



redhs

Leading our community to better health

Rochester and Elmore District Health Service



Annual Report 2017

REDHS 2020 STRATEGIC PLAN 2016 - 2020



VISION

Leading our community to better health

VALUES

Respect
Equity
Diligence
Honesty
Service

Strategic Priorities

Quality Healthcare

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



Collaborative Endeavours

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



People and Infrastructure

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



WHO WE ARE

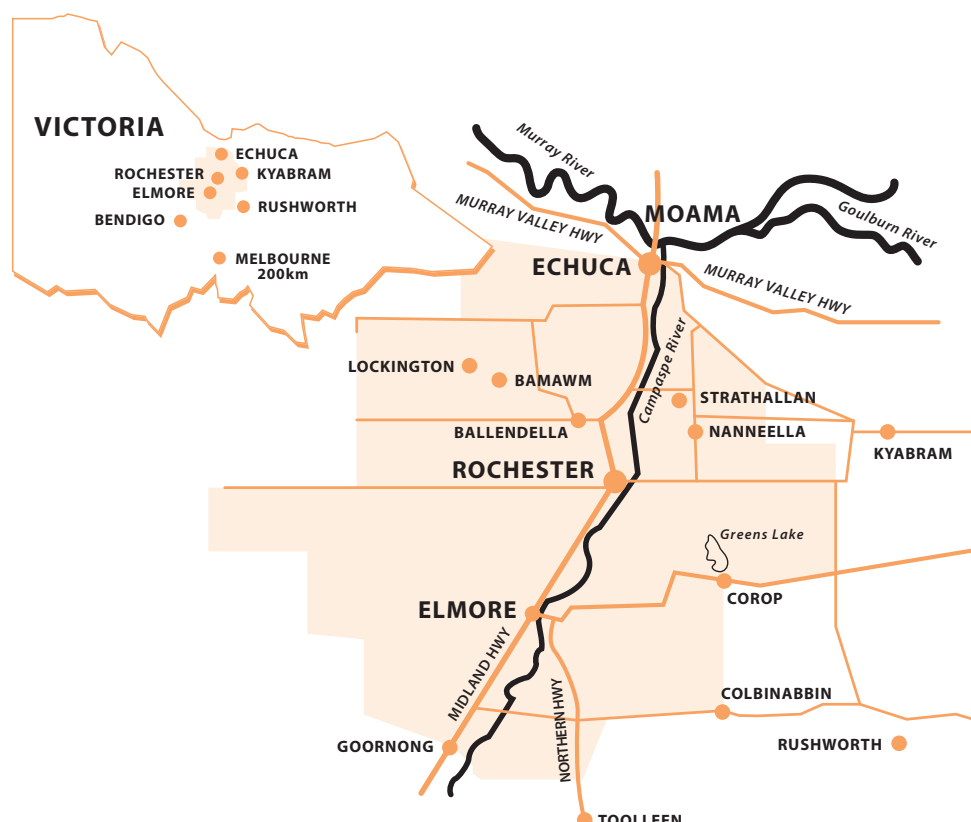
Rochester and Elmore District Health Service (REDHS) was established on 1 November 1993 following the amalgamation of the Rochester and District War Memorial Hospital and the Elmore District Hospital.

REDHS is an incorporated body under Section 31 of the Health Services Act 1988 providing a broad range of services including acute, residential aged and primary care services (including home nursing) to our catchment population of over 8,500 and has:

- 116 full time equivalent staff
- 30 high care residential aged care beds
- 30 ageing in place residential aged care beds (including respite and dementia-specific beds)
- 2 Transition Care Program beds (residential)
- 1 Transition Care Program bed (community)
- 12 inpatient beds including 1 palliative care bed
- Urgent Care Centre
- Day Procedure Unit
- Primary Care Services

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

OUR LOCATION



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YEAR IN BRIEF 2016-17

Acute Ward

Total Acute Ward Separations	356
Acute Bed Days	2,069
Average Length of Stay (Days)	8.1

Day Procedure Unit (DPU)

Total DPU Separations	80
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Aged Care

Nursing Home Bed Days	10,572
Nursing Home Separations	11
Hostel Bed Days	10,773
Hostel Separations	7

Non-admitted Occasions of Service

District Nursing	5,917
Urgent Care Centre	761
Radiology	1,152
National Respite for Carers	257
Social Support Group	3,304
Diabetes Education	222
Dietetics	686
Exercise Physiology	116
Group Fitness	817
Occupational Therapy	372
Physiotherapy	1,551
Podiatry	2,711
Social Work/Counselling	831
Drug and Alcohol Withdrawal Service	420

Services available at REDHS

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

PRESIDENT AND CEO REPORT

On behalf of the Board of Management, we are pleased to present the 24th Annual Report of Rochester and Elmore District Health Service for the year ended 30 June 2017. The report highlights the significant achievements and events that occurred during the year and is prepared in accordance with the *Financial Management Act 1994*.

There have been a number of achievements that are detailed in this report and reflect the dedication and care provided by our staff, visiting medical officers (VMOs) and volunteers in delivering services for the community.

Governance

The Board of Management consisted of eight members with Ben Maw continuing as Board Chair until his resignation due to a career opportunity in December 2016. Carol McKinstry was then elected as Chair with Tim Fulton remaining as the Deputy Chair and new Board member, Jodie Smith, taking on the position of Treasurer. David Rosaia joined the Board in April 2016 which enhanced the Board's skills and knowledge of clinical governance. We were also pleased to introduce Independent members onto the Risk Management and Planning sub-committee during the year, with Frank Oliver and Phillip Johnson accepting the inaugural positions. Ben Devanny joined the Audit committee to fulfill a vacancy as Phillip had completed his two terms.

The new strategic plan, more commonly known as REDHS 2020, was launched in July and will guide the Board's focus for the next four years. The new vision of *"Leading our Community to Better Health"* easily depicts what REDHS aims to achieve and the value we place on our community. The three strategic priorities: Quality Healthcare, Collaborative Endeavours, and People and Infrastructure provide the framework for the strategies, actions and deliverables.

Aligning with the release of the Targeting Zero report completed by Dr Stephen Duckett, the Board has increased the focus on clinical governance with enhanced clinical reports along with Board members completing dedicated training to increase their skills and knowledge of the intricacies of clinical governance. The Board, through the efforts of the Quality of Care committee, have committed to the Loddon Mallee Region Clinical Governance committee and state wide clinical services review.

Risk Management

As part of a comprehensive two-year review (2015-2017), REDHS Strategic Risk Register was updated to align with REDHS Strategic Plan and provides guidance for managing risks that may impact on REDHS meeting its strategic objectives.

Strategic Plan and Statement of Priorities

During the year, the Board has regularly reviewed the objectives and progress of the REDHS Strategic Plan July 2016 – June 2020. The Board was also required to participate in the Department of Health and Human Services annual Statement of Priorities process.

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

Quality Healthcare

- REDHS was the proud recipient of the Victorian Healthcare Association award for *Innovation in Clinical Governance* which recognised the initiatives undertaken to improve the reporting of consumer care and safety information to the board
- Third year implementation of the *Studer Evidence Based Leadership Framework* for leadership coaching and focus on person-centred care, guided by the employment of a dedicated internal Studer coach



Dr Carol McKinstry
Board President

Anne McEvoy
Chief Executive
Officer

PRESIDENT AND CEO REPORT

- 100 % of aged care residents have been engaged regarding an advance care plan
- Consumer engagement in the design and delivery of services was enhanced via increased consumer members on committees
- Health Promotion role in Primary Care was increased by 50%
- Video conferencing technologies for geriatric reviews were introduced into aged care
- Successful recruitment drive for volunteers, with the signing of a further seven volunteers during "Voluntober"
- Considerable planning to determine the most suitable primary care intake model for future implementation which will support client access to services
- A new home care service commenced in January 2017 which supports our community to access personal, home and respite care from REDHS
- Major government reforms in home care and disability programs required dedicated project resources to support the transitioning processes which will continue into next year
- Implemented a Registered Nurse Care Coordinator role into residential aged care

Collaborative Endeavours

- Led the obesity priority of the *Healthier Campaspe* initiative
- Reviewed and redesigned the radiology services model to ensure sustainability of this community service for X-Ray and ultrasound services
- Following a trial period, progress towards the implementation of the REDHS/ Echuca Regional Health surgical services model enabled the reinstatement of theatre services
- Increase in outreach physiotherapy and dietetic services to Rushworth and Tatura
- Membership of the local Ice Action Committee which was successful with a Commonwealth submission to develop a Local Drug Action Team (LDAT)

People and Infrastructure

- Implementation of the new 8:8:10 roster model for nursing and care staff
- Five year plans for the replacement of equipment, Information and Communication Technology (ICT) and preventative maintenance were developed
- An application to the Rural Health Infrastructure Fund for theatre equipment and an upgrade to the duress messaging systems was successful for a total of \$585K
- Fully implemented the requirements for purchasing and contractors in line with Health Purchasing Victoria mandated compliance obligations
- Research conducted to identify the options for future aged care commenced with future service planning a priority
- An organisation-wide commitment to reducing bullying and harassment was enacted with all staff attending education sessions

Partnerships

REDHS values the numerous partnerships with stakeholders who add value to our organisation and community. REDHS has been a key partner in collaborating with other health services within the Campaspe area in implementing the *Healthier Campaspe* initiative. This plan aims to strengthen health collaboration and integration and is an innovative model which is focussed on improving the health and wellbeing of people living in Campaspe.

Accreditation

We are delighted to report that a successful EQulP National Periodic Review was conducted in May 2017 for our acute, primary care and corporate services with full accreditation status being maintained. Rochester Nursing Home Annexe and Rochester and District Hostel have both had unannounced aged care support visits during the year with all requirements met. We acknowledge the mighty team efforts in these achievements, which reflect our organisation's commitment to quality and safety.

Community Support

REDHS is truly grateful for the support of our community, local organisations and people through generous donations of time and money to support our vision. Numerous donations and bequests have been received and we would like to particularly acknowledge the significant efforts of Rochester and District Hospital Auxiliary whose members continue to work tirelessly in raising money for the purchase of medical equipment. This year they raised over \$5,000 which was put towards the purchase of electric beds.

Our Thanks

Further to the above, the Board wishes to pass on its thanks to the many groups and individuals who provide significant support to our health service, in particular, our staff, volunteers, medical practitioners, contractors and all levels of government. We continue to appreciate the support and assistance of the Victorian Department of Health and Human Services and the Commonwealth Department of Health.

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



Dr Carol McKinstry
Board Chair



Anne McEvoy
Chief Executive Officer

CORPORATE GOVERNANCE

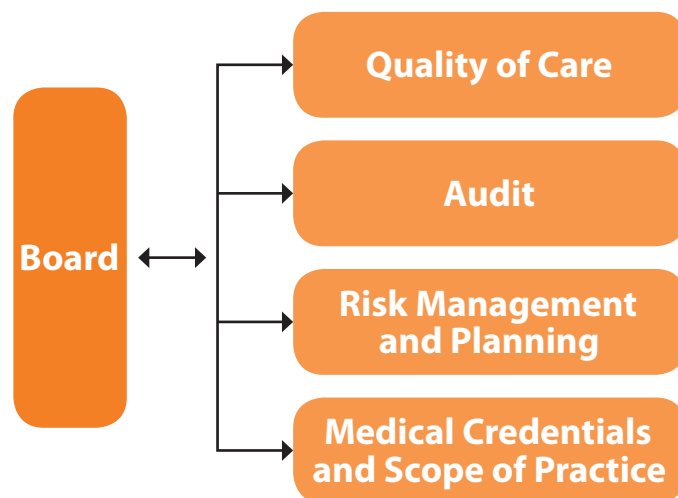
REDHS Board of Management

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 with oversight of care quality and safety, finances and risk management.

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, the appointment of visiting medical officers and other senior staff.

Board Committee Structure



Board Members



Benjamin Maw

President (1.7.16 – 30.11.16)
RN, B Hlth Sc (Nursing), GAICD
Aged Care Manager, Barwon Health
Date appointed: 1.7.2011



Dr Carol McKinstry

President (1.12.16 – 30.6.17)
B App Sc (OT), MHLth Sc, PhD, Grad Cert
Higher Ed. GAICD
Senior Lecturer OT, College of Science
Health and Engineering, La Trobe Rural
Health School
Registered occupational therapist
Date appointed: 1.7.2014



Timothy Fulton

Vice President (1.7.16 – 30.6.17)
B.Bus (Accounting/ Economics), Diploma
of Financial Planning GAICD
Agribusiness Manager, Devondale Murray
Goulburn
Date appointed: 1.7.2009



Jodie Smith

Treasurer
B Bus. (Economics), GAICD, Grad Dip
Applied Science (Agriculture), Grad Cert
(Acc), CPA, Masters of Animal Science
Accountant, Jodie Smith Accounting
Date appointed: 1.7.2016



Kate Lee

Logistics Officer, Parmalat
Date appointed: 1.7.2011



Keith Oberin

Dip Ed GAICD
General Manager, Economic and
Community Development, Shire of
Campaspe
Date appointed: 1.7.2008



Michelle O'Sullivan

B Commerce/Laws (Hons)
Solicitor, Principal, O'Sullivan Johanson
Lawyers
Date appointed: 1.7.2014



David Rosaia

RN, Grad Dip (Health Sciences), GAICD
Director of Nursing, Acute Health, Acting
Chief Nursing and Midwifery Officer,
Bendigo Health
Date appointed 26.04.2017

Meeting Attendance

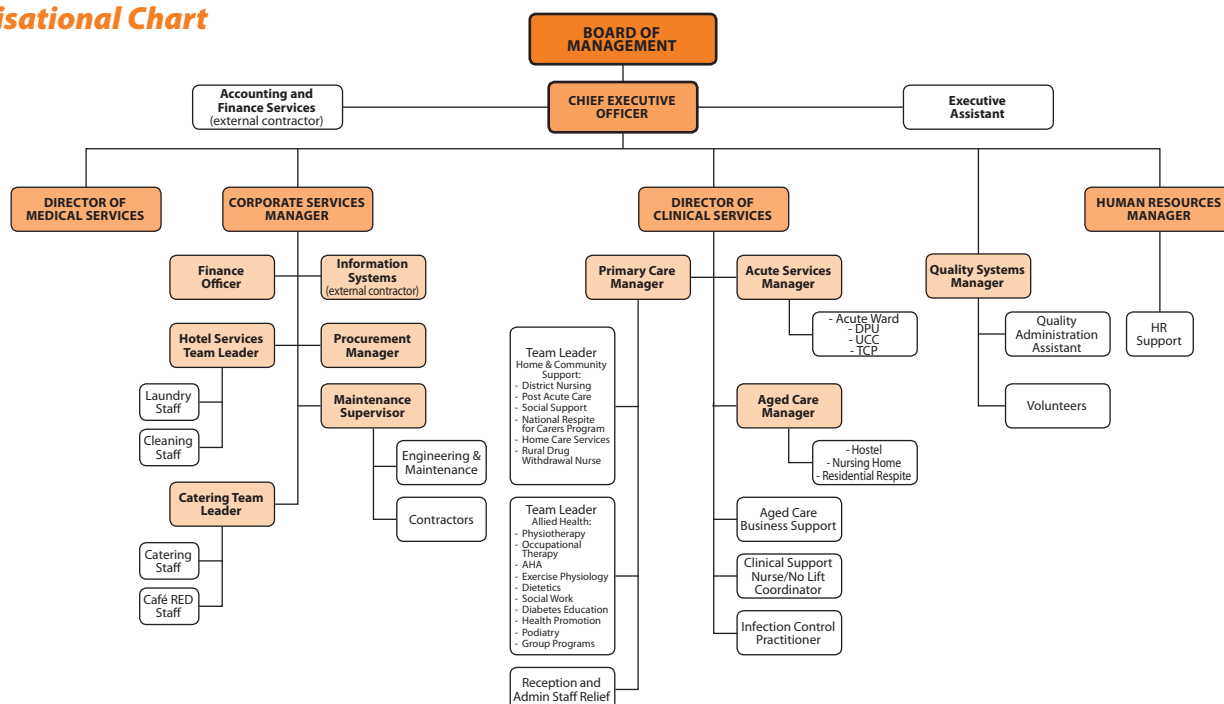
Board Meetings													AGM (17/11/2016)	Total
2015						2016								
Board member	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr (1 May)	May (29 May)	Jun		
Benjamin Maw	✓	✓	A	A	NM	✓	A	A	A	A	A	✓	✓	5/12
Carol McKinstry	✓	✓	✓	✓	NM	✓	✓	✓	✓	✓	✓	✓	✓	12/12
Timothy Fulton	✓	✓	✓	✓	NM	A	✓	✓	✓	✓	✓	✓	✓	11/12
Kate Lee	✓	✓	✓	✓	NM	✓	✓	✓	✓	✓	✓	A	✓	11/12
Keith Oberin	✓	✓	A	✓	NM	✓	✓	✓	A	✓	✓	✓	✓	10/12
Michelle O'Sullivan	✓	A	✓	✓	NM	✓	A	✓	A	✓	✓	✓	A	8/12
Jodie Smith	✓	✓	✓	✓	NM	✓	✓	✓	✓	✓	✓	✓	✓	12/12
David Rosaia	NN	NN	NN	NN	NM	✓	✓	✓	A	✓	✓	✓	NN	7/7

A = Apology L = Leave of Absence NM = no meeting held NN = not necessary to attend (appointed Dec 2016)

Committee Membership

	Quality of Care Committee	Audit Committee	Risk Management and Planning Committee	Medical Credential and Scope of Practice Committee
Board Members				
Benjamin Maw	✓			
Timothy Fulton		✓		
Alan Darbyshire		✓		
Keith Oberin			✓	✓
Carol McKinstry	✓			✓
Michelle O'Sullivan		✓		
Jodie Smith		✓	✓	
Kate Lee			✓	
Independent Members				
Ben Devanny		✓		
Troy Holmberg		✓		
Phillip Johnson			✓	
Frank Oliver			✓	
David Rosaia	✓			✓
Christine Wright	✓			

Organisational Chart



KEY PERSONNEL

Executive

Chief Executive Officer

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

Director of Clinical Services

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

Corporate Services Manager

Clare Ireland
B.Sc, Dip. Bus

Human Resources Manager

(from 28 April 2016 to 6 January
2017)

Susan Briggs
B.Com (HRM)

Human Resources Manager

(from 11 October 2016)

Gaye Pilven
MHRM, BBA, Cert IV WHS

Director of Medical Services

Dr Glenn Howlett
MB BS LLB; Grad Dip Hlth Serv
Man; FRACGP

Department Heads

Acute Services Manager

Meredith Hodder
RN, B.Nursing, Post Grad Dip
Perioperative Nursing

Aged Care Manager (to 3 April 2017)

Michele Bibby
RN, B Nursing

Aged Care Manager

(from 4 April 2017)

Jennifer Putna
RN, RM, BA (Psych Welfare)

Primary Care Manager (to 9 June 2017)

Sam Campi
Masters Health Service Man, BA
Public Relations and Marketing

Quality Systems Manager

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

Infection Control Practitioner

Gayle Kerlin
RN, Dip. Primary Care
Coordination, Cert. Infection
Control and Sterilisation, Cert. IV
Cleaning Standards Auditing

Clinical Support Nurse

Cheryl Petrini
RN, Cert. IV Training and
Assessment

Maintenance Supervisor

Brett Shotton

Procurement Manager

Gayle McConnell

Team Leaders

Allied Health

Meaghan Sully
B. Social Work

Allied Health - Community and Home Support (from 17 October 2016)

Megan Purvis
RN

Social Support Coordinator

Ann-Maree Hewlett

Catering

Rebecca O'Sullivan
Cert III Comm Cookery, Cert IV
Frontline Man

Support Services

Kerri McEllister
David Watson

Visiting Medical Officers

General Practitioners

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

Dr M Attalh, MBBS (Egypt)
(until 23 February 2017)

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

Dr E Ekeanyanwu, MBBS
(Nigeria), FRACGP

Dr N Fang, MBBS, DRANZCOG,
FRACGP

Dr S Mansour, MBBS (Egypt),
MSc (Canada)

Dr P Nzegwu, MBBS (Nigeria), AMC

GP Registrars

Dr M Siapno

Dr B Cumming

Dr J Quay

General Surgeons

Ms J Arnold, MBBS, FRACS

Dr J Azzopardi, MBBS DA (UK)
DRACOG FRACGP

Mr M Oliver, MBChB, FRCSEd,
FRACS

Urologist

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

GP Anaesthetists

Dr C Hunt, MBBS DRACOG DA
ACRRM

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

Dr C Taverna, MB BS

Specialist Anaesthetists

Dr P Buncle, MBBS, FANZCA

Dr K Davenport, MBChB,
FANZCA

Dr L Hamond, MBBS, FANZCA,
Dip RACOG

Dr S Hams, MBBS, FANZCA

Dr J Harding, MBBS, FANZCA

Dr G Hay, MBBS, DRACOG,
FRACGP, FRACRRM

Dr P Mazur, MBBS FANZCA

Dr M Nerlekar, MBBS DA MD
FANZCA

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

Dr M Shapiro, MBBCh, H DA
FANZCA

Visiting Radiology Service

Goulburn Valley Imaging

PERFORMANCE AGAINST STATEMENT OF PRIORITIES *(Part A)*

Quality and Safety

Action	Deliverable	Outcome
Implement systems and processes to recognise and support person-centred and end of life care in all settings, with a focus on providing support for people who choose to die at home.	Implement strategy to upskill staff in the Advance Care Model for aged care residents and acute patients, including home-based advance care plans, by June 2017.	Implemented. Staff routinely engage residents and patients in the advance care planning program resulting in a high level of uptake.
Advance care planning is included as a parameter in an assessment of outcomes including: mortality and morbidity review reports, patient experience and routine data collection.	Include assessment of Advance Care Planning in mortality reviews by December 2016.	Complete. Assessment included in mortality reviews.
Progress implementation of a whole-of-hospital model for responding to family violence.	Implement the Strengthening Hospital Responses to Family Violence model by June 2017.	Implementation commenced but it was determined that the model is not an "ideal fit" for a small, rural health service. Working Group in place. Clinical Support Nurse attended "Train the Trainer" session.
Develop a regional leadership culture that fosters multidisciplinary and multi-organisational collaboration to promote learning and the provision of safe, quality care across rural and regional Victoria.	Sign Memorandum of Understanding with other health services in Loddon Mallee region by December 2016 to establish regional Clinical Governance committee.	Memorandum of Understanding being finalised by the Department of Health and Human Services.
Use patient feedback, including the Victorian Healthcare Experience Survey, to drive improved health outcomes and experiences through a strong focus on person and family centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first.	Promote Victorian healthcare Experience Survey with patients. Report and action improvement activities through clinical governance committees on a quarterly basis.	Survey promoted but insufficient number of patients to generate statistically significant reports regularly. Other feedback mechanisms used to inform improvement activities and to provide quarterly reports.
Develop a whole-of-hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint.	Review restraint policies to ensure the least restrictive practices are in place by June 2017.	Policies in place.

Supporting Healthy Populations

Action	Deliverable	Outcome
Support shared population health and wellbeing planning at a local level - aligning with the Local Government Municipal Public Health and Wellbeing Plan and working with other local agencies and Primary Health Networks.	Partner to implement actions of the Healthier Campaspe integrated health plan 2016-20 and as executive sponsor for elements of the plan, develop implementation strategies by June 2017.	Healthier Campaspe initiative implemented as per plan.
Focus on primary prevention, including suicide prevention activities, and aim to impact on large numbers of people in the places where they spend their time adopting a place based, whole-of-population approach to tackle the multiple risk factors of poor health.	50 per cent increase in health promotion investment to include focus on primary prevention by October 2016.	Achieved. Community education events and support delivered during the 'dairy crisis' in the form of community events and support strategies.
Develop and implement strategies that encourage cultural diversity such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.	Collaborate with local Shire in establishing a shared Cultural Diversity plan which will enable more inclusive practices by June 2017.	Active participation and integration of cultural diversity project with Campaspe Primary Care Partnership.
Improve the health outcomes of Aboriginal and Torres Strait Islander people establishing culturally safe practices which recognise and respect their culture identities and safely meets their needs, expectations and rights.	Collaboration with the Dja Dja Wurrung for Aboriginal acknowledgement event held in July 2016 to enhance Rochester and Elmore District Health Service cultural appreciation.	Event conducted.
Drive improvements to Victoria's mental health system through focus and engagement in activity delivering on the 10 Year Plan for Mental Health and active input into consultations on the Design, Service and Infrastructure Plan for Victoria's Clinical mental health system.	Mental health promotion and suicide prevention to be incorporated into health promotion program by December 2016.	Mental health included in health promotion activities and mental health supports promoted through a regional Dairy Support contact card.
Using the Government's Rainbow eQuality Guide, identify and adopt 'actions for inclusive practices' and be more responsive to the health and wellbeing of lesbian, gay, bisexual, transgender and intersex individuals and communities.	Complete an audit against the Rainbow Tick program and develop an action plan towards achieving the standards by June 2017.	Audit conducted as part of the Socially Inclusive Organisations initiative. Work towards achieving the standards is continuing.

Governance and Leadership

Action	Deliverable	Outcome
<p>Demonstrate implementation of the Victorian Clinical Governance Policy Framework:</p> <p>Governance for the provision of safe, quality healthcare at each level of the organisation, with clearly documented and understood roles and responsibilities.</p> <p>Ensure effective integrated systems, processes and leadership are in place to support the provision of safe, accountable and person centred healthcare.</p> <p>It is an appreciation that health services implement to best meet their employees' and community's needs, and that clinical governance arrangements undergo frequent and formal review, evaluation and amendment to drive continuous improvement.</p>	Review quality reporting program to Quality of Care Board Committee by March 2017.	Quality reporting enhanced and approved by Quality of Care Board sub-committee.
	Sign Memorandum of Understanding with other health services in the Loddon Mallee region to establish a shared regional Clinical Governance committee by December 2016.	Memorandum of Understanding is being finalised by the Department of Health and Human Services.
<p>Contribute to the development and implementation of Local Region Action Plans under the series of statewide design, service and infrastructure plans being progressively released from 2016/17. Development of Local Region Action Plans will require partnerships and active collaboration across regions to ensure plans meet both regional and local service needs, as articulated in the statewide design, service and infrastructure plans.</p>	Participate in regional Leadership Forum which will develop Local Region Action Plans in response to statewide clinical services stream and service development plans as plans are published by the Department of Health and Human Services.	Participated in leadership forums to support the development of the regional clinical council.
	Partner to implement actions of the Healthier Campaspe integrated health plan 2016-20 as executive sponsor for elements of the plan, develop implementation strategies by June 2017.	Healthier Campaspe initiative implemented as per plan.
<p>Ensure that an anti-bullying and harassment policy exists and includes the identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal and the policy specifies regular review schedule.</p>	Review existing policies and procedures for bullying and harassment and include appropriate behavioural expectations, including values and "above and below the line" behaviours by June 2017.	Policy review has been undertaken and all staff have undertaken "Above and Below the Line Behaviour" training.
<p>Board and senior management ensure that an organisational wide occupational health and safety risk management approach is in place which includes:</p> <p>(1) A focus on prevention and the strategies used to manage risks, including the regular review of these controls;</p> <p>(2) Strategies to improve reporting of occupational health and safety incidents, risks and controls, with a particular focus on prevention of occupational violence and bullying and harassment, throughout all levels of the organisation, including to the board; and</p> <p>(3) Mechanisms for consulting with, debriefing and communicating with all staff regarding outcomes of investigations and controls following occupational violence and bullying and harassment incidents.</p>	A review of Occupational Health and Safety reports to Risk Management and Planning subcommittee by March 2017.	Review completed. Quarterly reports generated and meet the current needs of the committee through inclusion of incidents, risks, WorkCover data as well as staff survey results and subsequent actions relating to bullying and harassment, occupational violence and staff wellbeing.

Action	Deliverable	Outcome
Implement and monitor workforce plans that: improve industrial relations; promote a learning culture; align with the Best Practice Clinical Learning Environment Framework; promote effective succession planning; increase employment opportunities for Aboriginal and Torres Strait Islander people; ensure the workforce is appropriately qualified and skilled; and support the delivery of high-quality and safe person centred care.	Revise Rochester and Elmore District Health Service current Workforce Development Plan to support future workforce needs by June 2017.	REDHS Workforce Plan is in development for 2017 - 2022 and is to be completed by December 2017.
Create a workforce culture that: (1) includes staff in decision making; (2) promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and (3) includes consumers and community.	Implement People Excellence Program using Studer framework by June 2017.	Implemented across all departments assisting with improved communication with consumers and between peers and the reward and recognition of outstanding performance.
Ensure that the Victorian Child Safe Standards are embedded in everyday thinking and practice to better protect children from abuse, which includes the implementation of: strategies to embed an organisational culture of child safety; a child safe policy or statement of commitment to child safety; a code of conduct that establishes clear expectations for appropriate behaviour with children; screening, supervision, training and other human resources practices that reduce the risk of child abuse; processes for responding to and reporting suspected abuse of children; strategies to identify and reduce or remove the risk of abuse and strategies to promote the participation and empowerment of children.	Implement recommendations from Health Legal review that are specific to our service delivery model to meet compliance requirements by June 2017.	Self-assessment completed and submitted to Department of Health and Human Services. Action plan developed. Standing agenda item for reporting of progress to Quality of Care Committee.
Implement policies and procedures to ensure patient facing staff have access to vaccination programs and are appropriately vaccinated and/or immunised to protect staff and prevent the transmission of infection to susceptible patients or people in their care.	Review policy and procedures, to ensure compliance with guidelines, complete mandatory reporting with a focus on hepatitis vaccination for direct care staff by June 2017.	Policies reviewed. New staff immuniser in training to facilitate access.

Access and Timeliness

Action	Deliverable	Outcome
Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. The Health Independence Program or telemedicine).	Expand health promotion and develop a portfolio role for the lead staff member on Health Promotion by December 2016.	Health promotion role expanded and health promotion plan developed.
Develop and implement a strategy to ensure the preparedness of the organisation for the National Disability and Insurance Scheme and Home and Community Care program transition and reform, with particular consideration to service access, service expectations, workforce and financial management.	Dedicated project resource July-December 2016 to support preparedness for National Disability and Insurance Scheme transition and Home and Community Care forum.	Complete.

Financial Sustainability

Action	Deliverable	Outcome
Further enhance cash management strategies to improve cash sustainability and meet the financial obligations as they are due.	Audit cash management processes to ascertain compliance with organisational policies and identify strategies for improvement by December 2016.	Complete.
Actively contribute to the implementation of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impact with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measurable target related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling.	Complete review of environmental management plan 2013-16 and recommend actions for improvement by December 2016.	Review yet to be completed. Development of an environmental sustainability strategy will be undertaken in 2017-18 with resources from HPV utilised. See also Environment and Sustainability section (page 20).

PERFORMANCE AGAINST STATEMENT OF PRIORITIES *(Part B)*

Statement of Priorities

Part B Service Performance Priorities	Target	2016/17 Actuals
Quality and Safety		
Compliance with National Safety and Quality Health Service Standards	Full compliance	Compliant
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Compliant
Cleaning standards		
Overall compliance with standards	Full compliance	Achieved
Very high risk (Category A)	90 points	Achieved
High risk (Category B)	85 points	Achieved
Moderate risk (Category C)	85 points	Achieved
Submission of infection surveillance data to VICNISS	Full compliance	Achieved
Compliance with the Hand Hygiene Australia program	80%	91%
Percentage of healthcare workers immunised for influenza	75%	87%
Patient experience		
Victorian Healthcare Experience Survey - data submission	Full compliance	Not Achieved**
Victorian Healthcare Experience Survey – patient experience Quarter 1	95% positive experience	Not Compliant**
Victorian Healthcare Experience Survey – patient experience Quarter 2	95% positive experience	96%
Victorian Healthcare Experience Survey – patient experience Quarter 3	95% positive experience	Full compliance*
Victorian Healthcare Experience Survey – discharge care Quarter 1	75% very positive experience	Not Compliant**
Victorian Healthcare Experience Survey – discharge care Quarter 2	75% very positive experience	88%
Victorian Healthcare Experience Survey – discharge care Quarter 3	75% very positive experience	Full compliance*
Governance, leadership and culture performance		
People Matter Survey - percentage of staff with a positive response to safety culture questions	80%	65%

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

** Data submission deadline missed for one month in 2016.

Note: Performance against the Statement of Priorities Part B (Financial Sustainability Performance), Part C (Activity and Funding) and Part D can be found in the financial report.

HUMAN RESOURCES AND STAFF DEVELOPMENT

REDHS is committed to enhancing its culture; this then enables the attraction and retention of high calibre staff that are committed to the delivery of quality care. We continue to enhance our culture by providing professional development opportunities, providing a safe work environment and promoting accountability and excellence through participation in our People Excellence Program.

REDHS Leadership Team is committed to promoting the behaviours we want to see which are aligned to our values – respect, equity, diligence, honesty and service.

Highly skilled and engaged staff lead to better clinical outcomes and quality of life for people in our care. We then achieve our Strategic objective of *Leading our community to better health*.

Encouraging tomorrow's workforce

REDHS continued to support students from a wide range of courses including Bachelor of Nursing, Diploma of Nursing, podiatry, occupational therapy, physiotherapy, social work and dietetics as well as Certificate III students.

There has been a decrease in the number of student days over the last year from 1193 to 930. REDHS hosted 12 secondary college work experience and allied health Vocational and Education Training (VET) students this year.

REDHS hosted a Year 9 *Careers in Health* morning for Rochester Secondary College and 66 students attended, and they were given the opportunity to see what careers are available within the health industry and to meet with clinical staff.

REDHS again offered two traineeships in 2016/17, one in Administration and the other in Allied Health.

People Matter Survey

REDHS again participated in the Victorian Public Sector Commission's People Matter Survey (PMS) in 2016. The survey plays a crucial role in supporting public sector organisations to build positive workplace cultures, founded on the shared public sector values and employment principles. It provides valuable information to help REDHS become a model employer that reflects the diversity of the Victorian community. The survey also provides a vehicle for gathering employee perceptions of patient safety. Aside from completing the core survey our employees are also able to provide feedback on diversity and inclusion; wellbeing; sexual harassment; change management; and learning and development. All staff are encouraged to participate in the survey.

An action plan was developed for implementation in 2015/16 to address feedback from the 2015 survey i.e. communication, change management, orientation for new staff and employee wellbeing. The effectiveness of the actions taken was reflected in an increased level of participation in the 2016 Survey. Our employees provided positive feedback in respect to equal opportunity, responsiveness to our client's needs, clarity in respect to their roles within the organisation, the importance of the work they do and contribution to REDHS. Our employees

also provided positive feedback on the effectiveness of our OHS processes to ensure they have a safe working environment.

Areas for improvement identified and addressed through the PMS Action Plan 2016 were;

- a. Leadership, including leading change
- b. Sexual Harassment
- c. Bullying
- d. Well-being including stress management
- e. Job satisfaction

All staff participated in Above and Below the Line Behavior Training during 2017 to ensure they have the necessary knowledge and understanding of their rights and responsibilities in respect to bullying and harassment. This has been supported by policy and processes to ensure our employees are aware of how to report incidents and the process for resolving same.

REDHS employees have been encouraged to participate in the 2017 survey and we will analyse further the effectiveness of our improvement actions undertaken.

People Excellence

REDHS enhanced its existing People Excellence program in 2014 through a partnership with Studer Group to implement a values based leadership development program. This partnership has grown and in 2016 we partnered with Bendigo Health to appoint a Studer Coach for one day per week.

The program aims to 'hardwire', or embed, a set of standard practices in terms of performance and behavior. This then leads to excellence in patient care through improvements in patient safety and clinical outcomes together with increased patient and staff satisfaction.

To achieve these outcomes we;

- Committed to excellence
- Measure the important things
- Build a culture around service
- Create and develop great leaders
- Focus on employee satisfaction
- Build individual accountabilities
- Align our expected behaviours of staff with REDHS goals and values
- Recognise and reward success

We measure our success through the annual Victorian Public Sector People Matters Survey and quarterly patient satisfaction results.

Gaye Pilven
Human Resources Manager

Workforce Data

Total Staff

	Ongoing		Fixed Term		Casual		Total	
	Head Count	FTE	Head Count	FTE	Head Count	FTE	Head Count	FTE
Total June 2017	133	89.53	12	9.16	61	17.09	206	115.78
Total June 2016	132	89.6	12	9.2	59	17.39	203	116.19

Staff by Age

	Ongoing		Fixed Term & Casual		Total	
	Head Count	FTE	Head Count	FTE	Head Count	FTE
Under 25	8	6.58	4	2.74	12	9.32
25 – 34	15	10.26	11	2.47	26	12.73
35 – 44	20	12.22	11	2.91	33	15.14
45 – 54	49	34.08	17	5.96	66	40.04
55 – 64	47	30.28	14	3.78	61	34.05
65 +	6	4.26	2	0.23	8	4.50

Note: All figures reflect active employees in the last full pay period of June 2017.

Ongoing means people engaged in an open ended contract of employment.

FTE = Full Time Equivalent.

Staff by Occupational Group

	June Current Month FTE		June YTD FTE	
	2016	2017	2016	2017
Nursing	48.83	52.53	48.43	52.53
Administration and Clerical	15.37	13.74	16.44	13.74
Medical Support	10.00	0	9.91	0
Hotel and Allied Services	30.13	36.08	31.05	36.08
Medical Officers	0.10	0.05	0.10	0.10
Hospital Medical Officers	0	0	0	0
Sessional Clinicians	0	0	0	0
Ancillary Staff (Allied Health)	10.57	13.38	10.26	13.38
Totals	115.00	115.78	116.19	115.78

Recognition of Staff Service

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

10 years

Christine Dicketts
Heather Hayes
Anne Shaw
Diana Tighe-Parker
Anita Ward

15 years

Andrea Howarth

25 Years

Susan Anley
Tracey Boyack
Sherrill Carr

30 years

Lynette Godden
Valerie Naughton

OCCUPATIONAL HEALTH & SAFETY

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

Occupational Health and Safety (OHS) coordinator responsibilities were overseen by Cheryl Petrini until the appointment of a Human Resources Manager in October 2016.

Health and Safety Representatives (HSRs) continued to meet bi-monthly for a full day, facilitated by the OHS Coordinator, to conduct workplace audits and risk assessments, develop or review and update policies and prepare and deliver education to staff in their respective areas. The Occupational Health and Safety Committee also meet on this day.

In December 2016, the OHS Committee was renamed to include Wellbeing, following feedback from the People Matters Survey and REDHS' commitment to enhancing and supporting the wellbeing of our staff - physical, mental and emotional.

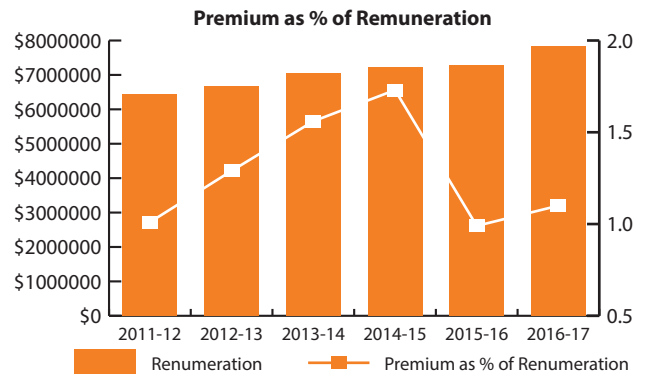
In January 2017, we undertook a Staff Wellbeing Survey, the results of which informed the development of an action plan by the OHSW Committee and REDHS Health Promotion Officer. The OHSW Committee has taken responsibility for ensuring the implementation of the action plan during 2017/18. Key actions are focused on achieving a Healthy Culture, Healthy Physical Environment, Health and Wellbeing opportunities and Healthy Community Connections.

REDHS again participated in Safety Week in October; the committee ran events and competitions to raise safety awareness throughout the week.

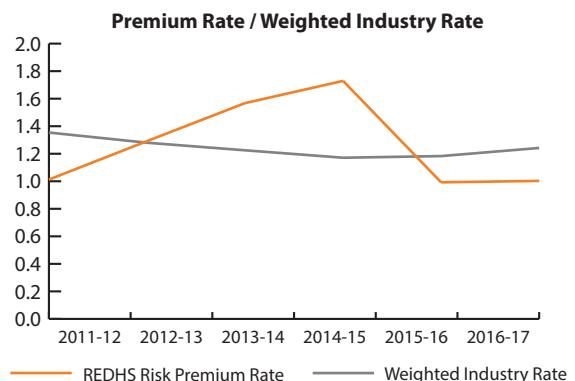
In 2016/17, there were 52 occupational health and safety incidents, near misses and hazards recorded, which equates to 44 reports per 100 FTE. By comparison, there were 51 incidents per FTE reported in 2015/16. This is a significant decrease, which is reflective of increased staff awareness of safety, a commitment by all staff to be responsible and accountable for their wellbeing and to ensure all risks are identified and reported. The HSRs continue to be very engaged and committed to promoting our safety culture within their designated work groups.

Occupational Violence risks remain a high priority; Occupational Violence Prevention and Management is now an important component of the risk management framework.

By comparison there were 53 incidents per FTE reported in 2015/16. This is a significant decrease, which is reflective of increased staff awareness of occupational violence through our investment in Code Grey training in 2015/16. We will continue to invest in Code Grey training to ensure all staff are aware of how to deal with and manage instances of occupational violence.



REDHS' Workers Compensation premium is higher this year due to a claim resulting from a knee injury requiring surgery and rehabilitation.



REDHS' Risk Premium Rate reflects our better than average performance when compared to the industry as a whole.

Occupational Violence

In 2016/17, there were 20 incidents involving occupational violence with 1 (5%) resulting in a minor injury. 16 (80%) of incidents occurred in Aged Care, 3 (15%) in Urgent Care and 1 (5%) in Primary Care. There were no WorkCover claims regarding occupational violence and no lost time due to injury.

Gaye Pilven

Occupational Health Safety and Wellbeing Coordinator

Occupational violence statistics

2016-17

1. WorkCover accepted claims with an occupational violence cause per 100 FTE	0
2. Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	0
3. Number of occupational violence incidents reported	20
4. Number of occupational violence incidents reported per 100 FTE	17
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition	5

CLINICAL SERVICES

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

In the previous year we redesigned our quality reporting process; this year, supported by our Board of Management, has seen further refinements. These changes in reporting from each clinical area allow departments to demonstrate the active management of actions such as our clinical indicators. I would like to take this opportunity to acknowledge the Quality Team and all departmental managers who have contributed to these refinements. Proudly, our quality system was acknowledged by winning the VHA award for Innovation in Clinical Governance.

Development of our leaders remains a priority at REDHS. Our leadership group has welcomed the application of further Studer principles of leadership and management. This has in-turn enhanced consistency of communication and accountability across the organisation.

Education and Innovation

The extensive contributions provided by our Clinical Support Nurse, Cheryl Petrini cannot be under estimated; resulting in the following achievements.

REDHS has continued to participate in the Northern Rivers Graduate Nurse Program and provides a graduate year for four nurses on a rotational basis. This has enabled those registered nurse graduates to gain experience in both small rural and regional health facilities. Last year also saw the continued participation in the Enrolled Nurse Graduate Program which allowed the ENs to have a four month rotation in aged care at REDHS.

Student placements have continued at REDHS across nursing and allied health disciplines and for which all clinical staff have provided support for the students.

The Education Committee has continued to work on the elements identified within Best Practice Clinical Learning Environment; we have seen improvements implemented as a result of this.

Educational opportunities have been provided for staff in prioritised areas such as personal threat training, urgent care centre presentations management, patient assessment and the deteriorating patient.

REDHS hosted an information session conducted by Transgender Victoria on LGBTIQ awareness, inviting other health services to attend.

Primary Care

This year has been extremely productive for Primary Care including enhancing working relationships within REDHS itself and further development of collaborative opportunities with other health services. The recent trial of home care has been incredibly successful and in a relatively short period has helped 15 people in the region through our home care model. Community engagement and support has also flourished, including support during the dairy crisis and extensive work

with drug dependence presentations. The Primary Care team has taken ownership of its targets for each group. Megan Purvis has joined Meaghan Sully as a Primary Care team leader and both have stepped up with outstanding mentorship and support for their teams. Both Meaghan and Megan have assisted in guiding projects such as our central intake and e-referral projects.

Our social support group (formerly Planned Activity Group) has had program advancement in provision of different activities and accessibility to primary care staff such as group exercise sessions, dietetics education and live music events.

District Nursing has continued the personalised support for which the staff are renowned. Their recent increase in activity is testament to diversity of care they can provide.

Dietetics has outreached to five different health services this year. Provision of services to local clients includes involvement in the 'obesity' workgroup of the *Healthier Campaspe Project* and, within REDHS, local food forums resulted in menu upgrades and review of oral nutritional supplements which has improved care for those with special dietary needs.

REDHS' *Drug and Alcohol Withdrawal Program* has sustained efforts in providing community connection through presentations to community groups around the dangers of alcohol, ice and other drugs, the focus being to support the Rochester and Elmore community with information/ education on lifestyle changes for a healthier life. Support for people withdrawing from addictions has been strong through in-patient and out-patient management. Links to other supporting organisations, such as the Salvation Army and MIND Australia, have been created to minimise relapse.

Health promotion initiatives have flourished this year and have been provided for a variety of age-groups in our community. Support for initiatives such as Ice 'the Snowball effect', National Youth Week events, 'It's ALL about respect' sexual health project have all been successful. REDHS staff support through our Health Promotion and Health and Wellbeing plans and provision of 'Healthy Choices' implemented at Café RED have benefited our people.

Podiatry services continue to be a strong provider of outreach services with additional services this year at Rushworth. University student placements have seen positive feedback as has the provision of education to in-patients, out-patients and community groups across the wider community.

Allied health assistant support for our clients and practitioners has been extensive across the range of services. Examples include Transition Care Program support and conducting Tai Chi classes at Rushworth. Glowing feedback for programs involving our Allied Health Assistants has been received from clients and practitioners.

Occupational therapists (OT) has been involved in a broad range of activities promoting independence and safety such as review of all mobility aids in the nursing home as well as bed pole assessment and policy review. Staff have also benefited from the OT's expertise with office ergonomic assessments and OT Week "Survivor" activities to promote fun between departments while raising the profile of occupational therapy.

Diabetes education and exercise physiology have been involved in many initiatives such as working with the dietitian on *National Diabetes Week Sugar Free Bake Off*, kindergarten education and

CLINICAL SERVICES

cooking session for children and education session for parents. The Diabetes Educator has conducted a rigorous review of diabetic management in aged care with significant effect on processes undertaken to care for residents living with diabetes. External programs such as our Type 2 Diabetes Group and LIFE! program continue to support our outpatient cohort.

Social work has been involved in many programs including working directly with patients, residents and clients through a range of issues - clinical, emotional and financial. Participation in external forums such as membership and participation in the Socially Inclusive Organisations initiative and the Campaspe Family Violence Action Group with the successful delivery of community events with guest Rosie Batty providing a future for those in this high need area.

Aged Care

The last twelve months have seen an increase in permanent occupancy in aged care and significant efforts from all staff have resulted in accommodating resident care needs.

Physical changes in aged care include floor covering and skirting board replacement, additional water features and garden upgrades. Each of these was carefully planned by Aged Care Manager Michele Bibby (who has since stepped aside from the role), and Acting Aged Care Manager Jennifer Putna, together with resident feedback and engagement. We appreciate the cooperation of our residents and families with our wonderful maintenance team and contractors as works such as these are carried out.

Our aged care staff have been involved in guiding the implementation and recruitment of our Registered Nurse Clinical Care Coordinator who will support and guide care delivery across aged care. This position is designed to further enhance communication between residents, staff and families and will assist in meeting the needs associated with increased acuity.

The introduction of the MedSig medication system was a significant change and has improved safety in medication administration and information, contributing to a 68% reduction in medication incidents this year.

Recent significant donations have facilitated the purchase of specialised lifting equipment, pressure relieving beds and multi-position chairs. These purchases will make significant positive impacts on our residents' lives.

Our Leisure and Lifestyle Team continues to engage and support our residents with different initiatives and creativity in resident entertainment and care; an example being the introduction of coffee club mornings for nursing home residents and increased use of computers and i-Pads.

The Quality Team has provided outstanding support, promoting resident forums and subsequent engagement as consumer input is essential in meeting people's expectations. This includes the extensive review of the Resident Handbook, with the involvement of a number of family members in content review and development.

We have recently had an unannounced visit from the Australian Aged Care Quality Agency with a positive result, the words they "wished they could bottle what we are doing here" indicate strong support for our quality of care.

Day Procedure Unit

The trial involving Echuca Regional Health (ERH) providing staff for our Day Procedure Unit (DPU) completed in August. There was a period of negotiation and agreement has been reached for ERH to staff DPU. The collaborative support from our regional partner will provide safe care for our patients.

We are pleased to acknowledge receipt of a significant grant to update much of our DPU equipment via the Regional Health Infrastructure fund. This upgrade will secure quality equipment for our surgeons and therefore have significant benefit for our patients.

Acute Ward

Our acute ward, including the Transitional Care Program (TCP), has continued to provide person centred care throughout the year. All staff, particularly our After Hours Managers, have worked closely with our local general practitioners to adapt to the different care needs required by our patients.

Meredith Hodder, Nurse Unit Manager, has adopted many of the Studer principles and staff have benefited from these including 'Rounding' and 'Huddles' used for information sharing and education purposes.

The successful application for an Occupational Violence Prevention grant to improve staff safety resulted in implementation of security cameras, redesign of the waiting room and glass for the reception area.

TCP has made a significant impact on patients' lives, building their confidence and capabilities as they plan for discharge. Acute staff have embraced and actively supported this program, allowing REDHS to meet target activity.

There have been quite a few changes in the acute staff group, all of which are important, but it would be remiss not to acknowledge Margaret Stanford's retirement after 36 years of service. We thank Marg for her dedicated and professional approach and wish her well for the future.

The depth of skills present in the acute team has been evidenced as all staff members stepped up, allowing Meredith Hodder to be relieved of her manager duties for three months to conduct a significant project; the commencement of 8:8:10 shift configuration. This project, funded to support the lengthening of the nightshift to 10 hours, will affect both acute and aged care and significantly reduce staff fatigue.

Infection Control

REDHS would like to acknowledge its Infection Control Practitioner Gayle Kerlin's contribution to our organisation's infection control standards which are wide ranging. During this period, REDHS has achieved benchmarked requirements for influenza vaccination, improved significantly on hepatitis vaccination, and included changes in infection control standards for sterilising and maintenance in theatre.

Gayle has engaged our infection control representatives and empowered them to be proactive in oversight of their departments including audits of infection control processes such as hand hygiene and aseptic technique.

We have welcomed our first consumer representative, Hannah Thompson, to our Infection Control Committee meetings and acknowledge the community perspective Hannah brings to the meetings.

Mark Nally

Director of Clinical Services

CORPORATE SERVICES

Hotel Services

Team leaders, Kerri McEllister and David Watson, oversaw the continued provision of cleaning services by the Hotel Services team across the health service. The low turnover of staff in this area means that experienced team members are able to cover all aspects of cleaning to a consistently high standard.

Cleaning was carried out in accordance with *Cleaning Standards for Victorian Health Facilities* with both internal and external cleaning audits conducted out to monitor compliance. Once again, the team is to be congratulated on achieving outstanding results (see page 13) that form a major component of REDHS' infection control prevention and management system. The reporting of cleaning standards will change in the coming year reducing the burden of intensive reporting and ensuring that resources are focused towards providing exceptional service for residents and patients.

Team members have attended a number of training sessions this year including Code Grey (unarmed personal threat) and bullying and harassment as well as mandatory training in hand hygiene and chemical handling. Team leaders undertook further training in leadership, communication and team management, and were involved in improving communication by using Studer techniques including rounding and huddles with team members.

The laundry chemical system was reviewed and changed to reduce the amount of chemicals required, reducing environmental impact. A new laundry soaker system was implemented into the laundry to ensure clothes are returned to residents as clean as possible.

The Hotel Services team worked with nursing staff to ensure continuous care for residents as new carpet was laid in the common spaces and hallways of the Nursing Home. Team members have also replaced curtains, blinds and shower curtains in the Nursing Home, purchased new slide sheets for clinical departments as well as assisting with the mattress replacement program, which will result in at least ten mattresses being replaced.

Catering

The catering team provided meals to aged care residents, inpatients (acute ward and day procedure unit) and social support clients. In addition, catering was provided for a number of external functions including the Rochester Fine Art Exhibition and Elmore Bachelor and Spinster Ball and internal functions and celebrations such as St Patrick's Day and Pancake Tuesday, Board meetings and volunteer celebrations. Birthday cakes were provided for all aged care residents to share with fellow residents, friends and family.

The catering team provides the food for Café RED and was instrumental in the changes in the café menu to enable REDHS to achieve Victorian Public Hospital Healthy Choices accreditation. In collaboration with REDHS' dietitian and Health Promotion Officer, the Café removed all soft drinks and made many other menu swaps to support our staff and customers in balancing nutritional requirements.

The catering team was pleased to again be involved in the support of dietetic student placements. This year's students completed a review of the use of supplements for our residents and patients. They provided many low cost solutions and improvements which have been implemented. The students also completed a review of policies and monitored the performance of the catering team in preparing meals suitable for those with allergies and intolerances. Opportunities for improvement were identified and actions taken as a result of this review. Two Rochester Secondary College students undertook a five-week VCAL placement at REDHS. These students had the opportunity to serve meals to residents and patients, bake cakes and slices and prepare and serve meals in the café.

The kitchen underwent the second half of a major upgrade to the flooring surface (with the first part undertaken in 2015/16). This significant work has improved staff and food safety. In addition, significant items were replaced in the kitchen including the plate warming system and the ice machine.

In June 2017, the annual external Food Safety audit was carried out, with REDHS passing all requirements to maintain its status as a Class 1 premises. This is a credit to all members of the catering team who apply stringent control measures around food storage, preparation and delivery that are essential to the delivery of safe, high quality foods.

Procurement

Health Purchasing Victoria (HPV) compliance reporting continued to be a focus of the Supply Department this year. In April, REDHS undertook the three year mandated audit and achieved positive results. My thanks go to Procurement Officer, Gayle McConnell, for her diligence and efforts in achieving these results. This audit led to a further review of policies to ensure that they are appropriate in a small, rural health setting. REDHS continues to support local businesses where possible.

Significant capital asset replacements were undertaken, allowing patient and resident care to be supported with up-to-date equipment. The replacement program is ongoing, with REDHS also receiving money through donations to be spent on equipment to continually improve care provision.

The Supply Department has effectively maintained minimum stock levels whilst ensuring continuous supply for all areas of the organisation.

The process for ordering catering supplies was changed this year, with contracts being put through HPV, resulting in cost savings.

Fleet

REDHS' fleet continued to be administered by the Supply Department. Vehicles were serviced as per schedule and maintained in a safe, clean condition. The provision of a reliable fleet supports the delivery of primary care outreach services to the community including district nursing and podiatry and also enables staff to attend professional development opportunities out of town. Full compliance with Public Transport Victoria bus requirements was achieved.

Information and Communication Technology

With the rapid changes that characterise Information and Communication Technology (ICT), it is a constant challenge to keep up to date with both hardware and software. There is a continual focus on ensuring the network is secure.

REDHS is a member of the Loddon Mallee Rural Health Alliance (LMRHA) and many of the systems are purchased and administered by the Alliance which continues to look for solutions that improve work flows, assist staff to deliver safe, quality care and assist the organisation to meet statutory obligations.

REDHS continued its outsourcing arrangement with DWM Solutions to provide support for staff with computer inquiries and issues and to arrange network access for new staff. They have a representative at REDHS one day per week and the help desk is available to all staff during business hours. They also monitor network backups to ensure they occur as required. With two significant world wide security threats occurring in 2016/17, REDHS network proved secure to these attacks which is essential in ensuring patient information is secure.

Infrastructure supporting the aged care patient management system (MANAD) was replaced this year to facilitate an upgrade to the system in 2017/18. Significant replacement of telephones and infrastructure was undertaken through the LMRHA unified communications project. Ongoing support has been provided for the electronic medication system implemented in our aged care facilities in July 2016.

Maintenance

The maintenance team, led by Maintenance Supervisor Brett Shotton, continued to maintain REDHS' facilities and grounds this year, in addition to coordinating capital works and refurbishments.

Team members, Wayne Cody and Judy Olney, ensure that outdoor spaces are clean and attractive and provide interest for residents, patients and visitors. Mandy Dockery continued to provide administration support for the team half a day per week.

Maintenance requests and preventative maintenance continued to be managed through the Building Equipment and Inventory Maintenance System (BEIMS) hosted by Echuca Regional Health. In 2016/17, the maintenance team completed 952 maintenance requests, compared to 837 last year, 57% of which came from our aged care facilities. In addition to addressing requests, the maintenance team refurbished seven bedrooms in our aged care facilities and oversaw flooring replacement in communal areas of the nursing home, acute ward staff areas and in the main kitchen.

In response to consumer and staff feedback about the difficulties of opening ensuite doors in the acute ward, significant works have been completed for the installation of sliding doors, improving functionality and safety.

The team was instrumental in refurbishing the courtyard adjacent to REDHS Café which included the installation of new seating and new plantings for the enjoyment of staff and visitors. Improvements were also made to the scooter parking area at the hostel entrance and a car parking area for the Men's Shed.

Finance

Finance Officer, Sharon Chapman, continued to manage all accounts payable and financial spreadsheets this year and has been working on a number of improvements including:

- transparency of funds spent
- the streamlining of invoice approval processes
- the development and embedding of policies for all financial operations
- working closely with the Procurement Manager as part of the HPV compliance review
- cash management across the organisation

Significant work has been completed to ensure that capital replacements are funded and form part of planned expenditure.

Finance and supply departments continue to work together to ensure that all of these functions are consistent across the organisation, leading to maximum efficiency.

Environment and Sustainability

REDHS continues to explore opportunities and implements sustainability initiatives presented by the Department of Health and Human Services and Health Purchasing Victoria.

Improvements have been made to the internal lighting system to allow it to communicate with the access control system and shut down automatically in unused areas of the buildings. External lights were all replaced with LED globes. These actions are part of a strategy for saving energy and are intended to lead to a reduction in electricity consumption.

REDHS has commenced its 'War on Waste', with key initiatives being developed through an in-house recycling group, including investigating further use of reusable products, education and implementation of an improved recycling system, replacing existing single use items with environmentally friendly products where possible.

Waste is segregated into landfill, cardboard and clinical categories. All categories are monitored monthly and this will assist in measuring improvements due to the 'War on Waste' initiative.

Clare Ireland
Corporate Services Manager

COMMUNITY INVOLVEMENT AND **SUPPORT**

Volunteers

REDHS is very fortunate to have 92 registered volunteers who generously donate their time to support REDHS staff in providing activities for clients and residents, predominantly in the Social Support Group and the residential aged care facilities.

In October, a successful volunteer drive (*Voluntober*), resulted in seven new volunteers commencing, bringing with them some new skill sets to enhance the lives of residents and clients including two drivers, meal delivery assistance, crafts and garden maintenance.

Paula Grech commenced in the Volunteer Coordinator's role in September 2016. She has attended training in the *National Standards for Volunteer Involvement- Standard 4 & 5*, Campaspe Primary Care Partnership - *Understanding Inclusion* workshop as well as attending monthly Campaspe Primary Care Partnership Volunteer Network meetings.

Paula is also a member of the Campaspe Vibrant Volunteers Project whose main objective is to improve capacity and sustainability of volunteering practices across the Campaspe and Murray areas. A digital story was produced that showcases volunteers from nine organisations from across the Campaspe region including two REDHS volunteers. The volunteer video can be accessed at www.redhs.com.au

Following consultation, smart new-look, volunteer uniform shirts are to be released in the coming months.

Training opportunities for volunteers were provided and were well attended. The sessions covered a range of topics including privacy, infection control/hand hygiene, emergency responses, manual handling and bus orientation.

A highlight for the year was a Volunteers' Christmas Lunch with all the trappings in December in which staff served the volunteers their meals. A rendition of the Twelve Days of Christmas, which was led and had the lyrics adapted by Activities Coordinator Deb Leed, was sung by our volunteers and was a huge hit on the day.

Another highlight was a celebratory afternoon tea in May for National Volunteer Week. The delicious food was enjoyed by 35 volunteers who participated in a presentation and activities that included guessing sugar content in foods, personal wellbeing and diet with Health Promotion Officer, Crystie Ballard. Deb Leed, again led the way with a sing- a-long, Don't Worry, Be Happy, which complemented the 2017 Volunteering Australia Volunteer Week theme of Give Happy, Live Happy. A group photo was also taken and published on the front page of the REDHS Community Newsletter- Winter Edition. All volunteers in attendance received a certificate and badge in recognition of their efforts.

In the coming year, volunteer training days will again be offered and volunteers will also have the opportunity to attend free Dementia training conducted by Alzheimer's Australia.

Our volunteers improve the quality of life for clients and residents and help them to maintain connections to the wider community. We thank them all.

If you are interested in becoming a volunteer at REDHS, contact REDHS Reception staff either in person or on (03) 5484 4465.

Rochester and District Hospital Auxiliary

It is with great pleasure and pride that I present the 2016/17 annual report on behalf of all members.

The Hospital Auxiliary had another successful year of fundraising with \$6,000 donated to assist REDHS in the purchase of equipment. Activities have included an Open Garden Day held in November, six raffles and a Cup Day Luncheon which were all great successes. The Easter egg raffle proved especially popular and raised \$900.

Thank you to all auxiliary members who gave so freely of their time to support auxiliary activities and to community members who supported our activities through the purchase of goods and tickets or attended our functions. To Geoff Sharp, thank you for again donating Easter eggs for the raffle.

Thanks also to REDHS Chief Executive Officer, Anne McEvoy, for coming to our meetings and keeping us up to date with what is happening at the health service.

Maureen Leahy
President

Donations and Bequests (\$100 and over)

Lolly Trolley	\$350.00
Hospital Auxiliary	\$6000.00
Ron Fiedler and Nadine Boyd	\$100.00
Gavin Fiedler	\$250.00
Grace Haines	\$300.00
Rochester Bowling Club	\$250.00
Nanneella Hall and Committee Reserve	\$500.00
Estate of Tom Honey	\$50,000.00
Total	\$57,750.00

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 5.2 of the Standing Directions of the Minister for Finance under the Act and Financial Reporting Directions.

Attestation for compliance with the Ministerial Standing Direction 3.7.1 – Risk Management Framework and Processes

I, Anne McEvoy, certify that the Rochester and Elmore District Health Service has complied with Ministerial Direction 3.7.1 – Risk Management Framework and Processes. This has been verified by Rochester and Elmore District Health Service's Risk Management and Planning Committee.



Anne McEvoy,
Accountable Officer
Rochester and Elmore District Health Service
31 July 2017

Attestation on Compliance with Health Purchasing Victoria (HPV) Health Purchasing Policies

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



Anne McEvoy,
Accountable Officer
Rochester and Elmore District Health Service
31 July 2017

Availability of Additional Information

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

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

Building Compliance

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

Carer's Recognition

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

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

Consumer feedback

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

Compliments, suggestions and complaints should be directed to:

Chief Executive Officer, REDHS,

PO Box 202, Rochester Vic 3561

Ph: (03) 5484 4451

Email: rochhosp@redhs.com.au

Web: 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. All employees have been correctly classified in workforce data collections.

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 2016/17 financial year, two requests for information were received, with both requests granted in full. Information regarding Information regarding making a Freedom of Information request can be found at www.redhs.com.au and requests can be made by contacting the health service Freedom of Information Officer on (03) 5484 4451.

National Competition Policy

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

National Police Record (NPR) Checks

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

Protected Disclosure

The Protected Disclosure Act 2012 (Vic) (the Act) provides for the protection of persons who make a protected disclosure under the Act from detrimental action by officers, members, employees and contractors of Rochester and Elmore District Health Service. REDHS has policies and procedures in place to protect people against action that might be taken against them if they choose to make a protected disclosure. During the 2016/17 year, no applicable disclosures were made.

Safe Patient Care Act

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

Victorian Industry Participation Policy (VIPP) Disclosures

Rochester and Elmore District Health Service's procurement practices and purchasing policies comply with the Victorian Industry Participation Policy Act 2003 as applicable. During 2016/17, 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 or Volunteer Program

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

Your Help Is Needed – And Will Be Appreciated

If you would like to make a donation or bequest, please contact Executive Support on (03) 5484 4451 or rochhosp@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 is prepared to facilitate identification of the Department's compliance with statutory disclosure requirements.

Legislation	Requirement	Page Reference
Ministerial Directions		
Report of Operations		
Charter and Purpose		
FRD 22H	Manner of establishment and the relevant Ministers	1
FRD 22H	Purpose, functions, powers and duties	1
FRD 22H	Initiatives and key achievements	3-4
FRD 22H	Nature and range of services provided	2
Management and Structure		
FRD 22H	Organisational Structure	6
Financial and other information		
FRD 10A	Disclosure Index	24
FRD 11A	Disclosure of ex-gratia expenses	FR
FRD 21C	Responsible person and executive officer disclosures	FR
FRD 22H	Application and operation of Protected Disclosure 2012	23
FRD 22H	Application and operation of <i>Carers Recognition Act 2012</i>	23
FRD 22H	Application and operation of <i>Freedom of Information Act 1982</i>	23
FRD 22H	Compliance with building and maintenance provisions of <i>Building Act 1993</i>	22
FRD 22H	Details of consultancies over \$10,000	FR
FRD 22H	Details of consultancies under \$10,000	FR
FRD 22H	Employment and conduct principles	23
FRD 22H	Information and Communication Technology Expenditure	FR
FRD 22H	Major changes or factors affecting performance	FR
FRD 22H	Occupational Violence	16
FRD 22H	Operational and budgetary objectives and performance against objectives	3-4, 8-13, FR
FRD 24C	Reporting of office-based environmental impacts	20
FRD 22H	Significant changes in financial position during the year	FR
FRD 22H	Statement on National Competition Policy	23
FRD 22H	Subsequent events	FR
FRD 22H	Summary of the financial results for the year	FR
FRD 22H	Additional information available on request	22
FRD 22H	Workforce Data Disclosures including a statement on the application of employment and conduct principles	15, 23
FRD 25C	Victorian Industry Participation Policy disclosures	23
FRD 29B	Workforce data disclosures	15
FRD 103F	Non-Financial Physical Assets	FR
FRD 110A	Cash flow Statements	FR
FRD 112D	Defined Benefit Superannuation Obligations	FR
SD 5.2.3	Declaration in report of operations	3-4
SD 3.7.1	Risk management framework and processes	22
Other requirements under Standing Directions 5.2		
SD 5.2.2	Declaration in financial statements	FR
SD 5.2.1(a)	Compliance with Australian accounting standards and other authoritative pronouncements	FR
SD 5.2.1(a)	Compliance with Ministerial Directions	FR
Legislation		
	<i>Freedom of Information Act 1982</i>	23
	<i>Protected Disclosure Act 2012</i>	23
	<i>Carers Recognition Act 2012</i>	23
	<i>Victorian Industry Participation Policy Act 2003</i>	23
	<i>Building Act 1993</i>	22
	<i>Financial Management Act 1994</i>	3, 22
	<i>Safe Patient Care Act 2015</i>	23

• FR - Financial Report

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 4451 or from www.redhs.com.au

Front cover:

REDHS primary care staff coordinated the very successful Great Sugar-free Bake Off during Diabetes Week.

Pictured (clockwise from the top): Ash (Diabetes Educator), Jackson (exercise physiology student), Garry (primary care client and one of the Bake Off winners) and Katherine (dietitian).

Back cover:

Pictured from top: Some of REDHS' valued volunteers, healthy choices at REDHS' Cafe, one of the new water features and REDHS' Maintenance Team (Brett, Judy and Wayne).



redhs

Leading our community to better health

Rochester and Elmore District Health Service



Financial Report 2017

PERFORMANCE AGAINST STATEMENT OF PRIORITIES

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

There were no significant changes in the financial position during 2016/17.

PART A: Strategic Priorities

See REDHS 2016/17 Report of Operations pages 8-12 for details.

PART B: Performance Priorities

Service Performance: See REDHS 2016/17 Report of Operations page 13 for details.

Financial Sustainability Performance

Key Performance Indicator	Target	2016/17 Result
Finance		
Operating Result (\$M)	0.16	0.47
Trade creditors	60 days	61 days
Patient debtor fees	60 days	9 days
Adjusted current asset ratio	0.7	1.46
Number of days with available cash	14 days	137 days
Asset Management		
Basic asset management plan	Full compliance	Achieved

PART C: Activity and Funding

Funding Type	2016/17 Activity Achievement
Small Rural	
Small Rural HACC (hours)	*1,076
Small Rural Residential Care (bed days)	21,345
Health Workforce	4
Total	

*Finalised data not available at time of printing, result correct as at 8/8/17.

Financials in Brief

The table below is a summary of the financial results for 2016/17, from annual financial statements, with comparative results for the preceding four financial years.

	2017 \$000	2016 \$000	2015 \$000	2014 \$000	2013 \$000
Total Revenue	14,265	13,344	13,053	12,789	12,723
Total Expenses	14,730	14,158	14,252	13,888	13,321
Net Result for the Year (incl. Capital and Specific Items)	(466)	(814)	(1,199)	(1,099)	(597)
Retained Surplus/ (Accumulated Deficit)	11,120	11,624	12,458	13,703	14,586
Total Assets	46,904	46,965	46,007	45,715	36,190
Total Liabilities	9,435	9,030	7,258	5,767	6,761
Net Assets	37,470	37,935	38,749	39,948	29,429
Net Cash Result	1,090	796	(1,950)	1,236	671
Total Equity	37,470	37,935	38,749	39,948	29,429

Details of consultancies

In 2016/17, there were seven consultancies where the total fees payable to the consultants were less than \$10,000. The total expenditure incurred during 2016/17 in relation to these consultancies is \$32,142.27 (excl. GST).

In 2016/17, there were no consultancies where the total fees payable to the consultants were \$10,000 or greater.

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

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

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2017 and the financial position of Rochester and Elmore District Health Service at 30 June 2017.

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

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



.....

Carol McKinstry
Chairperson

Rochester
28 August 2017



.....

Anne McEvoy
Accountable Officer
Chief Finance and Accounting Officer

Rochester
28 August 2017

Independent Auditor's Report

To the Board of Rochester and Elmore District Health Service

Opinion	<p>I have audited the financial report of Rochester and Elmore District Health Service (the health service) which comprises the:</p> <ul style="list-style-type: none"> • balance sheet as at 30 June 2017 • comprehensive operating statement for the year then ended • statement of changes in equity for the year then ended • cash flow statement for the year then ended • notes to the financial statements, including a summary of significant accounting policies • board member's, accountable officer's and chief finance & accounting officer's declaration. <p>In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2017 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the <i>Financial Management Act 1994</i> and applicable Australian Accounting Standards.</p>
Basis for Opinion	<p>I have conducted my audit in accordance with the <i>Audit Act 1994</i> which incorporates the Australian Auditing Standards. My responsibilities under the Act are further described in the <i>Auditor's Responsibilities for the Audit of the Financial Report</i> section of my report.</p> <p>My independence is established by the <i>Constitution Act 1975</i>. My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 <i>Code of Ethics for Professional Accountants</i> (the Code) that are relevant to my audit of the financial report in Australia. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code.</p> <p>I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.</p>
Board's responsibilities for the financial report	<p>The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the <i>Financial Management Act 1994</i>, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error.</p> <p>In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, and using the going concern basis of accounting unless it is inappropriate to do so.</p>

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

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

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

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

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



MELBOURNE
31 August 2017

Ron Mak
as delegate for the Auditor-General of Victoria

Rochester and Elmore District Health Service

Comprehensive Operating Statement for the financial year ended 30 June 2017

	NOTE	2017 \$	2016 \$
Revenue from Operating Activities	2.1	13,402,275	12,767,432
Revenue from Non-operating Activities	2.1	204,369	170,626
Employee Expenses	3.1	(10,170,672)	(9,443,509)
Non Salary Labour Costs	3.1	(396,634)	(499,363)
Supplies and Consumables	3.1	(1,131,261)	(1,100,978)
Other Expenses	3.1	(1,439,025)	(1,467,081)
Net Result Before Capital and Specific Items		469,052	427,127
Capital Purpose Income	2.1	620,946	367,879
Depreciation	4.4	(1,493,645)	(1,513,749)
Expenditure for Capital Purpose	3.1	(73,685)	(132,987)
Net Result after capital and specific items		(477,332)	(851,730)
Other economic flows included in the net result			
Gain/(Loss) on Sale of Assets	7.2	37,061	37,859
Revaluation of Long Service Leave	3.1	(25,574)	-
Total other economic flows included in the net result		11,487	37,859
NET RESULT FOR THE YEAR		(465,845)	(813,871)
COMPREHENSIVE RESULT		(465,845)	(813,871)

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

Rochester and Elmore District Health Service

Balance Sheet as at 30 June 2017

	NOTE	2017	2016
		\$	\$
Current Assets			
Cash and Cash Equivalents	6.1	8,078,320	7,752,309
Receivables	5.1	520,835	463,752
Investments and other financial assets	4.1	3,064,067	2,223,205
Inventories	5.2	45,171	53,635
Prepayments and Other Assets	5.4	129,283	125,228
Total Current Assets		11,837,676	10,618,129
Non-Current Assets			
Receivables	5.1	205,110	274,256
Property, Plant & Equipment	4.3	34,861,701	36,072,982
Total Non-Current Assets		35,066,811	36,347,238
TOTAL ASSETS		46,904,487	46,965,367
Current Liabilities			
Payables	5.5	832,880	461,011
Provisions	3.3	2,326,090	2,205,016
Other Current Liabilities	5.3	5,957,049	6,113,085
Total Current Liabilities		9,116,019	8,779,112
Non-Current Liabilities			
Provisions	3.3	318,829	250,771
Total Non-Current Liabilities		318,829	250,771
TOTAL LIABILITIES		9,434,848	9,029,883
NET ASSETS		37,469,639	37,935,484
EQUITY			
Property, Plant & Equipment Revaluation Surplus	8.1	18,053,026	18,053,026
Restricted Specific Purpose Surplus	8.1	927,164	888,835
Contributed Capital	8.1	7,369,839	7,369,839
Accumulated Surpluses	8.1	11,119,610	11,623,784
TOTAL EQUITY		37,469,639	37,935,484
Contingent Assets and Contingent Liabilities	7.3		
Commitments	6.2		

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

Rochester and Elmore District Health Service

Statement of Changes in Equity for the financial year ended 30 June 2017

		Property, Plant and Equipment Revaluation Surplus	Restricted Special Purpose Surplus	Contribution by Owners	Accumulated Surpluses / (Deficits)	Total
	Note	\$	\$	\$	\$	\$
Balance at 1 July 2015		18,053,026	868,005	7,369,839	12,458,485	38,749,355
Net result for the year	8.1	-	-	-	(813,871)	(813,871)
Transfers		-	20,830	-	(20,830)	-
Other comprehensive income for the year	8.1	-	-	-	-	-
Balance at 30 June 2016		18,053,026	888,835	7,369,839	11,623,784	37,935,484
Net result for the year	8.1	-	-	-	(465,845)	(465,845)
Transfers		-	38,329	-	(38,329)	-
Other comprehensive income for the year	8.1	-	-	-	-	-
Balance at 30 June 2017		18,053,026	927,164	7,369,839	11,119,610	37,469,639

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

Rochester and Elmore District Health Service

Cash Flow Statement for the financial year ended 30 June 2017

	NOTE	2017 \$	2016 \$
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		10,108,033	9,430,812
Capital Grants from Government		484,763	99,732
Patient and Resident Fees Received		1,948,694	1,939,430
Donations and Bequests Received		58,505	36,438
GST Received from/(paid to) ATO		180,231	176,173
Interest Received		145,864	243,064
Other Capital Receipts		106,915	156,439
Other Receipts		1,522,119	1,125,245
Total Receipts		14,555,124	13,207,333
Employee Expenses Paid		(10,100,069)	(9,626,969)
Non Salary Labour Costs		(208,958)	(315,901)
Payments for Supplies & Consumables		(1,275,165)	(1,100,978)
Other Payments		(1,400,105)	(1,646,184)
Total Payments		(12,984,297)	(12,690,032)
NET CASH FLOW FROM OPERATING ACTIVITIES	8.2	1,570,827	517,301
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of Investments		-	736,745
Proceeds from Sale of Investments		(865,335)	-
Payments for Non-Financial Assets		(290,375)	(541,836)
Proceeds from sale of Non-Financial Assets		47,793	84,159
NET CASH FLOW FROM/(USED IN) INVESTING ACTIVITIES		(1,107,917)	279,068
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		462,910	796,369
Cash and Cash Equivalents at beginning of financial year		1,415,370	619,001
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.1	1,878,280	1,415,370

This Statement should be read in conjunction with the accompanying notes

Basis of presentation

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

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

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

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

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

Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements made in the preparation of these financial statements are disclosed in the notes where amounts affected by those judgements are disclosed. 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 future periods that are affected by the revision. Judgements and assumptions made by management in applying the application of AASB that have significant effect on the financial statements and estimates are disclosed in the notes under the heading: 'Significant judgement or estimates'.

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

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 2017. This report provides 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 AASBs, which include interpretations issued by the Australian Accounting Standards Board (AASB). They are presented in a manner consistent with the requirements of AASB 101 *Presentation of Financial Statements*.

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

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

The annual financial statements were authorised for issue by the Board of Rochester and Elmore District Health Service on the 28th August 2017.

(b) 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.

(c) Basis of accounting preparation and measurement

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

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2017, and the comparative information presented in these financial statements for the year ended 30 June 2016.

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 when new indices are published by the Valuer General to ensure that the carrying amounts do not materially differ from their fair values;
- 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.

(d) 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.

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

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 Human Services 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.

Residential Aged Care Service

The *Residential Aged Care Service* operations are an integral part of the *Rochester and Elmore District Health Service* and shares its resources. An apportionment of land and buildings has been made based on floor space. The results of the two operations have been segregated based on actual revenue earned and expenditure incurred by each operation in Notes 2 and 3 to the financial statements.

The *Residential Aged Care Service* is substantially funded from Commonwealth bed-day subsidies.

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 Human Services 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 2.2). 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:
 - Write-down of inventories
 - Non-current asset revaluation increments/decrements
 - Restructuring of operations (disaggregation/aggregation of Health Services)
 - Litigation settlements
 - Reversals of provisions

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

- 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 4.1 & 7.1)
- depreciation and amortisation, as described in 4.4;
- assets provided or received free of charge (refer to Note 2.2); 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.

Other economic flows; are changes arising from market remeasurements. They include:

- gains and losses from disposals of non-financial assets;
- revaluations and impairments of non-financial physical and intangible assets;
- remeasurement arising from defined benefit superannuation plans; and
- fair value changes of financial instruments.

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 dollar unless otherwise stated.

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

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

(e) 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 acute and subacute admitted patient services, where services are delivered in public hospitals.

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

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

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 and secure extended care units.

Other Services not reported elsewhere – (Other) comprises 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, drug services including drug withdrawal, counselling and the needle and syringe program, 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.

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 2.1: Analysis of Revenue by Source

	Admitted Patients 2017	Residential Aged Care 2017	Aged Care 2017	Primary Health 2017	Other 2017	Total 2017
	\$	\$	\$	\$	\$	\$
Government Grants	2,896,014	5,491,826	571,149	955,427	142,431	10,056,847
Indirect contributions by Department of Health and Human Services	3,801	12,204	1,154	5,013	26,773	48,945
Patient & Resident Fees	319,609	1,357,000	54,986	81,253	65,201	1,878,049
Commercial Activities	-	-	-	84,195	94,714	178,909
Other Revenue from Operating Activities	301,248	5,777	30,268	700,117	202,115	1,239,525
Total Revenue from Operating Activities	3,520,672	6,866,807	657,557	1,826,005	531,234	13,402,275
Interest	-	-	-	-	145,864	145,864
Other Revenue from Non-Operating Activities	-	-	-	-	58,505	58,505
Total Revenue from Non-Operating Activities	-	-	-	-	204,369	204,369
Capital Purpose Income (excluding Interest)	-	11,268	-	-	507,526	518,794
Capital Interest	-	102,152	-	-	-	102,152
Gain/(Loss) on Sale of Assets (refer Note 7.2)	-	-	-	-	37,061	37,061
Total Capital Purpose Income	-	113,420	-	-	544,587	658,007
Total Revenue	3,520,672	6,980,227	657,557	1,826,005	1,280,190	14,264,651

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

	Admitted Patients 2016	Residential Aged Care 2016	Aged Care 2016	Primary Health 2016	Other 2016	Total 2016
	\$	\$	\$	\$	\$	\$
Government Grants	3,056,094	5,205,880	667,404	518,218	57,959	9,505,555
Indirect contributions by Department of Health and Human Services	(77,760)	(14,726)	-	-	17,743	(74,743)
Patient and Resident Fees	314,172	1,413,370	49,886	82,534	79,468	1,939,430
Commercial Activities	-	-	14,166	65,678	154,742	234,586
Other Revenue from Operating Activities	290,124	63,589	11,549	227,459	569,883	1,162,604
Total Revenue from Operating Activities	3,582,629	6,668,114	743,005	893,889	879,795	12,767,432
Interest	-	2,832	-	-	131,356	134,188
Other revenue from Non - Operating Activities	-	-	-	-	36,438	36,438
Total Revenue from Non - Operating Activities	-	2,832	-	-	167,794	170,626
Capital Purpose Income (excluding Interest)	-	22,765	-	-	233,406	256,171
Capital Interest	-	-	-	-	111,708	111,708
Gain/(loss) on Sale of Assets (Note 7.2)	-	-	-	-	37,859	37,859
Total Capital Purpose Income	-	22,765	-	-	382,973	405,738
Total Revenue	3,582,629	6,693,711	743,005	893,889	1,430,562	13,343,796

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

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

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

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

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

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

Indirect Contributions from the Department of Health and Human Services

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

-Long Service Leave (LSL) – Revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Metropolitan Health and Aged Care Services Division Hospital Circular 04/2017 (update for 2016-17).

Patient and Resident Fees

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

Private Practice Fees

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

Revenue from commercial activities

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

Donations and Other Bequests

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

Interest Revenue

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

Sale of investments

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

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

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

Other Income

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

Note 2.2: Assets received free of charge or for nominal consideration

During the reporting period, the fair value of assets received free of charge, was as follows:

	2017	2016
	\$	\$
Computers and Communications	-	13,331
Total	-	13,331

Note 3.1: Analysis of Expenses by Source

	Admitted Patients 2017	Residential Aged Care 2017	Aged Care 2017	Primary Health 2017	Other 2017	Total 2017
	\$	\$	\$	\$	\$	\$
Employee Expenses	1,573,265	3,846,754	357,457	1,451,178	2,942,018	10,170,672
Non Salary Labour Costs	238,411	130,096	-	20,096	8,031	396,634
Supplies & Consumables	204,185	209,474	5,677	78,360	633,565	1,131,261
Other Expenses	151,018	151,481	16,693	149,140	970,693	1,439,025
Total Expenditure from Operating Activities	2,166,879	4,337,805	379,827	1,698,774	4,554,307	13,137,592
Expenditure for Capital Purpose	-	-	-	-	73,685	73,685
Revaluation of Long Service Leave	-	-	-	-	25,574	25,574
Depreciation (refer Note 4.4)	-	-	-	-	1,493,645	1,493,645
Total Other Expenses	-	-	-	-	1,592,904	1,592,904
Total Expenses	2,166,879	4,337,805	379,827	1,698,774	6,147,211	14,730,496

	Admitted Patients 2016	Residential Aged Care 2016	Aged Care 2016	Primary Health 2016	Other 2016	Total 2016
	\$	\$	\$	\$	\$	\$
Employee Expenses	1,616,030	3,513,400	358,347	1,042,203	2,913,529	9,443,509
Non Salary Labour Costs	364,018	107,840	-	5,592	21,913	499,363
Supplies & Consumables	288,260	188,807	5,737	15,157	603,017	1,100,978
Other Expenses	156,715	173,570	19,829	61,394	1,055,573	1,467,081
Total Expenditure from Operating Activities	2,425,023	3,983,617	383,913	1,124,346	4,594,032	12,510,931
Expenditure for Capital Purpose	-	-	-	-	132,987	132,987
Depreciation (refer Note 4.4)	-	-	-	-	1,513,749	1,513,749
Total Other Expenses	-	-	-	-	1,646,736	1,646,736
Total Expenses	2,425,023	3,983,617	383,913	1,124,346	6,240,768	14,157,667

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

Other operating expenses

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

Supplies and consumables

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

Bad and doubtful debts

Refer to Note 4.1 Investments and Other 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.

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(j) *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 (j)); and
- disposals of financial assets and derecognition of financial liabilities

Other gains/ (losses) from other comprehensive income

Other gains/ (losses) include:

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

Derecognition of financial liabilities

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

When an existing financial liability is replaced by another from the same lender on substantially different terms, or the terms of an existing liability are substantially modified, such an exchange or modification is treated as a derecognition of the original liability and the recognition of a new liability. The difference in the respective carrying amounts is recognised as an expense in the consolidated comprehensive operating statement.

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 3.2: Analysis of expense and revenue by internally managed and restricted specific purpose funds

	Expense		Revenue	
	2017	2016	2017	2016
	\$	\$	\$	\$
Commercial Activities				
Radiology	52,353	62,258	73,387	90,101
Meals on Wheels	41,866	27,380	51,492	52,034
Cafeteria	46,943	81,308	33,952	39,557
Primary Care Partnership	396,515	402,318	392,689	409,725
Total	537,677	573,264	551,520	591,417

Note 3.3: Employee Benefits in the Balance Sheet

	2017	2016
	\$	\$
Current Provisions		
Employee Benefits (Note 3.3(a))		
Annual Leave (Note 3.3(a))		
- Unconditional and expected to be settled within 12 months (ii)	739,698	665,307
- Unconditional and expected to be settled after 12 months (ii)	123,405	109,173
Accrued Day Off (Note 3.3(a))		
- Unconditional and expected to be settled within 12 months (ii)	6,703	7,891
- Unconditional and expected to be settled after 12 months (ii)	1,110	1,295
Long Service Leave (Note 3.3(a))		
- Unconditional and expected to be settled within 12 months (ii)	128,423	83,009
- Unconditional and expected to be settled after 12 months (ii)	903,598	853,007
Provisions related to employee benefit on-costs		
- Unconditional and expected to be settled within 12 months (ii)	91,976	79,472
- Unconditional and expected to be settled after 12 months (ii)	13,075	101,882
Salaries and Wages (Note 3.3(a))	318,102	303,980
Total Current Provisions	2,326,090	2,205,016
Non-Current Provisions		
Employee Benefits (i) (Note 3.3(a))	201,721	226,770
Provisions related to employee benefits on-costs (Note 3.3(a) and 3.3(b))	117,108	24,001
Total Non-Current Provisions	318,829	250,771
Total Provisions	2,644,919	2,455,787
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and Related On-Costs		
Annual Leave Entitlements	863,103	774,480
Accrued Wages and Salaries	318,102	303,980
Accrued Days Off	7,813	9,186
Unconditional Long Service Leave Entitlements	1,032,021	936,016
Current On-Costs	105,051	181,354
Non-Current Employee Benefits and Related On-Costs		
Conditional Long Service Leave Entitlements (iii)	201,721	226,770
Non-Current On-Costs	117,108	24,001
Total Employee Benefits and Related On-Costs	2,644,919	2,455,787
(b) Movements in Provisions		
Movement in Long Service Leave:		
Balance at start of year	1,255,228	1,288,474
Provision made during the year	171,211	117,828
Settlement made during the year	(125,453)	(151,074)
Balance at end of year	1,300,986	1,255,228

(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.

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. An unconditional right arises after a qualifying period.

The components of this current LSL liability are measured at:

- Undiscounted value – if the health service expects to wholly settle within 12 months; and
- Present value – where the entity does not expect to settle a component of this current liability 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 estimations e.g. bond rate movements, inflation rate movements and changes in probability factors which are then recognised as other economic flow.

On-costs related to employee expense

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

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 3.4: Superannuation

	2017	2016
	\$	\$
Defined Contribution plans:		
First State Super	555,304	604,167
Host Plus Super	605	-
HESTA Administration	227,355	186,707
TOTAL	783,264	790,874

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

The name and details of the major employee superannuation funds and contributions made by Rochester and Elmore District Health Services are disclosed in Note 3.4: *Superannuation*.

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.

Note 4.1: Investments and Other Financial Assets

	Capital		Total	
	2017	2016	2017	2016
	\$	\$	\$	\$
CURRENT				
Term Deposit				
Aust. Dollar Term Deposits(i)	3,064,067	2,223,205	3,064,067	2,223,205
Total Current	3,064,067	2,223,205	3,064,067	2,223,205
Represented by:				
Health Services Investments	3,064,067	2,223,205	3,064,067	2,223,205
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	3,064,067	2,223,205	3,064,067	2,223,205

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 7.1 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 7.1 for the nature and extent of credit risk arising from investments and other financial assets.

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;
- 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.

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

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

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

Doubtful debts

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

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 4.2: Jointly controlled operations and assets

Name of entity	Principal Activity	Ownership Interest	
		2017 %	2016 %
Loddon Mallee Rural Health Alliance	Information Technology	4.06	4.05

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

	2017 \$	2016 \$
CURRENT ASSETS		
Cash and Cash Equivalents	242,991	223,848
Receivables	14,474	12,207
Prepayments	26,235	22,465
TOTAL CURRENT ASSETS	283,700	258,520
NON-CURRENT ASSETS		
Property, Plant and Equipment	6,137	8,581
TOTAL NON-CURRENT ASSETS	6,137	8,581
TOTAL ASSETS	289,837	267,101
CURRENT LIABILITIES		
Payables	51,004	46,797
TOTAL CURRENT LIABILITIES	51,004	46,797
NET ASSETS	238,833	220,304

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

Revenue from Continuing Operations	310,169	344,023
Capital Purpose Income	(6,927)	(62,064)
Total Revenue	303,242	281,959
Other Expenses from Continuing Operations	284,713	309,281
Total Expenses	284,713	309,281
Net Result	18,529	(27,322)

Contingent Assets and Liabilities

The joint venture does not have any known contingent assets or contingent liabilities as at 30 June 2017.

Investments in jointly controlled assets and operations

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

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

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 4.3: Property, Plant and Equipment**(a) Gross carrying amount and accumulated depreciation**

	2017	2016
	\$	\$
Land		
- Land at Fair Value	382,000	382,000
- Landscaping at Fair Value	257,000	257,000
Less Accumulated Depreciation	(19,703)	(10,280)
Total Land	619,297	628,720
Buildings		
- Buildings at Fair Value	36,325,000	36,325,000
Less Accumulated Depreciation	(3,335,760)	(2,223,840)
Total Buildings	32,989,240	34,101,160
Plant and Equipment		
- Plant and Equipment at Fair Value	2,797,892	2,778,339
Less Accumulated Depreciation	(2,225,524)	(2,134,291)
- Loddon Mallee Rural Health Alliance at Fair Value	33,442	36,382
Less Accumulated Depreciation	(27,304)	(27,807)
Total Plant and Equipment	578,506	652,622
Computers and Communication		
- Computers and Communication at Fair Value	267,577	211,062
Less Accumulated Depreciation	(148,221)	(85,095)
Total Computers and Communications	119,356	125,966
Furniture and Fittings		
- Furniture and Fittings at Fair Value	873,810	851,219
Less Accumulated Depreciation	(471,161)	(430,176)
Total Furniture and Fittings	402,649	421,044
Motor Vehicles		
- Motor Vehicles at Fair Value	381,402	398,527
Less Accumulated Depreciation	(228,749)	(255,057)
Total Motor Vehicles	152,653	143,470
TOTAL	34,861,701	36,072,982

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 4.3: Property, Plant and Equipment (Continued)**(b) 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
	\$	\$	\$	\$	\$	\$	\$	\$
Balance at 1 July 2015	633,860	35,213,080	539,989	232,785	110,744	190,133	170,176	37,090,767
Additions	-	-	312,375	21,588	68,913	93,447	45,513	541,836
Transfers In/(out)	-	-	-	215,689	-	-	(215,689)	-
Loddon Mallee Rural Health Alliance	-	-	428	-	-	-	-	428
Disposals	-	-	(1,350)	4,302	(672)	(48,580)	-	(46,300)
Depreciation (see Note 4.4)	(5,140)	(1,111,920)	(198,820)	(53,320)	(53,019)	(91,530)	-	(1,513,749)
Balance at 30 June 2016	628,720	34,101,160	652,622	421,044	125,966	143,470	-	36,072,982
Additions	-	-	107,755	33,910	61,195	87,515	-	290,375
Transfers In/(out)	-	-	-	-	-	-	-	-
Loddon Mallee Rural Health Alliance	-	-	2,721	-	-	-	-	2,721
Disposals	-	-	(419)	-	(47)	(10,266)	-	(10,732)
Depreciation (see Note 4.4)	(9,423)	(1,111,920)	(184,173)	(52,305)	(67,758)	(68,066)	-	(1,493,645)
Balance at 30 June 2017	619,297	32,989,240	578,506	402,649	119,356	152,653	-	34,861,701

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 103F. Management have obtained second-hand values for equipment where possible, or completed an assessment of value based on depreciated replacement cost.

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 4.3: Property, plant & equipment (continued)

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

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

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

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 4.3: Property, plant & equipment (continued)

(c) Fair value measurement hierarchy for assets as at 30 June 2016

	Carrying amount as at 30 June 2016	Fair value measurement at end of reporting period using:		
		Level 1 ⁽¹⁾	Level 2 ⁽¹⁾	Level 3 ⁽¹⁾
Land at fair value				
Non-specialised land	140,200	-	140,200	-
Specialised land	241,800	-	-	241,800
Total of land at fair value	382,000	-	140,200	241,800
Buildings at fair value				
Non-specialised buildings	1,490,775	-	1,490,775	-
Specialised buildings	32,610,385	-	-	32,610,385
Total of building at fair value	34,101,160	-	1,490,775	32,610,385
Land Improvements at fair value				
Specialised land improvements	246,720	-	-	246,720
Total of land improvements at fair value	246,720	-	-	246,720
Plant and Equipment at fair value				
Plant and Equipment	652,622	-	-	652,622
Total of plant and equipment at fair value	652,622	-	-	652,622
Computer and Communication at fair value				
Computers and Communication	125,966	-	-	125,966
Total Computer and communication at fair value	125,966	-	-	125,966
Furniture and Fittings at fair value				
Furniture and Fittings	421,044	-	-	421,044
Total Furniture and Fittings at fair value	421,044	-	-	421,044
Motor Vehicles at fair value				
Motor Vehicles	143,470	-	-	143,470
Total Motor Vehicles at fair value	143,470	-	-	143,470
	36,072,982	-	1,630,975	34,442,007

Note

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

Note 4.3: Property, plant & equipment (continued)

(c) Fair value measurement hierarchy for assets as at 30 June 2016

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

- the fair value of land, buildings, infrastructure, plant and equipment, (refer to Note 7.1);
- 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 3.3); and
- equities and management investment schemes classified at level 3 of the fair value hierarchy

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.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision, and future periods if the revision affects both current and future periods. Judgements and assumptions made by management in the application of AASBs that have significant effects on the financial statements and estimates, with a risk of material adjustments in the subsequent reporting period, relate to:

- the fair value of land, buildings, infrastructure, plant and equipment (refer to Note 7.1);
- superannuation expense (refer to Note 3.4); 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 3.3).

Fair value measurement

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

The fair value measurement is based on the following assumptions:

- that the transaction to sell the asset or transfer the liability takes place either in the principal market (or the most advantageous market, in the absence of the principal market), either of which must be accessible to the Health Service at the measurement date;

- that the Health Service uses the same valuation assumptions that market participants would use when pricing the asset or liability, assuming that market participants act in their economic best interest.

The fair value measurement of a non-financial asset takes into account a market participant's ability to generate economic benefits by using the asset in its highest and best use or by selling it to another market participant that would use the asset in its highest and best use.

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

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

In considering the HBU for non-financial physical assets, valuers are probably best placed to determine highest and best use (HBU) in consultation with Health Services. Health Services and their valuers therefore need to have a shared understanding of the circumstances of the assets. A Health Service has to form its own view about a valuer's determination, as it is ultimately responsible for what is presented in its audited financial statements.

In accordance with paragraph AASB 13.29, Health Services can assume the current use of a non-financial physical asset is its

HBU unless market or other factors suggest that a different use by market participants would maximise the value of the asset.

Therefore, an assessment of the HBU will be required when the indicators are triggered within a reporting period, which suggest the market participants would have perceived an alternative use of an asset that can generate maximum value. Once identified,

Health Services are required to engage with VGV or other independent valuers for formal HBU assessment.

These indicators, as a minimum, include:

External factors:

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

In addition, Health Services need to assess the HBU as part of the 5-year review of fair value of non-financial physical assets. This is consistent with the current requirements on FRD 103F *Non-financial physical assets* and FRD 107B *Investment properties*.

Valuation hierarchy

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

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

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 4.3: Property, plant & equipment (continued)**(d) Reconciliation of Level 3 fair value 2017**

	Land	Buildings	Land Improvements	Plant and Equipment	Computers & Communication	Furniture & Fittings	Motor Vehicles	Assets under construction
Opening Balance	241,800	32,610,385	246,720	652,622	125,966	421,044	143,470	-
Purchases (sales)	-	-	-	110,057	61,148	33,910	77,250	-
Transfers in (out) of Level 3	-	-	-	-	-	-	-	-
Gains or losses recognised in net result								
- Depreciation	-	(1,111,920)	(9,423)	(184,173)	(67,758)	(52,305)	(68,066)	-
Subtotal	241,800	31,498,465	237,297	578,506	119,356	402,649	152,654	-
Items recognised in other comprehensive income								
- Revaluation	-	-	-	-	-	-	-	-
Subtotal	-	-	-	-	-	-	-	-
Closing Balance	241,800	31,498,465	237,297	578,506	119,356	402,649	152,654	-
	241,800	31,498,465	237,297	578,506	119,356	402,649	152,654	-

Note

There have been no transfers between levels during the period.

(d) Reconciliation of Level 3 fair value 2016

	Land	Buildings	Land Improvements	Plant and Equipment	Computers & Communication	Furniture & Fittings	Motor Vehicles	Assets under construction
Opening Balance	241,800	33,722,305	251,860	539,989	110,744	232,785	190,133	170,176
Purchases (sales)	-	-	-	311,453	68,241	25,890	44,867	45,513
Transfers in (out) of Level 3	-	-	-	-	-	215,689	-	(215,689)
Gains or losses recognised in net result								
- Depreciation	-	(1,111,920)	(5,140)	(198,820)	(53,019)	(53,320)	(91,530)	-
Subtotal	241,800	32,610,385	246,720	652,622	125,966	421,044	143,470	-
Items recognised in other comprehensive income								
- Revaluation	-	-	-	-	-	-	-	-
Subtotal	-	-	-	-	-	-	-	-
Closing Balance	241,800	32,610,385	246,720	652,622	125,966	421,044	143,470	-
	241,800	32,610,385	246,720	652,622	125,966	421,044	143,470	-

Note

There have been no transfers between levels during the period.

Identifying unobservable inputs (level 3) fair value measurements

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

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

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

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

Non-specialised land and non-specialised buildings

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

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

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.

Note 4.3: Property, plant & equipment (continued)

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 it 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 2017.

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

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

	Valuation technique (1)	Significant unobservable inputs (1)
Specialised land	Market approach	Community Service Obligation (CSO) adjustment
Specialised buildings	Depreciated replacement cost	Direct cost per square metre Useful life of specialised buildings
Landscaping & Grounds	Depreciated replacement cost	Direct replacement cost Useful life of Landscaping & Grounds
Plant & Equipment	Depreciated replacement cost	Cost per unit Useful life of PPE
Motor Vehicles	Depreciated replacement cost	Cost per unit Useful life of vehicles
Computers and Communication	Depreciated replacement cost	Cost per unit Useful life of furniture & fittings
Furniture & Fittings at fair value	Depreciated replacement cost	Cost per unit Useful life of furniture & fittings

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 4.3 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.

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 4.3: Property, plant & equipment (continued)

Revaluations of non-current physical assets

Non-current physical assets are measured at fair value and are revalued in accordance with FRD 103F *Non-current physical assets*. This revaluation process normally occurs 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 103F, Rochester and Elmore District Health Service's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

Note 4.4: Depreciation

	2017	2016
	\$	\$
Buildings	1,111,920	1,111,920
Land Improvements	9,423	5,140
Plant & Equipment	179,014	187,391
Motor Vehicles	68,066	91,530
Furniture and Fittings	52,305	53,320
Computer and Communications	67,758	53,019
Loddon Mallee Rural Health Alliance	5,159	11,429
Total Depreciation	1,493,645	1,513,749

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.

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 and Human Services. Assets with a cost in excess of \$1,000 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.

	2017	2016
Buildings		
- Structure Shell Building Fabric	45 to 60 years	45 to 60 years
- Site Engineering Services and Central Plant	20 to 30 years	20 to 30 years
Central Plant		
- Fit Out	20 to 30 years	20 to 30 years
- Trunk Reticulated Building Systems	30 to 40 years	30 to 40 years
Plant & Equipment	3 to 20 years	3 to 20 years
Medical Equipment	5 to 10 years	5 to 10 years
Computers and Communication	3 years	3 years
Furniture and Fitting	3 to 40 years	3 to 40 years
Motor Vehicles	2 to 5 years	2 to 5 years

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

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 5.1: Receivables

	2017	2016
	\$	\$
CURRENT		
Contractual		
Trade Debtors	204,546	168,797
Patient Fees	17,038	68,791
Accrued Investment Income	21,054	19,084
Accrued Revenue - Other	90,171	45,026
Loddon Mallee Rural Health Alliance Receivables	7,634	6,988
Less Allowance for Doubtful Debts Patient Fees	(1,721)	(1,721)
	338,722	306,965
Statutory		
GST Receivable	177,053	152,422
Loddon Mallee Rural Health Alliance GST Receivables	5,060	4,365
	182,113	156,787
TOTAL CURRENT RECEIVABLES	520,835	463,752

Statutory

Long Service Leave - Department of Health and Human Services

	205,110	274,256
	205,110	274,256
TOTAL NON-CURRENT RECEIVABLES	205,110	274,256
TOTAL RECEIVABLES	725,945	738,008

(a) Movement in the Allowance for doubtful debts

Balance at the beginning of year - REDHS

Balance at the beginning of year - LMRHA

Increase/(decrease) in allowance recognised in net result

Balance at end of year

	2017	2016
	\$	\$
	1,721	1,721
	-	-
	-	-
	1,721	1,721

(b) Ageing analysis of receivables

Please refer to note 7.1 for the ageing analysis of contractual receivables.

(c) Nature and extent of risk arising from receivables

Please refer to note 7.1 for the nature and extent of credit risk arising from contractual 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.

Note 5.2: Inventories

	2017	2016
	\$	\$
CURRENT		
Pharmaceuticals - at cost	11,406	9,945
Catering Supplies - at cost	7,159	9,827
Housekeeping Supplies - at cost	1,098	1,000
Medical and Surgical Lines - at cost	20,859	29,556
Administration Stores - at cost	2,868	2,452
Inventory - LMRHA	1,781	855
TOTAL INVENTORIES	45,171	53,635

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

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

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

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

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

Note 5.3: Other Current Liabilities

	2017	2016
	\$	\$
CURRENT		
Monies Held in Trust*		
- Patient Monies Held in Trust	-	21,606
- Accommodation Bonds (Refundable Entrance Fees)	5,949,982	6,084,561
Rochester Community House	7,067	6,918
TOTAL CURRENT	5,957,049	6,113,085

*** Total Monies Held in Trust****Represented by the following assets:**

Cash Assets (refer to Note 6.1)	-	21,606
Cash and Cash Equivalents (refer to Note 6.1)	5,949,982	6,084,561
Rochester Community House	7,067	6,918
TOTAL	5,957,049	6,113,085

Note 5.4: Prepayments and Other Assets

	2017	2016
	\$	\$
Current:		
Prepayments	103,048	102,763
Loddon Mallee Rural Health Alliance	26,235	22,465
TOTAL CURRENT OTHER ASSETS	129,283	125,228
TOTAL OTHER ASSETS	129,283	125,228

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.

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 5.5: Payables

	2017	2016
	\$	\$
CURRENT		
Contractual		
Trade Creditors	419,891	180,475
Accrued Expenses	125,024	130,367
Accrued Audit Fees	16,500	16,500
Other Payables	96,567	11,843
Loddon Mallee Rural Health Alliance	51,005	46,797
	708,987	385,983
Statutory		
GST Payable	123,893	75,028
TOTAL CURRENT	123,893	75,028
TOTAL PAYABLES	832,880	461,011

(a) Maturity analysis of payables

Please refer to Note 7.1 for the ageing analysis of contractual payables.

(b) Nature and extent of risk arising from payables

Please refer to note 7.1 for the nature and extent of risks arising from contractual 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.

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 6.1: 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.

	2017	2016
	\$	\$
Cash on Hand	700	700
Cash at Bank	8,077,620	7,751,609
Total Cash and Cash Equivalents	8,078,320	7,752,309
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	1,878,280	1,415,370
Cash for Monies Held in Trust		
- Deposits at Call	7,067	6,919
- Accommodation Bonds (Refundable Entrance Fees)	5,949,982	6,084,561
- Resident Trust Account	-	21,606
- Loddon Mallee Rural Health Alliance	242,991	223,853
Total Cash and Cash Equivalents	8,078,320	7,752,309

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.

Note 6.2: Commitments for Expenditure

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

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

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 7.1: 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)
- 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 \$	Contractual financial assets/liabilities held- for-trading at fair value through profit/loss \$	Contractual financial assets - loans and receivables \$	Contractual financial assets - available for sale \$	Contractual financial liabilities at amortised cost \$	Total \$
2017						
Contractual Financial Assets						
Cash and cash equivalents	-	-	8,078,320	-	-	8,078,320
Receivables						-
- Trade Debtors	-	-	221,584	-	-	221,584
- Other Receivables	-	-	117,138	-	-	117,138
Other Financial Assets						
- Term Deposit	-	-	3,064,067	-	-	3,064,067
Total Financial Assets ⁽ⁱ⁾	-	-	11,481,109	-	-	11,481,109
Financial Liabilities						
Payables	-	-	-	-	708,987	708,987
Other Financial Liabilities						
- Patient Monies in Trust	-	-	-	-	-	-
- Accomodation bonds	-	-	-	-	5,949,982	5,949,982
- Rochester Community House	-	-	-	-	7,067	7,067
Total Financial Liabilities ⁽ⁱⁱ⁾	-	-	-	-	6,666,036	6,666,036

	Contractual financial assets/liabilities designated at fair value through profit/loss \$	Contractual financial assets/liabilities held- for-trading at fair value through profit/loss \$	Contractual financial assets - loans and receivables \$	Contractual financial assets - available for sale \$	Contractual financial liabilities at amortised cost \$	Total \$
2016						
Contractual Financial Assets						
Cash and cash equivalents	-	-	7,752,309	-	-	7,752,309
Receivables						-
- Trade Debtors	-	-	237,588	-	-	237,588
- Other Receivables	-	-	69,377	-	-	69,377
Other Financial Assets						
- Term Deposit	-	-	2,223,205	-	-	2,223,205
Total Financial Assets ⁽ⁱ⁾	-	-	10,282,479	-	-	10,282,479
Financial Liabilities						
Payables	-	-	-	-	385,983	385,983
Other Financial Liabilities						
- Patient Monies in Trust	-	-	-	-	21,606	21,606
- Accomodation bonds	-	-	-	-	6,084,561	6,084,561
- Rochester Community House	-	-	-	-	6,918	6,918
Total Financial Liabilities ⁽ⁱⁱ⁾	-	-	-	-	6,499,068	6,499,068

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

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

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 7.1: Financial Instruments (continued)

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

	Net holding gain/(loss) \$	Total interest income / (expense) \$	Fee income / (expense) \$	Impairment loss \$	Total \$
2017					
Financial Assets					
Loans and Receivables	-	242,991	-	-	242,991
Total Financial Assets	-	242,991	-	-	242,991
2016					
Financial Assets					
Loans and Receivables	-	245,896	-	-	245,896
Total Financial Assets	-	245,896	-	-	245,896

(c) 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 Elmore District Health Service's maximum exposure to credit risk without taking account of the value of any collateral obtained.

Credit quality of contractual financial assets past that are neither due nor impaired.

	Financial Institutions (AA credit Rating) \$	Government agencies (AAA credit Rating) \$	Financial Institutions (BBB credit Rating) \$	Other \$	Total \$
2017					
Financial Assets					
Cash and cash equivalents	-	-	8,077,620	-	8,077,620
Receivables					-
- Trade Debtors	-	-	-	221,584	221,584
- Other Receivables	-	-	-	117,138	117,138
Other Financial Assets					
- Term Deposit	-	3,064,067	-	-	3,064,067
Total Financial Assets	-	3,064,067	8,077,620	338,722	11,480,409
2016					
Financial Assets					
Cash and cash equivalents	2,317,191	-	5,435,118	-	7,752,309
Receivables					-
- Trade Debtors	-	-	-	237,588	237,588
- Other Receivables	-	-	-	69,377	69,377
Other Financial Assets					
- Term Deposit	-	2,223,205	-	-	2,223,205
Total Financial Assets	2,317,191	2,223,205	5,435,118	306,965	10,282,479

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 7.1: Financial Instruments (continued)
(c) Credit Risk (continued)
Ageing analysis of Financial Assets as at 30 June

	Total Carrying Amount \$	Not Past Due and Not Impaired \$	Past Due But Not Impaired			
			Less than 1 Month \$	1 to 3 Months \$	3 months to 1 Year \$	1 to 5 Years \$
2017						
Financial Assets						
Cash & Cash Equivalents	8,077,620	8,077,620	-	-	-	-
Receivables						
- Trade Debtors	221,584	194,646	16,523	10,415	-	-
- Other Receivables	117,138	117,138	-	-	-	-
Other Financial Assets						
-Term Deposit	3,064,067	3,064,067	-	-	-	-
Total Financial Assets	11,480,409	11,453,471	16,523	10,415	-	-
2016						
Financial Assets						
Cash & Cash Equivalents	7,752,309	7,752,309	-	-	-	-
Receivables						
- Trade Debtors	237,588	154,370	74,081	9,137	-	-
- Other Receivables	69,377	69,377	-	-	-	-
Other Financial Assets						
- Term Deposit	2,223,205	2,223,205	-	-	-	-
Total Financial Assets	10,282,479	10,199,261	74,081	9,137	-	-

(i) Aging analysis of financial assets must exclude the types of statutory financial assets (ie GST input tax)

(d) 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 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 \$	Maturity Dates			
			Less than 1 Month \$	1 to 3 Months \$	3 months to 1 Year \$	1 to 5 Years \$
2017						
Financial Liabilities						
Payables	708,987	708,987	708,987	-	-	-
Other Financial Liabilities(i)						
- Monies Held in Trust	5,949,982	5,949,982	63,296	41,456	5,845,230	-
- Rochester Community House	7,067	7,067	7,067	-	-	-
Total Financial Liabilities	6,666,036	6,666,036	779,350	41,456	5,845,230	-
2016						
Financial Liabilities						
Trade Creditors & Accruals	385,983	385,983	385,983	-	-	-
Other Financial Liabilities(i)						
- Monies Held in Trust	6,113,085	6,113,085	65,031	42,592	6,005,462	-
- Patient Monies in Trust	21,606	21,606	21,606	-	-	-
- Rochester Community House	6,918	6,918	6,918	-	-	-
Total Financial Liabilities	6,527,592	6,527,592	479,538	42,592	6,005,462	-

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

Note 7.1: Financial Instruments (continued)

(e) 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		
			Fixed Interest Rate \$	Variable Interest Rate \$	Non Interest Bearing \$
2017					
Financial Assets					
Cash & Cash Equivalents	2.32	8,077,620	7,178,485	899,135	-
Receivables(i)					
- Trade Debtors		221,584	-	-	221,584
- Other Receivables		117,138	-	-	117,138
Other Financial Assets					
- Term Deposits	1.84	3,064,067	3,064,067	-	-
Total Financial Assets		11,480,409	10,242,552	899,135	338,722
Financial Liabilities					
Payables(i)		708,987	-	-	708,987
Other Financial Liabilities					
- Monies Held in Trust		5,949,982	-	-	5,949,982
- Patient Monies in Trust		-	-	-	-
- Rochester Community House		7,067	-	-	7,067
Total Financial Liabilities		6,666,036	-	-	6,666,036
2016					
Financial Assets					
Cash & Cash Equivalents	2.47	7,752,309	6,738,731	1,013,578	-
Receivables(i)					
- Trade Debtors		237,588	-	-	237,588
- Other Receivables		69,377	-	-	69,377
Other Financial Assets					
- Term Deposits	2.11	2,223,205	2,223,205	-	-
Total Financial Assets		10,282,479	8,961,936	1,013,578	306,965
Financial Liabilities					
Payables(i)		385,983	-	-	385,983
Other Financial Liabilities					
- Monies Held in Trust		6,084,561	-	-	6,084,561
- Patient Monies in Trust		21,606	-	-	21,606
- Rochester Community House		6,918	-	-	6,918
Total Financial Liabilities		6,499,068	-	-	6,499,068

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

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 7.1: Financial Instruments (continued)
(e) Market Risk (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 2.08%.

A parallel shift of 1% in inflation rate from year end rates of 2.08%.

A movement of 15% up and down (2017: 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% Profit \$	-1% Equity \$	+1% Profit \$	+1% Equity \$	-1% Profit \$	-1% Equity \$	+1% Profit \$	+1% Equity \$
2017									
Financial Assets									
Cash & Cash Equivalents	8,077,620	(80,776)	(80,776)	80,776	80,776	-	-	-	-
Receivables									
- Trade Debtors	221,584	-	-	-	-	-	-	-	-
- Other Receivables	117,138	-	-	-	-	-	-	-	-
Other Financial Assets									
- Term Deposits	3,064,067	(30,641)	(30,641)	30,641	30,641	-	-	-	-
Financial Liabilities									
Payables	708,987	-	-	-	-	-	-	-	-
Other Financial Liabilities									
- Monies Health in Trust	5,949,982	-	-	-	-	-	-	-	-
- Patient Monies in Trust	-	-	-	-	-	-	-	-	-
- Rochester Community Health	7,067	-	-	-	-	-	-	-	-
		(111,417)	(111,417)	111,417	111,417	-	-	-	-

	Carrying Amount \$	Interest Rate Risk				Other Price Risk			
		-1% Profit \$	-1% Equity \$	+1% Profit \$	+1% Equity \$	-1% Profit \$	-1% Equity \$	+1% Profit \$	+1% Equity \$
2016									
Financial Assets									
Cash & Cash Equivalents	7,752,309	(77,523)	(77,523)	77,523	77,523	-	-	-	-
Receivables									
- Trade Debtors	237,588	-	-	-	-	-	-	-	-
- Other Receivables	69,377	-	-	-	-	-	-	-	-
Other Financial Assets									
-Term Deposits	2,223,205	(22,232)	(22,232)	22,232	22,232	-	-	-	-
Financial Liabilities									
Payables	385,983	-	-	-	-	-	-	-	-
Other Financial Liabilities									
- Monies Health in Trust	6,084,561	-	-	-	-	-	-	-	-
- Patient Monies in Trust	21,606	-	-	-	-	-	-	-	-
- Rochester Community Health	6,918	-	-	-	-	-	-	-	-
		(99,755)	(99,755)	99,755	99,755	-	-	-	-

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

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

	Carrying Amount 2017	Fair value 2017	Carrying Amount 2016	Fair value 2016
	\$	\$	\$	\$
Financial Assets				
Cash and Cash Equivalents	8,077,620	8,077,620	7,752,309	7,752,309
Receivables				
- Trade Debtors	221,584	221,584	237,588	237,588
- Other Receivables	117,138	117,138	69,377	69,377
Other Financial Assets				
- Term Deposit	3,064,067	3,064,067	2,223,205	2,223,205
Total Financial Assets	11,480,409	11,480,409	10,282,479	10,282,479
Financial Liabilities				
Payables	708,987	708,987	322,685	322,685
Other Financial Liabilities				
- Monies Held in Trust	5,949,982	5,949,982	6,084,561	6,084,561
- Patient Monies in Trust	-	-	21,606	21,606
- Rochester Community House	7,067	7,067	6,918	6,918
Total Financial Liabilities	6,666,036	6,666,036	6,435,770	6,435,770

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, as required AASB 139 para 55. Any dividend or interest on a financial asset is recognised in the net result for the year.

Financial assets and liabilities at fair value through profit and loss include the majority of the Rochester and Elmore District Health Service's equity investments, debt securities and borrowings.

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 6.1), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 7.2: Net Gain/(Loss) on Disposal of Non-Financial Assets

	2017	2016
	\$	\$
Proceeds from Disposals of Non-Current Assets		
Motor Vehicles	47,273	74,727
Plant and Equipment	520	9,000
Computer Equipment	-	432
Total Proceeds from Disposal of Non-Current Assets	47,793	84,159
Less: Written Down Value of Non-Current Assets Sold		
Motor Vehicles	(10,266)	(48,580)
Plant and Equipment	(419)	(1,350)
Computer Equipment	(47)	(672)
Furniture and Fittings	-	4,302
Total Written Down Value of Non-Current Assets Sold	(10,732)	(46,300)
Net Gain/(Loss) on Disposal of Non-Financial Assets	37,061	37,859

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 8.1 – '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.

Note 7.3: Contingent Assets & Contingent Liabilities

Rochester and Elmore District Health Service is not aware of any contingent assets and liabilities at 30 June 2017.

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

Note 8.1: Equity

(a) Surpluses

Property, Plant and Equipment Revaluation Surplus

Balance at the beginning of the reporting period

- Land

- Buildings

Balance at the end of the reporting period

Balance at the end of the reporting period*

*** Represented by:**

- Land

- Buildings

Restricted Specific Purpose Surplus

Balance at the beginning of the reporting period

Transfer to and from Restricted Purpose Surplus

Balance at the end of the reporting period

TOTAL SURPLUSES

(b) Contributed Capital

Balance at the beginning of the reporting period

Balance at the end of the reporting period

(c) Accumulated Surpluses/(Deficits)

Balance at the beginning of the reporting period

Net Result for the year

Transfer to and from Restricted Purpose Surplus

Balance at the end of the reporting period

TOTAL EQUITY AT END OF FINANCIAL YEAR

	2017	2016
	\$	\$
	196,325	196,325
	17,856,701	17,856,701
	18,053,026	18,053,026
	196,325	196,325
	17,856,701	17,856,701
	18,053,026	18,053,026
	888,835	868,005
	38,329	20,830
	927,164	888,835
	18,980,190	18,941,861
	7,369,839	7,369,839
	7,369,839	7,369,839
	11,623,784	12,458,485
	(465,845)	(813,871)
	(38,329)	(20,830)
	11,119,610	11,623,784
	37,469,639	37,935,484

Contributed capital

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

Transfers of net assets arising from administrative restructurings are treated as contributions by owners. Transfers of net liabilities arising from administrative restructures are to go through the comprehensive operating statement.

Property, plant & equipment revaluation surplus

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

Specific restricted purpose surplus

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

Note 8.2: Reconciliation of the net result for the year to net cash inflow/(outflow) from operating activities

Net result for the period

Non-cash movements:

Depreciation

Share of Net Result from LMRHA

Movements included in investing and financing activities:

Net (Gain)/Loss from Sale of Motor Vehicles

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

Net (Gain)/Loss from Sale of Computer Equipment

Net (Gain)/Loss from Sale of Furniture & Fittings

Movements in assets and liabilities:

Change in operating assets and liabilities

(Increase)/Decrease in Receivables

(Increase)/Decrease in Prepayments

Change in Inventories

Increase/(Decrease) in Payables

Increase/(Decrease) in Provisions

NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES

	2017	2016
	\$	\$
	(465,845)	(813,871)
	1,493,645	1,513,749
	(18,529)	27,322
	(37,007)	(26,147)
	(101)	(7,650)
	47	240
	-	(4,302)
	(12,063)	(93,255)
	(4,055)	16,070
	(8,464)	(7,624)
	434,067	(171,429)
	189,132	84,198
	1,570,827	517,301

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 8.3: Operating Segments

	Health Services		RACS		Other Services		Total	
	2017	2016	2017	2016	2017	2016	2017	2016
	\$	\$	\$	\$	\$	\$	\$	\$
REVENUE								
External Segment Revenue	6,093,809	5,850,177	6,861,518	6,668,114	1,061,309	579,421	14,016,636	13,097,712
Total Revenue	6,093,809	5,850,177	6,861,518	6,668,114	1,061,309	579,421	14,016,636	13,097,712
EXPENSES								
External Segment Expenses	(5,072,547)	(5,047,949)	(4,748,723)	(4,298,827)	(4,909,226)	(4,810,704)	(14,730,496)	(14,157,480)
Total Expenses	(5,072,547)	(5,047,949)	(4,748,723)	(4,298,827)	(4,909,226)	(4,810,704)	(14,730,496)	(14,157,480)
Net Result from ordinary activities	1,021,262	802,228	2,112,795	2,369,287	(3,847,917)	(4,231,283)	(713,860)	(1,059,768)
Interest Expense	-	-	-	-	-	-	-	-
Interest Income	126,656	110,525	102,152	114,540	19,207	20,831	248,015	245,897
Net Result for Year	1,147,918	912,753	2,214,947	2,483,827	(3,828,710)	(4,210,452)	(465,845)	(813,871)
OTHER INFORMATION								
Segment Assets	15,930,684	14,089,610	20,472,714	23,482,683	-	-	36,403,398	37,572,293
Unallocated Assets	-	-	-	-	10,501,089	9,393,074	10,501,089	9,393,074
Total Assets	15,930,684	14,089,610	20,472,714	23,482,683	10,501,089	9,393,074	46,904,487	46,965,367
Segment Liabilities	1,606,566	1,995,820	6,933,892	6,143,741	-	-	8,540,458	8,139,561
Unallocated Liabilities	-	-	-	-	894,390	890,322	894,390	890,322
Total Liabilities	1,606,566	1,995,820	6,933,892	6,143,741	894,390	890,322	9,434,848	9,029,883
Acquisition of property, plant and equipment and intangible assets	62,334	512,376	69,059	37,157	158,982	162,479	290,375	712,012
Depreciation expense	(774,712)	(908,249)	(410,919)	(302,750)	(308,014)	(302,750)	(1,493,645)	(1,513,749)
Non cash expenses other than depreciation	-	-	-	-	-	-	-	-

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

Business Segments	Services
Residential Aged Care Services (RACS)	Nursing Home Services Hostel Facilities
Health Services	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 8.4: 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:	Period
The Honourable Jill Hennessy, MLC, Minister for Health, Minister for Ambulance Services	01/07/2016-30/06/2017
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Health	01/07/2016-30/06/2017
Governing Boards	
Mr T Fulton	01/07/2016-30/06/2017
Ms K Lee	01/07/2016-30/06/2017
Mr B Maw	01/07/2016-30/11/2016
Dr C McKinstry	01/07/2016-30/06/2017
Mr K Oberin	01/07/2016-30/06/2017
Ms M O'Sullivan	01/07/2016-30/06/2017
Miss J Smith	01/07/2016-30/06/2017
Mr D Rosala	25/04/2017-30/06/2017
No remuneration was paid to any Governing Board Members for the Financial Year ended 30 June 2017.	

Accountable Officers	
Mrs Anne McEvoy	01/07/2016-30/06/2017

Remuneration of Responsible Persons

Remuneration received or receivable by the responsible persons was in the range of: \$150,000 - \$159,000 (\$130,000 - \$139,000 in 2015-16).

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

Note 8.5: 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 table below. Total annualised employee equivalent provides a measure of full time equivalent executive officers over the reporting period.

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

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

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

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

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

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

	Total Remuneration	
	2017	2016
	\$	\$
Compensation		
Short term employee benefits	135,406	
Post-employment benefits	13,360	
Other long-term benefits	3,385	
Termination benefits	-	
Share based payments	-	
Total	152,151	
Total number of executives	2	
Total annualised employee equivalent (AEE)	2	

Notes:

(a) No comparatives have been reported because remuneration in the prior year was determined in line with the basis and definition under FRD 21B. Remuneration previously excluded non-monetary benefits and comprised any money, consideration or benefit received or receivable, excluding reimbursement of out-of-pocket expenses, including any amount received or receivable from a related party transaction. Refer to the prior year's financial statements for executive remuneration for the 2015-16 reporting period.

(b) Remuneration represents the expenses incurred by the entity in the current reporting period for the employee, in accordance with AASB 119 Employee Benefits.

(c) The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of the entity under AASB 124 Related Party Disclosures and are also reported within the related parties note disclosure (Note 8.6).

(d) Annualised employee equivalent is based on the time fraction worked over the reporting period. This is calculated as the total number of days the employee is engaged to work during the week by the total number of full-time working days per week (this is generally five full working days per week).

Note 8.6: Related Parties

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

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

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

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

Compensation	2017
Short term employee benefits	227,106
Post-employment benefits	22,072
Other long-term benefits	5,678
Termination benefits	-
Share based payments	-
Total	254,856

Transactions with key management personnel and other related parties

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

Significant transactions with government related entities

The Rochester & Elmore District Health Service received funding from the Department of Health and Human Services of \$6,713,933 (\$6,326,593 in 2015-16)

Note 8.7: Remuneration of auditors

Victorian Auditor-General's Office	2017	2016
	\$	\$
Audit or review of financial statements	16,500	16,500
TOTAL	16,500	16,000

Rochester and Elmore District Health Service

Notes to and forming part of the Financial Statements for the year ended 30 June 2017

Note 8.8: AASBs issued that are not yet effective

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2017 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 2017, 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.

Standard/Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on public sector entity financial statements
AASB 9 Financial Instruments	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1-Jan-18	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. While there will be no significant impact arising from AASB 9, there will be a change to the way financial instruments are disclosed.
AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)	<p>The requirements for classifying and measuring financial liabilities were added to AASB 9. The existing requirements for the classification of financial liabilities and the ability to use the fair value option have been retained. However, where the fair value option is used for financial liabilities the change in fair value is accounted for as follows:</p> <ul style="list-style-type: none"> The change in fair value attributable to changes in credit risk is presented in other comprehensive income (OCI); and Other fair value changes are presented in profit and loss. If this approach creates or enlarges an accounting mismatch in the profit or loss, the effect of the changes in credit risk are also presented in profit or loss. 	1-Jan-18	<p>The 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>Changes in own credit risk in respect of liabilities designated at fair value through profit and loss will now be presented within other comprehensive income (OCI).</p> <p>Hedge accounting will be more closely aligned with common risk management practices making it easier to have an effective hedge.</p> <p>For entities with significant lending activities, an overhaul of related systems and processes may be needed.</p>
AASB 2014-1 Amendments to Australian Accounting Standards [Part E Financial Instruments]	<p>Amends various AASBs to reflect the AASB's decision to defer the mandatory application date of</p> <p>AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.</p>	1-Jan-18	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9	Amends various AASBs to incorporate the consequential amendments arising from the issuance of AASB 9.	1-Jan-18	The assessment has indicated that there will be no significant impact for the public sector.
AASB 15 Revenue from Contracts with Customers	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1-Jan-18	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications.
AASB 2016-7 Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities	This Standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019.	1-Jan-19	This amending standard will defer the application period of AASB 15 for not-for-profit entities to the 2019-20 reporting period.
AASB 2016-8 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities	<p>This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events. The amendments:</p> <ul style="list-style-type: none"> require non-contractual receivables arising from statutory requirements (i.e. taxes, rates and fines) to be initially measured and recognised in accordance with AASB 9 as if those receivables are financial instruments; and clarifies circumstances when a contract with a customer is within the scope of AASB 15. 	1-Jan-19	The assessment has indicated that there will be no significant impact for the public sector, other than the impacts identified for AASB 9 and AASB 15 above.
AASB 16 Leases	The key changes introduced by AASB 16 include the recognition of most operating leases (which are current not recognised) on balance sheet.	1-Jan-19	<p>The assessment has indicated that as most operating leases will come on balance sheet, recognition of the right-of-use assets and lease liabilities will cause net debt to increase.</p> <p>Rather than expensing the lease payments, depreciation of right-of-use assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus.</p> <p>No change for lessors.</p>
AASB 2016-4 Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities	The standard amends AASB 136 Impairment of Assets to remove references to using depreciated replacement cost (DRC) as a measure of value in use for not-for-profit entities.	1 Jan 2017	The assessment has indicated that there is minimal impact. Given the specialised nature and restrictions of public sector assets, the existing use is presumed to be the highest and best use (HBU), hence current replacement cost under AASB 13 <i>Fair Value Measurement</i> is the same as the depreciated replacement cost concept under AASB 136.
AASB 1058 Income of Not-for-Profit Entities	This standard replaces AASB 1004 Contributions and establishes revenue recognition principles for transactions where the consideration to acquire an asset is significantly less than fair value to enable to not-for-profit entity to further its objectives.	1-Jan-19	The assessment has indicated that revenue from capital grants that are provided under an enforceable agreement that have sufficiently specific obligations, will now be deferred and recognised as performance obligations are satisfied. As a result, the timing recognition of revenue will change.

Note 8.9: Events occurring after the Balance Sheet Date.

No events occurred after

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