Inglewood & Districts Health Service

22nd Annual Report 2016-2017

INGLEWOOD & DISTRICTS HEALTH SERVICE

Services offered by IDHS

- **Acute Care**
- **Residential Aged Care**
- **Community Services**
  - **Nursing Services**: Community Health, Community Mental Health and District Nursing, Diabetes Educator.
  - **Social Welfare Services:** Social Worker and Alcohol and Other Drugs Worker.
  - **Social Support Services:** Planned Activity Groups, Volunteer Visiting and Volunteer Transport.
  - **Community Development:** Health Promotion/Education, Capacity Building, Strength Training, Youth Services.
  - **Allied Health Services:** Physiotherapy, and Dietician. Visiting services Podiatry, Dietetics and Occupational Health.

CONTENTS

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; and;
- 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 to achieve life-long health and wellbeing.
- We respect each individual's rights, needs and choices including the right to refuse treatment.
- We provide equality 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 staff and others.
- We encourage the personal and professional development of 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

INCORPORATION

The Inglewood & Districts Health Service is a public hospital incorporated under Section 65 of the Health Services Act 1988 and listed in Schedule 1 of the Health Services Act 1988. The health service was formed on the 1st January 1996, by the amalgamation of The Inglewood Hospital (1863) and the Inglewood and Districts Community Health Centre Inc (1977).

The responsible Minister is as follows:-

The Honourable Jill Hennessy MLA
Minister for Health

The Honourable Martin Foley MLA
Minister for Mental Health

The Honourable Martin Foley, MLA
Minister for Housing, Disability and Ageing

HISTORICAL BACKGROUND

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

The Health Service is located in Inglewood. The town was established around 1860 and is part of the Golden Triangle tourist region. Agriculture is the main economic activity in the area. We also provide community services from a second site in Wedderburn. Towns in our catchment include Bridgewater, Serpentine, Tarnagulla and Korong Vale.

The Health Service has seen many changes. 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. In 1978 the hospital was partly remodeled to accommodate Nursing Home Residents. The kitchen was rebuilt in 1982 and a new Hostel added in 1994.

Following amalgamation in 1996 the Community Health Services were relocated to the hospital site. In 1998 a new administration area and front entrance were built. A new Nursing Home, and refurbished Acute Wards and Accident and Emergency department were completed in 2001. The vacated nursing home was refurbished as office space for community health staff. As well, in 2001 a new building for the Inglewood Medical Practice was completed.

In 2005 the Wedderburn service moved to the Wedderburn Community Centre, a refurbished multipurpose site at the old Primary School. A wide range of services is provided from this site in conjunction with other co-located services.

More than 15 years since amalgamation, the health service continues to grow and change to meet community needs. In 2006 the previous Inglewood doctor's surgery was remodeled for use as a Community Health and Wellbeing Centre. It is here the strength training exercise program is located. 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.

Building upgrades provide modern functional facilities to accommodate this dynamic and progressive health service. This small rural health service offers a diverse range of services including acute and urgent care, residential aged care, district and community health nursing, welfare and social work services, youth support, mental health, alcohol & other drugs and community development workers, planned activity groups and social support.

SERVICES PROVIDED

The Inglewood & Districts Health Service provides a diverse and comprehensive range of services including acute inpatient and urgent care services, residential services for the frail aged and disabled and community based services.

RESIDENTIAL SERVICES

Acute Hospital

Eight (8) beds are available for acute inpatient medical services as well as Transition Care Program which is provided for longer term rehabilitation and transition to home. Urgent Care medical services are provided by two private Medical Practitioners who charge a fee for service.

Residential Aged Care

Accommodation is provided for frail aged and disabled persons unable to be cared for in their own homes. Fifteen Nursing Home beds are provided for residents with high care needs requiring nursing care. Twenty Hostel beds are available for low care residents who require some assistance with activities of daily living.

COMMUNITY SERVICES

District Nurses

The District Nursing Service aims to maintain their clients' independence and assisting them to remain in the community. Services include: post hospital care, clinical treatments (e.g. wound management and dressings), diabetes monitoring & education, palliative care, counseling, individual and family support.

Community Health Nursing

The Community Health Nurses are concerned with the promotion of health and prevention of injury, illness and disability. They adhere to the principles of the Social Model of health acknowledging that health is affected by the total environment. Services include health promotion and education to individuals and groups on issues such as: injury/falls prevention, nutrition, cancer prevention, communicable diseases and chronic conditions e.g. asthma, diabetes and heart disease. They also provide cardiac rehabilitation programs, school health programs, men's and women's health programs, and health screening clinics including pap tests, and support groups. Well received Rural Health Days have been held following the cessation the Sustainable Farming Families programs. The LIFE (education) program continues to enhance the Diabetes program.

Physical Activity

One health promotion priority is promoting physical activity; this includes providing Strength Training, Tai Chi and other programs. A Physical Activity Coordinator offers a Strength Training exercise program twice per week in Inglewood, Wedderburn, Korong Vale (weekly) and Tarnagulla where Tai Chi is also offered. Everyone (young or old) is welcome to attend, age is no barrier. Additional programs have commenced for Younger Women in Bridgewater and two youth group programs.

Community Development

The Community Development Worker facilitates and leads programs which build individual and community capacity and wellbeing. Physical Activity and Healthy Eating have been a focus over the last year. The CDW complements the Youth Worker from the ENGAGE Program, and activities are provided in collaboration with the Loddon Shire. The focus of these programs is leadership and individual and community capacity building. Personal development programs are also held in schools and the community.

Social Support Program

The Social Support Program provides a Volunteer Visiting Program to elderly or disabled people in their homes. There is also a Volunteer Transport Service to assist with access to specialist medical appointments. Volunteers are encouraged to apply.

Planned Activity Groups (PAG)

The PAGs provides social contact and relief for carers through individual and group therapy in Day Centres to assist aged and/or disabled people to remain in the community. PAGs are conducted at Bridgewater, Korong Vale, Inglewood and Wedderburn. There are some weekend and holiday programs offered as well.

Alcohol & Other Drugs

The Alcohol & Other Drugs worker provides individual and family counseling, as well as support and education to those experiencing problems as a result of the misuse of alcohol and other drugs. Community and school education programs have been provided enhancing the knowledge and understanding for people of all ages about these issues.

Mental Health

The community Mental Health Nurse provides clinical intervention, individual and family counseling and support and education to those with mental health problems. The nurse liaises with the regional community, acute and aged psychiatric services and GPs. Support and advice is also provided to community organisations such as the Healthy Minds Network when requested.

Social Welfare

The Social Welfare team provides comprehensive individual and family counseling services, including income, social security and accommodation inquiries. There is support and counseling for family breakdown, relationship issues, grief and bereavement, depression, anxiety and conflict, as well as referrals, advocacy and liaison with other services.

Physiotherapy

Physiotherapy provides services to help recovery from injury, reduce pain and stiffness, improve mobility and prevent falls. Treatment is available for residents in the nursing home and hostel, hospital patients and community patients in both Inglewood and Wedderburn. The physiotherapist has assistance from an Allied Health Assistant.

Visiting Services

These services include Bendigo Psychiatric Services, Podiatry, Dietetics, Speech Therapy services and the Rural Allied Health and Aged Care Assessment Teams.

PRESIDENT & CHIEF EXECUTIVE OFFICER REPORT

On behalf of the Board of Management, Executive and staff of Inglewood and Districts Health Service IDHS), we are pleased to present the twenty second (22nd) Annual Report for the year ended 30th June 2017.

We would like to commence this report by acknowledging everyone's involvement in IDHS and thanking them for their commitment and dedication. This has resulted in IDHS achieving the positive outcomes contained in this report.

Statement of Priorities and Strategic Plan

Our Statement of Priorities (SoP) provides the formal funding and monitoring agreement between Inglewood and Districts Health Service and the Secretary for Health; in accordance with Section 26 of the Health Services Act 1988.

The agreement, which is produced annually, facilitates delivery of or substantial progress towards the key shared objectives of financial viability, improved access and quality of service provision.

Our Statement of Priorities is consistent with our Strategic Plan and is aligned to government policy directions and priorities. The outcomes of our SoP can be found on pages 12-19 of this report.

We continue to work towards the objectives of our five year (2015-2020) Strategic Plan in addition to the developments in our Statement of Priorities.

As part of our strategic planning process a service deliver plan was undertaken by Biruu Health in July 2016. In addition to this IDHS participated in the development of the Loddon Gannawarra Health Needs Analysis which involved a number of agencies from these regions.

Service Provision

Acute, residential and community services continue to provide excellent services which meet all standards as evidenced by accreditation and support visits.

Our transition care program continues to be highly utilised and provides long term care and support for many people in our community allowing them to return home after a period of care and rehabilitation.

Target Zero avoidable harm program has resulted in a review of our systems and reporting to and by our Director of Medical Services.

In May 2017 the Murray Primary Health Network (PHN) advised that they would in future be focusing on addressing the impact of the tree top chronic diseases identified in the region.

These are; Cardiovascular, Chronic Obstructive Pulmonary Disease (COPD) and Diabetes.

This resulted in the mental health support and social work services provided by IDHS not being funded after 30 June 2017. Following concern from the communities and discussion with Murray PHN the funding was extended until 30 September 2017, during this time members from Murray (PHN) will develop a plan using data and information provided to develop a transition strategy and shape the services for the future.

Finance

IDHS achieved a small surplus result this year. This surplus was possible due to tight fiscal management, improved funding in aged care and constant occupancies of our transitional and aged care beds.

A comprehensive financial report for the 2016/17 year can be found in the financial section at the end of this report.

Continuous Improvement

We continue to strive to improve our services and our commitment to quality is evident in the positive feedback we receive from patients/residents and the community.

During the year a number of quality activities were undertaken and data collected and analysed to provide information to guide improvements.

As part of our improvements to our buildings and infrastructure we finalised the upgrade to our en-suites including the addition of 2 new en-suites in aged care.

In May 2017 a full audit of our District Nursing and Program Activity Group services was undertaken by the Aged Care Standards and Accreditation Agency. This Agency also conducted an unannounced visit of our Nursing Home and Hostel in the same month. Outcomes from both visits were positive with compliance in all areas.

In early August 2018 Inglewood and Districts Health Service will undergo a full audit of our residential aged care services.

A comprehensive report of our Continuous Improvement activities and achievements will be outlined in our 2016/17 Quality Account which will be available at the end of 2017.

Staff

The best asset of an organisation is its staff and at IDHS staff continue to work hard and demonstrate their dedication to the organisation, its consumers and to the community. We would like to extend our thanks to them for their continued enthusiasm and excellent service. The knowledge and skills each staff member bring to their roles assists in the provision of a high level of care and services to all. We congratulate them all on their professionalism and commitment.

To assist in improving their skills and knowledge they actively participated in a number of training programs during the year, including but not limited to, on-line education sessions, webinars, conferences and formal training sessions.

A number of Nursing staff attended an ACFI Master class program while many staff were involved in the "Prevent, Detect, Correct" training program aimed at increasing awareness of differing personality types and providing tools to work together and decreasing bullying and/or inappropriate behaviour.

This year has been particularly difficult with the sudden death of the Nurse Unit Manager, Val Bissett and subsequent difficulties in filling this position.

After 12 years at the helm of IDHS as its CEO, Michael Parker retired in April 2017. Kathy Huett was appointed as interim CEO after Michael's departure while IDHS undertook a recruitment process to appoint a new CEO.

As President and behalf of the Board I would like to thank Michael for his service and dedication to IDHS and thank Kathy for the work she undertook as interim CEO including the recruitment process for our new CEO.

Board

Board members are responsible for the Strategic direction of the organisation and continue to govern IDHS and provide support and guidance to the executive team.

In addition to monthly Board meetings, members regularly participate in Board sub committees and other committees/meetings to monitor the safety and performance of the organisation.

To assist in their development Board members are provided with opportunities to attend education sessions, conferences and forums provided by IDHS, the Department of Health and Human Services and other industry groups.

Board members Ian Penny and Anne Canfield attended their last IDHS Board meeting on Wednesday 28 June 2017. Unfortunately due to changes in her employment Sue McConnachie tendered her resignation in June. The Board was pleased to 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 Board members:

- Ian Marshall
- Michael Oerlemans

Acknowledgements

Our Medical Staff continues to work well with our staff to ensure a high level of care and services to our communities. These partnerships are very much appreciated, highly regarded and vital to the ongoing health of our communities and the development of future directions in health.

We thank Doctor Shakker Issa from the clinic in Wedderburn and Doctors Hadi Rafi, Syed Ansari and Charu Banerji from the Marong Medical Practice who collectively provided services to IDHS throughout the year.

Our Director of Medical Services, Craig Winter continued to visit regularly to provide support and advice in relation to clinical governance and credentialing of Doctors. We acknowledge and thank him for the service he provides.

Thank you to all who have provided donations to IDHS which assist in the provision of extra equipment and furnishings which would be difficult to purchase/replace without this assistance.

Particular thanks go to the Rheola Charity Carnival who regularly provides large donations to IDHS.

As part of a number of partnerships we acknowledge the work undertaken and the participation of the following:

- Loddon Shire
- Murray PHN
- Bendigo Loddon Primary Care Partnership
- Wedderburn Neighbourhood House
- Inglewood Neighbourhood House
- Loddon Mallee Rural Health Alliance
- Loddon Gannawarra Health Service Executive Network
- Loddon Mallee Regional Clinical Governance Council
- Bendigo & District Aboriginal Co-operative
- Bendigo Health

Our thanks are extended to our local media for their support and balanced reporting of news items related to our health service.

We thank the Minister for Health, State and Federal parliament representatives and the Department of Health and Human Services for their support and assistance throughout the year.

Towards our Future

Inglewood and Districts Health Service has an exciting year ahead. In addition to a new Chief Executive Officer we will be appointing a new Director of Clinical and Community Services (formerly Director of Nursing and Community Services) due to the current DNCS, Mary Evans proceeding on leave early in the new year and then retiring.

The changes to the Executive staff along with changes to Board members will assist in providing new ideas as we work towards the achievements of the 2015-2020 Strategic Plan.

We will continue to strive to attract the required funding to fully implement our plans and services required by our communities in line with both Federal and State policies.

Peter Moore
President

Kathy Huett
Acting Chief Executive Officer

CORPORATE GOVERNANCE

BOARD OF MANAGEMENT & PRINCIPAL OFFICERS AS AT 30 JUNE 2017

BOARD OF MANAGEMENT

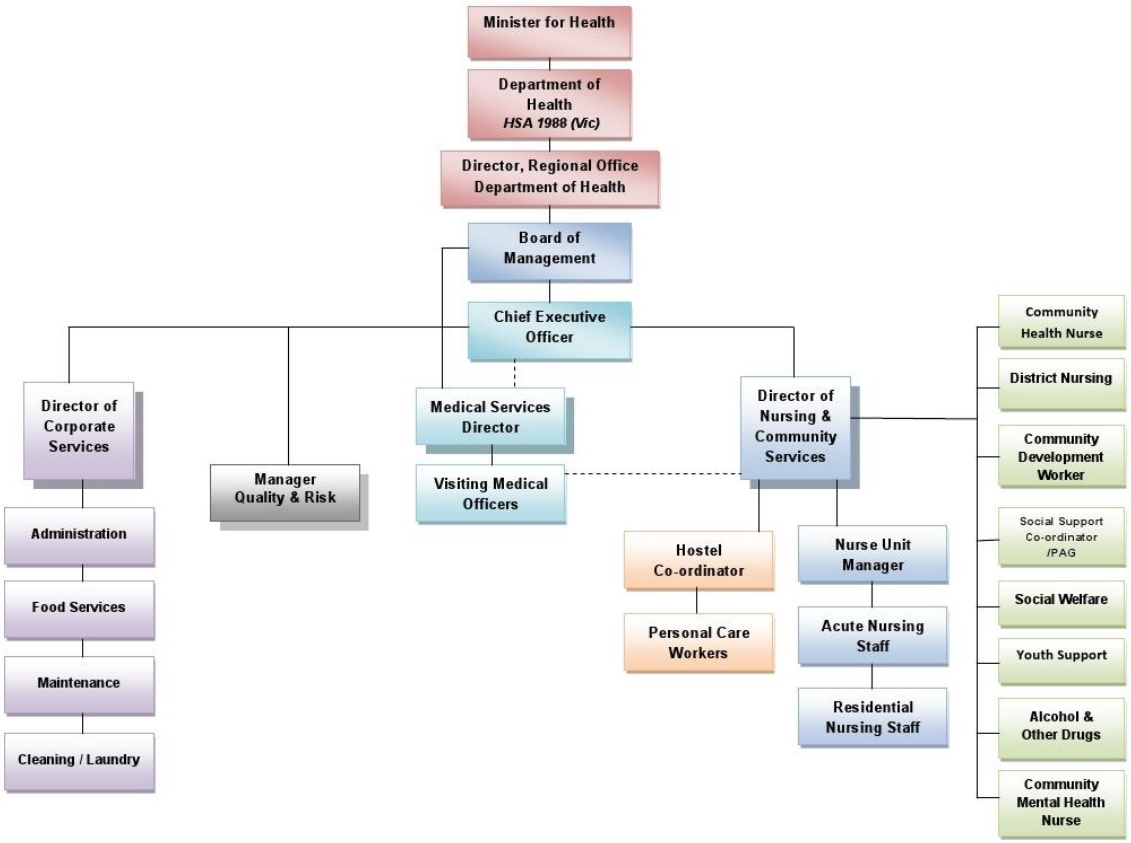
PRESIDENT	Mr P Moore
SENIOR VICE PRESIDENT	Mrs V Hicks
JUNIOR VICE PRESIDENT	Mrs C Norman
BOARD MEMBERS	Mrs A Canfield
	Mrs C Gibbins
	Mr WI Penny
	Mrs S McConnachie
	Mrs R Vella

Independent Community Representatives
Audit & Risk Committee

Mrs J Hobbs
Mr D Peterson

Auditors
External - Victorian Auditor General's Office Agent – RSD Auditors
Internal - Accounting and Audit Solutions Bendigo (AASB)

ORGANISATIONAL CHART



STATEMENT OF PRIORITIES
PART A: STRATEGIC

Quality and Safety

Action	Deliverables	Outcomes
Implement systems and processes to recognise and support person-centred end of life care in all settings, with a focus on providing support for people who choose to die at home.	Respecting Patient Choices system to be adopted by District Nurse service by 31 December 2016.	**Achieved** - *Implemented*
	Ensure staff have access to appropriate education on end of life care by 30 June 2017.	**Achieved** - *Staff have access through the on line learning system Reshen.*
Advance care planning is included as a parameter in an assessment of outcomes including: mortality and morbidity review reports, patient experience and routine data collection.	Include audits of Advance Care Plan documentation in Medical History reviews undertaken by the Director of Medical Services by 30 June 2017.	**In Progress -** DMS is undertaking the reviews. Results recorded in minutes of Clinical Review Committee
Progress implementation of a whole-of- hospital model for responding to family violence.	Family Violence Kit to be utilised in review of policy and procedures and an action plan developed to address deficiencies by 30 June 2017.	**In Progress** - *Action plan being developed by Social Worker*
Develop a regional leadership culture that fosters multidisciplinary and multi-organisational collaboration to promote learning and the provision of safe, quality care across rural and regional Victoria.	Participate in the establishment of Regional Clinical Governance Committee by 31 December 2016.	**Achieved** - *DMS on Council; CEO an active member*
	Establish a Leadership Partnership with other health services in the Gannawarra and Loddon Shires by September 2016 to develop a sub regional plan for collaboration on service delivery.	**Achieved** - *Loddon Gannawarra Health Needs Analysis undertaken CEO group developing a TOR*
Use patient feedback, including the Victorian Healthcare Experience Survey to drive improved health outcomes and experiences through a strong focus on person and family centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first.	Participate in Victorian Health Experience Survey and review annual data 31 March 2017 to identify improved patient centred care strategies.	**Achieved**
Develop a whole of hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint.	Review restraint and policies to ensure the least restrictive practices are in place by June 2017.	**Achieved**

Access and Timelines

Action	Deliverables	Outcomes
Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine).	In partnership with other health services in the Gannawarra and Loddon Shires by 31 December 2016 to establish a sub regional plan for collaboration on service delivery.	**Achieved** - *Loddon Gannawarra Health Needs Analysis undertaken Funding of $20,000 provided to fund actions from needs analysis. MOU in final development.*
	Trial telehealth services with Loddon Murray Rural Health Alliance by June 2017.	**Achieved** - *Tested video conferencing. Signed MOU for telehealth for Diabetes with RFDS. Implemented Geri-connect.*
Develop and implement a strategy to ensure the preparedness of the organisation for the National Disability and Insurance Scheme and Home and Community Care program transition and reform, with particular consideration to service access, service expectations, workforce and financial management.	Develop Strategic Plan for National Disability Insurance Scheme and Home and Community Care transition including training needs for staff, allocation of required resources and a marketing strategy by June 2017.	**Achieved** - *After careful consideration it was agreed by the Board that IDHS not register for NDIS.* *Transition re Commonwealth Home Support Program undertaken.*

Supporting Healthy Populations

Action	Deliverables	Outcomes
Support shared population health and wellbeing planning at a local level - aligning with the Local Government Municipal Public Health and Wellbeing plan and working with other local agencies and Primary Health Networks.	Undertake service planning in partnership with Murray Primary Health Network; Loddon and Gannawarra Shires; Primary Care Partnerships and other service providers by December 2016	**Achieved**
Focus on primary prevention, including suicide prevention activities, and aim to impact on large numbers of people in the places where they spend their time adopting a place based, whole of population approach to tackle the multiple risk factors of poor health.	Implement the identified Mental Health strategies in the Integrated Health and Health Promotion strategies by 30 June 2017.	**Achieved** - *WOW for Women's Day and Men Matter workshops held to promote mental health.*
Develop and implement strategies that encourage cultural diversity such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.	Review Inglewood and Districts Health Service Cultural Responsiveness Plan to include a staff education plan by 30 June 2017.	**Achieved** - *Staff access via e-learning package.*
Improve the health outcomes of Aboriginal and Torres Strait Islander people by establishing culturally safe practices which recognise and respect their cultural identities and safely meets their needs, expectations and rights.	Enhance engagement with the Aboriginal community by supporting Bendigo District Aboriginal Cooperative Sports Day in June 2017.	**Achieved** - *Plan has been reviewed and support for the BOAC sports day is in place.* *Vicky Walker has been contacted to explore opportunities to educate the Board and staff on culturally responsive services.* *Active member of Koolin Balit Steering Committee.*
	Develop a Memorandum of Understanding with Bendigo District Aboriginal Cooperative by 30 June 2017.	**In Progress -** *Numerous attempts made by IDHS however not followed up by cooperative.*
Drive improvements to Victoria's mental health system through focus and engagement in activity delivering on the 10 Year Plan for Mental Health and active input into consultations on the Design, Service and infrastructure Plan for Victoria's Clinical mental health system.	Participate in the planning and execution of a community based Mental Health project identified through the local Healthy Minds Network by 30 June 2017.	**Achieved** - *Active participant in Healthy Minds Network.*

Supporting Healthy Populations *cont..*

Action	Deliverables	Outcomes
Using the Government's Rainbow eQuality Guide, identify and adopt 'actions for inclusive practices' and be more responsive to the health and wellbeing of lesbian, gay, bisexual, transgender and intersex individuals and communities.	Complete an audit utilising the Rainbow Tick Program and develop an action plan by 31 March 2017.	**Achieved** - *Staff education undertaken. Due to Executive staff changes this will not be completed until October 2017.*

Governance and Leadership

Action	Deliverables	Outcomes
Demonstrate implementation of the Victorian Clinical Governance Policy Framework: Governance for the provision of safe, quality healthcare at each level of the organisation, with clearly documented and understood roles and responsibilities. Ensure effective integrated systems, processes and leadership are in place to support the provision of safe, quality, accountable and person centred healthcare. It is an expectation that health services implement to best meet their employees' and community's needs, and that clinical governance arrangements undergo frequent and formal review, evaluation and amendment to drive continuous improvement.	Review Clinical Governance Policy and Procedures to ensure alignment with the Regional Clinical Governance Model by January 2017.	**In Progress** - *Policies will be reviewed as more clearer roles of the Clinical Governance Committee's TOR is finalised.*
	Participate in the Loddon Mallee Regional Clinical Governance Committee and collaborate with other health services to strengthen Clinical Governance by June 2017.	**Achieved** - *Membership within the Governance Framework is as an active participant.* *DMS is a member of the Regional Clinical Governance Committee and is currently reviewing the Clinical Governance Organisational Framework.*
Contribute to the development and implementation of Local Region Action Plans under the series of statewide design, service and infrastructure plans being progressively released from 2016 Development of Local Region Action Plans will require partnerships and active collaboration across regions to ensure plans meet both regional and local service needs, as articulated in the statewide design, service and infrastructure plans.	Complete local catchment service plan by December 2016.	**Achieved** - *Service plan completed*
	Participate and lead partnerships and collaborations for local service delivery such as Memorandum of Understanding with Dingee Bush Nursing Centre by 30 June 2017.	**In Progress** - *A Memorandum Of Understanding with Dingee was completed, however operationally this continues to be a work in progress. Support and involvement in the Loddon Shire Municipal Public Health & Wellbeing Plan and the Loddon Gannawarra Health Services Executive Network Health Needs Analysis continues.*
	Support and participate in the development of the Local Government Municipal Public Health Plan by 30 June 2017.	**Achieved** - *Priority setting meetings undertaken.*

Governance and Leadership *cont..*

Action	Deliverables	Outcomes
Ensure that an anti-bullying and harassment policy exists and includes the identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal and the policy specifies a regular review schedule.	Current Anti-Bullying and Harassment policy and procedure will be reviewed and aligned with current legislation, and identified education gaps will be addressed by 30 June 2017.	**Achieved** - *Training undertaken via e-learning.* *Policies and procedures reviewed.* *Zero tolerance for bullying enforced at staff meetings.* *Maureen Kyne & Associates conducted workshops for Managers.*
Board and senior management ensure that an organisational wide occupational health and safety risk management approach is in place which includes: (1) A focus on prevention and the strategies used to manage risks, including the regular review of these controls; (2) Strategies to improve reporting of occupational health and safety incidents, risks and controls, with a particular focus on prevention of occupational violence and bullying and harassment, throughout all levels of the organisation, including to the board; and (3) Mechanisms for consulting with, debriefing and communicating with all staff regarding outcomes of investigations and controls following occupational violence and bullying and harassment incidents.	Develop a plan to manage and reduce the likelihood of adverse outcomes resulting from occupational violence by December 2016.	**Achieved** - *Completion of 10 point action plan.* *Action plan provided to ANMF at their request*
Implement and monitor workforce plans that: improve industrial relations; promote a learning culture; align with the Best Practice Clinical Learning Environment Framework; promote effective succession planning; increase employment opportunities for Aboriginal and Torres Strait Islander people; ensure the workforce is appropriately qualified and skilled; and support the delivery of high-quality and safe person centred care.	Redesign the role of the Director Corporate Services in conjunction with review of Human Resources Plan by 30 June 2017.	**In Progress** - *Given changes to CEO this will be reviewed by the new CEO.*

Governance and Leadership *cont..*

Action	Deliverables	Outcomes
Create a workforce culture that: (1) includes staff in decision making; (2) promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and (3) includes consumers and the community.	Implement the next phase of the Working Hard With You staff engagement project by 31 March 2017.	**In Progress** - *PDC used to look at/imbed culture and to support staff reform, however due to executive changes the 2nd phase will commence in late 2017.*
Ensure that the Victorian Child Safe Standards are embedded in everyday thinking and practice to better protect children from abuse, which includes the implementation of: strategies to embed an organisational culture of child safety; a child safe policy or statement of commitment to child safety; a code of conduct that establishes clear expectations for appropriate behaviour with children; screening, supervision, training and other human resources practices that reduce the risk of child abuse; processes for responding to and reporting suspected abuse of children; strategies to identify and reduce or remove the risk of abuse and strategies to promote the participation and empowerment of children.	Review current policies and procedures to ensure compliance with Victorian Child Safe Standards by 31 January 2017.	**Achieved** - Policies and procedures reviewed and in place. Child safe code of conduct agreement signed by relevant staff.
Implement policies and procedures to ensure patient facing staff have access to vaccination programs and are appropriately vaccinated and/or immunised to protect staff and prevent the transmission of infection to susceptible patients or people in their care.	Provide access to vaccination clinics at "shift friendly" times. Completion by 30 June 2017.	**Achieved**
	Dialogue with each staff member who works across multiple agencies to appropriately record those who have been vaccinated elsewhere. Completion by 31 May 2017.	**Achieved**

Financial Sustainability

Action	Deliverables	Outcomes
Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	Review Debt Recovery Policies by 30 June 2016.	**Achieved**
	Implement rigorous adherence to the Debt Recovery Policies, including negotiated repayment strategies with individual debtors where appropriate by 30 June 2016.	**Achieved** – *continuing to review processes.*
Actively contribute to the implementation of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measureable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling.	Develop a Solar Power implementation plan by 30 June 2017.	**In Progress**

STATEMENT OF PRIORITIES
PART B: PERFORMANCE

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%	84%
Percentage of healthcare workers immunised for influenza	75%	76%
Submission of infection surveillance data to VICNISS[1]	Full compliance	Compliant

1 VICNISS is the Victorian Hospital Acquired Infection Surveillance System

PATIENT EXPERIENCE AND OUTCOMES

Key performance indicator	Target	2016-17 Results
Victorian Healthcare Experience Survey - data submission	Full compliance	Achieved
Victorian Healthcare Experience Survey – patient experience Quarter 1	95% positive experience	Full compliance
Victorian Healthcare Experience Survey – patient experience Quarter 2	95% positive experience	Full compliance
Victorian Healthcare Experience Survey – patient experience Quarter 3	95% positive experience	Full compliance
Victorian Healthcare Experience Survey – discharge care Quarter 1	75% positive experience	Full compliance
Victorian Healthcare Experience Survey – discharge care Quarter 2	75% positive experience	Full compliance
Victorian Healthcare Experience Survey – discharge care Quarter 3	75% positive experience	Full compliance

*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 Survey - percentage of staff with a positive response to safety culture questions	80%	89%

FINANCIAL SUSTAINABILITY

Key performance indicator	Target	Actual
Finance		
Operating result ($m)	$0.00m	$0.101m
Trade creditors	< 60 days	52
Patient fee debtors	< 60 days	78
Adjusted current asset ratio	0.7	0.96
Number of days with available cash	14 days	40 days
Asset management		
Basic asset management plan	Full compliance	Compliant

CORPORATE SERVICES

Social Club

Our very active staff social club continues to provide wonderful opportunities for social interaction, promoting good will and morale among staff and engagement with the residents. Noel Pianto, Michael Pascoe and many others must be thanked for their extensive contributions to this committee which results in a wonderful Christmas Party for staff, cooked breakfasts and Christmas in July and BBQ;'s with Residents. Not to mention Cards and Gifts to staff if ill, or when celebrating births or leaving IDHS.

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.

Education and training ranges from Advanced Life Support to the Deteriorating Patient; the Diabetes Symposium to updated Asthma education; or Family Violence to Defusing Aggressive behaviour, through to documentation for ACFI claims.

Our learning environment is enhanced by the presence of trainees, and Nursing or PCW 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 on our casual bank following completion of the year.

WORK FORCE DATA

	Ongoing		Fixed Term		Casual		Total	
	Head count	*FTE*	*Head count*	*FTE*	*Head count*	*FTE*	*Head count*	*FTE*
June 2016	57	35.20	20	11.70	18	5.60	95	52.50
June 2017	57	35.80	15	9.72	19	6.49	91	52.01

	Ongoing		Fixed Term & Casual		Total	
	Head count	*FTE*	*Head count*	*FTE*	*Head count*	*FTE*
Male	7	6.31	5	1.33	12	7.64
Female	50	29.49	29	14.88	79	44.37

Staff by Age	Ongoing		Fixed Term & Casual		Total	
	Head count	*FTE*	*Head count*	*FTE*	*Head count*	*FTE*
Under 25	1	0.21	5	3.64	6	3.85
25 - 34	6	2.78	6	2.98	12	5.76
35 - 44	8	5.13	9	3.12	17	8.25
45 -54	22	14.83	4	1.66	26	16.49
55 - 64	14	9.15	9	4.39	23	13.54
65 +	6	3.70	1	0.42	7	4.12

Labour Category	June – Current Month FTE		June – YTD FTE	
	2016	2017	2016	2017
Nursing	27.42	23.18	26.65	25.12
Administration and Clerical	6.68	5.36	5.98	6.84
Medical Support	7.71	12.70	8.46	11.47
Hotel and Allied Services	10.48	13.38	11.96	13.39
Medical Officers	0.06	0.05	0.05	0.05
Ancillary Staff (Allied Health)	0.00	0.00	0.00	0.00
Personal Care Workers	1.91	1.87	1.89	1.03
Total	**58.03**	**56.53**	**58.42**	**57.89**

OCCUPATIONAL VIOLENCE STATISTICS 2016-2017

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

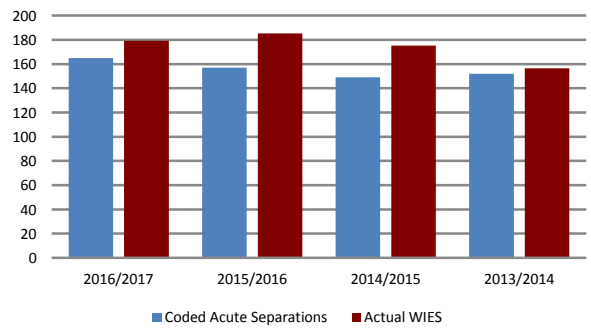
EFFICIENCY - COST PER INPATIENT DAY

	2016/2017	2015/2016	2014/2015	2013/2014	2012/2013
Acute (including TCP)	$ 982	$ 1,159	$ 1,259	$ 1,192	$ 2,462
Nursing Home	$ 285	$ 305	$ 276	$ 262	$ 234
Hostel	$ 178	$ 170	$ 163	$ 140	$ 146
Cost per Outpatient Attendance:	$ 216	$ 207	$ 163	$ 188	$ 226
Cost per Community Health Contact	$ 82	$ 65	$ 63	$ 61	$ 69

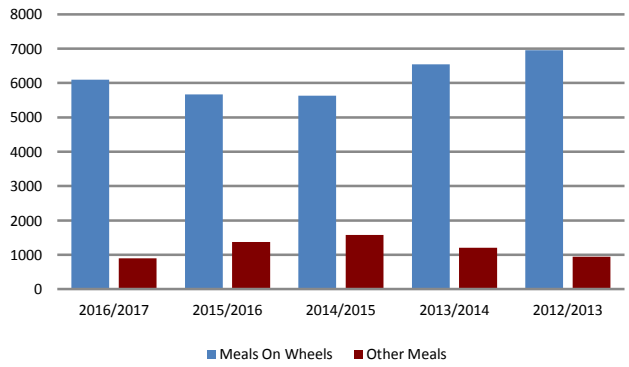
PART C – ACTIVITY AND FUNDING

	ACTIVITY
Small Rural HACC	2,830
Small Rural Residential Care	12,447
Small Rural Primary Health	1,232
Health Workforce	2
Other specified funding	1,268

Casemix Throughput Data

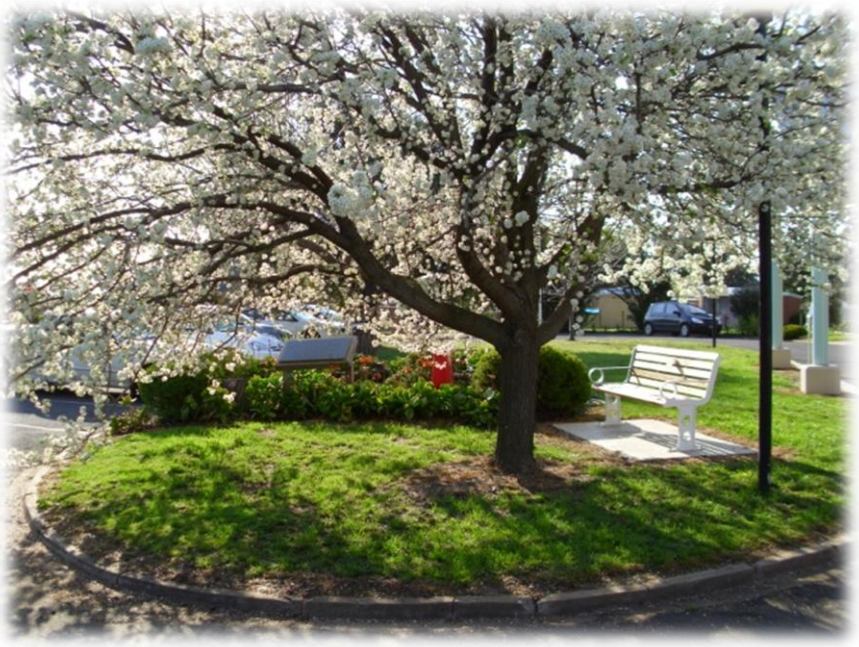


Meals Provided



LIFE GOVERNORS AS AT 30th JUNE 2017

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. Souslby
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



** Denotes appointed as Life Governor of both previous organisations*

NURSING & COMMUNITY SERVICES

As Director of Nursing & Community Services (DON&CS) for Inglewood & Districts Health Service (IDHS) It is my pleasure and privilege to present this report on behalf of the clinical services staff. It has been my privilege to provide leadership and management for clinical care across the organization, over the last 15 years. As this is to be my final report I would like to acknowledge and thank all the staff and management team who have supported and assisted me over the years. Together we have ensured the patients, clients and residents have received the highest quality of care as evidenced by our ongoing and unbroken accreditation record.

Together we strive to create a happy, harmonious workplace, where people chose to work and turnover is minimal. I with other managers have provided mentoring and support for the residential care and community health teams, and I am very proud to have provided many staff with opportunities to expand their roles and grow their careers.

This last year has been particularly challenging and very sad but with the support of the staff we have maintained our high quality care and services.

Our ward staff and others were shocked and very saddened at the sudden death of our long standing and very highly regarded, Unit Manager, Val Bissett. Val advised and supported so many of the staff both professionally and personally. She epitomised the professional, caring and competent nurse. Val was a credit to the profession.

Clinical Care Team

We provide a diverse and comprehensive range of services at Inglewood & Districts Health Service designed to meet the needs of our community. Services range from hospital and residential aged care,
urgent care, transition care, to the many community services.

Paula Richards along with Di Andrews job shared the Unit Manager role for some time, while still retaining their quality roles. This leadership was much appreciated by staff and management. Rosalie Ball the Hostel Supervisor also provides leadership to a very cohesive and happy team

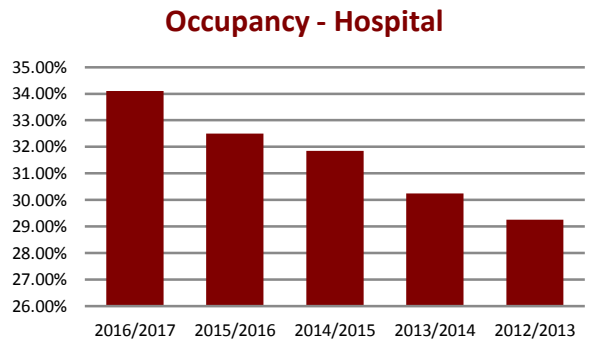
Many staff took on additional responsibility during what has been a trying year and we are all very grateful.
I would also like to acknowledge and thank all our staff for their efforts and contributions.

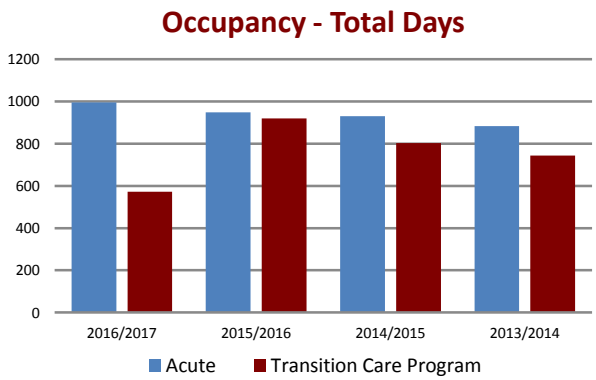
Acute Hospital and Urgent Care

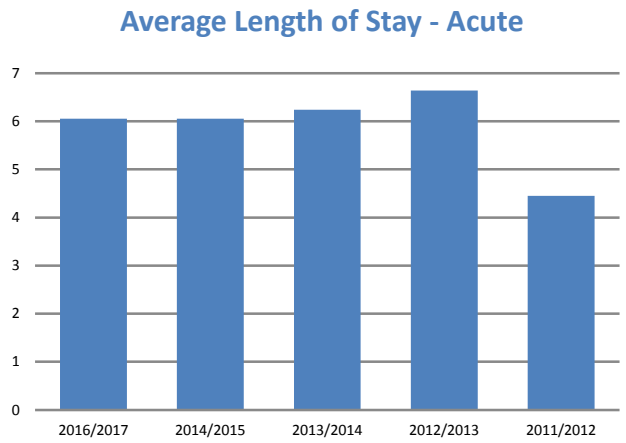
Led by the Unit Manager, the nursing staff provide quality, evidenced based care to patients and nursing home residents. They maintain their clinical competencies, and provide person centered care including palliative care as desired and Advanced Care Planning.

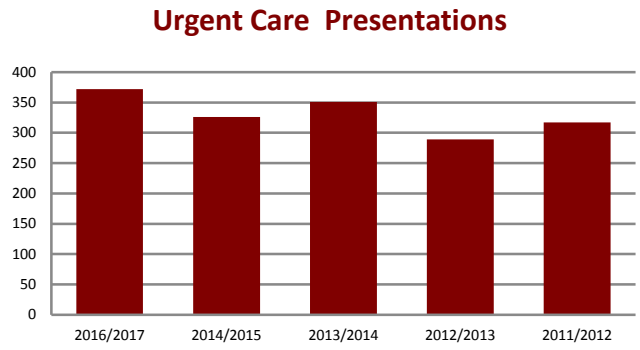
Our acute hospital care is provided for a range of conditions from acute to chronic illness and people may be transferred from other hospitals for recovery. All efforts are made to accommodate patients as required where their treatment can be continued satisfactorily.

The graphs demonstrates our acute hospital occupancy levels and length of stay.









Urgent Care (previously known as Accident and Emergency) is also provided at IDHS by our Visiting Medical Officers and the nursing staff. Attendances are noted in the table above. This service is primarily aimed at providing after hours care and diagnosis, and treatment for moderately ill people. For serious illness and emergencies or major traumas patients are transferred directly to Bendigo by Ambulance. For emergencies please call 000.

Transition Care Program

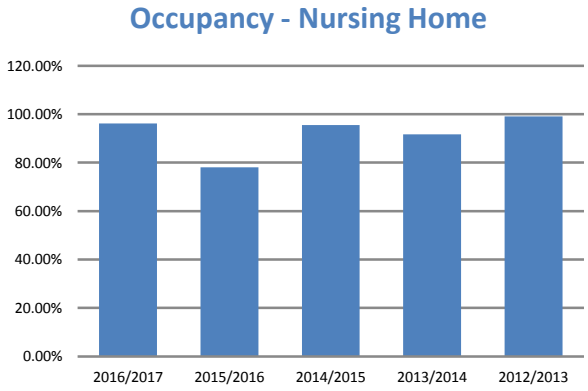
Transition Care occupancy is also noted in the table above, this clearly indicates a high and growing demand. This program has been very successful in offering frail patients additional support to transition home following a hospital admission or if necessary into care. The program provides twelve weeks of support including Physiotherapy, Counselling, Nursing assistance or other services to help patients to regain their full independence. This is provided at home or in hospital.

Nursing Home

The nursing staff together with assistance from other staff provide exemplary care, which consistently meets the aged care standards. The Nursing home provides an aesthetically pleasing homelike environment, which is well maintained, rooms are repainted for each new resident and all ensuites were recently fully refurbished and two new ones added, ensuring all rooms now have individual ensuite facilities. Many visitors comment on the lovely "feel" of the Nursing Home.

The Nursing Home is generally fully occupied although waiting lists are usually short. However as the table below demonstrates we allow people time to move into the home. Respite care is also provided when a short term vacancy exists in the Nursing Home. This respite provides support for carers, assisting them to maintain their family members at home for longer.

Fees and charges for our Nursing Home are extremely competitive and can be compared on line with the market. All enquiries are most welcome, including those from people with family and friends outside the local area. A tour of the home can be arranged at short notice.



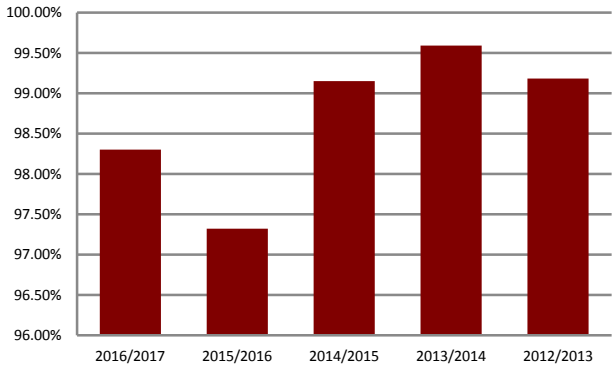
Hostel

The Hostel team, led by Rosalie Ball, are highly motivated and committed to enhancing the wellbeing and happiness of the residents. This is clearly demonstrated by the many small donations and kindnesses from these staff, to enhance care. Their efforts are very much appreciated and must be applauded.

Hostel Residents require support and assistance but not constant nursing care, although access to nurses and medical advice is available twenty four hours per day every day. Residents come from across the Loddon Shire or have families living in the shire who bring them from other areas in the state.

The Hostel is very friendly, and home like where residents are encouraged to interact with each other and engage with the community. Independence is encouraged while support and assistance is provided as necessary. As the figures below demonstrate we seldom have a vacancy, with short waiting lists. We encourage all interested people to enquire and come and visit our facility. Again our fees are very competitive and attractive.

Occupancy - Hostel



Physiotherapy

Physiotherapy is now available full time through our highly regarded Physiotherapist Janet Cobden and our casual physios. The service is provided for acute hospital patients, TCP patients and our residential aged care residents. The service has greatly assisted with pain management and mobility for residents and rehabilitation for others.

Lifestyle and Leisure

The Lifestyle and Leisure (L&L) Team are committed to enhancing the lifestyle and wellbeing of our residents. They, in collaboration with residents develop a varied and interesting monthly plan of activities, ranging from outings in the bus and pub lunches, to football tipping and cooking. A trip on the "Orient Express" has been planned this year and will be as successful as the "World Cruise" last year.

One of the very popular and long term team members Louise Lamprell has returned from Maternity while another, Michael Lamprell has resigned his position. I'd like to thank Michael for his many contributions to this program and the residents.

Volunteers are integral to the success of the L&L Team, their assistance and contribution of ideas for activities is invaluable, their participation is very much appreciated.

Infection Control

Di Andrews has accepted the responsibility of the Infection Control Nurse position from Rebekah Ryan. Di is completing the tasks involved and is committed to being to supporting and educating staff. Di has ensured the benchmarks for staff Flu Vaccinations and Hand Hygiene audit results have remained satisfactory, and an Antimicrobial Stewardship System has been implemented.

Community Health

Jenny Boromeo the Diabetes Educator and another long standing staff member also retired in the last 12 months, and deserves a special mention. Jenny's commitment to improving patient and resident care, particularly the management of diabetes is to be applauded. Jenny provided this service in both the community and residential care. She provided support and advice for staff and VMO's alike on treatments. And she facilitated diabetes prevention programs such as LIFE while

educating and supporting those with diabetes, individually, or through the Chronic Illness Group. Angela Roney has taken Jenny's place and is committed to maintaining this exemplary service.

The Community Health team comprises Community Health Nurses, a Community Mental Health Nurse (CMH), District Nurses, Welfare and Social Workers, Alcohol and Other Drugs Worker (AOD), a Community Development and Health Promotion Workers (CDW), and Physical Activity Coordinators (PAC). This dedicated team promotes the social model of health, emphasising health promotion, individual resilience and capacity building, while providing chronic disease management education and health coaching and injury prevention information.

IDHS plans and provides services in conjunction with community members with a focus on identified needs. Services are directed through the Integrated Health Promotion Plan (IHHP) and the Murray Primary Health Network Service Plan (PHNSP).

The IHHP is funded by the Department of Health and Human Services (DHHS) and focusses on the priority areas of Physical Activity, Sexual Health and Mental Health, these priorities are reviewed each three years and the plan redeveloped.

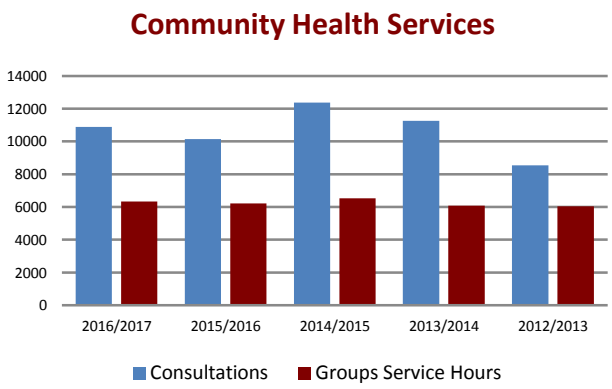
The PHNSP is funded through the Murray Primary Health Network (MPHN) by the Commonwealth Government, it provides a work plan which is used as a framework to provide services. The services provided to achieve these planned outcomes are integrated and provided collaboratively both internally and with other organisations including the Bendigo Loddon Primary Care Partnership (BLPCP). This cooperative service provision is complementary and ensures our community is well served. Unfortunately the focus of this funding is now changing and will impact on the services we can provide. However we will maintain some critical funding such as Diabetes services and every effort is being made during a transition period to identify other funding models to maintain our other PHN funded services which are valued by the community.

The current PHN services and programs include individual 1:1 services such as counselling, health education such as the management of diabetes and asthma, provision of Pap tests and women's health information, among others. Health Promotion and education Programs are also provided to enhance health and wellbeing, including the well received Rural Health Days, Puberty Sessions in schools and Men Matter Days. In addition there are group activities such as the Chronic Illness Support Group (previously the diabetes support group), Cardiac Rehabilitation group and Strength Training groups.

All of these groups are well attended, but the strength training groups are particularly popular with new groups formed to address community demand such as two groups for youth, a Bridgewater group, and also an additional Inglewood group which is supported by a collaboration with Loddon Shire.

Our community health staff provide programs and services across the southern part of the Loddon Shire including all towns and communities. Counselling and Welfare, Alcohol and Other Drugs and Community Mental Health services are provided from Korong Vale to Wedderburn, Bridgewater to Tarnagulla, Inglewood to Serpentine, either from our centres or in people's homes when required.

As the graph below indicates our Community Health Staff provide an extensive service, making contact with many clients over the year. The aim of this contact is to inform and support people to enhance their health and wellbeing.



District Nursing

The District Nursing team is highly skilled and committed to providing high quality care and service as evidenced by the success of the HACC and more recently the CHSP accreditation. These nurses provide exemplary services, ranging from pathology tests to wound management, nursing care and pain management in palliative care. They support and advise family members and patients alike, and mentor nursing students on a regular basis.

The District Nurses travel across the south part of the shire providing services 6 days per week in client homes. Clients reside across our service area from Wychitella, Korong Vale to Bears Lagoon in the north to Yarraberb, Laanecoorie, Moligul and Logan in the South and encompassing Wedderburn, Bridgewater, Serpentine, Newbridge, Tarnagulla and Inglewood in-between.

Planned Activity Groups & NRCP

The Planned Activity Groups (PAG's also known as Day Centres) provides Social Support for the frail aged and disabled. The National Respite Care Program (NRCP) a partnership with Uniting Aged Care provides respite for carer's and social engagement for clients.

Wendy Wilson provides excellent leadership and management of these groups. With the assistance of Di Vesey she maintains a very successful program while demand grows.

PAG groups are held weekly in Wedderburn, Inglewood, and Korong Vale on designated days. All eligible community members from across all communities in the southern part of the shire are welcome, enquiries are encouraged.

Volunteer Transport

A Volunteer Transport program for HACC/CHSP eligible clients is also 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. Please enquire.

Volunteers

Volunteers fill many roles in this organisation, from assisting with the Lifestyle and Leisure program and the Garden, to providing Volunteer Transport (with Health Service Vehicles) for specialist medical appointments and home visits or palliative care support. Our volunteers range from school students to grandparents and all ages in between.

Visits by students from local schools, the Inglewood Primary School, and St Mary's, and the preschool children are a highlight for the residents, and the students contribution are very much appreciated. These visits bring much joy and happiness to residents.

New Volunteers are always welcome, and we can provide a diverse range of activities for volunteers, from those listed above, to assisting in the laundry, kitchen or administration if desired. Please enquire. Without these wonderful people we could not continue to provide care as we do. Everyone can contribute something for someone.

We thank all our wonderful volunteers who so willingly give of their time to enhance the happiness and wellbeing others.

Acknowledgments

I would like to thank Mr Peter Moore President of the Board of Management, and Mrs Barbara Mason Treasurer (before her retirement this year) and the other members of the Board of Management for their support over the last year, it is most appreciated. Thank you also to Paula Richards for acting in my position when I have taken leave, it is appreciated.

I would like to thank Mr Mike Parker CEO for his support for myself and the staff. Mike has now resigned. Kathy Huett is currently the interim CEO and I'd like to thank her for her advice and support.

I trust IDHS will continue to promote participative and collaborative leadership styles which encourage staff engagement ensuring our staff remain enthusiastic, motivated and committed to IDHS.

And finally I would like to say thank you to our community for their contributions participation and support of IDHS. This is my final report, it has been a great privilege to lead our clinical care and grow IDHS. I wish everyone well for the future.

Mary A. Evans
Director of Nursing & Community Services

STATUTORY REPORTING REQUIREMENTS

Building ACT 1993

Inglewood and 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 Principles

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; and
- Ensure that all employees can pursue their duties free from discrimination and discrimination and harassment.

Consultants Engaged

In 2016-17, there was one (1) consultant where the total fees payable were $10,000 or greater. The total expenditure incurred during 2016-17 in relation to the consultancy is $29,918.18

Details of individual consultancies can be viewed at the Health Service.

Consultant – Maureen Kyne & Associates
Purpose of consultancy – Bullying and Harassment Training
Start Date – February 2017
End Date – March 2017
Total approved project fee (ex GST) - $29,918.18
Expenditure 2016/2017 (ex GST) - $29,918.18
Future expenditure (ex GST) - $Nil

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 two requests under the Freedom of Information Act 1982.

Government Policies on Competitive Neutrality and National Competition

The Inglewood & Districts Health Service will 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.

Workcover and Occupational Health and Safety

The Occupational Health and Safety Committee including staff representatives investigate unsafe work practices and in consultation with staff recommend corrective actions. The committee also monitors staff welfare issues, an Employee Assistance Program offers counseling when required. Work Accidents and Loss of Hours are used to monitor OH&S Performance. In the last year no employees were absent from duty as a result of work related incidents.

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

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 & 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.

Ex-gratia Payments

No payments have been made in this financial year.

Victorian Industry Participation Policy Disclosures

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

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 the 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. Recycled toilet tissues have been used within the health service for some time.

An active recycling program has existed at IDHS for many years incorporating cardboard, tin cans, plastics, printer cartridges and paper. A rainwater tank also feeds into sections of the health service.

Another opportunity that will be started shortly is the installation of LED lighting. This will have a positive impact for the environment and improve efficiency within the health service.

Further information on the trends and figures are available on our website.

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).

Carers Recognition Act

The Board and management takes all practicable measures to ensure that its employees, agents and persons who are in care relationships receiving services have an awareness and understanding of the care relationship principles. We reflect the care relationship principles in developing, providing or evaluating support and assistance for persons in care relationships.

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.

Compliance with DataVic Access Policy

Consistent with the DataVic Access Policy issued by the Victorian Government in 2012, the information included in this Annual Report will be available at http://www.data.vic.gov.au

ATTESTATIONS

Compliance with the Ministerial Standing Direction 3.7.1– Risk Management Framework and Processes

I, Kathy Huett certify that the Inglewood & Districts Health Service has complied with Ministerial Direction 3.7.1 – Risk Management Framework and Processes. The Inglewood & Districts Health Audit Committee has verified this.

Kathy Huett
Accountable Officer
Inglewood & Districts Health Service
30 June 2017

Compliance with Health Purchasing Victoria (HPV) Health Purchasing Policies

I, Kathy Huett 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.

Kathy Huett
Accountable Officer
Inglewood & Districts Health Service
30 June 2017

Details of Information and Communication Technology Expenditure

Business as usual expenditure (ex GST)	$197,925
There was no non-business as usual ICT Expenditure in this financial year.	

DISCLOSURE INDEX

The annual report of the Inglewood and 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 Reference
Ministerial Directions		
Report of Operations		
FRD 22H	Manner of establishment and the relevant 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
Management and structure		
FRD 22H	Organisational structure	11
Financial and other information		
FRD 10A	Disclosure Index	31
FRD 11A	Disclosure of ex-gratia expenses	29
FRD 21C	Responsible person and executive officer disclosures	FS
FRD 22H	Application and operation of *Protected Disclosure 2012*	29
FRD 22H	Application and operation of *Carers Recognition Act 2012*	29
FRD 22H	Application and operation of *Freedom of Information Act 1982*	29
FRD 22H	Compliance with building and maintenance provisions of *Building Act 1993*	29
FRD 22H	Details of consultancies over $10,000	28
FRD 22H	Details of consultancies under $10,000	28
FRD 22H	Employment and conduct principles	28
FRD 22H	Information and Community Technology Expenditure	30
FRD 22H	Major changes or factors affecting performance	8-10
FRD 22H	Occupational Violence	21
FRD 22H	Operational and budgetary objectives and performance against objectives	12
FRD 24C	Reporting of office-based environmental impacts	29
FRD 22H	Significant changes in financial position during the year	8-10
FRD 22H	Statement on National Competition Policy	28
FRD 22H	Subsequent events	FS
FRD 22H	Summary of the financial results for the year	FS
FRD 22H	Additional information available on request	
FRD 22H	Workforce Data Disclosures including a statement on the application of employment and conduct principles	20,21,29
FRD 25C	Victorian Industry Participation Policy disclosures	29
FRD 29B	Workforce Data disclosures	20,21
FRD 103F	Non-Financial Physical Assets	FS
FRD 110A	Cash Flow Statements	FS
FRD 112D	Defined Benefit Superannuation Obligation	FS
SD 5.2.3	Declaration in report of operations	FS
SD 3.7.1	Risk management framework and processes	FS

Legislation	Requirement	Page Reference
Other requirements under Standing Directions 5.2		
SD 5.2.2	Declaration in financial statement	FS
SD 5.2.1 (a)	Compliance with Australian accounting standards and other authoritative pronouncements.	FS
SD 5.2.1 (a)	Compliance with Ministerial Directions	FS
Legislation		
Freedom of Information Act 1982		28
Protected Disclosure Act 2012		29
Carers Recognition Act 2012		29
Victorian Industry Participation Policy Act 2003		29
Building Act 1993		28
Financial Management Act 1994		FR
Safe Patient Care Act 2015		29

**FR - As per financial statements*

AN APPEAL FOR ASSISTANCE

Notwithstanding the amount of Government subsidy received during the year, the Health Service is still dependent upon the financial support of the public to enable it to continue to develop its services.

YOU CAN HELP BY:

Becoming an Annual Subscriber

Donating towards a specific item of equipment

Remembering the Health Service in your Will

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

YOUR SUPPORT IS NEEDED AND IS APPRECIATED

WHO TO CONTACT

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

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

To make a donation, 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 make a donation for a specific purpose, please contact the Chief Executive Officer at the address or phone number listed above.

Inglewood & Districts Health Service
Hospital Street, Inglewood VIC. 3517
Telephone: (03) 5431 7000 Fax: (03) 5431 7004
Email: admin@idhs.vic.gov.au
ABN 59289296574

INGLEWOOD & DISTRICTS HEALTH SERVICE

BOARD MEMBER'S, ACCOUNTABLE OFFICER'S AND CHIEF FINANCE & ACCOUNTING 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 Minsiter for Finance under the *Financial* Management Act 1994, applicable *Financial Reporting Directions,* Australian Accounting Standards including Interpretations and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the Comprehensive Operating Statement, Balance Sheet, Statement of Changes in Equity, Cash Flow Statement, and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2017 and financial position of Inglewood & Districts Health Service at 30 June 2017.

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

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

Peter Moore	Tracey Wilson	Geoffrey Vendy
Board Chair	Chief Executive Officer	Chief Finance & Accounting Officer
Inglewood	Inglewood	Inglewood
14/09/2017	14/09/2017	14/09/2017

Independent Auditor's Report

Victorian Auditor-General's Office

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 2017 • comprehensive operating statement for the year then ended • statement of changes in equity for the year then ended • cash flow statement for the year then ended • notes to the financial statements, including a summary of significant accounting policies • board member's, accountable officer's and chief finance & accounting officer's declaration. In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2017 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *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. My responsibilities under the Act are further described 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 Australia. 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, and using the going concern basis of accounting unless it is inappropriate to do so.

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
18 September 2017

Ron Mak
as delegate for the Auditor-General of Victoria

INGLEWOOD & DISTRICTS HEALTH SERVICE
COMPREHENSIVE OPERATING STATEMENT
FOR THE YEAR ENDED 30 JUNE 2017

	Note	2017 $	2016 $
Revenue from Operating Activities	2.1	6,801,814	6,069,047
Revenue from Non-operating Activities	2.1	106,215	130,106
Employee Expenses	3.1	(5,217,731)	(4,909,692)
Non Salary Labour Costs	3.1	(236,432)	(205,930)
Supplies and Consumables	3.1	(340,645)	(304,963)
Other Expenses	3.1	(1,012,092)	(971,908)
Net Result Before Capital & Specific Items		**101,129**	**(193,340)**
Capital Purpose Income	2.1	94,921	55,248
Depreciation	4.4	(766,415)	(743,374)
Expenditure Using Capital Purpose Income	3.1	(69,362)	(165,217)
Specific Expense	3.2	0	(115,114)
Net Result after capital and specific items		**(639,727)**	**(1,161,797)**
Other economic flows included in net result			
Revaluation of Long Service Leave		(6,392)	(1,284)
NET RESULT FOR THE YEAR		**(646,119)**	**(1,163,081)**
Other comprehensive income			
Items that will not be recalssified subsequently to net result			
Changes to financial assets available-for-sale revaluation surplus	8.1a	6,478	(5,802)
COMPREHENSIVE RESULT		**(639,641)**	**(1,168,883)**

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

INGLEWOOD & DISTRICTS HEALTH SERVICE
BALANCE SHEET
AS AT 30 JUNE 2017

	Note	2017 $	2016 $
Current Assets			
Cash and Cash Equivalents	6.1	1,108,084	256,560
Receivables	5.1	422,866	364,891
Investments and Other Financial Assets	4.1	1,694,485	1,985,882
Prepayments and Other Assets	5.3	29,569	23,553
Total Current Assets		**3,255,004**	**2,630,886**
Non-Current Assets			
Receivables	5.1	216,050	196,259
Property, Plant & Equipment	4.3	9,730,940	10,412,681
Total Non-Current Assets		**9,946,990**	**10,608,940**
TOTAL ASSETS		**13,201,994**	**13,239,826**
Current Liabilities			
Payables	5.4	472,398	304,423
Provisions	3.3	1,507,163	1,521,430
Other Liabilities	5.2	1,996,922	1,596,309
Total Current Liabilities		**3,976,483**	**3,422,162**
Non-Current Liabilities			
Provisions	3.3	154,420	106,932
Total Non-Current Liabilities		**154,420**	**106,932**
TOTAL LIABILITIES		**4,130,903**	**3,529,094**
NET ASSETS		**9,071,091**	**9,710,732**
EQUITY			
Property, Plant & Equipment Revaluation Surplus	8.1a	8,201,358	8,201,358
Financial Asset Available for Sale Revaluation Surplus	8.1a	6,494	16
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	(5,071,810)	(4,425,691)
TOTAL EQUITY		**9,071,091**	**9,710,732**
Contingent Assets and Contingent Liabilities	7.3		
Commitments	6.2		

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

INGLEWOOD & DISTRICTS HEALTH SERVICE
STATEMENT OF CHANGES IN EQUITY
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017

	Note	Property, Plant & Equipment Revaluation Surplus $	Financial ssets Available fo Sale Revaluation Surplus $	Restricted Specific Purpose Surplus $	Contributed Capital $	Accumulated Supluses/ (Deficits) $	Total $
Balance at 1 July 2015		8,201,358	5,818	650,349	5,284,700	(3,262,610)	10,879,615
Net result for the year		0	0	0	0	(1,163,081)	(1,163,081)
Other comprehensive income for the year	8.1a	0	(5,802)	0	0	0	(5,802)
Balance at 30 June 2016		**8,201,358**	**16**	**650,349**	**5,284,700**	**(4,425,691)**	**9,710,732**
Net result for the year		0	0	0	0	(646,119)	(646,119)
Other comprehensive income for the year	8.1a	0	6,478	0	0	0	6,478
Balance at 30 June 2017		**8,201,358**	**6,494**	**650,349**	**5,284,700**	**(5,071,810)**	**9,071,091**

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

INGLEWOOD & DISTRICTS HEALTH SERVICE
CASH FLOW STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017

	Note	2017 $	2016 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		5,119,000	5,083,534
Capital Grants from Government		22,342	42,864
Patient and Resident Fees Received		767,657	642,467
Donations and Bequests Received		56,866	13,185
GST (Paid to)/received from ATO		15,044	(23,265)
Interest Received		136,657	207,545
Other Receipts		628,997	168,001
Total Receipts		**6,746,563**	**6,134,331**
Employee Expenses Paid		(5,185,376)	(5,004,496)
Non Salary Labour Costs		(236,432)	(205,930)
Payments for Supplies and Consumables		(340,645)	(304,963)
Other Payments		(758,540)	(1,133,711)
Total Payments		**(6,520,993)**	**(6,649,100)**
NET CASH FLOW FROM / (USED IN) OPERATING ACTIVITIES	8.2	**225,570**	**(514,769)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Proceeds from sale of Investments		4,917	421,177
Payments for Non-Financial Assets		(107,182)	(385,196)
Proceeds from Sale of Non-Financial Assets		24,000	63,000
NET CASH FLOW FROM / (USED IN) INVESTING ACTIVITIES		**(78,265)**	**98,981**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		**147,305**	**(415,788)**
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		**201,400**	**617,188**
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.1	**348,705**	**201,400**

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

Basis of presentation

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

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

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

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

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

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

Revisions to accounting estimates are recognised in the period in which the estimate is revised and also in future periods that are affected by the revision. Judgements and assumptions made by management in the application of AASB that have significant effects on the financial statements and estimates are disclosed in the notes under the heading: 'Significant judgment 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 for the period ending 30 June 2017. The report provides users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

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

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

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

The annual financial statements were authorised for issue by the Board of Inglewood & Districts Health Service on 14 September 2017.

(b) Reporting Entity
The financial statements include all the controlled activities of Inglewood & Districts Health Service.
Its principal address is:
3 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.

Objectives and funding
Inglewood & Districts Health Service overall objective is to provide quality health services which respond to community needs and enhance wellbeing within the community.

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

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

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

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

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

- Non-current physical assets, which subsequent to acquisition, are measured at a revalued amount being their fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made and are reassessed when new indices are published by the Valuer-General to ensure that the carrying amounts do not materially differ from their fair values;
- Available-for-sale investments which are measured at fair value with movements reflected in equity until the asset is derecognised; and
- The fair value of assets other than land is generally based on their depreciated replacement value.

Historical cost is based on the fair value of the consideration given in exchange for assets.

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

(d) Principles of consolidation

Intersegment Transactions

Transactions between segments within Inglewood & Districts Health Service have been eliminated to reflect the extent of Inglewood & Districts Health Service's operations as a group.

Note 2: FUNDING DELIVERY OF OUR SERVICE

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

To enable the hospital to fulfil its objective it receives income based on parliamentary appropriations. The hospital 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	Residential Aged Care	Aged Care	Primary Health	Other	TOTAL
	2017 $	2017 $	2017 $	2017 $	2017 $	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
Loddon Mallee Rural Health Alliance	171,896	0	0	0	0	171,896
Catering	0	0	0	0	51,623	51,623
Property Income	0	0	0	0	125,336	125,336
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**
Bank & Investment Income	106,215	0	0	0	0	106,215
Donations	0	0	0	0	0	0
Total Revenue from Non-Operating Activities	**106,215**	**0**	**0**	**0**	**0**	**106,215**
Capital Purpose Income	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 the Health Service.
These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

Note 2: FUNDING DELIVERY OF OUR SERVICE (Continued)

	Admitted Patients	Residential Aged Care	Aged Care	Primary Health	Other	TOTAL
	2016 $	2016 $	2016 $	2016 $	2016 $	2016 $
Government Grants	1,769,277	1,845,635	1,009,774	401,448	0	5,026,134
Indirect Contributions by Department of Health and Human Services	(6,834)	4,263	434	1,513	0	(624)
Patient and Resident Fees	64,664	609,919	17,943	0	0	692,526
Loddon Mallee Rural Health Alliance	186,681	0	0	0	0	186,681
Catering	0	0	0	0	46,932	46,932
Property Income	0	0	0	0	12,050	12,050
Other Revenue from Operating Activities	20,127	35,748	36,903	12,566	4	105,348
Total Revenue from Operating Activities	**2,033,915**	**2,495,565**	**1,065,054**	**415,527**	**58,986**	**6,069,047**
Interest and Dividends	116,921	0	0	0	0	116,921
Donations	0	0	0	0	13,185	13,185
Total Revenue from Non-Operating Activities	**116,921**	**0**	**0**	**0**	**13,185**	**130,106**
Capital Purpose Income	42,864	21,627	0	0	(9,243)	55,248
Capital Interest	0	0	0	0	0	0
Total Capital Purpose Income	**42,864**	**21,627**	**0**	**0**	**(9,243)**	**55,248**
Total Revenue	**2,193,700**	**2,517,192**	**1,065,054**	**415,527**	**62,928**	**6,254,401**

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

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 Metropolitan Health and Aged Care Services Division Hospital Circular 05/2017.

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 provision of meals to external users is recognised at the time the 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 reserve, such as specific restricted purpose reserve.

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

Interest Revenue
Interest revenue is recognised on a time proportionate basis that takes in account the effective yield of the financial asset.

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

Category Groups
Inglewood & Districts Health Service has used the following category groups for reporting purposes for the current and previous financial years.

Admitted Patient Services (Admitted Patients) comprises all recurrent health revenue/expenditure on admitted patient services, where services are delivered in public hospitals, or free standing day hospital facilities, or alcohol and drug treatment units or hospitals specialising in dental services, hearing and ophthalmic aids.

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

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

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

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

Note 3: THE COST OF DELIVERING SERVICES

This section provides an account of the expenses incurred by the hospital in delivering services and outputs. In Section 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 Specific expenses
3.3 Provisions
3.4 Superannuation

Note 3.1: ANALYSIS OF EXPENSE BY SOURCE

	Admitted Patients	**Residential Aged Care**	**Aged Care**	**Primary Health**	**Other**	**TOTAL**
	2017	2017	2017	2017	2017	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 and Consumables	101,849	153,319	23,166	650	61,661	340,645
Other Expenses from continuing operations	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**
Depreciation (refer note 4.4)	0	0	0	0	766,415	766,415
Expenditure for Capital Purposes	0	0	0	0	69,362	69,362
Specific Expense (refer note 3.2)	0	0	0	0	0	0
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**

	Admitted Patients	**Residential Aged Care**	**Aged Care**	**Primary Health**	**Other**	**TOTAL**
	2016	2016	2016	2016	2016	2016
	$	**$**	**$**	**$**	**$**	**$**
Employee Expenses	1,680,223	2,013,552	321,709	793,675	100,533	4,909,692
Non Salary Labour Costs	205,930	0	0	0	0	205,930
Supplies and Consumables	106,865	135,002	17,347	433	45,316	304,963
Other Expenses from continuing operations	239,096	367,978	76,416	123,922	164,496	971,908
Total Expenditure from Operating Activities	**2,232,114**	**2,516,532**	**415,472**	**918,030**	**310,345**	**6,392,493**
Depreciation (refer note 4.4)	0	0	0	0	743,374	743,374
Expenditure for Capital Purposes	0	0	0	0	165,217	165,217
Specific Expense (refer note 3.2)	0	0	0	0	115,114	115,114
Total Other Expenses	**0**	**0**	**0**	**0**	**1,023,705**	**1,023,705**
Total Expenses	**2,232,114**	**2,516,532**	**415,472**	**918,030**	**1,334,050**	**7,416,198**

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

Cost of goods sold

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

Employee expenses

Employee expenses include:

- Wages and salaries;
- Annual leave;
- Sick leave;
- Long service leave; and
- Superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

Grants and other transfers

Grants and other transfers to third parties (other than contribution to owners) are recognised as an expense in the reporting period in which they are paid or payable. They include transactions such as: grants, subsidies and personal benefit payments made in cash to individuals.

Other operating expenses

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

Supplies and consumables

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

Bad and doubtful debts

Refer to Note 4.1 Investments and other financial assets.

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

Contributions of resources provided free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them, irrespective of whether restrictions or conditions are imposed over the use of the contributions, unless received from another agency as a consequence of a restructuring of administrative arrangements. In the latter case, such a transfer will be recognised at its carrying amount.

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

Other economic flows are changes in the volume or value of assets or liabilities that do not result from transactions.

Net gain/(loss) on non-financial assets
Net gain/(loss) on non-financial assets and liabilities includes realised and unrealised gains and losses as follows:
Revaluation gains/(losses) of non-financial physical assets
Refer to Note 4.3 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 and is the difference between the proceeds and the carrying value of the asset at the time.

Share of net profits/ (losses) of associates and jointly controlled entities, excluding dividends.
Refer to Note 1 (d) *Basis of consolidation*.

Other gains/ (losses) from other economic flows
Other gains/ (losses) include:
(a) 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
(b) transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

NOTE 3.2: SPECIFIC EXPENSES	2017 **$**	2016 **$**
Payment for Inglewood Medical Practice	0	115,114

NOTE 3.3: EMPLOYEE BENEFITS IN THE BALANCE SHEET	2017 $	2016 $
Current Provisions		
Employee Benefits (i)		
Accrued Salary and wages		
- unconditional and expected to be settled within 12 months (ii)	193,201	79,261
Accrued Days Off		
- unconditional and expected to be settled within 12 months (ii)	14,923	37,559
Annual Leave		
- unconditional and expected to be settled within 12 months (ii)	398,672	408,519
- unconditional and expected to be settled after 12 months (iii)	67,211	67,333
Long Service Leave		
- unconditional and expected to be settled within 12 months (ii)	293,819	328,890
- unconditional and expected to be settled after 12 months (iii)	405,751	454,181
Provisions related to employee benefit on-costs		
- unconditional and expected to be settled within 12 months (nominal value) (ii)	82,460	85,613
- unconditional and expected to be settled after 12 months (present value) (iii)	51,126	60,074
Total Current Provisions	**1,507,163**	**1,521,430**
Non-Current Provisions		
Employee Benefits (iii)	140,603	97,211
Provisions related to employee benefit on-costs (iii)	13,817	9,721
Total Non-Current Provisions	**154,420**	**106,932**
Total Provisions	**1,661,583**	**1,628,362**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and Related On-Costs		
Unconditional Long Service Leave Entitlements	772,675	861,378
Annual Leave Entitlements	526,364	531,550
Accrued Salaries and Wages	193,201	87,187
Accrued Days Off	14,923	41,315
Non-Current Employee Benefits and Related On-Costs		
Conditional Long Service Leave Entitlements (present value) (iii)	154,420	106,932
Total Employee Benefits and Related On-Costs	**1,661,583**	**1,628,362**

(i) Provisions for employee benefits consist of amounts for annual leave and long service leave accrued by employees, not including on-costs.
(ii) The amounts disclosed are nominal amounts
(iii) The amounts disclosed are discounted to present values

(b) Movements in Provisions	2017 $	2016 $
Movement in Long Service Leave:		
Balance at start of year	968,310	931,821
Provision made during the year		
- Revaluations	129,952	1,284
- Expense recognising Employee Service	6,392	97,851
Settlement made during the year	(177,559)	(62,646)
Balance at end of year	**927,095**	**968,310**

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

The amount recognised as a liability is the best estimate of the consideration required to settle the present obligation at reporting date, taking into account the risks and uncertainties surrounding the obligation. Where a provision is measured using the cash flows estimated to settle the present obligation, its carrying amount is the present value of those cash flows, using a discount rate that reflects the time value of money and risks specific to the provision.

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

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

Wages and Salaries, Annual Leave, and Accrued Days Off
Liabilities for wages and salaries, including non-monetary benefits, annual leave, and accrued days off which are to be settled expected within 12 months of the reporting date are recognised in the provision for employee benefits in respect of employee's services up to the reporting date, and are classified as current liabilities and measured at their nominal values.

Those liabilities that are not expected to be settled within 12 months are recognised in the provision for employee benefits as current liabilities, measured at present value of the amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

Long Service Leave
The liability for long service leave (LSL) is recognised in the provision for employee benefits.

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

The components of this current LSL liability are measured at:
- Undiscounted value - if the health service expects to wholly settle within 12 months; and
- Present value - if the health service does not expect to wholly settle within 12 months.

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

Any gain or loss followed revaluation of the present value of non-current LSL liability is recognised as a transaction, except to the extent that a gain or loss arises due to changes in bond interest rates for which it is then recognised as an other economic flow.

Termination Benefits
Termination benefits are payable when employment is terminated before the normal retirement date or when an employee accepts voluntary redundancy in exchange for these benefits.

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

On-Costs
Employee benefit on-costs, such as payroll tax, workers compensation, superannuation are recognised together with provisions for employee benefits.

NOTE 3.4: SUPERANNUATION

Fund		Paid Contributions for the year			Contribution Oustanding at	
		2017	**2016**		**2017**	**2016**
		$	**$**		**$**	**$**
Defined Benefit Plans:	First State Super	12,192	15,630		467	0
Defined Contribution Plans:	First State Super	307,695	310,527		16,708	0
	HESTA	68,949	64,954		1,717	0
	ING	0	0		0	0
	HostPlus	2,343	0		181	0
	VicSuper	1,435	0		0	0
	MikeCarol	31,855	36,095		0	0
	Vision Super	5,159	4,682		195	0
	Common	0	0		0	0
	Australian Super	4,635	6,989		159	0
	Other	10,334	15,576		384	0
Total		**444,597**	**454,453**		**19,811**	**0**

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

However superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the comprehensive operating statement of the Health Service.

The name, details and amounts expense in relation to the major employee superannuation funds and contributions made by the Health Service are set out in the table above.

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

Defined benefit superannuation plans
The amount charged to the comprehensive operating statement in respect of defined benefit superannuation plans represents the contributions made by the Health Service to the superannuation plans in respect of the services of current Health Service staff during the reporting period. Superannuation contributions are made to the plans based on the relevant rules of each plan, and are based upon actuarial advice.

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

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

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY

The hospital 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 Jointly controlled operations and assets
4.3 Property, plant & equipment
4.4 Depreciation and amortisation

NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS

	Operating Fund		Specific Purpose Fund		Capital Fund		Total	
	2017	2016	2017	2016	2017	2016	2017	2016
CURRENT	$	$	$	$	$	$	$	$
Loans and receivables								
Term Deposit								
Aust. Dollar Term Deposits (i)	280,029	980,045	688,051	285,932	0	0	968,080	1,265,977
Available for sale								
Equities and Managed Investment Schemes								
Managed Funds	0	0	590,006	565,068	91,500	116,415	681,506	681,483
Shares	44,899	38,422	0	0	0	0	44,899	38,422
Total Investment and Other Financial Assets	**324,928**	**1,018,467**	**1,278,057**	**851,000**	**91,500**	**116,415**	**1,694,485**	**1,985,882**
Represented by:								
Health Service Investments	324,928	37,935	0	285,932	0	0	324,928	323,867
LMRHA Investments	0	0	0	0	91,500	116,415	91,500	116,415
Monies Held in Trust Accommodation Bonds	0	980,532	1,278,057	565,068	0	0	1,278,057	1,545,600
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**324,928**	**1,018,467**	**1,278,057**	**851,000**	**91,500**	**116,415**	**1,694,485**	**1,985,882**

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

(a) Ageing analysis of investments and other financial assets

Please refer to note 7.1 for the ageing analysis of investments and other financial assets

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

Please refer to note 7.2 for the nature and extent of credit risk arising from investments and other financial assets

Investments and Other Financial Assets

Hospital investments must be in accordance in Stranding Direction 3.7.2– Treasury Investment Risk Management. Investments are recognised and derecognised on trade date where purchase or sale of an investment is under a contract whose terms require delivery of the investment within the timeframe established by the market concerned, and are initially measured at fair value, net of transaction costs.

Investments are classified in the following categories:
- 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 purpose for which the assets were acquired. Management determines the classification of its other financial assets at initial recognition.

Inglewood & Districts Health Service assesses at each balance sheet date whether a financial asset or group of financial assets is impaired.

All financial assets are subject to annual review for impairment.

Derecognition of financial assets

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

- the rights to receive cash flows from the asset have expired; or

- the Health Service retains the right to receive cash flows from the asset, but has assumed an obligation to pay them in full without material delay to a third party under a 'pass through' arrangement; or

- the Health Service has transferred its rights to receive cash flows from the asset and either:

(a) has transferred substantially all the risks and rewards of the asset; or

(b) has neither transferred nor retained substantially all the risks and rewards of the asset, but has transferred control of the asset.

Where the 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 and 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.

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.

NOTE 4.2: JOINTLY CONTROLLED OPERATIONS AND ASSETS

Investments in jointly controlled assets and operations

For jointly controlled operations Inglewood & Districts Health Service recognises:
- the assets that it controls;
- the liabilities that it incurs;
- expenses that it incurs; and
- the share of income that it earns from selling outputs of the joint venture

Name of Entity	Principal Activity	Ownership Interest 2017 %	Ownership Interest 2016 %
Loddon Mallee Rural Health Alliance	Information Systems	2.25	2.20

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

	2017 $	2016 $
Current Assets		
Cash and Cash Equivalents	40,014	4,451
Other Financial Assets	91,500	116,415
Receivables	8,021	6,625
Prepayments	14,539	12,191
Total Current Assets	**154,074**	**139,682**
Non Current Assets		
Property, Plant & Equipment	3,404	4,657
Total Non Current Assets	3,404	4,657
Total Assets	**157,478**	**144,339**
Current Liabilities		
Payables	24,964	23,032
Accrued Expenses	3,303	2,363
Total Current Liabilities	**28,267**	**25,395**
Total Liabilities	**28,267**	**25,395**

Inglewood and District Health Services interest in revenues and expenses resulting from jointly controlled operations and assets is detailed below:

Revenues		
Revenue from Operating Activities	171,896	186,681
Capital Grants	(3,839)	(33,681)
Total Revenue	**168,057**	**153,000**
Expenses		
Information Technology and Administrative Expenses	155,184	161,798
Depreciation	2,859	6,029
Asset Disposal	(255)	0
Total Expenses	**157,788**	**167,827**
Net Result	**10,269**	**(14,827)**

Contingent Liabilities and Capital Commitments

There are no known contingent liabilities for Loddon Mallee Rural Health Alliance as at the date of this report.

Commitments for Expenditure

There are no known capital commitments for Loddon Mallee Rural Health Alliance as at the date of this report.

NOTE 4.3: PROPERTY, PLANT & EQUIPMENT
(a) Gross carrying amount and accumulated depreciation

	2017 $	2016 $
Land		
- Land at Fair Value	182,000	182,000
Total Land	**182,000**	**182,000**
Buildings		
- Buildings Under Construction at Cost	0	268,600
Less Accumulated Depreciation	0	0
- Buildings at Fair Value	10,842,322	10,477,258
Less Accumulated Depreciation	1,751,983	1,154,418
Total Buildings	**9,090,339**	**9,591,440**
Plant & Equipment		
- Loddon Mallee Rural Health Alliance at Fair Value	18,536	19,747
Less Accumulated Depreciation	15,132	15,090
- Plant and Equipment at Fair Value	584,052	573,335
Less Accumulated Depreciation	312,209	241,030
Total Plant and Equipment	**275,247**	**336,962**
Medical Equipment		
- Medical Equipment at Fair Value	247,258	247,258
Less Accumulated Depreciation	184,159	151,184
Total Medical Equipment	**63,099**	**96,074**
Furniture and Fittings		
- Furniture and Fittings at Fair Value	73,339	73,339
Less Accumulated Depreciation	30,682	24,350
Total Furniture and Fittings	**42,657**	**48,989**
Motor Vehicles		
- Motor Vehicles at Fair Value	283,313	328,162
Less Accumulated Depreciation	205,715	170,946
Total Motor Vehicles	**77,598**	**157,216**
TOTAL	**9,730,940**	**10,412,681**

NOTE 4.3: PROPERTY, PLANT & EQUIPMENT (Cont'd)
(b) Reconciliations of the carrying amounts of each class of asset

	Land	Buildings	Plant & Equipment	Motor Vehicle	Medical Equipment	Furniture & Fittings	Work in Progress	Total
	$	$	$	$	$	$	$	$
Balance at 1 July 2015	182,000	9,901,753	332,562	269,277	95,324	53,022	8,764	10,842,702
Additions	0	0	69,585	25,400	28,446	1,929	259,836	385,196
LMRHA	0	0	400	0	0	0	0	400
Disposals	0	0	0	(72,243)	0	0	0	(72,243)
Depreciation (note 4.4)	0	(578,913)	(65,585)	(65,218)	(27,696)	(5,962)	0	(743,374)
Balance at 1 July 2016	**182,000**	**9,322,840**	**336,962**	**157,216**	**96,074**	**48,989**	**268,600**	**10,412,681**
Additions	0	0	10,718	0	0	0	96,464	107,182
LMRHA	0	0	1,606	0	0	0	0	1,606
Disposals	0	365,064	0	(24,114)	0	0	(365,064)	(24,114)
Depreciation (note 4.4)	0	(597,565)	(74,039)	(55,504)	(32,975)	(6,332)	0	(766,415)
Balance at 30 June 2017	**182,000**	**9,090,339**	**275,247**	**77,598**	**63,099**	**42,657**	**0**	**9,730,940**

Land and buildings carried at valuation
An independent valuation of the Health Service's property, plant & equipment was performed by the Valuer-General Victoria to determine the value of the land and buildings. 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.

Plant and Equipment carried at fair value
Fair value of plant and equipment has been assessed by management in accordance with Financial Reporting Direction 103F. Management have obtained secondhand values for equipment where possible, or completed an assessment of value based on depreciated replacement cost.

(c) Fair value measurement hierarchy for assets

	Carrying amount as at 30 June 2017	Fair value measurement at end of reporting period using:		
		Level 1 [(i)]	Level 2 [(i)]	Level 3 [(i)]
Land at fair value	$	$	$	$
Non-specialised land	24,000	0	24,000	0
Specialised land	158,000	0	0	158,000
Total of land at fair value	182,000	0	24,000	158,000
Buildings at fair value				
Non-specialised buildings	322,000	0	322,000	0
Specialised buildings	8,768,339	0	0	8,768,339
Total of building at fair value	9,090,339	0	322,000	8,768,339
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles	77,598	0	0	77,598
- Plant and equipment	317,904	0	0	317,904
Total of plant, equipment and vehicles at fair value	395,502	0	0	395,502
Medical equipment at fair value				
Total medical equipment at fair value	63,099	0	0	63,099
	9,730,940	0	346,000	9,384,940

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

NOTE 4.3: PROPERTY, PLANT & EQUIPMENT (Continued)
Fair value measurement hierarchy for assets

	Carrying amount as at 30 June 2016	Fair value measurement at end of reporting period using:		
		Level 1 (i)	Level 2 (i)	Level 3 (i)
Land at fair value	$	$	$	$
Non-specialised land	24,000	0	24,000	0
Specialised land	158,000	0	0	158,000
Total of land at fair value	182,000	0	24,000	158,000
Buildings at fair value				
Non-specialised buildings	322,000	0	322,000	0
Specialised buildings	9,269,440			9,269,440
Total of building at fair value	9,591,440	0	322,000	9,269,440
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles	157,216	0	0	157,216
- Plant and equipment	385,951	0	0	385,951
Total of plant, equipment and vehicles at fair value	543,167	0	0	543,167
Medical equipment at fair value				
Total medical equipment at fair value	96,074	0	0	96,074
	10,412,681	0	346,000	10,066,681

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

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

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy, described as follows, based on the lowest level input that is significant to the fair value measurement as a whole:
- Level 1 – Quoted (unadjusted) market prices in active markets for identical assets or liabilities
- Level 2 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable
- Level 3 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

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

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

Valuation hierarchy

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

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy. It is based on the lowest level input that is significant to the fair value measurement as a whole:
- Level 1 – Quoted (unadjusted) market prices in active markets for identical assets or liabilities;
- Level 2 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable;
- Level 3 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

NOTE 4.3: PROPERTY, PLANT & EQUIPMENT (Continued)

Non-specialised land, non-specialised buildings and artwork
Non-specialised land, non-specialised buildings and artworks are valued using the market approach. Under this valuation method, the assets are compared to recent comparable sales or sales of comparable assets which are considered to have nominal or no added improvement value.
For non-specialised land and non-specialised buildings, an independent valuation was performed by independent valuers to determine the fair value using the market approach. Valuation of the assets was determined by analysing comparable sales and allowing for share, size, topography, location and other relevant factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30 June 2014.
To the extent that non-specialised land, non-specialised buildings and artworks do not contain significant, unobservable adjustments, these assets are classified as Level 2 under the market approach.
Specialised land and specialised buildings
The market approach is also used for specialised land and specialised buildings although is adjusted for the community service obligation (CSO) to reflect the specialised nature of the assets being valued. Specialised assets contain significant, unobservable adjustments; therefore these assets are classified as Level 3 under the market based direct comparison approach.
The CSO adjustment is a reflection of the valuer's assessment of the impact of restrictions associated with an asset to the extent that is also equally applicable to market participants. This approach is in light of the highest and best use consideration required for fair value measurement, and takes into account the use of the asset that is physically possible, legally permissible and financially feasible. As adjustments of CSO are considered as significant unobservable inputs, specialised land would be classified as Level 3 assets.
For the health services, the depreciated replacement cost method is used for the majority of specialised buildings, adjusting for the associated depreciation. As depreciation adjustments are considered as significant and unobservable inputs in nature, specialised buildings are classified as Level 3 for fair value measurements.
An independent valuation of the Health Service's specialised land and specialised buildings was performed by the Valuer-General Victoria. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation is 30 June 2014.
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 is 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 2017.
For all assets measured at fair value, the current use is considered the highest and best use.

(d) Reconciliation of Level 3 fair value

2017	Land	Buildings	Plant and equipment	Medical equipment
	$	$	$	$
Opening Balance	158,000	9,269,440	543,167	96,074
Purchases (sales)	0	96,464	12,324	0
Transfers in (out) of Level 3	0	0	0	0
Gains or losses recognised in net result				
- Depreciation	0	(597,565)	(135,875)	(32,975)
Unrealised gains/(losses) on non-financial assets	0	0	(24,114)	0
	158,000	8,768,339	395,502	63,099

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

2016	Land	Buildings	Plant and equipment	Medical equipment
	$	$	$	$
Opening Balance	158,000	9,588,517	654,861	95,324
Purchases (sales)	0	259,836	97,314	28,446
Transfers in (out) of Level 3	0	0	0	0
Gains or losses recognised in net result				
- Depreciation	0	(578,913)	(136,765)	(27,696)
Items recognised in other comprehensive income				
- Revaluation	0	0	0	0
Unrealised gains/(losses) on non-financial assets	0	0	(72,243)	0
	158,000	9,269,440	543,167	96,074

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

NOTE 4.3: PROPERTY, PLANT & EQUIPMENT (Continued)
(e) Description of significant unobservable inputs to Level 3 valuations:

	Valuation technique	Significant unobservable inputs
Specialised land	**Market approach**	Community Service Obligation (CSO)
Specialised buildings	**Depreciated replacement cost**	Direct cost per square metre
		Useful life of specialised buildings
Plant and equipment at fair value	**Depreciated replacement cost**	Cost per unit
		Useful life of PPE
Vehicles	**Depreciated replacement cost**	Cost per unit
		Useful life of vehicles
Medical equipment at fair value	**Depreciated replacement cost**	Cost per unit
		Useful life of medical equipment

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.

Property, Plant and Equipment

All non-current physical assets are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and impairment. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. Assets transferred as part of a merger or machinery of government are transferred at their carrying amount. More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 4.3 Property, plant and equipment.

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 constructive 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 restriction will no longer apply.

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

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

Revaluations of Non-current Physical Assets

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

Revaluation increments are 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 immediately as expenses in the net result, except that, to the extent that a credit balance exists in the asset revaluation surplus in respect of the same class of assets, they are debited directly to the asset revaluation surplus.

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 derecognition of the relevant asset.

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 4.4: DEPRECIATION	2017	2016
	$	**$**
Depreciation		
Buildings	597,565	578,913
Plant & Equipment	74,039	65,585
Motor Vehicles	55,504	65,218
Medical Equipment	32,975	27,696
Furniture and Fittings	6,332	5,962
TOTAL DEPRECIATION	**766,415**	**743,374**

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

Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives, residual value and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health and Human Services. Assets with a cost in excess of $1,000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

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

	2017	**2016**
Buildings		
- Structure Shell Building Fabric	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 7 years	3 to 7 years
Medical Equipment	7 to 10 years	7 to 10 years
Computers and Communication	3 years	3 years
Furniture & Fittings	13 years	13 years
Motor Vehicles	10 years	10 years
Leasehold Improvements	6 to 7 years	6 to 7 years

NOTE 5: OTHER ASSETS AND LIABILITIES

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

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

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

NOTE 5.1: RECEIVABLES

	2017	2016
CURRENT	$	$
Contractual		
Trade Debtors	78,443	163,659
Patient Fees	185,044	168,916
Loddon Mallee Rural Health Alliance Receivables	5,217	4,256
Accrued Revenue	154,040	27,263
Less Allowance for Doubtful Debts		
Trade Debtors	(12,151)	(26,085)
	410,593	338,009
Statutory		
GST Receivable - Health Service	9,469	24,513
Loddon Mallee Rural Health Alliance GST Receivable	2,804	2,369
	12,273	26,882
TOTAL CURRENT RECEIVABLES	422,866	364,891
NON CURRENT		
Statutory		
Long Service Leave - Department of Health and Human Services	216,050	196,259
TOTAL NON-CURRENT RECEIVABLES	216,050	196,259
TOTAL RECEIVABLES	**638,916**	**561,150**

(a) Movement in the Allowance for doubtful debts	2017	2016
	$	$
Balance at beginning of year	26,085	18,114
Amounts written off during the year	23,934	0
Increase in allowance recognised in net result	10,000	7,971
Balance at end of year	**12,151**	**26,085**

(b) Ageing analysis of receivables
Please refer to note 7.1 for the ageing analysis of receivables

(c) Nature and extent of risk arising from receivables
Please refer to note 7.1 for the nature and extent of credit risk arising from contractual receivables

Receivables

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

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

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

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

NOTE 5.2: OTHER LIABILITIES

	2017 $	2016 $
CURRENT		
Monies Held in Trust*		
- Patient Monies Held in Trust	73,127	82,732
- Accommodation Bonds (Refundable Entrance Fees)	1,886,921	1,480,398
- Other Monies Held in Trust	36,874	33,179
TOTAL CURRENT	**1,996,922**	**1,596,309**
*** Total Monies Held in Trust**		
Represented by the following assets:		
Cash Assets (refer to Note 6.1	718,865	50,709
Other Financial Assets (refer to Note 4.1)	1,278,057	1,545,600
TOTAL	**1,996,922**	**1,596,309**

NOTE 5.3: PREPAYMENTS AND OTHER ASSETS

	2017 $	2016 $
Health Service Prepayments	15,030	11,362
Loddon Mallee Rural Health Alliance Prepayments	14,539	12,191
TOTAL OTHER ASSETS	**29,569**	**23,553**

NOTE 5.4: PAYABLES

	2017 $	2016 $
CURRENT		
Contractual		
Trade Creditors	120,158	76,858
Accrued Audit Fees	15,120	15,100
Loddon Mallee Rural Health Alliance Payables	28,267	25,395
Salary Packaging	29,838	38,266
Superannuation	30,353	0
Other	128,808	34,476
	352,544	**190,095**
Statutory		
Department of Health and Human Services	57,400	57,400
FBT Payable	2,430	2,430
PAYG Withheld	60,024	54,498
	119,854	**114,328**
TOTAL PAYABLES	**472,398**	**304,423**

(a) Maturity analysis of payables
Please refer to Note 7.1 for the ageing analysis of contractual payables
(b) Nature and extent of risk arising from payables
Please refer to note 7.1 for the nature and extent of risks arising from contractual payables

Payables consist of:
• contractual payables which consist predominantly of accounts payable representing liabilities for goods and services provided to the health service prior to the end of the financial year that are unpaid, and arise when the health service becomes obliged to make future payments in respect of the purchase of those goods and services. The normal credit terms for accounts payable are usually Nett 30 days.
• statutory payables, such as goods and services tax and fringe benefits tax payables.

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

NOTE 6: HOW WE FINANCE OUR OPERATIONS

This section provides information on the sources of finance utilised by the hospital 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

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

	2017 $	2016 $
Cash on Hand	1,650	1,650
Cash at Bank	1,106,434	254,910
TOTAL CASH AND CASH EQUIVALENTS	**1,108,084**	**256,560**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	348,705	201,400
Cash for Loddon Mallee Rural Health Alliance	40,014	4,451
Cash for Monies Held in Trust		
- Cash on Hand	500	500
- Cash at Bank	718,865	50,209
TOTAL CASH AND CASH EQUIVALENTS	**1,108,084**	**256,560**

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 and are subject to insignificant risk of changes in value.

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

NOTE 6.2: COMMITMENTS FOR EXPENDITURE

There are no known commitments for expenditure at the date of this report.

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 goods and services tax ("GST") payable. In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant individual projects are stated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

NOTE 7: RISKS, CONTINGENCIES & VALUATION UNCERTAINTIES

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

Structure
7.1 Financial instruments
7.2 Net gain/ (loss) on disposal of non-financial assets
7.3 Contingent assets and contingent liabilities

NOTE 7.1: FINANCIAL INSTRUMENTS

(a) Financial Risk Management Objectives and Policies
The Inglewood & Districts Health Service's principal financial instruments comprise of:
- Cash Assets
- Term Deposits
- Receivables (excluding statutory receivables)
- Investments in Equities and Managed Investment Schemes
- Payables (excluding statutory receivables)
- Accommodation Bonds

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

The health service's main financial risks include credit risk, liquidity risk, interest rate risk, and equity price risk. The health service manages these financial risks in accordance with its financial risk management policy.

The health service uses different methods to measure and manage the different risks to which it is exposed. Primary responsibility for the identification and management of financial risks rests with the Audit & Risk Committee of the health service.

The main purpose in holding financial instruments is to prudentially manage Inglewood & Districts Health Service financial risks within the government policy parameters.

Categorisation of financial instruments
Details of each category in accordance with AASB 139, is disclosed either on the face of the balance sheet or in the notes.

2017	Contractual financial assets - loans and receivables	Contractual financial liabilities at amortised cost	Contractual financial assets - available for sale	Total
		$	$	$
Financial Assets				
Cash and cash equivalents	1,108,084	0	0	1,108,084
Receivables				
- Trade Debtors	66,292	0	0	66,292
- Other receivables	344,301	0	0	344,301
Other Financial Assets				
-Term Deposit	968,080	0	0	968,080
- Shares in Other Entities	0	0	726,405	726,405
Total Financial Assets (i)	**2,486,757**	**0**	**726,405**	**3,213,162**
Financial Liabilities				
Payables	0	352,544	0	352,544
Other Financial Liabilities				
- Accommodation Bonds	0	1,886,921	0	1,886,921
- Other	0	110,001	0	110,001
Total Financial Liabilities (ii)	**0**	**2,349,466**	**0**	**2,349,466**

(i) The total amount of financial assets disclosed here excludes statutory receivables (i.e. GST input tax credit recoverable)
(ii) The total amount of financial liabilities disclosed here excludes statutory payables (i.e. Taxes payable)

NOTE 7.1: FINANCIAL INSTRUMENTS (Cont'd)
(a) Financial Risk Management Objectives and Policies (Cont'd)

2016	Contractual financial assets - loans and receivables	Contractual financial liabilities at amortised cost	Contractual financial assets - available for sale	Total
		$	$	$
Financial Assets				
Cash and cash equivalents	256,560	0	0	256,560
Receivables				
- Trade Debtors	137,574	0	0	137,574
- Other Receivables	200,435	0	0	200,435
Other Financial Assets				
-Term Deposit	1,265,977	0	0	1,265,977
- Shares in Other Entities	0	0	719,905	719,905
Total Financial Assets (i)	**1,860,546**	**0**	**719,905**	**2,580,451**
Financial Liabilities				
Payables	0	0	190,095	190,095
Other Financial Liabilities				
- Accommodation Bonds	0	0	1,480,398	1,480,398
- Other	0	0	115,911	115,911
Total Financial Liabilities (ii)		**0**	**1,786,404**	**1,786,404**

(i) The total amount of financial assets disclosed here excludes statutory receivables (i.e. GST input tax credit recoverable)
(ii) The total amount of financial liabilities disclosed here excludes statutory payables (i.e. Taxes payable)

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

	Net Holding Gain/(Loss) 2017 $	**Net Holding Gain/(Loss)** 2016 $
Financial Assets		
Loans and Receivables	90,059	108,106
Available for sale (i)	16,156	8,815
Total Financial Assets	**16,156**	**8,815**
Financial Liabilities		
At amortised cost (ii)	0	0
Total Financial Liabilities	**0**	**0**

(i) For cash and cash equivalents, loans or receivables and available-for-sale financial assets, the net gain or loss is calculated by taking 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; and
(ii) For financial liabilities measure at amortised cost, the net gain or loss is calculated by taking the interest expense, plus or minus foreign exchange gains or losses arising from the revaluation of financial liabilities measured at amortised cost.
(iii) For financial assets and liabilities that are held for trading, the net gain or loss is calculated by taking the movement in the fair value of the financial assets or liability

(c) Credit Risk

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

Credit risk associated with the Health Service's contractual financial assets is minimal because the main debtor is the Victorian Government.

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

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

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
(c) Credit Risk (Continued)

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

2017	Financial Institutions (Minimum A- credit rating) $	Government agencies (AAA credit rating) $	Government agencies (BBB credit rating) $	Other $	Total $
Financial Assets					
Cash and Cash Equivalents	1,108,084	0	0	0	1,108,084
Loans and Receivables (i)					
- Trade Debtors	0	0	0	66,292	66,292
- Other Receivables	0	0	0	344,301	344,301
- Term Deposit	968,080	0	0	0	968,080
- Shares in Other Entities	0	0	0	726,405	726,405
Total Financial Assets	2,076,164	0	0	1,136,998	3,213,162
2016					
Financial Assets					
Cash and Cash Equivalents	256,560	0	0	0	256,560
Loans and Receivables (i)					
- Trade Debtors	0	0	0	137,574	137,574
- Other Receivables	0	0	0	200,435	200,435
- Term Deposit	1,265,977	0	0	0	1,265,977
- Shares in Other Entities	0	0	0	719,905	719,905
Total Financial Assets	1,522,537	0	0	1,057,914	2,580,451

(i) The total amounts disclosed here exclude statutory amounts (e.g. amounts owing from Victorian Government and GST input tax credit recoverable).

Ageing analysis of financial asset as at 30 June

			Past Due But Not Impaired				
2017	**Carrying Amount** $	**Not Past due and not impaired** $	**Less than 1 Month** $	**1 - 3 Months** $	**3 Months - 1 Year** $	**1 - 5 Years** $	**Impaired Financial Assets** $
Financial Assets							
Cash and Cash Equivalents	1,108,084	1,108,084	0	0	0	0	0
Loans and Receivables							
- Trade Debtors	66,292	26,517	19,888	13,258	6,629	0	0
- Other Receivables	344,301	137,721	103,290	68,860	34,430	0	0
- Term Deposit	968,080	968,080	0	0	0	0	0
- Shares in Other Entities	726,405	726,405	0	0	0	0	0
Total Financial Assets	**3,213,162**	**2,966,807**	**123,178**	**82,118**	**41,059**	**0**	**0**
2016							
Financial Assets							
Cash and Cash Equivalents	256,560	256,560	0	0	0	0	0
Loans and Receivables							
- Trade Debtors	137,574	112,213	5,621	1,758	17,982	0	0
- Other Receivables	200,435	163,485	8,189	2,562	26,199		
- Term Deposit	1,265,977	1,265,977	0	0	0	0	0
- Shares in Other Entities	719,905	719,905	0	0	0	0	0
Total Financial Assets	**2,580,451**	**2,518,140**	**13,810**	**4,320**	**44,181**	**0**	**0**

Contractual financial assets that are either past due or impaired

There are no material financial assets which are individually determined to be impaired. Currently Inglewood & Districts Health Service does not hold any collateral as security nor credit enhancements relating to any of its financial assets.

There are no financial assets that have had their terms renegotiated so as to prevent them from being past due or impaired, and they are stated at the carrying amount as indicated. The ageing analysis table above discloses the ageing only of contractual financial assets that are past due but not impaired.

(d) Liquidity Risk

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
(d) Liquidity Risk (Continued)

The Health Service's maximum exposure to liquidity risk is the carrying amounts of financial liabilities as disclosed in the face of the balance sheet. The Health Service manages its liquidity risk by rolling term deposits evenly throughout the year and utilising the State Governments High Yield Investment Account.

The following table discloses the contractual maturity analysis for Inglewood & Districts Health Service's financial liabilities. For interest rates applic each class of liability refer to individual notes to the financial statements.

Maturity analysis of financial liabilities as at 30 June

			Maturity Dates			
	Carrying Amount	Nominal Amount	Less than 1 Month	1 - 3 Months	3 Months - 1 Year	1 - 5 Years
2017	$	$	$	$	$	$
Financial Liabilities						
Payables	352,544	352,544	352,544	0	0	0
Other Financial Liabilities						
- Accommodation Bonds	1,886,921	1,886,921	0	0	1,886,921	0
- Other	110,001	110,001	110,001	0	0	0
Total Financial Liabilities	**2,349,466**	**2,349,466**	**462,545**	**0**	**1,886,921**	**0**
2016						
Financial Liabilities						
Payables	190,095	190,095	190,095	0	0	0
Other Financial Liabilities						
- Accommodation Bonds	1,480,398	1,480,398	0	0	1,480,398	0
- Other	115,911	115,911	115,911	0	0	0
Total Financial Liabilities	**1,786,404**	**1,786,404**	**306,006**	**0**	**1,480,398**	**0**

(e) Market Risk
Inglewood & Districts Health Service's exposures to market risk are primarily through interest rate risk with only insignificant exposure to foreign currency and other price risks. Objectives, policies and processes used to manage each of these risks are disclosed in the paragraph below.

Currency Risk
Inglewood & Districts Health Service is exposed to insignificant foreign currency risk through its payables relating to purchases of supplies and consumables from overseas. This is because of a limited amount of purchases denominated in foreign currencies and a short timeframe between commitment and settlement.

Interest Rate Risk
Exposure to interest rate risk's arise primarily through the Inglewood & Districts Health Service's other financial assets. Minimisation of risk is achieved by mainly holding fixed rate or non-interest bearing financial instruments. For financial liabilities the Health Service mainly holds financial liabilities with relatively even maturity profiles.

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

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

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

Other Price Risk
The Health Servicel is exposed to normal price fluctuations from time to time through market forces. Where adequate notice is provided by suppliers, additional purchases are made for long term goods. Supplier contracts are also in place for major product lines purchased by the Health Service on a monthly basis. These contracts have set price arrangements and are reviewed on a regular basis.

The Health Service has investments in direct shares and managed funds. Changes in market prices, such as share prices, effect the Health Service income. The Health Service manages the risk by reviewing the mnovements on a monthly basis and reviewing longer term projections.

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
Interest Rate Exposure of Financial Assets and Liabilities as at 30 June

2017	Weighted Average Effective Interest Rate (%)	Carrying Amount $	Interest Rate Exposure		
			Fixed Interest Rate $	Variable Interest Rate $	Non - Interest Bearing $
Financial Assets					
Cash and Cash Equivalents	1.65	1,108,084	0	1,106,434	1,650
Receivables					
- Trade Debtors		66,292	0	0	66,292
- Other Receivables		344,301	0	0	344,301
- Term Deposit	2.26	968,080	876,580	91,500	0
Available for sale					
- Shares and Managed Funds		726,405	0	0	726,405
Total Financial Assets		**3,213,162**	**876,580**	**1,197,934**	**1,138,648**
Financial Liabilities					
Payables		352,544	0	0	352,544
Other Financial Liabilities					
- Accommodation Bonds		1,886,921	0	0	1,886,921
- Other		110,001	0	0	110,001
Total Financial Liabilities		**2,349,466**	**0**	**0**	**2,349,466**
2016					
Financial Assets					
Cash and Cash Equivalents	1.90	256,560	0	254,910	1,650
Receivables					
- Trade Debtors		137,574	0	0	137,574
- Other Receivables		200,435	0	0	200,435
- Term Deposit	2.48	1,265,977	1,149,562	116415	0
Available for sale					
- Shares and Managed Funds		719,905	0	0	719,905
Total Financial Assets		**2,580,451**	**1,149,562**	**371,325**	**1,059,564**
Financial Liabilities					
Payables		190,095	0	0	190,095
Other Financial Liabilities					
- Accommodation Bonds		1,480,398	0	0	1,480,398
- Other		115,911	0	0	115,911
Total Financial Liabilities		**1,786,404**	**0**	**0**	**1,786,404**

Sensitivity Disclosure Analysis
Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, Inglewood & Districts Health Service believes the following movements are 'reasonably possible' over the next 12 months (base rates are sourced from the Bendigo Bank).
- A parallel shift of +1% and -1% in market interest rates (AUD) from year-end rates of 3.45%;
- A parallel shift of +1% and -1% in inflation rate from year-end rates of 2%

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(e) Market Risk (Continued)

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

	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-1%		+1%		-10%		+10%	
		Profit	Equity	Profit	Equity	Profit	Equity	Profit	Equity
2017	$	$	$	$	$	$	$	$	$
Financial Assets									
Cash and Cash Equivalents (i)	1,108,084	(11,064)	(11,064)	11,064	11,064	0	0	0	0
Receivables									
- Trade Debtors	66,292	0	0	0	0	0	0	0	0
- Other Receivables	344,301	0	0	0	0	0	0	0	0
- Term Deposit	968,080	(9,681)	(9,681)	9,681	9,681	0	0	0	0
Available for sale									
- Shares and Managed Funds	726,405	0	0	0	0	(72,641)	(72,641)	72,641	72,641
Financial Liabilities									
Payables	352,544	0	0	0	0	0	0	0	0
Other Financial Liabilities									
- Accommodation Bonds	1,886,921	0	0	0	0	0	0	0	0
- Other	110,001	0	0	0	0	0	0	0	0
		(20,745)	**(20,745)**	**20,745**	**20,745**	**(72,641)**	**(72,641)**	**72,641**	**72,641**
2016									
Financial Assets									
Cash and Cash Equivalents(i)	256,560	(2,549)	(2,549)	2,549	2,549	0	0	0	0
Receivables									
- Trade Debtors	137,574	0	0	0	0	0	0	0	0
- Other Receivables	200,435	0	0	0	0	0	0	0	0
- Term Deposit	1,265,977	(12,660)	(12,660)	12,660	12,660	0	0	0	0
Available for sale									
- Shares and Managed Funds	719,905	0	0	0	0	(71,991)	(71,991)	71,991	71,991
Financial Liabilities									
Payables	190,095	0	0	0	0	0	0	0	0
Other Financial Liabilities									
- Accommodation Bonds	1,480,398	0	0	0	0	0	0	0	0
- Other	115,911	0	0	0	0	0	0	0	0
		(15,209)	**(15,209)**	**15,209**	**15,209**	**(71,991)**	**(71,991)**	**71,991**	**71,991**

(f) Fair Value

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

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

The financial assets include holdings in unlisted shares. Fair value of these is determined by projecting future cash inflows from expected future dividends and subsequent disposals of the securities. These cash flows are then discounted back to their present value using a discount rate of 4.31 per cent.

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
(f) Fair Value (Continued)

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

Comparison between carrying amount and fair value

	Carrying Amount 2017 $	Fair Value 2017 $	Carrying Amount 2016 $	Fair Value 2016 $
Financial Assets				
Cash and Cash Equivalents	1,108,084	1,108,084	256,560	256,560
Receivables (i)				
- Trade Debtors	66,292	66,292	137,574	137,574
- Other Receivables	344,301	344,301	200,435	200,435
- Term Deposit	968,080	968,080	1,265,977	1,265,977
Available for sale				
- Shares and Managed Funds	726,405	726,405	719,905	719,905
Total Financial Assets	**3,213,162**	**3,213,162**	**2,580,451**	**2,580,451**
Financial Liabilities				
Payables	352,544	352,544	190,095	190,095
Other Financial Liabilities (i)				
-Accommodation Bonds	1,886,921	1,886,921	1,480,398	1,480,398
-Other	110,001	110,001	115,911	115,911
Total Financial Liabilities	**2,349,466**	**2,349,466**	**1,786,404**	**1,786,404**

(i) The carrying amount excludes statutory financial assets and liabilities (i.e. GST input tax credit and GST payable)

2017	Carrying amount as at 30 June	Fair value measurement at end of reporting period using: Level 1	Level 2	Level 3
Financial assets at fair value through profit or loss	$	$	$	$
Equities and Managed Funds	726,405	721,405	5,000	0
Total Financial Assets	**726,405**	**721,405**	**5,000**	**0**
2016				
Financial assets at fair value through profit or loss				
Equities and Managed Funds	719,905	714,905	5,000	0
Total Financial Assets	**719,905**	**714,905**	**5,000**	**0**

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

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
(f) Fair Value (Continued)

The following refers to financial instruments unless otherwise stated.

Categories of non-derivative financial instruments

Loans and receivables

Loans and receivables are financial instrument assets with fixed and determinable payments that are not quoted on an active market.

These assets are initially recognised at fair value plus any directly attributable transaction costs. Subsequent to initial measurement, loans and receivables are measured at amortised cost using the effective interest method, less any impairment.

Loans and receivables category includes cash and deposits, term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

Available-for-sale financial assets

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

Financial liabilities at amortised cost

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

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

NOTE 7.2: NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS	2017 $	2016 $
Proceeds from Disposal of Non-Current Assets		
- Land and Buildings	0	0
- Motor Vehicles	24,000	63,000
Total Proceeds from Disposal of Non-Current Assets	**24,000**	**63,000**
Less: Written Down Value of Non-Current Assets Sold		
- Motor Vehicles	24,114	72,243
Total Written Down Value of Non-Current Assets Sold	**24,114**	**72,243**
NET GAINS/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS	**(114)**	**(9,243)**

Disposal of Non-Financial Assets
Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement.

Impairment of Non-Financial Assets
All assets are assessed annually for indications of impairment, except for:
• inventories;
• assets arising from construction contracts.

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

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

It is deemed that, in the event of the loss or destruction of an asset, the future economic benefits arising from the use of the asset will be replaced unless a specific decision to the contrary has been made. The recoverable amount for most assets is measured at the higher of depreciated replacement cost and fair value less costs to sell. Recoverable amount for assets held primarily to generate net cash inflows is

NOTE 7.3: CONTINGENT ASSETS AND CONTINGENT LIABILITIES

There are no known contingent assets or liabilities at the date of this report.

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

NOTE 8: OTHER DISCLOSURES

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

Structure
8.1 Equity
8.2 Reconciliation of net result for the year to net cash inflow/(outflow) from operating activities
8.3 Operating segments
8.4 Responsible persons disclosures
8.5 Executive officer disclosures
8.6 Related parties
8.7 Remuneration of auditors
8.8 AASBs issued that are not yet effective
8.9 Events occurring after the balance sheet date

NOTE 8.1: EQUITY

	2017 $	2016 $
(a) Surpluses		
Property, Plant & Equipment Revaluation Surplus		
Balance at beginning of the reporting period	8,201,358	8,201,358
Balance at the end of the reporting period	**8,201,358**	**8,201,358**
Represented by:		
- Land	37,456	37,456
- Buildings	6,822,372	6,822,372
- Other	1,341,530	1,341,530
	8,201,358	**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	**16**	**5,818**
Valuation gain/(loss) recognised	6,478	(5,802)
Balance at the end of the reporting period	**6,494**	**16**
Total Surpluses	**8,858,201**	**8,851,723**
(b) Contributed Capital		
Balance at the beginning of the reporting period	5,284,700	5,284,700
Capital Repayments	0	0
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	(4,425,691)	(3,262,610)
Net Result for the Year	(646,119)	(1,163,081)
Balance at the end of the reporting period	**(5,071,810)**	**(4,425,691)**
Total Equity at end of financial year	**9,071,091**	**9,710,732**

NOTE 8: OTHER DISCLOSURES (Continued)
NOTE 8.1: EQUITY (Continued)

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 or distributions that have been designated as contributed capital are also treated as contributed capital.

Property, Plant & Equipment Revaluation Surplus

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

Financial Asset Available-for-Sale Revaluation Surplus

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

General Purpose Surplus

No general purpose surpluses are in existence at the date of this report.

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 NET RESULT FOR THE YEAR TO NET CASH INFLOWS/(OUTFLOWS) FROM OPERATING ACTIVITIES

	2017 $	2016 $
NET RESULT FOR THE PERIOD	(646,119)	(1,163,081)
Depreciation	766,415	743,374
Share of Net Result from Joint Venture	(13,128)	8,798
Net (Gain)/Loss from Disposal of Plant and Equipment	114	9,243
Change in Operating Assets & Liabilities		
(Increase)/Decrease in Receivables	(73,496)	8,742
(Increase)/Decrease in Prepayments	(3,668)	25,543
Increase/(Decrease) in Payables	162,231	(53,868)
Increase/(Decrease) in Provisions	33,221	(93,520)
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**225,570**	**(514,769)**

NOTE 8.3: OPERATING SEGMENTS

	ACUTE		RACS		OTHER SERVICES		TOTAL	
	2017	2016	2017	2016	2017	2016	2017	2016
	$	$	$	$	$	$	$	$
REVENUE								
External Segment Revenue	2,248,112	2,076,779	2,841,812	2,517,192	1,790,984	1,543,509	6,880,908	6,137,480
Total Revenue	**2,248,112**	**2,076,779**	**2,841,812**	**2,517,192**	**1,790,984**	**1,543,509**	**6,880,908**	**6,137,480**
EXPENSES								
External Segment Expenses	2,118,583	2,233,398	2,763,968	2,516,532	2,766,518	2,667,552	7,649,069	7,417,482
Total Expenses	**2,118,583**	**2,233,398**	**2,763,968**	**2,516,532**	**2,766,518**	**2,667,552**	**7,649,069**	**7,417,482**
Net Result from ordinary activities	**129,529**	**(156,619)**	**77,844**	**660**	**(975,534)**	**(1,124,043)**	**(768,161)**	**(1,280,002)**
Interest Income	106,215	116,921	0	0	15,827	0	122,042	116,921
Net Result for Year	**235,744**	**(39,698)**	**77,844**	**660**	**(959,707)**	**(1,124,043)**	**(646,119)**	**(1,163,081)**
OTHER INFORMATION								
Segment Assets	5,835,751	5,640,688	4,399,109	4,034,045	2,967,134	3,565,093	13,201,994	13,239,826
Total Assets	**5,835,751**	**5,640,688**	**4,399,109**	**4,034,045**	**2,967,134**	**3,565,093**	**13,201,994**	**13,239,826**
Segment Liabilities	529,899	502,565	2,830,632	2,430,019	770,372	596,510	4,130,903	3,529,094
Total Liabilities	**529,899**	**502,565**	**2,830,632**	**2,430,019**	**770,372**	**596,510**	**4,130,903**	**3,529,094**
Acquisition of property, plant and equipment and intangible assets	79,058	284,124	3,241	11,648	24,883	89,424	107,182	385,196
Depreciation & amortisation expense	476,326	462,006	224,568	217,817	65,521	63,552	766,415	743,374
Non cash expenses other than depreciation	28,026	(624)	0	0	0	0	28,026	(624)

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

Business Segments	**Services**
Acute	Acute Hospital services
Residential Aged Care	Nursing Home facilities Hostel facilities
Other	Primary Health services

Geographical Segment
Inglewood & Districts Health Service operates predominantly in Inglewood, Victoria. More than 90% of revenue, net surplus from ordinary activities and segment assets relate to operations in Inglewood, Victoria.

NOTE 8.4: RESPONSIBLE PERSON 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.

	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	01/07/2016 - 30/06/2017
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	01/07/2016 - 30/06/2017
Governing Boards	
Mr Peter Moore	01/07/2016 - 30/06/2017
Mrs Anne Canfield	01/07/2016 - 30/06/2017
Mr Ian Penny	01/07/2016 - 30/06/2017
Mrs Carol Gibbins	01/07/2016 - 30/06/2017
Mrs Catherine Norman	01/07/2016 - 30/06/2017
Mrs Vannessa Hicks	01/07/2016 - 30/06/2017
Mrs Susan McChonnachie	01/07/2016 - 30/06/2017
Mrs Robyn Vella	01/07/2016 - 30/06/2017
Accountable Officers	
Mr Mike Parker	01/7/2016 - 05/04/2017
Mrs Kathy Huett	01/5/2016 - 30/06/2017

Remuneration of Responsible Persons
The remuneration received or receivable by the responsible persons was in the range of $390,000 - $399,999 ($180,000 - 189,999 in 2015-16).

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

Note 8.5: Executive Officer Disclosures

Executive Officers' Remuneration

The number of executive officers, other than Ministers and Accoutable 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 for 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.

Remuneration	**2017**	**2016**
Short-term benefits	139,359	145,966
Post-employment benefits	11,445	11,901
Total Remuneration	**150,804**	**157,867**
Total number of executives	1	1
Total annualised employee equivalent	1	1

Note 8.6: Related parties

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

- all key management personnel and their close family members;

- all cabinet ministers and their close family members; and

- all health service and public sector entities that are controlled and consolidated into the whole of state consolidated financial statements.

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

Key management personnel (KMP) of the hospital include the Portfolio Ministers and Cabinet Ministers and KMP as determined by the hospital. The KMP determined by the Hospital are the Board and CEO as listed above. The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The Minister's remuneration and allowances is set by the *Parliamentary Salaries and Superannuation Act 1968*, and is reported within the Department of Parliamentary Services' Financial Report.

Key management personnel consist of responsible ministers, the board of management and accountable officers as detailed in Note 8.4.

Remuneration	**2017**
	$
Short-term benefits	273,534
Post-employment benefits	31,854
Termination benefits	90,983
Total Remuneration	**396,371**

Transactions with key management personnel and other related parties

Given the breadth and depth of State government activities, related parties transact with the Victorian public sector in a manner consistent with other members of the public e.g. stamp duty and other government fees and charges. Further employment of processes within the Victorian public sector occur on terms and conditions consistent with the *Public Administration Act 2004* and Codes of Conduct and Standards issued by the Victorian Public Sector Commission.

Procurement processes occur on terms and conditions consistent with the Victorian Government Procurement Board requirements. Outside of normal citizen type transactions with the department, there were no related party transactions that involved key management personnel except as noted below. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

	2017 $	2016 $
Mr P. Moore is the proprietor of Inglewood IGA Supermarket and Hardware and Inglewood Newsagency which provides goods to the Health Service on normal terms and conditions.	21,894	23,902

Significant transactions with with government related entities

The health service received funding from the Department of Health and Human Services of $3.03 million (2016 $3.31 million).

Note 8.7: Remuneration of auditors

	2017 $	2016 $
Victorian Auditor-General's Office		
Audit or review of financial statement	15,100	14,400

NOTE 8.8: AASs issued that are not yet effective

Certain new Australian accounting standards and interpretations have been published that are not mandatory for 30 June 2016 reporting period. DTF assesses the impact of all these new standards and advises the Health Service of their applicability and early adoption where applicable.

As at 30 June 2017, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. Inglewood & Districts Health Service has not and does not intend to adopt these standards early.

NOTE 8.8: AASs issued that are not yet effective (Continued)

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 hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1-Jan-18	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. While there will be no significant impact arising from AASB 9, there will be a change to the way financial instruments are disclosed.
AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)	The requirements for classifying and measuring financial liabilities were added to AASB 9. The existing requirements for the classification of financial liabilities and the ability to use the fair value option have been retained. However, where the fair value option is used for financial liabilities the change in fair value is accounted for as follows: • The change in fair value attributable to changes in credit risk is presented in other comprehensive income (OCI); and • Other fair value changes are presented in profit and loss. If this approach creates or enlarges an accounting mismatch in the profit or loss, the effect of the changes in credit risk are also presented in profit or loss.	1-Jan-18	The assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss. Changes in own credit risk in respect of liabilities designated at fair value through profit and loss will now be presented within other comprehensive income (OCI). Hedge accounting will be more closely aligned with common risk management practices making it easier to have an effective hedge. For entities with significant lending activities, an overhaul of related systems and processes may be needed.
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 as a consequence of Chapter 6 Hedge Accounting, 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.	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. 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 • the amount can be measured reliably.	1 Jan 2017, 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.

NOTE 8.8: AASs issued that are not yet effective (Continued)

Standard / Interpretation [1]	Summary	Applicable for annual reporting periods beginning on	Impact on public sector entity financial statements
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	This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events. The amendments: • require non-contractual receivables arising from statutory requirements (i.e. taxes, rates and fines) to be initially measured and recognised in accordance with AASB 9 as if those receivables are financial instruments; and • clarifies circumstances when a contract with a customer is within the scope of AASB 15.	1-Jan-19	The assessment has indicated that there will be no significant impact for the public sector, other than the impacts identified for AASB 9 and AASB 15 above.
AASB 16 Leases	The key changes introduced by AASB 16 include the recognition of most operating leases (which are current not recognised) on balance sheet.	1-Jan-19	The assessment has indicated that as most operating leases will come on balance sheet, recognition of the right-of-use assets and lease liabilities will cause net debt to increase. Rather than expensing the lease payments, depreciation of right-of-use assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. No change for lessors.

NOTE 8.8: AASs issued that are not yet effective (Continued)

Standard / Interpretation [1]	Summary	Applicable for annual reporting periods beginning on	Impact on public sector entity financial statements
AASB 2016-4 Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities	The standard amends AASB 136 Impairment of Assets to remove references to using depreciated replacement cost (DRC) as a measure of value in use for not-for-profit entities.	1-Jan-17	The assessment has indicated that there is minimal impact. Given the specialised nature and restrictions of public sector assets, the existing use is presumed to be the highest and best use (HBU), hence current replacement cost under AASB 13 Fair Value Measurement is the same as the depreciated replacement cost concept under AASB 136.
AASB 1058 Income of Not-for-Profit Entities	This standard replaces AASB 1004 Contributions and establishes revenue recognition principles for transactions where the consideration to acquire an asset is significantly less than fair value to enable to not-for-profit entity to further its objectives.	1-Jan-19	The assessment has indicated that revenue from capital grants that are provided under an enforceable agreement that have sufficiently specific obligations, will now be deferred and recognised as performance obligations are satisfied. As a result, the timing recognition of revenue will change.

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 2016-17 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 2016-1 *Amendments to Australian Accounting Standards – Recognition of Deferred Tax Assets for Unrealised Losses* [AASB 112]
- AASB 2016-2 *Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107*
- 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 2017-2 *Amendments to Australian Accounting Standards – Further Annual Improvements 2014-16 Cycle*

Note 8.9: Events Occurring after the Balance Sheet Date

There are no known events that have occurred after the balance sheet date that would require adjustment to or disclosure in the financial statements.