



redhs

Leading our community to better health

Rochester and Elmore District Health Service



**Annual Report** 2018

# REDHS 2020 STRATEGIC PLAN 2016 - 2020



## VISION

Leading our community to better health

## VALUES

Respect  
Equity  
Diligence  
Honesty  
Service

## Strategic Priorities

### Quality Healthcare

Enhance person centred approach to care  
Focus on wellbeing including quality ageing  
Strengthen community and consumer engagement



### Collaborative Endeavours

Develop and provide services to meet community need  
Nurture strategic partnerships and develop cluster arrangements  
Transform models and systems for efficiency and quality



### People and Infrastructure

Engage in innovation driven opportunities  
Develop our people  
Strengthen our governance and quality systems  
Progress contemporary physical and technical infrastructure



**Front cover:**  
Former Rochester resident and Executive Manager of the ANZAC Centenary Touring Exhibition, Major-General Brian Dawson, unveiled the war memorial statues in November 2017.  
The Veterans' Grant Sculpture Working Party and sculptor, Richard Yates, worked together to develop a design.  
Pictured from left to right: John Foster, Eric Kneebone, John Glover, Richard Yates, Major-General Brian Dawson, Karen Tognolini, Hedley Moon, Linda Charles and Anne McEvoy.

**Back cover:**  
Pictured from top: Board Director, Kate Lee, with some of REDHS' valued volunteers wearing the new volunteer uniform.  
Board Chair, Dr Carol McKinstry, and Board Director, Carl Wood, were very pleased to accept a cheque from Hospital Auxiliary members, Kath Bubb and Maureen Leahy.

## WHO WE ARE

Rochester and Elmore District Health Service (REDHS) was established on 1 November 1993 following the amalgamation of the Rochester and District War Memorial Hospital and the Elmore District Hospital.

REDHS is an incorporated body under Section 31 of the Health Services Act 1988 providing a broad range of services including acute, residential aged and primary care services (including home nursing) to our catchment population of over 6,700 and has:

- 118 full time equivalent staff
- 60 aged care beds
- 2 Transition Care Program beds (residential)
- 1 Transition Care Program bed (community)
- 10 inpatient beds including 1 palliative care bed
- Urgent Care Centre
- Day Procedure Unit
- Primary Care Services

The responsible minister is the Victorian Minister for Health, the Honourable Jill Hennessy MLA.

## OUR LOCATION



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# YEAR IN BRIEF 2017-18

## Acute Ward

Total Separations	544
Total Bed Days	1,654
Average Length of Stay (Days)	6.1

## Day Procedure Unit (DPU)

Total DPU Separations	264
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## Aged Care

Nursing Home Bed Days	10,426
Nursing Home Separations	15
Hostel Bed Days	10,422
Hostel Separations	10

## Non-admitted Occasions of Service

District Nursing	4,791
Urgent Care Centre	720
Radiology	1,038
Planned Activity Group	1,866
Diabetes Education	256
Dietetics	282
Exercise Physiology	131
Group Fitness	1,408
Occupational Therapy	303
Physiotherapy	1,509
Podiatry	2,627
Social Work/Counselling	897
Drug and Alcohol Withdrawal Service	318

## Services available at REDHS

- Acute Ward
- Cardiac Rehabilitation
- Carers' Support Program
- Chiropractic
- Day Surgery
- Diabetes Education
- Dietetics
- District Nursing
- Drug and Alcohol Counselling
- Exercise Physiology
- Group Fitness
- Health Promotion
- Hearing Services
- Immunisation
- LIFE program (Diabetes Prevention)
- National Respite for Carers Program
- Occupational Therapy
- Palliative Care
- Pathology Collection
- Physiotherapy
- Planned Activity Group
- Podiatry
- Psychology
- Radiology (X-rays and Ultrasounds)
- Residential Aged Care
- Rural Withdrawal Service
- Social Work
- Transition Care Program
- Urgent Care Centre
- Volunteer Program

# PRESIDENT AND CEO REPORT

On behalf of the Board of Directors, we are pleased to present the 25th Annual Report of Rochester and Elmore District Health Service for the year ended 30 June 2018. The report highlights the significant achievements and events that occurred during the year and is prepared in accordance with the *Financial Management Act 1994*.

A number of achievements, including REDHS being a finalist in the 2017 Victorian Small Rural Health Service of the Year, are included in this report and reflect the dedication and care provided by our staff, visiting medical officers (VMOs) and volunteers in delivering services for our community.

## Governance

The Board experienced several changes this year, firstly with the retirement of Keith Oberin after 10 years of dedicated service. We thank Keith for his valued directorship and advocacy in providing services relevant to the community. The Board welcomed four new directors with the appointments in July 2017 of Kate Lemon, Carl Wood, Frank Oliver and Ben Devanny, bringing the total number of Board directors to nine. The Board executive consisted of Dr Carol McKinstry who continued as Chair, David Rosaia being elected as Deputy Chair and Jodie Smith remained in the Treasurer role.

The model of including independent representatives on each of the Board subcommittees was enhanced with further appointments to each of the committees - Gaylene Whitten to Quality of Care, Jackie Roberts and Jim Brooks to Risk Management and Planning and we welcomed back Alan Darbyshire to the Audit and Finance Subcommittee. The Board also instigated a Remuneration Committee to support its governance responsibilities.

## Strategic Plan and Statement of Priorities

During the year, the Board regularly reviewed the objectives and progress of REDHS Strategic Plan, which is operationalised via the annual business plan. The Board was also required to

participate in the Department of Health and Human Services annual Statement of Priorities process.

The following points summarise key achievements by REDHS during the year:

### Quality Healthcare

- Implemented a new primary care intake system as the gateway to REDHS
- Expanded the graduate nurse program to a fifth member and completed a project based on future collaborative opportunities with St Anthony's Family Medical Practice
- Developed for the first time a staff health and wellbeing plan
- Increased focus on strengthening hospitals response to family violence and remained an active participant in the Campaspe Family Violence Action group
- Increased aged care activities hours by 40% following a successful trial
- Home care services rapidly expanded to approximately triple the hours of service delivered in the previous year with servicing of NDIS clients a key success factor
- Facilitated a review of REDHS medical models of care based upon Urgent Care Centre and our Doctor on Call model.
- Commitment to Loddon Mallee Regional Clinical Governance Council by endorsement of Memorandum of Understanding (MOU) and aligned to the new REDHS Quality Plan.
- Determined viability for REDHS administering Home Care Packages and hence commenced a dedicated role as a home care client advisor
- Senior staff commenced education in clinical redesign processes
- Implemented a dedicated falls prevention review project to benchmark with best practice and recommend actions to minimise falls and the impact of falls on our clients.
- REDHS is actively involved in the Loddon Mallee Regional Clinical Council with the Board Chair and Quality Systems Manager as members.



**Dr Carol McKinstry**  
Board President

**Anne McEvoy**  
Chief Executive  
Officer

### Collaborative Endeavours

- Completed a REDHS aged care service plan which provided key information towards a successful submission to the Commonwealth's Regional Jobs and Infrastructure Program to explore an enhanced model of aged care accommodation as well as assisting with evidence for an application to DHHS for extending the Nursing Home dining room
- Implemented a new intranet site
- Increased primary care physiotherapy outreach services to Lockington Bush Nursing Centre and Waranga Medical Clinic at Rushworth
- Developed a partnership with Echuca Community for the Aged and Warramunda Village Inc to service the Shire of Campaspe with Commonwealth Home Support Program personal care hours
- Signed an MOU with Echuca Regional Health for a shared surgical services model to staff the REDHS Day Procedure Unit to enable the provision of this service
- Implemented the action plan of the Rochester and Elmore Local Drug Action Team (RELDAT) which was supported by a vibrant committee
- Signed an MOU with Lockington and District Bush Nursing Centre to support its clinical quality and safety processes

### People and Infrastructure

- Increased staff safety by engaging a security contract for after-hours support along with a successful submission to the 3rd round of DHHS Occupational Violence Fund to implement a remote alert system for staff working offsite.
- Action plans were developed to support the revised Strategic Risk Register and Board and Executive staff underwent a facilitated session on risk appetite
- An organisation wide commitment to reducing bullying and harassment was continued with all staff attending further mandatory education sessions on above and below the line behaviours
- Reviewed staffing models in administration and activities services to support a more contemporary workforce and to align with changing service delivery requirements
- Maintained an operating surplus to support future capital needs of REDHS

### Partnerships

REDHS values the numerous partnerships with stakeholders who add value to our organisation and community. REDHS continues to be a key partner in collaborating with other health services within the Campaspe area in implementing the *Healthier Campaspe* initiative. The initiative was supported by the recruitment of a project manager which supports the partnership efforts. REDHS led the obesity priority and now proudly boasts achieving "Healthy Choices" recognition for the work undertaken at the REDHS Café.

### Accreditation

REDHS received two unannounced aged care support visits in the past year with all requirements met. We acknowledge the mighty team efforts in maintaining the various accreditation requirements which reflects our organisation's commitment to quality and safety. With the Commonwealth Department of Health's move to a single aged care quality framework in the next 12 months there will be more changes on the horizon.

### Community Support

REDHS is truly grateful for the support of our community, local organisations and people through generous donations of time and money to support our vision. Numerous donations and bequests have been received and we would like to particularly acknowledge the significant efforts of Rochester and District Hospital Auxiliary whose members continue to work tirelessly in raising money for the purchase of medical equipment. This year they raised over \$7,000 which was put towards the purchase of electric beds for aged care. The fifth Rochester Fine Art Exhibition was held in April and contributed \$8,500 towards the bed replacement campaign. Thanks to this committed Committee for its fundraising efforts for REDHS. The commissioning of the cypress sculptures of the soldier and nurse epitomised the historical context of the health service as a War Memorial site and their unveiling at the 2017 Annual General Meeting was further recognition of the contributions and sacrifices of our service men and women. We are grateful to the working party who led this project from concept to fruition with such passion.

### Our Thanks

Further to the above, on behalf of the Board of Directors, we pass on our thanks to the many groups and individuals who provide significant support to our health service, in particular, our staff, volunteers, medical practitioners, contractors and all levels of government. We continue to appreciate the support and assistance of the Victorian Department of Health and Human Services and the Commonwealth Department of Health. Above all we thank our residents, patients and clients as your feedback on our services assists in the pursuit for quality excellence.

We acknowledge your assistance in "Leading our community to better health".



**Dr Carol McKinstry**  
Board Chair



**Anne McEvoy**  
Chief Executive Officer



# CORPORATE GOVERNANCE

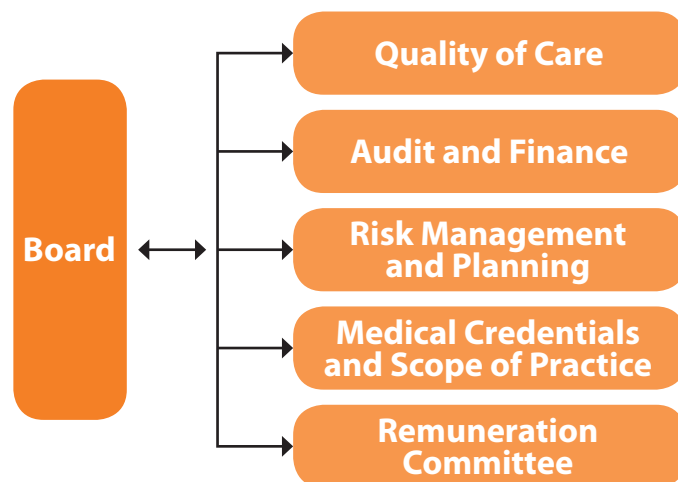
## REDHS Board of Directors

Rochester and Elmore District Health Service (REDHS) is an incorporated body listed under Schedule 1 of the *Health Services Act 1988*. Board directors are recommended by the Minister and appointed by the Governor-In-Council for a term of up to three years and act in a voluntary capacity.

The strategic direction of REDHS is determined by the Board of Directors, which meets regularly with the Chief Executive Officer and Executive staff to determine governance, compliance and policy. The Board is supported in its decision-making by a number of sub-committees.

Subject to the requirements of government and the Health Service By-Laws, the Board of Directors exercises decisions including the control of funds, determining the range of services to be provided, and the appointment of visiting medical officers and other senior staff.

## Board Committee Structure



### Dr Carol McKinstry

*Chair*  
B App Sc (OT), MHLth Sc, PhD,  
Grad Cert Higher Ed. GAICD  
Senior Lecturer OT,  
College of Science Health and Engineering,  
La Trobe Rural Health School  
Registered occupational therapist  
*Date appointed: 1.7.2014*



### Timothy Fulton

*Deputy Chair (1.7.16 – 27.11.17)*  
B.Bus (Accounting/ Economics),  
Diploma of Financial Planning  
Agribusiness Manager, Saputo  
(Murray-Goulburn)  
*Date appointed: 1.7.2009*



### Jodie Smith

*Treasurer*  
*Chair: Audit and Finance Committee*  
B Bus. (Economics), Grad Dip Applied  
Science (Agriculture), Grad Cert (Acc), CPA,  
Masters of Animal Science  
Accountant, Jodie Smith Accounting  
*Date appointed: 1.7.2016*



### David Rosaia

*Deputy Chair (from 27.11.17)*  
RN, Grad Dip (Health Sciences)  
Director of Nursing, Acute Health, Acting  
Chief of Nursing and Midwifery,  
Bendigo Health  
*Date appointed 26.04.2017*



### Kate Lee

*Chair: Risk Management and  
Planning Committee*  
Logistics Officer (Parmalat)  
*Date appointed: 1.7.2011*



### Kate Lemon

MBA, Grad Dip (Business Management),  
Cert IV Frontline Management, Cert IV  
Business Development, Cert IV  
Assessment and Care Planning, Home and  
Community Care  
Public Environments Manager,  
Campaspe Shire Council  
*Date appointed: 1.7.2017*



### Frank Oliver

GAICD, *Retired*  
*Date appointed: 1.7.2017*



### Ben Devanny

B. Bus (Accounting/Economics), CPA,  
*Manager – Business Services,*  
*City of Greater Bendigo*  
*Date appointed: 1.7.2017*



### Carl Wood

MBA, Grad Dip (Accounting), Grad Dip  
(Applied Corporate Governance), Grad Dip  
(Risk Management), Grad Cert  
(Planning), RFD, BJ *Retired*  
*Date appointed: 1.7.2017*

## Meeting Attendance

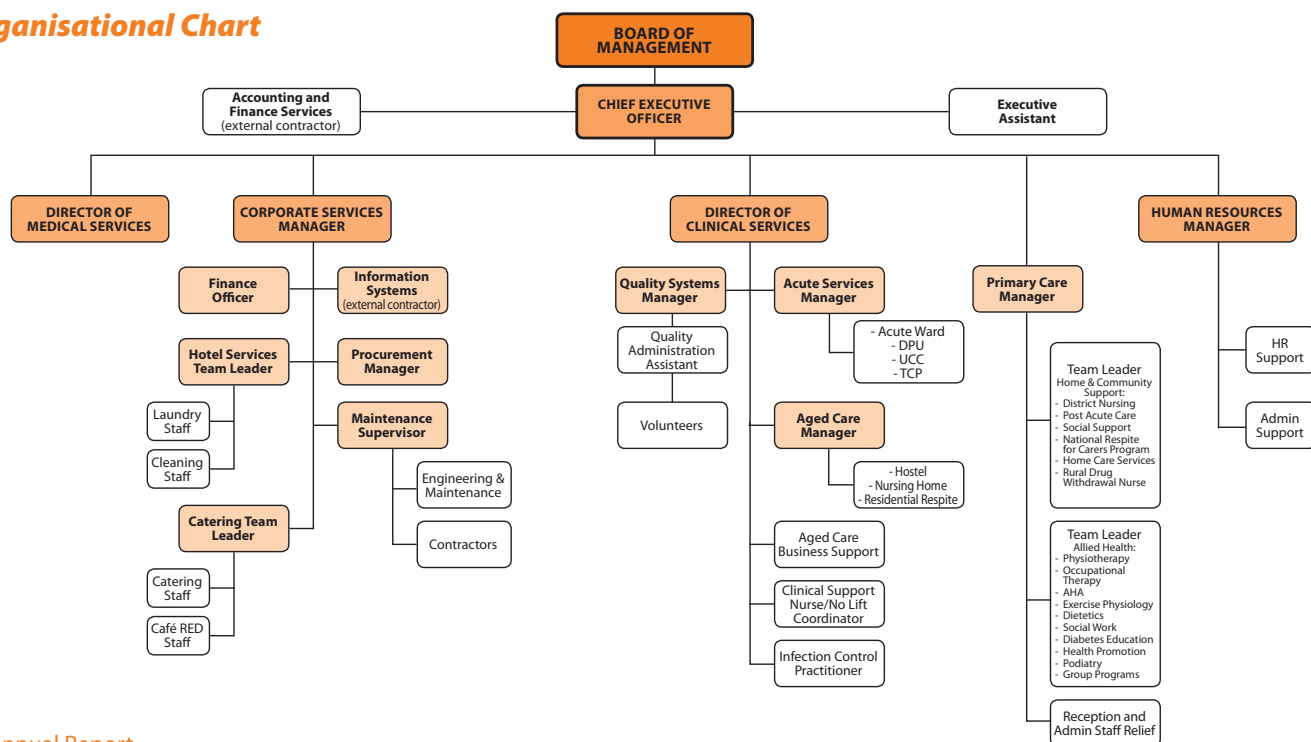
Board Meetings														
Board member	2017						2018						AGM (9/11/2017)	Total
	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		
Ben Devanny	✓	✓	✓	✓	✓	NM	✓	✓	✓	✓	✓	✓	✓	12/12
Timothy Fulton	✓	✓	✓	A	✓	NM	✓	✓	A	A	✓	✓	✓	9/12
Kate Lee	✓	✓	✓	✓	✓	NM	✓	A	✓	✓	✓	✓	✓	11/12
Kate Lemon	✓	✓	✓	✓	A	NM	✓	✓	✓	✓	✓	✓	✓	11/12
Carol McKinstry	✓	✓	✓	✓	✓	NM	✓	✓	✓	✓	A	✓	✓	11/12
Frank Oliver	✓	A	✓	✓	✓	NM	✓	✓	✓	✓	A	✓	✓	10/12
David Rosaia	✓	✓	✓	✓	✓	NM	✓	✓	✓	✓	✓	✓	✓	11/12
Jodie Smith	✓	✓	✓	✓	✓	NM	✓	✓	✓	✓	✓	✓	✓	12/12
Carl Wood	✓	✓	✓	✓	✓	NM	✓	✓	✓	✓	✓	A	✓	11/12

A = Apology L = Leave of Absence NM = no meeting held

## Committee Membership

	Risk Management and Planning Committee	Audit and Finance Committee	Medical Credentials and Scope of Practice Committee	Quality of Care Committee	Remuneration Committee
<b>Board Members</b>					
Carol McKinstry	✓	✓	✓	✓	✓
David Rosaia			✓	✓	✓
Ben Devanny	✓	✓			
Timothy Fulton		✓			
Jodie Smith	✓	✓			✓
Kate Lee	✓		✓		
Kate Lemon				✓	
Frank Oliver	✓				
Carl Wood					✓
<b>Independent Members</b>					
Phillip Johnson	✓				
Christine Wright				✓	
Jackie Roberts	✓				
Jim Brooks	✓				
Alan Darbyshire		✓			
Gaylene Whitten				✓	

## Organisational Chart





# KEY PERSONNEL

## Executive

### Chief Executive Officer

Anne McEvoy

RN, B.Hlth Sc (Nursing) Grad Dip Man, Grad Cert Gerontology, Grad Cert Diabetes Education, GAICD

### Director of Clinical Services

Mark Nally

RN, B.Hlth Sc (Nursing), CCRN, M.Hlth Sc.

### Corporate Services Manager (to 21 January 2018)

Clare Ireland

B.Sc, Dip. Bus

### Corporate Services Manager (from 22 January 2018)

Colin Wellard

MBA, GradDip SocSc, GradCert SocSc

### Human Resources Manager

Gaye Pilven

MHRM, BBA, Cert IV WHS

### Director of Medical Services

Dr Glenn Howlett

MB BS LLB; Grad Dip Hlth Serv Mt; FRACGP

## Department Heads

### Acute Services Manager

Meredith Hodder

RN, B.Nursing, Post Grad Dip Perioperative Nursing

### Aged Care Manager (from 4 April 2017 to 30 July 2017)

Jennifer Putna

RN, RM, BA (Psych Welfare)

### Aged Care Manager (from 31 July 2017)

Mark Cresp

RN

### Primary Care Manager (from 29 November 2017)

Meaghan Sully

BSocWk, Dip Mgt

### Quality Systems Manager

Lynn Wolfe

Adv Dip Bus Man, Adv. Dip Bus Man (HR Bridging), Dip App Sci (Hort)

### Infection Control Practitioner

Natasha Collins

RN, Registered Nurse Immuniser, Foundations of Infection Prevention and Control (undergoing), HIV and Hepatitis C Pre and Post Test Discussion, Cert IV, Training and Assessment

### Clinical Support Nurse

Cheryl Petrini

RN, Cert. IV Training and Assessment

### Maintenance Supervisor

Brett Shotton

### Procurement Manager

Gayle McConnell

## Team Leaders

### Allied Health (from 3 April 2018)

Susannah Hargreaves

BHlthSc, MPodPrac

### Community and Home Support

Megan Purvis

RN

### Planned Activity Group Coordinator

Ms Ann-Maree Hewlett

### Catering

Ms Rebecca O'Sullivan

Cert III Comm Cookery, Cert IV Frontline Man

### Support Services

Ms K McEllister

Mr D Watson (until 28 August 2017)

## Visiting Medical Officers

### General practitioners

Dr A Asaid, MBBS (Egypt), AMC, FRACGP, FACRRM

Dr J Duggan, MBBS (Uni of WA), MPHIC (Flinders)

Dr E Ekeanyanwu, MBBS (Nigeria), FRACGP

Dr N Fang, MBBS, DRANZCOG, FRACGP

Dr P Nzegwu, MBBS (Nigeria), AMC

### GP registrars

Dr B Cumming

Dr J Quay

### General surgeons

Ms J Arnold, MBBS, FRACS

Dr J Azzopardi, MBBS DA (UK), DRACOG FRACGP

Mr M Oliver, MBChB, FRCSEd, FRACS

## Urologist

Dr R Hall, B.Med, B.Sc, FRACS

## GP anaesthetists

Dr C Hunt, MBBS DRCOG DA ACRRM

Dr S Kennedy, MBBS, FRACGP, ARTP (Anaes)

Dr C Taverna, MB BS

## Specialist anaesthetists

Dr P Buncle, MBBS, FANZCA

Dr K Davenport, MBChB, FANZCA

Dr L Hamond, MBBS, FANZCA, Dip RACOG

Dr S Hams, MBBS, FANZCA

Dr P Koudos, MBBS FANZCA

Dr M Nerlekar, MBBS DA MD FANZCA

Dr A Purcell, MBBS DA (UK) Dip Obs RACOG FANZCA

Dr M Shapiro, MBBCh, H DA FANZCA

## Visiting Radiology Service

Goulburn Valley Imaging

# PERFORMANCE AGAINST STATEMENT OF PRIORITIES *(Part A)*

## Statement of Priorities

Goals	Strategies	Health Service Deliverables	Outcomes
BETTER HEALTH			
<p>A system geared to prevention as much as treatment</p> <p>Everyone understands their own health and risks</p> <p>Illness is detected and managed early</p> <p>Healthy neighbourhoods and communities encourage healthy lifestyles</p>	Reduce state-wide risks	REDHS will embrace initiatives promoted by Campaspe Primary Care Partnership guidelines, enhancing our profile as a socially inclusive organisation.	<p>Review of Diversity Plan completed for DHHS in November 2017.</p> <p>REDHS supported "Wear Orange Day" May 2018.</p> <p>Gender equity training session for staff held.</p>
	Build healthy neighbourhoods		
	Help people to stay healthy		
	Target health gaps	<p>REDHS will strengthen its response to family violence utilising support, hospital guidance and involvement in the Campaspe Family Violence Action Group (CFVAG).</p> <p>Community participation in health promotion activities in accordance with REDHS Health Promotion Plan 2017- 2020.</p> <p>REDHS will lead local communities and strengthen partnerships through the Local Drug Action Team health promotion initiative.</p>	<p>REDHS has communicated information to Board Directors (via briefing paper) regarding DHHS funding of sub regional Strengthening Hospital Responses to Family Violence initiative.</p> <p>Project worker presentation to REDHS Leadership Team May 2018. REDHS is progressing internal policy and procedure in preparation for staff education.</p> <p>REDHS has sustained commitment to CFVAG.</p> <p>Domestic Violence Centre delivered education session at REDHS June 2018.</p> <p>Tracking favourably as per plan.</p> <p>Project completed and Phase 2 application to the Alcohol and Drug Foundation submitted.</p>

## Statement of Priorities

Goals	Strategies	Health Service Deliverables	Outcomes
<b>BETTER ACCESS</b>			
<b>Better Access</b> Care is always there when people need it People are connected to the full range of care and support they need There is equal access to care More access to care in the home and community People are connected to the full range of care and support they need There is equal access to care	<b>Better Access</b> Plan and invest Unlock innovation Provide easier access Ensure fair access	REDHS will implement a new primary care intake system as the gateway to accessing REDHS services, optimising consumer access to appropriate services.	New intake worker role commenced October 2017 and working effectively. Complete.
		Focus primary care service delivery on the five priorities identified by the "Healthier Campaspe" (HC) initiative: obesity, mental health, alcohol and drugs, diabetes and cancer.	Active member of all working parties. New HC Project worker (REDHS employee) commenced May 2018.  REDHS commitment to initiative displayed by significant outcomes in the Obesity priority.
		REDHS will implement a Commonwealth Home Support Programme (CHSP) personal care collaborative model to meet targets and provide personal care services.	Delivering service to CHSP clients, however minimal referrals continue to limit efforts to achieve targets. Department of Health advice is that targets not achieved can be rolled over to 2018-19.
		REDHS will create a permanent home care service and determine viability for REDHS administering home care packages and delivering services to National Disability Insurance Scheme (NDIS) clients.	Home care package client advisor administration role commenced January 2018.  Delivering services to NDIS clients via primary care team – tracking favourably.

## Statement of Priorities

Goals	Strategies	Health Service Deliverables	Outcomes
<b>BETTER CARE</b>			
<b>Better Care</b> Target zero avoidable harm Healthcare that focusses on outcomes Patients and carers are active partners in care Care fits together around people's needs	<b>Better Care</b> Put Quality First Join up care Partner with patients Strengthen the workforce Embed evidence Ensure equal care	<b>3 Mandatory actions against the 'Target zero avoidable harm' Goal:</b>  <u>Develop and implement a plan to educate staff about obligations to report patient safety concerns</u>	REDHS has provided education on reporting obligations to senior staff and reviewed relevant policies including Elder Abuse.  REDHS Quality Reports are provided to staff closing the feedback loop and promoting engagement in Quality of Care.
		REDHS will actively promote incident and near miss reporting for patient safety concerns and will engage managers in the process of monthly review of this data.	REDHS has had a 64% improvement in VHIMS completion rate.  See also Performance against Statement of Priorities (Part B).
		REDHS will implement a training program against the Department of Health and Human Services guide for violence and aggression training in Victorian health services.	REDHS OHSW Committee has endorsed revised Code Grey and Code Black policies December 2017.  Code Grey training was provided to front line staff in September 2017. Occupational Violence (OV) reports to the Board quarterly at Risk Management and Planning meetings.  Security Service contract commenced November 2017.
		<u>[For smaller hospitals] Establish agreements to involve with external specialists in clinical governance processes for each major area of activity (including mortality and morbidity review)</u>  REDHS will use its existing internal mortality and morbidity review processes and refer these through our Director of Medical Services (DMS) to the Regional Clinical Governance Council or other external specialist as required.	REDHS continues to refine mortality review process to ensure effective use of DMS time without compromising quality of review.



## Statement of Priorities

Goals	Strategies	Health Service Deliverables	Outcomes
BETTER CARE			
		<p><u>In partnership with consumers, identify three priority improvement areas using Victorian Healthcare Experience Survey data and establish an improvement plan for each. These should be reviewed every 6 months to reflect new areas for improvement in patient experience.</u></p> <p>REDHS has identified three priority improvement areas using the Victorian Healthcare Experience Survey data. These pertain to communication and engagement. A communication framework for REDHS staff will be implemented. This communication strategy will be guided by the consumer 'critical friends' group.</p>	<p>Due to low admission numbers which affects VHES data, REDHS has focussed on care improvement using real time feedback from patient rounding. Rounding has been conducted with patients throughout the year and has resulted in improvements including the provision of a gym area.</p> <p>Another area of focus has been improving patient experience with community services being put in place. Previous VHES results (2016) had indicated that adequate arrangements had only been made 76% of the time. This had improved to 90% in September 2017. This was achieved through raised staff awareness and enhanced discharge co-ordination.</p>

# PERFORMANCE AGAINST STATEMENT OF PRIORITIES *(Part B)*

## Statement of Priorities

Part B Service Performance Priorities	Target	2017/18 Actuals
<b>Quality and Safety</b>		
Accreditation against the National Safety and Quality Health Service Standards	Full compliance	Compliant
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Compliant
<b>Infection Prevention and Control</b>		
Compliance with the Hand Hygiene Australia program	80%	87%
Percentage of healthcare workers immunised for influenza	75%	89%
<b>Patient experience</b>		
Victorian Healthcare Experience Survey – percentage of positive patient experience responses	95% positive experience	Full compliance*
Victorian Healthcare Experience Survey – percentage of very positive responses to questions on discharge care	75% very positive experience	Full compliance*
Victorian Healthcare Experience Survey – patients' perception of cleanliness	70%	Full compliance*
<b>Adverse Events</b>		
Number of sentinel events	Nil	Achieved
Mortality – number of deaths in low mortality DRGs**	Nil	Achieved
<b>Strong governance, leadership and culture</b>		
People Matter Survey – percentage of staff with an overall positive response to safety and culture questions	80%	73%
People Matter Survey – percentage of staff with a positive response to the question, "I am encouraged by my colleagues to report any patient safety concerns I may have"	80%	88%
People Matter Survey – percentage of staff with a positive response to the question, "Patient care errors are handled appropriately in my work area"	80%	78%
People Matter Survey – percentage of staff with a positive response to the question, "My suggestions about patient safety would be acted upon if I expressed them to my manager"	80%	74%

## Statement of Priorities

Part B Service Performance Priorities	Target	2017/18 Actuals
<b>Strong governance, leadership and culture (cont'd)</b>		
People Matter Survey – percentage of staff with a positive response to the question, “The culture in my work area makes it easy to learn from the errors of others”	80%	68%
People Matter Survey – percentage of staff with a positive response to the question, “Management is driving us to be a safety-centred organisation”	80%	77%
People Matter Survey – percentage of staff with a positive response to the question, “This health service does a good job of training new and existing staff”	80%	66%
People Matter Survey – percentage of staff with a positive response to the question, “Trainees in my discipline are adequately supervised”	80%	56%
People Matter Survey – percentage of staff with a positive response to the question, “I would recommend a friend or relative to be treated as a patient here”	80%	76%

\*Less than 42 responses were received for the period due to relative size of the Health Service.

\*\*DRG: Diagnosis Related Group

Note: Performance against the Statement of Priorities Part B (Financial Sustainability Performance) and Part C (Activity and Funding) can be found in the Financial Report on page 26.

# HUMAN RESOURCES AND STAFF DEVELOPMENT

## Equal Opportunity, Merit and Equity

Recruitment, selection and employment at REDHS comply with employment conditions as specified in relevant Health Awards and Enterprise Bargaining Agreements. The employment of staff satisfies equal employment opportunity requirements,

legislative and moral obligations and terms and conditions of the Fair Work Act 2009, Public Sector Management Act 1992 and Victorian Charter of Human Rights and Responsibilities 2008. All employees have been correctly classified in workforce data collections.

## Workforce Data

### Total Staff

Staff	2017–2018	2016–2017
Equivalent Full-Time Staff – June	118.19	115.78
Total Staff	184	206

### Staff by Occupational Group

	June Current Month FTE		June YTD FTE	
	2017	2018	2017	2018
Nursing	52.53	52.06	52.53	52.32
Administration and Clerical	13.74	14.72	13.74	14.72
Hotel and Allied Services	36.08	37.57	36.08	37.82
Medical Officers	0.05	0.05	0.05	0.05
Ancillary Staff (Allied Health)	13.38	13.79	13.38	13.79
<b>Totals</b>	<b>115.78</b>	<b>118.19</b>	<b>115.78</b>	<b>118.7</b>

**Note:** All figures reflect active employees in the last full pay period of June 2018.

FTE = Full Time Equivalent.

### Recognition of Staff Service

This year, REDHS recognises the long-standing service of the following staff:

#### 10 years

Wesley Brierley  
Paul Hughes  
Flordeliza Marsh  
Alan Read  
Brett Shotton  
Gillian Wall

#### 15 years

Tania Else  
Ann-Maree Hewlett  
Joanne Sparkes  
Susan Walsh

#### 30 years

Gayle McConnell



# OCCUPATIONAL HEALTH, SAFETY & WELLBEING

REDHS is committed to providing a safe and healthy environment for staff, patients, residents, visitors, volunteers and contractors. This commitment includes a commitment to significant resourcing to maximise safety and maintain a strong focus on risk identification, continuous improvement and injury prevention and management.

Since January 2017, wellbeing was included in the occupational health and safety program at REDHS (hence OHSW).

Human Resources Manager, Gaye Pilven, was OHSW Coordinator throughout 2017-18 and worked with REDHS' health and safety representatives (HSRs) to ensure OHSW systems and processes were being followed as required.

HSRs met bi-monthly for a full day, supported by the OHSW Coordinator, to conduct workplace audits and risk assessments, developed, reviewed and updated policies and prepare and delivered education to staff in their respective areas. The Occupational Health and Safety Committee also met on this day.

Following on from the Staff Wellbeing survey conducted in January 2017, the OHSW Committee took responsibility for the implementation of the Staff Wellbeing Plan.

OHSW Week was celebrated in October 2017. Activities centred on the Mental Health and Wellbeing theme.

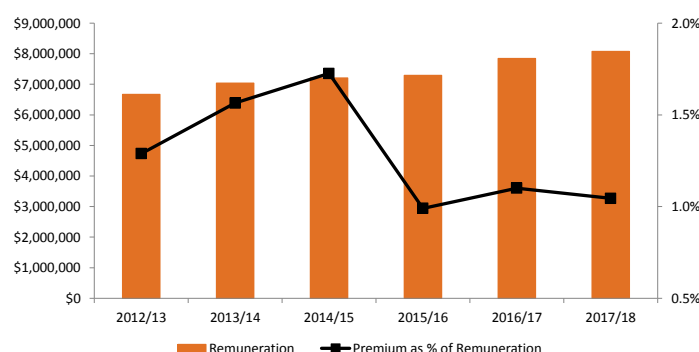
In 2017-18, there were 69 occupational health and safety incidents, near misses and hazards recorded which equates to 56 reports per 100 FTE. By comparison, there were 52 incidents per 100 FTE reported in 2016-17. This is a slight increase and indicates sustained staff awareness of safety, a commitment by all staff to be responsible and accountable for their wellbeing and to ensuring risks are identified and reported. The HSRs continue to be very engaged and committed to promoting our safety culture within their designated work groups.

In 2017-18, there were seven "lost time" claims per 100 full-time equivalent staff members. The average cost per claim was \$3,118. There were no fatalities.

## Occupational Violence

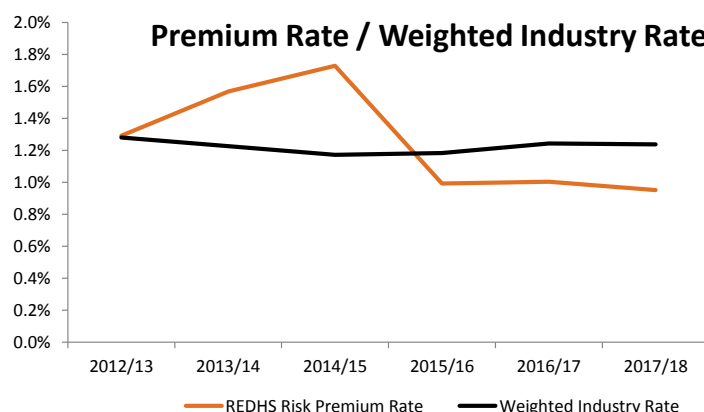
There were 16 incidents involving occupational violence in 2017-18. Thirteen incidents occurred in residential aged care, one in the Urgent Care Centre and two in the acute ward. There were no WorkCover claims regarding occupational violence and no lost time due to injury.

Premium as % of Remuneration



REDHS' premium has reduced significantly since 2014/15 due to one high cost claim from 2014/15 no longer forming part of the basis for calculating REDHS premium. WorkCover premiums are calculated using claims costs (known as experience) for the past three years.

Premium Rate / Weighted Industry Rate



The above table depicts REDHS premium rate, shown against the weighted (or average) industry rate, with the orange line demonstrating a significant reduction in the last 3 years, mainly due to our decreased WorkCover claims costs.

## Occupational violence statistics

2017-18

1. WorkCover accepted claims with an occupational violence cause per 100 FTE	0
2. Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	0
3. Number of occupational violence incidents reported	16
4. Number of occupational violence incidents reported per 100 FTE	12.9
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition	0%

# CLINICAL SERVICES

During the last year, each of the clinical services at REDHS have actively embraced the organisation's Strategic Plan and participated actively in our vision - *Leading our community to better health*. The strategic priorities, *Quality Healthcare, Collaborative Endeavours and People and Infrastructure*, provide clear guidance on how we are to conduct business and are therefore readily incorporated.

There are wide-ranging achievements that REDHS deserves to celebrate, many of which are detailed below. Highlights include: development and focus on our Falls Project, review of our medical models of care and significant progress in the area of consumer engagement.

I would like to acknowledge the contributions of volunteers, committee members, and consumers but mainly the contributions of our staff who continue to go above and beyond their duties in the personalised care of their clients.

## Quality Unit

Our Quality Unit continues to impress with its wide ranging contributions to REDHS. The REDHS Quality Plan has been reviewed to align with our Strategic Plan. The plan outlines how REDHS will deliver quality healthcare for every person, every time across every level of the organisation. In 2018-19, all REDHS departmental business plans will be aligned with the Quality Plan to ensure that all areas are contributing to the delivery of quality care.

In order to maintain REDHS' accreditation status for the Acute ward, a self-assessment was submitted to the Australian Council on Healthcare Standards as assurance that REDHS continued to meet requirements and was working on recommendations received following previous surveys.

Considerable work has been done to partner with consumers at levels other than direct care. Consumer representative recruiting for REDHS Infection Control and Medication Advisory Committees was undertaken. Co-Production training workshops for staff and consumers were held in June for both groups to learn how to effectively work together on projects from the initial stages. Quarterly community newsletters were published and distributed throughout the year.

Significant achievements during the last year include enhancing the policy management system and incident management process which in both cases have enhanced timeliness of completion and contributed to improved consumer safety.

Our award winning clinical governance process continues to evolve with the linchpin, our Quality Report, providing insight into our critical areas of care at all governance levels. Our Board understands our clinical demands and supported our request for a Falls Project Officer for six months to undertake a review of REDHS Falls Prevention and Management program. Our own Helen Lavery embraced this role and through this review provided assurance that REDHS is applying best practice principles, but also recommended enhancements to our systems to minimise falls.

REDHS provides active support for the Loddon Mallee Clinical Care Council with input on the Consumer, Surgical and Anaesthetic and Urgent Care Centre working groups. We are also progressing support for Lockington District Bush Nursing Centre in relation to quality processes.

## Volunteers

REDHS is very fortunate to have 85 registered volunteers who generously donate their time to support REDHS staff in providing activities for clients and residents. Volunteers supported many activities held at REDHS over the year which included the Veteran's Sculpture Unveiling, Annual General Meeting, Rochester Fine Art Exhibition, ANZAC Day and many more.

Training opportunities attended by volunteers this year include dementia training conducted by Alzheimer's Australia, Advocacy training conducted by the Rights Information and Advocacy Centre (RIAC) and annual volunteer refresher training.

REDHS volunteer coordinator, Paula Grech, has provided many opportunities during the year to celebrate and acknowledge the volunteer contributions including Christmas lunch, National Volunteer Week and the Campaspe Volunteer Network Wellbeing Day. Paula also represents REDHS on the Vibrant Volunteer Network Steering Committee and has attended the recent National Volunteer Conference in Sydney.

We know our volunteers contribute to the quality of life for clients and residents and help them to maintain connections to the wider community. We thank them all and look forward to introducing innovation in volunteering opportunities in the coming year.

## Education and Innovation

With the assistance of our Clinical Support Nurse, Cheryl Petrini, there have been many achievements attributed to the education and innovation. These include conducting a Care for the Dying workshop, which was open to all hospitals in the region; this was then followed by the implementation of the Care for the Dying program across the organisation.

REDHS has continued to participate in the Northern Rivers Graduate Nurse Program and has increased this year to five graduate year positions. This has enabled those registered nurse graduates to gain experience in both small rural and regional health facilities, in both aged care and acute settings. Our Clinical Support Nurse has worked closely with our Human Resources Manager to support two trainee Personal Care Workers to be introduced into our workforce. This successful program will be replicated in coming years, providing opportunities for people in our community to enter into caring roles in health. REDHS has also collaborated with other organisations in the Campaspe region for the planned Registered Undergraduate Student of Nursing project which will commence in the coming financial year. This will provide opportunity for on-the-job work whilst people continue their nursing studies.

REDHS has been a driving force to have the University of Tasmania Clinical Redesign course presented within the Campaspe region; this will benefit many hospitals within our region with developing leadership skills in relating change management processes in health.

REDHS has actively progressed involvement in the state-wide initiative, Strengthening Hospitals Response to Family Violence. We have embraced the suggested action plan and will support our staff as a first step to supporting our community in this important initiative.

### **Aged Care**

Occupancy in Aged Care has again been sound over the last twelve months and is reliant on staff continuing to develop person centred care plans for our residents to adapt care to the person's needs.

This year has again seen coming and goings of staff. We welcomed Mark Cresp to the Nurse Manager role. Mark brings a wide-ranging knowledge of Aged Care and he has actively embraced the Studer methodologies such as Huddles for staff and Monthly Accountability Meetings.

We farewelled and thanked Jenny Putna who has made significant contributions in many roles in Aged Care, most recently in the Care Coordinator role. We wish Jenny well in future endeavours, but with Jenny's departure there is then opportunity, which has led to Tyson Gleeson joining our Aged Care team, we warmly welcome Tyson.

Collaboration and communication is a focus area of aged care. I would like to acknowledge the combined effort and collaboration of residents, family members and staff in the development of our submission of refurbishment of the Nursing Home kitchen/dining area. We are hopeful of a positive result as the impact will be enormously beneficial for residents and their families and improve functionality for staff. Feedback and mechanisms from residents and their families have created ideas that lead to opportunities for development. These include development of a sensory room in our Deravin wing, purchase of specialist beds to reduce falls (utilising money donated by the Rochester Hospital Auxiliary) and expanding our Leisure and Lifestyle staff with a trial extending into the early evening. Our Food Reference Group continues to provide excellent ideas for improvement and many of these have been implemented.

We have also taken the opportunity to embrace technology in our involvement in the regional Geri-Connect program, whereby a geriatrician is able to consult with residents by electronic means, preventing the need for the resident to travel to Bendigo or beyond.

Our staff continue to impress us with ideas that make a difference to residents' care, such as promoting the need for a cat for the Hostel, reducing environmental impact with our War-on-Waste and suggesting natural ventilation to the Hostel staff room.

### **Day Procedure Unit**

Our existing arrangement with Echuca Regional Health in contracting DPU work to its specialist nursing team continues to promote continuity of care from an experienced staffing group and in-turn increased safety for patients. Our system of ensuring we work within a strict scope of practice and building a sound mechanism of governance further enhances patient safety. Our equipment replacement grant has provided new range of endoscopy equipment which ensures availability and quality for the surgeons who visit our hospital.

### **Acute Ward**

Our Acute Ward, incorporating Urgent Care and Transitional Care Program (TCP), has continued to provide person centred care throughout the year. All staff, particularly our After Hours Managers, have worked closely with our local general practitioners to adapt to the different care needs of the people in our care. Meredith Hodder, Nurse Unit Manager, has led the team to implement "AIDET", the Studer technique of communication; this is a structured approach to communication to ensure consistency and that we meet the person's needs. Decision making processes regarding people's care ensure patient safety is always sound.

This year we have worked with our GPs to review our Medical Model of Care with a view to ensuring we have a sustainable system of medical review. We are participating in a regional telemedicine trial to ensure we embrace technological opportunities that arise to support our patients and our GPs. In addition, three of our nurses have undertaken their Rural and Isolated Practice Endorsed Registered Nurse training. This provides advanced assessment and treatment skills, empowering them to care for our Urgent Care Centre patients.

TCP has made a significant impact on patients' lives, building their confidence and capabilities as they plan for discharge. This year our program has had many success stories with people achieving their personal aims. For the 2017-2018 financial year we have achieved 101.7% occupancy; this has been possible by welcoming opportunity for additional TCP beds when available. Acute staff have embraced and actively supported this program, allowing REDHS to exceed target activity. To complement this, a new model of care has been established within the department including developing a gymnasium to ensure people retain physical condition while in our care.

### **Infection Control**

REDHS would like to acknowledge the achievements this year of Natasha Collins. Natasha has rapidly developed her skills in infection control and is undertaking formal infection control training. Natasha has wisely used the guidance from the regional infection control unit and provided excellent oversight of the infection control program, which is overseen by the Infection Control Committee. During this period Natasha has ensured our influenza vaccination rates are above the state-wide target and has been active with all our immunisers to provide this service to our staff and volunteers.

Through a shared responsibility with our Visiting Medical Officers there has been a significant improvement in our antimicrobial stewardship results. These pleasing results are our way of contributing to reducing resistance to antibiotics.

**Mark Nally**  
**Director of Clinical Services**

# SUPPORT SERVICES

The term “Care Team” is mentioned frequently by health services across the globe. The term relates to a team of health care professionals with the training and skill needed to provide high quality coordinated care. REDHS is fortunate to possess a highly skilled and dedicated group of professionals who form our Care Team which includes those members of the environmental, catering, supply, finance and maintenance teams.

This team of dedicated staff provide a range of services to our residents and patients that are pivotal to their care and wellbeing. From ensuring that meals are nutritiously made, that rooms are clean and comfortable, that all of the equipment operates as it should, the services provided by the Corporate Services team makes a direct contribution to the care received by our residents and patients and forms an important part of their journey at REDHS.

## **Hotel Services**

The Environmental team has been busy this year continuing to ensure that all rooms, facilities and equipment are clean and hygienic. This function is of utmost importance as a clean environment is pivotal in preventing the transfer of unwanted germs and viruses and therefore a clean environment protects everybody at REDHS, particularly those people who might be more susceptible or vulnerable due to age or illness. The regular interactions of the Environmental staff with our residents and patients is not only a great way to have a warm and friendly interaction between staff and the resident or patient, but also provides a great opportunity to undertake a quick assessment of their respective surrounds and to be able to contribute positively to the care of the person by simply asking “Is there anything I can do for you?”. This powerful question allows the Environmental staff to be able to check in with the resident or patient to ensure they are comfortable and satisfied with the level of care and to engage with the resident or patient so as to provide as high a level of quality care possible.

## **Catering**

Our Catering team also enjoys the opportunity to have those regular interactions. Nutritious meals are the order of the day and with the support of REDHS’ Dietician, the catering team has been able to deliver over 100,000 meals during the year to our residents, patients and consumers. The catering team is very proud to be able to deliver such quality meals and values the input and feedback from residents and their families as we regularly discuss the delivery of catering services and how the dining experience can be further enhanced. During this year the catering team received feedback regarding challenges associated with ordering meals in aged care and subsequently developed a Menu Flip Book which has been of great benefit to our residents. Great memories have been created with the catering team providing a range of delicious food for special events including Oaks Day, Australia Day celebrations, Valentine’s Day, St Patrick’s Day and a very special pre-Christmas Function for Residents.

The Catering team has also been kept busy managing “Café REDHS” where staff and visitors to REDHS can call in and purchase a beverage, snack or tasty meal. REDHS Café is an approved Victorian Public Hospital Healthy Choices accredited Café where the menu is arranged in a “Traffic Light” system to classify foods into **GREEN (best choices)**, **AMBER (choose carefully)** and **RED (limit)** thereby helping to support staff and consumers to make healthier food choices. The catering team also provided its support to the broader community by providing catering to events in Elmore as well as the Rochester Fine Art Exhibition.

## **Procurement**

Like all public health services, REDHS has a requirement to be responsible and prudent with its financial spending. REDHS has a responsibility to ensure that public funds are being spent as effectively and efficiently as possible. The Supply team at REDHS has had a busy year ensuring that goods and services are sourced and procured in line with Government and Health Purchasing Victoria (HPV) guidelines. The Supply team has again ensured that REDHS complies with its responsibilities under HPV and thereby ensuring the health service is receiving best value for money. During the busy year, the team facilitated probity education for REDHS staff and Board members as well as the implementation of the Oracle R12 program and the roll-out of barcoding across the health service. Undertaking all of this work, while trialing new equipment and managing REDHS’ contracts with service providers, demonstrates the Supply team’s dedication and commitment to providing the highest level of quality care possible.

## **Finance**

Working closely with the procurement team, and indeed with all staff across the health service, is the Finance team. This year the Finance team continued to provide effective oversight of the health services accounts payable, the health services taxation and staff entitlement responsibilities, financial reporting, cash management as well as a high level of operational reporting of financial activity to both staff, the Executive and the Board ensuring that there is compliance, transparency and accountability in the financial practices of the health service.

## **Maintenance**

The resident and patient environment is important in providing quality care and the Maintenance team plays a pivotal role in maintaining these areas. The Maintenance team does more than working toward ensuring that the health services grounds, facilities, plant and equipment are maintained and are safe for us all to use. The Maintenance team also places the resident or patient at the centre of care and works constantly with all staff to ensure that the residents or patients environment is as conducive as possible to good health and well-being. From the painting of rooms, changing of floor coverings, the upgrading of bathrooms, to the hanging of residents televisions, the Maintenance team works hard to ensure that the environment from where the care is being delivered is in the best condition that it can possibly be. This work has been challenging with



the Maintenance team being heavily involved in a number of capital and planning projects during the year including the development of the Campaspe water pipe to enable watering of the gardens, planning for the installation of a new hot water system in aged care and undertaking feasibility planning for the potential installation of roof mounted solar panels, however like the other members of the Corporate Services team, the Maintenance team are focused toward being an active part of the Care Team.

The approaching year presents Corporate Services with a great opportunity to continue developing not only its already strong focus toward being active members of the Care Team but also to investigate new opportunities to make further contributions not only to the residents and patients of REDHS but also to the health services internal and external stakeholders. With a compliment of dedicated and staff within the Corporate Services team, 2018-19 looks to be an exciting year.

### ***Environment and Sustainability***

REDHS is committed to continuing the improvement of our environmental practices and minimizing the adverse environmental effects of our operations. REDHS recognizes the importance of using resources more efficiently and effectively and reducing environmental impact. Through the implementation of enhanced environmental sustainability practices we aim to achieve efficient and sustainable outcomes for energy, materials and water that will also comply with environmental legislation, regulations and Government policies.

We will apply these principles by:

- Committing to principles of pollution prevention
- Purchasing goods and services that provide value for money and minimize damage to the environment
- Continually striving to reduce waste to landfill through reduction, reuse and recycling
- Minimize the use of water
- Minimizing the production of greenhouse gases through efficient practices of energy usage in the health environment, commuting and usage of vehicle
- Continually improving environmental performance through maintaining, reviewing and implementing the REDHS Environmental Plan
- Educating staff, volunteers and clients utilising REDHS services regarding environmental best practices

REDHS's commitment to the implementation of environmental sustainability practices is demonstrated by the development of the REDHS Environmental Plan 2018-23 which details a course of action for REDHS to take to achieve its environmental goals including the implementation of the Regional Health Services Solar Program.

***Colin Wellard***  
**Corporate Services Manager**

# COMMUNITY INVOLVEMENT AND **SUPPORT**

## **Rochester and District Hospital Auxiliary**

It is with pleasure and pride that we are able to report that the auxiliary had another successful year, with the 15 members working tirelessly on a variety of fund raising activities.

Fund raising activities this year have included the Easter egg raffle, providing Devonshire Tea at the Rochester Fine Art Exhibition, Fashion Parade, Father's Day raffle and the popular Cup Day Luncheon. The auxiliary also supported "Cuppa for Cancer", the Great Northern Show (Rochester) and St John's Fair group exhibits.

Thank you to auxiliary members for willingly giving of their time to plan and support our activities.

New electric beds are high on the request list and our funds go towards this very necessary equipment. This year we were able to donate \$7,000 to assist with their purchase.

The auxiliary wishes to thank the community for their continuing support and REDHS Chief Executive Officer, Anne McEvoy, for attending our meetings and keeping us informed of what is happening at the health service.

**Maureen Leahy**  
President

## **Donations and Bequests (\$100 and over only are listed)**

Anonymous x 3	550
Rochester Hospital Auxiliary	7,000
In memory of Hazel Walsh	300
Eric Kneebone	500
In memory of Geoff Carr	100
In memory of Norma Clarke	120
Sonya Else	500
Lolly Trolley	200
Rochester Development Committee from the Rochester Fine Art Show*	1,613
<b>Total (all donations and bequests)</b>	<b>\$10,933</b>

*\*Note: An additional donation from the Fine Art Show was received after 30 June 2018 and will appear in the 2018-19 report.*

# STATUTORY INFORMATION

## **Financial Management Compliance attestation**

I, Carol McKinstry, on behalf of the Responsible Body, certify that Rochester and Elmore District Health Service has complied with the applicable Standing Directions of the Minister for Finance under the Financial Management Act 1994 and Instructions.



**Dr Carol McKinstry,  
Board Chair  
Rochester and Elmore District Health Service  
31 July 2018**

## **Availability of Additional Information**

In compliance with the requirements of Standing Direction FRD22H of the Minister for Finance, details in respect of the items listed below have been retained by Rochester and Elmore District Health Service and are available to the relevant Ministers, Members of Parliament and the public in request (subject to the freedom of information requirements, if applicable):

- (a) Declarations of pecuniary interests has been duly completed by all relevant officers;
- (b) Details of shares held by a senior officer as nominee or held beneficially;
- (c) Details of publications produced by the Health Service about its activities, and how these can be obtained;
- (d) Details of changes in prices, fees, charges, rates and levies charged by the Health Service;
- (e) Details of any major external reviews carried out on the Health Service;
- (f) Details of major research and development activities undertaken by the Health Service that are not otherwise covered either in the Report of Operations or in a document that contains the financial statements and Report of Operations;
- (g) Details of overseas visits undertaken including a summary of the objectives and outcomes of each visit;
- (h) Details of major promotional, public relations and marketing activities undertaken by the Health Service to develop community awareness of the Health Service and its services;
- (i) Details of assessments and measures undertaken to improve the occupational health and safety of employees;
- (j) A general statement on industrial relations within the Health Service and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the Report of Operations;

- (k) A list of major committees sponsored by the Health Service, the purposes of each committee and the extent to which the purposes have been achieved;
- (l) Details of all consultancies and contractors including consultants/ contractors engaged, services provided and expenditure committed to for each engagement.

## **Building Compliance**

Rochester and Elmore District Health Service ensures that all buildings, plant and equipment in its control are maintained and operated according to the statutory requirements of the Building Act 1993 and the Minister for Finance Guideline Building Act 1993 Standards for Publicly Owned Buildings November 1994.

## **Carer's Recognition**

In accordance with the Carer's Recognition Act 2012 (Carers Act), Rochester and Elmore District Health Service is taking all practicable measures to ensure that:

- management and employees have an awareness and understanding of the Statement for Australia's Carers; and
- persons who are in care relationships and who are receiving services in relation to the care relationship from REDHS, have an awareness and understanding of the care relationship principles; and
- REDHS' management and employees reflect the care relationship principles in developing, providing or evaluating support and assistance for persons in care relationships implementing, providing or evaluating care supports.

## **Conflict of Interest**

I, Anne McEvoy, certify that Rochester and Elmore District Health Service has put in place appropriate internal controls and processes to ensure that it has complied with the requirements of hospital circular 07/2017. Compliance reporting in health portfolio entities (Revised) and has implemented a 'Conflict of Interest' policy consistent with the minimum accountabilities required by the VPSC. Declaration of private interest forms have been completed by all executive staff within Rochester and Elmore District Health Service and members of the board, and all declared conflicts have been addressed and are being managed. Conflict of interest is a standard agenda item for declaration and documenting at each executive board meeting.

## **Consumer feedback**

We welcome feedback in regard to the quality of our service and it assists the health service with the development of strategies for continuous improvement. Feedback forms are available throughout the health service. Alternatively, feedback can be emailed directly to the address below or via [www.redhs.com.au](http://www.redhs.com.au)

Compliments, suggestions and complaints should be directed to:

**Chief Executive Officer, REDHS,**

**PO Box 202, Rochester Vic 3561**

**Ph: (03) 5484 4451**

**Email: [rochhosp@redhs.com.au](mailto:rochhosp@redhs.com.au)**

**Web: [www.redhs.com.au](http://www.redhs.com.au)**

### **Date Integrity**

I, Anne McEvoy certify that Rochester and Elmore District Health Service has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. Rochester and Elmore District Health Service has critically reviewed these controls and processes during the year.

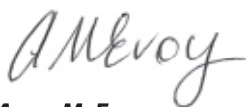
### **Freedom of Information**

The Freedom of Information Act 1982 provides the public with a means to obtain information held by the Rochester and Elmore District Health Service. During the 2017/18 financial year, four requests were received from the general public. Three requests were granted in full. One request was denied, in accordance with the Act, as the work involved in processing the request would substantially and unreasonably divert the resources of REDHS from other operations (i.e. outside normal activity).

Information regarding making a Freedom of Information request can be found at [www.redhs.com.au](http://www.redhs.com.au). Requests can be made by contacting the health service Freedom of Information Officer on (03) 5484 4451.

### **Compliance with Health Purchasing Victoria (HPV) Health Purchasing Policies**

I, Anne McEvoy, certify that Rochester and Elmore District Health Service has put in place appropriate internal controls and processes to ensure that it has complied with all requirements set out in the HPV Health Purchasing Policies including mandatory HPV collective agreements as required by the Health Services Act 1988 (Vic) and has critically reviewed these controls and processes during the year.



**Anne McEvoy,**

**Accountable Officer**

**Rochester and Elmore District Health Service**

**31 July 2018**

### **National Competition Policy**

Rochester and Elmore District Health Service continues to comply with the National Competition Policy. In addition, the Victorian Government's Competitive Neutrality Policy principles have been applied to all relevant business activities.

### **National Police Record (NPR) Checks**

Rochester and Elmore District Health Service requires all staff, volunteers and contractors to have a current, satisfactory national police register (NPR) check (also known as National Criminal History Checks). Employment or volunteering with Rochester and Elmore District Health Service does not commence until this requirement is met. NPR checks are deemed valid for three years. Some staff are also required to hold a satisfactory "Working with Children" check.

### **Protected Disclosure**

The Protected Disclosure Act 2012 (Vic) (the Act) provides for the protection of persons who make a protected disclosure under the Act from detrimental action by officers, members, employees and contractors of Rochester and Elmore District Health Service. REDHS has policies and procedures in place to protect people against action that might be taken against them if they choose to make a protected disclosure. The policy is accessible to staff via REDHS intranet and publicly available at [www.redhs.com.au](http://www.redhs.com.au). During the 2017/18 year, no applicable disclosures were made.

### **Safe Patient Care Act**

REDHS has no matters to report in relation to its obligations under section 40 of the Safe Patient Care Act 2015.

### **Victorian Industry Participation Policy (VIPP) Disclosures**

REDHS' procurement practices and purchasing policies comply with the Victorian Industry Participation Policy Act 2003. During 2017/18, REDHS did not commence or complete any contracts to which VIPP applied.

## **YOUR COMMUNITY – YOUR HEALTH SERVICE**

### **You Can Help In Many Ways**

Donations and bequests play a vital part in the provision of services to residents in our community. REDHS relies on the generosity of individuals and organisations within our community.

You can help by:

- Making a donation towards a specific item
- Defraying the cost of much needed equipment
- Remembering the Health Service in your will
- Joining the Hospital Auxiliary or Volunteer Program

Donations in memory of loved ones or in lieu of flowers are also appreciated. Envelopes are available for this purpose from the Health Service. Receipts are issued, acknowledgement letters are written, and when totals are known, summary letters are mailed to the decedent's next of kin.

**Your Help Is Needed – And Will Be Appreciated**



# DISCLOSURE INDEX

The Annual Report of Rochester and Elmore District Health Service is prepared in accordance with all relevant Victorian legislation. This index is prepared to facilitate identification of the Department's compliance with statutory disclosure requirements.

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<b>Legislation</b>		
<i>Freedom of Information Act 1982</i>		22
<i>Protected Disclosure Act 2012</i>		22
<i>Carers Recognition Act 2012</i>		21
<i>Victorian Industry Participation Policy Act 2003</i>		22
<i>Building Act 1993</i>		21
<i>Financial Management Act 1994</i>		3, 21
<i>Safe Patient Care Act 2015</i>		22

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redhs

Leading our community to better health

Rochester and Elmore District Health Service



# Financial Report 2018

## PERFORMANCE AGAINST STATEMENT OF PRIORITIES

The statement of priorities is the key accountability agreement between the Secretary for Health and Human Services and Rochester and Elmore District Health Service.

There were no significant changes in the financial position during 2017/18.

### PART A: Strategic Priorities

See REDHS 2017/18 Report of Operations pages 8-11 for details.

### PART B: Performance Priorities

**Service Performance:** See REDHS 2017/18 Report of Operations pages 12-13 for details.

#### Effective financial management

Key Performance Indicator	Target	2017-18 Result
<b>Finance</b>		
Operating Result (\$M)	0.12	0.15
Average number of days to paying trade creditors	60 days	55 days
Average number of days to receiving patient fee debtors	60 days	4 days
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	1.39
Number of days with available cash	14 days	119 days

### PART C: Activity and Funding

Funding type	2017-18 Activity Achievement
<b>Small Rural</b>	
Small Rural Acute	9
Small Rural HACC (service hours)	
- Occupational Therapy	27
- Physiotherapy	7
- Podiatry	62
- Nursing	457
- Planned Activity Group	959
Small Rural Residential Care	20,848
Health Workforce	4

#### Financials in Brief

The table below is a summary of the financial results for 2017/18, from annual financial statements, with comparative results for the preceding four financial years.

	2018 \$000	2017 \$000	2016 \$000	2015 \$000	2014 \$000
Total Revenue	14,600	14,265	13,344	13,053	12,789
Total Expenses	15,528	14,730	14,158	14,252	13,888
Net Result for the Year (incl. Capital and Specific Items)	(928)	(466)	(814)	(1,199)	(1,099)
Retained Surplus/ (Accumulated Deficit)	10,193	11,120	11,624	12,458	13,703
Total Assets	50,574	46,904	46,965	46,007	45,715
Total Liabilities	10,742	9,435	9,030	7,258	5,767
Net Assets	39,832	37,470	37,935	38,749	39,948
Net Cash Result	(103)	463	796	(1,950)	1,236
Total Equity	39,832	37,470	37,935	38,749	39,948

**Details of consultancies**

Details of Consultancies (under \$10,000)

In 2017/18 there were nine consultancies where the total fees payable to the consultants were less than \$10,000. The total expenditure incurred during 2017-18 in relation to these consultancies is \$48,481.73 excl. GST.

Details of Consultancies (valued at \$10,000 or greater)

In 2017/18 there were no consultancies where the total fees payable to the consultants were \$10,000 or greater.

**Information and Communication Technology (ICT) disclosure**

The total ICT expenditure incurred during 2017-18 is \$335,376.93 excl. GST, with the details shown below

Business as Usual (BAU) ICT expenditure	Non Business as Usual (non-BAU) ICT Expenditure		
	Total of Operational and Capital Expenditure	Operational expenditure	Capital expenditure
\$335,376.93	\$19,945.29	\$10,058.18	\$9,887.11



## **Rochester and Elmore District Health Service Board Member's, Accountable Officer's and Chief Finance & Accounting Officer's declaration**

The attached financial statements for Rochester and Elmore District Health Service have been prepared in accordance with Direction 5.2 of the Standing Directions of the Minister for Finance under the Financial Management Act 1994, applicable Financial Reporting Directions, Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2018 and the financial position of Rochester and Elmore District Health Service at 30 June 2018.

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

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



.....

Carol McKinstry  
Chairperson

Rochester  
22 August 2018



.....

Anne McEvoy  
Accountable Officer  
Chief Finance and Accounting Officer

Rochester  
22 August 2018

# Independent Auditor's Report

## To the Board of Rochester and Elmore District Health Service

<b>Opinion</b>	<p>I have audited the financial report of Rochester and Elmore District Health Service (the health service) which comprises the:</p> <ul style="list-style-type: none"> <li>• balance sheet as at 30 June 2018</li> <li>• comprehensive operating statement for the year then ended</li> <li>• statement of changes in equity for the year then ended</li> <li>• cash flow statement for the year then ended</li> <li>• notes to the financial statements, including significant accounting policies</li> <li>• board member's, accountable officer's and chief finance &amp; accounting officer's declaration.</li> </ul> <p>In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2018 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the <i>Financial Management Act 1994</i> and applicable Australian Accounting Standards.</p>
<b>Basis for Opinion</b>	<p>I have conducted my audit in accordance with the <i>Audit Act 1994</i> which incorporates the Australian Auditing Standards. I further describe my responsibilities under that Act and those standards in the <i>Auditor's Responsibilities for the Audit of the Financial Report</i> section of my report.</p> <p>My independence is established by the <i>Constitution Act 1975</i>. My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 <i>Code of Ethics for Professional Accountants</i> (the Code) that are relevant to my audit of the financial report in Victoria. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code.</p> <p>I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.</p>
<b>Board's responsibilities for the financial report</b>	<p>The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the <i>Financial Management Act 1994</i>, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error.</p> <p>In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.</p>

**Auditor's  
responsibilities  
for the audit  
of the financial  
report**

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

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

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

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

MELBOURNE  
27 August 2018



Ron Mak

*as delegate for the Auditor-General of Victoria*

## Rochester and Elmore District Health Service

### Comprehensive Operating Statement for the Financial Year Ended 30 June 2018

	NOTE	2018 \$	2017 \$
Revenue from Operating Activities	2.1	13,972,286	13,402,275
Revenue from Non-operating Activities	2.1	195,516	204,369
Employee Expenses	3.1	(10,746,029)	(10,170,672)
Non Salary Labour Costs	3.1	(500,694)	(396,634)
Supplies and Consumables	3.1	(1,181,266)	(1,131,261)
Other Expenses	3.1	(1,583,113)	(1,439,025)
<b>Net Result Before Capital and Specific Items</b>		<b>156,700</b>	<b>469,052</b>
Capital Purpose Income	2.1	441,348	620,946
Depreciation	4.3	(1,497,182)	(1,493,645)
Expenditure for Capital Purpose	3.1	(36,910)	(73,685)
<b>Net Result After Capital and Specific Items</b>		<b>(936,044)</b>	<b>(477,332)</b>
<b>Other Economic Flows Included in the Net Result</b>			
Gain/(Loss) on Sale of Assets	2.1	(9,544)	37,061
Revaluation of Long Service Leave	3.1	17,556	(25,574)
<b>Total Other Economic Flows Included in the Net Result</b>		<b>8,012</b>	<b>11,487</b>
<b>NET RESULT FOR THE YEAR</b>		<b>(928,032)</b>	<b>(465,845)</b>
<b>COMPREHENSIVE RESULT FOR THE YEAR</b>		<b>(928,032)</b>	<b>(465,845)</b>

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

## Rochester and Elmore District Health Service

### Balance Sheet as at 30 June 2018

	NOTE	2018 \$	2017 \$
<b>Current Assets</b>			
Cash and Cash Equivalents	6.1	9,436,662	8,078,320
Receivables	5.1	349,303	520,835
Investments and Other financial assets	4.1	3,121,749	3,064,067
Inventories	5.2	45,930	45,171
Prepayments and Other Assets	5.4	139,968	129,283
<b>Total Current Assets</b>		<b>13,093,612</b>	<b>11,837,676</b>
<b>Non-Current Assets</b>			
Receivables	5.1	260,628	205,110
Property, Plant & Equipment	4.2	37,219,873	34,861,701
<b>Total Non-Current Assets</b>		<b>37,480,501</b>	<b>35,066,811</b>
<b>TOTAL ASSETS</b>		<b>50,574,113</b>	<b>46,904,487</b>
<b>Current Liabilities</b>			
Payables	5.5	519,417	832,880
Provisions	3.3	2,629,539	2,326,090
Other Current Liabilities	5.3	7,439,377	5,957,049
<b>Total Current Liabilities</b>		<b>10,588,333</b>	<b>9,116,019</b>
<b>Non-Current Liabilities</b>			
Provisions	3.3	153,309	318,829
<b>Total Non-Current Liabilities</b>		<b>153,309</b>	<b>318,829</b>
<b>TOTAL LIABILITIES</b>		<b>10,741,642</b>	<b>9,434,848</b>
<b>NET ASSETS</b>		<b>39,832,471</b>	<b>37,469,639</b>
<b>EQUITY</b>			
Property, Plant & Equipment Revaluation Surplus	8.1	21,343,890	18,053,026
Restricted Specific Purpose Surplus	8.1	925,988	927,164
Contributed Capital	8.1	7,369,839	7,369,839
Accumulated Surpluses	8.1	10,192,754	11,119,610
<b>TOTAL EQUITY</b>		<b>39,832,471</b>	<b>37,469,639</b>
Contingent Assets and Contingent Liabilities	7.3		
Commitments	6.2		

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



## Rochester and Elmore District Health Service

### Statement of Changes in Equity for the Financial Year Ended 30 June 2018

		Property, Plant and Equipment Revaluation Surplus	Restricted Special Purpose Surplus	Contribution by Owners	Accumulated Surpluses / (Deficits)	Total
	Note	\$	\$	\$	\$	\$
<b>Balance at 1 July 2016</b>		18,053,026	888,835	7,369,839	11,623,784	37,935,484
Net result for the year	8.1	-	-	-	(465,845)	(465,845)
Transfers		-	38,329	-	(38,329)	-
Other comprehensive income for the year	8.1	-	-	-	-	-
<b>Balance at 30 June 2017</b>		<b>18,053,026</b>	<b>927,164</b>	<b>7,369,839</b>	<b>11,119,610</b>	<b>37,469,639</b>
Net result for the year	8.1	-	-	-	(928,032)	(928,032)
Transfers		3,290,864	(1,176)	-	1,176	3,290,864
Other comprehensive income for the year	8.1	-	-	-	-	-
<b>Balance at 30 June 2018</b>		<b>21,343,890</b>	<b>925,988</b>	<b>7,369,839</b>	<b>10,192,754</b>	<b>39,832,471</b>

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

## Rochester and Elmore District Health Service

### Cash Flow Statement for the Financial Year Ended 30 June 2018

	NOTE	2018 \$	2017 \$
<b>CASH FLOWS FROM OPERATING ACTIVITIES</b>			
Operating Grants from Government		10,912,919	10,108,033
Capital Grants from Government		321,017	484,763
Patient and Resident Fees Received		1,732,889	1,948,694
Donations and Bequests Received		26,536	58,505
GST Received from/(paid to) ATO		213,342	180,231
Interest Received		158,177	145,864
Other Capital Receipts		97,182	106,915
Other Receipts		1,053,222	1,522,119
<b>Total Receipts</b>		<b>14,515,284</b>	<b>14,555,124</b>
Employee Expenses Paid		(10,897,216)	(10,100,069)
Non Salary Labour Costs		(267,096)	(208,958)
Payments for Supplies & Consumables		(1,182,026)	(1,275,165)
Other Payments		(1,640,807)	(1,400,105)
<b>Total Payments</b>		<b>(13,987,145)</b>	<b>(12,984,297)</b>
<b>NET CASH FLOW FROM OPERATING ACTIVITIES</b>	8.2	<b>528,139</b>	<b>1,570,827</b>
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>			
Proceeds/(Purchase) from Sale of Investments		(78,760)	(865,335)
Payments for Non-Financial Assets		(558,925)	(290,375)
Proceeds from sale of Non-Financial Assets		6,792	47,793
<b>NET CASH FLOW FROM/ (USED IN) INVESTING ACTIVITIES</b>		<b>(630,893)</b>	<b>(1,107,917)</b>
<b>NET INCREASE/ (DECREASE) IN CASH AND CASH EQUIVALENTS HELD</b>		<b>(102,754)</b>	<b>462,910</b>
Cash and Cash Equivalents at beginning of financial year		1,878,280	1,415,370
<b>CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR</b>	6.1	<b>1,775,526</b>	<b>1,878,280</b>

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

**Rochester and Elmore District Health Service**  
**Note to the Financial Statements**  
**For the Financial Year Ended 30 June 2018**

## **Basis of preparation**

The financial statements are prepared in accordance with Australian Accounting Standards and relevant FRDs.

These financial statements are in Australian dollars and the historical cost convention is used unless a different measurement basis is specifically disclosed in the note associated with the item measured on a different basis.

The accrual basis of accounting has been applied in preparing these financial statements, whereby assets, liabilities, equity, income and expenses are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

Consistent with the requirements of AASB 1004 Contributions, contributions by owners (that is, contributed capital and its repayment) are treated as equity transactions and, therefore, do not form part of the income and expenses of the Health Service.

Additions to net assets which have been designated as contributions by owners are recognised as contributed capital. Other transfers that are in the nature of contributions to or distributions by owners have also been designated as contributions by owners.

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

Revisions to accounting estimates are recognised in the period in which the estimate is revised and also in future periods that are affected by the revision. Judgements and assumptions made by management in applying AAS that have significant effects on the financial statements and estimates are disclosed in the notes under the heading: **Significant judgement or estimates**

## **Note 1 – Summary of Significant Accounting Policies**

These annual financial statements represent the audited general purpose financial statements for Rochester and Elmore District Health Service and its controlled entities for the year ended 30 June 2018. The report provides users with information about the Health Service's stewardship of resources entrusted to it.

### **(a) Statement of Compliance**

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

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

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

The annual financial statements were authorised for issue by the Board of Rochester and Elmore District Health Service on 22nd August 2018.

### **(b) Reporting Entity**

The financial statements include all the controlled activities of Rochester and Elmore District Health Service.

Its principal address is:

1 Pascoe Street

Rochester VIC 3551.

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

### **(c) Basis of Accounting Preparation and Measurement**

Accounting policies are selected and applied in a manner which ensures that the resulting financial information satisfies the concepts of relevance and reliability, thereby ensuring that the substance of the underlying transactions or other events is reported.

The accounting policies have been applied in preparing the financial statements for the year ended 30 June 2018, and the comparative information presented in these financial statements for the year ended 30 June 2017.

The financial statements are prepared on a going concern basis.

These financial statements are presented in Australian dollars, the functional and presentation currency of Rochester and Elmore District Health Service.

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

The Rochester and Elmore District Health Service operates on a fund accounting basis and maintains three funds: Operating, Specific Purpose and Capital Funds.

The financial statements, except for cash flow information, have been prepared using the accrual basis of accounting. Under the accrual basis, items are recognised as assets, liabilities, equity, income or expenses when they satisfy the definitions and recognition criteria for those items, that is, they are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

Judgements, estimates and assumptions are required to be made about the carrying values of assets and liabilities that are not readily apparent from other sources. The estimates and underlying assumptions are reviewed on an ongoing basis. The estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

Revisions to accounting estimates are recognised in the period in which the estimate is revised and also in future periods that are affected by the revision. Judgements and assumptions made by management in the application of AASBs that have significant effects on the financial statements and estimates relate to:

- The fair value of land, buildings and plant and equipment (refer to Note 4.2 Property, Plant and Equipment);
- Superannuation expense (refer to Note 3.4 Superannuation);
- Employee benefit provisions are based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.3 Employee Benefits in the Balance Sheet); and

**(c) Basis of Accounting Preparation and Measurement (continued)**

**Goods and Services Tax (GST)**

Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the Australian Taxation Office (ATO). In this case the GST payable is recognised as part of the cost of acquisition of the asset or as part of the expense.

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

Cash flows are presented on a gross basis. The GST components of cash flows arising from investing or financing activities which are recoverable from, or payable to the ATO, are presented as operating cash flow.

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

**(d) Jointly Controlled Operation**

Joint control is the contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control.

☐ In respect of any interest in joint operations, Rochester and Elmore District Health Service recognises in the financial statements: its assets, including its share of any assets held jointly;

☐ any liabilities including its share of liabilities that it had incurred;

☐ its revenue from the sale of its share of the output from the joint operation;

☐ its share of the revenue from the sale of the output by the operation; and

☐ its expenses, including its share of any expenses incurred jointly.

Rochester and Elmore District Health Service is a Member of the LMRHA Joint Venture and retains joint control over the arrangement, which it has classified as a joint operation (refer to Note 8.9 Jointly Controlled Operations).



## **Note: 2 Funding Delivery of Our Services**

The Health Service's overall objective is to deliver programs and services that support and enhance the wellbeing of all Victorians.

Rochester and Elmore District Health is predominantly funded by accrual based grant funding for the provision of outputs. The health service also receives income from the supply of services.

### **Structure**

#### **2.1 Analysis of Revenue by Source**

**Note 2.1: Analysis of Revenue by Source**

	Admitted Patients 2018 \$	Residential Aged Care 2018 \$	Aged Care 2018 \$	Primary Health 2018 \$	Other 2018 \$	Total 2018 \$
Government Grants	3,390,619	5,723,406	623,458	1,036,340	72,823	10,846,646
Indirect contributions by Department of Health and Human Services	6,106	13,469	1,306	5,683	27,605	54,169
Patient & Resident Fees	163,559	1,418,789	33,470	81,864	57,261	1,754,943
Commercial Activities				77,902	69,798	147,700
Other Revenue from Operating Activities	316,797	11,425	61,237	692,756	86,613	1,168,828
<b>Total Revenue from Operating Activities</b>	<b>3,877,081</b>	<b>7,167,089</b>	<b>719,471</b>	<b>1,894,545</b>	<b>314,100</b>	<b>13,972,286</b>
Interest	-	-	-	-	158,177	158,177
Other Revenue from Non-Operating Activities	-	-	-	-	37,339	37,339
<b>Total Revenue from Non-Operating Activities</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>195,516</b>	<b>195,516</b>
Capital Purpose Income (excluding Interest)	-	7,990	-	-	328,574	336,564
Capital Interest	-	104,784	-	-	-	104,784
Gain/(Loss) on Sale of Assets	-	-	-	-	(9,544)	(9,544)
<b>Total Capital Purpose Income</b>	<b>-</b>	<b>112,774</b>	<b>-</b>	<b>-</b>	<b>319,030</b>	<b>431,804</b>
<b>Total Revenue</b>	<b>3,877,081</b>	<b>7,279,863</b>	<b>719,471</b>	<b>1,894,545</b>	<b>828,646</b>	<b>14,599,606</b>

Department of Health and Human Services makes certain payments on behalf of Rochester and Elmore District Health Service. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

	Admitted Patients 2017 \$	Residential Aged Care 2017 \$	Aged Care 2017 \$	Primary Health 2017 \$	Other 2017 \$	Total 2017 \$
Government Grants	2,896,014	5,491,826	571,149	955,427	142,431	10,056,847
Indirect contributions by Department of Health and Human Services	3,801	12,204	1,154	5,013	26,773	48,945
Patient and Resident Fees	319,609	1,357,000	54,986	81,253	65,201	1,878,049
Commercial Activities	-	-	-	84,195	94,714	178,909
Other Revenue from Operating Activities	301,248	5,777	30,268	700,117	202,115	1,239,525
<b>Total Revenue from Operating Activities</b>	<b>3,520,672</b>	<b>6,866,807</b>	<b>657,557</b>	<b>1,826,005</b>	<b>531,234</b>	<b>13,402,275</b>
Interest	-	-	-	-	145,864	145,864
Other revenue from Non - Operating Activities	-	-	-	-	58,505	58,505
<b>Total Revenue from Non - Operating Activities</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>204,369</b>	<b>204,369</b>
Capital Purpose Income (excluding Interest)	-	11,268	-	-	507,526	518,794
Capital Interest	-	102,152	-	-	-	102,152
Gain/(loss) on Sale of Assets	-	-	-	-	37,061	37,061
<b>Total Capital Purpose Income</b>	<b>-</b>	<b>113,420</b>	<b>-</b>	<b>-</b>	<b>544,587</b>	<b>658,007</b>
<b>Total Revenue</b>	<b>3,520,672</b>	<b>6,980,227</b>	<b>657,557</b>	<b>1,826,005</b>	<b>1,280,190</b>	<b>14,264,651</b>

Department of Health and Human Services makes certain payments on behalf of Rochester and Elmore District Health Service. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

**Revenue Recognition**

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

Amounts disclosed as revenue are, where applicable, net of returns, allowances and duties and taxes.

**Government Grants and other transfers of income (other than contributions by owners)**

In accordance with AASB 1004 *Contributions*, government grants and other transfers of income (other than contributions by owners) are recognised as income when the Health Service gains control of the underlying assets irrespective of whether conditions are imposed on the Health Service's use of the contributions.

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

**Indirect Contributions from the Department of Health and Human Services**

-Insurance is recognised as revenue following advice from the Department of Health and Human Services.

-Long Service Leave (LSL) – Revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Metropolitan Health and Aged Care Services Division Hospital Circular 04/2018 (update for 2017-17).

**Patient and Resident Fees**

Patient fees are recognised as revenue at the time invoices are raised.

**Private Practice Fees**

Private practice fees are recognised as revenue at the time invoices are raised.

**Revenue from commercial activities**

Revenue from commercial activities such as commercial laboratory medicine is recognised at the time invoices are raised.

**Donations and Other Bequests**

Donations and bequests are recognised as revenue when received. If donations are for a special purpose, they may be appropriated to a surplus, such as the specific restricted purpose surplus.

**Interest Revenue**

Interest revenue is recognised on a time proportionate basis that takes in account the effective yield of the financial asset, which allocates interest over the relevant period.

**Sale of investments**

The gain/loss on the sale of investments is recognised when the investment is realised.

**Fair value of assets and services received free of charge or for nominal consideration**

Resources received free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them, irrespective of whether restrictions or conditions are imposed over the use of the contributions, unless received from another Health Service or agency as a consequence of a restructuring of administrative arrangements. In the latter case, such transfer will be recognised at carrying value. Contributions in the form of services are only recognised when a fair value can be reliably determined and the service would have been purchased if not received as a donation.

**Other Income**

Other income includes non-property rental, dividends, forgiveness of liabilities, and bad debt reversals.

**Category Groups**

Rochester and Elmore District Health Service has used the following category groups for reporting purposes for the current and previous financial years.

**Admitted Patient Services (Admitted Patients)**

comprises all acute and subacute admitted patient services, where services are delivered in public hospitals.

**Aged Care**

comprises a range of in home, specialist geriatric, residential care and community based programs and support services, such as Home and Community Care (HACC) that are targeted to older people, people with a disability, and their carers.

**Residential Aged Care**

comprises those Commonwealth-licensed residential aged care services.

**Primary Health**

comprises a range of home based, community based, community and primary health services including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy.

### **Note 3: The Cost of Delivering Our Services**

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

#### **Structure**

3.1 Analysis of Expenses by Source

3.2 Analysis of Expense and Revenue by Internally Managed and Restricted Specific Purpose Funds

3.3 Employee Benefits in the Balance Sheet

3.4 Superannuation

**Note 3.3: Employee Benefits in the Balance Sheet**

	2018	2017
	\$	\$
<b>Current Provisions</b>		
Employee Benefits (Note 3.3(a))		
Annual Leave (Note 3.3(a))		
- Unconditional and expected to be settled within 12 months (ii)	809,521	739,698
- Unconditional and expected to be settled after 12 months (ii)	137,241	123,405
Accrued Day Off (Note 3.3(a))		
- Unconditional and expected to be settled within 12 months (ii)	5,167	6,703
- Unconditional and expected to be settled after 12 months (ii)	878	1,110
Long Service Leave (Note 3.3(a))		
- Unconditional and expected to be settled within 12 months (ii)	133,386	128,423
- Unconditional and expected to be settled after 12 months (ii)	953,310	903,598
Provisions related to employee benefit on-costs		
- Unconditional and expected to be settled within 12 months (ii)	99,604	13,075
- Unconditional and expected to be settled after 12 months (ii)	114,999	91,976
Salaries and Wages (Note 3.3(a))	375,433	318,102
<b>Total Current Provisions</b>	<b>2,629,539</b>	<b>2,326,090</b>
<b>Non-Current Provisions</b>		
Employee Benefits (i) (Note 3.3(a))	138,689	201,721
Provisions related to employee benefits on-costs (Note 3.3(a) and 3.3(b))	14,620	117,108
<b>Total Non-Current Provisions</b>	<b>153,309</b>	<b>318,829</b>
<b>Total Provisions</b>	<b>2,782,848</b>	<b>2,644,919</b>
<b>(a) Employee Benefits and Related On-Costs</b>		
<b>Current Employee Benefits and Related On-Costs</b>		
Annual Leave Entitlements	946,762	863,103
Accrued Wages and Salaries	375,433	318,102
Accrued Days Off	6,680	7,813
Unconditional Long Service Leave Entitlements	1,086,696	1,032,021
Current On-Costs	213,968	105,051
<b>Non-Current Employee Benefits and Related On-Costs</b>		
Conditional Long Service Leave Entitlements (iii)	138,689	201,721
Non-Current On-Costs	14,620	117,108
<b>Total Employee Benefits and Related On-Costs</b>	<b>2,782,848</b>	<b>2,644,919</b>
<b>(b) Movements in Provisions</b>		
<b>Movement in Long Service Leave:</b>		
<b>Balance at start of year</b>	<b>1,300,986</b>	<b>1,255,228</b>
Provision made during the year	176,833	171,211
Settlement made during the year	(237,814)	(125,453)
<b>Balance at end of year</b>	<b>1,240,005</b>	<b>1,300,986</b>

(i) Employee benefits consist of annual leave and long service leave accrued by employees. On-costs such as payroll tax and workers compensation insurance are not employee benefits and are reflected as a separate provision.

(ii) The amounts disclosed are at present values.

**Employee Benefits Recognition**

Provision is made for benefits accruing to employees in respect of wages and salaries, annual leave and long service leave for services rendered to the reporting date as an expense during the period the services are delivered.

**Provisions**

Provisions are recognised when the Health Service has a present obligation, the future sacrifice of economic benefits is probable, and the amount of the provision can be measured reliably.

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

**Employee benefits**

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

**Wages and salaries, annual leave, sick leave and accrued days off**

Liabilities for wages and salaries, including non-monetary benefits, annual leave, and accumulating sick leave are all recognised in the provision for employee benefits as 'current liabilities', because the Health Service does not have an unconditional right to defer settlements of these liabilities.

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

- Undiscounted value – if the Health Service expects to wholly settle within 12 months; or
- Present value – if the Health Service does not expect to wholly settle within 12 months.

**Long service leave (LSL)**

Liability for LSL is recognised in the provision for employee benefits.

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

The components of this current LSL liability are measured at:

- Undiscounted value – if the Health Service expects to wholly settle within 12 months; or
- Present value – if the Health Service does not expect to wholly settle within 12 months.

Conditional LSL is disclosed as a non-current liability.

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

**On-costs related to employee expense**

Provision for on-costs, such as workers compensation and superannuation are recognised together with provisions for employee benefits.

**Note 3.2: Analysis of Expense and Revenue by Internally Managed and Restricted Specific Purpose Funds**

	Expense		Revenue	
	2018	2017	2018	2017
	\$	\$	\$	\$
<b>Commercial Activities</b>				
Radiology	71,225	52,353	60,476	73,387
Meals on Wheels	41,761	41,866	29,427	51,492
Cafeteria	58,150	46,943	37,992	33,952
Primary Care Partnership	330,360	396,515	337,723	392,689
<b>Total</b>	<b>501,496</b>	<b>537,677</b>	<b>465,618</b>	<b>551,520</b>



**Note 3.1: Analysis of Expenses by Source**

	<b>Admitted Patients 2018 \$</b>	<b>Residential Aged Care 2018 \$</b>	<b>Aged Care 2018 \$</b>	<b>Primary Health 2018 \$</b>	<b>Other 2018 \$</b>	<b>Total 2018 \$</b>
Employee Expenses	1,716,866	4,278,119	384,122	1,545,982	2,820,940	10,746,029
Non Salary Labour Costs	362,827	117,067	-	20,800	-	500,694
Supplies & Consumables	229,801	229,487	5,357	15,396	701,225	1,181,266
Other Expenses	150,734	172,782	18,640	104,994	1,135,964	1,583,113
<b>Total Expenditure from Operating Activities</b>	<b>2,460,229</b>	<b>4,797,455</b>	<b>408,119</b>	<b>1,687,172</b>	<b>4,658,129</b>	<b>14,011,102</b>
Expenditure for Capital Purpose	-	-	-	-	36,910	36,910
Revaluation of Long Service Leave	-	-	-	-	(17,556)	(17,556)
Depreciation (refer Note 4.3)	-	-	-	-	1,497,182	1,497,182
<b>Total Other Expenses</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>1,516,536</b>	<b>1,516,536</b>
<b>Total Expenses</b>	<b>2,460,229</b>	<b>4,797,455</b>	<b>408,119</b>	<b>1,687,172</b>	<b>6,174,665</b>	<b>15,527,638</b>

	<b>Admitted Patients 2017 \$</b>	<b>Residential Aged Care 2017 \$</b>	<b>Aged Care 2017 \$</b>	<b>Primary Health 2017 \$</b>	<b>Other 2017 \$</b>	<b>Total 2017 \$</b>
Employee Expenses	1,573,265	3,846,754	357,457	1,451,178	2,942,018	10,170,672
Non Salary Labour Costs	238,411	130,096	-	20,096	8,031	396,634
Supplies & Consumables	204,185	209,474	5,677	78,360	633,565	1,131,261
Other Expenses	151,018	151,481	16,693	149,140	970,693	1,439,025
<b>Total Expenditure from Operating Activities</b>	<b>2,166,879</b>	<b>4,337,805</b>	<b>379,827</b>	<b>1,698,774</b>	<b>4,554,307</b>	<b>13,137,592</b>
Expenditure for Capital Purpose	-	-	-	-	73,685	73,685
Revaluation of Long Service Leave	-	-	-	-	25,574	25,574
Depreciation (refer Note 4.3)	-	-	-	-	1,493,645	1,493,645
<b>Total Other Expenses</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>1,592,904</b>	<b>1,592,904</b>
<b>Total Expenses</b>	<b>2,166,879</b>	<b>4,337,805</b>	<b>379,827</b>	<b>1,698,774</b>	<b>6,147,211</b>	<b>14,730,496</b>

**Expense Recognition**

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

**Employee expenses**

Employee expenses include:

- wages and salaries;
- leave entitlements;
- workcover premiums;
- termination payments;
- fringe benefits tax; and
- superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

**Other operating expenses**

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

**Supplies and consumables**

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

**Fair value of assets, services and resources provided free of charge or for nominal consideration**

Contributions of resources provided free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them.

**Net gain/ (loss) on non-financial assets**

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

- o Revaluation gains/ (losses) of non-financial physical assets (Refer to Note 4.4 Property plant and equipment).
- o Net gain/ (loss) on disposal of non-financial assets

Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal and is the difference between the proceeds and the carrying value of the asset at the time.

**Net gain/ (loss) on financial instruments**

Net gain/ (loss) on financial instruments includes:

- o Realised and unrealised gains and losses from revaluations of financial instruments at fair value;
- o Impairment and reversal of impairment for financial instruments at amortised cost; and
- o Disposals of financial assets and derecognition of financial liabilities

**Other gains/ (losses) from other economic flows**

Other gains/ (losses) include:

- o The revaluation of the present value of the long service leave liability due to changes in the bond rate movements, inflation rate movements and the impact of changes in probability factors; and
- o Transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

**Derecognition of financial liabilities**

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

**Note 3.2: Analysis of Expense and Revenue by Internally Managed and Restricted Specific Purpose Funds**

	Expense		Revenue	
	2018	2017	2018	2017
	\$	\$	\$	\$
<b>Commercial Activities</b>				
Radiology	71,225	52,353	60,476	73,387
Meals on Wheels	41,761	41,866	29,427	51,492
Cafeteria	58,150	46,943	37,992	33,952
Primary Care Partnership	330,360	396,515	337,723	392,689
<b>Total</b>	<b>501,496</b>	<b>537,677</b>	<b>465,618</b>	<b>551,520</b>

**Note 3.3: Employee Benefits in the Balance Sheet**

	2018	2017
	\$	\$
<b>Current Provisions</b>		
Employee Benefits (Note 3.3(a))		
Annual Leave (Note 3.3(a))		
- Unconditional and expected to be settled within 12 months (ii)	809,521	739,698
- Unconditional and expected to be settled after 12 months (ii)	137,241	123,405
Accrued Day Off (Note 3.3(a))		
- Unconditional and expected to be settled within 12 months (ii)	5,167	6,703
- Unconditional and expected to be settled after 12 months (ii)	878	1,110
Long Service Leave (Note 3.3(a))		
- Unconditional and expected to be settled within 12 months (ii)	133,386	128,423
- Unconditional and expected to be settled after 12 months (ii)	953,310	903,598
Provisions related to employee benefit on-costs		
- Unconditional and expected to be settled within 12 months (ii)	99,604	13,075
- Unconditional and expected to be settled after 12 months (ii)	114,999	91,976
Salaries and Wages (Note 3.3(a))	375,433	318,102
<b>Total Current Provisions</b>	<b>2,629,539</b>	<b>2,326,090</b>
<b>Non-Current Provisions</b>		
Employee Benefits (i) (Note 3.3(a))	138,689	201,721
Provisions related to employee benefits on-costs (Note 3.3(a) and 3.3(b))	14,620	117,108
<b>Total Non-Current Provisions</b>	<b>153,309</b>	<b>318,829</b>
<b>Total Provisions</b>	<b>2,782,848</b>	<b>2,644,919</b>
<b>(a) Employee Benefits and Related On-Costs</b>		
<b>Current Employee Benefits and Related On-Costs</b>		
Annual Leave Entitlements	946,762	863,103
Accrued Wages and Salaries	375,433	318,102
Accrued Days Off	6,680	7,813
Unconditional Long Service Leave Entitlements	1,086,696	1,032,021
Current On-Costs	213,968	105,051
<b>Non-Current Employee Benefits and Related On-Costs</b>		
Conditional Long Service Leave Entitlements (iii)	138,689	201,721
Non-Current On-Costs	14,620	117,108
<b>Total Employee Benefits and Related On-Costs</b>	<b>2,782,848</b>	<b>2,644,919</b>
<b>(b) Movements in Provisions</b>		
<b>Movement in Long Service Leave:</b>		
<b>Balance at start of year</b>	<b>1,300,986</b>	<b>1,255,228</b>
Provision made during the year	176,833	171,211
Settlement made during the year	(237,814)	(125,453)
<b>Balance at end of year</b>	<b>1,240,005</b>	<b>1,300,986</b>

(i) Employee benefits consist of annual leave and long service leave accrued by employees. On-costs such as payroll tax and workers compensation insurance are not employee benefits and are reflected as a separate provision.

(ii) The amounts disclosed are at present values.

**Employee Benefits Recognition**

Provision is made for benefits accruing to employees in respect of wages and salaries, annual leave and long service leave for services rendered to the reporting date as an expense during the period the services are delivered.

**Provisions**

Provisions are recognised when the Health Service has a present obligation, the future sacrifice of economic benefits is probable, and the amount of the provision can be measured reliably.

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

**Employee benefits**

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

**Wages and salaries, annual leave, sick leave and accrued days off**

Liabilities for wages and salaries, including non-monetary benefits, annual leave, and accumulating sick leave are all recognised in the provision for employee benefits as 'current liabilities', because the Health Service does not have an unconditional right to defer settlements of these liabilities.

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

- Undiscounted value – if the Health Service expects to wholly settle within 12 months; or
- Present value – if the Health Service does not expect to wholly settle within 12 months.

**Long service leave (LSL)**

Liability for LSL is recognised in the provision for employee benefits.

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

The components of this current LSL liability are measured at:

- Undiscounted value – if the Health Service expects to wholly settle within 12 months; or
- Present value – if the Health Service does not expect to wholly settle within 12 months.

Conditional LSL is disclosed as a non-current liability.

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

**On-costs related to employee expense**

Provision for on-costs, such as workers compensation and superannuation are recognised together with provisions for employee benefits.

**Note 3.4: Superannuation**

**Defined Contribution plans:**

First State Super

Host Plus Super

HESTA Administration

**TOTAL**

<b>2018</b>	<b>2017</b>
<b>\$</b>	<b>\$</b>
571,791	555,304
4,240	605
262,033	227,355
<b>838,064</b>	<b>783,264</b>

Employees of Rochester and Elmore District Health Service are entitled to receive superannuation benefits and Rochester and Elmore District Health Service contributions paid or payable for the reporting period are included as part of the employee benefits in the comprehensive operating statement of the Health Service.

**Defined Contribution Superannuation Plans**

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

**Defined Benefit Superannuation Plans**

The amount charged to the Comprehensive Operating Statement in respect of defined benefit superannuation plans represents the contributions made by Rochester and Elmore District Health Services to the superannuation plans in respect of the services of current Rochester and Elmore District Health Service's staff during the reporting period. Superannuation contributions are made to the plans based on the relevant rules of each plan and are based upon actuarial advice.

Rochester and Elmore District Health Services does not recognise any unfunded defined benefit liability in respect of the plans because the Health Service has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due. The Department of Treasury and Finance discloses the State's defined benefits liabilities in its disclosure for administered items.

However superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the Comprehensive Operating Statement of Rochester and Elmore District Health Services.

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

**Note 4: Key Assets to Support Service Delivery**

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

**Structure**

- 4.1 Investments and Other Financial Assets
- 4.2 Property, Plant & Equipment
- 4.3 Depreciation and Amortisation

**Note 4.1: Investments and Other Financial Assets**

	<b>Capital</b>		<b>Total</b>	
	<b>2018</b>	<b>2017</b>	<b>2018</b>	<b>2017</b>
	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>
<b>CURRENT</b>				
<b>Term Deposit</b>				
Aust. Dollar Term Deposits(i)	3,121,749	3,064,067	3,121,749	3,064,067
<b>Total Current</b>	<b>3,121,749</b>	<b>3,064,067</b>	<b>3,121,749</b>	<b>3,064,067</b>
<b>Represented by:</b>				
Health Service Investments	3,121,749	3,064,067	3,121,749	3,064,067
<b>TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS</b>	<b>3,121,749</b>	<b>3,064,067</b>	<b>3,121,749</b>	<b>3,064,067</b>

**Investment Recognition**

Investments are recognised and derecognised on trade date where purchase or sale of an investment is under a contract whose terms require delivery of the investment within the timeframe established by the market concerned, and are initially measured at fair value, net of transaction costs.

Investments are classified as held to maturity financial assets.

The Rochester and Elmore District Health Service classifies its other financial assets between current and non-current assets based on the purpose for which the assets were acquired. Management determines the classification of its other financial assets at initial recognition.

Rochester and Elmore District Health Service assesses at each balance date whether a financial asset or group of financial assets is impaired.

All financial assets, except those measured at fair value through the Comprehensive Operating Statement are subject to annual review for impairment.

**Derecognition of financial assets**

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

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

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

**Impairment of financial assets**

At the end of each reporting period, Rochester and Elmore District Health Service assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. All financial instrument assets, except those measured at fair value through profit or loss, are subject to annual review for impairment.

The amount of the allowance is the difference between the financial asset's carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate.

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

**Doubtful debts**

Receivables are assessed for bad and doubtful debts on a regular basis. Those bad debts considered as written off by mutual consent are classified as a transaction expense. Bad debts not written off by mutual consent and the allowance for doubtful debts are classified as other economic flows in the net result.



## Rochester and Elmore District Health Service

### Note 4.2: Property, Plant and Equipment

#### (a) Gross carrying amount and accumulated depreciation

	<b>2018</b>	<b>2017</b>
	<b>\$</b>	<b>\$</b>
<b>Land</b>		
- Land at Fair Value	382,000	382,000
- Landscaping at Fair Value	257,000	257,000
Less Accumulated Depreciation	(24,843)	(19,703)
<b>Total Land</b>	<b>614,157</b>	<b>619,297</b>
<b>Buildings</b>		
- Buildings at Fair Value	35,168,184	36,325,000
Less Accumulated Depreciation	-	(3,335,760)
<b>Total Buildings</b>	<b>35,168,184</b>	<b>32,989,240</b>
<b>Plant and Equipment</b>		
- Plant and Equipment at Fair Value	2,850,729	2,797,892
Less Accumulated Depreciation	(2,057,703)	(2,225,524)
- Loddon Mallee Rural Health Alliance at Fair Value	55,341	33,442
Less Accumulated Depreciation	(31,359)	(27,304)
<b>Total Plant and Equipment</b>	<b>817,008</b>	<b>578,506</b>
<b>Computers and Communication</b>		
- Computers and Communication at Fair Value	277,464	267,577
Less Accumulated Depreciation	(220,037)	(148,221)
<b>Total Computers and Communications</b>	<b>57,427</b>	<b>119,356</b>
<b>Furniture and Fittings</b>		
- Furniture and Fittings at Fair Value	933,261	873,810
Less Accumulated Depreciation	(521,628)	(471,161)
<b>Total Furniture and Fittings</b>	<b>411,633</b>	<b>402,649</b>
<b>Motor Vehicles</b>		
- Motor Vehicles at Fair Value	377,272	381,402
Less Accumulated Depreciation	(272,968)	(228,749)
<b>Total Motor Vehicles</b>	<b>104,304</b>	<b>152,653</b>
<b>Work In Progress</b>		
Work In Progress at Cost	47,160	-
<b>Total Work In Progress</b>	<b>47,160</b>	<b>-</b>
<b>TOTAL</b>	<b>37,219,873</b>	<b>34,861,701</b>

**Note 4.2: Property, Plant and Equipment (Continued)**

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

	Land	Buildings	Plant & Equipment	Furniture & Fittings	Computer Equip	Motor Vehicles	Work in Progress	Total
	\$	\$	\$	\$	\$	\$	\$	\$
<b>Balance at 1 July 2016</b>	628,720	34,101,160	652,622	421,044	125,966	143,470	-	36,072,982
Additions	-	-	107,755	33,910	61,195	87,515	-	290,375
Loddon Mallee Rural Health Alliance	-	-	2,721	-	-	-	-	2,721
Disposals	-	-	(419)	-	(47)	(10,266)	-	(10,732)
Depreciation (see Note 4.3)	(9,423)	(1,111,920)	(184,173)	(52,305)	(67,758)	(68,066)	-	(1,493,645)
<b>Balance at 30 June 2017</b>	619,297	32,989,240	578,506	402,649	119,356	152,653	-	34,861,701
Additions	-	-	416,364	61,537	9,887	23,977	47,160	558,925
Loddon Mallee Rural Health Alliance	-	-	21,901	-	-	-	-	21,901
Disposals	-	-	(16,336)	-	-	-	-	(16,336)
Revaluation increments/(decrements)	-	3,290,864	-	-	-	-	-	3,290,864
Depreciation (see Note 4.3)	(5,140)	(1,111,920)	(183,427)	(52,553)	(71,816)	(72,326)	-	(1,497,182)
<b>Balance at 30 June 2018</b>	614,157	35,168,184	817,008	411,633	57,427	104,304	47,160	37,219,873

**Land and buildings carried at valuation**

An independent valuation of the Health Service's land was performed by the Valuer-General Victoria to determine the fair value of the land. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments. The effective date of the valuation is 30 June 2014.

In compliance with FRD 103F, in the year ended 30 June 2018, Rochester and Elmore District Health Service's management conducted an annual assessment of the fair value of land and buildings and leased buildings. To facilitate this, management obtained from the Department of Treasury and Finance the Valuer General Victoria indices for the financial year ended 30 June 2018.

The fair value of the Building has been adjusted by a managerial revaluation in 2018. The indexed value was then compared to individual assets written down book value as at 30 June 2018 to determine the change in their fair values. The Department of Health and Human Services approved a managerial revaluation which resulted in an increment of the buildings asset class of \$3.29m.

**Note 4.2: Property, plant & equipment (continued)**

**(c) Fair value measurement hierarchy for assets as at 30 June 2018**

	Carrying amount as at 30 June 2018	Fair value measurement at end of reporting period using:		
		Level 1 <sup>(1)</sup>	Level 2 <sup>(1)</sup>	Level 3 <sup>(1)</sup>
<b>Land at fair value</b>				
Non-specialised land	140,200	-	140,200	-
Specialised land	241,800	-	-	241,800
<b>Total of land at fair value</b>	<b>382,000</b>	<b>-</b>	<b>140,200</b>	<b>241,800</b>
<b>Buildings at fair value</b>				
Non-specialised buildings	1,520,812	-	1,520,812	-
Specialised buildings	33,647,372	-	-	33,647,372
<b>Total of building at fair value</b>	<b>35,168,184</b>	<b>-</b>	<b>1,520,812</b>	<b>33,647,372</b>
<b>Land Improvements at fair value</b>				
Specialised land improvements	232,157	-	-	232,157
<b>Total of land improvements at fair value</b>	<b>232,157</b>	<b>-</b>	<b>-</b>	<b>232,157</b>
<b>Plant and Equipment at fair value</b>				
Plant and Equipment	817,008	-	-	817,008
<b>Total of plant and equipment at fair value</b>	<b>817,008</b>	<b>-</b>	<b>-</b>	<b>817,008</b>
<b>Computer and Communication at fair value</b>				
Computers and Communication	57,427	-	-	57,427
<b>Total Computer and Communication at fair value</b>	<b>57,427</b>	<b>-</b>	<b>-</b>	<b>57,427</b>
<b>Furniture and Fittings at fair value</b>				
Furniture and Fittings	411,633	-	-	411,633
<b>Total Furniture and Fittings at fair value</b>	<b>411,633</b>	<b>-</b>	<b>-</b>	<b>411,633</b>
<b>Motor Vehicles at fair value</b>				
Motor Vehicles	104,304	-	-	104,304
<b>Total Motor Vehicles at fair value</b>	<b>104,304</b>	<b>-</b>	<b>-</b>	<b>104,304</b>
<b>Work in Progress at fair value</b>				
Work in Progress	47,160	-	-	47,160
<b>Work in Progress at fair value</b>	<b>47,160</b>	<b>-</b>	<b>-</b>	<b>47,160</b>
	<b>37,219,873</b>	<b>-</b>	<b>1,661,012</b>	<b>35,558,861</b>

*Note*

<sup>(1)</sup> Classified in accordance with the fair value hierarchy, see Note 1. There have been no transfers between levels during the period.

**Note 4.2: Property, plant & equipment (continued)**

(c) Fair value measurement hierarchy for assets as at 30 June 2017

	Carrying amount as at 30 June 2017	Fair value measurement at end of reporting period using:		
		Level 1 <sup>(1)</sup>	Level 2 <sup>(1)</sup>	Level 3 <sup>(1)</sup>
<b>Land at fair value</b>				
Non-specialised land	140,200	-	140,200	-
Specialised land	241,800	-	-	241,800
<b>Total of land at fair value</b>	<b>382,000</b>	<b>-</b>	<b>140,200</b>	<b>241,800</b>
<b>Buildings at fair value</b>				
Non-specialised buildings	1,490,775	-	1,490,775	-
Specialised buildings	31,498,465	-	-	31,498,465
<b>Total of building at fair value</b>	<b>32,989,240</b>	<b>-</b>	<b>1,490,775</b>	<b>31,498,465</b>
<b>Land Improvements at fair value</b>				
Specialised land improvements	237,297	-	-	237,297
<b>Total of land improvements at fair value</b>	<b>237,297</b>	<b>-</b>	<b>-</b>	<b>237,297</b>
<b>Plant and Equipment at fair value</b>				
Plant and Equipment	578,506	-	-	578,506
<b>Total of plant and equipment at fair value</b>	<b>578,506</b>	<b>-</b>	<b>-</b>	<b>578,506</b>
<b>Computer and Communication at fair value</b>				
Computers and Communication	119,356	-	-	119,356
<b>Total Computer and communication at fair value</b>	<b>119,356</b>	<b>-</b>	<b>-</b>	<b>119,356</b>
<b>Furniture and Fittings at fair value</b>				
Furniture and Fittings	402,648	-	-	402,648
<b>Total Furniture and Fittings at fair value</b>	<b>402,648</b>	<b>-</b>	<b>-</b>	<b>402,648</b>
<b>Motor Vehicles at fair value</b>				
Motor Vehicles	152,654	-	-	152,654
<b>Total Motor Vehicles at fair value</b>	<b>152,654</b>	<b>-</b>	<b>-</b>	<b>152,654</b>
	<b>34,861,701</b>	<b>-</b>	<b>1,630,975</b>	<b>33,230,726</b>

*Note*

<sup>(1)</sup> Classified in accordance with the fair value hierarchy, see Note 1. There have been no transfers between levels during the period.

**Note 4.2: Property, plant & equipment (continued)**
**(d) Reconciliation of Level 3 fair value 2018**

	Land	Buildings	Land Improvements	Plant and Equipment	Computers & Communication	Furniture & Fittings	Motor Vehicles	Work in Progress
<b>Balance at 1 July 2017</b>	241,800	31,498,465	237,297	578,506	119,356	402,649	152,653	-
Additions/(Disposals)	-	-	-	421,929	9,887	61,537	23,977	47,160
Gains or losses recognised in net result	-	-	-	-	-	-	-	-
- Depreciation	-	(1,076,130)	(5,140)	(183,427)	(71,816)	(52,553)	(72,326)	-
Items recognised in other comprehensive income	-	-	-	-	-	-	-	-
- Revaluation	-	3,225,037	-	-	-	-	-	-
<b>Balance at 30 June 2018</b>	<b>241,800</b>	<b>33,647,372</b>	<b>232,157</b>	<b>817,008</b>	<b>57,427</b>	<b>411,633</b>	<b>104,304</b>	<b>47,160</b>

	Land	Buildings	Land Improvements	Plant and Equipment	Computers & Communication	Furniture & Fittings	Motor Vehicles	Work in Progress
<b>Balance at 1 July 2016</b>	241,800	32,574,595	246,720	652,622	125,966	421,044	143,470	-
Additions/(Disposals)	-	-	-	110,057	61,148	33,910	77,250	-
Gains or losses recognised in net result	-	-	-	-	-	-	-	-
- Depreciation	-	(1,076,130)	(9,423)	(184,173)	(67,758)	(52,305)	(68,067)	-
Items recognised in other comprehensive income	-	-	-	-	-	-	-	-
- Revaluation	-	-	-	-	-	-	-	-
<b>Balance at 30 June 2017</b>	<b>241,800</b>	<b>31,498,465</b>	<b>237,297</b>	<b>578,506</b>	<b>119,356</b>	<b>402,649</b>	<b>152,653</b>	<b>-</b>

**Note 4.2: Property, plant & equipment (continued)**

**(e) Fair Value Determination**

	Likely valuation approach	Significant inputs
<b>Specialised land</b>	Market approach	Community Service Obligation (CSO) adjustment
<b>Specialised buildings</b>	Depreciated replacement cost	Direct cost per square metre Useful life of specialised buildings
<b>Landscaping &amp; Grounds</b>	Depreciated replacement cost	Direct replacement cost Useful life of Landscaping & Grounds
<b>Plant &amp; Equipment</b>	Depreciated replacement cost	Cost per unit Useful life of PPE
<b>Motor Vehicles</b>	Depreciated replacement cost	Cost per unit Useful life of vehicles
<b>Computers and Communication</b>	Depreciated replacement cost	Cost per unit Useful life of furniture & fittings
<b>Furniture &amp; Fittings at fair value</b>	Depreciated replacement cost	Cost per unit Useful life of furniture & fittings



## **Note 4.2: Property, plant & equipment (continued)**

### **Non-specialised land and non-specialised buildings**

Non-specialised land and non-specialised buildings are valued using the market approach. Under this valuation method, the assets are compared to recent comparable sales or sales of comparable assets which are considered to have nominal or no added improvement value.

For non-specialised land and non-specialised buildings, an independent valuation was performed by independent valuers Countrywide Valuers on behalf of the Valuer-General Victoria to determine the fair value using the market approach. Valuation of the assets was determined by analysing comparable sales and allowing for share, size, topography, location and other relevant factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30 June 2014.

### **Specialised Land and Specialised Buildings**

Specialised land includes Crown Land which is measured at fair value with regard to the property's highest and best use after due consideration is made for any legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset. Theoretical opportunities that may be available in relation to the assets are not taken into account until it is virtually certain that any restrictions will no longer apply. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best use.

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

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

For the Health Service, the depreciated replacement cost method is used for the majority of specialised buildings, adjusting for the associated depreciation. As depreciation adjustments are considered as significant and unobservable inputs in nature, specialised buildings are classified as Level 3 for fair value measurements.

An independent valuation of the Health Service's specialised land and specialised buildings was performed by the Valuer-General Victoria. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation is 30 June 2014.

In June 2018 a managerial valuation was carried out in accordance with FRD 103F to revalue the buildings to fair value.

### **Motor Vehicles**

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

### **Plant and Equipment**

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

There were no changes in valuation techniques throughout the period to 30 June 2018.

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

### **Revaluations of Non-Current Physical Assets**

Non-current physical assets are measured at fair value and are revalued in accordance with FRD 103F *Non-Current Physical Assets*. This revaluation process normally occurs every five years, based upon the asset's Government Purpose Classification, but may occur more frequently if fair value assessments indicate material changes in values. Independent valuers are used to conduct these scheduled revaluations and any interim revaluations are determined in accordance with the requirements of the FRDs. Revaluation increments or decrements arise from differences between an asset's carrying value and fair value.

Revaluation increments are recognised in 'Other Comprehensive Income' and are credited directly to the asset revaluation surplus, except that, to the extent that an increment reverses a revaluation decrement in respect of that same class of asset previously recognised as an expense in net result, the increment is recognised as income in the net result.

Revaluation decrements are recognised in 'Other Comprehensive Income' to the extent that a credit balance exists in the asset revaluation surplus in respect of the same class of property, plant and equipment.

Revaluation increases and revaluation decreases relating to individual assets within an asset class are offset against one another within that class but are not offset in respect of assets in different classes.

Revaluation surplus is not transferred to accumulated funds on de-recognition of the relevant asset, except where an asset is transferred via contributed capital.

In accordance with FRD 103F, Rochester and Elmore District Health Service's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

## **Note 4.2: Property, plant & equipment (continued)**

### **Initial Recognition**

Items of property, plant and equipment are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and impairment loss. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. Assets transferred as part of a merger/machinery of government change are transferred at their carrying amounts.

The cost of a leasehold improvement is capitalised as an asset and depreciated over the shorter of the remaining term of the lease or the estimated useful life of the improvements.

The initial cost for non-financial physical assets under finance lease is measured at amounts equal to the fair value of the leased asset or, if lower, the present value of the minimum lease payments, each determined at the inception of the lease.

Crown land is measured at fair value with regard to the property's highest and best use after due consideration is made for any legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset. Theoretical opportunities that may be available in relation to the asset(s) are not taken into account until it is virtually certain that any restrictions will no longer apply. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best uses.

Land and buildings are recognised initially at cost and subsequently measured at fair value less accumulated depreciation and accumulated impairment loss.

### **Subsequent Measurement**

Consistent with AASB 13 Fair Value Measurement, Rochester and Elmore District Health Service determines the policies and procedures for recurring property, plant and equipment fair value measurements, in accordance with the requirements of AASB 13 and the relevant FRDs.

All property, plant and equipment for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy.

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

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

For the purpose of fair value disclosures, Rochester and Elmore District Health Service has determined classes of assets and liabilities on the basis of the nature, characteristics and risks of the asset or liability and the level of the fair value hierarchy as explained above.

In addition, Rochester and Elmore District Health Service determines whether transfers have occurred between levels in the hierarchy by re-assessing categorisation (based on the lowest level input that is significant to the fair value measurement as a whole) at the end of each reporting period.

The Valuer-General Victoria (VGV) is Rochester and Elmore District Health Service's independent valuation agency.

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

### **Fair value measurement**

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

#### ***Consideration of highest and best use (HBU) for non-financial physical assets***

Judgements about highest and best use must take into account the characteristics of the assets concerned, including restrictions on the use and disposal of assets arising from the asset's physical nature and any applicable legislative/contractual arrangements.

In accordance with paragraph AASB 13.29, Health Services can assume the current use of a non-financial physical asset is its HBU unless market or other factors suggest that a different use by market participants would maximise the value of the asset.

Therefore, an assessment of the HBU will be required when the indicators are triggered within a reporting period, which suggest the market participants would have perceived an alternative use of an asset that can generate maximum value. Once identified, Health Services are required to engage with VGV or other independent valuers for formal HBU assessment.

These indicators, as a minimum, include:

External factors:

- Changed acts, regulations, local law or such instrument which affects or may affect the use or development of the asset;
- Changes in planning scheme, including zones, reservations, overlays that would affect or remove the restrictions imposed on the asset's use from its past use;
- Evidence that suggest the current use of an asset is no longer core to requirements to deliver a Health Service's service obligation;
- Evidence that suggests that the asset might be sold or demolished at reaching the late stage of an asset's life cycle.

#### ***Valuation hierarchy***

Health Services need to use valuation techniques that are appropriate for the circumstances and where there is sufficient data available to measure fair value, maximising the use of relevant observable inputs and minimising the use of unobservable inputs.

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy.

#### ***Identifying unobservable inputs (level 3) fair value measurements***

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

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

Assumptions about risk include the inherent risk in a particular valuation technique used to measure fair value (such as a pricing risk model) and the risk inherent in the inputs to the valuation technique. A measurement that does not include an adjustment for risk would not represent a fair value measurement if market participants would include one when pricing the asset or liability i.e., it might be necessary to include a risk adjustment when there is significant measurement uncertainty. For example, when there has been a significant decrease in the volume or level of activity when compared with normal market activity for the asset or liability or similar assets or liabilities, and the Health Service has determined that the transaction price or quoted price does not represent fair value.

A Health Service shall develop unobservable inputs using the best information available in the circumstances, which might include the Health Service's own data. In developing unobservable inputs, a Health Service may begin with its own data, but it shall adjust this data if reasonably available information indicates that other market participants would use different data or there is something particular to the Health Service that is not available to other market participants. A Health Service need not undertake exhaustive efforts to obtain information about other market participant assumptions. However, a Health Service shall take into account all information about market participant assumptions that is reasonably available. Unobservable inputs developed in the manner described above are considered market participant assumptions and meet the object of a fair value measurement.

**Note 4.3: Depreciation**

	<b>2018</b>	<b>2017</b>
	<b>\$</b>	<b>\$</b>
Buildings	1,111,920	1,111,920
Land Improvements	5,140	9,423
Plant & Equipment	179,372	179,014
Motor Vehicles	72,326	68,066
Furniture and Fittings	52,553	52,305
Computer and Communications	71,816	67,758
Loddon Mallee Rural Health Alliance	4,055	5,159
<b>Total Depreciation</b>	<b>1,497,182</b>	<b>1,493,645</b>

**Depreciation**

All infrastructure assets, buildings, plant and equipment and other non-financial physical assets (excluding items under operating leases, assets held for sale, land and investment properties) that have finite useful lives are depreciated. Depreciation is generally calculated on a straight-line basis at rates that allocate the asset's value, less any estimated residual value over its estimated useful life (refer AASB 116 *Property, Plant and Equipment*).

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

	<b>2018</b>	<b>2017</b>
Buildings		
- Structure Shell Building Fabric	45 to 60 years	45 to 60 years
- Site Engineering Services and Central Plant	20 to 30 years	20 to 30 years
Central Plant		
- Fit Out	20 to 30 years	20 to 30 years
- Trunk Reticulated Building Systems	30 to 40 years	30 to 40 years
Plant & Equipment	3 to 20 years	3 to 20 years
Medical Equipment	5 to 10 years	5 to 10 years
Computers and Communication	3 years	3 years
Furniture and Fitting	3 to 40 years	3 to 40 years
Motor Vehicles	2 to 5 years	2 to 5 years

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

## **Note 5: Other Assets and Liabilities**

This section sets out those assets and liabilities that arose from the Health Service's operations.

### **Structure**

5.1 Receivables

5.2 Inventories

5.3 Other Liabilities

5.4 Prepayments and Other Assets

5.5 Payables

**Note 5.1: Receivables**

**CURRENT**

**Contractual**

	2018 \$	2017 \$
Trade Debtors	149,192	204,546
Patient Fees	19,463	17,038
Accrued Investment Income	26,119	21,054
Accrued Revenue - Other	53,470	90,171
Loddon Mallee Rural Health Alliance Receivables	18,021	7,634
Less Allowance for Doubtful Debts Patient Fees	(1,721)	(1,721)
	<b>264,544</b>	<b>338,722</b>

**Statutory**

GST Receivable	77,826	177,053
Loddon Mallee Rural Health Alliance GST Receivables	6,933	5,060
	<b>84,759</b>	<b>182,113</b>

**TOTAL CURRENT RECEIVABLES**

	<b>349,303</b>	<b>520,835</b>
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**Statutory**

Long Service Leave - Department of Health and Human Services	260,628	205,110
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**TOTAL NON-CURRENT RECEIVABLES**

	<b>260,628</b>	<b>205,110</b>
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**TOTAL RECEIVABLES**

	<b>260,628</b>	<b>205,110</b>
	<b>609,931</b>	<b>725,945</b>

**(a) Movement in the Allowance for doubtful debts**

	2018 \$	2017 \$
Balance at the beginning of year - REDHS	1,721	1,721
Balance at the beginning of year - LMRHA	-	-
Increase/(decrease) in allowance recognised in net result	-	-

**Balance at end of year**

	<b>1,721</b>	<b>1,721</b>
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**Receivables Recognition**

Receivables consist of:

- contractual receivables, which includes mainly debtors in relation to goods and services, loans to third parties, accrued investment income, and finance lease receivables; and
- statutory receivables, which includes predominantly amounts owing from the Victorian Government and Goods and Services Tax ("GST") input tax credits recoverable.

Receivables that are contractual are classified as financial instruments and categorised as loans and receivables. Statutory receivables are recognised and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments because they do not arise from a contract.

Receivables are recognised initially at fair value and subsequently measured at amortised cost, using the effective interest method, less any accumulated impairment.

Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition. Collectability of debts is reviewed on an ongoing basis, and debts which are known to be uncollectible are written off. A provision for doubtful debts is recognised when there is objective evidence that the debts may not be collected and bad debts are written off when identified.

**Note 5.2: Inventories**

**CURRENT**

Pharmaceuticals - at cost  
Catering Supplies - at cost  
Housekeeping Supplies - at cost  
Medical and Surgical Lines - at cost  
Administration Stores - at cost  
Inventory - LMRHA

**TOTAL INVENTORIES**

2018	2017
\$	\$
10,870	11,406
8,875	7,159
2,557	1,098
16,948	20,859
2,432	2,868
4,248	1,781
<b>45,930</b>	<b>45,171</b>

Inventories include goods and other property held either for sale, consumption or for distribution at no or nominal cost in the ordinary course of business operations. It excludes depreciable assets.

Inventories held for distribution are measured at cost, adjusted for any loss of service potential. All other inventories, including land held for sale, are measured at the lower of cost and net realisable value.

Inventories acquired for no cost or nominal considerations are measured at current replacement cost at the date of acquisition.

The bases used in assessing loss of service potential for inventories held for distribution include current replacement cost and technical or functional obsolescence. Technical obsolescence occurs when an item still functions for some or all of the tasks it was originally acquired to do, but no longer matches existing technologies. Functional obsolescence occurs when an item no longer functions the way it did when it was first acquired.

Cost for all other inventory is measured on the basis of weighted average cost.

**Note 5.3: Other Liabilities**

**CURRENT**

Monies Held in Trust\*  
- Accommodation Bonds (Refundable Entrance Fees)  
Rochester Community House

**TOTAL CURRENT**

2018	2017
\$	\$
7,439,377	5,949,982
-	7,067
<b>7,439,377</b>	<b>5,957,049</b>

**\* Total Monies Held in Trust**

**Represented by the following assets:**

Cash and Cash Equivalents (refer to Note 6.1)  
Rochester Community House

**TOTAL**

7,439,377	5,949,982
-	7,067
<b>7,439,377</b>	<b>5,957,049</b>

**Note 5.4: Prepayments and Other Assets**

**Current:**

Prepayments  
Loddon Mallee Rural Health Alliance

**TOTAL CURRENT OTHER ASSETS**

**TOTAL OTHER ASSETS**

2018	2017
\$	\$
116,946	103,048
23,022	26,235
<b>139,968</b>	<b>129,283</b>
<b>139,968</b>	<b>129,283</b>

Other non-financial assets include prepayments which represent payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period.



**Note 5.5: Payables**

	<b>2018</b>	<b>2017</b>
	<b>\$</b>	<b>\$</b>
<b>CURRENT</b>		
<b>Contractual</b>		
Trade Creditors	237,195	419,891
Accrued Expenses	89,399	125,024
Accrued Audit Fees	13,000	16,500
Other Payables	83,383	96,567
Loddon Mallee Rural Health Alliance	65,434	51,005
	<b>488,411</b>	<b>708,987</b>
<b>Statutory</b>		
GST Payable	31,006	123,893
<b>TOTAL CURRENT</b>	<b>31,006</b>	<b>123,893</b>
<b>TOTAL PAYABLES</b>	<b>519,417</b>	<b>832,880</b>

Payables consist of:

- contractual payables which consist predominantly of accounts payable representing liabilities for goods and services provided to the Health Service prior to the end of the financial year that are unpaid, and
- statutory payables, that are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from contracts.

**Note 5.5 (a) Maturity analysis of Financial Liabilities as at 30 June**

	Carrying Amount \$	Nominal Amount \$	Maturity Dates			
			Less than 1 Month \$	1 to 3 Months \$	3 months to 1 Year \$	1 to 5 Years \$
<b>2018</b>						
<b>Financial Liabilities</b>						
Payables	457,464	457,464	457,464	-	-	-
Other Financial Liabilities(i)						
- Monies Held in Trust	7,439,377	7,439,377	-	400,000	7,039,377	-
- Rochester Community House	-	-	-	-	-	-
<b>Total Financial Liabilities</b>	<b>7,896,841</b>	<b>7,896,841</b>	<b>457,464</b>	<b>400,000</b>	<b>7,039,377</b>	<b>-</b>
<b>2017</b>						
<b>Financial Liabilities</b>						
Payables	708,987	708,987	708,987	-	-	-
Other Financial Liabilities(i)						
- Monies Held in Trust	5,949,982	5,949,982	63,296	41,456	5,845,230	-
- Rochester Community House	7,067	7,067	7,067	-	-	-
<b>Total Financial Liabilities</b>	<b>6,666,036</b>	<b>6,666,036</b>	<b>779,350</b>	<b>41,456</b>	<b>5,845,230</b>	<b>-</b>

(i) Aging analysis of financial liabilities excludes the types of statutory financial liabilities (ie GST Payable)

## **Note 6: How we Finance Our Operations**

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

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

### **Structure**

6.1 Cash and Cash Equivalents

6.2 Commitments for Expenditure

**Note 6.1: Cash and Cash Equivalents**

	<b>2018</b>	<b>2017</b>
	<b>\$</b>	<b>\$</b>
Cash on Hand	900	700
Cash at Bank	9,435,762	8,077,620
<b>Total Cash and Cash Equivalents</b>	<b>9,436,662</b>	<b>8,078,320</b>

**Represented by:**

Cash for Health Service Operations (as per Cash Flow Statement)	1,775,526	1,878,280
Cash for Monies Held in Trust		
- Deposits at Call	-	7,067
- Accommodation Bonds (Refundable Entrance Fees)	7,439,377	5,949,982
- Loddon Mallee Rural Health Alliance	221,759	242,991
<b>Total Cash and Cash Equivalents</b>	<b>9,436,662</b>	<b>8,078,320</b>

Cash and cash equivalents recognised on the Balance Sheet comprise cash on hand and in banks, deposits at call and highly liquid investments (with an original maturity of three months or less), which are held for the purpose of meeting short term cash commitments rather than for investment purposes, which are readily convertible to known amounts of cash are subject to insignificant risk of changes in value.

For cash flow statement presentation purposes, cash and cash equivalents include bank overdrafts, which are included as liabilities on the Balance Sheet.

**Note 6.2: Commitments for Expenditure**

Rochester and Elmore District Health Service does not have any commitments.

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

## **Note 7: Risks, Contingencies & Valuation Uncertainties**

The Health Service is exposed to risk from its activities and outside factors. In addition, it is often necessary to make judgements and estimates associated with recognition and measurement of items in the financial statements. This section sets out financial instrument specific information, (including exposures to financial risks) as well as those items that are contingent in nature or require a higher level of judgement to be applied, which for the hospital is related mainly to fair value determination.

### **Structure**

7.1 Financial Instruments

7.2 Contingent Assets and Contingent Liabilities

## Note 7.1: Financial Instruments

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of Rochester and Elmore District Health Service's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 Financial Instruments: Presentation.

### Categorisation of financial instruments

Details of each categories in accordance with AASB 139, shall be disclosed either on the face of the balance sheet or in the notes.

	Contractual financial assets - loans and receivables \$	Contractual financial assets - available for sale \$	Contractual financial liabilities at amortised cost \$	Total \$
<b>2018</b>				
<b>Contractual Financial Assets</b>				
Cash and cash equivalents	9,436,662	-	-	9,436,662
Receivables				
- Trade Debtors	168,655	-	-	168,655
- Other Receivables	95,889	-	-	95,889
Other Financial Assets				
- Term Deposit	3,121,749	-	-	3,121,749
<b>Total Financial Assets <sup>(i)</sup></b>	<b>12,822,955</b>	<b>-</b>	<b>-</b>	<b>12,822,955</b>
<b>Financial Liabilities</b>				
Payables	-	-	488,411	488,411
Other Financial Liabilities				
- Patient Monies in Trust	-	-	-	-
- Accomodation bonds	-	-	7,439,377	7,439,377
- Rochester Community House	-	-	-	-
<b>Total Financial Liabilities <sup>(ii)</sup></b>	<b>-</b>	<b>-</b>	<b>7,927,788</b>	<b>7,927,788</b>
<b>2017</b>				
<b>Contractual Financial Assets</b>				
Cash and cash equivalents	8,078,320	-	-	8,078,320
Receivables				
- Trade Debtors	221,584	-	-	221,584
- Other Receivables	117,138	-	-	117,138
Other Financial Assets				
- Term Deposit	3,064,067	-	-	3,064,067
<b>Total Financial Assets <sup>(i)</sup></b>	<b>11,481,109</b>	<b>-</b>	<b>-</b>	<b>11,481,109</b>
<b>Financial Liabilities</b>				
Payables	-	-	708,987	708,987
Other Financial Liabilities				
- Patient Monies in Trust	-	-	-	-
- Accomodation bonds	-	-	5,949,982	5,949,982
- Rochester Community House	-	-	7,067	7,067
<b>Total Financial Liabilities <sup>(ii)</sup></b>	<b>-</b>	<b>-</b>	<b>6,666,036</b>	<b>6,666,036</b>

(i) The total amount of financial assets disclosed here excludes statutory receivables

(ii) The total amount of financial liabilities disclosed here excludes statutory payables (i.e. Taxes payable)

### (a) Financial Risk Management Objectives and Policies

Details of the significant accounting policies and methods adopted, including the criteria for recognition, the basis of measurement and the basis on which income and expenses are recognised, with respect to each class of financial asset, financial liability and equity instrument are disclosed in Note 1 to the financial statements.

The Health Service's main financial risks include credit risk, liquidity risk and interest rate risk. The Health Service manages these financial risks in accordance with its financial risk management policy.

The Health Service uses different methods to measure and manage the different risks to which it is exposed. Primary responsibility for the identification and management of financial risks rests with the financial risk management committee of the Health Service.

The main purpose in holding financial instruments is to prudentially manage Rochester and Elmore District Health Services financial risks within the government policy parameters.

**Note 7.1: Financial Instruments (continued)**

**(b) Net holding gain/ (loss) on financial instruments by category**

	Net holding gain/ (loss)	Total interest income / (expense)	Fee income/ (expense)	Impairment loss	Total
	\$	\$	\$	\$	\$
<b>2018</b>					
<b>Financial Assets</b>					
Cash and Cash Equivalents	-	262,961	-	-	262,961
<b>Total Financial Assets</b>	-	<b>262,961</b>	-	-	<b>262,961</b>
<b>2017</b>					
<b>Financial Assets</b>					
Cash and Cash Equivalents	-	242,991	-	-	242,991
<b>Total Financial Assets</b>	-	<b>242,991</b>	-	-	<b>242,991</b>

**Categories of financial instruments**

**Loans and receivables and cash** are financial instrument assets with fixed and determinable payments that are not quoted on an active market. These assets are initially recognised at fair value plus any directly attributable transaction costs. Subsequent to initial measurement, loans and receivables are measured at amortised cost using the effective interest method, less any impairment.

The Rochester and Elmore District Health Service's principal financial instruments comprise of:

- Cash Assets
- Term Deposits
- Receivables (excluding statutory receivables)
- Payables (excluding statutory payables)
- Accommodation Bonds

**Held to maturity financial assets:** If the Rochester and Elmore District Health Service has the positive intent and ability to hold nominated investments to maturity, then such financial assets may be classified as held to maturity. These are recognised initially at fair value plus any directly attributable transaction costs. Subsequent to initial recognition, held to maturity financial assets are measured at amortised cost using the effective interest method, less any impairment losses.

The held to maturity category includes certain term deposits and debt securities for which the Rochester and Elmore District Health Service intends to hold to maturity.

**Financial liabilities at amortised cost** are initially recognised on the date they are originated. They are initially measured at fair value plus any directly attributable transaction costs. Subsequent to initial recognition, these financial instruments are measured at amortised cost with any difference between the initial recognised amount and the redemption value being recognised in profit and loss over the period of the interest bearing liability, using the effective interest rate method. The Rochester and Elmore District Health Service recognises the following liabilities in this category:

- payables (excluding statutory payables); and
- borrowings (including finance lease liabilities).

**Offsetting financial instruments:** Financial instrument assets and liabilities are offset and the net amount presented in the consolidated Balance Sheet when, and only when, the Rochester and Elmore District Health Service concerned has a legal right to offset the amounts and intend either to settle on a net basis or to realise the asset and settle the liability simultaneously.

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



**Note 7.1: Financial Instruments (continued)**

**(b) Net holding gain/ (loss) on financial instruments by category (continued)**

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

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

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

**Impairment of financial assets:** At the end of each reporting period, the Rochester and Elmore District Health Service assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. All financial instrument assets, except those measured at fair value through profit or loss, are subject to annual review for impairment.

The allowance is the difference between the financial asset's carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate. In assessing impairment of statutory (non-contractual) financial assets, which are not financial instruments, professional judgement is applied in assessing materiality using estimates, averages and other computational methods in accordance with AASB 136 Impairment of Assets.

**Reclassification of financial instruments:** Subsequent to initial recognition and under rare circumstances, non-derivative financial instruments assets that have not been designated at fair value through profit or loss upon recognition, may be reclassified out of the fair value through profit or loss category, if they are no longer held for the purpose of selling or repurchasing in the near term.

Financial instrument assets that meet the definition of loans and receivables may be reclassified out of the fair value through profit and loss category into the loans and receivables category, where they would have met the definition of loans and receivables had they not been required to be classified as fair value through profit and loss. In these cases, the financial instrument assets may be reclassified out of the fair value through profit and loss category, if there is the intention and ability to hold them for the foreseeable future or until maturity.

Available-for-sale financial instrument assets that meet the definition of loans and receivables may be reclassified into the loans and receivables category if there is the intention and ability to hold them for the foreseeable future or until maturity.

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

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

**Note 7.2: Contingent Assets & Contingent Liabilities**

Rochester and Elmore District Health Service is not aware of any contingent assets and liabilities at 30 June 2018.

Contingent assets and contingent liabilities are not recognised in the Balance Sheet, but are disclosed by way of note and, if quantifiable, are measured at nominal value. Contingent assets and contingent liabilities are presented inclusive of GST receivable or payable respectively.

**Note 8: Other Disclosures**

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

**Structure**

- 8.1 Equity
- 8.2 Reconciliation of Net Result for the Year to Net Cash Inflow/(Outflow) From Operating Activities
- 8.3 Responsible Persons
- 8.4 Remuneration of Executives
- 8.5 Related Parties
- 8.6 Remuneration of Auditors
- 8.7 AASBs Issued that are Not Yet Effective
- 8.8 Events Occurring After the Balance Sheet Date
- 8.9 Jointly Controlled Operations

**Note 8.1: Equity**

**(a) Surpluses**

**Property, Plant and Equipment Revaluation Surplus**

Balance at the beginning of the reporting period

Revaluation Increment

- Buildings (refer Note 4.2b)

**Balance at the end of the reporting period**

**Balance at the end of the reporting period\***

**\* Represented by:**

- Land

- Buildings

**Restricted Specific Purpose Surplus**

Balance at the beginning of the reporting period

Transfer to and from Restricted Purpose Surplus

**Balance at the end of the reporting period**

**TOTAL SURPLUSES**

**(b) Contributed Capital**

Balance at the beginning of the reporting period

**Balance at the end of the reporting period**

**(c) Accumulated Surpluses/ (Deficits)**

Balance at the beginning of the reporting period

Net Result for the year

Transfer to and from Restricted Purpose Surplus

**Balance at the end of the reporting period**

**TOTAL EQUITY AT END OF FINANCIAL YEAR**

2018	2017
\$	\$
18,053,026	18,053,026
3,290,864	-
<b>21,343,890</b>	<b>18,053,026</b>
196,325	196,325
21,147,565	17,856,701
<b>21,343,890</b>	<b>18,053,026</b>
927,164	888,835
(1,176)	38,329
<b>925,988</b>	<b>927,164</b>
<b>22,269,878</b>	<b>18,980,190</b>
7,369,839	7,369,839
<b>7,369,839</b>	<b>7,369,839</b>
11,119,610	11,623,784
(928,032)	(465,845)
1,176	(38,329)
<b>10,192,754</b>	<b>11,119,610</b>
<b>39,832,471</b>	<b>37,469,639</b>

**Contributed Capital**

Consistent with Australian Accounting Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities* and FRD 119A *Contributions by Owners*, appropriations for additions to the net asset base have been designated as contributed capital. Other transfers that are in the nature of contributions to or distributions by owners that have been designated as contributed capital are also treated as contributed capital.

Transfers of net assets arising from administrative restructurings are treated as contributions by owners. Transfers of net liabilities arising from administrative restructures are to go through the Comprehensive Operating Statement.

**Property, Plant & Equipment Revaluation Surplus**

The asset revaluation surplus is used to record increments and decrements on the revaluation of non-current physical assets.

**Specific Restricted Purpose Surplus**

A specific restricted purpose surplus is established where the Health Service has possession or title to the funds but has no discretion to amend or vary the restriction and/or condition underlying the funds received.

**Note 8.2: Reconciliation of the net result for the year to net cash from operating activities**

**Net result for the Year**

**Non-cash movements:**

Depreciation

Share of Net Result from LMRHA

**Movements included in investing and financing activities:**

Net (Gain)/Loss from Sale of Plant & Equipment

**Movements in assets and liabilities:**

Change in operating assets and liabilities

(Increase)/Decrease in Receivables

(Increase)/Decrease in Prepayments

(Increase)/Decrease in Inventories

Increase/(Decrease) in Payables

Increase/(Decrease) in Provisions

**NET CASH INFLOW/ (OUTFLOW) FROM OPERATING ACTIVITIES**

2018	2017
\$	\$
(928,032)	(465,845)
1,497,182	1,493,645
18,991	(18,529)
9,544	(37,061)
116,014	(12,063)
(10,685)	(4,055)
759	(8,464)
(313,463)	434,067
137,829	189,132
<b>528,139</b>	<b>1,570,827</b>

### **Note 8.3: Responsible Persons Disclosures**

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

#### **Responsible Ministers:**

The Honourable Jill Hennessy, MLC, Minister for Health, Minister for Ambulance Services  
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Health

Period
01/07/2017-30/06/2018
01/07/2017-30/06/2018

#### **Governing Boards**

Mr B Devanny	01/07/2017-30/06/2018
Mr T Fulton	01/07/2017-30/06/2018
Ms K Lee	01/07/2017-30/06/2018
Mrs K Lemon	01/07/2017-30/06/2018
Dr C McKinstry	01/07/2017-30/06/2018
Mr F Oliver	01/07/2017-30/06/2018
Miss J Smith	01/07/2017-30/06/2018
Mr D Rosaia	01/07/2017-30/06/2018
Mr C Wood	01/07/2017-30/06/2018

No remuneration was paid to any Governing Board Members for the Financial Year ended 30 June 2018.

#### **Accountable Officers**

Mrs Anne McEvoy	01/07/2017-30/06/2018
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#### **Remuneration of Responsible Persons**

Accountable officer's remuneration was in the range of \$120,000-\$129,999 (\$140,000-\$149,999 in 2016-17).

Board members did not receive any remuneration for their roles.

Amounts relating to Responsible Ministers are reported in the financial statements of the Department of Premier and Cabinet.

### **Note 8.4: Remuneration of Executives**

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

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

**Short-term employee benefits** include amounts such as wages, salaries, annual leave or sick leave that are usually paid or payable on a regular basis, as well as non-monetary benefits such as allowances and free or subsidised goods or services.

**Post-employment benefits** include pensions and other retirement benefits paid or payable on a discrete basis when employment has ceased.

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

**Termination benefits** include termination of employment payments, such as severance packages.

**Share-based payments** are cash or other assets paid or payable as agreed between the health service and the employee, provided specific vesting conditions, if any, are met.

	Total Remuneration	
	2018	2017
<b>Remuneration of Executive Officers</b>		
<b>(including Key Management Personnel Disclosed in Note 8.5)</b>	<b>\$</b>	<b>\$</b>
Short term employee benefits	102,706	86,700
Post-employment benefits	9,757	8,712
Other long-term benefits	2,568	2,168
Termination benefits	-	-
Share based payments	-	-
<b>Total</b>	<b>\$115,031</b>	<b>\$97,579</b>
<b>Total number of executives</b>	<b>1</b>	<b>1</b>
<b>Total annualised employee equivalent (AEE)</b>	<b>1</b>	<b>1</b>

Notes:

(a) The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of the entity under AASB 124 Related Party Disclosures and are reported within Note 8.5 Related Parties.

(b) Annualised employee equivalent is based on the time fraction worked over the reporting period.

## Rochester and Elmore District Health Service

### Note 8.5: Related Parties

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

- all key management personnel and their close family members;
- all Cabinet ministers and their close family members; and
- all hospitals and public sector entities that are controlled and consolidated into the State of Victoria financial statements.

All related party transactions have been entered into on an arm's length basis.

Key management personnel (KMP) of the Health Service include the Portfolio Ministers and Cabinet Ministers and KMP as determined by the Health Service. The Health Service has determined that key management personnel includes all board members, the CEO and the Director of Clinical Services. The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The Minister's remuneration and allowances is set by the *Parliamentary Salaries and Superannuation Act 1968*, and is reported within the Department of Parliamentary Services' Financial Report.

#### KMPs

Mrs A McEvoy  
Mr M Nally  
Mr B Devanny  
Mr T Fulton  
Ms K Lee  
Mrs K Lemon  
Dr C McKinstry  
Mr F Oliver  
Miss J Smith  
Mr D Rosaia  
Mr C Wood

#### Position Title

CEO  
Director of Clinical Services  
Board Member  
Board Member  
Board Member  
Board Member  
Board Member  
Board Member  
Board Member  
Board Member  
Board Member

Short term employee benefits  
Post-employment benefits  
Other long-term benefits  
Termination benefits  
Share based payments  
**Total**

2018	2017
\$	\$
217,405	212,106
20,796	22,072
5,435	5,303
-	-
-	-
<b>243,636</b>	<b>239,480</b>

#### Transactions with key management personnel and other related parties

Given the breadth and depth of State government activities, related parties transact with the Victorian public sector in a manner consistent with other members of the public e.g. stamp duty and other government fees and charges. Further employment of processes within the Victorian public sector occur on terms and conditions consistent with the *Public Administration Act 2004* and Codes of Conduct and Standards issued by the Victorian Public Sector Commission. Procurement processes occur on terms and conditions consistent with the Victorian Government Procurement Board requirements. Outside of normal citizen type transactions with the department, there were no related party transactions that involved key management personnel and their close family members. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

#### Significant transactions with government related entities

The Rochester & Elmore District Health Service received funding from the Department of Health and Human Services of \$6,853,688 (\$6,713,933 in 2016-17)

### Note 8.6: Remuneration of auditors

#### Victorian Auditor-General's Office

Audit and Review of financial statements

#### TOTAL

2018	2017
\$	\$
16,500	16,500
<b>16,500</b>	<b>16,500</b>

**Note 8.7: AASBs issued that are not yet effective**

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2018 reporting period. Department of Treasury and Finance assesses the impact of all these new standards and advises the Health Service of their applicability and early adoption where applicable.

Appendix 1 lists all the standards and interpretations that have been issued by the AASB but were not yet effective at at 30 June 2018. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. Rochester and Elmore District Health Service has not and does not intend to adopt these standards early.

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**Note 8.8: Events occurring after the Balance Sheet Date.**

No events occurred after Balance Date.

Assets, liabilities, income or expenses arise from past transactions or other past events. Where the transactions result from an agreement between Rochester and Elmore District Health Service and other parties, the transactions are only recognised when the agreement is irrevocable at or before the end of the reporting period.

Adjustments are made to amounts recognised in the financial statements for events which occur between the end of the reporting period and the date when the financial statements are authorised for issue, where those events provide information about conditions which existed at the reporting date. Note disclosure is made about events between the end of the reporting period and the date the financial statements are authorised for issue where the events relate to conditions which arose after the end of the reporting period that are considered to be of material interest.



**Note 8.9: Jointly Controlled Operations**

Name of entity	Principal Activity	Ownership Interest	
		2018	2017
Loddon Mallee Rural Health Alliance	Information Technology	4.26%	4.06

Rochester and Elmore District Health Service's interest in the above jointly controlled operations and assets is detailed below. The amounts are included in the financial statements under their respective asset categories:

	2018 \$	2017 \$
<b>CURRENT ASSETS</b>		
Cash and Cash Equivalents	221,754	242,991
Receivables	29,201	14,474
Other	23,022	26,235
<b>Total Current Assets</b>	<b>273,977</b>	<b>283,700</b>
<b>NON CURRENT ASSETS</b>		
Property, Plant and Equipment	23,988	6,137
<b>Total Non Current Assets</b>	<b>23,988</b>	<b>6,137</b>
<b>Total Assets</b>	<b>297,965</b>	<b>289,837</b>
<b>CURRENT LIABILITIES</b>		
Payables	65,434	51,004
<b>Total Current Liabilities</b>	<b>65,434</b>	<b>51,004</b>
<b>Total Liabilities</b>	<b>65,434</b>	<b>51,004</b>
<b>Net Assets</b>	<b>232,531</b>	<b>238,833</b>

Rochester and Elmore District Health Service's interest in revenues and expenses resulting from jointly controlled operations and assets is detailed below:

	2018 \$	2017 \$
<b>REVENUES</b>		
Operating Activities	316,850	310,169
Capital Purpose Income	(10,120)	(6,927)
<b>Total Revenue</b>	<b>306,730</b>	<b>303,242</b>
<b>EXPENSES</b>		
Other Expenses from Continuing Operations	325,721	284,713
Expenditure using Capital Purpose Income	0	0
<b>Total Expenses</b>	<b>325,721</b>	<b>284,713</b>
<b>Net Result</b>	<b>(18,991)</b>	<b>18,529</b>

**CONTINGENT LIABILITIES AND CAPITAL COMMITMENTS**

The joint venture does not have any known contingent assets or contingent liabilities as at 30 June 2018 (2017: Nil).

**Investments in joint operations**

In respect of any interest in joint operations, Rochester and Elmore District Health Service recognises in the financial statements:

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

**Note 8.10: Economic Dependency**

Rochester and Elmore District Health Service is dependent on the Department of Health and Human Services for the majority of its revenue used to operate the entity.

At the date of this report, the Board of Directors has no reason to believe the Department will not continue to support Rochester and Elmore District Health Service.

**Appendix 1**

**Issued but not yet effective Australian accounting and reporting pronouncements**

Standard/ Interpretation <sup>1</sup>	Summary	Applicable for annual reporting periods beginning on	Impact on public sector entity financial statements
AASB 9 <i>Financial Instruments</i>	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedge accounting model and a revised impairment loss model to recognise expected impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1-Jan-18	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals.  The initial application of AASB 9 is not expected to significantly impact the financial position however there will be a change to the way financial instruments are classified and new disclosure requirements.
AASB 2014-1 <i>Amendments to Australian Accounting Standards [Part E Financial Instruments]</i>	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018, and to amend reduced disclosure requirements.	1-Jan-18	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2014-7 <i>Amendments to Australian Accounting Standards arising from AASB 9</i>	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1-Jan-18	The assessment has indicated that there will be no significant impact for the public sector.
AASB 15 <i>Revenue from Contracts with Customers</i>	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer. Note that amending standard AASB 2015-8 <i>Amendments to Australian Accounting Standards – Effective Date of AASB 15</i> has deferred the effective date of AASB 15 to annual reporting periods beginning on or after 1 January 2018, instead of 1 January 2017.	1-Jan-18	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications.
AASB 2014-5 <i>Amendments to Australian Accounting Standards arising from AASB 15</i>	Amends the measurement of trade receivables and the recognition of dividends as follows: <ul style="list-style-type: none"> <li>Trade receivables that do not have a significant financing component, are to be measured at their transaction price, at initial recognition.</li> <li>Dividends are recognised in the profit and loss only when: <ul style="list-style-type: none"> <li>the entity's right to receive payment of the dividend is established;</li> <li>it is probable that the economic benefits associated with the dividend will flow to the entity; and</li> </ul> </li> <li>the amount can be measured reliably.</li> </ul>	1 Jan 2018, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.
AASB 2015-8 <i>Amendments to Australian Accounting Standards – Effective Date of AASB 15</i>	This Standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1-Jan-18	This amending standard will defer the application period of AASB 15 for for-profit entities to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2016-3 <i>Amendments to Australian Accounting Standards – Clarifications to AASB 15</i>	This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: <ul style="list-style-type: none"> <li>a promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation;</li> <li>for items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer; and</li> <li>for licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access).</li> </ul>	1-Jan-18	The assessment has indicated that there will be no significant impact for the public sector, other than the impact identified for AASB 15 above.
AASB 2016-7 <i>Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities</i>	This Standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019.	1-Jan-19	This amending standard will defer the application period of AASB 15 for not-for-profit entities to the 2019-20 reporting period.
AASB 2016-8 <i>Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities</i>	AASB 2016-8 inserts Australian requirements and authoritative implementation guidance for not-for-profit entities into AASB 9 and AASB 15. This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events.	1-Jan-19	This standard clarifies the application of AASB 15 and AASB 9 in a not-for-profit context. The areas within these standards that are amended for not-for-profit application include:  <i>AASB 9</i>  <ul style="list-style-type: none"> <li>Statutory receivables are recognised and measured similarly to financial assets <i>AASB 15</i></li> <li>The 'customer' does not need to be the recipient of goods and/or services;</li> <li>The 'contract' could include an arrangement entered into under the direction of another party;</li> <li>Contracts are enforceable if they are enforceable by legal or 'equivalent means';</li> </ul>

**Appendix 1**

**Issued but not yet effective Australian accounting and reporting pronouncements**

Standard/ Interpretation <sup>1</sup>	Summary	Applicable for annual reporting periods beginning on	Impact on public sector entity financial statements
AASB 16 <i>Leases</i>	The key changes introduced by AASB 16 include the recognition of operating leases (which are currently not recognised) on balance sheet.	1-Jan-19	<ul style="list-style-type: none"> <li>Contracts do not have to have commercial substance, only economic substance; and</li> <li>Performance obligations need to be 'sufficiently specific' to be able to apply AASB 15 to these transactions.</li> </ul> <p>The assessment has indicated that most operating leases, with the exception of short term and low value leases will come on to the balance sheet and will be recognised as right of use assets with a corresponding lease liability.</p> <p>In the operating statement, the operating lease expense will be replaced by depreciation expense of the asset and an interest charge.</p> <p>There will be no change for lessors as the classification of operating and finance leases remains unchanged.</p>
AASB 1058 <i>Income of Not-for-Profit Entities</i>	<p>AASB 1058 standard will replace the majority of income recognition in relation to government grants and other types of contributions requirements relating to public sector not-for-profit entities, previously in AASB 1004 <i>Contributions</i>.</p> <p>The restructure of administrative arrangement will remain under AASB 1004 and will be restricted to government entities and contributions by owners in a public sector context,</p> <p>AASB 1058 establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objective.</p>	1-Jan-19	<p>The current revenue recognition for grants is to recognise revenue up front upon receipt of the funds.</p> <p>This may change under AASB 1058, as capital grants for the construction of assets will need to be deferred. Income will be recognised over time, upon completion and satisfaction of performance obligations for assets being constructed, or income will be recognised at a point in time for acquisition of assets.</p> <p>The revenue recognition for operating grants will need to be analysed to establish whether the requirements under other applicable standards need to be considered for recognition of liabilities (which will have the effect of deferring the income associated with these grants). Only after that analysis would it be possible to conclude whether there are any changes to operating grants.</p> <p>The impact on current revenue recognition of the changes is the phasing and timing of revenue recorded in the profit and loss statement.</p>
AASB 1059 <i>Service Concession Arrangements: Grantor</i>	<p>This standard applies to arrangements that involve an operator providing a public service on behalf of a public sector grantor. It involves the use of a service concession asset and where the operator manages at least some of the public service at its own direction. An arrangement within the scope of this standard typically involves an operator constructing the asset used to provide the public service or upgrading the assets and operating and maintaining the assets for a specified period of time.</p> <p>The State has 2 types of PPPs:</p> <ol style="list-style-type: none"> <li>1. Social Infrastructure: A PPP that requires the government to make payments to the operator upon commencement of services: <ul style="list-style-type: none"> <li>• Operator finances and constructs the infrastructure; and</li> <li>• State pays unitary service payments over the term.</li> </ul> </li> <li>2. Economic Infrastructure: A PPP that is based on user pays model: <ul style="list-style-type: none"> <li>• Operator finances and constructs the infrastructure;</li> <li>• State does not pay for the cost of the construction; and</li> <li>• Operator charges asset users and recovers the cost of construction and operation for the term of the contract.</li> </ul> </li> </ol>	1-Jan-19	<p>For an arrangement to be in scope of AASB 1059 all of the following requirements are to be satisfied:</p> <ul style="list-style-type: none"> <li>• Operator is providing public services using a service concession asset;</li> <li>• Operator manages at 'least some' of public services under its own discretion;</li> <li>• The State controls/regulates: <ul style="list-style-type: none"> <li>☐ what services are to be provided;</li> <li>☐ to whom; and</li> <li>☐ at what price;</li> </ul> </li> <li>• State controls any significant residual interest in the asset.</li> </ul> <p>If the arrangement does not satisfy all the above requirements the recognition will fall under the requirements of another applicable accounting standard.</p> <p>Currently the social infrastructure PPPs are only recognised on the balance sheet at commercial acceptance. The arrangement will need to be progressively recognised as and when the asset is being constructed. This will have the impact of progressively recognising the financial liability and corresponding asset as the asset is being constructed.</p> <p>For economic infrastructure PPP arrangements, that were previously not on balance sheet, the standard will require recognition of these arrangements on balance sheet. There will be no impact to net debt, as a deferred revenue liability will be recognised and amortised over the concession term.</p>
AASB 17 <i>Insurance Contracts</i>	The new Australian standard eliminates inconsistencies and weaknesses in existing practices by providing a single principle-based framework to account for all types of insurance contracts, including reinsurance contract that an insurer holds. It also provides requirements for presentation and disclosure to enhance comparability between entities.	1-Jan-21	The assessment has indicated that there will be no significant impact for the public sector.

**Appendix 1**

**Issued but not yet effective Australian accounting and reporting pronouncements**

Standard/ Interpretation <sup>1</sup>	Summary	Applicable for annual reporting periods beginning on	Impact on public sector entity financial statements
	This standard does not apply to the not-for-profit public sector entities. The AASB is undertaking further outreach to consider the application of this standard to the not-for-profit public sector.		

In addition to the new standards and amendments above, the AASB has issued a list of other amending standards that are not effective for the 2017-18 reporting period (as listed below). In general, these amending standards include editorial and references changes that are expected to have insignificant impacts on public sector reporting.

- AASB 2016-5 *Amendments to Australian Accounting Standards – Classification and Measurements of Share-based Payment Transactions*
- AASB 2016-6 *Amendments to Australian Accounting Standards – Applying AASB 9 Financial Instruments with AASB 4 Insurance Contracts*
- AASB 2017-1 *Amendments to Australian Accounting Standards – Transfers of Investment Property, Annual Improvements 2014-16 Cycle and Other Amendments*
- AASB 2017-3 *Amendments to Australian Accounting Standards – Clarifications to AASB 4*
- AASB 2017-4 *Amendments to Australian Accounting Standards – Uncertainty over Income Tax Treatments*
- AASB 2017-5 *Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128 and Editorial Corrections*
- AASB 2017-6 *Amendments to Australian Accounting Standards – Prepayment Features with Negative Compensation*
- AASB 2017-7 *Amendments to Australian Accounting Standards – Long-term Interests in Associates and Joint Ventures*
- AASB 2018-1 *Amendments to Australian Accounting Standards – Annual Improvements 2015 – 2017 Cycle*
- AASB 2018-2 *Amendments to Australian Accounting Standards – Plan Amendments, Curtailment or Settlement*

Note:

1. For the current year, given the number of consequential amendments to AASB 9 *Financial Instruments*, AASB 15 *Revenue from Contracts with Customers*, and AASB 16 *Leases*, the standards/interpretations have been grouped together to provide a more relevant view of the upcoming changes.



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