# Annual Report

## 2016-17

The Kilmore & District Hospital

**This report:**

- Covers the period 1 July 2016 to 30 June 2017
- 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 The Kilmore & District Hospital's Annual General Meeting in November 2017
- Acknowledges the support of our community
- Respects our environment and is printed in Ecostar Silk 100% recycled stock

**Acknowledgement of Traditional Owners:**
The Kilmore & District Hospital respectfully acknowledges the traditional custodians of the land on which its facilities stand as the Taungurung people.

# About Our Organisation

The Kilmore & District Hospital is located in Victoria in the Mitchell Shire and services a population over 35,000 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.

Comprehensive acute and aged care services are provided to our rapidly increasing catchment population. In 2016-17 over 2,600 patients were treated, 247 babies born, 100 residents accommodated, more than 280 staff employed and operating expenditure amounts in excess of $20.5 million.

This Annual Report should be read in conjunction with our 2016-17 Quality Account Calendar. Both documents are available on our website.

### Our Vision

The community sees The Kilmore & District Hospital and Aged Care Services as the preferred provider and facilitator for its whole-of-life health related service.

### Our Mission

The Kilmore & District Hospital and Aged Care Services will provide the community with high quality progressive health care and accommodation.

### Our Values

- Recognition of the dignity, integrity and rights of the individual
- Excellence in all aspects of our work
- Staff commitment and support
- Accountability to all stakeholders
- Visibility in the community
- Co-operation with other health care providers

### Our Priorities

- Quality of care for our patients, residents and clients
- Care and development of workforce
- Business continuity
- Connection with the community
- Strategic relationships

# Board President and CEO Message

## It has been another year of change and progress at The Kilmore & District Hospital. We continue to embrace improvements to the way we provide patient-centred care as we develop the future model of service provision to meet the growing and changing needs of our community.

We continued to experience high demand on our services in 2016-17, with the hospital caring for over 2,600 inpatients, 6,000 outpatients and 8,500 patients requiring urgent care. In addition our maternity service welcomed 247 babies into the world.

In the hospital we operated 24 inpatient beds supporting patients needing acute, restorative and end-of-life care. Our hospital occupancy has increased by close to 10% over the past year with over 700 more days of care provided.

Our aged care services supported 40 care recipients in Caladenia Nursing Home, providing 8,858 beddays with occupancy of 81%. Dianella Hostel supported 61 care recipients throughout the year, providing 10,614 beddays with occupancy of 97%.

Our Home-based services are provided to support and assist elderly people or people with disabilities living at home or in the community and their families. Our District Nursing Service delivered over 4,500 visits in 2016-17 and we provided over 9,000 meals to the local community through Meals on Wheels, over 1,000 more meals than last year.

### Governance and Leadership

We have significantly enhanced and strengthened our governance of safety and quality across our organisation over the past year. The development of our performance dashboard for safety and quality, workforce and finance information to the Board, Board Committees and Operational Committees has improved transparency and accountability across our organisation.

The Executive Team has worked hard to strengthen and stabilise the senior leadership capability and capacity in our organisation, which has been subject to significant change over the past 12 months. The Board endorsed the review of our governance model and to structurally support this review with the establishment of a new Directorate for Development and Improvement. We have strengthened the governance and accountability across our clinical and corporate services with the revised framework now in place.

In addition we have also had a significant focus on improving the engagement with our senior leadership team. A more inclusive approach has been taken in involving the senior leadership group in the planning, development and monitoring of our services.

This has been underpinned by a clear strategy to embed a culture and practice of transparency in flow of information and decision making from the ward to our Board. The senior leadership team has helped shape the governance model and is now working to apply the structures, systems and processes developed to our day-to-day operational practice.

The newly established Director Development and Improvement position was filled in October 2016 by Ms Kirrily Gilchrist who previously held the role of Manager Health Information within the organisation. Ms Denise Marshall was appointed to the Manager Health Information position that became vacant on Ms Gilchrist's promotion to the Director role.

In November 2016, the Manager Human Resources position became vacant and the role was redefined as Manager People and Culture with an increased focus on our workforce capability and culture. This position was filled in January 2017 by Ms Kate Bishop.

Our Director Medical Services, Dr Ka Chun (KC) Tse resigned in March 2017 to take up a more substantive appointment at Swan Hill District Health. During Dr Tse's time with our health service he made a significant contribution to the organisation and particularly to our senior leadership team. He led the introduction of our revised clinical review processes and established the Clinical Appointments Committee.

We are fortunate to have recruited Dr Martin Duffy to the role of Director Medical Services. Dr Duffy joined our organisation in April 2017 and is a respected clinician and manager with experience in both surgical and obstetric anaesthesia and health administration roles.

There have been a number of other changes to our senior leadership team with the following people appointed and welcomed to the team:

- Ms Karen Gates to the newly established Manager Maternity Services position;
- Ms Tania Nicholson to the redefined Inpatient Services Manager position encompassing oversight of the District Nursing Service with Ms Veronica Penrose appointed as the Clinical Coordinator for our District Nursing Service;
- Ms Susan Wray to the Manager Caladenia Nursing Home; and
- Ms Louise Hunter as our Assistant Accountant.

## National Accreditation – Periodic Review

In June 2017 The Kilmore & District Hospital participated in the periodic review against the National Safety and Quality Health Service Standards to ensure that we are still providing quality safe care. Accreditation is public recognition by a health care accreditation body of the achievement of accreditation standards by a health care organisation; this is demonstrated by an independent external peer assessment of a level of performance in relation to standards. The review highlighted significant improvement in organisational governance, medical workforce credentialling and consumer participation.

A highlight that we shared with the survey team was our evolving approach to consumer engagement across our health service. We recognise the vital contribution that consumers can make to how we plan, design and deliver services and recognise the need to further embed engagement in all aspects of the organisation.

We would like to congratulate and thank all our staff for their support and commitment to providing high quality safe care to our patients.

## Clinical Service Development

In July 2016 we commenced the implementation of the action plan developed in response to the recommendations received from an external review of our maternity service undertaken earlier in 2016. The purpose of this review was to critically analyse our self-assessment against the Victorian Maternity and Newborn Capability Framework, including clinical governance, clinical risk management, maternity staff education and professional competency requirements and equipment.

A further objective of the review was to highlight the areas of clinical and governance risks within the maternity service and provide recommendations to mitigate potential risk and improve maternity outcomes for women. The organisation has made considerable progress in implementing the review recommendations with significant improvements achieved in the training and development of our workforce and the strengthening of our service capability.

We have also undertaken preliminary internal reviews of our Perioperative Service and our Day Oncology Service. These internal reviews have assisted with decision-making processes required to inform the provision of services and future planning initiatives.

## Acknowledgements

The Board President and CEO would like to thank Board members, clinicians, volunteers and all staff for their continued dedication and passion throughout the year. This commitment ensures that we continue to provide high quality care to our patients.

We would like to extend our thanks to Ms Camille Lawson and Mr Geoffrey Sekfy for their contribution during their time on the Board of Management. We also welcome Ms Kathryn Harris and Associate Professor Peter Nottle to the Board.

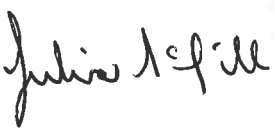
A number of independent external experts sit on our governance committees and we would like to sincerely thank these people for their willingness to share their expertise and time.

## Thank you

The Kilmore & District Hospital is most grateful for the generosity of its supporters. Financial support from our loyal donors helps the hospital to continue its work in providing high quality services for our local community.

We are also sincerely grateful to our volunteers, Hospital Auxiliary, Opportunity Shop Committee and Community Advisory Board Subcommittee members who offer their time to help others and make the patient experience a more positive and memorable one. We recognise the vital contribution that consumers can make to how we plan, design and deliver services and recognise the need to further embed engagement in all aspects of the organisation.

In accordance with the Financial Management Act 1994, the hospital is pleased to present the Report of Operations for The Kilmore & District Hospital for the year ending 30 June 2017.



**Julia McGill**
President, Board of Management

**Sue Race**
Chief Executive Officer

# 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 standards 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


## 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
- 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

## 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

# Board of Management and Board Subcommittees

## The Board of Management 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 The Kilmore & District Hospital and is responsible for its financial performance, strategic directions, the quality of its health care services and strengthening community involvement through greater partnerships.

The Kilmore & District Hospital 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 members are required to attend a minimum of eight meetings each year. Twelve meetings were held during the year and all board members met the attendance requirement with the exception of one member who resigned in November 2016.

| | *Date = First Appointment* | *2016-17 Attendance* |
|---|---|---|
| **Board President** | **Mrs Julia McGill** 1 November 2005 | 12 |
| **Board Vice President** | **Ms Camille Lawson** 1 July 2013[#] | 2 |
| | **Ms Ulla Lonnqvist** 1 July 2014[##] | 11 |
| **Members** | **Mr Wally Arnott** 1 January 1978 | 11 |
| | **Mr John Dixon** 1 January 1994 | 12 |
| | **Dr Leonard Whitehouse** 1 July 2011 | 12 |
| | **Mr Allan Wilcox** 1 July 2013 | 8 |
| | **Ms Kathryn Harris** 1 July 2016 | 10 |
| | **Assoc. Prof. Peter Nottle** 1 July 2016 | 10 |

*[#] Ms Camille Lawson resigned from the Board of Management in November 2016 which was accepted by the Governor in Council on 21 February 2017.*

*[##]Ms Ulla Lonnqvist stepped into the Board Vice President position from November 2016.*

### Audit and Enterprise Risk Committee

The Audit and Enterprise Risk Committee membership comprises a minimum of three Board of Management members and at least two members to be independent of the agency, 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 will be one of the independent members of the Committee and will be nominated by the Audit and Enterprise Risk Committee on an annual basis.

The Audit and Enterprise Risk Committee membership includes the following Board of Management members: Ms Kathryn Harris, Mrs Julia McGill, Ms Ulla Lonnqvist and Dr Leonard Whitehouse. In 2016-17 the independent members were Mr Peter Appleton and Mr Bryce Poorter with Mr Peter Appleton nominated as Committee Chair for this year.

The Audit and Enterprise Risk Committee meets bi-monthly and assists the Board in monitoring compliance with laws, regulations, standards and internal controls.

Key responsibilities for the Audit and Enterprise Risk Committee include monitoring the hospital's strategic and operational risks, developing the hospital's strategic internal audit plan, oversight of the Internal Audit Program, review of the draft Annual Accounts and review of the relevant risk policies and procedures. All the committee members are independent of management.

### Clinical Governance Committee

The Clinical Governance Committee membership comprises a minimum of three Board of Management members and two independent clinical experts. The membership includes the following Board of Management members: Mr John Dixon (Chair), Mr Wally Arnott, Ms Camille Lawson (until November 2016), Mrs Julia McGill (from November 2016); and Associate Professor Peter Nottle. The independent members appointed to the committee are Ms Chris Best and Dr Megan Robb.

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

## Community Advisory Committee

The Community Advisory Committee membership comprises a minimum of two Board of Management members and up to eight consumer members who will represent a diverse community perspective. The Chair of the Committee will be one of the consumer members and is nominated by the Community Advisory Committee on an annual basis.

The Community Advisory Committee membership includes the following Board of Management members: Mr Allan Wilcox and Dr Leonard Whitehouse.

Three consumer consultants sit on the Community Advisory Committee: Mrs Helen Clancy, Ms Gwenda Phillips and Mrs Debbie Davis. In accordance with the Terms of Reference a consumer member now holds the position of Committee Chair, and we are grateful for the work of Gwenda Phillips as Chair in 2017. We now also benefit from the involvement of a young community member, Ms Maneet Hora, who is eager to provide her input to the committee and attends as an invitee around her school commitments.

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

## Remuneration Committee

The Remuneration Committee membership includes the following Board of Management members: Mrs Julia McGill (Chair), Ms Camille Lawson (until November 2016), Ms Ulla Lonnqvist (from November 2016) and Mr John Dixon.

The Remuneration Committee meets quarterly and makes assessments and recommendations to the Board concerning the performance against the agreed Performance Plan, remuneration and terms and conditions of employment for the Chief Executive Officer. The committee also provides oversight of the remuneration and conditions of employment of the Directors of the hospital.

# Executive Management

### Chief Executive Officer

**Mrs Sue Race**

**BAgrSc (Hons) BNutDiet MPPM FCHSM**

The Chief Executive Officer is accountable to the Board for executive leadership and management of operational, policy and strategic goals 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 Finance and Support Services

### Chief Financial and Procurement Officer

**Mr Colin Clark**

**BEC (ACCT)**

The Director Finance and Support Services is the Chief Financial and Procurement Officer and is responsible for providing financial management leadership and oversight of the organisational 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, human resources, information technology services and knowledge management.

### Director Clinical and Aged Care Services

### Chief Nursing and Midwifery Officer

**Ms Kate Pryde**

**RN RM MBA**

The Director Clinical and Aged Care Services is responsible for overseeing the inpatient and non-admitted clinical services, after-hours' coordination, clinical support, allied health and aged care services. As Chief Nursing and Midwifery Officer, the role also has professional responsibility and leadership for all nursing staff, the clinical competence framework and nurse education.

### Director Development and Improvement

**Ms Kirrily Gilchrist**

**BHIM**

The Director Development and Improvement is 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, patient safety, health information management and service performance and planning.

### Director Medical Services

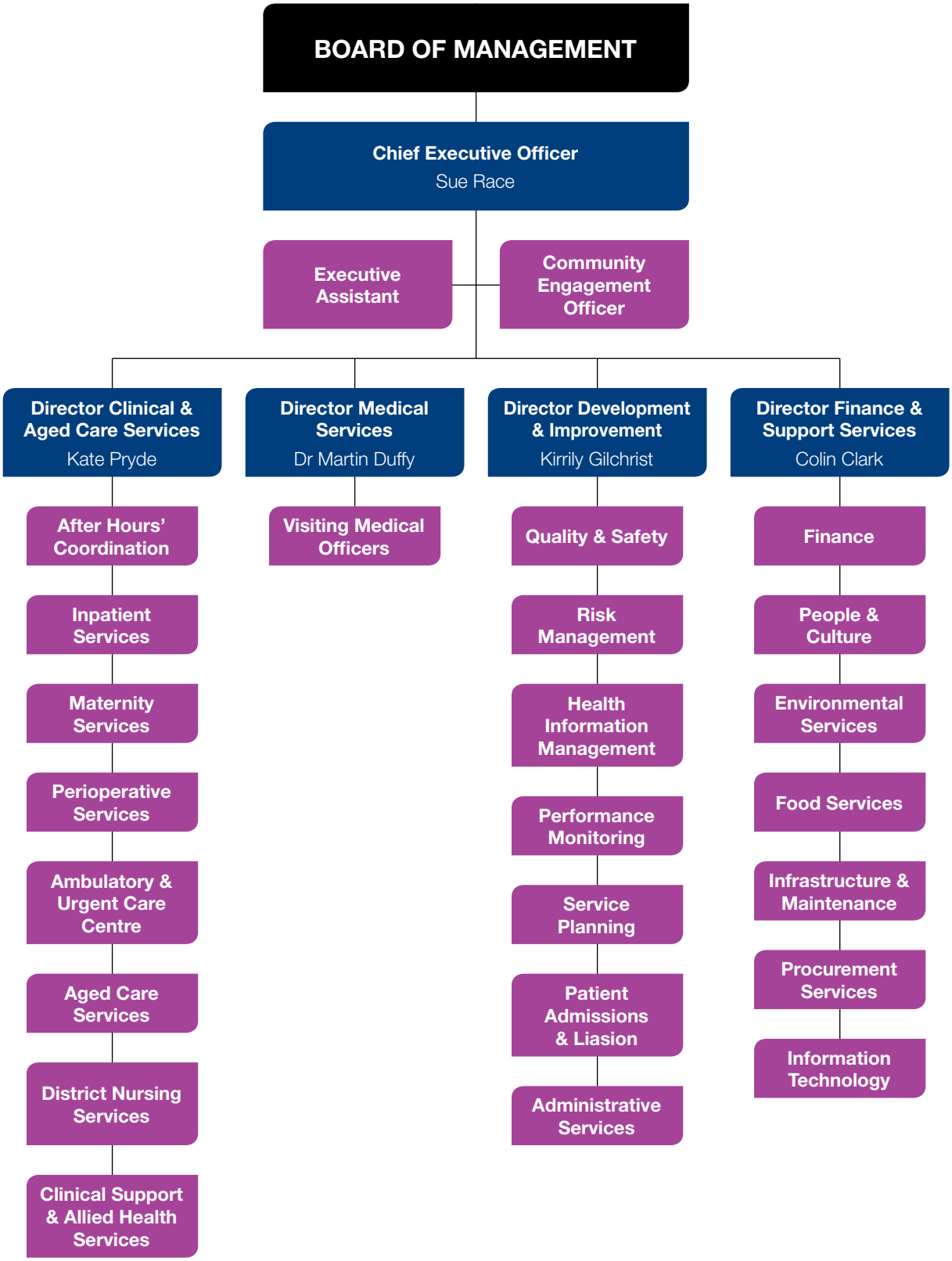
### Chief Medical Officer

**Dr Martin Duffy**

**MBBS MPH AFRACMA FANZCA**

The Director Medical Services is 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.

# Organisational Structure



# Donors and Supporters

## The Kilmore & District Hospital is most appreciative of the continued support of our donors, Hospital Auxiliary, Opportunity Shop Committee and volunteers.

The financial donations and funding we receive enable us to improve our services to patients through the purchase of new equipment. In 2016-17 we received close to $230,000 from our donors.

### Our Major Donors, Corporate and Community Supporters

**Major Donors**

- Mr David Keath
- Mrs Wilma Keath
- The Kilmore & District Hospital Opportunity Shop Committee
- The Kilmore & District Hospital Auxiliary
- Estate of John Kelly

**Donors**

- Estate of Beatrice O'Brien
- Estate of Russell Arthur William Rank
- Overseas Medical Graduate Association (in memory of Dr Poroor Vikraman)
- Dr Sarwat Shenouda
- Ms Carol Wright

**Community Supporters**

- Bunnings Warehouse Craigieburn
- Ivanhoe Grammar School (Mernda Campus)
- Kilmore Alcoholics Anonymous
- Kilmore Trackside
- Rotary Club of Southern Mitchell
- The Elms Retirement Estate
- The Kilmore Men's Shed

### Hospital Auxiliary

We take this opportunity to thank our Hospital Auxiliary members who continue to raise vital funds both within the hospital and the wider community. In 2016-17 the Auxiliary provided the hospital with funds raised in excess of $15,000.

This year after funding support by the Hospital Opportunity Shop Committee the Hospital Auxiliary commenced a new initiative in 2017 with the commencement of the Hospital Trolley. Designed and built by volunteer Ray Miller, the trolley offers small items for sale to patients and visitors. Patients also enjoy the opportunity for a friendly conversation with auxiliary volunteers during their walk around the wards.

The Hospital Auxiliary run a number of fundraising events throughout the year including regular raffles at Easter, Christmas, Mother's Day and Father's Day. This year they were also supported by Kilmore Trackside who provided space to sell raffle tickets over a six to eight week period. Through their generous donations of gift hampers the Hospital Auxiliary also support raffles run at Caladenia Nursing Home and Dianella Hostel throughout the year. The Hospital Auxiliary holds a stall at the monthly Wallan community market. One of their major events has been the successful Annual Fashion Parade bringing together local businesses and the community to enjoy a morning of fashion and fun.

### Opportunity Shop Committee

A group of very dedicated volunteers run the Opp Shop Thursday, Friday and Saturday mornings and the profits raised directly benefit The Kilmore & District Hospital. The work of these volunteers is invaluable. Since the opening of the Opp Shop in November 2005, they have raised more than $500,000 which has been used to purchase equipment, furniture and services for both our Hospital and Aged Care Facilities. In 2016-17 the Opportunity Shop Committee provided the hospital with funds raised in excess of $70,000.

### Volunteers

The hospital is fortunate to have a very dedicated and growing group of volunteers who assist in a range of roles and offer that extra bit of help to reassure patients in need. This year we were fortunate to welcome 23 new volunteers to The Kilmore & District Hospital, increasing our workforce to over 110 volunteers.

Our volunteers have provided direct assistance to almost 500 patients and aged care recipients over the past year. These volunteers have on average given approximately 340 hours per week of their time. Volunteers assist in our Inpatient Unit, Theatre Suite, Aged Care Services and the Outpatient Consulting Suites. In addition we value the ongoing community service hours offered by students from The Kilmore International School and Assumption College Kilmore throughout the year. We sincerely thank all our volunteers for their hard work.

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 six 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 we are working towards the implementation of Working with Children Checks 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 The Kilmore & District Hospital.

Service worthy of note may include: excellence/length of service as a volunteer; significant philanthropy; outstanding professional service; an exceptional contribution in years of service or effort; initiating a new and/or innovative idea; or making a contribution 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 The Kilmore & District Hospital.

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

**The Kilmore & District Hospital's Life Governors:**

- Mrs Pat Arnott
- Ms Nancy Bidstrup
- Mrs Kaye Chapman
- Mrs Joyce Chard
- Dr Peter Condos
- Dr Walter Cosolo
- Dr Barry Dawson
- Mrs Astrid Djulinac
- Mrs Marguerite Fagg
- Dr John Griffiths
- Mrs Shirley Jean Hillier
- Dr Denis Holland
- Dr Suresh Jain
- Mrs Denise Lee
- Mrs M Merritt
- 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

**The Kilmore & District Hospital acknowledges the death of two Life Governors during 2016-17, Mr Ian A. Johnson and Mr Patrick (Pat) M Kelly. Our deepest sympathy is extended to their families and many friends throughout the community.**

## Vale Pat Kelly (19.2.1926 - 9.3.2017)

The Kilmore & District Hospital said farewell to one of our longest standing Board of Management members, Mr Patrick (Pat) Kelly, who passed away peacefully at Caladenia Nursing Home on 9 March 2017.

Pat was first appointed to the Board of Management of The Kilmore & District Hospital and The Kilmore & District Nursing Home in 1961. He served on the Board for more than 33 years, resigning in November 1994. Pat was appointed as President of the Board of Management on 1 October 1985 and held this positon for almost seven years until 30 June 1992. He then held the positon of Vice President for a further two years until his resignation from the Board in 1994.

One of his proudest achievements was when he was President of The Kilmore & District Hospital Board of Management and he was instrumental in fundraising for, and the development of, the Caladenia Nursing Home – the first nursing home in the district.

For the last three years of Pat's life there were significant health changes and at the age of 89 he made the choice to go into care and he joined the community at Dianella Hostel.

In August 2016 he was proud to receive an invitation to the 25th birthday celebration of the Caladenia Nursing Home. Little did he know that following an episode of illness he would become a resident of Caladenia the following month.

Pat was a highly respected person in this area and beyond and The Kilmore & District Hospital acknowledges the significant contribution he made to the organisation during his time on the Board of Management. The staff and volunteers of Dianella Hostel and Caladenia Nursing Home hold fond memories of his time shared in their communities.

# Service Overview

The Kilmore & District Hospital has provided health care services to our local community since it was founded in 1854. The hospital is accountable to the people of Victoria, through the Minister for Health and the Minister for Housing, Disability and Ageing.

### Manner of Establishment and Relevant Minister

The Kilmore & District Hospital was established in 1854 and was incorporated under the provisions of the Hospitals & Charities Act on 17 November 1864.

The responsible Ministers during the reporting period were:

- The Honourable Jill Hennessey MLA, Minister for Health, Minister for Ambulance Services
- The Honourable Martin Foley MLA, Minister for Housing, Disability and Ageing, Minister for Mental Health

### Powers and Duties

The powers and duties of The Kilmore & District Hospital are prescribed by the Health Services Act 1988.

### Nature and Range of Services

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.

#### Hospital Based Services

The Kilmore & District Hospital provides a variety of health care services. Inpatient and outpatient services are offered to the community of Kilmore and district including maternity, medical, surgical and subacute care.

As the only provider of maternity services in the Mitchell Shire, the hospital supports up to 300 women and families assessed as having a normal risk pregnancy to birth close to home.

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.

Our 24 hour Urgent Care Centre is attended by highly skilled and experienced nursing staff. Staff collaborate with local GPs, 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 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

In 2016-17 our District Nursing Service transitioned to the Commonwealth Home Support Programme (CHSP). This service helps older people stay independent and in their homes and communities for longer. We also continue to provide support to younger people with disabilities living at home and produce delivered meals through the Victorian Home and Community Care program.

### Our People

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

#### Recruiting Staff

In 2016–17 The Kilmore & District Hospital employed 287 staff. We recruited 47 new staff through a mixture of permanent and casual positions. There was an additional focus on boosting our administrative support services as a result of an ongoing review of this workgroup.

In addition to the induction process for this year has been the development and implementation of our Corporate Orientation. The day-long session incorporates overviews of all services delivered, safety and reporting processes, and community engagement. The day is then rounded out with safety procedure training in emergency response management including the use of the helipad, infection control, respectful workplace behaviours, basic life support and manual handling.

Merit, fairness and reasonable treatment, equal opportunity and avenues of redress are reinforced in our policies and procedures to support our decision making processes. The organisation's Values and Code of Conduct are widely promoted and form the basis of how we work together.

#### Employee Assistance Program

The Employee Assistance Program (EAP) is a confidential external counselling service available to staff and their families. The service provides assistance in addressing personal concerns or work related issues that have an impact on wellbeing and quality of life.

There were six staff or family members who accessed the service during 2016–17. The EAP is also available to support staff debriefing sessions that may be required following a clinical incident. In 2016-17 EAP provided two site visits to support staff through this process.

### Workforce by Labour Category

| Labour Category | June 2016 Current Month FTE | June 2017 Current Month FTE | June 2016 YTD FTE | June 2017 YTD FTE |
|---|---|---|---|---|
| Nursing | 78.19 | 80.31 | 75.31 | 78.42 |
| Administration and Clerical | 11.7 | 16.42 | 14.55 | 15.16 |
| Medical Support | 1.7 | 2.6 | 1.85 | 2.1 |
| Hotel and Allied | 33.58 | 33.14 | 32.28 | 33.72 |
| Hospital Medical Officers | 0 | 0.15 | 0 | 0.09 |
| Sessional Medical Specialists | 0.21 | 0.21 | 0.21 | 0.21 |
| Allied Health | 2.65 | 3.11 | 2.62 | 2.95 |
| **Total** | **128.07** | **135.97** | **126.82** | **132.65** |

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

### Pre-employment Verification

The organisation has further improved the process for credentialling 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 The Kilmore & District Hospital 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 we are working towards the implementation of Working with Children Checks as part of our Child Safe Policy requirement. All new staff joining our organisation are required to hold a relevant Working with Children Check.

### Developing Our Workforce

The Kilmore & District Hospital'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 was developed and rolled out in line with the Australian Council on Health Care Standards. The mandatory training matrix 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.

Along with this, our Managers have been working with our Clinical Educator to review the skill sets required in each department and then conducting a skills gap analysis. The purpose of this work is to enable us to target training and education opportunities to help ensure our staff have the appropriate skills and knowledge to support our community and their health care needs.

### Workplace Training and Experience

In 2016-17 The Kilmore & District Hospital provided placement opportunities for over 100 students. The majority were participating in nursing professional practice placements with 75 students working across our Inpatient, Urgent Care, District Nursing and Aged Care Services. Six overseas trained medical officers were able to participate in observation placements during the year.

Fourteen Vocational Education and Training students were provided experience with our Catering, Environmental and Maintenance Services. In addition we provided opportunities for students undertaking certificate studies in Allied Health, Leisure and Lifestyle, Theatre Technician and Individual Support to gain valuable work place experience.

Each year we support our local schools' work experience program and six students from Assumption College Kilmore, Wallan Secondary College and Broadford Secondary College joined us for their placements.

The Kilmore & District Hospital has established relationships with many universities and training organisations including: Victoria University, Charles Sturt University, Go Tafe, Swinburne 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 objectives.

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

In 2016-17 The Kilmore & District Hospital participated in the Australasian College of Health Service Management Health Management Internship Program. Ms Shevaun O'Loghlen joined the Directorate of Development and Improvement for a six month placement from January to June 2017. During this time Ms O'Loghlen completed a significant project involving the development and implementation of the Knowing How We're Going consumer communication boards.

### Payroll

Payroll is managed in-house with over 6,464 pays processed during 2016–17.

## Work Health Safety

The Kilmore & District Hospital 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 2007, the Workplace Injury Rehabilitation and Compensation Act 2013 and other relevant legislation.

In 2016-17, staff were involved in health and safety decisions through meetings of the Health and Safety Committee and regular consultation with health and safety representatives.

Immediately following an incident, an investigation is undertaken to identify and implement remedial action. Quarterly preventative workplace inspections are carried out by management 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.

### Occupational Violence Statistics 2016-17

| | |
|---|---|
| Workcover accepted claims with an occupational violence cause per 100 FTE | 0.8% |
| 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 | 48 |
| Number of occupational violence incidents reported per 100 FTE | 36.2 |
| Percentage of occupational violence incidents resulting in a staff injury, illness or condition | 9% |

***Definitions:***

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

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

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

***Accepted WorkCover claims:*** *Accepted WorkCover claims that were lodged in 2016-17.*

***Lost time:*** *Is defined as greater than one day.*

### Workers Compensation

The total number of WorkCover claims lodged increased in 2016–17 resulting in six new claims adding to the two pre-existing ones.

Three of the new claims have successfully been supported back to full pre-injury duties. One of the remaining new claims is participating in a gradual return to work and making significant progress through this.

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

| | Number of Claims | Total cost of claims per year | Average claim cost |
|---|---|---|---|
| 2013-14 | 4 | $21,876 | $5,469 |
| 2014-15 | 1 | $242,081 | $242,081 |
| 2015-16 | 2 | $3,676 | $1,838 |
| 2016-17 | 6 | $47,983 | $7,998 |

## Legislative Compliance

### Privacy

Privacy is an important part of the culture at The Kilmore & District Hospital. 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.

The Kilmore & District Hospital's Privacy Officer role is delegated to the Manager Health Information, Ms Denise Marshall.

### Protected Disclosures

Under the Protected Disclosures Act 2012 (the Act), complaints about certain serious misconduct or corruption involving public health services in Victoria should be made directly to the Independent Broadbased Anti-corruption Commission (IBAC) in order to remain protected under the Act. The Kilmore & District Hospital was not required to disclose any issues under the Act in the 2016-17 financial year.

### Carers Recognition

The Carers Recognition Act 2012 recognises, promotes and values the role of carers. The Kilmore & District Hospital understands the different needs of carers and the value they provide to the community. The Kilmore & District Hospital 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. The Kilmore & District Hospital was not required to make any disclosures during the reporting period.

### Freedom of Information

The Victorian Freedom of Information (FOI) Act 1982 provides members of the public with the right to apply, in writing, to The Kilmore & District Hospital for access to information held by the hospital. The hospital provides an annual report of all FOI requests to the Victorian Department of Justice.

In 2016-17 The Kilmore & District Hospital received 27 requests for information under the Freedom of Information Act (1982). Of the 27 applications, five of which were from the general public, all were granted.

### 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. The Kilmore & District Hospital 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 Kilmore & District Hospital was not required to make any disclosures during the reporting period.

### Building and Maintenance Compliance

During 2016-17 The Kilmore & District Hospital's 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.

### Environmental Achievements

The Kilmore & District Hospital is committed to reducing its carbon footprint and minimising the impact on the environment. New and ongoing energy saving initiatives include:

- The replacement of halogen lights with LEDs throughout the organisation; and
- Rain water is now used systematically throughout the facility.

### Victorian Industry Participation Policy Disclosure

The Kilmore & District Hospital complies with the intent of the Victorian Industry Participation Policy Act 2003 and has no requirements of disclosures for the 2016-17 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.

### National Competition Policy

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

The Kilmore & District Hospital 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 The Kilmore & District Hospital.

### Compliance

The Kilmore & District Hospital has complied substantially with the requirements of the Victorian Public Sector Financial Management Compliance Framework for the year ended 30 June 2017.

### Consultancies less than $10,000

In 2016-17 The Kilmore & District Hospital engaged one consultant where the total fees payable to the consultant were less than $10,000, with a total expenditure of $1,800 (excluding GST).

### Consultancies more than $10,000

In 2016-17 The Kilmore & District Hospital engaged two consultancies where the total fees payable were in excess of $10,000 (excluding GST):

| Consultancy | Purpose of Consultancy | Total Expenditure |
|---|---|---|
| Health Recruitment Specialists | Director Recruitment | $10,000 |
| Lehr Consultants International (Australia) Pty Ltd | Fire Safety Audit | $19,300 |

### Disclosure of Ex-Gratia Payments

The Kilmore & District Hospital made no ex-gratia payments for the year ending 30 June 2017.

### Disclosure of Information and Communication Technology (ICT) Expenditure

The Kilmore & District Hospital's total entity ICT Business As Usual expenditure (excluding GST) for the 2016-17 financial year was $291,380. This expenditure is comprised of $212,474 for operating expenses and $78,906 for capital expenses.

### Additional Information Available on Request (FRD 22F Appendix)

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 The Kilmore & District Hospital 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 The Kilmore & District Hospital.
- 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 The Kilmore & District Hospital and its services.
- Details of assessments and measures undertaken to improve the occupational health and safety of employees.
- General statement on industrial relations within The Kilmore & District Hospital and details of time lost through industrial accidents and disputes.
- A list of major committees sponsored by The Kilmore & District Hospital, 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.

# Key Financial and Service Performance Reporting

## Service Performance at a Glance

| Admitted | 2016-17 | 2015-16 | 2014-15 | 2013-14 | 2012-13 |
|---|---|---|---|---|---|
| **Acute** | | | | | |
| Number of Inpatients treated incl. same day | 2,443 | 2,451 | 1,786 | 2,333 | 2,176 |
| Beddays | 4,940 | 5,037 | 4,316 | 5,385 | 5,939 |
| Average Length of Stay | 2.02 | 2.06 | 2.42 | 2.30 | 2.73 |
| **Geriatric Evaluation and Management (GEM)** | | | | | |
| Number of Separations* | 178 | 147 | | | |
| Beddays* | 3,290 | 2,722 | | | |
| Average Length of Stay* | 18.48 | 18.70 | | | |
| **Operating Theatre** | | | | | |
| Number of Operations | 1,508 | 1,509 | 787 | 1,298 | 1,160 |
| Number of Contract Operations* | 315 | 255 | 129 | 131 | |
| **Maternity** | | | | | |
| Births | 247 | 292 | 199 | 228 | 197 |
| **Non-Admitted** | | | | | |
| Outpatient Attendances | 5,969 | 5,757 | 3,870 | 3,341 | 2,660 |
| Urgent Care Centre (UCC ) Attendances | 8,521 | 8,337 | 8,487 | 8,531 | 7,907 |
| **Community Services** | | | | | |
| District Nurse Visits | 4,501 | 4,997 | 5,244 | 6,082 | 5,725 |
| Meals on Wheels | 9,022 | 7,786 | 9,059 | 11,370 | 12,933 |
| **Aged Care** | | | | | |
| **Nursing Home** | | | | | |
| Beddays | 8,858 | 8,495 | 8,455 | 9,123 | 10,723 |
| Occupancy | 80.89 | 77.37 | 77.20 | 83.32 | 97.20 |
| Residents Accommodated | 40 | 37 | 39 | 53 | 43 |
| Average Length of Stay | 709 | | | | |
| **Hostel** | | | | | |
| Beddays | 10,614 | 10,337 | 10,175 | 9,985 | 10,644 |
| Occupancy | 96.93 | 94.14 | 92.93 | 91.19 | 97.21 |
| Residents Accommodated | 61 | 60 | 88 | 96 | 72 |
| Average Length of Stay | 618 | | | | |

** Service contracted with Northern Health*

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 2016/17.

Non-admitted data is in accordance with the definitions in the AIMS manual.

# Statement of Priorities

## Part A: Strategic Priorities

| Priority | Action | Deliverables | Outcomes |
|---|---|---|---|
| **Quality & Safety – Growing and improving the delivery of safe, high quality care** | Implement systems and processes to recognise and support person-centred end-of-life care in all settings, with a focus on providing support for people who choose to die at home. | End-of-Life referral pathways in place to support person-centred care in all settings by December 2016.<br>Care Plan for the Dying Person - Victoria implemented across inpatient and residential care services by June 2017.<br>Advance Care Directives and/or Plans developed for 100% of patients who are transitioning to residential care and consent to have one, by June 2017. | **Significantly progressed**<br>End-of-Life Care Plan (Qld) is in place across inpatient and residential care services.<br>Care Plan for the Dying Person Victoria (CPDP-Vic) released in June 2017 and the process for implementation is under development.<br>Development of Advance Care Planning processes commenced. |
| | Advance care planning is included as a parameter in an assessment of outcomes including: mortality and morbidity review reports, patient experience and routine data collection. | Death audit process reviewed and modified to encompass the evaluation of inclusion and adherence to Advance Care Plans, for 100% of death reviews by August 2016.<br>The Kilmore & District Hospital will explore how Advance Care Plans are stored /recorded in the client record and how to obtain reports of usage from VITAL and UNITI software programs. | **Completed and ongoing**<br>Death audit process and associated form reviewed and updated.<br>Mechanism established within the Patient Master Index to report the usage of Advance Care Plans.<br>Use of Advance Care Plans is monitored and reported through the organisational Mortality and Morbidity Committee. |
| | Progress implementation of a whole-of-hospital model for responding to family violence. | Continue relationship and connection with Goulburn Valley Health (GVH) who have been funded to provide support to health services in the Hume region to implement whole-of-hospital responses to family violence.<br>Increased capability and capacity of managers and staff to identify and respond to family violence.<br>Local service networks established to support the hospital's response to family violence. | **Commenced and ongoing**<br>GVH presentation on Strengthening Hospital Responses to Family Violence (SHRFV) Service Model, including the two overarching principles on Gender Equality and Sensitive Practice, attended and relationship established.<br>Work plan developed and key staff identified to lead the SHRFV work to increase capability and capacity of managers and staff to identify and respond to family violence and build networks with local service networks. |
| | Develop a regional leadership culture that fosters multidisciplinary and multi-organisational collaboration to promote learning and the provision of safe, quality care across rural and regional Victoria. | Multidisciplinary Mortality and Morbidity Committees established that incorporate external peer review for the Maternity, Preoperative and Urgent Care clinical streams of care by June 2017. | **Completed and ongoing**<br>Overarching Mortality and Morbidity Committee established and processes in place.<br>All clinical stream Mortality and Morbidity Committees incorporating external peer review convened. |

| Priority | Action | Deliverables | Outcomes |
|---|---|---|---|
| | Establish a Foetal Surveillance Competency Policy and associated procedures for all staff providing maternity care that includes the minimum training requirements, safe staffing arrangements and ongoing compliance monitoring arrangements. | Foetal Surveillance Competency Policy and associated procedures developed and implemented by December 2016.<br>100% of midwives trained with a Level 2 competency attained as a minimum requirement by December 2016.<br>100% of midwives and medical staff involved with clinical evaluation (Antenatal Clinic and Birthing Suite) attain a Level 3 competency by June 2017.<br>Revised Model of Care and associated staffing establishment implemented by June 2017. | **Completed and ongoing**<br>All midwives have completed the mandated training and assessment requirements.<br>100% of midwives attained at least a Level 2 competency in foetal surveillance.<br>100% of midwives in the clinical evaluation units hold a Level 3 competency in foetal surveillance.<br>The current Foetal Surveillance Competency Policy ensures that competency is assessed annually and that Level 3 competency requirements form a standard credentialling requirement for The Kilmore & District Hospital employed midwives. |
| | Use patient feedback, including the Victorian Healthcare Experience Survey (VHES) to drive improved health outcomes and experiences through a strong focus on person and family-centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first. | In partnership with the Community Advisory Board Subcommittee, The Kilmore & District Hospital will review the VHES results and other consumer/client feedback surveys to determine areas of improvement.<br>Strategy and process to communicate patient feedback effectively with staff developed and implemented by June 2017. | **Completed and ongoing**<br>Community Advisory Board Subcommittee has reviewed the VHES results and identified areas for improvement.<br>"Knowing How We're Going" communication boards developed in partnership with consumer consultants and in place across the organisation.<br>Key data from the VHES displayed on the "Knowing How We're Going" Boards. |
| | Develop a whole-of-hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint. | Review of hospital approach to the use of restrictive practices undertaken through audit of adherence to best practice guidelines. | **Completed**<br>Audit of the approach to the use of restrictive practices completed.<br>Organisational policy and procedure reviewed against the National Framework for Reducing and Eliminating the Use of Restrictive Practices. |
| **Access and Timeliness** | Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine). | Better Residential Care Together program implemented to support enhanced aged care pathways across all care settings. | **Completed and ongoing**<br>Structured strength and balance exercise program for residents developed and established.<br>Falls Information Sheet introduced as a standard process within the admission process.<br>Falls Standardised Care Process targeting appropriate footwear as a major contributing factor in maintaining good gait implemented. |

| Priority | Action | Deliverables | Outcomes |
|---|---|---|---|
| | Develop and implement a strategy to ensure the preparedness of the organisation for the National Disability and Insurance Scheme and Home and Community Care Program transition and reform, with particular consideration to service access, service expectations, workforce and financial management. | Participate in initiatives to strengthen the regional governance and leadership for Home and Community Care Program and the transition process.<br>Develop organisational business systems and processes to ensure Home and Community Care and National Disability and Insurance Scheme (NDIS) initiatives are effectively and efficiently responded to. | **Commenced and ongoing**<br>The Kilmore & District Hospital is a member agency of the regional governance body supporting the transition process.<br>District Nursing Service transitioned to the Commonwealth Home Support Program.<br>All data reviewed and uploaded into My Aged Care portal with systems under development. |
| **Supporting Health Populations** | Support shared population health and wellbeing planning at a local level - aligning with the Local Government Municipal Public Health and Wellbeing Plan and working with other local agencies and Primary Health Networks. | Active participation in the Lower Hume Primary Care Partnership Population Health Planning Project to better understand and respond to current and future health needs of the catchment.<br>Active participation in the planning and implementation of the Municipal Public Health and Wellbeing Plan to improve prospective health outcomes for the catchment. | **Completed and ongoing**<br>The Kilmore & District Hospital participated in the Lower Hume Primary Care Partnership Planning Project.<br>The Kilmore & District Hospital participated in the consultation workshops undertaken by the Mitchell Shire on the development of the Municipal Public Health and Wellbeing Plan. |
| | Focus on primary prevention, including suicide prevention activities, and aim to impact on large numbers of people in the places where they spend their time adopting a place based, whole-of-population approach to tackle the multiple risk factors of poor health. | Stage 2 of the Healthy Together Victoria Workplace Achievement Program implemented across The Kilmore & District Hospital. | **Completed and ongoing**<br>The organisational Work Health Safety Committee Terms of Reference reviewed and broadened to encompass staff and volunteer health and wellbeing.<br>The Kilmore & District Hospital participated in the Active April initiative. |
| | Develop and implement strategies that encourage cultural diversity such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices. | Diversity, Inclusion and Health Literacy Action Group established by October 2016.<br>Collaborate with Mitchell Shire in cultural diversity plan.<br>Diversity Action Plan developed by December 2016. | **Completed and ongoing**<br>Diversity, Inclusion and Health Literacy Action Group convened in March 2017.<br>Actively supported the Mitchell Shire as a participating agency in the Mitchell Multicultural Street Festival.<br>Diversity Action Plan completed through the Lower Hume Primary Care Partnership as a member organisation further refined for internal purposes. |

| Priority | Action | Deliverables | Outcomes |
|---|---|---|---|
| | Improve the health outcomes of Aboriginal and Torres Strait Islander people by establishing culturally safe practices which recognise and respect their cultural identities and safely meets their needs, expectations and rights. | Aboriginal Health Audit implemented to identify opportunities to establish culturally safe practices.<br>Aboriginal Health Transition Officer (AHTO) supported to improve the sustainability of the AHTO role across the Lower Hume Primary Care Partnership (LHPCP) agencies.<br>The Kilmore & District Hospital's Aboriginal Health Plan developed and informing improved Aboriginal patient identification and staff engagement in cultural awareness training. | **Significantly progressed**<br>Koolin Balit Cultural Framework Audit completed.<br>Active member of Seymour Local Aboriginal Network and worked closely with the AHTO and LHPCP agencies.<br>Aboriginal Health issues actioned through Diversity, Inclusion and Health Literacy Action Group and associated plan.<br>Staff engagement in cultural awareness initiatives commenced. |
| | Drive improvements to Victoria's mental health system through focus and engagement in activity delivering on the 10 Year Plan for Mental Health and active input into consultations on the Design, Service and Infrastructure Plan for Victoria's Clinical mental health system. | Active contribution to consultations regarding the Design, Service and Infrastructure Plan -Victoria's Clinical mental health system.<br>Collaborate with Goulburn Valley Health to draft a regional Mental Health Plan which aligns with the outcomes and actions required for the delivery of the 10 Year Plan for Mental Health | **Not progressed**<br>Opportunities to contribute to the development of the Design, Service and Infrastructure Plan -Victoria's Clinical mental health system and the regional Mental Health Plan not provided. |
| | Using the Government's Rainbow eQuality Guide, identify and adopt 'actions for inclusive practices' and be more responsive to the health and wellbeing of lesbian, gay, bisexual, transgender and intersex individuals and communities. | Current level of lesbian, gay, bisexual, transgender and intersex (LGBTI) inclusivity assessed using the Gay and Lesbian Health Victoria Audit Tool to identify opportunities for support and training to implement gender-sensitive practice.<br>Organisational procedures, protocols and practices reviewed to reflect LGBTI inclusive practice by June 2017. | **Significantly progressed**<br>LGBTI inclusivity forms a key objective of the Diversity, Inclusion and Health Literacy Action Group.<br>Lead agency for LGBTI actions included within the Lower Hume Primary Care Partnership Diversity Plan.<br>Review of organisational procedures, protocols and practices commenced. |
| **Governance and Leadership** | Demonstrate implementation of the Victorian Clinical Governance Policy Framework: Governance for the provision of safe, quality healthcare at each level of the organisation, with clearly documented and understood roles and responsibilities. Ensure effective integrated systems, processes and leadership are in place to support the provision of safe, quality, accountable and person-centred healthcare. It is an expectation that health services implement to best meet their employees' and community's needs, and that clinical governance arrangements undergo frequent and formal review, evaluation and amendment to drive continuous improvement. | Evidence based clinical governance model to support the effective flow of patient and system level clinical information from ward and/or service to Board established.<br>Increased compliance with Victorian Clinical Governance Policy Framework improving the 2015-16 baselines of 38% to 90% by June 2017. | **Completed and ongoing**<br>Clinical governance model supporting ward/service to Board reporting established.<br>Increased compliance with reporting to Board on quality and safety by introduction of standard agenda item for Quality and Safety and regular reporting and monitoring of Quality Dashboard established.<br>Significant increase in compliance with Victorian Clinical Governance Policy Framework achieved, improving the 2015-16 baseline of 38% to 82%. |

| Priority | Action | Deliverables | Outcomes |
|---|---|---|---|
| | Contribute to the development and implementation of Local Region Action Plans under the series of statewide design, service and infrastructure plans being progressively released from 2016-17. Development of Local Region Action Plans will require partnerships and active collaboration across regions to ensure plans meet both regional and local service needs, as articulated in the statewide design, service and infrastructure plans. | The Kilmore & District Hospital actively contributes to the Department of Health and Human Services Northern Growth Corridor Service Plan.<br>Implement actions from the statewide maternity service plan to meet the capability requirements of a Level 3 service provider by December 2016.<br>Partner with Northern Health for the provision of the elective surgical services to deliver treatment in a timelier manner in the local community. | **Completed and ongoing**<br>Actively contributed to the development of the Northern Growth Corridor Service Plan with organisational representation at both the Steering Committee and Working Group.<br>Actions implemented to achieve the capability requirements of a Level 3 maternity service provider with confirmation of compliance received in March 2017.<br>Partnered with Northern Health to increase access to surgical services providing 315 patients with more timely surgery closer to home (against a target of 272). |
| | Ensure that an Anti-bullying and Harassment Policy exists and includes the identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal and the policy specifies a regular review schedule. | Review of Anti-bullying and Harassment Policy completed and review schedule established by March 2017.<br>Managers and supervisors trained on investigation, reporting and feedback processes.<br>Systematic and integrated approach to occupational health and safety established in accordance with our obligations under the Occupational Health and Safety Act 2004. | **Commenced and ongoing**<br>Anti-bullying and Harassment policy review commenced.<br>Organisational Work Health Safety Committee Terms of Reference reviewed and support systematic and integrated approach to occupational health and safety. |
| | Board and senior management ensure that an organisational-wide occupational health and safety risk management approach is in place which includes: (1) a focus on prevention and the strategies used to manage risks, including the regular review of these controls; (2) strategies to improve reporting of occupational health and safety incidents, risks and controls, with a particular focus on prevention of occupational violence and bullying and harassment, throughout all levels of the organisation, including to the Board; and (3) mechanisms for consulting with, debriefing and communicating with all staff regarding outcomes of investigations and controls following occupational violence and bullying and harassment incidents. | Evidence based corporate governance model to support the effective flow of incident and system level workforce information from ward and/or service to Board established.<br>Workforce Capability and Culture Committee convened, key performance indicators agreed and communication process implemented by December 2016.<br>Mechanisms for involving and consulting with staff in the review of the effectiveness of controls implemented by June 2017. | **Commenced and ongoing**<br>Corporate governance model that supports the effective flow of incident and system level workforce information from ward and/or service to Board established.<br>Workforce Capability and Culture Committee convened and key performance indicators agreed.<br>Mechanisms for involving and consulting with staff commenced. |

| Priority | Action | Deliverables | Outcomes |
|---|---|---|---|
| | Implement and monitor workforce plans that: improve industrial relations; promote a learning culture; align with the Best Practice Clinical Learning Environment Framework; promote effective succession planning; increase employment opportunities for Aboriginal and Torres Strait Islander people; ensure the workforce is appropriately qualified and skilled; and support the delivery of high-quality and safe person-centred care. | Leadership Development Program targeting middle management team undertaken.<br>Performance appraisal and personal professional development planning processes reviewed to ensure individual plans align with role and career goals. | **Commenced and ongoing**<br>Planning for middle management development program commenced.<br>Performance appraisal and personal professional development planning review cycle completed.<br>Reviewed processes to ensure individual plans align with role and career goals commenced. |
| | Create a workforce culture that: (1) includes staff in decision making; (2) promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and (3) includes consumers and the community. | Workforce Recognition Program developed and established by October 2016.<br>Internal communication strategy developed with agreed structures and processes in place by June 2017. | **Significantly progressed**<br>Workforce Recognition Program development commenced. Recognition of all staff groups celebrated.<br>Internal communication processes supported by organisation-wide reporting structure. |
| | Ensure that the Victorian Child Safe Standards are embedded in everyday thinking and practice to better protect children from abuse, which includes the implementation of: strategies to embed an organisational culture of child safety; a Child Safe Policy or Statement of Commitment to Child Safety; a Code of Conduct that establishes clear expectations for appropriate behaviour with children; screening, supervision, training and other human resources practices that reduce the risk of child abuse; processes for responding to and reporting suspected abuse of children; strategies to identify and reduce or remove the risk of abuse and strategies to promote the participation and empowerment of children. | Gap analysis of Victorian Child Safe Standards completed.<br>Development of a Child Safe Policy Framework which includes:<br>• Code of Conduct for appropriate behaviour with children.<br>• Practices to identify and reduce the risk of child abuse.<br>• Processes for responding and reporting suspected child abuse.<br>• Strategies to promote the participation and empowerment of children.<br>• Relevant training and education provided to staff working in high risk areas.<br>• Active participation in the local area Vulnerable Children's Network ensuring a collaborative response to vulnerable children and families. | **Completed and ongoing**<br>Child Safe Action Group which includes a community youth representative convened.<br>Child Safe Policy implemented and forms part of the organisational orientation process.<br>Human Resource practices and policies compliant with Child Safe Standards.<br>Multidisciplinary, consultative group formally established to support the identification and support of vulnerable children and families.<br>End of year Internal audit of current compliance indicates a shift from low level compliance to moderate-to-high level compliance across all seven standards. |
| | Implement policies and procedures to ensure patient facing staff have access to vaccination programs and are appropriately vaccinated and/or immunised to protect staff and prevent the transmission of infection to susceptible patients or people in their care. | Department of Health and Human Services target for staff vaccination 2016-17 achieved.<br>100% of new staff screened for serological status by December 2016.<br>Evidence of serological immunity or vaccination history provided by 100% of Category A staff by June 2017. | **Completed and ongoing**<br>Department of Health and Human Services staff vaccination target achieved with 78% of staff vaccinated, against a target of 75%.<br>100% of new staff screened for serological status.<br>Evidence of serological immunity or vaccination history provided by new Category A staff. |

| Priority | Action | Deliverables | Outcomes |
|---|---|---|---|
| **Financial Sustainability – Being socially responsible & using resources sustainably** | Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due. | Budget surplus projected for 2016-17 to support a cash-flow positive position.<br>Creditors will be paid within the state benchmark of 60 days.<br>Budget and reporting tool implemented that will deliver greater control and accountability at a cost centre level for all levels of expenditure.<br>Formal alliance with Goulburn Valley Health (GVH) established to provide consumable stock items to The Kilmore & District Hospital that will allow for economies from a procurement perspective as well as providing greater accountability on consumable purchases.<br>The Kilmore & District Hospital will fully participate in Hume region procurement strategies to ensure that the organisation promotes fair and open competition so that appropriate goods and services are received at the best possible price. | **Significantly progressed**<br>$420,000 deficit reported against a target of $200,000 surplus due to a number of factors including higher than anticipated activity, personal leave and agency use as well lower than anticipated revenues in aged care.<br>Creditor target days have been met.<br>Budgeting and reporting tool implemented and fully functional for the 2017-18 year.<br>Alliance with GVH with regards consumable stock items has not been achieved.<br>The Kilmore & District Hospital is an active participant on the Hume Health Purchasing Victoria (HPV) Committee. The Kilmore & District Hospital met HPV compliance for 2016-17. |
| | Actively contribute to the implementation of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measureable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling. | Energy usage and waste management strategies reviewed and identified improvements implemented.<br>Replacement program of all existing halogen and incandescent lighting implemented by December 2016.<br>Plan for the use of harvested rain water formalised.<br>Options for the installation of skylights to reduce electricity usage reviewed.<br>Options for solar and wind harvesting of electricity reviewed. | **Significantly progressed**<br>Environmental Strategy and Policy developed and endorsed.<br>All halogen lights replaced with LEDs throughout the organisation.<br>Rain water now used systematically throughout the organisation.<br>Options for skylights and solar and wind harvesting to be considered in 2017-18. |

# Part B: Performance Priorities

### Safety and Quality

| Key performance indicator | Target | 2016-17 Result |
|---|---|---|
| Compliance with NSQHS Standards Accreditation | Full compliance | Achieved |
| Compliance with Commonwealth's Aged Care Accreditation Standards | Full compliance | Full compliance |
| Cleaning standards — Acceptable Quality Level | Full compliance | Achieved |
| Very high risk (Category A) | 90 points | 98 points |
| High risk (Category B) | 85 points | 95 points |
| Moderate risk (Category C) | 85 points | 98 points |
| Compliance with Hand Hygiene Australia program | 80% | 84.8% |
| Percentage of healthcare workers immunised for influenza | 75% | 78% |
| Submission of infection surveillance data to VICNISS^ | Full compliance | Achieved |

### Patient Experience and Outcomes

| Key performance indicator | Target | 2016-17 Result |
|---|---|---|
| Victorian Healthcare Experience Survey – data submission | Full compliance | Achieved |
| Victorian Healthcare Experience Survey – patient experience Quarter 1 | 95% positive experience | 99% |
| Victorian Healthcare Experience Survey – patient experience Quarter 2 | 95% positive experience | 99% |
| Victorian Healthcare Experience Survey – patient experience Quarter 3 | 95% positive experience | 98% |
| Victorian Healthcare Experience Survey – discharge care Quarter 1 | 75% very positive response | 95.4% |
| Victorian Healthcare Experience Survey – discharge care Quarter 2 | 75% very positive response | 98.9% |
| Victorian Healthcare Experience Survey – discharge care Quarter 3 | 75% very positive response | 93.7% |

** An insufficient sample number of survey results provided for each quarter. As a result, multiple quarter results have been* combined to provide a sufficient sample for unique reporting.

### Governance, Leadership and Culture

| Key performance indicator | Target | 2016-17 Result |
|---|---|---|
| People Matter Survey – percentage of staff with a positive response to safety culture questions | 80% | 89% |

### Financial Sustainability

| Key performance indicator – Finance | Target | 2016-17 Result |
|---|---|---|
| Operating Result ($M) | 0.06 | -0.42 |
| Creditors Average Days | < 60 days | 60 |
| Debtors Average Days | < 60 days | 16 |

| Key performance indicator – Asset Management | Target | 2016-17 Result |
|---|---|---|
| Asset management plan | Full compliance | Achieved |
| Adjusted current asset ratio | 0.7 | 0.82 |
| Days of available cash | 14.0 | 26 |

# Part C: Activity and Funding

Public hospitals, denominational hospitals and public health services (excluding DHSV) per the Health Services Act

| Funding type | Activity | 2016-17 Activity Achievement | Budget ($'000) |
|---|---|---|---|
| Small Rural Acute | 1,433 | 1,403 | $10,929 |
| Small Rural Residential Care | 20,973 | 19,472 | $970 |
| Small Rural HACC | 473 | 646 | $44 |
| Health Workforce | 3 | 4 | $88 |
| Other specified funding | | | $483 |
| **Total funding** | | | **$12,515** |

# Financial Overview

### For the year ended 30 June 2017 compared with the last five financial years

| | 2016-17 $'000 | 2015-16 $'000 | 2014-15 $'000 | 2013-14 $'000 | 2012-13 $'000 |
|---|---|---|---|---|---|
| Total Revenue | 20,294 | 18,920 | 20,755 | 23,575 | 18,745 |
| Total Expenses | 22,878 | 21,286 | 19,187 | 18,408 | 17,449 |
| **Net Result for the Year** | **(2,584)** | **(2,366)** | **1,568** | **5,168** | **1,296** |
| | | | | | |
| Retained Surplus / (Accumulated Deficit) | 11,692 | 14,276 | 16,271 | 7,721 | 2,611 |
| Total Assets | 39,234 | 39,844 | 41,732 | 31,919 | 15,343 |
| Total Liabilities | 9,996 | 8,147 | 8,040 | 6,779 | 5,967 |
| Net Assets | 29,238 | 31,697 | 33,692 | 25,141 | 9,376 |
| **Total Equity** | **29,238** | **31,697** | **33,692** | **25,141** | **9,376** |

*Prepared in accordance with Australian Accounting Standards which include A-IFRS*

### Significant Changes in Financial Position During 2016–17

There was a significant change in financial position during 2016-17. A budget surplus of $200,000 was forecast at the beginning of the year however the end result was a deficit of $420,000.

### 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 rate of personal leave incurred, increased utilisation of agency staff, reduction in residential aged care revenue from the Commonwealth due to the changes to the Aged Care Funding Instrument (ACFI) and the suboptimal assessment of the ACFI for care recipients.

### 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 2017

| Average Collection Days | 2016-17 | 2015-16 |
|---|---|---|
| Private Inpatient Fees | 52.1 | 54.3 |
| District Nursing Services | 62.6 | 78.6 |

### Outstanding Debtors as at 30 June 2017

| Average Collection Days | Under 30 Days | 30-60 Days | 61-90 Days | Over 90 Days | Total June 2017 | Total June 2016 |
|---|---|---|---|---|---|---|
| Hospital - Inpatient Fees | 29,063 | 11,266 | 4,049 | 4,240 | 48,618 | 59,066 |
| District Nursing Fees | 29,640 | | | | 29,640 | 11,705 |
| Residential Aged Care | 11,940 | | | | 11,940 | 1,475 |
| **Total** | **70,643** | **11,266** | **4,049** | **4,240** | **90,198** | **72,245** |

# Attestations

### Attestation on Compliance with Health Purchasing Victoria (HPV) Health Purchasing Policies

I, Sue Race, certify that The Kilmore & District Hospital has put in place appropriate internal controls and processes to ensure that it has complied with all the requirements set out in the *HPV Health Purchasing Policies* including mandatory HPV collective agreements as required by the Health Services Act 1988 (Vic) and has critically reviewed these controls and processes during the year.

**Sue Race**

Accountable Officer
The Kilmore & District Hospital
22 August 2017

### Attestation on Compliance with Ministerial Standing Direction 3.7.1 – Risk Management Framework and Processes

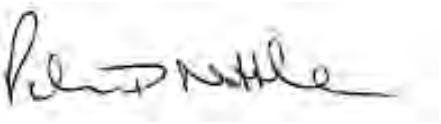
I, Sue Race, certify that The Kilmore & District Hospital has complied with Ministerial Direction 3.7.1 – Risk Management Framework and Processes. The Kilmore & District Hospital Audit and Enterprise Risk Committee has verified this.

**Sue Race**

Accountable Officer
The Kilmore & District Hospital
22 August 2017

### Responsible Bodies Declaration

In accordance with the Financial Management Act 1994, I am pleased to present the Report of Operations for The Kilmore & District Hospital for the year ending 30 June 2017.



**Associate Professor Peter Nottle**

President Elect, Board of Management
The Kilmore & District Hospital
22 August 2017

# Disclosure Index

The Annual Report of The Kilmore & District Hospital 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.

## Ministerial Directions

| Legislation Requirement | Page Reference |
|---|---|
| **Charter and purpose** | |
| FRD 22H Manner of establishment and the relevant Ministers | 12 |
| FRD 22H Purpose, functions, powers and duties | 12 |
| FRD 22H Initiatives and key achievements | 2 |
| FRD 22H Nature and range of services provided | 12 |
| **Management and structure** | |
| FRD 22H Organisational structure | 9 |
| **Financial and other information** | |
| FRD 10A Disclosure index | 28 |
| FRD 11A Disclosure of ex gratia payments | 15 |
| FRD 21C Responsible person and executive officer disclosures | 81 |
| FRD 22H Application and operation of Protected Disclosure Act 2012 | 14 |
| FRD 22H Application and operation of Carers Recognition Act 2012 | 14 |
| FRD 22H Application and operation of Freedom of Information Act 1982 | 14 |
| FRD 22H Compliance with building and maintenance provisions of Building Act 1993 | 15 |
| FRD 22H Details of consultancies over $10,000 | 15 |
| FRD 22H Details of consultancies under $10,000 | 15 |
| FRD 22H Information and Communication Technology expenditure | 15 |
| FRD 22H Employment and conduct principles | 13 |
| FRD 22H Major changes or factors affecting performance | 26 |
| FRD 22H Occupational violence | 14 |
| FRD 22H Operational and budgetary objectives and performance against objectives | 24 |
| FRD 24C Reporting of office-based environmental impacts | 15 |
| FRD 22H Significant changes in financial position during the year | 26 |
| FRD 22H Statement on National Competition Policy | 15 |
| FRD 22H Subsequent events | 26 |
| FRD 22H Summary of the financial results for the year | 26 |
| FRD 22H Additional information available on request | 15 |
| FRD 22H Workforce Data Disclosures including a statement on the application of employment and conduct principles | 13 |
| FRD 22H Victorian Industry Participation Policy Disclosure | 15 |
| FRD 22H Workforce Data Disclosure | 13 |
| FRD 103F Non-Financial Physical Assets | 49 |
| FRD 110A Cash flow Statements | 37 |
| FRD 112D Defined Benefit Superannuation Obligations | 47 |

| Legislation Requirement Page Reference | |
|---|---|
| SD 5.2.3 Declaration in report of operations | 27 |
| SD 3.7.1 Risk management framework and processes | 27 |
| **Other requirements under Standing Directions 5.2** | |
| SD 5.2 Declaration in financial statements | 30 |
| SD 5.2.1(a) Compliance with Australian accounting standards and other authoritative pronouncements | 39 |
| SD 5.2.1(a) Compliance with Ministerial Directions | 39 |
| **Legislation** | |
| Freedom of Information Act 1982 | 14 |
| Building Act 1993 | 15 |
| Financial Management Act 1994 | 27 |
| Health Records Act 2001 | 14 |
| Victorian Industry Participation Policy Act 2003 | 15 |
| Victorian Occupational Health and Safety Act 2004 | 14 |
| Protected Disclosure Act 2012 | 14 |
| Workplace Injury Rehabilitation and Compensation Act 2013 | 14 |
| Carers Recognition Act 2012 | 14 |
| Privacy and Data Protection Bill 2014 | 14 |
| Safe Patient Care Act 2015 | 15 |

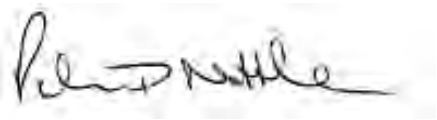
# Board Member's, Accountable Officer's and Chief Finance and Account Officer's Declaration

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

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

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

We authorise the attached financial report for issue 22 August 2017.



Assoc. Prof. P Nottle
Board President

Kilmore
22 August 2017

Mrs. S. Race
Chief Executive Officer

Kilmore
22 August 2017

Mr. C. Clark
Chief Finance and Accounting Officer

Kilmore
22 August 2017

# 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 hospital) which comprises the:

- balance sheet as at 30 June 2017
- comprehensive operating statement for the year then ended
- statement of changes in equity for the year then ended
- cash flow statement for the year then ended
- notes to the financial statements, including a summary of significant accounting policies
- board member's, accountable 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 hospital as at 30 June 2017 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.

**Basis for Opinion**

I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. My responsibilities under the Act are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report.

My independence is established by the *Constitution Act 1975.* My staff and I are independent of the hospital in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Australia. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

**Board's responsibilities for the financial report**

The Board of the hospital 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 hospital's ability to continue as a 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 our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the hospital'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 hospital'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 hospital to cease to continue as a going concern.
- evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

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

MELBOURNE
25 August 2017

Ron Mak
*as delegate for the Auditor-General of Victoria*

# Financial Statements

# Comprehensive Operating Statement

## For the financial year ended 30 June 2017

| | Note | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|---|
| Revenue from Operating Activities | 2.1 | 19,262 | 18,046 |
| Revenue from Non-Operating Activities | 2.1 | - | - |
| Employee Expenses | 3.1 | (13,357) | (12,232) |
| Non Salary Labour Costs | 3.1 | (2,449) | (2,108) |
| Supplies and Consumables | 3.1 | (1,598) | (1,491) |
| Other Expenses | 3.1 | (2,278) | (2,107) |
| **Net Result Before Capital & Specific Items** | | **(420)** | **108** |
| Capital Purpose Income | 2.1 | 1,055 | 899 |
| Expenditure for Capital Pupose | 3.1 | (6) | - |
| Depreciation and Amortisation | 4.3 | (3,214) | (3,330) |
| | | **(2,165)** | **(2,431)** |
| **NET RESULT FOR THE YEAR** | | **(2,585)** | **(2,323)** |
| **Other economic flows included in net result** | | | |
| Net gain/(loss) on non-financial assets | 7.2 | (23) | (25) |
| Revaluation of Long Service Leave | | 24 | (18) |
| **Other economic flows included in net result** | | **1** | **(43)** |
| **COMPREHENSIVE RESULT** | | **(2,584)** | **(2,366)** |

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

# Balance Sheet

## For the financial year ended 30 June 2017

| | Note | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|---|
| **Current Assets** | | | |
| Cash and Cash Equivalents | 6.2 | 1,183 | 798 |
| Receivables | 5.1 | 826 | 609 |
| Investments and Other Financial Assets | 4.1 | 5,630 | 4,498 |
| Inventories | 5.2 | 114 | 133 |
| Prepayments and Other Assets | 5.4 | 12 | 9 |
| **Total Current Assets** | | **7,765** | **6,047** |
| Non-Current Assets | | | |
| Receivables | 5.1 | 380 | 263 |
| Property, Plant & Equipment | 4.2 | 31,019 | 33,494 |
| Intangible Assets | 4.4 | 70 | 40 |
| **Total Non-Current Assets** | | **31,469** | **33,797** |
| **TOTAL ASSETS** | | **39,234** | **39,844** |
| **Current Liabilities** | | | |
| Payables | 5.5 | 1,258 | 830 |
| Borrowings | 6.1 | 29 | 34 |
| Provisions | 3.4 | 3,060 | 2,722 |
| Other Current Liabilities | 5.3 | 5,228 | 4,150 |
| **Total Current Liabilities** | | **9,575** | **7,736** |
| **Non-Current Liabilities** | | | |
| Borrowings | 6.1 | 32 | 41 |
| Provisions | 3.4 | 389 | 370 |
| **Total Non-Current Liabilities** | | **421** | **411** |
| **TOTAL LIABILITIES** | | **9,996** | **8,147** |
| **NET ASSETS** | | **29,238** | **31,697** |
| **EQUITY** | | | |
| Asset Revaluation Reserve | 8.1a | 17,546 | 17,421 |
| Contributed Capital | 8.1b | 11,532 | 11,532 |
| Accumulated Surpluses/(Deficits) | 8.1c | 160 | 2,744 |
| **TOTAL EQUITY** | 8.1c | **29,238** | **31,697** |
| Contingent Assets and Contingent Liabilities | 7.3 | | |
| Commitments | 6.3 | | |

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

# Statement of Changes in Equity

## For the financial year ended 30 June 2017

| Total | Note | Property, Plant & Equipment Revaluation Surplus $'000 | Contributions by Owners $'000 | Accumulated Surpluses/ (Deficits) $'000 | Total $'000 |
|---|---|---|---|---|---|
| **Balance at 1 July 2015** | | **17,421** | **11,161** | **5,110** | **33,692** |
| Net result for the year | | - | - | (2,366) | (2,366) |
| Capital appropriation received from Victorian Government | | - | 371 | - | 371 |
| **Balance at 30 June 2016** | | **17,421** | **11,532** | **2,744** | **31,697** |
| Net result for the year | | - | - | (2,584) | (2,584) |
| Other comprehensive income for the year | | 125 | - | - | 125 |
| Capital appropriation received from Victorian Government | | - | - | - | - |
| **Balance at 30 June 2017** | | **17,546** | **11,532** | **160** | **29,238** |

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

# Cash Flow Statement

## For the financial year ended 30 June 2017

| | Note | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES** | | | |
| Operating Grants from Government | | 12,965 | 11,634 |
| Capital Grants from Government | | 482 | 426 |
| Patient and Resident Fees Received | | 4,167 | 4,241 |
| GST Received from/(paid to) ATO | | 358 | 606 |
| Recoupment from Private Practice for use of Hospital Facilities | | 43 | 38 |
| Other Capital Receipts | | 229 | 198 |
| Other Receipts | | 2,353 | 2,005 |
| ***Total Receipts*** | | **20,597** | **19,148** |
| Employee Expenses Paid | | (13,143) | (11,977) |
| Fee for Service Medical Officers | | (2,544) | (2,235) |
| Payment for Supplies & Consumables | | (3,930) | (4,013) |
| ***Total Payments*** | | **(19,617)** | **(18,225)** |
| **NET CASH FLOW FROM / (USED IN) OPERATING ACTIVITIES** | **8.2** | **980** | **923** |
| **CASH FLOWS FROM INVESTING ACTIVITIES** | | | |
| Disposal of Investments | | (56) | (4) |
| Purchase of Non Financial Assets | | (664) | (1,277) |
| Proceeds from Sale of Non-Financial Assets | | 52 | 33 |
| **NET CASH FLOW FROM / (USED IN) INVESTING ACTIVITIES** | | **(668)** | **(1,248)** |
| **CASH FLOWS FROM FINANCING ACTIVITIES** | | | |
| Contributed Capital from Government | | - | 371 |
| **NET CASH FLOW FROM / (USED IN) FINANCING ACTIVITIES** | | **-** | **371** |
| **NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD** | | **312** | **46** |
| CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR | | 712 | 666 |
| **CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR** | **6.2** | **1,024** | **712** |

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

# Basis of Presentation

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

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

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

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

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

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

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

# **Note 1:** Summary of Significant Accounting Policies

These annual financial statements represent the audited general purpose financial statements for The Kilmore & District Hospital for the period ending 30 June 2017. The report provides users with information about the Hospital's stewardship of resources entrusted to it.

### (a) Statement of Compliance

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

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

The Hospital is a not-for profit entity and therefore applies the additional Aus paragraphs applicable to "not-for-profit" Hospitals under the AASBs.

The annual financial statements were authorised for issue by the Board of The Kilmore & District Hospital on 22 August 2017.

### (b) Reporting Entity

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

Its principal address is:
Rutledge St
Kilmore
Victoria 3764.

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

#### Objectives and funding

The Kilmore & District Hospital's overall objective is to provide the community with high quality progressive health care and accommodation, as well as improve the quality of life to Victorians.

The Kilmore & District Hospital is predominantly funded by accrual based grant funding for the provision of outputs.

### (c) Basis of Accounting Preparation and Measurement

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

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

The going concern basis was used to prepare the financial statements. Please refer to Note 8.11.

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

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

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

- non-current physical assets, which subsequent to acquisition, are measured at a revalued amount being their fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made and are re-assessed when new indices are published by the Valuer General to ensure that the carrying amounts do not materially differ from their fair values;
- available-for-sale investments which are measured at fair value with movements reflected in equity until the asset is derecognised (i.e. other comprehensive income – items that may be reclassified subsequent to net result).
- the fair value of assets other than land is generally based on their depreciated replacement value.

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

### (d) Principles of Consolidation

#### Jointly controlled assets or operations

Interests in jointly controlled assets or operations are not consolidated by The Kilmore & District Hospital, but are accounted for in accordance with the policy outlined in Note 8.10.

# **Note 2:** Funding Delivery of Our Services

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

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

Structure

2.1 Analysis of Revenue by Source

# **Note 2.1:** Analysis of Revenue by Source

| | Admitted Patients 2017 $'000 | EDS 2017 $'000 | RAC 2017 $'000 | Aged Care 2017 $'000 | Other 2017 $'000 | Total 2017 $'000 |
|---|---|---|---|---|---|---|
| Government Grant | 10,210 | 1,444 | 970 | 256 | - | 12,880 |
| Indirect contributions by Department of Health and Human Services | 7 | - | 6 | - | - | 13 |
| Patient and Resident Fees | 440 | - | 3,659 | 81 | - | 4,180 |
| Commercial Activities | - | - | - | - | 346 | 346 |
| Northern Hospital Contracted Throughput | 1,843 | - | - | - | - | 1,843 |
| Other Revenue from Operating Activities | - | - | - | - | - | - |
| **Total Revenue from Operating Activities** | **12,500** | **1,444** | **4,635** | **337** | **346** | **19,262** |
| Capital Purpose Income (excluding Interest) | - | - | - | - | 1,008 | 1,008 |
| Capital Interest | 12 | - | 12 | - | - | 24 |
| **Total Capital Purpose Income** | **12** | **-** | **12** | **-** | **1,008** | **1,032** |
| **Total Revenue** | **12,512** | **1,444** | **4,647** | **337** | **1,354** | **20,294** |

| | Admitted Patients 2016 $'000 | EDS 2016 $'000 | RAC 2016 $'000 | Aged Care 2016 $'000 | Other 2016 $'000 | Total 2016 $'000 |
|---|---|---|---|---|---|---|
| Government Grant | 9,148 | 1,420 | 971 | 251 | - | 11,790 |
| Indirect contributions by Department of Health and Human Services | 4 | - | 5 | - | - | 9 |
| Patient and Resident Fees | 434 | - | 3,759 | 97 | - | 4,290 |
| Commercial Activities | - | - | - | - | 282 | 282 |
| Northern Hospital Contracted Throughout | 1,622 | - | - | - | - | 1,622 |
| Other Revenue from Operating Activities | 28 | - | - | - | - | 28 |
| **Total Revenue from Operating Activities** | **11,236** | **1,420** | **4,735** | **348** | **282** | **18,021** |
| Capital Purpose Income (excluding Interest) | - | - | - | - | 877 | 877 |
| Capital Interest | 11 | - | 11 | - | - | 22 |
| **Total Capital Purpose Income** | **11** | **-** | **11** | **-** | **877** | **899** |
| **Total Revenue** | **11,247** | **1,420** | **4,746** | **348** | **1,159** | **18,920** |

# **Note 2.1:** Analysis of Revenue by Source (continued)

Income is recognised in accordance with AASB 118 Revenue and is recognised as to the extent that it is probable that the economic benefits will flow to The Kilmore & District Hospital and the income can be reliably measured at fair value. Unearned income at reporting date is reported as income received in advance.

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

Government Grants and other transfers of income (other than contributions by owners)

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

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

Indirect Contributions from the Department of Health and Human Services

- Insurance is recognised as revenue following advice from the Department of Health and Human Services.
- Long Service Leave (LSL) – Revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Metropolitan Health and Aged Care Services Division Hospital Circular 04/2017 (update for 2016/17).

Patient and Resident Fees

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

Private Practice Fees

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

Revenue from Commercial Activities

Revenue from commercial activities such as commercial laboratory medicine is recognised at the time invoices are raised.

Donations and Other Bequests

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

Interest Revenue

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

Sale of investments

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

### Category Groups

The Kilmore & District Hospital has used the following category groups for reporting purposes for the current and previous financial years.

Admitted Patients comprises all acute and subacute admitted patient services, where services are delivered in public hospitals.

Emergency Department Services (EDS) comprises all emergency department services.

Aged Care comprises a range of in home, specialist geriatric, residential care and community based programs and support services, such as Home and Community Care (HACC) that are targeted to older people, people with a disability, and their carers.

Residential Aged Care (RAC) comprises those Commonwealth-licensed residential aged care services. It excludes all other residential services funded under the mental health program, such as mental health funded community care units and secure extended care units.

Other Services not reported elsewhere (Other) comprises services not separately classified above, including: Public Health Services including laboratory testing, blood borne viruses / sexually transmitted infections clinical services, Kooris liaison officers, immunisation and screening services, drugs services including drug withdrawal, counselling and the needle and syringe program, Disability services including aids and equipment and flexible support packages to people with a disability, Community Care programs including sexual assault support, early parenting services, parenting assessment and skills development, and various support services. Health and Community Initiatives also falls in this category group.

# **Note 3:** The Cost of Delivering Our Services

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

Structure

3.1 Analysis of expenses by source

3.2 Analysis of expense and revenue by internally managed and restricted specific purpose funds

3.3 Finance costs

3.4 Provisions

3.5 Superannuation

# **Note 3.1:** Analysis of Expenses by Source

| | Admitted Patients 2017 $'000 | EDS 2017 $'000 | RAC 2017 $'000 | Aged Care 2017 $'000 | Other 2017 $'000 | Total 2017 $'000 |
|---|---|---|---|---|---|---|
| Employee Expenses | 6,758 | 1,333 | 4,862 | 333 | 71 | 13,357 |
| Other Operating Expenses | | | | | | |
| — Non Salary Labour Costs | 2,269 | 71 | 109 | - | - | 2,449 |
| — Supplies & Consumables | 1,071 | 16 | 454 | 10 | 47 | 1,598 |
| — Other Expenses | 1,990 | 16 | 255 | 16 | 1 | 2,278 |
| **Total Expenditure from Operating Activities** | **12,088** | **1,436** | **5,680** | **359** | **119** | **19,682** |
| Other Non-Operating Expenses | | | | | | |
| — Expenditure for Capital Purposes | - | - | - | - | 6 | 6 |
| Depreciation and Amortisation (refer Note 4.3) | - | - | - | - | 3,214 | 3,214 |
| **Total other expenses** | **-** | **-** | **-** | **-** | **3,220** | **3,220** |
| **Total Expenses** | **12,088** | **1,436** | **5,680** | **359** | **3,339** | **22,902** |

| | Admitted Patients 2016 $'000 | EDS 2016 $'000 | RAC 2016 $'000 | Aged Care 2016 $'000 | Other 2016 $'000 | Total 2016 $'000 |
|---|---|---|---|---|---|---|
| Employee Expenses | 5,906 | 1,321 | 4,566 | 373 | 66 | 12,232 |
| Other Operating Expenses | | | | | | |
| — Non Salary Labour Costs | 1,950 | 84 | 74 | - | - | 2,108 |
| — Supplies & Consumables | 1,004 | 10 | 424 | 11 | 42 | 1,491 |
| — Other Expenses | 1,709 | 25 | 360 | 13 | - | 2,107 |
| **Total Expenditure from Operating Activities** | **10,569** | **1,440** | **5,424** | **397** | **108** | **17,938** |
| Depreciation and Amortisation (refer Note 4.3) | - | - | - | - | 3,330 | 3,330 |
| **Total other expenses** | **-** | **-** | **-** | **-** | **3,330** | **3,330** |
| **Total Expenses** | **10,569** | **1,440** | **5,424** | **397** | **3,438** | **21,268** |

# **Note 3.1:** Analysis of Expenses by Source (continued)

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

*Employee expenses*

Employee expenses include:

- wages and salaries;
- fringe benefits tax;
- leave entitlements;
- termination payments;
- workcover premiums; and
- superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

*Grants and other transfers*

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

*Other operating expenses*

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

*Supplies and consumables*

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

*Bad and doubtful debts*

Refer to Note 4.1 Investments and other financial assets.

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

Contributions of resources provided free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them, irrespective of whether restrictions or conditions are imposed over the use of the contributions, unless received from another agency as a consequence of a restructuring of administrative arrangements. In the latter case, such a transfer will be recognised at its carrying amount.

Contributions in the form of services are only recognised when a fair value can be reliably determined and the services would have been purchased if not donated.

*Borrowing costs of qualifying assets*

In accordance with the paragraphs of AASB 123 Borrowing Costs applicable to not-for-profit public sector entities, the Hospital continues to recognise borrowing costs immediately as an expense, to the extent that they are directly attributable to the acquisition, construction or production of a qualifying asset.

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

*Net gain/ (loss) on non-financial assets*

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

*Revaluation gains/ (losses) of non-financial physical assets*

Refer to Note 4.2 *Property plant and equipment*.

*Net gain/ (loss) on disposal of non-financial assets*

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

Net gain/ (loss) on financial instruments

Net gain/ (loss) on financial instruments includes:

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

*Amortisation of non-produced intangible assets*

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

*Impairment of non-financial assets*

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

Refer to Note 4.1 Investments and other financial assets.

*Revaluations of financial instrument at fair value*

Refer to Note 7.1 Financial instruments.

*Share of net profits/ (losses) of associates and jointly controlled entities, excluding dividends.*

Refer to Note 1 (d) *Basis of consolidation*.

*Other gains/ (losses) from other economic flows*

Other gains/ (losses) include:

a. the revaluation of the present value of the long service leave liability due to changes in the bond rate movements, inflation rate movements and the impact of changes in probability factors; and

b. transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

# Note 3.1: Analysis of Expenses by Source (continued)

**Derecognition of Financial Liabilities**

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

**Financial Guarantee**

Payments that are contingent under financial guarantee contracts are recognised as a liability at the time the guarantee is issued.

The liability is initially measured at fair value, and if there is a material increase in the likelihood that the guarantee may have to be exercised, then it is measured at the higher of the amount determined in accordance with AASB 137 Provisions, Contingent Liabilities and Contingent Assets and the amount initially recognised less cumulative amortisation, where appropriate.

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

# Note 3.2: Analysis of Expense and Revenue by Internally Managed and Restricted Specific Purpose Funds

| | Expense | | Revenue | |
|---|---|---|---|---|
| Purpose Funds | Total 2017 $'000 | Total 2016 $'000 | Total 2017 $'000 | Total 2016 $'000 |
| Catering | 92 | 109 | 106 | 92 |
| Radiology | - | - | 92 | 87 |
| **TOTAL** | **92** | **109** | **198** | **179** |

# Note 3.3: Finance Costs

| | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|
| Finance Charges on Finance Leases - Hume Rural Health Alliance | 2 | 3 |
| **Total Finance Costs** | **2** | **3** |

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

Finance costs include:

- interest on bank overdrafts and short-term and long-term borrowings (Interest expense is recognised in the period in which it is incurred);
- amortisation of discounts or premiums relating to borrowings;
- amortisation of ancillary costs incurred in connection with the arrangement of borrowings; and
- finance charges in respect of finance leases recognised in accordance with AASB 117 *Leases*.

# NOTE 3.4: Employee Benefits in the Balance Sheet

| | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|
| **Current Provisions** | | |
| Employee Benefits[i] | | |
| Annual leave | | |
| – Unconditional and expected to be settled wholly within 12 months[ii] | 721 | 733 |
| – Unconditional and expected to be settled wholly after 12 months[iii] | 401 | 208 |
| Long service leave | | |
| – Unconditional and expected to be settled wholly within 12 months[ii] | 200 | 190 |
| – Unconditional and expected to be settled wholly after 12 months[iii] | 1,210 | 1,132 |
| Accrued days off | | |
| – Unconditional and expected to be settled wholly within 12 months[ii] | 39 | 24 |
| – Unconditional and expected to be settled wholly after 12 months[iii] | - | - |
| Accrued salaries and wages | | |
| – Unconditional and expected to be settled wholly within 12 months[ii] | 182 | 181 |
| – Unconditional and expected to be settled wholly after 12 months[iii] | - | - |
| | 2,753 | 2,468 |
| Provisions related to Employee Benefit On-Costs | | |
| – Unconditional and expected to be settled wholly within 12 months[ii] | 127 | 109 |
| – Unconditional and expected to be settled wholly after 12 months[iii] | 180 | 145 |
| | 307 | 254 |
| **Total Current Provisions** | **3,060** | **2,722** |
| **Non Current Provisions** | | |
| Employee Benefits[i] | 347 | 331 |
| | 42 | 39 |
| **Total Non-Current Provisions** | **389** | **370** |
| **Total Provisions** | **3,449** | **3,092** |
| **(a) Employee Benefits and Related On-Costs** | | |
| **Current Employee Benefits and Related On-Costs** | | |
| Unconditional LSL Entitlement | 1,578 | 1,480 |
| Annual Leave Entitlements | 1,256 | 1,034 |
| Accrued Wages and Salaries | 182 | 181 |
| Accrued Days Off | 44 | 27 |
| **Non-Current Employee Benefits and Related On-Costs** | | |
| Conditional Long Service Leave Entitlements | 389 | 370 |
| **Total Employee Benefits and Related On-Costs** | **3,449** | **3,092** |

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

| | | |
|---|---|---|
| **Movement in Provisions** | | |
| **Movement in Long Service Leave:** | | |
| **Balance at start of year** | 1,850 | 1,654 |
| Provisions made during the year | | |
| – Revaluations | (24) | 18 |
| – Expense recognising Employee Service | 407 | 446 |
| Settlement made during the year | (266) | (268) |
| **Balance at end of year** | **1,967** | **1,850** |

# **NOTE 3.4:** Employee Benefits in the Balance Sheet (continued)

**Provisions**

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

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

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

**Employee Benefits**

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

***Wages and salaries, annual leave and accrued days off***

Liabilities for wages and salaries, including non-monetary benefits and annual leave are all recognised in the provision for employee benefits as 'current liabilities' because The Kilmore & District Hospital does not have an unconditional right to defer settlements of these liabilities.

Depending on the expectation of the timing of settlement, liabilities for wages and salaries and annual leave are measured at:

- Undiscounted value — if The Kilmore & District Hospital expects to wholly settle within 12 months; or
- Present value — if The Kilmore & District Hospital does not expect to wholly settle within 12 months.

***Long Service Leave (LSL)***

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

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

The components of this current LSL liability are measured at:

- Undiscounted value – it The Kilmore & District Hospital expects to settle within 12 months; and
- Present value – if The Kilmore & District Hospital does not expect to wholly settle within 12 months.

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

Any gain or loss followed revaluation of the present value of non-current LSL liability is recognised as a transaction, except to the extent that a gain or loss arises due to changes in bond interest rates for which it is then recognised as an other economic flow.

***Termination Benefits***

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

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

***On-costs related to employee expense***

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

# **Note 3.5.** Superannuation

| | Paid Contribution for the Year | | Contribution Outstanding at Year End | |
|---|---|---|---|---|
| | **Total 2017 $'000** | **Total 2016 $'000** | **Total 2017 $'000** | **Total 2016 $'000** |
| **(i) Defined benefit plans:** | | | | |
| Health Super | 18 | 21 | - | - |
| **Defined Contribution Plans:** | | | | |
| Health Super | 778 | 775 | - | - |
| Hesta | 228 | 174 | - | - |
| **Total** | **1024** | **970** | **-** | **-** |

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

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

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

However superannuation contributions paid and payable for the reporting period are included as part of employee benefits in the comprehensive operating statement of the Hospital. The name, details and amounts expense in relation to the major employee superannuation funds and contributions made by the Hospital are as follows:

*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.

*Defined benefit superannuation plans*

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

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

The name and details of the major employee superannuation funds and contributions made by The Kilmore & District Hospital are disclosed in note 3.6: Superannuation

*Superannuation liabilities*

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

# Note 4: Key Assets to Support Service Delivery

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

Structure

4.1 Investments and other financial assets

4.2 Property, plant & equipment

4.3 Depreciation and amortisation

4.4 Intangible assets

# Note 4.1: Investments and Other Financial Assets

| | Operating Fund | | Total | |
|---|---|---|---|---|
| | 2017 $'000 | 2016 $'000 | 2017 $'000 | 2016 $'000 |
| **CURRENT** | | | | |
| Term Deposit | | | | |
| Australian Dollar Term Deposits > 3 months | 5,630 | 4,498 | 5,630 | 4,498 |
| **Total Current** | **5,630** | **4,498** | **5,630** | **4,498** |
| **Represented by:** | | | | |
| Investments | 401 | 347 | 401 | 347 |
| Monies Held in Trust | 5,229 | 4,151 | 5,229 | 4,151 |
| **TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS** | **5,630** | **4,498** | **5,630** | **4,498** |

**(a) Ageing analysis of investments and other financial assets**

Please refer to note 4.1 for the ageing analysis of other financial assets

**(b) Nature and extent of risk arising from investments and other financial assets**

Please refer to note 4.1 for the nature and extent of credit risk arising from other financial assets

### Investments and other financial assets

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

Investments are classified in the following categories:

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

The Kilmore & District Hospital classifies its other financial assets between current and non-current assets based on the purpose for which the assets were acquired. Management determines the classification of its other financial assets at initial recognition.

The Kilmore & District Hospital assesses at each balance sheet date whether a financial asset or group of financial assets is impaired.

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

### 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:

- other rights to receive cash flows from the asset have expired; or
- the Hospital retains the right to receive cash flows from the asset, but has assumed an obligation to pay them in full without material delay to a third party under a 'pass through' arrangement; or
- the Hospital has transferred its rights to receive cash flows from the asset and either:

  (a) has transferred substantially all the risks and rewards of the asset; or

  (b) has neither transferred nor retained substantially all the risks and rewards of the asset, but has transferred control of the asset.

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

# Note 4.1: Investments and Other Financial Assets (continued)

### Impairment of financial assets

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

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

### Doubtful debts

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

# Note 4.2: Property, Plant & Equipment

### (a) Gross carrying amount and accumulated depreciation

| | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|
| **Land** | | |
| Land at Fair Value | 1,219 | 1,094 |
| **Total Land** | **1,219** | **1,094** |
| **Buildings** | | |
| Buildings Under Construction at cost | 64 | - |
| Buildings at Fair Value | 53,597 | 53,598 |
| Less Accumulated Depreciation | 25,863 | 23,018 |
| **Total Buildings** | **27,798** | **30,580** |
| **Plant & Equipment** | | |
| Plant & Equipment at Fair Value | 5,467 | 5,016 |
| Less Accumulated Depreciation | 3,725 | 3,414 |
| **Total Plant & Equipment** | **1,742** | **1,602** |
| **Motor Vehicles** | | |
| Motor Vehicles at fair value | 242 | 197 |
| Less Accumulated Depreciation | 43 | 54 |
| **Total Motor Vehicles** | **199** | **143** |
| **Leased Assets** | | |
| IT Equipment - Hume Rural Health Alliance | 128 | 148 |
| Less Accumulated Amortisation | 67 | 73 |
| **Total Leased Assets** | **61** | **75** |
| **TOTAL** | **31,019** | **33,494** |

# **Note 4.2:** Property, Plant & Equipment (continued)

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

| | Crown Land $'000 | Buildings $'000 | Plant & Equipment $'000 | Motor Vehicles $'000 | Leased Assets $'000 | Total $'000 |
|---|---|---|---|---|---|---|
| **Balance at 1 July 2015** | **1,094** | **32,766** | **1,549** | **145** | **49** | **35,603** |
| Additions | - | 832 | 341 | 75 | 29 | 1,277 |
| Disposals | - | - | - | (58) | - | (58) |
| Depreciation expense (note 4.3) | - | (3,018) | (288) | (19) | (3) | (3,328) |
| **Balance at 30 June 2016** | **1,094** | **30,580** | **1,602** | **143** | **75** | **33,494** |
| Additions | - | 63 | 486 | 150 | 10 | 709 |
| Disposals | - | - | - | (75) | (22) | (97) |
| Revaluation Increments/(Decrements) | 125 | - | - | - | - | 125 |
| Depreciation expense (note 4.3) | - | (2,845) | (346) | (19) | (2) | (3,212) |
| **Balance at 30 June 2017** | **1,219** | **27,798** | **1,742** | **199** | **61** | **31,019** |

**Land and buildings carried at valuation**

An independent valuation of the Hospitals land and buildings was performed by the Valuer-General Victoria to determine the fair value of the land and buildings.

The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgable willing parties in an arm's length transaction. The valuation was based on independent assessments.

The effective date of the valuation is 30 June 2014. A managerial valuation was conducted on the hospital's land which was effective 30 June 2017.

**Plant and Equipment at fair value**

A valuation of the Hospitals plant and equipment was undetaken by management to determine fair value of the plant and equipment.

**Crown Land**

The land upon which the Hospital and Nursing Home is sited was originally granted to the Hospital by the Queen in 1889.

It is Crown land permanently reserved for "hospital and offices and conveniences connected therewith".

# **Note 4.2:** Property, Plant & Equipment (continued)

### (c) Fair value measurement hierarchy for assets

| | Carrying amount as at 30 June 2017 $'000 | Fair value measurement at end of reporting period using: Level 1[i] $'000 | Level 2[ii] $'000 | Level 3[ii] $'000 |
|---|---|---|---|---|
| **Land at Fair Value** | | | | |
| Non-Specialised Land | | | | |
| Specialised Land | 1,219 | - | - | 1,219 |
| Total of Land at Fair Value | 1,219 | | | 1,219 |
| **Buildings at Fair Value** | | | | |
| Non-Specialised Buildings | | | | |
| Specialised Buildings | 27,734 | - | - | 27,734 |
| Total of Building at Fair Value | 27,734 | - | - | 27,734 |
| **Plant and Equipment at Fair Value** | | | | |
| Plant Equipment and Vehicles at Fair Value | | | | |
| - Vehicles (li) | 199 | 199 | | |
| - Plant and Equipment | 1,742 | | | 1,742 |
| Total of Plant, Equipment and Vehicles at Fair Value | 1,941 | 199 | - | 1,742 |
| **Assets Under Construction at Fair Value** | | | | |
| Specialised Buildings | 64 | - | - | 64 |
| Total Assets Under Construction at Fair Value | 64 | - | - | 64 |
| | **30,958** | **199** | **-** | **30,759** |

| | Carrying amount as at 30 June 2016 $'000 | Fair value measurement at end of reporting period using: Level 1[i] $'000 | Level 2[ii] $'000 | Level 3[ii] $'000 |
|---|---|---|---|---|
| Land at Fair Value | | | | |
| Non-Specialised Land | | | | |
| Specialised Land | 1,094 | - | - | 1,094 |
| Total of Land at Fair Value | 1,094 | | | 1,094 |
| Buildings at Fair Value | | | | |
| Non-Specialised Buildings | | | | |
| Specialised Buildings | 30,580 | - | - | 30,580 |
| Total of Building at Fair Value | 30,580 | - | - | 30,580 |
| Plant and Equipment at Fair Value | | | | |
| Plant Equipment and Vehicles at Fair Value | | | | |
| - Vehicles (li) | 143 | 143 | | |
| - Plant and Equipment | 1,602 | | | 1,602 |
| Total of Plant, Equipment and Vehicles at Fair Value | 1,745 | 143 | - | 1,602 |
| Assets Under Construction at Fair Value | | | | |
| Specialised Buildings | - | - | - | - |
| Total Assets Under Construction at Fair Value | - | - | - | - |
| | **33,419** | **143** | **-** | **33,276** |

Note

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

(ii) Vehicles are categorised to Level 3 assets if the depreciated replacement cost is used in estimating the fair value. However, entities should consult with independent valuers in determining whether a market approach is appropriate for vehicles with an active resale market available. If yes, a Level 2 categorisation for such vehicles would be appropriate.

There have been no transfers between levels during the period.

# **Note 4.2:** Property, Plant & Equipment (continued)

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

- the fair value of land, buildings, infrastructure, plant and equipment, (refer to Note 7.1);
- superannuation expense (refer to Note 3.6);
- actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.5); and
- equities and management investment schemes classified at level 3 of the fair value hierarchy

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

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

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

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

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

The Valuer-General Victoria (VGV) is The Kilmore & District Hospital's independent valuation agency.

The Kilmore & Distict Hospital, in conjunction with VGV monitors the changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision, and future periods if the revision affects both current and future periods. Judgements and assumptions made by management in the application of AASBs that have significant effects on the financial statements and estimates, with a risk of material adjustments in the subsequent reporting period, relate to:

- the fair value of land, buildings, infrastructure, plant and equipment (refer to Note 7.1);
- superannuation expense (refer to Note 2.3); and
- actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.5).

**Fair value measurement**

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

The fair value measurement is based on the following assumptions:

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

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

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

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

In considering the HBU for non-financial physical assets, valuers are probably best placed to determine highest and best use (HBU) in consultation with Health Services. Health Services and their valuers therefore need to have a shared understanding of the circumstances of the assets. A Health Service has to form its own view about a valuer's determination, as it is ultimately responsible for what is presented in its audited financial statements.

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

# **Note 4.2:** Property, Plant & Equipment (continued)

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

These indicators, as a minimum, include:

External factors

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

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

***Valuation hierarchy***

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

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

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

# **Note 4.2:** Property, Plant & Equipment (continued)

### (d) Reconciliation of Level 3 fair value

| 30 June 2017 | Land | Buildings | Plant and equipment | Assets under construction |
|---|---|---|---|---|
| **Opening Balance** | 1,094 | 30,580 | 1,632 | - |
| **Purchases (sales)** | - | - | 451 | 64 |
| **Transfers in (out) of Level 3** | 125 | - | - | - |
| Gains or losses recognised in net result | | | | |
| - Depreciation | - | (2,846) | (311) | - |
| - Impairment loss | - | - | - | - |
| **Subtotal** | **1,219** | **27,734** | **1,742** | **64** |
| Items recognised in other comprehensive income | | | | |
| - Revaluation | - | - | - | - |
| **Subtotal** | **-** | **-** | **-** | **-** |
| **Closing Balance** | **1,219** | **27,734** | **1,742** | **64** |
| Unrealised gains/(losses) on non-financial assets | - | - | - | - |
| | **1,219** | **27,734** | **1,742** | **64** |

| 30 June 2016 | Land | Buildings | Plant and equipment | Assets under construction |
|---|---|---|---|---|
| **Opening Balance** | 1,094 | 13,408 | 1,549 | 19,358 |
| **Purchases (sales)** | - | 832 | 336 | - |
| **Transfers in (out) of Level 3** | - | 19,358 | - | (19,358) |
| Gains or losses recognised in net result | | | | |
| - Depreciation | - | (3,018) | (283) | - |
| - Impairment loss | - | - | - | - |
| **Subtotal** | **1,094** | **30,580** | **1,602** | **-** |
| Items recognised in other comprehensive income | | | | |
| - Revaluation | - | - | - | - |
| **Subtotal** | **-** | **-** | **-** | **-** |
| **Closing Balance** | **1,094** | **30,580** | **1,602** | **-** |
| Unrealised gains/(losses) on non-financial assets | - | - | - | - |
| | **1,094** | **30,580** | **1,602** | **-** |

There have been no transfers between levels during the period.

# **Note 4.2:** Property, Plant & Equipment (continued)

**Non-specialised land, non-specialised buildings**

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

For non-specialised land and non-specialised buildings, an independent valuation was performed by independent valuers, Matheson Stephen Valuations, to determine the fairvalue using the market approach. Valuation of the assets was determined by analysing comparable sales and allowing for share, size, topography, location and other relevant factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30 June 2014. A managerial valuation was conducted on the hospital's land which was effective 30 June 2017.

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

**Specialised land and specialised buildings**

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

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

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

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

**Vehicles**

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

**Plant and equipment**

Plant and equipment is held at carrying value (depreciated cost). When plant and equipment is specialised in use, such that it is rarely sold other than as part of a going concern, the depreciated replacement cost is used to estimate the fair value.

Unless there is market evidence that current replacement costs are significantly different from the original acquisition cost, it is considered unlikely that depreciated replacement cost will be materially different from the existing carrying value.

There were no changes in valuation techniques throughout the period to 30 June 2014.

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

# **Note 4.2:** Property, Plant & Equipment (continued)

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

| 2017 | Valuation technique (i) | Significant unobservable inputs (i) | Range (weighted average) (i) | Sensitivity of fair value measurement to change in significant unobservable inputs |
|---|---|---|---|---|
| **Specialised Land** Hospital | Market Approach | Community Service Obligation (CSO) adjustment | 50% (ii) | A significant increase or decrease in the CSO adjustment would result in a significantly lower (higher) fair value |
| **Specialised Buildings** Hospital | Depreciated replacement cost | Direct cost per square metre | $1,372 - $1,999m$^2$ | A significant increase or decrease in direct cost per square metre adjustment would result in a significantly higher or lower fair value A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation |
| | | Useful life of specialised buildings | 8 - 50 years | |
| **Plant and Equipment at fair value** | Depreciated replacement cost | Cost per unit | $1,000 - $180,000 | A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation |
| | | Useful life of PPE | 3 - 10 years | |
| **Vehicles** | Depreciated replacement cost | Cost per unit | $10,000 - $42,000 | A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation |
| | | Useful life of vehicles | 1 - 10 years | |
| **Assets under construction at fair value** | Depreciated replacement cost | Cost per unit | $1,000 - $1,343,000 | A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value |

| 2016 | Valuation technique (i) | Significant unobservable inputs (i) | Range (weighted average) (i) | Sensitivity of fair value measurement to change in significant unobservable inputs |
|---|---|---|---|---|
| **Specialised Land** Hospital | Market Approach | Community Service Obligation (CSO) adjustment | 50% (ii) | A significant increase or decrease in the CSO adjustment would result in a significantly lower (higher) fair value |
| **Specialised Buildings** Hospital | Depreciated replacement cost | Direct cost per square metre | $1,372 - $1,999m$^2$ | A significant increase or decrease in direct cost per square metre adjustment would result in a significantly higher or lower fair value A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation |
| | | Useful life of specialised buildings | 8 - 50 years | |
| **Plant and Equipment at fair value** | Depreciated replacement cost | Cost per unit | $1,000 - $180,000 | A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation |
| | | Useful life of PPE | 3 - 10 years | |
| **Vehicles** | Depreciated replacement cost | Cost per unit | $10,000 - $42,000 | A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation |
| | | Useful life of vehicles | 1 - 10 years | |
| **Assets under construction at fair value** | Depreciated replacement cost | Cost per unit | $1,000 - $1,343,000 | A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value |

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

# **Note 4.2:** Property, Plant & Equipment (continued)

**Property, plant and equipment**

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

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 4.2 *Property, plant and equipment.*

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

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

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

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

**Revaluations of Non-current Physical Assets**

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

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

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

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

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

In accordance with FRD 103F, The Kilmore & District Hospital's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

# **Note 4.3:** Depreciation and Amortisation

| | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|
| **Depreciation** | | |
| Buildings | 2,845 | 3,018 |
| Plant & Equipment | 346 | 288 |
| Motor Vehicles | 19 | 19 |
| IT Equipment - Leased Assets | 2 | 3 |
| **Total Depreciation** | **3,212** | **3,328** |
| **Amortisation** | | |
| Intangible Assets - HRHA | 2 | 2 |
| **Total Amortisation** | **2** | **2** |
| **Total Depreciation and Amortisation** | **3,177** | **3,330** |

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

Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health & Human Services. Assets with a cost in excess of $1,000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

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

| | 2017 | 2016 |
|---|---|---|
| Buildings | | |
| – Structure Shell Building Fabric | 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 |

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

# **Note 4.4:** Intangible Assets

| | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|
| Hume Rural Health Alliance | 76 | 44 |
| – Less Acc'd Amortisation | 6 | 4 |
| **Total Intangible Assets** | **70** | **40** |

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

| | Software $'000 | Total $'000 |
|---|---|---|
| **Balance at 1 July 2015** | **29** | **29** |
| Additions | 13 | 13 |
| Amortisation (note 4.3) | (2) | (2) |
| **Balance at 1 July 2016** | **40** | **40** |
| Additions | 32 | 32 |
| Amortisation (note 4.3) | (2) | (2) |
| **Balance at 30 June 2017** | **70** | **70** |

### Intangible assets

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

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

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

When the recognition criteria in AASB 138 *Intangible Assets* are met, internally generated intangible assets are recognised and measured at cost less accumulated depreciation/amortisation and impairment.

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:

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

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

### Amortisation

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

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

Intangible assets with indefinite useful lives are not amortised, but are tested for impairment annually or whenever there is an indication that the asset may be impaired. The useful lives of intangible assets that are not being amortised are reviewed each period to determine whether events and circumstances continue to support an indefinite useful life assessment for that asset. In addition, the Health Service tests all intangible assets with indefinite useful lives for impairment by comparing the recoverable amount for each asset with its carrying amount:

- annually; and
- whenever there is an indication that the intangible asset may be impaired

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

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

# Note 5: Other Assets and Liabilities

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

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

# Note 5.1: Receivables

| | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|
| **CURRENT** | | |
| **Contractual** | | |
| Inpatient Fees | 49 | 59 |
| District Nursing Fees | 30 | 12 |
| Aged Care Fees | 12 | 5 |
| Simplified Billing | 14 | 15 |
| Trade Debtors | 466 | 360 |
| Hume Rural Health Alliance | 115 | 43 |
| Accrued Revenue | 15 | 24 |
| Less Allowance for Doubtful Debts | (3) | (2) |
| | **698** | **516** |
| **Statutory** | | |
| GST Receivable | 128 | 93 |
| | **128** | **93** |
| **Total Current Receivables** | **826** | **609** |
| **NON-CURRENT** | | |
| **Statutory** | | |
| Long Service Leave - Department of Health and Human Services | 380 | 263 |
| **TOTAL NON-CURRENT RECEIVABLES** | **380** | **263** |
| **TOTAL RECEIVABLES** | **1,206** | **872** |

| (a) Movement in the Allowance for doubtful debts | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|
| Balance at beginning of year | 2 | 7 |
| Amounts written off during the year | - | - |
| Amounts recovered during the year | - | - |
| Increase/(decrease) in allowance recognised in net result | 1 | (5) |
| **Balance at end of year** | **3** | **2** |

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

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

# **Note 5.1:** Receivables (continued)

Receivables consist of:

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

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

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

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

# **Note 5.2:** Inventories

| | **Total 2017 $'000** | **Total 2016 $'000** |
|---|---|---|
| Pharmaceuticals - at cost | 4 | 22 |
| Catering Supplies - at cost | 40 | 41 |
| Medical and Surgical Lines - at cost | 70 | 70 |
| **TOTAL INVENTORIES** | **114** | **133** |

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

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

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

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

Cost is assigned to land for sale (undeveloped, under development and developed) and to other high value, low volume inventory items on a specific identification of cost basis.

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

# Note 5.3: Other Liabilities

| | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|
| **CURRENT** | | |
| **Monies Held In Trust** | | |
| Resident Monies Held in Trust* | - | - |
| Accommodation Bonds* | 5,228 | 4,150 |
| **Total Other Liabilities** | **5,228** | **4,150** |
| *** Total Monies Held In Trust** | | |
| **Represented by the following assets:** | | |
| Cash Assets (refer to note 6.2) | - | - |
| Investment and other Financial Assets (refer to Note 4.1) | 5,228 | 4,150 |
| | **5,228** | **4,150** |

# Note 5.4: Prepayments and Non-financial Assets

| | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|
| Prepayments | 6 | 6 |
| Prepayments - Hume Rural Health Alliance | 6 | 3 |
| **TOTAL OTHER ASSETS** | **12** | **9** |

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

# Note 5.5: Payables

| | Total 2017 $'000 | Total 2016 Restated $'000 |
|---|---|---|
| **CURRENT** | | |
| **Contractual** | | |
| Trade Creditors | 1,150 | 762 |
| Accrued Expenses | 14 | 44 |
| Hume Rural Health Alliance | 22 | 24 |
| **Statutory** | | |
| Department of Health and Human Services | 72 | - |
| **TOTAL PAYABLES** | **1,258** | **830** |

**(a) Maturity analysis of payables**

Please refer to note 7.1 for the ageing analysis of payables

**(b) Nature and extent of risk arising from payables**

Please refer to note 7.1 for the nature and extent of risks arising from contractual payables

Payables consist of:

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

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

# **Note 6:** How We Finance Our Operations

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

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

Structure

6.1 Borrowings

6.2 Cash and cash equivalents

6.3 Commitments for expenditure

# **Note 6.1:** Borrowings

| | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|
| **CURRENT** | | |
| Finance Lease Liability | 29 | 34 |
| **Total Australian Dollars Borrowings** | **29** | **34** |
| **Total Current** | **29** | **34** |
| **NON CURRENT** | | |
| Finance Lease Liability | 32 | 41 |
| **Total Australian Dollars Borrowings** | **32** | **41** |
| **Total Non-Current** | **32** | **41** |
| **Total Borrowings** | **61** | **75** |

### (a) Maturity analysis of borrowings

Please refer to note 7.1 for the ageing analysis of borrowings.

### (b) Nature and extent of risk arising from payables

Please refer to note 7.1 for the nature and extent of risks arising from borrowings.

### (c ) Finance and operating lease commitments

Please refer to note 7.1 for further information relating to finance and operating lease commitments.

### (d) Treasurer approval of borrowings

Under section 30 of the *Health Services Act 1998*, health service entities must be approved as a borrower by the Minister and the Treasurer. The Treasurer has provided approval for borrowings (lease liabilities).

### (e) Secured liabilities and assets pledged as security

Lease liabilities are effectively secured as the rights to the leased assets recognised in the financial statements revert to the lessor in the event of default.

# **Note 6.1:** Borrowings (continued)

## (a) Finance Lease liabilities

| | Minimum future lease payments | | Present Value of Minimum future lease payments | |
|---|---|---|---|---|
| | **2017** | **2016** | **2017** | **2016** |
| **Other Finance Lease Liabilities Payable** | | | | |
| Not longer than One Year | 29 | 34 | 29 | 34 |
| Longer than One Year but not longer than Five Years | 32 | 41 | 32 | 41 |
| **Minimum Future Lease Payments** | **61** | **75** | **61** | **75** |
| Less Future Finance Charges | - | - | - | - |
| **Present Value of Minimum Lease Payments** | **61** | **75** | **61** | **75** |
| **Included in the Financial Statements as:** | | | | |
| Current Borrowings Lease Liabilities | 29 | 34 | 29 | 34 |
| Non-Current Borrowings Lease Liabilities | 32 | 41 | 32 | 41 |
| | **61** | **75** | **61** | **75** |

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

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

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

All other leases are classified as operating leases.

### Finance leases

***Entity as lessee***

Finance leases are recognised as assets and liabilities at amounts equal to the fair value of the lease property or, if lower, the present value of the minimum lease payment, each determined at the inception of the lease.

The lease asset is accounted for as a non-financial physical asset and is depreciated over the shorter of the estimated useful life of the asset or the term of the lease.

If there is certainty that the hospital will obtain the ownership of the lease asset by the end of the lease term, the asset shall be depreciated over the useful life of the asset.

If there is no reasonable certainty that the lessee will obtain ownership by the end of the lease term, the asset shall be fully depreciated over the shorter of the lease term and its useful life.

Minimum lease payments are apportioned between reduction of the outstanding lease liability, and the periodic finance expense which is calculated using the interest rate implicit in the lease, and charged directly to the comprehensive operating statement.

Contingent rentals associated with finance leases are recognised as an expense in the period in which they are incurred.

# Note 6.2: Cash and Cash Equivalents

For the purposes of the cash flow statement, cash assets includes cash on hand and in banks, and short-term deposits which are readily convertible to cash on hand, and are subject to an insignificant risk of change in value, net of outstanding bank overdrafts.

| | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|
| Cash at Bank | 1,183 | 798 |
| Deposits at Call | - | - |
| **Total Cash and Cash Equivalents** | **1,183** | **798** |
| | | |
| **Represented by:** | | |
| Cash for Hospital Operations (as per Cash Flow Statement) | 1,024 | 712 |
| Cash - Hume Rural Health Alliance | 159 | 86 |
| **Total Cash and Cash Equivalents** | **1,183** | **798** |

### Cash and Cash Equivalents

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

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

# Note 6.3: Commitments for Expenditure

| | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|
| **Lease Commitments** | | |
| Finance Leases - HRHA | 61 | 75 |
| **Total lease commitments** | **61** | **75** |
| | | |
| **Finance Leases** | | |
| Commitments in relation to finance leases are payable as follows: | | |
| Current | 29 | 34 |
| Non-Current | 32 | 41 |
| Minimum Lease Payments | 61 | 75 |
| Less Future Finance Charges | - | - |
| **Total finance lease commitments** | **61** | **75** |

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

# **Note 7:** Risks, Contingencies and Valuation Uncertainties

Introduction

The Hospital is exposed to risk from its activities and outside factors. In addition, it is often necessary to make judgements and estimates associated with recognition and measurement of items in the financial statements. This section sets out financial instrument specific information, (including exposures to financial risks) as well as those items that are contingent in nature or require a higher level of judgement to be applied, which for the Hospital is related mainly to fair value determination.

Structure

7.1 Financial instruments

7.2 Net gain/ (loss) on disposal of non-financial assets

7.3 Contingent assets and contingent liabilities

7.4 Fair value determination

# **Note 7.1:** Financial Instruments

### (a) Financial risk management objectives and policies

The Kilmore & Distict Hospital's principal financial instruments comprise of:

- *Cash Assets*
- *Term Deposits*
- *Receivables (excluding statutory receivables)*
- *Payables (excluding statutory payables)*
- *Monies in Trust — Accommodation Bonds*

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

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

The Hospital uses different methods to measure and manage the different risks to which it is exposed. Primary responsibility for the identification and management of financial risks rests with the Financial Risk Management Committee of the Hospital.

The main purpose of holding financail instruments is to prudentially manage The Kilmore & District Hospital financial risks within the government policy parameters.

# **Note 7.1:** Financial Instruments

### Categorisation of financial instruments

| 2017 | Contractual financial assets - loans and receivables $'000 | Contractual financial liabilities at amortised cost $'000 | Total $'000 |
|---|---|---|---|
| **Financial Assets** | | | |
| Cash and Cash Equivalents | 1,183 | - | 1,183 |
| Trade debtors and accruals | 698 | - | 698 |
| Deposits | 5,630 | - | 5,630 |
| **Total Financial Assets [i]** | **7,511** | **-** | **7,511** |
| **Financial Liabilities** | | | |
| Trade creditors and accruals | - | 1,186 | 1,186 |
| Borrowings | - | 61 | 61 |
| Monies Held In Trust | - | 5,228 | 5,228 |
| **Total Financial Liabilities [ii]** | **-** | **6,475** | **6,475** |

| 2016 | Contractual financial assets - loans and receivables $'000 | Contractual financial liabilities at amortised cost $'000 | Total $'000 |
|---|---|---|---|
| **Financial Assets** | | | |
| Cash and Cash Equivalents | 798 | - | 798 |
| Trade debtors and accruals | 516 | - | 516 |
| Deposits | 4,498 | - | 4,498 |
| **Total Financial Assets [i]** | **5,812** | **-** | **5,812** |
| **Financial Liabilities** | | | |
| Trade creditors and accruals | - | 830 | 830 |
| Borrowings | - | 75 | 75 |
| Monies Held In Trust | - | 4,150 | 4,150 |
| **Total Financial Liabilities [ii]** | **-** | **5,055** | **5,055** |

(i) The total amount of financial assets disclosed here excludes statutory receivables.

(ii) The total amount of financial liabilities disclosed here excludes statutory payables (i.e. Taxes Payable).

# **Note 7.1:** Financial Instruments (continued)

### (b) Net holding gain/(loss) on financial instruments by category

| | Net holding gain/(loss) $'000 | Total interest income/ (expense) $'000 | Fee income / (expense) $'000 | Impairment loss $'000 | Total $'000 |
|---|---|---|---|---|---|
| **2017** | | | | | |
| **Fianacial Assets** | | | | | |
| Cash and Cash Equivalents (i) | - | - | - | - | - |
| Loans and Receivables (i) | - | 24 | - | - | 24 |
| Available for Sale (i) | - | - | - | - | - |
| **Total Financial Assets** | **-** | **24** | **-** | **-** | **24** |
| **Financial Liabilities** | | | | | |
| At Amortised Cost (ii) | - | - | - | - | - |
| **Total Financial Liabilities** | **-** | **-** | **-** | **-** | **-** |
| **2016** | | | | | |
| **Financial Assets** | | | | | |
| Cash and Cash Equivalents (i) | - | - | - | - | - |
| Loans and Receivables (i) | - | 22 | - | - | 22 |
| Available for Sale (i) | - | - | - | - | - |
| **Total Financial Assets** | **-** | **22** | **-** | **-** | **22** |
| **Financial Liabilities** | | | | | |
| At Amortised Cost (ii) | - | - | - | - | - |
| **Total Financial Liabilities** | **-** | **-** | **-** | **-** | **-** |

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

(ii) For financial liabilities measured at amortised cost, the net gain or loss is calculated by taking the interest expense, plus or minus foreign exchange gains or losses arising from the revaluation of financial liabilities measured at amortised cost; and

# **Note 7.1:** Financial Instruments (continued)

### (c) Credit Risk

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

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

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

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

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

**Credit quality of contractual financial assets that are neither past due nor impaired**

| 2017 | Financial institutions (AA credit rating) $'000 | Government agencies (AA credit rating) $'000 | Government agencies (BBB credit rating) $'000 | Other $'000 | Total $'000 |
|---|---|---|---|---|---|
| Financial Assets | | | | | |
| Cash and Cash Equivalents | 1,183 | - | - | - | 1,183 |
| Receivables | | | | | - |
| – Trade Debtors | - | - | - | 698 | 698 |
| – Other Receivables (i) | - | - | - | | - |
| – Term Deposit | 5,630 | - | - | - | 5,630 |
| **Total Financial Assets** | **6,813** | **-** | **-** | **698** | **7,511** |
| **2016** | | | | | |
| Financial Assets | | | | | |
| Cash and Cash Equivalents | 798 | - | - | - | 798 |
| Receivables | | | | | - |
| – Trade Debtors | - | - | - | 516 | 516 |
| – Other Receivables | - | - | - | - | - |
| – Term Deposit | 4,498 | - | - | - | 4,498 |
| **Total Financial Assets** | **5,296** | **-** | **-** | **516** | **5,812** |

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

# **Note 7.1:** Financial Instruments (continued)

**Ageing analysis of financial assets as at 30 June**

| 2017 | Carrying Amount $'000 | Not Past Due and Not Impaired $'000 | Past Due But Not Impaired | | | | Impaired Financial Assets $'000 |
|---|---|---|---|---|---|---|---|
| | | | Less Than 1 Month $'000 | 1-3 Months $'000 | 3 months - 1 Year $'000 | 1-5 Years $'000 | |
| **Financial Assets** | | | | | | | |
| **At amortised cost** | | | | | | | |
| Cash and Cash Equivalents | 1,183 | 1,183 | - | - | - | - | - |
| Trade debtors and accruals | 698 | 531 | 144 | 20 | - | - | 3 |
| Deposits | 5,630 | 5,630 | - | - | - | - | - |
| **Total Financial Assets** | **7,511** | **7,344** | **144** | **20** | **-** | **-** | **3** |
| **2016** | | | | | | | |
| **Financial Assets** | | | | | | | |
| Cash and Cash Equivalents | 798 | 798 | - | - | - | - | - |
| Trade debtors and accruals | 516 | 352 | 137 | 25 | - | - | 2 |
| Deposits | 4,498 | 4,498 | - | - | - | - | - |
| **Total Financial Assets** | **5,812** | **5,648** | **137** | **25** | **-** | **-** | **2** |

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

### Contractual financial assets that are either past due or impaired

There are no material financial assets which are individually determined to be impaired. Currently the Hospital does not hold any collateral as security nor credit enhancements relating to any of its financial assets.

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

# **Note 7.1:** Financial Instruments (continued)

### (d) Liquidity Risk

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

The Kilmore & District Hospital's maximum exposure to liquidity risk is the carrying amounts of financial liabilities as disclosed in the face of the balance sheet.

The Hospital manages its liquidity risk as follows:

The Kilmore & District Hospital manages liquidity risk by monitoring cashflows to ensure sufficient funds are maintained in the transitional bank account to meet liabilities as they fall due. Management monitor liquidity with monthly reports to the Board regarding cashflow position.

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

**Maturity analysis of financial liabilities as at 30 June**

| | | | Maturity Dates | | | |
|---|---|---|---|---|---|---|
| | Carrying Amount | Nominal Amount | Less Than 1 Month | 1-3 Months | 3 months - 1 Year | 1 - 5 Years |
| | $'000 | $'000 | $'000 | $'000 | $'000 | $'000 |
| **2017** | | | | | | |
| **Financial Liabilities** | | | | | | |
| At amortised cost | | | | | | |
| Trade creditors and accruals | 1,186 | 1,186 | 1,186 | - | - | - |
| Borrowings | 61 | 61 | - | - | 29 | 32 |
| Monies Held In Trust | 5,228 | 5,228 | 3,906 | 1,322 | - | - |
| **Total Financial Liabilities** | **6,475** | **6,475** | **5,092** | **1,322** | **29** | **32** |
| **2016** | | | | | | |
| **Financial Liabilities** | | | | | | |
| At amortised cost | | | | | | |
| Trade creditors and accruals | 830 | 830 | 830 | - | - | - |
| Borrowings | 75 | 75 | - | - | 34 | 41 |
| Monies Held In Trust | 4,150 | 4,150 | 2,986 | 1,164 | - | - |
| **Total Financial Liabilities** | **5,055** | **5,055** | **3,816** | **1,164** | **34** | **41** |

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

# Note 7.1: Financial Instruments (continued)

## (e) Market Risk

The Kilmore & District Hospital's exposures to market risk are primarily through interest rate risk with only insignificant exposure to foreign currency and other price risks. Objectives, policies and processes used to manage each of these risks are disclosed in the paragraph below.

### *Currency Risk*

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

### *Interest Rate Risk*

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

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

**Interest rate exposure of financial assets and liabilities as at 30 June**

| | Weighted Average Effective Interest Rates (%) | Carrying Amount $'000 | Interest Rate Exposure | | |
|---|---|---|---|---|---|
| 2017 | | | Fixed Interest Rate $'000 | Variable Interest Rate $'000 | Non Interest Bearing $'000 |
| **Financial Assets** | | | | | |
| Cash and Cash Equivalents | 2.20% | 1,183 | - | 1,183 | - |
| Trade debtors and accruals (i) | 0.00% | 698 | - | - | 698 |
| Deposits | 2.09% | 5,630 | 5,630 | - | - |
| | | **7,511** | **5,630** | **1,183** | **698** |
| **Financial Liabilities** | | | | | |
| At amortised cost | | | | | |
| Trade creditors and accruals (i) | 0.00% | 1,186 | - | - | 1,186 |
| Borrowings | 0.00% | 61 | - | - | 61 |
| Monies Held In Trust | 0.00% | 5,228 | - | - | 5,228 |
| | | **6,475** | **-** | **-** | **6,475** |
| **2016** | | | | | |
| **Financial Assets** | | | | | |
| Cash and Cash Equivalents | 2.60% | 798 | - | 798 | - |
| Trade debtors and accruals (i) | 0.00% | 516 | - | - | 516 |
| Deposits | 3.00% | 4,498 | 4,498 | - | - |
| | | **5,812** | **4,498** | **798** | **516** |
| **Financial Liabilities** | | | | | |
| At amortised cost | | | | | |
| Trade creditors and accruals (i) | 0.00% | 830 | - | - | 830 |
| Borrowings | 0.00% | 75 | - | - | 75 |
| Monies Held In Trust | 0.00% | 4,150 | - | - | 4,150 |
| | | **5,055** | **-** | **-** | **5,055** |

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

# **Note 7.1:** Financial Instruments (continued)

**Sensitivity Disclosure Analysis**

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, the Hospital believes the following movements are reasonably possible' over the next 12 months. (Base rates sourced from the Reserve Bank of Australia)

- A shift of 100 basis points up and down in market interest rates (AUD) from year-end rates of 3%;
- A parallel shift of +1% and -1% in inflation rate from year end rates of 2%.

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

| | | Interest Rate Risk | | | |
|---|---|---|---|---|---|
| | | -1% | | +1% | |
| 2017 | Carrying Amount | Profit $'000 | Equity $'000 | Profit $'000 | Equity $'000 |
| **Financial Assets** | | | | | |
| Cash and Cash Equivalents | 1,183 | (12) | (12) | 12 | 12 |
| Trade debtors and accruals | 698 | - | - | - | - |
| Deposits | 5,630 | (56) | (56) | 56 | 56 |
| **Financial Liabilities** | | | | | |
| At amortised cost | | | | | |
| Trade creditors and accruals (i) | 1,186 | 12 | 12 | (12) | (12) |
| Borrowings | 61 | 1 | 1 | (1) | (1) |
| Monies Held In Trust | 5,228 | - | - | - | - |
| | | **(56)** | **(56)** | **56** | **56** |

| | | Interest Rate Risk | | | |
|---|---|---|---|---|---|
| | | -1% | | +1% | |
| 2016 | Carrying Amount | Profit $'000 | Equity $'000 | Profit $'000 | Equity $'000 |
| **Financial Assets** | | | | | |
| Cash and Cash Equivalents | 798 | (8) | (8) | 8 | 8 |
| Trade debtors and accruals | 516 | - | - | - | - |
| Deposits | 4,498 | (45) | (45) | 45 | 45 |
| **Financial Liabilities** | | | | | |
| *At amortised cost* | | | | | |
| Trade creditors and accruals (i) | 830 | 8 | 8 | (8) | (8) |
| Borrowings | 75 | 1 | 1 | (1) | (1) |
| Monies Held In Trust | 4,150 | - | - | - | - |
| | | **(44)** | **(44)** | **44** | **44** |

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

# **Note 7.1:** Financial Instruments (continued)

### (f) Fair Value

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

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

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

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

**Comparison between carrying amount and fair value**

| | Carrying Amount 2017 $'000 | Fair Value 2017 $'000 | Carrying Amount 2016 $'000 | Fair Value 2016 $'000 |
|---|---|---|---|---|
| **Financial Assets** | | | | |
| Cash and Cash Equivalents | 1,183 | 1,183 | 798 | 798 |
| Trade debtors and accruals | 698 | 698 | 516 | 516 |
| Deposits | 5,630 | 5,630 | 4,498 | 4,498 |
| **Total Financial Assets** | **7,511** | **7,511** | **5,812** | **5,812** |
| **Financial Liabilities** | | | | |
| At amortised cost | | | | |
| Trade creditors and accruals (i) | 1,186 | 1,186 | 830 | 919 |
| Borrowings | 61 | 61 | 75 | 75 |
| Monies Held In Trust | 5,228 | 5,228 | 4,150 | 4,228 |
| **Total Financial Liabilities** | **6,475** | **6,475** | **5,055** | **5,055** |

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

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of The Kilmore & District Hospital's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation*. For example, statutory receivables arising from taxes, fines and penalties do not meet the definition of financial instruments as they do not arise under contract.

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

The following refers to financial instruments unless otherwise stated.

**Categories of Non-derivative Financial Instruments**

***Loans and receivables***

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

Loans and receivables category includes cash and deposits (refer to Note 6.1), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

***Financial Liabilities at amortised cost***

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

# **Note 7.2:** Net Gain/(Loss) on Disposal of Non-financial Assets

| | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|
| **Proceeds from Disposals of Non-Current Assets** | | |
| Motor Vehicles | 52 | 33 |
| **Total Proceeds from Disposal of Non-Current Assets** | **52** | **33** |
| **Less: Written Down Value of Non-Current Assets Sold** | | |
| Motor Vehicles | (75) | (58) |
| **Total Written Down Value of Non-Current Assets Sold** | **(75)** | **(58)** |
| **Net gain/(loss) on Disposal of Non-Financial Assets** | **(23)** | **(25)** |

### Disposal of Non-Financial Assets

Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement. Refer to note 8.1 'Comprehensive income'.

### Impairment of Non-Financial Assets

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

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

- inventories;
- financial assets; and
- non-current physical assets held for sale.

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

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

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

# **Note 7.3:** Contingent Assets and Contingent Liabilities

There are no known contingent liabilities or assets at balance date that will have a material effect on the financial statements.

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

# **Note 7.4:** Fair Value Determination

| Asset Class | Examples of types of assets | Likely Valuation Approach | Significant Inputs (Level 3 Only) |
|---|---|---|---|
| **Non-specialised Land** | In areas where there is an active market:<br>— vacant land<br>— land not subject to restrictions as to use or sale | Market approach | N/A |
| **Specialised Land** | Land subject to restrictions as to use and/or sale<br>Land in areas where there is not an active market | Market approach | CSO Adjustments |
| **Non-specialised Buildings** | For general/commercial buildings that are just built | Market approach | N/A |
| **Specialised Buildings (i)** | Specialised buildings with limited alternative uses and/or substantial customisation e.g. prisons, hospitals, and schools | Depreciated replacement cost approach | Cot per square metre<br>Useful life |
| **Dwellings (i)** | Social/public housing/employee housing | Market approach<br><br>Depreciated replacement cost approach | N/A<br>Cot per square metre<br><br>Useful life |
| **Infrastructure** | Any type | Depreciated replacement cost approach | Cot per square metre<br>Useful life |
| **Road, Infrastructure and Earthworks** | Any type | Depreciated replacement cost approach | Cot per square metre<br>Useful life |
| **Plant and Equipment (i)** | Specialised items with limited alternative uses and/or substantial customisation | Depreciated replacement cost approach | Cot per square metre<br>Useful life |
| **Vehicles** | If there is an active resale market available<br><br>If there is no active resale market available | Market approach<br><br>Depreciated replacement cost approach | N/A<br>Cot per square metre<br><br>Useful life |
| **Cultural Assets** | Items for which there is an active market and there are operational uses for the item | Market approach | N/A |
| **Cultural Assets** | Items for which there is no active market and for which there are limited uses | Depreciated replacement cost approach | Cot per square metre<br>Useful life |

(i) Newly built/acquired assets could be categorised as level 2 assets as depreciatin would not be a significant unobservable input (based on the 10% materiality threshold).

# **Note 8:** Other Disclosures

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

Structure

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

# **Note 8.1:** Equity

| | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|
| **(a) Surpluses** | | |
| **Property, Plant & Equipment Revaluation Surplus** | | |
| Balance at the beginning of the reporting period | 17,421 | 17,421 |
| Revaluation Increment/(Decrements) | | |
| - Land | 125 | - |
| - Buildings | - | - |
| **Balance at the end of the reporting period** | **17,546** | **17,421** |
| Represented by: | | |
| – Land | 1,219 | 1,094 |
| – Buildings | 16,327 | 16,327 |
| **Total Reserves** | **17,546** | **17,421** |
| **(b) Contributed Capital** | | |
| Balance at the beginning of the reporting period | 11,532 | 11,161 |
| Capital contribution received from Victorian Government | - | 371 |
| Capital Repayments | - | - |
| **Balance at the end of the reporting period** | **11,532** | **11,532** |
| **(c) Accumulated Surpluses/(Deficits)** | | |
| Balance at the beginning of the reporting period | 2,744 | 5,110 |
| Net Result for the Year | (2,584) | (2,366) |
| Transfers to and from Surplus | - | - |
| **Balance at the end of the reporting period** | **160** | **2,744** |
| **Total Equity at the end of financial year** | **29,238** | **31,967** |

### Contributed Capital

Consistent with Australian Accounting Interpretation 1038 *Contributions by Owners* Made to Wholly-Owned Public Sector Entities and FRD 119A Contributions by Owners, appropriations for additions to the net asset base have been designated as contributed capital.

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

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

### Property, Plant & Equipment Revaluation Surplus

The asset revaluation surplus is used to record increments and decrements on the revaluation of non-current physical assets.

# **Note 8.2:** Reconciliation of Net Result for the Year to Net Cash Inflow/(Outflow) from Operating Activities

| | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|
| **Net result for the period** | (2,584) | (2,366) |
| **Non-cash movements:** | | |
| Depreciation and Amortisation | 3,177 | 3,330 |
| Hume Rural Health Alliance | (180) | (38) |
| Provision for Doubtful Debts | 1 | (5) |
| **Movements included in investing and financing activities** | | |
| Net (Gain)/Loss from Disposal of Plant and Equipment | 23 | 25 |
| **Movements in assets and liabilities:** | | |
| Change in Operating Assets & Liabilities | | |
| (Increase)/Decrease in Receivables | (263) | (200) |
| (Increase)/Decrease in Other Assets | - | (2) |
| Increase/(Decrease) in Payables | 430 | (185) |
| Increase/(Decrease) in Provisions | 357 | 377 |
| (Increase)/Decrease in Inventories | 19 | (13) |
| **NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES** | **980** | **923** |

# **Note 8.3:** Operating Segments

| | RACS | | Other | | Total | |
|---|---|---|---|---|---|---|
| | 2017 $'000 | 2016 $'000 | 2017 $'000 | 2016 $'000 | 2017 $'000 | 2016 $'000 |
| **REVENUE** | | | | | | |
| External Segment Revenue | 4,635 | 4,735 | 15,635 | 14,163 | 20,270 | 18,898 |
| **Total Revenue** | **4,635** | **4,735** | **15,635** | **14,163** | **20,270** | **18,898** |
| **EXPENSES** | | | | | | |
| External Segment Expenses | 5,680 | 5,424 | 17,222 | 15,844 | 22,902 | 21,268 |
| **Total Expenses** | **5,680** | **5,424** | **17,222** | **15,844** | **22,902** | **21,268** |
| **Net Result from ordinary activities** | **(1,045)** | **(689)** | **(1,587)** | **(1,681)** | **(2,632)** | **(2,370)** |
| Interest Income | 12 | 11 | 12 | 11 | 24 | 22 |
| **Net Result for Year** | **(1,033)** | **(678)** | **(1,575)** | **(1,670)** | **(2,608)** | **(2,348)** |
| **OTHER INFORMATION** | | | | | | |
| Segment Assets | 10,572 | 10,442 | 29,118 | 29,402 | 39,690 | 39,844 |
| Unallocated Assets | - | - | - | - | - | - |
| **Total Assets** | **10,572** | **10,442** | **29,118** | **29,402** | **39,690** | **39,844** |
| Segment Liabilities | 6,140 | 4,968 | 4,312 | 3,179 | 10,452 | 8,147 |
| Unallocated Liabilities | - | - | - | - | - | - |
| **Total Liabilities** | **6,140** | **4,968** | **4,312** | **3,179** | **10,452** | **8,147** |
| Acquisition of Property, Plant & Equipment | 111 | 53 | 553 | 1,191 | 664 | 1,244 |
| Depreciation expense | **1,082** | **1,089** | **2,092** | **2,231** | **3,174** | **3,320** |

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

| **Business Segments** | **Services** |
|---|---|
| Residential Aged Care Services (RACS) | Nursing Home, Hostel & Respite residential aged care services. |
| Other (Acute Health) | Inpatient & outpatient acute health services. |

**Geographical Segment**

The Kilmore & District Hospital operates predominantly in Kilmore, Victoria. More than 90% of revenue, net surplus from ordinary activities and segment assets relate to operations in Kilmore, Victoria.

# **Note 8.4:** Responsible Persons Disclosures

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

| **Responsible Ministers:** | **Period** |
|---|---|
| The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services | 1/07/2016 - 30/06/2017 |
| The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health | 1/07/2016 - 30/06/2017 |
| **Governing Boards** | |
| J. McGill (President) | 1/07/2016 - 30/06/2017 |
| U. Lonnqvist | 1/07/2016 - 30/06/2017 |
| J. Dixon | 1/07/2016 - 30/06/2017 |
| L. Whitehouse | 1/07/2016 - 30/06/2017 |
| W.R. Arnott | 1/07/2016 - 30/06/2017 |
| C. Lawson | 1/07/2016 - 21/02/2017 |
| A. Wilcox | 1/07/2016 - 30/06/2017 |
| P. Nottle | 1/07/2016 - 30/06/2017 |
| C. Harris | 1/07/2016 - 30/06/2017 |
| **Accountable Officer** | |
| S. Race (Chief Executive Officer) | 1/07/2016 - 30/06/2017 |

### Remuneration

Remuneration received or receivable by responsible persons was in the range: $180,000 - $189,999 ($200,000 - $209,999 in 2015-16).

# **Note 8.5:** Executive Officer Disclosures

**Remuneration of executives**

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

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

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

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

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

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

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

| | Total Remuneration | |
|---|---|---|
| **Remuneration of Executive Officers (Including Key Management Personnel disclosed in note 8.6)** | **2017 $** | **2016[i] $** |
| Short-term employee benefits | 355,577 | |
| Post-employment benefits | 30,120 | |
| Other long-term benefits | 6,856 | |
| Termination benefits | - | |
| Share-based payments | - | |
| **Total remuneration [i][ii]** | **392,553** | |
| **Total number of executives** | **3** | **3** |
| **Total annualised employee equivilant (AEE) [iii]** | **3.00** | **3.00** |

Notes:

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

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

(iii) Annualised employee equivilent is based on the time fraction worked over the reporting period.

# **Note 8.6:** Related Parties

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

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

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

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

**Significant Transactions with Government-related Entities**

The Kilmore & District Hospital received funding from the Department of Health and Human Services of $13.2 million (2016: $12 million).

During the year, The Kilmore & District Hospital had the following government-related entity transactions:

- RAC funding from the Commonwealth Department of health and ageing of $2.4 million (2016: $2.6 million).

| Compensation | 2017 $'000 |
|---|---|
| Short term employee benefits | 522 |
| Post-employment benefits | 46 |
| Other long-term benefits | 12 |
| Termination benefits | 0 |
| Share based payments | 0 |
| **Total** | **580** |

**Transactions with Key Management Personnel and Other Related Parties**

Given the breadth and depth of State government activities, related parties transact with the Victorian public sector in a manner consistent with other members of the public e.g. stamp duty and other government fees and charges. Further employment of processes within the Victorian public sector occur on terms and conditions consistent with the Public Administration Act 2004 and Codes of Conduct and Standards issued by the Victorian Public Sector Commission. Procurement processes occur on terms and conditions consistent with the Victorian Government Procurement Board requirements. Outside of normal citizen type transactions with the department, there were no related party transactions that involved key management personnel and their close family members. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

**Key management personnel** of the agencies consolidated pursuant to section 53(1)(b) of the FMA into the Entity's financial statements include:

| | | |
|---|---|---|
| The Kilmore & District Hospital | J. McGill (President) | Board President |
| The Kilmore & District Hospital | U. Lonnqvist | Board Member |
| The Kilmore & District Hospital | J. Dixon | Board Member |
| The Kilmore & District Hospital | L. Whitehouse | Board Member |
| The Kilmore & District Hospital | W.R. Arnott | Board Member |
| The Kilmore & District Hospital | C. Lawson | Board Member |
| The Kilmore & District Hospital | A. Wilcox | Board Member |
| The Kilmore & District Hospital | P. Nottle | Board Member |
| The Kilmore & District Hospital | C. Harris | Board Member |
| The Kilmore & District Hospital | S. Race | Chief Executive Officer |
| The Kilmore & District Hospital | K. Pryde | Director of Clinical & Aged Care Services |
| The Kilmore & District Hospital | K. Gilchrist | Director of Development & Improvement |
| The Kilmore & District Hospital | C. Clark | Director of Finance & Support Services |

# Note 8.7. Remuneration of Auditors

| | 2017 | 2016 |
|---|---|---|
| **Victorian Auditor-General's Office** | **$'000** | **$'000** |
| Audit of financial statement | 14 | 14 |
| | **14** | **14** |

# Note 8.8. AASBs Issued That Are Not Yet Effective

| Standard/Interpretation | Summary | Applicable for annual reporting periods beginning on | Impact on public sector entity financial statements |
|---|---|---|---|
| **AASB 9 Financial Instruments** | The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred. | 1 Jan 2018 | The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. While there will be no significant impact arising from AASB 9, there will be a change to the way financial instruments are disclosed. |
| **AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)** | The requirements for classifying and measuring financial liabilities were added to AASB 9. The existing requirements for the classification of financial liabilities and the ability to use the fair value option have been retained. However, where the fair value option is used for financial liabilities the change in fair value is accounted for as follows:<br>• The change in fair value attributable to changes in credit risk is presented in other comprehensive income (OCI); and<br>• Other fair value changes are presented in profit and loss. If this approach creates or enlarges an accounting mismatch in the profit or loss, the effect of the changes in credit risk are also presented in profit or loss. | 1 Jan 2018 | The assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss.<br>Changes in own credit risk in respect of liabilities designated at fair value through profit and loss will now be presented within other comprehensive income (OCI).<br>Hedge accounting will be more closely aligned with common risk management practices making it easier to have an effective hedge.<br>For entities with significant lending activities, an overhaul of related systems and processes may be needed. |
| **AASB 2014-1 Amendments to Australian Accounting Standards [Part E Financial Instruments]** | Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements. | 1 Jan 2018 | This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements. |
| **AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9** | Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9. | 1 Jan 2018 | The assessment has indicated that there will be no significant impact for the public sector. |

# **Note 8.8.** AASBs Issued That Are Not Yet Effective (continued)

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

# **Note 8.8.** AASBs Issued That Are Not Yet Effective (continued)

| Standard/Interpretation | Summary | Applicable for annual reporting periods beginning on | Impact on public sector entity financial statements |
|---|---|---|---|
| **AASB 2016-7 Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities** | This Standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019. | 1-Jan-19 | This amending standard will defer the application period of AASB 15 for not-for-profit entities to the 2019-20 reporting period. |
| **AASB 2016-8 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities** | This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events. The amendments:<br>• require non-contractual receivables arising from statutory requirements (i.e. taxes, rates and fines) to be initially measured and recognised in accordance with AASB 9 as if those receivables are financial instruments; and<br>• clarifies circumstances when a contract with a customer is within the scope of AASB 15. | 1-Jan-19 | The assessment has indicated that there will be no significant impact for the public sector, other than the impacts identified for AASB 9 and AASB 15 above. |
| **AASB 16 Leases** | The key changes introduced by AASB 16 include the recognition of most operating leases (which are current not recognised) on balance sheet. | 1-Jan-19 | The assessment has indicated that as most operating leases will come on balance sheet, recognition of the right-of-use assets and lease liabilities will cause net debt to increase.<br>Rather than expensing the lease payments, depreciation of right-of-use assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus.<br>No change for lessors. |
| **AASB 2016-4 Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities** | The standard amends AASB 136 Impairment of Assets to remove references to using depreciated replacement cost (DRC) as a measure of value in use for not-for-profit entities. | 1 Jan 2017 | The assessment has indicated that there is minimal impact. Given the specialised nature and restrictions of public sector assets, the existing use is presumed to be the highest and best use (HBU), hence current replacement cost under AASB 13 Fair Value Measurement is the same as the depreciated replacement cost concept under AASB 136. |
| **AASB 1058 Income of Not-for-Profit Entities** | This standard replaces AASB 1004 Contributions and establishes revenue recognition principles for transactions where the consideration to acquire an asset is significantly less than fair value to enable to not-for-profit entity to further its objectives. | 1-Jan-19 | The assessment has indicated that revenue from capital grants that are provided under an enforceable agreement that have sufficiently specific obligations, will now be deferred and recognised as performance obligations are satisfied. As a result, the timing recognition of revenue will change. |

# **Note 8.9:** Events Occurring After the Balance Sheet Date

There were no events occurring after balance date which would have a material effect on the financial statements.

# Note 8.10: Jointly Controlled Operations and Assets

| | | Ownership Interest | |
|---|---|---|---|
| **Name of Entity** | **Principal Activity** | **2017** | **2016** |
| Hume Rural Health Alliance | Information Systems | **4.4%** | **4.53%** |

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

| | 2017 $'000 | 2016 $'000 |
|---|---|---|
| **Current Assets** | | |
| Cash and Cash Equivalents | 159 | 86 |
| Receivables | 115 | 43 |
| Prepayments | 6 | 3 |
| **Total Current Assets** | **280** | **132** |
| **Non Current Assets** | | |
| Property, Plant and Equipment | 1 | 1 |
| Intagible Assets | 70 | 40 |
| Lease Asset | 61 | 75 |
| **Total Non Current Assets** | **132** | **116** |
| **Total Assets** | **412** | **248** |
| **Current Liabilities** | | |
| Payables | 22 | 24 |
| Borrowings | 29 | 34 |
| **Total Current Liabilities** | **51** | **58** |
| **Non-Current Liabilities** | | |
| Borrowings | 32 | 41 |
| **Total Non-Current Liabilities** | **32** | **41** |
| **Total Liabilities** | **83** | **99** |

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

| | | |
|---|---|---|
| **Revenues** | | |
| Revenue from Operating Activities | 375 | 402 |
| Revenue from Non-Operating Activities | 1 | 1 |
| Capital Purpose Income | 176 | 43 |
| **Total Revenue** | **552** | **446** |
| **Expenses** | | |
| Employee Benefits | 75 | 86 |
| Other Expenses From Continuing Operations | 256 | 279 |
| Depreciation and Amortisation | 39 | 40 |
| Finance Charges | 2 | 3 |
| **Total Expenses** | **372** | **408** |
| **Net Result** | **180** | **38** |

The 2017 amounts disclosed above are based on the unaudited financial statements of the Hume Rural Health Alliance.

**Investments in joint operations**

In respect of any interest in joint operations, The Kilmore & District Hospital recognises in the financial statements:

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

# Note 8.11: Economic Dependency

The financial performance and position of The Kilmore & District Hospital has declined since the prior year, with the Hospital reporting a deficit net result before capital and specific items of $420,000 (2016: Surplus $83,000), a net current asset deficit of $1,810,000 (2016: deficit of $1,689,000), resulting in a current asset ratio of .82 (2016: .78) and a (continued) positive cash outflow from operations of $979,000 (2016: positive cash of $923,000).

As a result of the financial performance and position, The Kilmore & District Hospital has obtained a letter of support from the State Government and in particular, the Department of Health and Human Services (DHHS), confirming that the department will continue to provide The Kilmore & District Hospital adequate cash flow to meet its current and future obligations up to 30 September 2018. (A letter was also obtained for the previous financial year).

On that basis, the financial statements have been prepared on a going concern basis.

# Note 8.12: Alternative Presentation of Comprehensive Operating Statement

| | Note | Total 2017 $'000 | Total 2016 $'000 |
|---|---|---|---|
| Grants | | | |
| Operating | 2.1 | 12,893 | 11,799 |
| Capital | 2.1 | 482 | 426 |
| Interest and Dividends | 2.1 | 24 | 22 |
| Sales of Goods and Services | 2.1 | 6,369 | 6,222 |
| Other Income | | | |
| Other capital income | | 526 | 451 |
| **Revenue from Transactions** | | **20,294** | **18,920** |
| Employee Expenses | 3.1 | 13,357 | 12,232 |
| Operating Expenses | | | |
| Supplies and consumables | 3.1 | 1,598 | 1,491 |
| Non-salary labour costs | 3.1 | 2,449 | 2,108 |
| Other expenses | 3.1 | 2,278 | 2,107 |
| Non-Operating Expenses | | | |
| Expenditure for Capital Purpose | 3.1 | 6 | - |
| Depreciation and Amortisation | 4.3 | 3,214 | 3,330 |
| **Expenses from Transactions** | | 22,902 | 21,268 |
| **Net Result from Transactions** | | **(2,608)** | **(2,348)** |
| **Other economic flows included in net result** | | | |
| Revaluation of Long Service Leave | | 24 | (18) |
| **Other economic flows included in net result** | | **24** | **(18)** |
| **Comprehensive Result** | | **(2,584)** | **(2,366)** |

**THE KILMORE & DISTRICT HOSPITAL**
ABN 49 260 016 741


**The Kilmore & District Hospital**

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**Dianella Hostel**

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