TIMBOON
AND DISTRICT
HEALTHCARE
SERVICE

Annual Report

2017/2018

Enabling optimum health and wellness for our communities

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All images suppled as part of a Timboon and District Healthcare Service community photo competition (4/06/2018 to 16/07/2018)

The entries reflect community member's attempts to capture Our Vision Statement: "Enabling optimum Health & Wellness for our communities" and to depict locations or aspects of our service's catchment area.

This annual report fulfils Timboon and District Healthcare Service's reporting requirements to the community and to the Minister for Health. It summarises Timboon and District Healthcare Service's results, performance, outlook and financial position for 2017/2018.

The annual report outlines our performance against key objectives identified in the Timboon and District Healthcare Service strategic plan, and against the Victorian Government's objectives for the community and frontline services.

This annual report will be available on the Timboon and District Healthcare Service website at: www.timboonhealthcare.com.au/about/publications

Hard copies of the annual report can be obtained by phoning the office of the Chief Executive Officer, Timboon and District Healthcare Service, on (03) 5558 6029.

Timboon and District Healthcare Service is committed to providing accessible services. If you have difficulty in understanding this annual report, you can contact Timboon and District Healthcare Service on (03) 5558 6029 to arrange appropriate assistance.

Overview

"Timboon and District Healthcare Service is a Multipurpose Service (MPS) ... Service delivery includes acute, residential and community aged care and a comprehensive suite of primary care services

TIMBOON AND DISTRICT HEALTHCARE SERVICE (TDHS) IS A MULTIPURPOSE SERVICE ESTABLISHED UNDER AN AGREEMENT BETWEEN THE COMMONWEALTH AND VICTORIAN GOVERNMENTS AND INCORPORATED UNDER THE HEALTH SERVICES ACT 1988.

TDHS is governed by the Board of Governance, with its Directors appointed by the Governor-in-Council upon the recommendation of the Victorian Minister for Health.

Service delivery includes acute, residential and community aged care and a comprehensive suite of primary care services. Acute and residential aged care services are provided within 14 flexible beds and a 6 day-stay bed complex with an operating theatre suite and urgent care centre. Community Health Services are provided both in house and externally through community outreach programs. TDHS jointly manages the Timboon Medical Clinic which is located adjacent to the health service and contracts General Practitioners as Visiting Medical Officers to TDHS.

TDHS provide services within the southern half of the Corangamite Shire and the south eastern section of Moyne Shire. Key towns within the catchment area include: Timboon, Cobden, Nullawarre, Peterborough, Port Campbell, Princetown and Simpson.

We take this opportunity to thank our consumers, communities, staff and other health partners for their support and commitment and look forward with confidence to a positive year ahead as we continue to deliver the TDHS vision.

Our Vision

Enabling optimum health and wellness for our communities

Our Mission

To provide leading innovative health and wellness services of the highest quality

Our Core Values

We engage others in a respectful, fair and ethical manner

We will accept people as they are and display kindness and sensitivity to them

We show pride, enthusiam and dedication in everything that we do

We consult and collaborate with others and respect the diverse knowledge and skills of patients, families and each other

We create opportunities for education and are committed to continuous development

Our Board Chair and CEO's Report

ON BEHALF OF THE BOARD OF GOVERNANCE AND ALL STAFF WE ARE PLEASED TO PRESENT THE ANNUAL REPORT OF TIMBOON AND DISTRICT HEALTHCARE SERVICE (TDHS) FOR THE YEAR ENDING 30TH JUNE 2018, PREPARED IN ACCORDANCE WITH THE FINANCIAL MANAGEMENT ACT 1994.

The health service system continues to respond to changes in policy, technology and workforce. The end goal is the provision of high quality and safe services for our community. We actively support government directions in ensuring what we do at TDHS reflects the principles of safe care for all our patients and clients. TDHS is a vital community health service. As one of seven Multi-Purpose Health services (MPS) in Victoria, TDHS was established in 1999 by both Commonwealth and State governments to provide a range of relevant services for its rural and remote community. The model itself was a positive initiative between governments that enabled rural communities around Australia to have access to a variety of services close to home. They were designed to give rural people access to low level acute services, residential and community aged care, primary health and urgent care services whilst recognising that more complex and specialist services require more advanced treatment at higher level facilities.

We would both like to take this opportunity to formally acknowledge the work and dedication of our staff, volunteers and medical group who consistently strive to support the health needs of the people in our communities.

One of the great benefits of the MPS model is to enable communities to have input into the services provided to reflect local needs. This year the Board undertook an independent comprehensive community needs assessment, to seek input and evidence from the community, to identify key health issues and requirements. An extensive community consultation process was central to the assessment enabling community members and staff to speak directly with consultants, complete a survey either by hand or online or participate in small group workshops. This has provided the Board with a wonderful insight into the community's needs. We thank all those community members who contributed to this process. Along with government policy and standards, this was done to inform the Board in the development of their next 5 year strategic plan which is already under development and will be released in the first quarter of 2018/19.

The MPS model itself has been in operation for 20 plus years and with major changes in health policy taking place, is in need of review to take our service forward in a sustainable approach. Together with the Victorian Healthcare Association and the Victorian MPS network we engaged consultants in 2017 to conduct an environmental scan to outline the current abilities and issues that the MPS model is undergoing. In 2018, agreement has been reached to undertake stage 2 of the Victorian MPS review which will plan and develop a sustainable business and service model for the next 10-15 years and lay plans for our future development. We look forward to this project concluding in late 2018 building on the work in stage 1 and working with both the State and Commonwealth governments to continue to provide relevant and safe services to rural and remote communities.

Board of Governance members are appointed by the Minister for Health and are responsible to the Minister for Health for the corporate and clinical governance of TDHS. Through the Department of Health and Human Services the Minister monitors, evaluates and regulates what we do across all of our services and operations. This information is used to guide the Board's decision making.

We welcome the appointment of Ms Toinette Hutchins to our Board. Toinette brings significant and comprehensive clinical experience and will be a valuable addition to our Board. We farewelled some highly valued experienced members as well.

We acknowledge the wonderful contributions of Ms Wendy Cameron, Ms Glenda Stanislaw, Mr Paul Washington, Mr Jason Chuck and Mr John Renyard in leading a skilled Board in navigating the complex pathway of a rural health service system and the increasing demands of being a Board of Governance member. Their contribution has been much appreciated, respected and valued. Our Board of Governance was led by Chair Maryanne Puli Vogels and supported by two Vice Chair positions John Renyard and Josh McKenzie.

Reflecting back over the last 12 months it is pleasing to see a number of our key projects for the year achieved.

Much of the work detailed in this report has been achieved by enhancing our internal systems, ensuring that we are compliant with our ever increasing regulatory, financial and clinical governance obligations. This has put in place the building blocks on which to build and develop our health service for the next decade. With a comprehensive and consultative planning project undertaken our aim is to provide high quality, safe and relevant services locally whilst accessing more complex services in larger tertiary facilities in our region.

Our participation in a number of accreditation and audit processes, both external and internal, ensures that we continue to improve our service delivery and strive to achieve best practice outcomes. We received excellent results across all our audits, both corporate and clinical, as well as successfully achieving our accreditation for 5 years from the Australian Council of Healthcare Standards. Our congratulations go to all the staff who managed this process with the skill and diligence required to achieve these excellent results for TDHS. This, of course, is one aspect of a suite of quality assessments for health services. There are many others that are conducted on an internal basis that enable us to ensure our patients and clients are afforded the highest levels of quality health and community services. It is an area that requires continued attention and commitment.

Our Board Chair and CEO's Report

We again continued to increase service provision in a financially sustainable manner during 2017/18. Providing health and well-being services to our communities is our main goal. Our aim is to achieve this whilst ensuring we achieve a break even or small surplus operating result. We have achieved this major objective in 2017/18. However, financial balance is becoming increasingly challenging with costs increasing across the board. Planning to keep TDHS in a financial stable position is another reason to review, plan and develop our health service to meet the needs of our communities within the government policy.

We continue to work with our key stakeholders. It is vital to continue to build on these partnerships so we can provide a healthcare service that is meeting the community's expectations.

We are supportive of the Corangamite Region Health Collaborative, the Polwarth partnership, the Victorian MPS network and the Barwon South West CEO council. We continue to examine partnerships that assist and support achieving our vision of 'enabling optimum health and wellness for our communities'. The community's health requirements change over periods of time and services that were suitable and appropriate for local populations 40 years ago may not be in the same demand in 2018 or through to 2025.

Fundraising for TDHS continues to attract significant community support and this year has been no exception. The individual donors, the Timboon Cruisers with their cycle ride in the Murray to Moyne, and of course the wonderful TOPS group. Timboon Ritchies' IGA supermarket have supported the Service over the last 13 years through their Community Benefit card program. Generous benefactors have done so much to help develop TDHS over many years and it remains an inspiration to us all. This year's appeal is to raise funds for the purchase of Emergency care trolleys to ensure we can respond to emergencies more quickly with easy access to vital equipment.

The Board of Governance acknowledges the complex corporate and clinical challenges that governments and health services face and the realization that the health dollar needs to be efficiently managed whilst upholding the highest standards of safety and quality.

On behalf of the Board of Governance, I would like to extend our thanks to the State Department of Health and Human Services and the Commonwealth Department of Health for their continued support, planning and funding. We look forward to a continuation of productive partnerships.

We are looking forward to the years ahead where TDHS can continue to provide leadership in the field of rural health service and support the improvement in the health status of its communities, recognising the important role local rural health services have in the overall health system.

Ms Maryanne Puli Vogels
Board Chair

Mr Gerry Sheehan
Chief Executive

How did we *Care* for you this year?

Our Services

32,673
Occasions of Sevice Delivered to the Community

15,939
Meals Prepared by Our Kitchen

1,456
Patients Treated by Our Urgent Care

504
Exercise Classes Held

10,294
Hours of Services Delivered in Clients Home

1,732
Hours of Primary Health Care Services Delivered

Our People

89
People Employed By TDHS

54
Volunteers Give Time to Help TDHS

96%
Staff Immunised Against Influenza

75%
Staff Live in Our Local Catchment

94%
Staff Would Recommend Others to be Treated at TDHS

68%
Staff Are Clinicians Directly Providing a Service

Our Services

TIMBOON AND DISTRICT HEALTHCARE SERVICE (TDHS) PROVIDES A VARIETY OF HEALTHCARE SERVICE PROGRAMS. THESE INCLUDE:

ACUTE SERVICES

TDHS offers both inpatient and outpatient services to the community of Timboon and districts including - medical, minor surgical, endoscopy, palliative care and post-natal care. Medical imaging (X-Ray) is available on a Thursday and pathology services are available twice daily Monday to Friday and Saturday morning.

Our acute services are supported by four General Practitioners and a number of visiting/ locum medical practitioners including General Practitioners, General Surgeon and two Procedurals' Physicians.

URGENT CARE AND AFTER HOURS MEDICAL TREATMENT

A nurse assessment (triage) led model supported by on-call medical staff delivers Urgent Care and After Hours (e.g. week nights and weekends) treatment for medical emergencies to the community.

Emergency Telehealth support is now up and running. This enables staff to connect visually with a Doctor from Adult Retrieval Victoria (ARV) in a medical emergency if a Doctor is not available.

AGED AND RESIDENTIAL CARE

TDHS has four Nursing Home (High Care) beds providing a home-like atmosphere with the security of assistance when required. Respite care is also available.

HOME BASED SERVICES

Also known as Commonwealth Home Support Program (CHSP) and Home and Community Care (HACC), services include:

- Domestic Assistance
- Personal Care
- In-home Respite Care
- Garden Maintenance
- Meals on Wheels
- Social Support Groups
- District Nursing

The services are provided to support and assist elderly people or younger people with disabilities living at home or in the community and their families. TDHS is currently finalising the process to register as a provider for the National Disability Insurance Scheme (NDIS).

Home based services also provide care and support to palliative clients and families.

COMMUNITY HEALTH SERVICES

Community Health Services help in many ways to manage and maintain good health and independence in the community. These programs focus on community wide health promoting activity to prevent the onset of health problems i.e., helping people to eat well, stay physically fit, and stay socially connected.

Services available include:

- Physiotherapy
- Exercise Classes
- Cooking Classes
- Dietetics
- Speech Pathology
- Community Health Nurse
- Diabetes Education
- Podiatry
- Community Transport
- Continence Nurse
- Occupational Therapy

- Health Promotion and Education
- Audiology
- Immunisation Clinic
- Women's Health
- Ante-natal and Post-natal Care

ORAL HEALTH SERVICES

The dental clinic provides general oral health services, both public and private. The Royal Flying Doctor Service provided the public clinic in May/ June 2017 and returned to complete services to patients in July 2017.

Year in Review

IN JANUARY 2016 THE *TIMBOON AND DISTRICT HEALTHCARE SERVICE STRATEGIC PLAN 2015 - 2018* WAS APPROVED BY THE REGIONAL DIRECTOR – HEALTH, BARWON SOUTH WEST REGION. THE "DIRECTIONS" COLUMN IN THE BELOW SCHEDULE ARE THE PILLARS IN THIS STRATEGIC PLAN.

DIRECTIONS	ACTIONS	DELIVERABLES	OUTCOMES
Empower our communities to become avid health consumers responsible for their health and wellbeing needs	Enhance organisational/ volunteer collaboration	• Greater understanding of the volunteers and community issues and views • Safer working environments for volunteers; more structured approach to engage volunteers to deliver community services in accordance with government policy and standards	Commenced. Training provided to volunteers. Forums held with Volunteers.
	Initiate and implement world health organisation (WHO) obesity approach for our community in collaboration with Deakin university through the Corangamite Health Collaborative (CHC)	• Implement Timboon Health Promotion Plan	Achieved in collaboration with the Heart of Corangamite (HOC) Project Worker.
	Commence a community health literacy program incorporating a focus on staff, volunteers and the broader community	• Review current policy and process • Community Advisory Committee (CAC) reviewing resources for external use	Commenced. Developing communication via patient safety meeting. CAC reviewing resources.
	Develop a flexible approach to service delivery including focus on Urgent Care	• Rural & Isolated Practice Endorsed Registered Nurse (RIPERN) training for Associate Nurse Unit Managers (ANUM with TDHS support • Telehealth options being explored including a regional approach • Implement model of care framework for RIPERN nursing	Commenced. Telehealth options being explored. RIPERN Training in progress.
	Develop community health engagement program	• Implement a smoke free workplace • Provide opportunities to increase access for young people to understand the employment opportunities in health • Further enhance the use of local transport opportunities to benefit the health of the community	Commenced. Work Experience program in place for students.

DIRECTIONS	ACTIONS	DELIVERABLES	OUTCOMES
		• Continue to embed the Community Advisory Committee	
Leverage the flexibility of the MPS to align our services with emerging trends	Complete service delivery review and identify recommendations for strategic action	• Monitor relevant data streams on population growth, morbidity and mortality trends and hospital performance figures and use the data to inform planning decisions • Incorporate outcomes from service delivery review, MPS review, pricing review & external policy review into new strategic plan for TDHS • Evidence and understanding of community health needs • New Strategic Plan to be devised 2018-2023	Commenced. Community Health Needs Assessment (CHNA) completed and strategic plan in progress.
	Complete pricing review	• Complete cost analysis of existing services	Completed.
	Review outcomes and recommendations of Victoria MPS Review Project to inform TDHS strategic direction	• Develop plan and obtain Board endorsement	Stage 2 of MPS Review commenced.
	Complete external policy review National Disability Insurance Agency (NDIA)	• Register to be an NDIA provider	Commenced.
	Develop capital plan for TDHS facilities based on TDHS service profile	• Develop a master plan for TDHS incorporating repair & refurbishment	To be developed once Strategic Plan is complete.
	Implement TDHS Service Profile	• Develop a strategy for TDHS to attain a level of quality in service delivery to enable TDHS to submit proposal for Rural Health Service Awards	Commenced. Awaiting completion of strategic plan.
Develop alliances and collaboration opportunities	Strengthen and participate actively in local and sub-regional collaborative groups.	• Enable our community to receive the best quality and effective services in response to their health requirements • Shared opportunity to partner and standardise policy • More efficient clinical safety and quality safety • Allied health services review and mentoring opportunities • Collaborating with local primary health care organisations and Primary Health Networks	Commenced. Current participation in regional and sub-regional collaboratives and partnerships. Regional approach to SHRFV (Strengthen hospital response to family violence) is in progress. Still developing shared approach in patient pathways. Commenced partnership and shared models.

Year in Review

DIRECTIONS	ACTIONS	DELIVERABLES	OUTCOMES
	Develop & consolidate strategic alliances	• Participate & collaborate with local ambulance service to foster relationships and improve cooperation • Improve timelines of information flow between TDHS and other service providers	Commenced. Good relationship with local ambulance service.
	Maximise alignment opportunities with relevant education providers	• Cooperate with university partners & local high schools in planning student placements and programs	Commenced. Health promotion in place and student placements underway.
Operate safely and sustainably	Review internal and external data collection to ensure effective integrated systems and performance	• Improve data integrity and organisational response to performance creating a focus on evidence and data • Actively monitor and improve the quality and safety within committee structures	Commenced training and education. Achieved a standardised committee agenda and terms of reference reviewed. Data review and improvement in progress.
	Identify potential grant & funding opportunities	• Complete review of state health, federal health and other bodies re potential grant & funding opportunities	Commenced review. Additional Commonwealth funding obtained by converting low care to high care beds.
	Identify potential revenue opportunities	• Complete review of existing service charges and identify opportunities to increase charges / initiate charges	Completed. Fees and charges policy fully implemented. Additional revenues will be identified during Strategic Plan review.
	Develop asset management framework	• Develop and maintain Assets Register and asset management framework • Asset acquisition and disposal process established • Develop five year capital plan • Ensure that there is an ongoing review of equipment priorities	Completed. Commenced development of five year capital plan and maintenance system project under way.
	Develop OH&S framework	• Review policies and complete audits • Implement PPE, dangerous goods and hazardous chemicals register • Develop and communicate Standard Operating Procedures (SOP's)	Completed. A review of Occupational Health and Safety (OH&S) committee structure is currently underway.
	Develop & implement professional competence framework	• Review staff training policy and training matrix, and ensure mandatory training requirements met • Improve the efficiency of handover • Use existing collaborative links to	Commenced.

DIRECTIONS	ACTIONS	DELIVERABLES	OUTCOMES
		explore opportunities for TDHS to participate in appropriate research activities • Allocation of training budget reflective of policy and matrix requirements	
	Review & implement medical record system	• Identify electronic gaps in current system - move to filing all documents • Review, develop suite of medical record policies including management & storage • Move to full electronic health record for community health non-admitted patients	Commenced. Reviews underway.
	Develop & participate in regional clinical governance system	• Participate in development of terms of reference and establishment of group	Completed. Network and committees established to ensure ongoing governance.
	Develop & implement sustainable & compliance maintenance system	• Ensure compliance in essential safety measures and electrical tag and testing • Planned maintenance schedules • Clearing outstanding audit items	Completed. Maintenance system project underway.
	Complete review of Community Care	• Full review of care client lists/ rosters and findings model	Review commenced with all key stakeholders.
	Develop and implement emergency management process	• Develop emergency management procedures and business continuity plan. • Participate on the Local Disaster Management Committee for collaborative intra-service disaster planning and preparedness • Fire warden training	Completed. Plans and procedures developed and emergency management training commenced.
	Develop and implement contractor management process	• Develop contractor manual, sign in/sign out process/ permit process and hazardous activities OH & S induction	Completed.
	Ensure patients, carers, visitors, community and service providers are treated with dignity, respect and in an ethical manner	• Implement program to improve communication between staff and patients • Ensure staff complete Respecting the Difference: Cultural training course • Develop a local strategy framework for implementing quality care at end of life • Expand scope of TDHS morbidity and mortality reviews • Decrease patient falls • Prepare evaluation report on practice of receiving transfers and post-natal care, based on quality and safety	Commenced. Core values and accepted behaviours introduced as standing agenda items for all clinical meetings. Continue to monitor through Incidents and feedback.

Year in Review

DIRECTIONS	ACTIONS	DELIVERABLES	OUTCOMES
	Develop & implement organisational risk management approach	• Develop a risk management plan to facilitate identification and management of risks, and implement • Review risk organisation wide • Improve security arrangements	Commenced. Recommendations from Victorian Management Insurance Authority (VMIA) audit are currently being implemented.
Embed a positive workplace culture that strengthens our capacity to enable, anticipate and heighten positive community outcomes	Review & refine people framework, Human Resources (HR) tools and policies	• Review positions descriptions, performance appraisals, HR policies and procedures, new starter and exit process	Commenced. HR process review underway. Completed HR policy and procedure review.
	Implementing holistic leadership development approach	• Develop management and decision making skills by ensuring executive and managerial staff participate in training • Develop shared accountability for leadership and communication to staff • Review capability and capacity of clinical roles	Commenced. Middle managers meetings and ANUM meetings established. Leadership training in planning stage.
	Review & develop orientation process	• Evaluate current process and develop new employee program	Commenced. Forms and checklists completed.
	Measure & manage culture to improve team & organisation	• Participate in People Matters survey • Develop and implement People and Culture Plan • Ensure TDHS values are embedded into the organisation	Commenced. People Matters Survey completed. Promotion of TDHS values. People and Culture Plan in progress.
	Develop workforce plan & succession plan	• Explore and develop new opportunities for recruitment and retention • Identify positions that are difficult to recruit to and develop remedial measures • Develop a medical workforce plan for the future	Commenced. Recruitment policy reviewed and strategies developed.
	Workplace health	• Zero tolerance towards occupational violence and aggression, explore and implement duress options for all staff • Promote and encourage staff vaccination participation to achieve Department of Health & Human Services (DHHS) targets • Design & implement Staff Health & Wellbeing Program	Commenced. occupational violence and aggression policy completed. Vaccination targets achieved. Employee Assistance Program reviewed.

Our Performance Priorities

QUALITY AND SAFETY

KEY PERFORMANCE INDICATOR	TARGET	RESULT
Health Service Accreditation	Full Compliance	Full Compliance
Compliance with Cleaning Standards	Full Compliance	Full Compliance
Compliance with the Hand Hygiene Australia Program	80%	87%
Percentage of Healthcare Workers Immunised for Influenza	75%	90%
Victorian Health Experience Survey – patient experience **	Full Compliance	Full Compliance
Victorian Health Experience Survey – discharge care **	Full Compliance	Full Compliance

** Less than 42 responses were received for the period due to the relative size of the Health Service

GOVERNANCE AND LEADERSHIP

KEY PERFORMANCE INDICATOR	TARGET	RESULT
People Matter Survey – percentage of staff with a positive response to safety culture questions	80%	93%

FINANCIAL SUSTAINABILITY

KEY PERFORMANCE INDICATOR	TARGET	RESULT
Operating Result ($m)	0.000	0.341
Trade Creditors	60 Days	44
Patient Fee Debtors	60 Days	46
Adjusted Current Asset Ratio	0.7	3.4
Number of Days Available Cash	14 Days	217

FUNDED FLEXIBLE AGED CARE PLACES

CAMPUS	CAMPUS
Flexible High Care	14

UTILISATION OF FLEXIBLE AGED CARE PLACES

CAMPUS	NUMBER	OCCUPANCY LEVEL %
Flexible High Care	4	100%
Respite **	2	137%
Total	6	

**Beds can be used flexibly based on community need and demand for service

ACUTE CARE

SERVICE	TYPE OF ACTIVITY	ACTUAL 2017-18	ACTUAL 2016-17
Medical Inpatients	Bed days	1,435	1,511
Urgent Care	Presentations	1,458	1,883
Radiology	Number of clients	322	368

PRIMARY HEALTH CARE

SERVICE	TYPE OF ACTIVITY	ACTUAL 2017-18	ACTUAL 2016-17
Community Health Nursing	Hours of Service	398	271
Community Midwife	Hours of Service	216	305
Continence Services	Hours of Service	46	31
Diabetes Education	Hours of Service	41	69
Dietetics	Hours of Service	181	192
Exercise Classes	Occasions of Service	2,866	2,988
Occupational Therapy	Hours of Service	104	129
Physiotherapy**	Hours of Service	326	1168
Podiatry	Hours of Service	118	120
Speech Pathology	Hours of Service	304	250

**Hours of service have decreased because of a shortage of physiotherapists in the region and TDHS hasn't been able to maintain the budgeted staffing levels of this service.

COMMUNITY CARE

SERVICE	TYPE OF ACTIVITY	ACTUAL 2017-18	ACTUAL 2016-17
Delivered Meals	Number of Meals	8,583	7,846
Domestic Assistance	Hours of Service	5,411	4,966
Personal Care	Hours of Service	1,637	1,865
In-home Respite	Hours of Service	389	528
Property Maintenance	Hours of Service	1,094	1,166
Social Support Group	Hours of Service	6,248	7,135
Community Transport	Hours of Service	237	N/A
District Nursing**	Hours of Service	1,768	2,625

**District Nursing demand has decreased in 2017-18

Our Financial Results

5 YEAR FINANCIAL SUMMARY

	2018	2017	2016	2015	2014
Total Revenue	7,183	7,196	7,103	7,006	6,883
Total Expenses	6,842	6,976	7,102	6,937	6,945
Net Result Before Capital and Specific Items (Operating Result)	341	220	1	69	(62)
Total Assets	17,943	17,607	17,611	17,688	17,670
Total Liabilities	1,796	2,557	2,304	1,714	1,290
Net Assets	16,147	15,050	15,307	15,974	16,381
Total Equity	16,147	15,050	15,307	15,974	16,381

CURRENT FINANCIAL YEAR REVIEW

Timboon and District Healthcare Service ended the 2017-18 financial year in an operating surplus of $340,929, which equates to 4.7% of our revenue of $7.183 million. This was favourable in comparison to the operating budget which was a loss of $150,000. Our main variances to budget were higher than budgeted private patient and packages revenue ($198,266), additional Commonwealth funding as a result of converting beds from low care to high care ($128,150) and SWARH operating profit ($39,845).

The net result for the year was a loss of $85,374 compared to a net loss of $257,819 in financial year 2016-17.

The current asset ratio at 30 June 2018 is 2.6. This ratio indicates that the health service is in a healthy financial position, with adequate cash reserves to meet liabilities as they fall due.

Operating revenue decreased by $13,470 to $7.183 million. Employee expenses have decreased by $252,761 to $4.575 million. Other expenses have increased by $118,820 to $2.266 million.

Our People

LONG SERVICE AWARDS 2017/2018

Kristen Hain	10 years
Karen Kennett	10 years
Vickie Stevens	15 years
Amanda Nash	35 years

EXECUTIVE TEAM

Timboon and District Healthcare Service (TDHS) Executive team reports to and supports the Chief Executive Officer in evaluation of operational accountability and the delivery of healthcare services. The Executive team meets monthly to ensure effective management and achievement of TDHS performance and service targets in safety and quality, risk management, governance, human resources, finance and performance, and professional activity.

CHIEF EXECUTIVE OFFICER

Gerry Sheehan (from June 2014)

Qualifications: Dip Nursing, GDip Health Administration, MBA, MACHSM, MICF

The Chief Executive Officer is directly responsible to the Board of Governance for the overall management and financial accountability.

GENERAL MANAGER HEALTH SERVICES

Kerryn Charman (from October 2017)

Qualifications: Dip Nursing, GDip Nursing Midwifery, Dip Critical Care, GDip Leadership and Catholic Identity, GDip Integrated Risk Management

Kim White (to September 2017)

Qualifications: Bach Nursing, GDip Health Science, MBA, GCert Leadership and Catholic Culture

The General Manager Health Services is responsible for leading the Nursing, Community Health and Home Care services team to ensure a culture of patient centred care that is individualised, safe and responsive and is responsible for the implementation and monitoring of the Clinical Governance Framework

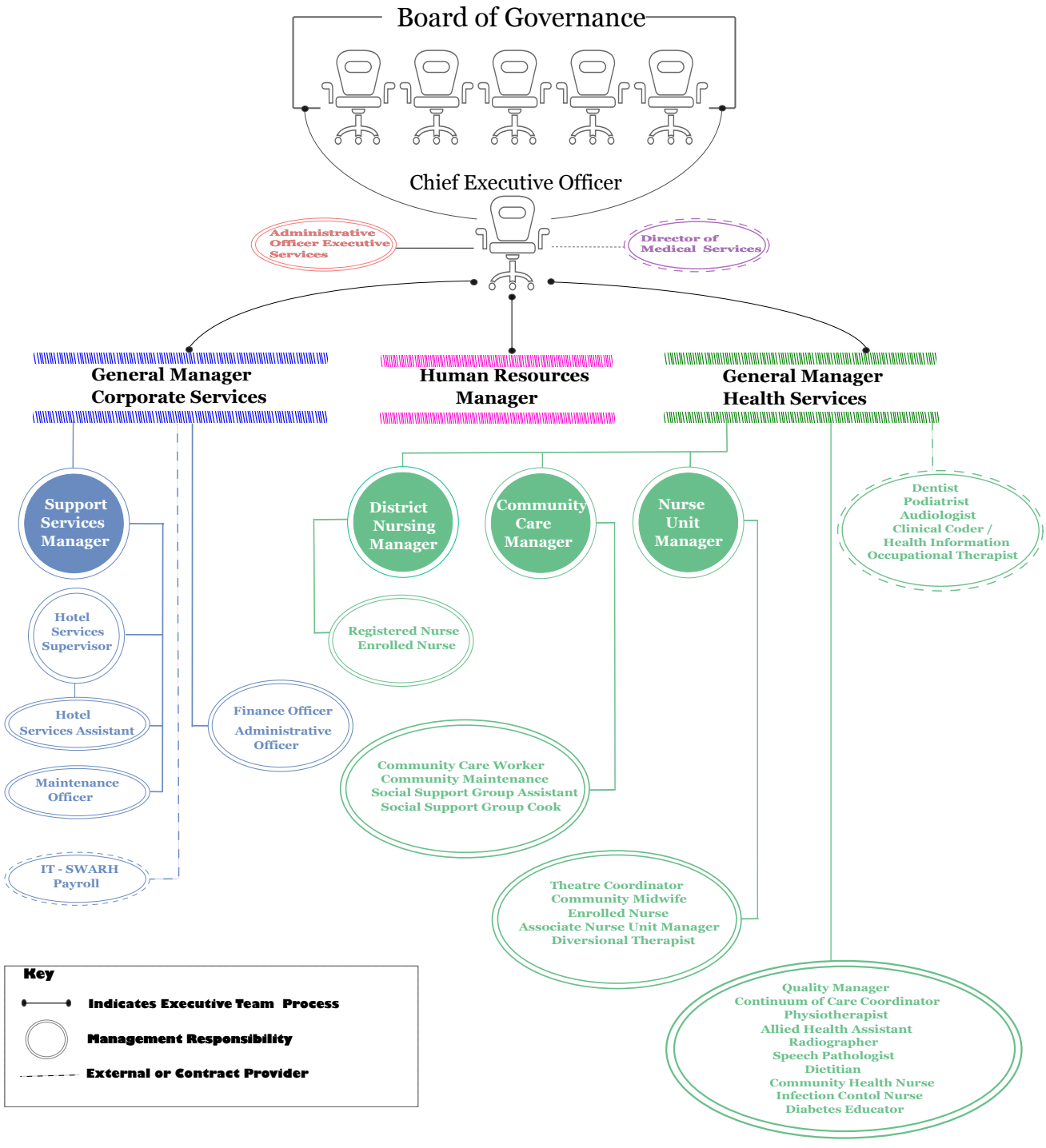
GENERAL MANAGER CORPORATE SERVICES

Nancy Johnson (from March 2016)

Qualifications: Bach Commerce, Bach International Business, CPA, GDip Education

The General Manager Corporate Services is responsible for managing Finance, Administration, Hotel Services, Maintenance, Occupational Health & Safety, Risk Management, Compliance, Payroll and Information Technology.

Our Structure



Our Workplace

SAFETY AND QUALITY

TDHS is committed to a philosophy of continuous quality improvement that integrates evidence based best practice elements and quality improvement methods in order to establish sustainable systems, processes and behaviours necessary to maintain high standards and to promote the pursuit of excellence.

PEOPLE AND CULTURE

The Executive team has undergone significant changes during the 12 month period, welcoming a new General Manager Health Services to the team. This resulted in a new focus which included bringing the new leadership team together. Emphasis involved individual development, team effectiveness and strategies to measure and improve our organisational culture (including participation in the People Matter Survey). Ongoing work continued with the next line of management during the year, with the view to continually strengthen our operational and strategic leadership.

PROFESSIONAL DEVELOPMENT

Mandatory practical days were held in July and August in the Education Centre for staff to obtain competencies in their required area. This was a great opportunity for staff to have discussions with management and learn in a relaxing environment, using current TDHS equipment. The current education matrix is open for staff to have their input into the areas they feel education is needed.

OCCUPATIONAL HEALTH AND SAFETY

TDHS is committed to fostering a positive safety culture where the inherent risks and hazards in healthcare are eliminated, minimised and controlled through the involvement and commitment of all employees, volunteers, contractors and other persons visiting workplaces under its control.

TDHS is divided into designated work groups (DWG) with each DWG having staff representation in the form of elected Health and Safety Representatives (HSR's). All HSR's sit on the TDHS Occupational Health and Safety Committee and their function is to flag potential organisational risks and hazards, be a conduit for staff safety issues and create opportunities for all staff to have input into our Occupational Health & Safety policy and procedures. HSR's are offered recognised training and refresher courses to assist them with their functions.

In addition to our risk management software system (Riskman), TDHS regularly reviews our Occupational Health & Safety policies and procedures and conducts safety audits to ensure a safe workplace and maintain best practice in the area. Our staff are also trained in Occupational Health & Safety theory and practice as part of the induction process as well as annually, as part of our mandatory training schedule.

EQUAL EMPLOYMENT OPPORTUNITY

TDHS is committed to providing a workplace environment that ensures compliance with the merit and equity principles in accordance with Equal Opportunity legislation for fair and equal work opportunities. Equal employment opportunity principles are included as standard practice for recruitment, training and promotion opportunities at TDHS.

Our Governance

HEALTH SERVICE GOVERNANCE

The activities of TDHS are directed through a three year tripartite funding agreement negotiated between The Department of Health, The Department of Health and Human Services and the Board of Governance.

RESPONSIBLE MINISTERS

Australian Government

Hon Greg Hunt MP - Minister for Health

Hon Ken Wyatt AM MP – Minister for Aged Care and Minister for Indigenous Health

Hon Dr David Gillespie MP – Assistant Minister for Health

Victorian Government

Hon Jill Hennessy MP, Minister for Health; Minister for Ambulance Services

Hon Martin Foley MP, Minister for Mental Health; Minister for Housing, Disability and Ageing

Hon Jenny Mikakos MP, Minister for Families and Children; Minister for Youth Affairs; Minister for Early Childhood Education

LEGAL AUTHORITY

TDHS was gazetted as a Multipurpose Service (MPS) in March 1998 under the Victorian Health Services Act 1988 and operates under the provisions of the Act. Also, as an MPS, TDHS is jointly administered under this Act and under the provisions of the Australian Government's *Aged Care Act.*

BOARD OF GOVERNANCE

Our Board of Governance is responsible for the governance of TDHS. This includes:

- Clinical Governance
- Strategic plan and directions
- Service development
- Overseeing finance and service performance
- Risk management
- Responding and adapting to challenges such as population growth and changing demographics and;
- Meeting the expectations regarding regulatory and government policy requirements and standards

PECUNIARY/ CONFLICT OF INTEREST

There were no instances where Members of the Board of Governance at Timboon and District Healthcare Service declared a pecuniary interest and withdrew from necessary proceedings.

Our Governance

Chair

Maryanne Puli Vogels

First appointed: 01.07.2017

Current term of appointment: 01.07.2017 – 30.06.2020

Vice Chair

John Renyard

First appointed: 01.07.2009

Current term of appointment: 01.07.2017 - 30.06.2018

Chair Audit Committee

Vice Chair

Josh McKenzie

First appointed: 01.11.2004

Current term of appointment: 01.07.2017 – 30.06.2019

Board Members

Anne Skordis

First appointed: 01.07.2017

Current term of appointment: 01.07.2017 - 30.06.2019

Bryce Morden

First appointed: 01.07.2016

Current term of appointment: 01.07.2016 - 30.06.2019

Chair Clinical Governance Quality and Credentialing Committee

Chris Stewart

First appointed: 01.07.2017

Current term of appointment: 01.07.2017 - 30.06.2020

Claire Murphy

First appointed: 01.07.2017

Current term of appointment: 01.07.2017 - 30.06.2020

Gerry Keely

First appointed: 01.07.2017

Current term of appointment: 01.07.2017 - 30.06.2020

Jason Chuck

First appointed: 01.07.2016

Current term of appointment: 01.07.2016 - 30.06.2018

Retiring

Jason Chuck

First appointed: 01.07.2016

Current term of appointment: 01.07.2016 - 30.06.2018

John Renyard

First appointed: 01.07.2009

Current term of appointment: 01.07.2017 - 30.06.2018

Resignations

Glenda Stanislaw

First appointed: 26.07.2016

Mrs Stanislaw resigned 17.10.2017

Paul Washington

First appointed: 01.07.2017

Mr Washington resigned 13.06.2018

Wendy Cameron

First appointed: 01.07.2016

Mrs Cameron resigned 13.06.2018

COMMITTEE STRUCTURE

The Board of Governance has established a committee structure with terms of references to assist in meeting its obligations.

BOARD SUB COMMITTEE	PURPOSE	MEMBERSHIP
Audit Committee	Monitors and oversees the financial performance and reporting processes; compliance with the *Financial Management Act*; the internal and external audit programs; and oversees the risk management program. This committee meets at least four times a year and its membership includes one community representative.	John Renyard (Chair) All Board Members are members of this committee Matt Hoffman (Consumer Representative)
Clinical Governance, Quality and Credentialing Committee (CGQC)	Monitors compliance to external and internal audit processes. The CGQC meets on a bi-monthly basis; its membership currently includes three community representatives. For effective and comprehensive monitoring of clinical governance, quality and credentialing at TDHS, the Board of Governance receives regular reports from the following committees: • Patient Safety and Quality Committee • Medical Consultative Committee • Community Health Committee	Bryce Morden (Chair) All Board Members are members of this committee Kate Makin (Consumer Representative, resigned 01.03.2018) Sharon Gaut (Consumer Representative, resigned 27.11.2017)
Nomination and Remuneration Committee	Appraises and reviews the Chief Executive Officer's performance regularly in line with contracted key performance indicators.	Maryanne Puli Vogels (Chair) John Renyard Josh McKenzie
Community Advisory Committee (CAC)	Provides strategic advice from a consumer, carer and community perspective to ensure THDS hear directly from, and works in partnership with, the communities it serves.	Donna Ellis (Chair) from 26.10.2017 John Wilson (Chair) up to 25.10.2017 Erica Elliot Sean Fitzpatrick Terry O'Connor Ray Smith

Our Generous Community

OUR VOLUNTEERS

Our volunteers form an integral part of the services we provide and they support our paid workforce in providing improved outcomes for our residents and clients, and sharing skills gained over a lifetime of experience. Our aim at TDHS is to ensure that each person is treated with respect and that we have in place policies and procedures to protect our workforce. We are extremely proud of all our volunteers and very grateful to the valuable contributions they make to TDHS.

We would like to thank each individual volunteer (past and present) and their families for their valuable time and efforts they have contributed to support TDHS.

OUR LIFE GOVERNORS

A Life Governor is an award bestowed by the Board of Governance on those members of the community who have made a valuable and significant contribution to TDHS in a voluntary capacity over a period of time.

Mrs. H. Bullen
Mrs. H. Herrin
Mrs. E. Padbury
Mr. J.A. Vogels MP
Ms. J. Burkhalter
Dr. D. Jackson
Mrs. K. Robbins
Mrs. P. Couch
Mrs. N. Joiner
Mrs. E. Rundle
Mrs. J. Duro
Mrs. Y. Lawson
Mr. K. Serong
Mr. A. Felmingham
Mrs M. McKenzie
Mrs. M. Serong
Mrs. E. Finch
Mr. R. McVilly
Mrs. M. Symons
Mrs. E. Finnigan
Mrs. H. Morris
Mrs. D. Taylor
Mr. N. Finnigan
Mrs. B. Newey
Mrs. J. Toller-Bond
Miss B. Fraser
Mrs. B. O'Brien
Mr. D. Trigg

VALE

In tribute, TDHS extends our sincere condolences to the families and friends of the following Life Governors who passed away during the course of the reporting period:

Mr. Ken Jepson
7 April, 1941 - 12 July, 2017

Miss Rose McMeel
17 November, 1926 - 5 March, 2018

Mrs Valmai Sharp
22 May, 1923 – 23 February, 2018

OUR DONORS

We express our sincere thanks to all our donors. Every contribution, large and small, is important to us as it represents your support for what we are aiming to achieve.

To respect the privacy of our donors, contributions are not stated in this annual report individually, but the generosity of our local communities is greatly appreciated and we extend a very sincere and warm thank you for the continued support from individuals and local groups and organisations. All community donations and fundraisers are extremely important for enabling TDHS to procure

Our Generous Community

vital equipment and infrastructure that enables us to sustain high quality service provision and optimum health and wellness for our communities.

DONATIONS 2017/18	
Annual Appeal	$16,804
Donations and Bequests	$19,715
Timboon Opportunity Shop (TOPS)	$3,850
Total	$40,369

Financial Statements

Timboon and District Healthcare Service

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

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

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

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

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

.....	.....	.....
Maryanne Puli	Gerry Sheehan	Nancy Johnson
Board Member	Chief Executive Officer	Chief Finance & Accounting Officer
Timboon	Timboon	Timboon
10/08/2018	10/08/2018	10/08/2018

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Timboon and District Healthcare Service

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

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
15 August 2018

Ron Mak
as delegate for the Auditor-General of Victoria

TIMBOON AND DISTRICT HEALTHCARE SERVICE
COMPREHENSIVE OPERATING STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2018

	Note	2018 $	2017 $
Revenue from Operating Activities	2.1	7,169,752	7,159,903
Revenue from Non Operating Activities	2.1	13,025	36,344
Employee Expenses	3.1	(4,575,170)	(4,613,418)
Non Salary Labour Costs	3.1	(502,190)	(594,603)
Supplies and Consumables	3.1	(373,354)	(385,869)
Other Expenses	3.1	(1,391,134)	(1,381,899)
Net Result Before Capital and Specific Items		340,929	220,458
Capital Purpose Income	2.1	230,655	277,082
Depreciation	4.4	(718,540)	(789,939)
Expenditure for Capital Purposes	3.1	(2,408)	(10,860)
Finance Costs	3.3	(4,748)	(26,951)
Share of Net Result of Associates and Joint Ventures Accounted for using the Equity Model	4.2	49,686	74,968
Net Result after Capital and Specific Items		(104,426)	(255,242)
Other economic flows included in net result			
Net gain/(loss) on non-financial assets		18,967	(3,836)
Revaluation of Long Service Leave	3.1,3.4	85	1,259
Total other economic flows included in net result		19,052	(2,577)
NET RESULT FOR THE YEAR		(85,374)	(257,819)
Other Comprehensive Income			
Items that will not be classified to net result			
Changes in physical asset revaluation surplus	8.1a	1,182,604	0
Total other comprehensive income		1,182,604	0
COMPREHENSIVE RESULT FOR THE YEAR		**1,097,230**	**(257,819)**

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

TIMBOON AND DISTRICT HEALTHCARE SERVICE
BALANCE SHEET
AS AT 30 JUNE 2018

	Note	2018 $	2017 $
Current Assets			
Cash and Cash Equivalents	6.2	630,821	927,337
Receivables	5.1	268,738	769,893
Investments & other Financial Assets	4.1	3,353,138	2,835,566
Inventories	5.2	1,321	614
Prepayments and Other Assets	5.3	99,160	74,357
Total Current Assets		4,353,178	4,607,767
Non-Current Assets			
Receivables	5.1	213,328	227,633
Investments Accounted for Using the Equity Method	4.2	1,060	76,712
Property, Plant and Equipment	4.3	13,375,728	12,694,407
Total Non-Current Assets		13,590,116	12,998,752
TOTAL ASSETS		17,943,294	17,606,519
Current Liabilities			
Payables	5.4	520,025	1,075,663
Borrowings	6.1	59,676	87,073
Provisions	3.4	1,072,094	1,153,514
Total Current Liabilities		1,651,795	2,316,250
Non-Current Liabilities			
Borrowings	6.1	0	105,613
Provisions	3.4	144,684	135,071
Total Non-Current Liabilities		144,684	240,684
TOTAL LIABILITIES		1,796,479	2,556,934
NET ASSETS		16,146,815	15,049,585
EQUITY			
Property, Plant and Equipment Revaluation Surplus	8.1a	6,682,701	5,500,097
Contributed Capital	8.1b	4,610,700	4,610,700
Accumulated Surpluses/(Deficits)	8.1c	4,853,414	4,938,788
TOTAL EQUITY	8.1	16,146,815	15,049,585
Commitments	6.3		
Contingent Assets and Contingent Liabilities	7.2		

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

TIMBOON AND DISTRICT HEALTHCARE SERVICE
CASH FLOW STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2018

	Note	2018 $ Inflows / (Outflows)	2017 $ Inflows / (Outflows)
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		5,843,588	5,726,061
Capital Grants from Government		113,044	141,595
Patient and Resident Fees Received		756,697	626,147
Dividends Received from Associates		69,185	66,000
Donations and Bequests Received		13,025	36,344
GST (Paid to)/received from ATO		(7,200)	(1,302)
Interest Received		81,824	56,175
Other Receipts		1,179,220	880,632
Total Receipts		***8,049,383***	***7,531,652***
Employee Expenses Paid		(4,668,230)	(4,617,718)
Non Salary Labour Costs		(502,190)	(594,603)
Payments for Supplies and Consumables		(373,354)	(385,869)
Finance Costs		(4,748)	(26,951)
Other payments		(1,948,505)	(1,146,325)
Total Payments		***(7,497,027)***	***(6,771,466)***
NET CASH FLOW FROM /(USED IN) OPERATING ACTIVITIES	8.2	552,356	760,186
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of Non-Financial Assets		(233,250)	(238,234)
Proceeds from sale of Non-Financial Assets		34,960	20,161
Proceeds from/(Purchase of) Investments		(517,572)	(18,626)
NET CASH FLOW FROM /(USED IN) INVESTING ACTIVITIES		(715,862)	(236,699)
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of Borrowings		(133,010)	(35,685)
NET CASH FLOW FROM /(USED IN) INVESTING ACTIVITIES		(133,010)	(35,685)
NET INCREASE / (DECREASE) IN CASH AND CASH EQUIVALENTS HELD		(296,516)	487,802
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		927,337	439,535
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.2	630,821	927,337

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

TIMBOON AND DISTRICT HEALTHCARE SERVICE
STATEMENT OF CHANGES IN EQUITY
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2018

		Property, Plant and Equipment Revaluation Surplus	Contributed Capital	Accumulated Surpluses/ (Deficits)	Total
		$	$	$	$
Balance at 1 July 2016		5,500,097	4,610,700	5,196,607	15,307,404
Net result for the year	8.1c	0	0	(257,819)	(257,819)
Other Comprehensive income for the year		0	0	0	0
Balance at 30 June 2017		**5,500,097**	**4,610,700**	**4,938,788**	**15,049,585**
Net result for the year	8.1c	0	0	(85,374)	(85,374)
Other Comprehensive income for the year		1,182,604	0	0	1,182,604
Balance at 30 June 2018		**6,682,701**	**4,610,700**	**4,853,414**	**16,146,815**

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

BASIS OF PRESENTATION

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

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

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

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

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

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

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

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

These annual financial statements represent the audited general purpose financial statements for Timboon and District Healthcare Service (ABN 44 836 142 460) for the year ended 30 June 2018. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

These financial statements are general purpose financial statements which have been prepared in accordance with the *Financial Management Act* 1994, and applicable 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 AASB101 *Presentation of Financial Statements.*

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

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

The annual financial statements were authorised for issue by the Board of Timboon and District Healthcare Service on 10th August, 2018

(b) Reporting Entity

The financial statements includes all the controlled activities of Timboon and District Healthcare Service.

Its principal address is:
21 Hospital Road
Timboon Vic 3268

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

(c) Basis of accounting preparation and measurement

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

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

The financial statements are prepared on a going concern basis.

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

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

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

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

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

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

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

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

- The fair value of land, buildings and plant and equipment (refer to Note 4.3 Property, Plant and Equipment);
- Employee benefit provisions are based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.4 Employee Benefits in the Balance Sheet)

Goods and Services Tax (GST)

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

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

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

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

(d) Principles of Consolidation

Intersegment Transactions

Transactions between segments within Timboon and District Healthcare Service have been eliminated to reflect the extent of Timboon and District Healthcare Service's operations as a group.

(e) Jointly Controlled Operation

Joint control is the contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control.
In respect of any interest in joint operations, Timboon and District Healthcare Service 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.

Timboon and District Healthcare Service is a Member of the Southwest Alliance of Rural Health Joint Venture and retains joint control over the arrangement, which it has classified as a joint operation (refer to Note 8.9)

NOTE 2: FUNDING DELIVERY OF OUR SERVICES

Timboon and District Healthcare Service's overall objective is to provide quality health services that support and enhance the wellbeing of all Victorians. Timboon and District Healthcare Service is predominantly funded by accrual based grant funding for the provision of outputs. The hospital also receives income from the supply of services.

Structure
2.1 Analysis of revenue by source

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE	Admitted Patients 2018 $	Aged Care 2018 $	Primary Health 2018 $	Other 2018 $	TOTAL 2018 $
Government Grants	4,720,398	808,930	313,069	0	5,842,397
Indirect Contributions by Department of Health and Human Services	(1,984)	(3,555)	(1,984)	(744)	(8,267)
Patient and Resident Fees	424,363	322,581	41,628	0	788,572
Interest and Dividends	219	392	219	82	912
Catering	0	0	0	11,409	11,409
Diagnostic Imaging	0	0	0	28,537	28,537
South West Alliance of Rural Health	0	0	0	363,719	363,719
Property Income	0	0	0	59,480	59,480
Other Revenue from Operating Activities	32,533	26,282	18,201	5,977	82,993
Total Revenue from Operating Activities	5,175,529	1,154,630	371,133	468,460	7,169,752
Donations and Bequests (non capital)	0	0	0	13,025	13,025
Total Revenue from Non-Operating Activities	0	0	0	13,025	13,025
Capital Purpose Income (excluding interest)	0	0	0	35,286	35,286
Capital Grants	0	0	0	113,044	113,044
Capital Interest	0	0	0	82,325	82,325
Total Capital Purpose Income	0	0	0	230,655	230,655
Net gain/(loss) on non-financial assets	0	0	0	18,967	18,967
Share of Net Result of Associates & Joint Ventures Accounted for using the Equity Model (refer note 4.2)	0	0	0	49,686	49,686
TOTAL REVENUE	5,175,529	1,154,630	371,133	780,793	7,482,085

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)	Admitted Patients 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	TOTAL 2017 $
Government Grants	3,216,271	1,803,121	494,799	95,124	5,609,315
Indirect Contributions by Department of Health and Human Services	13,606	24,377	13,606	5,102	56,691
Patient and Resident Fees	257,775	305,555	(3,475)	109	559,964
Interest and Dividends	2,252	4,034	2,252	844	9,382
Catering	0	0	0	11,645	11,645
Diagnostic Imaging	0	0	0	25,452	25,452
South West Alliance of Rural Health	0	0	0	762,308	762,308
Property Income	0	0	0	45,295	45,295
Other Revenue from Operating Activities	20,170	13,990	38,434	7,257	79,851
Total Revenue from Operating Activities	3,510,074	2,151,077	545,616	953,136	7,159,903
Donations and Bequests (non capital)	0	0	0	36,344	36,344
Total Revenue from Non-Operating Activities	0	0	0	36,344	36,344
Capital Purpose Income (excluding interest)	0	0	0	62,964	62,964
Capital Grants	0	0	0	141,595	141,595
Capital Interest	0	0	0	72,523	72,523
Total Capital Purpose Income	0	0	0	277,082	277,082
Net gain/(loss) on non-financial assets	0	0	0	(3,836)	(3,836)
Share of Net Result of Associates & Joint Ventures Accounted for using the Equity Model (refer note 4.2)	0	0	0	74,968	74,968
TOTAL REVENUE	3,510,074	2,151,077	545,616	1,341,530	7,548,297

The 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.

Revenue Recognition
Income is recognised in accordance with AASB 118 *Revenue* and is recognised as to the extent that it is probable that the economic benefits will flow to Timboon and District Healthcare Service 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.

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)

Indirect Contributions from the Department of Health and Human Services

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

Patient Fees

Patient fees are recognised as revenue on an accrual basis.

Private Practice Fees

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

Revenue from commercial activities

Revenue from commercial activities such as provision of meals to external users is recognised on an accrual basis.

Donations and Other Bequests

Donations and bequests are recognised as revenue when received. If donations are for a 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.

Other Income

Other income includes recoveries, sundry sales and minor facility charges.

Category Groups

Timboon and District Healthcare Service 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.

- **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.

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

NOTE 3: THE COST OF DELIVERING SERVICES

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

Structure

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

NOTE 3.1: ANALYSIS OF EXPENSE BY SOURCE	Admitted Patients 2018 $	Aged Care 2018 $	Primary Health 2018 $	Other 2018 $	TOTAL 2018 $
Employee Expenses	2,674,224	1,288,212	484,715	128,019	4,575,170
Other Operating Expenses					
Non Salary Labour Costs	319,909	119,625	48,531	14,125	502,190
Supplies and Consumables	192,593	150,928	13,982	15,851	373,354
Medical Indemnity Insurance	50,567	2,596	1,449	1,072	55,684
Fuel, Light Power and Water	73,262	16,402	6,561	24,556	120,781
Repairs and Maintenance	187,396	35,821	14,552	45,944	283,713
Administration Expenses	279,615	357,564	161,576	94,047	892,802
Other Expenses	8,917	15,768	8,763	4,706	38,154
Total Expenditure from Operating Activities	3,786,483	1,986,916	740,129	328,320	6,841,848
Expenditure for Capital Purposes	0	0	0	2,408	2,408
Depreciation (refer note 4.4)	0	0	0	718,540	718,540
Finance Costs (refer note 3.3)	328	587	328	3,505	4,748
Total Other Expenses	328	587	328	724,453	725,696
TOTAL EXPENSES	3,786,811	1,987,503	740,457	1,052,773	7,567,544

	Admitted Patients 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	TOTAL 2017 $
Employee Expenses	2,590,512	1,503,397	363,791	155,718	4,613,418
Other Operating Expenses					
Non Salary Labour Costs	345,538	144,810	81,026	23,229	594,603
Supplies and Consumables	222,741	109,206	12,090	41,832	385,869
Medical Indemnity Insurance	52,236	0	0	0	52,236
Fuel, Light Power and Water	47,564	10,649	4,259	20,686	83,158
Repairs and Maintenance	114,819	21,245	8,285	38,229	182,578
Administration Expenses	273,534	450,216	205,557	100,768	1,030,075
Other Expenses	9,582	13,734	7,658	2,878	33,852
Total Expenditure from Operating Activities	3,656,526	2,253,257	682,666	383,340	6,975,789
Expenditure for Capital Purposes	0	0	0	10,860	10,860
Depreciation (refer note 4.4)	0	0	0	789,939	789,939
Finance Costs (refer note 3.3)	0	0	0	26,951	26,951
Total Other Expenses	0	0	0	827,750	827,750
TOTAL EXPENSES	3,656,526	2,253,257	682,666	1,211,090	7,803,539

Note 3.1: Expense Recognition
Expenses are recognised as they are incurred and reported in the financial year to which they relate.

NOTE 3.1: ANALYSIS OF EXPENSE BY SOURCE (Continued)

Employee expenses

Employee expenses include:

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

Other operating expenses

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

- Supplies and Consumables - Supplies and service costs which are recognised as an expense in the reporting period in which they are incurred. The carrying amounts of any inventories held for distribution are expensed when distributed.
- Fair value of assets, services and resources provided free of charge or for nominal consideration - Contributions of resources provided free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them.

Net Gain / (Loss) on Non-Financial Assets

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

- Revaluation gain/ (losses) of non-financial physical assets (Refer to Note 4.3 Property, Plant and Equipment)
- Net gain/(loss) on disposal of Non-Financial Assets

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

Net gain/ (loss) on financial instruments

Net gain/ (loss) on financial instruments includes:

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

Other gains/(losses) from other economic flows

Other gains/(losses) include:

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

NOTE 3.2: ANALYSIS OF EXPENSE AND REVENUE BY INTERNALLY MANAGED AND RESTRICTED SPECIFIC PURPOSE FUNDS

	Expense		Revenue	
	2018 $	2017 $	2018 $	2017 $
Catering Services	11,356	51,486	11,409	14,784
Radiology	86,322	96,455	28,537	33,002
Opportunity Shop	5,104	5,602	13,025	36,344
Other Commercial Activities	225,042	129,292	65,457	56,527
TOTAL	327,824	282,835	118,428	140,657

NOTE 3.3: FINANCE COSTS

	2018 $	2017 $
Finance Charges on Finance Leases	4,748	26,951
TOTAL FINANCE COSTS	4,748	26,951

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

Finance costs include finance charges in respect of finance leases recognised in accordance with AASB 117 *Leases*

NOTE 3.4: EMPLOYEE BENEFITS IN THE BALANCE SHEET	2018	2017
Current Provisions	$	$
Employee Benefits (i)		
Accrued Wages, ADO & Annual Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	472,723	426,921
- unconditional and expected to be settled wholly after 12 months (iii)	7,697	70,000
Long Service Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	94,740	60,000
- unconditional and expected to be settled wholly after 12 months (iii)	401,822	493,015
	976,982	1,049,936
Provisions related to employee benefit on-costs		
- unconditional and expected to be settled wholly within 12 months (ii)	55,043	41,517
- unconditional and expected to be settled wholly after 12 months (iii)	40,069	62,060
	95,112	103,577
Total Current Provisions	1,072,094	1,153,513
Non-Current Provisions		
Employee Benefits (i)	134,303	121,154
Provisions related to employee benefit on-costs	10,381	13,917
Total Non-Current Provisions	144,684	135,071
Total Provisions	1,216,778	1,288,584

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

(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and Related On-Costs		
Employee Entitlements - South West Alliance of Rural Health	25,120	56,533
Unconditional Long Service Leave Entitlements	530,372	558,542
Annual Leave Entitlements	339,625	376,612
Accrued Salaries and Wages	174,310	158,872
Accrued Days Off	2,667	2,955
	1,072,094	1,153,514
Non-Current Employee Benefits		
Employee Entitlements - South West Alliance of Rural Health	9,819	9,819
Conditional Long Service Leave Entitlements (present value)	134,865	125,252
	144,684	135,071
Total Employee Benefits and Related On-Costs	1,216,778	1,288,585
(b) Movements in Provisions		
Movement in Long Service Leave		
Balance at start of year	683,794	624,041
Provision made during the year		
- Revaluations	(85)	(1,259)
- Expense Recognising Employee Service	82,274	125,944
Settlement made during the year	(100,746)	(64,932)
Balance at end of year	665,237	683,794

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

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

The amount recognised as a liability is the best estimate of the consideration required to settle the present obligation at reporting date, taking into account the risks and uncertainties surrounding the obligation.

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

Employee benefits

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

Salaries and Wages, Annual Leave and Accrued Days Off

Liabilities for wages and salaries, annual leave and accrued days off are all recognised in the provision for employee benefits as 'current liabilities', because the health service does not have an unconditional right to defer settlements of these liabilities.

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

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

Long Service Leave (LSL)

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

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

The components of this current LSL liability are measured at:

- Undiscounted value – if the health service expects to wholly settle within 12 months; or
- Present value – where the entity does not expect to settle a component of this current liability within 12 months.

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

Termination benefits

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

On-Costs related to employee expense

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

NOTE 3.5: SUPERANNUATION

Fund		Paid Contributions for the year		Outstanding Contributions at Year End	
		2018 $	**2017 $**	**2018 $**	**2017 $**
Defined Benefit Plans:	Health Super	0	126	0	0
Defined Contribution Plans:	Health Super	313,081	320,443	0	31,504
	HESTA	61,445	63,322	0	0

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

Defined contribution superannuation plans

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

Defined benefit superannuation plans

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

Timboon and District Healthcare 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 that have been expensed in relation to the major employee superannuation funds and contributions made by Timboon and District Healthcare Service are disclosed above.

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY

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

Structure

4.1 Investments and other financial assets
4.2 Investments accounted for using the equity method
4.3 Property, plant & equipment
4.4 Depreciation and amortisation

NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS	Capital		Total	
	2018	2017	2018	2017
CURRENT	$	$	$	$
Loans and Receivables				
Term Deposit				
Aust. Dollar Term deposits > 3 Months (i)	3,353,138	2,835,566	3,353,138	2,835,566
TOTAL CURRENT OTHER FINANCIAL ASSETS	3,353,138	2,835,566	3,353,138	2,835,566
Represented by:				
Health Service Investments	3,353,138	2,835,566	3,353,138	2,835,566
TOTAL	3,353,138	2,835,566	3,353,138	2,835,566

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

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

Investments are classified as loans and receivables financial assets.

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

Timboon and District Healthcare Service investments must comply with Standing Direction 3.7.2 - Treasury and Investment Risk Management.

All financial assets, except those measured at fair value through the Comprehensive Operating Statement are subject to annual review for impairment.

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

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

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

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

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

In order to determine an appropriate fair value as at 30 June 2018 for its portfolio of financial assets, the Health Service used the market value of investments held provided by the portfolio managers.

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

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

NOTE 4.2: INVESTMENTS ACCOUNTED FOR USING THE EQUITY METHOD

			Ownership Interest		Published Fair Value	
	Principal	Country of	2018	2017	2018	2017
Name of Entity	**Activity**	**Incorp'n**	**%**	**%**	**$**	**$**
Associates						
Timboon Medical Clinic	Medical Services	Australia	50%	50%	1,060	76,712

Summarised financial information in respect of the agency's material associate and joint venture is set below. The summarised financial information below represents amounts shown in the associate's financial statements prepared in accordance with AASB's, adjusted by the agency for equity accounting purposes.

Table 4.2.1: Summarised Financial Information for the Associate

	2018	2017
Summarised Balance Sheet:	$	$
Current Assets	237,251	267,746
Non-Current Assets	0	0
Total Assets	237,251	267,746
Current Liabilities	235,132	114,322
Total Liabilities	235,132	114,322
Net Assets	2,119	153,424
Share of Joint Venture Net Assets	1,060	76,712
Summarised Operating Statement:		
Total income from transaction	1,321,124	1,373,816
Net Result from Continuing Operation	99,372	149,937
Comprehensive Result for the Year	99,372	149,937
Share of Associates' Result After Income tax Dividends received from associates.	49,686	74,968
Dividends received/receivable from Associates	125,338	66,000

Movements in carrying amount of interests in the Joint Venture

	2018	2017
	$	$
Carrying amount at the beginning of the year	76,712	67,744
Share of the joint venture's net result after tax	49,686	74,968
Share of the joint venture's other comprehensive income	-	-
Dividends received/receivable from the joint venture	(125,338)	(66,000)
Carrying amount at the end of the year	**1,060**	**76,712**

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT **(a) Gross carrying amount and accumulated depreciation**	2018 $	2017 $
Land		
- Land at fair value (Crown Land)	1,687,195	1,495,000
Total Land	1,687,195	1,495,000
Buildings		
- Buildings at fair value	10,740,104	11,560,000
Less Accumulated Depreciation	0	1,363,395
	10,740,104	10,196,605
- Buildings at cost	0	8,368
Less Accumulated Depreciation	0	893
	0	7,475
Total Buildings	10,740,104	10,204,080
Plant and Equipment		
South West Alliance of Rural Health	8,159	17,237
- Plant and Equipment at fair value	2,164,154	1,941,706
Less Accumulated Depreciation	1,505,366	1,375,406
Total Plant and Equipment	666,947	583,537
Furniture and Fittings		
- Furniture and Fittings at fair value	266,843	240,558
Less Accumulated Depreciation	201,525	184,890
Total Furniture and Fittings	65,318	55,668
Motor Vehicles		
- Motor Vehicles at fair value	369,484	411,285
Less Accumulated Depreciation	207,769	235,663
Total Motor Vehicles	161,715	175,622
Leased Assets		
- Information Technology	54,449	481,714
Less Accumulated Amortisation	0	301,214
Total Leased Assets	54,449	180,500
TOTAL	13,375,728	12,694,407

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)
(b) Reconciliations of the carrying amounts of each class of asset

	Land	Buildings	Plant & Equipment	Motor Vehicles	Furniture & Fittings	Leased Assets	Total
	$	$	$	$	$	$	$
Balance at 1 July 2016	1,495,000	10,658,465	596,929	228,438	62,906	228,371	13,270,109
Additions	0	0	124,509	20,317	9,974	73,253	228,053
Southwest Alliance of Rural Health Movements	0	0	10,181	0	0	0	10,181
Disposals	0	0	(11,702)	(10,154)	(2,141)	0	(23,997)
Depreciation	0	(454,385)	(136,380)	(62,979)	(15,071)	(121,124)	(789,939)
Balance at 1 July 2017	1,495,000	10,204,080	583,537	175,622	55,668	180,500	12,694,407
Additions	0	0	239,229	59,808	26,285	0	325,322
Southwest Alliance of Rural Health Movements	0	0	(9,078)	0	0	(82,994)	(92,072)
Revaluation Increments/(Decrements)	192,195	990,409	0	0	0	0	1,182,604
Disposals	0	0	(1,918)	(14,075)	0	0	(15,993)
Depreciation	0	(454,385)	(144,823)	(59,640)	(16,635)	(43,057)	(718,540)
Balance at 30 June 2018	1,687,195	10,740,104	666,947	161,715	65,318	54,449	13,375,728

Land and buildings carried at valuation
An independent valuation of the Health Service's property, plant and equipment was performed by the Valuer-General Victoria to determine the 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.

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

The latest indices required a managerial revaluation in 2018. The indexed value was then compared to individual assets written down book value as at 30 June 2018 to determine the change in their fair values. The Department of Health and Human Services approved a managerial revaluation of land ($192,195) and the building class ($990,409).

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

(c) Fair value measurement hierarchy for assets

	Carrying amount as at 30 June 2018	Fair value measurement at end of reporting period using: Level 1 (1)	Level 2 (1)	Level 3 (1)
Land at fair value				
Non-specialised land	800,000	0	800,000	0
Specialised land	887,195	0	0	887,195
Total of land at fair value	1,687,195	0	800,000	887,195
Buildings at fair value				
Non-specialised buildings	698,125	0	698,125	0
Specialised buildings	10,041,979	0	0	10,041,979
Total of building at fair value	10,740,104	0	698,125	10,041,979
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	161,715	0	161,715	0
- Plant and equipment	666,947	0	0	666,947
Total of plant, equipment and vehicles at fair value	828,662	0	161,715	666,947
Furniture & Fittings at fair value				
Total furniture & Fittings at fair value	65,318	0	0	65,318

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

There have been no transfers between levels during the period.

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

	Carrying amount as at 30 June 2017	Fair value measurement at end of reporting period using: Level 1 (1)	Level 2 (1)	Level 3 (1)
Land at fair value				
Non-specialised land	800,000	0	800,000	0
Specialised land	695,000	0	0	695,000
Total of land at fair value	1,495,000	0	800,000	695,000
Buildings at fair value				
Non-specialised buildings	698,125	0	698,125	0
Specialised buildings	9,960,340	0	0	9,960,340
Total of building at fair value	10,658,465	0	698,125	9,960,340
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	228,438	0	228,438	0
- Plant and equipment	596,929	0	0	596,929
Total of plant, equipment and vehicles at fair value	825,367	0	228,438	596,929
Furniture & Fittings at fair value				
Total furniture & Fittings at fair value	62,906	0	0	62,906

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

There have been no transfers between levels during the period.

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)
(d) Reconciliation of Level 3 fair value

30-Jun-18	Land	Buildings	Plant and equipment	Furniture & Fittings
Opening Balance	1,495,000	10,204,080	583,537	55,668
Purchases (sales) & reclassifications	0	0	228,233	26,285
Gains or losses recognised in net result				
- Depreciation	0	(454,385)	(144,823)	(16,635)
- Impairment loss	0	0	0	0
Subtotal	1,495,000	9,749,695	666,947	65,318
Items recognised in other comprehensive income				
- Revaluation	192,195	990,409	0	0
Subtotal	192,195	990,409	0	0
Closing Balance	1,687,195	10,740,104	666,947	65,318

There have been no transfers between levels during the period.

30-Jun-17	Land	Buildings	Plant and equipment	Furniture & Fittings
Opening Balance	1,495,000	10,658,465	596,929	62,906
Purchases (sales) & reclassifications	0	0	122,988	7,833
Gains or losses recognised in net result				
- Depreciation	0	(454,385)	(136,380)	(15,071)
- Impairment loss	0	0	0	0
Subtotal	1,495,000	10,204,080	583,537	55,668
Items recognised in other comprehensive income				
- Revaluation	0	0	0	0
Subtotal	0	0	0	0
Closing Balance	1,495,000	10,204,080	583,537	55,668

There have been no transfers between levels during the period.

(e) Fair Value Determination

Asset Class	Examples of types assets	Expected fair value level	Likely valuation approach	Significant inputs (Level 3 only)
Specialised land (Crown/Freehold)	- Land subject to restriction as to use and/or sale - Land in areas where there is not an active market	Level 3	Market approach	Community Service Obligation Adjustments
Specialised Buildings (a)	Specialised buildings with limited alternative uses and/or substantial customisation eg. Hospitals	Level 3	Depreciated replacement cost approach	- Cost per square metre - Useful life
Vehicles	If there is no active resale market	Level 2	Market approach	n.a.
Plant and equipment	Specialised items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	- Cost per square metre - Useful life

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

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

Initial Recognition

Items of property, plant and equipment are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and impairment loss. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. Assets transferred as part of a merger/machinery of government change are transferred at their carrying amounts.

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

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

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

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

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

Subsequent Measure

Consistent with AASB 13 Fair Value Measurement, Timboon and District Healthcare Service determines the policies and procedures for both recurring property, plant and equipment fair value measurements, in accordance with the requirements of AASB 13 and the relevant FRDs.

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

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

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

In addition, the Health Service 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 Timboon and District Healthcare Service's independent valuation agency.

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

Fair value measurement

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

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

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

In accordance with paragraph AASB 13.29, Health Services can assume the current use of a non-financial physical asset is its HBU unless market or other factors suggest that a different use by market participants would maximise the value of the asset. Therefore, an assessment of the HBU will be required when the indicators are triggered within a reporting period, which suggest the market participants would have perceived an alternative use of an asset that can generate maximum value. Once identified, Health Services are required to engage with VGV or other independent valuers for formal HBU assessment.

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

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

Valuation hierarchy

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

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

Identifying unobservable inputs (level 3) fair value measurements

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

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

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

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

Specialised land and specialised buildings

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

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

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

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

In 2018 a managerial valuation was carried out in accordance with FRD 103F to revalue land and buildings to its fair value.

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 2018.

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

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

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 Timboon and District Healthcare Service's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

NOTE 4.4: DEPRECIATION	2018 $	2017 $
Depreciation		
Buildings	454,385	454,385
Plant and Equipment		
- Plant	144,823	136,380
- Motor Vehicles	59,640	62,979
Furniture and Fittings	16,635	15,071
Leased Assets - Southwest Alliance of Rural Health	43,057	121,124
TOTAL DEPRECIATION	718,540	789,939

Depreciation

All infrastructure assets, buildings, plant and equipment and other non-financial physical assets that have finite useful lives are depreciated (i.e. excludes land assets held for sale, and investment properties). Depreciation is generally calculated on a straight-line basis at rates that allocate the asset's value, less any estimated residual value over its estimated useful life (refer AASB 116 *Property, Plant and Equipment*).

Amortisation

Amortisation is the systematic allocation of the depreciable amount of an asset over its useful life. If a Health Service has items such as patents, trademarks, computer software or development expenses that are being capitalised, these should be included under 'Intangible Assets' (refer AASB 138 *Intangible Assets*) and amortised.

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

	2018	**2017**
Buildings		
- Structure Shell Building Fabric	45 to 60 years	45 to 60 years
- Site Engineering Services and Central Plant	20 to 30 years	20 to 30 years
Central Plant		
- Fit Out	20 to 30 years	20 to 30 years
- Trunk Reticulated Building Systems	30 to 40 years	30 to 40 years
Plant & Equipment	3 to 7 years	3 to 7 years
Medical Equipment	7 to 10 years	7 to 10 years
Computers and Communication	3 years	3 years
Furniture & Fittings	13 years	13 years
Motor Vehicles	10 years	10 years
Intangible Assets	3 years	3 years
Leasehold Improvements	6 to 7 years	6 to 7 years

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

NOTE 5: OTHER ASSETS AND LIABILITIES

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

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

NOTE 5.1: RECEIVABLES	2018	2017
CURRENT	$	$
Contractual		
Trade Debtors	5,606	25,717
Patient Fees	109,670	77,795
South West Alliance of Rural Health	30,032	607,717
Accrued Investment Income	40,259	38,846
Accrued Revenue - Other	56,153	0
	241,720	750,075
Statutory		
GST Receivable - Health Service	27,018	19,818
	27,018	19,818
TOTAL CURRENT RECEIVABLES	268,738	769,893
NON CURRENT		
Statutory		
Long Service Leave - Department of Health/Department of Human Services	213,328	227,633
TOTAL NON-CURRENT RECEIVABLES	213,328	227,633
TOTAL RECEIVABLES	482,066	997,526

Receivables consist of:

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

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

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

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

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

NOTE 5.2: INVENTORIES	Total	
	2018	2017
CURRENT	$	$
South West Alliance of Rural Health - at Cost	1,321	614
TOTAL INVENTORIES	1,321	614

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

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

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

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

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

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

NOTE 5.3: PREPAYMENTS AND OTHER ASSETS	Total	
	2018	2017
CURRENT	$	$
Prepayments	97,838	74,357
Prepayments - South West Alliance of Rural Health	1,322	0
TOTAL OTHER ASSETS	99,160	74,357

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

NOTE 5.4: PAYABLES	2018	2017
	$	$
CURRENT		
Contractual		
Trade Creditors	143,479	105,755
Payables - South West Alliance of Rural Health	95,922	695,770
Accrued Audit Fees	0	9,000
Accrued Expenses	145,769	110,136
	385,170	920,661
Statutory		
Australian Taxation Office - PAYG & FBT	66,218	56,052
Superannuation Obligations Outstanding	0	31,504
Department of Health and Human Services	68,637	67,446
	134,855	155,002
TOTAL	520,025	1,075,663

Payables consist of:

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

Note 5.4 (a): Maturity analysis of financial liabilities as at 30 June

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

			Maturity Dates			
	Total Carrying Amount	Nominal Amount	Less than 1 Month	1 - 3 Months	3 Months - 1 Year	1 - 5 Years
2018	$	$	$	$	$	$
Financial Liabilities						
At amortised cost						
Payables (i)	385,170	385,170	385,170	0	0	0
Borrowings	59,676	59,676	0	0	59,676	0
Total Financial Liabilities	444,846	444,846	385,170	0	0	0
2017						
Financial Liabilities						
At amortised cost						
Payables (i)	920,661	920,661	920,661	0	0	0
Borrowings	192,686	192,686	0	0	0	192,686
Total Financial Liabilities	1,113,347	1,113,347	920,661	0	0	192,686

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

NOTE 6: HOW WE FINANCE OUR OPERATIONS

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

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

Structure

NOTE 6.1: BORROWINGS	2018	2017
CURRENT	$	$
Australian Dollar Borrowings		
- Finance Lease Liability (South West Alliance of Rural Health)	59,676	87,073
TOTAL CURRENT	59,676	87,073
NON CURRENT		
Australian Dollar Borrowings		
- Finance Lease Liability (South West Alliance of Rural Health)	0	105,613
TOTAL NON CURRENT	0	105,613
TOTAL BORROWINGS	59,676	192,686

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

(a) Maturity analysis of borrowings
Please refer to note 5.4 for the ageing analysis of borrowings

(b) Defaults and breaches

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

Borrowing Recognition

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

Borrowings
All borrowings are initially recognised at fair value of the consideration received, less directly attributable transaction costs.
Subsequent to initial recognition, borrowings are measured at amortised cost with any difference between the initial recognised amount and the redemption value being recognised in the net result over the period of the borrowing using the effective interest method. Fair value is determined in the manner described in Note 7.1.

NOTE 6.2: CASH AND CASH EQUIVALENTS

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

	2018 $	2017 $
Cash on Hand	200	0
Cash at Bank	513,320	754,560
Cash at Bank - Southwest Alliance of Rural Health	117,301	172,777
TOTAL CASH AND CASH EQUIVALENTS	630,821	927,337
Represented by:		
Cash for Health Service Operations (as per cash flow statement)	630,821	927,337
TOTAL CASH AND CASH EQUIVALENTS	630,821	927,337

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

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

NOTE 6.3: COMMITMENTS FOR EXPENDITURE

	2018 $	2017 $
Capital Expenditure Commitments		
Kronos Capital Cost	0	50,156
Total Capital Expenditure Commitments	0	50,156
Lease commitments		
Commitments in relation to leases contracted for at the reporting date:		
Finance Leases (South West Alliance of Rural Health)	59,676	192,686
Total lease commitments	59,676	192,686
Finance Leases		
Commitments in relation to finance leases are payable as follows:		
Current	63,853	105,265
Non-current	0	100,000
Minimum lease payments	63,853	205,265
Less future finance charges	4,177	12,579
Total finance lease commitments	59,676	192,686
Total lease commitments	59,676	192,686

All amounts shown in the commitments note are nominal amounts inclusive of GST.

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

NOTE 7: RISKS, CONTINGENCIES & VALUATION UNCERTAINTIES

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

Structure

7.1 Financial instruments
7.2 Contingent assets and contingent liabilities

NOTE 7.1: FINANCIAL INSTRUMENTS

Financial Risk Management Objectives and Policies

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of Timboon and District Healthcare Service's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation.*

Categorisation of financial instruments

2018	Contractual financial assets/liabilities designated at fair value through profit/loss $	Contractual financial assets/liabilities held-for-trading at fair value through profit/loss $	Contractual financial assets - loans and receivables $	Contractual financial assets - available for sale $	Contractual financial liabilities at amortised cost $	Total $
Contractual Financial Assets						
Cash and cash equivalents	0	0	630,821	0	0	630,821
Receivables	0	0	241,720	0	0	241,720
Other Financial Assets						
- Term Deposits	0	0	3,353,138	0	0	3,353,138
Total Financial Assets (i)	0	0	4,225,679	0	0	4,225,679
Financial Liabilities						
Payables	0	0	0	0	385,170	385,170
Borrowings	0	0	0	0	59,676	59,676
Total Financial Liabilities(ii)	0	0	0	0	444,846	444,846

2017	Contractual financial assets/liabilities designated at fair value through profit/loss $	Contractual financial assets/liabilities held-for-trading at fair value through profit/loss $	Contractual financial assets - loans and receivables $	Contractual financial assets - available for sale $	Contractual financial liabilities at amortised cost $	Total $
Contractual Financial Assets						
Cash and cash equivalents	0	0	927,337	0	0	927,337
Receivables	0	0	750,075	0	0	750,075
Other Financial Assets						
- Term Deposits	0	0	2,835,566	0	0	2,835,566
Total Financial Assets (i)	0	0	4,512,978	0	0	4,512,978
Financial Liabilities						
Payables	0	0	0	0	920,661	920,661
Borrowings	0	0	0	0	192,686	192,686
Total Financial Liabilities(i)	0	0	0	0	1,113,347	1,113,347

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

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

	Net holding gain/(loss) $	Total interest income/ (expense) $	Fee income / (expense) $	Impairment loss $	Total $
2018					
Financial Assets					
Loans and Receivables(i)	0	83,237	0	0	83,237
Total Financial Assets	0	83,237	0	0	83,237
Financial Liabilities					
At amortised cost (ii)	0	(4,748)	0	0	(4,748)
Total Financial Liabilities	0	(4,748)	0	0	(4,748)
2017					
Financial Assets					
Loans and Receivables(i)	0	81,905	0	0	81,905
Total Financial Assets	0	81,905	0	0	81,905
Financial Liabilities					
At amortised cost (ii)	0	(26,951)	0	0	(26,951)
Total Financial Liabilities	0	(26,951)	0	0	(26,951)

(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 measured at amortised cost.

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

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

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

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

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

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

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

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

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

Reclassification of financial instruments

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

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

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

Derecognition of financial liabilities

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

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

NOTE 7.2: CONTINGENT ASSETS AND CONTINGENT LIABILITIES

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

There are no known contingent assets or liabilities for Timboon and District Healthcare Service as at the date of this report.

NOTE 8: OTHER DISCLOSURES

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

Structure

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

NOTE 8.1: EQUITY	2018 $	2017 $
(a) Surpluses		
Property, Plant and Equipment Revaluation Surplus [1]		
Balance at beginning of the reporting period	5,500,097	5,500,097
Revaluation Increment/(Decrement)		
- Land	192,195	0
- Buildings	990,409	0
Balance at the end of the reporting period	6,682,701	5,500,097
Represented by:		
- Land	743,230	551,035
- Buildings	5,939,471	4,949,062
	6,682,701	5,500,097
(b) Contributed Capital		
Balance at the beginning of the reporting period	4,610,700	4,610,700
Balance at the end of the reporting period	4,610,700	4,610,700

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

(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	4,938,788	5,196,607
Net Result for the Year	(85,374)	(257,819)
Balance at the end of the reporting period	4,853,414	4,938,788
Total Equity at end of financial year	16,146,815	15,049,585

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.

NOTE 8.2: RECONCILIATION OF NET RESULT FOR THE YEAR TO NET CASH INFLOW / (OUTFLOW) FROM OPERATING ACTIVITIES	2018 $	2017 $
NET RESULT FOR THE YEAR	(85,374)	(257,819)
Non-cash movements		
Depreciation	718,540	789,939
Movements included in investing and financing activities		
Net (Gain)/Loss from Sale of Plant and Equipment	(18,967)	3,836
Movements in assets and liabilities		
Change in Operating Assets & Liabilities		
(Increase)/Decrease in Receivables	618,130	(77,628)
(Increase)/Decrease in Prepayments	(24,803)	11,667
Increase/(Decrease) in Payables	(588,962)	332,686
Increase/(Decrease) in Employee Benefits	(65,501)	(44,155)
(Increase)/Decrease in Inventories	(707)	1,660
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	552,356	760,186

NOTE 8.3: RESPONSIBLE PERSON DISCLOSURES

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

	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	01/07/2017 - 30/06/2018
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	01/07/2017 - 30/06/2018
The Honourable Jenny Mikakos, MLC, Minister for Families and Children	01/07/2017 - 30/06/2018
Governing Boards	
Mrs M. Bull	01/07/2017 - 23/02/2018
Mr. J. McKenzie	01/07/2017 - 30/06/2018
Mrs. C. Marr	01/07/2017 - 30/06/2018
Mr. J. Renyard	01/07/2017 - 30/06/2018
Ms. S. (K) Waters	01/07/2017 - 01/02/2018
Mr B. Morden	01/07/2017 - 30/06/2018
Mr J. Chuck	01/07/2017 - 30/06/2018
Ms. W. Cameron	01/07/2017 - 30/06/2018
Ms. G. Stanislaw	01/07/2017 - 30/06/2018
Accountable Officers	
Mr G. Sheehan	01/07/2017 - 30/06/2018

Remuneration of Responsible Persons

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

	2018	2017
Income Band	**$**	**$**
$0 - $9,999	9	9
$160,000 - $169,999	0	1
$190,000 - $199,999	1	0
Total Numbers	10	0
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	$193,070	$169,171

Amounts relating to Governing Board Members and Accountable Officer are disclosed in the Health Service's financial statements.
Amounts relating to Responsible Ministers are reported within the Department of Parliamentary Services' Financial Report as disclosed in Note 8.5.

NOTE 8.4: EXECUTIVE OFFICER DISCLOSURES

Remuneration of executive officers	**Total Remuneration**	
	2018	**2017**
	$	**$**
Short-term employee benefits	237,597	257,943
Post-employment benefits	20,361	22,773
Other long-term benefits	8,089	7,464
Termination benefits	0	0
Share-based payments	0	0
Total Remuneration (i)	266,047	288,180
Total Number of executives	2	2
Total annualised employee equivalent (AEE) (ii)	2	2

Notes:

(i) The total number of executive officers includes persons, other than Ministers and Accountable Officers, who meet the definition of Key Management Personnel (KMP) of the entity under AASB 124 Related Party Disclosures. The Health Service does not consider any executive officers meet the definition of KMP.

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

NOTE 8.5: RELATED PARTIES

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

- all key management personnel and their close family members;
- all cabinet ministers and their close family members;
- Jointly Controlled Operation - A member of the Southwest Alliance of Rural Health; and
- all hospitals and public sector entities that are controlled and consolidated into the whole of state consolidated financial statements.

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

The Board of Directors and the Chief Executive Officer of Timboon and District Healthcare Service and it's controlled entities are deemed to be KMPs.

Entity	KMPs	Position Title
Timboon & District Healthcare Service	Mr. J. McKenzie	Chair of the Board
Timboon & District Healthcare Service	Mrs M. Bull	Board Member
Timboon & District Healthcare Service	Mrs. C. Marr	Board Member
Timboon & District Healthcare Service	Mr. J. Renyard	Board Member
Timboon & District Healthcare Service	Ms. S. (K) Waters	Board Member
Timboon & District Healthcare Service	Mr B. Morden	Board Member
Timboon & District Healthcare Service	Mr J. Chuck	Board Member
Timboon & District Healthcare Service	Ms. W. Cameron	Board Member
Timboon & District Healthcare Service	Ms. G. Stanislaw	Board Member
Timboon & District Healthcare Service	Mr G. Sheehan	Accountable Officer

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

COMPENSATION	2018 $	2017 $
Short term employee benefits	172,510	148,626
Post-employment benefits	15,296	15,281
Other long-term benefits	5,264	5,264
Termination benefits	0	0
Share based payments	0	0
Total	**193,070**	**169,171**

(i)Total remuneration paid to KMPs employed as a contractor during the reporting period through accounts payable has been reported under short-term employee benefits.
(ii)KMPs are also reported in Note 8.3 Responsible Persons.

Significant transactions with government-related entities
Timboon and District Healthcare Service received funding from the Department of Health and Human Services of $4,529,406 (2017: $4,545,363).

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

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

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

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

Outside of normal citizen type transactions with the Department of Health and Human Services, all other related party transactions that involved KMPs and their close family members have been entered into on an arm's length basis. Transactions are disclosed when they are considered material to the users of the financial report in making and evaluation decisions about the allocation of scare resources.

There were no related party transactions with Cabinet Ministers required to be disclosed in 2018.
There were no related party transactions required to be disclosed for Timboon and District Healthcare Service Board of Directors and Accountable Officers in 2018.

Note 8.6: REMUNERATION OF AUDITORS	**2018**	**2017**
Victorian Auditor-General's Office	**$**	**$**
Audit or review of financial statement	9,000	9,000
	9,000	9,000

NOTE 8.7: AASBs ISSUED THAT ARE NOT YET EFFECTIVE

Certain new Australian accounting standards and interpretations have been published that are not mandatory for 30 June 2018 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 2018, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. Timboon and District Healthcare Service has not and does not intend to adopt these standards early.

Topic	Key Requirements	Effective date	Impact on financial statements
AASB 9 Financial Instruments	The key changes introduced by AASB 9 include simplified requirements for the classification and measurement of financial assets, a new hedge accounting model and a revised impairment loss model to recognise expected impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	01-Jan-18	The assessment has identified the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. The initial application of AASB 9 is not expected to significantly impact the financial position however there will be a change to the way financial instruments are classified and new disclosure requirements.
AASB 2014-1 *Amendments to Australian Accounting Standards [Part E Financial Instruments]*	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018, and to amend reduced disclosure requirements.	01-Jan-18	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2014-7 *Amendments to Australian Accounting Standards arising from AASB 9*	Amends various AAS's to incorporate the consequential amendments arising from the issuance of AASB 9.	01-Jan-18	The assessment has indicated there will be no significant impact for the public sector.
AASB 15 Revenue from Contracts with Customers	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer. Note that amending standard AASB 2015-8 *Amendments to Australian Accounting Standards - Effective Date of AASB 15* has deferred the effective date of AASB 15 to annual reporting periods beginning on or after 1 January 2018, instead of 1 January 2017	01-Jan-18	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The standard will also require additional disclosures on service revenue and contract modifications.
AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15	Amends the measurement of trade receivables and the recognition of dividends as follows: - Trade receivables that do not have a significant financing component, are to be measured at their transaction price at initial recognition. - Dividends are recognised in the profit and loss only when: * the entity's right to receive payment of the dividend is established; * it is probable the economic benefits associated with the dividend will flow to the entity; and * the amount can be measured reliably.	01/01/2018 except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated there will be no significant impact for the public sector.
AASB 2015-8 *Amendments to Australian Accounting Standards - Effective Date of AASB 15*	This Standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2108	01-Jan-18	The amending standard will defer the application period of AASB 15 for for-profit entities to the 2018-19 reporting period in accordance with the transition requirements.

NOTE 8.7: AASBs ISSUED THAT ARE NOT YET EFFECTIVE (Continued)

Topic	Key Requirements	Effective date	Impact on financial statements
AASB 2016-3 *Amendments to Australian Accounting Standards - Clarifications to AASB 15*	This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: - A promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation; - For items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer; and - For licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access).	01-Jan-18	The assessment has indicated there will be no significant impact for the public sector, other than the impact identified for AASB 15 above.
AASB 2016-7 *Amendments to Australian Accounting Standards - Deferral of AASB 15 for Not-for-Profit-Entities*	This Standard defers the mandatory effective date of AASB 15 for not-for-profit-entities from 1 January 2018 to 1 January 2109.	01-Jan-19	The amending standard will defer the application period of AASB 15 for not-for-profit entities to the 2019-20 reporting period.
AASB 2016-8 *Amendments to Australian Accounting Standards - Australian Implementation Guidance for Not-for-Profit-Entities*	AASB 2016-8 inserts Australian requirements and authoritative implementation guidance for not-for-profit-entities into AASB 9 and AASB 15. This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events.	01-Jan-19	This standard clarifies the application of AASB 15 and AASB 9 in a not-for-profit context. The areas within these standards that are amended for not-for-profit application include: AASB 9 - Statutory receivables are recognised and measured similarly to financial assets. AASB 15 - The "customer" does not need to be the recipient of goods and/or services; - The "contract" could include an arrangement entered into under the direction of another party; - Contracts are enforceable if they are enforceable by legal or "equivalent means"; - Contracts do not have to have commercial substance, only economic substance; and - Performance obligations need to be "sufficiently specific" to be able to apply AASB 15 to these transactions
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of operating leases (which are currently not recognised) on balance sheet.	01-Jan-19	The assessment has indicated that most operating leases, with the exception of short term and low value leases will come on to the balance sheet and will be recognised as right of use assets with a corresponding lease liability. In the operating statement, the operating lease expense will be replaced by depreciation expense of the asset and an interest charge. There will be no change for lessors as the classification of operating and finance leases remains

NOTE 8.7: AASBs ISSUED THAT ARE NOT YET EFFECTIVE (Continued)

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

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

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

NOTE 8.8: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

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

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

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

NOTE 8.9: JOINTLY CONTROLLED OPERATIONS AND ASSETS

Name of Entity	Principal Activity	Ownership Interest 2018 %	Ownership Interest 2017 %
South West Alliance of Rural Health	Information Systems	1.59	3.30

Timboon & District Healthcare Service's interest in assets employed in the above jointly controlled operations are detailed below. The amounts are included in the consolidated financial statements under their respective categories.

	2018 $	2017 $
Current Assets		
Cash and Cash Equivalents	117,301	172,777
Receivables	30,032	607,717
Inventories	1,321	614
Prepayments	1,322	0
Total Current Assets	149,976	781,108
Non Current Assets		
Property, Plant and Equipment	62,608	197,737
Total Non Current Assets	62,608	197,737
Total Assets	212,584	978,845
Current Liabilities		
Payables	95,922	695,770
Borrowings	59,676	87,073
Employee Provisions	25,120	56,533
Total Current Liabilities	180,718	839,376
Non Current Liabilities		
Borrowings	0	105,613
Employee Provisions	4,639	9,819
Total Non Current Liabilities	4,639	115,432
Total Liabilities	185,357	954,808
Net Assets	27,227	24,037

Timboon & District Healthcare Service's interest in revenues and expenses resulting from jointly controlled operations and assets is detailed below:

	2018 $	2017 $
Revenues		
Operating Activities	361,373	743,807
Non Operating Activities	2,346	2,125
Capital Purpose Income	9,700	16,375
Total Revenue	373,419	762,307
Expenses		
Employee Expenses	125,767	214,514
Maintenance Contracts and IT Support	80,939	259,678
Operating Lease Costs	2,570	15,112
Other Expenses	114,599	116,814
Total Operating Expenses	323,875	606,118
Finance Costs	3,382	26,951
Impairment of Non Financials	0	2,212
Depreciation	43,057	121,124
Total Non Operating Expenses	46,439	150,287
Total Expenses	370,314	756,405
Net Result from Operating and Non Operating Activity	3,105	5,902
Other economic flows included in net result		
Revaluation of Long Service Leave	85	1,259
Net Result	3,190	7,161

Contingent Liabilities and Capital Commitments
There are no known contingent liabilities or capital commitments held by jointly controlled operations at balance date.

NOTE 8.10: ALTERNATIVE PRESENTATION OF COMPREHENSIVE OPERATING STATEMENT

	2018 $	2017 $
Grants		
Operating	5,834,130	5,666,006
Capital	113,044	141,595
Interest	83,237	81,905
Sales of goods and services	828,518	597,061
Other	604,189	1,061,730
Revenue from Transactions	**7,463,118**	**7,548,297**
Employee expenses	4,575,170	4,613,418
Depreciation	718,540	789,939
Other operating expenses	2,273,834	2,400,182
Expenses from Transactions	**7,567,544**	**7,803,539**
Net result from transactions - Net Operating Balance	**(104,426)**	**(255,242)**
Other economic flows included in net result		
Net gain/ (loss) on sale of non-financial assets	18,967	(3,836)
Net gain/(loss) from other economic flows	85	1,259
Total Other Economic flows included in Net Result	**19,052**	**(2,577)**
NET RESULT FOR THE YEAR	**(85,374)**	**(257,819)**

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

NOTE 8.11: ECONOMIC DEPENDENCY

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

Disclosure Index

THE ANNUAL REPORT OF TDHS IS PREPARED IN ACCORDANCE WITH ALL RELEVANT VICTORIAN LEGISLATION. THIS INDEX HAS BEEN PREPARED TO FACILITATE IDENTIFICATION OF THE DEPARTMENT'S AND ORGANISATION'S COMPLIANCE WITH STATUTORY DISCLOSURE REQUIREMENTS.

LEGISLATION	REQUIREMENT	PAGE REFERENCE
Charter and purpose		
FRD 22H	Manner of establishment and the relevant Ministers	22
FRD 22H	Purpose, functions, powers and duties	22-24
FRD 22H	Initiatives and key achievements	8-12
FRD 22H	Nature and range of services provided	6-7
Management and structure		
FRD 22H	Organisational structure	19
Financial and other information		
FRD 10A	Disclosure index	76
FRD 11A	Disclosure of ex-gratia expenses	N/A
FRD 21C	Responsible person and executive officer disclosures	80-81
FRD 22H	Application and operation of Protected Disclosure 2012	77
FRD 22H	Application and operation of Carers Recognition Act 2012	77
FRD 22H	Application and operation of Freedom of Information Act 1982	77
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SD 5.2.3	Declaration in report of operations	28
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Other requirements under Standing Directions 5.2		
SD 5.2.2	Declaration in financial statements	28
SD 5.2.1(a)	Compliance with Australian accounting standards and other authoritative pronouncements	35
SD 5.2.1(a)	Compliance with Ministerial Directions	35

Legislation	
Freedom of Information Act 1982	77
Protected Disclosure Act 2012	77
Carers Recognition Act 2012	77
Victorian Industry Participation Policy Act 2003	78
Building Act 1993	77
Financial Management Act 1994	81
Safe Patient Care Act 2015	78

Statutory Disclosures

BUILDING ACT 1993

TDHS complies with the Building Act 1993 and Standards for Publicly Owned Buildings November 1994 in all redevelopment and maintenance issues.

The buildings have been subject to a fire audit and we are currently updating our Fire Safety Handbook. Both of these tasks were completed by a Fire Safety Engineer.

During the reporting period, planned/preventative maintenance was carried out, including routine inspections and rectification to ensure the Healthcare Service's buildings were maintained to a safe and functional condition in compliance with the requirements of the Act, Building Code of Australia and various Australian Standards, as evidenced in the annual certificate of compliance of essential safety measures (ESM). The buildings ESM is also subject to external auditing.

We currently use a number of external specialists to assist with our compliance with the Department of Health and Human Services Fire Risk Management Guidelines.

Within the reporting period, the building and surrounds were also subject to a Risk Engineer's Site Risk Survey which scored the TDHS site as very good, demonstrating effective risk management, with risks appropriately controlled and where few or no recommendations were made.

FREEDOM OF INFORMATION ACT 1982

The *Freedom of Information (FOI) Act 1982* allows the public a right of access to documents held by THDS. Individuals or agencies who act on their behalf, such as solicitors or insurance companies, are entitled to access personal medical record information. TDHS is committed to protecting consumer privacy and all care is taken to ensure information is released only to the relevant individual or authorised representative.

During 2017/18 TDHS received and processed two applications from members of the public. All FOI applications are directed to the General Manager of Health Services and are processed in accordance with the provisions of the *Freedom of Information (FOI) Act 1982* within the legislated timeframes.

All FOI applications must be made in writing and addressed to:

ATT: General Manager Health Services
Timboon and District Healthcare Service
21 Hospital Road
Timboon VIC 3268

All applications will be charged a $28.90 application fee. Successful applicants will also incur additional access charges which vary depending on materials supplied. A schedule of these additional fees can be found on the freedom of information website (www.foi.vic.gov.au).

PROTECTED DISCLOSURE ACT 2012

TDHS is committed to the principles of the *Protected Disclosure Act 2012*. During the 2017/18 financial year there were no disclosures received by TDHS and no notification of disclosures to the Ombudsman or any other external agency.

CARERS RECOGNITION ACT 2012

TDHS complies with all requirements of the *Carers Recognition Act 2012* and was not required to make any disclosures during the reporting period.

COMPETITIVE NEUTRALITY POLICY VICTORIA

TDHS complies with the National Competition Policy and requirements of the *Competitive Neutrality Policy Victoria.*

Statutory Disclosures

VICTORIAN INDUSTRY PARTICIPATION POLICY (VIPP) ACT 2003

No contracts commenced in the financial year to which the VIPP Plan was required.

SAFE PATIENT CARE ACT 2015

TDHS complies with all the requirements of the *Safe Patient Care Act 2015* and has no matters to report in relation to its obligations under section 40 of the act.

CONSULTANCIES

Details of consultancies (under $10,000)

In 2017-18, there was one consultancy where the total fees payable to the consultants were less than $10,000. The total expenditure incurred during 2017-18 in relation to this consultancy is $6,800.

Details of consultancies (valued at $10,000 or greater)

In 2017-18, there were three consultancies where the total fees payable to the consultant was $10,000 or greater. The total expenditure incurred during 2017-18 in relation to these consultancies is $112,864. Details shown below.

CONSULTANTS ($ THOUSAND)

CONSULTANT	PURPOSE OF CONSULTANCY	START DATE	END DATE	TOTAL APPROVED PROJECT FEE (EX GST)	EXPENDITURE 2017-18 (EX GST)	FUTURE EXPENDITURE (EX GST)
O'Malley Consulting	Community Health Needs Assessment	25/03/18	25/06/18	61.8	61.8	0
O'Malley Consulting	Strategic Plan Development	25/03/18	25/6/18	21.1	21.1	0
Victorian Healthcare Association	MPS Stage 2 Review	19/6/18	19/6/18	30	30	0

INFORMATION AND COMMUNICATION TECHNOLOGY (ICT) EXPENDITURE ($ MILLIONS)

The total ICT expenditure incurred during 2017-18 is $378,276.21 with the details shown below.

BUSINESS AS USUAL (BAU) ICT EXPENDITURE TOTAL (EX GST)	NON BUSINESS AS USUAL (NON BAU) ICT EXPENDITURE (TOTAL=OPERATIONAL EXPENDITURE AND CAPITAL EXPENDITURE) (EX GST)	OPERATIONAL EXPENDITURE (EX GST)	CAPITAL EXPENDITURE (EX GST)
.359	.019	0.002	0.017

WORKFORCE DATA

HOSPITALS LABOUR CATEGORY	JUNE CURRENT MONTH FTE*		JUNE YTD FTE**	
	2017	2018	2017	2018
Nursing	17.8	17.5	17.4	17.9
Administration and Clerical	8.9	8.2	8.1	8.2
Medical Support	1.5	0.7	1.6	1.3
Hotel and Allied Services	13.0	14.2	14.3	13.5
Ancillary Staff (Allied Health)	1.4	1.3	2.2	1.3

OCCUPATIONAL VIOLENCE

OCCUPATIONAL VIOLENCE STATISTICS	2017-18
WorkCover accepted claims with an occupational violence cause per 100 FTE	0
Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	0
Number of occupational violence incidents reported	4
Number of occupational violence incidents reported per 100 FTE	9
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	0

OCCUPATIONAL HEALTH AND SAFETY

OCCUPATIONAL HEALTH & SAFETY	2015-16	2016-17	2017-18
Number of reported hazards/incidents for the year per 100 FTE *	103	103	24**
Number of 'lost time' standard claims for the year per 100 FTE	0	0	2
Average cost per claim for the year	$0	$0	$26,000

***Additional training was implemented to help staff identify actual OH&S incidents*

ENVIRONMENTAL MANAGEMENT PERFORMANCE

ENVIRONMENTAL PERFORMANCE	2015-16	2016-17	2017-18
Total greenhouse gas emissions (tonnes CO2e)			
Scope 1	32	31	32
Scope 2	392	391	393
Emissions per unit of floor space (kgCO2e/m2)	124.86	124.61	125.37
Total stationary energy purchased by energy type (GJ)			
Electricity	1,248	1,292	1,308
Liquefied Petroleum Gas	520	514	536
Energy per unit of floor space (GJ/m2)	0.52	0.53	0.54
Total water consumption (kL)			
Potable Water	1,934	1,556	1,812
Water per unit of floor space (kL/m2)	0.57	0.46	0.53
Waste (kg)			
Total waste generated	N/A	N/A	7,333
Total waste to landfill generated	N/A	N/A	3,723
Recycling rate %	N/A	N/A	51.11

Statutory Disclosures

ADDITIONAL INFORMATION AVAILABLE ON REQUEST

In compliance with the requirements of the Financial Reporting Directions 22H (Section 5.19) details in respect to the items listed below have been retained by TDHS and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements, if applicable):

a. Declarations of pecuniary interests have been duly completed by all relevant officers

b. Details of shares held by senior officers as nominee or held beneficially

c. Details of publications produced by the entity about itself, and how these can be obtained

d. Details of changes in prices, fees, charges, rates and levies charged by the Healthcare Service

e. Details of any major external reviews carried out on the Healthcare Service

f. Details of major research and development activities undertaken by the Healthcare Service that are not otherwise covered either in the Report of Operations or in a document that contains the financial statements and report of operations

g. Details of overseas visits undertaken including a summary of the objectives and outcomes of each visit

h. Details of major promotional, public relations and marketing activities undertaken by the Healthcare Service to develop community awareness of the Healthcare Service and its services

i. Details of assessments and measures undertaken to improve the occupational health and safety of employees

j. General statement on industrial relations within the Healthcare Service and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the Report of Operations

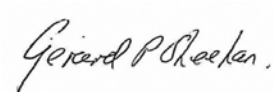
k. A list of major committees sponsored by the Healthcare Service, the purposes of each committee and the extent to which those purposes have been achieved

l. Details of all consultancies and contractors including consultants/contractors engaged, services provided, and expenditure committed for each engagement.

ATTESTATIONS

ATTESTATION ON DATA INTEGRITY

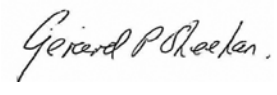
I, Gerry Sheehan, certify that Timboon and District Healthcare Service has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. The Timboon and District Healthcare Service has critically reviewed these controls and processes during the year.



Gerry Sheehan
Chief Executive Officer
Timboon
31/07/2018

ATTESTATION ON CONFLICT OF INTEREST

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



Gerry Sheehan
Chief Executive Officer
Timboon
31/07/2018

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

I, Gerry Sheehan, certify that Timboon and District Healthcare Service has put in place appropriate internal controls and processes to ensure that it has complied with all requirements set out in the HPV Health Purchasing Policies including mandatory HPV collective agreements as required by the Health Services Act 1988 (Vic) and has critically reviewed these controls and processes during the year.

Gerry Sheehan
Chief Executive Officer
Timboon
31/07/2018

ATTESTATION ON FINANCIAL MANAGEMENT COMPLIANCE

I, Maryanne Puli Vogels, on behalf of the Responsible Body, certify that Timboon and District Healthcare Service has complied with the applicable Standing Directions of the minister for Finance under the Financial Management Act 1994 and Instructions.

Maryanne Puli Vogels
Board Chair
Timboon
30/07/2018

TIMBOON
AND DISTRICT
HEALTHCARE
SERVICE

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