ALEXANDRA DISTRICT HEALTH

146TH

ANNUAL REPORT 2016 2017

Photo courtesy State Library of Victoria

OUR HISTORY

1870 In 1870, the local Council purchased two buildings for two pounds. They spent a further 50 pounds, converting an old hotel into a courthouse and the other section into a hospital.

1871 In December 1871 Alexandra Cottage Hospital was incorporated and registered as a Public Hospital.

1957 A fire destroyed a major part of the hospital destroying all records prior to that point.

1993 A redevelopment of the old hospital facility took place including a new urgent care and operating theatre.

2004 Alexandra District Health redeveloped its Community Health building at Alexandra and took on community health services at sites in Eildon and Marysville

2008 Alexandra District Health was awarded the Rural Health Service of the Year award in the Victorian Public Healthcare Awards.

2009 In 2009 the Black Saturday fires devastated the community. Alexandra District Health was directly involved in both the medical response and the rebuilding process including our facility in Marysville that was relocated to Buxton until Marysville was rebuilt.

2010 Construction commenced for the new hospital on the corner of Cooper and Wattle Streets.

2011 Alexandra District Health was awarded the Rural Health Service of the Year award in the Victorian Public Healthcare Awards.

Construction was completed and the hospital relocated to its new home in October 2011.

2015 On the 18th of June 2015 the name of our health service formerly changed from Alexandra District Hospital to Alexandra District Health.

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MISSION STATEMENT

Our Mission

Provision of quality integrated health services that meet the needs of our community.

Our Philosophy

The Alexandra District Health Service philosophy is based on an abiding concern for all patients and their families, but primarily the patient, and that concern revolves around:

1. Prompt attention.
2. Communicating explanations of treatment, delays, changes, re-locations and environment.
3. Comfort – mental, physical and spiritual.
4. Identifying each patient as an individual with individual needs, and help to reduce apprehension.
5. Finally, for staff to appreciate and possess a capacity to see the hospital and its services from the patient's point of view and convey the need for review through proper channels.

Strategic Plan Objectives

Our Vision and Strategic Intent

"To be recognised as a leader in rural health service provision, workforce development and consumer engagement."

Strategies

Be an organisation that is fit for the future.

We will maintain a commitment to robust governance framework and continue to monitor standards.

Have a workforce that is fit for the future.

We will develop education, recruitment and retention strategies that are aligned with service planning goals, staff aspirations, strategic relationships and principles of community enablement to ensure a workforce that is fit for the future.

Ensure the community is fit for the future

Alexandra District Health will promote the development of community focused service delivery in order to build community resilience and maintain services that are appropriate and relevant to community health needs.

Key Initiatives and Projects

- Recruit and maintain key management positions to ensure effective and efficient health service management
- Achieve all accreditation requirements
- Further develop telehealth projects to link to external services including North East Health, Mental Health Triage and Adult Retrieval services.

DISCLOSURE INDEX

The annual report of Alexandra District 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.

(F): Financial Report attached inside back cover of report.

REPORT FROM BOARD CHAIR AND CHIEF EXECUTIVE OFFICER/DIRECTOR OF NURSING

In accordance with the Financial Management Act 1994 we are pleased to present the Report of Operations for Alexandra District Health (ADH) for the year ending 30th June 2017.

ADH has continued to deliver safe, quality healthcare for our community over the past year, delivering on our strategic priorities and ensuring a person centred focus in all that we do.

Some of our achievements this year include:

- Successful ACHS health service accreditation across the 15 national Standards in October 2016
- Exceeding state-wide targets in hand hygiene compliance and health worker immunisation rates
- Our activity in the hospital has increased by 11% compared to last year
- Introduction of the "Pink Lady" volunteers, who do a marvellous job in the acute ward
- The addition of a 4th Registered Nurse credentialed to perform X-rays
- A successful NAIDOC celebration

Our Board

ADH has a dedicated Board providing governance oversight and strategic direction for the health service. In 2016/2017 we welcomed two new members, Sally Percy and Elizabeth Milford. During the year we farewelled Cheryl Nickels-Beattie and as the year draws to a close three members have retired after making significant contributions to the organisation. Margaret Rae retires after serving for 17 years and supported the organisation as Chair throughout the building of the new hospital. Ian McKaskill, also a past Chair, and Ray Twitchett retire after six and four years respectively. We are most grateful for their contributions.

Community Advisory Committee

The Board and staff of ADH were saddened by the passing of our Community Advisory Committee (CAC) member Uncle Roy Patterson in April 2017. Uncle Roy was an active member of the CAC and instrumental in the development of the gardens around the entrance of the new hospital building and for assisting us in ensuring we provide a welcoming environment for members of the aboriginal community who access services at ADH. During the NAIDOC celebrations a plaque was unveiled in acknowledgment of Uncle Roy.

Management Changes

ADH has experienced several changes in the management team this year. Mara Richards CEO/DON resigned in November 2016 and we appreciate the leadership shown by Margaret Baker, Perioperative Manager who acted as CEO/DON during the recruitment process.

The Director of Medical Services, Dr Peter Sloan resigned from ADH in May 2017, due to other work commitments. Peter had worked at ADH for the past 3 years and we thank him for his contribution to the health service.

In May, Andrew Lowe was appointed to the newly created position of Director of Corporate Services/ Chief Financial Officer/Chief Procurement Officer. A realignment of leadership positions resulted in Claire Palmer and Margaret Baker being recognised for their leadership roles as Deputy Directors of Nursing.

Appointment of new CEO/DON

In December 2016 the Board announced the successful recruitment of Debbie Rogers as the new CEO/ DON. Debbie commenced in the role in late January and brings with her a wealth of health service leadership and management skills. The Board is looking forward to working with Debbie and the executive team to deliver high quality health services for our community.

Financial Performance

When assessing the result prior to capital and specific items, the financial results for 2016-17 indicated a slight deterioration in the financial performance of the health service compared to the prior year. The overall result for the year after capital and specific items has improved significantly year on year.

The Future

ADH is planning to undertake three important projects in 2017/18. The first is a clinical governance review which will ensure our systems and processes remain safe and contemporary. Following this we will engage in clinical services planning to make sure our services meet community need within a capability framework, and the third project will review our assets and workforce and develop a plan to ensure ongoing sustainability of our health service.

Our success depends on the strong governance and commitment of our Board members, effective leadership from our executive, and the skills, knowledge and dedication of our staff, in partnership with our community advisors. We would also like to acknowledge the generosity of our fundraisers, volunteers and community whose contributions greatly assist in the purchase of new equipment.

We also thank our patients, and clients who have shared their journey to health with us.

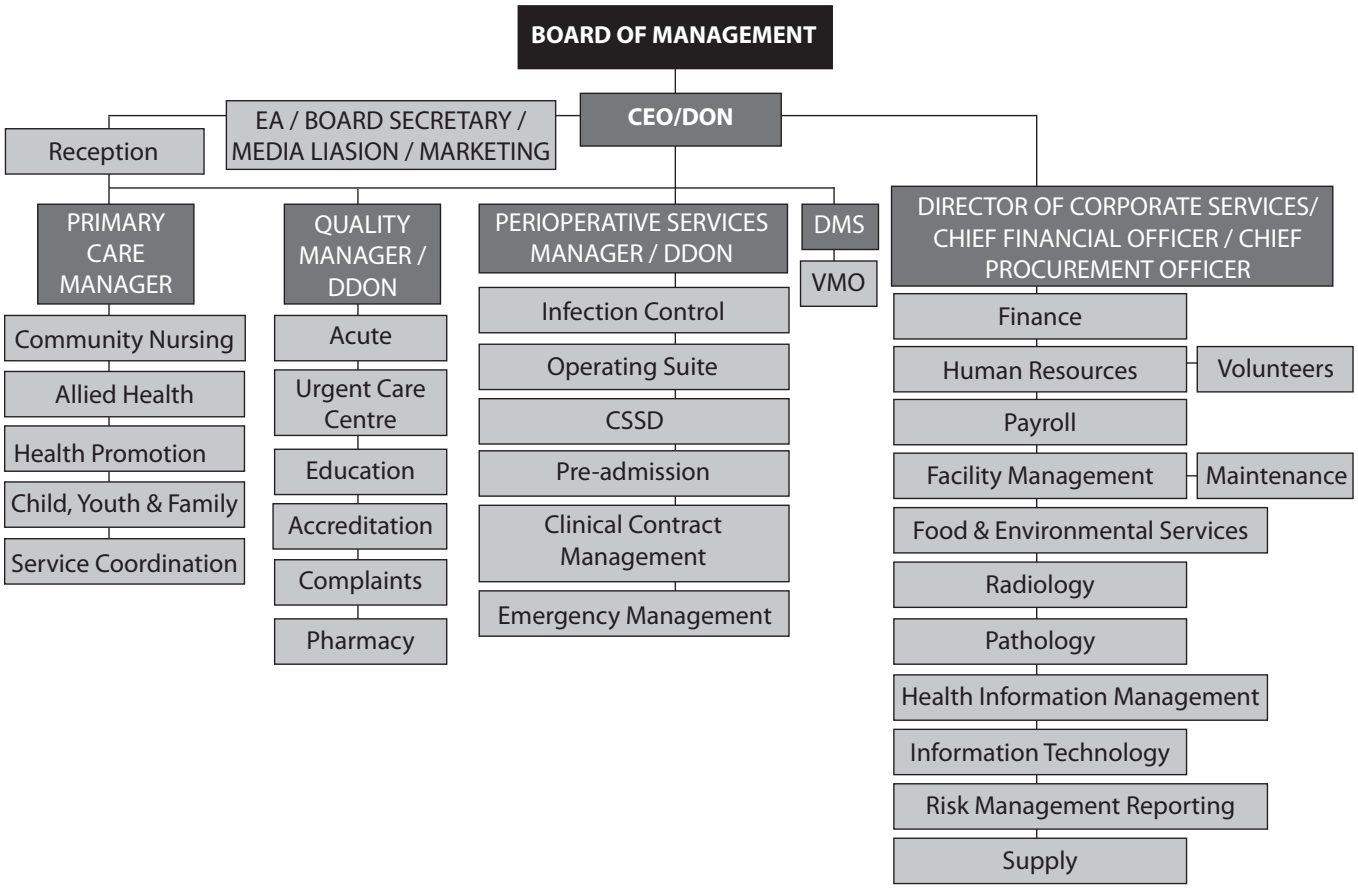
We acknowledge the support of the Victorian Government, Department of Health and Human Services and the Federal Government in the funding of our operations and initiatives.

It has been a busy and rewarding year for Alexandra District Health and we are proud to lead the health service into the future. We hope that you enjoy reading our 2017 Annual Report and learning more about our achievements in the past year.

Deborah Rogers CEO/DON

Carole Staley
Chair Board of Management

ORGANISATIONAL STRUCTURE



COMMITTEE REPORTING STRUCTURE

HOSPITAL PROFILE

Board of Management Chair
Ms Carole Staley

Chief Executive Officer/Director of Nursing
Mrs Mara Richards (to 25th November 2016)
Mrs Margaret Baker (Acting) from 28th November 2016 to 22nd January 2017)
Mrs Deborah Rogers (from 23rd January 2017)

Relevant Ministers
The Hon. Jill Hennessy, MP Minister for Health, Minister for Ambulance
The Hon. Martin Foley, MP Minister for Housing, Disability and Ageing, Minister for Mental Health

Originally Established
Incorporated December 11th, 1871 – Hospital and Charities Act (6274)

Accreditation Status
Fully Accredited to 9th March 2021

Workforce Data

	JUNE Current Month FTE		JUNE Year To Date FTE	
Labour Category	**2016**	**2017**	**2016**	**2017**
Nursing	19.66	20.69	20.09	20.89
Administration and Clerical	12.61	13.15	11.14	12.05
Medical Support	8.99	8.99	9.85	10.06
Hotel and Allied Services	11.22	11.22	10.75	10.94
Medical Officers	0.25	0.25	0.38	0.43
Ancillary Staff	0.62	0.62	0.59	0.58

All employees are correctly classified in workforce data collections and are required to comply with the Alexandra District Health Code of Conduct under their respective employment agreements. Alexandra District Health is committed to applying the Public Sector employment principles and upholds the key principles of merit and equity in all aspects of the employment relationship. To this end we have policies and practices in place to ensure all employment related decisions including recruitment, training and retention are based on merit.

Approved Beds
25 acute
6 day procedure

Office Bearers

Chair	Ms Carole Staley
Deputy Chair	Mrs Lorna Gelbert
Board Members	Mr Geoff Hyland
	Mr Ian McKaskill (retired 30/06/2017)
	Ms Margaret Rae (retired 30/06/2017)
	Mr Ray Twitchett (retired 30/06/2017)
	Mrs Jennifer Cummins
	Dr Elizabeth Milford
	Mrs Sally Percy
	Ms Cheryl Nickels-Beattie (resigned 02/05/17)
Auditor	Auditor General
Appointed Agent	Richmond, Sinnott & Delahunty
Bankers	ANZ, NAB
Solicitors	Phillips Fox / Health Legal

Responsible Bodies Declaration

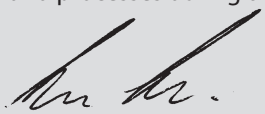
In accordance with the Financial Management Act 1994, I am pleased to present the Report of Operations for Alexandra District Health for the year ending 30 June 2017.

Carole Staley
Chair Board of Management
Alexandra
On the 30th June 2017

Attestation on Compliance with Health Purchasing Victoria (HPV) Health Purchasing Policies

Compliant

I, Andrew Lowe certify that Alexandra District 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.



Andrew Lowe
Chief Procurement Officer
Alexandra
on the 30th June 2017

SENIOR STAFF POSITIONS & ROLES

Chief Executive Officer/Director of Nursing:
Deborah Rogers

The CEO/DON is responsible for the operational, clinical, financial and human resource management of Alexandra District Health. Additionally, this position holds full responsibility for legislative compliance and organisational performance together with organisational development and enhancement.

Director of Corporate Services / Chief Finance Officer / Chief Procurement Officer
Andrew Lowe

The Director of Corporate Services / Chief Financial Officer (CFO) / Chief Procurement Officer (CPO) is a member of the Executive Team having responsibility for the leadership and management of the Corporate Services Division. The Director of Corporate Services is responsible for the overall finance and accounting function, assisting in the formation of financial and budgeting policies and procedures.

Director of Medical Services

The Director of Medical Services (DMS) acts on behalf of Alexandra District Hospital (ADH), in overseeing the professional performance of all contracted Visiting Medical Officers (VMO's) to enhance and develop medical service provision. The DMS is responsible for ensuring a safe medical care environment for patients of ADH.

Primary Health Manager:
Jane Judd

The Primary Health Manager is responsible for the planning, co-ordination, and monitoring of the provision of high quality and accessible Primary Health services at Alexandra, Eildon and Marysville.

Perioperative Services Manager / Deputy Director of Nursing (DDON):
Margaret Baker

The Perioperative Services Manager is responsible for the day to day function of the theatre department.
The DDON reports to and works collaboratively with the Director of Nursing (DON). This position has a strong operational focus overseeing and managing the work and services provided by the perioperative services clinical team. The DDON is responsible for the coordination of infection prevention and control and occupational health and safety throughout the organisation.

Quality Manager / Deputy Director of Nursing (DDON):
Claire Palmer

The Quality Manager is responsible for the development and management of the Alexandra District Health (ADH) Safety and Quality Management Plan and Risk Management Framework. The DDON reports to and works collaboratively with the Director of Nursing (DON). This position has a strong operational focus overseeing and managing the clinical teams in the acute ward and urgent care centre.

FINANCE REPORT

The financial results for 2016-17 indicated a slight deterioration in the financial performance of the health service compared to the prior year, when assessing the result prior to capital and specific items.

This is our operating result and reflects ongoing improvement in our hospital revenue activity, these gains however were offset by overruns in staff salaries and wages, visiting medical officer fees and increases in patient transfers (which are associated with the activity increases).

Importantly, this year revenue was impacted favourably with increased presentations of DVA patients and ongoing positive private patient results. The level of activity across all areas of care remains at high levels including, bed based service and client services in the community health areas.

The overall result for the year after capital and specific items has improved significantly year on year.

Andrew Lowe
Director of Corporate Services / Chief Financial Officer /Chief Procurement Officer

PERFORMANCE

Five Year Financial Comparison Summary:	**2017**	**2016**	**2015**	**2014**	**2013**
Total Revenue	7,825,428	7,656,794	7,134,199	7,037,653	7,014,411
Total Expenses	8,887,959	8,551,853	8,707,796	8,291,351	9,007,563
Net Result for the Year (including Capital and Specific items)	**(1,062,531)**	**(895,059)**	**(1,573,597)**	**(1,253,698)**	**(1,993,152)**
Retained Surplus/ (Accumulated Deficit)	**13,839,129**	**14,901,660**	**15,768,795**	**17,318,064**	**18,571,762**
Total Assets	26,670,067	27,732,716	28,515,494	30,059,698	25,898,409
Total Liabilities	1,729,863	1,729,981	1,645,624	1,640,559	1,534,386
Net Assets	**24,940,204**	**26,002,735**	**26,869,870**	**28,419,139**	**24,364,023**
Total Equity	**24,940,204**	**26,002,735**	**26,869,870**	**28,419,139**	**24,364,023**

BOARD OF MANAGEMENT

Board Chair
Ms Carole Staley

Carole is a Registered Nurse and holds qualifications in health service management. She has 30 years' experience within the health care sector including senior management roles. She has extensive experience in implementing new models of care and improvement initiatives, particularly at the interface between the acute hospital and community care area. Carole is currently employed by Eastern Health.

Deputy Chair
Mrs Lorna Gelbert

Lorna is a practicing Lawyer and an Accredited Property Law Specialist. Lorna was a partner with a medium sized law firm in Melbourne CBD, but in 2013 moved permanently to Buxton and set up her own small practice in partnership with her partner Colin. Lorna has previously been a Board Member of Places Victoria, Women's Legal Service Victoria and Family Law Legal Service. Aside from her legal practice, Lorna and her son Michael own and operate Buxton Ridge vineyard and winery.

Mrs Jennifer Cummins

Jenny is a qualified Physiotherapist who has held senior management positions in public hospitals. Jenny has experience in quality assurance, occupational health and safety management and has held directorships in a number of private companies.

Mr Ian McKaskill

Ian McKaskill is a mechanical engineer with over 35 years' experience. He has expertise in the project management and delivery of large capital works projects in the process industries. Ian is Executive Manager of the Upper Goulburn Landcare Network, and has involvement in Murrindindi East Chapter of U3A, Yea and District Community Bank, Murrindindi Shire Council Audit Advisory Committee and Alexandra Visitor Information Centre. Ian has served for 6 years, retiring 30th June 2017.

Ms Margaret Rae

Margaret has a background in both the public and private sectors and a professional career in academic management. Margaret has extensive experience on a range of boards and committees, including the Goulburn Valley Water Authority Board, Lake Mountain Alpine Resort Management Board and Buxton CFA, together with active involvement in local tourism and community organisations. Margaret has served on the hospital board for 17 years, retiring 30th June 2017.

Mr Geoff Hyland

Geoff has a background in finance and accounting having graduated with a Bachelor of Commerce degree and worked with a Melbourne accounting firm for seven years before being self employed as an on course bookmaker – a profession he has enjoyed for 35 years. Geoff has been involved in traders and tourism bodies in Marysville and Alexandra at committee level.

Mrs Cheryl Nickels-Beattie (resigned 2nd May 2017)

Cheryl's qualifications include a Bachelor of Business Accounting. She has experience in local government and health service senior management. Cheryl has worked in financial management, information management and Risk Management.

Mr Ray Twitchett

Ray has worked in the Construction and Water Industry for many years, having gained considerable experience in both the public and private sectors both as a contract plumber and in project management/ supervisory positions. Ray holds a Diploma in Project Management and is well versed in OH&S requirements. He has also held various positions at Board level with sporting bodies in both Euroa and Shepparton as well as being actively involved in the organisations. Ray served on the hospital board for four years, retiring 30th June 2017.

Ms Sally Percy

Sally is a Registered Nurse and has a long history of working in acute and community care settings. She completed her Master of Business Administration (Quality Management) and worked as a Quality and Risk Manager with a non-profit nursing organisation in Melbourne for over 26 years. She has extensive experience in developing and implementing Clinical Governance and Risk Management Frameworks and ensuring compliance with accreditation standards. She continues to undertake accreditation surveys in both hospitals and community settings for the Australian Council on Healthcare Standards.

Dr Elizabeth Milford

Dr Elizabeth Milford is a lecturer in clinical communications at the University of Melbourne and manager of a large community dental practice in northern Melbourne. Board positions include current finance, risk and audit committee member and former executive board member for Australian Dental Association (Victoria). Elizabeth has an MBA (Prof) from Melbourne Business School and is professional mentor for dentists at all stages of their career. Elizabeth enjoys visiting Alexandra year round for outdoor activities with her family and building her network of friends in the area.

CORPORATE GOVERNANCE

Alexandra District Health (ADH) Annual Report has been compiled to meet the requirements of the Public Administration Act, Financial Management Act and other requirements.

Information required by legislation – but not recorded elsewhere in this annual report is summarised below.

The organisation is governed by the Board of Management. The Board is appointed by the Governor-in-Council upon the recommendation of the Minister of Health, the Hon Jill Hennessy MP.

Board of Management

The functions of the board are:

- To provide strategic leadership to the organisation, monitor performance against agreed objectives ensure accountability and compliance.

The Board of Management Committee membership is governed by the Alexandra District Health Rules.

Quality and Clinical Governance Committee

The Quality and Clinical Governance Committee is a Board subcommittee responsible for the implementation of a strong Quality and Clinical Governance framework that encompasses the domains of quality and safety. This incorporates:

- Consumer participation
- Clinical effectiveness
- Effective workforce
- Risk Management

The Quality and Clinical Governance Framework will ensure that structures, policies, systems, processes and practices are in place and are developed, implemented, monitored and evaluated to support the consumer through their journey and to support the teams to deliver safe, high quality, effective care.

The committee oversees the clinical systems and frameworks that are in place.

The reporting of clinical key performance indicators is presented to the Board of Management

Finance, Audit and Risk Committee

The Alexandra District Health (ADH) Finance, Audit and Risk (FAR) Committee is a sub-committee of the ADH Board of Management. The Committee provides governance and oversight to:

1. Financial management (including asset management)
2. Risk management (including compliance management)
3. Internal and external audit.

Medical Appointments Committee

The committee meet as necessary and advises the Board regarding the appointment, suspension and removal from office of medical practitioners as required.

Consumer Advisory Committee

The Consumer Advisory Committee function is to improve the ADH partnerships with consumers in service planning, designing care and service measurement and evaluation. This is achieved by the following means:

- Providing advice to the Board on appropriate and effective processes and structures, for community participation and the integration of consumer, carer, and community views into all levels of health service operations, planning and policy development
- Advocating to the Board on behalf of the community, consumers and carers
- Identifying and advising the Board on priority areas and issues requiring consumer, carer and community participation
- Providing advice in the development of the Strategic Plan, the Cultural Diversity Plan and the annual Quality account.

Quality and Clinical Risk Committee

The Quality and Clinical Risk committee's duties and responsibilities are to:

- Coordinate the planned and systematic development, implementation and monitoring of care and services to ensure the provision of safe, high quality, effective care and a positive consumer experience
- Report review and monitor any current, new or emerging risks in line with ADH risk management framework
- Develop, implement and monitor the suite of Quality Key performance Indicators (KPI)
- Ensure relevant information on recommended actions for correction or improvement of any service provided is conveyed to the Board and to the relevant hospital department or personnel.

Occupational Health and Safety Committee

The committee is responsible for coordinating occupational health and safety including occupational violence, waste management and emergency management within the Hospital and:

- Facilitates co-operation between employers and employees in instigating, developing and carrying out measures designed to secure the health and safety of employees in the workplace
- Formulating and reviewing the health and safety standards, rules and procedures that are to be carried out or complied with in the workplace, and make them known to employees
- Identifying workplace risks through review and analysis of staff accidents and near miss/hazard reports. Refer significant risks to the Quality and Clinical Governance Committee and the Risk Register.

STATUTORY REPORTING

Alexandra District Health's Annual Report has been compiled to meet the requirements of the public Administration Act, Financial Management Act and other requirements.

Information required by legislation but not recorded elsewhere in this annual report is summarised below.

Pecuniary Interests

The Board of Management members are required to notify the Chair of the Board of any pecuniary interests. All members have completed a statement of pecuniary interests.

Health Services Act, 1988

Alexandra District Health does not administer any Acts. The Health Services Act of 1988 is the vehicle by which Health Services are incorporated and prescribes the manner in which they are regulated.

Complaints System

A complaints register is maintained and quarterly reports are made to the Health Services Commissioner.

Complaints are assessed promptly and the Board of Management is kept informed of the nature of complaints.

Complaints are used as a means to achieve continuous quality improvement in all facets of health care business.

Freedom of Information Act, 1982

The Freedom of Information Officer is the Chief Executive Officer (CEO). Persons wishing to access information under the Freedom of Information Act 1982 should apply in writing to the CEO.

During 2016/2017 there were 6 Freedom of Information requests.

Protected Disclosure Act, 2012

Alexandra District Health complied with the Protected Disclosure Act 2012 for the year 2016/2017.

Carers Recognition Act 2012

Alexandra District Health complied with the Carers Recognition ACT 2012 for the year 2016/2017.

Victorian Industry Participation Act, 2003

Alexandra District Health complied with the Victorian Industry Participation Policy ACT 2003 for the year 2016/17.

Safe Patient Care Act, 2015

Alexandra District Health complies with the Safe Patient Care Act 2015.

Employment and Conduct Principles

All employees are correctly classified in workforce data collections and are required to comply with the Alexandra District Health Code of Conduct under their respective employment agreements. Alexandra District Health is committed to applying the Public Sector employment principles and upholds the key principles of merit and equity in all aspects of the employment relationship. To this end we have policies and practices in place to ensure all employment related decisions including recruitment, training and retention are based on merit.

Fees and Charges

Alexandra District Health charges fees in accordance with the Department of Health Fee Schedule.

Occupational Health and Safety

Alexandra District Health has an Occupational Health and Safety (OH&S) Committee which meets regularly. Staff report incidents, accidents and near misses which are then assessed at monthly meetings and appropriate action is taken.

During 2016/17 Alexandra District Health has:

- Updated the online manual handling and occupational violence training for all staff
- Provided staff with training for managers and supervisors and refresher training for Health and Safety Representatives (HSR)
- Provided online training on anti-bullying and harassment to all staff
- Provided staff with annual fire extinguisher and hose reel and emergency management training
- Developed an action plan to address occupational violence and aggression.

Competitive Neutrality

Alexandra District Health has a policy in place for the implementation of the Victorian Government's policy on Competitive Neutrality.

Industrial Disputes

Time lost through industrial disputes:

Nil.

Overseas Travel

Nil.

Building Standards

Alexandra District Health complies with Regulation 1209 and 1215 of the Building Act 1993. Alexandra District Health engages an independent contractor to perform an assessment of all buildings in accordance with Section 22E of the Act. A current Annual Safety Measures Report is on display at the Urgent Care entry.

Outsourcing of services

- AASB Accounting and Audit Solutions – Accounting
- Clinical Labs – Pathology
- North East Health Wangaratta / Mansfield Radiographic Service – Radiology
- Sound Imaging – Ultrasound

Details of Consultancies Engaged

In 2016-17, there were no consultancies where the total fees payable to the consultant was $10,000 or greater.

In 2016-17, there was one consultancy where the total fee payable to the consultant was less than $10,000. The total expenditure incurred during 2016-17 in relation to this consultancy was $9,000 (excl. GST).

Consultant	Purpose of consultancy	Start date	End date	Expenditure 2016-17 (ex GST)
Health Recruitment Specialist	CEO/DON Recruitment	November 2016	January 2017	$9,000

Publications

The following publications dealing with the functions, powers, duties and activities of the hospital were produced in 2016/2017 and may be viewed at the health service upon request:

- Alexandra District Health 146TH Annual Report

Information and Communication Technology (ICT) Expenditure

The total ICT Expenditure of ADH is outlined below.

	Total ICT Costs 2016/17 (Ex GST)
Business As usual (BAU) ICT Expenditure (Total Ex GST)	$208,464
Non-Business As Usual (Non-BAU) ICT expenditure (total operational and capital expenditure ex GST)	$50,963
Operational expenditure (excluding GST)	$152,616
Capital Expenditure (excluding GST)	$106,811

Occupational Violence

Alexandra District Health publicly reports and monitors incidents of occupational violence.

The below table outlines these instances.

Occupational Violence Statistics	2016 2017
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	4
4. Number of occupational violence incidents reported per 100 FTE	7.28
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition	0

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.

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

Lost time – is defined as greater than one day.

Additional Information Available Upon Request

Items listed below have been retained by Alexandra District 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):

- Declarations of pecuniary interests have been duly completed by all relevant officers
- 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
- Details of changes in prices, fees, charges, rates and levies charged by the Health Service
- Details of any major external reviews carried out on the Health Service
- 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
- Details of all consultancies and contractors including consultants/contractors engaged, services provided, and expenditure committed for each engagement.

ENVIRONMENT & SUSTAINABILITY

Alexandra District Health (ADH) strives to provide a sustainable environment for the community and continue to work to reduce our carbon footprint.

How do we perform?

- We continue to monitor our solar production and have seen a significant reduction in the electricity consumed especially in the summer months. In 2016/17 we produced 125 Mega Watt Hours (MWH). The production of solar power has resulted in a carbon offset of 86.46 tons or the equivalent of 2217 trees.
- An ongoing commitment to educating staff on reducing clinical waste has resulted in an overall decrease of 34% in kilograms of clinical waste produced.
- Our theatre department continue to participate in a sterile wrap recycling project that means this product no longer ends up in landfill.
- We continue working on a replacement program to replace our halogen lighting to LED replacements throughout the hospital site.
- We reduced our overall general waste contributing to landfill by 11%.

Did we achieve our goals?

In 2016/17 ADH set a number of goals for the 2016/17 reporting period including:

Goal: Reduce clinical waste in total volume and containers through education of the correct separation of clinical and general waste practices.

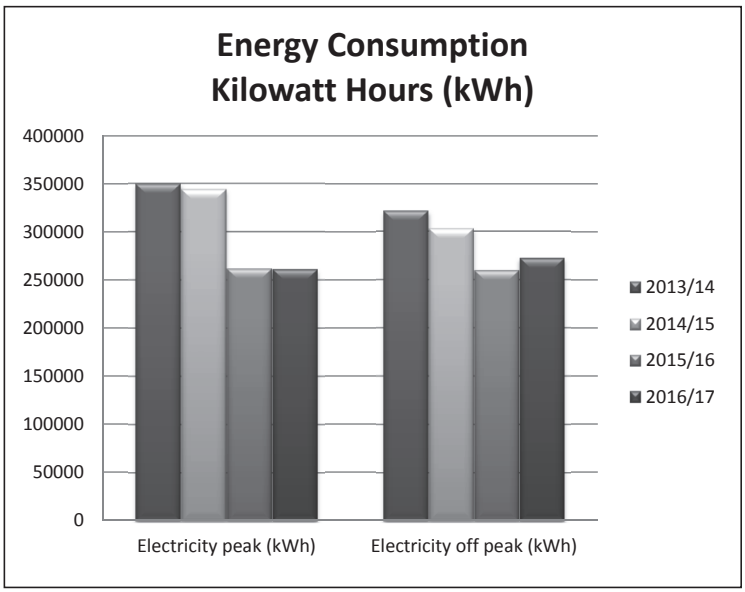
Result: An overall reduction of clinical waste of 34% (in totals kgs produced) and 13% (containers)

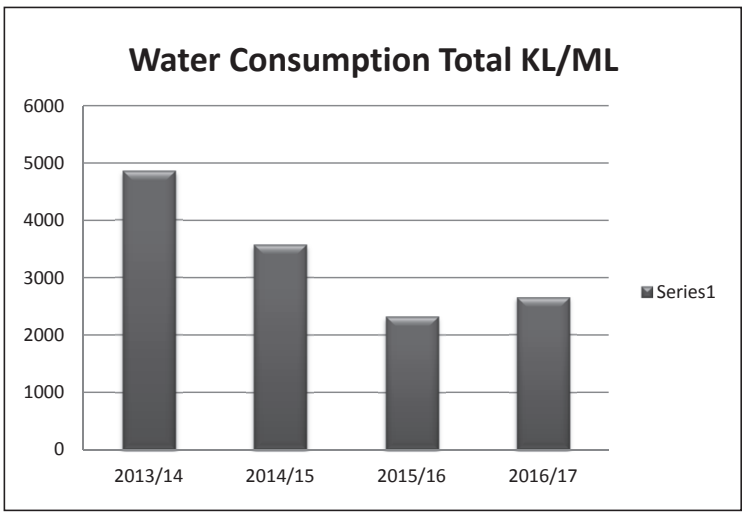
Goal: Reduce our overall carbon footprint by 50 tonnes by 30 June 2017 by reducing our electricity, water and gas usage through various environmental projects.

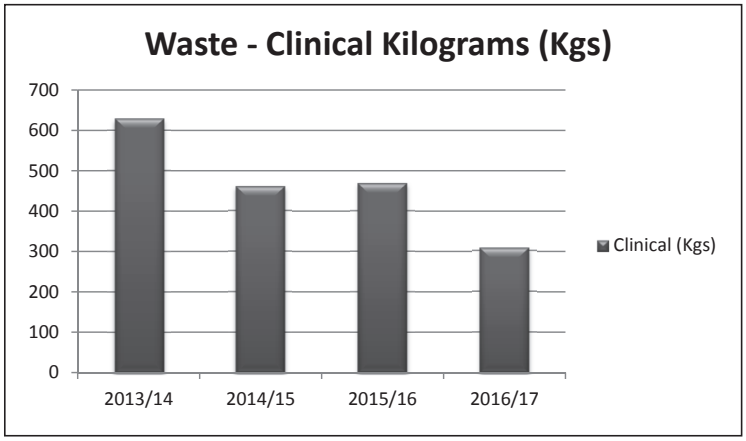
Result: ADH achieved an overall reduction of 31 tonnes. We will continue to work towards a further reduction in carbon emissions in 2016/17.

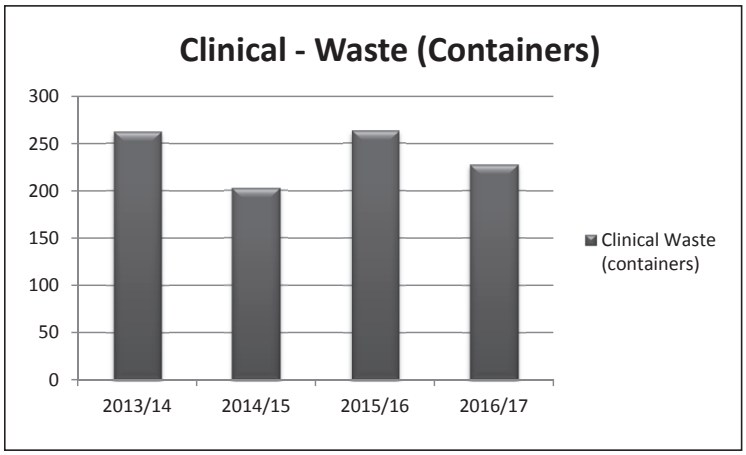
Goal: Overall fuel consumption target reduction of 5% by the end of 2016/17 by reducing non-essential travel and increased use of video conferencing.

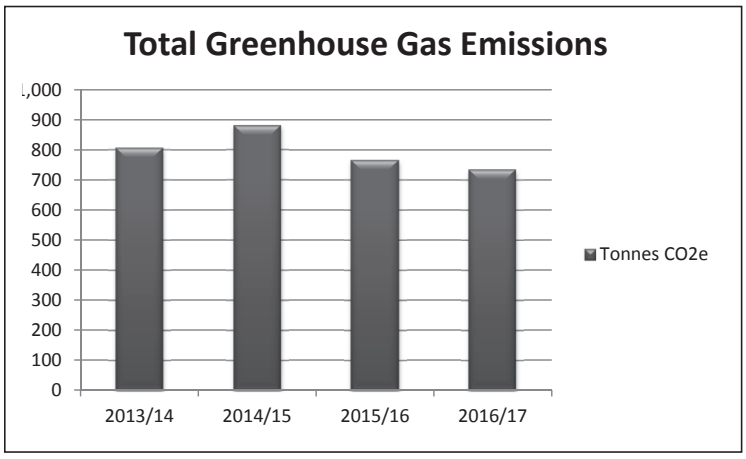
Result: Due to an increase in remote service provision and external training and meetings that are not provided via telehealth our result was a 21% increase in fuel consumption. We will continue to work towards a decrease in non-essential travel and use of telehealth facilities and aim for a 5% reduction on 2016/17 totals.

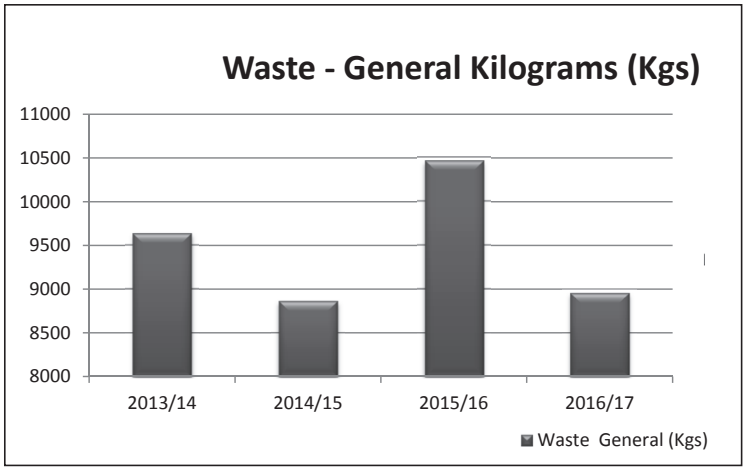










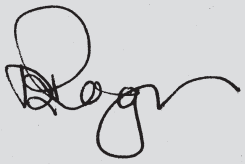


Attestation for compliance with Ministerial Standing Direction 3.7.1 – Risk Management Framework and Processes

I, Deborah Rogers, certify that Alexandra District Health has partially complied with Ministerial Standing Direction 3.7.1 - Risk Management Framework and Processes. The partial compliance is due to the evolving maturity of Alexandra District Health's risk management framework. Alexandra District Health is collaborating with the Victorian Managed Insurance Authority and other agencies to progressively strengthen and further integrate risk management structures and processes into its risk management framework and there is a detailed action plan in progress. The Alexandra District Health Finance, Audit and Risk Committee have verified this.

Alexandra District health is partially compliant in the following:

- A risk management framework is in place that is consistent with AS/NZS ISO 31000:2009
- The Risk Management Framework has been reviewed within the last 12 months
- Risk Management Framework has supported the development on a positive risk culture
- The Risk Management Processes have been effective in managing risks to a satisfactory level
- Responsibility for management of individual risks is clear
- Interagency risks have been addressed and Alexandra District Health has contributed to the management of shared risks as appropriate
- Alexandra District Health has contributed to the identification and management of state-significant risks as appropriate
- Risk management has been integrated into corporate and business planning processes
- Adequate resources have been assigned to the management of risk
- The Alexandra District Health risk profile has been reviewed within the last 12 months.



Deborah Rogers
Chief Executive Officer/
Director of Nursing
Alexandra
Date 30th
June 2017

STATEMENT OF PRIORITIES

Statement of Priorities Part A – Strategic Priorities for 2016/17

The Victorian Government's priorities and policy directions are outlined in the *Victorian Health Priorities Framework 2012–2022*. In 2016/17 Alexandra District Health (ADH) will contribute to the achievement of these priorities by:

Priority/Domain	Action	Deliverables	Outcome
Quality and safety	Implement systems and processes to recognise and support person-centred end of life care in all settings, with a focus on providing support for people who choose to die at home.	Implementation of person centred end of life pathways across all areas of Alexandra District Health, with a focus on community.	Achieved. Action Plan developed and implemented for "Having the Conversation" project includes legislative compliance, policy, training, community evaluation.
		Governance framework is in place to support the adaptation of specific pathways modelled on the Care Plan for the dying person. This will be a collaborative approach with our service partner, Lower Hume Palliative Care, who are directly linked with the Centre for Palliative Care at St Vincent's Hospital.	Achieved. Information obtained from Victorian End of Life Care and Care for the dying person. A care plan has been provided and an information session with be attended by Advanced Care Planning (ACP) Nurse and Nurse Educator with a plan to implement at Alexandra District Health.
		75% of line staff to complete E3 learning module to enable them to start the conversation.	Achieved. Staff education provided via the circulation of U-tube videos on Respecting patient Choices.
	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.	Senior managers to attend Public Advocate training and lead on site training by the Public Advocate Office will be conducted in 2016-17 to enhance understanding about early Advanced Care Planning. Evaluation of Advanced Care Planning outcomes reported through operational and clinical governance committees to include feedback from families and carers is included in the evaluation of the Advanced Care Planning.	Achieved. One management representative has attended Office of the Public Advocate training. Three staff have completed Advanced Care Planning (ACP) training. ACP Nurse presented to Probus in May the session topic 'Taking Control' and 'Advanced Care Planning'. ACP and Enduring Power of Attorney forms available for download by members of the public via ADH website. The Office of the Public Advocate (OPA) has completed a one day training session onsite at ADH with 14 attendees. Resources provided to staff that were unable to attend. Getting your Affairs in Order forums to be held in the community in October 2017. Ongoing audits of the number of Advanced Care Plans (ACP) in inpatient records. Care template is reviewed against ACP. Feedback (compliments) for palliative care collected separately and reported at Quality and Clinical Risk Committee. Quality manager/Deputy Director of Nursing have reviewed and improved mortality and morbidity to include ACP.

Priority/Domain	Action	Deliverables	Outcome
Quality and safety CONTINUED	Progress implementation of a whole-of-hospital model for responding to family violence.	Partnership with Goulburn Valley Health as part of a region wide Family Violence Initiative model.	In progress. ADH met with GV Health who presented the Strengthening Hospital Responses to Family Violence (SHRFV) Service Model, including the 2 overarching principles or Gender Equality and Sensitive Practice. The 6 key elements of work to ensure successful implementation were discussed and project resources shared. A work plan has been developed and key staff have been identified to lead the SHRFV work to increase capability and capacity of managers and staff to identify and respond to family violence and build networks with local service networks. Training staff to build capacity and capability is a critical element of the SHRFV model, however all foundation elements will be in place prior to staff training commencing. 'Train the trainer' sessions will be provided by GV Health in 2017-18.
		Increased capability and capacity of managers and staff to identify and respond to family violence.	In progress. As above. Attendance at statewide forum at Peter Mac is planned for August 2017.
		Development of policies and procedures including guidelines related to family violence.	In progress. As above.
		Relationships established including development of referral pathways internally and externally.	Achieved. Nexus is funded as the referral pathway for Men's Behaviour Change / Women and Children's Family Violence in this region. There are established referral pathways through service co-ordination to both internal and external program providers.
	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.	Chief Executive Officer and members of the Senior Management Team to actively participate in regional forums and networks that promote safe quality care.	Achieved. ADH is active in the following regional groups: • Victorian Perioperative Nurses Group • Gastroenterology Nurses Group • Hume Wound Care Regional Committee • Hume Chronic Care Committee • Hume Clinical Educators Group • DNS Regional Network • HACC and CH Managers forum • Hume CEO forum • Small Rural Health Service & MPS CEO forum • Riskman Support Group • Hume Region Infection Control Group • Hume Director of Nursing Meetings

Priority/Domain	Action	Deliverables	Outcome
Quality and safety CONTINUED	Develop a regional leadership culture CONTINUED	Regional leadership initiatives communicated within the organisation to promote and improve safe clinical practice.	Achieved. ADH has engaged in Safer Care Victoria and Better Care Victoria initiatives.
	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.	Involve consumers in the analysis of all available consumer feedback data to improve client services.	Achieved. Consumer Advisory Committee (CAC) agenda includes standard items around Safety and Quality. Victorian Health Experience Survey (VHES) and Primary Health Consumer Opinion Survey Project (PHCCOS). Feedback from consumers is presented to CAC for discussion and identification of further improvements.
		Utilise the data from the Victorian Healthcare Experience Survey as a basis for service planning on identified needs.	Achieved. Areas identified and appropriate actions taken e.g. discharge planning, food quality, students. Action Plan has been developed and implemented. These are updated quarterly.
		Report the Victorian Healthcare Experience Survey throughout the organisation and implement and monitor improvement actions to enhance patient experiences.	Achieved. Distributed to Board members and displayed on quality boards and communication book and discussed at staff meetings.
	Develop a whole of hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint.	Ongoing education of staff, consumers and their families of the organisation's zero restraint policy and implementation of an audit tool to monitor adherence.	Achieved. Policy and form developed. Audit tool designed and education underway with staff.
		Develop an organisational-wide policy to define and guide our approach to restrictive practices.	Achieved. Policy and form developed. Audit tool designed and education underway with staff.
		Develop indicators to monitor the use of restrictive practices and report through clinical committees via audit outcomes.	Achieved. Audit tool implemented.
Access and timeliness	Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine).	Implement the Hume Chronic Care Strategy priorities to prevent avoidable admissions and improve access to highest need cohorts.	Achieved. ADH provides leadership to the Regional Ovens Murray – Goulburn Chronic Care Committee. There are 3 priority projects addressing chronic disease reduction strategies. Urgent Care Management and partnerships with GP clinics. Chronic Disease Management discussed at Visiting Medical Officer (VMO) meetings.
		Work with the Primary Health Network to deliver Health Pathways with local General Practitioners.	Achieved. Murray Primary Health Care Networks presented Care Pathways to local GP clinics and staff in the Community Health Program on 6th March.
		Participate in service collaborative in Diabetes.	Achieved. ADH participates in the Diabetes Service Collaborative.

Priority/Domain	Action	Deliverables	Outcome
Access and timeliness CONTINUED	Identify opportunities and implement pathways CONTINUED	Provide education to staff of the referral pathways to the Health Independence Program at Alexandra District Health.	Achieved. ADH doesn't receive funding for HIP programs but provides brokered service for Seymour Post-Acute Care.
		Identify additional opportunities to engage health providers via telemedicine and related Information Technology systems.	Achieved. Primary Health staff use the video conference (VC) unit and have the capacity to consult / case conference with Melbourne specialists for local clients around continence, wound care and diabetes. Current VC linkages with Adult Retrieval Victoria and North East Health Wangaratta.
	Develop and implement a strategy to ensure the preparedness of the organisation for the National Disability and Insurance Scheme and Home and Community Care program transition and reform, with particular consideration to service access, service expectations, workforce and financial management.	Develop an action plan to achieve full compliance with the Commonwealth Home Support Program.	Achieved. ADH is fully compliant with the Commonwealth Home Support Program. ADH is registered as a service provider with My Aged Care. ADH has provided service delivery activity as per our service agreement through the Data Exchange (DEX) portal on schedule.
		Commit resources to the implementation of the Commonwealth Home Support Program and the National Disability and Insurance Scheme Action Plan.	Achieved. CEO/ DON and Primary Health Manager have attended an NDIS forum. Primary Health Manager to present paper to Board of Management regarding ADH's role in NDIS for August meeting. The Aged and Disability Network will present to local Boards in September led by Murrindindi Shire Council.
		Ongoing participation and collaboration in Hume Region Partnership, Home and Community Care transition and reform programs.	Achieved.
		Evaluate the effectiveness of the central intake role in maximising patient/client access to primary and community health services.	Achieved.
Supporting healthy populations	Support shared population health and wellbeing planning at a local level - aligning with the Local Government Municipal Public Health and Wellbeing plan and working with other local agencies and Primary Health Networks.	Knowledge of current service utilisation and characteristics of service users to better understand and respond to current and future health needs.	Achieved. ADH is a member of all Primary Care Partnership (PCP) Health Promotion and Chronic Illness initiatives, inclusive of population health.
		Active participation in the planning and implementation of the Municipal Public Health and Wellbeing Plan to address current and future needs of the catchment, collaboratively, without duplication.	Achieved. ADH is an active participant in local government planning forums – Municipal Health and Wellbeing Committee and Age and Disability Network.
		Analyse and share internal data and information provided through the Lower Hume Primary Care Partnership Population Health Planning Project.	Achieved. ADH is actively engaged with Primary Health networks.

Priority/Domain	Action	Deliverables	Outcome
Supporting healthy populations CONTINUED	Focus on primary prevention, including suicide prevention activities, and aim to impact on large numbers of people in the places where they spend their time adopting a place based, whole of population approach to tackle the multiple risk factors of poor health.	Implement the Population Health and Service plan using population health data and indicators to plan and develop services that respond to the identified risk factors in the community.	Achieved. ADH participates in Lower Hume Primary Care Partnership (LHPCP) for Murrindindi.
	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, implement and promote organisation wide social inclusion policy.	Achieved. ADH promotes social inclusion across the organisation. Policies and work practices are in place. Staff have access to training and capacity building strategies. ADH has access to interpreters. A folder of information has been developed and remains in the Acute ward.
	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.	Alexandra District Health to implement the Aboriginal Health Audit to identify opportunities for improvement.	Achieved. Aboriginal Competency Awareness Audit completed. Certificate awarded. Celebrate NAIDOC Week annually. Member of the PCP Implementation Group.
		Increase access to Health and Community services through the provision of a culturally welcoming environment.	Achieved. ADH has a strong tradition of provision of culturally sensitive practices and celebrating Aboriginal history and culture. The environment is welcoming and inclusive. Annual NAIDOC events are well attended.
		Audit all staff to identify which staff have completed Aboriginal Cultural Awareness training.	Achieved. 'Ask the Question' merchandise distributed with education of USB. U-tube education to be completed at orientation about asking the question.
		Health and Community staff to undertake Health Literacy training to ensure information is provided in ways which consider varying literacy levels and communications.	Achieved. Access to related training is available via video, USB and face to face sessions.
		Develop relationships with Aboriginal Outreach worker at Murray Primary Health Network to implement strategies to empower local indigenous people access our health service.	Achieved. Relationships with indigenous staff employed across the Health and Community Service sector is enhanced through working with network staff, especially the local PCP Koolin Ballit worker and the biannual network events hosted by ADH on Closing the Gap day.

Priority/Domain	Action	Deliverables	Outcome
Supporting healthy populations CONTINUED	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.	Work with Goulburn Valley Health and Lower Hume Health services to identify opportunities to develop mental health services that address local need.	In progress. Exploring telehealth opportunities with Goulburn Valley Area Mental Health Services.
	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.	Assess the current level of lesbian, gay, bisexual, transgender and intersex inclusivity using the Gay and Lesbian Health Victoria Audit Tool to identify opportunities for support and training to implement gender-sensitive practice.	Achieved. ADH Welcome sign developed and on display in all public areas. A visual welcome wall project is underway. The Consumer Advisory Committee will be involved in the concept of the project. The project will then engage community groups in the design of the wall.
		Update organisational procedures, protocols and practices to reflect lesbian, gay, bisexual, transgender and intersex – inclusive practice.	Achieved. Special Needs Interest Groups Policy updated. Cultural Diversity Plan in place.
		Review all education programs to identify opportunities to include lesbian, gay, bisexual, transgender and intersex – inclusive practice.	Achieved. The GLBTI alliance website has been identified as a resource. ADH website due for redevelopment and to include link resources and welcoming banners.
		Review the organisations promotional materials including the web to ensure they are lesbian, gay, bisexual, transgender and intersex inclusive.	Achieved. ADH Has developed a welcome sign for display in all public areas identifying that ADH is a diverse, inclusive, accepting, welcoming, safe place for everyone. Include banners / flag on the website when redeveloped this will not occur until 2017/18 financial year.
Governance and leadership	Demonstrate implementation of the Victorian Clinical Governance Policy Framework: Governance for the provision of safe, quality healthcare at each level of the organisation, with clearly documented and understood roles and responsibilities. Ensure effective integrated systems, processes and leadership are in place to support the provision of safe, quality, accountable and person centred healthcare. It is an expectation that health services implement to best meet their employees' and community's needs, and that clinical governance arrangements undergo frequent and formal review, evaluation and amendment to drive continuous improvement.	Review the organisation's current clinical governance against the Victorian Clinical Governance Policy Framework and implement a review and audit schedule to ensure that ongoing compliance and best practice occurs.	Achieved. Clinical Governance Policy reviewed against Victorian Clinical Governance Policy. Victorian Clinical Governance framework has been released. To be reviewed under the clinical risk committee. External Consultants engaged to undertake Clinical Governance Review in July 2017.

Priority/Domain	Action	Deliverables	Outcome
Governance and leadership CONTINUED	Contribute to the development and implementation of Local Region Action Plans under the series of statewide design, service and infrastructure plans being progressively released from 2016 17. Development of Local Region Action Plans will require partnerships and active collaboration across regions to ensure plans meet both regional and local service needs, as articulated in the statewide design, service and infrastructure plans.	Active participation and collaboration in the development and implementation of a Local Region Action Plan through meeting with our local and tertiary referral health services.	Achieved. CEO attended Victoria's Rural and Regional Health Services System, Design and Infrastructure Plan (the Rural Plan) second consultation forum in Albury in February 2017.
	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 the Anti-bullying and Harassment policy and work place procedure for reporting.	Achieved. Policy reviewed and updated. Reporting process on staff notice board and increased signage to ensure staff awareness. E3 training for supervisors completed.
		Present People Matters Survey findings to staff.	Achieved. Participation rate 33%. Aim to increase participation in 2017 survey.
		Monitor completion of mandatory training.	Achieved. Mandatory training completed every two years. Bullying and harassment module added for managers on E3 learning completed.
		Display complaints process in staff rooms.	Achieved. Worksafe poster highlighted with the process for making a complaint and displayed in the staff dining room.
		Develop an action plan that addresses in part education for staff accessing services and continue to work on developing an organisational wide culture of zero tolerance.	Achieved. Posters on staff notice board. Employee Assistance Scheme posters on staff notice board.

Priority/Domain	Action	Deliverables	Outcome
Governance and leadership CONTINUED	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.	Review and enhance organisation wide Occupational Health and Safety policy to ensure that it is reflective of a risk management approach with an emphasis on prevention, reporting and supporting staff.	Achieved. All staff are encouraged to: Discuss all OHS issues with HSRs, Department Managers or OHS Co-Ordinator Report incidents and near misses in Riskman Trend incidents discussed at OH&S and board committees monthly Policies are risk rated Mandatory annual fire and emergency training for all staff Staff access to Employee Assistance Program Annual manual handling and violence and aggression training Mandatory OH&S training at orientation
		Enhance pathways for all staff via staff and Occupational Health and Safety Committee meetings to encourage their views and feedback on policies and practices that affect them in the workplace.	Achieved. All staff are encouraged to participate in the development of new policies and work practice guidelines in the design stage when they directly affect their work area / role.
	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.	Review current workforce plan and update it to ensure it meets the changing workforce needs and best practice.	In progress. Alexandra District Health has undergone an organisational restructure. Workforce Plan to be developed in forward planning project.
		Develop and implement succession planning for staff acknowledging our aging workforce and seeking opportunities to develop the future potential of current staff.	In progress. Alexandra District Health has undergone an organisational restructure. Workforce Plan to be developed in forward planning project. Transition to retirement process implemented. Education provided onsite to staff on transition to retirement, financial planning and superannuation.
	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.	Promote a teamwork culture across the organisation through example, provision of education around respectful relationships and communications and address evidence of poor behaviour directly.	Achieved. Associate Nurse Unit Manager (ANUM) group developed. Have undertaken 'difficult conversation' and 'open communication' training. Dealing with difficult employees and embracing change DVDs to be presented at Leadership Meeting.

Priority/Domain	Action	Deliverables	Outcome
Governance and leadership CONTINUED	Create a workforce culture CONTINUED	Review the outcomes of the People Matter Survey and develop a board endorsed action plan to promote a culture of engagement and open communication.	Achieved. Action Plan from People Matters Survey 2016 – completed and distributed. People Matters Survey 2017 1-19 May completed. Results expected early July with an action plan to be developed if required to address areas of concern. Introduction and expansion of "The Staff Update" – staff newsletter. Clinical Housekeeping information circulated to clinical staff.
		Promote an organisational wide culture of 'teamwork' based upon mutual respect with a 'zero' tolerance to poor behaviour and conduct.	Achieved. Team building Workshop via Employee Assistance Program in January 2017. Fortnightly Leadership 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.	Develop a child safety policy or statement of commitment to child safety.	Achieved. Changes to legislation have been addressed through a Statement on ADH website. A display for staff around what it means to be a child safe organisation has been implemented. A comprehensive DHHS power point presentation is accessible to all staff.
		Review and update organisation code of conduct to include standards of conduct and care required when working and interacting with children.	Achieved. Code of Conduct has been reviewed. Primary Health Manager completed a 'quick quiz' for CH staff about their understanding of mandatory reporting and all staff identified they were clear in their responsibilities.
		Training calendar to be developed to enable all staff and volunteers to participate in training that will assist them to feel confident and comfortable in discussing any allegations of child abuse or child safety concerns.	Achieved. Quiz for Primary Health staff completed February 100% of staff identified they know their obligations. PowerPoint presentation 'Betrayal of Trust' sent to all staff. Code of Conduct updated. Child safety is part of the organisational orientation program. New policy developed to ensure that it meets current legislation and guidelines.
	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.	Alexandra District Health has a 93% vaccination level and will continue practices that have delivered this outcome.	Achieved. Staff Fluvax immunisation program continues with excellent uptake from staff.

Priority/Domain	Action	Deliverables	Outcome
Financial sustainability	Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	Review of existing budget framework and finance policies to ensure there is sufficient cash to meet financial obligations.	Achieved. Established new Board committee Finance, Audit and Risk that meets monthly. New Director of Corporate Services position established Chief Finance Officer and Chief Procurement Officer included. Successful recruitment to role ensures ADH has sufficient cash and financial obligations met.
	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.	Regularly monitor the carbon emissions generated by the organisation and review organisational practices and policies to assist in meeting environmental emissions targets.	Achieved. Carbon emissions monitored via EDMES. Currently we can monitor the emissions and provide comparisons but targets are not set and tracked.
		Continue the replacement program of all existing halogen and incandescent lighting to LED.	Achieved. Project commenced 10% of site completed. Plan to complete lighting upgrades in place and factored into Capital Management Plan.
		Reduce clinical waste volume through the education to staff identifying items that are general waste and items that are clinical waste.	Achieved. Established program in place.
		Increase recycling throughout the hospital hereby decreasing the general waste volume.	Achieved. ADH funds the recycling of Kimguard. Recycling PVC tubing and oxygen tubing recycled.
		Identify opportunities to improve our waste management through environmental audits and staff suggestions.	Achieved. Staff suggestion and feedback box commenced. Waste audits conducted outcomes to be provided with opportunities for improvement.
		Monitor solar production and report on the carbon savings.	Achieved. Monitored and reported to OH&S monthly.

KEY FINANCIAL & SERVICE PERFORMANCE

Part B: Performance priorities

SAFETY AND QUALITY PERFORMANCE

Key performance indicator	Target	2016-17 actual
Compliance with NSQHS Standards Accreditation	Full compliance	Full compliance
Cleaning Standards	Full compliance	Full compliance
Compliance with Hand Hygiene Australian program	80%	88%
Percentage of healthcare workers immunised for influenza	75%	92%
Submission of infection surveillance data to VICNISS	Full compliance	Full compliance
Patient Experience and outcomes performance	**Target**	**2016-17 Actual**
Key performance indicator		
Victorian Healthcare Experience Survey – data submission	Full compliance	Achieved
Victorian Healthcare Experience Survey – patient experience Quarter 1	95% positive experience	97% Achieved (Jul-Sep Result – Taken from Q1 Monitor)
Victorian Healthcare Experience Survey – patient experience Quarter 2	95% positive experience	98% Achieved (Oct-Dec Result – Taken from Q2 Monitor)
Victorian Healthcare Experience Survey – patient experience Quarter 3	95% positive experience	99% Achieved (Jan-March Result – Taken from Q3 Monitor)
Victorian Healthcare Experience Survey – discharge care Quarter 1	75% very positive experience	96% Achieved (Jul-Sep Result – Taken from Q2 Monitor)
Victorian Healthcare Experience Survey – discharge care Quarter 2	75% very positive experience	94% Achieved (Oct-Dec Result – Taken from Q3 Monitor)
Victorian Healthcare Experience Survey – discharge care Quarter 3	75% very positive experience	98% Achieved (Jan-March Result – Taken from Q4 Monitor)
Governance, leadership and culture performance		
Key performance indicator		
People Matter Survey – percentage of staff with a positive response to safety culture questions	80%	85%

FINANCIAL SUSTAINABILITY PERFORMANCE

Key performance indicator	Target	2016-17 Actual
Finance		
Operating result ($m)	0.10	0.03
Trade Creditors	<60 days	36
Debtors	<60 days	45

Asset Management	Target	2016-17 Actual
Asset Management Plan	Full compliance	Full compliance
Adjusted current asset ratio	0.7	3.4
Days of available cash	14 days	37

Small Rural Funding 2016 – 2017 Activity Achievement

Funding Type ~ SMALL RURAL	2016/17
Small Rural Primary Health	11,431
Small Rural HACC	1,349

OUR SERVICES

- Acute Ward
- Access Worker
- Asthma Education
- Audiology (private service)
- Cardiac Rehabilitation
- Childbirth Education
- Counselling services
- Heart Health Program
- Continence Management
- Diabetes Education
- Dietetics
- Dindi Early Intervention Program
- District Nursing Service
- Echocardiography (private service)
- Hearing Clinic (private service)
- Lung Function Testing (private service)
- Meals on Wheels
- Private Specialist Services: (General Surgeon, Gynaecologist, Ear, Nose and Throat Surgeon, Orthopaedic Surgeon, Paediatrician, Gastroenterologist, Eye Surgeon, Urologist, Cardiologist, Kidney Specialist, Respiratory Specialist)
- Occupational Therapy
- Pathology (private service)
- Physiotherapy
- Podiatry (private and HACC eligible)
- Pulmonary Rehabilitation Program
- Peer-led Support Groups
- Radiology (private service)
- Speech Pathology
- Strength Training Program
- Surgery including: General, Gynaecology, Ear, Nose and Throat, Orthopaedic, Endoscopy, Urology, Eye Surgery)
- Ultrasound (private provider)
- Urgent Care
- Women's Health Clinic
- Wound Management Clinic

Exercise Programs

- Gymnasium
- Stall the fall
- Gentle exercise
- Strength training
- Fit for birth
- Bounce Back with Babes

MEDICAL STAFF

Director of Medical Services:

Dr Peter Sloan MBBS (resigned 23/05/2017)

Medical Staff:

Dr T Chuah, MBBS

Dr J. Findlow, MB,Ch.B, DCH, MRCP

Dr L Fraser, MBBS

Dr M Lowe, MBBS

Dr E. Zadneprovskaya, MBBS

Dr M Ashti-Baghaei, MBBS

Dr M Moghadas, MBBS

Specialists:

General Surgeon

Mr R Masters MBBS, FRACS

Obstetrician / Gynaecologist

Dr A Lawrence, B.Sc. (Hons), MBBS (Hons), FRACOG, MRCOG

Gastroenterologist

Dr P Mahindra MBBS, FRACGP

Specialist Anaesthetists

Dr R Barnes, MBBS, FRANZCA

Dr P Brown, MBBS, B Sc (Hons), FRANZCA

Dr M Coghlan MBBS, FRANZCA

Dr N Gattuso, MBBS, FRANZCA

Dr M Keane, MBBS, FRANZCA

Dr S Kondogiannis, MBchB, FRANZCA

Dr J Marxsen, MBBS, FRANZCA

Dr J Monagle, MBBS, FRANZCA

Dr C Noonan, MBBS, FRANZCA

Dr B Slon, MBBS, FRANZCA

Orthopaedic Surgeons

Mr N Hartnett, MBchB, FRACS

Mr J Harvey, MBBS, FRACS orth

Mr C Kondogiannis, MBBS, FRACS

Specialist Ear, Nose, Throat

Mr A Guiney, FRACS

Ophthalmologist

Dr C Chesney MBBS, FRANZCO, Cataract Surgeon and General Ophthalmology

Urologist

Dr P Ruljancich MBBS, FRACS

Cardiologist

Dr E Kotschet MBBS (Hons) FRACP

Paediatrician

Dr D Cutting MBBS, FRACP

Nephrologist

Dr P Branley MBBS, BPharm

Respiratory Physician

Dr M Clarence, MBBS Surgery

LIFE GOVERNORS

Adie, Mr
Andrews, Miss H
Bamford, Mr W
Bond, F R
Bradbury, A K
Bunn, Dr P
Byrne, Ms H
Crooke, Dr C
Cumming, G F
De La Pierre, K
Dobson, Ms A
Dobson, Mrs B
Dobson, Mr G
Gale, Mrs M
Gale, Mr W
Griffiths, A L
Iser, Dr J
Johnston, Mrs D
Jolley, Mr T and Mrs B
Layton, Mr A
Lester, Mr J
Macdonald, Mrs A
Matthews, Mr G
McNair, Mrs I
Nihei, M
Noye, T J
Parsons, Mrs B
Pritchett, Mrs M
Proctor, Mrs W
Radford, M K
Reddrop Mr M and Mrs T
Robinson, Mrs H
Sartori, Mr P
Scott, Mr R
Shands, Mrs E B
Sims, Mrs D
Sloan, Mr R
Smith, Ms J
Taylor, Mrs M
Tate, R H
Thain, Mrs A
Webster, Mrs E S
Weeks, A J
Welch, Mrs J
Whittaker, J W
Williams, Mrs W

Alexandra District Health
12 Cooper Street, Alexandra, Victoria 3714
P: (03) 5772 0900 F: (03) 5772 0919

ALEXANDRA DISTRICT HEALTH
COMPREHENSIVE OPERATING STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017

	Note	2017 $	2016 $
Revenue from Operating Activities	2.1	7,544,872	7,301,656
Revenue from Non-Operating Activities	2.1	52,135	65,539
Employee Expenses	3.1	(5,192,333)	(4,767,139)
Non Salary Labour Costs	3.1	(543,493)	(583,095)
Supplies and Consumables	3.1	(629,409)	(636,663)
Other Expenses	3.1	(1,198,794)	(1,198,196)
Net Result Before Capital and Specific Items		32,978	182,102
Capital Purpose Income	2.1	226,921	289,599
Depreciation and Amortisation	4.4	(1,303,420)	(1,362,609)
Finance Costs	3.3	(1,101)	(1,683)
Expenditure Using Capital Purpose Income	3.1	(7,000)	(2,468)
Net Result After Capital and Specific Items		(1,051,622)	(895,059)
Other Economic Flows Included in Net Result			
Net gain/(loss) on Non-Financial Assets	7.2	1,500	27,500
Revaluation of Long Service Leave	3.4	(12,409)	424
Total Other Economic Flows Included in Net Result		(10,909)	27,924
NET RESULT FOR THE YEAR		(1,062,531)	(867,135)
Other Comprehensive Income		0	0
Total Other Comprehensive Income		0	0
COMPREHENSIVE RESULT		**(1,062,531)**	**(867,135)**

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

ALEXANDRA DISTRICT HEALTH
BALANCE SHEET
AS AT 30 JUNE 2017

	Note	2017 $	2016 $
Current Assets			
Cash and Cash Equivalents	6.2	829,098	928,195
Receivables	5.1	250,369	149,843
Investments and Other Financial Assets	4.1	1,503,393	1,500,000
Inventories	5.2	127,268	127,365
Prepayments and Other Assets	5.3	166,381	154,219
Total Current Assets		2,876,509	2,859,622
Non-Current Assets			
Receivables	5.1	89,710	59,380
Property, Plant and Equipment	4.3	23,664,851	24,791,759
Intangible Assets	4.5	38,997	21,955
Total Non-Current Assets		23,793,558	24,873,094
TOTAL ASSETS		26,670,067	27,732,716
Current Liabilities			
Payables	5.4	426,715	571,702
Lease Liabilities	6.1	15,941	18,911
Provisions	3.4	1,070,981	864,055
Total Current Liabilities		1,513,637	1,454,668
Non-Current Liabilities			
Lease Liabilities	6.1	18,068	22,692
Provisions	3.4	198,158	252,621
Total Non-Current Liabilities		216,226	275,313
TOTAL LIABILITIES		1,729,863	1,729,981
NET ASSETS		24,940,204	26,002,735
EQUITY			
Property, Plant and Equipment Revaluation Surplus	8.1a	7,484,801	7,484,801
Restricted Specific Purpose Surplus	8.1a	24,304	24,304
Contributed Capital	8.1b	3,591,970	3,591,970
Accumulated Surpluses	8.1c	13,839,129	14,901,660
TOTAL EQUITY		24,940,204	26,002,735
Commitments	6.3		
Contingent Assets and Contingent Liabilities	7.3		

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

ALEXANDRA DISTRICT HEALTH
STATEMENT OF CHANGES IN EQUITY
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017

	Note	Property, Plant and Equipment Revaluation Surplus $	Restricted Specific Purpose Surplus $	Contributed Capital $	Accumulated Surpluses $	Total $
Balance at 1 July 2015		7,484,801	24,304	3,591,970	15,768,795	26,869,870
Net result for the year		0	0	0	(867,135)	(867,135)
Balance at 30 June 2016	8.1	**7,484,801**	**24,304**	**3,591,970**	**14,901,660**	**26,002,735**
Net result for the year		0	0	0	(1,062,531)	(1,062,531)
Balance at 30 June 2017	8.1	**7,484,801**	**24,304**	**3,591,970**	**13,839,129**	**24,940,204**

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

ALEXANDRA DISTRICT HEALTH
CASH FLOW STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017

	Note	2017 $ Inflows / (Outflows)	2016 $ Inflows / (Outflows)
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		6,585,070	6,239,297
Capital Grants from Government		47,311	71,170
Patient and Resident Fees Received		287,104	255,590
Donations and Bequests Received		76,411	135,120
GST received from / (paid to) ATO		8,469	(13,369)
Interest Received		48,762	81,353
Other Receipts		610,380	463,311
Total Receipts		***7,663,507***	***7,232,472***
Employee Expenses Paid		(5,051,705)	(4,683,660)
Fee for Service Medical Officers		(543,493)	(583,095)
Payments for Supplies and Consumables		(629,312)	(626,569)
Other Payments		(1,335,053)	(714,175)
Total Payments		***(7,559,563)***	***(6,607,499)***
NET CASH FLOW FROM / (USED IN) OPERATING ACTIVITIES	8.2	103,944	624,973
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for Non-Financial Assets		(193,554)	(341,331)
Proceeds from sale of Non-Financial Assets		1,500	27,500
Proceeds from Sale of Investments		(3,393)	(8,905)
NET CASH FLOW FROM / (USED IN) INVESTING ACTIVITIES		(195,447)	(322,736)
CASH FLOWS USED IN FINANCING ACTIVITIES			
Repayment of borrowings		(7,594)	0
NET CASH FLOW USED IN FINANCING ACTIVITIES		(7,594)	0
NET DECREASE IN CASH AND CASH EQUIVALENTS HELD		(99,097)	302,237
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		928,195	625,958
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.2	829,098	928,195

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

BASIS OF PRESENTATION

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

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

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

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

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

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

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'.

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

These annual financial statements represent the audited general purpose financial statements for Alexandra District Health for the period ended 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 AASs, which include interpretations issued by the Australian Accounting Standards Board (AASB). They are presented in a manner consistent with the requirements of AASB101 *Presentation of Financial Statements.*

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

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

The annual financial statements were authorised for issue by the Board of Alexandra District Health on 1st September, 2017.

(b) Reporting Entity

The financial statements includes all the controlled activities of Alexandra District Health.

Its principal address is:
12 Cooper Street
Alexandra Vic 3714

A description of the nature of Alexandra District 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

Alexandra District Health's overall objective is to provide healthcare services to the community surrounding Alexandra as well as improve the quality of life to Victorians.

Alexandra District 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 criteria for basis, items are recognised as assets, liabilities, equity, income or expenses when they satisfy the definitions and recognition 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 with sufficient regularity 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 values of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

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

- The fair value of land, buildings, plant and equipment, (refer to Note 4.3);
- Superannuation expense (refer to Note 3.5);
- Employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.4); and

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

(d) Principles of Consolidation

Intersegment Transactions

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

NOTE 2: FUNDING DELIVERY OF OUR SERVICES

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

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

Structure
2.1 Analysis of revenue by source

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE	Admitted Patients 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	TOTAL 2017 $
Government Grants	5,843,744	299,243	496,252	0	6,639,239
Indirect Contributions by Department of Health and Human Services	46,955	0	0	0	46,955
Patient Fees	260,347	15,462	25,883	0	301,692
Recoupment from Private Practice for Use of Hospital facilities	39,450	0	0	0	39,450
Catering	0	0	0	54,677	54,677
Diagnostic Imaging	0	0	0	34,574	34,574
Property Income	0	0	0	50,399	50,399
Hume Rural Health Alliance	0	0	0	210,328	210,328
Other Revenue from Operating Activities	110,118	31,865	25,575	0	167,558
Total Revenue from Operating Activities	**6,300,614**	**346,570**	**547,710**	**349,978**	**7,544,872**
Interest Income	50,077	0	0	0	50,077
Other Revenue from Non-Operating Activities	0	0	0	1,692	1,692
Hume Rural Health Alliance	0	0	0	366	366
Total Revenue from Non-Operating Activities	**50,077**	**0**	**0**	**2,058**	**52,135**
Capital Purpose Income (Excluding Interest)	0	0	0	128,921	128,921
Hume Rural Health Alliance Capital Income	0	0	0	98,000	98,000
Total Capital Purpose Income	**0**	**0**	**0**	**226,921**	**226,921**
Net gain/(loss) on non-financial assets	0	0	0	1,500	1,500
TOTAL REVENUE	**6,350,691**	**346,570**	**547,710**	**580,457**	**7,825,428**

	Admitted Patients 2016 $	Aged Care 2016 $	Primary Health 2016 $	Other 2016 $	TOTAL 2016 $
Government Grants	5,630,770	276,162	488,715	0	6,395,647
Indirect Contributions by Department of Health and Human Services	36,421	0	0	0	36,421
Patient Fees	212,945	19,497	23,980	0	256,422
Recoupment from Private Practice for Use of Hospital facilities	49,027	0	0	0	49,027
Catering	0	0	0	48,934	48,934
Diagnostic Imaging	0	0	0	30,840	30,840
Property Income	0	0	0	52,274	52,274
Hume Rural Health Alliance	0	0	0	227,696	227,696
Other Revenue from Operating Activities	141,349	23,863	39,183	0	204,395
Total Revenue from Operating Activities	**6,070,512**	**319,522**	**551,878**	**359,744**	**7,301,656**
Interest Income	65,178	0	0	0	65,178
Hume Rural Health Alliance Non Operating Revenue	0	0	0	361	361
Total Revenue from Non-Operating Activities	**65,178**	**0**	**0**	**361**	**65,539**
Capital Purpose Income (Excluding Interest)	0	0	0	265,766	265,766
Hume Rural Health Alliance Capital Purpose Income	0	0	0	23,833	23,833
Total Capital Purpose Income	**0**	**0**	**0**	**289,599**	**289,599**
TOTAL REVENUE	**6,135,690**	**319,522**	**551,878**	**649,704**	**7,656,794**

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)

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 Alexandra District Health and the income can be reliably measured at fair value. Unearned income at reporting date is reported as income received in advance.

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

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

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

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

Indirect Contributions from the Department of Health and Human Services

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

Patient Fees

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

Private Practice Fees

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

Revenue from commercial activities

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

Donations and Other Bequests

Donations and bequests are recognised as revenue when received. If donations are for a special purpose, they may be appropriated to a surplus, such as 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 recoveries, sundry sales and minor facility charges.

Category Groups

Alexandra District 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 patients services, where services are delivered in public hospitals.
- **Aged Care** comprises a range of in home, specialist geriatric, residential care and community based programs and support services, such as Home and Community Care (HACC) that are targeted to older people, people with a disability, and their carers.
- **Primary, Community and Dental Health** comprises a range of home based, community based, community, primary health and dental services including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy and a range of dental health services.
- **Other Services not reported elsewhere - (Other)** comprises services not separately classified above, including: Public Health Services including laboratory testing, blood borne viruses / sexually transmitted infections clinical services, Koori liaison officers, immunisation and screening services, drugs services including drug withdrawal, counselling and the needle and syringe program, Disability services including aids and equipment and flexible support packages to people with a disability, Community Care programs including sexual assault support, early parenting services, parenting assessment and skills development, and various support services. Health and Community Initiatives also falls in this category group.

NOTE 3: THE COST OF DELIVERING SERVICES

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

Structure

3.1 Analysis of expenses by source
3.2 Analysis of expense and revenue by internally managed and restricted specific purpose funds
3.3 Finance Costs
3.4 Provisions
3.5 Superannuation

NOTE 3.1: ANALYSIS OF EXPENSE BY SOURCE	Admitted Patients 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	TOTAL 2017 $
Employee Expenses	4,006,067	140,463	968,643	77,160	5,192,333
Other Operating Expenses					
Non Salary Labour Costs	543,493	0	0	0	543,493
Supplies and Consumables	537,522	10,711	71,455	9,721	629,409
Other Expenses	993,413	14,353	38,072	152,956	1,198,794
Total Expenditure from Operating Activities	6,080,495	165,527	1,078,170	239,837	7,564,029
Finance Costs (refer note 3.3)	0	0	0	1,101	1,101
Other Non-Operating expenses					
Expenditure Using Capital Purpose Income	0	0	0	7,000	7,000
Depreciation and Amortisation (refer note 4.4)	0	0	0	1,303,420	1,303,420
Total Other Expenses	0	0	0	1,311,521	1,311,521
TOTAL EXPENSES	6,080,495	165,527	1,078,170	1,551,358	8,875,550

	Admitted Patients 2016 $	Aged Care 2016 $	Primary Health 2016 $	Other 2016 $	TOTAL 2016 $
Employee Expenses	3,652,553	117,974	948,642	47,546	4,766,715
Other Operating Expenses					
Non Salary Labour Costs	583,070	0	25	0	583,095
Supplies and Consumables	518,247	9,457	108,959	0	636,663
Other Expenses	960,638	12,725	43,544	181,289	1,198,196
Total Expenditure from Operating Activities	5,714,508	140,156	1,101,170	228,835	7,184,669
Finance Costs (refer note 3.3)	0	0	0	1,683	1,683
Other Non-Operating expenses					
Expenditure Using Capital Purpose Income	0	0	0	2,468	2,468
Depreciation and Amortisation (refer note 4.4)	0	0	0	1,362,609	1,362,609
Total Other Expenses	0	0	0	1,362,609	1,362,609
TOTAL EXPENSES	5,714,508	140,156	1,101,170	1,591,444	8,547,278

NOTE 3.1: ANALYSIS OF EXPENSE BY SOURCE (Continued)

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.

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

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

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

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

Borrowing costs of qualifying assets

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

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

Net gain/ (loss) on non-financial assets

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

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

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

Net gain/ (loss) on financial instruments

Net gain/ (loss) on financial instruments includes:

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

Amortisation of non-produced intangible assets

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

NOTE 3.1: ANALYSIS OF EXPENSE BY SOURCE (Continued)

Impairment of non-financial assets

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

Revaluations of financial instrument at fair value

Refer to Note 7.1 *Financial instruments.*

Other gains/ (losses) from other economic flows

Other gains/ (losses) include:

- 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
- 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.

Financial guarantee

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

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

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

	Expense		Revenue	
	2017 $	2016 $	2017 $	2016 $
Commercial Activities				
Catering	47,471	42,985	54,677	35,426
Property Expenses/Revenue	10,692	25,716	50,399	52,274
Diagnostic Imaging	21,293	20,642	34,574	30,840
TOTAL	79,456	89,343	139,650	118,540

NOTE 3.3: FINANCE COSTS

	2017 $	2016 $
Finance Charges on Finance Leases	1,101	1,683
TOTAL FINANCE COSTS	1,101	1,683

Finance costs are recognised as expenses in the period in which they are incurred.

Finance costs include:

- interest on bank overdrafts and short-term and long-term borrowings (Interest expense is recognised in the period in which it is incurred);
- amortisation of discounts or premiums related to borrowings;
- amortisation of ancillary costs incurred in connection with the arrangement of borrowings; and
- finance charges in respect of finance leases recognised in accordance with AASB 117 Leases.

NOTE 3.4: EMPLOYEE BENEFITS IN THE BALANCE SHEET

	2017 $	2016 $
Current Provisions		
Employee Benefits (i)		
Annual Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	308,451	321,369
- unconditional and expected to be settled wholly after 12 months (iii)	100,000	0
ADO's and Accrued Salaries and Wages		
- unconditional and expected to be settled wholly within 12 months (ii)	76,549	50,697
Long Service Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	118,148	36,464
- unconditional and expected to be settled wholly after 12 months (iii)	409,086	370,605
	1,012,234	779,135
Provisions related to employee benefit on-costs		
- unconditional and expected to be settled within 12 months (ii)	13,165	44,154
- unconditional and expected to be settled after 12 months (iii)	45,582	40,766
	58,747	84,920
Total Current Provisions	1,070,981	864,055
Non-Current Provisions		
Employee Benefits (i)	178,292	227,587
Provisions related to employee benefit on-costs	19,866	25,034
Total Non-Current Provisions	198,158	252,621
Total Provisions	1,269,139	1,116,676
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Annual Leave Entitlements	408,451	356,043
Accrued Salaries and Wages	70,723	52,733
Accrued Days Off	5,826	3,433
Unconditional Long Service Leave Entitlements	585,981	451,847
	1,070,981	864,056
Non-Current Employee Benefits and related On-Costs		
Conditional Long Service Leave Entitlements (ii)	198,158	252,620
Total Employee Benefits and Related On-Costs	1,269,139	1,116,676

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

NOTE 3.4: EMPLOYEE BENEFITS IN THE BALANCE SHEET (Continued)

Movements in provisions

Movement in Long Service Leave:		
Balance at start of year	704,467	658,572
Provision made during the year		
- Revaluations	(12,409)	424
- Expense recognising employee service	145,812	188,795
Settlement made during the year	(53,731)	(143,325)
Balance at end of year	784,139	704,467

Provisions

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

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

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

Employee Benefits

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

Wages and Salaries, Annual Leave and Accrued Days Off

Liabilities for wages and salaries, including non-monetary benefits, annual leave and 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 and annual 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; or
- 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.

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

On-Costs related to employee expense

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

NOTE 3.5: SUPERANNUATION

Fund		Paid Contributions for the Year		Outstanding Contributions at Year End	
		2017 $	2016 $	2017 $	2016 $
(i) Defined Benefit Plans:	Health Super	19,631	41,006	0	0
Defined Contribution Plans:	Health Super	362,347	310,406	0	0
	HESTA	47,701	41,830	0	0
Total		429,679	393,242	0	0

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

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

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

However, superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the comprehensive operating statement of the Health Service. The name, details and amounts expense in relation to the major employee superannuation funds and contributions made by the Health Services are disclosed in the table above:

Defined contribution superannuation plans

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

Defined benefit superannuation plans

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

Superannuation liabilities

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

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY

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

Structure

4.1 Investments and other financial assets
4.2 Jointly controlled operations and assets
4.3 Property, plant & equipment
4.4 Depreciation and amortisation
4.5 Intangible assets

NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS

	Operating Fund		Capital		Total	Total
	2017	2016	2017	2016	2017	2016
CURRENT	$	$	$	$	$	$
Loans and Receivable						
Term Deposit						
Aust. Dollar Term Deposits >3 months (i)	1,503,393	1,250,000	0	250,000	1,503,393	1,500,000
TOTAL CURRENT	1,503,393	1,250,000	0	250,000	1,503,393	1,500,000
Represented by:						
Health Service Investments	1,503,393	1,250,000	0	250,000	1,503,393	1,500,000
TOTAL	1,503,393	1,250,000	0	250,000	1,503,393	1,500,000

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

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

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

Investments and other financial assets
Hospital investments must be in accordance in 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.

Alexandra District 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.

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

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

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

NOTE 4.2: JOINTLY CONTROLLED OPERATIONS AND ASSETS

Name of Entity	Principal Activity	Ownership Interest 2017 %	Ownership Interest 2016 %
Hume Rural Health Alliance	Information Systems	2.45	2.51

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

	2017 $	2016 $
Current Assets		
Cash and Cash Equivalents	88,713	47,919
Receivables	63,888	23,647
Prepayments	3,362	1,879
Total Current Assets	155,963	73,445
Non Current Assets		
Property Plant and Equipment	34,344	42,077
Intangible Assets	38,997	21,955
Total Non Current Assets	73,341	64,032
Total Assets	229,304	137,477
Current Liabilities		
Payables	12,083	14,290
Borrowings	15,941	18,911
Total Current Liabilities	28,024	33,201
Non Current Liabilities		
Borrowings	18,068	22,692
Total Non Current Liabilities	18,068	22,692
Total Liabilities	46,092	55,893
Net Assets	183,212	81,584

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

Revenues		
Operating Revenue	209,115	222,943
Non Operating Revenue	366	361
Capital Purpose Income	98,000	23,833
Total Revenue	307,481	247,137
Expenses		
Employee Benefits	39,410	47,546
Information Technology and Administrative Expenses	142,264	155,307
Expenditure using Capital Income	3,454	1,683
Depreciation and amortisation	21,938	22,266
Total Expenses	207,066	226,802
Net Result	100,415	20,335

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

Investments in joint operations
In respect of any interest in joint operations, Alexandra District 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 AND EQUIPMENT (a) Gross carrying amount and accumulated depreciation	2017 $	2016 $
Land		
- Land at Fair Value	1,120,000	1,120,000
- Land Improvements at Fair Value	72,942	71,605
Less Accumulated Depreciation	6,140	2,560
	66,802	69,045
Total Land	1,186,802	1,189,045
Buildings		
- Buildings at Fair Value	25,070,701	25,070,701
Less Accumulated Depreciation	3,396,189	2,385,981
	21,674,512	22,684,720
Total Buildings	21,674,512	22,684,720
Plant & Equipment		
- Hume Rural Health Alliance	34,344	42,077
- Plant and Equipment at Fair Value	1,924,774	1,972,923
Less Accumulated Depreciation	1,746,712	1,797,687
	178,062	175,236
- Computers and Communication at Fair Value	258,750	197,660
Less Accumulated Depreciation	183,130	160,263
	75,620	37,397
- Furniture and Fittings at Fair Value	308,813	302,784
Less Accumulated Depreciation	267,635	262,162
	41,178	40,622
Total Plant and Equipment	329,204	295,332
Motor Vehicles		
- Motor Vehicles at Fair Value	202,948	202,948
Less Accumulated Depreciation	155,627	127,296
Total Motor Vehicles	47,321	75,652
Medical Equipment		
- Medical Equipment at Fair Value	1,534,645	1,594,823
Less Accumulated Depreciation	1,107,633	1,047,813
Total Medical Equipment	427,012	547,010
TOTAL PROPERTY, PLANT AND EQUIPMENT	23,664,851	24,791,759

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

	Land	Buildings	Plant & Equip	Motor Vehicles	Medical Equipment	Total
	$	$	$	$	$	$
Balance at 1 July 2015	1,120,000	23,835,072	263,750	84,699	445,829	25,749,350
Additions	1,561	48,955	73,253	28,391	251,226	403,386
Building Under Construction Credits	0	(62,055)	0	0	0	(62,055)
Transfers	70,044	(70,044)	0	0	0	0
Hume Rural Health Alliance	0	0	62,415	0	0	62,415
Depreciation (note 4.4)	(2,560)	(1,067,208)	(104,086)	(37,438)	(150,045)	(1,361,337)
Balance at 1 July 2016	1,189,045	22,684,720	295,332	75,652	547,010	24,791,759
Additions	1,337	0	118,686	0	42,284	162,307
Hume Rural Health Alliance	0	0	12,964	0	0	12,964
Depreciation (note 4.4)	(3,580)	(1,010,208)	(97,778)	(28,331)	(162,282)	(1,302,179)
Balance at 30 June 2017	1,186,802	21,674,512	329,204	47,321	427,012	23,664,851

Land and buildings carried at valuation
An independent valuation of the Health Service's property, plant and equipment was performed by the Valuer-General Victoria to determine the value of the land and buildings. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments.

The effective date of the valuation is 30 June 2014.

(c) Fair value measurement hierarchy for assets

	Carrying amount as at 30 June 2017	Fair value measurement at end of reporting period using: Level 1 [1]	Level 2 [1]	Level 3 [1]
Land at fair value	$	$	$	$
Non-specialised land	291,802	0	291,802	0
Specialised land	895,000	0	0	895,000
Total of land at fair value	1,186,802	0	291,802	895,000
Buildings at fair value				
Specialised buildings	21,674,512	0	0	21,674,512
Total of building at fair value	21,674,512	0	0	21,674,512
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles	47,321	0	0	47,321
- Plant and equipment	329,204	0	0	329,204
Total of plant, equipment and vehicles at fair value	376,525	0	0	376,525
Medical equipment at fair value				
Medical Equipment	427,012	0	0	427,012
Total medical equipment at fair value	427,012	0	0	427,012
TOTAL	23,664,851	0	291,802	23,373,049

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

A transfer from Level 2 to Level 3 has occurred for vehicles due to depreciated replacement cost being applied in 2017 for fair value assessments.

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

	Carrying amount as at 30 June 2016	Fair value measurement at end of reporting period using: Level 1 [1]	Level 2 [1]	Level 3 [1]
Land at fair value	$	$	$	$
Non-specialised land	294,045	0	294,045	0
Specialised land	895,000	0	0	895,000
Total of land at fair value	1,189,045	0	294,045	895,000
Buildings at fair value				
Specialised buildings	22,684,720	0	0	22,684,720
Total of building at fair value	22,684,720	0	0	22,684,720
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	75,652	0	75,652	0
- Plant and equipment	295,332	0	0	295,332
Total of plant, equipment and vehicles at fair value	370,984	0	75,652	295,332
Medical equipment at fair value				
Medical Equipment	547,010	0	0	547,010
Total medical equipment at fair value	547,010	0	0	547,010
TOTAL	24,791,759	0	369,697	24,422,062

(i) Classified in accordance with the fair value hierarchy,
(ii) Vehicles are categorised to Level 3 assets if the depreciated replacement cost is used in estimating the fair value. Where a market approach is considered appropriate due to an active resale market, a Level 2 categorisation for such vehicles is applied.

There were no transfers between levels during the 2016 period.

Consistent with AASB 13 *Fair Value Measurement* , Alexandra District 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.

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

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy, 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, Alexandra District 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, Alexandra District 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 Alexandra District Health's independent valuation agency.

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

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)
(c) Fair value measurement hierarchy for assets (Continued)
Fair value measurement
Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The fair value measurement is based on the following assumptions:

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

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

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

In accordance with AASB 13 paragraph 29, Health Services can assume the current use of a non-financial physical asset is its HBU unless market or other factors suggest that a different use by market participants would maximise the value of the asset.
Therefore, an assessment of the HBU will be required when the indicators are triggered within a reporting period, which suggest the market participants would have perceived an alternative use of an asset that can generate maximum value. Once identified, Health Services are required to engage with VGV or other independent valuers for formal HBU assessment.

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

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

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

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

30 June 2017	Land	Buildings	Plant and equipment	Motor Vehicles	Medical equipment
	$	$	$	$	$
Opening Balance	895,000	22,684,720	295,332	0	547,010
Purchases (sales)	0	0	131,650	0	42,284
Transfers in (out) of Level 3	0	0	0	75,652	0
Gains or losses recognised in net result					
- Depreciation	0	(1,010,208)	(97,778)	(28,331)	(162,282)
Subtotal	895,000	21,674,512	329,204	47,321	427,012
Closing Balance	895,000	21,674,512	329,204	47,321	427,012

A transfer from Level 2 to Level 3 has occurred for vehicles due to depreciated replacement cost being applied in 2017 for fair value assessments.

30 June 2016	Land	Buildings	Plant and equipment	Motor Vehicles	Medical equipment
	$	$	$	$	$
Opening Balance	895,000	23,835,072	263,750	0	445,829
Purchases (sales)	0	48,955	135,668	0	251,226
Transfers in (out) of Level 3	0	(132,099)	0	0	0
Gains or losses recognised in net result					
- Depreciation	0	(1,067,208)	(104,086)	0	(150,045)
Subtotal	895,000	22,684,720	295,332	0	547,010
Closing Balance	895,000	22,684,720	295,332	0	547,010

There have been no transfers between levels during the 2016 period.

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

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

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

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

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

For non-specialised land an independent valuation was performed by independent valuers Valuer-General Victoria to determine the fair value using the market approach.

Valuation of the assets was determined by analysing comparable sales and allowing for share, size, topography, location and other relevant factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30 June 2014.

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

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

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

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

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

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

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

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

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

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

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

The significant unobservable inputs have remained unchanged from 2016.
Refer to Note 7.4 for guidance on fair value measurement indicative expectations.

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

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

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

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

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

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

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

Revaluations of Non-current Physical Assets

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

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

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

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

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

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

NOTE 4.4: DEPRECIATION AND AMORTISATION	2017 $	2016 $
Depreciation		
Buildings	1,010,208	1,067,208
Land Improvements	3,580	2,560
Plant and Equipment	47,379	45,179
Computers and Communication	22,867	28,822
Motor Vehicles	28,331	37,438
Furniture and Fittings	6,835	9,091
Medical Equipment	162,282	150,045
Hume Rural Health Alliance	20,697	20,994
Total Depreciation	1,302,179	1,361,337
Amortisation		
Hume Rural Health Alliance Intangible Assets	1,241	1,272
TOTAL DEPRECIATION AND AMORTISATION	1,303,420	1,362,609

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

Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives, residual value and depreciation method for all assets are reviewed at least annually and adjustments made as appropriate. This depreciation charge is not funded by the Department of Health and Human Services.

Assets with a cost in excess of $1,000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

NOTE 4.4: DEPRECIATION AND AMORTISATION (Continued)

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

	2017	2016
Buildings		
- Structure Shell Building Fabric	5 to 47 years	5 to 47 years
- Site Engineering Services and Central Plant	2 to 20 years	2 to 20 years
Central Plant		
- Fit Out	2 to 3 years	2 to 3 years
- Trunk Reticulated Building Systems	3 to 5 years	3 to 5 years
Plant and Equipment	2 to 25 years	2 to 25 years
Medical Equipment	3 to 20 years	3 to 20 years
Computers and Communication	2 to 20 years	2 to 20 years
Furniture and Fittings	4 to 25 years	4 to 25 years
Motor Vehicles	2 to 3 years	2 to 3 years
Land Improvements	20 years	20 years

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

NOTE 4.5: INTANGIBLE ASSETS

	2017 $	2016 $
Intangible Assets - Hume Rural Health Alliance	42,514	24,286
Less Accumulated Amortisation	3,517	2,331
TOTAL INTANGIBLE ASSETS	38,997	21,955

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

	HRHA $	Total $
Balance at 1 July 2015	0	0
Additions	24,286	24,286
Amortisation (i)	2,331	2,331
Balance at 1 July 2016	21,955	21,955
Additions	18,283	18,283
Amortisation (i)	1,241	1,241
Balance at 30 June 2017	38,997	38,997

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

Intangible assets

Intangible assets represent identifiable non-monetary assets without physical substance such as patents, trademarks, and computer software.

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

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

Amortisation

Amortisation is allocated to intangible non-produced assets with finite useful lives on a systematic (typically straight-line) basis over the asset's useful life. Amortisation begins when the asset is available for use, that is, when it is in the location and condition necessary for it to be capable of operating in the manner intended by management. The consumption of intangible non-produced assets with finite useful lives is classified as amortisation.

The amortisation period and the amortisation method for an intangible asset with a finite useful life are reviewed at least at the end of each annual reporting period. In addition, an assessment is made at each reporting date to determine whether there are indicators that the intangible asset concerned is impaired. If so, the asset concerned is tested as to whether it's carrying amount exceeds it's recoverable amount.

Intangible assets with finite useful lives are amortised over 7 years.

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 Prepayments and other assets
5.4 Payables

NOTE 5.1: RECEIVABLES	2017 $	2016 $
CURRENT		
Contractual		
Trade Debtors	46,449	46,240
Patient Fees	41,103	26,515
Accrued Investment Income	16,385	15,070
Hume Rural Health Alliance Receivables	63,888	23,647
Accrued Revenue - Other	14,413	3,000
	182,238	114,472
Statutory		
Accrued Revenue - Department of Health & Human Services	41,229	0
GST Receivable - Health Service	26,902	35,371
	68,131	35,371
TOTAL CURRENT RECEIVABLES	250,369	149,843
NON CURRENT		
Statutory		
Long Service Leave - Department of Health and Human Services	89,710	59,380
TOTAL NON-CURRENT RECEIVABLES	89,710	59,380
TOTAL RECEIVABLES	340,079	209,223

(a) Ageing analysis of receivables
Please refer to note 7.1 for the ageing analysis of contractual receivables.

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

Receivables consist of:

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

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

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

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

NOTE 5.2: INVENTORIES	2017 $	2016 $
Pharmaceuticals - at cost	19,541	8,675
Catering Supplies - at cost	3,714	3,008
Housekeeping Supplies - at cost	4,700	8,188
Medical and Surgical Lines - at cost	94,941	104,731
Administration Stores - at cost	4,372	2,763
TOTAL INVENTORIES	127,268	127,365

NOTE 5.2: INVENTORIES (Continued)

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

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

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

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

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

NOTE 5.3: PREPAYMENTS AND OTHER NON-FINANCIAL ASSETS	2017 $	2016 $
CURRENT		
Prepayments	163,019	152,340
Prepayments - Hume Rural Health Alliance	3,362	1,879
TOTAL CURRENT OTHER ASSETS	166,381	154,219

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 5.4: PAYABLES	2017 $	2016 $
CURRENT		
Contractual		
Trade Creditors (i)	335,756	447,116
Accrued Audit Fees	18,501	18,380
Other	8,700	27,875
Hume Rural Health Alliance Payables	12,083	14,290
	375,040	507,661
Statutory		
Department of Health and Human Services (ii)	2,500	15,440
Amounts Payable to Government - PAYG & FBT Payable	49,175	48,601
	51,675	64,041
TOTAL PAYABLES	426,715	571,702

(i) The average credit period is 30 days. No interest is charged on payables.

(ii) Terms and conditions of amounts payable to the Department of Health and Human Services vary according to the particular agreement with the Department.

(a) Maturity analysis of payables

Please refer to Note 7.1 for the ageing analysis of contractual payables.

(b) Nature and extent of risk arising from payables

Please refer to note 7.1 for the nature and extent of risks arising from contractual payables.

Payables consist of:

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

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

NOTE 6: HOW WE FINANCE OUR OPERATIONS

This section provides information on the sources of finance utilised by the hospital during its operations, along with interest expenses (the cost of borrowings) and other information related to financing activities of the hospital.

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

Structure
6.1 Borrowings
6.2 Cash and cash equivalents
6.3 Commitments for expenditure

NOTE 6.1: BORROWINGS	2017 $	2016 $
CURRENT		
Finance Lease Liability - HRHA (i)	15,941	18,911
Total Lease Liabilities - Current	15,941	18,911
NON CURRENT		
Finance Lease Liability - HRHA (i)	18,068	22,692
Total Lease Liabilities -Non Current	18,068	22,692
Total Lease Liabilities	34,009	41,603

(i) Secured by the assets leased. Finance leases are effectively secured as the rights to the leased assets revert to the lessor in the event of default.

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

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

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

Finance Leases
A lease is a right to use an asset for an agreed period of time in exchange for payment. Leases are classified at their inception as inception as either operating or finance leases based on the economic substance of the agreement so as to reflect the risks and rewards incidental to ownership.

Leases of property, plant and equipment are classified as finance leases whenever the terms of the lease transfer substantially all the risks and rewards of ownership to the lessee.

For service concession arrangements, the commencement of the lease term is deemed to be the date the asset is commissioned.

All other leases are classified as operating leases.

Finance leases
Entity as lessee
Finance leases are recognised as assets and liabilities at amounts equal to the fair value of the lease property or, if lower, the present value of the minimum lease payment, each determined at the inception of the lease. The lease asset is accounted for as a non-financial physical asset and is depreciated over the shorter of the estimated useful life of the asset or the term of the lease.
If there is certainty that the health service will obtain the ownership of the lease asset by the end of the lease term, the asset shall be depreciated over the useful life of the asset. If there is no reasonable certainty that the lessee will obtain ownership by the end of the lease term, the asset shall be fully depreciated over the shorter of the lease term and its useful life.
Minimum lease payments are apportioned between reduction of the outstanding lease liability, and the periodic finance expense which is calculated using the interest rate implicit in the lease, and charged directly to the comprehensive operating statement.

Borrowings
All borrowings are initially recognised at fair value of the consideration received, less directly attributable transaction costs. The measurement basis subsequent to initial recognition depends on whether the Health Service has categorised its borrowings as either, financial liabilities designated at fair value through profit or loss, or financial liabilities at amortised cost. Any difference between the initial recognised amount and the redemption value is recognised in net result over the period of the borrowings using the effective interest method.

The classification depends on the nature and purpose of the borrowing. The Health Service determines the classification of its borrowing at initial recognition.

NOTE 6.2: CASH AND CASH EQUIVALENTS

	2017 $	2016 $
Cash on Hand	400	400
Cash at Bank	828,698	927,795
TOTAL CASH AND CASH EQUIVALENTS	829,098	928,195
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	829,098	928,195
TOTAL CASH AND CASH EQUIVALENTS	829,098	928,195

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

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

NOTE 6.3: COMMITMENTS FOR EXPENDITURE

(a) Commitments

	2017 $	2016 $
Lease Commitments		
Commitments in relation to leases contracted for at the reporting date:		
Finance Leases - HRHA	34,009	41,603
Total Lease Commitments	34,009	41,603
Finance Lease Commitments		
Commitments in relation to finance leases are as payable as follows:		
Current	16,897	20,262
Non Current	19,152	24,139
Minimum Lease Payments	36,050	44,401
Less Future Finance Charge	(2,041)	(2,798)
Total Finance Lease Commitments	34,009	41,603

(b) Commitments Payable

Lease Commitments Payable		
Less than 1 year	15,941	18,911
Longer than 1 year but not longer than 5 years	18,068	22,692
5 years or more	0	0
Total Finance Lease Commitments	34,009	41,603

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

NOTE 7: RISKS, CONTINGENCIES & VALUATION UNCERTAINTIES

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

Structure

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

NOTE 7.1: FINANCIAL INSTRUMENTS

Financial Risk Management Objectives and Policies

Alexandra District Health's principal financial instruments comprise of:

- *Cash Assets*
- *Term Deposits*
- *Receivables (excluding statutory receivables)*
- *Payables (excluding statutory payables)*
- *Lease Liabilities*

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 throughout notes 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 the different risks to which it is exposed. Primary responsibility for the identification and management of financial risks rests with the financial risk management committee of the Health Service.

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

Categorisation of financial instruments

2017	Contractual financial assets - loans and receivables $	Contractual financial liabilities at amortised cost $	Total $
Contractual Financial Assets			
Cash and cash equivalents	829,098	0	829,098
Receivables			0
- Trade Debtors	46,449	0	46,449
- Other Receivables	135,789	0	135,789
Other Financial Assets			
- Term Deposits	1,503,393	0	1,503,393
Total Financial Assets (i)	2,514,729	0	2,514,729
Financial Liabilities			
Payables	0	375,040	375,040
Lease Liabilities	0	34,009	34,009
Total Financial Liabilities(ii)	0	409,049	409,049

2016	Contractual financial assets - loans and receivables $	Contractual financial liabilities at amortised cost $	Total $
Contractual Financial Assets			
Cash and cash equivalents	928,195	0	928,195
Receivables			
- Trade Debtors	46,240	0	46,240
- Other Receivables	68,232	0	68,232
Other Financial Assets			
- Term Deposits	1,500,000	0	1,500,000
Total Financial Assets (i)	2,542,667	0	2,542,667
Financial Liabilities			
Payables	0	507,661	507,661
Lease Liabilities	0	41,603	41,603
Total Financial Liabilities(ii)	0	549,264	549,264

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

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

	Total interest income/ (expense) $	Total $
2017		
Financial Assets		
Loans and Receivables(i)	50,077	50,077
Total Financial Assets	50,077	50,077
Financial Liabilities		
At amortised cost (ii)	(1,101)	(1,101)
Total Financial Liabilities	(1,101)	(1,101)
2016		
Financial Assets		
Loans and Receivables(i)	65,178	65,178
Total Financial Assets	65,178	65,178
Financial Liabilities		
At amortised cost (ii)	(1,683)	(1,683)
Total Financial Liabilities	(1,683)	(1,683)

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

(ii) For financial liabilities measured at amortised cost, the net gain or loss is the interest expense, arising from the revaluation of financial liabilities measured at amortised cost.

(c) Credit Risk

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

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

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

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

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

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

2017	Financial Institutions (AA credit rating) $	Financial Institutions (min BB credit rating) $	Other (min BBB credit rating) $	Total $
Financial Assets				
Cash and Cash Equivalents	829,098	0	0	829,098
Loans and Receivables				
- Trade Debtors	0	0	87,552	87,552
- Other Receivables (i)	0	0	94,686	94,686
- Term Deposits	753,393	750,000	0	1,503,393
Total Financial Assets	1,582,491	750,000	182,238	2,514,729
2016				
Financial Assets				
Cash and Cash Equivalents	928,195	0	0	928,195
Loans and Receivables				
- Trade Debtors	0	0	72,755	72,755
- Other Receivables (i)	0	0	41,717	41,717
- Term Deposits	750,000	750,000	0	1,500,000
Total Financial Assets	1,678,195	750,000	114,472	2,542,667

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

Ageing analysis of financial assets as at 30 June

2017	Carrying Amount $	Not Past due and not impaired $	Past Due but Not Impaired Less than 1 Month $	1 - 3 Months $	3 Months - 1 Year $	1 - 5 Years $	Impaired Financial Assets $
Financial Assets							
Cash and Cash Equivalents	829,098	829,098	0	0	0	0	0
Loans and Receivables							
- Trade Debtors	87,552	65,700	17,843	765	3,244	0	0
- Other Receivables	94,686	94,686	0	0	0	0	0
- Term Deposits	1,503,393	1,503,393	0	0	0	0	0
Total Financial Assets	2,514,729	2,492,877	17,843	765	3,244	0	0
2016							
Financial Assets							
Cash and Cash Equivalents	928,195	928,195	0	0	0	0	0
Loans and Receivables							
- Trade Debtors	72,755	56,523	7,879	4,061	4,292	0	0
- Other Receivables	41,717	41,717	0	0	0	0	0
- Term Deposits	1,500,000	1,500,000	0	0	0	0	0
Total Financial Assets	2,542,667	2,526,435	7,879	4,061	4,292	0	0

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

Contractual financial assets that are neither past due or impaired
There are no material financial assets which are individually determined to be impaired. Currently the Health Service does not hold any collateral as security nor credit enhancements relating to its financial assets.

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(d) Liquidity Risk

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

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

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

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

Maturity analysis of financial liabilities as at 30 June

			Maturity Dates			
	Carrying Amount	Nominal Amount	Less than 1 Month	1 - 3 Months	3 Months - 1 Year	1 - 5 Years
2017	$	$	$	$	$	$
Financial Liabilities						
At amortised cost						
Payables	375,040	375,040	375,040	0	0	0
Lease Liabilities	34,009	34,009	1,329	3,985	11,956	16,739
Total Financial Liabilities	409,049	409,049	376,369	3,985	11,956	16,739
2016						
Financial Liabilities						
At amortised cost						
Payables	507,661	507,661	505,881	1,780	0	0
Lease Liabilities	41,603	41,603	1,689	5,065	13,508	21,341
Total Financial Liabilities	549,264	549,264	507,570	6,845	13,508	21,341

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

(e) Market Risk

Alexandra District Health's exposures to market risk are primarily through interest rate risk with only insignificant exposure to other price risks. Objectives, policies and processes used to manage each of these risks are disclosed in the paragraphs below.

Interest Rate Risk

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

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

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

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

Other Price Risk

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

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

2017	Weighted Average Effective Interest Rate (%)	Carrying Amount $	Interest Rate Exposure		
			Fixed Interest Rate $	Variable Interest Rate $	Non - Interest Bearing $
Financial Assets					
Cash and Cash Equivalents	0.65	829,098	0	828,698	400
Loans and Receivables (i)					
- Trade debtors		87,552	0	0	87,552
- Other receivables		94,686	0	0	94,686
- Term deposit	2.61	1,503,393	1,503,393	0	0
Total Financial Assets		2,514,729	1,503,393	828,698	182,638
Financial Liabilities					
At amortised cost					
Payables (i)		375,040	0	0	375,040
Lease Liabilities	4.10	34,009	34,009	0	0
Total Financial Liabilities		409,049	34009	0	375,040
2016					
Financial Assets					
Cash and Cash Equivalents	1.90	928,195	0	927,795	400
Loans and Receivables (i)					
- Trade debtors		72,755	0	0	72,755
- Other receivables		41,717	0	0	41,717
- Term deposit	2.89	1,500,000	1,500,000	0	0
Total Financial Assets		2,542,667	1,500,000	927,795	114,872
Financial Liabilities					
At amortised cost					
Payables (i)		507,661	0	0	507,661
Lease Liabilities	4.10	41,603	41,603	0	0
Total Financial Liabilities		549,264	41603	0	507,661

(i) The carrying amount must exclude types of 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, the Alexandra District 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 100 basis points up and down in market interest rates (AUD) from year-end rates of 1.75%;
- A parallel shift of +1% and -1% in inflation rate from year-end rates of 2%.

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(e) Market Risk (Continued)

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

	Carrying Amount	Interest Rate Risk			
		-1%		+1%	
2017	$	Profit $	Equity $	Profit $	Equity $
Financial Assets					
Cash and Cash Equivalents	828,698	(8,287)	(8,287)	8,287	8,287
Loans and Receivables					
- Trade debtors	87,552	0	0	0	0
- Other receivables	94,686	0	0	0	0
- Term deposit	1,503,393	(15,034)	(15,034)	15,034	15,034
Financial Liabilities					
At amortised cost					
Payables	375,040	0	0	0	0
Lease Liabilities	34,009	340	340	(340)	(340)
		(22,981)	(22,981)	22,981	22,981
2016					
Financial Assets					
Cash and Cash Equivalents	927,795	(9,278)	(9,278)	9,278	9,278
Loans and Receivables					
- Trade debtors	72,755	0	0	0	0
- Other receivables	41,717	0	0	0	0
- Term deposit	1,500,000	(15,000)	(15,000)	15,000	15,000
Financial Liabilities					
At amortised cost					
Payables	507,661	0	0	0	0
Lease Liabilities	41,603	416	416	(416)	(416)
		(23,862)	(23,862)	23,862	23,862

(f) Fair Value

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

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

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

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

Comparison between carrying amount and fair value

	Carrying Amount 2017 $	Fair Value 2017 $	Carrying Amount 2016 $	Fair Value 2016 $
Financial Assets				
Cash and Cash Equivalents	828,698	828,698	927,795	927,795
Loans and Receivables (i)				
- Trade Debtors	87,552	87,552	72,755	72,755
- Other Receivables	94,686	94,686	41,717	41,717
-Term Deposits	1,503,393	1,503,393	1,500,000	1,500,000
Total Financial Assets	**2,514,329**	**2,514,329**	**2,542,267**	**2,542,267**
Financial Liabilities				
At amortised cost				
Payables	375,040	375,040	507,661	507,661
Lease Liabilities	34,009	34,009	41,603	41,603
Total Financial Liabilities	**375,040**	**375,040**	**507,661**	**507,661**

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(f) Fair Value (Continued)

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of Alexandra District Health's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 Financial Instruments: Presentation. For example, statutory receivables arising from taxes, fines and penalties do not meet the definition of financial instruments as they do not arise under contract.

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

The following refers to financial instruments unless otherwise stated.

Categories of non-derivative financial instruments

Loans and receivables

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

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

Financial Liabilities at amortised cost

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

Financial instrument liabilities measured at amortised cost include all of 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.

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

	2017 $	2016 $
Proceeds from Disposal of Non-Current Assets		
- Plant	1,500	0
- Motor Vehicles	0	27,500
Total Proceeds from Disposal of Non-Current Assets	1,500	27,500
Less: Written Down Value of Non-Current Assets Sold		
- Plant	0	0
- Motor Vehicles	0	0
Total Written Down Value of Non-Current Assets Sold	0	0
NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS	1,500	27,500

Disposal of Non-Financial Assets

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

Impairment of Non-Financial Assets

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 an asset revaluation reserve amount applicable to that same class of asset.

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

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

Impairment of Non-Financial Assets (Continued)

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

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

There are no known contingent assets or contingent liabilities at the date of this report. (2016:NIL)

NOTE 7.4: FAIR VALUE DETERMINATION

Asset Class	Examples of types of assets	Expected fair value level	Likely valuation approach	Significant inputs (Level 3 only)
Non-specialised land	In areas where there is an active market: - vacant land - land not subject to restrictions as to use or sale	Level 2	Market approach	N/A
Specialised land	Land subject to restrictions as to use and/or sale Land in areas where there is not an active market	Level 3	Market approach	CSO adjustments
Specialised buildings [(i)]	Specialised buildings with limited alternative uses and/or substantial customisation e.g. prisons, hospitals, and schools	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Plant and equipment [(i)]	Specialised items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	Useful life
Vehicles	If there is an active resale market available;	Level 3	Depreciated replacement cost approach	Useful life

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

NOTE 8: OTHER DISCLOSURES

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

Structure

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

NOTE 8.1: EQUITY	2017 $	2016 $
(a) Surpluses		
Property, Plant and Equipment Revaluation Surplus [1]		
Balance at beginning of the reporting period		
- Land	703,250	703,250
- Buildings	6,781,551	6,781,551
Balance at the end of the reporting period	7,484,801	7,484,801
Represented by:		
- Land	703,250	703,250
- Buildings	6,781,551	6,781,551
	7,484,801	7,484,801

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

Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	24,304	24,304
Balance at the end of the reporting period	24,304	24,304
Total Surpluses	7,509,105	7,509,105
(b) Contributed Capital		
Balance at the beginning of the reporting period	3,591,970	3,591,970
Balance at the end of the reporting period	3,591,970	3,591,970
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	14,901,660	15,768,795
Net Result for the Year	(1,062,531)	(867,135)
Balance at the end of the reporting period	13,839,129	14,901,660
Total Equity at end of financial year	24,940,204	26,002,735

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

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

Property, Plant and Equipment Revaluation Surplus
The asset revaluation surplus is used to record increments and decrements on the revaluation of non-current physical assets.

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

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

	2017 $	2016 $
NET RESULT FOR THE YEAR	(1,062,531)	(867,135)
Non-cash movements		
Depreciation	1,303,420	1,362,609
Share of Net Result of Joint Operation (net of depreciation)	0	(47,354)
Movements included in investing and financing activities		
Net (Gain)/Loss from Disposal of Plant and Equipment	(1,500)	(27,500)
Movements in assets and liabilities		
Change in operating assets and liabilities		
(Increase)/Decrease in Receivables	(130,856)	165,000
(Increase)/Decrease in Prepayments	(12,162)	(22,191)
(Increase)/Decrease in Inventories	97	10,094
Increase/(Decrease) in Payables	(145,561)	15,941
Increase/(Decrease) in Provisions	153,037	35,509
NET CASH INFLOW / (OUTFLOW) FROM OPERATING ACTIVITIES	103,944	624,973

NOTE 8.3: OPERATING SEGMENTS

Alexandra District Health provides a range of health related services to the general public. Whilst the Hospital provides varying services, including Acute Health, Aged Support Services and Community Health Services, they are all within the one segment, being provision of health care services.

Geographical Segment

Alexandra District Health operates predominantly in Alexandra, Victoria. More than 90% of revenue, net surplus from ordinary activities and segments assets relate to operations in Alexandra, Victoria.

NOTE 8.4: RESPONSIBLE PERSON RELATED DISCLOSURES

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

	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	01/07/2016 - 30/06/2017
The Honourable Jenny Mikakos, MLC, Minister for Families and Children	01/07/2016 - 30/06/2017
Governing Boards	
Ian McKaskill	01/07/2016 - 30/06/2017
Carole Staley	01/07/2016 - 30/06/2017
Jennifer Cummins	01/07/2016 - 30/06/2017
Cheryl Nickels-Beattie	01/07/2016 - 15/01/2017
Margaret Rae	01/07/2016 - 30/06/2017
Ray Twitchett	01/07/2016 - 30/06/2017
Lorna Gelbert	01/07/2016 - 30/06/2017
Elizabeth Milford	01/07/2016 - 30/06/2017
Geoff Hyland	01/07/2016 - 30/06/2017
Penelope Percy	01/07/2016 - 30/06/2017
Accountable Officer	
Mara Richards	01/07/2016 - 27/11/2016
Margaret Baker	28/11/2016 - 22/01/2017
Deborah Rogers	23/01/2017 - 30/06/2017

Remuneration of Responsible Persons

Remuneration received or receivable by responsible persons was in the range: $160,000 - $169,999 ($160,000 - 169,999 in 2015-16).

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

Refer to Note 8.6 for further analysis of remuneration and transactions with Key Management Personnel.

NOTE 8.5: EXECUTIVE OFFICER DISCLOSURES

Remuneration of executives

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

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

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

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

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

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

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

Remuneration of executive officers	Total Remuneration	
	2017	2016(a)
	$	$
Short-term employee benefits	91,567	
Post-employment benefits	8,940	
Other long-term benefits	2,883	
Termination benefits	0	
Share-based payments	0	
Total Remuneration (b)	103,390	
Total Number of executives (c)	1.15	
Total annualised employee equivalent (AEE) (d)	1.15	

Notes:

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

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

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

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

NOTE 8.6: RELATED PARTIES

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

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

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

Key management personnel (KMP) of the hospital include the Portfolio Ministers and 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.

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

COMPENSATION	2017 $
Short term employee benefits	145,451
Post-employment benefits	13,182
Other long-term benefits	3,729
Termination benefits	0
Share based payments	0
Total	**162,362**

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.

Other Transactions of Responsible Persons and their Related Parties

There were no transactions with Responsible Persons or their Related Parties.

Significant transactions with government-related entities

Alexandra District Health received funding from the Department of Health and Human Services of $6,575,608 (2016: $6,442,358).

During the year, Alexandra District Health had the following other government-related entity transactions:
- Commonwealth Government funding received for health related programs totalling $160,397 (2016 $Nil).

NOTE 8.7: REMUNERATION OF AUDITORS

	2017 $	2016 $
Victorian Auditor-General's Office		
Audit or review of financial statement	18,500	18,380
	18,500	18,380

NOTE 8.8: 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. Alexandra District Health has not and does not intend to adopt these standards early.

Standard / Interpretation	Summary	Applicable for reporting periods beginning on	Impact on Health Service's Annual Statements
AASB 9 *Financial Instruments*	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1 January 2018	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. While there will be no significant impact arising from AASB 9, there will be a change to the way financial instruments are disclosed.
AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)	The requirements for classifying and measuring financial liabilities were added to AASB 9. The existing requirements for the classification of financial liabilities and the ability to use the fair value option have been retained. However, where the fair value option is used for financial liabilities the change in fair value is accounted for as follows: - The change in fair value attributable to changes in credit risk is presented in other comprehensive income (OCI); and - Other fair value changes are presented in profit and loss. If this approach creates or enlarges an accounting mismatch in the profit or loss, the effect of the changes in credit risk are also presented in profit or loss.	1 January 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. Changes in own credit risk in respect of liabilities designated at fair value through profit and loss will now be presented within other comprehensive income (OCI). Hedge accounting will be more closely aligned with common risk management practices making it easier to have an effective hedge. For entities with significant lending activities, an overhaul of related systems and processes may be needed.
AASB 2014-1 Amendments to Australian Accounting Standards [Part E Financial Instruments]	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	1 January 2018	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2014-7 Amendments to Australian Accounting *Standards arising from AASB 9*	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1 January 2018	The assessment has indicated that there will be no significant impact for the public sector.
AASB 15 Revenue from Contracts with Customers	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1 January 2018	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications.

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

Standard / Interpretation	Summary	Applicable for reporting periods beginning on	Impact on Health Service's Annual Statements
AASB 2014-5 Amendments to Australian Accounting *Standards arising from AASB 15*	Amends the measurement of trade receivables and the recognition of dividends. Trade receivables, that do not have a significant financing component, are to be measured at their transaction price, at initial recognition. Dividends are recognised in the profit and loss only when: - the entity's right to receive payment of the dividend is established; - it is probable that the economic benefits associated with the dividend will flow to the entity; and the amount can be measured reliably.	1 Jan 2017, except amendments to AASB 9 (Dec 2009) 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.
AASB 2015-8 Amendments to Australian Accounting Standards – Effective Date of AASB 15	This Standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1 January 2018	This amending standard will defer the application period of AASB 15 for for-profit entities to the 2018-19 reporting period in accordance with the transition requirements.
AASB 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 January 2018	The assessment has indicated that there will be no significant impact for the public sector, other than the impact identified for AASB 15 above.
AASB 2016-7 Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities	This Standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019.	1 January 2019	This amending standard will defer the application period of AASB 15 for not-for-profit entities to the 2019-20 reporting period.
AASB 2016-8 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities	This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events. The amendments - require non-contractual receivables arising from statutory requirements (i.e. taxes, rates and fines) to be initially measured and recognised in accordance with AASB 9 as if those receivables are financial instruments; and - clarifies circumstances when a contract with a customer is within the scope of AASB 15.	1 January 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 8.8: AASBs ISSUED THAT ARE NOT YET EFFECTIVE (Continued)

Standard / Interpretation	Summary	Applicable for reporting periods beginning on	Impact on Health Service's Annual Statements
AASB 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 January 2019	The assessment has indicated that as most operating leases will come on balance sheet, recognition of the right-of -use assets and lease liabilities will cause net debt to increase. Rather than expensing the lease payments, depreciation of right-of-use assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. No change for lessors.
AASB 2016-4 Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities	The standard amends AASB 136 Impairment of Assets to remove references to using depreciated replacement cost (DRC) as a measure of value in use for not-for-profit entities.	1 January 2017	The assessment has indicated that there is minimal impact. Given the specialised nature and restrictions of public sector assets, the existing use is presumed to be the highest and best use (HBU), hence current replacement cost under AASB 13 Fair Value Measurement is the same as the depreciated replacement cost concept under AASB 136.
AASB 1058 Income of Not-for-Profit Entities	This standard replaces AASB 1004 Contributions and establishes revenue recognition principles for transactions where the consideration to acquire an asset is significantly less than fair value to enable to not-for-profit entity to further its objectives.	1 January 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.

In addition to the new standards and amendments above, the AASB has issued a list of other amending standards that are not effective for the 2016-17 reporting period (as listed below). In general, these amending standards include editorial and references changes that are expected to have insignificant impacts on public sector reporting.

- AASB 2016-1 *Amendments to Australian Accounting Standards – Recognition of Deferred Tax Assets for Unrealised* Losses [AASB 112]
- AASB 2016-2 *Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107*
- AASB 2016-5 *Amendments to Australian Accounting Standards – Classification and Measurements of Share-based* Payment Transactions
- AASB 2016-6 *Amendments to Australian Accounting Standards – Applying AASB 9 Financial Instruments with AASB 4* Insurance Contracts
- AASB 2017-1 *Amendments to Australian Accounting Standards – Transfers of Investment Property, Annual Improvements* 2014-16 Cycle and Other Amendments
- AASB 2017-2 *Amendments to Australian Accounting Standards – Further Annual Improvements 2014-16 Cycle*

NOTE 8.9: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

Assets, liabilities, income or expenses arise from past transactions or other past events. Where the transactions result from an agreement between the Health Service and other parties, the transactions are only recognised when the agreement is irrevocable at or before the end of the reporting period.

Adjustments are made to amounts recognised in the financial statements for events which occur between the end of the reporting period and the date when the financial statements are authorised for issue, where those events provide information about conditions which existed at the reporting date. Note disclosure is made about events between the end of the reporting period and the date the financial statements are authorised for issue where the events relate to conditions which arose after the end of the reporting period that are considered to be of material interest.

There have been no events subsequent to the reporting date which require further disclosure.

NOTE 8.10: ALTERNATIVE PRESENTATION OF COMPREHENSIVE OPERATING STATEMENT

	Note	2017 $	2016 $
Grants			
Operating	2.1	6,638,883	6,360,898
Capital	2.1	47,311	71,170
Interest	2.1	50,077	65,178
Sales of goods and services	2.1	430,393	385,223
Other	2.1	657,264	774,325
Revenue from Transactions		**7,823,928**	**7,656,794**
Employee expenses	3.1	5,192,333	4,767,139
Depreciation	4.4	1,303,420	1,362,609
Other operating expenses	3.1	2,379,797	2,422,105
Expenses from Transactions		**8,875,550**	**8,551,853**
Net Result From Transactions		**(1,051,622)**	**(895,059)**
Other economic flows included in net result			
Net gain/ (loss) on sale of non-financial assets	7.2	1,500	27,500
Other gains/ (losses) from other economic flows included in net result	3.4	(12,409)	424
Total Other Economic Flows Included in Net Result		**(10,909)**	**27,924**
NET RESULT FOR THE YEAR		**(1,062,531)**	**(867,135)**
Items that may be reclassified subsequently to net result			
Changes to financial assets available-for-sale revaluation surplus		0	0
Total other comprehensive income		**0**	**0**
Comprehensive Result		**(1,062,531)**	**(867,135)**

ALEXANDRA DISTRICT HEALTH

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

The attached financial statements for Alexandra District Health have been prepared in accordance with Standing Direction 5.2 of the *Financial Management Act 1994*, applicable Financial Reporting Directions, Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement, and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2017 and financial position of Alexandra District 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.

Carole Staley Board Chair	Deborah Rogers Chief Executive Officer	Andrew Lowe Chief Finance Officer
Alexandra	Alexandra	Alexandra
1st September, 2017	1st September, 2017	1st September, 2017

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Alexandra District Health

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
4 September 2017

Ron Mak
as delegate for the Auditor-General of Victoria