Benalla HEALTH

ANNUAL REPORT 2017

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Benalla HEALTH

PART 1
2017 Report of Operations

Disclosure Index

The Annual Report of Benalla Health 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.

History

A ten bed Bush Nursing hospital was opened in 1935 and within the following decade an additional five beds were added.

In 1953 the hospital was incorporated as a Public Hospital and is registered as a Schedule 1 Public Hospital within the meaning of the Health Services Act (No 49 of 1988).

By 1992 the Hospital complex included 69 acute beds, a 30 bed Nursing Home and a Community Health Service.

The 24 bed John Lindell Wing was closed in 1994 following the completion of a 30 bed private nursing home in Benalla.

The Wing re-opened in 1998 as a 12 bed Day Stay Procedure Unit. In 2001 the Surgical/Midwifery Wing was extensively renovated.

Registered Objectives

The objectives of the Hospital are:-

1. To organise and provide health care services in the Benalla district and, in particular hospital based services, including regional services and services provided jointly with other agencies in accordance with the Health Services Act, 1988, and all existing or future relevant Acts and Regulations;

2. To utilise appropriate physical and personal resources, knowledge and available technologies to promote health and to prevent, treat and alleviate disease, disability, injury and suffering so far as is possible in the prevailing conditions;

3. To set and achieve standards consistent with prevailing principles of quality patient care and community health needs;

4. To foster continuing improvement in standards through education, research and training;

5. To manage and maintain a Community Health Service for all persons which will provide facilities, personnel and services to achieve the following aims:

   - promoting health awareness;
   - improving health standards;
   - fostering awareness and prevention of illness and disability;
   - supporting persons in their home environment; and
   - rehabilitation.

The 1936 Bush Nursing Hospital which contained 6 ward beds,
4 emergency beds, an x-ray plant and operating theatre.
The building cost approximately 4,000 pounds to build.

Chairman and Chief Executive Officer's Report

On behalf of the Board of Management and all staff we are pleased to present the 2016/17 Annual Report for Benalla Health.

The achievements of Benalla Health during the 2016/2017 year, which are outlined in this Report, would not have been possible without the dedicated commitment of all our staff, the medical workforce and our highly valued volunteers.

We would like to publically acknowledge the leadership of the Board of Management. All Board Members act in a voluntary capacity and the time that members devote to their important stewardship role is sincerely appreciated.

Four of our highly regarded and talented Board members have retired this year. Three members, Lisa McCoy, Robert Wright and Nathan McGrath served on the Board for 7, 5 and 2 years respectively. Their contributions during this time were invaluable.

Simultaneously Brendan Smith has resigned after serving on the Board for nearly 10 years with the last 3 years being in the Chairman role. Brendan was always a supportive and approachable leader who provided clear direction to the Board and Benalla Health. Furthermore his financial acumen and in-depth knowledge of governance enabled Benalla Health to continue being a high performing health service. His wisdom and shrewd advice is sincerely appreciated. Finally his unique sense of humour will leave a void that most likely won't be filled. We warmly thank him and wish him all the very best.

We welcomed a new Director of Clinical Services, Maree Woodhouse and a new Director of Finance and Corporate Services, Andrew Nitschke. Concurrently, for the first time, we appointed a Communications Officer to assist us to strengthen our community relationships. Our social media campaign has been very successful and we have really enjoyed interacting with our community through these platforms.

The Board set a Statement of Priorities (SoP) in agreement with the Department of Health and Human Services. The SoP was aligned with Benalla Health's strategic objectives and the Department's policy directions. The outcomes of the SoP are highlighted later on in this report.

We were delighted to receive the Large Business Excellence Award from the Benalla Business Network. This public recognition is a direct reflection of the outstanding service that all of our staff provides to the community we are privileged to serve.

Benalla Health in partnership with the local community demonstrated again its enduring commitment to reducing family violence in our community through its support of the 7th Annual 'March against Violence' held on White Ribbon Day on the 24th November 2016. We were very pleased that around 600 people attended the March which exceeded last year's numbers. Once again

White Ribbon Day

Benalla P-12 and FCJ College were very well represented on this day. Representatives from Benalla Health also attended the White Ribbon Day on Friday 25th November 2016 at Government House, Melbourne.

In order to continue to provide leadership in our local community we made the decision to sign up to the White Ribbon Workplace Accreditation Program. We were notified early in 2017 that we had completed all of the necessary actions to enable Benalla Health to become an accredited White Ribbon Workplace. This is an outstanding achievement and it is a credit to our staff for all their hard work with this initiative. In particular we recognise Neil Stott, Director of Community Health for the laudable leadership he has consistently demonstrated, over the last 5 years, in this domain.

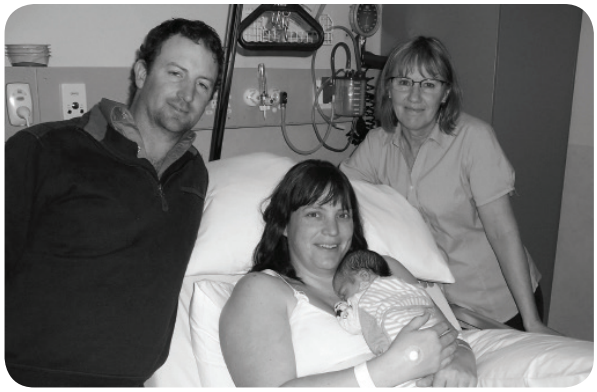
An enjoyable Christmas breakfast was held for all staff and volunteers on the 21st December 2016 with the

Staff Breakfast

event being well attended. This is just one way in which we can publically recognise our highly valued staff and thank them for all their hard work during the year.

We provided a range of acute inpatient, obstetric and surgical services and remain committed to continuing to provide these services into the future. We once again achieved our acute and community health activity targets and this is a reflection of the dedication of our loyal staff.

A sustained and concerted effort has resulted in our maternity services being strengthened and we are



Maternity Services

absolutely thrilled to report that our bookings are increasing nicely. Positive feedback has been received from women and their families regarding the outstanding professional care that continues to be provided by our dedicated midwives and general practitioners. The Board has declared its support for this very important community service.

The financial year ended with an operating surplus, which was achieved by all staff expending a considerable amount of effort to ensure that a high standard of care was delivered within an environment of fiscal restraint.

Our partnership with Goulburn Valley Health remains strong and we completed over 400 eye surgeries from their surgical waitlist. Patient satisfaction with this service is very high, which is a credit to the surgeons and our theatre and day procedure staff.

Morrie Evans Wing

We also partnered successfully with Northeast Health Wangaratta to undertake low acuity surgery from their surgical waitlist, thus enabling people to receive surgical treatment sooner than they may otherwise have. We intend to replicate this mutually beneficial initiative over the next 12 months to ensure that people receive timely surgical services relatively close to where they live.

Works associated with the refurbishment of Morrie Evans Wing (phase 2, stages 1a and 1b) were completed in 2017. We were elated with the news from the Department that we would be receiving $4.2 million to complete the refurbishment of MEW. This major capital works program will commence in December 2017 and will result in the

CRC/Allied Health

addition of 16 new single rooms with ensuites. All going well, towards the end of 2018, MEW will have 30 single rooms with ensuites, new sitting areas, extra storage spaces and new staff offices. We are very much looking

forward to continuing to provide exemplary aged care in a home like environment which facilitates resident dignity and privacy. Our community deserves nothing less than this.

We also commenced refurbishment works to create a contemporary Community Rehabilitation Centre (CRC) which is what our 2017 Annual Appeal is focused on. This CRC will support our talented staff to deliver evidence based rehabilitation programs for people living with chronic and complex diseases. It will also position Benalla Health to be the provider of choice when the National Disability Insurance Scheme becomes operational in our

Solar Panels

local government area in October 2017.

We have zero tolerance for occupational violence and we are committed to ensuring that our staff, patients, their loved ones, visitors and volunteers are safe. We received $30,000 through the Department's Violence Prevention fund to build on the initiatives that we already have in place to ensure that we have a safe workplace.

Stage 2 of our Solar Upgrade has been completed and this has resulted in significant savings being achieved with our electricity costs. We are pleased to report that we have also implemented LED lighting throughout the health service. Our impact on our environment is decreasing each year and we take great pride in the outcomes we have achieved.

Major pieces of capital equipment were purchased throughout the year and included:

- CSSD Sanitizer
- Motorised Stock Trolley
- Instrument Washer
- Ten alternating air mattresses and pumps
- Workstation - Endoscopic Tower
- Patient Trolley Chair

We receive regular feedback from patients through the Victorian Health Experience Survey (VHES). The results are impressive and indicate that patients who receive care at Benalla Health continue to be very pleased with the care they receive. Our results remain above the State average and this is a testament to the excellent care that is provided by our dedicated staff.

As in previous years, Benalla Health received outstanding support from the Benalla and District Memorial Hospital Auxiliary, Community groups and individuals who have generously donated their time and money to support the health service to deliver a broad range of high calibre services. The respectful assistance provided to staff from our volunteers and the extra equipment we purchased through donations is sincerely appreciated and we genuinely thank everyone for all their sustained efforts.

We would lastly like to publically recognise and sincerely thank the Department of Health and Human Services, Board members, our valued staff, medical officers, our partner organisations and our high functioning volunteers who have continued to willingly assist us to provide high quality health services to the community we are privileged to serve.

This Report is prepared in accordance with the Financial Management Act 1994.

L Armstrong

Louise Armstrong
Chairman

Benalla Health 22/ 08 /2017

Janine Holland

Janine Holland
Chief Executive Officer

Benalla Health 22/ 08 /2017

Corporate Governance - Board

The organisation is governed by an 11 person Board appointed by the Governor-in-Council upon the recommendation of the Minister for Health, Minister for Ambulance Services, The Hon. Jill Hennessy MP.

The functions of the Board as determined by the Health Services Act 1988 are:

- to oversee and manage the Organisation; and
- to ensure the services provided by the Organisation comply with the requirements of the Act and the aims of the organisation.

Governance by the Board is achieved through:

- strategic planning - to ensure the visionary direction of the Organisation is focused and aligned to the Mission Statement;
- effective management by the Chief Executive Officer – the Board performs an annual performance appraisal and sets realistic goals; the Chief Executive Officer is responsible for managing the Organisation at an operational level;
- funding of service agreements – the Board endorses plans, strategies and budgets and ensures annual agreements reflect accurate, achievable and desirable outcomes; the Board monitors the performance of the Organisation through appropriate budgetary processes;
- local policy setting and
- By-Laws and Operational Practices – these are reviewed regularly by the Board.

BOARD COMMITTEES

Audit Committee

The Committee receives and makes recommendations relating to internal and external audit reports and ensures compliance with any matters raised by the Auditor General's office. The Committee meets four times per year.

Medical Appointments Committee

The Committee has the important role of assessing medical and dental practitioners and recommending their scope of practice within Benalla Health. The Committee meets twice per year.

Medical Consultative Committee

The Committee provides a forum for local medical practitioners to meet with the Board to discuss common issues. The Committee meets twice per year.

Quality and Safety Committee

The Quality and Safety Committee provides clinical governance leadership, monitors the delivery of care, quality improvement and risk management (both clinical and non-clinical) throughout the organisation. The Committee meets monthly.

Cultural Diversity and Consumer Committee

The Committee provides direction and leadership in relation to the integration of consumer care and community views across all levels of health service planning, development and operations. The Committee meets bimonthly.

PECUNIARY INTEREST

Members of the Board of Management are required at each meeting to declare any pecuniary interest which might give rise to a conflict of interest.

The Board has developed a Policy and Code of Conduct which clarifies the responsibilities of Board Members.

THE MINISTER FOR HEALTH,
MINISTER FOR AMBULANCE SERVICES
The Hon. Jill Hennessy MP.

THE MINISTER FOR HOUSING,
DISABILITY & AGEING, MINISTER FOR MENTAL HEALTH
The Hon. Martin Foley MP.

AUDITORS
RSD Chartered Accountants, Agents for the Auditor General

BANKER
National Australia Bank

SOLICITORS
HDC Legal

GOVERNMENT POLICY

Health Service Boards are responsible to the Minister for setting the strategic directions of rural public healthcare agencies within the framework of Government policy. They are accountable for ensuring that rural public healthcare agencies:

- are effectively and efficiently managed;
- provide high quality care and service delivery;
- meet the needs of the community, and
- meet financial and non-financial performance targets.

The Government is committed to ensuring that there is strong governance and accountability of the Board for the performance of the Organisation and delivery of health services. Each rural public healthcare agency needs a balanced Board, which has the right mix of relevant skills, knowledge, attributes and expertise to be effective and achieve its objectives. This includes skills and expertise relating to the governance of health services, and an ability to represent the views of the Community.

Board of Management

Chairman

Brendan Smith

B. Bus (Acc.) FIPA FFA CFP FAICD

Committee Membership

- Audit
- Medical Appointments (Chairman)
- Medical Consultative (Chairman)

Brendan is a partner of local accounting practice Smith Dosser. He has over 39 years' experience in finance, tax and management. As a certified financial planner, he has also specialised in strategic consulting since 1999 with OzPlan Financial Services, a Victorian firm of which he is a founding director. He also brings his skills in corporate governance to the Benalla Health Board. Brendan and his family have lived in Benalla since 1987. Apart from a range of community activities over the years, Brendan's interests include travel, sport and reading.

Brendan retired from the Board 30/6/2017

Vice Chairman

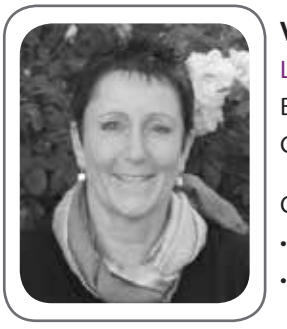
Kim Scanlon

Dip Teaching (Primary),
Grad Dip Outdoor Education
GAICD

Committee Membership

- Quality and Safety
- Medical Consultative

Kim is currently the Executive Officer of the Alpine Valleys Community Leadership Program, developing emerging community leaders from across the North East of Victoria. Prior to this Kim worked for the Victorian Education Department as a Primary teacher, with the majority of this time spent as the manager of 15 Mile Creek Camp. Kim has had experience on many community Boards, including the Rotary Club of Benalla, the Benalla Young Sportsperson Trust and the Winton Wetlands Committee of Management. Kim's personal interests include gardening, community activities and skiing.



Vice Chairman

Louise Armstrong

BInfoTech(InfoSys),
GCertMgt(ProfPrac), MAICD

Committee Membership

- Quality and Safety (Chairman)
- Medical Consultative

Louise has a background in information technology and training and was responsible for the overall management of a successful, award-winning small business for many years. She is currently doing some work for a local accounting firm, consulting in veterinary practice management in the region and overseeing the management of the family farm. Louise has lived most of her life in Benalla and has been involved in many community groups over the years, particularly Benalla Support Group for Children with Special Needs and Goomalibee Landcare. She is currently Chair of Benalla Business Network.

Treasurer

David Elford

AAPI, B.App.Sci (Val), Dip.
Acc

Committee Membership

- Audit (Chairman)
- Cultural Diversity and Consumer (Chairman)

David has spent the last 14 years as a property valuer conducting a broad range of property valuations with the Opteon property group, previously known as HMC Valuations. David covers an area extending throughout Northern and North East Victoria, the Goulburn Valley as well as southern and western New South Wales. He is a member of the Australian Institute of Company Directors. Prior to this, he was a farmer and professional wool classer in the Benalla district. David has played an active role in a number of community groups over the years and enjoys spending time with his family on his small farm, horse riding and various sports.

Lisa Marta

B.Pharm, MPS, AACPA

Committee Membership

- Quality and Safety
- Cultural Diversity and Consumer

Lisa is a pharmacist with over 30 years' experience in community and hospital pharmacy. Lisa is a partner in a local community pharmacy, with her husband Gareth. They moved to Benalla in 1995 and have 3 children. During this time Lisa has been involved in several community groups. In her spare times she enjoys tennis, craft and travel.

Lisa McCoy

Dip Social Service Work

Committee Membership

- Cultural Diversity and Consumer
- Audit
- Medical Appointments

Lisa has a background in Human Services, Community Development and Project Management spanning 20 years in both Canada and Australia. Lisa, her husband Gary and two sons moved to Benalla in 2009 and raise beef cattle on their property at Chesney Vale. Lisa operates a consulting business that supports strategic planning, research, evaluation and facilitation. Her more recent work has been with a range of local Governments to develop Youth and Early Years Strategies.

Lisa retired from the Board 30/6/2017

Robert Wright

Dip Ed; Grad Dip Ed Leadership; Grad Dip in Computers in Education

Committee Membership

- Quality and Safety
- Medical Appointments

After 40 years work in education, as a primary school teacher, principal and project coordinator, Robert has recently retired. He now plans to spend his time assisting various community groups and sailing his boat off the Queensland Coast. Robert is married to Louise. They live on a small farm at Warrenbayne.

Robert retired from the Board 30/6/2017

Nathan McGrath

B. Commerce, CPA, MIPA

Committee Membership

- Quality and Safety
- Audit

Nathan is a partner of local accounting practice Smith Dosser and specialises in taxation. Nathan grew up on a farm near Tumbarumba where he went to school and completed his university study in Canberra. He and his family have lived in Benalla since 2008. Apart from participation and volunteering in a range of community activities over the years, Nathan enjoys sport, music and spending time with family and friends.

Nathan retired from the Board 30/6/2017

Dr. Vikas Wadhwa

MBBS, FRACP, MBA

Committee Membership

- Quality and Safety

Vikas is a consultant physician in Internal Medicine, Respiratory and Sleep Disorders and is Director of General Medicine at Maroondah Hospital, Eastern Health with responsibility for work force leadership, training and mentoring, and with both executive and clinical roles. He is an active member of several expert advisory committees at Eastern Health. Vikas has academic appointments with Deakin and Monash Universities and has been the recipient of awards for excellence in consumer participation. He is an examiner for the RACP as well as for the medical undergraduate university exams. He is passionate about teaching and runs a robust and expanding clinical research program within Eastern Health.

Catherine Ross

Bachelor of Applied Science
Agribusiness

Committee Membership

- Quality and Safety

Catherine has worked in the major hazard industry for 12 years for a multinational company at both a corporate and facility level. Prior to this she worked in the food industry in North Western Victoria after graduating from Melbourne University – Dookie Campus. In her current role as Health, Safety and Environment Manager at a local major hazard facility, she leads a team of dedicated professionals who are responsible for facilitating aspects such as compliance, prevention programs, health promotion, sustainability programs, emergency management, work/non-work related injury management and is responsible for the ongoing environmental and safety management system certifications. Catherine has one son and she has been a member on a local School Council Committee and also operates a beef production business in the Stewarton area.

Dennis O'Brien

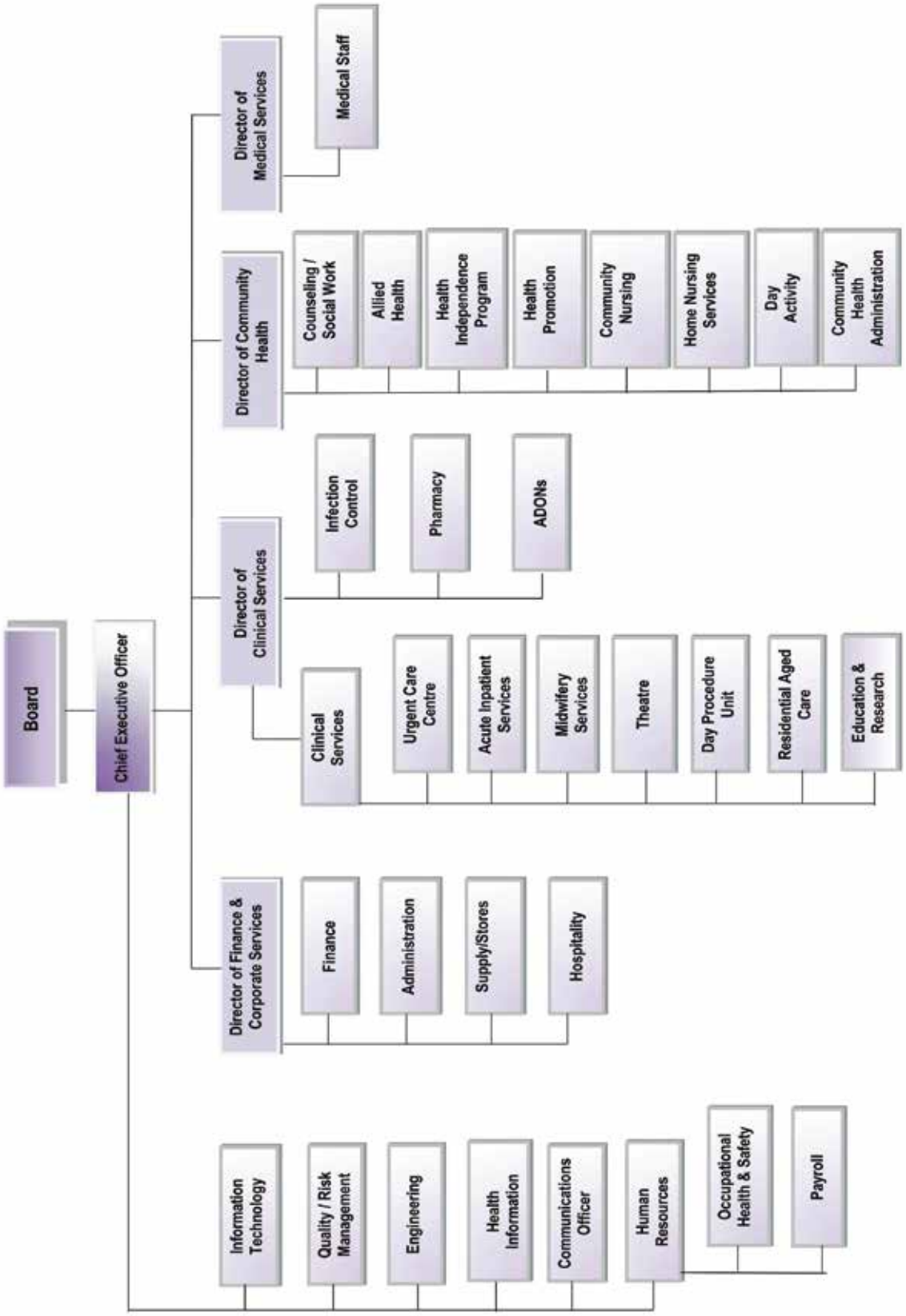
BScAg, Uni of Sydney; MSc,
Uni of Manitoba, Canada; PhD,
Oregon State Uni, USA

Committee Membership

- Cultural Diversity and Consumer
- Quality and Safety

After graduating with a PhD in 1981, Dennis worked for five years in the Philippines and Indonesia as well as working extensively in many overseas countries, returning to Australia with Gail and their children in 1985 and taking up an academic role at the University of Wollongong. He moved to Southern Cross University in 1993 as Head of the School of Business. In 2002, he was appointment Assoc Prof and Head of the Dookie Campus of the University of Melbourne. He is also Chair of the Winton Wetlands Committee of Management and a member of the Regional Development Australia Board for Hume.

Organisational Structure



Executive Team

Chief Executive Officer

Janine Holland

R.N. R.M. B.HSc, Grad Cert HSM, MPH, ACHSM, GAICD

The Chief Executive Officer is responsible to the Board of Managment for the efficient and effective management of the Health Service. Key responsibilites include the development and implementation of operational and strategic planning, maximising service efficiency, quality improvement and minimisation of risk. Janine is also an ACHS Surveyor.

Director of Clinical Services

Maree Woodhouse

R.N. R.M. BN, GCAdvNurs, GradDipMid, DIP MGT, MHA, ACHSM, MAICD

The Director of Clinical Services is responsible for all clinical services. The role encompasses clinical governance, clinical leadership and standards of practice, service and strategic planning, clinical risk management, quality improvement and resource management.

Business Manager

(to 22nd August, 2016)

Ian Hatton

B.Bus (Acc) CPA

The Business Manager has responsibility for the financial management and reporting requirements to the Board of Management and a number of external bodies, including the Department of Health and Human Services. Ian's role includes management of the Finance/Administration, Hospitality Services and Supply Departments.

Director of Finance and Corporate Services

(from 22nd August, 2016)

Andrew Nitschke

Bachelor of Business (Accounting), CPA, MBA, MAICD

Andrew joined Benalla Health in 2016 and has a diverse finance background. This includes working for the not for profit aged care sector for 11 years and in public health at both Mansfield and Seymour hospitals. This has given him a solid understanding of the pressures which face health services and the innovations they need to introduce to be resilient and best serve their communities.

Director of Community Health

Neil Stott

BA (Chr Min) Monash, Dip. Bus. (Gov) FICDA, Grad Cert Bus

The Director of Community Health oversees a range of allied health, nursing, palliative care, rehabiltation, chronic disease management and health promotion services and programs. Neil serves on a number of community committees within Benalla Rural City. He is also a White Ribbon Ambassador working with the local community to reduce the incidence of Family Violence.

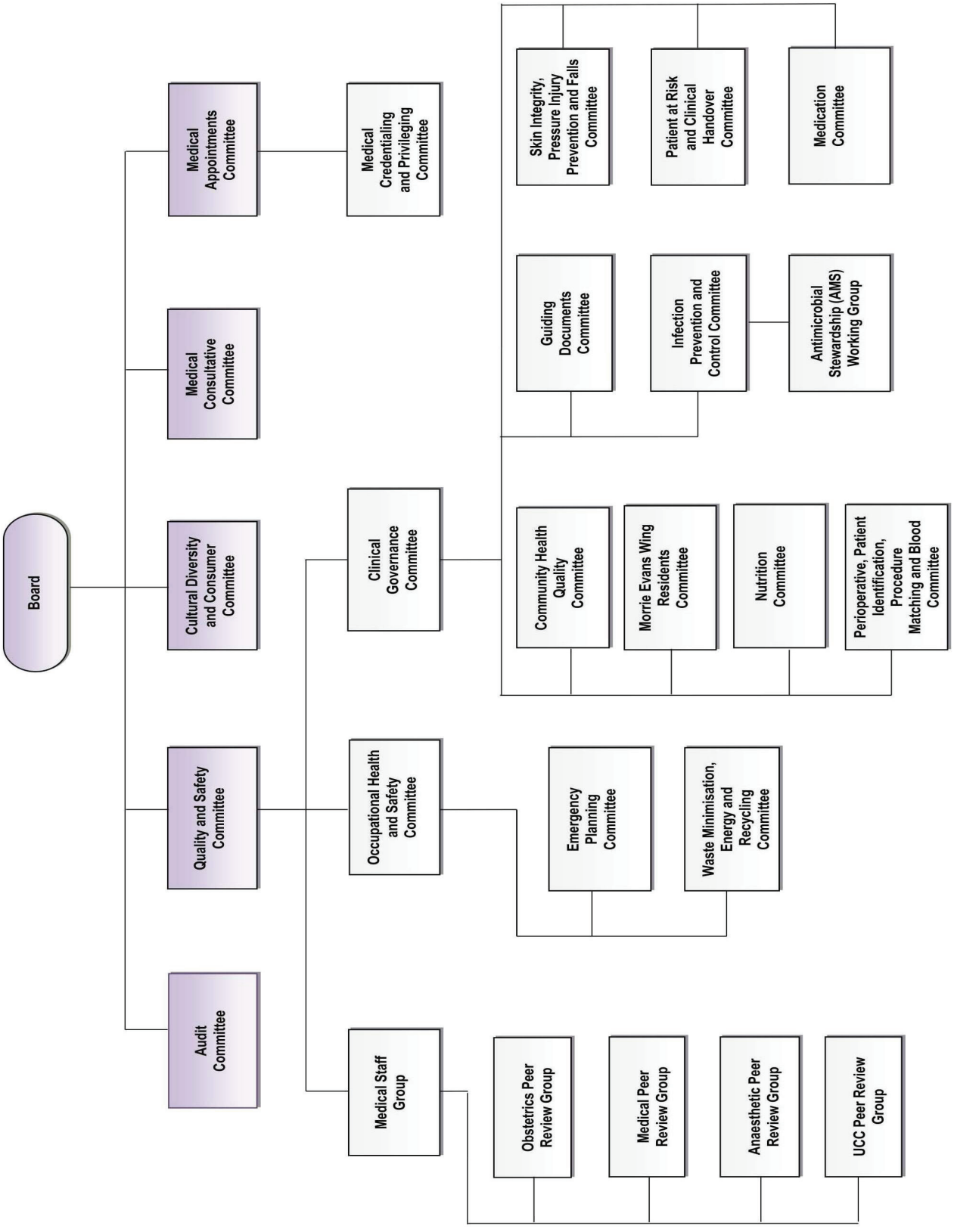
Director of Medical Services

Dr. Rick Lowen

MBBS, DObRCOG, FRACGP, AFCHSM

As Director of Medical Services Dr Lowen ensures all visiting medical officers are credentialed and have appropriate clinician privileges for the organisation. The DMS role involves liaison with visiting specialist and GP's as well as the provision of senior medical administrative support, advice and guidance to staff on clinical governance, medical service, clinical quality and medico-legal matters.

Committee Structure



5 Year Performance

5 YEAR FINANCIAL COMPARISON	2017	2016	2015	2014	2013
	$000	$000	$000	$000	$000
Total Revenue	28,865	28,431	27,388	25,679	27,577
Total Expenses	29,473	28,260	28,339	27,043	26,794
Net Result for the Year (inc. Capital and Specific Items)	(608)	171	(951)	(1,364)	783
Retained Surplus/(Accumulated Deficit)	(957)	(392)	(945)	(22)	1,320
Total Assets	35,129	37,051	34,797	36,536	36,576
Total Liabilities	7,720	9,034	6,951	7,739	6,986
Net Assets	27,409	28,017	27,846	28,797	29,590
Total Equity	27,409	28,017	27,846	28,797	29,590

Communication Technology (ICT)

Benalla Health's total ICT expenditure incurred during 2016-2017 is $896,000 (excluding GST) with the details shown below.

Business As Usual (BAU) ICT expenditure (Total) (excluding GST) (million)	Non Business As Usual (non BAU) ICT expenditure (Total=Operational expenditure and Capital Expenditure) (excluding GST)	Operational expenditure (excluding GST) (million)	Capital expenditure (excluding GST) (million)
$0.896	Nil	$0.87	$0.026

Consultancies

In 2016-2017 there were two consultancies where the total fees payable to the consultants was $10,000 or greater. The total expenditure during 2016-2017 in relation to these consultancies was $56,020 (excluding GST). Details of the consultancies, is listed below.

Consultant	Purpose of Consultancy	Start Date	End Date	Total Approved Project Fee (excluding GST)	Expenditure 2016-2017 (excluding GST)	Future Expenditure (excluding GST)
Maternity Care Consulting	Maternity Services Review	October 2016	December 2016	$18,000	$18,000	Nil
Aspex Consulting	Clinical Services Plan	March 2017	June 2017	$38,020	$38,020	Nil

In 2016-2017, Benalla Health did not have any consultancies where the total fees payable to consultants were less than $10,000.

Compliance

There are a number of specific compliance requirements that health services must meet and declare during the course of operations.

Accordingly:

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

I, Janine Holland certify that Benalla Health has put in place appropriate internal controls and processes to ensure that it has complied with all requirements set out in the HPV Health Purchasing Policies including mandatory HPV collective agreements as required by the Health Service Act 1998 (Vic). Benalla Health has critically reviewed these controls and processes during the year.

Janine Holland
Accountable Officer

Benalla 22/ 08 /2017

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

I, David Elford, Audit Committee Chairman certify that Benalla Health has complied with the Ministerial Standing Direction 3.7.1 – Risk Management Framework and Processes. The Audit Committee verifies this.

David Elford
Audit Committee Chairman

Benalla 22/ 08 /2017

Key Financial and Service Performance Reporting

Part A: Strategic Priorities

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

DOMAIN	ACTIONS	DELIVERABLES	OUTCOMES
Quality and Safety	Implement systems and processes to recognise and support person centred end of life care in all settings, with a focus on providing support for people who choose to die at home.	Benalla Health will continue to work towards full implementation of the Victorian End of Life and Palliative Care framework.	ACHIEVED The Hume Region Palliative Care Consortium is progressing well with the implementation of the End of Life and Palliative Care Framework. A project plan has been developed for Benalla Health staff to fully implement End of Life Care.
	Advance care planning is included as a parameter in an assessment of outcomes including mortality and morbidity review reports, patient experience and routine data collection.	Outcome assessment of mortality and morbidity review reports, patient experience and routine data collection will continue to be actioned to ensure the inclusion of Advance Care Planning.	ACHIEVED Formal governance systems are in place to support timely organisation wide mortality and morbidity reviews. Data collection and review includes the presence or exclusion of an Advance Care Plan.
		Benalla Health will explore how Advance Care Plans are stored / recorded in the client record and how to obtain reports of usage from our software programs.	ACHIEVED Advance Care Plan information is available for the community in printed form and on Benalla Health's website.
	Progress implementation of a whole-of-hospital model for responding to family violence.	Benalla Health will continue to strengthen its strategic partnerships with; • Benalla Family Violence Prevention Network; • White Ribbon Australia and • Centre Against Violence and other victim support agencies.	ACHIEVED Strategic partnerships have been strengthened and work will continue in 2017/18.

DOMAIN	ACTIONS	DELIVERABLES	OUTCOMES
Quality and Safety	Progress implementation of a whole-of-hospital model for responding to family violence.	The White Ribbon Workplace Accreditation process will be completed.	ACHIEVED White Ribbon Australia has accredited Benalla Health as a White Ribbon Workplace.
		The Royal Women's Hospital Family Violence Toolkit V2 will be implemented across Benalla Health.	ACHIEVED The Benalla Health working group is progressing well to implement the Royal Women's Hospital Family Violence Toolkit V2. Benalla Health staffs have received relevant training to build capacity and capability. Benalla Health has met with GV Health who presented the Strengthening Hospital Responses to Family Violence Service Model, including the two overarching principles of Gender Equality and Sensitive Practice. The six key elements of work to ensure successful implementation were discussed and project resources shared. Train the trainer sessions will be provided by GV Health in 2017-18.
		The whole of community place based Family Violence Prevention Strategy will be continued inclusive of; • White Ribbon Day; • White Ribbon Day Supporter's Program; • White Ribbon Breaking the Silence school program; • Rock and Water program; • Real Men Make Great Dads; • Parents Early Education Program and • Respectful Relationships in Schools	ACHIEVED Each strategy is progressing well and being supported by Benalla Health staff to ensure that our community has access to timely and effective programs.

DOMAIN	ACTIONS	DELIVERABLES	OUTCOMES
Quality and Safety	Develop a regional leadership culture that fosters multidisciplinary and multi-organisational collaboration to promote learning and the provision of safe, quality care across rural and regional Victoria.	Benalla Health will continue to participate in the Hume Region Nurse and Midwife Education Group and other multidisciplinary learning forums.	ACHIEVED Regular attendance occurring at the Hume Region Nurse and Midwife Education Group and other multidisciplinary learning forums.
	Establish a fetal surveillance competency policy and associated procedures for all staff providing maternity care that includes the minimum training requirements, safe staffing arrangements and ongoing compliance monitoring arrangements.	Benalla Health will develop a fetal surveillance competency policy and associated procedures for all staff providing maternity care inclusive of; • Safe staffing arrangements; • Ongoing compliance monitoring arrangements and • Minimum training requirements.	ACHIEVED Fetal surveillance competency policy developed.
	Use patient feedback, including the Victorian Healthcare Experience Survey to drive improved health outcomes and experiences through a strong focus on person and family centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first.	In partnership with the Cultural Diversity and Consumer Committee, Benalla Health will review the Victorian Healthcare Experience Survey results and other consumer/client feedback surveys to determine areas of improvement.	ACHIEVED The results of the Victorian Healthcare Experience Survey have been reviewed and shared with the Board, Cultural Diversity and Consumer Committee and staff. An action plan for improvement has been developed and is being monitored.
	Develop a whole of hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint.	Benalla Health will review its seclusion policy and ensure that the updated policy is available for all staff on SharePoint.	ACHIEVED Seclusion policy reviewed and available for all staff.

DOMAIN	ACTIONS	DELIVERABLES	OUTCOMES
Access and Timeliness		Benalla Health is working towards the implementation of an electronic referral and data management service through the Patient Administration System.	PARTIALLY ACHIEVED Awaiting finalisation of the Patient Administration System replacement project. Community Health staff are currently using Connecting Care for electronic referrals.
	Ensure the development and implementation of a plan in specialist clinics to: (1) optimise referral management processes and improve patient flow through to ensure patients are seen in turn and within time; and (2) ensure patient data is recorded in a timely, accurate manner and is working towards meeting the requirements of the Victorian Integrated Non-Admitted Health dataset.	The addition of an outpatient module in the Patient Administration System will ensure referrals are accurately tracked and recorded and will allow for the electronic collection of data items that will meet the requirements of the Victorian Integrated Non-Admitted Health data set.	PARTIALLY ACHIEVED Awaiting finalisation of the Patient Administration System replacement project.
		In preparation for this, data will in the initial stages be collected and collated in a database that mirrors the requirements of Victorian Integrated Non-Admitted Health. This will allow for patient level and aggregate data to be reported to the Department of Health and Human Services.	ACHIEVED Awaiting finalisation of the Patient Administration System project.
	Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine).	Discharge Planning practices from the acute sector will be reviewed to ensure timely referrals into the; • Health Independence Program; • High Risk Foot Clinic and • Community Health Key Workers.	ACHIEVED This project has nearly been completed and will be fully implemented after the organisation wide Accreditation survey in July 2017.

DOMAIN	ACTIONS	DELIVERABLES	OUTCOMES
Access and Timeliness	Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine).	Benalla Health will continue to access specialists via telemedicine to support the; • Health Independence Program and • High Risk Foot Clinic.	PARTIALLY ACHIEVED Further work required to establish telemedicine processes to support patients when they are transferred to Benalla Health.
		Benalla Health will continue to progress the establishment of telemedicine links into the Kerferd Mental Health triage team based at Northeast Health Wangaratta.	NOT ACHIEVED Benalla Health will actively ensure that communication channels remain open so that this initiative can progress in a timely manner in 2017/18.
	Develop and implement a strategy to ensure the preparedness of the organisation for the National Disability and Insurance Scheme and Home and Community Care program transition and reform, with particular consideration to service access, service expectations, workforce and financial management.	Benalla Health will continue to pre-plan and develop a business case for the provision of allied health services to the National Disability Insurance Scheme.	ACHIEVED Benalla Health is now registered with the National Disability Insurance Agency. An Action Plan has been developed to support clients once the National Disability Insurance Scheme commences on the 31st October 2017.
		Benalla Health will participate in relevant pre planning meetings and regional forums to progress the District Nursing Collaborative model and the Home and Community Care Governance Model.	ACHIEVED The sector has been advised that the current Home and Community Care funding arrangements will be maintained until 30th June 2020.
		Benalla Health will continue to work with My Aged Care to ensure that all services are appropriately listed and timely referrals made and acknowledged.	ACHIEVED Ongoing work is required in 2017/18 to ensure that the My Aged Care portal is responsive.

DOMAIN	ACTIONS	DELIVERABLES	OUTCOMES
Supporting Healthy Populations	Support shared population health and wellbeing planning at a local level aligning with the Local Government Municipal Public Health and Wellbeing plan and working with other local agencies and Primary Health Networks.	Benalla Health will continue to work in partnership with the Central Hume Primary Care Partnership, Benalla Rural City and Murray Primary Health Network to embed local Health Promotion objectives into the Benalla Rural City Municipal Public Health and Wellbeing Plan inclusive of; • Healthy Eating • Family Violence Prevention and Suicide Prevention.	ACHIEVED Ongoing work will continue in 2017/18.
	Focus on primary prevention, including Suicide Prevention activities, and aim to impact on large numbers of people in the places where they spend their time adopting a place based, whole of population approach to tackle the multiple risk factors of poor health.	Benalla Health will continue to focus on Suicide Prevention strategies through; • Involvement in the Connect Benalla project; • Involvement in the Benalla Mental Health Communication Working Group; • Targeting Community Education; • Marketing and Messaging; • Further developing the partnership with Albury Wodonga Health Mental Health services • Strengthening the partnership with local General Practitioner Clinics around Youth access to services.	ACHIEVED Work is continuing to further develop the partnership with Albury Wodonga Health Mental Health services and strengthen the partnership with local General Practitioner Clinics around youth access to services.
	Develop and implement strategies that encourage cultural diversity such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.	Benalla Health will continue to strengthen the partnership with the Central Hume Primary Care Partnership Aboriginal Community Development worker through regular attendance at relevant forums.	ACHIEVED Ongoing work continuing in 2017/18.

DOMAIN	ACTIONS	DELIVERABLES	OUTCOMES
Supporting Healthy Populations	Develop and implement strategies that encourage cultural diversity such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.	Benalla Health will continue to strengthen the REACH program to partner with disadvantaged community groups.	ACHIEVED Ongoing work continuing in 2017/18.
		Benalla Health will continue to strengthen the use of the Key Worker model in Community Health.	ACHIEVED Ongoing work continuing in 2017/18.
	Improve the health outcomes of Aboriginal and Torres Strait Islander people by establishing culturally safe practices which recognise and respect their cultural identities and safely meets their needs, expectations and rights.	Benalla Health will continue to strengthen the partnership with the Central Hume Primary Care Partnership Aboriginal Community Development worker. Benalla Health will continue culturally safe training of staff through Regional Health Service eLearning Network and implement the 'Ask the Question' training to front of house staff.	ACHIEVED Ongoing work continuing in 2017/18.
	Drive improvements to Victoria's mental health system through focus and engagement in activity delivering on the 10 Year Plan for Mental Health and active input into consultations on the Design, Service and infrastructure Plan for Victoria's Clinical mental health system.	Benalla Health will continue to strengthen the partnership with Albury Wodonga Health Mental Health services.	ACHIEVED Benalla Health has regular contact with the Albury Wodonga Health Director of Mental Health Services. An annual report is provided to the Board.
		Benalla Health will complete the project to establish telemedicine links into the Kerferd Mental Health triage team based at Northeast Health Wangaratta.	NOT ACHIEVED Benalla Health will actively ensure that communication channels remain open so that this initiative can progress in a timely manner.

DOMAIN	ACTIONS	DELIVERABLES	OUTCOMES
Supporting Healthy Populations	Using the Government's Rainbow eQuality Guide, identify and adopt actions for inclusive practices and be more responsive to the health and wellbeing of lesbian, gay, bisexual, transgender and intersex individuals and communities.	Benalla Health in partnership with the Cultural Diversity Consumer Committee will review and consider the Rainbow eQuality guide to determine areas of improvement.	ACHIEVED The Rainbow eQuality guide has been reviewed by the Cultural Diversity and Consumer Committee. It is a standing agenda item at this meeting. An Action Plan has been developed and approved. This committee will monitor the implementation of the Action Plan.
Governance and Leadership	Demonstrate implementation of the Victorian Clinical Governance Policy Framework: Governance for the provision of safe, quality healthcare at each level of the organisation, with clearly documented and understood roles and responsibilities. Ensure effective integrated systems, processes and leadership are in place to support the provision of safe, quality, accountable and person centred healthcare. It is an expectation that health services implement to best meet their employees' and community's needs, and that clinical governance arrangements undergo frequent and formal review, evaluation and amendment to drive continuous improvement.	Benalla Health will review its current Clinical Governance Framework to ensure that it aligns with the Victorian Clinical Governance Policy Framework.	ACHIEVED The Clinical Governance Framework has been reviewed and it is aligned with the Victorian Clinical Governance Policy Framework.
	Contribute to the development and implementation of Local Region Action Plans under the series of statewide design, service and infrastructure plans being progressively released from 2016/17. Development of Local Region Action Plans will require partnerships and active collaboration across regions to ensure plans meet both regional and local service needs, as articulated in the statewide design, service and infrastructure plans.	Benalla Health will actively contribute to the development and implementation of Local Region Action Plans when they are released through attendance at relevant forums and meetings.	ACHIEVED Relevant meetings with GV Health and Albury Wodonga Health attended.

DOMAIN	ACTIONS	DELIVERABLES	OUTCOMES
Governance and Leadership	Ensure that an anti-bullying and harassment policy exists and includes the identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal and the policy specifies a regular review schedule.	Benalla Health will review its current workplace bullying policy to ensure it includes the identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal.	ACHIEVED Bullying policy reviewed. A new employee guideline document was developed in May 2017 and it is available for all staff to access via the intranet or in hard copy.
	Board and Senior Management ensure that an organisational wide Occupational Health and Safety risk management approach is in place which includes: (1) A focus on prevention and the strategies used to manage risks, including the regular review of these controls; (2) Strategies to improve reporting of occupational health and safety incidents, risks and controls, with a particular focus on prevention of occupational violence and bullying and harassment, throughout all levels of the organisation, including to the board; and (3) Mechanisms for consulting with, debriefing and communicating with all staff regarding outcomes of investigations and controls following occupational violence and bullying and harassment incidents.	Benalla Health will continue to support its current multidisciplinary committee structure where the Chief Executive Officer chairs the monthly Occupational Health and Safety committee which reports up to the Board's Quality and Safety subcommittee. Standard agenda items are inclusive of; accidents and incidents, hazard register, security, quality and risk, legislative compliance, mandatory training and policy/procedure review. Minutes of meetings are available to all staff via the Meeting Workspace portal.	ACHIEVED Monthly meeting agendas and minutes available on Sharepoint for all staff. Minutes sent monthly to the Board's Quality and Safety subcommittee.
		Benalla Health will establish a Workplace Implementation Committee to implement the following Enterprise Bargaining Agreements; • Nurses and Midwives • Health Professionals, Health and Allied Services, Managers and Administrative Officers.	ACHIEVED Regular Workplace Implementation Committee meetings convened with all issues well managed.

DOMAIN	ACTIONS	DELIVERABLES	OUTCOMES
Governance and Leadership	Implement and monitor workforce plans that: • Improve industrial relations; • Promote a learning culture; • Align with the Best Practice Clinical Learning Environment Framework; • Promote effective succession planning; • Increase employment opportunities for Aboriginal and Torres Strait Islander people; • Ensure the workforce is appropriately qualified and skilled, and • Support the delivery of high-quality and safe person centred care.	A dedicated simulation laboratory training component will be integrated into Benalla Health's educational calendar.	ACHIEVED A dedicated simulation laboratory training component has been integrated into Benalla Health's educational calendar.
		Benalla Health will continue to comply with the Best Practice Clinical Learning Environment Framework reporting requirements. Common indicators will be benchmarked with Northeast Health Wangaratta and Mansfield District Hospital.	ACHIEVED Benalla Health is compliant with the Best Practice Clinical Learning Environment Framework reporting requirements.
		The current workforce plan, specific to succession planning, will be reviewed and updated.	ACHIEVED The reviewed workforce plan was endorsed by the Board.
		Benalla Health will continue to work with the Regional Human Resource Forum to align recruitment and retention strategies.	ACHIEVED The Hume Health Careers Facebook page has been developed and is operational.
		A specific Aboriginal employment plan will be developed along with implementation of an annual Aboriginal and Torres Strait Islander school based traineeship.	PARTIALLY ACHIEVED The Aboriginal employment plan requires more work. Improved data collection is occurring regarding employees who may choose to identify as ATSI.
		The e-credentialing software for Nursing and Allied Health will be implemented.	PARTIALLY ACHIEVED Researching the feasibility of this initiative has commenced. Implementation is progressing slowly.

DOMAIN	ACTIONS	DELIVERABLES	OUTCOMES
		Benalla Health will consider implementing the Australian Health Practitioner Regulation Agency practitioner registration alerts capability system.	PARTIALLY ACHIEVED Benalla Health is currently considering the benefits and associated costs of implementing the Australian Health Practitioner Regulation Agency practitioner registration alerts capability system.
		Benalla Health will implement AIDET (Acknowledge, Introduce, Duration, Explanation, and Thank You) as the customer service training tool to support person centred care.	ACHIEVED Implementation of AIDET has progressed well. Validation will occur towards the end of 2017.
Governance and Leadership	Create a workforce culture that: (1) includes staff in decision making; (2) promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and (3) includes consumers and the community.	Benalla Health will continue to support monthly leadership meetings and accountability meetings between managers and their direct reports.	ACHIEVED All meetings occurring.
		All staff will sign the Code of Conduct.	ACHIEVED Organisation wide compliance is at 100%.
		Regular staff forums will be held to share information and obtain feedback from staff.	ACHIEVED Regular staff forums held with feedback received and noted.
		Benalla Health will finalise the new Consumer Engagement Strategy 2016-2020.	ACHIEVED The new Consumer Engagement Strategy 2016 - 2020 has been aligned with the Strategic Plan 2016 – 2020. The Cultural Diversity and Consumer committee endorsed the new plan at their February 2017 meeting. The Board approved the plan at their March 2017 meeting.

DOMAIN	ACTIONS	DELIVERABLES	OUTCOMES
		Benalla Health will continue to provide Senior Leadership and Board support to the Cultural Diversity Consumer Committee.	ACHIEVED Committee meeting regularly with formal agendas and minutes.
Governance and Leadership	Ensure that the Victorian Child Safe Standards are embedded in everyday thinking and practice to better protect children from abuse, which includes the implementation of: strategies to embed an organisational culture of child safety; a child safe policy or statement of commitment to child safety; a code of conduct that establishes clear expectations for appropriate behaviour with children; screening, supervision, training and other human resources practices that reduce the risk of child abuse; processes for responding to and reporting suspected abuse of children; strategies to identify and reduce or remove the risk of abuse and strategies to promote the participation and empowerment of children.	Benalla Health will review its current Child Safe policy and Reporting of Child at Risk procedure to ensure both documents comply with its obligations under the Children, Youth and Families Act (2005) and the Crimes Amendment (Grooming) Act (2014), including; • Part 3.3 Community Services and • Part 4.4 Reporting	ACHIEVED Child Safe policy and Reporting of Child at Risk procedure reviewed. It complies with the Children, Youth and Families Act (2005) and the Crimes Amendment (Grooming) Act (2014), including; • Part 3.3 Community Services and • Part 4.4 Reporting
	Implement policies and procedures to ensure patient facing staff have access to vaccination programs and are appropriately vaccinated and/or immunised to protect staff and prevent the transmission of infection to susceptible patients or people in their care.	Benalla Health will continue to support its current Staff Health program to ensure that staffs receive appropriate vaccinations/ immunisations to protect them and the patients they care for.	ACHIEVED Many staff vaccinated - 81% coverage.

DOMAIN	ACTIONS	DELIVERABLES	OUTCOMES
Financial Sustainability	Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	Benalla Health will utilise the major refurbishment funding received in May 2016 to refurbish rooms in the Morrie Evans Wing bringing them to a standard that meets expectations of consumers, therefore increasing revenue.	ACHIEVED Refurbishment works successfully completed 12th May 2017. Full occupancy achieved 31st May 2017.
		Benalla Health will fully participate in Hume region procurement strategies to ensure that the organisation promotes fair and open competition so that appropriate goods and services are received at the best possible price.	ACHIEVED The Chief Procurement Officer has worked with other Health Services to develop and complete the Procurement Activity Plan for 2017-2018.
		Benalla Health will pursue further funding for Morrie Evans Wing to strengthen the competitive position of the facility.	ACHIEVED RHIF round 1 submissions were successful and funding received to complete stages 2 and 3 for the Morrie Evans Wing. This major capital works program will commence towards the end of 2017.
	Actively contribute to the implementation of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measureable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling.	Benalla Health will continue to support the current Waste Minimisation, Recycling and Energy committee which manages and reports on environmental impacts, waste, reduction of sharps, water and energy use and recycling performance.	ACHIEVED The Waste Committee continues to meet each quarter. Implementation of the stage 2 solar panels project has resulted in a significant reduction in electricity usage. At the 30th April 2017 Benalla Health recorded a 14% decrease in usage from the prior year period.

Key Financial and Service Performance Reporting

Part B: Performance Priorities

Safety and quality performance

Key Performance Indicator	2016-2017 Target	2016-2017 Actual
Compliance with NSQHS Standards accreditation	Full compliance	Full compliance
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Full compliance
Cleaning Standards	Full compliance	Full compliance
Compliance with the Hand Hygiene Australia program	80%	89%
Percentage of healthcare workers immunized for influenza	75%	89.1%
Submission of Data to VICNISS (1)	Full compliance	Full compliance
Patient experience and outcomes		
Victorian Hospital Experience Survey – data submission	Full compliance	Full compliance
Victorian Hospital Experience Survey – patient experience Quarter 1	95%	96.5%
Victorian Hospital Experience Survey – patient experience Quarter 2	95%	97.5%
Victorian Hospital Experience Survey – patient experience Quarter 3	95%	99.1%
Maternity - Percentage of women with prearranged postnatal home care (2))	100%	100%
Governance, leadership and culture		
People Matter Survey – percentage of staff with a positive response to safety culture questions	80%	87%

Financial sustainability performance

Key Performance Indicator	2016-2017 Target	2016-2017 Actual
Finance		
Annual operating result ($m)	0.14	0.73
Trade Creditors	<60 days	53
Patient Fee Debtors	<60 days	40
Public & Private WIES(3) performance to target	2,575	101.6%
Asset management		
Basic asset management plan	Full compliance	Full compliance
Adjusted current asset ratio	0.70	2.38
Days of available cash	14.0	171.2

(1) VICNISS is the Victorian Hospital Acquired Infection Surveillance system
(2) Perinatal Service Performance Indicator (PSPI) reports should be consulted for a description on the utility and business rules for these indicators. Note that data for 2016 and 2017 is provisional .
(3) The Victorian Health Experience Measurement Instrument (VHEMI) will succeed the VPSM as the instrument for measuring patient experience.

Key Financial and Service Performance Reporting

Part C - Activity and Funding

Funding Type	2016-2017 Activity Achievement
Acute Admitted	
WIES Public	2,121
WIES Private	495
WIES (Public and Private)	2,616
WIES DVA	148
WIES TAC	14
WIES TOTAL	2,778
Subacute & Non-acute Admitted	
WIES Maintenance Public	44
Subacute Non-Admitted	
Health Independence Program Contacts	6,056
Aged Care	
Residential Aged Care Days	9,129
HACC (under 65 years) hours	3,430
Primary Health	
Community Health / Primary Care Programs hours	9,157

Statutory Reporting

FREEDOM OF INFORMATION

Benalla Health is an agency subject to the Freedom of Information (Victoria) Act 1982. The Chief Executive Officer is the nominated Freedom of Information Officer. Persons wishing to access their information should complete the FOI Request form (available from the Benalla Health Website or at the Hospital Reception Desk).

During 2016/2017, 31 Freedom of Information requests were processed.

PROTECTED DISCLOSURE

Benalla Health is an agency subject to the Protected Disclosure Act 2012. The Protected Disclosure Act 2012 enables people to make disclosures about improper conduct within the public sector without fear of reprisal.

The Act aims to ensure openness and accountability by encouraging people to make disclosures and protecting them when they do.

Policies and guidelines are in place to protect people against action that might be taken against them if they choose to make a protected disclosure.

There were no disclosures in 2016/2017.

CARERS RECOGNITION ACT

Benalla Health is an agency subject to the Carers Recognition Act 2012. The Carers Recognition Act 2012 formally recognises and values the role of carers and the importance of care relationships in the Victorian community.

The Act includes a set of principles about the significance of care relationships, and specifies obligations for State Government agencies, Local Councils, and other organisations that interact with people in care relationships.

Benalla Health has;

- taken all practicable measures to comply with its obligations under the Act;
- promoted the principles of the Act to people in care relationships receiving our services and also to the broader community and
- reviewed our staff employment polices to include flexible working arrangements and leave provision ensuring compliance with the statement of principles in the Act.

There were no disclosures in 2016/2017.

OVERSEAS TRAVEL

No overseas trips were taken during 2016/2017.

VICTORIAN INDUSTRY PARTICIPATION POLICY ACT 2003

Benalla Health complied with the regulations within the Victorian Industry Participation Policy Act 2003 for the year 2016/2017.

No contracts were commenced and/or completed in the financial year to which the VIPP applied.

BUILDING MAINTENANCE

Benalla Health complies with the provisions of the Building Act 1993 which encompasses the Building Code of Australia and Standards for Publicly Owned Buildings November 1994.

SAFE PATIENT CARE ACT 2015

Benalla Health was not required to make any disclosures in relation to nurse to patient ratios during the reporting period under the Safe Patient Care Act 2015.

COMPETITIVE NEUTRALITY

It is Government policy that the costing policies of publicly funded organisations should reflect any competitive advantage available to the private sector. Benalla Health complies with the National Competitive Neutrality Policy Victoria.

STATEMENT OF FEES AND CHARGING RATES

Benalla Health charges fees in accordance with the Victorian Department of Health and Human Services directives issued under Regulation 8 of the Hospital and Charities (Fees) Regulations 1986, as amended.

EMPLOYMENT AND CONDUCT PRINCIPLES

Benalla Health is committed to the application of the employment and conduct principles and all employees have been correctly classified in workforce data collections. Benalla Health also ensures a fair and transparent process for recruitment, selection, transfer and promotion of staff. It bases its employment selection on merit, and complies with the relevant legislation. Policies and Procedures are in place to ensure staff are treated fairly, respected and provided with avenues for grievance and complaint processes.

PRIVACY

Benalla Health is committed to the protection of privacy of information for all patients, residents, clients and staff.

- Management of Violence and Aggression International Training (MOVAIT) has been scheduled to ensure all senior clinical staff has the ability to take a leading role in a Code Grey situation, followed by any front line staff. A total of six sessions, facilitated by trainers from Northeast Health Wangaratta, focused on effective communication and de-escalation.

PUBLICATIONS

The following publications dealing with the functions, powers, duties and activities of the Health Service were produced in 2016/2017. Electronic copies of the documents are available via Benalla Health's website and printed copies are held in the Executive Office:

- Benalla Health Annual Report
- Quality of Care Report
- Clinical Services Plan

ADDITIONAL INFORMATION

In compliance with FRD 22H (Section 6.19) the information detailed in this report is available on request by relevant Ministers, Members of Parliament and the public (subject to the Freedom of Information requirement if applicable).

Occupational Health and Safety

The objective of Health and Safety is prevention and active response. This is achieved by supportive and ongoing consultation between management, the Workplace Health and Safety Committee, employees, volunteers, students, Visiting Medical Officers, contractors and consumers. We aim to continuously review our practices, look for improvements and evaluate our systems on a regular basis, to ensure excellence in safety management.

CONSULTATION AND COMMUNICATION

- Health and Safety Newsletters are distributed quarterly promoting safety prevention, access to resources and information to all staff.
- Newsletter themes for 2017: promotion of Staff training opportunities, office ergonomics, White Ribbon Campaign, Safety in Summer Heat, Sun Smart, Health and Wellbeing Achievements Program.
- Benalla Health reinforced its commitment to ceasing family violence with the release of the 'say no to family violence' brochure for staff and clients. A Family Violence Policy, Family Violence Procedure and Family Violence Leave procedure were developed and endorsed.

OCCUPATIONAL VIOLENCE AND AGGRESSION

- Development of a 10 point plan.
- Management of Violence and Aggression International Training (MOVAIT) scheduled to commence July 2017 to ensure all front line staff have the ability to take a leading role in effective communication and de-escalation.

STAFF HEALTH AND WELLBEING PLAN

- The Staff Health and Wellbeing Program promotes a holistic approach to staff health and wellbeing.
- Staff Health and Wellbeing information is now available through the staff intranet. This is a central access point for information and resources around Mindfulness, Peer Support, Employment Assistance Program, Corporate Gym membership and the Quit smoking program.
- Benalla Health is actively working towards recognition through the 'Achievement's Program.'
- A staff survey was completed in June 2017 to obtaining feedback from staff on wellbeing issues.
- In 2017 a 'Health and Wellbeing committee has been established to work towards accomplishing the Achievements program.

INCIDENTS REPORTED TO WORKSAFE

- One Needle-stick injury
- Potential carbon monoxide exposure

EQUIPMENT INTRODUCED TO MINIMISE MANUAL HANDLING RISKS

- **Housekeeping:** Linen Provider (Princes Laundry Services) was notified not to deliver linen with 4 swivel wheel trolleys.
- **Housekeeping:** The Medical Imaging Department identified high dust clean as a manual handling risk. Task was reengineered.
- **Supply Department:** A new motorized trolley was purchased to eliminate manual handling tasks.
- **District Nursing** presented on dealing with difficult client behaviours.
- **Theatre:** The purchase of a new endoscope monitor with adjustable arm, has improving manual handling and twisting.
- **Urgent Care:** Heavy doors removed from resus room and replaced with curtain.
- **Urgent Care:** Replaced old bed with electronic remote bed to lift patient into sitting position.
- **Morrie Evans Wing:** Replaced old bed with new as a result of intermittent electrical faults.
- **Theatre:** Installation of a sink for cleaning of endoscopes to reduce manual handling risks.
- **Catering:** Introduced smaller storage containers to reduce manual handling risks.
- **Supply:** Office renovations have removed trip hazards and improved ergonomics.
- **Staff Dining Room**: microwave heights lowered.

INVESTIGATIONS

Acute needle stick injury, Pathology chemical injury, Theatre mowing contractor near miss, staff accommodation, potential carbon monoxide exposure.

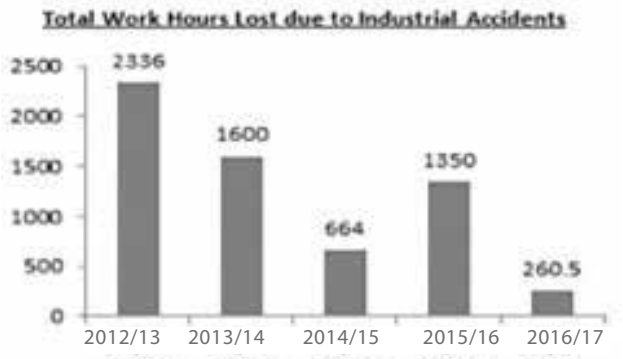
INJURY MANAGEMENT INITIATIVES

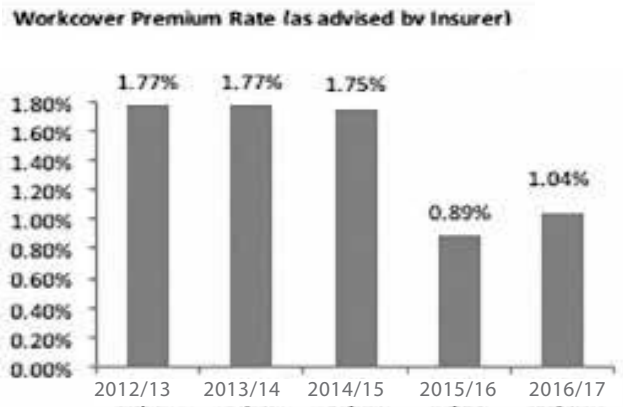
The Injury management / Fit for Work program assists employees return to work with a plan, after extended leave or after sustaining a non-work related injuries or illnesses. The plan aims to reduce any risk of aggravation. The 'Fit for Work' program is a supportive process identifying individual flexibility arrangements and communication to ensure staff are fully fit to perform their duties.

Workforce Information

INDUSTRIAL RELATIONS ACTIVITY

There has been nil time lost due to Industrial disputes.





Current Full Time Equivalent and other payroll information to the Department under the

Minimum Employee Data Set (MEDS)

Labor Category	JUNE Current Month FTE		JUNE YTD FTE	
	2016	2017	2016	2017
Nursing	102.74	103.46	97.97	100.60
Administration & Clerical	33.80	36.92	33.93	36.35
Medical Support	6.26	5.40	6.31	5.64
Hotel & Allied Services	44.44	44.77	43.74	44.83
Medical Officers	0.0	0.28	0.0	0.22
Sessional Clinicians	0.0	0.0	0.0	0.0
Ancillary Staff (Allied Health)	14.93	17.59	14.70	15.70
Total	202.38	208.42	196.73	203.34

DEFINITIONS

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

Occupational Violence: Any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment.

Incident: Occupational health and safety incidents reported in the health service incident reporting system. Code Grey reporting is not included.

Accepted Workcover Claims: Accepted Workcover claims that were lodged in 2016-17.

Lost Time: Is defined as greater than one day.

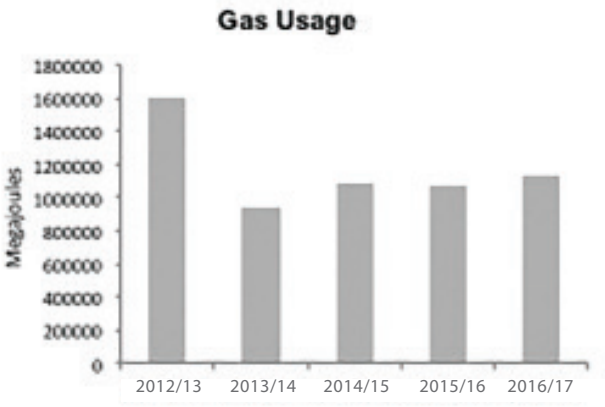
Occupational Violence Statistics	2016-2017
1. Workcover accepted claims with an occupational violence cause per 100 FTE.	0
2. Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	0
3. Number of occupational violence incidents reported.	22
4. Number of occupational violence incidents reported per 100 FTE.	10.87
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition.	0

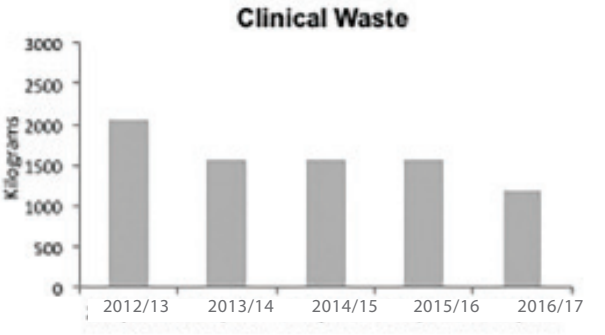
Environment

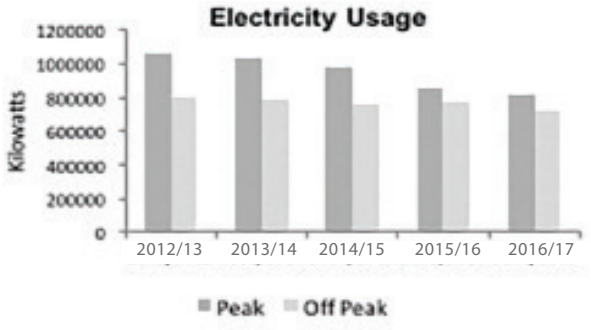
Benalla Health is committed to protecting the environment. When developing changes or making improvements, consideration is always given to conserving energy and water, reducing greenhouse emissions and improving waste management.

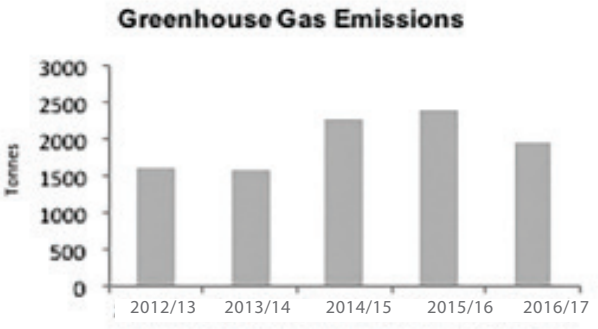
The graphs indicate that the Organisation's energy consumption has remained stable, despite the variations in climatic conditions. The greenhouse gas emissions are higher compared with previous years, but this is due to Benalla Health's Energy supplier altering the conversion factor from 0.8 to 1.34.

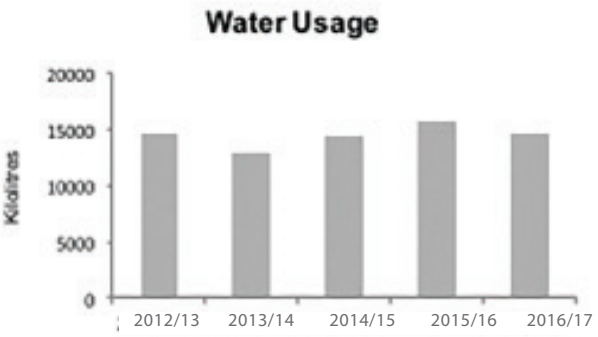
With continual segregation, further reductions in Kitchen and Clinical Waste has been achieved. As a consequence with an increase in General Waste providing cost efficiencies as General Waste removal charges are far less costly.











Benalla Health continues to monitor outcomes, ensuring best practice design for building and renovations, capturing natural light and sun's energy where ever possible.

Benalla Health continues to plan for the capture of roof water using Underground Water Storage and Artificial Grass wherever possible.

METHOD: An open cut rectangular section of ground measuring about 1.5 metres deep has been excavated and a heavy duty liner placed within 1 metre x 1 metre square crates (similar to milk crates). Each metre by metre cube holds 1,000 litres of water which only takes up a relatively shallow and small area. The crates are then covered with 200mm of crushed rock with the rock then being covered with artificial grass suitable for vehicular traffic.

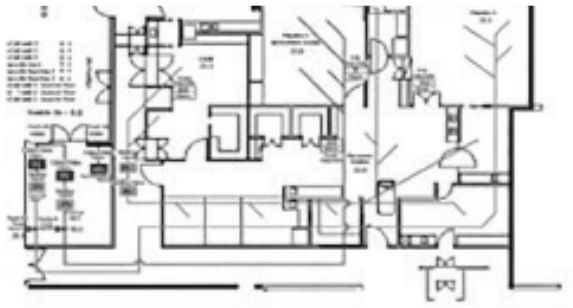
Underground Water Storage & Artificial Grass

Considerable financial gains have been made from the Conversion of Fluorescent Lighting and Downlights to LED's

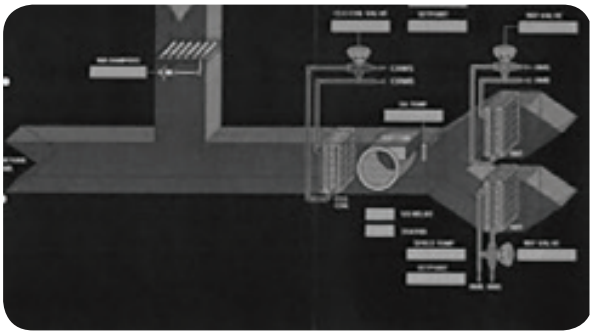
95% of all lighting has now been converted to LED's.
An asset management system is currently being developed, complimenting our existing system.

LED Lighting

Computerised Building Management System



Computerised Building Management System



Computerised Building Management System

Efficient Solar Electricity System with the doubling up of our existing solar panels, now saving approximately 14% of our total electricity bill.

Solar Upgrade

Reverse Osmosis Water Purification System

At our recent Accreditation review we were commended on being leaders on Reverse Osmosis Water Filtering Systems for Theatres, providing purified water for our Washer Disinfector and Utensil Sanitizer.

Water Purification System

Services

Hospital Services

- Acute Inpatient Services
- Residential Aged Care Facility
- Antenatal Clinic
- Breast Feeding Support Service
- Day Stay
- Domiciliary
- Education and Research Unit
- Infection Control
- Midwifery Service
- Health Information
- Pharmacy
- Operating Theatre
- Urgent Care Centre

Community Health Services

Diabetes Care Centre and Allied Health

- Dietetics
- Diabetes Education
- High Risk Foot Clinic
- Occupational Therapy (Benalla & Mansfield)
- Physiotherapy
- Podiatry
- Social Work/Counselling
- Speech Pathology

Home Nursing Service

- District Nursing Service
- Hospital in the Home
- Palliative Care (Benalla & Mansfield)

Health Promotion

- Healthy Eating
- Mental Health and Wellbeing

Other Services

- Early Intervention in Chronic Disease
- Day Activities Program
- Hydrotherapy Health Independence Programs
- Hospital Admission Risk Program

Health Independence Programs

- Hospital Admission Risk Program
- Sub-Acute Care
- Post Acute Care
- Rehabilitation Groups

Nursing

- Community Health Nursing

Support Groups

- Carer's
- Parkinson's Disease
- Arthritis

Ray Sweeney Centre

Benalla Rural City

- Family Day Care
- Aged and Disability Services
- Maternal and Child Health Services

Co-located Services

- Centre Against Violence
- Central Hume Dental Service
- Community Interlink
- Financial Counselling
- Dental Technician
- Drug and Alcohol Service
- Goulburn Valley Community Legal Service
- Hume Riverina Community Legal Service

Other Services

- Central Hume Primary Care Partnership
- Visiting Medical Officers
- Pathology
- Psychology Services
- Audiologist
- CT Scan
- Ultrasound
- X-ray

Diabetes Care Centre Team

Hospital Auxiliary

On behalf of the Auxiliary, it gives me considerable pleasure to present the 2016-2017 Annual Report which has been a satisfying and very successful year.

The Auxiliary has been very busy throughout the year attending monthly Lakeside markets, a Day in the Gardens and barbeques at Woolworths. Again we were invited to have a craft stall at the Heavy Horse Driving Group function. Our raffles have been extremely well supported by the Benalla and surrounding communities. We sincerely thank all the local businesses for their contributions and backing throughout the year. Without their assistance, our fund-raising would not be so successful.

Barbara Ramage and Cheryl Taylor of Violet Town opened their gardens for the Auxiliary. One a country garden, the other a town garden, and with Devonshire tea provided, it was a great day out. Thank you ladies.

A wreath was laid by the Auxiliary at both ANZAC and Remembrance Day ceremonies.

Our member numbers have dropped but the workload continues. We have lost members through death, leaving the district and age catching up. Fortunately our new members are prepared to step up.

A sincere thank you to Chief Executive Officer, Janine Holland, for attending our meetings, the support of the office staff, and also to the catering staff for the tasty afternoon teas provided for our meetings.

I also want to thank the Auxiliary members for their loyalty and hard work during my time as President.

Ann Sloan
President

BENALLA & DISTRICT MEMORIAL
HOSPITAL AUXILIARY
Receipts and Expenditure 1/7/2016 - 30/6/2017

BENDIGO CLUB CHEQUE ACCOUNT

Balance as at 1 July 2016	$2,845.06

RECEIPTS

Catering	$929.70
Christmas raffle	$5,008.25
CWA - craft stall	$153.00
Day in the Gardens - Craft and Jams	$576.00
Day in the Gardens - Plants	$1,142.85
Donations	$2,942.25
Heavy Horses - craft stall	$158.00
Lakeside Market - Craft and Jams	$2,346.00
Lakeside Market - Plants	$4,954.00
Meeting Raffle	$212.00
Open Gardens	$826.90
Recipe books	$885.00
Rug raffle [1]	$1,429.45
Rug raffle [2]	$1,156.05
Total Receipts	$22,719.45

EXPENDITURE

Audit	$451.00
Benalla Health - Urgent Care	$6,530.75
Catering	$283.00
Gifts	$120.00
Market fee	$50.00
Transfer to Investment Account	$14,500.00
Wreaths	$100.00
Total Expenditure	$22,034.75
Net Income	$684.70
Balance as at 30 June 2017	$3,529.76

BENDIGO INVESTMENT ACCOUNT

Balance as at 1 July 2016	$28,616.01
Interest	$539.80
Transfer from Cheque Account	$14,500.00
Balance as at 30 June 2017	$43,655.81

TOTAL HOLDINGS AS AT 30 JUNE 2017	$47,185.57

Senior Staff (as at 30/6/2017)

Chief Executive Officer

Ms. J. Holland R.N. R.M. B.HSc, Grad Cert HSM, MPH, ACHSM, GAICD

ACUTE AND AGED CARE

Director of Clinical Services
Mrs. M. Woodhouse R.N. R.M. B.N., GCAdvNurs, GradDipMid, DIP MGT, MHA, ACHSM, MAICD

Deputy Director of Clinical Services
Ms. Lisa Waite R.N. R.M. B.N.

Assistant Directors of Nursing
Mrs. J. Caramia R.N.
Mrs. L. Ford R.N.
Ms. C. Smith B.N., M.N., Critical Care.
Ms. H. Plummer R.N., Critical Care
Mrs. A. Thomas R.N.
Mr. S. Braithwaite R.N., Dip Bus, Dip Paramed, Dip TAE, Grad. Cert. Gerontics
Mrs. M. Parker R.N.
Mrs. R. Maffescioni R.N.

Nurse Unit Manager - Urgent Care Centre
Mrs. M Reid R.N.

Nurse Unit Manager - Acute Ward / Midwifery Services
Ms. K. Woosnam R.N. R.M. (Grad. Dip. Midwifery) Grad Dip Adv Nursing Critical Care, Grad Cert Aviation Nursing

Midwifery Co-Ordinator
Mrs. K. Barrow B.N. GradDipMid.

Nurse Unit Manager – Theatre/CSSD/ Day Procedure Unit
Mrs. K. Cheetham R.N.

Nurse Unit Manager - Morrie Evans Wing
Mr. N. Willoughby R.N. B.N.

Manager Education & Research/RHAN Co-Ordinator
Dr. S. Wilson, R.N., Paed Cert, Grad. Dip. Psych Nsg., BA, BSc, Grad. Dip. Ed., MEd, PhD

Infection Prevention and Control Co-ordinator
Ms. L. Carrington R.N, BAppSc(Ng), GradDip CritCareNurs, MPH (Communicable Disease Control)

Pharmacist
Ms. A. Lawrence B Pharm, Grad Dip Bus (IR), MBA, ASA, MPS

COMMUNITY HEALTH SERVICE

Director of Community Health
Mr. N. Stott B.A. (Chr Min) Monash; Dip. Bus. (Gov) FICDA; Grad Cert Bus

Nurse Unit Manager -Home Nursing Service
Ms. L. Eddy R.N. R.M, Dip App Sci, (Nursing), B.Nurs. Grad Dip CHN

Physiotherapy & Occupational Therapy Team Leader
Mr. G. Draper B.App.Sc (Physio)

Allied Health Team Leader
Mrs. S. Matheson B.Sp, M.S.P. A.A, C.P.S. P.

Social Work/Counselling Team Leader
Ms. L. Bowers Accredited Mental Health Social Worker

Administration Team Leader
Mrs. J. Fita

SUPPORT SERVICES

Director of Finance & Corporate Services
Mr. A. Nitschke Bachelor of Business (Accounting), CPA, MBA, MAICD

Chief Engineer
Mr. R. Grubissa M.I.H.E.A.

Human Resources Manager
Mrs. L. Daldy B. Bus (Human Resources), M.A.H.R.I

Quality and Risk Manager
Ms. B. Butler-Mack MHA, Cert HSM, Cert SIC, R.N., B.N. (Hons)

Chief Health Information Manager
Ms. V. Young BAppSc. (Medical Records Admin)

Support Services Manager
Ms. K. Bennetts GCM (Graduate Certificate in Management Professional Practice)

IT Manager
Mr. P. Hurley B.IT

Administration Manager
Mrs. M. Burrowes Dip.Bus., Dip. Mgt.

Media Relations
Mrs. S. Beattie

Team Leader – Food Production
Miss. H. Richardson

Team Leader – Food Services / Hospitality
Mrs. P. Winzer

VISITING MEDICAL OFFICERS

Director of Medical Services

Dr. R. Lowen MBBS, DObRCOG, FRACGP, AFCHSM

Visiting General Practitioners

Dr. G. Brownstein MBBS, (Hons.) Dip. Obs. Dip. Anaes., R.A.C.O.G.. F.R.A.C.G.P, F.A.C.R.R.M.
Dr. B. Buckley MBBS, F.R.A.C.G.P.
Dr. F. Christophersen MBBS, F.R.A.C.G.P. J.C.A.A
Dr Sheng Chen MBBS, B Sci (Hons), Diploma in Child Health
Dr. K.L. Chua MBBS(Hons), B.MedSc
Dr. R. de Crespigny MBBS, Dip. Anaes., Dip. Obs., R.A.C.O.G., F.A.C.R.R.M.
Dr. N. Fahn MBBS, F.R.A.C.G.P. J.C.A.A
Dr. N. Flanigan MBBS, F.R.A.C.G.P.
Dr. S. Hancock MBBS/BMedSci, DRANZCOG, FRACGP.
Dr. B. Hollins MBBS, (Hons), F.R.A.C.G.P.
Dr. P. Kelly MBBS, Dip.Obs., R.A.C.O.G., F.R.A.CGP., F.A.C.R.R.M.
Dr. A. Knight MBBS, Dip. Anaes., Dip. Obs., RANZCOG
Dr. J. Lambert MBBS, F.R.A.C.G.P., DRANZCOG
Dr. C. Lourensz MBBS, BSc(Hons)
Dr. D. Martin. MBBS, F.R.A.C.G.P., DRANZCOG Adv.
Dr. P. Murray MBBS
Dr. G. O'Brien MBBS, D.R.A.C.O.G., F.A.C.R.R.M.
Dr. C.X. O'Kane MBBS, M.Bioethics
Dr. P. Radford MBBS (Hons), F.R.A.C.G.P., F.A.C.R.R.M.
Dr. U. Read MBBS, F.R.A.C.G.P.
Dr. D. Rodgers MBBS, Dip. Obs., RANZCOG, FRCRRM
Dr. P. Slot MBBS, F.R.A.C.G.P., D.R.A.C.O.G., F.A.C.R.R.M.
Dr. S. Tarrant MBBS
Dr. Hung Phu Tran MD in Vietnam, LMCC from Canada, ECFMG Certificate from America
Dr. M. Vesey MBBS., F.R.A.C.G.P.
Dr. S. Warfe MBBS, B.Med.Sci
Dr. B. Weatherhead MBBS, B.Med.Sci
Dr. Clare Wright MBBS, PGCert Clin Ed, EM Cert. (ACEM), DCH, FACRRM

Visiting General Surgeons

A/Prof F. Miller MBBS, PhD., F.R.A.C.S.

Mr. P. R. Thomas MBBS (Melb), FRCS Ed, FRACS
Mr. A. Cichowitz MBBS (Hons), BMedSci, PGDipSurgAnat, FRACS
Mr. A. MacLeod MBBS, FRACS, BSci

Visiting Obstetricians & Gynaecologists

Dr. L. Fogarty MBBS, FRANZCOG
Dr. J. Krones MBBS, FRANZCOG.
Dr. L. Bennett MBBS (Hons), FRANZCOG

Visiting Ophthalmologists

Dr. N. Karunaratne MBBS, MPH, MBA, MMed, FRANZCO.
Mr. S. Permezel MBBS, F.R.A.N.Z.C.O., F.R.A.C.S., F.R.C. Ophth(UK)
Mr. A. Atkins B. Med Sci., MBBS, F.R.A.N.Z.C.O
Mr. A. Van Heerden MBChB, F.R.A.N.Z.C.O.
Mr. P. Meagher MBBS, F.R.A.N.Z.C.O., F.R.A.C.S.

Visiting Oral & Maxillofacial Surgeon

Mr. W. Besly MDSc, FRACDS(OMS), FRACDS

Visiting Orthopaedic Surgeons

Mr. I. Critchley B.Sc., M.B.Ch.B., F.R.C.S.(Ed), F.R.A.C.S., F.A.Orth.A.
Dr. W. R. Seager MBBS, F.R.A.C.S. F.A.Orth.A.

Visiting Paediatrician

Mr. T. Stubberfield MBBS, Dip R.A.C.O.G., DCH (London), F.R.A.C.P.

Visiting Physicians

Dr. R. Krones M.D. F.R.A.C.P.

Visiting Urologists

Mr. J. Goad MBBS, F.R.A.C.S.
Mr. M. Forbes MBBS (HONS), F.R.A.C.S.

Visiting Radiologists - Broken River Imaging

Dr. S. Begg MBBS, FRANZCR
Dr. I. Karunarathna MBBS, FRANZCR
Dr. A. Lakkaraju FRANZCR, FRCR (UK), MBBS
Dr. G. Miller MBBS, FRANZCR
Dr. P. Neelapriyantha MBBS, MD, FRANZCR
Dr. P. Neerhut MBBS, FRANZCR
Dr. J. Wong FRANZCR, MBBS (Melb), MMED (Radiology)

Visiting Dentists

Dental - Northeast Health Wangaratta
Dr. E. Pegan BDSc (Melb. Uni)
Dr. J. Ong BHSc(Dent)/MDent
Dr. I. Pandher BHSc(Dent)/MDent
Dr. Cara Epstein BDS

Oral Health Therapists

Ms. V. Contreras BOH (LaTrobe Uni)
Mr. G. Holtkamp BOHSc
Ms. S. Razga BOH (LaTrobe Uni)

Benalla Visiting Dentists

Dr. S. Jones BDSc
Dr. M. Zamani ADEC Certificate

Appreciation

This report was presented
to you with the compliments
of the Chairman and Board of
BENALLA HEALTH
in appreciation of your
interest and support.

Benalla HEALTH

BENALLA HEALTH

BOARD MEMBER'S, ACCOUNTABLE OFFICERS AND CHIEF FINANCE & ACCOUNTING OFFICER'S DECLARATION

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

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

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

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

L Armstrong	Janine Holland	
.....	.....	.....
Louise Armstrong Board Member	Janine Holland Accountable Officer	Andrew Nitschke Chief Finance & Accounting Officer
Benalla	Benalla	Benalla
18/08/2017	18/08/2017	18/08/2017

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Benella Health

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
24 August 2017

Ron Mak
as delegate for the Auditor-General of Victoria

BENALLA HEALTH
COMPREHENSIVE OPERATING STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017

	Note	2017 $'000	2016 $'000
Revenue from Operating Activities	2.1	27,843	27,090
Revenue from Non-Operating Activities	2.1	253	265
Employee Expenses	3.1	(18,213)	(16,964)
Non Salary Labour Costs	3.1	(3,088)	(2,991)
Supplies and Consumables	3.1	(2,042)	(1,955)
Other Expenses	3.1	(4,025)	(4,033)
Net Result Before Capital and Specific Items		728	1,412
Capital Purpose Income	2.1	726	664
Specific Income	2.1	0	10
Reversal of Impairment of Financial Assets	2.1	13	371
Depreciation and Amortisation	3.1	(2,174)	(2,164)
Finance Costs	3.3	(3)	(4)
Expenditure Using Capital Purpose Income	3.1	(30)	(149)
Net Result after Capital and Specific Items		(740)	140
Other economic flows included in net result			
Net gain/(loss) on Disposal of Non-financial Assets	7.2	30	31
Revaluation of Long Service Leave	3.4	102	0
Total other economic flows included in net result		132	31
NET RESULT FOR THE YEAR		(608)	171
Other Comprehensive Income			
Items that will not be classified to net result			
Changes in Physical Asset Revaluation Surplus	8.1	0	0
Total other comprehensive income		0	0
COMPREHENSIVE RESULT		**(608)**	**171**

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

BENALLA HEALTH
BALANCE SHEET
AS AT 30 JUNE 2017

	Note	2017 $'000	2016 $'000
Current Assets			
Cash and Cash Equivalents	6.2	3,456	4,845
Receivables	5.1	1,028	865
Investments and other Financial Assets	4.1	9,145	8,529
Inventory	5.2	154	145
Prepayments and Other Assets	5.4	53	38
Total Current Assets		13,836	14,422
Non-Current Assets			
Receivables	5.1	951	769
Property, Plant and Equipment	4.3	20,251	21,544
Intangible Assets	4.5	91	51
Investment Properties	4.6	0	265
Total Non-Current Assets		21,293	22,629
TOTAL ASSETS		35,129	37,051
Current Liabilities			
Payables	5.5	954	1,330
Borrowings	6.1	37	44
Provisions	3.4	4,240	4,293
Other Liabilities	5.3	1,980	2,781
Total Current Liabilities		7,211	8,448
Non-Current Liabilities			
Borrowings	6.1	42	52
Provisions	3.4	467	534
Total Non-Current Liabilities		509	586
TOTAL LIABILITIES		7,720	9,034
NET ASSETS		27,409	28,017
EQUITY			
Property, Plant and Equipment Revaluation Surplus	8.1(a)	14,608	14,608
General Purpose Surplus	8.1(a)	415	399
Restricted Specific Purpose Surplus	8.1(a)	50	109
Contributed Capital	8.1(b)	13,293	13,293
Accumulated Deficits	8.1(c)	(957)	(392)
TOTAL EQUITY		27,409	28,017
Commitments	6.3		
Contingent Assets and Contingent Liabilities	7.3		

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

BENALLA HEALTH
STATEMENT OF CHANGES IN EQUITY
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017

	Note	Property, Plant and Equipment Revaluation Surplus $'000	General Purpose Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributions by Owners $'000	Accumulated (Deficits) $'000	Total $'000
Balance at 1 July 2015		14,608	399	491	13,293	(945)	27,846
Net result for the year		0	0	0	0	171	171
Transfer (to)/from Accumulated Surplus		0	0	0	0	0	0
Other Comprehensive Income for the Year	8.1(a)	0	0	(382)	0	382	0
Balance at 30 June 2016		**14,608**	**399**	**109**	**13,293**	**(392)**	**28,017**
Net result for the year		0	0	0	0	(608)	(608)
Transfer (to)/from Accumulated Surplus	8.1(a)	0	16	(59)	0	43	0
Other Comprehensive Income for the Year	8.1(a)	0	0	0	0	0	0
Balance at 30 June 2017		**14,608**	**415**	**50**	**13,293**	**(957)**	**27,409**

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

BENALLA HEALTH
CASH FLOW STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017

	Note	2017 $'000 Inflows / (Outflows)	2016 $'000 Inflows / (Outflows)
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		23,149	22,989
Capital Grants from Government		498	592
Patient and Resident Fees Received		1,443	2,795
Donations and Bequests Received		72	342
GST (Paid to)/received from ATO		(4)	834
Interest Received		415	240
Other Receipts		2,880	3,226
Total Receipts		***28,453***	***31,018***
Employee Expenses Paid		(18,210)	(16,585)
Non Salary Labour Costs		(3,088)	(3,378)
Payments for Supplies and Consumables		(2,051)	(1,942)
Finance Costs		(3)	(4)
Other Payments		(4,443)	(4,962)
Total Payments		***(27,795)***	***(26,871)***
NET CASH FLOW FROM OPERATING ACTIVITIES	8.2	658	4,147
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of Investments		(1,153)	(4,758)
Payments for Intangible Assets		(43)	(16)
Purchase of Non-Financial Assets		(978)	(1,336)
Proceeds from sale of Non-Financial Assets		395	115
NET CASH FLOW USED IN INVESTING ACTIVITIES		(1,779)	(5,995)
CASH FLOWS FROM FINANCING ACTIVITIES			
Proceeds from borrowings		0	0
Repayment of finance leases		(17)	(45)
NET CASH FLOW USED IN FINANCING ACTIVITIES		(17)	(45)
NET DECREASE IN CASH AND CASH EQUIVALENTS HELD		(1,138)	(1,893)
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		4,430	6,323
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.2	3,292	4,430

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

BASIS OF PRESENTATION

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

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

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

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

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

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

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

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

These annual financial statements represent the audited general purpose financial statements for Benalla Health for the period ended 30 June 2017. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

These financial statements are general purpose financial statements which have been prepared in accordance with the *Financial Management Act* 1994, and applicable AASs, which include interpretations issued by the Australian Accounting Standards Board (AASB). They are presented in a manner consistent with the requirements of AASB101 *Presentation of Financial Statements.*

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

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

The annual financial statements were authorised for issue by the Board of Benalla Health on 8th August, 2017

(b) Reporting Entity

The financial statements includes all the controlled activities of Benalla Health.

Its principal address is:
45-63 Coster Street
Benalla Victoria 3672

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

Objectives and funding

Benalla Health's overall objective is to facilitate a healthy and resilient community through the provision of integrated healthcare services, as well as to improve the quality of life of Victorians.

Benalla Health is predominantly funded by accrual based grant funding for the provision of outputs.

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

(c) Basis of accounting preparation and measurement

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

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

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

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

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

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

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

• Available-for-sale investments which are measured at fair value with movements reflected in equity until the asset is derecognised (i.e. other comprehensive income - items that may be reclassified subsequent to net result).

• The fair value of assets other than land is generally based on their depreciated replacement value.

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

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

- The fair value of land, buildings, plant and equipment, (refer to Note 7.1);
- Superannuation expense (refer to Note 3.5); and
- Employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.5)

(d) Principles of Consolidation

Intersegment Transactions

Transactions between segments within Benalla Health have been eliminated to reflect the extent of Benalla Health operations as a group.

NOTE 2: FUNDING DELIVERY OF OUR SERVICES

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

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

Structure
2.1 Analysis of revenue by source

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE

	Admitted Patients 2017 $'000	Non-Admitted Patients 2017 $'000	Ambulatory 2017 $'000	Residential Aged Care 2017 $'000	Aged Care 2017 $'000	Primary Health 2017 $'000	Other 2017 $'000	TOTAL 2017 $'000
Government Grants	14,866	1,976	1,336	2,534	1,265	1,292	5	23,274
Indirect Contributions by Department of Health and Human Services	96	18	5	32	16	31	5	203
Patient and Resident Fees	760	0	7	621	35	35	0	1,458
Commercial Activities	0	0	0	0	0	0	231	231
Other Revenue from Operating Activities	1,579	82	27	92	130	521	246	2,677
Total Revenue from Operating Activities	**17,301**	**2,076**	**1,375**	**3,279**	**1,446**	**1,879**	**487**	**27,843**
Interest	0	0	0	29	0	0	224	253
Total Revenue from Non-Operating Activities	**0**	**0**	**0**	**29**	**0**	**0**	**224**	**253**
Capital Purpose Income (excluding interest)	0	0	0	0	0	0	228	228
Capital Grants	0	0	0	0	0	0	498	498
Total Capital Purpose Income	**0**	**0**	**0**	**0**	**0**	**0**	**726**	**726**
Net gain/(loss) on Non-Financial Assets	0	0	0	0	0	0	30	30
Reversal of Impairment Loss on Financial Assets	0	0	0	0	0	0	13	13
Specific Income (refer note 2.2)	0	0	0	0	0	0	0	0
TOTAL REVENUE	**17,301**	**2,076**	**1,375**	**3,308**	**1,446**	**1,879**	**1,480**	**28,865**

	Admitted Patients 2016 $'000	Non-Admitted Patients 2016 $'000	Ambulatory 2016 $'000	Residential Aged Care 2016 $'000	Aged Care 2016 $'000	Primary Health 2016 $'000	Other 2016 $'000	TOTAL 2016 $'000
Government Grants	14,287	2,008	1,289	2,423	1,274	1,167	0	22,448
Indirect Contributions by Department of Health and Human Services	39	6	3	14	7	12	0	81
Patient and Resident Fees	722	0	6	671	36	37	0	1,472
Commercial Activities	0	0	0	0	0	0	417	417
Other Revenue from Operating Activities	1,498	101	72	253	150	481	117	2,672
Total Revenue from Operating Activities	**16,546**	**2,115**	**1,370**	**3,361**	**1,467**	**1,697**	**534**	**27,090**
Interest	0	0	0	30	0	0	235	265
Total Revenue from Non-Operating Activities	**0**	**0**	**0**	**30**	**0**	**0**	**235**	**265**
Capital Purpose Income (excluding interest)	0	0	0	300	0	0	364	664
Capital Interest	0	0	0	0	0	0	0	0
Total Capital Purpose Income	**0**	**0**	**0**	**300**	**0**	**0**	**364**	**664**
Net Gain/(Loss) on Non-Financial Assets	0	0	0	0	0	0	31	31
Reversal of Impairment Loss on Financial Assets	0	0	0	0	0	0	371	371
Specific Income (refer note 2.2)	0	0	0	0	0	0	10	10
TOTAL REVENUE	**16,546**	**2,115**	**1,370**	**3,691**	**1,467**	**1,697**	**1,545**	**28,431**

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

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)
Income is recognised in accordance with AASB 118 *Revenue* and is recognised as to the extent that it is probable that the economic benefits will flow to Benalla Health and the income can be reliably measured at fair value.
Unearned income at reporting date is reported as income received in advance.

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

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

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

Indirect Contributions from the Department of Health and Human Services

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

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

Private Practice Fees
Private Practice fees are recognised as revenue at the time invoices are raised.

Revenue from commercial activities
Revenue from commercial activities such as provision of meals to external users is recognised at the time the invoices are raised.

Donations and Other Bequests
Donations and bequests are recognised as revenue when received. If donations are for a special purpose, they may be appropriated to a surplus, such as specific restricted purpose surplus.

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

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

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)

Category Groups
Benalla Health has used the following category groups for reporting purposes for the current and previous financial years.

- **Admitted Patient Services (Admitted Patients)** comprises all acute and subacute admitted patients services, where services are delivered in public hospitals.
- **Non Admitted Patient Services** comprises outpatient services provided via our Urgent Care Centre
- **Ambulatory Services** comprises all recurrent revenue/expenditure for services delivered under our Health Independence Program and Palliative Care service.
- **Aged Care** comprises a range of in home, specialist geriatric, residential care and community based programs and support services, such as Home and Community Care (HACC) that are targeted to older people, people with a disability, and their carers.
- **Primary, Community and Dental Health** comprises a range of home based, community based, community, primary health and dental services including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy and a range of dental health services.
- **Residential Aged Care including Mental Health (RAC incl. Mental Health)** referred to in the past as psychogeriatric residential services, comprises those Commonwealth-licensed residential aged care services in receipt of supplementary funding from the department under the mental health program. It excludes all other residential services funded under the mental health program, such as mental health funded community care units and secure extended care units.
- **Other Services not reported elsewhere - (Other)** comprises services not separately classified above, including: Public Health Services including laboratory testing, blood borne viruses / sexually transmitted infections clinical services, Kooris liaison officers, immunisation and screening services, drugs services including drug withdrawal, counselling and the needle and syringe program, Disability services including aids and equipment and flexible support packages to people with a disability, Community Care programs including sexual assault support, early parenting services, parenting assessment and skills development, and various support services. Health and Community Initiatives also falls in this category group.

NOTE 2.2: SPECIFIC INCOME	**2017 $'000**	**2016 $'000**
Revaluation of Investment Property	0	10
TOTAL SPECIFIC INCOME	0	10

NOTE 3: THE COST OF DELIVERING SERVICES

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

Structure

3.1 Analysis of expenses by source
3.2 Analysis of expense and revenue by internally managed and restricted specific purpose funds
3.3 Finance Costs
3.4 Provisions
3.5 Superannuation

NOTE 3.1: ANALYSIS OF EXPENSE BY SOURCE

	Admitted Patients 2017 $'000	Non-Admitted Patients 2017 $'000	Ambulatory 2017 $'000	Residential Aged Care 2017 $'000	Aged Care 2017 $'000	Primary Health 2017 $'000	Other 2017 $'000	TOTAL 2017 $'000
Employee Expenses	8,228	1,529	616	3,502	1,490	2,419	429	18,213
Other Operating Expenses								
Non Salary Labour Costs	2,940	60	17	43	8	19	1	3,088
Supplies and Consumables	1,466	79	88	187	50	37	135	2,042
Administration Expenses	1,440	140	97	293	173	316	91	2,550
Other Expenses	806	76	19	250	91	121	112	1,475
Total Expenditure from Operating Activities	**14,880**	**1,884**	**837**	**4,275**	**1,812**	**2,912**	**768**	**27,368**
Finance Costs (refer note 3.3)	0	0	0	0	0	0	3	3
Other Non-Operating Expense								
Expenditure Using Capital Purpose Income	0	0	0	0	0	0	30	30
Depreciation (refer note 4.4)	0	0	0	0	0	0	2,174	2,174
Total Other Expenses	0	0	0	0	0	0	2,207	2,207
TOTAL EXPENSES	**14,880**	**1,884**	**837**	**4,275**	**1,812**	**2,912**	**2,975**	**29,575**

	Admitted Patients 2016 $'000	Non-Admitted Patients 2016 $'000	Ambulatory 2016 $'000	Residential Aged Care 2016 $'000	Aged Care 2016 $'000	Primary Health 2016 $'000	Other 2016 $'000	TOTAL 2016 $'000
Employee Expenses	7,550	1,522	1,029	3,404	1,515	1,600	344	16,964
Other Operating Expenses								
Non Salary Labour Costs	2,790	56	13	18	26	14	74	2,991
Supplies and Consumables	1,360	112	91	130	73	78	111	1,955
Administration Expenses	1,386	112	57	347	124	202	207	2,435
Other Expenses	909	73	38	227	81	132	138	1,598
Total Expenditure from Operating Activities	**13,995**	**1,875**	**1,228**	**4,126**	**1,819**	**2,026**	**874**	**25,943**
Finance Costs (refer note 3.3)	0	0	0	0	0	0	4	4
Other Non-Operating Expense								
Expenditure Using Capital Purpose Income	0	0	0	0	0	0	149	149
Depreciation (refer note 4.4)	1,124	151	99	361	146	163	120	2,164
Total Other Expenses	1,124	151	99	361	146	163	273	2,317
TOTAL EXPENSES	15,119	2,026	1,327	4,487	1,965	2,189	1,147	28,260

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

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

NOTE 3.1: ANALYSIS OF EXPENSE BY SOURCE (Continued)

Employee expenses

Employee expenses include:

- Wages and salaries;
- Annual leave;
- Sick leave;
- Long service leave; and
- Superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

Grants and other transfers

Grants and other transfers to third parties (other than contribution to owners) are recognised as an expense in the reporting period in which they are paid or payable. They include transactions such as: grants, subsidies and personal benefit payments made in cash to individuals.

Other operating expenses

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

Supplies and consumables

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

Bad and doubtful debts

Refer to Note 4.1 *Investments and other financial assets*

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

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

Other economic flows included in net result

Other economic flows are changes in the volume or value of assets or liabilities that do not result from transactions.

Net gain/(loss) on non-financial assets

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

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

Net gain/(loss) on financial instruments

Net gain/(loss) on financial instruments includes:

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

Amortisation of non-produced intangible assets

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

Impairment of non-financial assets

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

Other gains/(losses) from other economic flows

Other gains/(losses) include:

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

Derecognition of financial liabilities

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

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

NOTE 3.2: ANALYSIS OF EXPENSE AND REVENUE BY INTERNALLY MANAGED AND RESTRICTED SPECIFIC PURPOSE FUNDS	2017 $'000	2016 $'000	2017 $'000	2016 $'000
	Expense		Revenue	
Commercial Activities				
Catering	97	245	231	152
Property	111	88	246	176
Regional Supply Service	0	25	0	28
Palliative Care - After Hours Support	0	40	0	100
Other	0	4	0	4
TOTAL	208	402	477	460

NOTE 3.3: FINANCE COSTS	2017 $'000	2016 $'000
Finance Charges on Finance Leases - Share of HRHA	3	4
TOTAL FINANCE COSTS	3	4

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

Finance costs include:

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

NOTE 3.4: EMPLOYEE BENEFITS IN THE BALANCE SHEET	2017 $'000	2016 $'000
Current Provisions		
Employee Benefits (i)		
Annual Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	1,132	1,125
- unconditional and expected to be settled wholly after 12 months (iii)	463	447
Long Service Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	398	311
- unconditional and expected to be settled wholly after 12 months (iii)	1,634	1,649
Accrued Wages and Accrued Days Off		
- unconditional and expected to be settled wholly within 12 months (ii)	250	384
	3,877	3,916
Provisions related to employee benefit on-costs		
- unconditional and expected to be settled wholly within 12 months (ii)	148	148
- unconditional and expected to be settled wholly after 12 months (iii)	215	229
	363	377
Total Current Provisions	4,240	4,293
Non-Current Provisions		
Employee Benefits (i)	422	480
Provisions related to employee benefit on-costs	45	54
Total Non-Current Provisions	467	534
Total Provisions	4,707	4,827

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

NOTE 3.4: EMPLOYEE BENEFITS IN THE BALANCE SHEET (Continued)	2017 $'000	2016 $'000
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and Related On-Costs		
Annual Leave Entitlements	1,594	1,723
Accrued Salaries and Wages	203	336
Accrued Days Off	47	54
Unconditional Long Service Leave Entitlements	2,396	2,180
	4,240	4,293
Non-Current Employee Benefits and Related On-Costs		
Conditional Long Service Leave Entitlements (iii)	467	534
	467	534
Total Employee Benefits and Related On-Costs	4,707	4,827

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

Movements in Provisions	2017	2016
Movement in Long Service Leave:	$'000	$'000
Balance at start of year	2,714	2,667
Provision made during the year		
- Revaluations	(102)	0
- Expense Recognising Employee Service	706	495
Settlement made during the year	(455)	(448)
Balance at end of year	2,863	2,714

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

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

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

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

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

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

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

Long Service Leave (LSL)

Liability for LSL is recognised in the provision for employee benefits.

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

The components of this current LSL liability are measured at:

- Undiscounted value – if the Health Service expects to wholly settle within 12 months; and
- Present value – if the Health Service does not expect to settle a component of this current liability within 12 months.

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

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

Termination Benefits

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

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

On-Costs related to employee expense

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

NOTE 3.5: SUPERANNUATION

Fund		Paid Contributions for the year		Outstanding Contributions at Year End	
		2017 $'000	**2016 $'000**	**2017 $'000**	**2016 $'000**
Defined Benefit Plans:	Health Super	52	60	0	1
Defined Contribution Plans:	Health Super	1,059	1,050	21	19
	HESTA	382	276	0	4
Total		1,493	1,386	21	24

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

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

However, superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the comprehensive operating statement of the Health Service. The name, details and amounts expense in relation to the major employee superannuation funds and contributions made by the Health Services are detailed above.

Defined contribution superannuation plans

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

NOTE 3.5: SUPERANNUATION (Continued)

Defined benefit superannuation plans

The amount charged to the comprehensive operating statement in respect of defined benefit superannuation plans represents the contributions made by the Health Service to the superannuation plans in respect of the services of current Health Service staff during the reporting period. Superannuation contributions are made to the plans based on the relevant rules of each plan, and are based upon actuarial advice.

Superannuation Liabilities

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

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY

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

Structure

4.1 Investments and other financial assets
4.2 Jointly Controlled Operations and Assets
4.3 Property, plant & equipment
4.4 Depreciation and amortisation
4.5 Intangible assets
4.6 Investment properties

NOTE 4.1: INVESTMENT OTHER FINANCIAL ASSETS

	Operating Fund		Specific Purpose Fund		Capital Fund		Total	Total
	2017	2016	2017	2016	2017	2016	2017	2016
CURRENT	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Loans and Receivables								
Term Deposit								
Aust. Dollar Term Deposits > 3 Months (i)	9,145	7,625	0	508	0	396	9,145	8,529
Total Current Other Financial Assets	9,145	7,625	0	508	0	396	9,145	8,529
TOTAL OTHER FINANCIAL ASSETS	9,145	7,625	0	508	0	396	9,145	8,529
Represented by:								
Health Service Investments	7,329	5,259	0	508	0	396	7,329	6,163
Monies Held in Trust								
- Central Hume PCP	427	614		0	0	0	427	614
- Refundable Accommodation Bonds	1,389	1,752	0	0	0	0	1,389	1,752
TOTAL	9,145	7,625	0	508	0	396	9,145	8,529

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

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

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

Investments and other financial assets
Hospital investments must be in accordance in Standing Direction 3.7.2 – Treasury and Investment Risk Management. Investments are recognised and derecognised on trade date where purchase or sale of an investment is under a contract whose terms require delivery of the investment within the timeframe established by the market concerned, and are initially measured at fair value, net of transaction costs.

Investments are classified in the following categories:

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

Benalla Health classifies its other financial assets between current and non-current assets based on the purpose for which the assets were acquired. Management determines the classification of its other financial assets at initial recognition.

Benalla Health assesses at each balance sheet date whether a financial asset or group of financial assets is impaired.

All financial assets, except those measured at fair value through profit and loss are subject to annual review for impairment.

NOTE 4.1: INVESTMENT OTHER FINANCIAL ASSETS (Continued)

Derecognition of financial assets

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

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

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

Impairment of Financial Assets

At the end of each reporting period Benalla Health assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. All financial instrument assets, except those measured at fair value through profit and loss, are subject to annual review for impairment.

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

Doubtful debts

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

NOTE 4.2: JOINTLY CONTROLLED OPERATIONS AND ASSETS

Name of Entity	Principal Activity	Ownership Interest 2017 %	Ownership Interest 2016 %
Hume Rural Health Alliance	Information Systems	5.71	5.80

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

	2017 $'000	2016 $'000
Current Assets		
Cash and Cash Equivalents	206	111
Receivables	149	55
Prepayments	8	4
Total Current Assets	363	170
Non Current Assets		
Property, Plant and Equipment	80	97
Intangible Assets	91	51
Total Non Current Assets	171	148
Total Assets	534	318
Current Liabilities		
Payables	28	31
Lease Liability	37	44
Total Current Liabilities	65	75
Non Current Liabilities		
Lease Liability	42	52
Total Non Current Liabilities	42	52
Total Liabilities	107	127
Share of Net Assets	427	191

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

Revenues		
Operating Activities	488	519
Non Operating Activities	1	1
Total Revenue	489	520
Expenses		
Information Technology and Administrative Expenses		
- Management Fees	92	110
- Other Expenses from Continuing Operations	332	357
Total Operating Expenses	424	467
Capital Purpose Income	228	55
Depreciation	(48)	(48)
Amortisation	(3)	(3)
Finance Lease Charges	(2)	(4)
Total Capital & Specific Items	175	0
Other Economic Flows included in the result		
Revaluation of Long Service Leave	(5)	0
Net Result	235	53

Contingent Liabilities and Capital Commitments

There are no known contingent assets or liabilities, and no capital commitments for Hume Rural Health Alliance as at the date of this report.

Investments in joint operations

In respect of any interest in joint operations, Benalla Health recognises in the financial statements:

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

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT

(a) Gross carrying amount and accumulated depreciation

	2017 $'000	2016 $'000
Land		
- Land at Fair Value		
Crown Land at Fair Value	343	343
Freehold Land	1,141	1,141
Total Land	1,484	1,484
Buildings		
- Buildings Under Construction at Cost	497	0
- Buildings at Fair Value	19,253	19,240
Less Accumulated Depreciation	3,921	2,560
	15,332	16,680
Total Buildings	15,829	16,680
Plant and Equipment		
- Plant and Equipment at Fair Value	5,583	5,521
Less Accumulated Depreciation	3,543	3,227
Total Plant and Equipment	2,040	2,294
Medical Equipment		
- Medical Equipment at Fair Value	3,517	3,442
Less Accumulated Depreciation	2,699	2,452
Total Medical Equipment	818	990
Leased Assets - Share of HRHA Leased Assets		
- Leased Assets at Fair Value	166	189
Less Accumulated Depreciation	86	93
Total Leased Assets	80	96
TOTAL	20,251	21,544

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

	Land	Buildings	Plant & Equipment	Medical Equipment	Assets Under Construction	Leased Assets	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2015	1,325	17,860	1,963	1,068	96	62	22,374
Additions	159	167	418	229	363	79	1,415
Disposals	0	0	(68)	(16)	0	0	(84)
Transfers Between Classes	0	0	459	0	(459)	0	0
Depreciation (Note 4.4)	0	(1,347)	(478)	(291)	0	(45)	(2,161)
Balance at 30 June 2016	1,484	16,680	2,294	990	0	96	21,544
Additions	0	14	312	123	497	32	978
Disposals	0	0	(95)	(5)	0	0	(100)
Revaluation Movements	0	0	0	0	0	0	0
Depreciation (Note 4.4)	0	(1,362)	(471)	(290)	0	(48)	(2,171)
Balance at 30 June 2017	1,484	15,332	2,040	818	497	80	20,251

Land and buildings carried at valuation

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

The effective date of the independent valuation was 30 June 2014.

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

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

	Carrying amount as at 30 June 2017	Fair value measurement at end of reporting period using:		
		Level 1 (i)	Level 2 (i)	Level 3 (i)
Land at fair value				
Non-specialised land	604	0	604	0
Specialised land	880	0	0	880
Total of land at fair value	1,484	0	604	880
Buildings at fair value				
Non-specialised buildings	4,265	0	665	3,600
Specialised buildings	11,067	0	0	11,067
Total of building at fair value	15,332	0	665	14,667
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	417	0	0	417
- Plant and equipment	1,623	0	0	1,623
Total of plant, equipment and vehicles at fair value	2,040	0	0	2,040
Medical equipment at fair value	818	0	0	818
Leased Assets (HRHA)	80	0	0	80
Assets under construction at fair value	497	0	0	497
	20,251	0	1,269	18,982

Fair value measurement hierarchy for assets as at 30 June 2016

	Carrying amount as at 30 June 2016	Fair value measurement at end of reporting period using:		
		Level 1 (i)	Level 2 (i)	Level 3 (i)
Land at fair value				
Non-specialised land	604	0	604	0
Specialised land	880	0	0	880
Total of land at fair value	1,484	0	604	880
Buildings at fair value				
Non-specialised buildings	4,265	0	665	3,600
Specialised buildings	12,415	0	0	12,415
Total of buildings at fair value	16,680	0	665	16,015
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	395	0	0	395
- Plant and equipment	1,899	0	0	1,899
Total of plant, equipment and vehicles at fair value	2,294	0	0	2,294
Medical equipment at fair value	990	0	0	990
Leased Assets (HRHA)	96	0	0	96
	21,544	0	1,269	20,275

(i) Classified in accordance with the fair value hierarchy.
(ii) Vehicles are categorised to Level 3 assets if the depreciated replacement cost is used in estimating the fair value. Where a market approach is considered appropriate due to an active resale market, a Level 2 categorisation for such vehicles is applied.

There have been no transfers between levels during the period.

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

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

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

Valuation Hierachy

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

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

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

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

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

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

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

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

Fair value measurement

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

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

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

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

Judgements about highest and best use must take into account the characteristics of the assets concerned, including restrictions on the use and disposal of assets arising from the asset's physical nature and any applicable legislative/contractual arrangements.
In considering the HBU for non-financial physical assets, valuers are probably best placed to determine highest and best use (HBU) in consultation with Health Services. Health Services and their valuers therefore need to have a shared understanding of the circumstances of the assets. A Health Service has to form its own view about a valuer's determination, as it is ultimately responsible for what is presented in its audited financial statements.

In accordance with AASB 13 paragraph 29, Health Services can assume the current use of a non-financial physical asset is its HBU unless market or other factors suggest that a different use by market participants would maximise the value of the asset.
Therefore, an assessment of the HBU will be required when the indicators are triggered within a reporting period, which suggest the market participants would have perceived an alternative use of an asset that can generate maximum value. Once identified, Health Services are required to engage with VGV or other independent valuers for formal HBU assessment.

These indicators, as a minimum, include:
External factors:

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

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

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

(d) Reconciliation of Level 3 fair value	Land	Buildings	Plant and Equipment	Medical Equipment	Assets Under Construction	Leased Assets
30 June 2017						
Opening Balance	880	16,015	2,294	990	0	96
Purchases (sales) & Reclassifications	0	14	217	118	497	32
Transfers in (out) of Level 3	0	0	0	0	0	0
Gains or losses recognised in net result						
- Depreciation	0	(1,362)	(471)	(290)	0	(48)
- Impairment loss	0	0	0	0	0	0
Subtotal	880	14,667	2,040	818	497	80
Items recognised in other comprehensive income						
- Revaluation	0	0	0	0	0	0
Subtotal	0	0	0	0	0	0
Closing Balance	880	14,667	2,040	818	497	80
Unrealised gains/(losses) on non-financial assets	0	0	0	0	0	0
	880	14,667	2,040	818	497	80

There have been no transfers between levels during the period.

30 June 2016	Land	Buildings	Plant and Equipment	Medical Equipment	Assets Under Construction	Leased Assets
Opening Balance	880	17,328	1,963	1,068	96	62
Purchases (sales) & Reclassifications	0	0	809	213	(96)	79
Transfers in (out) of Level 3	0	0	0	0	0	0
Gains or losses recognised in net result						
- Depreciation	0	(1,313)	(478)	(291)	0	(45)
- Impairment loss	0	0	0	0	0	0
Subtotal	880	16,015	2,294	990	0	96
Items recognised in other comprehensive income						
- Revaluation	0	0	0	0	0	0
Subtotal	0	0	0	0	0	0
Closing Balance	880	16,015	2,294	990	0	96
Unrealised gains/(losses) on non-financial assets	0	0	0	0	0	0
	880	16,015	2,294	990	0	96

There have been no transfers between levels during the period.

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

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

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

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

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

Specialised land and specialised buildings

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

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

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

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

Non-specialised land and non-specialised buildings

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

For non-specialised land and non-specialised buildings, an independent valuation was performed by the Valuer-General Victoria to determine the fair value using the market approach. Valuation of the assets was determined by analysing comparable sales and allowing for share, size, topography, location and other relevant factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30 June 2014.

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

Vehicles

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

Plant and equipment

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

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

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

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

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

	Valuation technique [(i)]	Significant unobservable inputs [(i)]
Specialised land	Market Approach	Community Service Obligation (CSO)
Specialised Buildings	Depreciated Replacement Cost	Direct cost per square metre Useful life of specialised buildings
Non Specialised Land and Buildings	Depreciated Replacement Cost	Direct cost per square metre Useful life of non specialised buildings
Plant and equipment at fair value	Depreciated Replacement Cost	Cost per Unit Useful life of PPE
Assets Under Construction	Depreciated Replacement Cost	Cost per Unit

Refer to Note 7.4 for guidance on fair value measurement indicative expectations.

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

Crown Land is measured at fair value with regard to the property's highest and best use after due consideration is made for any legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset. Theoretical opportunities that may be available in relation to the asset(s) are not taken into account until it is virtually certain that any restriction will no longer apply. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best uses.

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

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

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

Revaluations of non-current physical assets

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

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

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

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

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

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

NOTE 4.4: DEPRECIATION AND AMORTISATION	2017 $'000	2016 $'000
Depreciation		
Buildings	1,362	1,347
Plant and Equipment	471	478
Medical Equipment	290	291
Leased Assets - Share of HRHA Leased Assets	48	45
Total Depreciation	2,171	2,161
Intangible Assets - Share of HRHA Intangible Assets	3	3
Total Amortisation	3	3
TOTAL DEPRECIATION AND AMORTISATION	2,174	2,164

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

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

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

NOTE 4.4: DEPRECIATION (Continued)

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

	2017	2016
Buildings		
- Structure Shell Building Fabric	10 to 25 years	10 to 25 years
- Site Engineering Services and Central Plant	10 to 20 years	10 to 20 years
Central Plant		
- Fit Out	7 to 12 years	7 to 12 years
- Trunk Reticulated Building Systems	8 to 12 years	8 to 12 years
Plant and Equipment	3 to 30 years	3 to 10 years
Medical Equipment	4 to 20 years	5 to 10 years
Computers and Communication	3 to 12 years	3 to 8 years
Furniture and Fittings	5 to 20 years	5 to 13 years
Motor Vehicles	4 to 7 years	5 to 6 years

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

NOTE 4.5: INTANGIBLE ASSETS

	2017 $'000	2016 $'000
Share of HRHA Intangible Assets	99	57
Less Accumulated Amortisation	8	6
TOTAL INTANGIBLE ASSETS	91	51

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

	2017 $'000	2016 $'000
Balance at 1 July 2015	38	21
Additions	16	20
Amortisation (note 4.4)	(3)	(3)
Balance at 1 July 2016	51	38
Additions	43	16
Amortisation (note 4.4)	(3)	(3)
Balance at 1 July 2017	91	51

INTANGIBLE ASSETS

Intangible assets represent identifiable non-monetary assets without physical substance such as patents, trademarks and computer software and development costs (where applicable).

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

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

NOTE 4.5: INTANGIBLE ASSETS (Continued)
AMORTISATION
Amortisation is allocated to intangible non-produced assets with finite useful lives on a systematic (typically straight-line) basis over the asset's useful life. Amortisation begins when the asset is available for use, that is, when it is in the location and condition necessary for it to be capable of operating in the manner intended by management. The consumption of intangible non-produced assets with finite useful lives is classified as amortisation.

The amortisation period and the amortisation method for an intangible asset with a finite useful life are reviewed at least at the end of each annual reporting period. In addition, an assessment is made at each reporting date to determine whether there are indicators that the intangible asset concerned is impaired. If so, the asset concerned is tested as to whether its carrying amounts exceeds its recoverable amount.

Any excess of the carrying amount over the recoverable amount is recognised as an impairment loss.

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

Intangible assets with finite useful lives are amortised over 5 - 10 years.

NOTE 4.6: INVESTMENT PROPERTIES

(a) Movements in carrying value for investment properties as at 30 June 2017

	2017 $'000	2016 $'000
Balance at Beginning of Period	265	255
Disposals of Investment Property	(265)	0
Net Gain/(Loss) from Fair Value Adjustments	0	10
Balance at End of Period	0	265

(b) Fair value measurement hierarchy for investment properties as at 30 June 2017

	Carrying amount as at 30 June 2017	Fair value measurement at end of reporting period using:		
		Level 1 (i)	Level 2 (i)	Level 3 (i)
Investment Properties	0	0	0	0
	0	0	0	0

Fair value measurement hierarchy for investment properties as at 30 June 2016

	Carrying amount as at 30 June 2016	Fair value measurement at end of reporting period using:		
		Level 1 (i)	Level 2 (i)	Level 3 (i)
Investment Properties	265	0	265	0
	265	0	265	0

There have been no transfers between levels during the period. There were no changes in valuation techniques throughout the period to 30 June 2017.

For investment properties measured at fair value, the current use of the asset is considered the highest and best use.

The fair value of the Health Service's investment properties at 30 June 2016 had been arrived on the basis of an independent valuation carried out by the Valuer General Victoria. The valuation was determined by reference to market evidence of transaction process for similar properties with no significant unobservable adjustments, in the same location and condition and subject to similar lease and other contracts.

Investment Properties

Investment properties represent properties held to earn rentals or for capital appreciation or both. Investment properties exclude properties held to meet service delivery objectives of the Health Service.

Investment properties are initially recognised at cost. Costs incurred subsequent to initial acquisition are capitalised when it is probable that future economic benefits in excess of the originally assessed performance of the asset will flow to the Health Service.

Subsequent to initial recognition at cost, investments properties are revalued to fair value, determined annually be independent valuers. Fair values are determined based on a market comparable approach that reflects recent transaction prices for similar properties. Investment properties are neither depreciated nor tested for impairment.

Rental revenue from leasing of investment properties is recognised in the comprehensive operating statement in the periods in which it is receivable on a straight line basis over the lease term.

NOTE 5: OTHER ASSETS AND LIABILITIES

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

Structure

5.1 Receivables
5.2 Inventories
5.3 Other liabilities
5.4 Prepayments and other assets
5.5 Payables

NOTE 5.1: RECEIVABLES	2017 $'000	2016 $'000
CURRENT		
Contractual		
Inter Hospital Debtors	134	151
Trade Debtors	90	172
Trade Debtors - Share of HRHA Debtors	149	55
Patient Fees and Resident Debtors	181	166
Accrued Investment Income	48	54
Accrued Revenue Other	118	85
Less Allowance for Doubtful Debts		
- Trade Debtors	(13)	(16)
	707	667
Statutory		
GST Receivable	95	97
Accrued Grants - Department of Health and Human Services	226	101
	321	198
TOTAL CURRENT RECEIVABLES	1,028	865
NON CURRENT		
Statutory		
Long Service Leave - Department of Health / Department of Health and Human Services	951	769
TOTAL NON-CURRENT RECEIVABLES	951	769
TOTAL RECEIVABLES	1,979	1,634
(a) Movement in the Allowance for doubtful debts		
Balance at beginning of year	16	23
Amounts written during the year	0	(3)
Increase/(decrease) in allowance recognised in net result	(3)	(4)
Balance at end of year	13	16

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

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

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

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

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

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

NOTE 5.2: INVENTORIES

	2017 $'000	2016 $'000
Pharmaceuticals		
- At Cost	33	26
Main Store - Medical, Domestic & Administration		
- At Cost	121	119
TOTAL INVENTORIES	154	145

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

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

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

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

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

NOTE 5.3: OTHER LIABILITIES

	2017 $'000	2016 $'000
CURRENT		
Monies Held in Trust*		
- Patients Trust	8	15
- Central Hume PCP*	582	1,014
- Accommodation Bonds (Refundable Entrance Fees)	1,390	1,752
TOTAL OTHER LIABILITIES	1,980	2,781

*** Total Monies Held in Trust**

Represented by the following assets:		
Cash Assets (refer to Note 6.2)	164	415
Investments and other Financial Assets (refer to Note 4.1)	1,816	2,366
TOTAL	1,980	2,781

* Primary Care Partnerships (PCP) are a Department of Health and Human Services' initiative that aims to strengthen, improve and unite the delivery of primary health care in Victoria through a partnership approach.

The Central Hume PCP appointed Benalla Health as their funds holder from 1 January 2010. As the funds holder, the Health Service provides financial services on behalf of the PCP such as, receiving Department of Health and Human Services' grants and making payments to suppliers.

As at 30 June 2017 the amount of Central Hume PCP funds held by Benalla Health is $582,338 (2016: $1,013,532).

NOTE 5.4: PREPAYMENT AND OTHER NON-FINANCIAL ASSETS

	2017 $'000	2016 $'000
CURRENT		
Prepaid Expenses	45	34
Prepayments - Share of HRHA Current Assets	8	4
TOTAL OTHER ASSETS	53	38

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

NOTE 5.5: PAYABLES

	2017 $'000	2016 $'000
CURRENT		
Contractual		
Trade Creditors (i)	708	765
Accrued Expenses	180	511
Other - Share of HRHA Current Liabilities	28	31
	916	1,307
Statutory		
GST Payable	17	23
Superannuation Obligations Payable	21	0
	38	23
TOTAL PAYABLES	954	1,330

(i) The average credit period is 30 days. No interest is charged on outstanding balances.

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

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

Payables consist of:

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

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

NOTE 6: HOW WE FINANCE OUR OPERATIONS

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

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

NOTE 6.1: BORROWINGS	2017	2016
CURRENT	$'000	$'000
Australian Dollar Borrowings		
- Finance Lease Liability (Share of HRHA finance lease liability)	37	44
TOTAL CURRENT	37	44
NON CURRENT		
Australian Dollar Borrowings		
- Finance Lease Liability (Share of HRHA finance lease liability)	42	52
TOTAL NON CURRENT	42	52
TOTAL BORROWINGS	79	96

Finance leases are held by the Hume Rural Health Alliance and are secured by the rights to the leased assets being held by the lessor.

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

(b) Nature and extent of risk arising from borrowings
Please refer to Note 7.1 for the nature and extent of risks arising from borrowings.

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

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

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

For service concession arrangements, the commencement of the lease term is deemed to be the date the asset is commissioned.

All other leases are classified as operating leases.

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

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

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

NOTE 6.2: CASH AND CASH EQUIVALENTS

	2017 $'000	2016 $'000
Cash on Hand	2	1
Cash at Bank	1,175	1,981
Short Term Deposits (Maturity < 3 Months)	2,279	2,863
TOTAL CASH AND CASH EQUIVALENTS	3,456	4,845
Represented by:		
Cash for Health Service Operations		
- Benalla Health Cash	3,085	4,319
- Share of HRHA Cash	207	111
Cash for Health Service Operations (as per cash flow statement)	3,292	4,430
Cash for Monies Held in Trust		
- Cash at Bank	164	415
TOTAL CASH AND CASH EQUIVALENTS	3,456	4,845

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

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

NOTE 6.3: COMMITMENTS FOR EXPENDITURE

(a) Commitments Payable

Capital Expenditure Commitments

There are no capital expenditure commitments at 30 June 2017

	2017 $'000	2016 $'000
Lease commitments		
Commitments in relation to leases contracted for at the reporting date:		
Finance Leases (Hume Region Health Alliance)	79	96
Total lease commitments	79	96
Finance Leases		
Commitments in relation to finance leases are payable as follows:		
Current	40	47
Non-current	44	56
Minimum lease payments	84	103
Less future finance charges	5	7
Total finance lease commitments	79	96
Total lease commitments	79	96
Total Commitments	79	96

(b) Commitments payable

Nominal Values	2017 $'000	2016 $'000
Lease commitments payable		
Less than 1 year	41	48
Longer than 1 year but not longer than 5 years	46	57
Total lease commitments	87	106
Total Commitments (inclusive of GST)	87	106
Less GST recoverable from the Australian Tax Office	8	10
Total Commitments (exclusive of GST)	79	96

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

NOTE 7: RISKS, CONTINGENCIES & VALUATION UNCERTAINTIES

The Health Service 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

Note 7.1: FINANCIAL INSTRUMENTS

Financial Risk Management Objectives and Policies

Benalla Health principal financial instruments comprise of:

- *Cash Assets*
- *Term Deposits*
- *Receivables (excluding statutory receivables)*
- *Payables (excluding statutory payables)*
- *Finance Lease Payables*
- *Monies Held in Trust*

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

The Health Service's main financial risks include credit risk, liquidity risk and interest rate risk. The Health Service manages these financial risks in accordance with its financial risk management policy.

The Health Service uses different methods to measure and manage the different risks to which it is exposed. Primary responsibility for the identification and management of financial risks rests with the audit and risk committee of the Health Service.

The main purpose in holding financial instruments is to prudentially manage Benalla Health financial risk within the government policy parameters.

Categorisation of financial instruments

2017	Contractual financial assets - loans and receivables $'000	Contractual financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets			
Cash and cash equivalents	3,456	0	3,456
Receivables			
- Trade Debtors	541	0	541
- Other Receivables	166	0	166
Investments	9,145	0	9,145
Total Financial Assets (i)	13,308	0	13,308
Financial Liabilities			
Payables	0	916	916
Borrowings	0	79	79
Monies Held in Trust	0	1,980	1,980
Total Financial Liabilities(ii)	0	2,975	2,975

2016	Contractual financial assets - loans and receivables $'000	Contractual financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets			
Cash and cash equivalents	4,845	0	4,845
Receivables			
- Trade Debtors	528	0	528
- Other Receivables	139	0	139
Investments	8,529	0	8,529
Total Financial Assets (i)	14,041	0	14,041
Financial Liabilities			
Payables	0	1,307	1,307
Borrowings	0	79	79
Monies Held in Trust	0	2,781	2,781
Total Financial Liabilities(ii)	0	4,167	4,167

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
(b) Net holding gain/(loss) on financial instruments by category

	Total interest income/ (expense) $'000	Total $'000
2017		
Financial Assets		
Cash and cash equivalents(i)	40	40
Loans and Receivables(i)	711	711
Total Financial Assets	751	751
Financial Liabilities		
At amortised cost (ii)	(3)	(3)
Total Financial Liabilities	(3)	(3)
2016		
Financial Assets		
Cash and cash equivalents(i)	65	65
Loans and Receivables(i)	200	200
Total Financial Assets	265	265
Financial Liabilities		
At amortised cost (ii)	(4)	(4)
Total Financial Liabilities	(4)	(4)

(i) For cash and cash equivalents, loans or receivables and available-for-sale financial assets, the net gain or loss is calculated by taking the movement in the fair value of the asset, interest revenue and minus any impairment recognised in the net result;

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

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

Credit risk associated with the Health Service's contractual financial assets is minimal because the main debtor is the Victorian Government. For debtors other than the Government, it is the Health Service's policy to only deal with entities with high credit ratings of a minimum Triple-B rating and to obtain sufficient collateral or credit enhancements, where appropriate.

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

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

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
(c) Credit Risk (Continued)
Credit quality of contractual financial assets that are neither past due nor impaired

2017	Financial Institutions (Min BB credit rating) $'000	Government Agencies (AAA credit rating) $'000	Government Agencies (BBB credit rating) $'000	Other $'000	Total $'000
Financial Assets					
Cash and Cash Equivalents	3,454	0	0	2	3,456
Loans and Receivables					
- Trade Debtors	0	0	134	407	541
- Other Receivables	0	48	0	118	166
- Term Deposit	9,145	0	0	0	9,145
Total Financial Assets	12,599	48	134	527	13,308
2016					
Financial Assets					
Cash and Cash Equivalents	1,982	2,863	0	0	4,845
Loans and Receivables					
- Trade Debtors	0	0	151	377	528
- Other Receivables	0	54	0	85	139
- Term Deposit	0	8,529	0	0	8,529
Total Financial Assets	1,982	11,446	151	462	14,041

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

Ageing analysis of financial asset as at 30 June

			Past due and not impaired				
2017	Carrying Amount $'000	Not Past due and not impaired $'000	Less than 1 Month $'000	1 - 3 Months $'000	3 Months - 1 Year $'000	1 - 5 Years $'000	Impaired Financial Assets $'000
Financial Assets							
Cash and Cash Equivalents	3,456	3,456	0	0	0	0	0
Loans and Receivables (i)							
- Trade Debtors	541	484	23	2	19	0	13
- Other Receivables	166	166	0	0	0	0	0
- Term Deposit	9,145	9,145	0	0	0	0	0
Total Financial Assets	13,308	13,251	23	2	19	0	13
2016							
Financial Assets							
Cash and Cash Equivalents	4,845	4,845	0	0	0	0	0
Loans and Receivables							
- Trade Debtors	528	435	60	11	6	0	16
- Other Receivables	139	139	0	0	0	0	0
- Term Deposit	8,529	8,529	0	0	0	0	0
Total Financial Assets	14,041	13,948	60	11	6	0	16

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

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

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(d) Liquidity Risk

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

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

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

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

Maturity analysis of financial liabilities as at 30 June

			Maturity Dates			
2017	Total 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	916	916	916	0	0	0
Borrowings	79	79	4	11	31	33
Other Financial Liabilities (i)						
- Monies in Trust	1,980	1,980	1,980	0	0	0
Total Financial Liabilities	2,975	2,975	2,900	11	31	33
2016						
Financial Liabilities						
At amortised cost						
Payables	1,307	1,307	1,262	45	0	0
Borrowings	96	96	4	11	31	50
Other Financial Liabilities (i)						
- Monies in Trust	2,781	2,781	2,781	0	0	0
Total Financial Liabilities	4,184	4,184	4,047	56	31	50

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

(e) Market Risk

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

Currency Risk

Benalla Health is exposed to insignificant foreign currency risk through its payables relating to purchases of supplies and consumables from overseas. This is because of a limited amount of purchases denominated in foreign currencies and a short timeframe between commitment and settlement.

Interest Rate Risk

Exposure to interest rate risk's arise primarily through the Benalla Health's other financial assets. Minimisation of risk is achieved by mainly holding fixed rate or non-interest bearing financial instruments. For financial assets the Health Service mainly holds financial assets with relatively even maturity profiles.

Cash flow interest rate risk is the risk that the future cash flows of a financial instrument will fluctuate because of changes in market interest rates.

The Health Service has minimal exposure to cash flow interest rate risks through its cash and deposits and term deposits that are at floating rate.

The Health Service manages this risk by mainly undertaking fixed rate or non-interest bearing financial instruments with relatively even maturity profiles, with only insignificant amounts of financial instruments at floating rate. Management has concluded for cash at bank and bank overdraft, as financial assets that can be left at floating rate without necessarily exposing the Health Service to significant bad risk, management monitors movements in interest rates on a daily basis.

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
(e) Market Risk (Continued)
Other Price Risk
The Health Service is exposed to normal price fluctuations from time to time through market forces. Where adequate notice is provided by suppliers, additional purchases are made for long term goods. Supplier contracts are also in place for major product lines purchased by the Health Service on a monthly basis. These contracts have set price arrangements and are reviewed on a regular basis.

Interest Rate Exposure of Financial Assets and Liabilities as at 30 June

	Weighted Average Effective Interest Rate (%)	Carrying Amount	Interest Rate Exposure		
2017			Fixed Interest Rate $'000	Variable Interest Rate $'000	Non - Interest Bearing $'000
Financial Assets					
Cash and Cash Equivalents	1.64	3,456	2,279	1,175	2
Loans and Receivables (i)					
- Trade Debtors		541	0	0	541
- Other Receivables		166	0	0	166
- Term Deposit	1.94	9,145	9,145	0	0
Total Financial Assets		13,308	11,424	1,175	709
Financial Liabilities					
At amortised cost					
Payables (i)		916	0	0	916
Borrowings	4.80	79	79	0	0
Other Financial Liabilities					
- Accommodation Bonds		1,980	0	0	1,980
Total Financial Liabilities		2,975	79	0	2,896
2016					
Financial Assets					
Cash and Cash Equivalents	1.90	4,845	0	4,844	1
Loans and Receivables (i)					
- Trade Debtors		528	0	0	528
- Other Receivables		139	0	0	139
- Term Deposit	2.30	8,529	8,529	0	0
Total Financial Assets		14,041	8,529	4,844	668
Financial Liabilities					
At amortised cost					
Payables (i)		1,307	0	0	1,307
Borrowings	4.80	96	96	0	0
Other Financial Liabilities					
- Accommodation Bonds		2,781	0	0	2,781
Total Financial Liabilities		4,184	96	0	4,088

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
(e) Market Risk (Continued)
Sensitivity Disclosure Analysis
Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, Benalla Health believes the following movements are 'reasonably possible' over the next 12 months (base rates are sourced from the Reserve Bank of Australia).
- A shift of +1% and -1% in market interest rates (AUD) from year-end rates of 3%; and
- A parallel shift of +1% and -1% in inflation rate from year-end rates of 2%.

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

	Carrying Amount	Interest Rate Risk			
		-1%		+1%	
2017	$'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000
Financial Assets					
Cash and Cash Equivalents	3,456	(35)	(35)	35	35
Loans and Receivables					
- Trade Debtors	541	0	0	0	0
- Other Receivables	166	0	0	0	0
- Term Deposit	9,145	(91)	(91)	91	91
Financial Liabilities					
At amortised cost					
Payables	916	0	0	0	0
Borrowings	79	1	1	(1)	(1)
Other Financial Liabilities (i)					
- Monies Held in Trust	1,980	0	0	0	0
		(125)	(125)	125	125
2016					
Financial Assets					
Cash and Cash Equivalents	4,845	(48)	(48)	48	48
Loans and Receivables					
- Trade Debtors	528	0	0	0	0
- Other Receivables	139	0	0	0	0
- Term Deposit	8,529	(85)	(85)	85	85
Financial Liabilities					
At amortised cost					
Payables	1,307	0	0	0	0
Borrowings	96	1	1	(1)	(1)
Other Financial Liabilities (i)					
- Monies Held in Trust	2,781	0	0	0	0
		(133)	(133)	133	133

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(f) Fair Value

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

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

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

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

Comparison between carrying amount and fair value

	Carrying Amount 2017 $'000	Fair Value 2017 $'000	Carrying Amount 2016 $'000	Fair Value 2016 $'000
Financial Assets				
Cash and Cash Equivalents	3,456	3,456	4,845	4,845
Loans and Receivables (i)				
- Trade Debtors	541	541	528	528
- Other Receivables	166	166	139	139
Term Deposits	9,145	9,145	8,529	8,529
Total Financial Assets	**13,308**	**13,308**	**14,041**	**14,041**
Financial Liabilities				
At amortised cost				
Payables	916	916	1,307	1,307
Borrowings	79	79	96	96
Other Financial Liabilities (i)				
- Monies Held in Trust	1,980	1,980	2,781	2,781
Total Financial Liabilities	**2,975**	**2,975**	**4,184**	**4,184**

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

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 Benalla Health activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 Financial Instruments: Presentation. For example, statutory receivables arising from taxes, fines and penalties do not meet the definition of financial instruments as they do not arise under contract.

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

The following refers to financial instruments unless otherwise stated.

Categories of non-derivative financial instruments

Reclassification of financial instruments at fair value through profit or loss

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

Loans and receivables

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

Loans and receivables category includes cash and deposits (refer to Note 6.2), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

Held-to-maturity investments

If the Health Service has the positive intent and ability to hold nominated investments to maturity, then such financial assets may be classified as held-to-maturity. Held-to-maturity financial assets are recognised initially at fair value plus any directly attributable transaction costs. Subsequent to initial recognition held-to-maturity financial assets are measured at amortised cost using the effective interest rate method, less any impairment losses.

The Health Service makes limited use of this classification because any sale or reclassification of more than an insignificant amount of held-to-maturity investments not close to their maturity, would result in the whole category being classified as available-for-sale. The Health Service would also be prevented from classifying investment securities as held-to-maturity for the current and the following financial years.

The held-to-maturity category includes certain term deposits and debt securities for which the Health Service concerned intends to hold to maturity.

Reclassification of available-for-sale financial assets

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

Financial Liabilities at amortised cost

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

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

Net Gain/(Loss) on Financial Instruments

Net gain/(loss) on financial instruments includes:

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

NOTE 7.2: NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS	2017 $'000	2016 $'000
Proceeds from Disposal of Non-Current Assets		
- Medical Equipment	0	40
- Plant and Equipment	125	75
- Investment Properties	270	0
Total Proceeds from Disposal of Non-Current Assets	395	115
Less: Written Down Value of Non-Current Assets Sold		
- Medical Equipment	(5)	(16)
- Plant and Equipment	(95)	(68)
- Investment Properties	(265)	0
Total Written Down Value of Non-Current Assets Sold	(365)	(84)
NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS	30	31

Disposal of Non-Financial Assets
Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement. Refer to Note 8.1 - 'comprehensive income".

Impairment of Non-Financial Assets
Goodwill and intangible assets with indefinite lives (and intangible assets not yet available for use) are tested annually for impairment (as described below) and whenever there is an indication that the asset may be impaired.

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

- inventories;
- investment properties that are measured at fair value,
- non-current physical assets held for sale; and
- assets arising from construction contracts.

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

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

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

NOTE 7.3: CONTINGENT ASSETS AND CONTINGENT LIABILITIES

Details of estimates of maximum amounts of Contingent Assets or Contingent Liabilities are as follows:

Contingent Assets	2017	2016
Quantifiable	$'000	$'000
Dividends from the liquidation of Lehman Brothers Australia	47	60
Total Quantifiable Contingent Assets	47	60
Contingent Liabilities		
Quantifiable		
Success fee paid on any dividends received from the liquidation of Lehman Brothers Australia	5	6
Total Quantifiable Contingent Liabilities	5	6

Non-Quantifiable
Nil

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

NOTE 7.4: FAIR VALUE DETERMINATION

Asset Class	Examples of types of assets	Expected fair value level	Likely valuation approach	Significant inputs (Level 3 only)
Non-specialised land	In areas where there is an active market: - vacant land - land not subject to restrictions as to use or sale	Level 2	Market approach	N/A
Specialised land	Land subject to restrictions as to use and/or sale Land in areas where there is not an active market	Level 3	Market approach	CSO adjustments
Non-specialised buildings	For general/commercial buildings that are just built	Level 2	Market approach	N/A
Specialised buildings [(i)]	Specialised buildings with limited alternative uses and/or substantial customisation e.g. prisons, hospitals, and schools	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Plant and equipment [(i)]	Specialised items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Vehicles	If there is an active resale market available;	Level 2	Market approach	N/A
	If there is no active resale market available	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life

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

NOTE 8: OTHER DISCLOSURES

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

Structure

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

NOTE 8.1: EQUITY	2017 $'000	2016 $'000
(a) Surpluses		
Property, Plant and Equipment Revaluation Surplus [1]		
Balance at beginning of the reporting period		
- Land	413	413
- Buildings	14,195	14,195
Revaluation Increment / (Decrement)		
- Land	0	0
- Buildings	0	0
Balance at the end of the reporting period	14,608	14,608
Represented by:		
- Land	413	413
- Buildings	14,195	14,195
	14,608	14,608

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

General Purpose Surplus		
Balance at beginning of the reporting period	399	399
Transfer to and (from) General Surplus	16	0
Balance at the end of the reporting period	415	399
Restricted Specific Purpose Surplus		
Balance at beginning of the reporting period	109	491
Transfer to and (from) Restricted Specific Purpose Surplus	(59)	(382)
Balance at the end of the reporting period	50	109
Total Surpluses	15,073	15,116
(b) Contributed Capital		
Balance at the beginning of the reporting period	13,293	13,293
Balance at the end of the reporting period	13,293	13,293
(c) Accumulated Deficits		
Balance at the beginning of the reporting period	(392)	(945)
Net Result for the Year	(608)	171
Transfer (to)/from General Reserve	59	0
Transfer (to)/from Restricted Specific Purpose Surplus	(16)	382
Balance at the end of the reporting period	(957)	(392)
Total Equity at end of financial year	27,409	28,017

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

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

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

General Purpose Surplus
These reserves are generated from internally funded activities and allocated to reserve at the discretion of the board of management.

NOTE 8.1: EQUITY (Continued)

Restricted Specific Purpose Surplus

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

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

	2017 $'000	2016 $'000
NET RESULT FOR THE PERIOD	(608)	171
Non-cash movements		
Depreciation and Amortisation	2,174	2,164
Net (Gain)/Loss from Revaluation of Investment Properties	0	(10)
Movement in Provision for Doubtful Debts	(3)	0
Movements included in investing and financing activities		
Net (Gain)/Loss from Disposal of Non-Financial Physical Assets	(30)	(31)
Recoveries from Impaired Financial Assets	(13)	(371)
Movements in assets and liabilities		
Change in Operating Assets and Liabilities		
(Increase)/Decrease in Receivables	(342)	89
(Increase)/Decrease in Prepayments	(15)	16
(Increase)/Decrease in Inventory	(9)	13
Increase/(Decrease) in Payables	(376)	414
Increase/(Decrease) in Employee Benefits	(120)	363
Increase/(Decrease) in Other Liabilities	0	1,329
NET CASH INFLOW FROM OPERATING ACTIVITIES	**658**	**4,147**

NOTE 8.3: OPERATING SEGMENTS

	RACS		ACUTE & OTHER		TOTAL	
	2017	2016	2017	2016	2017	2016
	$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
REVENUE						
External Segment Revenue	3,308	3,661	25,304	24,505	28,612	28,166
Total Revenue	**3,308**	**3,661**	**25,304**	**24,505**	**28,612**	**28,166**
EXPENSES						
External Segment Expenses	(4,275)	(4,487)	(25,198)	(23,773)	(29,473)	(28,260)
Total Expenses	(4,275)	(4,487)	(25,198)	(23,773)	(29,473)	(28,260)
Net Result from ordinary activities	(967)	(826)	106	732	(861)	(94)
Interest Income	29	30	224	235	253	265
Net Result for Year	**(938)**	**(796)**	**330**	**967**	**(608)**	**171**
OTHER INFORMATION						
Segment Assets	3,787	4,383	31,342	32,668	35,129	37,051
Unallocated Assets	0	0	0	0	0	0
Total Assets	**3,787**	**4,383**	**31,342**	**32,668**	**35,129**	**37,051**
Segment Liabilities	1,980	2,502	5,740	6,532	7,720	9,034
Unallocated Liabilities	0	0	0	0	0	0
Total Liabilities	**1,980**	**2,502**	**5,740**	**6,532**	**7,720**	**9,034**
Acquisition of property, plant and equipment and intangible assets	0	21	1,021	1,394	1,021	1,415
Depreciation & amortisation expense	0	361	2,174	1,803	2,174	2,164
Non cash expenses other than depreciation	0	0	21	0	21	0

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

Business Segments	**Services**
Acute	Provider of hospital and community health services
Residential Aged Care (RACS)	Provider of residential aged care beds

Geographical Segment

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

NOTE 8.4: RESPONSIBLE PERSON DISCLOSURES

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

	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	01/07/2016 - 30/06/2017
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	01/07/2016 - 30/06/2017
Governing Boards	
C. Ross	01/07/2016 - 30/06/2017
B. Smith	01/07/2016 - 30/06/2017
L. Armstrong	01/07/2016 - 30/06/2017
K. Scanlon	01/07/2016 - 30/06/2017
L. McCoy	01/07/2016 - 30/06/2017
D. Elford	01/07/2016 - 13/01/2017
R. Wright	01/07/2016 - 30/06/2017
D. O'Brien	01/07/2016 - 30/06/2017
N. McGrath	01/07/2016 - 30/06/2017
L. Marta	01/07/2016 - 30/06/2017
Dr V. Wadhwa	06/09/2016 - 30/06/2017
Accountable Officers	
J. Holland (Chief Executive Officer)	01/07/2016 - 30/06/2017

Remuneration of Responsible Persons

Remuneration received or receivable by responsible persons was in the range: $240,000 - $249,999 ($270,000 - 279,999 in 2015-16).

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

Refer to Note 8.6 for further analysis of remuneration and transactions with Key Management Personnel.

NOTE 8.5: EXECUTIVE OFFICER DISCLOSURES

Remuneration of executives

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

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

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

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

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

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

Share-based payments are cash or other assets paid or payable as agreed between the health service and the employee, provided specific vesting conditions, if any, are met.

Remuneration of executive officers	**Total Remuneration**	
	2017 $'000	**2016(a) $'000**
Short-term employee benefits	394	
Post-employment benefits	36	
Other long-term benefits	12	
Termination benefits	0	
Share-based payments	0	
Total Remuneration (b)	442	
Total Number of executives (c)	4	4
Total annualised employee equivalent (AEE) (d)	4	4

Notes:

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

(b) Remuneration represents the expenses incurred by the entity in the current reporting period for the employee, in accordance with AASB 119 Employee benefits

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

(d) Annualised employee equivalent is based on the time fraction worked over the reporting period. This is calculated as the total number of days the employee is engaged to work during the week by the total number of full-time working days per week (this is generally five full working days per week).

NOTE 8.6: RELATED PARTIES

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

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

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

Key management personnel (KMP) of the hospital include the Portfolio Ministers and Cabinet Ministers and KMP as determined by the hospital. The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The Minister's remuneration and allowances is set by the *Parliamentary Salaries and Superannuation Act 1968,* and is reported within the Department of Parliamentary Services' Financial Report.

Key management personnel consist of responsible ministers, the board of management and accountable officers as detailed in Note 8.4.

COMPENSATION	2017 $'000
Short term employee benefits	226
Post-employment benefits	18
Other long-term benefits	5
Termination benefits	0
Share based payments	0
Total	**249**

Transactions with key management personnel and other related parties

Given the breadth and depth of State government activities, related parties transact with the Victorian public sector in a manner consistent with other members of the public e.g. stamp duty and other government fees and charges. Further employment of processes within the Victorian public sector occur on terms and conditions consistent with the *Public Administration Act 2004* and Codes of Conduct and Standards issued by the Victorian Public Sector Commission.

Procurement processes occur on terms and conditions consistent with the Victorian Government Procurement Board requirements. Outside of normal citizen type transactions with the department, there were no related party transactions that involved key management personnel and their close family members. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

Other Transactions of Responsible Persons and their Related Parties	**2017 $'000**	**2016 $'000**
B. Smith is a partner in Smith Dosser Accountants; and L. Armstrong and N. McGrath are employees of Smith Dosser Accountants. Smith Dosser provides financial and accounting services to the health service on normal commercial terms and conditions.	2	7
L. Marta is a partner in AMCAL Benalla Pharmacy. The health service purchases pharmaceutical supplies from the AMCAL pharmacy on normal commercial terms and conditions.	9	9

Significant transactions with government-related entities

Benalla Health received funding from the Department of Health and Human Services of $21,433,101 (2016: $21,597,482).

NOTE 8.7: PAYMENTS TO OTHER PERSONNEL

(i.e. Contractors with significant management responsibilities)

	2017 No.	**2016 No.**
Expense Band		
$10,000 - $19,999	0	1
	$'000	**$'000**
Total Expenses (exclusive of GST)	0	11

In accordance with FRD 21C the following disclosures are made in relation to other personnel of Benalla Health, i.e. contractors charged with significant management responsibilities.

Payments have been made to contractors with significant management responsibilities, which are disclosed with the $10,000 expense bands. These contractors are responsible for planning, directing or controlling (directly or indirectly) activities of the Health Service.

Note 8.8: REMUNERATION OF AUDITORS

	2017 $'000	2016 $'000
Victorian Auditor-General's Office		
Audit or review of financial statement	20	20
	20	20
Other Providers		
Internal Audit Services	27	36
	27	36

NOTE 8.9: AASBs ISSUED THAT ARE NOT YET EFFECTIVE

Certain new Australian accounting standards have been published that are not mandatory for 30 June 2017 reporting period. DFT assesses the impact of all these new standards and advises Benalla Health of their applicability and early adoption where applicable.

As at 30 June 2017, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. Benalla Health has not and does not intend to adopt these standards early.

Standard / Interpretation	**Summary**	**Applicable for reporting periods beginning on**	**Impact on Health Service's Annual Statements**
AASB 9 *Financial Instruments*	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1 January 2018	While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.
AASB 2010-7 *Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)*	The requirements for classifying and measuring financial liabilities were added to AASB 9. The existing requirements for the classification of financial liabilities and the ability to use the fair value option have been retained. However, where the fair value option is used for financial liabilities the change in fair value is accounted for as follows: - The change in fair value attributable to changes in credit risk is presented in other comprehensive income (OCI); and - Other fair value changes are presented in profit and loss. If this approach creates or enlarges an accounting mismatch in the profit or loss, the effect of the changes in credit risk are also presented in profit or loss.	1 January 2018	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals.

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

Standard / Interpretation	**Summary**	**Applicable for reporting periods beginning on**	**Impact on Health Service's Annual Statements**
AASB 15 *Revenue from Contracts with Customers*	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1 January 2018	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications. A potential impact will be the upfront recognition of revenue from licenses that cover multiple reporting periods. Revenue that was deferred and amortised over a period may now need to be recognised immediately as a transitional adjustment against the opening returned earnings if there are no former performance obligations outstanding.
AASB 2014‑1 *Amendments to* Australian Accounting Standards *[Part E Financial Instruments]*	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	1 January 2018	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2014-7 *Amendments to Australian Accounting Standards arising from AASB 9*	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1 January 2018	The assessment has indicated there will be no significant impact for the public sector.
AASB 2016-8 Amendments to Australian Accounting Standards - Effective Date of AASB 15	This standards defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1 January 2018	This amending standard will defer the application period of AASB 15 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of most operating leases (which are currently not recognised) on balance sheet.	1 January 2019	The assessment has indicated that as most operating leases will come on balance sheet, recognition of lease assets and lease liabilities will cause net debt to increase. Depreciation of lease assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. The amounts of cash paid for the principal portion of the lease liability will be presented within financing activities and the amounts paid for the interest portion will be presented within operating activities in the cash flow statement. No change for lessors.

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

Standard / Interpretation	**Summary**	**Applicable for reporting periods beginning on**	**Impact on Health Service's Annual Statements**
AASB 2015-8 Amendments to Australian Accounting Standards - Effective Date of AASB 15	This standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1 January 2018	This amending standard will defer the application period of AASB 15 to the 2018-19 reporting period.
AASB 2016-7 Amendments to Australian Accounting Standards - Deferral of AASB 15 for Not-for-Profit Entities	This standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019	1 January 2019	This amending standard will defer the application period of AASB 15 to the 2018-19 reporting period.
AASB 1058 Income of Not-for-Profit Entities	This Standard will replace AASB 1004 *Contributions* and establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objectives	1 January 2019	The impact of this Standard is yet to be fully assessed.

NOTE 8.10: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

Assets, liabilities, income or expenses arise from past transactions or other past events. Where the transactions result from an agreement between the Health Service and other parties, the transactions are only recognised when the agreement is irrevocable at or before the end of the reporting period.

Adjustments are made to amounts recognised in the financial statements for events which occur between the end of the reporting period and the date when the financial statements are authorised for issue, where those events provide information about conditions which existed at the reporting date. Note disclosure is made about events between the end of the reporting period and the date the financial statements are authorised for issue where the events relate to conditions which arose after the end of the reporting period that are considered to be of material interest.

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

NOTE 8.11: ALTERNATIVE PRESENTATION OF COMPREHENSIVE OPERATING STATEMENT	**2017 $'000**	**2016 $'000**
Grants		
Operating	23,477	22,529
Capital	498	592
Interest	253	265
Sales of goods and services	1,689	1,889
Other income	2,918	3,125
Revenue from Transactions	**28,835**	**28,400**
Employee expenses	18,213	16,964
Depreciation and amortisation	2,174	2,164
Other operating expenses	9,188	9,132
Expenses from Transactions	**29,575**	**28,260**
Net Result From Transactions	**(740)**	**140**
Other economic flows included in net result		
Net gain/ (loss) on sale of non-financial assets	30	31
Other gains/ (losses) from other economic flows included in net result	102	0
Total Other Economic Flows Included in Net Result	132	31
NET RESULT FOR THE YEAR	**(608)**	**171**