Kilmore District Health

Annual Report 2020-21

Kilmore District Health

Acknowledgement of Traditional Owners

Kilmore District Health acknowledges the Taungurung people, the traditional owners and custodians of the land and water on which we live, work and play. We pay respect to Elders past, present and emerging.

We affirm our commitment to reconciliation, and we make it happen by strengthening partnerships and continuing our work with Aboriginal peoples.

Kilmore District Health acknowledges that to 'Close the Gap' we need to work together with Aboriginal and Torres Strait Islander people, communities, staff and stakeholders to ensure that we meet community needs.

Child Safe Place

We comply with standards, and work to ensure that the safety of children is promoted, that child abuse is prevented, and that any allegations of child abuse are properly responded to.

Commitment Statement Against Family Violence

Our vision is a future where our community is free from family violence and where healthy, respectful relationships prevail.

All Welcome Here

Everybody matters. Kilmore District Health is committed to embracing diversity. We respect and welcome all people.

Our Annual Report

This report:

- Covers the period 1 July 2020 to 30 June 2021
- Is prepared for the Minister for Health, the Parliament of Victoria and the community we serve
- Is prepared in accordance with government and legislative requirements and FRD 30B guidelines
- Is prepared for presentation to the community at Kilmore District Health's Annual General Meeting in December 2021
- Acknowledges the support of our community
- Should be read in conjunction with our 2020-21 Quality Account Calendar
- Is available on our website www.kilmoredistricthealth.org.au/annual-reports
- Respects our environment and is printed in Ecostar Silk 100 percent recycled stock and available electronically.

Caring Together

Aged Care Residents
79
in 2020-21

Patients Admitted as Inpatients
1,904
in 2020-21

Babies Born
219
in 2020-21

District Nurse Home Visits
3,114
in 2020-21

Outpatient Appointments
6,401
in 2020-21

Urgent Care Attendances
18,244
in 2020-21

Staff Working at KDH
408
in 2020-21

Procedures Performed
1,863
in 2020-21

Meals on Wheels Produced
11,064
in 2020-21

Our Strategy

Our purpose is

Providing safe, quality, accessible care and a dynamic place to work and learn.

Our vision is

Caring Together. Better health and wellbeing for our community.

We live the values of REACH

We will work together to implement our Strategic Priorities

Quality Care

Consistently providing safe, compassionate care at the highest standard

People Who Care

Valuing, empowering and providing opportunities for our workforce

Partners in Care

Working collaboratively to deliver equitable and accessible care

Sustainable Care

Securing the future of effective and affordable local care

We will achieve the outcomes of

The best care for our consumers

A talented, engaged and satisfied workforce

Partnerships that provide services to best meet care needs

The best use of our resources

Our Message to the Community

"Due to the COVID-19 pandemic, 2020-21 has remained a challenging year for our organisation and our catchment community."

The health service's response to the COVID-19 pandemic has continued to take precedence over other priorities. We are proud that throughout this period we have continued to focus on providing best practice care for our patients, residents and clients, whilst also supporting our staff, the broader community and our partners.

Following widespread engagement and consultation, and despite the pandemic, we progressed and published our new strategic plan in December 2020. This included a change of name, with the service now known as Kilmore District Health, a name that reflects the range and scope of health services we deliver.

With the change of name, we have developed and implemented a new look for the health service that includes a new logo, updated website and style guide changes that reflect a modern and contemporary approach to health care delivery.

As the COVID-19 Commonwealth vaccine program was developed we have worked closely with the Goulburn Valley Public Health Unit to establish a COVID-19 Vaccination Clinic on our campus. This clinic was developed quickly, efficiently and safely, and is now delivering AstraZeneca and Pfizer vaccines for our staff and community.

Importantly we have continued to provide a full range of health care services within the COVID-19 pandemic restrictions regime, pivoting quickly to lockdowns and unexpected changes.

We recognise the vital contribution that consumers and carers can make to how we plan, design and deliver services and recognise the need to further embed engagement in all aspects of the organisation. Our commitment to effective community consultation continues to be supported by our Community Advisory Board Subcommittee and we recognise and thank the members for their support during the 2020-21 year.

Good governance has been upheld throughout the past year. Following a move to virtual board meetings in 2020 our Board is now proficient in operating via Microsoft Teams. The Board welcomed Ms Kathy Bell, Ms Jo-Anne Mazzeo and Ms Barbara Schade to the Board this year. We would like to acknowledge the valuable contributions made by Board Directors who are not continuing in 2021-22 and farewell Ms Jill Butty, Chair of the Clinical Governance Board Subcommittee and thank her for her significant contribution to our Health Service.

In December 2020, the Board farewelled our then Chief Executive Officer (CEO), Ms Sue Race after more than five years in the post. Sue's focus on communication, staff and consumer engagement, service reform and service improvement led to the sustainable development of a range of improved services, plus well developed clinical and operational governance processes. Sue is wished all the best for her move to Castlemaine Health.

Mr David Naughton commenced as the new CEO in January 2021, bringing with him a range of executive level rural and regional health service experience in both clinical and management roles.

A number of independent external experts sit on our governance committees and we would like to sincerely thank these people for their willingness to share their expertise and time.

Kilmore District Health is most grateful for the generosity of its supporters. Financial support from our loyal donors helps the Health Service to continue its work in providing high quality services for our local community. We are sincerely grateful to our Hospital Auxiliary and Opportunity Shop Committee members, plus individual donors for the contribution they make year after year to Kilmore District Health.

Despite the additional challenges and costs incurred by the health service to safely respond to the pandemic we are pleased to report a positive year end result with a surplus of $200,258 achieved.

In accordance with the *Financial Management Act 1994,* I am pleased to present the Report of Operations for Kilmore District Health for the year ending 30 June 2021.

Responsible Bodies Declaration – SD 5.2.3

Kathryn Harris
Chair, Board of Directors

Despite the COVID-19 pandemic challenges, we have continued to deliver high quality health care across all parts of the organisation, ensuring and maintaining high quality infection control standards to support our residents, patients, staff, contractors and the broader community.

Special thanks to the Australian Defence Force (ADF) who during the height of the pandemic with positive COVID-19 cases confirmed in Kilmore, worked with our clinical team to refine and improve our patient flow processes, COVID-19 testing/screening and practical logistics required to deliver safe ongoing care.

The pandemic has resulted in an increased use of virtual technology to deliver clinical care and corporate services. Work has been completed and is ongoing to improve the ICT infrastructure and technology in house.

Our staff have pivoted quickly to all the pandemic challenges and restrictions as they evolved. This includes delivering acute and urgent care cognisant of pandemic restrictions and maintaining high quality residential aged care across our two facilities. Of note has been the challenge in these residential facilities during periods of lock down and visitor restrictions. Our staff have worked closely with residents, carers and families to maintain social contact and communication. We celebrated the mass COVID-19 vaccination of our residents in April, with the second dose vaccine delivered in late June 2021.

We have continued to deliver COVID-19 testing/screening daily on an appointment basis, flexing to match demand as required. We have also delivered a comprehensive Respiratory Protection Program, n95 mask testing, ensuring maximum protection for our front of house staff.

In April 2021, we rapidly developed and implemented an on-site COVID-19 vaccination clinic now providing both AstraZeneca and Pfizer vaccines. We were successful in securing skilled and experienced fully credentialled clinical staff and administrative staff to deliver the vaccination program. Our clinic is responsive to the dynamic nature of COVID-19 vaccine delivery, rapidly responding to changing demand as priorities and need changes. We have actively engaged with our community to support the push to be vaccinated.

We continued to experience high demand on our services in 2020-21, with the hospital caring for 1,904 inpatients, 6,401 outpatients and 8,623 patients needing urgent care. The demand on our urgent care team was significantly impacted by COVID-19 with a 47 percent increase in activity that was mainly linked to the 9,621 COVID-19 tests provided. In addition, our normal risk maternity service welcomed 219 babies. During the year, and despite the restrictions and lockdowns, our activity has generally returned to pre -pandemic numbers.

In the hospital we operated 24 inpatient beds supporting patients needing acute, Geriatric Evaluation and Management and end-of-life care. Our hospital occupancy has remained high with 87 percent of available bed days utilised during the past year representing 7,643 days of care provided. Our Home-based services are provided to support and assist elderly people and people with disabilities, living at home or in the community, and their families. Our District Nursing Service delivered 3,114 visits in 2020-21 with pre-appointment screening continued to ensure it was safe to visit during the pandemic. Our health services provided over 11,064 meals to the local community through the Meals on Wheels program. We continued to partner with Nexus Primary Health to support the delivery of home based care to the community.

Our community remains supportive and engaged and our committed volunteers are the heart and soul of our health and aged care services. Like other services across the state, we had to pause our volunteer program during the pandemic and look forward to this re-starting as soon as possible. Kilmore District Health's achievements are not possible without the commitment and professionalism of our staff, along with the outstanding support of our team of Visiting Medical Officers. We value and recognise their dedication to our community and health service. We are proud of our dedicated staff and their achievements throughout the year, especially their ability to quickly flex and respond to the dynamic space that is pandemic management. Working through the pandemic, sometimes in full personal protective equipment, has been stressful and tiring. Like other health services across the broader system there has been an impact on our staff with planned leave and opportunities to recharge deferred. A positive staff culture is critical to ensure we deliver the best possible care at all times. Our staff are to be congratulated for the professionalism and dedication and capacity to cope with much change and uncertainty, both at work and at home.

The leadership shown by the Executive and Senior Managers has been exemplary and we acknowledge and thank them for their commitment to the health service. I also thank them for welcoming me to Kilmore and the excellent orientation and support provided.

I recommend our Annual Report to you and am proud to share the wonderful achievements of our team during the 2020-21 year.

David Naughton
Chief Executive Officer

Our Organisation

Kilmore District Health provides a comprehensive range of acute and aged care services to our rapidly increasing catchment population.

Kilmore District Health is located in Victoria in the Mitchell Shire and services a population over 40,000 that extends to Broadford and Pyalong in the north, Wallan and Craigieburn in the south, Lancefield and Romsey to the west; and Whittlesea to the east.

Kilmore District Health has provided health care services to our local community since it was founded in 1854. The hospital was incorporated under the provisions of the Hospitals & Charities Act on 17 November 1864 and is accountable to the people of Victoria, through the Minister for Health and the Minister for Disability, Ageing and Carers.

For the period 1 July 2020 to 26 September 2020
Jenny Mikakos MP
Minister for Health
Minister for Ambulance Services

From 26 September 2020 to 30 June 2021
The Hon Martin Foley MP
Minister for Health
Minister for Ambulance Services
Minister for Equality

The power and duties of Kilmore District Health are prescribed by the *Health Services Act 1988*. The agency operates from one site encompassing four facilities – the main hospital (housing multi-day beds, a perioperative suite and the Urgent Care Centre), Caladenia Nursing Home and Dianella Village Aged Care Hostel and the Outpatient Services Facility. Services are provided in home and community settings, including antenatal clinics operated from Seymour Health and Nexus Primary Health in Wallan.

Our Services

Kilmore District Health provides a comprehensive range of acute and aged care services to our rapidly increasing catchment population. Inpatient and outpatient services are offered to the Kilmore and district community.

Hospital Based Services

Our hospital services range from acute services in the areas of maternity, medical and surgical services, through to subacute care encompassing Geriatric Evaluation and Management, Transition Care and Palliative Care. The number and range of Visiting Specialists consulting from our Outpatient Facility continues to expand.

As the only provider of maternity services located in Mitchell Shire, the hospital supports over 300 women and families assessed as having a normal risk pregnancy to receive maternity (antenatal, birthing and postnatal) care close to home.

Our 24-hour Urgent Care Centre is attended by highly skilled and experienced nursing staff. Staff collaborate with local General Practitioners and Visiting Medical Officers, in providing first line care to all urgent attendances, and with Ambulance Victoria and receiving hospitals to stabilise and coordinate transfer to a higher level of care, where necessary.

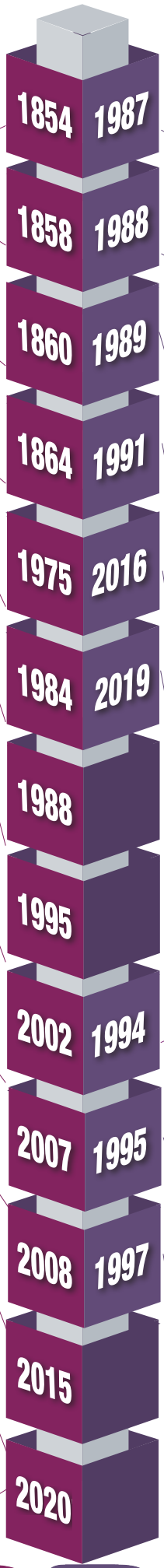
Aged Care Services

Caladenia Nursing Home and Dianella Village Hostel provide a home-like atmosphere with the security of assistance when required. Each facility has the capacity to support 30 care recipients. Respite care is also available.

Home Based Services

The District Nursing Service is funded through the Commonwealth Home Support Program (CHSP). This service helps older people stay independent and, in their homes, and communities for longer. We also receive state-based funding to provide support to younger people with disabilities living at home and produce delivered meals through the Victorian Home and Community Care program.

Our History



The Kilmore & District Hospital

1854
Hospital name was established

1858
The community raised funds of 1269 pounds and the Government granted 500 pounds for the building of a hospital

1860
Hospital opened and 86 patients treated in the first year

The original hospital is the second oldest of Victoria's District Hospitals and the most intact

1864
The Kilmore Hospital was incorporated under the provisions of the Hospitals & Charities Act on 17 November 1864

1975
The Hospital 20-bed ward was completed

1984
On the 29 July 1984 the extensions including the services wing and clinical support facilities were officially opened

1988
On the 23 November 1988, The Kilmore Hospital changed its name to The Kilmore & District Hospital to reflect the growing area that it served

1995
A major redevelopment project costing $2.2 million was completed on the 26 June 1995

Works included the renovations of existing operating theatre, general administration, the provision of new birthing suites, wards, a new accident and emergency area and 10 additional acute patient beds, increasing the total number of beds to 30 beds

2002
In 2002 an extension was built at the rear of the hospital to accommodate a dedicated reception for our Diagnostic Imaging service, capacity for the new CT scanner and ultrasound service

2007
Theatre Suite was renovated to ensure compliance with infection control standard and efficiency of patient service

2008
Hospital reception area was upgraded

2015
$20 million capital redevelopment was completed, including a dedicated outpatient facility, a second surgical suite, a day stay recovery area and an additional 30 acute inpatient beds

The project allowed for conversion of the existing consulting rooms into student accommodation and additional car parking

2020
The Kilmore & District Hospital changed name to Kilmore District Health

Caladenia Nursing Home

1987
On the 8 January 1987, The Kilmore Nursing Home Society was registered as a benevolent society under the provisions of the Hospital and Charities Act 1958

1988
Approval in principle to build Caladenia was received on the 25 May 1988 when we had funds in-hand of just $12,770

Three year fund raising campaign commenced with $1,502,730 in cash donations received over this time; $768,000 was received from the Commonwealth Government

1989
The Kilmore & District Nursing Home Society Inc. was incorporated under the Associations incorporation Act 1981 on 31 October 1989

1991
The construction of our 30 bed Nursing Home was completed during the 1990-91 financial year.

Our first resident moved in on the 17 June 1991 and Caladenia Nursing Home was officially opened on the 11 August 1991

2016
The Sensory Garden was opened on the 11 August 2016. This initiative was supported by a $10,000 grant from the Maggie Beer Foundation

2019
Significant Refurbishment (Stages 1 & 2) completed in February 2019

Dianella Village Hostel

1994
The Commonwealth Department of Human Services and Health granted approval in principle for a 30 bed Aged Care Hostel on 20 December 1994

1995
A major fundraising appeal was launched in 1995 with magnificent community support. Total donations of $707,000 were received. Together with the Commonwealth Government contribution of $847,000, Department of Veterans Affairs contribution of $160,000 and the Hospital contribution and borrowings, the total project funding and cost was $2.1m

1997
The construction of our 30 bed Hostel was completed during 1997

Our first resident moved in on the 18 August 1997

Dianella Village Hostel was officially opened on the 21 August 1997

Our Governance

Ms Kathryn Harris
Board Chair

Ms Wendy Kelly
Board Deputy Chair

Ms Jill Butty

Ms Kathryn Bell

Ms Kerry Free

Mrs Gillian Leach

Dr Jane Lovell

Ms Jo-Anne Mazzeo

Ms Barbara Schade

Mr Graham Thomson

The Board of Directors is appointed by the Governor in Council on the recommendation of the Victorian Minister for Health and is governed by the principles contained within the Health Services Act 1988 (as amended). The Board provides governance of Kilmore District Health and is responsible for its financial performance, strategic directions, the quality of its health care services and strengthening community involvement through greater partnerships.

Kilmore District Health by-laws enable the Board to delegate certain responsibilities. The by-laws are supported by the delegations of executive and operational responsibility, enabling designated executives and staff to perform their duties through the exercise of specified authority.

The Board meets monthly during the year with eleven General Committee Meetings and one special meeting focussing on strategic directions and planning. The Board Charter specifies a minimum of ten meetings to be held during the twelve-month period and Board Directors are required to attend a minimum of eight meetings each year. Twelve meetings were held during the year and all Board Directors met the attendance requirement.

All meetings of Board and Board Subcommittees during 2020-21 have been conducted virtually.

2020-21 Board Directors

Date = First Appointment		Attendance
Board Chair	Ms Kathryn Harris 1 July 2016	11
Board Deputy Chair	Mrs Wendy Kelly 1 July 2017	10
Directors	Ms Jill Butty 1 July 2018	10
	Ms Kathryn Bell 1 July 2020	11
	Ms Kerry Free 1 July 2019	7
	Mrs Gillian Leach 1 July 2019	12
	Dr Jane Lovell 1 July 2019	11
	Ms Jo-Anne Mazzeo 1 July 2020	9
	Ms Barbara Schade 1 July 2020	12
	Mr Graham Thomson 1 July 2019	12

Audit and Enterprise Risk Subcommittee

The Audit and Finance Subcommittee membership comprises four Board Directors, in accordance with the independence requirements of the Standing Directions of the Minister of Finance under the *Financial Management Act 1994*. The Chair of the Committee is nominated by the Audit and Finance Committee on an annual basis.

The Audit and Finance Committee membership included the following Board Directors: Mrs Gillian Leach, Ms Kathryn Harris, Ms Barbara Schade and Ms Jill Butty.

The Audit and Finance Committee meets bi-monthly and assists the Board in monitoring compliance with laws, regulations, standards and internal controls. Key responsibilities for the Audit and Finance Committee include developing and overseeing the hospital's internal audit plan and review of the draft Annual Accounts. All the committee members are independent of management.

Clinical Governance Subcommittee

The Clinical Governance Subcommittee membership comprises four Board Directors and two independent clinical experts. The membership included the following Board Directors: Ms Jill Butty (Chair), Dr Jane Lovell, Ms Kathryn Harris and Mr Graham Thomson. The independent members appointed to the committee were Ms Chris Best and Dr Wanda Stelmach.

Our consumer member Lauren Kathage continues to support this committee in 2020-21. Lauren provides positive feedback, with respect to her engagement on this committee.

The Clinical Governance Subcommittee aims to ensure that the community receives high quality and safe care close to home and that Kilmore District Health is committed to the constant improvement of all clinical and care services. The subcommittee meets bi-monthly to review and analyse information detailing the clinical care activities undertaken at Kilmore District Health.

Community Advisory Subcommittee

The Community Advisory Subcommittee membership comprises two Board Directors and up to ten consumer members who represent a diverse community perspective. The Chair of the committee is one of the consumer members and is nominated by the Committee on an annual basis.

The Community Advisory Subcommittee membership included the following Board Directors: Mrs Wendy Kelly and Mr Graham Thomson.

Eight consumer consultants sit on the Community Advisory Committee: Mrs Helen Clancy, Ms Gwenda Phillips, Mrs Debbie Davis, Ms Julie Metaxotos, Ms Roslyn Stewart, Mr Sarhalat Singhaphanh, Mr Darren Harris, Miss Maneet Hora, Fr Paul Walliker and Ms Emma Henderson. In accordance with the Terms of Reference a consumer member holds the position of committee chair, and we are grateful to Julie Metaxotos as Chair in 2020-21.

The Community Advisory Subcommittee meets bi-monthly and advises the Board on consumer and community participation in the development and delivery of services.

Governance and Remuneration Subcommittee

The Governance and Remuneration Subcommittee membership included the following Board Directors: Ms Kathryn Harris (Chair), Mrs Wendy Kelly and Ms Gillian Leach.

The Governance and Remuneration Committee meets three times per year and is responsible for advising and making recommendations to the Board of Directors in relation to matters involving organisational governance and administration, performance of the Chief Executive Officer, Executive staff remuneration; and recruitment and terms and conditions of employment.

Our Leadership

CHIEF EXECUTIVE OFFICER

Mr David Naughton

Cert MHN RN BN MPH FCHSM CHE

Accountable to the Board for the efficient and effective management of Kilmore District Health. Primary responsibilities include executive leadership, development and management of operational policy and strategic priorities agreed with the Board and in accordance with the funding, planning and regulatory framework of the Victorian Government Department of Health and Human Services.

DIRECTOR CLINICAL AND AGED CARE SERVICES, CHIEF NURSING AND MIDWIFERY OFFICER

Ms Jennifer Gilham

BNurs RIPERN GradDipHlthMgt

Responsible for overseeing the inpatient and non-admitted clinical services, after-hours' coordination, clinical support, infection control and aged care services. As Chief Nursing and Midwifery Officer, the role also has professional responsibility and leadership for all nursing and midwifery staff, the clinical competence framework and education.

DIRECTOR FINANCE AND SUPPORT SERVICES, CHIEF FINANCIAL AND PROCUREMENT OFFICER

Mr Colin Clark

BEc (Acc)

Responsible for providing financial management leadership and oversight of the organisations financial position. The position is also responsible for leading and managing the development of effective and efficient financial and corporate support services, including health support services, contracts and procurement, financial services and information technology services.

DIRECTOR MEDICAL SERVICES, CHIEF MEDICAL OFFICER

Dr Martin Duffy

MBBS MPH AFRACMA FANZCA

Responsible for professional leadership of the medical workforce. This role is accountable for the maintenance of professional standards of medical staff ensuring best practice guidelines and patient centred care philosophies are followed. Clinical governance, risk management, service development and continuity of care form the cornerstone of this role.

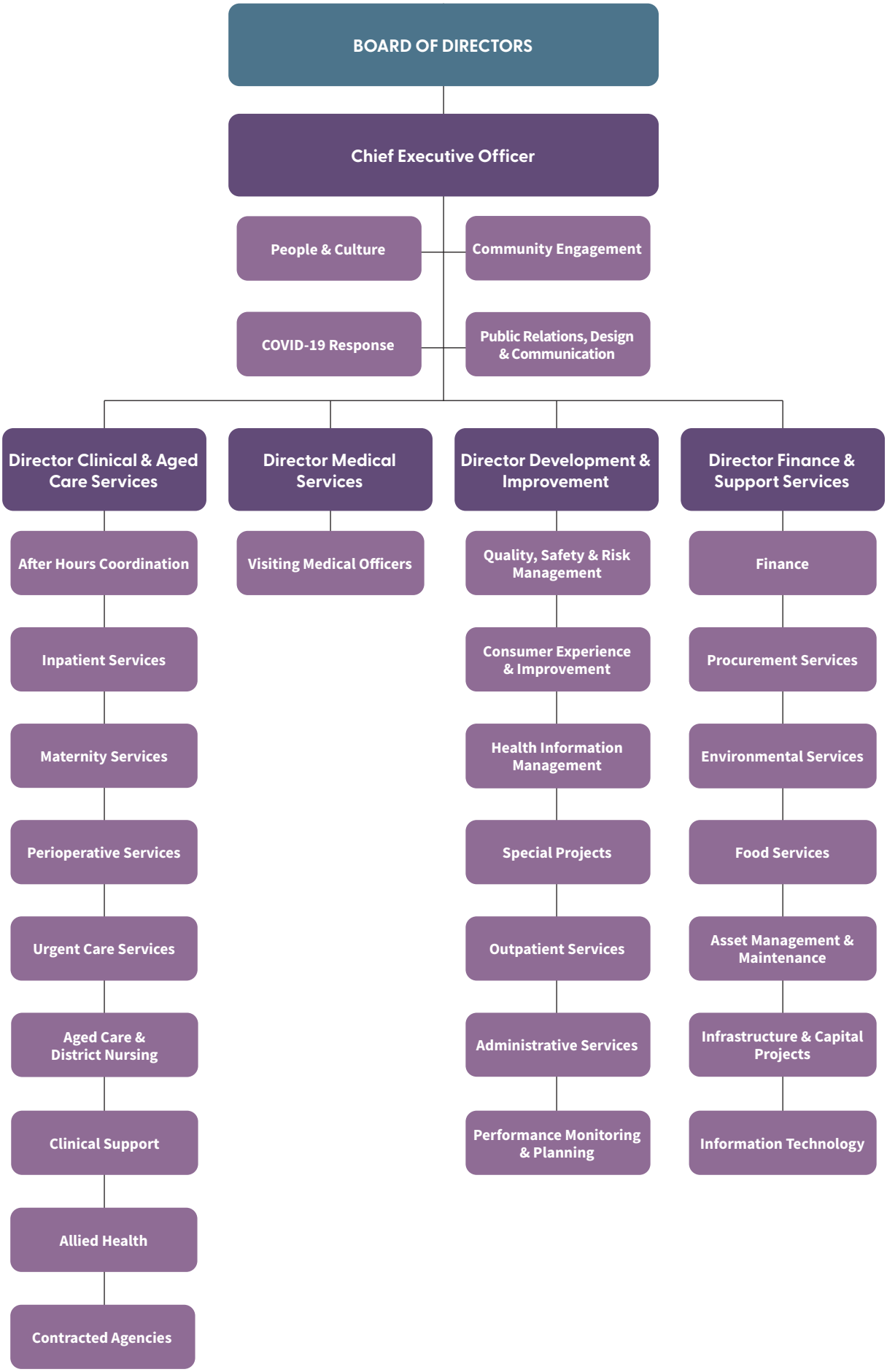
DIRECTOR DEVELOPMENT AND IMPROVEMENT

Ms Kirrily Gilchrist

BHIM

Accountable for the effective leadership and management of quality improvement, risk management and performance monitoring frameworks. This position is responsible for ensuring an effective, coordinated, organisation-wide approach to the provision of quality improvement, incident and risk management, health information; and performance monitoring and planning.

Organisational Structure



Our Supporters

Kilmore District Health is most appreciative of the continued support of our donors, Hospital Auxiliary, Opportunity Shop Committee and Volunteers.

Donors		Community Supporters
KDH Opportunity Shop	F Mock	Kilmore Alcoholics Anonymous
KDH Auxiliary	Conundrum Holdings Pty Ltd	Kilmore Toyota
Mr Greg Heffernan	D Thompson	Mitchell Masonic Lodge
Broadford Lions	R Buckley	Mitchell Shire Council
Victoria Police	M Steward	Rotary Club of Southern Mitchell
A Harris		The Kilmore Men's Shed

The financial donations and funding we receive enable us to improve our services to patients through the purchase of new equipment. In 2020-21 we received over $76,000 from our donors.

Hospital Auxiliary

We take this opportunity to thank our Hospital Auxiliary members who despite the pandemic continue to raise vital funds both within the hospital and the wider community. In 2020-21 the Auxiliary provided the hospital with funds raised in excess of $21,600. The opportunities available to the Auxiliary for fundraising were severely limited due to the restrictions resulting from the COVD-19 pandemic.

The funds raised by the Hospital Auxiliary have supported the purchase of the essential equipment for our Urgent Care Centre, visitor sofa beds for the inpatient unit and the replacement of blinds at Dianella Hostel. Upgrades to Theatre laptower, clinical equipment in maternity and Acute Services and an Interactive screen for Education/Telehealth.

Opportunity Shop Committee

A group of very dedicated volunteers run the Kilmore Opportunity (Opp) Shop Thursday, Friday and Saturday mornings and the profits raised directly benefit Kilmore District Health. The work of these volunteers is invaluable. Since the opening of the Opp Shop in November 2005, they have raised more than $600,000 which has been used to purchase equipment, furniture and services for both our Hospital and Aged Care Facilities. In 2020-21 the Opportunity Shop Committee provided the hospital with funds raised in excess of $11,000. These funds supported the purchase of essential equipment for our operating theatre.

Volunteers

Our Health Service is fortunate to have a very dedicated group of volunteers who assist in a range of roles and offer that extra bit of help to reassure patients in need. Our volunteer activity has been directly affected by the pandemic restrictions, with many of them belonging to identified vulnerable cohorts. Towards the end of 2020-21 some volunteer activity has been able to resume. Our volunteers assist in our Inpatient Unit, Theatre Suite, Aged Care Services, and Outpatient Consulting Suites whilst also supporting external events and initiatives.

We sincerely thank all our volunteers for their commitment to our organisation and look forward to welcoming them back in full when pandemic restrictions ease.

We also appreciate the contributions made by consumers who kindly provide their time to sit on our Community Advisory Board Subcommittee, act as patient ambassadors and are members of our consumer register. Our consumers make up a very special workforce who represent the voices of our patients. We currently have ten consumers on our register who have partnered with the hospital to provide their feedback and help us work towards implementing positive changes across the hospital.

All volunteers are required to maintain a satisfactory Criminal Record Check and Working with Children Check as part of our Child Safe Policy requirement.

Life Governors

An award of Life Governor may be conferred upon a person to recognise a significant contribution through voluntary, philanthropic and/or professional service to Kilmore District Health.

Service worthy of note may include: excellence/length of service as a volunteer; significant philanthropy; outstanding achievement and supporting service excellence; an exceptional contribution in years of service or effort; or contributing significantly above and beyond expectations of their role.

The purpose of the award is to recognise and honour people whose service and personal contributions, given willingly and freely, has resulted in a significant benefit to Kilmore District Health.

The award comprises a framed Certificate of Appointment, presented at the Annual General Meeting, usually held in the month of November.

Kilmore District Health's current Life Governors appointed up to and including 30 June 2021 are:

- Mr Peter Appleton
- Mrs Pat Arnott
- Mr Wally Arnott
- Ms Nancy Bidstrup
- Mrs Kaye Chapman
- Dr Peter Condos
- Dr Walter Cosolo
- Dr Barry Dawson
- Ms Elizabeth Dillon-Hensby
- Mr John Dixon
- Mrs Astrid Djulinac
- Dr John Griffiths
- Mrs Shirley Jean Hillier
- Dr Denis Holland
- Dr Suresh Jain
- Mrs M Merritt
- Ms Julia McGill
- Dr Das Panch
- Mrs Shirley Robinson
- Mr Allan Ryan
- Dr Frank Ryan
- Mr Allan L Smith
- Mr Ian Bentleigh Still
- Mr Alan J. Stute
- Mrs Barbara Sutton
- Mrs Marie Walters
- Mr Michael Wilson

Kilmore District Health conferred one new Life Governor Award at the Annual General Meeting held in December 2020.

Ms Julia McGill

For outstanding service provided over the 15 years served on the health service Board. It is noted that this included seven years as Board President/Chair. In addition, Julia served three years as Chair of the Audit Committee and three years as a member of the Clinical Governance Committee including one term as Chair.

In addition, under Julia's tenure, the Clinical Governance Board Subcommittee was established and the Community Advisory Subcommittee was formalised as a subcommittee of the board. To better support clinical credentialing, a Clinical Appointments Committee was convened. Julia is a worthy candidate for the award of Life Governor.

Our People

Kilmore District Health recruits high quality staff with the right skills to deliver the key objectives of the position, business units and organisation.

Workforce by Labour Category

Labour Category	June Current Month FTE 2020	June Current Month FTE 2021	Average Monthly FTE 2020	Average Monthly FTE 2021
Nursing	102.23	114.77	94.56	105.4
Administration and Clerical	25.10	33.51	22.14	26.94
Medical Support	3.32	3.26	2.14	3.57
Hotel and Allied	28.99	31.96	28.90	31.88
Hospital Medical Officers	1.49	2.09	1.44	1.89
Sessional Medical Specialists	0.25	0.25	0.25	0.25
Ancillary Staff (Allied Health)	11.11	10.61	9.97	11.06
Total	**172.49**	**196.45**	**159.40**	**180.99**

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

Recruiting Staff

Kilmore District Health had a very productive year in continuing to grow and develop our team. At the end of the 2020-21 financial year we had 408 employees with 115 new staff joining us over the year. This was an increase of 29 percent from the new staff joining our team in 2019-20. The new staff members included both permanent and casual employees.

Our Visiting Medical Officer (VMO) Group currently has a total of 81 credentialed VMOs. The VMO craft groups included Surgical, Obstetrics and Gynaecology, Urology, Geriatric Medicine, Sleep Therapy, Cardiology, Orthopaedics, Dental Surgery, Ears Nose and Throat and General Practice specialities. We have also increased our Shared Care Maternity base to nine, enabling more women from local areas to birth at Kilmore. In addition to the services provided by our VMOs, we have a reciprocal arrangement with both Northern Health and Austin Health VMOs to undertake Theatre lists from these organisations. The increase in VMOs and services has had a positive impact on the services and care being provided to the community.

Pre-employment Safety Screening

The organisation has a detailed and thorough credentialing and pre-employment verification to ensure we sustain safety and quality of health care provision. Applicable clinical staff are required to hold and maintain current registration with the relevant National Board in conjunction with the Australian Health Practitioner Regulation Agency (AHPRA) or equivalent. Registration verification has been streamlined through direct access to the AHPRA website. This enables Kilmore District Health to ensure that all clinical staff hold the necessary registration and notifies the organisation if any clinician has additional notifications or restrictions to their practice.

All staff are required to maintain a satisfactory Criminal Record Check and Working with Children Check as part of our Child Safe Policy requirement. This is part of our commitment to provide a Child Safe environment for all who enter and engage with Kilmore District Health.

Along with this, we are working on the implementation and roll out of the National Disability Insurance Scheme worker screening which came into effect on the 1 February 2021.

Payroll

Payroll is managed in-house with over 8,194 pays during 2020-21.

Employee Assistance Program

The Employee Assistance Program is a confidential external counselling service available to staff. The service helps in addressing personal concerns or work-related issues that have an impact on wellbeing and quality of life. There were 15 counselling sessions accessed by staff during 2020 -21. In addition to this, we had a Counsellor from Access EAP come onsite to conduct debrief sessions with our staff.

Developing Our Workforce

Kilmore District Health's education program develops the capacity, performance and capability of our staff. Education programs are specific for nursing, medical, allied health and administrative staff.

The mandatory training framework outlines training requirements by role. The online learning system profiles individual training schedules of mandatory and professionally recommended education courses for staff to ensure they maintain the knowledge and skills to perform their role safely.

Managers are required to conduct annual performance appraisals for their team members. This provides a formal framework to ensure performance discussions are held to review past achievements and set goals for the next twelve months.

An in-house education program provides informative sessions on a range of topics. In 2020 the introduction of social distancing measures saw our creative education team redeveloping competencies so that they could be completed on-line rather than delivered face to face. These changes have been well received by staff and many of the changes will be embedded in the program.

Workplace Training and Experience

In 2020-21 Kilmore District Health provided placement opportunities for over 160 students. The majority were participating in nursing professional practice placements both Registered Nursing and Enrolled Nursing students worked across our inpatient, theatre services, urgent care, district nursing and aged care services. We supported two nurses to complete placement required for re-entry into the nursing workforce to support their application for AHPRA registration.

Ten Vocational Education and Training students attended placement hours as part of their studies in Allied Health, Leisure and Lifestyle and Theatre Technician.

Each year we support our local schools' work experience program. Unfortunately, due to COVID-19 the program was cancelled again.

Kilmore District Health has established relationships with many universities and training organisations including: Federation University, Victoria University, Charles Sturt University, GOTafe, Deakin University, James Cook University, Charles Darwin University, RMIT, Latrobe University and the University of South Australia. Students may attend placement for two to eight weeks depending on the university or training organisation requirements and each placement is tailored to ensure the student achieves agreed upon objectives.

We take part in annual placement planning activities by the Department of Health to support ongoing facilitation of student placement, support and best practice in learning and education.

Work Health and Safety

Kilmore District Health is committed to providing a safe environment for employees, patients, visitors, volunteers and contractors. We operate in accordance with the Victorian Occupational Health and Safety Act 2004, Occupational Health and Safety (OHS) Regulations 2017, the Workplace Injury Rehabilitation and Compensation Act 2013 and other relevant legislation.

In 2020-21, staff were involved in health and safety decisions through meetings of the Work Health Safety Committee and regular consultation with health and safety representatives.

All OHS incidents are investigated to identify and implement remedial action. Regular workplace inspections are carried out and input is encouraged by health and safety representatives to ensure the identification and control of OHS hazards.

Work Health Safety education is provided at orientation and local induction and emergency response training is provided for emergency coordinators and area wardens. Our OHS training is led by our Work Health and Safety Advisor and includes: bullying and harassment awareness and prevention training for all managers; occupational violence and aggression management for clinical and front-line staff; manual handling 'train the trainer' education for clinical and support staff.

Staff wellbeing has been an ongoing focus of 2020-21 with the Wellbeing Working Group continuing to deliver regular inhouse wellbeing activities for staff, including terrarium making (supported by Bunnings).

Occupational Health and Safety

There were three new WorkCover claims accepted in 2020-21. This is a 76.9 percent reduction since 2018/19.

Two of the three employees with new claims have successfully been supported back to work on suitable duties, while the third is expected to return early in 2021/22. All four claimants from 2019/20 have made a full return to work.

The table below summarises the new workers' compensation claims lodged over the last three years. It shows a comparison of total new claims costs and the average cost per new claim.

Occupational Health and Safety Statistics	2020-21	2019-20	2018-19
The number of reported hazards/ incidents for the year per 100 FTE	89.3	56	53
The number of 'lost time' standard WorkCover claims for the year per 100 FTE	1.65	2.5	8.3
The average cost per WorkCover claim for the year ('000)	$5.5	$19	$5.3

Occupational Violence

Occupational violence is any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment, regardless of intent. The Work Health Safety Committee has oversight of occupational violence and agression issues across the organisation, reviewing incidents and addressing specific occupational violence concerns and promoting staff safety.

A drive to increase in reporting of occupational violence incidents has resulted in an increase in the reporting of no harm incidents in 2020-21.

Implementation of the action plan developed to address environmental security and staff safety risks continued in 2020-21, with a large-scale upgrade to closed circuit television system in progress but unfortunately delayed due to pandemic restrictions affecting non-essential contractors on site.

A system to manage occupational violence risk by early identification of behaviours that may become hazardous has been implemented. This gives staff a structured approach to ensuring staff safety and patient wellbeing by preventing the behaviours from escalating where possible. The use of personal duress alarms have been expanded for staff working on site as well as for those working in the community. Changes to the work environment included installation of additional security doors.

Kilmore District Health reports the following occupational violence statistics for 2020–21:

Occupational Violence Statistics	2020-21
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	195
Number of occupational violence incidents reported per 100 FTE	107.74
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	8.2%

Definitions:

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

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

Incident: An event or circumstance that could have resulted in, or did result in, harm to an employee.

Accepted WorkCover claims: Accepted WorkCover claims that were lodged in 2020-21.

Lost time: Is defined as greater than one day.

Injury, illness or condition: This includes all reported harm as a result of an incident, regardless of whether the employee required time off work or submitted a claim.

Employee recognition programs

Our staff continue to go above and beyond to achieve excellence. We aim to provide a platform for meaningful recognition that contributes to increased staff engagement and positive workplace behaviours.

In 2020-21 we continued our peer nominated awards program based on our REACH values of Respect, Excellence, Accountability, Compassion and Honesty (see opposite). Staff and volunteers nominate their peers who have gone above and beyond and exemplified one or more of our REACH values. Nominees are acknowledged at staff forums held every four months. Since the awards were introduced in July 2018 there have been over 400 nominations from across all disciplines of our workforce.

Dr Sarwat Shenouda Midwife Award

This award in honour of Dr Sarwat Shenouda is to recognise the Midwife who has made the most outstanding contribution for maternity services in the last year.

Announcing the recipient of the 2020-21 award was postponed due to COVID-19.

Recognising Excellence Staff Awards

Our Recognising Excellence Staff Awards highlight outstanding achievements demonstrated during the year.

Risk Management Award
UCC, Admin, Education & Infection Prevention
Introduction of drive through testing clinic for COVID-19

Workforce Award
Sarah Donehue
Increase in work health and safety across the health service

Consumer Award
Deb Davis, Helen Clancy & Alan Edwards
Co-design of discharge communication to improve consumer experience

Effectiveness Award
Aged Care Staff Caladenia & Dianella
Improving documentation through the use of progress note Macros in MANAD

Leadership And Culture Award
All Staff
Falls Prevention Project - To reduce the number and severity of falls occurring at KDH

2020-21 REACH Heroes

RESPECT Heroes

Gabrielle Hanson for supporting UCC staff by attending to staff screening when UCC was occupied with codes.
Lisa Keighran for changing work areas when required and always giving excellent care to patients.
Juliana Jesic shows respect and compassion when caring for residents, improving their mood and always being happy.
Kim Manuel helps others with things they may not fully understand.
Lisa Carlyon supported resident in Caladenia preventing the need to transfer to Hospital.

EXCELLENCE Heroes

Kylie Scott for mass communication work to multiple groups.
Sharon Jansen doing her job with great enthusiasm & dedication.
Flu Clinic Team for establishing and providing a fantastic service supporting over 400 people to be vaccinated.
Lucinda White for exceptional support of the COVID-19 testing clinic.
Outpatients Admin for being pro-active in finding new ways of doing tasks and dealing with infection control issues.
Jessica Renegado & Danielle Delaney for becoming Aged Care Infection Prevention and Control leads.

ACCOUNTABILITY Heroes

Environmental Services for their ability to respond to COVID-19 pandemic with professionalism and pride.
Maintenance Team for responding to the almost daily changing landscape during the COVID-19 pandemic.
Cameron Osborne has excelled in developing clinical skills within the District Nursing team over the last 6 months.
Shiree Brunt & Clare Taylor for working above expections to arrange stores in preparation for the new ordering system.
Chenoa Mullis, Deb Stavrinou & Jenn Grech for commitment to ensure their staff have their PDP completed on time.
Jo Dally for her commitment to hand hygiene auditing in 2020.

COMPASSION Heroes

All Personal Care Assistants for supporting residents through the COVID-19 pandemic.
Dr Nicole Astley for supporting UCC and seeing a patient whilst onsite in her downtime.
Louise Fall supports her team even when she is busy with her own patient load and has a positive attitude and smile.
Georgia Bell showed compassion caring for a resident during an acute medical episode. Handled the situation to high standard.
Bronwyn Kutz for her pleasant "nothing is too hard" attitude when assisting patients to understand private health fund matters.

HONESTY Heroes

Kate Barker for being honest to patients and giving them the correct information regarding COVID testing.
Wendy Pearce for contributing to the weekly falls meeting giving a honest account of the challenges in reducing falls.
Jessica Renegado is a great team leader, very honest and respectful. An outstanding RN with an amazing work ethic.
Antoinette Godinet follows all the values. Always gives 100% to her residents and staff. Supports us all.

REACH Superheroes

Lisa Carlyon for leading her team (during an extremely stressful busy time) in an exemplary manner.
Louise Hunter for managing PPE stores, on top of her multiple other roles, from the commencement of COVID.
Rebecca van de Paverd demonstrating commitment to quality, innovation and continuous improvement in Caladenia.
Emma Hoare amazing job with GEM clients, following nursing care plan and patient journey board to manage their care.

Our Priorities

Strategic Priorities

Goals	Strategies	Deliverables	Outcomes
COVID-19	How the health service maintains their COVID-19 readiness and response (including any arrangements in relation to hotel quarantine management)	Compliance with all COVID-19 policy directions and health service facility lock down restriction requirements	100 percent compliance
		Deliver COVID-19 testing/swabbing, including 'pop up' clinics during times of increased risk.	Appointment only drive through testing/swabbing clinic established, seven days per week. With capacity to flex up as required
		Establish a COVID-19 Vaccination Clinic	COVID-19 Vaccination clinic fully operational
		Support COVID-19 staff vaccination	Kilmore District Health Staff education and awareness campaigns delivered
		Ensure Residential Aged Care (RAC) residents receive COVID-19 vaccination	All RAC residents offered vaccination
		Regular staff COVID-19 communications	Regular Kilmore District Health newsletters, website and intranet updates. Flexed depending on COVID-19 status
		Regular staff COVID-19 meetings and briefing	Weekly Kilmore District Health Senior Leadership meetings
		Work with local government and other health service partners to deliver safe care and to support community awareness and strategies to improve access to care during the pandemic	Ongoing working relationship with Mitchell Shire and other key partners via the Lower Hume Primary Care Partnership

Goals	Strategies	Deliverables	Outcomes
Engaging with the community	How the health service engages with their community, especially with those who are most vulnerable including Aboriginal communities, and those whose treatment has been delayed due to COVID-19.	Community Connect quarterly newsletter	Published quarterly in print, distributed internally and to local GP clinics and electronically on Kilmore District Health website and social media
		Kilmore District Health Facebook	Active social media content
		Reconciliation Action Plan Committee	Regular virtual meetings with consistent consumer and community membership
		Compliments and Complaints	Complaints in 2020/21 total 100 with 4 being serious complaints. 82 percent of complaints were responded to within 30 days. Compliments are shared directly with managers, staff and consumers in person and on our Knowing How We Are Going boards. Compliments are also shared regularly to all committees as patient stories
		Engagement with local Media	Regular articles in the local paper that is delivered to all areas in our region and shared online

Goals	Strategies	Deliverables	Outcomes
Response to Mental Health and Aged Care Royal Commissions	How the health service will respond to the Mental Health and Aged Care Royal Commissions	Goulburn Mental Health and Wellbeing Steering Committee	Regular meeting engagement and attendance
		Lower Hume Primary Care Partnerships	Supported Lower Hume Mental Health workshop (30 April 2021) regarding the Mental Health Royal Commission next steps. Promoted and supported the development of a Population Health level Mental Health service plan
		Hospital Outreach Post-suicide Prevention Extension (HOPE) Steering Committee (led by Goulburn Valley Health)	Membership and active participation in the HOPE Steering Committee

Goals	Strategies	Deliverables	Outcomes
Local Partnerships with Aboriginal Community	How the health service develops and fosters local partnerships including with Aboriginal community controlled health organisations (ACCHOs), Traditional Owners, Registered Aboriginal Parties and local Aboriginal communities more broadly	Aboriginal and Torres Strait Islander cultural safety framework	Department of Health Cultural safety continuum audit tool demonstrates Kilmore District Health aligning between 'emerging' and 'competent' on both 'culturally safe workplace' and 'Aboriginal self-determination' continuums Plan to promote self audits with executive and senior leadership team in September 2021
		Reconciliation Action Plan	Registration with Reconciliation Australia to complete Kilmore District Health Reconciliation Action Plan. Plan endorsed on 06 July 2021 with the official launch and press release scheduled for late 2021 Actively work with Seymour Local Aboriginal Network to support community-based initiatives and advance work of the hospital Work closely with Lower Hume health & Wellbeing Program Officer on improving cultural safety at Kilmore District Health Developing relationships with Rumbalara Aboriginal Co-operative who provide services and support to consumers Development of Reconciliation Action Plan Working Group with community representation

Performance Priorities

High Quality and Safe Care

Key performance measure	Target	2020-21 Result
Infection prevention and control		
Compliance with Hand Hygiene Australia program	83%	90%
Percentage of healthcare workers immunised for influenza	90%	95%
Patient Experience		
Victorian Healthcare Experience Survey - Percentage of positive patient experience responses	95% positive experience	No surveys conducted in 2020-21
Victorian Healthcare Experience Survey - Percentage of very positive responses to questions on discharge care	75% very positive responses	No surveys conducted in 2020-21
Maternity and newborn		
Rate of singleton term infants without birth anomalies with Apgar score <7 to 5 minutes	≤ 1.4%	3.2%
Rate of severe foetal growth restriction (FGR) in singleton pregnancy undelivered by 40 weeks	≤ 28.6%	0%

Effective Financial Management

Key performance measure	Target	2020-21 Result
Operating result ($M)	0.03	0.2
Average number of days to paying trade creditors	60 days	65
Average number of days to receiving patient fee debtors	60 days	6
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	0.00
Actual number of days available cash, measured on the last day of each month	14.0 days	40.9
Variance between forecast and actual Net result from transactions (NRFT) for the current financial year ending 30 June	Variance ≤ $250,000	$734,182

Small Rural Health Service Activity Reporting

Funding type	2020-21 Activity Achievement	Units
Small Rural Acute	31	WIES Equivalents
Small Rural Primary Health & HACC	412.83	Service Hours
Small Rural Residential Care	20,028	Bed days
Health Workforce	112	Number of students

Our Performance at a Glance

Admitted	2020-21	2019-20	2018-19	2017-18	2016-17
Acute					
Number of Inpatients treated incl. same day	1,904	2,411	2,523	2,852	2,443
Beddays	3,934	4,880	5,245	5,890	4,937
Average Length of Stay	2.15	2.02	2.08	2.07	2.02
Geriatric Evaluation and Management (GEM)					
Number of Separations [i]	139	147	153	156	178
Beddays [i]	2,948	3,025	3,282	3,294	3,290
Average Length of Stay [i]	21.21	20.58	21.45	21.12	18.48
Operating Theatre					
Number of Operations	1,863	1,617	1,537	2,007	1,508
Number of Contract Operations [ii]	726	530	480	661	315
Maternity					
Births	219	212	240	258	247
Non-Admitted					
Outpatient Attendances	6,401	6,201	5,526	6,145	5,969
Urgent Care Centre (UCC) Attendances [iii]	18,244	9,556	8,938	9,199	8,521
Community Services					
District Nurse Visits	3,114	4,140	4,723	5,690	4,501
Meals on Wheels	11,064	8,821	8,868	10,589	9,022
Aged Care					
Nursing Home					
Beddays	9,566	10,061	9,763	9,927	8,858
Occupancy	87	91.88	88.67	90.66	80.89
Residents Accommodated	42	44	41	38	40
Average Length of Stay	651	691	781	660	709
Hostel					
Beddays	10,462	10,451	10,761	10,719	10,614
Occupancy	96	95.44	98.27	97.89	96.93
Residents Accommodated	37	38	37	52	61
Average Length of Stay	756	1,090	989	731	618

[i] Service undertaken in partnership with Northern Health

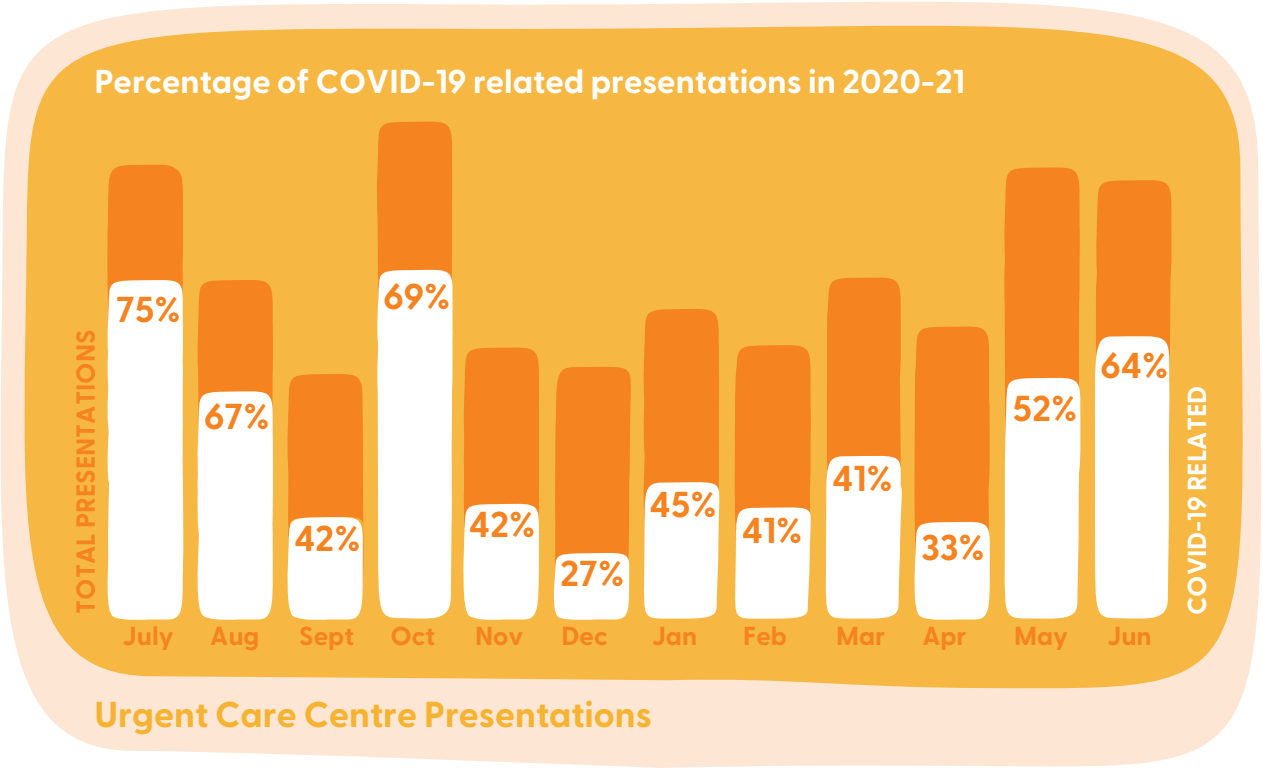
[ii] Service contracted with Northern Health & Austin Health (subset of the total number of operations)

[iii] UCC Attendances include COVID-19 testing for 2019-20 & 2020-21

Admitted patient data is to be sourced from the Victorian Admitted Episode Dataset (VAED), and definitions are in accordance with the standards in the VAED Manual. The VAED is not final for 2019-20.

Non-admitted data is in accordance with the definitions in the Agency Information Management System (AIMS) manual.

Our COVID-19 Response



Urgent Care Centre Presentations

10,046 COVID-19 Tests conducted

886 Asymptomatic testing

27 Average of daily swabs

COVID-19 Testing

210 Staff Fit Tested for masks

Fit Testing

100% Aged Care Residents vaccinated

1,430 Pfizer Vaccinations

2,329 AstraZeneca Vaccinations

5 Days of outreach vaccination clinics

212 vaccinations administered

31 Staff employed in Vaccination Clinic

3,759 Vaccinations administered during 2020-21

COVID-19 Vaccination Clinic

Our Finances

For the year ended 30 June 2021 compared with the last five financial years

	2021 $'000	2020 $'000	2019 $'000	2018 $'000	2017 $'000
Operating Result*	200	206	120	(122)	(420)
Total Revenue	31,601	27,563	26,169	23,721	20,317
Total Expenses	32,489	28,418	27,558	25,929	22,902
Net result from transactions	(888)	(855)	(1,389)	(2,208)	(2,585)
Total other economic flows	89	9	56	1	1
Net Result	**(799)**	**(846)**	**(1,333)**	**(2,208)**	**(2,584)**
Total Assets	38,646	39,549	36,918	36,918	39,234
Total Liabilities	13,872	13,976	10,500	9,888	9,996
Net Assets / Total Equity	**24,774**	**25,573**	**26,419**	**27,030**	**29,238**

* The Operating result is the result for which the Health Service is monitored in its Statement of Priorities
Prepared in accordance with Australian Accounting Standards which include A-IFRS

Reconciliation of Net Result from Transactions and Operating Result

	2020-21 $'000
Net Operating Result	**200**
Capital purpose income	1,200
Specific income	-
COVID-19 State Supply Arrangements	351
• Assets received free of charge or for nil consideration under the State Supply	
State supply items consumed up to 30 June 2021	351
Assets provided free of charge	-
Assets received free of charge	-
Expenditure for capital purposes	-
Depreciation and amortisation	2,208
Impairment of non-financial assets	-
Finance costs (other)	-
Net result from transactions	**(888)**

Significant Changes in Financial Position During 2020–21

A $79,579 operating deficit was forecast at the beginning of the year however the end result was a surplus of $200,258. The major factor for the improved result was the additional contracted surgery performed in partnership with the Austin and Northern Hospitals. Initial revenue targets set were $1.216m yet we achieved $2.2255m.

Summary of Major Changes or Factors which have Affected the Achievement of Operational Objectives for the Year

The major factors which have affected the achievement of operational objectives for the year included the improvement in residential aged care revenue due to additional resources allocated to support the Aged Care Funding Instrument process. The costs associated with COVID-19 were largely offset through additional grant allocations from Department of Health as well as Personal Protective Equipment stock received free of charge through the central state supply.

Events Subsequent to Balance Date, which may have a Significant Effect on the Operations of the Entity in Subsequent Years

There have been no significant events subsequent to balance date affecting the operations of the hospital.

Revenue Indicators as at 30 June 2021

Average Collection Days	2020-21	2019-20
Private Inpatient Fees	12.6	16.9
District Nursing Services	35.3	41.8

Outstanding Debtors as at 30 June 2021

Average Collection Days	Under 30 Days ($)	30-60 Days ($)	61-90 Days ($)	Over 90 Days ($)	Total June 2021 ($)	Total June 2020 ($)
Hospital - Inpatient Fees	29,634	-	-	4,689	34,324	37,512
District Nursing Fees	6,759	-	-	-	6,759	23,335
Residential Aged Care	5,666	-	-	-	5,666	3,120
Total					**46,749**	**63,967**

Consultancies less than $10,000

In 2020-21 Kilmore District Health engaged two consultants where the total fees payable to the consultant were less than $10,000, with a total expenditure of $12,296 (excluding GST).

Consultancies more than $10,000

In 2020-21 Kilmore District Health engaged one consultant where the total fees payable were in excess of $10,000 (excluding GST):

Consultancy	Purpose of Consultancy	Total Expenditure ($)
Health Recruitment Specialists	CEO Recruitment	$20,000

Disclosure of Ex-Gratia Payments

Kilmore District Health made no ex-gratia payments for the year ending 30 June 2021.

Disclosure of Information and Communication Technology (ICT) Expenditure

Kilmore District Health's total ICT expenditure incurred during 2020-21 is $0.865 million (excluding GST) with the details shown below:

Business as Usual (BAU) ICT expenditure	Non-Business as Usual (Non-BAU) ICT expenditure		
Total (excluding GST)	Total = Operational and Capital Expenditure (excluding GST)	Operational expenditure (excluding GST)	Capital expenditure (excluding GST)
$0.865 million	$0 million	$0 million	$0 million

Our Compliance

Building and Maintenance Compliance

During 2020-21 Kilmore District Health buildings complied with the *Building Act 1993* as evident in the annual certificate of compliance of essential services. In order to ensure buildings are maintained in a safe and functional condition, ongoing maintenance programs are in place. In addition, Kilmore District Health complies substantially with the Department of Health and Human Services Fire Risk Management Guidelines.

Carers Recognition

The *Carers Recognition Act 2012* recognises, promotes and values the role of carers. Kilmore District Health understands the different needs of carers and the value they provide to the community. Kilmore District Health takes practical measures to ensure that our staff have an awareness and understanding of the care relationship principles and this is reflected in our commitment to a model of patient- and family-centred care and to involving carers in the development and delivery of our services. Kilmore District Health was not required to make any disclosures during the reporting period.

Compliance

Kilmore District Health has complied substantially with the requirements of the Victorian Public Sector Financial Management Compliance Framework for the year ended 30 June 2021.

Freedom of Information

Members of the public can make a Freedom of Information (FOI) request in writing to Kilmore District Health, addressing it to the Manager of Health Information, who is the delegated officer for which requests are to be made. There is a standard application fee for all requests as well as any search, photocopying and postage fees which are determined on a case by case basis.

In 2020-21 Kilmore District Health received 43 FOI requests. All applications were assessed according to the *Freedom of Information Act (1982)* requirements and prescribed in section 7(4). Request types in 2020-21 ranged from solicitor and consumer requests.

Further information regarding FOI can be found at the https://ovic.vic.gov.au

Local Jobs First Act 2003

In 2020-21 there were no contracts requiring disclosure under the Local Jobs First Policy.

Kilmore District Health complies with the intent of the *Victorian Industry Participation Policy Act 2003* and has no requirements of disclosures for the 2020-21 financial year. The Act requires, wherever possible, local industry participation in supplies, taking into consideration the principle of value for money and transparent tendering processes.

Merit and equity principles

Kilmore District Health 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.

National Competition Policy

In accordance with the Competition Principles Agreement, Victoria is obliged to apply competitive neutrality policy and principles to all significant business activities undertaken by government agencies and local authorities.

Kilmore District Health continues to comply with the National Competition Policy. The Victorian Government's competitive neutrality pricing principles for all relevant business activities have also been applied by Kilmore District Health.

Privacy

Privacy is an important part of the culture at Kilmore District Health. Since the *Health Records Act (2001)* became legally binding in 2002, the hospital has aimed to ensure all staff are aware of the Act and its implications in the workplace. The hospital also aims to ensure compliance with the *Privacy and Data Protection Bill (2014)*.

Kilmore District Health's Privacy Officer role is delegated to the Manager Health Information, Ms Justine Muston (until October 2020) and Ms Chenoa Mullis (from November 2020).

Public Interest Disclosure

Kilmore District Health is an agency subject to the *Public Interest Disclosure Act (2012)* which 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 protecting them when they do. Kilmore District Health was not required to disclose any issues under the Act in 2020-21.

Safe Patient Care

The *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* aims to ensure quality care and better patient outcomes. The purposes of the Act are to provide for requirements that the operators of certain publicly funded health facilities staff certain wards with a minimum number of nurses and midwives and the reporting of compliance with and enforcement of those requirements.

Kilmore District Health understands the nurse to patient and midwife to patient ratios applicable to our organisation and takes practical measures to ensure that our service is staffed in accordance with the Act. The hospital has no matters to report in relation to its obligations under section 40 of the *Safe Patient Care Act 2015.*

Gender Equity Act 2020

The *Gender Equality Act 2020* promotes gender equality by requiring the Victorian public sector, local councils and universities to take positive action towards achieving workplace gender equality. As a result, Kilmore District Health is required to consider and promote gender equality in our policies, programs and services.

As an initial step, Kilmore District Health is currently conducting our workplace gender audit which forms the base line of information and data to analysis and create an action plan. The action plan is required to be finalised and submitted to the Commissioner for Gender Equality by the 1 December 2021.

In addition to this, as policies, procedure and new programs are being developed and reviewed, we will be conducting a Gender Impact Assessment to ensure we are taking steps to achieve gender equality.

Environmental Achievements

Kilmore District Health is committed to improving the way we manage our energy, materials and waste for a sustainable and thriving future. As a health service, we have a responsibility to contribute to a sustainable environment through planned and well managed policies and actions.

The Sustainability and Waste Action Group (SWAG) continues to guide the implementation of the Environmental Sustainability Strategy. In addition, this group monitors the energy efficiency and waste management program. The key achievements for 2020-21 include:

- Participation in the Victorian Regional Solar Energy project. Installation of solar panels was completed in June. We are hoping to see a reduction in energy consumption of 204K KWh per annum translating to a 16 percent reduction in C02e.
- The Environmental Sustainability Strategy for 2021-23 was endorsed by the board in October 2021. It contains a full set of KPIs that the SWAG group oversee and is reported to the board annually.

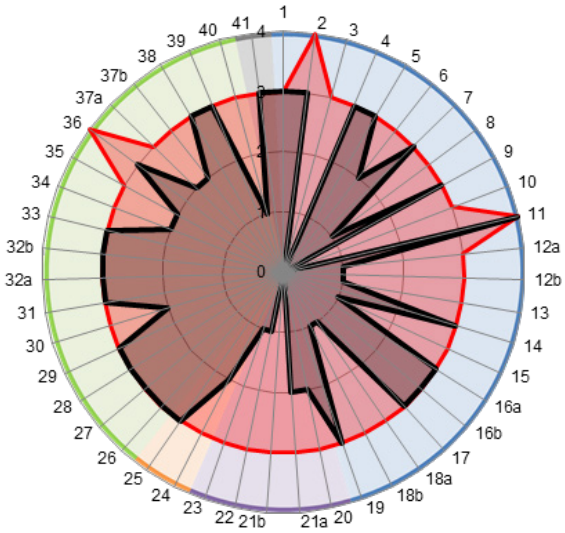
	2020-21	2019-20	2018-19
Gas (GJ)	7,739	8,357	7,841
Electricity (KWh)	991,309	1,020,559	1,015,306
CO2 (Tonnes)	1,507	1,610	1,623
Water (KL)	7,867	8,025	8,147
Clinical Waste (KG)	11,596	6,247	6,691

The reduction in C02e for the 2020-21 year was 6 percent which exceeded the target set for the year.

Asset Management Accountability Framework Maturity Assessment

The following sections summarise Kilmore District Health's assessment of maturity against the requirements of the Asset Management Accountability Framework (AMAF). The AMAF is a non-prescriptive, devolved accountability model of asset management that requires compliance with 41 mandatory requirements. These requirements can be found on the DTF website (https://www.dtf.vic.gov.au/infrastructure-investment/asset-management-accountability-framework).

Kilmore District Health's target maturity rating is 'competence', meaning systems and processes fully in place, consistently applied and systematically meeting the AMAF requirement, including a continuous improvement process to expand system performance above AMAF minimum requirements.



Leadership and Accountability (requirements 1-19)

Kilmore District Health has met its target maturity level under most requirements within this category. Kilmore District Health partially complied with some requirements in the areas of allocating asset management responsibility, monitoring asset performance, asset management system performance and evaluation of asset performance. There is no material non-compliance reported in this category. Kilmore District Health is developing a plan for improvement to establish processes to proactively identify potential leadership and accountability deficiencies and identify options for preventive action.

Planning (requirements 20-23)

Kilmore District Health has met its target maturity level under most requirements within this category. Kilmore District Health partially complied with some requirements in the areas of asset management strategy and risk management and contingency planning. There is no material non-compliance reported in this category. Kilmore District Health is developing a plan for improvement to establish processes to proactively identify potential leadership and accountability deficiencies and identify options for preventive action.

Acquisition (requirements 24 and 25)

Kilmore District Health has met its target maturity level under most requirements within this category. Kilmore District Health partially complied with some requirements in the areas of overview. There is no material non-compliance reported in this category. A plan for improvement is in place to improve Kilmore District Health's maturity rating in these areas.

Operation (requirements 26-40)

Kilmore District Health has met its target maturity level under most requirements within this category. Kilmore District Health partially complied with some requirements in the areas of monitoring and preventative action and information management. A plan for improvement is in place to improve Kilmore District Health's maturity rating in these areas.

Disposal (requirement 41)

Kilmore District Health has met its target maturity level in this category.

Additional Information Available on Request

In compliance with the requirements of FRD 22H Standard Disclosures in the Report of Operations, details in respect of the items listed below have been retained by Kilmore District Health and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the *Freedom of Information (FOI) Act 1982* requirements, if applicable):

- A statement that declarations of pecuniary interests have been duly completed by all relevant officers
- Details of shares held by senior officers as nominee or held beneficially in a statutory authority or subsidiary
- Details of publications produced by Kilmore District Health
- Details of changes in prices, fees, charges, rates and levies charged
- Details of any major external reviews carried out
- Details of major research and development activities undertaken
- Details of overseas visits undertaken including a summary of the objectives and outcomes of each visit
- Details of major promotional, public relations and marketing activities undertaken by the entity to develop community awareness of Kilmore District Health and its services
- Details of assessments and measures undertaken to improve the occupational health and safety of employees
- General statement on industrial relations within Kilmore District Health and details of time lost through industrial accidents and disputes
- A list of major committees sponsored by Kilmore District Health, the purposes of each committee and the extent to which those purposes have been achieved
- Details of all consultancies and contractors including consultants/contractors engaged, services provided, and expenditure committed for each engagement.

Attestations

Financial Management Compliance attestation – SD 5.1.4

I, Kathryn Harris, on behalf of the Responsible Body, certify that Kilmore District Health has no Material Compliance Deficiency with respect to the applicable Standing Directions under the *Financial Management Act 1994* and instructions.

Kathryn Harris
Chair, Board of Directors
Kilmore District Health
9 September 2021

Data Integrity Declaration

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

David Naughton
Accountable Officer
Kilmore District Health
9 September 2021

Conflict of Interest

I, David Naughton, certify that Kilmore District 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 Kilmore District 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.

David Naughton
Accountable Officer
Kilmore District Health
9 September 2021

Integrity, Fraud and Corruption Declaration

I, David Naughton, certify that Kilmore District Health has put in place appropriate internal controls and processes to ensure that integrity, fraud and corruption risks have been reviewed and addressed at Kilmore District Health during the year.

David Naughton
Accountable Officer
Kilmore District Health
9 September 2021

Disclosure Index

The Annual Report of Kilmore District Health is prepared in accordance with all relevant Victorian legislations and pronouncements. This index has been prepared to facilitate identification of the department's compliance with statutory disclosure requirements.

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Kilmore District Health

Opinion	I have audited the financial report of Kilmore District Health (the health service) which comprises the: • balance sheet as at 30 June 2021 • 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 2021 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.
Basis for Opinion	I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. I further describe my responsibilities under that Act and those standards in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report. My independence is established by the *Constitution Act 1975.* My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Victoria. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.
Board's responsibilities for the financial report	The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Financial Management Act 1994*, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error. In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.

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

Auditor's responsibilities for the audit of the financial report	As required by the *Audit Act 1994,* my responsibility is to express an opinion on the financial report based on the audit. My objectives for the audit are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report. As part of an audit in accordance with the Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also: • identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. • obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the health service's internal control • evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board • conclude on the appropriateness of the Board's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the health service's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the health service to cease to continue as a going concern. • evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation. I communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

MELBOURNE
7 October 2021

Dominika Ryan
as delegate for the Auditor-General of Victoria

Board member's, accountable officer's and chief finance and accounting officer's declaration

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

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2021 and financial position of Kilmore District Health as at 30 June 2021.

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

We authorise the attached financial report for issue on 9 September 2021.

Ms Kathryn Harris
Board Chair

Kilmore
9 September 2021

Mr David Naughton
Chief Executive Officer

Kilmore
9 September 2021

Mr. C. Clark
Chief Finance and Accounting Officer

Kilmore
9 September 2021

Financial Statements

Comprehensive Operating Statement

For the Financial Year Ended 30 June 2021

	Note	Total 2021 $'000	Total 2020 $'000
Revenue and income from transactions			
Operating Activities	2.1	31,566	27,481
Non-operating Activities	2.1	35	82
Total revenue and income from transactions		**31,601**	**27,563**
Expenses from transactions			
Employee Expenses	3.1	(24,970)	(21,688)
Supplies and Consumables	3.1	(3,081)	(2,575)
Depreciation and Amortisation	4.3	(2,208)	(2,116)
Other Operating Expenses	3.1	(2,230)	(2,039)
Total Expenses from transactions		**(32,489)**	**(28,418)**
Net result from transactions - net operating balance		**(888)**	**(855)**
Other economic flows included in net result			
Net gain/(loss) on non-financial assets	3.4	(11)	(7)
Other Gain/(Loss) from other economic flows	3.4	100	16
Total Other economic flows included in net result		**89**	**9**
Net result for the year		**(799)**	**(846)**
Other comprehensive income			
Items that will not be classified to the net result			
Changes to Property, Plant and Equipment Revaluation Surplus	4.1(b)	-	-
Total other comprehensive income		-	-
Comprehensive result for the year		**(799)**	**(846)**

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

Balance Sheet as at 30 June 2021

	Note	Total 2021 $'000	Total 2020 $'000
Current assets			
Cash and cash equivalents	6.2	9,564	10,537
Receivables	5.1	1,441	923
Inventories	4.4	228	206
Other financial assets		134	115
Total current assets		**11,367**	**11,781**
Non-current assets			
Receivables	5.1	1,206	1,083
Property, plant & equipment	4.1(a)	26,070	26,664
Intangible assets	4.2	3	21
Total non-current assets		**27,279**	**27,768**
Total assets		**38,646**	**39,549**
Current Liabilities			
Payables	5.2	2,385	1,692
Borrowings	6.1	170	8
Employee benefits	3.4	4,401	3,974
Other liabilities	5.3	6,143	7,451
Total current liabilities		**13,099**	**13,125**
Non-current liabilities			
Borrowings	6.1	318	396
Employee benefits	3.4	455	455
Total non-current liabilities		**773**	**851**
Total liabilities		**13,872**	**13,976**
Net assets		**24,774**	**25,573**
Equity			
Property, plant and equipment revaluation surplus	4.1(f)	18,268	18,268
Contributed capital	SCE	11,532	11,532
Accumulated surpluses/(deficits)	SCE	(5,026)	(4,227)
Total equity		**24,774**	**25,573**

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

Statement of Changes in Equity

For the Financial Year Ended 30 June 21

	Note	Property, Plant & Equipment Revaluation Surplus	Contributed Capital	Accumulated Surpluses/ (Deficits)	Total
		$'000	$'000	$'000	$'000
Balance at 1 July 2019		**18,268**	**11,532**	**(3,381)**	**26,419**
Net result for the year		-	-	(846)	(846)
Other comprehensive income for the year		-	-	-	-
Balance at 30 June 2020		**18,268**	**11,532**	**(4,227)**	**25,573**
Net result for the year		-	-	(799)	(799)
Other comprehensive income for the year		-	-	-	-
Balance at 30 June 2021		**18,268**	**11,532**	**(5,026)**	**24,774**

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

Cash Flow Statement

For the Financial Year Ended 30 June 2021

	Note	Total 2021 $'000	Total 2020 $'000
Cash Flows From operating activities			
Operating grants from government		20,223	17,958
Capital grants from government - State		598	99
Other capital receipts		450	82
Patient and resident fees received		5,518	5,020
GST Received from ATO		1,045	761
Recoupment from private practice for use of health services facilities		37	51
Other capital receipts		35	236
Other receipts		4,142	4,013
Total Receipts		**32,048**	**28,220**
Employee expenses paid		(24,794)	(21,801)
Payment for supplies & consumables		(5,112)	(5,281)
GST paid to ATO		(423)	(327)
Total payments		**(30,329)**	**(27,409)**
Net cash flows from/(used in) operating activities	8.1	**1,719**	**811**
Cash Flows From investing activities			
Purchase of Non-Financial Assets		(1,478)	(480)
Proceeds from disposal of property, plant and equipment		71	18
Net cash flows from/(used in) investing activities		**(1,407)**	**(462)**
Cash Flows from Financing Activities			
Proceeds from borrowings		-	303
Receipt of accommodation deposits		1,140	4,130
Repayment of accommodation deposits		(2,425)	(1,083)
Net Cash Flow from/(used in) Financing Activities		**(1,285)**	**3,350**
Net Increase/(Decrease) in Cash and Cash Equivilents Held		**(973)**	**3,699**
Cash and Cash Equivalents at Beginning of Year		10,537	6,838
Cash and Cash Equivalents at End of Year	6.2	**9,564**	**10,537**

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

Note 1: Basis of preparation

Structure

These annual financial statements represent the audited general purpose financial statements for Kilmore District Health for the year ended 30 June 2021. The report provides users with information about the Kilmore District Health's stewardship of resources entrusted to it.

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

Note 1.1: Basis of preperation of the financial statements

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

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

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

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

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

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

The financial statements are presented on a going concern basis (refer to Note 8.8 Economic Dependency).

The financial statements are in Australian dollars.

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

The annual financial statements were authorised for issue by the Board of Kilmore District Health on 9 September 2021.

Note 1.2: Impact of COVID-19 pandemic

In March 2020 a state of emergency was declared in Victoria due to the global coronavirus pandemic, known as COVID-19. Since this date, to contain the spread of COVID-19 and prioritise the health and safety of our community, Kilmore District Health was required to comply with various directions announced by the Commonwealth and State Governments, which in turn, has continued to impact the way in which Kilmore District Health operates.

Kilmore District Health introduced a range of measures in both the prior and current year, including:

- introducing restrictions on non-essential visitors
- greater utilisation of telehealth services
- implementing reduced visitor hours
- deferring elective surgery and reducing activity
- performing COVID-19 testing
- administering COVID-19 vaccinations
- implementing work from home arrangements where appropriate.

As restrictions have eased towards the end of the financial year the Health Service has been able to revise some measures where appropriate including the reintroduction of elective surgery.

Further information on the impacts of the pandemic are disclosed at:

- Note 2: Funding delivery of our services
- Note 3: The cost of delivering our services
- Note 4: Key assets to support service delivery
- Note 5: Other assets and liabilities
- Note 6: How we finance our operations.

Note 1.3: Abbreviations and terminology used in the financial statements

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

Reference	Title
AASB	Australian Accounting Standards Board
AASs	Australian Accounting Standards, which include Interpretations
DH	Department of Health
DTF	Department of Treasury and Finance
FMA	Financial Management Act 1994
FRD	Financial Reporting Direction
SD	Standing Direction
VAGO	Victorian Auditor General's Office
WIES	Weighted Inlier Equivalent Separation

Note 1.4: Joint arrangements

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

Kilmore District Health has the following joint arrangements:

- Hume Rural Health Alliance (ICT Services)

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

Note 1.5: Key accounting estimates and judgements

Management make estimates and judgements when preparing the financial statements.

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

Revisions to key estimates are recognised in the period in which the estimate is revised and also in future periods that are affected by the revision.
The accounting policies and significant management judgements and estimates used, and any changes thereto, are identified at the beginning of each section where applicable and are disclosed in further detail throughout the accounting policies.

Note 1.6: Accounting standards issued but not yet effective

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

Standard	Adoption Date	Impact
AASB 17: Insurance Contracts	Reporting periods on or after 1 January 2023	Adoption of this standard is not expected to have a material impact.
AASB 2020-1: Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-Current	Reporting periods on or after 1 January 2022.	Adoption of this standard is not expected to have a material impact.
AASB 2020-3: Amendments to Australian Accounting Standards – Annual Improvements 2018-2020 and Other Amendments	Reporting periods on or after 1 January 2022.	Adoption of this standard is not expected to have a material impact.
AASB 2020-8: Amendments to Australian Accounting Standards – Interest Rate Benchmark Reform – Phase 2	Reporting periods on or after 1 January 2021.	Adoption of this standard is not expected to have a material impact.

Note 1.7: Goods and Services Tax (GST)

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

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

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

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

Note 1.8: Reporting Entity

The financial statements include all the controlled activities of Kilmore District Health.

It's principal address is:
1 Anderson Road
Kilmore
Victoria 3764.

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

Note 2: Funding delivery of our services

The Health Service's overall objective is to provide quality health services that support and enhance the wellbeing of all Victorians.

The Health Service is predominantly funded by accrual based grant funding for the provision of outputs. The Health Service also receives funding from the supply of outputs.

The Health Service also receives income from the supply of services.

Structure

2.1 Revenue and income from transactions

2.2 Fair value of assets and services received free of charge or for nominal consideration

2.3 Other Income

Telling the COVID-19 story

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

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

Funding provided included:

- COVID-19 grants to fund the management of COVID-19 vaccination and testing programs which included the cost of clinical, administrative and allied health staff as well as the cost of capital works and equipment.
- Additional elective surgery funding to support the Surgical Blitz program.

Key judgements and estimates

This section contains the following key judgements and estimates:

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

Note 2.1: Revenue and income from transactions

Operating Activites	Total 2021 $'000	Total 2020 $'000
Revenue from contracts with customers		
Government Grants (State) - Operating	20,190	18,052
Patient and Resident Fees	5,501	4,996
Commercial Activities[1]	498	432
Contracted Throughput - Northern Hospital & Austin Hospital	3,373	2,475
Total Income from contracts with customers	**29,562**	**25,955**
Other sources of income		
Government Grants (State) - Capital	598	99
Other Capital purpose income	602	829
Assets received free of charge or for nominal consideration	351	52
Other Revenue from Operating Activities (including non-capital donations)	453	546
Total other sources of income	**2,004**	**1,526**
Total revenue and income from operating activities	**31,566**	**27,481**
Non-operating activites		
Income from other sources		
Capital Interest	35	82
Total other sources of income	**35**	**82**
Total Income from Non-Operating Activities	**35**	**82**
Total Income from Transactions	**31,601**	**27,563**

[1]Commercial activities represent business activities which the health service enter into to support their operations.

How we recognise revenue and income from transactions

Government operating grants

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

When both these conditions are satisfied, the Health Service:

- Identifies each performance obligation relating to the revenue
- recognises a contract liability for its obligations under the agreement
- recognises revenue as it satisfied its performance obligations, at the time or over time when services are rendered.

Where the contract is not enforceable and/or does not have sufficiently specific performance obligations, the Health Service:

- recognises the asset received in accordance with the recognition requirements of other applicable Accounting Standards (for example, AASB 9, AASB 16, AASB 116 and AASB 138)
- recognises related amounts (being contributions by owners, lease liabilities, financial instruments, provisions, revenue or contract liabilities from a contract with a customer), and
- recognises income immediately in profit or loss as the difference between the initial carrying amount of the asset and the related amount.

Note 2.1: Revenue and income from transactions (continued)

The types of government grants recognised under AASB 15: Revenue from Contracts with Customers includes:

Government grant	Performance obligation
Activity Based Funding (ABF) paid as Weighted Inlier Equivalent Separation (WIES) casemix	The performance obligations for ABF are the number and mix of patients admitted to hospital (defined as 'casemix') in accordance with the levels of activity agreed to, with the Department of Health in the annual Statement of Priorities. Revenue is recognised at a point in time, which is when a patient is discharged, in accordance with the WIES activity when an episode of care for an admitted patient is completed. WIES activity is a cost weight that is adjusted for time spent in hospital, and represents a relative measure of resource use for each episode of care in a diagnosis related group.
Other Government Grants	Block funding under the Small Rural Health Service funding model

Capital grants

Where the Health Service receives a capital grant, it recognises a liability for the excess of the initial carrying amount of the financial asset received over any related amounts (being contributions by owners, lease liabilities, financial instruments, provisions, revenue or contract liabilities arising from a contract with a customer) recognised under other Australian Accounting Standards.

Income is recognised progressively as the asset is constructed which aligns with Kilmore District Health's obligation to construct the asset. The progressive percentage of costs incurred is used to recognise income, as this most accurately reflects the stage of completion.

Patient and resident fees

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

Private practice fees

Private practice fees include recoupments from various private practice organisations for the use of hospital facilities. Private practice fees are recognised over time as the performance obligation, the provision of facilities, is provided to customers.

Commercial activities

Revenue from commercial activities includes items such as Meals on Wheels, Medical Imaging fees and Clinical Education. Commercial activity revenue is recognised at a point in time, upon provision of the goods or service to the customer.

Non-cash contributions from the Department of Health

The Department of Health makes some payments on behalf of the Health Service as follows:

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

Note 2.2: Fair value of assets and services received free of charge or for nominal consideration

	Total 2021 $'000	Total 2020 $'000
Personal Protective Equipment	351	52
Total fair value of assets received free of charge or for nominal consideration	**351**	**52**

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

Donations and bequests

Donations and bequests are generally recognised as income upon receipt (which is when Kilmore District Health usually obtained control of the asset) as they do not contain sufficiently specific and enforceable performance obligations. Where sufficiently specific and enforceable performance obligations exist, revenue is recorded as and when the performance obligation is satisfied.

Personal protective equipment

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

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

Contributions

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

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

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

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

Voluntary Services

Contributions by volunteers, in the form of services, are only recognised when fair value can be reliably measured, and the services would have been purchased if they had not been donated. Kilmore District Health has considered the services provided by volunteers and has determined the value of volunteer services cannot be readily determined and therefore it has not recorded any income related to volunteer services.

Note 2.3: Other income

	Total 2021 $'000	Total 2020 $'000
Capital Interest	35	82
Total other income	**35**	**82**

How we recognise other income

Interest Income

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.

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 Section 2, the funds that enable the provision of services were disclosed and in this note the cost associated with provision of services are recorded.

Structure

3.1 Expenses from Transactions

3.2 Employee Benefits in the Balance Sheet

3.3 Superannuation

3.4 Other Economic Flows

Telling the COVID-19 story

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

Additional costs were incurred to:

- Establish facilities within the Health Service for the testing of COVID patients resulting in an increase in employee costs, additional consumable costs and additional equipment purchases.
- Implement COVID safe practices throughout the health service including increased cleaning, increased administration and the consumption of personal protective equipment provided as resources free of charge.
- Establish vaccination clinics to administer vaccines to staff and the community resulting in an increase in employee costs, additional consumables purchased and additional equipment purchased.

Key judgements and estimates

This section contains the following key judgements and estimates:

Key judgements and estimates	Description
Measuring and classifying employee benefit liabilities	The Health Service applies significant judgment when measuring and classifying its employee benefit liabilities. Employee benefit liabilities are classified as a current liability if the Health Service does not have an unconditional right to defer payment beyond 12 months. Annual leave, accrued days off and long service leave entitlements (for staff who have exceeded the minimum vesting period) fall into this category. Employee benefit liabilities are classified as a non-current liability if the Health Service has a conditional right to defer payment beyond 12 months. Long service leave entitlements (for staff who have not yet exceeded the minimum vesting period) fall into this category. The Health Service also applies judgement to determine when it expects its employee entitlements to be paid. With reference to historical data, if the health service does not expect entitlements to be paid within 12 months, the entitlement is measured at its present value. All other entitlements are measured at their nominal value.

Note 3.1: Expenses from transactions

	Note	Total 2021 $'000	Total 2020 $'000
Salaries and wages		19,139	16,704
On-costs		1,744	1,540
Agency expenses		14	146
Fee for service visiting medical officer expenses		3,411	2,824
WorkCover Premium		662	474
Total employee expenses		**24,970**	**21,688**
Drug supplies		193	180
Medical and surgical supplies		1,372	963
Other supplies and consumables		1,516	1,432
Total supplies and consumables		**3,081**	**2,575**
Finance costs		-	1
Total finance costs		**-**	**1**
Fuel, light & power		338	368
Repairs and maintenance		495	464
Medical indemnity insurance		419	451
Other administrative expenses		978	756
Total other operating expenses		**2,230**	**2,039**
Total operating expense		**30,281**	**26,303**
Depreciation and amortisation	4.3	2,208	2,116
Total depreciation and amortisation		**2,208**	**2,116**
Total non-operating expense		**2,208**	**2,116**
Total expenses from transactions		**32,489**	**28,419**

How we recognise expenses from transactions

Expense recognition

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

Employee expenses

Employee expenses include:

- Salaries and wages (including fringe benefits tax, leave entitlements, termination payments);
- On-costs;
- Agency Expenses;
- Fee for service medical officer expenses;
- Work cover premium.

Supplies and consumables

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

Non-operating expenses

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

Other operating expenses

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

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

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

Note 3.2: Employee benefits in the balance sheet

	Total 2021 $'000	Total 2020 $'000
Current Provisions		
Annual leave		
– Unconditional and expected to be settled wholly within 12 months[(i)]	1,005	1,005
– Unconditional and expected to be settled wholly after 12 months[(ii)]	679	421
Long service leave		
– Unconditional and expected to be settled wholly within 12 months[(i)]	357	357
– Unconditional and expected to be settled wholly after 12 months[(ii)]	1,859	1,730
Accrued days off		
– Unconditional and expected to be settled wholly within 12 months[(i)]	29	35
	3,929	**3,548**
Provisions related to Employee Benefit On-Costs		
– Unconditional and expected to be settled wholly within 12 months[(i)]	200	204
– Unconditional and expected to be settled wholly after 12 months[(ii)]	272	222
	472	**426**
Total current employee benefits	**4,401**	**3,974**
Non-current provisions		
Conditional long service leave	406	406
Provisions related to employee benefit on-costs	49	49
Total non-current employee benefits	**455**	**455**
Total employee benefits	**4,856**	**4,429**

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

How we recognise employee benefits

Employee benefit recognition

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

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.

Annual Leave and Accrued Days Off

Liabilities for 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 annual leave and accrued days off are measured at:

- Nominal value – if the Health Service expects to wholly settle within 12 months; or
- Present value – if the Health Service does not expect to wholly settle within 12 months.

Long service leave

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

Unconditional LSL is disclosed in the notes to the financial statements as a current liability even where the 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

Note 3.2: Employee benefits in the balance sheet (continued)

entitlement should an employee take leave within 12 months. An unconditional right arises after a qualifying period.

The components of this current LSL liability are measured at:

- Nominal value – if the Health Service expects to wholly settle within 12 months; and
- Present value – if the Health Service does not expect to wholly settle a within 12 months.

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

Termination benefits

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

On-costs related to employee benefits

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

Note 3.2(a): Employee benefits and related on-costs

	Total 2021 $'000	Total 2020 $'000
Unconditional long service leave entitlement	2,483	2,338
Unconditional annual leave entitlements	1,886	1,597
Unconditional accrued days off	32	39
Non-current employee benefits and related on-costs	**4,401**	**3,974**
Conditional Long Service Leave Entitlements	455	455
Total Employee Benefits and Related On-Costs	**4,856**	**4,429**
Carrying amount at start of year		
Additional provisions recognised	49	52
Amounts incurred during the year	-	(3)
Carrying amount at end of year	**49**	**49**

Note 3.3: Superannuation

	Paid Contribution for the Year		Contribution Outstanding at Year End	
	Total 2021 $'000	Total 2020 $'000	Total 2021 $'000	Total 2020 $'000
Defined benefit plans: [i]				
Health Super	34	18	-	-
Defined Contribution Plans:				
Aware	937	907	-	-
Hesta	541	425	-	-
Other	232	190		
Total	**1,744**	**1,540**	**-**	**-**

[i] The bases for determining the level of contributions is determined by the various actuaries of the defined benefit superannuation plans.

How we recognise superannuation

Employees of the Health Service are entitled to receive superannuation benefits and it contributes to both defined benefit and defined contribution plans.

Defined Benefit Superannuation Plans

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

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

The DTF 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 and details of the major employee superannuation funds and contributions made by Kilmore District Health are disclosed above.

Defined Contribution Superannuation Plans

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

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

Note 3.4: Other economic flows

	Total 2021 $'000	Total 2020 $'000
Net loss on disposal of property plant and equipment	(11)	(7)
Total net gain/(loss) on non-financial assets	**(11)**	**(7)**
Net gain/(loss) from revaluation of long service liability	100	16
Total net gain/(loss) on financial instruments at Armortised Costs	**100**	**16**
Total other gains/(losses) from other economic flows	**89**	**9**

How we recognise other economic flows

Other economic flows are changes in the volume or value of an asset or liability that do not result from transactions. Other gains/(losses) from other economic flows include the gains or losses from:

- the revaluation of the present value of the long service leave liability due to changes in the bond interest rates; and
- reclassified amounts relating to available-for-sale financial instruments from the reserves to net result due to a disposal or derecognition of the financial instrument.
- This does not include reclassification between equity accounts due to machinery of government changes or 'other transfers' of assets.

Net gain/ (loss) on non-financial assets

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

- Revaluation gains/ (losses) of non-financial physical assets (Refer to Note 4.1 Property plant and equipment).
- Net gain/ (loss) on disposal of non-financial assets
- Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal.

Net gain/ (loss) on financial instruments

Net gain/ (loss) on financial instruments at fair value 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 7.1 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.

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 Health Service to be utilised for delivery of those outputs.

Structure

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

Telling the COVID-19 story

The measurement of assets used to support delivery of our services were impacted during the financial year which was partially attributable to the COVID-19 coronavirus pandemic.

The following key assets were impacted:

- Property, plant & equipment

Key judgements and estimates

This section contains the following key judgements and estimates:

Key judgements and estimates	Description
Measuring fair value of property, plant and equipment and investment properties	The Health Service obtains independent valuations for its non-current assets at least once every five years. If an independent valuation has not been undertaken at balance date, the Health Service service estimates possible changes in fair value since the date of the last independent valuation with reference to Valuer-General of Victoria indices. Managerial adjustments are recorded if the assessment concludes a material change in fair value has occurred. Where exceptionally large movements are identified, an interim independent valuation is undertaken.
Estimating useful life and residual value of property, plant and equipment	The Health Service assigns an estimated useful life to each item of property, plant and equipment, whilst also estimating the residual value of the asset, if any, at the end of the useful life. This is used to calculate depreciation of the asset. The Health Service reviews the useful life, residual value and depreciation rates of all assets at the end of each financial year and where necessary, records a change in accounting estimate.
Estimating useful life of right-of-use assets	The useful life of each right-of-use asset is typically the respective lease term, except where the Health Service is reasonably certain to exercise a purchase option contained within the lease (if any), in which case the useful life reverts to the estimated useful life of the underlying asset. The Health Service applies significant judgement to determine whether or not it is reasonably certain to exercise such purchase options.
Estimating restoration costs at the end of a lease	Where a lease agreement requires the Health Service to restore a right-of-use asset to its original condition at the end of a lease, the health service estimates the present value of such restoration costs. This cost is included in the measurement of the right-of-use asset, which is depreciated over the relevant lease term.
Estimating the useful life of intangible assets	The Health Service assigns an estimated useful life to each intangible asset with a finite useful life, which is used to calculate amortisation of the asset.
Identifying indicators of impairment	At the end of each year, the Health Service assesses impairment by evaluating the conditions and events specific to the health service that may be indicative of impairment triggers. Where an indication exists, the Health Service tests the asset for impairment. The Health Service considers a range of information when performing its assessment, including considering: • If an asset's value has declined more than expected based on normal use • If a significant change in technological, market, economic or legal environment which adversely impacts the way the Health Service uses an asset • If an asset is obsolete or damaged • If the asset has become idle or if there are plans to discontinue or dispose of the asset before the end of its useful life • If the performance of the asset is or will be worse than initially expected. Where an impairment trigger exists, the Health Services applies significant judgement and estimate to determine the recoverable amount of the asset.

Note 4.1: Property, plant and equipment

Note 4.1(a): Gross carrying amount and accumulated depreciation

	Total 2021 $'000	Total 2020 $'000
Land at fair value - Crown	1,251	1,251
Total land at fair value	**1,251**	**1,251**
Buildings at Fair Value	57,635	57,495
Less accumulated depreciation	36,183	34,401
Total buildings at fair value	**21,452**	**23,094**
Total land and buildings	**22,703**	**24,345**
Plant & equipment at fair value	8,244	6,827
Less accumulated depreciation	5,088	4,728
Total plant & equipment at fair value	**3,156**	**2,099**
Motor vehicles at fair value	74	206
Less accumulated depreciation	46	87
Total motor vehicles at fair value	**28**	**119**
Total plant, equipment and vehicles at fair value	**3,184**	**2,218**
IT Equipment - Hume Rural Health Alliance	14	26
Less Accumulated Amortisation	4	6
Total IT Equipment - Hume Rural Health Alliance	**10**	**20**
Right of use motor vehicles - Vicfleet	205	85
Less Accumulated Amortisation	32	4
Total right of use motor vehicles - Vicfleet	**173**	**81**
Total right of use equipment and vehicles at fair value	**183**	**101**
Total property, plant and equipment	**26,070**	**26,664**

Note 4.1(b): Property, plant & equipment - Reconciliations of carrying amount by class of asset

	Crown Land	Buildings	Plant & Equipment	Motor Vehicles	Right of use Assets HRHA	Right of use Assets VF	Total
	$'000	$'000	$'000	$'000	$'000		$'000
Balance at 1 July 2019	1,251	24,723	1,979	164	33	-	28,150
Additions	-	147	412	-	-	85	644
Disposals	-	-	-	(24)	(7)	-	(31)
Revaluation Increments/ (Decrements)	-	-	-	-	-	-	-
Depreciation expense (note 4.3)	-	(1,776)	(292)	(21)	(6)	(4)	(2,099)
Balance at 30 June 2020	**1,251**	**23,094**	**2,099**	**119**	**20**	**81**	**26,664**
Additions	-	140	1,417	-	-	120	1,677
Disposals	-	-	-	(82)	-	-	(82)
Revaluation Increments/ (Decrements)	-	-	-	-	-	-	-
Depreciation expense (note 4.3)	-	(1,782)	(360)	(9)	(10)	(28)	(2,189)
Balance at 30 June 2021	**1,251**	**21,452**	**3,156**	**28**	**10**	**173**	**26,070**

Land and Buildings and Leased Assets Carried at Valuation

The Valuer-General Victoria undertook a to re-value all of the Health Service's owned and leased land and buildings to determine their fair value. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which the assets could be exchanged between knowledgeable and willing parties in an arms length transaction. The valuation was based on independent assessments. The effective date of the valuation for both land and buildings was 30 June 2019.

How we recognise property, plant and equipment

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

Initial Recognition

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

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

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.

Subsequent measurement

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

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

Further information regarding fair value measurement is disclosed below.

Revaluation

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

Where an independent valuation has not been undertaken at balance date, the Health Service perform a managerial assessment to estimate possible changes in fair value of land and buildings since the date of the last independent valuation with

Note 4.1(b): Property, plant & equipment - Reconciliations of carrying amount by class of asset

reference to Valuer-General of Victoria (VGV) indices.

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

An independent valuation of the Health Service's property, plant and equipment was performed by the VGV on 30 June 2019. The valuation, which complies with Australian Valuation Standards, was determined by reference to the amount for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The managerial assessment performed at 30 June 2021 indicated an overall:

- increase in fair value of land of 1%
- increase in fair value of buildings of 1%

As the cumulative movement was less than 10% for land and buildings since the last revaluation a managerial revaluation adjustment was not required as at 30 June 2021.

Revaluation increases (increments) arise when an asset's fair value exceeds its carrying amount. In comparison, revaluation decreases (decrements) arise when an asset's fair value is less than its carrying amount. Revaluation increments and revaluation decrements relating to individual assets within an asset class are offset against one another within that class but are not offset in respect of assets in different classes.

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

Revaluation decrements are recognised in 'Other Comprehensive Income' to the extent that a credit balance exists in the asset revaluation reserve in respect of the same class of property, plant and equipment. Otherwise, the decrement is recognised as an expense in the net result.

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

Impairment

At the end of each financial year, the Health Service assesses if there is any indication that an item of property, plant and equipment may be impaired by considering internal and external sources of information. If an indication exists, the Health Service estimates the recoverable amount of the asset. Where the carrying amount of the asset exceeds its recoverable amount, an impairment loss is recognised. An impairment loss of a revalued asset is treated as a revaluation decrease as noted above.

The Health Service has concluded that the recoverable amount of property, plant and equipment which are regularly revalued is expected to be materially consistent with the current fair value. As such, there were no indications of property, plant and equipment being impaired at balance date.

How we recognise right-of-use assets

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

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

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

Class of right-of-use asset	Lease term
Leased plant, equipment, furniture, fittings and vehicles	1 to 10 years

Note 4.1(b): Property, plant & equipment - Reconciliations of carrying amount by class of asset (continued)

Presentation of right-of-use assets

The Health Service presents right-of-use assets as 'property plant equipment' unless they meet the definition of investment property, in which case they are disclosed as 'investment property' in the balance sheet.

Initial recognition

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

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

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

The Health Service's right of use lease agreements contain purchase options which the health service is not reasonably certain to exercise at the completion of the lease.

The Health Service holds lease agreements which contain significantly below-market terms and conditions, which are principally to enable the health service to further its objectives. The health service has applied temporary relief and continues to measure those right-of-use asset at cost. Refer to Note 6.1 for further information regarding the nature and terms of the concessional lease, and the Health Service's dependency on such lease arrangements.

Subsequent measurement

Right-of-use assets are subsequently measured at cost less accumulated depreciation and accumulated impairment losses where applicable. Right-of-use assets are also adjusted for certain remeasurements of the lease liability (for example, when a variable lease payment based on an index or rate becomes effective).

Impairment

At the end of each financial year, the Health Service assesses if there is any indication that a right-of-use asset may be impaired by considering internal and external sources of information. If an indication exists, the Health Service estimates the recoverable amount of the asset. Where the carrying amount of the asset exceeds its recoverable amount, an impairment loss is recognised.

The Health Service performed an impairment assessment and noted there were no indications of its right-of-use assets being impaired at balance date.

Note 4.1(c): Property, plant & equipment - fair value measurement heirarchy for assets

	Note	Consolidated Carrying amount 30 June 2021 $'000	Fair value measurement at end of reporting period using: Level 1[(i)] $'000	Level 2[(i)] $'000	Level 3[(i)] $'000
Specialised land		1,251	-	-	1,251
Total of land at fair value	4.1(a)	1,251			1,251
Specialised buildings		21,452	-	-	21,452
Total buildings at fair value	4.1(a)	21,452	-	-	21,452
Plant equipment and vehicles at fair value					
- Vehicles	4.1(a)	28	-	-	28
- Plant and equipment	4.1(a)	3,156	-	-	3,156
Total of plant, equipment and vehicles at fair value	4.1(a)	3,184	-	-	3,184
Total Property, Plant & Equipment		**25,887**	**-**	**-**	**25,887**

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

	Note	Consolidated Carrying amount 30 June 2020 $'000	Fair value measurement at end of reporting period using: Level 1[(i)] $'000	Level 2[(i)] $'000	Level 3[(i)] $'000
Specialised land		1,251	-	-	1,251
Total of land at fair value	4.1(a)	1,251	-	-	1,251
Specialised buildings		23,094	-	-	23,094
Total buildings at fair value	4.1(a)	23,094	-	-	23,094
Plant equipment and vehicles at fair value					
- Vehicles	4.1(a)	119	-	-	119
- Plant and equipment	4.1(a)	2,099	-	-	2,099
Total of plant, equipment and vehicles at fair value	4.1(a)	2,218	-	-	2,218
Total Property, Plant & Equipment		**26,563**	**-**	**-**	**26,563**

(i) Classified in accordance with the fair value hierarchy, see Note 1

Note 4.1(d): Property, plant & equipment - Reconciliation of level 3 Fair Value measurement

	Note	Land	Buildings	Plant and equipment	Assets under construction
Balance at 1 July 2019	4.1(b)	**1,251**	**24,723**	**1,979**	**-**
Additions/(Disposals)	4.1(b)	-	147	412	-
Assets provided free of charge		-	-	-	-
Net Transfers between classes	4.1(b)	**-**	**-**	**-**	**-**
Gains or losses recognised in net result					
- Depreciation	4.3	-	(1,776)	(292)	-
- Impairment loss		-	-	-	-
Items recognised in Other Comprehensive income					
- Revaluation		-	-	-	-
Balance at 30 June 2020	4.1(c)	**1,251**	**23,094**	**2,099**	**-**
Additions/(Disposals)	4.1(b)	**-**	**140**	**1,417**	**-**
Assets provided free of charge		-	-	-	-
Net Transfers between classes	4.1(b)	**-**	**-**	**-**	**-**
Gains or losses recognised in net result					
- Depreciation	4.3	-	(1,782)	(360)	-
- Impairment loss		-	-	-	-
Items recognised in Other Comprehensive income					
- Revaluation		-	-	-	-
Balance at 30 June 2021	4.1(c)	**1,251**	**21,452**	**3,156**	**-**

(i) Classified in accordance with the fair value hierarchy, refer note 4.1(c)

Note 4.1(e): Property, plant & equipment - fair value determination

Asset class	Likely valuation approach	Significant inputs (Level 3 only)
Specialised Land (Crown / Freehold)	Market approach	Community Service Obligations Adjustments (a)
Specialised buildings	Depreciated replacement cost approach	Cost per square metre Useful life
Heritage assets	Depreciated replacement cost approach	Cost per square metre Useful life
Dwellings	Depreciated replacement cost approach	Cost per square metre Useful life
Vehicles	Depreciated replacement cost approach	Cost per unit Useful life
Plant and equipment	Depreciated replacement cost approach	Cost per square metre Useful life
Infrastructure	Depreciated replacement cost approach	Cost per unit Useful life
Road, infrastructure & earthworks	Depreciated replacement cost approach	Cost per square metre Useful life

(a) A community service Obligation (CSO) of 50% was applied to the Health Service's specialised land Classified in accordance with the fair value hierarchy.

Note 4.1(e): Property, plant & equipment - fair value determination (continued)

How we measure fair value

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

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

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

There have been no transfers between levels during the period. In the prior year, there is a transfer between non-specialised land and specialised land to reflect the correct fair value as per the independent revaluation in 2019.

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

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

Valuation hierarchy

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

- Level 2 – valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable; and
- Level 3 – valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

Identifying unobservable inputs (level 3) fair value measurements

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

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

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 Fair Value Measurement paragraph 29, the Health Service has assumed 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.

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.

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

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

Note 4.1(e): Property, plant & equipment - fair value determination (continued)

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 Hospital's specialised land and specialised buildings was performed by the Valuer-General Victoria. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation is 30 June 2019.

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 amount (depreciated cost).

Plant and Equipment

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

There were no changes in valuation techniques throughout the period to 30 June 2021.

Note 4.1(f): Property, Plant & Equipment Revaluation Surplus

	Total 2021 $'000	Total 2020 $'000
Balance at the beginning of the reporting period	18,268	18,268
Revaluation increment		
- Land	-	-
Balance at end of the reporting period*	**18,268**	**18,268**
*** Represented by:**		
- Land	1,251	1,251
- Buildings	17,017	17,017
	18,268	**18,268**

Note 4.2: Intangible assets

Note 4.2(a): Intangible assets - Gross carrying amount and accumulated amortisation

	Total 2021 $'000	Total 2020 $'000
Hume Rural Health Alliance	21	42
Less Accumulated Amortisation	18	21
Total Intangible Assets	**3**	**21**

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

Note 4.2(b): Intangible assets - Reconciliation of the carrying amount by class of asset

	Software $'000	Total $'000
Balance at 1 July 2019	**26**	**26**
Additions	12	12
Disposals	-	-
Amortisation (note 4.3)	(17)	(17)
Balance at 1 July 2020	**21**	**21**
Additions	1	1
Disposals	-	-
Amortisation (note 4.3)	(19)	(19)
Balance at 30 June 2021	**3**	**3**

How we recognise intangible assets

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

Initial recognition

Purchased intangible assets are initially recognised at cost.

An internally generated intangible asset arising from development (or from the development phase of an internal project) is recognised if, and only if, all of the following are demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use or sale;
- an intention to complete the intangible asset and use or sell it;
- the ability to use or sell the intangible asset;
- the intangible asset will generate probable future economic benefits;
- the availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Expenditure on research activities is recognised as an expense in the period on which it is incurred.

Subsequent measurement

Intangible assets with finite useful lives are carried at cost less accumulated amortisation and accumulated impairment losses.

Impairment

Intangible assets with indefinite useful lives (and intangible assets not yet available for use) are tested annually for impairment and whenever there is an indication that the asset may be impaired. Intangible assets with finite useful lives are tested for impairment whenever an indication of impairment is identified.

Note 4.3: Depreciation and Amortisation

	Total 2021 $'000	Total 2020 $'000
Depreciation		
Buildings	1,782	1,776
Plant & Equipment	360	292
Motor Vehicles	9	21
Right of use assets		
IT Equipment - Leased Assets HRHA	10	6
VicFleet Vehicles - Leased Assets	**28**	4
Total Depreciation	**2,189**	**2,099**
Amortisation		
Intangible Assets - HRHA	19	17
Total Amortisation	**19**	**17**
Total Depreciation and Amortisation	**2,208**	**2,116**

How we recognise depreciation

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

How we recognise amortisation

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

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

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

	2021	2020
Buildings		
– Structure Shell Building Fabric	45 to 60 years	45 to 60 years
– Site Engineering Services and Central Plant	30 to 40 years	30 to 40 years
Central Plant		
– Fit Out	20 to 30 years	20 to 30 years
– Trunk Reticulated Building Systems	30 to 40 years	30 to 40 years
Plant & Equipment	Up to 10 years	Up to 10 years
Medical Equipment	Up to 10 years	Up to 10 years
Computers and Communication	3 years	3 years
Furniture and Fitting	Up to 10 years	Up to 10 years
Motor Vehicles	Up to 10 years	Up to 10 years
Intangible Assets	3 to 4 years	3 to 4 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: Inventories

	Total 2021 $'000	Total 2020 $'000
Catering Supplies - at cost	40	42
Medical and Surgical Lines - at cost	188	164
Total inventories	**228**	**206**

How we recognise inventories

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

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

Note 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 and contract assets

5.2 Payables and contract liabilities

5.3 Other liabilities liabilities

Telling the COVID-19 story

The measurement of other assets and liabilities were not materially impacted by the COVID-19 Coronavirus pandemic and its impact on our economy and the health of our community.

Key judgements and estimates	Description
Estimating the provision for expected credit losses	The Health Service uses a simplified approach to account for the expected credit loss provision. A provision matrix is used, which considers historical experience, external indicators and forward-looking information to determine expected credit loss rates.
Classifying a sub-lease arrangement as either an operating lease or finance lease	The Health Service applies significant judgement to determine if a sub-lease arrangement, where the health service is a lessor, meets the definition of an operating lease or finance lease. The Health Service considers a range of scenarios when classifying a sub-lease. A sub-lease typically meets the definition of a finance lease if: • The lease transfers ownership of the asset to the lessee at the end of the term • The lessee has an option to purchase the asset for a price that is significantly below fair value at the end of the lease term • The lease term is for the majority of the asset's useful life • The present value of lease payments amount to the approximate fair value of the leased asset and • The leased asset is of a specialised nature that only the lessee can use without significant modification. All other sub-lease arrangements are classified as an operating lease.
Measuring deferred capital grant income	Where the Health Service has received funding to construct an identifiable non-financial asset, such funding is recognised as deferred capital grant income until the underlying asset is constructed. The Health Service applies significant judgement when measuring the deferred capital grant income balance, which references the estimated the stage of completion at the end of each financial year.
Measuring contract liabilities	The Health Service applies significant judgement to measure its progress towards satisfying a performance obligation as detailed in Note 2. Where a performance obligation is yet to be satisfied, the health service assigns funds to the outstanding obligation and records this as a contract liability until the promised good or service is transferred to the customer.
Recognition of other provisions	Other provisions include the Health Service's obligation to restore leased assets to their original condition at the end of a lease term. The health service applies significant judgement and estimate to determine the present value of such restoration costs.

Note 5.1: Receivables and contract assets

	Notes	Total 2021 $'000	Total 2020 $'000
Current receivables and contract assets			
Contractual			
Inpatient Fees	7.1(c)	34	38
District nursing fees	7.1(c)	7	23
Aged care fees	7.1(c)	6	3
Department of Health	7.1(c)	-	88
Trade debtors	7.1(c)	1,318	639
Hume Rural Health Alliance	7.1(c)	37	41
Less allowance for impairment losses of contractual receivables	7.1(c)	(7)	(9)
Total contractual receivables		**1,395**	**823**
Statutory			
GST Receivable		46	100
Total statutory receivables		**46**	**100**
Total current receivables and contract assets		**1,441**	**923**
Non-current receivables and contract assets			
Contractual			
Long service leave - Department of Health		1,206	1,083
Total contractual receivables		**1,206**	**1,083**
Total non-current receivables and contract assets		**1,206**	**1,083**
Total receivables and contract assets		**2,647**	**2,006**

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

	Total 2021 $'000	Total 2020 $'000
Balance at beginning of year	9	12
Increase/(decrease) in allowance recognised in net result	(2)	(3)
Balance at end of year	**7**	**9**

How we recognise receivables

Receivables consist of:

- **Contractual receivables,** which mostly includes debtors in relation to goods and services. These receivables are classified as financial instruments and categorised as 'financial assets at amortised costs'. They are initially recognised at fair value plus any directly attributable transaction costs. The Health Service holds the contractual receivables with the objective to collect the contractual cash flows and therefore they are subsequently measured at amortised cost using the effective interest method, less any impairment.
- **Statutory receivables,** which mostly includes amounts owing from the Victorian Government and Goods and Services Tax (GST) input tax credits that are recoverable. Statutory receivables do not arise from contracts and are recognised

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

and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments for disclosure purposes. The Health Service applies AASB 9 for initial measurement of the statutory receivables and as a result statutory receivables are initially recognised at fair value plus any directly attributable transaction cost.

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

In assessing impairment of statutory (non-contractual) financial assets, which are not financial instruments, professional judgement is applied in assessing materiality using estimates, averages and other computational methods in accordance with AASB 136 Impairment of Assets.

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

Impairment losses of contractual receivables

Refer to Note 7.1 Contractual receivables at amortised costs for the Health Service's contractual impairment losses.

Note 5.2: Payables and contract liabilities

	Total 2021 $'000	Total 2020 $'000
Current payables and contract liabilities		
Contractual		
Trade Creditors	962	1,028
Accrued salaries and wages	624	463
Deferred grant income	114	-
Inter hospital creditors	240	-
Amounts owing to governments and agencies	111	
Hume Rural Health Alliance	334	201
Total conractual payables	**2,385**	**1,692**
Total current payables and contract liabilities	**2,385**	**1,692**
Total payables and contract liabilities	**2,385**	**1,692**

How we recognise payables and contract liabilities

Payables consist of:

- **Contractual payables,** which mostly includes payables in relation to goods and services. These payables are classified as financial instruments and measured at amortised cost. Accounts payable and salaries and wages payable represent liabilities for goods and services provided to the Health Service prior to the end of the financial year that are unpaid.
- **Statutory payables,** which mostly includes amounts payable to the Victorian Government and Goods and Services Tax (GST) payable. Statutory payables are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from contracts.

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

Note 5.2(a): Deferred capital grant income

	Total 2021 $'000	Total 2020 $'000
Openning balance of deferred grant income	-	-
Grant consideration for capital works received during the year	114	-
Deferred grant revenue recognised as revenue due to completion of capital works	-	-
Closing balance of deferred grant income	**114**	**-**

How we recognise deferred capital grant revenue

Grant consideration was received from the Department of Health to support the construction of sensory gardens and telehealth infrastructure. Capital grant revenue is recognised progressively as the asset is constructed, since this is the time when the Health Service satisfies its obligations. The progressive percentage of costs incurred is used to recognise income because this most closely reflects the percentage of completion of the building works. As a result, the Health Service has deferred recognition of a portion of the grant consideration received as a liability for the outstanding obligations.

The Health Service expects to recognise all of the remaining deferred capital grant revenue for capital works by December 2021.

Note 5.3: Other Liabilities

	Total 2021 $'000	Total 2020 $'000
Monies held in trust*: Auxilliary	-	13
Monies held in trust*: Refundable accommodation deposits	6,143	7,438
Total Current	**6,143**	**7,451**
*** Total Monies Held In Trust Represented by the Following Assets:**		
Cash Assets (refer to note 6.2)	6,143	7,451
TOTAL	**6,143**	**7,451**

Refundable Accommodation Deposit (RAD)/ Accommodation Bond liabilities

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

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

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

Telling the COVID-19 story

The level of cash and borrowings required to finance our operations were impacted during the financial year which was partially attributable to the COVID-19 Coronavirus pandemic and its impact on our economy and the health of our community.

The following items were impacted:

- Cash at bank

Key judgements and estimates

This section contains the following key judgements and estimates:

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

Note 6.1: Borrowings

	Total 2021 $'000	Total 2020 $'000
CURRENT		
Advances from government (ii)	62	-
Lease Liability (i)	108	24
Total Current Borrowings	**170**	**24**
NON CURRENT		
Lease Liability (i)	76	76
Advances from government (ii)	242	304
Total Non-Current	**318**	**380**
Total Borrowings	**488**	**404**

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

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

How we recognise borrowings

Borrowings refer to interest bearing liabilities mainly raised from advances from the Treasury Corporation of Victoria (TCV) and other funds raised through lease liabilities, service concession arrangements and other interest-bearing arrangements.

Initial recognition

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

Subsequent measurement

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

Maturity analysis

Please refer to note 7.1(b) for the maturity analysis of borrowings.

Defaults and breaches

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

Note 6.1(a): Lease liabilities

The Health Services' lease liabilities are summarised below:

	Minimum future lease payments		Present Value of Minimum future lease payments	
	2021	2020	2021	2020
Not longer than one year	108	24	108	24
Later than one year but not longer than five years	380	380	376	376
Minimum future lease payments	488	404	484	400
Less future finance charges	-	-	-	-
TOTAL	**488**	**404**	**484**	**400**
Included in the financial statements as:				
Current borrowings lease liabilities	108	24	108	24
Non-current borrowings lease liabilities	380	380	376	376
TOTAL	**488**	**404**	**484**	**400**

Note 6.1(a): Lease liabilities (continued)

How we recognise lease liabilities

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

To apply this definition the Health Service assesses whether the contract meets the following criteria:

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

Kilmore District Health's lease arrangements consist of the following:

Type of asset leased	Lease term
Leased plant, equipment, furniture, fittings and vehicles	1 to 10 years

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

Type of payment	Description of payment	Type of leases captured
Low value lease payments	Leases where the underlying asset's fair value, when new, is no more than $10,000	Non-medical equipment Computer equipment

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

Initial measurement

The lease liability is initially measured at the present value of the lease payments unpaid at the commencement date, discounted using the interest rate implicit in the lease if that rate is readily determinable or the Alliance's incremental borrowing rate. Our lease liability has been discounted by rates of between 0% to 2%.

Lease payments included in the measurement of the lease liability comprise the following:

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

The following types of lease arrangements, contain extension and termination options:

- Leased premises - 71 Williams Road, Shepparton

These terms are used to maximise operational flexibility in terms of managing contracts. The majority of extension and termination options held are exercisable only by the Alliance and not by the respective lessor.

In determining the lease term, the Hume Rural Health Alliance considers all facts and circumstances that create an economic incentive to exercise an extension option, or not exercise a termination option. Extension options (or periods after termination options) are only included in the lease term and lease liability if the lease is reasonably certain to be extended (or not terminated).

Subsequent measurement

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

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

Note 6.2: Cash and Cash Equivalents

	Total 2021 $'000	Total 2020 $'000
Cash at bank (excluding Monies held in trust)	3,421	3,086
Cash at bank (Monies held in trust)	6,143	7,451
Total cash and cash equivalents	**9,564**	**10,537**
Represented by:		
Cash for health service operations (as per Cash Flow Statement)	9,017	10,120
Cash - Hume Rural Health Alliance	547	417
Total cash and cash equivalents	**9,564**	**10,537**

How we recognise cash and cash equivalents

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

Note 6.3: Commitments for expenditure

	Total 2021 $'000	Total 2020 $'000
Capital expenditure commitments		
Less than one year	114	-
Total capital expenditure commitments	**114**	**-**
Total commitments for expenditure (exclusive of GST)	**114**	**-**

How we recognise cash and cash equivalents

Our commitments relate to capital expenditure.

Expenditure commitments

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed at their nominal value and are inclusive of the GST payable.

In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant projects are stated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the Balance Sheet.

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 Financial risk management objectives and policies

7.3 Contingent assets and contingent liabilities

Note 7.1: Financial instruments

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of the Health Service'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.*

Note 7.1(a): Financial instruments: categorisation

2021	Note	Financial Assets at Amortised Cost $'000	Financial Liabilities at Amortised Cost $'000	Total $'000
Contractual Financial Assets				
Cash and Cash Equivalents	6.2	9,564	-	9,564
Trade debtors and accruals	5.1	2,601	-	2,601
Total Financial Assets [(i)]		**12,165**	**-**	**12,165**
Financial Liabilities				
Payables	5.2	-	2,385	2,385
Borrowings	6.1	-	488	488
Monies Held In Trust	5.3	-	6,143	6,143
Total Financial Liabilities [(i)]		**-**	**9,016**	**9,016**

2020	Note	Contractual Financial Assets - Loans and Receivables and cash $'000	Contractual Financial Liabilities at Amortised Cost $'000	Total $'000
Contractual Financial Assets				
Cash and Cash Equivalents	6.2	10,537	-	10,537
Trade debtors and accruals	5.1	1,906	-	1,906
Total Financial Assets [(i)]		**12,443**	**-**	**12,443**
Financial Liabilities				
Payables	5.2	-	1,692	1,692
Borrowings	6.1	-	404	404
Monies Held In Trust	5.3	-	7,451	7,451
Total Financial Liabilities [(i)]		**-**	**9,547**	**9,547**

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

Note 7.1: Financial Instruments (continued)

How we categorise financial instruments

Categories of financial assets

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

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

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

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

Financial assets at amortised cost

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

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

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

The Health Service recognises the following assets in this category:

- cash and deposits
- receivables (excluding statutory receivables) and
- term deposits

Financial assets at fair value through other comprehensive income

A financial asset that meets the following conditions is subsequently measured at fair value through other comprehensive income:

- the assets are held by the Health Service to achieve its objective both by collecting the contractual cash flows and by selling the financial assets and
- the assets' contractual terms give rise to cash flows that are solely payments of principal and interest.

Equity investments are measured at fair value through other comprehensive income if the assets are not held for trading and the Health Service has irrevocably elected at initial recognition to recognise in this category.

The Health Service recognises the following assets in this category:

- investments in equity instruments.

Financial assets at fair value through net result

The Health Service initially designates a financial instrument as measured at fair value through net result if:

- it eliminates or significantly reduces a measurement or recognition inconsistency (often referred to as an "accounting mismatch") that would otherwise arise from measuring assets or recognising the gains and losses on them, on a different basis
- it is in accordance with the documented risk management or investment strategy and information about the groupings was documented appropriately, so the performance of the financial asset can be managed and evaluated consistently on a fair value basis or
- it is a hybrid contract that contains an embedded derivative that significantly modifies the cash flows otherwise required by the contract.

The initial designation of the financial instruments to measure at fair value through net result is a one-time option on initial classification and is irrevocable until the financial asset is derecognised.

Categories of financial liabilities

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

Financial liabilities at fair value through net result

A financial liability is measured at fair value through net result if the financial liability is:

- held for trading or
- initially designated as at fair value through net result.

Changes in fair value are recognised in the net results as other economic flows, unless the changes in fair value relate to changes in the Health Service's own credit risk. In this case, the portion of the change attributable to changes in the Health Service's own credit risk is recognised in other comprehensive income with no subsequent recycling to net result when the financial liability is derecognised.

Financial liabilities at amortised cost

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

Note 7.1: Financial Instruments (continued)

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

The Health Service recognises the following liabilities in this category:

- payables (excluding statutory payables and contract liabilities)
- borrowings and
- other liabilities (including monies held in trust).

Derivative financial instruments

A derivative financial instrument is classified as a held for trading financial asset or financial liability. They are initially recognised at fair value on the date on which a derivative contract is entered.

Derivatives are carried as assets when their fair value is positive and as liabilities when their fair value is negative. Any gains or losses arising from changes in the fair value of derivatives after initial recognition, are recognised in the consolidated comprehensive operating statement as an other economic flow included in the net result.

Offsetting financial instruments

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

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

Derecognition of financial assets

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

- the rights to receive cash flows from the asset have expired; or
- 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 Hospital's continuing involvement in the asset.

Derecognition of financial liabilities

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

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

Reclassification of financial instruments

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

A financial liability reclassification is not permitted.

Note 7.2: Financial risk management objectives and policies

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

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

The Health Service's main financial risks include credit risk, liquidity risk, interest rate risk and equity price risk.

The Health Service manages these financial risks in accordance with its financial risk management policy.

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

Credit risk refers to the possibility that a borrower will default on its financial obligations as and when they fall due. the Health Service's exposure to credit risk arises from the potential default of a counter party on their contractual obligations resulting in financial loss to the Health Service.

Note 7.2(a): Credit risk

Credit risk is measured at fair value and is monitored on a regular basis.

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

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

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

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

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

There has been no material change to the Health Service's credit risk profile in 2020-21.

Impairment of financial assets under AASB 9

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

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

Contractual receivables at amortised cost

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

On this basis, the Health Service determines the closing loss allowance at the end of the financial year as follows:

30 June 2021	Note		Current	Less than 1 month	1-3 months	3 months - 1 year	1-5 years	Total
Expected loss rate			0%	0%	0%	0%	0%	
Gross carrying amount of contractual receivables ($'000s)	5.1	2,608	1,773	704	130	0	0	2,608
Loss allowance			(7)	0	0	0	0	0

30 June 2020	Note		Current	Less than 1 month	1-3 months	3 months - 1 year	1-5 years	Total
Expected loss rate			0%	0%	0%	0%	0%	
Gross carrying amount of contractual receivables ($'000s)	5.1	1,915	1,302	517	96	0	0	1,915
Loss allowance			(9)	0	0	0	0	0

Statutory receivables and debt investments at amortised cost

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

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

Note 7.2(b): Liquidity risk

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

The Health Service is exposed to liquidity risk mainly through the financial liabilities as disclosed in the face of the balance sheet and the amounts related to financial guarantees. The Health Service manages its liquidity risk by:

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

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

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			
2021	Note	Carrying 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						
Trade creditors and accruals	5.2	2,274	2,274	-	-	-
Borrowings	6.1	488	-	-	170	318
Monies Held In Trust	5.3	6,143	-	676	2,395	3,072
Total Financial Liabilities		**8,905**	**2,274**	**676**	**2,565**	**3,390**
2020						
Financial Liabilities						
At amortised cost						
Trade creditors and accruals	5.2	1,692	1,692	-	-	-
Borrowings	6.1	404	-	-	24	380
Monies Held In Trust	5.3	7,451	-	820	2,905	3,726
Total Financial Liabilities		**9,547**	**1,692**	**820**	**2,929**	**4,106**

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

Note 7.2(c): Market risk

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

Sensitivity disclosure analysis and assumptions

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

- a change in interest rates of 1% up or down and
- a change in the top ASX 200 index of 15% up or down.

Interest rate risk

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

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

Note 7.3: Contingent assets and contingent liabilities

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

Note 8: Other Disclosures

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

Structure

8.1 Reconciliation of net result for the year to net cash flow from operating activities
8.2 Responsible persons disclosures
8.3 Remuneration of executives
8.4 Related parties
8.5 Remuneration of auditors
8.6 Events occurring after the balance sheet date
8.7 Jointly controlled operations
8.8 Equity
8.9 Economic Dependency

Telling the COVID-19 story

Our other disclosures were not materially impacted by the COVID-19 Coronavirus pandemic and its impact on our economy and the health of our community.

Note 8.1: Reconciliation of net result for the year to net cash inflow/outflow from operating activities

	Note	Total 2021 $'000	Total 2020 $'000
Net result for the Year		(799)	(846)
Non-cash movements:			
Net (Gain)/Loss from Disposal of Plant and Equipment		11	7
Depreciation and amortisation	4.3	2,208	2,116
Hume Rural Health Alliance		(84)	(61)
Provision for doubtful debts	5.1(a)	(2)	(3)
Assets received free of charge	2.2	(55)	(52)
Movements in Assets and Liabilities:			
Change in Operating assets & liabilities			
(Increase)/Decrease in receivables		(639)	(370)
(Increase)/Decrease in other Assets		(19)	(12)
Increase/(Decrease) in payables		693	(109)
Increase/(Decrease) in other liabilities		-	-
Increase/(Decrease) in employee benefits		427	178
(Increase)/Decrease in inventories		(22)	(37)
Net cash inflow from operating activities		**1,719**	**811**

Note 8.2: Responsible Persons Disclosures

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

	Period
The Honourable Martin Foley:	
Minister for Mental Health	1 Jul 2020 - 29 Sep 2020
Minister for Health	26 Sep 2020 - 30 Jun 2021
Minister for Ambulance Services	26 Sep 2020 - 30 Jun 2021
Minister for the Coordination of Health and Human Services: COVID-19	26 Sep 2020 - 09 Nov 2020
The Honourable Jenny Mikakos:	
Minister for Health	1 Jul 2020 - 29 Sep 2020
Minister for Ambulance Services	1 Jul 2020 - 29 Sep 2020
Minister for the Coordination of Health and Human Services: COVID-19	1 Jul 2020 - 29 Sep 2020
The Honourable Luke Donnellan:	
Minister for Child Protection	1 Jul 2020 - 30 Jun 2021
Minister for Disability, Ageing and Carers	1 Jul 2020 - 30 Jun 2021
The Honourable James Merlino:	
Minister for Mental Health	29 Sep 2020 - 30 Jun 2021
Governing Boards	
K. Harris (Chairperson)	1/07/2020 - 30/06/2021
W. Kelly	1/07/2020 - 30/06/2021
J. Butty	1/07/2020 - 30/06/2021
K. Bell	1/07/2020 - 30/06/2021
J. Mazzeo	1/07/2020 - 30/06/2021
B. Schade	1/07/2020 - 30/06/2021
K. Free	1/07/2020 - 30/06/2021
G. Leach	1/07/2020 - 30/06/2021
G. Thomson	1/07/2020 - 30/06/2021
J. Lovell	1/07/2020 - 30/06/2021
Accountable Officer	
S. Race (Chief Executive Officer)	1/07/2020 - 08/01/2021
D. Naughton (Chief Executive Officer)	18/01/2020 - 30/06/2021

Remuneration of Responsible Persons

The number of responsible persons are shown in their relevant income bands:

Income Band	Total 2021 No.	Total 2020 No.
$0 - $9,999	10	10
$80,000 - $80,999	1	-
$160,000 - $169,999	1	-
$200,000 - 209,999	-	1
Total Numbers	**12**	**11**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**$289,993**	**$255,792**

Note 8.3: 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.

	Total Remuneration	
Remuneration of executive officers (Including Key Management Personnel disclosed in note 8.4)	**2021** **$**	**2020** **$**
Short-term employee benefits	509,388	475,276
Post-employment benefits	42,584	39,785
Other long-term benefits	14,654	13,691
Termination benefits	-	-
Total remuneration [(i)(ii)]	**566,626**	**528,752**
Total number of executives	**4**	**4**
Total annualised employee equivilant (AEE) [(ii)]	**3.20**	**3.20**

(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 Note 8.4 Related Parties.

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

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

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

Short-term Employee Benefits

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

Post-employment Benefits

Pensions and other retirement benefits (such as superannuation guarantee contributions) paid or payable on a discrete basis when employment has ceased.

Other Long-term Benefits

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

Termination Benefits

Termination of employment payments, such as severance packages.

Note 8.4: Related Parties

The 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 (KMP) and their close family members;
- Cabinet ministers (where applicable) and their close family members; and
- all health services 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.

Key management personnel

The Board of Directors and the Executive Directors of the Health Service and it's controlled entities are deemed to be KMPs.

Entity	KMPs	Position Title
Kilmore District Health	K. Harris	Board Chair
Kilmore District Health	W. Kelly	Board Member
Kilmore District Health	J. Butty	Board Member
Kilmore District Health	K. Bell	Board Member
Kilmore District Health	J. Mazzeo	Board Member
Kilmore District Health	B. Schade	Board Member
Kilmore District Health	K. Free	Board Member
Kilmore District Health	G. Leach	Board Member
Kilmore District Health	G. Thomson	Board Member
Kilmore District Health	J. Lovell	Board Member
Kilmore District Health	S. Race	Chief Executive Officer
Kilmore District Health	D. Naughton	Chief Executive Officer
Kilmore District Health	J. Gilham	Director of Clinical & Aged Care Services
Kilmore District Health	K. Gilchrist	Director of Development & Improvement
Kilmore District Health	C. Clark	Director of Finance & Support Services
Kilmore District Health	M. Duffy	Director of Medical Services

The compensation detailed below is reported in $'000 and 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 - KMPs	**2021 $'000**	**2020 $'000**
Short term employee benefits	773,140	706,541
Post-employment benefits	62,107	58,312
Other long-term benefits	21,372	19,691
Termination benefits	-	-
Total	**856,619**	**784,544**

Note 8.4: Related Parties (continued)

Significant transactions with government-related entities

Kilmore District Health received funding from the Department of Health of $20.8 million (2020: $18.2 million).

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

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

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

Transactions with KMPs and Other Related Parties

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

Outside of normal citizen type transactions with the Health Service, there were no related party transactions that involved key management personnel, their close family members and their personal business interests. No provision has been required, nor any expense recognised, for impairment of receivables from related parties. There were no related party transactions with Cabinet Ministers required to be disclosed in 2021 (2020: none).

There were no related party transactions required to be disclosed for the Health Service Board of Directors and Executive Directors in 2021.

Note 8.5. Remuneration of Auditors

	2021	2020
Victorian Auditor-General's Office	**$'000**	**$'000**
Audit of the financial statements	15	15
Total remuneration of auditors	**15**	**15**

Note 8.6: Events occurring after the balance sheet date

The COVID-19 pandemic has created economic uncertainity. Actual economic events and conditions in the future may be materially different from those estimated by the Health Service at the reporting date. As responses by government continue to evolve, management recognises that it is difficult to reliably estimate with certainity the potential impact of the pandemic after the reporting date on the Health Service, its operations, its future results and financial position.

The state of emergency in Victoria was extended until 16th December 2021 and the state of disaster is still in place.

No other matters or circumstances have arisen since the end of the financial year which significantly affected or may significantly affect the operations of the Health Service, the results of those operations, or the state of affairs of the Health Service in subsequent financial years.

Note 8.7: Joint arrangements

Name of Entity	Principal Activity	Ownership Interest 2021	Ownership Interest 2020
		%	%
		5.0	4.8
Hume Rural Health Alliance	Information Systems		

Kilmore District Health's interest in assets and liabilities in the above jointly controlled operations are detailed below. The amounts are included in the financial statements under their respective categories:

	2021 $'000	2020 $'000
Current assets		
Cash and cash equivalents	547	417
Receivables	37	40
Prepayments	12	5
Total current assets	**596**	**462**
Non-current assets		
Property, plant and equipment	9	10
Intagible assets	3	21
Lease asset	10	20
Total non-current	**22**	**51**
Total assets	**618**	**513**
Current liabilities		
Payables	334	201
Borrowings	2	8
Total current liabilities	**336**	**209**
Non-current liabilities		
Borrowings	8	11
Total non-current liabilities	**8**	**11**
Total liabilities	**344**	**220**
Net assets	**274**	**293**
Equity		
Accumulated surpluses/(deficits)	274	293
Total equity	**274**	**293**

Note 8.7: Joint arrangements (continued)

Kilmore District Health interest in revenues and expenses resulting from joint arrangements are detailed below. The amounts are included in the consolidated financial statements under their respective categories:

Revenue		
Revenue from Operating Activities	309	313
Revenue from Non-Operating Activities	1	2
Capital Purpose Income	16	81
Total revenue	**326**	**396**
Expenses		
Employee Benefits	103	93
Other Expenses From Continuing Operations	174	239
Capital Purpose Expenditure	28	-
Depreciation and Amortisation	40	27
Finance Charges	-	1
Total expenses	**345**	**360**
Net result	**(19)**	**36**

Contingent liabilities and capital commitments

There are no known contingent liabilities or capital commitments held by the jointly controlled operations at balance date.

Note 8.8: Equity

Contributed Capital

Contributions by owners (that is, contributed capital and its repayment) are treated as equity transactions and, therefore, do not form part of the income and expenses of the Health Service.

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

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

Financial assets at fair value through comprehensive income revaluation reserve

The financial assets at fair value through other comprehensive income revaluation reserve arises on the revaluation of financial assets (such as equity instruments) measured at fair value through other comprehensive income. Where such a financial asset is sold, that portion of the reserve which relates to that financial asset may be transferred to accumulated surplus/deficit.

Specific restricted purpose reserves

The specific restricted purpose reserve 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 8.9. Economic Dependency

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

KILMORE DISTRICT HEALTH
ABN 49 260 016 741

Kilmore District Health

Address: 1 Anderson Road, Kilmore, Vic, 3764
Postal: PO Box 185, Kilmore, Vic, 3764
Phone: (03) 5734 2000
Email: kilmoreweb@kilmorehealth.org.au

Caladenia Nursing Home

Address: Kilmore District Health
1 Anderson Road, Kilmore, Vic, 3764
Phone: (03) 5734 2155
Email: kilmoreweb@kilmorehealth.org.au

Dianella Village Hostel

Address: Kilmore District Health
1 Anderson Road, Kilmore, Vic, 3764
Phone: (03) 5734 2170
Email: kilmoreweb@kilmorehealth.org.au

www.kilmoredistricthealth.org.au