STAWELL REGIONAL HEALTH

2017-2018

ANNUAL REPORT

Caring for our Community

Organisational Values

TRUST

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

RESPECT

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

ACCOUNTABILITY

We each take personal responsibility for our decisions and actions.

COMMUNICATION

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

SAFETY

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

STAWELL REGIONAL HEALTH

Contents

Our Profile

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

Our community is diverse and includes families, farmers, Aboriginal people, and people from a range of socio-economic backgrounds. Stawell Regional Health have been providing quality health care to all communities in the Stawell district and beyond for more than 150 years.

Our acute facilities include an Inpatient Ward, Day Procedure Unit, Operating Theatre, Oncology Day Centre, Urgent Care Centre and co-located Helipad. We also provide on-site Pharmacy, Pathology and Medical Imaging service including a cutting edge 64 slice CT scanner.

Stawell Regional Health offers a range of Community and Allied Health Services including District Nursing, Social Support Group, Memory Support Nurse, Post- Acute Care, Diabetes Education, Dietetics, Exercise Physiology, Speech Pathology, Physiotherapy, Occupational Therapy, Podiatry, Social Work and Integrated Health Promotion. Many of our Allied Health Services are delivered in our state of the art Community Rehabilitation Centre.

Located within a short distance of the hospital, Macpherson Smith Residential Care provides high quality aged care for our community. Stawell Regional Health also operates the Stawell Medical Centre general practice.

Our services are provided by a committed and caring team of highly respected nursing, medical, allied health and support staff together with our local general practitioners and visiting medical officers. Our services are further supplemented by the long-standing, generous support of our volunteers and local community fundraising groups.

How to contact us

27-29 Sloane Street
Stawell, Vic 3380

PO Box 800
Stawell, Vic 3380

03 5358 8500

info@srh.org.au

www.srh.org.au

Our Vision, Mission and Strategic Directions:

Our Vision:
Caring for our community

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

Strategic Direction

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

Chairman's Report

We are delighted that a significant highlight of the 2017-18 year was the announcement by the Premier of Victoria, the Hon Daniel Andrews and Minister for Health and Ambulance services, the Hon Jill Hennessy to announce funding of $2.2m from the Regional Health Infrastructure Fund.

The funding will enable the purchase of an additional chiller and replacement of aging infrastructure including air handling units, hot water boilers and the upgrade of electrical distribution boards. The installation work will commence later in 2018.

In addition, we are delighted to announce the near completion of upgrades to Macpherson Smith Residential Care. This will improve ensuite facilities for eight residents across the facility.

In common with many rural and regional organisations across Victoria, recruitment of nursing staff continues to be a challenge. To help us address this challenge, we welcomed our new HR Manager, Ceri Hugo who commenced in the latter part of 2017-18. As part of her HR remit, Ceri will play a key leadership role in the facilitation of our new People and Culture Committee. The committee, comprised of representatives across the organisation will provide leadership, monitoring and advice in the areas of organisational culture, workforce engagement, employee wellbeing and safety that is consistent with the values of Stawell Regional Health.

Our strong networks and partnerships are a major factor in our success. This year Stawell Regional Health has continued partnership arrangements with Ballarat Health Services, East Grampians Health Service, East Wimmera Health Service, Budja – Budja Aboriginal Cooperative, Wimmera Health Care Group, Western District Health Service, Grampians Community Health, Northern Grampians Shire and Grampians Pyrenees Primary Care Partnership.

Earlier this year Stawell Regional Health staff were joined by community members and past health service leaders to celebrate 50 years of service for Registered Nurse Mavis Graham. The number and diversity of people who attended to thank Mavis for her passion and commitment to quality patient care as well as her compassionate support of junior nurses and students demonstrated the esteem with which her colleagues hold her.

In 2018 we introduced inaugural International Nurses Day Awards with an award for Excellence in Clinical Leadership presented to Jocelyn Oberg and Excellence in Nursing that was presented to Deb Barry. This was an important time to recognise the work and dedication of all of our nursing staff.

The Board expresses its gratitude to those hard working committees who continue to raise money for Stawell Regional Health. Between them, Stawell Regional Health Foundation, Stawell Regional Hospital Auxiliary, the Y-Zetts and Murray to Moyne participants raised funds that allowed us to purchase much needed hospital equipment and infrastructure.

This year, we farewelled Liz McCourt, former Chief Executive Officer of Stawell Regional Health. Liz held a variety of senior management roles in her 16 years with the health service including the role of Chief Executive Officer since October 2014. I take this opportunity to thank Liz for her commitment, dedication and service to Stawell Regional Health and to the local community during her tenure.

I would like to extend my appreciation to Northeast Health Wangaratta who have enabled Libby Fifis to stay on as Acting CEO at Stawell Regional Health since February 2018. The Board is currently undertaking an extensive campaign to fill the key leadership role.

This year we farewelled Board Director Howard Cooper who has provided an outstanding nineteen years of service to the Stawell Regional Health Board and the Community. In addition to representing the Board on many committees, Howard was significantly involved in many major projects including, most recently, the Community Rehabilitation Centre.

Further we welcomed Arun Thomas and Peter Mees to the Board of Stawell Regional Health. I would like to thank my fellow Board members for their strategic leadership and commitment to the organisation and the community more broadly.

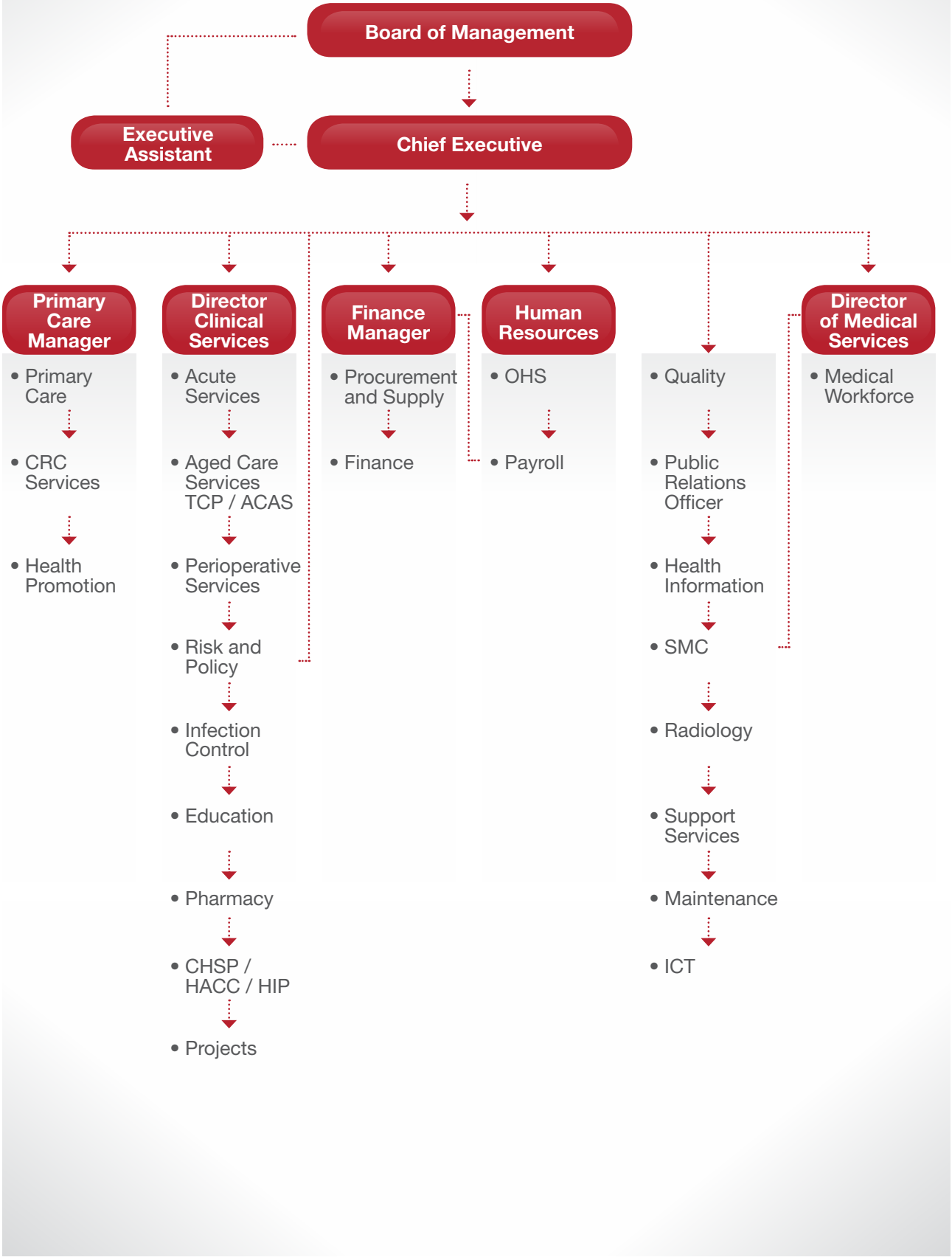
Responsible Bodies Declaration

In accordance with the Financial Management Act 1994, I am pleased to present the Report of Operations for Stawell Regional Health for the year ending 30 June 2018.

Rhian Jones
Board Chair
Stawell

27th August, 2018

ORGANISATIONAL CHART



Board of Management

RHIAN JONES

Date Appointed:
20th November 2013,
Board Sub-committees include Board Executive, Finance Committee, Audit and Risk Committee, Quality Improvement and Risk Management, Credentialing and Clinical Appointments.

BOARD CHAIR

HOWARD COOPER

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

PRIMARY PRODUCER

ARUN THOMAS

Date Appointed:
1st July 2017,
Board Sub-committees include, Audit and Risk Committee, Quality Improvement and Risk Management and Credentialing and Clinical Appointments

REGISTERED NURSE

ROSS HATTON

Date Appointed:
1st July 2008,
Board Sub-committees include Board Executive, Finance Committee, Audit and Risk Committee, Quality Improvement and Risk Management and Credentialing and Clinical Appointments.

DEPUTY CHAIR

PETER MEES

Date Appointed:
1st July 2017

LAWYER

JESSICA CASS

Date Appointed:
1st July 2016,
Board Sub-committees include Board Executive and Finance Committee (Chair).

ACCOUNTANT

AMY RHODES

Date Appointed:
1st July 2016, resigned as of 7th May 2018, Board Sub-committees include Community Relations Committee

MEDIA AND COMMUNICATIONS PROFESSIONAL

Stawell Regional Health Executive Team

Liz McCourt
Chief Executive
1/7/17 - 27/04/18

Janet Feeny
Human Resources Manager
1/7/17 - 20/12/2017

Robyn Wilson
Director of Clinical Services

Libby Fifis
Acting Chief Executive
5/2/18 - 30/06/18

Rhys Duncan
Primary Care Manager
Commenced
31/07/2017

Rick Lowen
Director of Medical Services

Shawn Lee
Primary Care Manager
1/7/17 - 27/07/17

Ian Martin
Finance Manager
Commenced
16/04/2018

The Year in Review

STAWELL REGIONAL HEALTH VISION

The vision for Stawell Regional Health is Caring for our Community. This requires us to provide an inclusive service that welcomes diversity and treats all community and staff members with sensitivity and respect. To this end our Cultural Security Action Plan has been developed to strengthen the way we work with our Budja Budja (and other Aboriginal) clients and patients. To further address diversity our newly appointed LGBTIQ champions will represent Stawell Regional Health on the Grampians Region LGBTIQ Network and work with staff and consumers to implement actions from the Rainbow Tick Equality Guide.

SRH EXECUTIVE AND SENIOR MANAGEMENT

As Stawell Regional Health has been without a permanent Finance Manager for the first eight months of the year, we were pleased to announce the arrival of Ian Martin, our new Finance Manager in April. We would like to take this opportunity to thank Nick Starkie and Jim Mathewson who aptly supported our health service (through Western District Health Service) during this time.

This year we also said farewell to Janet Feeny who had been the HR Manager at Stawell Regional Health for the past 8 years. Ceri Hugo recently commenced as the new HR manager and we look forward to the depth of experience Ceri will bring to the role.

FAMILY VIOLENCE

We were pleased to welcome Gemma Beavis, Project Officer, Strengthening Hospital Responses to Family Violence Initiative who works with us one day a week to strengthen Stawell Regional Health's response to Family Violence by helping us to shape our policies and practices around Family Violence.

NATIONAL DISABILITY INSURANCE SCHEME (NDIS)

We were proud to start offering NDIS services to people with disability. The services that we offer people with a disability include exercise physiology, dietetics, podiatry, physiotherapy, social support and district nursing. We can only provide these services to people who need them because of their disability.

MY AGED CARE

Stawell Regional Health commenced providing services through My Aged Care on 1 July 2017. These include services at Macpherson Smith Residential Care, Memory Support Nurse, Social Support Group and District Nurses.

DISTRICT OF WORKFORCE SHORTAGE

In March this year Stawell Medical Centre received the news that Stawell would become a District of Workforce Shortage meaning that the Medical Centre could now recruit doctors subject to 19AB of the Health Insurance Act. This opens up our scope to recruit people who were previously ineligible.

COMMUNITY ENGAGEMENT

In late 2017, we welcomed Noelene Gration as PR Officer. Noelene has a wealth of experience and has updated and strengthened our communication strategies to better engage with the community, including creating some videos that showcase our services, creating a Facebook page and digital presence and improving marketing materials. We look forward to further strengthening our community engagement activities in the coming year.

NATIONAL SAFETY AND QUALITY HEALTH SERVICE STANDARDS

Stawell Regional Health achieved full accreditation in January this year against the 10 National Safety and Quality Health Service Standards. We are in the process of comparing our performance against the new eight National standards (second edition) that were released in November 2017. Health services will be assessed to the second edition from January 2019.

Financial Overview

In 2017/2018 Stawell Regional Health remained committed to the mission of delivering high quality services to the community.

Provision of available services has continued to be enhanced with the purchase of advanced medical equipment and engagement of specialist clinicians. However, along with a challenging funding environment and escalating costs in all areas of health service provision the financial performance was well below that expected.

For the 2018 financial year Stawell Regional Health delivered a Consolidated Operating deficit of $1.1M compared to a Consolidated Operating deficit of $0.23M in the previous financial year.

The health service continues to be challenged by higher than inflation workforce and medical supply costs coupled with shortages in key local skilled staff. To continue to provide high quality care for the community the necessary engagement of locum medical, allied health and agency nursing staff has resulted in significantly higher operating costs.

For the 2018 financial year Operating revenue growth was only $0.26M (0.9%) but Operating Expenditure growth was $1.2M or 4.3% higher when compared to 2017.

Lower than expected resident numbers at the Macpherson Smith Residential Care Nursing Home has resulted in significant shortfalls to income for the current financial year further impacting on the overall Operating result.

Staffing costs, including Fee for Service and Agency staff have increased by $1.2M (6%) on the previous year (2017). This comes on top of a $1.4M (7.8%) increase from 2016 to 2017. These expenses totaling $20.7M have risen as a result of additional locum medical staff, very high numbers of Agency Nursing staff and annual wage increases. Use of agency nursing staff was much higher this year than previous years to overcome a critical shortage of available nurses particularly throughout the first half of the financial year.

Total Supplies, Consumables and Other Expenses were similar to the previous year however there were significant increase in energy and recruitment costs.

Capital Purpose Income was lower than the previous year at $0.16M compared to $0.46M in 2017.

In 2018 consolidated operating activities for the year resulted in a net cash outflow of $2.2M, of this $1.4M was invested in Capital Assets. Overall, consolidated cash holdings decreased by $1.7M for the year with total cash on hand amounting to $6.4M at 30th June 2018 compared to $8.1M at the end of the previous year.

Total cash includes fixed term invested funds and funds held in trust which are not included in the cash flow statement.

2017-18 Major Acquisitions and Projects:

Building Works	$
Bathroom Renovations (MSRC*)	$200,821
Critical Systems Upgrade	$44,854
Roof Anchor Points (OH&S)	$40,900
Plant and Medical Equipment	**$**
Theatre Towers	$285,876
Hot Water System Replacements	$100,654
ICT Equipment	$80,114
Floorline Beds (MSRC)*	$71,836
Backup Generator (MSRC)*	$66,208
Mobile C-Arm X-Ray Machine	$62,672
Catering Equipment	$42,406
Replacement Vehicles	$22,447
Dishwasher Replacement	$9,855
Examination Couches (3) and Lounge	$6,871
Minor Medical Equipment	$6,036
Minor Equipment non-medical	$5,491

*Macpherson Smith Residential Care

Financial Overview

PERFORMANCE INDICATORS

Comparative Consolidated Financial Results for the Past Five Financial Years

Key Performance Indicator	2018 $000	2017 $000	2016 $000	2015 $000	2014 $000
Total Revenue	27,295	27,351	27,072	25,473	27,382
Total Expenses	30,250	29,296	27,542	26,478	25,026
Other operating flows included in the Net Result for the Year	(66)	(49)	(68)	NA	NA
Net Result for the year	(2,955)	(1,945)	(470)	(1,028)	7,352
*Operating Result	(1,135)	(232)	277	23	942
Total Assets	33,281	34,408	36,197	35,737	37,071
Total Liabilities	6,043	5,716	5,560	4,630	4,958
Net Assets	27,238	28,692	30,637	31,107	32,113
Total Equity	27,238	28,692	30,637	31,107	32,113

*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 items.

Our People

Labour Category	June Current Month FTE		June Year to Date FTE	
	2017	2018	2017	2018
Nursing Services	78.07	78	80.45	71.12
Administration and Clerical	37.8	40	37.05	36.99
Medical Support Services	10.72	9.2	9.45	8.77
Hotel & Allied Services	27.45	31.6	28.81	29.71
Medical Officers	1.25	1.2	1.2	1.35
Sessional Medical Officers		0.2		0.15
Allied Health (Ancillary)	16.82	19.8	16.42	17.69

Occupational Health and Safety

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

The Occupational Health and Safety Committee review this information on a bi-monthly basis. Reports are provided to the OHS Office by the Risk and Policy Officer. The committee reviews data trends over a 12 month period to identify areas which may require controls and support to maintain staff and patient safety and wellbeing in the work place.

Occupational Health and Safety incidents entered into the VHIMS system by staff for 2017-2018 financial year decreased in comparison to the previous financial year. Of the total number of incidents reported, 60% reported no harm was sustained and 40% reported minor harm sustained. There were no moderate or serious incidents reported.

Degree of harm comparison by department 2017-2018

Occupational Health and Safety Incidents	Number of Severity 4	Number of Severity 3	2017-18
Allied Health	3	6	9
Administration	1	1	2
Environmental Services	3	7	10
MSRC	32	3	35
Oncology		1	1
Perioperative Unit	3	6	9
Simpson Ward	11	10	21
SMC	1	1	2
Supply		1	1
UCC		3	3
			93

OH&S Incidents by Severity: 2017-2018

Severity 2017-2018	Number of Incidents	Percentage
4 No Harm	56	60%
3 Mild	37	40%
2 Moderate	0	0%

MANUAL HANDLING

No Lift training is conducted during staff Orientation for all new employees in the following areas: Clinical staff, Allied Health Clinicians and Porters. A total of 97 employees completed their annual No Lift Competencies for this financial year.

Manual Handling training for products or equipment is provided through the ReHSeN electronic learning portal, 96 employees across all departments completed this training.

ANNUAL FIRE TRAINING

Stawell Regional Health Annual Fire Training is compulsory for all employees. The Fire training encompasses all components related to Stawell Regional Health's Code Red policy and the Australian Standard 4083-2010, Planning for Emergencies - Health Care Facilities across all sites under the control of Stawell Regional Health. 208 employees completed the On Line fire training for the financial year 2017-2018.

OCCUPATIONAL VIOLENCE

The Department of Health and Human Services introduced a statewide Code Grey Standard to provide more detailed guidance to assist in addressing Occupational Violence in both clinical and non-clinical settings.

Stawell Regional Health is actively involved in reducing the risk to employees from Occupational Violence. The formation of a Code Grey Occupational Violence Working party is currently identifying procedures and tools to assess the risk of Occupational Violence to assist with implementation of strategies to reduce the risk of Occupational Violence.

The Code Grey policy is being reviewed to incorporate the Code Grey Standards for the management of occupational violence involving Incidents of clinical and nonclinical aggression.

Training is currently being provided through the Melbourne Health "Management of Clinical Aggression" Training Program to groups of staff from all work areas. There were 12 sessions of 8 hour duration held for this financial year (2017-2018). The sessions are designed for both non-capital employees and direct care employees. Employee training includes theory, negotiating skills, harm minimisation and breakaway techniques. Direct care employees are also trained in restraint techniques which are only utilised when all other avenues have been exhausted. 135 employees completed training for the 2017-2018 financial year including 77 employees from (non-direct care), and 58 direct care employees.

There has been an increase of reported OV incidents for 2017-2018 in comparison to the reported incidents for 2016-2017. Employees are encouraged during the Management of Clinical Aggression training to report all occurrences of Occupational Violence and the increase in reports can be related to this training. In response Stawell Regional Health has developed an Occupational Violence Working Group with representatives from each department across the organisation.

Occupational violence statistics	2017-18
1. Workcover 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 OV incidents reported:	26
4. Number of OV incidents reported per 100 FTE:	14.44
5. Percentage of OV incidents resulting in staff injury, illness or condition:	42%

COMPLIANCE WITH HEALTH PURCHASING VICTORIA (HPV) HEALTH PURCHASING POLICIES

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

Libby Fifis
Acting Chief Executive Officer
Stawell
27th August 2018

ATTESTATION ON CONFLICT OF INTEREST

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

Libby Fifis
Acting Chief Executive Officer
Stawell
27th August 2018

FINANCIAL MANAGEMENT COMPLIANCE

I, Rhian Jones, on behalf of the Responsible Body, certify that Stawell Regional Health has complied with the applicable Standing Directions of the Minister for Finance under the Financial Management Act 1994 and Instructions.

Rhian Jones
Board Chair
Stawell
27th August 2018

DATA INTEGRITY

I, Libby Fifis, certify that Stawell Regional Health has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. Stawell Regional Health has critically reviewed these controls and processes during the year.

Libby Fifis
Acting Chief Executive Officer
Stawell
27th August 2018

Additional information available on request

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

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

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

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

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

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

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

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

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

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

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

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

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

Objectives, Functions, Powers and Duties of Stawell Regional Health

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

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

The Chief Executive Officer determines how services are delivered.

Stawell Regional Health is accountable, through its Board of Management, to The Honourable Jill Hennessy MLA, Minster for Health and Minister for Ambulance Services and The Honourable Martin Foley MLA, Minister for Mental Health and Minister for Housing, Disability and Ageing.

Summary of Services

PRIMARY CARE

- Audiology (visiting)
- Community Health Nursing
- Continence Physiotherapy
- Diabetes Education
- Exercise Physiology
- Multidisciplinary Rehabilitation
- National Disability Insurance Scheme (NDIS)
- Nutrition & Dietetics
- Health Promotion
- Occupational Therapy
- Outreach
- Allied Health/Community Services to outlying communities
- Support for Budja Budja Aboriginal Co-Operative Health Service at Halls Gap
- Physiotherapy
- Podiatry
- Social Work
- Speech Pathology

COMMUNITY SERVICES

- Social Support Group
- District Nursing Service
- 'Hospital in the Home'
- Post-Acute Care
- Transition Care Program
- Hospital Admission Risk Program (HARP)

ACUTE CARE

- Day Oncology Unit
- Inpatient Care
- Urgent Care Centre

MEDICAL IMAGING

- X-ray
- CT
- Ultrasound

RESIDENTIAL AGED CARE

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

MEDICAL SPECIALTIES

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

SURGICAL AND ANAESTHETIC SERVICES

- Pre Admission Clinic
- Day Procedure Unit
- Operating Suite / Sterilising Department

PATHOLOGY SERVICES

Australian Clinical Laboratories

STAWELL MEDICAL CENTRE

Part A: Strategic Priorities

In 2017–18 Stawell Regional Health Service will contribute to the achievement of the Victorian Government's commitments by:

Goals	Strategies	Health Service Deliverable	Outcomes
Better Health A system geared to prevention as much as treatment Everyone understands their own health and risks Illness is detected and managed early Healthy neighbourhoods and communities encourage healthy lifestyles	**Better Health** Reduce statewide risks Build healthy neighbourhoods Help people to stay healthy Target health gaps	Partner with Ballarat Health Services, Wimmera Healthcare Group and other members of the Grampians and Wimmera Southern Mallee Health Alliances to develop and implement policies and protocols to provide a safe and appropriate regional response to Family Violence.	Stawell Regional Health has partnered with Ballarat Health Service, and other members of the Grampians and Wimmera Southern Mallee Health Alliance to implement Strengthening Hospital Response to Family Violence (SHRFV). The SHRFV project has led to the development and implementation of policies and protocols to reduce both local and statewide risks of family violence and target known health gaps.
		Partner with Ballarat Health Services, Wimmera Healthcare Group and other members of the Grampians and Wimmera Southern Mallee Health Alliances to develop and implement policies and protocols based on clinical capability of each health service to provide a safe and appropriate regional response to Child Safety.	Stawell Regional Health's response to child safety has included the appointment of a Child Safety Officer, development of a Child Safety Code of Conduct and implementation of Child Safe Standards. Stawell Regional Health has created a system geared towards prevention as much as treatment and addressed the statewide risks associated with the safety of children.
		Partner with East Grampians Health Service and Federation University to implement a model of care that will focus on chronic diseases of high prevalence including diabetes and cardiovascular disease.	Stawell Regional Health has partnered with East Grampians Health Service and Federation University to implement the Chronic Conditions Model of Care. The model focuses on providing treatment and intervention for people living with chronic conditions, as well improving their ability to self-manage their conditions. The Chronic Conditions Model of Care has reached over 300 people within our local catchment living with chronic disease helping them to stay healthy, and has targeted the significant health gaps associated with diabetes and cardiovascular disease. Stawell Regional Health will continue to deliver the Chronic Conditions Model of Care in 2018/19.

Goals	Strategies	Health Service Deliverable	Outcomes
		Develop and implement a four year regional integrated health promotion plan and contribute to the development and alignment of this plan with the Northern Grampians Shire Municipal Health and Wellbeing Plan.	Stawell Regional Health has partnered with health services in the Grampians region, and Northern Grampians Shire Council to implement a four year Integrated Health Promotion Plan that focuses on healthy eating, active living and improving mental health. This integrated approach ensures agencies are working together to build healthy neighbourhoods and communities that encourage healthy lifestyles.

Goals	Strategies	Health Service Deliverable	Outcomes
Better Access Care is always there when people need it More access to care in the home and community People are connected to the full range of care and support they need There is equal access to care	**Better Access** Plan and invest Unlock innovation Provide easier access Ensure fair access	Partner with Ballarat Health Services, Wimmera Healthcare Group and other members of the Grampians and Wimmera Southern Mallee Health Alliances to develop and implement policies and protocols based on clinical capability of each health service to provide safe and appropriate interagency hospital transfers.	Stawell Regional Health partnered with Wimmera Healthcare Group and other members of the Grampians and Wimmera Southern Mallee Health Alliance to develop a Health Service Capability Framework. The framework provides a shared understanding of health service clinical capability and underpins the proposed regional Transfer of Care protocol to ensure people are connected to the full range of care and support they need.
		In partnership with Ballarat Health Services, Grampians Integrated Cancer Services and other health care providers, contribute to regional initiatives in education and care pathways.	Stawell Regional Health partnered with Grampians Integrated Cancer Services, the Cancer Council Victoria, and other agencies in the Grampians region to implement the Telehealth for Supportive Survivorship Care Project. The project has unlocked innovation through utilising telehealth for group education and for 44 people that have finished receiving cancer treatment. The use of telehealth provides easier access to healthcare eliminating the need to travel long distances. The project has led to better access to care across the spectrum of cancer treatment. Stawell Regional Health is in discussions with partner agencies to ensure the sustainability of the program. Stawell Regional Health participated in a research project led by North Eastern Melbourne Integrated Cancer Service and the Grampians Integrated Cancer Services to evaluate the implementation and use of 'My Cancer Care Record' MCCR). MCCR is a hand held folder, developed by consumers, which seeks to support patient's records and organise their cancer and other related health information. Early indications of the project indicate an overwhelming number (97%) of patients find the record useful.

Goals	Strategies	Health Service Deliverable	Outcomes
Better Access Care is always there when people need it More access to care in the home and community People are connected to the full range of care and support they need There is equal access to care	**Better Access** Plan and invest Unlock innovation Provide easier access Ensure fair access	Partner with Ballarat Health Services to support timely access to surgical services through support of waiting list management. This will include development of an agreement and provision of surgery to clinically appropriate patients on the Ballarat Health Services waitlist.	Stawell Regional Health is well positioned to provide Ballarat Health Services assistance to manage their surgical wait list. Opportunities for further partnership and collaboration across a range of clinical services will continue to be explored.
		Partner with the Grampians Pyrenees Primary Care Partnership and Budja Budja Aboriginal Co-Operative to roll out actions as identified in the cultural safety plan.	Stawell Regional Health has partnered with Grampians Pyrenees Primary Care Partnership and Budja Budja Aboriginal Cooperative in Halls Gap to ensure there is fair and equal access to care for the Aboriginal population. By collaborating and consulting with Budja Budja Aboriginal Cooperative Stawell Regional Health has identified localised strategies to improve access to care.
		In partnership with the Grampians Lesbian, Gay, Bisexual, Transgender and Intersex individuals Regional Network Meeting, and using the Government's Rainbow eQuality Guide, identify and adopt 'actions for inclusive practices' and develop and implement an action plan for response to optimise the health and wellbeing of lesbian, gay, bisexual, transgender and intersex individuals and communities.	Stawell Regional Health is an active member of the Grampians Region LGBTI Network. The network is a collection of agencies and community members who are implementing a collaborative approach to promoting LGBTI inclusiveness and ensuring there is equal and fair access to care for the LGBTI community. The networks plan focuses on sharing resources for inclusive policy, increasing awareness through education, and strengthening leadership through the appointment of LGBTI champions.

Goals	Strategies	Health Service Deliverable	Outcomes
Better Care Target zero avoidable harm Healthcare that focusses on outcomes Patients and carers are active partners in care Care fits together around people's needs	**Better Care** Put quality first Join up care Partner with patients Strengthen the workforce Embed evidence Ensure equal care Mandatory actions against the 'Target zero avoidable harm' goal:	Continue to build our workforce capability to manage their health and wellbeing through the implementation of a workplace resilience program, raising awareness of the Employee Assistance Program and refreshing the Contact Officer Program at Stawell Regional Health.	In order to strengthen its workforce, Stawell Regional Health undertook Mental Health Awareness Training for staff. The broad aims of the sessions were to increase understanding of mental health and to provide staff with strategies to manage mental wellbeing. 101 participants attended from across the organisation. Post-session feedback received from participants supported the trainings purpose. Other initiatives undertaken this year also include the introduction of Mindfulness Training as well as a review of the Employee Assistance Program.
		In collaboration with other rural and regional hospitals investigate the provision of a combined leadership program for future clinical and non-clinical leaders that will also assist to promote partnerships and professional networks for staff.	In collaboration with other rural and regional hospitals Stawell Regional Health investigated the provision of a combined leadership program which was not able to be made available this year. Stawell Regional Health provided leadership development to two of its clinical leaders through the Clinician to Manager training program.
	Develop and implement a plan to educate staff about obligations to report patient safety concerns.	Develop and implement a whole of organisation approach called "It's never wrong to report" to support the identification and escalation of risk in the provision of safe care to patients.	Stawell Regional Health's commitment to targeting zero avoidable harm has led to a whole of organisation review of our Incident reporting and management system. As a result our processes have been modified to provide managers with access to regular reports of incident trends. Incident reporting processes, policies and procedures have been strengthened to provide clear roles and responsibilities for all staff. Education has been provided to ensure staff understand their role in identifying and escalating incidents and how incident data is used to provide a safe environment for patients.

Goals	Strategies	Health Service Deliverable	Outcomes
	Establish agreements to involve external specialists in clinical governance processes for each major area of activity (including mortality and morbidity review).	Partner with Ballarat Health Services to finalise agreements and consolidate clinical governance processes to support best practice clinical care, particularly in major areas of activity such as emergency medicine, theatre, general medicine, infection control and oncology.	Stawell Regional Health has formalised the arrangement with Ballarat Health Service for the provision of expertise in anaesthetic clinical governance. The agreement provides a Director of Clinical Governance – Anaesthetics to provide medical leadership (mentoring, support, education) and clinical expertise (case review, credentialing, and advice) to support the GP Anaesthetic service at Stawell Regional Health. Support for other service areas such as Urgent Care, Inpatient medicine and Oncology are still under discussion with Ballarat Health Service.
	In partnership with consumers, identify three priority improvement areas using Victorian Healthcare Experience Survey data and establish an improvement plan for each. These should be reviewed every six months to reflect new areas for improvement in patient experience.	Develop targeted strategies to ensure quantitative improvements in the following areas as identified in the Victorian Healthcare Experience Survey: communication between staff, patients and families; discharge planning within the acute program area and understanding the cost of community health in the community program.	**Community Client Fees** Stawell Regional Health has reviewed its Community Services Fee policy and implemented a system to guarantee access to care for vulnerable clients. Since its inception, there has been no reports of clients unable to access community services due to cost. **Bedside Handover** Stawell Regional Health has reviewed its Bedside Handover process to ensure patients and residents are central to the shift to shift handover process. **Discharge Policy** Further to the introduction of an Electronic Medical Record system (BoSSNet), Stawell Regional Health is developing added functionality which will allow for Electronic Discharge Summaries to be provided to patients and GP's at the time of discharge.

Part B: Performance Priorities

High quality and safe care		
Key performance indicator	**Target**	**2017–18 Results**
Accreditation		
Accreditation against the National Safety and Quality Health Service Standards	Full compliance	Achieved
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Achieved
Infection prevention and control		
Compliance with the Hand Hygiene Australia program	80%	85%
Percentage of healthcare workers immunised for influenza	75%	86%
Patient experience		
Victorian Healthcare Experience Survey - data submission	Full compliance	Achieved
Victorian Healthcare Experience Survey – positive patient experience – Quarter 1	95% positive experience	100%
Victorian Healthcare Experience Survey – positive patient experience – Quarter 2	95% positive experience	99.1%
Victorian Healthcare Experience Survey – positive patient experience – Quarter 3	95% positive experience	92%
Victorian Healthcare Experience Survey – discharge care. Quarter 1	75% very positive experience	91.3%
Victorian Healthcare Experience Survey – discharge care. Quarter 2	75% very positive experience	92.7%
Victorian Healthcare Experience Survey – discharge care. Quarter 3	75% very positive experience	80%
Victorian Healthcare Experience Survey – patients perception of cleanliness – Quarter 1	70%	90.5%
Victorian Healthcare Experience Survey – patients perception of cleanliness – Quarter 2	70%	80%
Victorian Healthcare Experience Survey – patients perception of cleanliness – Quarter 3	70%	80%
Adverse events		
Number of sentinel events	Nil	1
Mortality – number of deaths in low mortality DRGs[1]	NA[2]	

[1]DRG is Diagnosis Related Group.

[2]This indicator was withdrawn during 2017-18 and is currently under review by the Victorian Agency for Health Information

Strong governance, leadership and culture		
Key performance indicator	**Target**	**2017–18 Results**
Organisational culture		
People matter survey - percentage of staff with an overall positive response to safety and culture questions	80%	82%
People matter survey – percentage of staff with a positive response to the question, “I am encouraged by my colleagues to report any patient safety concerns I may have”	80%	89%
People matter survey – percentage of staff with a positive response to the question, “Patient care errors are handled appropriately in my work area”	80%	88%
People matter survey – percentage of staff with a positive response to the question, “My suggestions about patient safety would be acted upon if I expressed them to my manager”	80%	88%
People matter survey – percentage of staff with a positive response to the question, “The culture in my work area makes it easy to learn from the errors of others”	80%	79%
People matter survey – percentage of staff with a positive response to the question, “Management is driving us to be a safety-centred organisation”	80%	85%
People matter survey – percentage of staff with a positive response to the question, “This health service does a good job of training new and existing staff”	80%	69%
People matter survey – percentage of staff with a positive response to the question, “Trainees in my discipline are adequately supervised”	80%	76%
People matter survey – percentage of staff with a positive response to the question, “I would recommend a friend or relative to be treated as a patient here”	80%	82%

Effective financial management		
Key performance indicator	**Target**	**2017–18 Results**
Finance		
Operating result ($m)	0.00	-1.13
Average number of days to paying trade creditors	60 days	67
Average number of days to receiving patient fee debtors	60 days	14
Public and Private WIES[3] activity performance to target*	100%	91.68%
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	1.70
Number of days of available cash	14 days	50.4

*The changes arising in the WIES funding model following the introduction of AR-DRG version 8 in 2016–17 have impacted Stawell Regional Health's ability to recognise WIES activity in 2017–18.

The department has acknowledged these issues at a system level and provided assurances around minimum funding levels throughout 2017–18.

[3]WIES is a Weighted Inlier Equivalent Separation.

Part C: Activity and Funding

Funding type	2017–18 Activity Achievement
Admitted	
WIES Public	1,603
WIES Private	506
WIES DVA	32
WIES TAC	6
Acute Non-Admitted	
Home Enteral Nutrition	635
Specialist Clinics - Public	2,745
Subacute & Non-Acute Admitted	
Maintenance Public	15
Aged Care	
Residential Aged Care	8,784 bed days
HACC	18,633 service hours
Primary Health	
Community Health / Primary Care Programs	9,240 hours
Other	
Health Workforce	4 Nursing Graduates

STATUTORY REPORTING REQUIREMENTS

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

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

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

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

COMPLIANCE WITH THE BUILDING ACT 1993

Building Standards and Condition Assessments

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

ESSENTIAL SAFETY MEASURES MAINTENANCE
In accordance with regulatory requirements, service and maintenance records are kept to enable completion of an annual Essential Safety Measures Report for all properties owned by Stawell Regional Health. This is confirmation that all essential services are operational at the required level of performance. Records and reports are retained on the premises for inspection by all relevant authorities.

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

INDUSTRIAL RELATIONS
Stawell Regional Health experienced no days of work lost due to industrial activity during the year ending 30 June 2018.

PUBLICATIONS
Stawell Regional Health produces a number of publications to assist the community to gain a better understanding of our services and programs. They include the Annual Report, Quality of Care Report and a range of patient information brochures that are available throughout Stawell Regional Health. The Annual Report is presented at the Annual General Meeting each year.

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

FREEDOM OF INFORMATION
The Freedom of Information Act 1982 gives applicants the opportunity to request information. Exemptions can apply that relate to the privacy of patients and third parties.

In 2017-18 Stawell Regional Health received 27 requests for information under the Freedom of Information Act, an increase of 10 from 2016-17. Access to information was granted in 25 instances and in 2 instances there were no documents available.

VICTORIAN INDUSTRY PARTICIPATION POLICY
Stawell Regional Health complies with the Victorian Industry Participation Policy Act 2003.

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

FINANCIAL MANAGEMENT ACT 1994
In accordance with the Direction of the Minister for Finance, the information has been prepared and is available to the relevant Minister, and Members of Parliament.

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

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

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

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

DISCLOSURE OF ICT EXPENDITURE STAWELL REGIONAL HEALTH 2017 / 2018

The total ICT expenditure incurred during 2017-18 is $1.050m (excluding GST) with the details shown below

Business As Usual (BAU) ICT expenditure (Total) (excluding GST)	Non-Business As Usual (non BAU) ICT expenditure (Total=Operational expenditure and Capital Expenditure) (excluding GST)	Operational expenditure (excluding GST)	Capital expenditure (excluding GST)
$484,735	**$564,849**	**$484,735**	**$80,114**

Disclosure of Consultancy Expenditure Stawell Regional Health 2017/2018

DETAILS OF CONSULTANCIES UNDER $10,000

In 2017/2018 there were fourteen (14) consultancies where the total fees payable were less than $ 10,000. The total expenditure incurred during 2017/2018 in relation to these consultancies is $ 42,676 (excl. GST).

DETAILS OF CONSULTANCIES OVER $10,000

In 2017/2018 there were three (3) consultancies where the total fees payable were $ 10,000 or greater. The total expenditure incurred during 2017/2018 in relation to these consultancies is $44,909 (excl. GST).

Details of individual consultancies can be provided on written request.

Disclosure Index

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

Legislation	Requirement	Page
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Report of operations – FRD guidance		
Charter and purpose		
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FRD 22H	Initiatives and key achievements	Page 8-9
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Management and structure		
FRD 22H	Organisational structure	Page 6
Financial and other information		
FRD 10A	Disclosure index	Page 26-27
FRD 11A	Disclosure of ex gratia expenses	Page 75
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Legislation	Requirement	Page
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FRD 22H	Information and Communication Technology Expenditure	Page 26
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FRD 22H	Occupational Violence	Page 11-12
FRD 22H	Operational and budgetary objectives and performance against objectives	Page 16-23
FRD 22H	Summary of the entity's environmental performance	Page 25
FRD 22H	Significant changes in financial position during the year	Page 9-10
FRD 22H	Statement on National Competition Policy	Page 25
FRD 22H	Subsequent events	Financial Report
FRD 22H	Summary of the financial results for the year	Page 10
FRD 22H	Additional information available on request	Page 14
FRD 22H	Workforce Data Disclosures including a statement on the application of employment and conduct principles	Page 10
FRD 25C	Victorian Industry Participation Policy disclosures	Page 25
FRD 103F	Non-Financial Physical Assets	Financial Report
FRD 110A	Cash flow Statements	Financial Report
FRD 112D	Defined Benefit Superannuation Obligations	Financial Report
SD 5.2.3	Declaration in report of operations	Page 5
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Other requirements under Standing Directions 5.2		
SD 5.2.2	Declaration in financial statements	Financial Report
SD 5.2.1(a)	Compliance with Australian accounting standards and other authoritative pronouncements	Financial Report
SD 5.2.1(a)	Compliance with Ministerial Directions	Financial Report
Legislation		
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Victorian Industry Participation Policy Act 2003		Page 25
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Non Statutory Obligations		
Occupational Violence reporting		Page 11-12
Reporting of compliance Health Purchasing Victoria policy		Page 13
Reporting obligations under the Safe Patient Care Act 2015		Page 25
Reporting of outcomes from Statement of Priorities 2017–18		Page 16

Stawell Regional Health

Board member's, accountable officer's and chief finance & accounting officer's declaration

The attached financial statements for Stawell Regional Health and the Consolidated entity (SRH Foundation) have been prepared in accordance with Standing Direction 5.2 of the Financial Management Act 1994, applicable Financial Reporting Directions, Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2018 and the financial position of Stawell Regional Health and the Consolidated entity (SRH Foundation) as at 30 June 2018.

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

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

Rhian Jones	Libby Fifis	Ian Martin
Chair Board of Management	**Acting Chief Executive Officer**	**Chief Finance & Accounting Officer**
Stawell	Stawell	Stawell
27-Aug-18	27-Aug-18	27-Aug-18

Independent Auditor's Report

VAGO
Victorian Auditor-General's Office

To the Board of Stawell Regional Health

Opinion

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

- consolidated entity and health service balance sheet as at 30 June 2018
- consolidated entity and health service comprehensive operating statement for the year then ended
- consolidated entity and health service statement of changes in equity for the year then ended
- consolidated entity and health service cash flow statement for the year then ended
- notes to the financial statements, including significant accounting policies
- board member's, accountable officer's and chief finance & accounting officer's declaration.

In my opinion, the financial report presents fairly, in all material respects, the financial positions of the consolidated entity and the health service as at 30 June 2018 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.

Basis for Opinion

I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. I further describe my responsibilities under that Act and those standards in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report.

My independence is established by the *Constitution Act 1975*. My staff and I are independent of the health service and the consolidated entity in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Victoria. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Other Information

The Board of the health service are responsible for the Other Information, which comprises the information in the health service's annual report for the year ended 30 June 2018, but does not include the financial report and my auditor's report thereon.

My opinion on the financial report does not cover the Other Information and accordingly, I do not express any form of assurance conclusion on the Other Information. However, in connection with my audit of the financial report, my responsibility is to read the Other Information and in doing so, consider whether it is materially inconsistent with the financial report or the knowledge I obtained during the audit, or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude there is a material misstatement of the Other Information, I am required to report that fact. I have nothing to report in this regard.

Board's responsibilities for the financial report

The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Financial Management Act 1994*, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error.

In preparing the financial report, the Board is responsible for assessing the health service and the consolidated entity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
28 August 2018

Ron Mak
as delegate for the Auditor-General of Victoria

Stawell Regional Health
Comprehensive Operating Statement
For the Financial Year Ended 30 June 2018

	Note	Parent Entity 2018 $'000	Parent Entity 2017 $'000	Consol'd 2018 $'000	Consol'd 2017 $'000
Revenue from operating activities	2.1	26,975	26,666	26,975	26,666
Revenue from non-operating activities	2.1	160	198	160	198
Employee expenses	3.1	(15,862)	(15,351)	(15,862)	(15,351)
Non salary labour costs	3.1	(4,868)	(4,208)	(4,868)	(4,208)
Supplies and consumables	3.1	(4,397)	(4,107)	(4,397)	(4,107)
Other expenses	3.1	(3,136)	(3,424)	(3,143)	(3,430)
Net result before capital and specific items		**(1,128)**	**(226)**	**(1,135)**	**(232)**
Capital purpose income	2.1	251	386	160	459
Depreciation and Amortisation	4.3	(1,901)	(1,844)	(1,901)	(1,844)
Expenditure for Capital Purpose	3.1	(13)	(279)	(13)	(279)
Net Result after capital and specific items		**(2,791)**	**(1,963)**	**(2,889)**	**(1,896)**
Other economic flows included in net result					
Net gain/(loss) on non-financial assets		(35)	28	(35)	28
Revaluation of Long Service Leave	3.3	(31)	(77)	(31)	(77)
Total other economic flows included in net result		**(66)**	**(49)**	**(66)**	**(49)**
Net result from continuing operations		**(2,857)**	**(2,012)**	**(2,955)**	**(1,945)**
Net Result for the year		**(2,857)**	**(2,012)**	**(2,955)**	**(1,945)**
Items that will not be reclassified to net result					
Changes in physical asset revaluation surplus	8.1	1,501	-	1,501	-
Total other comprehensive income		**1,501**	**-**	**1,501**	**-**
COMPREHENSIVE RESULT FOR THE YEAR		**(1,356)**	**(2,012)**	**(1,454)**	**(1,945)**

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

Stawell Regional Health
Balance Sheet
As at 30 June 2018

	Note	Parent Entity 2018 $'000	Parent Entity 2017 $'000	Consol'd 2018 $'000	Consol'd 2017 $'000
Current assets					
Cash and cash equivalents	6.1	4,667	6,343	4,830	8,121
Receivables	5.2	631	707	645	724
Investments and other financial assets	4.1	-	-	1,520	-
Inventories	5.1	104	95	104	95
Prepayments and Other assets	5.4	88	351	88	351
Total current assets		**5,490**	**7,496**	**7,187**	**9,291**
Non-current assets					
Receivables	5.2	143	79	143	79
Property, plant & equipment	4.2	25,638	24,720	25,638	24,720
Intangible assets	4.4	313	318	313	318
Total non-current assets		**26,094**	**25,117**	**26,094**	**25,117**
TOTAL ASSETS		**31,584**	**32,613**	**33,281**	**34,408**
Current liabilities					
Payables	5.5	1,699	2,036	1,703	2,040
Provisions	3.3	3,240	3,048	3,240	3,048
Other current liabilities	5.3	422	38	422	38
Total current liabilities		**5,361**	**5,122**	**5,365**	**5,126**
Non-current liabilities					
Provisions	3.3	678	590	678	590
Total non-current liabilities		**678**	**590**	**678**	**590**
TOTAL LIABILITIES		**6,039**	**5,712**	**6,043**	**5,716**
NET ASSETS		**25,545**	**26,901**	**27,238**	**28,692**
EQUITY					
Property, plant & equipment revaluation surplus	8.1a	15,387	13,886	15,387	13,886
General purpose surplus	8.1a	500	500	500	500
Restricted specific purpose surplus	8.1b	2,331	1,989	2,331	1,989
Contributed capital	8.1b	9,345	9,345	9,345	9,345
Accumulated surpluses/(deficits)	8.1c	(2,018)	1,181	(325)	2,972
TOTAL EQUITY	8.1c	**25,545**	**26,901**	**27,238**	**28,692**
Contingent assets and contingent liabilities	7.3				
Commitments	6.2				

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

Stawell Regional Health
Statement of Changes in Equity
For the Financial Year Ended 30 June 2018

Consolidated	Note	Property, Plant & Equipment Revaluation Surplus $'000	General Purpose Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributed Capital $'000	Accumulated Surpluses/ (Deficits) $'000	Total $'000
Balance at 1 July 2016		**13,886**	**494**	**1,978**	**9,345**	**4,934**	**30,637**
Net result for the year		-	-	-	-	(1,945)	(1,945)
Transfer (to) from accumulated surplus		-	6	11	-	(17)	-
Balance at 30 June 2017		**13,886**	**500**	**1,989**	**9,345**	**2,972**	**28,692**
Net result for the year		-	-	-	-	(2,955)	(2,955)
Transfer to (from) accumulated surplus				342	-	(342)	-
Other comprehensive income for the year	8.1a	1,501	-	-	-	-	1,501
Balance at 30 June 2018		**15,387**	**500**	**2,331**	**9,345**	**(325)**	**27,238**

Parent	Note	Property, Plant & Equipment Revaluation Surplus $'000	General Purpose Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributed Capital $'000	Accumulated Surpluses/ (Deficits) $'000	Total $'000
Balance at 1 July 2016		**13,886**	**494**	**1,978**	**9,345**	**3,210**	**28,913**
Net result for the year		-	-	-	-	(2,012)	(2,012)
Transfer (to) from accumulated surplus		-	6	11	-	(17)	-
Balance at 30 June 2017		**13,886**	**500**	**1,989**	**9,345**	**1,181**	**26,901**
Net result for the year		-	-	-	-	(2,857)	(2,857)
Transfer to (from) accumulated surplus		-		342	-	(342)	-
Other comprehensive income for the year	8.1a	1,501	-	-	-	-	1,501
Balance at 30 June 2018		**15,387**	**500**	**2,331**	**9,345**	**(2,018)**	**25,545**

This Statement should be read in conjunction with the accompanying notes

Stawell Regional Health
Cash Flow Statement
For the Financial Year Ended 30 June 2018

	Note	Parent Entity 2018 $'000	Parent Entity 2017 $'000	Consol'd 2018 $'000	Consol'd 2017 $'000
CASH FLOWS FROM OPERATING ACTIVITIES					
Operating grants from government		20,385	20,109	20,385	20,109
Capital grants from government		220	344	220	344
Patient and resident fees received		4,684	4,585	4,684	4,585
Donations and bequests received		65	99	221	124
GST received from/(paid to) ATO		(93)	(101)	(93)	(101)
Interest received		125	174	166	220
Other receipts		1,696	1,912	1,696	1,912
Total receipts		**27,082**	**27,122**	**27,279**	**27,193**
Employee expenses paid		(15,630)	(15,211)	(15,630)	(15,211)
Non salary labour costs		(4,869)	(4,178)	(4,869)	(4,178)
Payments for supplies & consumables		(5,417)	(5,385)	(5,417)	(5,385)
Other payments		(2,159)	(2,105)	(2,166)	(2,107)
Total payments		**(28,075)**	**(26,879)**	**(28,082)**	**(26,881)**
NET CASH FLOW FROM/(USED IN) OPERATING ACTIVITIES	8.2	**(993)**	**243**	**(803)**	**312**
CASH FLOWS FROM INVESTING ACTIVITIES					
Payments for non-financial assets		(1,081)	(1,102)	(1,369)	(1,102)
Proceeds from sale of non-financial assets		16	59	16	59
Purchase of Investments		-	-	(1,520)	-
NET CASH FLOW FROM/(USED IN) INVESTING ACTIVITIES		**(1,065)**	**(1,043)**	**(2,873)**	**(1,043)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		**(2,058)**	**(800)**	**(3,676)**	**(731)**
Cash and cash equivalents at beginning of financial year		**6,306**	**7,106**	**8,084**	**8,815**
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.1	**4,248**	**6,306**	**4,408**	**8,084**

This Statement should be read in conjunction with the accompanying notes

Basis of presentation

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

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. Transfers of net liabilities arising from administrative restructurings are treated as distributions to owners.

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

Note 1: Summary of significant accounting policies

These annual financial statements represent the audited general purpose financial statements for Stawell Regional Health and its controlled entity for the period ending 30 June 2018. The report provides users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

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

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

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

The annual financial statements were authorised for issue by the Board of Stawell Regional Health on 27 August 2018.

(b) Reporting entity

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

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

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

(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 2018, and the comparative information presented in these financial statements for the year ended 30 June 2017.

The financial statements are prepared on a going concern basis (refer to Note 8.11 Economic Dependency).

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

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

Stawell Regional Health operates on a fund accounting basis and maintains three funds: Operating, Specific Purpose and Capital Funds. Stawell Regional Capital and Specific Purpose Funds include the Stawell Regional Health Foundation Capital funding set aside from the receipt of Bequests.

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

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

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

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

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

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

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

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

(d) Principles of consolidation

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

- The consolidated financial statements of Stawell Regional Health include all reporting entities controlled by Stawell Regional Health as at 30 June 2018;
- Control exists when Stawell Regional Health has the power to govern the financial and operating policies of a Health Service so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable are taken into account. The consolidated financial statements include the audited financial statements of the controlled entities listed in Note 8.10 Controlled Entities;
- The parent entity is not shown separately in the notes.

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

Entities consolidated into Stawell Regional Health reporting entity include:

- Stawell Regional Health Foundation

Intersegment Transactions

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

(e) Jointly Controlled Operation

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

- In respect of any interest in joint operations, Stawell Regional Health recognises in the financial statements:
- Its assets, including its share of any assets held jointly:
- any liabilities including its share of liabilities that it had incurred;
- its revenue from the sale of the output from the joint operation; and
- its expenses, including its share of any expenses incurred jointly.

Stawell Regional Health is a member of the Grampians Rural Health Alliance Jointly Controlled Operation and retains joint control over the arrangement, which it has classified as a joint operation (refer to Note 8.10 Jointly Controlled Operations).

Notes To and Forming Part of the Financial Statements
Stawell Regional Health Annual Report 2017/2018

Note 2: Funding Delivery of Our Services

Stawell Regional Health's overall objective is to provide quality health services that support and enhance the wellbeing of all Victorians.

Stawell Regional Health is predominantly funded by accrual based grant funding for the provision of outputs. The hospital also receives income from the supply of services.

Structure

2.1 Analysis of revenue by source
2.2 Assets received free of charge or for nominal consideration
2.3 Specific income

Note 2.1: Analysis of Revenue by Source

Consolidated	**Admitted Patients 2018 $'000**	**Non-Admitted 2018 $'000**	**RAC incl. Mental Health 2018 $'000**	**Aged Care 2018 $'000**	**Primary Health 2018 $'000**	**Other * 2018 $'000**	**Total 2018 $'000**
Government Grant	13,443	1,307	2,680	923	1,968	-	20,321
Indirect contributions by Department of Health and Human Services	86	-	-	-	-	-	86
Patient & Resident Fees	713	109	573	50	85	-	1,530
Commercial Activities	1,028	-	-	-	-	2,427	3,455
Other Revenue from Operating Activities	421	316	27	29	109	251	1,153
Grampians Rural Health Alliance						430	430
Total Revenue from Operating Activities	**15,691**	**1,732**	**3,280**	**1,002**	**2,162**	**3,108**	**26,975**
Interest	-	-	-	-	-	125	125
Other Revenue from Non-Operating Activities	-	-	-	-	-	35	35
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**-**	**-**	**160**	**160**
Capital Purpose Income (excluding Interest)	146	-	-	74	-	(101)	119
Capital Interest	-	-	-	-	-	41	41
Total Capital Purpose Income	**146**	**-**	**-**	**74**	**-**	**(60)**	**160**
Total Revenue	**15,837**	**1,732**	**3,280**	**1,076**	**2,162**	**3,208**	**27,295**

Consolidated	**Admitted Patients 2017 $'000**	**Non-Admitted 2017 $'000**	**RAC incl. Mental Health 2017 $'000**	**Aged Care 2017 $'000**	**Primary Health 2017 $'000**	**Other * 2017 $'000**	**Total 2017 $'000**
Government Grant	13,113	1,279	2,883	705	2,121	-	20,101
Indirect contributions by Department of Health and Human Services	21	-	-	-	-	-	21
Patient & Resident Fees	595	138	664	27	65	-	1,489
Commercial Activities	1,056	-	-	-	-	2,405	3,461
Other Revenue from Operating Activities	456	228	-	23	60	351	1,118
Grampians Rural Health Alliance						476	476
Total Revenue from Operating Activities	15,241	**1,645**	**3,547**	**755**	**2,246**	**3,232**	**26,666**
Interest	-	-	-	-	-	198	198
Other Revenue from Non-Operating Activities **Total Revenue from Non-Operating Activities** Capital	-	**-**	**-**	**-**	**-**	**198**	**198**
Purpose Income (excluding Interest) Capital Interest	145	-	-	-	-	292	437
Total Capital Purpose Income	-	-	-	-	-	22	22
Total Revenue	**-**	**-**	**-**	**-**	**-**	**314**	**459**
	15,241	**1,645**	**3,547**	**755**	**2,246**	**3,744**	**27,323**

* Other Programs include Commercial Activities, Special Purpose Funds and Capital.
Revenue has been classified across programs as defined in the Agency Information Management System (AIMS) guidelines. For clinical support, infrastructure and corporate and diagnostic laboratory and medical services, Full time Equivalent (FTE) has been used to allocate revenue across the programs.
Department of Health and Human Services makes certain payments on behalf of the Health Service. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

Notes To and Forming Part of the Financial Statements
Stawell Regional Health Annual Report 2017/2018

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

Revenue Recognition

Income is recognised in accordance with AASB 118 Revenue and is recognised as to the extent that it is probable that the economic benefits will flow to Stawell Regional Health and the income can be reliably measured at fair value. Unearned income at reporting date is reported as income received in advance.
Amounts disclosed as revenue are where applicable, net of returns, allowances and duties and taxes.

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

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

Donations and Other Bequests

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

Interest Revenue

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

Other income

Other income includes recoveries for salaries and wages and external services provided.

Category groups

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

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

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

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

Notes To and Forming Part of the Financial Statements
Stawell Regional Health Annual Report 2017/2018

Note 3: The Cost of Delivering Our Services

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

Structure
3.1 Analysis of expenses by source
3.2 Analysis of expense and revenue by internally managed and restricted specific purpose funds
3.3 Employee Benefits in the Balance Sheet
3.4 Superannuation

Note 3.1: Analysis of Expenses by Source

Consolidated	**Admitted Patients 2018 $'000**	**Non-Admitted 2018 $'000**	**RAC incl. Mental Health 2018 $'000**	**Aged Care 2018 $'000**	**Primary Health 2018 $'000**	**Other * 2018 $'000**	**Total 2018 $'000**
Employee Expenses	6,422	553	2,382	646	1,734	4,125	15,862
Other Operating Expenses							
Non Salary Labour Costs	2,567	713	213	-	56	1,319	4,868
Supplies & Consumables	3,427	177	149	18	58	568	4,397
Other Expenses	637	60	142	16	130	1,783	2,768
Share of Jointly Controlled Expenses	-	-		-	-	375	375
Activities	**13,053**	**1,503**	**2,886**	**680**	**1,978**	**8,170**	**28,270**
Expenditure for Capital Purposes	**-**	**-**	**-**	**-**	**-**	13	13
Depreciation & Amortisation (refer note 4.3)	-	-	-	-	-	1,901	1,901
Total other expenses	**-**	**-**	**-**	**-**	**-**	**1,914**	**1,914**
Total Expenses	**13,053**	**1,503**	**2,886**	**680**	**1,978**	**10,084**	**30,184**

Consolidated	**Admitted Patients 2017 $'000**	**Non-Admitted 2017 $'000**	**RAC incl. Mental Health 2017 $'000**	**Aged Care 2017 $'000**	**Primary Health 2017 $'000**	**Other * 2017 $'000**	**Total 2017 $'000**
Employee Expenses	6,429	590	2,403	710	1,696	3,523	15,351
Other Operating Expenses							
Non Salary Labour Costs	2,799	520	85	-	50	754	4,208
Supplies & Consumables	3,503	228	170	16	66	124	4,107
Other Expenses	631	68	55	8	138	2,138	3,038
Share of Jointly Controlled Expenses						365	365
Activities	**13,362**	**1,406**	**2,713**	**734**	**1,950**	**6,904**	**27,069**
Expenditure for Capital Purposes	**-**	**-**	**-**	**-**	**-**	279	279
Depreciation & Amortisation (refer note 4.3)	-	-	-	-	-	1,871	1,871
Total other expenses	**-**	**-**	**-**	**-**	**-**	**2,150**	**2,150**
Total Expenses	**13,362**	**1,406**	**2,713**	**734**	**1,950**	**9,054**	**29,219**

* Other Programs include Commercial Activities, Special Purpose Funds and Capital.
Expenditure has been classified across programs as defined in the Agency Information Management System (AIMS) guidelines. For clinical support, infrastructure and corporate and diagnostic laboratory and medical services, Full time Equivalent (FTE) has been used to allocate revenue across the programs.

Note 3.1: Expense Recognition

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

Employee Expenses
Employee expenses include:

- Salaries and wages;
- Fringe benefits tax;
- Leave entitlements;
- Termination payments;
- Workcover premiums; and
- Superannuation expenses

Grants and Other Transfers
These include transactions such as: grants, subsidies and personal benefit payments made in cash to individuals.

Other operating expenses

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

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

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

. Revaluation gains/(losses) of non-financial physical assets (refer to Note 4.2 Property, plant and equipment.)
. Net gain/(loss) on disposal of non-financial assets

Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal.

Other gains/ (losses) from other economic flows
Other gains/ (losses) include:

a. the revaluation of the present value of the long service leave liability due to changes in the bond rate movements, inflation rate movements and the impact of changes in probability factors; and

b. transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

Derecognition of financial liabilities

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

Note 3.2: Analysis of Expense and Revenue by Internally Managed and Restricted Specific Purpose Funds

	Expense		Revenue	
	Consol'd 2018 $'000	Consol'd 2017 $'000	Consol'd 2018 $'000	Consol'd 2017 $'000
Commercial Activities				
Private Practice and Other Patient Activities	2,242	2,185	2,102	2,094
Diagnostic Imaging	1,070	1,043	1,028	1,056
Cafeteria	111	121	130	142
Other Activities				
Fundraising and Community Support	37	179	196	73
TOTAL	**3,460**	**3,528**	**3,456**	**3,365**

Note 3.3: Employee benefits in the balance sheet

	Consol'd 2018 $'000	Consol'd 2017 $'000
Current Provisions		
Employee Benefits [(i)]		
Annual leave		
- Unconditional and expected to be settled wholly within 12 months [(ii)]	874	976
- Unconditional and expected to be settled wholly after 12 months [(iii)]	245	81
Long service leave		
- Unconditional and expected to be settled wholly within 12 months [(ii)]	348	207
- Unconditional and expected to be settled wholly after 12 months [(iii)]	1,164	1,229
Accrued Days Off		
- Unconditional and expected to be settled within 12 months [(ii)]	74	61
	2,705	**2,554**
Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months [(ii)]	127	164
- Unconditional and expected to be settled after 12 months [(iii)]	162	151
	289	**315**
Accrued Salaries and Wages	246	179
Total Current Provisions	**3,240**	**3,048**
Non-Current Provisions		
Employee Benefits [(i)]	615	534
Provisions related to Employee Benefit On-Costs	63	56
Total Non-Current Provisions	**678**	**590**
TOTAL PROVISIONS	**3,918**	**3,638**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Unconditional LSL Entitlement	1,653	1,588
Annual Leave Entitlements	1,255	1,103
Accrued Wages and Salaries	246	198
Accrued Days Off	86	67
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements [(ii)]	587	590
Conditional Annual Leave Entitlements	91	92
Total Employee Benefits	**3,918**	**3,638**
Total Employee Benefits and Related On-Costs	**3,918**	**3,638**

Notes:
(i) Provisions for employee benefits consist of amounts for annual leave and long service leave accrued by employees, not including on-costs

(ii) The amounts disclosed are nominal amounts
(iii) The amounts disclosed are discounted to present values

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

Movements in provisions	Consol'd 2018 $'000	Consol'd 2017 $'000
Movement in Long Service Leave:		
Balance at start of year	**2,178**	**1,930**
Provision made during the year		
- Revaluations	(31)	77
- Expense recognising Employee Service	442	378
Settlement made during the year	(349)	(207)
Balance at end of year	**2,240**	**2,178**

Employee Benefit Recognition

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

Provisions

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

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

Employee benefits

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

Wages and salaries, Annual Leave 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:

- Nominal 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

The 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:

- Nominal value – if the health service expects to wholly settle within 12 months; and
- Present value – where the entity 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.

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

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

Termination Benefits

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

On-costs related to employee expense

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

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Note 3.4: Superannuation

	Paid Contribution for the Year		Contribution Outstanding at Year End	
	Consol'd 2018 $'000	**Consol'd 2017 $'000**	**Consol'd 2018 $'000**	**Consol'd 2017 $'000**
Defined benefit plans:[1]				
First State Super	69	42	4	-
			-	-
Defined contribution plans:				
First State Super	844	874	35	
HESTA	230	238	9	
Others	113	117	5	-
Total	1256	1271	53	-

[1] The basis 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 Services contributes to both defined benefit and defined contribution plans. The defined benefit plan(s) provides benefits based on years of service and final average salary.

Defined contribution superannuation plans

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

Defined benefit superannuation plans

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

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

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

However superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the Comprehensive Operating Statement of Stawell Regional Health.

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

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Note 4: Key Assets to Support Service Delivery

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

Structure
4.1 Investments and Other Financial Assets
4.2 Property, plant & equipment
4.3 Depreciation and amortisation
4.4 Intangible assets

Note 4.1: Investments and Other Financial Assets

	Consol'd 2018 $'000	Consol'd 2017 $'000
Term Deposit (>3 Months)	1,520	-
TOTAL	**1,520**	**-**
		-
Represented by:		
Foundation Investment	1,520	
Australian Term Deposit (6 months maturity)		
	1,520	**-**

Note 4.2: Property, plant & equipment

(a) Gross carrying amount and accumulated depreciation

	Consol'd 2018 $'000	Consol'd 2017 $'000
Land		
Land at Fair Value	1,400	1,400
Total Land	**1,400**	**1,400**
Buildings		
Buildings Under Construction at cost	706	209
Buildings at Fair Value	20,354	24,038
Less Acc'd Depreciation	-	3,993
Total Buildings	**21,060**	**20,254**
Plant and Equipment		
Plant and Equipment at Fair Value	2,893	2,762
Less Acc'd Depreciation	1,794	1,662
Total Plant and Equipment	**1,099**	**1,100**
Medical Equipment		
Medical Equipment at Fair Value	5,299	5,037
Less Acc'd Depreciation	3,491	3,336
Total Medical Equipment	**1,808**	**1,701**
Jointly Controlled PP&E		
Jointly Controlled PP&E at Fair Value	360	330
Less Acc'd Depreciation	89	65
Total Cultural Assets	**271**	**265**
TOTAL	**25,638**	**24,720**

Note 4.2: Property, plant & equipment (continued)

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

	Land (i) $'000	Buildings $'000	Plant & Equipment $'000	Medical Equipment $'000	Jointly Cont PP&E $'000	Assets Under Construction $'000	Consol'd Total $'000
Balance at 1 July 2016	**1,400**	**21,308**	**706**	**1,825**	**176**	**-**	**25,415**
Additions	-	46	654	167	116	209	1,192
Disposals	-		(32)		-	-	(32)
Depreciation (Note 4.3)	-	(1,309)	(228)	(291)	(27)	-	(1,855)
Balance at 1 July 2017	**1,400**	**20,045**	**1,100**	**1,701**	**265**	**209**	**24,720**
Additions	-	-	247	434	32	626	1,339
Disposals	-		(21)	(31)	-	-	(52)
Revaluation Increments/(Decrements)	-	1,501		-	-	-	1,501
Net Transfers between Classes	-	119	21	1	-	(129)	12
Depreciation (Note 4.3)	-	(1,311)	(248)	(297)	(26)	-	(1,882)
Balance at 30 June 2018	**1,400**	**20,354**	**1,099**	**1,808**	**271**	**706**	**25,638**

Land and buildings carried at valuation

The Valuer-General Victoria undertook to re-value all of Stawell Regional Health's owned and leased land and buildings to determine their fair value. The Valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arms length transaction. The valuation was based on independent assessments. The effective date of the valuation is 30 June 2014.

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

The fair value of the Buildings has been adjusted by a managerial revaluation in 2018. The latest indices required a further managerial revaluation in 2018. The indexed value was then compared to individual assets written down book value as at 30 June 2018 to determine the change in their fair values. The Department of Health and Human Services approved a managerial revaluation of the building asset class of $1.501m ($0 in 2017).

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

Note 4.2: Property, plant & equipment (continued)

(c) Fair value measurement hierarchy for assets

Balance at 30 June 2018	Consol'd Carrying Amount	Fair value measurement at end of reporting period using: Level 1 [1]	Level 2 [1]	Level 3 [1]
Land at fair value				
Non-specialised land	350		350	
Specialised land	1,050			1,050
Total of land at fair value	1,400		350	1,050
Buildings at fair value				
Non-specialised buildings	105		105	
Specialised buildings	20,249			20,249
Total of building at fair value	20,354	-	105	20,249
Plant and equipment at fair value	1,099			1,099
Medical equipment at fair value	1,808			1,808
Jointly controlled equipment at fair value				
Total Jointly controlled equipment at fair value	271			271
Assets under construction at fair value				
Total assets under construction at fair value	706			706
	25,638	**-**	**455**	**25,183**

Balance at 30 June 2017	Consol'd Carrying Amount	Fair value measurement at end of reporting period using: Level 1 [1]	Level 2 [1]	Level 3 [1]
Land at fair value				
Non-specialised land	350		350	
Specialised land	1,050			1,050
Total of land at fair value	1,400	-	350	1,050
Buildings at fair value				
Non-specialised buildings	105		105	
Specialised buildings	19,940			19,940
Total of building at fair value	20,045	-	105	19,940
Plant and equipment at fair value	1,100			1,100
Medical equipment at fair value	1,701			1,701
Jointly controlled equipment at fair value				
Total Jointly controlled equipment at fair value	265			265
Assets under construction at fair value				
Total assets under construction at fair value	209			209
	24,720	**-**	**455**	**24,265**

Note

[i] Classified in accordance with the fair value hierarchy,

There have been no transfers between levels during the period.

Note 4.2: Property, plant & equipment (continued)

(d) Reconciliation of Level 3 fair value[1]

	Land	Buildings	Plant and equipment	Medical equipment
Consolidated				
Balance at 1 July 2017	1,050	20,149	1,365	1,701
Additions/(Disposals)	-	626	279	403
Transfers in (out) of Level 3		(10)		1
Gains or losses recognised in net result				
- Depreciation	-	(1,311)	(274)	(297)
Items recognised in other comprehensive income				
- Revaluation		1,501		
Balance at 30 June 2018	**1,050**	**20,955**	**1,370**	**1,808**

There have been no transfers between levels during the period

	Land	Buildings	Plant and equipment	Medical equipment
Consolidated				
Balance at 1 July 2016	1,050	21,203	855	1,825
Additions/(Disposals)		255	738	167
Gains or losses recognised in net result				
- Depreciation		(1,309)	(228)	(291)
Balance at 30 June 2017	**1,050**	**20,149**	**1,365**	**1,701**

[1]Classified in accordance with the fair value hierarchy, refer Note 4.2(c).

Note 4.2: Property, plant & equipment (continued)

(e) Fair Value Determination

Asset class	Examples of types of assets	Expected fair value level	Likely valuation approach	Significant inputs (Level 3 only)[(c)]
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 (Crown / Freehold)	- Land subject to restriction as to use and/or sale - Land in areas where there is not an active market	Level 3	Market approach	Community Service Obligations Adjustments [(c)]
Non-specialised buildings	For general/commercial buildings that are just built	Level 2	Market approach	n.a.
Specialised buildings [(a)]	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
Vehicles	If there is an active resale market available	Level 2	Market approach	n.a.
Plant and equipment [(a)]	Specialised items with limited alternative uses and/or substantial	Level 3	Depreciated replacement cost	- Cost per unit - Useful life
Medical Equipment	Any type	Level 3	Depreciated replacement cost	- Cost per unit - Useful life

Notes:
(c) CSO adjustment of 20% was applied to reduce the market approach value for Stawell Regional Health's Health Service's specialised land.

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

Note 4.2: Property, plant & equipment (continued)

(e) Fair Value Determination (continued)

Initial Recognition

Items of property, plant and equipment are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and impairment loss. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition.

Assets transferred as part of a merger/machinery of government change are transferred at their carrying amounts.

The cost of a leasehold improvement is capitalised as an asset and depreciated over the shorter of the remaining term of the lease or the estimated useful life of the improvements.

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

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

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

Subsequent Measure

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

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

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

For the purpose of fair value disclosures, the Health Service has determined classes of assets and liabilities on the basis of the nature, characterisitics and risks of the asset or liability and the level of the fair value hierarchy as explained above.

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

The Valuer-General Victoria (VGV) is Stawell Regional Health's independent valuation agency.

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

Fair value measurement

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

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

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

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

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

Valuation hierarchy

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

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

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.

Note 4.2: Property, plant & equipment (continued)

(e) Fair Value Determination (continued)

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 simlar 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 all information about market participation assumptions that is reasonably available. Unobservable inputs developed in the manner described above are market participant assumptions and meet the object of a fair value measurement.

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

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

For the health services, the depreciated replacement cost method is used for the majority of specialised buildings, adjusting for the associated depreciation. As depreciation adjustments are considered as significant and unobservable inputs in nature, specialised buildings are classified as Level 3 for fair value measurements.

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

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

Vehicles
The Health Service acquires new vehicles and at times disposes of them before completion of their economic life. The process of acquisition, use and disposal in the market is managed by the Health Service who set relevant depreciation rates during use to reflect the consumption of the vehicles. As a result, the fair value of vehicles does not differ materially from the carrying 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 2018.

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

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 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 Stawell Regional Health's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required. This assessment did not identify any significant movements that would require a revaluation.

Note 4.3: Depreciation and Amortisation

	Consol'd 2018 $'000	Consol'd 2017 $'000
Depreciation		
Buildings	1,311	1,309
Plant & Equipment	248	228
Medical Equipment	297	291
Joint Venture Assets	26	27
Total Depreciation	**1,882**	**1,855**
Amortisation		
Intangible Assets	19	16
Total Amortisation	**19**	**16**
Total Depreciation and Amortisation	**1,901**	**1,871**

Depreciation

All infrastructure assets, buildings, plant and equipment and other non-financial physical assets (excluding items under operating leases, assets held for sale, land and investment properties) that have finite useful lives are depreciated. Depreciation is generally calculated on a straight line basis at rates that allocate the assets value, less any residual value over its estimated useful life (refer AASB 116 *Property, Plant and Equipment*).
The useful lives illustrated in the guidelines are for illustrative purposes only. Health Services should determine the useful lives of assets by consideration of the nature and characteristics of specific assets. The estimated useful lives, residual values and depreciation method are reviewed at the end of each annual reporting period, and adjustments made where appropriate.

Amortisation

Amortisation is the systematic allocation of the depreciable amount of an asset over its useful life. If a Health Service has items such as patents, trademarks, computer software or development expenses that are being capitalised, these should be included under 'Intangible Assets' (refer AASB 138 *Intangible Assets*) and amortised.

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

	2018	2017
Buildings		
- Structure Shell Building Fabric	45 to 60 years	45 to 60 years
- Site Engineering Services and Central Plant	20 to 30 years	20 to 30 years
Central Plant		
- Fit Out	20 to 30 years	20 to 30 years
- Trunk Reticulated Building systems	30 to 40 years	30 to 40 years
Plant and Equipment	3 to 7 years	3 to 7 years
Medical Equipment	7 to 10 years	7 to 10 years
Computers and Communication	3 to 9 years	3 to 9 years
Furniture and Fittings	10 to 13 years	10 to 13 years
Motor Vehicles	5 to 10 years	5 to 10 years
Leasehold Improvements	2 to 10 years	2 to 10 years
Intangible Assets	3 to 4 years	3 to 4 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.

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Note 4.4: Intangible Assets

	Consolidated 2018 $'000	Consolidated 2017 $'000
Computer Software	431	556
Less Acc'd Amortisation	361	481
	70	**75**
Business Goodwill	243	243
	243	**243**
Total Intangible Assets	**313**	**318**

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

	Computer Software $'000	Business *Goodwill* $'000	Total $'000
Balance at 1 July 2016	**64**	**243**	**307**
Additions	26	-	26
Amortisation (Note 4.3)	(15)	-	(15)
Balance at 1 July 2017	**75**	**243**	**318**
Additions	21	-	21
Disposals	(7)	-	(7)
Amortisation (note 4.3)	(19)	-	(19)
Balance at 30 June 2018	**70**	**243**	**313**

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

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

Note 5: Other assets and liabilities

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

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

Note 5.1: Inventories

	Consol'd 2018 $'000	Consol'd 2017 $'000
Pharmaceuticals		
At cost	49	40
Medical and Surgical Lines		
At cost	55	55
TOTAL INVENTORIES	**104**	**95**

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.

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Note 5.2: Receivables

	Consol'd 2018 $'000	Consol'd 2017 $'000
CURRENT		
Contractual		
Receivables - Grampians Rural Health Alliance	18	28
Trade Debtors	239	190
Patient Fees	268	254
Accrued Investment Income	17	24
Accrued Revenue	69	84
Less Allowance for Doubtful Debts		
Trade Debtors	(2)	(8)
Patient Fees	(63)	(40)
	546	**532**
Statutory		
GST Receivable	99	192
Accrued Revenue - Department of Health / Department of Health and Human Services	-	-
	99	**192**
TOTAL CURRENT RECEIVABLES	**645**	**724**
NON CURRENT		
Contractual		
Long Service Leave - Department of Health and Human Services	143	79
TOTAL NON-CURRENT RECEIVABLES	**143**	**79**
TOTAL RECEIVABLES	**788**	**803**

(a) Movement in the Allowance for doubtful debts

	Consol'd 2018 $'000	Consol'd 2017 $'000
Balance at beginning of year	48	44
Amounts written off during the year	(2)	(31)
Increase/(decrease) in allowance recognised in net result	19	35
Balance at end of year	**65**	**48**

Note 5.2: Receivables (continued)

Receivables Recognition

Receivables consist of:
- contractual receivables, which includes mainly debtors in relation to goods and services and accrued investment income; and
- statutory receivables, which includes predominantly amounts owing from the Victorian Government and Goods and Services Tax (GST) input tax credits recoverable.

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

Receivables are recognised initially at fair value and subsequently measured at amortised cost less any accumulated impairment. Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition.

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

Note 5.3: Other liabilities

	Consol'd 2018 $'000	Consol'd 2017 $'000
CURRENT		
Monies Held in Trust		
- Patient Monies Held in Trust	31	31
- Accommodation Bonds (Refundable Entrance Fees)	387	-
- Other Monies Held in Trust	4	7
Total Current	**422**	**38**
Total Other Liabilities	**422**	**38**
Total Monies Held in Trust		
Represented by the following assets:		
Cash Assets (refer to Note 6.1)	422	38
		-
TOTAL	**422**	**38**

Note 5.4: Prepayments and other non-financial assets

CURRENT	Consol'd 2018 $'000	Consol'd 2017 $'000
Prepayments	74	349
Prepayments - Grampians Rural Health Alliance	11	2
Residential Property Bonds	3	-
TOTAL CURRENT OTHER ASSETS	**88**	**351**

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

Note 5.5: Payables

	Consol'd 2018 $'000	Consol'd 2017 $'000
CURRENT		
Contractual		
Trade Creditors	1,036	1,477
Payables - Grampians Rural Health Alliance	21	37
Accrued Expenses	319	405
Revenue in Advance	160	102
Amounts payable to Governments and Agencies		
Department of Health and Ageing	29	7
	1,565	**2,028**
Statutory		
Department of Health and Human Services		
Amounts payable to Government	138	12
	138	**12**
TOTAL CURRENT	**1,703**	**2,040**
TOTAL PAYABLES	**1,703**	**2,040**

Payables consist of:

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

Note 5.5: Payables (Continued)

(a) Maturity analysis of payables

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

Maturity analysis of Financial Liabilities as at 30 June

			Maturity Dates			
2018	**Carrying Amount $'000**	**Nominal Amount $'000**	**Less than 1 Month $'000**	**1-3 Months $'000**	**3 months - 1 Year $'000**	**1-5 Years $'000**
Financial Liabilities						
At amortised cost						
Payables	1,703	1,703	1,565	-	138	-
Other Liabilities						
- Accommodation Bonds	387	387	387	-	-	-
Monies Held in Trust	35	35	35	-	-	-
Total Financial Liabilities	**2,125**	**2,125**	**1,987**	**-**	**138**	**-**
2017						
Financial Liabilities						
At amortised cost						
Payables	1,662	1,662	1,650	-	12	-
Other Financial Liabilities (i)						
- Accommodation Bonds	402	402	402	-	-	-
Monies Held in Trust	46	46	46	-	-	-
Total Financial Liabilities	**2,110**	**2,110**	**2,098**	**-**	**12**	**-**

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

Note 6: How we finance our operations

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

	Consol'd 2018 $'000	Consol'd 2017 $'000
Cash on hand	2	2
Cash at bank	245	161
Bank overdrafts		
Short term money market	4,359	7,753
Cash & equivalents Grampians Rural Health Alliance	224	205
Total Cash and Cash Equivalents	**4,830**	**8,121**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)[1]	4,408	8,084
Cash for Monies Held in Trust		
- Patients Trust (note 5.3)	422	38
Total Cash and Cash Equivalents	**4,830**	**8,121**

[1] Cash and cash equivalents include Salary packaging

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

Note 6.2: Commitments for expenditure

a) Commitments other than Public Private Partnerships

	Consolidated 2018 $'000	Consolidated 2017 $'000
Capital expenditure commitments		
Payable:		
Land and buildings	116	-
Plant and equipment	-	-
Total capital expenditure commitments	**116**	**-**
Lease commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating leases	117	222
Total lease commitments	**117**	**222**
Total Commitments	**232**	**222**

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

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

Note 6.2: Commitments (continued)

(b) Commitments payable

	Consolidated 2018 $'000	Consolidated 2017 $'000
Capital expenditure commitments payable		
Less than 1 year	116	-
Longer than 1 year but not longer than 5 years	-	-
5 years or more	-	-
Total capital expenditure commitments	**116**	**-**
Lease commitments payable		
Less than 1 year	71	122
Longer than 1 year but not longer than 5 years	46	144
5 years or more	-	-
Total lease commitments	**117**	**266**
Total commitments (inclusive of GST)	**232**	
Less GST recoverable from the Australian Tax Office	(23)	(27)
Total commitments (exclusive of GST)	**209**	**239**

Note 7: Risks, contingencies and valuation uncertainties

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

Structure

7.1 Financial instruments
7.2 Contingent assets and contingent liabilities

Note 7.1: Financial Instruments

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of Stawell Regional Health's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 Financial Instruments: Presentation.

Financial Instrument Categorisation

Consolidated 2018	**Contractual financial assets - loans and receivables** $'000	**Contractual financial liabilities at amortised cost** $'000	**Consolidated Total** $'000
Contractual Financial Assets			
Cash and cash equivalents	4,830	-	4,830
Receivables			
- Trade Debtors	239	-	239
- Other Receivables	307	-	307
- Other Receivables		-	-
Other Financial Assets			
- Investments in Term Deposit	1,520	-	1,520
Total Financial Assets (i)	**6,896**	**-**	**6,896**
Financial Liabilities			
Payables		1,565	1,565
- Monies Held in Trust	-	422	422
Total Financial Liabilities (ii)	**-**	**1,987**	**1,987**

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

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

Note 7.1: Financial Instruments (continued)

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

	Total Interest Income/Expense $'000	Consolidated Total $'000
2018		
Financial Assets		
Loans and Receivables [(i)]	166	166
Total Financial Assets	**166**	**166**
2017		
Financial Assets		
Loans and Receivables [(i)]	220	220
Total Financial Assets	**220**	**220**

(i) For cash and cash equivalents, loans and receivables the net gain or loss is calculated by taking the movement in the fair value of the asset and interest revenue.

Categories of 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, (and for assets less any impairment).

Loans and receivables category includes:

. cash and deposits
. term deposits with maturity greater than 3 months;
. trade receivables; and
. loans and receivables but not statutory receivables .

Financial assets and liabilities at fair value through net result
are categorised as such at trade date, or if they are classified as held for trading or designated as such upon initial recognition. Financial instrument assets are designated at fair value through profit or loss on the basis that the financial assets form part of a group of financial assets that are managed based on their fair values and have their performance evaluated in accordance with documented risk management and investment strategies. Financial instruments at fair value through net result are initially measured at fair value; attributable transaction costs are expensed as incurred. Subsequently, any changes in fair value are recognised in the net result as other economic flows.

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

. payables, excluding statutory payables:

Note 7.1: Financial Instruments (continued)

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
- Stawell Regional Health 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
- Stawell Regional Health has transferred its rights to receive cash flows from
  - has transferred substantially all the risks and rewards of the asset; or
  - has neither transferred nor retained substantially all the risks and rewards of the asset, but has transferred control of the asset.

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

Impairment of financial assets:

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

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

Reclassification of financial instruments:

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

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

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

Derecognition of financial liabilities:

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

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

Note 7.2: Contingent Assets and Contingent Liabilities

As at balance date, the Board of Directors are unaware of the existence of any financial obligation that may have a material effect on the balance sheet as a result of any future event which may or may not happen. (2017 Nil).

Note 8: Other disclosures

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

Structure

Note 8.1: Equity

	Parent Entity 2018 $'000	Parent Entity 2017 $'000	Consol'd 2018 $'000	Consol'd 2017 $'000
(a) Surpluses				
Property, Plant & Equipment Revaluation Surplus [i]				
Balance at the beginning of the reporting period	124,752	36,840	13,886	13,886
Revaluation Increment/(Decrements) refer Note 4.2(b)			1,501	-
Balance at the end of the reporting period*	**124,752**	**124,752**	**15,387**	**13,886**
* Represented by:				
- Land	71,810	71,810	807	807
- Buildings	52,942	52,942	14,580	13,079
	124,752	**124,752**	**15,387**	**13,886**
General Purpose Surplus [ii]				
Balance at the beginning of the reporting period	-	-	500	494
Transfers to (from) Accumulated Surplus/(Deficits)	-	-		6
Balance at the end of the reporting period	**-**	**-**	**500**	**500**
Restricted Specific Purpose Surplus				
Balance at the beginning of the reporting period	3,971	2,702	1,989	1,978
Transfer from/(to) Accumulated Surplus/Deficit	(2,038)	1,269	342	11
Balance at the end of the reporting period	**1,933**	**3,971**	**2,331**	**1,989**
Total Surpluses	**126,709**	**128,745**	**18,218**	**16,375**

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Note 8.1: Equity (Continued)

(b) Contributed Capital	**Consol'd 2018 $'000**	**Consol'd 2017 $'000**
Balance at the beginning of the reporting period	9,345	9,345
Balance at the end of the reporting period	**9,345**	**9,345**
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	2,972	4,934
Net Result for the Year	(2,955)	(1,945)
Transfers from/(to) Restricted Specific Purpose Surplus	(342)	(17)
Transfers from Property, Plant and Equipment Revaluation Surplus		-
Share of decrement in Joint Venture Membership	-	-
Balance at the end of the reporting period	**(325)**	**2,972**
Total Equity at End of Year	**27,238**	**28,692**

[i] Represents the revaluation of Property, Plant and Equipment. The Crown Land previously classified as held for sale has been transferred to the Department of Health and Human Services in accordance with FRD 103F.

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

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 or 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
The Specific Restricted Purpose Surplus is established where the Stawell Regional Health has possession or title to the funds but has no discretion to amend or vary the restriction and/or condition underlying the funds received.

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

Note 8.2: Reconciliation of Net Result for the Year to Net Cash from Operating Activities

	Consol'd 2018 $'000	Consol'd 2017 $'000
Net result for the period	(2,955)	(1,945)
Non-cash movements:		
Depreciation and amortisation	1,901	1,871
Provision for doubtful debts	17	4
Movements included in investing and financing activities		
Net (gain)/loss from disposal of non financial physical assets	35	(28)
Movements in assets and liabilities:		
Change in operating assets and liabilities		
(Increase)/decrease in receivables	15	(382)
(Increase)/decrease in other assets	(13)	95
(Increase)/decrease in prepayments	263	(7)
Increase/(decrease) in payables	(337)	444
Increase/(decrease) in provisions	280	247
(Increase)/decrease in inventories	(9)	40
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**(803)**	**339**

Note 8.3: Responsible persons disclosures

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

	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	1/7/2017 - 30/6/2018
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	1/7/2017 - 30/6/2018
Governing Board	
Mrs R Jones (Board Chair)	1/7/2017 - 30/6/2018
Mr H L Cooper	1/7/2017 - 30/6/2018
Mr R Hatton	1/7/2017 - 30/6/2018
Ms J Cass	1/7/2017 - 30/6/2018
Mr P Mees	1/7/2017 - 30/6/2018
Mr A Thomas	1/7/2017 - 30/6/2018
Ms A Rhodes	1/7/2017 - 7/5/2018
Accountable Officers	
Mrs E McCourt	1/7/2017 - 4/2/2018
Ms L Fifis	5/2/2018 - 30/6/2018

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

	Parent	
	2018	2017
Income Band	No.	No.
$0 - $9,999	7	7
$90,000 - $99,999	1	-
$170,000 - $179,999	-	1
$280,000 - $289,999	1	-
Total Numbers	**9**	**8**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**$373,902**	**$176,248**

Amounts relating to the Governing Board Members and Accountable Officer are disclosed in Stawell Regional Health's controlled entities financial statements.

Amounts relating to Responsible Ministers are reported within the Department of Parliamentary Services' Financial Report as disclosed in Note 8.6 Related Parties.

Note 8.4: Remuneration of Executives

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

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

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

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

Note 8.4: Executive Officer Disclosures (Continued).

Other Long-term Benefits
Long service leave, other long-service benefit or deferred compensation.

Termination Benefits
Termination of employment payments, such as severance packages.

Total remuneration payable to executives during the year included additional executive officers and a number of executives who received bonus payments during the year. These bonus payments depend

Remuneration of Executive Officers	**Parent Total Remuneration**	
Remuneration	**2018 $**	**2017 $**
Short-term benefits	329,436	402,674
Post-employment benefits	29,274	33,559
Other long-term benefits	5,935	12,878
Total Remuneration[i]	**364,645**	**449,111**
Total Number of Executives	5	**6**
Total Annualised Employee Equivalent (AEE)[ii]	**2.8**	**3.8**

[i] The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of Stawell Regional Health's under AASB 124 Related Party Disclosures and are also reported within Note 8.5 Related Parties.

[ii] Annualised employee equivalent is based on working 38 ordinary hours per week over the reporting period.

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Note 8.5: Related Parties

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

. All key management personnel and their close family members;
. Controlled Entities - The Stawell Regional Health Foundation;
. Jointly Controlled Operation - A member of the Grampians Rural Health Alliance Joint Venture;
. Cabinet ministers (where applicable) and their close family members; and
. All hospitals and public sector entities that are controlled and consolidated into the State of Victoria financial statements.

KMPs are those people with the authority and responsibility for planning, directing and controlling the activities of Stawell Regional Health and its controlled entities, directly or indirectly.

The Board of Directors, Accountable Officers and the Executive Directors of Stawell Regional Health and it's controlled entities are deemed to be KMPs.

Entity	KMPs	Position Title	
Stawell Regional Health	Mrs R Jones	Chair of the Board	
Stawell Regional Health	Mr H L Cooper	Board member	
Stawell Regional Health	Mr R Hatton	Board member	
Stawell Regional Health	Ms J Cass	Board member	
Stawell Regional Health	Mr P Mees	Board member	
Stawell Regional Health	Mr A Thomas	Board member	
Stawell Regional Health	Ms A Rhodes	Board member	
Stawell Regional Health	Liz McCourt	Chief Executive Officer	1 Jul 17 - 4 Feb 18
Stawell Regional Health	Libby Fifis	Acting Chief Executive Officer	5 Feb 18 - 30 Jun 18
Stawell Regional Health	Robyn Wilson	Director of Clinical Services	1 Jul 17 - 30 Jun 18
Stawell Regional Health	Rhys Duncan	Director of Primary Care	27 Jul 17 - 30 Jun 18
Stawell Regional Health	Ian Martin	Chief Finance Officer	16 Apr 18 - 30 Jun 18
Stawell Regional Health	Shaun Lee	Director of Primary Care	1 Jul 17 - 26 Jul 17
Stawell Regional Health	Janet Feeny	Human Resources Director	1 Jul 17 - 20 Dec 18

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 - KMP's	**2018 $'000**	**2017 $'000**
Short-term benefits[i]	567,091	561,592
Post-employment benefits	47,883	46,519
Other long-term benefits	5,935	17,248
Termination Benefits	150,885	-
Total[ii]	**771,794**	**625,359**

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

[ii] KMPs are also reported in Note 8.3 Responsible Persons or Note 8.4 Remuneration of Executives.

Note 8.5: Related Parties (continued).

Significant Transactions with Government Related Entities
Stawell Regional Health received funding from the Department of Health and Human Services of $17,107,606 (2017: $16,508,382) and Indirect Contributions of $ 80,611 (2017: $ 75,642).

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

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

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

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

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

There were no related party transactions required to be disclosed for Stawell Regional Health Board of Directors, Accountable Officers, and Executive Directors in 2018.

Except for the transaction listed below, there were no other related party transactions required to be disclosed for Stawell Regional Health Foundation Board of Directors in 2018.

Note 8.5: Related Parties (continued).

Controlled Entities Related Party Transactions

Stawell Regional Health Foundation

The transactions between the two entities relate to reimbursements made by Stawell Regional Health Foundation to Stawell Regional Health for goods and services and the transfer of funds by way of distributions made to the hospital. All dealings are in the normal course of business and are on normal commercial terms and conditions.

	2018 $'000	2017 $'000
Distribution of funds by Stawell Regional Health Foundation	278	-

Note 8.6: Remuneration of auditors

	2018 $'000	2017 $'000
Victorian Auditor-General's Office		
Audit and Review of Financial Statements	17	16
TOTAL RENUMERATION OF AUDITORS	**17**	**16**

Note 8.7. Ex gratia payments

Stawell Regional Health has made the following ex gratia expenses:

	2018 $ '000	2017 $ '000
Compensation for economic loss	161	-
Total ex-gratia expenses	**161**	-

Includes ex-gratia for both individual items and in aggregate that are greater than or equal to $5,000.

Note 8.8: AASB's Issued that are not yet Effective

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2018 reporting period. Department of Treasury and Finance assesses the impact of all these new standards and advises Stawell Regional Health of their applicability and early adoption where applicable.

As at 30 June 2018, 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. Stawell Regional Health has not and does not intend to adopt these standards early.

Standard / Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on Stawell Regional Health's Financial Statements
AASB 9 Financial Instruments	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1 Jan 2018	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. The initial application of AASB 9 is not expected to significantly impact the financial positon however there will be a change to the way financial instruments are classified and new disclosure requirements.
AASB 2014-1 Amendments to Australian Accounting Standards [Part E Financial Instruments]	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018, and to amend reduced disclosure requirements.	1-Jan-19	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.
AASB 15 Revenue from Contracts with Customers	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer. Note that amending standard AASB 2015 8 Amendments to Australian Accounting Standards – Effective Date of AASB 15 has deferred the effective date of AASB 15 to annual reporting periods beginning on or after 1 January 2018, instead of 1 January 2017.	1 Jan 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.

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

Standard / Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on Stawell Regional Health's Financial Statements
AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15	Amends the measurement of trade receivables and the recognition of dividends as follows: Trade receivables, that do not have a significant financing component, are to be measured at their transaction price, at initial recognition. Dividends are recognised in the profit and loss only when: · the entity's right to receive payment of the dividend is established; · it is probable that the economic benefits associated with the dividend will flow to the entity; and · the amount can be measured reliably.	1 Jan 2018, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.
AASB 2015-8 Amendments to Australian Accounting Standards – Effective Date of AASB 15	This Standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018	1 Jan 2018	This amending standard will defer the application period of AASB 15 for for-profit entities to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2017-3 Amendments to Australian Accounting Standards – Clarifications to AASB 15	This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: · A promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation; · For items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer; and · For licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access).	1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector, other than the impact identified for AASB 15 above.

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

Standard / Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on Stawell Regional Health's Financial Statements
AASB 2017-7 Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities	This Standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019.	1 Jan 2019	This amending standard will defer the application period of AASB 15 for not-for-profit entities to the 2019-20 reporting period.
AASB 2017-8 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities	AASB 2016-8 inserts Australian requirements and authoritative implementation guidance for not-for-profit-entities into AASB 9 and AASB 15. This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events.	1 Jan 2019	This standard clarifies the application of AASB 15 and AASB 9 in a not-for-profit context. The areas within these standards that are amended for not-for-profit application include: *AASB 9* · Statutory receivables are recognised and measured similarly to financial assets *AASB 15* · The "customer" does not need to be the recipient of goods and/or services; · The "contract" could include an arrangement entered into under the direction of another party; · Contracts are enforceable if they are enforceable by legal or "equivalent means"; · Contracts do not have to have commercial substance, only economic substance; and · Performance obligations need to be "sufficiently specific" to be able to apply AASB 15 to these transactions.
AASB 16 Leases	The key changes introduced by AASB 16 include the recognition of most operating leases (which are currently not recognised) on balance sheet.	1 Jan 2019	The assessment has indicated that most operating leases, with the exception of short term and low value leases will come on to the balance sheet and will be recognised as right of use assets with a corresponding lease liability. In the operating statement, the operating lease expense will be replaced by depreciation expense of the asset and an interest charge. There will be no change for lessors as the classification of operating and finance leases remains unchanged.

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

Standard / Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on Stawell Regional Health's Financial Statements
AASB 1058 Income of Not-for-Profit Entities	AASB 1058 standard will replace the majority of income recognition in relation to government grants and other types of contributions requirements relating to public sector not-for-profit entities, previously in AASB 1004 *Contributions* .	1 Jan 2019	The current revenue recognition for grants is to recognise revenue up front upon receipt of the funds. This may change under AASB 1058, as capital grants for the construction of assets will need to be deferred. Income will be recognised over time, upon completion and satisfaction of performance obligations for assets being constructed, or income will be recognised at a point in time for acquisition of assets.
	The restructure of administrative arrangement will remain under AASB 1004 and will be restricted to government entities and contributions by owners in a public sector context,		The revenue recognition for operating grants will need to be analysed to establish whether the requirements under other applicable standards need to be considered for recognition of liabilities (which will have the effect of deferring the income associated with these grants). Only after that analysis would it be possible to conclude whether there are any changes to operating grants.
	AASB 1058 establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to		The impact on current revenue recognition of the changes is the phasing and timing of revenue recorded in the profit and loss statement.

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

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

Notes:

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

Note 8.9: Events Occurring after the Balance Sheet Date

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

Note 8.10: Controlled entities

		2018
Name of entity	**Country of incorporation**	**Equity Holding**
Stawell Regional Health Foundation	Australia	100%

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

Note 8.10: Jointly Controlled Operations and Assets

		Ownership Interest	
		2018	2017
Name of Entity	**Principal Activity**	**%**	**%**
Grampains Rural Health Alliance	Information Systems	6.38	6.34

Note 8.10: Jointly Controlled Operations and Assets - (Continued).

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

	2018 $'000	2017 $'000
Current Assets		
Cash and Cash Equivalents	224	206
Receivables	17	28
Prepayments	11	2
Total Current Assets	**252**	**236**
Non-Current Assets		
Property, Plant and Equipment	297	262
Less Accumulated Depreciation	26	27
Total Non Current Assets	**271**	**235**
Total Assets	**523**	**471**
Current Liabilities		
Payables	35	37
Total Current Liabilities	**35**	**37**
Total Liabilities	**35**	**37**
Total Net Assets	**488**	**434**

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

Revenues		
Operating Activities	365	348
Non Operating Activities	8	7
Total Revenue	373	355
Expenses		
Employee Expenses	99	97
Maintenance Contracts and IT Support	51	43
Operating Lease Costs	-	-
Other Expenses	198	198
Total Operating Expenses	348	338
Capital Purpose Income	53	121
Depreciation	26	27
Total Capital and Specific Items	27	94
Net Result	**52**	**111**

The financial results included for The Grampians Rural Health Alliance for 2018 are unaudited at the date of signing the financial statements.

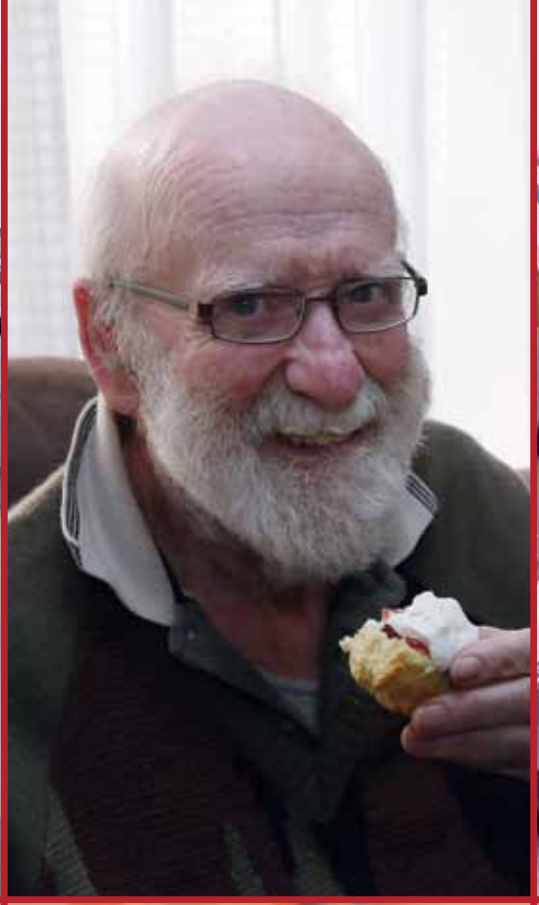
Contingent Liabilities and Capital Commitments
There are no known contingent assets or liabilities for The Grampians Rural Health Alliance as at the date of this report (2017 Nil).

Note 8.11: Economic Dependency

Stawell Regional Health is dependent on the Department of Health and Human Services for the majority of its revenue used to operate the entity. At the date of this report, the Board of Directors has no reason to believe the Department will not continue to support Stawell Regional Health.

Note 8.12: Alternate Presentation of Comprehensive operating
For the Year Ended 30 June 2018

	Note	Consol'd 2018 $'000	Consol'd 2017 $'000
Grants			
Operating	2.1	20,322	20,101
Capital	2.1	219	329
Interest and Dividends	2.1	166	220
Sales of Goods and Services	2.1	4,619	4,950
Other income	2.1	2,035	1,620
Other capital income	2.1	222	103
Revenue from Transactions		**27,583**	**27,323**
Employee Expenses	3.1	(15,861)	(15,351)
Operating Expenses			
Other		(12,723)	(11,745)
Non-Operating Expenses			
Expenditure for Capital Purpose	3.1	(13)	(279)
Depreciation and Amortisation	4.5	(1,875)	(1,844)
Expenses from Transactions		**(30,472)**	**(29,219)**
Net Result from Transactions		**(2,889)**	**(1,896)**
Other economic flows included in net result			
Net gain/(loss) on non-financial assets	2.1	(35)	28
Other gains/(losses) from other economic flows	2.1	(31)	(77)
Revaluation of Long Service Leave		-	-
Total other economic flows included in net result		(66)	(49)
Net result from continuing operations		**(2,955)**	**(1,945)**
Net result from discontinued operations		**-**	**-**
NET RESULT FOR THE YEAR		**(2,955)**	**(1,945)**

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