Annual report

2018–19

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Published by Bass Coast Health, 235 Graham Street, Wonthaggi Vic. 3995
Available at: https://www.gha2.net.au/BCH/Content/Publications/Annual-Reports

Our Mission

Delivering person centred care to improve health, wellbeing, care experience and health outcomes, with our community.

Our Vision

Excellence in care.

Our Values

Wellbeing

Equity

Compassion

Accountability

Respect

Excellence.

About this report

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

Bass Coast Health is established under the *Health Services Act 1988 (Vic)*.

Relevant Ministers

The relevant Ministers during this reporting period were:

- The Hon Jill Hennessy MP – Minister for Health, Minister for Ambulance Services 01/07/2018 – 29/11/2018
- Jenny Mikakos MLC – Minister for Health, Minister for Ambulance Services 29/11/2018 – 30/06/2019
- The Hon Martin Foley MP – Minister for Mental Health 01/07/2018 – 30/06/2019

Contents

Year in review

Report from Board Chair and CEO

It is with great pleasure that we present the Bass Coast Health (BCH) Annual Report for the 2018–19 financial year.

This Annual Report is developed in accordance with the *Financial Management Act 1994*, and highlights the excellent care, commitment and achievements of the BCH team over the last twelve months.

BCH is committed to the delivery of safe, high quality care, whilst continually growing services for our sub-region. We achieve this by working in partnership with:

- the Victorian Government Department of Health and Human Services (DHHS);
- the Commonwealth Department of Health;
- other federal and state government agencies;
- our sub-regional health service colleagues (South Gippsland Hospital (SGH) and Gippsland Southern Health Service (GSHS));
- our metropolitan health service colleagues, in particular Monash Health, Alfred Health and Peninsula Health;
- our medical staff including GP's from Wonthaggi Medical Group;
- Bass Coast Shire Council;
- Ambulance Victoria;
- our fantastic community members – Lions, Rotary, the Freemasons, Phillip Island Medical and Heath Action Group, Men's Sheds; and
- most importantly, all of our wonderful volunteers, auxiliaries and consumer advisors.

The delivery of health services relies on the contribution and expertise of so many community members – we are blessed to have such wonderful support from people who are truly committed to BCH.

In order to further increase the breadth and complexity of health services available to the Bass Coast community, we are continually expanding our links with metropolitan and tertiary services to bring medical specialists to Bass Coast. As a result of this collaboration, we now have specialists providing high quality care to BCH in:

- Medical oncology
- Urology
- Cardiology
- Ophthalmology
- Nephrology
- Orthopaedic surgery
- Haematology
- General surgery
- Obstetrics and gynaecology
- Geriatric medicine
- Plastic surgery
- Ear, nose and throat
- Gastroenterology
- Endocrinology

Collaborating with other health organisations ensures BCH is able to build capability as a sub-regional service provider. This collaboration ensures community members are able to access specialist services in their local environment. This will continue to grow in future years in line with the Victorian Government's commitment to improving access to medical specialists in regional communities. We are indebted to those dedicated medical staff who travel long distances from Melbourne to provide access to quality care in our region.

Health service collaboration with our sub-regional colleagues, Gippsland Southern Health Service and South Gippsland Hospital is both innovative and exciting. Significant progress has been made to implement the *South Coast Sub-Regional Clinical Services Plan* which ensures we work together to increase the number of collective services we can provide in our sub-region.

A strong commitment has been made by the three boards and executive teams to share resources, develop consistent processes and work together to grow services across the South Gippsland and Bass Coast Shires

to deliver sub-regional growth. The aim of this partnership is to strengthen each service's local presence, whilst ensuring the provision of safe and high-quality services for community members in Bass Coast and South Gippsland. Importantly, we have a strong focus on strengthening our prevention approach through the development of a sub-regional Prevention Partnership to ensure we focus on preventing ill health. This partnership is the first of its kind in Victoria and has stimulated much interest and support from government.

BCH is privileged to be supported by over 270 volunteers who selflessly donated an incredible 27,000 hours of their time throughout 2018–19. Our volunteers work tirelessly across all areas of our health service supporting patients, clients, family and staff. This year we are extremely pleased to acknowledge Candy Pile who was short-listed for the Outstanding Lifetime Achievement award at the 2018 Minister for Health Volunteers Awards, in recognition of her outstanding 20 years as a BCH volunteer. The Awards also recognised our wonderful San Remo Op Shop volunteers who last year raised some $127,000 and who were nominated for the Outstanding Achievement by a Volunteer – Better Care Victoria Innovation award.

There was significant success with fundraising this year with our four auxiliaries contributing some $160,000 to BCH infrastructure: the Wonthaggi Ladies Auxiliary, the San Remo Op Shop, the Inverloch Art Show Auxiliary and the Phillip Island Health Hub Auxiliary are to be commended for their dedication in supporting our local health service. These excellent fundraising efforts, along with the generous donations from local community groups, businesses and residents during 2018–19, provided highly valued specialised equipment and service enhancements. We genuinely thank and acknowledge all of our donors for their ongoing generosity and support.

Without doubt, the key contributor to BCH's success is our staff. On behalf of the BCH board and executive, we would like to pay tribute to, and sincerely thank, our team of skilled, dedicated and passionate employees for their ongoing commitment. Our staff are part of this wonderful community – they care for their own neighbours, family members and colleagues and they are dedicated to improving health outcomes and providing excellent person-centred care. Our staff have facilitated significant change in all areas of the service to improve what we do, and they have been unwavering in their pursuit of safe, high quality care. We commend them for ensuring our values of wellbeing, equity, compassion, accountability, respect and excellence are integral to the way they provide care.

In 2018–19, BCH partnered with consumers, community members, and employees to deliver on the five key strategic goals for the organisation. These strategic goals aim to improve: Safety and Quality; Service Capability; People; Innovation and Technology; and Financial Health. Below is a list of some of our key achievements against these strategic goals in 2018–19:

Safety and Quality

- We evaluated our care and services through a range of independent reviews and:
  - ✓ Achieved successful re-accreditation of our residential aged care facility, Griffiths Point Lodge under the Aged Care Quality Standards.
  - ✓ Maintained accreditation of our residential aged care facility, Kirrak, under the Commonwealth Aged Care Quality Standards.
  - ✓ Achieved successful mid-cycle review under Human Services Standards for Integrated Family Services, Sexual Assault Support Services; and Family Violence Support Services.
- We developed and implemented capability frameworks for key service areas such as maternity, surgery/ anaesthetics and subacute.
- We were recognised as a finalist for the Most Outstanding Regional Hospital in Australia by the Australian Patients Association.

- We were an active member of the Bass Coast Reconciliation Network along with Westernport Water, Phillip Island Nature Parks, Bass Coast Shire Council, Bunurong Land Council, BLCAC, community members and local elders.

Service Capability

- We commenced planning for the $115 million Wonthaggi Hospital expansion project in collaboration with the Victorian Health and Human Services Building Authority (VHHSBA).
- We opened the Minor Injury and Illness Clinic (MICC) at the Phillip Island Health Hub in December and saw over 7,000 presentations up until June 2019.
- We commenced planning for a new Urgent Care Centre at the Phillip Island Health Hub.
- We announced land purchase for the new Community Hospital at Phillip Island.
- We opened two post-natal maternity rooms.
- We commenced non-cytotoxic chemotherapy treatment.
- We refurbished the triage and fast track areas within the Wonthaggi Emergency Department.
- We transitioned to new radiology provider, iMed.
- We established the Gippsland South Coast Health Transport Connections Program.
- We actively participated in the *Change for Sam* strategy.

People

- We grew our workforce from 408.2 full-time equivalent (FTE) staff in June 2018 to 425.3 FTE staff in June 2019.
- We progressed preparation for Rainbow Tick Accreditation.
- We expanded the medical specialists appointed to BCH and increased our outpatient clinics at Phillip Island and Wonthaggi.
- We appointed a full-time Clinical Director of Emergency Services.
- We implemented the Leadership Development Program for our leadership group, expanding skills in coaching, change management and capacity building.
- We increased numbers through the Nurse Graduate Program, providing rotations through a range of clinical areas.
- We facilitated integration of health promotion resources across the sub-region to develop an integrated prevention partnership.
- We engaged with local secondary schools to establish a Work Experience Program.
- We increased our junior medical workforce with the addition of 3 hospital medical officer (HMO) rotations.

Innovation and Technology

- We implemented the Master Care patient and client management system for outpatient and community care services.
- We established a fibre connection to our Wonthaggi site ensuring reliable connectivity.
- We installed a new access control system at San Remo Community Health.
- We collaborated with the Alfred Hospital to deliver telemedicine aged care services to our community.
- We increased the number of stroke patients who benefited from the Victorian Stroke Telemedicine (VST) program in the Wonthaggi Emergency Department.
- We were actively involved in a number of research projects.

Financial Health

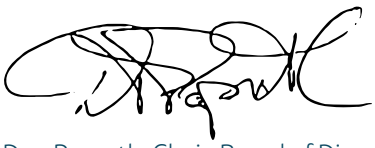
- We expended over $3.6m in funds received from DHHS and generous donations in capital works to improve the fabric of our infrastructure.
- We developed a strong capital management plan that forecast our requirements for sustainable growth.
- We treated significantly more patients, and sicker patients, which resulted in a significant funding increase.
- We welcomed the Commonwealth Government funding announcement of $3.5m for capital works.

- We received funding for infrastructure upgrades for the Urgent Care Centre at Phillip Island, Kirrak House, for the helipad, for violence prevention funding and San Remo security upgrades.
- We installed solar panels at Wonthaggi Hospital and Griffiths Point Lodge.
- We completed the sale of underutilised properties in Inverloch and Wonthaggi.
- We launched key fundraising campaigns including We Care about Cancer, We Care about Kids and the Freemasons We Care about Armitage House Palliative Care appeal.

The Board and Executive are immensely proud of the progress BCH has made in growing from a local rural service, to a sub-regional service. DHHS acknowledged our excellent progress this year with significant funding support which enabled increased services. DHHS formally recognised BCH as a sub-regional service provider; and for the first time in many years the BCH board delegate was removed, signalling clear confidence in BCH's governance.

Our focus is always on the safety and quality of care we provide; there is nothing more important. We are continually working to ensure there are strong foundations for good care, whilst also making sure we are growing our services to better meet the needs of our patients and their families.

It is a privilege to serve our community and we look forward to continued collaboration in building the services provided by BCH to provide Excellence in Care.



Don Paproth, Chair, Board of Directors

22 August 2019

Jan Child, Chief Executive Officer

22 August 2019

Our service profile

Acute Services

- 54 registered beds
- 4 day surgery beds
- High Dependency Unit
- Clinical services
  - Emergency
  - Haemodialysis
  - Hospital in the Home
  - Maternity
  - Medical
  - Medical Day Unit
  - Minor Injury and Illness Clinic
  - Operating Suite
  - Palliative Care
  - Short Stay Unit
  - Surgical

Sub-Acute Services

- Armitage House – Sub-acute services include Geriatric Evaluation and Management (GEM), Rehabilitation, Palliative Care

Residential Aged Care

- Kirrak House – 30 beds
- Griffiths Point Lodge – 29 beds.

Clinical Support Services

- Breast screening (Gippsland BreastScreen)
- Pathology (Gippsland Pathology)
- Pharmacy
- Radiology and ultrasonography (I-MED Radiology Network)
- South West Gippsland Community Mental Health Service (Latrobe Regional Hospital)
- Acute/ Aged Persons Mental Health Service (Latrobe Regional Hospital).

Volunteer Programs

- Meals on Wheels
- Medical transport driving – cars and buses
- Ward visitors
- Palliative care support
- Administration
- Residential aged care support
- Pastoral care
- Car washing
- Men's Shed (The San Remo Shack)
- Planned Activity Groups
- Auxiliaries (fundraising)
- Advisory groups.

Primary and Community Care Programs and Services

- Allied Health Paediatric Service: individual and group
- Antenatal education
- Autism and mental health program
- Best Start
- Breast Care Nurse
- Cancer Support Group
- Cardiac Rehabilitation Program
- Communication Skills Support Group
- Community Rehabilitation Program
- Continence Clinic
- Counselling services: general, family violence, alcohol and other drugs, sexual assault, psychological therapies
- Dental service
- Diabetes Self-Management Group
- Dietetics
- Domiciliary care
- Falls Prevention / Falls and Balance Clinic
- Family Day Care
- Health Promotion
- Home Care Packages (Flexihealth)
- Hospital Admission Risk Program
- Hip and Knee Joint Rehabilitation Group
- Integrated Family Services
- Lactation Services
- Maternal and Child Health
- Meals on Wheels
- Needle and Syringe Program
- Nursing programs: district and palliative care nursing, asthma and respiratory, stop smoking program, stomal therapy, chronic disease management, continence, Residential In-Reach and diabetes education.
- Occupational Therapy, including hand therapy
- Pastoral care
- Power Girls Group (women specific) Cardiac/ Pulmonary Rehabilitation Support
- Physiotherapy, including lymphoedema management, hydrotherapy and Strength Training Group
- Planned Activity Groups: general, men and dementia
- Podiatry and footcare
- Post Acute Care
- Pregnancy Care Clinic
- Pulmonary Rehabilitation Program
- School Focused Youth Service
- Social Work
- Speech Pathology
- Supported Playgroups
- Transition Care Program in the home
- Trauma and mental health program
- Walking groups (Heart Foundation)
- Weight Wise Group
- Wonthaggi Wheezers (Pulmonary Rehabilitation Support Group).

Corporate governance

Board of Directors

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

Functions of the Board include:

- develop a statement of priorities and strategic plan for the operation of BCH and monitor its compliance;
- develop financial and business plans, strategies and budgets to ensure accountable and efficient provision of health services and long-term financial viability of BCH;
- establish and maintain effective systems to ensure that BCH meets the needs of the community, ensuring the views of users and providers of health services are taken into account; and
- monitor the performance of BCH.

Chair

Don Paproth BA, Dip Ed

Don joined the BCH Board in July 2015 and has been the Chair of the Board of Directors for the last three years. Prior to that he had 48 years of experience in education, working as a secondary teacher, principal, deputy regional director and as the director of major projects in the Gippsland Region with the Department of Education and Early Childhood Development. He was Chair of the Council of the Victorian Institute of Teaching, the body which regulates the teaching profession across the state. Don is a member of the Finance, Audit and Risk and Remuneration Committees and the Development Council.

Deputy Chair

Christine Hammond Adv Cert Mgt, GAICD

Christine has strong experience in business management in both public and private sectors, including 21 years in the health industry. Christine is a former director of Bass Coast Community Health Service and was appointed to the Board of BCH in July 2014. Christine is a member of the Development Council, Remuneration Committee and the Community Advisory Committee and also served on the Project Control Group which oversaw construction of the Phillip Island Health Hub.

Mim Kershaw

Mim has more than 31 years' management experience in both private and public listed companies. Mim has experience in setting and achieving budgets, strategic planning, team development and retention, ethical sourcing and Quality Assurance and Quality Control. Mim is a former director of Bass Coast Community Health Service. She joined the BCH Board in July 2014 and is a member of the Development Council and the Quality and Clinical Governance Committee.

Mary Whelan B. App Sc (Physiotherapy), Grad Dip Man Therapy, Cert App Ergonomics for Injury Mgt, Cert IV Workplace Training.

Mary Whelan is a former clinical physiotherapist with 38 years' experience in public health and private practice. She founded a company to design and develop mobility aides to address the needs of patients and the occupational health and safety of staff in hospitals and aged care facilities. Mary joined the BCH Board in August 2015 is the Chair of the Quality and Clinical Governance Committee and is also a member of the Community Advisory Committee.

Ian Thompson BBus (Accounting), Grad Dip (Corp Finance), CPA, GAICD.

Ian is a risk professional with more than 30 years' experience in financial markets, having worked in various credit, economic, quality, risk management and governance roles here in Australia and in the UK. Ian spent the bulk of his career with leading global credit rating agency, Standard and Poor's Rating Services, most recently as a Senior Managing Director and Global Chief Credit Officer. Ian is a member of the Board of Snowdome Foundation, a charity focussed on funding research into blood cancer, and an independent member of State Sport Centre Trust's Audit and Risk committee and the Uniting Church's (Vic and Tas Synod) risk management committee. Ian joined the BCH Board in July 2016 and chairs the Finance, Audit and Risk Committee and is a member of the Quality and Clinical Governance Committee and Development Council.

Kate Mccullogh LLB, BCom (Accounting), Grad Dip (Intellectual Property Law), Advanced Diploma (Mechanical Engineering)

Kate is an experienced legal practitioner who was appointed to the BCH Board in July 2017. Kate has significant expertise in the health and disability sectors having acted as legal counsel for a Victorian public health service, a pharmaceutical company and a non-for-profit disability service provider. Kate also has experience advising on commercial contracting, tendering and procurement, legislative and regulatory compliance, business acquisitions, sale of assets, intellectual property, privacy and freedom of information matters. Kate is currently the General Counsel at BlueCross and is a member of the Finance, Audit and Risk Committee.

Dr Richard King AM, MBBS, FRACP

Dr Richard King is an Honorary Physician at Monash Health. Before his retirement he was Head of Investigative Services and Pharmacy at Monash Health. Prior to that he was Head of Medicine for 20 years. He is on the Board of Goulburn Valley Health and on the Board Quality Committee of the Northern Hospital. He chairs the Committee of Chairs of Board Quality Committee at DHHS. He is past Chair of the Council of the Australian Medical Association Victoria and past Chair of the State Committee of the College of Physicians. He received the AM for services to medicine and teaching. Richard joined the BCH Board in September 2017 and is a member of the Finance, Audit and Risk and Quality and Clinical Governance Committees.

Simon Jemmett BHSc Grad Cert Mgt, Dip Proj Mgt, MAICD

Simon has more than 30 years' experience in health, initially working in the public and private hospital systems before moving to Ambulance Victoria. Simon has an intensive care paramedic background and substantial experience across both the metropolitan and rural sectors in clinical and operational management, education, audit and clinical governance. Simon is was the Regional Director Gippsland for Ambulance Victoria for the last four years and is now leading some of Ambulance Victoria's transformative IT projects. Simon is on the Governance Committee for the Emergency Care Clinical Network. Simon joined the BCH Board in July 2017 and is a member of the Quality and Clinical Governance Committee.

Ian Leong Bach Bldg (QS) (Hons), Grad Dip Comp Sc, MBA, GAICD

Ian has over 40 years in the industry, working in both government and private sectors. Initially, Ian has significant experience as a property/building consultant, but more recently has managed his own general consultancy firm, providing advice to private and government clients. Ian is currently the Executive Director Redevelopment, Planning and Infrastructure at the Royal Victorian Eye and Ear Hospital, his role having overarching responsibility for capital redevelopment, future strategy/health service delivery and patient experience. Ian joined the BCH Board in August 2018 and is a member of the Finance, Audit and Risk Committee.

Mary O'Connor JP

Mary is a business proprietor of three national franchise businesses, a Justice of the Peace in Victoria and member of the South Gippsland branch of Justices of the Peace. Mary is also the President of the Wonthaggi branch of Ambulance Victoria and has active roles with Victoria Police, Rotary and in the criminal justice system. Mary is an active volunteer with many community groups and has experience in emergency management and high-risk youth issues, as well as experience in local government management as a past local government councillor for the Bass Coast Shire Council. Mary was appointed to the BCH Board in 2004 and is a member of the Remuneration and Community Advisory Committees.

Nigel McCormick CA, MA (Cantab), DipM, GAICD

Nigel is a Chartered Accountant and a graduate of Cambridge University. He migrated to Australia from Northern Ireland in 2010 and is now an Australian citizen. Nigel has broad experience across the public sector including the education, water, social security, arts, regional infrastructure, emergency services and central government policy sectors. His career has encompassed a mixture of policy and finance roles including senior executive positions leading policy and legislation, program and project management and institutional reform and acting as Chief Financial Officer of various agencies and departments. Nigel joined the BCH Board in July 2016 and is a member of the Finance, Audit and Risk Committee.

Jim Fletcher (Board Delegate) BHA, MIPAA, AFCHSE, MAICD

Jim has more than 30 years' experience at senior executive and board level in the health and human services industry across metropolitan and regional Victoria. His background includes executive appointments with the Department of Health, Chief Executive Officer of the state's three largest psychiatric hospitals – leading these services through major reform – and, more recently, Chief Executive of Western District Health Service until his retirement in July 2014. Jim commenced as the Minister's delegate to the BCH Board in August 2015 until September 2018.

Board committees

Finance Audit and Risk Committee

Chairperson: Ian Thompson

The Finance, Audit and Risk Committee is a sub-committee of the Board responsible for oversight, advice and recommendations to the Board regarding:

- financial management, including asset management;
- risk management, including compliance management; and
- internal and external audit.

Independent Members

Carol Clarke BA (Public Policy Management), Cert Investigation Services, Cert Government (Investigations)

Carol is a member of the Institute of Internal Auditors and has substantial experience in internal audit, risk, strategic governance, investigations and fraud, supported by a background in compliance and quality assurance within the public sectors of Australia and Ireland.

Carol is an independent external member of BCH Finance, Audit and Risk Committee.

Joanne Harris BA (Business), CPA, Master of Taxation

Joanne is an experienced finance professional with over 20 years of experience across a variety of sectors from private, through to health, education and local government in Australia, UK and Ireland. Carol is an independent external member of BCH Finance, Audit and Risk Committee.

Quality and Clinical Governance Committee

Chairperson: Mary Whelan

The Quality and Clinical Governance Committee is a sub-committee of the Board responsible for implementation of a strong quality and clinical governance framework, encompassing the domains of quality and safety:

- Leadership and culture
- Consumer partnerships
- Workforce
- Risk management
- Clinical Practice.

Remuneration Committee

Chairperson: Don Paproth

The Remuneration Committee is a sub-committee of the Board responsible for facilitating the remuneration and performance processes for the Chief Executive Officer.

Development Council

Chairperson: Christine Hammond

The Development Council is responsible for the development, implementation, and monitoring of BCH's fundraising strategy.

Community Advisory Committee

Chairperson: Hilary Kerrison

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

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

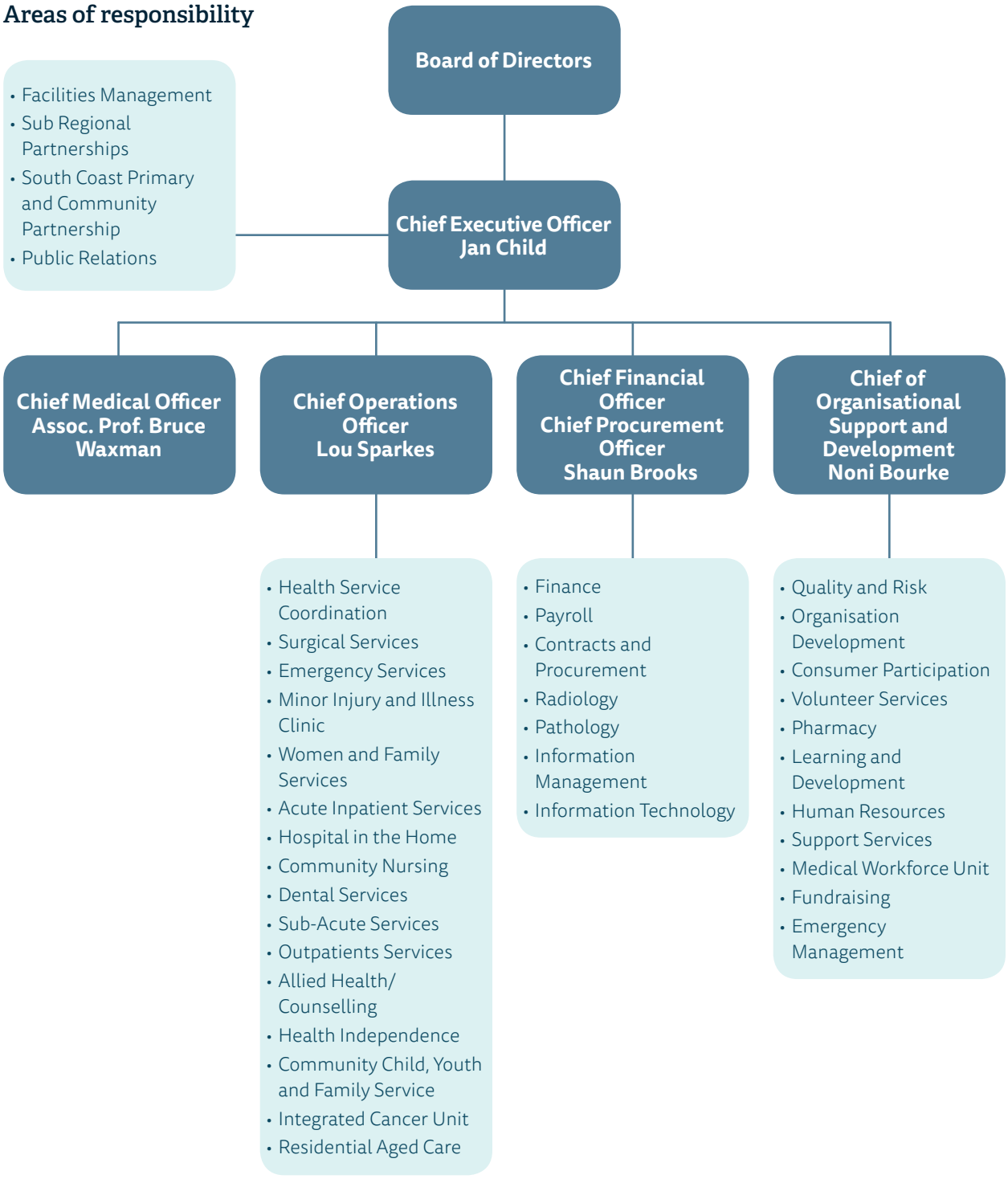
The following occurred in 2018–19:

Retirements	
Mary O'Connor	01 November 2004 to 30 June 2019
Nigel McCormick	01 July 2016 to 30 June 2019
Jim Fletcher (Board Delegate)	24 August 2015 to 24 September 2018
Reappointments	
Don Paproth	1 July 2018 to 30 June 2021
Mary Whelan	1 July 2018 to 30 June 2021
Appointments	
Ian Leong	2 August 2018 to 2 August 2021

Board membership and meeting attendance

Board member	Board of Directors	Finance, Audit and Risk Committee	Quality and Clinical Governance Committee	Remuneration Committee	Community Advisory Committee	Development Council
Don Paproth	91%	90%	-	100%	-	100%
Christine Hammond	91%	-	-	100%	83%	50%
Mary O'Connor	46%	-	-	100%	50%	-
Mim Kershaw	82%	-	100%	-	-	100%
Simon Jemmett	82%	-	100%	-	-	-
Kate McCullough	91%	90%	-	-	-	-
Mary Whelan	100%	-	100%	-	100%	-
Ian Leong	82%	78%-	-	-	-	-
Ian Thompson	91%	90%	83%	-	-	100%
Richard King	100%	100%	100%	-	-	-
Nigel McCormick	82%	78%	-	-	-	-
Board Delegate						
Jim Fletcher	100%	78%	83%	-	-	-
Independent Audit Committee member						
Carol Clarke	-	89%	-	-	-	-
Joanne Harris	-	56%	-	-	-	-

Organisation chart



Our executive

Jan Child

Chief Executive Officer
Reg Nurse, Grad Dip Behavioural Science, Masters Public Health, GAICD

Jan is a Registered Nurse with post graduate qualifications in behavioural sciences, health administration and a Masters in Public Health. She is a graduate of the Australian Institute of Company Directors and a surveyor with the Australian Council of Healthcare Services. She has more than 30 years' experience in public health, having trained in rural western Victoria, and then worked across metropolitan Melbourne including at Peninsula Health, Alfred Health, DHHS, alcohol and drug agencies and the community health sector. Jan was appointed as Chief Executive Officer in September 2016, following a six-month interim role commencing in March 2016.

Assoc. Professor Bruce P Waxman OAM

Chief Medical Officer
BMedSc (Hons), MBBS (Hons), FRACS, FRCS, FACS, AFRACMA, MAICD

Bruce is an honours medical graduate of Monash University, trained in general and colorectal surgery and was in consultant surgical practice, both in the public and private sectors for 30 years – 20 years of which as Associate Professor at Monash University. He retired from surgical practice in 2014 and transitioned into medical administration and has been Executive Director of Medical Services and now Chief Medical Officer at BCH since July 2016. Bruce is also an assessor with the Australian Council on Health Care Standards (ACHS) and a surveyor with the Postgraduate Medical Council of Victoria (PMCV).

Shaun Brooks

Chief Financial Officer / Chief Procurement Officer
B Commerce, Grad Dip Charted Accounting

Shaun is a Chartered Accountant who has worked in the Victorian public health sector for more than 7 years. He has held leadership positions in the financial professional services industry, with a subsequent appointment as Deputy Director of Finance at Peninsula Health. Shaun brings a broad range of commercial and financial management skills and joined BCH in 2017.

Louise Sparkes

Chief Operating Officer / Chief Nurse and Midwife
Reg Nurse, Grad Cert ED Nursing, Master of Nursing

Louise is a Registered Nurse with a number of post graduate qualifications in Emergency Nursing and Nursing Education. Louise brings more than 30 years' experience both in health care service provision and academia. She was appointed to the role of Executive Director of Access and Emergency Services in October 2016, before taking an executive lead for all Acute Services, as well as Chief Nursing and Midwifery role in 2017.

Noni Bourke

Chief of Organisational Support and Development
B App Sc (Speech Pathology), Grad Cert Gerontology, Grad Cert Health Professional Education, Dip Project Management, Masters Health Services Management

Noni has more than 30 years' experience in public health, working initially as a Speech Pathologist and then within quality and safety across acute, sub-acute, aged care and community health services. She has worked in clinical and leadership roles in metropolitan, rural and remote health services. Noni commenced with BCH in 2016.

Legislative compliance

Freedom of Information Act 1982

In accordance with the *Freedom of Information Act 1982*, the public can request access to documents held at BCH via a written application directly to BCH's Principal Freedom of Information (FOI) Officer, or by completing the *Freedom of Information Access Request Form* available on the BCH website. A valid request must clearly identify what types of documents are being sought and to whom the information is to be released. The valid request must also be accompanied by an application fee. BCH are required to respond to the applicant within 30 days of receiving a valid request.

Requests are to be addressed to:

Principal FOI Officer
Bass Coast Health
PO Box 120
Wonthaggi Vic. 3995

BCH's Principal Officer is the Chief Executive Officer.

An application fee of $28.90 applies and other charges may be incurred associated with collating the information levied strictly in accordance with the Freedom of Information (Access Charges) Regulation 2004.

During 2018–19, BCH received 116 requests. Access to 95 were granted in full, 0 were granted in part, 3 were withdrawn and 8 not proceeded with. There were no documents for 3 requests and 7 are in progress. Of these requests, 49 were from lawyers, 29 from the police, 10 from insurance agencies and the remainder from the general public.

Building Act 1993

BCH is subject to, and complies with, the *Building Act 1993* under the guidelines for publicly owned buildings issued by the Minister for Finance (1994) in all redevelopment and maintenance matters.

Protected Disclosure Act 2012

BCH is subject to, and complies with, the *Protected Disclosure Act 2012* that replaced the former *Whistleblowers Protection Act 2001*. The *Protected Disclosure Act 2012* came into effect with a purpose to facilitate disclosures of improper conduct by public officers, public bodies and to provide the appropriate level of protection for people who make disclosures without fear of reprisal.

Statement on National Competition Policy

BCH is subject to and complies with the National Competition Policy. All procurement activities are undertaken in an open and fair manner and these principles are imbedded in BCH's Procurement Policy.

During 2018–19, BCH has participated in two cluster sourcing activities involving a market approach with multiple health services. These sourcing activities relate to the provision of outsourced imaging services and pathology services. Both activities have been undertaken under the auspice of Health Purchasing Victoria (HPV).

Carers Recognition Act 2012

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

Safe Patient Care Act 2015

BCH is subject to the *Safe Patient Care Act 2015* and has no matters to report in relation to its obligations under Section 40 of the Act.

Local Jobs First Act 2003

In 2018-2019 there were no contracts requiring disclosure under the Local Jobs First Policy.

Our workforce

Workforce data

Full Time Equivalent (FTE) employees

	Current Month FTE June		Year to date (YTD) FTE	
	2018	**2019**	**2018**	**2019**
Nursing	175.9	191.6	167.9	185.9
Administration and Clerical	71.3	88.5	68.7	81.4
Medical Support	45	45.6	41	45.9
Hotel and Allied Services	65.3	56.1	60.8	55.1
Medical Officers	0	0	0	0
Hospital Medical Officers	15.6	13.8	16.3	16.1
Sessional Clinicians	6	7	4.8	5.9
Ancillary Staff (Allied Health)	62.3	67.7	56.3	65

Occupational violence statistics

Occupational violence statistics	2018–19
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	110
Number of occupational violence incidents reported per 100 FTE	24.16
Percentage of occupational violence incidents resulting in staff injury, illness or condition	10%

Occupational Health and Safety (OHS) statistics

OHS statistics	2016–17	2017–18	2018–19
# of reported hazards/incidents per 100 FTE staff	48.8	43.5	42.4
# of 'lost time' standard claims per 100 FTE staff	2.27	3.12	1.32
Average cost per claim (including payments to date and an estimate of outstanding claim costs as advised by WorkSafe)	$43,493	$67,875	$205,473*
Circumstances / details of fatalities (where applicable)	Nil	Nil	Nil

* Average cost per claim for the 2018–19 period has risen due to the acceptance of a mental health claim (for diseases of the psychological system/other reaction to stressors). The impact of that claim and a similar 2016–17 claim has impacted significantly on the residual claims cost estimate, noting that the premium has been capped for the 2019–20 year.

Equal Employment Opportunity

BCH actively promotes the principles of Equal Employment Opportunity (EEO) and has established processes to ensure that EEO principles are upheld and applied to all Human Resource (HR) activity including recruitment, promotion and employee education. BCH is committed to ensuring that HR activities are carried out in a fair and equitable manner and that they comply with all EEO legislative requirements.

Orientation and Credentialing

All employees commencing with BCH or returning to duty after a period of leave greater than 12 months, are required to participate in an orientation program ensuring they understand their role and the broader organisation. Credentialing for senior clinical employees is undertaken via the interdisciplinary Senior Appointments Committee.

Employee Assistance Program

BCH acknowledges the importance of supporting employees, volunteers and their immediate families with the provision of a confidential Employee Assistance Program (EAP), providing free access to external counselling and support with experienced and qualified professionals.

Environmental performance

BCH's Environmental Sustainability Policy and Sustainability Plan incorporate a suite of Key Performance Indicators (KPIs) regarding waste and energy conservation, reportable to the Board. Initiatives include a waste management program for the segregation and collection of waste streams, incorporating strategies to further reduce carbon emissions. Correct segregation of waste is encouraged with additional recycling streams introduced including hard plastics, resulting in decreased levels of waste going to landfill. The hospital's café promotes the use of reusable cups and has a range of biodegradable products, bamboo cutlery and recycled napkins to further reduce carbon footprint and waste.

Consideration to environmental sustainability is specified for all renovations to existing, and construction of new facilities. Solar panels have been installed at Wonthaggi Hospital and Griffiths Point Lodge Residential Aged Care, as well as a replacement program to efficient LED lights and upgraded air handling units.

Results for internal cleaning audits conducted throughout 2018–19 have averaged well above the Agreed Quality Level at 97%. These results are monitored by BCH's Infection Control Committee and reported to the Board.

Statement of Priorities

Part A: Strategic Priorities

The Victorian Government's priorities and policy directions are outlined in *Victorian Health Priorities Framework 2012 – 2022*. In 2018–19 BCH will contribute to the achievement of the Victorian Government's commitments by:

Goals	Strategies	Health Service Deliverables	Outcomes
Better Health A system geared to prevention as much as treatment Everyone understands their own health and risks Illness is detected and managed early Healthy neighbourhoods and communities encourage healthy lifestyles	**Better Health** Reduce state-wide risks Build healthy neighbourhoods Help people to stay healthy Target health gaps	Facilitate integration of health promotion resources across the sub-region (including the health promotion resources of the PCP) to develop an integrated prevention partnership.	**Achieved** South Coast Prevention Manager appointed. South Coast Prevention Team established and priority areas identified.
		Review BCH cafeteria and catering and implement changes to work towards achieving alignment with the Healthy Choice framework.	**Achieved** Healthy choices are available for staff and visitors as per the Healthy Choices guidelines.
		Continue to implement the smoking cessation strategy for BCH patients and staff using the ABCD approach to supporting people who smoke.	**Achieved** Implementation of the Smoking Cessation Action Plan continues including policy, education, supports for patients and staff. Engagement has continued with the Gippsland Smoking Cessation Working Group.
		Attain recognition for the healthy workplaces achievement program - mental health wellbeing.	**Partially Achieved** Progress towards recognition for the healthy workplaces achievement program – mental health wellbeing through leadership support, staff education and training, resource provision,
Better Access Care is always there when people need it More access to care in the home and community People are connected to the full range of care and support they need There is equal access to care	**Better Access** Plan and invest Unlock innovation Provide easier access Ensure fair access	In line with the clinical services plan and in collaboration with partner agencies, BCH, Gippsland Southern Health Service and South Gippsland Hospital will progress the endorsed Primary and Community Clinical Services Plan (CSP) implementation plan actions for year one. This will include ongoing meetings of the Primary and Community Steering Committee, the establishment of the South Coast Prevention Partnership and progression of actions regarding models of care, service delineation and a sub-regional capability framework.	**Achieved** South Coast Primary Care Partnership established and Executive Officer appointed. Year one Primary and Community CSP Implementation Plan actions achieved.

Goals	Strategies	Health Service Deliverables	Outcomes
Better Access (continued) Care is always there when people need it More access to care in the home and community People are connected to the full range of care and support they need There is equal access to care	**Better Access (continued)** Plan and invest Unlock innovation Provide easier access Ensure fair access	In line with the BCH CSP, Gippsland Southern Health Service and South Gippsland Hospital will progress the endorsed Surgery and Anaesthetics CSP Implementation Plan actions for year one. This will see ongoing meetings of a sub-regional Surgery and Anaesthetics Steering Committee and progression of actions regarding Models of Care, Service Delineation and a sub-regional Capability framework.	**Achieved** Year one Surgery and Anaesthetics CSP Implementation Plan actions achieved. Sub-regional capability and suitability frameworks are under development. Service mapping commenced.
		In line with the CSP BCH, Gippsland Southern Health Service and South Gippsland Hospital will progress the endorsed Maternity CSP Implementation Plan actions for year one. This will see ongoing meetings of a sub-regional Maternity Steering Committee and progression of actions regarding Models of Care, Service Delineation and a sub-regional Capability framework.	**Achieved** Year one Maternity CSP Implementation Plan actions achieved. Subregional Maternity Capability Framework implemented.
		Develop and implement BCH capability frameworks for Surgery/ Anaesthetics, High Dependency Unit (HDU), Emergency, Sub-Acute and Medical – and where possible, align these to state-wide capability work.	**Partially Achieved** Capability Frameworks for Surgery/Anaesthetics, HDU, Sub-Acute developed and in use within relevant service areas. ED and Medical Capability Frameworks drafted. Ongoing review in response to service development and development of state-wide capability frameworks.
Better Care Target zero avoidable harm Healthcare that focusses on outcomes Patients and carers are active partners in care Care fits together around people's needs	**Better Care** Put quality first Join up care Partner with patients Strengthen the workforce Embed evidence Ensure equal care	Facilitate service planning and development to deliver cancer services for the Bass Coast Community including oncology and haematology consulting services and chemotherapy chairs.	**Achieved** Oncology and Haematology consulting services commenced. Non-cytotoxic chemotherapy commenced.
		Finalise tender process and implement new radiology contract for BCH.	**Achieved** iMed commenced service at BCH in October 2019.

Goals	Strategies	Health Service Deliverables	Outcomes
Specific 2018–19 priorities (mandatory)	**Disability Action Plans** Draft disability action plans are completed in 2018–19.	Submit a Disability Action Plan to the department by 30 June 2019 and outline the approach to fully implement the plan within the health service by 30 June 2020.	**Achieved** South Gippsland Coast Partnership Disability Action Plan Framework endorsed.
	Volunteer engagement Ensure that the health service executives have appropriate measures to engage and recognise volunteers.	Expand the volunteer program through the establishment of a ward visitor scheme and palliative care volunteers.	**Partially Achieved** Palliative Care Volunteer and Ward Visitor Programs have been developed and will be implemented in September 2019.
	Bullying and harassment Actively promote positive workplace behaviours and encourage reporting. Utilise staff surveys, incident reporting data, outcomes of investigations and claims to regularly monitor and identify risks related to bullying and harassment, in particular include as a regular item in Board and Executive meetings. Appropriately investigate all reports of bullying and harassment and ensure there is a feedback mechanism to staff involved and the broader health service staff.	Ensure the BCH bullying and harassment policy is regularly reviewed and available for all staff on the Prompt document control system.	**Achieved** BCH Bullying and Harassment Policy available for all staff. Active participation in state-wide programs to support policy implementation.
		Expected standards of behaviours are discussed at the monthly corporate orientation sessions. Ensure two yearly completion of the E3 mandatory bullying and harassment prevention learning module by all staff.	**Achieved** Bullying and harassment module incorporated in corporate orientation. Online training module compliance monitored locally and by the Board.

Goals	Strategies	Health Service Deliverables	Outcomes
Specific 2018–19 priorities (continued)	**Occupational violence** Ensure all staff who have contact with patients and visitors have undertaken core occupational violence training, annually. Ensure the department's occupational violence and aggression training principles are implemented.	Deliver Occupational Violence and Aggression (OVA) awareness training for all staff including targeted training dependent on role.	**Achieved** Tiered training program implemented incorporating online and face to face modules. Active engagement with state-wide initiatives.
		Ensure the OVA policy is regularly reviewed and available for all staff on the Prompt document control system.	**Achieved** BCH OVA Policy available for all staff. Engagement with state-wide initiatives to support implementation.
		Progress prevention and management of the BCH OVA action plan developed in line with the ANMF Ten Point plan.	**Achieved** OVA Action Plan progressed with focus on specific needs of individual work groups.
	Environmental Sustainability Actively contribute to the development of the Victorian Government's: policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measureable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling.	Ensure the BCH environmental sustainability policy is available for all staff on the Prompt document control system.	**Achieved** Sustainability Policy developed in line with DHHS guidelines.
		Develop an environment sustainability plan inclusive of a suite of KPIs for waste and energy conservation which will be reported to the board.	**Achieved** BCH Environmental Sustainability Plan developed. Sustainability-related KPIs developed for reporting locally and to the Board in 2019–20.

Goals	Strategies	Health Service Deliverables	Outcomes
Specific 2018–19 priorities (continued)	**LGBTI** Develop and promulgate service level policies and protocols, in partnership with LGBTI communities, to avoid discrimination against LGBTI patients, ensure appropriate data collection, and actively promote rights to free expression of gender and sexuality in healthcare settings. Where relevant, services should offer leading practice approaches to trans and intersex related interventions.	In partnership with the South Coast Inclusion Network (LGTBI advisory group), conduct an organisational audit and subsequently develop and commence implementation of an action plan that commences the process towards Rainbow Tick accreditation.	**Achieved** Gap analysis against Rainbow Tick Accreditation Standards complete and Action Plan developed and commenced, aiming for accreditation in early 2020.

Part B: Performance Priorities

High quality and safe care

Key performance indicator	Target	2018–19 Result
Accreditation		
Accreditation against the National Safety and Quality Health Service Standards	Accredited	Achieved
Compliance with the Commonwealth's Aged Care Accreditation Standards	Accredited	Achieved
Infection prevention and control		
Compliance with the Hand Hygiene Australia program	80%	90%
Percentage of healthcare workers immunised for influenza	80%	95%
Patient experience		
Data submission	Full compliance	Achieved
Positive patient experience – Quarter 1	95% positive experience	97%
Positive patient experience – Quarter 2	95% positive experience	96%
Positive patient experience – Quarter 3	95% positive experience	96%

Key performance indicator	Target	2018–19 Result
Patient experience (continued)		
Discharge care – Quarter 1	75% very positive experience	85%
Discharge care – Quarter 2	75% very positive experience	87%
Discharge care – Quarter 3	75% very positive experience	85%
Patients perception of cleanliness – Quarter 1	70% positive experience	89%
Patients perception of cleanliness – Quarter 2	70% positive experience	85%
Patients perception of cleanliness – Quarter 3	70% positive experience	89%
Adverse events		
Sentinel events – root cause analysis (RCA) reporting	All RCA reports submitted within 30 business days	Achieved
Maternity and Newborn		
Rate of singleton term infants without birth anomalies with APGAR score <7 to 5 minutes	≤ 1.4%	1.7%
Rate of severe foetal growth restriction (FGR) in singleton pregnancy undelivered by 40 weeks	≤ 28.6%	N/A*
Continuing Care		
Functional independence gain from an episode of rehabilitation admission to discharge relative to length of stay	≥ 0.645	0.706

* Less than 10 cases of severe foetal growth restriction in singleton pregnancy recorded.

Strong governance, leadership and culture

Key performance indicator	Target	2018–19 Result
Organisational culture		
Overall positive response to safety and culture questions	80%	92%
Positive response to the question, "I am encouraged by my colleagues to report any patient safety concerns I may have"	80%	97%
Positive response to the question, "Patient care errors are handled appropriately in my work area"	80%	96%
Positive response to the question, "My suggestions about patient safety would be acted upon if I expressed them to my manager"	80%	96%
Positive response to the question, "The culture in my work area makes it easy to learn from the errors of others"	80%	91%
Positive response to the question, "Management is driving us to be a safety-centred organisation"	80%	95%
Positive response to the question, "This health service does a good job of training new and existing staff"	80%	82%

Key performance indicator	Target	2018–19 Result
Organisational culture (continued)		
Positive response to the question, "Trainees in my discipline are adequately supervised"	80%	86%
Positive response to the question, "I would recommend a friend or relative to be treated as a patient here"	80%	92%

Timely access to care

Key performance indicator	Target	2018–19 Result
Emergency care		
Percentage of patients transferred from ambulance to emergency department within 40 minutes	90%	91%
Percentage of Triage Category 1 emergency patients seen immediately	100%	100%
Percentage of Triage Category 1 to 5 emergency patients seen within clinically recommended time	80%	77%
Percentage of emergency patients with a length of stay in the emergency department of less than four hours	81%	77%
Number of patients with a length of stay in the emergency department greater than 24 hours	0	1

Effective financial management

Key performance indicator	Target	2018–19 Result
Finance		
Operating result ($m)	$0.000	$(0.581)
Average number of days to paying trade creditors	60 days	57 days
Average number of days to receiving patient fee debtors	60 days	36 days
Public and Private WIES[1] activity performance to target	100%	99.99%
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	1.18
Forecast number of days a health service can maintain its operations with unrestricted available cash (based on end of year forecast)	14 days	7 days
Actual number of days a health service can maintain its operations with unrestricted available cash, measured on the last day of each month.	10 or more months for which 14 days of available cash has been attained	Achieved

1 WIES is a Weighted Inlier Equivalent Separation

Part C: Activity and funding

Key performance indicator	2018–19 Result
Acute Admitted	
WIES Public	4,962.14
WIES Private	139.26
WIES DVA	65.08
WIES TAC	10.02
Acute Non-Admitted	
Home Enteral Nutrition	40 service events
Specialist Clinics - Public	4,838 service events
Sub-Acute and Non-Admitted	
Sub-Acute WIES – Rehabilitation Public	203.54
Sub-Acute WIES – Rehabilitation Private	1.29
Sub-Acute WIES – GEM Public	161.64
Sub-Acute WIES – GEM Private	9.24
Sub-Acute WIES – Palliative Care Public	39.41
Sub-Acute WIES – Palliative Care Private	2.75
Sub-Acute WIES - DVA	12.66
Sub-Acute Non-Admitted	
Health Independence Program - Public	18,772 client contacts
Aged Care	
Residential Aged Care	18,661 bed days
HACC	8,210 hours
Primary Health	
Community Health/ Primary Care programs	12,887 hours
Other	
Health Workforce	26

Statutory requirements

Finance

The information within this Report is based on the Standing Directions of the Minister for Finance (Section 4 Financial Management Reporting) and Financial Reporting Directions under the *Financial Management Act 1994* and has been prepared and is available to the relevant Minister, Member of Parliament and the public, upon request.

Additional information available on request

Details in respect of the items listed below have been retained by the health service and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements, if applicable):

- declarations of pecuniary interests have been duly completed by all relevant officers;
- details of shares held by senior officers as nominee or held beneficially;
- details of publications produced by the entity about itself, and how these can be obtained;
- details of changes in prices, fees, charges, rates and levies charged by the health service;
- details of any major external reviews carried out on the health service;
- details of major research and development activities undertaken by the health 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;
- details of overseas visits undertaken including a summary of the objectives and outcomes of each visit;
- details of major promotional, public relations and marketing activities undertaken by the health service to develop community awareness of the health service and its services;
- details of assessments and measures undertaken to improve the occupational health and safety of employees;
- a general statement on industrial relations within the health service and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the report of operations;
- a list of major committees sponsored by the health service, the purposes of each committee and the extent to which those purposes have been achieved; and
- details of all consultancies and contractors including consultants/contractors engaged, services provided, and expenditure committed for each engagement.

Competitive neutrality

BCH's policies and procedures complied with competitive neutrality requirements.

Ex-gratia payments

No ex-gratia payments were incurred during this period.

Fees and charges

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

Private admitted fees as set by DHHS increased by 1.4% in this financial year. Basic daily fees as set by the Commonwealth Department of Health for nursing home and hostel residents increased by 2.1% in this financial year.

Operational and budgetary objectives and factors affecting performance

Each year, BCH is required to negotiate a statement of priorities with DHHS. The statement incorporates both system-wide priorities set by Government and locally generated agency-specific priorities. BCH has met 87% of deliverables from the Statement of Priorities for 2018–19.

The Board budgeted for a break-even operating result before capital items and depreciation for the 2018–19 financial year. The final result for the year was a $(0.580m) operating deficit before capital items and depreciation.

Events subsequent to balance date

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

Other disclosures

Consultancies under $10,000

In 2018–19, there were four consultancies where the total fees payable to the consultants were less than $10,000. The total expenditure incurred during 2018–19 in relation to these consultancies is $35,270 (excl. GST).

Consultancies over $10,000

In 2018–19, there was one consultancy where the total fees payable to the consultant was $10,000 or greater. The total expenditure incurred during 2018–19 in relation to this consultancy is $63,351 (excluding GST).

Consultant	Purpose of consultancy	Start Date	End Date	Total approved project fee (ex GST)	Expenditure 2018–19 (ex GST)	Future Expenditure 2019/20 (ex GST)
Health Economics	Financial Services	1/7/18	30/6/19	$63,351	$63,351	$15,000

Information and Communication Technology (ICT) disclosure

The total ICT expenditure incurred during 2018–19 is $2,170,220 (excluding GST) with the details shown below:

Business As Usual (BAU) ICT expenditure	Non-Business As Usual (non BAU) ICT expenditure		
Total (excluding GST)	Total = Operational expenditure and Capital expenditure (excluding GST) (a) + (b)	Operational expenditure (excluding GST) (a)	Capital expenditure (excluding GST) (b)
$1,587,688	$582,533	$169,255	$413,278

Summary of financial results

For the year ending 30 June 2019

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

Operating result	2018–19	2017–18	2016–17	2015–16	2014–15
	$'000	$'000	$'000	$'000	$'000
Total revenue	79,404	75,609	66,508	55,772	54,920
Total expenses	77,606	66,494	61,459	57,779	58,172
Net result from transactions	**1,798**	**9,115**	**5,049**	**(2,007)**	**(3,252)**
Total other economic flows	271	(143)	(4)	60	4,572
Net result	**2,069**	**8,972**	**5,045**	**(1,947)**	**1,320**
Total assets	81,445	75,027	58,297	54,693	56,673
Total liabilities	26,491	24,736	20,802	22,243	22,276
Net assets / Total equity	**54,954**	**50,291**	**37,495**	**32,450**	**34,397**

Major changes or factors affecting performance

BCH's financial performance in 2018–19 was in line with activity-based targets and most financial targets for the year, with a small operating deficit from operations (recorded before capital income, depreciation and other revaluation expenses) of ($0.580m). The surplus generated from net transactions enabled capital development and new capital items for the health service to be funded. BCH remains committed to maintaining its financial sustainability, through the ongoing delivery of safer and more expanded services with the ongoing support from DHHS.

Reconciliation between the Net result from transactions reported in the model to the operating result as agreed in the Statement of Priorities

Reconciliation items	2018–19
	$'000
Net operating result*	**(580)**
Capital and specific items	
Capital purpose income	4,530
Specific income	0
Assets provided free of charge	0
Assets received free of charge	0
Expenditure for capital purpose	0
Depreciation and amortisation	(2,057)
Impairment of non-financial assets	0
Finance costs (other)	(95)
Net result from transactions	**1,798**

* The *net operating result* is the result which the health service is monitored against in its Statement of Priorities.

Attestations

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

- BCH is the major public health service provider within the Bass Coast Shire. A comprehensive range of services are provided that include acute, sub-acute, residential aged care, ancillary, medical and community-based services.
- The health service delivers healthcare to approximately 30,000 residents and approximately 3.4 million visitors each year to the Bass Coast and South Gippsland regions.
- BCH, through the Board, reports to Jenny Mikakos, Minister for Health and Minister for Ambulance Services.
- BCH is classified as a Group C Hospital and is incorporated under the Health Services Act 1988 (Vic).
- Auditor for the 2018 Annual Report was the Office of the Auditor General.
- Members of BCH's Finance, Audit and Risk Committee, at 30th June 2019 were:
  - Ian Thompson, Board Director (Chair)
  - Nigel McCormick, Board Director
  - Kate McCullough, Board Director
  - Don Paproth, Board Director
  - Richard King, Board Director
  - Ian Leong, Board Director
  - Carol Clarke, Independent Member
  - Joanne Harris, Independent Member.

Jan Child, Chief Executive Officer
22 August 2019

Responsible Bodies declaration

I, Don Paproth, on behalf of the Responsible Body, certify that BCH has complied with the applicable Standing Directions 2018 under the *Financial Management Act 1994* and Instructions.

Don Paproth, Chair, Board of Directors
BCH
22 August 2019

Attestation on compliance with Health Purchasing Victoria (HPV) Health Purchasing Policies

I, Jan Child, certify that BCH 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.

Jan Child, Chief Executive Officer
22 August 2019

Data integrity

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

Jan Child, Chief Executive Officer
22 August 2019

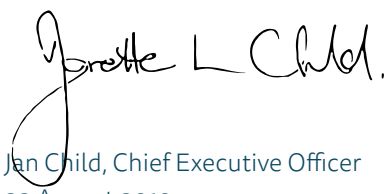
Conflict of interest

I, Jan Child, certify that BCH 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 BCH 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.

Jan Child, Chief Executive Officer
22 August 2019

Integrity, fraud and corruption

I, Jan Child, certify that BCH has put in place appropriate internal controls and processes to ensure that Integrity, fraud and corruption risks have been reviewed and addressed at BCH during the year.



Jan Child, Chief Executive Officer
22 August 2019

Disclosure index

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

Legislation	Requirement	Page
Charter and purpose		
FRD 22H	Manner of establishment and the relevant Ministers	iii
FRD 22H	Purpose, functions, powers and duties	31
FRD 22H	Nature and range of services provided	5
FRD 22H	Activities, program and achievements for the reporting period	1
Management structure		
FRD 22H	Organisational structure	12
FRD 22H	Workforce data /employment and conduct principles	17
FRD 22H	Occupational Health and Safety	17
Financial and other information		
FRD 22H	Summary of financial results for the year	30
FRD 22H	Significant changes in financial position during the year	30
FRD 22H	Operational and budgetary objectives and performance against objectives	28
FRD 22H	Subsequent events	28
FRD 22H	Details of consultancies under $10,000	29
FRD 22H	Details of consultancies over $10,000	29
FRD 22H	Disclosure of ICT expenditure	29
Legislation		
FRD 22H	Application and operation of Freedom of Information Act 1982	15
FRD 22H	Compliance with building and maintenance provisions of *Building Act 1993*	15
FRD 22H	Application and operation of *Protected Disclosure 2012*	15
FRD 22H	Statement of National Competition Policy	15
FRD 22H	Application and operation of *Carers Recognition Act 2012*	15
FRD 22H	Summary of the entity's environmental performance	18
FRD 22H	Additional information available on request	27
Other relevant reporting directives		
FRD 25D	*Local Jobs First Act 2003* disclosures	16
SD 5.1.4	Financial management compliance attestation	31
SD 5.2.3	Declaration in report of operations	31
Attestations		
Attestation on Data Integrity		32
Attestation on managing Conflicts of Interest		32
Attestation on Integrity, fraud and corruption		32
Other reporting requirements		
Reporting of outcomes from Statement of Priorities 2018–19		19
Occupational violence reporting		17
Reporting of compliance Health Purchasing Victoria Policy		32
Reporting obligations under the *Safe patient Care Act 2015*		16

Board members, accountable officers and chief finance and accounting officers' declaration

BASS COAST HEALTH

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

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

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2019 and the financial position of Bass Coast Health at 30 June 2019.

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

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

Don Paproth Board Chair	Jan Child Accountable Officer	Shaun Brooks Chief Finance & Accounting Officer
Wonthaggi	Wonthaggi	Wonthaggi
22nd August 2019	22nd August 2019	22nd August 2019

Independent auditor's report from VAGO

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Bass Coast Health

Opinion	I have audited the financial report of Bass Coast Health (the health service) which comprises the: • balance sheet as at 30 June 2019 • 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 2019 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.

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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
29 August 2019

Travis Derricott
as delegate for the Auditor-General of Victoria

Start of financials

BASS COAST HEALTH
COMPREHENSIVE OPERATING STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2019

	Note	2019 $'000	2018 $'000
Income from Transactions			
Operating Activities	2.1	78,962	75,237
Non-operating Activities	2.1	442	372
Total Income from Transactions		79,404	75,609
Expenses from Transactions			
Employee Expenses	3.1	(57,241)	(48,621)
Supplies and Consumables	3.1	(10,655)	(8,905)
Other Operating Expenses	3.1	(7,607)	(7,045)
Depreciation and Amortisation	3.1	(2,057)	(1,923)
Other Non-Operating Expenses	3.1	(46)	-
Total Expenses from Transactions		(77,606)	(66,494)
Net Result from Transactions - Net Operating Balance		1,798	9,115
Other Economic Flows Included in Net Result			
Net Gain/(Loss) on Sale of Non-Financial Assets	3.2	490	14
Net Gain/(Loss) on Financial Instruments at fair value	3.2	(106)	(140)
Other Gain/(Loss) from Other Economic Flows	3.2	(113)	(17)
Total Other Economic Flows Included in Net Result		271	(143)
Net Result for the year		2,069	8,972
Other Comprehensive Income			
Items that will not be reclassified to Net Result			
Changes in Property, Plant and Equipment Revaluation Surplus	4.2b	2,592	1,368
Total Other Comprehensive Income		2,592	1,368
Comprehensive result for the year		**4,661**	**10,340**

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

BASS COAST HEALTH
BALANCE SHEET AS AT 30 JUNE 2019

	Note	2019 $'000	2018 $'000
Current Assets			
Cash and Cash Equivalents	6.2	23,697	17,776
Receivables	5.1	1,986	1,987
Investments and Other Financial Assets	4.1	-	2,020
Inventories		161	171
Other Financial Assets		56	46
Total Current Assets		25,900	22,000
Non-Current Assets			
Receivables	5.1	2,074	1,483
Property, Plant and Equipment	4.2	53,471	51,544
Total Non-Current Assets		55,545	53,027
TOTAL ASSETS		81,445	75,027
Current Liabilities			
Payables	5.2	7,173	6,209
Borrowings	6.1	1,575	1,800
Provisions	3.3	9,996	8,519
Other Current liabilities	5.3	5,538	4,649
Total Current Liabilities		24,282	21,177
Non-Current Liabilities			
Borrowings	6.1	629	2,108
Provisions	3.3	1,580	1,451
Total Non-Current Liabilities		2,209	3,559
TOTAL LIABILITIES		26,491	24,736
NET ASSETS		54,954	50,291
EQUITY			
Property, Plant and Equipment Revaluation Surplus	4.2f	25,012	22,420
Restricted Specific Purpose Surplus		293	293
Contributed Capital		15,896	15,894
Accumulated Surpluses		13,753	11,684
TOTAL EQUITY		54,954	50,291

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

BASS COAST HEALTH
CASH FLOW STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2019

	Note	2019 $'000	2018 $'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		67,589	58,709
Capital Grants from Government		3,919	8,131
Patient Fees Received		2,423	2,259
Donations and Bequests Received		19	41
Capital Donations and Bequests Received		611	2,025
GST Received from/(paid to) from ATO		199	(130)
Interest Received		443	309
Other Receipts		2,119	2,031
Total Receipts		***77,322***	***73,375***
Employee Expenses Paid		(55,861)	(47,471)
Payments for Supplies and Consumables		(10,645)	(6,388)
Payments for Medical Indemnity Insurance		(844)	(786)
Payments for Repairs and Maintenance		(614)	(718)
Payment for share of Rural Health Alliance		(1,114)	(976)
Other Payments		(2,595)	(3,800)
Total Payments		***(71,673)***	***(60,139)***
NET CASH FLOWS FROM / (USED IN) OPERATING ACTIVITIES	8.1	**5,649**	**13,236**
CASH FLOWS FROM INVESTING ACTIVITIES			
Proceeds from Disposal/(Purchase) of Investments		2,020	(2,020)
Purchase of Non-Financial Assets		(3,602)	(7,392)
Proceeds from Disposal of Non-Financial Assets		2,698	15
NET CASH FLOWS FROM /(USED IN) INVESTING ACTIVITIES		**1,116**	**(9,397)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of Borrowings		(1,704)	(1,500)
Proceeds from Borrowings		0	726
Net Receipt of Monies Held in Trust		5,538	0
Contributed Capital from Government		0	2,456
NET CASH FLOWS FROM /(USED IN) FINANCING ACTIVITIES		**3,834**	**1,682**
NET INCREASE / (DECREASE) IN CASH AND CASH EQUIVALENTS HELD		**10,599**	**5,521**
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR		12,373	6,852
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.2	**22,972**	**12,373**

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

BASS COAST HEALTH
STATEMENT OF CHANGES IN EQUITY
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2019

	Property, Plant and Equipment Revaluation Surplus	Restricted Specific Purpose Surplus	Contributed Capital	Accumulated Surpluses	Total
	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2017	21,052	293	13,438	2,712	37,495
Net result for the year	-	-	-	8,972	8,972
Other comprehensive income for the year	1,368	-	-	-	1,368
Contributed Capital	-	-	2,456	-	2,456
Balance at 30 June 2018	**22,420**	**293**	**15,894**	**11,684**	**50,291**
Net result for the year	-	-	-	2,069	2,069
Other comprehensive income for the year	2,592	-	-	-	2,592
Contributed Capital	-	-	2	-	2
Balance at 30 June 2019	**25,012**	**293**	**15,896**	**13,753**	**54,954**

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

BASIS OF PREPARATION

These financial statements are 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.

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

These annual financial statements represent the audited general purpose financial statements for Bass Coast Health (ABN 86 627 309 026) for the year ended 30 June 2019. The report provides users with information about Bass Coast Healths' stewardship of resources entrusted to it.

(a) Statement of compliance

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

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

Bass Coast Health is a not-for profit entity and therefore applies the additional AUS paragraphs applicable to "not-for-profit" Health Services under the AASBs.

The annual financial statements were authorised for issue by the Board of Bass Coast Health 22nd August, 2019.

(b) Reporting Entity

The financial statements include all the controlled activities of Bass Coast Health.

Its principal address is:
235-237 Graham Street
Wonthaggi, Victoria 3995

A description of the nature of Bass Coast Health'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 have been applied in preparing the financial statements for the year ended 30 June 2019, and the comparative information presented in these financial statements for the year ended 30 June 2018.

The financial statements are prepared on a going concern basis (refer note 8.8 Economic Dependency).

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

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

Bass Coast Health 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.

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

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

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 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 4.2 Property, Plant and Equipment);
- Defined benefit superannuation expense (refer to Note 3.4 Superannuation); and
- 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 3.3 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) 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, Bass Coast Health recognises in the financial statements:

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

Bass Coast Health is a Member of the Gippsland Health Alliance Joint Venture and retains joint control over the arrangement, which it has classified as a joint operation (refer to Note 8.7 Jointly Controlled Operations)

(e) Equity

Contributed Capital

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 Bass Coast Health.

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

NOTE 2: FUNDING DELIVERY OF OUR SERVICES

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

Structure
2.1 Income from Transactions

Note 2.1: Income from Transactions

	TOTAL 2019 $'000	TOTAL 2018 $'000
Government Grants - Operating	67,495	58,807
Government Grants - Capital	3,919	8,171
Other Capital Purpose Income (including capital donations)	611	2,020
Indirect Contributions by Department of Health and Human Services	624	347
Patient and Resident Fees	2,429	2,430
Private Practice Fees	-	-
Commercial Activities	394	553
Other Revenue from Operating Activities (including non-capital donations)	3,490	2,909
Total Income from Operating Activities	**78,962**	**75,237**
Other Interest	442	372
Total Income from Non-Operating Activities	**442**	**372**
Total Income from Transactions	**79,404**	**75,609**

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)

Revenue Recognition

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

Amounts disclosed as revenue are, where applicable, net of returns, allowances, 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 Bass Coast Health gains control of the underlying assets irrespective of whether conditions are imposed on Bass Coast Health's use of the contributions.

The Department of Health and Human Services makes certain payments on behalf of Bass Coast Health.
These amounts have been brought to account as grants in determining the operating result for the year by recording them as revenue.

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

Non-cash contributions from the Department of Health and Human Services

The Department of Health and Human Services makes some payments on behalf of health services as follows:

- The Victorian Managed Insurance Authority non-medical indemnity insurance payments are 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 long service leave funding arrangements set out in the relevant Department of Health and Human Services Hospital Circular
- Public Private Partnership (PPP) lease and service payments are paid directly to the PPP consortium. Revenue and the matching expense are recognised in accordance with the nature and timing of the monthly or quarterly service payments made by the Department of Health and Human Services.

Patient Fees

Patient and resident 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 into account the effective yield of the financial asset, which allocates interest over the relevant period.

Other Income

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

NOTE 3: THE COST OF DELIVERING SERVICES

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

Structure
3.1 Expenses from Transactions
3.2 Other Economic Flows
3.3 Employee benefits in the Balance Sheet
3.4 Superannuation

Note 3.1: Expenses from Transactions

	TOTAL 2019 $'000	TOTAL 2018 $'000
Salaries and Wages	45,650	39,884
On-costs	3,916	3,611
Agency Expenses	2,924	1,135
Fee for Service Medical Officer Expenses	4,236	3,591
Workcover Premium	515	400
Total Employee Expenses	**57,241**	**48,621**
Drug Supplies	1,016	757
Medical & Surgical Supplies (including Prosthesis)	2,732	2,562
Diagnostic and Radiology Supplies	2,493	1,804
Other Supplies and Consumables	4,414	3,782
Total Supplies and Consumables	**10,655**	**8,905**
Fuel, Light, Power and Water	841	890
Repairs and Maintenance	614	718
Maintenance Contracts	378	350
Medical Indemnity Insurance	844	786
Other Administration Expenses	4,930	4,301
Total Other Operating Expenses	**7,607**	**7,045**
Depreciation and Amortisation (refer note 4.3)	2,057	1,923
Assets and Services Provided Free of Charge or for Nominal Consideration	46	-
Total Other Non-Operating Expenses	**2,103**	**1,923**
Total Expenses from Transactions	**77,606**	**66,494**

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

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

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

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

Other operating expenses
Other operating expenses generally represent the day-to-day running costs incurred in normal operations and include:
- Fuel, light and power
- Repairs and maintencance
- Other administrative expenses
- Expenditure for capital purposes (represents expenditure related to the purchase of assets that are below the capitalisation threshold).

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

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

Note 3.2: Other economic flows included in net result

	2019 $'000	2018 $'000
Net gain/(loss) on sale of non-financial assets		
Net gain on disposal of property plant and equipment	490	14
Total net gain/(loss) on non-financial assets	490	14
Net gain/(loss) on financial instruments at fair value		
Other Gains/(Losses) from Other Economic Flows	(106)	(140)
Total net gain/(loss) on financial instruments at fair value	(106)	(140)
Other gains/(losses) from other economic flows		
Net gain/(loss) arising from revaluation of long service liability	(113)	(17)
Total other gains/(losses) from other economic flows	(113)	(17)
Total other gains/(losses) from economic flows	271	(143)

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

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

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

- Revaluation gain/ (losses) of non-financial physical assets (Refer to Note 4.2 Property, Plant and Equipment)
- Net gain/(loss) on disposal of Non-Financial Assets
- Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal.

Net gain/ (loss) on financial instruments
Net gain/ (loss) on financial instruments includes:

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

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 3.3: Employee benefits in the balance sheet

	2019	2018
Current Provisions	$'000	$'000
Employee Benefits (i)		
Accrued Days Off		
- unconditional and expected to be settled wholly within 12 months (ii)	156	96
Annual Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	3,226	3,178
- unconditional and expected to be settled wholly after 12 months (iii)	621	248
Long Service Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	736	859
- unconditional and expected to be settled wholly after 12 months (iii)	4,246	3,277
	8,985	**7,658**
Provisions related to Employee Benefit On-Costs		
- unconditional and expected to be settled wholly within 12 months (ii)	463	464
- unconditional and expected to be settled wholly after 12 months (iii)	548	397
	1,011	**861**
Total Current Provisions	**9,996**	**8,519**
Non-Current Provisions		
Conditional Long Service Leave	1,420	1,304
Provisions related to Employee Benefit On-Costs	160	147
Total Non-Current Provisions	**1,580**	**1,451**
Total Provisions	**11,576**	**9,970**

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

(a) Employee Benefits and Related On-Costs

	2019	2018
Current Employee Benefits and Related On-Costs	$'000	$'000
Unconditional Long Service Leave Entitlements	5,542	4,601
Annual Leave Entitlements	4,280	3,811
Accrued Days Off	174	107
Non-Current Employee Benefits and Related on-costs		
Conditional Long Service Leave Entitlements	1,580	1,451
Total Employee Benefits and Related On-Costs	**11,576**	**9,970**

(b) Movement in On-Costs Provision

	2019	2018
	$'000	$'000
Balance at start of year	1,008	930
Additional provisions recognised	681	538
Unwinding of discount and effect of changes in the discount rate	(11)	(2)
Reduction due to transfer out	(507)	(458)
Balance at end of year	1,171	1,008

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 Bass Coast Health has a present obligation, the future sacrifice of economic benefits is probable, and the amount of the provision can be measured reliably.

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

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

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

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

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

NOTE 3.3: EMPLOYEE BENEFITS IN THE BALANCE SHEET (CONTINUED)

Long Service Leave (LSL)

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

Unconditional LSL is disclosed in the notes to the financial statements as a current liability, even where the health service does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the 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 Bass Coast Health expects to wholly settle within 12 months; or
- Present value – if Bass Coast Health does not expect to wholly settle 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 workers compensation and superannuation are recognised together with provisions for employee benefits.

NOTE 3.4: SUPERANNUATION

Fund		Paid Contributions for the year		Outstanding Contributions at Year End	
		2019 $'000	**2018 $'000**	**2019 $'000**	**2018 $'000**
Defined Benefit Plans (i):	First State Super	110	123	9	12
Defined Contribution Plans:	First State Super	2,198	2,071	175	247
	HESTA	1,186	1,055	101	127
	Other	390	204	38	36
Total		**3,884**	**3,453**	**323**	**422**

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

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

Defined benefit superannuation plans

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

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

Defined contribution superannuation plans

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

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY

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

Structure

4.1 Investments and other financial assets
4.2 Property, plant & equipment
4.3 Depreciation and amortisation

NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS

	Capital		Total	
	2019	2018	2019	2018
CURRENT	$'000	$'000	$'000	$'000
Loans and Receivables				
Central Banking System	-	-	-	-
Term Deposits > 3 months (i)	-	2,020	-	2,020
TOTAL CURRENT OTHER FINANCIAL ASSETS	**-**	**2,020**	**-**	**2,020**
Represented by:				
Health Service Investments	-	2,020	-	2,020
Monies Held in Trust				
- Refundable Accommodation Bonds	-	-	-	-
TOTAL	**-**	**2,020**	**-**	**2,020**

(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 or available-for-sale financial assets.

Bass Coast Health classifies its other financial assets between current and non-current assets based on the Board'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.

Bass Coast Health 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 Bass Coast Health 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, Bass Coast Health 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 2019 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.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT

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.

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.

Revaluations of Non-financial Physical Assets
Non-financial physical assets are measured at fair value and are revalued in accordance with FRD 103H *Non-financial physical assets.* This revaluation process normally occurs 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 de-recognition of the relevant asset, except where an asset is transferred via contributed capital.

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

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.

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

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

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

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

Valuation hierarchy
In determining fair values a number of inputs are used. To increase consistency and comparability in the financial statements, these inputs are categorised into three levels, also known as the fair value hierarchy. The levels are as follows:
- Level 1 - quoted (unadjusted) market prices in active markets for identical assets or liabilities;
- Level 2 - valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable; and
- Level 3 - valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

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

Unobservable inputs 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.

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, Bass Coast Health has assumed the current use of a non-financial physical asset is its HBU unless market or other factors suggest that a different use by market participants would maximise the value of the asset.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

Specialised land and specialised buildings

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

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

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

Vehicles

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

Plant and equipment

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

There were no changes in valuation techniques throughout the period to 30 June 2019.

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

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued) (a) Gross carrying amount and accumulated depreciation	2019 $'000	2018 $'000
Land		
- Land at Fair Value	7,674	9,277
Total Land	**7,674**	**9,277**
Buildings		
- Buildings at Fair Value	38,948	41,109
Less Accumulated Depreciation	-	3,456
	38,948	37,653
Total Buildings	**38,948**	**37,653**
Plant and Equipment		
- GHA IT Alliance	9	13
- Plant and Equipment at Fair Value	6,580	5,394
Less Accumulated Depreciation	4,383	4,072
Total Plant and Equipment	**2,206**	**1,335**
Motor Vehicles		
- Motor Vehicles at Fair Value	1,365	1,388
Less Accumulated Depreciation	1,214	1,177
Total Motor Vehicles	**151**	**211**
Medical Equipment		
- Medical Equipment at Fair Value	5,860	4,907
Less Accumulated Depreciation	3,790	3,420
Total Medical Equipment	**2,070**	**1,487**
Computers and Communication Equipment		
- Computers and Communication Equipment at Fair Value	1,392	1,127
Less Accumulated Depreciation	1,089	940
Total Computers and Communication Equipment	**303**	**187**
Furniture and Fittings		
- Furniture and Fittings at Fair Value	955	955
Less Accumulated Depreciation	553	480
Total Furniture and Fittings	**402**	**475**
Under Construction		
Assets Under Construction	1,717	919
Total Assets Under Construction	**1,717**	**919**
TOTAL	**53,471**	**51,544**

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

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

	Land	Buildings	Plant & Equipment	Motor Vehicles	Medical Equipment	Computers & Comm Equipment	Furniture & Fittings	Assets Under Construction	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2017	7,909	32,056	1,356	165	1,407	159	275	1,375	44,702
Additions	-	-	314	144	381	206	262	6,091	7,398
Transfers	-	6,547	-	-	-	-	-	(6,547)	-
Revaluation Increments	1,368	-	-	-	-	-	-	-	1,368
Disposals	-	-	-	-	-	-	(1)	-	(1)
Depreciation and Amortisation (note 4.3)	-	(950)	(335)	(98)	(301)	(178)	(61)	-	(1,923)
Balance at 1 July 2018	**9,277**	**37,653**	**1,335**	**211**	**1,487**	**187**	**475**	**919**	**51,544**
Additions	-	-	1,297	23	953	265	-	1,061	3,599
Transfers	-	263	-	-	-	-	-	(263)	-
Revaluation Increments	322	2,270	-	-	-	-	-	-	2,592
Disposals	(1,925)	(208)	(69)	(5)	-	-	-	-	(2,207)
Depreciation and Amortisation (note 4.3)	-	(1,030)	(357)	(78)	(370)	(149)	(73)	-	(2,057)
Balance at 30 June 2019	**7,674**	**38,948**	**2,206**	**151**	**2,070**	**303**	**402**	**1,717**	**53,471**

Land and buildings carried at valuation

The Valuer-General Victoria undertook to re-value all of Bass Coast Health's owned and leased land and buildings to determine their fair value. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which 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 2019.

(c) Fair value measurement hierarchy for assets

	Consolidated Carrying Amount	Fair value measurement at end of reporting period using:		
		Level 1 (i)	Level 2 (i)	Level 3 (i)
Balance at 30 June 2019	$'000	$'000	$'000	$'000
Land at Fair Value				
Non-specialised land	-	-	-	-
Specialised land	-	-	-	-
Hospital and Aged Care Sites	7,674		-	7,674
Total Land at Fair Value	7,674	-	-	7,674
Buildings at Fair Value				
Non-specialised buildings	-	-	-	-
Specialised buildings	38,948	-	-	38,948
Total Building at Fair Value	38,948	-	-	38,948
Plant and Equipment at Fair Value	2,206	-	-	2,206
Motor Vehicles at Fair Value	151	-	151	-
Medical Equipment at Fair Value	2,070	-	-	2,070
Computers and Communication Equipment at Fair Value	303	-	-	303
Furniture and Fittings at Fair Value	402	-	-	402
Assets under construction at fair value	1,717	-	-	1,717
Total Property, Plant and Equipment	**53,471**	**-**	**151**	**53,320**

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. However, entities should consult with an independent valuer in determining whether a market approach is appropriate for vehicles with an active resale market available. If yes, a level 2 categorisation for such vehicles would be appropriate.

There have been no transfers between levels during the period.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)
(c) Fair value measurement hierarchy for assets (Continued)

	Consolidated Carrying Amount	Fair value measurement at end of reporting period using:		
		Level 1 (i)	Level 2 (i)	Level 3 (i)
Balance at 30 June 2018	$'000	$'000	$'000	$'000
Land at Fair Value				
Non-specialised land	1,925	-	1,925	-
Specialised land	-		-	-
Hospital and Aged Care Sites	7,352		-	7,352
Total Land at Fair Value	9,277	-	1,925	7,352
Buildings at Fair Value				
Non-specialised buildings	229	-	229	-
Specialised buildings	37,424	-	-	37,424
Total Building at Fair Value	37,653	-	229	37,424
Plant and Equipment at Fair Value	1,335	-	-	1,335
Motor Vehicles at Fair Value	211	-	211	-
Medical Equipment at Fair Value	1,487	-	-	1,487
Computers and Communication Equipment at Fair Value	187	-	-	187
Furniture and Fittings at Fair Value	475	-	-	475
Assets under construction at fair value	919	-	-	919
Total Property, Plant and Equipment	**51,544**	**-**	**2,365**	**49,179**

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. However, entities should consult with an independent valuer in determining whether a market approach is appropriate for vehicles with an active resale market available. If yes, a level 2 categorisation for such vehicles would be appropriate.
There have been no transfers between levels during the period.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)
(d) Reconciliation of Level 3 fair value

Consolidated	Land $'000	Buildings $'000	Plant and Equipment $'000	Medical Equipment $'000	Computers & Comm Equipment $'000	Furniture & Fittings $'000	Assets Under Construction $'000
Balance at 1 July 2018	7,352	37,424	1,335	1,487	187	475	919
Additions/(Disposals)	-	284	1,228	953	265	-	798
Gains/(Losses) recognised in Net Result							
- Depreciation and Amortisation	-	(1,030)	(357)	(370)	(149)	(73)	-
Items recognised in Other Comprehensive Income							
- Revaluation	322	2,270	-	-	-	-	-
Balance at 30 June 2019	**7,674**	**38,948**	**2,206**	**2,070**	**303**	**402**	**1,717**

Consolidated	Land $'000	Buildings $'000	Plant and Equipment $'000	Medical Equipment $'000	Computers & Comm Equipment $'000	Furniture & Fittings $'000	Assets Under Construction $'000
Balance at 1 July 2017	6,109	31,827	1,358	1,407	159	275	1,375
Additions/(Disposals)	-	6,547	312	381	206	261	(456)
Gains/(Losses) recognised in Net Result							
- Depreciation and Amortisation	-	(950)	(335)	(301)	(178)	(61)	-
Items recognised in Other Comprehensive Income							
- Revaluation	1,243	-	-	-	-	-	-
Balance at 30 June 2018	**7,352**	**37,424**	**1,335**	**1,487**	**187**	**475**	**919**

(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 an active resale market available	Level 2	Market approach	n.a.
Plant and equipment	Specialised items with limited alternative uses and/or substantial cutomisation	Level 3	Depreciated replacement cost approach	- Cost per square metre - Useful life

(f) Property, Plant and Equipment Revaluation Surplus

	2019 $	2018 $
Property, Plant and Equipment Revaluation Surplus		
Balance at the beginning of the reporting period	22,420	21,052
Revaluation Increment		
- Land	322	1,368
- Buildings	2,270	-
Balance at the end of the reporting period*	**25,012**	**22,420**
***Represented by:**		
- Land	5,318	4,996
- Buildings	19,694	17,424
	25,012	**22,420**

NOTE 4.3: DEPRECIATION AND AMORTISATION

	2019 $'000	2018 $'000
Depreciation		
Buildings	1,030	950
Plant and Equipment	357	335
Medical Equipment	370	301
Computers and Communication	149	178
Furniture and Equipment	73	61
Motor Vehicles	78	98
Total Depreciation	**2,057**	**1,923**

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*).

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

	2019	**2018**
Buildings		
- Structure Shell Building Fabric	37 to 42 Years	37 to 42 Years
- Site Engineering Services and Central Plant	27 Years	27 Years
Central Plant		
- Fit Out	12 Years	12 Years
- Trunk Reticulated Building Systems	17 years	17 years
Plant & Equipment	5 to 10 years	5 to 10 years
Medical Equipment	5 to 20 years	5 to 20 years
Computers and Communication	4 years	4 years
Motor Vehicles	5 years	5 years
Leasehold Improvements	5 to 10 years	5 to 10 years

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

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 Payables
5.3 Other liabilities

NOTE 5.1: RECEIVABLES

	2019	2018
CURRENT	$'000	$'000
Contractual		
Trade Debtors	850	324
Patient Fees	164	306
Accrued Investment Income	4	5
GHA IT Alliance	365	392
Accrued Revenue - Other	344	510
Less Allowance for impairment losses of contractual receivables		
Patient Fees	(103)	(70)
Trade Debtors	(52)	(138)
	1,572	1,329
Statutory		
Accrued Revenue - Department of Health & Human Services	219	313
GST Receivable	195	345
	414	658
TOTAL CURRENT RECEIVABLES	**1,986**	**1,987**
NON CURRENT		
Statutory		
Long Service Leave - Department of Health and Human Services	2,074	1,483
TOTAL NON-CURRENT RECEIVABLES	2,074	1,483
TOTAL RECEIVABLES	**4,060**	**3,470**
NOTE 5.1(a) Movement in the allowance for doubtful debts		
Balance at beginning of the year	208	156
Amounts written off during the year	(148)	(88)
Amounts recovered during the year	-	-
Increase/(decrease) in allowance recognised in net result	95	140
Balance at end of year	**155**	**208**

Receivables consist of:

- Contractual receivables, which consists of debtors in relation to goods and services and accrued investment income. These receivables are classified as financial instruments and categorised as 'financial assets at amortised costs'. They are initially recognised at fair value plus any directly attributable transaction costs. The Health Service holds the contractual receivables with the objective to collect the contractual cash flows and therefore subsequently measured at amortised cost using the effective interest method, less any impairment.
- Statutory receivables, which predominantly includes amounts owing from the Victorian Government and Goods and Services Tax (GST) input tax credits recoverable. Statutory receivables do not arise from contracts and are recognised and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments for disclosure purposes. The Health Service applies AASB 9 for initial measurement of the statutory receivables and as a result statutory receivables are initially recognised at fair value plus any directly attributable transaction cost.

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

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

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

Impairment losses of contractual receivables
Refer to Note 7.1 (c) Contractual receivables at amortised costs for the Health Service's contractual impairment losses.

NOTE 5.2: PAYABLES

	2019 $'000	2018 $'000
CURRENT		
Contractual		
Trade Creditors (i)	2,079	1,872
Accrued Salaries and Wages	1,681	1,688
Accrued Expenses	3,009	2,135
GHA IT Alliance	323	482
	7,092	6,177
Statutory		
GST Payable	81	32
	81	32
TOTAL	**7,173**	**6,209**

(i) The average credit period is 65 days.

Payables consist of:

- contractual payables, classified as finanical instruments and measured at amortised cost. Accounts payable and salaries and wages payable represent liabilities for goods and services provided to Bass Coast Health prior to the end of the financial year that are unpaid; and
- statutory payables, that are recognised and measured similiarly 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.

Maturity analysis of payables
Please refer to Note 7.1(b) for the ageing analysis of payables.

NOTE 5.3: OTHER LIABILITIES

	2019 $'000	2018 $'000
CURRENT		
Monies Held in Trust*		
- Patient Monies Held in Trust*	377	41
- Accommodation Bonds (Refundable Entrance Fees)*	5,161	4,608
TOTAL CURRENT	**5,538**	**4,649**
*** Total Monies Held in Trust**		
Represented by the following assets:		
Cash Assets (refer to Note 6.2)	5,538	4,649
Investments and other Financial Assets (refer to Note 4.1)	-	-
TOTAL OTHER LIABILITIES	**5,538**	**4,649**

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

	2019 $'000	2018 $'000
Current Borrowings		
Australian Dollar Borrowings		
– Department of Health & Human Services - less than one year (i)	1,575	1,800
Total Australian Dollars Borrowings	1,575	1,800
Total Current Borrowings	**1,575**	**1,800**
Non-Current Borrowings		
Australian Dollar Borrowings		
– Department of Health & Human Services - two to five years (i)	629	2,108
Total Australian Dollars Borrowings	629	2,108
Total Non-Current Borrowings	**629**	**2,108**

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

Maturity analysis of borrowings
Please refer to Note 7.1(b) for the ageing analysis of borrowings.

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

Finance Leases

Entity as lessor
The Health Service does not hold any finance lease arrangements with other parties.

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

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

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.

	2019 $'000	2018 $'000
Cash on Hand	3	3
Cash at Bank	23,694	17,773
TOTAL CASH AND CASH EQUIVALENTS	**23,697**	**17,776**
Represented by:		
Cash for Health Service Operations (as per cash flow statement)	22,972	12,373
GHA IT Alliance	725	754
Cash for Monies Held in Trust	-	4,649
TOTAL CASH AND CASH EQUIVALENTS	**23,697**	**17,776**

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. From 1 July 2018, the cash flow statement includes monies held in trust.

NOTE 6.3: COMMITMENTS FOR EXPENDITURE

	2019 $'000	2018 $'000
(a) Commitments		
Capital Expenditure Commitments		
Payable:		
Land and Buildings	1,664	700
Total Capital Expenditure Commitments	**1,664**	**700**
Lease Commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating leases	372	562
Total Lease Commitments	**372**	**562**
Operating Leases		
IT Computers and Printers payable as follows:		
Not later than one year	189	192
Later than one year and not later than 5 years	183	370
Total Operating Lease Commitments	**372**	**562**
Total Commitments (inclusive of GST)	2,036	1,262
less GST recoverable from the Australian Taxation Office	(185)	(115)
Total Commitments (exclusive of GST)	**1,851**	**1,147**

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 at their nominal value and are inclusive of the goods and services tax ("GST") payable. In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant individual projects are stated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

NOTE 7: RISKS, CONTINGENCIES & VALUATION UNCERTAINTIES

The 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(a) Financial instruments: categorisation

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

2019	Financial Assets at Amortised Cost $'000	Financial Liabilities at Amortised Cost $'000	Total $'000
Contractual Financial Assets			
Cash and cash equivalents	23,697	-	23,697
Receivables			
- Trade Debtors	859	-	859
- Other Receivables	713	-	713
Investments and Other Financial Assets			
- Term Deposits	-	-	-
Total Financial Assets (i)	25,269	-	25,269
Financial Liabilities			
Payables	-	7,092	7,092
Borrowings	-	2,204	2,204
Other Financial Liabilities			
- Accommodation Bonds	-	5,161	5,161
- Other	-	377	377
Total Financial Liabilities(i)	-	14,834	14,834

2018	Contractual Financial Assets - Loans and Receivables and Cash $'000	Contractual Financial Liabilities at Amortised Cost $'000	Total $'000
Contractual Financial Assets			
Cash and cash equivalents	17,776	-	17,776
Receivables			
- Trade Debtors	422	-	422
- Other Receivables	907	-	907
Investments and Other Financial Assets			
- Term Deposits	2,020	-	2,020
Total Financial Assets (i)	21,125	-	21,125
Financial Liabilities			
Payables	-	6,177	6,177
Borrowings	-	3,908	3,908
Other Financial Liabilities			
- Accommodation Bonds	-	4,608	4,608
- Other	-	41	41
Total Financial Liabilities(i)	-	14,734	14,734

(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)

From 1 July 2018, Bass Coast Health applies AASB 9 and classifies all of its financial assets based on the business model for managing the assets and the asset's contractual terms.

Categories of financial assets under AASB 9

Financial assets at amortised cost
Financial assets are measured at amortised costs if both of the following criteria are met and the assets are not designated as fair value through net result:
- the assets are held by Bass Coast Health to collect the contractual cash flows; and
- the assets' contractual terms give rise to cash flows that are solely payments of principal and interests.

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

The Department recognises the following assets in this category:
- cash and deposits;
- receivables (excluding statutory receivables);
- term deposits; and
- certain debt securities.

Categories of financial assets previously under AASB 139

Loans and receivables and cash are financial instrument assets with fixed and determinable payments that are not quoted on an active market. These assets and liabilities 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 (and for assets, less any impairment). Bass Coast Health recognises the following assets in this category:

- cash and deposits;
- receivables (excluding statutory receivables);
- term deposits; and
- certain debt securities.

Available-for-sale financial instrument assets are those designated as available-for-sale or not classified in any other category of financial instrument asset. Such assts are initially recognised at fair value. Subsequent to initial recognition, they are measured at fair value with gains and losses arising from changes in fair value, recognised in 'Other economic flows - other comprehensive income' until the investment is disposed. Movements resulting from impairment and foreign currency changes are recognised in the net result as other economic flows. On disposal, the cumulative gain or loss previously recognised in 'Other economic flows - other comprehensive income' is transferred to other economic flows in the net result.

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

Derecognition of financial liabilities: A financial liability is derecognised when the obligation under the liability is discharged, cancelled or expires.

Impairment of financial assets : At the end of each reporting period, Bass Coast Health assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. All financial 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)

Note 7.1 (b): 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			
	Note	Total Carrying Amount	Nominal Amount	Less than 1 Month	1 - 3 Months	3 Months - 1 Year	1 - 5 Years
2019		$'000	$'000	$'000	$'000	$'000	$'000
Financial Liabilities							
At amortised cost							
Payables	5.2	7,092	7,092	6,963	129	-	-
Borrowings	6.1	2,204	2,204	125	250	1,201	628
Other Financial Liabilities (i)							
- Accommodation Deposits	5.3	5,161	5,161	-	-	5,161	-
- Other	5.3	377	377	-	44	333	-
Total Financial Liabilities		14,834	14,834	7,088	423	6,695	628
2018							
Financial Liabilities							
At amortised cost							
Payables	5.2	6,177	6,177	6,078	99	-	-
Borrowings	6.1	3,908	3,908	150	300	1,350	2,108
Other Financial Liabilities (i)							
- Accommodation Deposits	5.3	4,608	4,608	-	-	4,608	-
- Other	5.3	41	41	-	41	-	-
Total Financial Liabilities		14,734	14,734	6,228	440	5,958	2,108

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

Note 7.1 (c): Contractual receivables at amortised costs

1-Jul-18	*Current*	*Less than 1 month*	*1-3 months*	*3 months - 1 year*	*1-5 years*	*Total*
Expected loss rate	0%	14%	20%	50%	90%	
Gross carrying amount of contractual receivables ($'000)	1130	53	45	216	93	1537
Loss allowance ($'000)	0	7	9	108	84	208

30-Jun-19	*Current*	*Less than 1 month*	*1-3 months*	*3 months - 1 year*	*1-5 years*	*Total*
Expected loss rate	0%	7%	10%	35%	70%	
Gross carrying amount of contractual receivables ($'000)	1243	121	51	218	94	1727
Loss allowance ($'000)	0	8	5	76	66	155

Impairment of financial assets under AASB 9 – applicable from 1 July 2018

From 1 July 2018, the the Health Service has been recording the allowance for expected credit loss for the relevant financial instruments, replacing AASB 139's incurred loss approach with AASB 9's Expected Credit Loss approach. Subject to AASB 9 impairment assessment include the the Health Service's contractual receivables, statutory receivables and its investment in debt instruments.

Equity instruments are not subject to impairment under AASB 9. Other financial assets mandatorily measured or designated at fair value through net result are not subject to impairment assessment under AASB 9. While cash and cash equivalents are also subject to the impairment requirements of AASB 9, the identified impairment loss was immaterial.

Contractual receivables at amortised cost

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

On this basis, the the Health Service determines the opening loss allowance on initial application date of AASB 9 and the closing loss allowance at end of the financial year as disclosed above.

Reconciliation of the movement in the loss allowance for contractual receivables

	2019	***2018***
Balance at the beginning of the year	208	156
Opening retained earnings adjustment on adoption of AASB 9	-	-
Opening Loss Allowance	208	156
Modification of contractual cash flows on financial assets	-	-
Increase in provision recognised in the net result	95	140
Reversal of provision of receivables written off during the year as uncollectible	(148)	(88)
Reversal of unused provision recognised in the net result	-	-
Balance at end of the year	155	208

Credit loss allowance is classified as other economic flows in the net result. Contractual receivables are written off when there is no reasonable expectation of recovery and impairment losses are classified as a transaction expense. Subsequent recoveries of amounts previously written off are credited against the same line item.

In prior years, 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. A provision is made for estimated irrecoverable amounts from the sale of goods when there is objective evidence that an individual receivable is impaired. Bad debts considered as written off by mutual consent.

Statutory receivables and debt investments at amortised cost [AASB2016-8.4]

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

The Health Service also has investments in: Centralised Banking System (CBS)

Both the statutory receivables and investments in debt instruments are considered to have low credit risk, taking into account the counterparty's credit rating, risk of default and capacity to meet contractual cash flow obligations in the near term. As the result, the loss allowance recognised for these financial assets during the period was limited to 12 months expected losses. No loss allowance recognised at 30 June 2018 under AASB 139. No additional loss allowance required upon transition into AASB 9 on 1 July 2018.

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 contingent liabilities for Bass Coast Health 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

NOTE 8.1: RECONCILIATION OF NET RESULT FOR THE YEAR TO NET CASH INFLOW / (OUTFLOW) FROM OPERATING ACTIVITIES

	2019 $'000	2018 $'000
NET RESULT FOR THE YEAR	2,069	8,972
Non-cash movements		
Depreciation and Amortisation	2,057	1,923
Share of Net Result of Joint Venture	(99)	-
Discount Interest on Loan Net Present Value	-	14
Movements included in investing and financing activities		
Net (gain)/loss from disposal of non financial physical assets	(490)	(14)
Movements in assets and liabilities		
Change in Operating Assets & Liabilities		
(Increase)/Decrease in Receivables	(617)	(784)
(Increase)/Decrease in Prepayments	(10)	(3)
Increase/(Decrease) in Payables	1,130	1,982
Increase/(Decrease) in Provisions	1,599	1,169
Change in Inventories	10	(23)
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	5,649	13,236

NOTE 8.2: 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 and Minister for Ambulance Services	01/07/2018 - 29/11/2018
The Honourable Jenny Mikakos, Minister for Health and Minister for Ambulance Services	29/11/2018 - 30/06/2019
The Honourable Martin Foley, Minister for Mental Health	01/07/2018 - 30/06/2018
The Honourable Martin Foley, Minister for Housing, Disability and Ageing	01/07/2018 - 29/11/2018
The Honourable Luke Donellan, Minister for Child Protection, Minister for Disability, Ageing and Carers	29/11/2018 - 30/06/2019
Governing Boards	
Christine Hammond	01/07/2018 - 30/06/2019
Simon Jemmett	01/07/2018 - 30/06/2019
Mim Kershaw	01/07/2018 - 30/06/2019
Richard King	01/07/2018 - 30/06/2019
Ian Leong	01/07/2018 - 30/06/2019
Nigel McCormick	01/07/2018 - 30/06/2019
Kate McCullough	01/07/2018 - 30/06/2019
Mary O'Connor	01/07/2018 - 30/06/2019
Don Paproth	01/07/2018 - 30/06/2019
Ian Thompson	01/07/2018 - 30/06/2019
Mary Whelan	01/07/2018 - 30/06/2019
Accountable Officers	
Jan Child	01/07/2018 - 30/06/2019

Remuneration of Responsible Persons

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

Income Band	**2019 $**	**2018 $**
$0 - $9,999	3	11
$10,000 - $19,999	8	0
$320,000 - $329,999	0	1
$330,000 - $339,999	1	0
Total Numbers	12	12
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	$450,039	$323,975

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

NOTE 8.3: REMUNERATION OF EXECUTIVES

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

Remuneration of executive officers	Total Remuneration	
	2019	2018
	$'000	$'000
Short-term Benefits	790	916
Post-employment Benefits	75	87
Other Long-term Benefits	27	31
Total Remuneration (i)	892	1,034
Total Number of Executives	5	7
Total Annualised Employee Equivalent (ii)	**4**	**5**

(i) The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of the entity under AASB 124 Related Party Disclosures and are also reported within Note 8.4 Related Parties.
(ii) Annualised employee equivalent is based on working 38 ordinary hours per week over the reporting period.

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

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

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

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

Termination Benefits
Termination of employment payments, such as severance packages.

NOTE 8.4: RELATED PARTIES

The Health Service is a wholly owned and controlled entity of the State of Victoria. Related parties of the health service include:

- All key management personnel (KMP) and their close family members;
- Cabinet ministers (where applicable) and their close family members;
- Jointly Controlled Operation - A member of the Gippsland Health Alliance; and
- All hospitals and public sector entities that are controlled and consolidated into the State of Victoria 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 Executive Directors of the Health Service and it's controlled entites are deemed to be KMPs.

		Period
Key Management Personnel	**Position Title**	
Don Paproth	Chair of the Board	01/07/2018 - 30/06/2019
Christine Hammond	Board Member	01/07/2018 - 30/06/2019
Simon Jemmett	Board Member	01/07/2018 - 30/06/2019
Mim Kershaw	Board Member	01/07/2018 - 30/06/2019
Richard King	Board Member	01/07/2018 - 30/06/2019
Ian Leong	Board Member	01/07/2018 - 30/06/2019
Nigel McCormick	Board Member	01/07/2018 - 30/06/2019
Kate McCullough	Board Member	01/07/2018 - 30/06/2019
Mary O'Connor	Board Member	01/07/2018 - 30/06/2019
Ian Thompson	Board Member	01/07/2018 - 30/06/2019
Mary Whelan	Board Member	01/07/2018 - 30/06/2019
Jan Child	Chief Executive Officer	01/07/2018 - 30/06/2019
Noni Bourke	Chief of Organisational Support and Development	01/07/2018 - 30/06/2019
Shaun Brooks	Chief Financial Officer	01/07/2018 - 30/06/2019
Paul Greenhalgh	Executive Director of Sub Acute and Community Care	01/07/2018 - 25/08/2018
Louise Sparkes	Chief Operating Officer	01/07/2018 - 30/06/2019
Bruce Waxman	Chief Medical Officer	01/07/2018 - 30/06/2019

The compensation detailed below is reported in $'000 and excludes the salaries and benefits the Portfolio Ministers receive. The Minister's remuneration and allowances is set by the *Parliamentary Salaries and Superannuation Act 1968*, and is reported within the Department of Parliamentary Services' Financial Report.

COMPENSATION	2019 $'000	2018 $'000
Short-term Employee Benefits (i)	1,191	1,202
Post-employment Benefits	113	114
Other Long-term Benefits	37	41
Total (ii)	**1,341**	**1,357**

(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 8.2 Responsible Persons or Note 8.3 Remuneration of Executives.

Significant transactions with government-related entities
Bass Coast Health received funding from the Department of Health and Human Services of $60.5 million (2018: $58 million).
Bass Coast Health made payments to Ambulance Victoria of $1.8 million (2018: $1.2 million).

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 the Victorian Managed Insurance Authority.

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

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

Outside of normal citizen type transactions with the Health Service, there were no related party transactions that involved key management personnel, their close family members and their personal business interests. No provision has been required, nor any expense recognised, for impairment of receivable from related parties. There were no related party transactions with Cabinet Ministers required to be disclosed in 2019.

There were no related party transactions required to be disclosed for the Bass Coast Health Board of Directors, Chief Executie Officer and Executive Directors in 2019.

NOTE 8.5: REMUNERATION OF AUDITORS

	2019 $'000	2018 $'000
Victorian Auditor-General's Office		
Audit of the Financial Statements	47	46
Total Remuneration of Auditors	47	46

NOTE 8.6: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

There are no events occurring after the Balance Sheet Date.

NOTE 8.7: JOINTLY CONTROLLED OPERATIONS AND ASSETS

Name of Entity	Ownership Interest 2019 %	2018 %
Gippsland Health Alliance	10.36	10.61

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

	2019 $'000	2018 $'000
Current Assets		
Cash and Cash Equivalents	725	754
Receivables	113	131
Other Current Assets	252	261
Total Current Assets	**1,090**	**1,146**
Non Current Assets		
Property, Plant and Equipment	9	13
Total Non Current Assets	**9**	**13**
Total Assets	**1,099**	**1,159**
Current Liabilities		
Payables and Accrued Expenses	92	56
Other Current Liabilities	232	426
Total Current Liabilities	**324**	**482**
Total Liabilities	**324**	**482**
Net Assets	**775**	**677**
Equity		
Accumulated Surpluses/(Deficits)	775	677
Total Equity	**775**	**677**

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

Revenues		
GHA Revenue	1,480	1,382
Capital Income	-	-
Total Revenue	**1,480**	**1,382**
Expenses		
Information Technology and Administrative Expenses	1,379	1,359
Capital Expense	3	2
Total Expenses	**1,382**	**1,361**
Net Result	**98**	**21**

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

NOTE 8.8: ECONOMIC DEPENDENCY

The Health Service is solely dependent on the continued financial support of the State Government and in particular, the Department of Health and Human Services. The Department of Health and Human Services has provided confirmation that it will continue to provide Bass Coast Health adequate cash flow support to meet its current and future operational obligations as and when they fall due for a period up to September 2020, should this be required to enable continued trade in the short term. On that basis, the financial statements have been prepared on a going concern basis.

Throughout 2018-19, Bass Coast Health was in regular discussion with Department of Health and Human Services Officers regarding ongoing concern issues including budget performance and cash flow management, and made the necessary arrangements to address these issues.
Bass Coast Health's forecast viability indicators for the period to September 2020, particularly indicators for net operating result, cash flow from operations and days of available cash, are key reasons for requiring cash flow support from the Department of Health and Human Services in the short term.

NOTE 8.9: AASBs ISSUED THAT ARE NOT YET EFFECTIVE

Certain new Australian accounting standards and interpretations have been published that are not mandatory for 30 June 2019 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 2019, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. Bass Coast Health has not and does not intend to adopt these standards early.

Standard/Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on public sector entity financial statements
AASB 15 Revenue from Contracts with Customers	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer. 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 for Not-for-Profit entities.	1 January 2019	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. Revenue from grants that are provided under an enforceable agreement that have sufficiently specific obligations, will now be deferred and recognised as the performance obligations attached to the grant are satisfied.
AASB 2018-4 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Public-Sector Licensors	AASB 2018-4 amends AASB 15 and AASB 16 to provide guidance for revenue recognition in connection with taxes and Non-IP licences for Not-for-Profit entities.	1 January 2019	AASB 2015-4 provides additional guidance for not-for-profit public sector licenses, which include: Matters to consider in distinguishing between a tax and a license, with all taxes being accounted for under AASB 1058; IP Licenses to be accounted for under AASB 15; and • Non-IP, such as casino licenses, are to be accounted for in accordance with the principles of AASB 15 after first having determined whether any part of the arrangement should be accounted for as lease under AASB 16.
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.	1 January 2019	This standard clarifies the application of AASB 15 and AASB 9 in a not-for-profit context. The areas within these standards that 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 most operating leases (which are currently not recognised) on balance sheet.	1 January 2019	The assessment has indicated that most operating leases, with the exception of short term and low value leases will come on to the balance sheet and will be recognised as right of use assets with a corresponding lease liability. In the operating statement, the operating lease expense will be replaced by depreciation expense of the asset and an interest charge. There will be no change for lessors as the classification of operating and finance leases remains unchanged. As operating leases are minor, the impact is not expected to be significant.
AASB 2018-8 Amendments to Australian Accounting Standards – Right of Use Assets of Not-for-Profit entities	This standard amends various other accounting standards to provide an option for not-for-profit entities to not apply the fair value initial measurement requirements to a class or classes of right of use assets arising under leases with significantly below-market terms and conditions principally to enable the entity to further its objectives. This Standard also adds additional disclosure requirements to AASB 16 for not-for-profit entities that elect to apply this option.	1 January 2019	Under AASB 1058, not-for-profit entities are required to measure right-of-use assets at fair value at initial recognition for leases that have significantly below-market terms and conditions. For right-of-use assets arising under leases with significantly below market terms and conditions principally to enable the entity to further its objectives (pepperorn leases). AASB 2018-8 provides a temporary option for Not- for-Protit entities to measure at initial recognition, a class or classes of right-of-use assets at cost rather than at fair value and requires disclosure of the adoption. The State has elected to apply the temporary option in AASB 2018-8 for not-for-profit entities to not apply the fair value provisions under AASB 1058 for these right-of-use assets.
AASB 1058 Income of Not-for-Profit Entities	AASB 1058 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	1 January 2019	Grant revenue is currently recognised up front upon receipt of the funds under AASB 1004 Contributions. The timing of revenue recognition for grant agreements that fall under the scope of AASB 1058 may be deferred. For example, revenue from capital grants for the construction of assets will need to be deferred and recognised progressively as the asset is being constructed. The impact on current revenue recognition of the changes is the potential phasing and deferral of revenue recorded in the operating statement. Future impact will be dependant upon the timing of the receipt of funding and the satisfaction of specific milestones required to recognise this funding.

AASB 17 Insurance Contracts	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.	1 January 2021	The assessment has indicated that there will be no significant impact for the public sector.
AASB 2018-7 Amendments to Australian Accounting Standards – Definition of Material	This Standard principally amends AASB 101 Presentation of Financial Statements and AASB 108 Accounting Policies, Changes in Accounting Estimates and Errors. The amendments refine and clarify the definition of material in AASB 101 and its application by improving the wording and aligning the definition across AASB Standards and other publications. The amendments also include some supporting requirements in AASB 101 in the definition to give it more prominence and clarify the explanation accompanying the definition of material.	1 January 2020	The standard is not expected to have a significant impact on the public sector.
AASB 1059 Service Concession Arrangements: Grantor	This standard applies to arrangements that involve an operator providing a public service on behalf of a public sector grantor. It involves the use of a service concession asset and where the operator manages at least some of the public service at its own direction. An arrangement within the scope of this standard typically involves an operator constructing the asset used to provide the public service or upgrading the assets and operating and maintaining the assets for a specified period of time.	1 January 2020 (The State is intending to early adopt AASB 1059 for annual reporting periods beginning on or after 1 January 2019)	For an arrangement to be in scope of AASB 1059 all the following requirements are to be satisfied: Operator is providing public services using a service concession asset; Operator manages at 'least some' of public services under its own discretion; The state controls / regulates" ; - what services are to be provided; - to whom; and - at what price State controls any significant residual interest in the asset. If the arrangement does not satisfy all the above requirements the recognition will fall under the requirements of another applicable accounting standard.
AASB 2018-5 Amendments to Australian Accounting Standards – Deferral of AASB 1059	This standard defers the mandatory effective date of AASB 1059 from 1 January 2019 to 1 January 2020.	1 January 2020 (The State is intending to early adopt AASB 1059 for annual reporting periods beginning on or after 1 January 2019)	The standard defers the mandatory effective date of AASB 1059 for periods beginning on or after 1 January 2019 to 1 January 2020. As the State has elected to early adopt AASB 1059, the financial impact will be reported in the financial year ending 30 June 2019, rather than the following year.

In addition to the new standards and amendments above, the AASB has issued a list of other amending standards that are not effective for the 2018-19 reporting period (as listed below). In general, these amending standards include editorial and references changes that are expected to have insignificant impacts on public sector reporting.

- AASB 2017-1 Amendments to Australian Accounting Standards – Transfers of Investment Property, Annual Improvements 2014-16 Cycle and Other Amendments
- AASB 2017-4 Amendments to Australian Accounting Standards – Uncertainty over Income Tax Treatments
- 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
- AASB 2018-3 Amendments to Australian Accounting Standards – Reduced Disclosure Requirements
- AASB 2018-6 Amendments to Australian Accounting Standards – Definition of a Business

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Map of service sites

Main Site

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

Satellite Sites

2. San Remo
   1 Back Beach Road, San Remo Vic. 3925
   Phone: 03 5671 9200
3. Phillip Island Health Hub
   50-54 Church Street, Cowes Vic. 3922
   Phone: 03 5951 2100

Outreach Sites

4. Grantville
   Grantville Transaction Centre
   Cnr. Bass Highway & Pier Road, Grantville Vic. 3984
   Phone: 03 5671 3333
5. Corinella
   Corinella & District Community Centre
   48 Smythe Street, Corinella Vic. 3984
   Phone: 03 5671 3333

Residential Aged Care Facilities

6. Kirrak House
   Baillieu Street, Wonthaggi Vic. 3995
   Phone: 03 5671 3250
7. Griffiths Point Lodge
   Davis Point Road, San Remo Vic. 3925
   Phone: 03 5678 5311

Maternal and Child Health Sites

8. Wonthaggi
   Miners Dispensary
   169 Graham Street, Wonthaggi, Vic. 3995
   Phone: 03 5671 3136
9. Inverloch
   16 A'Beckett Street, Inverloch Vic. 3996
   Phone: 03 5671 3136
10. San Remo
    San Remo Kindergarten
    23 Back Beach Road, San Remo Vic. 3925
    Phone: 03 5951 2302
11. Cowes
    Phillip Island Early Learning Centre
    161 Settlement Road, Cowes Vic. 3922
    Phone: 03 5952 2938