STAWELL REGIONAL HEALTH

2016/2017 ANNUAL REPORT

Organisational Values

TRUST
We act openly and honestly as individuals and as a team.

RESPECT
We treat each other with respect and courtesy and value the opinions and contributions of others.

ACCOUNTABILITY
We each take personal responsibility for our decisions and actions.

COMMUNICATION
We encourage the sharing of information within our team and with the community.

SAFETY
We are committed to the safety of our workforce and our customers.

STAWELL REGIONAL HEALTH

Contents

Our Profile

Stawell Regional Health is located in Stawell, 236 kms North West of Melbourne. We are located approximately 24kms from the Grampians National Park.

Stawell Regional Health has been providing quality health care to families in the Stawell district and beyond for more than 150 years.

Our facilities – including helipad – together with a complete suite of integrated health services, are backed by a committed and caring team of highly respected medical professionals, visiting specialists, nursing, allied health and support staff.

We have an acute ward, Day Procedure unit, Operating Theatres and an Urgent Care Centre. These areas are supported by Medical Imaging, Pharmacy and Pathology. Our Radiology service includes a cutting edge 64 slice CT scanner.

Stawell Regional Health also offers a state of the art Community Rehabilitation and Oncology Centre.

Key clinical services include Post-Acute Care, Chemotherapy, Diabetes Education, Dietetics, Exercise Physiology, Speech Pathology, Physiotherapy, Occupational Therapy, Podiatry and Social Work, whilst our outreach programs include District Nursing.

We support our community by providing residential aged care in Macpherson Smith Residential Care.

Stawell Regional Health is one of rural Victoria's leading health care providers, a long-standing status made possible with the ongoing, generous support of our vibrant local community.

How to contact us

27-29 Sloane Street
Stawell, Vic 3380

PO Box 800
Stawell, Vic 3380

03 5358 8500

info@srh.org.au

www.srh.org.au

Our Vision, Mission and Strategic Directions:

Our Vision:

Caring for our Community

Our Mission:

In partnership with our community, Stawell Regional Health will deliver high quality care and improve health outcomes by providing safe, accessible and integrated services.

To achieve our Vision and Mission, we will focus on the following strategic directions:

1. **Service**
   Deliver innovative, community-focused and responsive health service provision for the future.
2. **Sustainability**
   Ensure a sustainable future for Stawell Regional Health
3. **Partnerships**
   Develop and enhance strategic partnerships to strengthen service access and service integration and
4. **Community**
   Foster an informed and involved community.

President's Report

Stawell Regional Health has enjoyed a productive year on many fronts. Through continued collaboration with regional centres and universities, we have been able to provide new and expanded services to the people of our community and region, and provide training opportunities to our existing staff and health workers of the future. We are proud of our achievements, and provide you with some highlights below.

The hospital has worked hard towards achieving the targets agreed to between the Department of Health and Human Services and the Board in the Statement of Priorities. Difficulties with newly-installed infrastructure resulted in an extended unplanned theatre closure. The theatre team worked hard to ensure that patients were not disadvantaged by the theatre closure. The closure did have an impact on our overall activity levels, which is reflected in our financial result this year. Despite this, Stawell Regional Health continues to maintain a strong financial position with significant resources available.

As a hospital ages, it requires further capital investment. We are fortunate the Department of Health and Human Services provided $220k to replace the steriliser in the Central Sterilising Department of the operating theatre. Other capital investments included installation of overhead tracking in Macpherson Smith Residential Care to increase resident and staff safety, and installation of anchors and protective railings on the roofs of both the acute hospital and Macpherson Smith Residential Care to provide additional safety for our maintenance staff and contractors.

The expansion of oncology services in partnership with both Ballarat Regional Integrated Cancer Service and Ballarat and Austin Radiation Oncology service has continued.

We increased our surgical activity in the latter part of the year, providing greater opportunities for people requiring eye surgeries. As part of this activity, we welcomed Dr David McKnight back to Stawell.

Our student placement program has grown from strength to strength. In the past 12 months we provided high quality placements for enrolled and registered student nurses, and students of occupational therapy, radiology, podiatry, physiotherapy, exercise physiology, dietetics, allied health assistance and medicine. We were also pleased to welcome two medical students and two General Practitioner registrars to the Stawell Medical Centre for the year.

We invested in our staff by providing organisation-wide training to increase our understanding of mental health and well-being, including how to recognise and support co-workers and community members facing challenges.

Staff were also provided with training in managing occupational aggression, a growing concern for health workers.

We have focussed on increasing the level of consumer participation this year, and have welcomed community representatives on our Quality Improvement and Risk Management, Clinical Improvement and Nutrition Committees. Consumers have also attended a number of staff meetings throughout the hospital in nursing, education and allied health to share their experiences with our health service with staff. This has been an extremely valuable exercise for our staff.

We have continued to develop our strong relationships through the Grampians Health Alliance, with significant work directed at strategic projects that support collaboration and connectivity across the sub region.

We farewelled Mrs Lynn Jensz and Mr Sam Campbell-Huruglica from the Board of Management this year, and welcomed both Ms Jess Cass and Ms Amy Rhodes. We are fortunate that Mrs Lynn Jensz has joined the Audit and Risk Committee, continuing to support the organisation with her finance skills as an independent Committee member.

Responsible Bodies Declaration

In accordance with the Financial Management Act 1994, I am pleased to present the Report of Operations for Stawell Regional Health for the year ending 30 June 2017.

Rhian Jones
Board Chair
Stawell

25th August, 2017

Organisational Chart

Board of Management

Rhian Jones

Date Appointed: 20th November 2013, Board Chair, Board Representative on Board Executive, Audit and Risk Committee, Quality Improvement and Risk Management , Governance and Medical Appointment Committees.

Mum

Howard Cooper

Date Appointed: 1st April 1999, Board President, Board Representative on Quality Improvement and Risk Management and Audit and Risk Committees

Primary Producer

Peter Martin

Date Appointed: 1st April 1999, Board Representative on Governance and Quality Improvement and Risk Management Medical Appointments Committees.

Retired School Principal

Ross Hatton

Date Appointed: 1st July 2008, Board Representative on Board Executive, Governance, Community Relations and Audit and Risk Committee.

Company Director

Joan Brilliant

Date Appointed: 1st October 1986, Board Representative on Governance and on Quality Improvement and Risk Management Committee.

Retired Postal Manager Australia Post Stawell

Jessica Cass

Date Appointed: 1st July 2016, Board Representative on Quality Improvement & Risk Management Committee and Finance Committee.

Accountant

Amy Rhodes

Date Appointed: 1st July 2016, Board Representative on the Community Relations committee.

Media and Communications Professional

SRH Executive Team

Liz McCourt
Chief Executive

Janet Feeny
Human Resources Manager

Robyn Wilson
Director of Clinical Services

Rhys Duncan
Acting Primary Care Manager

Rick Lowen
Director of Medical Services

Shawn Lee
Primary Care Manager

The Year in Review

SRH Executive and Management Teams

The Board and Executive farewelled Mrs Mary Bruce, Director of Clinical Services in August, and welcomed Ms Robyn Wilson to the role.

We also welcomed Mr Shawn Lee into the role of Primary Care Manager, and Mrs Dianne Martin to the Nurse Unit Manager role following the departure of Mr Jarrod Hunter. Bec Peters has also taken on the role of Acting Manager of Education.

Stawell Regional Health Mission

As part of the strategic planning process, the staff of Stawell Regional Health were asked to provide input into a new Mission statement. After a highly engaged process, the teams recommended the following Mission to the Board:

In partnership with our community, Stawell Regional Health will deliver high quality care and improve health outcomes by providing safe, accessible and integrated services.

The Mission encapsulates how our team of dedicated staff at Stawell Regional Health view their work.

Community Rehabilitation and Oncology Centre

The Community Rehabilitation and Oncology Centre (CRC) has been at almost full capacity during the last 12 months, with a greater number of rehabilitation programs and individual treatment sessions provided to the community.

Our state of the art oncology centre provides a comfortable location for our patients to visit the three medical oncologists and three radiation oncologists. These highly skilled doctors are supported by the oncology nurses and an experienced regional oncology Nurse Practitioner.

The purpose-built facility is the base for inpatient and outpatient rehabilitation services such as exercise physiology, physiotherapy, occupational therapy and speech pathology. Several rehabilitation programs are conducted in the gym, and include the gait and balance rehabilitation program, pulmonary rehabilitation, cardiac rehabilitation, and an eight week oncology rehabilitation program offered to our community members living with cancer.

Dedicated community volunteers, an integral part of our team, are often present to support our patients waiting for appointments and treatment.

The well-appointed consulting rooms are utilized by a number of other consulting medical specialists including orthopaedic surgeons, general surgeons, paediatricians, rheumatologists, ophthalmologists, urologist, and an ear, nose and throat specialist.

Stawell Regional Health continues to attract specialists to support our community to access services that are usually provided at a significant distance from Stawell.

Wellness and Life after Cancer Exercise and Supportive Care

On average, 209 people in the Grampians Region are diagnosed with cancer each year. Many people who have had cancer have trouble adjusting to their new "normal" life after active treatment of their cancer finishes.

Research shows that exercise rehabilitation programs help cancer survivors manage pain, reduce fatigue and improve quality of life; while group-based education programs develop resilience and empower people to improve their health and wellbeing.

The new eight week program "Wellness and Life after Cancer - Exercise and Supportive Care" is offered to Grampians residents to provide the tools they need to get back into exercise and to deal with changes in their lives at home and at work.

The first eight-week program commenced in June in both Stawell and Warracknabeal in June, and assists people to:

- Increase their fitness and strength
- Improve their ability to perform daily tasks
- Learn to cope with life now
- Identify local support services available.

The education sessions are delivered in Stawell and Warracknabeal using video conferencing to link participants together.

The program is offered in partnership with The Cancer Council, the Victorian Department of Health and Human Services, the Grampians Integrated Cancer Service, and Rural North West Health in Warracknabeal.

Primary Care Nursing Students

Great effort went into planning for the 2017 allied health and primary care student clinical placements by the Primary Care Clinical Placement Coordinator which resulted in:

- An increase in the number of clinical placements: 17 in 2017 compared to 11 in 2016. An increase in student placement days from 326 in 2016 to 385 in 2017.
- Speech Therapy hosted their first student in September 2016 and have had two clinical placements in 2017. The second placement was a shared opportunity with East Grampians Health Service.
- There has been a focus on providing placement opportunities for final year students in 2017 with the goal of leading to longer term workforce gains. Of the 16 placements, nine were final year students.
- A former final year Dietetics student from 2016 was employed into a new graduate role with the Allied Health team this year.
- Planning has commenced to include Social Work students in 2018.

Nursing student placement days:

2015	1650
2016	820
2017	1530

In 2016, student nurse numbers were low owing to challenges with recruitment of a student support nurse.

With successful recruitment to the student support role in 2017, Stawell Regional Health has been able to re-establish both our university partnerships and our capacity to support students for this very important component of their career.

New partnerships for this year included Royal Melbourne Institute of Technology Nursing Diploma and Bachelor students, Australian Catholic University Nursing Diploma students, Monash University Masters of Nursing students and students studying Nursing Diplomas from Menzies Institute of Technology.

Stawell Regional Health is recognised for our high quality nursing placements, which have in turn supported our graduate nurse program and our recruitment of newly graduated nurses.

All four graduate nurses from 2016 have become valued permanent employees, and eighty-five percent (85%) of applications for the 2018 Graduate Nurse Program have been attributed to successful completion of student placements at Stawell Regional Health.

Financial Overview

In 2016/2017 Stawell Regional Health remained committed to the mission of delivering high quality services to the community.

Provision of available services has been enhanced with the purchase of advanced medical equipment and increasing engagement of specialist clinicians. However, along with a challenging funding environment, increasing costs in health service provision and an unplanned theatre shutdown in December 2016 the financial performance was not as expected.

For the 2017 financial year Stawell Regional Health delivered a Consolidated Operating deficit of $0.23M compared to a Consolidated Operating surplus of $0.27M in the previous financial year. Other than the effect that the unplanned theatre shutdown had on financial performance due to lower revenues and unexpected remediation costs the health service continues to be challenged by higher than inflation workforce and medical supplies costs coupled with shortages in key local skilled staff. To continue to provide high quality care for the community the necessary engagement of locum medical, allied health and agency nursing staff has resulted in higher operating costs.

For the 2017 financial year revenue growth was $1.2M (4.9%) and Operating Expenditure growth was $1.7M or 6.9% compared to 2016.

Expenditure on Labour increased by $1.4M (7.8%) on the previous year. These expenses totaling $19.6M have risen as a result of additional locum and agency staff and award increases, some dating back to the 2015/2016 financial year.

Supplies, Consumables and Other Expenses increased by $0.34M (4.7%) due to increases in Drug and Medical and Surgical supply costs.

Capital Purpose Income was $0.87M lower than in 2016 due to DHHS funding grants for specific projects and equipment being lower in the 2017 financial year.

In 2017 consolidated operating activities for the year resulted in a net cash inflow of $1.8M, of this $1.1M was invested in Capital Assets. Overall, consolidated cash holdings decreased by $0.73M for the year with total cash on hand amounting to $8.1M at 30th June 2017.

Major Acquisitions and Projects

2016-17 Major Acquisitions and Projects:

Building Works	**$**
Painting & Upgrade works (MSRC*)	$36,663
Hospital Signage	$5,297
Plant and Medical Equipment	**$**
Laparoscopes	$72,914
Opthalmic Trolleys	$43,380
Biometric Readers	$17,732
Treatment Chair	$6,710
Replacement Vehicles	$114,339
Overhead Tracking	$71,230
Washer Disinfector	$36,487
Macerators	$18,900
Security Upgrades	$15,892
Software Upgrades	$13,316
Operating room dehumidifier	$13,000
Port switch (ICT)	$12,266
Foodwaste Disposer	$7,120
Hoverjack Patient lifter	$5,890
Shower commode	$5,495
Nocospray Steriliser	$4,954

*Macpherson Smith Residential Care

Financial Overview

Performance Indicators

Comparative Consolidated Financial Results for the Past Five Financial Years

Key Performance Indicator	2017 $000	2016 $000	2015 $000	2014 $000	2013 $000
Total Revenue	27,351	27,072	25,473	27,382	25,097
Total Expenses	29,296	27,542	26,478	25,026	23,768
Other operating flows included in the Net Result for the Year	(49)	(68)	na	na	na
Net Result for the year	(1,945)	(470)	(1,028)	7,352	2,042
* Operating Result	(226)	277	27	945	791
Total Assets	34,408	36,197	35,737	37,071	29,521
Total Liabilities	5,716	5,560	4,630	4,958	5,999
Net Assets	28,692	30,637	31,107	32,113	23,821
Total Equity	28,692	30,637	31,107	32,113	23,821

*The Operating result is the result for which the hospital is monitored in its Statement of Priorities and also referred to as the Net Result before Capital and Specific items.

Valuing Our People

People Matter Survey

Stawell Regional Health has focused on improving communication within each department in line with the feedback from the People Matter Survey 2016 results. The survey results highlighted the need for senior managers across the organisation to increase their communication with staff and provide greater feedback on the objectives of Stawell Regional Health. This is a continuing project with the production of a fortnightly newsletter, monthly leadership meetings, quarterly staff forums, shared operational reporting and access to webmail for all staff through the website.

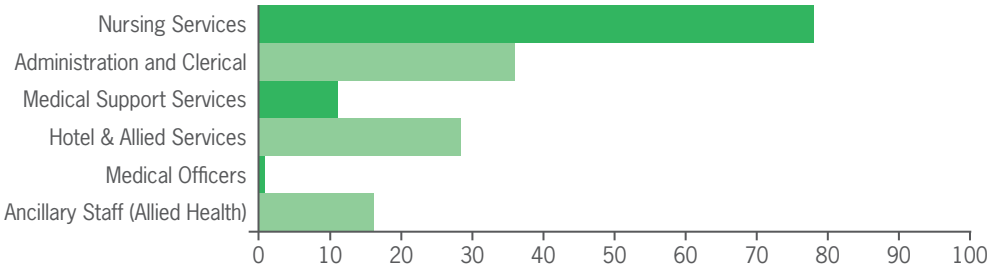
Staff participation in the people matter survey

2017	2016	2015	2014	2013	2012
50%	51%	49%	23%	19%	32%

Our Work Experience Program

The organisation was extremely pleased to receive ten local students for work experience this year. The students were rostered to work a rotating morning or afternoon shift in a wide variety of departments, including allied health, nursing, perioperative services, health information and catering services. Whilst the students are working within the organisation, staff and managers make every attempt to ensure what they are doing contributes to the service. This may be typing up policies, cutting up vegetables, talking with residents, attending available in-services from our staff such as dysphagia management or helping the Physiotherapists on the Ward. Every effort is appreciated and all staff commented on the willingness of all the students to "get in and have a go" in each area.

Staff by labour category



Labour Category	June Current Month FTE		June Year to Date FTE	
	2017	2016	2017	2016
Nursing Services	78.07	80.01	80.45	85.06
Administration and Clerical	37.8	37.06	37.05	36.47
Medical Support Services	10.72	12.35	9.45	8.95
Hotel & Allied Services	27.45	28.63	28.81	28.46
Medical Officers	1.25	1.2	1.20	1.05
Ancillary Staff (Allied Health)	16.82	14.4	16.42	14.65

Occupational Health and Safety

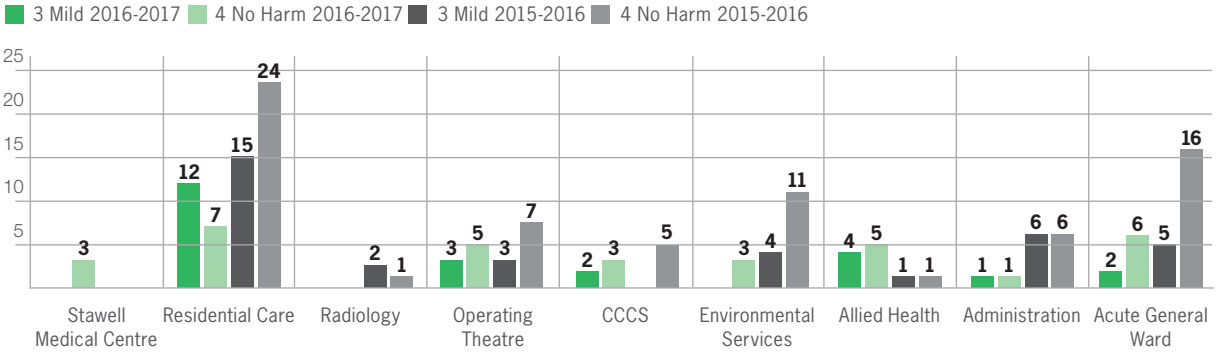
Incidents across the organisation are reported through the Victorian Health Incident Management System (VHIMS).

The Occupational Health and Safety (OH&S) Committee reviews this information on a bi-monthly basis. The Committee reviews data trends over a 12 month period to identify areas which may require controls and support to maintain staff and patient safety and wellbeing in the workplace.

OH&S incidents entered into the VHIMS system by staff for 2016-2017 financial year have decreased for the period in comparison to the previous year. Of the total number of incidents reported, 58% reported no harm was sustained and 42% reported minor harm sustained. There were no moderate or serious incidents reported.

Severity 2015-2016	Number of reported incidents	Percentage
4 No Harm	71	65%
3 Mild	36	33%
2 Moderate	1	2%
Severity 2016-2017	**Number of reported incidents**	**Percentage**
4 No Harm	33	58%
3 Mild	24	42%
2 Moderate	0	0

Degree of Harm comparison by department



Manual Handling.

The installation of overhead tracking in MacPherson Smith Residential Care was completed and will significantly reduce the risk to employees from moving residents in lifting machines within a resident's rooms. The overhead tracking enables residents to transfer from bed to chair and chair to bed with a lifter that attaches to a track that runs across the ceiling and over the bed.

All MSRC direct care employees have achieved the required competency following training in the use of the overhead tracking system. A comprehensive instruction sheet also provides a reference guide on the correct use of the equipment.

Annual Fire Training

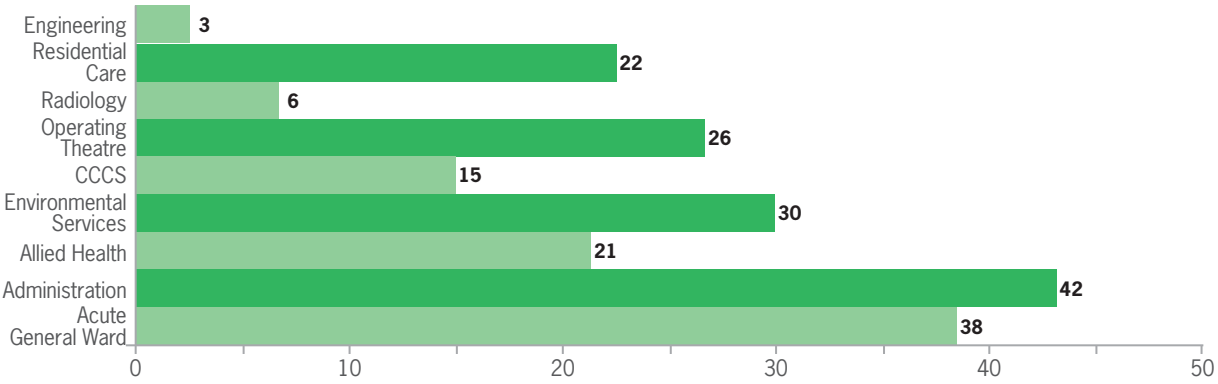
Stawell Regional Health has undertaken a review and made improvements to the Annual Fire Training 'in-house' education package in response to an identified need to improve employee knowledge of available equipment in each department.

The online training package includes a requirement that employees identify the type and location of emergency equipment required in response to different emergency scenarios. A series of questions are also answered by the employee undertaking the program to ensure comprehension of the material.

New employees are provided face to face training at orientation. 203 employees successfully completed the training for the year 2016-2017.

* CCCS - Community and Complex Care Services

Completion of Annual fire/evacuation training - Number of Employees by department 2016-17



Fire Extinguisher Simulation Training

Fire Extinguisher training was provided throughout June 2017 using the shared resource "Bulls Eye Fire Extinguisher Training System" purchased through the Grampians Regional Health Emergency Manager Network in 2013. Training sessions conducted across sites resulted in 55 staff experiencing, in a simulated environment, best practice extinguisher operation procedure.

The scenario for this year's simulation program was based on staff members discovering a fire. This tested staff knowledge of the Code Red policy, safe procedures prior to and while in a fire zone, reporting to the Emergency Coordinator, and safe extinguisher use. All employees successfully completed a related training quiz.

Completion of Fire Extinguisher training - Number of Employees by department 2016-17

Fire and Evacuation Drills.

Drills in Code Red Fire Procedures and Code Orange Evacuation Procedures are undertaken throughout the year.

These are conducted in all workplaces, either through table-top scenarios or active drills. The active drill is intended to test employee responses to the sounding of alarms, emergency alerts and managing an evacuation. Additional prompt cards have been introduced to assist the Emergency Coordinators response to Code Red following feedback from drills.

Completion of Fire Drill training - Number of Employees by department 2016-17

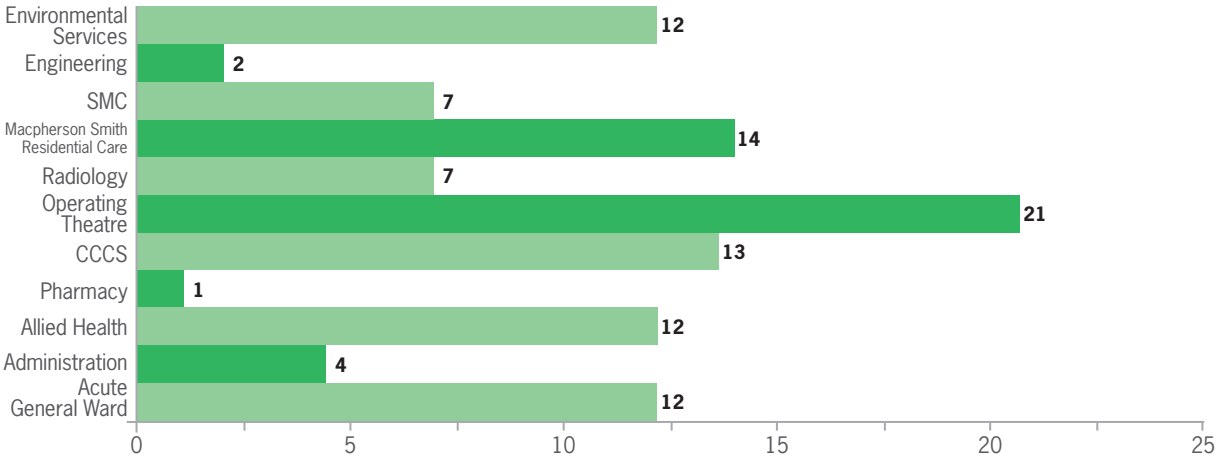
* CCCS - Community and Complex Care Services

Occupational Violence

The Department of Health and Human Services introduced a state wide policy for Code Grey response in hospitals to provide more detailed guidance to assist in addressing Occupational Violence in both clinical and non-clinical settings. SRH is actively involved in reducing the risk to employees from Occupational Violence.

Training is currently being provided through the Melbourne Health "Management of Clinical Aggression" Training Program to groups of staff from all work areas. 15 sessions of 8 hours duration were run in the 2016-2017 financial year. The sessions are designed for both nonclinical and direct care employees. Employee training includes theory, negotiating skills, harm minimisation and breakaway techniques. Direct care employees are also trained in restraint techniques which would be utilised when all other avenues have been exhausted. 105 employees completed training for the reporting period 2016-2017 financial year including 58 employees (non-direct care) and 47 direct care employees.

Completion of Management of Clinical Aggression Training - Number of employees by department 2016-17

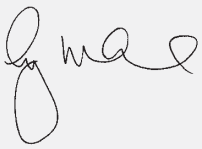


Occupational violence statistics	2016-17
1. Workcover accepted claims with an occupational violence cause per 100 FTE	0
2. Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	0
3. Number of occupational violence incidents reported	12
4. Number of occupational violence incidents reported per 100 FTE	6.94
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition	42%

* CCCS - Community and Complex Care Services

Attestation on HPV Compliance

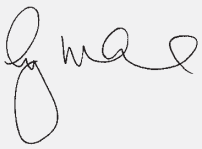
I, Liz McCourt, certify that Stawell Regional Health has put in place appropriate internal controls and processes to ensure that it has complied with all requirements set out in the HPV Health Purchasing Policies including mandatory HPV collective agreements as required by the Health Services Act 1988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



Liz McCourt
Chief Executive
Stawell
25th August 2017

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

I, Liz McCourt, certify that Stawell Regional Health has complied with Ministerial Direction 3.7.1. – Risk Management Framework and Processes. The Stawell Regional Health Audit Committee has verified this.



Liz McCourt
Chief Executive
Stawell
25th August 2017

Additional information available on request

Consistent with FRD 22H (Section 6.19) the report of operations should confirm that details in respect of the items listed below have been retained by Stawell Regional Health and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements, if applicable):

(a) Declarations of pecuniary interests have been duly completed by all relevant officers

(b) Details of shares held by senior officers as nominee or held beneficially;

(c) Details of publications produced by the entity about itself, and how these can be obtained

(d) Details of changes in prices, fees, charges, rates and levies charged by the Health Service;

(e) Details of any major external reviews carried out on the Health Service;

(f) Details of major research and development activities undertaken by the Health Service that are not otherwise covered either in the report of operations or in a document that contains the financial statements and report of operations;

(g) Details of overseas visits undertaken including a summary of the objectives and outcomes of each visit;

(h) Details of major promotional, public relations and marketing activities undertaken by the Health Service to develop community awareness of the Health Service and its services;

(i) Details of assessments and measures undertaken to improve the occupational health and safety of employees;

(j) General statement on industrial relations within the Health Service and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the report of operations;

(k) A list of major committees sponsored by the Health Service, the purposes of each committee and the extent to which those purposes have been achieved;

(l)Details of all consultancies and contractors including consultants/ contractors engaged, services provided, and expenditure committed for each engagement.

Objectives, Functions, Powers and Duties of Stawell Regional Health

Stawell Regional Health (SRH) is a public hospital established under the Health Services Act 1988. We provide public health and ancillary services as authorised under the Act, and operate residential care services under the Aged Care Act 1997.

The Board of Management provides strategic direction to the hospital and its' services. The Board is comprised of members of the community appointed by the Minister for Health under the Health Services Act.

The Chief Executive Officer determines how services are delivered. For the period 1 July 2016 to 30 June 2017 Stawell Regional Health was accountable, through its Board of Management, to The Honourable Jill Hennessy MLA, Minster for Health and Minister for Ambulance Services and The Honourable Martin Foley MLA, Minister for Mental Health and Minister for Housing, Disability and Ageing.

Summary of Services

Allied Health
- Audiology (visiting)
- Community Health Nursing
- Continence Clinic
- Diabetes Education
- Exercise Physiology
- Nutrition & Dietetics
- Health Promotion
- Occupational Therapy
- Physiotherapy
- Podiatry
- Social Work
- Speech Pathology

Community Services
- Planned Activities Group (Bennett Centre for Community Activities)
- District Nursing Service
- 'Hospital in the Home'
- Post-Acute Care
- Transition Care Program
- Hospital Admission Risk Program (HARP)

Stawell Medical Centre
- Day Oncology Unit
- Acute Care
- Urgent Care Centre

Medical Imaging
- X-ray
- CT
- Ultrasound

Residential Aged Care
- Residential Aged Care Facility- Macpherson Smith Residential Care
- Aged Care Assessment Service

Rural Primary Care
- Allied Health/Community Services to outlying communities
- Support for Budja Budja Aboriginal Co-Operative Health Service at Halls Gap

Medical Specialties
- General
- Endoscopy
- Gynaecology
- Obstetrics
- Ear, Nose and Throat
- Urology
- Orthopaedics
- Ophthalmology
- Medical Oncology
- Paediatrics
- Rheumatology
- Radiation Oncology

Surgical and Anaesthetic Services
- Pre Admission Clinic
- Day Procedure Unit
- Operating Suite / Sterilising Department

Australian Clinical Laboratories
- Pathology Services

Strategic priorities

In 2016–17 Stawell Regional Health will contribute to the achievement of the Government's commitments by:

Domain	Action	Deliverable	Progress
Quality and safety	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.	Monitor and review the use of end of life care plans across Stawell Regional Health and ensure the choice to die at home is offered in partnership with Grampians Region Palliative Care Service.	The use of end of life care plans across Stawell Regional Health has been reviewed. The choice for patients to die at home is offered in partnership with Grampians Region Palliative Care Service.
	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.	Using the patient experience tracker, obtain consumer feedback on the advance care planning process.	Following significant review, it was identified that the patient experience tracker was not the ideal platform for obtaining feedback regarding advance care plans.
	A more sensitive and comprehensive survey has been developed and implemented. The results are not available at this time.	Develop and implement a policy, including a staff education component, aimed at increasing the awareness of and appropriate response to suspected or actual incidents of family violence particularly in community settings.	Meeting with local stakeholders such as Victoria Police Family Violence team, and Grampians Community Health Chief Executive Officer regarding joint collaboration and education initiatives, and strengthening of referral pathways. Information for staff and victims has been obtained and made available in public waiting areas. Joint staff education held in collaboration with Grampians Community Health Family Violence Team.
	Progress implementation of a whole-of-hospital model for responding to family violence.	Review the family violence policy and implement any required improvements.	A comprehensive Family Violence Policy is in place.
		Provide family violence patient information packs in the urgent care centre.	Family violence patient information packs have been developed and are available in the Urgent Care Centre.
		Implement staff education across the organisation by December 2016.	Education in identifying and responding to Family Violence was provided to staff in December 2016 through the Simvan and Grampians Community Health Centre.
	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.	Contribute to regional initiatives in education and care pathways in partnership with Ballarat Health Services, Grampians Integrated Cancer Services and other health care providers.	The Stawell Regional Health Executive and the organisation as a whole have committed to regional collaboration in both education and care delivery. This has included support for and participation in programs such as "Wellness on Wheels" and partnering in the regional Cancer Survivorship telehealth project "Wellness after Cancer".
	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.	Through the use of patient feedback received from the Victorian Healthcare Experience Survey; Stawell Regional Health's suggestions, compliments and complaints; and patient experience tracker data, identify improvement opportunities and develop and implement new models of "putting patients first".	The acute Victorian Healthcare Experience Survey identified two areas for further improvement this year: 1. Communication between staff, patients and families: education has been provided to staff. 2. Discharge planning: working with local doctors to provide discharge letters following presentation at the Urgent Care Centre. The most recent results indicate our performance in this area has significantly improved.

Domain	Action	Deliverable	Progress
	Develop a whole of hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint.	Review the current restraint policy and practices to ensure that a whole of hospital approach to restraint is clearly documented and consistent, and that staff are aware of the organisational approach.	A whole of hospital approach to restraint is clearly documented and consistent, and the staff are aware of the organisational approach.
Access and timeliness	Ensure the development and implementation of a plan in specialist clinics to: (1) optimise referral management processes and improve patient flow through to ensure patients are seen in turn and within time; and (2) ensure patient data is recorded in a timely, accurate manner and is working toward meeting the requirements of the Victorian Integrated Non-Admitted dataset.	Appoint a project worker to review patient flow and processes in the specialist clinics, including in the preadmission and subacute ambulatory care clinics. Strategies will be implemented by February 2017 to improve processes and ensure compliance with the Victorian Integrated Non-Admitted dataset requirements.	A Project Worker was appointed to review patient flow and processes in the specialist clinics, including in the preadmission and subacute ambulatory care clinics. Strategies have been made to improve processes and ensure compliance with the Victorian Integrated Non-Admitted dataset requirements are under development.
		Implement strategies to strengthen and streamline specialist clinics from January 2017. Evaluate data to demonstrate improvements in patient flow.	Data analysis ongoing with evaluation yet to occur.
	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).	Review referral patterns from the urgent care centre and local general practice clinics to identify patients who would be suitable for referral to the Hospital Admission Risk Program and/or to the gait and balance clinic to aid prevention and optimise care in the community.	Review of the Hospital Admission Risk Program identified opportunities for improvement. The Allied Health Gait and Balance program for reducing falls has also been reviewed and significant improvements have been made.
	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.	Establish Home and Community Care change champions in key departments and implement staff consultation and education through Stawell Regional Health by December 2016. Develop the National Disability Insurance Scheme change model by March 2017 to support local implementation of National Disability Insurance Scheme and provide quarterly implementation progress reports to the executive team and Board of Management.	Home and Community Care change champions were identified in in key departments. Staff consultation and education completed by December 2016. A National Disability Insurance Scheme Champion has been identified, and key staff have attended significant training events to enable preparation for NDIS Implementation. A National Disability Insurance Scheme transition working party has been established. Proposed timelines for National Disability Insurance Scheme transition have been established and have been presented to the Board of Management.
Supporting healthy populations	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.	In collaboration with the Grampians Pyrenees Primary Care Partnership, the Western Victorian Primary Health Network and other local agencies, actively participate in planning to ensure alignment with state and regional health priorities and the Northern Grampians Shire's Public Health and Wellbeing plan.	The Health Promotion Officer of Stawell Regional Health collaborates with Grampians Pyrenees Primary Care Partnership and the Northern Grampians Shire to review and implement Municipal Health and Wellbeing plan which aligns with the Early Years Plan and the organisation's Integrated Health Promotion. The Victorian public health and wellbeing plan 2015-2019: Taking action-the first two years is used to inform our local planning.
	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.	In partnership with Grampians Community Health, the Neighbourhood House and local schools strengthen involvement in local food security initiatives.	The Stawell Food Connect program is now collecting food that is not suitable for sale but fit for human consumption five days per week. Organisations and services are collecting regularly for their food programs which includes schools and school breakfast programs. This successful collaborative has now held three highly successful community lunches.

Domain	Action	Deliverable	Progress
	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.	In partnership with the Grampians Pyrenees Primary Care Partnership and Budja Budja Aboriginal Co-Operative build on the cultural safety initiatives commenced in 2015–16. Review acute admission and intake process to strengthen identification of Aboriginal and Torres Strait Islander people to facilitate appropriate post care referral as/if required.	Following review of acute admission and intake processes, and development of an Initial Needs Identification worker across all primary care and allied health programs, Stawell Regional Health has strengthened identification of Aboriginal and Torres Strait Islander people. This has enabled staff to facilitate appropriate post care referral as required.
	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.	Using the "Strengthening Cultural Security" action plan as a guide, identify opportunities for staff to attend cultural safety training, and work with local Aboriginal and Torres Strait Islander people to improve the physical environment of Stawell Regional Health.	In conjunction with Budja Budja Aboriginal Co-Operative and local artists, Stawell Regional Health is identifying opportunities to provide a more welcoming and culturally safe and inclusive environment for Aboriginal and Torres Strait Islander people.
	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.	Working with key regional partners, identify and implement improved mental health referral and access pathways designed to respond to the mental health needs and preferences of Stawell community.	Stawell Regional Health has partnered with East Grampians Health Service and Federation University to implement a Chronic Disease Model for Rural Allied Health Services with focus on four chronic diseases of high prevalence.
	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.	Review the Rainbow eQuality Guide to identify opportunities and associated actions to be more inclusive and responsive to the health and wellbeing of lesbian, gay, bisexual, transgender and intersex individuals and communities and incorporate actions into the health service Cultural Diversity Action Plan.	Stawell Regional Health is an active partner in the Grampians Community Health Rainbow Committee and has identified a key executive contact for monitoring and evaluating identified improvements and actions. In March 2017, Stawell hosted the Lesbian, gay, bisexual, transgender and intersex individuals and communities Equality Roadshow led by Ro Allen, Victorian Commissioner for Gender and Sexuality. The inaugural Lesbian, gay, bisexual, transgender and intersex individuals Regional Network meeting was held in June 2017. The purpose of the network is to provide collective leadership and work together on innovative approaches that promote inclusion and equity for consumers and their allies through a whole of community approach. The network will meet monthly for the first three months and bi-monthly thereafter.
Governance and leadership	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.	Utilise the Clinical Governance Policy Framework expanded checklist to identify required improvements and develop an action plan to guide implementation of any changes required. Include any new requirements arising from the state-wide clinical governance reviews currently underway.	Utilising relevant checklists from the Clinical Governance Framework, Stawell Regional Health reviewed current Clinical Governance processes. A new Clinical Governance Framework has been developed, and supporting policies and processes are in draft form. The recommended templates for meeting agendas such as the Board of Management and Governance Committees have been adopted with minor changes. There is an agreement with Ballarat Health Services regarding the provision of clinical governance support in areas of high risk, such as surgical, medical and emergency medicine.

Domain	Action	Deliverable	Progress
	Contribute to the development and implementation of Local Region Action Plans under the series of state-wide design, service and infrastructure plans being progressively released from 2016 17. Development of Local Region Action Plans will require partnerships and active collaboration across regions to ensure plans meet both regional and local service needs, as articulated in the state-wide design, service and infrastructure plans.	Actively contribute to the development and implementation of Local Regional Action Plans and worked in partnership and collaboration to ensure the plans meet both regional and local service needs.	Stawell Regional Health has actively participated in all regional planning initiatives.
	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.	Review existing policy, feedback mechanisms and staff processes related to anti-bullying and harassment by December 2016.	The existing policy, feedback mechanisms and staff processes related to anti-bullying and harassment have been reviewed. Following this review, Stawell Regional Health has undertaken to identify education to rebuild the Contact Officer program and training at SRH. Resilience and communication strategies for bullying and harassment have been incorporated into the staff Orientation program. The appropriate policies have a scheduled three year review.
	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.	Deliver organisation wide education in prevention and management strategies for both occupational violence and bullying and harassment by December 2016. Include data in relation to bullying and harassment incidents as part of the human resources key performance indicator report provided to the Board of Management. Conduct an environmental review/audit of the urgent care centre to identify opportunities for improving staff security by March 2017.	Management Of Clinical Aggression training has been provided to all staff. The Management Of Clinical Aggression trainer is now accredited with Melbourne Health program. Data in relation to bullying and harassment incidents as part of the human resources key performance indicator report is provided to the Board of Management. Initial review completed. Improvements have been identified, including changes to entry and exit of preadmission/clinic room. Additional monitoring will be implemented. Quotations are currently being obtained for planned works.
	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.	Develop a workforce plan which focuses on enhancing and expanding student placements and graduate programs and ensuring staff responsible for supporting education in the organisation are appropriately qualified.	Education staff are undertaking Certificate IV Workforce Training and Assessment (where this has not already been obtained) to ensure qualified support for workforce. A Registered Nurse with experience and qualifications in education has been employed to support students and in-house education. There has been a significant increase in the number of nursing and allied health student placements when compared to the previous year.

Domain	Action	Deliverable	Progress
	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.	Assess the outcomes of the 2016 People Matters Survey and fully engage staff in responding to any issues identified.	Outcomes assessed with the themes highlighted for 2017 of "Communication from the Senior Team" and "Reward and Recognition". Feedback from staff was also sought through Department meetings to identify other potential changes and improvements.
	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.	Assess the outcomes of the 2016 People Matters Survey and fully engage staff in responding to any issues identified.	Outcomes assessed with the themes highlighted for 2017 of "Communication from the Senior Team" and "Reward and Recognition". Feedback from staff was also sought through Department meetings to identify other potential changes and improvements.
	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 the organisational child abuse mandatory reporting policy against the Victorian Child Safe Standards to ensure the process for responding and reporting suspected child abuse is well identified. Provide staff education to ensure the protocol and processes for identifying and reporting suspected child abuse is understood and adhered to.	The Victorian Child Safe Standards checklist was completed. This identified the need for a specific policy regarding Child Safety to encompass all departments due to differing needs and organisation interaction. The Policy is currently under development and will be delivered as part of a broader staff education program. Education of senior staff has been refreshed. Stawell Regional Health is currently investigating online or other programs to assist in maintaining awareness of all 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.	Review current knowledge and increase awareness and access of clinical staff to vaccination and immunisation programs to support a safe environment for both staff and patients.	Following a significant change in the delivery of the vaccination program, a record number of staff have received immunisation for influenza this year.

Domain	Action	Deliverable	Progress
Financial sustainability	Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	Engage an external consultant to identify opportunities in cash management strategies to improve cash sustainability and continue to meet financial obligations as they are due.	An external consultant was engaged to undertake a comprehensive review of core business and the current financial situation. The annual budget for the 2016-17 year was revised. Strategies for increased efficiencies were considered and implemented. The organisation continues to maintain a positive cash position.
	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.	Review recycling practices across the organisation including incorporating changes in signage, bin location, and bin types to reduce general waste heading to landfill in line with the Environmental Management Strategic Plan 2015–2020.	A survey completed regarding recycling practices across the organisation identified the majority of respondents were confused by the recycling information available. This included workplace recycling and food packaging recycling. Signage that is easier to understand is currently being developed. This will be implemented with a revised education program. A quarterly newsletter to refresh staff on sustainable practices at SRH and at home is under development.

Part B: Performance Priorities

Quality and safety

Key performance indicator	Target	2016–17 Actual
Accreditation		
Compliance with NSQHS Standards accreditation	Full compliance	Achieved
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Achieved
Infection prevention and control		
Compliance with cleaning standards	Full compliance	Achieved
Very high risk (Category A)	90%	100%
High risk (Category B)	85%	98%
Moderate risk (Category C)	85%	96%
Submission of infection surveillance data to VICNISS	Full compliance	Achieved
Compliance with the Hand Hygiene Australia program	80%	91%
Percentage of healthcare workers immunised for influenza	75%	78%
Patient experience		
Victorian Healthcare Experience Survey - data submission	Full compliance	Achieved
Victorian Healthcare Experience Survey – patient experience Quarter 1	95% positive experience	97%
Victorian Healthcare Experience Survey – patient experience Quarter 2	95% positive experience	100%
Victorian Healthcare Experience Survey – patient experience Quarter 3	95% positive experience	100%
Victorian Healthcare Experience Survey – discharge care Quarter 1	75% very positive response	86%
Victorian Healthcare Experience Survey – discharge care Quarter 2	75% very positive response	93%
Victorian Healthcare Experience Survey – discharge care Quarter 3	75% very positive response	94%

Governance and leadership		
Key performance indicator	**Target**	**2016–17 Actual**
People Matter Survey - percentage of staff with a positive response to safety culture questions	80%	92%

Financial sustainability		
Key performance indicator	**Target**	**2016–17 Actual**
Finance		
Operating result ($m)	0.03	(0.23)
Trade creditors	60 days	67 days
Patient fee debtors	60 days	13 days
Public & private WIES performance to target	100%	95.32%
Adjusted current asset ratio	0.7	2.2
Number of days with available cash	14 days	83 days
Asset management		
Basic asset management plan	Full compliance	Achieved

Statement of Employment and Conduct Principles

Stawell Regional Health ensures a fair and transparent process for recruitment, selection, transfer and promotion of staff. It bases its employment selection on merit, and complies with the relevant legislation.

Policies and procedures are in place to ensure staff are treated fairly, respected and provided with avenues for grievance and complaint processes.

Part C: Activity and Funding

Funding type	2016–17 Activity Achievement
Acute Admitted	
WIES DVA	70
WIES Public	1,741
WIES Private	471
WIES TAC	7
Acute Non-Admitted	
Home Enteral Nutrition	71
Aged Care	
HACC	18,343
Residential Aged Care	8,277
Subacute & Non-Acute Admitted	
Subacute WIES – Maintenance Public	13
Subacute Non-Admitted	
Health Independence Program - Public	8,592
Primary Health	
Community Health / Primary Care Programs	8,862
Health Workforce	4

Statutory Reporting Requirements

Pecuniary interests

Members of the Board of Management are required under the Hospital By-Laws to declare their pecuniary interest in any matter that may be discussed by the Board or Board Sub-Committees.

Equal Opportunity

Stawell Regional Health (SRH) is committed to providing an Equal Employment Opportunity (EEO) work environment for both existing and prospective staff members. It is the responsibility of each and every employee within SRH to observe EEO principles.

The Chief Executive Officer or their appointed delegates have primary responsibility for all aspects of the Equal Employment Opportunity Policy and related programs within SRH.

Hospital fees

The Hospital charges fees in accordance with the Department of Health and Human Services (Vic), Department of Health and Ageing and Home and Community Care (HACC) directives.

Compliance with Data Vic 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 in machine readable format.

Staffing profile

A total of 256 persons were employed by Stawell Regional Health: During this period Full time 69, Part time 126 and Casual 61.

Compliance with the Building Act 1993

BUILDING STANDARDS AND CONDITION ASSESSMENTS

Fire audits and risk assessments are undertaken by consultant fire engineers in compliance with the Department of Health Fire Risk Management Engineering Guidelines Series 7. Recommendations from the fire audits and risk assessments are actioned in conjunction with the Department of Health and Human Services to maintain a high degree of fire safety. All bed-based facilities are audited at intervals of a maximum of five years. Stawell Regional Health was last audited on 9th September, 2016 by ARUP Fire (Fire Engineers) and Brian Sherwell & Associates (Building Surveyor). The current five year cycle audits have commenced. Stawell Regional Health has contracted Brian Sherwell & Associates to carry out the audits. A plan is in place to guide and prioritise actions arising from these reviews.

ESSENTIAL SAFETY MEASURES MAINTENANCE

In accordance with regulatory requirements, service and maintenance records are kept to enable completion of an annual Essential Safety Measures Report for all properties owned by Stawell Regional Health. This is confirmation that all essential services are operational at the required level of

Performance. Records and reports are retained on the premises for inspection by all relevant authorities.

Legislative Compliance

Stawell Regional Health uses the Riskman Software System to manage Risk, Quality Improvement, feedback, incidents and to manage compliance obligations in line with State and Commonwealth legislation and Australian Standards.

Industrial Relations

Stawell Regional Health experienced no days of work lost due to industrial activity during the year ending 30 June, 2016.

Publications

Stawell Regional Health produces a number of publications for the community to assist them to gain a better understanding of our services and programs. They include the Annual Report, Quality of Care Report and a range of patient information brochures that are available throughout Stawell Regional Health.

The Annual Report is presented at the Annual General Meeting each year.

Protected Disclosure Act 2012

Stawell Regional Health is committed to the aims and objectives of the Protected Disclosure Act 2012 (the Act). Stawell Regional Health Service addresses this through leadership and management, including raising awareness of the Act and educating staff.

Freedom of Information

Stawell Regional Health has received 17 requests for information under the Freedom of Information Act (1982) during the 2016-17 financial year, a decrease of one (7) on the previous financial year.

- Sixteen cases were granted in full
- No cases where the records were destroyed.
- No requests for access were denied
- No cases where no documents were available
- One case was referred to VCAT for a decision on the release of information.
- There were no cases where the requests were not finalised at the time of reporting.

Victorian Industry Participation Policy

Stawell Regional Health complies with the Victorian Industry Participation Policy Act 2003.

Competitive Neutrality

All competitive neutrality requirements were met in accordance with the requirements of the Government policy statement, Competitive Neutrality Policy Victoria and subsequent reforms.

Financial Management Act 1994

In accordance with the Direction of the Minister for Finance, the information has been prepared and is available to the relevant Minister, and Members of Parliament.

Disability Action Plan (DAP)

Stawell Regional Health has developed a Disability Action Plan, with input from departments across the Service, to combine key details around the current and future needs of service and access for people with a disability.

Further implementation, including evaluation and review, will be undertaken in the near future through the Executive to continue to determine key priorities in current strategic planning processes.

Carers Recognition Act 2012

Stawell Regional Health has taken measures to ensure awareness and understanding of care relationship principles, in line with Section 11 of the Carer's Recognition Act 2012.

Reporting on Office Based Environmental Data

Stawell Regional Health is committed to reducing our greenhouse footprint, and conducts Environmental Meetings each quarter to achieve a reduction in water consumption and landfill and increase recycling rates and energy efficiency. Environmental data is reported to the Department of Health and Human Services via the Agency Information Management System (AIMS).

Safe Patient Care Act 2015

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

Disclosure of ICT Expenditure

The total ICT expenditure incurred during 2016-17 is $1.206m (excluding GST) with the details shown below

Business As Usual (BAU) ICT expenditure (Total) (excluding GST)	Non-Business As Usual (non BAU) ICT expenditure (Total=Operational expenditure and Capital Expenditure) (excluding GST)	Operational expenditure (excluding GST)	Capital expenditure (excluding GST)
$560,802	**$645,529**	**560,802**	**$84,727**

Consultancies

Details of consultancies (under $10,000)

In 2016-17 there were two (2) consultancies where the total fees payable to the consultants were less than $10,000. The total expenditure incurred during 2016-17 in relation to these consultancies is $14,551 (excl. GST).

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

In 2016-17 there were four (4) consultancies where the total fees payable to the consultants were $10,000 or greater. The total expenditure incurred during 2016-17 in relation to these consultancies is $134,206 (excl. GST).

Details of individual consultancies can be viewed at www.srh.org.au

Disclosure Index

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

Legislation	Requirement	Page
Ministerial Directions		
Report of operations – FRD guidance		
Charter and purpose		
FRD 22H	Manner of establishment and the relevant Ministers	Page 14
FRD 22H	Purpose, functions, powers and duties	Page 14
FRD 22H	Initiatives and key achievements	Pages 8-9
FRD 22H	Nature and range of services provided	Page 15
Management and structure		
FRD 22H	Organisational structure	Page 6
Financial and other information		
FRD 10A	Disclosure index	Page 25
FRD 11A	Disclosure of ex gratia expenses	N/A
FRD 21C	Responsible person and executive officer disclosures	Page 89
FRD 22H	Application and operation of Protected Disclosure 2012	Page 24
FRD 22H	Application and operation of Carers Recognition Act 2012	Page 24
FRD 22H	Application and operation of Freedom of Information Act 1982	Page 24
FRD 22H	Compliance with building and maintenance provisions of Building Act 1993	Page 23
FRD 22H	Details of consultancies over $10,000	Page 24
FRD 22H	Details of consultancies under $10,000	Page 24
FRD 22H	Employment and conduct principles	Page 22
FRD 22H	Information and Communication Technology Expenditure	Page 24
FRD 22H	Major changes or factors affecting performance	Page 9-10
FRD 22H	Occupational violence	Page 13
FRD 22H	Operational and budgetary objectives and performance against objectives	Pages 16-22
FRD 22H	Significant changes in financial position during the year	Pages 9-10
FRD 22H	Statement on National Competition Policy	Page 24
FRD 22H	Subsequent events	N/A
FRD 22H	Summary of the financial results for the year	Page 10
FRD 22H	Additional information available on request	Page 14
FRD 22H	Workforce Data Disclosures including a statement on the application of employment and conduct principles	Pages 10-11

Legislation	Disclosure Required	Page
FRD 25C	Victorian Industry Participation Policy disclosures	Page 24
FRD 103F	Non-Financial Physical Assets	Pages 54-55
FRD 110A	Cash flow Statements	Page 32
FRD 112D	Defined Benefit Superannuation Obligations	Page 46
SD 5.2.3	Declaration in report of operations	Page 5
SD 3.7.1	Risk management framework and processes.	Page 14
Other requirements under Standing Directions 5.2		
SD 5.2.2	Declaration in financial statements	Page 26
SD 5.2.1(a)	Compliance with Australian accounting standards and other authoritative pronouncements	Page 33
SD 5.2.1(a)	Compliance with Ministerial Directions	Page 14
Legislation		
Freedom of Information Act 1982		Page 24
Protected Disclosure Act 2012		Page 24
Carers Recognition Act 2012		Page 24
Victorian Industry Participation Policy Act 2003		Page 24
Building Act 1993		Page 23
Financial Management Act 1994		Page 24
Safe Patient Care Act 2015		Page 24

Stawell Regional Health

Board Member's, Accountable Officer's and Chief Finance & Accounting Officer's Declaration

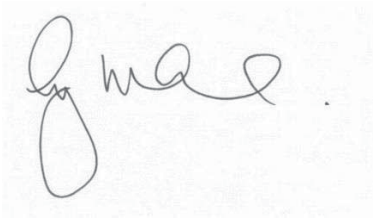
The attached financial statements for Stawell Regional Health and the consolidated entity (SRH Foundation) have been prepared in accordance with Standing Direction 4.2 of the Financial Management Act 1994, applicable Financial Reporting Directions, Australian Accounting Standards, Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2017 and the financial position of Stawell Regional Health and the Consolidated entity (SRH Foundation) at 30 June 2017.

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

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

Rhian Jones
Board Chair
Stawell
25th August 2017



Liz McCourt
Accountable Officer
Stawell
25th August 2017

Nick Starkie
Chief Finance & Accounting Officer
Stawell
25th August 2017

Independent Auditor's Report

VAGO
Victorian Auditor-General's Office

To the Board of Stawell Regional Health

Opinion

I have audited the consolidated financial report of Stawell Regional Health (the health service) and its controlled entity (together the consolidated entity), which comprises the:

- consolidated entity and health service balance sheet as at 30 June 2017
- consolidated entity and health service comprehensive operating statement for the year then ended
- consolidated entity and health service statement of changes in equity for the year then ended
- consolidated entity and health service 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 positions of the consolidated entity and 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 that Act and those standards 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 and the consolidated entity 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 and the consolidated entity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.

Level 31 / 35 Collins Street, Melbourne Vic 3000
T 03 8601 7000 enquiries@audit.vic.gov.au www.audit.vic.gov.au

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 and the consolidated entity'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 and the consolidated entity'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 and the consolidated entity 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
- obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the health service and consolidated entity to express an opinion on the financial report. I remain responsible for the direction, supervision and performance of the audit of the health service and the consolidated entity. I remain solely responsible for my audit opinion.

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
26 August 2017

Ron Mak
as delegate for the Auditor-General of Victoria

2

Stawell Regional Health
Comprehensive Operating Statement
For the Financial Year Ended 30 June 2017

	Note	Parent Entity 2017 $'000	Parent Entity 2016 $'000	Consol'd 2017 $'000	Consol'd 2016 $'000
Revenue from operating activities	2.1	26,666	25,340	26,666	25,340
Revenue from non-operating activities	2.1	198	280	198	280
Employee expenses	3.1	(15,351)	(15,361)	(15,351)	(15,361)
Non salary labour costs	3.1	(4,208)	(2,790)	(4,208)	(2,790)
Supplies and consumables	3.1	(4,107)	(4,067)	(4,107)	(4,067)
Other expenses	3.1	(3,424)	(3,125)	(3,430)	(3,129)
Net result before capital and specific items		**(226)**	**277**	**(232)**	**273**
Capital purpose income	2.1	386	1,206	459	1,325
Depreciation and Amortisation	4.3	(1,844)	(1,993)	(1,844)	(1,993)
Expenditure for Capital Purpose	3.1	(279)	(7)	(279)	(7)
Net Result after capital and specific items		**(1,963)**	**(517)**	**(1,896)**	**(402)**
Other economic flows included in net result					
Net gain/(loss) on non-financial assets	7.2	**28**	**20**	**28**	**20**
Revaluation of Long Service Leave		**(77)**	**(88)**	**(77)**	**(88)**
Total other economic flows included in net result		**(49)**	**(68)**	**(49)**	**(68)**
Net Result for the year		**(2,012)**	**(585)**	**(1,945)**	**(470)**
Comprehensive result		**(2,012)**	**(585)**	**(1,945)**	**(470)**

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

Stawell Regional Health
Balance Sheet
As at 30 June 2017

	Note	Parent Entity 2017 $'000	Parent Entity 2016 $'000	Consol'd 2017 $'000	Consol'd 2016 $'000
Current assets					
Cash and cash equivalents	6.1	6,343	7,554	8,121	9,263
Receivables	5.2	707	706	724	725
Inventories	5.1	95	135	95	135
Prepayments and Other assets	5.4	351	355	351	355
Total current assets		**7,496**	**8,750**	**9,291**	**10,478**
Non-current assets					
Receivables	5.2	79	24	79	24
Property, plant & equipment	4.2	24,720	25,388	24,720	25,388
Intangible assets	4.4	318	307	318	307
Total non-current assets		**25,117**	**25,719**	**25,117**	**25,719**
TOTAL ASSETS		**32,613**	**34,469**	**34,408**	**36,197**
Current liabilities					
Payables	5.5	2,036	1,718	2,040	1,722
Provisions	3.3	3,048	2,811	3,048	2,811
Other current liabilities	5.3	38	448	38	448
Total current liabilities		**5,122**	**4,977**	**5,126**	**4,981**
Non-current liabilities					
Provisions	3.3	590	579	590	579
Total non-current liabilities		**590**	**579**	**590**	**579**
TOTAL LIABILITIES		**5,712**	**5,556**	**5,716**	**5,560**
NET ASSETS		**26,901**	**28,913**	**28,692**	**30,637**
EQUITY					
Property, plant & equipment revaluation surplus	8.1a	13,886	13,886	13,886	13,886
General purpose surplus	8.1a	500	494	500	494
Restricted specific purpose surplus	8.1b	1,989	1,978	1,989	1,978
Contributed capital	8.1b	9,345	9,345	9,345	9,345
Accumulated surpluses/(deficits)	8.1c	1,181	3,210	2,972	4,934
TOTAL EQUITY	8.1c	**26,901**	**28,913**	**28,692**	**30,637**
Contingent assets and contingent liabilities	7.3				
Commitments	6.2				

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

Stawell Regional Health
Statement of Changes in Equity
For the Financial Year Ended 30 June 2017

Consolidated	Note	Property, Plant & Equipment Revaluation Surplus $'000	General Purpose Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributed Capital $'000	Accumulated Surpluses/ (Deficits) $'000	Total $'000
Balance at 1 July 2015		**13,886**	**316**	**2,089**	**9,345**	**5,471**	**31,107**
Net result for the year		-	-	-	-	(470)	(470)
Transfer (to) from accumulated surplus		-	178	(111)	-	(67)	-
Balance at 30 June 2016		**13,886**	**494**	**1,978**	**9,345**	**4,934**	**30,637**
Net result for the year		-	-	-	-	(1,945)	(1,945)
Transfer to (from) accumulated surplus	8.1b	-	6	11	-	(17)	-
Balance at 30 June 2017		**13,886**	**500**	**1,989**	**9,345**	**2,972**	**28,692**

Parent	Note	Property, Plant & Equipment Revaluation Surplus $'000	General Purpose Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributed Capital $'000	Accumulated Surpluses/ (Deficits) $'000	Total $'000
Balance at 1 July 2015		**13,886**	**316**	**2,089**	**9,345**	**3,862**	**29,498**
Net result for the year		-	-	-	-	(585)	(585)
Transfer (to) from accumulated surplus		-	178	(111)	-	(67)	-
Balance at 30 June 2016		**13,886**	**494**	**1,978**	**9,345**	**3,210**	**28,913**
Net result for the year		-	-	-	-	(2,012)	(2,012)
Transfer to (from) accumulated surplus	8.1b	-	6	11	-	(17)	-
Balance at 30 June 2017		**13,886**	**500**	**1,989**	**9,345**	**1,181**	**26,901**

This Statement should be read in conjunction with the accompanying notes

Stawell Regional Health
Cash Flow Statement
For the Financial Year Ended 30 June 2017

	Note	Parent Entity 2017 $'000	Parent Entity 2016 $'000	Consol'd 2017 $'000	Consol'd 2016 $'000
CASH FLOWS FROM OPERATING ACTIVITIES					
Operating grants from government		20,109	19,576	20,109	19,576
Capital grants from government		344	1,153	344	1,153
Patient and resident fees received		4,585	1,888	4,585	1,888
Donations and bequests received		99	53	124	124
GST received from/(paid to) ATO		(101)	45	(101)	45
Interest received		174	228	220	262
Other receipts		1,912	3,475	1,912	3,475
Total receipts		**27,122**	**26,418**	**27,193**	**26,523**
Employee expenses paid		(15,211)	(15,104)	(15,211)	(15,104)
Non salary labour costs		(1,253)	(2,790)	(1,253)	(2,790)
Payments for supplies & consumables		(5,953)	(3,612)	(5,953)	(3,612)
Other payments		(4,462)	(3,106)	(4,464)	(3,110)
Total payments		**(26,879)**	**(24,612)**	**(26,881)**	**(24,616)**
NET CASH FLOW FROM/(USED IN) OPERATING ACTIVITIES	8.2	**243**	**1,806**	**312**	**1,907**
CASH FLOWS FROM INVESTING ACTIVITIES					
Payments for non-financial assets		(1,102)	(1,307)	(1,102)	(1,307)
Payment for intangible assets		-	(54)		(54)
Proceeds from sale of non-financial assets		59	27	59	27
Cash from/(used in) joint venture		-	70	-	70
NET CASH FLOW FROM/(USED IN) INVESTING ACTIVITIES		**(1,043)**	**(1,264)**	**(1,043)**	**(1,264)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		**(800)**	**542**	**(731)**	**643**
Cash and cash equivalents at beginning of financial year		**7,106**	**6,564**	**8,815**	**8,172**
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.1	**6,306**	**7,106**	**8,084**	**8,815**

This Statement should be read in conjunction with the accompanying notes

Basis of presentation

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

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

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

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

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

Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements made in the preparation of these financial statements are disclosed in the notes where amounts affected by those judgements are disclosed. Estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

Note 1: Summary of significant accounting policies

These annual financial statements represent the audited general purpose financial statements for Stawell Regional Health 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 AASBs, which include interpretations issued by the Australian Accounting Standards Board (AASB). They are presented in a manner consistent with the requirements of AASB 101 *Presentation of Financial Statements.*

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

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

The annual financial statements were authorised for issue by the Board of Stawell Regional Health on 25th August 2017.

(b) Reporting entity

The financial statements include all the controlled activities of the *Stawell Regional Health*.

Its principal address is:
27-29 Sloane Street
Stawell
Victoria 3380.

A description of the nature of *Stawell Regional Health*'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
Stawell Regional Health's overall objective is to deliver high quality care and improve health outcomes by providing safe, accessible and integrated services and to improve the quality of life to Victorians.

Stawell Regional Health is predominantly funded by accrual based grant funding for the provision of outputs.

(c) Basis of accounting preparation and measurement

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

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

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

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

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

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

- non-current physical assets, which subsequent to acquisition, are measured at a revalued amount being their fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made and are re-assessed when new indices are published by the Valuer General to ensure that the carrying amounts do not materially differ from their fair values;
- available-for-sale investments which are measured at fair value with movements reflected in equity until the asset is derecognised (i.e. other comprehensive income – items that may be reclassified subsequent to net result).
- the fair value of assets other than land is generally based on their depreciated replacement value.

Judgements, estimates and assumptions are required to be made about the carrying 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

These statements are presented on a consolidated basis in accordance with AASB 10 *Consolidated Financial Statements*:

- The consolidated financial statements of *Stawell Regional Health* include all reporting entities controlled by *Stawell Regional Health* as at 30 June 2017; and
- The consolidated financial statements exclude bodies of *Stawell Regional Health* that are not controlled by *Stawell Regional Health*, and therefore are not consolidated.
- Control exists when *Stawell Regional Health* has the power to govern the financial and operating policies of a Health Service so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable are taken into account. The consolidated financial statements include the audited financial statements of the controlled entities listed in note 8.8.
- The parent entity is not shown separately in the notes.

Where control of an entity is obtained during the financial period, its results are included in the comprehensive operating statement from the date on which control commenced. Where control ceases during a financial period, the entity's results are included for that part of the period in which control existed. Where entities adopt dissimilar accounting policies and their effect is considered material, adjustments are made to ensure consistent policies are adopted in these financial statements.

Entities consolidated into *Stawell Regional Health* reporting entity include:

Stawell Regional Health Foundation

Intersegment Transactions

Transactions between segments within the *Stawell Regional Health* have been eliminated to reflect the extent of the Stawell Regional Health's operations as a group.

Note 2: Funding Delivery of Our Services

The hospital's overall objective is to deliver programs and services that support and nhance the wellbing 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 2017 $'000	Non-Admitted 2017 $'000	RAC incl. Mental Health 2017 $'000	Aged Care 2017 $'000	Primary Health 2017 $'000	Other 2017 $'000	Total 2017 $'000
Government Grant	14,392	-	2,883	705	2,121	-	20,101
Indirect contributions by Department of Health and Human Services	21	-	-	-	-	-	21
Patient & Resident Fees	595	29	664	132	69	-	1,489
Commerical Activities	-	-	-	-	-	3,461	3,461
Other Revenue from Operating Activities	1,005	-	-	23	60	30	1,118
Grampians Rural Health Alliance						476	476
Total Revenue from Operating Activities	**16,013**	**29**	**3,547**	**860**	**2,250**	**3,967**	**26,666**
	-	-	-	-	-	-	
Interest	-	-	-	-	-	198	198
Other Revenue from Non-Operating Activities	-	-	-	-	-		-
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**-**	**-**	**198**	**198**
Capital Purpose Income (excluding Interest)	-	-	-	-	-	437	437
Capital Interest	-	-	-	-	-	22	22
Total Capital Purpose Income	**-**	**-**	**-**	**-**	**-**	**459**	**459**
Total Revenue	**16,013**	**29**	**3,547**	**860**	**2,250**	**4,624**	**27,323**

	Admitted Patients 2016 $'000	Non-Admitted 2016 $'000	RAC incl. Mental Health 2016 $'000	Aged Care 2016 $'000	Primary Health 2016 $'000	Other 2016 $'000	Total 2016 $'000
Government Grant	13,794	-	2,954	691	2,070	-	19,509
Indirect contributions by Department of Health and Human Services	24	-	-	-	-	-	24
Patient & Resident Fees	785	113	736	114	105	-	1,853
Commerical Activities	-	-	-	-	-	2,593	2,593
Other Revenue from Operating Activities	765	-	-	25	47	-	837
Grampians Rural Health Alliance						524	524
Total Revenue from Operating Activities	**15,368**	**113**	**3,690**	**830**	**2,222**	**3,117**	**25,340**
Interest		-	-	-	-	176	176
Other Revenue from Non-Operating Activities	104	-	-	-	-	20	124
Total Revenue from Non-Operating Activities	**104**	**-**	**-**	**-**	**-**	**196**	**300**
Capital Purpose Income (excluding Interest)		-	-	-	-	1,277	1,277
Capital Interest	-	-	-	-	-	48	48
Capital Dividends							
Total Capital Purpose Income	**-**	**-**	**-**	**-**	**-**	**1,325**	**1,325**
Total Revenue	**15,472**	**113**	**3,690**	**830**	**2,222**	**4,638**	**26,965**

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 Stawell Regional Health 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.

Note 2.1: Analysis of Revenue by Source (cont).

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

Indirect Contributions from the Department of Health and Human Services

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

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

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

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

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

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

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

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

Category groups

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

· Admitted Patient Services (Admitted Patients) comprises all acute and subacute admitted patient services, where services are delivered in public hospitals.

· Mental Health Services (Mental Health) comprises all specialised mental health services providing a range of inpatient, community based residential, rehabilitation and ambulatory services which treat and support people with a mental illness and their families and carers. These services aim to identify mental illness early, and seek to reduce its impact through providing timely acute care services and appropriate longer-term accommodation and support for those living with a mental illness.

· Non Admitted Services comprises acute and subacute non admitted services, where services are delivered in public hospital clinics and provide models of integrated community care, which significantly reduces the demand for hospital beds and supports the transition from hospital to home in a safe and timely manner.

Note 2.1: Analysis of Revenue by Source (cont).

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

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

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

· Other Services not reported elsewhere - (Other) comprises services not separately classified above, including: Public Health Services including laboratory testing, blood borne viruses / sexually transmitted infections clinical services, immunisation and screening services, drugs services including drug withdrawal, counselling and the needle and syringe program, Disability services including aids and equipment and flexible support packages to people with a disability, Community Care programs including sexual assault support, early parenting services, parenting assessment and skills development, and various support services. Health and Community Initiatives also falls in this category group.

Note 3: The Cost of Delivering Our 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 Analysis of expense and revenue by internally managed and restricted specific purpose funds
3.3 Employee Benefits in the Balance Sheet
3.4 Superannuation

Note 3.1: Analysis of Expenses by Source

	Admitted Patients 2017 $'000	Non-Admitted 2017 $'000	RAC incl. Mental Health 2017 $'000	Aged Care 2017 $'000	Primary Health 2017 $'000	Other 2017 $'000	Total 2017 $'000
Employee Expenses	6,429	729	3,246	864	2,360	1,723	15,351
Other Operating Expenses							
Non Salary Labour Costs	2,799	160	231	70	189	759	4,208
Supplies & Consumables	2,796	24	182	17	157	931	4,107
Other Expenses	1,213	152	106	14	327	1,253	3,065
Share of Jointly Controlled Expenses	-	-	-	-	-	365	365
Total Expenditure from Operating Activities	**13,237**	**1,065**	**3,765**	**965**	**3,033**	**5,031**	**27,096**
Expenditure for Capital Purposes	**-**	**-**	**-**	**-**	**-**	279	279
Depreciation & Amortisation (refer note 4.5)	-	-	-	-	-	1,844	1,844
Total other expenses	**-**	**-**	**-**	**-**	**-**	**2,123**	**2,123**
Total Expenses	**13,237**	**1,065**	**3,765**	**965**	**3,033**	**7,154**	**29,219**

	Admitted Patients 2016 $'000	Non-Admitted 2016 $'000	RAC incl. Mental Health 2016 $'000	Aged Care 2016 $'000	Primary Health 2016 $'000	Other 2016 $'000	Total 2016 $'000
Employee Expenses	6,816	378	3,704	825	2,128	1,510	15,361
Other Operating Expenses							
Non Salary Labour Costs	2,219	189	45	-	180	157	2,790
Supplies & Consumables	3,510	22	49	12	40	434	4,067
Other Expenses	2,094	26	160	13	125	395	2,813
Share of Jointly Controlled Expenses	-	-	-	-	-	404	404
Total Expenditure from Operating Activities	**14,639**	**615**	**3,958**	**850**	**2,473**	**2,900**	**25,435**
Expenditure for Capital Purposes	**-**	**-**	**-**	**-**	**-**	7	7
Depreciation & Amortisation (refer note 4.5)	-	-	-	-	-	1,993	1,993
Total other expenses	**-**	**-**	**-**	**-**	**-**	**2,000**	**2,000**
Total Expenses	**14,639**	**615**	**3,958**	**850**	**2,473**	**4,900**	**27,435**

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

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

Employee expenses
Employee expenses include:

- wages and salaries;
- fringe benefits tax;
- leave entitlements;
- workcover premiums; 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.

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.

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

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:

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 amount of the asset at the time.

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.

Derecognition of financial liabilities

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

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

Note 3.2: Analysis of expense and revenue by internally managed and restricted specific purpose funds for services supported by hospital and community initiatives

	Expense		Revenue	
	Consol'd 2017 $'000	Consol'd 2016 $'000	Consol'd 2017 $'000	Consol'd 2016 $'000
Commercial Activities				
Private Practice and Other Patient Activities	2,185	1,128	2,094	927
Diagnostic Imaging	1,043	1,058	1,056	1,149
Cafeteria	121	155	142	181
Other Activities				
Fundraising and Community Support	179	150	73	860
TOTAL	**3,528**	**2,491**	**3,365**	**3,117**

Note 3.3: Employee benefits in the balance sheet

	Consol'd 2017 $'000	Consol'd 2016 $'000
Current Provisions		
Employee Benefits [(i)]		
Annual leave		
- Unconditional and expected to be settled wholly within 12 months [(ii)]	976	837
- Unconditional and expected to be settled wholly after 12 months [(iii)]	81	70
Long service leave		
- Unconditional and expected to be settled wholly within 12 months [(ii)]	207	104
- Unconditional and expected to be settled wholly after 12 months [(iii)]	1,229	1,200
Accrued Days Off		
- Unconditional and expected to be settled within 12 months [(ii)]	61	59
Accrued Salaries and Wages		
- Unconditional and expected to be settled within 12 months [(ii)]	179	252
	2,733	2,522
Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months [(ii)]	164	155
- Unconditional and expected to be settled after 12 months [(iii)]	151	134
	315	289
Total Current Provisions	**3,048**	**2,811**
Non-Current Provisions		
Employee Benefits [(i)]	534	523
Provisions related to Employee Benefit On-Costs	56	56
Total Non-Current Provisions	**590**	**579**
Total Provisions	**3,638**	**3,390**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Unconditional LSL Entitlement	1,588	1,442
Annual Leave Entitlements	1,103	1,025
Accrued Wages and Salaries	198	279
Accrued Days Off	67	65
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements [(ii)]	590	488
Conditional Annual Leave Entitlements	92	91
Total Employee Benefits and Related On-Costs	**3,638**	**3,390**

Notes:
(i) Provisions for employee benefits consist of amounts for annual leave and long service leave accrued by

employes, not including on-costs
(ii) The amounts disclosed are nominal amounts
(iii) The amounts disclosed are discounted to present values

Note 3.3: Employee benefits in the balance sheet (cont.)

Movements in provisions	Consol'd 2017 $'000	Consol'd 2016 $'000
Movement in Long Service Leave:		
Balance at start of year	**1,930**	**1,899**
Provision made during the year		
- Revaluations	77	88
- Expense recognising Employee Service	378	236
Settlement made during the year	(207)	(293)
Balance at end of year	**2,178**	**1,930**

Provisions

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

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

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

Employee benefits

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

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

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

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

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

Long service leave (LSL)

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

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

The components of this current LSL liability are measured at:

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

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

Note 3.3: Employee benefits in the balance sheet (cont.)

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

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

Note 3.4: Superannuation

	Paid Contribution for the Year		Contribution Outstanding at	
	Consol'd 2017 $'000	**Consol'd 2016 $'000**	**Consol'd 2017 $'000**	**Consol'd 2016 $'000**
Defined benefit plans:				
First State Super	42	72	-	-
Other				
Defined contribution plans:				
First State / HESTA/ Others	1229	1204	-	-
Other				
Total	1271	1276	-	-

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

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

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

The name, details and amounts expense in relation to the major employee superannuation funds and contributions made by the Health Services are as follows:

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 Stawell Regional Health are entitled to receive superannuation benefits and Stawell Regional Health 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

Stawell Regional Health does not recognise any unfunded defined benefit liability in respect of the superannuation plans because the Health Service has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due.

Note 4: 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 Jointly Controlled Operations and Assets
4.2 Property, plant & equipment
4.3 Depreciation and amortisation
4.4 Intangible assets

Note 4.1: Jointly Controlled Operations and Assets

			Ownership Interest	
Name of Entity	**Principal Activity**	**Country of Incorporation**	**2017 %**	**2016 %**
Joint Operations				
Grampains Rural Health Alliance	Information Systems	Australia	6.34	6.21

Note 4.1: Jointly Controlled Operations and Assets (Continued)

Stawell Regional Health's interest in assets employed in the above jointly controlled operations and assets is detailed below. The amounts are included in the financial statements and consolidated under their respective asset categories.

	2017 $'000	2016 $'000
Current Assets		
Cash and Cash Equivalents	206	132
Receivables	28	80
Inventories	-	-
Prepayments	2	11
Total Current Assets	**236**	**223**
Non-Current Assets		
Property, Plant and Equipment	235	149
Total Non Current Assets	**235**	**149**
Total Assets	**471**	**372**
Current Liabilities		
Payables	37	49
Borrowings	-	-
Employee Provisions	-	-
Total Current Liabilities	**37**	**49**
Non-Current Liabilities		
Payables	-	-
Total Non Current Liabilities	**-**	**-**
Total Liabilities	**37**	**49**
Total Net Assets	**434**	**323**

Stawell Regional Health's interest in revenues and expenses resulting from jointly controlled operations and assets is detailed below:

Revenues		
Operating Activities	348	383
Non Operating Activities	7	8
Total Revenue	355	391
Expenses		
Employee Expenses	97	107
Maintenance Contracts and IT Support	43	48
Operating Lease Costs	-	-
Other Expenses	198	219
Total Operating Expenses	338	374
Capital Purpose Income	121	133
Finance Lease Charges		
Depreciation	27	30
Total Capital and Specific Items	94	103
Other Economic Flows included in the result		
Revaluation of Long Service Leave		
Net Result	**111**	**120**

The financial results included for The Grampians Rural Health Alliance for 2017 are unaudited at the date of signing the financial statements.

Contingent Liabilities and Capital Commitments
There are no known contingent assets or liabilities for The Grampians Rural Health Alliance as at the date of this report.

Investments in joint operations

In respect of any interest in joint operations, Stawell Regional Health recognises in the financial statements:

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

Note 4.2: Property, plant & equipment

(a) Gross carrying amount and accumulated depreciation

	Consol'd 2017 $'000	Consol'd 2016 $'000
Land		
Land at Fair Value	1,400	1,400
Total Land	**1,400**	**1,400**
Buildings		
Buildings Under Construction at cost	209	177
Buildings at Fair Value	24,038	23,815
Less Acc'd Depreciation	3,993	2,684
Total Buildings	**20,254**	**21,308**
Plant and Equipment		
Plant and Equipment at Fair Value	2,762	2,259
Less Acc'd Depreciation	1,662	1,553
Total Plant and Equipment	**1,100**	**706**
Medical Equipment		
Medical Equipment at Fair Value	5,037	4,877
Less Acc'd Depreciation	3,336	3,052
Total Medical Equipment	**1,701**	**1,825**
Jointly Controlled PP&E		
Jointly Controlled PP&E at Fair Value	265	187
Less Acc'd Depreciation	-	38
Total Cultural Assets	**265**	**149**
TOTAL	**24,720**	**25,388**

Note 4.2: Property, plant & equipment (continued)

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

	Land (i) $'000	Buildings $'000	Plant & Equipment $'000	Medical Equipment $'000	Jointly Cont PP&E $'000	Assets Under Construction $'000	Consol'd Total $'000
Balance at 1 July 2015	**1,400**	**22,391**	**671**	**1,324**	**69**	**-**	**25,855**
Additions	-	37	301	889	80	177	1,484
Disposals	-	-	-	(7)	-	-	(7)
Depreciation (Note 4.3)	-	(1,297)	(266)	(381)	-	-	(1,944)
Balance at 1 July 2016	**1,400**	**21,131**	**706**	**1,825**	**149**	**177**	**25,388**
Additions	-	46	654	167	116	209	1,192
Disposals	-	-	(32)	-	-	-	(32)
Depreciation (Note 4.3)	-	(1,309)	(228)	(291)	-	-	(1,828)
Balance at 30 June 2017	**1,400**	**19,868**	**1,100**	**1,701**	**265**	**386**	**24,720**

Land and buildings carried at valuation

An independent valuation of the Health Service's land and buildings was performed by *the Valuer-General Victoria* to determine the fair 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*

Note 4.2: Property, plant & equipment (continued)

(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 (1)	Level 2 (1)	Level 3 (1)
Land at fair value				
Non-specialised land	350	-	350	-
Specialised land	1,050	-	-	1,050
Total of land at fair value	1,400	-	350	1,050
Buildings at fair value				
Non-specialised buildings	105	-	105	-
Specialised buildings	19,940	-	-	19,940
Heritage assets				
Total of building at fair value	20,045	-	105	19,940
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	293	-	-	293
- Plant and equipment	807	-	-	807
Total of plant, equipment and vehicles at fair value	1,100	-	-	1,100
Medical equipment at fair value				
Total medical equipment at fair value	1,701	-	-	1,701
Jointly controlled equipment at fair value				
Jointly controlled equipment at fair value		-	-	265
Total Jointly controlled equipment at fair value	265	-	-	265
Assets under construction at fair value				
Total assets under construction at fair value	209	-	-	209
	24,720	**-**	**455**	**24,265**

Note 4.2: Property, plant & equipment (continued)

	Carrying amount as at 30 June 2016	Fair value measurement at end of reporting period using:		
		Level 1 (1)	Level 2 (1)	Level 3 (1)
Land at fair value				
Non-specialised land	350	-	350	-
Specialised land	1,050	-	-	1,050
Total of land at fair value	1,400	-	350	1,050
Buildings at fair value				
Non-specialised buildings	105	-	105	-
Specialised buildings	21,026	-	-	21,026
Buildings Under Construction	-	-	-	
Total of building at fair value	21,131	-	105	21,026
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	290	-	-	290
- Plant and equipment	416	-	-	416
Total of plant, equipment and vehicles at fair value	706	-	-	706
Medical equipment at fair value				
Total medical equipment at fair value	1,825	-	-	1,825
Jointly controlled equipment at fair value				
Total Jointly controlled equipment at fair value	149	-	-	149
Assets under construction at fair value				
Total assets under construction at fair value	177	-	-	177
	25,388	**-**	**455**	**24,933**

Note

(i) Classified in accordance with the fair value hierarchy,

(ii) Vehicles are categorised to Level 3 assets if the depreciated replacement cost is used in estimating the fair value. Where a market approach is appropriate for vehicles with an active resale market available, a Level 2 categorisation for such vehicles would be appropriate.

There have been no transfers between levels during the period.

Note 4.2: Property, plant & equipment (continued)

Consistent with AASB 13 Fair Value Measurement, Stawell Regional Health 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 judgement is directly or indioreectly 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, Stawell Regional Health 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, Stawell Regional Health 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 Stawell Regional Health's independent valuation agency. Stawell Regional Health, in conjunction with VGV monitors the changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required.

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

- the fair value of land, buildings, infrastructure, plant and equipment (refer to Note 7.1):
- superannuation expense (refer to Note 3.4); and
- actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.3).

Fair value measurement

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

The fair value measurement is based on the following assumptions:

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

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

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

Note 4.2: Property, plant & equipment (continued)

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

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

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

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

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

These indicators, as a minimum, include:
External factors:
. Changed acts, regulations, local law or such instrument which affects or may affect the use or development of the asset;

. Changes in planning scheme, including zones, reservations, overlays that would affect or remove the restrictions imposed on the asset's use from its past use;
. Evidence that suggest the current use of an asset is no longer core to requirements to deliver a Health Service's service obligation;

. Evidence that suggests that the asset might be sold or demolished at reaching the late stage of an asset's life cycle.

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

Valuation hierarchy

Health Services need to use valuation techniques that are appropriate for the circumstances and where there is sufficient data available to measure fair value, maximising the use of relevant observable inputs and minimising the use of unobservable inputs.
All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy. It is based on the lowest level input that is significant to the fair value measurement as a whole:

Level 1 – Quoted (unadjusted) market prices in active markets for identical assets or liabilities;
Level 2 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable;
Level 3 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

Note 4.2: Property, plant & equipment (continued)

(d) Reconciliation of Level 3 fair value

30 June 2017	Land	Buildings	Plant and equipment	Medical equipment
Opening Balance	1,050	21,203	855	1,825
Purchases (sales)	-	255	738	167
Gains or losses recognised in net result				
- Depreciation	-	(1,309)	(228)	(291)
Closing Balance	**1,050**	**20,149**	**1,365**	**1,701**

There have been no transfers between levels during the period

30 June 2016	Land	Buildings	Plant and equipment	Medical equipment
Opening Balance	1,050	22,463	740	1,324
Purchases (sales)	-	37	381	882
Gains or losses recognised in net result				
- Depreciation	-	(1,297)	(266)	(381)
Closing Balance	**1,050**	**21,203**	**855**	**1,825**

There have been no transfers between levels during the period

Note 4.2: Property, plant & equipment (continued)

Identifying unobservable inputs (level 3) fair value measurements

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

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

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

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

Non-specialised land, non-specialised buildings and artwork

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

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

Note 4.2: Property, plant & equipment (continued)

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.

Note 4.2: Property, plant & equipment (continued)

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

	Valuation technique [(i)]	Significant unobservable inputs [(i)]
Specialised land	Market approach	Community Service Obligation (CSO) adjustment
Specialised buildings	Depreciated replacement cost	Direct cost per square metre Useful life of specialised buildings
Plant 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
Assets under construction at fair value	Depreciated replacement cost	Cost per unit

Note 4.2: Property, plant & equipment (continued)

Property, plant and equipment
All non-current physical assets are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and accumulated impairment loss. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. Assets transferred as part of a merger/machinery of government 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 4.4 *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 physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset. Theoretical opportunities that may be available in relation to the asset(s) are not taken into account until it is virtually certain that any restrictions will no longer apply. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best uses.

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

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

Note 4.2: Property, plant & equipment (continued)

Revaluations of non-current physical assets

Non-current physical assets are measured at fair value and are revalued in accordance with FRD 103F *Non-current physical assets* . This revaluation process normally occurs 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 amount and fair value.

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

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

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

Revaluation surplus is not normally transferred to accumulated funds on derecognition of the relevant asset.

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

Note 4.3: Depreciation and amortisation

	Consol'd 2017 $'000	Consol'd 2016 $'000
Depreciation		
Buildings	1,309	1,297
Plant & Equipment	228	266
Medical Equipment	291	381
Total Depreciation	**1,828**	**1,944**
Amortisation		
Intangible Assets	16	49
Total Amortisation	**16**	**49**
Total Depreciation and Amortisation	**1,844**	**1,993**

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

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

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

	2017	2016
Buildings		
- Structure Shell Building Fabric	45 to 60 years	45 to 60 years
- Site Enginerring Services and Central Plant	20 to 30 years	20 to 30 years
Central Plant		
- Fit Out	20 to 30 years	20 to 30 years
- Trunk Reticulated Building systems	30 to 40 years	30 to 40 years
Plant and 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 and Fittings	13 years	13 years
Motor Vehicles	10 years	10 years
Leasehold Inprovements	2 to 10 years	2 to 10 years

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

Note 4.4: Intangible Assets

	Consolidated 2017 $'000	Consolidated 2016 $'000
Development Costs Capitalised	556	530
Less Acc'd Amortisation	481	466
	75	**64**
Business Goodwill	243	243
Less Acc'd Amortisation	-	-
	243	**243**
Total Intangible Assets	**318**	**307**

Reconciliation of the carrying amounts of intangible assets at the beginning and end of the previous and current financial year:

	Development Costs Capitalised $'000	Business *Goodwill* $'000	Total $'000
Balance at 1 July 2015	**59**	**243**	**302**
Additions	54	-	54
Additions from Internal Developments	(49)	-	(49)
Balance at 1 July 2016	**64**	**243**	**307**
Additions	26	-	26
Amortisation (note 4.3)	(15)	-	(15)
Balance at 30 June 2017	**75**	**243**	**318**

(i) The consumption of separately acquired intangible assets is included in the 'amortisation' line item, where the consumption of the internally generated intangible assets is included in 'net gain/(loss) on non-financial assets' line item on the comprehensive operating statement
(ii) Impairment losses are included in the line item 'net gain/(loss) on non-financial assets' in the comprehensive operating statement.

Intangible assets

Intangible assets represent identifiable non-monetary assets without physical substance such as computer software.

Intangible assets are initially recognised at cost. Subsequently, intangible assets with finite useful lives are carried at cost less accumulated amortisation and accumulated impairment losses. Costs incurred subsequent to initial acquisition are capitalised when it is expected that additional future economic benefits will flow to the Health Service.

When the recognition criteria in AASB 138 *Intangible Assets* are met, internally generated intangible assets are recognised and measured at cost less accumulated depreciation/amortisation and impairment.

Note 4.4: Intangible Assets

Amortisation
Amortisation is allocated to intangible non-produced assets with finite useful lives on a systematic (typically straight-line) basis over the asset's useful life. Amortisation begins when the asset is available for use, that is, when it is in the location and condition necessary for it to be capable of operating in the manner intended by management. The consumption of intangible non-produced assets with finite useful lives is classified as amortisation.
The amortisation period and the amortisation method for an intangible asset with a finite useful life are reviewed at least at the end of each annual reporting period. In addition, an assessment is made at each reporting date to determine whether there are indicators that the intangible asset concerned is impaired. If so, the asset concerned is tested as to whether its carrying amount exceeds its recoverable amount.

Intangible assets with indefinite useful lives are not amortised, but are tested for impairment annually or whenever there is an indication that the asset may be impaired. The useful lives of intangible assets that are not being amortised are reviewed each period to determine whether events and circumstances continue to support an indefinite useful life assessment for that asset. In addition, the Health Service tests all intangible assets with indefinite useful lives for impairment by comparing the recoverable amount for each asset with its carrying amount:

- annually; and
- whenever there is an indication that the intangible asset may be impaired

Any excess of the carrying amount over the recoverable amount is recognised as an impairment loss.

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

Note 5: Other assets and liabilities

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

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

Note 5.1: Inventories

	Consol'd 2017 $'000	Consol'd 2016 $'000
Pharmaceuticals		
At cost	40	82
Medical and Surgical Lines		
At cost	55	53
Total Medical and Surgical lines	**55**	**53**
TOTAL INVENTORIES	**95**	**135**

All categories are valued at Cost and/or Net Realisable Value.

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

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

Inventories acquired for no cost or nominal considerations are measured at current replacement cost at the date of acquisition.
Cost for all other inventory is measured on the basis of weighted average cost.

Note 5.2: Receivables

	Consol'd 2017 $'000	Consol'd 2016 $'000
CURRENT		
Contractual		
Receivables - Grampians Rural Health Alliance	28	80
Trade Debtors	190	174
Patient Fees	254	243
Accrued Investment Income	24	41
Accrued Revenue	84	117
Less Allowance for Doubtful Debts		
Trade Debtors	(8)	-
Patient Fees	(40)	(44)
	532	**611**
Statutory		
GST Receivable	192	92
Accrued Revenue - Department of Health / Department of Health and Human Services	-	22
	192	**114**
TOTAL CURRENT RECEIVABLES	**724**	**725**
NON CURRENT		
Contractual		
Long Service Leave - Department of Health / Department of Health and Human Services	79	24
TOTAL NON-CURRENT RECEIVABLES	**79**	**24**
TOTAL RECEIVABLES	**803**	**749**

(a) Movement in the Allowance for doubtful debts

	Consol'd 2017 $'000	Consol'd 2016 $'000
Balance at beginning of year	44	31
Amounts written off during the year	(31)	(1)
Increase/(decrease) in allowance recognised in net result	35	14
Balance at end of year	**48**	**44**

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

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

Note 5.2: Receivables (continued)

Receivables consist of:

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

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

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

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

Note 5.3: Other liabilities

	Consol'd 2017 $'000	Consol'd 2016 $'000
CURRENT		
Monies Held in Trust		
- Patient Monies Held in Trust	31	42
- Accommodation Bonds (Refundable Entrance Fees)	-	402
- Other Monies Held in Trust	7	4
Total Current	**38**	**448**
Total Other Liabilities	**38**	**448**
Total Monies Held in Trust		
Represented by the following assets:		
Cash Assets (refer to Note 6.1)	38	448
	-	-
TOTAL	**38**	**448**

Note 5.4: Prepayments and other non-financial assets

	Consol'd 2017 $'000	Consol'd 2016 $'000
CURRENT		
Prepayments	349	344
Prepayments - Grampians Rural Health Alliance	2	11
TOTAL CURRENT OTHER ASSETS	**351**	**355**

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

Note 5.5: Payables

	Consol'd 2017 $'000	Consol'd 2016 $'000
CURRENT		
Contractual		
Trade Creditors	1,477	1,212
Payables - Grampians Rural Health Alliance	37	49
Accrued Expenses	405	230
Income Received in Advance	102	171
Amounts payable to governments and agencies		
Department of Health and Ageing	7	-
	2,028	**1,662**
Statutory		
Department of Health and Human Services		
Amounts payable to Government	12	60
	12	**60**
TOTAL CURRENT	**2,040**	**1,722**
TOTAL PAYABLES	**2,040**	**1,722**

(a) Maturity analysis of payables
Please refer to Note 7.1 for the ageing analysis of contractual payables

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

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

. statutory payables, such as goods and services tax and fringe benefits tax payables.

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

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 hospital.

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

Structure
6.1 Cash and cash equivalents
6.2 Commitments for expenditure

Note 6.1: Cash and Cash Equivalents

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.

	Consol'd 2017 $'000	Consol'd 2016 $'000
Cash on hand	2	2
Cash at bank	161	595
Short term money market	7,753	8,534
Cash & equivalents Grampians Rural Health Alliance	205	132
Total Cash and Cash Equivalents	**8,121**	**9,263**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	8,084	8,815
Cash for Monies Held in Trust		
- Patients Trust (note 5.3)	38	448
Total Cash and Cash Equivalents	**8,121**	**9,263**

Cash and cash equivalents recognised on the balance sheet comprise cash on hand and cash at bank, deposits at call and highly liquid investments (with an original maturity of three months or less), which are held for the purpose of meeting short term cash commitments rather than for investment purposes, which are readily convertible to known amounts of cash with an insignificant risk of changes in value.
For cash flow statement presentation purposes, cash and cash equivalents include bank overdrafts, which are included as liabilities on the balance sheet.

Note 6.2: Commitments for expenditure

a) Commitments payable.

	Consolidated 2017 $'000	Consolidated 2016 $'000
Lease commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating leases	222	144
Total lease commitments	**222**	**144**
Operating leases		
Not later than one year	121	32
Later than 1 year and not later than 5 years	144	126
Later than 5 years	-	-
Total	**265**	**158**
Total Lease Commitments	**222**	**144**

All amounts shown in the commitments note are nominal amounts inclusive of GST.

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

Note 7: Risks, contingencies and 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
7.4 Fair value determination

Note 7.1: Financial Instruments

Financial risk management objectives and policies

The Stawell Regional Health's principal financial instruments comprise of:
- *cash assets*
- *term deposits*
- *receivables (excluding statutory receivables)*
- *payables (excluding statutory payables)*

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, foreign currency risk and equity price risk (*amend as appropriate*). The Health Service manages these financial risks in accordance with its financial risk management policy.

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

The main purpose in holding financial instruments is to prudentially manage Stawell Regional Health financial risks within the government policy parameters.

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

2017	Contractual financial assets - loans and receivables	Contractual financial liabilities at amortised cost	Consolidated Total
	$'000	$'000	$'000
Contractual Financial Assets			
Cash and cash equivalents	8,121	-	8,121
Receivables			
- Trade Debtors	190	-	190
- Other Receivables	342	-	342
Total Financial Assets [(i)]	**8,653**	**-**	**8,653**
Financial Liabilities			
Payables		2,028	2,028
- Monies Hed in Trust	-	38	38
Total Financial Liabilities [(ii)]	**-**	**2,066**	**2,066**

Note 7.1: Financial Instruments (continued)

2016	Contractual financial assets - loans and receivables $'000	Contractual financial liabilities at amortised cost $'000	Consolidated Total $'000
Contractual Financial Assets			
Cash and cash equivalents	9,263	-	9,263
Receivables			
- Trade Debtors	174	-	174
- Other Receivables	437	-	437
Total Financial Assets [(i)]	**9,874**	**-**	**9,874**
Financial Liabilities			
Payables		1,662	1,662
- Monies Hed in Trust	-	448	448
Total Financial Liabilities [(ii)]	**-**	**2,110**	**2,110**

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

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

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

	Total Interest Income/Expense $'000	Consolidated Total $'000
2017		
Financial Assets		
Cash and Cash Equivalents [(i)]	220	220
Total Financial Assets	**220**	**220**
2016		
Financial Assets		
Cash and Cash Equivalents [(i)]	224	448
Total Financial Assets	**224**	**448**

(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 movement in the fair value of the asset, 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;

(ii) For financial liabilities measured 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; and

Note 7.1: Financial Instruments (continued)

(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. For debtors other than the Government, it is the Health Service's policy to only deal with entities with high credit ratings of a minimum Triple-B rating and to obtain sufficient collateral or credit enhancements, where appropriate.

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

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

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

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

	Financial institutions (BB credit rating)	Government agencies (AA credit rating)	Government agencies (BBB credit rating)	Other (min BBB credit rating)	Total
2017	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Financial Assets					
Cash and Cash Equivalents	4,121	4,000	-	-	8,121
Loans and Receivables					
- Trade Debtors	-	-	-	190	190
- Other Receivables (i)	-			342	342
Total Financial Assets	**4,121**	**4,000**	**-**	**532**	**8,653**
2016					
Financial Assets					
Cash and Cash Equivalents	4,763	4,500	-	-	9,263
Loans and Receivables					
- Trade Debtors	-	-	-	174	174
- Other Receivables	-	-	-	437	437
Total Financial Assets	**4,763**	**4,500**	**-**	**611**	**9,874**

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

Note 7.1: Financial Instruments (continued)

(c) Credit Risk (continued)

Ageing analysis of Financial Assets as at 30 June

	Consol'd Carrying Amount	Not Past Due and Not Impaired	Past Due But Not Impaired		
			Less than 1 Month	1-3 Months	3 months - 1 Year
2017	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Financial Assets					
Cash and Cash Equivalents	8,121	8,121	-	-	-
Loans and Receivables					
- Trade Debtors	190	-	195	8	15
- Other Receivables	342	314	-	-	-
Total Financial Assets	**8,653**	**8,435**	**195**	**8**	**15**
2016					
Financial Assets					
Cash and Cash Equivalents	9,263	9,263	-	-	-
Loans and Receivables					
- Trade Debtors	174	-	157	15	2
- Other Receivables	437	437	-	-	-
Total Financial Assets	**9,874**	**9,700**	**157**	**15**	**2**

(i) Ageing analysis of financial assets must exclude the types of statutory financial assets (i.e GST input tax credit)

Contractual financial assets that are either past due or impaired

There are no material financial assets which are individually determined to be impaired. Currently the Health Service does not hold any collateral as security nor credit enhancements relating to 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 their carrying amounts as indicated. The ageing analysis table above discloses the ageing only of contractual financial assets that are past due but not impaired.

Note 7.1: Financial Instruments (continued)

(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.

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 as follows:

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

Maturity analysis of Financial Liabilities as at 30 June

			Maturity Dates			
	Carrying Amount	Nominal Amount	Less than 1 Month	1-3 Months	3 months - 1 Year	1-5 Years
2017	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Financial Liabilities						
At amortised cost						
Payables	2,028	2,028	2,028	-	-	-
Monies Held in Trust	38	38	38	-	-	-
Total Financial Liabilities	**2,066**	**2,066**	**2,066**	**-**	**-**	**-**
2016						
Financial Liabilities						
At amortised cost						
Payables	1,662	1,662	1,662	-	-	-
Other Financial Liabilities (i)						
- Accommodation Bonds	402	402	402	-	-	-
Monies Held in Trust	46	46	46	-	-	-
Total Financial Liabilities	**2,110**	**2,110**	**2,110**	**-**	**-**	**-**

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

Note 7.1: Financial Instruments (continued)

(e) Market risk
The Stawell Regional Health'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
The Stawell Regional Health 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 might arise primarily through the Stawell Regional Health's interest bearing liabilities. Minimisation of risk is achieved by mainly undertaking fixed rate or non-interest bearing financial instruments. For financial liabilities, the health service mainly undertake 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 Service 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. Thses contracts have set price arrangements and are reviewed on a regular basis.

Interest rate exposure of financial assets and liabilities as at 30 June

	Weighted Average Effective Interest	Carrying Amount	Interest Rate Exposure		
			Fixed Interest Rate	Variable Interest Rate	Non-Interest Bearing
2017	**Rate (%)**	**$'000**	**$'000**	**$'000**	**$'000**
Financial Assets					
Cash and Cash Equivalents	1.31	368	2.53	8,119	2
Loans and Receivables [(i)]					
- Trade Debtors		190	-	-	-
- Other Receivables	-	342	-	-	-
- Term Deposit	2.53	7,753	7,753	-	-
		8,653	**7,756**	**8,119**	**2**
Financial Liabilities					
At amortised cost					
Payables[(i)]		2,028	-	-	2,028
Monies held in trust	-	38	-	-	38
		2,066	**-**	**-**	**2,066**
2016					
Financial Assets					
Cash and Cash Equivalents	1.31	909	2.79	9,261	2
Loans and Receivables [(i)]					
- Trade Debtors		174	-	-	174
- Other Receivables		437	-	-	437
- Term Deposit	2.79	8,354	8,354	-	-
		9,874	**8,357**	**9,261**	**613**
Financial Liabilities					
At amortised cost					
Payables[(i)]		1,662	-	-	1,662
Other Financial Liabilities					
- Accommodation Bonds	-	402	-	-	402
- Monies held in trust	-	46	-	-	46
		2,110	**-**	**-**	**2,110**

(i) The carrying amount must exclude types of statutory financial assets and liabilities (i.e. GST input tax credit and GST payable)

Note 7.1: Financial Instruments (continued)

(e) Market risk (continued)

Sensitivity disclosure analysis

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

- A shift of +1% and - 1% in market interest rates (AUD) from year-end rates of 2.5%; and
- A parallel shift of +1% and -1% in inflation rate from year-end rates of 2%

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

	Carrying Amount	Interest Rate Risk			
		-1%		+1%	
		Profit	Equity	Profit	Equity
2017		$'000	$'000	$'000	$'000
Financial Assets					
Cash and Cash Equivalents [(i)]	368	(4)	(4)	4	4
Loans and Receivables [(i)]					
- Trade Debtors	190	-	-	-	-
- Other Receivables	342	-	-	-	-
Financial Liabilities					
At amortised cost					
Payables	2,028	-	-	-	-
Monies held in trust	38	-	-	-	-
		(81)	**(81)**	**81**	**81**
2016					
Financial Assets					
Cash and Cash Equivalents [(i)]	909	(9)	(9)	9	9
Loans and Receivables [(i)]					
- Trade Debtors	174	-	-	-	-
- Other Receivables	437	-	-	-	-
Financial Liabilities					
At amortised cost					
Payables	1,662	-	-	-	-
Other Financial Liabilities[(ii)]					
- Accommodation Bonds	402	-	-	-	-
- Monies held in trust	46	-	-	-	-
		(93)	**(93)**	**93**	**93**

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

Note 7.1: Financial Instruments (continued)

(f) Fair value

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

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

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

Comparison between carrying amount and fair value

	Consol'd Carrying Amount 2017 $'000	Fair value 2017 $'000	Consol'd Carrying Amount 2016 $'000	Fair value 2016 $'000
Financial Assets				
Cash and Cash Equivalents	368	368	909	909
Loans and Receivables (i)				
- Trade Debtors	190	190	174	174
- Other Receivables	342	342	437	437
Total Financial Assets	**900**	**900**	**1,520**	**1,520**
Financial Liabilities				
At amortised cost				
Payables	2,028	2,028	1,662	1,662
Other Financial Liabilities(i)				
- Monies held in trust	38	38	448	448
Total Financial Liabilities	**2,066**	**2,066**	**2,110**	**2,110**

(i) The carrying amount must exclude types of statutory financial assets and liabilities (i.e. GST input tax credit and GST payable).

Note 7.1: Financial Instruments (continued)

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of the Stawell Regional Health'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.

Held-to-maturity investments

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

The Health Service makes limited use of this classification because any sale or reclassification of more than an insignificant amount of held-to-maturity investments not close to their maturity, would result in the whole category being reclassified as available-for-sale. The Health Service would also be prevented from classifying investment securities as held-to-maturity for the current and the following two financial years.

The held-to-maturity category includes certain term deposits and debt securities for which the entity concerned intends to hold to maturity.

Financial liabilities at amortised cost

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

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

7.1 Fin Inst Comment

Note 7.2: Net gain/(loss) on disposal of non-financial assets

	Consol'd 2017 $'000	Consol'd 2016 $'000
Proceeds from Disposals of Non-Current Assets		
Medical Equipment	-	9
Motor Vehicles	59	18
Total Proceeds from Disposal of Non-Current Assets	**59**	**27**
Less: Written Down Value of Non-Current Assets Sold		
Medical Equipment	-	7
Motor Vehicles	31	-
Total Written Down Value of Non-Current Assets Sold	**31**	**7**
Net gain/(loss) on Disposal of Non-Financial Assets	**28**	**20**

Note 7.3: Contingent Assets and Contingent Liabilities

As at balance date, the Board of Directors are unaware of the existence of any financial obligation that may have a material effect on the balance sheet as a result of any future event which may or may not happen. (2016 Nil).

Note 7.4 Fair value determination

Asset class	Examples of types of assets	Expected fair value level	Likely valuation approach	Significant inputs (Level 3 only)
Non-specialised land	In areas where there is an active market: - vacant land - land not subject to restrictions as to use or sale	Level 2	Market approach	N/A
Specialised land	Land subject to restrictions as to use and/or sale Land in areas where there is not an active market	Level 3	Market approach	CSO adjustments
Non-specialised buildings	For general/commercial buildings that are just built	Level 2	Market approach	N/A
Specialised buildings [(i)]	Specialised buildings with limited alternative uses and/or substantial customisation e.g. prisons, hospitals, and schools	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Plant and equipment [(i)]	Specialised items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Vehicles	If there is an active resale market available; If there is no active resale market available	Level 2 Level 3	Market approach Depreciated replacement cost approach	N/A Cost per square metre Useful life

[(i)] Newly built / acquired assets could be categorised as Level 2 assets as depreciation would not be a significant unobservable input (based on the 10% materiality threshold)

Mote 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 AASB's issued but are not yet effiective
8.9 Events occurring after the balance sheet date
8.10 Controlled entities
8.11 Alternative presentation of comprehensive operating statement

Note 8.1: Equity

	Consol'd 2017 $'000	Consol'd 2016 $'000
(a) Surpluses		
Property, Plant & Equipment Revaluation Surplus [1]		
Balance at the beginning of the reporting period	13,886	13,886
Revaluation Increment/(Decrements)		
Balance at the end of the reporting period*	**13,886**	**13,886**
Represented by:		
- Land	807	807
- Buildings	13,079	13,079
	13,886	**13,886**
(b) General Purpose Surplus		
Balance at the beginning of the reporting period	494	316
Transfer to General Purpose Surplus	6	178
Balance at the end of the reporting period	**500**	**494**
Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	1,978	2,089
Transfer to Restricted Specific Purpose Surplus	11	(111)
Balance at the end of the reporting period	**1,989**	**1,978**
Total Surpluses	**16,375**	**16,358**
Contributed Capital		
Balance at the beginning of the reporting period	9,345	9,345
Capital Contribution received from Victorian Government	-	-
Capital Repayments	-	-
Balance at the end of the reporting period	**9,345**	**9,345**
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	4,934	5,471
Net Result for the Year	(1,945)	(470)
Transfers to General Purpose and Restricted Specific Purpose Surplus	(17)	(67)
Balance at the end of the reporting period	**2,972**	**4,934**
Total Equity at end of financial year	**28,692**	**30,637**

Contributed capital

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

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

Property, plant & equipment revaluation surplus

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

Note 8.1: Equity (continued)

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.

General Purpose Surplus
Stawell Regional Health General purpose surplus refers to the surplus transferred by SRH Foundation.

Note 8.2: Reconciliation of Net Result for the Year to Net Cash Inflow/(Outflow) from Operating Activities

	Consol'd 2017 $'000	Consol'd 2016 $'000
Net result for the period	(1,945)	(470)
Non-cash movements:		
Depreciation and amortisation	1,844	1,993
Provision for doubtful debts	4	12
Movements included in investing and financing activities		
Net (gain)/loss from disposal of non financial physical assets	(28)	(20)
Movements in assets and liabilities:		
Change in operating assets and liabilities		
(Increase)/decrease in receivables	(382)	45
(Increase)/decrease in other assets	95	-
(Increase)/decrease in prepayments	(7)	(212)
Increase/(decrease) in payables	444	444
Increase/(decrease) in provisions	247	143
Change in inventories	40	(30)
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**312**	**1,905**

Note 8.3: Operating segments

	RAC		Acute		Other Services		Consol'd	
	2017 $'000	2016 $'000	2017 $'000	2016 $'000	2017 $'000	2016 $'000	2017 $'000	2016 $'000
REVENUE								
External Segment Revenue	3,547	3,690	16,013	15,472	7,128	7,171	26,688	26,333
GRAH (Joint Operation)	-	-	-		437	524	437	524
Total Revenue	**3,547**	**3,690**	**16,013**	**15,472**	**7,565**	**7,695**	**27,125**	**26,857**
EXPENSES								
External Segment Expenses	(4,225)	(3,958)	(15,626)	(14,639)	(9,003)	(8,434)	(28,854)	(27,031)
GRAH (Joint Operation)	-	-	-	-	(365)	(404)	(365)	(404)
Total Expenses	**(4,225)**	**(3,958)**	**(15,626)**	**(14,639)**	**(9,368)**	**(8,838)**	**(29,219)**	**(27,435)**
Net Result from ordinary activities	**(678)**	**(268)**	**387**	**833**	**(1,803)**	**(1,143)**	**(2,094)**	**(578)**
Interest Income	-	-	-	-	198	176	198	176
Net Result for Year	**(678)**	**(268)**	**387**	**833**	**(1,605)**	**(967)**	**(1,896)**	**(402)**
OTHER INFORMATION								
Segment Assets	6,881	7,239	25,118	26,424	2,409	2,534	34,408	36,197
Total Assets	**6,881**	**7,239**	**25,118**	**26,424**	**2,409**	**2,534**	**34,408**	**36,197**
Segment Liabilities	1,143	1,112	4,173	4,059	400	389	5,716	5,560
Total Liabilities	**1,143**	**1,112**	**4,173**	**4,059**	**400**	**389**	**5,716**	**5,560**
Acquisition of Property, Plant and Equipment and Intangible Assets	-	331	-	896	-	-	-	1,227
Depreciation & Amortisation Expense	-	399	-	1,455	-	140	-	1,994

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

Business Segments
Residential Aged Care Services (RACS)
Acute
Ohers
Others (List)
- Primary Health
- District Nursing
- Radiology Services
- Catering Services

Services
Hgh Level andPsychogeriatric Care
Acute Medical Surgical Services

- Day Centre
- Phone Triage
- Consulting Rooms
- Fundraising

Geographical Segment

Stawell Regional Health operates predominantly in Stawell, Victoria. More than 90% of revenue, net surplus from ordinary activities and segment assets relate to operations in Stawell, Victoria.

Note 8.4: Responsible persons disclosures

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

	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	1/7/2016 - 30/6/2017
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	1/7/2016 - 30/6/2017
Governing Board	
Mr H. L. Cooper	1/7/2016 - 30/6/2017
Mr. R. Hatton	1/7/2016 - 30/6/2017
Mrs. J. M. Brilliant	1/7/2016 - 30/6/2017
Mr. P. J. Martin	1/7/2016 - 30/6/2017
Mrs. R. Jones	1/7/2016 - 30/6/2017
Mr. S. Campbell-Huruglica	1/7/2016 - 29/11/2016
Ms Jessica Cass	1/7/2016 - 30/6/2017
Ms Amy Rhodes	1/7/2016 - 30/6/2017
Accountable Officers	
Mrs. E McCourt	1/7/2016 - 30/6/2017

Remuneration of Responsible Persons

Remuneration received or receivable by responsible persons was in the range: $170,000 - $179,999 ($150,000 - 159,999 in 2015-16).

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

Note 8.5: Executive Officer Disclosures

Remuneration	**2017 $'000**
Short-term benefits	403
Post-employment benefits	33
Other long-term benefits	13
Total remuneration	**449**
Total number of executives	**6**
Total annualised employee equivalent (AEE)	**3.8**

Notes:

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

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

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

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

Note 8.6: Related Parties

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

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

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

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

Key Management personnel include those as listed in note 8.4 plus the Director of Clinical Services, the Director of Primary and Community Care, the Human Resources Manager and the Finance Manager.

Compensation	**2017 $'000**
Short-term benefits	562
Post-employment benefits	46
Other long-term benefits	17
Total remuneration	**625**
Total number of executives	**7**
Total annualised employee equivalent (AEE)	**4.8**

(i) Annualised employee equivalent is based on the time fraction worked during the reporitng period. This is calculated as the total number of days the employee is engaged to work during the week by the total number of full-time working days per week.

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 he Victorian Public Sector Commission.

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

Other Transactions of Responsible Persons and their Related Parties
There were no transactions with Responsible Persons or their Related Parties.

Significant transactions with government-related entities
Stawell Regional Health received funding from the Department of Health and Human Services of $16,508,382 (2016: $17,410,753).

Note 8.6: Related Parties (continued).

During the year, Stawell Regional Health had the following other government-related entity transactions:
- Commonwealth Government funding received for health related programs totalling $3,961,989 (2016 $3,324,413).

Transactions with key management personnel and other related parties

Given the breadth and depth of State procurement activities, related parties transact with the Victorian public sector in a manner consistent with other members of the pubic 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 isssued by the Victorian public Sector Commission.

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

Note 8.7: Remuneration of auditors

($ thousand)	2017	2016
Victorian Auditor-General's Office		
Audit of financial statement	16	13
	16	**13**

Note 8.8: New and Revised Accounting Standards

The AASB has issued a number of Exposure Drafts (ED) and Accounting Standards applicable for the current and future reporting periods.

These accounting pronouncements are outlined in the tables below. Health Services need to be cognisant of changes and where relevant incorporate these requirements into their annual reports.

Below is a list of standards/interpretations effective for 2016-17 reporting period onwards.

Topic	Key requirements	Effective date
AASB 2014-9 Amendments to Australian Accounting Standards – Equity Method in Separate Financial Statements	Amends AASB 127 to allow entities to use the equity method of accounting for investments in subsidiaries, joint ventures and associates in their separate financial statements.	1-Jan-16
[AASB 1, 127 & 128]	In particular, dividends from a subsidiary, a joint venture or an associate are recognised in profit or loss in the separate financial statements of an entity when the entity's right to receive the dividend is established.	
	The dividend is recognised in profit or loss unless the entity elects to use the equity method, in which case the dividend is recognised as a reduction from the carrying amount of the investment.	
AASB 2014-10 Amendments to Australian Accounting Standards – Sale or Contribution of Assets between an Investor and its Associate or Joint Venture [AASB 10 & AASB 128]	Amends AASB 10 and AASB 128 to ensure consistent treatment in dealing with the sale or contribution of assets between an investor and its associate or joint venture. The amendments require that: • a full gain or loss to be recognised when a transaction involves a business (whether it is housed in a subsidiary or not); and • a partial gain or loss to be recognised when a transaction involves assets that do not constitute a business, even if these assets are housed in a subsidiary. •	1-Jan-16

Note 8.8: New and Revised Accounting Standards (continued).

Topic	Key requirements	Effective date
AASB 2015-1 Amendments to Australian Accounting Standards – Annual Improvements to Australian Accounting Standards 2012–2014 Cycle	Amends the methods of disposal in AASB 5 Non-current assets held for sale and discontinued operations .	1-Jan-16
[AASB 1, AASB 2, AASB 3, AASB 5, AASB 7, AASB 11, AASB 110, AASB 119, AASB 121, AASB 133, AASB 134, AASB 137 & AASB 140]	Amends AASB 7 Financial Instruments by including further guidance on servicing contracts.	
AASB 2015-6 Amendments to Australian Accounting Standards – Extending Related Party Disclosures to Not-for-Profit Public Sector Entities	AASB 2015-6 extends the scope of AASB 124 Related Party Disclosures to not-for-profit public sector entities. Guidance has been included to assist the application of the Standard by not-for-profit public sector entities.	1-Jul-16
[AASB 10, AASB 124 & AASB 1049]		
AASB 2014-4 Amendments to Australian Accounting Standards – Clarification of Acceptable Methods of Depreciation and Amortisation	Amends AASB 116 and AASB 138 to:	1-Jan-16
[AASB 116 & AASB 138]	• establish the principle for the basis of depreciation and amortisation as being the expected pattern of consumption of the future economic benefits of an asset;	
	• clarify that the use of revenue-based methods to calculate the depreciation of an asset is not appropriate because revenue generated by an activity that includes the use of an asset generally reflects factors other than the consumption of the economic benefits embodied in the asset; and	
	• clarify that revenue is generally presumed to be an inappropriate basis for measuring the consumption of the economic benefits embodied in an intangible asset. This presumption, however, can be rebutted in certain limited circumstances.	

Note 8.8: New and Revised Accounting Standards (continued).

Current reporting period
The following accounting pronouncements effective from the 2016-17 reporting period are considered to have insignificant impacts on public sector reporting:

- AASB 1056 Superannuation Entities
- AASB 1057 Application of Australian Accounting Standards
- AASB 2014-1 Amendments to Australian Accounting Standards [Part D – Consequential Amendments arising from AASB 14 Regulatory Deferral Accounts only]
- AASB 2014-3 Amendments to Australian Accounting Standards – Accounting for Acquisitions of Interests in Joint Operations [AASB 1 & AASB 11]
- AASB 2014-6 Amendments to Australian Accounting Standards – Agriculture: Bearer Plants [AASB 101, AASB 116, AASB 117, AASB 123, AASB 136, AASB 140 & AASB 141]
- AASB 2015-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 101 [AASB 7, AASB 101, AASB 134 & AASB 1049]
- AASB 2015-5 Amendments to Australian Accounting Standards – Investment Entities: Applying the Consolidation Exception [AASB 10, AASB 12, AASB 128]
- AASB 2015-9 Amendments to Australian Accounting Standards – Scope and Application Paragraphs [AASB 8, AASB 133 & AASB 1057]
- AASB 2015-10 Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128
- 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

Note 8.9: Events Occurring after the Balance Sheet Date

There have been no events subsequent to balance date that require further disclosure.

Note 8.10: Controlled entities

		2017
Name of entity	**Country of incorporation**	**Equity Holding**
Stawell Regional Health Foundation	Australia	100%

		2016
Name of entity	**Country of incorporation**	**Equity Holding**
Stawell Regional Health Foundation	Australia	100%

Note 8.11: Alternate Presentation of Comprehensive operating
For the Year Ended 30 June 2017

	Note	Consol'd 2017 $'000	Consol'd 2016 $'000
Grants			
Operating	2.1	20,101	19,533
Capital	2.1	329	-
Interest and Dividends	2.1	220	224
Sales of Goods and Services	2.1	4,950	4,446
Other income	2.1	1,621	2,742
Other capital income	2.1	103	
Revenue from Transactions		**27,324**	**26,945**
Employee Expenses	3.1	(15,351)	(15,273)
Operating Expenses			
Other		(11,745)	(10,081)
Non-Operating Expenses			
Expenditure for Capital Purpose	3.1	(279)	-
Depreciation and Amortisation	4.5	(1,844)	(1,993)
Expenses from Transactions		**(29,219)**	**(27,347)**
Net Result from Transactions		**(1,895)**	**(402)**
Other economic flows included in net result			
Net gain/(loss) on non-financial assets	2.1	27	20
Other gains/(losses) from other economic flows	2.1	(77)	(88)
Revaluation of Long Service Leave		-	-
Total other economic flows included in net result		(50)	(68)
Net result from continuing operations		**(1,945)**	**(470)**
Net result from discontinued operations		**-**	**-**
NET RESULT FOR THE YEAR		**(1,945)**	**(470)**

Photography Mr Peter Pickering

STAWELL
REGIONAL HEALTH

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