ANNUAL REPORT 2017

Echuca Regional Health

CONTENTS

PURPOSE

Supporting everyone to be healthy and live well

The health service has an operating budget of $66 million and a staff base of 651, representing 458 equivalent full time staff.

Echuca Regional Health (ERH) will report on annual performance in two separate documents for the financial year ended 30 June 2017.

This document complies with statutory reporting requirements whilst the Quality Account provides information on quality, risk management and performance improvement.

OUR COMMUNITY

Echuca Regional Health is located approximately 180 kilometres directly north of Melbourne in the Shire of Campaspe (Victoria), adjacent to the community of Moama (Murray River Council, New South Wales). Echuca-Moama is surrounded by the majestic Murray River, which provides for an area prosperous with agriculture, tourism, industry, development and new residents.

A predominantly rural area covering 4,517 square kilometres 36,881 people reside in the Shire of Campaspe. Located on the New South Wales/Victorian border, Moama is the Murray River Council's main township. The combined catchment areas for the Shire of Campaspe and Murray River Council serve an estimated 44,000 people.

INCORPORATION

The Governor-in-Council issued an order on 26 October 1993 declaring Echuca Regional Health to be a public hospital. The order took effect on 1 November 1993 and Schedule 1 of the *Health Services Act 1988* was amended accordingly.

The health service is established under the *Health Services Act 1988*. The responsible Ministers during the reporting period were The Honourable Jill Hennessy, MP, Minister for Health, Minister for Ambulance Services and The Honourable Martin Foley, MP, Minister for Housing, Disability and Ageing, Minister for Mental Health.

OUR VALUES

Collaboration

Accountability

Respect

Excellence

ACKNOWLEDGEMENT OF COUNTRY

We acknowledge the Traditional Owners of this Land and pay our respect to their Elders, past and present.

03 PRESIDENT AND CHIEF EXECUTIVE REPORT

On behalf of the Board and Staff we are pleased to present the 135th Annual Report of Echuca Regional Health for the year ended 30 June 2017.

This report highlights the major developments and achievements that occurred during the year and is prepared in accordance with the *Financial Management Act 1994*.

INFRASTRUCTURE DEVELOPMENTS

The new and expanded Echuca Hospital redevelopment which was completed in August 2015, has proven to meet all expectations as the health service activity continues to achieve record levels.

As patient activity increases and operating grants increase, the health service is able to commission additional beds provided in the hospital redevelopment. In February 2017, the Short Stay Unit (4 beds) located within the Emergency Department was commissioned and has been a valuable addition to hospital inpatient services.

In the next financial year, the expectation is that the four remaining beds in the 24 rehabilitation ward will be opened reflecting the continued demand for rehabilitation services in our community.

In addition, the new public cafeteria will be commissioned in August 2017 and is located within the new front entrance.

In October 2016, the Victorian Healthcare Association (VHA) presented an award to ERH in recognition of the building and environmental innovations that were included in the new and expanded Echuca Hospital.

PATIENT AND CLIENT ACTIVITY

A total of 11,138 hospital admissions occurred during the financial year which was 17% higher than the previous year. The specialities with the highest percentage growth were Surgical 11% and Medical 7%. The importance of our Emergency Department is demonstrated by the continued growth in its activity with a total of 20,689 presentations, a 8% increase on the previous year.

A detailed analysis of each departments activity is provided in a later section of this report.

LIFE GOVERNORSHIP AWARDS

At the 134th annual meeting held 7 November 2016 the board presented Life Governorships to two individuals, Mrs Judy Cook and Mrs Janet Whelan, who, in very different ways, have, what the Board has considered, made an outstanding contribution to our health service.

Mrs Janet Whelan commenced working at Echuca District Hospital on 2 January 1966. During her fifty years of employment at our health service, Janet worked in a number of areas including clinical nurse education, human resources and quality and safety.

Mrs Judy Cook was first appointed to the board in November 2001 and was a valued and respected contributor of the Board for 15 years, as well as serving periods on the ERH Board as both President (3 years) and Vice President. Mrs Cook did not seek re-appointment to the board after her 15 years' service.

VALE

The Board of Management, Executive and staff were saddened by the deaths of Mrs Mary McWhinney, highly respected former member of nursing staff and Dr Basil Bennett, former Medical Administrator/Geriatric Medical Officer.

PRESIDENT AND CHIEF EXECUTIVE REPORT

STRATEGIC PRIORITIES

The Board focus on two documents in advancing the Strategic Priorities of the Health Service, were namely;

The Annual Statement of Priorities agreed with the State Health Minister and the Health Services four year Strategic Plan that was adopted in August 2015.

The Board was particularly pleased with the strengthening of partnerships that had been achieved in the last twelve months. Examples include completion of the 'Campaspe Health Needs Analysis'. This analysis identified the following conditions as having the most significant impact on our community; Obesity, Mental Health; Cancer; Drug and Alcohol and Diabetes.

Importantly, coordinated strategies have now been implemented to address these five identified priorities.

In addition, ERH has provided 'Executive Leadership' to Cohuna District Hospital since 1 July 2016 and provided twice monthly operating theatre lists at Rochester Hospital.

Progress and outcomes of the objectives contained in the Strategic Plan and Statement of Priorities are detailed in a later section of this report.

QUALITY AND RISK

In 2016 the Department of Health and Human Services released a report titled "Targeting Zero; the review of Hospital Safety and Quality assurance in Victoria" (The Duckett Review). This report was commissioned by the State Government following the discovery of a cluster of potentially avoidable newborn and stillborn deaths at Djerriwarrh Health Service.

This review allowed the board of ERH to review the quality, safety and risks of the services we provide in consultation with our clinicians and consumers. It is pleasing to report that our clinical governance and risk minimization framework complies with current industry standards.

BOARD OF MANAGEMENT

In July 2016, the Board welcomed three new board Members namely; Suzanna Barry, Jillian Hamit and Shane Weller. These three individuals and their contributions to board deliberations have already proven integral and will continue throughout the course of the coming year.

Following three and a half years as Chair of the Board, Mrs Mary Boek stepped down from this role in December 2016. In light of the above, the Board then elected Mr Chris Bilkey as Board Chair.

QUALITY IMPROVEMENTS

Our commitment to continuous quality improvement by our dedicated and skilled staff has ensured that the health service has maintained full accreditation compliance for all services including:

- All Hospital and Primary Care Services; National Safety and Quality Health Service Standards
- Glanville Village Aged Care Service; Aged Care Standards Agency
- Medical Consulting Suites; Royal Australian College: General Practice Standards
- Home and Community Care (HACC) Services: Community Care Common Standards
- Family Services; Department of Human Services Standards

Our contracted services are also fully accredited:

- Goulburn Valley Imaging Group: National Safety and Quality Health Service Standards
- Goulburn Valley Health Pathology: Pathology National Association of Testing Authorities

PRESIDENT AND CHIEF EXECUTIVE REPORT

CONCLUSION

Once again ERH has received outstanding support from many groups and individuals who have donated time and money to help us deliver health services.

In particular, we wish to thank the 'Make your Mark' Committee, led by Neil Thomas; the Art Acquisition Advisory Group, led by Kerry Williams; the Seniors Advisory Group, led by Dennis King and the Victoria Police Blue Ribbon Foundation Echuca Branch led by Mark Urbaniak.

To all our staff, medical practitioners, volunteers and contractors we record our thanks for your contribution and support.

We continue to value and appreciate the ongoing support of the Department of Health and Human Services, our political representatives and local media.

The significant involvement and commitment of the ERH Board of Management members is acknowledged, greatly appreciated and highly valued.

In accordance with the *Financial Management Act 1994*, we are pleased to present the Report of Operations for Echuca Regional Health for the year ended 30 June 2017.

Mr Chris Bilkey
President
Echuca Regional Health
8 August 2017

Mr Michael Delahunty
Chief Executive
Echuca Regional Health
8 August 2017

OUR PROFILE

OUR SERVICES

- Aboriginal Liaison
- Alcohol and Other Drugs
- Ambulatory Services Unit
- Antenatal Classes
- Cardiac Rehabilitation Program
- Chemotherapy/Cancer Support Services
- Community Health Nursing
- Community Rehabilitation
- Complex Care
- Dental
- Diabetes Education
- Dietetics
- Discharge Planning
- District Nursing
- Education Department
- Emergency Department
- Finance
- Glanville Village Aged Care
- General Counselling
- Health Promotion
- Infection Prevention and Control
- Meals on Wheels
- Occupational Therapy
- Palliative Care
- Pathology
- Perioperative Unit
- Pharmacy
- Physiotherapy
- Podiatry
- Preoperative Clinic
- Primary Care Clinic
- Quality and Safety Unit
- Radiology
- Renal Dialysis Unit
- Social Services
- Speech Pathology
- Transition Care Program
- Volunteers
- Women's Health

OUR FACILITIES

ACUTE HOSPITAL FACILITIES

69 Acute Beds

- Haemodialysis
- High Dependency
- Medical
- Obstetric
- Paediatric
- Surgical

SUB - ACUTE HOSPITAL FACILITIES

24 Sub - Acute Beds

- Palliative Care
- Rehabilitation
- Geriatric Evaluation and Management

RESIDENTIAL AGED CARE

60 High Care Beds

SHORT STAY UNIT

6 Beds (4 currently operating)

OUR HISTORY

1882 First patient admitted to hospital
1890 New south wing of the hospital was built
1907 Operating Theatre, Nurses Home and Doctors' accommodation constructed
1925 Installation of the first x-ray plant
1938 Opening of Camray Ward
1962 Construction of Midwifery Unit - Rose Baker Wing
1965 Soldiers' Memorial Wing refurbished to geriatric ward
1968 The opening of Johnstone Wing
1970 Physiotherapy and Occupational Therapy services commenced
1975 Establishment of the new Day Hospital
1978 Lumeah Nursing Home opened
1993 Echuca District Hospital became Echuca Regional Health
1999 Completion of the Hopwood Centre (Primary Care)
2003 Glanville Village aged care service opened
2006 Opening of the Alan Henry Thrum Operating Theatre
2008 Official opening of the Community Rehabilitation Centre
2009 Commencement of Master Plan process for new hospital
2010 Feasibility study and schematic designs commenced
2011 $65.6 million secured for hospital redevelopment
2012 Construction commenced on the new and expanded Echuca hospital
2014 Official opening of the new Echuca hospital stage one
2015 Completion and official opening of stage two
2016 Installation of Magnetic Resonance Imaging (MRI)
2017 Opening of the Short Stay Unit and new ERH Public Café

07 STRATEGIC PRIORITIES

PRIORITY 1 – OUR SERVICES

The Strategic Plan (2015 – 2018) has five priorities:

1. Develop services
2. Develop our workforce
3. Further develop infrastructure
4. Strengthen our teaching role
5. Take a leadership role; develop enablers which include managing our finances for sustainability and growth and strengthening partnerships with key organisations.

STRATEGY	ACTION	OUTCOME
1.1. DEVELOP SERVICES TO MEET COMMUNITY NEEDS	1.1.1 Analyse service utilisation, needs and gaps from a sub-regional perspective and develop a new service plan	• A new service plan is scheduled to be completed by December 2017.
	1.1.2 Enhance the provision of services in community settings	• Increase the number of outreach services provided in the community. • Active involvement in the dairy support initiatives.
	1.1.3 Expand prevention and early intervention initiatives in collaboration with other providers	• Commencement of new GP with the Fellow of the Royal Australian College of General Practitioners and interest in sports medicine, four days per week.
1.2. REDESIGN SERVICES FOR EFFICIENCY AND QUALITY	1.2.1 Implement innovative models of care that are evidence-based and consumer-focused	• ERH has employed a prostate cancer support nurse and an additional medical oncologist.

PRIORITY 2 – OUR WORKFORCE

STRATEGY	ACTION	OUTCOME
2.1. DEVELOP SERVICES TO MEET COMMUNITY NEEDS	2.1.1 Implement an education and training framework that supports our staff to deliver quality services	• Practical Obstetric Multi-Professional Training continues. • 2017 Emergency Care Improvement Clinical Network project: early recognition and management of sepsis.
	2.1.2 Implement a framework that supports enhanced performance and creates a culture of clinical, service and operational excellence	• Leader Evaluation Manager system implemented for 'cascading ' CEO goals and monitoring actions to achieve at all levels of the organisation. • All teams have developed 'Above and Below the Line Behaviours' which aligns expected behaviours to ERH Values. • Leaders are further developing their skills in evolving and managing high performing teams.
2.2. IMPROVE THE SUSTAINABILITY OF OUR WORKFORCE	2.2.1 Continue to expand training opportunities	• DHHS funded Loddon Mallee Medical Training Pathways Coordinator appointed to strengthen regional training opportunities in procedural and emergency medicine. • VMO Continuing Professional Development; Partnering for Improved Patient Outcome meetings.
	2.2.2 Identify service areas where the employment of Aboriginal staff would support "Closing the Gap"	• Continued implementation of ERH's Aboriginal Employment Program. • Three trainees have been recruited through DHHS' Koolin Balit Aboriginal Employment program and we are soon to be recruiting a fourth trainee. • ERH has employed an Aboriginal apprentice cook in the Corporate Services department. • An Aboriginal Workforce Research Project is currently underway. The objective of the project is to enhance pathways for local Aboriginal people into education and employment opportunities in the Health Industry.
	2.2.3 Strengthen organisation-wide workforce plans to ensure optimal staffing and skill levels	• Workforce plans have been reviewed and implemented across most Divisions of ERH.
	2.2.4 Collaborate with regional partners to develop a strategy for supporting and retaining mature workers	• A Mature Aged Workers Toolkit has been developed and made available to Managers and employees. • A Mature Aged Workforce Project including a 'Transition to Retirement Program' is currently being developed and will be piloted in Glanville Village.

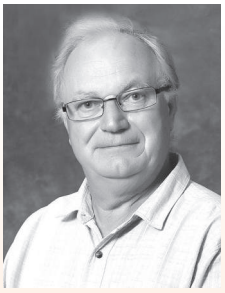
PRIORITY 3 – OUR INFRASTRUCTURE

STRATEGY	ACTION	OUTCOME
3.1. PROVIDE PHYSICAL AND TECHNOLOGICAL INFRASTRUCTURE TO SUPPORT QUALITY SERVICES	3.1.1 Undertake a post-occupancy evaluation of the new and expanded hospital	• ERH is the only rural health service participating in a DHHS environmental audit tool pilot to determine the impact of environment on patient outcomes.
	3.1.2 Develop a new master plan to replace the 2009 master plan	• Scheduled to occur between January and June 2018, at conclusion of service planning process.
	3.1.3 Maintain ageing infrastructure and prioritise sections for refurbishment prior to completion of new master plan	• Achieved
	3.1.4 Continue to upgrade the motor vehicle fleet and implement a new fleet management system	• Contract has been signed with VicFleet, the Victorian Government fleet management provider. VicFleet are currently waiting on legislative change to widen vehicle selection.
	3.1.5 Capture opportunities to use information technology and mobile devices effectively and efficiently	• ERH are actively working with the Loddon Mallee Rural Health Alliance (LMRHA) to develop a business case for Electronic Medical Records for the region.
3.2. HEALTH PRECINCT PLANNING	3.2.1 Work with Local Government to establish a health precinct around ERH	• This strategy will be further advanced as part of a new master plan in 2018.

PRIORITY 4 – OUR ROLE

STRATEGY	ACTION	OUTCOME
4.1. STRENGTHEN ERH'S COMMUNITY LEADERSHIP ROLE	4.1.1. Actively promote ERH's local and sub-regional role in the provision of services	• ERH has been providing Executive Leadership to Cohuna District Hospital Service 1st July 2016. • ERH undertaking Nurse Workforce Planning in partnership with Cohuna. • Clinician to Manager Leadership Program established at ERH with participants from 5 local health services. • ERH has been funded to be the lead agency for 4 other health services to roll out the Strengthening Hospitals Response to Family Violence initiative.
4.2. ENHANCE ERH'S ROLE AS A TEACHING HOSPITAL	4.2.1. Collaborate with other providers in sub-regional education, training and research	• Discussions have commenced with the University of Melbourne regarding Regional Training Hubs. • ERH has received funding for Allied Health training on behalf of a cluster of local services.

OUR BOARD OF MANAGEMENT

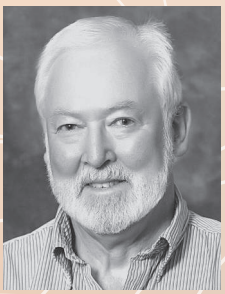


CHRIS BILKEY

PRESIDENT

MARY BOEK

SENIOR VICE PRESIDENT



JOHN QUIRK

JUNIOR VICE PRESIDENT

GREG DWYER

TREASURER

BOARD OF MANAGEMENT

The twelve (12) volunteer members of the Board of Management are responsible for setting the strategic direction of Echuca Regional Health within the framework of Government policy. The Board of Management oversee the quality of care provided, taking an active role in planning, monitoring and evaluation. Convening once a month, these meeting also incorporate Finance, Clinical Governance and Quality.

They are accountable for ensuring Echuca Regional Health:

- Is efficiently managed
- Provides high quality care and service delivery
- Meets the needs of the community
- Meets financial and non-financial performance targets

Members are appointed for a term by the Governor in Council on the recommendation of the Minister for Health.
They are required to declare a pecuniary interest when applicable, during Board debate and withdraw from proceedings.

CHRIS BILKEY

PRESIDENT

Appointed 1 July 2010

Attended 11/12 Board of Management Meetings

- Audit and Risk Committee
- History Display Committee

MARY BOEK

SENIOR VICE PRESIDENT

Appointed 1 November 2004

Attended 11/12 Board of Management meetings

- Glanville Project Control Group
- Asset Utilisation Committee
- Governance Committee
- Audit and Risk Committee
- History Display Committee
- Aboriginal Health Advisory Steering Committee

GREG DWYER

TREASURER

Appointed 1 July 2013

Attended 12/12 Board of Management Meetings

- Asset Utilisation Committee
- Audit and Risk Committee

JOHN QUIRK

JUNIOR VICE PRESIDENT

Appointed 1 July 2013

Attended 10/12 Board of Management Meetings

- Glanville Project Control Group
- Asset Utilisation Committee
- Governance Committee
- Audit and Risk Committee

OUR BOARD OF MANAGEMENT

SUZANNA BARRY

Appointed 1 July 2016

Attended 10/12 Board of Management Meetings

- Asset Utilisation Committee
- Governance Committee

JILLIAN HAMIT

Appointed 1 July 2016

Attended 11/12 Board of Management Meetings

- Governance Committee
- Audit and Risk Committee

GEOFF KELLY

Appointed 1 July 2014

Attended 10/12 Board of Management Meetings

- Glanville Project Control Group
- Asset Utilisation Committee
- Audit and Risk Committee
- History Display Committee

DIANNE MACFARLANE OAM

Appointed 16 October 1985

Attended 5/12 Board of Management Meetings

- Governance Committee
- Audit and Risk Committee

NICHOLAS ROLFE

Appointed 1 July 2014

Attended 7/12 Board of Management Meetings

- Governance Committee
- Audit and Risk Committee

BRIAN SHARP OAM

Appointed 1 July 2012

Attended 11/12 Board of Management Meetings

- Governance Committee
- Audit and Risk Committee

LARNA TARRANT

Appointed 1 July 2014

Attended 11/12 Board of Management Meetings

- Audit and Risk Committee

SHANE WELLER

Appointed 1 July 2016

Attended 10/12 Board of Management Meetings

- Asset Utilisation Committee
- Audit and Risk Committee

OUR BOARD COMMITTEES

AUDIT AND RISK COMMITTEE

The Audit and Risk Committee reports to and assists the Board in fulfilling its corporate governance and oversight responsibilities in relation to Echuca Regional Health's financial reporting, internal control structure, risk management systems, and the internal and external audit functions.

Four (4) meetings were held during the last financial year.

GOVERNANCE COMMITTEE

The Governance Committee makes recommendations to the Board on specific matters relating to Corporate Governance (eg review of By-Laws and Governance Policies), manage the process of recruitment and retirement/ resignation of Board members and oversee the induction of new Board members.

Two (2) meetings were held during the last financial year.

MEDICAL STAFF GROUP

The Medical Staff Group was chaired by Dr Sam Kennedy from February 2015 to February 2017, at which time Dr Kate Schultz then assumed the position of chair. It provides a forum for local medical practitioners and visiting specialists to advise and make recommendations to the Board of Management regarding clinical services and related matters.

Six (6) meetings were held during the last financial year.

ASSET UTILISATION

The role of the Asset Utilisation Committee is to identify priorities of remaining sections of the master plan requiring redevelopment that are not included in the current redevelopment project.

One (1) meeting was held during the last financial year.

CREDENTIALS, SCOPE OF CLINICAL PRACTICE AND APPOINTMENTS COMMITTEE FOR MEDICAL STAFF

The purpose of the Credentials, Scope of Clinical Practice and Appointments Committee for Medical Staff is to review credentials to ensure that only medical practitioners with appropriate qualifications, skills and experience are appointed to ERH and to recommend their scope of clinical practice to the Board of Management.

Two (2) meetings were held during the last financial year.

NEW ECHUCA HOSPITAL EQUIPMENT COMMITTEE ('MAKE YOUR MARK')

The purpose of the New Echuca Hospital Equipment Committee is to raise substantial funds to ensure the new Echuca hospital has the best and most technically advanced equipment, furniture and fittings.

Five (5) meetings were held during the last financial year.

ABORIGINAL HEALTH ADVISORY STEERING COMMITTEE

The Aboriginal Health Advisory Steering Committee was formed to assist in improving health outcomes for local Aboriginal and Torres Strait Islander people. Echuca Regional Health works closely with Njernda Aboriginal Corporation to offer leadership, plan services and provide resources to meet these needs.

One (1) meeting was held during the last financial year.

HISTORY DISPLAY COMMITTEE

A committee has been formed to oversee the establishment of an Echuca hospital history panel in the foyer of the hospital entrance in Service Street.

The display will be both static and electronic.

Three (3) meetings were held during the last financial year.

OUR ORGANISATIONAL STRUCTURE

BOARD OF MANAGEMENT

CHIEF EXECUTIVE

MICHAEL DELAHUNTY

Executive Director of Primary Care & Chief Allied Health Officer
MERRIN PRICTOR

- Alcohol and Other Drugs
- Allied Health Assistants
- Children's Allied Health
- Community Rehabilitation
- Dental
- Diabetes Education
- Dietetics
- Falls and Balance
- Family Services
- General Counselling
- Health Promotion
- Occupational Therapy
- Physiotherapy
- Podiatry
- Primary Care Reception
- Referral Centre
- Rural Health Academic Network
- Social Work
- Specialist Continence
- Speech Pathology
- Women's Health

Executive Director of Nursing & Chief Nursing Officer
JUNE DYSON

- Aboriginal Liaison
- Access and Demand
- Acute Inpatient Services
  - Medical
  - Surgical
  - High Dependency
  - Obstetric Paediatric
- After Hours Managers
- Community Nursing
  - Community Nursing
  - Community Palliative Care
  - Hospital in the Home
- Emergency
- Infection Prevention and Control
- Inpatient Rehabilitation
- In Reach and Post Acute Care
  - Complex Care
  - Residential In Reach
- Medical Day Procedure
  - Cancer Support
  - Chemotherapy
  - Oncology
  - Renal Dialysis
- Perioperative
  - Day Surgery
  - Operating Theatre
  - Theatre Liaison
- Quality and Safety
- Residential Aged Care

Executive Director of Medical Services & Chief Medical Officer
DR GLENN HOWLETT

- Medical Staff
  - Junior Medical Officers
  - Senior Medical Officers
  - Visiting Medical Officers
- Diagnostic Services
  - Medical Imaging
  - Pathology
- Education
- Medical Consulting Suites
- Medical Workforce Unit
- Medico-Legal
- Freedom of Information
- Pharmacy

Executive Director of Finance & Corporate Services
ROBYN RUDGE

- Accommodation Services
- Business Innovation and Design
- Catering and Public Cafeteria
- Cleaning
- Finance
- Health Information Services
- Information, Communication and Technology
- Facilities Management
- Fleet
- Front Office Reception
- Linen and Laundry
- Procurement and Supply
- Security
- Waste Management

Executive Director of Human Resources
JACKIE CLINGAN
VICKI WINWOOD (Acting)

- Employee Assistance
- Emergency Planning
- Human Resources
- Occupational, Health and Safety
- Work Cover
- Payroll
- Aboriginal Employment Plan
- Reconciliation Action Plan

EXECUTIVE ADMINISTRATION

OUR SENIOR OFFICERS

MICHAEL DELAHUNTY

CHIEF EXECUTIVE OFFICER

BEcon; GradDipHlthServMt; M.Bus (HlthServMgt); ACHSM; CPA; FAICD

The Chief Executive Officer is responsible to the Board of Management for the efficient and effective management of Echuca Regional Health. Key responsibilities include the development and implementation of operational plans, strategic planning, maximising service efficiency, quality improvement and minimisation of risk.

JUNE DYSON

EXECUTIVE DIRECTOR OF NURSING AND CHIEF NURSING OFFICER

RN, RM, BHlthSc, GradDipMgt (Bus)

The Executive Director of Nursing is responsible for nursing professional standards across all services and has operational responsibility for Acute Inpatient Services; Maternity, Emergency Department, HDU, Perioperative Services, Aboriginal Liaison, Glanville Village Aged Care, Community Nursing and Palliative Care, Medical Day Procedures, Renal Dialysis and After Hours Management. The Quality and Safety Unit is headed by the Deputy Director of Nursing and ensures quality standards are maintained and ERH continues to meet accreditation requirements for each service.

MERRIN PRICTOR

EXECUTIVE DIRECTOR OF PRIMARY CARE AND CHIEF ALLIED HEALTH OFFICER

B.Phty; Dip.Bus; M.Bus (Mgt); WCLP (05);MHlthandMedLaw; AFCHSM; AFAAQHC; MAICD

In addition to organisational wide executive responsibilities, the Executive Director of Primary Care leads a comprehensive range of allied health, community and primary care services. This includes Alcohol and Other Drugs, Children's Allied Health, Community Rehabilitation, Dental Services, Dietetic Services, Health Promotion, Occupational Therapy, Physiotherapy, Podiatry, Rural Health Academic Network, Social Services, Speech Pathology, and a range of support staff and project workers.

DR GLENN HOWLETT

EXECUTIVE DIRECTOR OF MEDICAL SERVICES AND CHIEF MEDICAL OFFICER

MB BS LLB; GradDipHlthServMt; FRACGP; AFRACMA

All medical staff report professionally to the Chief Medical Officer. The Executive Director of Medical Services portfolio also includes the Medical Workforce Unit, Medico-Legal Services (including Freedom of Information), Pharmacy, Education, Medical Consulting Suites, and the contracted services of Pathology and Medical Imaging.

ROBYN RUDGE

EXECUTIVE DIRECTOR OF FINANCE AND CORPORATE SERVICES, CHIEF PROCUREMENT AND FINANCIAL OFFICER

B.Comm, CPA

The Executive Director of Finance and Corporate Services is responsible for the day to day provision of non-clinical support services throughout the health service, including Finance and Governance, Information and Communication Technology, Engineering, Health Information Services, Food and Café Services, Fleet, Cleaning, Procurement and Supply, Environmental and Security Services.

JACKIE CLINGAN

(Commenced Parental Leave 17 April 2017)

BBusMgt; GradDipPsych

EXECUTIVE DIRECTOR OF HUMAN RESOURCES ECHUCA REGIONAL HEALTH, KERANG DISTRICT HEALTH AND COHUNA DISTRICT HOSPITAL

VICKI WINWOOD

(Commenced in role 17 April 2017)

ACTING EXECUTIVE DIRECTOR OF HUMAN RESOURCES

BBus HR

The Executive Director of Human Resources provides an internal service supporting people managers in workforce planning, recruitment and talent selection, on-boarding, employee engagement, performance development, change management and industrial relations matters. Human Resources is responsible for managing the ERH Payroll, Aboriginal employment plan, the Occupational Health and Safety function as well as WorkCover and strategic projects linked to these areas.

WORKFORCE DATA

Echuca Regional Health applies principles of merit and equity in recruitment, promotion, staff development, access to facilities and treatment of staff.

At the 30th June 2017 Echuca Regional Health had 651 paid Employees equating to 458.04 full time equivalent employees.

In addition approximately 134 volunteers support our patients, residents and visitors throughout the organisation.

LABOUR CATEGORY	JUNE Current Month FTE*		JUNE YTD FTE*	
	2017	2016	2017	2016
Hotel and Allied Services	88.02	85.44	89.18	83.98
Nursing	213.2	215	210.39	210.06
Allied Health	49.35	39.54	45.04	42.63
Medical Support	19.36	27.02	25.03	25.87
Admin & Clerical	65.44	61.55	62.3	58.39
Medical Officers	3.99	3.08	3.39	2.4
Hospital Medical Officer	16.64	18.58	18.62	18.46
Sessional Clinicians	2.04	2.42	2.08	2.37

MERIT AND EQUITY

Echuca Regional Health is an equal opportunity employer. Appointments are based on merit, without regard to race, gender, religious belief or any other factor not related to the pursuit of excellent patient care.

INDUSTRIAL RELATIONS

Echuca Regional Health had no industrial relations disputes during this year. We continue to work in collaboration with Unions and employee advocacy groups and have participated in enterprise bargaining through the VHIA for several key staff groups during the 2016-17 year.

HUMAN RESOURCES INITIATIVES

This year the Human Resources (HR) team has focused on streamlining HR processes and procedures across all areas of the organisation. This has included improving our recruitment and employment contract management; as well as strengthening policies and providing ongoing training in cultural diversity and mental health.

CARE Matters is a framework that supports enhanced performance and creates a culture of clinical, service and operational excellence, with the support of Studer Group Australia. As ERH services expand to meet community needs, it is essential that we provide development opportunities for all people managers to have the tools and capabilities to continue to build a sustainable and fulfilled workforce. ERH have entered a four year partnership with Studer Group Australia to embed CARE Matters as a culture of excellence across the organisation.

OCCUPATIONAL VIOLENCE STATISTICS	2016-17
1. Workcover accepted claims with an occupational violence cause per 100 FTE	0
2. Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	0
3. Number of occupational violence incidents reported	148
4. Number of occupational violence incidents reported per 100 FTE	32.31
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition	4.05%

DEFINITIONS

For the purposes of the above statistics the following definitions apply.

Occupational violence - any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment.

Incident - occupational health and safety incidents reported in the health service incident reporting system. Code Grey reporting is not included.

Accepted Workcover claims – Accepted Workcover claims that were lodged in 2016-17.

Lost time – is defined as greater than one day.

FTE figures required in the above table should be calculated consistent with the Workforce information FTE calculation. These do not include contracted staff (e.g. Agency nurses, Fee-for-Service Visiting Medical Officers) who are not regarded as employees for this purpose.

FINANCIAL AND SERVICE PERFORMANCE

SUMMARY OF FINANCIAL RESULTS FOR THE YEAR ENDED

	2017 $000	2016 $000	2015 $000	2014 $000	2013 $000
OPERATING STATEMENT					
Revenue excluding capital purpose income	66,915	61,595	55,963	51,372	48,795
Expenses excluding depreciation	(66,392)	(61,061)	(56,235)	(51,338)	(49,069)
Net result before capital and depreciation	523	534	(272)	34	(274)
Capital purpose income	1,500	528	2,222	31,916	11,986
Impairment of Non-Financial Assets	(16)	58	-	(527)	-
Depreciation	(5,278)	(5,629)	(3,308)	(4,160)	(4,757)
Net result for the year	(3,271)	(4,509)	(1,358)	27,263	6,955
BALANCE SHEET					
Total Assets	101,968	104,769	103,747	92,967	62,266
Total Liabilities	(19,742)	(19,532)	(17,094)	(15,822)	(14,369)
Net Assets/Total Equity	82,226	85,237	86,653	77,145	47,897

PERFORMANCE STATISTICS

ADMITTED INPATIENT ACTIVITY	2016/2017	2015/2016	2014/2015	2013/2014	2012/2013
ACUTE ADMISSIONS					
Surgical	3,991	3,067	3,155	3,112	3,065
Medical	3,533	3,490	3,149	2,712	2,505
Renal Dialysis	1,501	1,618	1,798	1,722	1,566
Chemotherapy	894	897	724	510	414
Obstetrics	838	725	534	588	610
Total Acute Admissions	10,757	9,797	9,360	8,644	8,160

SUB-ACUTE ADMISSIONS	2016/2017	2015/2016	2014/2015	2013/2014	2012/2013
Geriatric Management and Evaluation	74	89	33	-	-
Rehabilitation	242	208	97	-	-
Palliative Care	65	64	55	-	-
TOTAL SUB-ACUTE ADMISSIONS	381	361	185	-	-
Babies Born	330	389	305	322	350
Theatre Procedures	3,870	3,542	3,610	4,329	3,690

OCCASIONS OF SERVICE

OCCASIONS OF SERVICE	2016/2017	2015/2016	2014/2015
Emergency Department Presentations	20,691	19,041	18,099
Acute Bed Days	20,862	19,619	19,551
Sub-Acute Bed Days	5,685	5,447	2,823
Aged Care Bed Days	21,103	21,395	22,748
Transition Care Bed Days	4,025	4,206	4,421
Medical Suites Consultations	17,650	18,082	21,909

NURSING COMMUNITY BASED SERVICES	2016/2017	2015/2016	2014/2015
Community Nursing	9,729	8,826	8,985
Homecare Midwifery Services	433	473	446
Complex Care	1,609	1,527	1,376
Palliative Care	4,189	3,409	2,428
Post-Acute Care	4,972	5,324	4,121
Residential In Reach	519	802	591
Hospital in the Home	1,016	1,097	818
Total Nursing Community Based Contacts	22,467	21,458	18,765

ALLIED HEALTH SERVICES	2016/2017	2015/2016	2014/2015
Aboriginal Liaison	376	257	228
Alcohol and Other Drugs	483	927	477
Community Rehabilitation	9,576	9,031	8,580
Counselling	4,815	4,955	3,218
Dental Services	5,937	7,006	7,319
Diabetes Education	289	378	425
Dietetic Services	692	702	777
Occupational Therapy	523	1,463	2,639
Physiotherapy	1,998	2,518	2,733
Podiatry	939	848	1,048
Speech Pathology	1,050	1,097	1,188
Women's Health	318	366	586
Total Allied Health Contacts	26,996	29,548	29,218
Total Occasions of Service	**139,479**	**138,796**	**137,534**

An increase in total acute admissions and occasions of service was experienced this year.

STATEMENT OF PRIORITIES - PART A

The Statement of Priorities, under the *Health Services Act 1988*, is an annual accountability agreement between Victorian public healthcare services and the Minister for Health. They outline the key performance expectations, targets and funding for the year as well as government service priorities.

In 2016-17 Echuca Regional Health contributed to the achievement of these priorities by:

DOMAIN – QUALITY AND SAFETY		
ACTION	**DELIVERABLES**	**OUTCOME**
Implement systems and processes to recognise and support person-centred end of life care in all settings, with a focus on providing support for people who choose to die at home.	Develop a formal policy and processes that outline the key principles underpinning a palliative approach to end of life care by February 2017.	• Completed - Palliative Care Policy and Procedure updated to include WHO definition and key principles and identifies the program of staff education available to all ERH staff.
Advance care planning is included as a parameter in an assessment of outcomes including: mortality and morbidity review reports, patient experience and routine data collection.	Develop a process that ensures advanced care planning status is recorded on admission by November 2016.	• Completed – Any patients with an advanced care plan, Medical Power of Attorney, or substitute decision maker are identified on admission and flagged via various documents and the alert system on the patient administration system. Palliative Care nurses' document advanced care plan status for all Community Palliative Care patients enrolled in the program.
Progress implementation of a whole-of- hospital model for responding to family violence.	Partner with Bendigo Health to implement Strengthening Hospital Responses to Family Violence initiative by 30 June 2017.	• Working Party implemented at ERH. • Highly successful health providers forum held at ERH with Rosie Battie as keynote speaker. • Training provided to ERH staff by Bendigo Health as part of the Strengthening Hospital Responses to Family Violence initiative
Develop a regional leadership culture that fosters multidisciplinary and multi- organisational collaboration to promote learning and the provision of safe, quality care across rural and regional Victoria.	Sign Memorandum of Understanding with other health services in Loddon Mallee Region by December 2016 to establish regional Clinical Governance committee. Collaborate with other agencies in the delivery of Healthier Campaspe integrated service plan. Finalise implementation strategies for elements of the plan led by Echuca Regional Health by December 2016.	• Completed with MOU being signed in July,2017. • ERH has the lead for Priority 3 – cancer services as part of the Healthier Campaspe initiative. Implementation strategies have been refined and agreed. • Funding has been secured for project worker and implementation strategies.

STATEMENT OF PRIORITIES - PART A

DOMAIN – QUALITY AND SAFETY		
ACTION	**DELIVERABLES**	**OUTCOME**
Establish a foetal surveillance competency policy and associated procedures for all staff providing maternity care that includes the minimum training requirements, safe staffing arrangements and ongoing compliance monitoring arrangements.	Review Foetal Surveillance Education Program policy and process to ensure full compliance with minimum training requirements by February 2017.	• Completed - Foetal surveillance program reviewed and the policy updated to reflect minimum training requirements. Midwives are now fully compliant with minimum training requirements.
Use patient feedback, including the Victorian Healthcare Experience Survey to drive improved health outcomes and experiences through a strong focus on person and family centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first.	Establish mechanisms for Victorian Healthcare Experience Survey data to be used by key clinical committees as a means of informing practice improvement by March 2017.	• Completed - VHES results are now reviewed at all relevant standards committees and strategies to improve performance identified and monitored.
Develop a whole of hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint.	Review restraint policy to ensure least restricted practices are identified by October 2016.	• Completed - Policy reviewed and updated
Ensure the development and implementation of a plan in specialist clinics to: (1) optimise referral management processes and improve patient flow through to ensure patients are seen in turn and within time; and (2) ensure patient data is recorded in a timely, accurate manner and is working toward meeting the requirements of the Victorian Integrated Non-Admitted Health dataset.	Review referral processes, patient flow and accuracy of patient data in the specialist clinics compared to the requirements of Victorian Integrated Non- Admitted Health by December 2016.	• Referral process reviewed, with new specialists triaging referrals to identify urgency of appointments
Ensure the implementation of a range of strategies (including processes and service models) to improve patient flow, transfer times and efficiency in the emergency department, with particular focus on patients who did not wait for treatment and/or patients that re-presented within 48 hours.	Review Emergency Department data regarding people who have an unplanned representation and did not wait for treatment to identify and address any system and practice issues by December 2016.	• Short Stay Unit (SSU) opened to improve patient flow.

STATEMENT OF PRIORITIES - PART A

DOMAIN – SUPPORTING HEALTHY POPULATIONS		
ACTION	**DELIVERABLES**	**OUTCOME**
Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine).	Trial new telehealth activities, for example neuropsychology, to prevent tertiary referrals by March 2017.	• Neuropsychology telemedicine service has been in place for the 2017 year. Funded as a project until October 2017. This targets patients who have suffered a stroke and are receiving care in our inpatient rehabilitation ward.
Develop and implement a strategy to ensure the preparedness of the organisation for the National Disability and Insurance Scheme and Home and Community Care program transition and reform, with particular consideration to service access, service expectations, workforce and financial management.	Board to endorse a detailed plan to meet the challenges and access the opportunities that Home and Community Care and National Disability Insurance Scheme reform provide by May 2017.	• A detailed plan was presented and endorsed at the April 2017 ERH Board meeting.
Support shared population health and wellbeing planning at a local level - aligning with the Local Government Municipal Public Health and Wellbeing plan and working with other local agencies and Primary Health Networks.	In partnership with other health services in Campaspe Shire implement agreed actions of the Healthier Campaspe integrated service plan addressing identified priority areas of obesity, cancer, diabetes, mental health and alcohol and other drugs by June 2017.	• Progressing as scheduled. A number of the implementation strategies are funding dependent
Focus on primary prevention, including suicide prevention activities, and aim to impact on large numbers of people in the places where they spend their time adopting a place based, whole of population approach to tackle the multiple risk factors of poor health.	In partnership with other health services in Campaspe Shire implement agreed actions of the Healthier Campaspe integrated service plan addressing identified priority areas of obesity, cancer, diabetes, mental health and alcohol and other drugs by June 2017.	• Progressing as scheduled. A number of the implementation strategies are funding dependent
Develop and implement strategies that encourage cultural diversity such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.	Develop Echuca Regional Health's Reconciliation Action Plan with Reconciliation Australia by June 2017.	• Aboriginal Employment Plan endorsed with support of local community. • Signed Algabonyah Partnership Agreement in place. • Reconciliation Action Plan currently under development.

STATEMENT OF PRIORITIES - PART A

Improve the health outcomes of Aboriginal and Torres Strait Islander people by establishing culturally safe practices which recognise and respect their cultural identities and safely meets their needs, expectations and rights.	Ensure cultural safety training for all direct care staff is undertaken annually by June 2017.	• Aboriginal Employment Officer appointed. • 'Share our Pride' learning module included in the e-learning program for all ERH staff. • Managers supported to undertake face to face Cultural Awareness Training. Four managers have completed Cultural Awareness Training during 2017. • ERH ALO awarded the University of Sydney Rowan Nicks Russell Drysdale Fellowship to undertake research during 2017 on "How can ERH support Aboriginal and Torres Strait Islander people to seek a career at ERH?"
Drive improvements to Victoria's mental health system through focus and engagement in activity delivering on the 10 Year Plan for Mental Health and active input into consultations on the Design, Service and infrastructure Plan for Victoria's Clinical mental health system.	In collaboration with Bendigo Health, develop a suicide risk assessment tool for patients awaiting formal assessment by Bendigo Health mental health clinicians by April 2017.	• Suicide risk assessment tool developed and implemented in collaboration with Bendigo Mental Health.
Using the Government's Rainbow eQuality Guide, identify and adopt 'actions for inclusive practices' and be more responsive to the health and wellbeing of lesbian, gay, bisexual, transgender and intersex individuals and communities.	Develop and implement an inclusive care policy that makes direct reference to people who are lesbian, gay, bisexual, transgender, transsexual or intersexed by December 2016.	• Poster identifying ERH support for cultural and gender diversity developed and displayed.

DOMAIN – GOVERNANCE AND LEADERSHIP

ACTION	DELIVERABLES	OUTCOME
Demonstrate implementation of the Victorian Clinical Governance Policy Framework: Governance for the provision of safe, quality healthcare at each level of the organisation, with clearly documented and understood roles and responsibilities.	Sign Memorandum of Understanding with other health services in Loddon Mallee Region by December 2016 to establish regional Clinical Governance committee.	• Completed with MOU being signed in July,2017.

STATEMENT OF PRIORITIES - PART A

DOMAIN – GOVERNANCE AND LEADERSHIP		
ACTION	**DELIVERABLES**	**OUTCOME**
Ensure effective integrated systems, processes and leadership are in place to support the provision of safe, quality, accountable and person centred healthcare. It is an expectation that health services implement to best meet their employees' and community's needs, and that clinical governance arrangements undergo frequent and formal review, evaluation and amendment to drive continuous improvement.	Review Echuca Regional Health Clinical Governance framework and related systems in response to recommendations of the statewide quality and safety review by May 2017.	• Visiting specialists are facilitating clinical audit meetings in surgery, obstetrics, medicine, anaesthetics, emergency medicine. • ERH participating in the Loddon Mallee Regional Maternal and Perinatal Mortality and Morbidity Committee meetings • Maternity and Newborn capability self-assessments undertaken.
Contribute to the development and implementation of Local Region Action Plans under the series of statewide design, service and infrastructure plans being progressively released from 2016 Development of Local Region Action Plans will require partnerships and active collaboration across regions to ensure plans meet both regional and local service needs, as articulated in the statewide design, service and infrastructure plans.	Participate in Regional Leadership Forum involving Chief Executives of each public health service in Loddon Mallee Region established by December 2016. Leadership Forum to develop Local Region Action Plans in response to statewide design, service and infrastructure plans as they are published by the Department of Health and Human Services.	• ERH CEO has participated in Regional Leadership forums and contributed to developing local region action plans.
Ensure that an anti-bullying and harassment policy exists and includes the identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal and the policy specifies a regular review schedule.	Review existing Anti-Bullying and Harassment and Grievance policies and include Care Matters principles by December 2016. Implement above and below the line behaviours across the organisation by September 2016.	• Bullying, Harassment and Discrimination Policy implemented. • All new staff trained at orientation. • All teams completed face to face bullying training including the Care Matters tactic – 'Calling Above and Below the Line Behaviours' during 2016/17. • Bullying Contact Officer network extended (Four new Contact Officers appointed). Contact Officers have undertaken refresher training.

STATEMENT OF PRIORITIES - PART A

Board and senior management ensure that an organisational wide occupational health and safety risk management approach is in place which includes: (1) A focus on prevention and the strategies used to manage risks, including the regular review of these controls; (2) Strategies to improve reporting of occupational health and safety incidents, risks and controls, with a particular focus on prevention of occupational violence and bullying and harassment, throughout all levels of the organisation, including to the board; and (3) Mechanisms for consulting with, debriefing and communicating with all staff regarding outcomes of investigations and controls following occupational violence and bullying and harassment incidents.	Implementation of recommendations from 'Our Pathway to Change: Eliminating bullying and harassment in healthcare' by February 2017, including expansion of our Contact Officer network and embedding behaviours aligned with Echuca Regional Health values through Care Matters activities.	• Consultation Policy implemented. Consultation framework in place including defined Designated Work Groups and Health and Safety Representatives (HSR's). All HSR's complete refresher training annually. • Hazard Identification and Incident Reporting policies implemented. • Environmental policy implemented and inspection program in place. • Incident reported to the OH&S Committee monthly (Executive representation) and to the Executive/Board through the quarterly ERH KPI report. • Bullying Contact Officer Network extended (four additional Contact Officers appointed. All Contact Officers complete refresher training annual. • Bullying training (including Above and Below the line behaviours) delivered to all teams during 16/17. • Occupational Violence (OV) Action Plan developed and endorsed (includes OV training). • Emergency Planning Committee established. Emergency Plan and Policies implemented.
Implement and monitor workforce plans that: improve industrial relations; promote a learning culture; align with the Best Practice Clinical Learning Environment Framework; promote effective succession planning; increase employment opportunities for Aboriginal and Torres Strait Islander people; ensure the workforce is appropriately qualified and skilled; and support the delivery of high-quality and safe person centred care.	Finalise an Aboriginal Employment Plan 2016-2019 by September 2016 and commence implementation. Develop and deliver a medical engagement and collaboration strategy by June 2017, inclusive of medical workforce strategy.	• Aboriginal Employment Plan endorsed with the support of community organisations. Implementation commenced. • Three trainees employed. Recruitment of fourth trainee underway. • Clinical engagement includes Medical Staff Group meetings and individual VMO Partnering for Improved Patient Outcome meetings, focusing on skills and training to support scope of clinical practice

STATEMENT OF PRIORITIES - PART A

DOMAIN – GOVERNANCE AND LEADERSHIP		
ACTION	**DELIVERABLES**	**OUTCOME**
Create a workforce culture that: (1) includes staff in decision making; (2) promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and (3) includes consumers and the community.	Partner with Studer Group Australia to implement Care Matters as a framework that supports enhanced performance and creates a culture of clinical, service and operational excellence by June 2017.	• Through our partnership with the Studer Group, we continue to implement the Care Matters program. Tools and tactics used to improve culture such as 'Calling Above and Below the line behaviours' have been implemented. In addition we have implemented leader rounding and Traffic Light Reports which have resulted in improved communication and decision making. • Implementation of the Leader Evaluation System is currently underway. Organisational goals have been developed and cascaded to managers and staff to be monitored through 'Monthly Accountability Meetings'.
Ensure that the Victorian Child Safe Standards are embedded in everyday thinking and practice to better protect children from abuse, which includes the implementation of: strategies to embed an organisational culture of child safety; a child safe policy or statement of commitment to child safety; a code of conduct that establishes clear expectations for appropriate behaviour with children; screening, supervision, training and other human resources practices that reduce the risk of child abuse; processes for responding to and reporting suspected abuse of children; strategies to identify and reduce or remove the risk of abuse and strategies to promote the participation and empowerment of children.	Implement staff education and awareness raising to promote compliance with the Child Safe Standards by April 2017.	• A detailed review of compliance with the Child Safe Standards has been undertaken.

STATEMENT OF PRIORITIES - PART A

DOMAIN – FINANCIAL SUSTAINABILITY		
ACTION	**DELIVERABLES**	**OUTCOME**
Implement policies and procedures to ensure patient facing staff have access to vaccination programs and are appropriately vaccinated and/ or immunised to protect staff and prevent the transmission of infection to susceptible patients or people in their care.	Review staff immunisation policy and process to identify improvement strategies by June 2017.	• Completed - Healthcare Worker Immunisation Policy and procedure reviewed. Additional nurse immunisers trained and immunisation offered on-site in the key clinical areas resulting in an increase in the rate of immunisation amongst direct care staff.
Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	Develop a cash management plan to improve long term cash sustainability by May 2017.	• Completed – Financial Management Strategy (including 5 year projections) presented to the Board of Management; 4 May 2017.
Actively contribute to the implementation of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measureable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling.	Develop an environmental Sustainability Plan that harnesses the strategic power of sustainability. Particular focus to be given to sustainability opportunities in energy, water, supply chain, waster, commissioning by March 2017.	• Completed – adopted by Staff Executive March 2017 and will be rolled out across ERH in 2017/18.

27 ADDITIONAL INFORMATION (FRD 22H)

Consistent with FRD 22H the Report of Operations, details in respect of the items listed below have been retained by Echuca 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;

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

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

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

(e) 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;

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

(g) 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;

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

(i) 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;

(j) 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;

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

DATAVIC

I, Michael Bernard Delahunty, certify that Echuca Regional Health in has complied with the DataVic Access Policy issued by the Victorian Government in 2012, the information all data tables included in this Annual Report will be available at http://www.data.vic.gov.au/ in machine readable format.

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

I, Michael Bernard Delahunty, certify that Echuca Regional Health has complied with Ministerial Direction 3.7.1 – Risk Management Framework and Processes. The Echuca Regional Health Audit and Risk Committee has verified this.

ATTESTATION ON COMPLIANCE WITH THE CARERS RECOGNITION ACT 2012

I, Michael Bernard Delahunty, certify that Echuca Regional Health takes all practicable measures to ensure that its employees and agents have an awareness and understanding of the care relationship principles. All practical measures are taken to ensure that persons who are in care relationships and who are receiving services in relation to the care relationship from Echuca Regional Health have an awareness and understanding of the care relationship principles. Echuca Regional Health and its employees and agents take all practical measures to reflect the care relationship principles in developing, providing or evaluating support and assistance for persons in care relationships.

ATTESTATION WITH HEALTH PURCHASING VICTORIA (HPV)

I, Michael Bernard Delahunty, certify that Echuca 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.

Mr Michael Delahunty

Accountable Officer

Echuca Regional Health

8 August 2017

COMPLIANCE

OCCUPATIONAL HEALTH AND SAFETY

Occupational Health and Safety (OHandS) continues to be a high priority for Echuca Regional Health who is committed to supporting a culture that proactively works to identify, assess and either eliminate or reduce health and safety risks in the workplace.

Echuca Regional Health complies with the *Occupational Health and Safety Act 2004* and there were no serious incidents during the last financial year that required reporting to Worksafe under Part 5 of the *Occupational Health and Safety Act 2004*.

FIRE AUDIT COMPLIANCE

Echuca Regional Health and Glanville Village aged care facility maintain current Fire Audits.

PROTECTED DISCLOSURES

Echuca Regional Health has policies and guidelines in place which comply with the *Protected Disclosure Act 2012* to protect people against action that might be taken against them if they choose to make a protected disclosure. No disclosures have been made.

REGULATIONS

The current regulations administered by Echuca Regional Health are contained in the Constitution, Objects and Bylaws of Echuca Regional Health Inc dated 7 December 2006. These Bylaws were developed by the Board of Management in accordance with the Department of Human Services Model Bylaws and subsequently approved by that authority.

FREEDOM OF INFORMATION

In accordance with the *Freedom of Information Act 1982*, requests for information are processed in accordance with the legislation.

In 2016/2017, 146 formal requests were processed under FOI.

CONTRACTS – VICTORIAN INDUSTRY PARTICIPATION POLICY ACT 2003

Echuca Regional Health abides by the principles of the *Victorian Industry Participation Policy Act 2003* (VIPP). During the financial year ended 30 June 2016 there were no regional projects were commenced to which the VIPP applies.

CONSULTANCIES

There were no consultants engaged during the year costing in excess of $10,000 per consultancy. There were no consultants engaged during the financial year ended 30 June 2017 whose fees were less than $10,000.

ICT EXPENDITURE

ICT Business As Usual (BAU) expenditure (excluding GST)		$1,535,564
ICT Non-Business As Usual expenditure (excluding GST)	Operational Expenditure	$0
	Capital Expenditure	$6,033
Total NON-BAU ICT Expenditure (ex GST)		$6,033

BUILDING AND MAINTENANCE

Echuca Regional Health complies with the *Building Act 1993*.

COMPETITIVE NEUTRALITY

Echuca Regional Health complies with National Competition Policy, including compliance with the requirements of the policy statement 'Competitive Neutrality Policy Victoria'.

PRIVACY

Echuca Regional Health is committed to the protection of privacy of information for all patients, residents, clients and staff.

SAFE PATIENT CARE

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

ENVIRONMENTAL PERFORMANCE

Echuca Regional Health is committed to protecting the environment. When developing changes or making improvements, consideration is given to conserving energy and water, reducing greenhouse emissions and improving waste management.

Increase usage of electricity, gas and water is indicative of the new and expanded Echuca hospital.

ELECTRICITY	2016/2017	2015/2016	2014/2015	2013/2014
Peak kWh	1,926,470	1,969,411	1,988,252	1,702,525
Off Peak KWh	1,878,957	1,888,826	1,687,758	1,241,495

GAS	2016/2017	2015/2016	2014/2015	2013/2014
Mj	26,915,570	27,466,450	30,412,354	25,137,796

WATER	2016/2017	2015/2016	2014/2015	2013/2014
kL	32,540	43,519	34,127	28,535
Recycled kL	15,859	11,124	6,448	7,190

ECHUCA REGIONAL HEALTH FLEET VEHICLES

Echuca Regional Health currently has a total of 24 active fleet cars, together with one commuter bus, a truck, one utility and a community nursing vehicle, bringing the total number of fleet vehicles to 28.

During the last financial year ERH purchased 37,238 litres of petrol. Total CHG gas emissions averaged 7.07 tonnes per month.

DISCLOSURE INDEX

DISCLOSURE INDEX

The Annual Report of Echuca 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 REFERENCE
MINISTERIAL DIRECTIONS		
REPORT OF OPERATIONS		
CHARTER AND PURPOSE		
FRD 22H	Manner of establishment and the relevant Ministers	2
FRD 22H	Purpose, functions, powers and duties	2
FRD 22H	Initiatives and key achievements	3
FRD 22H	Nature and range of services provided	6
MANAGEMENT AND STRUCTURE		
FRD 22H	Organisational structure	14
FINANCIAL AND OTHER INFORMATION		
FRD 10A	Disclosure index	31
FRD 11A	Disclosure of ex-gratia expenses	NONE
FRD 21C	Responsible person and Executive Officer disclosures	FINANCIAL REPORT
FRD 22H	Application and operation of *Protected Disclosure 2012*	29
FRD 22H	Application and operation of *Carers Recognition Act 2012*	28
FRD 22H	Application and operation of *Freedom of Information Act 1982*	29
FRD 22H	Compliance with *building and maintenance provisions of Building Act 1993*	30
FRD 22H	Details of consultancies over $10,000	29
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FRD 22H	Employment and conduct principles	16
FRD 22H	Information and Communication Technology Expenditure	29
FRD 22H	Major changes or factors affecting performance	17
FRD 22H	Occupational violence	16
FRD 22H	Operational and budgetary objectives and performance against objectives	17
FRD 24C	Reporting of office based environmental impacts	30
FRD 22H	Significant changes in financial position during the year	FINANCIAL REPORT
FRD 22H	Statement on National Competition Policy	30
FRD 22H	Subsequent events	FINANCIAL REPORT
FRD 22H	Summary of the financial results for the year	FINANCIAL REPORT
FRD 22H	Additional information available on request	27
FRD 22H	Workforce Data Disclosures including a statement on the application of employment and conduct principles	16

DISCLOSURE INDEX

LEGISLATION REQUIREMENT		PAGE REFERENCE
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FRD 103F	Non-Financial Physical Assets	FINANCIAL REPORT
FRD 110A	Cash flow Statements	FINANCIAL REPORT
FRD 112A	Defined Benefit Superannuation Obligations	FINANCIAL REPORT
SD 5.2.3	Declaration in report of operations	3
SD 3.7.1	Risk management framework and processes	28
OTHER REQUIREMENTS UNDER STANDING DIRECTIONS 5.2		**PAGE REFERENCE**
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		**PAGE REFERENCE**
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ACKNOWLEDGEMENTS

The Annual Report was compiled by the Executive Administration Team with the support of numerous Echuca Regional Health staff of who we'd like to thank for their assistance and involvement in the production of this Report.

FINANCIAL REPORT

The Financial Report which forms part of this Annual Report can be found attached. If the Financial Report is not attached a copy can be obtained from www.erh.org.au

SUGGESTIONS AND PUBLICATIONS

This Report has been designed to be both informative and easy to read. Suggestions on ways to improve our Annual Report or requests to obtain copies of this report or other publications on services Echuca Regional Health provide; can be forwarded to Echuca Regional Health, 226 Service Street, Echuca 3564 or via email enquiries@erh.org.au (03) 5485 5000.

Information is also available on the Echuca Regional Health web site www.erh.org.au.

PRINTING AND PRODUCTION

Colour It Creative Designs, PO Box 2100, Echuca Vic 3564
T: 0407 568 651

ANNUAL FINANCIAL REPORT CONTENTS

PART B: PERFORMANCE PRIORITIES

QUALITY AND SAFETY		
KEY PERFORMANCE INDICATOR	**TARGET**	**ACTUAL 2016/17**
ACCREDITATION		
Compliance with NSQHS Standards accreditation	Full compliance	Full compliance
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Full compliance
INFECTION PREVENTION AND CONTROL		
Compliance with cleaning standards	Full compliance	Full compliance
Submission of infection surveillance data to VICNISS	Full compliance	Full compliance
Compliance with the Hand Hygiene Australia program	80%	86%
Percentage of healthcare workers immunised for influenza	75%	77%
PATIENT EXPERIENCE		
Victorian Healthcare Experience Survey - data submission	Full compliance	Full compliance
Victorian Healthcare Experience Survey – patient experience Quarter 1	95% positive experience	97%
Victorian Healthcare Experience Survey – patient experience Quarter 2	95% positive experience	97%
Victorian Healthcare Experience Survey – patient experience Quarter 3	95% positive experience	94%
Victorian Healthcare Experience Survey – discharge care Quarter 1	75% very positive response	85%
Victorian Healthcare Experience Survey – discharge care Quarter 2	75% very positive response	85%
Victorian Healthcare Experience Survey – discharge care Quarter 3	75% very positive response	85%
	GOVERNANCE AND LEADERSHIP	
KEY PERFORMANCE INDICATOR	**TARGET**	**ACTUAL 2016/17**
People Matter Survey - percentage of staff with a positive response to safety culture questions	80%	78%

PART B: PERFORMANCE PRIORITIES

ACCESS AND TIMELINESS		
KEY PERFORMANCE INDICATOR	TARGET	ACTUAL 2016/17
EMERGENCY CARE		
Percentage of ambulance patients transferred within 40 minutes	90%	95%
Percentage of Triage Category 1 emergency patients seen immediately	100%	100%
Percentage of Triage Category 1 to 5 emergency patients seen within clinically recommended times	80%	77%
Percentage of emergency patients with a length of stay less than four hours	81%	82%
Number of patients with a length of stay in the emergency department greater than 24 hours	0	0
SPECIALIST CLINICS		
Percentage of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days	100%	N/A
Percentage of routine patients referred by GP or external specialist who attended a first appointment within 365 days	90%	N/A

FINANCIAL SUSTAINABILITY		
KEY PERFORMANCE INDICATOR	TARGET	ACTUAL 2016/17
FINANCE		
Operating result ($m)	0.16M	0.52M
Trade creditors	60 days	61
Patient fee debtors	60 days	49
Public & private WIES performance to target	100%	102%
Adjusted current asset ratio	0.7	0.40
Number of days with available cash	14 days	3.6
ASSET MANAGEMENT		
Basic asset management plan	Full compliance	Full compliance

PART C: ACTIVITY AND FUNDING

FUNDING TYPE	2016-17 ACTIVITY ACHIEVEMENT
ACUTE ADMITTED	
WIES DVA	154.47
WIES Private	1214
WIES Public	4624.8
WIES TAC	20.19
ACUTE NON-ADMITTED	
Emergency Services	20691
AGED CARE	
HACC	11,894
Residential Aged Care	21,103
SUBACUTE AND NON-ACUTE ADMITTED	
Subacute WIES - GEM Private	3
Subacute WIES - GEM Public	64.1
Subacute WIES - Palliative Care Private	4.0
Subacute WIES - Palliative Care Public	32.4
Subacute WIES - Rehabilitation Private	41.8
Subacute WIES - Rehabilitation Public	175.5
Subacute WIES - DVA	16.3
SUBACUTE NON-ADMITTED	
Health Independence Program - DVA	0
Health Independence Program - Public	16,676
Palliative Care Non-admitted	0
PRIMARY HEALTH	
Community Health / Primary Care Programs	21,752
Community Health Other - Dental	6481
OTHER	
Health Workforce	45

Echuca Regional Health

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

The attached Financial Statements for Echuca Regional Health have been prepared in accordance with Direction 5.2 Direction 5.2 of the Standing Directions of the Minister for Finance under the Financial Management Act 1994, applicable Financial Reporting Directions, Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements.

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

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

We authorise the attached Financial Statements for issue on this day.

C. Bilkey
Board Chair

Echuca
23/08/2017

M B Delahunty
Chief Executive Officer

Echuca
23/08/2017

R Rudge
Chief Finance and Accounting Officer

Echuca
23/08/2017

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Echuca Regional Health

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

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
24 August 2017

Ron Mak
as delegate for the Auditor-General of Victoria

ECHUCA REGIONAL HEALTH

COMPREHENSIVE OPERATING STATEMENT

FOR THE YEAR ENDED 30 JUNE 2017

	Note	2017 $000	2016 $000
Revenue from Operating Activities	2.1	**66,564**	61,489
Revenue from Non-operating Activities	2.1	**351**	106
Employee Expenses	3.1	**(42,716)**	(40,360)
Non Salary Labour Costs	3.1	**(5,308)**	(4,900)
Supplies & Consumables	3.1	**(10,434)**	(8,572)
Other Expenses	3.1	**(7,934)**	(7,229)
Net Result Before Capital & Specific Items		**523**	534
Capital Purpose Income	2.1	**1,466**	520
Impairment of Non-Financial Assets	3.1	**(16)**	58
Depreciation and Amortisation	4.4	**(5,278)**	(5,629)
Assets Received Free of Charge	2.2	**34**	8
NET RESULT FOR THE YEAR		**(3,271)**	(4,509)
Other Comprehensive Income			
Items that will not be reclassified to net result			
Changes in Physical Asset Revaluation Reserve	8.1	260	-
Total Other Comprehensive Income		260	-
COMPREHENSIVE RESULT		**(3,011)**	(4,509)

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

ECHUCA REGIONAL HEALTH

BALANCE SHEET AS AT 30 JUNE 2017

	Note	2017 $000	2016 $000
ASSETS			
Current Assets			
Cash and Cash Equivalents	6.2	**459**	704
Receivables	5.1	**2,528**	1,317
Investments and Other Financial Assets	4.1	**3,473**	3,691
Inventories	5.2	**721**	658
Prepayments and Other Non-Financial Assets	5.4	**267**	266
Total Current Assets		**7,448**	6,636
Non-Current Assets			
Receivables	5.1	**2,440**	1,993
Property, Plant & Equipment	4.3	**92,080**	96,140
Total Non-Current Assets		**94,520**	98,133
TOTAL ASSETS		**101,968**	104,769
LIABILITIES			
Current Liabilities			
Payables	5.5	**3,406**	3,637
Borrowings	6.1	**275**	-
Employee Benefits	3.3	**12,287**	11,800
Other Liabilities	5.3	**1,980**	2,154
Total Current Liabilities		**17,948**	17,591
Non-Current Liabilities			
Payables	5.5	**343**	361
Borrowings	6.1	**783**	1,042
Employee Benefits	3.3	**668**	538
Total Non-Current Liabilities		**1,794**	1,941
TOTAL LIABILITIES		**19,742**	19,532
NET ASSETS		**82,226**	85,237
EQUITY			
Property, Plant & Equipment Revaluation Surplus	8.1a	**24,916**	24,656
Restricted Specific Purpose Surplus	8.1b	**300**	-
Contributed Capital	8.1c	**24,804**	24,804
Accumulated Surpluses	8.1d	**32,206**	35,777
TOTAL EQUITY		**82,226**	85,237
Contingent assets and contingent liabilities	7.3		
Commitments	6.3		

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

ECHUCA REGIONAL HEALTH

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2017

2017	Note	Equity at 1 July 2016	Comprehensive Result	Transfers to / from Accumulated Surplus	Equity at 30 June 2017
		$000	$000	$000	$000
Accumulated Surplus / (Deficit)	8.1d	35,777	(3,271)	(300)	**32,206**
Contribution by Owners	8.1c	24,804	-	-	**24,804**
Property Plant and Equipment Revaluation Surplus	8.1a	24,656	260	-	**24,916**
Restricted Specific Purpose Surplus	8.1b	-	-	300	**300**
Total Equity at the end of the financial year		**85,237**	**(3,011)**	**-**	**82,226**

2016	Note	Equity at 1 July 2015	Comprehensive Result	Transfers to / from Accumulated Surplus	Equity at 30 June 2016
		$000	$000	$000	$000
Accumulated Surplus / (Deficit)	8.1d	40,286	(4,509)	-	**35,777**
Contribution by Owners	8.1c	21,711	3,093	-	**24,804**
Property Plant and Equipment Revaluation Surplus	8.1a	24,656	-	-	**24,656**
Restricted Specific Purpose Surplus	8.1b	-	-	-	**-**
Total Equity at the end of the financial year		**86,653**	**(1,416)**	**-**	**85,237**

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

ECHUCA REGIONAL HEALTH

CASH FLOW STATEMENT

FOR THE YEAR ENDED 30 JUNE 2017

	Note	2017 $000	2016 $000
Cash Flows From Operating Activities			
Operating Grants from Government		**53,354**	52,974
Capital Grants from Government		**1,009**	383
Patient and Resident Fees Received		**4,268**	4,123
Donations and Bequests Received		**763**	513
GST Received from/(paid to) ATO		**1,759**	4,384
Interest Received		**90**	106
Other Capital Receipts		**-**	125
Other Receipts		**6,631**	5,223
Total Receipts		**67,874**	67,831
Employee Expenses Paid		**(42,362)**	(40,103)
Non Salary Labour Costs		**(5,403)**	(5,309)
Payments for Supplies & Consumables		**(10,933)**	(9,725)
Other Payments		**(8,884)**	(9,945)
Total Payments		**(67,582)**	(65,082)
Net Cash Flow From / (Used In) Operating Activities	8.2	**292**	2,749
Cash Flows From Investing Activities			
Purchase of Properties, Plant & Equipment		**(935)**	(9,110)
Proceeds from Sale of Non-Current Assets		**-**	26
Proceeds from Sale of Investments		**218**	533
Net Cash Inflow / (Outflow) From Investing Activities		**(717)**	(8,551)
Cash Flows From Financing Activities			
Proceeds from Borrowings		**-**	1,100
Contributed Capital from Government		**-**	2,963
Net Cash Flow From / (Used In) Financing Activities		**-**	4,063
Net Increase/(Decrease) In Cash And Cash Equivalents Held		**(425)**	(1,739)
Cash And Cash Equivalents At Beginning Of Financial Year		**151**	1,890
Cash And Cash Equivalents At End Of Financial Year	6.2	**(274)**	151

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

ECHUCA REGIONAL HEALTH

Basis of presentation

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

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

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

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

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

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

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

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

Note 1: Summary of significant accounting policies

These annual financial statements represent the audited general purpose financial statements for Echuca Regional Health for the period ending 30 June 2017.
The report provides users with information about the Health Services' stewardship of resources entrusted to it.

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

The financial statements also comply with relevant Financial Reporting Directions (FRDs) issued by the Department of Treasury & Finance, and relevant Standing Directions (SDs) authorised by the Minister for Finance.
The Health Service is a not-for profit entity and therefore applies the additional Aus paragraphs applicable to "not-for-profit" Health Services under the AASBs.
The annual financial statements were authorised for issue by the Board of Echuca Regional Health on xx/xx/2017.

(b) Reporting Entity
The financial statements include all the controlled activities of Echuca Regional Health. Its principal address is 226 Service Street, Echuca Victoria 3564.

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

Objectives and funding
Echuca Regional Health's overall objective is to help everyone to be and stay healthy.

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

(c) Basis of accounting preparation and measurement
Accounting policies are selected and applied in a manner which ensures that the resulting financial information satisfies the concepts of relevance and reliability, thereby ensuring that the substance of the underlying transactions or other events is reported. The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2017, and the comparative information presented in these financial statements for the year ended 30 June 2016.

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

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

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

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

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

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

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

The estimations and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision, and future periods if the revision affects both financial statements and estimates, with a risk of material adjustments in the subsequent reporting period, related to:

- the fair value of land, buildings, infrastructure, plant and equipment (refer to Note 4.3);
- actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.3).

ECHUCA REGIONAL HEALTH

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

Note 2: Funding Delivery of Our Services

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

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

Structure
2.1 Analysis of revenue by source
2.2 Assets received free of charge or for nominal consideration

Note 2.1: Analysis of Revenue by Source

	Admitted Patients 2017 $'000	Non Admitted 2017 $'000	EDs 2017 $'000	RAC 2017 $'000	Aged Care 2017 $'000	Primary Health 2017 $'000	Other 2017 $'000	Total 2017 $'000
Government Grants	34,838	1,687	8,582	5,620	1,331	2,698	110	**54,866**
Indirect Contributions by Department of Health & Human Services	353	31	44	6	4	57	4	**499**
Patient and Resident Fees	1,820	220	95	1,616	49	406	-	**4,206**
Commercial Activities	-	-	-	-	-	-	1,124	**1,124**
Other	5,244	425	11	10	8	166	5	**5,869**
Total Revenue from Operating Activities	42,255	2,363	8,732	7,252	1,392	3,327	1,243	**66,564**
Interest	51	-	-	-	-	-	-	**51**
Other	-	-	-	-	-	-	300	**300**
Total Revenue from Non-Operating Activities	51	-	-	-	-	-	300	**351**
Capital Purpose Income (excluding interest)	-	-	-	-	-	-	1,427	**1,427**
Assets Received Free of Charge	-	-	-	-	-	-	34	**34**
Capital Interest	-	-	-	-	-	-	39	**39**
Total Capital Purpose Income	-	-	-	-	-	-	1,500	**1,500**
Total Revenue	42,306	2,363	8,732	7,252	1,392	3,327	3,043	**68,415**

	Admitted Patients 2016 $'000	Non Admitted 2016 $'000	EDs 2016 $'000	RAC 2016 $'000	Aged Care 2016 $'000	Primary Health 2016 $'000	Other 2016 $'000	Total 2016 $'000
Government Grants	33,053	1,639	8,124	5,038	1,264	2,514	178	**51,810**
Indirect Contributions by Department of Health & Human Services	102	(3)	5	7	10	8	1	**130**
Patient and Resident Fees	1,811	216	55	1,479	37	465	-	**4,063**
Commercial Activities	-	-	-	-	-	-	1,117	**1,117**
Other	3,749	427	16	8	-	169	-	**4,369**
Total Revenue from Operating Activities	38,715	2,279	8,200	6,532	1,311	3,156	1,296	**61,489**
Interest	106	-	-	-	-	-	-	**106**
Total Revenue from Non-Operating Activities	106	-	-	-	-	-	-	**106**
Capital Purpose Income (excluding interest)	-	-	-	-	-	-	516	**516**
Assets Received Free of Charge							8	**8**
Capital Interest	-	-	-	-	-	-	4	**4**
Total Capital Purpose Income	-	-	-	-	-	-	528	**528**
Total Revenue	38,821	2,279	8,200	6,532	1,311	3,156	1,824	**62,123**

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

Income is recognised in accordance with AASB 118 *Revenue* and is recognised as to the extent that it is probable that the economic benefits will flow to Echuca 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.

Note 2.1: Analysis of Revenue by Source (Continued)

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 (update for 2016-17).

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

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

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

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

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

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

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

Category Groups
Echuca Regional Health 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.

Emergency Department Services (EDs) comprises all emergency department services

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

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

Residential Aged Care (RAC) comprises those Commonwealth-licensed residential aged care services in receipt of supplementary funding from the Department of Health and Human Services.

Other Services not reported elsewhere - (Other) comprises services not separately classified above, including: Koori Liaison Officers, Drugs services including drug withdrawal, counselling and the needle and syringe program and Clinical Education, and various support services. Health and Community Initiatives also falls in this category group.

Note 2.2: Assets Received Free of Charge or For Nominal Consideration

	2017 $'000	2016 $'000
During the reporting period, the fair value of assets received free of charge, was as follows:		
Medical Equipment	**34**	8
Total	**34**	8

Assets received from University of Melbourne 2017; Humpty Dumpty Foundation 2016.

ECHUCA REGIONAL HEALTH

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

Note 3: The Cost of Delivering Services

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

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

Note 3.1: Analysis of Expenses by Source

	Admitted Patients 2017 $'000	Non Admitted 2017 $'000	EDs 2017 $'000	RAC 2017 $'000	Aged Care 2017 $'000	Primary Health 2017 $'000	Other 2017 $'000	Total 2017 $'000
Employee Expenses	28,573	1,209	2,574	4,649	1,059	4,229	423	**42,716**
Non Salary Labour Costs	4,975	17	191	-	8	117	-	**5,308**
Supplies & Consumables	7,517	94	2,030	144	313	335	1	**10,434**
Other Expenses	6,213	80	1,005	405	37	97	90	**7,927**
Total Expenses from Operating Activities	47,278	1,400	5,800	5,198	1,417	4,778	514	**66,385**
Expenses for Capital Purposes	-	-	-	-	-	-	7	**7**
Impairment of Financial Assets	-	-	-	-	-	-	16	**16**
Depreciation (refer note 4.4)	-	-	-	-	-	-	5,278	**5,278**
Total Other Expenses	-	-	-	-	-	-	5,301	**5,301**
Total Expenses	47,278	1,400	5,800	5,198	1,417	4,778	5,815	**71,686**

	Admitted Patients 2016 $'000	Non Admitted 2016 $'000	EDs 2016 $'000	RAC 2016 $'000	Aged Care 2016 $'000	Primary Health 2016 $'000	Other 2016 $'000	Total 2016 $'000
Employee Expenses	27,211	1,047	2,198	4,490	1,042	3,948	424	**40,360**
Non Salary Labour Costs	4,636	13	194	-	8	49	-	**4,900**
Supplies & Consumables	5,960	134	1,731	191	294	257	5	**8,572**
Other Expenses	5,519	87	978	394	27	106	107	**7,218**
Total Expenses from Operating Activities	43,326	1,281	5,101	5,075	1,371	4,360	536	**61,050**
Expenditure for Capital Purposes	-	-	-	-	-	-	11	**11**
Impairment of Financial Assets	-	-	-	-	-	-	(58)	**(58)**
Depreciation (refer note 4.4)	-	-	-	-	-	-	5,629	**5,629**
Total Other Expenses	-	-	-	-	-	-	5,582	**5,582**
Total Expenses	43,326	1,281	5,101	5,075	1,371	4,360	6,118	**66,632**

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

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

Employee expenses
Employee expenses include: wages and salaries; fringe benefits tax; leave entitlements; termination payments; workcover premiums; and superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

Note 3.1: Analysis of Expenses by Source (Continued)

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

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

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

Bad and Doubtful Debts
Refer to Note 4.1 *Investments and other financial assets.*

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

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

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

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

Revaluation gains / (losses) of non-financial physical assets
Refer to Note 4.3 Property plant and equipment.

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

Revaluation gains / (losses) of non-financial physical assets
Refer to Note 4.3 Property plant and equipment.

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

Net gain/ (loss) on financial instruments
Net gain/ (loss) on financial instruments includes:
- realised and unrealised gains and losses from revaluations of financial instruments at fair value;
- impairment and reversal of impairment for financial instruments at amortised cost refer to Note 4.1 *Investments and other financial assets* ; and
- disposals of financial assets and derecognition of financial liabilities

Amortisation of non-produced intangible assets
Intangible non-produced assets with finite lives are amortised as an 'other economic flow' on a systematic basis over the asset's useful life. Amortisation begins when the asset is available for use that is when it is in the location and condition necessary for it to be capable of operating in the manner intended by management.

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

Revaluations of financial instrument at fair value
Refer to Note 7.1 *Financial instruments.*

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

Note 3.1: Analysis of Expenses by Source (Continued)

Other gains/ (losses) from other economic flows
Other gains/ (losses) include:
a. the revaluation of the present value of the long service leave liability due to changes in the bond rate movements, inflation rate movements and the impact of changes in probability factors; and
b. transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

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

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

	Expense		Revenue	
	2017 $000	**2016 $000**	**2017 $000**	**2016 $000**
Commercial Activities				
Cafeteria	**141**	151	**203**	182
Residential Accommodation	**104**	131	**144**	137
Property	**1**	1	**443**	402
Public Relations	**50**	67	**272**	393
Other	**-**	-	**62**	3
Total	**296**	350	**1,124**	1,117

Note 3.3: Employee Benefits

	2017 $000	**2016 $000**
Current		
Long Service Leave		
- Unconditional and expected to be settled within 12 months	**700**	600
- Unconditional and expected to be settled after 12 months	**5,456**	5,163
Annual Leave Entitlements		
- Unconditional and expected to be settled within 12 months	**2,700**	2,550
- Unconditional and expected to be settled after 12 months	**964**	972
Accrued Wages and Salaries	**1,361**	1,475
Accrued Days Off	**69**	74
Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months	**342**	310
- Unconditional and expected to be settled after 12 months	**695**	656
Total	**12,287**	11,800
Non-Current		
Conditional Long Service Leave Entitlements (present value)	**602**	485
Provisions related to Employee Benefit On-Costs	**66**	53
Total	**668**	538
Movement in Long Service Leave:		
Balance at start of year	**6,929**	6,625
Provision made during the year	**1,145**	877
Settlement made during the year	**(573)**	(573)
Balance at end of year	**7,501**	6,929

Note 3.3: Employee Benefits (Continued)

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

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

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

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

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

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

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

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

Long service leave (LSL)
Liability for LSL is recognised in the provision for employee benefits.

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

The components of this current LSL liability are measured at:

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

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

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

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

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

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

ECHUCA REGIONAL HEALTH

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

Note 3.4: Superannuation

	Paid Contribution for the Year 2017 $'000	Paid Contribution for the Year 2016 $'000	Contribution Outstanding at Year End 2017 $'000	Contribution Outstanding at Year End 2016 $'000
(i) Defined benefit plans:				
First State Super Fund	**147**	160	**-**	-
Defined contribution plans:				
First State Super Fund	**2,407**	2,370	**-**	8
Hesta Fund	**962**	850	**-**	-
Other	**37**	44	**-**	-
Total	**3,553**	3,424	**-**	8

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

Employees of the Health Service are entitled to receive superannuation benefits and the Health Services contributes to both defined benefit and defined contribution plans. The defined benefit plans provides benefits based on years of service and final average salary.
The Health Service does not recognise any defined benefit liability in respect of the plans because the entity has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation
The Department of Treasury and Finance discloses the State's defined benefits liabilities in its disclosure for administered items.
contributions as they fall due.
However superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the comprehensive operating statement of the Health Service.
The name, details and amounts expense in relation to the major employee superannuation funds and contributions made by the Health Services are listed above.

Note 4: Key Assets to Support Service Delivery
The hospital controls infrastructure and other investments that are utilised in fulfilling its objectives and conducting its activities. They represent the key resources that have been entrusted to the hospital to be utilised for delivery of those outputs.

Structure
4.1 Investments and other financial assets
4.2 Jointly Controlled Operations and Assets
4.3 Property, Plant & Equipment
4.4 Depreciation

Note 4.1: Investments and Other Financial Assets

	Operating Fund 2017 $'000	Operating Fund 2016 $'000	Specific Purpose Fund 2017 $'000	Specific Purpose Fund 2016 $'000	Capital Fund 2017 $'000	Capital Fund 2016 $'000	2017 $'000	2016 $'000
Current								
Term Deposits *	**373**	791	**300**	-	**2,800**	2,900	**3,473**	3,691
Total	**373**	791	**300**	-	**2,800**	2,900	**3,473**	3,691
Represented by:								
Investments	**373**	791	**300**	-	**947**	986	**1,620**	1,777
Monies Held in Trust								
- Accommodation Bonds (Refundable Entrance Fees)					**1,849**	1,600	**1,849**	1,600
- Other	**-**	-	**-**	-	**4**	314	**4**	314
Total	**373**	791	**300**	-	**2,800**	2,900	**3,473**	3,691

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

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

* The Specific Purpose Fund is Murray Plains monies held on their behalf.

Note 4.1: Investments and Other Financial Assets (Continued)

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

Investments are classified in the following categories:
- financial assets at fair value through profit or loss;
- held-to-maturity;
- loans and receivables; and
- available-for-sale financial assets.

Echuca Regional Health classifies its other financial assets between current and non-current assets based on the purpose for which the assets were acquired. Management determines the classification of its other financial assets at initial recognition.

Echuca Regional Health assesses at each balance sheet date whether a financial asset or group of financial assets is impaired.
All financial assets, except those measured at fair value through profit or loss are subject to annual review for impairment.

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

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

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

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

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

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

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

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

Note 4.2: Jointly Controlled Operations and Assets

Echuca Regional Health has entered into a joint operation called the Loddon Mallee Rural Health Alliance which was established to improve the operations' joint capability and capacity to use and acquire information and communication technology products and services. Echuca Regional Health has a 9.82% (2016: 9.74%) participating interest in this joint operation and is entitled to share in its output of services. Echuca Regional Health's interest in the assets employed in the joint operation are included in the balance sheet as below:

	2017	2016
	$000	$000
Current Assets		
Cash and Cash Equivalents	**174**	20
Receivables	**31**	27
Inventories	**4**	2
Other Financial Assets	**373**	481
Other Assets	**63**	54
Total Current Assets	**645**	584
Non-Current Assets		
Computers	**81**	88
Accumulated Depreciation	**(66)**	(67)
Total Non-Current Assets	**15**	21
Current Liabilites		
Payables	**123**	113
Total Current Liabilites	**123**	113
Net share of assets employed in joint operation	**537**	492

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

	2017	2016
	$000	$000
Revenue from Operating Activities	**750**	828
Operating Expenses	**(677)**	(717)
Net Result Before Capital and Specific Items	**73**	111
Capital Purpose Income	**1**	-
Expenditure for Capital Purposes	**(17)**	(149)
Depreciation	**(12)**	(27)
Net Result after Capital and Specific Items	**(28)**	(176)
Net Result for the Year	**45**	(65)

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

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

Note 4.3: Property, Plant & Equipment

(a) Gross carrying amount and accumulated depreciation	**2017 $'000**	**2016 $'000**
Land		
Land at Valuation	**2,218**	1,958
Total Land	**2,218**	1,958
Buildings		
Buildings Under Construction at cost	**193**	1,705
Buildings at Cost	**60,620**	58,737
Less Accumulated Depreciation	**(3,981)**	(1,975)
	56,639	56,762
Buildings at Valuation	**29,873**	29,873
Less Accumulated Depreciation	**(5,489)**	(4,079)
	24,384	25,794
Total Buildings	**81,216**	84,261
Plant and Equipment		
Plant and Equipment	**3,449**	2,299
Less Accumulated Depreciation	**(989)**	(798)
	2,460	1,501
Work in Progress at cost	**375**	1,257
Total Plant and Equipment	**2,835**	2,758
Medical Equipment		
Medical Equipment	**7,618**	7,642
Less Accumulated Depreciation	**(4,834)**	(4,344)
Total Medical Equipment	**2,784**	3,298
Computers and Communication		
Computers and Communication	**5,385**	5,390
Less Accumulated Depreciation	**(3,700)**	(3,069)
Total Computers and Communication	**1,685**	2,321
Furniture and Fittings		
Furniture and Fittings	**1,912**	1,896
Less Accumulated Depreciation	**(1,128)**	(994)
Total Furniture and Fittings	**784**	902
Motor Vehicles		
Motor Vehicles	**667**	633
Less Accumulated Depreciation	**(528)**	(465)
Total Motor Vehicles	**139**	168
Other Equipment		
Other Equipment	**1,255**	1,219
Less Accumulated Depreciation	**(836)**	(745)
	419	474
Total	**92,080**	96,140

Where not otherwise stated figures are at fair value.

Note 4.3: Property, Plant & Equipment (Continued)

(b) Reconciliations of the carrying amounts of each class of asset for the consolidated entity at the beginning and end of the previous and current financial year is set out below.

	Land	Buildings	Plant & Equipment	Medical Equipment	*Computers & Communicat'n	Furniture & Fittings	Motor Vehicles	Other Equipment	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2015	1,958	81,560	2,051	2,957	2,682	809	198	458	**92,673**
Additions	-	6,561	805	1,029	310	239	57	109	**9,110**
Disposals	-	-	-	-	-	-	(14)	-	**(14)**
Depreciation (Note 4.4)	-	(3,860)	(98)	(688)	(671)	(146)	(73)	(93)	**(5,629)**
Balance at 30 June 2016	1,958	84,261	2,758	3,298	2,321	902	168	474	**96,140**
Additions	-	372	268	168	58	31	34	37	**968**
Disposals	-	-	-	(10)	-	-	-	-	**(10)**
Revaluation Increments/(Decrements)	260	-	-	-	-	-	-	-	**260**
Depreciation (Note 4.4)	-	(3,417)	(191)	(672)	(694)	(149)	(63)	(92)	**(5,278)**
Balance at 30 June 2017	2,218	81,216	2,835	2,784	1,685	784	139	419	**92,080**

* Computers and communication additions during the year ended 30 June 2017 includes $7K (2016: $Nil) relating to the joint operation.

Land and Buildings carried at valuation
An independent valuation of Echuca Regional Health's land and buildings was performed by the Valuer-General Victoria to determine the fair value of the land and buildings. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments.
The effective date of the valuation was 30 June 2014. In accordance with FRD103F *Non-Current Physical Assets* were assessed by management resulting in a valuation increment to land as at 30 June 2017.

(c) Fair Value measurement hierarchy for assets

	Carrying Amount as at 30 June 2017	Fair Value Measurement at End of Reporting Period using:			Carrying Amount as at 30 June 2016	Fair Value Measurement at End of Reporting Period using:		
		Level 1 *	Level 2 *	Level 3 *		Level 1 *	Level 2 *	Level 3 *
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Land at Fair Value								
Specialised Land	**2,218**	**-**	**-**	**2,218**	1,958	-	-	1,958
Buildings at Fair Value								
Specialised Buildings	**81,023**	**-**	**-**	**81,023**	82,556	-	-	82,556
Plant and Equipment at Fair Value								
Plant and Equipment at Fair Value								
- Plant and Equipment	**2,460**	**-**	**-**	**2,460**	1,501	-	-	1,501
- Computers and Communication	**1,685**	**-**	**-**	**1,685**	2,321	-	-	2,321
- Furniture and Fittings	**784**	**-**	**-**	**784**	902	-	-	902
- Vehicles	**139**	**-**	**-**	**139**	168	-	-	168
- Other Equipment	**419**	**-**	**-**	**419**	474	-	-	474
Total	**5,487**	**-**	**-**	**5,487**	5,366	-	-	5,366
Medical Equipment at Fair Value	**2,784**	**-**	**-**	**2,784**	3,298	-	-	3,298
	91,512	**-**	**-**	**91,512**	93,178	-	-	93,178

* Classified in accordance with the fair value hierarchy.
** Vehicles are categorised to Level 3 assets as if the depreciated replacement cost is used in estimating fair value.

There have been no transfers between levels during the period.

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

Note 4.3: Property, Plant & Equipment (Continued)

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

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

For the purpose of fair value disclosures, Echuca Regional Health has determined classes of assets and liabilities on the basis of the nature, characteristics and risks of the asset or liability and the level of the fair value hierarchy as explained above. In addition, Echuca Regional Health determines whether transfers have occurred between levels in the hierarchy by re-assessing categorisation (based on the lowest level input that is significant to the fair value measurement as a whole) at the end of each reporting period. The Valuer-General Victoria (VGV) is Echuca Regional Health's independent valuation agency.

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

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

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

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

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

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

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

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

Note 4.3: Property, Plant & Equipment (Continued)

(d) Reconciliation of Level 3 fair value

2017	Land $'000	Buildings $'000	Plant & Equipment $'000	Medical Equipment $'000
Opening Balance	1,958	84,440	5,366	3,298
Purchases (Sales)	-	-	1,310	158
Gains or losses recognised in net result				
- Depreciation	-	(3,417)	(1,189)	(672)
Items recognised in other comprehensive income				
- Revaluation	260	-	-	-
Closing Balance	**2,218**	**81,023**	**5,487**	**2,784**

2016	Land $'000	Buildings $'000	Plant & Equipment $'000	Medical Equipment $'000
Opening Balance	1,958	86,416	4,219	2,864
Purchases (Sales)	-	-	4,258	1,122
Gains or losses recognised in net result				
- Depreciation	-	(3,860)	(1,081)	(688)
Items recognised in other comprehensive income				
- Revaluation	-	-	-	-
Closing Balance	**1,958**	**82,556**	**7,396**	**3,298**

* Classified in accordance with the fair value hierarchy.

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

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

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

An independent valuation of the Health Service's specialised land and specialised buildings was performed by the Valuer-General Victoria. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation is 30 June 2014. In accordance with FRD103F *Non-Current Physical Assets* were assessed by management resulting in a valuation increment to land as at 30 June 2017.

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

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

There were no changes in valuation techniques throughout the period to 30 June 2017. For all assets measured at fair value, the current use is considered the highest and best use.

Note 4.3: Property, Plant & Equipment (Continued)

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

	Valuation Technique	Significant unobservable inputs	Range (weighted average)	Sensitivity of fair value measurement to changes in significant unobservable inputs
Specialised Land	Market approach	Community Service Obligation (CSO) adjustment	20%-20% (20%)	A significant increase or decrease in the CSO adjustment would result in a significantly lower (higher) fair value
Specialised Buildings	Depreciated replacement cost	Direct cost per square metre Useful life of specialised buildings	$634 - $2,600/m2 ($1,670) 1-47 years (30 years)	A significant increase or decrease in direct cost per square metre adjustment would result in a significantly higher or lower fair value. A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Plant and Equipment, Computers and Communication, and Furniture and Fittings	Depreciated replacement cost	Useful life of PPE	2-15 years (5 years)	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Vehicles	Depreciated replacement cost	Useful life of Vehicles	4-10 years (6 years)	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Medical Equipment	Depreciated replacement cost	Useful life of Medical Equipment	3-20 years (7 years)	A significant increase (decrease) in useful life of the asset would result in a significantly higher (lower) fair value.

The significant unobservable inputs have remained unchanged from 2016.

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

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

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

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

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

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

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

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

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

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

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

Note 4.4: Depreciation

	2017 $'000	2016 $'000
Depreciation		
Buildings	**3,417**	3,860
Plant & Equipment	**191**	98
Medical Equipment	**672**	688
Computers and Communication	**694**	671
Furniture and Fittings	**149**	146
Motor Vehicles	**63**	73
Other Equipment	**92**	93
Total Depreciation	**5,278**	5,629

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

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

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

	2017	2016
Buildings		
- Structure, Shell and Building Fabric	2 to 47 years	3 to 47 years
- Site Engineering Services and Central Plant	3 to 33 years	3 to 33 years
- Fit Out	1 to 17 years	1 to 17 years
- Trunk Reticulated Building Systems	1 to 19 years	1 to 19 years
Plant and Equipment	7 to 15 years	7 to 15 years
Medical Equipment	3 to 20 years	3 to 20 years
Computers and Communications	2 to 10 years	2 to 10 years
Furniture and Fitting	5 to 15 years	5 to 15 years
Motor Vehicles	4 to10 years	4 to10 years

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

Note 5: Other Assets and Liabilities

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

Structure
5.1 Receivables
5.2 Inventories
5.3 Other Liabilities
5.4 Prepayments and Other Non-Financial Assets
5.5 Payables

Note 5.1: Receivables

	2017 $000	2016 $000
Current		
Inter Hospital Debtors	**427**	338
Trade Debtors	**219**	103
Patient Fees	**592**	536
Accrued Investment Income	**5**	18
Accrued Revenue - Department of Health & Human Services	**790**	-
Accrued Revenue - Other	**435**	297
GST Receivable	**233**	196
Refundable Rental Bonds	**1**	1
Total	**2,702**	1,489
Less Allowance for Doubtful Debts		
Trade Debtors	**(116)**	(103)
Patient Fees	**(58)**	(69)
Total Current Receivables	**2,528**	1,317
Non-Current		
Department of Health & Human Services - Long Service Leave	**2,440**	1,993
Total Non-Current Receivables	**2,440**	1,993
Total Receivables	**4,968**	3,310

(a) Movement in the Allowance for Doubtful Debts		
Balance at beginning of year	**172**	106
Increase/(decrease) in allowance recognised in net result	**2**	66
Balance at end of year	**174**	172

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

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

Receivables consist of:

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

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

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

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

Note 5.2: Inventories

	2017 $'000	2016 $'000
Current		
Pharmaceuticals - at cost	**147**	111
General Stores - at cost	**204**	185
Theatre Stores - at cost	**225**	224
Wards Stores - at cost	**129**	122
Engineering Stores - at cost	**12**	14
Administration Stores - at cost	**4**	2
Total Current Inventories	**721**	658

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

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

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

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

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

Note 5.3: Other Liabilities

	2017 $'000	2016 $'000
Current		
Monies Held in Trust*		
- Patient Monies Held in Trust	**80**	62
- Accommodation Bonds (Refundable Entrance Fees)	**1,849**	1,600
- Other Monies Held in Trust	**51**	492
Total	**1,980**	2,154
*** Total Monies Held in Trust**		
Represented by the following assets:		
Cash Assets (refer note 6.2)	**131**	553
Investments and Other Financial Assets (refer note 4.1)	**1,849**	1,600
Land & Buildings	**-**	1
Total	**1,980**	2,154

Note 5.4: Prepayments and Other Non-Financial Assets

	2017 $'000	2016 $'000
Current		
Prepayments	**267**	266
Total Current Other Assets	**267**	266

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

	2017	2016
Current	**$000**	**$000**
Trade Creditors	**2,457**	2,095
Accrued Expenses	**855**	791
Accrued Expenses - Department of Health & Human Services	**-**	685
GST Payable	**62**	48
Income in Advance	**32**	18
Total Current	**3,406**	3,637
Non Current		
Income in Advance	**343**	361
Total Non Current	**343**	361
Total Payables	**3,749**	3,998

(a) Maturing analysis of payables
Please refer to Note 7.1(c) for the ageing analysis of contractual payables.

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

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.

Stucture
6.1 Borrowings
6.2 Cash and Cash Equivalents
6.3 Commitments for Expenditure

Note 6.1: Borrowings

	2017	2016
	$'000	**$'000**
Current		
- Loan *	**275**	-
Total Australian Dollar Borrowings	**275**	-
Non-Current		
- Loan *	**783**	1,042
Total Australian Dollar Borrowings	**783**	1,042
Total Interest Bearing Liabilities	**1,058**	1,042

* The Department of Health & Human Services have provided a five year interest free loan.

(a) Maturing analysis of interest bearing liabilities
Please refer to Note 7.1(c) for the ageing analysis of borrowings.

(b) Nature and extent of risk arising from interest bearing liabilities
Please refer to Note 7.1(c) for the nature and extent of risks arising from borrowings.

(c) Defaults and breaches
During the current and prior year, there were no defaults and breaches of any of the borrowings.

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

Note 6.2: Cash and Cash Equivalents
For the purposes of the Cash Flow Statement, cash assets includes cash on hand and in banks, and short-term deposits which are readily convertible to cash on hand, and are subject to an insignificant risk of change in value, net of outstanding bank overdrafts.

	2017 $'000	2016 $'000
Cash on Hand	**4**	4
Cash at Bank	**455**	700
Total Cash and Cash Equivalents	**459**	704
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	**(274)**	151
Other	**733**	553
Total	**459**	704

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

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

Note 6.3: Commitments for Expenditure

There are no commitments for expenditure as at June 2017 (2016 $Nil).

Note 7: Risks, Contingencies and Valuation Uncertainties

Introduction

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

Structure
7.1 Financial Instruments
7.2: Net Gain / (Loss) on Disposal of Non-Financial Assets
7.3 Contingent Assets and Contingent Liabilities
7.4 Fair Value Determination

Note 7.1: Financial Instruments

(a) Financial Risk Management Objectives and Policies
Echuca Regional Health's principal financial instruments comprise of:
- Cash Assets
- Term Deposits
- Receivables (excluding statutory receivables)
- Payables (excluding statutory payables)
- Accommodation Bonds

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

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

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

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

Categorisation of Financial Instruments

Financial Assets	**Contractual Financial Assets and Receivables 20176 $'000**	**Contractual Financial Liabilities at Amortised Cost 2017 $'000**	**Total 2017 $'000**	**Contractual Financial Assets and Receivables 2016 $'000**	**Contractual Financial Liabilities at Amortised Cost 2016 $'000**	**Total 2016 $'000**
Cash and cash equivalents	**459**	**-**	**459**	704	-	704
Receivables	**2,295**	**-**	**2,295**	1,121	-	1,121
Other Financial Assets	**3,473**	**-**	**3,473**	3,691	-	3,691
Total Financial Assets	**6,227**	**-**	**6,227**	5,516	-	5,516
Financial Liabilities						
Payables	**-**	**3,344**	**3,344**	-	3,589	3,589
Interest Bearing Liabilities		**-**	**-**		-	-
Accommodation Bonds	**-**	**1,849**	**1,849**	-	1,600	1,600
Other Liabilities	**-**	**131**	**131**	-	554	554
Total Financial Liabilities	**-**	**5,324**	**5,324**	-	5,743	5,743

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

Note 7.1: Financial Instruments (Continued)

(b) Credit risk

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

Credit risk associated with the Health Service's contractual financial assets is minimal because the main debtor is the Victorian Government. For debtors other than the Government, it is the Health Service's policy to only deal with entities with high credit ratings of a minimum Triple-B rating and to obtain sufficent collateral on credit enhancements, where appropriate.

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

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

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

Credit quality of contractual Financial Assets that are neither past due nor impaired

	Financial Institutions $'000	Government Agencies $'000	Other $'000	Total $'000
2017				
Financial Assets				
Cash and Cash Equivalents	459	-	-	459
Receivables	5	-	2,290	2,295
Other Financial Assets	3,473	-	-	3,473
Total Financial Assets	3,937	-	2,290	6,227
2016				
Financial Assets				
Cash and Cash Equivalents	704	-	-	704
Receivables	6	-	1,115	1,121
Other Financial Assets	3,691	-	-	3,691
Total Financial Assets	4,401	-	1,115	5,516

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

Note 7.1: Financial Instruments (Continued)

(b) Credit risk (continued)

Ageing analysis of Financial Assets as at 30 June

	Carrying Amount $'000	Not past Due and Not Impaired $'000	Past Due But Not Impaired					Impaired Financial Assets $'000
			Less than 1 Month $'000	1-3 Months $'000	3 Months - 1 Year $'000	1-5 Years $'000	Over 5 Years $'000	
2017								
Financial Assets								
Cash and Cash Equivalents	459	459	-	-	-	-	-	-
Receivables	2,295	-	1,945	168	182	-	-	174
Other Financial Assets	3,473	3,473	-	-	-	-	-	-
Total Financial Assets	**6,227**	**3,932**	**1,945**	**168**	**182**	**-**	**-**	**174**
2016								
Financial Assets								
Cash and Cash Equivalents	704	704	-	-	-	-	-	-
Receivables	1,121	-	757	185	179	-	-	172
Other Financial Assets	3,691	3,691	-	-	-	-	-	-
Total Financial Assets	**5,516**	**4,395**	**757**	**185**	**179**	**-**	**-**	**172**

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

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

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

Contractual financial assets that are either past due or impaired
There are no material financial assets which are individually determined to be impaired. Currently the Health Service does not hold any collateral as security nor credit enhancements relating to its financial assets.

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

Note 7.1: Financial Instruments (Continued)

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

The Health Service's maximum exposure to liquidity risk is the carrying amounts of financial liabilities as disclosed in the face of the balance sheet. The Health Service manages its liquidity risk as follows:

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

Maturity analysis of Financial Liabilities as at 30 June

			Maturity Dates			
	Carrying Amount $'000	Nominal Amount $'000	Less than 1 Month $'000	1-3 Months $'000	3 Months - 1 Year $'000	1-5 Years $'000
2017						
Payables						
Trade Creditors and Accruals	3,344	3,344	3,181	163	-	-
Interest bearing liabilites						
- Borrowings	783	783	-	-	-	783
Accommodation Bonds	1,849	1,849	-	311	340	1,198
Other	131	131	-	-	5	126
Total Financial Liabilities	**6,107**	**6,107**	**3,181**	**474**	**345**	**2,107**
2016						
Payables						
Trade Creditors and Accruals	3,589	3,589	3,092	497	-	-
Interest bearing liabilites						
- Finance Leases	-	-	-	-	-	-
- Borrowings	1,042	1,042	-	-	-	1,042
Accommodation Bonds	1,600	1,600	-	404	359	837
Other	554	554	-	24	154	376
Total Financial Liabilities	**6,785**	**6,785**	**3,092**	**925**	**513**	**2,255**

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

(d) Market Risk
Echuca Regional Health exposures to market risk are primarily through interest rate risk with only insignificant exposure to foreign currency and other other price risks.

(e) Currency Risk
Echuca Regional Health is exposed to insignificant foreign currency risk through its payables relating to purchases of supplies and consumables from overseas. This is because of a limited amount of purchases denominated in foreign currencies and a short timeframe between commitment and settlement.

(f) Interest Rate Risk
Exposure to interest rate risk arises primarily through Echuca Regional Health's interest bearing assets. Minimisation of risk is achieved by mainly undertaking fixed rate or non-interest bearing financial instruments. For financial liabilites, Echuca Regional Health mainly undertake financial liabilities with relatively even maturity profiles.

Note 7.1: Financial Instruments (Continued)

Interest Rate Exposure of Financial Assets and Liabilities as at 30 June

	* Weighted Average Effective Interest Rates (%)	Interest Rate Exposure			
		Carrying Amount $'000	Fixed Interest Rate $'000	Variable Interest Rate $'000	Non Interest Bearing $'000
2017					
Financial Assets					
Cash and Cash Equivalents	1.61%	459	-	70	389
Receivables		2,295	-	-	2,295
Other Financial Assets	2.83%	3,473	3,473	-	-
Total Financial Assets		**6,227**	**3,473**	**70**	**2,684**
Financial Liabilities					
Trade Creditors & Accruals		3,344	-	-	3,344
Interest Bearing Liabilities		783	-	-	783
Other Financial Liabilities					
- Accommodation Bonds	3.75%	1,849	1,849	-	-
- Other	1.61%	131	300	48	(217)
Total Financial Liabilities		**6,107**	**2,149**	**48**	**3,910**
2016					
Financial Assets					
Cash and Cash Equivalents	1.97%	704	-	55	649
Receivables		1,121	-	-	1,121
Other Financial Assets	2.84%	3,691	3,691	-	-
Total Financial Assets		**5,516**	**3,691**	**55**	**1,770**
Financial Liabilities					
Trade Creditors & Accruals		3,589	-	-	3,589
Other Financial Liabilities					
- Accommodation Bonds	3.75%	1,600	1,600	-	-
- Other	1.97%	554	-	154	400
Total Financial Liabilities		**6,785**	**1,600**	**154**	**5,031**

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

Sensitivity Disclosure Analysis

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

- A shift of +1% and -1% in market interest rates (AUD) from year-end rates of 2.53%;

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

	Carrying Amount	Interest Rate Risk			
		-1%		+1%	
		Profit	Equity	Profit	Equity
2017	$'000	$'000	$'000	$'000	$'000
Financial Assets					
Cash and Cash Equivalents	459	(5)	(5)	5	5
Other Financial Assets	3,473	(35)	(35)	35	35
		(40)	**(40)**	**40**	**40**
2016					
Financial Assets					
Cash and Cash Equivalents	704	(7)	(7)	7	7
Other Financial Assets	3,691	(37)	(37)	37	37
		(44)	(44)	44	44

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

Note 7.1: Financial Instruments (Continued)

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

All financial assets are in the Level 1 category.

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

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

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

Categories of non-derivative financial instruments
Financial assets are categorised as fair value through profit or loss at trade date 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 by the Health Service concerned 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 profit or loss are initially measured at fair value and attributable transaction costs are expensed as incurred. Subsequently, any changes in fair value are recognised in the net result as other comprehensive income. Any dividend or interest on a financial asset is recognised in the net result for the year.

Reclassification of Financial Instruments at Fair Value through Profit or Loss
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.

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

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

Available-for-Sale Financial Assets
Available-for-sale financial instrument assets are those designated as available-for-sale or not classified in any other category of financial instrument asset. Such assets are initially recognised at fair value. Subsequent to initial recognition, gains and losses arising from changes in fair value are recognised directly in 'other comprehensive income' until the investment is disposed of or is determined to be impaired, at which time the cumulative gain or loss previously recognised in equity is included in net result for the period. Fair value is determined in the manner described in Note 7.1.

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

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

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

Offsetting Financial Instruments
Financial instrument assets and liabilities are offset and the net amount presented in the consolidated balance sheet when, and only when, the Health Service concerned has a legal right to offset the amounts and intend either to settle on a net basis or to realise the asset and settle the liability simultaneously.

Note 7.2: Net Gain / (Loss) on Disposal of Non-Financial Assets

	2017 $'000	2016 $'000
Proceeds from Disposals of Non Current Assets		
Medical Equipment	-	1
Motor Vehicles	-	25
Total Proceeds from Disposal of Non Current Assets	-	26
Less: Written Down Value of Non-Current Assets Sold		
Medical Equipment	**11**	-
Motor Vehicles	-	14
Total Written Down Value of Non-Current Assets Sold	**11**	14
Net Gain/(Loss) on Disposal of Non-Financial Assets	**(11)**	12

Disposal of non-financial assets
Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement. Refer to Note 8.1 – 'comprehensive income'.

Impairment of non-financial assets
Goodwill and intangible assets with indefinite lives (and intangible assets not yet available for use) are tested annually for impairment (as described below) and whenever there is an indication that the asset may be impaired.

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

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

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

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

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

NOTE 7.3: Contingent Assets and Contingent Liabilities

There are no Contingent Assets or Contingent Liabilities as at June 2017 (2016 $Nil).

NOTE 7.4: Fair Value Determination

Asset Class	Examples of types of assets	Expected fair value level	Likely valuation approach	Signficant inputs (Level 3 only)
Non-specialised land	In areas where there is an active market; - vacant land - land not subject to restrictions as to use or sale	Level 2	Market Approach	N/A
Specialised land	Land subject to restrictions as to use and/or sale Land in areas where there is not an active market	Level 3	Market Approach	CSO adjustments
Non-specialised buildings	For general/commercial buildings that are just built	Level 2	Market Approach	N/A
Specialised buildings	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.
Infrastructure	Any type	Level 3	Depreciated replacement cost approach	Cost per square metre. Useful life.
Plant and equipment	Specialised items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	Cost per square metre. Useful life.
Vehicles	If there is an active resale market available; If there is an active resale market available	Level 2 Level 3	Market Approach Depreciated replacement cost approach	N/A Useful life

Note 8: Other Disclosures

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

Structure
8.1 Equity
8.2 Reconciliation of Net Result for the Year to Net Cash Inflow/(Outflow) from Operating Activities
8.3 Operating Segments
8.4 Responsible Persons Disclosures
8.5 Executive Officer Disclosures
8.6 Related Parties
8.7 Significant transactions with Government Entities
8.8 Remuneration of auditors
8.9 AASBs issued that are not yet effective
8.10 Alternate Presentation of Comprehensive Operating Statement

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

Note 8.1: Equity

	2017 $'000	2016 $'000
(a) Reserves		
Property, Plant & Equipment Revaluation Surplus		
Balance at the Beginning of the Reporting Period	**24,656**	24,656
Revaluation Increment/(Decrements)		
- Land	**260**	-
- Buildings	**-**	-
Balance at the End of the Reporting Period	**24,916**	24,656
Represented by:		
Land	**260**	-
Buildings	**24,656**	24,656
Total	**24,916**	24,656
(b) Restricted Specific Purpose Surplus		
Balance at the Beginning of the Reporting Period	**-**	-
Transfer to and from Restricted Specific Purpose Reserve	**300**	-
Balance at the End of the Reporting Period	**300**	-
Total Reserves	**25,216**	24,656
Funds held on behalf of Murray Plains Division of General Practice		
(c) Contributed Capital		
Balance at the Beginning of the Reporting Period	**24,804**	21,711
Capital Contribution Received from Victorian Government	**-**	3,093
Balance at the End of the Reporting Period	**24,804**	24,804
(d) Accumulated Surpluses		
Balance at the Beginning of the Reporting Period	**35,777**	40,286
Net Result for the Year	**(3,271)**	(4,509)
Transfer to and from Restricted Specific Purpose Reserve	**(300)**	-
Balance at the End of the Reporting Period	**32,206**	35,777
Total Equity at end of financial year	**82,226**	85,237

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

	2017 $'000	2016 $'000
Net Result for the Year	**(3,271)**	(4,509)
Non-Cash Movements:		
Depreciation	**5,278**	5,629
Impairment of Financial Assets	**(16)**	58
Assets Received Free of Charge	**(34)**	(8)
Movements included in Investing and Financing		
Net (Gain)/Loss from Sale of Assets	**(11)**	12
Movements in Assets and Liabilities		
(Increase)/Decrease in Receivables	**(1,658)**	388
(Increase)/Decrease Inventories	**(63)**	16
(Increase)/Decrease in Prepayments	**(1)**	(130)
Increase/(Decrease) in Payables	**(549)**	988
Increase/(Decrease) in Employee Benefits	**617**	305
Net Cash Inflow/(Outflow) from Operating Activities	**292**	2,749

ECHUCA REGIONAL HEALTH

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

Note 8.3: Operating Segments

	Hospital		RAC		Primary Health		Other		Eliminations		Consolidated	
	2017 $'000	**2016 $'000**	**2017 $'000**	**2016 $'000**	**2017 $'000**	**2016 $'000**	**2017 $'000**	**2016 $'000**	**2017 $'000**	**2016 $'000**	**2017 $'000**	**2016 $'000**
REVENUE												
External Segment Revenue	**53,401**	49,300	**7,252**	6,532	**3,327**	3,156	**4,435**	3,135	**-**	-	**68,415**	62,123
Intersegment Revenue	**4,822**	5,038	**-**	77	**1,977**	1,858	**1**	1	**(6,800)**	(6,974)	**-**	-
Total Revenue	**58,223**	54,338	**7,252**	6,609	**5,304**	5,014	**4,436**	3,136	**(6,800)**	(6,974)	**68,415**	62,123
EXPENSES												
Allocated Segment Expenses	**(54,478)**	(49,708)	**(5,198)**	(5,075)	**(4,778)**	(4,360)	**(7,232)**	(7,489)	**-**	-	**(71,686)**	(66,632)
Intersegment Expenses	**(1,621)**	(1,622)	**(1,956)**	(1,928)	**(436)**	(442)	**3,196**	3,370	**817**	622	**-**	-
Total Expenses	**(56,099)**	(51,330)	**(7,154)**	(7,003)	**(5,214)**	(4,802)	**(4,036)**	(4,119)	**817**	622	**(71,686)**	(66,632)
Net Result from ordinary activities	**2,124**	3,008	**98**	(394)	**90**	212	**400**	(983)	**(5,983)**	(6,352)	**(3,271)**	(4,509)
Interest Income	**-**	-	**-**	-	**-**	-	**90**	110	**(90)**	(110)	**-**	-
Net Result for Year	**2,124**	3,008	**98**	(394)	**90**	212	**490**	(873)	**(6,073)**	(6,462)	**(3,271)**	(4,509)
OTHER INFORMATION												
Segment Assets	**79,595**	84,446	**11,743**	10,931	**585**	638	**114**	105	**-**	-	**92,037**	96,120
Unallocated Assets	**-**	-	**-**	-	**-**	-	**-**	-	**9,931**	8,649	**9,931**	8,649
Total Assets	**79,595**	84,446	**11,743**	10,931	**585**	638	**114**	105	**9,931**	8,649	**101,968**	104,769
Segment Liabilities	**-**	-	**-**	-	**-**	-	**-**	-	**-**	-	**-**	-
Unallocated Liabilities	**-**	-	**-**	-	**-**	-	**-**	-	**19,742**	19,532	**19,742**	19,532
Total Liabilities	**-**	-	**-**	-	**-**	-	**-**	-	**19,742**	19,532	**19,742**	19,532
Acquisition of property, plant & equipment	**-**	-	**-**	-	**-**	-	**968**	9,110	**-**	-	**968**	9,110
Depreciation & amortisation expense	**-**	-	**-**	-	**-**	-	**5,278**	5,629	**-**	-	**5,278**	5,629

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

Segments:	Services:
Hospital	Hospital-based inpatient and non-inpatient services
RAC	Residential Aged Care services
Primary Health	Primary and community health services
Other	District nursing services and public health.

The cost of providing meals from Acute Care to RACS includes a component for salaries and wages.

Segment revenue, segment expenses and segment result include transfers between business segments. Such transfers are accounted for at competitive market prices charged to unaffiliated third-parties for similar goods and services. Those transfers are eliminated in consolidation.

GEOGRAPHICAL SEGMENT

Echuca Regional Health Service operates predominantly in Echuca-Moama. More than 90% of revenue, net surplus from ordinary activities and segment assets relate to operations in Northern Victoria and Southern New South Wales.

Note 8.4: Responsible Persons Disclosures
In accordance with the Ministerial Directions issued by the Minister for Finance under the Financial Management Act 1994, the following disclosures are made regarding responsible persons for the reporting period.

Responsible Ministers:	The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health
Governing Board:	Mr C Bilkey Mr B Sharp OAM Mr G Dwyer Mrs D M Macfarlane Mrs M Boek Mr S Weller Mr G Kelly Ms L Tarrant Mr J Quirk Nr N Rolfe Mrs S Barry Mrs J Hamit
Accountable Officer	Mr M B Delahunty (Chief Executive Officer)

Remuneration of Responsible Persons
Amounts relating to Responsible Ministers are reported in the financial statements of the Department of Parliamentary Services.

Members of the Board do not receive remuneration.

Remuneration received or receivable by the Accountable Officer during the year was in the $320,000 to $329,999 band (2016 $300,000 to $309,999).

Note 8.5: Executive Officer Disclosures
The numbers of executive officers, other than Ministers and Accountable Officers, and their total remuneration during the reporting period are shown in the table below. Total annualised employee equivalent provides a measure of full time equivalent executive officers over the reporting period.

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

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

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

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

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

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

Remuneration	**2017**
Short-term benefits	**$873,223**
Post-employment benefits	**$88,113**
Other long-term benefits	**$46,275**
Total Remuneration	**$1,007,611**
Total number of Executives	**6**
Total Annualised Employee Equivalents (AEE) (i)	**5.2**

(i) Annualised employee equivalent is based on paid working hours of 38 ordinary hours per week over the 52 weeks for a reporting period.

(ii) No comparatives have been reported because remuneration in the prior year was determined in line with the basis and definition under FRD21B. Remuneration previously excluded non-monetary benefits and comprised any money consideration if the benefit was received or receivable, excluding reimbursement of out-of-pocket expenses, including any amount received or receivable from a related party transaction.

Refer to prior year's financial statements for executive remuneration for the 2015-16 reporting period.

Note 8.6: Related Parties

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

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

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

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

Compensation	**2017**
Short-term benefits	**$1,167,079**
Post-employment benefits	**$115,269**
Other long-term benefits	**$63,603**
Total	**$1,345,951**

Transactions with key management personnel and other related parties
Given the breadth and depth of State government activities, related parties transact with the Victorian public sector in a manner consistent with other members of the public e.g. stamp duty and other government fees and charges. Further employment of processes within the Victorian public sector occur on terms and conditions consistent with the *Public Administration Act 2004* and Codes of Conduct and Standards issued by the Victorian Public Sector Commission. Procurement processes occur on terms and conditions consistent with the Victorian Government Procurement Board requirements. Outside of normal citizen type transactions with the department, there were no related party transactions that involved key management personnel and their close family members. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

During the year, related parties of key management personnel were awarded contracts on terms and conditions equivalent for those that prevail in arm's length transactions under the State's procurement process. The transactions involved the provision of lease of property with an aggregated value of $27,041.

All other transactions that have occurred with KMP and their related parties have been trivial or domestic in nature. In this context, transactions are only disclosed when they are considered of interest to users of the financial report in making and evaluation decisions about the allocation of scare resources.

Note 8.7: Significant transactions with Government Entities

Echuca Regional Health received funding from the Department of Health and Human Services of $47.6 million (2016 $50.5 million).

Note 8.8: Remuneration of auditors

	2017 $'000	2016 $'000
Victorian Auditor-General's Office		
Audit of Financial Statement	**38**	41
Total	**38**	41

Note 8.9: AASBs issued that are not yet effective

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

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

The table below outlines the accounting pronouncements that have been issued but not effective for 2016-17, which may result in potential impacts on public sector reporting for future reporting periods.

Standard/Interpretation	Summary	Applicable for annual reporting periods beginning on	Impacts on 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 financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss. While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.
AASB 15 *Revenue from Contracts with Customers*	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1 Jan 2018	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications. A potential impact will be the upfront recognition of revenue from licenses that cover multiple reporting periods. Revenue that was deferred and amortised over a period may now need to be recognised immediately as a transitional adjustment against the opening returned earnings if there are no former performance obligations outstanding.
AASB 2014 1 *Amendments to Australian Accounting Standards [Part E Financial Instruments]*	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	1 Jan 2018	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.

ECHUCA REGIONAL HEALTH

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

Note 8.9: AASBs issued that are not yet effective (Continued)

AASB 2010-7 *Amendments to Australian Accounting Standards arising from AASB 9* (December 2010)	The requirements for classifying and measuring financial liabilities were added to AASB 9. The existing requirements for the classification of financial liabilities and the ability to use the fair value option have been retained. However, where the fair value option is used for financial liabilities the change in fair value is accounted for as follows: • The change in fair value attributable to changes in credit risk is presented in other comprehensive income (OCI); and • Other fair value changes are presented in profit and loss. If this approach creates or enlarges an accounting mismatch in the profit or loss, the effect of the changes in credit risk are also presented in profit or loss.	1 Jan 2018	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. Changes in own credit risk in respect of liabilities designated at fair value through profit and loss will now be presented within other comprehensive income (OCI). Hedge accounting will be more closely aligned with common risk management practices making it easier to have an effective hedge. For entities with significant lending activities, an overhaul of related systems and processes may be needed.
AASB 2014-7 *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 2014-5 *Amendments to Australian Accounting Standards arising from* AASB 15	Amends the measurement of trade receivables and the recognition of dividends. Trade receivables, that do not have a significant financing component, are to be measured at their transaction price, at initial recognition.	1 Jan 2017, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.
AASB 2015-8 A*mendments 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 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2016-7 *Amendments to Australian Accounting Standards - Clarifications to* AASB15	This Standard defers the mandatory effective date of AASB 15 for 1 January 2019 not-for-profit entities from 1 January 2018 to 1 January 2019.	1 Jan 2019	This Standard defers the mandatory effective date of AASB 15 for 1 January 2019 not-for-profit entities from 1 January 2018 to 1 January 2019.
AASB 2016-3 *Amendments to Australian Accounting Standards – Clarifications to* AASB 15	This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: • A promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation; • For items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer; and • For licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access).	1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector, other than the impact identified in AASB 15.
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of most operating leases (which are current not recognised) on balance sheet.	1 Jan 2019	The assessment has indicated that as most operating leases will come on balance sheet, recognition of lease assets and lease liabilities will cause net debt to increase. Depreciation of lease assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. The amounts of cash paid for the principal portion of the lease liability will be presented within financing activities and the amounts paid for the interest portion will be presented within operating activities in the cash flow statement. No change for lessors.

Note 8.9: AASBs issued that are not yet effective (Continued)

AASB 1058 *Income of Not-for-Profit Entities*	This Standard will replace AASB 1004 *Contributions* and establishes principles for transactions that are not within the scope of AASB 15, where the consideraton to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objectives.	1 Jan 2019	The assessment has indicated that revenue from capital grants that are provided under an enforceable agreement that have sufficiently specific obligations, will now be deferred and recognised as performance obligations are satisfied. As a result, the timing recognition of revenue will change.
AASB 2016-8 *Amendments to Australian Accounting Standards - Australian Implementation Guidance for Not-for-Profit Entities*	This Standard amends AASB 9 and AASB 15 to include requirements and implementation guidance to assist not-for-profit entities in applying the respective standards to particular transactions and events.	1 Jan 2019	The assessment has indicated that there will be no significant impact for the public sector, other than the impacts identified for AASB 9 and AASB 15 above.

Note 8.10: Alternate Presentation of Comprehensive Operating Statement

	Note	2017 $'000	2016 $'000
Grants			
- Operating	2.1	**55,365**	51,940
- Capital	2.1	**1,068**	383
Interest	2.1	**90**	110
Sale of Goods and Services	2.1	**11,199**	9,549
Other Income	2.1	**693**	141
Total Revenue		**68,415**	62,123
Employee Expenses	3.1	**42,716**	40,360
Operating Expenses			
- Supplies and Consumables	3.1	**5,308**	4,900
- Non Salary Labour Costs	3.1	**10,434**	8,572
- Other Operating Expenses		**7,927**	7,218
Non-Operating Expenses			
- Impairment of Financial Assets	3.1	**16**	(58)
- Expenditure for Capital Purpose	3.1	**7**	11
Depreciation	4.4	**5,278**	5,629
Total Expenses		**71,686**	66,632
Net Result		**(3,271)**	(4,509)
Other Comprehensive Income			
Changes in Physical Asset Revaluation Reserve	8.1	260	-
Total Other Comprehensive Income		260	-
Comprehensive Result		**(3,011)**	(4,509)

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