ANNUAL REPORT
2021 – 2022

MANSFIELD
DISTRICT HOSPITAL

Disclosure Index

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

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Manner in Which the Health Service was Established

Mansfield District Hospital is a public health service established under the *Health Services Act 1988* (Vic).

Responsible Ministers

The Hon Martin Foley MP Minister for Health Minister for Ambulance Services Minister for Equality	1 July 2021 – 27 June 2022
The Hon Mary-Anne Thomas MP Minister for Health Minister for Ambulance Services	27 June 2022 – 30 June 2022
The Hon James Merlino MP Minister for Mental Health Minister for Disability, Ageing and Carers (Acting)	1 July 2021 – 27 June 2022 12 October 2021 – 5 December 2021
The Hon Gabrielle Williams MP Minister for Mental Health Minister for Treaty and First Peoples	27 June 2022 – 30 June 2022
The Hon Luke Donnellan MP Minister for Child Protection Minister for Disability, Ageing and Carers	1 July 2021 – 11 October 2021
The Hon Anthony Carbines MP Minister for Child Protection and Family Services Minister for Disability, Ageing and Carers	6 December 2021 – 27 June 2022
The Hon Colin Brooks MP Minister for Child Protection and Family Services Minister for Disability, Ageing and Carers	27 June 2022 – 30 June 2022

Purpose, Function, Powers and Duties

In accordance with Mansfield District Hospital By-Laws Section 3:

3.1 The objects of the Health Service are to:

3.1.1 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.

3.1.2 provide a range of health and related services ancillary to those services described in clause 3.1.1;

3.1.3 carry on any other activity or business that it is convenient to carry on in connection with providing the services described in clauses 3.1.1 and 3.1.2, or which are intended or calculated to make any of the Health Service's assets or activities more efficient and effective; and

3.1.4 to do all things that are conducive or incidental to achieving the Health Service's objects.

3.1.5 to ensure the accountable and efficient provision of health services and the long-term financial viability of the Health Service;

3.1.6 to ensure effective and accountable systems are in place to monitor and improve the quality, safety and effectiveness of the health services provided by the Health Service;

3.1.7 to strive to improve continuously the quality and safety of the health services provided and to foster innovation;

3.1.8 to ensure the effective and efficient use of the Health Service's resources;

3.1.9 to develop arrangements with other agencies and service providers to enable effective and efficient service delivery and continuity of care;

3.1.10 to facilitate health education to improve the training and knowledge of staff;

3.1.11 to establish and maintain effective systems to ensure:
1. that health services meet the needs of the community served by the Health Service; and
2. effective consultation with the community to take account of the views of users of the health services.

3.2 The Health Service must not do or permit anything to be done that is inconsistent with its objects or is not otherwise authorised by or under the Act.

Vision

Healthy communities, trusted healthcare

Mission

We deliver healthcare locally for our rural communities. We lead and advocate for the healthcare needs of the people of Mansfield and surrounding communities. In addition to providing safe and clinical best practice care, we focus on health promotion and preventative care to deliver the best possible outcomes for our consumers.

Nature and Range of Services Provided

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 residential aged care while Bindaree Retirement Centre provides 42 residential aged care beds. The Primary Care Centre provides a visiting nursing service, community health nursing, a wide 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. During the COVID-19 pandemic services have included COVID-19 testing, vaccination and in-home monitoring. The health service also operates a medical clinic on Mt Buller during the alpine ski season.

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 approximately 10,000 permanent residents. In holiday seasons this population increases three-fold. For obstetric services the catchment extends to include part of Murrindindi Shire.

Organisational Structure

BOARD OF DIRECTORS

Mrs Rosalind Adams
Mr Murray Beattie
Dr Karen Bennetts
Dr Pamela Dalgliesh
Mr Matthew Hoskin
Assoc Prof Lou Irving
Ms Katie Lockey
Ms Lisa Morgan
Mr Phillip Officer
Mr Richard Ray
Ms Amanda Vogt

AUDIT & RISK MANAGEMENT COMMITTEE

Dr Karen Bennetts
Mr Mark Evans (Community member)
Mr John Lazarov (Community member)
Ms Katie Lockey
Ms Lisa Morgan
Mr Richard Ray

Chair, Board of Directors:
Mr Murray Beattie

Chair, Audit & Risk Management:
Ms Lisa Morgan

Chair, Safety & Quality:
Dr Pamela Dalgliesh

Chair, Finance:
Mr Murray Beattie

Chair, Governance, Nominations and Executive Performance:
Dr Pamela Dalgliesh

Chair, Community Advisory:
Mrs Rosalind Adams

Chair, External Stakeholders Engagement:
Mr Phillip Officer

EXECUTIVE

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

Director of Clinical Services:
Ms Elizabeth Sinclair, B AppSci (Nursing) Gr Dip Education and Training MBA Cert Critical Care

Director of Medical Services:
Dr Susanty Tay MBBS DCH MHM FRACMA
1 July 2021 – 20 March 2022

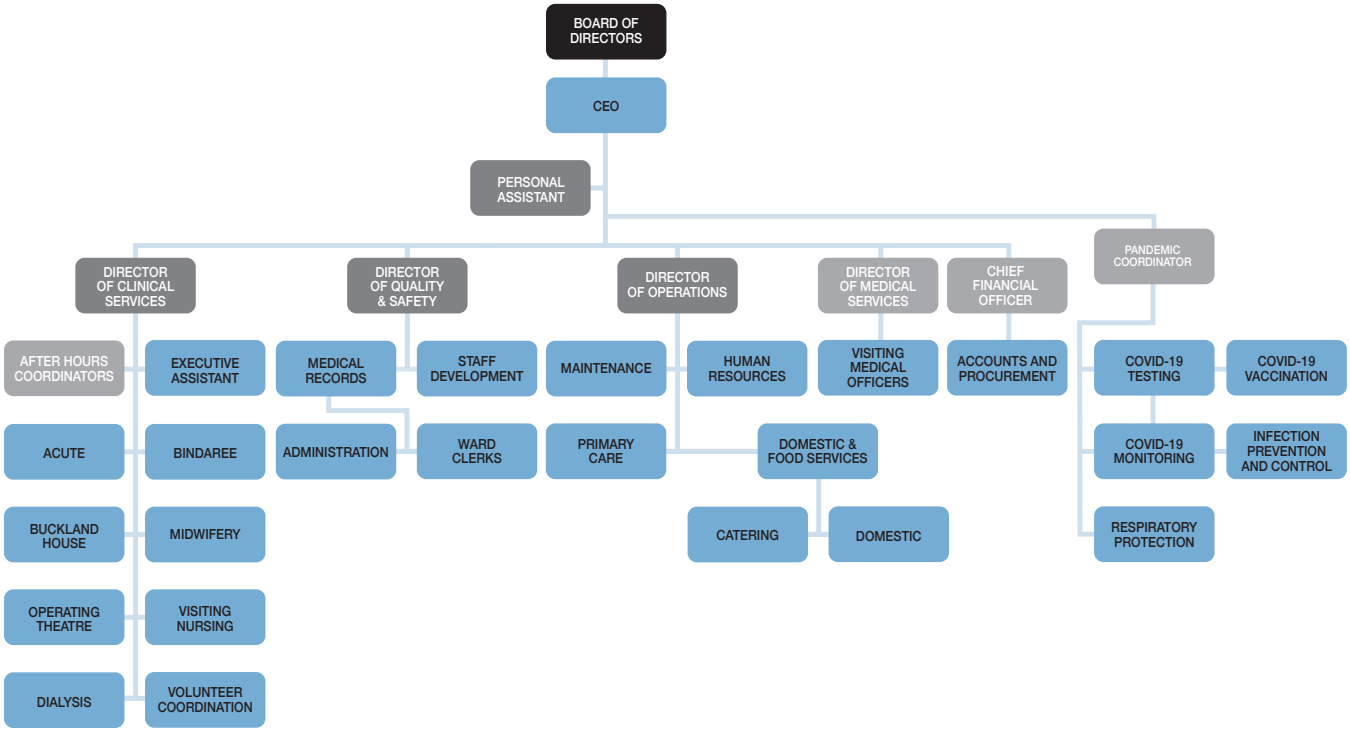
Dr Sophie Ping MBBS PhD BA Bsc Hons
21 March 2022 – 30 June 2022

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

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

Chief Financial Officer:
Ms Kirstie-Bree Fotheringham, B Acc GradDIP Ed.

Personal Assistant to CEO:
Ms Tracy Rekers



Visiting Medical Officers

Dr S Begin, MBBS FRACGP
Dr L Carter, MBBS BSC (Hons) FRACRM FRACGP
Dr D Chakraborty, MBBS FRACGP RANZCOG DRANZCOG
Dr D Cook, MBBS FACRRM FRACGP
Dr A Davis, MBBS
Dr E Dirksen, MBBS
Dr D Friday, MBBS DRANZCOG FRACGP
Dr K Green, MBBS
Dr J Harper, MBBS
Dr P Jolly, MBBS
Dr D Le Brocque, MBBS
Dr M Morrissey, MBBS BSc DCH DRANZCOG
Dr M Moyes, MBBS
Dr B Nally, MBBS
Dr S Naylor, MBBS
Dr J Penate, MBBS
Dr R Radford, MBBS
Dr M Reed, MBBS FRACGP
Dr S Richards, MBBS Dip Ed BA
Dr M Sathveegarajah, MD BSc
Dr G Slaney, MBBS DRANZCOG FRACGP MPH DA DRCOG FACRRM
Dr R Stobie, MBBS DRANZCOG FRACGP
Dr P Swart, MBBS FRACP RACGP
Dr W Twycross, MBBS DA DRANZCOG DTPH
Dr B Weatherhead, MBBS
Dr C Weatherhead, MBBS
Dr A Wettenhall, MBBS FRACGP
Dr. S Wiles, MBBS JCCA

Visiting Specialists

Dr L Dhakal, MBBS FRACP MD MPH
Mr M Forbes, MBBS FRACS
Dr P MacLeish, MBBS FRACP
Dr S Pearce, MBBS FRANZCOG
Mr P Ruljancich, MBBS FRACS
Dr W Seager, MBBS FRACS (Ortho)
Mr M Shears, MBBS (Hons) BBiomedSc PGDipAnat FRACS

Visiting Dental Practitioner

Dr D Kohli B.D Sc

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 2022.

Karen Bennetts
Board Director
Mansfield District Hospital

27th September 2022

MANSFIELD DISTRICT HOSPITAL

Year in review

Introduction

Mansfield District Hospital (MDH) and its Board of Directors are pleased to present the 2021–2022 Annual Report to the community. As the COVID-19 pandemic continues to impact us all, the unwavering dedication of our hard-working staff, under the leadership of our Chief Executive Officer (CEO), Cameron Butler, and the Executive team, has enabled the continued delivery of high-quality health care to serve the Mansfield district. I thank them for their ongoing diligence in prioritising vaccination and testing services during the year, while also managing to maintain and elevate health service delivery, despite the year's extraordinarily challenges.

Safety and Quality

MDH continues to offer a diverse range of health services to the community including primary care, acute care, urgent care, operating theatre, maternity services, together with community-based services and residential aged care facilities. MDH also operates the medical centre at Mount Buller. Across all these services, our prime focus is the consistent provision of healthcare that is safe and of the highest possible quality to consumers, their close family members and the broader Mansfield community.

The underlying quality is tested and assured with a suite of accreditation standards continuing to be fully met:

- National Safety and Quality Health Service Standards
- Aged Care Quality Standards; and
- ISO 9001:2015, an international standard dedicated to Quality Management Systems

Further, MDH has played a leadership role in the Ovens and Murray Board Quality Chairs Committee, which fosters collaboration on safety and quality issues between regional public health services.

The *Statement of Priorities*, agreed with the Department of Health for 2021–2022, and the health service key performance indicators, are included within this annual report. The broader priorities emphasised:

- Maintaining COVID-19 readiness and responsiveness
- Collaboration within our health service partnerships to support optimum use of services, facilities and resources.
- Addressing community needs, especially those of the vulnerable
- Addressing critical mental health demands and supporting mental health system reforms
- Embedding the Aboriginal and Torres Strait Islander Cultural Safety Framework

MDH also offers a number of preventative and restorative programs to benefit longer term wellbeing. Such programs include:

- **Restart:** to assist those who want to recover from substance abuse
- **Armed:** to reduce the likelihood of falls and the consequent injuries
- **Respond:** a community-led, place-based approach to improving the health and wellbeing of local children; and
- **Chronic disease programs** such as cardiac and pulmonary rehabilitation

While some services have been deferred, MDH has been able to maintain most health services together with the additional COVID-19 responses as a direct result of support from the Department of Health. Throughout the past year, the Department of Health has devoted substantial resources to give every Victorian health service the operational framework and financial support to meet community needs resulting from the COVID-19 pandemic. The Mansfield community should note that MDH has reliably met all the applicable directives and we thank the Department of Health for their assistance.

Our People

Our people are at the heart of all we do at MDH. The leadership and commitment of our CEO, Cameron Butler and his Executive team, have been particularly valued through the demands of this past year. We acknowledge their consistent efforts to keep the Board of Directors well-informed in support of MDH governance.

The Visiting Medical Officers (VMOs) together with all of our staff enable our professional and caring health service. This year we welcome Dr Sophie Ping as our new Director of Medical Services, a critical role in maintaining clinical standards, relationships and capability frameworks. The Board extends its thanks to the entire staff team.

Our Community

While MDH receives government funding for its operational and capital development, the health service is generously supported by our local community. We are very grateful for the ongoing support and assistance offered by the MDH Auxiliary and the Bindaree Auxiliary. We also thank the Harry and Clare Friday Foundation for their generous donation that allowed us to purchase dementia specific equipment for Buckland House and Bindaree. The Mansfield Golf Club and a number of generous individuals and organisations in the Mansfield area are also thanked for their continued assistance.

MDH also benefits from collaboration and partnerships with other health services, particularly within the Hume Region. We value our relationship with Mansfield Shire Council and the Mount Buller and Mount Stirling Resort Management Board and thank them for their support during the year.

Our community also assists MDH with representation on three of our Board committees – Safety and Quality, Audit and Risk Management, and Community Advisory. The input of community representatives is an important contribution to MDH's strategic objectives. We thank those who have volunteered for these roles during the year and welcome expressions of interest from the wider Mansfield community for future participation.

Governance

MDH is fortunate to have a strong, stable and diverse group of people who serve on our Board of Directors. In partnership with MDH's operational management, led by the CEO, the Board is tasked with good governance, including compliance with all legislative and regulatory directives of the Department of Health. The Board is also responsive to serving the needs of the local community today and into the future.

I would like to acknowledge the nine-year maximum contribution of MDH director Murray Beattie, who recently retired from the Board and his position of Chair. We thank Murray for his hard work and dedication to MDH over such a long period. His experience and insight will be sadly missed.

Board Directors are expected to be able to make decisions on matters across all areas of the hospital's work. This responsibility can be very rewarding but calls for a contribution of time and energy. On behalf of the Mansfield community, I thank the MDH Directors for their ongoing commitment to service.

Key Initiatives

MDH continues to strive for improvement into the future. During the year, MDH prepared to take up the provision from 1 July 2022 of Community Aged Services that had previously been provided by Mansfield Shire Council. MDH also continued with management of the Mount Buller Medical Centre.

Masterplan for the development of MDH

The masterplan process has continued this year through collaboration with the state government. We were delighted to receive confirmation in May 2022 that significant funding would be provided to enable Stage 1 of the masterplan to proceed. This stage involves the redevelopment of all MDH's 72 aged care beds to create a modernised and co-located aged care facility. We look forward to progressing the design phase for Stage 1 in the coming year.

MDH Strategic Plan for 2020–24

This important cornerstone for Mansfield District Hospital outlines the key drivers regarding the importance of staff, the community and the quality of the healthcare. The five-year plan clearly prioritises the core values of MDH and the means for achieving them. The document is available on the MDH website and we encourage everyone to read it.

Financial Performance

I am pleased to report MDH's sound financial performance for the 2021–2022 budget year. Once again, COVID-19 had a significant impact on our operating expenditure. However, we were again fortunate to have substantial financial support from the Department of Health.

MDH met all financial management measures outlined within the Statement of Priorities. The full financial reports are included within this annual report. I would like to acknowledge the strength of the financial result, which is a credit to our CEO, Executive team and our Chief Finance Officer Kirstie-Bree Fotheringham.

Acknowledgements

As we come to terms with living with COVID-19, I once again want to recognise the work of MDH's entire team, staff, VMOs, community volunteers and donors, as they work to support our provision of great care, day in, day out. On behalf of the Board of Directors, we thank you for your wholehearted service and support, your patience, resilience and enthusiasm in these difficult times. Together with my colleagues on the Board of Directors, we thank you one and all.

Karen Bennetts
Board Chair

Mansfield District Hospital Auxiliary Report

Well, it's been another interesting twelve months for our Auxiliary. We said goodbye to one of our hardworking members – Kaye Woods, and welcomed three new members – Rosemary Holt, Kathy Irvin, and Eliza Foster.

Despite limited fundraising opportunities, we had another successful year. Our efforts yielded $77,180.93 due to the success of the Annual Golf Day, the Art Installation at the Produce Store, and generous donations.

While we were unable to hold the Art Show yet again this year, we did, in conjunction with the Produce Store, stage an Art Installation over an eight-week period starting in October and ending with the final rotation of art in January. This proved to be very popular with the artists and with the patrons of the Produce Store.

We've been so lucky to be able to hold the Annual Golf Day all through this pandemic, and once again, it was fantastic. The weather co-operated and the course was in fabulous condition. Local business, individuals and donors from out of Mansfield generously supported the event and we hope this continues for the foreseeable future. Mr. Craig Willis was our M.C. on the day and Andy Marshall of Mansfield FoodWorks, donated the food for the lunch that was prepared by Chef Marcus Van Clute. The on-course BBQ was manned by A Third Hand. Thanks go to our Major Sponsors Rennie De Maria of PSC Alliance Insurance and Dion Theodossi who kindly provided a car for the Hole in One, Jenny Gould of Mansfield DPG who sponsored the putting competition, and Rod and Sandra Glue of Vacuum Trucks. Also, thanks to David Joyce and to Greg Nugent for providing the Golf Club and course for the day and to his hard-working staff, notably Tony Cooksey and his staff for the magnificent state of the course. Without the support of these generous and community minded people as well as many other supporters who provide goods and services for auctions, silent auctions and raffles, we could not hold this popular and successful event. Our thanks also go to all those who worked tirelessly to run the event; Susan Kinloch, Auxiliary members, Friends of the Auxiliary and many other family and friends who helped on the day.

Unfortunately, due to things beyond our control, that was the end of our fundraising for the year. We are currently planning the Art Exhibition and Sale that was unable to be held for the last two years, and this will be our 44th Art Exhibition and Sale.

I have no doubt the next 12 months will be interesting as it will be the 100th Anniversary of the Mansfield Hospital Auxiliary in its many forms – so be on the lookout for new functions from the Mansfield District Hospital Auxiliary.

Sue Swan
President
Mansfield District Hospital Auxiliary

Bindaree Auxiliary Report

The COVID-19 pandemic has continued to impact on the ability of the Auxiliary to operate as effectively as we would wish this year. We endeavoured to maintain contact with activities staff at Bindaree, and offer financial support for some of the activities.

Auxiliary is pleased to note the continued successful operation of the Shopping Trolley – now operated by residents under the supervision of staff. This is felt to be a very positive outcome. Supplies are replenished using funds raised, with the Auxiliary augmenting these funds on request.

We were able to attend a couple of residents' meetings and hear the residents' views on items they would like. In consultation with the activities staff and residents, approval has been given to use funds in the Residents' Account for the purchase of exercise equipment for the residents use under the supervision of the Physiotherapist. Auxiliary will give additional funds for this project if required.

COVID-19 restrictions continued to impact on fundraising activities. A planned Floral Art demonstration was in jeopardy when our guest presenter caught COVID-19 two days prior to the demonstration. We were most grateful to Christine Leatham – another talented local, who stepped up and conducted a most interesting demonstration, with the floral arrangement also being painted by local artist Jenny Gibney. The arrangement and painting were donated as prizes and together with afternoon tea and raffles a most satisfactory amount was raised.

Auxiliary was most interested to hear from Hospital CEO – Cameron Butler – details of the successful grant for the proposed re-development of Mansfield's Aged Care facilities – with an upgrade to Bindaree and relocation of Buckland House, so that all Aged Care provision will be on the one site. This was very welcome news indeed and congratulations are due to the Hospital Board and all those involved in the grant application. We look forward to hearing more as the plans proceed.

Bindaree Auxiliary like many other similar groups has declined in number over the past two years, but we have been pleased to welcome some new members recently. With the proposed redevelopment of the site and relocation of Buckland House, it seems timely to consider how Auxiliaries will function & support the new development going forward. Accordingly, we plan to liaise with the Hospital Auxiliary to plan for the future.

Lyn Uren
Acting President
Bindaree Auxiliary

Norma Pearce
Secretary
Bindaree Auxiliary

Workforce

Mansfield District Hospital adheres to the public sector employment principles. These align to our organisational values and together they shape the working environment we offer to our employees. They assist in maintaining the workplace culture whereby there are productive and harmonious working relationships, employees are treated well, have career opportunities and can safely raise their concerns.

As a result of the pandemic our employees have been challenged like never before. A strong organisational culture and commitment to wellbeing has assisted them to deal with uncertainty, stress and workforce shortages.

Mansfield District Hospital Values:

CONSUMERS ARE AT THE CENTRE OF OUR CARE

- WE DELIVER GREAT CARE – We strive for the best health outcomes for our consumers and communities every time. Consumers are at the centre and we consistently provide high-quality, safe and personalised care. We demonstrate empathy and kindness in every aspect of our care.
- WE RESPECT EACH OTHER – We respect our peers, our consumers, our hospital and our environment. Care is delivered thoughtfully and with compassion. We are considerate of our consumers' dignity and privacy, and our consumers trust and have confidence in our quality of care. We actively listen and act fairly, impartially and without judgement.
- WE WORK TOGETHER – We work as a cohesive team and feel connected to the work we do together. We maintain strong connections to our diverse communities in and outside of Mansfield. We work in collaboration with our partners to deliver exceptional care. We have honest and open conversations with our staff, consumers and the community.
- WE EMPOWER EACH OTHER – We support and trust each other to deliver an exceptional consumer experience. We give our consumers the information and resources they need to make considered and informed decisions about their health care. We continuously support our staff in their development and empower them to make decisions based on their best judgement.

All employees have been correctly classified in workforce data collections.

Hospitals Labour Category	JUNE Current Month FTE*		Average Monthly FTE**	
	2021	2022	2021	2022
Nursing	73.05	73.01	71.40	76.87
Administration and Clerical	22.46	23.25	19.53	24.37
Medical Support	1.00	1.00	1.00	1.13
Hotel and Allied Services	40.23	37.16	40.07	38.46
Medical Officers	–	–	–	–
Hospital Medical Officers	–	–	–	0.09
Sessional Clinicians	0.21	–	0.07	0.04
Ancillary Staff (Allied Health)	9.57	11.39	9.41	11.40
TOTAL	**146.52**	**145.81**	**141.48**	**152.36**

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

Occupational Health and Safety

Mansfield District Hospital is committed to providing a safe environment for employees, consumers and members of the public. The Health Service complies with the requirements of the Occupational Health and Safety Act (Vic) 2004 and the Victorian Occupational Health and Safety Regulations 2017.

Health and Safety Representatives work hard to find ways to eliminate or mitigate the risk of injury within the workplace. This builds on a culture to identify and report issues early. Where injury has occurred, the health service seeks to achieve the safe, appropriate, supportive and timely return to work of employees.

Reported Incidents

Occupational Health and Safety Statistics	2021–22	2020–21	2019–20
The number of reported hazards for the year per 100 FTE	2.6	8.5	10
The number of reported incidents for the year per 100 FTE	28	30	25
The number of 'lost time' standard WorkCover claims for the year per 100 FTE	2	0	0
The average cost per WorkCover claim for the year ('000)	$1.85	$0	$0

Occupational Violence

Occupational Violence Statistics	2021–22
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	17
Number of occupational violence incidents reported per 100 FTE	11
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	6.6%

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 2020–21.
- **Lost time** – lost time is defined as greater than one day.
- **Injury, illness or condition** – this includes all reported harm as a result of the incident, regardless of whether the employee required time off work or submitted a claim.

Financial Results

Summary of Financial Results for last five years

	2022 $000	2021 $000	2020 $000	2019 $000	2018 $000
Operating result*	**5**	**0**	**52**	**279**	**67**
Total revenue	26,021	21,286	19,560	19,695	18,276
Total expenses	27,477	23,126	20,800	19,109	18,234
Net result from transactions	**(1,456)**	**(1,300)**	**(1,240)**	**586**	**42**
Total other economic flows	177	134	(35)	(133)	6
Net result	**(1,279)**	**(1,166)**	**(1,275)**	**453**	**48**
Total assets	48,439	51,157	49,065	48,777	40,118
Total liabilities	17,054	20,915	18,066	16,503	16,695
Net assets/Total equity	**31,385**	**30,242**	**30,999**	**32,274**	**23,423**

* The Operating result is the result for which the heath service is monitored in its Statement of Priorities.

Reconciliation of Net Result from Transactions and Operating Result

	2021–22 $000
Operating result	**5**
Capital purpose income	416
Specific income	–
COVID-19 State Supply Arrangements Assets received free of charge or for nil consideration under the State Supply	585
State supply items consumed up to 30 June 2022	(578)
Assets provided free of charge	–
Assets received free of charge	–
Expenditure for capital purpose	(67)
Depreciation and amortisation	(1,808)
Impairment of non-financial assets	–
Finance costs (other)	(9)
Net results from transactions	**(1,456)**

Consultancies

Details of consultancies (under $10,000)
In 2021–2022 there were two consultancies where the total fees payable to the consultants were less than $10,000. The total expenditure during 2021–2022 in relation to these consultancies is $3,800 (exc. GST).

Details of consultancies (valued at $10,000 or greater)
In 2021–2022 there were nil consultancies where the total fees payable to the consultants were $10,000 or greater (exc. GST).

Information and Communication Technology (ICT) expenditure

The total ICT expenditure incurred during 2021–2022 is $831,800 (excluding GST) with the details shown below.

Business As Usual (BAU) ICT expenditure	Non-Business As Usual (non-BAU) ICT expenditure		
Total (excluding GST)	Total = Operational expenditure and capital expenditure (excluding GST)	Operational expenditure (excluding GST)	Capital expenditure (excluding GST)
$805,600	$26,200	$–	$26,200

Disclosures Required Under Legislation

Freedom of Information Act 1982

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

In 2021–2022 there were nineteen applications made to the organisation under these provisions. Of these all nineteen 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.

Information on making a Freedom of Information request can be found at http://mdh.org.au/contact/make-a-foi-request/. Applications may be submitted by post or in person.

Building Act 1993

Mansfield District Hospital has complied with building and maintenance provisions of the *Building Act 1993* guidelines for publicly owned buildings. Mansfield District Hospital also complied with the relevant provisions of the National Construction Code.

In 2021–2022 a Fire Risk Management Survey was undertaken in accordance with Department of Health Fire Risk Management Guidelines.

Public Interest 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). Individuals with concerns about corrupt or improper conduct are encouraged to raise the matter directly with IBAC.

Mansfield District Hospital is committed to extending the protections under the *Public Interest 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.ibac.vic.gov.au and http://www.ombudsman.vic.gov.au

Statement on National Competition Policy

Mansfield District Hospital complied with government policies regarding competitive neutrality including *Competitive Neutrality Policy Victoria.*

Carers Recognition Act 2012

Mansfield District Hospital service recognises and respects carers and fulfils its responsibilities and obligations under the Act for people in care relationships and the role of carers in our community. The health service actively works with carers to find ways for people in care relationships to have input into care planning and service delivery complying with all requirements of the Act. Mansfield District Hospital has complied with its obligations under Section 11 of the Act for the reporting period 1st July 2021 to 30th June 2022.

Environmental Performance

Public environment report – Mansfield District Hospital – 2021/2022

GREENHOUSE GAS EMISSIONS

Total greenhouse gas emissions (tonnes CO_2e)	2019/2020	2020/2021	2021/2022
Scope 1	233.110	227.302	180.319
Scope 2	806.464	788.468	679.489
Total	**1,040**	**1,016**	**860**

Normalised greenhouse gas emissions	2019/2020	2020/2021	2021/2022
Emissions per unit of floor space ($kgCO_2e/m^2$)	156.941	153.347	129.802
Emissions per unit of Separations ($kgCO_2e$/Separations)	572.453	582.437	442.516
Emissions per unit of bed-day (LOS+Aged Care OBD) ($kgCO_2e$/OBD)	37.108	36.164	30.977

STATIONARY ENERGY

Total stationary energy purchased by energy type (GJ)	2019/2020	2020/2021	2021/2022
Electricity	2846.345	2896.414	2688.088
Liquefied Petroleum Gas	3839.837	3697.148	2975.559
Total	**6,686**	**6,594**	**5,664**

Normalised stationary energy consumption	2019/2020	2020/2021	2021/2022
Energy per unit of floor space (GJ/m^2)	1.009	0.995	0.855
Energy per unit of Separations (GJ/Separations)	3.682	3.781	2.915
Energy per unit of bed-day (LOS+Aged Care OBD) (GJ/OBD)	0.239	0.235	0.204

WATER

Total water consumption by type (kL)	2019/2020	2020/2021	2021/2022
Potable Water	5680.666	6801.767	7353.192
Total	**5,681**	**6,802**	**7,353**

Normalised water consumption (Potable + Class A)	2019/2020	2020/2021	2021/2022
Water per unit of floor space (kL/m^2)	0.858	1.027	1.110
Water per unit of Separations (kL/Separations)	3.128	3.900	3.784
Water per unit of bed-day (LOS+Aged Care OBD) (kL/OBD)	0.203	0.242	0.265

WASTE AND RECYCLING

Waste	2019/2020	2020/2021	2021/2022
Total waste generated (kg clinical waste+kg general waste+kg recycling waste)	57267.850	58292.140	55924.570
Total waste to landfill generated (kg clinical waste+kg general waste)	44480.350	45339.640	44209.570
Total waste to landfill per patient treated ((kg clinical waste+kg general waste)/PPT)	1.491	1.520	1.489
Recycling rate % (kg recycling/(kg general waste+kg recycling))	23.727	24.134	23.763

Additional information available on request

Details in respect of the items listed below have been retained by the health service and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements, if applicable):

- Declarations of pecuniary interests have been duly completed by all relevant officers;
- Details of shares held by senior officers as nominee or held beneficially;
- Details of publications produced by Mansfield District Hospital about itself, and how these can be obtained;
- Details of changes in prices, fees, charges, rates and levies charged by the Health Service;
- Details of any major external reviews carried out on the Health Service;
- Details of major research and development activities undertaken by the Health Service;
- Details of overseas visits undertaken including a summary of the objectives and outcomes of each visit;
- Details of major promotional, public relations and marketing activities undertaken by the Health Service to develop community awareness of the Health Service and its services;
- Details of assessments and measures undertaken to improve the occupational health and safety of employees;
- Information on industrial relations matters within the Health Service and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the report of operations;
- A list of major committees sponsored by the Health Service, the purposes of each committee and the extent to which those purposes have been achieved;
- Details of all consultancies and contractors including consultants/contractors engaged, services provided, and expenditure committed for each engagement.

Local Jobs First Act 2003

There were no contracts undertaken requiring reporting in this category in 2021–22.

Gender Equality Act 2020

Mansfield District Hospital has undertaken and revised health service policies and work instructions relevant to the Gender Equality Act 2020. Mansfield District Hospital has completed a Gender Equality Audit and Gender Equality Action Plan that has been submitted to the Department for consideration and approval.

Attestations and Declarations

Financial Management Compliance Attestation

I, Karen Bennetts, on behalf of the Responsible Body, certify that Mansfield District Hospital has no Material Compliance Deficiency with respect to the applicable Standing Directions under the *Financial Management Act 1994* and Instructions.

Karen Bennetts
Responsible Officer
Mansfield District Hospital
27th September 2022

Data Integrity Declaration

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
27th September 2022

Conflict of Interest Declaration

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
27th September 2022

Integrity, Fraud and Corruption Declaration

I, Cameron Butler, certify that Mansfield District Hospital has put in place appropriate internal controls and processes to ensure that integrity, fraud and corruption risks have been reviewed and addressed at Mansfield District Hospital during the year.

Cameron Butler
Accountable Officer
Mansfield District Hospital
27th September 2022

Safe Patient Care Act 2015

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

Statement of Priorities

Priority	Outcome against priority
Maintain robust COVID-19 readiness and response, working with the Department to ensure a rapid response to outbreaks, if and when, they occur, which includes providing testing for community and staff, where necessary, and if required. This includes preparing to participate in, and assist with, the implementation of COVID-19 vaccine immunisation program rollout, ensuring our local community's confidence in the program.	Over the course of 2021–2022 the health service has worked exceedingly hard to minimize the impact of COVID-19 to the local community. This has included maintaining testing both in Mansfield and Mt Buller. The Vaccination Clinic played a major role in ensuring in excess of 95% of the community were vaccinated along with providing a service to neighbouring communities and residential aged care facilities. Local outbreaks have been dealt with in partnership with the Local Public Health Unit.
Actively collaborate on the development and delivery of priorities within our Health Services Partnership, contribute to inclusive and consensus-based decision-making, support optimum utilization of services, facilities and resources within the Partnership, and be collectively accountable for delivering against Partnership accountabilities as set out in the *Health Services Partnership Policy and Guidelines.*	There has been ongoing participation in the Regional Health Services Partnership.
Engage with our community to address the needs of patients, especially our most vulnerable whose care has been delayed due to the pandemic and provide necessary catch-up care to support and get them back on track. Work collaboratively with our Health Services Partnership to: • Implement the *Better at Home* initiative to enhance the in-home and virtual models of patient care when it is safe, appropriate ad consistent with patient preference. • Improve elective surgery performance and ensure that patients who have waited longer than clinically recommended for treatment have their needs addressed as a priority.	There has been ongoing engagement with the local community to provide catch-up care. Whilst elective surgery was at a lower level than previously, notably as a result of COVID-19, the health service has increased the number of theatre sessions per month by 33% and increased the numbers of visiting specialists. This is in response to community feedback on being able to access service closer to home.
Address critical mental health demand pressures and support the implementation of mental health system reforms to embed integrated mental health and suicide prevention pathways for people with, or at risk of, mental illness or suicide through a whole-of-system approach as an active participant in our Health Service Partnership and through our Partnership's engagement with Regional Mental Health and Wellbeing Boards.	Through participation in the Regional Health Services Partnership there has been planning for implementation of mental health system reforms. There was also participation in the development of a sub-acute clinical services plan with a public mental health provider through membership of the Steering Committee and contributing to the plan.
Embed the Aboriginal and Torres Strait Islander Cultural Safety Framework into our organisation and build a continuous quality improvement approach to improving cultural safety, underpinned by Aboriginal self-determination, to ensure delivery of culturally safe care to Aboriginal patients and families, and to provide culturally safe workplaces for Aboriginal employees.	There has been ongoing involvement with Gadhaba Local Aboriginal Network. This provides for engagement with key members of the network and allows them to have input into policy and practice. There is First Nations representation on the Community Advisory Committee.

Statement of Priorities – Key Performance Measures Part B

High quality and safe care

Key Performance Measure	Target	Result
Infection prevention and control		
Compliance with Hand Hygiene Australia program	85%	89.1%
Percentage of healthcare workers immunised for Influenza	92%	89%
Patient experience		
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – Quarter 1	95%	N/A*
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – Quarter 2	95%	N/A*
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – Quarter 3	95%	N/A*
Maternity and newborn		
Rate of singleton term infants without birth anomalies with APGAR score <7 to 5 minutes	≤ 1.4%	0.0%
Rate of severe fetal growth restriction (FGR) in singleton pregnancy undelivered by 40 weeks	< 28.6%	0.0%

* Less than 10 responses received

Strong governance, leadership and culture

Key Performance Measure	Target	Result
Governance, leadership and culture		
Safety Culture Among Healthcare Workers	62%	86%

Effective financial management

Key Performance Measure	Target	Result
Operating result ($m)	$0m	$0.05m
Average number of days to pay trade creditors	60 days	50
Average number of days to receive patient fee debtors	60 days	51
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	1.35
Actual number of days available cash, measured on the last day of each month	14 days	26.7 days
Variance between forecast and actual Net result from transactions (NRFT) for the current financial year ending 30 June	Variance ≤ $250,000	$860,000

Statement of Priorities – Part C

Funding type	Activity	Unit of Measure
Small Rural		
Small Rural Acute	976.84	**NWAU**
Small Rural Primary Health		**Service Hours**
Nursing	1,500	Service Hours
Allied Health		
• Counselling/Casework	500	Service Hours
• Dietetics	531	Service Hours
• Occupational Therapy	831	Service Hours
• Physiotherapy	915	Service Hours
• Speech Therapy	687	Service Hours
• Initial Needs Identification	654	Service Hours
Small Rural HACC-PYP (Visiting Nursing)	**343**	**Service Hours**
Commonwealth Home Support Program (Visiting Nursing)	**3,118**	**Service Hours**
Small Rural Residential Care	**22,969**	**Beddays**

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Mansfield District Hospital

ABN 65 866 548 895

Financial Statements for the Financial Year ended 30 June 2022

FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2022

Mansfield District Hospital presents its audited general purpose financial statements for the financial year ended 30 June 2022 in the following structure to provide users with the information about Mansfield District Hospital's stewardship of the resources entrusted to it.

TABLE OF CONTENTS

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 Assistant Treasurer 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 2022 and the financial position of Mansfield District Hospital at 30 June 2022.

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

We authorise the attached financial statements for issue on 27 September 2022.

Dr. K Bennetts
Board Chair

Mansfield
27-Sep-22

Mr C. Butler
Chief Executive Officer

Mansfield
27-Sep-22

Ms K. Fotheringham
Chief Financial Officer

Mansfield
27-Sep-22

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Mansfield District Hospital

Opinion	I have audited the financial report of Mansfield District Hospital (the health service) which comprises the: • balance sheet as at 30 June 2022 • 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 officer's and chief finance & accounting officer's declaration. In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2022 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
25 October 2022

Dominika Ryan
as delegate for the Auditor-General of Victoria

Mansfield District Hospital

COMPREHENSIVE OPERATING STATEMENT

for the Financial Year Ended 30 June 2022

	Note	**Total 2022 $'000**	Total 2021 $'000
Revenue and income from transactions			
Operating activities	2.1	25,331	21,135
Non-operating activities	2.1	375	406
Share of revenue from Hume Rural Health Alliance JV	8.7	315	285
Total revenue and income from transactions		**26,021**	**21,826**
Expenses from transactions			
Employee expenses	3.1	(20,222)	(16,752)
Supplies and consumables	3.1	(2,799)	(2,115)
Finance costs	3.1	(2)	(3)
Depreciation and amortisation	4.4	(1,808)	(1,771)
Other administrative expenses	3.1	(1,400)	(1,441)
Other operating expenses	3.1	(919)	(719)
Other non-operating expenses	3.1	(15)	(35)
Share of expenses from Hume Rural Health Alliance JV	8.7	(312)	(290)
Total expenses from transactions		**(27,477)**	**(23,126)**
Net result from transactions – net operating balance		**(1,456)**	**(1,300)**
Other economic flows included in net result			
Net gain/(loss) on sale of non financial assets	3.2	–	9
Other gain/(loss) from other economic flows	3.2	177	135
Share of other economic flows from Hume Rural Health Alliance JV	8.7	–	(10)
Total other economic flows included in net result		**177**	**134**
Net result for the year		**(1,279)**	**(1,166)**
Other comprehensive income			
Items that will not be reclassified to net result			
Changes in buildings revaluation surplus	4.3	2,206	–
Changes in land revaluation surplus	4.3	216	409
Total other comprehensive income		**2,422**	**409**
Comprehensive result for the year		**1,143**	**(757)**

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

Mansfield District Hospital

BALANCE SHEET

as at 30 June 2022

	Note	**Total 2022 $'000**	Total 2021 $'000
Current assets			
Cash and cash equivalents	6.2	19,162	23,457
Receivables and contract assets	5.1	665	476
Inventories	4.5	113	116
Prepaid expenses		142	169
Share of current assets in Hume Rural Health Alliance JV	8.7	510	540
Total current assets		**20,592**	**24,758**
Non-current assets			
Receivables and contract assets	5.1	1,367	923
Property, plant and equipment	4.1	26,466	25,456
Share of non-current assets in Hume Rural Health Alliance JV	8.7	14	20
Total non-current assets		**27,847**	**26,399**
Total assets		**48,439**	**51,157**
Current liabilities			
Payables and contract liabilities	5.2	1,198	1,462
Borrowings	6.1	94	38
Employee benefits	3.3	4,464	4,106
Other Liabilities	5.3	10,487	14,571
Share of current liabilities in Hume Rural Health Alliance JV	8.7	268	302
Total current liabilities		**16,511**	**20,479**
Non-current liabilities			
Borrowings	6.1	44	141
Employee benefits	3.3	494	287
Share of non-current liabilities in Hume Rural Health Alliance JV	8.7	5	8
Total non-current liabilities		**543**	**436**
Total liabilities		**17,054**	**20,915**
Net assets		**31,385**	**30,242**
Equity			
Property, plant and equipment revaluation surplus	SCE	27,932	25,510
Contributed capital	SCE	10,853	10,853
Accumulated deficit	SCE	(7,400)	(6,121)
Total equity		**31,385**	**30,242**

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 2022

	Property, Plant and Equipment Revaluation Surplus $'000	Contributed Capital $'000	Accumulated Deficits $'000	Total $'000
Balance at 30 June 2020	**25,101**	**10,853**	**(4,955)**	**30,999**
Net result for the year	–	–	(1,166)	(1,166)
Other comprehensive income for the year	409	–	–	409
Balance at 30 June 2021	**25,510**	**10,853**	**(6,121)**	**30,242**
Net result for the year	–	–	(1,279)	(1,279)
Other comprehensive income for the year	2,422	–	–	2,422
Balance at 30 June 2022	**27,932**	**10,853**	**(7,400)**	**31,385**

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

Mansfield District Hospital

CASH FLOW STATEMENT

for the Financial Year Ended 30 June 2022

	Note	**Total 2022 $'000**	Total 2021 $'000
Cash flows from operating activities			
Operating grants from Government		20,358	17,861
Capital grants from Government – State		91	151
Patient fees received		1,931	2,357
Donations and bequests received		158	224
GST received from ATO		562	502
Interest and investment income received		355	406
Other receipts		2,050	716
Total receipts		**25,505**	**22,217**
Employee expenses paid		(19,656)	(16,003)
Payments for supplies and consumables		(3,021)	(2,327)
Payments for repairs and maintenance		(447)	(276)
Finance costs		(2)	(3)
Other payments		(2,144)	(1,943)
Total payments		**(25,270)**	**(20,552)**
Net cash flows from operating activities	8.1	**235**	**1,665**
Cash flow from investing activities			
Purchase of property, plant and equipment		(427)	(632)
Proceeds from sale of non-financial assets		–	1
Net cash flows from investing activities		**(427)**	**(631)**
Cash flow from financing activities			
Repayment of borrowings		(15)	(14)
Receipt of accommodation deposits		812	5,292
Repayment of accommodation deposits		(4,900)	(3,929)
Net cash flows from/(used in) financing activities		**(4,103)**	**1,349**
Net increase/(decrease) in cash and cash equivalents held		**(4,295)**	**2,383**
Cash and cash equivalents at beginning of year		23,457	21,074
Cash and cash equivalents at end of year	6.2	**19,162**	**23,457**

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

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2022

Structure

NOTE 1: BASIS OF PREPARATION

These financial statements represent the audited general purpose financial statements for Mansfield District Hospital for the year ended 30 June 2022. The report provides users with information about Mansfield District Hospital's stewardship of the resources entrusted to it.

This section explains the basis of preparing the financial statements and identifies the key accounting estimates and judgements.

NOTE 1.1: BASIS OF PREPARATION OF THE FINANCIAL STATEMENTS

These financial statements are general purpose financial statements which have been prepared in accordance with the Financial Management Act 1994 and applicable Australian Accounting Standards, 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 (DTF), and relevant Standing Directions (SDs) authorised by the Assistant Treasurer.

Mansfield District Hospital is a not-for-profit entity and therefore applies the additional AUS paragraphs applicable to a "not-for-profit" health service under the Australian Accounting Standards.

Australian Accounting Standards set out accounting policies that the AASB has concluded would result in financial statements containing relevant and reliable information about transactions, events and conditions. Apart from the changes in accounting policies, standards and interpretations as noted below, material accounting policies adopted in the preparation of these financial statements are the same as those adopted in the previous period.

The financial statements, except for the cash flow information, have been prepared on an accruals basis and are based on historical costs, modified, where applicable, by the measurement at fair value of selected non-current assets, financial assets and financial liabilities.

The financial statements have been prepared on a going concern basis (refer to Note 8.9 Economic Dependency).

The financial statements are in Australian dollars.

The amounts presented in the financial statements have been rounded to the nearest thousand dollars. Minor discrepancies in tables between totals and sum of components are due to rounding.

The annual financial statements were authorised for issue by the Board of Mansfield District Hospital and its controlled entities on 27 September 2022.

NOTE 1.2: IMPACT OF COVID-19 PANDEMIC

In March 2020 a state of emergency was declared in Victoria due to the global coronavirus pandemic, known as COVID-19. On 2 August 2020 a state of disaster was added with both operating concurrently. The state of disaster in Victoria concluded on 28 October 2020 and the state of emergency concluded on 15 December 2021.

The COVID-19 pandemic has created economic uncertainty. Actual economic events and conditions in the future may be materially different from those estimated by the health service at the reporting date. Management recognises that is difficult to reliably estimate with certainty, the potential impact of the pandemic after the reporting date on the health service, its operations, its future results and financial position.

In response to the ongoing COVID-19 pandemic, Mansfield District Hospital has:

- introduced restrictions on non-essential visitors
- greater utilisation of telehealth services
- implemented reduced visitor hours
- deferred elective surgery and reducing activity
- performed COVID-19 testing
- established and operated a vaccination clinic
- changed infection control practices
- implemented work from home arrangements, where appropriate.

Where financial impacts of the pandemic are material to Mansfield District Hospital, they are disclosed in the explanatory notes. For Mansfield District Hospital, this includes:

- Note 2: Funding delivery of our services
- Note 3: The cost of delivering our services

NOTE 1.3: ABBREVIATIONS AND TERMINOLOGY USED IN THE FINANCIAL STATEMENTS

The following table sets out the common abbreviations used throughout the financial statements:

Reference	Title
AASB	Australian Accounting Standards Board
AASs	Australian Accounting Standards, which include Interpretations
DH	Department of Health
DTF	Department of Treasury and Finance
FMA	Financial Management Act 1994
FRD	Financial Reporting Direction
NWAU	National Weighted Activity Unit
SD	Standing Direction
VAGO	Victorian Auditor General's Office
WIES	Weighted Inlier Equivalent Separation
MDH	Mansfield District Hospital
HRHA	Hume Rural Health Alliance

NOTE 1.4: JOINT ARRANGEMENTS

Interests in joint arrangements are accounted for by recognising in Mansfield District Hospital's financial statements, its share of assets and liabilities and any revenue and expenses of such joint arrangements.

Mansfield District Hospital has the following joint arrangements:

- Hume Rural Health Alliance joint venture.

Details of the joint arrangements are set out in Note 8.7.

NOTE 1.5: KEY ACCOUNTING ESTIMATES AND JUDGEMENTS

Management make estimates and judgements when preparing the financial statements.

These estimates and judgements are based on historical knowledge and best available current information and assume any reasonable expectation of future events. Actual results may differ.

Revisions to key estimates are recognised in the period in which the estimate is revised and also in future periods that are affected by the revision.

The accounting policies and significant management judgements and estimates used, and any changes thereto, are identified at the beginning of each section where applicable and are disclosed in further detail throughout the accounting policies.

NOTE 1.6: ACCOUNTING STANDARDS ISSUED BUT NOT YET EFFECTIVE

An assessment of accounting standards and interpretations issued by the AASB that are not yet mandatorily applicable to Mansfield District Hospital and their potential impact when adopted in future periods is outlined below:

Standard	Adoption Date	Impact
AASB 17: *Insurance Contracts*	Reporting periods on or after 1 January 2023	Adoption of this standard is not expected to have a material impact
AASB 2020-1: *Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-Current*	Reporting periods on or after 1 January 2022	Adoption of this standard is not expected to have a material impact
AASB 2020-3: *Amendments to Australian Accounting Standards – Annual Improvements 2018–2020 and Other Amendments*	Reporting periods on or after 1 January 2022	Adoption of this standard is not expected to have a material impact
AASB 2021-2: *Amendments to Australia Accounting Standards – Disclosure of Accounting Policies and Definitions of Accounting Estimates.*	Reporting periods on or after 1 January 2023	Adoption of this standard is not expected to have a material impact
AASB 2021-5: *Amendments to Australian Accounting Standards – Deferred Tax related to Assets and Liabilities arising from a Single Transaction*	Reporting periods on or after 1 January 2023	Adoption of this standard is not expected to have a material impact
AASB 2021-6: *Amendments to Australian Accounting Standards – Disclosure of Accounting Policies: Tier 2 and Other Australian Accounting Standards*	Reporting periods on or after 1 January 2023	Adoption of this standard is not expected to have a material impact
AASB 2021-7: *Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128 and Editorial Corrections*	Reporting periods on or after 1 January 2023	Adoption of this standard is not expected to have a material impact

There are no other accounting standards and interpretations issued by the AASB that are not yet mandatorily applicable to Mansfield District Hospital in future periods.

NOTE 1.7: GOODS AND SERVICES TAX (GST)

Income, expenses and assets are recognised net of the amount of GST, except where the GST incurred is not recoverable from the Australian Taxation Office (ATO). In these circumstances the GST is recognised as part of the cost of acquisition of the asset or as part of the expense.

Receivables and payables in the Balance Sheet are stated inclusive of the amount of GST. 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 included in the Cash Flow Statement on a gross basis, except for the GST components of cash flows arising from investing or financing activities which are recoverable from, or payable to the ATO, which are disclosed as operating cash flows.

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

NOTE 1.8: REPORTING ENTITY

The financial statements include all the activities of Mansfield District Hospital.

Its principal address is:

53 Highett, Street
Mansfield, Victoria 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.

NOTE 2: FUNDING DELIVERY OF OUR SERVICES

Mansfield District Hospital's overall objective is to provide quality health services that support and enhance the wellbeing of all Victorians.

Mansfield District Hospital is predominantly funded by grant funding for the provision of outputs. Mansfield District Hospital also receives income from the supply of services.

Structure

2.1 Revenue and income from transactions
2.2 Fair value of assets and services received free of charge or for nominal consideration

Telling the COVID-19 story

Revenue recognised to fund the delivery of our services increased during the financial year which was partially attributable to the COVID-19 coronavirus pandemic.

This included funding provided by the Department of Health to compensate for reductions in revenue and to cover certain direct and indirect COVID-19 related costs.

Funding provided included:

- COVID-19 grants to fund maintenance of an Acute Respiratory Assessment Clinic and a Testing Clinic
- Additional elective surgery funding for the Deferred Surgery Blitz
- Local public health unit (LPHU) funding for the COVID-19 Vaccination Clinic

Key judgements and estimates

This section contains the following key judgements and estimates:

Key judgements and estimates	Description
Identifying performance obligations	Mansfield District Hospital applies significant judgment when reviewing the terms and conditions of funding agreements and contracts to determine whether they contain sufficiently specific and enforceable performance obligations. If this criteria is met, the contract/funding agreement is treated as a contract with a customer, requiring Mansfield District Hospital to recognise revenue as or when the health service transfers promised goods or services to customers. If this criteria is not met, funding is recognised immediately in the net result from operations.
Determining timing of revenue recognition	Mansfield District Hospital applies significant judgement to determine when a performance obligation has been satisfied and the transaction price that is to be allocated to each performance obligation. A performance obligation is either satisfied at a point in time or over time.
Determining time of capital grant income recognition	Mansfield District Hospital applies significant judgement to determine when its obligation to construct an asset is satisfied. Costs incurred is used to measure the health service's progress as this is deemed to be the most accurate reflection of the stage of completion.

NOTE 2.1: REVENUE AND INCOME FROM TRANSACTIONS

	Note	**Total 2022 $'000**	Total 2021 $'000
Operating activities			
Revenue from contracts with customers			
Government grants (State) – operating		803	456
Government grants (Commonwealth) – operating		4,848	4,849
Patient and resident fees		2,118	2,401
Commercial activities [1]		125	119
Other revenue from operating activities [2]		173	34
Total revenue from contracts with customers	2.1(a)	**8,067**	**7,859**
Other sources of income			
Government grants (State) – operating		15,263	12,190
Government grants (State) – capital		91	151
Other capital purpose income		158	223
Assets received free of charge or for nominal consideration	2.2	585	261
Other revenue from operating activities (including non-capital donations)		1,167	451
Total other sources of income		**17,264**	**13,276**
Total revenue and income from operating activities		**25,331**	**21,135**
Non-operating activities			
Income from other sources			
Other Interest		375	406
Total other sources of income		**375**	**406**
Total income from non-operating activities		**375**	**406**
Total Revenue and income from transactions		**25,706**	**21,541**

1 Commercial activities represent business activities which the health service enter into to support their operations
2 Other revenue from operating activities represent funding from non-government sources – Murray PHN & Central Hume PCP

NOTE 2.1 (A): TIMING OF REVENUE FROM CONTRACTS WITH CUSTOMERS

Mansfield District Hospital disaggregates revenue by the timing of revenue recognition	**Total 2022 $'000**	Total 2021 $'000
Goods and services transferred to customers:		
At a point in time	8,067	7,859
Total revenue from contracts with customers	**8,067**	**7,859**

NOTE 2.1: REVENUE AND INCOME FROM TRANSACTIONS (Continued)

How we recognise revenue and income from operating activities

Government operating grants

To recognise revenue, Mansfield District Hospital assesses whether there is a contract that is enforceable and has sufficiently specific performance obligations in accordance with AASB 15: *Revenue from Contracts with Customers.*

When both these conditions are satisfied, the health service:
- identifies each performance obligation relating to the revenue
- recognises a contract liability for its obligations under the agreement
- recognises revenue as it satisfied its performance obligations, at the time or over time when services are rendered.

If a contract liability is recognised, Mansfield District Hospital recognises revenue in profit or loss as and when it satisfies its obligations under the contract, unless a contract modification is entered into between all parties. A contract modification may be obtained in writing, by oral agreement or implied by customary business practices.

Where the contract is not enforceable and/or does not have sufficiently specific performance obligations the health service:
- recognises the asset received in accordance with the recognition requirements of other applicable Accounting Standards (for example, AASB 9, AASB 16, AASB 116 and AASB 138)
- recognises related amounts (being contributions by owners, lease liabilities, financial instruments, provisions, revenue or contract liabilities from a contract with a customer), and
- recognises income immediately in profit or loss as the difference between the initial carrying amount of the asset and the related amount in accordance with AASB 1058 Income for not-for-profit-entities.

In contracts with customers, the 'customer' is typically a funding body, who is the party that promises funding in exchange for Mansfield District Hospital's goods or services. Mansfield District Hospital funding bodies often direct that goods or services are to be provided to third party beneficiaries, including individuals or the community at large. In such instances, the customer remains the funding body that has funded the program or activity, however the delivery of goods or services to third party beneficiaries is a characteristic of the promised good or service being transferred to the funding body.

This policy applies to each of Mansfield District Hospital's revenue streams, with information detailed below relating to Mansfield District Hospital's significant revenue streams:

Government grant	Performance obligation
Activity Based Funding (ABF) paid as Weighted Inlier Equivalent Separation (WIES) casemix – *including TAC, DVA, Renal and National Bowel Cancer Screening Program (NBCSP)*	The performance obligations for ABF are the number and mix of patients admitted to hospital (defined as 'casemix') in accordance with the levels of activity agreed to, with the Department of Health in the annual Statement of Priorities. Revenue is recognised at a point in time, which is when a patient is discharged, in accordance with the WIES activity when an episode of care for an admitted patient is completed. WIES activity is a cost weight that is adjusted for time spent in hospital, and represents a relative measure of resource use for each episode of care in a diagnosis related group (DRG). WIES was superseded by NWAU from 1 July 2021, for acute, sub-acute and state-wide (which includes specified grants, state-wide services and teaching and training). Services not transitioning at this time include mental health and small rural services.

NOTE 2.1: REVENUE AND INCOME FROM TRANSACTIONS (Continued)

Government grant	Performance obligation
Activity Based Funding (ABF) paid as Weighted Inlier Equivalent Separation (WIES) casemix – *including TAC, DVA, Renal and National Bowel Cancer Screening Program (NBCSP)*	NWAU funding commenced 1 July 2021 and supersedes WIES for acute, sub-acute and state-wide services (which includes specified grants, state-wide services and teaching and training). Services not transitioning at this time include mental health and small rural services. NWAU is a measure of health service activity expressed as a common unit against which the national efficient price (NEP) is paid. The performance obligations for NWAU are the number and mix of admissions, emergency department presentations and outpatient episodes, and is weighted for clinical complexity. Revenue is recognised at point in time, which is when a patient is discharged.
Deferred Elective Surgery Blitz Funding	The performance obligations for Deferred Elective Surgery Blitz Funding are the number of procedures performed, agreed to with the Department of Health through the Hume Cluster Elective Surgery Blitz Funding program. Revenue is recognised at a point in time, which is when a patient is discharged, in accordance with the NWAU activity when an episode of care for an admitted patient is completed. Revenue amounts will be recognised as per directive from the Hume Cluster Elective Surgery Blitz Funding letter.
Residential Aged Care	Funding is provided for the provision of care for aged care residents within facilities at Mansfield District Hospital. The performance obligations include provision of residential accommodations and care from nursing staff and personal care workers. Revenue is recognised at the point in time when the service is provided within the residential aged care facility.
Department of Health grants linked to Statement of Priorities	Funding is received from Department of Health that have performance obligations linked to the Statement of Priorities agreed upon between the health service and DH. The performance obligation is a requirement to provide a stipulated number of hours of service delivery or service contracts. Revenue is recognised over time as the services are provided.

Capital Grants

Where Mansfield District Hospital receives a capital grant, it recognises a liability for the excess of the initial carrying amount of the financial asset received over any related amounts (being contributions by owners, lease liabilities, financial instruments, provisions, revenue or contract liabilities arising from a contract with a customer) recognised under other Australian Accounting Standards. Income is recognised progressively as the asset is constructed which aligns with Mansfield District Hospital's obligation to construct the asset. The progressive percentage of costs incurred is used to recognise income, as this most accurately reflects the stage of completion.

Patient and resident fees

Patient and resident fees are charges that can be levied on patients for some services they receive. Patient and resident fees are recognised at a point in time when the performance obligation, the provision of services, is satisfied, except where the patient and resident fees relate to accommodation charges. Accommodation charges are calculated daily and are recognised over time, to reflect the period accommodation is provided.

Commercial activities

Revenue from commercial activities includes items such as catering and property rental income. Commercial activity revenue is recognised at a point in time, upon provision of the goods or service to the customer.

NOTE 2.1: REVENUE AND INCOME FROM TRANSACTIONS (Continued)

How we recognise revenue and income from non-operating activities

Interest income

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

NOTE 2.2: FAIR VALUE OF ASSETS AND SERVICES RECEIVED FREE OF CHARGE OR FOR NOMINAL CONSIDERATION

	Total 2022 $'000	Total 2021 $'000
Plant and Equipment	–	33
Personal protective equipment and other consumables	585	228
Total fair value of assets and services received free of charge or for nominal consideration	**585**	**261**

How we recognise the fair value of assets and services received free of charge or for nominal consideration

Personal protective equipment

In order to meet the State of Victoria's health system supply needs during the COVID-19 pandemic, the purchasing of essential personal protective equipment (PPE) and other essential plant and equipment was centralised.

Generally, the State Supply Arrangement stipulates that Health Purchasing Victoria (trading as HealthShare Victoria) sources, secures and agrees terms for the purchase of PPE. The purchases are funded by the Department of Health, while Monash Health takes delivery and distributes an allocation of the products to health services. Mansfield District Hospital received these resources free of charge and recognised them as income.

Contributions

Mansfield District Hospital may receive assets for nil or nominal consideration to further its objectives. The assets are recognised at their fair value when Mansfield District Hospital obtains control over the asset, irrespective of whether restrictions or conditions are imposed over the use of the contributions.

On initial recognition of the asset, Mansfield District Hospital recognises related amounts being contributions by owners, lease liabilities, financial instruments, provisions and revenue or contract liabilities arising from a contract with a customer.

Mansfield District Hospital recognises income immediately in the profit or loss as the difference between the initial fair value of the asset and the related amounts.

The exception to this policy is when an asset is received from another government agency or department as a consequence of a restructuring of administrative arrangements, in which case the asset will be recognised at its carrying value in the financial statements of Mansfield District Hospital as a capital contribution transfer.

NOTE 2.2: FAIR VALUE OF ASSETS AND SERVICES RECEIVED FREE OF CHARGE OR FOR NOMINAL CONSIDERATION (Continued)

Voluntary Services

Mansfield District Hospital receives volunteer services from members of the community in a number of areas.
Mansfield District Hospital recognises contributions by volunteers in tis financial statements, if the fair value can be readily measured and the services would have been purchased had they not been donated.

Mansfield District Hospital greatly values the services contributed by volunteers but it does not depend on volunteers to deliver its services.

Non-cash contributions from the Department of Health

The Department of Health makes some payments on behalf of Mansfield District Hospital as follows:

Supplier	Description
Victorian Managed Insurance Authority	The Department of Health purchases non-medical indemnity insurance for Mansfield District Hospital which is paid directly to the Victorian Managed Insurance Authority. To record this contribution, such payments are recognised as income with a matching expense in the net result from transactions.
Department of Health	Long Service Leave (LSL) revenue is recognised upon finalisation of movements in LSL liability in line with the long service leave funding arrangements set out in the relevant Department of Health Hospital Circular.

NOTE 3: THE COST OF DELIVERING OUR SERVICES

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

Structure

3.1 Expenses from Transactions
3.2 Other economic flows
3.3 Employee benefits in the Balance Sheet
3.4 Superannuation

Telling the COVID-19 story

Expenses incurred to deliver our services increased during the financial year which was partially attributable to the COVID-19 coronavirus pandemic.

Additional costs were incurred to:

- establish and maintain facilities within Mansfield District Hospital for the treatment of suspected COVID-19 patients resulting in an increase in employee costs, additional VMO costs, additional equipment purchases, and additional consumable purchases
- implement COVID-19 safe practices throughout Mansfield District Hospital including increased cleaning, increased security, consumption of personal protective equipment provided as resources free of charge, increased administrative expenses, changes to the most effective rostering management to ensure the minimisation of staff mobility across sites and departments, changes in salaries and wages due to greater demand for staff during the pandemic
- establish and maintain testing clinics to service staff and the community resulting in an increase in employee costs, additional cleaning costs, additional consumption of personal protective equipment provided as resources free of charge and significantly increased Pathology costs
- establish and maintain vaccination clinics to administer vaccines to staff and the community resulting in an increase in employee costs, additional equipment purchased, additional rent costs, additional consumption of personal protective equipment provided as resources free of charge and additional VMO costs.

NOTE 3: THE COST OF DELIVERING OUR SERVICES (Continued)

Key judgements and estimates

This section contains the following key judgements and estimates:

Key judgements and estimates	Description
Classifying employee benefit liabilities	Mansfield District Hospital applies significant judgment when measuring and classifying its employee benefit liabilities. Employee benefit liabilities are classified as a current liability if Mansfield District Hospital does not have an unconditional right to defer payment beyond 12 months. Annual leave, accrued days off and long service leave entitlements (for staff who have exceeded the minimum vesting period) fall into this category. Employee benefit liabilities are classified as a non-current liability if Mansfield District Hospital has a conditional right to defer payment beyond 12 months. Long service leave entitlements (for staff who have not yet exceeded the minimum vesting period) fall into this category. The health service also applies judgement to determine when it expects its employee entitlements to be paid. With reference to historical data, if the health service does not expect entitlements to be paid within 12 months, the entitlement is measured at its present value. All other entitlements are measured at their nominal value.
Measuring employee benefit liabilities	Mansfield District Hospital applies significant judgment when measuring its employee benefit liabilities. The health service applies judgement to determine when it expects its employee entitlements to be paid. With reference to historical data, if the health service does not expect entitlements to be paid within 12 months, the entitlement is measured at its present value, being the expected future payments to employees. Expected future payments incorporate anticipated future wage and salary levels, durations of service and employee departures, and are discounted at rates determined by reference to market yields on government bonds at the end of the reporting period. All other entitlements are measured at their nominal value.

NOTE 3.1: EXPENSES FROM TRANSACTIONS

	Total 2022 $'000	Total 2021 $'000
Salaries and Wages	15,476	13,748
On-costs	2,213	1,876
Agency Expenses	191	14
Fee for Service Medical Officer Expenses	2,251	952
Workcover Premium	91	162
Total Employee Expenses	**20,222**	**16,752**
Drug Supplies	183	146
Medical and Surgical Supplies	1,053	628
Diagnostic and Radiology Supplies	776	596
Other Supplies and Consumables	787	745
Total Supplies and Consumables	**2,799**	**2,115**
Finance Costs	2	3
Total Finance Costs	**2**	**3**
Other Administrative Expenses	1,400	1,441
Total Other Administrative Expenses	**1,400**	**1,441**
Fuel, Light, Power and Water	277	259
Repairs and Maintenance	272	190
Maintenance Contracts	175	86
Medical Indemnity Insurance	144	149
Expenditure for Capital Purposes	51	35
Total other operating expenses	**919**	**719**
Depreciation and Amortisation (refer Note 4.5)	1,808	1,771
Total Depreciation and Amortisation	**1,808**	**1,771**
Bad and doubtful debt expense	15	35
Total other non-operating expenses	**15**	**35**
Total Expenses from Transactions	**27,165**	**22,836**

How we recognise expenses from transactions

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

Employee expenses
Employee expenses include:
- Salaries and wages (including fringe benefits tax, leave entitlements, termination payments)
- On-costs
- Agency expenses
- Fee for service medical officer expenses
- Work cover premiums.

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

NOTE 3.1: EXPENSES FROM TRANSACTIONS (Continued)

Finance Costs

Finance costs include:
- interest on bank overdrafts and short-term and long-term borrowings (interest expense is recognised in the period in which it is incurred)
- amortisation of discounts or premiums relating to borrowings
- amortisation of ancillary costs incurred in connection with the arrangement of borrowings and
- finance charges in respect of leases which are recognised in accordance with AASB 16 *Leases.*

Other operating expenses

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

- Fuel, light and power
- Repairs and maintenance
- Other administrative expenses
- Expenditure for capital purposes (represents expenditure related to the purchase of assets that are below the capitalisation threshold of $1,000).

The Department of Health also makes certain payments on behalf of Mansfield District Hospital. These amounts have been brought to account as grants in determining the operating result for the year by recording them as revenue and also recording the related expense.

Non-operating expenses

Other non-operating expenses generally represent expenditure outside the normal operations such as depreciation and amortisation, and assets and services provided free of charge or for nominal consideration.

NOTE 3.2: OTHER ECONOMIC FLOWS

	2022 $'000	2021 $'000
Impairment of property plant and equipment (including intangible)		
Net gain/(loss) on disposal of property plant and equipment	–	9
Total net gain/loss on non-financial assets	**–**	**9**
Net gain/(loss) arising from revaluation of long service liability	177	135
Total other gains/(losses) from other economic flows	**177**	**135**
Total gains/(losses) from other economic flows	**177**	**144**

How we recognise other economic flows

Other economic flows are changes in the volume or value of an asset or liability that do not result from transactions.
Other gains/(losses) from other economic flows include the gains or losses from:
- the revaluation of the present value of the long service leave liability due to changes in the bond interest rates.

Net gain/(loss) on non-financial assets

Net gain/(loss) on non-financial assets and liabilities includes realised and unrealised gains and losses as follows:
- revaluation gains/(losses) of non-financial physical assets (Refer to Note 4.1 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.

NOTE 3.3: EMPLOYEE BENEFITS IN THE BALANCE SHEET

	2022 $'000	2021 $'000
Current Provisions		
Accrued days off		
Unconditional and expected to be settled within 12 months (i)	44	37
	44	**37**
Annual Leave		
Unconditional and expected to be settled within 12 months (i)	1,675	1,472
Unconditional and expected to be settled after 12 months (ii)	271	260
	1,946	**1,732**
Long Service Leave		
Unconditional and expected to be settled within 12 months (i)	230	277
Unconditional and expected to be settled after 12 months (ii)	1,760	1,647
	1,990	**1,924**
Provisions Related to Employee Benefit On-Costs		
Unconditional and expected to be settled within 12 months (i)	213	226
Unconditional and expected to be settled after 12 months (ii)	271	187
	484	**413**
Total current employee benefits	**4,464**	**4,106**
Non-Current Provisions		
Conditional long service leave (ii)	434	258
Provisions Related to Employee Benefit On-Costs (ii)	60	29
Total non-current employee benefits	**494**	**287**
Total employee benefits	**4,958**	**4,393**

(i) The amounts disclosed are nominal amounts.
(ii) The amounts disclosed are discounted to present values.

NOTE 3.3 (a): Employee Benefits and related on-costs

	2022 $'000	2021 $'000
Current employee benefits and related on-costs		
Unconditional Accrued Days Off	44	37
Unconditional Annual leave Entitlements	1,946	1,927
Unconditional Long Service Leave Entitlements	2,474	2,142
Total Current Employee Benefits and related on-costs	**4,464**	**4,106**
Non-current employee benefits and related on-costs		
Conditional Long Service Leave Entitlements	494	287
Total Non-Current Employee Benefits and Related On-Costs	**494**	**287**
Total Employee Benefits and Related On-Costs	**4,958**	**4,393**
Attributable to:		
Employee benefits	4,414	3,951
Provision for related on costs	544	442
Total employee benefits and related on-costs	**4,958**	**4,393**

NOTE 3.3: EMPLOYEE BENEFITS IN THE BALANCE SHEET (Continued)

	2022 $'000	2021 $'000
Carrying amount at start of year	442	362
Additional provisions recognised	214	163
Amounts incurred during the year	(150)	(115)
Net gain/(loss) arising from revaluation of long service liability	38	32
Carrying amount at end of year	**544**	**442**

How we recognise employee benefits

Employee benefit recognition

Employee benefits are accrued for employees in respect of accrued days off, annual leave and long service leave for services rendered to the reporting date as an expense during the period the services are delivered.

No provision has been made for sick leave as all sick leave is non-vesting and it is not considered probable that the average sick leave taken in the future will be greater than the benefits accrued in the future. As sick leave is non-vesting, an expense is recognised in the Statement of Comprehensive Income as it is taken.

Annual leave and accrued days off

Liabilities for annual leave and accrued days off are 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 annual leave and accrued days off are measured at:
- Nominal value – if Mansfield District Hospital expects to wholly settle within 12 months or
- Present value – if Mansfield District Hospital does not expect to wholly settle within 12 months.

Long Service Leave

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

Unconditional LSL is disclosed in the notes to the financial statements as a current liability even where the Mansfield District 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:
- Nominal value – if Mansfield District Hospital expects to wholly settle within 12 months or
- Present value – if Mansfield District Hospital does not expect to wholly settle within 12 months.

Conditional LSL is measured at present value and is disclosed as a non-current liability. 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 other economic flows.

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.

Provisions for on-costs related to employee benefits

Provision for on-costs such as workers compensation and superannuation are recognised separately from provisions for employee benefits.

NOTE 3.4: SUPERANNUATION

		Paid Contributions		Contributions outstanding at the year end	
		2022 $'000	2021 $'000	**2022 $'000**	2021 $'000
Fund					
Defined Benefit Plans: (i)	Aware Super	**–**	–	**–**	–
Defined Contribution Plans:	Aware Super	**679**	659	**–**	–
	HESTA	**607**	572	**–**	–
	Other	**434**	239	**–**	–
Total		**1,720**	1,470	**–**	–

(i) The basis for determining the level of contributions is determined by the various actuaries of the defined benefit superannuation plans.

How we recognise superannuation

Employees of Mansfield District Hospital are entitled to receive superannuation benefits and it contributes to defined contribution plans. There are no employees who are members of defined benefit plans.

Defined contribution superannuation plans

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

The name, details and amounts that have been expensed in relation to the major employee superannuation funds and contributions made by Mansfield District Hospital are disclosed above.

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY

Mansfield District 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 Mansfield District Hospital to be utilised for delivery of those outputs.

Structure

4.1 Property, plant & equipment
4.2 Right-of-use assets
4.3 Revaluation surplus
4.4 Depreciation and amortisation
4.5 Inventories
4.6 Impairment of assets

Telling the COVID-19 story

Assets used to support the delivery of our services during the financial year were not materially impacted by the COVID-19 coronavirus pandemic.

Key judgements and estimates

This section contains the following key judgements and estimates:

Key judgements and estimates	Description
Estimating useful life and residual value of property, plant and equipment	Mansfield District Hospital assigns an estimated useful life to each item of property, plant and equipment. This is used to calculate depreciation of the asset. The health service reviews the useful life, residual value and depreciation rates of all assets at the end of each financial year and where necessary, records a change in accounting estimate.
Estimating useful life of right-of-use assets	The useful life of each right-of-use asset is typically the respective lease term, except where the health service is reasonably certain to exercise a purchase option contained within the lease (if any), in which case the useful life reverts to the estimated useful life of the underlying asset. Mansfield District Hospital applies significant judgement to determine whether or not it is reasonably certain to exercise such purchase options.
Identifying indicators of impairment	At the end of each year, Mansfield District Hospital assesses impairment by evaluating the conditions and events specific to the health service that may be indicative of impairment triggers. Where an indication exists, the health service tests the asset for impairment. The health service considers a range of information when performing its assessment, including considering: • If an asset's value has declined more than expected based on normal use • If a significant change in technological, market, economic or legal environment which adversely impacts the way the health service uses an asset • If an asset is obsolete or damaged • If the asset has become idle or if there are plans to discontinue or dispose of the asset before the end of its useful life • If the performance of the asset is or will be worse than initially expected. Where an impairment trigger exists, the health services applies significant judgement and estimate to determine the recoverable amount of the asset.

NOTE 4.1: PROPERTY, PLANT AND EQUIPMENT

NOTE 4.1(a): Gross Carrying Amount and Accumulated Depreciation

	2022 $	2021 $
Land		
Land at fair value – Crown	812	738
Land at fair value – Freehold	1,858	1,716
Total Land at Fair Value	**2,670**	**2,454**
Landscaping Improvements at Fair Value	527	494
Less Accumulated Depreciation	(56)	(37)
Total Landscaping Improvements at Fair Value	**471**	**457**
Buildings at Fair Value	21,347	23,271
Less Accumulated Depreciation	(84)	(2,790)
Total Buildings at Fair Value	**21,263**	**20,481**
Building work in progress at cost	–	272
Total Land and Buildings	**24,404**	**23,664**
Plant and Equipment at Fair Value	3,155	2,769
Less Accumulated Depreciation	(2,124)	(2,010)
Total Plant and Equipment at Fair Value	**1,031**	**759**
Motor Vehicles at Fair Value	316	316
Less Accumulated Depreciation	(262)	(224)
Right of use – Motor Vehicles	104	103
Less Accumulated Depreciation	(33)	(18)
Total Motor Vehicles at Fair Value	**125**	**177**
Medical Equipment at Fair Value	2,598	2,407
Less Accumulated Depreciation	(1,872)	(1,748)
Total Medical Equipment at Fair Value	**726**	**659**
Computers and Communication at Fair Value	57	31
Less Accumulated Depreciation	(23)	(16)
Total Computers and Communication at Fair Value	**34**	**15**
Furniture and Fittings at Fair Value	635	631
Less Accumulated Depreciation	(489)	(449)
Total Furniture and Fittings at Fair Value	**146**	**182**
Total Property, Plant and Equipment	**26,466**	**25,456**

NOTE 4.1: PROPERTY, PLANT AND EQUIPMENT (Continued)

NOTE 4.1(b): Reconciliation of the carrying amount of class by asset

	Note	Land $'000	Land Improvements $'000	Buildings under construction $'000	Buildings $'000	Plant and Equipment $'000	Motor Vehicles $'000	Right of Use Motor Vehicles $'000
Balance at 1 July 2020		**2,045**	**475**	**71**	**21,770**	**627**	**141**	**99**
Additions/(disposals)		–	–	379	–	211	–	–
Revaluation Increments /(decrements)		409	–	–	–	–	–	–
Net Transfer Between Classes		–	–	(178)	125	39	–	–
Depreciation	4.4	–	(18)	–	(1,414)	(118)	(49)	(14)
Balance at 1 July 2021	4.1(a)	**2,454**	**457**	**272**	**20,481**	**759**	**92**	**85**
Additions/(disposals)		–	–	135	–	18	–	–
Revaluation increments /(decrements)		216	–	–	2,206	–	–	–
Net Transfers between Classes		–	33	(407)		374	–	–
Depreciation	4.4	–	(19)	–	(1,424)	(120)	(38)	(14)
Balance at 30 June 2022	4.1(a)	**2,670**	**471**	**–**	**21,263**	**1,031**	**54**	**71**

	Note	Medical Equipment $'000	Computers & Commun. Equipment $'000	Furniture & Fittings $'000	Total $'000
Balance at 1 July 2020		**567**	**18**	**164**	**25,977**
Additions/(disposals)		212	–	39	**841**
Revaluation Increments /(decrements)		–	–	–	**409**
Net Transfer Between Classes		–	–	14	**–**
Depreciation	4.4	(120)	(3)	(35)	**(1,771)**
Balance at 1 July 2021	4.1(a)	**659**	**15**	**182**	**25,456**
Additions/(disposals)		212	27	4	**396**
Revaluation increments /(decrements)		–	–	–	**2,422**
Net Transfers between Classes		–	–	–	**–**
Depreciation	4.4	(145)	(8)	(40)	**(1,808)**
Balance at 30 June 2022	4.1(a)	**726**	**34**	**146**	**26,466**

Land and Buildings and Leased Assets
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 was 30 June 2019 for buildings, and 30 June 2022 for land.

NOTE 4.1: PROPERTY, PLANT AND EQUIPMENT (Continued)

How we recognise property, plant and equipment

Property, plant and equipment are tangible items that are used by Mansfield District Hospital in the supply of goods or services, for rental to others, or for administration purposes, and are expected to be used during more than one financial year.

Initial recognition

Items of property, plant and equipment (excluding right-of-use assets) are initially measured at cost. Where an asset is acquired for no or nominal cost, being far below the fair value of the asset, the deemed cost is its fair value at the date of acquisition. Assets transferred as part of an amalgamation/machinery of government change are transferred at their carrying amounts.

The cost of constructed non-financial physical assets includes the cost of all materials used in construction, direct labour on the project and an appropriate proportion of variable and fixed overheads.

Subsequent measurement

Items of property, plant and equipment (excluding right-of-use assets) are subsequently measured at fair value less accumulated depreciation and impairment losses where applicable.

Fair value is determined with reference to the asset's highest and best use (considering legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset).

Further information regarding fair value measurement is disclosed below.

Revaluation

Fair value is based on periodic valuations by independent valuers, which normally occur once every five years, based upon the asset's Government Purpose Classification, but may occur more frequently if fair value assessments indicate a material change in fair value has occurred.

Where an independent valuation has not been undertaken at balance date, Mansfield District Hospital perform a managerial assessment to estimate possible changes in fair value of land and buildings since the date of the last independent valuation with reference to Valuer-General of Victoria (VGV) indices.

An adjustment is recognised if the assessment concludes that the fair value of land and buildings has changed by 10% or more since the last revaluation (whether that be the most recent independent valuation or managerial valuation). Any estimated change in fair value of less than 10% is deemed immaterial to the financial statements and no adjustment is recorded. Where the assessment indicates there has been an exceptionally material movement in the fair value of land and buildings since the last independent valuation, being equal to or in excess of 40%, Mansfield District Hospital would obtain an interim independent valuation prior to the next scheduled independent valuation.

An independent valuation of Mansfield District Hospital's property, plant and equipment was performed by the VGV on 15th February 2019. The valuation, which complies with Australian Valuation Standards, was determined by reference to the amount for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The managerial assessment performed at 30 June 2022 indicated an overall:

- increase in fair value of land of 40% ($0.21m)
- increase in fair value of buildings of 10.44% ($2.21m)

As the cumulative movement was greater than 40% for land since the last revaluation, an interim independent valuation was required as at 30 June 2022 and an adjustment was recorded.

As the cumulative movement was greater than 10% but less than 40% for buildings since the last revaluation, a managerial revaluation adjustment was required as at 30 June 2022.

NOTE 4.1: PROPERTY, PLANT AND EQUIPMENT (Continued)

Revaluation (continued)

Revaluation increases (increments) arise when an asset's fair value exceeds its carrying amount. In comparison, revaluation decreases (decrements) arise when an asset's fair value is less than its carrying amount. Revaluation increments and revaluation decrements 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 increments are recognised in 'Other Comprehensive Income' and are credited directly to the asset revaluation reserve, 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, in which case 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 reserve in respect of the same class of property, plant and equipment. Otherwise, the decrement is recognised as an expense in the net result.

The revaluation reserve included in equity in respect of an item of property, plant and equipment may be transferred directly to retained earnings when the asset is derecognised.

NOTE 4.2: RIGHT OF USE ASSETS

NOTE 4.2 (a): Gross Carrying Amount and Accumulated Depreciation

	2022 $	2021 $
Right of use – Motor Vehicles at fair value	104	103
Less Accumulated Depreciation	(33)	(18)
Total Right of use Motor Vehicles at Fair Value	**71**	**85**
Total Right of use assets	**71**	**85**

NOTE 4.2 (b): Reconciliations of carrying amount by class of asset

	Note	**Right of Use Motor Vehicles $'000**	Total $'000
Balance as at 1 July 2020		**99**	**99**
Additions/(disposals)		–	–
Revaluation Increments/(decrements)		–	–
Net Transfer Between Classes		–	–
Depreciation	4.4	(14)	(14)
Balance as at 1 July 2021	4.2(a)	**85**	**85**
Additions/(disposals)		–	–
Revaluation Increments/(decrements)		–	–
Net Transfer Between Classes		–	–
Depreciation	4.4	(14)	(14)
Balance as at 30 June 2022	4.2(a)	**71**	**71**

NOTE 4.2: RIGHT OF USE ASSETS (Continued)

How we recognise right-of-use assets

Where Mansfield District Hospital enters a contract, which provides the health service with the right to control the use of an identified asset for a period of time in exchange for payment, this contract is considered a lease.

Unless the lease is considered a short-term lease or a lease of a low-value asset (refer to Note 6.1 for further information), the contract gives rise to a right-of-use asset and corresponding lease liability. Mansfield District Hospital presents its right-of-use assets as part of property, plant and equipment as if the asset was owned by the health service.

Right-of-use assets and their respective lease terms include:

Class of right-of-use Asset	Lease Term
Lease Motor Vehicles – Vic Fleet	3 years

Initial recognition

When a contract is entered into, Mansfield District Hospital assesses if the contract contains or is a lease. If a lease is present, a right-of-use asset and corresponding lease liability is recognised. The definition and recognition criteria of a lease is disclosed at Note 6.1.

The right-of-use asset is initially measured at cost and comprises the initial measurement of the corresponding lease liability, adjusted for:

- any lease payments made at or before the commencement date
- any initial direct costs incurred and
- an estimate of costs to dismantle and remove the underlying asset or to restore the underlying asset or the site on which it is located, less any lease incentive received.

Subsequent measurement

Right-of-use assets are subsequently measured at fair value, with the exception of right-of-use asset arising from leases with significantly below-market terms and conditions, which are subsequently measured at cost, less accumulated depreciation and accumulated impairment losses where applicable.

Right-of-use assets are also adjusted for certain remeasurements of the lease liability (for example, when a variable lease payment based on an index or rate becomes effective).

Further information regarding fair value measurement is disclosed in Note 7.4.

NOTE 4.3: REVALUATION SURPLUS

	Note	**2022 $'000**	2021 $'000
Balance at the beginning of the reporting period		**25,511**	**25,102**
Revaluation increment			
Land	4.1(b)	216	409
Buildings	4.1(b)	2,206	–
Balance at the end of the Reporting Period		**27,933**	**25,511**
*** Represented by:**			
Land		2,173	1,957
Buildings		25,760	23,554
		27,933	**25,511**

NOTE 4.4: DEPRECIATION AND AMORTISATION

	2022 $'000	2021 $'000
Depreciation		
Property, plant and equipment		
Buildings	1,424	1,414
Land Improvements	19	18
Plant and Equipment	120	118
Motor Vehicles	38	49
Computers and Communication	8	3
Medical Equipment	145	120
Furniture and Fittings	40	35
Total Depreciation – property, plant and equipment	**1,794**	**1,757**
Right of use assets		
Right of use – Motor Vehicles at fair value	14	14
Total Depreciation – right of use assets	**14**	**14**
Total Deprecation	**1,808**	**1,771**

How we recognise depreciation

All buildings, plant and equipment and other non-financial physical assets (excluding items under 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.

Right-of-use assets are depreciated over the lease term or useful life of the underlying asset, whichever is the shortest. Where a lease transfers ownership of the underlying asset or the cost of the right-of-use asset reflects that the health service anticipates to exercise a purchase option, the specific right-of-use asset is depreciated over the useful life of the underlying asset.

NOTE 4.4: DEPRECIATION AND AMORTISATION (Continued)

How we recognise amortisation

Amortisation is the systematic allocation of the depreciable amount of an asset over its useful life.

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

	2022	2021
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
Intangible Assets	1 to 3 years	1 to 3 years

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

NOTE 4.5: INVENTORIES

	Total 2022 $'000	Total 2021 $'000
Medical and Surgical consumables at cost	64	53
Pharmacy supplies at cost	31	46
General stores at cost	18	17
Total inventories	**113**	**116**

How we recognise inventories

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

NOTE 4.6: IMPAIRMENT OF ASSETS

How we recognise impairment

At the end of each reporting period, Mansfield District Hospital reviews the carrying amount of its tangible and intangible assets that have a finite useful life, to determine whether there is any indication that an asset may be impaired.

The assessment will include consideration of external sources of information and internal sources of information.

External sources of information include but are not limited to observable indications that an asset's value has declined during the period by significantly more than would be expected as a result of the passage of time or normal use. Internal sources of information include but are not limited to evidence of obsolescence or physical damage of an asset and significant changes with an adverse effect on Mansfield District Hospital which changes the way in which an asset is used or expected to be used.

If such an indication exists, an impairment test is carried out. Assets with indefinite useful lives (and assets not yet available for use) are tested annually for impairment, in addition to where there is an indication that the asset may be impaired.

When performing an impairment test, Mansfield District Hospital compares the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, to the asset's carrying amount. Any excess of the asset's carrying amount over its recoverable amount is recognised immediately in net result, unless the asset is carried at a revalued amount.

Where an impairment loss on a revalued asset is identified, this is recognised against the asset revaluation surplus in respect of the same class of asset to the extent that the impairment loss does not exceed the cumulative balance recorded in the asset revaluation surplus for that class of asset.

Where it is not possible to estimate the recoverable amount of an individual asset, Mansfield District Hospital estimates the recoverable amount of the cash-generating unit to which the asset belongs.

An allowance for impairment losses of receivables for the year ended 30 June 2022 has been made and disclosed at note 5.1.

NOTE 5: OTHER ASSETS AND LIABILITIES

This section sets out those assets and liabilities that arose from Mansfield District Hospital's operations.

Structure

5.1 Receivables and contract assets
5.2 Payables and contract liabilities
5.3 Other liabilities

Telling the COVID-19 story

Other assets and liabilities used to support the delivery of our services during the financial year were not materially impacted by the COVID-19 coronavirus pandemic.

Key judgements and estimates

This section contains the following key judgements and estimates:

Key judgements and estimates	Description
Estimating the provision for expected credit losses	Mansfield District Hospital uses a simplified approach to account for the expected credit loss provision. A provision matrix is used, which considers historical experience, external indicators and forward-looking information to determine expected credit loss rates.
Measuring deferred capital grant income	Where Mansfield District Hospital has received funding to construct an identifiable non-financial asset, such funding is recognised as deferred capital grant income until the underlying asset is constructed. Mansfield District Hospital applies significant judgement when measuring the deferred capital grant income balance, which references the estimated the stage of completion at the end of each financial year.
Measuring contract liabilities	Mansfield District Hospital applies significant judgement to measure its progress towards satisfying a performance obligation as detailed in Note 2. Where a performance obligation is yet to be satisfied, the health service assigns funds to the outstanding obligation and records this as a contract liability until the promised good or service is transferred to the customer.

NOTE 5.1: RECEIVABLES AND CONTRACT ASSETS

	Note	2022 $'000	2021 $'000
Current receivables and contract assets			
Contractual			
Inter Hospital Debtors		52	42
Trade Debtors		89	50
Patient Fees		364	276
Allowance for impairment losses	5.1(a)	(20)	(20)
Accrued Revenue		88	27
Total contractual receivables		**573**	**375**
Statutory			
GST Receivable		92	101
Total Statutory Receivables		**92**	**101**
Total current receivables and contract assets		**665**	**476**
Non-current receivables and contract assets			
Contractual			
Long Services Leave – Department of Health		1,367	923
Total statutory receivables		**1,367**	**923**
Total non-current receivables and contract assets		**1,367**	**923**
Total receivables and contract assets		**2,032**	**1,399**
Total receivables and contract assets		2,032	1,399
GST receivable		(92)	(101)
Total financial assets	7.1(a)	**1,940**	**1,298**

(i) Financial assets classified as receivables and contract assets (Note 7.1(a))

NOTE 5.1(a): Movement in the allowance for impairment losses of contractual receivables

	2022 $'000	2021 $'000
Balance at beginning of the year	20	12
Increase in allowance recognised in the net result	15	28
Amounts written off during the year	(15)	(20)
Balance at End of Year	**20**	**20**

How we recognise receivables

Receivables consist of:

- **Contractual receivables,** which mostly includes debtors in relation to goods and services. These receivables are classified as financial instruments and categorised as 'financial assets at amortised costs'. They are initially recognised at fair value plus any directly attributable transaction costs. The health service holds the contractual receivables with the objective to collect the contractual cash flows and therefore they are subsequently measured at amortised cost using the effective interest method, less any impairment.

NOTE 5.1: RECEIVABLES AND CONTRACT ASSETS (Continued)

How we recognise receivables (continued)

- **Statutory receivables,** which mostly includes amounts owing from the Victorian Government and Goods and Services Tax (GST) input tax credits that are recoverable. Statutory receivables do not arise from contracts and are recognised and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments for disclosure purposes. The health service applies AASB 9 for initial measurement of the statutory receivables and as a result statutory receivables are initially recognised at fair value plus any directly attributable transaction cost.

Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition.

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.

Mansfield District Hospital is not exposed to any significant credit risk exposure to any single counterparty or any group of counterparties having similar characteristics. Trade receivables consist of a large number of customers in various geographical areas. Based on historical information about customer default rates, management consider the credit quality of trade receivables that are not past due or impaired to be good.

Impairment losses of contractual receivables

Refer to Note 7.2 (a) for Mansfield District Hospital's contractual impairment losses.

NOTE 5.2: PAYABLES AND CONTRACT LIABILITIES

	Note	**2022 $'000**	2021 $'000
Current payables and contract liabilities			
Contractual			
Trade Creditors		370	518
Accrued Salaries and Wages		496	501
Accrued Expenses		17	62
Contract liabilities	5.2(b)	271	322
Inter-hospital creditors		4	24
Total Contractual Payables		**1,158**	**1,427**
Statutory			
GST Payable		40	35
Total Statutory Payables		**40**	**35**
Total current payables and contract liabilities		**1,198**	**1,462**
Total payables and contract liabilities		**1,198**	**1,462**
Total payables and contract liabilities		1,198	1,462
Contract liabilities		(271)	(322)
GST Payable		(40)	(35)
Total financial liabilities	7.1(a)	**887**	**1,105**

(i) Financial assets classified as receivables and contract assets (Note 7.1(a))

NOTE 5.2: PAYABLES AND CONTRACT LIABILITIES (Continued)

How we recognise payables and contract liabilities

Payables consist of:

- **Contractual payables,** which mostly includes payables in relation to goods and services. These payables are classified as financial instruments and measured at amortised cost. Accounts payable and salaries and wages payable represent liabilities for goods and services provided to the Mansfield District Hospital prior to the end of the financial year that are unpaid.
- **Statutory payables,** which most includes amount payable to the Victorian Government and Goods and Services Tax (GST) payable. 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 contracts.

The normal credit terms for accounts payable are usually Net 60 days.

NOTE 5.2(a): Contract Liabilities

	2022 $'000	2021 $'000
Opening balance of contract liabilities	322	355
Grant consideration for sufficiently specific performance obligations received during the year	5,600	5,272
Revenue recognised for the completion of a performance obligation	(5,651)	(5,305)
Total contract liabilities	**271**	**322**
*** Represented by**		
– Current contract liabilities	271	322
	271	**322**

How we recognise contract liabilities

Contract liabilities include consideration received in advance from customers in respect of DH Renal, DVA and NBCSP NWAU activity above the activity funding provided, DH funding for the RESTART program, Murray PHN Chronic Disease Funding, Murray PHN Health Navigator Funding and Central Hume PCP WASP Funding.

Contract liabilities are derecognised and recorded as revenue when promised goods and services are transferred to the customer. Refer to Note 2.1.

Financial guarantees

Payments that are contingent under financial guarantee contracts are recognised as a liability, at fair value, at the time the guarantee is issued. Subsequently, should there be a material increase in the likelihood that the guarantee may have to be exercised, the liability is recognised at the higher of the amount determined in accordance with the expected credit loss model under AASB 9 Financial Instruments and the amount initially recognised less, when appropriate, cumulative amortisation recognised.

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

Maturity analysis of payables

Please refer to Note 7.2(b) for the ageing analysis of payables.

NOTE 5.3: OTHER LIABILITIES

	Note	**2022 $'000**	2021 $'000
Current monies held in trust			
Refundable Accommodation Deposits		10,487	14,571
Total current monies held in trust		**10,487**	**14,571**
Total other liabilities		**10,487**	**14,571**
*** Represented by:**			
– Cash Assets	6.2	10,487	14,571
		10,487	**14,571**

How we recognise other liabilities

Refundable Accommodation Deposit (RAD)/Accommodation Bond liabilities

RADs/accommodation bonds are non-interest-bearing deposits made by some aged care residents to Mansfield District Hospital upon admission. These deposits are liabilities which fall due and payable when the resident leaves the home. As there is no unconditional right to defer payment for 12 months, these liabilities are recorded as current liabilities.

RAD/accommodation bond liabilities are recorded at an amount equal to the proceeds received, net of retention and any other amounts deducted from the RAD/accommodation bond in accordance with the Aged Care Act 1997.

Hume Rural Health Alliance PAS Monies in Trust

Hume Rural Health Alliance PAS Monies in Trust are monies held by Hume Rural Health Alliance in relation to a Patient Administration System to be utilised by Health Services in the Hume Region.

NOTE 6: HOW WE FINANCE OUR OPERATIONS

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

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

Telling the COVID-19 story

Our finance and borrowing arrangements were not materially impacted by the COVID-19 coronavirus pandemic.

Key judgements and estimates

This section contains the following key judgements and estimates:

Key judgements and estimates	Description
Determining if a contract is or contains a lease	Mansfield District Hospital applies significant judgement to determine if a contract is or contains a lease by considering if the health service: • has the right-to-use an identified asset • has the right to obtain substantially all economic benefits from the use of the leased asset and • can decide how and for what purpose the asset is used throughout the lease.
Determining if a lease meets the short-term or low value asset lease exemption	Mansfield District Hospital applies significant judgement when determining if a lease meets the short-term or low value lease exemption criteria. The health service estimates the fair value of leased assets when new. Where the estimated fair value is less than $10,000, the health service applies the low-value lease exemption. The health service also estimates the lease term with reference to remaining lease term and period that the lease remains enforceable. Where the enforceable lease period is less than 12 months the health service applies the short-term lease exemption.
Discount rate applied to future lease payments	Mansfield District Hospital discounts its lease payments using the interest rate implicit in the lease. If this rate cannot be readily determined, which is generally the case for the health service's lease arrangements, Mansfield District Hospital uses its incremental borrowing rate, which is the amount the health service would have to pay to borrow funds necessary to obtain an asset of similar value to the right-of-use asset in a similar economic environment with similar terms, security and conditions.
Assessing the lease term	The lease term represents the non-cancellable period of a lease, combined with periods covered by an option to extend or terminate the lease if Mansfield District Hospital is reasonably certain to exercise such options. Mansfield District Hospital determines the likelihood of exercising such options on a lease-by-lease basis through consideration of various factors including: • If there are significant penalties to terminate (or not extend), the health service is typically reasonably certain to extend (or not terminate) the lease. • If any leasehold improvements are expected to have a significant remaining value, the health service is typically reasonably certain to extend (or not terminate) the lease. • The health service considers historical lease durations and the costs and business disruption to replace such leased assets.

NOTE 6.1: BORROWINGS

	2022 $'000	2021 $'000
CURRENT		
Current borrowings – Vic Fleet Liability (i)	71	15
Loan with DH (ii)	23	23
Total Current Borrowings	**94**	**38**
NON CURRENT		
Non-Current borrowings – Vic Fleet Liability (i)	–	71
Loan with DH (ii)	44	70
Total Non Current Borrowings	**44**	**141**
TOTAL BORROWINGS	**138**	**179**

(i) Secured by the assets leased.

(ii) These are secured loans which bear no interest.

How we recognise borrowings

Borrowings refer to interesting bearing liabilities mainly raised from advances from the DH and other funds raised through lease liabilities.

Initial recognition

All borrowings are initially recognised at fair value of the consideration received, less directly attributable transaction costs. The measurement basis subsequent to initial recognition depends on whether the Mansfield District Hospital has categorised its liability as either 'financial liabilities designated at fair value through profit or loss', or financial liabilities at 'amortised cost'.

Subsequent measurement

Subsequent to initial recognition, interest bearing borrowings are measured at amortised cost with any difference between the initial recognised amount and the redemption value being recognised in the net result over the period of the borrowing using the effective interest method. Non-interest bearing borrowings are measured at 'fair value through profit or loss'.

Maturity Analysis

Please refer to Note 7.2(b) for the maturity analysis of borrowings.

Defaults and Breaches

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

NOTE 6.1(a): Lease liabilities

Mansfield District Hospitals' lease liabilities are summarised below:

	2022 $'000	2021 $'000
Total undiscounted lease liabilities	82	102
Less unexpired finance expenses	(4)	(5)
Net lease liabilities	**78**	**97**

NOTE 6.1: BORROWINGS (Continued)

The following table sets out the maturity analysis of lease liabilities, showing the undiscounted lease payments to be made after the reporting date.

	2022 $'000	2021 $'000
Not longer than one year	75	20
Longer than one year but not longer than five years	7	82
Longer than five years	–	–
Minimum future lease liability	**82**	**102**
Less unexpired finance expenses	(4)	(5)
Present value of lease liability	**78**	**97**
*** Represented by:**		
– Current liabilities	73	18
– Non-current liabilities	5	79
	78	**97**

How we recognise lease liabilities

A lease is defined as a contract, or part of a contract, that conveys the right for Mansfield District Hospital to use an asset for a period of time in exchange for payment.

To apply this definition, Mansfield District Hospital ensures the contract meets the following criteria:

- the contract contains an identified asset, which is either explicitly identified in the contract or implicitly specified by being identified at the time the asset is made available to Mansfield District Hospital and for which the supplier does not have substantive substitution rights
- Mansfield District Hospital has the right to obtain substantially all of the economic benefits from use of the identified asset throughout the period of use, considering its rights within the defined scope of the contract and Mansfield District Hospital has the right to direct the use of the identified asset throughout the period of use and
- Mansfield District Hospital has the right to take decisions in respect of 'how and for what purpose' the asset is used throughout the period of use.

Mansfield District Hospital's lease arrangements consist of the following:

Type of asset leased	**Lease Term**
Lease Motor Vehicles – Vic Fleet	3 years

All leases are recognised on the balance sheet, with the exception of low value leases (less than $10,000 AUD) and short term leases of less than 12 months.

Separation of lease and non-lease components

At inception or on reassessment of a contract that contains a lease component, the lessee is required to separate out and account separately for non-lease components within a lease contract and exclude these amounts when determining the lease liability and right-of-use asset amount.

NOTE 6.1: BORROWINGS (Continued)

Initial measurement

The lease liability is initially measured at the present value of the lease payments unpaid at the commencement date, discounted using the interest rate implicit in the lease if that rate is readily determinable or the Hume Rural Health Alliance's (where applicable) incremental borrowing rate. The lease liability has been discounted by rates of between 1% to 2%.

Lease payments included in the measurement of the lease liability comprise the following:
- fixed payments (including in-substance fixed payments) less any lease incentive receivable
- variable payments based on an index or rate, initially measured using the index or rate as at the commencement date
- amounts expected to be payable under a residual value guarantee and
- payments arising from purchase and termination options reasonably certain to be exercised.

Subsequent measurement

Subsequent to initial measurement, the liability will be reduced for payments made and increased for interest. It is remeasured to reflect any reassessment or modification, or if there are changes in-substance fixed payments.

When the lease liability is remeasured, the corresponding adjustment is reflected in the right-of-use asset, or profit and loss if the right of use asset is already reduced to zero.

NOTE 6.2: CASH AND CASH EQUIVALENTS

	Note	**2022 $**	2021 $
– Cash on Hand (excluding monies held in trust)		1	1
– Cash at Bank (excluding monies held in trust)		1,773	1,517
– Cash at Bank – CBS (excluding monies held in trust)		6,901	7,368
Total cash held for operations		**8,675**	**8,886**
– Cash at Bank (monies held in trust)		10,487	14,571
Total cash held as monies in trust		**10,487**	**14,571**
Total cash and cash equivalents	7.1(a)	**19,162**	**23,457**

How we recognise cash and cash equivalents

Cash and cash equivalents recognised on the balance sheet comprise cash on hand and in banks, deposits at call and highly liquid investments (with an original maturity date 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. The cash flow statement includes monies held in trust.

NOTE 6.3: COMMITMENTS FOR EXPENDITURE

	2022 $'000	2021 $'000
Non-cancellable short term and low value asset lease commitments		
Less than one year – printer and photocopier agreement	51	37
Longer than one year but not longer than five years	–	–
Five years or more	–	–
Total non-cancellable short term and low value asset lease commitments	**51**	**37**
Total commitments for expenditure (inclusive of GST)	51	37
Less GST recoverable from Australian Tax Office	(5)	(3)
Total commitments for expenditure (exclusive of GST)	**46**	**34**

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

How we disclose our commitments

Our commitments relate to expenditure and short term and low value leases.

Expenditure commitments

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed 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 projects are stated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the Balance Sheet.

Short term and low value leases

Mansfield District Hospital discloses short term and low value lease commitments which are excluded from the measurement of right-of-use assets and lease liabilities. Refer to Note 6.1 for further information.

NOTE 7: RISKS, CONTINGENCIES AND VALUATION UNCERTAINTIES

Mansfield District 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 health service is related mainly to fair value determination.

Structure

7.1 Financial instruments
7.2 Financial risk management objectives and policies
7.3 Contingent assets and contingent liabilities
7.4 Fair value determination

Key judgements and estimates

This section contains the following key judgements and estimates:

Key judgements and estimates	Description
Measuring fair value of non-financial assets	Fair value is measured with reference to highest and best use, that is, the use of the asset by a market participant that is physically possible, legally permissible, financially feasible, and which results in the highest value, or to sell it to another market participant that would use the same asset in its highest and best use. In determining the highest and best use, Mansfield District Hospital has assumed the current use is its highest and best use. Accordingly, characteristics of the health service's assets are considered, including condition, location and any restrictions on the use and disposal of such assets. Mansfield District Hospital uses a range of valuation techniques to estimate fair value, which include the following: • Market approach, which uses prices and other relevant information generated by market transactions involving identical or comparable assets and liabilities. The fair value of Mansfield District Hospital's [specialised land, non-specialised land, non-specialised buildings, investment properties and cultural assets] are measured using this approach. • Cost approach, which reflects the amount that would be required to replace the service capacity of the asset (referred to as current replacement cost). The fair value of Mansfield District Hospital's [specialised buildings, furniture, fittings, plant, equipment and vehicles] are measured using this approach. • Income approach, which converts future cash flows or income and expenses to a single undiscounted amount. Mansfield District Hospital does not this use approach to measure fair value. The health service selects a valuation technique which is considered most appropriate, and for which there is sufficient data available to measure fair value, maximising the use of relevant observable inputs and minimising the use of unobservable inputs. Subsequently, the health service applies significant judgement to categorise and disclose such assets within a fair value hierarchy, which includes: • Level 1, using quoted prices (unadjusted) in active markets for identical assets that the health service can access at measurement date. Mansfield District Hospital does not categorise any fair values within this level. • Level 2, inputs other than quoted prices included within Level 1 that are observable for the asset, either directly or indirectly. Mansfield District Hospital does not categorise any fair values in this level. • Level 3, where inputs are unobservable. Mansfield District Hospital categorises specialised land, specialised buildings, plant and equipment, furniture and fittings, vehicles, right-of-use motor vehicles and right-of-use plant and equipment in this level.

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 (for example, taxes, fines and penalties). Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation.*

NOTE 7.1(a): Categorisation of financial instruments

2022	Note	Financial assets at amortised cost $'000	Financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets				
Cash and cash equivalents	6.2	19,162	–	19,162
Receivables – Trade Debtors	5.1	485	–	485
Other Receivables	5.1	88	–	88
Long Service Leave – Department of Health	5.1	1,367		1,367
Total Financial Assets (i)		**21,102**	**–**	**21,102**
Financial Liabilities				
Payables	5.2	–	887	887
Borrowings	6.1	–	138	138
Other Financial Liabilities				
– Refundable Accommodation Deposits	5.3	–	10,487	10,487
Total Financial Liabilities (ii)		**–**	**11,512**	**11,512**

2021	Note	Financial assets at amortised cost $'000	Financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets				
Cash and cash equivalents	6.2	23,457	–	23,457
Receivables – Trade Debtors	5.1	348	–	348
Other Receivables	5.1	27	–	27
Long Service Leave – Department of Health	5.1	923		923
Total Financial Assets (i)		**24,755**	**–**	**24,755**
Financial Liabilities				
Payables	5.2	–	1,105	1,105
Borrowings	6.1	–	179	179
Other Financial Liabilities				
– Refundable Accommodation Deposits	5.3	–	14,571	14,571
Total Financial Liabilities (ii)		**–**	**15,855**	**15,855**

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

How we categorise financial instruments

Categories of financial assets

Financial assets are recognised when Mansfield District Hospital becomes party to the contractual provisions to the instrument. For financial assets, this is at the date Mansfield District Hospital commits itself to either the purchase or sale of the asset (i.e. trade date accounting is adopted).

Financial instruments (except for trade receivables) are initially measured at fair value plus transaction costs, except where the instrument is classified at fair value through net result, in which case transaction costs are expensed to profit or loss immediately.

Where available, quoted prices in an active market are used to determine the fair value. In other circumstances, valuation techniques are adopted.

Trade receivables are initially measured at the transaction price if the trade receivables do not contain a significant financing component or if the practical expedient was applied as specified in AASB 15 para 63.

Financial assets at amortised cost

Financial assets are measured at amortised cost if both of the following criteria are met and the assets are not designated as fair value through net result:

- the assets are held by Mansfield District Hospital solely to collect the contractual cash flows and
- the assets' contractual terms give rise to cash flows that are solely payments of principal and interest on the principal amount outstanding on specific dates.

These assets are initially recognised at fair value plus any directly attributable transaction costs and are subsequently measured at amortised cost using the effective interest method less any impairment.

Mansfield District Hospital recognises the following assets in this category:
- cash and deposits and
- receivables (excluding statutory receivables).

Categories of financial liabilities

Financial liabilities are recognised when Mansfield District Hospital becomes a party to the contractual provisions to the instrument. Financial instruments are initially measured at fair value plus transaction costs, except where the instrument is classified at fair value through profit or loss, in which case transaction costs are expensed to profit or loss immediately.

Financial liabilities at amortised cost

Financial liabilities are measured at amortised cost using the effective interest method, where they are not held at fair value through net result.

The effective interest method is a method of calculating the amortised cost of a debt instrument and of allocating interest expense in net result over the relevant period. The effective interest is the internal rate of return of the financial asset or liability. That is, it is the rate that exactly discounts the estimated future cash flows through the expected life of the instrument to the net carrying amount at initial recognition.

Mansfield District Hospital recognises the following liabilities in this category:
- payables (excluding statutory payables and contract liabilities)
- borrowings and
- other liabilities (including monies held in trust).

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

Offsetting financial instruments

Financial instrument assets and liabilities are offset and the net amount presented in the consolidated balance sheet when, and only when, Mansfield District Hospital has a legal right to offset the amounts and intend either to settle on a net basis or to realise the asset and settle the liability simultaneously.

Some master netting arrangements do not result in an offset of balance sheet assets and liabilities. Where Mansfield District Hospital does not have a legally enforceable right to offset recognised amounts, because the right to offset is enforceable only on the occurrence of future events such as default, insolvency or bankruptcy, they are reported on a gross basis.

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
- Mansfield District 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
- Mansfield District 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 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 Mansfield District Hospital's continuing involvement in the asset.

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.

Reclassification of financial instruments

A financial asset is required to be reclassified between fair value between amortised cost, fair value through net result and fair value through other comprehensive income when, and only when, Mansfield District Hospital's business model for managing its financial assets has changed such that its previous model would no longer apply.

A financial liability reclassification is not permitted.

NOTE 7.2: FINANCIAL RISK MANAGEMENT OBJECTIVES AND POLICIES

As a whole, Mansfield District Hospital's financial risk management program seeks to manage the risks and the associated volatility of its financial performance.

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

Mansfield District Hospital's main financial risks include credit risk, liquidity risk and interest rate risk. Mansfield District Hospital manages these financial risks in accordance with its financial risk management policy.

Mansfield District Hospital uses different methods to measure and manage the different risks to which it is exposed. Primary responsibility for the identification and management of financial risks rests with the Accountable Officer.

NOTE 7.2: FINANCIAL RISK MANAGEMENT OBJECTIVES AND POLICIES (Continued)

NOTE 7.2(a): Credit risk

Credit risk refers to the possibility that a borrower will default on its financial obligations as and when they fall due. Mansfield District Hospital's exposure to credit risk arises from the potential default of a counter party on their contractual obligations resulting in financial loss to Mansfield District Hospital. Credit risk is measured at fair value and is monitored on a regular basis.

Credit risk associated with Mansfield District Hospital's contractual financial assets is minimal because the main debtor is the Victorian Government. For debtors other than the Government, the health service is exposed to credit risk associated with patient and other debtors.

In addition, Mansfield District Hospital does not engage in hedging for its contractual financial assets and mainly obtains contractual financial assets that are on fixed interest, except for cash and deposits, which are mainly cash at bank. As with the policy for debtors, Mansfield District Hospital's policy is to only deal with banks with high credit ratings.

Provision of impairment for contractual financial assets is recognised when there is objective evidence that Mansfield District Hospital will not be able to collect a receivable. Objective evidence includes financial difficulties of the debtor, default payments, debtors that are more than 60 days overdue, and changes in debtor credit ratings.

Contract financial assets are written off against the carrying amount when there is no reasonable expectation of recovery. Bad debt written off by mutual consent is classified as a transaction expense. Bad debt written off following a unilateral decision is recognised as other economic flows in the net result.

Except as otherwise detailed in the following table, the carrying amount of contractual financial assets recorded in the financial statements, net of any allowances for losses, represents Mansfield District Hospital's maximum exposure to credit risk without taking account of the value of any collateral obtained.

There has been no material change to Mansfield District Hospital's credit risk profile in the 2022 year.

Impairment of financial assets under AASB 9

Mansfield District Hospital records the allowance for expected credit loss for the relevant financial instruments applying AASB 9's Expected Credit Loss approach. Subject to AASB 9, impairment assessment includes the health service's contractual receivables and its investment in debt instruments.

Equity instruments are not subject to impairment under AASB 9. Other financial assets mandatorily measured or designated at fair value through net result are not subject to impairment assessment under AASB 9.

Credit loss allowance is classified as other economic flows in the net result. Contractual receivables are written off when there is no reasonable expectation of recovery and impairment losses are classified as a transaction expense. Subsequent recoveries of amounts previously written off are credited against the same line item.

NOTE 7.2: FINANCIAL RISK MANAGEMENT OBJECTIVES AND POLICIES (Continued)

Contractual receivables at amortised cost

Mansfield District Hospital applies AASB 9's simplified approach for all contractual receivables to measure expected credit losses using a lifetime expected loss allowance based on the assumptions about risk of default and expected loss rates. Mansfield District Hospital has grouped contractual receivables on shared credit risk characteristics and days past due and select the expected credit loss rate based on Mansfield District Hospital's past history, existing market conditions, as well as forward looking estimates at the end of the financial year.

On this basis, Mansfield District Hospital determines the closing loss allowance at the end of the financial year as follows:

30-Jun-21	Current	Less than 1 month	1–3 months	3 months – 1 year	1–5 years	Total
Expected loss rate	2.0%	3.0%	5.0%	8.0%	50.0%	
Gross carrying amount of contractual receivables ($'000)	164	33	20	178	–	395
Loss Allowance	**3**	**1**	**1**	**15**	**–**	**20**

30-Jun-22	Current	Less than 1 month	1–3 months	3 months – 1 year	1–5 years	Total
Expected loss rate	1.5%	2.0%	3.0%	4.5%	50%	
Gross carrying amount of contractual receivables ($'000)	195	49	30	319	–	593
Loss Allowance	**3**	**1**	**1**	**15**	**–**	**20**

Statutory receivables and debt investments at amortised cost

Mansfield District Hospital's non-contractual receivables arising from statutory requirements are not financial instruments. However, they are nevertheless recognised and measured in accordance with AASB 9 requirements as if those receivables are financial instruments.

Statutory receivables are considered to have low credit risk, taking into account the counterparty's credit rating, risk of default and capacity to meet contractual cash flow obligations in the near term. As a result, no loss allowance has been recognised.

NOTE 7.2(b): Liquidity risk

Liquidity risk arises from being unable to meet financial obligations as they fall due.

Mansfield District Hospital is exposed to liquidity risk mainly through the financial liabilities as disclosed in the face of the balance sheet and the amounts related to financial guarantees. The health service manages its liquidity risk by:

- close monitoring of its short-term and long-term borrowings by senior management, including monthly reviews on current and future borrowing levels and requirements
- maintaining an adequate level of uncommitted funds that can be drawn at short notice to meet its short-term obligations
- holding investments and other contractual financial assets that are readily tradeable in the financial markets and
- careful maturity planning of its financial obligations based on forecasts of future cash flows.

Mansfield District Hospital's exposure to liquidity risk is deemed insignificant based on prior periods' data and current assessment of risk. Cash for unexpected events is generally sourced from liquidation of investments and other financial assets.

NOTE 7.2: FINANCIAL RISK MANAGEMENT OBJECTIVES AND POLICIES (Continued)

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

				Maturity Dates			
2022	Note	**Carrying Amount $'000**	**Nominal Amount $'000**	**Less than 1 month $'000**	**1–3 months $'000**	**3 months – 1 year $'000**	**1–5 years $'000**
Financial Liabilities at amortised cost							
Payables	5.2	887	887	887	–	–	–
Borrowings	6.1	138	138	2	2	8	126
Other Financial Liabilities – Refundable Accommodation Deposits	5.3	10,487	10,487	209	420	1,992	7,866
Total Financial Liabilities		**11,512**	**11,512**	**1,098**	**422**	**2,000**	**7,992**

2021	Note	**Carrying Amount $'000**	**Nominal Amount $'000**	**Less than 1 month $'000**	**1–3 months $'000**	**3 months – 1 year $'000**	**1–5 years $'000**
Financial Liabilities at amortised cost							
Payables	5.2	1,105	1,105	1,105	–	–	–
Borrowings	6.1	179	179	2	3	11	163
Other Financial Liabilities – Refundable Accommodation Deposits	5.3	14,571	14,571	291	583	2,768	10,929
Total Financial Liabilities		**15,855**	**15,855**	**1,398**	**586**	**2,779**	**11,092**

The maturity dates of the refundable accommodation deposits in the table represent the estimated timing of the repayments. Ageing analysis of financial liabilities excludes statutory financial liabilities (ie GST payable).

NOTE 7.2(c): Market risk

Mansfield District Hospital's exposures to market risk are primarily through interest rate risk, foreign currency risk and equity price risk. Objectives, policies and processes used to manage each of these risks are disclosed below.

Sensitivity disclosure analysis and assumptions

Mansfield District Hospital's sensitivity to market risk is determined based on the observed range of actual historical data for the preceding five-year period. Mansfield District Hospital's fund managers cannot be expected to predict movements in market rates and prices. The following movements are 'reasonably possible' over the next 12 months:

- a change in interest rates of 2% up or down

Interest rate risk

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate because of changes in market interest rates. Mansfield District Hospital does not hold any interest-bearing financial instruments that are measured at fair value, and therefore has no exposure to fair value interest rate risk.

Cash flow interest rate risk is the risk that the future cash flows of a financial instrument will fluctuate because of changes in market interest rates. Mansfield District Hospital has minimal exposure to cash flow interest rate risks through cash and deposits, term deposits and bank overdrafts that are at floating rate.

Foreign currency risk

All foreign currency transactions during the financial year are brought to account using the exchange rate in effect at the date of the transaction. Foreign monetary items existing at the end of the reporting period are translated at the closing rate at the date of the end of the reporting period.

Mansfield District Hospital has minimal exposure to foreign currency risk.

NOTE 7.3: CONTINGENT ASSETS AND CONTINGENT LIABILITIES

At balance date, the Board are not aware of any contingent assets or liabilities.

How we measure and disclose contingent assets and contingent liabilities

Contingent assets and contingent liabilities are not recognised in the balance sheet but are disclosed and, if quantifiable, are measured at nominal value.

Contingent assets and liabilities are presented inclusive of GST receivable or payable respectively.

Contingent assets

Contingent assets are possible assets that arise from past events, whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the health service.

These are classified as either quantifiable, where the potential economic benefit is known, or non-quantifiable.

Contingent liabilities

Contingent liabilities are:
- possible obligations that arise from past events, whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the health service or
- present obligations that arise from past events but are not recognised because:
  - It is not probable that an outflow of resources embodying economic benefits will be required to settle the obligations or
  - the amount of the obligations cannot be measured with sufficient reliability.

Contingent liabilities are also classified as either quantifiable or non-quantifiable.

NOTE 7.4: FAIR VALUE DETERMINATION

How we measure fair value

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

The following assets and liabilities are carried at fair value:
- Property, plant and equipment
- Right-of-use assets
- Lease liabilities

In addition, the fair value of other assets and liabilities that are carried at amortised cost, also need to be determined for disclosure.

Valuation hierarchy

In determining fair values a number of inputs are used. To increase consistency and comparability in the financial statements, these inputs are categorised into three levels, also known as the fair value hierarchy. The levels are as follows:

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

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. There have been no transfers between levels during the period.

Mansfield District Hospital monitors changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required. The Valuer-General Victoria (VGV) is Mansfield District Hospital's independent valuation agency for property, plant and equipment.

NOTE 7.4: FAIR VALUE DETERMINATION (Continued)

Identifying unobservable inputs (level 3) fair value measurements

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

Unobservable inputs are 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.

NOTE 7.4 (a): Fair value determination of non-financial physical assets

	Note	Total Carrying Amount 30 June 2022 $'000	Fair Value Measurement at End of Reporting Period Using: Level 1[i] $'000	Level 2[i] $'000	Level 3[i] $'000
Specialised Land		2,670	–	–	2,670
Total Land at Fair Value	4.1(a)	**2,670**	**–**	**–**	**2,670**
Land Improvements		471	–	–	471
Total Land Improvements at Fair Value		**471**	**–**	**–**	**471**
Buildings at Fair Value					
Specialised Buildings		21,263	–	–	21,263
Total Buildings at Fair Value	4.1(a)	**21,263**	**–**	**–**	**21,263**
Plant and Equipment at Fair Value	4.1(a)	1,031	–	–	1,031
Motor Vehicles at Fair Value	4.1(a)	54	–	–	54
Right of Use Motor Vehicles at Fair Value	4.1(a)	71	–	–	71
Medical Equipment at Fair Value	4.1(a)	726	–	–	726
Computers and Communication at Fair Value	4.1(a)	34	–	–	34
Furniture & Fittings at Fair Value	4.1(a)	146	–	–	146
Total Other Plant and Equipment at Fair Value	4.1(a)	**2,062**	**–**	**–**	**2,062**
Total non-financial physical assets at fair value		**26,466**	**–**	**–**	**26,466**

NOTE 7.4: FAIR VALUE DETERMINATION (Continued)

	Note	Total Carrying Amount 30 June 2021 $'000	Fair Value Measurement at End of Reporting Period Using: Level 1[(i)] $'000	Level 2[(i)] $'000	Level 3[(i)] $'000
Specialised Land		2,454	–	–	2,454
Total Land at Fair Value	4.1(a)	**2,454**	**–**	**–**	**2,454**
Land Improvements		457	–	–	457
Total Land Improvements at Fair Value		**457**	**–**	**–**	**457**
Buildings at Fair Value					
Specialised Buildings		20,481	–	–	20,481
Total Buildings at Fair Value	4.1(a)	**20,481**	**–**	**–**	**20,481**
Plant and Equipment at Fair Value	4.1(a)	759	–	–	759
Motor Vehicles at Fair Value	4.1(a)	92	–	–	92
Right of Use Motor Vehicles at Fair Value	4.1(a)	85	–	–	85
Medical Equipment at Fair Value	4.1(a)	659	–	–	659
Computers and Communication at Fair Value	4.1(a)	15	–	–	15
Furniture & Fittings at Fair Value	4.1(a)	182	–	–	182
Total Other Plant and Equipment at Fair Value	4.1(a)	**1,792**	**–**	**–**	**1,792**
Total non-financial physical assets at fair value		**25,184**	**–**	**–**	**25,184**

How we measure fair value of non-financial assets

The fair value measurement of non-financial physical assets takes into account the market participant's ability to use the asset in its highest and best use, or to sell it to another market participant that would use the same asset in its highest and best use.

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 AASB 13 Fair Value Measurement paragraph 29, Mansfield District Hospital has assumed the current use of a non-financial physical asset is its highest and best use unless market or other factors suggest that a different use by market participants would maximise the value 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.

NOTE 7.4: 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 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 Mansfield District Hospital's specialised land was performed by the Valuer-General Victoria. The effective date of the valuation is 30 June 2022. No revaluation of Mansfield District Hospital's specialised buildings was performed by the Valuer-General Victoria.

Vehicles

Mansfield District 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 health service who set relevant depreciation rates during use to reflect the consumption of the vehicles. As a result, the fair value of vehicles does not differ materially from the carrying amount (depreciated cost).

Furniture, fittings, plant and equipment

Furniture, fittings, plant and equipment (including medical equipment, computers and communication equipment) 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 2022.

NOTE 7.4: FAIR VALUE DETERMINATION (Continued)

Reconciliation of level 3 fair value measurement

	Note	Land $'000	Land Improvements $'000	Buildings $'000	Plant and Equipment $'000	Medical Equipment $'000
Balance at 1 July 2020	4.1(b)	**2,045**	**475**	**21,770**	**627**	**567**
Additions/(disposals)	4.1(b)	–	–	–	211	179
Assets provided free of charge		–	–	–	–	33
Net transfers between classes	4.1(b)	–	–	125	39	–
Gains/(losses) recognised in net result – Depreciation	4.5	–	(18)	(1,414)	(118)	(120))
Items recognised in other comprehensive income – Revaluation		409	–	–	–	–
Balance at 30 June 2021	4.1(b)	**2,454**	**457**	**20,481**	**759**	**659**
Additions/(disposals)	4.1(b)	–	–	–	18	212
Assets provided free of charge		–	–	–	–	–
Net transfers between classes	4.1(b)	–	33	–	374	–
Gains/(losses) recognised in net result – Depreciation	4.4	–	(19)	(1,424)	(120)	(145)
Items recognised in other comprehensive income – Revaluation		216	–	2,206	–	–
Balance at 30 June 2022	4.1(b)	**2,670**	**471**	**21,263**	**1,031**	**726**

	Note	Computers & Commun. Equipment $'000	Furniture & Fittings $'000	Motor Vehicle incl. RoU $'000
Balance at 1 July 2019	4.1(b)	**18**	**164**	**240**
Additions/(disposals)	4.1(b)	–	39	–
Assets provided free of charge		–	–	–
Net transfers between classes	4.1(b)	–	14	–
Gains/(losses) recognised in net result – Depreciation	4.4	(3)	(35)	(63)
Items recognised in other comprehensive income – Revaluation		–	–	–
Balance at 30 June 2020	4.1(b)	**15**	**182**	**177**
Additions/(disposals)	4.1(b)	27	4	–
Assets provided free of charge		–	–	–
Net transfers between classes	4.1(b)	–	–	–
Gains/(losses) recognised in net result – Depreciation	4.4	(8)	(40)	(53)
Items recognised in other comprehensive income – Revaluation		–	–	–
Balance at 30 June 2021	4.1(b)	**34**	**146**	**125**

Classified in accordance with the fair value hierarchy, refer Note 7.4

NOTE 7.4: FAIR VALUE DETERMINATION (Continued)

NOTE 7.4 (b) Fair value determination

Asset Class	Likely Valuation Approach	Significant inputs (Level 3 only)
Specialised land	Market approach	– Community Service Obligations (CSO) adjustments (a)
Specialised buildings	Depreciated replacement cost approach	– Cost per square metre – Useful life
Motor Vehicles	Depreciated replacement cost approach	– Cost per unit – Useful life
Plant and Equipment	Depreciated replacement cost approach	– Cost per unit – Useful life
Computers and Furniture	Depreciated replacement cost approach	– Cost per unit – Useful life
Medical Equipment	Depreciated replacement cost approach	– Cost per unit – Useful life

(a) CSO adjustment of 20% was applied to reduce the market approach value for the hospital's specialised land.

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 Reconciliation of net result for the year to net cash inflow/(outflow) from operating activities
8.2 Responsible persons disclosure
8.3 Remuneration of executives
8.4 Related parties
8.5 Remuneration of auditors
8.6 Events occurring after the balance sheet date
8.7 Jointly controlled operations
8.8 Equity
8.9 Economic dependency

Telling the COVID-19 story

Our other disclosures were not impacted during the financial year as a result of COVID-19 Coronavirus pandemic.

NOTE 8.1: RECONCILIATION OF NET RESULT FOR THE YEAR TO NET CASH INFLOW/ (OUTFLOW) FROM OPERATING ACTIVITIES

	2022 $'000	2021 $'000
NET RESULT FOR THE YEAR	(1,279)	(1,166)
Non-cash movements		
Depreciation and Amortisation	1,808	1,771
Bad and doubtful debts	15	35
Assets and services Received Free of Charge	(585)	(261)
Assets and services Received Free of Charge utilised as Expense	578	–
(Gain)/Loss from Disposal of Non-financial physical assets	–	1
(Gain)/loss on revaluation of long service leave liability	(177)	(135)
Movements in assets and liabilities		
(Increase)/Decrease in receivables and contract assets	(633)	113
(Increase)/Decrease in Inventories	3	(32)
(Increase)/Decrease in Prepaid expenses	27	188
Increase/(Decrease) in payables and contract liabilities	(264)	575
Increase/(Decrease) in employee benefits	742	576
Net Cash Inflow/(Outflow) from Operating Activities	**235**	**1,665**

NOTE 8.2: RESPONSIBLE PERSON DISCLOSURE

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

	Period
Responsible Ministers:	
The Honourable Martin Foley:	
Minister for Health	01/07/2021 – 27/06/2022
Minister for Ambulance Services	01/07/2021 – 27/06/2022
Minister for Equality	01/07/2021 – 27/06/2022
The Honourable Mary-Anne Thomas	
Minister for Health	27/06/2022 – 30/06/2022
Minister for Ambulance Services	27/06/2022 – 30/06/2022
The Honourable James Merlino:	
Minister for Mental Health	01/07/2021 – 27/06/2022
Minister for Disability, Ageing and Carers (acting)	12/10/2021 – 05/12/2021
The Honourable Gabrielle Williams:	
Minister for Mental Health	27/06/2022 – 30/06/2022
The Honourable Harriet Shing:	
Minister for Equality	27/06/2022 – 30/06/2022
The Honourable Luke Donnellan:	
Minister for Child Protection	01/07/2021 – 11/10/2021
Minister for Disability, Ageing and Carers	01/07/2021 – 11/10/2021
The Honourable Anthony Carbines:	
Minister for Child Protection and Family Services	06/12/2021 – 27/06/2022
Minister for Disability, Ageing and Carers	06/12/2021 – 27/06/2022
The Honourable Colin Brooks:	
Minister for Child Protection and Family Services	27/06/2022 – 30/06/2022
Minister for Disability, Ageing and Carers	27/06/2022 – 30/06/2022
Governing Boards	
Mr M. Beattie (Chair of the Board)	01/07/2021 – 30/06/2022
Mr P. Officer	01/07/2021 – 30/06/2022
Mrs R. Adams	01/07/2021 – 30/06/2022
Dr. P. Dalgliesh	01/07/2021 – 30/06/2022
Dr. K. Bennetts	01/07/2021 – 30/06/2022
Ms. L. Morgan	01/07/2021 – 30/06/2022
Ms. K. Lockey	01/07/2021 – 30/06/2022
Assoc. Prof. L. Irving	01/07/2021 – 30/06/2022
Mr. R. Ray	01/07/2021 – 30/06/2022
Mr. M. Hoskin	01/07/2021 – 30/06/2022
Ms. A. Vogt	01/07/2021 – 30/06/2022
Accountable Officers	
Cameron Butler (Chief Executive Officer)	01/07/2021 – 30/06/2022

NOTE 8.2: RESPONSIBLE PERSON DISCLOSURE (Continued)

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

	2022 No.	2021 No.
$0 – $199,000	11	11
$200,000 – $209,999	1	1
Total Numbers	**12**	**12**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to ($'000):	**276**	**273**

Amounts relating to the Governing Board Members and Accountable Officer of Mansfield District Hospital's controlled entities are disclosed in their own financial statements. Amounts relating to Responsible Ministers are reported within the State's Annual Financial Report.

NOTE 8.3: REMUNERATION OF EXECUTIVES

The number of executive officers, other than Ministers and the Accountable Officer, 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.

	Total Remuneration	
Remuneration of executive officers (including Key Management Personnel Disclosed in Note 8.4)	**2022 $'000**	2021 $'000
Short term benefits	494	460
Post-employment benefits	41	39
Other long-term benefits	12	11
Total remuneration (i)	**547**	**510**
Total number of executives	3	4
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 Mansfield District Hospital under AASB 124 Related Party Disclosures and are also reported within Note 8.4 Related Parties.
(ii) Annualised employee equivalent is based on working 38 ordinary hours per week 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 (such as superannuation guarantee contributions) 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.

NOTE 8.4: RELATED PARTIES

The Mansfield District Hospital is a wholly owned and controlled entity of the State of Victoria. Related parties of the health service include:

- all key management personnel (KMP) and their close family members and personal business interests
- cabinet ministers (where applicable) and their close family members
- jointly controlled operations – A member of the Hume Rural Health Alliance Joint Venture and
- all health services 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 and its controlled entities, directly or indirectly.

Key management personnel of Mansfield District Hospital

The Board of Directors and the Executive Directors of the Mansfield District Hospital are deemed to be KMPs. This includes the following:

Entity	KMPs	Position Title
Mansfield District Hospital	Mr M. Beattie	Chair of the Board
Mansfield District Hospital	Mr P. Officer	Board Member
Mansfield District Hospital	Mrs R. Adams	Board Member
Mansfield District Hospital	Dr. P. Dalgliesh	Board Member
Mansfield District Hospital	Dr. K. Bennetts	Board Member
Mansfield District Hospital	Ms. L. Morgan	Board Member
Mansfield District Hospital	Ms. K. Lockey	Board Member
Mansfield District Hospital	Assoc. Prof. L. Irving	Board Member
Mansfield District Hospital	Mr. R. Ray	Board Member
Mansfield District Hospital	Mr. M. Hoskin	Board Member
Mansfield District Hospital	Ms. A. Vogt	Board Member
Mansfield District Hospital	Mr. C. Butler	Chief Executive Officer
Mansfield District Hospital	Ms. E. Sinclair	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

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 State's Annual Financial Report.

NOTE 8.4: RELATED PARTIES (Continued)

Compensation – KMPs	2022 $'000	2021 $'000
Short term Employee Benefits	745	710
Post-employment Benefits	60	57
Other Long-term Benefits	18	16
Total	**823**	**783**

KMPs are also reported in Note 8.2 Responsible Persons or Note 8.3 Remuneration of Executives.

Significant Transactions with Government Related Entities

The Mansfield District Hospital received funding from the Department of Health of $16.2m (2021: $12.68m) and indirect contributions of $0.5m (2021: $0.3m).

Expenses incurred by the Mansfield District Hospital in delivering services and outputs are in accordance with HealthShare Victoria requirements. Goods and services including procurement, diagnostics, patient meals and multi-site operational support are provided by other Victorian Health Service Providers on commercial terms.

Professional medical indemnity insurance and other insurance products are obtained from the Victorian Managed Insurance Authority.

The Standing Directions of the Assistant Treasurer require the Mansfield District Hospital to hold cash (in excess of working capital) in accordance with the State of Victoria's centralised banking arrangements. All borrowings are required to be sourced from Treasury Corporation Victoria unless an exemption has been approved by the Minister for Health and the Treasurer.

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 HealthShare Victoria and Victorian Government Procurement Board requirements.

Outside of normal citizen type transactions with the Mansfield District Hospital, there were no related party transactions that involved key management personnel, their close family members or their personal business interests. No provision has been required, nor any expense recognised, for impairment of receivables from related parties. There were no related party transactions with Cabinet Ministers required to be disclosed in 2022 (2021: none).

There were no related party transactions required to be disclosed for the Mansfield District Hospital Board of Directors, Chief Executive Officer and Executive Directors in 2022 (2021: none).

NOTE 8.5: REMUNERATION OF AUDITORS

	2022 $'000	2021 $'000
Victorian Auditor-General's Office		
Audit of financial statement	28	25

NOTE 8.6: EVENTS OCCURING AFTER THE BALANCE SHEET DATE

There are no events occurring after the Balance Sheet date.

NOTE 8.7: JOINTLY CONTROLLED OPERATIONS

		Ownership Interest	
Name of Entity	**Principal Activity**	**2022 %**	2021 %
Hume Rural Health Alliance	The Member Entities have committed to the establishment of Information Systems – including ICT investment facilitation, project delivery, workplace services, business application services, collaboration services and vendor management.	4.55	4.38

Mansfield District Hospital's interest in assets and liabilities of the above joint arrangements are detailed below. The amounts are included in the consolidated financial statements under their respective categories:

	2022 $'000	2021 $'000
Current Assets		
Cash and Cash Equivalents	455	491
Receivables	45	36
Prepayments	10	13
Total Current Assets	**510**	**540**
Non-Current Assets		
Property, Plant and Equipment and Intangibles	14	20
Total Non Current Assets	**14**	**20**
Total Assets	**524**	**560**
Current Liabilities		
Payables	87	299
PAS Monies in Trust	179	–
Borrowings	2	3
Total Current Liabilities	**268**	**302**
Non Current Liabilities		
Borrowings	5	8
Total Non Current Liabilities	**5**	**8**
Total Liabilities	**273**	**310**
Net Assets	**251**	**250**

Mansfield District Hospital's interest in revenues and expenses of the above joint arrangements are detailed below. The amounts are included in the consolidated financial statements under their respective categories:

	2022 $'000	2021 $'000
Revenues		
Operating Activities	142	128
Other Income	155	142
Interest Income	1	1
Capital Purpose Income	17	14
Total Revenue	**315**	**285**
Expenses		
Management Fee	100	90
Other Expenses from Continuing Operations	186	151
Finance Costs	–	–
Capital Purpose Expenditure	16	24
Depreciation and Amortisation	10	25
Other Economic Flows – Impairment of Intangible Assets	–	10
Total Expenses	**312**	**300**
Net Result	**3**	**(15)**

Contingent Liabilities and Capital Commitments
There are no known contingent liabilities or capital commitments held by Hume Rural Health Alliance as at balance date.

NOTE 8.8: EQUITY

Contributed capital

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 Mansfield District Hospital.

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.

Other transfers that are in the nature of contributions or distributions or that have been designated as contributed capital are also treated as contributed capital.

NOTE 8.9: ECONOMIC DEPENDENCY

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

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