NSW Health

Accounting Policy Manual

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Foreword

This accounting policy manual provides guidance on the preparation and presentation of its financial information and performance to ensure compliance with the *Government Sector Finance Act 2018 and the Government Sector Finance Regulation 2018*.

The policy manual incorporates relevant guidance from Australian Accounting Standards (which include Australian Accounting Interpretations) for not-for-profit entities, and the financial reporting directives, including Treasury Circulars and Treasury Policies and Guideline papers issued by the NSW Treasury.

Important information about this policy manual:

- This policy manual does not replace any of the existing accounting manuals. The following policy documents still remain active:
  - *Accounting Manual for Ministry of Health*
  - *Accounting Manual for Public Health Organisations*
  - *Audit and Accounts Determination for Public Health Organisations*

  The new manual is a supplementary accounting policy manual and focusses on the financial accounting and reporting aspects.
- The policy manual has been prepared based on the current applicable Australian Accounting Standards and Treasury Directives as at 31 August 2023. Further revisions will be made to incorporate any new accounting standards or Treasury Directives.

Structure and materiality

This policy manual provides guidance and examples that will help you determine the correct accounting treatment for transactions happening at their health entities as well as preparation of the annual financial statements. The structure is based on the most common and significant issues. While the manual will provide you with guidance on the application of such accounting requirement, there's no "one size fits all" approach. We recommend you engage with Central finance team for complex issues to determine the most relevant approach.

Additional Guidance

The NSW Ministry of Health's Financial Accounting team constantly publish additional guidance on specific accounting matters impacting Health entities. Health entities should refer to those publications for detailed assessment and guidance, in addition to this document. That guidance can be accessed from the following Sharepoint page: https://nswhealth.sharepoint.com/sites/MOH-FAS

Changes in this edition

The main changes that you will see from the previous version of this accounting manual are:

- the re-organisation of the chapters
- updated guidance and references to new Treasury Guidance and Policies
- new guidance added on Derivatives and Hedge accounting (Chapter 14.4.6)
- updated accounting policies resulting from revised useful lives of specialised buildings
- updated guidance on desktop revaluations (Chapter 10.4.6)
- new guidance on cloud computing (Chapter 7.4.2)
- a number of new examples added or refreshed
- minor corrections or some content changes where applicable.

Not for profit accounting

This accounting manual has been prepared to provide guidance and direction to the Health entities' employees in deciding the appropriate accounting treatment for transactions. The document includes a number of worked examples (using past situations) to bring the guidance to life.

Consideration has been made in developing the guidance of the NSW Ministry of Health's and its entities' status as government organisations, and the requirement to follow not-for-profit accounting requirements, and also the TPP/TPG's issued by NSW Treasury.

Throughout this document reference is made to "economic benefit". This is a standard term used in a number of the accounting standards and applies equally to all Health entities. However, the "economic benefit" provided by Health entities is not consistent with for profit entities.

In for-profit entities revenue or profits are generated from assets to demonstrate economic benefits, but this is not applicable to the not-for-profit sector. Societal benefits through improved services, increased capacity, reduced waiting times etc. all represent "economic benefits" as a consequence of Health entities services.

Structure

Each chapter deals with a different topic, includes specific references to the accounting standards and also NSW Treasury TPPs. Included in boxes on the left hand side of each chapter are references to paragraphs in the applicable accounting standard, providing the user with easy access to the actual text from the standard.

Consultation

Accounting and accounting standards can often be complex, and this manual has been developed to help improve the understanding of users. It is however, not expected to replace the need for discussion and consultation. It is expected that where a Health entity has an accounting issue, that a level of investigation (consideration of this manual, additional guidance published on the NSW Ministry of Health's Sharepoint site, a review of the applicable standard, etc.) has been performed prior to consultation with the NSW Ministry of Health central financial accounting team.

Where issues or complex transactions are identified please reach out to the NSW Ministry of Health central financial accounting team, who are available to help ensure the appropriate accounting treatment is reached.

Applicable entities

This accounting policy manual is applicable to all the below listed health entities (collectively referred as "NSW Health" and individually as "Health entity"):

Parent
NSW Ministry of Health

Local Health Districts
Central Coast
Illawarra Shoalhaven
Nepean Blue Mountains
Northern Sydney
South Eastern Sydney
South Western Sydney
Sydney
Western Sydney
Far West
Hunter New England
Mid North Coast
Murrumbidgee
Northern NSW
Southern NSW
Western NSW

Speciality Networks
Sydney Children's Hospitals Network
Justice Health and Forensic Mental Health Network

Health Administration Corporation and its divisions
NSW Ambulance
Health Infrastructure
HealthShare NSW
NSW Health Pathology
eHealth
Health System Support Group

Pillar agencies
Agency for Clinical Innovation (ACI)
Bureau of Health Information (BHI)
Cancer Institute NSW
Clinical Excellence Commission (CEC)
Health Education and Training Institute (HETI)

Other entities

Albury Base Hospital
Albury Wodonga Health Employment Division
Graythwaite Charitable Trust
Special Purpose service entities

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1 Conceptual framework

1.1 Scope

1.1.1 Applicability

This Policy provides the guidance on the objective of the financial statements, the qualitative characteristics that determine the usefulness of information in financial statements and the definition, recognition and measurement of the elements from which financial statements are constructed, as well as providing concepts of capital and capital maintenance.

1.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- Framework for the *Preparation and Presentation of Financial Statements* (AASB)

1.2 Overview and purpose

The purpose of this document is to provide illustrative guidance on the framework with respect to the objective and preparation of the financial statements.

The framework must meet the guidelines as set out in Framework for the *Preparation and Presentation of Financial Statements* as compiled by the Australian Accounting Standards Board.

1.3 Policy statement

Financial statements portray the financial effects of transactions and other events by grouping them into broad classes according to their economic characteristics. These broad classes are termed the elements of financial statements. The elements directly related to the measurement of financial position in the Statement of Financial Position are assets, liabilities and equity. The elements directly related to the measurement of performance in the income statement are income and expenses. The cash flow statement usually reflects income statement elements and changes in balance sheet elements.

1.4 Application guidance

1.4.1 Objective of general purpose financial reporting

The objective of general purpose financial reporting is to provide financial information about the reporting entity that is useful to existing and potential resource providers (such as government bodies, existing lenders and other creditors), recipients of goods and services (such as members of the community) and parties performing a review or oversight function on behalf of other users (such as advisors and members of parliament). Such users may make resource allocation decisions with respect to the NSW Health. An example of these decisions include

- Parliament deciding whether to fund particular programmes conducted by NSW Health by way of appropriations
- Donors may decide whether to donate resources to NSW Health

With respect to users of the financial statements, these users would be concerned with the ability of NSW Health to achieve its objectives, which in turn may depend, at least in part on NSW Health's prospects for future net cash flows. In order to assess NSW Health's prospects for future net cash inflows, the users of the financial statements would need information about the resources of the entity, claims against the entity, and how efficiently and effectively the entity's management and chief executives have discharged their responsibilities to use the entity's resources.

The Framework establishes the concepts that underlie those estimates, judgements and models in which the financial report are based on.

1.4.2 Information about a reporting entity's economic resources, claims against the entity and changes in resources and claims

General purpose financial reports provide information about the financial position of a reporting entity (the Health entity), which is information about the Health entity's economic resources and claims against the Health entity. The report also provide information about the effects of transactions and other events that change a reporting entity's economic resources and claims.

Changes in a reporting entity's economic resources and claims result from that of the entity's financial performance as disclosed in the statement of comprehensive income, as well as from other events or transactions such as the contribution or distribution by/to owners of wholly owned public sector entities. To properly assess the prospects for future cash flow from the reporting entity, users need to be able to distinguish between both of these changes.

Information about the Health entity's financial performance helps users to understand the return that the Health entity has produced on its economic resources and how well management has discharged its responsibilities to make efficient and effective use of the Health entity's resources.

Financial performance reflected by accrual accounting

Accrual accounting depicts the effects of transactions and other events and circumstances on the Health entity's economic resources and claims in the periods in which those effects occur, even if the resulting cash receipts and payments occur in a different period. The accrual basis of accounting provides a better basis for assessing the Health entity's past and future performance rather than information prepared solely on cash accounting basis during the period.

Information about the Health entity's financial performance during a period, reflected by changes in its economic resources and claims is useful in assessing the Health entity's past and future ability to generate net cash inflows, through its operations rather than by obtaining additional resources directly from creditors. This in turn, is useful for users to assess whether income from donors or parliament or other sources was sufficient, and is likely to remain sufficient to meet the cost of a given volume and quality of goods and services to which the Health entity provides.

1.4.3 Qualitative characteristics of useful financial information

If financial information is to be useful, it must be relevant and faithfully represent what it purports to represent. The usefulness of financial information is enhanced if it is comparable, verifiable, timely and understandable.

Relevance

Financial information is regarded as relevant if it is capable of making a difference in the decisions made by the users. These would be relevant if it has predictive value (financial information can be used as an input to processes employed by users to predict future outcomes) or confirmatory value (where information provides feedback about previous evaluations).

Faithful representation

For information to be useful, financial information must not only be relevant, but it must also faithfully represent what it purposes to represent. The financial information should be complete, neutral and free of error. A complete depiction may require explanations of significant facts about the quality and nature of the items, factors and circumstances that might affect their quality and nature, and the process used to determine the amount recognised.

1.4.4 Statement of financial position

The financial position includes assets, liabilities and equity which are defined as follow:

- An asset is a resource controlled by the entity as a result of past events and from which future economic benefits are expected to flow to the entity. In the instance of NSW Health which is a not-for-profit in the public sector, the asset provides a means for NSW Health to achieve their objective in providing goods and services that has the capacity to satisfy the needs of the community. This would be in the form of future economic benefits or service potential.
- A liability is a present obligation of the entity arising from past events, the settlement of which is expected to result in an outflow from the entity of resources embodying economic benefits.
- Equity is the residual interest in the asset of the entity after deducting all its liabilities.

In assessing whether an item meets the definition of an asset, liability or equity, the Health entity should assess the underlying substance and economic reality and not only its legal form. As an example, in the case of a capital project partly funded by an external party, where the external party makes an upfront contribution to the Health entity for the construction of an asset (building) that will be owned by the Health entity and upon completion of the asset, a peppercorn lease is entered into providing the external party access to certain nominated space in the constructed asset (building). The substance and economic reality is that the upfront funding provided by the external party (lessee) is in exchange for the peppercorn lease for a specified period, therefore the upfront payment should be accounted for as prepaid lease payments (liability), amortised over the life of the lease, rather than recognising the funding as upfront revenue under AASB 1058 for acquiring or constructing a non-financial asset to be controlled by the Health entity.

Assets

Assets may result from past transactions or other past events. NSW Health would normally obtain assets by purchasing or constructing them (such as infrastructure assets), or receiving the assets from a government body.

Further, while there is a close association between incurring expenditure and generating assets, the two do not necessarily coincide. Hence, when NSW Health incurs expenditure, this may provide evidence that economic benefits were sought, however may not satisfy the definition of an asset. Refer to Chapter 9 of the policy document with respect to the capitalisation of assets.

Assets employed to satisfy the objective of NSW Health

An entity usually employs its assets to produce goods or services capable of satisfying the wants or needs of customers. The provision of goods and services by NSW Health may not result in net cash inflows to NSW Health as the recipients of the goods and services may not transfer cash or other benefits to NSW Health in exchange. The fact that the provision of health services were not charged fully to the beneficiaries does not deprive those assets of value.

Form of assets

Many assets, for example property, plant and equipment have a physical form. However physical form is not essential to the existence of an asset. These can have an intangible form (such as intangible assets per Chapter 7 of the policy document).

Liabilities

An essential characteristic of a liability is that the entity has a present obligation which would result from past transactions or past events. An obligation is a duty or responsibility to act or perform in a certain way. These may be legally enforceable as a consequence of a binding contract or statutory requirement. Obligations also arise, from normal business practice, and a desire to maintain good relations or act in an equitable manner.

The Health entity should also assess whether there is a present obligation versus a future commitment. A decision by the Health entity to acquire assets in the future does not give rise to a present obligation. An obligation normally arises only when the asset is delivered or the Health entity enters into an irrevocable agreement to acquire the asset.

Equity

Equity is defined as a residual, however is sub-classified in the Statement of Financial Position of the Health entity between accumulated funds and asset revaluation surplus. The movement in the accumulated fund will result from contributions arising from the transfer of assets or liabilities from/to another wholly owned public sector entity. Refer to Chapter 22 of this policy document with respect to contributions by owners made to wholly-owned public sector entity. The accumulated fund will also increase/decrease based on the net result arising from the profit or loss of the Health entity during the year.

The revaluation of assets, carried at fair value will also result in an increase or decrease in the asset revaluation surplus. Refer to Chapter 10 of this policy document with respect to the valuation of physical non-current assets.

1.4.5 Statement of comprehensive income

The statement of comprehensive income includes elements of income and expenses which are defined as follow:

- Income is increases in economic benefits during the accounting period in the form of inflows or enhancements of assets or decreases of liabilities that result in increases in equity, other than those relating to contributions from owners of wholly owned public sector entities.
- expenses are decreases in economic benefits during the accounting period in the form of outflows or depletion of assets or incurrences of liabilities that result in decreases in equity, other than those relating to distributions to owners of wholly owned-public sector entities.

Income

The definition of income includes both revenue and gain. Revenue arises from the course of ordinary activities of NSW Health and includes parliamentary appropriations, sale of goods and services such as patient fees, grants and contributions and reimbursements by the Crown Entity with respect to employee benefits. Gains represent other items that meet the definition of income and may or may not arise in the course of ordinary activities of NSW Health. When gains are recognised in the income statement, they are usually disclosed separately because knowledge of them is useful for the users to make economic decisions. Gains are often reported net of related expenses.

Expenses

The definition of expenses encompasses losses as well as those expenses that arise in the course of ordinary activities of the entity. Expenses that arise in the ordinary activities of NSW Health includes salaries and wages, cost of drug and medical supplies, depreciation and grants and contributions made to other organisations. They usually take the form of an outflow of depletion of assets such as cash and cash equivalents, inventory, property, plant and equipment.

Losses represent other items that meet the definition of expenses and may or may not arise in the course of ordinary activities of NSW Health. The losses may include those resulting from disasters such as fire and flood, as well as those arising from the disposal of non-current assets. When losses are recognised in the income statement, they are usually shown separately because knowledge of them is useful for the purpose of making economic decisions by the users. Losses are often reported net of related income.

1.4.6 Recognition of the elements of financial statements

Recognition is the process of incorporating in the Statement of Financial Position or income statement an item that meets the definition of an element and satisfies the criteria for recognition.

The criteria for recognition is as follows:

a) it is probable that any future economic benefit associated with the item will flow to or from the entity and

b) the item has a cost or value that can be measured with reliability. If the item fails to meet this criteria, the item may qualify for recognition at a later date as a result of subsequent circumstances or events.

An item that possesses the essential characteristics of an element but fails to meet the criteria for recognition may warrant disclosure in the notes or in supplementary schedules. This is appropriate when knowledge of the item is considered to be relevant in the evaluation of the financial statements by users of the financial statements.

SAC 4.38

Recognition of assets

An asset is recognised in the Statement of Financial Position when it is probable that the future economic benefits by way of increasing service potential will flow to NSW Health and the asset has a cost or value that can be measured reliably.

An asset is not recognised when expenditure has been incurred for which it is considered improbable that economic benefits will flow to NSW Health beyond the current reporting period. Instead, this transaction should be recognised as an expense in the income statement.

SAC 4.65

Recognition of liabilities

A liability is recognised in the Statement of Financial Position when it is probable that an outflow of resources embodying economic benefits will result from the settlement of a present obligation and the amount at which the settlement will take place can be measured reliably.

In practice, obligations under contracts that are equally proportionately unperformed (such as liabilities for inventories ordered but not received) are generally not recognised as liabilities. However such obligations may meet the definition of liabilities (provided the above criteria is met). In such circumstances, recognition of liabilities entails recognition of related assets or expenses.

Recognition of income

Income is recognised in the income statement when an increase in future economic benefits related to an increase in an asset or a decrease of a liability has arose which can be measured reliably. The recognition of income occurs simultaneously with the recognition of increases in assets or decreases in liabilities.

Recognition of expenses

Expenses are recognised in the income statement when a decrease in future economic benefits related to a decrease in an asset or an increase of a liability has arose which can be measured reliably. The recognition of expenses occur simultaneously with the recognition of an increase in liabilities or a decrease in asset.

Expenses are recognised in the income statement on the basis of a direct association between the costs incurred and the earning of specific items of income. This is referred to as matching of costs and revenues. An example of this is the simultaneous recognition of revenue generated from sale of prescription drugs and the cost of those prescription drugs sold.

When economic benefits are expected to arise over more than one accounting period, the expenses are recognised in the income statement on the basis of systematic and rational allocation procedures. An example of this is with property, plant and equipment in which the associated depreciation is recognised on a straight line basis in the income statement.

Other than the above circumstances, an expense is recognised immediately in the income statement when an expenditure produces no future economic benefits or when, to the extent that future economic benefits do not qualify, or cease to qualify, for recognition in the Statement of Financial Position as an asset. An expense is also recognised when a liability is incurred without the recognition of an asset.

2 Presentation of the financial statements and other disclosures

2.1 Scope

2.1.1 Applicability

This Policy prescribes the basis for presentation of general purpose financial statements to ensure comparability both with the Health entity's financial statements of previous periods and with the financial statements of other health entities and agencies. The policy sets out the guidance on presentation of financial statements and guidelines for their structure and minimum requirements for their content.

2.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- *AASB 101 Presentation of financial statements.*
- *TPG23-04 Mandates of options and major policy decisions under Australian Accounting Standards*
- *TPG23-03 Financial Reporting Code for NSW General Government Sector Entities*

2.2 Overview and purpose

The purpose of this document is to provide the Health entities with illustrative guidance presenting their financial statements as required under the accounting standards *AASB 101 Presentation of financial statements* for general purpose financial reporting.

2.3 Policy statement

General purpose financial statements are defined as those financial statements intended to meet the needs of users who are not in a position to require an entity to prepare reports tailored to their particular information needs.

2.4 Application guidance

2.4.1 Financial statements

Financial statements are a structured representation of the financial position and financial performance of an entity. The objective of financial statements is to provide information about the financial position, financial performance and cash flows of an entity that is useful to a wide range of users in making economic decisions. The financial statements provide information about the entity's:

- assets
- liabilities
- equity
- income and expenses, including gains and losses
- contributions and distributions to owners of wholly-owned public sector entities and
- cash flows

The above information, along with other information in the notes, assists users of financial statements in predicting the entity's future cash flows and in particular, their timing and certainty.

A complete set of financial statements comprises

AASB 101.9-10

- a statement of financial position as at the end of the year
- a statement of comprehensive income for the year
- a statement of changes in equity for the year
- a statement of cash flows for the year
- notes, comprising significant accounting policies and other explanatory information
- comparative information in respect of the preceding year
- As per the Treasury Policy and Guidelines *TPG23-04 Mandates of options and major policy decisions under Australian Accounting Standards*, the Health entities should prepare a single statement of comprehensive income.

2.4.2 General features of financial statements

Going concern

The Health entity should prepare financial statements on a going concern basis, unless there is an administrative restructure. When management is aware, in making its assessment of material uncertainties related to events or conditions that may cast significant doubt on the Health entity's ability to continue as a going concern, the Health entity shall disclose those uncertainties. When the Health entity does not prepare financial statements on a going concern basis, it shall disclose that fact, together with the basis on which it prepared the financial statements and the reason why it is not regarded as a going concern.

Accrual basis of accounting

The Health entity should also prepare the financial statements, except for cash flow information, an on accrual basis of accounting.

Materiality and aggregation

The Health entity should present separately each material class of similar items. Items of a dissimilar nature should be presented separately unless they are immaterial.

Omissions or misstatements are material if they could, individually or collectively influence users' economic decisions. The materiality depends on the size and nature of the omission or misstatement, judged in the surrounding circumstances.

Offsetting/netting

The Health entity is not permitted to offset or net assets and liabilities or income and expenses, except where expressly required or permitted by the Australian Accounting Standards. Items that are not considered offsetting of assets and liabilities include accumulated depreciation and amortisation, provisions against inventory and impairment provisions.

Frequency of reporting

Financial statements should be prepared by the Health entity on an annual basis.

Comparative information

The Health entity should present comparative information in respect of the preceding period for all amounts reported in the current period's financial statements. This should include comparative information for narrative and descriptive information if it is relevant to understanding the current period's financial statements. As a minimum, two financial statements (statement of financial position, statement of comprehensive income, statement of changes in equity and statement of cash flows should be prepared to present the current period and the comparative period.

Where the Health entity changes the accounting policies retrospectively, or makes retrospective restatements (refer to Chapter 4 of the policy document), an opening statement of financial position should be prepared.

Where it is impractical to restate comparative figures when it changes the presentation or classification of items in the financial statements, the Health entity should disclose the reason for not restating and the nature of the adjustments that would have been made had it been practical to do so. It is 'impracticable' to apply a requirement if it cannot be applied after making every reasonable effort to do so.

Consistency of presentation

The Health entity should retain the presentation and classification of items in the financial statements from one period to the next unless:

1. It is apparent, following a significant change in the nature of the Health entity's operations or a review of its financial statements, that another presentation or classification provides relevant and more reliable information
2. A change in the Australian Accounting Standards require a change in presentation

The Health entity should only change the presentation where it is likely to continue to be used in future periods.

2.4.3 Structure and content

Financial statements should be identified and distinguished from other information presented in the same annual report.

As part of the annual report, the Health entity should clearly identify each financial statement and the notes and the following information should be displayed prominently:

1. the entity's name and any change in it since the previous period end
2. whether the financial statements are of an individual entity or a group of entities
3. the date at the end of the reporting period or the period covered by the financial statements or notes
4. the presentation currency
5. the level of rounding used

2.4.4 Statement of financial position

The statement of financial position should include line items which present the following amounts:

- Right-of-use assets
- property, plant and equipment
- investment property
- intangible assets
- financial assets at fair value, separately disclosing derivatives, TCorpIM Funds (other than the TCorpIM Cash Fund which is included as 'cash assets'), shares and other major categories. The TCorpIM Funds investment facilities that are normally part of the 'financial assets at fair value' category include the Short Term Income Fund, Medium Term Growth Fund and Long Term Growth Fund
- Other financial assets, separately disclosing other loans and deposits (e.g. Treasury Corporation deposits greater than 90 days), advances receivable and other major categories of investments
- inventories
- Receivables, distinguishing between sale of goods and services from contracts with customers, retained taxes, fees and fines, prepayments and other major categories of receivables (e.g. personnel services receivable for entities providing personnel services per TC15-07)
- contract assets
- cash and cash equivalents
- assets classified as held for sale
- any major categories of other assets
- payables, separately disclosing accrued salaries, wages and on-costs, creditors and other major categories (e.g. personnel services payable for entities receiving personnel services per TC15-07)
- provisions, separately disclosing (a) employee benefits and related on-costs – including annual leave, long service leave and other major categories; (b) other provisions – including restoration costs and other major categories (e.g. personnel services liabilities for entities receiving personnel services per TC 15-07)
- financial liabilities and borrowings, separately disclosing bank overdrafts, derivatives, NSW Treasury advances repayable, TCorp borrowings, other loans and deposits, lease liabilities, service concession financial liabilities and other major categories (e.g. financial guarantee liabilities, where material)

- contract liabilities
- other liabilities, separately disclosing liability to Consolidated Fund, grant of right to operate liability under service concessions, Liabilities under transfers to acquire or construct non-financial assets to be controlled by the entity, unearned revenue and other major categories of other liabilities
- liabilities included in disposal groups classified as held for sale
- equity reserves attributable to owners of wholly-owned public sector entities

AASB 101.60-61

The Health entity is required to disclose separately, the current and non-current assets and liabilities on the face of the statement of financial position as mandated through the Treasury Policy and Guidelines *TPG23-04 Mandates of options and major policy decisions under Australian Accounting Standards*. The Health entity is also required to make additional disclosures in respect of each asset and liability line item that combines amounts expected to be recovered or settled within 12 months with those expected to be recovered or settled after more than 12 months.

Current assets

An asset is a current asset if:

1. the Health entity expects to realise the asset, or intends to sell or consume it in its normal operating cycle (per the Treasury Mandate, the 12 month operating cycle should be adopted for NSW Health)
2. it is held primarily for the purpose of trading
3. the Health entity expects to realise the asset within 12 months after the reporting period or
4. it is a cash or a cash equivalent, unless the asset is restricted from being exchanged or used to settle a liability for at least 12 months after the reporting period.

All other assets are non-current.

AASB 101.66-76

Current liabilities

A current liability is:

1. a liability which the Health entity expects to settle in its normal operating cycle
2. a liability held primarily for the purpose of trading
3. a liability due to be settled within 12 months after the reporting period
4. a liability whose settlement the Health entity does not have an unconditional right to defer for at least 12 months after the reporting period.

All other liabilities are non-current.

Information to be presented either in the statement of financial position or in the notes

The Health entity should disclose, either in the statement of financial position or in the notes, further sub classifications of the line items presented, classified in a manner appropriate to the entity's operations.

The Health entity should also disclose the following, either in the statement of financial position or the statement of changes in equity or in the notes, a description of the nature of purpose of each reserve within equity. The Health entity should also disclose changes during the period in each category of equity interest.

2.4.5 Statement of other comprehensive income

The statement of comprehensive income should present the following sections:

- profit or loss
- total other comprehensive income
- comprehensive income for the period, being the total of profit or loss and other comprehensive income

The profit or loss and the comprehensive income should be split between non-controlling interests and owners of the parent.

The profit or loss line item should present the following line items for the period:

- revenue, presenting separately appropriations, sale of goods and services from contracts with customers, investment revenue, retained taxes, fees and fines, grants and other contributions, acceptance by the Crown of employee benefits and other liabilities and other income
- expenses, presenting separately employee-related expenses, operating expenses, depreciation and amortisation, grants and subsidies, finance costs and other expenses
- gains / (losses) on disposal
- impairment losses
- share of the profit or loss of associates and joint ventures accounted for using the equity method
- if a financial asset is reclassified out of the amortised cost measurement category so that it is measured at fair value through profit or loss, any gain or loss arising from a difference between the previous amortised cost of the financial asset and its fair value at reclassification
- if a financial asset is measured at fair value through profit or loss, any cumulative gain or loss previously recognised in other comprehensive income that is reclassified to profit or loss.
- other gains / (losses)

AASB 101.81-105

As mandated through the Treasury Policy and Guidelines *TPG23-04 Mandates of options and major policy decisions under Australian Accounting Standards*, the following transactions should be disclosed separately where material:

- employee related expenses: salaries and wages (including annual leave), superannuation – defined benefit plans, superannuation – defined contribution plans, long service leave, workers compensation insurance, payroll tax and fringe benefits tax and other major categories
- auditor's remuneration, cost of sales, costs of inventories held for distribution, expense relating to short-term leases, expense relating to leases of low-value assets, variable lease payments not included in lease liabilities, maintenance, insurance, consultants, other contractors, research and development and other major categories of operating expenses
- nature and amount of major categories of grant and subsidy expenses
- investment revenue (including interest income from financial assets at amortised cost, from financial assets at fair value through other comprehensive income and from statutory receivables, finance income on the net investment in the lease, gains/(losses) from TCorpIM Funds measured at fair value through profit or loss, rental income, dividends and royalties)
- revenue from retained taxes, fees and fines

- acceptance by the Crown: superannuation – defined benefit, long service leave provision, borrowings and other major categories
- major categories of other revenue, including forgiveness of liabilities and fee income
- gains or losses on disposal of each category of financial instruments.

The Treasury Mandate also mandates that the expenses within the profit or loss section should be presented on the basis of their nature as oppose to the function of the Health entity.

The other comprehensive income section should present the following items:

- items of other comprehensive income classified by nature and grouped into those that:
  a) will not be reclassified subsequently to profit or loss and
  b) will be reclassified subsequently to profit or loss when specific conditions are met

The above should also separately disclose the share of other comprehensive income of associates and joint ventures accounted for using the equity method.

2.4.6 Statement of changes in equity

The statement of changes in equity should present the following information:

- Total comprehensive income for the period
- For each components of equity, the effects of retrospective application or retrospective restatement recognised as per Chapter 4 of this policy document
- For each component of equity, a reconciliation between the carrying amount at the beginning and the end of the period, separately (as a minimum) disclosing changes from:
  i) Profit or loss
  ii) Other comprehensive income and
  iii) Transactions with owners of wholly-owned public sector entity, showing separately contributions by and distributions to owners

2.4.7 Statement of cash flows

Refer to Chapter 3 of this policy document with respect to the requirements for the presentation and disclosure of cash flow information.

2.4.8 Notes to the financial statements

The notes to the financial statements should:

- present information about the basis of preparation of the financial statements and the specific accounting policies used
- disclose the information required by Australian Accounting Standards that is not presented elsewhere in the financial statements and
- provide information that is not presented elsewhere in the financial statements, but is relevant to an understanding of them

The Health entity should present notes in a systematic manner, by cross referencing each item in the statement of financial position, statement of comprehensive income, statement of changes in equity and statement of cash flows to any related information in the notes.

Significant accounting policies

The Health entity should disclose its significant accounting policies which comprises:

- the measurement basis (or bases) used in preparing the financial statements and
- the other accounting policies used that are relevant to an understanding of the statements

In addition to the significant accounting policies, the Health entity should disclose the judgements that management has made in the process of applying NSW Health's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Sources of estimation uncertainty

The Health entity should disclose information about the assumptions it makes about the future, and other major sources of estimation uncertainty at the end of the reporting period that has a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year. In respect of these assets and liabilities, the notes should include details of:

- their nature; and
- their carrying amount as at the end of the reporting period.

Trust Funds

Trust funds that do not meet the asset/liability recognition criteria (refer chapter 1.4.6 for recognition criteria), should not be brought to account in the financial statements but are shown in the notes for information purposes. The Treasury Mandate mandates disclosure of types, purposes and movements of trust funds by broad categories in the notes of the financial statements.

3 Cash flow statements

3.1 Scope

3.1.1 Applicability

This Policy provides the accounting guidance to prepare a statement of cash flow as an integral part of the Health entity's financial statements and prescribes the criteria for classifying cash and cash equivalents in the period, classifying these as arising from operating, investing or financing cash flows.

3.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- AASB 107 Statement of cash flows
- Treasury Policy and Guidelines *TPG23-04 Mandates of options and major policy decisions under Australian Accounting Standards*.

3.2 Overview and purpose

The purpose of this document is to provide illustrative guidance on the accounting and reporting requirements with respect to the preparation of the statement of cash flows.

The accounting treatment for inventories must meet the guidelines as set out in *AASB 107 Statement of cash flows*. The policy provides guidance on classifying cash and cash equivalents in the period and classifying these as arising from operating, investing or financing cash flows.

3.3 Policy Statement

Cash flows are defined as “inflows and outflows of cash and cash equivalents”. The statement of cash flows reports changes in the cash and cash equivalents in the period, classifying these as arising from operating, investing or financing activities. The statement of cash flows should focus on identifying the cash effects of transactions with parties that are external to the reporting entity and their impact on its cash position.

3.4 Application guidance

3.4.1 Cash and cash equivalents

Cash is defined as being cash on hand and demand deposits and cash equivalents are defined as short-term, highly liquid investments that are readily convertible to known amounts of cash and which are subject to an insignificant risk of changes in value.

In order to be a cash equivalent, an investment will normally have a short maturity which would be a period of three months or less, commencing from the investment's acquisition date. Further, for a security to be a cash equivalent, it should be readily convertible, with a short maturity and the Health entity should consider it as a means for settling liabilities and not as an investment or for any other purpose.

Bank overdrafts

Bank overdrafts that are repayable on demand and that are integral to the Health entity's cash management should be included as a component of cash and cash equivalents. A characteristic of such banking arrangements is that the bank balance often fluctuates from being positive to overdrawn.

AASB 107.10-17

3.4.2 Format of statement of cash flows

The format of the statement of cash flows should be classified and reported according to the activity which give rise to them as follows:

- operating activities
- investing activities
- financing activities

Operating cash flows

Operating activities are defined as the principal revenue-producing activities of the entity and other activities that are not investing or financing activities.

Cash flows from operating activities will represent the movements in cash and cash equivalents resulting from the operations shown in the statement of comprehensive income in arriving at profit or loss. The following are examples of operating cash flows:

- receipts from the sale of goods and the rendering of services
- receipts from grants and contributions
- receipts from parliamentary appropriations
- payments to suppliers for goods and services
- payments for grants and subsidies
- reimbursements from the Crown Entity
- payments to and on behalf of employees
- payments and refunds of income taxes
- interest paid and received and dividends received (as mandated by Treasury Policy and Guidelines TPG23-04)

The Health entity should report the operating cash flows using the direct method in accordance with Treasury Policy and Guidelines *TPG23-04 Mandates of options and major policy decisions under Australian Accounting Standards*.

The direct method reports the major classes of gross operating cash receipts and gross operating cash payments. These gross operating cash flows are aggregated to produce the entity's net operating cash flows.

Investing activities

Investing activities is defined as the acquisition and disposal of long-term assets and other investments not included in cash equivalents. Hence, cash flows from investing activities include the cash effects of transactions relating to the acquisition and disposal of any long-term asset or current asset investment (other than those regarded as cash equivalents).

The following are examples of cash flows classed as investing activities:

- Payments to acquire long-term assets (including property, plant and equipment, intangibles and payments relating to capitalised development cost and infrastructure assets)
- Receipts from sale of long-term assets
- Payments to acquire equity or debt instruments of other entities
- Advances and loans made to other parties (other than those made by a financial institution)
- Receipts from the repayment of advances and loans made to other parties (other than those received by a financial institution)

Financing activities

Financing activities are defined as activities that result in changes in the size and composition of the contributed equity and the borrowings of the entity. Therefore, cash flows from financing activities generally comprise receipts or payments in relation to the obtaining, servicing and repayment or redemption of debt and equity sources of finance. This applies except to bank overdrafts and where borrowings are classified as cash and cash equivalents (ie short-term borrowings of three months or less).

The following are examples of cash flows from financing activities:

- Repayments of amounts borrowed
- Proceeds of amounts borrowed
- Principal portion of lease repayments

3.4.3 Gross or net cash flows

The standard requires the major classes of gross receipts and payments to be presented separately on the face of the cash flow statement. However the standard also allows certain cash flows to be reported on a net basis in limited circumstances as follows:

- cash receipts and payments on behalf of customers when the cash flows reflect the activities of the customer rather than those of the entity and
- cash receipts and payments for items in which the turnover is quick, the amounts are large, and the maturities are short

Under Treasury Policy and Guidelines *TPG23-04 Mandates of options and major policy decisions under Australian Accounting Standards*, the Treasury Circular mandates that the Health entities should report the relevant cash flows on a net basis under the limited circumstances as noted above. Cash flows must be reported gross in all other circumstances.

4 Accounting policies, accounting estimates and errors

4.1 Scope

4.1.1 Applicability

This Policy prescribes the criteria for selecting and applying accounting policies, and addresses the accounting treatment and disclosure requirements of changes in accounting policies and accounting estimates and correction of prior period errors.

4.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- AASB 108 Accounting Policies, Changes in Accounting, Estimates and Errors

4.2 Overview and purpose

Accounting policies are the specific principles, bases, conventions, rules and practices that an entity applies when preparing and presenting financial statements. NSW Health selects its accounting policies in accordance with the Australian International Financial Reporting Standards (AIFRS) which the AASB develops and reviews. NSW Health is also required to comply with the Treasurer's directions when determining its own policies. The health entities should refer to this policy document with respect to the accounting policies.

4.3 Selecting and applying accounting policies

Entities do not need to apply accounting policies contained in AIFRS where the effect of applying them is immaterial.

When considering materiality, the Health entity needs to understand the characteristics of the users of the financial statements and how it reasonably expects them to influence such users economic decisions.

The Health entity should also apply the accounting policies consistently unless permitted under the guidelines of this accounting policies (an example of this would be different accounting policies to different categories of PP&E as noted in Chapter 5 of this document). The consistency principle also applies from one accounting period to the next.

4.4 Changes in accounting policies

The Health entity should change its accounting policy only if:

- a standard or an interpretation requires the change or
- the change will result in the financial statements providing reliable and more relevant information about the effects of transactions, other events or conditions on the entity's financial position, financial performance or cash flows.

Any changes to Health entity's accounting policies should be approved by the NSW Ministry of Health.

It is not a change in accounting policy where NSW Health introduces an accounting policy to account for transactions or events that are different in substance from those previously occurring. Further, adopting an accounting policy for events or transactions that previously did not occur, or were immaterial, is not a change of accounting policy.

A change in accounting policy that is made on the initial application of an AASB standard (including early adoption) should be accounted for in accordance with the specific transitional provisions of that standard or interpretation, if any. New or revised standards often includes specific transitional provisions to allow prospective, rather than retrospective application of the standard. Early adoption of a new standard is not treated as a voluntary change and hence any specific transitional provisions in the new standard should be applied. NSW Health is not permitted to early adopt new Australian Accounting Standards, unless NSW Treasury determines otherwise.

Voluntary changes to accounting policy

The Health entity should retrospectively apply voluntary changes to the new accounting standards or accounting policies where there are no specific transitional rules, including changes in presentation to the extent that it is impracticable. All comparative amounts should be adjusted to show the results and financial position of prior periods as if the new accounting policy had always applied.

The Health entity should report the adjustment to all periods prior to those presented as an adjustment to the opening balance of each affected component of equity for the earliest period presented.

4.5 Changes in accounting estimates

Estimates involve judgements based on the latest available, reliable information. Examples of estimates include:

- Determining an allowance for doubtful debts
- Provision for slow-moving or obsolete inventory
- Useful lives of property, plant and equipment and intangible assets
- Fair values of non-current physical assets

A change in accounting estimates refer to an adjustment of the carrying amount of an asset or a liability, or the amount of the periodic consumption of an asset, that results from the assessment of the present status of, and expected future benefits and obligations associated with assets and liabilities.

Changes in accounting estimates do not, by their nature relate to prior periods and are not corrections of errors. Therefore, the accounting treatment for changes to accounting estimates differ from accounting policies. Changes in accounting estimates result from new information or developments and therefore are not correction of errors.

The Health entity should recognise the effect of a change in accounting estimate prospectively (ie from date of change) by including it in profit or loss in:

- The period of the change, if the change affects that period only or
- The period of the change and future periods, if the change affects both

Where the change affects the asset or liabilities, or relates to an equity item instead of profit or loss, the Health entity should recognise such changes by adjusting the carrying amount of the related assets and liabilities or the equity item in the period of change. Change in estimate would generally adjust the difference to profit or loss where the corresponding adjustments to an asset, a liability or an equity item are not equal.

Example 4.1 Changes in accounting estimates

An amount of $50,000 was initially expensed as it was assessed not probable that future economic benefits would result, based on information available at the time. This expenditure was incurred in connection with the development of a new vaccine.

New information has subsequently come to light to change that assessment, where the development of the vaccine is determined to be feasible and the probability criterion for the economic benefits is determined to be met. An asset should be recognised for the subsequent expenditure on intellectual property. $150,000 was subsequently spent on further developing the intellectual property and therefore was capitalised but not the previous $50,000.

How should the above be accounted for?

Expenditure that was expensed in the prior period must not be reversed and capitalised as part of the cost of the asset, as this is not a correction of an error, rather it is similar to a revision of an accounting estimate.

4.6 Prior period errors

Material errors may relate to one or more periods for which financial statements have already been issued. These errors are corrected by adjusting the comparative information for the periods affected that are included in the current period's financial statements.

The term prior period errors refers to omissions from, and misstatements in the entity's financial statements for one or more prior periods arising from a failure to use, or misuse of reliable information that:

- was available when financial statements for those periods were authorised for issue and
- could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts and fraud.

Determining whether or not there has been an error in the prior period requires consideration of whether there was reliable information available that could have been reasonably been obtained at the time when the error was made. If the information was determined to be available at the time yet the information was disregarded or misused, then this would require a correction or error rather than a change in the accounting estimate.

The Health entity should correct material prior period errors retrospectively, by amending comparatives and restating retained earnings at the beginning of the earliest period presented in the first set of financial statements authorised for issue after their discovery. The following restatement would be required:

- Restating comparative amounts for the prior period presented in which the error occurred or
- If the error occurred before the earliest prior period presented in the financial statements, restating the opening balances of assets, liabilities and equity for the earliest prior period presented.

Example 4.2 Correction of prior period error – Recognition of previous unrecognised building

The Health entity conducted a physical verification of buildings in June 20X4. It was found that one building had not previously been recorded in the asset register. Upon investigation it was revealed that the building was transferred to the Health entity when one of the health corporations had dissolved under a legislative amendment on 1 July 20X1. At July 20X1 the building had a fair value of $1,000,000 and accumulated depreciation of $100,000. The building has a useful life of 50 years and as at 1 July 20X1, a remaining useful life of 45 years. It is depreciated on a straight line basis at $20,000 per year.

How should the above be accounted for?

As the error occurred before the earliest period presented in the financial statements, the Health entity would need to make the following entry to the opening balances of the earliest period presented in its financial report (ie in 20X2 to 20X3 to correct the omission.

June 20X4:

Dr Buildings $1,000,000
Cr Accumulated Depreciation $100,000
Cr Contributed equity $900,000

To record asset at its original transfer value against contributed equity as it results from a transfer of the building from another health corporation

Dr Accumulated surplus $40,000
Cr Accumulated depreciation $40,000

To record prior period depreciation from 20X1 to 20X2 of $20,000 and from 20X2 to 20X3 of $20,000

Dr Depreciation expense $20,000
Cr Accumulated depreciation $20,000

To record current year depreciation from 20X3 to 20X4

4.7 Impracticality of retrospective application or restatement

In limited circumstances, full retrospective application or restatement might not be practicable. Full retrospective application or restatement is not required to the extent that it is impracticable to determine either the period-specific effects or the cumulative effects of changing an accounting policy or the correction of material prior period errors.

The Health entity may consider it be impracticable to apply a change in accounting policy or correct a prior period retrospectively where:

1. The effects of the retrospective application or retrospective restatement are not determinable
2. The retrospective application or restatement requires assumptions about what management's intent would have been in that period or
3. The retrospective application or restatement requires significant estimates of amounts, and it is impossible to distinguish objective information about those estimates that
   - provides evidence of circumstances that existed on the date at which those amounts are to be recognised, measured or disclosed and
   - would have been available when the financial statements for that prior period were authorised for issue, from other information

4.8 Disclosures – changes in accounting policies, accounting estimates and correction of prior period errors

Where the Health entity has retrospectively applied an accounting policy, or restated or reclassified items in its financial statements, and this has a material effect on the information in the balance sheet at the beginning of the preceding period, it presents that balance sheet. The additional balance sheet is given as at the beginning of the preceding period. The Health entity is not required to disclose the notes related to the additional balance sheet.

Where there is a change in the accounting estimate, the Health entity should disclose the nature and amount of change in an accounting estimate that has an effect in the current period or is expected to have an effect in future period, except for the disclosure of the effect on future periods when it is impracticable to estimate that effect.

5 Property, plant and equipment

5.1 Scope

5.1.1 Applicability

This Policy applies to the accounting treatment for property, plant and equipment (PPE), including recognition of assets, determination of their carrying amounts and the depreciation charges to be recognised in relation to PPE.

5.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- AASB 116 Property, plant and equipment
- TPP21-09 Accounting Policy: Valuation of Physical Non-Current Assets at Fair Value
- TPP 06-06 Guidelines for capitalisation of property, plant and equipment

5.2 Overview and purpose

The purpose of this document is to provide Health entities with illustrative guidance on:

- The recognition criteria for assets
- The policy for subsequent measurement of PPE
- The method of depreciation to be used by the Health entities
- The policy for useful lives

Expenditure to be capitalised must meet the accounting capitalisation criteria as described in NSW Treasury's TPP 06-06 Guidelines for capitalisation of property, plant and equipment ("TPP 06-06)") which is based on Australian equivalents to International Financial Reporting Standards (AIFRS).

There is a separate policy on the capitalisation of costs (Chapter 9). To the extent the assets are costs related to capital expenditures, that policy should be used.

5.3 Policy statement

AASB 116.6

Property, plant and equipment is defined as tangible items that are held for use in the production or supply of goods or services, for rental to others or for administrative purposes and are expected to be used during more than one period.

The Health entity is required to apply judgement as to what constitutes an item of property, plant and equipment and is required in applying the recognition criteria based on the Health entity's specific circumstances.

The following property, plant and equipment are covered under this policy:

- Land
- Buildings
- Electro medical equipment
- Computer equipment
- Infrastructure systems
- Leasehold improvements
- Motor vehicles
- Office equipment
- Plant and machinery
- Linen
- Furniture, fittings and furnishings

5.4 Application guidance

5.4.1 Recognition criteria

AASB 116.7

Property, plant and equipment is only recognised as an asset if is it probable that the Health entity will receive the expected future economic benefits over 12 months and the cost of the asset can be measured reliably. Future economic benefits in the context of Health entity assets is their ability to generate cash flows, such as using medical equipment to treat patients who pay fees.

Probability that future economic benefits will eventuate

In determining whether to recognise an asset, the Health entity must consider the degree of uncertainty that attaches to the flow of future economic benefits from the particular asset. If it considers that it is more likely rather than less likely that future economic benefit will arise, then the probability criteria is met.

Asset can be measured reliably

The value of assets can usually be measured reliably using a number of methods which may include:

- Price charged by the supplier for purchased assets
- For internally developed assets, the value can be derived using information from labour and other costing systems
- Independent valuation advice for land and buildings or infrastructure assets
- In certain circumstances, the Health entity may need to make an estimation of a cost or value using a reasonable estimation basis. For example estimating future cash flows the asset will generate in order to value the asset.

5.4.2 Initial recognition and measurement

The initial recognition of assets may arise from the following circumstances:

- Acquisition of assets involving a transfer of consideration
- Assets acquired at no cost or for nominal consideration
- Assets not previously recognised

Refer to Chapter 9 Capitalisation of costs for additional guidance.

Acquisition of assets involving a transfer of consideration

Property, plant and equipment should initially be measured at cost. Cost is the fair value of consideration given for the asset.

The cost of an item of property, plant and equipment comprises the purchase price and any costs directly attributable to bringing the asset to the location and condition necessary for it to be capable of operating in the manner intended by management. The cost should also include the estimated costs for dismantling and removing the asset and restoring the site on which it is located. Trade discounts and rebates are deducted in arriving at cost.

The following represent examples of costs which can be capitalised and costs which should be expensed. Refer to Chapter 9 for further guidance:

Capitalisable costs	Non-capitalisable costs
• Employee benefit costs arising directly from the development of an integrated system (such as a dedicated IT development manager to the eMR Connect Program) • Costs of site preparation associated with building a bridge on a hospital ground • Initial delivery and handling costs • Installation and assembly costs • Costs of testing whether the asset such as a medical device is functioning properly • Professional fees directly associated with a purchase of a hospital building (e.g stamp duty and legal costs)	• Administration and other general overheads (e.g. management's labour costs pertaining to the oversight of a capitalised project) • start-up costs • relocation and reorganisation costs (e.g. re-organisation of hospital beds) • costs of opening a new hospital wing (e.g. cleaning costs, grand opening expenditure) • costs of introducing a new product or service • costs of advertising and promotional activities (e.g. medical pamphlets) • costs of consumables (e.g. hospital gloves) • costs of staff training • costs incurred when the asset (e.g. Healthcare Observer) is capable of operating as management intends, but has not yet been brought into use or is operating at less than full capacity as not all data had been transferred across to Healthcare Observer

Assets acquired in a non-cash exchange

One or more items of property, plant and equipment may be acquired in exchange for a non-monetary asset (such land, buildings or medical equipment), monetary assets or a combination of the two. The cost of such an item of PP&E must be measured at fair value unless:

- the exchange transaction lacks commercial substance (i.e. the exchange will not affect the future cash flows of the Health entity entity); or
- the fair value of neither the asset received nor the asset given up is reliably measurable

Cost of donated assets

Assets acquired at no cost should be recognised initially at fair value as at the date of acquisition.

Assets not previously recognised

Assets which were not previously recognised but had subsequently met the recognition criteria (not due to error) shall be recognised from the date the criteria are met.

Example 5.1: Painting previously expensed as amount is below the threshold

The Health entity had purchased a painting for $2,000 as part of its furnishings for a new hospital wing. This amount was expensed at the time as the asset recognition threshold was $5,000. Three years later, the demand for the works of this particular artist had increased which resulted in the painting now being valued at $50,000.

This is considered as a change in the accounting estimate. The increase in value is treated as a revaluation of an asset recognised initially at zero value and the following accounting entry is required:

Dr Asset $50,000
Cr Asset Revaluation Surplus $50,000

For example of newly discovered building, please refer to example 5.2.

5.4.3 Recognition threshold

Refer to Chapter 9.4.2 Initial measurement of costs and threshold.

5.4.4 Subsequent measurement

TPP 21-09 mandates PPE to be measured at fair value, with fair value being:

- An asset is carried at a revalued amount, less any subsequent accumulated depreciation and impairment losses under the revaluation model. Refer to Chapter 10 Fair Value measurement for further details with respect to the accounting of assets subject to fair value.

Non-specialised assets with a short useful life are measured at depreciated historical cost, as an approximation of fair value. This policy allows recognition at depreciated historical cost as an acceptable method for approximation of fair value.

Revaluation must be applied to an entire class of property, plant and equipment to which that item belongs.

Where the asset's carrying amount has increased due to a revaluation, the increase should be recognised within the statement of comprehensive income and recognised in the statement of changes in equity as a revaluation surplus. The increase should only be recognised in the profit or loss to the extent that it reverses a revaluation decrease (ie past impairment) of the same class of asset previously recognised in profit or loss.

A revaluation decrement of a non-current asset must be recognised immediately as an expense in profit or loss, except to the extent that a credit balance exists in the asset revaluation reserve in respect of that same class of non-current assets.

The group should assess subsequent costs which may add to, replace part of or service property, plant and equipment. The policy choice is by class of asset rather than by individual assets within a class. Refer to Chapter 9 Capitalisation of Costs for determination of the accounting treatment pertaining to the subsequent costs.

As stated above all assets are required to be held at fair value. To ensure that the asset class is stated at fair value NSW Health generally uses the measurement as specified in the table below:

Nature of expenditure	Measurement	Also refer to
Artwork	Revaluation method (fair value)	Chapter 10 – Fair Value Measurement
Buildings	Revaluation method (fair value)	Chapter 10 – Fair Value Measurement
Electro Medical Equipment	Cost (as approximation of fair value)	Chapter 9 – Capitalisation of costs
Computer Equipment	Cost (as approximation of fair value)	Chapter 9 – Capitalisation of costs
Infrastructure Systems	Revaluation method (fair value)	Chapter 10 – Fair Value Measurement
Leasehold Improvements	Revaluation method (fair value)	Chapter 10 – Fair Value Measurement
Motor Vehicles	Cost (as approximation of fair value)	Chapter 9 – Capitalisation of costs
Office equipment	Cost (as approximation of fair value)	Chapter 9 – Capitalisation of costs
Plant and Machinery	Cost (as approximation of fair value)	Chapter 10 – Fair Value Measurement
Linen	Cost (as approximation of fair value)	Chapter 9 – Capitalisation of costs
Furniture, Fittings and Furnishings	Cost (as approximation of fair value)	Chapter 9 – Capitalisation of costs
Intangible assets (ie. software)	Cost (as approximation of fair value)	Chapter 9 – Capitalisation of costs

While TPP21-09 requires all physical non-current assets to be measured at fair value, the transaction price or cost is considered to be a key element of fair value.

5.5 Depreciation

AASB 116.43-62

Depreciation is defined as the systematic allocation of the depreciable amount of an asset over its useful life, where the depreciable amount is defined as the cost of an asset or other amount substituted for cost, less its residual value.

Example 5.2: Straight line method (with no residual value)

An ultrasound machine had a cost of $30,000 with no residual value and a useful life of ten years. An amount of $3,000 would be recorded each year as depreciation under the straight line method.

Depreciation is charged even if an asset carried at cost less depreciation has a fair value in excess of that carrying amount, so long as the asset's residual value does not exceed its carrying amount.

Depreciation of an asset should commence when the asset is available for use (ie the asset is in the location and condition necessary for it to be operating in the manner intended by management). Depreciation of the asset would only cease when the asset becomes held for sale or included in a held for sale group of assets. Depreciation does not end when the asset becomes idle or retired from active use – unless the asset is fully depreciated.

Depreciation of separate components

An asset might include several different significant components. Each component is treated separately for depreciation purposes and depreciated over its individual useful life. Where the useful life and pattern of consumption is similar, the components can be grouped for depreciation purposes.

NSW Health has componentise all specialised building into the following components:

i) *Sure / shell / building fabric*

ii) *Fit out*

iii) *Combined fit out and trunk reticulated building systems*

iv) *Site engineering services / central plant*

The different components are depreciated using different useful lives.

There are no other assets that require componentisation.

5.5.1 Useful lives

AASB 116.6

Useful life is defined as the period over which an asset is expected to be available for use by the Health entity, or the number of production or similar units expected to be obtained from the asset by the Health entity. The estimate of an asset's useful life is a matter of judgement based on experience with similar assets and can be determined through consideration of the following factors:

- Expected usage
- Expected physical wear and tear
- Technical or commercial obsolescence
- Legal or similar units on use

The following table specifies the depreciation rates (effectively useful lives) used by Health.

Category	Percentage	Years
Artwork	5%	20
Buildings – specialised*		
• Structure / shell / building fabric	1.43%	70
• Fit out	3.33%	30
• Combined fit out and trunk reticulated building systems	3.33%	30
• Site engineering services / central plant	1.82%	55
Buildings – non-specialised	2.5%	40
Electro Medical Equipment		
• Costing less than $200,000	10%	10
• Costing more than or equal to $200,000	12.5%	8
Computer Equipment	20%	5
Infrastructure Systems	2.5%	40
Leasehold Improvements	10%	10
Motor Vehicle		
• Sedans	12.5%	8
• Trucks and Vans	20%	5
Office Equipment	10%	10
Plant and Machinery	10%	10
Linen	25%	4
Furniture, Fittings and Furnishings	5%	20
Intangible assets (ie. software)	6.67% to 25%	4-15

* The new useful lives are effective from 1 July 2022. Prior to that, the useful life was 40 years for specialised buildings

The method of depreciation adopted should reflect the pattern in which the asset's future economic benefits are expected to be consumed by the entity. The common method is the straight line depreciation method.

5.5.2 Residual value

AASB 116.6, 53 & 54

The residual value is the estimated amount realised from the current disposal of the asset if the asset is in the age and condition to be expected at the end of its useful life.

Example 5.3: Straight line method (with a residual value):

An incubator had a cost of $20,000, a residual value of $2,000 and a useful life of five years. Depreciation of $3,600 would be recorded each year as depreciation under the straight line method [(20,000-2,000)/5 = $3,600].

5.6 Categories of PPE

AASB 116.43-62

The following table outlines the main categories of PPE, their subsequent measurement, the appropriate valuation technique and the appropriate method of depreciation (as applicable).

Nature of expenditure	Subsequent measurement	Valuation technique where revaluation model is used	Method of depreciation (for assets measured at fair value)
Artwork	Revaluation model	Market or income approach	Net method
Land	Revaluation model	Market or income approach	N/A – as land is not depreciated
Buildings – specialised	Revaluation model	Cost approach	Gross method
Buildings – non specialised	Revaluation model	Market or income approach	Net method
Electro Medical Equipment	Cost (as approximation of fair value)		Straight line method
Computer Equipment	Cost (as approximation of fair value)		Straight line method
Infrastructure Systems	Revaluation model	Cost approach	Gross method
Leasehold Improvements	Revaluation model	Cost approach	Gross method
Motor Vehicles	Cost (as approximation of fair value)		Straight line method
Office equipment	Cost (as approximation of fair value)		Straight line method
Plant and Machinery – specialised	Cost (as approximation of fair value)		Straight line method
Plant and equipment	Cost (as approximation of fair value)		Straight line method
Linen	Cost (as approximation of fair value)		Straight line method
Furniture, Fittings and Furnishings	Cost (as approximation of fair value)		Straight line method
Intangible assets (ie. software)*	Revaluation model	Market or income approach	Net method

*Note: Intangible assets are only required to be revalued if there is an “active market”, otherwise it should be carried at its cost less any accumulated amortisation and impairment losses.

The carrying amount of an asset upon revaluation can be adjusted in either of the following methods:

- Gross method – restates the gross value before depreciation of the asset and restates accumulated depreciation
- Net Method – eliminates accumulated depreciation against the carrying amount of the asset and then revalue the net carrying amount

As per TPP 21-09 Accounting Policy: Valuation of Physical Non-Current Assets at Fair Value (“TPP 21-09”), the gross method should be applied whenever the cost approach is used. Where the income or market approach is used, the net method should be adopted.

Example 5.4: Revaluation increase under the gross method

A hospital building was purchased for $100,000 was to be depreciated at 10% straight line. After three years, the asset’s written-down value is $70,000 after accumulated depreciation of $30,000. The asset’s fair value was determined to be $84,000 using the depreciated replacement cost technique. The gross replacement cost of the asset, as determined by the valuer, has increased to $120,000. The remaining useful life remains at 7 years

The accounting entries to recognise the revaluation:

Dr Hospital building $20,000
Cr Accumulated depreciation $6,000
Cr Asset revaluation surplus $14,000

To revalue hospital building from $70,000 to $84,000 WDV

Dr Depreciation expense $12,000
Cr Accumulated depreciation $12,000

Annual depreciation expense subsequent to revaluation ($84,000/7 OR $120,000 at 10%)

Example 5.5: Revaluation increase (net method)

A hospital building was purchased for $100,000 and was to be depreciated at 10% straight line. After three years, the asset’s net written-down value is $70,000 after accumulated depreciation of $30,000 (based on the net method being applied since acquisition). The asset’s fair value was determined to be $84,000 based on recent published buying prices for items in similar condition and with similar features. The remaining useful life remains at 7 years.

Accounting entries to recognise the revaluation
Dr Accumulated depreciation $30,000
Cr Hospital building $16,000
Cr Asset revaluation surplus $14,000

To revalue hospital building from $70,000 to $84,000 WDV

Dr Depreciation expense $12,000
Cr Accumulated depreciation $12,000

Annual depreciation expense subsequent to revaluation ($84,000/7)

Example 5.6: Revaluation decrease (gross method)

An item of infrastructure asset was purchased for $100,000 and was depreciated at 10% straight line. After three years, the asset's written down value is $70,000 after accumulated depreciation of $30,000. The asset's fair value was determined to be $60,000 using the depreciated replacement cost technique. The gross replacement cost of the asset, as determined by the valuer, has decreased to $120,000. The remaining useful life is 5 years.

Accounting entries to recognise revaluation:
Dr Asset revaluation surplus $10,000
Dr Infrastructure asset $20,000
Cr Accumulated depreciation $30,000

To account for the revaluation of infrastructure asset from $70,000 to $60,000 WDV, adjust against the asset revaluation surplus if that class has sufficient credit in the asset revaluation surplus balance. To the extent that the asset revaluation surplus has insufficient credit, this should be recognised as an expense in the Statement of Comprehensive Income, as follows:

Dr Impairment loss $10,000
Dr Infrastructure asset $20,000
Cr Accumulated depreciation $30,000
Annual depreciation expense subsequent to revaluation (120,000/10 OR 60,000/5)

Dr Depreciation expense $12,000
Cr Accumulated depreciation $12,000

Example 5.7: Revaluation decrease (net method)

An item of infrastructure asset was purchased for $100,000 and was depreciated at 10% straight line. After three years, the asset's written down value is $70,000 after accumulated depreciation of $30,000 (based on the net method being applied since acquisition). The asset's fair value was determined to be $60,000 based on recent published buying prices for items in similar condition and with similar features. The remaining useful life is 5 years.

Accounting entries to recognise revaluation:

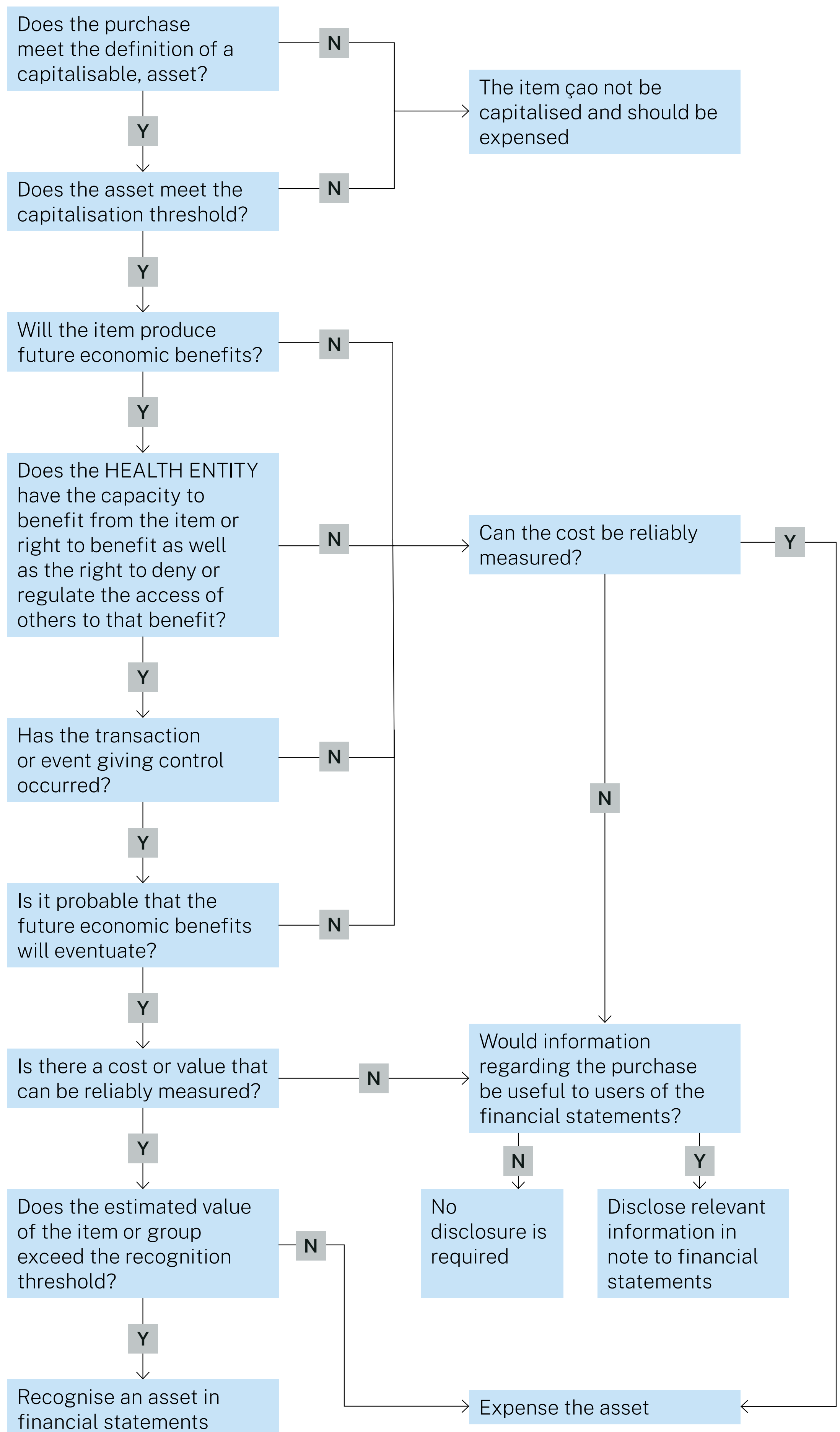
Dr Asset revaluation surplus $10,000
Cr Infrastructure asset $10,000

To account for revaluation of the infrastructure asset from $70,000 to $60,000 WDV, adjust against asset revaluation reserve if that class has sufficient credit of the asset revaluation surplus balance (to the extent that the asset revaluation surplus credit balance is insufficient, recognise as expense in Statement of Comprehensive Income, as follows:

Dr Impairment loss $10,000
Cr Infrastructure asset $10,000

Annual depreciation expense subsequent to revaluation ($60,000/5)
Dr Depreciation expense $12,000
Cr Accumulated depreciation $12,000

5.7 Summary of assets recognition criteria



6 Service concession arrangements

This represents a complex area of accounting, if you have circumstances which are consistent with this chapter, please contact the Ministry of Health Financial Accounting team.

6.1 Scope

6.1.1 Applicability

This Policy applies to the accounting treatment for arrangements that involve an operator (generally a private sector entity) providing public services related to a service concession asset on behalf of a public sector grantor (NSW Health in this case) for a specified period of time and managing at least some of those services. Service concession arrangements are commonly referred as 'Privately Financed Projects' or 'Public Private Partnership' arrangements.

6.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- AASB 1059 Service Concession Arrangements: Grantors
- TPP 19-06 AASB 1059 Service Concession Arrangements: Grantors – Scoping

6.2 Overview and purpose

The purpose of this document is to provide an overview of the required accounting by the Health entity with respect to their involvement in the Service Concession Arrangements.

AASB 1059 Service Concession Arrangements: Grantors (AASB 1059 or the Standard) represents the accounting for a service concession arrangement from the perspective of a public sector grantor. As such, it both defines a service concession arrangement and provides guidance on the recognition and measurement of the associated assets and liabilities. The standard equally applies to arrangements where the operator is another public sector entity, instead of a private sector entity.

AASB 1059 approaches the concept of service concessions through applying a control-based approach, as opposed to the previous approach of identifying and analysing the risks and rewards of the transaction (for example, as previously used in *TPP 06-8: Accounting for Privately Financed Projects* (TPP 06-8)). Note that TPP 06-8 was withdrawn, with effect from 1 July 2020 and onwards.

This document provides illustrative guidance on:

- The scope of AASB 1059 *Service Concession Arrangements*;
- The recognition and measurement of the associated assets and liabilities; and
- The disclosure requirements.

6.3 Policy statement

The Standard applies to service concession arrangements where an operator:

- Provides public services related to a service concession asset on behalf of a grantor; and
- The operator manages at least some of those public services under its own discretion, rather than at the discretion of the grantor.

Where AASB 1059 applies, the public sector grantor will recognise a service concession asset if:

- The grantor controls or regulates what services the operator must provide with the asset, to whom it must provide them, and at what price; and
- The grantor controls – through ownership, beneficial entitlement or otherwise – any significant residual interest in the asset at the end of the term of the arrangement; or
- The asset will be used in the arrangement for the asset's entire economic life (a whole-of-life asset).

Service concession assets are generally infrastructure assets comprising of public facilities pertaining to the health industry in order to provide essential healthcare services to the general public, for example, a hospital building.

The Health entity is required to apply judgement as to what arrangements fall in the scope of the Standard by applying the scoping criteria in the Standard.

6.4 Application guidance

6.4.1 Identifying the service concession asset

The assessment of whether a grantor should recognise a service concession asset is made on an asset by asset basis. As one arrangement may cover several assets it is important to first identify the assets to be assessed. Assets should be assessed separately if they are:

- Physically separable;
- Capable of being operated independently; and
- Meet the definition of a cash-generating unit under AASB 136 Impairment of Assets. That is, capable of generating independent cash inflows.

It is implicit that individual assets can provide an independent service.

Example 6.1: Separate assets

An operator constructs and operates a hospital with private and public wings. The two wings are in separate buildings and have their own facilities. Each wing has its own staff and resources and patients are charged separately.

The public and private wings are likely to be considered two separate assets as they are physically distinct (being in two separate buildings) and are operating independently of each other.

The grantor would need to assess each asset under AASB 1059 separately.

Examples of some different types of service concession assets are:

- *Public Hospitals*
- *Hospital car parks*
- *Installation of a new digital theatre within a local district hospital*
- *Expansion of emergency departments (new resuscitation bay or new ambulance bays)*

Service concession assets can also be internally generated intangibles that the grantor would not have previously been able to recognise under AASB 138 Intangible Assets (AASB 138). For example, an existing state titling registry containing a database of information. As the database of information is internally generated, the state agency would not have been able to recognise the database on its balance sheet under AASB 138. However, where the database is part of a service concession arrangement, AASB 1059 would allow the grantor to recognise the value of the database as a service concession asset.

6.4.2 Public services

AASB 1059 is applicable where "the operator has the right of access to the service concession asset to provide public services on behalf of the grantor for a specified period of time".

Service concession assets should be broken into individual components to help identify the services the asset is used to provide. For example, a hospital (the asset) that contains operating theatres, wards and shops (the components); the components provide medical services and retail services respectively. But all these services are provided by the asset as a whole.

In assessing whether each asset is providing a public service, the Health entity should consider which of the identified services are primary services, and which are ancillary, for each identified asset.

Primary services are those services which are:

- identified as being provided by the asset, and
- which are significant to the arrangement as a whole

Ancillary services are those services which are:

- identified as being provided by the asset, and
- which are insignificant to the arrangement as a whole

Primary services will need to be assessed as to whether they are a public service. Ancillary services are ignored for the public service assessment.

If the primary services are public service in nature, the asset as a whole is considered to be providing public services.

If an asset has more than one primary service, and these present a mix of public service(s) and non-public service(s), further analysis and consultation with the NSW Ministry of Health is advised.

Example 6.2: Ancillary services

A public hospital has an administration office for their finance team. Hospital services are the primary service for the public hospital. Whether administrative services are primary or ancillary in nature, will depend on whether the administrative services are insignificant to the entire arrangement. If insignificant, it will be ancillary in nature and will not form part of the public service assessment.

However, if the administrative services provided by the operator through the administration offices are determined to be significant in relation to the contractual arrangement between grantor and operator as a whole, it will also be necessary to assess whether these services are providing a public service.

It is possible, in this way, for there to be more than one primary service.

AASB 1059 does not provide a "bright-line" in determining whether a service is significant. Factors to consider, individually or in combination, in determining whether a service is significant include, but are not limited to:

- *Compensation to the operator for the service compared to other services provided under the arrangement;*
- *Resource requirements (e.g. direct labour, service costs etc.) for the provision of the service relative to others provided under the arrangement;*
- *Impact on agreed outcomes, performance and/or KPIs under the arrangement;*
- *Senior management time and resources committed to the service relative to others provided under the arrangement*
- *Physical apportionment of the asset between different services*

Determining whether a service is significant will require significant judgement. Health entities should take into consideration the factors that are most relevant to each specific arrangement.

In certain circumstances, a public sector entity may contract with a third-party provider (whether public sector or private sector) to provide services it then wholly consumes in the process of providing services to the public. For example, a public sector entity might contract a third party to provide payroll services in relation to its employees; or for the provision of a wireless communication network for emergency services. Such services are unlikely to be service concession arrangements, but rather accounted for as an outsourcing arrangement or a lease.

Factors that are relevant in determining whether an arrangement is an outsourcing arrangement include:

- *the amount the agency pays is dependent on the level of services consumed by the agency rather than dependent on the services consumed by the public e.g. staff hours on internal IT projects.*
- *the significance of the service performed by the operator relative to the service the asset is used to provide (e.g. cleaning of hospital wards is relatively insignificant to the overall service provided by the hospital).*

6.4.3 Operator managing the services

For an arrangement to fall within the scope of AASB 1059, not only does the asset have to provide a public service, but the operator must be managing at least some of the public service under its own discretion. This criterion can be broken down into the following limbs:

1. The operator is "managing at least some" of the public service; and
2. The service is provided under the operator's discretion

AASB 1059 has not defined the term "at least some" and therefore judgement is required in determining whether this criterion is met. However, the Standard does indicate that the services the operator is managing should be managerial in nature and "significant" in relation to the public service provided by the asset. In other words, the Standard is looking for the operator to be managing "at least some" of the more "significant activities" that contribute to the public service being provided by the asset.

Example 6.3: General maintenance and security services

Under the arrangement, the operator will construct and provide general maintenance and security services for a public hospital. The operator will not perform any other services.

As the operator is only providing general maintenance and security services, it is unlikely that the operator is "managing at least some" of the public service. While these services are important, they are relatively insignificant to the other services required (e.g. scheduling of staff) which enable the hospital to provide health services. These services are also unlikely to be managerial in nature in the context of providing health services. This criterion is generally met where the service(s) provided by the operator contribute significantly to the public service provided by the asset.

Under a service concession arrangement, the operator also needs to be managing at least some of the services provided at its own discretion. This is to distinguish these service concession arrangements from outsourcing (or other) arrangements where the operator is merely acting as an agent for the grantor. Namely, where the grantor would direct the operator in all aspects of what and how services are to be rendered.

Example 6.4: Structural maintenance of hospital carparks

Under the arrangement, the operator manages car parks for the hospital. The day to day services required are considered a routine part of the car park management as car parks generally operate on a self-service basis. The significant service required for carparks are around maintenance and upkeep of the car parks to ensure that these are available to customers. Because under this arrangement, the operator has limited to no discretion around the maintenance plans and does not have substantive ability to decide on what maintenance works are to be performed, the operator is not deemed to be managing the services at its own discretion.

To be deemed "managing under its own discretion", the operator must have the substantive ability to decide when and how it performs its service.

6.4.4 The concept of "Control" in a service concession arrangement

AASB 1059 applies a control-based approach that focuses on the grantor's control over the service potential of the service concession asset. A grantor controls and therefore recognises a service concession asset if, and only if, all of the following criteria are met:

i) The grantor controls or regulates:

- What services the asset is providing
- To whom the services are provided (i.e. recipients)
- What price the services are provided at

ii) The grantor controls any significant residual interest in the asset at the end of the term of the arrangement or the asset will be used in a service concession arrangement for its entire economic life.

Through control of the asset during the term of the service concession arrangement (control of services/recipients/pricing) and control of any significant residual interest in the asset at the end of the arrangement, the grantor effectively establishes control of the asset over its entire economic life.

A grantor can establish control of the services to be provided by an asset through:

- rights held under the contractual arrangement. The rights must be substantive i.e. the grantor must have the practical ability to exercise those rights, rather than protective.

  Or

- as a result of regulation by a State body or a third-party regulator.

To establish control over the service concession asset, the grantor must also control to whom the services are provided by an asset i.e. the recipient and the price of the services. Again, this can be through explicit control or implicit control through regulation.

The Standard does not require the grantor to explicitly set the price, but rather the grantor may be deemed to control the price where regulation removes the ability of the operator to determine the price.

The final criteria under control-based approach is that the grantor is required to control the significant residual interest in the asset. AASB 1059 considers the grantor to have control over the significant residual interest where:

i) the grantor controls – through ownership, beneficial entitlement or otherwise – any significant residual interest in the asset at the end of the term of the arrangement; or

ii) the asset will be used in the arrangement for its entire economic life, such that any residual interest at the end of the term is insignificant (a whole-of-life asset).

All the above requirements should be met, for the asset to be recognised as a service concession asset in the grantor's books.

6.4.5 Partially regulated assets

Where an operator has the ability to determine what services are provided by an asset, or the price of those services or to whom services are provided, health entities should consider whether the asset being considered is partly regulated i.e. where the services/recipient/prices are partly controlled by the grantor and partly not controlled by the grantor.

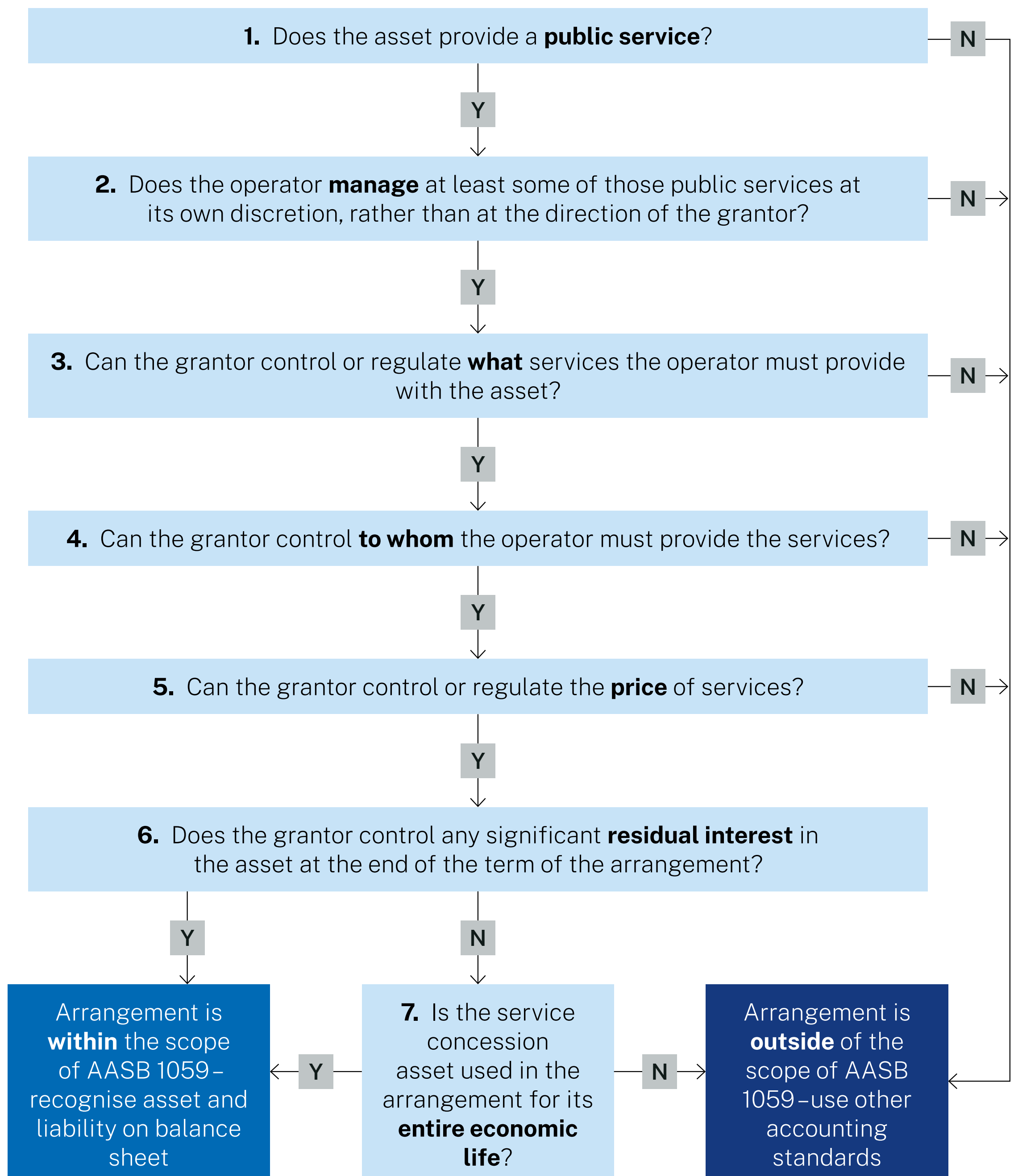
For assets that are partly regulated but not physically separable and therefore not assessed as a separate asset, judgement is required as to the relative significance of the regulated versus unregulated activities in order to determine whether the grantor has control of the asset. When purely ancillary activities are unregulated, the control tests shall be applied as if those services did not exist i.e. ancillary services are ignored.

For example, a hospital where there is no separate private wing, but where there is a mixture of both public and private patients. In this example, if admissions are expected to comprise substantially public patients, then the admission of private patients would be considered as ancillary (unregulated) and the hospital considered to be used wholly for regulated purposes.

It is a matter of judgement to determine whether enough of the services provided by an asset are regulated in order to demonstrate that the grantor has control of the asset.

6.4.6 Summary of key scoping requirements

The Standard requires the grantor to only recognise an asset as service concession arrangement if all the above noted conditions have been met. These requirements are summarised in the decision tree below:



6.4.7 Initial recognition – service concession asset

The Standard requires the grantor to initially measure a service concession asset constructed, developed or acquired by the operator or reclassified by the grantor at current replacement cost in accordance with the cost approach to fair value in *AASB 13 Fair Value Measurement*.

It is important to note that if the asset is being constructed/developed as part of a service concession arrangement, the costs incurred should be captured in the grantor's books as the asset is being constructed/developed. Similar accounting applies as in *AASB 116 Property, Plant and Equipment* for assets that are constructed/developed internally.

6.4.8 Subsequent measurement – service concession asset

Subsequent to the initial recognition or reclassification of the asset, the service concession asset is accounted for in accordance with *AASB 116 Property, Plant and Equipment* or *AASB 138 Intangible Assets*, as appropriate.

The following requirements apply:

- depreciation or amortisation of the depreciable amount of the asset over the useful life in accordance with *AASB 116 Property, Plant and Equipment* or *AASB 138 Intangible Assets*, as appropriate
- recognise any impairment in accordance with *AASB 136 Impairment of Assets*; and
- fair value measurement of service concession assets under a revaluation model using a replacement costs basis, as required under *AASB 13 Fair Value Measurement*.

At the end of the service concession term, the asset is reclassified and measured under other applicable accounting standards. The asset is derecognised in accordance with AASB 116 or AASB 138, as appropriate, only when the grantor loses control of the asset.

6.4.9 Measurement of service concession liability

The grantor should recognise a corresponding liability measured initially at the fair value (current replacement cost) of the service concession asset, adjusted for any other consideration between the grantor and the operator. The liability is recognised using either or both of the following models:

i) the financial liability model

ii) the grant of a right to the operator model (GORTO)

The financial liability model

This model applies where the grantor has an obligation to deliver cash or another financial asset to the operator for the delivery of the service concession asset.

This model requires the grantor to allocate the payments to the operator under the contract and account for them according to their substance as payments relating to the liability recognised or charges for services provided by the operator.

Payments to operator should be split between asset and service components of a service concession arrangement. Where the asset and service components are not separately identifiable, the service component of payments from the grantor to the operator shall be determined using estimation techniques.

Contractual obligation to pay cash or another financial asset to the operator for the construction, development, acquisition, or upgrade of a service concession asset is recognised as a financial liability.

Charges for services provided by the operator in a service concession arrangement shall be accounted for in accordance with other relevant Standards.

AASB 9 Financial Instruments, AASB 132 Financial Instruments: Presentation and AASB 7 Financial Instruments: Disclosures apply to the financial liability recorded under this model.

Example 6.5: Accounting under Financial liability model

Under the arrangement, the operator constructs and operates the public hospital for an agreed term of 20 years. The payments made to the operator includes capital payments for the construction of the hospital and monthly service charges for running the hospital.

The accounting entries are as follows:

Dr Service concession asset – capital WIP (at replacement cost)
Cr Financial Liability
(during the construction phase)

Dr Service concession asset – land, building, infrastructure, P&E
Cr Service concession asset – capital WIP
(on completion of construction)

Dr Depreciation – SCA
Cr Accumulated Dep – SCA
(subsequent to capitalisation, monthly depreciation entry)

Dr Interest expense – financial liability
Dr Financial liability (repayment)
Cr Cash
(ongoing payment towards the SCA)

Dr Expenses – services related charges
Cr Cash
(ongoing payment towards the services related charges)

The grant of a right to the operator model

This model applies where the grantor grants the operator the right to earn revenue from third-party users of the service concession asset. Instead of the grantor directly compensating the operator for the asset, the grantor grants the operator the right to collect revenue from users of the service concession asset.

This model requires the grantor to recognise a liability reflecting the unearned portion of the revenue arising from the exchange of the assets between the grantor and the operator. The grantor recognises revenue over the period of the service concession arrangement according to the substance of the arrangement and reduces the liability as the revenue is recognised.

Example 6.6: Accounting under GORTO model

Under the arrangement, the operator constructs and operates the public hospital carpark for 20 years. The grantor has granted the right to the operator to operate the carpark and generate and keep revenue from the operations of the carpark. The grantor does not have any contractual payments to make to the operator towards the construction and operation of the carpark.

The accounting entries are as follows:

Dr Service concession asset – capital WIP (at replacement cost)
Cr GORTO liability
(during the construction phase)

Dr Service concession asset
Cr Service concession asset – capital WIP
(on completion of construction)

Dr Depreciation – SCA
Cr Accumulated Dep – SCA
(subsequent to capitalisation, monthly depreciation entry)

Dr GORTO liability
Cr Income
(ongoing amortisation of GORTO liability on a straight-line basis)

6.4.10 Disclosures

The grantor is required to disclose sufficient information to enable users of financial statements to understand the nature, amount, timing and uncertainty of assets, liabilities, revenue and cash flows arising from service concession arrangements, by considering the disclosure of information such as the following:

i) a description of the arrangements;

ii) significant terms of the arrangements that may affect the amount, timing and uncertainty of future cash flows;

iii) the nature and extent of the grantor's rights and obligations (such as rights to receive specified services and assets from the operator, and obligations to provide the operator with access to service concession assets or other revenue-generating assets) and renewal and termination options; and

iv) changes in arrangements during the reporting period.

These disclosures are generally presented in a tabular format in the notes of the financial statements.

7 Intangible assets

7.1 Scope

7.1.1 Applicability

This Policy applies to the accounting treatment for intangible assets, including recognition of assets and determination of their carrying amounts.

7.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- *TPG23-04 Mandates of options and major policy decisions under Australian Accounting Standards*
- TPP21-09 Valuation of Physical Non-Current Assets at Fair Value
- AASB 138 Intangible Assets

7.2 Overview and purpose

The purpose of this document is to provide Health entities with illustrative guidance on:

- The initial recognition criteria for intangible assets
- The initial measurement of intangible assets
- The policy for subsequent measurement of intangible assets
- The policy for useful lives with respect to intangible assets

Impairment of intangible assets is addressed in Chapter 11 of this policy document. Fair value measurement is addressed in Chapter 10 of this policy document.

The valuation of intangible assets must meet the valuation guidelines as described in the NSW treasury accounting policy ("Valuation of Physical Non-Current Assets at Fair Value") and as per the Treasury Policy and Guidelines TPG23-04 ("Mandates of Options and Major Policy Decisions under Australian Accounting Standards). The Treasury Policy and Guidelines mandates intangible assets to be measured at fair value (ie the revaluation model) option.It also notes that it will be uncommon for fair value to exist, as there is unlikely to be an "active market" (although it may happen). Where there is no active market, the asset shall be carried at its cost less any accumulated amortisation and impairment losses. For NSW Health, most of the intangible assets have no active market and are therefore carried at cost less any accumulated amortisation and impairment losses.

7.3 Policy statement

Intangible asset is defined as an identifiable non-monetary asset without physical substance.

The Health entity is required to apply judgement as to what constitutes an item intangible asset and is required in applying the recognition criteria based on the Health entity's specific circumstances.

7.4 Application Guidance

7.4.1 Recognition criteria

AASB 138.21-23

Intangible assets can only recognised as an asset if is it probable that the Health entity will receive the expected future economic benefits over 12 months and the cost of the intangible asset can be measured reliably.

Probability that future economic benefits will eventuate

In determining whether to recognise an intangible asset, the Health entity must consider the degree of uncertainty that attaches to the flow of future economic benefits from the particular asset. If it considers that it is more likely rather than less likely that future economic benefit will arise, then the probability criteria is met.

Asset can be measured reliably

The value of assets can usually be measured reliably using a number of methods which may include:

- For intangible assets acquired in a business combination, the value can be derived from its fair value as valued by the independent valuation expert at the acquisition date
- For internally developed assets, the value can be derived using information from labour and other costing systems

7.4.2 Initial recognition and measurement

An item should be recognised as an intangible asset if it meets the definition of an intangible asset and it meets the recognition criteria as per 7.4.1.

The key characteristics of an intangible asset is that it:

- Is a resource controlled by the entity from which the entity expects to derive future economic benefits
- Lacks physical substance
- Is identifiable to be distinguished from goodwill

AASB 138.25-32

Acquisition of intangible assets involving a transfer of consideration

An intangible asset is identifiable when it:

- Is separable (ie it is capable of being separated or divided from the entity and sold, transferred, licensed, rented or exchanged, either individually or together with a related contract, asset or liability); or
- Arises from contractual or other legal rights, regardless of whether the rights are transferable or separable from the entity or from other rights and obligations

The cost of a separately acquired intangible asset can be measured initially at cost. This comprises its purchase price and any attributable costs of preparing the asset for its intended use.

Direct attributable costs may include

- Costs of materials and services used or consumed in generating the intangible assets
- Costs of employee benefits arising from the generation of the intangible asset
- Fees to register a legal right and
- Amortisation of patents and licences that are used to generate the intangible asset

The following represent examples of costs which can be capitalised and costs which should be expensed. Refer to Chapter 9 for further guidance:

Example costs incurred	Treatment
Purchase price (including import duties, non-refundable purchase taxes, minus any trade discounts and rebates)	Capitalise – this represents initial cost to acquire the asset.
Material and services in generating the asset	Capitalise – directly attributable in preparing the asset for its intended uses.
Fees to register a legal right	Capitalise – directly attributable in preparing the asset for its intended uses
Costs incurred in testing a system in pre-production	Capitalise – this forms part of the development phase.
Systems configuration	Capitalise – this is part of developing the system and is directly attributable in preparing the system for its intended use.
Costs incurred in examining a viable option for replacing a system	Expense – investigation undertaken and is part of research phase – unable to demonstrate that an intangible asset exists that will generate probable future economic benefits.
Training	Expense – not directly attributable in preparing the asset for use.
Software user licences	Expense where the individual licences do not meet to recognition threshold criteria of $50,000 for intangible asset.
Costs incurred in documenting policies and guidelines	Expense – these activities are in connection with the development of an asset but are not necessary in preparing it for use.

AASB 138.33-67

Assets acquired at no cost or for a nominal consideration

Assets acquired at no cost or for a nominal consideration, other than those acquired through restructuring, must be recognised initially at fair value as at the date of acquisition. Fair value must only be recognised where there is an active market for the asset concerned. Where there is no active market, and a fair value is not available, the cost of the item at the date it is acquired becomes its fair value.

When an intangible asset is acquired free of charge, or for nominal consideration, by way of a government grant, the Health entity is to recognise both the asset and the grant at fair value, in accordance with AASB 1058.

Internally generated intangible assets

To assess whether an internally generated intangible asset meets the criteria for recognition, the generation of the asset is to be classified into either:

- A research phase or
- A development phase

Recognition – research phase

Research is defined as the original and planned investigation undertaken with the prospect of gaining new scientific or technical knowledge and understanding.

No intangible asset arising from research can be recognised as it cannot be demonstrate that an intangible asset exists that will generate probable future economic benefits.

Any expenditure on research must be recognised as an expense. Expenditure on an intangible item that was initially recognised as an expense cannot be recognised as part of the capitalised cost of an intangible asset at a later date.

Recognition – development phase

An intangible asset arising from development can only be recognised if the Health entity can demonstrate all of the following:

- The technical feasibility completing the intangible asset so that it will be available for use or sale
- The intention to complete the intangible asset and use or sell it
- The ability to use or sell the intangible asset
- How the intangible asset will generate probable future economic benefits (including demonstration of the existence of a market for the output of the intangible asset or the intangible asset itself or, if it is to be used internally, the usefulness of the intangible asset)
- The availability of adequate technical, financial or other resources to complete the development to use or sell the intangible asset, and
- The ability to measure reliably the expenditure attributable to the intangible asset during its development

Example 7.1: Recognition of intangible assets

The Health entity wants to implement the new electronic health records (eHRs). This comprises of two systems being the electronic medical records (eMRs) and the Personally Controlled Electronic Health Record (PCEHR). The eMR is a computerised medical record which is part of a secure stand-alone health information system which allows access to the patient's information to all medical staff within that setting. The PCEHR is a secure electronic subsequent of a person's total health information which is stored and shared in a network of connected system. In late 20X0 a business case was submitted to extend the original eMR functionality to eMR2. During this period, the following is incurred:

- *$10,000 in labour costs of service managers in ensuring health care personnel have timely access to paper based and electronic health care records*
- *$50,000 in labour costs of service managers to monitor the compliance with the policy of the eHRs including health care record audit programs and acting on the audit results*
- *$20,000 of training costs incurred on health care personnel for use of the eMRs and PCEHR*
- *$10,000 costs incurred in designing and implementing the health care record forms*
- *$30,000 incurred in implementing new eMR functionality such as the ability to document progress notes and mandatory assessments electronically and tailoring it to specific specialties*
- *$15,000 incurred in labour costs of the software engineer in testing the extended eMR in pre-production phase*

What of the above can be capitalised?

The cost of implementing the health care record forms and implementing the new eMR functionality, the cost of which can be reliably measured can be capitalised as these are directly attributable in bringing the asset to its intended use. The training costs and labour costs of service managers to monitor the compliance of the policy associated with the eMR is not a directly attributable costs and should be expensed. Labour costs of service managers in ensuring the health care personnel has timely access to electronic health records should also be expensed as this not directly attributable in preparing the extended eMRs for use. However the labour costs associated with testing the extended eMR should be capitalised as this is directly attributable to bringing the extended eMR to its intended use. The table below sets out the specific costs which can be capitalised.

Expenditure	Amount	Capitalise	Expense
Service managers – costs in ensuring health care personnel has timely access to electronic health records	$10,000	✗	✓
Service managers – monitoring compliance with the policy of eHRs	$50,000	✗	✓
Training costs	$20,000	✗	✓
Design costs and implementation of electronic health care forms	$40,000	✓	✗
Software engineer – testing of extended eMR pre-production	$15,000	✓	✗

Cloud Computing Arrangements

Cloud computing arrangements (CCAs) are arrangements where the reporting entity does not possess the underlying software or hardware assets, but rather can access and use it as needed. CCA's encompass software as a service (SAAS), infrastructure-as-a-service and other hosting, file sharing and data storage arrangements.

In SAAS arrangements:

- *the entity has the right to access the supplier's application software over the contract term, usually over the internet or a dedicated line*
- *the software is run on the information technology (IT) infrastructure of the provider or a third party*
- *the entity may incur costs associated with the configuration or customisation of the application software, either by the supplier or a third party.*

The International Financial Reporting Standards (IFRS) Interpretations Committee (the 'Committee') issued two Agenda Decisions in March 2019 and April 2021 that provide guidance on accounting for SAAS arrangements.

In its March 2019 Agenda Decision, the Committee considered that SAAS contracts are:

- *not intangible assets under AASB 138 Intangible assets (AASB 138), where the customer does not control the application software*
- *not a lease under AASB 16 Leases, where the customer does not obtain decision-making rights about how and for what purpose the application software is used.*

Based on above, SAAS contracts may only be capitalised under AASB 138 and AASB 16 if:

- *there is a contractual right to take possession of the application software at any time during the hosting period without significant penalty*

  AND

- *the customer has the right to and can feasibly either run the application software on their own hardware or contract another party, unrelated to the vendor, to host the software.*

Where SAAS arrangements does not meet the above requirements, and only provide customers with a right to receive access to the supplier's application software are regarded as service contracts. Therefore, costs associated with such SAAS arrangements should be expensed. If any configuration and customisation costs are incurred in a SAAS arrangement, refer guidance below for accounting treatment.

Note: Where the customer pays fees in advance of receiving the contracted service, a prepayment should be recognised.

Configuration or customisation in a SAAS arrangement

For configuration or customisation of application software in a SAAS contract, an entity recognises an intangible asset only if the expenditure meets both the definition and recognition criteria in AASB 138 (paragraphs 11-17 and 21-23 respectively).

SAAS costs that do not represent a lease or intangible asset are usually service costs, and are expensed as the service is received.

There may be costs to customise or configure the supplier's cloud-based software for the entity's specific use. These costs may be capable of capitalisation where they constitute an intangible asset in their own right i.e. have future economic benefits controlled by the entity.

Some examples:

- *Changes are made to the underlying application software code in the SAAS arrangement, which is not controlled by the entity. These costs would be expensed.*
- *If the code could be used by the entity in other arrangements, or the entity retains the intellectual property rights the costs may be capitalised. For example, the development of bridging modules to existing customer systems or dedicated additional software capability.*
- *Costs to modify or enhance your existing software or systems, that is controlled by the entity and the costs to modify meets the definition and recognition criteria in AASB 138.*
- *Any hardware costs that meets the recognition criteria under AASB 116 Property, Plant and Equipment are capitalised.*
- *All other costs would typically be expensed, such as training, data conversion, testing and research costs (paragraph 54 of AASB 138).*

Note: Where the supplier does the customisation/configuration (or has its own contractors do it); and configuration/customisation services are not distinct from the other SAAS services (AASB 15 provides guidance on distinct and indistinct services), then the costs may be treated as a prepayment and expensed over the remainder of the contract term (as an integral part of the total arrangement).

Example 7.2: Recognition of costs incurred in a SAAS arrangement

An entity implements SoftwareABC as an IT tool and pays an annual fee for the use of the software in a SAAS contract. The entity has significant implementation costs which include modifications to its existing hardware and software.

The contract provides the entity with access to the application software, SoftwareABC, over the contract term. The entity does not control the application software and control remains with the provider. In accordance with AASB 138, no intangible asset can be recognised for the access arrangements and the annual fee must be expensed.

Modification costs from purchasing and/or upgrading hardware should be accounted for in accordance with AASB 116 Property, Plant and Equipment. Expenditure on modifying the entity's own software should be assessed against the definition and recognition criteria of intangible assets in AASB 138. Any expenditure on modifying the SoftwareABC itself would be expensed, consistent with the accounting of the underlying SAAS arrangement.

7.4.3 Subsequent measurement

Where there is an active market, intangible assets are to be carried at fair value (refer to Chapter 10 of this policy document) which can be determined by reference to an active market. If an active market ceases to exist, such intangibles must be held at cost, with the fair value that was last determined by reference to an active market being deemed to be "cost" from that time until such time as an active market exists.

If an intangible asset (that has never been revalued) in a class of revalued intangible asset cannot be revalued because there is no active market for the asset, the asset is to be carried at its original cost to the entity less any accumulated amortisation or impairment losses.

If the fair value of a revalued intangible asset can no longer be determined by reference to an active market, the carrying amount of the asset is to be its revalued amount at the date of the last revaluation by reference to the active market, less any subsequent accumulated amortisation and any subsequent impairment losses.

The fact that an active market no longer exists for a revalued intangible asset may indicate that the asset may be impaired and should be tested in accordance with Chapter 11 of this policy document.

Where costs were previously recognised as expensed, these cannot be capitalised nor re-instated on the balance sheet.

Intangible assets, both at cost and fair value, are subject to amortization and impairment testing.

7.4.4 Amortisation of intangible assets

AASB 138.97-99

The depreciable amount of an intangible asset with a finite useful life is to be amortised on a systematic basis over the useful life of the asset.

An intangible asset with an indefinite useful life is not amortised. The term 'indefinite' does not mean 'infinite'. It is unlikely that the Health entity would have an intangible asset with an infinite useful life. However, the Health entity may have an intangible asset which, at the time it is developed has an indefinite useful life (e.g. the intellectual property associated with a vaccine would not be amortised but would be tested for impairment at each reporting period).

Similar to depreciation, amortisation is usually recognised in profit or loss but may be absorbed into the carrying amount of other assets (e.g. amortisation of intangible assets used in the production process could be included in the carrying amount of inventories).

Also similar to depreciation, the amortisation method for an intangible asset with a finite life is to be reviewed at least at the end of each annual reporting period. The useful life of all intangible assets should be assessed annually (even intangibles with indefinite lives – to confirm they continue to be indefinite).

7.4.5 Revaluation

Refer to 5.6 of this policy document for guidance pertaining to the revaluation of intangible assets.

7.4.6 Useful lives

Refer to 5.5.1 of this policy document for guidance pertaining to the useful lives of intangible assets.

7.4.7 Residual value

Refer to 5.5.2 of this policy document for guidance pertaining to the residual value of intangible assets.

8 Asset held for sale and discontinued operations

8.1 Scope

8.1.1 Applicability

This Policy applies to the accounting for assets held for sale, and the presentation and disclosure of discontinued operations within NSW Health.

It should be noted that these are rare scenarios and not very common for Health entities.

8.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- AASB 5 Non-current Assets Held for Sale and Discontinued Operations

8.2 Overview and purpose

The purpose of this document is to provide Health entities with illustrative guidance on accounting for non-current assets that are held for sale under *AASB 5 Non-current Assets Held-for-Sale and Discontinued Operations* ("AASB 5").

This guidance and AASB 5 excludes from its scope:

- Restructuring of administrative arrangements
- Restructuring of administered activities of government departments

However, if a government discontinues one of its department's administered activity, that government may constitute a discontinued operation.

8.3 Policy statement

This policy requires all physical non-current assets to be reclassified as held for sale where they meet the held for sale criteria in AASB 5.

8.4 Application guidance

8.4.1 Criteria for classification as HFS

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through sale rather than through continuing use.

Held for sale classification is only achieved where:

- the asset is **available for immediate sale** in its present condition; and
- and the **sale is highly probable**.

AASB 5.7 & 8

The following criteria must be met for a sale to be highly probable:

- Appropriate level of management is committed to sell the asset
- There is an active program to locate a buyer and complete the plan
- The asset is actively marketed for a reasonable sale price in relation to its current fair value
- Sale is expected to complete within one year of classification
- It is unlikely that any significant changes will be made to the plan or that it will be withdrawn.

The held-for-sale criteria apply to non-current assets or disposals groups that will be recovered through sale rather than through continuing use and must be met at the balance sheet date. The criteria does not apply to assets that are being scrapped, wound down, or abandoned.

Example 8.1: Negotiations for sale fall through post year end

In May, the Health entity (which has a June year-end) decides to sell a portion of land. Management begins to actively market the land and negotiate with potential buyers. At 30 June, management considers it highly probable that the sale will be completed within 12 months. However in August, negotiations fall through and the Health entity decides to retain the land to open up a community centre instead of selling it.

How should the land be accounted for?

The land meets the criteria to be classified as held for sale at the year end. The decision to keep the land does not affect the conditions that existed at the year end, and management should not use hindsight when classifying the land. However, after August, the held for sale classification would no longer apply and in the subsequent period, the land should be reclassified as part of PP&E. However management should make appropriate subsequent events disclosure regarding the change in circumstances, if it has happened before the annual accounts are signed.

Example 8.2: Transfer from Property, plant and equipment to Assets Held for Sale

Land and Buildings at Facility X met the recognition criteria of Assets Held for Sale on 31 March 20X8 and the NSW Ministry of Health approved of the transaction being processed at 30 April 20X8.

The current written down value as of 30 April 20X8 of the Land was $725,000 and Buildings was $2,204,887.

In preparation for the sale, a valuation was performed and the valuer valued the land at 30 April 20X8 at $725,000 and Buildings at $125,000.

How to account the transfer of assets from PPE to HFS?

Journal Entry 1

At 30 April 20X8, immediately before being classified as held for sale, the asset is to be measured at the lower of its carrying amount and fair value less costs to sell. If the fair value less costs to sell is lower than its carrying amount the following entry will need to be processed before being classified as held for sale:

	Dr	Cr
Dr. Inc/Dec Building Revaluations	*2,079,887.49*	
Cr. Building revaluations	*2,079,887.49*	

Note – Fixed Asset Register (FAR) Amendment and Journals

- *Immediately before being classified as held for sale, the asset should be retired from FAR*
- *Reverse the system posted retirement journal in GL*
- *Move the asset to asset held for sale account as shown below in journal No:2*

Journal Entry 2

The assets are now measured at the lower of its carrying amount and fair value less costs to sell.

The following journal is processed to transfer to Non-Current Assets Held for Sale which will move them to a separate note in the Statutory Financial Statements:

	Dr	Cr
Dr. Land Held for Sale	*725,000.00*	
Cr. Land Held for Sale Transfer		*725,000.00*

	Dr	Cr
Dr. Building Held for Sale	*125,000.00*	
Dr. Building Accm. Depr. Held for Sale	*36,103,512.52*	
Cr. Building Held for Sale Transfer		*36,228,512.52*

Journal Entry 3

To complete the transaction when the assets have been sold for $900,000, the gain on Sale is $50,000.

The journal entry required to recognise the sale of the Non-Current Assets held for Sale is as follows:

	Dr	Cr
Dr. Debtor Capital Sale Proceeds	*900,000.00*	
Cr. Land Held for Sale Proceeds		*900,000.00*

	Dr	Cr
Dr. Gain/loss on Disposal Asset HFS	*850,000.00*	
Cr. Building HFS Disposal		*125,000.00*
Cr. Land HFS Disposal		*725,000.00*

Journal Entry 4

Only when the asset is sold, any value against the Asset Revaluation Reserve (ARR) will need to be transferred to a retained earnings account.

	Dr	Cr
Dr. Asset Reval. Trf. Land	*50,000.00*	
Dr. Asset Reval. Trf. Building	*10,000.00*	
Cr. Accm. Funds Assets Reval Trf		*60,000.00*

8.4.2 Definition of a disposal group

A disposal group is a group of assets to be disposed of, by sale or otherwise, together as a group in a single transaction, and liabilities directly associated with those assets that will be transferred in the transaction.

8.4.3 Measurement at classification date

Under AASB 5, a non-current asset held for sale is measured at the lower of its:

- carrying amount; and
- fair value less costs to sell.

However, given the carrying amount of Health entity Property, Plant and Equipment is measured by its fair value, a non-current Health entity's asset held for sale will already be measured by fair value less costs to sell.

An impairment loss is recognised if the fair value less costs to sell is lower than the carrying value of the non-current asset or disposal group. The impairment loss forms part of continuing operations, unless the non-current asset or disposal group is a discontinued operation. Depreciation of these assets ceases and they are presented separately in the Statement of Financial Position.

Impairment considerations

Where the impairment loss is identified, the impairment should be allocated in the following order:

1. Reduce the carrying amount of any goodwill of the disposal group
2. The impairment is allocated to the other assets of the disposal group on a pro rata basis
3. A reversal of impairment is allocated on the same basis, except that impairment of goodwill cannot be reversed

8.4.4 Subsequent measurement

The measurement of assets or disposal groups that meet the held for sale criteria are updated as of each reporting date until disposal, or until the criteria are no longer met. Updating the subsequent measurement requires the following:

- measure the carrying amounts of current assets, current liabilities, non-current assets and non-current liabilities outside the measurement scope of AASB 5, in accordance with the relevant AAS; and
- measure the fair value less cost to dispose of the disposal group

The Health entity should monitor the conditions in para 7 to 9 of AASB 5 to determine whether the held for sale criteria has been met as of each reporting date. If an asset or disposal group held for sale no longer meets the held for sale criteria, the Health entity should cease to classify such an asset as held for sale.

Extension of the period to complete the sale beyond one year

The period to complete the sale might be extended beyond one year. The asset could remain as held for sale if:

- the delay is caused by events and circumstances beyond the Health entity's control and
- there is sufficient evidence that the Health entity remains committed to the plan to sell the asset

The exception to the one year requirement applies if one of the following criteria is met:

- The Health entity reasonably expects, at the date when it commits itself to the sale plan, that a party other than the buyer will impose conditions on the sale that will extend it beyond one year and:
  - Actions necessary to respond to those conditions can only be initiated after a firm purchase commitment is obtained and
  - A firm purchase commitment is highly probably within one year
- A non-current asset was already held for sale and, as a result of obtaining a firm purchase commitment, a buyer or another party unexpectedly imposes conditions that extend the sale beyond one year and
  - Timely actions to respond to the conditions have been taken; and
  - The delaying factors are expected to be favourably resolved
- A non-current asset was already held for sale, and circumstances that were previously considered unlikely to arise cause the asset to not be sold in the initial one-year period, and:
  - The entity took the necessary actions to respond to the circumstances during the initial period
  - The non-current asset is being actively marketed to a reasonable price, given the change in circumstances
  - The highly probable criteria in AASB 5, para 7 and 8 are met.

The event that occurs must not prevent the asset from being sold in its present condition, once the Health entity has taken action to respond to the event; otherwise the held for sale criteria are not met.

Example 8.3: Regulatory approval required for sale

The Health entity is committed to a plan to sell one of their public hospitals to a private operator. The sale requires regulatory approval, which could extend the period required to complete the sale beyond one year. Actions necessary to obtain that approval cannot be initiated until after a buyer is known and a firm purchase commitment is obtained. However, a firm purchase commitment is highly probable within one year. In this instance, the conditions for an exception to the one-year requirement under AASB 5 are met.

In this situation, at the time of initial classification, the Health entity expected to meet all of the conditions set out in AASB 5, para 7 and 8; however when a firm purchase agreement is entered into within a year of classification as held for sale, the buyer or another party imposes conditions.

How should the above be accounted for?

The Health entity can retain the original classification, provided that it has taken action to respond to the conditions and it expects that it will be able to meet them and the sale will be successful.

Example 8.4: Environmental damage identified after sale agreement entered into

The Health entity is committed to a plan to sell a land in its present condition, and it classifies the land as held for sale at that date. After a firm purchase commitment is obtained, the buyer's inspection of the land identifies environmental damage that was not previously known to exist.

The Health entity is required by the buyer to make good the damage, which will extend beyond one year the period required to complete the sale. The Health entity has initiated actions to make good the damage, and satisfactory rectification of the damage is highly probably?

How should the above be accounted for?

The additional conditions for the exception to the one-year requirement has been met and the land can continue to be recognised as held for sale.

8.4.5 Definition of discontinued operations

A discontinued operation is a component of a department or an agency that can be distinguished operationally and financially for financial reporting purposes from the rest of the entity and:

- represents a separate major line of business or geographical area of operation;
- is part of a single co-ordinated plan to dispose of a separate major line of business or major geographical area of operation; or
- is a subsidiary acquired exclusively with a view for resale.

Health entities normally have a number of distinguishable operations, eg aged care, mental health, community health, surgery etc. The operation may also be distinguished by geographical location such as Northern Sydney, Central Coast and Southern NSW.

8.4.6 Disclosures in relation to discontinued operations

An operation is classified as discontinued only at the date on which the operation meets the criteria to be classified as held for sale or when the entity has disposed of the operation. Although balance sheet information is neither restated nor remeasured for discontinued operations, the statement of comprehensive income information does have to be restated for the comparative period.

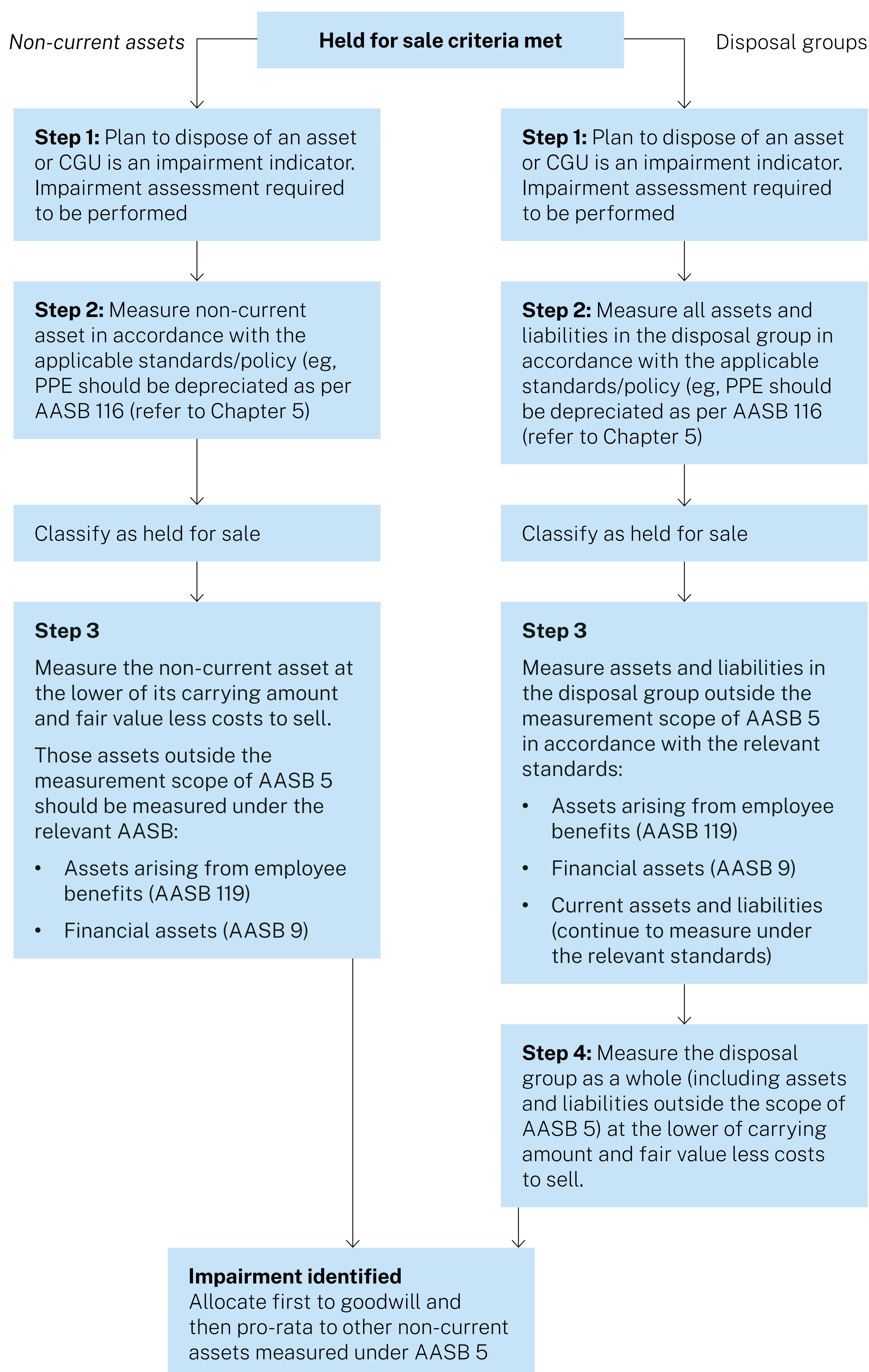
Discontinued operations are presented separately in the income statement and the cash flow statement. There are additional disclosure requirements in relation to discontinued operations.

The date of disposal of a subsidiary or disposal group is the date on which control passes. The consolidated income statement includes the results of a subsidiary or disposal group up to the date of disposal; the gain or loss on disposal is the difference between (a) the carrying amount of the net assets plus any attributable goodwill and amounts accumulated in other comprehensive income (for example, foreign translation adjustments and available-for-sale reserves); and (b) the proceeds of sale.

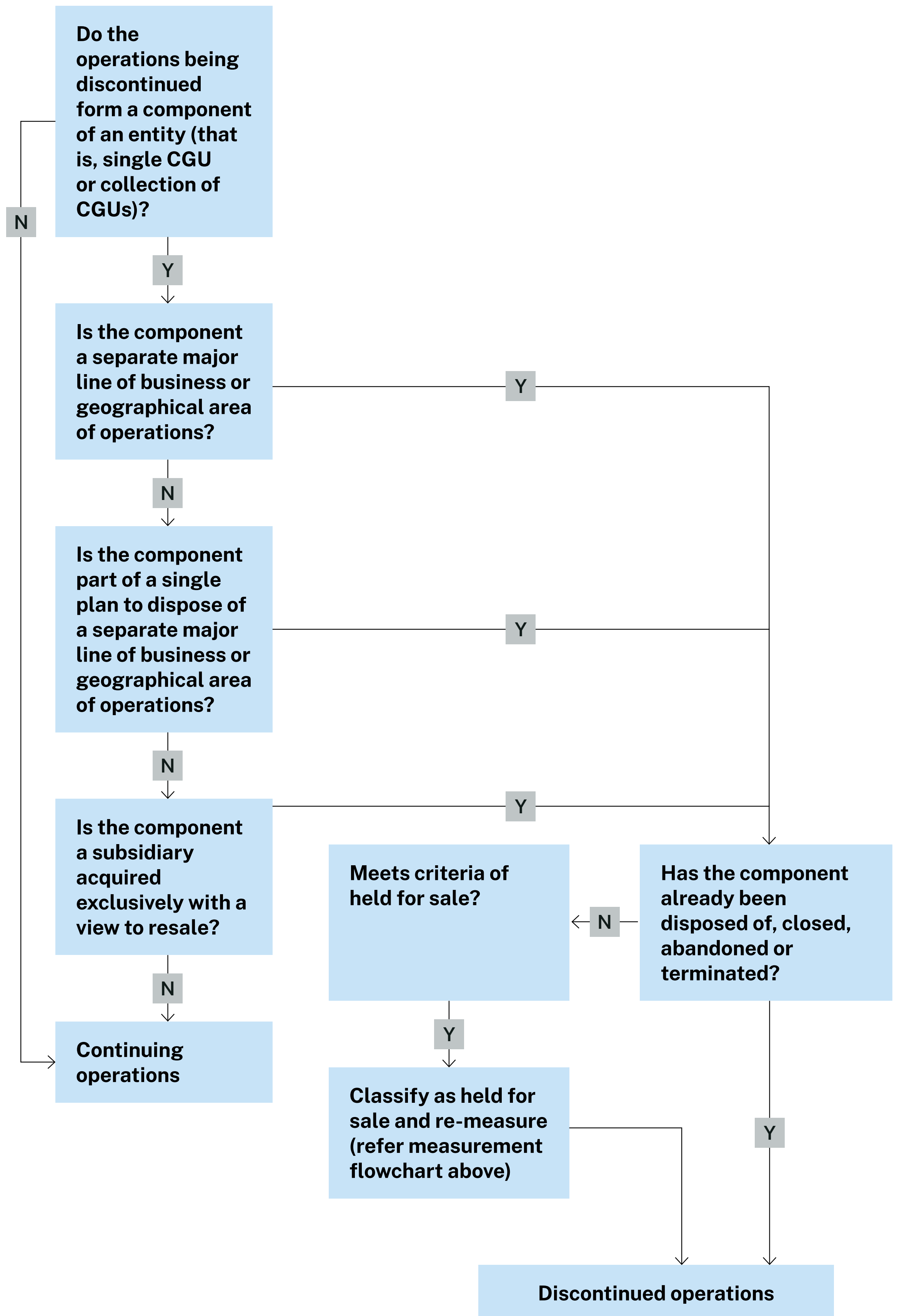
8.4.7 Summary diagram

Measurement for non-current asset and disposal group

There are three measurement steps for a non-current asset and four measurement steps for a disposal group once the Health entity makes a decision to sell or dispose. Refer to the flowchart below for the measurement approach.



Classification of discontinued operation



9 Capitalisation of costs

9.1 Scope

9.1.1 Applicability

This Policy applies to the identification and disclosure of capitalisation of costs within NSW Health.

9.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- AASB 116 Property, plant and equipment
- TPP 06-06 Accounting Policy: Guidelines for capitalisation of expenditure on property, plant and equipment

9.2 Overview and purpose

The purpose of this document is to provide Health entities with illustrative guidance on when expenditure should be capitalised or expensed and on the measurement and elements of cost.

Expenditure to be capitalised must meet the accounting capitalisation criteria as described in TPP 06-06 Guidelines for capitalisation of property, plant and equipment (“TPP 06-06”) which is based on Australian equivalents to International Financial Reporting Standards (AIFRS).

9.3 Policy statement

An asset is defined as a resource controlled by the entity as a result of past events and from which future economic benefits are expected to flow to the entity.

9.4 Application guidance

9.4.1 Asset definition

SAC 4.14

Assets are resources controlled by the entity as a result of past events and from which future economic benefits are expected to flow to the entity:

- Control – the Health entity controls an asset if it has the power to obtain future economic benefits flowing from the resource and to restrict the access of others to those benefits. Legal ownership is not required for Health entity to have control, and therefore obtain future economic benefits, of the asset.
- Past event – will generally be the purchase of the asset, however other transaction or events can generate assets for example a project to develop and build an asset or entering into a finance lease.
- Future economic benefit – benefits can take the form of cash flows or provision of goods and services in accordance with the objectives of the Health entity that will arise over multiple reporting periods, such as fees received for the provision of health services. This is normally achieved only when the risks and rewards of the asset have passed to the Health entity, that is, when an unconditional and irrevocable contract is put in place. In practice, the transfer of risks and rewards often occurs when the asset is delivered or when completion certificate issued for a new constructed asset.

Meanwhile, expenses encompasses losses as well as those expenses that arise in the course of the ordinary activities of the entity. They usually take the form of an outflow or depletion of assets.

9.4.2 Initial measurement of costs and threshold

In addition to the recognition criteria under Chapter 1, the following thresholds should be noted in determining whether the Health entity should capitalise costs incurred:

- Physical non-current asset or parts of an asset costing more than $10,000 individually (or $50,000 for software) should be capitalised.
- Assets or parts of an asset with acquisition cost less than $10,000 (or $50,000 for software) should be charged as an expense in the period when the asset was first acquired.
- The costs of assets or parts of an asset that form part of a network (such as electricity plant, water network, etc. which consist of several parts, with each parts are required for the asset to function as a whole) should be aggregated together when applying the capitalisation threshold.

Summary of capitalisation threshold

Asset Class	Asset recognition threshold
Land	Recognised regardless of cost
Buildings	$10,000
Infrastructure	$10,000
Plant and Equipment	$10,000
Intangible assets	$10,000
Software	$50,000

9.4.3 Elements and measurement of costs

AASB 116.16

The cost of an item of property, plant and equipment comprises of the following elements:

a) its purchase price, including import duties and non-refundable purchase taxes, after deducting trade discounts and rebates

b) directly attributable costs of bringing the asset to the location and condition necessary for it to be capable of operating in the manner intended;

c) The initial estimate of costs of dismantling and removing the item and restoring the site on which it is located, the obligation for which an entity incurs either when the item is acquired or as a consequence of having used the item during a particular period for purposes other than to produce inventories during that period.

Examples of directly attributable costs include the following:

- Costs of site preparation (such as the preparation of a site for construction of new hospital ward)
- Initial delivery and handling costs (e.g. the delivery cost associated with an MRI scanner)
- Installation and assembly costs (costs incurred by the manufacturer or a specialists installing the medical device ready for use)
- Professional fees (such as stamp duty or legal fees associated with the acquisition of a building)
- Costs of employee benefits which arose from construction of the item
- Costs of testing whether the asset is functioning as intended, after deducting net proceeds from selling any items produced while bringing the asset to that location and condition

Specific guidance for directly attributable costs:

What professional fees can be capitalised?

External professional fees incurred in finding a suitable asset can be capitalised. External professional fees should only be capitalised as part of the cost of an asset where they relate directly to the acquisition or construction of the asset (such as infrastructure assets). Costs on speculative projects or aborted projects should not be capitalised. Other fees incurred in acquiring the asset such as fees and stamp duty would be included in the cost of an asset.

Example of costs	Are costs directly attributable	Reason
Legal fees	Yes	Legal fees incurred with respect to acquiring an asset would be included in the cost of an asset.
Stamp duty	Yes	Stamp duties incurred with respect to acquiring an asset such as property would be included in the cost of an asset.
Feasibility costs	Yes – but can only be recognised when feasibility is established and probability criterion has been met	If the feasibility costs are incurred on a project which is still uncertain, then it is not certain that the future economic benefit will flow to the Health entity. Therefore costs cannot be capitalised until feasibility is established and it is probable that the future economic benefit will flow to the entity.
Development costs	Yes	Qualifying costs are capitalised.
Site preparation	Yes	Site preparation in relation to a specific site selected can be capitalised. Site preparation for a site not eventually selected cannot be capitalised since these costs are not directly attributable to the developed site.
Labour costs	Yes	Labour costs associated with bringing the asset to its intended use (such as programmers to test and customise medical equipment) are directly attributable costs and should be capitalised.
Project manager cost	Yes – only as much as % of time allocated to the related project.	Project Manager usually is totally dedicated with the specific project development and as such should be capitalised. When the commitment is less than 100%, the capitalised portion will need to be pro-rate accordingly.

Treatment of incremental costs

Where the incremental costs were incurred in acquiring a new asset, such costs should not be capitalised if these incremental costs did not bring the asset into the location and condition necessary for it to be capable of operating in the manner intended by management. An example of this includes the costs of retraining employees which cannot be capitalised since the Health entity does not have control over the employees and the recognition criteria has not been met in this instance.

Example 9.1: Treatment of labour costs including oncosts such as superannuation

Hospital A has acquired medical equipment and is capitalising labour costs of their software engineer who will be customising/programming the medical equipment to bring the medical equipment to its working condition. The software engineer will dedicate 10% of his/her time to this project. The software engineer will also have oncosts such as superannuation contribution. What costs should be capitalised?

Costs that are directly attributable to bringing the medical equipment into the location and condition necessary to be capable of operating in the manner intended should be capitalised. Hence 10% of the software engineer's labour costs including their related oncosts are regarded as directly attributable to the medical equipment and therefore should be capitalised. Superannuation is part of his/her employment cost and should be capitalised in this context.

Example 9.2: New hospital wing

The Health entity wants to expand its hospital by adding a new wing. The Health entity took three months preparing a business case prior to submission for approval. During this period, the following is incurred:

- *$50,000 in environmental studies*
- *$25,000 in social studies*
- *$20,000 economic appraisal*
- *$30,000 financial appraisal*

These costs include external experts to assist with each study as well as the Health entity's internal resources.

On 1 July 20X6, the business case was approved. Immediately the Health entity initiates the preparation of the land where the hospital wing will be built. A landscaping company has been contracted to prepare the site for construction. The cost of site preparation is $200,000.

The Health entity submits a purchase order for the initial construction materials. The invoice includes $600,000 of materials and $60,000 in delivery costs. Equipment was also required to be hired to facilitate the building project costing $200,000.

ABC Engineering was contracted to construct the new hospital wing, the total cost of which includes the engineers, architecture design and labour per the contract is $5,000,000.

A second purchase order for materials has been placed in the amount of $1,250,000 plus delivery costs in the amount of $125,000.

The construction is estimated to take two years and the Health entity will have a full time project manager totally dedicated to overseeing the building of the new hospital wing.

The CFO is responsible for overseeing the execution of a number of projects within the Health entity, as part of their general responsibilities. It is estimated that approximately 10% of their time each week is generally spent on steering committee meetings, reviewing business cases or understanding the status of projects.

Costs of $5,000 were also incurred in obtaining all the necessary inspections (building / fire certificates). Cleaning costs for the new hospital wing are $5,000 per month.

What of the above can be capitalised?

The cost of adding a new wing to the hospital should be capitalised. The additional rooms increase the servicing capacity with the future economic benefits of patient fees flowing to the Health entity, the cost of which can be reliably measured. By contrast, the cost of cleaning the patient rooms is a period cost of servicing the hospital and should be expensed as incurred. The table below sets out the specific costs which can be capitalised.

Expenditure	Amount	Capitalise	Expense
Environmental study	$50,000	✗	✓
Social study	$25,000	✗	✓
Economical appraisal(*)	$20,000	✗	✓
Financial appraisal(*)	$30,000	✗	✓
Site preparation	$200,000	✓	✗
Materials	$600,000	✓	✗
Delivery costs	$60,000	✓	✗
Equipment hire	$200,000	✓	✗
Engineers and Labours	$5,000,000	✓	✗
Second Materials	$1,250,000	✓	✗
Delivery costs	$125,000	✓	✗
50% of Project Manager's salaries & costs	$110,000	✓	✗
Cost of statutory required certificates	$5,000	✓	✗
CFO costs	$90,000	✗	✓
Cleaning costs	$5,000	✗	✓

(*) As defined in the NSW treasury Guidelines for Business Cases.

With respect to the labour costs, the project manager is totally dedicated to that specific project development, their salaries, superannuation contributions, paid annual leave and sick leave, annual bonuses or even non cash benefits such as cars should be included in the cost of the new hospital wing. If the project manager was not 100% dedicated to the project but say only 50% dedicated to the project, then only 50% of the costs of that project manager can be capitalised.

However, for the CFO, their time is not contributing to the creation of the asset. Hence, their time cannot be capitalised, and must be expensed as normal. This would be true for other staff members who have some level of oversight but are not part of the core project team.

The Health entity can only capitalise costs which are directly attributable to the cost of the new or in this case redevelop/significantly upgrade the building. Any cost which falls outside of this definition, such as any relocation costs or rent, may not be capitalised and must be expensed. Also any costs which arise before the final decision has been made to redevelop the property, such as environmental and social studies, tendering for and selecting service providers, plus any appraisals must be expensed as they are not directly attributable to the to the cost of the redevelopment. Any cost incurred after the final decision has been made to redevelop the property shall be capitalised according to these capitalisation requirements to the extent it does not changed the decision to redevelop the property.

Any costs of day-to-day servicing, repair or maintenance of the property or equipment cannot be capitalised.

Example 9.3: Redevelopment of a hospital administrative block

The Health entity has an existing property which is outdated and in desperate need of repairs. The decision is made not to fix, but instead to knock it down and redevelop. During the redevelopment period, the Health entity moves the operations of the administrative block of the hospital to another temporary site. The following incremental costs will be incurred for the relocation:

- *$50,000 to install equipment in the new location*
- *$150,000 to rent and*
- *$30,000 relating to removal costs to transport the equipment from its location to the new temporary location.*

Cost of redevelopment is $825,000 per the contract which includes architecture, design, materials, labour costs related to the workers completing the redevelopment and a new fit-out for $225,000 plus $30,000 delivery and assembly costs. During the redevelopment of the property, the Health entity will have a project manager who will dedicate 50% of their time to this project (total cost $130,000).

The construction of the building is completed twelve months later. Included in the capital budget is a morning tea, to celebrate the opening of the building which cost $15,000.

What of the above can be capitalised?

Because the project manager is only 50% dedicated to that specific project execution, only 50% of their salaries, superannuation contributions, paid annual and sick leave, annual bonuses or even non-cash benefits such as cars and subsidised goods or services (e.g. accommodation, petrol, mobile phone, etc.) should be included in the cost of the property.

On the other hand, the costs incurred in moving to a temporary location do not enhance the value of the new asset being built, and therefore cannot be capitalised and must be expensed.

Expenditure	Amount	Capitalise	Expense
Set-up costs of equipment	$50,000	✗	✓
Rent	$150,000	✗	✓
Moving costs	$30,000	✗	✓
Redevelopment Costs (inc preliminaries)	$825,000	✓	✗
Fit-out	$225,000	✓	✗
Delivery and assembling costs	$30,000	✓	✗
50% of Project Manager's salaries & costs	$65,000	✓	✗
Morning tea	$15,000	✗	✓

Measurement of cost

Property, plant and equipment that qualifies for recognition as an asset must be measured at its cost. However with not for profit entities, where an asset is acquired at no cost or for a nominal cost, the cost is measured at its fair value as at the date of acquisition.

Additional guidance on inter-health assets transfer

Any major capital project that the Health entity had will be managed by Health Infrastructure (HI). Regularly HI will transfer the cost incurred to the Health entity for further capitalisation assessment.

Example 9.4: Transfer of WIP from HI to Health entity

On 14 March 20X1, A received a grant from the NSW Ministry of Health for a total of $50million for a development of a hospital. At the end of the month, total WIP incurred for the related project was $20 million. HI transfers this to A.

From HI perspective

1. *The NSW Ministry of Health will provide HI with the grant of $20million*

Dr. Cash	*$20 million*	
Cr. Subsidy		*$20 million*

2. *Recognition of project cost incurred to date*

Dr. WIP – Project cost A	*$20 million*	
Cr. Cash		*$20 million*

3. *Transfer of WIP to A at the end of the month*

Dr. Subsidy	*$20 million*	
Cr. WIP – Project cost A		*$20 million*

From Health entity A perspective

A only record the WIP when this have been transfers by HI. A will need to assess the appropriateness of such capitalisation before recognised the amount transferred as WIP. For example out of the $20 million amount transferred only $15 million could be capitalised, the remaining amount will then need to be expensed as incurred.

Dr. WIP	*$15 million*	
Dr. Expenses	*$5 million*	
Cr. Subsidy		*$20 million*

9.4.4 Subsequent treatment – enhancements

The Health entity should assess whether there are future economic benefits when identifying the asset by considering the service capacity (where it meets increases in demand), service quality (improvement in the quality or standard of services provided) and useful life when assessing the expenditure.

Subsequent costs can only be accounted for as an enhancement if they effectively and materially increase the asset's useful life.

Example	Can costs be capitalised	Reason
Extension to hospital ward	Yes	Creation of service capacity – effective if it meets increases in demand from patients
Refurbishment of the interior furnishings of a hospital ward	Yes	Enhancement in service quality which represents an enhancement to extend the life of the existing asset, being the fit out of the hospital ward.
Aesthetic improvement to an asset such as hospital ward	No	Aesthetic improvement does not result in creation of service capacity or service quality and hence would not be recognised as an asset.
Rectification of breakdown in equipment	No	Repair and maintenance does not extend an asset's useful life but only allows the existing useful life of the asset to be realised.
Spare parts and servicing equipment	No	These are usually carried as inventory and recognised in profit or loss as consumed.
Replacement of components	No	For specialised assets, significant components with different estimated useful lives are separately identified for accounting purposes. Deciding whether expenditure on asset components should be capitalised follow the same process outlined for assets above. Refer to 9.4.5 below.
Overhauls/refurbishments (*also refer to Chapter 15 – Provisions*)	Maybe – if asset recognition criteria is met	Some items of PP&E may have parts which require replacement at regular intervals. The Health entity should recognise the cost of replacing part of such an item in the carrying amount of PP&E when the cost is incurred only if the asset recognition criteria is met.
Regular major inspections	Maybe – if asset recognition criteria is met	When each major inspection is performed, its cost is recognised as a replacement in the carrying amount of the item of P&E if the recognition criteria are satisfied.

As a general rule, costs relating to maintenance and repairs of items of property, plant and equipment do not qualify for capitalisation and should be expensed as incurred.

Example 9.5: Generators annual maintenance

The Health entity is preparing a business case for the annual maintenance of generators installed in the hospital wings. The Health entity incurred upfront costs in preparing the business case prior to submission for approval. The following costs were incurred:

- *$2,000 in economic appraisal*
- *$3,000 financial appraisal*
- *$5,000 tendering for and selecting the service provider*

All these costs include external experts to assist with each study as well as the Department's internal resources.

ABC Generators were selected to perform the work. The Health entity incurred the following costs:

- *$40,000 in professional fees paid to ABC Generators*
- *$15,000 in minor parts replacement*
- *$10,000 in general repairs*

During the inspection one of the generators at Liverpool Hospital was identified as broken beyond repair and had to be replaced. A new generator was acquired and the Health entity incurred the following costs:

- *$68,000 for a new generator*
- *$3,000 in delivery fees*
- *$5,000 in professional fees paid to ABC Generators to install the new equipment*

What of the above can be capitalised?

The costs related to the annual maintenance cannot be capitalised because the maintenance is intended to keep the generators able to fulfil its useful life rather than extending it. Costs to qualify for capitalisation must relate to the replacement of major parts that ultimately results in extension of useful life.

The cost of the new generator, the delivery fees and professional fees paid to the generator installed should be capitalised.

The table below details which of the specific costs can and cannot be capitalised:

Expenditure	Amount	Capitalise	Expense
Economic appraisal	$2,000	✗	✓
Financial appraisal	$3,000	✗	✓
Tendering for and selecting service provider	$5,000	✗	✓
Maintenance professional fees	$40,000	✗	✓
Replacement of minor parts	$15,000	✗	✓
General repairs	$10,000	✗	✓
New Generator	$68,000	✓	✗
Delivery costs for new generator	$3,000	✓	✗
Professional fees for installation of generator	$5,000	✓	✗

9.4.5 Subsequent treatment – asset replacement

AASB 116.7,13&14

The replacement of an asset must be capitalised if the recognition criteria are satisfied. If the major parts of an asset has a useful life materially different from the main asset, each part is depreciated over the shorter of its useful life and the asset's useful life.

Complex assets such as specialised building assets may comprise a number of major parts which have different useful lives and may be replaced during the useful life of the complex asset.

The replacement of physical parts of assets, such as the roof of a building, or the interior walls of a hospital wall may have to be replaced. In such scenarios, the carrying amount of the replacement part should be recognised while the carrying amount of the part being replaced should be derecognised.

Where it is not possible to determine the carrying amount of the replaced part of an item of assets, best estimates are required. Entities could use the cost of the new part to estimate the cost of the replaced part at the time of its acquisition or construction. This may involve using the replacement cost of the component, indexed back to the original component's inception and adjusted for any subsequent depreciation and impairment.

Where an asset has been revalued, the value will be apportioned over the significant components already recognised for separate depreciation. Judgment is required to determine the most appropriate method to achieve that apportionment and the treatment of any revaluation surplus thus created.

Example 9.6: Trade-in equipment which reduce the cost of new items

See below example in regards to an item of P&E that have been advised they are getting a trade in amount for an asset valued $700. The carrying value of the old assets was $200 and valued at $100.

How to account for it?

Disposal of the old asset

Dr. Accm depreciation (assets disposal) $300		
Dr. P&E Sale proceeds	*$100*	
Dr. Loss on disposal	*$100*	
Cr. Assets disposal		*$500*

Recognition of the new assets

Dr. WIP/Asset	*$700*	
Cr. P&E Sale proceed		*$100*
Cr. Creditor control		*$600*

Example 9.7: Intra Health Asset Transfers

When an asset is transferred between two Health Entities the following process needs to be taken so the asset is correctly removed from one Health entity and then correctly recognised in the new controlling entity.

As an example, assume on 31 March 20X1, entity A bought new equipment at a total of $48 million. The useful life of this equipment is 4 years (straight line) with no residual value. As of 30 Jun 20X1, this equipment will be transferred to Children Network with no cash payment involved. Total depreciation incurred to 30 Jun 20X1 is $3 million.

How to account for it?

Entity A level

Entity A will removes the asset from at its written down value to reflect the carrying value as of transfer date with a contract account to intra health asset in kind expense.

Dr. P&E Intra Health Transfers	*$48 million*	
Cr. P&E Dep W/Back Intra Health Transfers		*$3 million*
Cr. Intra Health Asset in Kind Revenue		*$45 million*

Children network level

Children network will recognises the new asset at it's written down value in the GL to reflect the latest carrying value with a contra account of intra health asset in kind revenue account.

Dr. Intra Health Asset in Kind Expense	*$45 million*	
Dr. P&E Dep W/Back Intra Health Transfers	*$3 million*	
Cr. P&E Intra Health Transfers		*$48 million*

These entries will all eliminate on consolidation at a state level, if the entries are taken up as above. The written down value of the asset will still only be reflected once in the consolidated financial statements.

9.4.6 Capitalisation guidance based on project life-cycle

Refer to capitalisation guidance below for treatment on various cost depending on the project life-cycle for capital upgrade or new capital.

Summary of Accounting Treatment of Capital Upgrades

PHASE	STEPS	COST ITEMS	ACCOUNTING TREATMENT
Phase 1 – Application for Capital Upgrade Funding	Preparation of Strategic Asset Management Plan	Staff costs: • Project team • Everyday operational	 Expense Expense
Phase 2 – Forward Design	Engage Project Director/Manager	Staff costs: • Project team • Everyday operational Procurement costs: • Project Management costs • Travel costs	 Capitalise Expense Capitalise Capitalise
	Design Agent produces the required design documents	Architectural / Design Consultant costs Quantity Surveyor costs Specialist Consultant costs Travel costs	Capitalise Capitalise Capitalise Capitalise
	Design Acceptance	Staff costs: • Project team • Everyday operational	Capitalise Expense
Phase 3 – Construction	Pre-Construction Relocation (Staff are moved to temporary accommodation ([where applicable])	Staff costs: • Project team • Everyday operational Site preparation costs Relocating costs Rental costs Minor fit-out costs	 Capitalise Expense Capitalise Expense Expense Expense
	Project Director/ Manager goes out to tender for construction	Staff costs: • Project team • Everyday operational Procurement costs: • Project Management costs Tender costs Insurance costs Travel costs	 Capitalise Expense Capitalise Capitalise Capitalise Capitalise

PHASE	STEPS	COST ITEMS	ACCOUNTING TREATMENT
	Project Director/ Manager engages Builder and other construction contractors	Staff costs: • Project team • Everyday operational Procurement costs: • Project Management costs • Construction costs	 Capitalise Expense Capitalise Capitalise
	Defect period commences after formal handover. Staff, through Project Director (or Project Manager), ensure defects list is completed and defects fixed.	Staff costs: • Project team • Everyday operational	Capitalise Expense
Phase 4 – Fit-Out	Tender for Project Manager	Staff costs: • Project team • Everyday operational Tender costs	 Capitalise Expense Capitalise
	Project manager selected for fit-out	Staff costs: • Project team • Everyday operational Project Management costs Consultant costs	 Capitalise Expense Capitalise Capitalise
	Purchase of fit-out items	Asset Purchase costs	Capitalise
	Installation of assets	Fit-out costs	Capitalise
Phase 5 – Post-Construction Relocation	Moving into completed building (where applicable)	Staff costs: • Project team • Everyday operational Removalist costs	 Expense Expense Expense
Phase 6 – Running Costs	There are costs that agencies should take note of after the project completion stage for planning their future funding requirements.	Depreciation Ongoing repair & maintenance Insurance cost	Expense Expense Expense
Whole of Project Costs	There are a number of costs that may be incurred during any phase of a capital works project.	Training costs – all phases Meeting costs – all phases Steering Committee costs – all phases Borrowing costs – all phases	Expense Expense Expense Expense

Summary of Accounting Treatment of New Construction

PHASE	STEPS	COST ITEMS	ACCOUNTING TREATMENT
Phase 1 – Concept Development	STEPS Project Concept Brief	Staff costs: • Project team • Everyday operational	 Expense Expense
Phase 2 – Feasibility Study (Financial and Economic Business Case)	Proposal requesting Capital Works funding for a feasibility study	Staff costs: • Project team • Everyday operational Consultant costs Travel costs	 Expense Expense Expense Expense
	Feasibility Study (Needs Assessment)	Staff costs: • Project team • Everyday operational Consultant costs Travel costs	 Expense Expense Expense Expense
	Forward Design Proposal and Cost Benefit Analysis (both prepared using Feasibility Study results)	Staff costs: • Project team • Everyday operational Consultant costs Travel costs	 Expense Expense Expense Expense
Phase 3 – Forward Design	Engage Project Director/Manager	Staff costs: • Project team • Everyday operational Procurement costs: • Project Management costs Travel costs	 Capitalise Expense Capitalise Capitalise
	Design Agent produces the required design documents	Architectural / Design Consultant costs Quantity Surveyor costs Specialist Consultant costs Travel costs	Capitalise Capitalise Capitalise Capitalise
	Design Acceptance	Staff costs: • Project team • Everyday operational	 Capitalise Expense
	Business Case Proposal for Construction Funding (using results from Feasibility Study and Forward Design)	Staff costs: • Project team • Everyday operational	 Capitalise Expense

PHASE	STEPS	COST ITEMS	ACCOUNTING TREATMENT
Phase 4 – Construction	Pre-Construction Relocation (Staff are moved to temporary accommodation ([where applicable])	Staff costs: • Project team • Everyday operational Site preparation costs Relocating costs Rental costs Minor fit-out costs	 Capitalise Expense Capitalise Expense Expense Expense
	Project Director/ Manager goes out to tender for construction	Staff costs: • Project team • Everyday operational Procurement costs: • Project Management costs • Tender costs Insurance costs Travel costs	 Capitalise Expense Capitalise Capitalise Capitalise Capitalise
	Project Director/ Manager engages Builder and other construction contractors	Staff costs: • Project team • Everyday operational Procurement costs: • Project Management costs • Construction costs	 Capitalise Expense Capitalise Capitalise
	Defect period commences after formal handover. Staff, through Project Director (or Project Manager), ensure defects list is completed and defects fixed.	Staff costs: • Project team • Everyday operational	 Capitalise Expense
Phase 5 – Fit-Out	Tender for Project Manager	Staff costs: • Project team • Everyday operational Tender costs	 Capitalise Expense Capitalise
	Project manager selected for fit-out	Staff costs: • Project team • Everyday operational Project Management costs Consultant costs	 Capitalise Expense Capitalise Capitalise
	Purchase of fit-out items	Asset Purchase costs	Capitalise
	Installation of assets	Fit-out costs	Capitalise

PHASE	STEPS	COST ITEMS	ACCOUNTING TREATMENT
Phase 6 – Post-Construction Relocation	Moving into completed building (where applicable)	Staff costs: • Project team • Everyday operational Relocating costs	 Expense Expense Expense
Phase 7 – Running Costs	There are costs that agencies should take note of after the project completion stage for planning their future funding requirements.	Depreciation Ongoing repair & maintenance Insurance cost	Expense Expense Expense
Whole of Project Costs	There are a number of costs that may be incurred during any phase of a capital works project.	Training costs – all phases Meeting costs – all phases Steering Committee costs – all phases Borrowing costs – all phases	Expense Expense Expense Expense

10 Valuation of physical non-current assets at fair value

10.1 Scope

10.1.1 Applicability

This Policy applies to the identification and accounting for physical non-current assets at fair value within Local Health District ("the Health entity").

10.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- AASB 13 Fair Value Measurement
- TPP21-09 Accounting Policy: Valuation of Physical Non-Current Assets at Fair Value

10.2 Overview and purpose

The purpose of this document is to provide Health entities with illustrative guidance on valuing physical non-current assets at fair value for general purpose financial reporting.

The valuation of physical non-current assets must meet the valuation guidelines as described in the NSW treasury accounting policy ("Valuation of Physical Non-Current Assets at Fair Value") which is based on Australian equivalents to International Financial Reporting Standards (AIFRS). The TPP21-09 mandates physical non-current assets to be measured at fair value under AASB 116, AASB 1059 and AASB 140, consistent with *AASB 1049 Whole of Government and General Government Sector Financial Reporting*. The policy provides guidance on how to measure the fair value of assets taking into account the unique circumstances in the public sector. Many assets in the public sector have few or no alternative uses, and many assets, including infrastructure assets are highly specialised.

10.3 Policy statement

This policy requires all physical non-current assets to be revalued at fair value, subsequent to initial recognition. After initial recognition, *Australian Accounting Standard AASB 116 Property, Plant and Equipment and AASB 1059 Service Concession Arrangements: Grantor* requires each non-current asset class to be measured using either the cost model of the revaluation model (ie on a fair value basis). The fair value is defined as "the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date".

10.4 Application guidance

10.4.1 General valuation principles

The fair value concept as defined above and the fair value guidance throughout this policy document reflect an 'exit price' approach.

To calculate a fair value, information must be obtained, and/or assumptions made, about a range of factor which includes a range of factors including:

- The characteristics, e.g. the condition and location of the asset
- Which market a sale of the asset would take place in
- Who would buy the asset and what they would take into account
- What is the highest and best use for the asset and
- Which costs are to be taken into account (e.g transaction costs are not to be included)

The data used for the fair value calculation must reflect the information and assumptions that market participants would use when pricing the asset, not necessarily how the Health entity currently uses, or intends to use, the asset.

Market and market participants

AASB 113.22-23

Fair value measurement assumes that the transactions are taking place in either the principal market or, in the absence of a principal market, the most advantageous market for the asset. The Health entity must have access to the relevant market at the measurement date.

There may be situations where specific markets and/or market participants are not readily available. In such circumstances, the Health entity should consider:

- What the asset can be used for
- Who would use it for those purposes
- What would those market participants take into account in determining a price to pay for the asset

The Health entity should ensure they have given appropriate consideration to the existence of available observable inputs – refer 10.4.4 below.

10.4.2 Highest and best use

AASB 113.27-30

The fair value of all non-current physical assets is required to be measured based on its highest and best use from a market participant's perspective, regardless of how the asset is currently used or the Health entity's present intention to use the asset.

The highest and best use takes into account the asset's use that is:

Physically possible – the physical characteristics that market participants would consider (for example, property location or size).

Legally permissible – takes into account the legal restrictions on the asset's use that market participants would consider (e.g planning or zoning requirements).

Financially feasible – takes into account whether an asset's use generates adequate income or cash flows to produce an investment return that market participants would require.

Fair value takes account any restrictions on the sale or use of an asset, if those restrictions relate to the asset rather than to the holder of the asset and a market participant would take those restrictions into account in determining the market price that they are determined to pay.

Impact of restrictions on highest and best use

NSW Health is subject to restrictions resulting from mandates imposed by NSW Government which would require health services to be provided to the public. This imposes restrictions on the sale or use of most government assets since the Health entity is not able to sell or change the use of the asset. As a result, restrictions imposed by the government regarding the use and disposal of assets in the public sector are a characteristic of the asset. In addition, most of the land held by the Health entity (such as the land under the hospitals) as the Health entity may be mandated to continue to provide services for the benefit of the public. Hence the land may be subject to restrictions imposed by the government which may substantially eliminate alternative uses of the asset. Such restrictions mean that alternative uses are not available and therefore should not be taken into account in valuing particular assets, especially with respect to infrastructure assets and the land under them given the specialised nature of these assets.

The highest and best use must take account of the characteristics of the asset being measured which include the mandated restrictions imposed by government on the use or disposal of assets and the risk that the Government may not permit the sale or alternative use of the land or the assets on the land.

Under the above circumstances, a market participant would price these assets based on its current restricted use. In limited circumstances however, a higher restricted alternative use is available such as in the rare circumstances where there is the expectation that the previously mandated service is no longer required or mandated.

Current restricted use (or existing use):

Restrictions imposed by government substantially eliminate alternative uses in the land as noted above. Such restrictions mean that alternative uses are not legally permissible and therefore should not be taken into account in valuing particular assets, especially with respect to specialised infrastructure assets (specialised hospital buildings) and the land beneath these assets. Therefore the highest and best use for these assets is their current restricted use (or existing use) as NSW Health is mandated to continue to deliver health services in that particular location.

Higher restricted alternative use:

An asset may have higher restricted feasible alternative use in limited circumstances (such as land under a historic or heritage building located within the hospital grounds). The historical building could be used for housing a foundation museum or other purposes –in such cases, the highest and best use is the higher of the current use and any restricted alternative uses.

Higher unrestricted alternative use:

There are limited circumstances where the highest and best use of an asset will be the higher of the current use and any higher unrestricted alternative use. For example, a hospital may no longer be required in that location because of consolidation of the delivery of health services for strategic and efficiency reasons. Generally this would be supported by a government decision that the asset is a surplus asset. Under this circumstances, the fair value measurement can assume a different zoning if market participants would do so. This would incorporate the cost to convert the asset (including demolition costs) and in obtaining the different zoning permission.

Example 10.1: Restrictions on the use of an asset

A donor contributes land in an otherwise developed residential area to a not for profit association. The land is currently used as a playground. The donor specifies that the land must continue to be used by the not for profit as a playground in perpetuity. Upon review of relevant documentation, the association determined that the fiduciary responsibility to meet the donor's restriction would not be transferred to market participants if the association sold the asset, since the donor restriction is specific to the association. Furthermore, the association is not restricted from selling the land. Without the restriction on the use of land by the association, the land could be used as a site for residential development. In addition, the land is subject to an easement (a legal right that enables a utility to run power lines across the land).

How to account for the above restriction under the higher and best use:

The donor restriction on the use of land is specific to the association and hence the restriction is not transferred to market participants. The fair value of the land would be the higher of its fair value used as a playground and its fair value as a site for residential development, regardless of the restriction on the use of the land by the association.

The easement for utility lines is specific to the land and hence would be transferred to the market participant with the land. Hence the fair value measurement of the land would take into account the effect of easement, regardless of whether the higher and best use is as a playground or as a site for residential development.

Consideration of unit of account

The unit of account is the level of disaggregation at which an asset is measured and accounted for e.g. the level an asset is recognised and disclosed at.

The unit of account is important when the Health entity measures the fair value of an asset subsequent to initial recognition because fair value is measured for each particular asset. Although each particular asset is measured separately, its fair value is determined with reference to assumptions about whether its highest and best use is as a stand-alone asset or as part of a group. Whether an asset is a stand-alone asset or part a group will depend on its unit of account. The following should be taken into consideration when determining the use of accounts:

- *How the business is managed which may be evidenced by:*
  - *How management assesses and monitors performance*
  - *Whether the business is managed on an individual, functional or geographical or total entity basis*
  - *Whether it's business is managed on the basis of a cash generating unit*
  - *Regulatory approach adopted by regulators in respect of the Health entity's economic and operational activities*
- *What is an operating asset:*
  - *Whether an item can be operated on its own or only when operating in conjunction with other items of PP&E (ie whether the components work together as an integrated whole to provide a service or bundle of related services to the end customer)*
  - *What items of PP&E would be aggregated to constitute an asset for the purposes of disposal as evidenced by observable market transactions*

Accounting for the high and best use on a standalone or group basis

The fair value measurement is affected by the unit of account used for the asset. The Health entity should apply professional judgement to determine the unit of account for measurement based on the specific circumstances taking into account the highest and best use of the asset, how the asset is managed and used, and the availability and quality of relevant observable data.

Where the unit of account is based on the group of assets then:

- *It is assumed that the asset would be used within such a group and that the other assets and liabilities would be available to market participants*
- *Assumptions about highest and best use should be consistent for all assets classed within a group*

Fair value measurement assumes that the asset is sold consistent with the unit of account, and not as a group because it is assumed the market participant is assumed to have those other assets.

Synergies associated with the asset group may be factored into the fair value of the individual assets. For example, if NSW Health has a specialised building with different components (a parking bay, the hospital wing and the bridge connected to the hospital ground) and the highest and best use of the specialised building is achieved in combination, then the valuation for the different components of these assets is achieved in combination, then the valuation of any one of these assets (e.g the hospital wing) is valued on the assumption that the market participant (such as a private health operator) already hold the other two assets (the hospital bridge and the parking bays).

10.4.3 Valuation techniques

Where a price for an identical asset is not observable, an entity measures fair value using another valuation technique that maximises the use of relevant observable inputs and minimises the use of unobservable inputs. The below are three different types of valuation technique:

1. Market approach
2. Cost approach
3. Income approach

AASB 113.61-66, B5-B11

Market approach

The market approach is defined as a valuation technique that uses prices and other relevant information generated by market transactions involving identical or comparable (ie similar) assets, liabilities or a group of assets and liabilities, such as a business. Example where the market approach would be appropriate is land with references to prices achieved in sales of comparable properties. Where buildings are specialised (such as the hospital building), it is unlikely that a market price would capture the value that the specialised assets contributes to the business, since these assets are rarely traded and reliable comparisons with similar assets can rarely be made due to the specialised features. Under this scenario, the income or cost approach may be most appropriate.

Cost approach

Valuation technique that reflects the amount that would be required currently to replace the service capacity of an asset (referred to as the replacement cost of a modern equivalent asset). This assumes that fair value is the cost to acquire or construct a substitute asset of comparable. The cost approach would only be used when other approaches are not available or produced unreasonable results and would be most appropriate to use where the assets are specialised since these are rarely traded.

With respect to public sector entities such as NSW Health, the cost approach is the most appropriate approach since:

1. The Health entities within NSW Health do not operate with the objective to generate a profit, and the cost in the delivery of health services is subsidised by the government in the form of grants. As a result, the income approach is normally not relevant
2. The market approach will generally not be relevant, because identical or similar assets are rarely traded and the specialised features of the assets (such as hospital buildings) would rarely allow relevant comparisons with the prices of similar assets
3. The cost approach will be more widely relevant given the specialised nature of the infrastructure assets.

Income approach

The income approach is defined as the valuation technique that covert future amounts (such as cash flows or income and expenses) to a single current amount. The fair value measurement is determined on the basis of the value indicated by current market expectations about those future amounts. Examples of income approach includes:

- Present value techniques (discounted cash flow method)
- Multi period excess earnings method

The Health entity should aim to choose a valuation technique which would maximise the use of relevant observable data inputs and minimise the use of unobservable inputs. Once a valuation technique has been selected, it should be applied consistently to assets within that class. An example is the Land which is valued based on the market approach.

The income approach will generally be appropriate to for-profit entities or cash generating units of not-for-profit entities with respect to specialised assets. Given the objectives of NSW Health (NSW Health does not operate for a profit), the following policy choice is applied with respect to the valuation techniques for the following classes of assets:

Class of assets	Valuation Approach
Land	Market approach
Specialised buildings	Cost approach
Non specialised buildings	Market approach
Infrastructure systems	Cost approach
Service concession assets*	Cost approach

*Note: AASB 1059 mandates the measurement of a service concession asset at current replacement cost in accordance with the cost approach to measuring fair value in AASB 13.

10.4.4 Inputs to valuation techniques

Fair value measurement is based on a hierarchy of inputs ranked from highest to lowest priority where the highest priority is given to level 1 inputs while level 3 inputs is ranked the lowest priority.

- Level 1 inputs – quoted prices in active markets for identical assets
- Level 2 inputs – inputs other than quoted prices observable for the asset, either directly or indirectly
- Level 3 inputs – unobservable inputs

Inputs are defined as the assumptions that market participants would use when pricing the asset. Including assumptions about risk, such as the risk inherent in a particular valuation technique and the risk inherent in the inputs to the valuation technique.

Management should assess the significant unobservable inputs by:

- Considering the sensitivity of the asset's overall value to changes in the data
- Re-assess the likelihood of variability in the data over the life of the asset

Examples of inputs

Inputs	Example
Level 1 input	• Share price of shares traded on the stock exchange
Level 2 input	• For a building held and used – the price per square metre for the building (a valuation multiple) derived from observable market data • for a cash generating unit – multiple of earnings or similar performance measure derived from observable market data involving similar businesses
Level 3 input	• Use of financial forecasts for measuring the fair value of a cash generating unit • Use of replacement cost for Hospital Improvement.

Transfers between levels

From year to year, the Health entity must review the fair value levels assigned to their assets in light of changed asset characteristics (e.g. age, condition etc.), changes in market conditions and/or valuation techniques and changes in the nature/quality and significance of data inputs used in determining fair value. Transfers of asset values between fair value levels are otherwise expected by the Health entity to be rare.

Any necessary transfers of asset values between fair value levels are to take effect in conjunction with the recognition of the associated revaluations.

10.4.5 Application of fair value measurement for specific assets

1) Valuation of land

Highest and best use

Highest and best use is qualified by the asset's characteristics including any restrictions on the use and disposal of land, as well as the risk that any alternative use will not be approved.

Most hospitals are mandated by the ministerial directives or legal requirements to continue to provide the services that the land assists them in providing. Land assets where there are no feasible alternative use may include land under specialised buildings or infrastructure assets that are restricted in use as a result of mandates for service delivery. The highest and best use may be assessed in a group of assets (such as specialised buildings or infrastructure on the land).

In contrast, other land may not be restricted in use and can be valued based on any higher feasible alternative use. In such cases, the highest and best use may be either stand alone or in combination with any building or structure on the land.

Valuation technique

Land will usually be measured using the market approach based on a market selling price. Market approach will usually be available even where land has no feasible alternative use.

Fair value hierarchy

Land valuations are likely to be assessed at level 2 or level 3 of the fair value hierarchy, depending on the market conditions and whether similar types of land are actively traded.

Low level of fair value hierarchy may be more likely where the use of the land are restricted as there may be less market evidence available.

Example 10.2: Land used for operational purposes

NSW Health controls a property in a regional suburb in NSW from which it is planned to build a hospital carpark on that land. There is an active market for property in that suburb (and surrounding locality) with sufficient available information about sales of commercial land over the past year. The highest and best use of the land is considered to be for commercial/retail activities. Therefore a market approach is appropriate.

The valuer compares the property with comparable properties with similar characteristics (e.g. land area, street frontage and access, etc.) sold over the past year. This approach is based on the comparable recent land sales, and so entails some professional judgement based on observable market data. The process also reflects how a commercial investor would determine an appropriate amount to pay for that land. The resulting valuation is categorised into level 2 of the fair value hierarchy.

Example 10.3: Vacant land

NSW Health controls a large parcel of vacant land in a regional town. It was previously intended that a new hospital will be constructed on that land, but a recent change in service delivery strategy with respect to the hospital network resulted in a decision to abandon that plan. NSW Health has no other foreseeable use for the land, and there are no legislative restrictions on the land that prevent certain uses. The land is surrounded by well-established and profitable orachards, so the highest and best use of the land is considered to be for farming purposes. Sales of farms in the area are rare. The relevant market evidence available is sales of nearby orcharges over a number of years. A market approach is used.

The valuer applies a moderate amount of professional judgement to compare the sale price for the orchards, taking into account current market conditions in that area, as well as any costs that would be incurred to prepare the land for farming purposes. The judgements made by the valuer reflect the valuer's assessment of how a potential farmer (a market participant) would "price" the land, including any assumptions a potential farmer would make in that process. The resulting valuation is categorised into level 2 of the fair value hierarchy.

Example 10.4: Reserve land

The Health entity administers vacant land reserve land on behalf of the Crown. Under the Crown Lands Act 1989, such reserve land is dedicated by the Minister for community purposes. The Minister can remove this usage restriction by way of approval as required by the Health Services Act 1997. Such removal of the restriction and conversion of the land to freehold title must be undertaken prior to the sale of such land. A similar local government town planning restriction also exists over the land.

A directly observable market and market participants are not available for reserve land while it is subject to the Minster's restriction. However there is an active market for vacant land in that local government area, where such land is subject solely to town planning restrictions. Hence recent data on such land sales is a reliable starting point to estimate the fair value of the land. A direct comparison (ie a market approach) is used for valuation purposes.

The fact that the Minister would need to remove the reserve restriction prior to sale is a key assumption in the valuation process. The valuer gives particular consideration to those recent land sales where the land is of a similar topography or in similar circumstances to the land.

Highest and best use is limited by the town planning restrictions. The valuer uses significant professional judgement (i.e unobservable inputs) in extrapolating from the recent land sales, taking into account the town planning restrictions and any significant differences between the agency's land and the land recently sold. The resulting valuation is categorised into level 3 of the fair value hierarchy.

2) Valuation of buildings (specialised)

Highest and best use

Highest and best use is qualified by any restrictions on the use and disposal of the building as well as the risk that any alternative use will not be approved.

Specialised buildings are designed for a specific limited purpose such as buildings in hospitals and emergency services for ambulances. Such buildings have no feasible alternative use since the Health entity is mandated to continue to provide the services as the building permits.

In contrast, specialised buildings may not be restricted in use in which the services can be moved to another location or are no longer required. In such circumstances, management should take into consideration as to whether the highest and best use may be achieved by demolishing the building and selling the land underneath it as a vacant site. The highest and best use should take into account demolition costs and other costs of conversion.

Valuation technique

Specialised buildings would generally be measured using the cost approach, or if part of a cash generating unit, the income approach.

Fair value hierarchy

Specialised buildings are likely to be assessed at level 3 of the fair value hierarchy due to lack of market evidence being available.

Example 10.5: Aged care facility centre built on hospital grounds

The aged care facility centre has been in operation for 10 years and is expected to be continued to be used in the foreseeable future. The facilities' records indicate that the average occupancy of the facility over its useful life is 62% and has never exceeded 80% at any given time. The population and demographics in the surrounding has remained stable over the last 10 years and there are no local developments which is expected to have a significant impact in the foreseeable future. Property sales in the area are very infrequent. The internal design of the aged care facilities has limit the building's potential for other uses, so the present use is considered to represent the highest and best use. Therefore a cost approach is used.

Estimated costs are determined for each element of the facility, using a combination of historical records of construction costs (labour and materials) of aged care facilities built in other regions in the past five years (adjusted for design differences), and published construction rates for various standard components of buildings. Given the history of less than full occupation of the facility, costs are estimated to reproduce a facility of only 80% of the current capacity (as a market participant would not place any value on the excess capacity). The valuer also uses significant judgements to assess the remaining service potential of the building, given local climatic and environmental conditions. The remaining service potential is reflected in the valuation of the building. The judgement is based on the records of the current condition of the facility, along with local experience with other buildings within the community. The methodology used reflects the valuer's expectations about how a potential private operator would determine the maximum amount they are prepared to pay for the facility. The resulting valuation is categorised into level 3 of the fair value hierarchy.

3) Valuation of buildings (non-specialised)

Highest and best use

For non-specialised buildings, the valuation should be based on existing use or any higher feasible alternative use. This will be measured in combination with the land on which it is built. Consideration would need to be given to whether the highest and best use in combination with the land is achieved through selling the land as a vacant site. The building and the land under the building must be valued consistently.

Valuation technique

Non-specialised buildings should be measured using the market approach (if part of a cash generating unit) or the income approach (based on market rental income scheme).

Fair value hierarchy

Non-specialised buildings are likely to be assessed on level 2 or level 3 of the fair value hierarchy, depending on market conditions. Where the building is actively traded on the real estate market, fair value may be classified as level 2 (such as price per square metre), depending on the significance of adjustments to observable data. In inactive or less transparent markets (or where significant adjustments is required to be made on observable data), it may be classified as level 3.

4) Valuation of infrastructure assets

Highest and best use

Infrastructure assets include assets which are highly specialised and by nature they are designed for a specific limited purpose. In most cases, such specialised assets and the land under them have no feasible alternative use, as the government mandates that assets continue to be used to provide the services which the infrastructure is used to provide. Under these circumstances, the infrastructure assets will be measured in combination with the land on which it is built.

Valuation technique

Infrastructure assets would generally be measured using the cost approach, or if part of a cash generating unit, the income approach.

Fair value hierarchy

Infrastructure assets are likely to be assessed at level 3 of the fair value hierarchy due to lack of market evidence being available.

5) Service concession assets

A service concession asset is defined in AASB 1059 as "an asset (other than goodwill) to which the operator has the right of access to provide public services on behalf of the grantor in a service concession arrangement that:

- *the operator constructs, develops, upgrades or replaces major components, or acquires from a third party or is an existing asset of the operator; or*
- *is an existing asset of the grantor, including a previously unrecognised identifiable intangible asset and land under roads, or an upgrade to or replacement of a major component of an existing asset of the grantor."*

AASB 1059 mandates the measurement of a service concession asset at current replacement cost in accordance with the cost approach to measuring fair value in AASB 13. This measurement approach is required for initial measurement and, when revaluation model is adopted, subsequent measurement of the assets.

Service concession assets are considered a subset of an existing class of assets, such as land & buildings, infrastructure etc. (AASB 1059 para 29). Therefore, for guidance on the application of AASB 13 fair value principles to particular categories of physical non-current assets, refer to discussion in the previous sections.

Where the grantor retains control of the asset after the end of the service concession arrangement, the fair value measurement of the asset is no longer restricted to the cost approach. However, the asset will continue to be subject to the fair value principles.

For land that is not in the scope of AASB 1059, the market approach is typically used to measure fair value, rather than the cost approach. However, the market approach is consistent with the current replacement cost approach when measuring the fair value of land. This is because the market approach represents the amount a buyer would pay, in the market, to replace the service potential of that land. A valuer will consider the service capacity limitations of the asset when determining the current replacement cost of the land, including restrictions on sale/use e.g. zoning. A valuer will consider these characteristics when applying either a market or income approach valuation technique.

Ultimately, the cost approach for land fundamentally applies the same AASB 13 and valuation framework principles and concepts that equally apply to a market approach valuation of land (characteristics of the asset, highest & best use, valuation premise etc.).

6) Assets under construction

Accounting standards do not preclude revaluation of assets under construction.

The value of assets under construction will generally reflect the costs incurred to date in the creation of the asset. In most cases, especially when an asset's fair value is determined based on current replacement cost, the cumulative construction cost of the asset before completion of construction and sometime after is not materially different from its fair value. Therefore, assets under construction and assets recently constructed do not usually require revaluation.

However, revaluation may need to be considered in the following circumstances:

- *there is evidence the asset is impaired;*
- *construction occurs over a substantial number of years and historical costs no longer accurately reflect fair value (e.g. as a result of declines or increases in key cost inputs such as materials or labour); or*
- *construction costs capitalised in accordance with AASB 116 do not satisfy criteria for incorporation into fair value under AASB 13, (e.g. site preparation costs such as costs of demolishing or relocation of existing buildings in some circumstances)*

In these circumstances, health entities need to assess whether the construction costs are materially different to fair value and therefore may need to revalue those assets under construction.

Fair value measurement – Summary

Asset class/ category	Examples of types of assets	Expected fair value level	Likely valuation approach	Net vs gross revaluation method
Land	In areas where there is an active market: • vacant land • land not subjected to restrictions to use or sale	Level 2	Market or income approach	N/A – as land is not depreciated
Land	Land subject to restrictions as to use and/or sale Land in areas where there is not an active market	Level 3	Market or income approach	N/A – as land is not depreciated
Buildings – non specialised	General office/commercial buildings	Level 2 or 3, according to significance of adjustments using unobservable data/ judgements	Market or income approach	Net method
Buildings – specialised	Specialised buildings with limited alternative uses and/or substantial customisation e.g. hospitals	Level 3	Cost approach	Gross method
Infrastructure	Any type	Level 3	Cost approach	Gross method

Asset class/ category	Examples of types of assets	Expected fair value level	Likely valuation approach	Net vs gross revaluation method
Infrastructure	Any type where highest and best use would be to generate net cash inflows	Level 3	Income approach	Net method
Major plant and equipment	Non-specialised	Level 2 or 3, according to significance of adjustments using unobservable data/ judgements	Market or income approach*	Net method
Major plant and equipment	Specialised items with limited alternative uses and/or substantial customisation	Level 3	Cost approach	Gross method
Intangibles	Where there is an active market for that intangible (otherwise intangibles must not be revalued)	Level 2	Market approach**	Net method
Service concession arrangements	Specialised assets providing public service, which are operated by private operators on behalf of NSW Health	Level 3	Cost approach	Gross method

**For NSW Health, all major plant and equipment are specialised and are therefore measured using a cost approach.*
***For NSW Health, most of the intangible assets have no active market and are therefore carried at cost less any accumulated amortisation and impairment losses.*

10.4.6 Conduct of revaluation

Frequency and types of revaluations

AASB 116.31-38

AASB 116 provides that:

- Revaluations should be made with sufficient regularity to ensure that the carrying amount does not differ materially from that which would be determined using fair value at the end of the reporting period (AASB 116, para 31)
- Some items of property, plant and equipment experience significant and volatile changes in fair value which necessitates annual revaluation (AASB 116, para 34)
- If an item of PP&E is revalued then the entire class of property, plant and equipment to which the asset belongs to must be revalued
- Items within a class of property, plant and equipment are revalued simultaneously to avoid selective revaluation, but a class may be revalued on a rolling basis provided revaluation of the class is completed within a short period and provided revaluations are kept up to date (AASB 116, para 38)

Consistent with the above, the Health entity must assess at each reporting date, where there is any indication that an asset's carrying amount differs materially from fair value. Where any indication exists, the entities' asset (and class) must be revalued. This requires consideration of external and internal sources of information, including consideration of relevant price indices.

The useful life and residual value of the asset must also be reviewed by the Health entity at the end of each annual reporting period. The Health entity should also document the annual assessment of fair value, useful lives and residual values including reasons why the Health entity concluded carrying value is not materially different to fair value.

If an item of property, plant and equipment is revalued then the entire class of property, plant and equipment to which the asset belongs must be revalued.

Comprehensive revaluation

Comprehensive revaluation must be conducted using externally professionally qualified valuers either to conduct the revaluation or to review the revaluation. The frequency of comprehensive revaluation for each class is as follows:

Asset class/category	Frequency of revaluation
Land, building and Infrastructure	At least every 3 years
Other asset classes requiring revaluation	At least every 3 years

The above guidance will ensure that the assets are revalued frequently enough to ensure the carrying amount of the asset does not differ materially from fair value (AASB 116, para 31).

Health entities are required to perform comprehensive revaluation based on the triennial rolling schedule prepared by the NSW Ministry of Health. All comprehensive revaluations should be performed as at 31 December.

Desktop revaluations

Desktop (or interim) revaluations are less detailed than a comprehensive revaluation.

The Health entity is required to conduct interim revaluations between comprehensive revaluations where cumulative changes to indicators/indices suggest fair value may differ materially from carrying value.

Health entities are required to obtain market indices as of 30 June every year for movements in market prices from the last comprehensive revaluation date. Based on the market indices obtained, health entities should calculate the impact of market indices on the value of land, buildings and infrastructure assets and recognise any resulting revaluation adjustments.

Where the market indices show a movement to indicators greater than 20%, consideration must be given as to whether comprehensive revaluation is required to be performed more frequently. This decision must be made in conjunction with or subject to the review of an external professionally qualified valuer.

Qualifications of valuers

This policy requires that comprehensive revaluations and interim formal revaluations be conducted using external professionally qualified valuers (either to conduct the revaluation or to review the revaluation).

The decision as to whether a valuation is conducted rather than reviewed by an external valuer requires consideration of the below:

- The expertise required to value the assets
- The availability of in house expertise and whether it would be more appropriate to use staff for their core duties and
- The objectivity of in house staff

An approach that combines the local knowledge and expertise of in-house staff with the expertise of external valuer will be the most effective strategy. The involvement of an external valuer will help ensure independence of the revaluation process.

Recognition date of revaluations

Revalued assets must be depreciated based on the revalued amounts from the day after the date of revaluation.

At reporting date, the Health entity must assess whether there is any indication that an asset's carrying amount differs materially from fair value. Where there is an indication the carrying amount differs materially from fair value, the Health entity must update the asset value by using relevant indices to roll forward the balances to year end.

Management of an asset revaluation

Management must assign responsibility within the Health entity to either undertake or oversee the revaluation process, regardless of whether it is comprehensive or interim revaluation.

The Health entity must ensure the valuation approach is sufficiently documented and supported/reviewed by senior management through preparation of a valuation plan. This could include documentation of the following:

- The proposed valuation cycle
- The data sources
- The scope of the valuation
- How the valuation process is managed and who is responsible for managing it

Specific items that must be documented includes:

- How the Health entity has ensured that the fair values are not materially misstated at the reporting date
- How the Health entity determines when it will undertake a comprehensive or interim revaluation
- The basis and annual assessment for any indices applied
- How the Health entity chose the valuation approach and how the approach complies with the accounting standards
- The key assumptions used in the valuation approach and the evidence to support the assumptions

When working with external valuers, the Health entity must instruct the valuation to be made in accordance with TPP21-09 Accounting Policy: Valuation of Physical Non-Current Assets at Fair Value. The Health entity must provide written instructions as follows:

- Date and purpose of revaluation (i.e. (i.e. for financial reporting purposes under Australian Accounting Standards and Treasury's Asset Valuation Policy)
- Unit of account issues (refer to 10.4.2 above)
- Whether the highest and best use is the existing use or a feasible alternative use (refer to 10.4.2 above)
- Reference market (refer to 10.4.1 above)
- Characteristics of assets to be taken into account, including existence of any contamination/damage to property including areas where there is a legal or constructive obligation (refer to 10.4.1 above)
- Timing of any major inspection costs
- Different categories of assets to be valued, and the quantity and quality of information available
- When valuation is required
- Scope of the site inspections
- Reference to fair value hierarchy and maximising observable inputs
- Listing of valuer assumptions, sources of information, details of comparable sales and adjustments for support/audit etc.
- For current replacement cost valuations, the consideration and treatment/adjustments for all forms of obsolescence
- Requirement to perform condition assessments if applicable

The valuer should provide a confirmation letter to confirm the scope of their work and should include the following statements:

- The valuation is made or reviewed in accordance with AASB 13, AASB 116 and AASB 140 (where relevant) and the TPP21-09 Accounting Policy: Valuation of Physical Non-Current Assets at Fair Value
- The method used in determining fair values for each class of assets and
- The reason for the method used

It is the responsibility of the Health entity to review any independent valuations to ensure they are appropriate before they are relied on or used by the Health entity.

11 Impairment of assets

11.1 Scope

11.1.1 Applicability

This Policy applies to the accounting treatment for the impairment of assets, including indicators of impairment, recoverable amounts, cash generating units and recording an impairment loss.

11.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- TPP21-09 Valuation of Physical Non-Current Assets at Fair Value
- AASB 136 Impairment of Assets

11.2 Overview and purpose

The purpose of this document is to provide Health entities with illustrative guidance on the accounting and reporting requirements for impairment of assets.

The impairment of physical non-current assets must meet the guidelines as described in the NSW treasury accounting policy ("Valuation of Physical Non-Current Assets at Fair Value") which is based on Australian equivalents to International Financial Reporting Standards (AIFRS). The TPP21-09 mandates physical non-current assets to be subject to an impairment test as part of *AASB 136 Impairment of Assets*. The policy provides guidance on how to assess physical non-current assets in the public sector for impairment.

11.3 Policy statement

An impairment is defined as the decline in the future economic benefits or service potential of an asset over and above the use reflected through depreciation.

A review for impairment indicators must be performed and documented annually.

For physical non-current assets and intangible assets. The Health entity should test an asset for impairment if there are indicators of impairment.

11.4 Application Guidance

11.4.1 Indicators of impairment

AASB 136.12

Health entities must assess every year at reporting date whether there are any indicators that an asset may be impaired. This would apply equally to an individual asset or a cash generating unit. The Health entity is not required to make a formal estimate of recoverable amount of an asset if no indicators of impairment are identified.

In assessing whether there is any indication that an asset might be impaired, the Health entity should consider the following:

External sources of information including:

- Observable indications that the asset's value has declined during the period significantly more than would be expected as a result of the passage of time or normal use. Changes in market values reflect economic conditions, so a significant fall in value could be a symptom of another more pervasive change
- Significant adverse changes that have taken place in the technological, market, economic or legal environment in which the entity operates or in its markets
- Increases in interest rates, or other market rates of return, that might materially affect the discount rate used in calculating the asset's recoverable amount
- Where the carrying amount of the entity's net assets exceeds the entity's market capitalisation

Internal sources of information including:

- Obsolescence or physical damage affecting the asset
- Significant adverse changes that have taken place in the extent to which, or in the way that an asset is used or expected to be used.
- Deterioration in the expected level of the asset's performance
- Where management's own forecasts of future net cash inflows or operating profits show a significant decline from previous budgets or forecasts.

Example 11.1: Demand ceases for services provided by the asset

A hospital closed because of a lack of demand for health services arising from a population shift to other areas. It is not anticipated that this demographic trend affecting the demand for health services will reverse in the foreseeable future.

How should the above be accounted for?

The lack of demand for health services is an indicator of impairment and the carrying value of the hospital should be assessed for impairment.

Example 11.2: Significant long-term changes in the technological environment with an adverse effect on the Health entity

A medical diagnostic equipment is rarely or never used because a newer machine embodying more advanced technology provides more accurate results.

How should the above be accounted for?

The medical diagnostic equipment should be assessed for impairment due to a newer machine being available, this making the existing medical diagnostic equipment idle and obsolete.

11.4.2 Recoverable amount

Recoverable amount is determined as the higher of an asset's net selling price (fair value less costs to sell) and its value in use.

AASB 136.18-23

Fair value less costs to sell

Fair value less costs to sell is the amount obtainable from the sale of the asset in an arm's length transaction between knowledgeable, willing parties, less the costs of disposal.

Refer to Chapter 10 of this policy document for guidance on determining fair values.

Costs to sell are incremental costs directly attributable to the disposal of an asset, excluding finance costs and income tax expense. Where the disposal costs are negligible, the recoverable amount of a revalued asset is close to or greater than its revalued amount and under this circumstances, the recoverable amount would not need to be estimated as the revalued asset is unlikely to be impaired.

In most circumstances, it is not expected that such disposal costs would be material and hence impairment of physical non-current assets within the NSW Health sector to be rare. However, where the disposal costs are not negligible, the Health entities should assess whether the asset is impaired. The revalued asset will be impaired if its value in use is less than its revalued amount.

Value in use

Value in use is defined as:

- the present value of the future cash flows expected to be derived from an asset or cash generating unit
- depreciated replacement cost where the future economic benefits of an asset are not primarily dependent on the asset's ability to generate net cash inflows and where the entity would, if deprived of the asset, replace its remaining future economic benefits. This applies to not for profit entities. The future economic benefits of the asset is to provide a service and not to generate a commercial return. For further guidance on the depreciated replacement cost refer to Chapter 5 of this policy document.

Where the value in use is the depreciated replacement cost, then the value in use is the same as fair value (determined using the cost approach) under Chapter 5 of this policy document. As a result, revalued assets are unlikely to be impaired.

However, notwithstanding the above, the Health entities must assess at each reporting date whether there is any indication that an asset or cash-generating unit may be impaired. If such an indication exists, the Health entity must estimate the recoverable amount.

11.4.3 Value in use

Determining the value in use involves estimating the future cash flows that are expected to arise from the asset or CGU being tested for impairment. The cash flows consist of those expected to arise from the continued use of the asset in its current condition, if any expected to result from its ultimate disposal. An appropriate discount rate is then applied to those cash flows, in order to arrive at their present value.

Relevant cash flow forecasts should be made on the basis of reasonable and supportable assumptions that represent management's best estimate of the economic circumstances that will prevail over the asset of CGU's remaining life.

The Health entities should examine the causes of any difference between actual cash flows and past projections to assess whether assumptions are reasonable. The current assumptions should be consistent with past actual outcomes, except in the instance where circumstances have changed or subsequent events have occurred which makes the current assumptions inappropriate.

Cash flows should be based on the most up to date budgets and forecasts that have been formally approved by the NSW Ministry of Health, excluding cash inflows and outflows arising from future restructuring or enhancements. If budgets are revised, they should be approved by the NSW Ministry of Health before they can be used in the value in use calculation.

Length of forecast in estimates of future cash flows

The cash flow projections of a CGU with a defined life should be an estimate of the value for that defined life. The cash flows for periods beyond those covered by formal budgets and plans should assume a steady or declining growth rate. This rate should not exceed the long-term average growth rate for the market in which the asset is used.

Value in use – asset in its current condition

The costs and benefits of future expenditure that is intended to improve or enhance the assets should not be included in the cash flow forecasts, since the future cash flows are estimated for assets in their current condition.

Cash outflows for servicing the asset, to maintain its current capability on the other hand are taken into account in the estimates

11.4.4 Identifying cash-generating units

Identifying the cash-generating unit ("CGU") is the first step in carrying out the impairment review. An impairment test should be done at the lowest level of independent cash inflows.

AASB 136.66

Once the cash-generating units have been identified, these are to be consistently applied from year to year, unless a change is justified.

The recoverable amount should be calculated for the CGU to which the asset belongs only where the recoverable amount for the individual asset cannot be identified.

An impairment review of a CGU should cover all of its tangible assets and intangible assets. The carrying value of each CGU containing the assets and goodwill being reviewed should be considered with the higher of its value in use and fair value less costs of disposal (i.e. the recoverable amount).

A cash generating unit is not a separate asset for reporting purposes. A cash-generating unit is used solely for the determination of impairment losses.

Example 11.3: Should an impaired asset be tested as part of a CGU?

A roof of the hospital wing is part of a specialised hospital building. The roof has been damaged but it still operates as normal and there is no intention to scrap or sell the roof. The roof's recoverable amount cannot be determined, because it does not generate cash flows independently of the hospital building. The scrap value of the roof would be below its carrying amount. If the recoverable amount of the CGU to which the roof belongs to is above the CGU's carrying amount – no impairment would be recognised with respect to the damaged roof.

11.4.5 Allocating assets and liabilities to CGUs

The carrying amount of a CGU is established by allocating assets and liabilities to individual CGUs. The carrying amount of a CGU consists of:

- assets that are directly and exclusively attributable to the CGU
- An allocation of assets that are indirectly attributable on a reasonable and consistent basis

The assets attributed to CGUs should be consistent with the cash flows that are identified for calculating the recoverable amount. Cash flows prepared for fair value less costs of disposal are prepared on a different basis from those for value in use.

Allocating working capital

Value in use cash flows should exclude working capital cash flows, whereas they will be used in fair value less costs of disposal cash flows. Only movements in working capital can be incorporated as part of the value in use model since this is required to operate the relevant non-current assets and generate the cash flows from those assets.

Allocating financing activities

The cash outflows associated with financing the CGU's operations are excluded from value in use calculations. Carrying amount of the CGU should also exclude liabilities that relate to financing the CGU's operations.

Allocating tax

The cash flows in a value in use calculation should be prepared on a pre-tax basis. Tax assets and liabilities (including deferred tax) should not be included as part of the CGU's carrying value.

11.4.6 Measuring a recoverable amount

The below table sets out the measurement of the recoverable amount under the value in use and the fair value less costs of disposal method

	Fair value less costs of disposal	Value in use
Whose perspective is considered	Future cash flows based on market participant's perspective (see Chapter 10 of this policy document)	Health entity's expectation of future cash flows
What discount rate should be used	An appropriate post-tax discount rate is used	An appropriate pre-tax discount rate is used
What should be the starting point for cash flows	Health entities own budgets and forecasts can be used as a starting point when applying a present value technique, adjusting for market conditions	Health entities own budgets and forecasts can be used. Differences between the market participant's perspective and the Health entity's perspective should be justified
Should deferred and current income taxes be included in the carrying value?	Deferred and current income taxes should be included in the carrying value. Tax losses are excluded	Deferred and current income taxes should be excluded from carrying value. Tax losses are excluded
Should enhancements be included in cash flows?	Yes – only if a market participant would reasonably expect such enhancements to take place	No – can only be included if they are incurred
Should the effects of restructuring which has not yet been recognised be included?	Yes – only if a market participant would reasonably expect such restructuring to take place	No – unless a related provision has been recognised in accordance with Chapter 15 of this policy document

11.4.7 Recording an impairment loss

AASB 136.60

An impairment loss is recognised immediately in the profit or loss, unless the asset is carried at a revalued amount. When an asset is measured at a revalued amount, the impairment loss is to be treated in the same way as a revaluation decrement by way of an offset against the asset revaluation surplus to the extent available – refer to Chapter 5 of the policy document for further guidance with respect to recording the revaluation decrement.

An impairment loss on a revalued asset must be offset against a revaluation surplus for the same class of asset.

Following the recognition of an impairment loss, the depreciation/amortisation charge for the asset is to be adjusted in future periods to allocate the asset's revised carrying amount, less its residual value (if any), on a systematic basis over its remaining useful life.

Cash generating unit – allocating an impairment loss

While the impairment loss is determined for a cash-generating unit, the loss is allocated against individual assets. The impairment loss is allocated on a pro-rata basis against the carrying amounts of each asset in the unit.

These reductions are treated and recognised as an impairment loss on individual assets.

In allocating an impairment loss of a cash-generating unit across all assets in the unit, the Health entity must not reduce the carrying amount of an asset below the highest of:

a) its fair value less costs to sell

b) its value in use

c) zero

If the entire amount of an impairment loss cannot be allocated to an individual asset due to the rules above, the remaining impairment loss that would otherwise have been allocated to the asset is allocated pro rata to the other assets of the cash-generating unit.

Allocation of impairment losses based on depreciated replacement cost

For public sector agencies such as NSW Health, it may not be easy to determine the fair value less costs of disposal for some individual assets (such as specialised buildings or infrastructure assets) when allocating an impairment loss. In order to allocate the impairment loss as appropriate, the Health entities may consider using a depreciated replacement cost approach to determine a proxy for fair value less costs of disposal (refer to Chapter 5 of this policy document). Although the depreciated replacement cost is not used when determining the recoverable amount, it would be acceptable to use this measure when allocating an impairment loss.

11.4.8 Reversals of impairment losses

The Health entity should assess at each reporting date, where there is any indication that an impairment loss for an asset either no longer exists or has decreased. If there is any such indication then the Health entity should estimate the recoverable amount – this applies to both individual assets and CGUs.

Health entities should consider whether there have been favourable events or changes in circumstances since the impairment loss was recognised, that would indicate that the impairment loss no longer exists or might have decreased. A reversal of the impairment loss should recognise an increase in the estimated service potential of an asset, either from use or sale, since the last impairment test. These changes are required to be identified by the Health entities. These changes may arise from:

- Change in the basis for recoverable amount (ie whether it is based on fair value less costs of disposal or value in use)
- If recoverable amount was based on value in use, a change in amount or timing of estimated future cash flows or in the discount rate
- If recoverable amount was based on fair value less costs of disposal. A change in the estimate of the fair value less costs of disposal

The reversal of an impairment loss for a revalued asset should be recognised in profit or loss to the extent that the original impairment loss (adjusted for subsequent depreciation) was recognised in profit or loss. Any remaining balance of the reversal should be recognised in other comprehensive income. The increased carrying amount of the asset cannot exceed the original carrying amount of the asset had no impairment been recorded and as adjusted for the depreciation that would have applied.

With respect to allocating the reversal of an impairment loss to assets of a CGU – the asset's carrying amount should not be increased above the lower of:

- Its recoverable amount and
- The carrying amount that would have been determined if no impairment loss had been recognised previously, adjusted for subsequent depreciation or amortisation

Any surplus reversal which remains should be allocated to the CGU's remaining assets on a pro rata basis.

Example 11.4: Reversal of impairment loss on revalued asset

At 30 June 20X1, imaging equipment was purchased for $100,000. Its expected useful economic life is 20 years. Three years later, it was revalued to $136,000.

At 30 June 20X6, the asset was reviewed for impairment and written down to its recoverable amount at $65,000. As of 30 June 20X6, the asset revaluation reserve for that class of assets is at $53,000.

The following table shows the movements in the asset's book value as actually recognised in the financial statements.

	Revalued carrying amount
	$'000
30 June 20X1	*100*
Depreciation (3 years) (100,000/20 years x 3 years)	*(15)*
Revaluation	*51*
30 June 20X4	*136*
Depreciation (2 years) (136,000/17 x 2 years)	*(16)*
30 June 20X6	*120*
Impairment loss	*(55)*
30 June 20X6 (after impairment loss)	*65*

For not-for-profit entities, the impairment loss of $55,000 at 30 June 20X6 shall be recognised in other comprehensive income to the extent of any credit balance existing in any revaluation surplus in respect of that same class of asset. Hence despite the surplus reserve for the particular asset is only $51,000, but since the whole class of assets have a reserve of $53,000, the excess surplus could be used to offset the impairment loss and any remaining loss to be recognised in the income statement as follows:

	Revalued carrying amount
	$'000
Other comprehensive income	*53*
Income statement	*2*
Impairment loss	***55***

The impairment loss is charged to other comprehensive income to the extent of the revaluation surplus held in other comprehensive income that relates to the class of asset. As there was a $53,000 credit balance in 30 June 20X4 for that class of assets, entities are allowed to use the whole surplus for that particular class of assets which are allowed under the accounting standard, specific for not-for-profit entities. Should the impairment loss is higher than the surplus reserve; remaining loss will be recognised in the income statement.

At 30 June 20X8, economic conditions have improved and the asset's recoverable amount is estimated to be $90,000.

If no impairment loss had been recognised, the carrying value at 30 June 20X8 would have been $104,000 ($120,000 as at 30 June 20X6, less two years of depreciation of $16,000) which is greater than the recoverable amount of $90,000. Therefore the whole of the increase in the carrying value can be treated as a reversal of the previous impairment loss. If the carrying value had been increased to higher than $104,000, the excess would have been treated as a revaluation and not a reversal of impairment (refer to Chapter 5 of this policy document).

The impairment loss should be reversed as follows:

	Carrying value
	$'000
30 June 20X6	*65*
Depreciation ($65,000/15 X 2 years)	*(9)*
30 June 20X8	*56*
Reversal of impairment loss	*34*
30 June 20X8 after reversal	*90*

The reversal of the impairment loss of $34,000 is recognised as follows:

	Revalued carrying amount
	$'000
Other comprehensive income	*32*
Income statement	*2*
Reversal of impairment loss	***34***

12 Leases

12.1 Scope

12.1.1 Applicability

This Policy applies to the accounting treatment for leases, including recognition of assets and determination of their carrying amounts.

12.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- AASB 16 Leases
- NSW Treasury policy – Guidance for AASB 16 Leases
- TC18-05 AASB 16 Leases transition election
- TC20-02 AASB 16 Leases Subsequent Measurement of Right of Use Assets
- Treasury Policy and Guidelines TPG23-04 Mandates of Options and Major Policy Decisions under Australian Accounting Standards

12.2 Overview and purpose

The purpose of this document is to provide Health entities with illustrative guidance on bringing all lease assets and liabilities onto the balance sheet as required under the new accounting standards AASB 16 Leases for general purpose financial reporting. The only exceptions are short-term and low-value leases.

The accounting treatment for leases must meet the guidelines as described in NSW Treasury accounting policy ("Guidance for AASB 16 Leases") which is based on Australian equivalents to International Financial Reporting Standards (AIFRS).

12.3 Policy statement

A lease is defined as a contract, or part of a contract, that conveys the right to use an asset (the underlying asset) for a period of time in exchange for consideration.

This policy requires the Health entity to adopt the new accounting standard under AASB 16 leases which is effective for NSW public sector agencies from 1 July 2019. This policy requires recognition of all leases on the balance sheet with some exceptions. The accounting by lessors under the new standard is substantially unchanged and lessors will continue to classify all leases using existing principles in distinguishing between operating and finance leases.

12.4 Application Guidance

12.4.1 Recognition exemption by lessee

The following is exempted from the recognition and measurement requirements of this policy:

AASB 16.5-8, B3-B8

- **Leases for which the underlying asset is of low value**

Lessees are not required to recognise assets or liabilities for leases of low value assets, such as tablets and personal computers, telephones and office items. NSW Treasury has specified that individual assets that are valued at less than $10,000 (when new) will qualify for exemption under this policy.

- **Short-term leases**

AASB 16.5-8

Lessees may elect not to recognise assets and liabilities for leases with a lease term of 12 months or less. In such cases, a lessee recognises the lease payments in profit or loss on a straight-line basis over the lease term. This exemption is required to be applied by class of underlying assets.

In order to apply this exemption, the Health entity need to determine the lease term. Determination of a short-term lease is consistent with the definition of a lease term (ie the option to extend should be taken into account if an entity is reasonably certain to exercise an option to extend or not terminate a lease. Any lease that contains a purchase option is not a short-term lease.

Example 12.1: Extension option

Health entity leases a non-specialised building from a real estate company which provides the right of use of the asset for five years with an option to extend it for another five years. The option to extend is at market conditions and there are no specific economic incentives for the Health entity to exercise the option at the commencement of the contract.

How should the above be accounted for?

The lease period at the commencement of the contract is five years.

Example 12.2: Extension option where there is significant leasehold improvement

Further to example 12.1 above, the Health entity undertook a significant investment for a leasehold improvement prior to the commencement of the lease. The economic life of the leasehold improvement is estimated at ten years.

How should the above be accounted for?

Health entity should consider if the leasehold improvement has a significant economic value at the end of the initial five year lease period. If the improvement result in the underlying asset having greater utility to the lessee than alternative assets that could be leased for a similar amount, it can be concluded that the Health entity has a significant economic incentive to exercise the option to extend the lease for another five years.

This might also apply for example if the Health entity would have to invest a significant amount in leasehold improvements if they were to move premises at the end of the initial 5 year term rather than stay in the existing premises and continue to use the leasehold improvements they already have.

12.4.2 Peppercorn lease

AASB 2019-8, Aus25.2, Aus35.1

Peppercorn lease refers to those leases with rental payments that are significantly below-market terms, for example, with a notional rent of $1 per annum. For those leases, *AASB 2019-8 Amendments to Australian Accounting Standards – Class of Right-of Use Assets arising under Concessionary Leases* provide an option for a Whole of Government and General Government Sector to measure right-of-use assets arising under concessionary leases (peppercorn leases) at cost or at fair value in subsequent measurements. NSW Treasury has mandated, as part of *TPG23-03 Mandates of Options and Major Policy Decisions under Australian Accounting Standards* for agencies to apply the cost model to all right-of-use assets, including right-of-use assets arising from concessionary leases (peppercorn leases).

In other words, Health entity should measure the right-of-use assets at initial recognition and subsequently at the present value of the payments required, which may be an insignificant amount. However, Health entity needs to disclose additional qualitative and quantitative information about those leases including, but not limited to:

- the entity's dependence on leases that have significantly below-market terms and conditions principally to enable the entity to further its objectives; and
- the nature and terms of the leases, including:
  - i) the lease payments;
  - ii) the lease term;
  - iii) a description of the underlying assets; and
  - iv) restrictions on the use of the underlying assets specific to the entity.

12.4.3 Identifying a lease

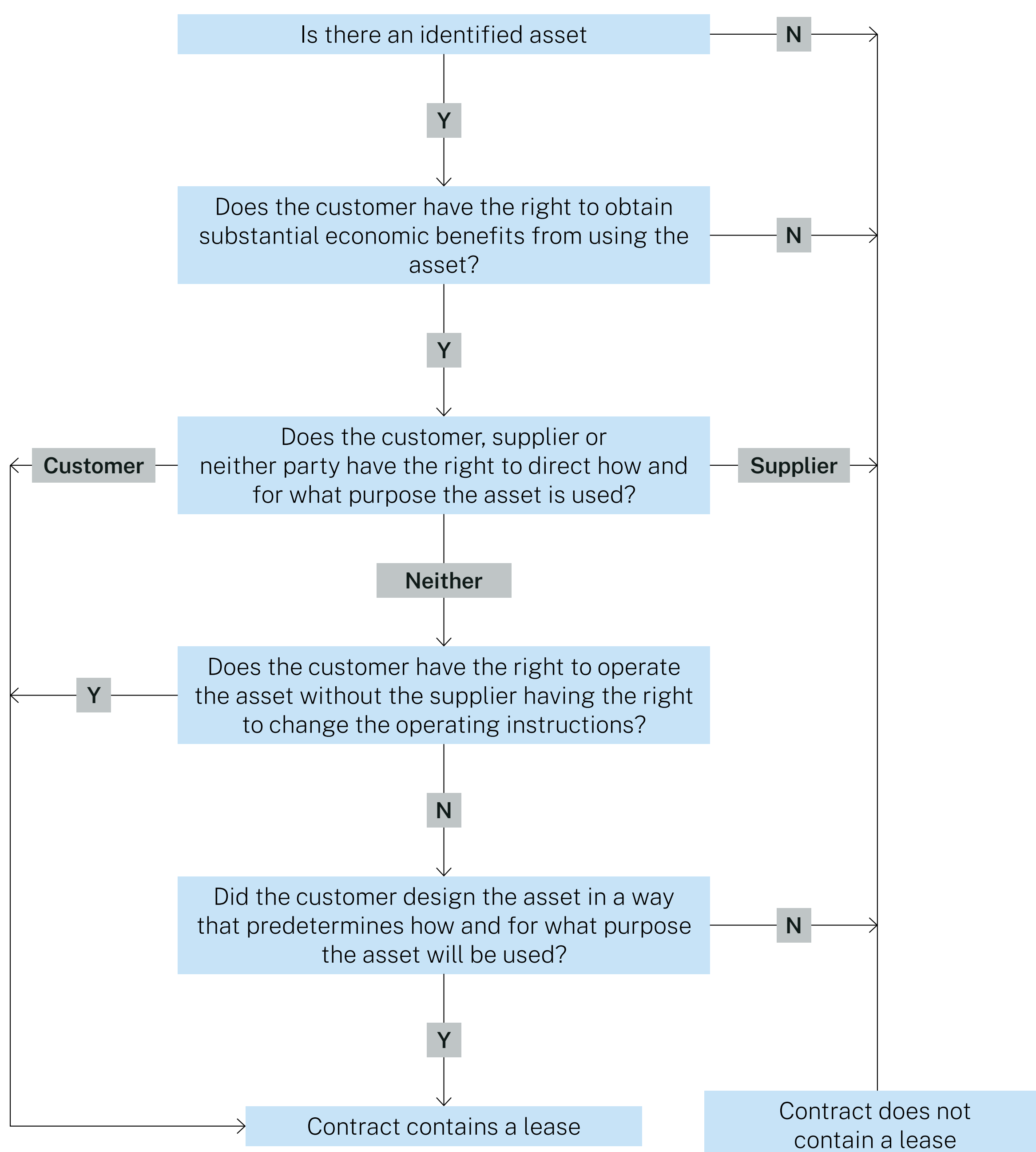
At inception of a contract, the Health entity should assess whether the contract is or contains a lease. A contract is a lease if the contract conveys the right to control the use of an identified an asset for a period of time in exchange for a consideration.

For the Health entity to assess whether a contract conveys the right to control the use of an identified asset, the Health entity should assess, in relation to the term of use whether all the following conditions can be met:

- an asset can be identified either explicitly or implicitly
- the customer has right to obtain substantially all of the economic benefits from use of the identified asset and
- the customer has the right to direct the use of the identified asset

If the customer has the right to control the use of an identified asset for only a portion of the term of the contract, the contract contains a lease for that portion of the term.

The flow chart below summaries the analysis to be made to evaluate whether a contract contains a lease:



- **Identified asset**

An asset is typically identified by being explicitly specified in a contract. However, an asset can also be identified by being implicitly specified at the time that the asset is made available for use by the customer (e.g. a specific equipment being included in a consumable purchase contract).

- **Substantive substitution rights**

If the supplier has substantive rights to substitute the asset then the customer has no right to direct the use of an identified asset and therefore there is no lease. This is the case where the supplier has the practical ability to substitute the underlying asset and would benefit economically from doing so.

- **Right to obtain economic benefits**

To control the use of an identified asset, a customer is required to have the right to obtain substantially all of the economic benefits from use of the asset throughout the period of use. Economic benefits from use of an asset include its primary output and by-products and other economic benefits from using the asset that could be realised from a commercial transaction with a third party.

- **Right to direct the use of the identified asset**

This right arises when either:

- the customer has the right to direct how and for what purpose the asset is used throughout the period of use or
- relevant decisions about how and for what purpose the asset is used are predetermined in the contract and either
  - the customer has the right to operate the asset (or to direct others to operate the asset in a manner it determines) throughout the period of use, without the supplier having the right to change those operating instructions; or
  - the customer designed the asset (or specific aspects of the asset) in a way that predetermines how and for what purpose the asset will be used throughout the period of use

A customer has the right to direct how and for what purpose the asset is used if, within the scope of its right of use defined in the contract, it can change how and for what purpose the asset is used throughout the period of use. In making this assessment, the Health entity should consider the decision making rights that are most relevant to changing how and for what purpose the asset is used throughout the period of use. The decision making rights are relevant when they affect the economic benefits to be derived from use.

Examples of decision making rights include:

- rights to change the type of output that is produced by the asset (example to decide upon the mix of products sold from the retail space of a hospital)
- rights to change when the output is produced (for example, to decide when the new operating theatre will be used)
- rights to change where the output is produced (for example, to decide upon the destination for a patient carpark or to decide where an item of medical equipment is used) and
- rights to change whether the output is produced, and the quantity of that output (for example, to decide whether to service additional hospital beds in a particular hospital wing, and how many extra hospital beds are required to service the additional patients)

Examples of decision making rights that do not grant the right to change how and for what purpose the asset is used include rights that are limited to operating or maintaining the asset since they are often dependent on the decision about how and for what purpose the asset is used.

Example 12.3: Lease vs service

The Health entity had entered into a fixed three year contract with a private landlord for two parking spots in the ground floor of a building. The contract specified the location of each spot to be used by Health entity, but it also grant the landlord right to change the location of the spots allocated to the Health entity at any time. There are many parking spots in the ground floor that are available and would meet the specification for the space in the contract.

How should the above be accounted for?

The contract does not contain a lease because there is no identified asset. The contract is for 2 parking spots, and these can be changed at the discretion of the landlord. The landlord has the substantive right to substitute the space which the Health entity used because:

a) *the supplier has the practical ability to change the space used at any time without the Health entity's approval*

b) *the Supplier would benefit economically from substituting the space.*

Example 12.4: Consumable contracts

Entity A (supplier) is a medical device company that provides Health entity with a standard medical device, and consumables that are needed in conjunction with the operation of that device. There are other suppliers on the market offering the consumables required for use with the machine.

Entity A enters into a supplying arrangement with Health entity with key features as follows:

- *Health entity is required to purchase at least 3,000 consumables per annum from entity A for a period of 36 months after contract inception. The purchase price is fixed in the contract*
- *Based on past experience, Health entity expects to consume 5,000 disposables per annum.*
- *Entity A also grants Health entity the right to use the medical device for 36 months at no cost. Title to the equipment remains with entity A, and the device will be returned at the end of the contract period.*
- *Entity A has no right to take the machine back during the contract period.*

Does the contract contain a lease component?

The contract contains a lease of the medical device for the reasons below:

- *Is there an identified asset? Yes, the medical device is explicitly specified in the contract and the supplier does not have the right to substitute it. The medical device is an identified asset.*
- *Does Health entity have the right to obtain substantially all of the economic benefits from the use of the medical device? Yes, Health entity has the exclusive use of the medical device throughout the period of use, because it physically control the use of the device and has the right to obtain substantially all of the economic benefits from the use of the device.*
- *Has the customer the right to direct the use of the power plant? Decisions about how and for what purpose the power plant is used are made by the customer. Health entity therefore, has the right to direct the use of the device.*

As such, the purchase of 3,000 consumables per annum is directly linked to the lease of the medical device. The contract contains lease (right of use of the medical device) and non-lease (purchase of consumables) components that should be accounted for separately. See further guidance regarding allocation between lease and non-lease components in 12.4.4.

12.4.4 Separating lease and non-lease components

AASB 16.12, B32-B33

Under the new leases standard, lessee accounting for separating lease and non-lease components in one contract will change because leases will have to be recognised on the balance sheet.

Both lessees and lessors are required to separate lease components from non-lease components in their contract if both of the following criteria are met:

a) the lessee can benefit from use of the underlying asset either on its own or together with other resources that are readily available to the lessee. Readily available resources are goods or services that are sold or leased separately (by the lessor or other suppliers) or resources that the lessee has already obtained (from the lessor or from other transactions or events) and

b) b) the underlying asset is neither highly dependent on, nor highly interrelated with, the other underlying assets in the contract.

Each lease component within a contract shall be accounted for as a lease separately from non-lease components in accordance with TC18-05 AASB 16 Leases transition election.

After the identification of lease and non-lease components, payments should be allocated as follows:

- Lessors should apply the guidance as set out in Chapter 16 of this policy document when allocating the transaction price to separate components. Allocation is based on relative standalone selling prices (SSP).
- Lessees should separate lease components from non-lease components. Activities that do not transfer a good or service to the lessee are not non-lease components in a contract. Allocation of payments should be similar to lessors as described above.

Example 12.5: Separating lease components

The Health entity enters into a 10-year contract for the right to use a magnetic resonance imaging (MRI) device and maintenance services. The Health entity makes all of the decisions about the use of the MRI device. The Health entity concluded that the contract contains a lease.

How should the above be accounted for?

The agreement consists of the lease of the MRI device and maintenance services. The observable standalone prices can be determined based on the amounts for similar lease contracts and maintenance contracts entered into separately. If no observable inputs are available, the Health entity has to estimate the standalone price of both components.

12.4.5 Lease term

AASB 16.18-21,B34-B41

In determining the lease term and assessing the length of the non-cancellable period of a lease, the Health entity shall apply the definition of a contract and determine the period for which the contract is enforceable.

The lease term is defined as the non-cancellable period of a lease, together with both

- periods covered by an option to extend the lease if the lessee is reasonably certain to exercise that option; and
- periods covered by an option to terminate the lease if the lessee is reasonably certain not to exercise that option.

When the lessee and the lessor each have the right to terminate the lease without permission from the other party with no more than an insignificant penalty, the enforceable period of the lease ends at the earliest point in time at which both parties can leave the contract and its contractual obligations. The enforceability of a lease contract does not require assessment of what is reasonably certain.

Example 12.6: Identify the lease term

The Health entity enters into a lease of small office space. The lease continues in perpetuity, but both the lessor and the lessee have termination options. The termination options are exercisable at any time, with a three-month notice period. The entity exercising the termination option will bear no more than an insignificant penalty.

How should the above be accounted for?

In the agreement, both the lessee and the lessor have a termination right, with a three-month notice period, and the entity exercising it will bear no more than an insignificant penalty. Hence, the lease term is only three months, and so the lease qualifies as a short-term lease at the commencement date.

Rent free period and fit-out period

The lease term begins at the commencement date and includes any rent-free periods provided to the lessee. Commencement date is defined as the date on which the lessor makes an underlying asset available for use by a lessee. This date could be different to lease inception or payment start date.

The lessee should initially recognise and measures right-of-use assets and lease liabilities on commencement date.

Lessor may also provide some fit-out period for some fit-out work before lease commencement date. If the lessee has exclusive right to use the lease assets during the fit-out period, the lease commencement date would be the beginning of the fit-out period as it is the date on which the lessor makes the underlying asset available for use by the Health entity even if there is no lease payment made during that period. It is in substance a free rent period. Fit-out period include as a lease term as the commencement date, when the lessee has the exclusive right to use the asset for fit out purpose.

Option for early termination of the lease

If only the lessee has the right to terminate a lease, that right is considered to be an early termination option and may affect the determination of lease term based on Health entity's assessment at the lease commencement date.

Three scenarios are possible for termination options:

- *Only the lessee has a termination option: the period covered by the termination option is included in the lease term only if the lessee is reasonably certain not to exercise the termination option.*
- *Only the lessor has a termination option: the period covered by the termination option is part of the non-cancellable lease period.*
- *Each party has the right to terminate the lease: the period covered by the termination options is not part of the lease term, provided that each party has the right to terminate the lease without permission from the other party and with no more than an insignificant penalty.*

Option to extend the lease

At commencement date, the Health entity should assess whether the lessee is reasonably certain to exercise an option to extend the lease or to purchase the underlying asset, or not to exercise an option to terminate the lease. Factors to consider include the following:

- *Contractual terms and conditions for the optional periods compared with market rates such as:*
  - *The amount of payments for the lease in any optional period*
  - *The amount of any variable payments for the lease or other contingent payments, such as payments resulting from termination penalties and residual value guarantees; and*
  - *The terms and conditions of any options that are exercisable after initial optional periods*

- *Significant leasehold improvements undertaken (or expected to be undertaken) over the term of the contract that are expected to have significant economic benefit for the lessee when the option to extend or terminate the lease, or to purchase the underlying asset, becomes exercisable*
- *Costs relating to the termination of the lease, such as negotiation costs, relocation costs, costs of identifying another underlying asset suitable for the lessee's needs, costs of integrating a new asset into the lessee's operations or termination penalties and similar costs, including costs associated with returning the underlying asset in a contractually specified condition or to a contractually specified location*
- *The importance of that underlying asset to the lessee's operations, considering for example, whether the underlying asset is a specialised asset, the location of the underlying asset and the availability of suitable alternatives*
- *Conditions associated with exercising the option and the likelihood those conditions will exist*

If a material event or significant changes in circumstances that is within the control of the lessee occurs and affects the reasonably certain criteria, the Health entity is required to make another reassessment of the lease term.

12.4.6 Accounting for leases by lessee

The distinction between operating and finance leases is no longer relevant for lessees' accounting, and a new lease asset (which represents the right to use of the leased item during the lease term) and lease liability (which represent the obligation to pay rentals) are recognised for all leases except for certain exceptions as explained in Chapter 12.4.1.

Initial recognition

Lessees should initially recognise a right-of-use asset and lease liability based on the discounted payments required under the lease, taking into account the lease term as defined in Chapter 12.4.5 of this policy document.

Initial measurement for right-of-use asset

AASB 16.24

For right-of-use asset the following components should be initially recognised at cost:

- the amount of the initial measurement of the lease liability
- any lease payments made at or before the commencement date, less any lease incentives received
- any initial direct costs incurred by the lessee (Incremental costs of obtaining a lease that would not have been incurred if the lease had not been obtained) and
- an estimate of costs to be incurred by the lessee in dismantling and removing the underlying asset, restoring the site on which it is located or restoring the underlying asset to the condition required by the terms and conditions of the lease.

Lease incentives are often given to lessees to incentivise them to sign the lease and may include:

- contributions to relocation or start-up costs
- the assumption of liabilities, such as the rentals under an old lease which would otherwise become vacant property
- the gift of an asset, such as the lessor bearing directly all of the costs of fitting out the property to the lessee's specifications and
- a rent-free period or period where a reduced rent is payable

- **Initial measurement of lease liability**

AASB 16.22-28

At commencement date, a lessee should measure the lease liability at the present value of the lease payments that are not paid at that date. The lease payments should be discounted using the interest rate implicit in the lease. When the implicit rate cannot be determined in the lease, the lessee's incremental borrowing rate will be used. And since health entities does not borrow from the market and don't have incremental borrowing rate, Treasury publishes rates bi-annually that should be used as incremental borrowing rates. These are published on NSW Treasury website: https://www.treasury.nsw.gov.au/information-public-entities/accounting-policy/changes-australian-accounting-standards/incremental

The lease liability comprises the following payments:

- fixed payments less any lease incentives receivable
- variable lease payments that depend on an index or rate, initially measured using the index (for example benchmark interest rates, or consumer price index) or rate (for example market rent review for property lease) as at the commencement date
- amounts expected to be payable by the lessee under residual value guarantees
- the exercise price of a purchase option if the lessee is reasonably certain to exercise that option
- payments of penalties for terminating the lease, if the lease term reflects the lessee exercising an option to terminate the lease

Subsequent measurement of the right-of-use asset

After the commencement date, a lessee should measure the right-of-use asset at cost, subject to impairment. The lessee should apply the depreciation requirements as set out in Chapter 5 of this policy document. If the lease transfers ownership of the underlying asset to the lessee by the end of the lease term, or if the cost of the right-of-use asset reflects that the lessee will exercise a purchase option, the lessee should depreciate the right-of-use asset from the commencement date to the end of the useful life of the underlying asset.

Impairment of the right-of-use asset

The lessee should assess at the end of each reporting period whether there is any indicators of impairment. If any such indications exist, the entity shall estimate the recoverable amount of the ROUA. If, and only if, the recoverable amount of a ROUA is less than its carrying amount, the carrying amount of the asset shall be reduced to its recoverable amount. That reduction is an impairment loss, which should be recognised in the statement of comprehensive income. After the recognition of an impairment loss, the depreciation charge for the asset shall be adjusted in future periods based on the asset's revised carrying amount and its remaining useful life.

Under *TC20-02 AASB 16 Leases Subsequent Measurement of Right of Use Assets*, NSW Treasury acknowledges that obtaining external valuations for the fair value of ROUAs recognised under AASB 16 by lessees will increase costs for agencies and in some circumstances may provide little benefit. Therefore, NSW Treasury has provided practical expedients for when assets require an external valuation for the purpose of an impairment assessment, allowing in some instances for an asset's depreciated historical cost to be a proxy for its fair value. This is consistent with the current accounting policy under PPE that allows non-specialised assets with short useful lives to be measured at depreciated historical cost, as an estimate for fair value.

The practical expedients only apply where there is an impairment indicator. Under the practical expedient, except for motor vehicle leases, external valuations are required where there is an impairment indicator and the lease term is greater than 5 years and the lease term is closely aligned to the ROUA's useful life.

In determining the fair value of property leases less than five years or greater than five years, but substantially shorter than the asset's useful life, market indices published by Property NSW (for general office accommodation) or market data obtained from other sources (for non office accommodation leases) should be used.

For unspecialised motor vehicle leases, the depreciated historical cost of the corresponding ROUA is deemed as an acceptable surrogate for fair value. However, health entities are still required to consider indications of impairment, especially if the lease is longer than a standard 3-5 years' term. This should include consideration of accelerated depreciation where appropriate.

For all other leases, it is expected in most instances that assets will depreciate over their useful life with minimal instances of an upward or downward movements in fair values. Thus, for leases of five years or less, lessees are not required to undertake a valuation either by management or externally to determine the fair value. For leases greater than five years, but where the lease term is substantially shorter than the asset's useful life, management is required to perform a formal management assessment of the fair value when an impairment assessment is needed.

- **Subsequent measurement of the lease liability**

After the commencement date, a lessee should measure the lease liability by:

- increasing the carrying amount to reflect interest on the lease liability
- reducing the carrying amount to reflect the lease payments made and
- remeasuring the carrying amount to reflect any reassessment of lease modifications or to reflect revised in-substance fixed lease payments

Further, the lessee should recognise the costs within the profit or loss with respect to interest expense on the lease liability and variable lease payments not included in the measurement of the lease liability, in the period in which the event or condition that triggers those payments occurs.

Example 12.7: Emergency vehicle lease

Health entity leases a new emergency vehicle for a period of four years starting on 1 Jan 20X0. The vehicle's market value is $35,845. The lease requires payments of $668 on a monthly basis for the duration of the lease term (ie $8,016 per annum). The annual lease component of the lease payment is $6,672 and the service component is $1,344. The expected residual value of the emergency vehicle at the end of the lease term is $14,168. There is no option to renew the lease or purchase the emergency vehicle and there is no residual value guarantee. The rate implicit in the lease is 5%. The net present value of the lease payments using a 5% discount rate is $24,192.

How should the above be accounted for?

The impact of the lease on the balance sheet and the profit and loss is as follows:

	Jan 20X0	Dec 20X0	Dec 20X1	Dec 20X2	Dec 20X3	Total
Right-of-use asset	24,192	18,144	12,096	6,048	-	
Lease liability	(24,192)	(18,580)	(12,697)	(6,498)	-	
Operating expense – service	-	1,344	1,344	1,344	1,344	**5,376**
Depreciation	-	6,048	6,048	6,048	6,048	**24,192**
Interest expense	-	1,083	797	496	120	**2,496**
Net income	-	**(8,475)**	**(8,189)**	**(7,888)**	**(7,512)**	**(32,064)**

Reassessment of lease liabilities

AASB 16.39-43

The Health entity (as a lessee) shall remeasure the lease liability by discounting the revised lease payments using a revised discount rate, if either:

- *there is a change in the lease term resulting from a reassessment over the extension option or early termination option, upon the occurrence of either a significant event or a significant change in circumstances which is a) within the control of Health entity and b) affects the reasonable certain assessment; or*
- *there is a change in the assessment of an option to purchase the underlying asset, assessed considering the events and circumstances above but in the context of a purchase option.*

The Health entity shall remeasure the lease liability by discounting the revised lease payments using unchanged discount rates, if either:

- *there is a change in the amounts expected to be payable under a residual value guarantee. A lessee shall determine the revised lease payments to reflect the change in amounts expected to be payable under the residual value guarantee.*
- *there is a change in future lease payments resulting from a change in an index or a rate used to determine those payments, for example a change to reflect changes in market rental rates following a market rent review. The lessee shall remeasure the lease liability to reflect those revised lease payments only when there is a change in the cash flows (i.e. when the adjustment to the lease payments takes effect). A lessee shall determine the revised lease payments for the remainder of the lease term based on the revised contractual payments.*

AASB 16.44-46

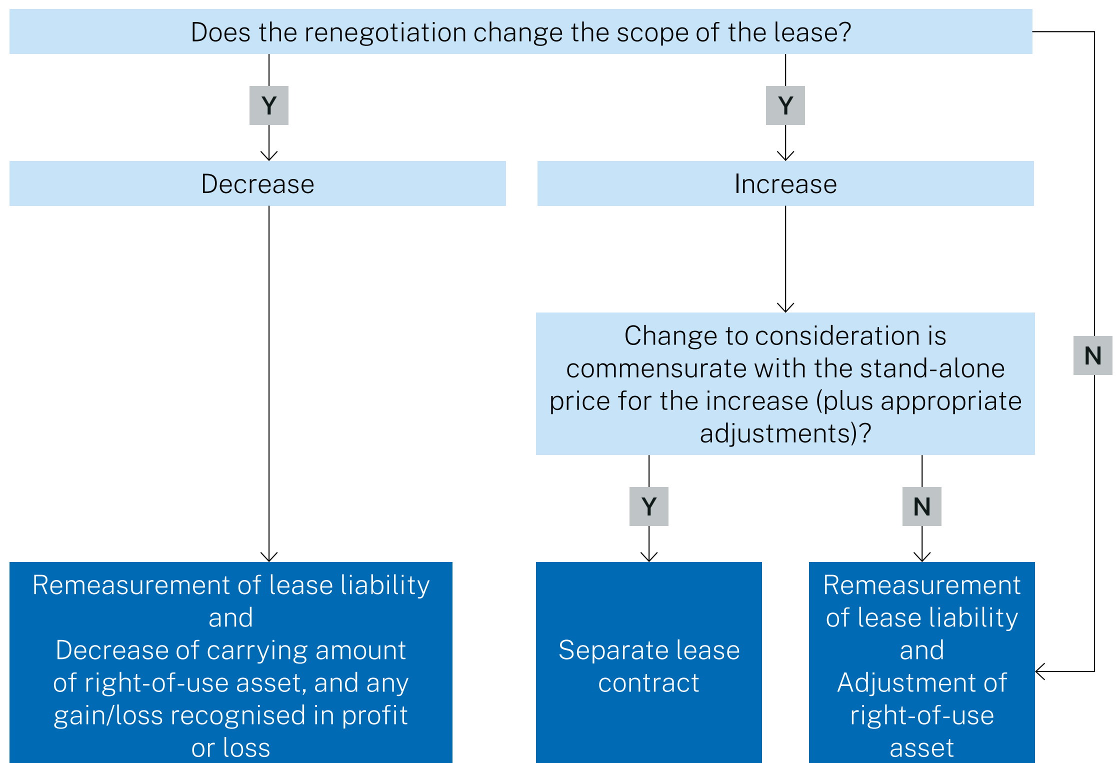
Modification

A lease modification is a change in the scope of a lease, or the consideration for a lease, that was not part of the original terms and conditions of the lease. Any change that is triggered by a clause that is already part of the original lease contract, including changes due to a market rent review clause or the exercise of an extension option, is a re-assessment (see above) and not a modification.

The accounting for a lease modification depends on how the contract is modified. There are four different scenarios:

Changes in lease scope	Accounting treatment
Decrease in lease scope	• Remeasures the lease liability using a revised discount rate • Reduces the carrying amount of the ROU assets in proportion to reduction in scope • Difference is gain or loss in income statements
Increase – both the ROU assets and the consideration increased commensurately	• As a separate lease • Recognise new ROU assets and lease liability based on revised discount rate
Other increase	• Remeasures the lease liability using a revised discount rate • Corresponding adjustments to the ROU assets
No change in lease scope. Change in lease consideration, outside the original terms of the contract.	• Remeasures the lease liability using a revised discount rate • Corresponding adjustments to the ROU assets

The flow chart below summaries the different scenarios:



12.4.7 Accounting for leases by lessor

Classification of lease

AASB 16.62-64

The lessor can classify each of its leases as either an operating lease or finance lease. A lease would be classified as a finance lease if it transfers substantially all the risks and rewards incidental to ownership of an underlying asset. A lease is classified as an operating lease if it does not transfer all of the risks and rewards incidental to ownership of an underlying asset.

The following examples, individually or in combination would normally lead to a lease being classified as a finance lease:

- The lease transfers ownership of the asset to the lessee by the end of the lease term
- The lessee has the option to purchase the asset at a price that is expected to be sufficiently lower than the fair value at the date the option becomes exercisable for it to be reasonably certain, at the inception of the lease, that the option will be exercised
- The lease term is for the major part of the economic life of the asset, even if title is not transferred
- At the inception of the lease, the present value of the minimum lease payments amounts to at least substantially all of the fair value of the leased asset
- The leased assets are of a specialised nature such that only the lessee can use them without major modifications being made
- If the lessee can cancel the lease, the lessor's losses associated with the cancellation are borne by the lessee
- Gains or losses from the fluctuation in the residual's fair value fall to the lessee
- The lessee has the ability to continue the lease for a secondary period at a rent that is substantially lower than market rent

Accounting for operating lease

The lessor should recognise lease payments from operating leases as income on either a straight-line basis or another systematic basis. The lessor should apply another systematic basis if that basis is more representative of the pattern in which benefit from the use of the underlying asset is diminished.

Any costs, including depreciation incurred in earning the lease income should be recognised as an expense.

Initial direct costs incurred in negotiating and arranging for the operating lease should be added to the carrying amount of the underlying asset. These costs should be recognised as an expense over the lease term on the same basis as the lease income.

Refer to Chapter 5 of this policy document with respect to the depreciation policy to be applied for depreciable underlying assets which is subject to operating leases.

With respect to impairment of the underlying asset, refer to Chapter 11 of this policy document.

Accounting for finance lease

The amount due from the lessee under a finance lease should be recognised in the lessor's balance sheet as a receivable at an amount equal to the lessor's net investment in the lease on commencement of the lease.

The net investment in a lease is a gross investment in the lease, discounted at the interest rate implicit in the lease. The gross investment in the lease is equal to the minimum lease payments, plus any guaranteed residual accruing to the lessor.

At any time during the lease term, the net investment represents the following:

- remaining minimum lease payments (the amounts that the lessor is guaranteed to receive under the lease from either the lessee or third parties)
- less part of the minimum lease payments that is attributable to future gross earnings (i.e. interest)
- initial direct costs which reduces the amount of income recognised over the lease term

AASB 16.70

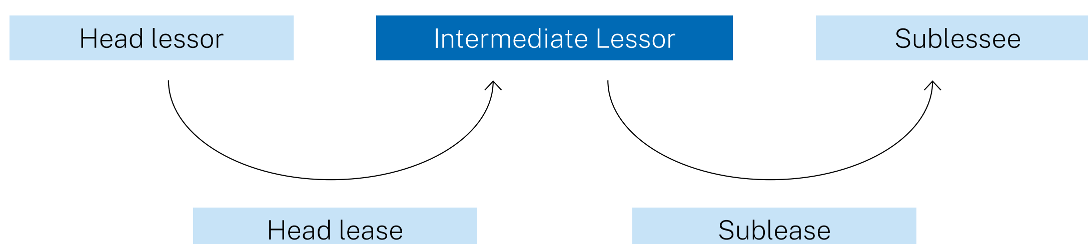
The minimum lease payments comprises of the following payments for the right to use the underlying asset during the lease term:

- fixed payments less any lease incentive payable
- variable lease payments that depend on an index (for example consumer price index) or a rate, initially measured using the index or rate as at the commencement date
- any residual value guarantees provided to the lessor by the lessee, a party related to the lessee or a third party unrelated to the lessor that is financially capable of discharging the obligations under the guarantee
- the exercise price of a purchase option of the lessee is reasonably certain to exercise that option
- payments of penalties for terminating the lease, if the lease term reflects the lessee exercising an option to terminate the lease

The lessor should recognise the finance income over the lease term, based on a pattern reflecting a constant periodic rate of return on the lessor's net investment in the lease.

Refer to Chapter 8 of this policy document with respect to the accounting treatment for assets under a finance lease which is classed as held for sale.

12.4.8 Sublease



AASB 16.B58

In classifying a sublease, an intermediate lessor (the head lessee) shall classify the sublease as a finance lease or an operating lease as follows:

- if the head lease is a short-term lease, the sublease shall be classified as an operating lease.
- otherwise, the sublease shall be classified by reference to the right-of-use asset arising from the head lease, rather than by reference to the underlying asset (for example, the item of property, plant or equipment that is the subject of the lease).

The lessor shall use the interest rate implicit in the sublease to measure the net investment in the sublease. If the interest rate implicit in the sublease cannot be readily determined, an intermediate lessor may use the discount rate used for the head lease (adjusted for any initial direct costs associated with the sublease) to measure the net investment in the sublease.

Initial direct costs are included in the initial measurement of the net investment in the sublease and reduce the amount of income recognised over the sublease term.

12.4.9 Portfolio application

As a practical expedient, an entity may apply a portfolio of leases with similar characteristics if the entity reasonably expects that the effects on the financial statements of applying this Standard to the portfolio would not differ materially from applying this Standard to the individual leases within that portfolio. If accounting for a portfolio, an entity shall use estimates and assumptions that reflect the size and composition of the portfolio.

A lessee may apply a single discount rate to a portfolio of leases with reasonably similar characteristics (such as leases with a similar remaining lease term for a similar class of underlying asset in a similar economic environment).

13 Inventories

13.1 Scope

13.1.1 Applicability

This Policy applies to the accounting treatment of inventories, including carrying value of inventories and transactions involving inventory such as inventories on consignment and sale of inventories.

13.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- AASB 102 Inventories

13.2 Overview and purpose

The purpose of this document is to provide Health entities with illustrative guidance on the accounting and reporting requirements for inventories.

The accounting treatment for inventories must meet the guidelines as set out in AASB 102 Inventories. The policy provides guidance on the amount of cost to be recognised as an asset and carried forward until the related revenue is recognised.

13.3 Application Guide

13.3.1 Recognition

The Health entities should initially recognise inventory when it has control of the future economic benefits, and the cost of inventory can be measured reliably. Inventories comprises those assets that are:

- held for sale in the ordinary course of business
- In the form of materials or supplies to be consumed by the hospitals in the rendering of services

Spare parts and servicing equipment which do not meet the definition of property, plant and equipment as per Chapter 5 of this policy document are treated as inventory.

13.3.2 Measurement

AASB 102.9

Initial measurement of inventories should be at cost. After initial recognition, inventories should be measured at the lower of cost and net realisable value. Cost is defined as all costs of purchase, and other costs incurred in bringing the inventories to their present location and condition.

The costs of purchase comprises:

- purchase price
- import duties and other taxes (other taxes which is not recoverable from the tax authorities)
- transport and handling costs
- any other directly attributable costs, less trade discounts, rebates and similar items

The costs of inventories should exclude the following:

- storage costs
- administrative overheads that do not contribute to bringing inventories to their present location and condition
- selling costs

Costs should be assigned to particular items of inventory using the weighted average cost method. This method assigns weighted average costs arrived at by means of a continuous calculation, a periodic calculation or a moving periodic calculation.

The Health entities should segregate between those inventory items held for resale and those held for consumption by the hospitals.

Items in stores held for the hospitals own consumption should be valued at weighted average cost and should be expensed as consumed, rather than when purchased.

Inventories acquired at no cost

In respect of not-for-profit entities, where inventories are acquired at no cost, or for nominal consideration, the cost shall be the current replacement cost as at the date of acquisition.

Net realisable value and Loss of service potential

AASB 102.28-33

Inventories are measured at the lower of cost and net realisable value.

For not-for-profit entity, inventories held for distribution are measured at cost, adjusted when applicable for any loss of service potential.

Inventories held for distribution are defined in the context of not-for-profit entities, as assets:

a) held for distribution at no or nominal consideration in the ordinary course of operations;

b) in the process of production for distribution at no or nominal consideration in the ordinary course of operations; or

c) in the form of materials or supplies to be consumed in the production process or in the rendering of services at no or nominal consideration.

If there is no reasonable expectation of sufficient future revenue or service potential to cover the cost incurred, the irrecoverable cost should be charged as an expense. As such, any weighted average cost assigned to the inventory should be adjusted for any loss of service potential to reflect the net realisable value.

A not-for-profit entity may hold inventories whose future economic benefits or service potential are not directly related to their ability to generate net cash inflows. These types of inventories may arise when an entity has determined to distribute certain goods at no charge or for a nominal amount. In these cases, the future economic benefits or service potential of the inventory for financial reporting purposes is reflected by the amount the entity would need to pay to acquire the economic benefits or service potential if this was necessary to achieve the objectives of the entity. Where the economic benefits or service potential cannot be acquired in the market, an estimate of replacement cost will need to be made. The replacement cost that an entity would be prepared to incur in respect of an item of inventory would reflect any obsolescence or any other impairment.

Other situations in which the net realisable value is likely to be less than cost includes:

- physical deterioration of inventories
- obsolescence of products
- an error in purchasing of the products

The write-down of inventory to net realisable value is normally made on an individual item basis. However it may be more appropriate to make the write-down by reference to groups of similar or related items. This would be the case where the products have a similar purpose or end use, are used in the same hospital and cannot practicably be distinguished from other items in that product line. However it is not appropriate to group items for this purpose by reference to general categories or classifications of inventory, such as finished goods.

After a write-down has been made, net realisable value should be re-assessed in each subsequent period. If the circumstances that caused the write-down cease to exist, such that all or part of the write-down is no longer needed, it should be reversed to that extent. The new carrying value of the inventory therefore would be at the lower of cost and the revised net realisable value.

Write down of inventories to net realisable value result in the amount of the inventory being written down to be recognised as an expense in the period in which the write-down occurs. If and when a write-down is reversed, the reversal should be recognised in the profit or loss when the reversal occurs, and the amount of inventories is increased accordingly. The reversal is offset against the amount of inventories recognised as an expense in the period.

13.3.3 De-recognition of inventory and recognition as an expense

The inventory should be de-recognised as and when they are used (such as prescription drugs) or sold. At that point they are recognised as an expense in the profit or loss, in the same period in which the service has been rendered (for example, a surgeon operating on a patient would consume the surgical supplies initially capitalised as inventory is then recognised as an expense when the service of performing the surgery has been rendered).

Similarly, the Health entity should also de-recognise inventory when it has no future economic value (for example obsolete inventory).

13.3.4 Inventory on consignment

There may be some instances where there is an arrangement between the Health entity and the manufacturer with respect to consignment inventory. Arrangement where goods are supplied from a manufacturer to the hospital on consignment basis is generally not recorded as inventory in the books of the Health entity. This is due to the title of the consignment inventory generally being retained by the manufacturer until these inventory are consumed by the hospital in the rendering of a service. The date which the title transfers is generally sometime after the inventory item is physically transferred to the hospital.

Example 13.1 Manufacturer supplies goods to the hospital on a consignment basis

A hospital purchases medical supplies from a medical manufacturer on extended credit and stores the medical supplies in their hospital unit until these medical supplies are used on a patient. Legal title of the goods passes to the hospital when the hospital receives them. The hospital does not have to pay for the goods until it receives payment from the health fund and/or the patient. If the medical supplies are not used within the three month period, the hospital can either return them to the medical manufacturer or pay for them and keep them.

How should the above be accounted for

Until it is known that the goods have been used, the goods should be treated as the manufacturer's inventory (that is, consignment inventory) and is excluded from the Health entity's balance sheet.

14 Financial instruments

14.1 Scope

14.1.1 Applicability

This Policy provides guidance on the accounting treatment of financial assets and financial liabilities, equity instruments.

14.1.2 Relevant Guidance

This policy should be read in conjunction with the following guidance:

- *AASB 9 Financial Instruments*
- *AASB 132 Financial Instruments: Presentation*

14.2 Overview and purpose

The purpose of this document is to provide Health entities with illustrative guidance on the following transactions and events:

- General requirements for the classification, recognition and measurement of financial instruments
- Guidance on the impairment of financial assets

14.3 Policy Statement

AASB 132.11

A financial instrument is any contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

A financial asset is any asset that is:

- Cash
- An equity instrument in another entity, e.g. shares
- A contractual right to receive cash or another financial asset from another entity, e.g. accounts receivable
- A contractual right to exchange financial assets or financial liabilities with another entity under conditions that are potentially favourable to the Health entity.
- Please refer to AASB 132 paragraph 11 for a definition of financial assets that involve equity instruments.

A financial liability is any liability that is:

- A contractual obligation for the Health entity to deliver cash or another financial asset to another entity, e.g. accounts payable.
- A contractual obligation for the Health entity to exchange financial assets or financial liabilities with another entity under conditions that are potentially unfavourable to Health entity.
- Please refer to AASB 132 paragraph 11 for a definition of financial liabilities that involve equity instruments.

An equity instrument is any contract that evidences a residual interest in the assets of the Health entity after deducting all of its liabilities.

Financial instruments are recognised in the Health entity's statement of financial position when the Health entity becomes a party to the contractual provisions of the instrument. Subsequent to initial recognition, financial instruments are classified into categories outlined in AASB 9, or derecognised depending on certain criteria.

14.4 Application Guidance

14.4.1 Classification and measurement

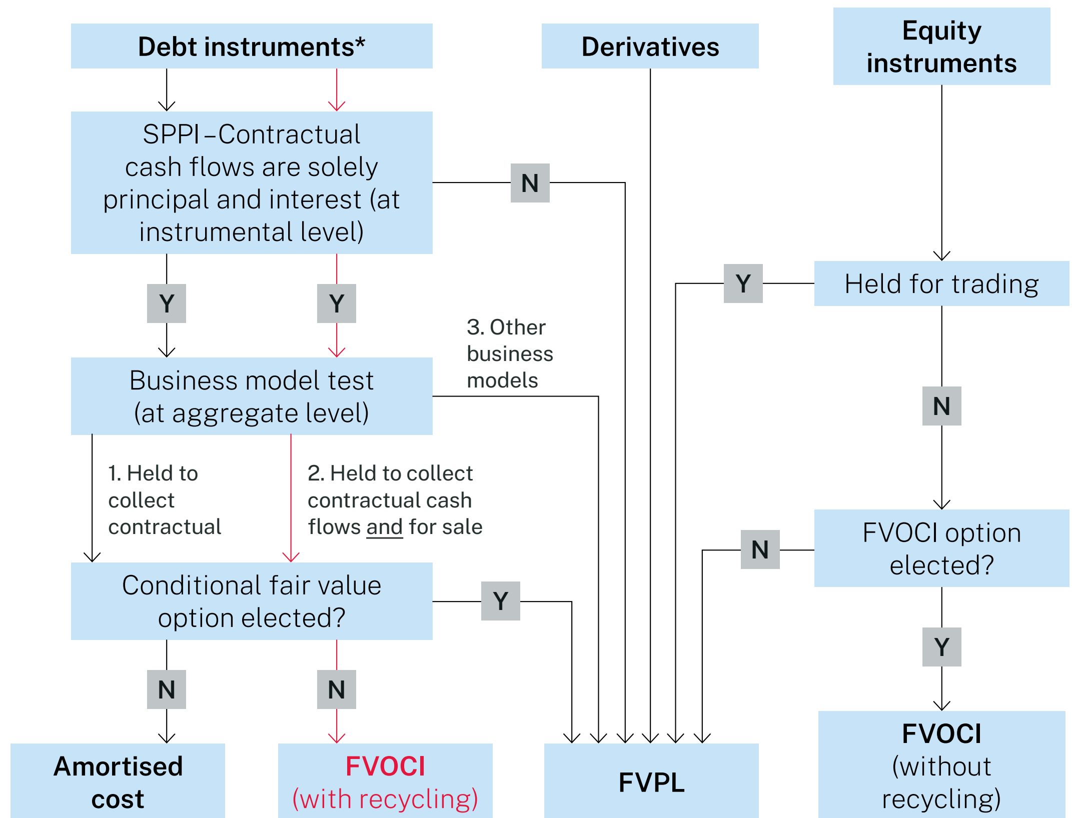
AASB 9 introduces a new model that distinguishes between financial assets based on an entity's business model and on the contractual cash flow characteristics of the financial asset. There are no changes to the classification of financial liabilities, except for the recognition of changes in own credit risk in other comprehensive income for liabilities designated at fair value through profit or loss. Below is a summary of the classification and measurement of financial assets and liabilities.

Classification	Measurement	Example
Financial assets – debt instruments		
Amortised cost	Amortised cost using the effective interest method.	Trade and other receivables – held to collect contractual cash flows.
Fair value through OCI (FVOCI)	Measured at fair value, with changes in other comprehensive income (OCI), except for the impairment charges, interest revenue and foreign exchange difference. Note: Please consult the NSW Ministry of Health before classifying any instrument as FVOCI.	Loans, receivables and debt securities – held to both collect contractual cash flows and to sell these assets.
Fair value through P&L (FVPL)	Measured at fair value, with changes taken through profit and loss (PL).	Loans, receivables and debt securities – held to sell (for example, for factoring purposes). Treasury mandates. TCorpIM Funds (other than the TCorpIM Funds cash facility which is included as 'cash assets') to be classified at FVPL. The TCorpIM Funds that are normally part of the 'financial assets at fair value' category include the strategic cash facility, medium-term growth and long-term growth facilities.
Financial assets – equity instruments		
FVPL	Measured at fair value, with changes in PL.	Equity investments held for investment or trading purposes.
FVOCI	Optional irrevocable designation – Measured at fair value, with changes in OCI except for dividend income. No recycling from OCI to PL, nor any impairment requirements.	Equity investments that are not held for trading purpose, and designated as FVOCI by the Health entity.
Financial liabilities		
Amortised cost	Amortised cost using the effective interest method.	Bank borrowings; Intercompany borrowings.
FVPL	Measured at fair value, and for FV changes related to changes in own credit risk, it is presented in OCI without recycling to PL.	Not applicable to MOH.

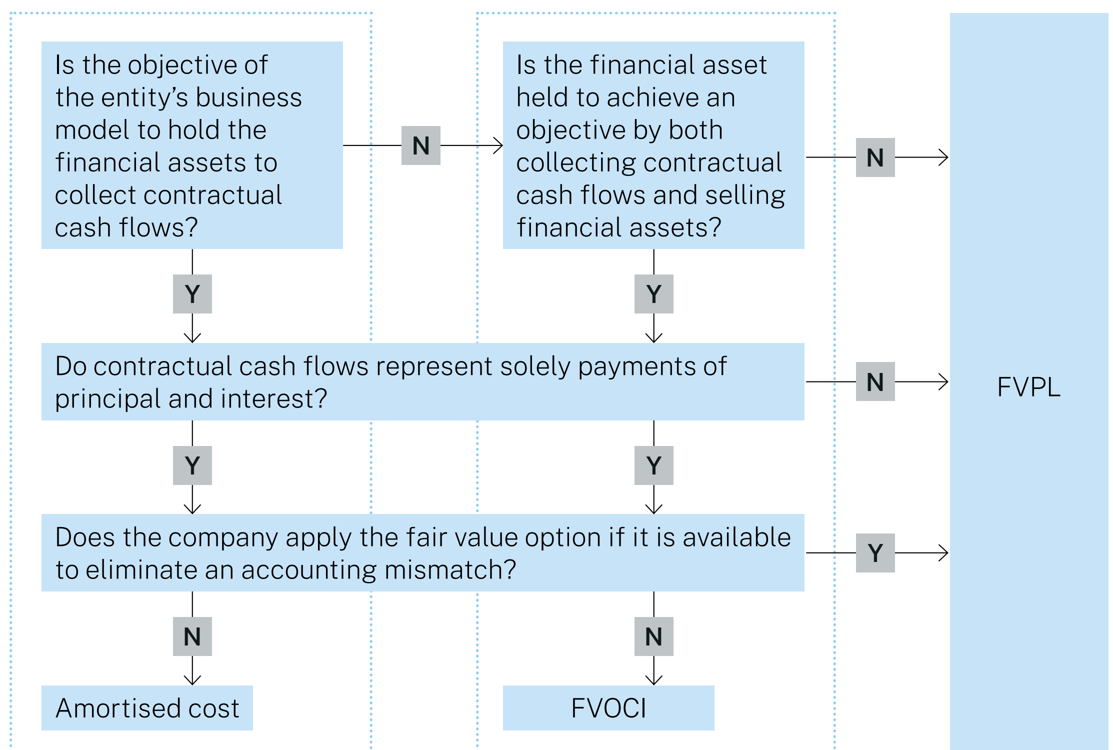
14.4.2 Financial assets – debt instruments

Below is a diagram that summarises the three main categories of financial assets and how to determine their classification:

*Financial assets with embedded derivatives are considered in their entirety when determining whether their cash flows are solely payment of principal and interest



For classification of investments in debt instruments, it is driven by the Health entity's business model for managing financial assets and their contractual cash flow characteristic.



Amortised cost

AASB 9.4.1.2

A financial asset is measured at amortised cost if both of the following criteria are met:

- The asset is held to collect its contractual cash flows; and
- The asset's contractual cash flows represent 'solely payments of principal and interest' ('SPPI').

Financial assets included within this category are initially recognised at fair value and adjusted for transaction costs, except for the trade receivables that do not contain a significant financing component. Such trade receivables are initially measured at the transaction price in accordance with AASB 15 (see chapter 16).

Financial assets included within this category are subsequently measured at amortised cost, with interest income calculated using the effective interest rate method. Any gain or loss arising from derecognition is recognised directly in profit or loss.

FVOCI

AASB 9.4.1.2A

A financial asset is measured at fair value through OCI if both of the following criteria are met:

- The objective of the business model is achieved both by collecting contractual cash flows and selling financial assets; and
- The asset's contractual cash flows represent SPPI.

Financial assets included within the FVOCI category are initially recognised at fair value and adjusted for transaction costs that are directly attributable to the acquisition of the financial asset.

Financial assets included within the FVOCI category are subsequently measured at fair value with movements in the carrying amount taken through OCI, except for the recognition of impairment gains or losses, interest income and foreign exchange gains and losses which are recognised in profit or loss.

When the financial asset is derecognised, the cumulative gain or loss previously recognised in OCI is reclassified from equity to profit or loss.

Note: Please consult the NSW Ministry of Health before classifying any instrument as FVOCI.

FVPL

AASB 9.4.1.4

Debt instruments that do not meet the criteria for amortised cost or FVOCI are measured at FVPL.

FVPL assets should be measured at fair value with all changes taken through profit or loss. Transaction costs of financial assets carried at FVPL are expensed in profit or loss.

14.4.3 Financial assets – equity instruments

AASB 9.5.7.5

Investments in equity instruments are always measured at fair value. Equity instruments that are held for trading are required to be classified at FVPL. For all other equities, Health entity has the ability to make an irrevocable election on initial recognition, on an instrument-by-instrument basis, to present changes in fair value in OCI (FVOCI) rather than profit or loss (FVPL).

If this election of FVOCI is made, only qualifying dividends are recognized in profit or loss, all other changes in fair value are recognised in OCI and never reclassified to profit or loss, even if the investment is impaired, sold or otherwise derecognised.

Changes in the fair value of financial assets at FVPL are recognised in profit or loss. Impairment losses (and reversal of impairment losses) on equity investments measured at FVOCI are not reported separately from other changes in fair value.

AASB 9 no longer permits an entity to measure unquoted equity investments at cost where the fair value cannot be determined reliably. But it indicates that, in limited circumstances, cost might be used as an estimate of fair value. For example, this might include where more recent available information is insufficient to determine fair value; or where there is a wide range of possible fair value measurements and cost represents the best estimate of fair value within that range.

14.4.4 Financial liabilities

AASB 9.4.2.1 and 4.2.2

All financial liabilities are classified at amortised cost except where a financial liability meets the requirements to be classified as FVPL. In some circumstances, an entity may have the option to irrevocable designate a financial liability at fair value through profit or loss. For such liabilities (FVPL), changes in fair value related to changes in own credit risk, are presented separately in OCI. Amounts in OCI relating to own credit are not recycled to profit or loss even when the liability is derecognised and the amounts are realised.

Borrowings are typical financial liabilities measured at amortised cost. Borrowings are initially recognised at fair value, net of transaction costs incurred. Borrowings are subsequently measured at amortised cost. Any difference between the proceeds (net of transaction costs) and the redemption amount is recognised in profit or loss over the period of the borrowings using the effective interest method.

Entities are still required to separate derivatives embedded in financial liabilities where they are not closely related to the host contract.

When a financial liability measured at amortised cost is modified without this resulting in derecognition, a gain or loss should be recognised in profit or loss. The gain or loss is calculated as the difference between the original contractual cash flows and the modified cash flows discounted at the original effective interest rate.

14.4.5 Impairment

Overview of expected credit loss model

AASB 9.5.5.1

AASB 9 establishes an expected credit loss (ECL) model for recognition and measurement of expected credit losses in loans and receivables that are measured at amortised costs or FVOCI. For example, the model should be applied to:

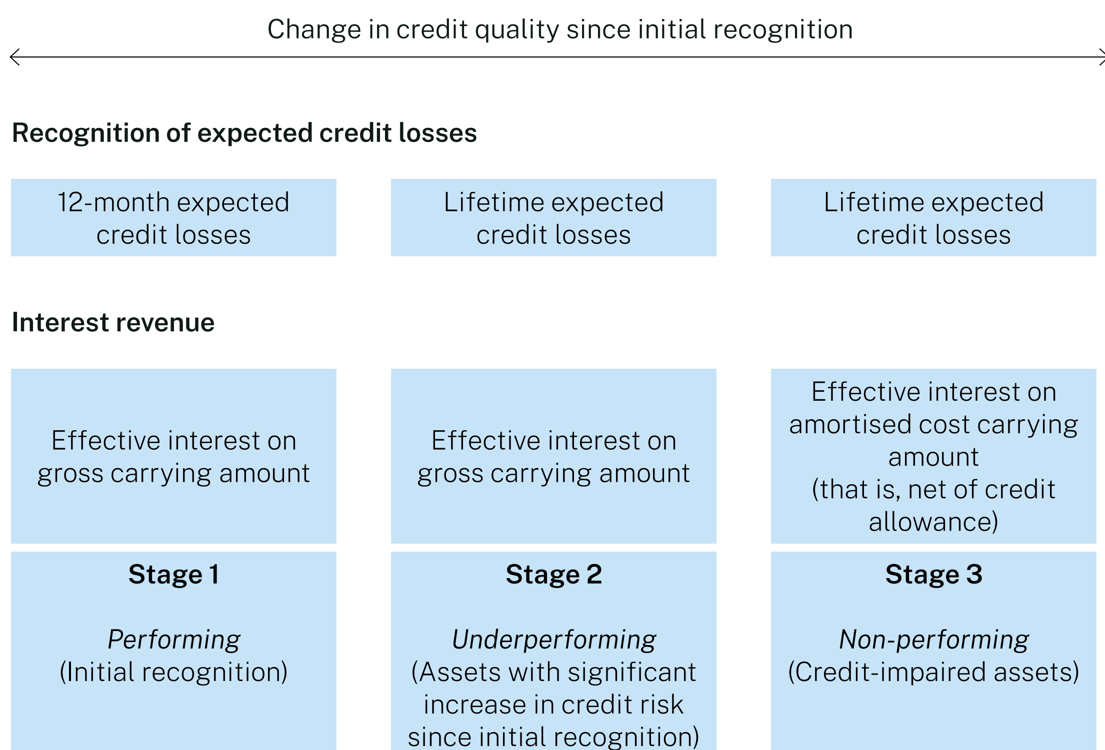
- trade receivables or contract assets within the scope of AASB 15
- intergroup receivables
- lease receivables
- debt investments carried at amortised cost
- debt investment carried at FVOCI

Expected losses are recognised and measured according to one of three approaches:

- a general approach (for assets not covered by other approaches)
- a simplified approach (for particular trade and lease receivables)
- the credit adjusted approach (for purchased or originated credit-impaired assets)

General approach

The general approach is typically a three-stage process in recognising a loss allowance. This covers financial instruments with varying degree of credit quality as set out below:



AASB 9.5.5.3

Under the general approach, Health entity recognises a loss allowance based on:

- 12-month ECL – if the credit risk of the financial instrument has not increased significantly since initial recognition; or
- lifetime ECL – if there has been a significant deterioration in credit quality since initial recognition.

	Stage 1	Stage 2	Stage 3
Credit risk	When there is no significant increase in credit risk since initial recognition	When there has been a significant increase in credit risk since initial recognition	When there is objective evidence of credit impairment of the financial asset
Loss Allowance	12 month expected credit losses	Lifetime expected credit losses	Lifetime expected credit losses
Effective interest rate applied to	Gross carrying amount	Gross carrying amount	Net carrying amount (Gross Carrying amount – Loss Allowance)

Example 14.1 – impairment for intercompany loan

Health entity is required to calculate expected credit losses on all financial assets, including intercompany loans within the scope of AASB 9. Below examples outline some key considerations for intercompany loans:

Example 1 – Intercompany loans repayable on demand, which may or may not be interest free.

For loans that are repayable on demand, expected credit losses are based on the assumption that repayment of the loan is demanded at the reporting date. If the borrower has sufficient accessible highly liquid assets in order to repay the loan if demanded at the reporting date, the expected credit loss is likely to be immaterial.

Example 2 – Intercompany loans with low credit risk

Health entity holding an intercompany loan that has low credit risk at the reporting date could choose to assume that there has not been a significant increase in credit risk since the loan was first recognised. This allows the Health entity to calculate a 12-month expected credit loss under stage 1 of the general model, which is a simpler calculation than calculating lifetime expected credit losses under stage 2 or 3.*

** note: the loans are considered to be low credit risk when they have a low risk of default and the borrower has a strong capacity to meet its contractual cash flow obligations in the near term*

Example 3 – Intercompany loans with no significant increase in credit risk (Stage 1 loans), or intercompany loans with a life of 12 months or less

If the lender has assessed that there has not been a significant increase in credit risk since the loan was initially recognised, the loan is in 'stage 1' of the impairment model and a 12-month expected credit loss should be calculated. Similarly, if the loan has a maturity of less than 12 months, lifetime and 12-month expected credit losses will be the same, so 12-month expected credit losses can be calculated.

Simplified approach – qualifying trade and lease receivables

AASB 9.5.5.15

AASB 9 establishes a simplified impairment approach for qualifying trade receivables, contract assets within the scope of AASB 15 and lease receivables (see table below).

For trade receivables or contract assets that do not contain a significant financing component, the loss allowance should be measured at initial recognition and throughout the life of the receivable at an amount equal to lifetime ECL.

For trade receivables or contract assets which contain a significant financing component in accordance with AASB 15 and lease receivables, an entity has an accounting policy choice: either it can apply the simplified approach (that is, to measure the loss allowance at an amount equal to lifetime ECL at initial recognition and throughout its life), or it can apply the general model.

Health entity can apply the simplified 'provision matrix' for calculating expected losses to estimate the lifetime ECL, which is based on Health entity's historical default rate over the expected life of the trade receivables and is adjusted for forward-looking estimates. The expected loss rates are based on the payment profiles of sales over a defined period that is representative of the characteristics of the credit for the trade receivables. The historical loss rates are adjusted to reflect current and forward-looking information on macroeconomic factors affecting the ability of the customers to settle the receivables. Impairment losses on trade receivables and contract assets are presented as net impairment losses within operating profit. Subsequent recoveries of amounts previously written off are credited against the same line item.

Example 14.2 – Example of a Provision Matrix Approach

	Current	1-30 days past due	31-60 days past due	61-90 days past due	Over 90 days past due
Default rate (A)	0.3%	1.6%	3.6%	6.6.%	10.6%
Gross carrying amount (B)	15,000	7,500	4,000	2,500	1,000
Lifetime expected credit loss (A x B)	45	120	144	165	106

Note: above figures are used for illustrative purpose only.
The simplified approach does not apply to intercompany loans.

14.4.6 Derivatives and Hedge accounting

A derivative is a financial instrument with the following three characteristics [AASB 9 Appendix A]:

- its value changes in a specified interest rate, financial instrument price, commodity price, foreign exchange rate, index of prices or rates, credit rating or credit index, or other variable, provided in the case of a non-financial variable that the variable is not specific to a party to the contract (sometimes called the 'underlying'),
- it requires no or comparatively little initial net investment, and
- it is to be settled at a future date.

Derivatives are carried as financial assets when the fair value is positive and as financial liabilities when the fair value is negative.

All derivatives are deemed to be held for trading and are therefore classified as FVPL, unless they are financial guarantee contracts or have been designated and are effective hedging instruments [AASB 9. Appendix A].

Fair value changes from derivatives are recognised in profit or loss unless hedge accounting is elected. Hedge accounting can be elected by designating the derivative as a hedging instrument in an eligible hedging relationship, where some or all gains or losses may be recognised in OCI.

Considering materiality, complexity of hedge accounting and onerous administrative requirements around hedge accounting documentation, NSW Health has opted not to elect for hedge accounting. This means any fair value movement in derivatives are recognised in the income statement rather than OCI.

NSW Health's derivatives are restricted to FX contracts. NSW Treasury has prepared the NSW Government Foreign Exchange (FX) Risk Policy to assist agencies to manage their FX risk arising from exposure to foreign currencies when Government Entities purchase, sell, or intend to purchase or sell goods and services either directly from/to overseas, or indirectly through domestic providers.

To comply with this policy, HealthShare NSW generally enters into FX forward contracts with NSW TCorp to manage foreign exchange risks associated with contracts with payment obligations due in foreign currencies in the future. HealthShare manages all FX contracts and therefore recognises derivative financial instruments in their financial statements. Health entities do not enter into the FX forward contracts, and are not exposed to any derivative accounting.

FX forward contract, for financial reporting, is a derivative financial instrument and is required to be measured at its fair value at inception and each reporting date. Its fair value movement is recognised immediately in the Statement of Comprehensive Income under *AASB 9 Financial Instruments*.

Example 14.3 – Accounting for FX Hedge contract as a derivative financial instrument

In FY 20x2, Health entity enters into a commitment for the supplier to provide aeromedical services in financial year 20x4. All amounts will be payable in USD currency. The commitment amount is USD $70,000.

To minimise the risk of fluctuations in USD/AUD currency, HealthShare NSW enters into a hedge contract with TCorp at contract signing date to buy USD currency at a forward rate of 0.721665. AUD amount payable in 20x4 is therefore $97,000.

Accounting entries as follows:

i) Entering into a commitment
There is no entry required by HealthShare or Health entity, as it is only a commitment to receive services in future.

ii) Entering into a FX forward contract
There is no entry required to record the forward contract at inception of the hedge because it is an at-market forward with a fair value of zero. No entries at HealthShare or Health entity.

iii) At 30 June 20x2 reporting period – fair value entries HealthShare's ledger

Dr Derivatives (B/S)	*1,000*	
Cr FV gains – derivatives (P&L)		*1,000*
(Mark to Market revaluation entry)		

Note: No entries are required in Health entity ledger for the derivative, as they are not a party to the hedge contract.

iv) At 30 June 20x3 reporting period – fair value entries (similar to (iii) above)

Dr Derivatives (B/S)	*500*	
Cr FV gains – derivatives (P&L)		*500*
(Mark to Market revaluation entry)		

v) In FY20X4 – Services are performed/Forward contract matures/Supplier is paid

Health Entities ledger

Dr Expenses (at spot rate) (70,000 /0.7143)	*98,000*	
Cr AP Control (at spot rate)		*98,000*

(When services are performed, expenses are recognised at prevailing Fx spot rate)

Dr FX gain/loss	*2,000*	
Cr AP Control (at spot rate of 0.7000)		*2,000*

(USD AP balance is revalued using the spot rate at month end – assuming payment is done in the following month)

HealthShare's ledger

Dr Derivatives (B/S)	*1,500*	
Cr FV gains – derivatives (P&L)		*1,500*

(Fair value entry on maturity of forward contract)

Dr Cash at bank – USD bank account (at spot rate of 0.7000)	*100,000*	
Cr Cash at bank – AUD bank account		*97,000*
Cr Derivatives (B/S)		*3,000*

(Exchange of currency with TCorp on maturity of forward contract)

*Dr Intra-health receivable**	*100,000*	
Cr Cash at bank – USD bank account		*100,000*

(Overseas supplier is paid)

Health Entities ledger

Dr AP Control	*100,000*	
*Cr Intrahealth payable**		*100,000*

** – for simplicity, intrahealth receivable and payable accounts have been used. Additional entries may be required around settlement of intrahealth balances and issuance of subsidies. This is not demonstrated here.*

15 Provisions, contingent liabilities and contingent assets

15.1 Scope

15.1.1 Applicability

This Policy applies to the accounting treatment for provisions, contingent liabilities and contingent assets.

15.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- AASB 137 Provisions, Contingent Liabilities and Contingent Assets.
- Treasury circular TPG23-21 – Determining the present value of a provision

15.2 Overview and purpose

The purpose of this document is to provide Health entities with illustrative guidance on the accounting treatment with respect to provisions, contingent liabilities and contingent assets as required under the accounting standard *AASB 137 Provisions, Contingent Liabilities and Contingent Assets* for general purpose financial reporting.

15.3 Policy Statement

A provision is defined as a liability of uncertain timing or amount. Provisions differ from other liabilities in the degree of certainty about the amount or the timing of payment.

Contingent is defined as liabilities and assets that are not recognised because their existence will be confirmed only by the occurrence or non-occurrence of one of more uncertain future events that are not wholly within the entity's control. The term "contingent liability" is also used for liabilities that do not meet the recognition criteria.

15.4 Application guidance

15.4.1 Recognition – provisions

AASB 137.14

Recognition of provision

Provisions should be recognised by the Health entity when the following criteria are met:

- the Health entity has a present obligation (legal or constructive) as a result of a past event
- it is probable that an outflow of resources embodying the economic benefits will be required to settle the obligation and
- a reliable estimate can be made of the amount of the obligation

The above criteria are further explored below.

Past event

A liability exists only when something has happened in the past to trigger a present obligation. The past event is known as an obligating event, which is an event that creates a legal or constructive obligation that results in an entity having no realistic alternative to settling that obligation.

No obligation arises from a past event if there is a realistic opportunity that the Health entity can avoid settlement. The Health entity has no realistic alternative to settling an obligation only where:

- the settlement of the obligation can be enforced by law
- the event, in the case of a constructive obligation, creates a valid expectation in others that the Health entity will discharge the obligation.

Constructive obligation

A constructive obligation arises where:

- by an established pattern of past practice, published policies or a sufficiently specific current statement, the entity has indicated to other parties that it will accept certain responsibilities and
- as a result, the entity has created a valid expectation on the part of those other parties that it will disclose those responsibilities.

An example of where a constructive obligation may arise is where a potentially obligating event has taken place, such as environmental damage arising from the construction of an infrastructure asset. The Health entity could create a constructive obligation by making a public statement that the damage will be rectified and there is no realistic alternative but to carry out the rectification work.

Probable outflow of economic benefits

No provision is necessary where the outflow is not probable, but a contingent liability exists and should be disclosed unless the possibility of an outflow is remote. Refer to Chapter 15.4.3 below.

Reliable estimate

Provisions should be based on circumstances at balance sheet date but adjusted to reflect the current best estimate. The current best estimate will be based on information available to the Health entity up to the date when the financial statements are authorised for issue.

Where it is not possible to make a reliable estimate of the obligation, the liability is disclosed as a contingent liability. Refer to Chapter 15.4.3 below.

Reimbursements

Where some or all of the expenditure required to settle a provision is expected to be reimbursed by another party, the reimbursement should be recognised only when it is virtually certain that reimbursement will be received if the Health entity settles the obligation. However, the Health entity typically remains liable for the entire obligation, and reimbursements are therefore presented separately as assets. The amount recognised should not exceed the amount of the related provision.

Within the statement of comprehensive income, the Health entity may present the expense relating to the provision net of the amount recognised for a reimbursement.

Example 15.1: Implications of post balance sheet events for the recognition of insurance recoveries

Legal action was undertaken against a public hospital for a misdiagnosis of a patient. The legal action is in progress at the year end and an outflow is probable. The Health entity is also negotiating a reimbursement with its insurer. The insurer had agreed that reimbursement would be made if the hospital lost the case, although the amount was uncertain until the settlement was agreed.

How should the above be accounted for?

An asset for the reimbursement should be recognised, because it is virtually certain at the balance sheet date that reimbursement will be received if the hospital settles the obligation. The post-year end settlement confirms the existence and amount of the liability and the related reimbursement asset. The reimbursement asset cannot exceed the liability. The provision for the obligation and the receivable for the expected recovery are presented gross on the balance sheet, but could be netted in the profit or loss.

15.4.2 Recognition – provision associated with a restructure

A restructuring provision is recognised only when an obligating event has arose. The obligation for restructuring is often constructive (refer to Chapter 15.4.1 above). A constructive obligation only arises only when both of the below conditions exist:

a) A detailed formal plan for the restructuring which identifies at least

- the unit or part of a unit concerned
- the principal locations affected
- the location function and approximate number of employees who will be compensated for terminating their services
- the expenditure that will be undertaken and
- when the plan will be implemented

b) A valid expectation, in those affected, that the entity will carry out the restructuring by starting to implement that plan or announcing its main features to those affected by it

A constructive obligation will arise from a public announcement only when it raises a valid expectation in employees, patients, suppliers, or others affected by it in a sufficiently specific manner that the Health entity has no alternative but to discharge its responsibilities.

Costs of restructuring

A restructuring provision should include only the direct expenditures arising from the restructuring which are those that are both:

- necessarily entailed by the restructuring and
- not associated with the ongoing activities of the entity

Retaining or relocating continuing staff or investment in new systems should not be included in a restructuring provision since these represent costs relating to the ongoing activities of the entity.

15.4.3 Measurement – provisions

Provisions are generally estimated using:

- the single most likely outcome; or
- weighted average of all of the possible outcomes (the 'expected value' method). This method can be applied to a large population of similar claims, as well as a single obligation with various possible outcomes.

Provisions are measured at the present value of the expected outflow where the effect of the time value of money is material. The discount rate should be a pre-tax rate that reflects the current market assessments of the time value of money and the risks specific to the liability. For the purpose of this policy the discount rate applied should be based on the market yield on Commonwealth government bonds as published by the Reserve Bank of Australia.

The unwinding of the discount associated with a provision over a period of time should be recognised within the profit or loss.

Re-assessment of provisions

Provisions should be re-assessed at the end of each reporting period and adjusted to reflect current best estimates. This re-assessment should include the estimated cash flows and the discount rate. A re-assessment should be undertaken at least once every reporting period. The discount rate should be a current rate at each reporting date.

15.4.4 Recognition – contingent liabilities

AASB 137.27-30

Contingent liabilities arise where there is a:

- possible obligation as a result of a past event that might, but will probably not, require an outflow of resources embodying economic benefits or
- present obligation as a result of a past event
- that probably requires an outflow of resources embodying economic benefits, but where the obligation cannot be measured reliably or
- that might, but will probably not, require an outflow of resources embodying economic benefits

Contingent liability should not be recognised, however it should be disclosed in the financial statements, unless the possibility of the outflow is remote.

Example 15.2: Uncertainty as to whether a present obligation exists

A public hospital has received a notice from the Medical Liability panel with respect to allegations of clinical negligence. The investigation will only consider whether the medical negligence was incurred by a medical practitioner. Management of the public hospital is unsure whether it has all the information about the entire history of the patients concerned, so neither management can assess whether the public hospital has a present obligation until the investigation is completed.

How should the above be accounted for?

The obligating event is for clinical negligence which has occurred in the past, not the outcome of the future investigation, and management cannot determine whether the obligating event has occurred until the investigation is complete. Management considers all the available evidence, including evidence obtained after the balance sheet date, in assessing whether or not a present obligation exists. Management concludes that the evidence available does not support a conclusion that a present obligation exists, so a provision is not recognised. However a contingent liability for potential penalties and fines that might be imposed if negligence has been proved, should be disclosed.

15.4.5 Recognition – contingent assets

AASB 137.31-35

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the entity.

Contingent assets will generally arise from unplanned or other unexpected events that give rise to a possibility of an inflow of resources embodying economic benefits to the entity.

Contingent assets (similar to contingent liabilities above) should be disclosed in the financial statements and recognised, only where the inflow of economic benefits is probable.

16 Revenue from contracts with customers and income of not-for-profit entities

16.1 Scope

16.1.1 Applicability

This Policy provides the accounting guidance for the treatment of revenue arising from the ordinary activities of the Health entity.

This policy provides the accounting guidance for the treatment of revenue arising from contracts with customers related to the ordinary activities of the Health entity. It also provides guidance for transactions where the consideration to acquire an asset is significantly less than its fair value, principally to enable the Health entity to further its objectives, i.e., a 'donation' transaction or the receipt of volunteer services.

16.1.2 Relevant Guidance

This Policy should be read in conjunction with the following guidance:

- *AASB 15 Revenue from contracts with customers*
- *AASB 1058 Income of Not-for profit entities*
- *AASB 2016-8 Amendments to Australian Accounting Standards – Accounting implementation guidance for Not-for-profit entities*
- NSW Government Treasury Guidance – *AASB 1058 Income of not-for-profit entities*
- NSW Government Treasury Guidance – *AASB 15 Revenue from Contracts with Customers*

16.2 Overview and purpose

The purpose of this document is to clarify the income recognition requirements that apply to Health entity. The Health entity will apply AASB 15 for income generating transactions that are contracts with customers, and AASB 1058 for other income generating transactions.

AASB 15 provides a single framework for revenue recognition using a five-step model as follows:

Step 1: Identify the contract(s) with the customer	Step 2: Identify the separate performance obligations in the contract(s)	Step 3: Determine the transaction price	Step 4: Allocate the transaction price to the performance obligations	Step 5: Recognise revenue when (or as) the entity satisfies the performance obligations

This model is designed to deal with customer contracts and evolving business models and introduces a new process for recognising revenue. The core principle is that an entity will recognise revenue at an amount that reflects the consideration entitled in exchange for transferring goods or services to a customer.

There is also additional disclosure needed under this policy. The objective of the disclosure requirements is for an entity to disclose sufficient information to enable users of financial statements to understand the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers.

16.3 Policy Statement

Revenues are inflows or other enhancements, or savings of outflows, which arise in the course of ordinary activities of the Health entity that result in an increase in equity, other than those relating to contributions from equity participants. Revenue is referred to by a variety of names including the sale of goods such as prosthesis and pharmacy products, patient and facility fees received for providing services and royalties.

For transactions where the consideration to acquire an asset is significantly less than its fair value principally to enable the entity to further its objectives, Health entity should recognise income for the excess amount in profit or loss immediately, or when the entity satisfies its obligation.

16.4 Identify relevant accounting standards

The Health entity should first determine whether a transaction (or a component of the transaction) is a contract with a customer under AASB 15. If a transaction is not a revenue contract with customers, it may apply the recognition and measurement of income arising from the transaction in accordance with AASB 1058.

To be in the scope of AASB 15, there should be:

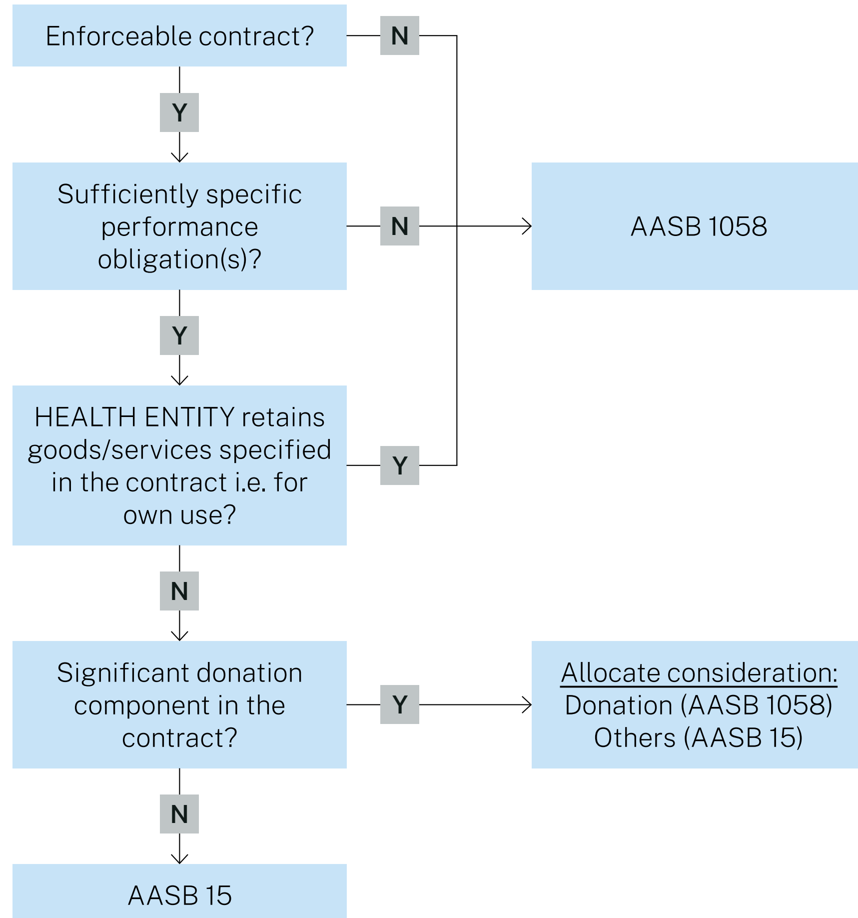
AASB 2016-8, Appendix F

- an 'enforceable contract' – i.e. the contract between two or more parties must create enforceable rights and obligations
- 'sufficiently specific performance obligations' – i.e. the Health entity's promise to transfer a good or service must be sufficiently specific
- 'underlying goods or services are not retained or controlled by the entity' – i.e. the goods or services will be transferred to the customer or to other parties on behalf of the customer and not retained by the entity for its own use.

If any of the above criteria are not met, then Health entity will apply AASB 1058 if it meets one of the scenario below:

- the contract contains a donation component – when the consideration to acquire an asset is significantly less than its fair value (i.e. significant donation component), and the intent is to primarily to enable the entity to further its objectives; or
- the entity receives a volunteer service

Below is the flow chart to identify which standard to apply:



16.5 Application guidance – AASB 15

16.5.1 Scope exemption

AASB 15.5

The Health entity should apply AASB 15 to all contracts with customers, except:

- lease contracts;
- insurance contracts;
- non-monetary exchanges between entities in the same line of business to facilitate sales to customers or potential customers; and
- financial instruments and other contractual rights or obligations within the scope of AASB 9 Financial Instruments, AASB 10 Consolidated Financial Statements, AASB 11 Joint Arrangements, AASB 127 Separate Financial Statements and *AASB 128 Investments in Associates and Joint Ventures*.

16.5.2 Portfolio approach

AASB 15.4

As a practical expedient, the Health entity may record the revenue from contract with customers by using a portfolio approach. The portfolio approach is permitted if the entity reasonably expects that the effect of applying the guidance to the portfolio would not differ materially from applying the guidance to each contract or performance obligation individually. When accounting for a portfolio, the Health entity shall use estimates and assumptions that reflect the size and composition of the portfolio. Determining when the use of a portfolio approach is appropriate will require judgment and a consideration of all of the facts and circumstances.

16.5.3 Step 1: Identify the contract with the customer

The first step is to determine if a contract exists and whether the contract meets all the criteria to be in the scope of AASB 15. This assessment is made on a contract-by-contract basis, although as a practical expedient an entity may apply this guidance to a portfolio of similar contracts.

Contract criteria

The Health entity should account for a contract with a customer under AASB 15 if all of the following criteria are met:

AASB 15.9

- the parties to the contract have approved the contract (in writing, orally or in accordance with other customary business practices) and are committed to perform their respective obligations
- the entity can identify each party's rights regarding the goods or services to be transferred
- the entity can identify the payment terms for the goods or services to be transferred
- the contract has commercial substance (i.e. the risk, timing or amount of the entity's future cash flows is expected to change as a result of the contract)
- it is probable that the entity will collect the consideration entitled in exchange for the underlying goods or services.

Once an arrangement has met the above criteria, management does not reassess the criteria again unless there are indications of significant changes in facts and circumstances. The determination of whether there is a significant change in facts or circumstances depends on the specific situation and requires judgement.

If a contract does not meet the above criteria, the entity should recognise the consideration received as revenue only when:

AASB 15.15

- the Health entity has no remaining obligations, receives all or substantial consideration which is non-refundable; or
- the contract has been terminated and the consideration received is non-refundable.

Customer of Health entity

The customer of Health entity is sometimes not clearly identifiable. The customer is the party that promises consideration in exchange for goods or services that are an output of the entity's ordinary activities. The customer might direct goods or services to be provided to third-party beneficiaries (including individuals or the community at large).

In these contracts, the customer remains the party that has contracted with the entity and promises consideration in exchange for those goods or services, and the provision of goods or services to third-party beneficiaries is a characteristic of the promised transfer of goods or services to the customer.

Example 16.1 Identify the customer

The Health entity receives consideration from an individual X for the specified purpose of providing first-aid training to members of the community.

Who is the customer?

In this instance, the individual X is the customer because he/she has contracted with the Health entity to provide the first-aid training services. This conclusion is not affected by the fact that individual X specifies those services are to be provided to members of the community.

Enforceable agreement

An inherent feature of a contract with a customer is that the Health entity makes promises in an agreement that creates enforceable rights and obligations. Enforceability of the rights and obligations in a contract is a matter of law. Contracts can be written, oral or implied by an entity's customary business practices. The Health entity shall consider the establishing contracts with customers practices and processes in determining whether and when an agreement with a customer creates enforceable rights and obligations.

Key considerations on enforceability are listed below:

- *Enforceability needs to be considered in relation to particular terms of an agreement and any additionally agreed terms as a result of further discussions or actions. Examples of terms in agreements that result in enforceability:*
  - *a refund in cash or kind when the agreed specific performance has not occurred;*
  - *the customer, or another party acting on its behalf, has a right to enforce specific performance or claim damages;*
  - *the customer has the right to a financial interest in assets purchased or constructed by the entity;*
  - *the parties to the agreement are required to agree on alternative uses of the resources provided under the agreement, and*
  - *an administrative process exists to enforce agreements between sovereign States or between a State and another party*
- *The enforceability of agreements does not depend on their form. For example, documents such as Memoranda of Understanding, Heads of Agreement and Letters of Intent can constitute legally enforceable agreements.*

AASB 2016-08. F11-F17

- *Agreements that explicitly state they are not intended to be legally binding may nonetheless become enforceable agreements if the parties act in a manner that is inconsistent with the stated intention.*
- *Agreements that lack elements of a contract may nonetheless become legally enforceable if there is conduct by one party that causes the other party to act in reliance on such conduct. Enforcement mechanisms may arise from administrative arrangements or statutory provisions e.g. a directive given by a Minister or government department to Health entity.*

- *A capacity to impose a severe penalty for non-performance can exist without a capacity to require a return of transferred assets or assets of equivalent value. The authority to require compensation may be the key determinant of the enforceability of an agreement involving a promise to transfer goods or services.*
- *A contract could still be enforceable despite a lack of history of enforcement and despite the customer's intention not to enforce. The customer's intent not to enforce is at its discretion and does not affect their right to enforce. Enforceability depends on the customer's capacity to enforce.*
- *A Statement of Intent is generally a public policy statement and does not identify the parties who could enforce the statement. Such a statement of intent, of itself, would be insufficient to create an enforceable agreement. This is in contrast to a Letter of Intent which is typically an agreement between specifically identified parties.*
- *A transferor's capacity to withhold future funding to which the Health entity is not presently entitled, would not, by itself, create an enforceable agreement.*

Commercial Substance

AASB 2016-08. F19

A contract may have commercial substance even if it is non-commercial to Health entity (for example, subsidised goods or services). 'Commercial substance' should be read as a reference to economic substance i.e. giving rise to substantive rights and obligations.

Contract term

AASB 15.11

The contract term is the period during which the parties to the contract have present and enforceable rights and obligations. It impacts the determination and allocation of the transaction price and recognition of revenue.

The Health entity should consider termination clauses when assessing contract duration. If a contract can be terminated by either party at any time without penalty, the parties do not have enforceable rights and obligations, regardless of the stated term. In contrast, a contract that can be terminated early, but requires payment of substantive compensation costs, is likely to have a contract term equal to the stated term.

16.5.4 Step 2: Identifying performance obligations

This step requires an entity to determine whether the contract with a customer contains performance obligations. These are promises to transfer distinct goods or services.

Assessing whether goods or services are 'distinct'

AASB 15.23

At contract inception, Health entity shall assess the goods or services promised in a contract with a customer and shall identify as a performance obligation each promise to transfer to the customer either:

- a good or service (or a bundle of goods or services) that is distinct; or
- a series of distinct goods or services that are substantially the same and that have the same pattern of transfer to the customer.

A good or service that is promised to a customer is distinct if both of the following criteria are met:

- the customer can benefit from the good or service either on its own or together with other resources that are readily available to the customer (ie the good or service is capable of being distinct);
- the Health entity's promise to transfer the good or service to the customer is separately identifiable from other promises in the contract (ie the good or service is distinct within the context of the contract).

Factors that indicate that two or more promises to transfer goods or services to a customer are not separately identifiable within the context of the contract include, but are not limited to, the following:

- the entity provides a significant service of integrating the goods or services with other goods or services promised in the contract into a bundle of goods or services that represent the combined output or outputs for which the customer has contracted.
- one or more of the goods or services significantly modifies or customises, or is significantly modified or customised by, one or more of the other goods or services promised in the contract
- the goods or services are highly interdependent or highly interrelated. In other words, each of the goods or services is significantly affected by one or more of the other goods or services in the contract.

Sufficiently specific performance obligations

The promise of the Health entity should be sufficiently specific to determine when the obligation is satisfied, as this indicates the transfer of goods or services is not at its discretion.

AASB 2016-8, Appendix F

The following are some key considerations in determining a 'sufficiently specific' performance obligation:

- Judgement is necessary to assess whether a promise is sufficiently specific. This takes into account any explicit or implicit conditions regarding the promised goods or services, including conditions on:
  - the nature or type of the goods or services
  - the cost or value of the goods or services
  - the quantity of the goods or services
  - the period over which the goods or services must be transferred.

A service can include an arrangement whereby one entity undertakes specific activities on behalf of another entity. Activities may include service delivery, research or asset management, among others. However, performance obligations do not include activities undertaken to fulfil a contract unless those activities transfer a good or service to a customer. For example, research activities undertaken to develop intellectual property that the entity will license to a customer are not themselves a transfer of goods or services to the customer.

A statement of intent, charter or stated objectives alone would generally not be enough to create a performance obligation.

A condition that the Health entity should transfer unspecified goods or services within a particular period does not, by itself, meet the 'sufficiently specific' criterion. For example, where Health entity receives an endowment to be used for an unspecified purpose over a particular time period, such a promise is not sufficiently specific.

If the transfer does not specify the period over which the Health entity must use the funds or the services to be provided (such as the number of counselling sessions), the Health entity would not meet the 'sufficiently specific' criterion because it would be unable to determine when it meets the performance obligations.

Although not a necessary precondition, an acquittal process to demonstrate progress towards transferring goods or services may provide evidence of a sufficiently specific promise. For example, an agreement may require the entity to report on progress toward specified outputs or outcomes in an acquittal process.

The promise of the Health entity should be sufficiently specific to determine when the obligation is satisfied, as this indicates the transfer of goods or services is not at its discretion.

16.5.5 Step 3: Determining the transaction price

As discussed in Section 12.4, the Health entity need to first determine whether a transaction (or a component of the transaction) is a contract with a customer under AASB 15. That is,

- in step 1: it is an 'enforceable contract'; and
- In step 2: the contract contains a 'sufficiently specific performance obligations'

If a transaction does not meet both criteria above, it is not a revenue contract with customers and no need to go through the remaining steps under this section. Rather, it may apply the guidance in accordance with AASB 1058 outlined in Section 12.6 below.

If it is a revenue contract with customers, the Health entity needs to determine the transaction price under AASB 15. The transaction price is the amount of consideration to which Health entity expects to be entitled in exchange for transferring promised goods or services to a customer, excluding amounts collected on behalf of third parties (for example, some sales taxes). The consideration promised in a contract with a customer may include fixed amounts, variable amounts, or both.

For the purpose of determining the transaction price, Health entity shall assume that the goods or services will be transferred to the customer as promised in accordance with the existing contract and that the contract will not be cancelled, renewed or modified.

The nature, timing and amount of consideration promised by a customer affect the estimate of the transaction price. When determining the transaction price, Health entity shall consider the effects of all of the following:

- variable consideration and constraining estimates of variable consideration
- the existence of a significant financing component in the contract
- non-cash consideration
- consideration payable to a customer

Variable consideration

An amount of variable consideration can vary because of discounts, rebates, refunds, credits, price concessions, incentives, performance bonuses, penalties or other similar items. The promised consideration can also vary if the consideration is contingent on the occurrence or non-occurrence of a future event. For example, a product was sold with a right of return, or a performance bonus is promised on achievement of a specified milestone.

AASB 15.56

AASB 15 imposes a constraint on the estimate of variable consideration. The estimate of variable consideration can only be recognised to the extent it is highly probable that a significant revenue reversal will not occur in future periods.

Health entity should estimate an amount of variable consideration based on either of:

- the expected value – the sum of probability-weighted amounts in a range of possible consideration amounts. This is appropriate when the Health entity has a large number of contracts with similar characteristics.
- the most likely amount – the single most likely amount in a range of possible consideration amounts (i.e. the single most likely outcome of the contract). This is appropriate when the contract has only two possible outcomes (e.g. the Health entity either achieves a performance bonus or not).

The method used is not a policy choice. Management of the Health entity should use the method that it expects best predicts the amount of consideration to which the entity will be entitled based on the terms of the contract.

Significant financing component

Some contracts contain a financing component (either explicitly or implicitly) when payment by a customer occurs either significantly before or after the performance obligations. This can, in effect, provide the customer or the Health entity with a significant financing benefit.

AASB 15.63

Health entity should apply the practical expedient in AASB 15, and disregard the effects of a financing component if the period between transferring of promised goods or service and payment is less than 12 months.

Example 16.2 Significant financing component – customer pays in arrears

Health entity contracts to provide a machine with payments from the customer over 3 years in monthly instalments of $5,500 totaling $198,000. The cash selling price of the machine would be $185,000 where payment is on delivery.

How should the above be accounted for?

There is a difference of $13,000 between the cash selling price of $185,000 and the promised consideration (total of monthly instalments) of $198,000. Health entity assesses this is the combined effect of the expected length of time to receive the full consideration and prevailing relevant market interest rates. Therefore Health entity determines the contract includes a financing component.

The implicit rate is computed as 7% based on the cumulative interest ($13,000) and the settlement period. Health entity determines that the financing component is significant as it represents 7% of the selling price. Therefore an adjustment is required to adjust the time value of money.

Health entity recognises:

- *Revenue of $185,000 when the performance obligation is satisfied (i.e. when the machine is delivered); and*
- *Interest income on a monthly basis using the effective interest method. The interest income for each month is based on the outstanding balance receivable.*

Non-cash consideration

Any non-cash consideration received from a customer needs to be included when determining the transaction price. Non-cash consideration is measured at fair value.

Consideration payable to customer

The consideration payable to a customer includes cash amounts that a Health entity pays, or expects to pay, to the customer, or credit or other items (e.g., a coupon or voucher) that can be applied against amounts owed to the Health entity.

16.5.6 Step 4: Allocation of the transaction price to separate performance obligation

The allocation of the total transaction price to performance obligations is done at the inception of the contract, by:

- determining the stand-alone selling price (the price at which Health entity would sell a distinct good or service separately on a stand-alone basis) of the distinct performance obligation; and
- allocating the transaction price (identified in step 3) to each of the performance obligations (identified in step 2), in the same proportion as the stand-alone selling prices.

Dual purpose transactions: providing goods/service (AASB 15) and receiving a donation (AASB 1058)

A customer may enter into a contract with Health entity with a dual purpose of obtaining goods or services and to help the Health entity achieve its objectives.

AASB 2016-8.F28

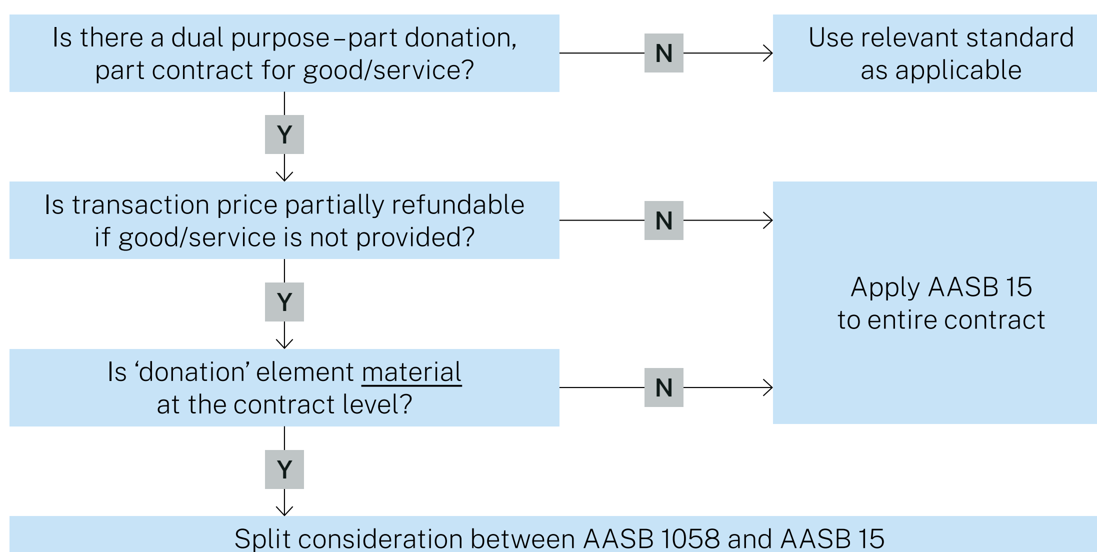
For these contracts, there is a rebuttable presumption that the transaction price relates wholly to the transfer of promised goods or services. The presumption is rebutted where the transaction price is partially refundable in the event the Health entity does not deliver the promised goods or services.

Where the presumption is not rebutted, Health entity should recognise the full transaction price as revenue under AASB 15.

Where the presumption is rebutted, the entity should disaggregate the transaction price and account for:

- the component that relates to the transfer of promised goods or services in accordance with AASB 15; and
- the remainder of the transaction price as a donation component in accordance with AASB 1058.

Below is the flow chart for dual purpose accounting:



Example 16.3 Dual purpose transactions: providing goods/service and receiving a donation

Health entity sells online subscriptions that provide access to particular publications for a year (a promised service to each customer) and also invites subscribers to donate a non-refundable nominated amount to generally assist the entity in pursuing its broad objectives. The voluntary donation is separately identifiable from the price of the annual subscription. The annual subscription fee and the donation are both refundable if access were not provided for the entire subscription period.

How should the above be accounted for?

The presumption that the transaction price relates wholly to the transfer of promised goods or services is not rebutted as the transaction price is refundable in full. Hence the donation should not be accounted for separately. Instead, the entire transaction price is allocated to the performance obligation of providing membership access. Consequently, the donation should be recognised as revenue when (or as) performance obligations under the arrangement are satisfied in accordance with this policy.

16.5.7 Step 5: Recognising revenue

AASB 15.31 – 32

Health entity shall recognise revenue when (or as) the entity satisfies a performance obligation by transferring a promised good or service (i.e. an asset) to a customer. An asset is transferred when (or as) the customer obtains control of that asset.

For each performance obligation, an entity should determine, at contract inception, whether it satisfies the performance obligation:

- over time (select an appropriate method to measure progress over time and recognise revenue over time); or
- at a point in time (recognise revenue at a point in time when control of good or service passes to customer).

Performance obligations satisfied over time

This is the case if any of the following criteria are met then it's a performance obligation satisfied over time. Otherwise, the performance obligation is taken to occur at a single point in time. The criteria as follows:

- The customer simultaneously receives and consumes the benefits, as the Health entity performs its obligations.
- The Health entity's performance creates or enhances an asset that the customer controls as the asset is created or enhanced.
- The Health entity's performance does not create an asset with an alternative use to the entity and it has an enforceable right to payment for performance completed to date.

AASB 15.41

If one of the above criteria is met, revenue is recognised over time, using a method that depicts its performance i.e. progress towards satisfaction of a performance obligation. The measurement method may be either an output method or input method (see examples in below table):

Output method	Input method
A direct measure of value to customer	*Based on the entity's efforts*
• Surveys or appraisals	• Costs incurred
• Milestones	• Resources consumed
• Time elapsed	• Labour hours expended
• Units produced	

Example 16.4 Measuring progress over time – input method

Health entity contracts to build an intellectual property asset for a fixed price of $4 million. The contract contains a single performance obligation that is satisfied over time. Total estimated contract costs are $3.75 million. Costs incurred in year one are $750,000. Health entity concludes that the performance obligation is satisfied over time as the customer controls the intellectual property asset as it is created.

How should the above be accounted for?

In the early stages of the contract, Health entity may not be able to reasonably measure the outcome of a performance obligation. Hence, an input method using costs incurred (relative to the total expected cost) is an appropriate measure of progress toward satisfying the performance obligation. Health entity recognises revenue based on a calculation of costs incurred relative to the total expected costs, based on the following calculation: Progress towards completion – 20% ($750,000 / $3.75 million). So revenue to be recognised is $800,000 (i.e. 20% of the transaction price of $4 million).

Performance obligations satisfied a point in time

If a performance obligation is not satisfied over time, control is transferred and revenue is recognised at a point in time. Indicators of transfer of control include:

- *Health entity has a present right to receive payment*
- *Customer has legal title to the asset*
- *Health entity has transferred physical possession of the asset*
- *Customer has significant risks and rewards of ownership of the asset*
- *Customer has accepted the asset*

16.5.8 Combination of contracts

AASB 15.17

The Health entity shall combine two or more contracts entered into at or near the same time with the same customer (or related parties of the customer) and account for the contracts as a single contract if one or more of the following criteria are met:

- the contracts are negotiated as a package with a single commercial objective;
- the amount of consideration to be paid in one contract depends on the price or performance of the other contract; or
- the goods or services promised in the contracts (or some goods or services promised in each of the contracts) are a single performance obligation.

16.5.9 Contract modification

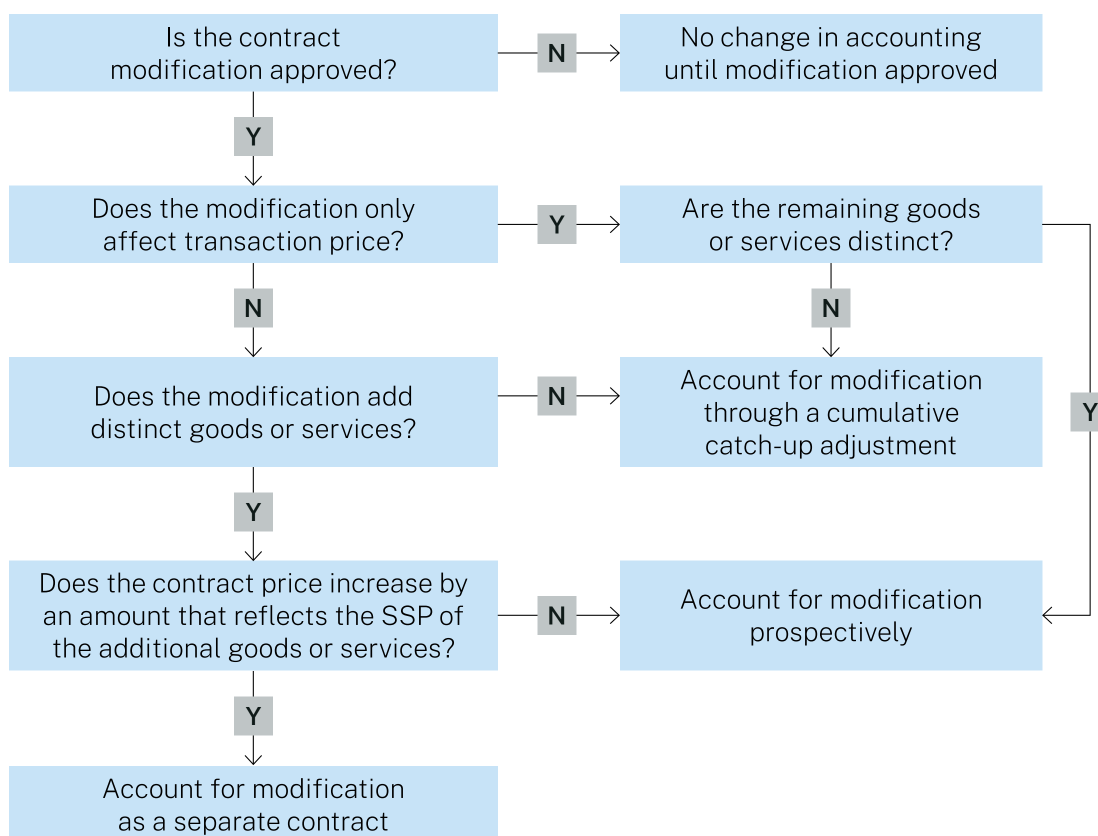
AASB 15.18

A contract modification could change the scope of the contract, the price of the contract, or both. A contract modification exists where the parties to the contract approve the modification either in writing, orally, or based on the parties' customary business practices. There is a contract modification when the contracting parties approve the modification that either creates new or changes existing enforceable rights of the contracting parties.

Contract modifications are accounted for either as a separate contract or as part of the existing contract, depending on the nature of the modification:

- as a separate contract – when both below conditions are met:
  - the scope of the contract increases because of the addition of promised goods or services that are distinct
  - the price of the contract increases by an amount of consideration that reflects the entity's stand-alone selling prices of the additional promised goods or services and any appropriate adjustments to that price to reflect the circumstances of the particular contract
- as termination of the existing contract and creation of a new contract – if the remaining goods or services are distinct from those transferred before the modification date. This method accounts for the changes prospectively.
- as if the modification is part of the existing contract – where the new goods or services are not distinct. This method uses the cumulative catch-up basis.

Contact modification flow chart as below:



16.5.10 Principal vs Agent

Some arrangements involve two or more unrelated parties that contribute to providing a specified good or service to a customer. Health entity needs to determine whether it has promised to provide the specified good and service itself (as a principal) or to arrange for those specified good or service to be provided by another party (as an agent).

AASB 15.B35

Health entity is the principal if it obtains control of the specified goods or services before they are transferred to the customer. When another party is involved in providing goods or services to a customer, Health entity may obtain control of any one of the following:

- a good or another asset from the other party that it then transfers to the customers;
- a right to a service to be performed by the other party, which gives Health entity the ability to direct that party to provide the service to the customer on its behalf; or
- a good or service from the other party that it then combines with other goods or services in providing the specific good or service to the customer

  Indicators that an entity is a principal include, but are not limited to, the following:

- the entity is primarily responsible for fulfilling the promise to provide the specified good or service.
- the entity has inventory risk before the specified good or service has been transferred to a customer, or after transferring the control to the customer (for example, if the customer has a right of return);
- the entity has discretion in establishing the prices for the specified goods or services

No single indicator is determinative or weighted more heavily than other indicators. Some indicators might provide stronger evidence than others.

16.5.11 Contract costs

Costs to obtain a contract

AASB 15.91-94

Incremental costs of obtaining a contract are costs that would not otherwise have been incurred if the contract had not been obtained (for example, sales commissions).

Health entity should recognise incremental costs incurred to obtain a contract as assets (i.e. contract assets) if it expects to recover these costs. These assets are then amortised on a basis consistent with the transfer of goods or services to the customer. If the amortisation period of the asset is one year or less, the cost can be expensed immediately.

There is a practical expedient that permits Health entity to expense the incremental costs as incurred where the expected amortisation period is one year or less.

Costs to fulfil a contract

AASB 15.95-99

Contract fulfilment costs are capitalised if all of the following criteria are met:

- the costs relate directly to an existing contract or specific anticipated contract;
- the costs generate or enhance resources of Health entity that will be used to satisfy the performance obligations in the future; and
- the costs are expected to be recovered

Health entity shall recognise the following costs as expenses when incurred:

- general and administrative costs;
- costs of wasted materials, labour or other resources to fulfil the contract that were not reflected in the price of the contract;
- costs that relate to satisfied performance obligations (or partially satisfied performance obligations) in the contract (ie costs that relate to past performance); and
- costs for which an entity cannot distinguish whether the costs relate to unsatisfied performance obligations or satisfied performance obligations (or partially satisfied performance obligations).

Contract cost assets are capitalised and amortised on a systematic basis consistent with the expected pattern of transfer of the related goods or services under the contract.

16.5.12 Disclosure

AASB 15.110

The objective of the disclosure requirements is for Health entity to disclose sufficient information to enable users of financial statements to understand the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers.

To achieve that objective, an entity shall disclose qualitative and quantitative information about all of the following:

- its contracts with customers (disaggregation of revenue, contract balances, and performance obligations)
- the significant judgements, and changes in the judgements, made in applying this Standard to those; and
- any assets recognised from the costs to obtain or fulfil a contract with a customer.

Contract balances

AASB 15.106-108

A contract asset is an entity's right to consideration in exchange for goods or services that the entity has transferred to a customer, and it should be presented separately.

A receivable is an entity's right to consideration that is unconditional. A contract asset becomes a receivable when receipt of the consideration is conditional only on the passage of time.

Health entity should recognise a contract liability if the customer's payment of consideration precedes the entity's performance (for example, by paying a deposit).

The key disclosure requirements are summarised in the below table:

Disclosures	Key requirements
Disaggregated revenue	Disaggregation of revenue into categories that show how economic factors affect the nature, amount, timing, and uncertainty of revenue and cash flows (e.g. by major product line, geographical region etc.).
Reconciliation of contract balances	Contract assets and liabilities and explanation of movements
Performance obligations	• Description of performance obligations • Transaction price allocated to remaining performance obligations and when revenue will be recognised
Significant judgements	• Method used to recognise revenue for performance obligations satisfied over time and why the method is appropriate • Transfer of control for performance obligations satisfied at a point in time • Methods, inputs, and assumptions used to determine and allocate the transaction price
Costs to obtain or fulfil a contract	• Judgements made to determine these and method of amortisation • Closing balances of assets and amount of amortisation/impairment
Practical expedients	Use of either: • The expedient regarding the existence of a significant financing component • The expedient for expensing certain costs of obtaining the contract

16.6 Application guidance – AASB 1058

16.6.1 Scope exemption

The Health entity should apply AASB 1058 to transactions where the consideration to acquire an asset is significantly less than fair value principally to enable the entity to further its objectives (i.e. donation transactions), and the receipt of volunteer services, except for:

- share-based payment transactions;
- business combinations;
- insurance contracts;
- licences outside the scope of AASB 15;
- income taxes; and
- restructures of administrative arrangements within the scope of AASB 1004.

16.6.2 General guidance under AASB 1058

AASB 1058.1(a)

Donation transactions have the following key characteristics:

- the Health entity receives an asset (cash or other assets);
- the consideration for that asset is significantly less than its fair value;
- the transaction is principally to enable the Health entity to further its objectives

The approach in this policy is to operate on a residual basis. Health entity should recognise the asset received and then any related liabilities, with the donation being the residual and recognised as income immediately. The exception to immediate income recognition is a capital grant.

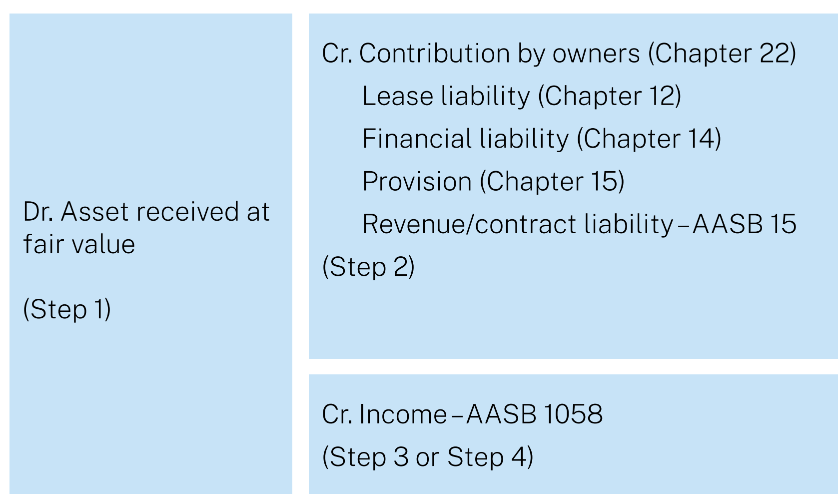
AASB 1058.15

A capital grant is a type of donation where the Health entity:

- receives a financial asset to acquire or construct a non-financial asset to identified specifications;
- retains control of the non-financial asset (i.e. for its own use); and
- the transaction is enforceable

Health entity should recognise a capital grant as income when (or as) it satisfies its obligations under the transfer.

An illustrative diagram on accounting for 'Donation' transactions



Step 1 Recognise the asset in accordance with applicable Australian Accounting Standard. For example:

- if cash is received – recognised as a financial asset
- if inventory is donated – recognised inventory under AASB 102 Inventories (Chapter 13)

Step 2 Consider if the nature of the transaction gives rise to a 'related amount' in accordance with another Accounting Standard

Step 3 Recognise the residual as income immediately. The only exception to this rule is a capital grant under Step 4.

Step 4 Receipt of capital grants – Health entity recognises the residual (Step 1 minus Step 2) as income when (or as) Health entity satisfies its obligations under the transfer.

16.6.3 Donation transactions

This section discusses the recognition and measurement of some common 'donation' transactions in the Health entity sector with examples.

Transfers to enable an entity to acquire or construct a recognisable non-financial asset (capital grants)

AASB 1058.B16

An entity may receive cash or other financial assets to construct or acquire a non-financial asset (e.g. building) for its own use i.e. a capital grant. In substance, this is a donation and should be accounted for under AASB 1058. The entity should recognise the financial asset received and the related obligation to acquire or construct the non-financial asset. Income is recognised when (or as) the obligation is satisfied.

Example 16.5 Cash grant for the construction of a recognisable asset – income recognised over time

A donator transferred $50,000,000 to Health entity as an endowment. Health entity is required to build a specific hospital within 2 years. If Health entity breaches the terms of the endowment, it will be required to return the transferred amount to the donator.

A survey work completed indicated that 60% ($30,000,000) of the building was completed in Year 1 and another 40% ($20,000,000) of the building will be completed in Year 2.

How should the above be accounted for?

The cash endowment is an asset acquired by Health entity for no consideration to further its objectives. It is therefore within the scope of AASB 1058. The entity controls the cash, upon receipt, as a financial asset within the scope of AASB 9. The related amount is a contract liability representing a performance obligation that is:

- *enforceable – the funds are required to be refunded if the terms are breached; and*
- *sufficiently specific – the obligation to build a specific hospital within 3 years.*

Health entity will recognise cash of $50,000,000 as a financial asset on receipt. $50,000,000 is recognised as a related contract liability since the value will be equal to the building cost. And will recognise grant income as the performance obligation satisfied over time.

Journal entry:
Initial recognition

Dr Cash 50,000,000
Cr Obligation 50,000,000

Year 1:
Dr Building – Construction in progress 30,000,000
Cr Cash 30,000,000

Dr Obligation 30,000,000
Cr Grant income 30,000,000

Year 2:
Dr Building – Construction in progress 20,000,000
Cr Cash 20,000,000

Dr Obligation 20,000,000
Cr Grant income 20,000,000

Example 16.6 Non-cash grant (in-kind contribution) of a recognisable asset

Hospital X will receive 16 intensive care hospital beds that will be controlled by the Hospital X and used in its operations with the value of $ 160,000. Six beds are received by Hospital X in year 1, and the remaining ten beds in year 2.

How should the above be accounted for?

Hospital X recognises income as it received and controls the hospital beds.
Journal entries:
Year 1 received donation of 6 beds:
Dr Equipment 60,000
Cr Income 60,000

Year 2 received remaining donation of 10 beds:
Dr Equipment 100,000
Cr Income 100,000

16.6.4 Volunteer services

Volunteer services are services received by Health entity from individuals or other entities without charge or for consideration significantly less than the fair value of those services.

AASB 1058.18

Health entity shall recognise an inflow of resources in the form of volunteer services as an asset (or an expense, when the definition of an asset is not met) if:

- the fair value of those services can be measured reliably; and
- the services would have been purchased if they had not been donated.

AASB 1058.B7

Accounting treatment for volunteer services

When volunteer services are recognised, by requirement or election, they should be measured at fair value and recorded as:

- an asset – if the definition of an asset is met, otherwise an expense
- as income – except to the extent there are any related liabilities, equity contributions etc.

In many instances, the economic benefits of volunteer services will be consumed as the services are acquired, and will be expensed immediately. In other cases, the volunteer services could contribute to the development of an asset and therefore be included in the carrying amount of that asset.

16.6.5 Summary of income recognition by income streams

The table below summarises the accounting for various income streams:

Categories of income	Accounting treatment
Capital grants – transfers to enable Health entity to acquire or construct a non-financial asset for its own use.	The Health entity will recognise a liability for the cash or other financial assets received. Income is recognised when (or as) the obligations under the transfer are satisfied. This is recognized under AASB 1058.
Parliamentary appropriations – funding to Government Departments and Special Offices, for the purposes of recurrent services, capital works and services or repayment of debt.	The timing of income recognition under AASB 1058 is determined by reference to the characteristics of the appropriation process. Unspent appropriations at the end of the reporting year should be recognised as a liability rather than income, as the authority to spend the money lapses under the GSF Act and the unspent amount is repayable to the Consolidated Fund.
Grants from Government departments – grants to cluster agencies to support their broad objectives.	Significant judgement should be made based on individual contract terms and conditions. Depending on whether the arrangement is enforceable or/and contains sufficiently specific obligations, it may be accounted for as income under AASB 1058 or revenue under AASB 15.
Commonwealth General assistance funding – general revenue assistance arrangements allow funds to be used for the broad objectives of the public sector recipient.	These arrangements are unlikely to meet the 'sufficiently specific' criteria in AASB 15. Accordingly, income is recognised when the entity obtains control of the cash.
Commonwealth Specific purpose funding – these arrangements require funds to be used for specific objectives, outcomes, outputs etc.	Where these arrangements are enforceable through legal or equivalent means and contain sufficiently specific obligations relating to the delivery of goods and services, revenue would be recognised in accordance with AASB 15. If such funding does not meet the 'sufficiently specific' and 'enforceability' criteria of AASB 15, income is recognised under AASB 1058 when the recipient entity controls the cash.

Categories of income	Accounting treatment
Endowments, bequests etc. – assets (financial or non-financial) received for the ongoing support of the NFP entity's objectives.	Consider whether the conditions of the transfer give rise to any related contract liability under AASB 15 or financial liability or provision. Any excess would be recognised as income.
Dual purpose transactions –providing goods/service and receiving a donation	If the transaction price is only partially refundable in the event the promised goods or services are not delivered, disaggregate: • the component that relates to the transfer of promised goods or services, in accordance with AASB 15; and • the remainder of the transaction price in accordance with AASB 1058.
Grants from external parties – various types of grants received (research, clinical drug trials, fundraising, donations, etc.	Significant judgement should be made based on individual contract terms and conditions. Depending on whether the arrangement is enforceable or/and contains sufficiently specific obligations, it may be accounted for as income under AASB 1058 or revenue under AASB 15.
Patient related revenue –various type of fees and charges to non-public patients.	For service provided to non-public patients which is in scope of AASB 15, revenue should be recognised either point in time or over time, depending on when and how the control over service is transferred.

16.6.6 Disclosure

The objective of the disclosure requirements is for Health entity to disclose sufficient information to enable users of financial statements to understand the effects of volunteer services and other transactions in the scope of AASB 1058 on the financial position, financial performance and cash flows of Health entity.

Income categories

AASB 1058.26

Income shall be disaggregated into categories reflecting significant income streams.

Recommended categories include:

- grants, bequests and donations of cash, other financial assets and goods;
- recognised volunteer services
- appropriations by class

Other qualitative disclosures

AASB 1058.27

To assist users to make informed judgements about the contribution of volunteer services and inventories to the achievement of Health entity's objectives during the reporting period, and Health entity's dependence on such contributions for the achievement of its objectives in the future, Health entity is encouraged to disclose qualitative information, by major class of transaction, about the nature of Health entity's dependence arising from:

- volunteer services it receives, including those not recognised; and
- inventories held but not recognised as assets during the period.

Capital grants

Health entity required to disclose as follow related to a capital grant received:

- opening and closing balances of financial assets received and associated liabilities arising from capital grants
- income recognised during the year from the reduction of the associated liability
- information about obligations under the capital grants, including a description of when the obligations are typically satisfied
- explanation (qualitatively or quantitatively) when the liability for unsatisfied obligations will be recognised as income
- methods used to recognise income and their justification
- judgments and changes in judgements related to recognising capital grants received.

External restrictions

AASB 1058.37

Health entity is encouraged to disclose information about externally imposed restrictions that limit or direct the purpose for which resources controlled by the Health entity may be used.

Parliamentary appropriations and other related authorities for expenditure

AASB 1058.39

Health entity shall disclose:

- a summary of the recurrent, capital or other major categories of amounts authorised for expenditure (including parliamentary appropriations), disclosing separately:
- the original amounts appropriated; and
- the total of any supplementary amounts appropriated and amounts authorized other than by way of appropriation (eg by the Treasurer, other Minister or other legislative authority);
- the expenditures in respect of each of the items disclosed in the previous point;
- the reasons for any material variances between the amounts appropriated or otherwise authorised and the resulting associated expenditures, and any financial consequences for the entity of unauthorised expenditure.

17 Employee benefits

17.1 Scope

17.1.1 Applicability

This Policy applies to the accounting treatment for short term, long term and post-employment benefits.

17.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- AASB 119 Employee benefits
- Treasury Circular TC21-03 Accounting for Long Service Leave and Annual Leave
- Treasury Circular TC18-10 Accounting for Superannuation

17.2 Overview and purpose

The purpose of this document is to provide Health entities with illustrative guidance on the accounting treatment with respect to employee benefits under the accounting standard AASB 119 Employee Benefits for general purpose financial reporting.

The accounting treatment for employee benefits must meet the guidelines as described in NSW Treasury Circular 18-10 ("Accounting for Superannuation") and Treasury Circular 21-03 ("Accounting for Long Service Leave and Annual Leave") which is based on Australian equivalents to International Financial Reporting Standards (AIFRS).

17.3 Policy statement

Employee benefits are all forms of considerations given by the Health entity in exchange for service rendered by employees or for termination of employment. Employee benefits include:

- short-term benefits, including wages, salaries, holiday pay, sick leave, RDO and bonuses expected to be settled within 12 months of the balance sheet date
- Post-employment benefits, such as pensions and post-retirement medical insurance
- Long-term benefits such as long-term incentive plans, long-service awards, holiday pay, bonuses expected to be settled more than 12 months after the balance sheet date
- Termination benefits such as redundancy payments

17.4 Application guidance

17.4.1 Recognition

AASB 119.11

For an employee benefit liability to be recognised, it must be probable that settlement will be required and that the liability can be measured reliably. All entitlements that vest in an employee satisfy the definitions of expenses and liabilities and should be measured and reported. Non-vesting employee benefits may satisfy the definition of expenses or liabilities but they may not meet the recognition criteria as it may not be possible to reliably measure the liability or expense.

17.4.2 Short term employee benefits – sick leave

A present obligation in respect of employee's accumulated sick leave entitlements arises only when it is probable that the sick leave to be taken by employees in any future reporting period will be greater than the entitlements that will be accumulated in that future period.

Where expense indicates that, on average, sick leave taken each reporting period is less than or equal to the entitlement accruing in that period and this trend is expected to recur in future periods, it is unlikely that existing accumulated entitlements will be used by employees. Accordingly, no liability for unused sick leave entitlements should be recognised

17.4.3 Short term employee benefits – annual leave, allocated day off (ADO) and Paid Parental leave

Annual leave

Annual leave can only be recognised as a short-term employee benefit where these benefits are expected to be settled wholly before 12 months after the end of the annual reporting period in which the employees render the related service. Short term annual leave is measured on an undiscounted basis using remuneration rates expected to be paid when the obligation is settled.

Given that it is unlikely the annual leave benefit will be settled wholly before 12 months after the end of the annual reporting period in NSW Health, annual leave is likely to be a long-term benefit in which the present value of the estimated future cash flows to be made to employees for services provided.

However in practice, the impact of measuring annual leave as a short term (undiscounted) employee benefit rather than a long term employee benefit (present value) may be immaterial. As per TC21-03 Accounting for long service leave and annual leave, the view is that the net impact of salary inflation, promotional increases and discounting to present value is likely to be immaterial to annual leave.

Accordingly, TC21-03 confirms that even where annual leave is determined as a long-term employee benefit, health entities can apply the nominal (undiscounted) balance plus the annual leave entitlements accrued while taking annual leave (i.e. annual leave-on-annual leave liability) to approximate the present value of the annual leave liability.

The annual leave-on-annual leave liability for determined by TC21-03 is calculated at a factor (example 8.4%) on the nominal value of annual leave.

For example, if a Health entity has a nominal value of annual leave totalling $1,000,000, the present value is calculated as follows:

Nominal value of annual leave	$1,000,000
Annual leave on annual leave liability of 7.9%	$ 84,000
Present value of annual leave	$1,084,000

The Health entity should assess if there is a high proportion of annual leave balances significantly in excess of 40 days. Where there are annual leave balances in excess of 40 days, they should consider projecting future cash outflows, expected to be made to employees and discounting the annual leave to its present value. This should be assessed annually by the Health entity. The Health entity should also assess whether there is likely to be any material difference between the present value and undiscounted basis.

Annual leave – on-costs

AASB 119.11

The on-costs associated with annual leave (i.e. payroll tax, workers compensation insurance, long service leave and superannuation), are recognised as expenses and liabilities (and revenue where assumed by the Crown), when employees have rendered related service to the entity.

Given that the long service leave and defined benefit superannuation (State Authorities Superannuation Scheme and State Superannuation Scheme) are assumed by the Crown entity, the on-costs associated with these should be recognised as non-monetary revenue and disclosed as 'Acceptance by the Crown Entity of Employee Benefits'.

The defined benefit superannuation on-cost on annual leave

Where defined benefit superannuation is assumed by the Crown, any additional superannuation liability accruing on the annual leave liability as an on-cost is also assumed by the Crown and is recognised as an expense and revenue.

Defined contribution superannuation on-cost on annual leave

The defined contribution superannuation on-cost is not assumed by the Crown and hence the Health entity should recognise this on-cost as an expense and liability in their financial statements.

On-cost of accruing LSL on annual leave

Given that long service leave is assumed by the Crown, the accruing cost in annual leave is also assumed by the Crown. The on-cost pertaining to the long service leave accruing on the annual leave should be recognised as an expense and revenue.

Allocated day off (ADO)

Similar to annual leave, ADO need to be accrued and recognised as a short-term employee benefit where these benefits are expected to be settled wholly before 12 months after the end of the annual reporting period in which the employees render the related service. ADO is measured on an undiscounted basis using remuneration rates expected to be paid when the obligation is settled plus on-costs.

Paid Parent Leave (PPL)

Determination (Section 52(1) Determination No 4 Of 2022) under the *Government Sector Employment Act 2013* for Paid Parental leave is applicable from 1 October 2022. Under the new parent leave benefit, an employee who has or will have completed not less than 40 weeks continuous service prior to date of birth, adoption, time of altruistic surrogacy or permanent out of home care placement of their child is entitled to up to 16 weeks (including 2 bonus weeks) of paid parental leave.

Paid parental leave is temporarily accumulating, that is, the unused entitlement can be carried forward for 24 months. After which it becomes non-accumulating as the employee loses the benefit after 24 months from the birth of the child.

Part of the benefit is also vesting for the 24 months under the Health awards, as it will be paid out if employee leaves employment within 24 months. For Crown employees, it is non-vesting. The bonus entitlement of 2 weeks is non-vesting at all times.

NSW Health expects that the probability that employees will utilise the benefit (14 weeks + 2 bonus weeks) is 100%. Therefore, as and when the employee notifies health entities of the birth or expected birth of the child, 16 weeks of PPL provision should be recognised.

Similar to annual leave and ADO, PPL is measured on an undiscounted basis using remuneration rates expected to be paid when the obligation is settled plus on-costs.

17.4.4 Long term employee benefits – long service leave

Employees reach an unconditional legal entitlement to long service leave after a qualifying period of service. For shorter service periods, long service leave may be payable on exit in some circumstances.

Long service leave liability is recognised even though a legal entitlement may not have yet arisen and should be measured as the present value of the estimated future cash outflows to be made by the Health entity for services provided by employees up to the reporting date. The discount rate used must be determined by the market yields on government bonds, consistent with the estimated term of the obligation.

The Crown assumes the long service liability for the Health entity. As such, the long service leave liability is not recognised in the Health entity’s Statement of Financial Position. Instead the long service leave should be recognised as a debit to the expense and a credit to non-monetary revenue to represent the liabilities assumed by the Crown as and when the employees have rendered related services to the entity during the reporting period.

Long service leave on-costs

The long service leave on-costs is assumed by the Crown where it relates to the defined benefits superannuation on-costs, and hence the on-cost associated with the defined benefit superannuation on-cost should be recognised as a debit to the expense and a credit to non-monetary revenue. All other long service leave on-costs is not assumed by the Crown and should be recognised as a debit to an expense with a corresponding credit to the liability in the Health entity’s Statement of Financial Position.

For the breakdown of on-costs assumed and not assumed by the Crown, and the on-cost factor to be applied refer to the table below:

On-costs on long service leave	Assumed by the Crown	On-costs factor
Superannuation – defined benefits	Yes	0.8% of present value of the total long service leave liability
Superannuation – defined contribution	No	6.6% of present value of the total long service leave liability
Annual leave accrued while on long service leave taken in service	No	5.6% of present value of the total long service leave liability
Workers Compensation Insurance	No	1% of present value of the total long service leave liability
Payroll Tax	No	Nil

Note: the on-costs factors are reviewed by Treasury's actuary every 3 years. The above rates apply for FY21, FY22 and FY23. New rates are expected in FY24.

The above on-cost rate is currently effective based on the actuarial valuation of LSL performed by Treasury's actuary. Any changes to the on-costs are to be treated in the current year as a change in estimate in accordance with Chapter 4 of this policy document.

The same factors are applied to both the current and non-current portion of the long service leave liability.

17.4.5 Post-employment benefits – Defined benefit superannuation

Defined benefit plans are defined as plans other than defined contribution plans. These benefits include the State Authorities Superannuation Scheme and State Superannuation Scheme.

In defined benefit schemes the formula for calculating the benefit is generally specified in terms of years of service or membership of the fund and final salary or final average salary (over the last three years of service). The future benefits accruing to a member of a defined benefit scheme are the same regardless of the performance of the scheme's invested assets. If investment returns are low, or if gross liabilities increase as a consequence of changes in underlying assumptions in an annual review or an actuarial triennial valuation, the employer may need to increase its superannuation contribution to allow the fund to meet its required benefits.

As a result, a superannuation liability (i.e. excess of gross superannuation liability over the scheme's assets) or prepaid superannuation asset (i.e. excess of scheme's assets over the gross liability) must be recognised by the Crown.

The Crown assumes the defined benefit superannuation benefit/funding responsibility. The Health entity as a result do not recognise a superannuation asset in the Statement of Financial Position since these are recognised by the Crown. The Health entity is therefore required to recognise a debit to the notional superannuation expense with a corresponding credit to non-monetary revenue for the assumption of the liability by the Crown.

Factors for the defined benefit schemes

The following formula must be used to calculate the superannuation expense and equivalent revenue for the defined benefit schemes to be recognised through profit or loss in the Health entity's Statement of Comprehensive Income. The superannuation expense for the reporting period is calculated as a multiple of the employee's superannuation contribution. The factors/multiple shown in the table below were reviewed by the actuary and reflect the results of the 2017 Annual Review of the four superannuation schemes.

State Superannuation Scheme

Actual employee contributions paid to Mercer Administration Services in respect of the financial year x 1.0.

State Authorities Superannuation Scheme

Actual employee contributions paid to Mercer Administration Services in respect of the financial year x 1.9.

Any change in the above factors as compared to the previous financial year should be treated prospectively, consistent with Chapter 4 of this policy document.

Payroll tax on superannuation contributions

Payroll tax applies to the payment of employer superannuation contributions in respect of services rendered. Where the Crown assumes the superannuation liability, the Crown also assumes the cost of the associated payroll tax. The Health entity is still required to recognise the payroll tax expense with a corresponding credit to non-monetary revenue for the assumption of the payroll tax liability, by multiplying the superannuation expense by the payroll tax rate for the year.

17.4.6 Post-employment benefit – defined contribution scheme

Defined contribution plans/schemes is defined where the employer pays fixed contributions (e.g. the superannuation guarantee charge) into a separate entity (a fund). The employer has no legal or constructive obligation to pay any additional contributions. The employer's expense equals its contributions and the employer's liability is restricted to any outstanding contributions at the end of the financial reporting period.

With respect to NSW Health, any employees who are not members of the defined benefit plans above, are mostly members of the First State Superannuation Scheme which is a defined contribution scheme.

The defined contribution is the responsibility of the Health entity. In NSW Health, the First State Superannuation Scheme is the default defined contribution scheme.

The accounting treatment for defined contribution is outlined below.

Superannuation liability/asset

An asset or liability for a defined contribution scheme is only recognised in the Statement of Financial Position at the end of the reporting period, where there are:

- Prepaid contributions that will result in a reduction in future payments or cash refund or;
- Outstanding contributions for that period

Superannuation expense

An expense must be recognised for the contribution payable to the defined contribution scheme, for service provided by an employee, except to the extent the amount forms part of the cost of an asset.

For the First State Superannuation Scheme, the superannuation expense is represented by the amount of the superannuation guarantee contribution, which is based on a specified portion of the employee's ordinary time earnings. The superannuation guarantee contribution is 11% (in FY24) and is expected to increase progressively to 12% over a number of years. The superannuation expense for the reporting period is calculated as a percentage (11%) of the employee's salary.

17.4.7 Post-employment benefits – termination benefits

Termination benefits result from either:

- an entity's decision to terminate an employee's employment (compulsory termination benefits).
- an employee's decision to accept an offer of voluntary redundancy in exchange for those benefits (voluntary termination benefits).

Termination benefits do not include employee benefits resulting from the voluntary departure of the employee without an offer from the entity, or as a result of mandatory retirement requirements. Further, an employee benefit is provided in exchange for services, rather than termination if the benefit is conditional on future services being provided or the benefit is provided in accordance with the terms of an employee benefit plan.

Accounting for termination benefits

The Health entity should recognise a liability and expense for termination benefits at the earlier of the following dates:

- when the Health entity can no longer withdraw the offer of those benefits and
- when the Health entity recognises costs for a restructuring that is within the scope Chapter 15 of this policy document with respect to provisions.

For voluntary benefits, the point in time when the Health entity can no longer withdraw the offer is the earlier of:

- when the employee accepts the offer and
- when a restriction (for example, a legal, regulatory or contractual requirement or other restriction) on the Health entity's ability to withdraw the offer takes effect. This would be when the offer is made, if the restriction existed at the time of the offer

For compulsory termination benefits, the Health entity can no longer withdraw the offer of termination benefits once it has communicated to the affected employees a plan of termination that meets all of the following criteria:

- actions required to complete the plan indicate that it is unlikely the significant changes to the plans will be made.
- the plan identifies the number of employees whose employment is to be terminated, their job classifications or functions and their locations (but the plan need not identify each individual employee) and the expected completion date.
- the plan establishes the termination benefits that employees will receive in sufficient detail that employees can determine the type and amount of benefits that they will receive when their employment is terminated.

If the termination benefits are expected to be settled wholly before 12 months after the end of the annual reporting period in which the termination benefit is recognised, the Health entity should apply the requirements for short term employee benefits (with respect to not discounting and accounting for as a current liability or provision). If the termination benefits are not expected to be settled wholly before 12 months after the end of the annual reporting period, discounting to the net present value should be applied and the portion expected to be settled beyond 12 months should be recognised as part of non-current liabilities or provision.

Example 17.1: Voluntary redundancy payment with a time limit

The Health entity plans to restructure its operations. The Health entity aims to reduce the staff numbers by 100 in February 20X4. Also in December 20X3, management had communicated an offer of $5,000 for voluntary redundancy to be accepted by the end of January 20X4. The offer for any remaining employees can be withdrawn at any time. If sufficient staff do not accept the offer, management will terminate the employment of additional staff to reach the target of 100. Each employees whose employment is terminated involuntarily are entitled to a termination payment of $4,000 each.

As of 31 December 20X3, 60 employees have accepted the voluntary termination offer.

How should the above be accounted for?

At 31 December 20X3, 60 employees have accepted the voluntary termination offer amounting to $300,000 (60 employees x $5,000). A further $160,000 (40 employees x $4,000) is recognised as an additional liability, because management is committed to the plan to terminate 100 staff. A contingent liability of $40,000 for the additional amount that would be payable if the maximum number of employees accepted the termination voluntarily should also be disclosed.

17.4.8 Employee benefits under various assignments

There are various types of assignments within the NSW Health Entities. Some of the assignment could be permanent and some could be temporary. These have created instances of employees being employed by different Health entity from its Legal Employer.

Under such arrangement, employee costs should be borne by the entity to which the employee is performing services to (costed entity) and employee benefits provisions should be reflected in the balance sheet of the employer that will settle/pay the liability (legal employer).

Refer to table below for details of the current practice of employee's leave entitlement calculation for each type of assignment.

Type of assignment	Annual Leave expense incurred to be recorded by:	Annual Leave Provision to be recorded by:
Executive Service Staff (CEs)	Costed entity	Costed entity
Split Costing	Expense to be split by both entities for their share of service rendered.	Legal employer
Internal secondment – Formal Recruitment Arrangement	Costed entity	Legal employer
Internal secondment – Informal Secondment Arrangement	Costed entity	Legal employer
Rotations	Costed entity	Legal employer

18 Consolidation

18.1 Scope

18.1.1 Applicability

This Policy sets out the principles around the concept of group and consolidated financial statements and the guidelines with respect to the control assessment for not for profit entities.

18.1.2 Relevant Guidance

This Policy should be read in conjunction with the following guidance:

- AASB 10 Consolidated Financial Statements
- AASB 1049 Whole of Government and General Government Sector Financial Reporting

18.2 Overview and purpose

The purpose of this document is to provide Health entities with illustrative guidance on the accounting and reporting requirements on consolidations.

The consolidation procedures must meet the guidelines as described in the *AASB 10 Consolidated Financial Statements* and *AASB 1049 Whole of Government and General Government Sector Financial Reporting*. The policy provides guidance on how to assess whether the NSW Ministry of Health has control over an entity and should be consolidated for reporting purposes. The guidance is also relevant to Health entities in assessing whether another entity should be consolidated as part of the Health entity's financial statements.

18.3 Policy statement

Control is defined where an investor is exposed or has rights to variable returns from its involvement with the investee and has the ability to affect those returns through its power over the investee.

For the NSW Ministry of Health or the Health entities, this power will often arise through rights resulting from administrative arrangements or statutory requirements rather than ownership of equity.

The investor is generally regarded as a reporting entity that has interest in another entity by way of contractual and non-contractual involvement which exposes an entity to variability of returns from the performance of the other entity.

18.4 Application Guidance

18.4.1 Assessment of control

AASB 10.5-9, B2-B4

An investor assesses whether it has control over an investee. Where control is established, the investor will be a parent and that investee will be its subsidiary.

The factors that the NSW Ministry of Health or the Health entity (as the investor) should consider during its assessment of control over an investee are:

- the investee's purpose and design
- what the relevant activities are
- how decisions about those relevant activities are made
- whether the rights of the investor give it the current ability to direct the relevant activities
- whether the investor is exposed, or has rights to variable returns from its involvement with the investee and
- whether the investor has the ability to use its power over the investee to affect the amount of the investor's return

Where two or more investors collectively control an investee in the instance where they are required to act together to direct the relevant activities, then each investor would account for its interest in the investee. Refer to Chapter 19 of this policy document – associates and joint arrangements.

18.4.2 Power to direct relevant activities

Relevant activities is defined as those activities of the investee that significantly affect the investee's returns.

The NSW Ministry of Health or the Health entity should identify what the relevant activities of an investee are, since this will help the NSW Ministry of Health or the Health entity understand whether they are involved in decision-making activities that significantly affect those activities. Examples of relevant activities include:

- establishing budgets and making key decisions about relevant activities
- selling and purchasing goods and services
- managing financial assets during their life
- selecting, acquiring or disposing of assets
- researching and developing products or processes
- obtaining funding by way of government grant
- appointing/terminating and remunerating key management personnel (refer to Chapter 20 of this policy document).

Example 18.1: Ability to set the specified conditions in form of government grants

An affiliated health organisation currently receives funding from the NSW Ministry of Health in the form of government grants for capital construction. In order to receive the government grant, specified conditions are required to be met.

How should the above be accounted for?

The NSW Ministry of Health may not have the current ability to direct the relevant activities of the private hospital since the governing body of the private hospital has the discretion with respect to whether they will accept resources from the NSW Ministry of Health or the manner in which their resources are to be deployed. This would be the case even if government grants provided to the affiliated health organisational requires them to comply with specified conditions.

The NSW Ministry of Health or the Health entity is deemed to have power over an investee when the NSW Ministry of Health or the Health entity has existing rights which gives it the current ability to direct the relevant activities of the investee, being those activities that significantly affect the investee's return. This power will often arise through rights resulting from administrative arrangements or statutory requirements rather than ownership of equity. The statutory requirements from an enabling legislation may specify the investor's rights to direct the relevant activities.

Examples of rights can give an investor power may include the following:

- *Rights to give policy directions to the governing body of the investee that give the holder the ability to direct the relevant activities of the investee and*
- *Rights to approve or veto operating and capital budgets relating to the relevant activities of the investee*

Rights are divided into the following:

- *Substantive rights*
- *Protective rights*

Substantive rights

AASB 10.B22-B25

Substantive rights are those that confer power on an investor and are typically exercisable without cause. In assessing whether there are substantive rights, the NSW Ministry of Health or the Health entity should consider whether there are any barriers that restrict their practical ability to exercise them. These could be in the form of legal restrictions, cultural or social in nature which may make the exercise of such rights difficult. However, if the NSW Ministry of Health or the Health entity chooses to exercise the rights despite such barriers, then the rights are still considered substantive.

In addition to the barriers or restrictions, the below factors are also relevant in determining whether the rights are considered substantive

- *Whether practical mechanisms exist to exercise rights and whether agreement requires more than one investor – lack of such mechanism is an indicator that the rights are not substantive*
- *Whether the investor benefits from the exercise of the rights that it holds – if holder of the right benefits from the exercise then there is a greater incentive to obtain rights to give it power and hence more likely it will have power over the investee*

Substantive rights also needs to be exercisable when decisions about relevant activities are being made. These may commonly arise as a result of current statutory arrangements however future rights expected to arise from substantively enacted legislation may still be considered substantive if they will be exercisable when decisions about relevant activities are made.

Protective rights

AASB 10.B26-B28

Protective rights do not confer power on an investor and are usually designed to protect an investor's holdings.

Rights that restrict rather than direct the way another entity operates or that become exercisable only under specific circumstances such as non-compliance or non-performance are typically classified as protective rights.

Example 18.2: Protective rights

One of the main objectives of a not for profit cancer institute which operates as a statutory health corporation is to undertake research for the advancement of knowledge and benefit and well-being of patients affected by the condition. The institute therefore establishes a research trust and appoints a trustee. The trustee is responsible for making decisions about the financing and operating activities of the trust in accordance with the trust deed. The trustee is remunerated commensurate for its services. The objective of the trust is to undertake research and the NFP Institute can only replace the trustee for misconduct.

How should the above be accounted for?

The trustee is deemed to have power over the trust as it has existing rights that give it the current ability to direct the relevant activities of the trust. The Institute itself is not deemed to have power over the trust as it cannot remove the trustee other than for misconduct.

The institute's ability to remove the trustee only for misconduct would be considered a protective right and would not be deemed to give rise to power over the research trust.

18.4.3 Exposure or rights to variable returns from an investee

AASB 10.B55-B57

An investor must be exposed or have the rights to variable returns from an investee, regardless of whether they are direct or indirect. In the instance of the NSW Ministry of Health or the Health entity, this would encompass non-financial returns. Such returns can include the achievement of the NSW Ministry of Health or the Health entity's objectives or furtherance of its social policy objectives (such as provision of health services to the community). Such returns to the NSW Ministry of Health or the Health entity would reflect factors such as the efficiency and effectiveness for the delivery of health services and changes in the outcomes for the wider community.

Example 18.3: Exposure to variable returns

Further to the example set above in example 18.2, one of the main objectives of a not for profit cancer institute is to undertake research for the advancement of knowledge and benefit and well-being of patients affected by the condition. As the trust works towards achieving its own specific research objectives it also assists the institute to achieve its overall objectives in furthering its knowledge for the benefit of their patients and the wider community. As a result, the institute would be deemed to be exposed to the variable returns from the trust. On the other hand, the trustee would not be deemed to have sufficient exposure or rights to variable returns from its involvement in the trust as the trustee's remuneration is consistent with what a trustee would receive for providing such services and the returns are not significant in relation to the total returns from the trust.

18.4.4 Link between power and returns

An investor must also have the ability to exercise its power to affect the amount of its return from the investee. When making this assessment, it is important for an investor with decision-making rights to determine whether they are a principal acting in their own right or an agent with delegated power.

An agent is one who is primarily engaged to make decisions on behalf of a principal. In these situations the powers held by the agent are attributed to the principal when determining the existence of control.

The below factors are relevant in determining whether the investor (with decision making rights) is acting as an agent with delegated power:

- The scope of its decision-making authority over the investee
- The rights held by other parties
- The decision maker's exposure to variability of returns from other interests that it holds in the investee

An agent does not consolidate the investee, since the necessary link between power and returns is not present. In contrast, the principal can control the relevant activities of an investee (which may be carried out by an agent) and might be exposed to variable returns and hence would be required to consolidate the investee as its subsidiary.

Scope of its decision-making authority over the investee

The scope of its decision-making authority of the NSW Ministry of Health or the Health entity should take into consideration of the following:

- The activities that are permitted by the decision-making agreement and by law, and whether these are relevant activities
- The level of discretion that the NSW Ministry of Health or the Health entity has in directing the relevant activities

If the NSW Ministry of Health or the Health entity's authority as the decision maker is limited by legislation or an administrative arrangement, it is not always considered an agent. NSW Ministry of Health or the Health entity may still have power over an investee if it has the ability to direct its relevant activities, even if these are restricted.

Rights held by other parties

Parties other than the NSW Ministry of Health or the Health entity may have other rights over the investee. These can prevent the NSW Ministry of Health or the Health entity as the decision maker from exercising power on its own behalf. Such rights held by other parties may be substantive (refer to Chapter 18.4.2 of this policy document above). The NSW Ministry of Health or the Health entity should assess whether such substantive rights give the other parties the practical ability to prevent the decision maker from directing the investee's relevant activities.

If a single investor holds the substantive right to remove the decision maker without cause, the decision maker is an agent. However, there the agreement of more than one party is required to remove a decision maker, then consideration of number of parties involved and whether there is a mechanism in place. The greater number of parties required to agree, then the less weight is placed on the substantive right.

Exposure to variability of returns

The greater the magnitude and variability associated with the NSW Ministry of Health or the Health entity's interests in the investee, taking into consideration the non financial benefits (achievement of its social policy objectives), the more likely it is that the NSW Ministry of Health or the Health entity is a principal.

Example 18.4: Principal vs agent

In example 18.2 and 18.3 above, the trustee would be deemed to have power over the trust as it has the current ability to direct the relevant activities of the trust, The fact that the trustee must act in accordance with the trust deed and for the benefit of the beneficiaries does not prevent the trustee from having power. However, while the trustee has power to affect the returns of the trust (being the non-financial for the provision of cancer research), it does not have sufficient exposure or rights to variable returns from its involvement in the trust as the trustee's remuneration is consistent with what a trustee would receive for providing such services and the returns are not significant in relation to the total returns of the trust. On this basis the trustee does not control the trust.

While the trust is carrying out activities which would result in the furtherance of the Institute's objectives, it is the trustee and not the institute which has power over the activities that most significantly affect the returns of the trust. The institute has no power over the trust as it cannot remove the trustee. The ability to remove the trustee only for misconduct is a protective right and not a substantive right.

On the other hand, if the institute could replace the trustee at its discretion, the trustee would be considered to be acting as an agent of the institute. In this case, it would be deemed that the institute would have power over the trust on the basis that it has power over the trustee and is exposed to variable returns to the extent to which its research objectives are achieved or furthered through the activities of the trust.

Consideration of principle vs agency arrangement with respect to the NSW Ministry of Health or the Health entity

The NSW Ministry of Health or the Health entity acts in relation to an investee only as an agent of the responsible Minister when the NSW Ministry of Health or the Health entity or an official of the NSW Ministry of Health or the Health entity is merely authorised by the Minister to act on the Minister's behalf. An example of this is with respect to the affiliated health organisation which provides health services and recognised as part of the public health system under the Health Services Act 1997. The Secretary of the NSW Ministry of Health is appointed by the Minister to determine the functions and activities of the affiliated health organisation however consultation is required with the relevant organisation. In this instance, the NSW Ministry of Health is determined to be acting as an agent and hence the affiliated health organisations are not consolidated and not deemed to be controlled by the NSW Ministry of Health. The NSW Ministry of Health's activities in relation to the investee would be reflected in its reporting under AASB 1050 Administered Items.

Alternatively, the NSW Ministry of Health would be acting as a principal under a delegation of powers from the Minister as the department or an official of the department exercises their own discretion, not subject to specific direction by the Minister. In this instance, the NSW Ministry of Health should report its activities in relation to the investee as its own transactions. The NSW Ministry of Health would need to assess whether the delegated powers give it the current ability to direct the relevant activities of the investee and whether the other control criteria are satisfied in deciding whether the department controls the investee and should consolidate it. An example of this are statutory health corporations. For chief executive governed statutory health corporation ("SHC") as an example, the chief executive is subject to the control and direction of the Secretary of NSW Health. The day to day relevant activities are managed and controlled by the Chief Executive. In this instance, the chief executive governed statutory health corporation is consolidated as the NSW Ministry of Health is deemed to have control over the SHC.

Example 18.5: Statutory authority established under the health legislation

A statutory authority is established under the Health Services Act 1997. The statutory authority has a governing council that oversees the authority's operations and is responsible for its day to day operations. The Minister of Health appoints the authority's governing council and, subject to the Minster's approval, the authority's governing council appoints the chief executive of the authority.

The NSW Ministry of Health in this instance acts as a manager for the NSW public health system. This role includes:

- *Strategic leadership, such as the development of State-wide health service plans*
- *Directions for the delivery of health services, such as entering into service agreements, capital works approval and management of State-wide industrial relations, including employment terms and conditions for the authority's employees and*
- *Monitoring of performance of the authority and taking remedial action when performance does not meet specified performance measures*

The Minister's approval is specifically required for the following major decisions:

- *Entering into service agreements with the authority*
- *Issuing binding health service directives*
- *Finalisation of state-wide health service plans and capital works*
- *Employment and remuneration of the authority's executive staff*

How should the above be accounted for?

The NSW Ministry of Health in this instance is acting as an agent of the State Health Minister in relation to the statutory authority. This is evident from the restricted decision-making authority held by the NSW Ministry of Health. The NSW Ministry of Health does not control the statutory authority.

As the State Health Minister appoints the statutory authority's governing council and approves the major decisions affecting the authority's activities, the Minister has the power to direct the relevant activities of the authority. Assuming that the other control criteria (variable returns and link between power and returns) are satisfied, as would be expected, then the Minister would control the statutory authority. As a result, the statutory authority would not be consolidated by the NSW Ministry of Health, but would be consolidated directly into the whole of government general purpose financial statements.

Example 18.6: Delegation of power by the Minister

Assuming the facts are the same as in Example 18.5 above except that

- *The Minister has delegated the power to appoint members of the statutory authority's governing council to the Secretary of the NSW Health*
- *The appointment of the authority's chief executive by the governing council does not require Ministerial approval*
- *The Minister has delegated the power to approve the major decisions to the Secretary of the NSW Health and*
- *Assessments of the Ministry's performance encompass the performance of the statutory authority*

How should the above be accounted for?

In this example, the scope of the decision-making authority held by the NSW Ministry of Health has increased significantly as a result of the delegations by the Minister to the Secretary of the NSW Health. As the Ministry acts as a principal under the delegations, the NSW Ministry of Health has the current ability to direct the relevant activities of the authority so as to achieve the health service objectives of the NSW Ministry of Health. As the NSW Ministry of Health also has the ability to use its power over the authority to affect the nature and amount of the NSW Ministry of Health's returns, the NSW Ministry of Health controls the statutory authority.

AASB 10.19-21, B86-B93

The NSW Ministry of Health would consolidate the statutory authority into its consolidated financial statements. The NSW Ministry of Health's consolidated financial statements would then be consolidated into the whole of government financial statements.

18.4.5 Consolidated financial statements

The NSW Ministry of Health prepares consolidated financial statements since it meets the definition of a group.

The group is defined as a parent and its subsidiaries under AASB 10. The annual report of the NSW Ministry of Health should be presented as a single economic entity. The consolidation process involves the parents and its subsidiaries being combined, using uniform accounting policies for similar transactions and by adding together like items of assets, liabilities, equity, income and expenses.

18.4.6 Loss of control

AASB 10.25-26, B97-B99

An investor loses control of an investee (the subsidiary) when it no longer has the power to direct the investee's relevant activities and hence loses the ability to vary its returns. The NSW Ministry of Health or the Health entity may lose control where an entity was dissolved under legislation.

In the instance where there is a loss of control, the NSW Ministry of Health or the Health entity would be required to de-consolidate the investee from the date when it loses control. The NSW Ministry of Health or the Health entity is required to continuously assess whether it has control over its investees.

Accounting for loss of control

A subsidiary's income and expenses should be included in the consolidated financial statements until the NSW Ministry of Health or the Health entity ceases to control the subsidiary. When an entity ceases to be a subsidiary, the NSW Ministry of Health or the Health entity may retain an ownership interest and the entity might still be treated as an associate or be subject to a joint arrangement. For the accounting of this refer to Chapter 19 of this policy document.

The loss of control of a subsidiary results in recognising a gain or loss on the sale of the subsidiary.

Where the NSW Ministry of Health or the Health entity loses control of a subsidiary it:

- De-recognises any assets and liabilities of the subsidiary at their carrying amounts at the date when control is lost.
- De-recognises the carrying amount of any non-controlling interest at the date when control is lost (including any components of accumulated other comprehensive income attributable to it).
- Recognises any investment retained in the former subsidiary at its fair value at the date when control is lost.
- Reclassifies to income or transfers directly to retained earnings, the amounts recognised in other comprehensive income in relation to that subsidiary.
- Recognises any resulting difference as a gain or loss in the income statement attributable to the parent.

If the NSW Ministry of Health or the Health entity expects that it will sell or lose control of a subsidiary, then this will trigger the need to test the subsidiary's assets for impairment. If the assets are impaired, the impairment loss should be recognised in the income statement. Refer to Chapter 11 of this policy document.

19 Associates and joint arrangements

19.1 Scope

19.1.1 Applicability

This Policy provides guidance on applying the equity method when accounting for investments in associates and joint ventures.

19.1.2 Relevant guidance

This policy should be read in conjunction with the following guidance:

- *AASB 128 Investments in Associates and Joint Ventures*
- *AASB 5 Non-current Assets Held for Sale and Discontinuing Operations*
- *AASB 9 Financial Instruments*

19.2 Overview and purpose

The purpose of this document is to provide Health entities with illustrative guidance on accounting for investments in an associate or joint venture.

19.3 Policy Statement

AASB 128.5-9

An associate is an entity in which the Health entity has invested in and has significant influence over. Generally, if the Health entity holds 20 per cent or more of the voting power of the investee it is presumed to have significant influence. However, significant influence by the Health entity may also be evidenced by:

- Representation on the board of directors (or equivalent governing body) of the investee
- Participation in policy-making processes, including participation in decisions about dividend or other distributions
- Material transactions between the Health entity and its investee
- Interchange of managerial personnel
- Provision of essential technical information.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement.

TPG23-04

Under AASB 128 there are exemptions from applying the equity method, however NSW Treasury mandates the equity method must be used to account for a Health entity investment in an associate or joint venture (TPG23-04).

19.4 Application guidance

19.4.1 Recognition under the equity method

On initial recognition the investment in an associate or a joint venture is recognised at cost, and the carrying amount is increased or decreased to recognise the Health entity's share of the profit or loss of the investee after the date of acquisition. This share of the profit or loss of the investee is recognised in the Health entity's profit or loss.

Distributions received from an investee reduce the carrying amount of the investment. Adjustments to the carrying amount may also be necessary for changes in the Health entity's proportionate interest in the investee arising from changes in the investee's other comprehensive income, for example the revaluation of property, plant and equipment or from foreign exchange translation differences.

AASB 128.26-39

Comprehensive equity method procedures are detailed in AASB 128 paragraphs 26-39.

The investment in an associate or joint venture is classified as a non-current asset, unless the investment or portion of the investment is classified as held for sale. See Chapter 8.4.2 for guidance on investments classified as held for sale.

19.4.2 Classification as held for sale

HEALTH ENTITIES will also apply AASB 5 to an investment, or portion of an investment, in an associate or joint venture that meets the criterial to be classified as held for sale under paragraphs 6-14. We note that this is not very common for Health entities.

Any retained portion of an investment or joint venture is accounted for using the equity method until disposal of that portion takes place. After disposal takes place, the Health entity will account for any retained interest in the associate or joint venture in accordance with AASB 9, unless the retained interest continues to be an associate or joint venture. In which case the Health entity uses the equity method.

If an investment, or portion of investment, in an associate or joint venture previously classified as held for sale no longer meets the criteria in AASB 5 paragraphs 6-14, the Health entity will account for the investment using the equity method retrospectively as from the date of its classification as held for sale.

19.4.3 Discontinuing the use of the equity method

The Health entity discontinues the use of the equity method from the date its investment ceases to be an associate or joint venture, i.e. the Health entity no longer has an investment or significant influence over the associate or joint venture.

- If the investment becomes a subsidiary, the Health entity accounts for its investment in accordance with AASB 3 and AASB 10.
- If the retained interest in the former associate or joint venture is a financial asset, the Health entity measures the retained interest at fair value in accordance with AASB 9.

19.4.4 Impairment losses

After the application of the equity method, the Health entity must determine whether there is any objective evidence that the net investment in the associate or joint venture is impaired. Objective evidence that the net investment is impaired includes observable data that comes to the attention of the Health entity about the following loss events:

- significant financial difficulty of the associate or joint venture
- a breach of contract, such as a default or delinquency in payments by the associate or joint venture
- the Health entity, for economic or legal reasons relating to its associate's or joint venture's financial difficulty, granting to the associate or joint venture a concession that the entity would not otherwise consider
- it becoming probable that the associate or joint venture will enter bankruptcy or other financial reorganisation
- the disappearance of an active market for the net investment because of financial difficulties of the associate or joint venture

The Health entity will apply AASB 128 paragraphs 41A-41C to determine evidence of impairment. If evidence of impairment exists, the impairment guidance in AASB 136 Impairment of Assets is applied.

20 Related party transactions

20.1 Scope

20.1.1 Applicability

This Policy applies to the identification and required disclosure as a consequence of related parties or related party transactions within NSW Health.

20.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- *AASB 124 Related Parties*
- *TPG23-16 Related party disclosures*

20.2 Overview and purpose

The purpose of this document is to provide the Health entities with illustrative guidance on:

- Identification of related parties
- Related party transactions
- Disclosures pertaining to related parties
- Key Management Personnel ("KMP")

The identification and disclosure of related parties must meet the accounting guidelines as described in NSW Treasury's Policy and Guidelines TPG23-16 Related Parties which is based on Australian equivalents to International Financial Reporting Standards (AIFRS).

20.3 Policy statement

This policy requires management to consider qualitative and quantitative aspects in determining whether a related party transaction is material for disclosure. For practical reasons this policy has determined certain transactions are unlikely to be material.

20.4 Application guidance

20.4.1 Identifying related parties

AASB 124.9

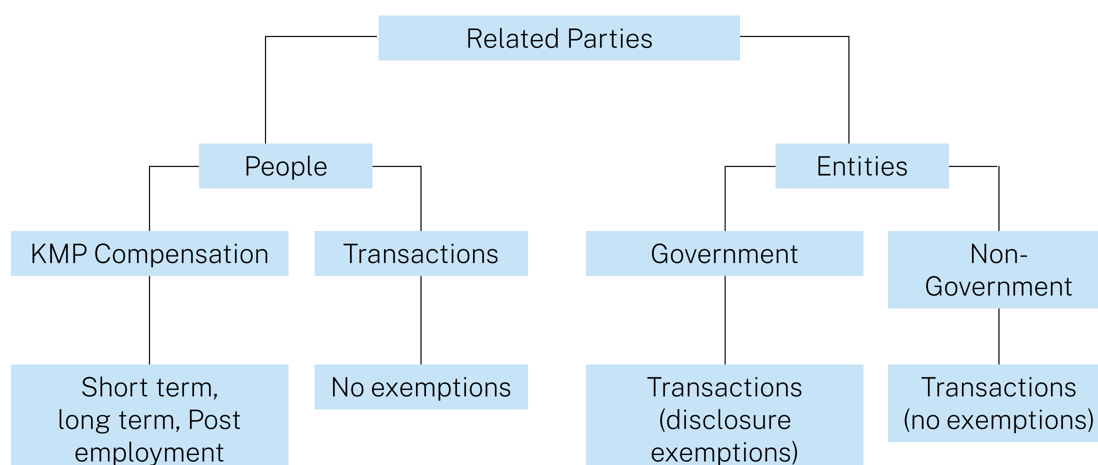
A related party is a person or entity that is related to the entity that is preparing its financial statements. The definition of the related party includes

- A person or a close family member of that person who:
  - Has control, joint control or significant influence over the reporting entity
  - Is a KMP of the reporting entity or
  - Is a KMP of a parent of the reporting entity
- An entity (government or non-government) is related to a reporting entity if it is:
  - A member of the same group (ie parent, subsidiary and fellow subsidiaries
  - An associate or joint venture of the reporting entity or of a member of a group of which the reporting entity is a member
  - A fellow joint venture of the same third party
  - A fellow associate of the same third party
  - A post-employment benefit plan for the benefits of the employees of the reporting entity or an entity related to the reporting entity
  - Controlled or jointly controlled by a person (or close family member of that person who:
    a) Has control or joint control of the reporting entity
    b) Has significant influence over the reporting entity or
    c) Is a KMP of the reporting entity or the parent of the reporting entity
- Providing KMP services to the reporting entity, or to the parent of the reporting entity, or is a member of a group providing such services

Key Definitions:

Terminology	Definition
Control	Control has the same meaning as "An investor controls an investee when it is exposed, or has rights, to variable returns from its involvement with the investee and has the ability to affect those returns through its power over the investee. "Power" in this context is the current ability to direct the activities that significantly influence returns.
Joint Control	Joint control is the contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control.
Significant influence	The power to participate in the financial and operating policy decisions of an entity, but is not control or joint control of those policies.
Close family members	Close family members of a person are those family members who might be expected to influence or be influenced by, that person in their dealings with the entity. They include: • The person's children and spouse or domestic partner • Children of the person's spouse or domestic partner • Dependants of the person or the person's spouse or domestic partner.

The below diagram summarises the identification of the related parties as follows:



An updated list of government related entities will be circulated to Heath Entities on an annual basis. Refer to Appendix A for the link to a related party list.

20.4.2 Related party transactions

AASB 124.9

Related party transaction is a transfer of resources, services or obligations between a reporting entity and a related party, regardless of whether a price is charged.

Examples of related party transactions:

- Purchases or sale of goods, property and other assets
- Rendering or receiving of services
- Leases
- Transfers of research and development
- Transfers under licence agreements and finance arrangements
- Provision of guarantees or collateral
- Commitments and executory contracts
- Settlement of liabilities on behalf of the entity or by the entity on behalf of that related party

Example 20.1: Identification of related parties and related party transactions

Mr L is the Minister of NSW Health. Mrs L is Mr L's wife and is the sole director of Entity A. Entity A is an external consulting firm that provides employment resources to public sector entities.

NSW Health had entered into an annual recurring contract with Entity A for the provision of temporary staff. The annual fee payable to Entity A is between $90,000 and $120,000. The contract with the Department represents 50% of Entity A's annual revenue.

What Related party considerations are there from this situation?

Mr L is the Minister of NSW Health and therefore should be regarded as a KMP as the Minister has the authority and responsibility for planning, directing and controlling the activities of NSW Health. MR L's role is akin to that of a director in a company as he discharges his role and responsibilities regarding the Department and is ultimately responsible for the performance of the Department.

Mrs L is the Minister's wife and should be regarded as a close family member of the KMP.

Entity A is a related party as the Minister's wife is the sole director of Entity A and can therefore be assumed that she has control of entity A.

The related party transaction is identified as the provision of $90k to $120k of employment resources by Entity A to NSW Health since there is a transfer of services and resources between NSW Health and Entity A.

As this is a recurring contract, the total contract value could be worth more than $120k and the following consideration should be made:

- *Whether the transaction is an arm's length transaction*
- *If awarding of the contract was subject to an open tender process*
- *Closeness of the relation – however given husband and wife, this would be considered as qualitatively material*

Disclosure requirements:

The partial disclosure exemptions does not apply to KMP (as they are individuals), their CFM (as they are individuals) or to related parties and hence the following should be disclosed (refer to 20.8.3 below):

- *Name and nature of the relationship with Entity A*
- *Details of balances due to Entity A at balance sheet date, including any provision for bad and doubtful debts*

20.4.3 Related party disclosures

The NSW Ministry of Health or the Health entity must disclose all material transactions and outstanding balances with related parties during the reporting period. Hence, all material related party transactions should be disclosed irrespective of whether a price is charged. Further a transaction might be regarded as immaterial to the NSW Ministry of Health or the Health entity but material to the related party. The NSW Ministry of Health or the Health entity should therefore disclose related party transactions that are material to either the NSW Ministry of Health or the Health entity or the related party or both.

Small transactions entered into by a KMP (refer to section below) should be aggregated to determine whether they are material from the KMP's point of view. They should be disclosed if they are material when aggregated.

AASB 124. BC17, IG11

Materiality considerations

Disclosure of related party transactions is required only if the transactions are material

- Qualitative vs quantitative disclosures
- Judgement is required to determine whether transactions are material
- Immaterial transactions which are a result of public service provider/tax paper relationship are excluded from disclosures
- For government-related entities, judgement is required to determine individually significant transactions v collectively significant transactions
- Level of aggregation

Materiality considerations for government-related entities (in determining if transaction is individually significant):

Factors to consider when determining if the transaction is individually significant:

- Closeness of related party relationship
- Significant in terms of size
- Carried out on non-market terms
- Outside normal day-to-day business operations
- Disclosed to regulatory or supervisory authorities
- Reported to senior management
- Subject to shareholder approval

Disclosure requirements

The disclosure requirements differ between related party transactions with non-government related entities, and related party transactions with government related entities.

Related party transactions and outstanding balances, including commitments, are exempt from disclosure where they are with:

- A government that has control, joint control or significant influence over the reporting entity and
- Another entity that is a related party because the same government has control, joint control or significant influence over both the reporting entity and the other entity

"Government" is defined as "government, government agencies and similar bodies whether local, national or international". Government-related entities are those that are controlled, jointly controlled or significantly influenced by a government.

The disclosure requirements are outlined as follows:

Disclosure requirements	Non-Government entities	Government related entities
Name of the related party	Yes	Yes – name of the government
Nature of the related party relationship	Yes	Yes
Amount of the transaction	Yes	Yes
Amount of outstanding balances including commitments and: • Their terms and conditions including whether they are secured, and the nature of the consideration to be provided in settlement and • Details of any guarantees given or received	Yes	Yes – the nature and amount of each individually significant transactions and for other transactions that are collectively, but not individually significant, a qualitative or quantitative indication of their extent
Provisions for doubtful debts related to the amount of outstanding balances	Yes	No
Expense recognised during the period in respect of bad or doubtful debts due from related parties	Yes	No
Relationship between parent and subsidiaries regardless of whether there have been transactions between them	Yes	No
Name of reporting entity's parent	Yes	No
Name of reporting entity's ultimate controlling party (i.e. NSW Government)	Yes	No

The above disclosures should be made separately for each of the following categories:

- The parent
- Entities with joint control of, or significant influence over the entity
- Subsidiaries
- Associates
- Joint ventures in which the entity is a joint venturer
- Key management personnel of the entity or its parent and
- Other related parties

Disclosure requirements – transactions that are in common with the general public

Transactions that are in common with the general public in the course of delivering an entity's public service objectives and that are entered into under the same terms and conditions as a public citizen are unlikely to require disclosure. Examples of these include:

- Paying taxes, stamp duty, levies, fines or any other statutory charges
- Receiving tax refunds or rebates
- Using public services (such as public swimming pools, schools, hospitals, transport etc.)
- Payments for electricity, water and utility services
- Renewing licences and registrations

Due to the nature of related party transactions, more weight is given to qualitative factors of the transactions such as the closeness of the related party relationship in establishing the level of significance of the transaction.

Example 20.2: Transactions which are common with the public or trivial in nature

Which of the following transactions are common with the public or trivial in nature?

- *Grant of licence to private health facilities*
- *Sale of a property to NSW Government*
- *Medicare rebates*
- *Payment of water rates*
- *Maternity leave compensation paid to the Chief Executive for a local health district*

How should the above be accounted for in the identification of related parties?

The grant of licence to private health facilities is regarded as a transaction which is available to the general public and no disclosure is required. The sale of a property to NSW Government may require disclosure and consideration need to be made as to whether the transaction occurred on terms and conditions applying to the general public (ie was it available to all and whether the consideration paid was at market value?) If not, then this would be considered material in nature and a related party transaction which should be disclosed.

Payment of water rates is not required to be disclosed as the transaction is available to the general public.

The payment of maternity leave to the Chief Executive is a related party transaction and should be disclosed in the financial statements in accordance with the KMP compensation requirements. (refer to 20.4.4 below)

A list of common transactions with suggested disclosures within NSW Health have been circulated to Health entities for reference.

20.4.4 Key Management Personnel

AASB 124. 9, IG3-IG6

RA KMP is a person who has the authority and responsibility for planning, directing and controlling the activities of the reporting entity, directly or indirectly, including any director (whether executive or otherwise).

Director means a person who is a director under the Corporations Act 2001; and in the case of entities governed by bodies not called a board of directors, a person who, regardless of the name that is given to the position, is appointed to the position of a member of the governing body, council, commission or authority.

The Secretary of NSW Health, and the Chief Executives of local health districts, specialty networks, statutory health corporation and the Health Administration Corporation are considered to the KMP. In most circumstances, the Health Portfolio Ministers are likely to be a KMP of the entities within their portfolio. Entities with more than one responsible Minister will need to assess the facts and circumstances to determine whether both Ministers are KMP of that entity.

These are explored further as follows:

Related parties in the NSW public sector	Considerations
Chief Executives	The day to day activities of departments and statutory departments managed by the Chief Executive, or the NSW Health executive team would be considered KMP of their respective local health districts, specialty networks, or statutory health corporations as they have direct authority and responsibility to plan, direct and control the activities. The NSW Ministry of Health will need to assess on a case by case basis whether these department heads' authority extends to other agencies within the Health cluster.
Minister	The Portfolio Minister is likely to be a KMP of agencies that are controlled by the NSW government within their portfolio. This is because they usually have the authority and responsibility for planning, directing and controlling, directly or indirectly the activities of Specialty Health Networks, Board-governed organisations and Chief Executive-governed organisations. Some agencies may have more than one responsible Minister –in such cases, those agencies will need to assess the facts and circumstances to determine whether one, both or neither Ministers are KMP of their agency.
The Premier	Although the Premier has the power to allocate agency portfolios to Ministers and appoint and remove Ministers, it is the Health Ministers who have the overall responsibility to make decisions in relation to their agencies under legislation. Ministers' powers arise from legislation rather than delegation from the Premier. Therefore Health Ministers are considered principal decision makers over their responsive portfolio and the Premier is not considered to be a KMP of agencies outside of their portfolio.
Cabinet Members	NSW Cabinet's role is to direct overall government policy and make decisions about State issues. NSW Cabinet as a group, comprising of all NSW Ministers and the Attorney General, makes decisions collectively. Having regards to NSW Cabinet's powers and structure, all members are considered KMP of the State. Cabinet members are related parties of every State-controlled entity (ie including the NSW Ministry of Health).

Related parties in the NSW public sector	Considerations
Expenditure Review Committee	The role of the Expenditure Review Committee ("ERC") is to assist the Cabinet and the Treasurer in: • Framing the fiscal strategy and the Budget for Cabinet's consideration • Driving expenditure controls within agencies and monitoring financial performance • Considering proposals with financial implications brought forward by Ministers. ERC does not have final decision making authority and hence its members are not considered to be a KMP.

Based on the assessment made on the terms of reference of health entities' leadership team's authority and responsibility, The NSW Ministry of Health has determined the following persons are Key Management Personnel of NSW Health Entities:

NSW Ministry of Health	HAC (consolidated)	HAC divisions
• Minister for Health • Secretary • Deputy Secretaries	• Minister for Health • Secretary • Chief Executives of divisions	• Minister for Health • Secretary • Chief Executive

LHDs & Specialty Networks	Pillars	Employment Divisions
• Minister for Health • Secretary • Deputy Secretaries • Chief Executive • All members of a statutory board	• Minister for Health • Secretary • Deputy Secretaries • All members of a statutory board, including the Chief Executive [ACI, BHI, CEC and Cancer Institute] • Chief Executive [HETI]	• Secretary • Chief Executive of the associated Health entity

Please Note: Tier 2 Directors are not considered KMP of the Health Entities

KMP Compensation – Disclosure Requirements

The NSW Ministry of Health or the Health entity is required to disclose the KMP compensation in aggregate for each of the following categories:

- Short-term employee benefits
- Post-employment benefits
- Other long-term benefits
- Termination benefits
- Share-based payment

KMP compensation includes all forms of consideration paid, payable or provided by the entity, or on behalf of the entity, in exchange for services rendered to the entity. If a person became a KMP of a reporting entity during a reporting period, no disclosure is required for any remuneration paid to that person before that person's appointment as KMP. If a person ceases to be a KMP during a reporting period, the entity is required to disclose that person's compensation for the period until cessation.

Short term employee benefits includes monetary (such as salaries and wages) and non-monetary benefits. Examples of non-monetary benefits are private health insurance, housing, cards, and free or subsidised goods or services. Reimbursement of business related expenses is not compensation. For example – flights and travel expenses to attend a business meeting is not a compensation, however a benefit provided to a KMP that is personal in nature is considered compensation. In cases of defined benefit superannuation plans, the defined benefit expense relating to KMP should be disclosed as part of post-employment benefits. This could be calculated as the proportion of the defined benefit obligation assigned to KMP as a percentage of the total defined benefit obligation, applied to the expense recognised for the period.

Other long-term benefits include long service leave, in accordance with AASB 119.

Examples of KMP compensation and categories:

Category	Examples
Short-term employee benefits	• Directors' fees • Cash salaries of the KMP • Visiting Medical Officer and Staff Specialist Payments • Bonuses, profit share, commission, incentive payments (payable within 12 months of reporting period end) • Payment for consulting services not related to the management of the group • Club membership fees (unless business expenses) • Private insurance premiums paid, including indemnity insurance (during employment) • Use of entity services or property for private purposes • Staff Specialists' Training, Education and Study Leave (TESL) payments • Expatriate package cost • Goods and services provided • Annual and sick leave entitlements • Motor vehicle provided for private use • Personal expense payments
Post-employment benefits	• Private insurance premiums paid, including indemnity insurance (post-employment) • Long service leave, sabbatical, jubilee, disability • Expense associated with superannuation benefits • Payments made by a superannuation fund • Other retirement benefits • Payment of retirement benefits previously disclosed when accrued
Other long-term benefits	• Bonuses, profit share, commission, incentive payments (payable later than 12 months after reporting period)
Termination benefits	• Redundancy payments • Ex-gratia payments • Any compensation for loss of office
Share-based payments	• Share options issued to KMP in respect of services to the entity

AASB 124.9

Close family members of KMP

A close family member of KMP of the entity or of a parent of the entity or of any person that controls, or has joint control or significant influence over the entity is a related party of the entity.

Close family members include:

- That person's children and spouse or domestic partner;
- Children of that person's spouse or domestic partner; and
- Dependents of that person or that person's spouse or domestic partner

The above is not exhaustive and it is necessary to consider whether there are any other family members who may be expected to influence or be influenced by the person in their dealings with the entity.

Example 20.3: Identification of close family members

The Chief Executive of a local health district is a key management personnel. The Chief Executive's family comprises of his sibling, partner (not co-habiting), ex-wife (co parenting and receiving support payments), grown up children who are financially independent, cousins, parents of his partners and in-laws that live in a house owned by the Chief Executive, as well as children who are minors.

What Related party considerations are there from this situation?

The sibling is not regarded as a close family member unless the sibling is expected to influence or be influenced by the KMP in their dealings with the entity. Partner and ex-wife may be regarded as a close family member if they are regarded as being financially dependent on the Chief Executive. Both the grown up children, and the children who are regarded as minors are regarded as close family members. The parents of the Chief Executive partner and the Chief Executive's cousins are unlikely to be regarded as a close family member – unless they are financially dependent on the Chief Executive. The in-laws that live in a house owned by the Chief Executive may possibly be regarded as a close family member if they are financially dependent.

The below factors are relevant in considering whether the person is regarded as a close family member of the KMP:

- *Does the person live under the same roof as the KMP*
- *Is the person financially dependent on the KMP*
- *Does the person engage in business relations with the KMP*
- *Does the relationship between the person and the KMP lend itself to either party having influence over each other*

21 Foreign currencies

21.1 Scope

21.1.1 Applicability

This Policy applies to the accounting treatment for transactions and balances in foreign currencies and provides guidance on translating the NSW Health's results and financial position into a presentation currency.

21.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- *AASB 121 Foreign Currencies*
- *TPG23-04 Mandates of options and major policy decisions under Australian Accounting Standards*

21.2 Overview and purpose

The purpose of this document is to provide Health entities with illustrative guidance on the following as required under the accounting standard *AASB 121 Foreign Currencies* for general purpose financial reporting:

- Accounting for transactions and balances in foreign currencies
- Translating the NSW Health's results and financial position into a presentation currency

21.3 Policy statement

Foreign currency is defined as a currency other than the functional currency. Under the requirements of this policy, the health entity is required to determine its functional currency and measure its results and financial position in that currency.

21.4 Application guidance

21.4.1 Functional currency

AASB 121.9-14

The NSW Health is required to determine its functional currency and measure its results and financial position in that currency. With respect to the consolidated accounts, the functional currency is determined at the level of each entity within a group. It follows that different entities within a group could have different functional currencies.

The following indicators would need to be considered by the NSW Health in determining its functional currency:

Primary indicators	Factors to be considered by the NSW Health in determining the functional currency
Sales and cash inflows	a) The currency that mainly influence the sales price for its goods and services. This will often be the currency in which sales price for goods and services are denominated and settled. b) The currency of the country whose regulations mainly determine the sales prices of its goods and services. Where sales prices of the entity's products are determined by local government regulations, then the currency of the country of operation is likely to be the functional currency.
Expenses and cash outflows	The currency that mainly influences labour, material and other costs of providing goods and services. This is often the currency in which such costs are denominated and settled.

Secondary indicators of functional currency:

Secondary indicators	Factors to be considered by the NSW Health in determining the functional currency
Financing activities	The currency in which funds from financing activities are generated.
Retention of operating income	The currency in which receipts from operating activities are usually retained. This is the currency in which the entity maintains its working capital balance.

Taking into consideration the above indicators, the NSW Health's functional currency is the currency of the primary economic environment in which the entity operates. Given that the NSW Ministry of Health and its controlled entities operates in the Australian economic environment, the functional currency will be in Australian dollars.

Given that the NSW Health does not have a foreign operation, no additional factors are considered necessary in determining the functional currency.

Once the functional currency of the NSW Health is determined, it should be used consistently, unless changes in economic facts, events and conditions indicate that the functional currency has changed.

A change in functional currency should be accounted for prospectively from the date of change. In the rare instance where there is a change in functional currency, the NSW Health should translate all items (including balance sheet, income statement and statement of comprehensive income items) into the new functional currency, using the exchange rate at the date of change. As all items are translated using the exchange rate at the date of change, the resulting translated amounts for non-monetary items are treated as their historical cost.

21.4.2 Foreign currency transactions – initial recognition

AASB 121.20-22

A foreign currency transaction is recorded, on initial recognition, at the spot exchange rate between the functional currency and the foreign currency at the date of the transaction. This process is known as 'translation'.

The date of transaction is the date on which the transaction first qualifies for recognition in accordance with AIFRS. For revenues, expenses, gains and losses, the spot exchange rate at the dates on which those elements are recognised should be used. However where this is not practical, the Health entities may use a rate that approximates to the actual rate (such as an average rate).

21.4.3 Foreign currency transactions – subsequent measurement

A foreign currency transaction might give rise to assets and liabilities that are denominated in a foreign currency. The procedure for translating such assets and liabilities into the functional currency of AUD at each balance sheet date will depend on whether they are monetary or non-monetary.

Translation of monetary items

Monetary items are units of currency held, and assets and liabilities to be received or paid in a fixed, determinable number of units of currency. Examples of monetary items include the following:

- financial assets, such as cash, bank balances and receivables
- financial liabilities such as debt
- provisions that are settled in cash
- pension and other employee benefits to be paid in cash

The Health entity is required to translate foreign currency monetary items outstanding at the end of the balance sheet date using the closing rate. The closing rate is the spot exchange rate at the balance sheet date. An exchange rate that is fixed under the terms of the relevant contract cannot be used to translate monetary assets and liabilities.

Translation of non-monetary items

Non-monetary items are all items other than monetary items. The right to receive (or an obligation to deliver) a fixed or determinable number of units of currency is absent in a non-monetary item. Examples of these include the following:

- intangible assets
- property, plant and equipment
- inventories
- amounts prepaid for goods and services
- provisions that are to be settled by the delivery of a non-monetary asset

For assets measured at fair value such as specialised assets or infrastructure assets, these assets are translated using the exchange rates at the date when the fair value was determined. Changes in fair value include foreign exchange differences arising on the re-translation of the opening foreign currency fair value.

Recognition of exchange differences – monetary items

Exchange differences arising on the settlement of monetary items, or on translating monetary items at rates different from those at which they were translated on initial recognition during the period or in previous financial statements, are recognised in profit or loss in the period in which they arise.

Recognition of exchange differences – non-monetary items

When a gain or loss on a non-monetary item is recognised directly in other comprehensive income, any exchange component of that gain or loss is recognised directly in other comprehensive income. This would apply to non-current assets measured at fair value as per Chapter 10 of this policy document.

When a gain or loss on a non-monetary item is recognised in profit or loss, any exchange difference is recognised in the profit or loss.

21.4.4 Presentation currency

As per the TPG23-04 Mandates of options and major policy decisions under Australian Accounting, it is a requirement for the NSW Health to prepare the financial statements using the Australian Dollars as the presentation currency. Given that the functional currency of the NSW Ministry of Health and its controlled entities is in Australian dollars (as per Chapter 21.4.1 of this policy document), no additional translation methodology would apply in translating from a different functional currency to the presentation currency.

22 Contributions by owners made to wholly-owned Public Sector Entities

22.1 Scope

22.1.1 Applicability

This Policy applies to the transfer of assets and/or liabilities between wholly-owned public sector entities. It establishes the criteria for determining whether transfers satisfy the definition of ‘contributions by owners.

22.1.2 Relevant guidance

This Policy should be read in conjunction with the following guidance:

- *TPP21-08 Contributions by owners made to wholly-owned Public Sector Entities*
- *AASB 1004 Contributions by owners*
- *AASB 1058 Income of Not-for profit entities*

22.2 Overview and purpose

AASB 1058.5 & 9

Contributions by owner is defined in AASB 1058 as future economic benefits that have been contributed to the entity by parties external to the entity, other than those which result in liabilities of the entity, that give rise to a financial interest in the net assets of the entity which:

a) conveys entitlement both to distributions of future economic benefits by the entity during its life, such distributions being at the discretion of the ownership group or its representatives and to distributions of any excess of assets over liabilities in the event of the entity being wound up; and/or

b) can be sold, transferred or redeemed

Entities considered to be ‘wholly owned’ by the NSW Ministry of Health are those that are ‘controlled’ by the NSW Ministry of Health for financial reporting purposes. For an understanding of the concept of control, refer to Chapter 18 of this policy document.

Contributions by owners is separate to other contributions. For other contributions refer to Chapter 16 of this policy document.

This policy is consistent with TPP21-08 Contributions by owners made to wholly-owned Public Sector Entities.

Entities controlled by the NSW Ministry of Health in scope

Non-reciprocal transfers between those entities controlled by the NSW Ministry of Health are to be accounted for as contributions by/distributions to owners by the transferor and the recipient.

For the purpose of this policy document the following entities are considered to be controlled by the entity

- Local health districts
- Sydney Children's Hospital Network
- Justice Health and Forensic Mental Health Network
- Clinical Excellence Commission
- Bureau of Health Information
- Agency for Clinical Innovation
- Health Education and Training Institute
- Cancer Institute NSW
- Albury Base Hospital
- Albury Wodonga Health Employment Division
- Graythwaite Trust
- Health Administration Corporation

It should be noted that the affiliated health organisations are not controlled by the NSW Ministry of Health and as such, any transactions between the NSW Ministry of Health and the affiliated health organisations are considered to be, and are accounted for, as transactions with a party external to the NSW Ministry of Health and hence does not fall within the scope of this chapter.

22.3 Policy Statement

This policy requires the NSW Ministry of Health to apply judgement as to whether the transfer of assets or liabilities from another agency results in a contribution by owners or distribution to owners and whether these meet the pre-approved designation. Where the designation could not be determined, the NSW Ministry of Health is required to obtain approval from NSW Treasury prior to the date of transfer.

22.4 Application Guidance

22.4.1 Transfer of assets or liabilities

Transfers of assets and/or liabilities are either reciprocal or non-reciprocal. A-non reciprocal transfer is where a recipient and transferor directly assume/transfer assets and/or liabilities without giving/receiving approximately equal value in exchange. Asset and/or liability transfers as a consequence of machinery of Government changes are examples of non-reciprocal transfers.

Whether a transfer of an asset is voluntary (ie at the discretion of the NSW Ministry of Health) or involuntary (arising from a machinery of Government change), is irrelevant when determining the appropriate accounting treatment.

Transfers of assets and/or liabilities are contributions by owners and distributions to owners and are accounted for against equity. Refer to Chapter 22.4.2 below for the accounting treatment.

22.4.2 Criteria for transfers to be adjusted within equity

Any non-reciprocal transfer of assets and/or liabilities (including a net liability position) to another wholly-owned NSW Health entity is to be treated as a contribution by owners and accounted for directly against equity only if the following criteria are met:

- The Government has made a deliberate policy decision to either increase or decrease the financial resources of a public sector entity; and
- The transaction is undertaken at other than fair value consideration; and
- The transfer of assets/liabilities are formally designated in terms of AASB Interpretation 1038, in the following circumstances:
  - Transfers effected by Public Sector Employment and Management Orders
  - Corporatisations
  - Establishment of new statutory bodies
  - Transfers of programs/ functions between entities
  - Transfers of assets/liabilities associated with parts of programs/functions due to reassessment of use by the Government ‘equity appropriations’
  - Other transfers to adjust an entity’s capital structure
  - Other transfers with a Government controlled parent entity.

If the NSW Ministry of Health is of the view that other contributions (not pre-designated above) are in the nature of a contribution by owners, or is unclear whether a transfer falls into one of the pre-designated categories above, the NSW Ministry of Health should approach NSW Treasury for designation on a case by case basis before the transfer.

Further details on the designation outlined below:

Designation	Comment
Transfers effected by Public Sector Employment and Management Orders	Refers to restructure of entities that are effected by way of Public Sector Employment and Management Order. These orders are used to transfer functions between entities, establish or abolish entities or remove or add branches to entities.
Corporatisations	Corporatisations are authorised by an Act of Parliament. They may involve the transfer of an entire business undertaking to a new statutory State Owned Corporation (SOC) or some segmens of the transferor entity's operations may remain while other segments are transferred to one or more new SOCs.
Establishment of new statutory bodies	The establishment of a new statutory body is usually authorised by an act of Parliament and generally arises from a restructuring/reallocation of functions between statutory bodies or departments.
Transfers of programs/ functions between entities	This refers to transfers of individual programs/functions between public sector entities mandated by the Government that are not included under any of the preceding categories.
Transfers of assets/ liabilities associated with parts of programs/functions due to reassessment of use by the Government	The Government may mandate the transfer of assets/liabilities between public sector entities due to re-assessment of the use of those assets/liabilities by the Government. Such transfers include transfers of parts of programs or functions, including individual assets or liabilities.
Equity appropriations	'Equity appropriations' that fund payments to adjust a for-profit entity's capital structure will be identified in the Appropriation Act and /or Budget Papers or other legislation. This will occur where equity injections (i.e. contributions by owners) are being made through an agency to a for-profit entity to adjust its capital structure. In these circumstances: • the agency recognises an equity injection on receipt of the appropriation and an equity withdrawal on payment to the for-profit entity • the for-profit entity recognises an equity injection on receipt of funds from the agency.
Other transfers with a Government controlled parent entity	This refers to transfers that take place with a Government controlled parent entity, where the transferee is wholly owned by their controlling government. A Government controlled parent entity may decide to transfer assets between its subsidiaries/controlled entities other than at fair value consideration. These types of transfers typically involve controlled entities of statutory bodies and SOCs and represent a policy decision by a parent entity to reallocate equity within its ownership group.

Other Contributions

All other contributions not required by AASB 1004 to be accounted for as contributions by owners and that are not designated above must be recognised as revenue, unless NSW Treasury provides approval to the contrary. Refer to Chapter 16 of this policy document for further guidance.

22.4.3 Restructure of administrative arrangement

A restructure of administrative arrangements is defined as the reallocation or reorganisation of assets, liabilities, activities and responsibilities amongst the entities that the government controls that occurs as a consequence of a rearrangement in the way in which activities and responsibilities as prescribed under legislation or other authority are allocated between the government's controlled entities.

The scope of the requirements relating to restructures of administrative arrangements is limited to the transfer of a business. The requirements do not apply to a transfer of an individual asset or a group of assets that is not a business.

A business is defined as an integrated set of activities and assets conducted and managed for the purpose of providing:

a) a return to investors

b) lower costs or other economic benefits directly and proportionally to policyholders or participants.

A transfer involving government controlled not-for-profit entities may still be accounted for as a contribution by owners, even where the definition for a restructure of administrative arrangement is not satisfied - however this would occur where the transfer is designated as a contribution by owners under Chapter 22.4.2 above. The accounting measurement for the restructure of administrative arrangement should be at fair value (consistent with Chapter 22.4.4 below).

22.4.4 Accounting treatment

Contributions by owners

Contributions by owners can occur upon establishment of the entity or at a subsequent stage of the entity's existence. Contributions by owners can be in the form of cash, nonmonetary assets such as property, plant and equipment or the provision of services.

Assets and/or liabilities transferred for no consideration, or for nominal consideration should generally be transferred at the amounts at which they were recognised by the transferor immediately prior to the transfer. This means, in relation to property, plant and equipment, the gross value, accumulated depreciation and accumulated impairment loss if any, may be recognised by the recipient at its carrying value. Refer to Chapter 5 of this policy document for further guidance.

Contributions by owners is accounted for as an increase in Accumulated Funds.

Distribution to owners

Distribution to owners is accounted for as a reduction in Accumulated Funds. The distribution to owners can be in the form of a transfer of assets, a rendering of services or an increase in liabilities.

Measurement principle

Contributions by owners and distributions to owners are required to be measured at fair value at the date of transfer. Any unrealised gain or loss must be recognised by the transferor.

The fair value approach requires the transferred assets and liabilities to be recognised by both the transferor and transferee at fair value to the transferee.

In most cases, the carrying amounts of the transferor's assets and liabilities will not be materially different from the fair value to the transferee, where the existing use is the same. This is due to fair value being adopted as the basis of valuation of physical non-current assets as noted in Chapter 5 of this policy document.

Where the existing use of physical assets is different between the two entities, the transferor's fair value prior to the transfer is likely to be different to the fair value of the asset recognised by the transferee. This would be the case where the fair value must be measured based on existing use, where there is no feasible alternative use - under this circumstance, the difference in value between the carrying amount previously recognised by the transferor and the fair value to be recognised by the transferee must be recognised by the transferor in its financial report immediately prior to the transfer. Any balance remaining in the asset revaluation reserve of the transferor in respect of those assets transferred must be moved to accumulated funds.

Transfer of intangibles

For intangibles acquired by way of an equity transfer, the transferee will not recognise the contributed asset at fair value in the following circumstances:

- Where the transferor entity has recognised an intangible asset at amortised cost because there is no active market. The transferee must recognise that transferred intangible asset at the transferor's carrying amount
- Where the transferor entity does not recognise an internally generated intangible, the transferee must not recognise that asset

Recognition of adjustment to equity

The NSW Ministry of Health must recognise any contributions by/distributions to owners as an adjustment to Accumulated Funds.

The entity making the transfer of assets and/or liabilities should record a decrease in its assets and/or liabilities with a corresponding decrease/increase in Accumulated Funds. Conversely, the receiving entity should recognise a matching increase in assets/liabilities with a corresponding adjustment to Accumulated Funds.

23 Events after balance sheet date

23.1 Scope

23.1.1 Applicability

This Policy applies to the accounting and disclosure of events that happen between the balance sheet date and the date when the financial statements are authorised for issue.

23.1.2Relevant guidance

This Policy should be read in conjunction with the following guidance:

- AASB 110 *Events after the Balance Sheet Date*

23.2 Overview and purpose

The purpose of this document is to provide Health entities with illustrative guidance on the accounting and the disclosure of events that happen between the balance sheet date and the date when the financial statements are authorised for issue under the accounting standard *AASB 110 Events After The Balance Sheet Date* for general purpose financial reporting.

23.3 Policy Statement

This policy requires the Health entity to distinguish between events that require changes in the amounts to be included in the financial statements as an adjusting event, and events that only require disclosure as a non-adjusting event in accordance with *AASB 110 Events After the Balance Sheet Date*.

23.4 Application Guidance

23.4.1 Adjusting event

AASB 110.8-9

A material post balance sheet event requires changes in the amounts to be included in the financial statements where either of the following applies:

- It is an adjusting event (that is, an event that provides additional evidence relating to conditions that existed at the balance sheet date).
- The event indicates that it is not appropriate to apply the going concern basis of accounting.

Examples of adjusting events include the following:

- The settlement of a court case after the balance sheet date which confirms that the entity had a present obligation at the balance sheet date. The Health entity should adjust for any existing provision for the obligation or create a new provision under this circumstance (refer to Chapter 15 of this policy document).
- The receipt of information after the balance sheet date, indicating that an asset was impaired as at the balance sheet date (e.g. costs pertaining to a feasibility study with respect to infrastructure assets which was capitalised due to the probability criterion being met, is no longer seen as satisfying the probability criterion after the balance sheet date).
- The determination after the balance sheet date, of the consideration for assets sold or purchased before the balance sheet date.
- The discovery of fraud or errors that show that the financial statements are incorrect.

Going concern basis

The Secretary should assess the NSW Health's ability to continue as a going concern at the time of preparing the financial statements. This assessment must cover the NSW Health's prospects for at least 12 months from the balance sheet date. The NSW Health should not prepare its financial statements on the going concern basis if it is determined after the reporting period that operations will cease as a result of an administrative restructure.

23.4.2 Non-adjusting event

AASB 110.10-11

A A non-adjusting event is an event that arises after the balance sheet date that is indicative of conditions that arose after the balance sheet date. Adjustments to amounts recognised in the financial statements are not made for material non-adjusting post balance sheet events. They are however, disclosed in the notes to the financial statements if they are material.

The Health entity should disclose the nature of the event, and an estimate of its financial effect for each material category of non-adjusting event. If it is not possible to make an estimate of an event's financial effect, the Health entity must disclose that fact.

Examples of non-adjusting post balance sheet events include the following:

- Administrative restructure imposed under legislation after the balance sheet date.
- Major purchases of assets, classification of assets held for sale as per Chapter 8 of this policy document and other disposal of assets.
- The destruction of a specialised building by fire after the balance sheet date.
- Announcing or commencing a major restructuring.
- Commencing major litigation arising solely out of events that occurred after the balance sheet date.

Non-adjusting event – Administrative restructure

Administrative restructure that are made after the balance sheet date are usually non-adjusting post balance sheet events that require only disclosure on financial statements. Where operations ceased to exist post balance sheet date as a result of an administrative restructure, this may provide evidence of impairment (as per Chapter 11 of this policy document).

Non-adjusting event – Held for sale

As per Chapter 8 of this policy document, the Health entity cannot classify a non-current asset or disposal group as held for sale if it only meets the criteria to be classified as held for sale after the balance sheet date. However, if the criteria are met between the balance sheet date and the date when the financial statements are authorised, the Health entity should disclose

- A description of the non-current asset or disposal group
- A description of the facts and circumstances of the sale, or those leading to an expected disposal, and the expected method and timing of the disposal

Example 23.1 Asset sales near the period end (conditional)

The Health entity intends to sell a property adjacent to the hospital grounds. The sale of the property is conditional on planning permission being granted. Planning permission is granted and the sale is complete, with both these events occurring after the balance sheet date but before the financial statements are authorised for issue.

How should the above be accounted for?

The receipt of planning permission does not permit the sale to be recognised at period end, because there is no existing condition at the balance sheet date, for which the grant of planning permission provides additional evidence. Instead the sale is recognised in the period in which planning permission is granted (that is, in the period in which the sale becomes unconditional).

Example 23.2 Asset sales near the period end (unconditional)

The property as noted in example 23.1 above is sold unconditionally before the period end, and the amount of the consideration is dependent on whether or not planning permission is obtained.

How should the above be accounted for?

The probability of planning permission being obtained is taken into account in determining the fair value of the receivable at the balance sheet date as per Chapter 8 of this policy document. The granting or refusal of planning permission after the balance sheet date is a non-adjusting event. The difference between the receivable's value at balance sheet date and the amount received subsequently is recognised in the period when the planning permission is granted or refused.

23.4.3 Date of authorisation of financial statements for issue

The Health entity is required to disclose both the date on which the financial statements are authorised for issue and who gives that authorisation. If the Accountable Authority have the power to amend the financial statements after issue, that fact should also be disclosed.

Appendix A
Related parties

For a complete and up to date list of NSW Government-related entities for disclosure under AASB 124, as complied by NSW Treasury, please refer to https://www.service.nsw.gov.au/nswgovdirectory/atoz#h

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