ANNUAL REPORT
2023–24

MANSFIELD
DISTRICT HOSPITAL

Disclosure Index

The annual report of the Mansfield District Hospital is prepared in accordance with all relevant Victorian legislation. This index has been prepared to facilitate identification of the Department's compliance with statutory disclosure requirements

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Manner in Which the Health Service was Established

Mansfield District Hospital is a public health service established under the *Health Services Act 1988* (Vic).

Responsible Ministers

Minister for Health:
The Hon. Mary-Anne Thomas 01/07/2023 – 30/06/2024

Minister for Ambulance Services:
The Hon. Gabrielle Williams 01/07/2023 – 02/10/2023
The Hon. Mary-Anne Thomas 02/10/2023 – 30/06/2024

Minister for Mental Health:
The Hon. Gabrielle Williams 01/07/2023 – 02/10/2023
The Hon. Ingrid Stitt 02/10/2023 – 30/06/2024

Minister for Disability, Ageing and Carers:
The Hon. Lizzie Blandthom 01/07/2023 – 02/10/2023

Minister for Disability/Minister for Children:
The Hon. Lizzie Blandthom 02/10/2023 – 30/06/2024

Minister for Ageing:
The Hon. Ingrid Stitt 02/10/2023 – 30/06/2024

Purpose, Function, Powers and Duties

In accordance with Mansfield District Hospital By-Laws Section 3:

3.1 The objects of the Health Service are to:

3.1.1 operate a public hospital in accordance with the Act, and any enabling Commonwealth or Victorian legislation, including the provision of the following services:
(a) public hospital services;
(b) primary health services;
(c) aged care services; and
(d) community health services.

3.1.2 provide a range of health and related services ancillary to those services described in clause 3.1.1;

3.1.3 carry on any other activity or business that it is convenient to carry on in connection with providing the services described in clauses 3.1.1 and 3.1.2, or which are intended or calculated to make any of the Health Service's assets or activities more efficient and effective; and

3.1.4 to do all things that are conducive or incidental to achieving the Health Service's objects.

3.1.5 to ensure the accountable and efficient provision of health services and the long-term financial viability of the Health Service;

3.1.6 to ensure effective and accountable systems are in place to monitor and improve the quality, safety and effectiveness of the health services provided by the Health Service;

3.1.7 to strive to improve continuously the quality and safety of the health services provided and to foster innovation;

3.1.8 to ensure the effective and efficient use of the Health Service's resources;

3.1.9 to develop arrangements with other agencies and service providers to enable effective and efficient service delivery and continuity of care;

3.1.10 to facilitate health education to improve the training and knowledge of staff;

3.1.11 to establish and maintain effective systems to ensure:
1. that health services meet the needs of the community served by the Health Service; and
2. effective consultation with the community to take account of the views of users of the health services.

3.2 The Health Service must not do or permit anything to be done that is inconsistent with its objects or is not otherwise authorised by or under the Act.

Vision

Healthy communities, trusted healthcare

Mission

We deliver healthcare locally for our rural communities. We lead and advocate for the healthcare needs of the people of Mansfield and surrounding communities. In addition to providing safe and clinical best practice care, we focus on health promotion and preventative care to deliver the best possible outcomes for our consumers.

Nature and Range of Services Provided

Mansfield District Hospital provides acute, primary and aged services. Acute services include medical, surgical and obstetric care. Emergency care is provided in the Urgent Care Centre. Buckland House Nursing Home provides 30 beds for high level residential aged care while Bindaree Retirement Centre provides 42 residential aged care beds. Primary Care comprises a visiting nursing service, community health nursing, home support and social inclusion programs along with a wide range of allied health services and health promotion and prevention services to the community. Community nurses visit Jamieson and Woods Point on a weekly basis. The health service also operates a medical clinic on Mt Buller during the alpine ski season.

Services offered by Mansfield District Hospital are:

- General Medicine
- Elective Surgery
- Obstetrics
- Haemodialysis
- Urgent Care
- Community Health
- Health Promotion
- Residential Aged Care
- Visiting Nursing
- Home Support
- Social Inclusion
- Medical Imaging

The health service serves the catchment of Mansfield Shire with a population of approximately 10,000 permanent residents. In holiday seasons this population increases three-fold. For obstetric services the catchment extends to include part of Murrindindi Shire.

Organisational Structure

BOARD OF DIRECTORS

Dr Karen Bennetts (Chair)
Mr Matthew Hoskin
Ms Katie Lockey
Ms Lisa Morgan
Mr Phillip Officer
Ms Rachel Paulus
Mr Richard Ray
Mr Peter Valerio
Ms Amanda Vogt

AUDIT & RISK MANAGEMENT COMMITTEE

Ms Katie Lockey (Chair) 01/07/2023 – 31 /12/2023
Mr Richard Ray (Chair) 01/01/2024 – 30/06/2024
Ms Lisa Morgan
Mr Peter Valerio
Ms Leeanne Darmanin (Community member) from 01/01/2024
Mr Mark Evans (Community member)
Mr David Roff (Community Member) from 01/01/2024

COMMUNITY ADVISORY COMMITTEE

Ms Amanda Vogt (Chair)
Ms Katie Lockey
Ms Rachel Paulus
Ms Nola Andrews (Community/Consumer Representative)
Ms Di Bergelin (Community/Consumer Representative)
Ms Poppe Davis (Community/Consumer Representative)
01/07/2023 – 01/12/2023
Aunty Ann-Marie Fletcher (Community/Consumer Representative)
Prof Brenda Happell (Community/Consumer Representative)
Ms Mary Reilly (Community/Consumer Representative)

FINANCE COMMITTEE

Ms Lisa Morgan (Chair)
Mr Matthew Hoskin
Mr Richard Ray

GOVERNANCE, NOMINATIONS AND EXECUTIVE PERFORMANCE

Dr Karen Bennetts (Chair)
Mr Phillip Officer
Ms Amanda Vogt

SAFETY AND QUALITY COMMITTEE

Mr Matthew Hoskin (Chair)
Mr Peter Valerio
Ms Amanda Vogt
Ms Nola Andrews (Consumer Representative)
Ms Kristina Zlatic (Consumer Representative)

EXECUTIVE

Chief Executive Officer:
Mr Cameron Butler, RN B. Bus

Director of Clinical Services:
Ms Anne Jewitt, RN RM, IBCLC 01/07/2023 – 09/02/2024
Ms Michelle Spence, RN PGDip CritCareNsg from 09/02/2024

Director of Medical Services:
Prof Louis Irving MBBS FRACGP FRACP FThor Soc

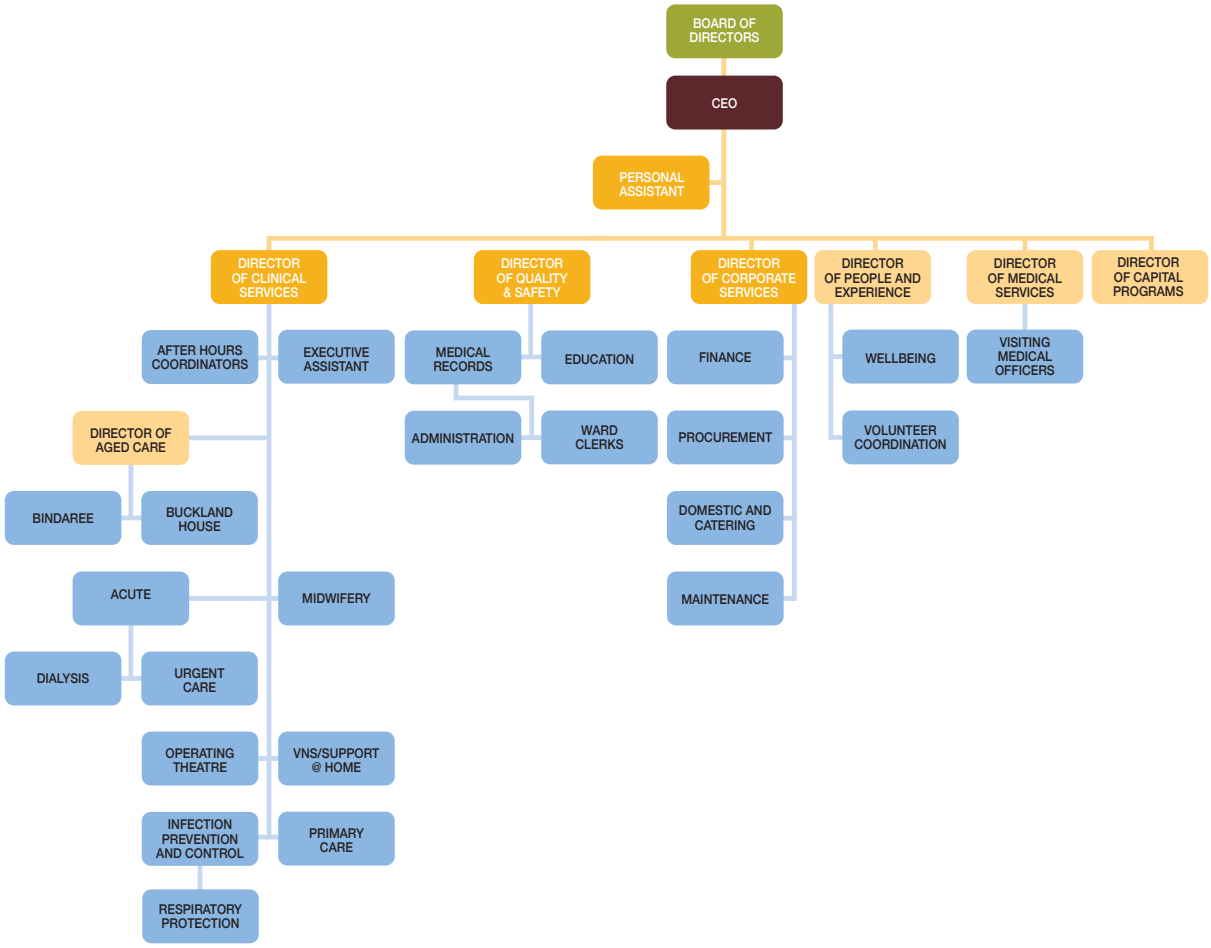
Director of Operations:
Ms Melanie Green, BSci(Speech Pathology) MHHSM GradDIP Risk & Bus Continuity to 01/04/2024

Director of Quality & Safety:
Mrs Kate Les, RN BN Gr Dip Neuroscience

Chief Financial Officer:
Ms Kirstie-Bree Fotheringham, B Acc CPA GradDIP Ed. to 01/04/2024

Director of Finance & Corporate Services:
Ms Kirstie-Bree Fotheringham, B Acc CPA GradDIP Ed. from 01/04/2024

Personal Assistant to CEO: Ms Tracy Rekers



Visiting Medical Officers

Dr L Carter, MBBS Bsc(Hons) FRACGP FACRRM JCCA
Dr D Chakraborty, MBBS FRACGP RANZCOG DRANZCOG
Dr D Cook, MBBS Dip RACOG FRACGP FACRRM
Dr A Davis, BBiomed MD SCHP EMC (ACEM)
Dr K De Silva, MD
Dr E Dirksen, MBBS
Dr D Friday, MBBS DRANZCOG FRACGP
Dr K Green, BSci MD SCHP EMC (ACEM)
Dr J Harper, MBBS
Dr K Hudson, BMedSc(Hons) MD DRANZCOG
Dr P Jolly, MBBS
Dr D Le Brocque, BAppSc MSc MBBS FRACGP
Dr C Lewis, MBChB
Dr P Murray, MBBS DRANZCOG Adv FRACGP
Dr B Nally, MBBS
Dr J Penate, MBBS
Dr L Plant, MBBS BBiomed
Dr R Radford, MBBS
Dr G Reynolds, MBBS RACGP DRANZCOG Adv
Dr S Richards, MBBS Dip Ed BA
Dr M Sathveegarajah, MD BSc
Dr G Slaney, MBBS MPH DA DRCOG FACRRM
Dr W Twycross, MBBS DA DRANZCOG DTPH
Dr B Weatherhead, MBBS BMedSci FRACGP JCCA
Dr C Weatherhead, BMedSci(Hons) MBBS DCH DRANZCOG FRACGP
Dr A Wettenhall, MBBS FRACGP
Dr S Wiles, MBBS, JCCA

Visiting Specialists

Dr L Dhakal, MBBS FRACP MD MPH
Mr M Forbes, MBBS FRACS
Dr P MacLeish, MBBS FRACP
Dr S Pearce, MBBS FRANZCOG
Mr P Ruljancich, MBBS FRACS
Mr M Shears, MBBS (Hons) BBiomedSc PGDipAnat FRACS

Visiting Dental Practitioner

Dr D Kohli B.D Sc

Responsible Bodies Declaration

In accordance with the *Financial Management Act 1994*, I am pleased to present the report of operations for Mansfield District Hospital for the year ending 30 June 2024.

K. L. Bennetts

Karen Bennetts
Board Director
Mansfield District Hospital

17 October 2024

MANSFIELD DISTRICT HOSPITAL

Introduction

Mansfield District Hospital (MDH) and its Board of Directors are pleased to present the 2023–2024 Annual Report to the community. This report provides an opportunity for us to share some of our achievements, and to share the enduring commitment of MDH staff, under the leadership of our Chief Executive Officer (CEO), Mr Cameron Butler, and the Executive team. We thank them for their ongoing diligence in prioritising the continued delivery of safe and high-quality health care to serve the Mansfield district. They do this while also maintaining and developing the delivery of a broad suite of health services under a mix of extraordinary post-pandemic challenges. I also want to make special mention of the Board's Secretary, Ms Tracy Rekers for her tireless efforts in support of MDH's governance.

Safety and Quality

MDH continues to offer a diverse range of health services to the community including primary care, acute care, urgent care, operating theatre, maternity services, together with community-based services and residential aged care facilities. MDH also continues to operate the medical centre at Mt Buller. Across all these services, our prime focus is the consistent provision of healthcare that is safe and of the highest possible quality, to consumers, their close family members and the broader Mansfield community.

The underlying quality is tested and assured with a suite of accreditation standards continuing to be fully met:

- National Safety and Quality Health Service Standards
- Aged Care Quality Standards; and
- ISO 9001:2015, an international standard dedicated to Quality Management Systems

The *Statement of Priorities*, agreed with the Department of Health for 2023–2024, and the health service key performance indicators, are included within this annual report. The broader priorities emphasised:

- Keeping people healthy and well in the community
- Providing care closer to home
- Keep innovating and improving care
- Improving Aboriginal health and wellbeing
- Moving from competition to collaboration
- A stronger and more sustainable workforce
- A safe and sustainable health, wellbeing and care system

MDH also offers a number of preventative and restorative programs to benefit longer term well-being. Such programs include:

- **Restart:** to assist those who want to recover from substance abuse
- **Respond:** a community-led, place-based approach to improving the health and wellbeing of local children; and
- **Chronic disease programs** such as cardiac and pulmonary rehabilitation

Our People

Our people are at the heart of all we do at MDH. Once again, the leadership and commitment of our CEO and Executive team, have been particularly valued through the demands of this past year. We acknowledge their consistent efforts to keep the Board of Directors well-informed.

This year our leadership structure was enhanced in line with our strategic priorities. We were fortunate to have Ms Michelle Spence and Ms Anna Burchell join our team as Director of Clinical Services and Director of People and Experience respectively. Ms Anne Jewitt took on a new role as Director of Aged Care and Ms Kate Les was appointed as the new Director of Quality and Safety. Ms Melanie Green took on the new role of Director of Capital Programs and Ms Kirstie-Bree Fotheringham accepted responsibility for Corporate Services in addition to Finance.

Professor Lou Irving continued in his role as Director of Medical Services. Our Visiting Medical Officers (VMOs) together with the nursing staff enable our professional and caring health service, supported by trusted ancillary staff. The Board is proud of the way staff managed another year of challenges and extends its thanks to the entire staff team.

Our Community

While MDH receives government funding for its operational and capital development, the health service is generously supported by our local community. We are very grateful for the ongoing support and assistance offered by our two hospital auxiliaries, the MDH Auxiliary and the Bindaree Auxiliary. The Bindaree Auxiliary chose to amalgamate with the MDH Auxiliary during the year.

We also thank the Harry and Clare Friday Foundation for their generous donation that allowed us to purchase an Isolette. The Mansfield Golf Club and several individuals and organisations in the Mansfield area are also thanked for their generous assistance.

MDH benefits from collaboration and partnerships with other health services, particularly within the Hume Region. We value our membership of the Victorian Healthcare Association who support us through a range of avenues. We also value our good relationship with Mansfield Shire Council and Alpine Resorts Victoria and thank them for their support during the year.

The Mansfield district community assists us with consumer representation on three MDH Board committees – Safety and Quality, Audit and Risk Management, and Community Advisory. The input of community representatives is an important contribution to MDH's strategic objectives. We thank those who have volunteered for these roles during the year and welcome expressions of interest from the wider Mansfield community for future participation.

Governance

MDH is fortunate to have a strong and stable group of people with diverse backgrounds and skills serving as our Board of Directors. In partnership with MDH's operational management, led by the CEO, the Board is tasked with good governance, including compliance with all legislative and regulatory directives of the Department of Health. The Board is also responsive to serving the needs of the local community today and into the future.

This year we welcomed two new Directors to the Board, Ms Rachel Paulus and Mr Peter Valerio, both from the local district, and both bringing relevant skills and experience to our governance.

I would like to acknowledge the substantial legacy of Mr Phillip Officer, who recently retired from the Board following 9 years of service, the maximum term for directors. Phil is a former Board Chair who also chaired and participated in a variety of Board committees and panels. Phil was a valued mentor for other Directors and we thank him for the many ways in which he contributed his expertise.

MDH Board members have responsibilities that call for a contribution of time and energy. On behalf of the Mansfield community, I thank all the MDH directors, including our Deputy Chair, Amanda Vogt, for their ongoing commitment to good governance in the best interests of MDH and the broader health system.

Key Initiatives

MDH continues to strive for improvement into the future. This year MDH progressed a number of local initiatives that focussed our attention on the consumer experience. Included in this work was a new website with enhanced information on the services we provide for our local community. We also welcomed new nursing staff from overseas to the Mansfield district which has been very helpful in enabling us to meet workforce requirements. The Board expanded its oversight work to include MDH's environmentally sustainable practices.

Masterplan for the development of MDH

Stage 1 of our masterplan moved to the detailed design for redevelopment of MDH's aged care facilities which will create a modernised and co-located aged care facility. The tendering process was completed in the second half of the year and we now look forward to the appointment of the builder and construction progressing in the coming year.

MDH Strategic Plan for 2020–24

This important five-year plan outlines the key drivers regarding the importance of staff, the community and the quality of the healthcare at Mansfield District Hospital, prioritising the core values of MDH and the means to keep at the heart of our work. The plan is available on the MDH website and we encourage everyone to read it. Future strategic planning will take place within the context of proposed reforms to the Victoria public health sector, to be outlined in the Health Services Plan.

Financial Performance

The 2023-2024 budget year provided many challenges for the hospital. Rising operational costs had a significant impact on our operating expenditure. However, we were again fortunate to have the support of the Department of Health and we look forward to returning to a stronger financial result in the coming year.

MDH met all financial management measures outlined within the *Statement of Priorities*. The full financial reports are included within this annual report. The Board would like to acknowledge the hard work of our Director of Finance and Corporate Services, Ms Kirstie-Bree Fotheringham and our CEO, Cameron Butler in navigating this difficult year.

Acknowledgements

We once again want to recognise the work of MDH's entire team, staff, VMOs, community volunteers and donors, as they work to support our provision of great care, day in, day out. On behalf of the Board of Directors, I express my sincere gratitude for your wholehearted service and support, your patience, resilience and enthusiasm in these difficult times. Together with my colleagues on the Board of Directors, we thank you one and all.

Karen Bennetts
Board Chair

Mansfield District Hospital Auxiliary Report

After celebrating our Centenary in 2023, the Auxiliary has continued to move forward in a most positive way. We finalised the amalgamation with Bindaree Auxiliary and this has given us a very healthy membership of over thirty which means more hands-on support for all our activities. Our support now encompasses the Hospital, Bindaree and Buckland House.

We have continued with our two major fund-raising events. The annual Cup Weekend Art Show was again most successful, raising over $10,000. The show was judged by local artist Shanley Cleeland with the major awards going to Cherry Manders (Rotary Award) and Wendy Jagger (Harry and Clare Friday Foundation Award). Many thanks to the Art Show committee which has always been a well-oiled machine, but special thanks go to Sue Swan who has retired from the coordinating role after many years.

Our second major fundraising event is the Annual Golf Day which takes place every February. This was our 17h year for the event and it was again highly successful, raising $45,000. That makes well over $440,000 raised in total over those 17 years. We continue to receive wonderful community support for our golf day with corporate support from local business and generous major sponsorships from Mansfield Motor Group, DPG property group, Vacuum Trucks, Elders, FoodWorks and the golf club. Special thanks to the organising committee for their tireless efforts again this year.

An important regular activity for the Auxiliary continues to be the provision of a goods trolley for Bindaree residents. A weekly roster means the residents have access to a range of items, especially confectionery and stationery which they may not always be able to get for themselves. The amalgamation of the two auxiliaries has meant this service continues without too much fuss.

Bindaree Auxiliary members have worked hard during the year to raise extra funds through the Golf Club Cash Cow and we thank them for the regular effort in organising this.

We were most pleased to have Michelle Spence visit our meeting and talk about general needs for the hospital. We are still in the process of considering the purchases for 2024 but it will include new chairs for the Dialysis program and support for Urgent Care patient monitoring.

The Auxiliary can only continue to provide such valuable support to the Hospital, Bindaree and Buckland because of the dedication of all our wonderful members. They work tirelessly to make our key events a success and thanks go to every single one of them. We also express our thanks to the hospital administration for their invaluable support of our activities and the open access that we have with them.

Val Doyle
President
Mansfield District Hospital Auxiliary

Workforce

Mansfield District Hospital adheres to the public sector employment principles. These align to our health service's values and shape our working environment. We aim for a culture where there are productive working relationships, employees are treated well, treat each other well, can safely raise concerns and have career opportunities.

Mansfield District Hospital Values:

CONSUMERS ARE AT THE CENTRE OF OUR CARE

- WE DELIVER GREAT CARE – We strive for the best health outcomes for our consumers and communities every time. Consumers are at the centre and we consistently provide high-quality, safe and personalised care. We demonstrate empathy and kindness in every aspect of our care.
- WE RESPECT EACH OTHER – We respect our peers, our consumers, our hospital and our environment. Care is delivered thoughtfully and with compassion. We are considerate of our consumers' dignity and privacy, and our consumers trust and have confidence in our quality of care. We actively listen and act fairly, impartially and without judgement.
- WE WORK TOGETHER – We work as a cohesive team and feel connected to the work we do together. We maintain strong connections to our diverse communities in and outside of Mansfield. We work in collaboration with our partners to deliver exceptional care. We have honest and open conversations with our staff, consumers and the community.
- WE EMPOWER EACH OTHER – We support and trust each other to deliver an exceptional consumer experience. We give our consumers the information and resources they need to make considered and informed decisions about their health care. We continuously support our staff in their development and empower them to make decisions based on their best judgement.

Facing challenges in recruiting employees we have actively and successfully recruited international registered nurses. The shortage of available and affordable housing has had an impact on filling vacancies domestically.

All employees have been correctly classified in workforce data collections.

Hospitals Labour Category	JUNE Current Month FTE*		Average Monthly FTE**	
	2023	2024	2023	2024
Nursing	72.96	74.31	78.69	71.00
Administration and Clerical	25.32	23.47	26.1	23.51
Medical Support	1.00	4.46	1.00	3.20
Hotel and Allied Services	43.17	44.30	43.44	44.68
Sessional Clinicians	–	0.21	–	0.26
Ancillary Staff (Allied Health)	11.08	14.30	12.05	14.05
TOTAL	**153.53**	**161.05**	**161.28**	**156.70**

The FTE figures required in the table above are those excluding overtime. These do not include contracted staff (e.g. agency nurses and fee-for-service visiting Medical Officers) who are not regarded as employees for this purpose.

Occupational Health and Safety

Mansfield District Hospital is committed to providing a safe environment for employees, consumers and members of the public. The Health Service complies with the requirements of the *Occupational Health and Safety Act (Vic) 2004* and the Victorian Occupational Health and Safety Regulations 2017.

Health and Safety Representatives seek to find ways to eliminate or mitigate the risk of injury within the workplace. We aim for a workplace culture where people identify and report issues early. Where injury has occurred, the health service seeks to achieve the safe, appropriate, supportive and timely return to work of employees.

Reported Incidents

Occupational Health and Safety Statistics	2021–22	2022–23	2023–24
The number of reported hazards for the year per 100 FTE	2.6	1.5	1.9
The number of reported incidents for the year per 100 FTE	28	39.8	34.2
The number of 'lost time' standard WorkCover claims for the year per 100 FTE	2	1.3	2.6
The average cost per WorkCover claim for the year ('000)	$1.85	$134	$8.69

Occupational Violence

Occupational Violence Statistics	2023-24
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	23
Number of occupational violence incidents reported per 100 FTE	14.68
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	**0**

Definitions

For the purposes of the above statistics the following definitions apply

- **Occupational violence** – any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment.
- **Incident** – an event or circumstance that could have resulted in, or did result in, harm to an employee. Incidents of all severity ratings are included. Code Grey reporting is not included, however, if an incident occurred during the course of a planned or unplanned Code Grey it is included.
- **Accepted WorkCover claims** – accepted WorkCover claims that were lodged in 2023–24
- **Lost time** – lost time is defined as greater than one day.
- **Injury, illness or condition** – this includes all reported harm as a result of the incident, regardless of whether the employee required time off work or submitted a claim.

Financial Results

Summary of Financial Results for last five years

	2024 $000	2023 $000	2022 $000	2021 $000	2020 $000
Operating result*	**(1,581)**	**15**	**5**	**0**	**52**
Total revenue	27,162	27,692	26,021	21,286	19,560
Total expenses	29,779	28,872	27,477	23,126	20,800
Net result from transactions	**(2,617)**	**(1,180)**	**(1,456)**	**(1,300)**	**(1,240)**
Total other economic flows	19	(19)	177	134	(35)
Net result	**(2,598)**	**(1,199)**	**(1,279)**	**(1,166)**	**(1,275)**
Total assets	58,075	49,023	48,439	51,157	49,065
Total liabilities	19,619	18,837	17,054	20,915	18,066
Net assets/Total equity	**38,456**	**30,186**	**31,385**	**30,242**	**30,999**

* The Operating result is the result for which the heath service is monitored in its Statement of Priorities.

Mansfield District Hospital's net result for 2023–24 is a $2.598 million deficit, which considers other economic flows (such as Long Service Leave liability revalued for changed bond rates), capital purpose income and depreciation and amortisation costs. The Operating Result, of $1.581m deficit for the year, was favourable to the target included in the Statement of Priorities of $1.65m deficit.

Reconciliation between the Net Result from Transactions reported in the Financial Statements to the Operating Result as agreed in the Statement of Priorities

	2023–24 $000
Operating result	**(1,581)**
Capital purpose income	670
COVID-19 State Supply Arrangements Assets received free of charge or for nil consideration under the State Supply	67
State supply items consumed up to 30 June 2024	(57)
Expenditure for capital purpose	(22)
Depreciation and amortisation	(1,648)
Finance costs (other)	(27)
Net results from transactions	**(2,598)**

Consultancies

Details of consultancies (under $10,000)
In 2023–2024 there were 9 consultancies where the total fees payable to the consultants were less than $10,000. The total expenditure during 2023–2024 in relation to these consultancies is $42,165 (exc. GST).

One consultancy related to a review of the Human Function and management within the health service. One was to conduct a training course for staff. Three consultancies were engaged to assist in the preparation of a submission to the Regional Worker Accommodation Fund and four consultancies were to assist in the submission for operating theatre and Urgent Care upgrades to the Rural Health Infrastructure Fund (RHIF) and were funded in the previous year's RHIF funding.

Details of consultancies (valued at $10,000 or greater)
In 2023–2024 there was 1 consultancy where the total fees payable to the consultants were $10,000 or greater (exc. GST). The total expenditure during 2023–2024 in relation to this consultancy was $33,220 (exc. GST).

Consultant	Purpose of Consultancy	Start Date	End Date	Total approved project fee (excl. GST)	Expenditure 2023–24 (excl. GST)	Future Expenditure (excl. GST)
JWP ARCHITECTS	Architecture support in the development of Theatre and Urgent Care RHIF funding submission – design development and documentation – Urgent Care and Theatre compliance upgrade	Jan-23	Ongoing	Estimated $170,000	$33,220	$135,000

Information and Communication Technology (ICT) expenditure

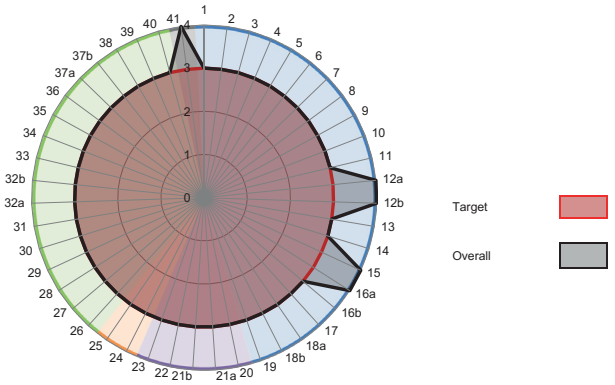
The total ICT expenditure incurred during 2023–2024 is $1,168,097 (excluding GST) with the details shown below.

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)	Operational expenditure (excluding GST)	Capital expenditure (excluding GST)
$1,168,097	$0	$0	$0

Asset Management Accountability Framework

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

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



Status	Scale
Not Applicable	N/A
Innocence	0
Awareness	1
Developing	2
Competence	3
Optimising	4
Unassessed	U/A

Disclosure of review and study expenses

There were no reviews or studies undertaken in 2023–24.

Disclosures Required Under Legislation

Freedom of Information Act 1982

During 2023–24, Mansfield District Hospital received 23 applications. Of these requests, 0 were carried over from 2022–23. All requests were made by members of the general public.

Mansfield District Hospital made 23 FOI decisions during the 12 months ended 30 June 2024.

There were 23 decisions made within the statutory time periods. Of the decisions made outside time, 0 were made within a further 45 days and 0 decisions were made in greater than 45 days. A total; of 20 FOI access decisions were made where access to documents was granted in full, granted in part or denied in full. Nil decisions were made after mandatory extensions had been applied or extensions were agreed upon by the applicant. Of requests finalised, the average number of days over/under the statutory time (including extended timeframes) to decide the request was 15 days.

During 2023–24 0 requests were subject to a complaint/internal review by Office of the Victorian Information Commissioner. No requests progressed to the Victorian Civil and Administrative Tribunal (VCAT).

Freedom of Information applications are made to the Freedom of Information Officer and are dealt with in accordance with the Act. Any charges applied are in accordance with the Act and Regulations.

Information on making a Freedom of Information request can be found at https://mdh.org.au/freedom-information-requests.html. Applications may be submitted by post or in person.

Building Act 1993

Mansfield District Hospital has complied with building and maintenance provisions of the *Building Act 1993* guidelines for publicly owned buildings. Mansfield District Hospital also complied with the relevant provisions of the National Construction Code.

Public Interest Disclosure Act 2012

Complaints about certain serious misconduct or corruption involving public health services in Victoria can be made by individuals directly to the Independent Broad-based Anti-corruption Commission (IBAC). Individuals with concerns about corrupt or improper conduct are encouraged to raise the matter directly with IBAC.

Mansfield District Hospital is committed to extending the protections under the *Public Interest Disclosure Act 2012* (Vic) to individuals who make protected disclosures under that Act, or who cooperate with investigations into protected disclosures. Websites of interest for complaint procedures regarding this Act are: http://www.ibac.vic.gov.au and http://www.ombudsman.vic.gov.au

Statement on National Competition Policy

Mansfield District Hospital complied with government policies regarding competitive neutrality including *Competitive Neutrality Policy Victoria.*

Carers Recognition Act 2012

Mansfield District Hospital has complied with its obligations under Section 11 of the Act for the reporting period 1 July 2023 to 30 June 2024.

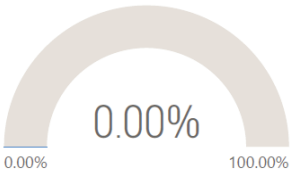
The Health Service has taken practical measures to comply with its obligations under the Act.

These include:

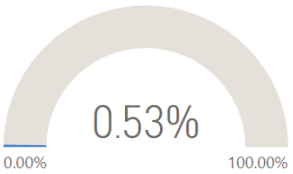
- ensuring our staff have an awareness and understanding of the care relationship principles set out in the Act
- considering the care relationships principles set out in the Act when setting policies and providing services. We have employment policies allowing for flexible working arrangements and leave provisions that promote and facilitate a work life balance.
- implementing priority actions that recognise and support Victoria's carers.

Social Procurement Activities

Social Benefit Supplier Spend as a Proportion of Total Supplier Spend

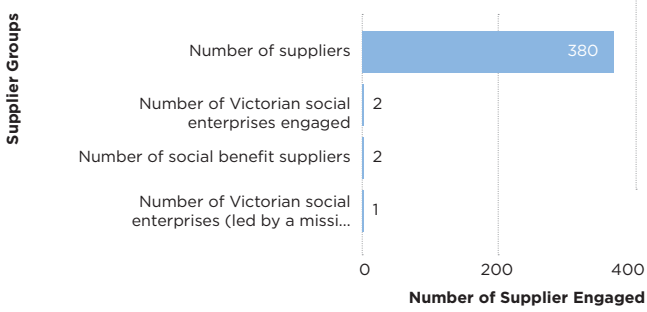


Social Benefit Suppliers as a Proportion of Total Suppliers



Total Expenditure by Spend Metric Description

Total Number of Suppliers by Supplier Group



Public environment report – Mansfield District Hospital – 2023–2024

GREENHOUSE GAS EMISSIONS

Total greenhouse gas emissions (tonnes CO_2e)	2021–22	2022–23	2023–24
Scope 1	184	74	231
Scope 2	678	656	510
Scope 3	147	181	194
Total	**1,009**	**842**	**935**

Normalised greenhouse gas emissions	2021–22	2022–23	2023–24
Emissions per unit of floor space ($kgCO_2e/m^2$)	152.3313	127.1452	141.2228
Emissions per unit of Separations ($kgCO_2e$/Separations)	519.5892	448.4611	517.4005
Emissions per unit of bed-day (LOS+Aged Care OBD) ($kgCO_2e$/OBD)	36.7365	30.8536	33.3581

STATIONARY ENERGY

Total stationary energy purchased by energy type (GJ)	2021–22	2022–23	2023–24
Electricity	2,682	2,797	2,792
Liquefied Petroleum Gas	2,976	2,051	3,759
Total	**5,658**	**4,848**	**6,551**

Normalised stationary energy consumption	2021–22	2022–23	2023–24
Energy per unit of floor space (GJ/m^2)	0.8541	0.7319	0.9890
Energy per unit of Separations (GJ/Separations)	2.9132	2.5816	3.6234
Energy per unit of bed-day (LOS+Aged Care OBD) (GJ/OBD)	0.2060	0.1776	0.2336

WATER

Total water consumption by type (kL)	2021–22	2022–23	2023–24
Potable Water	7,692	6,811	7,043
Total	**7,692**	**6,811**	**7,043**

Normalised water consumption (Potable + Class A)	2021–22	2022–23	2023–24
Water per unit of floor space (kL/m^2)	1.1612	1.0316	1.0632
Water per unit of Separations (kL/Separations)	3.9608	3.6426	3.8954
Water per unit of bed-day (LOS+Aged Care OBD) (kL/OBD)	0.2800	0.2496	0.2511

WASTE AND RECYCLING

Waste	2021–22	2022–23	2023–24
Total waste generated (kg clinical waste + kg general waste + kg recycling waste)	61,169	57,487	41,953
Total waste to landfill generated (kg clinical waste + kg general waste)	48,217	44,782	32,300
Total waste to landfill per patient treated ((kg clinical waste + kg general waste)/PPT)	1.6395	1.3822	1.0230
Recycling rate % (kg recycling/(kg general waste + kg recycling))	23.9595%	22.1007%	23.0081%

TRANSPORT

Corporate Transport	2021–22	2022–23	2023–24
Tonnes CO_2-e Corporate transport	3.4068	3.1989	3.7129

EXPENDITURE

Expenditure Rates ($ thousand)	2021–22	2022–23	2023–24
Electricity	140.5575	146.0271	150.0287
LPG	82.41393	46.12	71.68
Potable Water	22.0358	20.37	22.3153
Total	**245**	**213**	**244**

Normalised expenditure rates (Electricity, Natural Gas, Potable Water, Steam, Diesel Oil in Buildings)	2021–22	2022–23	2023–24
Expenditure per unit of floor space ($ thousand/m^2)	0.025	0.032	0.037
Expenditure per unit of Separations ($ thousand/separation)	0.084	0.113	0.135
Expenditure per unit of bed-day ($ thousand/(LOS+Aged Care OBD))	0.006	0.008	0.009
Expenditure per unit of Aged Care Bed Day ($ thousand/Aged Care OBD)	0.007	0.009	0.011

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):

- a statement that declarations of pecuniary interests have been duly completed by all relevant officers
- details of shares held by senior officers as nominee or held beneficially in a statutory authority or subsidiary;
- details of publications produced by Mansfield District Hospital 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;
- 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;
- 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.

Local Jobs First Act 2003

There were no contracts undertaken requiring reporting in this category in 2023–24.

Gender Equality Act 2020

Mansfield District Hospital has undertaken and revised health service policies and work instructions relevant to the *Gender Equality Act 2020*. Mansfield District Hospital has completed a Gender Equality Audit and Gender Equality Action Plan that has previously been submitted to the Department for consideration and approval.

Attestations and Declarations

Financial Management Compliance Attestation

I, Karen Bennetts, on behalf of the Responsible Body, certify that Mansfield District Hospital has no Material Compliance Deficiency with respect to the applicable Standing Directions under the *Financial Management Act 1994* and Instructions.

Karen Bennetts
Responsible Officer
Mansfield District Hospital
17 October 2024

Data Integrity Declaration

I, Cameron Butler, certify that Mansfield District Hospital has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. Mansfield District Hospital has critically reviewed these controls and processes during the year.

Cameron Butler
Accountable Officer
Mansfield District Hospital
17 October 2024

Conflict of Interest Declaration

I, Cameron Butler, certify that Mansfield District Hospital has put in place appropriate internal controls and processes to ensure that it 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 Mansfield District Hospital 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 documentation at each executive board meeting.

Cameron Butler
Accountable Officer
Mansfield District Hospital
17 October 2024

Integrity, Fraud and Corruption Declaration

I, Cameron Butler, certify that Mansfield District Hospital has put in place appropriate internal controls and processes to ensure that integrity, fraud and corruption risks have been reviewed and addressed at Mansfield District Hospital during the year.

Cameron Butler
Accountable Officer
Mansfield District Hospital
17 October 2024

Compliance with Health Share Victoria (HSV) Purchasing Policies

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

Cameron Butler
Accountable Officer
Mansfield District Hospital
17 October 2024

Safe Patient Care Act 2015

The hospital has no matters to report in relation to its obligations under Part 3 (clause 40) of the *Safe Patient Care Act 2015*.

Statement of Priorities – Part A Strategic Priorities

In 2023–24 Mansfield District Hospital contributed to the achievement of the Victorian Government's commitments by:

EXCELLENCE IN CLINICAL GOVERNANCE

Goals	Health Service Deliverables	Achievements/Outcome
MA1 Develop strong and effective relationships with consumer and clinical partners to drive service improvements.	MA 1 Participating in SCV's 100,000 Lives Program – Stay Well, Stay Home Collaborative which focuses on reducing hospital acquired complications in cardiovascular disease.	Status: Ongoing In progress as part of Hume Health Partnership we are collaborating with Goulburn Valley Health on recommendations.
	MA 1 Implement the actions and recommendations from MDH external review into consumer engagement.	Status: Ongoing Recommendations from the review into consumer engagement have commenced and will continue throughout 2024–25.
MA6 Improve access to timely emergency care by implementing strategies that improve whole of system patient flow to reduce emergency department wait times and improve ambulance to health service handover times.	MA 6 Adopt models of care that ensure the appropriate skill mix, and senior decision makers in the right places to manage the volume of patients and health service demands.	Status: Achieved New model of care introduced to provide experienced clinical staff to the Urgent Care Centre.
	MA6 Work with VMOs to ensure 24/7 presence and availability of medical practitioners to Urgent Care.	Status: Achieved Medical workforce rostered to the Urgent Care Centre each day with additional resources during peak holiday periods.
MA11 Develop strong and effective systems to support early and accurate recognition and management of deterioration of paediatric patients.	MA11 Partner with Safer Care Victoria (SCV) and relevant multidisciplinary groups to establish protocols and auditing processes to manage effective monitoring escalation of deterioration in paediatric patients via ViCTOR charts.	Status: Ongoing Participation with Acute Care Learning Health Network (SAFERCARE) and introduction to ViCTOR – The Education Hub (rch.org.au) to manage effective monitoring and escalation of deteriorating paediatric patients.
	MA11 Improve paediatric patient outcomes through implementation of the ViCTOR track and trigger observation chart and escalation system, whenever children have observations taken.	Status: Ongoing ViCTOR charts implemented into Mansfield District Hospital (MDH) Urgent Care Centre. Regular audit and review of paediatric patient deterioration in Morbidity and Mortality Meetings to identify learnings.
	MA11 Implement staff training on the ViCTOR track and trigger tool to enhance identification and prompt response to deteriorating paediatric patient conditions.	Status: Ongoing Workforce participation in scheduled training on the ViCTOR track and trigger tool and all staff access to ViCTOR – The Education Hub (rch.org.au). Multidisciplinary SIM sessions, Royal Children's Hospital Outreach Program – Urgent Care Centre Paediatric Education attended to continue to enhance early identification and response to the deteriorating paediatric patient.

WORKING TO ENSURE LONG TERM FINANCIAL SUSTAINABILITY

Goals	Health Service Deliverables	Achievements/Outcome
MB1 Co-operate with and support Department-led reforms that look towards reducing waste and improving efficiency to address financial sustainability, operational and safety performance, and system management.	MB1 Operational efficiency improvements: Develop and implement strategies to improve operational efficiency, such as reducing waiting times, improving patient flow, and optimising resource allocation.	Status: Achieved Strategies implemented to reduce waiting time for surgery, haemodialysis, home support services and residential aged care.
	MB1 Data-driven decision-making: Utilise data analytics and performance metrics to identify areas of inefficiency and waste, and make evidence-based decisions to improve financial sustainability and operational performance.	Status: Ongoing Continuous reporting of financial results and data to management via internal performance meetings. Support in interpretation of results to engage management in the identification of areas of efficiency improvement. Utilisation of information provided by management to inform budgeting and forecasting, supporting financial sustainability. Implementation of plans developed in collaboration with management and executive for improvement of operational performance.
MB2 Development of a health service financial sustainability plan in partnership with the Department with a goal to achieving long term health service safety and sustainability.	MB2 Financial forecasting and risk management: Develop robust financial forecasting models to project future revenue and expenditure, identify financial risks, and implement risk mitigation strategies to ensure long-term sustainability.	Status: Ongoing Financial forecasting model developed to identify financial risks both current and future including the impact on residential aged care revenue resulting from the capital building project.
	MB2 Long-term investment planning: Develop a comprehensive investment plan that aligns with the health service's strategic priorities, focusing on initiatives that have a positive impact on health outcomes and financial sustainability.	Status: Ongoing Investment plan developed to maximise financial return on available funds. Current master plan in review to ensure alignment with strategic priorities.

IMPROVING ACCESS TO HEALTHCARE AND WELLBEING

Goals	Health Service Deliverables	Achievements/Outcome
MC1 Address service access issues and equity of health outcomes for rural and regional people including more support for primary, community, home-based and virtual care, and addiction services.	MC1 Plans to identify and prioritise the health, wellbeing and service needs of the Aboriginal catchment population and service users – including improved patient identification, discharge planning and outpatient care.	Status: Achieved Development of the Charter for Inclusion 2023–2026. Review of Admission and Discharge policies, Work Instructions, Risk Assessment tools, Consumer information to strengthen Aboriginal and Torres Strait Islander patient identification and consent to access Aboriginal specific services as an inpatient and after discharge.
	MC1 Partner with Local Aboriginal Network to identify and remedy key barriers to access and utilisation of services by Aboriginal consumers.	Status: Ongoing Continue to link and attend meetings with Gadhaba Local Indigenous Network where discussions take place regarding MDH services, barriers to access and future service redesign.

Goals	Health Service Deliverables	Achievements/Outcome
MC3 Enhance the provision of appropriate and culturally safe services, programs and clinical trials for and as determined by Aboriginal people, embedding the principles of self-determination.	MC3 Design of clinical practice guidelines and learning modules that support optimal clinical assessment, treatment, and management of Aboriginal patients, including protocols that recognise cultural needs, patient complexity and condition prevalence.	Status: Achieved As a member of the Aboriginal Health Innovation Initiative Steering Committee, we have reviewed Admission and Discharge policies, Work Instructions and Risk Assessment tools to strengthen Aboriginal and Torres Strait Islander patient identification, risk and clinical assessment including cultural needs.
	MC3 Promote a culturally safe welcoming environment with Aboriginal cultural symbols and spaces demonstrating, recognising, celebrating and respecting Aboriginal communities and culture.	Aboriginal cultural safety enhanced through use of artwork acknowledging the traditional owners. Collaborating with Gadhaba Local Indigenous Network to identify culturally sensitive place names and art to be included in the aged care redevelopment.

A STRONGER WORKFORCE

Goals	Health Service Deliverables	Achievements/Outcome
MD1 Improve employee experience across four initial focus areas to assure safe, high-quality care: leadership, health and safety, flexibility, and career development and agility.	MD1 Deliver programs to improve employee experience across four initial focus areas: leadership, safety and wellbeing, flexibility, and career development and agility.	Status: Ongoing MDH implemented a range of wellbeing initiatives throughout the year. Additionally, the internal leadership program LEAD took place to nominated future leaders and three staff participated in the regional Clinician 2 Manager program.
	MD1 Support the pilot and/or implementation of new and contemporary models of care and practice, including future roles and building capability for multidisciplinary practice.	Status: Ongoing New model of care for the Urgent Care Centre has been introduced and a model of care for residential aged care to be effective at the completion of the building project is under development.
MD2 Explore new and contemporary models of care and practice, including future roles and capabilities.	MD2 Pilot, implement or evaluate new and contemporary models of care and practice, including future roles and building capability for multidisciplinary practice.	Status: Ongoing New model of care for the Urgent Care Centre has been introduced and a model of care for residential aged care to be effective at the completion of the building project is under development. The new model of care for residential aged care will allow for multidisciplinary practice to enhance the experience of residents through the establishment of a stimulating, safe and homelike environment.
	MD2 Partner with regional and metropolitan health services to provide employment secondment opportunities for employees to work in different health services to broaden knowledge and experience.	Status: Ongoing Attempts at partnering with regional and metropolitan health services to provide secondment opportunities for operating theatre staff and midwives were made. Whilst supported by the health services no staff took up the offer.

MOVING FROM COMPETITION TO COLLABORATION

Goals	Health Service Deliverables	Achievements/Outcome
ME1 Partner with organisations (for example community health, ACCHOs, PHNs, General Practice, private health) to drive further collaboration and build a more integrated system.	ME1 Work with the relevant PHN and community health providers to develop integrated service models that will provide earlier care to patients and support patients following hospital discharge.	Status: Achieved Have continued working with Murray PHN to develop and maintain integrated service models. These include supporting health service clinicians in General Practice, expanding the Mansfield Restart program to support and rehabilitate people living with problems associated with addiction. Further the ongoing Care finder role assists elderly people negotiate the health system to identify and access services.
	ME1 Reviewing specialist workforce requirements at a regional or sub-regional level and developing a shared workforce model, including coordinating efforts to attract and retain workforce at a regional or sub-regional level.	Status: Achieved Specialist workforce requirements have been met and a succession plan implemented to assist with recruitment and retention of a medical workforce.
ME2 Engage in integrated planning and service design approaches, whilst assuring consistent and strong clinical governance, with partners to join up the system to deliver seamless and sustainable care pathways and build sector collaboration.	ME2 Regional, sub-regional or local regional health needs assessment to develop a population health plan.	Status: Ongoing Participation in the Hume Region Strategic Services Partnership has occurred. Working towards implementation of the recommendations inline with other partnership members.
	ME2 Partner with referring health services to facilitate early transfer of consumers back to the health service.	Status: Ongoing Have actively worked with larger health services, both regional and metropolitan to enable the transfer of consumers back to Mansfield as soon as possible.

EMPOWERING PEOPLE TO KEEP HEALTHY AND SAFE IN THE COMMUNITY

Goals	Health Service Deliverables	Achievements/Outcome
EA2 Improve the health and wellbeing of our communities, families and individuals by focusing on areas of healthy eating, climate change impacts, increased physical activity and reduced rates of harmful drug, alcohol and substance behaviours including vaping.	EA2 Embed smoking and vaping identification and cessation pathways into routine care.	Status: Ongoing Smoking and vaping is identified upon hospital admission and cessation pathways are offered and implemented where there is consumer choice to do so. Smoking and vaping cessation programs are also offered as part of Mansfield Restart.
	EA2 Further implement the Respond program building on the learnings and evaluation undertaken to date.	Status: Ongoing The Respond program continues to be implemented and evaluated with the support of an engaged and active community group.
EA4 Enhance health literacy and promote high-quality health information so that the local community, including those in priority cohorts can apply this knowledge to their own circumstances.	EA4 Support shared patient care, promoting collaboration and sharing of knowledge tailored to specific patient cohorts and circumstances.	Status: Ongoing Collaboration with Hume Health Services Partnership to introduce patient videos as part of pre-operative care. Collaboration with Northeast Health Wangaratta in the ERAS (Early Referral After Surgery) program. ERAS allows select orthopaedic patients to be transferred back to their local health service very soon after surgery.
	EA4 Continue to develop health literacy within consumers through review of language used in current resources and respond to feedback of consumers.	Status: Achieved Consumers were engaged to review language in the website upgrade. All brochures and publications are reviewed by a consumer group.

ELECTIVE: CARE CLOSE TO HOME

Goals	Health Service Deliverables	Achievements/Outcome
EB1 Improve pathways through the health system and implement models of care to enable more people to access care closer to, or in their homes.	EB1 Implement and/or evaluate new/ expanded models of care that address barriers to patients receiving care closer to, or in their home.	Status: Ongoing Haemodialysis has been expanded from three to six days per week allowing more people to access care locally. The infusion service has continued to expand in terms of days of frequency allowing more people to access the service. There has been ongoing collaboration and participation in the work of the regional partnership to increase surgical options closer to home. Continued commitment to a birthing service and ensuring the presence of a medical and midwifery workforce has enabled local women to birth closer to home.
	EB1 Implement programs that increase the number of clinical staff capable and confident to deliver at-home care.	Status: Achieved In conjunction with GOTAFE have run a Certificate program to increase the number and skills of home care workers.

Statement of Priorities – Part B Performance Priorities

High quality and safe care

Key Performance Measure	Target	Result
Infection prevention and control		
Compliance with Hand Hygiene Australia program	85%	88.2%
Percentage of healthcare workers immunised for Influenza	94%	100%
Patient experience		
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – Quarter 1	95%	96.7%
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – Quarter 2	95%	100%
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – Quarter 3	95%	100%
Maternity and newborn		
Percentage of full-term babies (without congenital anomalies) who are considered in poor condition shortly after birth (APGAR score <7 to 5 minutes)	≤ 1.4%	2.5%
Percentage of singleton babies with severe fetal growth restriction (FGR) delivered at 40 or more weeks gestation	< 28.6%	0%
Aboriginal Health		
Percentage of Aboriginal admitted patients who left against medical advice	25% reduction in gap based on prior year's annual rate	N/A

Strong governance, leadership and culture

Key Performance Measure	Target	Result
Organisational culture		
People matter survey – Percentage of staff with an overall positive response to safety culture survey questions	62%	74%

Effective financial management

Key Performance Measure	Target	Result
Operating result ($m)	$(1.650m)	$(1.581m)
Average number of days to pay trade creditors	60 days	45 days
Average number of days to receive patient fee debtors	60 days	40 days
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	1.28
Variance between forecast and actual Net result from transactions (NRFT) for the current financial year ending 30 June	Variance ≤ $250,000	Achieved
Actual number of days available cash, measured on the last day of each month	14 days	4.6 days

* The data included in this annual report was accurate at the time of publication and is subject to validation by official sources from the Department of Health.

Statement of Priorities – Part C

Funding type	2023–24 Activity Achievement	Budget ($'000)
Small Rural		
Supplementation funding	69	**9,798**
Small Rural Primary Health & HACC	3,325	**613**
Small Rural Residential Care	22,748	**1,128**
Small Rural Health Workforce		**336**
Small Rural Other specified funding		**669**
Supplementation funding		**585**
Total Funding		**13,128**

* The data included in this annual report was accurate at the time of publication and is subject to validation by official sources from the Department of Health.

Mansfield District Hospital

ABN 65 866 548 895

Financial Statements for the Financial Year ended 30 June 2024

FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

Mansfield District Hospital presents its audited general purpose financial statements for the financial year ended 30 June 2024 in the following structure to provide users with the information about Mansfield District Hospital's stewardship of the resources entrusted to it.

TABLE OF CONTENTS

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

The attached financial statements for Mansfield District Hospital 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 2024 and the financial position of Mansfield District Hospital at 30 June 2024.

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 17 October 2024.

Dr. K Bennetts
Board Chair

Mansfield
17-Oct-24

Mr C. Butler
Chief Executive Officer

Mansfield
17-Oct-24

Ms K. Fotheringham
Chief Financial Officer

Mansfield
17-Oct-24

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Mansfield District Hospital

Opinion	I have audited the financial report of the Mansfield District Hospital (the health service) which comprises the: • balance sheet as at 30 June 2024 • 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 material accounting policy information • board member's, accountable officer's and chief financial 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 2024 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 of a financial report that is free from material misstatement, whether due to fraud or error. In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
21 October 2024

Dominika Ryan
as delegate for the Auditor-General of Victoria

COMPREHENSIVE OPERATING STATEMENT

for the Financial Year Ended 30 June 2024

	Note	**Total 2024 $'000**	Total 2023 $'000
Revenue and income from transactions			
Operating activities	2.1	25,262	26,433
Non-operating activities	2.1	1,188	919
Share of revenue from Hume Rural Health Alliance JV	8.7	712	340
Total revenue and income from transactions		**27,162**	**27,692**
Expenses from transactions			
Employee expenses	3.1	(22,558)	(22,130)
Supplies and consumables	3.1	(1,790)	(2,062)
Finance costs	3.1	(2)	(2)
Depreciation and amortisation	4.2	(1,648)	(1,682)
Other administrative expenses	3.1	(2,049)	(1,674)
Other operating expenses	3.1	(880)	(948)
Other non-operating expenses	3.1	(152)	(24)
Share of expenses from Hume Rural Health Alliance JV	8.7	(700)	(350)
Total expenses from transactions		**(29,779)**	**(28,872)**
Net result from transactions – net operating balance		**(2,617)**	**(1,180)**
Other economic flows included in net result			
Other gain/(loss) from other economic flows	3.2	19	(19)
Total other economic flows included in net result		**19**	**(19)**
Net result for the year		**(2,598)**	**(1,199)**
Other comprehensive income			
Items that will not be reclassified to net result			
Changes in buildings revaluation surplus	4.1(b)	10,770	–
Changes in land revaluation surplus	4.1(b)	98	–
Total other comprehensive income		**10,868**	**–**
Comprehensive result for the year		**8,270**	**(1,199)**

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

BALANCE SHEET

as at 30 June 2024

	Note	**Total 2024 $'000**	Total 2023 $'000
Current assets			
Cash and cash equivalents	6.2	20,423	20,595
Receivables	5.1	541	742
Inventories		131	113
Prepaid expenses		121	394
Share of current assets in Hume Rural Health Alliance JV	8.7	726	672
Total current assets		**21,942**	**22,516**
Non-current assets			
Receivables	5.1	1,326	1,320
Property, plant and equipment	4.1	34,779	25,154
Share of non-current assets in Hume Rural Health Alliance JV	8.7	28	23
Total non-current assets		**36,133**	**26,497**
Total assets		**58,075**	**49,013**
Current liabilities			
Payables	5.2	1,464	1,328
Contract liabilities	5.3	477	141
Borrowings	6.1	89	79
Employee benefits	3.3	5,163	4,867
Other Liabilities	5.4	11,389	11,484
Share of current liabilities in Hume Rural Health Alliance JV	8.7	414	401
Total current liabilities		**18,996**	**18,300**
Non-current liabilities			
Borrowings	6.1	161	22
Employee benefits	3.3	451	492
Share of non-current liabilities in Hume Rural Health Alliance JV	8.7	11	13
Total non-current liabilities		**623**	**527**
Total liabilities		**19,619**	**18,827**
Net assets		**38,456**	**30,186**
Equity			
Property, plant and equipment revaluation surplus	SCE	38,800	27,932
Contributed capital	SCE	10,853	10,853
Accumulated deficit	SCE	(11,197)	(8,599)
Total equity		**38,456**	**30,186**

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

CASH FLOW STATEMENT

for the Financial Year Ended 30 June 2024

	Note	**Total 2024 $'000**	Total 2023 $'000
Cash flows from operating activities			
Operating grants from Government		20,351	21,401
Capital grants from Government – State		61	60
Patient fees received		2,513	2,347
Donations and bequests received		568	253
GST received from ATO		569	582
Interest and investment income received		1,188	933
Other receipts		1,701	1,860
Total receipts		**26,951**	**27,436**
Employee expenses paid		(22,284)	(22,004)
Payments for supplies and consumables		(1,790)	(1,836)
Payments for repairs and maintenance		(414)	(455)
Finance costs		(2)	(2)
Other payments		(2,109)	(2,228)
Total payments		**(26,599)**	**(26,525)**
Net cash flows from operating activities	8.1	**352**	**911**
Cash flow from investing activities			
Purchase of property, plant and equipment		(388)	(439)
Proceeds from sale of non-financial assets		–	1
Net cash flows from investing activities		**(388)**	**(438)**
Cash flow from financing activities			
Repayment of borrowings		(41)	(37)
Receipt of accommodation deposits		3,033	4,758
Repayment of accommodation deposits		(3,128)	(3,761)
Net cash flows from/(used in) financing activities		**(136)**	**960**
Net increase/(decrease) in cash and cash equivalents held		**(172)**	**1,433**
Cash and cash equivalents at beginning of year		20,595	19,162
Cash and cash equivalents at end of year	6.2	**20,423**	**20,595**

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

STATEMENT OF CHANGES IN EQUITY

for the Financial Year Ended 30 June 2024

	Property, Plant and Equipment Revaluation Surplus $'000	Contributed Capital $'000	Accumulated Deficits $'000	Total $'000
Balance at 30 June 2022	**27,932**	**10,853**	**(7,400)**	**31,385**
Net result for the year	–	–	(1,199)	(1,199)
Balance at 30 June 2023	**27,932**	**10,853**	**(8,599)**	**30,186**
Net result for the year	–	–	(2,598)	(2,598)
Other comprehensive income for the year	10,868	–	–	10,868
Balance at 30 June 2024	**38,800**	**10,853**	**(11,197)**	**38,456**

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

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

Structure

NOTE 1: BASIS OF PREPARATION

These financial statements represent the audited general purpose financial statements for Mansfield District Hospital for the year ended 30 June 2024. The report provides users with information about Mansfield District Hospital's stewardship of the resources entrusted to it.

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

NOTE 1.1: Basis of preparation of the Financial Statements

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

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

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

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

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

The financial statements have been prepared on a going concern basis (refer to Note 8.9 Economic Dependency).

The financial statements are in Australian dollars.

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

The annual financial statements were authorised for issue by the Board of Mansfield District Hospital on 17 October 2024.

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 1.2: Abbreviations and terminology used in the financial statements

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

Reference	Title
AASB	Australian Accounting Standards Board
AASs	Australian Accounting Standards, which include Interpretations
DH	Department of Health
DTF	Department of Treasury and Finance
FMA	Financial Management Act 1994
FRD	Financial Reporting Direction
NWAU	National Weighted Activity Unit
SD	Standing Direction
VAGO	Victorian Auditor General's Office
MDH	Mansfield District Hospital
HRHA	Hume Rural Health Alliance

NOTE 1.3: Joint arrangements

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

Mansfield District Hospital has the following joint arrangements:

- Hume Rural Health Alliance joint venture.

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

NOTE 1.4: Material accounting estimates and judgements

Management make estimates and judgements when preparing the financial statements.

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

Revisions to key estimates are recognised in the period in which the estimate is revised and also in future periods that are affected by the revision.

The material accounting policies and significant management judgements and estimates used, and any changes thereto, are identified at the beginning of each section where applicable and relate to the following disclosures:

- Note 2.1: Revenue and income from transactions
- Note 3.3: Employee benefits and related on-costs
- Note 4.1: Property, plant and equipment
- Note 4.2: Depreciation and amortisation
- Note 5.1: Receivables
- Note 5.2: Payables
- Note 5.3: Contract liabilities
- Note 7.4: Fair value determination

NOTE 1.5: Accounting standards issued but not yet effective

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

Standard	Adoption Date	Impact
AASB 2022-5: *Amendments to Australian Accounting Standards – Lease Liability in a Sale and Leaseback*	Reporting periods beginning on or after 1 January 2024	Adoption of this standard is not expected to have a material impact
AASB 2022-9: *Amendments to Australian Accounting Standards – Insurance Contracts in the Public Sector*	Reporting periods beginning on or after 1 January 2026	Adoption of this standard is not expected to have a material impact
AASB 2022-10: *Amendments to Australian Accounting standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities*	Reporting periods beginning on or after 1 January 2024	An assessment of the impact of the adoption of this standard has not yet been completed.

There are no other accounting standards and interpretations issued by the AASB that are not yet mandatorily applicable to Mansfield District Hospital in future periods.

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 1.6: Goods and Services Tax (GST)

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

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

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

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

NOTE 1.7: Reporting Entity

The financial statements include all the activities of Mansfield District Hospital.

Its principal address is:

53 Highett, Street
Mansfield, Victoria 3722

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

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 2: FUNDING DELIVERY OF OUR SERVICES

Mansfield District Hospital's overall objective is to provide quality health services that support and enhance the wellbeing of all Victorians.

Mansfield District Hospital is predominantly funded by grant funding for the provision of outputs. Mansfield District Hospital also receives income from the supply of services.

Structure

2.1 Revenue and income from transactions

Material judgements and estimates
This section contains the following material judgements and estimates:

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

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 2.1: Revenue and income from transactions

	Note	**Total 2024 $'000**	Total 2023 $'000
Operating activities			
Revenue from contracts with customers			
Government grants (State) – operating		423	340
Government grants (Commonwealth) – operating		7,150	5,968
Patient and resident fees		2,513	2,442
Other revenue from operating activities [1]		313	208
Total revenue from contracts with customers	2.1(a)	**10,399**	**8,958**
Other sources of income			
Government grants (State) – operating		12,778	15,081
Government grants (State) – capital		61	60
Other capital purpose income		569	514
Other revenue from operating activities (including non-capital donations)		1,455	1,820
Total other sources of income		**14,863**	**17,475**
Total revenue and income from operating activities		**25,262**	**26,433**
Non-operating activities			
Income from other sources			
Other interest		1,188	919
Total other sources of income		**1,188**	**919**
Total income from non-operating activities		**1,188**	**919**
Total Revenue and income from transactions		**26,450**	**27,352**

1 Other revenue from operating activities, represent funding from non-government sources, including Murray Primary Health Network.

NOTE 2.1(a): Timing of revenue from contracts with customers

Mansfield District Hospital disaggregates revenue by the timing of revenue recognition	**Total 2024 $'000**	Total 2023 $'000
Goods and services transferred to customers:		
At a point in time	10,399	8,958
Total revenue from contracts with customers	**10,399**	**8,958**

NOTE 2.1(a): Timing of revenue from contracts with customers (continued)

How we recognise revenue and income from operating activities

Government operating grants

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

When both these conditions are satisfied, the health service:
- identifies each performance obligation relating to the revenue
- recognises a contract liability for its obligations under the agreement
- recognises revenue as it satisfied its performance obligations, at a point in time or over time as and when services are rendered.

If a contract liability is recognised, Mansfield District Hospital recognises revenue in profit or loss as and when it satisfies its obligations under the contract, unless a contract modification is entered into between all parties. A contract modification may be obtained in writing, by oral agreement or implied by customary business practices.

Where the contract is not enforceable and/or does not have sufficiently specific performance obligations the health service:
- recognises the asset received in accordance with the recognition requirements of other applicable Accounting Standards (for example, AASB 9, AASB 16, AASB 116 and AASB 138)
- recognises related amounts (being contributions by owners, lease liabilities, financial instruments, provisions, revenue or contract liabilities from a contract with a customer), and
- recognises income immediately in profit or loss as the difference between the initial carrying amount of the asset and the related amount in accordance with AASB 1058 *Income for not-for-profit-entities*.

In contracts with customers, the 'customer' is typically a funding body, who is the party that promises funding in exchange for Mansfield District Hospital's goods or services. Mansfield District Hospital funding bodies often direct that goods or services are to be provided to third party beneficiaries, including individuals or the community at large. In such instances, the customer remains the funding body that has funded the program or activity, however the delivery of goods or services to third party beneficiaries is a characteristic of the promised good or service being transferred to the funding body.

This policy applies to each of Mansfield District Hospital's revenue streams, with information detailed below relating to Mansfield District Hospital's significant revenue streams:

Government grant	Performance obligation
Activity Based Funding (ABF) paid as National Weighted Activity Unit (NWAU)	NWAU is a measure of health service activity expressed as a common unit against which the national efficient price (NEP) is paid. The performance obligations for NWAU are the number and mix of admissions, emergency department presentations and outpatient episodes, and is weighted for clinical complexity. Revenue is recognised at point in time, which is when a patient is discharged.
Residential Aged Care	Funding is provided for the provision of care for aged care residents within facilities at Mansfield District Hospital. The performance obligations include provision of residential accommodations and care from nursing staff and personal care workers. Revenue is recognised at the point in time when the service is provided within the residential aged care facility.

NOTE 2.1(a): Timing of revenue from contracts with customers (continued)

Capital Grants

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

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

Patient and resident fees

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

Commercial activities

Revenue from commercial activities includes items such as catering and property rental income. Commercial activity revenue is recognised at a point in time, upon provision of the goods or service to the customer.

How we recognise income from non-operating activities

Interest income

Interest income is recognised on a time proportionate basis that considers the effective yield of the financial asset, which allocates interest over the relevant period.

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 2.1(b): Fair value of assets and services received free of charge or for nominal consideration

Voluntary Services

Mansfield District Hospital receives volunteer services from members of the community in a number of areas.

Mansfield District Hospital recognises contributions by volunteers in tis financial statements, if the fair value can be readily measured and the services would have been purchased had they not been donated.

Mansfield District Hospital greatly values the services contributed by volunteers but it does not depend on volunteers to deliver its services.

Non-cash contributions from the Department of Health

The Department of Health makes some payments on behalf of Mansfield District Hospital as follows:

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

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 3: THE COST OF DELIVERING OUR SERVICES

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

Structure

3.1 Expenses from Transactions
3.2 Other economic flows
3.3 Employee benefits and related on-costs
3.4 Superannuation

Material judgements and estimates

This section contains the following material judgements and estimates:

Key judgements and estimates	Description
Classifying employee benefit liabilities	Mansfield District Hospital applies material judgment when measuring and classifying its employee benefit liabilities. Employee benefit liabilities are classified as a current liability if Mansfield District Hospital does not have an unconditional right to defer payment beyond 12 months. Annual leave, accrued days off and long service leave entitlements (for staff who have exceeded the minimum vesting period) fall into this category. Employee benefit liabilities are classified as a non-current liability if Mansfield District Hospital has a conditional right to defer payment beyond 12 months. Long service leave entitlements (for staff who have not yet exceeded the minimum vesting period) fall into this category. The health service also applies judgement to determine when it expects its employee entitlements to be paid. With reference to historical data, if the health service does not expect entitlements to be paid within 12 months, the entitlement is measured at its present value. All other entitlements are measured at their nominal value.
Measuring employee benefit liabilities	Mansfield District Hospital applies material judgment when measuring its employee benefit liabilities. The health service applies judgement to determine when it expects its employee entitlements to be paid. With reference to historical data, if the health service does not expect entitlements to be paid within 12 months, the entitlement is measured at its present value, being the expected future payments to employees. Expected future payments incorporate • an inflation rate of 4.450%, reflecting the future wage and salary levels • durations of service and employee departures, which are used to determine the estimated value of long service leave that will be taken in the future, for employees who have not yet reached the vesting period. The estimated rates are between 24.49% and 65.57% • discounting at the rate of 4.348%, as determined with reference to market yields on government bonds at the end of the reporting period. All other entitlements are measured at their nominal value.

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 3.1: Expenses from transactions

	Note	**Total 2024 $'000**	Total 2023 $'000
Salaries and Wages		17,054	16,811
On-costs		2,074	2,046
Agency Expenses		511	139
Fee for Service Medical Officer Expenses		2,694	3,008
Workcover Premium		225	126
Total Employee Expenses		**22,558**	**22,130**
Drug Supplies		165	166
Medical and Surgical Supplies		529	710
Diagnostic and Radiology Supplies		138	284
Other Supplies and Consumables		958	902
Total Supplies and Consumables		**1,790**	**2,062**
Finance Costs		2	2
Total Finance Costs		**2**	**2**
Other Administrative Expenses		2,049	1,674
Total Other Administrative Expenses		**2,049**	**1,674**
Fuel, Light, Power and Water		295	280
Repairs and Maintenance		208	235
Maintenance Contracts		206	220
Medical Indemnity Insurance		146	167
Expenditure for Capital Purposes		25	46
Total other operating expenses		**880**	**948**
Depreciation and Amortisation	4.2	1,648	1,682
Total Depreciation and Amortisation		**1,648**	**1,682**
Bad and doubtful debt expense		152	24
Total other non-operating expenses		**152**	**24**
Total Expenses from Transactions		**29,079**	**28,522**

How we recognise expenses from transactions

Expense recognition

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

Employee expenses

Employee expenses include:

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

Supplies and consumables

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

NOTE 3.1: Expenses from transactions (continued)

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 leases which are recognised in accordance with AASB 16 Leases.

Other operating expenses

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

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

The Department of Health also makes certain payments on behalf of Mansfield District Hospital. These amounts have been brought to account in determining the operating result for the year, by recording them as revenue and recording a corresponding expense.

Non-operating expenses

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

NOTE 3.2: Other economic flows

	2024 $'000	2023 $'000
Net gain/(loss) arising from revaluation of long service liability	19	(19)
Total other gains/(losses) from other economic flows	**19**	**(19)**
Total gains/(losses) from other economic flows	**19**	**(19)**

How we recognise other economic flows

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

- the revaluation of the present value of the long service leave liability due to changes in the bond interest rates.

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 3.3: Employee benefits in the Balance Sheet

	2024 $'000	2023 $'000
Current Provisions		
Accrued days off		
Unconditional and expected to be settled within 12 months (i)	65	65
	65	**65**
Annual Leave		
Unconditional and expected to be settled within 12 months (i)	2,041	1,907
Unconditional and expected to be settled after 12 months (ii)	325	301
	2,366	**2,208**
Long Service Leave		
Unconditional and expected to be settled within 12 months (i)	281	233
Unconditional and expected to be settled after 12 months (ii)	1,865	1,881
	2,146	**2,114**
Provisions Related to Employee Benefit On-Costs		
Unconditional and expected to be settled within 12 months (i)	292	202
Unconditional and expected to be settled after 12 months (ii)	294	278
	586	**480**
Total current employee benefits	**5,163**	**4,867**
Non-Current Provisions		
Conditional long service leave (ii)	397	434
Provisions Related to Employee Benefit On-Costs (ii)	54	58
Total non-current employee benefits	**451**	**492**
Total employee benefits	**5,614**	**5,359**

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

NOTE 3.3(a): Employee Benefits and related on-costs

	2024 $'000	2023 $'000
Current employee benefits and related on-costs		
Unconditional Accrued Days Off	65	65
Unconditional Annual leave Entitlements	2,366	2,208
Unconditional Long Service Leave Entitlements	2,732	2,594
Total Current Employee Benefits and related on-costs	**5,163**	**4,867**
Non-current employee benefits and related on-costs		
Conditional Long Service Leave Entitlements	451	492
Total Non-Current Employee Benefits and Related On-Costs	**451**	**492**
Total Employee Benefits and Related On-Costs	**5,614**	**5,359**
Attributable to:		
Employee benefits	4,974	4,820
Provision for related on costs	640	539
Total employee benefits and related on-costs	**5,614**	**5,359**

NOTE 3.3(b): Provision for related on-costs movement schedule

	2024 $'000	2023 $'000
Carrying amount at start of year	539	544
Additional provisions recognised	204	152
Amounts incurred during the year	(105)	(155)
Net gain/(loss) arising from revaluation of long service liability	2	(2)
Carrying amount at end of year	**640**	**539**

How we recognise employee benefits

Employee benefit recognition

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

No provision has been made for sick leave as all sick leave is non-vesting and it is not considered probable that the average sick leave taken in the future will be greater than the benefits accrued in the future. As sick leave is non-vesting, an expense is recognised in the Statement of Comprehensive Income as sick leave is taken.

Annual leave and accrued days off

Liabilities for annual leave and accrued days off are recognised in the provision for employee benefits as 'current liabilities' because Mansfield District Hospital does not have an unconditional right to defer settlements of these liabilities.

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

- Nominal value – if Mansfield District Hospital expects to wholly settle within 12 months or
- Present value – if Mansfield District Hospital does not expect to wholly settle within 12 months.

Long Service Leave

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

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

The components of this current LSL liability are measured at:

- Nominal value – if Mansfield District Hospital expects to wholly settle within 12 months or
- Present value – if Mansfield District Hospital does not expect to wholly settle within 12 months.

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

Termination benefits

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

Provisions for on-costs related to employee benefits

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

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 3.4: Superannuation

		Paid Contributions	
		2024 $'000	2023 $'000
Fund			
Defined Contribution Plans:	Aware Super	**753**	726
	HESTA	**612**	655
	Other	**608**	504
Total		**1,973**	1,885

There were no contributions outstanding at 30 June 2024.

How we recognise superannuation

Employees of Mansfield District Hospital are entitled to receive superannuation benefits and it contributes to defined contribution plans. There are no employees who are members of defined benefit plans.

Defined contribution superannuation plans

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

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

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY

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

Structure

4.1 Property, plant & equipment
4.2 Depreciation and amortisation
4.3 Impairment of assets

Material judgements and estimates

This section contains the following material judgements and estimates:

Key judgements and estimates	Description
Estimating useful life and residual value of property, plant and equipment	Mansfield District Hospital assigns an estimated useful life to each item of property, plant and equipment. This is used to calculate depreciation of the asset. The health service reviews the useful life, residual value and depreciation rates of all assets at the end of each financial year and where necessary, records a change in accounting estimate.
Estimating useful life of right-of-use assets	The useful life of each right-of-use asset is typically the respective lease term, except where the health service is reasonably certain to exercise a purchase option contained within the lease (if any), in which case the useful life reverts to the estimated useful life of the underlying asset. Mansfield District Hospital applies material judgement to determine whether or not it is reasonably certain to exercise such purchase options.
Identifying indicators of impairment	At the end of each year, Mansfield District Hospital assesses impairment by evaluating the conditions and events specific to the health service that may be indicative of impairment triggers. Where an indication exists, the health service tests the asset for impairment. The health service considers a range of information when performing its assessment, including considering: • If an asset's value has declined more than expected based on normal use • If a significant change in technological, market, economic or legal environment which adversely impacts the way the health service uses an asset • If an asset is obsolete or damaged • If the asset has become idle or if there are plans to discontinue or dispose of the asset before the end of its useful life • If the performance of the asset is or will be worse than initially expected. Where an impairment trigger exists, the health services applies material judgement and estimate to determine the recoverable amount of the asset.

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 4.1: Property, plant and equipment

NOTE 4.1(a): Gross Carrying Amount and Accumulated Depreciation

	2024 $	2023 $
Land at fair value – Crown	1,060	812
Land at fair value – Freehold	1,785	1,858
Total Land at Fair Value	**2,845**	**2,670**
Landscaping Improvements at Fair Value	350	527
Less Accumulated Depreciation	–	(78)
Total Landscaping Improvements at Fair Value	**350**	**449**
Buildings at Fair Value	29,521	21,347
Less Accumulated Depreciation	–	(1,343)
Total Buildings at Fair Value	**29,521**	**20,004**
Building work in progress at cost	–	18
Total Land and Buildings	**32,716**	**23,141**
Medical Equipment at Fair Value	2,964	2,828
Less Accumulated Depreciation	(2,157)	(2,005)
Total Medical Equipment	**807**	**823**
Equipment at Fair Value	3,293	3,242
Less Accumulated Depreciation	(2,409)	(2,274)
Equipment at Fair Value	**884**	**968**
Motor Vehicles at Fair Value	316	316
Less Accumulated Depreciation	(303)	(288)
Right of use – Motor Vehicles	294	104
Less Accumulated Depreciation	(67)	(47)
Motor Vehicles at Fair Value	**240**	**85**
Computers and Communication at Fair Value	86	57
Less Accumulated Depreciation	(47)	(34)
Computers and Communication at Fair Value	**39**	**23**
Furniture and Fittings at Fair Value	649	640
Less Accumulated Depreciation	(556)	(526)
Furniture and Fittings at Fair Value	**93**	**114**
Total Plant and Equipment	**1,256**	**1,189**
Total Property, Plant and Equipment	**34,779**	**25,154**

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 4.1(b): Reconciliation of the carrying amount of class by asset

	Note	Land $'000	Land Improvements $'000	Buildings under construction $'000	Buildings $'000	Plant and Equipment $'000
Balance at 1 July 2022		**2,670**	**471**	**0**	**21,263**	**1,336**
Additions		–	–	18	–	92
Depreciation	4.2	–	(22)	–	(1,259)	(238)
Balance at 1 July 2023	4.1(a)	**2,670**	**449**	**18**	**20,004**	**1,190**
Additions		–	–	–	10	259
Revaluation increments		175	(77)	–	10,770	–
Net Transfers between Classes		–	–	(18)	–	18
Depreciation	4.2	–	(22)	–	(1,263)	(211)
Balance at 30 June 2024	4.1(a)	**2,845**	**350**	**–**	**29,521**	**1,256**

	Note	Medical Equipment $'000	Total $'000
Balance at 1 July 2022		**726**	**26,466**
Additions		260	370
Depreciation	4.2	(163)	(1,682)
Balance at 1 July 2023	4.1(a)	**823**	**25,154**
Additions		136	405
Revaluation increments		–	10,868
Net Transfers between Classes		–	–
Depreciation	4.2	(152)	(1,648)
Balance at 30 June 2024	4.1(a)	**807**	**34,779**

Land and Buildings and Leased Assets

The Valuer-General Victoria undertook to re-value all of Mansfield District Hospitals 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 was 30 June 2024.

NOTE 4.1(b): Reconciliation of the carrying amount of class by asset (continued)

How we recognise property, plant and equipment

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

Initial recognition

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

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

Subsequent measurement

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

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

Further information regarding fair value measurement is disclosed in Note 7.4.

Revaluation

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

An independent valuation of Mansfield District Hospital's property, plant and equipment was performed by the VGV on 30 June 2024. The valuation, which complies with Australian Valuation Standards, was determined with reference to the amount for which an orderly transaction to sell the asset or transfer the liability would take place between market participants at the measurement date, under current market conditions.

Revaluation Surplus

	Note	**2024 $**	2023 $
Balance at the beginning of the reporting period		27,932	27,932
Revaluation increment			
Land	4.1(b)	98	-
Buildings	4.1(b)	10,770	-
Balance at the end of the Reporting Period		**38,800**	**27,932**
*** Represented by:**			
Land		2,270	2,172
Buildings		36,530	25,760
		38,800	**27,932**

NOTE 4.2: Depreciation and amortisation

	2024 $'000	2023 $'000
Depreciation		
Property, plant and equipment		
Buildings	1,263	1,259
Land Improvements	22	22
Plant and Equipment	211	238
Medical Equipment	152	163
Total Depreciation	**1,648**	**1,682**

How we recognise depreciation

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

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

How we recognise amortisation

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

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

	2024	2023
Buildings		
– Structure Shell Building Fabric	5 to 45 years	10 to 40 years
– Land improvements	5 to 45 years	10 to 40 years
– Site Engineering Services and Central Plant	5 to 45 years	10 to 40 years
Central Plant		
– Fit Out	5 to 45 years	10 to 40 years
– Trunk Reticulated Building Systems	5 to 45 years	10 to 40 years
Plant and Equipment	3 to 20 years	3 to 20 years
Medical Equipment	3 to 20 years	3 to 20 years
Computers and Communication	3 to 4 years	3 to 4 years
Furniture and Fittings	5 to 10 years	5 to 10 years
Motor Vehicles	4 to 10 years	4 to 10 years
Intangible Assets	1 to 3 years	1 to 3 years

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

NOTE 4.3: Impairment of assets

How we recognise impairment

At the end of each reporting period, Mansfield District Hospital reviews the carrying amount of its tangible and intangible assets that have a finite useful life, to determine whether there is any indication that an asset may be impaired. The assessment will include consideration of external sources of information and internal sources of information.

If such an indication exists, an impairment test is carried out. Assets with indefinite useful lives (and assets not yet available for use) are tested annually for impairment, in addition to where there is an indication that the asset may be impaired.

When performing an impairment test, Mansfield District Hospital compares the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, to the asset's carrying amount. Any excess of the asset's carrying amount over its recoverable amount is recognised immediately in net result, unless the asset is carried at a revalued amount.

Where an impairment loss on a revalued asset is identified, this is recognised against the asset revaluation surplus in respect of the same class of asset to the extent that the impairment loss does not exceed the cumulative balance recorded in the asset revaluation surplus for that class of asset.

Where it is not possible to estimate the recoverable amount of an individual asset, Mansfield District Hospital estimates the recoverable amount of the cash-generating unit to which the asset belongs.

An allowance for impairment losses of receivables for the year ended 30 June 2024 has been made and disclosed at note 5.1.

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 5: OTHER ASSETS AND LIABILITIES

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

Structure

5.1 Receivables
5.2 Payables
5.3 Contract liabilities
5.4 Other liabilities

Material judgements and estimates

This section contains the following material judgements and estimates:

Key judgements and estimates	Description
Estimating the provision for expected credit losses	Mansfield District Hospital uses a simplified approach to account for the expected credit loss provision. A provision matrix is used, which considers historical experience, external indicators and forward-looking information to determine expected credit loss rates.
Measuring deferred capital grant income	Where Mansfield District Hospital has received funding to construct an identifiable non-financial asset, such funding is recognised as deferred capital grant income until the underlying asset is constructed. Mansfield District Hospital applies material judgement when measuring the deferred capital grant income balance, which references the estimated the stage of completion at the end of each financial year.
Measuring contract liabilities	Mansfield District Hospital applies material judgement to measure its progress towards satisfying a performance obligation as detailed in Note 2. Where a performance obligation is yet to be satisfied, the health service assigns funds to the outstanding obligation and records this as a contract liability until the promised good or service is transferred to the customer.

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 5.1: Receivables

	Note	2024 $'000	2023 $'000
Current receivables			
Contractual			
Inter Hospital Debtors		75	83
Trade Debtors		171	161
Patient Fees		158	392
Allowance for impairment losses	5.1(a)	(25)	(25)
Accrued Revenue		102	45
Total contractual receivables		**481**	**656**
Statutory			
GST Receivable		60	86
Total Statutory Receivables		**60**	**86**
Total current receivables		**541**	**742**
Non-current receivables			
Contractual			
Long Services Leave – Department of Health		1,326	1,320
Total contractual receivables		**1,326**	**1,320**
Total non-current receivables		**1,326**	**1,320**
Total receivables		**1,867**	**2,062**
Total receivables and contract assets		1,867	2,062
GST receivable		(60)	(86)
Total financial assets classified as receivables	7.1(a)	**1,807**	**1,976**

(i) Financial assets classified as receivables and contract assets (Note 7.1(a))

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

	2024 $'000	2023 $'000
Balance at beginning of the year	25	20
Increase in allowance	152	20
Amounts written off during the year	(152)	(15)
Balance at End of Year	**25**	**25**

How we recognise receivables

Receivables consist of:

- **Contractual receivables,** including debtors that relate to goods and services. These receivables are classified as financial instruments and are categorised as 'financial assets at amortised costs'. They are initially recognised at fair value plus any directly attributable transaction costs. The health service holds the contractual receivables with the objective to collect the contractual cash flows and therefore they are subsequently measured at amortised cost using the effective interest method, less any impairment.

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

How we recognise receivables (continued)

- **Statutory receivables,** including Goods and Services Tax (GST) input tax credits that are 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 the nominal amounts 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*.

Impairment losses of contractual receivables

Refer to Note 7.2 (a) for Mansfield District Hospital's contractual impairment losses.

NOTE 5.2: Payables

	Note	**2024 $'000**	2023 $'000
Current payables			
Contractual			
Trade Creditors		247	596
Accrued Salaries and Wages		875	621
Accrued Expenses		313	72
Inter-hospital creditors		10	18
Total Contractual Payables		**1,445**	**1,307**
Statutory			
GST Payable		19	21
Total Statutory Payables		**19**	**21**
Total current payables		**1,464**	**1,328**
Total payables		**1,464**	**1,328**
Total payables		1,464	1,328
GST Payable		(19)	(21)
Total financial liabilities classified as payable	7.1(a)	**1,445**	**1,307**

(i) Financial assets classified as payables (Note 7.1(a))

NOTE 5.2: Payables (continued)

How we recognise payables

Payables consist of:

- **Contractual payables,** including payables that relate to the purchase of goods and services. These payables are classified as financial instruments and measured at amortised cost. Accounts payable and salaries and wages payable represent liabilities for goods and services provided to the Mansfield District Hospital prior to the end of the financial year that are unpaid.
- **Statutory payables,** including Goods and Services Tax (GST) payable. Statutory payables are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from contracts.

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

NOTE 5.3: Contract Liabilities

	Note	**2024 $'000**	2023 $'000
Current			
Contract liabilities		477	141
Total contract liabilities		**477**	**141**

NOTE 5.3(a): Movement in contract liabilities

	2024 $'000	2023 $'000
Opening balance of contract liabilities	141	271
Add: grant consideration for sufficiently specific performance obligations received during the year	8,170	6,333
Less: revenue recognised for the completion of a performance obligation	(7,834)	(6,463)
Total contract liabilities	**477**	**141**

How we recognise contract liabilities

Contract liabilities include consideration received in advance from customers in respect of a number of activity based funding streams from the State Government, Commonwealth Government and Primary Health Network.

Contract liabilities are derecognised and recorded as revenue when promised goods and services are transferred to the customer. Refer to Note 2.1.

NOTE 5.3(a): Movement in contract liabilities (continued)

Financial guarantees

Payments that are contingent under financial guarantee contracts are recognised as a liability, at fair value, at the time the guarantee is issued. Subsequently, should there be a material increase in the likelihood that the guarantee may have to be exercised, the liability is recognised at the higher of the amount determined in accordance with the expected credit loss model under AASB 9 Financial Instruments and the amount initially recognised less, when appropriate, cumulative amortisation recognised.

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

Maturity analysis of payables

Please refer to Note 7.2(b) for the maturity of payables.

NOTE 5.4: Other liabilities

	Note	**2024 $'000**	2023 $'000
Current monies held in trust			
Refundable Accommodation Deposits		11,389	11,484
Total current monies held in trust		**11,389**	**11,484**
Total other liabilities		**11,389**	**11,484**
*** Represented by:**			
– Cash Assets	6.2	11,389	11,484
		11,389	**11,484**

How we recognise other liabilities

Refundable Accommodation Deposit (RAD)/Accommodation Bond liabilities

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

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

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 6: HOW WE FINANCE OUR OPERATIONS

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

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

Structure

6.1 Borrowings
6.2 Cash and cash equivalents
6.3 Commitments for expenditure

Material judgements and estimates

This section contains the following material judgements and estimates:

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

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 6.1: Borrowings

	2024 $'000	2023 $'000
CURRENT		
Current borrowings – Vic Fleet Liability (i)	66	56
Loan with DH (ii)	23	23
Total Current Borrowings	**89**	**79**
NON CURRENT		
Non-Current borrowings – Vic Fleet Liability (i)	161	–
Loan with DH (ii)	–	22
Total Non Current Borrowings	**161**	**22**
TOTAL BORROWINGS	**250**	**101**

(i) Secured by the assets leased.

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

How we recognise borrowings

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

Initial recognition

All borrowings are initially recognised at fair value of the consideration received, less directly attributable transaction costs.

Subsequent measurement

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

Maturity Analysis

Please refer to Note 7.2(b) for the maturity analysis of borrowings.

Defaults and Breaches

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

NOTE 6.2: Cash and cash equivalents

	Note	**2024 $**	2023 $
– Cash on Hand (excluding monies held in trust)		1	1
– Cash at Bank – CBS (excluding monies held in trust)		9,033	9,110
Total cash held for operations		**9,034**	**9,111**
– Cash at Bank (monies held in trust)		11,389	11,484
Total cash held as monies in trust		**11,389**	**11,484**
Total cash and cash equivalents	7.1(a)	**20,423**	**20,595**

How we recognise cash and cash equivalents

Cash and cash equivalents recognised on the balance sheet comprise cash on hand and in banks, deposits at call and highly liquid investments (with an original maturity date of three months or less).

Cash and cash equivalents are held for the purpose of meeting short term cash commitments rather than for investment purposes and 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. The cash flow statement includes monies held in trust.

NOTE 6.3: Commitments for expenditure

	2024 $'000	2023 $'000
Non-cancellable short term and low value asset lease commitments		
Less than one year – printer and photocopier agreement	41	53
Total non-cancellable short term and low value asset lease commitments	**41**	**53**
Total commitments for expenditure (inclusive of GST)	41	53
Less GST recoverable from Australian Tax Office	(4)	(5)
Total commitments for expenditure (exclusive of GST)	**37**	**48**

How we disclose our commitments

Our commitments relate to expenditure and short term and low value leases.

Expenditure commitments

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

Short term and low value leases

Mansfield District Hospital discloses short term and low value lease commitments which are excluded from the measurement of right-of-use assets and lease liabilities. Refer to Note 6.1 for further information.

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 7: RISKS, CONTINGENCIES AND VALUATION UNCERTAINTIES

Mansfield District 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 health service is related mainly to fair value determination.

Structure

7.1 Financial instruments
7.2 Financial risk management objectives and policies
7.3 Contingent assets and contingent liabilities
7.4 Fair value determination

Material judgements and estimates

This section contains the following material judgements and estimates:

Key judgements and estimates	Description
Measuring fair value of non-financial assets	Fair value is measured with reference to highest and best use, that is, the use of the asset by a market participant that is physically possible, legally permissible, financially feasible, and which results in the highest value, or to sell it to another market participant that would use the same asset in its highest and best use. In determining the highest and best use, Mansfield District Hospital has assumed the current use is its highest and best use. Accordingly, characteristics of the health service's assets are considered, including condition, location and any restrictions on the use and disposal of such assets. Mansfield District Hospital uses a range of valuation techniques to estimate fair value, which include the following: • Market approach, which uses prices and other relevant information generated by market transactions involving identical or comparable assets and liabilities. The fair value of Mansfield District Hospital's [specialised land, non-specialised land, non-specialised buildings, investment properties and cultural assets] are measured using this approach. • Cost approach, which reflects the amount that would be required to replace the service capacity of the asset (referred to as current replacement cost). The fair value of Mansfield District Hospital's [specialised buildings, furniture, fittings, plant, equipment and vehicles] are measured using this approach. The health service selects a valuation technique which is considered most appropriate, and for which there is sufficient data available to measure fair value, maximising the use of relevant observable inputs and minimising the use of unobservable inputs. Subsequently, the health service applies material judgement to categorise and disclose such assets within a fair value hierarchy, which includes: • Level 1, using quoted prices (unadjusted) in active markets for identical assets that the health service can access at measurement date. Mansfield District Hospital does not categorise any fair values within this level. • Level 2, inputs other than quoted prices included within Level 1 that are observable for the asset, either directly or indirectly. Mansfield District Hospital does not categorise any fair values in this level. • Level 3, where inputs are unobservable. Mansfield District Hospital categorises specialised land, specialised buildings, plant and equipment, furniture and fittings, vehicles, right-of-use motor vehicles and right-of-use plant and equipment in this level.

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 7.1: Financial Instruments

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

NOTE 7.1(a): Categorisation of financial instruments

2024	Note	Financial assets at amortised cost $'000	Financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets				
Cash and cash equivalents	6.2	20,423	–	20,423
Receivables – Trade Debtors	5.1	379	–	379
Other Receivables	5.1	102	–	102
Long Service Leave – Department of Health	5.1	1,326		1,326
Total Financial Assets (i)		**22,230**	**–**	**22,230**
Financial Liabilities				
Payables	5.2	–	1,445	1,445
Borrowings	6.1	–	250	250
Other Financial Liabilities				
– Refundable Accommodation Deposits	5.4	–	11,389	11,389
Total Financial Liabilities (i)		**–**	**13,084**	**13,084**

2023	Note	Financial assets at amortised cost $'000	Financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets				
Cash and cash equivalents	6.2	20,595	–	20,595
Receivables – Trade Debtors	5.1	611	–	611
Other Receivables	5.1	45	–	45
Long Service Leave – Department of Health	5.1	1,320		1,320
Total Financial Assets (i)		**22,571**	**–**	**22,571**
Financial Liabilities				
Payables	5.2	–	1,307	1,307
Borrowings	6.1	–	101	101
Other Financial Liabilities				
– Refundable Accommodation Deposits	5.4	–	11,484	11,484
Total Financial Liabilities (i)		**–**	**12,893**	**12,893**

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

NOTE 7.1(a): Categorisation of financial instruments (continued)

How we categorise financial instruments

Categories of financial assets

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

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

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

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

Financial assets at amortised cost

Financial assets are measured at amortised cost 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 Mansfield District Hospital solely to collect the contractual cash flows and
- the assets' contractual terms give rise to cash flows that are solely payments of principal and interest on the principal amount outstanding on specific dates.

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

Mansfield District Hospital recognises the following assets in this category:

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

Categories of financial liabilities

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

Financial liabilities at amortised cost

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

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

Mansfield District Hospital recognises the following liabilities in this category:

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

NOTE 7.1(a): Categorisation of financial instruments (continued)

Offsetting financial instruments

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

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

Derecognition of financial assets

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

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

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

Derecognition of financial liabilities

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

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

Reclassification of financial instruments

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

A financial liability reclassification is not permitted.

NOTE 7.2: Financial risk management objectives and policies

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

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

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

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

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 7.2: Financial risk management objectives and policies (continued)

NOTE 7.2(a): Credit risk

Credit risk refers to the possibility that a borrower will default on its financial obligations as and when they fall due. Mansfield District Hospital's exposure to credit risk arises from the potential default of a counter party on their contractual obligations resulting in financial loss to Mansfield District Hospital. Credit risk is measured at fair value and is monitored on a regular basis.

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

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

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

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

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

There has been no material change to Mansfield District Hospital's credit risk profile in the 2024 year.

Impairment of financial assets under AASB 9

Mansfield District Hospital records the allowance for expected credit loss for the relevant financial instruments applying AASB 9's Expected Credit Loss approach. Subject to AASB 9, the impairment assessment includes the health service's contractual 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 an impairment assessment under AASB 9.

The credit loss allowance is classified as an other economic flows in the net result.

NOTE 7.2(a): Credit risk (continued)

Contractual receivables at amortised cost

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

On this basis, Mansfield District Hospital determines the closing loss allowance at the end of the financial year as follows:

30-Jun-23	Current	Less than 1 month	1–3 months	3 months – 1 year	1–5 years	Total
Expected loss rate	2.5%	3.5%	3.0%	5.5%	50.0%	
Gross carrying amount of contractual receivables ($'000)	267	150	67	197	–	681
Loss Allowance	**7**	**5**	**2**	**11**	**–**	**25**

30-Jun-24	Current	Less than 1 month	1–3 months	3 months – 1 year	1–5 years	Total
Expected loss rate	4.0%	5.0%	6.0%	7.0%	50%	
Gross carrying amount of contractual receivables ($'000)	231	128	72	75	–	506
Loss Allowance	**9**	**6**	**4**	**6**	**–**	**25**

Statutory receivables and debt investments at amortised cost

Mansfield District Hospital'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.

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

NOTE 7.2(b): Liquidity risk

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

Mansfield District Hospital is exposed to liquidity risk mainly through the financial liabilities as disclosed in the face of the balance sheet and the amounts related to financial guarantees. The health service manages its liquidity risk by:

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

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

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 7.2(b): Liquidity risk (continued)

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

				Maturity Dates			
2024	Note	**Carrying Amount $'000**	**Nominal Amount $'000**	**Less than 1 month $'000**	**1–3 months $'000**	**3 months – 1 year $'000**	**1–5 years $'000**
Financial Liabilities at amortised cost							
Payables	5.2	1,445	1,445	1,445	–	–	–
Borrowings	6.1	250	250	2	5	15	228
– Refundable Accommodation Deposits		11,389	11,389	160	160	660	10,409
Total Financial Liabilities		**13,084**	**13,084**	**1,607**	**165**	**675**	**10,637**
2023	Note	**Carrying Amount $'000**	**Nominal Amount $'000**	**Less than 1 month $'000**	**1–3 months $'000**	**3 months – 1 year $'000**	**1–5 years $'000**
Financial Liabilities at amortised cost							
Payables	5.2	1,307	1,307	1,307	–	–	–
Borrowings	6.1	101	101	1	2	6	92
– Refundable Accommodation Deposits		11,484	11,484	166	166	666	10,486
Total Financial Liabilities		**12,892**	**12,892**	**1,474**	**168**	**672**	**10,578**

The maturity dates of the refundable accommodation deposits in the table represent the estimated timing of the repayments. Ageing analysis of financial liabilities excludes statutory financial liabilities (ie GST payable).

NOTE 7.2(c): Market risk

Mansfield District Hospital's exposures to market risk are primarily through interest rate risk and equity price risk. Objectives, policies and processes used to manage each of these risks are disclosed below.

Sensitivity disclosure analysis and assumptions

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

- a change in interest rates of 1% up or down

Interest rate risk

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

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

Foreign currency risk

All foreign currency transactions during the financial year are brought to account using the exchange rate in effect at the date of the transaction. Foreign monetary items existing at the end of the reporting period are translated at the closing rate at the date of the end of the reporting period.

NOTE 7.3: Contingent assets and contingent liabilities

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

NOTE 7.4: Fair value determination

How we measure fair value

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

The following assets and liabilities are carried at fair value:
- Property, plant and equipment
- Right-of-use assets
- Lease liabilities

In addition, the fair value of other assets and liabilities that are carried at amortised cost, also need to be determined for disclosure.

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.

Mansfield District Hospital determines whether transfers have occurred between levels in the hierarchy by reassessing categorisation (based on the lowest level input that is significant to the fair value measurement as a whole) at the end of each reporting period. There have been no transfers between levels during the period.

Mansfield District Hospital monitors changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required. The Valuer-General Victoria (VGV) is Mansfield District Hospital's independent valuation agency for property, plant and equipment.

Identifying unobservable inputs (level 3) fair value measurements

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

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

NOTE 7.4(a): Fair value determination of non-financial physical assets

	Note	Total Carrying Amount 30 June 2024 $'000	Fair Value Measurement at End of Reporting Period Using: Level 1 $'000	Level 2 $'000	Level 3 $'000
Specialised Land		2,845	–	–	2,845
Total Land at Fair Value	4.1(a)	**2,845**	**–**	**–**	**2,845**
Land Improvements		350	–	–	350
Total Land Improvements at Fair Value		**350**	**–**	**–**	**350**
Buildings at Fair Value					
Specialised Buildings		29,521	–	–	29,521
Total Buildings at Fair Value	4.1(a)	**29,521**	**–**	**–**	**29,521**
Plant and Equipment at Fair Value	4.1(a)	1,256	–	–	1,256
Medical Equipment at Fair Value	4.1(a)	807	–	–	807
Total Other Plant and Equipment at Fair Value		**2,063**	**–**	**–**	**2,063**
Total non-financial physical assets at fair value		**34,779**	**–**	**–**	**34,779**

	Note	Total Carrying Amount 30 June 2023 $'000	Fair Value Measurement at End of Reporting Period Using: Level 1 $'000	Level 2 $'000	Level 3 $'000
Specialised Land		2,670	–	–	2,670
Total Land at Fair Value	4.1(a)	**2,670**	**–**	**–**	**2,670**
Land Improvements		449	–	–	449
Total Land Improvements at Fair Value		**449**	**–**	**–**	**449**
Buildings at Fair Value					
Specialised Buildings		20,004	–	–	20,004
Total Buildings at Fair Value	4.1(a)	**20,004**	**–**	**–**	**20,004**
Plant and Equipment at Fair Value	4.1(a)	1,190	–	–	1,190
Medical Equipment at Fair Value	4.1(a)	823	–	–	823
Total Other Plant and Equipment at Fair Value		**2,013**	**–**	**–**	**2,013**
Total non-financial physical assets at fair value		**25,136**	**–**	**–**	**25,136**

NOTE 7.4(a): Fair value determination of non-financial physical assets (continued)

How we measure fair value of non-financial assets

The fair value measurement of non-financial physical assets considers the market participant's ability to use the asset in its highest and best use, or to sell it to another market participant that would use the same asset in its highest and best use.

Judgements about highest and best use must consider 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.

Mansfield District Hospital has assumed the current use of a non-financial physical asset is its highest and best use unless market or other factors suggest that a different use by market participants would maximise the value of the asset.

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

Specialised land and specialised buildings

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

During the reporting period, Mansfield District Hospital held Crown Land. The nature of this asset means that there are certain limitations and restrictions imposed on its use and/or disposal that may impact their fair value.

The market approach is also used for specialised land 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 reflects 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 considers 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 Mansfield District Hospital, the current 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 Mansfield District Hospital's specialised land and specialised buildings was performed by the Valuer-General Victoria. The effective date of the valuation is 30 June 2024.

Vehicles

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

Furniture, fittings, plant and equipment

Furniture, fittings, plant and equipment (including medical equipment, computers and communication equipment) 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 current replacement cost will be materially different from the existing carrying amount.

There were no changes in valuation techniques throughout the period to 30 June 2024.

NOTE 7.4(a): Fair value determination of non-financial physical assets (continued)

Reconciliation of level 3 fair value measurement

	Note	Land $'000	Land Improvements $'000	Buildings $'000
Balance at 1 July 2022	4.1(b)	**2,670**	**471**	**21,263**
Additions/(disposals)	4.1(b)	–	–	–
Gains/(losses) recognised in net result – Depreciation	4.2	–	(22)	(1,259)
Balance at 30 June 2023	4.1(b)	**2,670**	**449**	**20,004**
Additions/(disposals)	4.1(b)	–	–	10
Net transfers between classes	4.1(b)	–	–	–
Gains/(losses) recognised in net result – Depreciation	4.2	–	(22)	(1,263)
Items recognised in other comprehensive income – Revaluation		175	(77)	10,770
Balance at 30 June 2024	4.1(b)	**2,845**	**350**	**29,521**

	Note	Plant and Equipment $'000	Medical Equipment $'000
Balance at 1 July 2022	4.1(b)	**1,336**	**726**
Additions/(disposals)	4.1(b)	92	260
Gains/(losses) recognised in net result – Depreciation	4.4	(238)	(163)
Balance at 30 June 2023	4.1(b)	**1,190**	**823**
Additions/(disposals)	4.1(b)	259	136
Net transfers between classes	4.1(b)	18	–
Gains/(losses) recognised in net result – Depreciation	4.4	(211)	(152)
Items recognised in other comprehensive income – Revaluation		–	–
Balance at 30 June 2024	4.1(b)	**1,256**	**807**

Classified in accordance with the fair value hierarchy, refer Note 7.4.

NOTE 7.4(a): Fair value determination of non-financial physical assets (continued)

Fair value determination of level 3 fair value measurement

Asset Class	Likely Valuation Approach	Significant inputs (Level 3 only)
Specialised land	**Market approach**	**– Community Service Obligations (CSO) adjustments [(a)]**
Specialised buildings	**Current replacement cost approach**	**– Cost per square metre – Useful life**
Plant and Equipment	**Current replacement cost approach**	**– Cost per unit – Useful life**
Medical Equipment	**Current replacement cost approach**	**– Cost per unit – Useful life**

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

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 8: OTHER DISCLOSURES

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

Structure

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

NOTE 8.1: Reconciliation of net result for the year to net cash flow from operating activities

	2024 $'000	2023 $'000
NET RESULT FOR THE YEAR	(2,596)	(1,199)
Non-cash movements		
Depreciation and Amortisation	1,648	1,682
Bad and doubtful debts	152	24
Assets and services Received Free of Charge	(67)	(162)
Assets and services Received Free of Charge utilised as Expense	57	156
(Gain)/loss on revaluation of long service leave liability	(19)	19
Movements in assets and liabilities		
(Increase)/Decrease in receivables and contract assets	195	(30)
(Increase)/Decrease in Inventories	(18)	–
(Increase)/Decrease in Prepaid expenses	273	(252)
Increase/(Decrease) in payables and contract liabilities	472	271
Increase/(Decrease) in employee benefits	255	401
Net Cash Inflow/(Outflow) from Operating Activities	**352**	**911**

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 8.2: Responsible persons disclosure

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

	Period
Responsible Ministers:	
The Honourable Mary-Anne Thomas:	
Minister for Health	01/07/2023 – 30/06/2024
Minister for Ambulance Services	02/10/2023 – 30/06/2024
The Honourable Ingrid Stitt MP:	
Minister for Mental Health	02/10/2023 – 30/06/2024
Minister for Ageing	02/10/2023 – 30/06/2024
The Honourable Gabrielle Williams:	
Minister for Mental Health	01/07/2023 – 02/10/2023
Minister for Ambulance Services	01/07/2023 – 02/10/2023
The Honourable Lizzie Blandthorn:	
Minister for Children/Minister for Disability	02/10/2023 – 30/06/2024
Minister for Disability, Ageing and Carers	01/07/2023 – 02/10/2023
Governing Boards	
Dr. K. Bennetts (Chair of the Board)	01/07/2023 – 30/06/2024
Mr. M Hoskin	01/07/2023 – 30/06/2024
Ms. K Lockey	01/07/2023 – 30/06/2024
Ms. L Morgan	01/07/2023 – 30/06/2024
Mr P. Officer	01/07/2023 – 30/06/2024
Ms. R Paulus	01/07/2023 – 30/06/2024
Mr. R Ray	01/07/2023 – 30/06/2024
Mr P. Valerio	01/07/2023 – 30/06/2024
Ms. A Vogt	01/07/2023 – 30/06/2024
Accountable Officer	
Cameron Butler (Chief Executive Officer)	01/07/2023 – 30/06/2024

NOTE 8.2: Responsible persons disclosure (Continued)

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

Income Bands	**2024 No.**	2023 No.
$0 – $10,000	9	10
$200,000 – $209,999	1	1
Total Numbers	**10**	**11**
Total remuneration received by Responsible Persons from the reporting entity amounted to ($'000):	**346**	**291**

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

NOTE 8.3: Remuneration of executives

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

	Total Remuneration	
Remuneration of executive officers (including Key Management Personnel Disclosed in Note 8.4)	**2024 $'000**	2023 $'000
Short term benefits	513	563
Post-employment benefits	51	46
Other long-term benefits	22	14
Total remuneration [i]	**586**	**623**
Total number of executives	4	4
Total annualised employee equivalent [ii]	4	4

i The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of Mansfield District Hospital 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 (such as superannuation guarantee contributions) paid or payable on a discrete basis when employment has ceased.

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

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

NOTE 8.4: Related parties

The Mansfield District Hospital 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 and personal business interests
- cabinet ministers (where applicable) and their close family members
- jointly controlled operations – A member of the Hume Rural Health Alliance Joint Venture and
- all health services 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 Mansfield District Hospital and its controlled entities, directly or indirectly.

Key management personnel

The Board of Directors and the Executive Directors of the Mansfield District Hospital are deemed to be KMPs. This includes the following:

Entity	KMPs	Position Title
Mansfield District Hospital	Dr. K Bennetts	Chair of the Board
Mansfield District Hospital	Mr. M Hoskin	Board Member
Mansfield District Hospital	Ms. K Lockey	Board Member
Mansfield District Hospital	Ms. L Morgan	Board Member
Mansfield District Hospital	Mr P. Officer	Board Member
Mansfield District Hospital	Ms R Paulus	Board Member
Mansfield District Hospital	Mr. R Ray	Board Member
Mansfield District Hospital	Mr P. Valerio	Board Member
Mansfield District Hospital	Ms. A Vogt	Board Member
Mansfield District Hospital	Mr. C Butler	Chief Executive Officer
Mansfield District Hospital	Ms. A Jewitt	Director of Clinical Services
Mansfield District Hospital	Ms. M Spence	Director of Clinical Services
Mansfield District Hospital	Ms. M Green	Director of Operations
Mansfield District Hospital	Ms. K Les	Director of Quality and Safety
Mansfield District Hospital	Ms. K Fotheringham	Director of Finance and Corporate Services

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

NOTE 8.4: Related parties (continued)

Compensation – KMPs	2024 $'000	2023 $'000
Short term Employee Benefits	814	826
Post-employment Benefits	76	68
Other Long-term Benefits	44	20
Total	**934**	**914**

KMPs are also reported in Note 8.2 Responsible Persons or Note 8.3 Remuneration of Executives.

Significant Transactions with Government Related Entities

The Mansfield District Hospital received funding from the Department of Health of $13.261m (2023: $15.38m) and indirect contributions of $0.092m (2023: $0.097m).

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

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

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

Transactions with KMPs and Other Related Parties

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

Outside of normal citizen type transactions with the Mansfield District Hospital, there were no related party transactions that involved key management personnel, their close family members or their personal business interests. No provision has been required, nor any expense recognised, for impairment of receivables from related parties. There were no related party transactions with Cabinet Ministers required to be disclosed in 2024 (2023: none).

There were no related party transactions required to be disclosed for the Mansfield District Hospital Board of Directors, Chief Executive Officer and Executive Directors in 2024 (2023: none).

NOTE 8.5: Remuneration of auditors

	2024 $'000	2023 $'000
Victorian Auditor-General's Office		
Audit of financial statement	31	30
Total remuneration of auditors	**31**	**30**

NOTE 8.6: Events occurring after the balance sheet date

There are no events occurring after the Balance Sheet date.

NOTE 8.7: Jointly arrangements

			Ownership Interest	
Name of Entity	**Principal Activity**	**%**	**2024** %	2023
Hume Rural Health Alliance	The Member Entities have committed to the establishment of Information Systems – including ICT investment facilitation, project delivery, workplace services, business application services, collaboration services and vendor management.		5.15	4.73

Mansfield District Hospital's interest in assets and liabilities of the above joint arrangements are detailed below. The amounts are included in the consolidated financial statements under their respective categories:

	2024 $'000	2023 $'000
Current Assets		
Cash and Cash Equivalents	590	590
Receivables	120	67
Prepayments	16	15
Total Current Assets	**726**	**672**
Non Current Assets		
Property, Plant and Equipment and Intangibles	28	23
Total Non Current Assets	**28**	**23**
Total Assets	**754**	**695**
Current Liabilities		
Payables	312	252
PAS Monies in Trust	99	147
Borrowings	3	3
Total Current Liabilities	**414**	**402**
Non Current Liabilities		
Borrowings	11	13
Total Non Current Liabilities	**11**	**13**
Total Liabilities	**425**	**415**
Net Assets	**329**	**280**

Mansfield District Hospital's interest in revenues and expenses of the above joint arrangements are detailed below. The amounts are included in the consolidated financial statements under their respective categories:

	2024 $'000	2023 $'000
Revenues		
Operating Activities	459	149
Other Income	187	164
Interest Income	26	16
Capital Purpose Income	40	11
Total Revenue	**712**	**340**
Expenses		
Management Fee	284	122
Other Expenses from Continuing Operations	385	189
Capital Purpose Expenditure	22	28
Depreciation and Amortisation	9	11
Total Expenses	**700**	**350**
Net Result	**12**	**(10)**

*Figures obtained from the audited HRHA Joint Venture annual report

Contingent Liabilities and Capital Commitments

There are no known contingent liabilities or capital commitments held by Hume Rural Health Alliance as at balance date.

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2024

NOTE 8.8: Equity

Contributed capital

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

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

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

Property, plant and equipment revaluation surplus

The property, plant and equipment revaluation surplus arises on the revaluation of infrastructure, land and buildings. The revaluation surplus is not normally transferred to the accumulated surpluses/(deficits) on derecognition of the relevant asset.

NOTE 8.9: Economic dependency

Mansfield District Hospital is dependent on the Department of Health for the majority of its revenue used to operate the health service. At the date of this report, the Board of Directors believes the Department of Health will continue to support Mansfield District Hospital.

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