ANNUAL REPORT
2017 – 2018

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.

Legislation	Requirement	Page Reference

Ministerial Directions

Report of Operations

Charter and purpose

FRD 22H	Manner of establishment and the relevant Ministers	4
FRD 22H	Purpose, functions, powers and duties	4
FRD 22H	Initiatives and key achievements	6
FRD 22H	Nature and range of services provided	8

Management and structure

FRD 22H	Organisational structure	9

Financial and other information

FRD 10A	Disclosure index	3
FRD 11A	Disclosure of ex-gratia expenses	68
FRD 21C	Responsible person and executive officer disclosures	64–65
FRD 22H	Application and operation of *Protected Disclosure 2012*	13
FRD 22H	Application and operation of *Carers Recognition Act 2012*	13
FRD 22H	Application and operation of *Freedom of Information Act 1982*	13
FRD 22H	Compliance with building and maintenance provisions of *Building Act 1993*	13
FRD 22H	Details of consultancies over $10,000	11
FRD 22H	Details of consultancies under $10,000	11
FRD 22H	Employment and conduct principles	10
FRD 22H	Information and Communication Technology Expenditure	11
FRD 22H	Major changes or factors affecting performance	5–6
FRD 22H	Occupational violence	12
FRD 22H	Operational and budgetary objectives and performance against objectives	14–16
FRD 22H	Summary of the entity's environmental performance	13
FRD 22H	Significant changes in financial position during the year	16
FRD 22H	Statement on National Competition Policy	13
FRD 22H	Subsequent events	71
FRD 22H	Summary of financial results for the year	11
FRD 22H	Additional information available on request	18
FRD 22H	Workforce Data Disclosures including a statement on the application of employment and conduct principles	10
FRD 25C	Victorian Industry Participation Policy disclosures	N/A
FRD 103F	Non-Financial Physical Assets	43–50
FRD 110A	Cash Flow Statements	26
FRD 112D	Defined Benefit Superannuation Obligations	40
SD 5.1.4	Financial Management Compliance Attestation	16
SD 5.2.3	Declaration in report of operations	9

Other requirements under Standing Directions 5.2

SD 5.2.2	Declaration in financial statements	20
SD 5.2.1(a)	Compliance with Australian accounting standards and other authoritative pronouncements	28
SD 5.2.1(a)	Compliance with Ministerial Directions	28

Legislation

Freedom of Information Act 1982
Protected Disclosure Act 2012
Carers Recognition Act 2012
Victorian Industry Participation Policy Act 2003
Building Act 1993
Financial Management Act 1994
Safe Patient Care Act 2015

NA – Not Applicable

Manner in which the health service was established

In 1869 a meeting was held to establish a hospital for Mansfield and district. It opened in June 1871 and was incorporated as a public hospital in 1876.

Responsible Ministers

Victorian Government

Hon Jill Hennessy MP,
Minister for Health
Minister for Ambulance

Martin Foley MP,
Minister for Housing, Disability and Ageing
Minister for Mental Health

Hon Jenny Mikakos MP,
Minister for Families and Children

Hon Natalie Hutchins MP,
Minister for Prevention of Family Violence

Objectives, Functions, Powers and Duties

The objectives 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.

Year in review

Governance

2017–18 was a year of consolidation as we implemented changes that emanated from the comprehensive governance review undertaken in the prior year. In particular we welcomed the involvement and valuable insights of community and consumer members who joined our Safety and Quality committee for the first time and those who continue to assist on other governance committees.

In July 2017 we welcomed Karli Brkljacic to the Board. Karli has a strong clinical background which is particularly relevant as we implement the recommendations of the Targeting Zero review of the Victorian Health system.

During the year we continued to further develop Board member skills through participation and engagement in development workshops and seminars that address key issues across all aspects of the health service with particular emphasis on Safety and Quality, Consumer Engagement and Finance.

The Board of Management is a cohesive and engaged group of volunteers who give of themselves tirelessly in the best interests of MDH. I thank them for their selfless contribution during the year as we strive to provide a safe, high quality and caring health service to our community.

Safety and Quality

As a Small Rural Health Service, MDH provides a broad range of services including residential aged care, maternity, acute care, operating theatre, urgent care, primary care and community based services. Provision of a safe, high quality and consumer centric health service to our community is our prime objective. To this end, and following on from the 2016 Targeting Zero review of Hospital Safety and Quality Assurance in Victoria, we embarked on a busy program in 2017/18 wherein we met or exceeded accreditation standards and implemented new programs or initiatives as follows:

- National Safety & Quality Health Service (NSQHS) standards
- Residential Aged Care Accreditation Standards: Buckland House and Bindaree
- Visiting Nursing – Home Care Standards
- Implemented a framework addressing Occupational Violence and Aggression (OVA)
- Ongoing participation in PROMPT (Practical Obstetric Multi-Professional Training)
- Ongoing positive results in the Victorian Health Experience Survey (VHES)
- Increased consumer representation on advisory groups or committees

In a targeted approach to bridging health gaps and helping all Mansfield residents to stay healthy we implemented actions determined by the Aboriginal Cultural Competence Audit and the cultural diversity framework. Of particular significance was the establishment of an Aboriginal and Torres Strait Islander friendly resource in the reception area.

Without the ongoing support and commitment of all of our staff we would not be able to offer the comprehensive range of services provided to our community. We thank all our staff for their dedication and commitment to providing a high quality and safe health service to our community in 2017/18.

During the year MDH played a leadership role in the formation of the Hume Region Safety and Quality Committee Chairs forum with the objective of fostering greater collaboration on safety and quality issues between health services. I would like to acknowledge the contribution of fellow Board member Dr Pamela Dalgliesh in the establishment and success of this forum in her role as the inaugural Chair.

Our People

Reflecting on what makes MDH a successful health service, it all comes down to the people! People form the basis of everything that we do!

We value the contribution of all our staff and are committed to investing in the development of our people.

In 2017/18 we increased our number of undergraduate students and graduate nurses; we have offered midwifery scholarships, provided leadership training for 14 Heads of Department and Better Care Victoria leadership training for 3 staff.

All our staff contribute to the care of our patients, residents and clients. We actively strive to support the efforts of all staff and we encourage their feedback, in particular via the People Matter Survey as this is instrumental in providing direction for us.

We are also committed to providing a safe work place for all staff. We continue to work to eradicate Occupational Violence and Aggression (OVA) via the OVA Framework and to develop, monitor, review and report Occupational Health and Safety at all levels of the organisation.

I would like to make special mention of the excellent leadership provided in 2017/18 by our CEO, Cameron Butler. Cameron and his Executive team have worked tirelessly over the past year to provide a high quality and safe health service to our community in a challenging and constantly changing environment; we thank them for their efforts and in particular the support that they have provided to the Board of Management.

We are again indebted to our dedicated and professional Visiting Medical Officers (VMOs) without whom we could not provide the range of services that are vital to meeting the needs of our community. I would like to make special mention of Dr Stephen Flew who has retired after seven years of dedicated service to MDH. We thank him for his commitment and wish him well in his future endeavours.

I would also like to acknowledge our outgoing Physiotherapist, Cheryl Apps who retired in June after 41 years of dedicated service to MDH. We thank her for her exceptional service and wish her well in her retirement.

Our Community

As a Small Rural Health Service providing a range of health services to a fast growing, diverse and in some cases remote community, we are fortunate to be well supported by those that we serve.

Over the past twelve months we have received generous community support including in excess of $100,000 raised through the annual appeal. We have also benefitted from the hard work and tireless efforts of our two Auxiliaries, the MDH Auxiliary and the Bindaree Auxiliary, both raising significant amounts to enable the purchase of much needed hospital equipment or specific items for use within our two residential aged care facilities, Buckland House and Bindaree.

We also continue to be well supported by The Friday Foundation and A Third Hand who have made significant contributions in support of MDH. We offer our sincere thanks to all our support organisations and the volunteers who so generously give of their time and have contributed so much in 2017/18.

I would also like to make special mention of the very generous bequest from the late Pat O'Brien. This gift to MDH will enable a significant upgrade of the hospital facility in future years.

Just as our community is generous in support of their hospital, we believe that MDH is an integral part of the community that we serve. As an organisation we continue to forge strong links where opportunities present and where we can make a difference. In 2017/18 we extended the involvement of community members on significant Board Committees including the Safety and Quality Committee, the Audit and Risk Management Committee and the Community Advisory Committee (CAC). The CAC provides guidance on policies, publications and is an avenue for consumer and community feedback to the Board of Management, the hospital CEO and the Executive.

Building on the initiatives undertaken in 2016/17, we continue to strengthen our partnerships with the Mansfield Shire and local schools. It is through these partnerships that MDH supports initiatives that promote the health and well-being of all Mansfield residents.

I would like to mention in particular the launch in May 2018 of the Mansfield RESTART program, a community led approach to address addiction and substance abuse in Mansfield and surrounding communities. This program has been developed locally for the benefit of the Mansfield community and to date has been an outstanding success.

As a publicly funded Small Rural Health Service we continue to work closely and collaborate with other health services within the Hume region, in particular Northeast Health Wangaratta. We acknowledge and thank them for their support during the past twelve months. We also acknowledge the invaluable clinical and non-clinical support and advice provided by the Department of Health and Human Services.

Key Initiatives

Following on from the Clinical Service Plan completed in early 2017, we commenced in 2018 on the development of a Master Plan for MDH that will determine what infrastructure is needed now and in the future to deliver the services required by our community. While the Master Plan is a work in progress, when completed it will form the basis of a funding submission to the Department of Health and Human Services (and the Victorian Government). The ongoing generous support from within our community and the bequest will provide great impetus to our proposal.

Our Clinical Service Plan identified strong consumer preference for the expansion of primary care options such as physiotherapy, chronic disease management and allied health services – these changes have been made and will impact in the year ahead. In addition to increasing Primary Care Centre services we have also increased Operating Theatre services.

In regard to Urgent Care, presentations have increased by 5% in the past year as Mansfield continues to grow and attract tourists year round in increasing numbers, underscoring the need to include the Urgent Care Centre in any planned redevelopment.

In April 2017 we received funding to upgrade Buckland House. This significant capital works program to renovate bathrooms in Buckland House was commenced in 2018. During the year we also completed an upgrade to the MDH Operating Theatre.

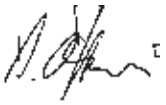
Financial Performance

Once again I am pleased to report a sound financial performance for the budget year, culminating in an operating surplus of $67,208. This is a particularly pleasing outcome as it was achieved in a tightly constrained fiscal environment while also achieving our targets in relation to activity, safety and quality of service.

In 2018/19 we will continue to focus our efforts on providing a high quality and safe health service that prioritises the best interests of our consumers and the community that we serve.

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 is pleased to report we have had another successful year with our fundraising. Upon writing my report the Auxiliary has not made a final decision on what items of equipment we will be donating to the Hospital at this stage.

Our Annual Art Exhibition for 2017 was a huge success with many local and Melbourne artists exhibiting. We had 190 pieces of work on show. We were delighted to have Amanda Hall as our Judge. Amanda is a member of the Board of Arts Project Australia and Chair of the Exhibition and Collection Committee. Amanda was very impressed with the high standard of entries. Mr Phillip Officer Chair of the Hospital Board opened the exhibition and was MC for the evening. We are most grateful to have The Harry & Clare Friday Foundation and Mansfield Rotary as our Major Sponsors. The People's Choice award was very kindly donated by John Bertalli.

We would also like to thank the following: Countrywide Automotive Repairs, Mansfield Hunting & Fishing, Mansfield FlooringXtra, Mansfield Lotto Centre and Mansfield Motor Panel Repairs who all generously donated to encourage our local Autistic School Artists to continue their interest in art. The Auxiliary is most appreciative of Jacqui Mallard, Neil Allen, Rolf Koren, Snowgum Nursery, Tom Forrest and his able friends, Ros Ritchie Wines and Delatite Wines who all assisted in so many ways. Finally to the Masonic Lodge we thank them for their continued support in allowing us the use of their venue for the duration of the exhibition.

In February 2018 we held our Annual Golf Day. Once again the day was enjoyed by 140 local and Melbourne golfers. We especially want to thank Foodworks for donating all the food. Mingo from the Rangeview Restaurant provided the delicious meal. Garry Hubbard generously donated his services to be our MC and Auctioneer. Dion Theodossi, Martins Garage is our major sponsor and kindly provides a car for the Hole in One. We are so very appreciative of Dion's continued support. Finally to Chris Anderson and staff we say thank you for providing the Golf Club and Course for the day as we would not be able to hold such a large event without their commitment.

We held a film night in March which was well attended and enjoyed by all. In August we had a Wine & Canape evening at the Beolite Hall. Ros Ritchie supplied all the lovely wines for tasting. Gill Belle provided the delicious Canapes. The evening was well attended by 80 people and enjoyed by all.

In November we had The Ark Clothing Company provide a mini workshop of their new season's range. The morning was very popular with 60 ladies attending who all had a fun time.

We would like to especially mention the wonderful donation we received from Buller Ski Lifts. Mr. Rino Grollo most generously gave a cheque for $20,940 to the Auxiliary for which we are most grateful for his support.

Unfortunately Adele Foster a member of our committee has had to resign this year so we thank Adele for her involvement over the past two years. We welcome Sheryl Sargent to the committee and look forward to her friendship.

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 items of equipment for our hospital.

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

Ann Mudge
President

Bindaree Auxiliary Report

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

Auxiliary membership continues, though not large in number. Members are committed to providing extras for the welfare and benefit of Bindaree residents. We continue to be encouraged by the contribution of some of the founder members of the Auxiliary, who have actively supported our activities for over 40 years, and who are an example to us all.

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 Bridge 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.

A roster of Auxiliary members ensures a weekly visit to the residents of a shopping trolley. This enables us to have personal time with residents, giving them an opportunity to purchase personal items and goods which they can share with family and friends. Residents look forward to this service and can give orders for particular items they may wish to purchase.

The Activities team at Bindaree is always involved in the provision of stimulating programs for the residents. Word games are popular and the Auxiliary was pleased to purchase a large whiteboard to assist with this. It is good to see active participation of the residents. Several Bindaree residents take advantage of the opportunity to go on outings in the bus provided via the Friday Foundation. The Auxiliary has been pleased to fund some of these trips, and the morning or afternoon teas which are part of these outings. We feel that any opportunities which enable residents to join in community events are very worthwhile.

We continue to seek new members to the Auxiliary, and new ideas for fundraising. We are greatly assisted by support from local businesses and members of the community as we continue to find ways to assist Bindaree. Sincere thanks to all who have assisted in so many ways over the past year.

Norma Pearce
Secretary

Nature and range of services

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 are:

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

The health service serves the catchment of Mansfield Shire with a population of 8,200 residents. In holiday seasons this population can increase three fold.

Administrative structure

Board of Management

Board Members

Mrs Rosalind Adams
Mr Murray Beattie
Mrs Gill Belle
Ms Karli Brkljacic
Dr Pamela Dalgliesh
Assoc Prof Jane Freemantle
Ms Katie Lockey
Mr Phillip Officer
Ms Laurie Watters

Audit & Risk Management

Mr Mark Evans (Independent member)
Mr Geoff Gravenall (Independent member)
Mr Jaya Naidu (Independent member)
Mrs Rosalind Adams
Ms Katie Lockey

Chair, Board of Management

Mr Phillip Officer

Chair, Audit & Risk Management

Mr Jaya Naidu (Independent member)

Chair, Safety & Quality

Dr Pamela Dalgliesh

Chair, Finance

Mr Murray Beattie

Chair, Governance, Nominations and Executive Performance

Mrs Gill Belle

Chair, Community Advisory

Mrs Rosalind Adams

Chair, Health Professionals Scope of Practice and Appointments

Assoc Prof Jane Freemantle

Executive

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 John Elcock, BMedSci (Hons), MB BS, MBA, FRACGP, FRACMA, GAICD

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

Ms Tracy Rekers

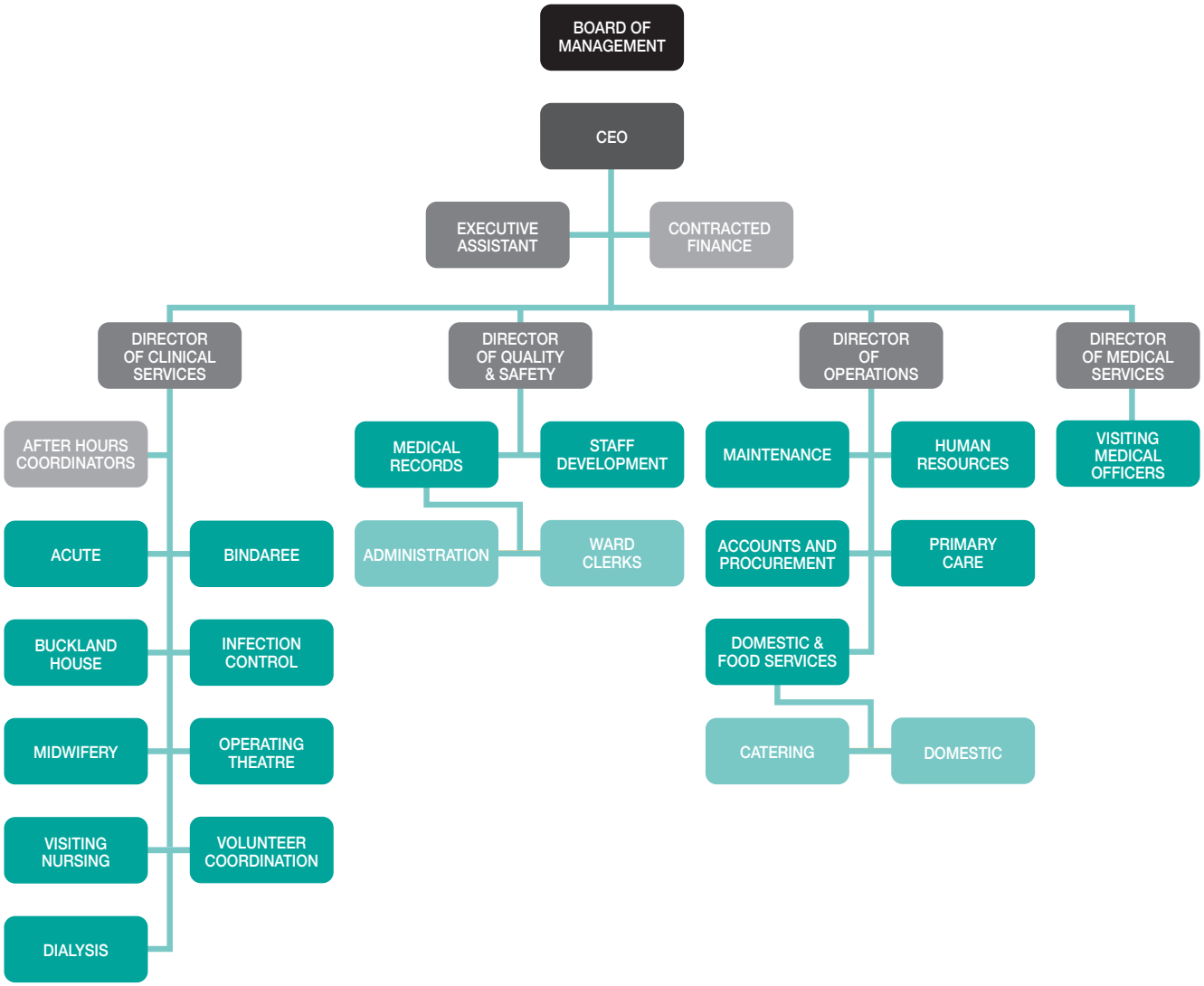
Visiting Medical Officers

Dr S Begin, MB, BS
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 E Dirksen, MB, BS
Dr D Friday, MB, BS, DRANZCOG, FRAGP
Dr J Hall, MB, BS
Dr T Ibrahim, MB, BS
Dr D Le Brocque, MB, BS
Dr M Morrissey , MB, BS, BSc, DCH, DRANZCOG
Dr B Nally, MB, BS
Dr R Radford, MB, BS
Dr M Reed, MB, BS, FRACGP
Dr M Sathveegarajah, MD, BSC
Dr K Savage, MB, BS
Dr G Slaney, MB, BS, DRANZCOG, FRACGP, MPH, DA DRCOG, FACRRM
Dr W Twycross, MB, BS, DA, DRANZCOG, DTPH
Dr A Wettenhall, MB, BS, FRACGP

Visiting Specialists

Dr L Dhakal, MB, BS, FRACP, MD, MPH
Dr K Ibrahim, MB, BS, FANZCA
Dr P MacLeish, MB, BS, FRACP
Dr A MacLeod, MB, BS (Hons), FRACS
Assoc Prof F Miller, MB, BS, PhD, FRACS
Dr S Pearce, MB, BS, FRANZCOG
Mr W Seager, MB, BS, FRACS (Ortho)
Mr P Thomas, MB, BS, FRCSEd, FRACS

Organisational Structure



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 2018.

Phillip Officer
Board Member
Mansfield District Hospital

13 September 2018

MANSFIELD DISTRICT HOSPITAL

Workforce

Mansfield District Hospital adheres to the public sector employment principles outlined in the Public Administration Act 2004 These principles help shape the type of working environment we offer to our employees. They help set the right conditions for productive and harmonious working relationships by ensuring that employees are treated well, have career opportunities and can safely raise their concerns.

In addition 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.

All employees have been correctly classified in workforce data collections.

Hospitals Labour Category	JUNE Current Month FTE*		JUNE YTD FTE**	
	2017	2018	2017	2018
Nursing	68.17	65.01	65.85	67.76
Administration and Clerical	13.98	14.44	13.72	13.85
Medical Support	0.84	0.95	0.81	0.90
Hotel and Allied Services	39.39	43.16	37.82	41.22
Medical Officers	–	–	–	–
Hospital Medical Officers	.05	–	0.04	–
Sessional Clinicians	N/A	N/A	N/A	N/A
Ancillary Staff (Allied Health)	6.9	6.41	5.93	7.65
TOTAL	**129.33**	**129.97**	**124.17**	**131.38**

The FTE figures required in the table above are those excluding overtime. These do not include contracted staff (e.g. Agency nurses or 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.

Financial Results

Summary of Financial Results for last five years

	2018	2017	2016	2015	2014
Total Revenue	16,500,235	16,398,500	15,393,125	14,000,423	13,758,367
Total Expenses	16,433,027	16,169,903	15,055,563	14,236,363	13,569,326
Other Operating Flows Included in the Net Result for the Year					
Net Result before Capital & Specific Items	**67,208**	**228,597**	**337,562**	**(235,940)**	**189,041**
Total Assets	40,117,807	39,466,244	34,563,150	30,759,482	29,723,667
Total Liabilities	16,695,289	16,092,017	14,546,585	10,203,337	9,747,314
Net Assets	**23,422,518**	**23,374,227**	**20,016,565**	**20,556,145**	**19,976,353**
Total Equity	**23,422,518**	**23,374,227**	**20,016,565**	**20,556,145**	**19,976,353**

The net result before capital and specific items was a surplus of $67,208. This was achieved as a result of revenue from operating activities remaining constant with that of 2017. Revenue from non-operating activities increased by 3.8% for the same period. This was offset by a 4.3% increase in employee expenses from the previous year. Employee expenses represent 73% of total operating expenditure compared to 71% for 2017. In addition to salary increase arising from Enterprise Bargaining Agreements, employee expenses increased as a result of an increase of full-time equivalent (FTE) staff, with an emphasis on increasing employee numbers in areas which are a strong contributor to patient care, notably nursing, allied health and hotel and allied services.

Consultancies

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

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

Total Cost to MDH of $12,565

Information and Communication Technology (ICT) expenditure

The total ICT expenditure incurred during 2017–18 is $694,495 (excluding GST) with the details shown below.

Business As Usual (BAU) expenditure (excl. GST)	Non-Business As Usual (non-BAU) expenditure (excl. GST)	Operational expenditure (excl. GST)	Capital expenditure (excl. GST)
$694,495	$0	$694,495	$0

Occupational Violence

Occupational Violence Statistics	2017–18
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	18
Number of occupational violence incidents reported per 100 FTE	13.7
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** – an event or circumstance that could have resulted in, or did result in, harm to an employee. Incidents of all severity ratings are included. Code Grey reporting is not included, however if an incident occurred during the course of a planned or unplanned Code Grey it is included.
- **Accepted WorkCover claims** – accepted WorkCover claims that were lodged in 2017–2018.
- **Lost time** – lost time is defined as greater than one day.
- **Injury, illness or condition** – includes all reported harm as a result of the incident, regardless of whether the employee required time off work or submitted a claim.

Occupational Health and Safety

Mansfield District Hospital is a responsible leader in the safety of its employees, consumers and members of the public. The Service complies with the requirements of the Occupational Health and Safety Act (Vic) 2004 and the Victorian Occupational Health and Safety Regulations 2017.

The Service continues to work with Health and Safety Representatives to eliminate or mitigate the risk of injury within the workplace. Where injury has occurred the organisation seeks to achieve the safe, appropriate and timely Return to Work of its employees.

Occupational Health and Safety incidents have remained constant and this builds on the measures taken over the past two years to promote safety within the workplace and reduce workplace incidents. All work areas have health and safety representation.

In 2017–18 workplace safety education was provided for all representatives and an Internal Audit of Occupational Health and Safety was conducted Crowe Horwath, our appointed Internal Auditors, with the findings and recommendations reported through the Audit & Risk Management Committee.

Reported Incidents

Year	Incidents	Incidents per 100 FTE
2017–18	41	31
2016–17	38	30
2015–16	46	39

Reported Hazards

Year	Hazards	Hazards per 100 FTE
2017–18	22	17
2016–17	6	5
2015–16	35	29

Hazard and near miss reporting is encouraged as it as it allows for the identification and rectification of potential sources of workplace injury.

Lost Time Standard Claims

Year	Lost Time Claims	Lost Time Claims per 100 FTE Employees	Days Lost	Payments to Date	Average Cost per Claim	Estimation of Outstanding Claims Costs
2017–18	1	0.8	72	$20,307	$20,307	Nil
2016–17	3	2.4	11	$1,958	$653	Nil
2015–16	1	0.8	64	$21,374	$21,374	Nil

In 2017–18 there was one long term injury requiring surgery. The staff member was supported and transitioned to back to work at the earliest opportunity. The employee is now at pre-injury functioning.

Other Disclosures

Competitive Neutrality

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

Environmental Performance

Reducing the impact of our health services on the environment is a priority area for Mansfield District Hospital. In 2017-18 a commitment to install 167 solar panels was made. Installation should be complete by March 2019.

Disclosures Required Under Legislation

Victorian Industry Participation Policy Act 2003

There were no contracts undertaken requiring reporting in this category in 2017-18.

Freedom of Information Act 1982

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

In 2017–18 there were 13 applications were made to the organisation under these provisions. All requests were approved and processed.

Freedom of Information applications are made to the Freedom of Information Officer and are dealt with in accordance with the Act. Any charges applied are in accordance with the Act and Regulations.

Protected Disclosure Act 2012

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 2017–18.

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 has strategies and actively works 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.

Safe Patient Care Act 2015

Mansfield District Hospital has no matters to report in relation to its obligations under section 40 of the *Safe Patient Care Act 2015.*

Statement of Priorities

Part A – Strategic Priorities for 2017–18

The Statement of Priorities is an accountability agreement between Mansfield District Hospital and the Minister for Health containing key performance expectations, targets and funding for the year as well as government service priorities.

Goals	Strategies	Health Service Deliverables	Outcome
Better Health A system geared to prevention as much as treatment. Everyone understands their own health and risks. Illness is detected and managed early. Healthy neighbourhoods and communities encourage healthy lifestyles.	**Better Health** Reduce Statewide risks. Build healthy neighbourhoods. Help people to stay healthy. Target health gaps.	Work in partnership with local and regional services to deliver a prevention plan that supports local priorities as per the Mansfield Municipal Health and Wellbeing Plan and Regional Prevention Priorities.	Achieved
		Embed Child Safe Standards across Mansfield District Hospital including recognised staff holding Working with Children Checks.	Achieved
		Work in partnership with regional partners to embed the whole of hospital approach to family violence.	Achieved
		Implement actions determined by the Aboriginal Cultural Competence Audit.	Achieved
		Implement the organisation's cultural diversity framework across all areas of Mansfield District Hospital.	Achieved
Better Access Care is always there when people need it. More access to care in the home and community. People are connected to the full range of care and support they need. There is equal access to care.	**Better Access** Plan and invest. Unlock innovation. Provide easier access. Ensure fair access.	Invest in executive and senior manager leadership training via local and Statewide programs to aid in the better identification of process improvements.	Achieved
		Continue to improve access through the use of telehealth.	Achieved
		Implement the Ice and Other Drugs community rehabilitation model (over 3 years).	Achieved
		Conduct an external clinical governance review of a high risk clinical area.	Achieved
		Implementation of a workforce plan that will deliver improved safety, quality and efficiency for staff and patients.	Achieved
		Continue to enhance maternity services via Partnerships, improved access and improved pathways.	Achieved
Better Care Target zero avoidable harm. Healthcare that focusses on outcomes. Patients and carers are active partners in care. Care fits together around people's needs.	**Better Care** Put quality first. Join up care. Partner with patients. Strengthen the workforce. Embed evidence. Ensure equal care. Better care. **Mandatory actions against the 'Target zero avoidable harm' goal.**	Implement and organisation wide action plan to help prevent and manage occupational violence and aggression.	Achieved
		Continue to monitor and improve antimicrobial stewardship across Mansfield District Hospital.	Achieved
	Develop and implement a plan to educate staff about obligations to report patient safety concerns.	Improve patient experience through the implementation of patient diaries and patient stories.	Achieved
	Establish agreements to involve with external specialists in clinical governance processes for each major area of activity (including mortality and morbidity review).	Continually review and improve clinical governance across Mansfield District Hospital by: participating in regional Morbidity and Mortality meetings and the ongoing appointment of Sub-Regional Directors in Anaesthetics, Obstetrics and Geriatrics.	Achieved
	In partnership with consumers, identify three priority improvement areas using Victorian Healthcare Experience Survey data and establish an improvement plan for each. These should be reviewed every six months to reflect new areas for improvement in patient experience.	Three priority areas have been identified using Victorian Health Experience Survey (VHES) data. They include: Communicating in way that provides a consistent message, improving communication between staff and consumers taking into account each consumer's level of health literacy and ensuring services are provided in a clean and safe environment.	Achieved

Part B – Performance Priorities

High Quality and Safe Care

Key performance indicator	Target	2017–18 Result
Accreditation		
Accreditation against the National Safety and Quality Health Service Standards	Full Compliance	Full Compliance
Compliance with the Commonwealth Aged Care Accreditation Standards	Full Compliance	Full Compliance
Infection prevention and control		
Compliance with Hand Hygiene Australia Program	80%	84.6%
Percentage of healthcare workers immunised for Influenza	75%	91%
Patient experience		
Victorian Healthcare Experience Survey – percentage of positive patient experience responses	95% positive experience	100% positive experience
Victorian Healthcare Experience Survey – percentage of very positive responses to questions on discharge care	75% very positive experience	91.2% very positive experience
Victorian Healthcare Experience Survey – patients' perception of cleanliness	70%	93.3%
Adverse events		
Number of sentinel events	Nil	2
Mortality – number of deaths in low mortality DRGs[1]	Nil	N/A*
Maternity and newborn		
Rate of singleton term infants without birth anomalies with Apgar score <7 to 5 minutes	≤ 1.6%	0
Rate of severe foetal growth restriction (FGR) in singleton pregnancy undelivered by 40 weeks	≤ 28.6%	0

*This indicator was withdrawn during 2017–18 and is currently under review by the Victorian Agency for Health Information.

1. DRG is Diagnosis Related Group

Strong Governance, Leadership and Culture

Key performance indicator	Target	2017–18 Result
Organisational culture		
People Matter Survey – percentage of staff with an overall positive response to safety and culture questions	80%	94%
People Matter Survey – percentage of staff with a positive response to the question *"I am encouraged by my colleagues to report any patient safety concerns I may have"*	80%	97%
People Matter Survey – percentage of staff with a positive response to the question *"Patient care errors are handled appropriately in my work area"*	80%	98%
People Matter Survey – percentage of staff with a positive response to the question *"My suggestions about patient safety would be acted upon if I expressed them to my manager"*	80%	97%
People Matter Survey – percentage of staff with a positive response to the question *"The culture in my work area makes it easy to learn from the errors of others"*	80%	90%
People Matter Survey – percentage of staff with a positive response to the question *"Management is driving us to be a safety-centred organisation"*	80%	96%
People Matter Survey – percentage of staff with a positive response to the question *"The health service does a good job of training new and existing staff"*	80%	89%
People Matter Survey – percentage of staff with a positive response to the question *"Trainees in my discipline are adequately supervised"*	80%	87%
People Matter Survey – percentage of staff with a positive response to the question *"I would recommend a friend or relative to be treated as a patient here"*	80%	97%

Effective Financial Management

Key performance indicator	Target	2017–18 Result
Finance		
Operating result ($m)	0.00	0.07
Average number of days to paying trade creditors	60 days	46 days
Average number of days to receiving patient fee debtors	60 days	25 days
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	1.32
Number of days available cash	14 days	31.3

Part C – Activity and funding

Funding type	2017–18 Result
Acute Admitted	
WIES Public	704.05
WIES Private	233.29
TOTAL PPWIES (Public and Private)	937.34
WIES Renal	40.93
WIES DVA	19.65
WIES TAC	3.06
WIES TOTAL	960.05

Funding type	2017–18 Result
Aged Care	
Residential Aged Care – occupancy	
• Buckland House Nursing Home	78.00%
• Bindaree Retirement Centre	97.66%
Visiting Nursing Service	
Small Rural HACC	384 hours
Commonwealth Home Support Program	3,153 hours
Primary Care Centre	
Small Rural Primary Health	3,635 hours

Attestations

Data Integrity

I Cameron Butler certify that Mansfield District Hospital has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. Mansfield District Hospital has critically reviewed these controls and processes during the year.

Cameron Butler
Accountable Officer
Mansfield District Hospital
13 September 2018

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 the 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
13 September 2018

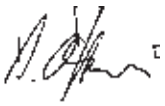
Conflict of Interest

I Cameron Butler, certify that Mansfield District Hospital has put in place appropriate internal controls and processes to ensure that it has complied with the requirements of hospital circular 07/2017 Compliance reporting in health portfolio entities (Revised) and has implemented a *Conflict of Interest* policy consistent with the minimum accountabilities required by the VPSC. Declaration of private interest forms have been completed by all executive staff within Mansfield District Hospital and members of the Board, and all declared conflicts have been addressed and are being managed. Conflict of interest is a standard agenda item for declaration and documentation at each executive board meeting.

Cameron Butler
Accountable Officer
Mansfield District Hospital
13 September 2018

Financial Management Compliance

I Phillip Officer, on behalf of the Responsible Body, certify that Mansfield District Hospital has complied with the applicable Standing Directions of the Minister for Finance under the Financial Management Act 1994 and Instructions.



Phillip Officer
Board Chair
Mansfield District Hospital
13 September 2018

Life Governors

Mansfield District Hospital Life Governors

Ms J Acaster
Mrs J Adams
Mrs M E Black
Mrs N Buckland
Mr O Buttula
Mrs C Cameron
Mr H B Clark
Mrs J Clark
Mrs N Corr
Mrs B Cox
Mrs C Cox
Mr J M Cummins
Dr J M Curtis
Mr C Durran
Mrs M Egan
Dr H R Esser
Mr W H Glen
Mrs R Gray
Sir A Grimwade
Mr T Gunnerson
Mrs M Hood
Mr P Howarth
Mrs B Hughes
Mrs D Kilford
Mrs Z Kirley
Mr P McCann
Mrs V McCormack
Dr P Mackay
Mr A Maxwell-Davis
Mr H A Nix
Mrs W Nix
Mrs Y O'Connor
Mrs S Parsons
Mr W E Parsons
Mr G Ritchie
Miss F B Shaw
Mr G Smith
Mr A Tehan
Mr C Thomas
Miss S M Turner
Miss B Walsh
Mr F Wickham
Mr D T Yencken

Bindaree Retirement Centre Life Governors

G Adamson
L R Carter
C C Crawford
M L Evans
R D Gunning
V C McCormack
E Mahoney
E O'Brien
T M R Ryan
H D T Williamson

Donor and Contributors

Major Donors

Anon	$50,000
J Canavan	$8,000
Estate of EP O'Brien	$1,175,000
B Gale	$6,000
Mansfield Golf Club Inc.	$23,394
Marks IGA	$6,717
Peter Mackay Bequest	$33,105
EP O'Brien Motors	$75,000
The Harry and Clare Friday Foundation	$20,000

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

M Adcock
R & M Allan
J & C Barling
A & D Barnett
D Beck
S & D Bergelin
K Bourchier
J Brega
C Brenchley
J Burns
C Chaston
G Collins
M & R Collins
R Collins
B Cooper
K Davey
G Desmond
E Eisner
F & H Formica
Mr & Mrs G Fox
F & C Frazer
N Friday
B Gerrish
J Giddons
R Gilder
H & R Gogal
M & N Hanlon
K Holland
M Hume
B Howie
P & E Jaksch
M Katapodis
I & T Keating
M Kingston
A Lahore
D Lowden
B McArthur
A J McDowell
E McLeod
B Mahoney
L & R Miller
D Millott
J Muddyman
B C Nichols
R Nizel
MD & JL O'Brien
Mr and Mrs P Officer
D Oppenheim
D Ord
G J Padbury
R Parsons
W Parsons
F & JF Pollard
A & I Rice
E Rogers
A & K Stephens
A & R Swaney
A & J Tehan
S Templeton
K Thomas
C Thomson
B Trevaskis
A Van Der Heyden
Mr & Mrs A Walsh
R Watson
W Wells
Alpine Country Car Club Jamieson
Alpine Helicopter Charter
Amcal Walking Group
Central General Practice
Commercial Hotel
Community Association for Woods Point
Jenan Traders
Lions Club of Mansfield
Mansfield Bowls Club Inc.
Mansfield Community Cubby House
MDH Staff
MDMBA
McCormack's Funerals
Merrijig Campdraft Association Inc.
Mt Buller Mt Stirling RMB
Peter Pedder Memorial
William A Bon Charitable Trust

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 2017–2018, 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;

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

Mansfield District Hospital

ABN 65 866 548 895

Financial Statements for the Financial Year ended 30 June 2018

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

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2018 and the financial position of Mansfield District Hospital as at 30 June 2018.

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 13th September 2018.

Mr P. Officer
Board Chair

Mansfield

13-Sep-18

Mr C. Butler
Chief Executive Officer

Mansfield

13-Sep-18

Ms J. Ball
Financial Services
Northeast Health Wangaratta

Mansfield

13-Sep-18

Independent Auditor's Report

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 2018 • 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 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 2018 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. I further describe my responsibilities under that Act and those standards 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 Victoria. 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, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.

Level 31 / 35 Collins Street, Melbourne Vic 3000
T 03 8601 7000 enquiries@audit.vic.gov.au www.audit.vic.gov.au

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 my 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
13 September 2018

Ron Mak
as delegate for the Auditor-General of Victoria

Mansfield District Hospital

COMPREHENSIVE OPERATING STATEMENT

for the financial year ended 30 June 2018

	Note	2018 $	2017 $
Revenue from Operating Activities	2.1	15,826,570	15,749,264
Revenue from Non-Operating Activities	2.1	673,665	649,236
Employee Expenses	3.1	(12,042,588)	(11,548,228)
Non Salary Labour Costs	3.1	(728,126)	(807,116)
Supplies and Consumables	3.1	(1,181,395)	(1,098,191)
Other Expenses	3.1	(2,480,918)	(2,716,368)
Net Result Before Capital and Specific Items		67,208	228,597
Capital Purpose Income	2.1	1,776,196	4,129,963
Depreciation and Amortisation	4.3	(1,480,731)	(1,464,856)
Finance Costs	3.3	(3,492)	(1,806)
Expenditure using Capital Purpose Income	3.1	(300,474)	(69,701)
Other Expenses	3.1	–	(4,773)
Net Result After Capital and Specific Items		58,707	2,817,424
Other Economic Flows Included in Net Result			
Revaluation of Long Service Leave	3.1	(10,416)	82,007
Total Other Economic Flows Included in Net Result		(10,416)	82,007
NET RESULT FOR THE YEAR		48,291	2,899,431
Other Comprehensive Income			
Items That Will Not Be Reclassified to Net Result			
Changes in Physical Asset Revaluation Surplus	8.1	–	458,231
COMPREHENSIVE RESULT		**48,291**	**3,357,662**

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

Mansfield District Hospital

BALANCE SHEET

as at 30 June 2018

	Note	2018 $	2017 $
Current Assets			
Cash and Cash Equivalents	6.2	1,116,860	4,000,711
Receivables	5.1	681,531	593,911
Investments and Other Financial Assets	4.1	17,736,736	13,167,554
Inventories	5.2	76,326	87,941
Prepayments and Other Assets	5.4	341,090	258,312
Total Current Assets		19,952,543	18,108,429
Non-Current Assets			
Receivables	5.1	801,649	780,138
Property, Plant and Equipment	4.2	19,344,376	20,513,690
Intangible Assets	4.4	19,239	63,987
Total Non-Current Assets		20,165,264	21,357,815
TOTAL ASSETS		40,117,807	39,466,244
Current Liabilities			
Payables	5.5	1,111,247	628,262
Lease Liabilities	6.1	16,954	26,157
Provisions	3.4	2,950,177	2,845,509
Other Liabilities	5.3	12,175,692	12,235,495
Total Current Liabilities		16,254,070	15,735,423
Non-Current Liabilities			
Lease Liabilities	6.1	16,980	29,646
Provisions	3.4	424,239	326,948
Total Non-Current Liabilities		441,219	356,594
TOTAL LIABILITIES		**16,695,289**	**16,092,017**
NET ASSETS		23,422,518	23,374,227
EQUITY			
Property, Plant and Equipment Revaluation Surplus	8.1a	16,703,287	16,703,287
Contributed Capital	8.1b	10,852,525	10,852,525
Accumulated Deficits	8.1c	(4,133,294)	(4,181,585)
TOTAL EQUITY		**23,422,518**	**23,374,227**
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 2018

	Note	Property, Plant and Equipment Revaluation Surplus $	Contributions by Owners $	Accumulated Deficits $	Total $
Balance at 1 July 2016		16,245,056	10,852,525	(7,081,016)	20,016,565
Net Result for the Year	8.1c	–	–	2,899,431	2,899,431
Other Comprehensive Income for the Year	8.1a	458,231	–	–	458,231
Balance at 30 June 2017		**16,703,287**	**10,852,525**	**(4,181,585)**	**23,374,227**
Net Result for the Year	8.1c	–	–	48,291	48,291
Other Comprehensive Income for the Year	8.1a	–	–	–	–
Balance at 30 June 2018		**16,703,287**	**10,852,525**	**(4,133,294)**	**23,422,518**

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

Mansfield District Hospital

CASH FLOW STATEMENT

for the financial year ended 30 June 2018

	Note	2018 $	2017 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		12,876,808	12,662,998
Patient and Resident Fees Received		1,921,135	1,984,658
Donations and Bequests Received		1,545,224	3,257,674
GST Received from/(paid to) ATO		766	(4,374)
Interest Received		671,879	651,675
Other Receipts		965,366	1,007,034
Total Receipts		***17,981,178***	***19,559,665***
Employee Expenses Paid		(11,840,567)	(11,225,297)
Fee for Service Medical Officers		(728,126)	(807,116)
Payments for Supplies and Consumables		(698,410)	(1,107,866)
Finance Costs		(3,492)	(1,806)
Other Payments		(2,821,427)	(2,746,337)
Total Payments		***(16,092,022)***	***(15,888,422)***
Cash Generated from Operations		**1,889,156**	**3,671,243**
Capital Grants from Government		54,708	470,782
NET CASH FLOW FROM OPERATING ACTIVITIES	8.2	1,943,864	4,142,025
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of Non-Financial Assets		(294,706)	(500,750)
Purchase of Investments (Term Deposits)		(4,628,987)	(844,671)
Proceeds from Sale of Non-Financial Assets		24,818	40,546
NET CASH FLOW USED IN INVESTING ACTIVITIES		(4,898,875)	(1,304,875)
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of Finance Leases		–	(12,651)
NET CASH FLOW FROM FINANCING ACTIVITIES		–	(12,651)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		(2,955,011)	2,824,499
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		3,854,981	1,030,482
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.2	899,970	3,854,981

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

BASIS OF PRESENTATION

The financial statements are prepared in accordance with Australian Accounting Standards and relevant FRDs.

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

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

Consistent with the requirements of AASB 1004 Contributions, contributions by owners (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 contributions by owners. Transfers of net liabilities arising from administrative restructurings are treated as distributions to owners.

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 2018. The purpose of the report is to provide users with information about the hospitals' 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 hospital is a not-for-profit entity and therefore applies the additional AUS paragraphs applicable to "not-for-profit" hospitals under the AASBs.

The annual financial statements were authorised for issue by the Board of Mansfield District Hospital on 13 Sptember, 2018.

(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.

(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 2018, and the comparative information presented in these financial statements for the year ended 30 June 2017.

The financial statements are prepared on a going concern basis (refer to Note 8.12 Economic Dependency).

These financial statements are presented in Australian Dollars, the functional and presentation currency of the Mansfield District Hospital.

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.

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.

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).

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

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

Goods and Services Tax (GST)
Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the Australian Taxation Office (ATO). In this case the GST payable is recognised as part of the cost of acquisition of the asset or as part of the expense.

Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the ATO is included with other receivables or payables in the Balance Sheet.

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

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

(d) Jointly Controlled Operation

Joint control is the contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control.

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.

Mansfield District Hospital is a Member of the Hume Rural Health Alliance Joint Venture and retains joint control over the arrangement, which it has classified as a joint operation (refer to Note 8.10 Jointly Controlled Operations).

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.

Mansfield District Hospital is predominantly funded by accrual based grant funding for the provision of outputs. 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 2018 $	EDS 2018 $	Residential Aged Care 2018 $	Aged Care 2018 $	Primary Health 2018 $	Other* 2018 $	TOTAL 2018 $
Government Grants	6,707,264	245,560	5,259,387	373,025	388,092	98,708	13,072,036
Indirect Contributions by Department of Health and Human Services	28,572	–	6,355	706	–	–	35,633
Patient and Resident Fees	327,388	–	1,500,039	75,383	118,271	–	2,021,081
Catering	–	–	–	–	–	68,478	68,478
Property Income	–	–	–	–	–	35,497	35,497
Commercial Activities and Specific Purpose Funds	–	–	–	–	–	146,070	146,070
Hume Rural Health Alliance	–	–	–	–	–	319,898	319,898
Other Revenue from Operating Activities	46,475	–	–	–	18,848	62,554	127,877
Total Revenue from Operating Activities	**7,109,699**	**245,560**	**6,765,781**	**449,114**	**525,211**	**731,205**	**15,826,570**
Interest	29,975	208	640,553	935	208	–	671,879
Hume Rural Health Alliance – Non Operating Revenue	–	–	–	–	–	1,786	1,786
Total Revenue from Non-Operating Activities	**29,975**	**208**	**640,553**	**935**	**208**	**1,786**	**673,665**
Capital Purpose Income	–	–	–	–	–	1,614,656	1,614,656
Hume Rural Health Alliance – Capital Purpose Income	–	–	–	–	–	161,540	161,540
Total Capital Purpose Income	**–**	**–**	**–**	**–**	**–**	**1,776,196**	**1,776,196**
TOTAL REVENUE	**7,139,674**	**245,768**	**7,406,334**	**450,049**	**525,419**	**2,509,187**	**18,276,431**

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)

	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	–	12,703,657
Indirect Contributions by Department of Health and Human Services	193,487	–	6,890	766	–	–	201,143
Patient and Resident Fees	323,414	–	1,582,432	87,671	69,642	–	2,063,159
Catering	–	–	–	–	–	72,377	72,377
Property Income	–	–	–	–	–	35,061	35,061
Commercial Activities and Specific Purpose Funds	–	–	–	–	–	137,558	137,558
Hume Rural Health Alliance	–	–	–	–	–	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	–	648,636
Hume Rural Health Alliance – Non Operating Revenue	–	–	–	–	–	600	600
Total Revenue from Non-Operating Activities	**17,794**	**409**	**628,184**	**1,840**	**409**	**600**	**649,236**
Capital Purpose Income	–	–	–	–	–	3,969,163	3,969,163
Hume Rural Health Alliance – Capital Purpose Income	–	–	–	–	–	160,800	160,800
Total Capital Purpose Income	**–**	**–**	**–**	**–**	**–**	**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**

Indirect contributions by Department of Health and Human Services.

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

* Other Programs include Commercial Activities, Special Purpose Funds and Capital.

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)

REVENUE RECOGNITION

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 hospital gains control of the underlying assets irrespective of whether conditions are imposed on the hospital's use of the contributions.

Contributions are deferred as income in advance when the hospital 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 National Health Care Agreement (NHCA) (Other) comprises services not separately classified above, including: sexually transmitted infections clinical services, Koori liaison officers, immunisation and screening services, drugs services and community care programs including sexual assault support, early parenting services and parenting assessment and skills development.

NOTE 2.2: ASSETS RECEIVED FREE OF CHARGE OR FOR NOMINAL CONSIDERATION

	2018 $	2017 $
During the reporting period, the fair value of assets received free of charge, was as follows:		
– Motor Vehicle – Bus	–	119,487
Total	–	119,487

Source of asset received:
2017 – Donated by the Harry & Clare Friday Foundation, Charitable Trust, Mansfield VIC

The revenues and assets recognised as a result of such transactions shall be measured at the fair value of resources received.

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

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

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 Note 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 Employee Benefits in the Balance Sheet
3.5 Superannuation

NOTE 3.1: ANALYSIS OF EXPENSE BY SOURCE

	Admitted Patients 2018 $	EDS 2018 $	Residential Aged Care 2018 $	Aged Care 2018 $	Primary Health 2018 $	Other* 2018 $	TOTAL 2018 $
Employee Expenses	4,651,682	145,676	5,815,590	547,736	614,625	267,279	12,042,588
Non Salary Labour Costs	680,432	46,110	1,446	104	34	–	728,126
Supplies and Consumables	481,943	34,477	507,788	21,985	20,140	115,062	1,181,395
Other Expenses	1,794,007	17,307	454,119	42,434	40,369	132,682	2,480,918
Total Expenditure from Operating Activities	**7,608,064**	**243,570**	**6,778,943**	**612,259**	**675,168**	**515,023**	**16,433,027**
Employee Expenses (LSL Bond Rate Movement)	10,416	–	–	–	–	–	10,416
Expenditure Using Capital Purpose Income	–	–	–	–	–	300,474	300,474
Finance Leases	–	–	–	–	–	3,492	3,492
Depreciation (Refer Note 4.3)	–	–	–	–	–	1,480,731	1,480,731
Other Expenses	–	–	–	–	–	–	–
Total Other Expenses	**10,416**	**–**	**–**	**–**	**–**	**1,784,697**	**1,795,113**
TOTAL EXPENSES	**7,618,480**	**243,570**	**6,778,943**	**612,259**	**675,168**	**2,299,720**	**18,228,140**

	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	–	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	–	–	–	–	–	69,701	69,701
Finance Leases	–	–	–	–	–	1,806	1,806
Depreciation (Refer Note 4.3)	–	–	–	–	–	1,464,856	1,464,856
Other Expenses	–	–	–	–	–	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**

* Other Programs include Commercial Activities, Special Purpose Funds and Capital.

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.

Employee expenses
Employee expenses include:
- wages and salaries;
- leave entitlements;
- fringe benefits tax;
- workcover premiums;
- terminations payments; and
- superannuation expenses.

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.

Net gain/(loss) on financial instruments
Net gain/(loss) on financial instruments includes:
- realised and unrealised gains and losses from revaluations of financial instruments at fair value;
- impairment and reversal of impairment for financial instruments at amortised cost (refer to Note 4.1 *Investments and other financial assets*); and
- disposals of financial assets and derecognition of financial liabilities.

Amortisation of non-produced intangible assets
Intangible non-produced assets with finite lives are amortised as an 'other economic flow' on a systematic basis over the asset's useful life. Amortisation begins when the asset is available for use that is when it is in the location and condition necessary for it to be capable of operating in the manner intended by management.

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

	2018 $	2017 $	**2018 $**	2017 $
	Expense		**Revenue**	
Commercial Activities				
Diagnostic Imaging	87,728	83,121	107,972	98,114
Catering Services	32,870	36,212	68,478	72,377
Fundraising & Other	16,486	16,006	40,627	39,444
TOTAL	137,084	135,339	217,077	209,935

NOTE 3.3: FINANCE COSTS

	2018 $	2017 $
Finance Charges on Finance Leases (HRHA)	3,492	1,806
TOTAL FINANCE COSTS	3,492	1,806

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

Finance costs include:

- Finance charges in respect of finance leases recognised in accordance with AASB 117 *Leases*.

NOTE 3.4: EMPLOYEE BENEFITS IN THE BALANCE SHEET

	2018 $	2017 $
Current Provisions		
Employee Benefits (i)		
Annual Leave		
– unconditional and expected to be settled within 12 months (ii)	1,017,099	898,333
– unconditional and expected to be settled after 12 months (iii)	176,474	204,335
Long Service Leave (Note 3.4(a))		
–unconditional and expected to be settled within 12 months (ii)	170,783	239,860
– unconditional and expected to be settled after 12 months (iii)	1,095,380	1,050,576
Accrued Wages & ADO		
– unconditional and expected to be settled within 12 months (ii)	221,260	168,480
Provisions Related to Employee Benefit On-Costs		
– unconditional and expected to be settled within 12 months (ii)	126,199	114,427
– unconditional and expected to be settled after 12 months (iii)	142,982	169,498
Total Current Provisions	2,950,177	2,845,509
Non-Current Provisions		
Long Service Leave (iii)	380,957	293,599
Provisions Related to Employee Benefit On-Costs	43,282	33,349
Total Non-Current Provisions	424,239	326,948
Total Provisions	3,374,416	3,172,457
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and Related On-Costs		
Annual Leave Entitlements	1,318,899	1,226,167
Accrued Salaries and Wages	202,020	160,783
Accrued Days Off	19,239	21,510
Unconditional Long Service Leave Entitlements	1,410,019	1,437,049
Non-Current Employee Benefits and Related On-Costs		
Conditional Long Service Leave Entitlements (iii)	424,239	326,948
Total Employee Benefits and Related On-Costs	3,374,416	3,172,457
(b) Movements in Provisions		
Movement in Long Service Leave:		
Balance at Start of Year	1,763,997	1,634,882
Provision Made During the Year		
– Revaluations	10,416	(82,007)
– Expense Recognising Employee Service	432,368	463,690
– Settlement Made During the Year	(372,523)	(252,568)
Balance at End of Year	1,834,258	1,763,997

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)

Employee Benefit Recognition
Provision is made for benefits accruing to employees in respect of wages and salaries, annual leave and long service leave for services rendered to the reporting date as an expense during the period the services are delivered.

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

The amount recognised as a liability is the best estimate of the consideration required to settle the present obligation at reporting date, taking into account the risks and uncertainties surrounding the obligation.

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 salaries and wages, annual leave and accrued days off are all recognised in the provision for employee benefits as 'current liabilities' because Mansfield District Hospital does not have an unconditional right to defer settlements of these liabilities.

Depending on the expectation of the timing of settlement, liabilities for salaries and wages, annual leave and accrued days off are measured at:
- Undiscounted value – if the hospital expects to wholly settle within 12 months; or
- Present value – if the hospital 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 hospital 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 hospital expects to wholly settle within 12 months; and
- Present value – if the hospital 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 hospital 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		Contributions Outstanding at the Year End	
Fund		**2018 $**	2017 $	**2018 $**	2017 $
Defined Benefit Plans:	Health Super	13,385	10,157	–	–
Defined Contribution Plans:	Health Super	497,233	508,158	–	–
	HESTA	455,602	405,179	–	–
	Other	19,034	11,225	–	–
Total		985,254	934,719	–	–

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

There are no superannuation contributions outstanding at 30 June 2018 (2017: 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 hospital to the superannuation plans in respect of the services of current hospital 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.

The Hospital does not recognise any defined benefit liability in respect of the plan(s) because the entity has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due. The Department of Treasury 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 Mansfield District Hospital.

The name, details and amounts expense in relation to the major employee superannuation funds and contributions made by the hospitals are disclosed in the table above.

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 Property, plant & equipment
4.3 Depreciation and amortisation
4.4 Intangible assets

NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS

	Operating Fund		Total	
	2018 $	2017 $	**2018 $**	2017 $
CURRENT				
Loans and Receivables				
Term Deposits				
Aust. Dollar Term deposits > 3 months	17,736,736	13,167,554	17,736,736	13,167,554
TOTAL CURRENT	17,736,736	13,167,554	17,736,736	13,167,554
Represented by:				
Hospital Investments	5,561,212	932,227	5,561,212	932,227
Monies Held in Trust – Accommodation Bonds (Refundable Accommodation Deposits) (Note 5.3)	12,175,524	12,235,327	12,175,524	12,235,327
TOTAL	17,736,736	13,167,554	17,736,736	13,167,554

Investment Recognition

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.

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

The hospital's investments must comply with Standing Direction 3.7.2 – Treasury and Investment Risk Management.

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 hospital 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 hospital 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 hospital has neither transferred nor retained substantially all the risks and rewards or transferred control, the asset is recognised to the extent of the hospital'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 the Comprehensive Income Statement, are subject to annual review for impairment.

The above valuation process was used to quantify the level of impairment (if any) on the portfolio of financial assets as at year end.

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: PROPERTY, PLANT AND EQUIPMENT

(a) Gross Carrying Amount and Accumulated Depreciation

	2018 $	2017 $
Land		
Land at Fair Value	2,399,231	2,399,231
Total Land	2,399,231	2,399,231
Landscaping Improvements at Fair Value	361,629	361,629
Less Accumulated Depreciation	(66,222)	(49,607)
	295,407	312,022
Buildings		
Buildings Under Construction at Cost	1,048	1,772
	1,048	1,772
Buildings at Fair Value	19,168,185	19,128,721
Less Accumulated Depreciation	(4,061,685)	(2,994,716)
	15,106,500	16,134,005
Total Buildings	15,107,548	16,135,777
Plant and Equipment		
Plant and Equipment – Hume Rural Health Alliance	46,348	50,582
Plant and Equipment at Fair Value	2,195,894	2,154,422
Less Accumulated Depreciation	(1,683,037)	(1,559,471)
Total Plant and Equipment	559,205	645,533
Medical Equipment		
Medical Equipment at Fair Value	1,933,307	1,851,519
Less Accumulated Depreciation	(1,380,493)	(1,249,271)
Total Medical Equipment	552,814	602,248
Computers and Communication		
Computers and Communication at Fair Value	31,069	6,279
Less Accumulated Depreciation	(6,908)	(2,316)
Total Computers and Communication	24,161	3,963
Furniture and Fittings		
Furniture and Fittings at Fair Value	519,825	476,674
Less Accumulated Depreciation	(344,469)	(304,977)
Total Furniture and Fittings	175,356	171,697
Motor Vehicles		
Motor Vehicles at Fair Value	408,320	412,905
Less Accumulated Depreciation	(177,666)	(169,686)
Total Motor Vehicles	230,654	243,219
TOTAL	19,344,376	20,513,690

NOTE 4.2: 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 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	–	1,785	93,729	–	81,934	122,201	2,811	82,521	65,225	450,206
Hume Rural Health Alliance Assets	–	–	–	–	(15,378)	–	–	–	–	(15,378)
Contributions	–	–	–	–	–	–	–	–	119,487	119,487
Revaluation Increments	458,231	–	–	–	–	–	–	–	–	458,231
Disposals	–	(4,338)	–	–	–	–	–	–	(28,418)	(32,756)
Net Transfer Between Classes	–	–	(1,736,720)	1,736,720	–	–	–	–	–	–
Depreciation (Note 4)	–	(17,295)	–	(1,055,081)	(165,455)	(130,162)	(1,292)	(27,191)	(66,445)	(1,462,921)
Balance at 30 June 2017	**2,399,231**	**312,022**	**1,772**	**16,134,005**	**645,533**	**602,248**	**3,963**	**171,697**	**243,219**	**20,513,690**
Additions	–	–	37,746	994	41,472	85,242	24,790	43,150	64,917	298,311
Hume Rural Health Alliance Assets	–	–	–	–	23,498	–	–	–	–	23,498
Contributions	–	–	–	–	–	(3,454)	–	–	–	(3,454)
Disposals	–	–	–	–	–	–	–	–	(9,184)	(9,184)
Net Transfers between Classes	–	–	(38,470)	38,470	–	–	–	–	–	–
Depreciation (Note 4)	–	(16,615)	–	(1,066,969)	(151,298)	(131,222)	(4,592)	(39,491)	(68,298)	(1,478,485)
Balance at 30 June 2018	**2,399,231**	**295,407**	**1,048**	**15,106,500**	**559,205**	**552,814**	**24,161**	**175,356**	**230,654**	**19,344,376**

Land and Buildings Carried at Valuation

The Valuer-General Victoria undertook to re-value all of Mansfield District Hospital owned and leased land and buildings to determine their fair value. 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.

In compliance with FRD 103F, in the year ended 30 June 2018, Mansfield District Hospital's management conducted an annual assessment of the fair value of land and buildings and leased buildings. To facilitate this, management obtained from the Department of Treasury and Finance the Valuer General Victoria indices for the financial year ended 30 June 2018.

There was no material financial impact on change in fair value of land and buildings in 2018.

The fair value of the land had been adjusted by a managerial revaluation in 2017.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

(c) Fair Value Measurement Hierarchy for Assets as at 30 June 2018

	Carrying Amount as at 30 June 2018 $	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	–	–	2,399,231
Total Land at Fair Value	2,399,231	–	–	2,399,231
Land Improvements at Fair Value				
Land Improvements	295,407	–	–	295,407
Total Land Improvements at Fair Value	295,407	–	–	295,407
Buildings at Fair Value				
Specialised Buildings	15,106,500	–	–	15,106,500
Total Buildings at Fair Value	15,106,500	–	–	15,106,500
Plant and Equipment at Fair Value				
Plant and Equipment at Fair Value	559,205	–	–	559,205
Total Plant and Equipment at Fair Value	559,205	–	–	559,205
Medical Equipment at Fair Value				
Medical Equipment at Fair Value	552,814	–	–	552,814
Total Medical Equipment at Fair Value	552,814	–	–	552,814
Computers & Communication at Fair Value				
Computers and Communication at Fair Value	24,161	–	–	24,161
Total Computers and Communication at Fair Value	24,161	–	–	24,161
Furniture & Fittings at Fair Value				
Furniture & Fittings at Fair Value	175,356	–	–	175,356
Total Furniture & Fittings at Fair Value	175,356	–	–	175,356
Motor Vehicles at Fair Value				
Motor Vehicles at Fair Value	230,654	–	230,654	–
Total Motor Vehicles at Fair Value	230,654	–	230,654	–
	19,343,328	–	230,654	19,112,674

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

NOTE 4.2: 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	–	–	2,399,231
Total Land at Fair Value	2,399,231	–	–	2,399,231
Land Improvements at Fair Value				
Land Improvements	312,022	–	–	312,022
Total Land Improvements at Fair Value	312,022	–	–	312,022
Buildings at Fair Value				
Specialised Buildings	16,134,005	–	–	16,134,005
Total Buildings at Fair Value	16,134,005	–	–	16,134,005
Plant and Equipment at Fair Value				
Plant and Equipment at Fair Value	645,533	–	–	645,533
Total Plant and Equipment at Fair Value	645,533	–	–	645,533
Medical Equipment at Fair Value				
Medical Equipment at Fair Value	602,248	–	–	602,248
Total Medical Equipment at Fair Value	602,248	–	–	602,248
Computers & Communication at Fair Value				
Computers and Communication at Fair Value	3,963	–	–	3,963
Total Computers and Communication at Fair Value	3,963	–	–	3,963
Furniture & Fittings at Fair Value				
Furniture & Fittings at Fair Value	171,697	–	–	171,697
Total Furniture & Fittings at Fair Value	171,697	–	–	171,697
Motor Vehicles at Fair Value				
Motor Vehicles at Fair Value	243,219	–	243,219	–
Total Motor Vehicles at Fair Value	243,219	–	243,219	–
	20,511,918	–	243,219	20,268,699

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

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

(d) Reconciliation of Level 3 Fair Value as at 30 June 2018

	Land $	Land Improvements $	Buildings $	Plant and Equipment $	Medical Equipment $	Computers & Commun. $	Furniture & Fittings $
Opening Balance	2,399,231	312,022	16,134,005	645,533	602,248	3,963	171,697
Purchases, Sales & Reclassifications	–	–	994	64,970	81,788	24,790	43,150
Transfers Between Classes	–	–	38,470	–	–	–	–
Gains or Losses Recognised in Net Result – Depreciation	–	(16,615)	(1,066,969)	(151,298)	(131,222)	(4,592)	(39,491)
Sub Total	2,399,231	295,407	15,106,500	559,205	552,814	24,161	175,356
Items Recognised in Other Comprehensive Income – Revaluation	–	–	–	–	–	–	–
Sub Total	–	–	–	–	–	–	–
Closing Balance	2,399,231	295,407	15,106,500	559,205	552,814	24,161	175,356

Reconciliation of Level 3 Fair Value as at 30 June 2017

	Land $	Land Improvements $	Buildings $	Plant and Equipment $	Medical Equipment $	Computers & Commun. $	Furniture & Fittings $
Opening Balance	1,941,000	331,870	15,452,366	744,432	610,209	2,444	116,367
Purchases, Sales & Reclassifications	–	(2,553)	–	66,556	122,201	2,811	82,521
Transfers Between Classes	–	–	1,736,720	–	–	–	–
Gains or Losses Recognised in Net Result – Depreciation	–	(17,295)	(1,055,081)	(165,455)	(130,162)	(1,292)	(27,191)
Sub Total	1,941,000	312,022	16,134,005	645,533	602,248	3,963	171,697
Items Recognised in Other Comprehensive Income – Revaluation	458,231	–	–	–	–	–	–
Sub Total	458,231	–	–	–	–	–	–
Closing Balance	2,399,231	312,022	16,134,005	645,533	602,248	3,963	171,697

(i) Classified in accordance with the fair value hierarchy, refer Note 4.2(c).

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

(e) Fair Value determination

Asset Class	Examples of Types of Assets	Expected Fair Value Level	Likely Valuation Approach	Significant inputs (Level 3 only) (c)
Specialised land	– Land subject to restriction as to use and or sale – Land in areas where there is no active market	Level 3	Market approach	Community service obligation adjustments (c)
Specialised buildings (a)	Specialised buildings with limited alternative uses and/or substantial custisation e.g prisons, hospitals	Level 3	Depreciated replacement cost approach	– Cost per square metre – Useful life
Plant and equipment (a)	Specialied items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	– Cost per unit – Useful life
Computers and Furniture (a)	Specialied items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	– Cost per unit – Useful life
Medical equipment at fair value (a)	Specialied items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	– Cost per unit – Useful life
Motor Vehicles	Motor Vehicles with an active resale market available	Level 2	Market approach	n.a.

(a) Newly built/acquired assets could be categorised as Level 2 assets as depreciation would not be a significant unobservable input (based on the 10 per cent materiality threshold).
(b) AASB 13 Fair Value Measurement provides an exemption for not for profit public sector entities from disclosing the sensitivity analysis relating to 'unrealised gains/(losses) on non-financial assets' if the assets are held primarily for their current service potential rather than to generate net cash inflows.
(c) CSO adjustment of 20% was applied to reduce the market approach value for the hospital's specialised land.

Initial Recognition
Items of property, plant and equipment are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and impairment loss. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. Assets transferred as part of a merger/machinery of government change are transferred at their carrying amounts.

The initial cost for non-financial physical assets under finance lease (refer to Note 6.1) is measured at amounts equal to the fair value of the leased asset or, if lower, the present value of the minimum lease payments, each determined at the inception of the lease

Crown land is measured at fair value with regard to the property's highest and best use after due consideration is made for any legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset.

Theoretical opportunities that may be available in relation to the asset(s) are not taken into account until it is virtually certain that any restrictions will no longer apply. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best uses.

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

Subsequent Measurement
Consistent with AASB 13 Fair Value Measurement, Mansfield District Hospital determines the policies and procedures for recurring property, plant and equipment fair value measurements, in accordance with the requirements of AASB 13 and the relevant FRDs

All property, plant and equipment for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy.

For the purpose of fair value disclosures, the hospital has determined classes of assets on the basis of the nature, characteristics and risks of the asset 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 reassessing 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.

For the purpose of fair value disclosures, the 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 hospital's independent valuation agency.

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

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

(e) Fair Value determination (continued)

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

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

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

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

These indicators, as a minimum, include:

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

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

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy.

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 hospital has determined that the transaction price or quoted price does not represent fair value.

A hospital shall develop unobservable inputs using the best information available in the circumstances, which might include the hospital's own data. In developing unobservable inputs, a hospital 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 hospital that is not available to other market participants. A hospital need not undertake exhaustive efforts to obtain information about other market participant assumptions. However, a hospital 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 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

(e) Fair Value determination (continued)

Specialised Land and Specialised Buildings
Specialised land includes Crown Land which 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 assets are not taken into account until it is virtually certain that any restrictions will no longer apply. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best use.

During the reporting period, Mansfield District Hospital held Crown Land. The nature of this asset means that there are certain limitations and restrictions imposed on its use and/or disposal that may impact their fair value.

The market approach is also used for specialised land and specialised buildings although it 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 Mansfield District Hospital, 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 Masnfield District Hospital's specialised land and specialised buildings was performed by the Valuer-General Victoria. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation is 30 June 2014.

In June 2017 a managerial valuation was carried out in accordance with FRD 103F to revalue the land to its fair value.

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

Plant and Equipment
Plant and equipment (including medical equipment, computers and communication equipment and furniture and fittings are held at carrying amount (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 amount.

There were no changes in valuation techniques throughout the period to 30 June 2018.

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

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 every five years, based upon the asset's Government Purpose Classification, but may occur more frequently if fair value assessments indicate material changes in values. Independent valuers are used to conduct these scheduled revaluations and any interim revaluations are determined in accordance with the requirements of the FRDs. Revaluation increments or decrements arise from differences between an asset's carrying value and fair value.

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

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

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

Revaluation surplus is not transferred to accumulated funds on de-recognition of the relevant asset, except where an asset is transferred via contributed capital.

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.

NOTE 4.3: DEPRECIATION

	2018 $	2017 $
Depreciation		
Buildings	1,066,969	1,055,081
Land Improvements	16,615	17,295
Plant and Equipment		
– Plant	125,812	131,392
– Motor Vehicles	68,298	66,445
Computers and Communication	4,592	1,292
Medical Equipment	131,222	130,162
Furniture and Fittings	39,491	27,191
Hume Rural Health Alliance	25,486	34,063
Total Depreciation	1,478,485	1,462,921
Amortisation		
Intangible Assets (HRHA)	2,246	1,935
Total Amortisation	2,246	1,935
Total Depreciation and Amortisation	1,480,731	1,464,856

Depreciation and amortisation recognition

Depreciation
All infrastructure assets, buildings, plant and equipment and other non-financial physical assets (excluding items under operating leases, assets held for sale, land and investment properties) that have finite useful lives are depreciated. Depreciation is generally calculated on a straight-line basis at rates that allocate the asset's value, less any estimated residual value over its estimated useful life (refer AASB 116 Property, Plant and Equipment).

The useful lives illustrated in the guidelines are for illustrative purposes only. Health Services should determine the useful lives of assets by consideration of the nature and characteristics of specific assets. The estimated useful lives, residual values and depreciation method are reviewed at the end of each annual reporting period, and adjustments made where appropriate.

Amortisation
Amortisation is the systematic allocation of the depreciable amount of an asset over its useful life. If a Health Service has items such as patents, trademarks, computer software or development expenses that are being capitalised, these should be included under 'Intangible Assets' (refer AASB 138 Intangible Assets) and amortised.

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

	2018	2017
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 4.4: INTANGIBLE ASSETS

	2018 $	2017 $
Depreciation		
Intangible Produced Assets – HRHA	27,256	69,758
Less Accumulated Depreciation	(8,017)	(5,771)
TOTAL INTANGIBLE ASSETS	19,239	63,987

Reconciliation of the carrying amounts of intangible assets at the beginning and end of the previous and current financial year:

	HRHA	Total
Balance as at 1 July 2016	**36,124**	**36,124**
Additions	29,798	29,798
Depreciation and Amortisation (refer Note 4.3)	(1,935)	(1,935)
Balance as at 1 July 2017	**63,987**	**63,987**
Additions	(42,502)	(42,502)
Depreciation and Amortisation (refer Note 4.3)	(2,246)	(2,246)
Balance as at 30 June 2018	**19,239**	**19,239**

Intangible assets represent identifiable non-monetary assets without physical substance such as computer software.

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

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

	2018 $	2017 $
CURRENT		
Contractual		
Trade Debtors	185,516	82,985
Patient and Resident Fees	136,259	168,889
Accrued Investment Income	105,883	83,467
Accrued Revenue – Other	37,284	11,913
Hume Rural Health Alliance – Other Receivables	152,727	110,345
Less Allowance for Doubtful Debts		
Patient and Resident Fees	(24,001)	(21,722)
	593,668	435,877
Statutory		
GST Receivable	73,003	63,534
Accrued Revenue – Department of Health and Human Services	–	94,500
Department of Health & Ageing – Commonwealth	14,860	–
	87,863	158,034
TOTAL CURRENT RECEIVABLES	681,531	593,911
NON CURRENT		
Statutory		
Long Service Leave – Department of Health and Human Services	801,649	780,138
TOTAL NON-CURRENT RECEIVABLES	801,649	780,138
TOTAL RECEIVABLES	1,483,180	1,374,049

(a) Movement in the Allowance for Doubtful Debts		
Balance at beginning of year	17,721	–
Increase/(Decrease) in Allowance Recognised in Net Result	2,279	17,721
Balance at End of Year	**20,000**	**17,721**

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 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.

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

NOTE 5.2: INVENTORIES

	2018 $	2017 $
Pharmaceuticals – at cost	30,701	43,799
Housekeeping Supplies – at cost	9,919	9,714
Medical and Surgical Lines – at cost	30,740	30,907
Administration Stores – at cost	4,966	3,521
TOTAL INVENTORIES	76,326	87,941

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

	2018 $	2017 $
CURRENT		
Monies Held in Trust*		
– Simplified Billing Trust Account	168	168
– Accommodation Bonds (Refundable Entrance Fees)	12,175,524	12,235,327
TOTAL CURRENT	12,175,692	12,235,495
*** Total Monies Held in Trust**		
Represented by the following assets:		
Cash and cash equivalents (refer to Note 6.2)	168	168
Investments and other Financial Assets (refer to Note 4.1)	12,175,524	12,235,327
TOTAL	12,175,692	12,235,495

NOTE 5.4: PREPAYMENTS AND OTHER ASSETS

	2018 $	2017 $
Prepayments	335,415	252,796
Hume Rural Health Alliance Prepayments	5,675	5,516
TOTAL OTHER CURRENT ASSETS	341,090	258,312

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

	2018 $	2017 $
CURRENT		
Contractual		
Trade Creditors	244,117	410,467
Accrued Audit Fees	26,400	23,500
Hume Rural Health Alliance Payables	196,631	19,826
Income in Advance	288,400	45,000
Other	105,953	101,222
	861,501	600,015
Statutory		
GST Payable	31,276	7,600
Department of Health and Human Services	218,470	–
Department of Health & Ageing – Commonwealth	–	20,648
	249,746	28,247
TOTAL	1,111,247	628,262

(i) The average credit period is 30 days.

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.

(a) Maturity Analysis of Financial Liabilities as at 30 June

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 Dates			
	Carrying Amount $	Nominal Amount $	Less than 1 Month $	1–3 Months $	3 Months – 1 Year $	1–5 Years $
2018						
Financial Liabilities						
Payables	861,501	861,501	861,501	–	–	–
Hume Rural Health Alliance Finance Lease Liability	33,934	33,934	1,413	4,239	11,302	16,980
Other Financial Liabilities (i)						
– Accommodation Bonds	12,175,524	12,175,524	243,510	487,021	2,313,350	9,131,643
Total Financial Liabilities	**13,070,959**	**13,070,959**	**1,106,424**	**491,260**	**2,324,652**	**9,148,623**
2017						
Financial Liabilities						
Payables	600,015	600,015	600,015	–	–	–
Hume Rural Health Alliance Finance Lease Liability	55,803	55,803	2,180	4,360	19,617	29,646
Other Financial Liabilities (i)						
– Accommodation Bonds	12,235,327	12,235,327	244,707	489,413	2,324,712	9,176,495
Total Financial Liabilities	**12,891,145**	**12,891,145**	**846,902**	**493,773**	**2,344,329**	**9,206,141**

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

NOTE 6: HOW WE FINANCE OUR OPERATIONS

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

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

Structure

6.1 Borrowings
6.2 Cash and cash equivalents
6.3 Commitments for expenditure

NOTE 6.1: BORROWINGS

	2018 $	2017 $
CURRENT		
Australian Dollar Lease Liabilities		
– Hume Rural Health Alliance Finance Lease Liability (i)	16,954	26,157
Total Current	16,954	26,157
NON CURRENT		
Australian Dollar Lease Liabilities		
– Finance Lease Liability (i)	16,980	29,646
Total Non Current	16,980	29,646
TOTAL LEASE LIABILITIES	33,934	55,803

(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.

Finance costs of the Health Service incurred during the year are accounted for as follows:		
Amount of finance costs recognised as expenses:	3,392	1,806

(a) Maturity Analysis of Borrowings
Please refer to note 5.5 for the ageing analysis of borrowings.

(b) Defaults and Breaches
During the current and prior year, there were no defaults and breaches of any of the borrowings.

(c) Finance Lease Liabilities
HRHA lease liabilities

	Minimum future lease payments (i)		Present value of minimum future lease payments	
	2018 $	2017 $	2018 $	2017 $
HRHA finance lease liabiliities payable (ii)				
Not longer than one year	17,996	27,536	16,954	26,157
Longer than one year but not longer than five years	17,615	31,060	16,980	29,646
Minimum future lease payments	35,611	58,596	33,934	55,803
Less future finance charges	(1,677)	(2,793)	–	–
Present value of minimum lease payments	33,934	55,803	33,934	55,803
Included in the financial statements as:				
Current lease liabilities	16,954	26,157	16,954	26,157
Non Current lease liabilities	16,980	29,646	16,980	29,646
TOTAL	**33,934**	**55,803**	**33,934**	**55,803**

(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.

NOTE 6.1: LEASE LIABILITIES (Continued)

(d) Finance Lease Liabilities (Continued)

Borrowing Recognition

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

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

All other leases are classified as operating leases.

Finance leases

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.

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.

NOTE 6.2: CASH AND CASH EQUIVALENTS

	2018 $	2017 $
Cash on Hand	500	500
Cash at Bank	1,116,360	4,000,211
TOTAL CASH AND CASH EQUIVALENTS	**1,116,860**	**4,000,711**
Represented by:		
Cash for Health Service Operations as per Cashflow Statement	899,970	3,854,981
Share of Cash Held at Hume Rural Health Alliance	216,722	145,562
Cash for Monies Held in Trust (Note 5.3)		
– Cash at Bank	168	168
TOTAL CASH AND CASH EQUIVALENTS	**1,116,860**	**4,000,711**

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 FOR EXPENDITURE

	2018 $	2017 $
Operating Commitments		
Information and Communication Technology Services	55,571	79,387
Total Operating Commitments (Inclusive of GST)	**55,571**	**79,387**
Operating Commitments Payable		
Not later than one year	31,755	28,868
Later than 1 and not later than 5 years	23,816	50,519
Total Operating Commitments (Inclusive of GST)	**55,571**	**79,387**
Lease Commitments Payable		
Commitments in relation to leases contracted for at the reporting date:		
Finance Leases – Hume Rural Health Alliance	37,327	61,383
Total Lease Commitments (Inclusive of GST)	**37,327**	**61,383**
Lease Commitments Payable		
Not later than one year	18,649	36,673
Later than 1 and not later than 5 years	18,678	24,710
Total Lease Commitments (Inclusive of GST)	**37,327**	**61,383**
Total Commitments (Inclusive of GST)	92,898	140,770
Less GST recoverable from Australian Tax Office	8,445	12,797
Total Commitments (exclusive of GST)	**84,453**	**127,973**

Future finance lease payments are recognised on the balance sheet, refer to Note 6.1 Borrowings.

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

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed by way of a note at their nominal value and are inclusive of the GST payable. In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant individual projects are sated. 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 Contingent assets and contingent liabilities

NOTE 7.1: 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 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.

(a) Financial instruments: categorisation

2018	Contractual financial assets – loans and receivables $	Contractual financial liabilities at amortised cost $	Total $
Contractual Financial Assets			
Cash and cash equivalents	1,116,860	–	1,116,860
Receivables			
– Trade Debtors	321,775	–	321,775
– Other Receivables	295,894	–	295,894
Other Financial Assets			
– Term Deposits	17,736,736	–	17,736,736
Total Financial Assets (i)	**19,471,265**	**–**	**19,471,265**
Financial Liabilities			
Payables	–	861,501	861,501
Lease Liabilities	–	33,934	33,934
Other Financial Liabilities			
– Accommodation Bonds	–	12,175,524	12,175,524
– Other	–	168	168
Total Financial Liabilities (ii)	**–**	**13,071,127**	**13,071,127**

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

(i) The carrying amount excludes statutory receivables (i.e. GST receivable and DHHS receivable) and statutory payables (i.e. Revenue in Advance and DHHS payable).

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(b) Net Holding Gain/(Loss) on Financial Instruments by Category

	Net holding gain/(loss) $	Total interest Income/ (expense) $	Total $
2018			
Financial Assets			
Cash and cash equivalents	–	31,326	31,326
Loans and Receivables	–	640,553	640,553
Available for sale	–	–	–
Total Financial Assets	–	671,879	671,879
Financial Liabilities			
At amortised cost	–	3,492	3,492
Total Financial Liabilities	–	3,492	3,492
2017			
Financial Assets			
Cash and cash equivalents	–	20,453	20,453
Loans and Receivables	–	628,184	628,184
Available for sale	17,607	–	17,607
Total Financial Assets	17,607	648,637	666,244
Financial Liabilities			
At amortised cost	–	1,806	1,806
Total Financial Liabilities	–	1,806	1,806

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

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

Categories of financial instruments

Loans and receivables and cash are financial instrument assets with fixed and determinable payments that are not quoted on an active market. These assets and liabilities 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 (and for assets, less any impairment). The hospital recognises the following assets in this category:

- Cash and deposits
- Receivables (excluding statutory receivables); and
- Term deposits

Financial liabilities at amortised cost 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. The Mansfield District Hospital recognises the following liabilities in this category:

- Payables (excluding statutory payables); and
- Borrowings (including finance lease liabilities).

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(b) Net Holding Gain/(Loss) on Financial Instruments by Category (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 hospital 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 hospital has transferred its rights to receive cash flows from the asset and either:
  - has transferred substantially all the risks and rewards of the asset; or
  - has neither transferred nor retained substantially all the risks and rewards of the asset, but has transferred control of the asset.

Where the Mansfield District Hospital has neither transferred nor retained substantially all the risks and rewards or transferred control, the asset is recognised to the extent of the hospital's continuing involvement in the asset.

Impairment of financial assets: At the end of each reporting period, the 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 or loss, are subject to annual review for impairment.

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

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

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

NOTE 7.2: CONTINGENT ASSETS AND CONTINGENT LIABILIITES

There are no known contingent assets or liabilities for Mansfield District Hospital as at the date of this report (2017: 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 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 Responsible persons
8.4 Remuneration of Executives
8.5 Related parties
8.6 Remuneration of auditors
8.7 Ex-gratia expenses
8.8 AASBs issued that are not yet effective
8.9 Events occurring after the balance sheet date
8.10 Jointly Controlled Operations
8.11 Alternative Presentation of Comprehensive Operating Statement
8.12 Economic Dependency

NOTE 8.1: EQUITY

	2018 $	2017 $
(a) Surpluses		
Property, Plant and Equipment Revaluation Surplus [1]		
Balance at beginning of the Reporting Period		
– Land	1,687,231	1,229,000
– Buildings	15,011,456	15,011,456
– Plant & Equipment	4,600	4,600
Revaluation Increment/(Decrement)		
– Land	–	458,231
Balance at the end of the reporting period	16,703,287	16,703,287
Represented by:		
– Land	1,687,231	1,687,231
– Buildings	15,011,456	15,011,456
– Plant & Equipment	4,600	4,600
	16,703,287	16,703,287
Total Surpluses	16,703,287	16,703,287
(b) Contributed Capital		
Balance at the beginning of the reporting period	10,852,525	10,852,525
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	(4,181,585)	(7,081,016)
Net Result for the Year	48,291	2,899,431
Balance at the end of the reporting period	(4,133,294)	(4,181,585)
Total Equity at End of Financial Year	23,422,518	23,374,227

(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

	2018 $	2017 $
NET RESULT FOR THE YEAR	48,291	2,899,431
Non-cash movements		
Depreciation and Amortisation	1,480,731	1,464,856
Bad debts	–	1,971
Non-cash contributions	–	(119,487)
Impairment of Non-financial Assets – HRHA	(74,174)	–
Movements included in investing and financing activities		
Net (Gain)/Loss from Sale of Plant and Equipment	(15,635)	(7,790)
Movements in assets and liabilities		
Change in Operating Assets & Liabilities		
(Increase)/Decrease in Receivables	(109,131)	(304,077)
(Increase)/Decrease in Prepayments	(82,778)	27,258
(Increase)/Decrease in Inventories	11,615	(8,909)
Increase/(Decrease) in Payables	482,985	(46,532)
Increase/(Decrease) in Provisions	201,959	235,304
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	1,943,862	4,142,025

NOTE 8.3: 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	01/07/2017 – 30/06/2018
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health, Minister for Creative Industries, Minister for Equality	01/07/2017 – 30/06/2018
Governing Boards	
Mrs R. Adams	01/07/2017 – 30/06/2018
Mr M. Beattie	01/07/2017 – 30/06/2018
Mrs G. Belle	01/07/2017 – 30/06/2018
Mrs K Brkljacic	01/07/2017 – 30/06/2018
Assoc. Prof J. Freemantle	01/07/2017 – 30/06/2018
Mr P. Officer	01/07/2017 – 30/06/2018
Dr. P. Dalgliesh	01/07/2017 – 30/06/2018
Ms. K Lockey	01/07/2017 – 30/06/2018
Ms. L Watters	01/07/2017 – 30/06/2018
Accountable Officers	
Cameron Butler (Chief Executive Officer)	01/07/2017 – 30/06/2018

Remuneration

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

	Parent	
	2018 No.	2017 No.
NIL	9	9
NIL to $190,000	–	–
$190,000 – $199,999	1	1
Total Numbers	**10**	**10**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**$206,185**	**$194,455**

Amounts relating to Responsible Ministers are reported within the Department of Parliamentary Services' Financial Report as disclosed in Note 8.5 Related Parties.

NOTE 8.4: REMUNERATION OF EXECUTIVES

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

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

Short-term Employee Benefits
Salaries and wages, 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
Pensions and other retirement benefits paid or payable on a discrete basis when employment has ceased.

Other Long-term Benefits
Long service leave, other long-service benefit or deferred compensation.

Termination Benefits
Termination of employment payments, such as severance packages. Total remuneration payable to executives during the year included additional executive officers and a number of executives who received bonus payments during the year. These bonus payments depend on the terms of individual employment contracts.

	Total Remuneration	
Remuneration of Executive Officers (including Key Management Personnel Disclosed in Note 8.5)	**2018 $**	2017 $
Short term Benefits	345,689	333,153
Post-employment Benefits	31,645	29,444
Other long-term Benefits	8,642	11,370
Total Remuneration (i)	**385,976**	**373,967**
Total Number of Executives	3	3
Total Annualised Employee Equivalent (ii)	3	3

i The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of the Mansfield District Hospital under AASB 124 Related Party Disclosures and are also reported within Note 8.5 Relates Parties.

ii Annualised employee equivalent is based on working 38 ordinary hours per week over the reporting period.

NOTE 8.5: 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 (KMP) and their close family members;
- Cabinet ministers (where applicable) and their close family members;
- Jointly Controlled Operation – A member of the Hume Rural Health Alliance Joint Venture; and
- All hospitals and public sector entities that are controlled and consolidated into the State of Victoria financial statements.

KMPs are those people with the authority and responsibility for planning, directing and controlling the activities of the Mansfield District Hospital directly or indirectly.

The Board of Directors and the Executive Directors of the hospital are deemed to be KMPs.

Entity	KMPs	Position Title
Mansfield District Hospital	Mr P. Officer	Chair of the Board
Mansfield District Hospital	Mrs R. Adams	Board Member
Mansfield District Hospital	Mr M. Beattie	Board Member
Mansfield District Hospital	Mrs G. Belle	Board Member
Mansfield District Hospital	Mrs K Brkljacic	Board Member
Mansfield District Hospital	Assoc. Prof J. Freemantle	Board Member
Mansfield District Hospital	Dr. P. Dalgliesh	Board Member
Mansfield District Hospital	Ms. K Lockey	Board Member
Mansfield District Hospital	Ms. L Watters	Board Member
Mansfield District Hospital	Mr. C Butler	Chief Executive Officer
Mansfield District Hospital	Ms. M Hood	Executive Director of Clinical Services
Mansfield District Hospital	Ms. M Green	Executive Director of Operations
Mansfield District Hospital	Ms. A Jewitt	Executive Director of Quality and Safety
Mansfield District Hospital	Ms. S Shinns	Acting Executive Director of Clinical Services

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.

Ms. S Shinns was acting as the Director of Clinical Services for a short period of time since Ms. M Hood was on paid annual leave. Ms S Shinns remuneration is not included KMPs compensation calculations.

Compensation – KMPs	**2018 $**	2017 $
Short term Employee Benefits	530,630	508,235
Post-employment Benefits	48,264	45,447
Other Long-term Benefits	13,266	16,622
Total	**592,161**	**570,304**

KMPs are also reported in Note 8.3 Responsible Persons or Note 8.4 Remuneration of Executives.

NOTE 8.5: RELATED PARTIES (Continued)

Transactions with KMPs 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.

	2018 $	2017 $
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	4,610	2,076
Mrs G. Belle through involvement in the business Delatite Hotel on normal commercial terms and conditions	4,553	924

Significant transactions with government-related entities
Mansfield District Hospital received funding from the Department of Health and Human Services of $8.6 million (2017: $8.9 million).

NOTE 8.6: REMUNERATION OF AUDITORS

	2018 $	2017 $
Victorian Auditor-General's Office		
Audit or review of financial statement	26,400	23,500
Crowe Horwath (Albury)		
Internal audit services	24,640	29,630
	51,040	53,130

NOTE 8.7: EX-GRATIA EXPENSES

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

NOTE 8.8: 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.

Topic	Key Requirements	Applicable for annual reporting periods beginning on	Impact on entity's financial statements
AASB 9 *Financial Instruments*	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedge accounting model and a revised impairment loss model to recognise expected impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	01 January 2018	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. The initial application of AASB 9 is not expected to significantly impact the financial position however there will be a change to the way financial instruments are classified and new disclosure requirements.
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, and to amend reduced disclosure requirements.	01 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.	01 January 2018	The assessment has indicated that there will be no significant impact for the public sector.
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. Note that amending standard AASB 2015-8 *Amendments to Australian Accounting Standards – Effective Date of AASB 15* has deferred the effective date of AASB 15 to annual reporting periods beginning on or after 1 January 2018, instead of 1 January 2017.	01 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.
AASB 2014-5 *Amendments to Australian Accounting Standards arising from AASB 15*	Amends the measurement of trade receivables and the recognition of dividends as follows: • Trade receivables that do not have a significant financing component, are to be measured at their transaction price, at initial recognition. • Dividends are recognised in the profit and loss only when: – the entity's right to receive payment of the dividend is established; – it is probable that the economic benefits associated with the dividend will flow to the entity; and – the amount can be measured reliably.	1 Jan 2018, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.
AASB 2015-8 *Amendments to Australian Accounting Standards – Effective Date of AASB 15*	This Standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	01 January 2018	This amending standard will defer the application period of AASB 15 for for-profit entities to the 2018-19 reporting period in accordance with the transition requirements.

NOTE 8.8: AASs ISSUED THAT ARE NOT YET EFFECTIVE (Continued)

Topic	Key Requirements	Applicable for annual reporting periods beginning on	Impact on entity's financial 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).	01 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 2016-7 *Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities*	This Standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019.	01 January 2019	This amending standard will defer the application period of AASB 15 for not-for-profit entities to the 2019–20 reporting period.
AASB 2016-8 *Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities*	AASB 2016-8 inserts Australian requirements and authoritative implementation guidance for not-for-profit-entities into AASB 9 and AASB 15. This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events.	01 January 2019	This standard clarifies the application of AASB 15 and AASB 9 in a not-for-profit context. The areas within these standards that are amended for not-for-profit application include: AASB 9 • Statutory receivables are recognised and measured similarly to financial assets AASB 15 • The "customer" does not need to be the recipient of goods and/or services; • The "contract" could include an arrangement entered into under the direction of another party; • Contracts are enforceable if they are enforceable by legal or "equivalent means"; • Contracts do not have to have commercial substance, only economic substance; and • Performance obligations need to be "sufficiently specific" to be able to apply AASB 15 to these transactions.
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of operating leases (which are currently not recognised) on balance sheet.	01 January 2019	The assessment has indicated that most operating leases, with the exception of short term and low value leases will come on to the balance sheet and will be recognised as right of use assets with a corresponding lease liability. In the operating statement, the operating lease expense will be replaced by depreciation expense of the asset and an interest charge. There will be no change for lessors as the classification of operating and finance leases remains unchanged.

NOTE 8.8: AASs ISSUED THAT ARE NOT YET EFFECTIVE (Continued)

Topic	Key Requirements	Applicable for annual reporting periods beginning on	Impact on entity's financial statements
AASB 1058 *Income of Not-for-Profit Entities*	AASB 1058 standard will replace the majority of income recognition in relation to government grants and other types of contributions requirements relating to public sector not-for-profit entities, previously in AASB 1004 *Contributions.* The restructure of administrative arrangement will remain under AASB 1004 and will be restricted to government entities and contributions by owners in a public sector context. AASB 1058 establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objective.	01 January 2019	The current revenue recognition for grants is to recognise revenue up front upon receipt of the funds. This may change under AASB 1058, as capital grants for the construction of assets will need to be deferred. Income will be recognised over time, upon completion and satisfaction of performance obligations for assets being constructed, or income will be recognised at a point in time for acquisition of assets. The revenue recognition for operating grants will need to be analysed to establish whether the requirements under other applicable standards need to be considered for recognition of liabilities (which will have the effect of deferring the income associated with these grants). Only after that analysis would it be possible to conclude whether there are any changes to operating grants. The impact on current revenue recognition of the changes is the phasing and timing of revenue recorded in the profit and loss statement.
AASB 17 *Insurance Contracts*	The new Australian standard eliminates inconsistencies and weaknesses in existing practices by providing a single principle-based framework to account for all types of insurance contracts, including reissuance contract that an insurer holds. It also provides requirements for presentation and disclosure to enhance comparability between entities. This standard does not apply to the not-for-profit public sector entities. The AASB is undertaking further outreach to consider the application of this standard to the not-for-profit public sector.	01 January 2021	The assessment has indicated that there will be no significant impact for the public sector.

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 2017–18 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 2016-5 *Amendments to Australian Accounting Standards – Classification and Measurements of Share-based Payment Transactions*
- AASB 2016-6 *Amendments to Australian Accounting Standards – Applying AASB 9 Financial Instruments with AASB 4 Insurance Contracts*
- AASB 2017-1 *Amendments to Australian Accounting Standards – Transfers of Investment Property, Annual Improvements 2014-16 Cycleand Other Amendments*
- AASB 2017-3 *Amendments to Australian Accounting Standards – Clarifications to AASB 4*
- AASB 2017-4 Amendments to Australian Accounting Standards – Uncertainty over Income Tax Treatments
- AASB 2017-5 Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128 and Editorial Corrections
- AASB 2017-6 Amendments to Australian Accounting Standards – Prepayment Features with Negative Compensation
- AASB 2017-7 Amendments to Australian Accounting Standards – Long-term Interests in Associates and Joint Ventures
- AASB 2018-1 Amendments to Australian Accounting Standards – Annual Improvements 2015 – 2017 Cycle
- AASB 2018-2 Amendments to Australian Accounting Standards – Plan Amendments, Curtailment or Settlement

NOTE 8.9: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

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

NOTE 8.10: JOINTLY CONTROLLED OPERATIONS

		Ownership Interest	
Name of Entity	**Principal Activity**	**2018 %**	2017 %
Hume Rural Health Alliance	Information Systems	3.94	4.02

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:

	2018 $	2017 $
Current Assets		
Cash and Cash Equivalents	216,722	145,562
Receivables	152,727	104,829
Other	5,675	5,516
Total Current Assets	375,124	255,907
Non-Current Assets		
Property, Plant and Equipment and Intangibles	73,604	120,340
Total Non-Current Assets	73,604	120,340
Total Assets	448,728	376,247
Current Liabilities		
Payables	196,631	19,826
Lease Liability	16,954	26,157
Total Current Liabilities	213,585	45,983
Non-Current Liabilities		
Lease Liability	16,980	29,646
Total Non-Current Liabilities	16,980	29,646
Total Liabilities	230,565	75,629
Net Assets	218,163	300,618
Equity		
Accumulated Surplus/(Deficit)	218,163	300,618
TOTAL EQUITY	218,163	300,618

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

Revenues		
Operating Activities	189,545	217,815
Member Contributions	130,353	124,829
Non-Operating Activities	1,786	600
Capital Purpose Income	161,540	160,800
Total Revenue	483,224	504,044
Expenses		
Employee Benefits	50,313	68,525
Information Technology and Administrative Expenses	222,583	233,428
Capital Purpose Expenditure	74,174	–
Expenditure PAS – GVH / AWH / NHW	177,300	–
Depreciation and Amortisation	31,224	35,998
Finance Charges	1,455	1,806
Total Revenue	557,049	339,757
Net Result	(73,825)	164,287

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 8.11: ALTERNATIVE PRESENTATION OF COMPREHENSIVE OPERATING STATEMENT

	2018 $	2017 $
Interest	671,879	648,636
Sales of goods and services	2,271,263	2,474,237
Grants	13,107,670	12,904,800
Other Income	2,209,985	4,493,000
Total Revenue	**18,260,797**	**20,520,673**
Employee Expenses	12,042,588	11,548,228
Depreciation & Amortisation	1,480,731	1,464,856
Other Operating Expenses	4,694,406	4,697,955
Total Expenses	**18,217,725**	**17,711,039**
Net result from transactions – Net operating balance	**43,072**	**2,809,634**
Net gain/(loss) on sale of non-financial assets	15,635	7,790
Other gains/(losses) from other economic flows	(10,416)	82,007
Total other economic flows included in net result	5,219	89,797
NET RESULT FOR THE YEAR	**48,291**	**2,899,431**
Other Comprehensive Income		
Items that will not be reclassified to net result		
Changes in physical asset revaluation surplus	-	458,231
COMPREHENSIVE RESULT	**48,291**	**3,357,662**

NOTE 8.12: ECONOMIC DEPENDENCY

Mansfield District Hospital is dependent on the Department of Health and Human Services for the majority of its revenue used to operate the entity. At the date of this report, the Board of Directors has no reason to believe the Department will not continue to support Mansfield District Hospital.

NOTES

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