Financial

Glossary

AAS – Australian Accounting Standard

AASB – Australian Accounting Standards Board

AIMS – Agency Information Management System

AHCA – Australian Health Care Agreement

CCU – Critical Care Unit

CEO – Chief Executive Officer

CFO – Chief Finance Officer / Director of Finance

DHS – Department of Human Services

DTF – Department of Treasury and Finance

DVA – Department of Veterans' Affairs

EBA – Enterprise Bargaining Agreement

EFT – Equivalent Full Time

HACC – Home and Community Care

HSA – Health Services Agreement

LSL – Long Service Leave

MHS – Metropolitan Health Service

NHT – Nursing Home Type

SPF – Specific Purpose Fund

TAC – Transport Accident Commission

UIG – Urgent Issues Group

VAED – Victorian Admitted Episode Database

VDP – Voluntary Departure Package

WIES – Weighted Inlier Equivalent Separation

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Finance Return
Form F1

Reporting Requirements

Form F1 is used to report agency level financial data for all sources of funding. The data is requested in accordance with the Health Services Act 1988. The key feature of the financial statements and ratios on the AIMS Form F1 return is to provide the Department of Human Services with information to determine the performance and viability of each reporting entity.

AIMS Form F1 is divided into six parts:

- Statement of Financial Performance
- Statement of Financial Position
- Indicators
- Statement of Cash Flows
- Supplementary Data on Expenses, and
- CEO's or CFO's Comments.

Return of Forms

Forms are to be returned to the Department *within 12 calendar days* following the end of the month for all metropolitan health services, Barwon Health, Bendigo Health Care Group and Ballarat Health Services. All other hospitals are to return the completed F1 within 14 calendar days. Hospitals are to submit data to the Department via the AIMS Online Entry System.

Print outs of the original signed forms must be retained by the hospital and be available to officers of the Department upon request.

Assistance

If assistance is required with the completion of this return, please contact your Regional Office (for regional base and rural hospitals) and respective account manager (for Metropolitan Health Services). For technical assistance on AIMS related problems, please contact the AIMS Help Desk on 03 9616 8595.

Instructions for Completing Form F1

The instructions for completing the F1 are found in the following pages arranged in the numerical order of the F1 format. These instructions are applicable to the actual as well as the projected position. The instructions should be closely adhered to so that the monthly financial returns of the metropolitan health services (MHS) and hospitals are prepared on a consistent and comparable basis. The disclosure requirements of items 42 to 60 will further enhance the understanding and comparability of the financial result and position of the MHS and hospitals.

The projections required of the financial performance, financial position and cash flow statements are for the whole of the financial year 2002–2003. These projections should be based on the budgets of the MHS and hospitals periodically adjusted for change in assumptions and new developments.

Accounting and Reporting Issues

The monthly F1 provides information on the financial result and position of MHS and hospitals to the Department on an accrual basis. The analysis carried out on this information forms the basis of monitoring the industry by the Department and the Minister, which is formalised in the Hospital Performance Reports provided to the Government's Expenditure Review Committee. There have been inconsistencies in the reporting of certain revenue and expenses between MHS and hospitals. The inconsistencies have distorted the comparability of financial results and performance between MHS and hospitals. In particular, the issues relate to the treatment of:

- Non-reciprocal transfers or grants
- The timing of recognising funding revenue for salary increases
- Changes in provision for employee entitlements
- Accounting for public holiday expenses
- Industrial disputes or force majeure events

As usual there are differing views within the industry on accounting policies and Boards may have differing opinions on the best way of recording these items. In order to accommodate these diverse opinions and practices, a disclosure box was introduced to allow the Department to collect further information relevant to explaining and understanding the financial performance of the MHS and hospitals. *These disclosures are found in items 53 to 60 of the F1.*

In addition to financial information provided through monthly F1, hospitals also provide financial information through Annual Reports, Mid Year Financial Reports and Annual Financial Reports. Inconsistencies in reporting of financial information between these financial returns or reports have been identified in the past. The areas of most significance were inconsistencies in the reporting of:

- agency nursing. Some agencies have rightly reported agency nursing costs as 'Agency Costs' in the monthly F1 but classified the same costs as 'Salaries and Wages' in the Annual Report. For the current year F1, agency nursing costs are to be reported in item 2 (Agency Costs – Nursing) of F1 Part 5 costs; and

- recovery of employee related expenses between hospitals. It is common practice among MHS that their medical officers are sent to work in regional / rural hospitals. Some hospitals treated the recovery of costs and expenses relating to these medical officers not as revenue but as a reduction on employee related expenses. All recoveries should be treated as revenue without any offset.

Major Changes for 2002–2003

Statement of Financial Performance

- Output group 129 Aged and Home Care
  i) Items 2ii, 2vi and 20iii are new lines to collect information on nursing home State support and HACC.
  ii) Inpatient Accommodation Fees no longer exist, as there are no inpatients in this output group.

Performance Indicators

- A column for TAC throughput is added.
- Two new indicators have been added namely item 103 VACS Weighted Encounters and item 104 Allied Health—Occasions of Service.

Supplementary Data on Expenses

- Item 2 is amended to read Agency Costs—Nursing. Under this caption, only agency nursing costs are to be reported in this line. Other contracted services depending on their nature should be reported under ‘Supplies and Consumables’ or ‘Other Expenses’.

Fund Accounting

The Finance and Accounting Manual for Public Hospitals describes ‘Fund Accounting’ as separate accounting for cash inflows according to their source and a matching of expenditure according to the source of funds used in expenditure transactions.

Three funds namely the Operating Fund, Capital Fund and Specific Purpose Funds are used to enable a distinction to be drawn in relation to both stocks and flows of funds between those relating to activities undertaken at the behest of government and those undertaken as a result of local community initiatives.

For the purpose of monitoring the financial performance of MHSs/public hospitals, the reporting of operating revenue and expenses in the F1 are grouped into ‘Services supported by Health Service Agreement’ which represents the Operating Fund and ‘Non-HSA initiatives’ which combines the Specific Purpose and Capital Funds. As the non-HSA initiatives play an important part in the financial management of the MHSs/hospitals, the format makes a clear demarcation between controllable non-HSA activities and restricted specific purpose funds which are deemed not under the control of the Boards.

Consolidation and Elimination Column

The F1 requires the reporting of consolidated figures. However it does not provide an elimination column, as the details of elimination are not required. As such all elimination of inter funds transactions should be done outside the F1 in your consolidation worksheet. The 'consolidated' column in AIMS F1 reports only transactions between the entity and third parties.

Part 1A: Revenue

Government Operating Fund

Acute Revenue—Government (Item 1(i))

Variable payment rates for 2002–2003 in respect of Casemix revenue are:

Inpatients

Payment	All Hospitals	Major Providers	Rural Group B >13000 WIES	Rural Group B 7500-13000 WIES	Rural Group B 5000-7500 WIES	Rural Group B <5000 WIES	Rural Group C	Rural Group D & E
Inpatients:								
Public WIES10		$2,515	$2,629	$2,707	$2,773	$2,788	$2,625	$2,659
Private WIES10		$2,058	$2,151	$2,215	$2,270	$2,282	$2,155	$2,187
Rural /Isolate Hospital Payment per WIES10	$17/$42							
Nursing Home Type patient per day	$154							
DVA per WIES 10		$2,603	$2,632	$2,662			$2,702	$2,736
Sub-acute:								
CRAFT (episode)	$10,226							
Rehabilitation level 1	$470							
Rehabilitation level 2	$390							
Geriatric Evaluation and Management	$390							
Interim Care Beds	$269							

(A full listing of the unit rates and conditions of payments for all WIES10 are found in Section A Chapter 5 Summary of 2002–2003 Public Hospital Payment Rate of the Policy and Funding Guidelines 2002–2003).

Non-Admitted Patients (Group A Hospitals, Ballarat and Bendigo)

VACS Variable Grant is $125 per weighted encounter for throughput up to target.
Allied Health per occasion of service is $45 for throughput up to target.

Note that these rates are subject to variation during the year.

All casemix revenue received or accrued for the year-to-date should be recorded in this cell.

Where actual WIES10 for the period is not available, hospitals would need to multiply the actual separations by the most recent estimate of the average conversion factor to derive the estimated WIES10.

The actual/estimated public and private WIES10 and VACS variable grant relating to non-admitted patients weighted encounters should be multiplied by the relevant rates disclosed above to determine the government accrued revenue.

In addition to the above payments, non-reciprocal transfers of an operating nature made to the hospital by the Government should be reported in this cell. Non-reciprocal transfer means a transfer in which the entity receives assets or services or has liabilities extinguished without directly giving approximately equal value in exchange to the other party or parties to the transfer. With the introduction of Statement of Accounting Concept 4 and more importantly the adoption by the Government of Australian Accounting Standards and Accounting and Financial Reporting Bulletin Issue 39 issued by the Department of Treasury and Finance, non-reciprocal transfers or contributions in the form of grants, donations and gifts must be recognised as revenues. An example of these grants is block grants provided by the Department to all MHSs and public hospitals for general equipment and infrastructure maintenance purposes. As these grants are provided for general maintenance of infrastructure and equipment that are mostly located in acute health, it should be reported in this cell. Similarly targeted equipment grants, being specifically dedicated to equipment purchases, are to be reported as capital purposes revenue in item 39(i). Donations and gifts of an operating nature should be reported under item 1(iii) Other Income.

For 2001–2002 same day medical targets are standardised at 6.5% of total funded throughput across Victoria. Some hospitals are excluded from same day medical targets and will not contribute to MHS targets. The exclusions to the caps introduced in 1999–2000 will continue to apply in 2001–02. Same day medical throughput in excess of targets will not be funded except where negotiated under the Department's Hospital Demand Management Strategy.

NHT days are paid for patients in an acute facility or geriatric facility where the length of stay has exceeded 35 days, except where an acute care certificate or equivalent has been signed.

Where actual/estimated WIES10 throughput for the reporting period is greater than target, revenue should be accrued to target. Where actual/estimated WIES10 throughput for the reporting period is lower than target, revenue should be accrued to actual. Section A Chapter 5 and Section B part 5.3 of the Public Hospitals Policy and Funding Guidelines (http://www.health.vic.gov.au/pfg2002/) provide further details that have a bearing on recognition of revenue.

Insurance payments made on behalf of the hospital by the Department of Human Services are contra entries and should be accrued and apportioned between programs based on their proportional amount of expenditure. Such indirect payments should be recorded under 'Government'.

Acute Revenue—Inpatient Accommodation Fees (Item 1(ii))
All accrued private patient fees (with the exception of accrual for the inpatient revenue shortfall, if any, should be taken up in item (i)) must be recorded in this item. Under the Australia Health Care Agreement, Treasury and Finance through the Department will no longer automatically make up for any fall in private patient revenue. However, if the private

health insurance participation rate falls below 29.3% and private patient revenue falls below that of 1998–99; under AHCA, funding will be provided to make up the revenue shortfall. Further details on private patient revenue are also found in Section B part 5.3 of the Public Hospitals Policy and Funding Guidelines.

Bad debts recovered should be offset against doubtful debt provision incurred by this program in item 19.

Acute Revenue—Other Income (Item 1(iii))
This cell includes all accrued outpatient fees and pharmaceutical charges as well as interest income. Income from Operating Fund's bank accounts and other investments should be allocated to their output group. If this data is unavailable, interest income should be apportioned on the basis of the output group's percentage share of total revenue.

Facilities fees recovered on revenue from Medicare funded MRI services is to be reported here. Corresponding MRI operating expenses are to be reported in item 19(ii) Acute Non-Admitted Services.

Hospitals that receive 'cash' donations or donations and gifts of an operating nature should record these amounts as revenue in the Operating Fund or Specific Purpose Fund depending upon whether or not the donor specifies obligations/conditions with respect to disbursement and according to the program that raises the cash. For example, general donations collected from 'Accident and Emergency' area should be recorded in the Operating Fund as revenue against Output Group 111: Acute Health.

Aged and Home Care Revenue—Government (Item 2(i))
Aged Care revenue from Government grants includes nursing homes, palliative care, adult day centres, and all other approved and funded services and special initiatives. Hospitals that receive an operating grant for aged care services should report these amounts in this item.

The component of this item relating to aged care services from government grants should reflect the accrued revenue for the period based on the actual level of activity in each of the sub program levels for the reporting period. These accruals should take account of any limits of sub program and ensure that cumulative revenue does not exceed the agreed revenue figure, where applicable, that exists in the Health Service Agreement. The following example is provided to illustrate the point.

Cognitive Dementia Memory Services Clinic

Budget	$100,000 pa
Target	1,000 attendances
Unit costs per attendance	$100
YTD attendances to 31/5/01	950
Accrued revenue to 31/5/01	$95,000

If the agency recorded 80 attendances in the month of June, it would be incorrect to record the accrued revenue for the period as 80 x $100 or $8,000 as only $5,000 of this revenue will be received from the Department (that is, the difference between the May accrued revenue of $95,000 and the annual budget of $100,000).

Note: As non-admitted services budgets are capped, the maximum amount an agency will receive for the provision of CDAMS services in the above example is $100,000, so it is therefore incorrect to accrue greater than the 1,000 attendances *at the budget unit cost.*

This does not however, preclude an agency from utilising productivity improvement in order to increase total attendances thus reducing unit costs.

Only the Department of Human Services recurrent grants should be reported in this item.

All Commonwealth contributions for residential care are to be reported as inpatients accommodation fees in item 2(v). All hostel activities should be reported in the non-Health Services Agreement initiatives section (under item 9 for revenue and item 27 for expenditure).

Government – Nursing Home State Support (Item 2(ii))
Refers to State funding to supplement Commonwealth SAM payment which includes small nursing home top up and rural supplements

Aged and Home Care Revenue—Nursing Home Resident Fees (Item 2(iii))
This item includes fees paid by residents of nursing homes. The care fees paid by all residents are 85% of the aged pension or the equivalent amount for non-pensioners. There is an additional care fee that is income-tested in accordance with Commonwealth guidelines.

Payments received from the State Government such as the adjusted subsidy reduction (formerly know as the SAM top-up) should be reported under 2(ii) and EBA top-up funding should be reported under item 2(i).

Payments received from the Commonwealth Government for nursing home residents should be recorded under item 2(iv).

Aged and Home Care Revenue—Nursing Home Commonwealth Revenue (Item 2(iv))
This item includes all revenue received from the Commonwealth for nursing home resident services. This item should record resident's care subsidy payments and other supplement payments such as the oxygen supplement, enternal supplement, and pensioner concessional supplement.

Aged and Home Care Revenue—HACC (Item 2(v))
Refers to State funding for the provision of community services such as nursing, allied health, house maintenance and meals on wheels

Aged and Home Care Revenue—Other Income (Item 2(vi))
Includes investment income and contributions readily identifiable with Aged and Home Care services. For further information, refer to item 1(iii).

Mental Health Revenue—Government (Item 3(i))
'Psychiatric Services' includes public psychiatric specialist units, mainstreamed psychiatric acute care units, psycho-geriatric services, crisis assessment teams, mobile support and treatment, home based outreach program, community residential rehabilitation care, psychosocial rehabilitation day program and related support services. The amount reported here should be accrued by dividing the annual grant as stated in the Health Service Agreement by the number of days in the year and then multiply that amount by the number of days in the month.

Mental Health Revenue—Inpatient Accommodation Fees (Item 3(ii))
Revenue from patients and Commonwealth contributions for jointly funded services such as psycho-geriatric residential aged services should be recorded under this item.

Mental Health Revenue—Other Income (Item 3(iii))
Includes investment income and contributions readily identifiable with psychiatric care. For more information, please refer to Item 1(iii).

Primary Health Revenue—Government (Item 4(i))
Primary health includes community health services (e.g. podiatry, community health nursing, counselling), innovative health services for homeless youth, alcohol and drug, family planning and suicide prevention. The component of this item related to primary health services should be accrued by dividing the annual grant as stated in the Health Service Agreement by the number of days in the year and then multiply that amount by the number of days in the month.

Primary Health Revenue—Other Income (Item 4(ii))
Includes investment income and contributions readily identifiable with primary health. For further information, refer to Item 1(iii).

Other Output Group Revenue (Item 5)
Public Health and programs other than those mentioned above are to be reported under this heading. The above explanatory notes are also applicable to the appropriate sub headings. Non-admitted patient fees are fees derived from outpatients.

Total HSA Revenue (Item 6)
The total for this item is computed by the system automatically and is the sum of items 1 to 5 in the services supported by Health Services Agreement column.

Non-HSA Initiatives

Non-HSA initiatives generally refer to activities, which *do not have financial support from the Department of Human Services.* A clear demarcation is established under these initiatives between activities that the Boards have control and those that they do not have. Business unit, controlled entity, hostel and property investment activities established and controlled by the Board are categorised as controllable non-HSA activities. All restricted specific purpose funds are considered as not within the control of the Boards.

Business Units (Item 7)
A business unit is a part of the MHS or hospital and is usually not a separate legal entity. The business units provide a range of services to public as well as private patients and others at a profit. The revenue earned and expenses incurred on the provision of goods and services to public patients must be reported in the HSA part of the F1 as public patients are funded under HSA. All other revenue earned and expenses incurred by business units are to be reported under this item. The general characteristics of 'business units' include but are not limited to:

- the sale of goods and services of a retail and commercial or medical nature to external parties;
- the separate accountability such as cost or profit centres for revenue and expenditure; and
- does not receive any income or support from the Department of Human Services on services or goods provided to external party or private patient.

Examples of business units include: cafeterias, food catering, car park, linen services, cleaning services and privatised clinical services.

Property Income (Item 8)
This refers to gross rental income earned on property leases. These properties are generally held for commercial/investment purposes.

Hostel Resident Fees (Item 9(i))
This item refers to accommodation and care fees collected from hostel residents.
Revenue obtained from interest on resident accommodation bonds or retention amounts from accommodation bonds should be reported under Item 40(ii).

Hostel Fees From Commonwealth (Item 9(ii))
This item refers to all funding received from the Commonwealth to support hostel accommodation and care of residents.

Interest and Dividend (Item 10)
This refers to interest and dividend earned on bank accounts and investments attributable to the business unit operations and the management of donations and specific purposes grants. Interest earned on capital funds should be reported in item 40 as 'Other Capital Purpose Income'.

Controlled Entity (Item 11(i))
Controlled entity is a separately incorporated body that includes subsidiaries such as private hospitals. However, the decision making capacity is dominated directly or indirectly by the reporting MHS/hospital in relation to the financial and operating policies of the entity so as to enable the entity to operate under those policies in pursuing the objectives of the reporting hospital. A common form of control within the public hospital industry is the capacity of the reporting hospital to dominate the composition of the board of directors or governing board of another entity.

Controlled Entity—Fund Raising Activities (Item 11(ii))
This refers to controlled entity primarily engages in fund raising activities for the benefit of the MHS/hospital.

General Donations (Item 12)
All untied donations, except those raised for a particular ward or program area, other than tied donations and capital donations are to be reported in this cell. These donations are generally provided without any form of restriction and/or condition.

Other Revenue (Item 13)
This includes all sundry income not reported under items 7 to 12.

Total Controllable Non-HSA Revenue (Item 14)
The total for this item is computed by the system automatically and is the sum of items 7 to 13 in the Non Health Services Agreement Initiatives column.

Total HSA and Controllable Non-HSA Revenue (Item 15)
The total for this item is computed by the system automatically and is the sum of item 6 and item 14 from the respective Health Services Agreement and Non Health Services Agreement Initiatives column.

Restricted Specific Purposes Revenue (Item 16)
This is introduced as a result of the review by an external consultant of the SP Funds. The Consultancy Report indicated three categories of SPF namely certain business units (item7), internally managed SPF (item 13) and restricted purpose SPF. The Department has also issued Guidelines for the Identification and Establishment of SPFs. The Guidelines can be accessed via the Department's website at:

http://www.health.vic.gov.au/ publichospitals/ spfund/spfund.pdf.

The characteristics of a restricted purpose SPF include the following features:

- The fund is established for a *particular or specific purpose (that is, a restriction or condition)* through some forms of legal instrument such as a trust or legal undertaking to comply with the condition or purpose for which the fund is established. The common types would be donation provided to purchase a specified equipment and research grant provided for particular field of interest (items 16i and 16ii).
- A separate board or a separate committee normally manages the fund such as a foundation managed by a separate board. Alternatively, this could be managed by a management auxiliary to the hospital's Board (item 16iii).

The hospital's Board has no effective control on the restricted purpose SPF other than to comply with or to implement the purpose for which the fund is set up. All funding and donations specifically provided for *capital works* are to be reported as such in item 39 or item 40.

Total Restricted Specific Purpose Revenue (Item 17)
The total is computed automatically by the system and is the sum of Items 16(i) to 16(iv) in the Non-HSA Initiatives column.

Total Entity Operating Revenue (Item 18)
The amount in 'Total HSA Revenue' (item 6) will be transferred to 'Total Entity Operating Revenue' (item 18) in the Services Supported by Health Service Agreement column.

The sum of 'Total Controllable Non-HSA Initiatives Revenue' (item 14) and 'Total Restricted Specific Purpose Revenue' (item 17) will be transferred to 'Total Entity Operating Revenue' (item 18) in the Non-HSA Initiatives column.

The System will require the user to key in the Total Entity Operating Revenue in the All Activities Consolidated column. The amount keyed in must equal to the sum of 'Total Entity Operating Revenue' in the Services Supported by Health Service Agreement column and Non-HSA Initiatives column, otherwise the system will display an error message upon completion of data entry and not allow the user to proceed with authorisation until the error is corrected.

Part 1B: Expenses

Items 19 to 23 refer to recurrent expenses accrued on services supported by Health Service Agreement or any other supplementary agreement made with the Department of Human Services.

Acute Services (Item 19)
The expenses include cost of direct patient care for patients admitted to designated acute care beds in public hospitals but exclude the cost of direct patient care for palliative care and psycho-geriatric programs. In 2002–03 these services include sub-acute services such as rehabilitation level 1 and 2, geriatric evaluation and management, nursing home type days and respite. The expenses are to be reported under the classification of Admitted Patients and Non-admitted Patients Services.

Admitted patient is a patient who undergoes a hospital's formal admission process and is admitted as a same-day patient or overnight stay patient. Non-admitted patient is a patient who does not undergo a hospital's formal admission process. There are three categories of non-admitted patient:

- emergency department patient
- outpatient
- other non-admitted patient.

Aged and Home Care—Nursing Home (Item 20(i))
This item refers to expenditure on residential aged care services for nursing home residents. Agencies should ensure that cost attributions of corporate overheads and staff who work part-time in services funded by other output groups (for example, nurses who work across residential aged care and acute or sub-acute services) are accurate and reviewed regularly.

Aged and Home Care—Community Based Services (Item 20(ii))
This item refers to expenditure on programs such as district nursing, community palliative care and cognitive dementia memory services clinic. Agencies should ensure that cost attributions of corporate overheads and staff who work part-time in services funded by other output groups (that is, nurses who work across residential aged care and acute or sub-acute services) are accurate and reviewed regularly.

Aged and Home Care—HACC (Item 20(iii))
Refers to expenses incurred on the provision of community services such as nursing, allied health, house maintenance and meals on wheels.

Aged and Home Care—Other (Item 20(iv))
This item refers to other expenditure not classified in the items above.

Mental Health—Admitted Patients (Item 21(i))
This item refers to expenditure on admitted patients services including mental health acute services, CCU and mental health sub-acute services.

Expenditure on psycho-geriatric residential aged care services should be reported under Item 21(ii).

Mental Health—Others (Item 21(ii))
This item refers to expenditure on psycho-geriatric residential aged care services for nursing home residents and community based mental health services including CATT, MST services. Expenditure under the primary mental health initiative should also be recorded under this item.

Primary Health—Non-admitted Services (Item 22(i))
This item refers to expenditure on client services programs such as primary health and includes community health services (for example, podiatry, community health nursing and counselling, innovative health services for homeless youth, alcohol and drug, family planning and suicide prevention). Agencies should ensure that cost attributions of corporate overheads and staff who work part-time in services funded by other output groups (for example, allied health staff who work across acute or sub-acute services) are accurate and reviewed regularly.

Primary Health—Other (Item 22(ii))
This item refers to expenditure on programs that are not targeted to individual clients such as health promotion, community health planning and primary care partnership developments.

Other Output Groups (Item 23)
This refers to expenditure not reported in output groups mentioned above in items19 to 22. The classification of admitted and non-admitted patients as mentioned in item 19 applies to this output group.

Total HSA Supported Services Expenses (Item 24)
The total shown here is automatically calculated by the system and equals to the sum of items 19 to 23 in the Services Supported by Health Services Agreement column.

Non-HSA Initiatives

Business Units (Item 25)
This relates to all expenses incurred on an accrual basis in generating the revenue of business units as described in item 7.

Property Expenses (Item 26)
This relates to all expenses incurred in generating the property income as described in item 8.

Hostel (Item 27)
This item refers to expenditure on residential aged care services for hostel residents. Agencies should ensure that cost attributions of corporate overheads and staff who work part-time in services funded by other output groups are accurate and reviewed regularly.

Controlled Entities (Item 28(i))
This refers to all expenses incurred on an accrual basis in generating the revenue of controlled entities as described in item 11(i).

Controlled Entities—Fund Raising Activities (Item 28(ii))
This refers to all expenses incurred on an accrual basis in generating the revenue of controlled entities engaged in fund raising activities as described in item 11(ii).

Other Expenses (Item 29)
This refers to all expenses accruing on the Non-HSA initiatives but not included under items 25 to 28 and item 32.

Total Controllable Non-HSA Expenses (Item 30)
The total shown here is automatically calculated by the system and is the sum of items 25 to 29.

Total HSA and Controllable Non-HSA Expenses (Item 31)
The total shown here is automatically calculated by the system and is the sum of items 24 and 30.

Restricted Specific Purposes Expenses (Item 32)
This refers to all expenses accruing on the delivery of services funded under item 16.

Total Entity Operating Expenses (Item 33)
'Total HSA Supported Services Expenses' (item 24) and the sum of 'Total Controllable Non-HSA Initiatives Expenses' (item 30) and 'Restricted Specific Purposes Expenses' (item 32) will be automatically transferred to this item under the respective activity columns. The system allows users to key in the total in the All Activities Consolidated column and compare with the total calculated automatically. The total entered here is the sum of items 24, 30 and 32. If the total does not add up, the system will display an error message upon completion of data entry and not allow the user to proceed with authorisation until the error is corrected.

Surplus (Deficit)—HSA and Controllable Non-HSA Initiatives (Item 34)
The system will generate a total in the respective HSA and Non-HSA activity columns. The system requires a total (=items 6+14-24-30) to be entered into the All Activities Consolidated column and is compared with the total which is calculated automatically. If the total does not match with the automated total, the system will display an error message upon completion of data entry and will not allow the user to proceed with authorisation until the error is corrected.

Entity Operating Surplus/(Deficit) (Item 35)
The system requires totals to be entered into the respective column and is compared with the total which is calculated automatically. The system will also automatically deduct totals in item 33 from those in item 18 to determine the surplus or deficit for the respective activities. If the total does not match, the system will display an error message upon completion of data entry and will not allow user to proceed with authorisation until the error is corrected.

Depreciation (Item 36)
Non-HSA Initiatives activities include those of the Capital Fund that is deemed to hold all the hospital's fixed assets. As such, depreciation on these assets should be treated as an expense of the Non-HSA Initiatives activities. The three common depreciation methods are spelt out in page 51 of the Department of Human Services' Finance and Accounting Manual. The Victorian Healthcare Association has issued a list of depreciation rates that are suitable for use by public hospitals, subject only to unusual conditions prevailing with respect to particular assets. This list appears in the Appendices (page 114) of the Department of Human Services' Finance and Accounting Manual for Public Hospitals.

Depreciation in the first year of acquisition must be computed according to the time the asset was used during the year. Fractions of a month are to be disregarded.

Specific (Abnormal) Items (Item 37)
In 2000–2001, the reference to abnormal items disappears from the accounting standards. Not withstanding this, the Department intends to continue following the existing presentation in the financial statements where depreciation, capital purpose income and abnormal items are shown separately below the 'entity operating surplus/deficit' line. However, abnormal items for this year will be described as 'specific items'. The existing presentation is retained so that results are comparable and consistent with previous years. As the F1 serves the specific monitoring purpose of the Department, the specific revenue or an expense is of such a *size, nature or incidence* that its disclosure is relevant in explaining and understanding the financial performance of the MHSs and hospitals. The requirement is in compliance with section 5.4 of AAS1 (AASB 1018), which became operative from 1 July 2000. Some of the circumstances that may give rise to the separate disclosure of these specific revenues and expenses include:

- the write-down of inventories or non-current assets and, where applicable, the reversal of such write-downs
- litigation settlements
- reversals of provisions
- restructuring of operations
- changes in accounting policies, other than those changes made to comply with a Standard or an Urgent Issues Group Consensus View that requires initial adjustments to be recognised as a direct credit to equity or a direct debit to equity.

A new note is included in the F1 to facilitate the reporting of these specific revenue and expenses (items 42 to 51).

Extraordinary Items (Item 38)
Extraordinary items are to be reported in this cell. Extraordinary items are items of revenue and expense that are attributable to transactions or other events of type that are outside the ordinary operations of the entity and are not of a recurring nature. For example, the sale of a significant operation or all the assets associated with such an operation or the unintended destruction of a property.

Reporting entity is encouraged to provide additional information of these items in Part 6 'CEO's or CFO's Comments on Performance' section of the F1 for better understanding of the operating result.

Capital Purposes Grants (Item 39)
This relates to all tied grants received *for the purpose of acquiring non-current assets such as capital works, plant and equipment* and should be reported as revenue in the Non-HSA Initiatives column.

In 2002–2003 the Department will continue with the capital equipment funding process comprising of two major annual funding pools briefly described as follows:

General Equipment and Infrastructure Maintenance Grants: The annual infrastructure and maintenance grant is provided to hospitals and health services for general equipment and infrastructure maintenance purposes. The grant is provided as a contribution towards maintenance costs of the agencies. Separate funding is provided by the Department to agencies for the replacement of equipment (See *Targeted Equipment Grants).* The allocation of the infrastructure and maintenance grant is based on:

- the size and relative age of equipment of each hospital/health service;
- the inpatient and non admitted patient outputs; and
- the relative financial capacity and resources of the hospital/health service.

The funding source for this grant is the Department of Treasury and Finance's (DTF) appropriation to the Department for the funding of hospital/health service outputs. DTF Bulletin 39 requires that all appropriations for the provision of outputs must be recognised as revenue. The introduction of whole of government reporting for the State of Victoria also requires the consistent treatment of assets, liabilities, revenues and expenses between the Government, Departments and wholly owned public entities. This facilitates the process of uniform reporting and proper consolidation of all the entities involved.

Given the above background and the existing practice of recognising maintenance costs as operating expenses, the Department requires all public hospitals/health services to treat the infrastructure and maintenance grants as an item of recurrent operating revenue in the HSA section of the F1. The Department has issued a Circular 17/2002 advising hospitals of this treatment.

Targeted Equipment Grants: From this funding pool MHS/hospitals bid for grants towards higher cost replacement or new items of equipment not funded under other special purpose capital funding programs. The allocation of these grants is submission based and for the purchase of equipment only. As such funding received under this program has to be reported as capital purpose income.

Hospitals should note the introduction of Accounting and Financial Reporting Bulletin 39 entitled 'Accounting for Contributed Capital' in April 2002. The Bulletin prescribes:

- The public sector entities that can apply Abstract 38 (paragraph 7(c))

- The nature of transfer that is permissible for classification and recognition as contributed capital.

Unless otherwise designated, capital grants made by the Department are to be reported under the 'DHS' sub heading while those made by the community and the Commonwealth are reported under the 'Others' sub-heading.

Other Capital Purpose Income (Item 40(i))
All income (other than those reported in item 39) received *for the specific purpose of acquiring non-current assets such as capital works, plant and equipment should be reported as revenue in the Non-HSA Initiatives column.* The common items to be included here are:

- Donations and bequests specified for the purchase of fixed assets (item 40i)
- The cost of equipment donated by medical practitioners (item 40i)
- Interest earned on accommodation bonds from residents (item 40ii)
- Profit or loss on sale of fixed assets (item 40iii)

Other Capital Purpose Income (Item 40 (ii))
This item refers to income generated from interest on hostel resident's accommodation bonds. This item should also include the monthly retention amount that may be deducted from an accommodation bond. Commonwealth policy requires that these funds are used for capital purposes to providing care for the residents and are managed in accordance with prudential requirements.

The receipt or refund of the principal of accommodation bonds should not be recorded under this item.

Entity Surplus/(Deficit) (Item 41)
The system requires totals to be entered into the respective column and is compared with the total of items 35, 36, 37, 38, 39 and 40 which is calculated automatically. If the total does not match, the system will display an error message upon completion of data entry and will not allow the user to proceed with authorisation until the error is corrected.

Specific Items (Items 42 to 52)
Australian Accounting Standard No.1 no longer makes any reference to abnormal items. Notwithstanding this, the Department intends to continue following the existing presentation in the monthly financial return where depreciation, capital purpose income and abnormal items are shown separately below the line, however abnormal items for this year will be described as 'specific items'. The Department is maintaining the present format for consistency with previous years and to enable readers to focus on the result without the capital items and 'abnormal'. These disclosures refer to those specific revenues and expenses when '... revenue or an expense from ordinary activities is of such a size, nature or incidence that its disclosure is relevant in explaining the financial performance of the entity for the reporting period'. For this reason the F1 has provided a predetermined list of specific revenue and expenses by way of disclosure note for consistent reporting among MHSs and hospitals.

Supplementary Information on Profit and Loss Statement (Item 53)
This refers to disclosure of operating expenses incurred in the current financial year in relation to revenue recognised in the last financial year. This situation is a consequence of recognising non-reciprocal transfer as revenue in previous year with corresponding operating expenses accounted for in the current year.

Supplementary Information on Profit and Loss Statement (Item 54)
This refers to disclosure of revenue recognised in the current financial year without accruing the corresponding operating expenses or having operating expenses recognised only in the following financial year. This situation is a consequence of recognising non-reciprocal transfer as revenue in the current year with corresponding operating expenses accounted for in the following year.

Supplementary Information on Profit and Loss Statement (Item 55)
This refers to disclosure of loss of throughput due to industrial dispute/force majeure and *accrued as revenue*. The WIES lost should not be recognised as revenue until the Department agrees to compensate for the loss. The number of WIES lost is to be disclosed in the 'Allocation' column and the revenue amount accrued is to be reported in the 'Year to Date' column.

Supplementary Information on Profit and Loss Statement (Item 56)
This refers to disclosure of loss of throughput due to industrial dispute/force majeure and *not accrued as revenue*. It is prudent not to recognise the WIES lost as revenue until the Department agrees to compensate for the loss. The number of WIES lost is to be disclosed in the 'Allocation' column and the revenue amount lost is to be reported in the 'Year to Date' column.

Supplementary Information on Profit and Loss Statement (Item 57)
This refers to disclosure of salary increases charged to profit and loss without a similar accrual of the Department's funding. This is a common issue noted on inconsistent recognition of salary expenses and revenue arising from award increases funded by the Department. The problem occurs in the year of renegotiating the awards where the percentage adjustment to salary remains unknown for a few months until final agreement is reached. It follows that funding from the Department through the revised WIES rate is paid in arrears. It often happens that the increased salary costs are accrued without a similar accrual of funding to be received from the Department.

Supplementary Information on Profit and Loss Statement (Item 58)
This refers to change in provision for employee entitlements due to renegotiation of awards. The change in the provision creates a corresponding increase in employee entitlements expense. Currently there is a lack of uniformity in the recognition of this increase in the profit and loss statement among MHS's and hospitals. Some MHS's recognise the increase fully as it happens while others account for the increase pro-rated over the months in the financial year. This information allows the Department to assess the impact of MHS's accounting policy on their respective operating result. The percentage and amount of increase charged to profit and loss are to be disclosed respectively in the 'Allocation' and 'Year to Date' column.

Supplementary Information on Profit and Loss Statement (Item 59)
This refers to the treatment of public holiday costs. Various methods are in use by MHS's and hospitals to account for public holiday costs in the profit and loss statement. This disclosure item requires the reporting of the number and costs of public holidays charged to profit and loss respectively in the 'Allocation' and 'Year to Date' column.

Supplementary Information on Profit and Loss Statement (Item 60)
This refers to Infrastructure and Maintenance grants that are provided by the Department to the MHSs and hospitals for capital purchases as well as for the provision of services. As mentioned in item 39 infrastructure maintenance grants are provided for maintenance purposes and are to be reported as operating revenue in the HSA section. Disclosure made here assists the Department in identifying the respective amount of infrastructure and maintenance grants reported as operating and capital purpose income.

Part 2A: Statement of Financial Position—Equity and Liabilities

Equity

Retained Earnings (Item 61)
This refers to the closing balance on the retained earnings/(accumulated deficit) as at the reporting date.

Contributed Capital (Item 62)
This refers to appropriations or contributions that satisfy the requirements of AAS29 and UIG Abstract 38 on reporting these transfers as contributions by owners. DTF in April 2002 issued an Accounting and Financial Reporting Bulletin 39 that prescribes certain requirements with respect to the application of paragraph 7 (c) of Abstract 38 by wholly – owned public sector entities. The Bulletin prescribes:

- The public sector entities that can apply Abstract 38 (*Appendix D of the Bulletin listed all public hospitals as wholly – owned public sector entities*),
- The nature of transfers that are permissible for classification and recognition as contributed capital,
- The mode and timing of a formal designation that is required for the transfers to be classified and recognised as contributed capital, and
- The measurement basis for the recognition of the transfers as contributed capital.

The Department has also issued Circulars (18/2002 and 19/2002) to provide guidance to hospitals on the working of Bulletin 39. A significant point to note is that no capital grant revenues should be recorded as contributed capital unless notified in writing by the Department.

Major Redevelopment Equity (Item 63)
This forms part of the contributed capital. This line is for reporting of capital grants received for major works such as redevelopment of hospitals. For the allowable transactions (such as appropriation or major works) to be classified as contributed capital they need to be formally designated on or before the time of the transaction. Due to the complexity of the appropriation of funding from DTF to the Department and its on passing to the agencies, no hospital should treat capital grants for major works as contributed capital (major redevelopment equity) unless notified in writing by the Department.

Restricted Specific Purpose Reserves (Item 64)
This refers to funds held for restricted purposes and funds held in perpetuity. Funds held for restricted purposes refer to funds that because of the terms on which they are given or because of a decision of the Board of Management are not available to be used for general activities of the hospital. Examples of these funds are Research Funds, Education Funds, Prize Funds, Charitable Trusts and Private Practice Funds. Funds held in perpetuity refer to endowments from donors where the amount and duration of the gifts continue for an infinite period. Interest earned from these funds is added to the original sum to maintain its value. Funds held for restricted purposes and for perpetuity must be classified under Specific Purpose Fund. (Please also refer to item 16 on the reporting of restricted purpose revenue.)

All Other Equity/Reserves (Item 65)
'Other Equity' includes asset revaluation reserve and other reserves not included in items 62, 63 and 64. Asset Revaluation Reserve is an equity account that contains the movements in asset values and any upward or downward movement in asset values is recorded against this reserve account.

Total Equity and Reserves (Item 66)
The total keyed into the Consolidated column is the sum of items 61, 62, 63, 64 and 65. If the total does not add up, the system will display an error message upon completion of data entry and not allow the user to proceed with authorisation until the error is corrected.

Current Liabilities

Bank Overdraft (Item 67)
Bank overdraft utilised within the approved limit is not a quick liability although it remains a current liability being payable at call. The credit balance of a bank overdraft drawn within limit should only be reported in item 67(i). Bank overdraft must not be set-off against the debit balance in another bank account.

Where an overdraft has exceeded its approved overdraft limit the overdrawn amount should be reported in item 67(ii) and it is treated as a quick liability. For example, if a hospital has an overdraft limit of $100,000 and this is exceeded by $20,000 (that is, the account has a credit balance of $120,000) then $20,000 should be reported in item 67(ii) and $100,000 should be reported in item 67(i).

Creditors Payable (Item 68)
The reported balance here should be supported by a listing of outstanding suppliers' accounts that agrees with, or is reconciled to, the relevant general ledger balances. Accounts payable are all amounts that are owing and unpaid for goods delivered and services rendered at a point in time.

Item 68(i)
Refers to all accounts due for immediate payment as well as those due within 30 days.

Item 68(ii)
Refers to all accounts due for payment after 30 days but before 60 days.

Item 68(iii)
Refers to all accounts due for payment after 60 days.

Accrued Expenses (Item 69)
Accrued expenses arise when the expense incurred for the period is not paid for in the same period. As long as payment for expenses and incurrence of the expenses do not take place in the same accounting period, accrual of expenses become necessary for the purpose of matching revenue with expenses. Amounts commonly included in this item are utility charges.

Accrued Salaries and Wages (Item 70)
The component of salaries and wages (including fringe benefits and non-monetary benefits) arising from services rendered by employees during the reporting period that is not paid as at the reporting date (that is, month end or year end).

Provision for Employee Entitlements (Item 71)
Employee entitlements means benefit entitlements which employees accumulate as a result of the rendering of their services to the hospital up to the reporting date, and include, but are not limited to, annual leave, long service leave, superannuation and other post-employment benefits. Accounting for employee entitlements should comply with the provisions of AAS 30. In respect of measurement of long service leave, a working guide on this matter is found in 'Accounting for Long Service Leave' jointly issued by the Australian Accounting Research Foundation and Coopers and Lybrand.

The proportion of employee entitlements estimated to be payable within the next 12 months is to be included under this item. The portion not due for settlement within the next 12 months is to be classified as non-current in item 78. If total provision is say $1,000,000 and $150,000 is required to be settled in the next 12 months, $150,000 is shown as current liabilities while $850,000 is shown as non-current liabilities.

Income in Advance (Item 72)
AAS 15 draws a distinction between reciprocal and non-reciprocal transfer of assets in the recognition of revenue. Non-reciprocal transfer generally means a transfer in which the entity receives assets without directly giving approximately equal value in exchange to the other party. Subject to certain conditions (AAS15 para 9.1), all non-reciprocal transfers must be recognised as revenue. A common example is donated asset, donation in genera and non-reciprocal transfers with stipulations. Income in Advance arises from the non-completion or partial completion of services established under the reciprocal transfers. Failure in providing the goods and/or services may render the assets transferred repayable.

In March 2002, the Department sought written clarification from the Victorian Auditor General's Office (VAGO) in regard to the appropriate treatment of Income Received in Advance. The advice received unequivocally states that income received in advance should be recognised as a liability only when it meets the recognition criteria for a liability. VAGO accepts that funding to be returned under the WIES arrangements can be reported as a liability at balance date. It is accepted because the funding to be returned meets the recognition criteria for a liability at balance date given that the present obligation and amount to be repaid has been determined at that point. VAGO further advised that in their view WIES and other grants, even if output measures are attached, are non-reciprocal at the time of receipt by a hospital. The opinion of VAGO is based on the definitions of non-reciprocal and reciprocal contained in AAS15 'Revenue' and Statement of Accounting Concept 4. Paragraph 102 of SAC states that '…for a transfer to be reciprocal, it is not sufficient that the transfer receives benefit *indirectly* as a result of the transfer'. VAGO explained that while hospitals receive an asset (in the form of WIES funding and grant moneys), they are not required to give approximately equal value in exchange to the other party (DHS/Government) involved in the transfer as the recipients of the benefit are essentially the individuals receiving the health service. As such WIES and other grants are non-reciprocal and should be recognised as revenue when received.

The Department issued a Circular (17/2002) to give effect to VAGO's view on Income in Advance.

Monies held in Trust (Item 73)
Refers to funds held on behalf of patients during their stay in hospital. Upon discharge, the funds are remitted to the patient. Revenue earned such as interest, together with the amount paid out under instruction from the patient, represent increases and decreases respectively in the liability to the patient. The liability must be matched by an asset (usually a bank account) held in trust in the statement of financial position.

Restricted Specific Purpose Funds are characterised by either or both of a condition and restriction over the way the assets may be dealt with. A condition or restriction may fail due to non-compliance, thus creating a legal obligation to repay the funds received. The liability arising from of this situation should be reported here.

Lease Liabilities (Item 74)
Relates to finance lease liabilities due within 12 months. For further information, refer to 'Leased Assets' in the Department of Human Services Finance and Accounting Manual for Public Hospitals.

Loans (Item 75)
Short-term loans or cash advances from all sources including the Department of Human Services should be shown in this item.

Other Current Liabilities (Item 76)
Relates to any amount not otherwise included in items 67 to 75.

Total Current Liabilities (Item 77)
The total keyed here must be equal to the sum of items 67 to 76. If the total does not add up, the system will display an error message upon completion of data entry and not allow the user to proceed with authorisation until the error is corrected.

Non-Current Liabilities

Provision for Employee Entitlements (Item 78)
Refers to that portion of provision for employee entitlements that is not due and payable within 12 months.

Lease Liabilities (Item 79)
Relates to finance lease liabilities not due within 12 months. For further information, refer to 'Leased Assets' in the Department of Human Services Finance and Accounting Manual for Public Hospitals and 'Leases' in AAS17 (AASB1008).

Other Non-Current Liabilities (Item 81)
Refers to any amount not otherwise included in items 78, 79 and 80.

Total Non-Current Liabilities (Item 82)
The total keyed here must be equal to the sum of items 78 to 80. If the total does not add up, the system will display an error message upon completion of data entry and not allow user to proceed with authorisation until the error is corrected.

Total Liabilities (Item 83)
Manual input is required for comparison with the sum of items 77 and 82. The system will also automatically transpose the sum of items 77 and 82 to this item.

Total Equity and Liabilities (Item 84)
The system will automatically transpose the sum of items 66 and 83 to this item. Manual input is also required for comparison with the sum of items 66 and 83.

Part 2B: Statement of Financial Position—Current Assets

Current assets means cash or other assets of the entity that in the ordinary course of operations of the entity are sold, realised, consumed or converted into cash as part of entity operating cycle which is normally within twelve months after the end of the last reporting period of the entity.

Cash at Bank/On Hand (Item 85)
This refers to the consolidated debit bank balances of the entity.

Where a material amount of cheques have been drawn but not issued to suppliers, the amount should be added back to creditors payable and cash at bank for F1 reporting purposes. An amount equal or greater than 10% of the base amount is regarded as material. The base amount in this case is the total value of cheques drawn in the month.

Patient Fees Receivable (Item 86)
This item should only include patient fees. The amounts are to be shown net of any provision for doubtful debts. The Department of Human Services grants are to be included in accrued revenue (Item 90).

Monies held in Trust (Item 87)
Refer to monies held in trust by the hospital on behalf of other parties. These are normally kept in a bank account for safekeeping.

Stores (Item 88)
The amount should be shown at book value at the lower of cost and net realisable value. Cost is determined principally by the first-in, first-out method. The amount reported should be net of any provision for stock obsolescence.

Prepayments (Item 89)
Prepayment arises when the hospital makes a payment during the current financial year that applies partly to a period within the current financial year and partly to a future period. The portion pertains to the future period is shown as prepayments. Commonly occurring prepayments include telephone rentals, insurance premiums and journal subscriptions.

Accrued Revenue Receivable (Item 90)
This is a receivable account representing the difference between revenue accrued and payments received from the Department of Human Services. However, cash advances or loans from the Department are to be excluded.

Debtors (Item 91)
Refers to all amounts receivable within one year that have not been included in items 86, 89 and 90, for example, invoiced trade debtors.

Short Term Investments (Item 92)
Investments held by the hospital should be recorded at the lower of cost and net realisable value. This item is divided into cash and others. The reason for reporting the cash part of the investments is to facilitate its inclusion in the Cash at Beginning of Period and Cash at

End of Period. Cash investments would include investments in money market instruments, bank or financial institution deposits and investments at call or which are highly liquid and readily convertible into cash within 24 hours. The classification between current and non-current assets depends on the expected timing of disposal of the investment. If disposal is not anticipated within 12 months the amount should be recorded in item 95.

Other Current Assets (Item 93)
Other current assets' includes all amounts due within 12 months that are not specifically covered in items 85 to 92.

Total Current Assets (Item 94)
The total keyed into the Total All Funds column must equal to the sum of items 85 to 93. If the total does not add up, the system will display an error message upon completion of data entry and not allow the user to proceed with authorisation until the error is corrected.

Non-Current Assets

Non-current assets mean all assets other than current assets.

Long Term Investments (Item 95)
General investments held by the hospital should be recorded at the lower of cost and net realisable value. Revaluation of land and buildings held as investments should comply with the relevant accounting standard. The classification between current and non-current assets depends on the expected timing of disposal of the investment. If the anticipated disposal is within 12 months for an investment then it should be recorded as a short-term investment under item 92.

Long Service Leave Debtor – DHS (Item 96)
Since the 2000–2001 financial year, the Department has assumed the liability arising from the net increase in the long service leave (LSL) provision of public hospitals. Hospitals will therefore record a net increase in the LSL liability as revenue with the Department a debtor. Hospitals are requested to seek further guidance from Circular 12/2002 (which replaces Circular 13/2001) issued on 28 May 2002 (http://www.dhs.vic.gov.au/ahs/circular/index.htm) by the Department.

Non-Current Assets at Gross Cost (Item 97)
The non-current assets include land and buildings, plant and equipment, leasehold improvements, motor vehicles, office furniture, assets under construction and library books. It should be noted that the threshold for recognition and capitalisation of a non-current physical asset is $1,000.

Accumulated Depreciation (Item 98)
Apart from land, all other fixed assets should be depreciated over its remaining useful life. The Victorian Healthcare Association has issued a list of depreciation rates that are suitable for use by public hospitals, subject only to unusual conditions prevailing with respect to particular assets. This list appears in Appendix ii (page 111) of the Finance and Accounting Manual for Public Hospitals. If an asset has been revalued, the depreciation should be calculated on the revalued amount rather than the historical cost. No depreciation is to be charged on capital works until the facility is complete and ready for use.

Intangibles (Item 99)
These include the purchase of intellectual property or capitalised value of copyrights, patents, trademarks and licences that represent an enforceable right or benefit. Intangibles should be brought to account when an asset exists and has service potential or provides a future economic benefit. Research costs incurred and are expected beyond any reasonable doubt to be recoverable (for example, there is future economic benefit) should be deferred to future financial years. The deferred costs could then be amortised and matched with future benefits.

Total Non-Current Assets (Item 100)
Total keyed in the Total Consolidated column must equal the sum of items 95(i) and (ii), 96, the difference between items 97 and 98(i) and (ii) and item 99. If the total does not reconcile, the system will display an error message upon completion of data entry and not allow the user to proceed with authorisation until the error is corrected.

Total Assets

Total Assets (Item 101)
Total Consolidated column has to be input manually and must equal to the sum of items 94 and 100. The system will also automatically transpose the sum of items 94 and 100 to this item. If the total does not correspond, the system will display an error message upon completion of data entry and not allow the user to proceed with authorisation until the error is corrected. The system also automatically compares this item with item 84 (Total Equity, Reserves and Liabilities).

Part 3: Indicators

Performance Indicators

WIES (Item 102)

The intention is to establish the hospital's YTD throughput performance in relation to its targets and to understand what throughput the hospital is recognising in its YTD revenue.

The starting point is to record the YTD WIES estimate which will be coded as fundable and refine that figure to ascertain the WIES recognised as revenue. Separate columns for DVA, non-DVA and TAC are provided because over 'target' DVA and TAC throughput still earns revenue. The non-DVA column is further divided into 'public' and 'private' WIES due to different condition of funding such as rate differential.

YTD Fundable WIES (Item 102 (1i))

The exact current month WIES will in most cases not be known. The YTD WIES should include:

- The most recent YTD VAED fundable WIES for the prior months.
- VIMD fundable separations for the current month (include uncoded) converted to WIES.
- Accrual for patients not yet separated.

WIES that are subject to special funding arrangements and have been coded as such should be included in item 5 *Other Department of Human Services' funded WIES included as revenue.* A 1998–1999 example of this would be the AHCA elective WIES.

Same Day Medical Penalty (Item 102 (2i))

WIES over the same day medical cap is not funded. If a hospital believes that despite being over its estimated YTD cap it will be under the cap by end of the year, it should continue to accrue the over cap WIES as revenue. If the over cap situation is likely to persist, then that revenue should not be accrued and should be shown here. For example, if YTD over same day medical cap is 100 and at the end of year this is estimated to be 50 only, the end of year over target estimate of 50 should be entered here.

Other over target WIES not accrued as revenue (Item 102 (2ii))

The main inclusions here will be:

- Late coded throughput where significant
- Non-DVA throughput being over target at the end of the year and therefore not funded

If the hospital believes that despite being over its estimated YTD target it will be on or under the target by end of the year, it should continue to accrue the target WIES as revenue.

VACS Weighted Encounters (Item 103)

The Victorian Ambulatory Classification System (VACS) covers all Group A hospitals, and Ballarat Health Services and the Bendigo Health Care Group. Weighted Encounter refers to one episode of care provided to a non-admitted patient multiplies by the VACS cost weight for each clinical service. Cost weights and VACS throughput targets are provided in Victoria—Public Hospitals Policy and Funding Guidelines. Further details on the development of VACS, the definition of the 'encounter' and the ambulatory funding model,

including the base grant and teaching component, are outlines in the publication Victorian Ambulatory Classification and Funding System—VACS, September 1998 (http://www.dhs.vic.gov.au/ahs/vacs/index.htm)

The throughput reported here must reconcile to S9 of the Monthly Statistical Return.

Allied Health—Occasions of Service (Item 104)
Occasions of service refer to the number of occasions of examination, consultation, treatment or other service provided to a non-admitted patient in each functional unit of a health service establishment. Each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department consists of one occasion of service.

The throughput reported here must reconcile to S2 and S9 of the Monthly Statistical Return.

Quick Assets (Item 105)
This refers to liquid assets that can be converted into cash fairly quickly. For the purpose of this return, a cut off period of 60 days is used. Quick assets include Cash at Bank/on Hand, Patient Fees Receivable within 60 days (items 86(i) and (ii)), Accrued Revenue Receivable, Short Term Investments and the 60 days portion of Debtors and Other Current Assets.

Quick Liabilities (Item 106)
Quick liabilities are Bank Overdraft (item 67(ii) exceeded limit portion), Accrued Salaries and Wages, Creditors Payable within 60 days (items 68(i) and (ii)) and the 60 days portion of Accrued Expenses, Provision for Long Service Leave, Lease Liabilities, Loans and Other Current Liabilities.

Solvency: Quick Asset Ratio (Item 107)
This ratio is a measure of the hospital’s ability to satisfy it immediate obligations (quick liabilities) in the short term using a two-month time horizon. The measure is also known as the acid test on the immediate liquidity of the hospital. A hospital with a higher ratio is considered to have more liquidity. This ratio is computed by the system and is derived from dividing Quick Assets (item 103) by Quick Liabilities (item 104).

Current Assets Ratio (Item 108)
This ratio is a measure of the hospital’s ability to satisfy its obligations (current liabilities) in the short term using a twelve month time horizon. This is a very broad measure of the margin of safety to creditors. The ratio is computed by the system and is derived from dividing Current Assets (item 94) by Current Liabilities (item 77). The ‘Total All Activities Budget ‘current assets ratio is derived from the projected balance sheet as at 30 June 2002.

DTF Liquidity Indicator (Item 109)
The liquidity indicator was requested by Department of Treasury and Finance (DTF) and first introduced in 2000–2001 as part of the F1 reporting routine. The indicator is now incorporated into the 2001–2002 F1 to measure the short-term (three months) liquidity of hospitals. DTF also provided a formula, which is provided below to guide hospitals in computing the indicator. The indicator measures the number of times average trade

creditors are covered by free cash available. DTF recommended a minimum coverage of two times.

In the year of introduction, there was wide variability in the size of indicator reported. While these indicators are no indication of inconsistency, there is strong indication that inconsistencies existed among MHS/hospitals in determining the key average trade creditors for computing the liquidity indicator. The Department is proposing the following guidelines for the determination of average trade creditors to minimise the inconsistencies noted.

1. Accrual of Expenses
Accrued expenses relating to trade goods/services received but not been billed by suppliers or creditors at month end should be included as trade creditors of the MHS/hospital. Some examples of these are utility charges, medical supplies, food and consumables.

2. Salaries and Wages
Group tax and salary packaging are part of salary calculation and therefore form part of salaries and wages. These items should be excluded from trade creditors.

Employer's contribution of the superannuation is a liability if not paid by month end. This should be included as trade creditors.

Fringe Benefit Tax payable by employer is a liability if not paid by month end. This should be included as trade creditors.

3. GST
Net GST payable is a liability if not paid by month end. This should be included as trade creditors.

4. Builders' Accounts
The 'Free Cash Available' as required by the DTF indicator is net of capital works obligations on which payments were received in advance. If the builders' accounts relate to this category of capital work obligations, these accounts should not be included as trade creditors for purpose of determining these creditors. Otherwise there would be double counting of obligations or creditors.

5. Average Monthly Trade Creditors
The average is preferred as it helps to minimise fluctuations. The average means the simple average of trade creditors at the beginning and at the end of the reporting month.

For example, if trade creditors have an opening balance of $1m and a closing balance of $1.5m for the month, the average trade creditors for the month is $1.25m.

DTF Liquidity Indicator—Formulae (Item 109)

A: Liquid Assets

- Bank balances
- Unencumbered liquid investments (below three months)
- Encumbered liquid investments (below three months)
    - a) Capital purposes
    - b) Specific purposes
    - c) Others (e.g. operating received in advance)

ADD

B: DHS operating grants for next 3 months *less* wages and salaries for next 3 months

LESS

C: DHS operating and Capital Works obligations for payments in advance (excluding SP funds) as at beginning of period.

a) Operating
b) DHS capital works
c) Commonwealth capital works

ADD (LESS)

D: Other Known Significant Cash Flows

For example, major changes in:
a) SP Income versus Expenditure
b) Debtor balances
c) Any other items

Equals: Free Cash Available

Indicator: Divide Free Cash Available by average monthly trade creditors (exclude funded capital work creditors) and other creditors (non-salary/wage items).

Efficiency Indicators

Entity Operating Surplus (Deficit)/Total Revenue Per Cent (Item 110)

This refers to entity operating surplus/deficit (item 35), which is divided by Total Entity Revenue (item 18). This ratio measures the relative operating efficiency of the hospital in terms of entity operating surplus as a percentage of the total revenue.

The System computes the year-to-date ratio.

Patient Fees Receivable Turnover (in days) (Item 111)

The hospital is required to calculate this monthly ratio and enter it here. Turnover of patients' fees receivable is calculated by dividing the average amount receivable at the beginning and the end of the month by the daily average patient fees earned for the same month. The result is expressed as a number of days that patient fees are taken to collect. This turnover rate will be influenced by the speed with which private health funds and statutory bodies such as TAC settle their accounts. A fall in the ratio or a low rate indicates more effective collection.

Viability Indicators

Entity Operating Surplus or (Deficit) (Item 112)

The system automatically transposes year-to-date operating results (item 35) on to the YTD column. But the *monthly* result has to be computed manually and keyed into the current month column. The operating surplus (deficit) is a key indicator of viability and performance within the given constraints because it indicates the net result of all revenue and expenses (before items 36, 37, 38, 39 and 40). At entity level, it measures operating performance in financial terms. Trends in the entity's surplus or deficit are important indicators of viability as they indicate the extent to which the hospital's operating activities are adding to or eroding its asset base over time.

Part 4: Statement of Cash Flow

The Statement of Cash Flow requires the combined presentation of information on actual as well as on projected basis. Under this format, cash flows are to be provided on a monthly basis for the current financial year. For example in the July F1 return, the July column reports on the actual cash flow for that month while the remaining eleven months provide the projected cash flow for the respective month. The 'Total' column is an aggregation of the actual and projected cash flows for the financial year.

The form and content (except for the projection requirement) of the Statement of Cash Flow is consistent with those of the Annual Report. The Statement provides useful information on the cash requirements of the public hospitals and how these requirements are satisfied. The information provided in the statement of cash flows together with other information in the financial report will assist in assessing the ability of a public hospital to generate cash flows and meet its financial commitments as they fall due. A Statement of Cash Flows is also required from hospitals in order to enable the Department to meet the Government reporting requirements of the Department of Treasury and Finance.

A reconciliation of cash flows arising from operating activities to operating surplus of deficit as reported in the profit and loss account is not required for the Statement of Cash Flow.

In preparing this Statement of Cash Flow, hospitals should be guided by the provisions of AAS28. Most of the cash flow activities reported in the Statement are self explanatory or have been explained in other parts of the 'Instructions for Completing the F1' and the Annual Reporting Guidelines. The following clarifications are provided to facilitate the preparation of the Statement.

Cash

Cash means cash on hand and cash equivalents. These cash equivalents consist of highly liquid investments with the following characteristics:

- short maturity periods,
- readily convertible to cash on hand at the hospital's option,
- subject to insignificant risk of changes in value

Borrowings which are integral to the cash management function and which are not subject to a term facility are to be included as cash. For purpose of the Statement of Cash Flow in the F1, 'Cash at End of Period' consists of overdraft (item 67), cash at bank/on hand (item 85), money held in trust (item 87) and short term investment—cash (item 92i).

Capital Grants

This refers to grants received from government for capital purposes.

Non-Government Capital Income
This refers principally to donations and bequests received for the purpose of acquiring non-current assets such as plant and equipment.

Contributed Capital From Government
This principally refers to liquidity injection and capital grants provided by the government for major redevelopment of hospitals. These contributions are normally recognised as revenue in the books of the receiving hospitals (Department of Treasury and Finance Bulletin No.39). Notwithstanding the receiving hospitals are not allowed to report the contributions as contributed capital unless notified in writing by the Department to treat the liquidity injection and/or capital grants as contributions of capital.

Return of contributed capital to Government is also reported here.

Sale and Purchase of Investments
Investments in this context refer to investment in shares and properties.

Part 5: Supplementary Data on Expenses

This part of the F1 is an adaptation of the note on operating expenses contained in the Annual Reports. It is intended to provide a better understanding of the behaviour of costs and EFT level in relation to output and enable the Department to meet Government reporting requirements of the Department of Treasury and Finance. The following notes are provided to assist you in completing the return. These notes are applicable to both HSA and Non-HSA Services.

Salary and Wages (Items 1i and 7i)
Salary and wages are divided into two categories. This includes salary and wages of all employees working a full-time or part-time basis and excludes fee-for-service medical officers. The 'Basic' grouping refers to the *ordinary rate* of salary and wages, annual leave, sick leave, other leave entitlements and public holidays. The 'Others' grouping is for staff costs such as overtime, penalty and allowances.

Salary and wages should be reported gross and not net of deductions or salary sacrifice arrangements.

Workcover (Items 1ii and 7ii)
All expenditure incurred for Workcover is reported here.

Departure Packages (Items 1iii and 7iii)
All expenditure incurred (including Long Service Leave) as a result of VDPs approved and funded by the Department or the hospital. Both Targeted Separation Packages and Voluntary Departure Packages should be included.

Long Service Leave (Items 1iv and 7iv)
The total amount you would have provided for in the annual report (including adjustment arising from movements in bond/wage inflation rates) as required by AAS30 but excluding all expenditure related to VDP Packages.

Superannuation (Items 1v and 7v)
All superannuation expenditure related to the various schemes.

Agency Costs – Nursing (Items 2 and 8)
All expenditure incurred in engaging agency nursing staff.

Fee-for-Service Medical Officers (Items 3 and 9)
This refers to payments made to a visiting medical officer appointed by the hospital to provide medical services on a fee-for-service basis.

Supplies and Consumables (Items 4 and 10)
This includes the costs of supplying food and beverages to patients, consumables of a medical and surgical nature and pharmaceutical supplies.

Other Expenses (Items 5 and 11)

Other Expenses includes all expenses not reported in items 1 to 4 or items 7 to 10 of F1 Part 5.

Total Expenses (Item 13)

'Total Expenses' of this form must agree with item 33 of F1 Part 1. The system matches the two figures automatically.

EFT (Item 14)

The EFT information requested in item 14 is the overall actual current month base EFT figure without overtimes, penalty and allowances.

Part 6: CEO or CFO Comments on Performance

The comment should include the following areas:

Review Performance

Review the monthly and year-to-date operating result with reference to the key influences on the reported surplus or deficit position. These influences may be financial (for example, accounting adjustments) and non-financial (for example, lower throughput).

Review of Projected Year End Result

The key assumptions made on Projected Year End result should be disclosed and explained. If the trend in actual result appears to be contrary to the projected one, the disparity or variance should be explained.

Strategies and Progress Plan

Details of action plan and the corresponding progress report is needed where the entity is reporting a significant deficit. The Plan generally outlines the major saving strategies and the progress report updated each month to tracks its implementation and effectiveness in financial terms.

Major Events

Details of major events that have occurred beyond the control of the management and have a significant impact on the operating result or financial position of the entity. Examples of such events are industrial dispute, major break down of plant and equipment or forced shut down of facilities.

Off Balance Sheet Items

The information is requested to enhance disclosure and better understanding of the financial performance and position of the Hospital. If any of the following items is applicable please provide the necessary details.

Unrealised Losses

This refers to unrealised loss arising from transaction pending completion, maturity or disposal. Common transactions in this regard are investments in equity and managed funds where losses are not provided for in the accounts.

Litigation/Contingent Liabilities

Litigation/Contingent Liabilities are those liabilities arising from decision, settlement or obligation that become payable or enforceable in certain circumstances against the Hospital. Examples would be:

- A guarantee given by the entity to secure a third party's debt.
- Litigation where the probable outcome is unfavourable and may result in a material impact on the financial position of the entity.

Capital Commitments

This refers to contractual obligation relating to capital project and purchases.

Finance	Finance Return
Form F1 Part 6	CEO or CFO Comments on Performance

Subsequent Events
This refers to event occurring after balance sheet date but relating to a condition existing as at that balance sheet date.

Cash Flows Variances
Hospitals are requested to complete the table provided. Hospitals are also requested to provide explanation on the reported variances and are encouraged to use result of the variance analysis to improve forecast for future months.