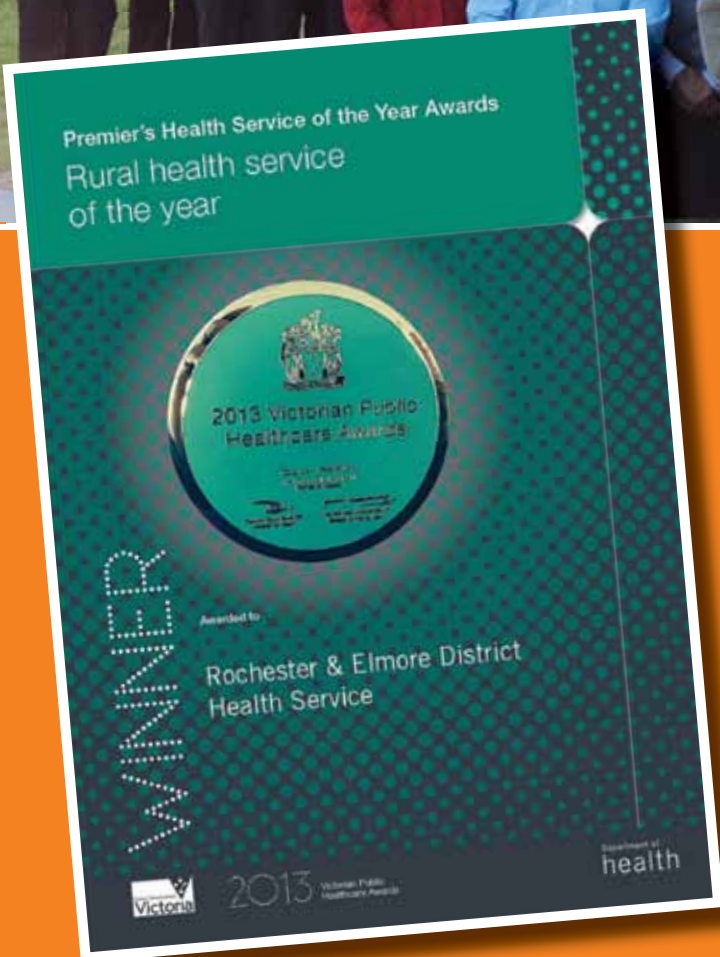


# ANNUAL REPORT 2014



  
**redhhs**

*More Than a Hospital*  
Rochester and Elmore District Health Service

# STRATEGIC INITIATIVES, GOALS AND OBJECTIVES

## 2013 – 2016

### VISION

Rochester and Elmore District Health Service (REDHS) is widely recognised for its excellence in responsive, sustainable rural health services and compassionate care.

### VALUES

**The Board, management and staff of REDHS value:**

**R**espect, dignity and understanding

**E**quity, access, participation and consultation

**D**iligence, responsibility and accountability

**H**onesty, trust and fairness

**S**ervice, professionalism, improvement and innovation



Initiative	Goal	Objectives
<b>Professional People &amp; Defining Culture</b>	REDHS people, culture and structure will provide a platform to:	<ul style="list-style-type: none"> <li>embed our vision, values, service philosophy and initiatives</li> <li>attract and retain high calibre, caring and enthusiastic staff, volunteers and students</li> <li>continue professional development of new or existing staff, volunteers and students that aligns with our workforce development plan</li> <li>enhance our organisation's operational structure, roles and responsibilities</li> </ul>
<b>Great Care &amp; Service Excellence</b>	REDHS consumers will have access to a range of integrated, high quality primary, home-based, acute and aged care health services that:	<ul style="list-style-type: none"> <li>embed the great care and service philosophy across the organisation for every consumer, every time, in all areas</li> <li>ensure existing and new services are consistent with current policy, are proactive and founded on reputable research and evidence based practice that has been undertaken by REDHS or independent third parties</li> <li>delay the impacts of ageing, promote health and wellbeing and build their capacity to live independently and self manage their health and daily activities</li> <li>link consumers and their carers or families to relevant primary, home based, acute and aged care information and services</li> </ul>
<b>Community Engagement &amp; Strategic Relationships</b>	REDHS will have meaningful engagement, partnerships and contributions to services from consumers, families, volunteers, communities and key external stakeholders in the achievement of our vision and strategic initiatives to:	<ul style="list-style-type: none"> <li>develop and implement specific engagement, partnership and education strategies with consumers, the community and service providers</li> <li>enable involvement of people and partners in, and to contribute to strategic initiatives, projects and activities</li> <li>increase donations, sponsorship, bequests and fundraising to benefit service delivery</li> </ul>
<b>Social, Economic &amp; Environmental Sustainability</b>	REDHS will ensure we are sustainable through social, economic and environmental strategies that:	<ul style="list-style-type: none"> <li>enable consumers to have access to high quality services that meet identified needs and improve the overall health of the community ensure</li> <li>each program area, and the health service overall, is economically viable and able to fund our vision and strategic direction</li> <li>contribute in a positive way to the management of the environment of our health service, our local area and broader region</li> </ul>
<b>Systems Enhancement &amp; Business Excellence</b>	The Board, management and staff of REDHS will have timely, accurate and informative data and knowledge to enable:	<ul style="list-style-type: none"> <li>the operation of a robust and secure Information and Communication Technology platform with contemporary and integrated organisational and service systems</li> <li>effective decision making and outcomes in primary, home based, acute and aged care services</li> <li>innovation and continuous improvement initiatives that enhance effectiveness and efficiency</li> <li>internal and external service providers and consultants to undertake specific projects and activities to enhance service delivery</li> </ul>

# WHO WE ARE

Rochester and Elmore District Health Service 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 8,697 and has:

- 115.74 full time equivalent staff
- 30 high care residential aged care beds
- 28 low care residential aged care beds (including one respite and 10 dementia-specific beds)
- 2 Transition Care Program beds (residential)
- 1 Transition Care Program bed (community)
- 12 inpatient beds, including 1 palliative care bed
- An Urgent Care Centre
- Primary Care services

The responsible minister is the Victorian Minister for Health, the Honourable David Davis MLC.

# OUR LOCATION



# CONTENTS

<b>2</b>	Year in Brief
<b>3</b>	Report from President and CEO
<b>5</b>	Corporate Governance
<b>7</b>	Key Personnel
<b>8</b>	Performance against Statement of Priorities (Part A)
<b>13</b>	Quality Systems and Performance
<b>14</b>	Human Resources
<b>16</b>	Clinical Services Report
<b>17</b>	Acute Services
<b>18</b>	Day Procedure Unit
<b>19</b>	Transition Care Program
<b>20</b>	Residential Aged Care
<b>22</b>	Primary Care Services
<b>26</b>	Support Services
<b>29</b>	Occupational Health and Safety
<b>30</b>	Campaspe Primary Care Partnership
<b>31</b>	Community Involvement and Support
<b>32</b>	Statutory Information
<b>34</b>	Performance against Statement of Priorities (Parts B & C)
<b>35</b>	Disclosure Index
<b>36</b>	Glossary

# YEAR IN BRIEF 2013-14

## Acute Ward:

Total Acute Ward Separations	452
Acute Bed Days	3,122
Average Length of Stay (Days)	7.4

## Day Procedure Unit (DPU)

Total DPU Separations	373
-----------------------	-----

## Aged Care

Nursing Home Bed Days	10,757
Nursing Home Separations	11
Hostel Bed Days	9,322
Hostel Separations	11

## Total Non-admitted Occasions of Service

Urgent Care Centre	1,043
Radiology	1,183
District Nursing	5,789
Planned Activity Group	1,703
Meals on Wheels	4,257

## Primary Care:

Diabetes Education	285
Dietetics	838
Exercise Physiology (excl. FOAP)	239
Fitness for Older Adults	1,147
Occupational Therapy	562
Physiotherapy	1,317
Podiatry	2,815
Social Work/Counselling	447
Strength and Balance	792
Drug and Alcohol Withdrawal Service	1,021

## 2013-14

## Services offered by REDHS

- Acute ward
- Day Surgery
- Diabetes Education
- Dietetics
- District Nursing
- Exercise Physiology
- Health Promotion
- Fitness for Older Adults
- Occupational Therapy
- Palliative Care
- Physiotherapy
- Planned Activity Group
- Podiatry
- Radiology and Ultrasounds
- Residential Aged Care
- Respite Care
- Rural Drug and Alcohol Withdrawal
- Social Work and Counselling
- Strength and Balance
- Transition Care Program
- Urgent Care



## REPORT FROM PRESIDENT AND CEO



**Tim Fulton**  
Board President



**Anne McEvoy**  
Chief Executive  
Officer

In accordance with the *Financial Management Act 1994*, we are pleased to present the Report of Operations for Rochester and Elmore District Health Service for the year ending 30 June 2014.

There have been a number of achievements that are detailed in this annual report and we are truly proud of the dedication and care provided by our staff and volunteers in providing services for the community.

There continues to be growth in our services in the areas of primary care and our day procedure unit, while improvements in systems within our residential aged care services have been implemented throughout the year.

### **Rural Health Service of the Year 2013**

There is no doubt the key highlight of the year was REDHS being named a the winner in the 2013 Victorian Public Healthcare Awards for the Premier's Health Service of the Year – Rural Health Service of the Year category. The Premier's award for the most outstanding health service of the year is the most prestigious accolade to which a Victorian health service can aspire.

It was an honour for REDHS to receive the award and was acknowledgement of the dedicated efforts of the board, executive, leadership team, staff and volunteers who provide the best services possible to the community.

During the past 10 years, REDHS has been through some challenging times that have shaped the health service's history and made it a stronger organisation. This award was recognition of the resilience of REDHS, excellence in the services provided and the collective contribution of many people who are currently, and have been previously, involved with the organisation in large and small ways. Each and every person in the Rochester and Elmore district has played a role in creating the health service that REDHS is today and therefore should be proud to have received this award.



*REDHS representatives receiving the award from the Hon. David Davis MLC, Minister for Health*

### **Board of Management**

Board members David Gilbert and Jane Farmer did not seek re-election to the board and therefore completed their terms at the conclusion of the 2013-14 financial year. We acknowledge their contributions to REDHS as directors and their diligence in their obligations.

Changes in the board executive occurred following the annual general meeting. Keith Oberin completed his term as President however remained on the board executive as the Deputy President. Tim Fulton vacated the Treasurer's position to become President and Alan Darbyshire accepted the role of Treasurer.

The REDHS Board of Management again used the framework provided by the Australian Centre for Healthcare Governance to facilitate its annual evaluation and development plan. The results continued to be positive, showing the board's ongoing commitment to its governance obligations.

### **Executive Changes**

REDHS CEO Matt Sharp resigned in March 2014 to take up an executive director position at Eastern Health. Matt had been the CEO at REDHS for almost three years and in that time provided strong leadership and oversaw significant growth and stability across the organisation. The board and staff farewelled Matt,

wishing him the very best in his future endeavours. REDHS Director of Clinical Services Anne McEvoy was appointed Acting CEO during the recruitment phase of a new CEO.

There were further changes at the executive level with our Director of Medical Services, Dr John Christie, finishing to concentrate on a role closer to home. We were pleased to secure the services of Dr Glenn Howlett following Dr Christie's resignation. Acute Services Manager, Damian Holden, has been acting as Director of Clinical Services since March.

### Strategic Plan and Statement of Priorities

REDHS' Strategic Plan July 2013 – June 2016 provided the direction of focus for the board and executive.

The strategic initiatives were once again utilised to develop the annual Statement of Priorities, a requirement led by the Department of Health.

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

- increase in primary care activity of 62% being 5,178 additional occasions of service
- increase in day procedure unit activity of 3.8% being 14 additional procedures
- continued improvement of aged care business processes and implementation of a more contemporary staffing structure to support future viability and in response to aged care reforms
- participation in a number of partnerships and collaborations such as; REDHS being a partner in the cross region strengthening health services project, the lead agency for the Regional Aged Care Funding Instrument Project and a member of the Victorian Small Rural Health Service Alliance which initiated a benchmarking project
- the research partnership with La Trobe University to develop a long-term, inclusive, community-led process continued into its second year with the community consulted to identify health and wellbeing priorities. these priorities were adopted by the board in May 2014 and will provide the basis of key focus for future service planning
- the workplace culture program was rated by 88% of the staff as excellent or very good. An evaluation was completed and enhancements to the program implemented
- the completion of the major refurbishment of the hostel comprising a full repainting program, lighting replacement, plumbing upgrade, installation of new kitchen and window furnishings and new furniture throughout
- meeting ACHS EQIP National and Community Care Common Standards accreditation requirements.

### Dingee Bush Nursing Centre

Considerable efforts have been devoted by the REDHS Board of Management, executive and senior staff in supporting the Dingee Bush Nursing Centre (DBNC) Board of Management and staff during the year. REDHS provided a contracted management service to DBNC for the 2013-14 financial year together with advice regarding the operational management of existing DBNC services, monitoring the quality improvement plan and worked with the DBNC Board of Management regarding its compliance program.

### Community Support

REDHS is truly grateful for the support of the community, local organisations and individuals through generous donations of time and money to support our vision to be widely recognised for excellence in responsive, sustainable rural health services and compassionate care. Community funds previously committed, in addition to a very generous bequest in recent years, enabled the completion of the hostel refurbishment with a total cost of \$310,000. This project has greatly benefited the amenity of the hostel for which the residents have been most grateful.

The Rochester Art Exhibition raised \$6,700 and enabled the purchase of instruments to support our visiting gynaecological proceduralist in DPU. The Rochester branches of Heartbeat and the Lions Club generously donated funds to supply additional equipment for our primary care gym, which has enabled increased group programs supporting the management of chronic disease. We are also grateful for the ongoing support of the Rochester Hospital Auxiliary, which continues to raise funds for the benefit of our services.

Finally, the extension of the co-located Men's Shed at REDHS has been completed in partnership with the Rochester Community House. This is further evidence that working in partnerships benefits our community.

### Our Thanks

We would like to thank the Board of Management, our staff, volunteers, auxiliary members, partner organisations and many others who support REDHS in a variety of ways. In addition, we wish to thank our visiting medical officers, the Victorian Department of Health, Victorian Department of Human Services and the Commonwealth Department of Social Services. We are truly grateful for your assistance, support and services as we strive to improve the health and wellbeing of the communities in and around the Rochester and Elmore communities.

### Vale Dianne Niven and Joan Phelps

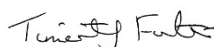
The REDHS Board of Management executive and staff were saddened by the sudden passing of two longstanding staff members during the year.

Dianne Niven passed away in October 2013. Di was our Executive Assistant for 15 years and was highly regarded as an efficient and diligent administration support for the REDHS Board and executive staff.

Joan Phelps, acute ward After-Hours Nurse Unit Manager, passed away in June 2014 after 35 years of service as a nursing staff member. Joan was much admired for her professional and caring nature towards her patients and fellow colleagues.

Both Di and Joan's dedication and commitment whilst staff members of REDHS were highly valued and they are both dearly missed.

#### Tim Fulton Board President



Rochester and Elmore District Health Service  
31 July 2014



#### Anne McEvoy Chief Executive Officer

Rochester and Elmore District Health Service  
31 July 2014



# CORPORATE GOVERNANCE

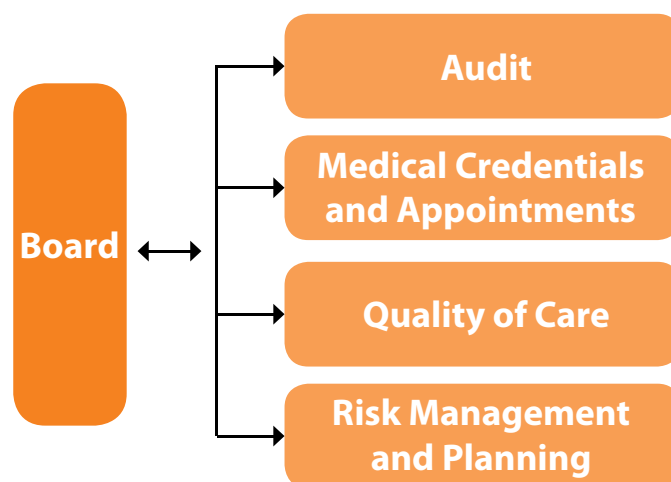
## REDHS Board of Management

Rochester and Elmore District Health Service (REDHS) is an incorporated body listed under Schedule 1 of the *Health Services Act 1988*. Board members 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 Management, 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 Management 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



## Board Members

### Keith Oberin

President (1.7.13 – 25.11.13):  
Vice President (25.11.13 – 30.6.14):  
Dip Ed  
Service Review Manager (Shire of Campaspe)  
Date appointed: 1.7.2008

### Graeme Hodgens

Vice President (1.7.13 – 25.11.13):  
B Ed, Dip Ed (Primary)  
Principal, Rochester Primary School  
Date appointed: 1.7.2011

### Alan Darbyshire

Treasurer (25.11.13 – 30.6.14):  
FCPA  
Registered Company Auditor and Tax Agent  
Date appointed: 1.7.2012

### Timothy Fulton

Treasurer (1.7.13 – 25.11.13):  
President (25.11.13 – 30.6.14):  
B Bus (Acc/Eco), Dip Financial Planning,  
GAICD  
Financial Accountant, Kagome  
Date appointed: 1.7.2009

### Kate Lee

Administration Coordinator  
(Murray Goulburn Co-op)  
Date appointed: 1.7.2011

### Jane Farmer

MA, PhD in Healthcare Management,  
PG Cert in Information Science, PG Cert in  
University Teaching, GAICD  
Associate Dean Research & Strategic Projects,  
Faculty of Health Sciences, La Trobe Rural Health  
School  
Date appointed: 1.7.2011

### Ben Maw

RN, B Hlth Sc (Nursing), GAICD  
Regional Business Manager  
(Benetas)  
Date appointed: 1.7.2011

### David Gilbert

Grad Cert Bus Ad.  
Business Manager - Retired  
Date appointed: 1.7.2010

### Reuben Johnson

B Ed, M Ed Leadership  
Principal, Our Lady of the Sacred Heart Primary  
School, Elmore  
Date appointed: 1.7.2012

## Meeting Attendance

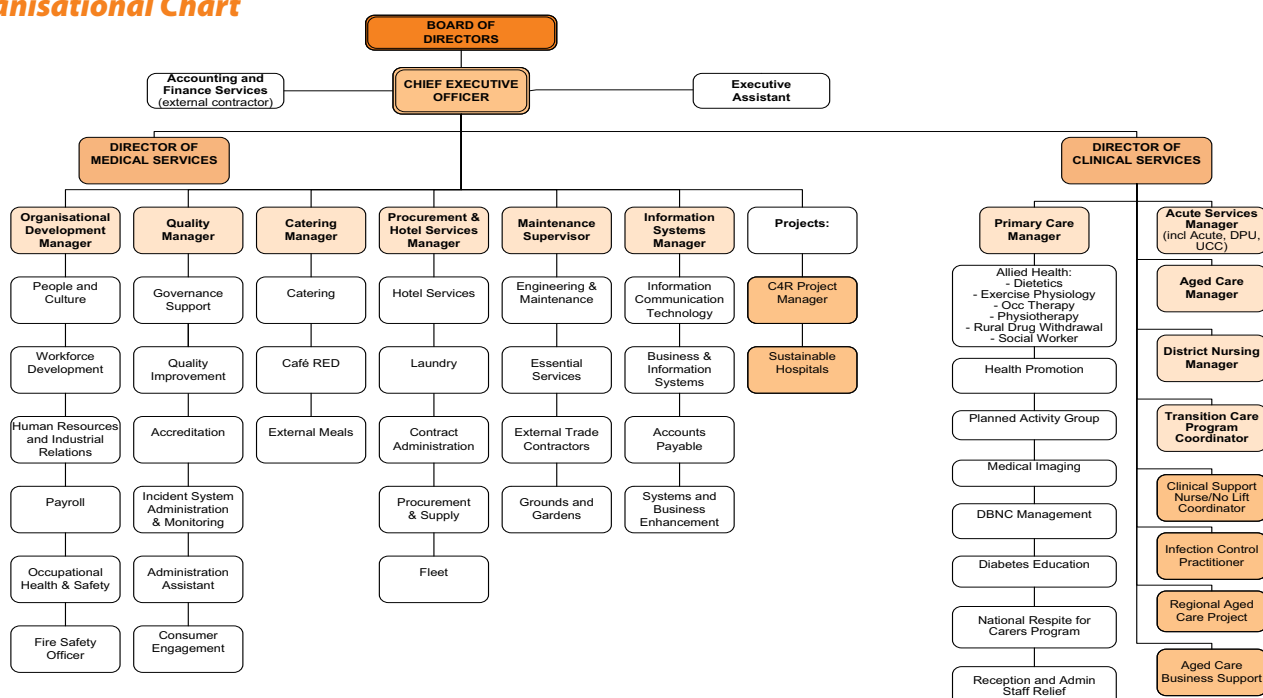
Board Meetings													Annual General Meeting	Total Attended
2013							2014							
	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		
Keith Oberin	✓	✓	✓	✓	✓	NA	✓	✓	✓	A	✓	✓	✓	11/12
Graeme Hodgens	A	✓	✓	✓	✓	NA	A	✓	A	✓	A	A	✓	7/12
Timothy Fulton	✓	✓	✓	A	✓	NA	✓	✓	✓	✓	✓	✓	✓	11/12
Alan Darbyshire	✓	✓	✓	✓	✓	NA	✓	✓	✓	✓	✓	✓	A	11/12
Jane Farmer	✓	✓	A	✓	✓	NA	✓	✓	✓	✓	A	✓	A	9/12
David Gilbert	✓	✓	L	A	✓	NA	✓	A	✓	A	✓	A	✓	7/12
Reuben Johnson	A	✓	✓	A	✓	NA	✓	A	✓	A	A	A	A	5/12
Kate Lee	✓	✓	✓	✓	✓	NA	✓	✓	A	✓	✓	✓	✓	11/12
Benjamin Maw	✓	✓	A	✓	✓	NA	✓	A	✓	✓	✓	A	✓	9/12

A = Apology, L = Leave of Absence, NA = no meeting held

## Committee Membership

	Risk Management & Planning Committee	Audit Committee	Credentials and Medical Appointments Advisory Committee	Quality of Care
Keith Oberin	✓ (4/4)	✓ (4/4)	✓ (2/2)	
Timothy Fulton	✓ (3/4)	✓ (4/4)	✓ (1/1)	
Jane Farmer				✓ (3/4)
David Gilbert	✓ (2/4)	✓ (4/4)	✓ (1/1)	
Graeme Hodgens			✓ (1/1)	
Kate Lee	✓ (2/2)		✓ (2/2)	✓ (3/4)
Alan Darbyshire		✓ (4/4)		
Benjamin Maw	✓ (3/4)			✓ (1/4)
Reuben Johnson	✓ (1/2)			
<b>Audit Committee (Independent) Members:</b>				
Phillip Johnson		✓ (2/4)		
Tracie Kyne		✓ (3/4)		
Rebecca Mitchell		✓ (3/4)		

## Organisational Chart



# KEY PERSONNEL

## Executive

### Chief Executive Officer

(until 30 March 2014)

### Mr Matthew Sharp

RN, B Nursing (Hons), PG Dip Crit Care Nursing, Masters of Business (Management), AFACHSE, AIMM, GAICD

### Director of Clinical Services and Acting CEO

(from 31 March 2014)

### Ms Anne McEvoy

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

### Acting Director of Clinical Services

(from 31 March 2014)

### Mr Damian Holden

RN, B Nursing Post Graduate Diploma, PGD paediatrics

### Director of Medical Services

(until 13 December 2013)

### Dr John Christie

Dip Med Surg, DTM&H, FAFPHM, FRACMA, MACTM

(from 17 February 2014)

### Dr Glenn Howlett

MB BS LLB, Grad Dip Hlth Serv Man, FRACGP

## Department Heads

### Organisational Development Manager

### Ms Aileen Dobson

Dip HR Man/IR, B Bus (HR Man)

### Acute Ward Unit Manager

### Mr Damian Holden

RN, B.N. Post Graduate Diploma, PGD paediatrics

### Day Procedure Unit – Associate Nurse Unit Manager

### Ms Meredith Hodder

RN Grad Cert Perioperative Nursing

### Hostel Supervisor

(until 6 November 2013)

### Ms Jennifer Ellis

RN, RM, B Hlth Sc, Grad Cert Dementia, Grad Cert Gerontology

### Nursing Home Unit Manager

(until 6 November 2013)

### Ms Anne Chirnside

RN, Cert Onc, Grad Cert Gerontology

### Aged Care Manager

(from 7 November 2013)

### Ms Jodie Holmes

RN, B Nursing

### District Nurse Unit Manager

(until 31 January 2014)

### Mr Colin Jones

RN, B Nursing

### Primary Care Manager

### Ms Alicia Cunningham

B Sc, MND, MPH

### Transition Care Manager

(until 19 April 14)

### Ms Meaghan Sully

B Social Work

### Infection Control Practitioner

### Ms Fleurette Hastings

RN, B Nursing, Grad Dip Renal Nursing, Grad Dip Crit Care

### Clinical Support Nurse

### Ms Cheryl Petrini

RN, Cert IV Training and Assessment

### Procurement and Hotel Services Manager

### Ms Gayle McConnell

### Catering Manager

### Ms Darlene Weeks

B Hlth Sc (Nutritional Medicine)

### Quality Systems Manager

### Ms Lynn Wolfe

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

### Information Systems Manager

(until 16 June 14)

### Ms Clare Ireland

B SC, Dip Bus

(from 16 June 2014)

### Mr David Edwards

B Bus, CPA

### Maintenance Supervisor

### Mr Brett Shotton

### Aged Care Business Support Officer

Ms Tania Else

## Visiting Medical Officers

### General Practitioners

### Dr M Attalh, MBBS (Egypt),

### Dr AS Asaid, MBBS (Egypt),

AMC, FRACGP, FACRRM

### Dr I Buadromo, MBBS, FRACGP

### Dr J Duggan, MBBS (Uni of WA),

MPHC (Flinders)

### Dr ED Ekeanyanwu, MBBS

(Nigeria), FRACGP

### Dr N Fang, MBBS, DRANZCOG,

FRACGP

### Dr S Mansour, MBBS (Egypt),

MSc (Canada)

(from 27 March 2013)

### Dr P Nzegwu, MBBS (Nigeria),

AMC

### Dr C Worme, MBBS, DRANCOG

### Dr Y Zhang, MBBS (Beijing),

AMC

### Consultant Physician

### Dr R Chapman

### General Surgeon

### Ms J Arnold, MBBS, FRACS

### Dr J Azzopardi, MBBS DA (UK)

DRACOG FRACGP

### Mr M Oliver, MBChB, FRCSEd,

FRACS

### Urologist

### Miss J Brennan, MBBS (Hons),

FRACS (Urology)

### Mr M McClatchey, MB ChB BAO

FRCS FRACS

### Visiting Gynaecologist

### Dr A Borozdina, VRAC,

FRANZCOG

### GP Anaesthetists

### Dr S Harrison, MBBS, DA

(London)

### Dr C Hunt, MBBS, DRACOG, DA,

ACRRM

### Dr S Kennedy, MBBS, FRACGP,

ARTP (Anaes)

### Dr C Taverna, MB, BS (GP

Registrar)

### Specialist Anaesthetists

### Dr P Buncle, MBBS, FANZCA

### Dr K Davenport, MBChB,

FANZCA

### Dr S Dobell, MBBS, FANZCA

### Dr L Hamond, MBBS, FANZCA,

Dip RACOG

### Dr S Hams, MBBS, FANZCA

### Dr G Hay, MBBS, DRACOG,

FRACGP, FRACRRM

### Dr B Hindson, MBBS, FANZCA

### Dr P Mazur, MBBS, FANZCA

### Dr M Nerlekar, MBBS, DA, MD,

FANZCA

### Dr D Noble, MBBS, FANZCA

### Dr A Purcell, MBBS, DA (UK),

Dip Obs, RACOG, FANZCA

### Dr M Shapiro, MBChB, H DA,

FANZCA

### Visiting Cardiologist:

### Dr A Jackson, MBBS, FRACP

### Dr N Nadarajah, MBBS, FRACP,

FRACP (Cardiology)

### Visiting Dentists:

### Dr A Shenai, BDS (India), ADC

### Visiting Radiology Service

Goulburn Valley Imaging

Group

# PERFORMANCE AGAINST STATEMENT OF PRIORITIES (Part A)

Initiative – Professional People and Defining Culture	Action	Deliverable	Outcome
1.1 Defining Our Vision, Values, Philosophy	Build workforce culture to sustain motivation, productivity, quality work and retention.	a) Embed the workplace culture and excellence program and evaluate its effectiveness.	Evaluation of 2013 program complete. Program has been revised for 2014 and enhancements implemented.
		b) Develop and implement a set of key HR metrics including lead indicators regarding culture.	Preliminary indicator suite being developed.
1.2 Attracting and Retaining Staff, Volunteers and Students	Build workforce capability and sustainability by supporting formal and informal clinical education and training for staff.	a) Evaluate the effectiveness of retention and succession planning strategies and implement identified improvements.	Strategy being implemented progressively.
		b) Develop and implement a management development program.	Framework established. Manager education program designed.
1.3 Continuing Professional Development	Optimise workforce productivity through identification and implementation of workforce models that enhance individual and team capacity and support flexibility.	a) Implement the <i>Rural and Isolated Practice Endorsed Registered Nurse</i> model.	Four registered nurses have completed the program and are awaiting endorsement. Model implementation making good progress.
		b) Implement the Allied Health Assistant <i>strategic plan</i> .	Completed.
		c) Develop and implement mechanisms to support existing staff upgrading their qualifications.	Staff up skilling qualifications.
1.4 Aligning Organisational Structure, Roles and Responsibilities	Build workforce capability and effectiveness by clearly defining structure, roles and accountabilities.	a) Implement the residential aged care staffing restructure.	New structure implemented September 2013. Aged Care Manager commenced November 2013. Evaluation of change management report received and action plan developed.
		b) Develop and implement a new structure in catering and hotel services.	Formal change process progressed. Implementation likely to be completed by end of 2014.
		c) Complete a review of all administration services.	Review completed.
		d) Review the organisation structure and align key responsibilities.	Identified organisational structure efficiencies in aged care, primary care and TCP program.

Initiative – Great care and Service Excellence	Action	Deliverable	Outcome
2.1 Delivering Great Care and Service Excellence	Evaluate current advanced care planning processes and extend into acute and community based services.	a) Review residential aged care advanced care planning processes.	Evaluation of current model completed.
		b) Implement advanced care planning for identified consumers in acute and primary care services .	Deferred strategy. Plan to be implemented in 2014-15.
	Respond to the specific needs of people with priority conditions	a) Increase primary care occasions of service.	62% increase achieved compared to previous year.
		b) Increase day procedure unit services by 5% compared to 2012/13.	3.8% increase achieved compared to previous year.
	Develop and implement improvement strategies that optimise access, patient flow, system coordination and the quality and safety of hospital services.	a) Fully implement the <i>Great Care and Service Excellence</i> framework and evaluate its effectiveness.	Implementation continues on track (see Quality and Performance page 13).
		b) Participate in the regional <i>Transition Care Program quality service review</i> .	Review completed.
2.2 Strengthening Evidence Based Practice, Our Services	Improve 30 day unplanned readmission rates.	Reduce the rate of unplanned readmissions.	Unplanned readmissions reduced by 1% compared to previous year.
2.3 Creating a New Service Model, Business Model	Consider new models of care and more coordinated services.	a) Review current home based services and identify further opportunities.	Community respite services (NRCP) operating effectively and supporting occupancy of residential aged care.
		b) Fully implement a revised primary care service and business model.	Implementation of business model completed.
		c) Review and update the REDHS Service Plan by 30 June 2014.	Delayed - Information from <i>La Trobe Community Participation Project</i> to inform services in 2014-15.
2.4 Promoting Health and Wellbeing Strategies	Improve capability for health promotion planning and wellbeing strategies.	Liaise with the Shire of Campaspe and Campaspe Primary Care Partnership regarding the development of the <i>Municipal Public Health Plan</i> and <i>Campaspe PCP Integrated Health Promotion Plan</i> .	Completed.

Initiative – Great care and Service Excellence	Action	Deliverable	Outcome
2.5 Shaping Service Integration	Ensure service coordination, discharge planning and referral processes support effective care transition and prioritisation of services.	a) Fully implement centralised intake, needs identification and prioritisation of services in all primary care programs.	IT plan to support centralisation progressing.
		b) Evaluate the effectiveness of person centred care practice.	Evaluation completed for the Active Service Model for HACC services.

Initiative – Community Engagement and Strategic Relationships	Action	Deliverable	Outcome
3.1 Strengthening Community Engagement	Improve health literacy and support informed choice by responding to the health information needs of consumers and consider new services.	a) Embed the <i>Improving the Health of Communities Through Participation</i> partnership with LaTrobe University.	Project on track. Five project priorities affirmed.
	Enhance communication with REDHS' catchment community	b) Fully embed the communication strategy ' <i>REDHS – more than a hospital</i> '.	Progressing, some delays with website upgrade.
3.2 Building Community Contributions	Actively promote existing initiatives that have utilized community funds and support to be undertaken and secure additional donations to support future initiatives.	a) Complete the Hostel Refurbishment	Completed.
		b) Support the Rochester Art Exhibition Committee	Completed.
3.3 Maximising Strategic Relationships	In partnership with other providers within the local area, develop area based planning initiatives that consider health care across the continuum and develop strategies that maximise the use of available resources across the local area.	a) Participate in shared service initiatives with other health services.	Evaluation of services complete.
		b) Formalise existing collaborations with neighbouring health services.	Progressing through <i>Strengthening Health Services</i> project.
		c) Identify joint strategic and service provision opportunities.	Contact made with other health services and funding agencies.
		d) Provide a contracted management service to Dingee Bush Nursing Centre for 2013-14.	Contracted management service provided.

Initiative– Social, Economic and Environmental Sustainability	Action	Deliverable	Outcome
4.1 Shaping Social Sustainability	Actively support the <i>Committee 4 Rochester (C4R)</i> .	Continue as the employing agency for the C4R Project Officer and provide assistance in ensuring the sustainability of the C4R.	Completed.
4.2 Enhancing Economic Sustainability	Reduce variation in health service administrative costs.	a) Carry out a review of contracted administration services.	Contracts being reviewed as per schedule
		b) Provide leadership and support to small rural health services in the region providing residential aged care.	Lead agency for ACFI project.
		c) Develop and implement a strategy to encourage patients to use private health insurance.	Completed. Significant improvement in PP revenue since project commenced.
	Prepare for, and respond to, changes in policy and regulation as a result of new aged care legislation.	Complete a formal review of changes and opportunities related to aged care reform.	Review completed. Identified priority for future business modelling.
4.3 Instituting Environmental Sustainability	Implement initiatives to enhance existing environmental strategies and secure funds for further initiatives.	a) Replace existing high energy globes with low energy globes	Completed.
		b) Install solar panels to reduce recurrent energy consumption.	Strategy deferred.
4.4 Securing Alternative Revenue Streams	Fully embed primary care service growth opportunities.	a) Consolidate the CMBS business processes.	Completed.
		b) Establish the <i>Rural Drug and Alcohol withdrawal</i> program.	Total of 1,021 occasions of service this year.

Initiative– Systems Enhancement and Business Excellence	Action	Deliverable	Outcome
5.1 Reviewing and Enhancing Systems	Improve performance reporting suite provided to management and the Board.	Review current processes and implement a new reporting system and set of indicators in a dashboard.	In progress, with implementation expected August 2014.
	Fully implement Streamlined Information Management Systems to improve organizational efficiency	Fully embed policy system.	Implementation completed.
5.2 Telehealth and Telecare Strategy	Maximise the use of health ICT infrastructure.	Video conferencing (VC) implemented for Transition Care Program.	Completed.
5.3 Facilitating Innovation in all Areas	Implement identified improvements	Consider recommendations arising from administration review.	Administration services review completed.
5.4 Advancing Service Excellence, Business Excellence	Prepare for the National Safety and Quality Health Service Standards.	Maintain accreditation under the <i>National Safety and Quality Health Service Standards</i> .	Achieved in September 2013.
	Implement systems that support streamlined approaches to clinical governance at all levels of the organisation.	Conduct a formal clinical governance review.	Clinical Governance Framework developed and approved by Board of Management.

# QUALITY SYSTEMS AND PERFORMANCE

*Providing Great Care* continued to be the aim of REDHS this year in accordance with REDHS Quality Plan. The plan is as a guiding tool for all staff and management as we strive to deliver safe, high quality care to everyone using our services.

REDHS' Quality Plan comprises four goals aimed at delivering not just quality care, but *Great Care*.

REDHS four quality goals are to provide care that is:

1. Responsive to, and focused on, individual needs
2. Right for each person and achieve what they are designed to do
3. Accessible, coordinated, streamlined and organised
4. Safe and free from preventable harm

Input into a definition of *Great Care* is being provided by board members, staff and consumers and will be finalised in late 2014. In the meantime, work is going ahead on achieving the four goals.

Throughout this Report of Operations you will read about the many departments and staff who provide services, some you see and others who work behind the scenes. All of these areas are monitored to make sure that Best Practice techniques are being used, that standards, laws and regulations are being met and that there are effective policies, procedures and systems in place to guide staff in the delivery of *Great Care*. The quality department manages and/or monitors the many systems that allow data and information to be collected and reported and conducts analyses to check "how we are going" in achieving the four quality goals.

There is little doubt that REDHS being awarded the Victorian Rural Health Service of the Year was due, in part, to the quality of care delivered across the entire health organisation and the systems in place to support this delivery.

Some of the systems used by the quality department are: incident reporting, risk assessments, legislation compliance registers, policy and procedure document control, primary care and patient information databases, consumer feedback (compliments, suggestions, complaints and surveys), infection control surveillance, radiology (X-rays) usage and the ImproveIT™ improvement database. Statistics and performance reports were generated and distributed to the Board of Management, managers and staff throughout the year. The Quality of Care Report was again published as a calendar, which has proved to be a popular format over the past two years.

Quality Systems Manager, Lynn Wolfe, continued to deliver education on quality of care and consumer expectations at staff training days. In September 2013, REDHS formalised its clinical governance framework, which determines who is in charge, who is responsible for particular clinical concerns and where performance indicators are to be reported. In December, we rolled out the PROMPT document control system organisation-wide.

REDHS' *Risk Management Framework* was updated this year in tandem with the Quality Plan and education provided to staff. The inaugural *Report a Risk Week* was held in July 2013 and was a great opportunity for all staff to become familiar with the risk matrix and understand how to prioritise risks. Some volunteers also received education in this important area. During this week, staff and volunteers reported risks that were reviewed

by the chief executive officer. As a result, three new risks were presented to the board for inclusion on the REDHS Risk Register. This was a pleasing result for all involved, to not only identify known risks, but to identify previously unidentified risks and work on rectifying the associated issues.

*The National Safety and Quality Health Service Standards* came into effect in January 2013. REDHS opted to be accredited against the *Australian Council on Healthcare Standards' EQulPNational program* (which includes the ten new national standards as well as an additional five standards that look at human resources, service delivery, information management and corporate and safety systems in more detail).

This year was a particularly challenging one regarding accreditation, with simultaneous assessments conducted in late September:

- REDHS underwent an EQulPNational Periodic Review that required the first three national standards to be met as well as some mandatory actions from the additional standards. Staff put in a huge team effort to interpret and address the new standards and support each other to ensure that the standards were being met. REDHS was deemed to have met all requirements to maintain full accreditation status in the acute ward, day procedure unit, Transition Care Program and applicable primary care services.
- REDHS Home and Community Care (HACC) services were reviewed against the *Community Care Common Standards* for the first time. REDHS also met all of the requirements in these services including the planned activity group, podiatry, district nursing, occupational therapy and physiotherapy.
- REDHS aged care facilities received an unannounced accreditation visit by the Aged Care Standards and Accreditation Agency to review all human resource systems and quality improvement activities and was found to be compliant with these requirements.

Next year will be another busy one in the quality department as we work on a number of projects:

- a data integrity project will be progressed as REDHS works to ensure the accuracy of its data. A set of business rules for internal performance indicators is being developed to ensure a consistent and thorough reporting process into the future
- the *Consumer Engagement Strategy* will be developed and implementation commenced with a view to increase opportunities for community members to be involved with REDHS in dynamic and mutually beneficial ways
- be working with the board, managers and staff to meet requirements for three different accreditation programs. The radiology department (X-rays) will be assessed against the requirements of the *Diagnostic Imaging Accreditation Scheme* in December 2014 and the Acute ward, DPU and some primary care services will be assessed against all fifteen standards in April 2015. Our aged care facilities will be assessed against the aged care standards in July/ August 2015
- we will be implementing and coordinating the risk assessment and legislative compliance processes electronically via the VHIMS software platform.



# HUMAN RESOURCES

## Cultural Enhancement Program

One of REDHS' strategic initiatives is enhancing our culture to enable us to:

- Embed our vision, values, service philosophy and initiatives
- Attract and retain high calibre, caring and enthusiastic staff, volunteers and students
- Continue professional development of new or existing staff, volunteers and students that aligns with our workforce development plan; and
- Enhance our organisation's operational structure, roles and responsibilities

Throughout 2013 and again this year, REDHS has utilised its mandatory staff training days to introduce the philosophies of *be there, make their day, choose your attitude and play* as a means of underpinning principles of quality customer service, effective teamwork and patient-centred care. Rather than presenting the philosophy as explicit concepts with manufactured activities and ideas, these principles are role-modelled during the learning activities. In turn, these learning activities encourage staff to bring their own meaning to the philosophies and to take these back to their own work environment and apply them to their daily work practices in ways that work for the team.

An evaluation was conducted at the end of 2013 that demonstrated:

- Participation has increased by 14%
- Three quarters of all participants reported having a lot of fun on the day
- A greater percentage of participants reported learning from the day compared to previous years
- A larger percentage of participants are rating the specific topics more highly than previous years

Some of the feedback received from staff demonstrates that staff learn more from the day because it is fun and they are more engaged. Parts of the feedback have already been used to make improvements to REDHS systems, such as emergency response training. Safety risks known by staff that have not previously been reported have also been addressed through the program.

Similarly, results from the *People Matters Survey* conducted by the State Services Authority demonstrated higher average satisfaction ratings in all areas when compared to previous surveys. Of particular note were results relating to staff's satisfaction of all forms of feedback received, being at 70% compared to 46% in previous years.

REDHS will build on these results throughout 2014-15 by implementing our *People Excellence Program* whereby staff evaluation will not only be based on performance but also competency and values based behaviours.

As part of REDHS philosophy to "Grow Our Own", many staff are undertaking study or have completed qualifications this year:

- seven enrolled nurses continued to undertake a Diploma of Nursing
- two enrolled nurses are continuing the Advanced Diploma of Nursing
- two enrolled nurses are undertaking a Bachelor of Nursing
- three registered nurses completed their RIPERN training
- one registered nurse completed a Certificate in Infection Control
- one registered nurse completed a Graduate Certificate in Perioperative Nursing with honours

Our maintenance and allied health trainees will complete their traineeships in December 2014. Our previous administration trainee, Haley Neate, completed a Cert II in Health Services at the end of 2013 and has gone on to study at Deakin University. In January 2014, Maddalyn Chapman took up the administration traineeship position after completing her Year 12 studies.

REDHS employed four nursing graduates this year as part of the *Northern Rivers Graduate Program* (see Acute Services report see page 17 for detail).

Student placements are a priority for REDHS to expose students to the provision of health services in a rural setting. In 2013-14, 92 students spent a total of 837 days at REDHS. Clinical support nurse, Cheryl Petrini, ensures that students are appropriately orientated to REDHS requirements and their own responsibilities. Cheryl is also implementing the Department

of Health's *Best Practice Clinical Learning Environment (BPCLE)* project at REDHS. The BPCLE framework provides guidance to REDHS, in partnership with the education providers, to facilitate the creation and maintenance of positive education cultures and improve student experience.

Once again, REDHS' onsite accommodation has been well patronised and is just one of the amenities that makes REDHS a popular place for students. Very positive feedback has been received from students (and their educational institutions) about their time spent in our community.

### Workforce Data:

	Ongoing		Fixed Term		Casual		Total	
	Head Count	FTE	Head Count	FTE	Head Count	FTE	Head Count	FTE
June 14	128	81.17	34	25.23	25	9.34	187	115.74
June 13	112	74.5	43	29.5	30	9.4	185	113.4

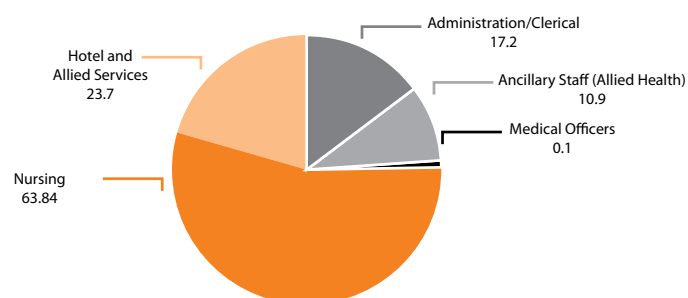
	June 2014			June 2013		
	Ongoing Employees		Fixed term & Casual	Ongoing Employees		Fixed term & Casual
	Head Count	FTE	FTE	Head Count	FTE	FTE
<b>Gender</b>						
Male	8	4.37	5.42	6.0	4.8	5.0
Female	120	76.81	29.14	106.0	69.7	34.1
<b>Age</b>						
Under 25	2	0.74	8.05	0.0	0.0	7.1
25 – 34	8	4.66	3.66	9.0	6.4	4.0
35 – 44	24	14.82	5.32	23.0	14	7.6
45 – 54	48	30.11	10.6	43.0	28.7	11.8
55 – 64	36	23.88	5.69	28.0	19.1	8.1
65+	10	6.97	1.24	9.0	6.5	0.6

**NOTES:** All figures reflect active employees in the last full pay period of June 2014. Ongoing means people engaged in an open ended contract of employment. FTE means full time equivalent.

### Staff by Occupational Group

Labour Category	Current Month		YTD	
	Jun 13	Jun 14	Jun 13	June 14
Nursing	59.49	63.84	53.75	58.06
Administration & Clerical	17.96	17.2	14.67	14.46
Medical Support	0	0	0	0
Hotel & Allied Services	25.4	23.7	23.65	21.95
Medical Officers	0.10	0.10	0.10	0.10
Sessional Clinicians	0	0	0	0
Hospital Medical Officers	0	0	0	0
Ancillary Staff (Allied Health)	10.4	10.9	9.47	10.1
<b>Totals</b>	<b>113.35</b>	<b>115.74</b>	<b>101.64</b>	<b>104.67</b>

### Staff - Full Time Equivalent



### Recognition of Staff Service

REDHS is fortunate to have many long-term staff with a relatively low turnover. This year, REDHS recognises the service of the following staff:

#### 10 years

Wendy Dey  
Jennifer Holt  
Lynn Wolfe

#### 15 years

Nicole Hickey

#### 20 Years

Denise Levy  
Ruth O'Connor  
Janice Prigg  
Darlene Weeks

#### 25 years

Gayle McConnell  
Mary McCormick

#### 30 years

Judith Kiefel

#### 45 years

Heather Oliver

# CLINICAL SERVICES **REPORT**

The clinical services at REDHS have diversified, improved and expanded in the past 12 months through the introduction of new initiatives and the further development and refinement of key services to align with our strategic direction. Most importantly we have sustained the high standards of care with an increased focus on the philosophy of person-centred care across all services.

Individual department achievements are highlighted throughout the annual report and are evidence of the high standard of leadership provided by clinical department managers, the commitment and professionalism of the staff employed in our various clinical services and the many volunteers who give freely of their time.

There have been many highlights in the delivery of our clinical services in 2013-14.

## **Primary Care**

Primary care services have continued to respond to community needs to effectively manage health conditions and independence. Home and community-based allied health, nursing and ancillary support services achieved a significant increase of 62% in occasions of service.

REDHS was fortunate to secure a contract partnership with Northern District Community Health Service to provide a Rural Drug and Alcohol Withdrawal Service across the Shire of Campaspe. The demand for this service has been consistently high since it commenced in September 2013 with 1,072 occasions of service provided.

There has also been an expansion of REDHS' social work services in 2014, with a focus on an *Advance Care Planning* initiative. Advance Care Planning assists people to express their preferences for treatment and care, and allows them to have confidence that health services are providing treatment and care tailored to their individual needs.

REDHS' nursing and planned activity group services have been complemented by the continuation of home and group based respite services under the *National Respite for Carers Program* (a partnership with Uniting Age Well). REDHS' post-acute care, Department of Veteran Affairs, Hospital in the Home, and domiciliary midwifery services allow greater access to nursing, allied health and home support services for the community.

Group programs in primary care have expanded in response to community demand. This year four new group-based programs were added to the schedule, including Cardiac Rehabilitation Maintenance, Type 2 Diabetes management, a low-level exercise group and an additional Fitness for Older Adults timeslot.

Primary care was also successful in achieving re-accreditation in September 2013 by meeting all required actions under the Community Common Care Standards (CCCS). This was the first time REDHS has been assessed under the CCCS accreditation framework for HACC funded services which include district nursing, physiotherapy, Planned Activity Group, podiatry and

occupational therapy. HACC services are jointly funded by the Australian and Victorian governments.

## **Aged Care**

In September 2013, following a 12-month consultative process with all key stakeholders, REDHS' new aged care staffing structure was implemented to support the level of care required for residents both in the nursing home and hostel. As part of the restructure, the nursing home and hostel managerial positions were combined into one overall manager. This has enabled a more streamlined communication and decision making process and has supported an increase in care staff hours, aiding care staff to devote more quality time to residents and improve other services dependant on staff time. The implementation process was further strengthened by the recruitment of REDHS' new Aged Care Manager, Jodie Holmes, who commenced in November 2013. I wish to acknowledge the positive manner in which aged care staff are adapting and working through the process change and implementation stages.

## **Acute**

During 2013-14, four of REDHS' acute registered nurses commenced further study by undertaking Queensland Health's Rural and Isolated Practice Registered Nurse course. This professional development program is accredited by the Australian Nursing and Midwifery Accreditation Council and will enable registered nurses to apply for Schedule Medicines (Rural and Isolated Practice) Endorsement through the Nursing and Midwifery Board of Australia. The model, which will support care delivered through our Urgent Care Centre, allows for health services, local doctors, pharmacists, nurses and paramedics to work together to achieve the best mix of services to meet the needs of the patient. Currently REDHS is in the implementation phase with governance and policy development being discussed with all key stakeholders including GPs, Ambulance Victoria and our local pharmacy.

## **Day Procedure Unit (DPU)**

Growth has continued in the DPU with a 3.8% increase in separations from last year.

REDHS also welcomed the appointment of an additional proceduralist, Dr Angelika Borozdina, providing gynaecological services.

As required, accreditation in both the acute and day procedure unit departments was achieved in Core Actions under the *National Safety and Quality Health Service Standards* 1 to 3, along with all Mandatory Actions under the EQulPNational Standards.

The significant increase in services, the upskilling of clinical staff and improvements being made as a result of consumer feedback illustrate our staff members' commitment to providing high quality, compassionate care to the community.



**Damian Holden**  
**Acting Director of Clinical Services**  
**31 July 2014**



## ACUTE SERVICES

REDHS Acute Services team members continued to provide high quality care for the community in 2013-14. In March 2014, Nurse Unit Manager, Damian Holden, moved into the Acting Director of Clinical Services position and DPU Associate Nurse Unit Manager, Meredith Hodder stepped into Damian's role as the Acting Acute Services Nurse Unit Manager.

There were 452 acute ward separations compared to 536 last year. The reduction is mainly due to a significant reduction in same-day patients (those who come in for procedures such as blood transfusions) which dropped to 77 compared to 134 in 2012-13. Patients stayed an average of 7.4 days compared to 6.2 last year. The increase is due mainly to an increase in patients awaiting aged care places. The Urgent Care Centre had 1,043 presentations, up from 895 last year. This increase is being investigated by the unit manager and results will be presented at Care Review Committee for analysis.

This year, education in the *RIPERN program* commenced. Four registered nurses obtained their RIPERN qualification for application in the Urgent Care Centre in 2014-15.

The acute ward hosted many nursing students throughout the year and are also working with the graduate nurses to help them to consolidate and apply the knowledge they gained during their studies.

Graduate nurses are supported by the Northern Rivers sub-regional consortium consisting of REDHS and health services at Boort, Cohuna and Echuca. The model has demonstrated a strong collaborative partnership, which has resulted in the provision of two additional graduate places at REDHS in 2013 (making a total of three) plus a further position in 2014.

Funding granted by the Victorian Department of Health Nurse Policy Branch supported REDHS to investigate further options to increase the number of graduate positions available. As a result, the fourth position created in 2014 combines employment within both REDHS and a medical practice.

Youstina Habashi is the first graduate nurse to be selected for this innovative graduate nursing position at REDHS. She is employed two days per week at REDHS in a hospital-based setting and two days per week at St Anthony's Family Medical Practice, predominantly at their Strathfieldsaye Primary Health site.

A change in approach has been required of all acute and day procedure unit staff to address the new national standards (see also Quality Systems and Performance page 13) that shift the focus of the accreditation process to direct patient care provided by nursing and allied health staff.

REDHS acute ward staff were pleased with maintaining their full accreditation status at the Periodic Review in September 2013. As part of the self-assessment in June 2014, acute ward staff reviewed their practices, both clinical and administrative, to contribute to the self-assessment against the standards. Now that this is complete, staff will be working with the quality department to meet the requirements of the standards in April 2015. This will involve policy review, risk assessments, conducting audits to ensure all staff are following guidelines and working on increasing the involvement of patients in their own care.

This year there was an initiative to increase the number of patients electing to be admitted as private patients. This has led to a number of benefits for private patients including the waiving of the gap or excess fees. As a result, an increase in private admissions has been recorded in the first half of 2014, with 92% of patients with private health insurance electing to be admitted as private.

To provide an environment for staff interested in management or team leader roles, the *Supported Shift Management Initiative* has been adopted. Staff have the opportunity to work side-by-side with managers to gain an insight into the skills required. This up-skilling is not only beneficial to nursing staff looking to improve their skill set but, importantly, caters for after-hours work and fill-in requirements for annual leave, long service leave and maternity leave positions.

Acute ward staff were shocked and saddened by the sudden passing of their colleague Joan Phelps in June 2014. Joan had been working in the acute ward for 35 years and had mentored many nurses and students during that time. Her colleagues fondly remember her many leadership attributes, attention to detail, ability to manage rosters, the imparting of her considerable knowledge and wisdom and her great compassion for the patients in her care. She is sadly missed.

## DAY PROCEDURE UNIT

All DPU staff are proud to provide more than just health care and work tirelessly to provide the best service possible.

As a result of DPU associate nurse unit manager, Meredith Hodder, moved into her acting role for acute services, Rebecca East and Karalyn Stewart stepped into a job-sharing arrangement as DPU associate nurse unit managers in March 2014.

One of the major highlights of the year has been the increase to six proceduralists, from only three in 2012-13. As a result, the services of additional casual, consultant anaesthetists have been acquired.

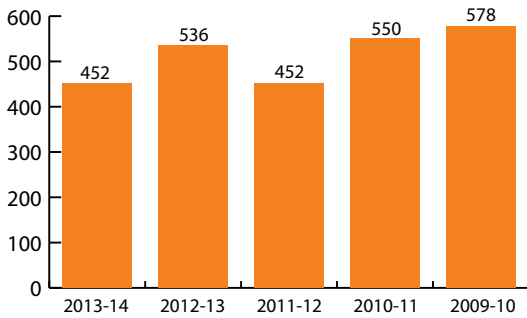
Activity levels in 2013-14 exceeded 2012-13, with 373 separations compared to 359 last year and increase of 3.8%.

Other highlights:

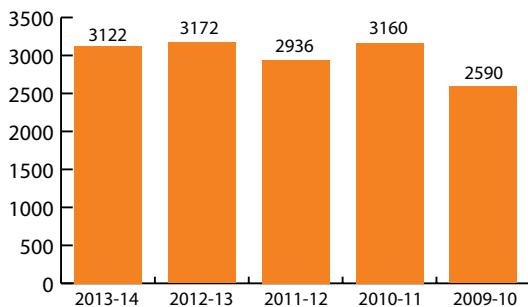
- the increase in patients from the local area accessing the DPU service as evidenced by a postcode analysis
- from a staffing perspective, the department was also able to increase its permanent FTE staff to four, compared to three the previous year
- some much-needed equipment has also been purchased over the past 12 months, including five instrument trays acquired through a \$6000 donation from the Rochester Art Exhibition. As a result a gynaecological surgeon can now offer a service not recently provided at REDHS
- the DPU also benefitted from a donation from the Auxiliary with the purchase of a new recliner for recovering patients post-surgery. There are multiple benefits from this type of donation including patient comfort and improved recovery
- the DPU Manager, Infection Control Practitioner and Procurement Manager combined efforts to obtain an instrument drying cabinet to meet infection control standards. This new piece of equipment allows for quicker and more efficient drying of surgical instruments and thus, provides a more efficient service
- an audit carried out on patient waiting times highlighted a significant reduction in waiting times from the same time last year. The March audit found the average patient waiting time had decreased by 15 mins to one hour and 45 minutes and well below the day surgery recommendation of two hours. This was a fantastic result for patients and is a wonderful reflection on the REDHS DPU team.
- feedback received from patients following surgery has been very pleasing and rewarding for all staff with an overwhelmingly positive response in relation to the service provided and follow-up care

Challenges for the DPU include staffing a unit that does not operate on a daily basis and acquiring and retaining an adequate bank of casual nursing staff. Despite the benefits of having four permanent nurses, staffing the DPU procedure list is a challenge as some staff also work at other health services. Planning well ahead with procedure lists and rostering staff in advance has helped alleviate this issue.

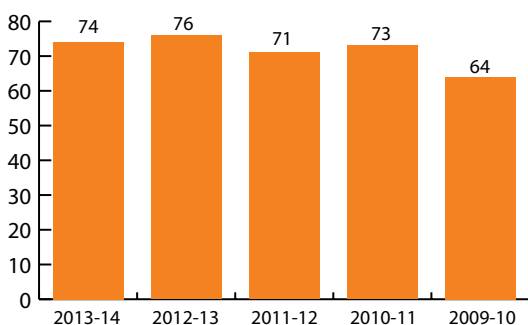
**Acute Ward Separations**



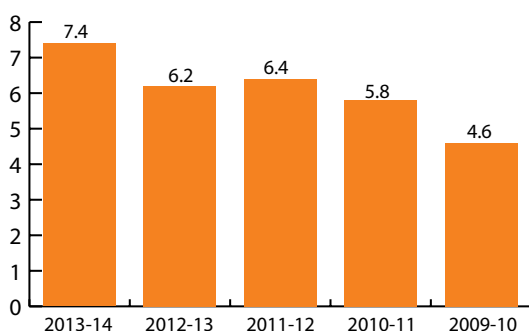
**Acute Ward Bed Days**



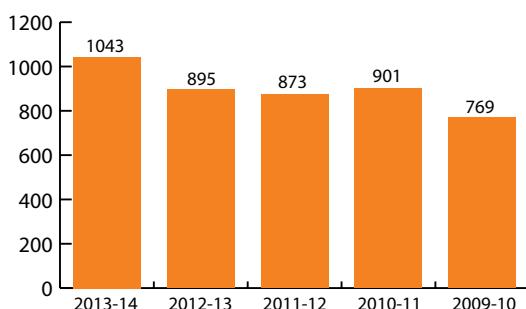
**Acute Ward Occupancy (Average %)**



**Acute Ward - Average length of stay (Days)**



**Urgent Care Centre Presentations**



From a quality point of view, a review process is underway to examine the post discharge information for all patients. This review will be conducted with direct consumer input to ensure that information is in an easily understood format and the health literacy of patients is improved.

In the next 12 months, the DPU team:

- aim to maintain the continued great work within their department
- will hold the first annual theatre study day in July 2014 to encompass training on procedures within the DPU department – from admissions all the way through to discharge. Aspects of the training day will include, scrubbing, sharps safety, sterile setups and recovery. The aim of the training is to ensure everyone understands all procedures and policies (and why they exist) across the entire department
- plans to increase the number of casual nursing staff
- will continue to work on improvements and adjust processes to maintain the high quality level of service.

## TRANSITION CARE PROGRAM

The Transition Care Program (TCP) provides goal-oriented, time-limited and therapy- focused care to help older people at the conclusion of their hospital stay. In its second full year, the program continued to be delivered in either REDHS' Hostel or the client's home.

In 2013-14, there were 23 clients on the program compared to 29 last year. On average, clients were in the program for 44 days (54 days in 2012-13).

With a target of 95%, the program maintained a consistently high occupancy rate throughout the year and recorded an overall rate of 94%. Although the target was not quite met, TCP has maintained a consistently high overall occupancy level.

Clients complete evaluation forms at the end of the program and there has been overwhelmingly positive feedback about the program and the results achieved. Most satisfying was the level of positive outcomes achieved by clients who reached their set goals.

TCP at REDHS was a stand-alone unit managed by Meaghan Sully until April 2014, when it was transitioned into aged care management. As a result, Aged Care Manager Jodie Holmes now manages TCP.

Clients were helped to achieve their goals with input from a number of allied health professionals including the physiotherapist, occupational therapist, nursing staff and allied health assistants.

For staff, the changes involved in transferring TCP to aged care management posed initial challenges in terms of adapting to the procedures. Pleasingly, those challenges were quickly overcome as a direct result of excellent planning and education,

enabling staff to adapt. Ultimately, what was initially perceived as a challenge soon became a positive for all. The benefits of the new set-up include a more streamlined process and improved communication between departments.

A major highlight for the TCP this year was the Bendigo Health Quality Services Review which investigated transition care programs at all health services in the Loddon Mallee region. Regionally, TCP's greatest challenge is that each health service sets up its program differently. Some are stand-alone departments, some sit within acute services, some within rehabilitation services, and others, as is now the case at REDHS, sit within aged care. The set-up is determined by each individual health service and each one approaches the best-fit from a different angle.

The over-arching objective of the TCP review was to improve the bigger picture by identifying strengths and weaknesses of the program and implementing changes that satisfy all parties.

Former TCP manager, Meaghan Sully, was a member of the project's steering committee and described the review process as a vital step toward achieving consistency between all health services offering TCP. The review enabled all participants to voice the positive and negative aspects of TCP to an external source and to work together towards a common goal of improving the program.

The review examined compliance and TCP standards, documentation, communication positives and negatives in terms of electronic recording of data and reporting time lines. Bendigo Health has recently finalised the report and it will now be submitted to the Department of Health. The findings will then be fed back to participating health services for implementation. From a Bendigo Health perspective, it will be looking at achieving greater cohesion and unifying processes and documents to streamline processes within all health service organisations.

The next 12 months will focus on refining processes and embedding TCP into REDHS aged care management. There will continue to be some changes, so it is likely to be a period of further adaptation and settling.



## RESIDENTIAL AGED CARE

It was a busy and challenging year for the staff and residents of our nursing home and hostel with restructuring of the management arrangements and the refurbishment of the hostel.

The hostel's major refurbishment project was made possible in part through a large bequest and donations from community events such as the Rochester Debutante Ball, Rochester Art Exhibition and the Elmore Summer Send-off Ball. The success of this wonderful project was made possible by the comprehensive forward planning of REDHS staff to minimise disruption and the cooperation of the residents, families, volunteers and visitors. The works included:

- repainting of all internal walls
- renovation of both kitchen/dining areas
- replacement of ensuite vanity units in Bacchaus unit
- replacement of tapware with lever taps in all ensuites
- conversion of all lighting to LED
- recommissioning of the heating system
- hanging of new window furnishings in all areas
- new furniture for all communal areas
- ten new bedside tables and armchairs

A few outdoor projects are underway to finish off the project including landscaping in the aged care courtyards and improvements to motorised scooter parking areas.

This year has seen major changes to the structure of aged care services as recommended in an independent review of REDHS' aged care services and its subsequent working group consultations. The restructure was designed to improve the coverage of our nursing and care services for residents in our nursing home and hostel, in line with industry best practice, particularly as residents grow more frail and need higher levels of care.

Effectively the two managerial positions of the nursing home and hostel were combined into one overall manager position. This has streamlined communication and decision-making and gave us the resources to increase the number of staff available in the facility overnight. We are also able to increase care staff

hours on certain shifts so we can devote more quality time to residents and improve other services that rely on staff.

In November 2013, Jodie Holmes commenced in the newly created aged care manager's position. Jodie has extensive experience in aged care, including three years as Nurse Unit Manager of Aged Care at Swan Hill District Health. Jodie also took over management of the Transition Care Program in April 2014 (see Transition Care Program report page 19).

Staff have been working hard during all the changes to provide continuity and strong support to a progressive management team, ensuring that high quality resident care has continued to be provided during the changes. Aged care staff are also involved in the *Great Care* model being implemented across the organisation.

Activities Coordinators Janine Bubb and Karen Tognolini and a number of volunteers have provided a variety of activities and outings:

- couples' afternoon tea on Valentine's Day
- memorial service conducted by local clergy and attended by family, friends and staff in remembrance of residents who had passed away in the previous twelve months
- pancakes were cooked by volunteers on Shrove Tuesday
- former staff member, Jenny Major, cooked a roast lunch in the hostel kitchen
- ANZAC Day and Remembrance Day services conducted in conjunction with Rochester RSL members
- monthly barbeque lunches
- bus outings around the local district and shopping trips
- Italian meal cooked in the nursing home kitchen
- footy tipping competition and bingo
- Winter Olympics activities and travel talks
- biggest Morning Tea held to raise money for cancer research
- Duke of Edinburgh secondary students volunteering once a week
- St Joseph's Primary School visit to make Easter bonnets with residents
- Museum Victoria "Memories of Childhood" exhibition of toys

Concerts were held regularly for the very appreciative residents. In addition to these much loved concerts, in 2014-15 there will be a very exciting singing program involving our residents and school children in 2014-15

A computer was installed in the Bacchaus south lounge and can regularly be seen in use. This is in addition to the *Broadband for Seniors* computer in the activities room.

Aged care residents and staff were very pleased to receive the kind donation of an outdoor setting from the REDHS Auxiliary.

Janine Bubb attended a *Brain Gym* study day and came back inspired with many ideas to be incorporated in the activities program.

After 1 July 2014 the federal government is replacing the terms high and low care with an overarching banner and will be another change to which staff must adjust. This may deliver a higher acuity of residents at REDHS and all staff must have a clear understanding of this new care model.

Plans for the upcoming 12 months in aged care are many and varied, including the establishment of a Team Nursing in aged care model. This is a state government funded program in which a project officer is employed to help staff with an opportunity to utilise their skills and it aims to recognise, and tap into, the wealth of skills at REDHS. Stage one of the program was implemented in June 2014.

The aged care department will work towards maintaining its full accreditation status in July 2015 and management and staff will continue to foster positive change and *great care*.

### Aged Care Project Officer

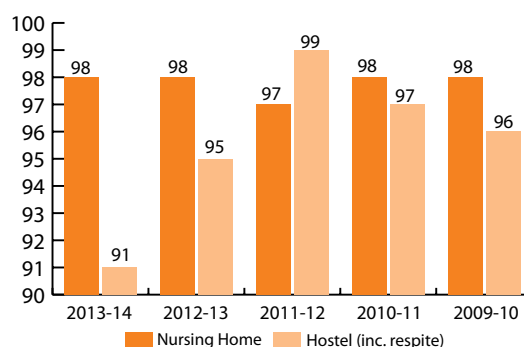
Dallas Coghill, the Aged Care Project Officer for small rural health services located in the Loddon Mallee region, is based at REDHS. Commencing in August 2013, the project covers Public Sector Residential Aged Care Services (PSRACS) inclusive of Inglewood, Boort, Cohuna, Rochester, Heathcote and Kerang. It was designed to develop the links between quality of care, evidence and reporting in small rural health services.

The main goal of this project is to further embed person-centred care within these small rural health services and provide a higher standard of documentation that is inclusive of the Aged Care Funding Instrument (ACFI) process.

To implement this, the project seeks to define successful residential aged care in applying evidence-based documentation that supports the ACFI tool through education, consultation and auditing.

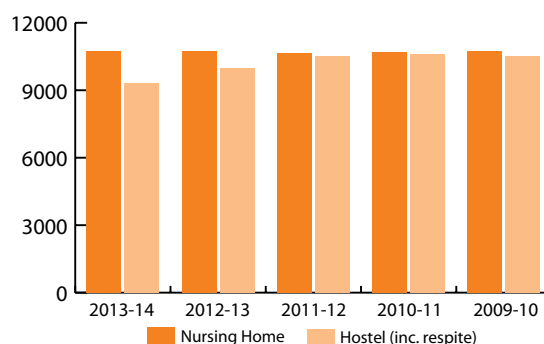
At REDHS, the project has provided education opportunities for aged care staff to develop a greater understanding of their responsibilities in regards to the documentation of the care of their residents. This has also led to an increase in accurate ACFI claims and improved documentation standards regarding care provision for the residents of our nursing home and hostel.

**Aged Care Occupancy (%)**



**The decrease in hostel occupancy is due mainly to the industry-wide decrease in demand for low care beds.**

**Aged Care Bed Days**



**In 2013-14, there were 10,757 Nursing Home bed days compared to 10,749 last year. Hostel bed days (including respite) reduced from 9,757 last year to 9,322 this year. Respite days increased to 748 days compared to 499 the previous year.**



# PRIMARY CARE SERVICES

## Overview

In the past 12 months, the primary care team has continued to introduce new programs and services to support people to enhance their health and wellbeing and maintain their independence by accessing services locally.

New programs and services have included:

- *National Respite for Carers Program* (from May 2013)
- *Rural Drug and Alcohol Withdrawal*
- *Community Kitchens*
- *Type 2 Diabetes management*
- *Cardiac Rehabilitation Maintenance*
- *supervised low-level exercise*

Two REDHS primary care allied health graduates, occupational therapist Nerae Anstee and podiatrist, Emily Gallagher, participated in the Inter-professional *Allied Health Graduate Program* with the four graduate nurses this year. The program supports new graduates to transition effectively from students to health care professionals in a number of ways. These include the development of skills to work in interdisciplinary teams, development of critical thinking and reflective skills and building a commitment to research, evidence-based practice and the concept of lifelong learning. The program is overseen by clinical support nurse, Cheryl Petrini.

## Allied Health Assistants

Allied health assistants are a valuable addition to the REDHS primary care team, and support the organisation's focus on person-centred care, and assisting clients to reach maximum potential and independence.

Allied health assistants, Kellyann Clarke and Jacinta McWhinney work in primary and aged care services and assist and support allied health professionals with their treatment plans for clients in acute, aged care and the community. Kellyann also leads and assists with group programs in primary care including Cardiac Rehabilitation Maintenance Group, Fitness for Older Adults, Strength and Balance, and a new lower impact exercise group. The Strength and Balance Group is conducted at the

Rochester Community House. In 2013-14, there were 792 attendances, up from 444 the previous year.

Kellyann was successful in obtaining a scholarship to attend the *Cardiovascular Disease, Rehabilitation and Secondary Prevention Training Program*.

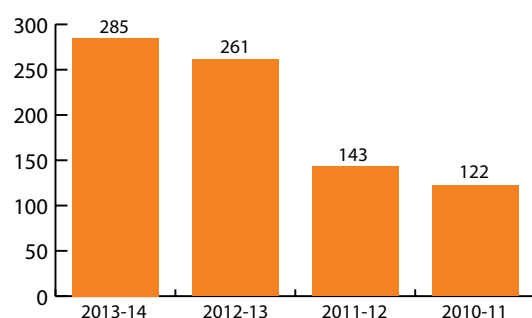
## Diabetes Education

REDHS' diabetes educator, Leanne Rankin continues to provide a service across the organisation to acute, aged care and the community. Leanne has maintained her status as a credentialled diabetes educator by attending a number of diabetes-related professional development opportunities during the year. She was also successful in obtaining a scholarship to be trained in integrated disease management for chronic heart failure.

Much of Leanne's efforts in the past 12 months have continued to focus on co-facilitating the Life! Program. *The Life!* Program is funded by the Victorian Government through Diabetes Australia – Victoria. It is a course that teaches participants to take control of their life, supporting them to adopt healthy behaviours and a more active lifestyle to reduce their risk of Type 2 diabetes. In 2013-14, there were 89 occasions of service in the LIFE! Program, compared to 62 the previous year.

There has also been a focus on developing a Type 2 diabetes program, to better support the increasing number of clients diagnosed with Type 2 diabetes, and provide a comprehensive approach to education and self management, including an exercise component.

Diabetes Education - Occasions of Service



## Dietetic Services

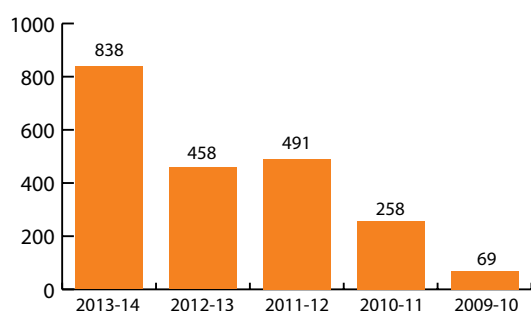
REDHS' dietitian, Katherine Watson, works closely with food services staff to ensure patients and residents are well nourished and have food choices for optimal health and wellbeing.

In 2013-14, there were 838 occasions of service, a significant increase on last year's total of 458.

REDHS' dietetics services continue to be contracted to provide nutrition expertise and management to clients residing at Wharparilla Lodge in Echuca, and has recently been successful in obtaining a *Rural Workforce Agency Victoria – Vic Outreach Program* to provide dietetics services to Dingee and surrounding communities.

Katherine has undertaken a number of initiatives in the past 12 months, including hosting two placements of dietetics students who coordinated a nutritional review of the food service approach at both REDHS and Wharparilla Lodge. Katherine has also been involved in the development of the Type 2 diabetes group program, and has spent time reinvigorating the community kitchen, operating from REDHS on a fortnightly basis.

Dietetics - Occasions of Service



## District Nursing

Throughout the year, REDHS' district nursing staff made 5,789 visits, covered 26,474 km and provided 3,855 hours of service.

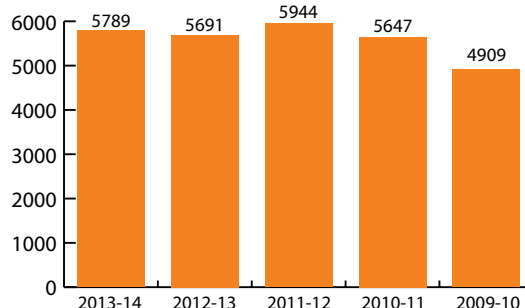
The district nursing team provided comprehensive nursing services through a number of programs tailored to meet the needs of the community. These services include post-acute care, Hospital in the Home, Department of Veteran Affairs' nursing services, palliative care and Home and Community Care (HACC) Nursing.

REDHS' district nurses are also actively involved in coordinated client care through a multidisciplinary team approach, working closely with allied health professionals on a number of community programs including *REDHS Planned Activity Group (PAG)* and *National Respite for Carer's Program*. They also work closely with nursing staff in the acute ward to ensure optimal care following hospital stays and provide opportunity for clients to maintain independent living in the community.

The team continues to contribute to service improvements through participating in quality improvement initiatives, such

as the Active Service Model, HACC Diversity Plan and service coordination. These initiatives aim to enhance the client's journey through the health system and increasingly involve the client and their carers in decisions and goal setting about their health and wellbeing.

District Nursing - Occasions of Service



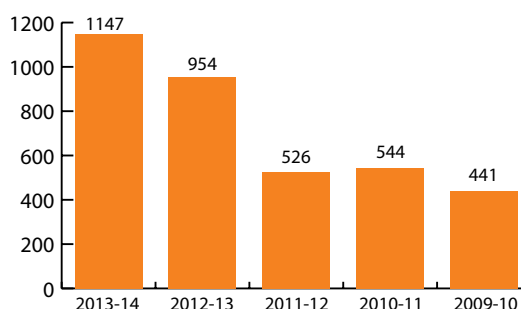
## Exercise Physiology

REDHS' exercise physiologist, Ash Watson specialises in clinical exercise prescription, health education and the delivery of exercise-based lifestyle and behaviour modification programs for the prevention and management of chronic disease and injury.

In partnership with our diabetes educator and allied health assistant, Ash continues to coordinate our group-based programs on Thursdays, including *Fitness for Older Adults Program*, the *Life! Pre-Diabetes Program*, and a gym session for clients with individualised exercise programs requiring supervision.

In 2013-14, the group exercise sessions continued to grow. Fitness for Older Adults attendances increased from 954 in 2012-13 to 1,147 this year.

"Fitness for Older Adults" Attendances



## National Respite for Carers Program (NRCP)

The REDHS' *National Respite for Carers program (NRCP)* supports carers and assists them by providing respite opportunities for frail, older people who have a carer. Over the past 12 months, REDHS has provided respite opportunities for 13 clients and their carers, five in their homes (70 visits) and eight through

a day program at *Planned Activity Group* (132 occasions of service).

In May, four NRCP clients were treated to a three night getaway in a respite house in Bendigo. This was a new initiative for REDHS which provided staff around the clock, transportation and food. The acting director of clinical services was on call to assist if necessary. The clients had a wonderful time and were full of praise for this exciting initiative, one saying that they “hadn’t had a holiday like that for years”. Another getaway is planned during 2014-15.

### Occupational Therapy

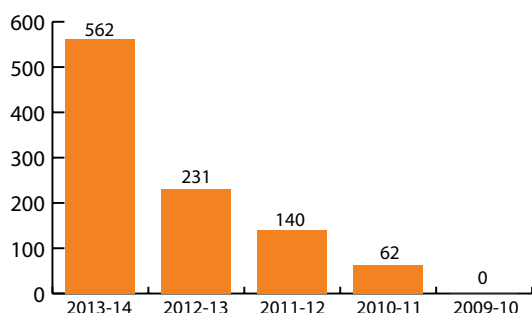
One of the highlights of the year for the occupational therapy department has been continued HACC funding which enabled occupational therapist, Casey James, the opportunity to work with Echuca Regional Health and Campaspe Shire, to provide opportunities for coordinated assessment and care planning to improve client independence.

The OT department also welcomed Nerae Anstee to the team. Nerae is a first year graduate from La Trobe University Bendigo who is providing a valuable service across primary care, acute and aged care services. She also provided a ten OT outreach service to Dingee.

In 2013-14, 562 occasions of service were provided, more than double the previous year’s total of 231.

In May and June 2014, REDHS also had the opportunity to provide a fourth year placement for occupational therapy student Shannon Moyle from La Trobe University. During her placement, Shannon was able to plan, implement and evaluate the annual primary care consumer satisfaction survey. This project allowed REDHS to better understand the consumer experience and identify areas for further improvement in terms of meeting consumer needs and expectations.

Occupational Therapy - Occasions of Service



### Physiotherapy

REDHS physiotherapist, Judy Lee, offers a service focusing on the assessment, diagnosis and treatment of movement disorders, as well as education for clients on managing their condition. This may include exercise programs to improve mobility and strengthen muscles, joint manipulation and mobilisation to reduce pain and stiffness. Also included is muscle re-education to improve control, airway clearance techniques, breathing exercises and massage therapy.

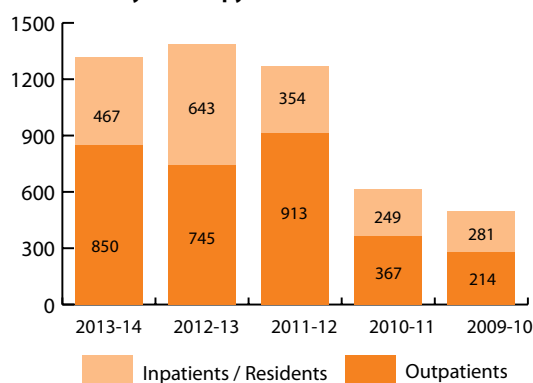
The physiotherapy services continue to be in regular demand, and due to the community and aged care needs, REDHS is currently seeking another full time physiotherapist to join the team.

In 2013-14, Judy provided physiotherapy services on 1,317 occasions, down slightly from 1,388 the previous year when there were additional physiotherapy hours provided by a locum.

REDHS continues to provide services to acute, aged care, transition care program, the community, and an outreach clinic at Lockington Bush Nursing Centre.

REDHS also hosts Bendigo Health Rural Health Team physiotherapy services once a fortnight to provide further physiotherapy services to those eligible under the *Home and Community Care* (HACC) program.

Physiotherapy - Occasions of Service



### Planned Activity Group

The *Planned Activity Group* (PAG) provides an opportunity for community members to interact in a setting that can accommodate people living independently yet require extra help because of health conditions, frailty or advancing age. The program offers friendship, a variety of activities, excursions and support.

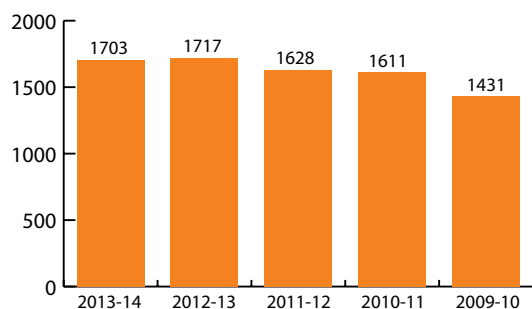
The planned activity group is wonderfully supported by regular volunteers who assist PAG staff to deliver this excellent program. New clients are welcomed warmly by staff, volunteers and other clients and quickly settle in. At the end of June 2014, PAG had 23 current clients with a maximum of 22 present at any one time. A total of 39 different clients attended throughout the year.

A new touchscreen computer was made available through the Australian Government funded *Broadband for Seniors* program this year. Clients have enjoyed accessing the internet and checking out their houses and streets on Google Earth as well as “visiting” tourist areas in Australia and overseas. Clients and volunteers check their emails and Facebook and search for general knowledge and trivia answers.

Clients have gone on bus outings around town, out through the local farm areas and to Echuca, bringing back lots of memories for clients. Several blind auctions have been held to raise funds for charities including the Jane McGrath Foundation.

During 2013-14, the *Planned Activity Group* delivered 1,703 occasions of service compared to 1,717 in 2012-13.

**Planned Activity Group - Occasions of Service**



## Podiatry

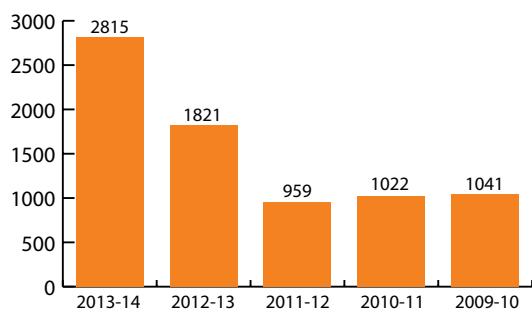
This year the, podiatry department has experienced some staffing changes. The team welcomed two new graduates, Emily Gallagher and Kelsie MacDonald, who both graduated in 2013 from La Trobe University Bendigo. Denise Fox remains the senior clinician, and provides valuable support to new team members.

In 2013-14, the podiatry team treated clients on 2,815 occasions, compared to 1821 the previous year. This reflects the increase in available podiatry hours.

The podiatry team continues to provide a range of services throughout a number of program areas, including HACC, Department of Veteran Affairs (DVA), Medicare Chronic Disease initiatives, private health insurance, aged care and outreach clinics to Stanhope and Rushworth.

The team also provides services to Echuca Regional Health and remains committed to regular professional development to enhance clinical podiatry skills and client-centred care. The REDHS podiatry department is also actively involved in supporting students with three student placements over the past 12 months.

**Podiatry - Occasions of Service**



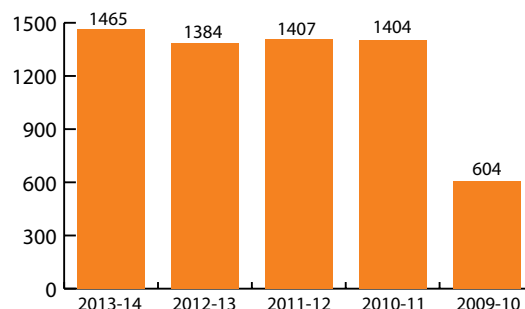
## Radiology

REDHS started out the year by continuing its radiology service two days per week but was pleased to be able to expand this service to four days a week from 31 March 2014 in partnership with the Goulburn Valley Imaging Group (GVIG). This is a great outcome for improved accessibility to care, reducing the need for community members to travel out of town for this valuable service.

In 2013-14, 1,465 images were taken of 1,183 clients compared to 1,384 images and 1,093 clients last year.

Also in partnership with GVIG, REDHS now supports an ultrasound service two days a week with 179 ultrasounds being performed since the end of March.

**Radiology - Images taken**

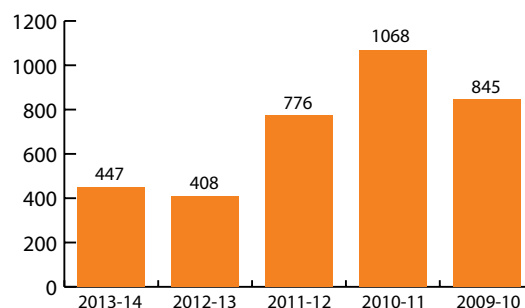


## Social Work

In recent months, the social work and counselling service has increased to four days a week. Social workers, Helen Larmour and Meaghan Sully, have provided support to clients on 447 occasions in 2013-14 compared to 408 the previous year.

Helen and Meaghan have been actively working on reviewing REDHS' advance care planning approach in aged care and will continue to develop and enhance the rollout of the approach across all REDHS services, including the acute and primary care departments.

**Social Work - Occasions of Service**



*The higher occasions of service in 2010-11 and 2011-12 reflect the additional social worker hours available as part of the Flood Recovery program.*

# SUPPORT SERVICES



## Catering

The catering department, led by Darlene Weeks has been kept busy throughout the year, catering for our patients, aged care residents, *Planned Activity Group* clients and the REDHS café on a daily basis. In 2013-14, catering staff provided 158,053 meals including *Meals on Wheels*, the Rochester Senior Citizens' weekly meal and internal catering occasions such as the Volunteers' Day. They also made 62 birthday cakes!

The catering team provides its services to approximately three local events per month and up to six major events each year. Highlights for the year included major catering jobs for the Elmore Summer Send-off Ball, the REDHS Art Exhibition as well as events for the local Probus group and REDHS auxiliary. Catering was also provided for ANZAC Day events for the RSL and the REDHS' Volunteer day. These catering projects help boost catering funds to offset the running costs of REDHS Café and also provide an important community link.

Another highlight has been the improving performance of REDHS Café with turnover increasing from the previous 12 month period. In addition, the catering team was pleased to pass both Shire of Campaspe and external food industry audits, with only minor issues identified that were easily rectified.

Our thanks go to the REDHS Auxiliary for donating money for a much needed meat slicer. This equipment will ensure that REDHS can continue to take on major catering projects in the coming year.

The rearrangement of the free-standing shelving in the food storeroom has significantly reduced the chance of manual handling injuries and is benefitting all catering staff in their day-to-day tasks.

Automatic temperature loggers have been utilised for all fridges this year and data downloaded on a monthly basis. The new loggers, which have saved many manual hours for staff, are serviced and calibrated annually.

The nursing home kitchen continues to be refurbished and will be completed in the second half of 2014. The oven was relocated, a dishwasher installed and the refrigerator and tea/coffee making facilities were moved. The modifications are providing much needed improvements to workflows for catering staff.

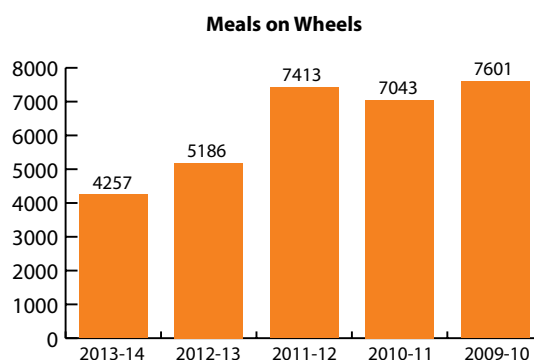
Over the past 12 months, the REDHS catering department has been working with the hotel services department towards separating the cleaning and catering teams. This process is set to be completed in early 2014-15.

Maintaining a bank of casual staff possessing the skills required for catering has been a challenge, but staffing levels have been maintained throughout the year.

Looking forward, the catering team hopes to replace one of its ovens and will continue to work on a service plan to replace items such as ovens and dishwashers into the future.

Meals on Wheels – Elmore	1,223
Meals on Wheels – Lockington	656
Meals on Wheels – Rochester	2,378
PAG – Elmore	3,165
PAG – Rochester	2,843
Patients – Acute ward	18,438
Residents – Hostel	59,704
Residents – Nursing Home	64,535
Senior Citizens Club – Rochester	700
Functions	4,411
<b>Total meals*</b>	<b>158,053</b>

\*Includes morning and afternoon teas and supper.



*The reduction in the number of Meals on Wheels is consistent with state-wide data.*

## Hotel Services

REDHS' hotel services, encompassing both cleaning and laundry services, purchased new equipment this year including a new steam cleaning machine and two new duplex (floor cleaning) machines to assist with everyday cleaning tasks. As a result, each department is now furnished with a full suite of cleaning equipment.

REDHS has also introduced an equipment replacement plan, and replaced three vacuum cleaners to assist cleaning staff, as well as purchasing a new safety ladder for the day procedure unit (DPU) to help meet cleaning standards. Feedback has been positive, with staff pleased that each department has up-to-date and efficient cleaning equipment to assist in maintaining a high level of safe, quality cleaning services.

In addition, all equipment has been serviced and maintained to meet all occupational health and safety standards as well as all infection control standards.

Throughout the past year, all staff members have undertaken manual handling training for the operation of all equipment and this will continue on a yearly basis.

An external cleaning audit produced an overall result of 93%, slightly down from last year but still above the minimum requirement. Staff continue reviews of work practices to ensure standards are achieved.

In the REDHS laundry, all washing machines have been maintained regularly which assists in providing a high level of service by eliminating machine down time and minimising issues with stains or recalls. A new, light-weight iron has ensured a more efficient ironing process. All aged care residents now have REDHS' easy-to-use clothing labels to assist with returning residents' clothing items promptly and efficiently.

Overall, the required laundry workload has been completed to the expected standard and all cleaning audit requirements have been met – a fine achievement for the department.

From a hygiene perspective, cleaning staff managed gastroenteritis outbreaks in 2014 extremely well and participated in debriefs with our Infection Control Practitioner that resulted in further improvements to procedures being made.

A major highlight of the year was the completion of the hostel refurbishment, including the replacement of all window coverings, furniture, paintwork and flooring throughout the building. This amazing project came together with great help from REDHS' staff as well as residents and their families, without too much inconvenience to all users.

Staff farewelled two long-time colleagues this year, both of whom have left in pursuit of new adventures. REDHS wishes Jenny and Tania all the best in their future plans. Jenny played a major role in the hostel refurbishment with daily coordinating of workers and residents, in addition to assisting with choosing new furnishings. Tania was well-known to our nursing home residents, having prepared and served many meals there as well as performing cleaning duties.

Challenges for the year have included ongoing discussions with staff to determine appropriate changes to work shifts. The changes will have long-term outcomes and meet current and ongoing needs for REDHS to deliver *Great Care*.

Plans for the next 12 months include the assembling of a dedicated cleaning team to ensure REDHS has skilled cleaning staff to meet consumer expectations and all Victorian cleaning standards. A dedicated cleaning team would also foster the introduction of an orientation skills training day. The laundry department is hoping to increase available cleaning cloths to eliminate added pressure on staff to turn around stock.

Hotel Services plan to continue to meet both accreditation standards for aged care and NSQHSS and continue to live up to standards expected by an award-winning health organisation such as REDHS.

## Procurement

In addition to managing Hotel Services, Gayle McConnell is also the procurement manager responsible for overseeing the Supply Department.

The Supply Department has worked diligently all year to ensure that the necessary supplies and equipment are available for consumer care and staff requirements. The Oracle purchasing system has been fine-tuned so that there is improved alignment with the finance system. This has facilitated the efficient payment of accounts and has enhanced reporting for the Powerbudget system, through which managers monitor expenditure.

A significant number of contract reviews have been undertaken this year. This involves reviewing the performance of the contractor and ensuring contracts reflect current legislative and regulatory requirements.

The growth of services in primary care has led to additional licensing agreements being negotiated. The increase in the number of student placements has also led to an increase in agreements with education providers that this department administers.

A comprehensive review of assets and service agreements for equipment has commenced to align with the preventive maintenance program and will continue in 2014-15.

## Information and Communication Technology

This year, REDHS' Information Systems Manager, Clare Ireland, developed REDHS' first Information and Communication Technology (ICT) Strategic Plan based on a 12-month review process by the board. The plan is the beginning of an exciting period for the health service whereby there is a clear future strategy. The plan outlines the aims and actions required in order for REDHS to remain in touch with best practice and provide the optimum ICT solutions to organisational business processes.

Work has also been done to complete an ICT Disaster Recovery Plan, which falls in line with REDHS' business continuity requirements and reducing risks within ICT. An example of this is a new and more stable network backup environment,

including off-site back up capabilities. This means that, in the event of a software issue or breakdown, the downtime has been greatly reduced with most previous issues now rectified. Other highlights for the year have included workstation rollouts to test out emerging technology and trialling varying layouts across the organisation.

One of the major challenges for the year in ICT has been Microsoft no longer supporting Windows XP. It has took almost six months to update all software and replace all old hardware – a challenging process.

Throughout the year special achievements in the ICT department have included an increase in, and training around, the use of mobile devices and technology, including the use of iPads for conducting audits. There was also an upgrade of the unified communications infrastructure.

Moving forward, plans for the upcoming year include projects focussed around the increased use of video conferencing and bringing staff up-to-speed with ICT training.

There will also be a focus towards, and increase in, the use of electronic medical records over the next one to five years, towards the ultimate goal of a paper-light health organisation, an area in which ICT will be heavily involved.

Projects around the use of virtual desktop spaces will be investigated over the coming months and ICT is also looking to further integrate its business system to improve financial and clinical reporting across the organisation.

## Maintenance

The Maintenance Department has had a busy 12 months at REDHS continuing with work on the Building Management System (BMS) Planned Maintenance schedule. It is expected this schedule will be completed by July 2014.

A major positive of the BMS will be its ability to monitor all lighting, heating and cooling across the facility. This will ensure a more efficient system and minimise unnecessary use, leading to a reduction in REDHS' carbon footprint.

The BMS project has been rolled out alongside an upgrade of the Building Equipment and Inventory Maintenance System (BEIMS), the facility asset management software system and maintenance system. The BEIMS system is progressing well and now allows for weekly reports to all area managers. These reports ensure maintenance issues are dealt with on a regular basis. Over the next 12 months the system will require additional fine tuning to ensure its ongoing efficiency. There are also plans to implement a BEIMS "app" which will allow for a more efficient and user-friendly data entry process.

The implementation of a new preventive maintenance system is also underway and due for completion by July 2014. This system was developed in conjunction with a dedicated REDHS project officer.

Another highlight was the re-cladding of the service building and aged care facility – a major task where teamwork was most important.

The co-located Rochester Men's Shed underwent a major extension, with which the maintenance team was heavily involved.

In the next twelve months, lawn watering systems for the aged care gardens will be installed and the installation of external LED lights will be completed.

## Environmental Sustainability

REDHS is committed to meeting its strategic objective of maintaining a culture of accountability and diligence in the use of its resources.

Chemical usage is monitored by the Procurement Manager and chemicals must be trialled by staff and then approved by the Occupational Health and Safety Committee.

REDHS is committed to best practice chemical usage regarding container size, neutral products and minimal handling requirements for staff. REDHS has a minimal number of chemicals on site with appropriate dispensing systems in our laundry and for all of our dishwashers.

REDHS' cleaning team continues to use neutral detergent across all departments, incorporating its use with the use of microfibre cleaning cloths, steam cleaning equipment and hard surface cleaning machines.

Energy and water usage is reported to the Department of Health. Rain water continues to be harvested from our roofs and roadways and stored in an underground tank for use in health services grounds and in the community garden.

Gas and electricity usage is being monitored to ensure that the most energy efficient heating source (hydronic or reverse cycle) is confirmed. Significant energy savings have been made over the past 12 months with the introduction of the HPV (Health Purchasing Victoria) contract and ongoing, external surveillance monitoring.

REDHS' monthly energy usage is independently monitored and a major highlight this year was that total power usage was the lowest recorded for the past four years. This can largely be attributed to the full rollout of all external LED lighting at REDHS which is providing a substantial long-term saving as well as reducing the organisation's carbon footprint.

This year, the hostel refurbishment works were completed. These included the installation of low energy LED lights to provide area-specific, improved lighting for residents whilst using less energy and increasing the time to replacement. All exterior lighting on the nursing home and support services building has been changed to 8 watt fittings (previously 36 watt) which operate 12 hours each night, seven days a week. Similarly the car park lighting has been changed from 200 watt lamps to 15 watt lamps running over the same time frame, which will amount to significant savings. The rollout will be continued in both the primary care and acute departments moving forward. Further adjustments are being investigated to improve the efficiency in the building management system to automatically turn off lights when not in use and provide suitable working and living temperatures throughout the facility.

As public transport options are limited in our area, staff are encouraged to car pool as much as possible and catch buses and trains when required (and as practical) to attend events in Melbourne. We encourage the use of REDHS for onsite workshops and meetings to minimise travel and teleconferencing facilities are available.

Like all health services, significant amounts of waste are produced daily. A review of clinical waste saw the introduction of Clinismart containers and instrument trays in our DPU, acute ward and podiatry areas for the segregation of single use items to enable safer collection and storage of used items. Cardboard, paper and plastics are segregated and recycled. A confidential shredding service is used for documentation as appropriate. Landfill waste continues to make up the majority of the waste produced, most of which is attributable to continence products and some paper products.

At present we randomly observe our waste volumes. We are investigating other monitoring methods which are easy to manage and time efficient.

REDHS continues to investigate new ways to minimise its environmental impact including additional solar power panels and improved efficiencies in building management. Water usage reductions are also being investigated though the installation of efficient watering systems for garden beds and mulching.

### Occupational Health and Safety

REDHS engaged an externally accredited service to undertake an Occupational Health and Safety (OHS) Management System Audit, which demonstrated compliance with the standard health and safety legislation and a commitment to overall health and safety objectives. The auditor noted, "In short, REDHS has embraced Occupational Health and Safety and endeavours to implement appropriate reporting, solutions and systems."

One recommendation from the audit was to provide Health and Safety staff representatives with a full day per month to resource health and safety within the organisation. This has been operating over the past twelve months and has resulted in greater capacity to identify and control risks, enhanced staff education and the resolution of OHS issues in a more timely manner.

The HSRs were very pleased to conduct workplace assessments using iPads this year. This has significantly reduced the time normally taken to complete the assessments with information entered directly as they walked through the facilities. The resulting reports are emailed direct to the OHS Coordinator and presented to department managers by HSRs so that rectification actions can be taken.

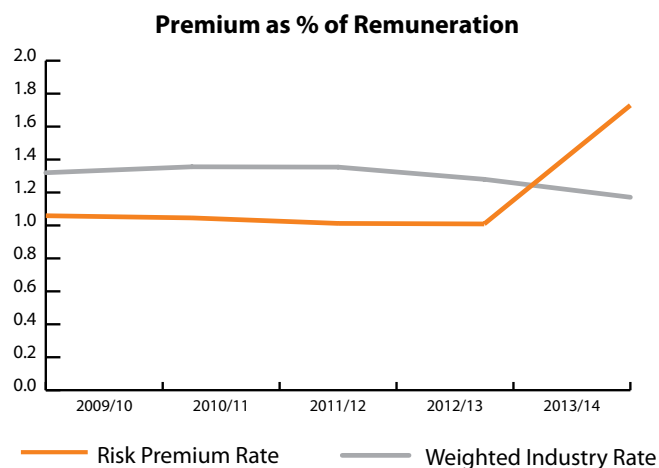
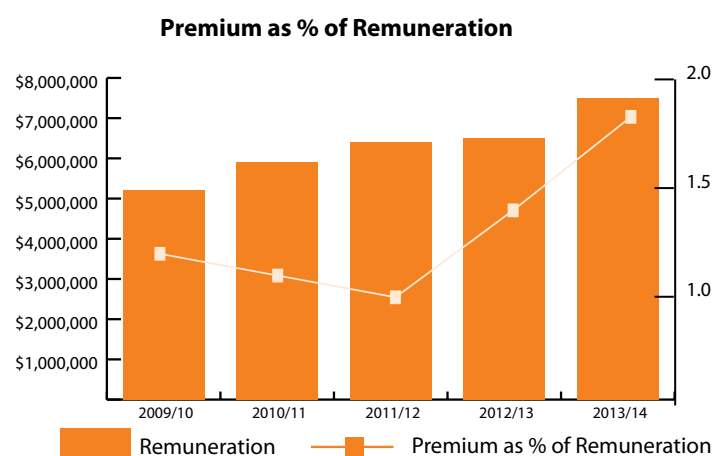
In 2013-14, there were 56 OHS incidents, near misses and hazards recorded (compared to 58 in 2012-13). These included six code red reports and 14 hazards. OHS incidents were predominantly made up of injuries such as muscle strain, lacerations and occupational violence and aggression. All incidents are investigated by department managers and reviewed by the OHS committee and executive staff. Information is fed back to staff via meetings to raise their awareness of incidents/ near misses and prevention/ management measures.

Specific education has been delivered to REDHS emergency controllers to assist them in managing emergencies and to increase familiarisation with the fire panel.

An evaluation of REDHS occupational violence program will be undertaken in 2014 -15.

A fatigue management policy is in place to assist staff and managers to identify when a staff member is fatigued so that self-management strategies can be put in place to maintain staff and consumer safety.

Following extensive research and successful trials, two standing desks have been introduced to the administration area to reduce the amount of time staff spend sitting down. The workbench in the acute ward will be modified to allow it to raise up, improving ergonomics for the ward clerk and other staff.



REDHS premium as a percentage of remuneration increased in 2013-14. Two long-term WorkCover claims from 2012-13 will continue to impact our premium until 2015-16. There were no long-terms claims in 2013-14.

# CAMPASPE PRIMARY CARE PARTNERSHIP

During 2014, the Campaspe Primary Care Partnership (PCP) chair continues to be Merrin Prictor, Executive Director of Primary Care with Echuca Regional Health. The deputy chair role is filled by Julie Russell, Director of Clinical Services at Kyabram District Health Services.

The Campaspe PCP Strategic Plan for 2013-2017 has been developed and reflects the commitment and contribution to this catchment plan by all involved partners to align priority issues and share responsibility for implementing objectives and strategies.

The Campaspe PCP Management Group has agreed on two key strategic areas to focus on for the 2013-2017 period.

1. access to services - To determine service access needs within Campaspe and advocate for improvements that support better access to services
2. improve health services availability and accessibility for young people in Campaspe

The partnership's ongoing priorities for this plan include:

- Aboriginal health
- governance and leadership
- early intervention and integrated care – service coordination practice, shared care planning, communication, needs identification, diabetes chronic disease management
- prevention - oral health, food security, social inclusion, physical activity
- consumer and community empowerment

## Healthy Communities Initiative

Funding through the federal government's *Healthy Communities Initiative* supported REDHS to deliver the *Healthy*

*Eating, Activity and Lifestyle (HEAL)* program, which enabled participants to develop lifelong healthy eating and physical activity behaviors.

The achievements of the *Healthy Communities Initiative* were:

- increased availability of accessible and affordable community based healthy lifestyle initiatives
- increased consumption of fruit and vegetables amongst Aboriginal adults by improving availability, accessibility and affordability of fresh fruit and vegetables
- increased participation of adults with a disability in healthy eating and physical activity programs
- an increase in the number of walking groups available in Murray and Campaspe and participation in those walking groups by adults with disabilities, Aboriginal adults and older adults
- capacity building and increased influence over infrastructure and policy change to promote physical activity and healthy eating across the Murray and Campaspe shires

REDHS was also able to establish a *Community Kitchen* where groups of individuals came together on a regular basis to socialise and cook affordable and nutritious meals.

In addition, the delivery of the *Strength and Balance* exercise program for older adults was continued throughout the year. This group-based program uses light weights to gradually increase muscle strength and continues to be very popular at REDHS. There has also been a development of strength and balance best practise guidelines for all Campaspe based organisations to complement programs such as this one.

# STRENGTHENING HEALTH SERVICES PROJECTS

*Strengthening Health Services Projects* - Hume and Loddon Mallee Regions began on 20 January 2014 and will run for twelve months, with a view to extend if benefits for health services are evident. Fiona Lukaitis has been appointed as project coordinator and is based at REDHS.

The core goal of the projects is to support hospitals to be efficient, effective and resilient and to function collaboratively as part of the regional health care system. The projects are focused on supporting hospitals to deliver quality services, adapt to meet evolving community demands and expectations, and ensure that the community has access to high value, sustainable hospital services when needed.

A governance committee has been established with four CEOs and the directors of Health and Aged Care representing each region.

Projects comprise:

- Maternity, Surgical and Urgent Care
- Improving Recruitment and Retention of Medical Workforce
- Clinical Support and Shared Services
- Non-Clinical Support and Shared Services

*The Maternity, Surgical and Urgent Care* and *the Improving Recruitment and Retention of Medical Workforce* projects are progressing well with terms of reference developed and the engagement of consultants through a tender process being implemented. The shared clinical and non-clinical support services projects will be run at a more local level. The project coordinator is currently meeting with CEOs across the regions to identify key issues and opportunities for collaborative work in these areas. It is expected that several key opportunities will be implemented in pilot sites, evaluated and then 'modelled up' to support other health services to adopt in the second phase.



# COMMUNITY INVOLVEMENT AND SUPPORT

## Volunteers

REDHS has been fortunate to have the continued support of 101 volunteers this year. The volunteers allow REDHS to provide support and activities to patients, clients and aged care residents that would otherwise not be possible. On any given day, volunteers are working alongside staff in the *Planned Activity Group* or with aged care residents. Their many activities include the *Community Garden*, happy hour, bingo, crafts and painting, indoor and outdoor games. Volunteers have also been involved in risk identification and their input "through fresh eyes" has been greatly appreciated.

Volunteers were recognised for their wonderful efforts throughout the year at a special morning tea in May. All were presented with commemorative badges as they arrived. Acting chief executive officer, Anne McEvoy, thanked them for their diligence and dedication on behalf of staff, clients and residents.

## Rochester Hospital Auxiliary

REDHS is fortunate to have the ongoing support of the Auxiliary that has been raising money for over 50 years.

We have had a very busy and successful year and welcomed three new members. We catered for morning and afternoon tea at the Rochester Art Exhibition, held two fashion parades (with one parade showing approximately 70 outfits), conducted a garden walk, hosted the Biggest Morning Tea for cancer research and the Cup Day luncheon, sold homemade strawberry jam and helped with the lolly trolley. A Christmas raffle of four large hampers was run, as was an Easter Egg raffle and we set up a stall at the local Farmer's Market for craft.

We participated in group exhibits for St John's Fair and the Great Northern Show at Rochester.

This year we donated money for the purchase of a garden setting for the hostel and a meat slicer for the health service kitchen. On a sad note, we will miss REDHS' staff members Di Niven and Joan Phelps and long-serving auxiliary member Andrea Teece, all of whom were outstanding in helping us.

Thank you to former CEO, Matt Sharp, for attending our meetings and keeping us up to date and thank you to REDHS staff for their support with raffle prizes and donations.

## Committee 4 Rochester

The *Committee 4 Rochester* (C4R) continued to be supported by REDHS last year. REDHS is the host organisation for the employment of the Community Recovery and Governance Project Officer, Graeme Robertson. Former REDHS CEO, Matt Sharp, played a key role in the initial establishment of C4R after the Flood Recovery Committee finished its role.

C4R has made significant progress in a number of areas including the development of a Rochester website and plans are well underway for the first Rochester Mural Festival (to be held in March 2015). The Committee has also been successful in securing a Victorian government grant to engage a consultant to assist in developing a strategic plan for Rochester.

## Donations and Bequests (\$100 and over)

Rochester Development Committee		Donations in memory of Janine Grogan	\$350.00
Rochester Art Exhibition	\$6,700.00	Donations in memory of Margaret Major	\$405.00
Rochester and Elmore District Health Service Auxiliary	\$6,482.00	Elmore Field Days	\$243.75
Rochester Community House	\$3,500.00	"Lolly Trolley"	\$250.00
Rochester Lions Club	\$1,850.00	Heartbeat Victoria Campaspe Branch	\$500.00
Anonymous	\$1,200.00	Campaspe CWA	\$100.00
Donations in memory of Filippo Cappelano	\$585.00	Donations under \$100	\$66.25
		<b>Total Donations for 2013-14</b>	<b>\$22,232.00</b>

The ongoing support of community groups is always gratefully accepted. Group members work hard to make regular donations of handmade goods and other items for use by our Aged Care residents, which is always appreciated.

# STATUTORY INFORMATION

The Rochester and Elmore District Health Service Annual Report has been prepared in compliance with the requirements of the Financial Management Act 1994 (the Act), Section 4.2 of the Standing Directions of the Minister for Finance under the Act and Financial Reporting Directions.

## Attestations

### 1. Data 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 reasonably reflects actual performance. Rochester and Elmore District Health Service has critically reviewed these controls and processes during the year.



**Anne McEvoy,**  
**Accountable Officer**  
**Rochester and Elmore District Health Service**  
**31 July 2014**

### 2. Compliance with the Ministerial Standing Direction 4.5.5.1 – Insurance

I, Anne McEvoy, certify that the Rochester and Elmore District Health Service has complied with Ministerial Direction 4.5.5.1 – Insurance.



**Anne McEvoy,**  
**Accountable Officer**  
**Rochester and Elmore District Health Service**  
**31 July 2014**

### 3. Compliance with Australian/New Zealand Risk Management Standard

I, Anne McEvoy, certify that Rochester and Elmore District Health Service has risk management processes in place consistent with the Australian/New Zealand Risk Management Standard, and an internal control system is in place that enables the executives to understand, manage and satisfactorily control risk exposures. The Risk Management and Planning Committee verifies this assurance and that the risk profile of Rochester and Elmore District Health Service has been critically reviewed within the last twelve months.



**Anne McEvoy,**  
**Accountable Officer**  
**Rochester and Elmore District Health Service**  
**31 July 2014**

## Availability of Additional Information

In compliance with the requirements of the Standing Directions 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) A statement 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 in a statutory authority or subsidiary;
- (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;
- (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) General statement on industrial relations within the Health Service and details of time lost through industrial accidents and disputes;
- (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; and
- (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 as per Minister for Finance Guideline Building Act 1993/ Standards for Publicly Owned Buildings November 1994.

## 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.

### **Carer's Recognition**

In accordance with the *Carer's Recognition Act 2012*, 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.

### **Consumer Feedback**

We welcome feedback in regard to the quality of our service to assist 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 REDHS website.

**Compliments, suggestions and complaints should be directed to:**

**Chief Executive Officer, REDHS,**  
PO Box 202, Rochester, Victoria 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)

### **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*.

### **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 2013-14 financial year, seven requests for information were received, with four requests granted in full. One request was withdrawn, one was not proceeded with and one is yet to be finalised. Freedom of information requests can be made by contacting the health service Freedom of Information Officer on (03) 5484 4451.

### **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 have a satisfactory "Working with Children" check.

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

Rochester and Elmore District Health Service's procurement practices and purchasing policies comply with the *Victorian Industry Participation Policy Act 2003* as applicable. In 2013-14, REDHS did not 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

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**

If you would like to make a donation or bequest, please contact us on (03) 5484 4451

# OPERATIONAL PERFORMANCE **SUMMARY**

## Factors affecting operational performance

During 2013-14, there was a significant increase of 62% in the occasions of service delivered by the primary care department. This was mainly due to the increase in FTE of podiatry services, the commencement of the Rural Drug and Alcohol Withdrawal Service, an increase in attendances at group activities and additional group programs.

## Activity

**Admitted Patients – Note (a)** see below

Separations	Acute
Same Day	454
Multi Day	373
<b>Total Separations</b>	827
Emergency	5
Electives	822
<b>Total Separations</b>	827
<b>Total WIES</b>	605.66
<b>Total Bed Days</b>	3,235

Non-Admitted Patients	Acute
<b>Urgent Care Centre Presentations</b>	1,043

### Note:

Note: Acute Admissions are Care Type (4,U)

Some estimations have had to be made in the above table due to unavailability of finalised VAED data for 2014 at time of printing.

## Statement of Priorities

### Part B Service performance priorities

Quality and Safety	Target	2013-14 Actuals
Health Service Accreditation	Full compliance	Achieved
Residential Aged Care Accreditation	Full compliance	Achieved
Cleaning standards (Overall)	Full compliance	Achieved
Cleaning standards (AQL-A)	90	97
Cleaning standards (AQL-B)	85	94
Cleaning standards (AQL-C)	85	91
Health care worker immunisation - influenza	75	71.5
Submission of data to VICNISS	Full compliance	Achieved
Hospital acquired infection surveillance	No outliers	Achieved
Hand Hygiene (rate)	70	90.6
Victorian Patient Satisfaction Monitor (OCI)	73	Data collection ceased *
Consumer Participation Indicator	75	Data collection ceased *
Victorian Hospital Experience Measurement Instrument	Full compliance	Achieved

\* VPSM ceased in June 2013. VHES data is being submitted as required but our actuals are not yet available.

**Note:** Performance against Statement of Priorities Part B (Financial Performance) and Part C can be found as an appendix in the financial report.

## Financial Report

The Financial Report which forms part of this annual Report of Operations can be found stapled at the rear of this report. If the Financial Report is not attached, a copy can be obtained from [www.redhs.com.au](http://www.redhs.com.au)

# DISCLOSURE INDEX

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

Legislation	Requirement	Page Reference
<b>Ministerial Directions</b>		
<b>Report of Operations – FRD Guidance</b>		
<b>Charter and Purpose</b>		
FRD 22D	Manner and establishment and the relevant Ministers	1,FR
FRD 22D	Objectives, functions, powers and duties	i
FRD 22D	Nature and range of services provided	2
<b>Management and Structure</b>		
FRD 22D	Organisational Structure	6
<b>Financial and other information</b>		
FRD 10	Disclosure Index	35
FRD 11A	Disclosure of ex-gratia payments	FR
FRD 21B	Responsible person and executive officer disclosures	FR
FRD 22D	Application and operation of the <i>Carers Recognition Act 2012</i>	33
FRD 22D	Application and operation of the <i>Freedom of Information Act 1982</i>	33
FRD 22D	Compliance with building and maintenance provisions of <i>Building Act 1993</i>	32
FRD 22D	Details of consultancies over \$10,000	FR
FRD 22D	Details of consultancies under \$10,000	FR
FRD 22D	Employment and conduct principles	33
FRD 22D	Major changes or factors affecting performance	34
FRD 22D	Occupational Health and Safety	29
FRD 22D	Operational and budgetary objectives and performance against objectives	3-4, 8-12, FR
FRD 24C	Reporting of office-based environmental impacts	28
FRD 22D	Significant changes in financial position during the year	FR
FRD 22D	Statement of availability of other information	32
FRD 22D	Statement on National Competition Policy	32
FRD 22D	Subsequent events	FR
FRD 22D	Summary of the financial results for the year	FR
FRD 22D	Workforce Data Disclosures including a statement on the application of employment and conduct principles	15, 33
FRD 25B	Victorian Industry Participation Policy disclosures	33
FRD 29	Workforce data disclosures	15
SD 4.2(g)	Specific information requirements	1-4, 8-12
SD 4.2(j)	Sign-off requirements	4
SD 3.4.13	Attestation on Data Integrity	32
SD 4.5.5.1	Ministerial Standing Direction 4.5.5.1 compliance attestation	32
SD 4.5.5	Risk management compliance attestation	32
<b>Financial Statements</b>		
<b>Financial statements required under Part 7 of the FMA</b>		
SD 4.2(a)	Statement of changes in equity	FR
SD 4.2(b)	Comprehensive operating statement	FR
SD 4.2(b)	Balance Sheet	FR
SD 4.2(b)	Cash flow Statement	FR
<b>Other requirements under Standing Directions 4.2</b>		
SD 4.2(a)	Compliance with Australian accounting standards and other authoritative pronouncements	FR
SD 4.2(c)	Accountable officer's declaration	FR
SD 4.2(c)	Compliance with Ministerial Directions	FR
SD 4.2(d)	Rounding of amounts	FR
<b>Legislation</b>		
Freedom of Information Act 1982		33
Carers Recognition Act 2012		33
Victorian Industry Participation Policy Act 2003		33
Building Act 1993		32
Financial Management Act 1994		3,32
*FR Financial Report		

# GLOSSARY

<b>ACHS</b>	Australian Council on Healthcare Standards
<b>ACFI</b>	Aged Care Funding Instrument
<b>Acuity</b>	The measurement of the intensity of care required for a patient/ resident
<b>ALOS</b>	Average Length of Stay
<b>CEO</b>	Chief Executive Officer
<b>CCCS</b>	Community Care Common Standards
<b>CMBS</b>	Commonwealth Medical Benefits Schedule
<b>DPU</b>	Day Procedure Unit
<b>EQulPNational</b>	ACHS accreditation program including NSQHSS
<b>FR</b>	Financial Report
<b>FTE</b>	Full Time Equivalent
<b>GP</b>	General Practitioner
<b>HACC</b>	Home and Community Care - jointly funded by the Australian and Victorian governments
<b>HR</b>	Human Resources
<b>HSR</b>	Health and Safety Representative
<b>IP</b>	Inpatient
<b>ICT</b>	Information and Communication Technology
<b>LED</b>	Light Emitting Diode
<b>FR</b>	Financial Report
<b>Nosocomial</b>	Acquired in hospital
<b>NRCF</b>	National Respite for Carers Program
<b>NSQHSS</b>	National Safety and Quality Health Service Standards
<b>Occupancy</b>	Percentage of beds filled per nominated period
<b>OCI</b>	Overall Care Index
<b>OHS</b>	Occupational Health and Safety
<b>OP</b>	Outpatient
<b>PAG</b>	Planned Activity Group
<b>PCP</b>	Primary Care Partnership
<b>PP</b>	Private Patient
<b>REDHS</b>	Rochester and Elmore District Health Service
<b>RIPERN</b>	Rural Isolated Practice Endorsed Registered Nurse
<b>Separation/Discharge</b>	The completion of an episode of care and the patient/ client leaves the organisation
<b>Statement of Priorities</b>	The formal funding and monitoring agreement between the Victorian Secretary for Health and REDHS
<b>TCP</b>	Transition Care Program
<b>UCC</b>	Urgent Care Centre
<b>VAED</b>	Victorian Admitted Episodes Dataset
<b>VHES</b>	Victorian Health Experience Survey
<b>VHIMS</b>	Victorian Health Incident Management System
<b>VICNISS</b>	Victorian Nosocomial Infection Surveillance System
<b>VMO</b>	Visiting Medical Officer
<b>VPSM</b>	Victorian Patient Satisfaction Monitor
<b>WIES</b>	Weighted Inlier Equivalent Separation
<b>YTD</b>	Year to date

**The Financial Report which forms part of this Annual Report is attached here.**

If the Financial Report is not attached, a copy can be obtained by phoning 03 5484 4400 or from **[www.redhs.com.au](http://www.redhs.com.au)**

# Award recognises resilience, quality of care and dedication

## Rural health service wins

BY MERRAN REED

ROCHESTER and Elmore District Health Service was named Rural Health Service of the Year at the Victorian Public Healthcare Awards last week.

The awards at the Grand Hyatt Melbourne recognised leadership, excellence and innovation in publicly-funded health care.

Rochester and Elmore District Health Service chief executive Matt Sharp said it was a privilege to win the award.

"Each and every person has played a role in creating the health service that REDHS is today and I would like to acknowledge the efforts and commitment of these people," he said.

"The awards celebrate the best of the best in public health care and we are delighted to have won the award.

"This award is recognition of the resilience of REDHS as a health service, and indeed of the collective contribution of many people who are currently, and have been previously, involved with the



WINNERS: Rochester and Elmore District Health Service staff with the award.

Picture: LIZ FLEMING

organisation in small and large ways.

"I am very proud of our staff and the services we provide to the community."

Mr Sharp said the floods in 2011 demonstrated the resilience of the health

service and character of the people involved.

The health service was one of 52 rural Victorian health services eligible for the award.

Clinical services director Anne McEvoy said

staff worked hard to develop a friendly culture.

"We are very involved with the community," she said.

"A lot of our staff live in Rochester and Elmore, too."

"I think our clients appreciate seeing friendly faces

they recognise. We offer professional services.

"Our staff have a real sense of pride, too."

"I think the award also recognises our innovation," she said.

Ms McEvoy said the

“Offering care where people don't have to travel too far from home is important.”

Anne McEvoy

staff provided critical primary care to clients.

"It is all about person-centered care," she said.

"Offering care where people don't have to travel too far from home is important."

Quality systems manager Lynn Wolfe said providing a service close to home was crucial in winning the award.

Mr Sharp praised the dedication of all staff.

"We have been on a journey with the community, assisted in times of need and I look forward to this continuing as we strive to provide high quality health care services," he said.



**Rochester and Elmore District Health Service**

PO Box 202 (Pascoe Street)

Rochester Victoria 3561 Australia

Ph: (03) 5484 4400

Fax: (03) 5484 2291

Email: rochhosp@redhs.com.au

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

2013 Premier's Health Service of the Year

Rochester and Elmore District Health Service: Winner of the Rural Health Service of the Year Award at the 2013 Victorian Public Healthcare Awards

# FINANCIAL REPORT 2014



Premier's Health Service of the Year Awards  
Rural health service  
of the year



Awarded to

Rochester & Elmore District  
Health Service

WINNER



2013 Victorian Public  
Healthcare Awards

Department of  
health



*More Than a Hospital*  
Rochester and Elmore District Health Service

## PERFORMANCE AGAINST STATEMENT OF PRIORITIES

The Statement of Priorities is the key accountability agreement between Rochester and Elmore District Health Service and the Victorian Minister for Health.

### PART A

See Report of Operations pages 8-9 for details.

### PART B: Performance Priorities

#### Financial performance

Operating Results	Target	2012-13 Actuals
Annual Operating result (\$m)	\$0.13m	\$0.07m
Creditors	< 60 days	60 days
Debtors	< 60 days	38 days

#### Service performance

Quality and Safety	Target	2012-13 Actuals
Health Service Accreditation	Full compliance	Achieved
Residential Aged Care Accreditation	Full compliance	Achieved
Cleaning standards	Full compliance	Achieved
Submission of data to VICNISS	Full compliance	Achieved
Hand Hygiene (rate)	70	80
Victorian Patient Satisfaction Monitor (OCI)	73	86
Consumer Participation Indicator	75	86
People Matter Survey	Full compliance	Achieved

### PART C: Activity and Funding

Small Rural	Target \$000	2012-13 Actuals \$000
Small Rural Acute	4,357	4,849
Small Rural Residential Care	887	870
Small Rural HACC	625	729
Total Funding	5,869	6,448

## **Rochester and Elmore District Health Service**

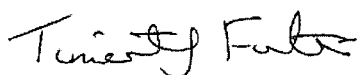
### **Board member's, accountable officer's and chief finance & accounting officer's declaration**

The attached financial statements for Rochester and Elmore District Health Service have been prepared in accordance with Standing Directions 4.2 of 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 2014 and the financial position of Rochester and Elmore District Health Service at 30 June 2014.

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.



.....  
Mr T Fulton  
Chairperson

Rochester

20 August 2014



.....  
Mrs A McEvoy  
Accountable Officer  
Chief Finance and Accounting Officer

Rochester

20 August 2014

## INDEPENDENT AUDITOR'S REPORT

### To the Board Members, Rochester and Elmore District Health Service

#### *The Financial Report*

The accompanying financial report for the year ended 30 June 2014 of the Rochester and Elmore District Health Service which comprises comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement, notes comprising a summary of significant accounting policies and other explanatory information, and the Board members', accountable officer's and chief finance and accounting officer's declaration has been audited.

#### *The Board Members' Responsibility for the Financial Report*

The Board Members of the Rochester and Elmore District Health Service are responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*, and for such internal control as the Board Members determine is necessary to enable the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error.

#### *Auditor's Responsibility*

As required by the *Audit Act 1994*, my responsibility is to express an opinion on the financial report based on the audit, which has been conducted in accordance with Australian Auditing Standards. Those standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The audit procedures selected depend on judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, consideration is given to the internal control relevant to the entity's preparation and fair presentation of the financial report 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 entity's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Board Members, as well as evaluating the overall presentation of the financial report.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

## Independent Auditor's Report (continued)

### *Independence*

The Auditor-General's independence is established by the *Constitution Act 1975*. The Auditor-General is not subject to direction by any person about the way in which his powers and responsibilities are to be exercised. In conducting the audit, the Auditor-General, his staff and delegates complied with all applicable independence requirements of the Australian accounting profession.

### *Opinion*

In my opinion, the financial report presents fairly, in all material respects, the financial position of the Rochester and Elmore District Health Service as at 30 June 2014 and of its financial performance and its cash flows for the year then ended in accordance with applicable Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*.

### *Matters Relating to the Electronic Publication of the Audited Financial Report*

This auditor's report relates to the financial report of the Rochester and Elmore District Health Service for the year ended 30 June 2014 included both in the Rochester and Elmore District Health Service's annual report and on the website. The Board Members of the Rochester and Elmore District Health Service are responsible for the integrity of the Rochester and Elmore District Health Service's website. I have not been engaged to report on the integrity of the Rochester and Elmore District Health Service's website. The auditor's report refers only to the subject matter described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these statements. If users of the financial report are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial report to confirm the information contained in the website version of the financial report.

MELBOURNE  
21 August 2014



Dr Peter Frost  
Acting Auditor-General

## Financial and Operational Performance Summary

### Financials in Brief

	2013-14 \$000's	2012-13 \$000's	2011-12 \$000's	2010-11 \$000's	2009-10 \$000's
Total Revenue	12,789	12,723	12,275	11,875	14,250
Total Expenses	13,888	13,321	12,840	12,048	10,531
Operating Surplus (Deficit)	(1,099)	(597)	(566)	(173)	379
Retained Surplus/(Accumulated Deficit)	13,703	14,586	15,245	16,606	16,779
Total Assets	45,715	36,190	33,431	33,657	33,651
Total Liabilities	5,767	6,761	5,747	5,407	5,228
Net Assets	39,948	29,429	27,684	28,250	28,423
Net Cash Result	1,236	671	(1,977)	701	(595)
Total Equity	39,948	29,429	27,684	28,250	28,423
Other (List)					

### Comprehensive Operating Statement for the financial year ended 30 June 2014

	NOTE	2014 \$	2013 \$
Revenue from Operating Activities	2	12,221,717	11,691,409
Revenue from Non-operating Activities	2	340,316	146,008
Employee Expenses	3	(9,411,194)	(8,754,709)
Non Salary Labour Costs	3	(445,975)	(416,009)
Supplies & Consumables	3	(696,739)	(727,884)
Other Expenses	3	(1,815,167)	(1,859,559)
<b>Net Result Before Capital and Specific Items</b>		<b>192,958</b>	<b>79,256</b>
Capital Purpose Income	2	226,976	885,890
Depreciation	4	(1,509,611)	(1,549,161)
Finance Costs	5	(9,691)	(13,463)
<b>NET RESULT FOR THE YEAR</b>		<b>(1,099,368)</b>	<b>(597,478)</b>
<b>OTHER COMPREHENSIVE INCOME</b>			
<b>Items that will not be reclassified to net result</b>			
Changes in physical asset revaluation surplus		11,618,455	2,342,497
<b>TOTAL OTHER COMPREHENSIVE INCOME</b>		<b>11,618,455</b>	<b>2,342,497</b>
<b>COMPREHENSIVE RESULT</b>		<b>10,519,087</b>	<b>1,745,019</b>

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

## Balance Sheet as at 30 June 2014

	NOTE	2014 \$	2013 \$
<b>Current Assets</b>			
Cash and Cash Equivalents	6	2,811,514	1,516,764
Receivables	7	667,477	771,628
Investments and other financial assets	8	3,475,237	6,056,145
Inventories	9	62,516	57,462
Other Assets	10	105,264	22,445
<b>Total Current Assets</b>		<b>7,122,008</b>	<b>8,424,444</b>
<b>Non-Current Assets</b>			
Receivables	7	296,676	390,611
Property, Plant & Equipment	11	38,296,796	27,374,524
<b>Total Non-Current Assets</b>		<b>38,593,472</b>	<b>27,765,135</b>
<b>TOTAL ASSETS</b>		<b>45,715,480</b>	<b>36,189,579</b>
<b>Current Liabilities</b>			
Payables	12	712,400	1,233,070
Borrowings	13	132,679	108,780
Provisions	14	2,065,816	2,009,981
Other Current Liabilities	16	2,450,112	2,913,810
<b>Total Current Liabilities</b>		<b>5,361,007</b>	<b>6,265,641</b>
<b>Non-Current Liabilities</b>			
Borrowings	13	0	68,289
Provisions	14	406,318	426,581
<b>Total Non-Current Liabilities</b>		<b>406,318</b>	<b>494,870</b>
<b>TOTAL LIABILITIES</b>		<b>5,767,325</b>	<b>6,760,511</b>
<b>NET ASSETS</b>		<b>39,948,155</b>	<b>29,429,068</b>
<b>EQUITY</b>			
Property, Plant and Equipment Revaluation Surplus	17a	18,053,026	6,434,571
Restricted Specific Purpose Surplus	17a	822,050	1,038,631
Contributed Capital	17b	7,369,839	7,369,839
Accumulated Surpluses	17c	13,703,240	14,586,027
<b>TOTAL EQUITY</b>		<b>39,948,155</b>	<b>29,429,068</b>
Contingent Assets and Contingent Liabilities	21		
Commitments	20		

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

# Statement of Changes in Equity for the financial year ended 30 June 2014

2014

		Equity at 1 July 2013	Net Result for the year	Equity at 30 June 2014
	Note	\$	\$	\$
<b>Accumulated Surplus/(Deficit)</b>	17c	15,442,725	(1,099,368)	14,343,357
Transfer to/(from) accumulated surplus	17c	(856,698)	216,581	(640,117)
		<b>14,586,027</b>	<b>(882,787)</b>	<b>13,703,240</b>
<b>Contributed Capital</b>	17b	7,369,839	0	7,369,839
		<b>7,369,839</b>	<b>0</b>	<b>7,369,839</b>
<b>Reserves</b>				
Property Plant and Equipment Revaluation Surplus	17a	6,434,571	11,618,455	18,053,026
Restricted Specific Purpose Surplus	17a	1,038,631	(216,581)	822,050
		<b>7,473,202</b>	<b>11,401,874</b>	<b>18,875,076</b>
<b>Balance as at 30 June 2014</b>		<b>29,429,068</b>	<b>10,519,087</b>	<b>39,948,155</b>

2013

		Equity at 1 July 2012	Net Result for the year	Equity at 30 June 2013
	Note	\$	\$	\$
<b>Accumulated Surplus/(Deficit)</b>	17c	16,040,203	(597,478)	15,442,725
Transfer to/(from) accumulated surplus	17c	(795,083)	(61,615)	(856,698)
		<b>15,245,120</b>	<b>(659,093)</b>	<b>14,586,027</b>
<b>Contributed Capital</b>	17b	7,369,839	0	7,369,839
		<b>7,369,839</b>	<b>0</b>	<b>7,369,839</b>
<b>Reserves</b>				
Property Plant and Equipment Revaluation Surplus	17a	4,092,074	2,342,497	6,434,571
Restricted Specific Purpose Surplus	17a	977,016	61,615	1,038,631
		<b>5,069,090</b>	<b>2,404,112</b>	<b>7,473,202</b>
<b>Balance as at 30 June 2013</b>		<b>27,684,049</b>	<b>1,745,019</b>	<b>29,429,068</b>

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

## Cash Flow Statement for the financial year ended 30 June 2014

	NOTE	2014 \$	2013 \$
<b>CASH FLOWS FROM OPERATING ACTIVITIES</b>			
Operating Grants from Government		8,594,374	8,864,919
Patient and Resident Fees Received		2,101,425	1,761,018
Donations and Bequests Received		5,381	26,341
GST Received from/(paid to) ATO		239,114	174,038
Interest Received		158,694	125,356
Other Receipts		1,395,186	1,630,483
<b>Total Receipts</b>		<b>12,494,174</b>	<b>12,582,155</b>
Employee Expenses Paid		(9,281,687)	(8,733,090)
Fee for Service Medical Officers		(313,337)	(416,009)
Payments for Supplies & Consumables		(1,161,282)	(727,884)
Finance Costs		(9,691)	(13,463)
Other Payments		(1,758,216)	(1,853,252)
<b>Total Payments</b>		<b>(12,524,213)</b>	<b>(11,743,698)</b>
<b>Cash Generated from Operations</b>		<b>(30,039)</b>	<b>838,457</b>
Capital Grants from Government		45,285	530,711
<b>NET CASH FLOW FROM OPERATING ACTIVITIES</b>	18	<b>15,246</b>	<b>1,369,168</b>
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>			
Payments for Non-Financial Assets		(902,044)	(419,498)
Proceeds from sale of Non-Financial Assets		106,974	36,877
Purchase of Investments		2,059,939	(282,155)
<b>NET CASH FLOW FROM INVESTING ACTIVITIES</b>		<b>1,264,869</b>	<b>(664,776)</b>
<b>CASH FLOWS FROM FINANCING ACTIVITIES</b>			
Repayments of Borrowings		(44,390)	(33,315)
<b>NET CASH FLOW USED IN FINANCING ACTIVITIES</b>		<b>(44,390)</b>	<b>(33,315)</b>
<b>NET INCREASE IN CASH AND CASH EQUIVALENTS HELD</b>		<b>1,235,725</b>	<b>671,077</b>
Cash and Cash Equivalents at beginning of financial year		1,333,362	662,285
<b>CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR</b>	6	<b>2,569,087</b>	<b>1,333,362</b>

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

## **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 for the period ending 30 June 2014. The purpose of the report is to provide users with information about the Health Services' 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 AASs, 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 AASs.

The annual financial statements were authorised for issue by the Board of Rochester and Elmore District Health Service on the 20<sup>th</sup> August 2014.

### **(b) 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 set out below have been applied in preparing the financial statements for the year ended 30 June 2014, and the comparative information presented in these financial statements for the year ended 30 June 2013.

The going concern basis was used to prepare the financial statements.

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

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.

The financial statements are prepared in accordance with the historical cost convention, except for:

- non-current physical assets, which subsequent to acquisition, are measured at a revalued amount being their fair value at the date of the revaluation less any

subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made

- and are re-assessed with sufficient regularity to ensure that the carrying amounts do not materially differ from their fair values;
- derivative financial instruments, managed investment schemes, certain debt securities, and investment properties after initial recognition, which are measured at fair value with changes reflected in the comprehensive operating statement (fair value through profit and loss); and
- available-for-sale investments which are measured at fair value with movements reflected in equity until the asset is derecognised (i.e. other comprehensive income – items that may be reclassified subsequent to net result);
- the fair value of assets other than land is generally based on their depreciated replacement value.

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 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 AASs that have significant effects on the financial statements and estimates relate to:

- the fair value of land, buildings, infrastructure, plant and equipment, (refer to Note 1(m));
- superannuation expense (refer to Note 1(h); and
- actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 1(n)).

Consistent with AASB 13 Fair Value Measurement, Rochester and Elmore District Health Service determines the policies and procedures for both recurring fair value measurements such as property, plant and equipment, investment properties and financial instruments, and for non-recurring fair value measurements such as non-financial physical assets held for sale, in accordance with the requirements of AASB 13 and the relevant FRDs.

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy, described as follows, based on the lowest level input that is significant to the fair value measurement as a whole:

- Level 1 – Quoted (unadjusted) market prices in active markets for identical assets or liabilities
- Level 2 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable

- Level 3 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

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.

Rochester and Elmore District Health Service, in conjunction with VGV monitors the changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required.

### **(c) Reporting entity**

The financial statements include all the controlled activities of the *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.

### **Objectives and funding**

*Rochester and Elmore District Health Service's* overall objective is to provide quality health care service, as well as improve the quality of life to Victorians.

*Rochester and Elmore District Health Service* is predominantly funded by accrual based grant funding for the provision of outputs.

### **(d) Principles of consolidation**

#### **Joint ventures**

Joint ventures are accounted for in accordance with the policy outlined in Note 1 Assets.

Interests in jointly controlled assets or operations are not consolidated by Rochester and Elmore District Health Service, but are accounted for in accordance with the policy outlined in Note 1(k) Assets.

Details of joint venture are set out in Note 23.

## **(e) Scope and presentation of financial statements**

### **Fund Accounting**

The *Rochester and Elmore District Health Service* operates on a fund accounting basis and maintains three funds: Operating, Specific Purpose and Capital Funds. The *Rochester and Elmore District Health Service's* Capital and Specific Purpose Funds include unspent capital donations and receipts from fund-raising activities conducted solely in respect of these funds.

### **Services Supported By Health Services Agreement and Services Supported By Hospital and Community Initiatives**

Activities classified as *Services Supported by Health Services Agreement* (HSA) are substantially funded by the Department of Health and includes Residential Aged Care Services (RACS) and are also funded from other sources such as the Commonwealth, patients and residents, while *Services Supported by Hospital and Community Initiatives* (H&CI) are funded by the Health Service's own activities or local initiatives and/or the Commonwealth.

### **Comprehensive operating statement**

The comprehensive operating statement includes the subtotal entitled 'net result before capital & specific items' to enhance the understanding of the financial performance of *Rochester and Elmore District Health Service*. This subtotal reports the result excluding items such as capital grants, assets received or provided free of charge, depreciation, expenditure using capital purpose income and items of an unusual nature and amount such as specific income and expenses. The exclusion of these items is made to enhance matching of income and expenses so as to facilitate the comparability and consistency of results between years and Victorian Public Health Services. The 'net result before capital & specific items' is used by the management of *Rochester and Elmore District Health Service*, the Department of Health and the Victorian Government to measure the ongoing operating performance of Health Services.

Capital and specific items, which are excluded from this sub-total, comprise:

- ❖ capital purpose income, which comprises all tied grants, donations and bequests received for the purpose of acquiring non-current assets, such as capital works, plant and equipment or intangible assets. It also includes donations of plant and equipment (refer Note 1 (i)). Consequently the recognition of revenue as capital purpose income is based on the intention of the provider of the revenue at the time the revenue is provided.
- ❖ specific income/expense, comprises the following items, where material:
  - Voluntary departure packages
  - Write-down of inventories
  - Non-current asset revaluation increments/decrements
  - Diminution/impairment of investments

- Restructuring of operations (disaggregation/aggregation of Health Services)
  - Litigation settlements
  - Non-current assets lost or found
  - Forgiveness of loans
  - Reversals of provisions
  - Voluntary changes in accounting policies (which are not required by an accounting standard or other authoritative pronouncement of the Australian Accounting Standards Board)
- ❖ impairment of financial and non-financial assets, includes all impairment losses (and reversal of previous impairment losses), which have been recognised in accordance with Notes 1 (j)
- ❖ depreciation and amortisation, as described in Note 1 (h);
- ❖ assets provided or received free of charge (refer to Notes 1 (g) and (h)); and
- ❖ expenditure using capital purpose income, comprises expenditure which either falls below the asset capitalisation threshold or doesn't meet asset recognition criteria and therefore does not result in the recognition of an asset in the balance sheet, where funding for that expenditure is from capital purpose income.

### **Balance sheet**

Assets and liabilities are categorised either as current or non-current (non-current being those assets or liabilities expected to be recovered/settled more than 12 months after reporting period), are disclosed in the notes where relevant.

### **Statement of changes in equity**

The statement of changes in equity presents reconciliations of each non-owner and owner changes in equity from opening balance at the beginning of the reporting period to the closing balance at the end of the reporting period. It also shows separately changes due to amounts recognised in the comprehensive result and amounts recognised in other comprehensive income.

### **Cash flow statement**

Cash flows are classified according to whether or not they arise from operating activities, investing activities, or financing activities. This classification is consistent with requirements under AASB 107 *Statement of Cash Flows*.

For the cash flow statement presentation purposes, cash and cash equivalents includes bank overdrafts, which are included as current borrowings in the balance sheet.

### **Rounding**

All amounts shown in the financial statements are expressed to the nearest \$1 unless otherwise stated.

Minor discrepancies in tables between totals and sum of components are due to rounding.

## **(f) Change in Accounting Policies**

### **AASB 13 Fair Value Measurement**

AASB 13 establishes a single source of guidance for all fair value measurements. AASB 13 does not change when a health service is required to use fair value, but rather provides guidance on how to measure fair value under Australian Accounting Standards when fair value is required or permitted. The health service has considered the specific requirements relating to highest and best use, valuation premise, and principal (or most advantageous) market. The methods, assumptions, processes and procedures for determining fair value were revised and adjusted where applicable. In light of AASB 13, the health service has reviewed the fair value principles as well as its current valuation methodologies in assessing the fair value, and the assessment has not materially changed the fair values recognised.

AASB 13 has predominantly impacted the disclosures of the health service. It requires specific disclosures about fair value measurements and disclosures of fair values, some of which replace existing disclosure requirements in other standards, including AASB 7 *Financial Instruments: Disclosures*.

The disclosure requirements of AASB 13 apply prospectively and need not to be provided for comparative periods, before initial application. Consequently, comparatives of these disclosures have not been provided for 2012-13, except for financial instruments, of which the fair value disclosures are required under AASB 7 *Financial Instruments Disclosures*.

### **AASB 119 Employee Benefits**

In 2013-14, the health service has applied AASB 119 *Employee Benefits (Sep 2011, as amended)*, and related consequential amendments for the first time.

The revised AASB 119 changes the accounting for defined benefit plans and termination benefits. The most significant change relates to the accounting for changes in defined benefit obligation and plan assets. As the current accounting policy is for the Department of Treasury and Finance to recognise and disclose the State's defined benefit liabilities in its financial statements, changes in defined benefit obligations and plan assets will have limited impact on Rochester and Elmore District Health Service.

The revised standard also changes the definition of short-term employee benefits. These were previously benefits that were expected to be settled within 12 months after the end of the reporting period in which the employees render the related service, however, short-term employee benefits are now defined as benefits expected to be settled wholly within 12 months after the end of the reporting period in which the employees render the related service. As a result, accrued annual leave balances which were previously classified as short-term employee benefits no longer meet this definition and are now classified as long-term employee benefits. This has resulted in a change of measurement for the annual leave provision from an undiscounted to discounted basis. This change in measurement has not resulted in a material change as at 30 June 2013.

## **(g) Income from transactions**

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**

- Insurance is recognised as revenue following advice from the Department of Health.
- 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 05/2013 (update for 2012-13).

### **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.

### **Dividend Revenue**

Dividend revenue is recognised when the right to receive payment is established.

### **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.

**(h) Expense recognition**

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

**Cost of goods sold**

Costs of goods sold are recognised when the sale of an item occurs by transferring the cost or value of the item/s from inventories.

**Employee expenses**

Employee expenses include:

- wages and salaries;
- annual leave;
- sick leave;
- long service leave; and
- superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

***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 the Health Service to the superannuation plans in respect of the services of current Health Service 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.

Employees of the *Rochester and Elmore District Health Service* are entitled to receive superannuation benefits and the *Rochester and Elmore District Health Service* contributes to both the defined benefit and defined contribution plans. The defined benefit plan(s) provide benefits based on years of service and final average salary.

The name and details of the major employee superannuation funds and contributions made by the *Rochester and Elmore District Health Service* are disclosed in Note 20: *Superannuation*.

## Depreciation

All infrastructure assets, buildings, plant and equipment and other non-financial physical assets that have finite useful lives are depreciated (i.e. excludes land assets held for sale, and investment properties). Depreciation begins when the asset is available for use, which is when it is in the location and condition necessary for it to be capable of operating in a manner intended by management.

Intangible produced assets with finite lives are depreciated as an expense from transactions on a systematic basis over the asset's useful life. Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives, residual value and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health. Assets with a cost in excess of \$1000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

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

	2014	2013
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 10 years	3 to 7 years
Medical Equipment	7 to 10 years	7 to 10 years
Computers and Communication	3 years	3 years
Furniture and Fitting	9 years	13 years
Motor Vehicles	3 years	10 years
Leasehold Improvements	2 to 10 Years	2 to 10 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.

Intangible produced assets with finite lives are depreciated as an expense on a systematic basis over the asset's useful life.

## Finance costs

Finance costs are recognised as expenses in the period in which they are incurred.

Finance costs include:

- interest on bank overdrafts and short-term and long-term borrowings (Interest expense is recognised in the period in which it is incurred);
- amortisation of discounts or premiums relating to borrowings;
- amortisation of ancillary costs incurred in connection with the arrangement of borrowings; and
- finance charges in respect of finance leases recognised in accordance with AASB 117 *Leases*.

### **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.

#### **Bad and doubtful debts**

Refer to Note 1 (k) *Impairment of financial assets*.

#### **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, irrespective of whether restrictions or conditions are imposed over the use of the contributions, unless received from another agency as a consequence of a restructuring of administrative arrangements. In the latter case, such a transfer will be recognised at its carrying value.

Contributions in the form of services are only recognised when a fair value can be reliably determined and the services would have been purchased if not donated.

#### **Borrowing costs of qualifying assets**

In accordance with the paragraphs of AASB 123 *Borrowing Costs* applicable to not-for-profit public sector entities, the Health Services continues to recognise borrowing costs immediately as an expense, to the extent that they are directly attributable to the acquisition, construction or production of a qualifying asset.

## **(i) Other comprehensive income**

Other comprehensive income measures the change in volume or value of assets or liabilities that do not result from transactions.

### **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:

#### **Revaluation gains/ (losses) of non-financial physical assets**

Refer to Note 1(k) *Revaluations of non-financial physical assets*.

**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:

- realised and unrealised gains and losses from revaluations of financial instruments at fair value;
- impairment and reversal of impairment for financial instruments at amortised cost (refer to Note 1 (k)); and
- disposals of financial assets and derecognition of financial liabilities

**Share of net profits/ (losses) of associates and joint entities, excluding dividends.**

Refer to Note 1 (d) *Principles of consolidation*.

**Other gains/ (losses) from other comprehensive income**

Other gains/ (losses) include:

- a. the revaluation of the present value of the long service leave liability due to changes in the bond interest rates; and
- b. transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

**(j) 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 the 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*. For example, statutory receivables arising from taxes, fines and penalties do not meet the definition of financial instruments as they do not arise under contract.

Where relevant, for note disclosure purposes, a distinction is made between those financial assets and financial liabilities that meet the definition of financial instruments in accordance with AASB 132 and those that do not.

The following refers to financial instruments unless otherwise stated.

**Categories of non-derivative financial instruments****Financial assets and liabilities at fair value through profit or loss**

Financial assets are categorised as fair value through profit or loss at trade date if they are classified as held for trading or designated as such upon initial recognition. Financial instrument assets are designated at fair value through profit or loss on the basis that the financial assets form part of a group of financial assets that are managed by the Health

Service concerned based on their fair values, and have their performance evaluated in accordance with documented risk management and investment strategies.

Financial instruments at fair value through profit or loss are initially measured at fair value and attributable transaction costs are expensed as incurred. Subsequently, any changes in fair value are recognised in the net result as other comprehensive income. Any dividend or interest on a financial asset is recognised in the net result for the year.

### **Loans and receivables**

Loans and receivables 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.

Loans and receivables category includes cash and deposits (refer to Note 1(k)), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

### **Available-for-sale financial assets**

Available-for-sale financial instrument assets are those designated as available-for-sale or not classified in any other category of financial instrument asset. Such assets are initially recognised at fair value. Subsequent to initial recognition, gains and losses arising from changes in fair value are recognised in 'other comprehensive income' until the investment is disposed of or is determined to be impaired, at which time the cumulative gain or loss previously recognised in equity is included in net result for the period. Fair value is determined in the manner described in Note 19.

### **Financial liabilities at amortised cost**

Financial instrument liabilities 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.

Financial instrument liabilities measured at amortised cost include all of the Health Service's contractual payables, deposits held and advances received, and interest-bearing arrangements other than those designated at fair value through profit or loss.

## **(k) Assets**

### **Cash and Cash Equivalents**

Cash and cash equivalents recognised on the balance sheet comprise cash on hand and cash at bank, 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 with an 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.

## Receivables

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.

## Investments and other financial assets

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 in the following categories:

- financial assets at fair value through profit or loss;
- held-to-maturity;
- loans and receivables; and
- available-for-sale 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 sheet date whether a financial asset or group of financial assets is impaired.

All financial assets, except those measured at fair value through profit or loss are subject to annual review for impairment.

## Inventories

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 is assigned to land for sale (undeveloped, under development and developed) and to other high value, low volume inventory items on a specific identification of cost basis. Cost for all other inventory is measured on the basis of weighted average cost.

### **Property, plant and equipment**

All non-current physical assets are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and impairment. 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 are transferred at their carrying amount.

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 11 *Property, plant and equipment*.

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 impairment.

**Plant, equipment and vehicles** are recognised initially at cost and subsequently measured at fair value less accumulated depreciation and impairment. Depreciated historical cost is generally a reasonable proxy for fair value because of the short lives of the assets concerned.

### **Revaluations of non-current physical assets**

Non-current physical assets are measured at fair value and are revalued in accordance with FRD103E *Non-current physical assets*. This revaluation process normally occurs at least 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 in equity 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 normally transferred to accumulated funds on derecognition of the relevant asset.

In accordance with FRD 103D, *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.

### **Prepayments**

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.

### **Disposal of non-financial assets**

Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement. Refer to note 1(i) – 'other comprehensive income'.

### **Impairment of non-financial assets**

All other non-financial assets are assessed annually for indications of impairment, except for:

- inventories;
- investment properties that are measured at fair value;
- non-current physical assets held for sale; and
- assets arising from construction contracts.

If there is an indication of impairment, the assets concerned are tested as to whether their carrying value exceeds their possible recoverable amount. Where an asset's carrying value exceeds its recoverable amount, the difference is written-off as an expense except to the extent that the write-down can be debited to an asset revaluation surplus amount applicable to that same class of asset.

If there is an indication that there has been a reversal in the estimate of an asset's recoverable amount since the last impairment loss was recognised, the carrying amount shall be increased to its recoverable amount. This reversal of the impairment loss occurs only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised in prior years.

It is deemed that, in the event of the loss or destruction of an asset, the future economic benefits arising from the use of the asset will be replaced unless a specific decision to the contrary has been made. The recoverable amount for most assets is measured at

the higher of depreciated replacement cost and fair value less costs to sell. Recoverable amount for assets held primarily to generate net cash inflows is measured at the higher of the present value of future cash flows expected to be obtained from the asset and fair value less costs to sell.

### **Investments in jointly controlled assets and operations**

In respect of any interest in jointly controlled assets, Rochester and Elmore District Health Service recognises in the financial statements:

- its share of jointly controlled assets;
- any liabilities that it had incurred;
- its share of liabilities incurred jointly by the joint venture;
- any income earned from the selling or using of its share of the output from the joint venture; and
- any expenses incurred in relation to being an investor in the joint venture.

For jointly controlled operations Rochester and Elmore District Health Service recognises:

- the assets that it controls;
- the liabilities that it incurs;
- expenses that it incurs; and
- the share of income that it earns from selling outputs of the joint venture

### **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.

Receivables are assessed for bad and doubtful debts on a regular basis. Bad debts considered as written off and allowances for doubtful receivables are expensed. Bad debt written off by mutual consent and the allowance for doubtful debts are classified as 'other comprehensive income' in the net result.

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.

Where the fair value of an investment in an equity instrument at balance date has reduced by 20 percent or more than its cost price or where its fair value has been less than its cost price for a period of 12 or more months, the financial asset is treated as impaired.

In order to determine an appropriate fair value as at 30 June 2014 for its portfolio of financial assets, Rochester and Elmore District Health Service obtained a valuation based on the best available advice using an estimated market value through a reputable financial institution. This value was compared against valuation methodologies provided by the issuer as at 30 June 2014. These methodologies were critiqued and considered to be consistent with standard market valuation techniques.

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*.

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

Net gain/(loss) on financial instruments includes:

- realised and unrealised gains and losses from revaluations of financial instruments that are designated at fair value through profit or loss or held-for-trading;
- impairment and reversal of impairment for financial instruments at amortised cost; and
- disposals of financial assets and derecognition of financial liabilities.

### ***Revaluations of financial instruments at fair value***

The revaluation gain/(loss) on financial instruments at fair value excludes dividends or interest earned on financial assets.

## **(I) Liabilities**

### **Payables**

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 arise when the Health Service becomes obliged to make future payments in respect of the purchase of those goods and services. The normal credit terms for accounts payable are usually Nett 30 days.
- statutory payables, such as goods and services tax and fringe benefits tax payables.

Contractual payables are classified as financial instruments and are initially recognised at fair value, and then subsequently carried at amortised cost. Statutory payables are

recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from a contract.

### **Borrowings**

All borrowings are initially recognised at fair value of the consideration received, less directly attributable transaction costs (refer also to note 1(m) Leases) The measurement basis subsequent to initial recognition depends on whether the Health Service has categorised its borrowings as either, financial liabilities designated at fair value through profit or loss, or financial liabilities at amortised cost. Any difference between the initial recognised amount and the redemption value is recognised in net result over the period of the borrowings using the effective interest method.

The classification depends on the nature and purpose of the borrowing. The Health Service determines the classification of its borrowing at initial recognition.

### **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. Where a provision is measured using the cash flows estimated to settle the present obligation, its carrying amount is the present value of those cash flows, using a discount rate that reflects the time value of money and risks specific to the provision.

When some or all of the economic benefits required to settle a provision are expected to be received from a third party, the receivable is recognised as an asset if it is virtually certain that recovery will be received and the amount of the receivable can be measured reliably.

### **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.

The components of this current LSL liability are measured at:

- Undiscounted value – if the health service expects to wholly settle within 12 months; and
- Present value – if the health service does not expect to wholly settle within 12 months.

Conditional LSL is disclosed as a non-current liability. There is an unconditional right to defer the settlement of the entitlement until the employee has completed the requisite years of service. This non-current LSL liability is measured at present value.

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 bond interest rates for which it is then recognised as an other economic flow.

### ***Termination benefits***

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

The health service recognises termination benefits when it is demonstrably committed to either terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

### ***On-costs***

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

### ***Superannuation liabilities***

The Rochester and Elmore District Health Service does not recognise any unfunded defined benefit liability in respect of the superannuation 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.

### ***(m) Leases***

A lease is a right to use an asset for an agreed period of time in exchange for payment. Leases are classified at their inception as either operating or finance leases based on the economic substance of the agreement so as to reflect the risks and rewards incidental to ownership.

Leases of property, plant and equipment are classified as finance leases whenever the terms of the lease transfer substantially all the risks and rewards of ownership to the lessee.

For service concession arrangements, the commencement of the lease term is deemed to be the date the asset is commissioned.

All other leases are classified as operating leases.

## **Finance leases**

### ***Entity as lessee***

Finance leases are recognised as assets and liabilities at amounts equal to the fair value of the lease property or, if lower, the present value of the minimum lease payment, each determined at the inception of the lease. The lease asset is accounted for as a non-financial physical asset and is depreciated over the shorter of the estimated useful life of the asset or the term of the lease. If there is certainty that the health service will obtain the ownership of the lease asset by the end of the lease term, the asset shall be depreciated over the useful life of the asset. If there is no reasonable certainty that the lessee will obtain ownership by the end of the lease term, the asset shall be fully depreciated over the shorter of the lease term and its useful life. Minimum lease payments are apportioned between reduction of the outstanding lease liability, and the periodic finance expense which is calculated using the interest rate implicit in the lease, and charged directly to the comprehensive operating statement. Contingent rentals associated with finance leases are recognised as an expense in the period in which they are incurred.

## **Operating leases**

### ***Entity as lessee***

Operating lease payments, including any contingent rentals, are recognised as an expense in the comprehensive operating statement on a straight line basis over the lease term, except where another systematic basis is more representative of the time pattern of the benefits derived from the use of the leased asset. The leased asset is not recognised in the balance sheet.

### ***Lease Incentives***

All incentives for the agreement of a new or renewed operating lease are recognised as an integral part of the net consideration agreed for the use of the leased asset, irrespective of the incentive's nature or form or the timing of payments.

In the event that lease incentives are received by the lessee to enter into operating leases, such incentives are recognised as a liability. The aggregate benefits of incentives are recognised as a reduction of rental expense on a straight-line basis, except where another systematic basis is more representative of the time pattern in which economic benefits from the leased asset is diminished.

## **(n) Equity**

### **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.

### **Financial asset available-for-sale revaluation surplus**

The available-for-sale revaluation surplus arises on the revaluation of available-for-sale financial assets. Where a revalued financial asset is sold that portion of the surplus which relates to that financial asset is effectively realised, and is recognised in the comprehensive operating statement. Where a revalued financial asset is impaired that portion of the surplus which relates to that financial asset is recognised in the comprehensive operating statement.

### **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.

## **(o) Commitments**

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed by way of a note (refer to note 20) 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.

## **(p) Contingent assets and contingent liabilities**

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.

## **(q) 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 taxation authority. 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 taxation authority 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 taxation authority, are presented as an operating cash flow.

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

#### **(r) AASs issued that are not yet effective**

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2014 reporting period. DTF assesses the impact of all these new standards and advises the Health Service of their applicability and early adoption where applicable.

As at 30 June 2014, the following standards and interpretations had been issued by the AASB but were not yet effective. 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.

<b>Standard/ Interpretation</b>	<b>Summary</b>	<b>Applicable for annual reporting periods beginning or ending on</b>	<b>Impact on financial statements</b>
ASSB 9 Financial Instruments	This standard simplifies requirements for the classification and measurement of financial assets resulting from Phase 1 of the IASB's project to replace IAS 39 Financial Instruments: Recognition and Measurement (AASB 139 Financial Instruments: Recognition and Measurement).	1 Jan 2017	<p>The preliminary assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss.</p> <p>While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.</p>

AASB 10 Consolidated Financial Statements	<p>This Standard forms the basis for determining which entities should be consolidated into an entity's financial statements. AASB 10 defines 'control' as requiring exposure or rights to variable returns and the ability to affect those returns through power over an investee, which may broaden the concept of control for public sector entities. The AASB has issued an Australian Implementation Guidance for Not-for-Profit Entities – Control and Structured Entities that explains and illustrates how the principles in the Standard apply from the perspective of not-for-profit entities in the private and public sectors.</p>	1 Jan 2014 (not-for-profit entities)	<p>For the public sector, AASB 10 builds on the control guidance that existed in AASB 127 and Interpretation 112 and is not expected to change which entities need to be consolidated.</p> <p>Ongoing work is being done to monitor and assess the impact of this standard.</p>
AASB 11 Joint Arrangements	<p>This Standard deals with the concept of joint control, and sets out a new principles-based approach for determining the type of joint arrangement that exists and the corresponding accounting treatment. The new categories of joint arrangements under AASB 11 are more aligned to the actual rights and obligations of the parties to the arrangement.</p>	1 Jan 2014 (not-for-profit entities)	<p>Based on current assessment, entities already apply the equity method when accounting for joint ventures. It is anticipated that there would be no material impact. Ongoing work is being done to monitor and assess the impact of this standard.</p>

AASB 12 Disclosure of Interests in Other Entities	This Standard requires disclosure of information that enables users of financial statements to evaluate the nature of, and risks associated with, interests in other entities and the effects of those interests on the financial statements. This Standard replaces the disclosure requirements in AASB 127 Separate Financial Statements and AASB 131 Interests in Joint Ventures.	1 Jan 2014 (not-for-profit entities)	The new standard is likely to require additional disclosures and ongoing work is being done to determine the extent of additional disclosure required.
AASB 127 Separate Financial Statements	This revised Standard prescribes the accounting and disclosure requirements for investments in subsidiaries, joint ventures and associates when an entity prepares separate financial statements.	1 Jan 2014 (not-for-profit entities)	Current assessment indicates that there is limited impact on Victorian Public Sector entities. Ongoing work is being done to monitor and assess the impact of this standard.
AASB 128 Investments in Associates and Joint Ventures	This revised Standard sets out the requirements for the application of the equity method when accounting for investments in associates and joint ventures.	1 Jan 2014 (not-for-profit entities)	Current assessment indicates that there is limited impact on Victorian Public Sector entities. Ongoing work is being done to monitor and assess the impact of this standard.

AASB 1055 Budgetary Reporting	AASB 1055 extends the scope of budgetary reporting that is currently applicable for the whole of government and general government sector (GGS) to NFP entities within the GGS, provided that these entities present separate budget to the parliament.	1 July 2014	[If separate budget is presented to the parliament]: The entity will be required to restate in the financial statements the budgetary information in accordance with the presentation format prescribed in Australian Accounting Standards and explain the significant variances from the original budget. [If separate budget is not presented to the parliament]: This Standard is not applicable as no budget disclosure is required.
AASB 1056 Superannuation Entities	AASB 1056 replaces AAS 25 Financial Reporting by Superannuation Plans. The standard was developed in light of changes in recent years, developments in the superannuation industry and Australia's adoption of IFRS.	1 July 2016	The standard was issued in June 2014. While preliminary assessment has not identified any material impact arising from AASB 1056, further work to assess the impact of this standard will be undertaken.

### **(s) Category groups**

The *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 recurrent health revenue/expenditure on admitted patient services, where services are delivered in public hospitals, or free standing day hospital facilities, or alcohol and drug treatment units or hospitals specialising in dental services, hearing and ophthalmic aids.

**Aged Care** comprises revenue/expenditure from Home and Community Care (HACC) programs, Allied Health, Aged Care Assessment and support services.

**Primary Health** comprises revenue/expenditure for Community Health Services including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy.

**Off Campus, Ambulatory Services (Ambulatory)** comprises all recurrent health revenue/expenditure on public hospital type services including palliative care facilities and rehabilitation facilities, as well as services provided under the following agreements: Services that are provided or received by hospitals (or area Health Services) but are delivered/received outside a hospital campus, services which have moved from a hospital to a community setting since June 1998, services which fall within the agreed scope of inclusions under the new system, which have been delivered within hospital's i.e. in rural/remote areas.

**Residential Aged Care including Mental Health (RAC incl. Mental Health)** referred to in the past as psychogeriatric residential services, comprises those Commonwealth-licensed residential aged care services in receipt of supplementary funding from DH under the mental health program. It excludes all other residential services funded under the mental health program, such as mental health funded community care units (CCUs) and secure extended care units (SECs).

**Other Services excluded from Australian Health Care Agreement (AHCA) (Other)** comprises revenue/expenditure for services not separately classified above, including: Public Health Services including Laboratory testing, Blood Borne Viruses / Sexually Transmitted Infections clinical services, Kooris liaison officers, immunisation and screening services, Drugs services including drug withdrawal, counselling and the needle and syringe program, Dental Health services including general and specialist dental care, school dental services and clinical education, Disability services including aids and equipment and flexible support packages to people with a disability, Community Care programs including sexual assault support, early parenting services, parenting assessment and skills development, and various support services. Health and Community Initiatives also falls in this category group.

**Note 2: Revenue****Revenue from Operating Activities**

Government Grants					
- Department of Health	6,579,411	6,447,890	0	0	6,579,411
- Commonwealth Government					
- Residential Aged Care Subsidy	2,014,964	1,994,947	0	0	2,014,964
<b>Total Government Grants</b>	<b>8,594,375</b>	<b>8,442,837</b>	<b>0</b>	<b>0</b>	<b>8,594,375</b>
					<b>8,442,837</b>

**Indirect Contributions by Department of Health**

- Insurance	17,323	779	0	0	17,323
- Long Service Leave	93,935	12,735	0	0	93,935

**Total Indirect Contributions by Department of Health**

	<b>111,258</b>	<b>13,514</b>	<b>0</b>	<b>0</b>	<b>111,258</b>
					<b>13,514</b>
Patient and Resident Fees					
- Patient and Resident Fees (refer note 2b)	477,416	473,318	0	0	477,416
- Residential Aged Care (refer note 2b)	1,566,014	1,514,199	0	0	1,566,014

**Total Patient and Resident Fees**

	<b>2,043,430</b>	<b>1,987,517</b>	<b>0</b>	<b>0</b>	<b>2,043,430</b>
					<b>1,987,517</b>
Commercial Activities & Specific Purpose Funds					
- Catering	698	3,592	117,913	124,846	118,611
- Property Income	91,295	91,446	1,385	5,120	92,680

**Total Commercial Activities & Specific Purpose Funds**

	<b>91,993</b>	<b>95,038</b>	<b>119,298</b>	<b>129,966</b>	<b>211,291</b>
					<b>225,004</b>
Interest and Dividends					
Loddon Mallee Rural Health Alliance Revenue	124,120	125,356	0	0	124,120
Other Revenue from Operating Activities	131,590	155,141	0	0	131,590
	1,005,653	742,040	0	0	1,005,653
<b>Total Revenue from Operating Activities</b>	<b>12,102,419</b>	<b>11,561,443</b>	<b>119,298</b>	<b>129,966</b>	<b>12,221,717</b>
					<b>11,691,409</b>

**Revenue from Non-Operating Activities**

Interest and Dividends	0	0	34,574	146,008	34,574
Other Revenue from Non-Operating Activities	300,361	0	5,381	0	305,742
<b>Total Revenue from Non-Operating Activities</b>	<b>300,361</b>	<b>0</b>	<b>39,955</b>	<b>146,008</b>	<b>340,316</b>
					<b>146,008</b>

**Capital Purpose Income**

State Government Capital Grants					
- Targeted Capital Works and Equipment	45,285	590,811	0	0	45,285
- Other	4,814	26,131	0	0	4,814
- Loddon Mallee Rural Health Alliance	27,309	64,116	0	0	27,309
Residential Accommodation Payments (refer Note 2b)	130,709	175,368	0	0	130,709
Net Gain/(Loss) on Disposal of Non-Financial Assets (refer note 2c)	2,208	3,123	0	0	2,208
Donations and Bequests	16,651	26,341	0	0	16,651

**Total Capital Purpose Income**

	<b>226,976</b>	<b>885,890</b>	<b>0</b>	<b>0</b>	<b>226,976</b>
					<b>885,890</b>

**Total Revenue (refer to note 2a)**

	<b>12,629,756</b>	<b>12,447,333</b>	<b>159,253</b>	<b>275,974</b>	<b>12,789,009</b>
					<b>12,723,307</b>

Indirect contributions by Department of Health: Department of Health makes certain payments on behalf of the Health Service. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

**Note 2a: Analysis of Revenue by Source**

**Revenue from Services Supported by Health Services Agreement**

Government Grants	4,730,777	0	3,054,525	566,296	208,767	34,010	8,594,375
Indirect contributions by Department of Health	111,258	0	0	0	0	0	111,258
Patient and Resident Fees (refer note 2b)	300,087	0	1,566,014	57,246	58,778	0	1,982,125
Business Units - Radiology (refer note 2b)	61,305	0	0	0	0	0	61,305
Interest and Dividends	0	0	0	0	0	124,120	124,120
Other	42,341	299,099	145,175	9,983	548,419	484,580	1,529,597
Capital Purpose Income (refer Note 2)	0	0	130,709	0	0	96,267	226,976

**Total Revenue from Services Supported by Health Services Agreement**

	<b>5,245,768</b>	<b>299,099</b>	<b>4,896,423</b>	<b>633,525</b>	<b>815,964</b>	<b>738,977</b>	<b>12,629,756</b>
--	------------------	----------------	------------------	----------------	----------------	----------------	-------------------

**Revenue from Services Supported by Hospital and Community Initiatives**

Catering	0	0	0	0	0	117,913	117,913
Bank & Investment Income	0	0	0	0	0	34,574	34,574
Other	0	0	0	0	0	6,766	6,766

**Total Revenue from Services Supported by Hospital and Community Initiatives**

	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>159,253</b>	<b>159,253</b>
	<b>5,245,768</b>	<b>299,099</b>	<b>4,896,423</b>	<b>633,525</b>	<b>815,964</b>	<b>898,230</b>	<b>12,789,009</b>

Indirect contributions by Department of Health: Department of Health makes certain payments on behalf of the Health Service. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

**Note 2a: Analysis of Revenue by Source**

**Revenue from Services Supported by Health Services Agreement**

Government Grants	4,596,960	0	2,952,122	586,005	181,788	125,962	8,442,837
Indirect contributions by Department of Health	13,514	0	0	0	0	0	13,514
Patient and Resident Fees (refer note 2b)	328,765	0	1,514,199	48,265	34,077	0	1,925,306
Business Units - Radiology (refer note 2b)	62,211	0	0	0	0	0	62,211
Interest and Dividends	0	0	40,963	0	0	84,393	125,356
Other	3,500	315,535	60,188	7,041	418,348	187,607	992,219
Capital Purpose Income (refer Note 2)	0	0	175,368	0	0	710,522	885,890

**Total Revenue from Services Supported by Health Services Agreement**

	<b>5,004,950</b>	<b>315,535</b>	<b>4,742,840</b>	<b>641,311</b>	<b>634,213</b>	<b>1,108,484</b>	<b>12,447,333</b>
--	------------------	----------------	------------------	----------------	----------------	------------------	-------------------

**Revenue from Services Supported by Hospital and Community Initiatives**

Catering	0	0	0	0	0	124,846	124,846
Bank & Investment Income	0	0	0	0	0	146,008	146,008
Other	0	0	0	0	0	5,120	5,120

**Total Revenue from Services Supported by Hospital and Community Initiatives**

	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>275,974</b>	<b>275,974</b>
	<b>5,004,950</b>	<b>315,535</b>	<b>4,742,840</b>	<b>641,311</b>	<b>634,213</b>	<b>1,384,458</b>	<b>12,723,307</b>

Indirect contributions by Department of Health: Department of Health makes certain payments on behalf of the Health Service. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

## **Rochester and Elmore District Health Service 30 June 2014**

### **Note 2b: Patient and Resident Fees Raised**

	<b>2014</b>	<b>2013</b>
	<b>\$</b>	<b>\$</b>
<b>Patient and Resident Fees</b>		
Acute (incl rehabilitation, GEM and other acute care types)		
– Inpatients(*)	300,087	328,765
Residential Aged Care		
– Nursing Home	890,353	833,175
– Hostel	675,661	681,024
Aged Care and Primary Health		
– District Nursing	48,048	34,704
Other	129,281	109,849
<b>TOTAL PATIENT AND RESIDENT FEES</b>	<b>2,043,430</b>	<b>1,987,517</b>
<b>Capital Purpose Income:</b>		
Residential Accommodation Payments(**)	130,709	175,368
<b>TOTAL CAPITAL PURPOSE INCOME</b>	<b>130,709</b>	<b>175,368</b>

(\*) Compensable payments paid to hospitals in grants from Department (such as TAC, WIES and DVA throughput) are excluded.

(\*\*) This includes accommodation charges, interest earned on accommodation bonds and retention amount (re to Circular 13/2005).

### **Note 2c: Net Gain/(Loss) on Disposal of Non-Financial Assets**

	<b>2014</b>	<b>2013</b>
	<b>\$</b>	<b>\$</b>
<b>Proceeds from Disposals of Non-Current Assets</b>		
Motor Vehicles	107,110	40,000
Furniture and Fittings	2,072	0
<b>Total Proceeds from Disposal of Non-Current Assets</b>	<b>109,182</b>	<b>40,000</b>
<b>Less: Written Down Value of Non-Current Assets Sold</b>		
Motor Vehicles	(102,153)	(34,192)
Plant and Equipment	(4,821)	(2,443)
Furniture and Fittings	0	(242)
<b>Total Written Down Value of Non-Current Assets Sold</b>	<b>(106,974)</b>	<b>(36,877)</b>
<b>NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS</b>	<b>2,208</b>	<b>3,123</b>

**Note 3: Expenses**

	HSA 2014 \$	HSA 2013 \$	Non HSA 2014 \$	Non HSA 2013 \$	2014 \$	2013 \$
<b>Employee Expenses</b>						
Salaries & Wages	8,279,471	7,753,919	52,795	34,187	8,332,266	7,788,106
WorkCover Premium	108,520	76,365	2,386	430	110,906	76,795
Long Service Leave	198,689	188,327	3,960	11,606	202,649	199,933
Superannuation (refer note 1(u))	758,211	686,156	7,162	3,719	765,373	689,875
<b>Total Employee Expenses</b>	<b>9,344,891</b>	<b>8,704,767</b>	<b>66,303</b>	<b>49,942</b>	<b>9,411,194</b>	<b>8,754,709</b>
<b>Non Salary Labour Costs</b>						
Fee for Service Medical Officers	313,337	321,177	0	0	313,337	321,177
Purchased Services	132,638	94,832	0	0	132,638	94,832
<b>Total Non Salary Labour Costs</b>	<b>445,975</b>	<b>416,009</b>	<b>0</b>	<b>0</b>	<b>445,975</b>	<b>416,009</b>
<b>Supplies &amp; Consumables</b>						
Drug Supplies	77,978	91,519	0	0	77,978	91,519
Medical, Surgical Supplies and Prosthesis	199,879	191,936	0	0	199,879	191,936
Pathology & Radiology Supplies	60,369	56,611	0	0	60,369	56,611
Special Services	24,466	40,284	0	0	24,466	40,284
Food Supplies	333,446	346,857	601	677	334,047	347,534
<b>Total Supplies &amp; Consumables</b>	<b>696,138</b>	<b>727,207</b>	<b>601</b>	<b>677</b>	<b>696,739</b>	<b>727,884</b>
<b>Other Expenses</b>						
Domestic Services & Supplies	182,632	178,653	261	58	182,893	178,711
Fuel, Light, Power and Water	205,493	204,020	0	0	205,493	204,020
Insurance costs funded by the Department of Health						
Motor Vehicle Expenses	17,323	19,277	0	0	17,323	19,277
Repairs & Maintenance	62,052	37,745	0	9,276	62,052	47,021
Maintenance Contracts	307,699	278,160	1,144	718	308,843	278,878
Patient Transport	66,659	69,163	2,887	0	69,546	69,163
Bad & Doubtful Debts	54,418	53,316	0	0	54,418	53,316
Administrative Expenses	24	24	0	0	24	24
Loddon Mallee Rural Health Alliance	605,020	694,575	532	536	605,552	695,111
Audit Fees	278,918	281,189	0	0	278,918	281,189
- VAGO - Audit of Financial Statements	14,500	15,250	0	0	14,500	15,250
- Other	15,605	17,599	0	0	15,605	17,599
<b>Total Other Expenses</b>	<b>1,810,343</b>	<b>1,848,971</b>	<b>4,824</b>	<b>10,588</b>	<b>1,815,167</b>	<b>1,859,559</b>
<b>Impairment of Assets</b>						
Depreciation	1,509,611	1,549,161	0	0	1,509,611	1,549,161
Finance Costs	9,691	13,463	0	0	9,691	13,463
<b>Total Impairment of Assets</b>	<b>1,519,302</b>	<b>1,562,624</b>	<b>0</b>	<b>0</b>	<b>1,519,302</b>	<b>1,562,624</b>
<b>TOTAL EXPENSES</b>	<b>13,816,649</b>	<b>13,259,578</b>	<b>71,728</b>	<b>61,207</b>	<b>13,888,377</b>	<b>13,320,785</b>

**Note 3a: Analysis of Expenses by Source**

	Admitted Patients 2014	Ambulatory 2014	Residential Aged Care 2014	Primary Health 2014	Other 2014	Total 2014
	\$	\$	\$	\$	\$	\$
<b>Services Supported by Health Services Agreement</b>						
Employee Expenses	1,678,199	54,741	3,500,633	1,100,225	2,606,718	9,344,890
Non Salary Labour Costs	324,384	9,779	5,261	0	105,441	445,975
Supplies & Consumables	184,932	198	180,353	24,801	300,952	696,138
Other Expenses from Continuing Operations	259,906	321	249,735	16,534	1,195,846	1,810,344
Depreciation (refer Note 4)	0	0	0	0	1,509,611	1,509,611
Finance Costs (refer Note 5)	0	0	0	0	9,691	9,691
<b>Total Expenses from Services Supported by Health Services Agreement</b>	<b>2,447,421</b>	<b>65,039</b>	<b>3,935,982</b>	<b>1,214,138</b>	<b>5,728,259</b>	<b>13,816,649</b>
<b>Services Supported by Hospital and Community Initiatives</b>						
Employee Expenses	0	0	0	0	66,303	66,303
Non Salary Labour Costs	0	0	0	0	0	0
Supplies & Consumables	0	0	0	0	601	601
Other Expenses from Continuing Operations	0	0	0	0	4,824	4,824
<b>Total Expenses from Services Supported by Hospital and Community Initiatives</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>71,728</b>	<b>71,728</b>
<b>Total Expenses</b>	<b>2,447,421</b>	<b>65,039</b>	<b>3,935,982</b>	<b>1,214,138</b>	<b>5,799,987</b>	<b>13,888,377</b>
<b>Services Supported by Health Services Agreement</b>						
Employee Expenses	1,557,459	126,368	3,146,322	921,618	2,554,901	8,704,767
Non Salary Labour Costs	341,520	9,026	60,176	27,120	1,337	443,129
Supplies & Consumables	215,915	0	102,595	4,344	374,796	727,207
Other Expenses from Continuing Operations	197,125	58,058	149,589	37,338	1,322,860	1,821,851
Depreciation (refer Note 4)	0	0	0	0	1,549,161	1,549,161
Finance Costs (refer Note 5)	0	0	0	1,731	4,876	13,463
<b>Total Expenses from Services Supported by Health Services Agreement</b>	<b>2,312,019</b>	<b>193,452</b>	<b>3,458,682</b>	<b>1,018,862</b>	<b>5,807,931</b>	<b>13,259,578</b>
<b>Services Supported by Hospital and Community Initiatives</b>						
Employee Expenses	0	0	0	0	49,942	49,942
Non Salary Labour Costs	0	0	0	0	0	0
Supplies & Consumables	0	0	0	0	677	677
Other Expenses from Continuing Operations	0	0	0	0	10,588	10,588
<b>Total Expenses from Services Supported by Hospital and Community Initiatives</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>61,207</b>	<b>61,207</b>
<b>Total Expenses</b>	<b>2,312,019</b>	<b>193,452</b>	<b>3,458,682</b>	<b>1,018,862</b>	<b>5,869,138</b>	<b>13,320,785</b>

**Note 3b: Analysis of expenses by internally managed and restricted specific purpose funds for services supported by hospital and community initiatives**

	<b>2014</b>	<b>2013</b>
	<b>\$</b>	<b>\$</b>
<b>Commercial Activities</b>		
Radiology	56,687	56,210
Meals on Wheels	46,396	91,802
Cafeteria	77,800	91,294
Primary Care Partnership	221,121	264,766
<b>TOTAL</b>	<b>402,004</b>	<b>504,072</b>

**Note 4: Depreciation**

	<b>2014</b>	<b>2013</b>
	<b>\$</b>	<b>\$</b>
Buildings	997,697	985,106
Land Improvements	16,000	16,000
Plant and Equipment	323,186	342,032
Motor Vehicles	88,937	127,716
Furniture and Fittings	66,123	61,820
Computer and Communications	11,789	11,380
Loddon Mallee Rural Health Alliance	5,879	5,107
<b>TOTAL DEPRECIATION</b>	<b>1,509,611</b>	<b>1,549,161</b>

**Note 5: Finance Costs**

	<b>2014</b>	<b>2013</b>
	<b>\$</b>	<b>\$</b>
Finance charges on Hire		
Purchase Liabilities	9,691	13,463
<b>TOTAL FINANCE COSTS</b>	<b>9,691</b>	<b>13,463</b>

**Note 6: Cash and Cash Equivalents**

For the purposes of the Cash Flow Statement, cash assets includes cash on hand and in banks, and short-term deposits which are readily convertible to cash on hand, and are subject to an insignificant risk of change in value, net of outstanding bank overdrafts.

	<b>2014</b>	<b>2013</b>
	<b>\$</b>	<b>\$</b>
Cash on Hand	670	650
Cash at Bank	2,810,844	1,516,114
<b>TOTAL CASH AND CASH EQUIVALENTS</b>	<b>2,811,514</b>	<b>1,516,764</b>
<b>Represented by:</b>		
Cash for Health Service Operations (as per Cash Flow Statement)	2,569,087	1,333,362
Cash for Monies Held in Trust		
- Deposits at Call	7,382	3,416
- Resident Trust Account	27,231	27,020
Cash Held for Loddon Mallee Rural Health Alliance	207,814	152,966
<b>TOTAL CASH AND CASH EQUIVALENTS</b>	<b>2,811,514</b>	<b>1,516,764</b>

**Note 7: Receivables**

	<b>2014</b>	<b>2013</b>
	<b>\$</b>	<b>\$</b>
<b>CURRENT</b>		
<b>Contractual</b>		
Inter Hospital Debtors		
Trade Debtors	276,695	150,201
Patient Fees	20,460	84,219
Accrued Investment Income	14,339	71,372
Accrued Revenue - Other	40,469	15,806
Loddon Mallee Rural Health Alliance Receivables	2,900	80,207
LESS Allowance for Doubtful Debts Patient Fees	(1,721)	(14,000)
LESS Allowance for Doubtful Debts LMRHA	(700)	(153)
	<b>352,442</b>	<b>387,652</b>
<b>Statutory</b>		
Accrued Revenue - Department of Health	53,030	-
FBT Credit	5,780	-
GST Receivable	252,030	380,666
Loddon Mallee Rural Health Alliance GST Receivable	4,195	3,310
	<b>315,035</b>	<b>383,976</b>
<b>TOTAL CURRENT RECEIVABLES</b>	<b>667,477</b>	<b>771,628</b>
<b>NON CURRENT</b>		
<b>Contractual</b>		
Bond Debtors	1,644	1,644
	<b>1,644</b>	<b>1,644</b>
<b>Statutory</b>		
Long Service Leave - DoH	295,032	388,967
	<b>295,032</b>	<b>388,967</b>
<b>TOTAL NON-CURRENT RECEIVABLES</b>	<b>296,676</b>	<b>390,611</b>
<b>TOTAL RECEIVABLES</b>	<b>964,153</b>	<b>1,162,239</b>

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

	<b>2014</b>	<b>2013</b>
	<b>\$</b>	<b>\$</b>
Balance at the beginning of year - REDHS	14,000	14,000
Balance at the beginning of year - LMRHA	312	312
Increase/(decrease) in allowance recognised in net result	(11,891)	(159)
<b>Balance at end of year</b>	<b>2,421</b>	<b>14,153</b>

**(b) Ageing analysis of receivables**

Please refer to note 19(b) for the ageing analysis of contractual receivables.

**(c) Nature and extent of risk arising from receivables**

Please refer to note 19(b) for the nature and extent of credit risk arising from contractual receivables.

## Note 8: Investments and Other Financial Assets

### CURRENT

#### Term Deposit

Aust. Dollar Term Deposits(i)

#### TOTAL CURRENT

	Capital		Total	
	2014	2013	2014	2013
	\$	\$	\$	\$
	3,475,237	6,056,145	3,475,237	6,056,145
<b>TOTAL CURRENT</b>	<b>3,475,237</b>	<b>6,056,145</b>	<b>3,475,237</b>	<b>6,056,145</b>

#### Represented by:

Health Services Investments

Accommodation Bonds (Refundable Entrance Fees)

Term Deposits

#### TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS

	1,058,982	1,152,803	1,058,982	1,152,803
	2,415,499	2,230,230	2,415,499	2,230,230
	756	2,673,112	756	2,673,112
<b>TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS</b>	<b>3,475,237</b>	<b>6,056,145</b>	<b>3,475,237</b>	<b>6,056,145</b>

Notes:

(i) Term deposits under 'investment and other financial assets' class include only term deposits with maturity greater than 90 days.

#### (a) Ageing analysis of other financial assets

Please refer to note 19(b) for the ageing analysis of investments and other financial assets.

#### (b) Nature and extent of risk arising from other financial assets

Please refer to note 19(b) for the nature and extent of credit risk arising from investments and other financial assets.

## Note 9: Inventories

### CURRENT

Pharmaceuticals - at cost

Catering Supplies - at cost

Housekeeping - at cost

Medical and Surgical Lines - at cost

Administration Stores - at cost

#### TOTAL INVENTORIES

	2014	2013
	\$	\$
	12,171	12,748
	16,961	8,508
	6,309	12,273
	22,425	19,612
	4,650	4,321
<b>TOTAL INVENTORIES</b>	<b>62,516</b>	<b>57,462</b>

**Note 10: Other Assets****Current:**

Prepayments

Loddon Mallee Rural Health Alliance

**TOTAL OTHER ASSETS**

<b>2014</b>	<b>2013</b>
<b>\$</b>	<b>\$</b>
98,078	15,262
7,186	7,183
<b>105,264</b>	<b>22,445</b>

**Note 11: Property, Plant and Equipment****(a) Gross carrying amount and accumulated depreciation****Land**

- Land at Fair Value

- Landscaping at Fair Value

Less Accumulated Depreciation

**Total Land**

<b>2014</b>	<b>2013</b>
<b>\$</b>	<b>\$</b>
382,000	439,000
257,000	320,000
-	(64,000)
<b>639,000</b>	<b>695,000</b>

**Buildings**

- Buildings at Fair Value

**Total Buildings**

36,325,000	24,888,041
<b>36,325,000</b>	<b>24,888,041</b>

**Plant and Equipment**

- Plant and Equipment at Fair Value

Less Accumulated Depreciation

- Loddon Mallee Rural Health Alliance Equipment at Fair Value

Less Accumulated Depreciation

**Total Plant and Equipment**

2,867,929	3,037,625
(2,170,296)	(2,000,081)
36,343	27,558
(17,985)	(23,150)
<b>715,991</b>	<b>1,041,952</b>

**Computers and Communication**

- Computers and Communication at Fair Value

Less Accumulated Depreciation

**Total Computers and Communications**

53,010	39,880
(11,789)	(11,380)
<b>41,221</b>	<b>28,500</b>

**Furniture and Fittings**

- Furniture and Fittings at Fair Value

Less Accumulated Depreciation

**Total Furniture and Fittings**

625,933	654,560
(336,807)	(380,228)
<b>289,126</b>	<b>274,332</b>

**Motor Vehicles**

- Motor Vehicles at Fair Value

Less Accumulated Depreciation

**Total Motor Vehicles**

530,538	537,137
(244,080)	(260,249)
<b>286,458</b>	<b>276,888</b>

**Under Construction**

- Work in Progress

**Total Assets under construction**

-	169,811
<b>0</b>	<b>169,811</b>

**TOTAL**

<b>38,296,796</b>	<b>27,374,524</b>
-------------------	-------------------

**Note 11: Property, Plant and Equipment (Continued)**

Reconciliations of the carrying amounts of each class of asset at the beginning and end of the previous and current financial year is set out below.

	Land	Buildings	Plant & Equipment	Furniture & Fittings	Computer Equip	Motor Vehicles	Under Construction	Total
	\$	\$	\$	\$	\$	\$	\$	\$
<b>Balance at 1 July 2012</b>	711,000	23,530,650	1,289,517	304,155	39,880	317,799	0	26,193,001
Additions	0	0	96,451	32,240	0	120,996	169,811	419,498
Revaluation Increments	0	2,342,497	0	0	0	0	0	2,342,497
Loddon Mallee Rural Health Alliance	0	0	5,566	0	0	0	0	5,566
Disposals	0	0	(2,443)	(243)	0	(34,191)	0	(36,877)
Depreciation (see Note 4)	(16,000)	(985,106)	(347,139)	(61,820)	(11,380)	(127,716)	0	(1,549,161)
<b>Balance at 1 July 2013</b>	695,000	24,888,041	1,041,952	274,332	28,500	276,888	169,811	27,374,524
Additions	0	12,950	59,871	127,347	24,510	200,660	476,706	902,044
Transfers In/(out)	0	763,251	(70,304)	(46,430)	0	0	(646,517)	0
Revaluation increments	(40,000)	11,658,455	0	0	0	0	0	11,618,455
Loddon Mallee Rural Health Alliance	0	0	18,358	0	0	0	0	18,358
Disposals	0	0	(4,821)	0	0	(102,153)	0	(106,974)
Depreciation (see Note 4)	(16,000)	(997,697)	(329,065)	(66,123)	(11,789)	(88,937)	0	(1,509,611)
<b>Balance at 30 June 2014</b>	639,000	36,325,000	715,991	289,126	41,221	286,458	0	38,296,796

**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.

Fair value of plant and equipment has been assessed by management in accordance with Financial Reporting Direction 103E. Management have obtained second-hand values for equipment where possible, or completed an assessment of value based on depreciated replacement cost.

## Note 11: Property, plant & equipment (continued)

### (c) Fair value measurement hierarchy for assets as at 30 June 2014

	Carrying amount as at 30 June 2014	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>140,200</b>	<b>241,800</b>
<b>Buildings at fair value</b>				
Non-specialised buildings	1,529,000		1,529,000	
Specialised buildings	34,796,000			34,796,000
<b>Total of building at fair value</b>	<b>36,325,000</b>		<b>1,529,000</b>	<b>34,796,000</b>
<b>Land Improvements at fair value</b>				
Specialised land improvements	257,000			257,000
<b>Total of land improvements at fair value</b>	<b>257,000</b>			<b>257,000</b>
<b>Plant and Equipment at fair value</b>				
Plant and Equipment	715,991			715,991
<b>Total of plant and equipment at fair value</b>	<b>715,991</b>			<b>715,991</b>
<b>Computer and Communication at fair value</b>				
Computers and Communication	41,221			41,221
<b>Total Computer and communication at fair value</b>	<b>41,221</b>			<b>41,221</b>
<b>Furniture and Fittings at fair value</b>				
Furniture and Fittings	289,126			289,126
<b>Total Furniture and Fittings at fair value</b>	<b>289,126</b>			<b>289,126</b>
<b>Motor Vehicles at fair value</b>				
Motor Vehicles	286,458			286,458
<b>Total Motor Vehicles at fair value</b>	<b>286,458</b>			<b>286,458</b>
	<b>38,296,796</b>	<b>-</b>	<b>1,669,200</b>	<b>36,627,596</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 11: Property, plant & equipment (continued)**

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

Non-specialised land, non-specialised buildings and artworks 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.

To the extent that non-specialised land and non-specialised buildings do not contain significant, unobservable adjustments, these assets are classified as Level 2 under the market approach.

**Specialised land , specialised buildings and specialised land improvements**

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 services, 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.

**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).

**Other Non-Financial Assets - Plant & Machinery, Medical Equipment, Furniture & Fitting, Computers & Communication, Non-Medical Equipment**

Other non-financial assets are held at carrying value (depreciated cost). When other non-financial assets are 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 value.

There were no changes in valuation techniques throughout the period to 30 June 2014.

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

**(d) Reconciliation of Level 3 fair value**

	Land	Buildings	Land Improvements	Plant and Equipment	Computers & Communication	Furniture & Fittings	Motor Vehicles	Assets under construction
Opening Balance	276,570	23,892,519	320,000	1,041,952	28,500	274,332	276,888	169,811
Purchases (sales)	-	-		(12,752)	24,510	83,032	114,292	(169,811)
Transfers in (out) of Level 3	-	-						
Gains or losses recognised in net result								
- Depreciation	-	-		(313,210)	(11,789)	(68,238)	(104,721)	-
- Impairment loss	-	-	-	-	-	-	-	-
Subtotal	276,570	23,892,519	320,000	715,990	41,221	289,126	286,459	-
Items recognised in other comprehensive income								
- Revaluation	(34,770)	10,903,481	(63,000)	-	-	-	-	-
Subtotal	(34,770)	10,903,481	(63,000)	-	-	-	-	-
Closing Balance	241,800	34,796,000	257,000	715,990	41,221	289,126	286,459	-
Unrealised gains/(losses) on non-financial assets	-	-	-	-	-	-	-	-
	241,800	34,796,000	257,000	715,990	41,221	289,126	286,459	-

*Note*

There have been no transfers between levels during the period.

# **Note 11: Property, plant & equipment (continued)**

## **(e) Description of significant unobservable inputs to Level 3 valuations:**

	Valuation technique <sup>(i)</sup>	Significant unobservable inputs <sup>(i)</sup>	Range (weighted average) <sup>(i)</sup>	Sensitivity of fair value measurement to changes in significant unobservable inputs
<b>Specialised land</b>	Market approach	Community Service Obligation (CSO) adjustment	20% (ii)	A significant increase or decrease in the CSO adjustment would result in a significantly lower (higher) fair value
<b>Specialised buildings</b>	Depreciated replacement cost	Direct cost per square metre  Useful life of specialised buildings	\$808 - \$1967/m2 (\$1739)  1 - 50 years (45 years)	A significant increase or decrease in direct cost per square meter adjustment would result in a significantly higher or lower fair value  A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
<b>Landscaping &amp; Grounds</b>	Depreciated replacement cost	Direct replacement cost  Useful life of Landscaping & Grounds	\$1,000-\$257,000  1 - 50 years (45 years)	A significant increase or decrease in direct cost would result in a significantly higher or lower fair value  A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
<b>Plant &amp; Equipment</b>	Depreciated replacement cost	Cost per unit  Useful life of PPE	\$175 -\$158,584 (\$87,707)  3-10 years (7 years)	A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value  A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
<b>Motor Vehicles</b>	Depreciated replacement cost	Cost per unit  Useful life of vehicles	\$1,646-\$87,686 (\$43,091)  2 - 10 years (3 years)	A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value  A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
<b>Computers and Communication</b>	Depreciated replacement cost	Cost per unit  Useful life of furniture & fittings	\$1,022 - \$8,250 (\$4,966)  2 - 5 years (3 years)	A significant increase or decrease in direct cost per unit meter adjustment would result in a significantly higher or lower fair value  A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
<b>Furniture &amp; Fittings at fair value</b>	Depreciated replacement cost	Cost per unit  Useful life of furniture & fittings	\$1,000 - \$56,041 (\$22,576)  2-20 years (9 years)	A significant increase or decrease in direct cost per unit meter adjustment would result in a significantly higher or lower fair value  A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.

(i) [Illustrations on the valuation techniques, significant unobservable inputs and the related quantitative range of those inputs are indicative and should not be directly used without consultation with entities' independent valuer.]

(ii) CSO adjustments of 20% were applied to reduce the market approach value for the specialised land.

**Note 12: Payables**

	<b>2014</b>	<b>2013</b>
	<b>\$</b>	<b>\$</b>
<b>CURRENT</b>		
<b>Contractual</b>		
Trade Creditors	260,484	648,899
Accrued Expenses	87,339	31,508
Accrued Audit Fees	11,719	15,250
Other Payable - Social Club/OffLine S & W	10,408	8,325
Loddon Mallee Rural Health Alliance Payables	30,651	21,391
	<b>400,601</b>	<b>725,373</b>
<b>Statutory</b>		
GST Payable	207,414	316,217
PAYG Payable	104,385	191,480
<b>TOTAL CURRENT</b>	<b>311,799</b>	<b>507,697</b>
<b>TOTAL PAYABLES</b>	<b>712,400</b>	<b>1,233,070</b>

**(a) Maturity analysis of payables**

Please refer to Note 19(c) for the ageing analysis of contractual payables.

**(b) Nature and extent of risk arising from payables**

Please refer to note 19(c) for the nature and extent of risks arising from contractual payables.

**Note 13: Borrowings**

	<b>2014</b>	<b>2013</b>
	<b>\$</b>	<b>\$</b>
<b>CURRENT</b>		
Australian Dollar Borrowings		
– Hire Purchase Liability (refer Note 19)	132,679	108,780
<b>Total Current Australian Dollars Borrowings</b>	<b>132,679</b>	<b>108,780</b>
<b>NON CURRENT</b>		
Australian Dollar Borrowings		
– Hire Purchase Liability (refer Note 19)	-	68,289
<b>Total Non-Current Australian Dollars Borrowings</b>	<b>-</b>	<b>68,289</b>
<b>TOTAL BORROWINGS</b>	<b>132,679</b>	<b>177,069</b>

Borrowings are secured by motor vehicles to which the agreements relate. Eight hire purchase agreements exist with terms of up to 24 monthly payments followed by a balloon payment. Interest rates vary between 5.2% and 5.5%.

The approved Bank Overdraft limit is \$150,000.

Finance costs of the Health Service incurred during the year are accounted for as follows:

Amount of Finance Costs recognised as expenses (see Note 5)	9,691	13,463
---	-------	--------

**(a) Maturity analysis of interest bearing liabilities**

Please refer to not 19(c) for the ageing analysis of interest bearing liabilities.

**(b) Nature and extent of risk arising from interest bearing liabilities**

Please refer to note 19(c) for the nature and extent of risks arising from interest bearing liabilities.

**(c) Defaults and breaches**

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

**Note 14: Provisions**

	2014 \$	2013 \$
<b>CURRENT PROVISIONS</b>		
Employee Benefits (Note 19(a))		
Annual Leave (Note 19(a))		
- Unconditional and expected to be settled within 12 months (ii)	521,612	523,324
- Unconditional and expected to be settled after 12 months (ii)	196,550	197,905
Long Service Leave (Note 19(a))		
- Unconditional and expected to be settled within 12 months (ii)	527,050	502,068
- Unconditional and expected to be settled after 12 months (ii)	740,937	699,143
Provisions related to employee benefit on-costs		
- Unconditional and expected to be settled within 12 months (ii)	57,863	74,410
- Unconditional and expected to be settled after 12 months (ii)	21,804	13,131
<b>TOTAL CURRENT PROVISIONS</b>	<b>2,065,816</b>	<b>2,009,981</b>
<b>NON-CURRENT PROVISIONS</b>		
Employee Benefits (i) (Note 19(a))	406,318	409,907
Provisions related to employee benefits on-costs (Note 19(a) and 19(b))	-	16,674
<b>TOTAL NON-CURRENT PROVISIONS</b>	<b>406,318</b>	<b>426,581</b>
<b>TOTAL PROVISIONS</b>	<b>2,472,134</b>	<b>2,436,562</b>
<b>(a) Employee Benefits and Related On-Costs</b>		
<b>CURRENT EMPLOYEE BENEFITS AND RELATED ON-COSTS</b>		
Annual Leave Entitlements	718,162	715,141
Accrued Wages and Salaries	279,791	174,236
Accrued Days Off	13,061	15,787
Unconditional Long Service Leave Entitlements	973,698	1,017,276
<b>NON-CURRENT EMPLOYEE BENEFITS AND RELATED ON-COSTS</b>		
Conditional Long Service Leave Entitlements (iii)	406,318	409,907
Current On-Costs	59,300	87,541
Non-Current On-Costs	21,804	16,674
<b>TOTAL EMPLOYEE BENEFITS AND RELATED ON-COSTS</b>	<b>2,472,134</b>	<b>2,436,562</b>
<b>(b) Movements in Provisions</b>		
<b>Movement in Long Service Leave:</b>		
Balance at start of year	1,427,183	1,326,602
Provision made during the year	140,299	191,876
Settlement made during the year	(187,466)	(91,295)
<b>Balance at end of year</b>	<b>1,380,016</b>	<b>1,427,183</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.

(iii) The provision for onerous lease contracts represents the present value of the future lease payments that the Health Service is presently obligated to make in respect of onerous lease contracts under non-cancellable operating lease agreements, less income expected to be earned on the lease including estimated future sub-lease income, where applicable. The estimate may vary as a result of changes in utilisation of the leased premises and sub lease arrangements where applicable. The unexpired term of the leases range from 3 to 5 years.

**Note 15: Superannuation**

Employees of the Health Service are entitled to receive superannuation benefits and the Health Services contributes to both defined benefit and defined contribution plans. The defined benefit plan(s) provides benefits based on years of service and final average salary.

The Health Service does not recognise any defined benefit liability in respect of the plan(s) because the entity 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 the Health Service. The name, details and amounts expense in relation to the major employee superannuation funds and contributions made by the Health Service are as follows:

	2014 \$	2013 \$
<b>Defined benefit plans:</b>		
Health Super	3,173	15,348
<b>Defined Contribution plans:</b>		
Health Super	634,245	608,705
Hesta	127,955	86,837
<b>TOTAL</b>	<b>765,373</b>	<b>710,890</b>

**Note 16: Other Current Liabilities**

	2014 \$	2013 \$
<b>CURRENT</b>		
Monies Held in Trust*		
- Patient Monies Held in Trust	27,231	27,020
- Accommodation Bonds (Refundable Entrance Fees)	2,415,499	2,883,374
Rochester Community House	7,382	3,416
<b>TOTAL CURRENT</b>	<b>2,450,112</b>	<b>2,913,810</b>
<b>* Total Monies Held in Trust</b>		
<b>Represented by the following assets:</b>		
Cash Assets (refer to Note 6)	27,231	27,020
Receivables (refer to Note 7)	1,644	1,644
Other Financial Assets (refer to Note 8)	1,762,355	2,230,230
Land and Buildings	651,500	651,500
Rochester Community House	7,382	3,416
<b>TOTAL</b>	<b>2,450,112</b>	<b>2,913,810</b>

**Note 17: Equity****(a) Surpluses****Property, Plant and Equipment Revaluation Surplus**

Balance at the beginning of the reporting period

- Land	253,325	253,325
- Buildings	6,181,246	3,838,749

**Revaluation Increment/Decrement**

- Land	(57,000)	0
- Buildings	11,675,455	2,342,497

**Balance at the end of the reporting period****18,053,026 6,434,571****Balance at the end of the reporting period\*****\* Represented by:**

- Land	196,325	253,325
- Buildings	17,856,701	6,181,246
	<b>18,053,026</b>	<b>6,434,571</b>

**Restricted Specific Purpose Surplus**

Balance at the beginning of the reporting period

1,038,631 977,016

Transfer to and from Restricted Purpose Surplus

(216,581) 61,615

Bequests

0 0

**Balance at the end of the reporting period****822,050 1,038,631****TOTAL SURPLUSES****18,875,076 7,473,202****(b) Contributed Capital**

Balance at the beginning of the reporting period

7,369,839 7,369,839

Capital Contribution received from Victorian Government

0 0

**Balance at the end of the reporting period****7,369,839 7,369,839****(c) Accumulated Surpluses/(Deficits)**

Balance at the beginning of the reporting period

14,586,027 15,245,120

Net Result for the year

(1,099,368) (597,478)

Transfer to and from Restricted Purpose Surplus

216,581 (61,615)

**Balance at the end of the reporting period****13,703,240 14,586,027****TOTAL EQUITY AT END OF FINANCIAL YEAR****39,948,155 29,429,068****Note 18: Reconciliation of the net result for the year to net cash flow used in operating activities****Net result for the period**

2014	2013
\$	\$
(1,099,368)	(597,478)

**Non-cash movements:**

Depreciation

1,509,611 1,549,161

Share of Net Result from Ventures

(21,873) (4,577)

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

Net (Gain)/Loss from Sale of Motor Vehicles

(2,208) (3,123)

**Movements in assets and liabilities:**

Change in operating assets and liabilities

(Increase)/Decrease in Receivables 195,730 (287,956)

(Increase)/Decrease in Prepayments (82,819) (9,715)

Change in Inventories (5,054) 6,235

Increase/(Decrease) in Payables (514,345) 703,781

Increase/(Decrease) in Provisions 35,572 12,840

**NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES****15,246 1,369,168**

## Note 19: Financial Instruments

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

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)
- Finance Lease Payables
- Accommodation Bonds

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.

### 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/liabilities designated at fair value through profit/loss \$'000	Contractual financial assets/liabilities held-for-trading at fair value through profit/loss \$'000	Contractual financial assets - loans and receivables \$'000	Contractual financial assets - available for sale \$'000	Contractual financial liabilities at amortised cost \$'000	Total \$'000
<b>2014</b>						
<b>Contractual Financial Assets</b>						
Cash and cash equivalents	-	-	2,811,514	-	-	2,811,514
Receivables	-	-	-	-	-	-
- Trade Debtors	-	-	297,155	-	-	297,155
- Other Receivables	-	-	54,808	-	-	54,808
Other Financial Assets	-	-	-	-	-	-
- Term Deposit	-	-	3,475,237	-	-	3,475,237
- Shares in Other Entities	-	-	-	-	-	-
<b>Total Financial Assets <sup>(i)</sup></b>	-	-	<b>6,638,714</b>	-	-	<b>6,638,714</b>
<b>Financial Liabilities</b>						
Payables	-	-	-	-	358,231	358,231
Other Financial Liabilities	-	-	-	-	-	-
- Accommodation bonds	-	-	-	-	2,415,499	2,415,499
- Other	-	-	-	-	132,679	132,679
<b>Total Financial Liabilities <sup>(ii)</sup></b>	-	-	-	-	<b>2,906,409</b>	<b>2,906,409</b>
<b>2013</b>						
<b>Contractual Financial Assets</b>						
Cash and cash equivalents	-	-	1,516,764	-	-	1,516,764
Receivables	-	-	-	-	-	-
- Trade Debtors	-	-	234,420	-	-	234,420
- Other Receivables	-	-	87,178	-	-	87,178
Other Financial Assets	-	-	-	-	-	-
- Term Deposit	-	-	6,056,145	-	-	6,056,145
- Shares in Other Entities	-	-	-	-	-	-
<b>Total Financial Assets <sup>(i)</sup></b>	-	-	<b>7,894,507</b>	-	-	<b>7,894,507</b>
<b>Financial Liabilities</b>						
Payables	-	-	-	-	688,732	688,732
Other Financial Liabilities	-	-	-	-	-	-
- Accommodation bonds	-	-	-	-	2,534,238	2,534,238
- Other	-	-	-	-	177,069	177,069
<b>Total Financial Liabilities <sup>(ii)</sup></b>	-	-	-	-	<b>3,400,039</b>	<b>3,400,039</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

**Note 19: Financial Instruments (continued)**

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

	Net holding gain/(loss) \$'000	Total interest income / (expense) \$'000	Fee income / (expense) \$'000	Impairment loss \$'000	Total \$'000
<b>2014</b>					
<b>Financial Assets</b>					
Cash and Cash Equivalents	0	124,120	0	0	0
Designated at Fair Value through Profit or Loss	0	0	0	0	0
Held-for-Trading at Fair Value through Profit or Loss	0	0	0	0	0
Loans and Receivables	0	0	0	0	0
Available for Sale	0	0	0	0	0
<b>Total Financial Assets</b>	<b>0</b>	<b>124,120</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Financial Liabilities</b>					
Designated at Fair Value through Profit or Loss	0	0	0	0	0
Held-for-Trading at Fair Value through Profit or Loss	0	0	0	0	0
At Amortised Cost	0	0	0	0	0
<b>Total Financial Liabilities</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>2013</b>					
<b>Financial Assets</b>					
Cash and Cash Equivalents	0	125,356	0	0	0
Designated at Fair Value through Profit or Loss	0	0	0	0	0
Held-for-Trading at Fair Value through Profit or Loss	0	0	0	0	0
Loans and Receivables	0	0	0	0	0
Available for Sale	0	0	0	0	0
<b>Total Financial Assets</b>	<b>0</b>	<b>125,356</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Financial Liabilities</b>					
Designated at Fair Value through Profit or Loss	0	0	0	0	0
Held-for-Trading at Fair Value through Profit or Loss	0	0	0	0	0
At Amortised Cost	0	0	0	0	0
<b>Total Financial Liabilities</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

**(b) Credit Risk**

Credit risk arises from contractual financial assets of the Health Service, which comprise cash and deposits, non-statutory receivables and available for sale contractual financial assets. The Health Service's exposure to credit risk arises from the potential default of a counter party on their contractual obligations resulting in financial loss to the Health Service. Credit risk is measured at fair value and is monitored on a regular basis.

Credit risk associated with the Health Service's contractual financial assets is minimal because the main debtor is the Victorian Government. For debtors other than the Government, it is the Health Service's policy to only deal with entities with high credit ratings of a minimum Triple-B rating and to obtain sufficient collateral or credit enhancements, where appropriate.

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

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

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

**Ageing analysis of Financial Assets as at 30 June 2014**

	Total Carrying Amount \$	Not Past Due and Not Impaired \$	Past Due But Not Impaired				Impaired Financial Assets \$
			Less than 1 Month \$	1 to 3 Months \$	3 months to 1 Year \$	1 to 5 Years \$	
<b>2014</b>							
<b>Financial Assets</b>							
Cash & Cash Equivalents	2,811,514	2,811,514	0	0	0	0	0
Receivables							
- Trade Debtors	297,155	190,464	94,805	11,886	0	0	0
- Other Receivables	54,808	54,808	0	0	0	0	0
Other Financial Assets							
-Term Deposit	3,475,237	3,475,237	0	0	0	0	0
<b>Total Financial Assets</b>	<b>6,638,714</b>	<b>6,532,023</b>	<b>94,805</b>	<b>11,886</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>2013</b>							
<b>Financial Assets</b>							
Cash & Cash Equivalents	1,516,764	1,516,764	0	0	0	0	0
Receivables							
- Trade Debtors	234,420	127,200	97,833	9,387	0	0	0
- Other Receivables	87,178	87,178	0	0	0	0	0
Other Financial Assets							
- Term Deposit	6,056,145	6,056,145	0	0	0	0	0
<b>Total Financial Assets</b>	<b>7,894,507</b>	<b>7,787,287</b>	<b>97,833</b>	<b>9,387</b>	<b>0</b>	<b>0</b>	<b>0</b>

## Note 19: Financial Instruments (continued)

### (c) Liquidity Risk

Liquidity risk is the risk that the Health Service would be unable to meet its financial obligations as and when they fall due. The Health Service operates under the Government's fair payments policy of settling financial obligations within 30 days and in the event of a dispute, making payments within 30 days from the date of resolution.

The Health Service's maximum exposure of liquidity risk is carrying amounts of financial liabilities as disclosed in the face of the balance sheet. The Health Service manages its liquidity risk as follows:

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

#### Maturity analysis of financial liabilities as at 30 June

	Carrying Amount \$	Nominal Amount \$	Less than 1 Month \$	1 to 3 Months \$	3 months to 1 Year \$	1 to 5 Years \$
<b>2014</b>						
<b>Financial Liabilities</b>						
Payables	358,231	358,231	358,231	0	0	0
Borrowings Note 13	132,679	132,679	3,052	9,239	120,388	0
Other Financial Liabilities(i)						
- Monies Held in Trust Note 16	2,415,499	2,415,499	25,150	4,516	2,385,833	0
<b>Total Financial Liabilities</b>	<b>2,906,409</b>	<b>2,906,409</b>	<b>386,433</b>	<b>13,755</b>	<b>2,506,221</b>	<b>0</b>
<b>2013</b>						
<b>Financial Liabilities</b>						
Trade Creditors & Accruals	688,732	688,732	688,732	0	0	0
Borrowings Note 13	177,069	177,069	19,857	8,403	80,520	68,289
Other Financial Liabilities(i)						
- Monies Held in Trust	2,913,810	2,913,810	27,020	3,416	2,883,374	0
<b>Total Financial Liabilities</b>	<b>3,779,611</b>	<b>3,779,611</b>	<b>735,609</b>	<b>11,819</b>	<b>2,963,894</b>	<b>68,289</b>

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

### (d) Market Risk

Rochester and Elmore District Health Service's exposures to market risk are primarily through interest rate risk with only insignificant exposure to foreign currency and other price risks. Objectives, policies and processes used to manage these risks are disclosed below.

#### Currency Risk

Rochester and Elmore District Health Service is exposed to insignificant foreign currency risk through its payables relating to purchases of supplies and consumables from overseas. This is because of a limited amount of purchases denominated in foreign currencies and a short timeframe between commitments and settlement.

#### Interest Rate Risk

Exposure to interest rate risk might arise primarily through the Rochester and Elmore District Health Services' other financial assets. Minimisation of risk is achieved by mainly holding fixed rate or non-interest bearing financial instruments. For financial liabilities, the Hospital mainly holds financial assets with relatively even maturity profiles.

Cash flow interest rate risk is the risk that the future cash flows of a financial instrument will fluctuate because of changes in market interest rates.

The Health Service has minimal exposure to cash flow interest rate risks through its cash and deposits, term deposits and bank overdrafts that are at floating rates.

The Health Service manages this risk by mainly undertaking fixed rate or non-interest bearing financial instruments with relatively even maturity profiles, with only insignificant amounts of financial instruments at floating rate. Management has concluded for cash at bank and bank overdraft, as financial assets that can be left at floating rate without necessarily exposing the Health Service to significant bad risk, management monitors movement in interest rates on a daily basis.

#### Interest rate exposure of Financial Assets and Liabilities as at 30 June

	*Weighted Average Effective Interest Rates	Carrying Amount	Interest Rate Exposure		
	Rates (%)	\$	Fixed Interest Rate	Variable Interest Rate	Non Interest Bearing
			\$	\$	\$
<b>2014</b>					
<b>Financial Assets</b>					
Cash & Cash Equivalents	2.25	2,811,514	0	2,811,514	0
Receivables(i)					
- Trade Debtors		297,155	0	0	297,155
- Other Receivables		54,808	0	0	54,808
Other Financial Assets					
- Term Deposits	3.45	3,475,237	3,475,237	0	0
<b>Total Financial Assets</b>		<b>6,638,714</b>	<b>3,475,237</b>	<b>2,811,514</b>	<b>351,963</b>
<b>Financial Liabilities</b>					
Payables(i)		358,231	0	0	358,231
Borrowings	5.38	132,679	132,679	0	0
Other Financial Liabilities					
- Monies Held in Trust		2,415,499	0	0	2,415,499
<b>Total Financial Liabilities</b>		<b>2,906,409</b>	<b>132,679</b>	<b>0</b>	<b>2,773,730</b>
<b>2013</b>					
<b>Financial Assets</b>					
Cash & Cash Equivalents	3.38	1,516,764	0	1,516,114	0
Receivables(i)					
- Trade Debtors		234,420	0	0	234,420
- Other Receivables		87,178	0	0	87,178
Other Financial Assets					
- Term Deposits	4.10	6,056,145	6,056,145	0	0
<b>Total Financial Assets</b>		<b>7,894,507</b>	<b>6,056,145</b>	<b>1,516,114</b>	<b>321,598</b>
<b>Financial Liabilities</b>					
Payables(i)		688,732	0	0	688,732
Borrowings	5.96	177,069	177,069	0	0
Other Financial Liabilities					
- Monies Held in Trust		2,913,810	0	0	2,913,810
<b>Total Financial Liabilities</b>		<b>3,779,611</b>	<b>177,069</b>	<b>0</b>	<b>3,602,542</b>

(i) The carrying amount must exclude types of statutory financial assets and liabilities (ie GST input tax credit and GST Payable)

# **Note 19: Financial Instruments (continued)**

## **Sensitivity Disclosure Analysis**

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, Rochester and Elmore District Health Service believes the following movements are 'reasonably possible' over the next 12 months (Based rates are sourced from Reserve Bank of Australia).

A parallel shift of 1% in market interest rates (AUD) from year end rates of 3%.

A parallel shift of 1% in inflation rate from year end rates of 3%.

A movemnet of 15% up and down (2013: 15%) for the top ASX 200 index.

The following table discloses the impact on net operating result and equity for each category of interest bearing financial instrument held by Rochester and Elmore District Health Service at year end as presented to key management personnel, if changes in the relevant risk occur.

	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-1%	+1%	-1%	+1%	-1%	+1%	-1%	+1%
		Profit	Equity	Profit	Equity	Profit	Equity	Profit	Equity
	\$	\$	\$	\$	\$	\$	\$	\$	\$
<b>2014</b>									
<b>Financial Assets</b>									
Cash & Cash Equivalents	2,811,514	(28,115)	(28,115)	28,115	28,115	0	0	0	0
Receivables									
- Trade Debtors	297,155								
- Other Receivables	54,808								
Other Financial Assets									
- Term Deposits	3,475,237	(34,752)	(34,752)	34,752	34,752	0	0	0	0
<b>Financial Liabilities</b>									
Payables	358,231								
Interest Bearing Liabilities	132,679	1327	1327	(1,327)	(1,327)	0	0	0	0
Other Financial Liabilities									
- Monies Held in Trust	2,415,499								
		(61,540)	(61,540)	61,540	61540	0	0	0	0

	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-1%	+1%	-1%	+1%	-1%	+1%	-1%	+1%
		Profit	Equity	Profit	Equity	Profit	Equity	Profit	Equity
	\$	\$	\$	\$	\$	\$	\$	\$	\$
<b>2013</b>									
<b>Financial Assets</b>									
Cash & Cash Equivalents	1,516,764	(15,168)	(15,168)	15,168	15,168	0	0	0	0
Receivables									
- Trade Debtors	234,420								
- Other Receivables	87,178								
Other Financial Assets									
-Term Deposits	6,056,145	(60,562)	(60,562)	60,562	60,562	0	0	0	0
<b>Financial Liabilities</b>									
Payables	688,732								
Interest Bearing Liabilities	177,069	1771	1771	(1,771)	(1,771)	0	0	0	0
Other Financial Liabilities									
-Monies Held in Trust	2,913,810								
		(73,959)	(73,959)	73,959	73959	0	0	0	0

## **(e) Fair Value**

The fair values and net fair values of financial instrument assets and liabilities are determined as follows:

- Level 1 - the fair value of financial instrument with standard terms and conditions and traded in active liquid markets are determined with reference to quoted market prices;
- Level 2 - the fair value is determined using using inputs other than quoted prices that are observable for the financial asset or liability, with directly or indirectly; and
- Level 3 - the fair value is determined in accordance with generally accepted pricing models based on discounted cash flow analysis using unobservable market inputs.

The financial assets include holdings in unlisted shares. Fair value of these is determined by projecting future cash inflows from expected future dividends and subsequent disposal of the securities. These cash flows are then discounted back to their present value using a discount rate of 2.5%

The Health Service considers that the carrying amount of financial statements to be a fair approximation of their fair values, because of the short-term nature of the financial instruments and the expectation that they will be paid in full.

The following table shows that the fair values of most of the contractual financial assets and liabilities are the same as the carrying amounts.

## **Comparison between carrying amount and fair value**

	Consol'd Carrying Amount	Fair value	Consol'd Carrying Amount	Fair value
	2013	2013	2012	2012
	\$	\$	\$	\$
<b>Financial Assets</b>				
Cash and Cash Equivalents	2,811,514	2,811,514	1,516,764	1,516,764
Receivables				
- Trade Debtors	297,155	297,155	234,420	234,420
- Other Receivables	54,808	54,808	87,178	87,178
Other Financial Assets				
- Term Deposit	3,475,237	3,475,237	6,056,145	6,056,145
<b>Total Financial Assets</b>	<b>6,638,714</b>	<b>6,638,714</b>	<b>7,894,507</b>	<b>7,894,507</b>
<b>Financial Liabilities</b>				
Payables	358,231	358,231	688,732	688,732
Interest Bearing Liabilities	132,679	132,679	177,069	177,069
Other Financial Liabilities				
- Monies Held in Trust	2,415,499	2,415,499	2,913,810	2,913,810
<b>Total Financial Liabilities</b>	<b>2,906,409</b>	<b>2,906,409</b>	<b>3,779,611</b>	<b>3,779,611</b>

## Note 20: Commitments

### Hire Purchases

Commitments in relation to Hire Purchases are payable as follows:

Less than 1 year

Longer than 1 year but not longer than 5 years

### Minimum Hire Purchase Payments

Less Future Finance Charges

### Total Hire Purchase Commitments

### Representing Hire Purchase Liabilities:

Current (refer Note 13)

Non-Current (refer Note 13)

### TOTAL COMMITMENTS

2014	2013
\$	\$
132,679	108,780
0	68,289
<b>132,679</b>	<b>177,069</b>
0	6,825
<b>132,679</b>	<b>170,244</b>
132,679	102,512
0	67,732
<b>132,679</b>	<b>170,244</b>

The weighted average interest rate implicit in leases is 5.38% (2013 5.96%)

## Note 21: Contingent Assets & Contingent Liabilities

Details and estimates of maximum amounts of contingent assets or contingent liabilities are as follows:

### Contingent Assets

Rochester and Elmore District Health Service does not have any known contingent assets at 30th June, 2014

### TOTAL

### Contingent Liabilities

Recallable grant

### TOTAL CONTINGENT ASSETS & CONTINGENT LIABILITIES

2014	2013
\$'000	\$'000
0	0
<b>0</b>	<b>0</b>
0	0
<b>0</b>	<b>0</b>

## Note 22: Operating Segments

	Health Services		RACS		Other Services		Consolidated	
	2014	2013	2014	2013	2014	2013	2014	2013
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
<b>REVENUE</b>								
External Segment Revenue	7,593,487	7,834,459	5,005,807	4,701,877	0	0	12,599,294	12,536,336
<b>Total Revenue</b>	<b>7,593,487</b>	<b>7,834,459</b>	<b>5,005,807</b>	<b>4,701,877</b>	<b>0</b>	<b>0</b>	<b>12,599,294</b>	<b>12,536,336</b>
<b>EXPENSES</b>								
External Segment Expenses	(9,516,894)	(9,766,520)	(4,361,792)	(3,540,802)	0	0	(13,878,686)	(13,307,322)
<b>Total Expenses</b>	<b>(9,516,894)</b>	<b>(9,766,520)</b>	<b>(4,361,792)</b>	<b>(3,540,802)</b>	<b>0</b>	<b>0</b>	<b>(13,878,686)</b>	<b>(13,307,322)</b>
<b>Net Result from ordinary activities</b>	<b>(1,923,407)</b>	<b>(1,932,061)</b>	<b>644,015</b>	<b>1,161,075</b>	<b>0</b>	<b>0</b>	<b>(1,279,392)</b>	<b>(770,986)</b>
Interest Expense	(9,691)	(13,463)	0	0	0	0	(9,691)	(13,463)
Interest Income	34,574	61,615	155,141	125,356	0	0	189,715	186,971
<b>Net Result for Year</b>	<b>(1,898,824)</b>	<b>(1,883,909)</b>	<b>799,156</b>	<b>1,286,431</b>	<b>0</b>	<b>0</b>	<b>(1,099,368)</b>	<b>(597,478)</b>
<b>OTHER INFORMATION</b>								
Segment Assets	7,277,519	4,800,713	21,815,717	13,779,167	0	0	29,093,236	18,579,880
Unallocated Assets	0	0	0	0	16,622,236	17,585,948	16,622,236	17,585,948
<b>Total Assets</b>	<b>7,277,519</b>	<b>4,800,713</b>	<b>21,815,717</b>	<b>13,779,167</b>	<b>16,622,236</b>	<b>17,585,948</b>	<b>45,715,472</b>	<b>36,165,828</b>
Segment Liabilities	2,065,808	2,351,096	3,162,512	3,824,698	0	0	5,228,320	6,175,794
Unallocated Liabilities	0	0	0	0	538,997	560,966	538,997	560,966
<b>Total Liabilities</b>	<b>2,065,808</b>	<b>2,351,096</b>	<b>3,162,512</b>	<b>3,824,698</b>	<b>538,997</b>	<b>560,966</b>	<b>5,767,317</b>	<b>6,736,760</b>
Acquisition of property, plant and equipment and intangible assets	0	21,502	0	209,281	0	195,755	0	426,538
Depreciation expense	(997,697)	(985,105)	(308,595)	(351,421)	(203,319)	(207,528)	(1,509,611)	(1,544,054)
Non cash expenses other than depreciation	0	0	0	0	0	0	0	0

The major products/services from which the above segments derive revenue are:

### Business Segments

Residential Aged Care Services (RACS)

Acute

### Services

Nursing Home Services

Hostel Facilities

Acute Hospital Services

Ambulatory

Aged Care Services

Primary Health Services

### Geographical Segment

Rochester and Elmore District Health Service operates predominantly in Rochester and Elmore, Victoria. More than 90% of revenue, net surplus from ordinary activities and segment assets related to operations in Rochester and Elmore, Victoria.

## Note 23: Jointly Controlled Operations and Assets

Name of entity	Principal Activity	Ownership Interest	
		2014 %	2013 %
Loddon Mallee Rural Health Alliance	Information Technology	3.88	3.89

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

	2014 \$	2013 \$
<b>CURRENT ASSETS</b>		
Cash and Cash Equivalents	207,808	152,972
Receivables	7,015	83,364
Prepayments	7,186	7,183
<b>TOTAL CURRENT ASSETS</b>	<b>222,009</b>	<b>243,519</b>
<b>NON CURRENT ASSETS</b>		
Property, Plant and Equipment	18,364	4,408
<b>TOTAL NON-CURRENT ASSETS</b>	<b>18,364</b>	<b>4,408</b>
<b>TOTAL ASSETS</b>	<b>240,373</b>	<b>247,927</b>
<b>CURRENT LIABILITIES</b>		
Payables	23,598	20,335
Accrued Expenses	7,053	1,056
<b>TOTAL CURRENT LIABILITIES</b>	<b>30,651</b>	<b>21,391</b>
<b>TOTAL LIABILITIES</b>	<b>30,651</b>	<b>21,391</b>
<b>NET ASSETS</b>	<b>209,722</b>	<b>226,536</b>

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

	2014 \$	2013 \$
<b>REVENUES</b>		
Operating Activities	131,590	155,141
Capital Purpose Income	27,309	64,116
<b>Total Revenue</b>	<b>158,899</b>	<b>219,257</b>
<b>EXPENSES</b>		
Other Expenses from Continuing Operations	284,797	286,297
Expenditure using Capital Purpose Income	0	0
<b>TOTAL EXPENSES</b>	<b>284,797</b>	<b>286,297</b>
<b>PROFIT</b>	<b>(125,898)</b>	<b>(67,040)</b>

### CONTINGENT LIABILITIES AND CAPITAL COMMITMENTS

The joint venture does not have any known contingent assets or contingent liabilities as at 30 June 2014

#### Commitments

LMRHA has entered into the following contract commitments for expenditure as at 30 June 2014:

	Not later than 1 year \$'000	Later than 1 year and not later than 5 years \$'000	Later than 5 years \$'000	Total \$'000
<u>Payable:</u>				
Information Communication Technology	90,000	0	0	90,000
<b>Total Capital Commitments</b>	<b>90,000</b>	<b>0</b>	<b>0</b>	<b>90,000</b>

LMRHA has entered into the following contract commitments for expenditure as at 30 June 2013:

	Not later than 1 year \$'000	Later than 1 year and not later than 5 years \$'000	Later than 5 years \$'000	Total \$'000
<u>Payable:</u>				
Information Communication Technology	101,000	0	0	101,000
<b>Total Capital Commitments</b>	<b>101,000</b>	<b>0</b>	<b>0</b>	<b>101,000</b>

## Note 24a: 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 David Davis, MLC, Minister for Health and Ageing  
The Honourable Mary Wooldridge, MLA, Minister for Mental Health

Period
01/07/2013-30/06/2014
01/07/2013-30/06/2014

### Governing Boards

Prof J. Farmer  
Mr T. Fulton  
Mr D. Gilbert  
Mr G. Hodgins  
Ms K. Lee  
Mr. A. Darbyshire  
Mr. R. Johnson  
Mr B. Maw  
Mr K. Oberin  
No remuneration was paid to any Governing Board Members for the Financial Year ended 30 June 2014.

01/07/2013 - 30/06/2014  
01/07/2013 - 30/06/2014  
01/07/2013 - 30/06/2014  
01/07/2013 - 30/06/2014  
01/07/2013 - 30/06/2014  
01/07/2013 - 30/06/2014  
01/07/2013 - 30/06/2014  
01/07/2013 - 30/06/2014  
01/07/2013 - 30/06/2014

### Accountable Officers

Mr Matthew Sharp  
Mrs Anne McEvoy

01/07/2013 - 28/03/2014  
29/03/2014 - 30/06/2014

### Remuneration of Responsible Persons

The number of Responsible Persons are shown in their relevant income

#### Income Band

\$0 - \$9,999  
\$30,000 - \$39,999  
\$110,000 - \$119,999  
\$160,000 - \$169,000

2014 No.	2013 No.
9	9
1	0
1	0
0	1
11	10
\$117,860	\$168,461

#### Total Numbers

#### Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:

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

### Other Transactions of Responsible Persons and their Related Parties

No responsible person or their related parties received any remuneration or retirement benefits during the year

## Note 25b: Executive Officer Disclosures

The numbers of executive officers, other than Ministers and Accountable Officers, and their total remuneration during the reporting period are shown in the first two columns in the table below in their relevant income bands. The base remuneration of executive officers is shown in the third and fourth columns. Base remuneration is exclusive of bonus payments, long-service leave payments, redundancy payments and retirement benefits.

The number of Responsible Persons are shown in their relevant income bands;

\$120,000 - \$129,999

#### TOTAL TOTAL REMUNERATION

2014 No.	2013 No.
0	1
0	1
\$0	\$122,582

## Note 26: Remuneration of auditors

### Victorian Auditor-General's Office

Audit or review of financial statements

#### TOTAL

2014 \$	2013 \$
14,500	14,700
14,500	14,700

## Note 27: Events occurring after the Balance Sheet Date.

No events occurred after Balance Sheet Date.

*This page has been intentionally left blank.*

*This page has been intentionally left blank.*