23RD ANNUAL REPORT 2017/18

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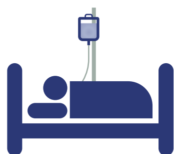
IDHS AT A GLANCE

The heath service was formed on 1 January 1996 by the amalgamation of The Inglewood Hospital (1863) and the Inglewood and Districts Community Health Centre Inc (1977).

Inglewood & Districts Health Service (IDHS) is an incorporated body under Section 13 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 approximately 5000 people and has:

- **60** full time equivalent staff
- **15** high care residential aged care beds
- **20** low care residential aged care beds
- **2** Transition Care Program (TCP) (bed based)
- **1** Transtion Care Program bed (community based)
- **8** inpatient beds
- Urgent Care Centre
- Primary Care Services

IN THE PAST 12 MONTHS



Bed days

Acute **1,347**

TCP (combined) **1,063**

Nursing home **5,388**

Hostel **7,248**

Occupancy

Acute **71%**

TCP (combined) **97%**

Nursing home **98.4%**

Hostel **97.9%**

Meals

Main meals **41,949**

Snacks and suppers **42,000**

Community meals **6,750**

Laundry

Sheets and towels **38,255**

Hostel and nursing home clients personal clothing is additional

SERVICES AVAILABLE AT IDHS

- Acute (hospital) beds
- Community Development
- Community Nursing
- Counselling
- Diabetes Education
- District Nursing Services
- Group Fitness
- Health Promotion
- Hearing Services
- LIFE Program (Diabetes Prevention)
- Mental Health
- Palliative Care
- Physiotherapy
- Podiatry
- Residential Aged Care
- Social Support (previously Planned Activity Group)
- Social work
- Transition Care Program
- Urgent Care Centre
- Volunteer Program

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

OBJECTIVES

To operate the business of a public hospital as authorised by or under the Health Services Act 1988 (Vic):

- To provide aged care services ensuring that at all times these services comply with the Charter of Residents' Rights and Responsibilities provided in the Aged Care Act 1997 (Commonwealth).
- To provide community based ancillary health, aged care, primary care and children's services.
- To conduct any other business that may be relevant to the business of a public hospital, nursing home, a hostel or community health service, or calculated to make more profitable any of the services assets or activities.
- To do all things that are incidental or conducive to the attainment of the objects of the service.

COMMITMENTS

- We encourage and assist our clients/patients and residents to achieve life-long health and wellbeing.
- We respect each client's rights, needs and choices including the right to refuse treatment.
- We provide equality and equity of access to services.
- We support the broad definition of health which includes meeting social, emotional, physical, cultural and spiritual needs through a multi-disciplinary approach.
- We seek to achieve quality health outcomes.
- We provide a safe and supportive environment for clients, staff, families and visitors.
- We encourage the personal and professional development of all our staff.
- We encourage participation by all members of the community in planning, implementing and evaluating service delivery.
- We facilitate partnerships with other service providers.
- We support and encourage a culture of continuous improvement across the organisation.

VISION STATEMENT

Excellence in health care now and the future

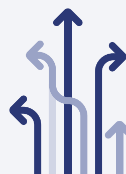
MISSION STATEMENT

Providing quality health services, supporting and enhancing community wellbeing.

VALUES

Care

Respect



Choice

Equality

BOARD PRESIDENT AND CEO REPORT

On behalf of the Board of Management, Executive and staff, we are pleased to present the 23rd Annual Report of Inglewood & Districts Health Service (IDHS), for the year ended 30th June 2018. The report highlights the significant changes, achievements and events that occurred during the past year and is prepared in accordance with the Financial Management Act 1994.

There are several achievements detailed in this report and they reflect the dedication and care provided by our staff, visiting medical officers (VMOs), partner organisations and volunteers in delivering care and services for our community.

GOVERNANCE

The Board and Executive of IDHS have undertaken significant training to ensure solid governance of IDHS for its community. IDHS as a result has adopted the five pillars of Clinical Governance, Leadership and Culture, Consumer Partnerships, Workforce, Risk Management and Clinical Practice, to report our achievements to the Board and its sub-committees. Further this has been adopted throughout the organisation at an executive and management levels. We have also added a sixth pillar, Corporate Performance, to capture the work and achievements in the financial areas of IDHS.

The Board have reviewed and refined all Board and sub-committees to reflect and support the focus on clinical Governance and care. The board have also implemented a dashboard that captures and reports key data and achievements in the clinical, corporate and financial arena in a consistent and clear manner at a Board, Executive, Management and Staff levels. As a result, we have a stronger focus on the areas that need attention across the service and wider community.

The Executive team have completed a detailed review of systems and reporting to the board and across the organisation this has seen significantly enhanced systems and reporting that is to be recognised.

The Board of Management would like to take the opportunity to recognise the work and tireless efforts of the outgoing President, Mr Peter Moore and committed Board member, Catherine Norman. The Board of Management have welcomed the incoming President Mrs Vanessa Hicks and Deputy President Mr Ian Marshall.

On behalf of the Board we would also like to farewell Robyn Vella whom was a great asset and has resigned for personal reasons. The Board acknowledge their dedication and commitment as Board Members to IDHS. We take this opportunity to thank all Board members for their contribution to the Governance and direction of IDHS and to welcome the following new and incoming Board members from 1 July 2018.

Greg Westbrook

Judith Holt

Khaled Selwanes

Robert Porter

BOARD SUB-COMMITTEES AND ACHIEVEMENTS

With the review and re-invigoration of Board sub-committees the Board has welcomed several community members to these committees.

The Audit and Risk Committee
Chaired by Mrs Jill Hobbs, has been focused on working with our internal and external auditors in partnership with the Executive team to refine and enhance our financial reports to the Board of Management.
A significant effort in this area has resulted in a clear and detailed understanding of the current financial position of IDHS, enabling exciting plans to be developed.

The Clinical Governance Committee
IDHS have implemented a Clinical Governance Committee, attended by all board members, the Executive and Management team and our consumer representative Mrs Annette Robertson. This committee reviews the clinical and audit results, ensuring strong clinical governance across IDHS. Our Visiting Medical Officers (VMOs) meet prior to this meeting so they can also review our results and work with us in partnership to continually improve the care and communication our patients and residents receive.

The Community Engagement Committee
Replacing the Consumer Advisory Committee, to ensure the focus of IDHS partnerships are broader than just our existing clients, patients and residents. This new committee will work with 'champions' in our small towns and communities to make sure we are providing the information, education and care they need when and where they need it.

THE EXECUTIVE AND MANAGEMENT TEAM

The past 12 months have seen significant change across IDHS, commencing with the arrival of our new Chief Executive Officer, Tracey Wilson in August 2017. Tracey was joined by the new Director Clinical and Community Services, Dallas Coghill, in September and together they have begun a significant transformation of this health service.

All areas of IDHS have been reviewed, refreshed and updated in some way, resulting in a fresh approach to all aspects of the service and a brighter and happier place to live, work and visit. Their efforts have not been limited to the buildings and offices, they have engaged with a wide and diverse portion of the community, resulting in a strengthening partnership with old and new partners to benefit our community.

In a year of significant change, IDHS has also seen new managers in the areas of clinical services, with Daryl Rowley appointed as the Nurse Unit Manager, Michelle Forrester appointed to a new role of Quality, Risk and Human Resources Manager, Vijin Vijay appointed to the role of Clinical Support Nurse, overseeing our student, graduate nurse and education programs and Bendigo Health providing Financial Support Services, with Jessica Pisevski working at IDHS three days per week from November.

With this level of change, it has been wonderful to see our staff accept the many changes and improvements. All of this, whilst still delivering exceptional care to our patients and residents.
This positive change in our health service was reflected in the exceptional results of the People Matter Survey. This survey, completed by staff has seen a significant increase in the number of staff taking part, with extremely positive results.

SERVICE ENHANCEMENTS

CAPITAL ENHANCEMENTS

The new executive team have cast fresh eyes over the entire facility and as a result there has been significant activity to refresh, relocate and enhance the look and feel of the health service, including:

- Relocating the District Nursing team to the Railway, providing them with much needed space and the ability to provide care to some patients in a dedicated consulting room.
- Moving the Executive team into a designated area, rather than scattered around the health service.
- Relocated the community-based staff to the front of the health service so they are available when their clients arrive for care. This has also allowed our reception team to support clients and staff with appointments.
- Creating a purpose-built reception and administration area to improve work flow for this busy team.
- Undertaking some necessary repairs to the exterior of the nursing home and hostel areas to ensure the safety of our residents and their families.
- Replacing all fluorescent tubes with LED to reduce electricity costs.

To ensure the safety and security of our residents and staff, we have invested in updating and increasing a range of safety and security across the health service. This has included:

- Update and repair of the Nurse Call System.
- Installation of additional annunciator panels so staff can see who needs assistance from all parts of the patient and resident areas.
- Installation of CCTV to improve safety and security, especially after hours.
- Installation of swipe access systems to ensure our residents are safe in the residential aged care areas.
- Extension and repairments the perimeter fencing around the Hostel and Nursing Home areas.

FUTURE PLANS AND INITIATIVES

- Installation of solar panels to further reduce our carbon footprint.
- Relocation of the hairdressing salon to create a relaxing space and experience for our residents.
- Refresh and update the resident's internal courtyard, living and dining areas to create a relaxing and sensory space inside and out for our residents to enjoy.

STATEMENT OF PRIORITIES (SOP) AND STRATEGIC PLAN

The 2017/18 SoP provides the formal funding and monitoring agreement between IDHS and the Secretary for Health; in accordance with Section 26 of the Health Services Act 1988 and facilitates the delivery and substantial progress towards the objectives of financial viability, improved access and quality of service provision. The IDHS Board of Management and Executive have regularly reviewed the objectives and progress of the priorities and actions outlined in the Statement of Priorities (SoP) as we continue to work towards the objectives of our five-year (2015-2020) Strategic Plan in addition to the activities and initiatives outlined in our Statement of Priorities.

Our organisation's focus is all about our communities and their people, and we want our work, plans and efforts to reflect this. For this reason, our current Strategic Plan will be reviewed in 2018/19 to refresh the priorities, strategies and actions to best reflect this for the future. We will keep you up to date and invite our community to be part of these conversations so that your health service can continue to meet your needs.

The following points under each pillar of IDHS, summarise the achievements, transformation and progress of IDHS over the 2017/18 year

CONSUMERS AND PARTNERSHIPS

- Refresh and renaming of the Community Advisory Committee to the Consumer Engagement Committee has seen a new focus and enthusiasm for IDHS within our communities. This has resulted in seven new community representatives joining this committee, representing the entire catchment of IDHS.
- Staff, Executive and Board members have attended several community events including:
  - Inglewood Alive
  - Rheola Charity Carnival
  - WoW for Women events included the dinner with guest speaker Dr Sally Feelgood
  - Men's Health Week celebration and BBQ at Wedderburn Men's Shed
  - ANZAC and Remembrance Day celebrations with our residents
- Partner organisations utilising spaces and rooms across IDHS include:
  - Bendigo Health rural allied health team delivering podiatry services
  - FMC financial counselling services visiting IDHS sites to provide financial advice and support
  - United Age Well have taken up residence in the 'Railway' space to better support people with packages in their homes
  - Catholic Care Sandhurst deliver counselling and support services from our premises
- Murray PHN (Primary Health Network) have supported IDHS to deliver diabetes services and, in partnership with Northern District Community Health, IDHS is delivering mental health services to the southern half of the shire.
- IDHS is a partner in the Loddon Gannawarra Health Services Executive Network, continuing to ensure services and funds are maximised across both shires. IDHS participated in the launch and implementation of the Loddon Gannawarra Health Needs Analysis which involved several agencies from these two shires. In 2018/19, this is to be further extended to include the Buloke shire as we continue to expand, develop and embed our partnerships across the three shires.

LEADERSHIP AND CULTURE

- New management team, commenced in 2017/18, beginning a transformation of IDHS to better meet the needs of our community into the future
- Review of all position descriptions to ensure staff have the skills, experience and expertise needed to deliver the services needed by our community
- Human Resources position created to ensure staff needs were met and IDHS was achieving all requirements of the various EBAs.
- Focus on reducing incidents of bullying and harassment as reported in the 2017 People Matter Survey. The results received in June 2018 indicate significant improvement.

WORKFORCE

- Recruitment processes have been reviewed to ensure transparent processes meet all legislative requirements for staff and volunteers.
- HR position established.
- Nurse Unit Manager (NUM) position filled following a period of instability.
- Quality and Risk Manager role developed to strengthen resources and focus.
- Clinical Support Nurse position established to support internal and external professional development and training opportunities.
- Significant increase in interest and applicants for Graduate Nurse Program.
- Aged Care Liaison Officer position created to provide a consistent approach for new residents and their families and maximising ACFI across IDHS.

CLINICAL PRACTICE

- Introduction of version 5.5 of MANAD enabled improved reporting and documentation for residential aged care services.
- Implemented a fortnightly visiting medical officer (VMO) and Nurse Unit Manager round reviewing all patients and residents to improve communication to benefit patients/residents.
- Implemented new handover practices and documentation to ensure staff have a detailed understanding of clinical needs of patients/residents.
- Improved the process of administering medications to reduce medication errors and missed signatures
- Reviewed and improved falls risk assessment, reporting and reviews for patients and residents, including the purchase of sensor mats to reduce the potential for a fall.
- Increased the range of education, training and professional development sessions for staff to be provided. A highlight for staff and some residents was session on Dementia provided by Alzheimer's Victoria. This session included some virtual reality goggles, and this provided a significant insight in to living with dementia for all who attended.

CORPORATE PERFORMANCE

- Significant focus on reporting systems for finances has significantly improved clarity and understanding of our financial position. IDHS will continue to embed the systems ensuring managers take a stronger role in developing budgets to strengthen the viability of IDHS in to the future.
- Successful funding submissions will enable enhancements of our residential care areas in the second half of 2018.
- Refurbishment of the main reception and administration area.
- Painting and maintenance upgrades across IDHS as services relocate to best meet the needs of our community.
- Installation of LED fluorescent light fittings across IDHS reducing our carbon footprint.
- IDHS selected to be part of a buyback program for the installation of solar panels. This will progress further in the next financial year.

THE PEOPLE

OUR RESIDENTS

IDHS has maintained very high occupancy across our Residential Aged Care Beds over the past 12 months. We are very much aware that we are working in their homes and we see this as an honour.

We know that the decision to enter a residential aged care facility is very difficult and frightening for the resident and their family. There are a myriad of documents and financial decisions to be made on admission.

To assist and support families through this process, IDHS has appointed a Residential Aged Care Liaison Officer. This role clarifies the various forms and financial details needed for an admission and explains the contract details with support from our finance team.

OUR STAFF

Inglewood and districts Health Service has 59 full time equivalent staff. This is made up by 121 individuals who have all made significant contributions to the health service and our clients, resident and patients through the year. We were delighted to award several tenure certificates at the Annual General Meeting, with some staff achieving 30+ years of service. It was a proud moment to see their passion and joy for their roles as well as the recognition by the Board, management and their colleagues at IDHS.

OUR VOLUNTEERS

Like many small rural health services, we are humbled by the dedication and commitment of our volunteers. They dedicate their time, predominantly in activities in our residential care areas and in our volunteer transport program. This program supports community members to attend various medical and specialist appointments in Bendigo, and to get to their local GP for regular appointments.

In 2017/18 IDHS recognised and celebrated a few of our outstanding volunteers, Mandy Cragg received an award at the AGM for more than 35 years as a volunteer across many areas of IDHS.

We nominated Betty Higgs for a Victorian Public Health Volunteer award in the category of lifetime achievement award for her 14+ years volunteering at IDHS. Betty visits our residents most weeks and at a spritely 90 years she is very much a part of our resident's lives. Greg Tobias was also nominated in the Victorian Public Health Awards for his significant contribution to IDHS.

Greg is a key member of the volunteer transport program and he is also a frequent visitor to our residents, especially on weekends when it can be a bit quiet. These are just a few of our wonderful volunteer team and we cannot thank them enough for all that they do for IDHS and our patients and residents.

TAKING COMMUNITY ENGAGEMENT TO A NEW LEVEL

In 2017/18 IDHS have taken community engagement to a new level with active involvement across a range of communities and locations. The new executive team identified that the community were not aware of the who, what, when and how, of the health service. To address this issue, we have:

- attended more than 35 community events
- joined more than 12 community and support groups, and
- we are actively involved or supporting a wide range of key groups and events across our region including:
  - **Inglewood Alive** – an amazing event that closes the Calder Highway through Inglewood for the day to support community connection, wellbeing and engagement
  - **Rheola Carniva**l – this event has been a strong supporter of IDHS for many years and this year IDHS joined in the fun taking residents, staff, executive and Board members along to enjoy the day and share our message
  - **WoW for Women day and events** – we took this annual event up a notch this year with a fantastic dinner including guest Speaker Dr Sally Cockburn (aka Dr Feelgood), who reminded all present to take the time to care for yourself so that we can care for all the people in our lives. The message was received with much joy and laughter and a strong message for IDHS to do more of that.

THANK YOU

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 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 that with your ongoing support, IDHS can achieve
"excellence in health care now and the future."

Vanessa Hicks
President

Tracey Wilson
Chief Executive Officer

HARRISON
VARSITY LEAGUE

Excellence
in health care
now and the
future
Certificate of Service

Certificate of Service

Room 14
STOP

KEY PERSONNEL AS AT JUNE 30, 2018

Mrs Tracey Wilson
Chief Executive Officer
Dip App Sc (Dental Therapy), MBA (Human Reosurces) GAICD

Mr Dallas Coghill
Director Clinical and Community Services
RN B.Hlth Sc (Nursing), Grad Cert P. Health, CCRN

Mr Geoff Vendy
(resigned 2 Oct 2017)
Finance Manager
Financial Services provided by Bendigo Health October – 30 June 2018

Michelle Forrester
(from February 2018)
Quality Risk and HR Manager
MBA, Grad Cert I.R., B. Bus

Dr Craig Winter
Director Medical Services
MBBS GMQ MBA FACEM

Mr Daryl Rowley
Nurse Unit Manager
RN B.Hlth Sc (Nursing)

Mr. Vijin Vijay
Clinical Support Nurse
RN B.Sc (Nursing) MHS (Nursing)

Ms Jodie Horan
Infection Control Practitioner
RN B.Hlth Sc (Nursing)

Mr Andrew Evans
Maintenance Supervisor
Certificate III Cleaning Support Services

Mrs Deborah Roberts
Hotel Services Manager
Certificate III Cleaning Support Services

Mr David Cripps
Head Chef
Cert III Cooking, Cert IV Workplace training , Food Safety certificate

Dr Shak Issa
Visiting Medical Officers
MBCHB, MOHS, PGDip R&RM, FRACGP, FRACRRM, FACTM, AFACTM

Dr Hadi Rafi
Visiting Medical Officer
MBBS

Dr Syed Ansari (resigned 18 June 2018)
Visiting Medical Officer
MBBS

CORPORATE GOVERNANCE

LEFT TO RIGHT: IAN MARSHALL (DEPUTY BOARD CHAIR), ROBERT PORTER (BOARD), PETER MOORE (RETIRING BOARD CHAIR), MICHAEL OERLEMANS (BOARD), CATHERINE NORMAN (RETIRING BOARD MEMBER), VANESSA HICKS (BOARD CHAIR), JESSICA PISEVSKI, CAROL GIBBINS (BOARD), TRACEY WILSON (CEO), DALLAS COGHILL.

BOARD OF MANAGEMENT AND PRINCIPLE OFFICERS AS AT 30 JUNE 2018

President Mrs Vanessa Hicks

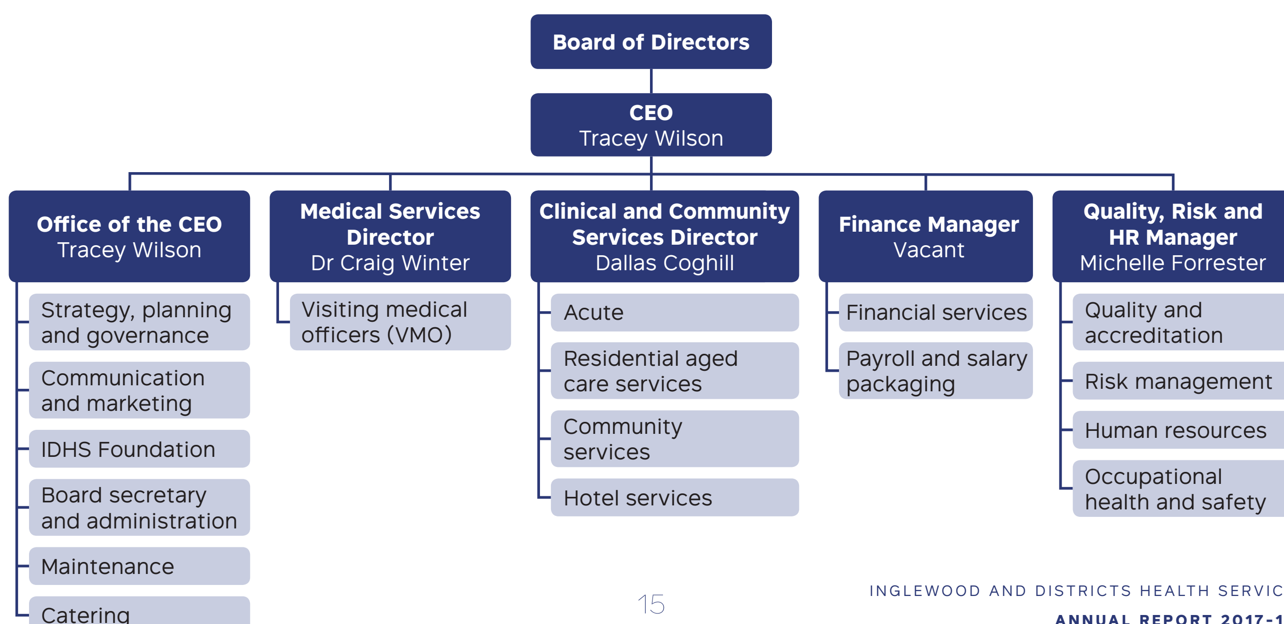
Vice President Mr Marshall

Board Members
Mr Peter Moore (retired 30 June 2018), Mrs C Gibbins,
Mrs C Norman (retired 30 June 2018), Mrs R Vella (resigned June 2018), Mr M Oerlemans

Independent Community Representatives Audit and Risk Committee
Mrs Hobbs, Mr D Peterson

Auditors
External - Victorian Auditor General's Office Agent - RSD Auditors
Internal - AFS Bendigo (commenced May 2018)

ORGANISATIONAL CHART



STATEMENTS OF PRIORITIES 2017-18
PART A

In 2017-18 Inglewood & Districts Health Service will contribute to the achievement of the Government's commitments by:

GOALS	STRATEGIES	HEALTH SERVICE DELIVERABLES	ACHIEVEMENTS
Better Health • A system geared to prevention as much as treatment • Everyone understands their own health and risks • Illness is detected and managed early • Healthy neighbourhoods and communities encourage healthy lifestyles	**Better Health** • Reduce state-wide risks • Build healthy neighbourhoods • Help people to stay healthy • Target health gaps	Work with the Primary Care Partnership and Local Government to align strategies of the Integrated Health Plan with Municipal Health Plan to maximise outcomes	**Achieved** Working with Loddon Shire to implement the Municipal Public Health Plan. IDHS is leading the subcommittees of: o Healthy Eating and Active Living (HEAL) o Loddon Family Violence Network
		Provide health promotion and education opportunities for the communities to build health literacy and capacity	**Achieved** Increasing opportunistic health promotion and prevention initiatives in the various communities through stands at local venues (supermarkets etc.).
		Implement healthy eating/ active living strategies in local communities	
		Work with the Loddon & Gannawarra Health Services Executive Network (LGHSEN) to action gaps identified in the needs analysis.	**Achieved** LGHSEN successfully submitted a joint application with the Murray PHN to secure ongoing funding for Mental Health.
Better Access • Care is always there when people need it • More access to care in the home and community • People are connected to the full range of care and support they need • There is equal access to care	**Better Access** • Plan and invest • Unlock innovation • Provide easier access • Ensure fair access	Work with other agencies and Murray PHN to develop a collaborative model of care for cardiovascular and COPD diseases	LGHSEN partnership successfully **achieved** funding for cardiovascular and COPD diseases
		Expand Tele-health program including the involvement of Royal Flying Doctor Service (RFDS)	**Achieved** RFDS is part of PHN submission for mental health utilising their psychiatrists and psychologists.
		Improve collaboration with General Practitioner clinics to improve service integration and seamless care	**Achieved** Establishing greater collaboration with the GP clinics. VMO meeting re-established in December 2017, with regular bi monthly VMO meetings to provide feedback and ideas to Clinical Governance meeting through DMS role.
		Promote registration of My Health Record	Nursing staff working with GPs to improve resident and patient admission process. Discharge planning meeting established to enhance the discharge and transition of care from inpatient to outpatient care.

GOALS	STRATEGIES	HEALTH SERVICE DELIVERABLES	ACHIEVEMENTS
Better Care • Target zero avoidable harm • Healthcare that focuses on outcomes • Patients and carers are active partners in care • Care fits together around people's needs	**Three mandatory actions against the 'Target zero avoidable harm' goal:** Develop and implement a plan to educate staff about obligations to report patient safety concerns	Re-evaluate the education system and ensure relevant education provided to embed 'Target zero'	**Achieved** Cinical Nurse educator role established November is building and enhancing staff education and understanding of care and reporting requirements Clinical Dashboard developed to focus attention and training on achieving 'Target zero'.
	In partnership with consumers, identify three priority improvement areas using Victorian Healthcare Experience Survey data and establish an improvement plan for each. These should be reviewed every 6 months to reflect new areas for improvement in patient experience.	Review Director Medical Service agreement and role in line with Loddon Mallee Clinical Governance Council	DMS role established with IDHS DMS and integral member of the LMCGC.
		Work with Loddon Mallee Clinical Governance Council to develop standard regioal reporting and benchmarks	**Achieved** DMS role has been reviewed with clear accountabilities established for review of mortality cases, UCC presentations and appropriate referral to GP On call is established. IDHS Executive team all attended and participated in the launch of the LMCGC. DMS and DCCS have ongoing positions within LMR Clinical Council. Board member attending LMRCC Quality Committee
	Better Access • Plan and invest • Unlock innovation • Provide easier access • Ensure fair access	Develop priority areas utilising IDHS Consumer Advisory Committee	**Achieved** Community Advisory Committee terms of reference and priorities reviewed as part of Board Strategic planning. Community Engagement Committee to be launched in May 2018. Launch delayed enabling community to attend information session about the various Board subcommittees.
		Conduct individualised 1:1 consultations with consumers	**Achieved** Patient, residents and clients surveyed the VHES system in 2017 (awaiting results and feedback) and IDHS individual surveys in early 2018 to understand their needs. IDHS team present at Inglewood Alive community Fun Day and Rheola Charity Carnival to raise our profile and gauge community needs and interests. Very successful community events for IDHS.

PART B - PERFORMANCE TABLE

SAFETY AND QUALITY

Key performance indicator	Target	Actual
Compliance with NSQHS Standards accreditation	Full compliance	Compliant
Compliance with the Commonwealth's Aged Care accreditation standards	Full compliance	Compliant
Cleaning standards	Full compliance	Compliant
Compliance with the Hand Hygiene Australia program	80%	82%
Percentage of healthcare workers immunised for influenza	80%	85%
Submission of infection surveillance data to VICNISS[1]	Full compliance	Compliant

[1] Victorian Hospital Acquired Infection Surveillance System

PATIENT EXPERIENCE AND OUTCOMES

Key performance indicator	Target	Actual
Victorian Healthcare Experience Survey - data submission	Full compliance	Achieved
Victorian Healthcare Experience Survey positive patient experience - Quarter 1	95% positive experience	Achieved
Victorian Healthcare Experience Survey positive patient experience - Quarter 2	95% positive experience	Achieved
Victorian Healthcare Experience Survey positive patient experience - Quarter 3	95% positive experience	Achieved
Victorian Healthcare Experience Survey discharge care - Quarter 1	75% very positive experiene	Achieved
Victorian Healthcare Experience Survey discharge care - Quarter 2	75% very positive experience	Achieved
Victorian Healthcare Experience Survey discharge care - Quarter 3	75% very positive experience	Achieved

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

GOVERNANCE, LEADERSHIP AND CULTURE

Key performance indicator	Target	Actual
People Matter survery - percentage of staff with a positive response to safety culture questions	80%	88%

FINANCIAL SUSTAINABILITY

Key performance indicator	Target	Actual
Finance		
Operating result ($m)	$0.00m	$0.55
Trade creditors	< 60 days	47
Patient fee debtors	< 60 days	56
Adjusted current asset ratio	0.7	1.06
Number of days with available cash	14 days	124
Asset management		
Basic asset management plan	Full compliance	Compliant

PART C - ACTIVITY AND FUNDING

Activity and funding	Activity	Budget ($'000)
Small Rural Acute	14	1,863
Small rural HACC	1,044	35
Small rural residential care	12,656	522
Small rural primary health	3,451	526
Health workforce	2	45
Other specified funding		143

HR AND STAFF DEVELOPMEMT

OCCUPATIONAL VIOLENCE AND PEOPLE MATTER SURVEY - HR RESULTS

STAFF PROFESSIONAL DEVELOPMENT

IDHS encourages and supports the personal and professional development of staff through online learning and onsite or external workshops and seminars. Opportunities are provided for staff to grow and learn, by taking on new and different roles whenever an opportunity arises.

Our learning environment is enhanced by the presence of trainees, Nursing, Personal Care Worker (PCW), and allied health students on clinical placements and the Graduate Nurse program. The Graduate Nurse program has been developed by IDHS and includes our nurses attending Bendigo Health for specialist clinical experience and clinical education. This program has been very successful with graduate nurses indicating their satisfaction with the program. Several graduates have continued to work at IDHS following completion of their graduate year.

In February 2018, our Nurse Unit Manager and Associate Nurse Unit Managers participated in the Clinician to Manager: Empowered Leadership course - hosted by the Australian Academy of Clinical Leadership. The main aim of the course was to help our senior nurses identify the skills required to transition from a clinician to a manager and the leadership style needed to become the stewards of the health service.

In May 2018, representatives from different areas of the health service, including some of our residents, participated in the Understanding Dementia Workshop, hosted by Alzheimer's Australia. One of the highlights of the Workshop was the opportunity for staff to see the world through the eyes of a person living with dementia through the use of a virtual reality smartphone app. The focus of training and increasing the understanding of our staff to people with dementia continued through the staff participation in the Understanding Dementia Online Course hosted by the University of Tasmania. The course is designed to be accessible to all those caring for a person with dementia - including health professionals, residential care staff and families - and aims to provide education about the latest in dementia care and research. The staff were impressed with the training and information received at each of these sessions.

IDHS has focussed on the EBA staffing requirements and ensuring that these levels are achieved. This has resulted in a number of our staff being appointed to new roles and also welcoming new staff to the teams. We have been very impressed with the applications and number and calibre of applicants applying for the range of vacancies. IDHS is now staffed by a dedicated, focused and experienced team across all areas of our service.

The appointment of the Clinical Support Nurse role has enabled a strong focus on education and development for all staff across the nursing, clinical and corporate areas as well as other health services. We have reviewed and updated the process for new staff and students ensuring the mentoring and support they receive assists them when they first join IDHS.

The Graduate Nurse Program has also benefited from this review and we were delighted with the number and skills of the two successful graduates. They are providing fresh ideas and views across our service and care.

WORKFORCE DATA

	Ongoing		Fixed term		Casual		Total	
	Head count	FTE	Head count	FTE	Head count	FTE	Head count	FTE
June 2017	57	35.8	15	9.72	19	6.49	**91**	**52.01**
June 2018	67	46.88	7	4.16	47	10.23	**121**	**61.27**

	Ongoing		Fixed term and casual		Total	
	Head count	FTE	Head count	FTE	Head count	FTE
Male	9	7.11	9	1.65	**18**	**8.76**
Female	58	39.76	45	12.75	**103**	**52.51**

Age	Ongoing		Fixed term and casual		Total	
	Head count	FTE	Head count	FTE	Head count	FTE
Under 25	2	1.39	6	2.06	**8**	**3.45**
25-34	10	5.13	9	2.58	**19**	**7.71**
35-44	11	7.93	6	1.55	**17**	**9.48**
45-54	23	17.32	18	4.72	**41**	**22.04**
55-64	16	11.18	15	3.48	**31**	**14.66**
65+	5	3.93	0	0	**5**	**3.93**

Labour category	June - current month FTE		June - YTD FTE	
	2017	2018	2017	2018
Nursing	23.18	25.93	25.12	24.89
Administration and clerical	5.36	6.50	6.84	6.24
Medical support	12.70	1.00	11.47	1.21
Hotel and allied services	13.38	24.16	13.39	22.90
Medical officers	0.05	0.05	0.05	0.05
Ancillary staff (Allied Heath)	0.00	4.80	0.00	4.49
Total	**56.53**	**62.44**	**57.89**	**59.77**

OCCUPATIONAL HEALTH AND SAFETY

OCCUPATIONAL VIOLENCE STATISTICS 2017-18

IDHS monitors the number and severity of incidents reported through the VHIMS system. This is reported to the Executive Team and Board of Management via the Dashboard reports. If the number or severity of cases is at a level above tolerance, this is further discussed to ensure mitigation strategies are addressing and correcting the concern to reduce recurrence. In the 2017-18 year, there have been no issues that have not been addressed or risks mitigated.

WORK COVER AND OCCUPATIONAL HEALTH AND SAFETY

The Occupational Health and Safety (OH&S) incidents are investigated to identify unsafe work practices and in consultation with staff, recommend and implement corrective actions. The Executive and Management team have also monitored staff welfare issues, and, due to the sudden passing of a staff member employed additional supports through the Employee Assistance Program to offer counseling when required. Work Accidents and Loss of Hours are used to monitor OH&S Performance. In the last year only one employee was absent from duty because of work related incidents for a period of two days.

Occupational incidents and reporting	2018	2017	2016
1. WorkCover accepted claims with an occupational violence cause per 100 FTE	0	0	0
2. Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	0	0	0
3. Number of occupational violence incidents reported	8	0	0
4. Number of occupational violence incidents reported per 100 FTE	15	0	0
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition	0	0	0
6. The number of incidents reported per 100 full time members	0	0	0
7. Number of lost time standard claims per 100 full time staff members	1	0	0
8. Average cost per claim for the year	0	0	0
9. No fatalities have occured at IDHS	0	0	0

We have received incident reports for four cases this year, each case was a resident to a staff member, thankfully with no injuries to the staff members. It has however, focused our attention to addressing these issues as our resident's dementia increases. A range of strategies have been put in to place to reduce the incidence of this type of violence towards our staff.

People Matter survey results - patient survey	2018	2017	2016
I am encouraged by my colleagues to report any patient safety concerns I may have	80%	80%	89%
Patient care errors are handled appropriately in my area	82%	71%	77%
My suggestions about patient safety would be acted upon if I expressed them to my manager	84%	71%	80%
The culture in my work area makes it easy to learn from the errors of others	65%	66%	69%
Management is driving us to be a safety-centred organisation	82%	68%	71%
The health service does a good job of training new and existing staff	67%	59%	63%
Trainees in my discipline are adequately supervised	64%	63%	69%
I would recommend a friend or relative to be treated as a patient here	82%	68%	71%

The annual People Matter Survey completed by our staff have returned some very positive results in 2018. The results in the previous year indicated that we had quite a lot of work to do to engage and value our staff. The Executive team have taken on this challenge and the results indicate that the approach is significantly improving the morale of our most important asset, our staff. We have some more work to do in this area but we feel that we are on the right track.

INCIDENTS OF BULLYING

Significant improvement was achieved in the area of Bullying within our staff team. It is very pleasing to see that the number of incidents have significantly reduced, those impacted feel empowered to raise their concern and that when they do, they are satisfied with how the situation is handled. In the previous survey this was the area of the greatest concern as staff were not reporting the incidents and when they did, they did not feel heard or that the situation was resolved.

The results in 2018 are a significant improvement and the Executive team are very grateful for all involved in the process of improving these results.

People Matter survey results - bullying	2018					
	Yes continuing	Yes but not currently	Total yes	No	Not sure	Don't know
Bullying						
Personally experienced bullying in the past 12 months	2%	20%	22%	78%	0%	0%
Of those that did experience bullying						
Submitted a formal complaint			42%	58%		
Percent of those who did submit a formal complaint						
Were you satisfied with the way your formal complaint was handled?			100%			

ACCREDITATION

IDHS is due to undergo accreditation in early 2019 and we are preparing for both the National Standards and the Aged Care reviews. In the past 12 months we have undertaken a mock audit with the support of the Department of Health and Human Services an also successfully passed an unannounced visit in June.

In each of these visits we have received great feedback on our level of commitment to our residents and also some insights into how we can continue to improve. We are in the midst of reviewing our policies and procedures to ensure they are current and reflect the legislation that covers health and residential aged care services.

DIRECTOR CLINICAL AND COMMUNITY SERVICES REPORT

CLINICAL CARE TEAM

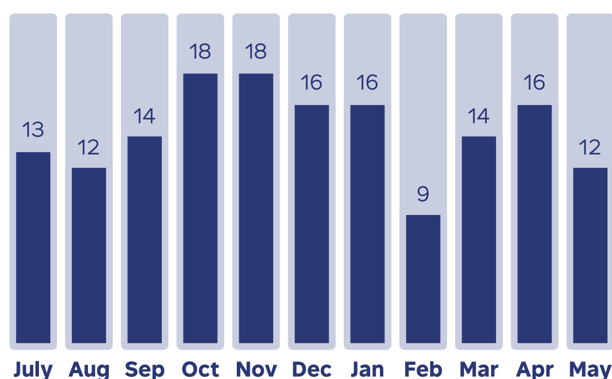
Inglewood & Districts Health Service provide a diverse and comprehensive range of services to the communities within the southern parts of the Loddon Shire. Services within the organisation include acute, residential aged care services, an urgent care unit, transitional care program and a variety of community-based services. Inglewood and Districts Health Services prides itself on providing client focused care to the community it serves.

ACUTE HOSPITAL AND URGENT CARE

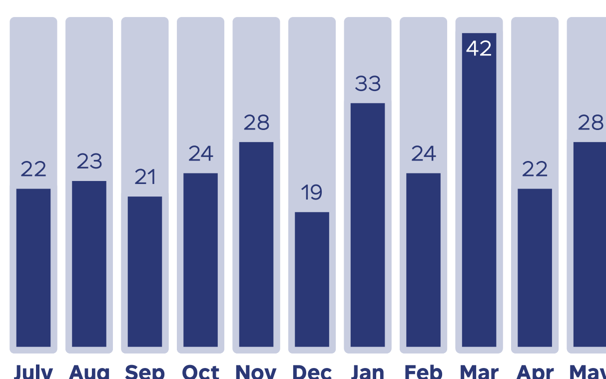
Inglewood and Districts Health Services operates an eight-bed acute inpatient (hospital) service and a two-bay Urgent Care Centre. The Acute and Urgent Care wards continue to provide vital care options for the community. A registered nurse is available 24 hours a day, seven days a week with support from a General Practitioner (GP) service either in Inglewood or Wedderburn. The General Practitioner/Visiting Medical Officer (VMO) service operates 24 hours seven days a week where a medical officer can be contacted to provide advice and regarding treatment options for clients, residents or patients.

Over the past 12 months IDHS has been able to create and foster working relationships with the local Ambulance service, Bendigo Health and other health services in the region through our attendance at working groups, networks and combined training programs. These relationships have enhanced IDHS's service delivery and provided greater pathways for appropriate care and referral for the community.

IDHS has undergone significant change to the staffing profile over the past 12 months. Daryl Rowley was appointed to the role of Nurse Unit Manager in November 2017. Daryl has an extensive background in clinical care and had reinvigorated the team with his leadership style and clinical knowledge.



ACUTE ADMISSIONS



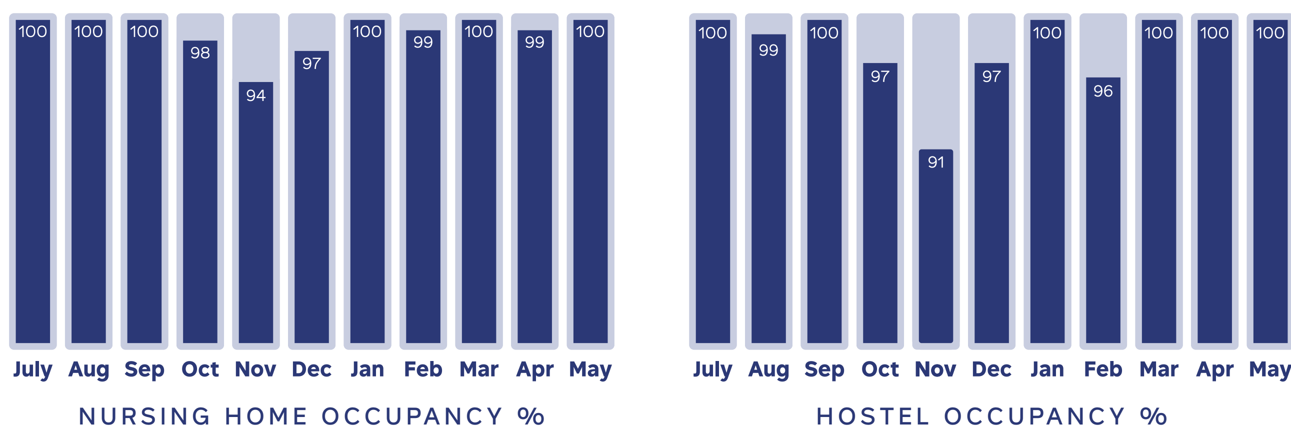
URGENT CARE PRESENTATIONS

TRANSITIONAL CARE PROGRAM

The Transitional Care Program is designed to provide an opportunity for the older person to be able to improve their independence and confidence after a hospital stay. IDHS provides a comprehensive program with significant assessment and treatment from nursing staff, physiotherapy and other allied health services as needed. Inglewood and Districts Health Service strive to provide an environment where clients receive the best outcomes for their future whether that be returning home with assistance or admission to residential services. Inglewood and Districts Health Services Transitional Care Program will endeavour to provide the best option for each individual client.

AGED CARE SERVICES

Inglewood and Districts Health Services provides 35 aged care beds within the Inglewood campus. Currently the profile is 20 hostel beds and 15 nursing home beds. IDHS provides residents with a home like environment that is supportive and caring to the residents. IDHS understands that everyone has differing needs and provides opportunities for everyone through tailored individual care plans. To do this IDHS ensures regular resident and relative meetings occur monthly, with this meeting chaired on a rotating basis by a current resident. IDHS also has resident representation on our leisure and lifestyle committee meeting. Outcomes of this process have been extremely positive with staff developing a better understanding of the residents needs and wants.



INFECTION CONTROL

IDHS has refreshed and reviewed the role of infection control nurse with Jodie Horan commencing in the role in early January 2018. IDHS understand the vital importance of infection control within our organisation and we are achieving benchmarking standards for staff and resident's influenza vaccinations, hand hygiene and maintaining levels with antimicrobial stewardship.

COMMUNITY SERVICES

IDHS understand the need to improve the health and wellbeing of the communities we serve, as a result IDHS has reinvigorated the service delivery in these communities. IDHS provides community programs such as diabetes education, cardiac rehabilitation, respiratory management including asthma and COPD (Chronic Obstructive Pulmonary Disease) education.

IDHS delivers a well-attended exercise program delivered in six communities across the southern part of the Loddon Shire. IDHS provides outpatient physiotherapy services in Inglewood and Wedderburn communities on a weekly basis with IDHS appointing a second physiotherapist in December 2017.

IDHS has again been successful in obtaining Engage Youth funding. This funding is allowing IDHS to provide opportunities around health programs for the youth of this region. Inglewood & Districts Health Service understand the need in our communities to access preventative and community services, and we are proud of the services we deliver and are always looking at opportunities to improve, expand and enhance our programs.

HEALTH PROMOTION

Inglewood and Districts Health Service has delivered a variety of community events this year. I would like to acknowledge the work that celebrated the 15th year of the WOW for women events in Wedderburn. A highlight this year was a dinner with guest speaker Dr Sally Cockburn (aka Dr Feelgood). This event was attended by over 80 people and was an opportunity for the community to reflect on the importance of caring for yourself, so you can care for all the important people in your life. Dr Feelgood concluded her presentation by reminding us all to take a good look at ourselves and tell ourselves that "...you are gorgeous!"

Inglewood & District Health Service continues to work in partnerships with other agencies such as Bendigo Health, Uniting Aged Well, Northern Districts Health Services, Catholic Care, The Salvation Army, Regional Eyecare and The Loddon Shire to provide best possible service delivery and outcomes for the communities we serve.

DISTRICT NURSING

Inglewood & District Health Service provide a district nursing service to the community six days a week. The IDHS district nursing team provides several programs tailored to the needs of individuals in their home in our community. Our district nurses are actively involved in coordinated client care, working closely with the allied health team to deliver care tailored to the needs of each individual client.

SOCIAL SUPPORT GROUPS

IDHS Social Support Groups previously known as Planned Activity Groups (PAG) provide opportunities for social contact for the aged, frail and disabled members of our community. Currently IDHS provides four days of group programs for social support in the community. Activities provided in these groups include, craft activities, games, shopping trips, attending events such as concerts and movies, meals, guest speakers and health promotion activities.

VOLUNTEER TRANSPORT

A Volunteer Transport program for eligible clients is available for transport to specialist medical services. This is a very busy and well used service. Volunteers are critical to this service, they are highly valued and made very welcome. There is a small reimbursement for volunteers and cars are provided.

Finally, I would like to acknowledge and thank all staff at Inglewood & Districts Health Service, the clinical and community teams for their ongoing commitment and passion to client centred care for the communities we serve.

Dallas Coghill
Director Clinical and Community Services

RECOGNITION OF STAFF AND VOLUNTEER SERVICE

Inglewood & Districts Health Service Tenure Certificates were provided to the following staff at the Annual General Meeting in November 2017:

FIVE YEARS SERVICE

Janet Cobden
Physiotherapist

Stuart Daw
Nursing Home

Evelyn Dingfelder
Strength training

Debbie Lamprell
Catering team

Lee-Anne Sullivan
Laundry

TEN YEARS SERVICE

Kerrie Redwood
Nursing

Daryl Rowley
Nursing

Susan Zimmer
Nursing

Dr. Shaker Issa
Visiting Medical Officer and GP

FIFTEEN YEARS SERVICE

Jennifer Perry
Catering team

TWENTY YEARS SERVICE

Beryl Clark
Hostel

Deborah Smith
Nursing Home

THIRTY YEARS SERVICE

Ann Harrison
Hostel

VOLUNTEERS RECOGNISED BY IDHS AT 2017 AGM

RHEOLA CARNIVAL NOMINEE:

Mr. Mark Gilmore
Spinning Wheel and Entrance Gate

COMMUNITY VOLUNTEER 35+ YEARS SERVICE:

Mandy Cragg

HISTORICAL BACKGROUND

The Inglewood & Districts Health Service is situated in the Loddon Shire, approximately 50 kilometres from Bendigo with the catchment area including the southern half of the Loddon Shire with a population of approximately 4,770 (Loddon Shire, 2013).

The Health Service is located in Inglewood. We also provide community services from the community centre in Wedderburn. The other towns in our catchment include Bridgewater, Serpentine, Tarnagulla and Korong Vale, with other small hamlets located through the area.

The first hospital was established in Inglewood in 1863. This two-storey building had new wings added in 1874; in 1937 it was remodeled to a single storey structure. The hospital was further remodeled in 1978 to accommodate Nursing Home Residents. The kitchen was rebuilt in 1982 and a new Hostel added in 1994.

Following amalgamation in 1996 Inglewood Community Health Services came under the IDHS banner and were relocated to the hospital site. In 1998 changes to the front entrance created a new administration area. Further works and refurbishments in 2001 created the Nursing Home, refreshed Acute Wards and Urgent Care Centre. The vacated nursing home was refurbished as office space for the community health team. A new building for the Inglewood Medical Practice was completed in 2001, a busy year for the health service.

In 2005 the Wedderburn services were moved to the Wedderburn Community Centre, a refurbished multipurpose site at the old Primary School. A wide range of outreach services are provided from this site by IDHS and our partners. In 2006 the previous Inglewood doctor's surgery on the hospital grounds were remodeled for use as a small gymnasium providing a location for the strength training exercise program. New residences have been built to house a Medical Practitioner and most recently a new Doctors Clinic has been built in Wedderburn and opened in December 2012.

More than 22 years since amalgamation, the health service continues to evolve to meet community needs. Building upgrades provide modern functional facilities to accommodate this dynamic and progressive health service. In the past 12 months significant painting and office relocations have occurred to accommodate the services delivered in 2017/18. The latest changes have refreshed the entrance and located the community-based staff at the entrance ready to assist and support the community needs in to the future.

The Hospital
Inglewood

INGLEWOOD HOSPITAL

STATUTORY REPORTING REQUIREMENTS

BUILDING ACT 1993

Inglewood & Districts 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.

MAJOR BUILDING COMPLIANCE REPORT

Building Works

Building Works certified for approval	0
Works in construction and the subject of mandatory inspections	0
Occupancy permits issued	0

Maintenance

Notices issued for rectification of substandard buildings requiring urgent attention	Nil
Involving major expenditure and urgent attention	Nil

Conformity

Number of buildings conforming with standards	3
Brought into conformity this year	0

EMPLOYMENT AND CONDUCT PRICIPLES

The Health Service is committed to complying with the Standards and Guidelines of the Public-Sector Employment Principles and Code of Conduct for Victorian Public Sector Employees. The documents are circulated.

EQUAL EMPLOYMENT OPPORTUNITY

The Health Service is subject to the provisions of the Public Authorities (Equal Employment Opportunity) Act 2010. As such the following information is reported in respect of equal employment opportunity.

The Inglewood & Districts Health Service is committed to providing an equal employment opportunity workforce free from discrimination for existing and prospective employees. In promoting an equal opportunity workplace Inglewood & Districts Health Service acknowledges and accepts the following principles:

- The Health Service shall obtain through the merit system the best employees possible to deliver services.
- It shall realise the potential contributions of each employee.
- Ensure that all employees can pursue their duties free from discrimination and harassment.

FREEDOM OF INFORMATION

The Freedom of Information Act 1982 provides the public with a means of obtaining information held by the Health Service. During the period under review Inglewood & Districts Health Service has received no requests under the Freedom of Information Act 1982.

GOVERNMENT POLICIES ON COMPETITIVE NEAUTRALITY AND NATIONAL COMPETITION

The Inglewood & Districts Health Service comply with the requirements of the Victorian Government's Competitive Neutrality Policy and any legislative changes made in relation to the National Competition Policy.

Competitive Neutrality is a mechanism which can be utilised to improve operating efficiencies through benchmarking and implementing better work practices.

PROTECTED DISCLOSURE ACT 2012

Inglewood & Districts Health Service is committed to the aims and objectives of the Protected Disclosures Act 2012 and does not tolerate improper conduct by its employees, officers or directors, nor the taking of reprisals against those who come forward to disclose such conduct.

Inglewood & Districts Health Service recognises the value of transparency and accountability in our administrative and management practices and supports the making of disclosures that reveal corrupt conduct or conduct involving a substantial mismanagement of public resources, or conduct involving a substantial risk to public health and safety or the environment.

Inglewood & Districts Health Service will take all reasonable steps to protect people who make such disclosures from any detrimental action in reprisal for making the disclosure.

CAR PARKING FEES

Inglewood & Districts Health Service complies with the DHHS hospital circular on car parking fees effective 1 February 2016. Car Parking is free at this health service.

REPORTING OF OFFICE-BASED ENVIRONMENTAL IMPACTS

IDHS is committed to making sure that resources are used in a safe and responsible manner. We actively participate in Health Purchasing Victoria contracts with energy use.

Another opportunity that commenced in 2018 was the installation of LED lighting. This will have a positive impact for the environment and improve efficiency within the health service.

In 2018, Inglewood & Districts Health Service was selected to take part in a solar panel program. IDHS will be part of an HPV tender process for the purchase of the panels, anticipated to occur later in 2018.

ADDITIONAL INFORMATION

In compliance with the requirements of the Standing Directions of the Minister for Finance, details in respect of the items listed below have been retained by Inglewood & Districts Health Service and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements, if applicable).

PECUNIARY INTERESTS

Members of the Board of Management and Senior Management are required to lodge declarations of pecuniary interest. The By-laws state any member of the Board who has a direct or indirect material financial interest in any matter brought before the Board for discussion shall disclose that interest forthwith to the other Board members and shall not be present during discussion on the matter or entitled to vote on the matter.

STATEMENTS OF FEES AND CHARGING RATES

The Health Service charges fees in accordance with the recommendations of the Department of Health.

PROMOTIONS, RESEARCH, EXTERNAL REVIEWS

There have been no major marketing or promotional activities, no major research projects and no external reviews this year.

SHARES HELD BY SENIOR OFFICERS

There are no shares held by senior officers or nominees or held beneficiary.

PUBLICATIONS

The publications produced by Inglewood & Districts Health Service including the Annual Report, Quality Account and Financial Report, can be obtained on our website idhs.vic.gov.au. Some copies will also be available from our office, please call 03 5431 7000 to reserve your copy.

PRICE CHANGES AT IDHS

There have been no changes in prices at IDHS during this financial year.

INDUSTRIAL RELATIONS

Industrial relations within the Health Service have been harmonious and no time has been lost due to industrial disputes in the period under review.

EX-GRATIA PAYMENT

No payments have been made in this financial year.

VICTORIAN INDUSTRY PARTICIPATION POLICY DISCLOSURES

All contracts entered within the last financial year have been in accordance with the Victorian Industry Participation Policy.

CONSULTANTS ENGAGED

In 2017-2018, there were no consultants engaged where the total fees payable was $10,000 or greater.

CARERS RECOGNITION ACT

Inglewood & Districts Health Service is an agency subject to the Carers Recognition Act 2012. The Carers Recognition Act 2012 formally recognises and values the role of carers and the importance of care relationships in the Victorian community. The Act includes a set of principles about the significance of care relationships, and specifies obligations for State Government agencies, Local Councils and other organisations that interact with people in care relationships.

Inglewood & Districts Health Service has:

- taken all practical measures to comply with its obligations under the Act
- promoted the principles of the Act to people in care relationships receiving our services and also to the broader community
- reviewed our staff employment policies to include flexible working arrangements and leave provision ensuring compliance with the statement of principles in the Act.

There were no disclosures in 2017/18.

SAFE PATIENT CARE ACT 2015

Inglewood and Districts Health Service has no matters to report in relation to its obligations under section 40 of the Safe Patient Care Act 2015.

ATTESTATIONS

Financial Management Act

I Vanessa Hicks, on behalf of the Responsible Body, certify that Inglewood & Districts Health Service has complied with the applicable Standing Directions of the Minister for Finance under the Financial Management Act 1994 and Instructions except for the following Material Compliance Deficiencies:

- **Direction 2.2 (c)** - IDHS have a risk register implemented which is a work in progress to be completed in the early part of 2018-19 financial year.
- **Direction 2.3.1 (b) and (c)** - IDHS did not have an internal auditor for the whole of the 2017-18 financial year. An internal auditor was appointed in May 2018 and an internal audit program is currently being designed for the coming year.
- **Direction 2.4.2 (b)** - IDHS are aware that for the 2017-18 financial year several policies and procedures were out of date or yet to be completed and are currently implementing the accounting procedure manual for the coming year.
- **Direction 3.1 (a) and (d)** - IDHS are implementing the accounting procedure manual to comply in 2018-19.
- **Direction 3.2.1.1 (a), (b), (e), (f), (h) and (i) and Direction 3.2.2.2** - IDHS will complete the implementation of the risk register and the audit committee will have the risk register at all audit committee meetings for review. With the appointment of the internal auditors in May 2018, the 2018-19 audit agendas will include audit recommendations as a standing item.
- **Direction 3.4** - IDHS have implemented the process for keeping all policies and procedures up to date and available as per Standing Direction.
- **Direction 3.7.1 and 3.7.2** - IDHS have a completed Business Continuity Plan which will be tested and updated as required by the Standing Direction and the risk register is to be completed in early 2018-19 and reviewed regularly.
- **Direction 3.7.2.3** - IDHS did not have an investment policy for the whole of 2017-18 and in June have implemented a Treasury and Investment policy in line with DTF requirements, and all investments have been reviewed to check compliance against Standing Directions.
- **Direction 4.2.1 (c) and Direction 4.2.1.2 (a) - (c) and Direction 4.2.3** - AMAF was not fully implemented for the 2017-18 year and management are working to implement and manage compliance for 2018-19.

Vanessa Hicks
Board President
Inglewood & Districts Health Service, 30 June 2018

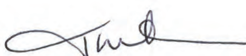
Financial Management Compliance Attestation

I, Tracey Wilson certify that the Inglewood & Districts Health Service has complied with the applicable Standing Directions of the Minister of Finance under the Financial Management Act 1994 and Instructions.

Tracey Wilson
Accountable Officer
Inglewood & Districts Health Service, 30 June 2018

Data integrity

I, Tracey Wilson, certify that the Inglewood & Districts Health Service has put in place appropriate internal controls and processes to ensure that the reported data accurately reflects actual performance. Inglewood & Districts health Service has critically reviewed these controls and processes during the year.

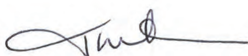


Tracey Wilson
Accountable Officer
Inglewood & Districts Health Service, 30 June 2018

ATTESTATIONS

Conflict of interest

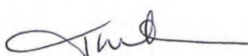
I, Tracey Wilson, certify that the Inglewood & Districts Health Service has put in place appropriate internal controls and processes to ensure that it has complied with the requirements of hospital circular 07/2017 compliance reporting in health portfolio entities (revised) and has implemented a 'Conflict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



Tracey Wilson
Accountable Officer
Inglewood & Districts Health Service, 30 June 2018

Compliance with Health Purchasing Victoria (HPV) health purchasing policies

I, Tracey Wilson, certify that Inglewood & Districts 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.



Tracey Wilson
Accountable Officer
Inglewood & Districts Health Service, 30 June 2018

DETAILS OF INFORMATION AND COMMUNICATION TECHNOLOGY EXPENDITURE

Business as usual expenditure (ex GST)	$199,094.00
There was no non-business as usual ICT Expenditure in this financial year.	

DISCLOSURE INDEX

The annual report of the Inglewood & Districts Health Service is prepared in accordance with all relevant Victorian legislation. This index has been prepared to facilitate identification of the Department's compliance with statutory disclosure requirements.

Legislation	Requirement	Page
	Ministerial Directions Report of Operations	
FRD 22H	Manner of establishment and the relevent Ministers	4
FRD 22H	Purpose, functions, powers and duties	3
FRD 22H	Initiatives and key achievements	8-10
FRD 22H	Nature and range of services provided	6-7
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Legislation	Requirement	Page
	Financial and other information	
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FR - as per financial statements

LIFE GOVERNORS AS AT 30 JUNE 2018

19.11.1953	Mr. J. Mason
29.03.1954	Mrs. F. Soulsby
17.03.1955	Victorian Police Highland Band
20.06.1957	Mr. G. Roberts
17.10.1957	Mrs. J. Soulsby
11.06.1958	Mrs. B. Mason*
11.06.1958	Mr. L. Leitch
25.08.1964	Mr. A. Attwood
27.05.1971	Mr. S. Payne
26.07.1973	Mr. J. Leach
26.07.1973	Mr. D. Roberts
26.07.1974	Mrs. E. Roberts
27.11.1975	Mr. E. Edwards
24.06.1976	Mr. A. Bellenger
28.04.1977	Mr. J. Kennedy
28.07.1978	Mr. R. Leach
29.03.1980	Mrs. S. Catto
25.02.1981	Mrs. D. Vanston
23.06.1982	Mrs. M. Catto
14.08.1983	Mrs. E. Younghusband
14.10.1984	Mr. L. Mitchell
26.06.1985	Mrs. J. Leach
26.06.1988	Mr. C. Chamberlain
21.06.1989	Mrs. K. Weston
12.06.1990	Mrs. A. Leach
12.06.1990	Mr. J. Murnane
19.06.1991	Mrs. J. Bellenger
23.10.1991	Mr. J. Barth
23.06.1992	Mrs. J. Soulsby
16.09.1992	Mr. W. Penny
16.06.1993	Mr. G. Leach
22.06.1994	Mrs. M. Duke
21.06.1995	Mrs. A. Adam
20.09.1995	Mr. F. Rose
27.06.1996	Mr. N. Roberts
24.09.1997	Mrs. J. Hobbs
27.05.1997	Mrs. H. Passalick
28.07.1998	Mrs. I. Chappel
28.07.1998	Mrs. B. Medcalf
28.07.1998	Mrs. E. Wilson
24.08.1999	Mrs. N. Wright
21.12.2004	Mr. S. Hando
21.11.2013	Mr. P Norman
29.11.2017	Mr. P. Moore
29.11.2017	Mrs. M. Evans

CAN YOU ASSIST IDHS?

IDHS receives State and Commonwealth Government funding to deliver care and services to our communities. There are opportunities to purchase services and equipment above and beyond the government funding to further extend and develop our services for our community.

In 2017 the IDHS Foundation was launched for this purpose. We appreciate all the support we receive from businesses groups and individuals in our community.

YOU CAN HELP BY

Donating towards a specific item or equipment

Remembering the Health Service in your Will

Becoming a Volunteer - Driver, Visitor, Hostel activities or other

Your support is needed and appreciated

WHO TO CONTACT

To inquire about becoming a volunteer, please contact reception at the Health Service.

Phone: (03) 5431 7000
Email: admin@idhs.vic.gov.au

To donate, simply make a payment at the Health Service Reception or forward your Cheque to:

Inglewood & Districts Health Service,
Hospital Street Inglewood VIC 3517

A receipt will be issued, all donations over $2.00 are tax deductible

If you would like to donate for a specific purpose, please contact the Chief Executive Officer at the address or phone number listed above.

Hospital Street, Inglewood VIC 3517
Phone: (03) 5431 7000
Fax: (03) 5431 7004
Email: admin@idhs.vic.gov.au
ABN 59 289 296 574

idhs.vic.gov.au

Hospital Street, Inglewood VIC 3517

Phone: (03) 5431 7000
Fax: (03) 5431 7004
Email: admin@idhs.vic.gov.au
ABN 59 289 296 574

idhs.vic.gov.au

VAGO
Victorian Auditor-General's Office

Independent Auditor's Report

To the Board of Inglewood & Districts Health Service

Opinion	I have audited the financial report of Inglewood & Districts Health Service (the health service) which comprises the: • balance sheet as at 30 June 2018 • 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 significant accounting policies • board member's and accountable officer's declaration. In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2018 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.
Basis for Opinion	I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. I further describe my responsibilities under that Act and those standards in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report. My independence is established by the *Constitution Act 1975.* 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 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Victoria. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.
Board's responsibilities for the financial report	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 *Financial Management Act 1994*, 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. In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.
Other Information	The Board of the health service is responsible for the Other Information, which comprises the information in health service's annual report for the year ended 30 June 2018, but does not include the financial report and my auditor's report thereon. My opinion on the financial report does not cover the Other Information and accordingly, I do not express any form of assurance conclusion on the Other Information. However, in connection with my audit of the financial report, my responsibility is to read the Other Information and in doing so, consider whether it is materially inconsistent with the financial report or the knowledge I obtained during the audit, or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude there is a material misstatement of the Other Information, I am required to report that fact. I have nothing to report in this regard.

Auditor's responsibilities for the audit of the financial report	As required by the *Audit Act 1994,* my responsibility is to express an opinion on the financial report based on the audit. My objectives for the audit are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report. As part of an audit in accordance with the Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also: • identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. • obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the health service's internal control • evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board • conclude on the appropriateness of the Board's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the health service's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the health service to cease to continue as a going concern. • evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation. I communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

MELBOURNE
10 September 2018

Ron Mak
as delegate for the Auditor-General of Victoria

BOARD MEMBER'S AND ACCOUNTABLE OFFICER'S DECLARATION

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

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

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

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

Vanessa Hicks
Board Chair
Inglewood
Date: 5 Spetmber 2018

Tracey Wilson
Chief Executive Officer
Inglewood
Date: 5 September 2018

Inglewood and Districts Health Service

Comprehensive Operating Statement for the financial year ended 30 June 2018

	NOTE	2018 $	2017 $
Revenue from Operating Activities	2.1	7,443,021	6,801,814
Revenue from Non-operating Activities	2.1	67,890	106,215
Employee Expenses	3.1	(5,416,653)	(5,217,731)
Non Salary Labour Costs	3.1	(288,448)	(236,432)
Supplies and Consumables	3.1	(486,136)	(340,645)
Other Expenses	3.1	(767,903)	(1,012,092)
Net Result Before Capital and Specific Items		551,771	101,129
Capital Purpose Income	2.1	213,615	94,921
Depreciation	4.3	(757,856)	(766,415)
Expenditure for Capital Purpose	3.1	(90,597)	(69,362)
Net Result after capital and specific items		(83,067)	(639,727)
Other economic flows included in the net result			
Gain/(Loss) on non-financial assets		14,755	-
Revaluation of Long Service Leave	3.1	7,427	(6,392)
Total other economic flows included in the net result		22,182	(6,392)
NET RESULT FOR THE YEAR		(60,885)	(646,119)
Other comprehensive income			
Items that will not be reclassified subsequently to net result			
Changes to financial assests available-for-sale revaluation surplus		895,065	6,478
COMPREHENSIVE RESULT		834,180	(639,641)

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

Inglewood and Districts Health Service

Balance Sheet as at 30 June 2018

	NOTE	2018 $	2017 $
Current Assets			
Cash and Cash Equivalents	6.1	1,955,428	1,108,084
Receivables	5.1	463,763	422,866
Investments and other financial assets	4.1	669,036	1,694,485
Inventories	5.2	30,847	-
Prepayments and Other Assets	5.4	36,958	29,569
Total Current Assets		3,156,032	3,255,004
Non-Current Assets			
Receivables	5.1	219,518	216,050
Property, Plant & Equipment	4.2	9,953,121	9,730,940
Total Non-Current Assets		10,172,639	9,946,990
TOTAL ASSETS		13,328,671	13,201,994
Current Liabilities			
Payables	5.5	268,106	472,398
Provisions	3.3	1,181,813	1,507,163
Other Current Liabilities	5.3	1,856,722	1,996,922
Total Current Liabilities		3,306,641	3,976,483
Non-Current Liabilities			
Provisions	3.3	116,759	154,420
Total Non-Current Liabilities		116,759	154,420
TOTAL LIABILITIES		3,423,400	4,130,903
NET ASSETS		9,905,271	9,071,091
EQUITY			
Property, Plant & Equipment Revaluation Surplus	8.1a	9,096,423	8,201,358
Financial Assest Available for Sale Revaluation Surplus	8.1a	6,494	6,494
Restricted Specific Purpose Surplus	8.1a	650,349	650,349
Contributed Capital	8.1b	5,284,700	5,284,700
Accumulated Surpluses/(Deficits)	8.1c	(5,132,695)	(5,071,810)
TOTAL EQUITY		9,905,271	9,071,091
Contingent Assets and Contingent Liabilities	7.2		
Commitments	6.2		

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

Statement of Changes in Equity for the financial year ended 30 June 2018

	Note	Property, Plant and Equipment Revaluation Surplus	Financial Assets Availale for Sale Revaluation Surplus	Restricted Special Purpose Surplus	Contribution by Owners	Accumulated Surpluses / (Deficits)	Total
		$	$	$	$	$	$
Balance at 1 July 2016		8,201,358	16	650,349	5,284,700	(4,425,691)	9,710,732
Net result for the year		-		-	-	(646,119)	(646,119)
Other comprehensive income for the year	8.1a	-	6,478	-	-	-	6,478
Balance at 30 June 2017		8,201,358	6,494	650,349	5,284,700	(5,071,810)	9,071,091
Net result for the year		-	-	-	-	(60,885)	(60,885)
Other comprehensive income for the year	8.1a	895,065	-	-	-	-	895,065
Balance at 30 June 2018		9,096,423	6,494	650,349	5,284,700	(5,132,695)	9,905,271

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

Inglewood and Districts Health Service

Cash Flow Statement for the financial year ended 30 June 2018

	NOTE	2018 $	2017 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		5,736,100	5,119,000
Capital Grants from Government		176,087	22,342
Patient and Resident Fees Received		993,756	767,657
Donations and Bequests Received		27,990	56,866
GST Received from/(paid to) ATO		42,890	15,044
Interest Received		86,872	136,657
Other Capital Receipts		17,947	-
Other Receipts		459,104	628,997
Total Receipts		7,540,746	6,746,563
Employee Expenses Paid		(5,854,673)	(5,185,376)
Non Salary Labour Costs		(216,906)	(236,432)
Payments for Supplies & Consumables		(516,983)	(340,645)
Other Payments		(861,381)	(758,540)
Total Payments		(7,449,943)	(6,520,993)
NET CASH FLOW FROM OPERATING ACTIVITIES	8.2	90,803	225,570
CASH FLOWS FROM INVESTING ACTIVITIES			
Proceeds from Sale of Investments		324,928	4,917
Payments for Non-Financial Assets		(131,119)	(107,182)
Proceeds from sale of Non-Financial Assets		14,755	24,000
NET CASH FLOW FROM/(USED IN) INVESTING ACTIVITIES		208,564	(78,265)
NET INCREASE IN CASH AND CASH EQUIVALENTS HELD		299,367	147,305
Cash and Cash Equivalents at beginning of financial year		348,705	201,400
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.1	648,072	348,705

This Statement should be read in conjunction with the accompanying notes

Basis of preparation

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

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

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

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

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

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

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

Note 1 – Summary of Significant Accounting Policies

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

(a) Statement of Compliance

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

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

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

The annual financial statements were authorised for issue by the Board of Inglewood & Districts Health Service on 5th September 2018.

(b) Reporting Entity

The financial statements include all the controlled activities of Inglewood & Districts Health Service.
Its principal address is:
Hospital Street
Inglewood VIC 3517

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

(c) Basis of Accounting Preparation and Measurement

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

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

The financial statements are prepared on a going concern basis.

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

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

The Inglewood & Districts Health Service operates on a fund accounting basis and maintains three funds: Operating, Specific Purpose and Capital Funds.

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

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

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

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

Goods and Services Tax (GST)

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

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

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

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

(d) Jointly Controlled Operation

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

In respect of any interest in joint operations, Inglewood & Districts 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.

Inglewood & Districts Health Service is a Member of the Loddon Mallee Rural Health Alliance Joint Venture and retains joint control over the arrangement, which it has classified as a joint operation (refer to Note 8.9 Jointly Controlled Operations).

Note 2 – Funding delivery of our services

Inglewood & District Health **Service's** overall objective is to provide quality health services that supports and enhances the wellbeing of the community and surround districts. Inglewood & Districts Health Service is predominantly funded by accrual based grant funding for the provision of outputs. The health service also receives income from the supply of services.

Structure

2.1 Analysis of Revenue by Source

Note 2.1: Analysis of Revenue by Source

	Admitted Patients 2018 $	Residential Aged Care 2018 $	Aged Care 2018 $	Primary Health 2018 $	Other 2018 $	Total 2018 $
Government Grants	2,011,029	2,840,524	485,394	403,112	-	5,740,059
Indirect contributions by Department of Health and Human Services	578	1,200	1,023	777	-	3,578
Patient & Resident Fees	110,673	773,736	17,213	27,622	-	929,244
Commerical Activites	-	-	-	-	183,350	183,350
Other Revenue from Operating Activities	315,549	30,630	28,820	211,791	-	586,790
Totol Revenue from Operating Activities	2,437,829	3,646,090	532,450	643,302	183,350	7,443,021
Interest	-	14,022	-	-	48,271	62,293
Other Revenue from Non-Operating Activities	-	-	-	-	5,597	5,597
Total Revenue from Non-Operating Activities	-	14,022	-	-	53,868	67,890
Capital Purpose Income (excluding Interest)	-	180,167	-	-	8,869	189,036
Capital Interest	-	15,476	-	-	9,103	24,579
Gain/(Loss) on Sale of Assets	-	-	-	-	14,755	14,755
Total Capital Purpose Income	-	195,643	-	-	32,727	228,370
Total Revenue	2,437,829	3,855,755	532,450	643,302	269,945	7,739,281

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

	Admitted Patients 2017 $	Residential Aged Care 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	Total 2017 $
Government Grants	1,913,330	2,130,560	779,595	394,641	0	5,218,126
Indirect contributions by Department of Health and Human Services	22,196	4,002	407	1,421	0	28,026
Patient and Resident Fees	101,320	674,393	26,100	375	0	802,188
Commercial Activities	171,896	0	0	0	176,959	348,855
Other Revenue from Operating Activities	17,028	32,857	344,219	10,515	0	404,619
Total Revenue from Operating Activities	2,225,770	2,841,812	1,150,321	406,952	176,959	6,801,814
Interest	106,215	0	0	0	0	106,215
Other Revenue from Non-Operating Activities	0	0	0	0	0	0
Total Revenue from Non - Operating Activities	106,215	0	0	0	0	106,215
Capital Purpose Income (excluding Interest)	22,342	0	0	0	56,752	79,094
Capital Interest	0	0	0	0	15,827	15,827
Total Capital Purpose Income	22,342	0	0	0	72,579	94,921
Total Revenue	2,354,327	2,841,812	1,150,321	406,952	249,538	7,002,950

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

Revenue Recognition

Income is recognised in accordance with AASB 118 Revenue and is recognised as to the extent that it is probable that the economic benefits will flow to Inglewood & Districts 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 Department of Health and Human Services Hospital Circular 04/2017.

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 Marong Medical Clinic is recognised at the time invoices are raised.

Donations and Other Bequests

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

Interest Revenue

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

Sale of investments

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

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

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

Other Income

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

Category Groups

The Inglewood & Districts Health Service has used the following category groups for reporting purposes for the current and previous financial year

Admitted Patient Services (Admitted Patients)

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

Primary and Community Health

Comprises services for Community Health including health promotion and counselling and physiotherapy.

Note 3: The cost of delivering our services

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

Structure
3.1 Analysis of expenses by source
3.2 Analysis of expense and revenue by internally managed and restricted specific purpose funds
3.3 Provisions
3.4 Superannuation

Note 3.1: Analysis of Expenses by Source

	Admitted Patients 2018 $	Residential Aged Care 2018 $	Aged Care 2018 $	Primary Health 2018 $	Other 2018 $	Total 2018 $
Employee Expenses	1,547,824	1,208,488	507,765	517,478	1,635,098	5,416,653
Non Salary Labour Costs	223,999	59,704	240	2,459	2,046	288,448
Supplies & Consumables	130,752	57,708	87	26,539	271,050	486,136
Other Expenses	55,186	23,113	25,355	39,881	624,368	767,903
Total Expenditure from Operating Activities	1,957,761	1,349,013	533,447	586,357	2,532,562	6,959,140
Expenditure for Capital Purpose	-	-	-	-	90,597	90,597
Revaluation of Long Service Leave	-	-	-	-	(7,427)	(7,427)
Depreciation (refer Note 4.3)	-	-	-	-	757,856	757,856
Total Other Expenses	-	-	-	-	841,026	841,026
Total Expenses	1,957,761	1,349,013	533,447	586,357	3,373,588	7,800,166

	Admitted Patients 2017 $	Residential Aged Care 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	Total 2017 $
Employee Expenses	1,526,761	2,213,866	367,426	929,439	180,239	5,217,731
Non Salary Labour Costs	236,432	0	0	0	0	236,432
Supplies & Consumables	101,849	153,319	23,166	650	61,661	340,645
Other Expenses	247,149	396,783	69,853	133,933	164,374	1,012,092
Total Expenditure from Operating Activities	2,112,191	2,763,968	460,445	1,064,022	406,274	6,806,900
Expenditure for Capital Purpose	0	0	0	0	766,415	766,415
Depreciation (refer Note 4.3)	0	0	0	0	69,362	69,362
Total Other Expenses	0	0	0	0	835,777	835,777
Total Expenses	2,112,191	2,763,968	460,445	1,064,022	1,242,051	7,642,677

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

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

Employee expenses
Employee expenses include:

- wages and salaries;
- leave entitlements;
- workcover premiums;
- termination payments;
- fringe benefits tax; and
- superannuation expenses

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

- Supplies and consumables - Supplies and services costs which are recognised as an expense in the reporting period in which they are incurred. The carrying amounts of any inventories held for distribution are expensed when distributed.
- Fair Value of Assets, Services and Resources Provided Free of Charge or for Nominal Consideration - Contributions of resources provided free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them, irrespective of whether restrictions or conditions are imposed over the use of the contributions.

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 4.2 Property plant and equipment.)
- 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.

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 4.1 Investments and other financial assets; and
- disposals of financial assets and derecognition of financial liabilities.

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

Other gains/ (losses) from other economic flows
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.

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

	Expense		Revenue	
	2018	2017	2018	2017
Commercial Activities	$	$	$	$
Marong Medical Clinic	76,866	133,544	128,532	106,972
Meals on Wheels	37,125	37,012	41,802	41,063
Total	113,991	170,556	170,334	148,035

Note 3.3: Employee Benefits in the Balance Sheet

	2018 $	2017 $
Current Provisions		
Employee Benefits (i)		
Annual Leave		
- Unconditional and expected to be settled within 12 months (ii)	357,782	398,672
- Unconditional and expected to be settled after 12 months (iii)	62,124	67,211
Accrued Day Off		
- Unconditional and expected to be settled within 12 months (ii)	8,192	14,923
- Unconditional and expected to be settled after 12 months (iii)	1,382	-
Long Service Leave		
- Unconditional and expected to be settled within 12 months (ii)	103,879	293,819
- Unconditional and expected to be settled after 12 months (iii)	454,622	405,751
Provisions related to employee benefit on-costs		
- Unconditional and expected to be settled within 12 months (ii)	49,376	82,460
- Unconditional and expected to be settled after 12 months (iii)	54,586	51,126
Salaries and Wages	89,870	193,201
Total Current Provisions	1,181,813	1,507,163
Non-Current Provisions		
Employee Benefits (i)	105,626	140,603
Provisions related to employee benefits on-costs	11,133	13,817
Total Non-Current Provisions	116,759	154,420
Total Provisions	1,298,572	1,661,583
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and Related On-Costs		
Annual Leave Entitlements	463,997	470,883
Accrued Wages and Salaries	89,870	193,201
Accrued Days Off	10,579	15,423
Unconditional Long Service Leave Entitlements	617,367	827,656
Non-Current Employee Benefits and Related On-Costs		
Conditional Long Service Leave Entitlements (iii)	116,759	154,420
Total Employee Benefits and Related On-Costs	1,298,572	1,661,583
(b) Movements in Provisions		
Movement in Long Service Leave:		
Balance at start of year	927,095	968,310
Provision made during the year	105,395	136,344
Settlement made during the year	(298,363)	(177,559)
Balance at end of year	734,127	927,095

(i) Employee benefits consist of amounts for accrued days off, annual leave and long service leave accrued by employees, not including on-costs.

(ii) The amounts disclosed are at nominal values.

(iii) The amounts disclosed are discounted to present values.

Employee Benefit Recognition

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

Provisions

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

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

Employee benefits

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

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

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

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

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

Long service leave (LSL)

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

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

The components of this current LSL liability are measured at:

- **Undiscounted value – if the health service expects to wholly settle within 12 months; and**
- **Present value –** where the entity does not expect to settle a component of this current liability

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.

Termination Benefits

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

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.

Note 3.4: Superannuation

	2018 $	2017 $
Defined Benefit Plans:		
First State Super	8,027	12,192
Defined Contribution plans:		
First State Super	331,649	307,695
HESTA	74,888	68,949
HostPlus	5,052	2,343
VicSuper	2,037	1,435
ANZ Super	3,823	-
Vison Super	5,730	5,159
MikeCarol	135	31,855
Australian Super	8,972	4,635
Other	17,782	10,334
TOTAL	458,095	444,597

[i] The basis for determining the level of contributions is determined by the various actuaries of the defined benefit superannuation plans.

Employees of Inglewood & Districts Health Service are entitled to receive superannuation benefits and it contributes to both defined benefit and defined contribution plans. The defined benefit plan provides benefits based on years of service and final average salary.

Defined Contribution Superannuation Plans

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

Defined Benefit Superannuation Plans

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

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

However superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the Comprehensive Operating Statement of Inglewood & Districts Health Services.

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

Note 4: Key Assets to support service delivery

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

Structure

4.1 Investments and other financial assets
4.2 Property, plant & equipment
4.3 Depreciation and amortisation

Note 4.1: Investments and Other Financial Assets

	Capital		Total	
	2018	2017	2018	2017
	$	$	$	$
CURRENT				
Loans and Receivables				
Aust. Dollar Term Deposits(i)	-	968,080	-	968,080
Available for Sale				
Managed Funds	614,543	681,506	614,543	681,506
Shares	54,493	44,899	54,493	44,899
Total Current	669,036	1,694,485	669,036	1,694,485
Represented by:				
Health Services Investments	-	324,928	-	324,928
LMRHA Investments	-	91,500	-	91,500
Monies Held in Trust				
- Accommodation Bonds	669,036	1,278,057	669,036	1,278,057
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	669,036	1,694,485	669,036	1,694,485

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

Investment Recognition

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

Investments are classified as loans and receivables and available-for-sale financial assets.

The Inglewood & Districts Health Service classifies its other financial assets between current and non-current assets based on the Board of **Management's** intention at balance date with respect to the timing of disposal of each asset. Inglewood & Districts Health Services assesses at each balance sheet date whether a financial asset or group of financial assets is impaired.

Inglewood & Districts Health Service's investments must comply with Standing Direction 3.7.2 - Treasury and Investment Risk Management. The investment portfolio of Inglewood & Districts Health Services is managed by Victorian Funds Management Corporation through specialist fund managers and a Master Custodian. The Master Custodian holds the investments and conducts settlements pursuant to instructions from the specialist fund managers.

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

Derecognition of financial assets

A financial asset (or, where applicable, a part of a financial asset or part of a group of similar financial assets)

- 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
- 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 Inglewood & Districts 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, Inglewood & Districts 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.

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

In order to determine an appropriate fair value as at 30 June 2018 for its portfolio of financial assets, Inglewood & Districts Health Services and its controlled entities used the market value of investments held provided by the portfolio managers.

The above valuation process was used to quantify the level of impairment (if any) on the portfolio of financial assets as at year end.

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.

Inglewood and Districts Health Service

Notes to the Financial Statement for the year ended 30 June 2018

Note 4.2: Property, Plant and Equipment

(a) Gross carrying amount and accummulated depreciation

	2018 $	2017 $
Land		
- Land at Fair Value	182,000	182,000
Total Land	182,000	182,000
Buildings		
- Buildings at Fair Value	9,383,053	10,842,322
Less Accumulated Depreciation	-	(1,751,983)
Total Buildings	9,383,053	9,090,339
Plant and Equipment		
- Plant and Equipment at Fair Value	728,158	749,950
Less Accumulated Depreciation	(500,665)	(463,831)
- Loddon Mallee Rural Health Alliance at Fair Value	30,922	18,536
Less Accumulated Depreciation	(17,520)	(15,132)
Total Plant and Equipment	240,895	289,523
Computers and Communication		
- Computers and Communication at Fair Value	95,330	81,360
Less Accumulated Depreciation	(57,971)	(32,537)
Total Computers and Communications	37,359	48,823
Furniture and Fittings		
- Furniture and Fittings at Fair Value	76,187	73,339
Less Accumulated Depreciation	(38,023)	(30,682)
Total Furniture and Fittings	38,164	42,657
Motor Vehicles		
- Motor Vehicles at Fair Value	274,674	283,313
Less Accumulated Depreciation	(203,024)	(205,715)
Total Motor Vehicles	71,650	77,598
TOTAL	9,953,121	9,730,940

Note 4.2: 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 2016	182,000	9,322,840	351,676	48,989	81,360	157,216	268,600	10,412,681
Additions	-	-	10,718	-	-	-	96,464	107,182
Transfers In/(out)	-	365,064	-	-	-	-	(365,064)	-
Loddon Mallee Rural Health Alliance	-	-	1,606	-	-	-	-	1,606
Disposals	-	-	-	-	-	(24,114)	-	(24,114)
Depreciation (see Note 4.4)	-	(597,565)	(74,477)	(6,332)	(32,537)	(55,504)	-	(766,415)
Balance at 30 June 2017	182,000	9,090,339	289,523	42,657	48,823	77,598	-	9,730,940
Additions	-	-	12,209	2,848	16,425	61,857	37,780	131,119
Transfers In/(out)	-	-	-	-	-	-	(37,780)	(37,780)
Revaluation	-	895,065	-	-	-	-	-	895,065
Loddon Mallee Rural Health Alliance	-	-	11,522	-	-	-	-	11,522
Disposals	-	-	(2,382)	-	-	(17,508)	-	(19,890)
Depreciation (see Note 4.3)	-	(602,352)	(69,977)	(7,341)	(27,889)	(50,297)	-	(757,856)
Balance at 30 June 2018	182,000	9,383,053	240,895	38,164	37,359	71,650	-	9,953,121

Land and buildings carried at valuation

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

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

The latest indices required a managerial revaluation for buildings in 2018. The indexed value was then compared to individual assets written down book value as at 30 June 2018 to determine the change in their fair values. The Department of Health and Human Services approved a managerial revaluation of the building asset class of $9.4m.

There was no material financial impact on change in fair value of Land.

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.

Note 4.2 Property, plant & equipment (continued)

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

	Carrying amount as at 30 June 2018	Fair value measurement at end of reporting period using:		
		Level 1 [1]	Level 2 [1]	Level 3 [1]
	$	$	$	$
Land at fair value				
Non-specialised land	24,000	-	24,000	-
Specialised land	158,000	-	-	158,000
Total of land at fair value	182,000	-	24,000	158,000
Buildings at fair value				
Non-specialised buildings	354,200	-	354,200	-
Specialised buildings	9,028,853	-	-	9,028,853
Total of building at fair value	9,383,053	-	354,200	9,028,853
Plant and Equipment at fair value				
Plant and Equipment	240,895	-	-	240,895
Total of plant and equipment at fair value	240,895	-	-	240,895
Computer and Communitcation at fair value				
Computers and Communication	37,359	-	-	37,359
Total Computer and communication at fair value	37,359	-	-	37,359
Furniture and Fittings at fair value				
Furniture and Fittings	38,164	-	-	38,164
Total Furniture and Fittings at fair value	38,164	-	-	38,164
Motor Vehicles at fair value				
Motor Vehicles	71,650	-	-	71,650
Total Motor Vehicles at fair value	71,650	-	-	71,650
	9,953,121	-	378,200	9,574,921

Note

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

(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	24,000	-	24,000	-
Specialised land	158,000	-	-	158,000
Total of land at fair value	182,000	-	24,000	158,000
Buildings at fair value				
Non-specialised buildings	322,000	-	322,000	-
Specialised buildings	8,768,339	-	-	8,768,339
Total of building at fair value	9,090,339	-	322,000	8,768,339
Plant and Equipment at fair value				
Plant and Equipment	289,523	-	-	289,523
Total of plant and equipment at fair value	289,523	-	-	289,523
Computer and Communitcation at fair value				
Computers and Communication	48,823	-	-	48,823
Total Computer and communication at fair value	48,823	-	-	48,823
Furniture and Fittings at fair value				
Furniture and Fittings	42,657	-	-	42,657
Total Furniture and Fittings at fair value	42,657	-	-	42,657
Motor Vehicles at fair value				
Motor Vehicles	77,598	-	-	77,598
Total Motor Vehicles at fair value	77,598	-	-	77,598
	9,730,940	-	346,000	9,384,940

Note

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

Note 4.2: Property, plant & equipment (continued)

(d) Reconciliation of Level 3 fair value 2018

	Land	Buildings	Plant and Equipment	Computers & Communication	Furniture & Fittings	Motor Vehicles	Assets under construction
	$	$	$	$	$	$	$
Opening Balance	158,000	8,768,339	289,523	48,823	42,657	77,598	-
Purchases (sales)	-	-	23,731	16,425	2,848	61,857	-
Transfers in (out) of Level 3	-	-	-	-	-	-	-
Gains or losses recognised in net result							
- Depreciation	-	(596,772)	(69,977)	(27,889)	(7,341)	(50,297)	-
- unrealised gains/(losses) from non-financial assets	-	(37,780)	(2,382)	-	-	(17,508)	
Subtotal	158,000	8,133,787	240,895	37,359	38,164	71,650	-
Items recognised in other comprehensive income							
- Revaluation	-	895,065	-	-	-	-	-
Subtotal	-	895,065	-	-	-	-	-
Closing Balance	158,000	9,028,853	240,895	37,359	38,164	71,650	-
	158,000	9,028,853	240,895	37,359	38,164	71,650	-

Note
There have been no transfers between levels during the period.

(d) Reconciliation of Level 3 fair value 2017

	Land	Buildings	Plant and Equipment	Computers & Communication	Furniture & Fittings	Motor Vehicles	Assets under construction
	$	$	$	$	$	$	$
Opening Balance	158,000	9,000,840	351,676	81,360	48,989	157,216	268,600
Purchases (sales)	-	-	12,324	-	-	-	96,464
Transfers in (out) of Level 3	-	365,064	-	-	-	-	(365,064)
Gains or losses recognised in net result							
- Depreciation	-	(597,565)	(74,477)	(32,537)	(6,332)	(55,504)	-
-Unrealised gains/(losses) on non-financial assets	-	-	-	-	-	(24,114)	
Subtotal	158,000	8,768,339	289,523	48,823	42,657	77,598	-
Items recognised in other comprehensive income							
- Revaluation	-	-	-	-	-	-	-
Subtotal	-	-	-	-	-	-	-
Closing Balance	158,000	8,768,339	289,523	48,823	42,657	77,598	-
	158,000	8,768,339	289,523	48,823	42,657	77,598	-

Note
There have been no transfers between levels during the period.

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

	Valuation technique (i)	Significant unobservable inputs (i)
Non-Specialised land	Market approach	N.A.
Non-Specialised buildings	Market approach	N.A.
Specialised land	Market approach	Community Service Obligation (CSO) adjustment
Specialised buildings	Depreciated replacement cost	Direct cost per square metre Useful life of specialised buildings
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

Note 4.2: Property, plant & equipment (continued)

Initial Recognition

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

Crown land is measured at fair value with regard to the property's highest and best use after due consideration is made for any legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset.

Theoretical opportunities that may be available in relation to the asset(s) are not taken into account until it is virtually certain that any restrictions will no longer apply. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best uses.

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

Subsequent Measurement

Consistent with AASB 13 Fair Value Measurement, Inglewood & Districts Health Services determines the policies and procedures for recurring property, plant and equipment fair value measurements, in accordance with the requirements of AASB 13 and the relevant FRDs.

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

For the purpose of fair value disclosures, Inglewood & Districts Health Services has determined classes of assets on the basis of the nature, characteristics and risks of the asset and the level of the fair value hierarchy as explained above.

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

For the purpose of fair value disclosures, Inglewood & Districts 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, Inglewood & Districts 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 Inglewood & Districts Health Service's independent valuation agency.

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

Fair value measurement

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

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

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

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

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

These indicators, as a minimum, include:

External factors:

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

Valuation hierarchy

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

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

Note 4.2: Property, plant & equipment (continued)

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, 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 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.

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

Specialised Land and Specialised Buildings

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

During the reporting period, Inglewood & Districts Health Services held Crown Land. The nature of this asset means that there are certain limitations and restrictions imposed on its use and/or disposal that may impact their fair value.

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

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

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

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

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 amount (depreciated cost).

Plant and Equipment

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

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

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

Note 4.2: 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 every five years, based upon the asset's Government Purpose Classification, but may occur more frequently if fair value assessments indicate material changes in values. Independent valuers are used to conduct these scheduled revaluations and any interim revaluations are determined in accordance with the requirements of the FRDs. Revaluation increments or decrements arise from differences between an asset's carrying value and fair value.

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

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

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

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

In accordance with FRD 103F, Inglewood & Districts Health Service's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

Note 4.3: Depreciation

	2018 $	2017 $
Buildings	602,352	597,565
Plant & Equipment	68,453	101,835
Motor Vehicles	50,297	55,504
Furniture and Fittings	7,340	6,332
Computer and Communications	27,889	2,320
Loddon Mallee Rural Health Alliance	1,525	2,859
Total Depreciation	757,856	766,415

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

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

	2018	2017
Buildings		
- Structure Shell Building Fabric	50 years	50 years
- Site Engineering Services and Central Plant	20 years	20 years
Central Plant		
- Fit Out	15 years	15 years
- Trunk Reticulated Building Systems	15 years	15 years
Plant & Equipment	3 to 10 years	3 to 10 years
Medical Equipment	5 to 10 years	5 to 10 years
Computers and Communication	3 years	3 years
Furniture and Fitting	3 to 10 years	3 to 10 years
Motor Vehicles	2 to 5 years	2 to 5 years

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

Note 5: Other assets and liabilities

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

Structure

5.1 Receivables
5.2 Inventories
5.3 Other liabilities
5.4 Prepayments and other assets
5.5 Payables

Note 5.1: Receivables

	2018 $	2017 $
CURRENT		
Contractual		
Trade Debtors	199,593	78,443
Patient Fees	114,153	185,044
Accrued Revenue - Other	106,490	154,040
Loddon Mallee Rural Health Alliance Receivables	10,068	5,217
Less Allowance for Doubtful Debts Patient Fees	(12,151)	(12,151)
	418,153	410,593
Statutory		
GST Receivable	41,736	9,469
Loddon Mallee Rural Health Alliance GST Receivables	3,874	2,804
	45,610	12,273
TOTAL CURRENT RECEIVABLES	463,763	422,866
Statutory		
Long Service Leave - Department of Health and Human Services	219,518	216,050
	219,518	216,050
TOTAL NON-CURRENT RECEIVABLES	219,518	216,050
TOTAL RECEIVABLES	683,281	638,916

(a) Movement in the Allowance for doubtful debts	2018 $	2017 $
Balance at the beginning of year - IDHS	12,151	26,085
Amounts written off during the year	(15,217)	(23,934)
Increase/(decrease) in allowance recognised in net result	15,217	10,000
Balance at end of year	12,151	12,151

Receivables Recognition

Receivables consist of:

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

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

Receivables are recognised initially at fair value and subsequently measured at amortised cost 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.

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.

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

	2018 $	2017 $
CURRENT		
Catering Supplies - at cost	8,106	-
Housekeeping Supplies - at cost	9,268	-
Medical and Surgucal Lines - at cost	10,644	-
Fuel, Light and Power Supplies	1,442	-
Inventory - LMRHA	1,387	-
TOTAL INVENTORIES	30,847	-

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 inventory is measured on the basis of weighted average cost.

Note 5.3: Other Liabilities

	2018 $	2017 $
CURRENT		
Monies Held in Trust*		
- Patient Monies Held in Trust	84,713	73,127
- Accommodation Bonds (Refundable Entrance Fees)	1,772,009	1,886,921
- Other Monies Held in Trust	-	36,874
TOTAL CURRENT	1,856,722	1,996,922
* Total Monies Held in Trust		
Represented by the following assets:		
Cash Assets (refer to Note 6.1)	1,187,686	718,865
Other Financial Assets (refer to Note 4.1)	669,036	1,278,057
TOTAL	1,856,722	1,996,922

Note 5.4: Prepayments and Other Assets

	2018 $	2017 $
Current:		
Prepayments	23,108	15,030
Loddon Mallee Rural Health Alliance	13,850	14,539
TOTAL CURRENT OTHER ASSETS	36,958	29,569
TOTAL OTHER ASSETS	36,958	29,569

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

Note 5.5: Payables

	2018 $	2017 $
CURRENT		
Contractual		
Trade Creditors	82,047	120,158
Accrued Expenses	6,198	-
Accrued Audit Fees	12,500	15,120
Superannuation	-	30,353
Salary Packaging	-	29,838
Other Payables	35,685	128,808
Loddon Mallee Rural Health Alliance	36,557	28,267
	172,987	352,544
Statutory		
Department of Health and Human Services	-	57,400
FBT Paybable	-	2,430
PAYG Withheld	70,760	60,024
GST Payable	24,359	-
TOTAL CURRENT	95,119	119,854
TOTAL PAYABLES	268,106	472,398

Payables consist of:

- contractual payables, classified as financial instruments and measured at amortised cost. Accounts payable represent liabilities for goods and services provided to the Department prior to the end of the financial year that are unpaid; and
- statutory payables, that are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from contracts.

Note 5.5: Payables and Borrowings Maturity Analysis

The following table discloses the contractual maturity analysis for Inglewood & Districts 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 18

			Maturity Dates			
2018	Carrying Amount $	Nominal Amount $	Less than 1 Month $	1-3 Months $	3 months - 1 Year $	1-5 Years $
Financial Liabilities						
At amortised cost						
Payables	172,987	172,987	172,987	-	-	-
Other Financial Liabilities (i)						
- Accommodation Bonds	1,772,009	1,772,009	-	-	1,772,009	-
- Patient Trusts	84,713	84,713	84,713	-	-	-
Total Financial Liabilities	2,029,709	2,029,709	257,700	-	1,772,009	-
2017						
Financial Liabilities						
At amortised cost						
Payables	352,544	352,544	352,544	-	-	
Other Financial Liabilities (i)						
- Accommodation Bonds	1,886,921	1,886,921	-	-	1,886,921	-
- Patient Trusts	73,127	73,127	73,127	-	-	-
- Other	36,874	36,874	36,874	-	-	-
Total Financial Liabilities	2,349,466	2,349,466	462,545	-	1,886,921	-

(i) Ageing analysis of financial liabilities excludes the types of statutory financial liabilities (i.e GST payable)

Note 6: How we finance our operations

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

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

Structure
6.1 Cash and Cash Equivalents
6.2 Commitments for expenditure

Note 6.1: Cash and Cash Equivalents

	2018 $	2017 $
Cash on Hand	1,850	1,650
Cash at Bank	1,953,578	1,106,434
Total Cash and Cash Equivalents	1,955,428	1,108,084
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	648,072	348,705
Cash for Monies Held in Trust		
- Deposits at Call	-	500
- Accommodation Bonds (Refundable Entrance Fees)	1,102,973	718,865
- Resident Trust Account	84,713	-
- Loddon Mallee Rural Health Alliance	119,670	40,014
Total Cash and Cash Equivalents	1,955,428	1,108,084

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

Inglewood & Districts 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 sated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

Note 7: Risks, contingencies & valuation uncertainties

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

Structure

7.1 Financial instruments
7.2 Contingent assets and contingent liabilities

Note 7.1: Financial Instruments

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of Inglewood & Districts 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.

(a) Financial instruments: categorisation

2018	Contractual financial assets - loans and receivables $	Contractual financial assets - available for sale $	Contractual financial liabilities at amortised cost $	Total $
Contractual Financial Assets				
Cash and cash equivalents	1,956,128	-	-	1,956,128
Receivables				-
- Trade Debtors	199,594	-	-	199,594
- Other Receivables	218,561	-	-	218,561
Other Financial Assets				
- Shares in Other Entities	-	669,036	-	669,036
Total Financial Assets (i)	2,374,283	-	-	3,043,319
Financial Liabilities				
Payables	-	-	172,987	172,987
Other Financial Liabilities				
- Patient Monies in Trust	-	-	84,713	84,713
- Accomodation bonds	-	-	1,772,009	1,772,009
Total Financial Liabilities (ii)	-	-	2,029,709	2,029,709

2017	Contractual financial assets - loans and receivables $	Contractual financial assets - available for sale $	Contractual financial liabilities at amortised cost $	Total $
Contractual Financial Assets				
Cash and cash equivalents	1,108,084	-	-	1,108,084
Receivables				-
- Trade Debtors	66,292	-	-	66,292
- Other Receivables	344,301	-	-	344,301
Other Financial Assets				
- Shares in Other Entities	-	726,405	-	726,405
- Term Deposit	968,080	-	-	968,080
Total Financial Assets (i)	2,486,757	-	-	3,213,162
Financial Liabilities				
Payables	-	-	352,544	352,544
Other Financial Liabilities				
- Patient Monies in Trust	-	-	718,865	718,865
- Accomodation bonds	-	-	1,278,057	1,278,057
Total Financial Liabilities (i)	-	-	2,349,466	2,349,466

(i) The carrying amount excludes statutory receivables (i.e GST receivable and DHHS receivable) and statutory paybales (i.e Revenue in Advance and DHHS Payables)

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

	Net holding gain/(loss) $	Total interest income / (expense) $	Fee income / (expense) $	Impairment loss $	Total $
2018					
Financial Assets					
Loans and Receivables	-	48,271	-	-	48,271
Available for Sale		14,022			14,022
Total Financial Assets (i)	-	62,293	-	-	62,293
2017					
Financial Assets					
Loans and Receivables	-	90,059	-	-	90,059
Available for Sale		16,156			16,156
Total Financial Assets (i)	-	106,215	-	-	106,215

[i] For cash and cash equivalents, loans or receivables and financial assets available-for-sale, the net gain or loss is calculated by taking the movement in the fair value of the asset, the interest revenue, plus or minus foreign exchange gains or losses arising from revaluation of the financial assets, and minus any impairment recognised in the net result.

Note 7.1: Financial Instruments (continued)

Categories of financial instruments

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

Inglewood & Districts Health Service's principal financial instruments comprise of:

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

Available-for-sale financial instrument assets are those designated as available-for-sale or not classified in any other category of financial instrument asset. Such assets are initially recognised at fair value. Subsequent to initial recognition, they are measured at fair value with gains and losses arising from changes in fair value, recognised in 'Other economic flows – other comprehensive income' until the investment is disposed. Movements resulting from impairment and foreign currency changes are recognised in the net result as other economic flows. On disposal, the cumulative gain or loss previously recognised in 'Other economic flows – other comprehensive income' is transferred to other economic flows in the net result.

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

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

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 Inglewood & Districts Health Service retains the right to receive cash flows from the asset, but has assumed an obligation
- the Inglewood & Districts Health Service has transferred its rights to receive cash flows from the asset and either:
  - has transferred substantially all the risks and rewards of the asset; or
  - has neither transferred nor retained substantially all the risks and rewards of the asset, but has transferred control of the asset.

Where the Inglewood & Districts 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 Inglewood & Districts Health Service's continuing involvement in the asset.

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

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

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

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

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

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

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

Note 7.2: Contingent Assets & Contingent Liabilities

Inglewood & Districts Health Service is not aware of any contingent assets and liabilities at 30 June 2018 (2017: Nil)

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

Note 8: Other disclosures

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

Structure

8.1 Equity
8.2 Reconciliation of net result for the year to net cash inflow/(outflow) from operating activities
8.3 Responsible persons
8.4 Remuneration of Executives
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8.8 Events occurring after the balance sheet date
8.9 Jointly Controlled Operations

Note 8.1: Equity

	2018 $	2017 $
(a) Surpluses		
Property, Plant and Equipment Revaluation Surplus (i)		
Balance at the beginning of the reporting period	8,201,358	8,201,358
Revaluation Increment		
- Buildings (refer to Note 4.2)	895,065	-
Balance at the end of the reporting period	9,096,423	8,201,358
Balance at the end of the reporting period*		
* Represented by:		
- Land	3,676,886	3,676,886
- Buildings	5,419,537	4,524,472
	9,096,423	8,201,358
Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	650,349	650,349
Balance at the end of the reporting period	650,349	650,349
Financial Asset Available for Sale Revaluation Surplus		
Balance at the beginning of the reporting period	6,494	16
Valuation gain/(loss) recognised	-	6,478
Balance at the end of the reporting period	6,494	6,494
TOTAL SURPLUSES	9,753,266	8,858,201
(b) Contributed Capital		
Balance at the beginning of the reporting period	5,284,700	5,284,700
Balance at the end of the reporting period	5,284,700	5,284,700
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	(5,071,811)	(4,425,691)
Net Result for the year	(60,885)	(639,626)
Transfer from Property, Plant and Equipment Revaluation Surplus	-	(6,494)
Balance at the end of the reporting period	(5,132,695)	(5,071,811)
TOTAL EQUITY AT END OF FINANCIAL YEAR	9,905,271	9,071,090

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

	2018 $	2017 $
Net result for the period	(60,885)	(646,119)
Non-cash movements:		
Depreciation	757,856	766,415
Share of Net Result from Joint Venture	58,491	(13,128)
Movements included in investing and financing activites:		
Net (Gain)/Loss from Sale of Motor Vehicles	(14,500)	-
Net (Gain)/Loss from Sale of Plant & Equipment	(255)	114
Movements in assets and liabilities:		
Change in operating assets and liabilities		
(Increase)/Decrease in Receivables	(44,365)	(73,496)
(Increase)/Decrease in Prepayments	(7,389)	(3,668)
Change in Inventories	(30,847)	-
Increase/(Decrease) in Payables	(204,292)	162,231
Increase/(Decrease) in Provisions	(363,011)	33,221
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	90,803	225,570

Note 8.3: Responsible Persons Disclosures

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

Responsible Ministers:	Period
The Honourable Jill Hennessy, Minster for Health and Minister for Ambulance Services	01/07/2016-30/06/2017
The Honourable Martin Foley, Minister for Housing, Disability and Ageing and Minister for Mental Health	01/07/2016-30/06/2017
Governing Boards	
Mr Peter Moore - Chair (01/07/2017-31/12/2017)	01/07/2017- 30/06/2018
Mrs Vanessa Hicks - Chair (01/01/2018-30/06/2018)	01/07/2017- 30/06/2018
Mr Michael Oerlemans	01/07/2017- 30/06/2018
Mr Ian Marshall	01/07/2017- 30/06/2018
Mrs Robyn Vella	01/07/2017- 30/06/2018
Mrs Jillian Hobbs	01/07/2017- 30/06/2018
Mrs Carol Gibbins	01/07/2017- 30/06/2018
Mr David Peterson	01/07/2017- 30/06/2018
Mrs Catherine Norman	01/07/2017- 30/06/2018

No remumeration was paid to any Governing Board Members for the Financial Year ended 30 June 2018 ($nil 2017).

Accountable Officers	
Mrs Kathy Huett	01/07/2017-01/08/2017
Mrs Tracey Wilson	01/08/2017-30/06/2018

Remuneration of Responsible Persons

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

Income Band	2018 No.	2017 No.
$120,000 - $129,999	2	1
$390,000 - $399,999	0	1
Total Number	2	2

Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	$ 164,812	$ 396,371

Amounts relating to Responsible Ministers are reported within the Department of Parliamentary Service's financial report as disclosed in Note 8.5 Related Parties.

Note 8.4: Remuneration of Executives

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

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

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

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

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

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

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

	Total Remuneration	
Compensation	2018 $	2017 $
Short term employee benefits	122,629	139,359
Post-employment benefits	17,834	11,445
Other long-term benefits	-	-
Termination benefits	14,800	-
Share based payments	-	-
Total	155,263	150,804
Total number of executives (i)	2	1
Total annualised employee equivalent (AEE) (ii)	2	1

Notes:
(i) 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 partieis note disclosure (Note 8.5).

(ii) 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 8.5: 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
- Jointly Controlled Operation - A member of the Loddon Mallee Rural Health Alliance
- all hospitals and public sector entities that are controlled and consolidated into the whole of state consolidated financial statements.

Key management personnel (KMP) are those people with the authority and responsibility for planning, directing and controlling the activities of Inglewood & Districts Health Service, directly or indirectly.

The Board of Directors and the Executive Directors of Inglewood & Districts Health Service are deemed to be KMP's.

Entity	KMPs	Position Title
Inglewood & Districts Health Service	Mr Peter Moore	Chair of the Board
Inglewood & Districts Health Service	Mrs Vanessa Hicks	Chair of the Board
Inglewood & Districts Health Service	Mrs Jillian Hobbs	Chair of Audit & Risk
Inglewood & Districts Health Service	Mr David Peterson	Audit & Risk Comittee Member
Inglewood & Districts Health Service	Mr Michael Oerlemans	Board Member
Inglewood & Districts Health Service	Mr Ian Marshall	Board Member
Inglewood & Districts Health Service	Mrs Carol Gibbins	Board Member
Inglewood & Districts Health Service	Mrs Catherine Norman	Board Member
Inglewood & Districts Health Service	Mrs Robyn Vella	Board Member
Inglewood & Districts Health Service	Mrs Kathy Huett	Chief Executive Officer
Inglewood & Districts Health Service	Mrs Tracey Wilson	Chief Executive Officer

The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The ministers remuneration and allowances is set by the Parliamentary Salaries and Superannuation Act 1998, and is reported within the Department of Parlimentary Services' Financial Report.

Compensation	2018 $	2017 $
Short term employee benefits (i)	274,237	412,893
Post-employment benefits	31,038	43,299
Termination benefits	14,800	90,983
Total (ii)	320,075	547,175

(i) Total remuneration paid to KMPs employed as a contractor during the reporting period through accounts payqable has been reported under short-term employee benefits.

(ii) KMPs are also reported in Note 8. Responsible Persons or Note 8.5 Remuneration of Executives

Significant transactions with government related entities

The Inglewood & Districts Health Service received funding from the Department of Health and Human Services of $3.68 million ($3.03 million in 2016-17)

Expenses incurred by Inglewood & Districts Health Service in delivering services and outputs are in accordance with Health Purchasing Victoria requirements. Goods and services including procurement, diagnostics, patient meals and multi-site operational support are provided by other Victorian Health Service Providers on commercial terms.

Professional medical indemnity insurance and other insurance products are obtained from a Victorian Public Financial Corporation.

Treasury Risk Management Directions require the Inglewood & Districts Health Service to hold cash (in excess of working capital) and investments, and source all borrowings from Victorian Public Financial Corporations.

Transactions with KMPs 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 of Health and Human Services, all other related party transactions that involved KMPs and their close family members have been entered into on an arm's length basis. Transactions are disclosed when they are considered material to the users of the financial report in making and evaluation decisions about the allocation of scare resources.

There were no related party transactions with Cabinet Ministers required to be disclosed in 2018.

	2018 $	2017 $
Mr P. Moore is the proprietor of Inglewood IGA Supermarket and Hardware and Inglewood which provides goods to the Health Service on normal terms and conditions.	25,129	21,894

Note 8.6: Remuneration of auditors

Victorian Auditor-General's Office	2018 $	2017 $
Audit or review of financial statements	16,500	16,500
TOTAL	16,500	16,500

Note 8.7: AASBs issued that are not yet effective

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

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

Standard/ Interpretation[1]	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 hedge accounting model and a revised impairment loss model to recognise expected impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1-Jan-18	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. The initial application of AASB 9 is not expected to significantly impact the financial positon however there will be a change to the way financial instruments are classified and new disclosure requirements.
AASB 2014-1 *Amendments to Australian Accounting Standards [Part E Financial Instruments]*	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018, and to amend reduced disclosure requirements.	1-Jan-18	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2014-7 *Amendments to Australian Accounting Standards arising from AASB 9*	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1-Jan-18	The assessment has indicated that there will be no significant impact for the public sector.
AASB 15 *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. Note that amending standard AASB 2015-8 *Amendments to Australian Accounting Standards – Effective Date of AASB 15* has deferred the effective date of AASB 15 to annual reporting periods beginning on or after 1 January 2018, instead of 1 January 2017.	1-Jan-18	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications.
AASB 2014-5 *Amendments to Australian Accounting Standards arising from AASB 15*	Amends the measurement of trade receivables and the recognition of dividends as follows: • Trade receivables that do not have a significant financing component, are to be measured at their transaction price, at initial recognition. • Dividends are recognised in the profit and loss only when: – the entity's right to receive payment of the dividend is established; – it is probable that the economic benefits associated with the dividend will flow to the entity; and	1 Jan 2018, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.

	– the amount can be measured reliably.		
AASB 2015-8 *Amendments to Australian Accounting Standards – Effective Date of AASB 15*	This Standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1-Jan-18	This amending standard will defer the application period of AASB 15 for for-profit entities to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2016-3 *Amendments to Australian Accounting Standards – Clarifications to AASB 15*	This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: • a promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation; • for items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer; and • for licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access).	1-Jan-18	The assessment has indicated that there will be no significant impact for the public sector, other than the impact identified for AASB 15 above.
AASB 2016-7 *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*	AASB 2016-8 inserts Australian requirements and authoritative implementation guidance for not-for-profit-entities into AASB 9 and AASB 15. This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events.	1-Jan-19	This standard clarifies the application of AASB 15 and AASB 9 in a not-for-profit context. The areas within these standards that are amended for not-for-profit application include: AASB 9 • Statutory receivables are recognised and measured similarly to financial assets AASB 15 • The 'customer' does not need to be the recipient of goods and/or services; • The 'contract' could include an arrangement entered into under the direction of another party; • Contracts are enforceable if they are enforceable by legal or 'equivalent means'; • Contracts do not have to have commercial substance, only economic substance; and • Performance obligations need to be 'sufficiently specific' to be able to apply AASB 15 to these transactions.
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of operating leases (which are currently not recognised) on balance sheet.	1-Jan-19	The assessment has indicated that most operating leases, with the exception of short term and low value leases will come on to the balance sheet and will be recognised as right of use assets with a corresponding lease liability. In the operating statement, the operating lease expense will be replaced by depreciation expense of the asset and an interest charge. There will be no change for lessors as the classification of operating and finance leases remains unchanged.
	AASB 1058 standard will replace the majority of income recognition in relation to government grants and other types of contributions requirements relating to public sector not-for-profit entities, previously in AASB 1004 *Contributions* .		The current revenue recognition for grants is to recognise revenue up front upon receipt of the funds.

AASB 1058 *Income of Not-for-Profit Entities*	The restructure of administrative arrangement will remain under AASB 1004 and will be restricted to government entities and contributions by owners in a public sector context, AASB 1058 establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objective.	1-Jan-19	This may change under AASB 1058, as capital grants for the construction of assets will need to be deferred. Income will be recognised over time, upon completion and satisfaction of performance obligations for assets being constructed, or income will be recognised at a point in time for acquisition of assets. The revenue recognition for operating grants will need to be analysed to establish whether the requirements under other applicable standards need to be considered for recognition of liabilities (which will have the effect of deferring the income associated with these grants). Only after that analysis would it be possible to conclude whether there are any changes to operating grants. The impact on current revenue recognition of the changes is the phasing and timing of revenue recorded in the profit and loss statement.

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

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

Note:

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

Note 8.8: Events occuring after the Balance Sheet Date.

No events occured after Balance Date.

Note 8.9: Jointly controlled operations and assets

Name of entity	Principal Activity	Ownership Interest 2018 %	Ownership Interest 2017 %
Loddon Mallee Rural Health Alliance	Information Technology	2.38	2.25

Inglewood & Districts 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:

	2018 $	2017 $
CURRENT ASSETS		
Cash and Cash Equivalents	23,313	40,014
Other Financial Assets	96,357	91,500
Receivables	16,315	8,021
Prepayments	12,862	14,539
TOTAL CURRENT ASSETS	148,847	154,074
NON-CURRENT ASSETS		
Property, Plant and Equipment	13,402	3,404
TOTAL NON-CURRENT ASSETS	13,402	3,404
TOTAL ASSETS	162,249	157,478
CURRENT LIABILITIES		
Payables	31,501	24,964
Accrued Expenses	5,056	3,303
TOTAL CURRENT LIABILITIES	36,557	28,267
NET ASSETS	125,692	129,211

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

	2018 $	2017 $
Revenue from Continuing Operations	177,023	171,896
Capital Purpose Income	(5,654)	(3,839)
Total Revenue	171,369	168,057
Other Expenses from Continuing Operations	181,980	157,788
Total Expenses	181,980	157,788
Net Result	(10,611)	10,269

Contingent Assets and Liabilities

The joint venture does not have any known contingent assets or contingent liabilities as at 30 June 2018.

Investments in jointly controlled assets and operations

In respect of any interest in joint operations, Inglewood and 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 pf the output from the joint operation;
- its share of the revenue from the sale of the output by the operation; and
- its expenses, including its share of any expenses incurred jointly.

Note 8.10: Economic Dependency

Inglewood & District Health Service is dependent on the Department of Health and Human Services for the majority of its revenue used to operate the entity. At the date of this report, the Board of Directors has no Reason to believe the Department will not continue to support Inglewood & Districts Health Service.

Note 8.11: Alternative Presentation of Comprehensive Operating Statement

	2018 $	2017 $
Interest	62,293	106,215
Sales of Goods and Services	929,244	802,188
Grants	5,740,059	5,218,126
Other Current Revenue	992,930	876,421
Total Revenue	7,724,526	7,002,950
Employee Expenses	(5,416,653)	(5,217,731)
Depreciation	(757,856)	(766,415)
Other Operating Expenses	(1,633,084)	(1,658,531)
Total Expenses	(7,807,593)	(7,642,677)
Net Result from Transactions - Net Operating Balance	(83,067)	(639,727)
Gain/(Loss) on non-financial assets	14,755	-
Other Gain/(Loss) from other economic flows	7,427	(6,392)
Total Other Economic Flows Included in the Net Result	22,182	(6,392)
Items that Will Not be Reclassified to Net Result		
Changes in Property, Plant and Equipment Revaluation Surplus	895,065	-
Items that May be Reclassified Subsequently to Net Result		
Changes to Financial Assets Available-For-Sale Revaluation Surplus	-	6,478
Net Result	834,180	(639,641)