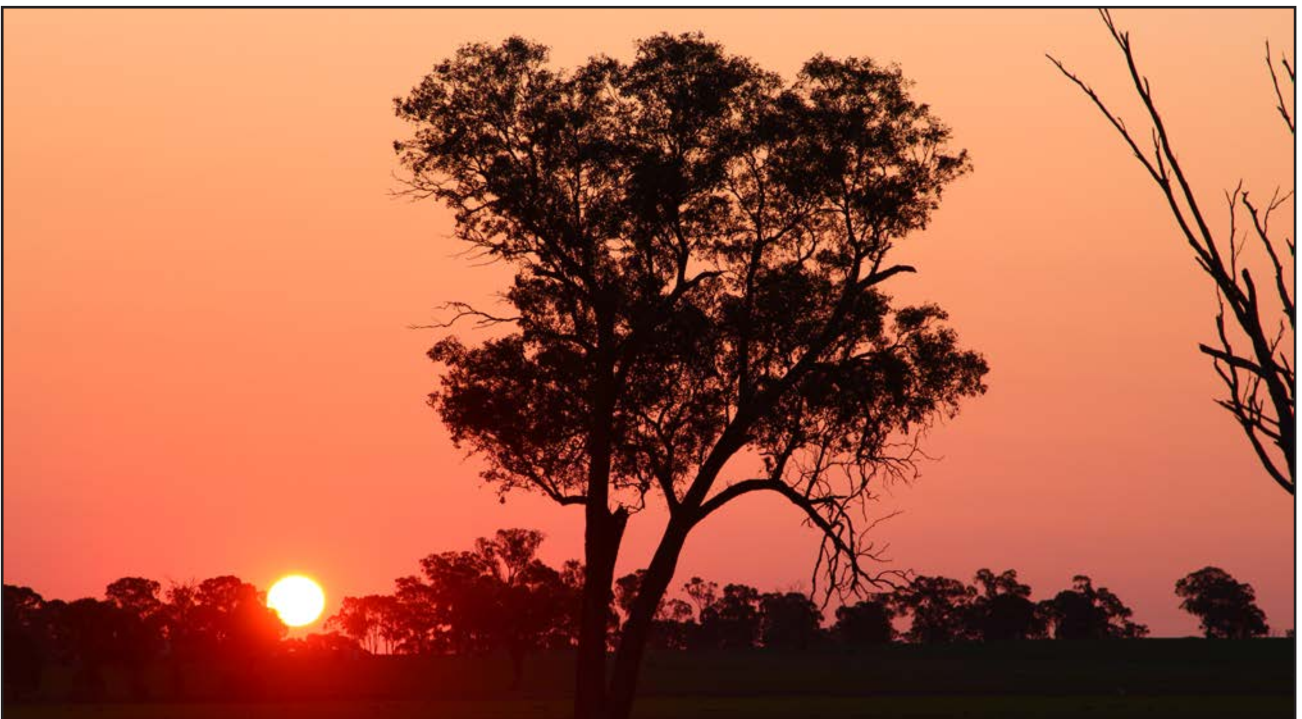
Benalla HEALTH

2017-2018
Annual Report



FRONT COVER: Goorambat sunset, taken September 2018, by Julie Harrison

Julie Harrison has worked in the catering department at Benalla Health since 2001.

When Julie isn't working here, she is out and about with her camera, a trait she and her brother obviously inherited from their late photographer father.

Others see an old fallen tree in a paddock and think no more of it, Julie perceives it as a beautiful image. She credits this to having the 'third eye'.

'The third eye is a mystical and esoteric concept of a speculative invisible eye which provides perception beyond sight -' Wikipedia'.

Julie's images, put on to canvas, can often be found on the walls at Benalla Health.

Contents

PART 1: Report of Operations

Disclosure Index p.5

History p.6

Registered Objectives p.6

Chairman and Chief Executive Officer's Report p.7

Corporate Governance – Board p.10

Board of Management p.12

Organisational Structure p.14

Executive Team p.15

Committee Structure p.16

Five Year Performance p.17

Compliance p.18

Key Financial and Service Performance Reporting

- Part A: Strategic Priorities p.19
- Part B: Performance Priorities p.22
- Part C: Activity and Funding p.24

Statutory Reporting p.25

Quality and Safety Performance p.27

Occupational Health and Safety p.28

Hospital Auxiliary p.29

Benalla Health Services p.31

Senior Staff List p.32

Visiting Medical Officers p.33

PART 2: Financial Statements

2017-2018 Financial Statements . . . . . from P.34

Premier's Medium Health Service of the Year

Benalla Health 45-63 Coster Street, Benalla, Victoria 3672, Australia

Phone: (03) 5761 4222 | Fax: (03) 5761 4246 | PO Box 406, Benalla Vic 3671

ABN 96 078 399 891

PART 1

2017-2018

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.

Legislation	Requirement	Page Reference
MINISTERIAL DIRECTIONS		
REPORT OF OPERATIONS		
Charter and purpose		
FRD 22H	Manner of establishment and the relevant Ministers	Part 1-6,11
FRD 22H	Purpose, functions, powers and duties	Part 1-6
FRD 22H	Initiatives and key achievements	Part 1-7,8, 9
FRD 22H	Nature and range of services provided	Part 1-31
Charter and purpose		
FRD 22H	Organisational structure	Part 1-14
Financial and other information		
FRD 10A	Disclosure index	Part 1-5
FRD 11A	Disclosure of ex-gratia expenses	N/A
FRD 21C	Responsible person and executive officer disclosures	Part 2-78,79
FRD 22H	Application and operation of Protected Disclosure 2012	Part 1-25
FRD 22H	Application and operation of Carers Recognition Act 2012	Part 1-25
FRD 22H	Application and operation of Freedom of Information Act 1982	Part 1-25
FRD 22H	Compliance with building and maintenance provisions of Building Act 1993	Part 1-25
FRD 22H	Details of consultancies over $10,000	Part 1-17
FRD 22H	Details of consultancies under $10,000	Part 1-17
FRD 22H	Employment and conduct principles	Part 1-26
FRD 22H	Information and Communication Technology Expenditure	Part 1-17
FRD 22H	Major changes or factors affecting performance	Part 1-7,8, 9
FRD 22H	Occupational violence	Part 1-28
FRD 22H	Operational and budgetary objectives and performance against objectives	Part 1-19-24
FRD 22H	Summary of the entity's environmental performance	Part 1-26
FRD 22H	Significant changes in financial position during the year	Part 17
FRD 22H	Statement on National Competition Policy	Part 1-26
FRD 22H	Subsequent events	Part 2-84
RD 22H	Summary of the financial results for the year	Part 1-17
FRD 22H	Additional information available on request	Part 1-26
FRD 22H	Workforce Data Disclosures including a statement on the application of employment and conduct principles	Part 1-26,27, 28
FRD 25C	Victorian Industry Participation Policy disclosures	Part 1-25
FRD 103F	Non-Financial Physical Assets	Part 2-39
FRD 110A	Cash flow Statements	Part 2-41
FRD 112D	Defined Benefit Superannuation Obligations	Part 2-53
SD 5.1.4	Financial Management Compliance Attestation	Part 1-18
SD 5.2.3	Declaration in report of operations	Part 1-9
Other requirements under Standing Directions 5.2		
SD 5.2.2	Declaration in financial statements	Part 2-35
SD 5.2.1(a)	Compliance with Australian accounting standards and other authoritative pronouncements	Part 2-35
SD 5.2.1(a)	Compliance with Ministerial Directions	Part 2-35
LEGISLATION		
Freedom of Information Act 1982		Part 1-25
Protected Disclosure Act 2012		Part 1-25
Carers Recognition Act 2012		Part 1-25
Victorian Industry Participation Policy Act 2003		Part 1-25
Building Act 1993		Part 1-25
Financial Management Act 1994		Part 1-9,18
Safe Patient Care Act 2015		Part 1-26

History

A 10-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 service 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;
    - rehabilitation.

The 1935 Nursing Hospital which contained six ward beds, four emergency beds, an x-ray plant and operating theatre. The building cost approximately 4000 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 2017-18 Annual Report for Benalla Health.

The achievements of Benalla Health during the 2017-18 year, outlined in this report, would not have been possible without the dedicated commitment of all staff, the medical workforce and our esteemed volunteers.

We would like to publically acknowledge the leadership of the Board of Management who act in a voluntary capacity. The time that all members devote to their important stewardship role is sincerely appreciated. One of our highly regarded Board members retired this year. Dennis O'Brien served on the Board for 3 years and his contributions during this time were invaluable.

After 8½ years of providing stable Executive Leadership to the Community Health division, Neil Stott tendered his resignation to pursue other professional opportunities. The Board would like to truly thank Neil for the excellent community health outcomes that were achieved during his tenure at Benalla Health. We wish him all the very best with his future endeavours.

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 participated in an organisation wide survey against the 10 National Standards in July 2017. We were delighted to achieve full compliance with all of the 256 actions and therefore maintained our accreditation.

Two senior staff members, Sue Wilson and Beverley Butler-Mack attended the international Studer leadership conference, which was convened in the USA during July/August 2017. The Board received a formal presentation from both staff members highlighting lessons learned and ideas for consideration.

We were thrilled to receive the Premier's Award for Medium Health Service of the Year, on the 26th October 2017, for our outstanding performance in 2016-17. This public recognition is a direct reflection of the outstanding care that all our staff and Visiting Medical Officers provide to the community we are privileged to serve.

The Staff Excellence Awards were presented at the Annual General Meeting, which was held on the 22nd November 2017. The following staff members were nominated by their peers and received due recognition for their superb performance during the 2016-17 financial year:

- Joda Plex (UCC), Excellence in Leadership
- The Engineering Department represented by Steve Grubissa, Excellence in Innovation and Sustainability
- Cris Pianta and Julie James (MEW), Excellence in Consumer Care and Engagement
- Tamarine Tuesley (Education Dept), Excellence in Quality Service

Benalla Health in partnership with the local community demonstrated once again its enduring commitment to reducing family violence in our community. The 8th Annual 'March against Violence' was held on White Ribbon Day on the 23rd November 2017. We were very pleased that around 600 people attended the March which exceeded last year's numbers. Benalla P-12 and FCJ College were well represented on this day.

We also completed the refurbishment of the Community Rehabilitation Centre (CRC). A successful community open day was held on the 29th November 2017. The CRC is supporting our talented staff to deliver evidence based rehabilitation programs for people living with chronic and complex diseases.

An enjoyable Christmas breakfast was held for all staff and volunteers on the 20th December 2017 with the event being well attended. This is just one way in which we can publically recognise our highly valued staff and volunteers 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.

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.

We also collaborated 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.

A sustained and concerted effort has resulted in our maternity services being strengthened and we are extremely pleased 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 ongoing 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.

The preliminary planning phase for the major capital works program for Morrie Evans Wing commenced in December 2017. Browns Wangaratta commenced building works in March 2018. The anticipated end date for the building works is January 2019. We are very much looking forward to continuing to provide exceptional aged care in a home like environment, which facilitates resident dignity and privacy. Our community deserves nothing less than this.

On the 18th April 2018, the Australian Aged Care Quality Agency undertook a review of our Home Nursing and Allied Health services. We achieved full compliance with all of the 18 expected outcomes, which was a wonderful achievement.

We were delighted to host a visit for The Hon. Jill Hennessy MP. Minister for Health, Minister for Ambulance Services, on the 20th April 2018. Minister Hennessy announced that Benalla Health will be receiving $200,000 through round 2 of the Regional Health Infrastructure Fund initiative. This significant amount of funding will enable us to upgrade our soluscope and drying equipment in the Theatre complex.

Staff also participated in a re-accreditation survey for Morrie Evans Wing on the 15th and 16th May 2018. Once again, full compliance was achieved with all of the 44 expected outcomes.

Our outstanding accreditation results are reflective of the leadership and commitment of the Quality and Risk department and the respective NUMs. Recognition is also extended to all clinical and non-clinical staff who were involved with this important compliance work.

Seven valued staff members attended the Studer Conference in Sydney on 22nd and 23rd May. Positive feedback was received with staff keen to implement more Studer initiatives to improve the health outcomes of our community.

We also supported Kim Woosnam to participate in the Alpine Valleys Community Leadership Program. All in attendance enjoyed her graduation evening, which was held on the 24th May.

We have zero tolerance for occupational violence and we are committed to ensuring that our staff, patients, their loved ones, visitors and volunteers are protected. To this end we have completed significant security upgrades throughout the health service.

Our impact on our environment is decreasing each year. We take great pride in the outcomes we have achieved which are highlighted later on in this report.

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

- GE Patient Monitors x2
- Omega Electric Lift Recliner
- Trauma Stretchers x2
- Rauland Duress System
- Olympus Flexible Cytoscopes x3
- Philips Heartstart XL and Defibrillator Monitor
- Examination Light
- Steam Cleaning Unit

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 confirms the excellent care that is consistently provided by our dedicated staff.

As in previous years, Benalla Health received terrific support from the Benalla and District Memorial Hospital Auxiliary, Community groups and individuals who 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 esteemed volunteers and the extra equipment we purchased through donations is greatly appreciated. We genuinely thank everyone for all their sustained efforts.

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

Louise Armstrong
Board Chair

Janine Holland
Chief Executive Officer

In accordance with the Financial Management Act 1994, I am pleased to present the report of operations for Benalla Health for the year ending 30 June 2018.

Louise Armstrong
Board Chair
Benalla, 23 August 2018

Corporate Governance - Board

The organisation is governed by a 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
- 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.

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 four times 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 as required.

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.

Community Advisory 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
- 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

Louise Armstrong

BInfoTech(InfoSys), GCertMgt(ProfPrac), MAICD

Committee Membership

- Quality and Safety
- Medical Consultative (Chairman)
- Appointments (Chairman)

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 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, BAppSci (Val), DipAcc

Committee Membership

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

David is 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 NSW. 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.

VICE CHAIRMAN

Kim Scanlon

Dip Teaching (Primary), Grad Dip Outdoor Education GAICD

Committee Membership

- Quality and Safety
- Medical Consultative
- Appointments

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, and the Benalla Young Sportsperson Trust and the Winton Wetlands Committee of Management.

VICE CHAIRMAN

Catherine Ross

Bachelor of Applied Science Agribusiness

Committee Membership

- Audit
- Community Advisory

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.

Board of Management (cont.)

Lisa Marta
BPharm, MPS, AACPA
Committee Membership

- Quality and Safety (Chairman)
- Community Advisory

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.

Dr Vikas Wadhwa
MBBS, FRACP, MBA
Committee Membership

- Audit
- Quality and Safety
- Medical Consultative
- Appointments

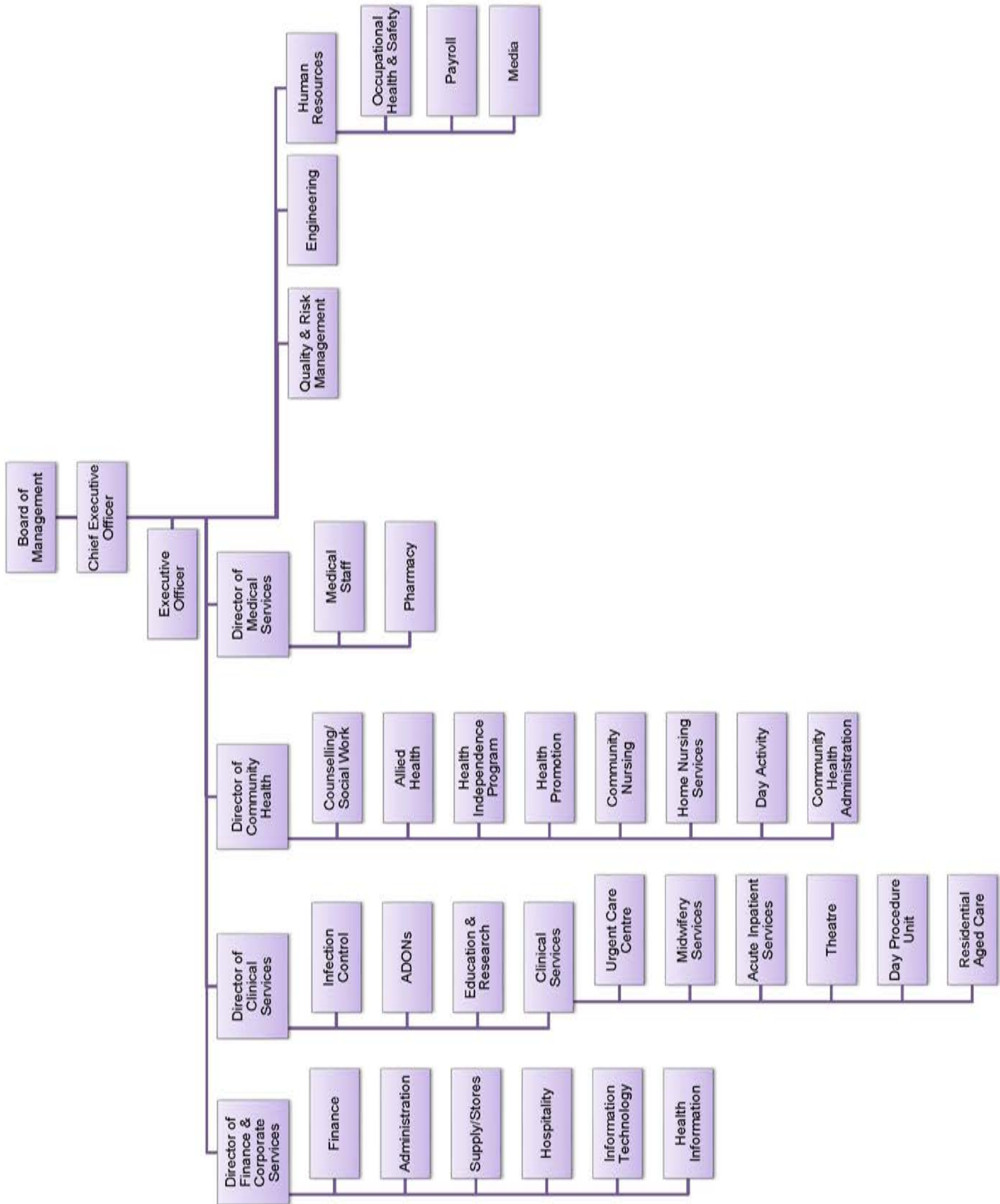
Vikas is a consultant physician in Internal Medicine, Respiratory and Sleep Disorders and is Director of General Medicine at Maroondah Hospital, Eastern Health with responsibility for work force leadership, training and mentoring. He is an active member of several expert advisory committees at Eastern 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.

Dennis O'Brien
BScAg, Uni of Sydney; MSc, Uni of Manitoba, Canada; PhD, Oregon State Uni, USA
Committee Membership

- Community Advisory
- Audit

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 appointed 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. Dennis resigned from the Board on 30th June 2018.

Organisational Structure



Executive Team

CHIEF EXECUTIVE OFFICER

Janine Holland

RN, RM, B HSc, Grad Cert HSM, MPH, ACHS Surveyor, GAICD

The Chief Executive Officer is responsible to the Board of Management for the efficient and effective management of the Health Service. Key responsibilities include the development and implementation of operational and strategic planning maximising service efficiency, quality improvement and minimisation of risk.

DIRECTOR OF CLINICAL SERVICES

Dr Sue Wilson

RN, Paed Cert, Grad Dip Psych Nsg, BA, BSc, Grad Dip Ed, MEd, PhD

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

DIRECTOR OF FINANCE AND CORPORATE SERVICES

Andrew Nitschke

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

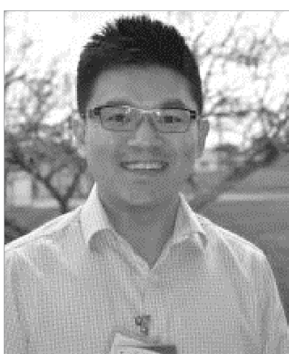
The Director of Finance & Corporate Services (DF&CS) is responsible for the finance and administration, supply, linen and hospitality departments. The DF&CS provides leadership in the management of financial and corporate support services.

DIRECTOR OF COMMUNITY HEALTH

Neil Stott

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

The Director of Community Health is responsible for a range of allied health, nursing, palliative care, rehabilitation/chronic disease management and health promotion services and programs.



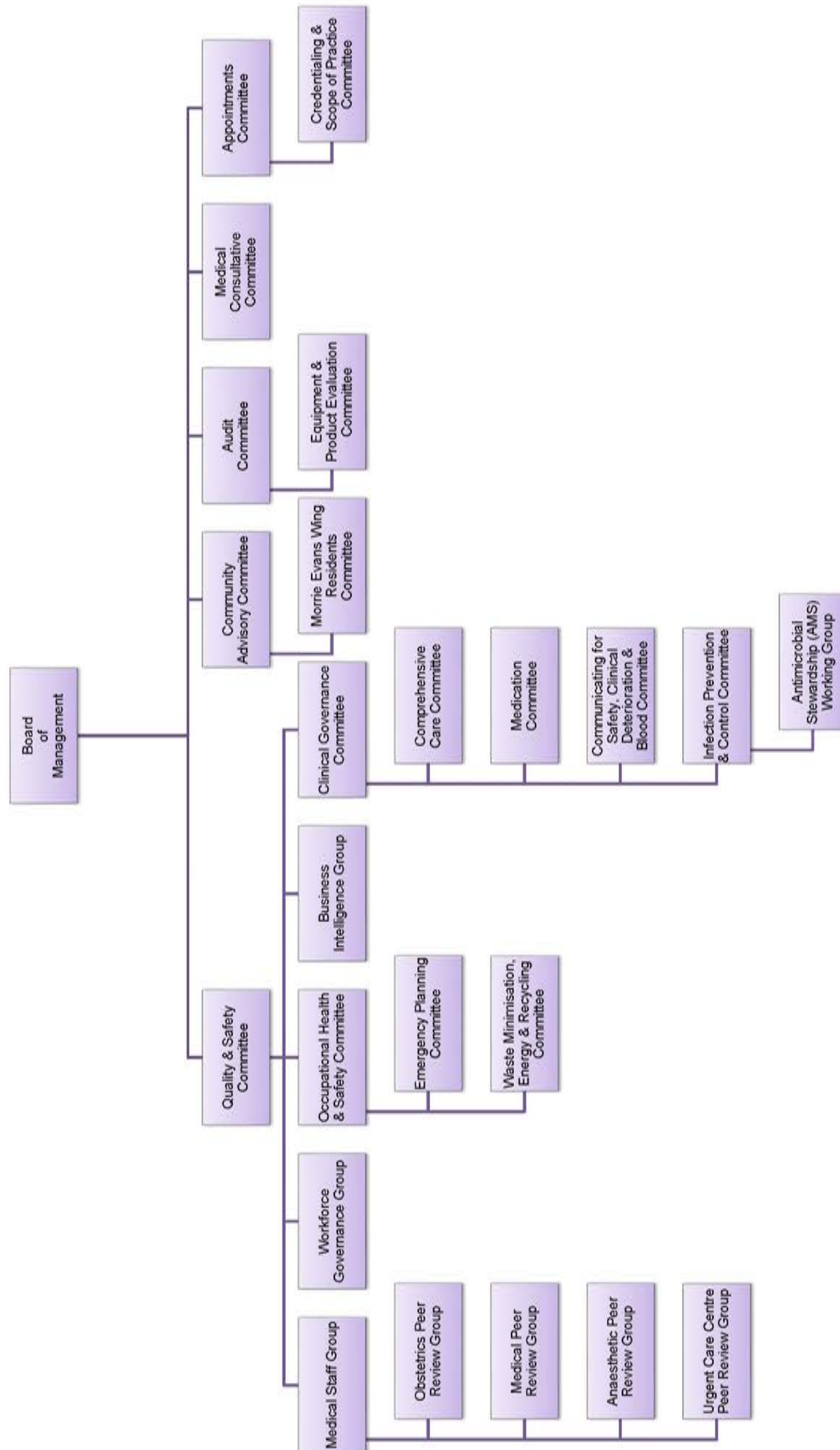
DIRECTOR OF MEDICAL SERVICES

Dr Ken Cheng

MBBS, BMedSc (Hons) Melb Uni, MBA, MCommerce

The Director of Medical Services involves liaison with visiting specialist and GP doctors 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



Five Year Performance

5 YEAR FINANCIAL COMPARISON	2018 $000	2017 $000	2016 $000	2015 $000	2014 $000
Total Revenue	32,228	28,865	28,431	27,388	25,679
Total Expenses	30,763	29,473	28,260	28,339	27,043
Net Result for the Year (inc. Capital and Specific Items)	**1,465**	**(608)**	**171**	**(951)**	**(1,364)**
Retained Surplus (Accumulated Deficit)	**473**	**(957)**	**(392)**	**(945)**	**(22)**
Total Assets	36,653	35,129	37,051	34,797	36,536
Total Liabilities	7,779	7,720	9,034	6,951	7,739
Net Assets	**28,874**	**27,409**	**28,017**	**27,846**	**28,797**
Total Equity	**28,874**	**27,409**	**28,017**	**27,846**	**28,797**

Consultancies

In 2017-18 there were no consultancies where the total fees payable to the consultants were less than $10,000 (excluding GST). There were no consultancies where the total fees payable to the consultants were $10,000 (excluding GST) or greater.

Information and communication technology (ICT)

The total ICT expenditure incurred during 2017-18 is $1.227m (excl. GST) with the details shown below:

Business As Usual (BAU) ICT expenditure	Non-Business As Usual (non-BAU) ICT Expenditure		
Total (excluding GST) (million)	Total = Operational expenditure and Capital Expenditure (excluding GST)	Operational expenditure (excluding GST) (million)	Capital expenditure (excluding GST) (million)
0.878	0.349	0	0.349

Compliance

There are a number of specific compliance requirements that health services must meet and declare during the course of operations. Accordingly, the following attestations are made:

Data Integrity

I, Janine Holland certify that Benalla Health has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. Benalla Health has critically reviewed these controls and processes during the year

Janine Holland, Chief Executive Officer
Accountable Officer
Benalla, 23 August 2018

Conflict of Interest

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

Janine Holland, Chief Executive Officer
Accountable Officer
Benalla, 23 August 2018

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 Services Act 1988 (Vic) and has critically reviewed these controls and processes during the year.

Janine Holland, Chief Executive Officer
Accountable Officer
Benalla, 23 August 2018

Ministerial Standing Direction 5.1.4(C) Financial Management

I, David Elford, on behalf of Benalla Health, certify that Benalla Health has complied with the applicable Standing Directions of the Minister for Finance under the Financial Management Act 1994 and instructions.

David Elford
Board Treasurer, Benalla Health
Benalla, 23 August 2018

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.

	Goals	Strategies	Health Service Deliverables	Outcomes
Better Health	A system geared to prevention as much as treatment. Everyone understands their own health and risks. Illness is detected and managed early. Healthy neighbourhoods and communities encourage healthy lifestyles.	• Reduce statewide risks • Build healthy neighbourhoods • Help people to stay healthy • Target health gaps	Benalla Health will continue to strengthen its strategic partnerships with Benalla Family Violence Prevention Network, White Ribbon Australia, Centre Against Violence and other victim support agencies.	**Achieved** Strategic partnerships with Benalla Family Violence Prevention Network, White Ribbon Australia, Centre Against Violence and other victim support agencies have and continue to be strengthened.
			The whole of community place based Family Violence Prevention Strategy will continue 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 the Respectful Relationships in Schools Program.	**Achieved** Health Promotion Plan 2017/2021 will continue to focus on Family Violence prevention initiatives until June 2019. Collective Impact Plan finalised and submitted to the Department of Health and Human Services.
			Benalla Health will partner with Northeast Health Wangaratta to fully implement The Royal Women's Hospital Family Violence Toolkit V2.	**Achieved** Implementation of The Royal Women's Hospital Family Violence Toolkit V2 is progressing very well.
			Benalla Health will establish a consumer advisory group from the local Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) community to assist with implementation of our LGBTI Action Plan.	**Partially Achieved** Staff attended the Benalla LGBTI Inclusion Planning session on Tuesday 13th February and IDAHOT day on Thursday 17th May 2018. A representative consumer advisory group will be convened in 2018.
			The Koolin Balit Aboriginal Health Cultural Competence Action Plan 2017-2020 will be implemented.	**Achieved** Implementation of the Koolin Balit Aboriginal Health Cultural Competence Action Plan 2017-2020 is progressing well.

	Goals	Strategies	Health Service Deliverables	Outcomes
Better Access	Care is always there when people need it. More access to care in the home and community. People are connected to the full range of care and support they need. There is equal access to care.	• Plan and invest • Unlock innovation • Provide easier access • Ensure fair access	Benalla Health will establish a sustainable National Disability Insurance Scheme (NDIS) service by recruiting existing NDIS eligible clients from Benalla Health's current programs and other clients from the community.	**Partially Achieved** Forty NDIS clients have been recruited with this number planned to increase in 2018/19.
			Benalla Health will continue to partner with Northeast Health Wangaratta to develop and implement a subacute model of care which will facilitate timely referrals into and out of the Thomas Hogan Rehabilitation Centre.	**Achieved** A total of 285 referrals were received from Northeast Health Wangaratta; 130 people were referred to Community Health, 61 people were referred to Health Independence Programs and 94 people were referred to Post Acute Care.
			Benalla Health will continue to partner with Central Hume health services to develop and implement a sustainable model of maternity care which will facilitate timely referrals and care closer to home for local women and their families.	**Partially Achieved** Further work is required to strengthen the sustainability of the medical and midwifery workforce to ensure that there is a sustainable model of maternity care.
			Benalla Health will establish telemedicine links into the Kerferd Mental Health triage team based at Northeast Health Wangaratta to ensure that people with mental health issues who present to our Urgent Care Centre receive a timely assessment and appropriate referral.	**Partially Achieved** Telehealth services, in partnership with Albury Wodonga Health, are available in the Urgent Care Centre for clients presenting with mental health needs. Evaluation has identified that access to the service needs to be strengthened as referrals have been very low.

	Goals	Strategies	Health Service Deliverables	Outcomes
Better Care	Target zero avoidable harm. Healthcare that focusses on outcomes. Patients and carers are active partners in care. Care fits together around people's needs.	• Put quality first • Join up care • Partner with patients • Strengthen the workforce • Embed evidence • Ensure equal care	Benalla Health will develop and implement a Leadership Capability Framework to enable its leadership team to reach its full potential.	**Achieved** Leadership Development adopted as the primary theme for the 2018 Studer Hardwiring Excellence coaching program.
		Mandatory actions against the 'Target zero avoidable harm' goal		
		Develop and implement a plan to educate staff about obligations to report patient safety concerns.	Benalla Health will develop and implement a plan to educate staff about their obligations to report patient safety concerns.	**Achieved** A 'No Pass' program with associated training for all staff has been implemented.
		Establish agreements to involve external specialists in clinical governance processes for each major area of activity (including mortality and morbidity review).	Benalla Health will continue to partner with Northeast Health Wangaratta to further strengthen the Central Hume Director of Clinical Governance model for Obstetrics, Medicine, Anaesthetics and the Urgent Care Centre.	**Achieved** Signed agreements are in place with Northeast Health Wangaratta, which define robust governance systems and processes to support the Central Hume Director of Clinical Governance model.
		In partnership with consumers, identify three priority improvement areas using Victorian Healthcare Experience Survey data and establish an improvement plan for each. These should be reviewed every six months to reflect new areas for improvement in patient experience.	In partnership with the Cultural Diversity Consumer Committee, Benalla Health will identify three priority improvement areas from the Victorian Healthcare Experience Survey data and establish an improvement plan for each one. A review will be completed in six months to reflect new areas for patient experience improvement.	**Achieved** Three priority improvement areas from the Victorian Healthcare Experience Survey identified and improvement plans developed for each one. New priorities for patient experience improvement will be identified in November 2018.

Part B: Performance Priorities

High quality and safe care

Key performance indicator	2017-18 Target	2017-18 Actual
Accreditation		
Accreditation against the National Safety and Quality Health Service Standards	Full compliance	Full compliance
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Full compliance
Infection prevention and control		
Compliance with the Hand Hygiene Australia program	80%	91.1%
Percentage of healthcare workers immunised for influenza	75%	85%
Patient experience		
Victorian Healthcare Experience Survey — percentage of positive patient experience responses	95% positive experience	100%
Victorian Healthcare Experience Survey — percentage of very positive responses to questions on discharge care	75% very positive experience	90.6%
Victorian Healthcare Experience Survey — patients perception of cleanliness	70%	93.6%
Adverse events		
Number of sentinel events	Nil	Nil
Mortality — number of deaths in low mortality DRG*	Nil	N/A*
Maternity and Newborn		
Rate of singleton term infants without birth anomalies with Apgar score <7 to 5 minutes	<1.6%	2.5%
Rate of severe foetal growth restriction (FGR) in singleton pregnancy undelivered by 40 weeks	28.6%	0%

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

Strong governance, leadership and culture

Key performance indicator	2017-18 Target	2017-18 Actual
Organisational culture		
People matter survey - percentage of staff with an overall positive response to safety and culture questions	80%	78%
People matter survey — percentage of staff with a positive response to the question, “I am encouraged by my colleagues to report any patient safety concerns I may have”	80%	88%
People matter survey — percentage of staff with a positive response to the question, “Patient care errors are handled appropriately in my work area”	80%	80%
People matter survey — percentage of staff with a positive response to the question, “My suggestions about patient safety would be acted upon if I expressed them to my manager”	80%	84%
People matter survey — percentage of staff with a positive response to the question, “The culture in my work area makes it easy to learn from the errors of others”	80%	72%
People matter survey — percentage of staff with a positive response to the question, “Management is driving us to be a safety-centered organisation”	80%	83%
People matter survey — percentage of staff with a positive response to the question, “This health service does a good job of training new and existing staff	80%	68%
People matter survey — percentage of staff with a positive response to the question, “Trainees in my discipline are adequately supervised”	80%	63%
People matter survey — percentage of staff with a positive response to the question, “I would recommend a friend or relative to be treated as a patient here”	80%	82%

Effective financial management

Key performance indicator	2017-18 Target	2017-18 Actual
Finance		
Operating result ($m)	0.12	0.38
Average number of days to paying trade creditors	60 days	33 days
Average number of days to receiving patient fee debtors	60 days	41 days
Public and Private WIES activity performance to target	100%	94.52%
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	3%
Number of days of available cash	14 days	154.8 days

Part C: Activity and Funding

Funding Type	2017-18 Activity Achievement
Acute admitted	
WIES Public	2070
WIES Private	427
WIES DVA	120
WIES TAC	9
Subacute & Non-Acute Admitted	
Maintenance Public	43
Subacute WIES – DVA	3
Subacute Non-Admitted	
Health Independence Program – Public	6276
Aged Care	
Residential Aged Care Days	9896
HACC Hours	7027
Primary Health	
Community Health/Primary Care Program Hours	18562

Statutory Reporting

Victorian Industry Participation Policy Act 2003

Benalla Health complied with the regulations within the Victorian Industry Participation Policy Act 2003 for the year 2017-18. One contract was commenced in the financial year to which the VIPP applied for an amount of $3,747,498.

Freedom of Information Act 1982

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 make a FOI request should do so by completing the FOI Request form (available from the Benalla Health Website or at the Hospital Reception Desk). The FOI Request form contains information relating to costs of accessing information, what information can be provided and timeline for provision of information to an applicant by Benalla Health.

Further information about the Freedom of Information Act is available from the Office of the Victorian Information Commissioner (www.foicommissioner.vic.gov.au). During 2017-18, 56 valid Freedom of Information requests were received, one of which was from a Member of Parliament, the balance mostly relating to requests to legally access medical and/or health care related information.

Privacy

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

Protected Disclosure Act 2017

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 2017-18.

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 policies to include flexible working arrangements and leave provision ensuring compliance with the statement of principles in the Act.

There were no disclosures in 2017-18.

Building Act 1993

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 has no matters to report in relation to its obligations under section 40 of 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 and its subsequent reforms.

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.

Environmental Performance Summary

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. Benalla Health's energy consumption has remained stable, despite the variations in climatic conditions. With continual segregation, further reductions in kitchen and clinical waste have been achieved with levelling off. Even with the added new projects contributing to waste, cost efficiencies continue to be sought. At one point during 2017-18 there was a slight increase in clinical waste activity due to the influenza outbreak which was still lower than previous financial years.

Additional Information

In compliance with FRD 22H 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 requirements if applicable).

Workforce Information

Workforce Information

Current Full Time Equivalent and other payroll information to the Department under the Minimum Employee Data Set (MDS).

Hospitals Labour Category	June Current month FTE		June YTD FTE	
	2017	**2018**	**2017**	**2018**
Nursing	103.46	100.86	100.60	100.02
Administration and Clerical	36.92	34.91	36.35	35.56
Medical Support	5.40	5.50	5.64	5.39
Hotel and Allied Services	44.77	43.76	44.83	44.11
Medical Officers	0.28	0.32	0.22	0.31
Sessional Clinicians	0.00	0.00	0.00	0.00
Ancillary Staff (Allied Health)	17.59	17.52	15.70	16.83
Total	**208.42**	**202.86**	**203.34**	**202.22**

Quality and Safety Performance

Health Care Worker Influenza Immunisation

Immunisation rate for the period 18th April 2017 to 19th August 2017 was 89.1%. Immunisation rate for the 2017-18 financial year is 85%.

Victorian Health Experience Survey Results

Patient experience		
Victorian Healthcare Experience Survey - data submission	**Full compliance**	**Achieved**
Victorian Healthcare Experience Survey – positive patient experience – Quarter 1	95% positive experience	94%
Victorian Healthcare Experience Survey – positive patient experience – Quarter 2	95% positive experience	98%
Victorian Healthcare Experience Survey – positive patient experience – Quarter 3	95% positive experience	100%
Victorian Healthcare Experience Survey – discharge care. Quarter 1	75% very positive experience	83%
Victorian Healthcare Experience Survey – discharge care. Quarter 2	75% very positive experience	93%
Victorian Healthcare Experience Survey – discharge care. Quarter 3	75% very positive experience	91%

The objective of Health and Safety is prevention and active response. This is achieved by supportive and ongoing consultation between management, the Occupational 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.

Occupational Health

Occupational Health and Statistics	2016-17	2017-18
Number of reported hazards/incidents for the year per 100 FTE staff	37.9	39.1
Number of lost time standard claims for the year per 100 FTE staff	2.95	2.47
Average cost per claim for the year (including payments to date and estimate of outstanding claim costs as advised by Worksafe)	$6,672	$6,226

Occupational Violence

Occupational violence statistics for 2017-18 are reported as per the table below.

Occupational Violence Statistics	2017-18
Workcover accepted claims with an occupational violence cause per 100 FTE	0
Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	0
Number of occupational violence incidents reported	16
Number of occupational violence incidents reported per 100 FTE	7.9
Percentage of occupational violence incidents resulting in staff injury, illness or condition	0

Definitions

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

- **Occupational Violence and Aggression:** Which is defined by Worksafe Victoria as 'any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or implied threat to safety, health or wellbeing, and
  - Threat means a statement or behavior that causes a person to believe they are in danger of being physically attacked. It may involve an actual or implied threat to safety, health or wellbeing, and
  - Physical attack means the direct or indirect application of force by a person to the body of, or clothing or equipment worn by, another person, where that application creates a risk to health and safety.'
- **Incident:** an event or circumstance that could have resulted in, or did result in, harm to an employee. Incidents of all severity rating are included. Code Grey reporting is not included.
- **Accepted Workcover Claims:** Accepted Workcover claims that were lodged in 2017-18.
- **Lost Time:** Is defined as greater than one day.
- **Injury, illness or condition:** Includes all reported harm as a result of the incident, regardless of whether the employee required time off work or submitted a claim.

Benalla and District Memorial Hospital Auxiliary

A big thank you to the committee and to all members who together have enabled the Benalla and District Memorial Hospital Auxiliary to raise funds for our tremendous hospital Benalla Health.

Two of our most senior members attend a meeting.

Without your dedication and assistance, we would not be able to assist the hospital to purchase much-needed equipment.

We are so fortunate to live in a town where the local businesses and community groups support one another to ensure the local hospital can provide services not only to Benalla residents, but surrounding areas and visitors.

This year we have raised funds that have enabled us to support Benalla Health provide equipment for the community health to purchase a tympanic membrane thermometer, the newly refurbished physiotherapist centre, midwifery mother/baby items and finalised our commitment to Morrie Evans Wing for equipment.

You may well ask how this has been achievable.

Each year the Auxiliary runs two raffles in the community, the major one being the giant Christmas stocking. Other activities include having a produce stall and plant stall at the monthly markets down by the foreshore, catering at open gardens and holding two local sausage sizzles.

We have a wonderful Auxiliary who, if they are not knitting, dressing dolls, making jams, crafting, cooking or propagating plants, are cooking sausages, selling raffle tickets, visiting business houses seeking donations, selling our wares and liaising with the public promoting Benalla Health and the role of the Hospital Auxiliary.

This year two of our members received awards on Australia Day, a great example of service above self. Our membership has remained static this year with a few passing on and newer members stepping up to fill their shoes. This showcases just a part of volunteering in our region and the community we support.

I take this opportunity to thank my committee and members for without you, there would be no auxiliary. I wish the new board every success in the coming year and look forward to working alongside you in our quest to support our local hospital, Benalla Health.

I would also like to thank Benalla Health for supporting our auxiliary and Chief Executive Officer Janine Holland and her representatives for attending our meetings and keeping us abreast on what Benalla Health is doing. We also appreciate Benalla Health allowing us to use the Michael Long Education Centre rooms for our meetings - as a team we strive to help Benalla Health to continue to meet the needs of our community.

Barbara Jennings
President
Benalla and District Memorial Hospital Auxiliary

BENALLA & DISTRICT MEMORIAL HOSPITAL AUXILIARY

Receipts and Expenditure 1/7/2017 - 30/6/2018

BENDIGO CLUB CHEQUE ACCOUNT	
Balance as at 1 July 2017	$3,529.76
RECEIPTS	
Catering	$750.75
Christmas raffle	$3,195.60
Day in the Gardens - Craft and Jams	$395.70
Day in the Gardens - Plants	$1,065.70
Donations	$1,104.00
Heavy Horses - craft stall	$91.50
Lakeside Market - Craft and Jams	$3,150.75
Lakeside Market - Plants	$5,809.65
Meeting Raffle	$199.00
Open Gardens	$2,105.50
Plant sales	$170.00
Recipe books	$90.00
Rug raffle [1]	$60.00
Rug raffle [2]	$576.60
Transfer from Investment Account	$23,500.00
Total Receipts	$42,264.75
EXPENDITURE	
Audit	$440.00
Benalla Health	$24,192.00
Gifts	$50.00
Plants - potting mix	$115.00
Transfer to Investment Account	$14,000.00
Wreaths	$50.00
Total Expenditure	$38,847.00
Net Income	$3,417.75
Balance as at 30 June 2018	$6,947.51

BENDIGO INVESTMENT ACCOUNT	
Balance as at 1 July 2017	$43,655.81
Christmas Raffle	$1,413.05
Interest	$428.06
Transfer from Cheque Account	$14,000.00
Transfer to Cheque Account	-$23,500.00
Balance as at 30 June 2018	$35,996.92

TOTAL HOLDINGS	
AS AT 30 JUNE 2018	**$42,944.43**

Benalla Health 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
- Physiotherapy
- Podiatry
- Social Work/Counselling
- Speech Pathology

Home Nursing Services

- District Nursing Service
- Hospital in the Home
- Palliative Care

Health Promotion

- Healthy Eating
- Mental Health and Wellbeing

Other Services

- Early Intervention in Chronic Disease
- Day Activities Program
- NDIS

Health Independence Programs

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

Nursing

- Community Health Nursing

Support Groups

- Carers
- 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

SENIOR STAFF
(as at 30 June 2018)

Chief Executive Officer
Ms J. Holland RN, RM, BHSc, Grad Cert HSM, MPH, ACHS Surveyor, GAICD

ACUTE AND AGED CARE
Director of Clinical Services
Dr S. Wilson RN, Paed Cert, Grad Dip Psych Nsg, BA, BSc, Grad Dip Ed, MEd, PhD

Deputy Director of Clinical Services
Ms L. Waite RN, RM, BN

Assistant Directors of Nursing
Mr S. Braithwaite RN, Dip Bus, Dip Paramed, Dip TAE, Grad Cert Gerontics
Ms J. Douglas RN
Mr M. Mills RN
Mr J. Taylorson RN
Mrs A. Thomas RN

Nurse Unit Manager - Urgent Care Centre
Mrs M. Reid RN

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

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

Nurse Unit Manager - Morrie Evans Wing
Mr N. Willoughby RN, BN

Infection Prevention and Control Co-ordinator
Ms T. Allan RN, Nurse Immuniser, Clinical Educator

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

COMMUNITY HEALTH

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

Physiotherapy & Occupational Therapy Team Leader
Mr G. Draper BAppSc (Physio)

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 BBus (Accounting), CPA, MBA, GAICD

Chief Engineer
Mr R. Grubissa MIHEA

Human Resources Manager
Mrs L. Daldy BBus (Human Resources), MAHRI

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

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

Support Services Manager
Ms K. Bennetts Grad Cert Management Professional Practice

Management Accountant
Mr I. Hatton BBus (Acc) C.P.A.

IT Manager
Mr P. Hurley BIT

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

Media Relations
Mrs S. Beattie

Team Leader – Food Services
Miss. H. Richardson

Team Leader – General Support Services
Mrs P. Winzer

VISITING MEDICAL OFFICERS
(as at 30 June 2018)

Director of Medical Services
Dr K. Cheng MBBS, BMedSc (Hons) Melb Uni, MBA, MCommerce

Visiting General Practitioners
Dr G. Brownstein MBBS (Hons) Dip Obs, Dip Anaes, RACOG, FRACGP, FACRRM
Dr B. Buckley MBBS, FRACGP
Dr S. Chapple MBBS
Dr F. Christophersen MBBS, FRACGP, JCAA
Dr K.L. Chua MBBS (Hons), BMedSc
Dr R. de Crespigny MBBS, Dip Anaes, Dip Obs, RACOG, FACRRM
Dr N. Fahn MBBS, FRACGP, JCAA
Dr N. Flanigan MBBS, FRACGP
Dr S. Hancock MBBS/BMedSci, DRANZCOG, FRACGP
Dr M. Higgs MBBS FACRRM
Dr S. Hancock MBBS, BMedSci, DRANZCOG, FRACGP
Dr B. Hollins MBBS (Hons), FRACGP
Dr P. Kelly MBBS, Dip Obs, RACOG, FRACGP, FACRRM
Dr A. Knight MBBS, Dip Anaes, Dip Obs, RANZCOG
Dr J. Lambert MBBS, FRACGP, DRANZCOG
Dr C. Lourensz MBBS, BSc (Hons)
Dr P. Murray MBBS
Dr G. O'Brien MBBS, D.RACOG, FACRRM
Dr C.X. O'Kane MBBS, M Bioethics
Dr C. Pring MBBS
Dr U. Read MBBS, FRACGP
Dr G. Reynolds MBBS DRACOG
Dr D. Rodgers MBBS, Dip Obs, RANZCOG, FRCRRM
Dr M. Shah MBBS
Dr P. Slot MBBS, FRACGP, DRACOG, FACRRM
Dr S. Sreenivasan MBBS
Dr S. Tarrant MBBS
Dr S. Warfe MBBS, BMedSci, Dip Child Health, FACRRM
Dr B. Weatherhead MBBS, BMedSci

Visiting General Surgeons
Mr A. Cichowitz MBBS (Hons), BMedSci, PG Dip SurgAnaes, FRACS
Mr A. MacLeod MBBS, FRACS, BSci
A/Prof F. Miller MBBS, PhD, FRACS
Mr P.R. Thomas MBBS (Melb), FRCS Ed, FRACS

Visiting Obstetricians & Gynaecologists
Dr L. Bennett MBBS (Hons), FRANZCOG
Dr L. Fogarty MBBS, FRANZCOG
Dr J. Krones MBBS, FRANZCOG

Visiting Ophthalmologists
Mr A. Atkins B. Med Sci., MBBS, FRANZCO
Dr N. Karunaratne MBBS, MPH, MBA, MMed, FRANZCO
Mr P. Meagher MBBS, FRANZCO, FRACS
Mr S. Permezel MBBS, FRANZCO, FRACS, FRC. Ophth (UK)
Mr A. Van Heerden MBChB, FRANZCO

Visiting Oral & Maxillofacial Surgeon
Mr W. Besly MDSc, FRACDS (OMS), FRACDS

Visiting Orthopaedic Surgeons
Mr I. Critchley B.Sc., MBChB, FRCS (Ed), FRACS, FA Orth A
Dr W.R. Seager MBBS, FRACS, FA Orth A

Visiting Paediatrician
Mr T. Stubberfield MBBS, Dip RACOG, DCH (London), FRACP

Visiting Physicians
Dr R. Krones MD, FRACP

Visiting Geriatrician
Dr L. Dhakal MBBS, MD, MPH

Visiting Urologists
Dr C. Dowling MS FRACS (Urol)
Mr M. Forbes MBBS (Hons), FRACS
Mr J. Goad MBBS, FRACS

Visiting Radiologists – Goulburn Valley Imaging Group
Dr I. Abeywardanalage MBBS, FRANZCR
Dr S. Begg MBBS, FRANZCR
Dr F. Ahmed MBBS, FCPS (Radiology), FRCR
Dr A. Lakkaraju FRANZCR, FRCR (UK), MBBS
Dr G. Miller MBBS, FRANZCR
Dr P. Neelapriyanthna 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

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

PART 2

2017-2018

Financial Statements

Part 2: 2017-2018 Financial Statements

BENALLA HEALTH

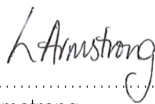
BOARD MEMBER'S, ACCOUNTABLE OFFICERS AND
CHIEF FINANCE & ACCOUNTING OFFICER'S DECLARATION

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

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

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

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



Louise Armstrong
Board Member

Benalla

23 / 08 / 18

Janine Holland
Accountable Officer

Benalla

23 / 08 / 18

Andrew Nitschke
Chief Finance & Accounting Officer

Benalla

23 / 08 / 18

Independent Auditor's Report

To the Board of Benalla Health

Opinion	I have audited the financial report of Benalla Health (the health service) which comprises the: • balance sheet as at 30 June 2018 • comprehensive operating statement for the year then ended • statement of changes in equity for the year then ended • cash flow statement for the year then ended • notes to the financial statements, including significant accounting policies • board member's, accountable officer's and chief finance & accounting officer's declaration. In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2018 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.
Basis for Opinion	I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. I further describe my responsibilities under that Act and those standards in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report. My independence is established by the *Constitution Act 1975.* My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Victoria. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.
Board's responsibilities for the financial report	The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Financial Management Act 1994*, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error. In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.

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

Part 2: 2017-2018 Financial Statements

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

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

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

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

MELBOURNE
31 August 2018

Ron Mak
as delegate for the Auditor-General of Victoria

Part 2: 2017-2018 Financial Statements

BENALLA HEALTH
COMPREHENSIVE OPERATING STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2018

	Note	2018 $'000	2017 $'000
Revenue from Operating Activities	2.1	28,306	27,843
Revenue from Non-Operating Activities	2.1	272	253
Employee Expenses	3.1	(18,806)	(18,213)
Non Salary Labour Costs	3.1	(3,087)	(3,088)
Supplies and Consumables	3.1	(2,131)	(2,042)
Other Expenses	3.1	(4,175)	(4,025)
Net Result Before Capital and Specific Items		379	728
Capital Purpose Income	2.1	3,640	726
Reversal of Impairment of Financial Assets	2.1	0	13
Depreciation and Amortisation	3.1	(2,121)	(2,174)
Finance Costs	3.3	(2)	(3)
Expenditure Using Capital Purpose Income	3.1	(438)	(30)
Net Result after Capital and Specific Items		1,458	(740)
Other Economic Flows Included in Net Result			
Net Gain on Disposal of Non-Financial Assets		10	30
Revaluation of Long Service Leave	3.4	(3)	102
Total Other Economic Flows Included in Net Result		7	132
NET RESULT FOR THE YEAR		1,465	(608)
Other Comprehensive Income			
Items that will not be classified to Net Result			
Changes in Property, Plant & Equipment Revaluation Surplus	8.1	0	0
Total other comprehensive income		0	0
COMPREHENSIVE RESULT FOR THE YEAR		1,465	(608)

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

Part 2: 2017-2018 Financial Statements

BENALLA HEALTH
BALANCE SHEET
AS AT 30 JUNE 2018

	Note	2018 $'000	2017 $'000
Current Assets			
Cash and Cash Equivalents	6.2	6,001	3,456
Receivables	5.1	1,075	1,028
Investments and other Financial Assets	4.1	9,074	9,145
Inventories	5.2	41	154
Prepayments and Other Assets	5.4	56	53
Total Current Assets		16,247	13,836
Non-Current Assets			
Receivables	5.1	1,049	951
Property, Plant and Equipment	4.2	19,330	20,251
Intangible Assets	4.4	27	91
Total Non-Current Assets		20,406	21,293
TOTAL ASSETS		36,653	35,129
Current Liabilities			
Payables	5.5	1,314	954
Borrowings	6.1	24	37
Provisions	3.4	4,301	4,240
Other Liabilities	5.3	1,617	1,980
Total Current Liabilities		7,256	7,211
Non-Current Liabilities			
Borrowings	6.1	24	42
Provisions	3.4	499	467
Total Non-Current Liabilities		523	509
TOTAL LIABILITIES		7,779	7,720
NET ASSETS		28,874	27,409
EQUITY			
Property, Plant and Equipment Revaluation Surplus	8.1(a)	14,608	14,608
General Purpose Surplus	8.1(a)	425	415
Restricted Specific Purpose Surplus	8.1(a)	75	50
Contributed Capital	8.1(b)	13,293	13,293
Accumulated Surplus/(Deficits)	8.1(c)	473	(957)
TOTAL EQUITY		28,874	27,409
Commitments	6.3		
Contingent Assets and Contingent Liabilities	7.2		

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 2018

	Note	Property, Plant and Equipment Revaluation Surplus $'000	General Purpose Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributions by Owners $'000	Accumulated Surplus/ (Deficits) $'000	Total $'000
Balance at 1 July 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/(Deficits)		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
Net result for the year		0	0	0	0	1,465	1,465
Transfer (to)/from Accumulated Surplus/(Deficits)	8.1(a)	0	10	25	0	(35)	0
Other Comprehensive Income for the Year	8.1(a)	0	0	0	0	0	0
Balance at 30 June 2018		14,608	425	75	13,293	473	28,874

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

BENALLA HEALTH
CASH FLOW STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2018

	Note	2018 $'000	2017 $'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		24,360	23,149
Capital Grants from Government		3,366	498
Patient and Resident Fees Received		1,327	1,443
Donations and Bequests Received		159	72
GST (Paid to)/Received from ATO		7	(4)
Interest Received		263	415
Other Receipts		2,761	2,880
Total Receipts		***32,243***	***28,453***
Employee Expenses Paid		(18,711)	(18,210)
Non Salary Labour Costs		(3,087)	(3,088)
Payments for Supplies and Consumables		(2,018)	(2,051)
Finance Costs		(2)	(3)
Other Payments		(4,372)	(4,443)
Total Payments		***(28,190)***	***(27,795)***
NET CASH FLOW FROM OPERATING ACTIVITIES	8.2	4,053	658
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of Investments		(755)	(1,153)
Payments for Intangible Assets		0	(43)
Purchase of Non-Financial Assets		(1,253)	(978)
Proceeds from Sale of Non-Financial Assets		68	395
NET CASH FLOW USED IN INVESTING ACTIVITIES		(1,940)	(1,779)
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of Finance Leases		(31)	(17)
NET CASH FLOW USED IN FINANCING ACTIVITIES		(31)	(17)
NET DECREASE IN CASH AND CASH EQUIVALENTS HELD		2,082	(1,138)
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		3,292	4,430
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.2	5,374	3,292

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

BASIS OF PREPARATION

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

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

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

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.

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 AAS 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 year ended 30 June 2018. 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 23rd August, 2018

(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.

(c) Basis of accounting preparation and measurement

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

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2018, and the comparative information presented in these financial statements for the year ended 30 June 2017.

The financial statements are prepared on a going concern basis.

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

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

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

All amounts shown in the financial statements have been rounded to the nearest thousand dollars, unless otherwise stated. Minor discrepancies in tables between totals and sum of components are due to rounding.

The Health Service operates on a fund accounting basis and maintains three funds: Operating, Specific Purpose and Capital Funds.

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

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

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

- The fair value of land, buildings and plant and equipment (refer to Note 4.2 Property, Plant and Equipment);
- Superannuation expense (refer to Note 3.5 Superannuation);
- Employee benefit provisions are based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.4 Employee Benefits in the Balance Sheet); and

Goods and Services Tax (GST)

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

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

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

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

(d) 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.

(e) Jointly Controlled Operation

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

In respect of any interest in joint operations, 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.

Benalla Health is a Member of the Hume Region Health Alliance Joint Venture and retains joint control over the arrangement, which it has classified as a joint operation (refer to Note 8.10).

NOTE 2: FUNDING DELIVERY OF OUR SERVICES

The health service's overall objective is to provide quality health services and deliver programs and services that support and enhance the wellbeing of all Victorians. Benalla Health is predominantly funded by accrual based grant funding for the provision of outputs.
The health service also receives income from the supply of services.

Structure
2.1 Analysis of revenue by source

Benalla Health
Notes to the Financial Statements
For the Financial Year Ended 30 June 2018

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE

	Admitted Patients 2018 $'000	Non-Admitted Patients 2018 $'000	Ambulatory 2018 $'000	Residential Aged Care 2018 $'000	Aged Care 2018 $'000	Primary Health 2018 $'000	Other * 2018 $'000	TOTAL 2018 $'000
Government Grants	15,190	2,038	1,494	2,866	1,253	1,262	8	24,111
Indirect Contributions by Department of Health and Human Services	65	8	4	16	9	16	3	121
Patient and Resident Fees	575	0	7	624	32	45	0	1,283
Commercial Activities	0	0	0	0	0	0	198	198
Other Revenue from Operating Activities	1,491	74	26	99	137	483	283	2,593
Total Revenue from Operating Activities	17,321	2,120	1,531	3,605	1,431	1,806	492	28,306
Interest	0	0	0	23	0	0	249	272
Total Revenue from Non-Operating Activities	0	0	0	23	0	0	249	272
Capital Purpose Income (excluding interest)	0	0	0	0	0	0	274	274
Capital Grants	0	0	0	0	0	0	3,366	3,366
Total Capital Purpose Income	0	0	0	0	0	0	3,640	3,640
Net gain/(loss) on Non-Financial Assets	0	0	0	0	0	0	10	10
TOTAL REVENUE	17,321	2,120	1,531	3,628	1,431	1,806	4,391	32,228

	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
TOTAL REVENUE	17,301	2,076	1,375	3,308	1,446	1,879	1,480	28,865

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

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)

Revenue Recognition

Income is recognised in accordance with AASB 118 *Revenue* and is recognised as to the extent that it is probable that the economic benefits will flow to 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 on an accrual basis.

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 on an accrual basis.

Donations and Other Bequests

Donations and bequests are recognised as revenue when received. If donations are for a specific 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 3: THE COST OF DELIVERING SERVICES

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

Structure

3.1 Analysis of Expenses by Source
3.2 Analysis of Expense and Revenue by Internally Managed and Restricted Specific Purpose Funds
3.3 Finance Costs
3.4 Employee Benefits in the Balance Sheet
3.5 Superannuation

NOTE 3.1: ANALYSIS OF EXPENSE BY SOURCE

	Admitted Patients 2018 $'000	Non-Admitted Patients 2018 $'000	Ambulatory 2018 $'000	Residential Aged Care 2018 $'000	Aged Care 2018 $'000	Primary Health 2018 $'000	Other * 2018 $'000	TOTAL 2018 $'000
Employee Expenses	8,375	1,568	626	3,951	1,352	2,526	408	18,806
Other Operating Expenses								
Non Salary Labour Costs	2,994	39	1	22	22	8	1	3,087
Supplies and Consumables	1,589	85	67	209	43	26	112	2,131
Medical Indemnity Insurance	338	0	0	0	0	0	0	338
Fuel, Light, Power & Water	227	30	5	60	40	57	30	449
Repairs and Maintenance	305	38	16	73	55	41	22	550
Administration Expenses	613	79	77	158	74	213	23	1,237
Other Expenses	904	92	23	279	107	112	84	1,601
Total Expenditure from Operating Activities	15,345	1,931	815	4,752	1,693	2,983	680	28,199
Finance Costs (refer note 3.3)	0	0	0	0	0	0	2	2
Other Non-Operating Expense								
Expenditure for Capital Purpose	0	0	0	0	0	0	438	438
Depreciation (refer note 4.3)	0	0	0	0	0	0	2,121	2,121
Total Other Expenses	0	0	0	0	0	0	2,561	2,561
TOTAL EXPENSES	15,345	1,931	815	4,752	1,693	2,983	3,241	30,760

	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
Medical Indemnity Insurance	312	0	0	0	0	0	0	312
Fuel, Light, Power & Water	151	20	3	40	18	51	25	308
Repairs and Maintenance	306	34	14	74	58	50	47	583
Administration Expenses	671	86	80	179	97	215	19	1,347
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 for Capital Purpose	0	0	0	0	0	0	30	30
Depreciation (refer note 4.3)	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

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

NOTE 3.1: ANALYSIS OF EXPENSE BY SOURCE (Continued)

Expense Recognition

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

Employee expenses

Employee expenses include:

- Wages and salaries;
- Fringe Benefits Tax;
- Leave Entitlements;
- Termination Payments;
- Workcover Premiums; and
- Superannuation expenses

Grants and other transfers

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

Other operating expenses

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

- Supplies and Consumables - Supplies and service costs which are recognised as an expense in the reporting period in which they are incurred. The carrying amounts of any inventories held for distribution are expensed when distributed.
- Fair value of assets, services and resources provided free of charge or for nominal consideration - Contributions of resources provided free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them.
- Borrowing Costs of Qualifying Assets - In accordance with the paragraphs of AASB 123 Borrowing Costs applicable to not-for-profit public sector entities, Benalla Health continues to recognise borrowing costs immediately as an expense, to the extent that they are directly attributable to the acquisition, construction or production of a qualifying asset.

Net Gain / (Loss) on Non-Financial Assets

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

- Revaluation gain/ (losses) of non-financial physical assets (Refer to Note 4.2 Property, Plant and Equipment)
- Net gain/(loss) on disposal of Non-Financial Assets

Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal.

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.

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.

Benalla Health
Notes to the Financial Statements
For the Financial Year Ended 30 June 2018

NOTE 3.2: ANALYSIS OF EXPENSE AND REVENUE BY INTERNALLY MANAGED AND RESTRICTED SPECIFIC PURPOSE FUNDS	2018 $'000	2017 $'000	2018 $'000	2017 $'000
	Expense		Revenue	
Commercial Activities				
Catering	419	97	198	231
Property	158	111	174	246
Other Activities				
Fundraising and Community Support	34	0	109	0
TOTAL	611	208	481	477

NOTE 3.3: FINANCE COSTS	2018 $'000	2017 $'000
Finance Charges on Finance Leases - Share of HRHA	2	3
TOTAL FINANCE COSTS	2	3

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

Finance costs include:

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

NOTE 3.4: EMPLOYEE BENEFITS IN THE BALANCE SHEET	2018 $'000	2017 $'000
Current Provisions		
Employee Benefits (i)		
Annual Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	1,164	1,132
- unconditional and expected to be settled wholly after 12 months (iii)	446	463
Long Service Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	405	398
- unconditional and expected to be settled wholly after 12 months (iii)	1,601	1,634
Accrued Wages and Accrued Days Off		
- unconditional and expected to be settled wholly within 12 months (ii)	331	250
	3,947	3,877
Provisions related to employee benefit on-costs		
- unconditional and expected to be settled wholly within 12 months (ii)	149	148
- unconditional and expected to be settled wholly after 12 months (iii)	205	215
	354	363
Total Current Provisions	4,301	4,240
Non-Current Provisions		
Employee Benefits (ii)	452	422
Provisions related to employee benefit on-costs	47	45
Total Non-Current Provisions	499	467
Total Provisions	4,800	4,707

Notes:
(i) Employee benefits consist of amounts for accrued days off, 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.

Benalla Health
Notes to the Financial Statements
For the Financial Year Ended 30 June 2018

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

	2018 $'000	2017 $'000
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and Related On-Costs (ii)		
Annual Leave Entitlements	1,610	1,594
Accrued Salaries and Wages	285	203
Accrued Days Off	46	47
Unconditional Long Service Leave Entitlements	2,360	2,396
	4,301	4,240
Non-Current Employee Benefits and Related On-Costs		
Conditional Long Service Leave Entitlements (iii)	499	467
	499	467
Total Employee Benefits and Related On-Costs	4,800	4,707

(b) Movements in Provisions	2018	2017
Movement in Long Service Leave:	$'000	$'000
Balance at start of year	2,863	2,714
Provision made during the year		
- Revaluations	3	(102)
- Expense Recognising Employee Service	500	706
Settlement made during the year	(507)	(455)
Balance at end of year	2,859	2,863

Employee Benefit Recognition

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

Provisions

Provisions are recognised when the 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.

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.

Salaries and Wages, Annual Leave and Accrued Days Off

Liabilities for wages and salaries, annual leave and accrued days off 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 accrued days off 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. Any gain or loss following revaluation of the present value of non-current LSL liability is recognised as a transaction, except to the extent that a gain or loss arises due to changes in estimations e.g. bond rate movements, inflation rate movements and changes in probability factors which are then recognised as other economic flows.

Termination Benefits

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

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	
		2018 $'000	2017 $'000	2018 $'000	2017 $'000
Defined Benefit Plans: (i)	Health Super	48	52	0	0
Defined Contribution Plans:	Health Super	1,056	1,059	26	21
	HESTA	442	382	0	0
Total		1,546	1,493	26	21

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

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.

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 defined contribution superannuation plans are expensed when incurred.

Defined benefit superannuation plans

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

Benalla Health 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 for administered items.

However superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the Comprehensive Operating Statement of the health service.

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

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 Property, Plant & Equipment
4.3 Depreciation and Amortisation
4.4 Intangible Assets
4.5 Investment Properties

NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS

	Operating Fund		Specific Purpose Fund		Capital Fund		Total	Total
	2018	2017	2018	2017	2018	2017	2018	2017
CURRENT	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Loans and Receivables								
Term Deposits								
Aust. Dollar Term Deposits > 3 Months	9,074	9,145	0	0	0	0	9,074	9,145
Total Current Other Financial Assets	9,074	9,145	0	0	0	0	9,074	9,145
TOTAL OTHER FINANCIAL ASSETS	9,074	9,145	0	0	0	0	9,074	9,145
Represented by:								
Health Service Investments	8,084	7,329	0	0	0	0	8,084	7,329
Monies Held in Trust								
- Central Hume PCP	0	427		0	0	0	0	427
- Refundable Accommodation Bonds	990	1,389	0	0	0	0	990	1,389
TOTAL	9,074	9,145	0	0	0	0	9,074	9,145

Note 4.1 Investment Recognition
Investments are recognised and derecognised on trade date where purchase or sale of an investment is under a contract whose terms require delivery of the investment within the timeframe established by the market concerned, and are initially measured at fair value, net of transaction costs.

Investments are classified as loans and receivable financial assets.

Benalla Health classifies its other financial assets between current and non-current assets based on the Board of Management's intention at balance date with respect to the timing of disposal of each asset. Benalla Health assesses at each balance sheet date whether a financial asset or group of financial assets is impaired.

Benalla Health's investments must comply with Standing Direction 3.7.2 - Treasury and Investment Risk Management. The investment portfolio of the health service is managed by Victorian Funds Management Corporation through specialist fund managers and a Master Custodian. The Master Custodian holds the investments and conducts settlements pursuant to instructions from the specialist fund managers.

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, the Health Service assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. All financial instrument assets, except those measured at fair value through the Comprehensive Operating Statement, are subject to annual review for impairment.

Where the fair value of an investment in an equity instrument at balance date has reduced by 20 percent or more than its cost price or where its fair value has been less than its cost price for a period of 12 or more months, the financial asset is treated as impaired.

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

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

Benalla Health
Notes to the Financial Statements
For the Financial Year Ended 30 June 2018

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT

(a) Gross carrying amount and accumulated depreciation

	2018 $'000	2017 $'000
Land		
- Land at Fair Value		
Crown Land	343	343
Freehold Land	1,141	1,141
Total Land	1,484	1,484
Buildings		
- Buildings Under Construction at Cost	845	497
- Buildings at Fair Value	19,535	19,253
Less Accumulated Depreciation	5,292	3,921
	14,243	15,332
Total Buildings	15,088	15,829
Plant and Equipment		
- Plant and Equipment at Fair Value	5,900	5,583
Less Accumulated Depreciation	3,868	3,543
Total Plant and Equipment	2,032	2,040
Medical Equipment		
- Medical Equipment at Fair Value	3,539	3,517
Less Accumulated Depreciation	2,861	2,699
Total Medical Equipment	678	818
Leased Assets - Share of HRHA Leased Assets		
- Leased Assets at Fair Value	124	166
Less Accumulated Depreciation	76	86
Total Leased Assets	48	80
TOTAL PROPERTY PLANT AND EQUIPMENT	19,330	20,251

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

	Land $'000	Buildings $'000	Plant & Equipment $'000	Medical Equipment $'000	Assets Under Construction $'000	Leased Assets $'000	Total $'000
Balance at 1 July 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)
Depreciation (Note 4.3)	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
Additions	0	282	498	118	348	7	1,253
Disposals	0	0	(57)	(1)	0	0	(58)
Depreciation (Note 4.3)	0	(1,371)	(449)	(257)	0	(39)	(2,116)
Balance at 30 June 2018	1,484	14,243	2,032	678	845	48	19,330

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.

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

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

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

(c) Fair value measurement hierarchy for assets

	Carrying amount as at 30 June 2018	Fair value measurement at end of reporting period using:		
	$'000	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	9,978	0	0	9,978
Total of building at fair value	14,243	0	665	13,578
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	417	0	0	417
- Plant and equipment	1,615	0	0	1,615
Total of plant, equipment and vehicles at fair value	2,032	0	0	2,032
Medical equipment at fair value	678	0	0	678
Leased Assets (HRHA)	48	0	0	48
	18,485	0	1,269	17,216

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:		
	$'000	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 buildings 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
	19,754	0	1,269	18,485

(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 these periods.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

(d) Reconciliation of Level 3 fair value

30-Jun-18	Land $'000	Buildings $'000	Plant and Equipment $'000	Medical Equipment $'000	Leased Assets $'000
Opening Balance	880	14,667	2,040	818	80
Additions/(Disposals)	0	282	441	117	7
Gains or losses recognised in net result					
- Depreciation	0	(1,371)	(449)	(257)	(39)
- Impairment loss	0	0	0	0	0
Subtotal	880	13,578	2,032	678	48
Items recognised in other comprehensive income					
- Revaluation	0	0	0	0	0
Subtotal	0	0	0	0	0
Balance at 30 June 2018	880	13,578	2,032	678	48

30-Jun-17	Land $'000	Buildings $'000	Plant and Equipment $'000	Medical Equipment $'000	Leased Assets $'000
Opening Balance	880	16,015	2,294	990	96
Additions/(Disposals)	0	14	217	118	32
Gains or losses recognised in net result					
- Depreciation	0	(1,362)	(471)	(290)	(48)
- Impairment loss	0	0	0	0	0
Subtotal	880	14,667	2,040	818	80
Items recognised in other comprehensive income					
- Revaluation	0	0	0	0	0
Subtotal	0	0	0	0	0
Balance at 30 June 2017	880	14,667	2,040	818	80

(e) Fair Value Determination

Asset Class (a)	Examples of types 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 us or sale	Level 2	Market approach	n.a.
Specialised land (Crown/Freehold)	- Land subject to restriction as to use and/or sale - Land in areas where there is not an active market	Level 3	Market approach	Community Service Obligation Adjustments
Non-specialised buildings	For general/commercial buildings that are just built.	Level 2	Market approach	n.a.
Specialised Buildings	Specialised buildings with limited alternative uses and/or substantial customisation eg. Hospitals	Level 3	Depreciated replacement cost approach	- Cost per square metre - Useful life
Vehicles	If there is no active resale market available	Level 3	Depreciated replacement cost approach	- Useful life
Plant and equipment Medical Equipment	Specialised items with limited alternative uses and/or substantial cutomisation	Level 3	Depreciated replacement cost approach	- Cost per square metre - Useful life

(a) AASB 13 Fair Value Measurement provides an exemption for not for profit public sector entities from disclosing the sensitivity analysis relating to 'unrealised gains/(losses) on non-financial assets' if the assets are held primarily for their current service potential rather than to generate net cash inflows.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

Initial Recognition

Items of property, plant and equipment are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and impairment loss. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition.

The cost of a leasehold improvement is capitalised as an asset and depreciated over the shorter of the remaining term of the lease or the estimated useful life of the improvements.

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

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

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

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

Subsequent Measurement

Consistent with AASB 13 Fair Value Measurement, 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.

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

For the purpose of fair value disclosures, 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.

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

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

In accordance with 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.

Valuation hierarchy

Health Services need to use valuation techniques that are appropriate for the circumstances and where there is sufficient data available to measure fair value, maximising the use of relevant observable inputs and minimising the use of unobservable inputs.
All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

Identifying unobservable inputs (level 3) fair value measurements

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

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

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

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

Specialised land and specialised buildings

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

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

The market approach is also used for specialised land and specialised buildings although 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 service, 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.

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).

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

Plant and equipment

Plant and equipment (including medical 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 amount.

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

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

Revaluations of non-current physical assets

Non-Current physical assets are measured at fair value and are revalued in accordance with FRD 103F *Non-current physical assets.* This revaluation process normally occurs 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, except where an asset is transferred via contributed capital.

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 4.3: DEPRECIATION AND AMORTISATION

	2018 $'000	2017 $'000
Depreciation		
Buildings	1,371	1,362
Plant and Equipment	449	471
Medical Equipment	257	290
Leased Assets - Share of HRHA Leased Assets	39	48
Total Depreciation	2,116	2,171
Intangible Assets - Share of HRHA Intangible Assets	5	3
Total Amortisation	5	3
TOTAL DEPRECIATION AND AMORTISATION	2,121	2,174

Depreciation
All infrastructure assets, buildings, plant and equipment and other non-financial physical assets that have finite useful lives are depreciated (i.e. excludes land assets held for sale, and investment properties). Depreciation is generally calculated on a straight-line basis at rates that allocate the asset's value, less any estimated residual value over its estimated useful life .

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

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

	2018	2017
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 30 years
Medical Equipment	4 to 20 years	4 to 20 years
Computers and Communication	3 to 12 years	3 to 12 years
Furniture and Fittings	5 to 20 years	5 to 20 years
Motor Vehicles	4 to 7 years	4 to 7 years

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

NOTE 4.4: INTANGIBLE ASSETS

	2018 $'000	2017 $'000
Share of HRHA Intangible Assets	38	99
Less Accumulated Amortisation	11	8
TOTAL INTANGIBLE ASSETS	27	91

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

	HRHA $'000	Total $'000
Balance at 1 July 2016	51	51
Additions	43	43
Amortisation (note 4.3)	(3)	(3)
Balance at 1 July 2017	91	91
Additions/(Disposals)	(59)	(59)
Amortisation (note 4.3)	(5)	(5)
Balance at 1 July 2018	27	27

INTANGIBLE ASSETS

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

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: INVESTMENT PROPERTIES

(a) Movements in carrying value for investment properties as at 30 June 2018

	2018 $'000	2017 $'000
Balance at Beginning of Period	0	265
Disposals of Investment Property	0	(265)
Net Gain/(Loss) from Fair Value Adjustments	0	0
Balance at End of Period	0	0

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	2018 $'000	2017 $'000
CURRENT		
Contractual		
Inter Hospital Debtors	244	134
Trade Debtors	79	90
Trade Debtors - Share of HRHA Debtors	216	149
Patient Fees and Resident Debtors	137	181
Accrued Investment Income	57	48
Accrued Revenue Other	97	118
Less Allowance for Doubtful Debts		
- Trade Debtors	(7)	(13)
	823	707
Statutory		
GST Receivable	98	95
Accrued Grants - Department of Health and Human Services	154	226
	252	321
TOTAL CURRENT RECEIVABLES	1,075	1,028
NON CURRENT		
Statutory		
Long Service Leave - Department of Health / Department of Health and Human Services	1,049	951
TOTAL NON-CURRENT RECEIVABLES	1,049	951
TOTAL RECEIVABLES	2,124	1,979
(a) Movement in the Allowance for doubtful debts		
Balance at beginning of year	13	16
Amounts written during the year	0	0
Increase/(decrease) in allowance recognised in net result	(6)	(3)
Balance at end of year	7	13

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.

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.

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

NOTE 5.2: INVENTORIES

	2018 $'000	2017 $'000
Pharmaceuticals		
- At Cost	21	33
Main Store - Medical, Domestic & Administration		
- At Cost	20	121
TOTAL INVENTORIES	41	154

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

	2018 $'000	2017 $'000
CURRENT		
Monies Held in Trust*		
- Patients Trust	5	8
- Central Hume PCP*	622	582
- Accommodation Bonds (Refundable Entrance Fees)	990	1,390
TOTAL OTHER LIABILITIES	1,617	1,980

* Total Monies Held in Trust		
Represented by the following assets:		
Cash Assets (refer to Note 6.2)	627	164
Investments and other Financial Assets (refer to Note 4.1)	990	1,816
TOTAL	1,617	1,980

* 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 2018 the amount of Central Hume PCP funds held by Benalla Health is $622,014 (2017: $582,338).

NOTE 5.4: PREPAYMENTS AND OTHER NON-FINANCIAL ASSETS

	2018 $'000	2017 $'000
CURRENT		
Prepayments	48	45
Prepayments - Share of HRHA Current Assets	8	8
TOTAL OTHER ASSETS	56	53

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

NOTE 5.5: PAYABLES

	2018 $'000	2017 $'000
CURRENT		
Contractual		
Trade Creditors (i)	501	708
Accrued Expenses	306	180
Other - Share of HRHA Current Liabilities	277	28
	1,084	916
Statutory		
GST Payable	27	17
Department of Health and Human Services	177	0
Superannuation Obligations Payable	26	21
	230	38
TOTAL PAYABLES	1,314	954

Payables consist of:

- contractual payables, classified as financial instruments and measured at amortised cost. Accounts payable represents liabilities for goods and services provided to the Department prior to the end of the financial year that are unpaid; and
- statutory payables, that are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from contracts.

Note 5.5 (a): Maturity analysis of financial liabilities as at 30 June

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

			Maturity Dates			
2018	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 (i)	1,084	1,084	1,084	0	0	0
Lease Liabilities	48	48	4	8	12	24
Other Financial Liabilities (i)						
- Monies in Trust	1,617	1,617	1,617	0	0	0
Total Financial Liabilities	2,749	2,749	2,705	8	12	24
2017						
Financial Liabilities						
At amortised cost						
Payables (i)	916	916	916	0	0	0
Lease Liabilities	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

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

NOTE 6: HOW WE FINANCE OUR OPERATIONS

This section provides information on the sources of finance utilised by the 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
6.1 Borrowings
6.2 Cash and cash equivalents
6.3 Commitments for expenditure

Benalla Health
Notes to the Financial Statements
For the Financial Year Ended 30 June 2018

NOTE 6.1: BORROWINGS	2018	2017
CURRENT	$'000	$'000
Australian Dollar Borrowings		
- Finance Lease Liability (Share of HRHA finance lease liability)	24	37
TOTAL CURRENT	24	37
NON CURRENT		
Australian Dollar Borrowings		
- Finance Lease Liability (Share of HRHA finance lease liability)	24	42
TOTAL NON CURRENT	24	42
TOTAL BORROWINGS	48	79

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 5.5 for the ageing analysis of borrowings.

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

(c) Finance lease Liabilities

	Minimum future lease payments		Present value of minimum future lease payments	
	2018	2017	2018	2017
Finance Leases	$'000	$'000	$'000	$'000
Repayments in relation to finance leases are payable as follows:				
Not later than one year	25	38	25	38
Later than 1 year and not later than 5 years	25	43	25	43
Minimum lease payments	50	81	50	81
Less future finance charges	2	2	2	2
TOTAL	48	79	48	79
Included in the financial statements as:				
Current borrowings finance lease liability	24	37	24	37
Non-current borrowings finance lease liability	24	42	24	42
Total Borrowings Finance Lease Liability	48	79	48	79

Borrowing Recognition
A lease is a right to use an asset for an agreed period of time in exchange for payment. Leases are classified at their inception as 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.

Finance leases
Entity as lessee
Finance leases are recognised as assets and liabilities at amounts equal to the fair value of the lease property or, if lower, the present value of the minimum lease payment, each determined at the inception of the lease. The lease asset is accounted for as a non-financial physical asset and is depreciated over the shorter of the estimated useful life of the asset or the term of the lease.
Minimum lease payments are apportioned between reduction of the outstanding lease liability, and the periodic finance expense which is calculated using the interest rate implicit in the lease, and charged directly to the Comprehensive Operating Statement.

Borrowings
All borrowings are initially recognised at fair value of the consideration received, less directly attributable transaction costs. Subsequent to initial recognition, borrowings are measured at amortised cost with any difference between the initial recognised amount and the redemption value being recognised in the net result over the period of the borrowing using the effective interest method.

NOTE 6.2: CASH AND CASH EQUIVALENTS	2018 $'000	2017 $'000
Cash on Hand	2	2
Cash at Bank	3,440	1,175
Short Term Deposits (Maturity < 3 Months)	2,559	2,279
TOTAL CASH AND CASH EQUIVALENTS	6,001	3,456
Represented by:		
Cash for Health Service Operations		
- Benalla Health Cash	5,068	3,085
- Share of HRHA Cash	306	207
Cash for Health Service Operations (as per cash flow statement)	5,374	3,292
Cash for Monies Held in Trust		
- Cash at Bank	627	164
TOTAL CASH AND CASH EQUIVALENTS	6,001	3,456

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	2018 $'000	2017 $'000
Capital Expenditure Commitments		
Payable:		
Aged Care Facility Redevelopment (i)	4,445	0
Total Capital Expenditure Commitments	4,445	0
Lease commitments		
Commitments in relation to leases contracted for at the reporting date:		
Finance Leases (Hume Region Health Alliance)	48	79
Total lease commitments	48	79
Lease commitments payable		
Less than 1 year	26	41
Longer than 1 year but not longer than 5 years	26	46
Total lease commitments	52	87
Total Commitments (inclusive of GST)	52	87
Less GST recoverable from the Australian Tax Office	4	8
Total Commitments (exclusive of GST)	48	79

(i) The health service is redeveloping and expanding the Morrie Evans wing aged care facility. The total project cost is $4,445,000 with the Department of Health and Human Services contributing $4,181,000 and Benalla Health $264,000. The project is due for completion by the 31st March, 2019.

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
7.1 Financial instruments
7.2 Contingent Assets and Contingent Liabilities

Note 7.1: FINANCIAL INSTRUMENTS

Financial Risk Management Objectives and Policies

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's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation.*

(a) Categorisation of financial instruments

2018	Contractual financial assets - loans and receivables $'000	Contractual financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets			
Cash and cash equivalents	6,001	0	6,001
Receivables			
- Trade Debtors	669	0	669
- Other Receivables	154	0	154
Investments and Other Financial Assets			
- Term Deposits	9,074	0	9,074
Total Financial Assets (i)	15,898	0	15,898
Financial Liabilities			
Payables	0	1,084	1,084
Lease Liabilities	0	48	48
Monies Held in Trust	0	1,617	1,617
Total Financial Liabilities(i)	0	2,749	2,749

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 and Other Financial Assets			
- Term Deposits	9,145	0	9,145
Total Financial Assets (i)	13,308	0	13,308
Financial Liabilities			
Payables	0	916	916
Lease Liabilities	0	79	79
Monies Held in Trust	0	1,980	1,980
Total Financial Liabilities(i)	0	2,975	2,975

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

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

	Total interest income/ (expense) $'000	Total $'000
2018		
Financial Assets		
Cash and cash equivalents(i)	25	25
Loans and Receivables(i)	247	247
Total Financial Assets	272	272
Financial Liabilities		
At amortised cost (ii)	(2)	(2)
Total Financial Liabilities	(2)	(2)
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)

(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.

Categories of financial instruments

Loans and receivables and cash

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

Loans and receivables category includes cash and deposits (refer to Note 6.1), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but excluding statutory receivables.

Financial liabilities at amortised cost

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

- payables (excluding statutory payables);
- borrowings (including finance lease liabilities).

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:
  - has transferred substantially all the risks and rewards of the asset; or
  - has neither transferred nor retained substantially all the risks and rewards of the asset, but has transferred control of the asset.

Where the 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.

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

Impairment of financial assets

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

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

Reclassification of financial instruments

Subsequent to initial recognition and under rare circumstances, non-derivative financial instruments assets that have not been designated at fair value through profit or loss upon recognition, may be reclassified out of the fair value through profit or loss category, if they are no longer held for the purpose of selling or repurchasing in the near term.

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.

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.

Derecognition of financial liabilities

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

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

NOTE 7.2: CONTINGENT ASSETS AND CONTINGENT LIABILITIES

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.

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

Contingent Assets	2018	2017
Quantifiable	$'000	$'000
Dividends from the liquidation of Lehman Brothers Australia	0	47
Total Quantifiable Contingent Assets	0	47

Contingent Liabilities		
Quantifiable		
Success fee paid on any dividends received from the liquidation of Lehman Brothers Australia	0	5
Total Quantifiable Contingent Liabilities	0	5

Non-Quantifiable

Nil

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
8.5 Remuneration of Executives
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 Jointly Controlled Operations and Assets
8.10 Alternative Presentation of Comprehensive Operating Statement
8.12 Economic Dependency

NOTE 8.1: EQUITY

	2018 $'000	2017 $'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
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.

	2018 $'000	2017 $'000
General Purpose Surplus		
Balance at beginning of the reporting period	415	399
Transfer to and (from) General Surplus	10	16
Balance at the end of the reporting period	425	415
Restricted Specific Purpose Surplus		
Balance at beginning of the reporting period	50	109
Transfer to and (from) Restricted Specific Purpose Surplus	25	(59)
Balance at the end of the reporting period	75	50
Total Surpluses	15,108	15,073
(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	(957)	(392)
Net Result for the Year	1,465	(608)
Transfer (to)/from General Reserve	(25)	59
Transfer (to)/from Restricted Specific Purpose Surplus	(10)	(16)
Balance at the end of the reporting period	473	(957)
Total Equity at end of financial year	28,874	27,409

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.

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

	2018 $'000	2017 $'000
NET RESULT FOR THE YEAR	1,465	(608)
Non-cash movements		
Depreciation and Amortisation	2,121	2,174
Impairment of Intangible Assets	59	0
Movement in Provision for Doubtful Debts	(6)	(3)
Movements included in investing and financing activities		
Net (Gain)/Loss from Disposal of Non-Financial Physical Assets	(10)	(30)
Recoveries from Impaired Financial Assets	0	(13)
Movements in assets and liabilities		
Change in Operating Assets and Liabilities		
(Increase)/Decrease in Receivables	(139)	(342)
(Increase)/Decrease in Prepayments	(3)	(15)
(Increase)/Decrease in Inventory	113	(9)
Increase/(Decrease) in Payables	360	(376)
Increase/(Decrease) in Employee Benefits	93	(120)
Increase/(Decrease) in Other Liabilities	0	0
NET CASH INFLOW FROM OPERATING ACTIVITIES	4,053	658

NOTE 8.3: OPERATING SEGMENTS

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	01/07/2017 - 30/06/2018
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health, Minister for Creative Industries and Minister for Equality.	01/07/2017 - 30/06/2018
Governing Boards	
C. Ross	01/07/2017 - 30/06/2018
L. Armstrong	01/07/2017 - 30/06/2018
K. Scanlon	01/07/2017 - 30/06/2018
D. Elford	01/07/2017 - 30/06/2018
R. Wright	01/07/2017 - 30/06/2018
D. O'Brien	01/07/2017 - 30/06/2018
L. Marta	01/07/2017 - 30/06/2018
Dr V. Wadhwa	01/07/2017 - 30/06/2018
Accountable Officers	
J. Holland (Chief Executive Officer)	01/07/2017 - 30/06/2018

Remuneration of Responsible Persons

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

Income Band	2018 **$**	2017 **$**
$0 - $9,999	8	11
$240,000 - $249,999	0	1
$270,000 - $279,999	1	0
Total Numbers	9	12
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	$274,959	$249,120

Amounts relating to Responsible Ministers are reported within the Department of Parliamentary Services' Financial Report as disclosed in Note 8.6.

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	
	2018 $'000	2017 $'000
Short-term employee benefits	383	394
Post-employment benefits	51	36
Other long-term benefits	12	12
Termination benefits	41	0
Share-based payments	0	0
Total Remuneration	487	442
Total Number of executives	4	4
Total annualised employee equivalent (AEE)	4	4

Notes:

(i) 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).

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

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;
- Jointly Controlled Operation - A member of the Hume Region Health Alliance; and
- all hospitals and public sector entities that are controlled and consolidated into the whole of state consolidated financial statements.

KMPs are those people with the authority and responsibility for planning, directing and controlling the activities of the Health Service and its controlled entities, directly or indirectly.

The Board of Directors and the Accountable Officer of Benalla Health and it's controlled entities are deemed to be KMPs.

Entity	KMPs	Position Title
Benalla Health	L. Armstrong	Chair of the Board
Benalla Health	C. Ross	Board Member
Benalla Health	K. Scanlon	Board Member
Benalla Health	D. Elford	Board Member
Benalla Health	R. Wright	Board Member
Benalla Health	D. O'Brien	Board Member
Benalla Health	L. Marta	Board Member
Benalla Health	Dr V. Wadhwa	Board Member
Benalla Health	J. Holland	Chief Executive Officer

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

COMPENSATION	2018 $'000	2017 $'000
Short term employee benefits	247	226
Post-employment benefits	22	18
Other long-term benefits	6	5
Termination benefits	0	0
Share based payments	0	0
Total	275	249

(i)Total remuneration paid to KMPs employed as a contractor during the reporting period through accounts payable has been reported under short-term employee benefits.
(ii)KMPs are also reported in Note 8.4 Resposible Persons or Note 8.5 Remuneration of Executives.

Significant transactions with government-related entities

Benalla Health received funding from the Department of Health and Human Services of $24,875,795 (2017: $21,433,101).

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

Professional medical indemnity insurance and other insurance products are obtained from a Victorian Public Financial Corporation.

Treasury Risk Management Directions require the Health Service to hold cash (in excess of working capital) and investments, and source all borrowings from Victorian Public Financial Corporations.

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.

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, other than those disclosed below. 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	2018 $'000	2017 $'000
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.	8	9

Note 8.7: REMUNERATION OF AUDITORS

	2018	2017
Victorian Auditor-General's Office	$'000	$'000
Audit or review of financial statement	21	20
	21	20
Other Providers		
Internal Audit Services	27	27
	27	27

NOTE 8.8: AASBs ISSUED THAT ARE NOT YET EFFECTIVE

Certain new Australian accounting standards have been published that are not mandatory for 30 June 2018 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 2018, 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.

Topic	Key Requirements	Effective date	Impact on financial statements
AASB 9 Financial Instruments	The key changes introduced by AASB 9 include simplified requirements for the classification and measurement of financial assets, a new hedge accounting model and a revised impairment loss model to recognise expected impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	01-Jan-18	The assessment has identified the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. The initial application of AASB 9 is not expected to significantly impact the financial position however there will be a change to the way financial instruments are classified and new disclosure requirements.
AASB 2014-1 *Amendments to Australian Accounting Standards [Part E Financial Instruments]*	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018, and to amend reduced disclosure requirements.	01-Jan-18	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 AAS's to incorporate the consequential amendments arising from the issuance of AASB 9.	01-Jan-18	The assessment has indicated there will be no significant impact for the public sector.
AASB 15 Revenue from Contracts with Customers	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer. Note that amending standard AASB 2015-8 *Amendments to Australian Accounting Standards - Effective Date of AASB 15* has deferred the effective date of AASB 15 to annual reporting periods beginning on or after 1 January 2018, instead of 1 January 2017.	01-Jan-18	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.

NOTE 8.8: AASBs ISSUED THAT ARE NOT YET EFFECTIVE

Topic	Key Requirements	Effective date	Impact on financial statements
AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15	Amends the measurement of trade receivables and the recognition of dividends as follows: - Trade receivables that do not have a significant financing component, are to be measured at their transaction price at initial recognition. - Dividends are recognised in the profit and loss only when: * the entity's right to receive payment of the dividend is established; * it is probable the economic benefits associated with the dividend will flow to the entity; and * the amount can be measured reliably.	01/01/2018 except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated there will be no significant impact for the public sector.
AASB 2015-8 *Amendments to Australian Accounting Standards - Effective Date of AASB 15*	This Standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2108	01-Jan-18	The amending standard will defer the application period of AASB 15 for for-profit entities to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2016-3 *Amendments to Australian Accounting Standards - Clarifications to AASB 15*	This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: - A promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation; - For items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer; and - For licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access).	01-Jan-18	The assessment has indicated there will be no significant impact for the public sector, other than the impact identified for AASB 15 above.

NOTE 8.8: AASBs ISSUED THAT ARE NOT YET EFFECTIVE

Topic	Key Requirements	Effective date	Impact on financial statements
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 2109.	01-Jan-19	The amending standard will defer the application period of AASB 15 for not-for-profit entities to the 2019-20 reporting period.
AASB 2016-8 *Amendments to Australian Accounting Standards - Australian Implementation Guidance for Not-for-Profit-Entities*	AASB 2016-8 inserts Australian requirements and authoritative implementation guidance for not-for-profit-entities into AASB 9 and AASB 15. This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events.	01-Jan-19	This standard clarifies the application of AASB 15 and AASB 9 in a not-for-profit context. The areas within these standards that are amended for not-for-profit application include: AASB 9 - Statutory receivables are recognised and measured similarly to financial assets. AASB 15 - The "customer" does not need to be the recipient of goods and/or services; - The "contract" could include an arrangement entered into under the direction of another party; - Contracts are enforceable if they are enforceable by legal or "equivalent means"; - Contracts do not have to have commercial substance, only economic substance; and - Performance obligations need to be "sufficiently specific" to be able to apply AASB 15 to these transactions.
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of operating leases (which are currently not recognised) on balance sheet.	01-Jan-19	The assessment has indicated that most operating leases, with the exception of short term and low value leases will come on to the balance sheet and will be recognised as right of use assets with a corresponding lease liability. In the operating statement, the operating lease expense will be replaced by depreciation expense of the asset and an interest charge. There will be no change for lessors as the classification of operating and finance leases remains unchanged.

NOTE 8.8: AASBs ISSUED THAT ARE NOT YET EFFECTIVE

Topic	Key Requirements	Effective date	Impact on financial statements
AASB 1058 *Income of Not-for-Profit-Entities*	AASB 1058 standard will replace the majority of income recognition in relation to government grants and other types of contributions requirements relating to public sector not-for-profit entities, previously in AASB 1004 *Contributions*. The restructure of administrative arrangement will remain under AASB 1004 and will be restricted to government entities and contributions by owners in a public sector context. AASB 1058 establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objective.	01-Jan-19	The current revenue recognition for grants is to recognise revenue up front upon receipt of the funds. This may change under AASB 1058, as capital grants for the construction of assets will need to be deferred. Income will be recognised over time, upon completion and satisfaction of performance obligations for assets being constructed, or income will be recognised at a point in time for acquisition of assets. The revenue recognition for operating grants will need to be analysed to establish whether the requirements under other applicable standards need to be considered for recognition of liabilities (which will have the effect of deferring the income associated with these grants). Only after that analysis would it be possible to conclude whether there are any changes to operating grants.

The following accounting pronouncements are also issued but not effective for the 2017-18 reporting period. At this stage, the preliminary assessment suggests they may have insignificant impacts on public sector reporting.

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

NOTE 8.9: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

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 8.10: JOINTLY CONTROLLED OPERATIONS AND ASSETS

Name of Entity	Principal Activity	Ownership Interest 2018 %	Ownership Interest 2017 %
Hume Rural Health Alliance	Information Systems	5.56	5.71

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:

	2018 $'000	2017 $'000
Current Assets		
Cash and Cash Equivalents	306	206
Receivables	216	149
Prepayments	8	8
Total Current Assets	530	363
Non Current Assets		
Property, Plant and Equipment	77	80
Intangible Assets	27	91
Total Non Current Assets	104	171
Total Assets	634	534
Current Liabilities		
Payables	277	28
Lease Liability	24	37
Total Current Liabilities	301	65
Non Current Liabilities		
Lease Liability	24	42
Total Non Current Liabilities	24	42
Total Liabilities	325	107
Share of Net Assets	309	427

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

	2018 $'000	2017 $'000
Revenues		
Operating Activities	448	488
Non Operating Activities	3	1
Total Revenue	451	489
Expenses		
Information Technology and Administrative Expenses		
- Management Fees	71	92
- Other Expenses from Continuing Operations	314	332
Total Operating Expenses	385	424
Capital Purpose Income	228	228
Depreciation	(39)	(48)
Expenditure from Capital Purpose Income	(355)	0
Amortisation	(5)	(3)
Finance Lease Charges	(2)	(2)
Total Capital & Specific Items	(173)	175
Other Economic Flows included in the result		
Revaluation of Long Service Leave	0	(5)
Net Result	(107)	235

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.

NOTE 8.11: ALTERNATIVE PRESENTATION OF COMPREHENSIVE OPERATING STATEMENT

	2018 $'000	2017 $'000
Grants		
Operating	24,232	23,477
Capital	3,366	498
Interest	272	253
Sales of goods and services	1,481	1,689
Other income	2,867	2,918
Total Revenue	32,218	28,835
Employee expenses	18,806	18,213
Depreciation and amortisation	2,121	2,174
Other operating expenses	9,833	9,188
Total Expenses	30,760	29,575
Net Result From Transactions - Net Operating Balance	1,458	(740)
Net gain/ (loss) on sale of non-financial assets	10	30
Other gains/ (losses) from other economic flows included in net result	(3)	102
Total Other Economic Flows Included in Net Result	7	132
NET RESULT	1,465	(608)

This alternative presentation reflects the format required for reporting to the Department of Treasury and Finance, which differs to the disclosures of certain transactions, in particular revenue and expenses, in the health service's annual report.

NOTE 8.12: ECONOMIC DEPENDENCY

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

Benalla
HEALTH