)**

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

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

The following refers to financial instruments unless otherwise stated.

### **Loan and receivables**

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

Loans and receivables category includes cash and deposits (refer to Note 6.1), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

### **Financial liabilities at amortised cost**

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

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

### **Net gain/(loss) on financial instruments**

- 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.

### **Revaluation of financial instruments at fair value**

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

## Note 7.2: Net Gain/(Loss) on Disposal of Non-Financial Assets

	2017 \$'000	2016 \$'000
<b>Proceeds from Disposals of Non-Current Assets</b>		
Plant & Equipment	-	-
Medical Equipment	0	40
Motor Vehicles	65	35
Computers & Communication		-
<b>Total Proceeds from Disposal of Non-Current Assets</b>	<b>65</b>	<b>75</b>
<b>Less: Written Down Value of Non-Current Assets Sold</b>		
Buildings	-	-
Plant & Equipment	28	3
Medical Equipment	16	23
Motor Vehicles	53	49
Computers & Communication	6	2
Furniture & Fittings	14	23
<b>Total Written Down Value of Non-Current Assets Sold</b>	<b>116</b>	<b>100</b>
<b>Net Loss on Disposal of Non-Financial Assets</b>	<b>(51)</b>	<b>(25)</b>

### 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 8.1 – 'comprehensive income'.

### Impairment of non-financial assets

All other 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 amount exceeds their possible recoverable amount. Where an asset's carrying amount exceeds its recoverable amount, the difference is written-off as an expense except to the extent that the write-down can be debited to an asset revaluation surplus amount applicable to that same class of asset.

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

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

## Note 7.3: Contingent Assets and Contingent Liabilities

No contingent assets or contingent liabilities as at 30 June 2017 (2016: nil).

## Note 7.4: Fair Value Determination

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

	Example of types of assets	Expected fair value level	Likely valuation approach	Significant inputs (Level 3 only)
<b>Non-specialised land</b>	Vacant land and land not subject to restrictions as to use or sale	Level 2	Market approach	N/A
<b>Specialised land</b>	Land subject to restrictions as to use and/or sale	Level 3	Market approach	Community Service Obligation (CSO) adjustments
<b>Non-specialised buildings</b>	For general/commercial buildings that are just built	Level 2	Market approach	N/A
<b>Specialised buildings</b>	Specialised buildings with limited alternative uses and/or substantial customisation eg. Prison, hospitals and schools	Level 3	Depreciated replacement cost approach	Direct cost per square metre  Useful life of specialised buildings
<b>Plant and Equipment</b>	Specialised items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	N/A
<b>Vehicles</b>	There is an active resale market available	Level 2	Market approach	N/A

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

## Note 8: Other Disclosures

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

### Structure

#### 8.1 Equity

#### 8.2 Reconciliation of net result for the year to net cash inflow/(outflow) from operating activities

#### 8.3 Operating segments

#### 8.4 Responsible persons disclosures

#### 8.5 Executive officer disclosures

#### 8.6 Related parties

#### 8.7 Remuneration of auditors

#### 8.8 Events occurring after the balance sheet date

#### 8.9 Ex-gratia expenses

#### 8.10 AASBs issued that are not yet effective

#### 8.11 Alternative presentation of comprehensive operating statement

## Note 8.1: Equity

### (a) Surpluses

#### Physical Assets Revaluation Surplus

Balance at the beginning of the reporting period

Revaluation Increments

- Land

- 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

- DHHS Capital

**Balance at the end of the reporting period**

#### Total Surpluses

### (b) Contributed Capital

Balance at the beginning of the reporting period

Capital Contribution received from Victorian Government

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**

2017 \$'000	2016 \$'000
24,218	24,218
-	-
-	-
<b>24,218</b>	<b>24,218</b>
1,987	1,987
22,231	22,231
<b>24,218</b>	<b>24,218</b>
747	381
33	5
444	360
1,058	-
<b>2,283</b>	<b>747</b>
<b>26,501</b>	<b>24,965</b>
21,394	20,971
-	423
<b>21,394</b>	<b>21,394</b>
1,886	5,135
9	(2,883)
(1,536)	(366)
<b>360</b>	<b>1,886</b>
<b>48,254</b>	<b>48,245</b>

#### Contributed capital

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

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

#### Property, plant & equipment revaluation surplus

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

#### Specific restricted purpose surplus

A specific restricted purpose surplus 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.

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

	2017 \$'000	2016 \$'000
<b>Net result for the period</b>	9	(2,883)
<b>Non-cash movements:</b>		
Depreciation and amortisation	4,291	4,110
Provision for doubtful debts	5	(19)
<b>Movements included in investing and financing activities</b>		
Net loss from disposal of non financial physical assets	51	25
<b>Movements in assets and liabilities:</b>		
Change in operating assets and liabilities		
(Increase)/decrease in receivables	23	(25)
(Increase)/decrease in other assets	945	(246)
(Increase)/decrease in inventories	(28)	(70)
(Decrease)/increase in payables	(1,978)	(1,987)
Increase/(decrease) in provisions	933	972
<b>NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES</b>	<b>4,252</b>	<b>(123)</b>

## Note 8.3: Operating Segments

	RAC			Radiology			Other			Consolidated		
	2017	2016		2017	2016		2017	2016		2017	2016	
	\$'000	\$'000		\$'000	\$'000		\$'000	\$'000		\$'000	\$'000	
<b>REVENUE</b>												
External Segment Revenue	8,159	8,184		5,237	4,750		74,761	67,292		88,157	80,226	
Intersegment Revenue	792	334		2,002	1,917		5,174	3,926		7,968	6,176	
<b>Total Revenue</b>	<b>8,950</b>	<b>8,518</b>		<b>7,239</b>	<b>6,666</b>		<b>79,936</b>	<b>71,218</b>		<b>96,125</b>	<b>86,403</b>	
<b>EXPENSES</b>												
External Segment Expenses	(7,342)	(7,111)		(4,589)	(4,113)		(76,755)	(72,516)		(88,685)	(83,740)	
Intersegment Expenses	(4,209)	(3,219)		(966)	(707)		(2,794)	(2,251)		(7,968)	(6,176)	
<b>Total Expenses</b>	<b>(11,550)</b>	<b>(10,330)</b>		<b>(5,554)</b>	<b>(4,820)</b>		<b>(79,549)</b>	<b>(74,766)</b>		<b>(96,654)</b>	<b>(89,916)</b>	
<b>Net Result from ordinary activities</b>	<b>(2,600)</b>	<b>(1,812)</b>		<b>1,685</b>	<b>1,846</b>		<b>387</b>	<b>(3,548)</b>		<b>(528)</b>	<b>(3,513)</b>	
Interest Expense	-	-		-	-		(37)	(41)		(37)	(41)	
Interest Income	228	295		-	-		347	377		575	671	
<b>Net Result for Year</b>	<b>(2,372)</b>	<b>(1,517)</b>		<b>1,685</b>	<b>1,846</b>		<b>697</b>	<b>(3,213)</b>		<b>9</b>	<b>(2,883)</b>	
<b>OTHER INFORMATION</b>												
Segment Assets	24,542	26,422		5,206	5,070		44,576	42,895		74,324	74,387	
<b>Total Assets</b>	<b>24,542</b>	<b>26,422</b>		<b>5,206</b>	<b>5,070</b>		<b>44,576</b>	<b>42,895</b>		<b>74,324</b>	<b>74,387</b>	
Segment Liabilities	13,051	11,842		861	771		12,158	13,530		26,070	26,143	
<b>Total Liabilities</b>	<b>13,051</b>	<b>11,842</b>		<b>861</b>	<b>771</b>		<b>12,158</b>	<b>13,530</b>		<b>26,070</b>	<b>26,143</b>	
Acquisition of Property, Plant and Equipment	775	36		13	2,566		2,717	2,873		3,505	5,474	
Depreciation Expense	160	143		258	257		3,873	3,710		4,291	4,110	

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

### Business Segments

Residential Aged Care Services (RAC)  
Radiology  
Rest of Health Service (Other)

### Services

Provider of Residential Aged Care  
Provider of Diagnostic Imaging  
Admitted, Outpatients, Emergency, HACC, Sub-Acute, Primary Health.

Pricing from the Radiology Segment is at 85% of MBS 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.



## Note 8.4: Responsible Persons Disclosures

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

### Responsible Ministers

The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance  
The Honourable Martin Foley, Minister for Housing, Disability and Ageing,  
Minister for Mental Health, Minister for Equality, Minister for Creative Industries

### Governing Boards

A. Hutson  
B. Moar  
C. Barry  
D. Vickers  
Dr T. Watford  
J. Small  
M. Urie  
P. Murphy  
L. Jones

### Accountable Officers

Mrs Therese Tierney

### Remuneration of Responsible Persons

Remuneration received or receivable by responsible persons was in the range: \$0 – \$340,000 (\$0 – \$300,000 in 2015-16).

Period
1/7/2016 - 30/6/2017
1/7/2016 - 30/6/2017
1/7/2016 - 30/6/2017
1/7/2016 - 30/6/2017
1/7/2016 - 30/6/2017
1/7/2016 - 30/6/2017
1/7/2016 - 30/6/2017
1/7/2016 - 30/6/2017
1/7/2016 - 03/8/2016

1/7/2016 - 30/6/2017
----------------------

## Note 8.5: Executive Officer Disclosures

### Executive Officers' Remuneration

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

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

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

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

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

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

Short-term employee benefits

Post-employment benefits

Other long-term benefits

Termination benefits

**Total remuneration**

**Total number of executives**

**Total annualised employee equivalents (AEE) <sup>(i)</sup>**

<b>Total Remuneration</b>	
<b>2017</b>	<b>2016</b>
<b>\$</b>	<b>\$</b>
967,528	717,683
93,533	48,357
-	-
-	-
<b>1,061,061</b>	<b>766,040</b>
<b>6</b>	<b>4</b>
<b>6.0</b>	<b>4.0</b>

Notes:

(i) No comparatives have been reported because remuneration in the prior year was determined in line with the basis and definition under FRD 21B. Remuneration previously excluded non-monetary benefits and comprised any money, consideration or benefit received or receivable, excluding reimbursement of out-of-pocket expenses, including any amount received or receivable from a related party transaction. Refer to the prior year's financial statements for executive remuneration for the 2015-16 reporting period.

(ii) The total number of executive officers includes person who meet the definition of Key Management Personnel (KMP) of the entity under AASB 124 *Related Party Disclosures* and are also reported within the related parties note disclosure (Note 8.6).

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

## Note 8.6: Related Parties

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

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

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

Key management personnel (KMP) of the hospital include the Portfolio Ministers and Cabinet Ministers and KMP as determined by the hospital. The other KMP that are not disclosed in Note 8.4 Responsible Persons Disclosures are:

### Directors

B. Brown  
B. Coulton  
B. Hammond  
D. Elks  
K. Banerjee  
T. Donaldson

Period
22/5/2017 - 30/6/2017
1/7/2016 - 30/6/2017
1/7/2016 - 30/6/2017
1/7/2016 - 30/6/2017
1/7/2016 - 30/6/2017
22/5/2017 - 30/6/2017

The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The Minister's remuneration and allowances is set by the Parliamentary Salaries and Superannuation Act 1968, and is reported within the Department of Parliamentary Services' Financial Report.

### Compensation

Short term employee benefits  
Post-employment benefits  
Other Long-term benefits  
Termination benefits  
Share based payments

### Total

2017 (\$'000)
1,278
122
-
-
-
1,400

### Transaction with key management personnel and other related parties

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

### Specific disclosure note

During the year, Dr. John Urie, the husband of Mendy Urie, was awarded a contract. The transaction involved provision of visiting medical officer services for three years. For the current year the value billed under the contract was \$260,000.

During the year, Therese Tierney and Angela Hutson were board members of East Gippsland Water. The transaction involved provision of water supply to the health service. For the current year the value billed was \$177,000.

## Note 8.6: Related Parties (continued)

All other transactions that have occurred with KMP and their related parties have been trivial or domestic in nature. In this context, transactions are only disclosed when they are considered of interest to users of the financial report in making and evaluation decisions about the allocation of scarce resources.

### Significant transactions with government-related entities

Bairnsdale Regional Health Service received funding from the Department of Health and Human Services, Commonwealth Department of Health and Dental Health Services Victoria of \$68 million (2016: \$65 million).

**Key management personnel** of the agencies consolidated pursuant to section 53(1)(b) of the FMA into the Entity's financial statements include:

Entity	Key Management Personnel	Position Title
Bairnsdale Medical Group	M. Urie	Wife of Principal
Corner Amcal Bairnsdale	B. Moar	Principal
East Gippsland Water	T. Tierney	Board Member
East Gippsland Water	A. Hutson	Board Member

## Note 8.7: Remuneration of Auditors

### Victorian Auditor-General's Office

Audit or review of financial statement

2017 \$'000	2016 \$'000
37	36

## Note 8.8: Events Occurring after the Balance Sheet Date

No events occurred after the balance sheet date to effect this report. (2016: Nil)

## Note 8.9: Ex-gratia Expenses

Bairnsdale Regional Health Service has made the following ex-gratia expenses:

Compensation for economic loss

### Total ex-gratia expenses

2017 \$'000	2016 \$'000
6	-
<b>6</b>	<b>-</b>

## Note 8.10: AASBs Issued that are not yet Effective

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2017 reporting period. DTF 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 2017, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. Bairnsdale Regional Health Service has not and does not intend to adopt these standards early.

<b>Standard/ Interpretation</b>	<b>Summary</b>	<b>Applicable for annual reporting periods beginning on</b>	<b>Impact on financial statements</b>
AASB 9 Financial Instruments	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1 Jan 2018	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals.  While there will be no significant impact arising from AASB 9, there will be a change to the way financial instruments are disclosed.
AASB 15 Revenue from Contracts with Customers	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1 Jan 2018	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements.  The Standard will also require additional disclosures on service revenue and contract modifications.
AASB 16 Leases	The key changes introduced by AASB 16 include the recognition of most operating leases (which are currently not recognised) on balance sheet.	1 Jan 2019	The assessment has indicated that as most operating leases will come on balance sheet, recognition of the right-of-use assets and lease liabilities will cause net debt to increase.  Rather than expensing the lease payments, depreciation of right-of-use assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus.  No change for lessors.
AASB 1058 Income of Not-for-Profit Entities	This Standard will replace AASB 1004 Contributions and establishes revenue recognition principles for transactions where the consideration to acquire an asset is significantly less than fair value to enable to not-for-profit entity to further its objectives	1 Jan 2019	The assessment has identified that the revenue from capital grants that are provided under an enforceable agreement that have sufficiently specific obligations, will now be deferred and recognised as performance obligations are satisfied. As a result, the timing recognition of revenue will change.

**Note 8.10: AASBs Issued that are not yet Effective (continued)**

AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)	The requirements for classifying and measuring financial liabilities were added to AASB 9. The existing requirements for the classification of financial liabilities and the ability to use the fair value option have been retained. However, where the fair value option is used for financial liabilities the change in fair value is accounted for as follows: <ul style="list-style-type: none"> <li>• The changes in fair value attributable to changes in credit risk is presented in other comprehensive income (OCI); and</li> <li>• Other fair value changes are presented in profit and loss. If this approach creates or enlarges an accounting mismatch in the profit or loss, the effect of the changes in credit risk are also presented in profit or loss.</li> </ul>	1 Jan 2018	The assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss. Changes in own credit risk in respect of liabilities designated at fair value through profit and loss will now be presented within other comprehensive income (OCI). Hedge accounting will be more closely aligned with common risk management practices making it easier to have an effective hedge. For entities with significant lending activities, an overhaul of related systems and processes may be needed.
AASB 2014-1 Amendments to Australian Accounting Standards [Part E Financial Instruments]	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018; as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	1 Jan 2018	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15	Amends the measurement of trade receivables and the recognition of dividends. Trade receivables, that do not have a significant financing component, are to be measured at their transaction price, at initial recognition. Dividends are recognised in the profit and loss only when: <ul style="list-style-type: none"> <li>• the entity's right to receive payment of the dividend is established;</li> <li>• it is probable that the economic benefits associated with the dividend will flow to the entity; and</li> <li>• the amount can be measured reliably.</li> </ul>	1 Jan 2017, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.
AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.
AASB 2015-8 Amendments to Australian Accounting Standards – Effective Date of AASB 15	This Standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1 Jan 2018	This amending standard will defer the application period of AASB 15 for not-for-profit entities to the 2018-19 reporting period in accordance with the transition requirements.

**Note 8.10: AASBs Issued that are not yet Effective (continued)**

AASB 2016-4 Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities	The standard amends AASB 136 Impairment of Assets to remove references to using depreciated replacement cost (DRC) as a measure of value in use for not-for-profit entities.	1 Jan 2017	The assessment has indicated that there is minimal impact. Given the specialised nature and restrictions of public sector assets, the existing use is presumed to be the highest and best use (HBU), hence current replacement cost under AASB 13 Fair Value Measurement is the same as the depreciated replacement cost concept under AASB 136.
AASB 2016-7 Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities	This standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019.	1 Jan 2019	This amending standard will defer the application period of AASB 15 for not-for-profit entities to the 2019-20 reporting period.
AASB 2016-8 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities	This Standard amends AASB 9 and AASB 15 to include requirements and implementation guidance to assist not-for-profit entities in applying the respective standards to particular transactions and events. The amendments: <ul style="list-style-type: none"> <li>• require non-contractual receivables arising from statutory requirements (i.e. taxes, rates and fines) to be initially measured and recognised in accordance with AASB 9 as if those receivables are financial instruments; and</li> <li>• clarifies circumstances when a contract with a customer is within the scope of AASB 15.</li> </ul>	1 Jan 2019	This assessment has indicated that there will be no significant impact for the public sector, other than the impacts identified for AASB 9 and AASB 15 above.
AASB 2016-3 Amendments to Australian Accounting Standards – Clarifications to AASB 15	This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: <ul style="list-style-type: none"> <li>• A promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation;</li> <li>• For items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer; and</li> <li>• For licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access).</li> </ul>	1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector, other than the impact identified for AASB 15 above.

## Alternate Presentation of Comprehensive Operating Statement

	2017 \$'000	2016 \$'000
Grants	68,792	65,080
Interest and dividends	575	671
Fair Value of assets and services received free of charge or for nominal consideration	1	-
Sales of goods and services	11,983	11,456
Other Income	7,265	3,590
<b>Revenue from transactions</b>	<b>88,616</b>	<b>80,797</b>
Employee expenses	56,211	51,755
Operating Expenses		
Supplies and consumables	9,930	10,700
Non salary labour costs	7,891	6,844
Other	10,421	10,249
Finance costs	37	41
Depreciation	4,291	4,110
<b>Expenses from transactions</b>	<b>88,781</b>	<b>83,699</b>
	-	-
<b>Net result from transactions</b>	<b>(165)</b>	<b>(2,902)</b>
<b>Other economic flows included in net result</b>		
Revaluation of long service leave	175	18
Other gains / (losses) from other economic flows	-	-
<b>Total other economic flows included in net result</b>	<b>175</b>	<b>18</b>
<b>Items that may be reclassified subsequently to net result</b>		
Changes to financial assets available-for-sale revaluation surplus	-	-
<b>Total other economic flows included in net result</b>	<b>-</b>	<b>-</b>
	-	-
<b>Comprehensive result</b>	<b>9</b>	<b>(2,883)</b>



## DISCLOSURE INDEX

The annual report of *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.

Legislation	Requirement	Page Reference
<b>Ministerial Directions</b>		
<b>Report of Operations</b>		
<b>Charter and purpose</b>		
FRD 22H	Manner of establishment and the relevant Ministers	3, 103
FRD 22H	Purpose, functions, powers and duties	3
FRD 22H	Initiatives and key achievements	15
FRD 22H	Nature and range of services provided	4
<b>Management and structure</b>		
FRD 22H	Organisational structure	12
<b>Financial and other information</b>		
FRD 10A	Disclosure index	111
FRD 11A	Disclosure of ex-gratia expenses	106
FRD 21C	Responsible person and executive officer disclosures	103
FRD 22H	Application and operation of <i>Protected Disclosure 2012</i>	19
FRD 22H	Application and operation of <i>Carers Recognition Act 2012</i>	19
FRD 22H	Application and operation of <i>Freedom of Information Act 1982</i>	18
FRD 22H	Compliance with building and maintenance provisions of <i>Building Act 1993</i>	18
FRD 22H	Details of consultancies over \$10,000	16
FRD 22H	Details of consultancies under \$10,000	16
FRD 22H	Employment and conduct principles	14
FRD 22H	Major changes or factors affecting performance	16
FRD 22H	Occupational violence	17
FRD 22H	Operational and budgetary objectives and performance against objectives	15
FRD 24C	Reporting of office-based environmental impacts	19
FRD 22H	Significant changes in financial position during the year	15
FRD 22H	Statement on National Competition Policy	19

<b>Legislation</b>	<b>Requirement</b>	<b>Page Reference</b>
FRD 22H	Subsequent events	16,106
FRD 22H	Summary of the financial results for the year	15
FRD22H	Additional information available on request	20
FRD 22H	Workforce Data Disclosures including a statement on the application of employment and conduct principles	14
FRD 25C	Victorian Industry Participation Policy disclosures	21
FRD 29B	Workforce Data disclosures	14
FRD103F	Non-Financial Physical Assets	65
FRD110A	Cash Flow Statements	44
FRD112D	Defined Benefit Superannuation Obligations	60
SD 5.2.3	Declaration in report of operations	3
SD 3.7.1	Risk management framework and processes	37
<b>Other requirements under Standing Directions 5.2</b>		
SD 5.2.2	Declaration in financial statements	40
SD 5.2.1 (a)	Compliance with Australian accounting standards and other authoritative pronouncements	40
SD 5.2.1 (a)	Compliance with Ministerial Directions	40
<b>Legislation</b>		
Freedom of Information Act 1982		18
Protected Disclosure Act 2012		19
Carers Recognition Act 2012		19
Victorian Industry Participation Policy Act 2003		21
Building Act 1993		18
Financial Management Act 1994		3, 38, 40, 45