BCH
Bass Coast Health

Annual Report 2015/16

About this Report

Bass Coast Health reports on its annual performance in two separate documents. This Annual Financial and Performance Report fulfils the statutory reporting requirements to Government by way of an Annual Report. This report is presented at Bass Coast Health's Annual General Meeting. The Quality Account reports on quality, risk management and performance improvement matters. Both documents are distributed and made available to the community.

Relevant Minister

The relevant Ministers during the reporting period were:

- The Hon Jill Hennessy MP – Minister for Health, Minister for Ambulance Services

  4th December 2014 to 30th June 2016

- The Hon Martin Foley MP – Minister for Housing, Disability & Ageing, Minister for Mental Health

  4th December 2014 to 30th June 2016

Values

We embrace the following values to fulfill our vision and mission:

- **Person Centered Focus**
- **Integrity, Trust and Respect**
- **Quality and Safety**
- **Accountability**
- **Working together**

Vision

Healthy People.

Healthy Community

Purpose

To plan and develop a sub-regional health service that meets the primary health needs of the local community in addition to providing secondary and specialist care to the extended population of the Gippsland South Coast. We are committed to work with our partners to achieve appropriate sub regional access to specialist services for the people of the South Coast.

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Year in Review

REPORT FROM BOARD CHAIR & CHIEF EXECUTIVE OFFICER

In accordance with the Financial Management Act 1994, it gives us great pleasure to present our annual report for 2015/16. This report highlights the work, commitment and achievements of Bass Coast Health and our people over the last twelve months.

Quality & Safety

Bass Coast Health (BCH) is committed to the provision of safe, high quality care. In partnership with our consumers staff are continually reviewing and reflecting on performance and patient experience and looking for ways to improve.

Recent achievements in this area include:

- Successful accreditation of Griffiths Point Lodge across the 44 Aged Care Standards
- Outstanding accreditation results for our Family Day Care service with the service consistently rated as exceeding national quality standards
- Enhancement of the BCH Risk Management Framework to ensure early identification and management of corporate and clinical risks
- Establishment of an enhanced Consumer Participation program ensuring the voice of the consumer and community is central to all service planning and development
- Preparation for the organisation-wide accreditation survey in early 2017 with a number of quality activities undertaken to reduce falls, prevent pressure injuries, manage patients who become unwell and reduce medication errors
- Exceeding state-wide performance targets for Hand Hygiene audits and staff immunisation to assist in Infection Prevention and Control.

We congratulate our team of dedicated staff and volunteers on their ongoing commitment to provide excellent, person centred care to our community.

Collaboration & Partnerships

BCH is committed to maintaining strong collaboration and partnerships with the many external stakeholders who help us achieve the best outcome possible for our community.

Partners such as the Wonthaggi Medical Group, Bass Coast Shire Council, Gippsland Health Alliance, Peninsula Health, the Department of Health and Human Services, LASA, Dental Health Services Victoria, the South Coast Primary Healthcare Partnership and the Phillip Island Health and Medical Action Group have all continued to assist BCH to achieve the best possible healthcare outcomes for the people we serve.

BCH has been particularly keen to continually improve our partnership with our community members and consumers. Our Community Advisory Committee has expanded to ensure we are able to hear the voice of the many and varied communities we serve. Consumer involvement in the planning and delivery of services is a key priority and we have increased the focus on involving individual consumers in their decision-making in their day to day care. BCH recognises that the best way for us to improve our care is to listen to the needs and experiences of our service users and we have a strong commitment to this across all service areas.

Our People

Serving a local community by providing the best health care service possible is a privilege that Bass Coast Health staff take seriously. Staff at Bass Coast Health are skilled, passionate, expert, loyal and professional. They understand their role is to improve patient experience and health outcomes and they focus on this every day.

We thank all staff for their continued support throughout changing times and we commend their commitment to the Bass Coast community

A Special Thank You to our Volunteers

BCH staff are privileged to work alongside many individuals and community groups who give generously of their time and skills to volunteer with us. We gratefully and sincerely acknowledge their contributions and efforts and thank them wholeheartedly for their commitment.

Through the strong support of over 250 volunteers, BCH volunteers contribute to the following services:

- Meals on Wheels / Emergency Meals on Wheels
- Transport Driving - Cars and Buses
- Ward Visitors
- Palliative Care Support
- Administration
- Family Services
- Nursing Home Support
- Community Rehabilitation Centre
- Emergency Pet Caretaking
- Pastoral Care

We would like to pay special tribute to the work of the Community Advisory Committee who have been instrumental in improving our consumer participation, to ensure our collaboration is real and meaningful.

We would also like to recognise and send our deepest appreciation to those volunteers who raise funds for equipment and infrastructure. Both the Ladies Auxiliary and the San Remo Op Shop volunteers in particular, work tirelessly to provide much needed support to BCH and their dedication is extraordinary.

Finally, we would like to congratulate those BCH volunteers nominated for the Premier's Award in recognition of their input to Planned Activity Groups and Volunteer Transport.

Our volunteers are special people and BCH could not achieve what it does without their continued support.

Some of Our Achievements

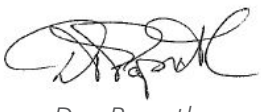
The 2015/16 year has seen many changes at BCH and whilst all change brings challenge, it also brings opportunity, and there have been some wonderful achievements. These include:

- Planning for the construction of the $5.8 million Health Hub at Cowes. We gratefully acknowledge funding support for this important project from the Bass Coast Shire Council, the Victorian State Government, the Federal Government and Leading Aged Services Australia (LASA) as trustee for the Warley Trust.
- Opening of the dedicated 4 bed Short Stay Unit adjacent to the Emergency Department at the Wonthaggi Hospital.
- Continued collaboration with our neighbouring health services and the Department of Health and Human Services to re-develop the clinical services plan for BCH.
- The installation of videoconferencing equipment in the resuscitation bay in the Emergency Department. This has enabled our Emergency Department to consult directly with Adult Retrieval Victoria about the treatment and transfer of acutely ill patients.
- Progression towards a single integrated intake and referral process, and single client file system in Primary and Community Services.
- Growth in the Residential In-Reach Program to prevent unwarranted presentations to the Emergency Department and avoid admissions to hospital.
- Realignment of the Hospital Admission Risk Program to target respiratory disease.
- Expansion of the Allied Health Services led Pre-School Screening Program and the Dental Services led Oral Health Promotion Week.
- Expansion of our team of highly skilled Allied Health Assistants.
- Development and launch of the 'LOOKING OUT Guide to GLBTIQ Health and Inclusive Practice'.
- Partnership with Alfred Health to provide Geriatrician services.
- Partnership with Peninsula Health and Peninsula Cardiology Services to enhance access to local Cardiology services.
- Expansion of the number of sub-acute and medical beds through the improved utilisation of Armitage House.
- Improvements to the staffing profile of Griffiths Point Lodge to enable a higher level of care to be provided in the home.
- Improvements to revenue and expenditure strategies resulting in a significantly improved financial performance.

These are but some of the many achievements we have made over the year, with the specific aim of improving what we do.

BCH would like to thank all of those people who helped make these achievements possible. We look forward to building on these achievements to safely grow our service and better serve our community.

Jan Child
Chief Executive Officer



Don Paproth
Interim Chair
Board of Directors

Year in Review

REPORT FROM BOARD CHAIR & CHIEF EXECUTIVE OFFICER

Acute Patient Admissions by Locality

Locality	2013/14	%	2014/15	%	2015/16	%
Wonthaggi District	3042	44%	3264	40%	2945	38%
Phillip Island / San Remo	1424	20%	1631	20%	1863	24%
Grantville District	324	5%	351	4%	380	5%
Inverloch	618	9%	699	9%	834	11%
Leongatha / Korumburra	702	10%	702	9%	682	9%
Walkerville / Tarwin / Venus Bay	295	4%	268	3%	268	3%
Other	564	8%	1224	15%	793	10%
Total	**6969**	**100%**	**8139**	**100%**	**7765**	**100%**

Age Profile of Admitted Patients Treated Last 3 years

Age	2013/14	%	2014/15	%	2015/16	%
0-14 years of age	385	6%	372	5%	395	5%
15-29 years of age	393	6%	413	5%	393	5%
30-44 years of age	484	7%	732	9%	856	11%
45-59 years of age	1074	15%	9144	11%	939	12%
60-79 years of age	3035	44%	3802	47%	3427	44%
80+ years of age	1598	23%	1906	23%	1755	23%
Total	**6969**	**100%**	**8139**	**100%**	**7765**	**100%**

Our History

1910 Temporary tent Hospital erected

1914 Permanent Hospital constructed

1928 Main core buildings constructed

1972 District Nursing commenced

1974 Sleeman Wing developed

1978 Introduction of Speech Pathology, Podiatry services and regional Dental Clinic

1984 Completion of Grabham Wing and the Stirton Day Hospital building

1986 Pathology Service on site

1988 Development of Family Resource Centre

1990 Construction of Armitage House

1991 Construction of Acute ward and Administration offices

1993 Establishment of the Inverloch Community Care Centre

1996 Acquisition of Griffiths Point Lodge

1997 Development of Day Surgery and Haemodialysis Units

2000 Redevelopment of Operating Suite, Emergency Department, Radiology, Kitchen, Laundry and Pharmacy

2003 Change of name from 'Wonthaggi & District Hospital' to 'Bass Coast Regional Health'. Refurbishment of Midwifery Ward and expansion of Community Health Services

2005 Kirrak House commissioned. Grabham Wing Consulting Suites and Education Centre developed

2006 Redevelopment of Family Resource Centre and Dental Clinic

2007 Completion of the new Haemodialysis unit and expansion of service. Development of new medical consulting suites. Development of aged mental health partnership with Latrobe Regional Hospital

2008 Employment of Hospital Medical Officers

2009 Employment of staff Senior Medical Officer. Planning for the Emergency Department expansion. Sub-regional planning commenced

2010 Redevelopment of the Emergency Department. Planning for redevelopment of Maternity Unit and Central Sterilising Department

2011 Redevelopment of Maternity Unit and Central Sterilising Department complete. Introduction of the Redesigning Care program. Appointment of Director of Service Development and a Geriatrician. Master planning commenced

2012 Redevelopment of Sleeman Wing and renovations in Grabham Wing. Commencement of the redevelopment of the Community Rehabilitation Centre (CRC) and Dental Clinic

2013 A five chair Dental Clinic completed in November and the extension of CRC redevelopment commenced

2014 Extension of the CRC building completed in June 2014. Integration of BCRH and BCCHS occurred on 1st July, forming the new organisation of Bass Coast Health

2015 New development of a combined Short Stay Unit attached to the Emergency Department and a two room medical consulting area commenced in May. Commencement of the new Health and Medical Hub to be built at Cowes

2016 Release of funds for the Phillip Island Health Hub at Cowes. Short Stay Unit fully operational

Our Service Profile

Acute Hospital Services

- 54 Registered available beds
- Haemodialysis
- Medical
- Midwifery
- Palliative Care
- Paediatric
- Rehabilitation
- Geriatric Evaluation & Management
- Surgical
- Emergency
- Short Stay Unit
- Hospital in The Home
- Transition Care
- Day Surgery
- Operating Suite
- Medical Day Stay

Residential Aged Care

- Armitage House
- Kirrak House
- Griffiths Point Lodge

Clinical Support Services

- Breast Screening (Gippsland BreastScreen)
- Pathology (Gippsland Pathology)
- Pharmacy
- Radiology and Ultrasonography (Bass Coast Imaging)
- South West Gippsland Community Mental Health Service (Latrobe Regional Hospital)
- Acute / Aged Mental Health Service (Latrobe Regional Hospital)

Primary & Community Services and Programs

- Access To Allied Psychological Services (ATAPS)
- Adolescent Health
- Allied Health Paediatric Service
- Antenatal Education
- Arthritis Support Group
- Asthma and Respiratory
- Blokes Community Kitchen
- Cancer Support Group
- Cardiac Rehabilitation Program
- Chronic Disease Management
- Communication Skills Support Group
- Community Rehabilitation Program
- Continence Clinic
- Counselling services: General, Family Violence, Alcohol & Other Drugs, Sexual Assault
- Dental Service
- Diabetes Education / Diabetes Self-Management Group
- Dietetics
- Disability Services
- District Nursing and Palliative Care Service
- Falls Prevention / Falls & Balance Clinic
- Family Day Care
- Hip and Knee Joint Rehabilitation Group
- Home Care Packages
- Hospital Admission Risk Program
- Hydrotherapy
- Integrated Family Services
- Lactation services
- Life Skills for Women
- Look Good...Feel Better
- Maternal and Child Health
- Meals on Wheels
- Men's Shed (The San Remo Shack)
- Needle Syringe Program
- Nursing programs
- Occupational Therapy
- Physiotherapy
- Planned Activity Groups: General, Men Specific and Dementia Specific
- Podiatry & Footcare
- Post-Acute Care
- Pregnancy Care Clinic
- Pulmonary Rehabilitation Program
- Residential In Reach
- Smoking Cessation Program
- Social Work
- Speech Pathology
- Stomal Therapy
- Supported Playgroups
- Transition Care Program in the home
- Walking Groups (Heart Foundation)
- Weight Wise
- Womens Health
- Wonthaggi Wheezers (Pulmonary Rehabilitation Support Group)

Our Workforce

Workforce Data

Full Time Equivalent (FTE) staff employed at 30 June 2016

	June Current Month FTE		June YTD FTE	
	2015	2016	2015	2016
Nursing Services	167.4	158.0	166.0	159.8
Administration and Clerical	63.5	63.1	61.8	59.6
Ancillary Staff (Allied Health)	44.1	45.5	43.4	43.5
Hospital Medical Officers	16.2	15.8	13.4	15.4
Medical Officers	0.0	0.0	0.0	0.5
Hotel and Allied Services	58.9	56.6	62.0	58.1
Medical Support Services	44.0	53.5	48.1	54.2
Sessional Clinicians	4.5	3.6	5.2	4.0
Total	**405.6**	**396.0**	**407.8**	**395.2**

Equal Employment Opportunity

BCH actively promotes the practices of Equal Employment Opportunity (EEO) and has established processes to ensure EEO principles are upheld and applied to all Human Resource activity including recruitment, promotion and staff education. BCH complies with all EEO legislative requirements.

BCH is committed to providing a safe and healthy workplace for its staff and volunteers. The safety of our workplace is essential to ensure we can consistently deliver high quality health care to our patients, clients and residents to meet their individual needs.

Our Workforce

Occupational Health & Safety

BCH is committed to providing a safe and healthy environment for everyone, including staff, visitors, patients, residents, clients, volunteers and contractors. The Occupational Health & Safety (OH&S) program focuses on continuous improvement in health and safety in order to maintain a healthy and safe environment and achieve compliance with legislative and regulatory obligations.

All safety matters are reported and monitored through the Occupational Health and Safety Sub Committee of the Improving Safety Committee, which reports to the Executive and Board of Management.

Work achieved in the 2015/16 period has culminated in the development of the Improving Safety Strategy for 2016/17, which has identified key projects relating to:

- Improved incident management and investigation
- Fire Safety and Emergency Management
- Enhanced training for staff in the management of aggression
- Improved work environment through proactive capital management and workplace design
- Enhanced OH&S workplace inspections and improvement plans

Orientation & Credentialing

All staff commencing with BCH undertake an orientation program to ensure they understand their role as well as the broader organisation.

Credentialing for all clinical staff is undertaken by the interdisciplinary Credentialing and Scope of Practice Committee.

Employee Assistance Program

BCH acknowledges the importance of supporting staff, volunteers and their families. A confidential Employee Assistance Program (EAP) is available to all staff, volunteers and their immediate families and provides access to external counselling and support.

WorkCover

The work undertaken in the 2015/16 period has enabled the health service to progress the implementation of preventative and management strategies to reduce risks in our workplace and eliminate or minimise injuries. Specific WorkCover improvement strategies for 2016/17 include:

- Establishing an alternate duties register to facilitate swift return to work following an injury
- Purchase of equipment to reduce Manual Handling
- Occupational Violence training

During 2015/16 there were nine new standard WorkCover claims. Two of these claims were rejected by the WorkCover agent. The premium is calculated based on the remuneration paid and claims experience and cost estimates.

WorkCover Premiums

Year	Premium
2015/16	$522,255
2014/15	$432,171
2013/14	$293,451

Number of Standard Claims

Year	Claims
2015/16	9
2014/15	7
2013/14	5

Occupational Violence Statistics

	2015-16
Workcover accepted claims with an occupational violence cause per 100 FTE	0.25
Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	1.51
Number of occupational violence incidents reported	65
Number of occupational violence incidents reported per 100 FTE	16.45
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	10.77%

Environmental Sustainability

BCH is committed to minimising our ecological footprint and protecting the environment to ensure its sustainability. When planning improvements, consideration is given to conserving energy and water, reducing greenhouse emissions and improving waste management, transport and fleet efficiency.

Cleaning

To comply with the Victorian Cleaning Standards for Health Services internal cleaning audits are conducted monthly for Very High and High Risk areas and every three months for Moderate Risk. Very High Risk areas have an Agreed Quality Level (AQL) of 90% whilst High and Moderate Risk areas have an AQL of 85%. External audits are conducted by a third party on an annual base and all audit results are reported to the Department of Health twice a year. BCH achieved results above the Agreed Quality Level for all areas.

Waste Management

BCH continues to enhance the comprehensive waste management program in place with further improvements in recycling anticipated with the introduction of new information posters and accessible bin placement.

Moderate Risk Area	89%
High Risk Area	96%
VeryHigh Risk Area	93%

Fleet Management

The staff and volunteers at BCH rely on fleet vehicles as a core tool of trade. Every day staff are out and about in the community providing care to people in their homes, or in other facilities, to improve their health and to keep them out of hospital. Fleet cars become like an office and are essential to ensure important services are provided. They are also important for transporting patients and families to appointments as necessary. Eco friendly vehicles are a priority when replacing and purchasing new cars at BCH. The addition of hybrid vehicles to the fleet has had a significant impact on the environmental footprint with a reduction in fuel consumption.

Of note, our wonderful volunteers assist with the cleaning of the fleet vehicles which is very much appreciated by all BCH users.

Our Environmental Performance

Electricity Usage and Cost

	2013/14	2014/15	2015/16
Electricity Usage (kilowatts)	1,996,231	2,323,678	2,348,874
Cost	$298,351	$282,793	$285,227

Gas Usage and Cost

	2013/14	2014/15	2015/16
Gas Usage (Litres)	422,103	464,111	465,618
Cost	$221,131	$173,867	$176,275

Water Consumption and Cost

	2013/14	2014/15	2015/16
Water consumed (Kilolitres)	17,637	17,766	17,070
Cost	$58,372	$56,059	$62,231

Fuel Consumption

	2013/14	2014/15	2015/16
Fuel Consumption (litres)	63,211	91,210	74,428
Kilometres travelled	682,109	1,096,650	833,714

Our Executive

Chief Executive Officer

JAN CHILD (Interim at 30 June, appointed permanently subsequent to year end)

RN, GradDip Behav Sc. Masters PH, GAICD

Jan is an experienced senior executive with more than 30 years experience in public health. She is a Registered Nurse and holds an Adjunct Clinical Associate Professor Nursing post at Monash University.

Jan has worked across all sectors of Public Health, having trained in rural Western Victoria, and most recently at Peninsula Health and before at Alfred Health, DHHS and Springvale Community Health. She is a Graduate of the Australian Institute of Company Directors and is also a surveyor for the Australian Council of Healthcare Standards.

Executive Director of Clinical Services / Chief Nurse & Midwife

DEBBIE ROGERS

RN, RM, Adv. Dip. Bus Man. Onc. Cert

Debbie is a Registered Nurse and Midwife with extensive clinical and leadership experience and has focused on midwifery, women's and children's health over the past nineteen years.

Debbie has worked in leadership roles in metropolitan, regional and rural health services and joined the Bass Coast Health Executive team in June 2014.

Executive Director of Medical Services (Acting)

ANDRE NEL

BMed, MBBCh, FRACMA, MBA

Andre holds a Bachelor of Medicine and Bachelor of Surgery and completed his internship in Johannesburg. Andre completed his FRACMA in 2001 and has held senior roles in Victoria, New Zealand and South Africa.

His most recent roles include Executive Director Medical Services at Western Health and prior to this Bendigo Health Care Group. Andre joined BCH in February 2016.

Chief Financial Officer (Acting)

PHILLIP MADDOCK

CA, B Bus (Accounting)

Phillip is a qualified Chartered Accountant with more than 10 years experience in financial and business management. He has held senior accounting and finance roles primarily in the Education sector, and has a Bachelor of Business (Accounting).

Phillip commenced with Bass Coast Health as Finance Manager in October 2015 and joined the Executive Team in March 2016 to act in the role of Chief Financial Officer.

Director of Quality & Risk

NONI BOURKE

BAppSc (Speech Pathology), Grad Cert Gerontology, Grad Cert Health Professional Education, Diploma Project Management

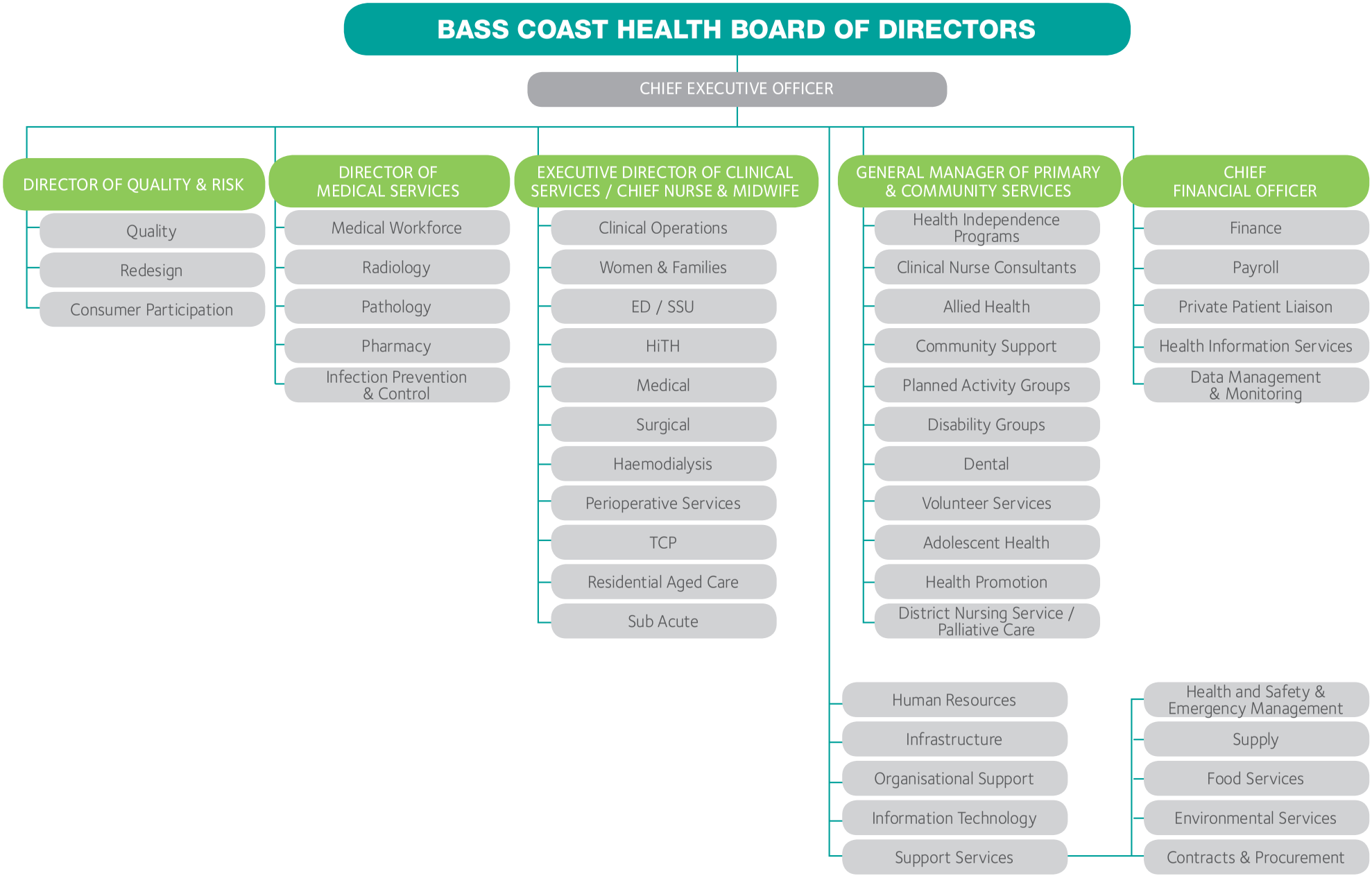
Noni has 25 years experience in public health having worked as a Speech Pathologist and within Quality across acute, sub-acute, aged and community health services. She has worked in clinical and leadership roles in metropolitan and rural and remote health services and joined Bass Coast Health in May 2016.

General Manager Primary and Community Services

PAUL GREENHALGH (Acting at 30 June, appointed permanently subsequent to year end)

Ba Nsg, RN, Dip. Business Management, Grad Cert Health Promotion

Paul has 25 years experience in public health, having worked as a Registered Nurse in acute, sub-acute, aged and community health settings. He has also been associated with Primary Health Care organisations and has leadership and management experience in both rural and metropolitan hospitals, as well as the Community Health area.


BASS COAST HEALTH BOARD OF DIRECTORS
CHIEF EXECUTIVE OFFICER
DIRECTOR OF QUALITY & RISK
Quality
Redesign
Consumer Participation
DIRECTOR OF MEDICAL SERVICES
Medical Workforce
Radiology
Pathology
Pharmacy
Infection Prevention & Control
EXECUTIVE DIRECTOR OF CLINICAL SERVICES / CHIEF NURSE & MIDWIFE
Clinical Operations
Women & Families
ED / SSU
HiTH
Medical
Surgical
Haemodialysis
Perioperative Services
TCP
Residential Aged Care
Sub Acute
GENERAL MANAGER OF PRIMARY & COMMUNITY SERVICES
Health Independence Programs
Clinical Nurse Consultants
Allied Health
Community Support
Planned Activity Groups
Disability Groups
Dental
Volunteer Services
Adolescent Health
Health Promotion
District Nursing Service / Palliative Care
CHIEF FINANCIAL OFFICER
Finance
Payroll
Private Patient Liaison
Health Information Services
Data Management & Monitoring
Human Resources
Infrastructure
Organisational Support
Information Technology
Support Services
Health and Safety & Emergency Management
Supply
Food Services
Environmental Services
Contracts & Procurement

Corporate Governance

BOARD OF DIRECTORS

The Board of Directors (the 'Board') of Bass Coast Health is accountable to the Minister for Health & the Minister for Ambulance Services for Bass Coast Health's performance. The role of the Board is to steer the entity on behalf of the Minister in accordance with government policy. This governance role broadly involves strategic leadership of the organisation, monitoring performance against agreed objectives and ensuring accountability and compliance.

Functions of the Board include:

- setting BCH vision, mission and values, and strategic direction
- approving the annual operating and capital budgets,
- ensuring effective systems are established and monitored to deliver effective and efficient health services that meet the needs of the communities served, and that incorporate the views of users of health services,
- ensuring effective and accountable systems are in place to monitor and improve the quality and effectiveness of health services provided by BCH,
- establishing and monitoring robust data and reporting systems,
- establishing and reviewing Board level policies on an annual basis,
- assuming overall responsibility for clinical governance structures within the Service, and for ensuring that patient care is safe, meets required standards and there are continuous quality improvement measures in place,
- developing arrangements with other health care agencies and health service providers to enable effective and efficient service delivery and continuity of care,
- monitoring and reviewing the effectiveness and currency of internal financial and operational risk management, compliance and reporting systems.

Chair (July 2015-Feb. 2016)

PETER LAYDON *Grad. Dip. MGT*

Peter had a strong background in senior and executive management in both the public and private sectors and was an active board member of several local organisations within the Bass Coast community. Peter had extensive experience in Corporate Governance, Strategic Planning and Change Management. Peter retired as Board Chair and from the Board in March 2016.

Interim Chair (March-June 2016)

DON PAPROTH *BA Arts, Dip Ed*

Don stepped in as Interim Chair in March and brought with him 48 years experience in education, working as a secondary teacher, principal, deputy regional director and as the director of major projects in the Gippsland Region with the Department of Education and Early Childhood Development. He was most recently Chair of the Victorian Institute of Teaching. Don has a strong commitment to education, particularly in the area of mentoring new principals and developing aspiring school leaders. He has also been very active in endeavours to improve learning opportunities for communities through initiatives for education precincts in a number of rural centres.

Deputy Chair

CHRISTINE HAMMOND *Adv. Cert. MGT, GAICD*

Christine has strong experience in business management in both public and private sectors, including 18 years in the health industry. Christine was a former director of Bass Coast Community Health Service and was appointed to the Board of Bass Coast Health in July 2014. Christine is the Chair of the Finance, Audit & Risk Committee.

Corporate Governance

BOARD OF DIRECTORS

MARGARET JARVIS *BA Soc. Sci., Grad. Dip. Conflict Resolution*

Margaret is a Conciliation Officer for the Accident Compensation Conciliation Service. Margaret has served as a Board Director since July 2009 and is a member of the Community Advisory Committee, Remuneration Committee and Quality & Clinical Governance Committee.

MARY O'CONNOR *J.P.*

Mary is a business proprietor of three national franchise businesses, a Justice of the Peace in Victoria and a member of the South Gippsland branch of Justices of the Peace. Mary is also the President of the Wonthaggi branch, Ambulance Victoria and has active roles with Victorian Police, Rotary and in the criminal justice system. Mary is an active volunteer with many community groups, and was appointed to the board in 2004. Mary is Chair of the Community Advisory Committee and a member of the Remuneration Committee.

MIM KERSHAW

Mim has more than 30 years management experience in both private and publically listed companies. Mim has experience in financial management, strategic planning, team development, ethical sourcing and quality assurance and quality control. Mim is a member of the Finance, Audit & Risk Committee.

MARY WHELAN *BApp Sc (Physiotherapy), Grad Dip Man Therapy, Cert App Ergonomics for Injury Management, Cert IV Workplace Training*

Mary is a former clinical physiotherapist with 38 years experience in public health and private practice. She founded a company StandEzy Solutions to design and develop mobility aides to address the needs of patients and the OH&S of staff in hospitals and aged care facilities. Mary is the Chair of Quality & Clinical Governance Committee and a member of the Community Advisory Committee.

TIM LARGE *B. Com, CA, GAICD*

Tim has 30 years of experience in executive and non-executive roles across Asia and Australia encompassing finance, strategic and commercial leadership roles. He is a Chartered Accountant, a Graduate of the Australian Institute of Company Directors, and now involved in both exececutive and non-executive roles while actively seeking to give back to the community. Tim is a member of the Finance, Audit and Risk Committee, the Community Advisory Committee and the Remuneration Committee.

PETER HARCOURT *OAM, MBBS FACSP, FASMF Dip. Obs.*

Peter is a practising clinician in sport and exercise medicine. He has also held positions in administration and management with experience in board governance, clinical review, audit and risk management. Peter has been awarded an OAM for services to sports medicine and is a member of the Quality and Clinical Governance Committee.

NEVILLE GOODWIN *OAM*

Neville is the Deputy Chairman for Grantville Hall Committee, Representative for the Victorian Desalination Plant and Past President/President Elect of Rotary Club. Neville is a member of the Quality & Clinical Governance Committee and Community Advisory Committee.

SANDRA BELL (July-December 2015)

Sandra was a Business Manager for Midnightsky: a company that assists organisations to develop their vision, mission and personality; facilitates individuals and teams to become influential communicators. Sandra was previously at the Department of Health and Human Services, is the current President of Social Housing Victoria and Vice President of YWCA Victoria and a member of the AICD. Sandra retired from the Board in December 2015.

DANNY LUNA *B.Bus (Accounting), B.Bus (Local Govt Mgmt), FCPA, JP*

Danny is the independent member of the Finance, Audit & Risk Committee. Danny has a strong background in senior executive management in the public sector. He has extensive experience in finance, corporate governance, strategic planning and risk management. Danny also has extensive experience on local community boards.

JIM FLETCHER *BHA, MIPAA, AFCHSE, MAICD*

Jim is the Department of Health & Human Services appointed delegate. He has more than 30 years experience at a Senior Executive and Board level in the Health and Human Services industry across both Metropolitan and Regional Victoria. His background includes executive appointments with the Department of Health, Chief Executive Officer of the state's 3 largest psychiatric hospitals, leading these services through major reform and more recently Chief Executive of Western District Health Service until retirement in July 2014 .He is currently the Minister's delegate to the BCH Board.

Corporate Governance

BOARD OF DIRECTORS

Board Membership and meeting attendances

Board Attendance	Board of Directors	Finance, Audit & Risk Committee	Visiting Medical Office Consultative Committee	Quality & Clinical Governance Committee	Remuneration Committee	Community Advisory Committee
Board Directors						
Peter Laydon	100%	86%			100%	
Don Paproth	73%	67%	100%	80%	100%	
Christine Hammond	73%	90%				
Margaret Jarvis	73%			60%	100%	67%
Mary O'Connor	64%		100%		67%	100%
Mim Kershaw	73%	80%				33%
Neville Goodwin	9%					
Peter Harcourt	82%		100%	100%		
Mary Whelan	80%			100%		100%
Tim Large	100%	90%			67%	67%
Sandy Bell	80%			50%	100%	
Board Delegate						
Jim Fletcher	100%	78%		60%		
Independent Member of Finance, Audit and Risk Committee						
Danny Luna		90%				

Retirements, re-appointments and appointments to the Board of Directors

The following occurred in 2015/16:

Retirements	
Sandra Bell	1 July 2014 to 16 December 2015
Peter Laydon	1 July 2012 to 29 February 2016
Reappointments	
Margaret Jarvis	1 July 2015 to 30 June 2018
New appointments	
Don Paproth	1 July 2015 to 30 June 2018
Tim Large	1 July 2015 to 30 June 2018
Mary Whelan	11 August 2015 to 30 June 2018

Corporate Governance

BOARD COMMITTEES

Finance, Audit & Risk Committee

The Finance, Audit and Risk Committee is a Board Sub-Committee responsible for oversight of, and advice and recommendations to, the Board of Directors on:

- Financial management, (including asset management)
- Risk management, (including compliance management) and
- Internal and external audit

Visiting Medical Officer Consultative Committee

The Visiting Medical Officer Consultative Committee makes recommendations on matters related to medical services and ensures effective communication between the health service and Visiting and Consultant Medical Officers.

Remuneration Committee

The Remuneration Committee is a Board subcommittee that is responsible for facilitating the remuneration and performance processes for the Chief Executive Officer (CEO) and for providing recommendations to the Board, in line with the Government Sector Executive Remuneration Panel (GSERP) requirements.

Community Advisory Committee

The primary role of the Community Advisory Committee is to bring the voice of consumers, carers and the community into decision-making processes within BCH, ensuring consumer and carer involvement in the planning, design, delivery and evaluation of healthcare at the individual level as well as program, department and health service level.

Quality & Clinical Governance Committee

The Quality and Clinical Governance Committee is a Board Sub-Committee responsible for implementation of a strong Quality and Clinical Governance framework that encompasses the domains of quality and safety. The domains of quality and safety incorporate:

- consumer participation
- clinical effectiveness
- effective workforce
- risk management

Statement of Priorities

PART A: STRATEGIC PRIORITIES

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

In 2015-16 BCH will contribute to the achievement of these priorities by:

Domain	Action	Deliverable	Outcome
Patient Experience and Outcomes	Drive improved health outcomes through a strong focus on patient-centred care in the planning, delivery and evaluation of services and the development of new models for putting patients first.	All new projects and initiatives undertaken will include community consultation as a core component. This will include establishing a community consultative group for the new Phillip Island Health & Medical Hub.	**Achieved:** • Community representation on key committees including National Standards working groups, Advance Care Planning working group. • Phillip Island Health Hub (PIHH) community consultative group established and actively involved in ongoing planning. Communication plan developed for Phillip Island project including multiple BCH presentations to community groups. • Consumer Participation Framework established.
	Strengthen the response of health services to family violence. This includes implementing interventions, processes and systems to prevent, identify and respond appropriately to family violence at an individual and community level.	Key staff to undertake training in identifying and responding to affected clients and patients. We will target staff in Midwifery Services, Maternal and Child Health Service and Community Services.	**In progress:** • BCH staff attended DHHS Strengthening Hospital Responses to Family Violence forum. • Progress towards implementation of the Strengthening Hospital Responses to Family Violence service model across BCH will continue over the next 12 months. • A gap analysis against the Child Safe Standards has been completed and an action plan endorsed.
	Use consumer feedback and develop participation processes to improve person and family centred care, health service practice and patient experiences.	Based on consumer feedback, introduce a family-initiated Medical Emergency Team (MET) call across the health service.	**In progress:** • Policy and procedure developed. Implementation has commenced as part of the revision of the organisation-wide emergency code system.

Statement of Priorities

PART A: STRATEGIC PRIORITIES

Domain	Action	Deliverable	Outcome
	Identify service users who are marginalised or vulnerable to poor health, and develop interventions that improve their outcomes relative to other groups, for example, women, Aboriginal people, people affected by mental illness, people at risk of elder abuse, people with disability, homeless people, refugees and asylum seekers, people whose alcohol and other drug use is damaging their health or impacting on their recovery.	Participate in the South Coast Primary Care Partnership Health Literacy pilot.	**Achieved:** • An organisational Health Literacy audit has been conducted and the Gippsland Guide to Becoming a Health Literate Organisation piloted by Allied Health Services.
	Support the effective delivery of alcohol and other drug treatment services.	Develop and run ICE forums in collaboration with Victoria Police, Bass Coast Shire and local schools.	**Achieved:** • Four ICE forums were held in 2015 and 2016 in collaboration with Victoria Police, Bass Coast Shire, local schools, Self Help Addiction Resource Centre (SHARC) and Turning Point Alcohol and Drug Centre. • BCH have appointed an ICE family support worker.
	Improve the health outcomes of Aboriginal and Torres Strait Islanders by increasing accessibility and cultural responsiveness of the Victorian health system.	Implement the Gippsland Aboriginal Health Cultural Competence Framework.	**In progress:** • An organisational audit has been completed, facilitated by the Aboriginal Regional Development Officer from the Gippsland Sectoral Development team. • A project plan for BCH to implement the Framework has been developed and the actions within the plan will be implemented through the BCH Diversity Committee.
	Implement an organisation-wide approach to advance care planning including a system for identifying, documenting and/or receiving advance care plans in partnership with patients, carers and substitute decision makers so that people's wishes for future care can be activated when medical decisions need to be made.	Complete the development and implementation of Advance Care Planning throughout the organisation and in the community.	**Achieved:** • A suite of policies supporting Advance Care Planning have been developed. • Admission and care planning documentation has been reviewed to facilitate identification and enacting of patient wishes. • Clinical champions have been trained and support Advance Care Planning across the organisation.

Domain	Action	Deliverable	Outcome
Governance, Leadership & Culture	Demonstrate an organisational commitment to Occupational Health and Safety, including mental health and wellbeing in the workplace.	Develop and implement a Staff Health and Wellbeing Plan.	**In progress:** • Health and Wellbeing plan commenced based on feedback from People Matter survey, including strategies for mental health and wellbeing in the workplace.
	Ensure accessible and affordable support services are available for employees experiencing mental ill health. Work collaboratively with the Department of Health and Human Services and professional bodies to identify and address systemic issues of mental ill health amongst the medical professions.	Complete a review of the existing Employee Assistance Program and implement any changes required to ensure any mental health issues are addressed in a timely and systematic manner as required.	**Achieved:** • Review of EAP services conducted. The top five presenting issues were identified including mental health issues. • EAP contract with current provider was extended until 30 September 2016.
	Monitor and publically report incidents of occupational violence. Work collaboratively with the Department of Health and Human Services to develop systems to prevent the occurrence of occupational violence.	Capture occupational violence incidents on Riskman and publish as required in the 2015/16 Quality of Care Report.	**Achieved:** Occupational violence incidents are captured on RiskMan and investigated. Risk assessments are undertaken following incidents of occupational violence to identify and reduce risks. Code Grey and training relating to occupational violence has been reviewed to develop an improved organisational response to incidents of occupational violence.
	Promote a positive workplace culture and implement strategies to prevent bullying and harassment in the workplace. Monitor trends of complaints of bullying and harassment and identify and address organisational units exhibiting poor workplace culture and morale.	Develop and implement a People and Culture Plan with a focus on improving organisational culture, safety and further developing the skills of the staff.	**In progress:** • Bullying & Harassment Risk Management Framework has been developed. • Framework identifies strategies to prevent and to monitor bullying & harassment in the workplace.
		Mandatory bullying and harassment training will be delivered to all staff upon commencement of employment and bi-annually thereafter.	**Achieved:** • Mandatory online learning package implemented and incorporated into education framework.
	Undertake an annual board assessment to identify and develop board capability to ensure all board members are well equipped to effectively discharge their responsibilities.	Undertake the Australian Centre for Healthcare Governance Board assessment process to identify opportunities to further develop Board capability.	**Achieved:** • ACHG Health Governance evaluator questionnaire and individual interviews completed by Board of Directors. • Key recommendations identified and actions for the delivery of these recommendations agreed. • Enhanced Board induction program developed and Board Governance documents including Terms of Reference and By Laws reviewed.

Statement of Priorities

PART A: STRATEGIC PRIORITIES

Domain	Action	Deliverable	Outcome
	Apply existing capability frameworks and clinical guidelines to inform service system planning, giving consideration to the capability of neighbouring services and how best to allocate available resources so as to deliver the maximum benefit to the local community.	Participate in the Maternity and Newborn Capability framework Gippsland review project.	**Achieved:** • Assessment and report of Capability undertaken by BCH and provided to DHHS. • BCH actively participate in the Gippsland Maternity working party. Project worker has been appointed and there is a separate working group developing obesity guidelines and BMI guidelines for standardisation throughout the region. BCH is a member of the obesity working group.
	Build workforce capability and sustainability by supporting formal and informal clinical education and training for staff and health students, in particular inter-professional learning.	Develop a medical workforce plan for Bass Coast Health for 2016-2020.	**In progress:** • Participation in Regional Senior Medical Staff review by Aspex Consulting. • Independent Clinical Governance Review including medical workforce and models of care undertaken and will inform future medical workforce plan.
	Support excellence in clinical training through productive engagement in clinical training networks and developing health education partnerships across the continuum of learning.	Build workforce capability and sustainability by supporting formal and informal clinical education on relevant systems and programs (for example PROMPT and e3 learning).	**Achieved:** • e3 learning platform implemented throughout organisation. • Organisation-wide Education Framework developed including identification of mandatory training and core competencies.
Safety and quality	Ensure management plans are in place to prevent, detect and contain Carbapenem Resistant Enterobacteriaceae as outlined in Hospital Circular 02/15 (issued 16 June 2015).	Implement Carbapenem Resistant Enterobacteriaceae management plans in line with National Safety and Quality Standard 3.	**Achieved:** • Policy incorporating reporting mechanisms developed and implemented including targeted staff education. • Admission procedure revised to include targeted questions.
	Implement effective antimicrobial stewardship practices and increase awareness of antimicrobial resistance, its implications and actions to combat it, through effective communication, education, and training.	Establish an Antimicrobial Stewardship working party to oversee audit results and to progress required education and training.	**Achieved:** • Antimicrobial Stewardship working group established and overseen by DMS. • Monitoring in place including audit schedule and annual review of Antibiogram. • Staff education ongoing including regular newsletter, annual antibiotic awareness week and informal education.

Domain	Action	Deliverable	Outcome
	Ensure that emergency response management plans are in place, regularly exercised and updated, including trigger activation and communication arrangements.	Develop and implement emergency management training (including fire drill training). Provide ongoing professional development for the Chief Warden.	**In progress:** • Emergency Management Governance structure revised and new Incident Command System established and being progressed. • Emergency Management responsibility built into formal role of Manager Health, Safety and Emergency Management.
	Develop perinatal mortality and morbidity review processes in alignment with the Clinical Practice Guideline for Perinatal Mortality.	Complete a review of existing perinatal morbidity and mortality processes and implement any changes required to ensure alignment with the Clinical Practice Guideline for Perinatal Mortality.	**Achieved:** • Perinatal review meeting commenced in collaboration with Monash Health. • Terms of Reference for revised committee developed and agreed. • Participation by BCH in Regional Perinatal discussions.
Financial sustainability	Improve cash management processes to ensure that financial obligations are met as they are due.	Daily review of cash management process with aim to improve creditor and debtor days outstanding by 5%.	**In Progress:** • Cash management improved. Daily updating of the cash flow report undertaken to allow forecasting between funding periods. Patient fee debtors reduced by year end.
	Identify opportunities for efficiency and better value service delivery.	Implement strategies identified in the 2015-2016 Financial Improvement Plan to improve financial sustainability.	**In Progress:** • A number of strategies identified in the 2015-2016 Financial Improvement Plan have been implemented with positive results. • Analysis and action plans in key financial risk areas have been completed including ED funding paper to DHHS, Tied Funds paper and subsequent development of a Capital Management Plan, and the Armitage House strategy. • Expenditure and Revenue strategies have been incorporated into 2016-2017 budget.
Access	Implement integrated care approaches across health and community support services to improve access and responses for disadvantaged Victorians.	Undertake redesign projects to improve admission and discharge processes to increase client access to services.	**Achieved:** • Armitage House strategy implemented with increased access to inpatient sub-acute and medical beds. • "Going Green" project developed to improve performance and access for Emergency, Inpatient Areas and Diversionary programs. • Planning commenced for a range of further initiatives including development of BCH HITH program and Medical, Surgical and Sub-Acute care models with aim to treat more local people, locally.

Statement of Priorities

PART A: STRATEGIC PRIORITIES

Domain	Action	Deliverable	Outcome
	Progress partnerships with other health services to ensure patients can access treatments as close to where they live when it is safe and effective to do so, making the most efficient use of available resources across the system.	Develop a collaborative partnership with Alfred Health in the areas of cardiology, infection control and leadership to develop capacity to enable patients to access clinical care locally.	**Achieved:** • Cardiology agreement developed and implemented with Peninsula Cardiology services and Peninsula Health - commencement of outpatient Cardiology at Wonthaggi and San Remo sites. • Agreement developed with Alfred Health re Geriatrician visits. • Partnership arrangement developed with Monash Health for Perinatal.
	Optimise alternatives to hospital admission.	Commission the new short stay unit by November 2015.	**Achieved:** • Short Stay Unit commissioned 23 November 2015. Post implementation review completed with DHHS.
	Contribute to the provision of additional dental services to achieve the targets, milestones and objectives of the National Partnership on Adult Public Dental Services.	Increase dental activity in accordance with National Partnership Agreement funding.	**Achieved:** • Chair capacity increased through the employment of a dentist funded by the National Partnership Agreement (NPA2). Client and waiting list targets and objectives of the NPA2 have been achieved.

Statement of Priorities

PART B: PERFORMANCE PRIORITIES

Financial Sustainability Performance

Operating Results	Target	2015/16 Result
Annual Operating Result ($m)	-$2.24	-$0.97
WIES Activity Performance		
Percentage of WIES (public and private) performance to target	100%	103.1%
Cash Management		
Creditors average days	< 60 days	93 days
Debtors average days	< 60 days	31 days
Asset Management		
Asset management plan	Full compliance	Achieved
Adjusted current asset ratio	0.70	0.58
Days of available cash	14 days	4.62 days

Safety and Quality Performance

Key performance indicator	Target	2015/16 Result
Patient experience and outcomes		
Victorian Healthcare Experience Survey - data submission	Full compliance	Achieved
Victorian Healthcare Experience Survey - patient experience Quarter 1 (Jul to Sep Result - Taken from Q2 Monitor)	95% positive experience	98% Achieved
Victorian Healthcare Experience Survey - patient experience Quarter 2 (Oct to Dec Result -Taken from Q3 Monitor)	95% positive experience	95% Achieved
Victorian Healthcare Experience Survey - patient experience Quarter 3 (Jan to March Result - Taken from Q4 Monitor)	95% positive experience	97% Achieved
Maternity - Percentage of women with prearranged postnatal home care	100%	98%
Governance, Leadership and Culture		
Patient Safety Culture	80	79%
Safety and Quality		
Health Service Accreditation	Full compliance	Achieved
Residential Aged Care Accreditation	Full compliance	Achieved
Cleaning Standards (overall)	Full compliance	Achieved
Cleaning Standards (AQL-A)	90 points	93
Cleaning Standards (AQL-B)	85 points	96
Cleaning Standards (AQL-C)	85 points	89
Submission of data to VICNISS (2)	Full compliance	Achieved
Hand Hygiene (rate) - Quarter 2	75%	74%
Hand Hygiene (rate) - Quarter 3	77%	93%
Hand Hygiene (rate) - Quarter 4	80%	86%
Health Care Worker immunisation - influenza (20 April 2015 to 21 August 2015)	75%	86%

Statement of Priorities

PART B: PERFORMANCE PRIORITIES

Access Performance

Key Performance Indicator	Target	2015/16 Actuals
Emergency Care		
Percentage of ambulance transfers within 40 minutes	90%	89%
Percentage of Triage Category 1 emergency patients seen immediately	100%	100%
Percentage of Triage Category 1 to 5 emergency patients seen within clinically recommended times	80%	82%
Percentage of emergency department patients with a length of stay less than four hours	81%	75%
Number of patients with a length of stay in the emergency department greater than 24 hours	0	6

Funding Type

	2015/16 Activity Achievement
Acute Admitted	
WIES Public	3,420.53
WIES Private	281.61
Total PPWIES (Public and Private)	3,702.14
WIES DVA	123.98
WIES TAC	10.37
WIES TOTAL	3,836.49
Subacute & Non-Acute Admitted (Actual Bed Days)	
Rehab Public	1,084
Rehab Private	128
GEM Public	2,768
GEM Private	359
GEM DVA	114
Palliative Care Public	431
Palliative Care Private	70
Palliative Care DVA	16
Subacute Non-admitted	
Health Independence Program	11,065
Aged Care	
Residential Aged Care (Bed Days)	25,773
HACC (Client Contact)	70,700
Mental Health and Drug Services	
Drug Services	309
Primary Health	
Community Health / Primary Care Programs	9,269

Statutory Requirements

Finance

The information is based on the Standing Directions of the Minister for Finance (Section 4 Financial Management Reporting) and Financial Reporting Directions and has been prepared and is available to the relevant Minister, Member of Parliament and the public on request.

Statement of Availability of Additional Information

The information has been prepared in compliance with the requirements of FRD 22F Standard Disclosures in the Report of Operations and the details have been retained by BCH and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the Freedom Of Information requirements, if applicable).

Buildings & Maintenance Compliance

Bass Coast Health complies with the Building Act 1993 under the guidelines for publicly owned buildings issued by the Minister for Finance 1994 in all redevelopment and maintenance.

Competitive Neutrality

The service's policies and procedures complied with competitive neutrality requirements.

Victorian Industry Participation Policy Act

There were no contracts in 2015/16 to which the Victorian Industry Participation Policy Act 2003 applied.

Carers Recognition Act 2012

In accordance with the Carers Recognition Act 2012 BCH takes all practical measures to ensure that staff and volunteers respect and recognise carers, support them as individuals, recognise their efforts and dedication, take into account their views and cultural identity, recognise their social wellbeing and provide due consideration of the effect of being a carer on matters of employment and education.

Protected Disclosure Act 2012

BCH is subject to the Protected Disclosure Act 2012 that replaced the former Whistleblowers Protection Act 2001. The Act came into effect with a purpose to facilitate disclosures of improper conduct by public officers, public bodies and to provide the appropriate level of protection for people who make disclosures without fear of reprisal. BCH complies with the Protected Disclosure Act 2012. There were no complaints made under this Act against BCH or its staff for 2015/16.

Fees & Charges

All fees and charges charged by BCH are regulated by the Commonwealth Department of Health & Ageing and the Hospitals & Charities (Fees) Regulations 1986, as amended and as otherwise determined by Department of Health and Human Services.

Private admitted fees as set by the Department of Health and Human Services increased by 2.9% in this financial year. Basic daily fees as set by the Department of Health and Ageing for nursing home and hostel residents has increased by 2.1% in this financial year.

Operational & Budgetary Objectives & Factors Affecting Performance

Each year, BCH is required to negotiate a Statement of Priorities with the Department of Health and Human Services. The Statement incorporates both system-wide priorities set by Government and locally generated agency-specific priorities. 70% of deliverables from the Statement of Priorities have been met for 2015/16.

The Board budgeted for a $2.25m deficit in financial position before capital items and depreciation for the 2015/16 financial year. The final result for the year was a $972k deficit before capital items and depreciation. This represents an improvement over last year's result by $2.94m.

Events Subsequent to Balance Date

There have been no events subsequent to balance date that will have a significant effect on the operations of the health service in subsequent years.

Financial Requirements

Consultancies Under $10, 000

There were eleven (11) consultants engaged under $10,000 by the service during the reporting period, totalling $29,381.

Consultancies Over $10, 000

Consultant	Purpose of consultancy	Start Date	End Date	Total approved project fee (ex GST)	Expenditure 2015/16 (ex GST)	Future Expenditure (ex GST)
Workplace Plus	Human Resource Review	01/07/15	30/06/16	$15,600	$15,600	Nil
Davison Trahaire Corpsych	Employee Counselling Services	01/07/15	30/06/16	$25,345	$25,345	Nil
Ernst & Young	Aged Care Review	01/07/15	30/06/16	$32,400	$32,400	Nil
RSM Bird	Business Case Analysis	01/07/15	30/06/16	$11,995	$11,995	Nil

Summary of Financial Results FOR THE YEAR ENDED 30 JUNE 2016

The following table provides a summary of the financial results for the year, with comparative results for the preceding four financial years. Previous years' data is included on the same basis where possible for comparative purposes.

Financial ($000's)	2015/16	2014/15	2013/14	2012/13	2011/12
Total Revenue	55,832	54,994	46,360	41,993	43,589
Total Expenses	57,779	58,172	47,980	44,534	43,523
Net Result for the Year *(inc. Capital and Specific Items)*	(1,947)	(3,178)	(1,620)	(2,541)	66
Retained Surplus (Accumulated Deficit)	(2,333)	(386)	(1,706)	(86)	2,455
Total Assets	54,693	56,673	52,015	43,332	43,455
Total Liabilities	22,243	22,276	18,938	15,305	12,886
Net Assets	32,450	34,397	33,077	28,027	30,568
Total Equity	32,450	34,397	33,077	28,027	30,568

Revenue Indicators

Average Collection Days	2015/16	2014/15	2013/14	2012/13	2011/12
Private	51	54	52	54	59
TAC	0	0	0	0	0
VWA	60	62	59	57	57
Other Compensable	0	0	0	0	0
Psychiatric	0	0	0	0	0
Residential Aged Care	34	36	35	37	39

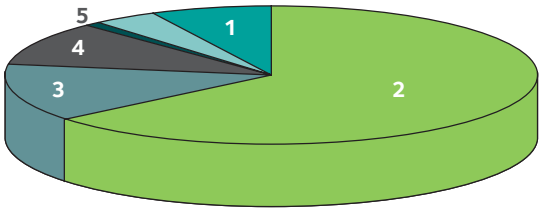
Debtors Outstanding as at 30 June 2016

	Under 30 Days	31 -60 Days	61-90 Days	Over 90 Days	Total 30/06/16	Total 30/06/15
Private	47,778	11,373	982	19,480	79,613	97,526
TAC	0	0	0	0	0	0
VWA	0	0	2,733	0	2,733	7,478
Other Compensable	1468	0	0	7,827	9,295	9,747
Residential Aged Care	106,315	0	3,750	7,666	117,731	140,421
Total	**155,561**	**11,373**	**7,465**	**34,973**	**209,372**	**255,172**

Summary of Financial Results FOR THE YEAR ENDED 30 JUNE 2016

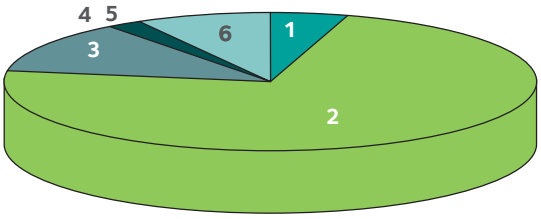
Expenditure by Major Categories

1	Other Expenses	$6,086,000
2	Employee Entitlements	$36,833,000
3	Patient Expenses	$7,051,000
4	Medical Officers	$5,330,000
5	Repairs & Maintenance	$586,000
6	Depreciation	$1,892,000



Income by Source

1	Patient Fees	$2,647,000
2	State Government Grants	$42,044,000
3	Commonwealth Grants	$6,075,000
4	Donations	$63,000
5	Capital Grants	$842,000
6	Sundry Income	$4,162,000



The financial position of the service was impacted by the following changes during the year:

- The Short Stay Unit (SSU) opened in November 2015 providing additional facilities for ED presentations
- Acute and sub-acute activity increased
- Residential Aged Care occupancy decreased
- There was a significant increase in total government funding to support increased activity

Legislative Compliance

The following information is required as part of the Standing Directions of the Minister for Finance and Financial Reporting Directions to provide the community with background and general information about the health service.

- Bass Coast Health is the major public health service provider within the Bass Coast Shire. A comprehensive range of services are provided that includes acute, sub-acute, residential aged care, ancillary, medical and community based services
- The health service delivers healthcare to approximately 30,000 residents and approximately 3.4 million visitors each year to the Bass Coast and South Gippsland region
- The health service, through the Board of Directors, reports to the Minister for Health, the Hon. Jill Hennessy, MP
- Members of Bass Coast Health's Finance, Audit and Risk Committee, at 30th June 2016 were:
  - ~ Don Paproth, Board Director
  - ~ Christine Hammond, Board Director
  - ~ Tim Large, Board Director
  - ~ Mim Kershaw, Board Director
  - ~ Jim Fletcher, Delegate
  - ~ Danny Luna - Independent Member
- Auditor for the 2015 Annual Report was the Office of the Auditor General
- Bass Coast Health is classified as a Group C Hospital and is incorporated under the Health Services Act 1988

Freedom of Information

There were 104 requests under the Freedom of Information Act 1982, and access to 97 was granted in full, 1 was withdrawn, 1 not proceeded with, there were no documents for 2 requests and 3 are in progress.

Responsible Bodies Declaration

In accordance with the Financial Management Act 1994, I am pleased to present the Report of Operations for Bass Coast Health for the year ending 30 June 2016.

Don Paproth, Interim Chair, Board of Directors
Wonthaggi, 31 August 2016

Attestation on Data Integrity

I, Jan Child, certify that Bass Coast Health has put in place appropriate internal controls and processes to ensure that reported data reasonably reflects actual performance. Bass Coast Health has critically reviewed these controls and processes during the year.

Jan Child, Chief Executive Officer
Wonthaggi, 31 August 2016

Attestation for Compliance with the Australian/New Zealand Risk Management Standard

I, Jan Child, certify that Bass Coast Health has risk management processes in place consistent with the Australian/ New Zealand Risk Management Standard, AS/NZS ISO 31000:2009, and an internal control system is in place that enables the Executive to understand, manage and satisfactorily control risk exposures. The Finance, Audit and Risk Committee verifies this assurance and that the risk profile of Bass Coast Health has been critically reviewed within the last 12 months.

Jan Child, Chief Executive Officer
Wonthaggi, 31 August 2016

Attestation for Compliance with the Ministerial Standing Direction 4.5.5.1 - Insurance

I, Jan Child, certify that Bass Coast Health has complied with Ministerial Direction 4.5.5.1 - Insurance.

Jan Child, Chief Executive Officer
Wonthaggi, 31 August 2016

Disclosure Index

Compliance Index

The Annual Report of Bass Coast Health is prepared in accordance with all relevant Victorian legislation. This index has been prepared to facilitate identification of the Department's compliance with statutory disclosure requirements.

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	Financial Management Act 1994	25

N/A = Not Applicable

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

The attached financial statements for Bass Coast Health have been prepared in accordance with Standing Direction 4.2 of the *Financial Management Act 1994, applicable Financial Reporting Directions,* Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2016 and the financial position of Bass Coast Health at 30 June 2016.

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

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

Don Paproth Board Member	Jan Child Accountable Officer	Phillip Maddock Chief Finance & Accounting Officer
Wonthaggi	Wonthaggi	Wonthaggi
31st August 2016	31st August 2016	31st August 2016

VAGO
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INDEPENDENT AUDITOR'S REPORT

To the Board Members, Bass Coast Health

The Financial Report

I have audited the accompanying financial report for the year ended 30 June 2016 of Bass Coast Health which comprises comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement, notes comprising a summary of significant accounting policies and other explanatory information, and the Board Member's, Accountable Officers and Chief Finance & Accounting Officer's Declaration.

The Board Members' Responsibility for the Financial Report

The Board Members of Bass Coast Health are responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*, and for such internal control as the Board Members determine is necessary to enable the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

As required by the *Audit Act 1994*, my responsibility is to express an opinion on the financial report based on the audit, which has been conducted in accordance with Australian Auditing Standards. Those standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The audit procedures selected depend on judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, consideration is given to the internal control relevant to the entity's preparation and fair presentation of the financial report 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 entity's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Board Members, as well as evaluating the overall presentation of the financial report.

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

Independent Auditor's Report (continued)

Independence

The Auditor-General's independence is established by the *Constitution Act 1975*. The Auditor-General is not subject to direction by any person about the way in which his powers and responsibilities are to be exercised. In conducting the audit, I and my staff and delegates complied with all applicable independence requirements of the Australian accounting profession.

Opinion

In my opinion, the financial report presents fairly, in all material respects, the financial position of the Bass Coast Health as at 30 June 2016 and of its financial performance and its cash flows for the year then ended in accordance with applicable Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*.

MELBOURNE
1 September 2016

Dr Peter Frost
Acting Auditor-General

Comprehensive Operating Statement

FOR THE YEAR ENDED 30 JUNE 2016

	Note	2016 $'000	2015 $'000
Revenue from Operating Activities	2	54,633	52,246
Revenue from Non Operating Activities	2	282	398
Employee Expenses	3	(36,870)	(36,636)
Non Salary Labour Costs	3	(5,330)	(5,788)
Supplies and Consumables	3	(4,398)	(5,870)
Administration Expenses	3	(3,287)	(3,511)
Patient Transport	3	(1,251)	(1,265)
Other Expenses	3	(4,751)	(3,489)
Net Result Before Capital and Specific Items		(972)	(3,915)
Capital Purpose Income	2	842	2,128
Discount Interest on Loan Net Present Value	2	15	148
Depreciation and Amortisation	4	(1,892)	(1,613)
Net Result After Capital and Specific Items		(2,007)	(3,252)
Other Economic Flows Included in Net Result			
Net gain/(loss) on non-financial assets	2a	23	35
Revaluation of Long Service Leave	3,13	37	39
Profit from Acquisition	16	-	4,498
Total Other Economic Flows Included in Net Result		60	4,572
NET RESULT FOR THE YEAR		(1,947)	1,320
Other Comprehensive Income			
Items that will not be classified to net result			
Changes in physical asset revaluation surplus	16	-	-
Total Other Comprehensive Income		-	-
COMPREHENSIVE RESULT		**(1,947)**	**1,320**

Balance Sheet

FOR THE YEAR ENDED 30 JUNE 2016

	Note	2016 $'000	2015 $'000
Current Assets			
Cash and Cash Equivalents	5	7,200	1,894
Receivables	6	1,079	1,667
Investments & Other Financial Assets	7	-	6,491
Inventories	8	156	218
Prepayments and Other Assets	9	779	689
Total Current Assets		9,214	10,959
Non-Current Assets			
Receivables	6	674	599
Property, Plant and Equipment	10	44,805	45,115
Total Non-Current Assets		45,479	45,714
TOTAL ASSETS		54,693	56,673
Current Liabilities			
Payables	11	4,913	4,151
Borrowings	12	500	870
Provisions	13	7,470	7,937
Other Current liabilities	15	3,162	2,927
Total Current Liabilities		16,045	15,885
Non-Current Liabilities			
Borrowings	12	4,581	5,038
Provisions	13	1,617	1,353
Total Non-Current Liabilities		6,198	6,391
TOTAL LIABILITIES		22,243	22,276
NET ASSETS		32,450	34,397
EQUITY			
Property, Plant and Equipment Revaluation Surplus	16a	21,052	21,052
Restricted Specific Purpose Surplus	16a	293	293
Contributed Capital	16b	13,438	13,438
Accumulated Surpluses/(Deficits)	16b	(2,333)	(386)
TOTAL EQUITY	16b	32,450	34,397
Commitments	19		
Contingent Assets and Contingent Liabilities	20		

Statement of Changes in Equity

FOR THE YEAR ENDED 30 JUNE 2016

		Property, Plant and Equipment Revaluation Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributed Capital $'000	Accumulated Surpluses/ (Deficits) $'000	Total $'000
Balance at 1 July 2014		21,052	293	13,438	(1,706)	33,077
Net result for the year	16c	-	-	-	(3,178)	(3,178)
Other Comprehensive income for the year	16c	-	-	-	4,498	4,498
Balance at 30 June 2015		**21,052**	**293**	**13,438**	**(386)**	**34,397**
Net result for the year	16c	-	-	-	(1,947)	(1,947)
Balance at 30 June 2016		**21,052**	**293**	**13,438**	**(2,333)**	**32,450**

Cash Flow Statement

FOR THE YEAR ENDED 30 JUNE 2016

	Note	2016 $'000 Inflows / (Outflows)	2015 $'000 Inflows / (Outflows)
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		48,498	43,281
Capital Grants from Government		750	1,616
Patient and Resident Fees Received		2,663	2,727
Donations and Bequests Received		63	80
GST (Paid to)/Received from ATO		(42)	(39)
Interest Received		235	252
Other Receipts		3,507	5,017
Total Receipts		***55,674***	***52,934***
Employee Expenses Paid		(36,827)	(35,815)
Non Salary Labour Costs		(5,330)	(5,784)
Payments for Supplies and Consumables		(4,336)	(3,819)
Other Payments		(8,144)	(9,372)
Total Payments		***(54,637)***	***(54,790)***
NET CASH FLOW FROM / (USED IN) OPERATING ACTIVITIES	17	1,037	(1,856)
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of Investments		3,638	1,404
Purchase of Non-Financial Assets		(1,683)	(1,522)
Proceeds from Sale of Non-Financial Assets		124	111
Proceeds from Community Health Service		-	318
NET CASH FLOW FROM /(USED IN) INVESTING ACTIVITIES		2,079	311
CASH FLOWS FROM FINANCING ACTIVITIES			
Proceeds from Borrowings		-	2,060
Repayment of Borrowings		(812)	(220)
NET CASH FLOW FROM /(USED IN) FINANCING ACTIVITIES		(812)	1,840
NET INCREASE / (DECREASE) IN CASH AND CASH EQUIVALENTS HELD		2,304	295
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		1,589	1,294
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	5	3,893	1,589

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

These annual financial statements represent the audited general purpose financial statements for Bass Coast Health (ABN 86 627 309 026) for the period ending 30 June 2016. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

These financial statements are general purpose financial statements which have been prepared in accordance with the *Financial Management Act 1994* and applicable Australian Accounting Standards (AASs), 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 Health Service is a not-for profit entity and therefore applies the additional Aus paragraphs applicable to "not-for-profit" Health Services under the AASs.

The annual financial statements were authorised for issue by the Board of Bass Coast Health 31st August, 2016.

(b) 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 2016, and the comparative information presented in these financial statements for the year ended 30 June 2015.

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

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

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

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

- Non-current physical assets, which subsequent to acquisition, are measured at a revalued amount being their fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made and are re-assessed when new indices are published by the Valuer General to ensure that the carrying amounts do not materially differ from their fair values;
- Derivative financial instruments, managed investment schemes, certain debt securities, and investment properties after initial recognition, which are measured at fair value with changes reflected in the comprehensive operating statements (fair value through profit and loss);
- 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); and
- The fair value of assets other than land is generally based on their depreciated replacement value.

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

(b) Basis of accounting preparation and measurement (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 AASs 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 1(j));
- Superannuation expense (refer to note 1(g)); 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 1(k)).

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

All 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, Bass Coast Health has determined classes of assets and liabilities on the basis of the nature, characteristics and risks of the asset or liability and the level of the fair value hierarchy as explained above.

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

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

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

The estimates and underlying assumptions are reviewed on an ongoing basis. 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 AASs 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 1(j));
- superannuation expense (refer to Note 1(g)); 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 1(k)).

(c) Reporting Entity

The financial statements includes all the controlled activities of Bass Coast Health.
Its principal address is:
235-237 Graham Street
Wonthaggi
Victoria 3995.

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

(c) Reporting Entity (Continued)

Objectives and funding

Bass Coast Health's overall objective is to be a leader in rural healthcare, providing a consumer-centred, multi-disciplinary service responding to the needs of the community, as well as improve the quality of life to Victorians.

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

(d) Principles of Consolidation

Intersegment Transactions

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

Jointly controlled assets or operations

Interest in jointly controlled assets or operations are not consolidated by Bass Coast Health, but are accounted for in accordance with the policy outlined in Note 1(j) Financial Assets.

(e) Scope and presentation of financial statements

Fund Accounting

The Bass Coast Health operates on a fund accounting basis and maintains three funds: Operating, Specific Purpose and Capital Funds. Bass Coast Health Capital and Specific Purpose Funds include unspent capital donations and receipts from fundraising activities conducted solely in respect of these funds.

Services Supported by Health Services Agreement and Services Supported by Hospital and Community Initiatives.

Activities classified as *Services Supported by Health Services Agreement* (HSA) are substantially funded by the Department of Health and Human Services and include Residential Aged Care Services (RACS) and are also funded from other sources such as the Commonwealth, patients and residents, while *Services Supported by Hospital and Community Initiatives* (H&CI) are funded by the Health Service's own activities or local initiatives and/or the Commonwealth.

Residential Aged Care Service

Kirrak House, Armitage House and Griffiths Point Lodge Residential Aged Care Service operations are an integral part of Bass Coast Health and share its resources. An apportionment of land and buildings has been made based on floor space. The results of the three operations have been segregated based on actual revenue earned and expenditure incurred by each operation in Note 2 and 3 of the financial statements.

Kirrak House, Armitage House and Griffiths Point Lodge Residential Aged Care Services are substantially funded from Commonwealth bed-day subsidies.

Comprehensive operating statement

The comprehensive operating statement includes the subtotal entitled 'net result before capital and specific items' to enhance the understanding of the financial performance of Bass Coast Health. This subtotal reports the result excluding items such as capital grants, assets received or provided free of charge, depreciation, expenditure using capital purpose income and items of an unusual nature and amount such as specific income and expenses. The exclusion of these items is made to enhance matching of income and expenses so as to facilitate the comparability and consistency of results between years and Victorian Public Health Services. The 'net result before capital and specific items' is used by the management of Bass Coast Health, the Department of Health and Human Services and the Victorian Government to measure the ongoing operating performance of Health Services.

(e) Scope and presentation of financial statements (Continued)

Capital and specific items, which are excluded from this sub-total comprise:

- capital purpose income, which comprises all tied grants, donations and bequests received for the purpose of acquiring non-current assets, such as capital works and plant and equipment. It also includes donations of plant and equipment (refer note 1 (f)). Consequently the recognition of revenue as capital purpose income is based on the intention of the provider of the revenue at the time the revenue is provided;

- specific income/expense, comprises the following items, where material:
    - Voluntary departure packages
    - Write-down of inventories
    - Non-current asset revaluation increments/decrements
    - Non-current assets lost or found
    - Forgiveness of loans
    - Reversals of provisions
    - Voluntary changes in accounting policies (which are not required by an accounting standard or other authoritative pronouncement of the Australian Accounting Standards Board);

- impairment of financial and non-financial assets, includes all impairment losses (and reversal of previous impairment losses), which have been recognised in accordance with note 1 (j);

- depreciation, as described in note 1 (g);

- assets provided or received free of charge (refer to Note 1 (f)); and

- expenditure using capital purpose income, comprises expenditure which either falls below the asset capitalisation threshold or doesn't meet asset recognition criteria and therefore does not result in the recognition of an asset in the balance sheet, where funding for that expenditure is from capital purpose income.

Other economic flows are changes arising from market remeasurements. They include:

- gains and losses from disposals of non-financial assets;

- revaluations and impairments of non-financial physical and intangible assets;

- remeasurement arising from defined benefit superannuation plans; and

- fair value changes of financial instruments.

Balance sheet

Assets and liabilities are categorised either as current or non-current (non-current being those assets or liabilities expected to be recovered / settled more than 12 months after reporting period), are disclosed in the notes where relevant.

Statement of changes in equity

The statement of changes in equity presents reconciliations of each non-owner and owner changes in equity from the opening balance at the beginning of the reporting period to the closing balance at the end of the reporting period. It also shows separately changes due to amounts recognised in the comprehensive result and amounts recognised in other comprehensive income.

Cash flow statement

Cash flows are classified according to whether or not they arise from operating activities, investing activities, or financing activities. This classification is consistent with requirements under AASB 107 *Statement of Cash Flows* .

For the cash flow statement presentation purposes, cash and cash equivalents includes bank overdrafts, which are included as current borrowings in the balance sheet.

Rounding

All amounts shown in the financial statements are expressed to the nearest $1,000 unless otherwise stated.

Minor discrepancies in tables between totals and sum of components are due to rounding.

(f) Income from transactions

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 Bass Coast Health and the income can be reliably measured at fair value. Unearned income at reporting date is reported as income received in advance.

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

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

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

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

Indirect Contributions from the Department of Health and Human Services

- Insurance is recognised as revenue following advice from the Department of Health and Human Services.
- Long Service Leave (LSL) - Revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Metropolitan Health and Aged Care Services Division Hospital Circular 05/2013 (updated for 2014-15).

Patient and Resident Fees

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

Private Practice Fees

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

Revenue from commercial activities

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

Donations and Other Bequests

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

Interest Revenue

Interest revenue is recognised on a time proportionate basis that takes in account the effective yield of the financial asset.

Sale of investments

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

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

Resources received 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 Health Service or agency as a consequence of a restructuring of administrative arrangements. In the latter case, such transfer will be recognised at carrying value. Contributions in the form of services are only recognised when a fair value can be reliably determined and the services would have been purchased if not donated.

Other income

Other income includes non-property rental, dividends, forgiveness of liabilities, and bad debt reversals.

(g) Expense recognition

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

Cost of goods sold

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

Employee expenses

Employee expenses include:

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

Defined contribution superannuation plans

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

Defined benefit superannuation plans

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

Employees of the Bass Coast Health are entitled to receive superannuation benefits and the Bass Coast Health contributes to both the defined benefit and defined contribution plans. The defined benefit plans 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 Bass Coast Health are disclosed in Note 14: Superannuation.

Depreciation

All infrastructure assets, buildings, plant and equipment and other non-financial physical assets that have finite useful lives are depreciated (i.e. excludes land assets held for sale, and investment properties). Depreciation 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.

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

(g) Expense recognition (Continued)
Depreciation (Continued)

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

	2016	2015
Buildings		
- Structure Shell Building Fabric	37 to 42 Years	37 to 42 Years
- Site Engineering Services and Central Plant	27 Years	27 Years
Central Plant		
- Fit Out	12 Years	12 Years
- Trunk Reticulated Building Systems	17 years	17 years
Plant & Equipment	5 to 10 years	5 to 10 years
Medical Equipment	5 to 20 years	5 to 20 years
Computers and Communication	4 years	4 years
Motor Vehicles	5 years	5 years
Leasehold Improvements	5 to 10 years	5 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.

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

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

Finance costs include:
- amortisation of discounts or premiums relating to borrowings.

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

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

Bad and Doubtful Debts
Refer to note 1 (j) *Impairment of 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 it's carrying value. Contributions in the form of services are only recognised when a fair value can be reliably determined and the services would have been purchased if not donated.

(h) Other Economic Flows Included in Net Result

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

Net gain / (loss) on non-financial assets

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

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

Refer to Note 1(j) *Revaluations of non-financial physical assets.*

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 value of the asset at the time.

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 interest rates, this will include the impact of changes related to the impact of moving from the 2004 long service leave model; and

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

(i) Financial Instruments

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

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

The following refers to financial instruments unless otherwise stated.

Categories of non-derivative financial instruments

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 1(j)), 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.

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

(j) Assets

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.

Receivables

Receivables consist of:

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

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

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

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

Investments and other financial assets

Hospital investments must be in accordance in Standing Direction 4.5.6 - Treasury 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:

- Loans and receivables

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

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

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

Inventories

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

Inventories 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.

(j) Assets (Continued)

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.

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 10 Property, plant and equipment.

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

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

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

Leasehold improvements

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

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 transferred to accumulated funds on derecognition of the relevant asset.

In accordance with FRD 103F Bass Coast Health's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

Prepayments

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.

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 1(h) - 'other comprehensive income'.

(j) Assets (Continued)

Investments in joint operations

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

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

Impairment of Financial Assets

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

Receivables are assessed for bad and doubtful debts on a regular basis. Bad debts considered as written off and allowance for doubtful receivables are expensed. Bad debt written off by mutual consent and the allowance for doubtful debts are classified as 'other comprehensive income' in the net result.

The amount of 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.

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

In order to determine an appropriate fair value as at 30 June 2016 for its portfolio of financial assets, Bass Coast Health obtained a valuation based on the best available advice using an estimated market value through a reputable financial institution. This value was compared against valuation methodologies provided by the issuer as at 30 June 2016. These methodologies were critiqued and considered to be consistent with standard market valuation techniques.

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.*

(k) Liabilities

Payables

Payables consist of:

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

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

Borrowings

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

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

(k) Liabilities (Continued)

Provisions

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

The amount recognised as a provision 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 health service does not have an unconditional right to defer settlements of these liabilities.

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

- Undiscounted value – if the health service expects to wholly settle within 12 months; or
- Present value – if the health service does not expect to wholly settle within 12 months.

Long service leave (LSL)

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

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

The components of this current LSL liability are measured at:
- Undiscounted value – if the health service expects to wholly settle within 12 months; and
- Present value – if the health service does not expect to 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 health service recognises termination benefits when it is demonstrably committed to either terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

(k) Liabilities (Continued)
Employee Benefits (Continued)

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

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

(l) Leases
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.

Lease 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.

All other leases are classified as operating leases.

Operating leases

Entity as lessor
Rental income from operating lease is recognised on a straight-line basis over the term of the relevant lease.

All incentives for the agreement of a new or renewed operating lease are recognised as an integral part of the net consideration agreed for the use of the lease asset, irrespective of the incentive's nature or form or the timing of payments.

In the event that lease incentives are given to the lessee, the aggregate cost of incentives are recognised as a reduction of rental income over the lease term, on a straight-line basis unless another systematic basis is more appropriate of the time pattern over which the economic benefit of the leased asset is diminished.

Entity as lessee
Operating lease payments, including any contingent rentals, are recognised as an expense in the comprehensive operating statement on a straight line basis over the lease term, except where another systematic basis is more representative of the time pattern of the benefits derived from the use of the leased asset. The leased asset is not recognised in the balance sheet.

Lease Incentives
All incentives for the agreement of a new or renewed operating lease are recognised as an integral part of the net consideration agreed for the use of the lease asset, irrespective of the incentive's nature or form or the timing of payments.

In the event that lease incentives are received by the lessee to enter into operating leases, such incentives are recognised as a liability. The aggregate benefits of incentives are recognised as a reduction of rental expense on a straight-line basis, except where another systematic basis is more representative of the time pattern in which economic benefits from the leased asset is diminished.

Leaseholder Improvements
The cost of leasehold improvements are capitalised as an asset and depreciated over the remaining term of the lease or the estimated useful life of the improvements, whichever is the shorter.

(m) Equity

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 or distributions, that have been designated as contributed capital are also treated as contributed capital.

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

Property, plant and equipment revaluation surplus

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

Specific restricted purpose surplus

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

(n) Commitments

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed by way of a note (refer to note 19) at their nominal value and are inclusive of the goods and services tax ("GST") payable. In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant individual projects are stated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

(o) Contingent assets and contingent liabilities

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

(p) Goods and Services Tax ("GST")

Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the taxation authority. In this case the GST payable is recognised as part of the cost of acquisition of the asset or as part of the expense.

Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the taxation authority is included with other receivables or payables in the balance sheet.

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

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

(q) AASs issued that are not yet effective

Certain new Australian accounting standards and interpretations have been published that are not mandatory for 30 June 2016 reporting period. DTF assesses the impact of all these new standards and advises the Health Service of their applicability and early adoption where applicable.

As at 30 June 2016, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. Bass Coast Health has not and does not intend to adopt these standards early.

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

(q) AASs issued that are not yet effective (Continued)

Standard / Interpretation	Summary	Applicable for reporting periods beginning on	Impact on Health Service's Annual Statements
AASB 15 *Revenue from Contracts with Customers*	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1 January 2018	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications. A potential impact will be the upfront recognition of revenue from licenses that cover multiple reporting periods. Revenue that was deferred and amortised over a period may now need to be recognised immediately as a transitional adjustment against the opening returned earnings if there are no former performance obligations outstanding.
AASB 2014-1 *Amendments to* Australian Accounting Standards *[Part E Financial Instruments]*	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	1 January 2018	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2015-6 *Amendments to* Australian Accounting *Standards – Extending Related Party Disclosures to Not-for-Profit Public Sector Entities [AASB 10, AASB 124 & AASB 1049]*	The Amendments extend the scope of AASB 124 Related Party Disclosures to not-for-profit public sector entities. A guidance has been included to assist the application of the Standard by not-for-profit public sector entities.	1 January 2016	The amending standard will result in extended disclosures on the entity's key management personnel (KMP), and the related party transactions.
AASB 2015-8 Amendments to Australian Accounting Standards - Effective Date of AASB 15	This standards defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1 January 2018	This amending standard will defer the application period of AASB 15 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of most operating leases (which are currently not recognised) on balance sheet.	1 January 2019	The assessment has indicated that as most operating leases will come on balance sheet, recognition of lease assets and lease liabilities will cause net debt to increase. Depreciation of lease assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. The amounts of cash paid for the principal portion of the lease liability will be presented within financing activities and the amounts paid for the interest portion will be presented within operating activities in the cash flow statement. No change for lessors.

(q) AASs issued that are not yet effective (Continued)

In addition to the new standards and amendments above, the AASB has issued a list of other amending standards that are not effective for the 2015-16 reporting period (as listed below). In general, these amending standards include editorial and references changes that are expected to have insignificant impacts on public sector reporting.

- AASB 2014-3 Amendments to Australian Accounting Standards – Accounting for Acquisitions of Interests in Joint Operations [AASB 1 & AASB 11]
- AASB 2015-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 101 [AASB 7, AASB 101, AASB 134 & AASB 1049]
- AASB 2015-9 Amendments to Australian Accounting Standards - Scope and Application Paragraphs [AASB 8, AASB 133 & AASB 1057]
- AASB 2015-10 Amendments to Australian Accounting Standards - Effective Date of Amendments to AASB 10 and AASB 128
- AASB 2016-2 Amendments to Australian Accounting Standards - Disclosure Initiative - Amendments to AASB107

(r) Category Groups

Bass Coast Health has used the following category groups for reporting purposes for the current and previous financial years.

Admitted Patient Services (Admitted Patients) comprises all acute and subacute admitted patients services, where services are delivered in public hospitals.

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.

Primary, Community and Dental Health comprises a range of home based, community based, community, primary health and dental services including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy and a range of dental health services.

Residential Aged Care including Mental Health (RAC incl. Mental Health) referred to in the past as psychogeriatric residential services, comprises those Commonwealth-licensed residential aged care services in receipt of supplementary funding from the department under the mental health program. It excludes all other residential services funded under the mental health program, such as mental health funded community care units and secure extended care units.

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

Note 2: ANALYSIS OF REVENUE BY SOURCE

	Admitted Patients 2016 $'000	EDS 2016 $'000	RAC incl. Mental Health 2016 $'000	Aged Care 2016 $'000	Primary Health 2016 $'000	Other 2016 $'000	TOTAL 2016 $'000
Government Grants	23,336	4,721	5,791	3,121	10,803	194	47,966
Indirect Contributions by Department of Health and Human Services	154	-	-	-	-	-	154
Patient and Resident Fees	470	28	1,346	146	660	-	2,650
Other Revenue from Operating Activities	250	294	-	510	1,284	1,525	3,863
Total Revenue from Operating Activities	**24,210**	**5,043**	**7,137**	**3,777**	**12,747**	**1,719**	**54,633**
Interest	-	-	-	-	-	219	219
Other Revenue from Non-Operating Activities	1	-	5	-	8	49	63
Total Revenue from Non-Operating Activities	**1**	**-**	**5**	**-**	**8**	**268**	**282**
Capital Purpose Income (Excluding Interest)	-	-	92	-	-	750	842
Discount Interest on Loan Net Present Value	-	-	-	-	-	15	15
Total Capital Purpose Income	**-**	**-**	**92**	**-**	**-**	**765**	**857**
TOTAL REVENUE	**24,211**	**5,043**	**7,234**	**3,777**	**12,755**	**2,752**	**55,772**

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

Note 2: ANALYSIS OF REVENUE BY SOURCE (Continued)

	Admitted Patients 2015 $'000	EDS 2015 $'000	RAC incl. Mental Health 2015 $'000	Aged Care 2015 $'000	Primary Health 2015 $'000	Other 2015 $'000	TOTAL 2015 $'000
Government Grants	19,885	3,831	6,074	3,599	10,191	175	43,755
Indirect Contributions by Department of Health and Human Services	455	-	-	-	-	-	455
Patient and Resident Fees	333	-	1,503	196	214	-	2,246
Other Revenue from Operating Activities	1,621	266	2	449	1,405	2,047	5,790
Total Revenue from Operating Activities	**22,294**	**4,097**	**7,579**	**4,244**	**11,810**	**2,222**	**52,246**
Interest	-	-	-	-	-	253	253
Other Revenue from Non-Operating Activities	2	-	1	-	27	115	145
Total Revenue from Non-Operating Activities	**2**	**-**	**1**	**-**	**27**	**368**	**398**
Capital Purpose Income (Excluding Interest)	-	20	176	70	366	1,496	2,128
Discount Interest on Loan Net Present Value	-	-	-	-	-	148	148
Total Capital Purpose Income	**-**	**20**	**176**	**70**	**366**	**1,644**	**2,276**
TOTAL REVENUE	**22,296**	**4,117**	**7,756**	**4,314**	**12,203**	**4,234**	**54,920**

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

NOTE 2a: NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS	2016 $	2015 $
Proceeds from Disposal of Non-Current Assets		
- Medical Equipment	-	3
- Motor Vehicles	124	108
Total Proceeds from Disposal of Non-Current Assets	**124**	**111**
Less: Written Down Value of Non-Current Assets Sold		
- Medical Equipment	-	-
- Motor Vehicles	101	76
Total Written Down Value of Non-Current Assets Sold	**101**	**76**
NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS	**23**	**35**

Note 3: ANALYSIS OF EXPENSE BY SOURCE

	Admitted Patients 2016 $'000	EDS 2016 $'000	RAC incl. Mental Health 2016 $'000	Aged Care 2016 $'000	Primary Health 2016 $'000	Other 2016 $'000	TOTAL 2016 $'000
Employee Expenses	9,435	5,492	6,019	844	8,844	6,236	36,870
Non Salary Labour Costs	3,181	581	-	-	1,426	142	5,330
Supplies and Consumables	2,671	288	554	30	588	267	4,398
Administration Expenses	50	103	25	183	1,114	1,812	3,287
Patient Transport	164	1,087	-	-	-	-	1,251
Other Expenses	1,136	1,237	265	4	118	1,991	4,751
Total Expenditure from Operating Activities	16,637	8,788	6,863	1,061	12,090	10,448	55,887
Depreciation and Amortisation (refer note 4)	-	-	-	-	-	1,892	1,892
Total Other Expenses	-	-	-	-	-	1,892	1,892
TOTAL EXPENSES	**16,637**	**8,788**	**6,863**	**1,061**	**12,090**	**12,340**	**57,779**

	Admitted Patients 2015 $'000	EDS 2015 $'000	RAC incl. Mental Health 2015 $'000	Aged Care 2015 $'000	Primary Health 2015 $'000	Other 2015 $'000	TOTAL 2015 $'000
Employee Expenses	9,282	4,644	6,376	1,354	8,511	6,469	36,636
Non Salary Labour Costs	3,873	683	-	-	1,211	21	5,788
Supplies and Consumables	2,948	1,207	608	72	633	402	5,870
Administration Expenses	57	22	22	91	907	2,412	3,511
Patient Transport	229	1,036	-	-	-	-	1,265
Other Expenses	911	92	439	8	93	1,946	3,489
Total Expenditure from Operating Activities	17,300	7,684	7,445	1,525	11,355	11,250	56,559
Depreciation and Amortisation (refer note 4)	-	-	-	-	-	1,613	1,613
Total Other Expenses	-	-	-	-	-	1,613	1,613
TOTAL EXPENSES	**17,300**	**7,684**	**7,445**	**1,525**	**11,355**	**12,863**	**58,172**

Note 4: DEPRECIATION AND AMORTISATION	2016 $'000	2015 $'000
Depreciation		
Buildings	852	697
Plant and Equipment	303	362
Medical Equipment	321	266
Computers and Communication	190	43
Furniture and Equipment	57	42
Motor Vehicles	169	203
Total Depreciation	1,892	1,613

NOTE 5: 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.

	2016 $'000	2015 $'000
Cash on Hand	3	3
Cash at Bank	1,843	1,891
Short Term Deposits	5,354	-
TOTAL CASH AND CASH EQUIVALENTS	7,200	1,894
Represented by:		
Cash for Health Service Operations (as per cash flow statement)	3,893	1,589
GHA IT Alliance	145	231
Cash for Monies Held in Trust	3,162	74
TOTAL CASH AND CASH EQUIVALENTS	7,200	1,894

NOTE 6: RECEIVABLES	2016	2015
CURRENT	$'000	$'000
Contractual		
Trade Debtors	323	715
Patient Fees	220	248
Accrued Investment Income	2	18
GHA IT Alliance	219	205
Accrued Revenue - Other	152	190
Less Allowance for Doubtful Debts		
Patient Fees	(32)	(47)
Trade Debtors	(84)	-
	800	1,329
Statutory		
Accrued Revenue - Department of Health & Human Services	76	158
GST Receivable	203	180
	279	338
TOTAL CURRENT RECEIVABLES	1,079	1,667
NON CURRENT		
Statutory		
Long Service Leave - Department of Health and Human Services	674	599
TOTAL NON-CURRENT RECEIVABLES	674	599
TOTAL RECEIVABLES	1,753	2,266
(a) Movement in the allowance for doubtful debts		
Balance at beginning of the year	47	36
Amounts written off during the year	-	(1)
Amounts recovered during the year	-	-
Increase/(decrease) in allowance recognised in net result	69	12
Balance at end of year	**116**	**47**

(b) Ageing analysis of receivables

Please refer to note 18(c) for the ageing analysis of contractual receivables.

(c) Nature and extent of risk arising from receivables

Please refer to note 18(c) for the nature and extent of credit risk arising from contractual receivables.

NOTE 7: INVESTMENTS AND OTHER FINANCIAL ASSETS

	Operating Fund		Specific Purpose Fund		Capital Fund		Total	
	2016	2015	2016	2015	2016	2015	2016	2015
CURRENT	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Loans and Receivables								
Term Deposit								
Aust. Dollar Term Deposits > 3 Months	-	2,853	-	220	-	3,418	-	6,491
TOTAL CURRENT OTHER FINANCIAL ASSETS	-	2,853	-	220	-	3,418	-	6,491
Represented by:								
Health Services Investments	-	-	-	-	-	3,000	-	3,000
Long Service Leave Liability	-	-	-	220	-	-	-	220
Other *(Community Health Employee Entitlements)*	-	-	-	-	-	418	-	418
Accommodation Bonds (Refundable Entrance Fees)	-	2,853	-	-	-	-	-	2,853
TOTAL	-	2,853	-	220	-	3,418	-	6,491

(a) Ageing analysis of investments and other financial assets
Please refer to note 18(c) for the ageing analysis of investments and other financial assets.

(b) Nature and extent of risk arising from investments and other financial assets
Please refer to note 18(c) for the nature and extent of credit risk arising from investments and other financial assets.

NOTE 8: INVENTORIES

	2016	2015
	$'000	$'000
Pharmaceuticals - at cost	33	29
Housekeeping supplies - at cost	5	8
Medical and surgical lines - at cost	117	180
Administration stores - at cost	1	1
TOTAL INVENTORIES	156	218

NOTE 9: PREPAYMENTS AND OTHER ASSETS

	2016	2015
CURRENT	$'000	$'000
Prepayments	779	689
TOTAL OTHER ASSETS	**779**	**689**

NOTE 10 PROPERTY, PLANT AND EQUIPMENT

	2016	2015
(a) Gross carrying amount and accumulated depreciation	$'000	$'000
Land		
- Land at Fair Value	7,909	7,909
Total Land	**7,909**	**7,909**
Buildings		
- Buildings at Fair Value	34,464	33,483
Less Accumulated Depreciation	1,643	797
	32,821	32,686
Total Buildings	**32,821**	**32,686**
Plant and Equipment		
- GHA IT Alliance	3	3
- Plant and Equipment at Fair Value	7,997	8,251
Less Accumulated Depreciation	5,655	5,286
Total Plant and Equipment	**2,345**	**2,968**
Medical Equipment		
-Medical Equipment at Fair Value	4,382	3,908
Less Accumulated Depreciation and Impairment	2,828	2,395
Total Medical Equipment	**1,554**	**1,513**

NOTE 10 PROPERTY, PLANT AND EQUIPMENT (Continued) (a) Gross carrying amount and accumulated depreciation (Continued)	2016 $'000	2015 $'000
Under Construction		
Assets Under Construction	176	39
Total Assets Under Construction	**176**	**39**
TOTAL	**44,805**	**45,115**

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

	Land $'000	Buildings $'000	Plant & Equipment $'000	Medical Equipment $'000	Assets Under Construction $'000	Total $'000
Balance at 1 July 2014	6,159	27,562	1,791	1,396	4,794	41,702
Additions	-		1,063	459		1,522
Transfers	-	4,518	237	-	(4,755)	-
Disposals	-	-	-	(76)	-	(76)
Net Additions through Restructuring	1,750	1,303	527	-	-	3,580
Depreciation and Amortisation (note 4)	-	(697)	(650)	(266)	-	(1,613)
Balance at 1 July 2015	7,909	32,686	2,968	1,513	39	45,115
Additions	-	948	197	362	176	1,683
Transfers	-	39	-	-	(39)	-
Disposals	-	-	(101)	-	-	(101)
Depreciation and Amortisation (note 4)	-	(852)	(719)	(321)	-	(1,892)
Balance at 30 June 2016	7,909	32,821	2,345	1,554	176	44,805

Land and buildings carried at valuation

An independent valuation of the Health Service's land and buildings was performed by the Valuer-General Victoria to determine the value of the land and buildings. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments.
The effective date of the valuation is 30 June 2014.

(c) Fair value measurement hierarchy for assets as at 30 June 2016

	Carrying amount as at 30 June 2016	Fair value measurement at end of reporting period using: Level 1 (i)	Level 2 (i)	Level 3 (i)
Land at fair value				
Non-specialised land	1,800	-	1,800	-
Specialised land	-	-	-	-
Hospital and Aged Care Sites	6,109		-	6,109
Total of land at fair value	7,909	-	1,800	6,109
Buildings at fair value				
Non-specialised buildings	229	-	229	-
Specialised buildings	32,592	-	-	32,592
Total of building at fair value	32,821	-	229	32,592
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	260	-	260	-
- Plant and equipment	2,085	-	-	2,085
Total of plant, equipment and vehicles at fair value	2,345	-	260	2,085
Medical equipment at fair value				
- Medical equipment	1,554	-	-	1,554
Total medical equipment at fair value	1,554	-	-	1,554
Assets under construction at fair value				
Specialised buildings	176	-	-	176
Total Assets under construction at fair value	176	-	-	176
	44,805	-	2,289	42,516

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 an independent valuer 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 10: PROPERTY, PLANT AND EQUIPMENT (Continued)

Fair value measurement hierarchy for assets as at 30 June 2015

	Carrying amount as at 30 June 2015	Fair value measurement at end of reporting period using: Level 1 (i)	Level 2 (i)	Level 3 (i)
Land at fair value				
Non-specialised land	1,800	-	1,800	-
Specialised land	-		-	-
Hospital and Aged Care Sites	6,109		-	6,109
Total of land at fair value	7,909	-	1,800	6,109
Buildings at fair value				
Non-specialised buildings	235	-	235	-
Specialised buildings	32,451	-	-	32,451
Total of building at fair value	32,686	-	235	32,451
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles	509	-	509	-
- Plant and equipment	2,459	-	-	2,459
Total of plant, equipment and vehicles at fair value	2,968	-	509	2,459
Medical equipment at fair value				
- Medical equipment	1,513	-	-	1,513
Total medical equipment at fair value	1,513	-	-	1,513
Assets under construction at fair value				
Specialised buildings	27	-	-	27
Signage	12	-	12	-
Total Assets under construction at fair value	39	-	12	27
	45,115	-	2,556	42,559

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 an independent valuer 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.

Non-specialised land and non-specialised buildings

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

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

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

Specialised land and specialised buildings

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

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

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

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

NOTE 10: PROPERTY, PLANT AND EQUIPMENT (Continued)
Vehicles

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

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

There were no changes in valuation techniques throughout the period to 30 June 2016.

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

(d) Reconciliation of Level 3 fair value as at 30 June 2016

	Land $'000	Buildings $'000	Plant and Equipment $'000	Medical Equipment $'000	Assets under construction $'000
Opening Balance	6,109	32,451	2,459	1,513	27
Purchases (sales)	-	966	176	362	176
Transfers in (out) of Level 3	-	27	-	-	(27)
Gains or losses recognised in net result					
- Depreciation	-	(852)	(550)	(321)	0
Subtotal	6,109	32,592	2,085	1,554	176
Unrealised gains/(losses) on non-financial assets (i)	-	-	-	-	-
Subtotal	-	-	-	-	
Closing Balance	6,109	32,592	2,085	1,554	176

Reconciliation of Level 3 fair value as at 30 June 2015

	Land $'000	Buildings $'000	Plant and Equipment $'000	Medical Equipment $'000	Assets under construction $'000
Opening Balance	4,359	27,327	2,519	1,396	-
Purchases (sales)	-	-	63	383	27
Transfers in (out) of Level 3	1,750	5,821	527	-	-
Gains or losses recognised in net result					
- Depreciation	-	(697)	(650)	(266)	-
Subtotal	6,109	32,451	2,459	1,513	27
Unrealised gains/(losses) on non-financial assets	-	-	-	-	-
Subtotal	-	-	-		
Closing Balance	6,109	32,451	2,459	1,513	27

NOTE 10: PROPERTY, PLANT AND EQUIPMENT (Continued)
(e) Description of significant unobservable inputs to Level 3 valuations

	Valuation technique	Significant unobservable inputs	Range (weighted average)	Sensitivity of fair value measurement to changes in significant unobservable inputs [i]
Specialised land				
Hospital and RACS Sites	Market approach	Community Service Obligation (CSO) adjustment	20% (i)	A significant increase or decrease in the CSO adjustment would result in a significantly lower (higher) fair value
Specialised Buildings				
Hospital and RACS Sites	Depreciated replacement cost	Direct cost per square metre	$600 - $1,900/m2 ($1,500)	A significant increase or decrease in direct cost per square meter adjustment would result in a significantly higher or lower fair value
		Useful life of specialised buildings	30-60 years (40 years)	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation
Plant and equipment at fair value				
Hospital Plant and Equipment	Depreciated replacement cost	Cost per Unit	$4,000 - $17,000 ($8,000)	A significant increase or decrease in direct cost per square meter adjustment would result in a significantly higher or lower fair value
		Useful life of PPE	5-10 years (7 years)	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation
Medical equipment at fair value				
Hospital Medical Equipment	Depreciated replacement cost	Cost per Unit	$3,000 - $15,000 ($5,500)	Increase (decrease) in gross replacement cost would result in a significantly higher (lower) fair value
		Useful life of medical equipment	5-10 years (7 years)	Increase (decrease) in useful life would result in a significantly higher (lower) fair value

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

NOTE 11: PAYABLES

	2016 $'000	2015 $'000
CURRENT		
Contractual		
Trade Creditors (i)	3,004	3,031
Accrued Expenses	522	320
GHA IT Alliance	106	159
	3,632	3,510
Statutory		
WIES Wrap-up Payable	450	-
GST Payable	9	28
ATO - PAYG Payable	822	613
	1,281	641
TOTAL	4,913	4,151

(i) The average credit period is 45 days.

(a) Maturity analysis of payables
Please refer to Note 18(c) for the ageing analysis of contractual payables.

(b) Nature and extent of risk arising from payables
Please refer to note 18(c) for the nature and extent of risks from arising contractual payables.

NOTE 12: BORROWINGS	2016 $'000	2015 $'000
Current Borrowings		
Cash Advance from Government	-	370
Australian Dollar Borrowings		
– Department of Health & Human Services - less than one year (i)	500	500
Total Australian Dollars Borrowings	500	870
Total Current Borrowings	**500**	**870**
Non-Current Borrowings		
Australian Dollar Borrowings		
– Department of Health & Human Services - two to five years (i)	4,581	5,038
Total Australian Dollars Borrowings	4,581	5,038
Total Non-Current Borrowings	**4,581**	**5,038**

(i) They are unsecured loans which bear no interest.

(a) Maturity analysis of borrowings
Please refer to note 18(c) for the ageing analysis of borrowings.

(b) Nature and extent of risk arising from borrowings
Please refer to note 18(c) for the nature and extent of risks arising from borrowings.

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

NOTE 13: PROVISIONS	2016 $'000	2015 $'000
Current Provisions		
Employee Benefits (i)		
Annual Leave		
- unconditional and expected to be settled within 12 months (ii)	2,651	2,370
- unconditional and expected to be settled after 12 months (iii)	152	421
Long Service Leave		
- unconditional and expected to be settled within 12 months (ii)	787	545
- unconditional and expected to be settled after 12 months (iii)	2,247	3,090
Other		
- Accrued Wages & Salaries	809	704
- Accrued Days Off	69	84
	6,715	7,214
Provisions related to Employee Benefit On-Costs		
- unconditional and expected to be settled within 12 months (ii)	485	366
- unconditional and expected to be settled after 12 months (iii)	270	357
	755	723
Total Current Provisions	**7,470**	**7,937**
Non-Current Provisions		
Employee Benefits (iii)	1,453	1,220
Provisions related to Employee Benefit On-Costs	164	133
Total Non-Current Provisions	**1,617**	**1,353**
Total Provisions	**9,087**	**9,290**

(a) Employee Benefits and Related On-Costs

Current Employee Benefits and Related On-Costs		
Annual Leave Entitlements	3,118	3,094
Accrued Wages and Salaries	900	705
Accrued Days Off	77	85
Unconditional LSL Entitlement	3,375	4,053
Non-Current Employee Benefits and related on-costs	7,470	7,937
Conditional Long Service Leave Entitlements (iii)	1,617	1,353
Total Employee Benefits	**9,087**	**9,290**

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

NOTE 13: PROVISIONS (Continued)	2016 $'000	2015 $'000
(b) Movements in Provisions		
Movement in Long Service Leave		
Balance at start of year	5,407	4,733
Provision made during the year		
- Revaluations	37	39
- Expense Recognising Employee Service	461	1,297
Settlement made during the year	(913)	(662)
Balance at end of year	4,992	5,407

NOTE 14: SUPERANNUATION

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

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

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

Fund		Paid Contributions for the year		Outstanding Contributions at Year End	
		2016 $'000	**2015 $'000**	**2016 $'000**	**2015 $'000**
Defined Benefit Plans:	First State Super	85	85	-	-
Defined Contribution Plans:	First State Super	2,098	2,151	7	6
	HESTA	866	816	-	-
Total		3,049	3,052	7	6

* The basis of determining the level of contributions is determined by the various actuaries of the defined benefit superannuation plans.

NOTE 15: OTHER LIABILITIES	2016 $'000	2015 $'000
CURRENT		
Monies Held in Trust*		
- Patient Monies Held in Trust*	39	43
- Accommodation Bonds (Refundable Entrance Fees)*	3,123	2,884
TOTAL CURRENT	**3,162**	**2,927**
*** Total Monies Held in Trust**		
Represented by the following assets:		
Cash Assets (refer to Note 5)	3,162	74
Investment and Other Financial Assets (refer to Note 7)	-	2,853
TOTAL OTHER LIABILITIES	**3,162**	**2,927**

NOTE 16: EQUITY	2016 $'000	2015 $'000
(a) Surpluses		
Property, Plant and Equipment Revaluation Surplus [1]		
Balance at beginning of the reporting period	21,052	21,052
Revaluation Increment/(Decrement)		
- Land	-	-
- Buildings	-	-
Balance at the end of the reporting period *	21,052	21,052
* Represented by:		
- Land	3,628	3,628
- Buildings	17,424	17,424
	21,052	21,052

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

NOTE 16: EQUITY (Continued)

(a) Surpluses (Continued)	2016 $'000	2015 $'000
Restricted Specific Purpose Surplus		
Balance at beginning of the reporting period	293	293
Balance at the end of the reporting period	293	293
Total Surpluses	21,345	21,345
(b) Contributed Capital		
Balance at the beginning of the reporting period	13,438	13,438
Balance at the end of the reporting period	13,438	13,438
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	(386)	(1,706)
Surplus on Acquisition	-	4,498
Net Result for the Year	(1,947)	(3,178)
Balance at the end of the reporting period	(2,333)	(386)
Total Equity at end of financial year	32,450	34,397

NOTE 17: RECONCILIATION OF NET RESULT FOR THE YEAR TO NET CASH INFLOW / (OUTFLOW) FROM OPERATING ACTIVITIES

	2016 $'000	2015 $'000
NET RESULT FOR THE YEAR	(1,947)	(3,178)
Non-cash movements		
Depreciation and Amortisation	1,892	1,613
Share of Net Result of Joint Venture	21	-
Discount Interest on Loan Net Present Value	(15)	-
Movements included in investing and financing activities		
Net (gain)/loss from disposal of non financial physical assets	(23)	(35)
Movements in assets and liabilities		
Change in Operating Assets & Liabilities		
(Increase)/Decrease in Receivables	526	(439)
(Increase)/Decrease in Prepayments	(90)	(596)
Increase/(Decrease) in Payables	577	(10)
Increase/(Decrease) in Provisions	6	786
Change in Inventories	90	3
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	1,037	(1,856)

NOTE 18: FINANCIAL INSTRUMENTS

(a) Financial Risk Management Objectives and Policies

Bass Coast Health' principal financial instruments comprise of:

- *Cash Assets*
- *Term Deposits*
- *Receivables (excluding statutory receivables)*
- *Payables (excluding statutory payables)*
- *Accommodation Bonds*
- *Borrowings*

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

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

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

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

NOTE 18: FINANCIAL INSTRUMENTS (Continued)

(a) Categorisation of financial instruments

2016	Contractual financial assets - loans and receivables $'000	Contractual financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets			
Cash and cash equivalents	7,200	-	7,200
Receivables			
- Trade Debtors	427	-	427
- Other Receivables	373	-	373
Other Financial Assets			
- Term Deposits	-	-	-
Total Financial Assets (i)	8,000	-	8,000
Financial Liabilities			
Payables	-	3,632	3,632
Borrowings	-	5,081	5,081
Other Financial Liabilities			
- Accommodation Bonds	-	3,123	3,123
- Other	-	3,162	3,162
Total Financial Liabilities(ii)	-	14,998	14,998

2015	Contractual financial assets - loans and receivables $'000	Contractual financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets			
Cash and cash equivalents	1,894	-	1,894
Receivables			
- Trade Debtors	838	-	838
- Other Receivables	491	-	491
Other Financial Assets			
- Term Deposits	6,491	-	6,491
Total Financial Assets (i)	9,714	-	9,714
Financial Liabilities			
Payables	-	3,510	3,510
Borrowings	-	5,908	5,908
Other Financial Liabilities			
- Accommodation Bonds	-	2,884	2,884
- Other	-	43	43
Total Financial Liabilities(ii)	-	12,345	12,345

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

NOTE 18: FINANCIAL INSTRUMENTS (Continued)
(a) Financial Risk Management Objectives and Policies (Continued)
Net holding gain/(loss) on financial instruments by category

	Net holding gain/(loss) $'000	Total interest income/ (expense) $'000	Total $'000
2016			
Financial Assets			
Cash and Cash Equivalents (i)	-	13	13
Loans and Receivables (i)	-	206	206
Total Financial Assets	-	219	219
Financial Liabilities			
At amortised cost (ii)	-	-	-
Total Financial Liabilities	-	-	-
2015			
Financial Assets			
Cash and Cash Equivalents (i)	-	15	15
Loans and Receivables (i)	-	238	238
Total Financial Assets	-	253	253
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 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.

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

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

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

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

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

NOTE 18: FINANCIAL INSTRUMENTS (Continued)
(b) Credit Risk (Continued)
Credit quality of contractual financial assets that are neither past due nor impaired

2016	Financial Institutions (Min BBB credit rating) $'000	Government agencies (AAA credit rating) $'000	Government agencies (BBB credit rating) $'000	Other (Min BBB credit rating) $'000	Other (no credit rating) $'000	Total $'000
Financial Assets						
Cash and Cash Equivalents	4,281	2,919	-	-	-	7,200
Loans and Receivables						
- Trade Debtors	-	-	-	239	-	239
- Patient Fees	-	-	-	-	188	188
- Other Receivables (i)	84	-	-	289	-	373
- Term Deposit	-	-	-		-	-
Total Financial Assets	4,365	2,919	-		188	8,000
2015						
Financial Assets						
Cash and Cash Equivalents	1,894	-	-	-	-	1,894
Loans and Receivables						
- Trade Debtors	-	-	-	838	-	838
- Patient Fees	-	-	-	-	248	248
- Other Receivables (i)	-	-	-	243	-	243
- Term Deposit	4,090	2,401	-	-	-	6,491
Total Financial Assets	5,984	2,401	-	1,081	248	9,714

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

Ageing analysis of financial asset as at 30 June

			Past Due But Not Impaired				
2016	Consol'd Carrying Amount $'000	Not Past Due and Not Impaired $'000	Less than 1 Month $'000	1 - 3 Months $'000	3 Months - 1 Year $'000	1 - 5 Years $'000	Impaired Financial Assets $'000
Financial Assets							
Cash and Cash Equivalents	7,200	7,200	-	-	-	-	-
Loans and Receivables (i)							
- Trade Debtors	239	190	-	5	128	-	(84)
- Patient Fees	188	178	11	4	27	-	(32)
- Other Receivables	373	373	-	-	-	-	-
- Term Deposit	-	-	-	-	-	-	-
Total Financial Assets	8,000	7,941	11	9	155	-	- 116
2015							
Financial Assets							
Cash and Cash Equivalents	1,894	1,894	-	-	-	-	-
Loans and Receivables (i)							
- Trade Debtors	838	559	3	189	87	-	-
- Patient Fees	248	234	1	6	7	-	-
- Other Receivables	243	210	15	65	-	-	(47)
- Term Deposit	6,491	6,491	-	-	-	-	-
Total Financial Assets	9,714	9,388	19	260	94	-	(47)

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

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

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

NOTE 18: FINANCIAL INSTRUMENTS (Continued)

(c) Liquidity Risk

Liquidity risk is the risk that the Health Service would be unable to meet its financial obligations as and when they fall due. The Health Service settles financial obligations within 90 days.

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

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

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

Maturity analysis of financial liabilities as at 30 June

			Maturity Dates			
	Total Carrying Amount	Nominal Amount	Less than 1 Month	1 - 3 Months	3 Months - 1 Year	1 - 5 Years
2016	$'000	$'000	$'000	$'000	$'000	$'000
Financial Liabilities						
At amortised cost						
Payables (i)	3,632	3,632	1,827	1,627	178	-
Borrowings	5,081	5,081	-	-	500	4,581
Other Financial Liabilities						
- Accommodation Bonds	3,123	3,123	-	-	3,123	-
- Other	3,162	3,162	-	3,162	-	-
Total Financial Liabilities	14,998	14,998	1,827	4,789	3,801	4,581
2015						
Financial Liabilities						
At amortised cost						
Payables (i)	3,510	3,510	2,746	764	-	-
Borrowings	5,908	5,908	-	-	500	5,408
Other Financial Liabilities						
- Accommodation Bonds	2,884	2,884	-	-	2,884	-
- Other	43	43	-	43	-	-
Total Financial Liabilities	12,345	12,345	2,746	807	3,384	5,408

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

(d) Market Risk

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

Currency Risk

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

Interest Rate Risk

For financial liabilities, Bass Coast Health mainly undertakes financial liabilities with relatively even maturity profiles.

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

The Health Service has minimal exposure to cash flow interest rate risks through its cash and deposits, 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.

NOTE 18: FINANCIAL INSTRUMENTS (Continued)
(d) Market Risk (Continued)
Other Price Risk
The Health Service is exposed to normal price fluctuations from time to time through market forces. Where adequate notice is provided by suppliers, additional purchases are made for long term goods. Supplier contracts are also in place for major product lines purchased by the Health Service on a monthly basis. These contracts have set price arrangements and are reviewed on a regular basis.

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

	Weighted Average Effective Interest Rate (%)	Carrying Amount $'000	Interest Rate Exposure		
2016			Fixed Interest Rate $'000	Variable Interest Rate $'000	Non - Interest Bearing $'000
Financial Assets					
Cash and Cash Equivalents	2.34	7,200	5,354	1,846	-
Loans and Receivables (i)					
- Trade Debtors	0.00	427	-	-	427
- Other Receivables	0.00	373	-	-	373
- Term Deposit	0.00	-	-	-	-
Total Financial Assets		8,000	5,354	1,846	800
Financial Liabilities					
Payables (i)	0.00	3,632	-	-	3,632
Borrowings	0.00	5,081	-	-	5,081
Other Financial Liabilities					
- Accommodation Bonds	0.00	3,123	-	-	3,123
- Other	0.00	3,162	-	-	3,162
Total Financial Liabilities		14,998	-	-	14,998
2015					
Financial Assets					
Cash and Cash Equivalents	2.20	1,894	-	1,894	-
Loans and Receivables (i)		-	-	-	-
- Trade Debtors	0.00	838	-	-	838
- Other Receivables	0.00	491	-	-	491
- Term Deposit	2.80	6,491	6,491	-	-
Total Financial Assets		9,714	6,491	1,894	1,329
Financial Liabilities					
Payables (i)	0.00	3,510	-	-	3,510
Borrowings	0.00	5,908			5,908
Other Financial Liabilities					
- Accommodation Bonds	0.00	2,884	-	-	2,884
- Other	0.00	43	-	-	43
Total Financial Liabilities		12,345	-	-	12,345

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

NOTE 18: FINANCIAL INSTRUMENTS (Continued)
(d) Market Risk (Continued)

Sensitivity Disclosure Analysis
Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, the Bass Coast Health believes the following movements are 'reasonably possible' over the next 12 months (base rates are sourced from the Reserve Bank of Australia).
- A shift of 100 basis points up and down in market interest rates (AUD) from year-end rates of 1.75%; and
- A parallel shift of +1% and -1% in inflation rate from year-end rates of 2.5%.

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

	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-1%		1%		-1%		1%	
		Profit	Equity	Profit	Equity	Profit	Equity	Profit	Equity
2016	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Financial Assets									
Cash and Cash Equivalents	7,200	(72)	(72)	72	72	-	-	-	-
Loans and Receivables									
- Trade Debtors	427	-	-	-	-	-	-	-	-
- Other Receivables	373	-	-	-	-	-	-	-	-
- Term Deposit	-	0	0	-	-	-	-	-	-
Financial Liabilities									
Payables	3,632	-	-	-	-	-	-	-	-
Borrowings	5,081	-	-	-	-	-	-	-	-
Other Financial Liabilities									
- Accommodation Bonds	3,123	0	0	-	-	-	-	-	-
- Other	3,162	0	0	-	-	-	-	-	-
	22,998	(72)	(72)	72	72	-	-	-	-
2015									
Financial Assets									
Cash and Cash Equivalents	1,894	(19)	(19)	19	19	-	-	-	-
Loans and Receivables									
- Trade Debtors	838	-	-	-	-	-	-	-	-
- Other Receivables	491	-	-	-	-	-	-	-	-
- Term Deposit	6,491	(65)	(65)	65	65	-	-	-	-
Financial Liabilities									
Payables	3,510	-	-	-	-	-	-	-	-
Borrowings	5,908	-	-	-	-	-	-	-	-
Other Financial Liabilities									
- Accommodation Bonds	2,884	-	-	-	-	-	-	-	-
- Other	43	-	-	-	-	-	-	-	-
		(84)	(84)	84	84	-	-	-	-

(e) 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.

Bass Coast Health considers that the carrying amount of financial instrument asset 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.

NOTE 18: FINANCIAL INSTRUMENTS (Continued)
(e) Fair Value (Continued)

Comparison between carrying amount and fair value

	Total Carrying Amount 2016 $'000	Fair Value 2016 $'000	Total Carrying Amount 2015 $'000	Fair Value 2015 $'000
Financial Assets				
Cash and Cash Equivalents	7,200	7,200	1,894	1,894
Loans and Receivables (i)				
- Trade Debtors	427	427	838	838
- Other Receivables	373	373	491	491
-Term Deposits	-	-	6,491	6,491
Total Financial Assets	**8,000**	**8,000**	**9,714**	**9,714**
Financial Liabilities				
Payables (i)	3,632	3,632	3,510	3,510
Borrowings	5,081	5,081	5,908	5,908
Other Financial Liabilities				
- Accommodation Bonds	3,123	3,123	2,884	2,884
- Other	3,162	3,162	43	43
Total Financial Liabilities	**6,285**	**6,285**	**12,345**	**12,345**

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

All financial assets held by Bass Coast Health are classified as Level 1.

NOTE 19: COMMITMENTS FOR EXPENDITURE	2016 $'000	2015 $'000
(a) Commitments		
Capital Expenditure Commitments		
Payable:		
Land and Buildings	-	1,317
Total Capital Expenditure Commitments	**-**	**1,317**
Lease Commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating leases	794	160
Total Lease Commitments	**794**	**160**
Operating Leases		
IT Computers and Printers payable as follows:		
Not later than one year	192	118
Later than one year and not later than 5 years	602	42
Total Operating Lease Commitments	**602**	**160**
Total Commitments (inclusive of GST)	794	1,477
less GST recoverable from the Australian Taxation Office	(72)	(134)
Total Commitments (exclusive of GST)	**722**	**1,343**

NOTE 20: CONTINGENT ASSETS AND CONTINGENT LIABILITIES

There are no known contingent assets or contingent liabilities for Bass Coast Health at the date of this report.

NOTE 21: OPERATING SEGMENTS

	RACS		HOSPITAL		TOTAL	
	2016 $'000	2015 $'000	2016 $'000	2015 $'000	2016 $'000	2015 $'000
REVENUE						
External Segment Revenue	7,234	7,756	48,342	51,444	55,576	59,200
Total Revenue	**7,234**	**7,756**	**48,342**	**51,444**	**55,576**	**59,200**
EXPENSES						
External Segment Expenses	(6,863)	(7,445)	(50,879)	(50,688)	(57,742)	(58,133)
Total Expenses	**(6,863)**	**(7,445)**	**(50,879)**	**(50,688)**	**(57,742)**	**(58,133)**
Net Result from Ordinary Activities	**371**	**311**	**(2,537)**	**756**	**(2,166)**	**1,067**
Interest Income	-	-	219	253	219	253
Net Result for Year	**371**	**311**	**(2,318)**	**1,009**	**(1,947)**	**1,320**
OTHER INFORMATION						
Segment Assets	10,932	11,328	43,761	45,345	54,693	56,673
Total Assets	**10,932**	**11,328**	**43,761**	**45,345**	**54,693**	**56,673**
Segment Liabilities	4,170	4,176	18,073	18,100	22,243	22,276
Total Liabilities	**4,170**	**4,176**	**18,073**	**18,100**	**22,243**	**22,276**
Acquisition of Property, Plant and Equipment and Intangible Assets	-	-	1,683	1,522	1,683	1,522
Depreciation and Amortisation Expenses	-	-	1,892	1,613	1,892	1,613
Non-Cash Expenses other than Depreciation	-	-	154	455	154	455

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

Business Segments	Services
Hospital	Provider of acute hospital services
Residential Aged Care (RACS)	Provider of residential aged care beds

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

NOTE 22: JOINTLY CONTROLLED OPERATIONS AND ASSETS

Name of Entity	Ownership Interest 2016 %	2015 %
Gippsland Health Alliance	9.98	9.09

Bass Coast Health's interest in assets employed in the above jointly controlled operations and assets is detailed below.
The amounts are included in the financial statements and consolidated financial statements under their respective categories:

	2016 $	2015 $
Current Assets		
Cash and Cash Equivalents	145	232
Receivables	135	123
Other Current Assets	84	82
Total Current Assets	**364**	**437**
Non Current Assets		
Property Plant and Equipment	3	3
Total Non Current Assets	**3**	**3**
Total Assets	**367**	**440**
Current Liabilities		
Payables and Accrued Expenses	64	95
Other Current Liabilities	42	63
Total Current Liabilities	**106**	**158**
Total Liabilities	**106**	**158**
Net Assets	**261**	**282**

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

Revenues		
GHA Revenue	962	866
Capital Income	-	25
Total Revenue	**962**	**891**
Expenses		
Information Technology and Administrative Expenses	983	1,499
Capital Expense	-	-
Total Expenses	**983**	**1,499**
Profit	**(21)**	**(608)**

Contingent Liabilities and Capital Commitments
There are no known contingent liabilities or capital commitments for Gippsland Health Alliance at the date of this report.

NOTE 23a: RESPONSIBLE PERSON DISCLOSURES
In accordance with the Ministerial Directions issued by the Minister for Finance under the Financial Management Act 1994, the following disclosures are made regarding responsible persons for the reporting period.

	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	01/07/2015 - 30/06/2016
The Honourable Jenny Mikakos, MLC, Minister for Families and Children	01/07/2015 - 30/06/2016
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	01/07/2015 - 30/06/2016
Governing Boards	
Peter Laydon	01/07/2015 - 23/03/2016
Don Paproth	01/07/2015 - 30/06/2016
Christine Hammond	01/07/2015 - 30/06/2016
Margaret Jarvis	01/07/2015 - 30/06/2016
Mary O'Connor	01/07/2015 - 30/06/2016
Mim Kershaw	01/07/2015 - 30/06/2016
Neville Goodwin	01/07/2015 - 30/06/2016
Peter Harcourt	01/07/2015 - 30/06/2016
Mary Whelan	11/08/2015 - 30/06/2016
Tim Large	01/07/2015 - 30/06/2016
Sandra Bell	01/07/2015 - 16/12/2015
Accountable Officers	
Veronica Jamison	01/07/2015 - 02/03/2016
Jan Child	03/03/2016 - 30/06/2016

NOTE 23a: RESPONSIBLE PERSON DISCLOSURES (Continued)
Remuneration of Responsible Persons
The number of Responsible Persons are shown in their relevant income bands;

	Total Remuneration 2016 No.	2015 No.
$0 - $9,999	11	12
$90,000 - $99,999	1	-
$230,000 - $239,999	-	1
$280,000 - $289,999	1	-
	13	13
Total remuneration for the reporting period for Responsible Persons included above amounted to:	$374,947	$233,611

Amounts relating to Responsible Ministers are reported in the financial statements of the Department of Premier and Cabinet. For information regarding related party transactions of ministers, the register of members' interests is publicly available from: www.parliament.vic.gov.au/publications/register of interests.

NOTE 23b: EXECUTIVE OFFICER DISCLOSURES
The numbers of executive officers, other than Ministers and Accountable Officers, and their total remuneration during the reporting period are shown in the first column in the table below in their relevant income bands. The base remuneration of executive officers is shown in the third and fourth columns. Base remuneration is exclusive of bonus payments, long service leave payments, redundancy payments and retirement benefits.

Several factors affected total remuneration payable to executives over the year. A number of employment contracts were completed during the year and negotiated and a number of executives received bonus payments during the year. These bonus payments depend on the terms of individual employment contracts. Some contracts provide for an annual bonus payment whereas other contracts only include the payment of bonuses on the successful completion of the full term of the contract. A number of these contract completion bonuses became payable during the year.

A number of executive officers retired, resigned or were retrenched in the past year. This has had a significant impact on total remuneration figures due to the inclusion of annual leave, long-service leave and retrenchment payments.

	Total Remuneration		**Base Remuneration**	
	2016 No.	**2015 No.**	**2016 No.**	**2015 No.**
$10,000 - $19,999	-	-	1	-
$30,000 - $39,999	-	-	1	-
$80,000 - $89,999	-	-	1	-
$90,000 - $99,999	1	-	-	-
$100,000 - $109,999	1	-	-	-
$110,000 - $119,999	1	-	-	-
$130,000 - $139,999	-	1	-	1
$150,000 – $159,999	1	1	1	1
$160,000 – $169,999	-	1	-	1
$190,000 – $199,999	1	-	1	-
$250,000 – $259,999	-	1	-	1
Total annualised employee equivalents (AEE) (i)	2.308	4	2.308	4
Total Remuneration	**$669,033**	**$712,040**	**$491,403**	**$606,215**

(i) Annualised employee equivalent is based on paid working hours of 38 ordinary hours per week over the 52 weeks for a reporting period.

Note 24: REMUNERATION OF AUDITORS	**2016 $'000**	**2015 $'000**
Victorian Auditor-General's Office	46	44
Audit or review of financial statement	46	44

NOTE 25: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE
There have been no material events which have occurred subsequent to the reporting date which require further disclosure.

NOTE 26: ECONOMIC DEPENDENCY
The financial performance and position of Bass Coast Health has further declined since the prior year, with the health service reporting a deficit net result before capital and specific items of $972K (2015: $3.915M), a negative current asset position of $6.831M (2015: $4.926M), resulting in a current asset ratio of 0.57 (2015: 0.69) and a cash inflow from operations of $1.037M (2015: $1.856M negative).

As a result of the financial performance and position, Bass Coast Health 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 Bass Coast Health adequate cash flow to meet its current and future obligations up to 30th September 2017. On that basis, the financial statements have been prepared on a going concern basis.

1. **Wonthaggi Hospital**
235 Graham Street, Wonthaggi Vic. 3995
Tel: 03 5671 3333

2. **Armitage House Nursing Home**
Baillieu Street, Wonthaggi Vic. 3995
Tel: 03 5671 3352

3. **Kirrak House Nursing Home**
Baillieu Street, Wonthaggi Vic. 3995
Tel: 03 5671 3250

4. **Wonthaggi – Maternal & Child Health Services**
Wonthaggi Hospital
235 Graham Street, Wonthaggi Vic. 3995
Tel: 03 5671 3136

5. **Bass Coast Health – Inverloch site**
14 Reilly Street, Inverloch Vic. 3996
Tel: 03 5671 9208

6. **Inverloch Maternal & Child Health Services**
Inverloch Community Hub
16 A'Beckett Street, Inverloch Vic. 3996
Tel: 03 5671 3136

7. **Griffiths Point Lodge**
Davis Point Road, San Remo Vic. 3925
Tel: 03 5678 5311

8. **Bass Coast Health – San Remo site**
1 Back Beach Road, San Remo Vic. 3925
Tel: 03 5671 9200

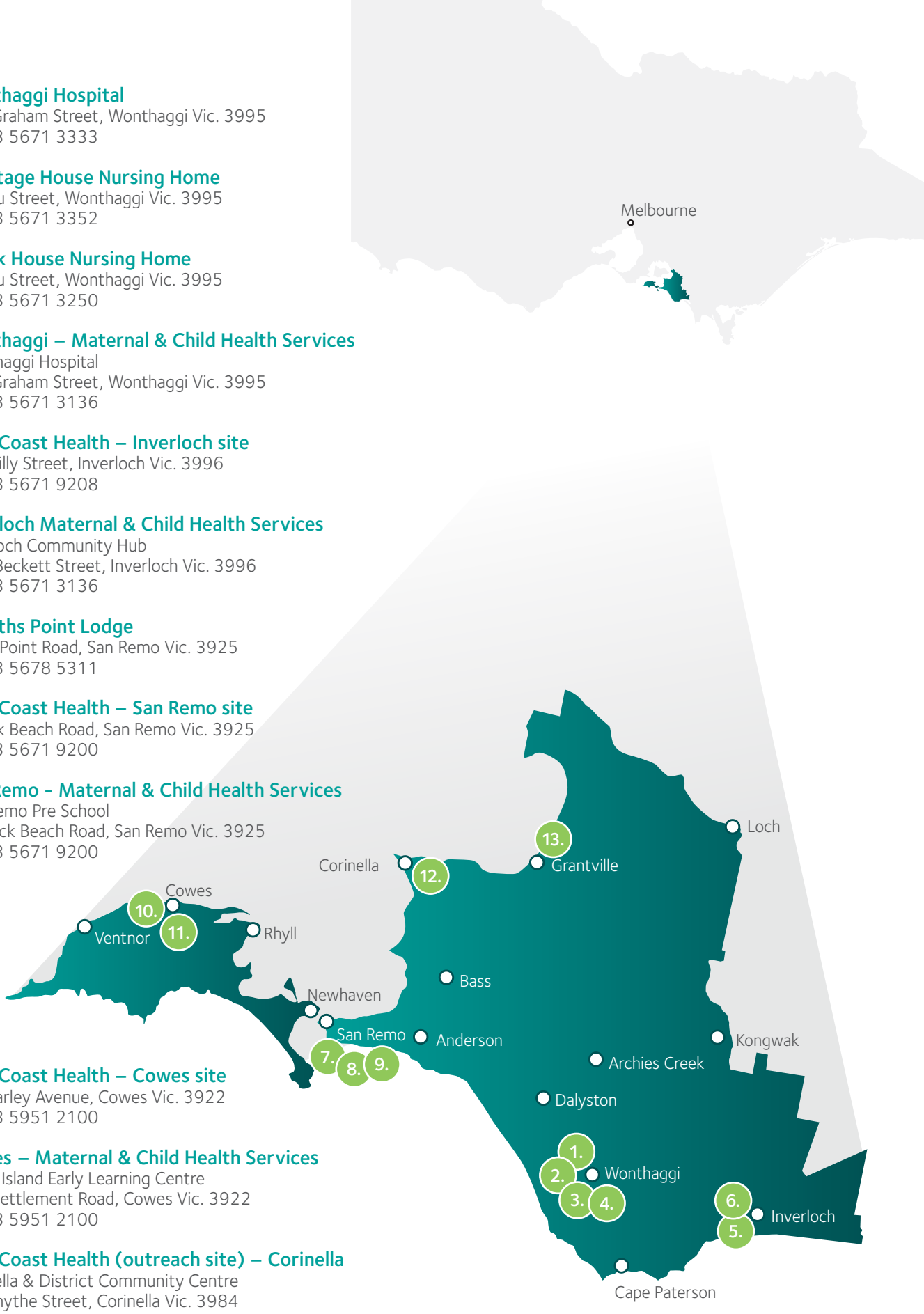
9. **San Remo - Maternal & Child Health Services**
San Remo Pre School
23 Back Beach Road, San Remo Vic. 3925
Tel: 03 5671 9200

10. **Bass Coast Health – Cowes site**
14 Warley Avenue, Cowes Vic. 3922
Tel: 03 5951 2100

11. **Cowes – Maternal & Child Health Services**
Phillip Island Early Learning Centre
161 Settlement Road, Cowes Vic. 3922
Tel: 03 5951 2100

12. **Bass Coast Health (outreach site) – Corinella**
Corinella & District Community Centre
48 Smythe Street, Corinella Vic. 3984
Tel: 03 5671 9200

13. **Bass Coast Health (outreach site) – Grantville**
Grantville Transaction Centre
Cnr. Bass Highway & Pier Road, Grantville Vic. 3984



BCH
Bass Coast Health

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