ANNUAL REPORT
2016 – 2017

MANSFIELD
DISTRICT HOSPITAL

Disclosure Index

The annual report of the Mansfield District Hospital is prepared in accordance with all relevant Victorian legislation.
This index has been prepared to facilitate identification of the Department's compliance with statutory disclosure requirements.

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NA – Not Applicable

This Report

Mansfield District Hospital's Annual Report:

- Is compliant with the requirements of the Standard Requirements for the Publication of Annual Reports;
- Details the principles guiding Mansfield District Hospital;
- Provides an overview of our services and their outcomes; and
- Is an open account of activities, achievements and financial performance.

Responsible Ministers

Victorian Government

Hon Jill Hennessy MP,
Minister for Health since 4 December 2014
Minister for Ambulance since December 2014

Hon Martin Foley MP,
Minister for Housing, Disability and Ageing
since 4 December 2014
Minister for Mental Health since 4 December 2014

Hon Jenny Mikakos MLC,
Minister for Families and Children since 4 December 2014

Location

Mansfield is located 188 km north east of Melbourne in the dramatic landscapes of Victoria's High Country renowned for its natural beauty and alpine mountains. Mansfield is very close to two large lakes, Lake Eildon and Lake Nillahcootie. The closest regional centres are Wangaratta (103km) and Shepparton (125km).

The Mansfield Shire has a current population of approximately 8,200 residents. The population significantly expands during weekends and holiday periods as people visit their holiday homes within the Shire, and /or attend for skiing, walking, cycling, water sports and other outdoor activities.

The greatest numbers of residents belong in the 45 – 64 year age bracket, at 24.8% with the median age being 44 years, which is considerably older than the Victorian average of 37 years. Mansfield and district has 17% of the population classified as aged and a projected increase in this area to greater than 50% by 2021.

The median weekly income of families is $891 compared to $1,216 for Victoria. These factors, combined with Mansfield's rural remoteness, place Mansfield and district residents at a high level of vulnerability.

The top 3 health conditions requiring hospitalisation for Mansfield residents are Diabetes complications, Chronic Obstructive Pulmonary Disease and Congestive Cardiac Failure.

History

Mansfield District Hospital was established and incorporated in 1876 to provide health services to the Mansfield district. In 1975 the hospital converted Bentley House to an aged care residential facility and expanded its nursing home accommodation to 20 beds in 1975. A further 10 beds were added in 1996 and the nursing home was renamed Buckland House. In 2000, Bindaree Retirement Centre amalgamated with Mansfield District Hospital to provide hostel level care to the district's residents enabling the integration of Mansfield's aged care services. In 2015 the Primary Care Centre was completed.

Today

Mansfield District Hospital is an acute medical, surgical and obstetric hospital with an attached Urgent Care Centre. Buckland House Nursing Home provides 30 beds for high level aged care while Bindaree Retirement Centre provides 42 aged care beds. The Primary Care Centre provides a visiting nursing service, community health nursing, a range of allied health services and health promotion and prevention services to the community. Community nurses visit Jamieson and Woods Point on a weekly basis.

Services offered by Mansfield District Hospital

- General Medicine
- General Surgery
- Obstetrics
- Renal Dialysis
- Urgent Care
- Community Health
- Health Promotion
- Residential Aged Care
- Visiting Nursing
- Medical Imaging

The Objectives of Mansfield District Hospital

The objects of the Health Service are to:

1. Operate a public hospital in accordance with the Act, and any enabling Commonwealth or Victorian legislation, including the provision of the following services:
   a. Public hospital services;
   b. Primary health services;
   c. Aged care services; and
   d. Community health services.
2. Provide a range of health and related services ancillary to those services described in clause 1;
3. Carry on any other activity or business that is convenient to carry on in connection with providing the services described in clauses 1 and 2, or which are intended or calculated to make any of the Health Service's assets or activities more efficient and effective.

Vision, Mission and Values

The Vision, Mission and Values of Mansfield District Hospital engender a common sense of purpose, provide direction for long term planning and establish sound principles and beliefs throughout the Service.

Our Vision

To be a leader in integrated health care.

Our Mission

To provide consistent quality health services to the community of Mansfield and district that reflect best clinical practice, are cost effective and responsive to community need.

Our Statement of Merit and Equity

Mansfield District Hospital is an Equal Employment Opportunity employer and has adopted the public sector merit and equity principles. Mansfield District Hospital is committed to the application of the employment and conduct principles and all employees have been correctly classified in workforce data collections.

The organisation has developed its own set of beliefs and values:

QUALITY – We believe in providing a high quality, effective and accessible health service that reflects best practice.

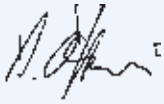
INTEGRITY – We believe it imperative to be open, honest, transparent and ethical in our decision-making and business transactions.

SUPPORT – We believe in providing a respectful, safe, fair and equitable environment for our staff where scholarship is valued and professional development is advanced.

SUSTAINABILITY – We believe in sustainable business and environmental practice.

Responsible Bodies Declaration

In accordance with the *Financial Management Act 1994*, I am pleased to present the Report of Operations for Mansfield District Hospital for the year ending 30 June 2017.



Phillip Officer
Board of Management
Mansfield District Hospital

23/08/2017

MANSFIELD DISTRICT HOSPITAL

Report from the Board Chair

On behalf of Mansfield District Hospital's Board of Management I am pleased to present the 146th Annual Report and the audited Balance Sheet and Financial Statements for the year ended 30th June 2017.

The past twelve months has been a time of progress and development for the health service as it welcomed new personnel, farewelled others and set about providing a comprehensive range of health services to our community and those visiting it.

Governance

Following our external review of governance undertaken in February 2016, much of our effort has been directed at implementing the numerous recommendations. In this regard the Board has benefitted from the strong leadership of the Chair, Jeremy Madin whose insight and experience allowed for clear delineation between matters of governance and operations which will undoubtedly hold us in good stead as we develop our strategic plan for the years ahead. Jeremy's resignation from the Board in May 2017 is a great loss to MDH and his energy, enthusiasm and wise counsel will be missed at all levels of the organisation.

Dr Marcus Kennedy, our Ministerial Delegate also provided invaluable assistance in enhancing governance capability and processes during the first half of the 2016/2017 year until his departure from the Board in December. His considered thought and advice was insightful and of particular relevance as the composition of the Board of Management underwent change and we welcomed our newly appointed CEO, Cameron Butler.

During the year a revised Board Committee structure was developed with updated Terms of Reference for each committee. This coincided with a comprehensive review of the MDH By Laws which were approved by the Department of Health and Human Services in April 2017. This review ensured that we complied with our legislative obligations and provided clear direction for how the Board of Management led the organisation. We are grateful to Ms Ann Lahore, a fellow Board member, who undertook this work on behalf of the Board of Management.

The Board of Management operates in a voluntary capacity and requires devotion of a considerable amount of time to fulfil the requirements of meetings, education and briefings. We are indebted to all of our members who selflessly make this commitment.

Over the course of the year we welcomed new Board members Dr Pamela Dalgliesh, Ms Katie Lockey and Ms Laurie Watters. Regretfully we accepted the resignations of Mr Jeremy Madin (Chair) and Ms Ann Lahore after lengthy periods of service as a Board members, and Mr James Yencken.

In addition to our Board members we thank other community and consumer members who assist on governance committees; notably Mr Jaya Naidu who chairs our Audit and Risk Management committee.

Leadership

In July we welcomed the commencement of Cameron Butler as Chief Executive Officer following his appointment in April. A review of the executive structure led to the appointment of Melanie Green as Director of Operations in October to oversee our risk program and reporting along with management of corporate services and primary care services. To further enhance safety and quality we expanded our Director of Medical Services role to two days per month. Our Director of Medical Services for the past ten years, Dr Rick Lowen was unable to allocate additional time to MDH and resigned with effect from June 2017. We extend to Dr Lowen our appreciation of his ten years of service to MDH and wish him well for the future.

Dr John Elcock, Director of Medical Service at Northeast Health Wangaratta (NHW) has been contracted to fulfil the role of Director of Medical Services to Mansfield District Hospital (MDH). Dr Elcock's appointment further strengthens the collaboration with NHW which is the major referral hospital for MDH.

Margaretanne Hood, Director of Clinical Services and Anne Jewitt, Director of Quality and Safety comprise the remainder of the executive. As Director of Clinical Services Margaretanne oversees the provision of the majority of clinical services, encompassing both acute and aged services. Anne is responsible for ensuring the services we provide are safe and effective. We thank them both for their diligence and professionalism in the way in which they undertake their work.

Safety and Quality

The provision of a safe and high quality health service is our primary objective at MDH. For a Small Rural Health Service we provide a broad range of services that require highly skilled clinicians. We are also committed to the provision of obstetric services within our capability. To this end we undertook in 2016/17 a review of our midwifery model of care and implemented the recommendations that arose from it.

To assist our clinicians to maintain their skills we progressively implemented PROMPT (Practical Obstetric Multi-Professional Training). This required the commitment of time on their part and we are fortunate to have at MDH a dedicated group of professionals who are fully committed to safety.

Across all aspects of Hospital services, be it residential aged care, operating theatre, urgent care presentations, renal dialysis or any of our community based services, safety and quality is our first priority. We thank all our staff for their dedication and uncompromising commitment to the delivery of a high quality health service in 2016/17.

Our People

We have been fortunate to have access for the past seventeen years to the skill and experience of Mr Peter Thomas, a highly credentialed and respected general surgeon. Peter recently relinquished his position as a visiting specialist surgeon at MDH and leaves with our thanks for his dedicated years of service and our best wishes for the future.

We have great admiration for all of our Visiting Medical Officers. Their commitment to their profession and the health service allows us to continue to provide services that a number of other health services of our size can no longer offer.

All our staff contribute to the care of our consumers, that is, the patients, residents and clients who use our service. We strongly believe that our staff should have the opportunity to provide feedback (and input) and that we in turn should listen to their views. Accordingly all employees are encouraged to complete the annual Victorian Public Sector Commission "People Matter Survey". In 2016, 56% of our employees took the opportunity to participate and in 2017 53%. Their responses provide valuable feedback and direction for us.

We also believe that safety in the workplace is of vital importance and that we must ensure that our employees feel safe when at work. Unfortunately occupational violence within the health sector is increasing in both prevalence and severity. In this annual report we highlight the number of occupational violence incidents our staff have been subjected to. From the Board down we take this issue seriously and are proactively addressing this issue through the "It's never OK" framework for Preventing and Managing Occupational Violence and Aggression.

Our Community

As an organisation we believe MDH is an integral part of the Mansfield community. In turn we are well supported by it.

Our community is extremely generous and each year we receive significant donations that allow us to purchase much needed equipment and resources. Information relating to donations is contained in this report. Special mention needs to be made of the bequest of $442,000 from the estate of Mrs Beryl Walsh and two anonymous donations of $50,000 to assist in launching a service to address ICE and other drug use in Mansfield. In addition we are grateful for the continued financial generosity and support of the Harry and Claire Friday Foundation and who in 2016 also transferred ownership of the community bus to MDH.

We are once again indebted to the ongoing generous support of our two auxiliaries, the Hospital Auxiliary led by Ann Mudge and Bindaree Auxiliary led by Linda Tucker. Comprehensive details of the scope of their work and activities and the generosity of their donations are within this report. Needless to say both groups comprise a tireless band of individuals who work extremely hard to make significant contributions to our organisation. We most sincerely thank them for all their hard work on behalf of MDH during the year.

Amongst examples of donations are:

- Sterilizer Washer for theatre
- Laparoscope
- Emergency Trolley
- 5 Chairs for Buckland House
- 30 chairs for Bindaree
- iPods and headsets for residents to listen to music

We again offer our sincere thanks to all our volunteers who have contributed so much in 2016/17.

MDH is fortunate to have broad based support from a vibrant and engaged community that takes an active interest in the health service with many community members taking the opportunity to have input into strategy and operations. During 2016 we held service planning forums in Tolmie, Jamieson, Mansfield, Merrijig and Bonnie Doon which were attended by more than fifty local people. We also have many community members on our Community Advisory Committee who provide feedback on publications, policies and service direction.

Our Partners

Over the past year we continued to develop strong partnerships with the Mansfield Shire and local schools and participated in projects to improving the health and wellbeing within our community. This has included improving pathways for aged care, aged care forums, White ribbon day events for the Elimination of Violence Against Women, Parent Child Mother Goose program to enable avenues for support networks for our young families and sessions focusing on healthy eating.

We also work closely with the Department of Health and Human Services who provide invaluable and generous support across all aspects of MDH operation, both clinical and non-clinical.

Key Initiatives Now and into the Future

There have been many achievements of the past twelve months in what has been a period of change and renewal.

It is pleasing to again report a sound financial performance with the recording of an operational surplus of $228,597 while also achieving our targets in relation to activity, safety and quality of service. Notably Urgent Care presentations for 2016/17 increased to 3,984, the highest on record and we continued to provide a much sought after maternity, acute, primary care and aged service to Mansfield and surrounding communities.

In April we were advised that our submission to the Rural Health Infrastructure Fund was successful, providing $475,000 for the much needed upgrade of Buckland House.

In February 2017 we completed a Clinical Service Plan which identified the services MDH should provide within the community over the next five years. This confirmed the need to continue and in some areas seek to expand our range of acute services, identified the need for building upgrades in order to meet service demand and indicated that there was scope for expansion of primary care services.

Accordingly we have sought to expand our primary care services either by the direct involvement by MDH staff or providing a facility for visiting health professionals. We have increased the hours for Intake, recruited an additional speech pathologist to work within local schools and provided a venue for mental health, drug and alcohol and community legal services.

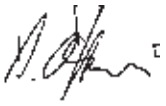
In 2014 a public forum to discuss the use of ICE and other drugs in the Mansfield community was attended by more than 200 people. With the assistance of the Penington Institute we have responded to this concern through the development of a community led pilot project to tackle the problem at a local level. Generous philanthropic support culminating in raising $390,000 will allow us to provide this service for three years. This initiative is complemented by funding we received from the Alcohol and Drug Foundation to establish a local drug action team and $65,000 from Murray Primary Health Network for suicide prevention.

MDH was successful in securing a Suicide prevention grant which will be activated during 2017/18 working in partnership with our community stakeholders as well as the Mansfield Shire, schools and General Practice.

In 2017/18 we will continue to focus our efforts on providing a safe, high quality health service with priority being given to the implementation of recommendations from the “Targeting Zero” review of Hospital Safety and Quality Assurance in Victoria.

Acknowledgements

While we have specifically acknowledged the contributions of many within this report, we express our warmest thanks and gratitude to our community, Board of Management Members, Executive team, Medical Officers, Staff and partner organisations.



Phillip Officer
Board Chair

Mansfield District Hospital Auxiliary Report

The Auxiliary has had another very successful year with our fundraising. To date the Auxiliary has provided monies to purchase the following items of equipment.

Sterilizer Washer for infection control.	$50,000.00
Laparoscope	$12,000.00
Emergency Trolley	$4,710.00
5 Chairs for Buckland House	$4,600.00
TOTAL	**$71,310.00**

Our Annual Art Exhibition in October was a celebration of 40 years. We had some 194 entries of Art on display. We were thrilled to have local well known Artist Tony Pridham as our Judge. He was most impressed with the art work displayed. Mr Jeremy Madin officially opened our Exhibition. We are very fortunate to have both Rotary and Harry & Clare Friday Foundation as our sponsors. The People's choice award was very kindly donated this year by the Mansfield Community Fund who also awarded a prize to the winner of our 40x40cm category, which was introduced this year as we were celebrating our 40th year.

We would also like to thank:

- Countrywide Automotive Repairs
- Mansfield Hunting & Fishing
- Mansfield Flooring Xtra
- Mansfield Lotto Centre
- Mansfield Motor Panel Repairs

They generously donated to encourage our local Autistic School Artists to continue their interest in art.

Finally we would like to thank the Masonic Lodge for their continued support in allowing us the use of their venue for the duration of our Exhibition.

In February we held our Annual Golf Day. This is always a very popular day with locals and players from out of town. We are most grateful to Foodworks for donating all of the food. We would like to thank Adam from the Rangeview Restaurant for providing such a delicious meal, James Cleeland for donating his time and conducting our auction and Dion Theodossi who provided a car for the "Hole in One". We are most appreciative of Dion's continued support. As the car is a huge draw card for both locals and out of town golfers.

Our film night was well attended with both cinemas booked and enjoyed by all who attended.

Unfortunately we have had two of our long standing members Helene Harkin and Susan Kinloch resign. We thank them both most sincerely for their work and friendship over many years. We are very happy to welcome Di Burton and Helen Clark to our Auxiliary and look forward to working with them in the times ahead.

On behalf of the Auxiliary I would like to thank the Mansfield community for their continued support and generosity, which enables the Auxiliary to provide much needed funds to assist the Mansfield District Hospital to purchase items of equipment.

Finally I personally would like to thank my committee for their tireless work and friendship over the past year.

Ann Mudge
President
Mansfield District Hospital Auxiliary

Bindaree Auxiliary Report

The Auxiliary is pleased to present this report of our activities over the past year.

Membership, though not large in number, is enthusiastic and committed to providing extras for the welfare and benefit of Bindaree residents. This commitment is exemplified by the continuing contribution of some of the founding members of the Auxiliary who have actively supported our activities for over 40 years, and who are an example to us all.

As with many other community organisations, we have had to work hard to gain our share of fundraising opportunities. Over the past year the main efforts have included the popular Movie Lunch at the Mansfield Cinema - once again well supported. Bingo at the Golf Club and the Trivia Night at the Delatite Hotel provided varied opportunities. Stalls at the Bush Market and at the Tolmie Christmas Market produced support from different parts of the community and provided an opportunity to publicise Bindaree Aged Care to the wider community. A very popular day was the Mah-jong and Card Day at the Golf Club. We are grateful to the Golf Club for the use of their facilities for a number of our fundraising activities, and to local businesses for their support in kind.

During the year our attention was drawn to the need for new furniture in the residents' lounges and a decision was made to purchase 30 new chairs for use in the Collie Lounge and the Shaw Wing, and also in the reception area where residents enjoy sitting. This was a most satisfying project, with the residents' opinions being sought re the chairs, the material and colours chosen. Matching cushions were also provided for all the chairs. This was a very significant purchase for the Auxiliary and we are grateful to our many supporters over recent years, which enabled us to spend a little over $31,140 on the provision of the furnishings.

The Activities team at Bindaree is always involved in the provision of stimulating programs for the residents. The Auxiliary has been pleased to purchase iPods and headsets for the residents. Music programs have been recorded and residents are able to listen individually to their favourite music. This has been very therapeutic and we look forward to the further development of this program.

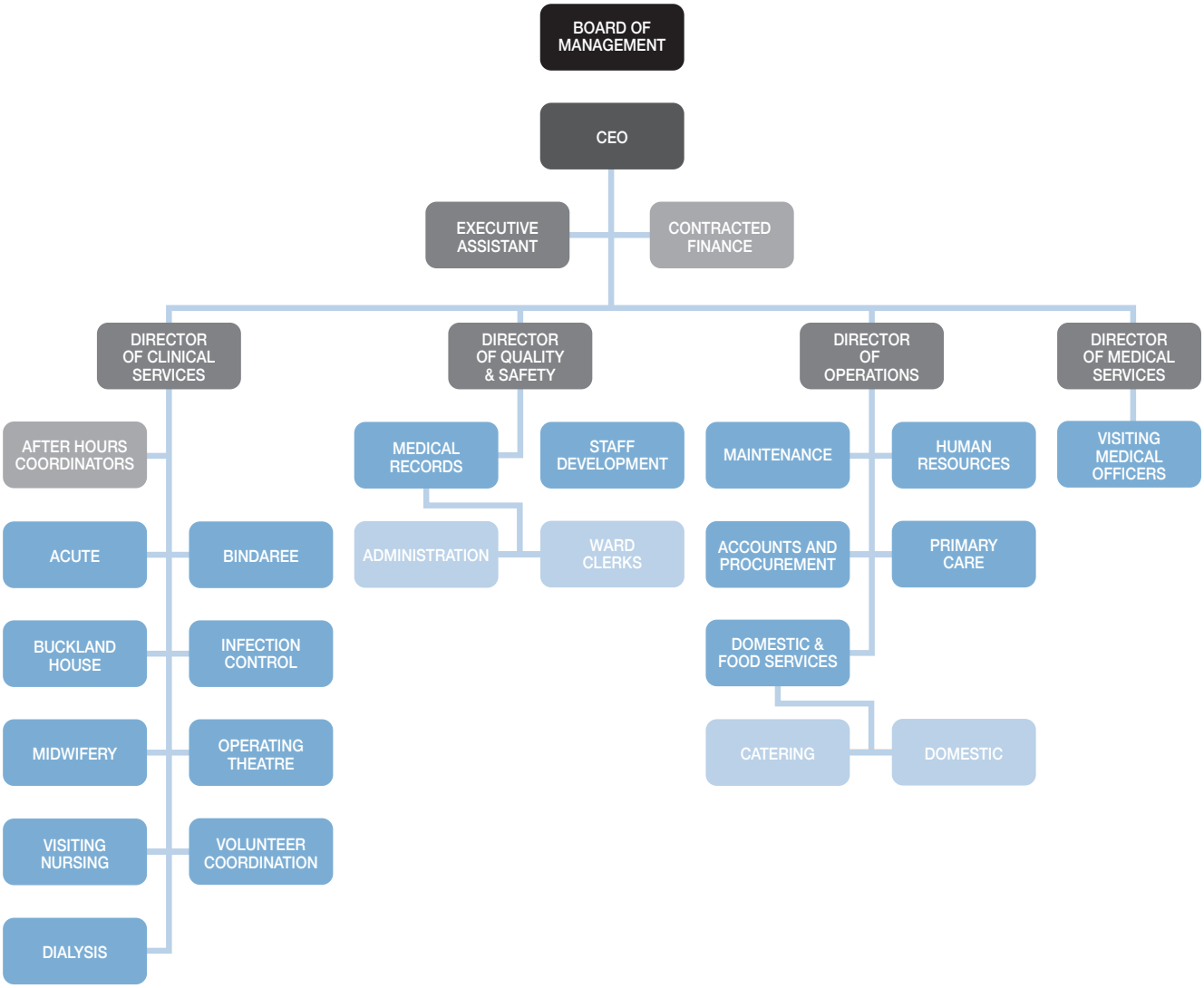
The Auxiliary liaises with the Nurse Unit Manager and Activities team to keep abreast of any items which may benefit the residents. The weekly visit of the shopping trolley is much appreciated by the residents and gives the Auxiliary Members an opportunity to make personal visits to residents.

The Auxiliary is keen to attract new members and is considering different ways of operating to ensure we can continue to support Bindaree in the future. Thanks are expressed to our retiring President Linda Tucker and members of the Executive for their enthusiastic contribution over the past year.

Norma Pearce
Secretary
Bindaree Auxiliary

Governance

Organisational Chart



Governance

Corporate Governance

Members of the Board of Management are appointed in accordance with the Health Services Act, 1988 and provide effective corporate and clinical governance for the Mansfield District Hospital. Board members are guided by the Victorian Public Sector Commission Code of Coduct for Directors and are not remunerated for their services.

Board of Management

Chair, Board of Management
Mr Jeremy Madin (1st July 2016 – 10th May 2017 resigned from Board)
Mr Phillip Officer (10th May – 30th June 2017)

Chair, Audit & Risk Management
Mr Jaya Naidu (Independent member)

Chair, Safety & Quality
Associate Professor Jane Freemantle (1st July –19th December 2016)
Dr Pamela Dalgliesh (20th February – 30th June 2017)

Chair, Finance
Mr Murray Beattie (1st July 2016 – 24th January 2017)
Mr Phillip Officer (28th February – 30th June 2017)

Board Members
Mrs Rosalind Adams
Mrs Gill Belle
Ms Ann Lahore (resigned 16th November 2016)
Ms Katie Lockey
Ms Laurie Watters
Mr James Yencken (resigned 13th February 2017)

Medical Staff Group Representative
Dr Graham Slaney

Audit and Risk Committee

Audit & Risk Management
Mr Jaya Naidu (Independent member)
Mr Geoff Gravenall (Independent member)
Mrs Rosalind Adams
Ms Katie Lockey

Executive Team

Chief Executive Officer
Mr Cameron Butler, RN, B. Bus

Director of Clinical Services
Ms Margaretanne Hood, RN, RM, BN, Cert Neuroscience

Director of Medical Services
Dr Richard Lowen, MB, BS DRCOG, RACGP, AACHSE (resigned 11th June 2017)
Dr John Elcock, BMedSci (Hons), MB BS, MBA, FRACGP, FRACMA, GAICD (17th February – 30th June 2017)

Director of Operations
Ms Melanie Green, BSci(Speech Pathology) MHHSM, GradDIP Risk & Bus Continuity

Director of Quality & Safety
Ms Anne Jewitt, RN, RM, IBCLC

Executive Assistant
Tracy Rekers

Associated Bodies as at 30 June 2017

Auditors
RSD Bendigo for J Doyle, Auditor General

Bankers
ANZ
Bendigo Bank
CBA
NAB
Westpac

Internal Auditors
Crowe Horwath

Visiting Medical Practitioners
Dr G Bourke, MB, BS, DRANZCOG, FACRRM, ACRRM
Dr L Carter, MB, BS, BSC (Hons), FRACRM, FRACGP
Dr D Cook, MB BS, FACRRM, FRACGP
Dr S Flew, MB, BS, DCH, DRANZCOG, FACRRM, FRSTM&H, MPH
Dr D Friday, MB, BS, DRANZCOG, FRAGP
Dr J Hall, MB, BS
Dr M Reed, MB, BS, FRACGP
Dr W Twycross, MB, BS, DA, DRANZCOG, DTPH
Dr M Sathveegarajah, MD, BSC
Dr K Savage, MB, BS
Dr G Slaney, MB, BS, DRANZCOG, FRACGP, MPH, DA DRCOG, FACRRM
Dr A Wettenhall, MB, BS, FRACGP
Dr D Le Brocque, MB, BS
Dr B Nally, MB, BS
Dr E Harrison, MB, BS
Dr R Radford, MB, BS
Dr S Begin, MB, BS
Dr E Dirksen, MB, BS
Dr T Ibrahim, MB, BS
Dr M Morissey, MB, BS, BSc, DCH, DRANZCOG

Visiting Consulting Medical Staff
Dr P MacLeish, MB, BS, FRACP
Dr S Pearce, MB, BS, FRANZCOG
Mr W Seager, MB, BS, FRACS (Ortho)
Mr P Thomas, MB, BS, FRCSEd, FRACS
Dr A McLeod, MB, BS(Hons), FRACS
Dr K Ibrahim, MB, BS, FANZCA

Statement of Priorities

Part A – Strategic Priorities for 2016–2017

The Victorian Government's priorities and policy directions are outlined in the *Victorian Health Priorities Framework 2012–2022.*

In 2016/17 Mansfield District Hospital contributed to the achievement of these priorities by:

Domain	Action	Deliverables	Outcome
Quality and Safety	Implement systems and processes to recognise and support person-centred end of life care in all settings, with a focus on providing support for people who choose to die at home.	Investigate and implement a care plan for the dying person as supported through the Centre for Palliative Care (St Vincent's Hospital).	**Achieved** Education and implementation of End of Life pathway from Centre for Palliative Care (St Vincent's Hospital).
	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.	Implementation of advanced care plans across Mansfield District Hospital.	**Achieved** Education of staff at MDH, Mansfield Medical Clinic and Central General Practice in use of the Advanced Care Planning tool. Information pack provided to all Visiting Nursing Service clients. Tracking for DHHS reporting commenced. Development with Central Hume PCP an area model. Education for community conducted in Mansfield in May.
	Progress implementation of a whole-of-hospital model for responding to family violence.	Implementation of a whole of organisation strategy to respond and prevent family violence in conjunction with Goulburn Valley Health and their whole-of-hospital model.	**Achieved** Pathway developed with Centre Against Violence for Mansfield Staff. Met with GV Health who presented the Strengthening Hospital Responses to Family Violence (SHRFV) Service Model, including the 2 overarching principles or Gender Equality and Sensitive Practice. The 6 key elements of work to ensure successful implementation were discussed and project resources shared. A work plan has been developed and key staff have been identified to lead the SHRFV work to increase capability and capacity of managers and staff to identify and respond to family violence and build networks with local service networks. Training staff to build capacity and capability is a critical element of the SHRFV model, however all foundation elements will be in place prior to staff training commencing. 'Train the trainer' sessions will be provided by GV Health in 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.	Participate in collaborative opportunities initiated by the Hume Health Service Chief Executive Officer group.	**Achieved** Regional Meeting attendance by CEO, Director Clinical Services and Director of Quality and Safety. Working with Northeast Health Wangaratta to improve M&M meetings including regional representative to improve service delivery.

Domain	Action	Deliverables	Outcome
Quality and Safety (continued)	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.	Foetal surveillance competency policy and procedures developed and implemented. The policy will be applicable to all staff involved in the provision of maternity care.	**Achieved** Developed policy and work instructions. Implementation across organisation.
	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.	Involve consumers in the analysis of all available consumer feedback data to improve services.	**Achieved** Implementation of Patient Diaries, Patient Stories and Hourly rounding of our patients. Consumer representation on committees.
	Develop a whole of hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint.	Ongoing education of staff, consumers and their families of the organisation's restraint policy.	**Achieved** Reviewed policy and work instructions. Implementation across organisation.
Access and timeliness	Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine).	Identify additional opportunities to engage health providers via telemedicine.	**Achieved** Participation in regional telehealth project. Data collection of telehealth use.
	Develop and implement a strategy to ensure the preparedness of the organisation for the National Disability and Insurance Scheme and Home and Community Care program transition and reform, with particular consideration to service access, service expectations, workforce and financial management.	Ongoing participation in Hume Region Home and Community Care transition and reform programs and commence planning for the introduction of the National Disability and Insurance Scheme in Ovens and Murray in 2017 through the development of appropriate systems to coordinate care and educate staff.	**Achieved** Registration with National Disability Insurance Scheme. Staff undertaking training in National Disability Insurance Scheme.
Supporting Healthy Populations	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.	Ongoing participation in local Primary Care Partnership initiatives to support the delivery of a local health and wellbeing plan.	**Achieved** Mansfield PCP membership. Working in partnership with Mansfield Shire Council in developing their Municipal Public Health and Wellbeing Plan.
	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.	Ongoing implementation and delivery of an Integrated Health Promotion plan developed to address identified local health priorities.	**Achieved** Mansfield Prevention plan focuses on: • Mental Health: Prevention of Violence Against Women and their Children • Health Eating New planning for 2017-2019 plan with Mansfield PCP and Mansfield Shire Council. Mansfield nominated as a Local Drug Action Team site.

Domain	Action	Deliverables	Outcome
Supporting Healthy Populations (continued)	Develop and implement strategies that encourage cultural diversity 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.	Develop and implement an organisation wide social inclusion policy.	**Achieved** Implementation of a diversity framework which focused on social inclusion for all.
	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.	Undertake a cultural audit to identify gaps and implement recommendations to meet Koolin Balit requirements.	**Achieved** Completion of Aboriginal Cultural Competence Audit and subsequent Action Plan to improve our Aboriginal Cultural Competence.
	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.	Collaborate with North East Border Mental Health Service to support the delivery of mental health services.	**Achieved** Renewed service agreement for rooms and services with North East Border Mental Health Service. Training of administration staff by North East Border Mental Health Service in customer management.
	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 individuals and communities.	Develop and implement an organisation wide social inclusion policy.	**Achieved** Implemented diversity framework.
Governance and leadership	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 and leadership are in place to support the provision of safe, quality, accountable and person centred healthcare. It is an expectation that health services implement to best meet their employees' and community's needs, and that clinical governance arrangements undergo frequent and formal review, evaluation and amendment to drive continuous improvement.	Review, implement and evaluate the organisation's clinical governance framework.	**Achieved** Safety and quality charter developed with annual workplan. Approved by Board of Management.
	Contribute to the development and implementation of Local Region Action Plans under the series of statewide design, service and infrastructure plans being progressively released from 2016/17. Development of Local Region Action Plans will require partnerships and active collaboration across regions to ensure plans meet both regional and local service needs, as articulated in the statewide design, service and infrastructure plans.	Active participation and collaboration in the development and implementation of a Local Region Action Plan.	**Achieved** Representation and collaboration on Local Regional Action Plan.
	Ensure that an anti-bullying and harassment policy exists and includes the identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal and the policy specifies a regular review schedule.	Implement a process to regularly review and evaluate existing anti-bullying and harassment policies to ensure that staff are provided adequate support. Ensure that processes for reporting, investigating and providing feedback are articulated and understood.	**Achieved** Reviewed and updated policy and work instruction. Reviewed and updated staff mandatory training.

Domain	Action	Deliverables	Outcome
Governance and leadership (continued)	Board and senior management ensure that an organisational wide occupational health and safety risk management approach is in place which includes: (1) A focus on prevention and the strategies used to manage risks, including the regular review of these controls; (2) Strategies to improve reporting of occupational health and safety 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 (3) Mechanisms for consulting with, debriefing and communicating with all staff regarding outcomes of investigations and controls following occupational violence and bullying and harassment incidents.	Through the normal process of staff reviews and meetings, strengthen the focus on the organisation wide Occupational Health and Safety policy.	**Achieved** Reviewed and updated Occupational Health and Safety reporting, including risk rating all actions (hazards). This corresponds to the organisation's risk framework. Reporting was further improved subsequent to requests by Board of Management.
	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.	Evaluate current workforce plan and update to ensure it meets changing workforce needs and best practice.	**Achieved** Reviewed the organisation's Workforce strategy and updated our workforce plan ensuring focuses on leadership, Best practice education, succession planning. Development of a diversity in employment strategy including updating organisations advertisement template and process.
	Create a workforce culture that: (1) includes staff in decision making; (2) promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and (3) includes consumers and the community.	Continued participation in the organisation wide Hardwiring for Excellence program that is designed to create and reinforce a positive workplace culture.	**Achieved** Monthly support via Studer group in embedding our Hardwiring for Excellence program culture. Implementation of hourly rounding across organisation.
	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 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 of children; strategies to identify and reduce or remove the risk of abuse and strategies to promote the participation and empowerment of children.	Implement the Victorian Child Safe Standards into organisational orientation and ongoing training programs.	**Achieved** Child Safe policy developed. Action plan developed to monitor compliance with our policy.
	Implement policies and procedures to ensure patient facing 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.	Review of organisational vaccination program to ensure that it protects all hospital staff and prevents the transmission of infection.	**Achieved** Review of Infection Control Manual which includes organization vaccination program.

Domain	Action	Deliverables	Outcome
Financial sustainability	Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	Review of existing budget framework and finance policies to ensure there is sufficient cash to meet financial obligations.	**Achieved** Review of organization policies. Budget and financial obligations met.
	Actively contribute to the implementation of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measureable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling.	Review the carbon emissions generated by the organisation and review organisational practices and policies to assist in meeting environmental emissions targets.	**Achieved** Environment Meeting part of the organisations Finance and Accountability meeting with organisations managers. Terms of Reference developed for Take 2 committee for 2017/18 financial year to improve our environment and sustainability approaches.

Part B – Performance

Safety and quality performance

Key performance indicator	Target	2016–2017 Actual	2016–2017 Result
Accreditation			
Compliance with NSQHS Standards Accreditation	Full Compliance	Full Compliance	✔
Compliance with the Commonwealth Aged Care Accreditation Standards	Full Compliance	Full Compliance	✔
Infection prevention and control			
Compliance with cleaning standards	Full Compliance	Full Compliance	✔
Submission of infection surveillance data for VICNISS	Full Compliance	Full Compliance	✔
Compliance with Hand Hygiene Australia Program	80%	86%	✔
Percentage of healthcare workers immunised for Influenza	75%	91%	✔

Cleaning standard measure	AQL target	2016–2017 Actual	Outcome
Overall compliance with standards	Full Compliance	Full Compliance	✔
Very high risk (Category A)	90 points	98.4	✔
High risk (Category B)	85 points	94.6	✔
Moderate risk (Category C)	85 points	98.6	✔

Patient experience and outcomes performance

Key performance indicator	Target	2016–2017 Actual	2016–2017 Result
Victorian Health Experience Survey – data submission	Full Compliance	Full Compliance	✔
Victorian Healthcare Experience Survey – patient experience Quarter 1	95% positive experience	99% positive experience	✔
Victorian Healthcare Experience Survey – patient experience Quarter 2	95% positive experience	98.5% positive experience	✔
Victorian Healthcare Experience Survey – patient experience Quarter 3	95% positive experience	100% positive experience	✔
Victorian Healthcare Experience Survey – discharge care Quarter 1	75% positive experience	93% positive experience	✔
Victorian Healthcare Experience Survey – discharge care Quarter 2	75% positive experience	90% positive experience	✔
Victorian Healthcare Experience Survey – discharge care Quarter 3	75% positive experience	86% positive experience	✔
Maternity and newborn			
Maternity – 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%	2.5% 2/80 deliveries	✘
Rate of severe foetal growth restriction in singleton pregnancy undelivered by 40 weeks	≤ 28.6%	≤ 28.6%	✔

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 Actual	2016–2017 Result
People Matter Survey – percentage of staff with a positive response to safety culture questions	80%	96%	✔

Financial sustainability

Key performance indicator	Target	2016–2017 Actual	2016–2017 Result
Finance			
Operating result ($m)	0.02	0.23	✔
Trade creditors	<60 days	<53 days	✔
Patient fee debtors	<60 days	<26 days	✔
Adjusted current asset ratio	0.7	1.23	✔
Days of available cash	14 days	36.2 days	✔
Asset management			
Asset management plan	Full Compliance	Full Compliance	✔

Part C – Activity and funding

Funding type	2016–2017 Activity Achievement
Acute Admitted	
WIES Public	776.76
WIES Private	273.08
TOTAL PPWIES (Public and Private)	1049.84
WIES Renal	57.5
WIES DVA	57.04
WIES TAC	6.15
WIES TOTAL	1113.03

Funding type	2016–2017 Activity Achievement
Aged Care	
Residential Aged Care – occupancy	
• Buckland House	77.36%
• Bindaree	96.72%
Visiting Nursing Service	
Small Rural HACC	541
Commonwealth Home Support Program	3466
Primary Care Centre	
Small Rural Primary Health	3178

Financial Overview

Summary of Financial Results for last five years

	2017	2016	2015	2014	2013
Total Revenue	20,528,463	15,972,454	14,933,425	14,312,595	13,629,344
Total Expenses	(17,629,032)	(16,512,034)	(15,615,088)	(14,738,776)	(14,613,425)
Net result for year (inc Capital & Specific Items)	**2,899,431**	**(539,580)**	**(681,663)**	**(426,181)**	**(984,081)**
Retained Surplus/(Accumulated Deficit)	(4,181,585)	(7,081,016)	(6,541,436)	(5,859,773)	(5,433,592)
Total Assets	39,466,244	34,563,150	30,759,482	29,723,667	21,165,420
Total Liabilities	16,092,017	14,546,586	10,203,337	9,747,314	8,416,457
Net Assets	**23,374,227**	**20,016,565**	**20,556,145**	**19,976,353**	**12,748,963**
Total Equity	**23,374,227**	**20,016,565**	**20,556,145**	**19,976,353**	**12,748,963**

Workforce

Mansfield District Hospital ensures a fair and transparent process for the recruitment, selection and promotion of employees. Policies and procedures ensure people are treated fairly with appropriate avenues for grievance and complaint processes.

Mansfield District Hospital is committed to the application of the employment and conduct principles and all employees have been correctly classified in workforce data collections.

Hospitals Labour Category	JUNE Current Month FTE*		JUNE YTD FTE**	
	2016	2017	2016	2017
Nursing	63.29	68.17	62.28	65.85
Administration and Clerical	12.63	13.98	12.77	13.72
Medical Support	0.63	0.84	0.75	0.81
Hotel and Allied Services	36.65	39.39	36.81	37.82
Medical Officers	–	–	–	–
Hospital Medical Officers	0.07	.05	0.08	0.04
Sessional Clinicians	N/A	N/A	N/A	N/A
Ancillary Staff (Allied Health)	5.45	6.9	4.77	5.93
TOTAL	**118.72**	**129.33**	**117.46**	**124.17**

The FTE figures required in the table above are those excluding overtime. These do not include contracted staff (e.g. Agency nurses, Fee-for-Service Visiting Medical Officers) who are not regarded as employees for this purpose. The above data should be consistent with the information provided in the Minimum Employee Data Set.

Occupational Health and Safety

Mansfield District Hospital is a responsible leader in the safety of its patients and clients and importantly also of its staff and contractors. The Service complies with the requirements of the Occupational Health and Safety Act 2004 and the Occupational Health and Safety Regulations 2007.

The Service continues to extend the work of its Occupational Health and Safety Committee and in particular the safe and appropriate Return to Work of its employees following injury or illness. Our Occupational Health and Safety strategies are monitored to guarantee that the effectiveness of our policies and processes maintain the safety of all.

Our leaders demonstrate their commitment to excellence in Occupational Health and Safety Management through provision and maintenance of a safe working environment and active promotion of the wellbeing of our people. A work environment that is safe and healthy enables our people to deliver outstanding services that ensure healthcare excellence for our customers. Mansfield District Hospital does this through its Safe Way of working system that is committed to the maintenance of health, safety and wellbeing focused on:

- Health and Wellbeing promotion;
- Risk Management
- Hazard identification and management;
- Incident reporting, recording, investigation and management;
- Occupational Violence Incidents; and
- Occupational Rehabilitation provision.

Reported Occupational Violence Incidents for the year

Occupational Violence Statistics	2016–2017
WorkCover accepted claims with an occupational violence cause per 100 FTE	0
Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	0
Number of occupational violence incidents reported	11
Number of occupational violence incidents reported per 100 FTE	8.86
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	0

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. Code Grey reporting is not included.
- **Accepted WorkCover claims** – accepted WorkCover claims that were lodged in 2016/17.
- **Lost time** – lost time is defined as greater than one day.

Further education of Code Grey, and occupational violence and aggression reporting has resulted in 11 occupational violence incidents reported at MDH during the year.

Reported OHS Incidents for the year per 100 Full-time Equivalent Staff Members

Year Incidents	Incidents	Incidents per 100 FTE Employees
2016–2017	38	0.30
2015–2016	46	0.39
2014–2015	29	0.2

Continued staff education in the importance of OHS incident reporting is demonstrated by the number of incidents that are reported in our incident management system.

Reported Hazards for the year per 100 Full-time Equivalent Staff Members

Year Hazards	Incidents	Hazards per 100 FTE Employees
2016–2017	6	0.05
2015–2016	35	0.29
2014–2015	22	0.19

Increased vigilance by staff in safety inspections has resulted in a reduced number of hazards being reported in our incident management system.

Lost Time Standard Claims for the year per 100 Full-time Equivalent Staff Members

Year	Lost Time Claims	Lost Time Claims per 100 FTE Employees	Days Lost	Net Costs incurred at 30/03/2017
2016–2017	3	0.02	11	$1,957.74
2015–2016	1	0.01	64	$21,374

A timely and responsive to injury management has realised a reduction in lost time claims and net organisational costs. We will continue to work on decreasing the duration of claims and claim costs, which the Service believes can be achieved by continuing to improve the responsiveness to Health and Safety risk assessments, as well as early incident notification and intervention.

Environmental Performance

Mansfield District Hospital is committed to improving the sustainability of its practices and buildings, including use of native flora in landscaping and installation of sustainability initiatives.

Activities Mansfield District Hospital has undertaken include:

- Installation of water saving shower heads in all bathrooms
- Installation of LED lights across the organisation
- Monitoring of paper usage across the organisation

To continually monitor and improve our environment and sustainability management Mansfield District Hospital is establishing a TAKE2 committee. The TAKE2 Committee's purpose is to assist Mansfield District Hospital to fulfil its objective of taking action against climate change and improving its management of energy, materials and waste and is aligned with Sustainability Victoria. The committee will develop an organisational TAKE2 Action Plan and monitor progress against agreed actions within the plan.

Donor and Contributors

Major Donors

Mansfield American Motorcycle Club	$5,000
Early Model Holden Club of Victoria Inc.	$5150
Marks IGA	$7,739
Margaret Evans	$10,000
Betty Gale	$10,000
Mansfield Golf Club	$10,950
AH & JC Lahore	$13,369
A Third Hand Volunteers Inc.	$15,000
Peter Mackay Bequest	$37,214
Michael Penington	$50,000
Anonymous	$50,000
Estate of the Late Beryl Walsh	$443,676
E.P. O'Brien	$2,453,000
E.P. & M.T. O'Brien Motors Pty. Ltd.	$47,000
Harry and Clare Friday Foundation (Transfer of Bus)	$119,487

Donors contributing more than $100 up to $5,000

Adcock M
Allan A, A &M
Alpine Country Car Club Jamieson
Andrews S&N
Barling J
Bimbi Museum
Bonn Charitable Trust
Bourke D&J
Brega F
Brook HN
Brooklyn Pastoral
Burke I
Burns JM
Calvert –Jones M
Chaston C
Choices Cafe
Corneille T
Cremona E
Chivers L
Crowe J
Cullen J&P
Cullen & Pratt
Curinier A
Curtis E
Davey K
Davies S
Davis R
Delatite Hotel
Egan J&M
Eisner E
Eisner J
Elliot D
Embleton G
Fisher P
Fitzpatrick J
Fitzpatrick M
Foodworks
Fraser M
Friday N
Gale B
Giddons J
Gilder R
Gogol H&R
Hanlon N
Hanrahan P
Hissenkemper & Fenn
Henry M
Hood & Williams
Houghton J&A
Hume D&M
Hutchinson J&S
Hutchinson R
Kerin JL
Kirley Z
Lawson D&J
Lehman P
Lockey K
Lowden D
McAllister J
McCrae R
McLeod E
Madin J&S
Magnus R
Mansfield District Racing Club
Mansfield Golf Club
Mansfield Gold Trade Day
Mansfield T.O.W.N Club
Mansfield Refrigeration
Martins Garage
Martin BJ&MJ
Merchant M
Mitch's Plastering Service
Mt Buller Mt Stirling Resort Management
Muhammad A
Mullins J&H
Neal E
Nizel RH
O'Brien S
Octigan R
Officer R&P
O'Halloran E
O'Keefe D&L
Opal Sale
Openheim D
Ord K
Padbury G
Parsons S&B
Pearce R&M
Pledger P
Pollard J&F
Pollard J
Purcell K
Purcell S&J
Rabson A
Rawson J
Richardson G
Rodwells Mansfield
Rogers E
Ross T&N
Steinlauf S
Steuberwakd H
Stinson B
Swaney A
Taylor W
Tehan T&J
The Pottenger Family
Thomas C
Tolmie Tavern
Trenfield M
Trevaskis B
Tugen, MC
Walsh A&N
Wettenhall A
White S
Willcox B&J
Woods Point Community Assn
Zeidler G

Legislative Compliance

Compliance with Relevant Acts, Regulations & Guidelines

Mansfield District Hospital is committed to complying with Victorian State Government Policy and endeavours to ensure it meets those requirements.

Freedom of Information Act 1982

The organisation is subject to the provisions of the *Freedom of Information Act 1982.*

In the 2016/17 year, 39 applications were made to the organisation under these provisions. All requests were approved and processed.

Applications are to be directed to the Chief Executive Officer. A fee and charges for associated costs may apply in accordance with the Act.

Protected Disclosure Act 2012

Mansfield District Hospital does not tolerate improper conduct by its employees or reprisals being taken against those who disclose such conduct, including under the *Protected Disclosure Act 2012* (Vic). Mansfield District Hospital supports the disclosure of corrupt conduct, conduct involving a substantial mismanagement of public resources or a substantial risk to public health and safety or the environment.

Complaints about certain serious misconduct or corruption involving public health services in Victoria can be made by individuals directly to the Independent Broad-based Anti-corruption Commission (IBAC). Mansfield District Hospital encourages individuals to raise their concerns about corrupt or improper conduct directly with IBAC.

Mansfield District Hospital is committed to extend the protections under the *Protected Disclosure Act 2012* (Vic) to individuals who make protected disclosures under that Act, or who cooperate with investigations into protected disclosures. Websites of interest for complaint procedures regarding this Act are: http://www.ombudsman.vic.gov.au and http://www.health.vic.gov.au/hsc

No disclosures were made in 2016/17.

Disclosures in writing will be received by the Chief Executive Officer or the Ombudsman, Level 22, 459 Collins Street, Melbourne Victoria 3000. Telephone 1800 806 314.

Carers Recognition Act 2012

The organisation recognises and supports its responsibilities and obligations under the Act for people in care relationships and the role of carers in our community. Mansfield District Hospital is actively developing strategies and working with carers to find ways for people in care relationships to have a say in care planning and service delivery complying with all requirements of the act.

Building Act 1993

Mansfield District Hospital has met the requirements of the *Building Act 1993* in accordance with DHS Capital Development Guidelines (Minister for Finance Guideline Building Act 1993/Standards for Publicly Owned Buildings 1994/Building (Interim) Regulations 2005 and Building Code of Australia 2004).

The buildings have been subject to a fire audit by a Fire Service Engineer.

Building permits have been issued and regular maintenance carried out in accordance with the permits and reported annually in our reports.

Victorian Industry Participation Policy disclosures

Mansfield District Hospital is committed to using local approved suppliers wherever possible and maintains an approved suppliers list that is audited on an annual basis. This abides with the principles of the Victorian Industry Participation Policy. There were no contracts undertaken requiring reporting in this category in 2016/17.

Competitive Neutrality

Mansfield District Hospital complies with the National Competitive Policy and requirements of the *Competitive Neutrality Policy Victoria.*

Safe Patient Care Act 2015

Mansfield District Hospital complies with requirements of the *Safe Patient Care Act 2015*.

Consultancies

Consultancies costing more than $10,000 (exc GST) per consultancy
Total Number – Two

Consultant	Purpose of Consultancy	Start Date	End Date	Total Approved Project Fee	Expenditure 2016–2017 (exc GST)	Future Expenditure
Biruu.Health	Clinical Services Plan	Sept 2016	Feb 2017	$31,923.64	$31,923.64	Nil
LEHR Consultancies	Fire Audit	July 2016	Dec 2016	$17,820.00	$17,820.00	Nil

Consultancies costing less than $10,000 (exc GST) per consultancy
Total Number – Four

Total Cost to MDH of $9,785

- AASB Midwifery Model review
- Proactive Complaint Management
- Kate Dawson
- Northeast health – Maintenance review

Information and Communication Technology (ICT) expenditure

The total ICT expenditure incurred during 2016/17 is $638,619 (excluding GST) with the details shown below.

Business As Usual (BAU) ICT expenditure	Non-Business As Usual (non-BAU) expenditure	Operational expenditure (excl. GST)	Capital expenditure (excl. GST)
$638,619	$0	$638,619	$0

Fees

Mansfield District Hospital charges inpatient, Primary Care and Community Care (HACC) fees in accordance with the Victorian Department of Health and Human Services fee directives, and aged care fees in accordance with the directives of the Commonwealth Government's Department of Health.

Car parking fees

Mansfield District Hospital complies with the DHHS hospital circular on car parking fees and details of car parking fees and concession benefits can be viewed at:

https://www2.health.vic.gov.au/about/news-and-events/hospitalcirculars/circ0515

*Mansfield District Hospital does not levy any fees from car parking

Police Record Checks

It is a legislative requirement that all staff and volunteers have a current police record check. No one is employed or accepted as a volunteer at this service without a valid police record check.

Publications

Publications such as the Annual Report, Quality Account, Newsletters, as well as patient information brochures are available from MDH. Additional information and most publications are also available on our website http://mdh.org.au/

Additional Information

The following information, where it relates to the Mansfield District Hospital and is relevant to the financial year 2016/17, is available upon request by relevant Ministers, members of Parliament and the public:

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 Mansfield District Hospital about itself, and how these can be obtained;
d. Details of changes in prices, fees, charges, rates and levies charged by the Mansfield District Hospital;
e. Details of any major external reviews carried out on the Mansfield District Hospital;
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 Mansfield District Hospital to develop community awareness of the Health Service and its services;
i. Details of assessments and measures undertaken to improve the occupational health and safety of employees;
j. General statement on industrial relations within the Health Service and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the Report of Operations;
k. A list of major committees sponsored by Mansfield District Hospital, the purposes of each committee and the extent to which those purposes have been achieved; and
l. Details of all consultancies and contractors including consultants/contractors engaged, services provided, and expenditure committed for each engagement.

Attestation for compliance with the Ministerial Standing Direction 3.7.1– Risk Management Framework and Processes

I, Cameron Butler certify that the *Mansfield District Hospital* has complied with Ministerial Direction 3.7.1 – Risk Management Framework and Processes. The Mansfield District Hospital Audit and Risk Committee has verified this.

Cameron Butler
Accountable Officer
Mansfield District Hospital

23/08/2017

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

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

Cameron Butler
Accountable Officer
Mansfield District Hospital

23/08/2017

Mansfield District Hospital

ABN 65 866 548 895

Financial Report
for year ended 30 June 2017

Board Member's, Accountable Officer's and Chief Finance & Accounting Officer's Declaration

The attached financial statements for Mansfield District Hospital have been prepared in accordance with Standing Direction 5.2 of the Financial Management Act 1994, applicable Financial Reporting Directions, Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements.

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

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

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

Mr P. Officer
Board Chair

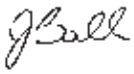
Mansfield

23/08/2017

Mr C. Butler
Chief Executive Officer

Mansfield

23/08/2017



Ms J. Ball
Financial Services
Northeast Health Wangaratta

Mansfield

23/08/2017

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Mansfield District Hospital

Opinion	I have audited the financial report of Mansfield District Hospital (the health service) which comprises the: • balance sheet as at 30 June 2017 • comprehensive operating statement for the year then ended • statement of changes in equity for the year then ended • cash flow statement for the year then ended • notes to the financial statements, including a summary of significant accounting policies • board member's, accountable officers and chief finance & accounting officer's declaration. In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2017 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.
Basis for Opinion	I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. My responsibilities under the Act are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report. My independence is established by the *Constitution Act 1975.* My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Australia. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.
Board's responsibilities for the financial report	The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Financial Management Act 1994*, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error. In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, and using the going concern basis of accounting unless it is inappropriate to do so.

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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
25 August 2017

Ron Mak
as delegate for the Auditor-General of Victoria

Mansfield District Hospital

COMPREHENSIVE OPERATING STATEMENT

for the financial year ended 30 June 2017

	Note	**2017 $**	2016 $
Revenue from Operating Activities	2.1	15,749,264	14,994,031
Revenue from Non-Operating Activities	2.1	649,236	399,094
Employee Expenses	3.1	(11,548,228)	(10,633,009)
Non Salary Labour Costs	3.1	(807,116)	(722,758)
Supplies and Consumables	3.1	(1,098,191)	(1,017,674)
Other Expenses	3.1	(2,716,368)	(2,682,122)
Net result before capital and specific items		228,597	337,562
Capital Purpose Income	2.1	4,129,963	579,329
Depreciation	4.4	(1,464,856)	(1,386,931)
Finance Costs	3.3	(1,806)	(2,770)
Expenditure using Capital Purpose Income	3.1	(69,701)	(66,770)
Other Expenses	3.1	(4,773)	0
Net result after capital and specific items		2,817,424	(539,580)
Other economic flows included in net result			
Revaluation of Long Service Leave	3.1	82,007	0
Total other economic flows included in net result		82,007	0
NET RESULT FOR THE YEAR		2,899,431	(539,580)
Other Comprehensive Income			
Items that will not be reclassified to net result			
Changes in physical asset revaluation surplus	8.1	458,231	0
COMPREHENSIVE RESULT		**3,357,662**	**(539,580)**

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

Mansfield District Hospital

BALANCE SHEET

as at 30 June 2017

	Note	2017 $	2016 $
Current Assets			
Cash and Cash Equivalents	6.2	4,000,711	1,030,482
Receivables	5.1	593,911	476,515
Investments and Other Financial Assets	4.1	13,167,554	11,101,273
Inventories	5.2	87,941	79,032
Other Assets	5.4	258,312	285,570
Total Current Assets		18,108,429	12,972,872
Non-Current Assets			
Receivables	5.1	780,138	593,457
Property, Plant and Equipment	4.3	20,577,677	20,996,821
Total Non-Current Assets		21,357,815	21,590,278
TOTAL ASSETS		39,466,244	34,563,150
Current Liabilities			
Payables	5.5	628,262	674,795
Lease Liabilities	6.1	26,157	31,116
Provisions	3.4	2,845,509	2,630,097
Other Liabilities	5.3	12,235,495	10,866,183
Total Current Liabilities		15,735,423	14,202,191
Non-Current Liabilities			
Lease Liabilities	6.1	29,646	37,338
Provisions	3.4	326,948	307,056
Total Non-Current Liabilities		356,594	344,394
TOTAL LIABILITIES		16,092,017	14,546,585
NET ASSETS		23,374,227	20,016,565
EQUITY			
Property, Plant and Equipment Revaluation Surplus	8.1a	16,703,287	16,245,056
Contributed Capital	8.1b	10,852,525	10,852,525
Accumulated Deficits	8.1c	(4,181,585)	(7,081,016)
TOTAL EQUITY		23,374,227	20,016,565
Commitments	6.3		
Contingent Assets and Contingent Liabilities	7.3		

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

Mansfield District Hospital

STATEMENT OF CHANGES IN EQUITY

for the financial year ended 30 June 2017

	Note	Property, Plant and Equipment Revaluation Surplus $	Contributions by Owners $	Accumulated Surplus/ (Deficits) $	Total $
Balance at 1 July 2015		16,245,056	10,852,525	(6,541,436)	20,556,145
Net result for the year	8.1c	0	0	(539,580)	(539,580)
Balance at 30 June 2016		**16,245,056**	**10,852,525**	**(7,081,016)**	**20,016,565**
Net result for the year	8.1c	0	0	2,899,431	2,899,431
Other comprehensive income for the year	8.1a	458,231	0	0	458,231
Balance at 30 June 2017		**16,703,287**	**10,852,525**	**(4,181,585)**	**23,374,227**

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

Mansfield District Hospital

CASH FLOW STATEMENT

for the financial year ended 30 June 2017

	Note	2017 $	2016 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating grants from government		12,662,998	12,124,524
Patient and resident fees received		1,984,658	1,902,765
Donations and bequests received		3,257,674	246,839
GST received from/(paid to) ATO		(4,374)	33,883
Interest received		651,675	335,066
Other Receipts		1,007,034	438,695
Total Receipts		***19,559,664***	***15,081,772***
Employee expenses paid		(11,225,297)	(10,085,275)
Fee for service medical officers		(807,116)	(708,758)
Payments for supplies and consumables		(1,107,866)	(1,017,674)
Finance costs		(1,806)	(2,770)
Other payments		(2,746,337)	(2,412,341)
Total Payments		***(15,888,422)***	***(14,226,818)***
Cash Generated from Operations		**3,671,243**	**854,954**
Capital grants from government		470,782	165,320
NET CASH FLOW FROM OPERATING ACTIVITIES	8.2	4,142,025	1,020,274
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of non-financial assets		(500,750)	(533,922)
Purchase of investments (term deposits)		(698,941)	0
Proceeds from sale of non-financial assets		40,546	5,909
NET CASH FLOW USED IN INVESTING ACTIVITIES		(1,159,145)	(528,013)
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of finance leases		(12,651)	0
NET CASH FLOW FROM FINANCING ACTIVITIES		(12,651)	0
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		2,970,229	492,261
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		1,030,482	538,221
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.2	4,000,711	1,030,482

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

BASIS OF PRESENTATION

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

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

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

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

Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements made in the preparation of these financial statements are disclosed in the notes where amounts affected by those judgements are disclosed. Estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

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

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

These annual financial statements represent the audited general purpose financial statements for Mansfield District Hospital (ABN 65 866 548 895) for the period ending 30 June 2017. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

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

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

The Health Service is a not-for profit entity and therefore applies the additional AUS paragraphs applicable to "not-for-profit" Health Services under the AAS's.

The annual financial statements were authorised for issue by the Board of Mansfield District Hospital 23 August, 2017.

(b) Reporting Entity

The financial statements includes all the controlled activities of Mansfield District Hospital.

Its principal address is:
53 Highett Street
Mansfield Vic 3722

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

Objectives and funding
Mansfield District Hospital's overall objective is to provide outstanding local care, as well as improve the quality of life to Victorians.

Mansfield District Hospital is predominately funded by accrual based grant funding for the provision of outputs.

(c) Basis of accounting preparation and measurement

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

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

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

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

The financial statements, 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 reassessed when new indices are published by the Valuer General to ensure that the carrying amounts do not materially differ from their fair values; and
- 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.

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

(c) Basis of accounting preparation and measurement (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 AASs that have significant effects on the financial statements and estimates relate to:

- the fair value of land, buildings, plant and equipment (refer to Note 7.1);
- superannuation expense (refer to Note 3.5); and
- 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).

The estimates and underlying assumptions are reviewed on an ongoing basis.

(d) Principles of Consolidation

Intersegment Transactions

Transactions between segments within Mansfield District Hospital have been eliminated to reflect the extent of Mansfield District Hospital's operations as a group.

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 $	EDS 2017 $	Residential Aged Care 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	TOTAL 2017 $
Government Grants	6,738,282	233,381	4,988,229	367,760	376,005	0	12,703,657
Indirect Contributions by Department of Health and Human Services	193,487	0	6,890	766	0	0	201,143
Patient and Resident Fees	323,414	0	1,582,432	87,671	69,642	0	2,063,159
Catering	0	0	0	0	0	72,377	72,377
Property Income	0	0	0	0	0	35,061	35,061
Commercial Activities and Specific Purpose Funds	0	0	0	0	0	137,558	137,558
Hume Rural Health Alliance	0	0	0	0	0	342,644	342,644
Other Revenue from Operating Activities	110,107	1,087	1,222	2,300	18,608	60,341	193,665
Total Revenue from Operating Activities	**7,365,290**	**234,468**	**6,578,773**	**458,497**	**464,255**	**647,981**	**15,749,264**
Interest	17,794	409	628,184	1,840	409	0	648,636
Hume Rural Health Alliance – Non Operating Revenue	0	0	0	0	0	600	600
Total Revenue from Non-Operating Activities	**17,794**	**409**	**628,184**	**1,840**	**409**	**600**	**649,236**
Capital Purpose Income	0	0	0	0	0	3,969,163	3,969,163
Hume Rural Health Alliance – Capital Purpose Income	0	0	0	0	0	160,800	160,800
Total Capital Purpose Income	**0**	**0**	**0**	**0**	**0**	**4,129,963**	**4,129,963**
TOTAL REVENUE	**7,383,084**	**234,877**	**7,206,957**	**460,337**	**464,664**	**4,778,544**	**20,528,463**

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)

	Admitted Patients 2016 $	EDS 2016 $	Residential Aged Care 2016 $	Aged Care 2016 $	Primary Health 2016 $	Other 2016 $	TOTAL 2016 $
Government Grants	6,257,177	221,806	4,915,206	354,782	369,308	0	12,118,279
Indirect Contributions by Department of Health and Human Services	132,712	0	9,747	1,028	0	0	143,487
Patient and Resident Fees	495,869	0	1,420,319	111,444	30,578	0	2,058,210
Catering	0	0	0	0	0	73,742	73,742
Property Income	0	0	0	0	0	25,496	25,496
Commercial Activities and Specific Purpose Funds	0	0	0	0	0	99,311	99,311
Hume Rural Health Alliance	0	0	0	0	0	368,691	368,691
Other Revenue from Operating Activities	29,767	294	163	4,710	8,291	63,590	106,815
Total Revenue from Operating Activities	**6,915,525**	**222,100**	**6,345,435**	**471,964**	**408,177**	**630,830**	**14,994,031**
Interest	16,163	366	379,827	1,608	536	0	398,500
Hume Rural Health Alliance – non operating revenue	0	0	0	0	0	594	594
Total Revenue from Non-Operating Activities	**16,163**	**366**	**379,827**	**1,608**	**536**	**594**	**399,094**
Capital Purpose Income	0	0	0	0	0	540,114	540,114
Hume Rural Health Alliance – Capital Purpose Income	0	0	0	0	0	39,215	39,215
Total Capital Purpose Income	**0**	**0**	**0**	**0**	**0**	**579,329**	**579,329**
TOTAL REVENUE	**6,931,688**	**222,466**	**6,725,262**	**473,572**	**408,713**	**1,210,753**	**15,972,454**

Indirect contributions by Department of Health and Human Services.

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)

INCOME FROM TRANSACTIONS

Income is recognised in accordance with AASB 118 Revenue and is recognised as to the extent that it is probable that the economic benefits will flow to Mansfield District Hospital 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.

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.

Patient and Resident Fees
Patient and resident fees are recognised as revenue at the time invoices are raised.

Revenue from commercial activities
Revenue from commercial activities such as provision of meals to external users is recognised at the time the 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 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 or liabilities and bad debt reversals.

CATEGORY GROUPS

The Mansfield District Hospital 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.

Emergency Department Services (EDS) 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 (CCUs) and secure extended care units (SECs).

Other Services excluded from Australian Health Care Agreement (AHCA) (Other) comprises services not separately classified above, including: Public Health Services including laboratory testing, blood borne viruses / sexually transmitted infections clinical services Kooris liaison officers, immunisation and screening services, drugs services including drug withdrawal, counselling and the needle and syringe program, 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

	2017 $	2016 $
During the reporting period, the fair value of assets received free of charge, was as follows:		
– Motor Vehicle – Bus	119,487	0
Total	119,487	0

Source of asset received:
Donated by the Harry & Clare Friday Foundation, Charitable Trust, Mansfield VIC

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

NOTE 3: THE COST OF DELIVERY 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 EXPENSE BY SOURCE

	Admitted Patients 2017 $	EDS 2017 $	Residential Aged Care 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	TOTAL 2017 $
Employee Expenses	4,548,858	130,698	5,548,547	555,532	532,514	232,079	11,548,228
Non Salary Labour Costs	754,254	51,106	1,603	115	38	0	807,116
Supplies and Consumables	440,292	34,711	464,469	19,687	21,705	117,327	1,098,191
Other Expenses	1,637,153	19,027	719,111	54,863	55,484	230,730	2,716,368
Total Expenditure from Operating Activities	**7,380,557**	**235,542**	**6,733,730**	**630,197**	**609,741**	**580,136**	**16,169,903**
Employee Expenses (LSL Bond Rate Movement)	(31,136)	(14,605)	(11,848)	(6,353)	(7,306)	(10,759)	(82,007)
Expenditure Using Capital Purpose Income	0	0	0	0	0	69,701	69,701
Finance Leases	0	0	0	0	0	1,806	1,806
Depreciation (refer note 4.4)	0	0	0	0	0	1,464,856	1,464,856
Other Expenses	0	0	0	0	0	4,773	4,773
Total Other Expenses	**(31,136)**	**(14,605)**	**(11,848)**	**(6,353)**	**(7,306)**	**1,530,377**	**1,459,129**
TOTAL EXPENSES	**7,349,421**	**220,937**	**6,721,882**	**623,844**	**602,435**	**2,110,513**	**17,629,032**

	Admitted Patients 2016 $	EDS 2016 $	Residential Aged Care 2016 $	Aged Care 2016 $	Primary Health 2016 $	Other 2016 $	TOTAL 2016 $
Employee Expenses	4,292,609	67,926	5,086,443	526,523	452,294	207,213	10,633,009
Non Salary Labour Costs	675,421	45,765	1,435	103	34	0	722,758
Supplies and Consumables	413,398	29,205	426,749	12,654	18,174	117,494	1,017,674
Other Expenses	1,616,514	18,787	710,045	54,171	54,784	227,821	2,682,122
Total Expenditure from Operating Activities	**6,997,943**	**161,683**	**6,224,672**	**593,451**	**525,286**	**552,528**	**15,055,563**
Expenditure Using Capital Purpose Income	0	0	0	0	0	66,770	66,770
Finance Leases	0	0	0	0	0	2,770	2,770
Depreciation (refer note 4.4)	0	0	0	0	0	1,386,931	1,386,931
Total Other Expenses	**0**	**0**	**0**	**0**	**0**	**1,456,471**	**1,456,471**
TOTAL EXPENSES	**6,997,943**	**161,683**	**6,224,672**	**593,451**	**525,286**	**2,008,999**	**16,512,034**

NOTE 3.1: ANALYSIS OF EXPENSE BY SOURCE (Continued)

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

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

Employee expenses
Employee expenses include:
- wages and salaries;
- leave entitlements;
- fringe benefits tax;
- workcover premiums;
- terminations payments; 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 transfers to third parties (other than contribution to owners) are recognised as an expense in the reporting period in which they are paid or payable. They include transactions such as: grants, subsidies and personal benefit payments made in cash to individuals.

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

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

Bad and doubtful debts
Refer to note 4.1 *Investments and other financial assets*.

Other economic flows are changes in the 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 gain / (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 proceeds and the carrying value of the asset at the time.

Impairment of non-financial assets
Goodwill and intangible assets with indefinite useful lives (and intangible assets not available for use) are tested annually for impairment and whenever there is an indication that the asset may be impaired. Refer to Note 4.1 Investments and other financial assets.

Other gains / (losses) from other comprehensive income
Other gains / (losses) include:
- the revaluation of the present value of the long service leave liability due to changes in the bond rate movements, inflation rate movements and the impact of changes in probability factors; and
- transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

NOTE 3.2: ANALYSIS OF EXPENSE AND REVENUE BY INTERNALLY MANAGED AND RESTRICTED SPECIFIC PURPOSE FUNDS

	2017 $	2016 $	**2017 $**	2016 $
	Expense		**Revenue**	
Commercial Activities				
Diagnostic Imaging	83,121	93,243	98,114	105,471
Catering Services	36,212	35,157	72,377	73,742
Fundraising & Other	16,006	15,540	39,444	38,295
TOTAL	135,339	143,940	209,935	217,508

NOTE 3.3: FINANCE COSTS

	2017 $	2016 $
Finance Charges on Finance Leases (HRHA)	1,806	2,770
TOTAL FINANCE COSTS	1,806	2,770

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

NOTE 3.4: EMPLOYEE BENEFITS IN THE BALANCE SHEET

	2017 $	2016 $
Current Provisions		
Employee Benefits (i)		
Annual Leave		
– unconditional and expected to be settled within 12 months (ii)	898,333	782,406
– unconditional and expected to be settled after 12 months (ii)	204,335	172,913
Long Service Leave (Note 3.4(a))		
–unconditional and expected to be settled within 12 months (ii)	239,860	190,952
– unconditional and expected to be settled after 12 months (ii)	1,050,576	1,007,791
Accrued Wages & ADO		
– unconditional and expected to be settled within 12 months (ii)	168,480	239,954
– unconditional and expected to be settled after 12 months (ii)	0	0
Provisions related to employee benefit on-costs		
– unconditional and expected to be settled within 12 months (ii)	114,427	87,630
– unconditional and expected to be settled after 12 months (ii)	169,498	148,449
Total Current Provisions	2,845,509	2,630,095
Non-Current Provisions		
Employee Benefits (i)	293,599	272,172
Provisions related to employee benefit on-costs	33,349	34,886
Total Non-Current Provisions	326,948	307,058
Total Provisions	3,172,457	2,937,153
(a) Employee Benefits and Related On-costs		
Current Employee Benefits and related on-costs		
Annual Leave Entitlements	1,226,167	1,062,317
Accrued Salaries and Wages	160,783	225,694
Accrued Days Off	21,510	14,260
Unconditional Long Service Leave Entitlements	1,437,049	1,327,826
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements (ii)	326,948	307,056
Total Employee Benefits and Related On-Costs	3,172,457	2,937,153
(b) Movements in provisions		
Movement in Long Service Leave:		
Balance at start of year	1,634,882	1,420,922
Provision made during the year		
– Revaluations	(82,007)	0
– Expense Recognising Employee Service	381,604	436,778
– Settlement made during the year	(252,568)	(222,818)
Balance at end of year	1,763,997	1,634,882

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

NOTE 3.4: EMPLOYEE BENEFITS IN THE BALANCE SHEET (Continued)

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

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

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

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

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

Depending on the expectation of the timing of settlement, liabilities for wages and salaries, annual leave and sick leave are measured at:
- *Undiscounted value* – if the health service expects to wholly settle within 12 months; or
- *Present value* – if the health service does not expect to wholly settle within 12 months.

Long Service Leave (LSL)
Liability for 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 following 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 an 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. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

On-costs related to employee expense
Provisions for on-costs, such as workers compensation and superannuation are recognised separately from the provision for employee benefits.

NOTE 3.5: SUPERANNUATION

		Paid Contributions for the Year	
Fund		**2017 $**	2016 $
Defined Benefit Plans:	Health Super	10,157	7,183
Defined Contribution Plans:	Health Super	508,158	494,914
	HESTA	405,179	341,200
Total		923,494	843,297

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

The Health Service does not recognise any defined benefit liability in respect of the plan(s) because the entity has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due. The Department of Treasury and Finance discloses the State's defined benefits liabilities in this 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 disclosed in the table above.

There are no superannuation contributions outstanding at 30 June 2017 (2016: Nil).

Defined contribution superannuation plans
In relation to defined contributions (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.

Superannuation Liabilities
The Mansfield District Hospital 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 Jointly controlled operations and assets
4.3 Property, plant & equipment
4.4 Depreciation and amortisation

NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS

	Operating Fund		Total	
	2017 $	2016 $	**2017 $**	2016 $
CURRENT				
Loans and Receivables				
Term Deposits				
Aust. Dollar Term deposits > 3 months (i)	13,167,554	10,985,039	13,167,554	10,985,039
Available for Sale Financial Assets				
Income Securities	0	116,234	0	116,234
TOTAL CURRENT	13,167,554	11,101,273	13,167,554	11,101,273
Represented by:				
Health Service Investments	932,227	235,413	932,227	235,413
Monies Held in Trust – Accommodation Bonds (Refundable Accommodation Deposits) (Note 5.3)	12,235,327	10,865,860	12,235,327	10,865,860
TOTAL	13,167,554	11,101,273	13,167,554	11,101,273

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

(a) Ageing analysis of other financial assets
Please refer to note 7.1 for the ageing analysis of other financial assets.

(b) Nature and extent of risk arising from other financial assets
Please refer to note 7.1 for the nature and extent of credit risk arising from other financial assets.

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

Investments are classified in the following categories:
– loans and receivables; and
– available-for-sale financial assets.

The Mansfield District Hospital 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.

Mansfield District Hospital 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 and loss are subject to annual review for impairment.

NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS (Continued)

Derecognition of financial assets
A financial asset (or, where applicable, a part of a financial asset or part of a group of similar financial assets) is derecognised when:
– the rights to receive cash flows from the asset have expired; or
– the Health Service retains the right to receive cash flows from the asset, but has assumed an obligation to pay them in full without material delay to a third party under a 'pass through' arrangement; or
– the Health Service has transferred its rights to receive cash flows from the asset and either:
  (a) has transferred substantially all the risks and rewards of the asset; or
  (b) has neither transferred nor retained substantially all the risks and rewards of the asset, but has transferred control of the asset.

Where the Health Service has neither transferred 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 Mansfield District Hospital assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. All financial instrument assets, except those measured at fair value through profit and loss, are subject to annual review for impairment.

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

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

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: JOINTLY CONTROLLED OPERATIONS AND ASSETS

Name of Entity	Principal Activity	Ownership Interest	
		2017 %	2016 %
Hume Rural Health Alliance	Information Systems	4.02	4.13

Mansfield District Hospital'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 categories:

	2017 $	2016 $
Current Assets		
Cash and Cash Equivalents	145,562	78,847
Receivables	104,829	38,909
Other	5,516	3,092
Total Current Assets	255,907	120,848
Non Current Assets		
Property Plant and Equipment	120,340	105,358
Total Non Current Assets	120,340	105,358
Total Assets	376,247	226,206
Current Liabilities		
Payables	19,826	23,514
Lease Liability	26,157	31,116
Total Current Liabilities	45,983	54,630
Non Current Liabilities		
Lease Liability	29,646	37,338
Total Non Current Liabilities	29,646	37,338
Total Liabilities	75,629	91,968
Net Assets	300,618	134,238
Equity		
Accumulated Surplus/(Deficit)	300,618	134,238
Total Equity	300,618	134,238

Mansfield District Hospital's interest in revenues and expenses resulting from jointly controlled operations and assets is detailed below:

	2017 $	2016 $
Revenues		
Operating Activities	217,815	221,613
Member Contributions	124,829	147,078
Non-Operating Activities	600	594
Capital Purpose Income	160,800	39,215
Total Revenue	504,044	408,500
Expenses		
Employee Benefits	68,525	78,233
Information Technology and Administrative Expenses	233,428	255,545
Depreciation and Amortisation	35,998	36,637
Finance Charges	1,806	2,770
Total Expenses	339,757	373,185
Net Result	164,287	35,315

Contingent Liabilities and Capital Commitments
There are no known contingent assets or liabilities for Hume Rural Health Alliance as at the date of this report.

NOTE 4.2: JOINTLY CONTROLLED OPERATIONS AND ASSETS (Continued)

AASB 11 Joint Arrangements
In accordance with AASB 11, there are two types of joint arrangements, i.e. joint operations and joint ventures. Joint operations arise where the investors have rights to the assets and obligations for the liabilities of an arrangement. A joint operator accounts for its share of the assets, liabilities, revenue and expenses. Joint ventures arise where the investors have rights to the net assets of the arrangement; joint ventures are accounted for under the equity method. Proportionate consolidation of joint ventures is no longer permitted.

Mansfield District Hospital has reviewed its existing contractual arrangements with other entities to ensure they are aligned with the new classifications under AASB 11.

On the basis of that review, Mansfield District Hospital has determined it's joint venture arrangements with the Hume Region Health Alliance should be accounted for as a joint operation.

Investments in joint operations
In respect of any interest in joint operations, Mansfield District Hospital 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 AND EQUIPMENT

(a) Gross carrying amount and accumulated depreciation

	2017 $	2016 $
Land		
Land at Fair Value	2,399,231	1,941,000
Total Land	2,399,231	1,941,000
Landscaping Improvements at Fair Value	361,629	366,344
Less Accumulated Depreciation	(49,607)	(34,474)
	312,022	331,870
Buildings		
Buildings Under Construction at cost	1,772	1,644,763
	1,772	1,644,763
Buildings at Fair Value	19,128,721	17,392,000
Less Accumulated Depreciation	(2,994,716)	(1,939,634)
	16,134,005	15,452,366
Total Buildings	16,447,799	17,428,999
Plant and Equipment		
Plant and Equipment – Hume Rural Health Alliance	120,340	105,358
Plant and Equipment at Fair Value	2,154,422	2,218,976
Less Accumulated Depreciation	(1,565,242)	(1,579,902)
Total Plant and Equipment	709,520	744,432
Medical Equipment		
Medical Equipment at Fair Value	1,851,519	1,762,856
Less Accumulated Depreciation	(1,249,271)	(1,152,647)
Total Medical Equipment	602,248	610,209
Computers and Communication		
Computers and Communication at Fair Value	6,279	3,468
Less Accumulated depreciation	(2,316)	(1,024)
Total Computers and Communication	3,963	2,444
Furniture and Fittings		
Furniture and Fittings at Fair Value	476,674	394,153
Less Accumulated depreciation	(304,977)	(277,786)
Total Furniture and Fittings	171,697	116,367
Motor Vehicles		
Motor Vehicles at Fair Value	412,905	291,871
Less Accumulated Depreciation	(169,686)	(138,501)
Total Motor Vehicles	243,219	153,370
TOTAL	20,577,677	20,996,821

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

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

	Land	Land Improvements	Buildings under construction	Buildings	Plant and Equipment	Medical Equipment	Computers & Commun.	Furniture & Fittings	Motor Vehicles	Total
	$	$	$	$	$	$	$	$	$	$
Balance at 1 July 2015	**1,941,000**	**349,117**	**1,418,468**	**16,437,871**	**762,953**	**635,353**	**3,332**	**92,330**	**209,406**	**21,849,830**
Additions	0	0	226,295	0	22,119	121,645	1,967	49,565	6,973	428,564
Hume Rural Health Alliance Assets	0	0	0	0	105,358	0	0	0	0	105,358
Revaluation Increments	0	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
Depreciation (note 4)	0	(17,247)	0	(985,505)	(145,998)	(146,789)	(2,855)	(25,528)	(63,009)	(1,386,931)
Balance at 30 June 2016	**1,941,000**	**331,870**	**1,644,763**	**15,452,366**	**744,432**	**610,209**	**2,444**	**116,367**	**153,370**	**20,996,821**
Additions	0	1,785	93,729	0	81,934	122,201	2,811	82,521	65,225	450,206
Hume Rural Health Alliance Assets	0	0	0	0	50,544	0	0	0	0	50,544
Contributions	0	0	0	0	0	0	0	0	119,487	119,487
Revaluation Increments	458,231	0	0	0	0	0	0	0	0	458,231
Disposals	0	(4,338)	0	0	0	0	0	0	(28,418)	(32,756)
Net Transfers between Classes	0	0	(1,736,720)	1,736,720	0	0	0	0	0	0
Depreciation (note 4)	0	(17,295)	0	(1,055,081)	(167,390)	(130,162)	(1,292)	(27,191)	(66,445)	(1,464,856)
Balance at 30 June 2017	**2,399,231**	**312,022**	**1,772**	**16,134,005**	**709,520**	**602,248**	**3,963**	**171,697**	**243,219**	**20,577,677**

Land and buildings carried at valuation

An independent valuation of the Health Service's property, plant and equipment was performed by the Valuer-General Victoria to determine the 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.

A managerial revaluation of land was performed as at 30 June 2017 in accordance with FRD103F.

NOTE 4.3: PROPERTY, PLANT AND 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(i)	Level 2(i)	Level 3(i)
Land at fair value				
Specialised land	2,399,231	0	0	2,399,231
Total land at fair value	2,399,231	0	0	2,399,231
Land Improvements				
Land improvements	312,022	0	0	312,022
Total land improvements at fair value	312,022	0	0	312,022
Assets under construction at fair value				
Buildings under Construction	1,772	0	0	1,772
Total assets under construction at fair value	1,772	0	0	1,772
Buildings at fair value				
Specialised buildings	16,134,005	0	0	16,134,005
Total building at fair value	16,134,005	0	0	16,134,005
Plant and equipment at fair value				
Plant and equipment at fair value	709,520	0	0	709,520
Total Plant and equipment at fair value	709,520	0	0	709,520
Medical equipment at fair value				
Medical Equipment at fair value	602,248	0	0	602,248
Total medical equipment at fair value	602,248	0	0	602,248
Computers & Communication				
Computers and Communication at fair value	3,963	0	0	3,963
Total Computers and Communication at fair value	3,963	0	0	3,963
Furniture & Fittings				
Furniture & Fittings at fair value	171,697	0	0	171,697
Total Furniture & Fittings at fair value	171,697	0	0	171,697
Motor Vehicles				
Motor Vehicles at fair value	243,219	0	243,219	0
Total Motor Vehicles at fair value	243,219	0	243,219	0
	20,577,677	0	243,219	20,334,458

Note:
(i) Classified in accordance with the fair value hierarchy.
There have been no transfers between levels during the period.

NOTE 4.3: PROPERTY, PLANT AND 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(i)	Level 2(i)	Level 3(i)
Land at fair value				
Specialised land	1,941,000	0	0	1,941,000
Total of land at fair value	1,941,000	0	0	1,941,000
Land Improvements				
Specialised buildings	331,870	0	0	331,870
Total of building at fair value	331,870	0	0	331,870
Assets under construction at fair value				
Buildings under Construction	1,644,763	0	0	1,644,763
Total assets under construction at fair value	1,644,763	0	0	1,644,763
Buildings at fair value				
Specialised buildings	15,452,366	0	0	15,452,366
Total of building at fair value	15,452,366	0	0	15,452,366
Plant and equipment at fair value				
Plant and equipment at fair value	744,432	0	0	744,432
Total Plant and equipment at fair value	744,432	0	0	744,432
Medical equipment at fair value				
Medical Equipment at fair value	610,209	0	0	610,209
Total medical equipment at fair value	610,209	0	0	610,209
Computers & Communication				
Computers and Communication at fair value	2,444	0	0	2,444
Total Computers and Communication at fair value	2,444	0	0	2,444
Furniture & Fittings				
Furniture & Fittings at fair value	116,367	0	0	116,367
Total Furniture & Fittings at fair value	116,367	0	0	116,367
Motor Vehicles				
Motor Vehicles at fair value	153,370	0	153,370	0
Total Motor Vehicles at fair value	153,370	0	153,370	0
	20,996,821	0	153,370	20,843,451

Note:
(i) Classified in accordance with the fair value hierarchy.
There have been no transfers between levels during the period.

Consistent with AASB 13 Fair Value Measurement, Mansfield District Hospital 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, Mansfield District Hospital has determined classes of assets and liabilities on the basis of the nature, characteristics and risks of the asset or liability and the level of the fair value hierarchy as explained above.

In addition, Mansfield District Hospital 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 Mansfield District Hospital's independent valuation agency.

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

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

(d) Reconciliation of Level 3 fair value as at 30 June 2017

	Land	Land Improvements	Buildings under construction	Buildings	Plant and Equipment	Medical Equipment	Computers & Commun.	Furniture & Fittings
	$	$	$	$	$	$	$	$
Opening Balance	1,941,000	331,870	1,644,763	15,452,366	744,432	610,209	2,444	116,367
Purchases, Sales & Reclassifications	0	(2,553)	93,729	0	132,478	122,201	2,811	82,521
Transfers between classes	0		(1,736,720)	1,736,720	0	0	0	0
Gains or losses recognised in net result – Depreciation	0	(17,295)	0	(1,055,081)	(167,390)	(130,162)	(1,292)	(27,191)
Subtotal	1,941,000	312,022	1,772	16,134,005	709,520	602,248	3,963	171,697
Items recognised in other comprehensive income – Revaluation	458,231	0	0	0	0	0	0	0
Subtotal	458,231	0	0	0	0	0	0	0
Closing Balance	2,399,231	312,022	1,772	16,134,005	709,520	602,248	3,963	171,697

There have been no transfers between levels during the period.

Reconciliation of Level 3 fair value as at 30 June 2016

	Land	Land Improvements	Buildings under construction	Buildings	Plant and Equipment	Medical Equipment	Computers & Commun.	Furniture & Fittings
	$	$	$	$	$	$	$	$
Opening Balance	1,941,000	349,117	1,418,468	16,437,871	762,953	635,353	3,332	92,330
Purchases, Sales & Reclassifications	0	0	226,295	0	127,477	121,645	1,967	49,565
Gains or losses recognised in net result – Depreciation	0	(17,247)	0	(985,505)	(145,998)	(146,789)	(2,855)	(25,528)
Subtotal	1,941,000	331,870	1,644,763	15,452,366	744,432	610,209	2,444	116,367
Items recognised in other comprehensive income – Revaluation	0	0	0	0	0	0	0	0
Subtotal	0	0	0	0	0	0	0	0
Closing Balance	1,941,000	331,870	1,644,763	15,452,366	744,432	610,209	2,444	116,367

There have been no transfers between levels during the period.

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.

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

(d) Reconciliation of Level 3 fair value as at 30 June 2017 (Continued)

Specialised land and specialised buildings

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

The CSO adjustment is a reflection of the valuer's assessment of the impact of restrictions associated with an asset to the extent that is also equally applicable to market participants. This approach is in light of the highest and best use consideration required for fair value measurement, and takes into account the use of the asset that is physically possible, legally permissible and financially feasible.

As adjustments of CSO are considered as significant unobservable inputs, specialised land would be classified as Level 3 assets.

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

An independent valuation of the 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. A managerial revaluation was performed in 2016-17 in accordance with FRD103F.

Vehicles

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

Plant and equipment

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

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

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

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

	Valuation technique (i)	**Significant unobservable inputs** (i)
Specialised land	Market Approach	Community Service Obligation (CSO)
Specialised buildings	Depreciated Replacement Cost	Direct cost per square metre Useful life of specialised buildings
Plant and equipment at fair value	Depreciated Replacement Cost	Cost per Unit Useful life of PPE
Computers and Furniture	Depreciated Replacement Cost	Cost per Unit Useful life of computers and furniture
Medical equipment at fair value	Depreciated Replacement Cost	Cost per Unit Useful life of medical equipment
Assets Under Construction	Depreciated Replacement Cost	Cost per Unit

(i) The significant unobservable inputs have remained unchanged from 2016.

Refer to Note 7.1 for fair value measurement indicative expectations.

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

(e) Description of significant unobservable inputs to Level 3 valuations (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 impairment. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. Assets transferred as part of a merger / machinery of government are transferred at their carrying amount.

Finance leases are recognised as assets and liabilities at amounts equal to the fair value of the lease property or, if lower, the present value of the minimum lease payment, each determined at the inception of the lease. The lease asset is accounted for as a non-financial physical asset and is depreciated over the shorter of the estimated useful life of the asset or the term of the lease. If there is certainty that the health service will obtain the ownership of the lease asset by the end of the lease term, the asset shall be depreciated over the useful life of the asset. If there is no reasonable certainty that the lessee will obtain ownership by the end of the lease term, the asset shall be fully depreciated over the shorter of the lease term and its useful life. Minimum lease payments are apportioned between reduction of the outstanding lease liability, and the periodic finance expense which is calculated using the interest rate implicit in the lease, and charged directly to the comprehensive operating statement.

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 restriction 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 impairment. Depreciated historical cost is generally a reasonable proxy for depreciated replacement cost because of the short lives of the assets concerned.

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

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 value and fair value.

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

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

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

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

In accordance with FRD 103F Mansfield District Hospital's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required. A managerial revaluation of land was required and performed for financial year ending 30 June 2017.

NOTE 4.4: DEPRECIATION

	2017 $	2016 $
Depreciation		
Buildings	1,055,081	985,505
Land Improvements	17,295	17,247
Plant and Equipment		
– Plant	131,392	109,361
– Motor Vehicles	66,445	63,009
Computers and Communication	1,292	2,855
Medical Equipment	130,162	146,789
Furniture and Fittings	27,191	25,528
Hume Rural Health Alliance	35,998	36,637
TOTAL DEPRECIATION	1,464,856	1,386,931

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

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

Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health and Human Services.

Assets with a cost in excess of $1,000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

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

	2017	2016
Buildings		
– Structure Shell Building Fabric	10 to 40 years	10 to 40 years
– Landscaping	10 to 40 years	10 to 40 years
– Site Engineering Services and Central Plant	10 to 40 years	10 to 40 years
Central Plant		
– Fit Out	10 to 40 years	10 to 40 years
– Trunk Reticulated Building Systems	10 to 40 years	10 to 40 years
Plant and Equipment	3 to 20 years	3 to 20 years
Medical Equipment	3 to 20 years	3 to 20 years
Computers and Communication	3 to 4 years	3 to 4 years
Furniture and Fittings	5 to 10 years	5 to 10 years
Motor Vehicles	4 to 10 years	4 to 10 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 $	2016 $
CURRENT		
Contractual		
Trade Debtors	82,985	109,389
Patient and resident Fees	168,889	146,773
Accrued Investment Income	83,467	63,434
Accrued Revenue – Other	11,913	8,672
Hume Rural Health Alliance – Other Receivables	110,345	42,001
Less Allowance for Doubtful Debts		
Patient and resident Fees	(21,722)	0
	435,877	370,269
Statutory		
GST Receivable	63,534	54,106
Accrued Revenue – Department of Health and Human Services	94,500	52,140
	158,034	106,246
TOTAL CURRENT RECEIVABLES	593,911	476,515
NON CURRENT		
Statutory		
Long Service Leave – Department of Health and Human Services	780,138	593,457
TOTAL NON-CURRENT RECEIVABLES	780,138	593,457
TOTAL RECEIVABLES	1,374,049	1,069,972

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

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

Receivables consist of:
– contractual receivables, which includes of mainly debtors in relation to goods and services and accrued investment income; 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 rate 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 an impairment loss has occurred. Bad debts are written off when identified.

NOTE 5.2: INVENTORIES

	2017 $	2016 $
Pharmaceuticals – at cost	43,799	40,887
Housekeeping Supplies – at cost	9,714	10,310
Medical and Surgical Lines – at cost	30,907	24,470
Administration Stores – at cost	3,521	3,365
TOTAL INVENTORIES	87,941	79,032

Inventories held by the Health Service are held for short periods of time with regular turnover. There is no material loss of service potential in inventories held at the end of the year.

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. Inventories are measured at the lower of cost and net realisable value.

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

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

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

NOTE 5.3: OTHER LIABILITIES

	2017 $	2016 $
CURRENT		
Monies Held in Trust*		
– Simplified Billing Trust Account	168	323
– Accommodation Bonds (Refundable Entrance Fees)	12,235,327	10,865,860
TOTAL CURRENT	12,235,495	10,866,183
*** Total Monies Held in Trust**		
Represented by the following assets:		
Cash and cash equivalents (refer to Note 6.2)	168	323
Investments and other Financial Assets (refer to Note 4.1)	12,235,327	10,865,860
TOTAL	12,235,495	10,866,183

NOTE 5.4: PREPAYMENTS AND OTHER ASSETS

	2017 $	2016 $
Prepayments	252,796	282,478
Hume Rural Health Alliance Prepayments	5,516	3,092
TOTAL OTHER CURRENT ASSETS	258,312	285,570

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

NOTE 5.5: PAYABLES

	2017 $	2016 $
CURRENT		
Contractual		
Trade Creditors	410,467	461,500
Accrued Audit Fees	23,500	23,400
Hume Rural Health Alliance Payables	19,826	23,514
Income in Advance	45,000	0
Other	101,222	88,666
	600,015	597,080
Statutory		
GST Payable	7,600	2,546
Department of Health and Human Services	0	0
Department of Health & Ageing – Commonwealth	20,648	75,168
	28,247	77,714
TOTAL	628,262	674,794

(i) The average credit period is 30 days.

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

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

Payables consist of:

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

NOTE 6.1: LEASE LIABILITIES

	2017 $	2016 $
CURRENT		
Australian Dollar Lease Liabilities		
– Hume Rural Health Alliance Finance Lease Liability (i)	26,157	31,116
Total Current	26,157	31,116
NON CURRENT		
Australian Dollar Lease Liabilities		
– Finance Lease Liability (i)	29,646	37,338
Total Non Current	29,646	37,338
Total Lease Liabilities	55,803	68,454

(i) Secured by the assets leased. Finance leases are effectively secured as the rights to the leased assets revert to the lessor in the event of default.

Amount of finance costs recognised as expenses:	1,806	2,770

(a) Maturity analysis of lease liabilities
Please refer to note 7.1 for the ageing analysis of lease liabilities.

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

(c) Defaults and breaches
During the current and prior year, there were no defaults and breaches of any of the lease liabilities.

(d) Finance lease liabilities
HRHA lease liabilities

	Minimum future lease payments (i)		**Present value of minimum future lease payments**	
	2017 $	2016 $	**2017 $**	2016 $
HRHA finance lease liabiliities payable (ii)				
Not longer than one year	27,536	33,339	26,157	31,116
Longer than one year but not longer than five years	31,060	39,719	29,646	37,338
Longer than five years	0	0	0	0
Minimum future lease payments	58,596	73,058	55,803	68,454
Less future finance charges	(2,793)	(4,604)	0	0
Present value of minimum lease payments	55,803	68,454	55,803	68,454

(i) Minimum future lease payments include the aggregate of all base payments and any guaranteed residual.

(ii) HRHA finance lease liabilities include obligations that are recognised on the balance sheet; the future payments related to operating and lease commitments are dislosed in Note 6.3.

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: LEASE LIABILITIES (Continued)

(d) Finance lease liabilities (Continued)

Finance leases
Entity as lessee
Finance leases are recognised as assets and liabilities at amounts equal to the fair value of the lease property or, if lower, the present value of the minimum lease payment, each determined at the inception of the lease. The lease asset is accounted for as a non-financial physical asset and is depreciated over the shorter of the estimated useful life of the asset or the term of the lease. If there is certainty that the health service will obtain the ownership of the lease asset by the end of the lease term, the asset shall be depreciated over the useful life of the asset. If there is no reasonable certainty that the lessee will obtain ownership by the end of the lease term, the asset shall be fully depreciated over the shorter of the lease term and its useful life.

Minimum lease payments are apportioned between reduction of the outstanding lease liability, and the periodic finance expense which is calculated using the interest rate implicit in the lease, and charged directly to the comprehensive operating statement. Contingent rentals associated with finance leases are recognised as an expense in the period in which they are incurred.

Finance leases are regarded as a financial accommodation and under Section 30 of the Health Services Act 1988, the Minister for Health and the Treasurer must declare a funded agency to be an approved borrower for the purposes of this section.

Mansfield District Hospital Service has received such approval prior to 30 June 2016, in a joint letter for all Health Services impacted by finance leases either directly or via a Jointly Controlled entity. The specific values approved for Mansfield District Hospital total $249,133.

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

All incentives for the agreement of a new or renewed operating lease are recognised as an integral part of the net consideration agreed for the use of the leased asset, irrespective of the incentive's nature or form or the timing of payments.

In the event that lease incentives are given to the lessee, the aggregate cost of incentives are recognised as a reduction of rental income over the lease term, on a straight-line basis unless another systematic basis is more appropriate of the time pattern over which the economic benefit of the leased asset is diminished.

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.

NOTE 6.2: CASH AND CASH EQUIVALENTS

	2017 $	2016 $
Cash on Hand	500	700
Cash at Bank	4,000,211	1,029,782
TOTAL	4,000,711	1,030,482
Represented by:		
Cash for Health Service Operations	3,854,981	951,312
Share of Cash Held at Hume Rural Health Alliance	145,562	78,847
Cash for Monies Held in Trust (Note 5.3)		
– Cash at Bank	168	323
TOTAL CASH AND CASH EQUIVALENTS	4,000,711	1,030,482

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

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

NOTE 6.3: COMMITMENTS

	2017 $	2016 $
Capital expenditure commitments		
Payable		
Land & Buildings	0	0
Total capital expenditure commitments	0	0
Lease Commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating Leases	79,387	108,255
Finance Leases	55,803	68,454
Total Lease Commitments	135,190	176,709
Operating Leases		
Commitments in relation to operating leases exist for a range of equipment including photocopiers, computers and theatre equipment and are payable as follows:		
Non-Cancellable		
Not later than one year	28,868	28,868
Later than 1 and not later than 5 years	50,519	79,387
Total Operating Lease Commitments	79,387	108,255
Finance Leases		
Commitments in relation to finance leases are payable as follows:		
Non-Cancellable		
Not later than one year	33,339	25,823
Later than 1 and not later than 5 years	22,464	42,631
Total Finance Lease Commitments	55,803	68,454
Total Lease Commitments	135,190	176,709

Commitments

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 goods and services tax ("GST") payable. In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant individual projects are stated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

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

The Mansfield District Hospital's principal financial instruments comprise of:
– Cash Assets
– Term Deposits
– Receivables (excluding statutory receivables)
– Payables (excluding statutory payables)
– Finance Lease Payables
– Accommodations Bonds

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 financial risk management committee of the Health Service.

The main purpose in holding financial instruments is to prudentially manage Mansfield District Hospitals financial risk within the government policy parameters.

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(a) Financial Risk Management Objectives and Policies (Continued)

Categorisation of financial instruments	Contractual financial assets – loans and receivables $	Contractual financial assets – available for sale $	Contractual financial liabilities at amortised cost $	Total $
2017				
Contractual Financial Assets				
Cash and cash equivalents	4,000,711	0	0	4,000,711
Receivables				
– Trade Debtors	251,874	0	0	251,874
– Other Receivables	205,725	0	0	205,725
Other Financial Assets				
– Term Deposits	13,167,554	0	0	13,167,5544
Total Financial Assets (i)	17,625,864	0	0	17,625,864
Financial Liabilities				
Payables	0	0	600,015	600,015
Lease Liabilities	0	0	55,803	0
Other Financial Liabilities				
– Accommodation Bonds	0	0	12,235,327	12,235,327
– Other	0	0	168	168
Total Financial Liabilities(ii)	0	0	12,891,313	12,835,510

	Contractual financial assets – loans and receivables $	Contractual financial assets – available for sale $	Contractual financial liabilities at amortised cost $	Total $
2016				
Contractual Financial Assets				
Cash and cash equivalents	1,030,482	0	0	1,030,482
Receivables				
– Trade Debtors	256,162	0	0	256,162
– Other Receivables	114,107	0	0	114,107
Other Financial Assets				
– Term Deposits	10,985,039	0	0	10,985,039
– Shares in Other Entities	0	116,234	0	116,234
Total Financial Assets (i)	12,385,790	116,234	0	12,502,024
Financial Liabilities				
Payables	0	0	597,080	597,080
Lease Liabilities	0	0	68,454	0
Other Financial Liabilities				
– Accommodation Bonds	0	0	10,865,860	10,865,860
– Other	0	0	323	323
Total Financial Liabilities (ii)	0	0	11,531,717	11,463,263

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(a) Financial Risk Management Objectives and Policies (Continued)

Net holding gain/(loss) on financial instruments by category	Total interest		
	Net holding gain/(loss) $	Income/ (expense) $	Total $
2017			
Financial Assets			
Cash and cash equivalents	0	20,453	20,453
Loans and Receivables	0	628,184	628,184
Available for sale	17,607	0	17,607
Total Financial Assets	17,607	648,637	666,244
Financial Liabilities			
At amortised cost	0	1,806	1,806
Total Financial Liabilities	0	1,806	1,806
2016			
Financial Assets			
Cash and cash equivalents	0	32,218	32,218
Loans and Receivables	0	366,282	366,282
Available for sale	(11,036)	0	(11,036)
Total Financial Assets	(11,036)	398,500	387,464
Financial Liabilities			
At amortised cost	0	2,770	2,770
Total Financial Liabilities	0	2,770	2,770

(i) For cash and cash equivalents, loans and 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, and interest revenue, minus impairment recognised in the net result;

(ii) For financial liabilities measured at amortised cost, the net gain or loss is calculated by taking the interest expense; and

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(b) Credit Risk

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

Credit risk associated with the Health Service's contractual financial assets is minimal because the main debtor is the Victorian Government. For debtors other than the Government, it is the Health Service's policy to only deal with entities with high credit ratings of a minimum Triple-B 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 Mansfield District Hospital's maximum exposure to credit risk without taking account of the value of any collateral obtained.

Credit quality of contractual financial assets that are neither past due nor impaired	Financial Institutions (Min BB credit rating) $	Other (Non Rated) $	Total $
2017			
Financial Assets			
Cash and Cash Equivalents	4,000,711	0	4,000,711
Loans and Receivables			
– Trade Debtors	0	251,874	251,874
– Other Receivables (i)	0	205,725	205,725
– Term Deposit	13,167,554	0	13,167,554
Total Financial Assets	17,168,266	457,599	17,625,864
2016			
Financial Assets			
Cash and Cash Equivalents	1,030,482	0	1,030,482
Loans and Receivables			
– Trade Debtors	0	256,162	256,162
– Other Receivables (i)	0	114,107	114,107
– Term Deposit	10,985,039	0	10,985,039
Available for sale			
– Shares in other entities	116,234	0	116,234
Total Financial Assets	12,131,755	370,269	12,502,024

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(b) Credit Risk (Continued)

Ageing analysis of financial asset as at 30 June	Carrying Amount $	Not Past due and not impaired $	Past due but not impaired				Impaired Financials Assets $
			Less than 1 Month $	1–3 Months $	3 Months – 1 Year $	1–5 Years $	
2017							
Financial Assets							
Cash and Cash Equivalents	4,000,711	4,000,711	0	0	0	0	0
Loans and Receivables (i)							
– Trade Debtors	251,874	123,739	7,332	8,492	90,589	0	21,722
– Other Receivables	205,725	145,064	9,390	40,237	11,034	0	0
– Term Deposit	13,167,554	13,167,554	0	0	0	0	0
Total Financial Assets	17,625,864	17,437,068	16,722	48,730	101,622	0	0
2016							
Financial Assets							
Cash and Cash Equivalents	1,030,482	1,030,482	0	0	0	0	0
Loans and Receivables (i)							
– Trade Debtors	256,162	114,974	70,728	40,710	29,750	0	0
– Other Receivables	114,107	80,461	5,208	22,318	6,120	0	0
– Term Deposit	10,985,039	10,985,039	0	0	0	0	0
Available for sale							
– Shares in other entities	116,234	116,234	0	0	0	0	0
Total Financial Assets	12,502,024	12,327,190	75,936	63,028	35,870	0	0

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

Contractual financial assets that are neither past due or impaired
There are no material financial assets which are individually determined to be impaired. Currently the Health Service does not hold any collateral as security nor credit enhancements relating to its financial assets.

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

(c) Liquidity Risk

Liquidity risk is the risk that the Health Service would be unable to meet its financial obligations as and when they fall due. The Health Service operates under the Government's fair payments policy of setting 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:

– Term Deposits and cash held at financial institutions are managed with variable maturity dates and take into consideration cashflow requirements of the Health Service from month to month.

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(c) Liquidity Risk (Continued)

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

Maturity analysis of financial liabilities as at 30 June	Carrying Amount $	Nominal Amount $	Maturity Dates: Less than 1 Month $	1–3 Months $	3 Months – 1 Year $	1–5 Years $
2017						
Financial Liabilities						
At amortised cost						
Payables	600,015	600,015	600,015	0	0	0
Leases	55,803	55,803	2,180	4,360	19,617	29,646
Other Financial Liabilities (i)						
– Accommodation Bonds	12,235,327	12,235,327	12,235,327	0	0	0
– Other	168	168	0	168	0	0
Total Financial Liabilities	12,891,313	12,891,313	12,837,522	4,528	19,617	29,646
2016						
Financial Liabilities						
At amortised cost						
Payables	597,080	597,080	597,080	0	0	0
Leases	68,454	68,454	2,778	8,335	22,226	35,115
Other Financial Liabilities (i)						
– Accommodation Bonds	10,865,860	10,865,860	10,865,860	0	0	0
– Other	323	323	0	323	0	0
Total Financial Liabilities	11,531,717	11,531,717	11,465,718	8,658	22,226	35,115

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

(d) Market Risk

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

Interest Rate Risk

Exposure to interest rate risk's arise primarily through the Mansfield District Hospital's other financial assets. Minimisation of risk is achieved by mainly holding fixed rate or non-interest bearing financial instruments. For financial assets the Health Service mainly holds financial assets 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 movements in interest rates on a daily basis.

Other Price Risk

The Health Service is exposed to normal price fluctuations from time to time through market forces. Where adequate notice is provided by suppliers, additional purchases are made for long term goods. Supplier contracts are also in place for major product lines purchased by the Health Service on a monthly basis. These contracts have set price arrangements and are reviewed on a regular basis.

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(d) Market Risk (Continued)

Interest Rate Exposure of Financial Assets and Liabilities as at 30 June	Weighted Average Effective Interest Rate (%)	Carrying Amount $	Interest Rate Exposure		
			Fixed Interest Rate $	Variable Interest Rate $	Non-Interest Bearing $
2017					
Financial Assets					
Cash and Cash Equivalents	1.42	4,000,711	0	4,000,711	0
Loans and Receivables (i)					
– Trade Debtors		251,874	0	0	251,874
– Other Receivables		205,725	0	0	205,725
– Term Deposit	2.57	13,167,554	13,167,554	0	0
Total Financial Assets		17,625,864	13,167,554	4,000,711	457,599
Financial Liabilities					
At amortised cost					
Payables (i)		600,015	0	0	600,015
Leases	4.10	55,803	55,803	0	0
Other Financial Liabilities					
– Accommodation Bonds		12,235,327	0	0	12,235,327
– Other		168	0	0	168
Total Financial Liabilities		12,891,313	55,803	0	12,835,510
2016					
Financial Assets					
Cash and Cash Equivalents	1.90	1,030,482	0	1,030,482	0
Loans and Receivables (i)					
– Trade Debtors		256,162	0	0	256,162
– Other Receivables		114,107	0	0	114,107
– Term Deposit	3.00	10,985,039	10,985,039	0	0
Available for sale					
– Shares in other entities		116,234	0	116,234	0
Total Financial Assets		12,502,024	10,985,039	1,146,716	370,269
Financial Liabilities					
At amortised cost					
Payables (i)		597,080	0	0	597,080
Leases	4.10	68,454	68,454	0	0
Other Financial Liabilities					
– Accommodation Bonds		10,865,860	0	0	10,865,860
– Other		323	0	0	323
Total Financial Liabilities		11,531,717	68,454	0	11,463,263

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(d) Market Risk (Continued)

Sensitivity Disclosure Analysis

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, the Mansfield District Hospital 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 100 basis points up and down in market interest rates (AUD) from year-end rates of 2.57%; and
– A parallel shift of +1% and -1% in inflation rate from year-end rates of 2%.

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

		Interest Rate Risk				Other Price Risk			
	Carrying Amount	-1%		+1%		-1%		+1%	
		Profit	Equity	Profit	Equity	Profit	Equity	Profit	Equity
	$	$	$	$	$	$	$	$	$
2017									
Financial Assets									
Cash and Cash Equivalents	4,000,711	(40,007)	(40,007)	40,007	40,007	0	0	0	0
Loans and Receivables									
– Trade Debtors	251,874	0	0	0	0	0	0	0	0
– Other Receivables	205,725	0	0	0	0	0	0	0	0
– Term Deposit	13,167,554	(131,676)	(131,676)	131,676	131,676	0	0	0	0
Financial Liabilities									
At amortised cost									
Payables	600,015	0	0	0	0	0	0	0	0
Leases	55,803	0	0	0	0	0	0	0	0
Other Financial Liabilities (i)									
– Accommodation Bonds	12,235,327	0	0	0	0	0	0	0	0
– Other	168	0	0	0	0	0	0	0	0
		(171,683)	(171,683)	171,683	171,683	0	0	0	0
2016									
Financial Assets									
Cash and Cash Equivalents	1,030,482	(10,305)	(10,305)	10,163	10,163	0	0	0	0
Loans and Receivables									
– Trade Debtors	256,162	0	0	0	0	0	0	0	0
– Other Receivables	114,107	0	0	0	0	0	0	0	0
– Term Deposit	10,985,039	(109,850)	(109,850)	109,850	109,850	0	0	0	0
Available for sale									
– Shares in other entities	116,234	0	0	0	0	(1,162)	(1,162)	1,162	1,162
Financial Liabilities									
At amortised cost									
Payables	597,080	0	0	0	0	0	0	0	0
Leases	68,454	0	0	0	0	0	0	0	0
Other Financial Liabilities (i)									
– Accommodation Bonds	10,865,860	0	0	0	0	0	0	0	0
– Other	323	0	0	0	0	0	0	0	0
		(120,155)	(120,155)	120,013	120,013	(1,162)	(1,162)	1,162	1,162

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(e) Fair Value

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

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

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

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

Comparison between carrying amount and fair value	Carrying Amount 2017 $	Fair Value 2017 $	Carrying Amount 2016 $	Fair Value 2016 $
Financial Assets				
Cash and Cash Equivalents	4,000,711	4,000,711	1,030,482	1,030,482
Loans and Receivables (i)				
– Trade Debtors	251,874	251,874	256,162	256,162
– Other Receivables	205,725	205,725	114,107	114,107
Term Deposits	13,167,554	13,167,554	10,985,039	10,985,039
Available for sale				
– Shares in Other Entities	0	0	116,234	116,234
Total Financial Assets	**17,625,864**	**17,625,864**	**12,502,024**	**12,502,024**
Financial Liabilities				
At amortised cost				
Payables	600,015	600,015	597,080	597,080
Leases	55,803	55,803	68,454	68,454
Other Financial Liabilities (i)				
– Accommodation Bonds	12,235,327	12,235,327	10,865,860	10,865,860
– Other	168	168	323	323
Total Financial Liabilities	**12,891,313**	**12,891,313**	**11,531,717**	**11,531,717**

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

Financial assets measured at fair value	Carrying amount as at 30 June $	Fair value measurement at end of reporting period using: Level 1 $	Level 2 $	Level 3 $
2017				
Financial assets at fair value through profit & loss				
Available for sale financial assets				
Listed securities	0	0	0	0
Total Financial Assets	**0**	**0**	**0**	**0**
2016				
Financial assets at fair value through profit & loss				
Available for sale financial assets				
Listed securities	116,234	116,234	0	0
Total Financial Assets	**116,234**	**116,234**	**0**	**0**

There have been no transfers between levels during the period.

The fair value of the financial assets and liabilities is included at the amount at which the instrument could be exchanged in a current transaction between willing parties, other than in a forced or liquidation sale. The following methods and assumptions were used to estimate fair value:

Listed securities

The listed share assets are valued at fair value with reference to a quoted (unadjusted) market price from an active market. The Health Service categorises these instruments as Level 1.

Financial Instruments

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

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

The following refers to financial instruments unless otherwise stated.

Categories of non-derivative financial instruments

Reclassification of financial instruments at fair value through profit or loss

Financial instrument assets that meet the definition of loans and receivables may be reclassified out of the fair value through profit and loss category into the loans and receivables category, where they would have met the definition of loans and receivables had they not been required to be classified as fair value through profit and loss. In these cases, the financial instrument assets may be reclassified out of the fair value through profit and loss category, if there is the intention and ability to hold them for the foreseeable future or until maturity.

Loans and receivables

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

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

Available-for-sale financial assets

Available-for-sale financial instrument assets are those designated as available-for-sale or not classified in any other category of financial instrument asset. Such assets are initially recognised at fair value. Subsequent to initial recognition gains and losses arising from changes in fair value are recognised in 'other comprehensive income' until the investment is disposed of or is determined to be impaired, at which time the cumulative gain or loss previously recognised in equity is included in net result for the period.

Reclassification of available-for-sale financial assets

Available-for sale financial instrument assets that meet the definition of loans and receivables may be classified into the loans and receivables category if there is the intention and ability to hold them for the foreseeable future or until maturity.

Financial Liabilities at amortised cost

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

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

NOTE 7.2: NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS

	2017 $	2016 $
Proceeds from Disposal of Non Financial Assets		
– Motor Vehicles	38,260	0
– Plant	0	5,909
– Equipment	2,286	0
Total Proceeds from Disposal of Non-Financial Assets	40,546	5,909
Less: Written Down Value of Non-Financial Assets Sold		
– Motor Vehicles	(32,756)	0
– Plant	(4,773)	0
– Equipment	0	0
Total Written Down Value of Non-Financial Assets Sold	(32,756)	0
NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS	7,790	5,909

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

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

Recoverable amount for assets held primarily to generate net cash inflows is measured at the higher of the present value of future cash flows expected to be obtained from the asset and fair value less costs of disposal.

NOTE 7.3: CONTINGENT LIABILIITES AND CONTINGENT ASSETS

There are no known contingent assets or liabilities for Mansfield District Hospital as at the date of this report (2016: NIL).

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

NOTE 7.4: FAIR VALUE DETERMINATION

Asset Class	Examples of types of assets	Expected Fair Value	Likely valuation approach	Significant inputs (Level 3 only)
Specialised land	Land subject to restrictions as to use and/or sale. Land in areas where there is not an active market.	Level 3	Market approach	CSO adjustments
Specialised Buildings (i)	Specialised buildings with limited alternative uses and/or substantial customisation e.g. hospitals and schools.	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Plant and equipment (i)	Specialised items with limited alternative uses and/or substantial customisation.	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Vehicles	If there is an active resale market available. If there is no active resale market available.	Level 2 Level 3	Market approach Depreciated replacement cost approach	NA Useful life

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

NOTE 8: OTHER DISCLOSURES

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

Structure

8.1 Equity
8.2 Reconciliation of net result for the year to net cash inflow/(outflow) from operating activities
8.3 Operating segments
8.4 Responsible persons disclosures
8.5 Executive officer disclosures
8.6 Related parties
8.7 Remuneration of auditors
8.8 Ex-gratia expenses
8.9 AASs issued that are not yet effective
8.10 Events occurring after the balance sheet date
8.11 Alternative presentation of comprehensive operating statement

NOTE 8.1: EQUITY

	2017 $	2016 $
(a) Surpluses		
Property, Plant and Equipment Revaluation Surplus [1]		
Balance at beginning of the Reporting Period		
– Land	1,229,000	1,229,000
– Buildings	15,011,456	15,011,456
– Plant & Equipment	4,600	4,600
Revaluation Increment/(Decrement)		
– Land	458,231	0
– Buildings	0	0
– Plant & Equipment	0	0
Balance at the end of the reporting period	16,703,287	16,245,056
Represented by:		
– Land	1,687,231	1,229,000
– Buildings	15,011,456	15,011,456
– Plant & Equipment	4,600	4,600
	16,703,287	16,245,056
Total Reserves	16,703,287	16,245,056
(b) Contributed Capital		
Balance at the beginning of the reporting period	10,852,525	10,852,525
Capital Contribution received from Victorian Government	0	0
Balance at the end of the reporting period	10,852,525	10,852,525
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	(7,081,016)	(6,541,436)
Net Result for the Year	2,899,431	(539,580)
Balance at the end of the reporting period	(4,181,585)	(7,081,016)
Total Equity at end of financial year	23,374,227	20,016,565

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

NOTE 8.1: EQUITY (Continued)

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

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

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

NOTE 8.2: RECONCILIATION OF NET RESULT FOR THE YEAR TO NET CASH INFLOW/ (OUTFLOW) FROM OPERATING ACTIVITIES

	2017 $	2016 $
NET RESULT FOR THE PERIOD	2,899,431	(539,580)
Non-cash movements		
Depreciation	1,464,856	1,386,931
Bad debts	1,971	0
Non-cash contributions	(119,487)	0
Movements included in investing and financing activities		
Net (Gain)/Loss from Sale of Plant and Equipment	(7,790)	(5,909)
Movements in assets and liabilities		
Change in Operating Assets & Liabilities		
(Increase)/Decrease in Receivables	(304,077)	(210,712)
(Increase)/Decrease in Prepayments	27,258	(237,516)
(Increase)/Decrease in Inventories	(8,909)	(2,478)
Increase/(Decrease) in Payables	(46,532)	211,894
Increase/(Decrease) in Provisions	235,304	417,644
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	4,142,025	1,020,274

NOTE 8.3: OPERATING SEGMENTS

	RACS		Hospital		Outpatients		Business Units		Total	
	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $
REVENUE										
External Segment Revenue	6,578,773	5,965,608	8,288,042	9,124,473	234,468	221,734	4,778,544	262,139	19,879,827	15,573,954
Total Revenue	6,578,773	5,965,608	8,288,042	9,124,473	234,468	221,734	4,778,544	262,139	19,879,827	15,573,954
EXPENSES										
External Segment Expenses	(7,496,816)	(6,918,138)	(9,247,712)	(9,288,273)	(220,937)	(161,683)	(663,567)	(143,940)	(17,629,032)	(16,512,034)
Total Expenses	(7,496,816)	(6,918,138)	(9,247,712)	(9,288,273)	(220,937)	(161,683)	(663,567)	(143,940)	(17,629,032)	(16,512,034)
Net Result from ordinary activities	(918,043)	(952,530)	(959,670)	(163,800)	13,531	60,051	4,114,977	118,199	2,250,795	(938,080)
Interest Income	628,184	381,435	20,452	16,529	0	536	0	0	648,636	398,500
Net Result for Year	(289,859)	(571,095)	(939,218)	(147,271)	13,531	60,587	4,114,977	118,199	2,899,431	(539,580)
OTHER INFORMATION										
Segment Assets	26,727,894	23,407,350	12,642,989	11,072,286	0	0	95,361	83,514	39,466,244	34,563,150
Total Assets	26,727,894	23,407,350	12,642,989	11,072,286	0	0	95,361	83,514	39,466,244	34,563,150
Segment Liabilities	10,898,066	10,866,183	5,155,069	3,680,402	0	0	38,883	0	16,092,017	14,546,585
Total Liabilities	10,898,066	10,866,183	5,155,069	3,680,402	0	0	38,883	0	16,092,017	14,546,585
Acquisition of property, plant and equipment	424,382	0	194,767	0	0	0	1,088	0	620,237	0
Depreciation expense	(774,934)	(733,711)	(672,012)	(637,023)	0	0	(17,910)	(16,197)	(1,464,856)	(1,386,931)

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

Business Segments	**Services**
Residential Aged Care Services (RACS)	High & Low level Aged Care Services
Hospital	Acute Medical & Surgical Services Visiting District Nursing and Community Health and Physiotherapy Services.
Outpatients	Non admitted medical services
Business Units	Sale of goods (Meals, Medical & Surgical Supplies) and services (Radiology and Laundry)

Geographical Segment

Mansfield District Hospital operates predominantly in Mansfield, Victoria. More than 90% of revenue, net surplus from ordinary activities and segment assets relate to operations in Mansfield, Victoria.

NOTE 8.4: RESPONSIBLE PERSON DISCLOSURES

(a) Responsible Persons

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

	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	01/07/2016 – 30/06/2017
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	01/07/2016 – 30/06/2017
Governing Boards	
Mrs R. Adams	01/07/2016 – 30/06/2017
Mr M. Beattie	01/07/2016 – 30/06/2017
Mrs G. Belle	01/07/2016 – 30/06/2017
Assoc. Prof J. Freemantle	01/07/2016 – 30/06/2017
Mr P. Officer	01/07/2016 – 30/06/2017
Dr. P. Dalgliesh	01/07/2016 – 30/06/2017
Mr J. Madin	01/07/2016 – 10/05/2017
Mr J. Yencken	01/07/2016 – 13/02/2017
Mrs A. Lahore	01/07/2016 – 16/11/2016
Accountable Officers	
Cameron Butler (Interim CEO)	04/07/2016 – 30/06/2017
Margaretanne Hood (Acting Chief Executive Officer)	01/07/2016 – 03/07/2016

Remuneration
Remuneration received or receivable by responsible persons was in the range: $190,000 – $199,999 ($40,000 – $259,999 in 2015–16).

Amounts relating to Responsible Ministers are reported in the financial statements of the Department of Premier and Cabinet. For information regarding related party transactions of ministers, the register of members' interest is publicly available from: www.parliament.vic.gov.au/publications/register of interests.

NOTE 8.5: EXECUTIVE OFFICER DISCLOSURES

Executive Officers' Remuneration

In addition to the Accountable Officer who is reported under Note 8.4: Responsible persons disclosures, there were 3 other Executive Officers employed by Mansfield District Hospital during 2016/17. They received employment benefits as follows:

Compensation	2017 ($'000)
Short term employee benefits	$333,153
Post-employment benefits	$29,444
Other long-term benefits	$11,370
Termination benefits	0
Share based payments	0
Total	$373,967

Remuneration comprises employee benefits in all forms of consideration paid, payable or provided by the entity, or on behalf of the entity, 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 benefits or deferred compensation.

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

Notes:

(a) No comparatives have been reported because remuneration in the prior year was determined in line with the basis and definition under FRD21B. Remuneration previously excluded non-monetary benefits and comprised any money, consideration or benefit received or receivable excluding reimbursement of out-of-pocket expenses, including any amount received or receivable from a related party transaction. Refer to the prior year's financial statements for executive remuneration for the 2015-16 reporting period.

(b) Remuneration represents the expenses incurred by the entity in the current reporting period for the employee, in accordance with AASB119 Employee benefits.

(c) The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of the entity under AASB124 Related Party Disclosures and are also reported within the related parties note disclosure (Note 8.6).

(d) Annualised employee equivalent is based on the time fraction worked over days per week (this is generally a five full working day week).

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 Mansfield District Hospital are listed as follows:

Responsible Ministers:
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health

Governing Board:
Mrs R. Adams
Mr M. Beattie
Mrs G. Belle
Assoc. Prof J. Freemantle
Mr P. Officer
Dr. P. Dalgliesh
Mr J. Madin
Mr J. Yencken
Mrs A. Lahore

Accountable Officer:
Cameron Butler (Chief Executive Officer)

Executive Team:
Margaretanne Hood (Director of Clinical Services)
Anne Jewitt (Director of Quality and Safety)
Melanie Green (Director of Operations)

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

Compensation	**2017 ($'000)**
Short term employee benefits	$508,235
Post-employment benefits	$45,447
Other long-term benefits	$16,622
Termination benefits	0
Share based payments	0
Total	$570,304

Transactions with key management personnel and other related parties
Given the breadth and depth of State government activities, related parties transact with the Victorian public sector in a manner consistent with other members of the public e.g. stamp duty and other government fees and charges. Further employment of processes within the Victorian public sector occur on terms and conditions consistent with the Public Administration Act 2004 and Codes of Conduct and Standards issued by the Victorian Public Sector Commission. Procurement processes occur on terms and conditions consistent with the Victorian Government Procurement Board requirements. Outside of normal citizen type transactions with the department, there were no 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.

	2017 $	2016 $
Other Transactions of Responsible Persons and their Related Parties		
The result of the period includes aggregate amounts attributable to transactions with Responsible Persons and Responsible Persons Related Parties in respect of:		
Mrs G. Belle through involvement in the business Mansfield Produce Store on normal commercial terms and conditions	2,076	5,999
Mrs G. Belle through involvement in the business Delatite Hotel on normal commercial terms and conditions	924	0
Mr J. Yencken through involvement in the business Yenckens Hardware Pty Ltd on normal commercial terms and conditions	6,728	7,082

Significant transactions with government-related entities
Mansfield District Hospital received funding from the Department of Health and Human Services of $8.9 million (2016: $8.4 million). During the year, Mansfield District Hospital had the following significant government-related entity transaction:
– Received funding from the Commonwealth Department of Health of $4.3 million (2016: $3.9 million) for the provision of aged care services.

NOTE 8.7: REMUNERATION OF AUDITORS

	2017 $	2016 $
Victorian Auditor-General's Office		
Audit or review of financial statement	23,500	23,400
Crowe Horwath (Albury)		
Internal audit services	29,630	10,625
	53,130	34,025

NOTE 8.8: EX-GRATIA EXPENSES

There have been no ex-gratia expenses relating to the reporting date which require further disclosure.

NOTE 8.9: AASs 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. Mansfield District Hospital has not and does not intend to adopt these standards early.

Standard / Interpretation	Summary	Applicable for reporting periods beginning on	Impact on Health Service's Annual Statements
AASB 9 *Financial Instruments*	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1 January 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. While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.
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 January 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 2014-7 *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 January 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 January 2018	This amending standard will defer the application period of AASB 15 to the 2018-19 reporting period in accordance with the transition requirements.

NOTE 8.9: AASs ISSUED THAT ARE NOT YET EFFECTIVE (Continued)

Standard / Interpretation	Summary	Applicable for reporting periods beginning on	Impact on Health Service's Annual Statements
AASB 2016-3 *Amendments to Australian Accounting Standards – Clarifications to AASB 15*	This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: • A promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation; • For items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer; and • For licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access).	1 January 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.
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of most operating leases (which are current not recognised) on balance sheet.	1 January 2019	The assessment has indicated that as most operating leases will come on balance sheet, recognition of lease assets and lease liabilities will cause net debt to increase. Depreciation of lease assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. The amounts of cash paid for the principal portion of the lease liability will be presented within financing activities and the amounts paid for the interest portion will be presented within operating activities in the cash flow statement. No change for lessors.
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 January 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.

In addition to the new standards and amendments above, the AASB has issued a list of other amending standards that are not effective for the 2015–16 reporting period (as listed below). In general, these amending standards include editorial and references changes that are expected to have insignificant impacts on public sector reporting.

– AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010).
– AASB 2014-3 Amendments to Australian Accounting Standards – Accounting for Acquisitions of Interests in Joint Operations [AASB 1 & AASB 11]
– AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15
– AASB 2014-6 Amendments to Australian Accounting Standards – Agriculture: Bearer Plants [AASB 101, AASB 116, AASB 117, AASB 123, ' AASB 136, AASB 140 & AASB 141]
– AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)
– AASB 2014-8 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014) – Application of AASB 9 (December 2009) and AASB 9 (December 2010) [AASB 9 (2009 & 2010)]
– AASB 2015-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 101 [AASB 7, AASB 101, ' AASB 134 & AASB 1049]
– AASB 2015-3 Amendments to Australian Accounting Standards arising from the Withdrawal of AASB 1031 Materiality

NOTE 8.10: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

There have been no events subsequent to the reporting date which require further disclosure.

NOTE 8.11: ALTERNATIVE PRESENTATION OF COMPREHENSIVE OPERATING STATEMENT

	2017 $	2016 $
Interest	648,636	398,500
Sales of goods and services	2,474,237	2,374,750
Grants	12,904,800	12,261,766
Other Income	4,493,000	931,529
Total Revenue	**20,520,673**	**15,966,545**
Employee Expenses	11,548,228	10,633,009
Depreciation	1,464,856	1,386,931
Other Operating Expenses	4,697,955	4,492,094
Total Expenses	**17,711,039**	**16,512,034**
Net result from transactions – Net operating balance	**2,809,634**	**(545,489)**
Net gain/(loss) on sale of non-financial assets	7,790	5,909
Other gains/(losses) from other economic flows	82,007	0
Total other economic flows included in net result	89,797	5,909
NET RESULT FOR THE YEAR	**2,899,431**	**(539,580)**
Other Comprehensive Income		
Items that will not be reclassified to net result		
Changes in physical asset revaluation surplus	458,231	0
COMPREHENSIVE RESULT	**3,357,662**	**(539,580)**

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