ANNUAL REPORT 2017

Edenhope & District Memorial Hospital

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REPORT OF OPERATIONS: BOARD PRESIDENT AND CHIEF EXECUTIVE OFFICER

On behalf of the Board of management, Executive and staff of Edenhope and District Memorial Hospital (EDMH) we are pleased to present this Annual Report for the year ending 30th June 2017. The Annual Report is a business and financial overview of the year, designed to be read in conjunction with the Quality of Care report which gives further detail on our services, achievements and improvements over the year.

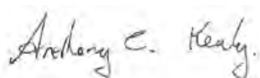
We would like to take this opportunity to thank everyone associated with EDMH for their commitment, hard work and dedication over the year which has assisted EDMH to continue to provide high quality healthcare to the community.

Mr Anthony Kealy
Board President

Mr Kevin Mills
Chief Executive Officer

RESPONSIBLE BODIES DECLARATION

In accordance with the *Financial Management Act 1994*, I am pleased to present the Report of Operations for Edenhope and District Memorial Hospital for the year ending 30 June 2017.



Mr Anthony Kealy
Board President

Edenhope
25th August 2017

DISCLOSURE INDEX

The Annual Report of Edenhope and District Memorial Hospital 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.

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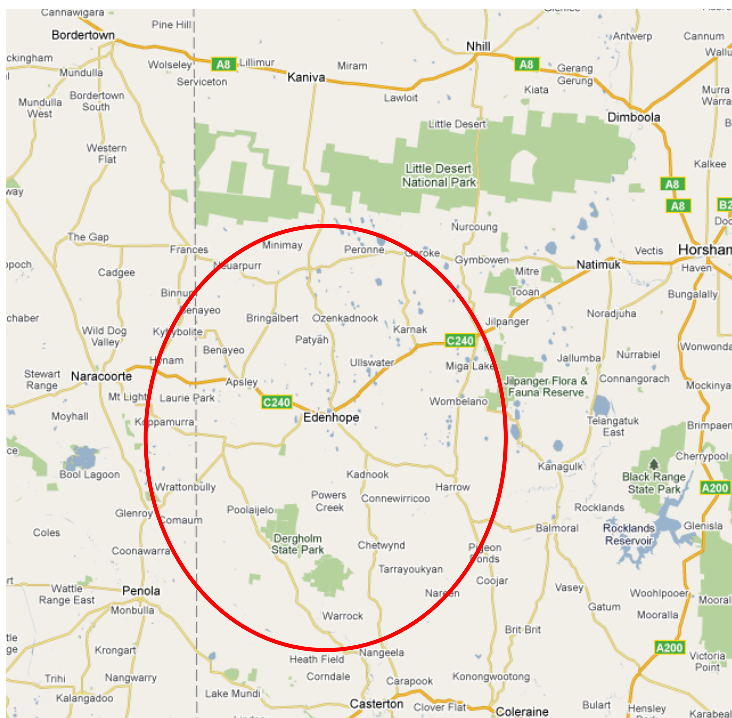
LOCATION AND CONTACT DETAILS

Edenhope and District Memorial Hospital

Incorporating The Lakes Hostel, Kowree Nursing Home, Barkala Flats, Elsie Bennett Community Centre, and Edenhope Hospital Medical Clinic.

128-134 Elizabeth Street (PO Box 75),
Edenhope, Victoria, 3318
Phone 03 5585 9800
Fax 03 5585 9891
Email info@edmh.org.au
Web www.edmh.org.au



The township of Edenhope is located in Western Victoria, and is the major town in the West Wimmera Shire. Edenhope and District Memorial Hospital is the main health care provider for local communities in the region including Edenhope, Apsley, Harrow, Minimay and surrounding districts.

Edenhope is 395 kilometres from Melbourne, which provide the majority of the community's requirements for tertiary health facilities.

Ballarat is 287 kilometres from Edenhope, and is the nearest regional health care facility. Horsham is 100 kilometres from Edenhope, and is the nearest sub-regional base hospital.

There are a number of similar or smaller sized Victorian health care facilities in the vicinity however none of these are located within an 80 kilometre radius of Edenhope.

OUR HISTORY

The Hospital began in 1910 as a privately owned and managed private Hospital. At that time it was situated in a house owned by Mrs Jerome Minogue, who was Mrs Daly's mother of Clunie at Harrow. This building was later owned by Mr Tabby Preece and is now known as 'Edenhope Antiques'.

The Hospital was rebuilt in 1930 on its present site, becoming two wards with a total of five beds. Donations for the construction were sought with the help of many district people including Mrs 'Tug' Kealy who ventured out to collect them via horse and cart. The Hospital continued to function as two wards until 1950, at which time management of the Hospital was transferred to the Hospitals and Charities Commission.

The 'Halahan Wing', which currently houses the Executive Offices, was the residence of Mr McDonald who operated Horsham Drays; a gravel contractor for the Kowree Shire. He also housed his horses at stables which were located where the current Elsie Bennett Community Centre stands today. In winter the stables were often flooded.

During 1961 the Hospital underwent an upgrade and was extended to a 23 bed facility. In 1981 approval was given for eight beds in the Nurses Home to be reallocated as Nursing Home beds, raising the total number of Hospital beds to 31.

In 1988-89 a new Nursing Home was built consisting of 18 beds. This created a facility of 20 acute beds and 18 Nursing Home beds.

In 1998 the Hospital opened a 17 bed Hostel which is now known as the Lakes Hostel. The Elsie Bennett Community Health Centre was also opening in 1998. .

The ownership of the Barkala Flats was transferred to Edenhope and District Memorial Hospital in 2001. The 19 flats are provided as independent living units for community members.

In 2003, five beds were added to the Hostel, providing a total of 22 hostel beds.

Master planning for redevelopment of the Hospital concluded in 2009.

In 2011 the Hospital secured funding through the Australian Government National Rural and Remote Health Infrastructure Program to build a medical clinic on-site, which was opened October 2012.

In 2014 the Board of Management allocated $2 million from retained earnings for the development of a 10 bedroom staff accommodation complex and a four bedroom executive residence to be built on the land directly opposite the hospital.

The accommodation complex allows staff and visiting specialists that work at Edenhope the opportunity to have first class accommodation while away from their homes and families. The complex was officially opened on 19th May 2016.

In 2017 the Hospital secured funding through the Rural Health Infrastructure Fund for the first stage of the Master Plan, which includes the redevelopment of the Nursing Home; with work due to commence in October 2017. We are also actively seeking funding for stage 2 which includes the Acute Ward, Urgent Care and administration services, and are hopeful this will be achieved in the near future.

MANAGEMENT AND STRUCTURE

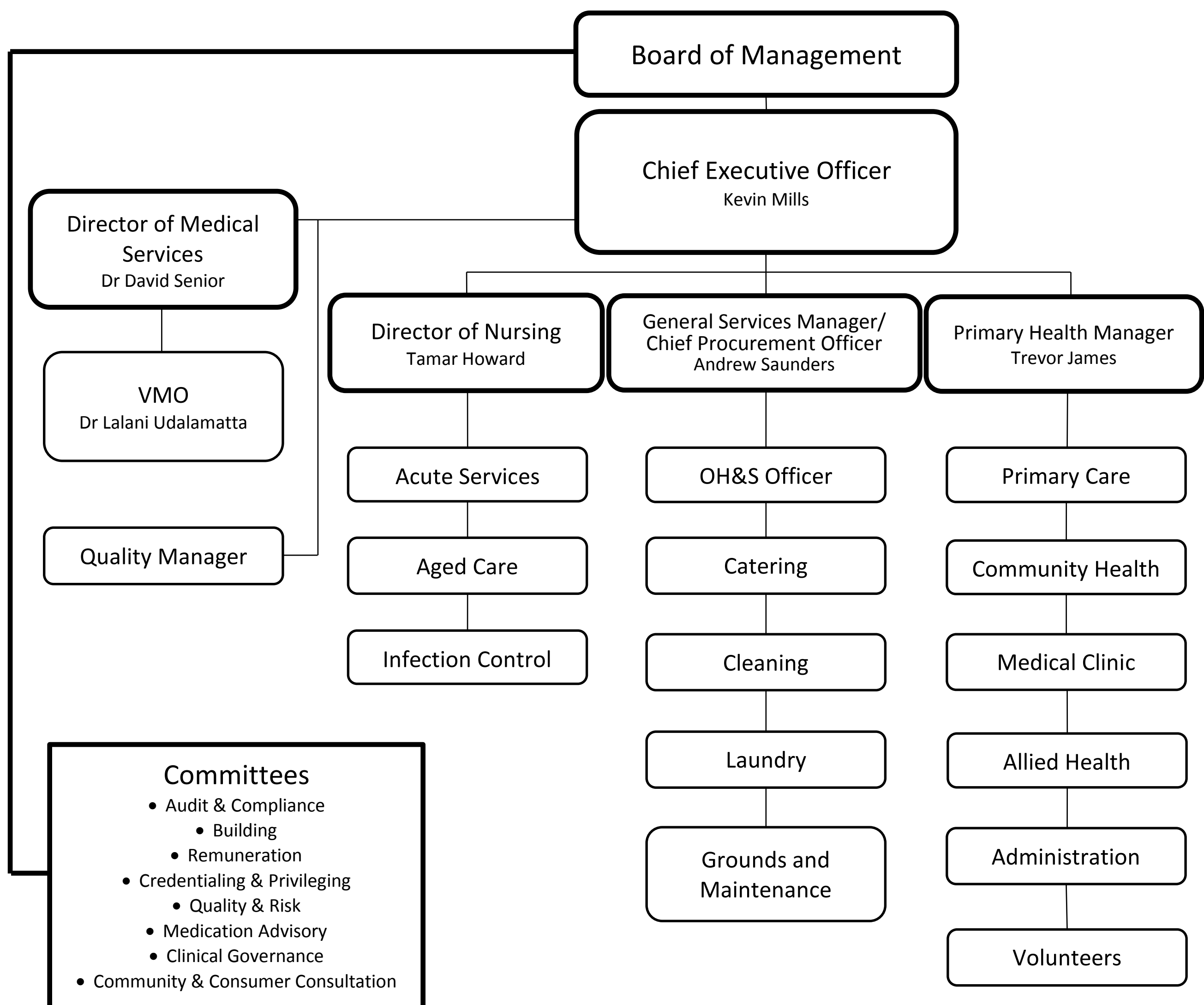
The Board of Management is appointed by the Governor-in-Council from recommendations made by the Edenhope and District Memorial Hospital and endorsed by the Minister for Health. The Hospital is a public agency established under the *Health Services Act 1988.* The responsible Ministers during the reporting period were:
The Hon. Jill Hennessy MLA, Minister for Health, Minister for Ambulance Services
The Hon. Martin Foley MLA, Minister for Mental Health, Minister for Housing, Disability and Ageing

The role of the Board of Management is to ensure Edenhope and District Memorial Hospital achieves its mission and strategic goals and objectives and, in doing so, meets all the legal and moral responsibilities accompanying 'best practice' corporate governance. Whilst the Board provide direction for the organisation and determine what must be done, the responsibility for determining how services are delivered is invested in the Chief Executive Officer.

Board of Management
Mr Anthony Kealy*, President
Cr Ron Hawkins, Senior Vice President
Mr Michael Holland, Junior Vice President
Mrs Kate Hausler*, Treasurer
Mrs Christine McCann*, Assistant Treasurer
Mrs Jan Grigg, Board Member
Mr Robert Okely, Board Member
Mrs Annie Osborn*, Board Member
Mrs Rosemary Medlock, Board Member
Mr David Kennedy, Board Member

*denotes member of Audit and Compliance Committee

ORGANISATIONAL STRUCTURE



NATURE AND RANGE OF SERVICES PROVIDED BY EDMH

Edenhope and District Memorial Hospital is a public agency established under the *Health Services Act 1988*. EDMH is authorised to provide public health and ancillary services as authorised under the *Health Service Act 1988*, and operate *Residential Care Services under the Aged Care Act 1997*.

Urgent Care Service
- 24 hour 7 day service (not registered)

Medical Services
- Haemodialysis
- Chemotherapy
- Acute Care

Medical Clinic
- GP consultations
- Antenatal clinic
- Blood collection

Visiting Specialists
- Optometrist
- Cardiology
- Geriatrics
- Psychiatry

Community Services
- Community Health Nurse
- District Nursing Service
- Post Acute Care
- Meals on Wheels
- Adult Day Centre
- Women's Health
- Cancer Resource Nurse
- Continence Nurse
- Laundry Services

Medical Imaging – Bendigo Radiology
- X-Ray

Pathology – Clinical Labs Pathology
- Daily pick-up and testing
- iStat point of care testing on-site

Primary Care
- Audiology
- Dentistry
- Diabetes Education
- Dietetics
- Health Promotion
- Occupational Therapy
- Physiotherapy
- Podiatry
- Social Work
- Speech Pathology
- Primary Mental Health

Residential Aged Care
- Two residential aged care facilities co-located with the main hospital catering for a broad range of care needs
- 17 independent living units (Barkala Flats)
- Respite care

FINANCIAL PERFORMANCE

Comparative Financial Results for the Past Five Financial Years					
	2016/17	**2015/16**	**2014/15**	**2013/14**	**2012/13**
	$'000	**$'000**	**$'000**	**$'000**	**$'000**
Total Revenue	10,007	11,156	8,439	8,447	8,887
Total Expenses	10,198	9,508	9,399	9,169	8,621
Other Operating Flows included in the net result	0	33	N/A	N/A	N/A
Net Result for the Year	(191)	1,649	(960)	(722)	266
*Operating result	(339)	(242)	(360)	43	375
Total Assets	16,613	15,903	14,146	14,261	11,581
Total Liabilities	5,741	4,840	4,764	3,920	3,415
Net Assets	10,872	11,064	9,382	10,341	8,166
Total Equity	10,872	11,064	9,382	10,341	8,166

**The operating result is the result for which the hospital is monitored in its Statement of Priorities also referred to as the Net result before capital and specific terms*.

WORKFORCE DATA DISCLOSURES

STAFF ARRAY				
Labour Category	**JUNE Current Month FTE**		**JUNE YTD FTE**	
	2017	**2016**	**2017**	**2016**
Nursing	34.09	33.8	34.61	36.23
Administration and Clerical	4.59	7.89	6.62	8.66
Medical Support	-	-	-	-
Hotel and Allied Services	34.80	28.53	32.36	28.40
Medical Officers	-	-	-	-
Hospital Medical Officers	-	-	-	-
Sessional Clinicians	-	-	-	-
Ancillary Staff (Allied Health)	2.22	3.00	2.14	2.98

STRATEGIC PLAN

The Edenhope and District Memorial Hospital Strategic Plan 2013 – 2018 can be found on our website.

www.edmh.org.au

OUR VISION

A healthy community in the Edenhope district

OUR MISSION

To competently care for our community with best practice health services.
To model best practice rural health care in Australia from a robust foundation primed for growth.
To embrace innovation in all aspects of our work.

OUR VALUES

Respect

For patients
For staff
For community

Pride

In our work
In our facilities
In our people

Excellence

In health services
In admission
In governance

Accountability

For quality
For sustainability

PERFORMANCE AGAINST THE STRATEGIC PLAN

GOAL 1: DELIVER THE BEST QUALITY CARE TO OUR COMMUNITY

Outcomes

- Range of services increased
- Community-wide needs analysis completed
- Significant increase in telehealth consultations
- Increased community health activities each year
- Increase in delivery of specialist and allied health services
- Staff flu vaccination rates have increased from last year to 70% - target is 75%.

STRATEGY	ACTIONS	OUTCOMES 2016-17
1. Increase the range of services available on site	a. Mapping of Edenhope and District Memorial Hospital services and benchmarking with other small rural health services in 2014 b. Undertake a community-wide needs analysis to identify priority areas for service expansion. Develop other ways to collect information relating to changing needs in the community c. Increase the number of visiting medical specialists at Edenhope and District Memorial Hospital d. Opportunistic service developments as resources become available, both funding and personnel	a. Revised services provided and addressed key service gaps. Continence nurse using medical clinic for consultations on a fortnightly basis. WHY Program Physiotherapist, Occupational Therapist and Dietician visiting weekly. Ballarat Mental Health Staff offering on-site consultations and Villa Maria Respite Worker in Elsie Bennett Community Centre one day per month. b. Edenhope and District Memorial Hospital links with a number of key stakeholders to collect community information and gain community feedback, including Wimmera Primary Care Partnership, Census data, West Wimmera Shire Council, Wimmera Development Association and via the Edenhope and District Memorial Hospital Community and Consumer Consultation Committee and Tea and Talk afternoons. Consumer Engagement lunches introduced with positive feedback on this form of engagement received. c. Video consultation service to cardiologist continuing. Alliance established with Royal Flying Doctor Service, Rural Northwest Health and Swinburne University for a new Telehealth model linking Edenhope to an expanding number of specialists. d. Weekly videoconferencing with Wimmera Health Care Group Discharge Coordinator and Edenhope and District Memorial Hospital Acute Unit Manager to discuss more timely transfers of patients back to Edenhope. Continence nurse from Kaniva provides regular service – commenced 13 November. Bladder scanner purchased for use in expanded service.

		New Optometry service introduced in 2016. Addition of Occupational Therapist service Primary Mental Health Service – Edenhope and District Memorial Hospital as lead in alliance with West Wimmera Health Service Increased Diabetes Educators
2. Embrace new models of care	a. Increase use of e-health by building confidence amongst patients and specialists in our capacity b. Identify and respond effectively to emerging trends in service delivery and report annually in the Quality of Care report c. Embed the Active Service Model philosophy (encouraging independence) within Primary Care	a. Increased provision of telehealth, particularly in Hospital Medical Clinic b. Cancer Wellness Nurse training and clinic launched c. Quality of Care report published d. Palliative approach and end of life pathways fully implemented into aged care and acute wards – staff training completed and all documentation updated. e. Active service model e-learning module now available for all staff to access. f. New Hub model- Wimmera Health Care Group will be the hub of an information network being used as a resource to provide practitioners in small hospitals advice on patient treatment and care. g. Grampians Emergency and Critical Care Committee have developed a list of minimum requirements for emergency departments. h. As a member of the Wimmera Southern Mallee Health Alliance, project started on e-health support for Urgent Care Centres. i. Alliance with the Royal Flying Doctors Service, Royal and Swinburne University – Telehealth Services established. The governance group has been established with recruitment of specialists underway – Project to be rolled out in 2017-18
3. Invest in community health programs	a. Ongoing implementation of the Grampians community health plan with local stakeholders b. Develop a range of strategies to engage the community to better target planning and participation in community health programs	a. Ongoing work with Wimmera Primary Care Partnership including Chronic Disease Network to implement local community health plan. Cancer Resource Nurse has been providing support to several individuals and anticipates more referrals of clients and carers from the new Social Worker. Numerous community events held including the stage show Four Funerals which was extremely well attended and numerous screenings of the Sugar Film. b. Building works to enclose the Elsie Bennett Community Centre front veranda to allow exercise equipment to be set up permanently. Expansion of out-of-hours exercise program as a result of consumer engagement.

		c. HelpDem project – Volunteer support for carers of people living with dementia or memory issues.
4. Work collaboratively to enhance existing services	a. Participate effectively in regional networks. Identify improvements in annual Quality of Care report b. Identify opportunities for collaboration and be ready to pilot new processes, technologies, equipment and work practices c. Review local patient transport service 3-yearly and seek options for improving outcomes	a. Ongoing participation in the Wimmera Southern Mallee Health Alliance, a variety of Department and public health peer networks including the Clinical Capability Framework, and Department and Local Government emergency management groups. b. Participation in pilot programs for Victor Paediatric escalation of care, and Age appropriate observation charts, with the Royal Children's Hospital. – Introduced age specific observation charts – made available, paediatric procedures reviewed and updated. Liaising with Wimmera Health Care Group to have regular videolink discharge planning meetings to increase discharges back to Edenhope and District Memorial Hospital. c. Not due in reporting period. d. Data trending 2013-2014-2015 of urgent care presentations completed. Overall dropped from 800/year to 630/year following the opening of the medical clinic. Progressive downward trending Triage 4 (non-urgent) 205 –185- 169: Triage 5 (less urgent) 454 – 303- 285 per year respectively. e. Ongoing participation in the West Wimmera Shire Council Municipal Emergency Management Planning Committee f. Participate in the Grampians Region Procurement Reform Steering Committee to establish positive purchasing outcomes for our region g. Working with the Centre for Participation on volunteer transport options. h. Establishment of Regional Partnerships for the Region. Significant investment and focus on partnerships with an initial four working groups established.

PERFORMANCE AGAINST THE STRATEGIC PLAN

GOAL 2: OPERATE EDENHOPE AND DISTRICT MEMORIAL HOSPITAL AT MAXIMUM EFFICIENCY

Outcomes

- Edenhope and District Memorial Hospital is a high performer in governance procedures
- Alternative funding sources contribute to non-core activities
- Low vacancy and high retention rates for staff
- Staff are valued and rewarded for their work

STRATEGY	ACTIONS	OUTCOMES 2016-17
1. Achieve excellence in governance	a. Develop Board training and development strategy including an annual audit of Board effectiveness b. Develop tools to assist the Board to more effectively monitor, plan and manage its responsibilities e.g. Annual Workplan, Property Development Register c. Each year develop clear directions for the CEO relating to budget expectations and CEO workplan d. Develop a calendar of regular reviews of the implementation of the 2013-18 Strategic Plan and report to stakeholders e. Increase transparency in Board operations through regular community engagement activities	a. Implemented b. Implemented, including regular presentations from staff regarding service activities, challenges and opportunities for the future. Review of Hospital KPIs and presentation format undertaken. c. Implemented d. Implemented Ongoing Board Development and Training Accreditations achieved, Standards 9.43 and 12.8.1 Met with Merit e. Open access board meeting completed. Board members attended West Wimmera Health Service Open Board Meeting and provided feedback to Board Meeting
2. Review alternative funding strategy	a. Identify and capture private patient revenue where applicable b. Review strategy for commercial hotel services activities c. 3-yearly review of corporate business activities in 2015 Implement Environmental Policy re reducing energy usage, recycling and reducing use of natural resources	a. Communication to patients regarding the benefits of private admission is improving, demonstrated by increasing number of private admissions. b. New contract to provide personal linen services to West Wimmera Health Service. c. Renewal of West Wimmera Shire Council Meals on Wheels supply contract. d. Review of Barkala Flat Rent undertaken and implemented. Not due in reporting period e. Environmental policy currently under review. Environmental performance data reported regularly. Ongoing funding sought for installation of a solar energy system. Environmental impacts considered in new building design – solar options to be explored f. Department of Health Human Services Ageing and aged care branch funding - $10000 for Nursing home equipment; $4300 Comprehensive health assessment training; $3500 Dementia therapeutic aids and resources. g. Ongoing arrangement with West Wimmera Health Service for the provision of Personal Laundering. Continuing to supply Meals on Wheels to the community through the West Wimmera Shire Council

		h. Environmental data reporting enhanced through the implementation of Eden Suite data collection process i. Primary Mental Health submission successful and uptake has this service at capacity. j. Grants received for projects such as HelpDem and Telehealth
3. Develop a workforce to meet current and future needs	a. Create a Workforce Development Plan by 2015, focusing on recruitment, induction (including in the community), retention of GPs, Registered Nurses and other staff, and replacement of retiring staff b. Build on existing professional development programs and strengthen links to performance reviews c. Formalize career pathways across the organisation including suitable leadership training d. Recognise the valuable contributions and achievements of staff	a. Complete b. Day Centre Staff enrolled in Certificate IV in Disability. New Social Worker employed. c. Nursing leadership training undertaken by senior nursing staff. Customer Service Training undertaken by staff members Nurse Unit Manager was employed for the Lakes Hostel, Succession planning being considered for key roles in hospital. d. Employee recognition program promoted and staff regularly encouraged to nominate a colleague, policy updated to include monetary allocation to employee of month and year winners to go towards improvements to their departments or an identified project. e. Clinical Educator role reviewed – uptake to Quality Manager position f. Planning staff hours in the Acute wards to maximise available hours and improve efficiency g. General Service Manager attended Emotional Intelligence training to enhance understanding of people's behaviours h. Adult Apprentice Chef appointed from existing staff. Staff training as Relief Chef. i. Three Hotel Services staff nominated as Employees of the month for managing the kitchen so professionally in the absence of the Chef j. 2 Scholarships received for RIPEN nurses k. Consumer Story has been undertaken in partnership with Southern Mallee Health Alliance for workforce training

PERFORMANCE AGAINST THE STRATEGIC PLAN

GOAL 3: BUILD OUR FUTURE

Outcomes

- The redevelopment of the Edenhope and District Memorial Hospital is underway and being managed effectively
- Barkala Flats strategic management plan is in place 2013
- Adequate staff and student accommodation is available and in use

STRATEGY	ACTIONS	OUTCOMES 2016-17
1. **Actively seek capital redevelopment funding**	a. Keep staff and community informed on progress with implementing the Masterplan, actively seeking feedback at every stage b. Progress project to 'investment ready stage' c. Continue liaising with State and Federal Governments regarding funding options and requirements d. Community fundraising to augment capital redevelopment and demonstrate community support to the project	a. Masterplan progress discussed at All Staff meeting and Community and Consumer Consultation Committee meetings. Regular articles in the local newspaper to update the community and seek input. b. Some progress toward planning of future fire management systems undertaken to ensure project is 'shovel ready' should funding be granted. c. Significant Refurbishment Grants for Hostel and Nursing Home upgrades – Hostel works completed in 2016. d. Successful grant application to Regional Health Infrastructure Fund to rebuild nursing home. $8M project. Nursing home significant refurbishment funding directed to Regional Health Infrastructure Fund Project
2. Manage the impact of the redevelopment during construction	a. Develop comprehensive contingency plan to ensure service delivery during construction b. Conduct community and staff consultations advising of contingency plans during construction c. Ensure ongoing service delivery during construction or alternative service options	a. Awaiting funding announcement prior to further action. b. Tea and Talk sessions held in December and April, community invited to sharing of information, Notice board erected at accommodation building site c. Planning underway with stage one of the Regional health Infrastructure Fund project

3. Build collaborative ownership and operation of the Barkala Flats	a. Development management plan for operation of the Barkala Flats and seek potential partners b. Ensure ongoing communication and comprehensive consultations for any planned changes, in recognition of the community sensitivity of the project c. Develop a strategy for funding, operating and maintaining the properties by 2013 and review annually	a. Implemented b. Structural works undertaken on all flats, reroofing and some verandas replaced and re-concreting. Two flats completely refurbished and tenanted in May. Various letters and a Residents meeting held regarding the ongoing works at the flats and the accommodation project. Community open day held to view refurbished flat. c. Funding strategy completed and five year timeline for renovations approved by Board of Management d. Flat 15 renovation complete and the unit occupied e. Ongoing renovations to the flats as funds become available – Units 1-3 currently being renovated through 2017. Due for completion 2018
4. Develop staff and student accommodation	a. Assess current and future accommodation requirements based on workforce development plan, update annually in Annual Report b. Acquisition of new or refurbished long-term accommodation options, including exploring partnerships with training and education organisations, alternative funding options and asset management implications 2016	a. Rental agreement for private residence for student and staff accommodation entered into to ensure Edenhope and District Memorial Hospital can meet workforce accommodation demands while building works are completed. b. All potential funding opportunities investigated and applications submitted as they become available. c. Newly completed executive accommodation and 10 room staff accommodation complex is extensively utilised

PERFORMANCE AGAINST THE STRATEGIC PLAN

GOAL 4: SHOW PRIDE IN OUR WORK

Outcomes

- Strong, positive reputation with community, partners, funders and staff, leading to stronger relationships
- Increased community activities at Edenhope and District Memorial Hospital site
- Community members actively involved in planning, feedback and evaluation of services

STRATEGY	ACTIONS	OUTCOMES 2016-17
1. Develop EDMH as a community Hub	a. Provide ongoing opportunities for community use of facilities b. Promote Edenhope and District Memorial Hospital as a community gathering place for a range of events, meetings and activities c. Better integrate Edenhope and District Memorial Hospital with other community events and activities	a. In partnership with Grampians Integrated Cancer Service providing Cancer Wellness support services to the community at Edenhope Library. b. Regular movie nights, exercise programs, community meetings held at the Elsie Bennett Community Centre in reporting period. c. Participation in RUOK day, heart health week, mental health and men's health nights with Edenhope Football and Netball Club, support in relocation of Edenhope Mens' Shed and associated committee development, coordination of breast check buses to Horsham, Edenhope and District Memorial Hospital team in Murray to Moyne Cycle Relay.
2. Develop a community engagement and communication plan	a. Develop and progressively implement the plan and processes by 2015 b. Update the branding of the organisation to convey a more contemporary image	a. Consumer Participation and Engagement Strategy developed and submitted at Community and Consumer Consultation Committee for community feedback. b. New logo adopted 2013. Roll-out complete. c. New draft communication plan completed
3. Enhance the Community Consultative Committee	a. Annually review the role of the Committee and establish shared expectations of members' role to progressively enhance its effectiveness. Report in the annual Quality of Care report b. Establish protocols for two-way flow of information between Committee, Executive and Board c. Equip members with information and tools to act as ambassadors and researchers in the community	a. Membership drive for committee conducted b. Reviewed process to ensure a board member always present at Committee meetings. Minutes of meeting circulated to board. c. Committee members provided with full briefing of hospital activities and empowered to act as advocates of the facility. Further, committee members are encouraged to feed community views back to the organisation.

STATEMENT OF PRIORITIES 2016-17

Part A Strategic Overview

Edenhope and District Memorial Hospital

Statement of Priorities
Strategic Priorities for 2016-17

In 2016–17 Edenhope and District Memorial Hospital will contribute to the achievement of the Government's commitments by:

Domain	Action	Deliverables	Outcomes
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.	Enlist support through the Centre for Palliative Care to develop policies and procedures for the implementation of care plans for people choosing to die at home.	Policy and procedures developed Advanced Care Plans and Goal Directed Care Plans database established to track client Advanced Care Plans
	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.	Set targets and develop a reporting process for tracking the uptake and utilisation of advance care planning; and complete audits that will track the effectiveness of its implementation.	Advanced Care Plans are offered to all clients and recorded on the Advance Care Database. Audits were undertaken to report on implementation of Advanced Care Plans. Advanced Care Plans offered as part of 75 health check at our Medical Clinic. District Nurse providing Advanced Care Plan interviews in person's home or from convenient location such as Medical Clinic. Nurse Unit Managers and Associate Nurse Unit Managers ensure that all nursing home residents have advance care plans and are reviewed regularly.
		Consult with patients and/or family members to evaluate their experience and ensure the care provided was consistent with their wishes and the directives.	Care plan review has been carried out by Registered Nurses and Nurse Unit Managers. Palliative care team and dementia/mental health services have provided input to care plans.

Domain	Action	Deliverables	Outcomes
	Progress implementation of a whole-of-hospital model for responding to family violence.	Utilise the Strengthening Hospital Response to Family Violence Toolkit to review policies and procedures in relation to responding to family violence to ensure Edenhope and District Memorial Hospital responds appropriately to incidents of family violence.	Policy and procedures developed Toolkit and interventions implemented. Training provided by social worker to all staff and Board / Executive team to assist in recognising and referring people affected by domestic violence. Nurse education package developed to assist in appropriate assessment and clinical interview of patients who may require assistance in response to family violence matters. Family violence assessment and notification requirements have been discussed at Nurse Manager and clinical healthcare staff meetings.
	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.	As a participating member of the Small Rural Research Team Alliance, undertake a project to enhance collaboration and deliver improvement in quality of care across rural and regional Victoria through shared learning and resources.	Regular education series/workshops held including video conferencing where practical. Quality Manager attended interview with Swinburne University Research Team investigating specific health management issues in small hospitals. Better Practice Research Project complete. Better practice projects presented. Video resources to be created in 2017.
	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.	Implement biannual 'consumer lunch' consumer consultation sessions to complement feedback received from the Victorian Healthcare Experience Survey to drive improvement in quality of care and patient experience.	First biannual consumer lunch complete. Victorian Healthcare Experience survey completed with limited numbers. Implemented Quality Improvement feedback process. Consumer/carer morning tea held with the Planned Activity Group. Morning meeting held at the Edenhope Coffee Shop. Conversations include Board of Management/Consumer Consultative Committee and Executive/Senior staff. Chief Executive Officer guest speaker engagements including Lions and Probus Clubs.

Domain	Action	Deliverables	Outcomes
	Develop a whole-of-hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint.	Audit compliance against the organisational restraint policy across all areas of service delivery and implement any required revisions to the policy including staff education as required.	Policy Reviewed and Code Grey implemented to reduce incidence of restraint and other restrictive practices Policy information distributed through staff meetings Management Of Clinical Aggression training completed, with modified version implemented 6 monthly physical restraint aged care audit conducted, restraint is not used unless clinically indicated and documented in patient case notes or medical history and patient/resident is referred for specialist review and transfer if required. Executive group will be seeking funding for upgrade of hospital entrances/exits to ensure a secure environment for patients and staff. Audit tool reviewed in 2015.
Access and timeliness	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).	Evaluate the current use of telehealth services across the organisation and develop an action plan to strengthen referral pathways and enhance client access to services to prevent the need for hospital admissions and enhance patient care.	Evaluation identified further need for increased array of services Specialist pathway to our GP clinic Collaboration with Royal Flying Doctor Service and Rural Northwest Health. Telehealth regularly used to reduce travel time for clients/carers and health practitioners. Wimmera Cardiac Rehabilitation group being expanded to include Edenhope and District Memorial Hospital clients. Western Victoria Primary Health Network provided list of potential specialist to complement ours. Use of Telehealth is encouraged for a larger number of staff to develop knowledge for improvement of client care and outcomes. Hospital nursing staff to undertake appointment facilitator roles in addition to Medical Centre staff. Memorandum of Understanding with Royal Flying Doctor Service signed 7 July 2017

Domain	Action	Deliverables	Outcomes
	Develop and implement a strategy to ensure the preparedness of the organisation for the National Disability and Insurance Scheme and Home and Community Care program transition and reform, with particular consideration to service access, service expectations, workforce and financial management.	Develop and participate in new and existing working groups focussing on managing the transition of the Victorian Home and Community Care program and the introduction of the National Disability Insurance Scheme. Evaluate services suitable for delivery by Edenhope and District Memorial Hospital.	Primary Health Manager attended numerous information days related to NDIS. Primary Health Manager attended Commonwealth Home Support Program VicHACC quarterly meetings. DEX set up to collate statistics from Uniti software. Due to potential small number of clients; discussions occurring re Edenhope and District Memorial Hospital being a sub-contractor to larger health service to deliver NDIS. Collaboration with West Wimmera Health established with West Wimmera Health to register as a NDIS provider and subcontract Edenhope and District Memorial Hospital. Commonwealth Home Support Program partnership model working group established.
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.	Provide input into Local Government Municipal Health Public Health and Wellbeing Plan ensuring there is an emphasis on diversity to deliver an integrated and collaborative service model.	Joint review of Diversity needs and Active Service Model in Local Government Authority: Primary Health Manager is now on the Municipal Public Health Plan Committee. Separate Active Service Model and Diversity Plan to Local Government Authority but regular monthly meetings to discuss issues and work together on health promotion activities eg Memory Lane Cafe/larger health promotion activities. Edenhope and District Memorial Hospital provides professional development support to local government authority when requested.
	Focus on primary prevention, including suicide prevention activities, and aim to impact on large numbers of people in the places where they spend their	Implement and evaluate the Sustainable Farm Families Program as a model of care to address mental health and wellbeing issues.	Attempted to run in Edenhope – Unsuccessful. Running in Harrow (July 2017) with good uptake.

Domain	Action	Deliverables	Outcomes
	time adopting a place based, whole of population approach to tackle the multiple risk factors of poor health.	Continue to work with the Primary Health Network to strengthen primary mental health service delivery models and referral pathways.	Continuing to work with the Primary Health Network. Psychological services program has been established in partnership with West Wimmera Health Service and is over prescribed in Edenhope and District Memorial Hospital catchment area
	Develop and implement strategies that encourage cultural diversity such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.	Collaborate with West Wimmera Shire to develop a shared diversity plan and develop cultural competency amongst staff through shared learning opportunities.	Cultural training - Elsie Bennett Community Centre/Community + Volunteers - Staff - Board - Management Diversity learning opportunities shared and provided onsite at Edenhope and District Memorial Hospital. Separate diversity plans but developed collaboratively. Interpreter service pamphlets have been placed in the hospital foyer for the general public. Nursing resource “interpreter services” has been added to the nursing shared resources for referral and assistance of clients speaking/understanding a language other than English. Collaboration with Wimmera Primary Care Partnership, Goolum Goolum and the Men’s Shed, established cultural flag stand to be utilised throughout the facility.

Domain	Action	Deliverables	Outcomes
	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.	In partnership with Goolum Goolum Aboriginal Co-operative, undertake a cultural audit of the health service to improve the organisation's cultural appropriateness for Aboriginal and Torres Strait Islander people.	Engage staff to attend regional training opportunities through VicHACC and Wimmera Primary Care Partnership. Cultural Competency Audit Report Sept 2012 (Received 21/12/2016). Agency Cultural Competency Physical Environment Audit Report: Goolum Goolum Aboriginal Consultant and Koolin Balit Project Officer of Wimmera Primary Care Partnership (Received 21/12/2016). A new partnership brochure was developed in 2016 and will assist with promotion of services. Pamphlets in the urgent care waiting area at the hospital entrance include those regarding interpreter services. Cultural training with all Day Centre staff completed training late 2016. Cultural training with managers, staff and board members completed March 2017. NAIDOC was recognised with ATSI flags in hospital entrance. Memorandum of Understanding with Goolum Goolum and Regional Commonwealth Home Support Program and VicHACC.
	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.	Increase service and consumer access to local and regional mental health services by streamlining and clarifying referral processes to primary mental health support services and clinical mental health services.	Mental Health referral and mental health plans provided by GP's. Clients have access to clinical mental health through face to face and phone contact/ telehealth at medical clinic. Access to mental health support services provided by Wimmera Uniting Care who confirmed that they service our area with Personal Helpers and Mentors program (PHaMs).

Domain	Action	Deliverables	Outcomes
	Using the Government's Rainbow eQuality Guide, identify and adopt 'actions for inclusive practices' and be more responsive to the health and wellbeing of lesbian, gay, bisexual, transgender and intersex individuals and communities.	Review and implement policies utilising the 'Lesbian, gay, bisexual, transgender and intersex inclusive practice guide for health and community services'.	Most interventions related to sexuality preferences is targeting residential care. Diversity Plan has this as a target. VicHACC training opportunity has been undertaken. On-line e-learning opportunities to enhance organisational knowledge. Lifestyle LGBTI procedure developed and implemented in aged care March 2016. Cultural Diversity Policy to supersede Cultural And Linguistically Diverse policy to better reflect client population. Edenhope and District Memorial Hospital recognises that all people are to be treated within the framework of Human Rights Conventions.
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.	Review documentation to ensure the organisation's clinical governance framework aligns with the Victorian Clinical Governance Policy Framework and undertake any modifications that may arise as a result of current reviews.	Clinical Governance training to build Board capabilities undertaken by Board of Management and Executive team. VHIA assistance in Webinars attended by Board of Management members and Chief Executive Officer. Policy and procedure review undertaken, policies updated in preparation for the implementation of PROMPT system. Director of Nursing has provided a presentation to Board of Management, emphasising the relevance of clinical governance to the entire hospital framework and overseeing the risk management of patient safety and clinical quality by revising and building upon existing policies, incident management and investigation systems. Redesign methodology has been undertaken to assist healthcare providers to review and improve the quality, effectiveness and efficiency of services.

Domain	Action	Deliverables	Outcomes
	Contribute to the development and implementation of Local Region Action Plans under the series of statewide design, service and infrastructure plans being progressively released from 2016– 17. Development of Local Region Action Plans will require partnerships and active collaboration across regions to ensure plans meet both regional and local service needs, as articulated in the statewide design, service and infrastructure plans.	By June 2017, actively contribute to the development and implementation of Local Regional Action Plans and worked collaboratively to ensure the plan meets both regional and local service needs.	Edenhope and District Memorial Hospital have been an active participant in the regional partnership development working with Ballarat Health Services and other Grampians Health Service in the implementation of a region wide approach to implement Safer Care Victoria guidelines and practices. The health service has also developed partnerships with several Wimmera health and support services in relation to client centred care, health literacy, rural issues and development of systems that counter barriers of isolation, lack of transport and engage technology to enhance client experiences in health care.
	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 to ensure it includes clear mechanisms for: reporting, investigation, feedback, consequence and appeal including a regular review schedule, the capacity to monitor incidence and adequate reporting processes. Ensure the policy has adequate visibility among staff and management to ensure accountability.	Policy and Procedure review completed. Newsletter campaign focusing on respect for other team members from the various teams that make up Edenhope and District Memorial Hospital. Bullying and Harassment Policy review completed. Workshops undertaken at staff team meetings to identify “above” and “below” the line behaviours. How we address these and build a culture of respect and stamping out of bullying. Director of Nursing has addressed bullying with healthcare staff and Nurse Unit Managers and has emphasised the professional expectations and consequences of bullying behaviour; at individual discussions and staff meetings. Ongoing review and evaluation of informal bullying reports.

Domain	Action	Deliverables	Outcomes
	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.	Ensure the organisational risk register has a section pertaining to occupation violence and aggression which is reported to the Quality and Risk Committee.	Organisational risk register updated to include section pertaining to occupation violence and aggression which is reported to the Quality and Risk Committee. Risk register reviewed at monthly Quality & Risk meetings. Reported to Board of Management through sub-committee, Quality and Risk Committee, and staff with remedy risks and controls. The elimination of occupational violence and aggression is to the most part everyone's responsibility. ReHSeN – online training added to training schedule.
		Implement training, utilising Management of Clinical Aggression principals to assist staff de-escalate challenging behaviours and reduce adverse incidents.	CODE Grey Procedure reviewed.
	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 and implement a workforce plan which aligns with our strategic plan, department priorities and local service profile.	Leadership training conducted to Influence organisational culture. Infection Control and Education positions being implemented with West Wimmera Healthcare Group. Edenhope and District Memorial Hospital is now registered as a placement site for international recruitment of nurses with work visas or permanent residency. Job descriptions have been revised. Portfolios for Nurses implemented.
	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	Ensure senior management are supported to better engage with the hospital and community at staff and consumer meetings.	All staff meeting February and August 2017. Senior management attend quarterly Community and Consumer Consultative Committee meetings.

Domain	Action	Deliverables	Outcomes
	the organisation; and (3) includes consumers and the community.	Provide opportunities for staff and consumers to be consulted on major projects such as capital development and refurbishment projects.	Whole of staff consultation in the development/review of organisational policies and procedures: Emergency Control Manual and Pets in Healthcare are two examples in last quarter of 2016. Conduct regular decision making days with community and staff: lead in with tell us what you want and then how do we do it. Delivered collaboration project with schools to promote rights of children within the hospital, work undertaken with schools to create posters promoting child safe/rights and responsibilities with winning posters used within the hospital and local community. Staff and resident consultation undertaken during the refurbishment of the Lakes Hostel bathroom renovations. Regional Health Infrastructure Fund grant approved. Considerable consultation processes have been included in the project plan.

Domain	Action	Deliverables	Outcomes
	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.	Conduct an internal review of the Edenhope and District child safe policy to ensure it meets our obligations under the Victorian Child Safe Standards. Support the implementation of the revised policy through periodic, mandatory education for all staff.	Policy completed. Education series to be conducted by Social Worker developed – delivered to Board of Management and executive team. Currently being rolled out to departments. Child Safe policy and review of Edenhope and District Memorial Hospital Code of Conduct completed and endorsed at Quality & Risk Meeting December 2016. Training is in progress. Social Worker and Exec Administration developed a short presentation for Staff and Board around new reporting requirements, to be delivered at departmental meeting so all staff aware. Quality Manager and Director of Nursing following up if E-learning is available – if available will be added to mandatory training for all staff (nil available when making initial enquiries in November 2016). Working with local schools to promote rights of children within the hospital, work with schools to create posters promoting child safe/rights and responsibilities with winning posters used within the hospital. Competitions and promotion in schools complete. Education delivered to Board and Executive staff. Staff education underway at staff meetings.
	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 the organisational vaccination policy to ensure it is clear, accessible and embedded within the organisation.	Vaccination Policy reviewed. Staff education and promotion conducted throughout the vaccination Staff clinics carried out in May and June. Job description forms for nursing staff indicate an essential expectation for proven immunisation/vaccination/immunity against vaccine preventable diseases as a requirement for new employees. Board of Management support for changes to policies including face masks.

Domain	Action	Deliverables	Outcomes
		Conduct education sessions aimed at increasing staff knowledge and awareness regarding the benefits of influenza immunisation.	Australian infection control provided an in-house service regarding influenza and vaccine preventable diseases. Fluvax clinic quarterly. Educational material promoted. IT to install popup reminders on all computers for staff to get the flu shot. Included in the communications plan for facebook and other social medias.
Financial sustainability	Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	Undertake an evaluation of the cash flow forecast and other board reports to identify opportunities to improve information provided to the Board. Provide feedback from the evaluation to the organisations external accountants to improve financial reporting to the Board.	AASBendigo completed changes to financial reports KPI/cashflow etc. Feedback received from the Board. Changes to be implemented. Board financial reporting training conducted with additional training for Q1 2017-18.
	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 current practices across the organisation and identify areas that demonstrate the greatest potential for carbon reduction.	Computer/printer shut down outside normal business hours etc., motion detector lights, LED. Review Gas consumption and investigate installation of instantaneous Hot Water Service to Aged Care to reduce holding heated water. • Installed in Hostel • Carbon reduction to be taken into account for the redevelopment of the Nursing home. Use of solar panels in the new building project is being investigated.
		Work to increase staff engagement with the Victorian Government's policy to be net zero carbon by 2050 and implement staff education to reduce carbon in identified areas for improvement.	Successful application to the Regional Health Infrastructure Fund for the redevelopment of the Nursing Home which will be built with environmental impact in mind. Renovations to maximise energy saving ratings. Increase staff awareness of recycling and reuse opportunities through better signage and displays.

Part B: Performance Priorities

Safety and quality performance

Key performance indicator	Target	2016–17 Result
Compliance with NSQHS Standards accreditation	Full compliance	Achieved
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Achieved
Compliance with cleaning standards	Full compliance	Achieved
Very high risk (Category A)	90 points	N/A
High risk (Category B)	85 points	98 Points
Moderate risk (Category C)	85 points	99 Points
Submission of infection surveillance data to VICNISS[1]	Full compliance	Achieved
Compliance with the Hand Hygiene Australia program	80%	85%
Percentage of healthcare workers immunised for influenza	75%	75.8%

Patient experience and outcomes performance

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

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

[1] VICNISS is the Victorian Hospital Acquired Infection Surveillance System

Governance, leadership and culture performance

Key performance indicator	Target	2016-17 Result
People Matter Survey - percentage of staff with a positive response to safety culture questions	80%	89%

Financial sustainability performance

Key performance indicator	Target	2016–17 Result
Finance		
Operating result ($m)	0.02	(0.34)
Trade creditors	60 days	33 days
Patient fee debtors	60 days	21 days
Adjusted current asset ratio	0.7	1.7
Number of days with available cash	14 days	172 days
Asset management		
Basic asset management plan	Full compliance	Achieved

Part C: Activity and Funding

Funding type	Activity
Small Rural Residential Care	13,871 Bed days
Small Rural HACC	
▪ Nursing	4,297 hours of service
▪ Planned Activity Group	14,707 hours of service
Health Workforce	2 Graduate Nurse Placements

SUMMARY OF SIGNIFICANT CHANGES IN FINANCIAL POSITION DURING THE YEAR

Edenhope and District Memorial Hospital reports a Net Operating deficit of $(0.34m) before capital and specific items against a budget surplus target of $0.02m. Factors impacting the ability to deliver a balanced budget include:

- Residential aged care consultancy of $190,000 which has identified $500,000 per year in additional recurrent funding
- Increases in employee benefit provisions as a result of the new pay rates of $145,000. Overall employee benefits provisions have reduced with the cessation of numerous long term employees
- Reduction in occupancy of the aged care facilities due to lower demand and the significant refurbishment works at the Hostel which required one room to be vacant over a 6 month period amounting to $70,000 between both factors
- There was increased Information Technology and Alliance costs $45,000
- Repairs and maintenance which are variable dependent upon need were $40,000 greater than the previous year
- The need for additional locum visiting medical officers was $30,000 greater than expected

STATUTORY REPORTING REQUIREMENTS

Building and Maintenance

All building works have been designed in accordance with the Department of Human Service's Guidelines and comply with the *Building Act 1993*.

Carer's Recognition Act 2012

The *Carers Recognition Act 2012* formally recognises and values the role of carers and the importance of care relationships in the Victorian community. EDMH complies with the philosophy and intent of this Act.

Consultancies

Provider Assist $190,472 (6 invoices) for ACFI review, resulting in an uplift in future revenue of approx. $800K per annum. There were no consultancies under $10,000.

Ex-Gratia Expenses

No ex-gratia payments were made during the reporting period.

Freedom of Information

There were no requests under the *Freedom of Information Act 1982*

Freedom of Information requests should be in writing and addressed to the Freedom of Information Officer, EDMH, PO Box 75, Edenhope, Vic, 3318.

National Competition Policy

Edenhope and District Memorial Hospital complies with all government policies regarding competitive neutrality with respect to all tender applications, including the requirements of the Government policy statement, *Competitive Neutrality Policy Victoria*, and subsequent reforms.

Occupational Health and Safety

Edenhope and District Memorial Hospital has a responsibility to ensure the provision of a safe environment for all staff, patients, residents and visitors.

During the reporting period there were no serious injuries, diseases or workplace deaths.

Protected Disclosure Act 2012

The *Protected Disclosure Act 2012* is designed to protect people who disclose information about serious wrongdoings within the Victorian Public Sector and to provide a framework for the investigation of these matters.

Edenhope and District Memorial Hospital's policies and procedures are consistent and compliant with the *Protected Disclosure Act 2012*.

Disclosures of improper conduct by EDMH or its employees may be made to:

The Protected Disclosure Officer – Kevin Mills
Phone 03 5585 9806
Email kevinm@edmh.org.au

or

The Ombudsman Victoria
570 Bourke Street
Melbourne, 3000
Phone 03 9613 6222, Toll Free 1800 806 314
www.ombudsman.vic.gov.au

Publications

Information in publications such as patient information brochures are reviewed regularly to ensure currency. The Annual and Quality of Care Reports are presented each year at Edenhope and District Memorial Hospital's Annual General Meeting, and are available on our website: www.edmh.org.au. No media advertising of greater value than $150,000 took place during the reporting period.

Victorian Industry Participation Policy

Edenhope and District Memorial Hospital complies with the *Victorian Industry Participation Policy (VIPP) Act 2003.* No contracts at EDMH were commenced nor completed which required information disclosure under this *Act* in the reporting period.

Workforce Data Disclosures

A total of 126 people were employed by EDMH: Full time 33; Part time 56; Casual 37.

There was no lost time due to industrial disputes.

Edenhope and District Memorial Hospital has an ongoing commitment to eliminate discrimination and inefficient work practices and to promote Equal Employment Opportunities in its workplace in accordance with the Public Authorities (Equal Employment Opportunity) Act of 1990.

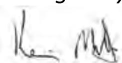
It bases its employment decisions on merit, treats employees fairly and reasonably, provides employees with an avenue of redress against unfair or unreasonable treatment and does not discriminate, directly or indirectly on the basis of various individual proclivities, personal characteristics, beliefs or social activities.

Safe Patient Care Act 2015

Edenhope and District Memorial Hospital has no matters to report in relation to its obligations under section 40 of the *Safe Patient Care Act 2015*.

ATTESTATION OF COMPLIANCE WITH HEALTH PURCHASING VICTORIA

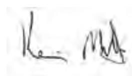
I, Kevin Mills certify that Edenhope and District Memorial Hospital has put in place appropriate internal controls and processes to ensure that it has complied with all requirements set out in the HPV Health Purchasing Policies including mandatory HPV collective agreements as required by the Health Services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



Kevin Mills
Chief Executive Officer
Edenhope
25th August 2017

ATTESTATION FOR COMPLIANCE WITH THE MINISTERIAL STANDING DIRECTION 3.7.1 – RISK MANAGEMENT FRAMEWORK AND PROCESSES

I, Kevin Mills certify that Edenhope and District Memorial Hospital has complied with the Ministerial Standing Direction 3.7.1 – Risk Management Framework and Process. The Edenhope and District Memorial Hospital Audit Committee verifies this.



Kevin Mills
Chief Executive Officer
Edenhope
25th August 2017

ENVIRONMENTAL PERFORMANCE

Edenhope and District Memorial Hospital is committed to sustainability and reducing its carbon footprint. New and ongoing energy saving initiatives include turning off computers, heaters and lights at the end of the day; photocopiers and printers defaulted to black and white print; blinds drawn each evening during summer and winter to assist with heating/cooling. Stage 1 masterplan funding was received in 2016 and construction will include environmental sustainability in the design.

DETAILS OF INFORMATION AND COMMUNICATION TECHNOLOGY (ICT) EXPENDITURE

The total ICT expenditure incurred during 2016-17 is $304,820 (excluding GST) with the details shown below.

Business as usual (BAU) ICT Expenditure	**Non-Business as Usual (non-BAU) ICT expenditure**		
	Total expenditure	Operational expenditure (excluding GST)	Capital expenditure (excluding GST)
$304,820	0	0	0

OCCUPATIONAL VIOLENCE STATISTICS

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.	2
4. Number of occupational violence incidents reported per 100 FTE.	2.6
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition.	0

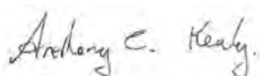
BOARD MEMBER'S, ACCOUNTABLE OFFICER'S, AND CHIEF FINANCE & ACCOUNTING OFFICER'S DECLARATION

We certify that the attached financial statements for Edenhope and District Memorial Hospital have been prepared in accordance with Standing Direction 5.2 of the Financial Management Act 1994, applicable *Financial Reporting Directions*, Australian Accounting Standards, Australian Accounting 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 Edenhope and District Memorial Hospital at 30 June 2017.

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

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



Mr Anthony Kealy
President and Member of Board

Edenhope
31st August 2017

Mr Kevin Mills
Chief Executive Officer
Chief Finance and Accounting Officer

Edenhope
31st August 2017

ADDITIONAL INFORMATION

Consistent with FRD 22H (Section 5.19) details in respect of the items listed below have been retained by Edenhope and District Memorial Hospital 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.

COMPREHENSIVE OPERATING STATEMENT

FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017

	Note	2017	2016
		$	$
Revenue from Operating Activities	2.1	8,924,582	8,202,738
Revenue from Non-Operating Activities	2.1	158,253	161,378
Employee Expenses	3.1	(6,618,140)	(6,140,279)
Non Salary Labour Costs	3.1	(708,754)	(682,141)
Supplies and Consumables	3.1	(528,918)	(442,154)
Administration Expenses	3.1	(882,836)	(673,007)
Other Expenses from Continuing Operations	3.1	(683,359)	(668,139)
Net Result Before Capital and Specific Items		(339,172)	(241,604)
Capital Purpose Income	2.1	924,039	2,792,305
Expenditure using Capital Purpose Income	3.1	5,929	(128,789)
Depreciation	4.4	(782,180)	(773,015)
Net Result After Capital and Specific Items		(191,384)	1,648,897
Other Economic Flow Included in Net Result			
Net gain/(loss) on disposal of non-financial assets	7.2	9,431	0
Revaluation of Long Service Leave	3.3	(9,249)	32,838
Total other economic flows included in net result		182	32,838
NET RESULT FOR THE YEAR		(191,202)	1,681,735
Other Comprehensive Income			
Items that will not be reclassified to net result			
Changes in physical asset revaluation surplus	8.1	0	0
COMPREHENSIVE RESULT		(191,202)	1,681,735

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

EDENHOPE AND DISTRICT MEMORIAL HOSPITAL
BALANCE SHEET
AS AT 30 JUNE 2017

	Note	2017 $	2016 $
ASSETS			
Current Assets			
Cash and Cash Equivalents	6.1	2,756,669	2,692,650
Receivables	5.1	495,155	252,132
Investments and Other Financial Assets	4.1	4,640,519	3,739,729
Inventories	5.2	23,463	25,684
Non-Financial Assets Classified as Held for Sale	5.4	0	156,875
Prepayments and Other Assets	5.5	47,623	74,791
Total Current Assets		7,963,429	6,941,861
Non-Current Assets			
Receivables	5.1	223,628	157,946
Property, Plant and Equipment	4.3	8,425,915	8,803,428
Total Non-Current Assets		8,649,543	8,961,374
TOTAL ASSETS		16,612,972	15,903,235
LIABILITIES			
Current Liabilities			
Payables	5.6	180,318	355,574
Provisions	3.3	1,766,733	1,771,181
Other Liabilities	5.3	3,615,369	2,589,730
Total Current Liabilities		5,562,420	4,716,485
Non-Current Liabilities			
Provisions	3.3	178,247	123,243
Total Non-Current Liabilities		178,247	123,243
TOTAL LIABILITIES		5,740,667	4,839,728
NET ASSETS		10,872,305	11,063,507
EQUITY			
Property, Plant and Equipment Revaluation Surplus	8.1a	5,174,189	5,174,189
Restricted Specific Purpose Surplus	8.1a	276,268	276,268
Contributed Capital	8.1b	3,981,684	3,981,684
Accumulated Surpluses / Deficits	8.1c	1,440,164	1,631,366
TOTAL EQUITY		10,872,305	11,063,507
Commitments	6.2		
Contingent Assets and Contingent Liabilities	7.3		

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

EDENHOPE AND DISTRICT MEMORIAL HOSPITAL
STATEMENT OF CHANGES IN EQUITY
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017

	Note	Property, Plant and Equipment Revaluation Surplus $	Restricted Specific Purpose Surplus $	Contributed Capital $	Accumulated Surpluses/ (Deficits) $	Total $
Balance at 1 July 2015		5,174,189	276,268	3,981,684	(50,369)	9,381,772
Net result for the year	8.1c	0	0	0	1,681,735	1,681,735
Other comprehensive income for the year		0	0	0	0	0
Balance at 30 June 2016		5,174,189	276,268	3,981,684	1,631,366	11,063,507
Net result for the year	8.1c	0	0	0	(191,202)	(191,202)
Other comprehensive income for the year		0	0	0	0	0
Balance at 30 June 2017		5,174,189	276,268	3,981,684	1,440,164	10,872,305

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

CASH FLOWS FROM OPERATING ACTIVITIES	Note	2017	2016
		$	$
Operating Grants from Government		6,511,029	6,320,151
Capital Grants from State Government		672,921	467,283
Patient and Resident Fees Received		1,248,167	1,258,568
Donations and Bequests Received		317,502	2,022,864
GST (Paid to)/received from ATO		9,037	30,919
Interest Received		136,449	190,731
Other Receipts		414,808	517,392
Total Receipts		*9,309,913*	*10,807,908*
Employee Expenses Paid		(6,534,619)	(6,076,081)
Non-Salary Labour Costs		(708,754)	(682,141)
Payments for Supplies and Consumables		(1,985,780)	(1,635,171)
Total Payments		*(9,229,153)*	*(8,393,393)*
NET CASH FLOW FROM / (USED IN) OPERATING ACTIVITIES	8.2	80,760	2,414,515
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for Non-Financial Assets		(349,849)	(1,746,197)
Proceeds from Sale of Non-Financial Assets		163,674	0
Redemption of Investments		65,909	1,102,754
NET CASH FLOW FROM / (USED IN) INVESTING ACTIVITIES		(120,266)	(643,443)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		(39,506)	1,771,072
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		2,507,311	736,239
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.1	2,467,805	2,507,311

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 Edenhope and District Memorial Hospital (ABN 19 442 911 836) for the period ending 30 June 2017. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

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

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

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

The annual financial statements were authorised for issue by the Board of Edenhope and District Memorial Hospital on:
31st August 2017.

(b) Reporting Entity

The financial statements includes all the controlled activities of Edenhope and District Memorial Hospital.

Its principal address is:
128 - 132 Elizabeth Street
Edenhope Vic 3318

A description of the nature of Edenhope and District Memorial Hospital'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

Edenhope and District Memorial Hospital's overall objective is to provide the highest standard of care and health related services that is responsive to community needs, as well as improve the quality of life to Victorians.

Edenhope and District Memorial Hospital is predominately funded by accrual based grant funding for the provision of outputs.

BASIS OF PRESENTATION (Continued)

(c) Basis of accounting preparation and measurement

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

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

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

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

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

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

- Non-current physical assets, which subsequent to acquisition, are measured at a revalued amount being their fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made and are reassessed when new indices are published by the Valuer General to ensure that the carrying amounts do not materially differ from their fair values; and

- The fair value of assets other than land is generally based on their depreciated replacement value.

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

(d) Principles of Consolidation

Intersegment Transactions

Transactions between segments within Edenhope and District Memorial Hospital have been eliminated to reflect the extent of Edenhope and District Memorial Hospital'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 enhance the wellbeing of all Victorians.

To enable the hospital to fulfil its objective it receives income based on parliamentary appropriations. The hospital also receives income from the supply of services.

Structure
2.1 Analysis of revenue by source

Note 2.1: ANALYSIS OF REVENUE BY SOURCE

	Admitted Patients 2017 $	Residential Aged Care 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	TOTAL 2017 $
Government Grants	3,467,266	2,598,141	354,510	225,699	56,413	6,702,029
Indirect Contributions by Department of Health and Human Services	39,036	30,199	2,210	2,210	0	73,655
Patient and Resident Fees	157,032	753,888	6,501	6,393	356,885	1,280,699
Catering	0	0	0	0	68,046	68,046
Property Income	0	0	0	0	124,147	124,147
Other Revenue from Operating Activities	51,771	50,999	4,671	35,826	532,739	676,006
Total Revenue from Operating Activities	3,715,105	3,433,227	367,892	270,128	1,138,230	8,924,582
Interest and Dividends	81,832	67,157	4,632	4,632	0	158,253
Total Revenue from Non-Operating Activities	81,832	67,157	4,632	4,632	0	158,253
Capital Purpose Income (excluding interest)	41,221	810,024	0	0	72,794	924,039
Total Capital Purpose Income	41,221	810,024	0	0	72,794	924,039
Total Revenue	3,838,158	4,310,408	372,524	274,760	1,211,024	10,006,874

	Admitted Patients 2016 $	Residential Aged Care 2016 $	Aged Care 2016 $	Primary Health 2016 $	Other 2016 $	TOTAL 2016 $
Government Grants	3,260,798	2,550,191	339,516	224,731	78,515	6,453,751
Indirect Contributions by Department of Health and Human Services	(3,547)	(2,745)	(201)	(201)	0	(6,694)
Patient and Resident Fees	118,441	746,198	5,017	5,665	361,106	1,236,427
Catering	0	0	0	0	75,286	75,286
Property Income	0	0	0	0	109,199	109,199
Other Revenue from Operating Activities	67,608	57,696	5,463	15,094	188,908	334,769
Total Revenue from Operating Activities	3,443,300	3,351,340	349,795	245,289	813,014	8,202,738
Interest and Dividends	85,531	66,165	4,841	4,841	0	161,378
Total Revenue from Non-Operating Activities	85,531	66,165	4,841	4,841	0	161,378
Capital Purpose Income	67,283	579,109	0	0	2,145,913	2,792,305
Total Capital Purpose Income	67,283	579,109	0	0	2,145,913	2,792,305
Total Revenue	3,596,114	3,996,614	354,636	250,130	2,958,927	11,156,421

Note 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)

Indirect Contributions by Department of Health & Human Services

Department of Health & 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 Edenhope and District Memorial Hospital and the income can be reliably measured at fair value.
Unearned income at reporting date is reported as income received in advance.

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

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

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

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

Indirect Contributions from the Department of Health and Human Services

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

Patient and Resident Fees

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

Private Practice Fees

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

Revenue from commercial activities

Revenue from commercial activities such as provision of meals to external users is recognised at the time the invoices are raised.

Donations and Other Bequests

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

Interest Revenue

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

Sale of investments

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

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

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

Note 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)

Category Groups

Edenhope and District Memorial Hospital 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 patients services, where services are delivered in public hospitals.

- Aged Care comprises a range of in home, specialist geriatric, residential care and community based programs and support services, such as Home and Community Care (HACC) that are targeted to older people, 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, Kooris liaison officers, 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 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 EXPENSE BY SOURCE

	Admitted Patients 2017 $	Residential Aged Care 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	TOTAL 2017 $
Employee Expenses	2,294,058	3,469,083	373,955	224,766	265,527	6,627,389
Other Operating Expenses						
Non Salary Labour Costs	244,581	20,237	1,481	66,083	376,372	708,754
Supplies and Consumables	199,549	267,587	2,979	46,668	12,135	528,918
Administration Expenses	349,255	438,507	41,548	37,606	15,920	882,836
Other Expenses	207,912	210,690	9,715	12,907	242,135	683,359
Total Expenditure from Operating Activities	3,295,355	4,406,104	429,678	388,030	912,089	9,431,256
Depreciation (refer note 4.4)	0	0	0	0	782,180	782,180
Expenditure using Capital Purpose Income	0	0	0	0	(5,929)	(5,929)
Total Other Expenses	0	0	0	0	776,251	776,251
Total Expenses	3,295,355	4,406,104	429,678	388,030	1,688,340	10,207,507

	Admitted Patients 2016 $	Residential Aged Care 2016 $	Aged Care 2016 $	Primary Health 2016 $	Other 2016 $	TOTAL 2016 $
Employee Expenses	2,284,175	3,091,152	324,782	204,175	203,157	6,107,441
Other Operating Expenses						
Non Salary Labour Costs	274,376	14,864	1,087	62,780	329,034	682,141
Supplies and Consumables	172,809	222,097	3,485	36,327	7,436	442,154
Administration Expenses	323,585	254,651	48,312	29,906	16,553	673,007
Other Expenses	199,660	227,505	5,687	21,485	213,802	668,139
Total Expenditure from Operating Activities	3,254,605	3,810,269	383,353	354,673	769,982	8,572,882
Depreciation (refer note 4.4)	0	0	0	0	773,015	773,015
Expenditure using Capital Purpose Income	0	0	0	0	128,789	128,789
Total Other Expenses	0	0	0	0	901,804	901,804
Total Expenses	3,254,605	3,810,269	383,353	354,673	1,671,786	9,474,686

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

Employee expenses

Employee expenses include:

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

Grants and Other Transfers

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

Note 3.1: ANALYSIS OF EXPENSE BY SOURCE (Continued)

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 service 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 expenses when distributed.

Bad and Doubtful Debts

Refer to Note 4.1 *Investments and other financial assets.*

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

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

Borrowing costs of qualifying assets

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

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

Net gain/ (loss) on non-financial assets

Net gain/ (loss) on non-financial assets and liabilities includes realised and unrealised gains and losses as follows:

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

Refer to Note 4.3 Property plant and equipment.

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

Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal and is the difference between the proceeds and the carrying amount of the asset at the time.

Net gain/ (loss) on financial instruments

Net gain/ (loss) on financial instruments includes:

- realised and unrealised gains and losses from revaluations of financial instruments at fair value;
- impairment and reversal of impairment for financial instruments at amortised cost refer to Note 4.1 Investments and other financial assets; and
- disposals of financial assets and derecognition of financial liabilities

Amortisation of non-produced intangible assets

Intangible non-produced assets with finite lives are amortised as an 'other economic flow' on a systematic 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.

Impairment of non-financial assets

Goodwill and intangible assets with indefinite useful lives (and intangible assets not available for use) are tested annually for impairment and whenever there is an indication that the asset may be impaired. Refer to Note 4.1 *Investments and other financial assets.*

Revaluations of financial instrument at fair value

Refer to Note 7.1 *Financial instruments.*

Other gains/ (losses) from other economic flows

Other gains/ (losses) include:

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

Note 3.1: ANALYSIS OF EXPENSE BY SOURCE (Continued)

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.

Financial guarantee

Payments that are contingent under financial guarantee contracts are recognised as a liability at the time the guarantee is issued. The liability is initially measured at fair value, and if there is a material increase in the likelihood that the guarantee may have to be exercised, then it is measured at the higher of the amount determined in accordance with AASB 137 *Provisions, Contingent Liabilities and Contingent Assets* and the amount initially recognised less cumulative amortisation, where appropriate.

In the determination of fair value, consideration is given to factors including the overall capital management/prudential supervision framework in operation, the protection provided by the State Government by way of funding should the probability of default increase, probability of default by the guaranteed party and the likely loss to the Health Service in the event of default.

Note 3.2: ANALYSIS OF EXPENSES AND REVENUE BY INTERNALLY MANAGED AND RESTRICTED SPECIFIC PURPOSE FUNDS

	Expense		Revenue	
	2017	2016	2017	2016
	$	$	$	$
Commercial Activities				
Private Practice	656,698	541,929	414,755	439,869
Property Expense / Revenue	38,988	33,280	68,555	77,319
Total	695,686	575,209	483,310	517,188

Note 3.3: EMPLOYEE BENEFITS IN THE BALANCE SHEET

	2017	2016
Current Provisions	$	$
Employee Benefits (i)		
Annual Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	776,312	752,912
- unconditional and expected to be settled wholly after 12 months (iii)	0	23,400
Long Service Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	149,000	108,000
- unconditional and expected to be settled wholly after 12 months (iii)	645,117	769,708
	1,570,429	1,654,020
Provisions related to employee benefit on-costs		
- unconditional and expected to be settled within 12 months (ii)	115,664	18,022
- unconditional and expected to be settled after 12 months (iii)	80,640	99,139
	196,304	117,161
Total Current Provisions	1,766,733	1,771,181
Non-Current Provisions		
Employee Benefits (i)		
Employee Termination Benefits	158,442	109,549
Provisions related to employee benefit on-costs	19,805	13,694
Total Non-Current Provisions	178,247	123,243
Total Provisions	1,944,980	1,894,424
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Annual Leave Entitlements	526,163	519,679
Accrued Salaries and Wages	310,462	238,662
Accrued Days Off	36,726	25,419
Unconditional Long Service Leave Entitlements	893,382	987,421
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements (ii)	178,247	123,243
Total Employee Benefits and Related On-Costs	1,944,980	1,894,424

Notes:
(i) Employee benefits consist of annual leave and long service leave accrued by employees. On-costs such as payroll tax and worker's compensation insurance are not employee benefits and are reflected as a separate provision.
(ii) The amounts disclosed are nominal values.
(iii) The amounts disclosed are at present values.

	2017	2016
Movements in Provisions	$	$
Movement in Long Service Leave:		
Balance at start of year	1,110,664	1,110,664
Provision made during the year		
- Revaluations	(9,249)	32,838
- Expense Recognising Employee Service	180,853	54,402
Settlement made during the year	(210,639)	(87,240)
Balance at end of year	1,071,629	1,110,664

Note 3.3: EMPLOYEE BENEFITS IN THE BALANCE SHEET (Continued)
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 – if the health service does not expect to wholly settle within 12 months.

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

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

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

The health service recognises termination benefits when it is demonstrably committed to either terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy.

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

Note 3.4: SUPERANNUATION

Fund		Paid Contributions for the year		Outstanding Contributions at Year End	
		2017 $	2016 $	2017 $	2016 $
Defined Benefit Plans: (i)	Health Super	40,056	38,850	0	0
Defined Contribution Plans:	Health Super / HESTA / Other	493,917	469,722	0	0
Total		533,973	508,572	0	0

(i) The bases for determining the level of contributions is determined by the various actuaries of the defined benefit superannuation plans.

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

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

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 expensed in relation to the major employee superannuation funds and contributions made by the Health Service are set out in the table above.

Defined contribution superannuation plans
In relation to defined contributions (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 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 Edenhope and District Memorial Hospital are entitled to receive superannuation benefits and Edenhope and District Memorial Hospital contributes to both the defined benefit and defined contribution plans. The defined benefit plans provide benefits based on years of service and final average salary.

Superannuation liabilities
Edenhope and District Memorial Hospital 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 Investments and other financial assets
4.2 Jointly controlled operations and assets
4.3 Property, plant & equipment
4.4 Depreciation

Note 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS	Capital Fund		Total	
	2017	2016	2017	2016
CURRENT	$	$	$	$
Loans and Receivables				
Term Deposit				
Aust. Dollar Term Deposits > 3 Months (i)	4,640,519	3,739,729	4,640,519	3,739,729
TOTAL CURRENT OTHER FINANCIAL ASSETS	4,640,519	3,739,729	4,640,519	3,739,729
Represented by:				
Investments - Health Service	1,191,144	1,257,053	1,191,144	1,257,053
Investments - Monies Held in Trust	3,449,375	2,482,676	3,449,375	2,482,676
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	4,640,519	3,739,729	4,640,519	3,739,729

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

(a) Ageing analysis of other financial assets
Please refer to Note 7.1 for the ageing analysis of other financial assets

(b) Nature and extent of risk arising from other financial assets
Please refer to Note 7.1 for the nature and extent of credit risk arising from other financial assets

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

Investments are classified in the following categories:
- Financial assets at fair value through profit or loss;
- Held-to-maturity;
- Loans and receivables; and
- Available-for-sale financial assets.

Edenhope and District Memorial Hospital classifies its other financial assets between current and non-current assets based on the purpose for which the assets were acquired. Management determines the classification of its other financial assets at initial recognition.

Edenhope and District Memorial Hospital assesses at each balance sheet date whether a financial asset or group of financial assets is impaired.

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

Derecognition of financial assets
A financial asset (or, where applicable, a part of a financial asset or part of a group of similar financial assets) is derecognised when:
- the rights to receive cash flows from the asset have expired; or
- the Health Service retains the right to receive cash flows from the asset, but has assumed an obligation to pay them in full without material delay to a third party under a 'pass through' arrangement; or
- the Health Service has transferred its rights to receive cash flows from the asset and either:
  (a) has transferred substantially all the risks and rewards of the asset; or
  (b) has neither transferred nor retained substantially all the risks and rewards of the asset, but has transferred control of the asset.

Where the Health Service has neither transferred nor retained substantially all the risks and rewards or transferred control, the asset is recognised to the extent of the Health Service's continuing involvement in the asset.

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

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

Note 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS (Continued)

Doubtful debts

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

Note 4.2: JOINTLY CONTROLLED OPERATIONS AND ASSETS

Name of Entity	Principal Activity	Ownership Interest 2017 %	Ownership Interest 2016 %
Grampians Rural Health Alliance	Information Systems	3.79	3.69

Edenhope & District Memorial Hospital's interest in assets employed in the above jointly controlled operations and assets is detailed below. The amounts are included in the financial statements under their respective categories:

	2017 $	2016 $
Current Assets		
Cash and Cash Equivalents	122,870	78,285
Receivables	16,485	47,744
Prepayments	1,302	6,435
Total Current Assets	140,657	132,464
Non Current Assets		
Property Plant and Equipment	140,582	88,396
Total Non Current Assets	140,582	88,396
Total Assets	281,239	220,860
Current Liabilities		
Payables	22,003	29,149
Total Current Liabilities	22,003	29,149
Total Liabilities	22,003	29,149
Net Assets	259,236	191,711

Edenhope & District Memorial Hospital interest in revenues and expenses resulting from jointly controlled operations and assets is detailed below:

	2017	2016
Revenues		
Operating Income	207,735	188,185
Capital Income	72,794	123,049
Total Revenue	280,529	311,234
Expenses		
Information Technology and Administrative Expenses	201,630	181,407
Capital Expense	16,570	11,177
Total Expenses	218,200	192,584
Profit	62,329	118,650

Contingent Liabilities and Capital Commitments

There are no known contingent liabilities or capital commitments for Grampians Rural Health Alliance as at the date of this report.

Investments in joint operations

In respect of any interest in joint operations, Edenhope & District Memorial Hospital 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 4.3: PROPERTY, PLANT AND EQUIPMENT (a) Gross carrying amount and accumulated depreciation	2017 $	2016 $
Land		
- Land at Fair Value	608,000	608,000
- Land Improvements at Fair Value	10,005	0
Less Accumulated Depreciation	131	0
Total Land	617,874	608,000
Buildings		
- Buildings at Fair Value	8,970,169	8,750,060
Less Accumulated Depreciation	1,944,602	1,297,942
Total Buildings	7,025,567	7,452,118
Plant and Equipment		
- Plant and Equipment at Fair Value	842,283	817,571
Less Accumulated Depreciation	519,611	443,903
Total Plant and Equipment	322,672	373,668
Medical Equipment		
- Medical Equipment at Fair Value	386,769	372,880
Less Accumulated Depreciation	338,076	324,300
Total Medical Equipment	48,693	48,580
Computers and Communication		
- Grampians Rural Health Alliance at Fair Value	175,763	108,999
Less Accumulated Depreciation	36,977	22,056
- Computers and Communication at Fair Value	234,060	219,169
Less Accumulated Depreciation	212,903	206,265
Total Computers and Communications	159,943	99,847
Motor Vehicles		
- Grampians Rural Health Alliance at Fair Value	3,397	1,947
Less Accumulated Depreciation	1,601	494
- Motor Vehicles at Fair Value	227,975	205,492
Less Accumulated Depreciation	160,765	148,247
Total Motor Vehicles	69,006	58,698
Furniture and Fittings		
- Furniture and Fittings at Fair Value	309,364	265,604
Less Accumulated Depreciation	127,204	103,087
Total Furniture and Fittings	182,160	162,517
TOTAL	8,425,915	8,803,428

Note 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)
(b) Reconciliation of the carrying amounts of each class of asset

	Land	Buildings	Plant & Equipment	Medical Equipment	Computers & Communication	Motor Vehicles	Furniture & Fittings	Total
	$	$	$	$	$	$	$	$
Balance at 1 July 2015	638,000	6,730,043	338,718	53,704	43,937	1,666	133,331	7,939,399
Additions	0	1,500,569	110,238	11,812	14,850	59,446	49,282	1,746,197
Disposals	0	0	0	0	0	0	0	0
Classified as Held for Sale	(30,000)	(126,875)	0	0	0	0	0	(156,875)
Grampians Rural Health Alliance	0	0	0	0	47,935	(213)	0	47,722
Depreciation (note 4.4)	0	(651,619)	(75,288)	(16,936)	(6,875)	(2,201)	(20,096)	(773,015)
Balance at 1 July 2016	608,000	7,452,118	373,668	48,580	99,847	58,698	162,517	8,803,428
Additions	10,006	220,109	24,712	13,890	14,890	22,482	43,760	349,849
Disposals	(30,000)	(124,243)	0	0	0	0	0	(154,243)
Classified as Held for Sale	30,000	126,875	0	0	0	0	0	156,875
Grampians Rural Health Alliance	0	0	0	0	51,843	343	0	52,186
Depreciation (note 4.4)	(132)	(649,292)	(75,708)	(13,777)	(6,637)	(12,517)	(24,117)	(782,180)
Balance at 30 June 2017	617,874	7,025,567	322,672	48,693	159,943	69,006	182,160	8,425,915

Land and Buildings Carried at Valuation
An independent valuation of Edenhope & District Memorial Hospital's property was performed by the *Valuer-General Victoria* to determine the fair value of the land and buildings. The valuation is at fair value based on replacement cost less accumulated depreciation as at the date of valuation. The effective date of the valuation is 30 June 2014.

(c) Fair value measurement hierarchy for assets

	Carrying amount as at 30 June 2017	Fair value measurement at end of reporting period using:		
		Level 1 (i)	Level 2 (i)	Level 3 (i)
	$	$	$	$
Land at fair value				
Non-Specialised land	280,000	0	280,000	0
Specialised land	337,874	0	0	337,874
Total of land at fair value	617,874	0	280,000	337,874
Buildings at fair value				
Non-Specialised buildings	673,125	0	673,125	0
Specialised buildings	6,352,442	0	0	6,352,442
Total of buildings at fair value	7,025,567	0	673,125	6,352,442
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles	69,006	0	69,006	0
- Plant and equipment	322,672	0	0	322,672
- Medical equipment	48,693	0	0	48,693
- Computers & Communication	159,943	0	0	159,943
- Furniture & Fittings	182,160	0	0	182,160
Total of plant, equipment and vehicles at fair value	782,474	0	69,006	713,468

Note
(i) Classified in accordance with the fair value hierarchy, see Note 1

There have been no transfers between levels during the period.

Note 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)
(c) Fair value measurement hierarchy for assets (Continued)

	Carrying amount as at 30 June 2016	Fair value measurement at end of reporting period using:		
		Level 1 (i)	Level 2 (i)	Level 3 (i)
	$	$	$	$
Land at fair value				
Non-Specialised land	280,000	0	280,000	0
Specialised land	328,000	0	0	328,000
Total of land at fair value	608,000	0	280,000	328,000
Buildings at fair value				
Non-Specialised buildings	673,125	0	673,125	0
Specialised buildings	6,778,993	0	0	6,778,993
Total of buildings at fair value	7,452,118	0	673,125	6,778,993
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	58,698	0	58,698	0
- Plant and equipment	373,668	0	0	373,668
- Medical equipment	48,580	0	0	48,580
- Computers & Communication	99,847	0	0	99,847
- Furniture & Fittings	162,517	0	0	162,517
Total of plant, equipment and vehicles at fair value	743,310	0	58,698	684,612

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

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

- The fair value of land, buildings, infrastructure, plant and equipment, (refer to Note 7.1);
- Superannuation expense (refer to Note 3.4);
- Actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.3); and
- Equities and management investment schemes classified at level 3 of the fair value hierarchy.

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

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

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

For the purpose of fair value disclosures, Edenhope And District Memorial Hospital 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, Edenhope And District Memorial Hospital 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 Edenhope And District Memorial Hospital’s independent valuation agency.

Edenhope And District Memorial Hospital, 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.

Note 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

(c) Fair value measurement hierarchy for assets (Continued)

Fair value measurement

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

- that the transaction to sell the asset or transfer the liability takes place either in the principal market (or the most advantageous market, in the absence of the principal market), either of which must be accessible to the Health Service at the measurement date;
- that the Health Service uses the same valuation assumptions that market participants would use when pricing the asset or liability, assuming that market participants act in their economic best interest.

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

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

Judgements about highest and best use must take into account the characteristics of the assets concerned, including restrictions on the use and disposal of assets arising from the asset's physical nature and any applicable legislative/contractual arrangements.
In considering the HBU for non-financial physical assets, valuers are probably best placed to determine highest and best use (HBU) in consultation with Health Services. Health Services and their valuers therefore need to have a shared understanding of the circumstances of the assets. A Health Service has to form its own view about a valuer's determination, as it is ultimately responsible for what is presented in its audited financial statements.

In accordance with paragraph AASB 13.29, Health Services can assume the current use of a non-financial physical asset is its HBU unless market or other factors suggest that a different use by market participants would maximise the value of the asset.
Therefore, an assessment of the HBU will be required when the indicators are triggered within a reporting period, which suggest the market participants would have perceived an alternative use of an asset that can generate maximum value. Once identified, Health Services are required to engage with VGV or other independent valuers for formal HBU assessment.

These indicators, as a minimum, include:
External factors:

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

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

Valuation hierarchy

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

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

Note 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)
(d) Reconciliation of Level 3 fair value

30 June 2017	Land	Buildings	Plant and equipment
	$	$	$
Opening Balance	328,000	6,778,993	684,612
Purchases / (sales)	10,006	222,741	149,095
Transfers in (out) of Level 3	0	0	0
Gains or losses recognised in net result			
- Depreciation	(132)	(649,292)	(120,239)
Subtotal	337,874	6,352,442	713,468
Items recognised in other comprehensive income			
- Revaluation	0	0	0
Subtotal	0	0	0
Closing Balance	337,874	6,352,442	713,468

There have been no transfers between levels during the period.

30 June 2016	Land	Buildings	Plant and equipment
	$	$	$
Opening Balance	328,000	5,930,043	569,690
Purchases / (sales)	0	1,500,569	234,117
Transfers in (out) of Level 3	0	0	0
Gains or losses recognised in net result			
- Depreciation	0	(651,619)	(119,195)
Subtotal	328,000	6,778,993	684,612
Items recognised in other comprehensive income			
- Revaluation	0	0	0
Subtotal	0	0	0
Closing Balance	328,000	6,778,993	684,612

There have been no transfers between levels during the period.

Identifying unobservable inputs (level 3) fair value measurements

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

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

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

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

Note 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)
(d) Reconciliation of Level 3 fair value (Continued)
Non-specialised land, non-specialised buildings
Non-specialised land, non-specialised buildings are valued using the market approach. Under this valuation method, the assets are compared to recent comparable sales or sales of comparable assets which are considered to have nominal or no added improvement value.

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

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

Specialised land 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 service, 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 value (depreciated cost).

Plant and equipment
Plant and equipment is held at carrying value (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 value.

There were no changes in valuation techniques throughout the period to 30 June 2017.

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

Note 4.3: PROPERTY, PLANT AND 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 buldings
Plant and equipment at fair value	Depreciated Replacement Cost	Cost per Unit Useful life of PPE

(i) Refer to Note 7.4 for guidance on fair value measurement indicative expectations.

Property, plant and equipment
All non-current physical assets are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and impairment. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. Assets transferred as part of a merger / machinery of government are transferred at their carrying amount.

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 4.3 *Property, plant and equipment* .

The initial cost for non-financial physical assets under finance lease is measured at amounts equal to the fair value of the leased asset or, if lower, the present value of the minimum lease payments, each determined at the inception of the lease.

Crown Land is measured at fair value with regard to the property's highest and best use after due consideration is made for any legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset. Theoretical opportunities that may be available in relation to the asset(s) are not taken into account until it is virtually certain that that any restriction 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 impairments.

Note 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

Property, plant and equipment (Continued)

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

Revaluations of Non-current Physical Assets

Non-Current physical assets are measured at fair value and are revalued in accordance with FRD 103F *Non-current physical assets.* This revaluation process normally occurs at least every five years, based upon the asset's Government Purpose Classification but may occur more frequently if fair value assessments indicate material changes in values.

Independent valuers are used to conduct these scheduled revaluations and any interim revaluations are determined in accordance with the requirements of the FRDs. Revaluation increments or decrements arise from differences between an asset's carrying value and fair value.

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

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

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

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

In accordance with FRD 103F, Edenhope & District Memorial Hospital's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

Note 4.4: DEPRECIATION	2017 $	2016 $
Depreciation		
Buildings	649,292	651,619
Land Improvements	132	0
Plant and Equipment		
- Plant	75,708	75,288
- Major Medical	13,777	16,936
- Computers and Communication	6,637	6,875
- Motor Vehicles	12,517	2,201
- Furniture and Fittings	24,117	20,096
TOTAL DEPRECIATION	782,180	773,015

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 as 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.

Note 4.4: DEPRECIATION (Continued)

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	5 to 38 years	5 to 38 years
- Site Engineering Services and Central Plant	5 to 38 years	5 to 38 years
Central Plant		
- Fit Out	5 to 38 years	5 to 38 years
- Trunk Reticulated Building Systems	5 to 38 years	5 to 38 years
Plant and Equipment	10 years	10 years
Medical Equipment	5 to 10 years	5 to 10 years
Computers and Communication	2 to 3 years	2 to 3 years
Furniture and Fittings	7 to 40 years	3 to 5 years
Motor Vehicles	4 to 5 years	4 to 5 years

As part of the buildings valuation, building values were separated into components and each component assessed for its useful life which is represented above. There has been a change in the useful lives assessment for furniture and fittings in 2016/17.

Note 5: OTHER ASSETS AND LIABILITIES

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

Structure

5.1 Receivables
5.2 Inventories
5.3 Other liabilities
5.4 Non financial physical assets classified as held for sale including disposal groups
5.5 Prepayments and other non-financial assets
5.6 Payables

Note 5.1: RECEIVABLES

	2017	2016
CURRENT	$	$
Contractual		
Trade Debtors - Health Service	119,368	21,608
Patient / Resident Debtors	89,487	79,134
Accrued Investment Income	59,124	37,320
Accrued Revenue - Other	37,380	33,857
Receivables - Grampians Rural Health Alliance	16,485	47,543
Less Allowance for Doubtful Debts	(7,821)	(30,000)
	314,023	189,462
Statutory		
Department of Health and Human Services	127,700	0
GST Receivable - Health Service	53,432	62,469
GST Receivable - Grampians Rural Health Alliance	0	201
	181,132	62,670
TOTAL CURRENT RECEIVABLES	495,155	252,132
NON CURRENT		
Statutory		
Long Service Leave - Department of Health and Human Services	223,628	157,946
TOTAL NON-CURRENT RECEIVABLES	223,628	157,946
TOTAL RECEIVABLES	718,783	410,078

(a) Movement in the Allowance for doubtful debts

	2017	2016
	$	$
Balance at beginning of year	30,000	0
Amounts written off during the year	(30,000)	0
Reversal of receivable written off	0	0
Amounts recovered during the year	7,821	0
Increase/(decrease) in allowance recognised in net result	0	30,000
Balance at end of year	7,821	30,000

(b) Ageing analysis of receivables

Please refer to Note 7.1 for the ageing analysis of receivables.

Note 5.1: RECEIVABLES (Continued)
(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 receivables.

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

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

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

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

Note 5.2: INVENTORIES	2017	2016
	$	$
CURRENT		
Pharmaceuticals - at cost	10,793	7,297
Catering Supplies - at cost	6,610	4,599
Housekeeping Supplies - at cost	1,919	5,392
Medical and Surgical Lines - at cost	4,141	8,396
TOTAL INVENTORIES	23,463	25,684

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

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

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

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

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

Note 5.3: OTHER LIABILITIES	2017	2016
	$	$
CURRENT		
Monies Held in Trust*		
- Patient Monies Held in Trust	41,151	48,994
- Accommodation Bonds (Refundable Entrance Fees)	3,449,375	2,482,676
- Other	124,843	58,060
TOTAL CURRENT	3,615,369	2,589,730
* Total Monies Held in Trust		
Represented by the following assets:		
Cash Assets (refer to Note 6.1)	165,994	107,054
Investment and other Financial Assets (refer to Note 4.1)	3,449,375	2,482,676
TOTAL OTHER LIABILITIES	3,615,369	2,589,730

Note 5.4: NON FINANCIAL PHYSICAL ASSETS CLASSIFIED AS HELD FOR SALE INCLUDING DISPOSAL GROUPS

	2017 $	2016 $
(A) Non-financial physical assets including disposal group assets classified as held for sale		
189 Elizabeth Street Edenhope	0	156,875
Total Non-financial physical assets classified as held for sale	0	156,875

(B) Fair value measurement of non-financial physical assets held for sale

	Carrying amount as at 30 June 2017	Fair value measurement at end of reporting period using:		
		Level 1 (i)	Level 2 (i)	Level 3 (i)
	$	$	$	$
189 Elizabeth Street Edenhope (i)	0	0	0	0
	0	0	0	0

	Carrying amount as at 30 June 2016	Fair value measurement at end of reporting period using:		
		Level 1 (i)	Level 2 (i)	Level 3 (i)
	$	$	$	$
189 Elizabeth Street Edenhope (i)	156,875	0	156,875	0
	156,875	0	156,875	0

Note
(1) Classified in accordance with the fair value hierarchy, see Note 1
(i) Non-physical assets classified as held for sale are carried at fair value less cost to disposal.

Non-financial physical assets classified as held for sale
Non-financial physical assets and disposal groups and related liabilities are treated as current and are classified as held for sale if their carrying amount will be recovered through a sale transaction rather than through continuing use. This condition is regarded as met only when the sale is highly probable, the asset's sale (or disposal group) is expected to be completed within 12 months from the date of classification, and the asset is available for immediate use in the current condition.

Non-financial physical assets (including disposal groups) classified as held for sale are treated as current and are measured at the lower of carrying amount and fair value less costs of disposal, and are not subject to depreciation or amortisation.

Note 5.5: PREPAYMENTS AND OTHER NON-FINANCIAL ASSETS

	2017 $	2016 $
CURRENT		
Prepayments - Health Service	46,321	68,356
Prepayments - Grampians Rural Health Alliance	1,302	6,435
TOTAL OTHER ASSETS	47,623	74,791

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 5.6: PAYABLES	2017	2016
	$	$
CURRENT		
Contractual		
Trade Creditors	82,661	156,683
Payables - Grampians Rural Health Alliance	22,003	29,149
Other Accrued Expenditure	75,654	106,442
	180,318	292,274
Statutory		
Department of Health and Human Services	0	63,300
	0	63,300
TOTAL PAYABLES	180,318	355,574

(a) Maturity analysis of payables
Please refer to note 7.1 for the ageing analysis of payables.

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

	2017	2016
	$	$
Cash on Hand	600	600
Cash at Bank	1,174,310	294,738
Deposits at Call	1,581,759	2,397,312
TOTAL CASH AND CASH EQUIVALENTS	2,756,669	2,692,650
Represented by:		
Cash for Health Service Operations (as per cash flow statement)	2,467,805	2,507,311
Cash for Grampians Rural Health Alliance	122,870	78,285
Cash for Monies Held in Trust		
- Cash at Bank	165,994	107,054
TOTAL CASH AND CASH EQUIVALENTS	2,756,669	2,692,650

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

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

Note 6.2: COMMITMENTS FOR EXPENDITURE

	2017	2016
	$	$
a) Commitments other than public private partnerships		
Lease commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating Leases	13,423	7,845
Total lease commitments	13,423	7,845
Operating leases - motor vehicles		
Operating lease for two motor vehicles and two photocopiers payable as follows:		
Cancellable	0	7,845
Total operating lease commitments	0	7,845
Total Commitments other than public private partnerships	13,423	7,845
b) Commitments payable		
Lease commitments payable		
Photocopiers		
Less than 1 year	2,730	1,246
Longer than 1 year but not longer than 5 years	10,693	0
Motor Vehicles		
Less than 1 year	0	6,598
Longer than 1 year but not longer than 5 years	0	0
Total lease commitments	13,423	7,845
Total commitments (inclusive of GST)	13,423	7,845
Less GST recoverable from the Australian Taxation Office	1,220	713
Total commitments (exclusive of GST)	12,203	7,132

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

Note 7: RISKS, CONTINGENCIES & VALUATION UNCERTAINTIES

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

Structure

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

Note 7.1: FINANCIAL INSTRUMENTS

(a) Financial Risk Management Objectives and Policies

Edenhope & District Memorial Hospital's principal financial instruments comprise of:

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

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

The Health Service's main financial risks include credit risk, liquidity risk and interest rate risk. The Health Service manages these financial risks in accordance with its financial risk management policy.

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

The main purpose in holding financial instruments is to prudentially manage Edenhope & District Memorial Hospital's financial risk within the government policy parameters.

Note 7.1: FINANCIAL INSTRUMENTS (Continued)
(a) Financial Risk Management Objectives and Policies (Continued)
Categorisation of financial instruments

2017	Contractual financial assets - loans and receivables $	Contractual financial liabilities at amortised cost $	Total $
Contractual Financial Assets			
Cash and cash equivalents	2,756,669	0	2,756,669
Receivables	314,023	0	314,023
Investments and Other Financial Assets	4,640,519	0	4,640,519
Total Financial Assets (i)	7,711,211	0	7,711,211
Financial Liabilities			
At amortised cost			
- Payables	0	180,318	180,318
- Other Liabilities	0	3,615,369	3,615,369
Total Financial Liabilities(ii)	0	3,795,687	3,795,687

2016	Contractual financial assets - loans and receivables $	Contractual financial liabilities at amortised cost $	Total $
Contractual Financial Assets			
Cash and cash equivalents	2,692,650	0	2,692,650
Receivables	189,462	0	189,462
Investments and Other Financial Assets	3,739,729	0	3,739,729
Total Financial Assets (i)	6,621,841	0	6,621,841
Financial Liabilities			
At amortised cost			
- Payables	0	292,274	292,274
- Other Liabilities	0	2,589,730	2,589,730
Total Financial Liabilities(ii)	0	2,882,004	2,882,004

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

Note 7.1: FINANCIAL INSTRUMENTS (Continued)
(b) Net holding gain/(loss) on financial instruments by category

	Net holding gain/(loss) $	Total interest (expense) $	Fee income / (expense) $	Impairment loss $	Total $
2017					
Financial Assets					
Cash and cash equivalents(i)	0	158,253	0	0	158,253
Total Financial Assets	0	158,253	0	0	158,253
Financial Liabilities					
At amortised cost (ii)	0	0	0	0	0
Total Financial Liabilities	0	0	0	0	0
2016					
Financial Assets					
Cash and cash equivalents(i)	0	161,378	0	0	161,378
Total Financial Assets	0	161,378	0	0	161,378
Financial Liabilities					
At amortised cost (ii)	0	0	0	0	0
Total Financial Liabilities	0	0	0	0	0

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

(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.

(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 Edenhope & District Memorial Hospital maximum exposure to credit risk without taking account of the value of any collateral obtained.

Note 7.1: FINANCIAL INSTRUMENTS (Continued)
(c) Credit Risk (Continued)
Credit quality of contractual financial assets that are neither past due nor impaired

2017	Financial Institutions (Min BBB credit rating) $	Government agencies (AAA credit rating) $	Other $	Total $
Financial Assets				
Cash and Cash Equivalents	2,140,115	615,954	600	2,756,669
Loans and Receivables				
- Trade Debtors	0	0	201,034	201,034
- Other Receivables (i)	0	0	112,989	112,989
- Term Deposit	4,640,519	0	0	4,640,519
Total Financial Assets	6,780,634	615,954	314,623	7,711,211
2016				
Financial Assets				
Cash and Cash Equivalents	815,526	1,876,524	600	2,692,650
Loans and Receivables				
- Trade Debtors	0	0	70,742	70,742
- Other Receivables (i)	0	0	118,720	118,720
- Term Deposit	3,739,729	0	0	3,739,729
Total Financial Assets	4,555,255	1,876,524	190,062	6,621,841

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

Ageing analysis of financial asset as at 30 June

			Past Due But Not Impaired				
2017	Carrying Amount $	Not Past due and not impaired $	Less than 1 Month $	1 - 3 Months $	3 Months - 1 Year $	1 - 5 Years $	Impaired Financial Assets $
Financial Assets							
Cash and Cash Equivalents	2,756,669	2,756,669	0	0	0	0	0
Loans and Receivables (i)							
- Trade Debtors	201,034	185,219	1,623	260	13,932	0	(7,821)
- Other Receivables	112,989	112,989	0	0	0	0	0
- Term Deposit	4,640,519	4,640,519	0	0	0	0	0
Total Financial Assets	7,711,211	7,695,396	1,623	260	13,932	0	(7,821)
2016							
Financial Assets							
Cash and Cash Equivalents	2,692,650	2,692,650	0	0	0	0	0
Loans and Receivables (i)							
- Trade Debtors	70,742	35,291	4,138	84	233	30,996	(30,000)
- Other Receivables	118,720	118,720	0	0	0	0	0
- Term Deposit	3,739,729	3,739,729	0	0	0	0	0
Total Financial Assets	6,621,841	6,586,390	4,138	84	233	30,996	(30,000)

(i) Ageing analysis of financial assets excludes statutory financial assets (i.e. GST input tax credit).

Contractual financial assets that are neither 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 Service operates under the Government's fair payments policy of setting 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:

- Term Deposits and cash held at financial institutions are managed with variable maturity dates and take into consideration cash flow requirements of the Health Service from month to month.

The following table discloses the contractual maturity analysis for Edenhope & District Memorial Hospital 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

	Total Carrying Amount	Nominal Amount	Maturity Dates			
			Less than 1 Month	1 - 3 Months	3 Months - 1 Year	1 - 5 Years
2017	$	$	$	$	$	$
Financial Liabilities						
At amortised cost						
Payables	180,318	180,318	170,634	2,835	6,849	0
Other Financial Liabilities (i)						
- Monies Held in Trust	3,615,369	3,615,369	41,151	0	499,419	3,074,799
Total Financial Liabilities	3,795,687	3,795,687	211,785	2,835	506,268	3,074,799
2016						
Financial Liabilities						
At amortised cost						
Payables	292,274	292,274	289,881	1,104	1,289	0
Other Financial Liabilities (i)						
- Monies Held in Trust	2,589,730	2,589,730	48,994	0	240,688	2,300,049
Total Financial Liabilities	2,882,004	2,882,004	338,875	1,104	241,977	2,300,049

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

(e) Market Risk

Edenhope & District Memorial Hospital'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 paragraphs below.

Currency Risk

Edenhope & District Memorial Hospital 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 risks arise primarily through the Edenhope & District Memorial Hospital's other financial assets. Minimisation of risk is achieved by mainly holding fixed rate or non-interest bearing financial instruments. For financial assets the Health Service mainly holds financial assets with relatively even maturity profiles.

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

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

Note 7.1: FINANCIAL INSTRUMENTS (Continued)
(e) Market Risk (Continued)
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. These 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 Rate (%)	Carrying Amount	Interest Rate Exposure		
2017		$	Fixed Interest Rate $	Variable Interest Rate $	Non - Interest Bearing $
Financial Assets					
Cash and Cash Equivalents	1.65	2,756,669	1,581,759	1,174,310	600
Loans and Receivables (i)					
- Trade Debtors	0.00	201,034	0	0	201,034
- Other Receivables	0.00	112,989	0	0	112,989
- Term Deposit	2.46	4,640,519	4,640,519	0	0
Total Financial Assets		7,711,211	6,222,278	1,174,310	314,623
Financial Liabilities					
At amortised cost					
Payables (i)	0.00	180,318	0	0	180,318
Other Financial Liabilities					
- Monies Held in Trust	0.00	3,615,369	0	0	3,615,369
Total Financial Liabilities		3,795,687	0	0	3,795,687
2016					
Financial Assets					
Cash and Cash Equivalents	1.90	2,692,650	0	2,692,050	600
Loans and Receivables (i)					
- Trade Debtors	0.00	70,742	0	0	70,742
- Other Receivables	0.00	118,720	0	0	118,720
- Term Deposit	2.51	3,739,729	3,739,729	0	0
Total Financial Assets		6,621,841	3,739,729	2,692,050	190,062
Financial Liabilities					
At amortised cost					
Payables (i)	0.00	292,274	0	0	292,274
Other Financial Liabilities					
- Monies Held in Trust	0.00	2,589,730	0	0	2,589,730
Total Financial Liabilities		2,882,004	0	0	2,882,004

(i) The carrying amount excludes 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, Edenhope & District Memorial Hospital Service 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 100 basis points up and down in market interest rates (AUD) from year-end rates of 6%; 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 interest bearing financial instrument held by Edenhope & District Memorial Hospital at year end as presented to key management personnel, if changes in the relevant risk occur.

	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-1%		+1%		-1%		+1%	
		Profit	Equity	Profit	Equity	Profit	Equity	Profit	Equity
2017	$	$	$	$	$	$	$	$	$
Financial Assets									
Cash and Cash Equivalents	2,756,069	(27,561)	(27,561)	27,561	27,561	0	0	0	0
Loans and Receivables (i)									
- Trade Debtors	201,034	0	0	0	0	0	0	0	0
- Other Receivables	112,989	0	0	0	0	0	0	0	0
- Term Deposit	4,640,519	(46,405)	(46,405)	46,405	46,405	0	0	0	0
Financial Liabilities									
At amortised cost									
Payables	180,318	0	0	0	0	0	0	0	0
Other Financial Liabilities (i)									
- Monies Held in Trust	3,615,369	0	0	0	0	0	0	0	0
		(73,966)	(73,966)	73,966	73,966	0	0	0	0
2016									
Financial Assets									
Cash and Cash Equivalents	2,692,050	(26,921)	(26,921)	26,921	26,921	0	0	0	0
Loans and Receivables (i)									
- Trade Debtors	70,742	0	0	0	0	0	0	0	0
- Other Receivables	118,720	0	0	0	0	0	0	0	0
- Term Deposit	3,739,729	(37,397)	(37,397)	37,397	37,397	0	0	0	0
Financial Liabilities									
At amortised cost									
Payables	292,274	0	0	0	0	0	0	0	0
Other Financial Liabilities (i)									
- Other	2,589,730	0	0	0	0	0	0	0	0
		(64,318)	(64,318)	64,318	64,318	0	0	0	0

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

(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 Service 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.

Note 7.1: FINANCIAL INSTRUMENTS (Continued)

(f) Fair Value (Continued)

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

	Total Carrying Amount 2017 $	Fair Value 2017 $	Total Carrying Amount 2016 $	Fair Value 2016 $
Financial Assets				
Cash and Cash Equivalents	2,756,669	2,756,669	2,692,650	2,692,650
Loans and Receivables (i)				
- Trade Debtors	201,034	201,034	70,742	70,742
- Other Receivables	112,989	112,989	118,720	118,720
-Term Deposits	4,640,519	4,640,519	3,739,729	3,739,729
Total Financial Assets	7,711,211	7,711,211	6,621,841	6,621,841
Financial Liabilities				
At amortised cost				
Payables	180,318	180,318	292,274	292,274
Other Financial Liabilities (i)				
- Monies Held in Trust	3,615,369	3,615,369	2,589,730	2,589,730
Total Financial Liabilities	3,795,687	3,795,687	2,882,004	2,882,004

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

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 Edenhope and District Memorial Hospital's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 Financial Instruments: Presentation. For example, statutory receivables arising from taxes, fines and penalties do not meet the definition of financial instruments as they do not arise under contract.

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

The following refers to financial instruments unless otherwise stated.

Categories of non-derivative financial instruments

Loans and receivables

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

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

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 Edenhope and District Memorial Hospital's contractual payables, deposits held and advances received, and interest-bearing arrangements other than those designated at fair value through profit or loss.

Note 7.2: NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS

	2017 $	2016 $
Proceeds from Disposal of Non-Current Assets		
- Land	30,000	0
- Buildings	133,674	0
Total Proceeds from Disposal of Non-Current Assets	163,674	0
Less: Written Down Value of Non-Current Assets Disposed		
- Land	(30,000)	0
- Buildings	(124,243)	0
Total Written Down Value of Non-Current Assets Disposed	(154,243)	0
NET GAIN / (LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS	9,431	0

Disposal of Non-Financial Assets

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

Impairment of non-financial assets

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

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

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

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

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

Note 7.3: CONTINGENT LIABILITIES AND CONTINGENT ASSETS

Edenhope and District Memorial Hospital will receive $6.3M to co-locate the residential aged care facilities as part of the State Government's Regional Health Infrasture Fund. The first payment of $631,700 was received in June 2017. (Nil contingent assets and liabilities in 2015/16).

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

Note 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
Dwellings (i)	Social/public housing/employee housing	Level 2, where there is an active market in the area	Market approach	N/A
		Level 3, where there is no active market in the area	Depreciated replacement cost approach	Cost per square metre Useful life
Plant and equipment	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;	Level 2	Market approach	N/A
	If there is no active resale market available	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life

NOTE 8: OTHER DISCLOSURES

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

Structure

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

Note 8.1: EQUITY

	2017	2016
(a) Surpluses	$	$
Property, Plant & Equipment Revaluation Surplus [1]		
Balance at beginning of the reporting period	5,174,189	5,174,189
Revaluation Increment/(Decrement)		
- Land	0	0
- Buildings	0	0
Balance at the end of the reporting period	5,174,189	5,174,189
Represented by:		
- Land	230,640	230,640
- Buildings	4,943,549	4,943,549
	5,174,189	5,174,189

(1) The property, plant and equipment asset revaluation surplus arises on the revaluation of property, plant and equipment.

	2017	2016
Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	276,268	276,268
Balance at the end of the reporting period	276,268	276,268
Total Surpluses	5,450,457	5,450,457
(b) Contributed Capital		
Balance at the beginning of the reporting period	3,981,684	3,981,684
Capital Contribution received from Victorian Government	0	0
Balance at the end of the reporting period	3,981,684	3,981,684
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	1,631,366	(50,369)
Net Result for the Year	(191,202)	1,681,735
Balance at the end of the reporting period	1,440,164	1,631,366
(d) Total Equity at end of financial year	10,872,305	11,063,507

Contributed capital

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

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 and equipment revaluation surplus

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

Specific restricted purpose surplus

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

Note 8.2: RECONCILIATION OF NET RESULT FOR THE YEAR TO NET CASH INFLOW / (OUTFLOW) FROM OPERATING ACTIVITIES

	2017 $	2016 $
NET RESULT FOR THE YEAR	(191,202)	1,681,735
Non-cash movements		
Depreciation	782,180	773,015
Share of Net Result from Joint Ventures	(62,329)	(118,650)
Movements included in investing and financing activities		
Net (Gain)/Loss from Disposal of Plant and Equipment	(9,431)	0
Movements in assets and liabilities		
Change in Operating Assets and Liabilities		
(Increase)/Decrease in Receivables	(345,160)	104,800
(Increase)/Decrease in Prepayments	22,035	(40,564)
Increase/(Decrease) in Payables	(168,110)	(11,749)
Increase/(Decrease) in Provisions	50,556	31,360
Change in Inventories	2,221	(5,432)
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	80,760	2,414,515

Note 8.3: OPERATING SEGMENTS

	HEALTH SERVICES		RACS		OTHER SERVICES		TOTAL	
	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $
REVENUE								
External Segment Revenue	4,394,346	4,105,667	4,243,251	3,930,449	1,220,455	2,958,927	9,858,052	10,995,043
Total Revenue	4,394,346	4,105,667	4,243,251	3,930,449	1,220,455	2,958,927	9,858,052	10,995,043
EXPENSES								
External Segment Expenses	(4,113,063)	(3,992,631)	(4,406,104)	(3,810,269)	(1,688,340)	(1,671,786)	(10,207,507)	(9,474,686)
Segment Result	281,283	113,036	(162,853)	120,180	(467,885)	1,287,141	(349,455)	1,520,357
Net Result from ordinary activities	281,283	113,036	(162,853)	120,180	(467,885)	1,287,141	(349,455)	1,520,357
Interest Income	91,096	95,213	67,157	66,165	0	0	158,253	161,378
Net Result for Year	372,379	208,249	(95,696)	186,345	(467,885)	1,287,141	(191,202)	1,681,735
OTHER INFORMATION								
Segment Assets	5,082,477	5,208,299	3,309,849	3,391,533	0	0	8,392,326	8,599,831
Unallocated Assets	0	0	0	0	8,220,646	7,303,404	8,220,646	7,303,404
Total Assets	5,082,477	5,208,299	3,309,849	3,391,533	8,220,646	7,303,404	16,612,972	15,903,235
Segment Liabilities	1,077,813	1,049,797	703,970	685,671	0	0	1,781,782	1,735,468
Unallocated Liabilities	0	0	0	0	3,958,885	3,104,260	3,958,885	3,104,260
Total Liabilities	1,077,813	1,049,797	703,970	685,671	3,958,885	3,104,260	5,740,667	4,839,728
Acquisition of property, plant and equipment	193,869	967,657	126,625	632,022	29,355	146,518	349,849	1,746,197
Depreciation expense	(433,446)	(428,367)	(283,104)	(279,786)	(65,630)	(64,862)	(782,180)	(773,015)
Non cash expenses other than depreciation	43,456	(3,949)	30,199	(2,745)	0	0	73,655	(6,694)

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

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

Geographical Segment

Edenhope & District Memorial Hospital Service operates predominantly in Edenhope, Victoria. More than 90% of revenue, net surplus from ordinary activities and segment assets relate to operations in Edenhope, Victoria.

Note 8.4: RESPONSIBLE PERSON DISCLOSURES

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

	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	01/07/2016 - 30/06/2017
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	01/07/2016 - 30/06/2017
Governing Boards	
Mr R Hawkins	01/07/2016 - 30/06/2017
Mr A Kealy	01/07/2016 - 30/06/2017
Mr M Holland	01/07/2016 - 30/06/2017
Mrs K Hausler	01/07/2016 - 30/06/2017
Mrs J Grigg	01/07/2016 - 30/06/2017
Mr R Okely	01/07/2016 - 30/06/2017
Mrs C McCann	01/07/2016 - 30/06/2017
Mrs C Osborn	01/07/2016 - 30/06/2017
Mrs R Medlock	01/07/2016 - 29/02/2017
Mr D Kennedy	01/07/2016 - 29/02/2017
Accountable Officers	
Mr K Mills	01/07/2016 - 30/06/2017

Remuneration of Responsible Persons

Remuneration received or receivable by responsible persons was in the range: $190,000 - $199,999 ($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 of executive officers	Total Remuneration	
	2017	2016(a)
	$	**$**
Short-term employee benefits	305,125	
Post-employment benefits	29,493	
Other long-term benefits	7,677	
Termination benefits	0	
Share-based payments	0	
Total Remuneration (b)	342,295	
Total Number of executives (c)	3	
Total annualised employee equivalent (AEE) (d)	3	

Notes:

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

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

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

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

Note 8.6: RELATED PARTIES

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

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

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

Key management personnel (KMP) of the hospital include the Portfolio Ministers and Chief Executive Officer as determined by the hospital (refer note 8.4).
The wife of the Chief Executive Officer is employed at Edenhope and District Memorial Hosital as an administration clerk.
The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The Minister's remuneration and allowances is set by the *Parliamentary Salaries and Superannuation Act 1968* , and is reported within the Department of Parliamentary Services' Financial Report.

COMPENSATION	2017 $
Short term employee benefits	195,741
Post-employment benefits	15,593
Other long-term benefits	4,263
Termination benefits	0
Share based payments	0
Total	215,597

Transactions with key management personnel and other related parties

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

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

Mrs K Hausler is a director of the Edenhope & District Community Bank, a branch of Bendigo Bank that provides financial products to the Health Service on normal commercial terms and conditions. The balance of cash and investments held at reportign date is $3,474,374 (2015/16 $2,667,537).

Significant transactions with government-related entities

Edenhope and District Memorial Hospital received funding from the Department of Health and Human Services of $5,000,779 (2016: $4,782,135).

During the year, Edenhope and District Memorial Hosital had the following other government-related entity transactions:
 - Commonwealth Government funding received for health related programs totalling $2,447,827 (2016 $2,053,690).

Note 8.7: REMUNERATION OF AUDITORS

	2017	2016
Victorian Auditor-General's Office	$	$
Audit or review of financial statement	12,000	11,500
	12,000	11,500

Note 8.8: AASBs ISSUED THAT ARE NOT YET EFFECTIVE

Certain new Australian accounting standards and interpretations have been published that are not mandatory for 30 June 2017 reporting period. DTF assesses the impact of all these new standards and advises the Health Service of their applicability and early adoption where applicable.

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

Standard / Interpretation	Summary	Applicable for reporting periods beginning on	Impact on Health Service's Annual Statements
AASB 9 *Financial Instruments*	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1 January 2018	While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.
AASB 2010-7 *Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)*	The requirements for classifying and measuring financial liabilities were added to AASB 9. The existing requirements for the classification of financial liabilities and the ability to use the fair value option have been retained. However, where the fair value option is used for financial liabilities the change in fair value is accounted for as follows: - The change in fair value attributable to changes in credit risk is presented in other comprehensive income (OCI); and - Other fair value changes are presented in profit and loss. If this approach creates or enlarges an accounting mismatch in the profit or loss, the effect of the changes in credit risk are also presented in profit or loss.	1 January 2018	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals.
AASB 15 *Revenue from Contracts with Customers*	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1 January 2018	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications. A potential impact will be the upfront recognition of revenue from licenses that cover multiple reporting periods. Revenue that was deferred and amortised over a period may now need to be recognised immediately as a transitional adjustment against the opening returned earnings if there are no former performance obligations outstanding.

Note 8.8: AASBs ISSUED THAT ARE NOT YET EFFECTIVE (Continued)

Standard / Interpretation	Summary	Applicable for reporting periods beginning on	Impact on Health Service's Annual Statements
AASB 2014-1 *Amendments to* Australian Accounting Standards *[Part E Financial Instruments]*	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	1 January 2018	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2014-7 *Amendments to Australian Accounting Standards arising from AASB 9*	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1 January 2018	The assessment has indicated there will be no significant impact for the public sector.
AASB 2016-8 Amendments to Australian Accounting Standards - Effective Date of AASB 15	This standards defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1 January 2018	This amending standard will defer the application period of AASB 15 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of most operating leases (which are currently not recognised) on balance sheet.	1 January 2019	The assessment has indicated that as most operating leases will come on balance sheet, recognition of lease assets and lease liabilities will cause net debt to increase. Depreciation of lease assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. The amounts of cash paid for the principal portion of the lease liability will be presented within financing activities and the amounts paid for the interest portion will be presented within operating activities in the cash flow statement. No change for lessors.
AASB 2015-8 Amendments to Australian Accounting Standards - Effective Date of AASB 15	This standard defers the mandatory effective of AASB 15 from 1 January 2017 to 1 January 2018.	1 January 2018	This amending standard will defer the application period of AASB 15 to the 2018-19 reporting period.
AASB 2016-7 Amendments to Australian Accounting Standards - Deferral of AASB 15 for Not-for-Profit Entities	This standard defers the mandatory effective of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019	1 January 2019	This amending standard will defer the application period of AASB 15 to the 2018-19 reporting period.
AASB 1058 Income of Not-for-Profit Entities	This Standard will replace AASB 1004 *Contributions* and establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objectives	1 January 2019	The impact of this Standard is yet to be fully assessed.

Note 8.9: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

There are no known events occurring after the balance sheet date that would materially effect the financial result.

Note 8.10 - ALTERNATIVE PRESENTATION OF COMPREHENSIVE OPERATING STATEMENT

	Note	2017 $	2016 $
Grants			
Operating	2.1	6,102,763	5,979,774
Capital	2.1	672,921	467,283
Interest	2.1	158,253	161,378
Sales of goods and services	2.1	1,348,745	1,311,713
Other	2.1	1,724,192	3,236,273
Revenue from Transactions		10,006,874	11,156,421
Employee expenses	3.1	6,618,140	6,140,279
Depreciation	4.4	782,180	773,015
Other operating expenses	3.1	2,797,938	2,594,230
Expenses from Transactions		10,198,258	9,507,524
Net Result From Transactions		(191,384)	1,648,897
Other economic flows included in net result			
Net gain/ (loss) on sale of non-financial assets	7.2	9,431	0
Other gains/ (losses) from other economic flows included in net result	2.1	(9,249)	32,838
Total Other Economic Flows Included in Net Result		182	32,838
NET RESULT FOR THE YEAR		(191,202)	1,681,735
Items that may be reclassified subsequently to net result			
Changes to financial assets available-for-sale revaluation surplus		0	0
Total other comprehensive income		0	0
Comprehensive Result		(191,202)	1,681,735

VAGO

Victorian Auditor-General's Office

Independent Auditor's Report

To the Board of Edenhope and District Memorial Hospital

Opinion	I have audited the financial report of Edenhope and District Memorial Hospital (the health service) which comprises the: • balance sheet as at 30 June 2017 • comprehensive operating statement for the year then ended • statement of changes in equity for the year then ended • cash flow statement for the year then ended • notes to the financial statements, including a summary of significant accounting policies • board member's, accountable officer's and chief finance & accounting officer's declaration. In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2017 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.
Basis for Opinion	I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. My responsibilities under the Act are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report. My independence is established by the *Constitution Act 1975.* My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Australia. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.
Board's responsibilities for the financial report	The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Financial Management Act 1994*, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error. In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, and using the going concern basis of accounting unless it is inappropriate to do so.

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

MELBOURNE
1 September 2017

Ron Mak
as delegate for the Auditor-General of Victoria