

Guidelines for Completing the F1 (Finance Return)

2011/12

1 Executive Summary

These guidelines are prepared to assist users in accessing, completing and submitting the F1 to the Department of Health (DH).

Victorian public hospitals complete the F1 to report agency level financial data for all sources of funding. The F1 includes (Appendix 1, Supporting Documents and the Website):

- Income Statement
- Balance Sheet
- Performance Indicators
- Cashflow Statement
- Notes (including accounting notes and a narrative note in the balance sheet)
- Budget
- Comments (by the Chief Executive Officer or Chief Finance Officer)

The instructions in these guidelines are arranged in the same order as the F1 and apply equally to the actual as well as the budgeted position.

Supporting documents, such as those that assist the selection of codes for the common chart of accounts, are also provided in these guidelines.

For further information, or to provide feedback on this or other documents on the finance pages of the DH site, access the department contacts list from the website <http://www.health.vic.gov.au/accounts/contact.htm>.

The terms "Public hospital(s)", "Hospital(s)", "Metropolitan health service(s)", "Health services", "Regional health service(s)" and "Multi Purpose Site(s)" wherever appear in these guidelines have the same meaning as "Hospitals and Public Health Services" as appeared in the Health Services Act.

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2 Introduction

Victorian public hospitals are required to meet financial reporting requirements. The F1 is used to report monthly financial data for all sources of funding. The data is requested in accordance with the *Health Services Act 1988*. The monthly F1 reports the financial position of public hospitals to the department on an accrual basis. The F1 includes (Appendix 1, Supporting Documents and the Website, see 5.1.1):

- Income Statement
- Balance Sheet
- Notes (including accounting notes and a narrative note in the balance sheet)
- Performance Indicators
- Cashflow Statement
- Budget
- Comments (by the Chief Executive Officer or Chief Finance Officer)

Each of these components of the F1 are detailed in this report.

Reporting of controlled entity activities is required. These activities mainly apply to hospitals that derive substantial assistance from charitable foundations. A consolidated income statement is required.

Major changes:

- **F1 manual entry value range Edit/Warning**
Range checking for these invalid values has been removed from point of entry. When an amount outside the value range is entered a warning message on validation will appear.
- **Locking of Automatically Populated cells (which could be edited previously)**
All Automatically populated cells are now locked and manual override of data will not be permitted. The following sheets are affected by this change: ABCPAndL, Balance Sheet, Performance Indicators for target only, Analysis YTD HSA Employee Benefits, Note Requiring Consolidation and Cash flow (selected notes only).
- **Status Report Sheet**
The Budget sheet has been split into four separate sheets: Budget Income, Budget Activity, Budget Balance Sheet and Budget Cashflow. As a result, the worksheet list on the Status Report has been amended to accommodate the four separate Budget sheets.
- **ABCPAndL Sheet**
Remaining non-CCOA agencies are converting to CCOA and manual uploads to ABCP&L have ceased. All automatically generated cells will be locked and manual entry of data is not permitted. Changes to ABCP&L can only occur by upload of a CCOA .csv file.
- **Budget Sheet**
 - (i) Sections which have been removed
Summary Operating Budgets (Quarterly YTD)
YTD EFT (Whole No's)
Forecasting revenue and expenses for SoP hospitals
 - (ii) Break-up of Budget sheet
Budget sheet is split into four separate sheets: Budget Income, Budget Activity, Budget Balance Sheet and Budget Cashflow.
 - (iii) Amend row label name
Income Statement (ABCPand L) label will change from 'Interest & Dividends' to 'Interest, Dividends & Gain(Loss) from Sale of Investments'. Change is to make Budget sheet label consistent with recent modification made to ABCP&L Sheet in V10.0.4 minor release.
 - (iv) Performance indicator targets to be added
Performance indicator activity targets have been added for:
Admitted paediatric rehabilitation (VAED Care Type P)
Restorative care (admitted)
Restorative care (non-admitted)

➤ Performance Indicators Sheet

(i) Rows that have been removed

Remove SACS, VACS and Allied Health performance indicators.

(ii) Rows that have been added

From 1 July 2011 the total WIES YTD target on the performance indicator sheet is to be automatically populated from the relevant Budget sheet.

Total WIES Over (under) target row for calculating variance between YTD Total WIES and YTD target.

Performance indicator rows for Admitted Rehabilitation Paediatric (VAED Care Type P), Restorative Care – Admitted and Restorative Care - Non-admitted.

Progressive YTD target rows for each performance indicator which are to be automatically populated from budget sheet.

(iii) Business rule changes

As a result of the automation mentioned in (ii) above a pre-condition rule will apply that the Budget Activity sheet must be completed before the Performance Indicators sheet can be completed in order for budget activity targets to be populated in the Performance Indicators sheet.

If a budget target figure is greater than zero, an activity actual should be entered on the performance indicator sheet but is not mandatory. A warning message will appear where an activity actual is expected but value is zero. If the budget YTD target is zero, activity may still be entered.

Data Entry

From 1 July 2011 all hospitals must submit a trial balance via the website by uploading a 'CSV' file. The income statement, balance sheet and some notes will be populated to the actual values as recorded in the trial balance. When a validation rule exists the data must be entered to the actual values as recorded in the trial balance (see 'Validation' below). In areas or segments where data are entered manually and not affected by applicable validation rules, public hospitals can continue to round data values to the nearest thousand.

Validation

Where the F1 requires a validation between items in the income statement, balance sheet, cashflow statement and the notes, where a trial balance has been submitted, data values must be entered to two decimal places. The current (actual) month data in the cashflow statement must also be entered with the actual values.

Previously, amounts outside the value ranges were deemed invalid. This rule has now been removed. When an amount outside the expected value range is entered, a warning message on validation of value will appear prompting a review of the value.

The financial statements, performance indicators and notes of the F1 provide the Department of Health with information to determine the performance and viability of each reporting entity. Analysis of this information forms the basis of monitoring the industry, by the department and the Minister. Hospital Performance Reports are also provided to the Government's Expenditure Review Committee.

In addition to the financial information provided via monthly F1 submissions, public hospitals also provide financial information through Annual Reports, Quarterly Financial Reports and Annual Returns. Inconsistencies in reporting of financial information between these reports have been identified in the past. These issues are being addressed by the following initiatives:

- Introduction of the common chart of accounts, including campus codes, account codes and cost centre codes.
- Mapping of the F1 to these codes.
- Mapping of the AFR to the common chart of accounts.
- Introduction of uniform recording of wages costs.
- The development of business rules for recording income and expenditure.
- Where there are inconsistencies between the F1, Quarterly Financial Reports and the Annual Report, public hospitals are required to resubmit the F1 in question and to resolve any inconsistencies.

In regards to the June F1 a revised version, consistent with the audited financial result is to be resubmitted on or before 31. August 2012.

Various support documents are available on the DH website (Appendix 1, Supporting Documents).

3 Classification of Transactions

For the purposes of monitoring the financial performance of public hospitals, the reporting of operating revenue and expenses in the F1 are grouped into (Appendix 1, F1 Reporting Format):

- Services supported by a Health Service Agreement, which represents the Operating Fund.
- Hospital and Community Initiatives (which are internally managed Specific Purpose Funds), which are controllable operating activities in the F1.

As other (non-controllable) operating activities also play an important part in the financial management of the public hospitals, the format makes a clear demarcation between controllable operating activities and restricted specific purpose funds (including any controlled entities), which are deemed not under the control of Hospital Boards. Departmental guidelines on specific purpose funds are found in <http://www.health.vic.gov.au/spfunds/index.htm>. A separate column is also set up for the reporting of capital purposes income and specific revenue and expenses.

3.1 Health Service Agreement (HSA) Transactions

The HSA category encompasses all the services that the Department funds, partly or wholly via a Health Services Agreement and/or Statement of Priorities. The HSA category also encompasses funding from third parties (e.g. Commonwealth) that support the operations of these services.

Examples of transactions to be classified to the HSA category which have been previously treated inconsistently include:

- Low care aged residential care services (hostels) which receives direct funding support for wage increases and indirect resources to support accreditation;
- Program of Aids for Disabled People which has been funded through the HSA; and
- Public hospital services provided to privately insured and other non-public patients.

Unless provided directly through separate specific purpose funds established in accordance with DH business rules, services to these patients are to be treated as a full or partial cost recovery of a HSA funded service.

3.2 Hospital & Community Initiatives (H&CI) Transactions

The H&CI category encompasses health expenses and revenues relating to Health Services that are not supported by the HSA as well as expenses and revenues for other kinds of services.

Services to be classified to the H&CI category include:

- Private hospitals owned by the public hospital/Health Service;
- Services provided under contract to co-located private hospitals;
- Separate internal and restricted specific purpose funds selling goods or services of a retail or commercial or medical nature to external parties (e.g. cafeterias, commercial diagnostic services, food catering, car park, linen services, cleaning services, privatised clinical services);
- Health services that are wholly funded by the Commonwealth, plus related client co-payments (e.g. CACPs, EACH, Day Therapy Centres);
- Services provided to DH under other arrangements, such as commercial contracts
- Health services provided on a contractual basis to external parties (e.g. public hospital beds provided to private hospitals);
- Special projects and trust funds that are required to be accounted for outside the HSA category (e.g. Coordinated Care trials); and
- Research wholly funded by the Commonwealth and other government or non-government agencies.

3.3 Consolidation and Elimination Column

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

4 Access, Completion and Timely Submission of the F1

The instructions in these guidelines, which aim to assist the completion of the F1, are arranged in the same order as the F1 document. The specific instructions apply to the actual and budgeted position.

4.1 Accessing the F1

The Common Chart of Accounts has been Adopted

From 1.7.2011 all public hospitals have adopted (or are mapping to) the common chart of accounts and are reporting against the common account codes and cost centre codes.

Completing the F1 requires hospitals to submit the general ledger electronically each month, through a dedicated DH website (www.health.vic.gov.au/aims). The chart of accounts general ledger information is automatically mapped to the F1 to produce the F1 income statement and the balance sheet. Manual data entry, except for Notes 1,7,11,12 and budget activity targets in the Performance Indicators sheet is required on the remainder of the F1 (ie the notes, cashflow statement and budget segments).

4.2 Completing the F1

Completion and validation of the F1

To improve the accuracy of information, a number of automated validation rules have been incorporated in the F1 for the actual monthly return. The rules enforce sequential form completion, as follows:

- Income Statement
- Balance Sheet
- Budget Sheet
- Notes and Performance Indicators
- Cashflow Statement

The validation process checks the order in which the forms are selected as 'completed'. While it is possible to enter data in a variation to this sequence, the completed box must be selected in this sequence for the file to pass all validation tests and to be successfully submitted.

(The system allows incomplete F1 form to be saved by clicking the POST button. The data can be retrieved later for completion. DH accepts F1 form as completed and validated only if the 'Completed' button is ticked by the submitting hospital).

Additional guidance on the completion of F1 is provided in Section 5.

4.3 Submitting the Completed F1

AIMS

The Agency Information Management System (AIMS) is a web based data entry system used by all public hospitals to report activity and finance data. Activity data includes non-admitted activity data, average available beds information, energy consumption reporting and so on.

Finance data is reported through the monthly F1 return. Data is submitted via a web based excel spreadsheet, which must be downloaded from www.healthcollect.vic.gov.au.

Instructions for the preparation of the trial balance and the F1 upload are located at <http://www.health.vic.gov.au/accounts/tbprep.pdf>

The first step is to obtain your agency's userid and password, which are required to logon at the Health Collect portal for access to the AIMS website.. Contact the HealthCollect Helpdesk at healthcollect_helpdesk@health.vic.gov.au or call the Help Desk on 9096 8595 to receive this information.

For assistance with the completion of the F1 return, please contact your regional office (for regional base and rural hospitals) and respective Performance Lead (for metropolitan health services). For assistance with submitting the F1 (technical assistance on AIMS) please contact the HealthCollect Help Desk on (03) 9096 8595.

Timing: All Public Hospitals

The completed form is to be submitted to the department within 12 calendar days following the end of the month for all public hospitals. Where the day falls on a weekend the return is required on the previous business day. Printouts of the original signed forms must be retained by the public hospitals and be available to officers of the department upon request.

5 Instructions and Information on Each of the F1 Components

5.1 Income Statement

5.1.1 Codes for Mapping the Income Statement Items of the F1 to the Common Chart of Accounts

The income statement consists of revenue and expense items. There is a series of roll-up codes and cost centres for mapping the F1 income statement to the common chart of accounts (Appendix 2 Tables 1-3). These roll-up account codes are not transmissible as they describe the range of categories available, while only specific codes within these ranges are transmissible. For instance 52000 represents any DH grant for non admitted services and is not transmissible. Whereas 52101, 52102 and 52103 which represent specific grants in the 52000 range are transmissible. Hospitals should use account codes in sequence. A list of all transmissible account codes can be downloaded from the website. For hospitals not using the common chart of accounts and cost centres, their general ledger should be closely aligned with these codes.

With regards to grants, the remittance advice from the Budget and Payments System (BPS) and Service Agreement Management System (SAMS), will provide the cost centre and account code mapping for each grant description. In addition, mapping information for BPS and SAMS payments is available from the website.

Hospitals are required to comply with the current Business Rules when accounting for revenue and expense items.

5.1.2 Selected Income Statement Instructions

Column Items of the Income Statement:

The 'Business Units Diagnostic, Laboratory and Medical Imaging Services' Column

These are confined to internally provided pathology and radiology services and are to be reported as part of the HSA initiatives in accordance with the current Business Rules (<http://www.health.vic.gov.au/accounts>).

The 'Restricted Specific Purpose' Column

The restricted specific purpose fund was introduced as a result of the review of the Specific Purpose Fund (SPF). The review indicated three categories of SPF:

- Specific commercial ventures (other than diagnostic laboratory and medical imaging services)
- Internally managed SPF
- Restricted purpose SPF

The department has issued *Guidelines for the Identification and Establishment of Specific Purpose Funds* (<http://www.health.vic.gov.au/spfunds/index.htm>).

The characteristics of a restricted purpose SPF include:

- The fund is established for a *particular or specific purpose (that is, a restriction or condition)* through some form of legal instrument such as a trust or legal undertaking to comply with the condition or purpose for which the fund is established. Common examples include a donation provided to purchase equipment and a research grant provided for a particular field of interest.
- A separate board or a separate committee normally manages these funds such as a Foundation managed by a separate board. Alternatively, this could be managed by a management auxiliary reporting to the hospital Board.

The hospital Board has no effective control of the restricted purpose SPF other than to comply with or to implement the purpose for which the fund is established.

All funding and donations specifically provided for *capital works* are to be reported as such in the 'Capital and Specific Items' column.

Those SPFs over which the hospital Board has effective control are reported as Internally managed SPFs.

The 'Controlled Entities' Column

This is part of the restricted SPF. It was created for fund raising activities and the main characteristic of this type of activity is that it is primarily for the benefit of the hospital. A separate column is now provided in the F1 Income Statement for the reporting of controlled entity activities.

The 'Capital and Specific Items' Column

The department requires that the following items continue to be recorded separately in the income statement consistent with Note 1(e) of the 2010-11 Health Services Annual Reporting Guidelines, after the 'Total Operating' column:

- Capital purpose income
- Specific items
- Impairment of non current assets
- Depreciation and amortisation
- Assets provided free of charge
- Expenditure using capital purpose income
- Sale of non current assets (Proceeds of Sales and Written Down Value of Assets Sold)

The existing presentation is retained so that results align with previous years.

Capital and specific items, which are included in the 'Capital and Specific Items' column, and should be excluded from the 'Total Operating' column ('Entity Surplus/Deficit' row), comprise:

- **Capital purpose income**, which comprises all tied grants, donations and bequests received for the purpose of acquiring non-current assets, such as capital works, plant and equipment. Consequently the recognition of revenue as capital purpose income is based on the intention of the provider of the revenue at the time the revenue is provided. In discussions with the auditor-general on the reporting of grants, the department has been advised that unless there is specific advice confirming that a grant is a capital grant, hospitals will be required to report the grant as an operating grant. The reporting of capital incorrectly will impact on the operating result reported to the department, the minister and as tabled in the parliament.
- **Specific income/expense**, comprises the following items, where material:
 - Voluntary departure packages.
 - Write-down of inventories.
 - Non-current asset revaluation increments/decrements.
 - Diminution in investments.
 - Restructuring of operations (disaggregation/aggregation of health services).
 - Litigation settlements.
 - Non-current assets lost or found.
 - Forgiveness of loans.
 - Reversals of provisions.
 - Voluntary changes in accounting policies (which are not required by an accounting standard or other authoritative pronouncement of the Australian Accounting Standards Board).
 - Discontinued operations.

The reporting entity is encouraged to provide additional information on these items in the comments section of the F1, as part of the commentary on the operating result.

- **Impairment of non current assets**, includes all impairment losses (and reversal of previous impairment losses), related to non current assets only which have been recognised in accordance with note 1 (k) of the Health Services Annual Reporting Guidelines.
- **Depreciation and amortisation**, as described in note 1 (h) of the Health Services Annual Reporting Guidelines.

In the Annual Report, H&CI include those initiatives of the Capital Fund that are deemed to hold all of the hospital's fixed assets. As such, depreciation on these assets should be treated as an expense of the H&CI activities. In the F1, this item is reported separately under Capital and Specific Items.

The three common depreciation methods are outlined in the Department of Health' 1996 Finance and Accounting Manual for Public Hospitals (FAM - page 51). The Victorian Healthcare Association 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 (FAM - page 114). 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. Please also refer to the current Business Rules.

When components of an asset have different useful lives or have different patterns of usage of its benefits, these components must be identified separately and depreciated accordingly in accordance with AASB 116.43 and AASB116.44.

- **Assets provided free of charge**, include donations of land, buildings, plant and equipment, as described in note 1 (h) of the Health Services Annual Reporting Guidelines.
- **Expenditure using capital purpose income**, which comprises expenditure using capital purpose income that falls below the asset capitalisation threshold, and therefore does not result in the recognition of an asset in the balance sheet.
- **Sale of non current assets** which is not part of the operating activity of the hospital, is to be disclosed separately in the 'Capital and Specific Items' column, under 'Proceeds from Sale of Non Current Assets' and 'Written Down Value of Assets Sold'.

Instructions for Other Selected Items:

General Equipment and Infrastructure Maintenance Grant

This grant is provided to hospitals and health services as a contribution towards the maintenance of general equipment and infrastructure. Separate funding is provided by the department for the replacement of equipment (see Capital Purposes Grants - 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;
- Inpatient and non-admitted patient outputs; and
- Relative financial capacity and resources of the hospital/health service.

The funding source for this grant is by appropriation of funds to the department from the Department of Treasury and Finance (DTF), based on hospital outputs.

DTF Financial Reporting Direction 119 (FRD 119 Paragraph 5.4b) on Contributions by Owners, requires that all appropriations for the provision of outputs be recognised as revenue (<http://www.dtf.vic.gov.au>).

Given the above background and the existing practice of recognising maintenance costs as operating expenses, the department requires all public hospitals and health services to treat the infrastructure and maintenance grant as an item of operating revenue in the HSA section of the F1 (Circulars 17/2002 and 7/2003).

These revenues should be reported in cost centre A8502 and account code 53601.

Capital Commitments has the same meaning as that in the current Annual Reporting Guidelines. The capital commitment refers to commitments on the purchase of property, plant and equipment.

Internal Allocations

Internal allocations for Transfer Pricing of Patient Expenses and Non-Patient Expenses are to be used for clearing Clinical Support, Infrastructure and Corporate expenses (net of any revenue) to various cost centres (implemented from 1 July 2005).

Similarly, transfer pricing of depreciation has the same function.

Capital Purposes Grants

This relates to all grants specifically received *for the purpose of acquiring non-current assets such as capital works, plant and equipment* and should be reported as revenue in the Capital and Specific Items column.

Since 2005–2006 the department has continued the targeted capital equipment program as follows:

- **Targeted Equipment Grants:** From this funding pool public 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 is to be reported as Capital Purpose Income.
- Hospitals should also note the requirement of FRD 119 (paragraph 7.4) on reporting capital grants as contributed capital.
- All Targeted Equipment Grants not reported as Contributed Capital should be reported in the

Capital and Specific Items column.

- All income (other than those reported as capital purposes grants) received for the specific purpose of acquiring non-current assets such as capital works, plant and equipment should be reported as revenue in the 'Capital and Specific Items' column. The common items to be included here are:
 - Donations and bequests specified for the purchase of fixed assets.
 - The cost of equipment donated by medical practitioners.
 - Interest earned on accommodation bonds from residents (refer to circular 13/2005).
 - The retention amount that may be deducted from accommodation bonds (refer to circular 13/2005).
 - Accommodation charges paid by nursing home residents (refer to circular 13/2005).
 - Capital interest.
 - Gain or loss on sale of fixed assets.

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

Recallable Capital Grants

These grants are provided by Department to assist health services in acquiring non-current assets. However, these grants are subjected to recall by way of future cash flow adjustments. Decisions about whether the recallable grants are to be repaid are solely at the discretion of the Department in consideration of the outcomes arising from the expenditure of the grant funds and other policy considerations. As such, hospitals at a given time have no obligation to repay the recallable grant unless the Department determines at some point that a cash flow adjustment in respect of the recallable grant is warranted.

As such, the recallable capital grant should be reported as a Contingent Liability in the Annual Report Financial statements at year end for the uncalled portion of the recallable capital grant.

Revenue Recognition and Expense Allocation

For small rural health services receiving acute program funding, the recognition of DH grant revenue is to be allocated to the program that the funding was sourced from. Therefore acute funded grants are to be allocated to the acute program in the F1, regardless of where these funds are ultimately expensed.

Similarly, expenses are to be allocated to the program against which the services are delivered, regardless of the program from which the funds were initially sourced. Therefore, funds sourced from the acute program and used to deliver primary health services are to be recognised as revenue under 'Acute' and as expenses under 'Primary Health'.

5.2 Balance Sheet

Standard account codes are provided in order to map the F1 balance sheet to the Common Chart of Accounts (Appendix 2 Table 4). This section covers the following areas:

- Equity
- Liabilities (Current and Non-Current)
- Assets (Current and Non-Current)

Completion Note for all agencies: Agencies are no longer required to complete the column with heading 'Projected Consolidated as at 30.6.2012'. As explained in the Budget section, this information is now collected through the budget sheet.

Equity

YTD Entity Surplus/(Deficit) - Current Year

This represents the year-to-date consolidated result in the Income Statement and is automatically populated.

Retained Earnings (Accumulated Deficits)

This refers to the balance on the retained earnings/(accumulated deficit) at the beginning of the financial year.

Contributed Capital

DTF issued a Financial Reporting Direction 119 that prescribes certain requirements with respect to classification of contributed capital. FRD 119 in paragraph 5.1 prescribes:

Transfers that meet all of the following criteria must be classified as contributions by owners by the transferee and distributions to owners by the transferor:

- (a) Transfers must involve public sector entities that are controlled by the Victorian Government; and
- (b) Transfers must meet the definition of contributions by owners; and
- (c) Transfers must either arise from:
 - (i) Parliamentary appropriations that are:
 - additions to net assets base (ATNAB); or
 - payments on behalf of State (POBOS) and special appropriations that are for capital expenditure purposes; or
 - (ii) as a result of a government decision that involves the transfer of one or more assets, possibly together with related liabilities that effectively occurs at or before the time of the transfers either:
 - from restructures of administrative arrangements; and/or
 - from all other arrangements which are deemed by an administrative instrument to be contributions by owners.

Transfers that do not meet the criteria above must be recognised as income by the transferee and as an expense by the transferor. Transfers of negative net assets (i.e. liabilities) must be recognised as an expense by the transferee and as income by the transferor.

Restricted Specific Purpose Reserves

This refers to funds held for restricted purposes and funds held in perpetuity that have not been appropriated. 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 restricted SPFs include Research Funds, Education Funds, Controlled Entities, Prize Funds, Foundations or 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. Any funds held for restricted purposes and for perpetuity must be classified as a SPF. The SPF Guidelines can be accessed at:

<http://www.health.vic.gov.au/spfunds/index.htm>

Asset Revaluation Reserves

Subsequent to their initial recognition as assets, all non-current physical assets are to be measured using the revaluation model (being its fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent accumulated impairment losses). For the plant, equipment and vehicles' class, and assets under construction / development, where the entity is able to demonstrate that there is no evidence that a reliable market-based fair value (or other relevant fair value indicators) exists for these assets, depreciated cost could represent a reasonable approximation of fair value.

Revaluations are made with sufficient regularity to ensure that the carrying amount of each asset does not differ materially from its fair value at the reporting date. This revaluation process normally occurs every five years.

Revaluation increments are credited directly to equity in the revaluation reserve, except that, to the extent that an increment reverses a revaluation decrement in respect of that class of asset, previously recognised as an expense in net result, the increment is recognised immediately as revenue in the net result.

Revaluation decrements are recognised immediately as expenses in the net result, except that, to the extent that a credit balance exists in the revaluation reserve in respect of the same class of assets, they are debited directly to the revaluation reserve.

Revaluation increments and decrements are offset against one another within a class of non-current assets.

Please also refer to FRD 103D and AASB 116 for full details.

All Other Equity and Reserves

These include all other equity or reserves not reported above.

Current Liabilities

In the classification of liabilities between current and non-current portions, take into consideration the requirements of paragraph 69, in particular 69(d) of AASB101.

Bank Overdraft

This refers to the amount of money owing to financial institutions arising from credit facilities entered into by the hospital. A bank overdraft must not be set-off against the debit balance in another bank account. Any bank overdraft utilised within the approved limit is not a quick liability, but remains a current liability being payable at call. Note 5 on Bank Overdraft, requires the provision of the hospital's bank overdraft limit.

Creditors Payable

This includes trade creditors that are owing and unpaid at the reporting date for goods delivered and services rendered at a point in time, salary and wages related creditors (including salary packaging), amount owing to the Department of Health and other hospitals.

Accrued Expenses

Accrued expenses arise when the expense incurred for the period is not paid for in the same period. When the 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. Utility charges are commonly included in this category.

Income in Advance

This represents income in advance from the Department of Health and any other sources.

Income in advance arises from the distinction drawn between the 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. All non-reciprocal transfers must be recognised as revenue (AASB 1004 Contributions, Paragraph 9). Common examples include a donated asset, a donation in general and non-reciprocal transfers with stipulations. Income in advance also arises from the non-completion, or partial completion, of services established under the reciprocal transfers. A failure to provide the goods or services, may render the transferred assets to be 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 (acquittal process) 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' which is superseded by AASB 1004 'Contributions'. VAGO explained that while hospitals receive an asset (in the form of WIES funding and grant monies), they are not required to give approximately equal value in exchange to the other party (DH/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. VAGO also referred to the analogous situations in AAS 27 paragraph 61 and AAS 29 paragraph 10.12.1 (see equivalents in AASB 1004 paragraphs 19 to 23).

Monies Held in Trust

Patient Trusts, Entry Contribution, Accommodation Bonds, other Patient Accommodation Deposits and Information Technology Alliance Funds should be allocated to Monies Held in Trust.

The common categories referred to in Note 8 are namely Patient Monies Held in Trust, Refundable Accommodation Bonds and Other Monies Held in Trust. These categories are defined as follows:

- *Patient Monies Held in Trust*: refer to funds held on behalf of patients or residents during their stay in hospital or at an aged care home. They may cover the general daily living activities of the patient or resident, and their daily care fees.
- *Refundable Accommodation Bonds*: refer to the funds (lump sum, periodic payment or a combination of both) payable for entry to an aged care home by residents who meet the specific criteria under the *Commonwealth Aged Care Act 1997*. They are in addition to the basic daily care fee and any income tested fee that may apply for that resident. The service provider can retain an amount out of the accommodation bond, with the balance of the bond to be refunded to the resident, or their estate, on departure. The bonds are subject to prudential arrangements (*Commonwealth Aged Care Act 1997, subdivision 57B* and the *User Rights Principles 1997, Part 4 division 3A*). The prudential arrangements have been designed so that residents can be certain that any outstanding lump sum accommodation bond amounts owing to them when they leave an aged care home, will be repaid within the time periods required by legislation. The liability must be matched by an asset (usually a bank account) held in trust in the balance sheet. In view of the provisions of the accounting standard AASB101 on what constitutes current liabilities and PSRACS Better Practice Toolkit - Tool A 5 'Managing Capital Purpose Income', all accommodation bonds should be classified as current liabilities.
- *Other Monies held in trust*: refers to any other monies held in trust that do not fit either of the above categories.

IT Alliance trusts monies are to be reported here.

Cash and cash equivalents representing monies held in trust **are not included in Cash at Bank or Cash On Hand in the balance sheet**. As such, they should not be included as part of the cashflows (Business Rules Section 11.3).

Borrowings

This generally includes short-term advances from DH, interest bearing loans and lease liabilities that are due to be repaid within 12 months.

For the purpose of reporting to the department, a loan is any financial accommodation from the department with a repayment period beyond the financial year in which it is provided. Cash advances will all have a recall schedule within the financial year in which they are made. Cash advances should be reported in the account range 85050-85099, whereas in the AFR A34350 should be used. The current portion of any departmental

loans should be reported in the account range 85001- 85049 and in the AFR A34350 should be used. Hospitals currently using the account code range 85001-85049 for reporting cash advances from the department will be required to close these accounts and use the 85050-85099 range. The non-current portion of any departmental loans should be reported in the account code range 89001-89099, and in the AFR A41650 should be used. Early payments of grants to meet operational requirements or for the purpose of settling early payment discounts on the workcover premium should not be treated as a 'cash advance' or 'loan'. The early payment of grants should be treated in the same manner as the fortnightly grant payments and credited to the account code range 80500- 80599. The account code listing has been updated for these changes and can be downloaded from the common chart.

Provision for Employee Benefits

Employee benefits: Refer to all forms of benefit entitlements which employees accumulate as a result of their employment with the hospital, up to the reporting date. Employee benefits include short-term employee benefits such as accrued salaries and wages, accrued days off, annual leave; long-term employee benefits such as long service leave; and post employment benefits such as pension and termination benefits. Accounting for employee benefits should comply with the provisions of AASB 119.

Long Service Leave: Provision is made in the accounts for obligations in respect to long service leave entitlements not taken at balance date. The liability for long service leave is expected to be settled within 12 months of the reporting date. This is generally recognised in the provision for employee benefits as a current liability. However the liability for long service leave expected to be settled more than 12 months from the reporting date is recognised in the provision for employee benefits as a non current liability and is measured as the present value of expected future payments, to be made in respect of services provided by employees up to the reporting date. For present value calculation, AASB 119 requires the discount rate to be determined by reference to market yields at the reporting date on high quality corporate bonds. In the absence of a deep market, the market yields at the reporting date on government bonds shall be used. AASB has decided that Australia does not currently have a sufficiently active and liquid market for high quality corporate bonds. Accordingly, market yields on government bonds shall be used for discounting long-term employment benefits such as long service leave. The LSL wage inflator and discount rate will be provided by DTF.

Annual Leave: Provision is made in the accounts for obligations in respect of annual leave entitlements not taken at balance sheet date. The amount is to be accrued at remuneration rates expected to apply when the obligation is settled (including the expected future increase in remuneration rate) and to comply with the requirements of AASB 119. For the monthly and annual reporting, provisions for annual leave should all be reported as a current liability and classified into short-term and long-term. Short-term annual leave that is expected to be settled within twelve months is measured at nominal value using the remuneration expected to apply at the time of settlement. Long-term annual leave that is not expected to be settled within twelve months is measured at the present value of the estimated future cash outflows, in respect of services provided by employees up to the reporting date. The present value of long-term annual leave is calculated in accordance with AASB 119 Employee Benefits. Expected future payments are discounted using interest rates on national Government guaranteed securities with terms to maturity that match, as closely as possible, the estimated future cash outflows.

Also refer to the requirements of AASB 101 paragraph 69 on Current Liabilities.

Other Current Liabilities

This refers to any amount not otherwise reported above. The liabilities to be reported here include other creditors, non-employee provision, deposits and GST payable.

Non Current Liabilities

Creditors Payable

Refers to that portion of creditors payable that is not due and payable within 12 months. Also see comments on Creditors Payable under Current Liabilities.

Other Non-Current Liabilities

This includes the non-current portion of Monies Held in Trust (see comment under Current Liabilities, other than accommodation bonds), income in advance – (DH and others),

other creditor, non-employee provisions and deposits.

Provision for Employee Benefits

This refers to that portion of provision for employee benefits that is not due and payable within 12 months. Also see comments on provision for employee benefits under Current Liabilities.

Borrowings

This refers to that portion of borrowings that is not due for repayment within 12 months. Also see comments on Borrowings under Current Liabilities.

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 the entity operating cycle. This is normally within twelve months after the end of the last reporting period of the entity. AASB 101 paragraph 66 provides a comprehensive definition on the classification of Current Assets.

Cash at Bank and on Hand

This refers to the consolidated debit bank balances and petty cash of the entity. Hospitals should not withhold a material amount of cheques drawn in favour of suppliers.

Monies Held in Trust

Refer to monies held in trust by the hospital on behalf of patients. These are normally kept in a bank account for safekeeping. Please note the current Business Rules section on Monies Held in Trust.

Short Term Investments

This includes investments (cash equivalents such as general, at call deposits and short-term money market); other investments (such as inscribed stocks and bonds, shares, fixed deposits, debentures and properties). Investments (other property) held by the hospital should be recorded at the lower of cost and net realisable value. Investment property after recognition must be measured using the fair value model, unless the hospital has received prior written approval from the Minister for Finance to use the cost model (FRD 107, FRD 114A, AASB 132 & 139 and notes on Long Term Investments).

Patient Fees Receivable

This item should only include patient fees. The amounts are to be shown net of any provision for doubtful debts. This includes fees receivable from private inpatients, private outpatients, nursing or hostel residents and diagnostic billings.

Debtors

This refers to all receivables other than patient fees and includes sundry debtors and receivables, from other hospitals, DH and related entities. The amounts are to be shown net of any provision for doubtful debts.

Accrued Revenue Receivable

This relates to the estimation of sundry revenue at month end. The common items are interest accrual and collection from shop or kiosk deposits, reported in the following month.

Inventories

This includes supplies, pharmacy, aids and appliances, food, linen and laundry. The amount should be shown at book value at the lower of-cost, and the current replacement cost. Cost is determined principally by the first-in, first-out method.

Prepayments

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 next of future financial years). The portion pertaining to the future period is shown as a prepayment. Commonly occurring prepayments include telephone rentals, insurance premiums and journal subscriptions.

Other Current Assets

This refers to assets that are not specifically covered above. Other current assets may include amounts such as GST receivable and deferred expenses.

Non Current Assets

Long Term Investments

Measurement of property held as investments should comply with the relevant accounting standard (AASB 140) and FRD 107. Investment properties are initially recognised at cost. Subsequent to initial recognition at cost, investment properties are revalued to fair value with changes in the fair value recognised as revenue or expenses in the period that they arise. FRD 107 limits the choice to measure investment property to the fair value model. The properties are not depreciated. The classification between current and non-current assets depends on the expected timing of disposal of the investment. If the anticipated disposal is more than 12 months for an investment then it should be recorded as non-current. Also see comments on Short Term Investments, Current Assets.

Debtors

This includes the non-current portion of sundry debtors and receivables from DH. Since the 2000–01 financial year, the department has assumed the liability arising from the net increase in the long service leave (LSL) provision of public hospitals. In past years funding for the cash component of long service leave has been incorporated into the WIES price. The basis for this has been that the department provides 1.8% of salaries and wages as a contribution to an agency's long service leave liability. From 1 July 2009 Circular 14/2009 replaced Circular 34/2008. The main amendment in Circular 14/2009 relates to the change in the loading contained in the pricing model, increasing by 1% from 1.8% to 2.8%. The 2.8% is to be treated as operating revenue. The difference between this contribution of 2.8% and the hospital's provision will be met through the creation of a non-cash DH debtor

Circular 34/2008 which required the additional funding of 1% to be treated as a reduction of the debtor balance owed by DH ceased effective 30 June 2009.

Circular 14/2009 also addresses the issue of long service leave liabilities arising from movements of staff members between hospitals covered by Circular 14/2009. Where employees transfer between applicable agencies their entitlements will transfer with them. However the agency from which the employee is transferring is not required to pay the new agency the entitlement that would have been otherwise paid to the employee.

Any increase or decrease in LSL provisions due to transfer of staff will be reflected in the net movement of LSL provisions of each agency and therefore will give rise to a corresponding increase or decrease in DH debtor balance which will enable a claim for cash settlement if and when required.

Other Non-Current Assets

This includes the non-current portion of accrued revenue and prepayments.

Intangibles (Net of Amortisation)

Intangible assets represent identifiable non-monetary assets without physical substance. For requirements on recognition of an intangible asset, measurement, capitalisation threshold, amortisation and review of impairment, please refer to AASB 138 and FRD 109.

Non-Current Fixed Assets

Non-current fixed assets include land, buildings, plant, medical equipment, non-medical equipment, leasehold improvements, motor vehicles, office furniture, computers, capital works (assets) under construction and library books. It should be noted that the department's recommended threshold for recognition and capitalisation of a non-current physical asset is \$1,000. Refer to comments above on Asset Revaluation Reserves (under equity), arising from the review of Properties, Plant and Equipment.

Accumulated Depreciation

Apart from land, all other fixed assets should be depreciated over their 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 (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 on the historical cost. No depreciation is to be charged on capital works until the facility is complete and ready for use. Refer to comments above on depreciation of Properties, Plant and Equipment.

5.3 Notes

Completion Note for all agencies: Agencies are no longer required to complete the column with heading "Projected Consolidated as at 30.6.2012". As explained in the Budget section, this information is now collected through the budget sheet.

Note 1: Analysis of Year-to-Date HSA Employee Benefits by Professional Grouping

The information required is for employment costs incurred as a result of Health Service Agreement activities. Every health service is required to fill out the FTE section. This is important as the data is required for benchmarking purposes.

Amounts in the Total column of this note must agree with the corresponding amounts in the Total Health Service Agreement column of the Income Statement. The rules for completion of the current month FTE for both HSA and H&CI employees are those used for reporting the Minimum Employee Dataset, a copy of which is available on the Website.

The following rules apply:

- FTE is based on cash transactions only (no accruals or reversals)
- FTE is based on nominated wage types only
- Standard Award Hours are defined by each award.
- FTE is calculated for each employee per pay period and reported monthly.
- Monthly FTE is the sum of the pay periods divided by the number of pays that fell in the month for the employee pay cycle.

Reporting of current month HSA and H&CI budgeted FTE is not required from 1.7.2011.

New business rule applies that 'Total' for each Current Month FTE must greater than zero. Sheet will not post data unless calculated totals are greater than zero.

Note 2: Residential Aged Care Payments

Refer to Circular 13/2005 for accounting treatment of these payments.

Note 3: Supplementary Information on Income Statement

This note was deleted with effect from 1.7.2010.

Note 4: Restricted Specific Purpose Reserves

This note shows the extent of the reserves that are supported by cash, short-term investment, long-term investment and non-cash assets.

Note 5: Bank Overdraft

A bank overdraft within limit refers to that part of the bank overdraft balance that is drawn within the facility limit. Bank overdraft exceeded limit refers to that part of the overdraft balance that has exceeded its approved overdraft limit. 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 \$100,000 should be reported as Bank Overdraft Within Limit with the \$20,000 reported as Bank Overdraft Exceeded Limit. It is a requirement to disclose the overdraft limit in this note. The overdraft limit is the amount approved under the Health Services Act 1988.

Note 6: Creditors Payable

This note is for ageing of creditors payable. The Consolidated Total must agree with the relevant line item in the Balance Sheet.

Note 7: Provision for Employee Benefits

See explanatory comments on this item under 'Balance Sheet'. The respective current and non-current Consolidated Total in the Note must agree with those in the Balance Sheet.

Note 8: Money Held in Trust

This note shows the type of assets supporting this liability. Please see the current business rules for a further definition.

Note 9: Patient Fees Receivable

This note is for ageing of Patient Fees Receivable. The Consolidated Totals must agree with the relevant line item in the balance sheet.

Note 10: Investment

This note provides a detailed listing of both current and non-current investments. The current and non-current Consolidated Total in the note must agree with those in the Balance Sheet. Please see the current business rules for a further definition of cash investments (Investment – Cash).

Note 11: Borrowings

This note provides details on all current and non-current borrowing undertaken by the entity. The current and non-current Consolidated Total in the note must agree with those in the Balance Sheet.

Note 12: Debtors

This note provides details of non-current debtors, which includes the non-current portion of sundry debtors and receivables from DH.

Note 13: Plant and Equipment Purchased During the Year

This is a disclosure note on purchases of medical and non-medical equipment.

Plant and Equipment includes medical equipment but excludes computers and communication equipment, furniture and fittings, transport and motor vehicles, cultural assets and leased assets.

Medical equipment is machinery designed to aid in the diagnosis and treatment of medical conditions. There are several basic types:

- Diagnostic equipment including medical imaging machines used to aid diagnosis. These include ultrasound, MRI, CAT-scans, PET, and x-ray machines.
- Therapeutic equipment such as infusion pumps and medical lasers.
- Life support equipment such as medical ventilators, heart-lung machines, ECMO, and dialysis machines.
- Medical monitors.
- Medical laboratory equipment.

Non-medical equipment includes plant and equipment such as lifts, elevators, boiler, air handling units, generators and laundry equipment.

Note 14: Note on Income Received in Advance

This Note is located immediately after item 79 in the balance sheet (see DH Circular 17/2002).

5.4 Performance Indicators

Completion Note for all Agencies:

1. WIES Activity (Item 98): YTD targets or expected (98ii) and Over (under) target or expected (98iii) are reinstated in the 2011/12 F1. The targets will be populated automatically from the budget sheet.
2. Sub-Acute Activity (Item 101 – 113): YTD target for these items are reinstated in the 2011/12 F1, the information will be populated automatically from the budget sheet.
3. SACS, VACS and Allied Health performance indicators are removed and indicators for Admitted Paediatric Rehabilitation, Restorative Care (admitted) and Restorative Care (non – admitted) are included in the 2011/12 F1.

Business Rules:

A pre-condition rule will apply that the Budget Activity sheet must be completed before the Performance Indicators sheet can be completed in order for budget activity targets to be populated on the Performance Indicators sheet. If a budget target figure is greater than zero, an activity actual should be entered on the performance indicator sheet but is not mandatory. A warning message will appear where an activity actual is expected but value is zero. If the budget YTD target is zero, activity may still be entered.

Reporting against performance indicators assists the department to establish a 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 to refine that figure to ascertain the WIES recognised as revenue. Separate columns for Private, Public, DVA, TAC, Renal and Special Initiatives are provided, because over target Renal, DVA and TAC throughput still earns revenue. The public and private WIES have different conditions of funding, such as rate differential.

The Special Initiatives requirement was introduced in 2006-07 for collecting data on special elective waiting list programs and Rural Patient Initiative (RPI WIES).

Private Patient

The following definition is extracted from Section 3 of the VAED Manual (20th Edition) on data definitions (<http://www.health.vic.gov.au/hdss/vaed/2010-11/manual/index.htm>).

A person who elects in writing to be treated (in a public or private hospital) as an admitted patient by a medical practitioner of their own choice and to be responsible for paying the charges referred to in clause 49 of the 1999 Australian Health Care Agreement.

Includes:

(1) A patient on whose behalf election has been made by another person with patient's express or implied consent.

(2) A patient admitted to a private facility where the hospital and/or clinician bulk bill Medicare for the patient's treatment.

Clause 49 of the *Australian Health Care Agreement* states 'Private patients, compensable patients and ineligible patients may be charged an amount for public hospital services as determined by Victoria'.

In addition to the private patients as defined, WIES funded private patients no longer include the following categories for care type 4 nor care type U:

- Victorian Workcover Authority
- Armed Services
- Seamen
- Common Law Recoveries
- Other Compensable
- Prisoners
- Ineligible

Sub acute, psychiatric, nursing home type and ineligible patients in the following categories no longer receive bed day funding from the department:

- Victorian Workcover Authority

Armed Services
Seamen
Common Law Recoveries
Other Compensable
Prisoners
Ineligible
TAC

YTD Total WIES

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.
- VAED fundable separations for the current month (including 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 Other Department of Health funded WIES included as revenue.

YTD Target or Expected

The YTD targets provided in Performance Indicators are to be automatically populated from the Budget sheet for the same period.

(Please note that targets as required here refer to agreed targets budgeted for cashflow purpose and not targets set internally by hospitals.)

Same Day Medical Target

In 2011–12, same day medical targets will not be applied, as it is considered that other mechanisms are in place to achieve an appropriate mix of admitted services. Health service and hospital activity will continue to be monitored and targets may be re-imposed in 2012–13.

Other WIES not Recognised as Revenue

Other over target WIES not accrued as revenue includes:

- 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.

Patient Fees Receivable Turnover (Days)

Hospital is required to calculate this YTD ratio and enter it here (blue data entry cell). Turnover of Patients' Fees Receivable is calculated by dividing the average amount receivable at the beginning of the year and the end of the current month, by the daily average patient fees earned YTD. 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.

Patients' Fees Receivable Days = $\frac{\text{Amount Receivable}_{\text{Average}} (\text{Account range 71001-71049})}{\text{Patient Fees}_{\text{Daily Average}} (\text{Account range 50001-50040; 50051-50749} + \text{private practice fees raised (50901-50999 and 59111-59499)})}$

Please note that with the creation of account code 50041, 50042 and 50043 for uninsured or under insured overseas visitors the fees and corresponding receivables from these visitors should not be included in account range 50001 – 50040.

Patients' Fees (Amount Receivable) should be the amount reported in the balance sheet.

Trade Creditor Turnover (Days)

Hospital is required to manually calculate this monthly indicator and enter it here (blue data entry cell). The indicator measures the number of days that trade suppliers' accounts are taking to settle. The turnover is calculated by dividing the average amount of trade creditors (account code range 80101 - 80149) outstanding at the beginning and end of the reporting month by the daily average of non-salary operating costs. These non-salary costs are your credit purchases of goods and services for the delivery of your services.

Trade Suppliers Days = $\frac{\text{Trade Creditors}_{\text{Average}}}{\text{Non Salary Operating Costs}_{\text{Daily Average}}}$

Other Throughput Indicators

The year-to-date actual throughput is required for the following performance indicators:

Casemix Rehabilitation and Funding Tree (CRAFT)

CRAFT is episode funded and applies to participating hospitals with Designated Rehabilitation Units. This model categorises Level 2 rehabilitation patients into sixteen groups according to clinical and functional levels. Categories cover the major clinical groupings in rehabilitation services including stroke/neurological, orthopaedic, cardiopulmonary, amputee, major head injury, spinal and burns patients and other rehabilitation. Given the statistical variability in episode length, amputee, major head injury, spinal and burns patients, these categories (Special Level 2) are funded on a per diem basis. For all other categories, payments are based on weighted units, short stay patients and same stay patients.

Geriatric Evaluation and Management (GEM)

This is per diem funded and refers to care type 9, aged patients with co-morbidities requiring sub-acute services.

Admitted Paediatric Rehabilitation (VAED Care Type P)

The paediatric rehabilitation caters for children and adolescents who require specialist interdisciplinary rehabilitation. This rehabilitation may be carried out as an inpatient at The Royal Children's Hospital or Monash Medical Centre or with non-admitted services at other selected sites.

Rehabilitation Level 1

This is funded per diem and refers to care type 2 spinal, amputee and major head injury patients in the first post-acute episode of rehabilitation.

Rehabilitation Level 2/Special Level 2

This is funded per diem and refers to general rehabilitation for non-CRAFT funded hospitals for care type 6 patients. Special Level 2 refers to care type 6 spinal, amputee and major head injury (other than level 1) patients in CRAFT funded hospitals.

Palliative Care

Activity to be reported here pertains to inpatient services for DVA and non-DVA categories under VAED care type '8'. Activities from hospice and community based services that are not included in bed-day targets in the Palliative Care Program– (Policy and Funding Guidelines) are excluded.

Changes to the targets (as published in the Policy and Funding Guidelines) for the Palliative Care Program, can only be undertaken after consultation with the DH's Continuing Care Unit.

Nursing Home Type (NHT)

Refers to care type 1 patients not requiring acute care.

Radiotherapy Weighted Activity Unit (WAU)

Non-admitted patient radiotherapy is funded primarily on an output basis. The units of output are weighted activity units (WAUS), which are specific to non-admitted patients, and which weight radiotherapy treatment received according to the megavoltage courses, simulation and dosimetry, and consultations received.

Transitional Care (Bed Based and Home Based)

This refers to transitional care services which replaces interim care activity for older people exiting public hospitals. TCP clients are non-admitted hospital patients. Transitional Care is divided into bed based and home based. Bed based refers to services provided in a residential care setting such as aged care facility or supported residential service whereas home based refers to services provided in the client's own home. The throughput measure for transitional care is the 'number of days' services are required.

Spinal Rehabilitation

Where there is a specific funding arrangement between the department and a health service for the provision of Spinal Rehab Level 1, the activity for this funding arrangement must be reported separately under the Performance Indicators section of the F1. Health services should ensure this activity is not recorded under any of the other activity categories. Where there is no funding arrangement with the department for the provision of Spinal Rehab Level 1, health services are not required to complete this activity indicator.

Restorative Care (Admitted)

Restorative Care (Non-Admitted)

Restorative Care is a model of care that enables people to complete their restorative process, optimise their functional capacity and if required, finalise longer term care arrangements. Patients are supported by a multi-disciplinary team and are provided with, at a minimum, low intensity therapy (such as physiotherapy and occupational therapy), case management and either nursing support and/or personal care. Therefore, Restorative Care is not a substitute for alternative forms of care, such as respite care.

Restorative Care operates currently as a bed based service, and is modelled on the TCP model of care. The primary difference between TCP and Restorative Care is that an Aged Care Assessment Service (ACAS) is not required to access Restorative Care and direct admission to the program is possible from the community where the individual is not managing and is at risk of a hospital presentation. Furthermore, Restorative Care is a Victorian State Government initiative and there is no reporting requirement to the Commonwealth.

The program may be delivered as either a:

- **non-admitted service** in a suitable residential care setting, such as a Supported Residential Service with 24 hour staffing support or a residential aged care facility.
- **admitted service** within a health service, in an environment that is more 'home-like', reflecting the needs of the patient cohort.

5.5 Selected Cashflow Statement Instructions

Completion Note for All Agencies: All agencies are not required to provide projected information in the Cashflow Statement or Cashflow Statement Part 2. Actual cashflow figures are required for these two statements. Projected cashflow figures are to be provided in the budget sheet.

Please note the special requirement below for "Cash at Beginning of Period".

The form and content (except for the treatment of capital grants and the projection requirement) of the Monthly Cashflow Statement 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 Monthly Cashflow Statement, 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. The Monthly Cashflow Statement also enables the department to meet the reporting requirements of the Department of Treasury and Finance.

All agencies are required to provide information in Cashflow 2 as follows:

- Coverage of Net Cash Available for Operations and short and long term investments on the corresponding commitments, such as restricted specific purpose funds.
- Additional details on cash receipts and payments.
- Reconciliation of the net entity result reported in the Income Statement to the net Cash Flows from Operating Activities.

In preparing this Monthly Cashflow Statement, hospitals should be guided by the provisions of AASB107. Most of the cash flow activities reported in the Cashflow 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 Cashflow Statement.

Cash

Cash means cash on hand and cash equivalents. Cash equivalents consist of highly liquid investments that:

- Have short maturity periods.
- Are readily convertible to cash on hand at the hospital's option.
- Are subject to an 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 the purposes of the Cashflow Statement in the F1, Cash at End of Period consists of Bank Overdraft, Cash at Bank and Cash On Hand. Investment Cash representing Monies Held in Trust should be excluded. Please refer to Business Rules on Cashflow Statement, Definition of Cash, Monies Held in Trust and Salary Packaging.

There is a validation process in place between the cash flow statement and the balance sheet item Cash at the End of Period. 'Cash at End of Period' should equal to the sum of balance sheet item 80 (Cash Assets – account codes 70001 to 70199) and Cash in Note 10 – Short Term Investment (account codes 70301 to 70329 and 70401 to 70449) less balance sheet item 64 (O/D account codes 80001 to 80099).

Row Items of the Cashflow Statement:

The 'Capital Grants' Row

This refers to grants received from government for capital purposes.

The 'Purchase of Investments' and 'Proceeds from Sale of Investments' Rows

This item includes the purchase or sale of any short term or long term investments.

The 'Non-Government Capital Income' Row

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

The 'Contributed Capital from (Returned to) Government' Row

This principally refers to liquidity injection and capital grants provided by the government for the major redevelopment of a hospital. These contributions are normally recognised as revenue in the books of the receiving hospitals (Department of Treasury and Finance FRD 119). 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 or capital grants as contributions

of capital. Return of Contributed Capital to government is also reported here.

Cash at Beginning of Period

This refers to the data entry cell in the July column. The data value in this cell must agree with the end (30 June) of previous financial year closing cash figure for each period of the new financial year up until the audited closing cash figure becomes available. When an audited closing cash figure becomes available, from that time onwards the July opening cash figure equals the closing cash figure as reported in the Cash Flow Statement in the prior year audited financial statement. The department will advise entities submitting F1 when audited figure has been applied to F1.

Cash Availability Section

Net Cash Available for Operations

The Cash Availability section is used to calculate *Net Cash Available for Operations* by taking into consideration commitments and obligations such as Salary Packaging Net GST payable, Capital Grants Received but Not Spent - Government, Capital Grants Received but Not Spent – Other, Committed Obligations for Other Restricted Purpose Funds, Monies Held in Trust (items 28 to 35) and Other Commitments (items 36 to 45) included in Cash at End of Period.

Committed Obligations for Other Restricted Purpose Funds generally refers to cash retained for restricted specific purposes (for definition see under Equity). Regional funds held for specific projects or initiatives and funds held on behalf of the regional IT alliance are to be included under Other Commitments.

Total Available Funds

The Cash Availability section has an automated total on *Total Available Funds*. This calculation is based on identifying Short and Long Term Investments – Other Financial Assets and then subtracting any specific commitments (items 46 to 49).

As a general guide, where the cash, cash equivalents, short and long term investments relate to a liability (e.g. funds held on behalf of the Regional IT alliance) or an obligation (e.g. donation provided to purchase fixed assets), such liability or obligation should be disclosed under Other Commitments.

If you are unsure on whether to report a certain item under *Other Commitments*, please consult your regional contact / performance lead.

Monthly Cashflow Statement

Monthly Cashflow Statement		July
Agency Period	Year	Inflows/ (Outflows) \$'000
Cash Flows from (used in) Operating Activities		V11.0.0
Receipts		
1.	Government Grants	0
2.	Other Receipts	0
3.	Total Receipts	0
Payments		
4.	Employee Entitlements	0
5.	Other Payments	0
6.	Total Payments	0
7.	Net Cash Flows From (Used In) Operating Activities	0
8.	Monies held by controlled entities - Net Cash Flows from Operating	0
Cash Flows From (Used In) Investing Activities		
9.	Purchase of Properties, Plant & Equipment - Government Funded	0
10.	Purchase of Properties, Plant & Equipment - Internally Funded	0
11.	Proceeds from Sale of Properties, Plant & Equipment	0
12.	Capital Grants	0

Monthly Cashflow Statement		July
Agency Period	Year	Inflows/ (Outflows) \$'000
13.	Purchase of Investments	0
14.	Proceeds from Sale of Investments	0
15.	Non Government Capital Income	0
16.	Net Cash From (Used In) Investing Activities	0
17.	Monies held by controlled entities - Net Cash Flows from Investing	0

Cash Flows From (Used In) Financing Activities

18.	Proceeds from Borrowings	0
19.	Repayment of Borrowings	0
20.	Contributed Capital from (Returned to) Government	0
21.	Net Cash Flows From (Used In) Financial Activities	0
22.	Monies held by controlled entities - Net Cash Flows from Financing Activities	0
23.	Net Increase/Decrease in Cash Held	0
24.	Monies held by controlled entities - Net Cash Increase/Decrease in Cash Held	0
25.	Cash at Beginning of Period	0
26.	Cash at End of Period	0

Note 1: The Statement provides information on actual cash flows only. Projected cash flows for the financial year are collected in the Budget sheet.

Note 2: "Cash At End of Period" should equal to the sum of Balance Sheet Item 80 (Cash Assets) and Cash in Note 10 - Short Term Investment Less Balance Sheet item 64(O/D)

Cash Availability

27.	Cash at end of period (Validate to Line 26 Above)	0
28.	Add: Money Held in Trust (Cash and Cash Equivalent Note 8 Item iv)	0
	Sub Total	0

Less

29.	Salary Packaging (80300-80399)	0
30.	Net GST Payables	0
31.	Capital Grants Received but Not Spent - Government	0
32.	Capital Grants Received but Not Spent - Other	0
33.	Other Grants Received but Not Spent	0
34.	Money Held in Trust	0
35.	Committed Obligations for Other Restricted Purpose Funds	0
	Other Commitments:	
36.		0
37.		0
38.		0
39.		0
40.		0
41.		0
42.		0
43.		0
44.		0
45.		0
	Sub Total Tied Funds	0

Net Cash Available for Operations 0

46.	Add: Short and Long Term Investments- Other Financial Assets (Note 10)	0
	Less: Other Commitments	
47.		0
48.		0
49.		0
	Sub Total	0
	Total Available Funds	0

5.6 Budget

The budget sheet now consists of four segments as follows:

- Income Statement (monthly);
- Activity Targets (Monthly);
- Balance Sheet; and
- Cashflow consisting of Cashflow Statement (Monthly), Reconciliation of Net Cash Flows (Monthly) and Cash Availability (monthly)

Guidelines and instructions provided under sections 3 and 5 (5.1 to 5.5) apply equally to the actual as well as the budgeted position.

For all public hospitals the Board approved budgets for Income Statement, Balance Sheet and Cashflow Statement are for the whole of the financial year. Budgets should be updated only as required to allow for any changes agreed in the Statement of Priorities.

The separate budget segment pages in the current F1 are to be completed in full at the commencement of the financial year by all health services / hospitals.

Queries arising from the budgeting process should be directed to the regional office contact person or respective performance lead. (See section 4.3)

5.7 Comments

Comments from the Chief Executive Officer or Chief Finance Officer should include the following:

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, reduced throughput).

Review of Budgeted Year End Result

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

Strategies and Progress Plan

Details of an action plan and corresponding progress reporting is needed in cases where the entity is reporting a significant deficit. The plan generally outlines the major saving strategies while the monthly progress report tracks its implementation and effectiveness against the identified strategies in financial terms.

Major Events

This comment should detail any major events that have occurred beyond the control of management and have had a significant impact on the operating result, or financial position of the entity. Examples of such events include industrial disputes, a major break down of plant and equipment, or a 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 are applicable please provide the necessary details.

Unrealised Losses

This refers to any unrealised loss arising from a transaction that is pending completion, maturity or disposal. Common transactions resulting in unrealised losses include investments in equity and managed funds where impairments are not provided for in the accounts.

Litigation and Contingent Liabilities

Litigation and Contingent Liabilities are those liabilities arising from a decision, settlement or obligation that become payable or enforceable in certain circumstances against the hospital. Examples include:

- Contingency arising from the effect of back pay on EBA. award.
- 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.

Subsequent Events

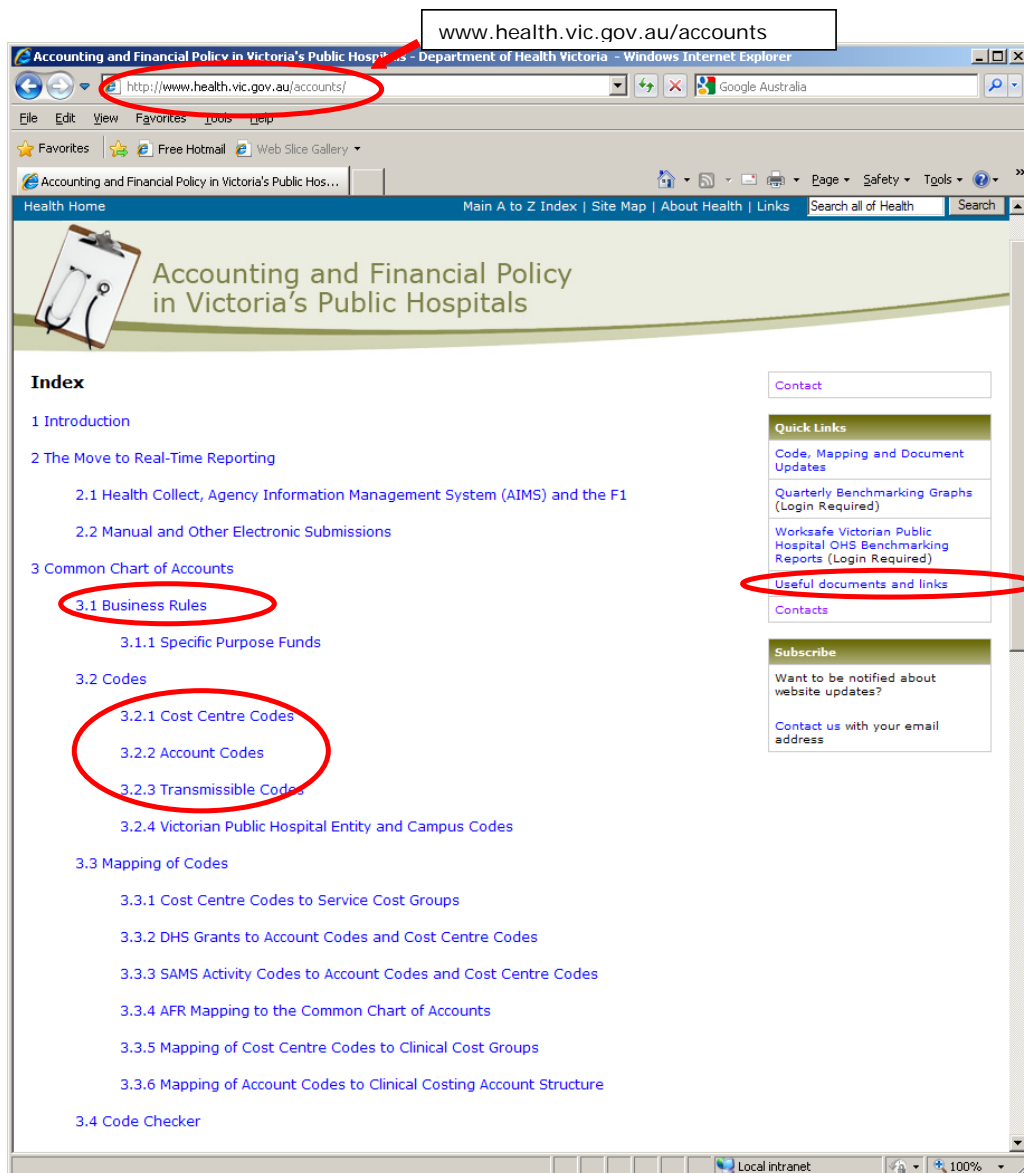
This refers to events occurring after the balance sheet date, but relating to a condition existing as at that balance sheet date.

6 Appendices

Appendix 1 Supporting Documents and the Website

You are advised to become familiar with the following documents, which are accessible through <http://www.health.vic.gov.au/accounts>.

- Business Rules
- Victorian Public Hospitals—Account Codes
- Victorian Public Hospitals—Cost Centres Codes
- Wage Type Mapping
- The Performa of F1 Forms and related guidelines



Accounting and Financial Policy in Victoria's Public Hospitals - Department of Health Victoria - Windows Internet Explorer

http://www.health.vic.gov.au/accounts/

File Edit View Favorites Tools Help

Accounting and Financial Policy in Victoria's Public Hos...

5.1 Monthly Financial Reporting

- 5.1.1 F1 Reporting Format
- 5.1.2 F1 Completion Guidelines
- 5.1.3 F1 General Ledger Specification
- 5.1.4 Instructions for preparing and uploading the trial balance into the F1

5.2 Quarterly Whole of Government Reporting (AFR)

5.3 Annual Report

5.4 Annual Return

5.5 Annual Commonwealth Aged Care Reporting

- 5.5.1 Conditional Adjustment Payment CAP

6 DHS Policy for Recognition of Revenue

7 Staff Entitlements

- 7.1 Annual Leave
 - 7.1.1 Annual Leave Provision
 - 7.1.2 Instructions for Calculating Annual Leave
- 7.2 Long Service Leave
- 7.3 Staff Expenditure

8 Salary Information

- 8.1 Labour Categories
- 8.2 Payroll and Workforce Minimum Dataset (MDS)

9 Useful Documents and Links

10 Archive of Superseded Documents

11 Frequently Asked Questions

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Last updated: 29 June, 2010
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Local intranet 100%

Appendix 2 Mapping the F1 to the Common Chart of Account and Cost Centre Codes

Table 1 Mapping F1 Revenue to Common Chart of Accounts Codes

	Revenue	Roll-Up Account Codes	Account Description
DH Grant Revenue	DH Acute Grant Revenue	52000	DH Grant - Non Admitted Services
		52100	DH Grant - Fixed Overhead Grants
		52200	DH Grant - Variable Grants
		52300	DH Grant - Patient Revenue Targets
		52400	DH Grant - Training and Development Grants
		52500	DH Grant - Specified - Formula adjustments
		52600	DH Grant - Specified - Non-admitted radiotherapy/Dialysis
		52700	DH Grant - Specified - Transplants
		52800	DH Grant - Specified - Trauma
		52900	DH Grant - Specified - Award Increases
		53000	DH Grant - Specified - Administration
		53300	DH Grant - Specified - Other Specified Grants
		53400	DH Grant - Specified - Information and Technology
		53500	DH Grant - Specified - Hospital Demand Management
		53600	DH Grant - Specified - Hospital Program
		53700	DH Grant - Specified - Hospital Quality
		53800	DH Grant - Specified - Service Development
	53900	DH Grant - Specified - Rural Health Grants	
	DH Sub Acute Grant Revenue	54100	DH Grant - Sub - Acute Specified Grants
		54200	DH Grant - Specified - Award Increases
		54300	DH Grant - Patient Revenue Targets
	DH Mental Health Grant Revenue	54500	DH Grant - Mental Health Specified Other
		54600	DH Grant - Clinical Community Care
		54700	DH Grant - Clinical Inpatient Care
	DH Aged Care Grant Revenue	54800	DH Grant - Psychiatric Disability Support Services
		55000	DH Grant - Aged Care Assessment Services (ACAS)
		55100	DH Grant - Aged Care Support Services
		55200	DH Grant -Aged Care Residential Care
		55300	DH Grant -Aged Care Service Development and Resourcing
	DH Other Programs Grant Revenue	55400	DH Grant - Aged Care- Award Increases
		55600	DH Grants - HACC
		55700	DH Grants - Primary Health/Community Health Care
		55800	DH Grants - Disability Services
DH Grants - Capital	55850	DH Grants - Drug Treatment Services	
	55900	DH Grants - Other Programs	
Non Cash Revenue from Services Provided (LSL)	56000	DH Capital Grants	
	56806-56899	DH Non Cash Grant - Other	
Other State Operating Grants	56500	Other Victorian State Agency Grants (Non DH)	
	56600	Other Victorian State Agency Grants (Non DH) - Capital	
Commonwealth Government	Commonwealth Government Grants	51000	Commonwealth Grants
DH	DH Indirect Contributions	56801	DH Non Cash Grant - DH Insurance
	Patient Fees Raised	50000	Admitted Patient Fees
		50400	Non-admitted Patient Fees
	Donations and Bequests	58200	Donations and Bequests (Cash Only)
		58400	Assets Received Free of Charge (including Assets Donated)
	Recoupment from Private Practice	50800	Recoupment Hospital Facilities - Private Practice
	Interest and Dividends	58500	Investment Income
		58520	Other Investment Income <i>Report Discount Interest Revenue on Financial Instruments in this range, under 58560 – 58599 (Other Investment Income).</i>
	Research Revenue	58100	Research Revenue (non Government)
	Other Revenue	50900 & 59110	Private Patient Fees
		57000	Other Operating Income
		58000	Coordinated Care Trial
	Specific Revenue	59000	Specific Revenue (ex Abnormal) <i>Report Forgiveness of the DH loan in this range.</i>

	Revenue	Roll-Up Account Codes	Account Description
	Proceeds from Sale of Non Current Assets	58600	Proceeds from Sale of Fixed Assets

Table 2 Mapping F1 Expenses to Common Chart of Accounts Codes

	Expenses	Account Codes	Account Description
Employee Benefits	Salaries and Wages	Basic	10000 Basic
		Sick Pay	10100 Sick Pay
		Overtime	10200 Overtime/Recall - Unrostered
			10300 Overtime - Rostered
		Penalties	10400 Penalties (other than public holiday)
			10500 Public Holiday Penalties
		Allowances	10600 Allowances
	Workcover	10700 Workcover	
	Departure Expenditure	10800 Departure Expenditure	
	Other	10900 Other Salaries and Wages	
	Fee for Service	12000 & 12200 Fee for Service	
	Nurse Agency Expense	12501-12550 Nurse Agency expense	
	Other Agency Expenses/External Contract Staff	12551 - 13099 External contract staff	
	Employee Entitlements	14000 Annual Leave	
		14100 Accrued Days Off Expense	
14200 Long Service Leave accrued expense			
Employee Entitlements	14300 Other Leave		
Superannuation	14400 Superannuation Expense		
Workcover Premium	14500 Workcover Premium		
Supplies and Consumables	Drug Supplies	27000 Drug Supplies	
		27100 S100 Costs	
		27200 PBS Costs	
	Medical and Surgical Supplies Including Prostheses	20000 Aids and Appliances Purchases	
		20300 Coordinated Health Care - Commonwealth Trial Expenses	
		20600 Dialysis Consumables	
		21000 Medical And Surgical Supplies	
		25000 Prosthesis	
		26000 Radiology Supplies	
		26100 External Contracted Services - Radiology	
	26200 Other Radiology		
	Food Supplies and Services	28000 Food Supplies	
	Pathology Supplies and Services	24000 Pathology Supplies	
		24100 Specialised blood and blood products	
		24200 External Contracted Services - Pathology	
24300 Other Pathology Costs			
Other Supplies and Consumables	22000 Patient Expenses - General		
Other Expenses	Domestic Services and Supplies	30070 Hotel services	
		32000 Domestic Supplies	
	Fuel, Light, Power and Water	31000 Electricity	
	Fuel, Light, Power and Water	31100 Other Fuel, Light and Power - excluding motor vehicles fuel costs	
	Repairs and Maintenance (excluding maintenance Contracts)	33000 Equipment Replacement and Additions	
		34000 Repairs And Maintenance	
	Maintenance Contracts	34200 Maintenance Contracts	
	Operating Leases	33500 Operating Leases	
		35000 Administration Expenses	
	Administrative Expenses	37000 Interest Expenses <i>Report Discount Interest Expense on Financial Instruments under this range, in account 37024.</i>	
		37200 Audit Fees	
		37400 Bad and Doubtful Expenses	
		37600 Insurances	
		23000 Patient Transport	
	Other	38000 Other Expenses	
Internal Allocations	60000 Transfer Pricing Accounts - Patient Expenses		
Internal Allocations - Non-Patient Expenses	61000 Transfer Pricing Accounts - Other Expenses		
Specific Expense	39000 Specific Expenses (ex Abnormal)		
Depreciation and Amortisation	40000 Depreciation		

	Expenses		Account Codes	Account Description
			40100	Amortisation
	Devaluation of Assets		44000	Devaluation of Assets
	Written Down Value of Assets Sold		43000	Written down value of assets disposed
			43100	Written down value of investment assets disposed

Table 3 Mapping F1 to Cost Centre Codes

		Cost Centre Codes	Cost Centre Description
Acute	Inpatient	A 0000	Acute Wards - Multi day
		A 3000	Acute Wards - Same day
		A 4000	Clinical Units
		A 8000	Operating Theatres Suites
		A 8500	Acute Inpatients
	Emergency	B 0000	Emergency
	Non-Admitted Patients	C 0000	Non-admitted Patient Services
	Other Services	D 0000	Other Acute Health Funded Services
	Sub-Acute Services	F 0000	Sub Acute Services
Aged	Residential Care - Low Care	J 0000	Aged Care Residential Low Care
	Residential Care - High Care	J 2000	Aged Care Residential High Care
	HACC	J 5000	Home and Community Care (HACC)
	Other	J 7000	Aged Care Other
Mental Health Services		H 0000	Mental Health Other
		H 8700	Mental Health Residential Care
Primary Health		L 0000	Primary Health
Other Programs		M 0000	Drug prevention services
		M 1000	Disability services
		M 1500	Public Health
		M 2000	Dental Health
		M 4000	Other Programs
		M 5000	Department Funded Research
		M 8500	Other Programs
Clinical Support, Infrastructure and Corporate		N 0000	Pharmacy
		N 2000	Allied Health Services
		N 8500	Clinical Services
		P 0000	Clinical Support
		R 0000	Infrastructure Services
		R 1000	Corporate Services
Business Units Diagnostic Laboratory and Medical Imaging Services		Y 0000	Diagnostic Laboratory Services
		Y 1000	Medical Imaging Services
Hand CI Internally Managed SPF		Y 2000	Internal
Restricted Specific Purpose		Z 0000	Restricted
Controlled Entities	Z 9002 to Z 9100		Controlled Entities
Research	Z 9102 to Z 9501		Restricted
Controlled Entities	Z 9502 to Z 9900		Controlled Entities
Capital and Specific Items		X 0000	Capital
	COA Codes 39000		Specific Expenses (ex Abnormal)
	COA Codes 44000		Devaluation of Assets
	COA Codes 59000		Specific Revenue (ex Abnormal)

Table 4 Mapping the F1 Balance Sheet to Common Chart of Account Codes

		Standard Account Codes	Account Description
Equity	YTD Entity Surplus/(Deficit) - Current Year	Automated Feed	
	Retained Earnings (Accumulated Deficits)	94000	Retained Earnings/Accumulated Losses
	Contributed Capital	90000	Contributed Capital State Government Sector
	Restricted Specific Purpose Reserves	91000	Restricted Purpose Fund Reserves
	Asset Revaluation Reserves	92000	Asset Revaluation Reserve
	All Other Equity/Reserves	93000	Reserves Other
Current Liabilities	Bank Overdraft	80000	Bank Overdraft
	Creditors Payable	80100	Current payables
	Accrued Expenses	81000	Accrued Expenses
	Income in Advance	82000	Income in Advance
	Monies held in Trust	83000	Monies Held in Trust
		83100	Patient Accommodation Deposits/IT Alliance Funds
	Borrowings	85000	Borrowings
	Provision for Employee Benefits (including accrued salaries and wages)	86000	Provision for Employee Entitlements - Current
Other Current Liabilities	84000	Other Current Liabilities	
Non-Current Liabilities	Creditors Payable	87000	Non Current Payables
	Other Non-Current Liabilities (including Money Held in Trust)	87500	Patient Accommodation Deposits/IT Alliance Funds
		88000	Other Non - Current Liabilities
	Provision for Employee Benefits	89500	Non-Current - Provision for Employee Entitlements
	Borrowings	89000	Non Current Borrowings
Current Assets	Cash At Bank and On Hand	70000	Cash At Bank and on hand
	Monies held in Trust	70200	Patients Trusts
	Short Term Investments – Cash Equivalents	70300	Short Term Investments
	Short Term Investments - Other	70400	Short Term Investments
	Patient Fees Receivable	71000	Patient Fees Receivable
	Debtors	71500	Debtors
	Accrued Revenue Receivable	72000	Accrued Revenue
	Inventories	72100	Inventory
	Prepayments	73000	Prepayments
	Other Current Assets	73100	Other Current Assets
Non-Current Assets	Long Term Investments	75000	Long Term Investments
	Debtors	75500	Debtors - non current
	Other Non-Current Assets	75800	Accrued Revenue - non current
		76000	Non-Current Prepayments
	Intangibles (net of amortisation)	76500	Intangible Assets
		76600	Accumulated Amortisation - Intangible Assets
	Non-Current - Fixed Assets	77000	Fixed Assets
Accumulated Depreciation	79000	Accumulated Depreciation	

Appendix 3 Glossary

Table 5 Glossary

Acronym	Name
AAS	Australian Accounting Standard
AASB	Australian Accounting Standards Board
AIMS	Agency Information Management System
AFR	Annual Financial Report
AHCA	Australian Health Care Agreement
BPS	Budget and Payments System
CACP	Community Aged Care Package
CCU	Critical Care Unit
CCOA	Common Chart of Accounts
CEO	Chief Executive Officer
CFO	Chief Finance Officer/Director of Finance
DH	Department of Health
DTF	Department of Treasury and Finance
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home
EBA	Enterprise Bargaining Agreement
EFT	Equivalent Full Time
HACC	Home and Community Care
H&CI	Hospital and Community Initiatives
HSA	Health Services Agreement
LSL	Long Service Leave
MHS	Metropolitan Health Service
NHT	Nursing Home Type
SACS	Sub-acute Ambulatory Care Services
SAMS	Service Agreement Management System
SPF	Specific Purpose Fund
TAC	Transport Accident Commission
UIG	Urgent Issues Group
VACS	Victorian Ambulatory Classification System
VAED	Victorian Admitted Episode Database
VDP	Voluntary Departure Package
WIES	Weighted Inlier Equivalent Separation