TERANG & MORTLAKE HEALTH SERVICE

ANNUAL REPORT

2016-17

OUR VISION

To be a leader in the development of a vibrant, healthier community.

WE VALUE

Compassion and responsiveness – We care for the needs of our community and each other

Equity and fairness – We make decisions objectively, without favouritism or bias

Ethical behaviour – We act in a transparent yet confidential way

Accountability – We use resources efficiently and fulfil our roles responsibly

Excellence – We strive for excellence in the delivery of healthcare

Respect – We respect the rights of all individuals

OUR STRATEGIC GOALS

Growth – Provide services that meet demand and support our community

Governance – Provide strong leadership to ensure best practice

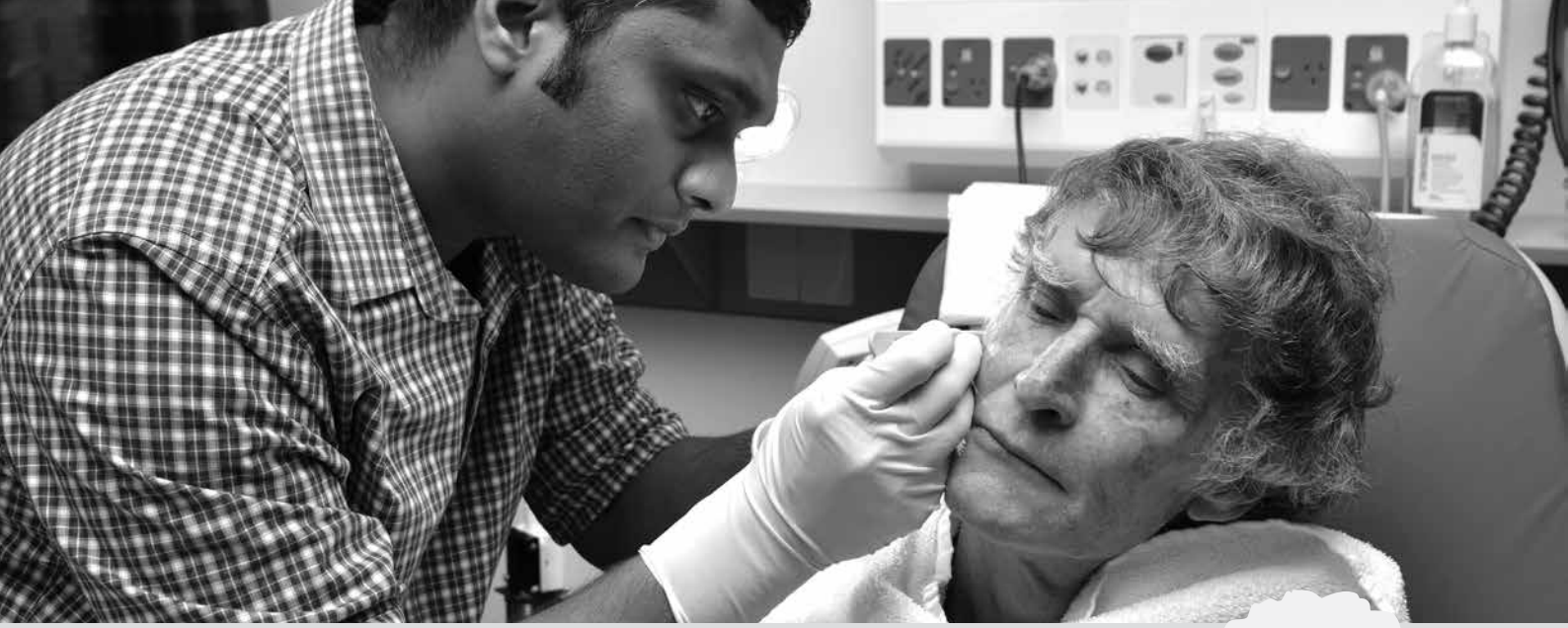
Culture – Promote a culture that supports the organisational vision and values

Financial – Build models of sustainability

Innovation in service delivery – Being responsive to changing landscapes

Marketing – Strengthen community awareness and engagement

CONTENTS



HEALTH SERVICE PROFILE

The Terang & Mortlake Health Service was established on 1st November 1994, following the amalgamation of the Terang & District (Norah Cosgrave) Hospital and the Mortlake District Hospital.

The Terang Hospital Campus comprises 14 acute beds together with accommodation for 15 aged care residents.

A wide range of health care services are provided from the Terang Campus. In addition to care provided by the General Practitioners, there are specialists in Obstetrics, Geriatrics and General Surgery who visit Terang on a regular basis.

The Terang Social Centre was established in 1985, and provides a focus for a variety of community based services which are of assistance to disabled, injured and elderly patients. Construction of the Josie Black Community Health Centre, at the front of the original Social Centre, was completed in May 2006. The Josie Black Community Health Centre now provides a modern venue for the delivery of services formerly provided at the Terang Hospital and at the Living Well Centre. These include District Nursing Services, Diabetes Education, Health Promotion and Allied Health Services such as Podiatry, Speech Pathology, Dietetics, Occupational Therapy and Physiotherapy.

The Terang and Tweddle Early Parenting day stay program began catering for the parenting needs of the South West in April 2001. The Terang Early Parenting Centre is operated in partnership with Tweddle Child and Family Health Services. The parenting centre provides a Day Program for families with babies and children up to 36 months old: education and help to manage parenting issues including feeding difficulties, unsettled/ irritable infants, infant/toddler sleeping problems, uncertainty with parenting issues, challenging toddler behaviour, maternal exhaustion, and postnatal anxiety & depression.

The former Mortlake District Hospital, which was established in March 1922, has undergone a significant role change following the amalgamation. Bed based services at Mortlake were de-commissioned, effective from 1st November 1994. The Mortlake Community Health Centre now provides a range of primary care, allied health, chronic disease management and health promotion programs.

SERVICES PROVIDED

Primary Care

The Primary Care department provides allied health and medical support services in the following areas.

- Arthritis Education and Support Group
- Blood Pressure Checks
- Josie Black Community Health Centre available to community groups
- Community Network Meetings
- Counselling Services
- Diabetes Education
- Dietetics
- ECG Checks
- Health Education and Screening
- Health Promotion
- Immunisation Nurse Practitioner
- Live Life Well Program
- Mortlake Community Health Centre Outpatients Clinic
- Occupational Therapy
- Physiotherapy
- Podiatry
- Pre and Post Natal Care
- Smoking Cessation
- Speech Pathology
- Well Womens' Clinic – Breast Screen, Pap Smear Clinic

Services are also provided to Community members to assist them with maintaining and improving their health:

- Advanced Care Planning
- Community education programs and events
- Carers Support Group
- Men's Mobility Group
- Parenting Programs
- Planned Activity Group
- Presentations to Community Groups and other Health Agencies
- Respite Outings for care recipients
- Strength Training
- Walking and Exercise Groups
- Yoga

Terang and Mortlake Health Service offers Coordinated Care to assist community members to achieve maximum independence compatible with abilities.

- District Nursing Service
- Community Transport
- Meals on Wheels

Acute Hospital Care

The acute hospital services are provided in our 14 bed Acute Wing, Theatre and Urgent Care departments. These areas are accessed through the administration area in the front of the Health Service building facing Austin Avenue.

- 24 hour Urgent Care
- General Medicine
- Surgical Care
- Palliative Care
- Obstetrics / Gynaecology

Aged Care

Mount View Aged Care Facility

Mount View is a purpose built 15 bed Aged Care facility. It is considered to be an outstanding example of residential aged care. It is located adjacent the hospital facing Austin Avenue.

- Aged Residential Care
- Access to Aged Care Assessment Team, Home Assessments and Domiciliary Assessments

Other Services and Programs

- Tax Help
- Centrelink Access Point (Terang)
- Playgroup (Mortlake)
- Early Parenting Centre
- Maternal and Child Health – Moyne Shire
- Planned Activity Groups – Moyne Shire

PRESIDENT, BOARD OF MANAGEMENT & CHIEF EXECUTIVE OFFICERS REPORT

The 2016-17 financial year has been another year of significant challenge and achievement for Terang & Mortlake Health Service as we strive to provide quality care to our community. The following information provides a summary of some of the year's highlights as we work towards embedding our organisation's vision which is *"To be a leader in the development of a vibrant, healthier community".*

The vision referred to above is based on the following beliefs and understanding:

- Terang & Mortlake Health Service (TMHS) is one of a number of organisations that plays a lead role in the community;
- As a leader in the community it is incumbent upon TMHS to foster innovation and challenge the status quo;
- That vibrant communities are characterised as empowered, having greater control over their destiny, a "can-do" attitude of self-belief and strong leadership;
- The healthier community envisaged adopts a social model of health and uses the World Health Organisation definition of health which is more than the absence of disease but 'a state of complete physical, mental and social wellbeing' *(W.H.O, 1946)*. Wellbeing is defined as 'the condition of being well, contented and satisfied with life. Wellbeing has several components, including physical, mental, social and spiritual' *(Environments for Health, Victorian Government, 2001)*

From a financial viewpoint it is pleasing to report an operating surplus before capital and specific items amounting to $290,633. The comprehensive result for the year amounts to a deficit of $378,478. It should be noted however, that this amount includes funds provided by the State government for capital infrastructure and equipment amounting to $89,852, interest on investments $87,762, donations and bequests $140,368 and depreciation on assets amounting to $1,003,566.

Government grants for capital improvements and equipment and, donations and bequests received are not used for funding day to day operations of the organisation but are required by accounting rules to be recorded in the accounts as contributing to the net result for the year.

A summary of the financial result may be found in the Financial Overview and of course, the Financial Report encompassing the Financial Statements and notes present a detailed record of the year's results.

Leadership and Governance

Terang & Mortlake Health Service is fortunate to have a high functioning and effective Board. The Health Service acknowledges the significant contribution made by retiring Board member, Mrs Helen Kenna. Helen joined the TMHS Board in 2012 and served as the Junior Vice President before taking on roles as Treasurer in 2013 & 2014 and Vice President in 2015. Helen has been instrumental in ensuring that Board members keep abreast of governance best practice by coordinating the Board's Governance Evaluation and Development program during her tenure. Helen was an active member of the Physical Resources and Planning and Quality Improvement Committees during this period. She has seen much change particularly with

the infrastructure changes to the health service during her appointment.

We sincerely thank Helen for her tireless contribution and wish her well.

Terang & Mortlake Health Service has continued to play a leading role in promoting positive health change initiatives in the Corangamite Shire as a key member of the Corangamite Health Collaborative (CHC). This advisory committee reports directly to the Department of Health & Human Services and includes executive staff representatives from Cobden District Health Service, Timboon & District Health Service, South West Healthcare, and the Corangamite Shire. The primary focus of the CHC committee is to review the delivery of health services within the Corangamite Shire and develop improved service models for residents in our region. Terang & Mortlake Health Service has been instrumental in helping to develop a Shire wide Aged Care marketing tool in order to promote the availability of aged care services close to home.

The Board of Management is the organisation's major policy making body and assumes overall responsibility for the strategic direction and operation of the Health Service. The Board is responsible for ensuring the service is well managed, provides high quality services that meet the needs of the community, and ensuring that objectives are met. To ensure the Board maintains its ability to undertake its role Board members participate in on-going education programmes. During the year Board members again undertook a self-assessment process to gauge their knowledge and understanding of governance matters and the maturity of governance systems and processes in place using a tool developed by the Australian Centre for Healthcare Governance (ACHG). Following the assessment an action plan has been implemented to further develop knowledge, systems and processes over the next year.

The Board of Management welcomed two new members last July - Mr Ashley Eccles and Ms. Erin Guiney. Both Ashley and Erin possess strong clinical nursing experience and add to the strength of our Board's skill based diversity.

We record our appreciation for the dedication and service provided to Terang & Mortlake Health Service by all of our Board members.

The Health Service's Vision, Values and Strategic goals are recorded on page 1 of this Annual Report. These provide direction and guidance to the Board of Management in the development of policy and plans and the delivery of services to our community.

Services to patients, residents and clients

Access to services has also been an achievement in the 2016-17 year. The Terang and Mortlake communities have been provided with increased access to integrated diabetes management services through the Mortlake Community Health Centre as well as the reintroduction of General Practitioner services offered through Warrnambool Medical Clinic. In July 2016, a speech pathologist was employed to service clients with communication and swallowing difficulties adding to the depth of allied health services available from Mortlake and Terang.

In the year in review the demand for services delivered has continued to be strong across the entire range of services provided by Terang & Mortlake Health Service. The demand for hospital beds reduced in comparison to the previous year, primarily due to the closure of the acute ward north wing for the duration of building refurbishment works. During the past year, we treated a total of 904 inpatients resulting in 2,159 patient bed days. Occupancy of the aged care facility was also adversely affected by building renovations with the beds occupied at 96.40% throughout the year (up from the 2015-16 figure of 95.57%). Moving forward, the fact that occupancy levels will no longer be affected by gender balance (due to all residents now having single rooms), should stand Mount View Aged Care Facility in good stead to be a facility of choice in our region.

Demand for non-admitted services remained high. 2,836 clients presented for treatment at the Terang Hospital Urgent Care department whilst 2,306 clients presenting to the Outpatients department in Mortlake where 1,209 hours of direct care was provided.

The demand for community based services continues to increase and place pressure on the available resources. At our two Community Health Centres based in Terang and Mortlake 4,179 hours of service were provided by Allied Health and Primary Care practitioners throughout the year to 1,359 clients.

Our District nurses provided 8,185 service hours to 338 individual clients. The Terang Social Centre provided 18,398 hours of service to 121 clients.

The 2016-17 financial year welcomed 25 babies being born at Terang & Mortlake Health Service, a rise from 17 in the previous year (equating to an increase of 58%). We are proud to continue to provide a safe and contemporary birthing service for low risk births, close to home, for local families with support from our local GP Obstetricians.

Human Resources

Terang & Mortlake Health Service is supported by a highly skilled and dedicated workforce across all areas of operations including Nursing, Primary Care & Community Health, Cleaning and Domestic, Catering, Administration and Maintenance services staff. We employed over 150 people in the past year and continue to be a major employer in the Terang & Mortlake districts

The Health Service has worked hard over the past 12 months to address workforce sustainability. One strategy that has been implemented is the employment of an Apprentice Chef in our Food Services Department. This strategic appointment led on from our employment of a Maintenance Trainee in the preceding year and has aimed to encourage youth into the organisation with the view to grow a sustainable workforce from the roots up and to encourage training opportunities for locals.

Throughout the organisation there is a strong commitment toward the provision of services that are safe and of the highest quality.

During the year we welcomed 19 new members of staff; 6 in nursing, 4 in hotel services, 3 in primary care services, 4 in our aged care facility and 2 in our administration department.
Terang & Mortlake Health Service encourages and values a culture of continuous learning. In the past twelve months, we have had a staff member complete a Traineeship (Certificate III in Health Support Services) and two managers continue studying a Diploma of Leadership with the aim of increasing formalised skill growth and intellectual property within the organisation.

All TMHS staff are actively encouraged to maintain and enhance their skills and, to participate in 'in-service' education sessions presented throughout the year. TMHS operates on a two-yearly 'face-to-face'mandatory training cycle meaning that all staff are required to complete a mandatory education session within a two year calendar period. Over the current two year cycle, a total of 140 staff (93.3%) have participated in a range of sessions and presentations including Infection Control; Occupational Health & Safety; Person Centred Care; Chronic Disease Management; Fire and Emergency Procedures; Quality Improvement; Risk Management; Environmental Management; Basic Life Support (BLS) and No-lift and Manual Handling.

Nursing staff also participate in the sub-regional Continuing Nurse Education program which provides education sessions on various topics chosen by the nursing workforce. In addition, our Mortlake nursing staff spent 2 days at the South West Healthcare Accident & Emergency Department in Warrnambool to ensure their skills are maintained at a high level.

The Collaborative Aged Care Graduate Nurse program is a joint initiative with South West Healthcare with two graduates rotating 6 monthly between the two facilities in order to gain valuable experience in both Aged Care and Acute nursing.

The Terang and Mortlake campuses continue to be well served by the local General Practitioners of the Terang and Mortlake based clinics, by General Surgeon Mr. Carl Murphy, General Practitioner Obstetrician Dr John Menzies, visiting Physicians from the Warrnambool Physicians Group and by visiting Obstetricians & Gynaecologists from the Greenwell Specialist Clinic. During the past year, we were also fortunate to gain the services of an additional General Practitioner Obstetrician - Dr Edith Masih.

Quality Improvement & Risk Management

The Quality Improvement Committee oversees the continuous development and improvement of our quality and risk management plans.

Our Health Service is subject to a number of periodic accreditation reviews which ensure that safety and quality benchmarks are achieved and that these factors remain a paramount focus.

In June, our Mount View Aged Care Facility participated in its three-yearly Aged Care Accreditation audit. The two day process saw two assessors from Aged Care Standards and

Accreditation Agency attend Mount View to thoroughly assess the care provided to residents against the Commonwealth Government's 44 Aged Care Quality Standards.

The areas of assessment related to:

- Management systems, staffing and organisational development
- Health and personal care
- Care recipient lifestyle
- Physical environment and safe systems

We are very pleased to report that our Mount View Aged Care Facility was successful in meeting all 44 standards with both assessors being highly complementary of the care given to residents.

Terang and Mortlake Health Service is also required to comply with the National Standards. These were developed by the Australian Commission on Safety and Quality in Healthcare (ACSQH) and have been adopted by the Health Minister in each State and Territory. The fundamental aim of the National Standards is to protect individuals from harm and improve the quality of health services delivered throughout the country. The Standards are deigned to provide a quality assurance mechanism against which health services can be assessed to determine whether relevant systems and processes are in place to meet minimum standards of quality and safety, and a quality improvement tool against which improvement can be measured.

There are ten national Standards under the following headings:

1. Governance for safety and quality in health service organisations
2. Partnering with consumers
3. Preventing and controlling healthcare associated infections
4. Medication safety
5. Patient identification and procedure matching
6. Clinical handover
7. Blood and blood products
8. Preventing and managing pressure injuries
9. Recognising and responding to clinical deterioration in acute health care
10. Preventing falls and harm from falls.

A comprehensive three-yearly Accreditation audit was conducted in June 2017 with full accreditation status being received. Standard 2, Partnering with Consumers was 'Met with Merit' with the accreditors being particularly impressed by the health service's input from the Community Advisory committee.

The Accreditation assessors also noted the progress that had been made with standards since the last accreditation review in 2014 and were impressed by the passion and professionalism that staff demonstrated in their day-to-day roles.

Our Mount View Aged Care Facility continues to build on its reputation for being a leader in providing the 'Montessori Dementia Model of Care.' In November 2015, Terang & Mortlake Health Service, through our Mount View Aged Care Facility was invited to participate in the 'Montessori' regional project.

The Montessori model of care was developed in Italy and is highly regarded as being 'best practice' for residents with dementia. The aim of the project is to promote independence to residents and to provide purposeful and meaningful activities.

Our Mount View staff were asked to showcase their learnings and implementation of the project to Alzheimers Victoria in mid-2016. This is indeed a testament to the success of the project.

Our aged care staff have continued to embed Montessori principles into standard practice and continue to see positive results, particularly with challenging behaviours and medication use.

Community Advisory Committee

The Community Advisory Committee formed in February 2010 continued to meet throughout the year to assist with the development of documentation for patients, consumers and carers.

Once again, a major achievement of the committee was the November publication of the 2015-16 Quality Account Report. Committee members played lead roles in the development of the report drafting the human interest stories based on community members experience with the Health Service. We received 14 overwhelmingly positive responses to our survey which sought to find whether people who received the report found it useful and of interest. The Committee is currently involved in the development of the 2016-17 Quality Account report which will be distributed throughout the TMHS catchment area toward the end of this year.

Mrs Eve Black continues to represent members of the Community Advisory Committee by attending meetings of the Quality Improvement Committee and the monthly meeting of the Board of Management to provide a consumer perspective to the matters discussed. Eve also participates in the delivery of training sessions for staff providing a consumer perspective during discussion surrounding the Person Centred Care training module.

The Consumer Advisory Committee is made up by 7 members of the community, Mrs Eve Black, Mrs Judy Blackburn, Mrs Judy Walters, Mrs Jean Edwards, Mr Geoff Barby, Mr Craig Coates and Mrs Julie Kenna. The welcome addition of two males in the past financial year has provided the important aspect of gender balance and allows the committee to be more representative of the community.

The Board is very appreciative of the critical role undertaken by the committee and looks forward to their on-going input and assistance.

Facilities & Equipment

On 24th February 2017, Terang and Mortlake Health Service officially opened the expanded and refurbished Mt View Aged Care Facility and North wing of the acute ward. The revamped hospital site was officially opened by the Honourable Gayle Tierney, Member for Western Victoria. Works to the facility included the expansion of a new dining space, 3 new bedrooms, kitchenette and an expansive outdoor deck area maximising views over to Mt Noorat in the North. Residents, family members and staff members have been glowing about the extra space and privacy that the new area has provided.

The refurbishment of the North wing acute ward was our most significant infrastructure project since 1957. Building works included a new 2 chair renal dialysis suite as well as en-suite bathrooms and refurbished rooms. Feedback from patients, staff and visiting medical officers has been extremely positive with the improvements making the area a significantly more pleasant area in which to recuperate and work.

Maintenance at both the Terang & Mortlake Campus' continue to provide us with an on-going challenge as we strive to provide modern day health care from ageing infrastructure.

Through fundraising activities, and a series of small capital grants provided by the Department

of Health & Human Services we have been able to replace and acquire a number of important capital equipment items during the past year. These include:

- New carpet in the Terang Hospital stairwell and administration zone;
- 7 x new beds for acute ward including 1 x high/low bed for Mount View;
- 2 x new commode chairs for the Terang Hospital acute ward.

A number of significant maintenance projects have also been undertaken during the past year. These include:

- New carpet throughout the acute ward, administration hallway and hospital entrance;
- Mortlake Community Health Centre refurbishment including carpeting and painting of consulting rooms and the GP Medical Clinic.

The members of the Terang Hospital Ladies Auxiliary group held a number of successful functions during the year. The auxiliary hosted an in-house music afternoon, which sold out well in advance, and an open garden weekend. The annual golf, bowls and croquet evening held in February was again a great success with over 120 participants taking part and enjoying the barbeque afterwards. We are extremely grateful for the untiring support of this dedicated band of ladies.

Community Support

The Health Service is well supported by our community, and we offer our sincere thanks to the members of the Terang Hospital Ladies Auxiliary, service clubs of Terang and Mortlake, the Terang Aged Care Trust, the Terang Op Shop, members of the Murray to Moyne Cycle Relay teams and individual community members who have assisted throughout the year by way of financial and in-kind support through volunteering.

During the year our Murray to Moyne Cycle Relay Team – the 'Terang Flyers' raised more than $24,000 towards the purchase of new medical equipment for our Health Service. An amazing $10,355 of this amount was provided by the Terang Op Shop and we are extremely grateful for their on-going support.

Funds raised by the Terang Murray to Moyne relay team were allocated toward the purchase of two new Cardiac Monitor/Defibrillator units for the Terang Hospital Urgent Care department and the Mortlake Primary Care department and six new chairs for inpatient rooms on the newly refurbished North wing of the Hospital acute ward.

We extend our sincere appreciation to the 120 plus community volunteers who assist with the delivery of services to clients at Mount View Aged Care Facility, the Terang and Mortlake Community Health Centres, Terang Day Centre and people living in the community. Our Meals on Wheels service, which provides meals to Terang residents on behalf of the Corangamite Shire 7 days per week has continued to grow.

This service is reliant on the 60+ volunteers who deliver meals throughout the town and we thank them for, and look forward to, their on-going support.

Thanks also go to Tweddle Child and Family Health Service, South West Healthcare, Timboon and District Health Service, Cobden & District Health Service, Colac Area Health, the South West Alliance of Rural Health (SWARH), South West Primary Care Partnership, Corangamite and Moyne Shires, South West Institute of TAFE, the Western Primary Health Network and all other providers of health and health related services that have assisted TMHS throughout the year.

Conclusion

The Board of Management, whilst reflecting on the achievements of the financial year in review, will continue to focus on the long-term strategic goals of the organisation. We look forward to continuing our participation in the Strengthening Rural Health Services Project and the Corangamite Health Collaborative which will provide new and additional opportunities to work collaboratively with the other agencies and providers throughout the region, and to the on-going implementation of our Strategic Quality Improvement Plan that will assist us to meet the health and well-being needs of the community.

We look forward to continuing to provide trusted health services to the Terang & Mortlake communities in 2017-18

Responsible Bodies Declaration

Finally, in accordance with the *Financial Management Act 1994*, we are pleased to present the Report of Operations for the Terang & Mortlake Health Service for the year ending 30 June 2016.

Barry Philp
Chair

Julia Ogdin
Chief Executive Officer

Terang
22nd August 2017

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 Terang & Mortlake Health Service contributed toward the achievement of these priorities by undertaking the following actions.

Priority	Action	Deliverable	Progress
Quality and safety	• Implement systems and processes to recognise and support person-centred end of life care in all settings, with a focus on providing support for people who choose to die at home.	• Review policies and procedures and implement strategies to ensure alignment with Victoria's End of Life Care and Palliative Care frameworks.	TMHS End of Life Care policies, audits & procedures reviewed to align with DHHS Victorian End of Life and Palliative Care framework. Insights and wishes of family and carers included into 100% of patients Advance Care plans. *Reviewed the Medical Treatment Planning and Decisions Act 2016.* Status: Complete
	• 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.	• Increase the completion of Advance Care Plans by 10% across the organisation and report results to the Quality Improvement Committee	2015-16 - 38 clients seen, 22 new ACP & 7 reviews 2016-17 - 50 clients seen, 29 new ACP & 14 reviews 12.9 % increase Status: Complete
	• Progress implementation of a whole-of-hospital model for responding to family violence.	• Increase staff awareness and responsiveness to family violence through the promotion of the 'Responding to Family Violence' policy. Monitor usage of family violence resources by the community. Include responding to family violence in the mandatory training cycle. Support staff members to complete the 'Recognising and responding to family violence' training module made available through Lifeline.	Recognising and Responding to Family Violence policies developed and implemented (for clients presenting and for staff affected by family violence) Mandatory Training includes a session on family violence all staff are required to attend bi-annually. Sixty five (65) staff have attended mandatory training sessions during 2016-17. Three (3) staff have completed 'Recognising and responding to family violence' training module made available through Lifeline. Reception staff member attended 'Prevention of Violence against Women' facilitated by BSW Women's Health on 27th April 2017. Status: Complete

Priority	Action	Deliverable	Progress
	• 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.	• Work with neighbouring health services on shared allied health positions commencing with a shared speech pathology position with Timboon and District Health Services.	Speech Pathologist appointed to shared position with Timboon District Health Services Corangamite Collaborative has appointed a project worker in the Allied Health Interdisciplinary Leadership role. The project objectives include a scoping exercise to map the local service system and development of a sustainable, sub-regional allied health workforce and service model. Status: Complete
	• Establish a foetal surveillance competency policy and associated procedures for all staff providing maternity care that includes the minimum training requirements, safe staffing arrangements and ongoing compliance monitoring arrangements.	• Host a Maternity MSEP/ PIPER forum with clinical input from Royal Women's Hospital and attendance from partnering agencies (South West Healthcare - Warrnambool & Camperdown, General Practice Obstetricians).	July 2016: MSEP/PIPER forum held @ Terang. Clinicians from major Melb hospital, Medical Director of PIPER 2 Nursing clinicians PIPER and lead obstetrician from Geelong hospital MHS held with Terang & Camperdown Midwives, GP Obs & Foetal surveillance policy adopted through committee structure to Board of Management on 26th October 2016. Four (4) Midwives have attended PROMPT training in Portland this year. TMHS midwifery staff are currently on waiting list for the next scheduled MSEP/PIPER forum. Status: Complete
	• 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.	• Conduct a community engagement forum at both the Josie Black Centre and the Mortlake Community Health Centre to elicit feedback regarding service provision. Consider feedback into future service planning processes. Distribute a minimum of 200 Victorian Healthcare Experience Survey's to clients accessing community health services and encourage submission of forms.	Victorian Healthcare Experience (Community Health) Surveys distributed from Community Health Centre (CHC) in Mortlake (Terang CHC did not receive surveys), throughout October/ November 2016; awaiting results from IPSOS. Community engagement forum held in May 2017 at the Josie Black CHC. Mortlake CHC forum to be convened following completion of current refurbishment works in July 2017. As a result of feedback received from clients attending the Terang CHC, a monthly women's bus trip program was implemented to promote social inclusion. Status: Complete

Priority	Action	Deliverable	Progress
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).	• Review and amend referral pathways for "Live Life Well" and "Integrated Diabetes Clinic" programs as required in order to maximise participation. Reduce 'fail to attend' events by 5% for specialist diabetes related appointments.	Meetings held with local GPs to review referral pathways to services based at Community Health Centres. Meeting with Terang Medical Clinic held 1st December agreements reached on referral pathways, information provided re: services available Use of "message media" and reminder phone calls for all appointments to CHC's implemented 1st November 2016 – working successfully to date. Significantly improved attendance rates. Greater than 5% reduction in 'fail to attend' instances has been achieved in 2016-17 in comparison to previous year's data. Status: Complete
	• Develop and implement a strategy to ensure the preparedness of the organisation for the National Disability and Insurance Scheme (NDIS) and Home and Community Care (HACC) program transition and reform, with particular consideration to service access, service expectations, workforce and financial management.	• Develop and implement a transition plan in preparedness for the National Disability and Insurance Scheme and review Home and Community Care program transition implementation by December 2016; implement remedial action as required. Provide a range of education sessions to staff regarding potential impacts of transition on service provision, data collection and reporting.	TMHS has been registered for NDIS. Development of a transition plan by the Director of Primary Health Care and District Nursing Service Nurse Unit Manager in progress which will incorporate plan for staff education. HACC to NDIS transition grant agreements in place Administration staff have been educated on changes to reporting systems and data collection. Manager Administration & Compliance (MAC) submitted data cleanse and spreadsheet upload of 43 NDIS eligible clients to DHHS (May 2017) in preparation for progressive transition of clients from HACC to NDIS program funding from October 2017. District Nursing and Allied Health staff attended a local NDIS information / education forum in late April 2017. Status: Complete

Priority	Action	Deliverable	Progress
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 (MPHWP)and working with other local agencies and Primary Health Networks	• Align strategic planning timeframe and process with both Corangamite and Moyne Shire's Health and Wellbeing Plans (2017-2020).	TMHS reviewed and updated its strategic plan for 2017-2020 in June 2016. The goals and action plan for the next 3 years will be aligned with the Corangamite and Moyne Shire's Health and Wellbeing plans where relevant and appropriate Confirmed shared planning opportunity with Corangamite Shire Manager of Community Services and Moyne Shire counterpart to develop integrated wellbeing plans. Corangamite Shire presented its approach to the development of the MPHWP to the Corangamite Health Collaborative (CHC). The CHC members agreed to work with the Shire to develop and implement the plan and in doing so will align with TMHS goals and actions TMHS Director of Primary Healthcare (DoPH) participates on the executive committee of the Southwest PCP. DoPH also participating in Moyne Shire Municipal Health and Wellbeing Plan external working group. TMHS CEO and DoPH meeting with Corangamite Shire MPHWP project worker to identify aligned strategies for collaboration. TMHS Health Promotion Officer (HPO) currently developing a Health Promotion Plan aligned with regional strategies and the TMHS Strategic Plan. Status: Complete
	• 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.	As part of the Heart of *Corangamite's* Nutrition and Physical Activity program, conduct two healthy eating workshops for students of Hampden Specialist School and one for parents.	Health eating workshops for students at Hampden Specialist School and a healthy morning tea for parents conducted in September 2016. Health Promotion Officer is a member of the *Heart of Corangamite* Health & Wellbeing committee. DoPH is a member of the project leadership group for the *Heart of Corangamite* program. Status: Complete

Priority	Action	Deliverable	Progress
	• Develop and implement strategies that encourage cultural diversity such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.	• Review and strengthen the current diversity plan to ensure it crosses all areas of the organisation and aligns from Board level through to frontline.	Commenced review of diversity plan October 2016. Diversity plan submitted and approved by DHHS. Status: Complete
	• 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.	• Continue to build on the outcomes of Aboriginal and Torres Strait Islander cultural audit by addressing identified gaps and encouraging cultural responsiveness by presenting a welcoming environment and respecting cultural identity.	Aboriginal children's picture books purchased and placed in waiting areas at CHCs and Acute Hospital. • Introduction of "Are you Aboriginal or Torres Strait Islander Descent?" brochure • Meeting convened in March 2017 with Kirrae Health Services to discuss collaborative service provision In principle agreement to commence an integrated diabetes clinic for Kirrae clients operating out of Mortlake CHC. Desktop flags (Australian/ Aboriginal/ Torres Strait Islands) have been purchased for all reception areas. Three aboriginal paintings from renowned local artist Fiona Clarke commissioned to hang in reception areas in order to provide a welcoming environment for indigenous consumers. Aboriginal Integrated Diabetes Clinic commenced at Mortlake CHC in May 2017. Status: Complete
	• 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.	• Undertake two Mental Health First Aid training courses for frontline staff	Mental Health First Aid training conducted for frontline administration staff in July 2016. Unable to access a second training session due to unavailability of a training facilitator. As an alternative measure, staff have accessed and completed an external program. Status: Complete

Priority	Action	Deliverable	Progress
	• Using the State 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 (LGBTI) and communities.	• Display lesbian, gay, bisexual, transgender and intersex individual's posters and stickers at all campuses that encourage and support members of this community to access health services in an inclusive and supportive environment. • Utilise lesbian, gay, bisexual, transgender and intersex individual's inclusive practice: working with rural community's document to assess health service alignment with National Standards for lesbian, gay, bisexual, transgender and intersex individual's inclusive practice. Assessment to be completed November 2016.	Updated posters ordered for acute, community and aged care. *Intimacy and Sexuality in the Aged Care* Setting policy reviewed and updated March 2017 to include LGBTI references Health Promotion Officer to completed assessment utilising National Standards requirements for LGTBI clients. TMHS Health Promotion Officer commenced a "sexual diversity health services audit' in June 2017. Status: In Progress
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.	• Ensure National and Aged Care Standards criteria are placed on the agenda for both the monthly Board meeting and the Bi-monthly Quality Improvement Committee meeting. Report on action taken by Terang and Mortlake Health Service to meet the standards.	National Aged Care Standards have been included on the Quality Improvement committee agenda which reports to the board on a bi-monthly basis. TMHS CEO & Director of Nursing (DON) attended a regional planning day for Clinical Governance Framework in May 2017, briefing reported to the TMHS Board of Management. Status: Complete

Priority	Action	Deliverable	Progress
	• 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.	• Seek opportunities to engage in joint planning with Corangamite and Moyne Shire Council's to better align Health and Wellbeing planning for the catchment.	Engaged with Corangamite Shire and Moyne Shire to participate in development of forthcoming 2017-2020 Health and Wellbeing plans. Participation in Corangamite Health Collaborative; 'Heart of Corangamite' and Southwest Primary Care Partnership (PCP) executive. Introduced annual meetings with Shire CEOs to strengthen partnership approach to service planning Status: Complete
	• 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.	• Promote the availability of support services for staff affected by bullying and harassment behaviour. Provide staff access to the Worksafe anti-bullying and harassment training program.	Face to face mandatory training as at 30/5/2017. 105 staff (70%) have attended – Bullying and workplace Harassments As at 30/5/2017, 140 TMHS staff members (93.33%) have completed on-line training - *TMHS Acceptable Workplace behaviour.* People matter survey completed in 2017 - 67 staff responses received (44% participation rate). 0% of survey respondents experienced behaviours consistent with sexual harassment. 12% of survey respondents indicated that they had experienced bullying at work in the last 12 months. Of these, 3% of survey respondents indicated that they were still experiencing bullying at the time of the survey. TMHS continues to actively promote the Employee Assistance Program (EAP) availability and access to Contact Officers for staff to utilise. Status: Complete

Priority	Action	Deliverable	Progress
	• 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.	• Conduct quarterly reviews of the Risk Register and present outcomes to the OH&S and Quality Improvement Committees. Track incidents logged on Riskman and provide regular feedback regarding outcomes to staff via newsletters.	Risk register reviewed June and December and presented to the Quality Improvement Committee. Quality Risk & Safety Manager (QR&SM) provides regular feedback on OH&S incidents recorded on *Riskman* at quarterly Occupational Health & Safety sub-committee meetings and in the quarterly *Safety Snippets* newsletter distributed to all staff. Status: Complete
	• 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.	• Encourage Aboriginal and Torres Strait Islander people to apply for positions within TMHS by adding a 'tag line' to advertising templates and circulation of all recruitment advertisements to Kirrae Aboriginal Co-operative via email. Through the provision of financial assistance and study leave, encourage staff to undertake further study.	A Tag line encouraging applications from Aboriginal and Torres Strait Islander people has been added to employment advertising. All employment advertisements are now being circulated to Kirrae Aboriginal Co-Operative via email distribution. Director of Primary Healthcare & Diabetes Educator are currently undertaking a *Diploma of Leadership and Management* via on-line tertiary education provider (Fortress Training). Manager Administration & Compliance and Deputy Manager in Catering department to consider intake for 2017-18 program. Status: Complete

Priority	Action	Deliverable	Progress
	• Create a workforce culture that: (1) includes staff in decision making; (2) promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and (3) includes consumers and the community.	• Present the employee charter to staff at mandatory training days and seek staff commitment to the charter at their annual performance appraisal. Encourage consumer feedback via the formal 'compliments and concerns' system.	As at 19th May 2017, 105 (70%) staff have attended Face to Face mandatory training as part of the current two year cycle.. Compliments and concerns reported monthly to staff via email and staff briefing. Reported at Consumer Advisory Committee and Quality Improvement Committee bi-monthly Status: Complete
	• 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 and promote a TMHS "Child Safe" statement that informs an organisational culture of child safety. Complete the Child Safety Standards Self-Audit Tool by December 2016 and implement strategies to minimise identified gaps by May 2017. Progress implementation of the *"Vulnerable Babies and Children"* policy developed by the Clinical Services and Drug Advisory Committee.	Presentation to TMHS Board of Management on Child Safe Standards at the February 2017 Board meeting. Child Safe Statement of Commitment drafted and endorsed by Board of Management at the February 2017 meeting Communication strategy drafted. Completed and submitted the *Child Safe Standards* safety audit. "*Vulnerable Babies and Children"* policy implemented. Staff education regarding referral pathways has been included in 'face-to face' mandatory training sessions and monthly staff briefings. Compulsory employee *Working with Children* checks/cards to be obtained by all TMHS employees by December 2017. Implementation strategy discussed at meeting of Senior Leadership Team – including financial hardship measures. Memo sent to staff in explaining the compulsory requirement. Status: Complete
	• 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.	• Introduce compulsory serology testing for all new staff.	Compulsory serology testing has been introduced for new staff. Status: Complete

Priority	Action	Deliverable	Progress
Financial Stability	• Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	• Ensure surplus funds over current operating requirements are invested on staggered maturity dates to maximise interest income whilst complying with legislative requirements and a low risk environment. Manager Administration & Compliance to issue Monthly departmental Actual versus Budget expenditure reports to Department Heads to ensure accountability and prudent financial management. Actively offer inpatients the choice to utilise their private health fund cover through local print media advertising; website and social media platforms	Surplus funds invested in TCV; NAB & ANZ Bank term deposits in compliance with DTF *Investment policy*. Staggered maturities ensure that a portion of invested funds are available for redemption each month; Actual versus Budget expenditure reports issued to Department Heads to provide feedback on variance analysis explanations. Not yet consistently provided on a monthly basis, but will be circulated monthly when new regional 'Powerbudget' reporting system is implemented from August 2017. Inpatients are provided with a brochure as part of their admission pack which offer them the choice to utilise their private health insurance cover where applicable. Inpatients presenting for elective surgery pre-operation appointments are also offered the choice to utilise their private health cover by administration staff and/or ward clerks. Status: Complete
	• 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.	• Monitor usage trends through the organisation-wide Environmental Management Plan designed to reduce energy use, conserve water and reduce the volume of waste sent to landfill. Review Environmental Management Plan to identify and investigate additional initiatives that will further reduce our carbon footprint and improve environmental sustainability. Reduce electricity & Liquid Petroleum Gas use by three percent; water consumption by five percent and landfill waste by percent Ongoing staff education regarding energy saving measures and recycling initiatives will continue to be promoted via month staff briefings and *"The Goss"* staff newsletter.	Environmental Sustainability Performance 2015-16 results update presented to staff at November 2016 Staff Briefing; New PVC recycling initiative introduced in October 2016. Two 120 litre bins designated for collection of clinical waste such as oxygen masks, tubing and IV bags. Infection Control Manager circulates quarterly recycling/waste management tips to all TMHS staff via email and *The Goss* staff newsletter for ongoing education requirements. Status: Complete

Part B: Service Performance for 2016-17

Financial Performance

Key Performance Indicators	Target	2016-17 Actuals
Operating Result		
Annual operating result ($m)	0.007	0.290
Cash Management		
Creditors (average payments days)	< 60 days	64
Debtors (average collection days)	< 60 days	51
Asset Management		
Adjusted current asset ratio	0.70	1.78
Days of available cash	14	128

Service Performance

Key Performance Indicators	Target	2016-17 Actuals
Safety and Quality		
Health service accreditation	Full compliance	Achieved
Residential aged care accreditation	Full compliance	Achieved
Cleaning Standards (Overall)	Full compliance	Achieved
Cleaning Standards – Very High Risk (AQL – A)	90 points	Achieved
Cleaning Standards – High Risk (AQL – B)	85 points	Achieved
Cleaning Standards – Moderate Risk (AQL – C)	85 points	Achieved
Health care worker immunisation - influenza	80%	Achieved - 92%
Submission of data to VICNISS (1) Hospital acquired infection surveillance	Full compliance	Achieved
Hand Hygiene Program rate	80%	Achieved - 93%
Governance, Leadership and Culture		
People Matter Survey	80%	Achieved
Maternity and Newborn		
Percentage of women with prearranged postnatal home care	100%	Achieved - 100%
Rate of singleton term infants without birth anomalies with APGAR score <7 to 5 minutes	< 1.6%	Achieved - 0%
Rate of servere foetal growth restrictions in singleton pregnany undelivered by 40 weeks.	< 28.6%	Achieved - 0%

"Preinatal Service performance Indicator (PSPI) reports should be consulted for a description on the utility and business rules for these indicators. Note that data or 2016 and 2017 is provisional".

Patient Experience and Outcomes		
Maternity Services - Percentage of women with prearranged postnatal home care	100%	100% Achieved
Victorian Health Experience Survey - data submission	Full complience	Achieved
Victorian Health Experience Survey - Patient Experience Quarter 1	95% positive experience	100% Achieved
Victorian Health Experience Survey - Patient Experience Quarter 2	95% positive experience	98.1% Achieved
Victorian Health Experience Survey - Patient Experience Quarter 3	95% positive experience	Full compliance*
Victorian Health Experience Survey - Patient Experience Quarter 4	95% positive experience	Full compliance*

* less than 42 responses were received for the period due to the relative size of the Health Service.
(1) VICNISS is the Victorian Hospital Acquired Infection Surveillance System
(2) The Victorian Health Experience Survey (VHES) was formerly known as the Victorian Health Experience Measurement Instrument (VHEMI)

Part C: Activity and funding

Funding Type	**2016-17 Activity Achievement**
Small Rural	
Small Rural HACC (Service Hours)	4,928
Small Rural Primary Health (Service Hours)	2,057
Small Rural Residential Care (Bed Days)	5,278

Principal Committees

The Principal Committees of the Board of Management oversee major areas of Health Service Management, Performance and Planning. Brief descriptions of each Committee, which are regularly reviewed against their respective terms of reference, are detailed as follows:-

Board of Management

The Board of Management is responsible for the overall direction of the Health Service including planning, staffing, patient care, safety and financial management.

The Board of Management is also responsible for the appointment of the Chief Executive Officer and whilst refraining from intervention in the day-to-day management entrusted to the Chief Executive Officer, the Board must be fully aware of the Health Services performance, needs and problems.

Senior staff are required to observe the Health Services by-laws and are responsible for the implementation and application of the established policies of the Board of Management and its committees.

Board Executive Committee

Includes the office bearers of the Board of Management. This Committee is empowered with the authority of the Board to act on its behalf on matters arising between meetings, but all decisions relating to policy must be referred to the next full meeting of the Board of Management.

Quality Improvement Committee

The Quality Improvement Committee is responsible for the co-ordination of the Quality Improvement Plan. Its functions include the assessment and evaluation of the quality services provided by the Health Service including the review of clinical practices or clinical competence of persons providing these services. Due to the sensitivity and confidentiality of this information the Committee has been granted statutory immunity under section 139 of the *Health Service Act 1988* (as amended).
Reports to the Board on the overall quality, effectiveness, appropriateness and use of services rendered to patients in the Health Service.

Medical Advisory/ Credentials Committee

Advises the Board on matters of a medical nature and provides an effective avenue of communication between the Visiting Medical Practitioners and the Board.

Assesses the suitability of applicants requesting appointment to the Health Service as Visiting Medical Practitioners and makes recommendations to the Board of Management. Delineates the privileges associated with such appointments and takes disciplinary action if necessary. Reviews all appointments every three years.

Physical Resources & Planning Committee

Monitors the maintenance of Health Service grounds, buildings and equipment, makes recommendations to the Board on major and minor works and replacements, plans for the future delivery of health services based on community need.

Audit & Compliance Committee

Assists the Health Service Board in fulfilling its financial oversight responsibilities in line with the requirements of the Financial Management Compliance framework.

This Committee monitors and oversees the following:

- Financial performance and the financial reporting process, including the annual financial statements.
- The scope of work, performance and independence of both internal and external auditors.
- The engagement and dismissal by management of any internal audit service providers.
- The operation and implementation of the financial risk management framework.
- Matters of accountability and internal control affecting the operations of the agency.
- The agency's process for monitoring compliance with laws and regulations and its own Code of Conduct and Code of Financial Practice.

Sub-committees

Clinical Services & Drug Advisory Committee

Develops recommendations and assists in implementing changes as required in policies and procedures. Monitors areas of concern in medical and nursing organisation and discusses matters pertinent to the managerial aspect of patients and staff.
Monitors the Pharmacy Service, formulates and recommends policies, and undertakes surveys to measure compliance in such areas a drug storage, administration and rationalisation. Drug incompatibilities are also monitored.
All findings are disseminated to relevant Departments and the Quality Improvement Committee, which acts as an advisory committee to the Board of Management.

Infection Control Committee

The Infection Control Committee makes recommendations to the Quality Improvement Committee on matters of policy, relating to the standards of practice regarding Health Service sanitation and medical asepsis in the promotion of a safe environment for patients, staff and visitors to the Health Service.

Primary Health Care Committee

The Primary Health Care Committee facilitates the development of philosophy, goals and objectives in the planning, development, implementation and evaluation of Population Health and Health Promotion programs.
This committee also promotes an understanding of population health and health promotion philosophy, goals and objectives throughout the organisation.
Provides a forum for health service planning and facilitate networking at a local, regional and state level.

Occupational Health and Safety Committee

The Occupational Health and Saftey Committee reviews and advises upon existing policies, programmes and practices of Health and Safety Issues and recommends solutions.

It examines and advises upon methods of reporting, recording, investigating and analysing hazardous acts, incidents, environment and work practices. It also considers written reports on incidents, accidents and injuries, formulating corrective and preventative guidelines.

Develops and initiates staff educational programmes.

Community Advisory Committee

The Community Advisory Committee provides direction and leadership to the integration of consumer, carer and community views toward the planning and delivery of services.

Department Heads Meeting

Provides a forum for fostering communication in relation to issues raised by departmental heads.

Information Management Committee

The Information Management Committee reviews client information, prior to it being made available for public distribution to ensure it is accurate, relevant and easily understandable. This committee is also responsible for ensuring that information is managed in a way that helps the organisation meet its goals in the provision of high quality care.

ORGANISATIONAL STRUCTURE

Board of Management

Principal Committees

Quality Improvement

Medical Advisory

Physical Resources and Planning

Audit & Compliance

Sub-committees

Reporting to Quality Improvement

Clinical Services/Drug Advisory

Infection Control

Primary Health Care

Community Advisory

Reporting to Physical Resources and Planning

Occupational Health & Safety

Information Management

Chief Executive Officer

Director of Nursing

Acute Inpatient Services

Aged Residential Services

Community Nursing

Urgent Care Nursing

Early Parenting Services

Infection Control

Director of Primary Healthcare

Mortlake Community Health

Day Centre

Primary Care Services

Health Promotion

Support Services

Quality & Risk Management

Catering Services

Environmental Services

Maintenance Services

Occupational Health & Safety

Manager Administration & Compliance

Administrative Services

Information Technology

OFFICE BEARERS AND COMMITTEE

For the year ended 30th June, 2017

President

Mr Barry Philp
First Appointed – 01.07.2012
Physical Resources & Planning Committee
Quality Improvement Committee
Medical Advisory Committee

Vice President

Mrs. Helen Kenna
B. Arts, Dip. Ed., Grad. Dip. Student Welfare
First Appointed – 01.07.2012
Physical Resources & Planning Committee
Quality Improvement Committee

Treasurer

Mr. Murray Whiting
B. Bus. (Acc.), C.P.A
First Appointed – 01.07.2014
Quality Improvement Committee
Audit & Compliance Committee

Committee Members

Mr. Geoff Barby
First Appointed – 01.07.2008
Physical Resources & Planning Committee
Audit & Compliance Committee
Quality Improvement Committee

Ms. Elizabeth Clarke
First Appointed – 01.07.2015
Physical Resources & Planning Committee
Audit & Compliance Committee
Quality Improvement Committee

Mr. Ashley Eccles
First Appointed – 01.07.2016
Audit & Compliance Committee
Quality Improvement Committee
Medical Advisory Committee

Ms. Erin Guiney
First Appointed – 01.07.2016
Quality Improvement Committee
Medical Advisory Committee

Mr. Colin Long
First Appointed – 01.07.2015
Medical Advisory Committee
Quality Improvement Committee

Mr. David Selman
First Appointed – 01.07.2010
Physical Resources & Planning Committee
Medical Advisory Committee

Independent Audit & Compliance Committee Members

Mr. Nigel Bruckner
B. Bus. (Acc.), C.A, F.T.I.A
First Appointed – 01.07.2013

Mr. Ken Davey
F. Inst. of Legal Executives (Vic)
First Appointed – 01.07.2010

Solicitors

Taits Legal

Bankers

Australia & New Zealand Banking Group Ltd.

Auditor-General's Agent

McLaren Hunt Financial Group
Warrnambool

EXECUTIVE STAFF

For the year ended 30th June, 2017

Chief Executive Officer

Ms. J.C. Ogdin, B. HSc. (Speech Path.), Grad. Cert. Quality Management, MIHM, AFHSM

Director of Nursing

Mrs. J. Fitzgibbon, R.N., B Nursing

Primary Health Care Coordinator

Mrs. M. Mitchell, R.N.

Manager, Administration & Compliance

Mr. B.A. Williams, Adv. Dip. Bus (Accounting)

STAFF LISTING

For the year ended 30th June, 2017

Unit Manager

Mrs. S. Williams, R.N., R.M., Grad. Dip. FCHN (Parenting Centre) IBCLC, Immunisation Certificate

Maintenance Supervisor

Mr. I. Barrand Painter and Decorator

Catering Supervisor

Mrs. K. Dwyer Cert III in Hospitality (Operations); Dip Business Management; Dip Human Resources

Environmental Services Officer

Mrs. G. Saunders

Quality, Risk & Safety Manager

Mrs. L.G Sanderson, Dip. OH&S, Dip. HRM, Dip. Quality Auditing; Cert IV Workplace Assessment & Training; Cert. IV OH&S

Health Information Officer

Ms. M. Covey, Clinical Coder

Nursing

Ms. M. Finnigan, R.N (Aged Care Nursing Unit Manager)

Mrs. R. Barby, R.N. (District Nursing)

Ms. J. O'Brien R.N., Cert Infection Control (Nursing)

Mrs. M. Symons, R.N., Graduate Certificate of Diabetes Education (Diabetes Educator)

Visiting Allied Health Staff

Mr. C. McLachlan, B. App. Sc. (Phys.)

Ms J. Reddrop, B. App. Sc. (Phys.)

Ms Z. Douglas, B. App. Sc. (Phys.),

Ms J. Morgan, B. App. Sc. (Phys.),

Ms. R. Rundell, B. (Podiatry), M.A. (Podiatry).A.

Mr. A. Gray, B.A., B. Bus., Grad. Dip. Couns. Psych., Dip. Ed., M.A.P.S.

Mr. J. Hill, B. App. Sc. (Phys.), Hons. M.A.P.A.

Mr. B. Hoekstra, Dip. Physio, M. Physio, B. Psych.

Ms. E. Adams, B. App. Sc. (Speech Pathology)

Visiting Medical Staff

Dr. N. Bayley, M.B., B.S., F.R.A.C.P.

Dr. C. J. Beaton, M.B., Ch.B. (Edin), F.R.A.N.Z.C.O.G., M.R.C.O.G., M.R.C.G.P.

Dr. A. Brown, M.B., B.S., F.R.A.C.G.P., D.R.A.C.O.G, A.C.R.R.M.

Dr. C. Charnley, M.B., B.S., F.R.A.C.P.

Dr. T.R.C. Fitzpatrick, M.B., B.S., F.R.A.C.G.P., D.R.A.C.O.G., Master. Dip. Family Medicine, Member Sports Medicine Aust.

Dr. N. H. Jackson, M.B., B.S., M.R.C.P. (U.K.), D.R.C.O.G., F.R.A.C.G.P.

Dr. A. Kishantha, M.B., B.S.

Dr. E. Masih, M.B., B.S.

Dr. D. McCubbery, M.B., B.S..

Dr. S. J. Menzies, M.B., B.S., M. Med. F.R.A.C.G.P., D.R.A.N.Z.C.O.G. (Advanced)

Dr. B. Morphett, M.B., B.S., F.R.A.C.G.P.

Mr. C. Murphy, M.B., Ch.B., F.R.A.C.S., F.R.C.S (Glasgow), F.R.C.S.I.

Dr. S. Nagarajah, M.B., B.S., F.R.A.C.G.P.

Dr. W. Rouse, M.B., B.S., F.R.A.C.G.P.

Dr. A. Singh, M.B., B.S.

Dr. N. Turner, M.B., B.S.

STATUTORY INFORMATION

In accordance with the Directions of the Minister for Finance under the *Financial Management Act 1994* Section 45 and 53Q(4) the following disclosures are made for the Responsible Ministers and the Accountable Officers.

Responsible Minister

The responsible Ministers during the reporting period were:

Current responsible Minister:

The Honourable Jill Hennessy MP,
Minister for Health & Human Services
Minister for Ambulance Services

The Honourable Martin Foley MP,
Minister for Mental Health, Minister for Housing, Disability and Ageing

The Honourable Jenny Mikakos MP,
Minister for Families and Children,
Minister for Youth Affairs

Manner of Establishment

Terang and Mortlake Health Service is an incorporated body under, and regulated by, the Health Services Act 1988

Declaration of Pecuniary Interest

When pecuniary interests exist, declarations of pecuniary interest have been obtained from relevant members of the Board of Management and senior management staff.

Setting of Fees

The Health Services charges Acute Care, Community Health, and Home Nursing fees in accordance with Department of Health & Human Services fees directive and Aged Care fees are charged in accordance with those determined by the Commonwealth Department of Health and Ageing.

Requests Lodged Under the Freedom of Information Act

Requests for documents in the possession of Terang and Mortlake Health Service are directed to the Chief Executive Officer, the nominated Freedom of Information Officer, and all requests are processed in accordance with the *Freedom of Information Act 1982*. A legislation fee and associated charges per application may apply.

A total of 3 valid requests for information under the *Freedom of Information Act* were processed during the 2015/16 financial year.

Merit & Equity

TMHS is subject to the *Equal Opportunity Act 1995*

The Purpose of the Act is:-

- to provide for equal employment opportunity programs in Public Authorities;
- to establish reporting requirements in relation to these programs; and
- to require Public Authorities to observe personnel management principles in employment matters.

The Terang & Mortlake Health Service has adopted principles and procedures to ensure that recruitment, promotion, and advancement will be determined on the basis of fair and open competition between qualified individuals and decisions to recruit/promote/advance will be made solely on the basis of relative ability, knowledge and skills in relation to the promotion involved.

The Health Service is further committed to ensuring that all employees will receive fair and equitable treatment in all aspects of personnel management regardless of political affiliation, race, colour, religion, national origin, sex, marital status or physical disability.

Work Place Incidents (Occupational Health & Safety)

Terang & Mortlake Health Service has continued to review and develop policies and procedures in accordance with relevant legislative requirements. There were three (3) new reported Work Cover incidents during the 2016-17 financial year. All three (3) were classified as standard claims, with a combined total of 20 days lost time has been recorded.

Occupational Violence

Terang & Mortlake Health Service is committed to preventing and addressing incidences of occupational violence.

In 2016-17, there were no reported occupational violence incidents:

Occupational violence statistics	2016-17
1. Workcover accepted claims with an occupational violence cause per 100 FTE	Nil
2. Number of accepted claims with lost time injury with an occupational violence cause per 100,000 hours worked	Nil
3. Number of occupational violence incidents reported	Nil
4. Number of occupational violence incidents reported per 100 FTE	Nil
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 the their employment.

Incident – occupational health and safety incidents reported in the health service incident reporting system (RiskMan). Code Grey reporting is not included.

Accepted Workcover claims – accepted workover claims that were lodged during the 2015-16 reporting period.

Lost time – is defined as greater than one day.

Consultancies

In 2016-17, there was (1) consultancies where the total fees payable to the consultant was $10,000 or greater. Total expenditure in 2016-17 in relation to this consultancy was $10,250 (excluding GST).

Details of individual consultancies (valued at $10,000) of greater see TABLE 1 at the bottom of this page.

There were four (4) consultancies where the total fees payable to the consultants were less than $10,000. Details of individual consultancies can be viewed at www.tmhs.vic.gov.au.

TABLE 1

Consultant	Purpose of Consultancy	Start Date	End Date	Total approved fee	Expenditure 2016-17 (excluding GST)	Future Expenditure (excluding GST)
Environmental Earth Sciences	Detailed site investigation	02/05/17	30/05/17	$10,250	$10,250	$0

Building Act 1993

Terang and Mortlake Health Service complies with the Building Act 1993, which encompasses the Building Code of Australia, under the guidelines for publicly owned buildings issued by the Minister for Finance 1994 in all redevelopment and maintenance issues.

Protected Disclosure Act 2012

Terang and Mortlake Health Service has in place appropriate procedures for disclosures in accordance with the *Protected Disclosures Act 2012*. No protected disclosures were made under the Act in 2015-16.

Carers Recognition Act 2012

The *Carers Recognition Act 2012* recognises, promotes and values the role of people in care relationships. Terang and Mortlake Health Service understands the different needs of persons in care relationships and that care relationships bring benefits to the patients, their carers and to the community. Terang and Mortlake Health Service takes all practicable measures to ensure that its employees, agents and carers have an awareness and understanding of the care relationship principles and this is reflected in our commitment to a model of patient and family centred care and to involving carers in the development and delivery of our services.

Safe Patient Care Act 2015

Terang & Mortlake Health Service has no matters to report in relation to it's obligations under section 40 of the *Safe Patient Care Act 2015.*

Comments and Complaints

Comments, suggestions and complaints are valued as they provide us with feedback on whether our services are meeting community needs or whether action is required to improve or extend services. Patients/clients are encouraged to discuss issues with the senior staff member on duty. The designated Complaints Officer is Ms. Julia Ogdin, Chief Executive Officer or unresolved complaints may be directed to the Health Services Commissioner on: (03) 8601 5200 or toll free 1800 136 066.

Competitive Neutrality Policy Statement Victoria

Terang and Mortlake Health Service has implemented competitive neutral pricing principles for all new contracts for services provided to the private sector, to ensure a level playing field.

Statement of Availability of Other Information

The following information, where it relates to Terang and Mortlake Health Service and is relevant to the financial year 2016-17 is available upon request by relevant Ministers, Members of Parliament and the public.

a. A Statement of pecuniary interest has been completed.
b. Details of shares held by senior officers as nominee or held beneficially.
c. Details of publications produced by the department about the activities of the Board and where they can be obtained.
d. Details of changes in prices, fees, charges, rates and levies charged by the board.
e. Details of any major external reviews carried out on the Board.
f. Details of major research and development activities undertaken by the Board that are not otherwise covered either in the report of Operations or in a document that contains the financial report and Report of Operations.
g. Details of overseas visits undertaken including a summary of the objectives and outcomes of each visit.
h. Details of major promotional, public relations and marketing activities undertaken by the board to develop community awareness of the Board and its services.
i. Details of assessments and measures undertaken to improve the occupational health and safety of employees.
j. General statement on the industrial relations within the Board and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the Report of Operations.
k. A list of major committees sponsored by the Board, the purposes of each Committee and the extent to which the purposes have been achieved.

Victorian Industry Participation Policy

In October 2003, the Victorian Parliament passed the *Victorian Industry Participation Policy Act 2003*, which requires public bodies and departments to report on the implementation of the Victorian Industry Participation Policy (VIPP). Departments and public bodies are required to apply VIPP in all tenders over $3 million in metropolitan Melbourne and $1 million in regional Victoria.

Terang and Mortlake Health Service abide by the principles of the Victorian Industry Participation Policy. In 2016/2017 there was one (1) contract completed by Terang and Mortlake Health Services under this Act.

Project Name	Acute ward & Mount View Aged Care facility redevelopment
Contractor	A.W Nicholson Construction
Total contract value (excluding GST)	$1,554,208
ICN reference number	2015/ICN39168
Local employee content committed under VIPP Plan	87% (8 employees – all regionally based)
No. of new local jobs created	1
No. of existing jobs to be retained	5
New apprenticeships/trainees created	0
Existing apprenticeships/trainees retained	2
Skills/technology outcomes committed to	General commitments were made for training and skill development of apprentices. However, no specific staff training, skills development or research & development programs have been designed for this tender.

Information and Communication Technology (ICT) expenditure

The total ICT expenditure incurred during 2016-17 is $336, 371 (excluding GST) with details shown below:

Business As Usual (BAU) ICT expenditure (excluding GST)	Non-Business As Usual (non-BAU) ICT expenditure (excluding GST)	Operational Expenditure (excluding GST)	Capital Expenditure (excluding GST)
$268,161	$68,210	$10,438	$57,772

Environmental Sustainability Performance

Terang and Mortlake Health Service (TMHS) is genuinely committed to maintaining and improving the health and wellbeing of the people and communities we serve.
To that end, we recognise the need to use our resources wisely and effectively without compromising our standards of care.

We also acknowledge our responsibility to provide a leadership role for environmental sustainability. In this regard, TMHS has developed and implemented an organisation-wide Environmental Management Plan to reduce energy use, conserve water and reduce the volume of waste sent to landfill. It is an expectation that all members of the TMHS team play their part to minimize unnecessary energy waste and actively participate in recycling initiatives.

A comparison of the Health Services' environmental performance over a five year period is as follows:

Utility	2016/17	2015/16	+/- % change	2014/15	2013/14	2012/13
Electricity (kwh)	442,280	423,057	+4.5%	431,951	423,256	524,301
LP Gas	58,274	56,275	+3.5%	51,405	53,270	54,338
Diesel (litres)	0	0	-	0	0	0
Water (KiloLitres)	4,049	4,712	-14.1%	5,555	6,089	6,005

Notes:

Since 2010, Terang & Mortlake Health Service has implemented a number of initiatives to reduce its carbon footprint and reduce energy costs. These include:

- Replacement of Diesel fired boilers with split system heating/cooling units at both the Terang & Mortlake campuses in early 2011;
- Installation of a solar hot water pre-heating system at Terang Hospital designed to reduce LPG and electricity usage;
- Installation of automatic time clocks for more efficient controls of our heating systems;
- We have a general waste recycling program in place;
- Replacement of Pan-sanitizers with Macerators has reduced water consumption;
- Centralization of internal laundry services in December 2011 with new energy efficient washers and a gas fired commercial dryer will reduce both electricity and water consumption;
- All fixed and hand held shower heads were replaced with variable flow models in May 2013 which reduce water usage from 12.5 litres per minute to less than 9 litres per minute (28% reduction in water use);
- Replacement of six cylinder vehicles with fuel efficient four cylinder models (District Nursing and fleet vehicles);
- Implementation of battery recycling in 2010;
- Replacement of disposable sharps containers with re-usable containers;
- Implementation of PVC plastics recycling in 2016.

Moving forward, our primary focus will be on a continued awareness program for staff, to educate all team members on the small actions they can take, both at work and in their own home that collectively make a positive impact.

Attestation on Data Accuracy

I, Julia Ogdin, certify that the Terang & Mortlake Health Service has put in place appropriate internal controls and processes to ensure that reported data reflects actual performance. The Terang & Mortlake Health Service has critically reviewed these controls and processes during the year.

Attestation on Compliance with Risk Management Framework and Processes

I, Julia Ogdin, certify that the Terang and Mortlake Health Service has complied with Ministerial Standing Direction 3.7.1 – Risk Management Framework and Processes. The Terang & Mortlake Health Service Audit and Compliance Committee verifies this.

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

I, Julia Ogdin, certify that Terang and Mortlake Health Service 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 1998* (Vic) and has critically reviewed these controls and processes during the year.

Julia Ogdin
Accountable Officer

Terang
22nd August, 2017

FINANCIAL OVERVIEW

The results outlined in the Financial Statements represent the consolidated accounts of the Agency, including consolidated government funded sector, health service initiatives and capital funds. These accounts have been prepared in accordance with the provisions of the *Financial Management Act 1994*.

As part of the Health Service Agreement process, this agency negotiated service targets for the 2016-17 financial year in the following program areas:

- Acute Health
- Aged Care and HACC
- Primary Care and Community Health

The Health Service completed the financial year with an overall deficit of $378,478 after allowing for capital revenue; changes in physical asset revaluation surplus and depreciation of non-current assets.

A comparison of the Health Services' operating performance over a five year period is as follows:

	2016/17	2015/16	2014/15	2013/14	2012/13
Total Expenses	11,612,516	10,752,909	10,464,851	11,316,507	11,358,116
Total Revenue	11,234,038	10,543,575	10,543,862	11,437,957	11,277,749
Operating Surplus/ (deficit)	(378,478)	(209,334)	79,011	121,450	(80,367)
Retained Surplus/ (Accumulated deficit)	394,368	772,846	982,180	903,169	781,719
Total Assets	14,280,415	14,340,256	13,381,857	13,115,334	11,107,077
Total Liabilities	4,189,343	3,870,706	2,702,973	2,515,461	2,286,694
Net Assets	10,091,072	10,469,550	10,678,884	10,599,873	8,820,383
Total Equity	10,091,072	10,469,550	10,678,884	10,599,873	8,820,383

There have been no events subsequent to balance date which may have a significant effect on the operations of the entity in subsequent years.

Staffing Profile

	June Current Month EFT 2017	EFT YTD 2016 (Average)	June Current Month Head Count	EFT YTD 2016 (Average)
Nursing	38.16	37.72	85	39.01
Administration and Clerical	13.72	13.92	20	12.42
Hotel and Allied Services	20.67	20.15	38	19.73
Ancillary Support (Allied Health)	2.35	2.03	5	0.98
Other	1.22	1.72	5	1.67
TOTAL	76.12	75.54	153	73.81

Revenue Indicators

	Average Collection Days		
	2017	2016	2015
Private	87	43	36
TAC	0	0	0
VWA	0	0	0
Nursing Home	29	35	36

Debtors Outstanding as at 30th June 2017

	Current	Under 30 Days	31 – 60 Days	61-90 Days	Over 90 Days	Total 30/06/2017	Total 30/06/2016	Total 30/06/2015
Private	18,715	31,671	2,766	1,117	427	54,696	68,901	45,468
Residential Aged Care	31,260	-	-	-	864	32,024	36,652	34,924

SERVICE, ACTIVITY AND EFFICIENCY TARGETS

	2016-17	2015-16	2014-15	2013-14	2012-13
1. Admitted Patients					
1.1 Separations					
A. Acute	432	524	551	569	656
B. Non Acute	4	6	6	9	8
C. Same Day	468	482	549	442	340
D. Nursing Home	6	10	7	8	7
1.2 Patient Days					
A. Acute	1,620	2,480	2,563	2,531	3,103
B. Non Acute	72	87	134	417	344
C. Same Day	468	482	549	442	340
D. Nursing Home	5,278	5,226	5,050	5,366	5,326
2. Non Admitted Patients					
Emergency Patients - Terang	2,836	2,939	3,078	2,845	3,047
Emergency Patients - Mortlake	2,306	2,091	1,994	2,062	2,194
Terang Day Centre	3,407	3,524	3,691	3,475	3,671
District Nursing Service	12,383	12,258	13,445	12,402	11,963
Allied Health & Primary Care	4,179	4,912	3,602	3,630	4,274
3. Occupancy Rate					
Acute Hospital	42.3%	34.7%	37.1%	38.7%	38.4%
Mt View Nursing Home	96.4%	95.2%	92.2%	98.0%	97.3%

DISCLOSURE INDEX

The Annual Report of Terang and Mortlake Health Service is prepared in accordance with all relevant Victorian legislation. This index has been prepared to facilitate identification of the organisation's compliance with statutory disclosure requirements.

Legislation	Requirement	Page
Ministerial Directions		
Report of Operations		
Charter and Purpose		
FRD 22H	Maintenance of establishment and the relevant Ministers	29
FRD 22H	Purpose, functions, powers and duties	2,3
FRD 22H	Initiatives and key achievements	4
FRD 22H	Nature and range of services provided	3
Management and Structure		
FRD 2H	Organisational structure	25
Financial and Other Information		
FRD 10A	Disclosure Index	37, 38
FRD 11A	Disclosure of ex-gratia expenses	n/a
FRD 21C	Responsible person and executive officer disclosures	90
FRD 22H	Application and operation of *Protected Disclosure 2012*	30
FRD 22H	Application and operation of *Carers Recognition Act 2012*	31
FRD 22H	Application and operation of *Freedom of Information Act 1982*	29
FRD 22H	Compliance with building and maintenance provisions of *Building Act 1993*	30
FRD 22H	Details of consultancies over $10,000	30
FRD 22H	Details of consultancies under $10,000	30
FRD 22H	Employment and conduct principles	30
FRD 22H	Information and Communication Technology Expenditure	32
FRD 22H	Major changes or factors affecting performance	34
FRD 22H	Occupational health and safety	31
FRD 22H	Operational and budgetary objectives and performance against objectives	11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 34, 35, 36
FRD 24C	Reporting of office-based environmental impacts	32, 33
FRD 22H	Significant changes in financial position during the year	34
FRD 22H	Statement on National Competition Policy	31
FRD 22H	Subsequent events	94
FRD 22H	Summary of the financial results for the year	34
FRD 22H	Additional information available on request	31
FRD 22H	Workforce Data Disclosures including a statement on the application of employment and conduct principles	30, 34
FRD 25C	Victorian Industry Participation Policy disclosures	32
FRD 29B	Workforce Data Disclosures	34
FRD 103F	Non-Financial Physical Assets	48, 65, 69
FRD 110A	Cash flow Statements	46

DISCLOSURE INDEX

Other requirements under Standing Directions 5.2 **Page**

Legislation **Page**

TERANG & MORTLAKE HEALTH SERVICE

FINANCIAL STATEMENTS

2016-17

DECLARATION

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

The attached financial statements for Terang & Mortlake Health Service 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 the financial position of Terang & Mortlake Health Service at 30 June 2017.

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

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

Mr Geoffrey Barby Board Member	Ms Julia Ogdin-Gubbins Accountable Officer	Mr Brendan Williams Chief Finance & Accounting Officer
Terang	Terang	Terang
22/08/2017	22/08/2017	22/08/2017

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Terang & Mortlake Health Service

Opinion	I have audited the financial report of Terang & Mortlake Health Service (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 officers 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
23 August 2017

Ron Mak
as delegate for the Auditor-General of Victoria

COMPREHENSIVE OPERATING STATEMENT

FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017

TERANG & MORTLAKE HEALTH SERVICE
COMPREHENSIVE OPERATING STATEMENT
FOR THE YEAR ENDED 30 JUNE 2017

	Note	2017 $	2016 $
Revenue from Operating Activities	2.1	10,823,517	10,232,195
Revenue from Non-Operating Activities	2.1	7,173	16,528
Employee Expenses	3.1	(7,655,887)	(7,163,423)
Non Salary Labour Costs	3.1	(438,933)	(544,682)
Supplies and Consumables	3.1	(353,976)	(409,767)
Administration Expenses	3.1	(1,564,947)	(980,255)
Other Expenses	3.1	(526,314)	(630,725)
Net Result Before Capital and Specific Items		290,633	519,871
Capital Purpose Income	2.1	396,487	299,533
Depreciation	4.4	(1,003,566)	(955,661)
Finance Costs	3.3	(40,704)	(19,919)
Expenditure Using Capital Purpose Income	3.1	(50,011)	(44,599)
Net Result After Capital and Specific Items		(407,161)	(200,775)
Other Economic Flows Included in Net Result			
Net gain/(loss) on non-financial assets	7.2	6,861	(4,681)
Revaluation of Long Service Leave	3.4	21,822	(3,878)
Total Other Economic Flows Included in Net Result		28,683	(8,559)
NET RESULT FOR THE YEAR		(378,478)	(209,334)
Other Comprehensive Income			
Items that will not be reclassified to net result			
Changes in physical asset revaluation surplus	8.1	0	0
Total Other Comprehensive Income		0	0
COMPREHENSIVE RESULT		**(378,478)**	**(209,334)**

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

TERANG & MORTLAKE HEALTH SERVICE
BALANCE SHEET
AS AT 30 JUNE 2017

	Note	2017 $	2016 $
Current Assets			
Cash and Cash Equivalents	6.2	690,301	1,082,916
Receivables	5.1	1,092,391	977,840
Investments and other Financial Assets	4.1	3,150,000	3,350,000
Inventories	5.2	42,010	47,143
Prepayments and Other Assets	5.4	53,035	54,817
Total Current Assets		5,027,737	5,512,716
Non-Current Assets			
Receivables	5.1	353,179	334,245
Property, Plant and Equipment	4.3	8,899,499	8,493,295
Total Non-Current Assets		9,252,678	8,827,540
TOTAL ASSETS		14,280,415	14,340,256
Current Liabilities			
Payables	5.5	1,444,418	1,313,570
Borrowings	6.1	130,697	146,603
Provisions	3.4	1,906,464	1,883,907
Other Liabilities	5.3	345,000	135,000
Total Current Liabilities		3,826,579	3,479,080
Non-Current Liabilities			
Borrowings	6.1	158,527	199,567
Provisions	3.4	204,237	192,059
Total Non-Current Liabilities		362,764	391,626
TOTAL LIABILITIES		4,189,343	3,870,706
NET ASSETS		10,091,072	10,469,550
EQUITY			
Property, Plant and Equipment Revaluation Surplus	8.1(a)	6,367,935	6,367,935
Contributed Capital	8.1(b)	3,328,769	3,328,769
Accumulated Surplus	8.1(c)	394,368	772,846
TOTAL EQUITY		10,091,072	10,469,550
Commitments for Expenditure	6.3		
Contingent Liabilities and Contingent Assets	7.3		

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

STATEMENT OF CHANGES IN EQUITY

FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017

TERANG & MORTLAKE HEALTH SERVICE
STATEMENT OF CHANGES IN EQUITY
FOR THE FINANCIALYEAR ENDED 30 JUNE 2017

	Property, Plant and Equipment Revaluation Surplus	Contributed Capital	Accumulated Surpluses/ (Deficits)	Total
	$	$	$	$
Balance at 1 July 2015	6,367,935	3,328,769	982,180	10,678,884
Net result for the year	0	0	(209,334)	(209,334)
Other comprehensive income for the year	0	0	0	0
Balance at 30 June 2016	**6,367,935**	**3,328,769**	**772,846**	**10,469,550**
Net result for the year	0	0	(378,478)	(378,478)
Other comprehensive income for the year	0	0	0	0
Balance at 30 June 2017	**6,367,935**	**3,328,769**	**394,368**	**10,091,072**

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

TERANG & MORTLAKE HEALTH SERVICE
CASH FLOW STATEMENT
FOR THE YEAR ENDED 30 JUNE 2017

	Note	2017 $ Inflows / (Outflows)	2016 $ Inflows / (Outflows)
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		8,613,703	8,412,440
Capital Grants from Government		89,852	82,256
Patient and Resident Fees Received		697,062	974,209
Donations and Bequests Received		140,368	115,489
GST (Paid to)/received from ATO		68,886	(69,319)
Interest Received		87,762	135,017
Other Receipts		329,745	388,366
Total Receipts		***10,027,378***	***10,038,458***
Employee Expenses Paid		(7,519,681)	(7,085,522)
Non Salary Labour Costs		(438,933)	(544,683)
Payments for Supplies and Consumables		(348,843)	(415,212)
Finance Costs		(40,704)	(19,919)
Other Payments		(1,111,977)	(801,395)
Total Payments		***(9,460,138)***	***(8,866,731)***
NET CASH FLOW FROM /(USED IN) OPERATING ACTIVITIES	8.2	567,240	1,171,727
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of Investments		500,000	0
Purchase of Non-Financial Assets		(1,449,091)	(1,349,095)
Cash recognised from SWARH Alliance		0	96,741
Proceeds from sale of Non-Financial Assets		46,182	43,099
NET CASH FLOW FROM /(USED IN) INVESTING ACTIVITIES		(902,909)	(1,209,255)
CASH FLOWS FROM FINANCING ACTIVITIES			
Proceeds from borrowings		0	37,786
Repayment of finance leases		(56,946)	0
NET CASHS FROM/(USED IN) FINANCING ACTIVITIES		(56,946)	37,786
NET INCREASE / (DECREASE) IN CASH AND CASH EQUIVALENTS HELD		(392,615)	258
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		1,082,916	1,082,658
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.2	690,301	1,082,916

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 Terang & Mortlake Health Service (ABN 43 323 722 091) for the year ended 30 June 2017. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

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

The annual financial statements were authorised for issue by the Board of Terang & Mortlake Health Service on 22nd August, 2017.

BASIS OF PRESENTATION
NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

(b) Reporting Entity

The financial statements includes all the controlled activities of Terang & Mortlake Health Service.

Its principle address is:
13 Austin Avenue
Terang Vic 3264

A description of the nature of Terang & Mortlake Health Service'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

Terang & Mortlake Health Service's overall objective is to provide healthcare services to the community surrounding Terang and Mortlake, as well as improve the quality of life to Victorians.

Terang & Mortlake Health Service is predominantly funded by accrual based grant funding for the provision of outputs.

(c) Basis of accounting preparation and measurement

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

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

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

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

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

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

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

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

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

(d) Principles of Consolidation

Intersegment Transactions

Transactions between segments within Terang & Mortlake Health Service have been eliminated to reflect the extent of Terang & Mortlake Health Service'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

NOTES TO THE FINANCIAL STATEMENTS

FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE	Admitted Patients 2017 $	Residential Aged Care 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	TOTAL 2017 $
Government Grants	5,234,552	1,397,592	846,660	1,198,708	90,000	8,767,512
Indirect Contributions by Department of Health and Human Services	4,054	2,293	1,202	1,202	0	8,751
Patient and Resident Fees	154,808	409,592	83,188	35,811	0	683,399
Catering	0	0	0	0	40,027	40,027
South West Alliance of Rural Health	0	0	0	0	1,119,657	1,119,657
Other Revenue from Operating Activities	46,478	49,723	16,740	37,077	54,153	204,171
Total Revenue from Operating Activities	**5,439,892**	**1,859,200**	**947,790**	**1,272,798**	**1,303,837**	**10,823,517**
Interest & Dividends	42	24	12	12	0	90
Donations & Bequests	4,500	500	1,310	773	0	7,083
Total Revenue from Non-Operating Activities	**4,542**	**524**	**1,322**	**785**	**0**	**7,173**
Capital Purpose Income (excluding interest)	0	0	0	0	302,125	302,125
Capital Interest	0	0	0	0	94,362	94,362
Total Capital Purpose Income	**0**	**0**	**0**	**0**	**396,487**	**396,487**
Net gain/(loss) on non-financial assets	0	0	0	0	6,861	6,861
TOTAL REVENUE	**5,444,434**	**1,859,724**	**949,112**	**1,273,583**	**1,707,185**	**11,234,038**

	Admitted Patients 2016 $	Residential Aged Care 2016 $	Aged Care 2016 $	Primary Health 2016 $	Other 2016 $	TOTAL 2016 $
Government Grants	5,064,308	1,313,004	797,338	1,177,916	0	8,352,566
Indirect Contributions by Department of Health and Human Services	(7,597)	1,285	1,285	2,450	0	(2,577)
Patient and Resident Fees	463,106	382,072	95,561	53,461	0	994,200
Catering	0	0	0	0	51,972	51,972
South West Alliance of Rural Health	0	0	0	0	670,731	670,731
Other Revenue from Operating Activities	48,865	9,485	15,005	22,472	69,476	165,303
Total Revenue from Operating Activities	**5,568,682**	**1,705,846**	**909,189**	**1,256,299**	**792,179**	**10,232,195**
Interest & Dividends	47	27	14	14	0	102
Donations & Bequests	0	1,000	1,426	0	14,000	16,426
Total Revenue from Non-Operating Activities	**47**	**1,027**	**1,440**	**14**	**14,000**	**16,528**
Capital Purpose Income (excluding interest)	0	0	0	0	182,456	182,456
Capital Interest	0	0	0	0	117,077	117,077
Total Capital Purpose Income	**0**	**0**	**0**	**0**	**299,533**	**299,533**
Net gain/(loss) on non-financial assets	0	0	0	0	(4,681)	(4,681)
TOTAL REVENUE	**5,568,729**	**1,706,873**	**910,629**	**1,256,313**	**1,101,031**	**10,543,575**

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)

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 Terang & Mortlake Health Service 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 Service

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

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

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

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

Interest revenue
Interest revenue is recognised on a time proportionate basis that takes in account the effective yield of the financial asset.

Sale of investments
The profit/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
Terang & Mortlake Health Service has used the following category groups for reporting purposes for the current and previous financial years.

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

- **Aged Care** comprises a range of in home, specialist geriatric, residential care and community based programs and support services, 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 counselling, physiotherapy, speech therapy, podiatry and occupational therapy and a range of dental health services.

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

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

NOTE 3: THE COST OF DELIVERING SERVICES

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

Structure

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

NOTE 3.1: ANALYSIS OF EXPENSE BY SOURCE	Admitted Patients 2017 $	Residential Aged Care 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	TOTAL 2017 $
Employee Expenses	2,946,597	2,347,704	1,164,356	902,099	295,131	7,655,887
Other Operating Expenses						
Non Salary Labour Costs	329,115	29,535	62,382	17,901	0	438,933
Supplies and Consumables	186,549	86,790	30,567	17,133	32,937	353,976
Administration Expenses	739,674	366,063	227,101	223,645	8,464	1,564,947
Other Expenses	226,276	109,664	54,616	117,792	17,966	526,314
Total Expenditure from Operating Activities	**4,428,211**	**2,939,756**	**1,539,022**	**1,278,570**	**354,498**	**10,540,057**
Depreciation (refer note 4.4)	0	0	0	0	1,003,566	1,003,566
Finance Costs (refer note 3.3)	0	0	0	0	40,704	40,704
Expenditure Using Capital Purpose Income	0	0	0	0	50,011	50,011
Total Other Expenses	**0**	**0**	**0**	**0**	**1,094,281**	**1,094,281**
TOTAL EXPENSES	**4,428,211**	**2,939,756**	**1,539,022**	**1,278,570**	**1,448,779**	**11,634,338**

	Admitted Patients 2016 $	Residential Aged Care 2016 $	Aged Care 2016 $	Primary Health 2016 $	Other 2016 $	TOTAL 2016 $
Employee Expenses	2,883,670	2,181,803	1,107,826	826,300	163,824	7,163,423
Other Operating Expenses						
Non Salary Labour Costs	412,753	43,410	39,510	49,009	0	544,682
Supplies and Consumables	233,650	90,238	35,361	16,654	33,864	409,767
Administration Expenses	433,862	236,242	155,671	149,830	4,650	980,255
Other Expenses	353,576	118,618	59,664	83,427	15,440	630,725
Total Expenditure from Operating Activities	**4,317,511**	**2,670,311**	**1,398,032**	**1,125,220**	**217,778**	**9,728,852**
Depreciation (refer note 4.4)	0	0	0	0	955,661	955,661
Finance Costs (refer note 3.3)	0	0	0	0	19,919	19,919
Expenditure Using Capital Purpose Income	0	0	0	0	44,599	44,599
Total Other Expenses	**0**	**0**	**0**	**0**	**1,020,179**	**1,020,179**
TOTAL EXPENSES	**4,317,511**	**2,670,311**	**1,398,032**	**1,125,220**	**1,237,957**	**10,749,031**

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

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

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.

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

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

Net gain/(loss) on disposal of Non-Financial Assets
Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal and is the difference between proceeds and the carrying value 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

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

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

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

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

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

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

	Expense		Revenue	
	2017 $	2016 $	2017 $	2016 $
Catering Services	195,635	182,181	29,138	51,972
Community Projects	158,863	39,475	155,041	72,000
TOTAL	354,498	221,656	184,179	123,972

NOTE 3.3: FINANCE COSTS

	2017 $	2016 $
Finance Charges on Finance Leases	40,704	19,919
TOTAL FINANCE COSTS	40,704	19,919

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

Finance costs include 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)		
Accrued Wages, ADO & Annual Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	709,131	598,193
- unconditional and expected to be settled wholly after 12 months (iii)	90,000	90,000
Long Service Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	100,000	100,000
- unconditional and expected to be settled wholly after 12 months (iii)	852,523	895,964
	1,751,654	1,684,157
Provisions related to employee benefit on-costs		
- unconditional and expected to be settled wholly within 12 months (ii)	50,034	64,005
- unconditional and expected to be settled wholly after 12 months (iii)	104,777	135,745
	154,810	199,750
Total Current Provisions	1,906,464	1,883,907
Non-Current Provisions		
Employee Benefits (i)	185,458	172,589
Provisions related to employee benefit on-costs	18,779	19,470
Total Non-Current Provisions	204,237	192,059
Total Provisions	2,110,701	2,075,966
(a) Employee Benefits and Related On Costs		
Current Employee Benefits		
South West Alliance of Rural Health Entitlements	84,857	86,153
Annual Leave Entitlements	504,892	438,253
Accrued Salaries and Wages	246,416	229,907
Accrued Days Off	12,999	9,135
Unconditional Long Service Leave Entitlements	1,057,300	1,120,459
Total Current Employee Benefits	1,906,464	1,883,907
Non-Current Employee Benefits		
South West Alliance of Rural Health Entitlements	14,738	16,826
Conditional Long Service Leave Entitlements (ii)	189,499	175,233
Total Non Current Employee Benefits	204,237	192,059
Total Employee Benefits and Related On-Costs	2,110,701	2,075,966
Movements in Provisions		
Movement in Long Service Leave:		
Balance at start of year	1,295,692	1,270,682
Provision made during the year		
- Revaluations	21,822	(3,878)
- Expense recognising Employee Service	103,833	154,798
Settlement made during the year	(174,548)	(125,910)
Balance at end of year	1,246,799	1,295,692

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)

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, annual leave and sick leave are measured at:

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

Long Service Leave (LSL)

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

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

The components of this current LSL liability are measured at:

- Undiscounted value – if the health service expects to wholly settle within 12 months; 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 payroll tax, 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 $
Defined Benefit Plans:	Health Super	30,823	28,724	0	0
Defined Contribution Plans:	Health Super	534,859	506,537	64,239	0
	HESTA	71,397	52,519	0	0
Total		637,079	587,780	64,239	0

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

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

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

Defined contribution superannuation plans

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

Defined benefit superannuation plans

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

Employees of the Terang & Mortlake Health Service are entitled to receive superannuation benefits and the Terang & Mortlake Health Service contributes to both the defined benefit and defined contribution plans. The defined benefit plans provide benefits based on years of service and final average salary.

The name and details of the major employee superannuation funds and contributions made by Terang & Mortlake Health Service disclosed in Note 14: Superannuation.

Superannuation Liabilities

The Terang & Mortlake Health Service 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

NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS

	2017 $	2016 $
CURRENT		
Loans and receivables		
Term Deposit		
Aust. Dollar Term Deposits > 3 Months (i)	3,150,000	3,350,000
Total Current Other Financial Assets	3,150,000	3,350,000
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	3,150,000	3,350,000
Represented by:		
Health Service Investments	2,850,000	3,350,000
Accommodation Bonds (Refundable Entrance Fees)	300,000	0
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	3,150,000	3,350,000

(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 financial assets
Please refer to note 7.1 for the ageing analysis of other financial assets.

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

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

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

Terang & Mortlake Health Service 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.

Terang & Mortlake Health Service assesses at each balance sheet date whether a financial asset or group of financial assets is impaired.

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

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

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

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

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

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 %
South West Alliance of Rural Health	Information Systems	4.95	4.79

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

	2017 $	2016 $
Current Assets		
Cash and Cash Equivalents	259,342	99,933
Receivables	912,192	715,223
Inventories	921	3,447
Prepayments	0	13,769
Total Current Assets	1,172,455	832,372
Non Current Assets		
Property, Plant and Equipment	296,806	356,865
Total Non Current Assets	296,806	356,865
Total Assets	1,469,261	1,189,237
Current Liabilities		
Payables	1,044,362	714,508
Borrowings	130,697	146,603
Employee Provisions	84,857	86,153
Total Current Liabilities	1,259,916	947,264
Non Current Liabilities		
Borrowings	158,527	199,567
Employee Provisions	14,738	16,826
Total Non Current Liabilities	173,265	216,393
Total Liabilities	1,433,181	1,163,657

Terang and Mortlake Health Service's interest in revenues and expenses resulting from jointly controlled operations and assets is detailed below:

Revenues		
Operating Activities	1,116,467	1,075,278
Non Operating Activities	3,189	0
Total Revenue	1,119,656	1,075,278
Expenses		
Employee Expenses	321,989	293,014
Maintenance Contracts and IT Support	389,781	565,578
Operating Lease Costs	22,684	0
Other Expenses	175,340	31,875
Total Operating Expenses	909,794	890,467
Capital Purpose Income	24,579	0
Finance Lease Charges	(40,704)	(19,919)
Impairment of Non Financial Assets	(3,320)	0
Depreciation	(181,808)	(164,317)
Total Capital & Specific Items	(201,253)	(184,236)
Other Economic Flows included in the result		
Revaluation of Long Service Leave	1,889	0
Net Result	10,498	575

The financial results included for SWARH are unaudited at the date of signing the financial statements.

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

NOTE 4.2: JOINTLY CONTROLLED OPERATIONS AND ASSETS (Continued)

Investments in joint operations

In respect of any interest in joint operations, Terang & Mortlake Health Service 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		
Freehold Land	935,000	935,000
- Land Improvements at Fair Value	17,487	17,487
Less Accumulated Depreciation	4,564	2,816
	12,923	14,671
Total Land	947,923	949,671
Buildings		
- Buildings Under Construction at Cost	72,674	931,470
	72,674	931,470
- Buildings at Fair Value	7,953,267	5,963,194
Less Accumulated Depreciation	1,563,124	1,025,312
	6,390,143	4,937,882
Total Buildings	6,462,817	5,869,352
Plant and Equipment		
Plant - South West Alliance of Rural Health	0	10,696
- Plant and Equipment at Fair Value	2,982,080	2,930,529
Less Accumulated Depreciation	2,130,827	1,929,837
Total Plant and Equipment	851,253	1,011,388
Motor Vehicles		
- Motor Vehicles at Fair Value	522,915	484,277
Less Accumulated Depreciation	182,215	167,563
Total Motor Vehicles	340,700	316,714
Leased Assets		
- Information Technology	734,326	601,882
Less Accumulated Amortisation	437,520	255,712
Total Leased Assets	296,806	346,170
TOTAL	8,899,499	8,493,295

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

	Land	Buildings	Plant & Equipment	Motor Vehicles	Leased Assets	Under Construction	Total
	$	$	$	$			$
Balance at 1 July 2015	951,419	5,439,713	1,093,854	290,537	308,384	63,734	8,147,641
Additions		942,664	119,879	149,265		(63,734)	1,148,074
South West Alliance of Rural Health	0	0	1,113	0	199,908	0	201,021
Disposals	0	0	0	(47,780)	0	0	(47,780)
Depreciation	(1,748)	(513,025)	(203,458)	(75,308)	(162,122)	0	(955,661)
Balance at 30 June 2016	949,671	5,869,352	1,011,388	316,714	346,170	0	8,493,295
Additions	0	1,111,891	70,940	144,512	121,748	0	1,449,091
South West Alliance of Rural Health	0	0	(10,696)	0	10,696	0	0
Transfer between Classes	0	19,387	(19,387)	0	0	0	0
Disposals	0	0	0	(39,321)	0	0	(39,321)
Depreciation	(1,748)	(537,813)	(200,992)	(81,205)	(181,808)	0	(1,003,566)
Balance at 30 June 2017	947,923	6,462,817	851,253	340,700	296,806	0	8,899,499

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 fair value of the land and buildings. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments.

The effective date of the valuation is 30 June 2014.

(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				
Specialised land	947,923	0	0	947,923
Total of land at fair value	947,923	0	0	947,923
Buildings at fair value				
Specialised buildings	6,462,817	0	0	6,462,817
Total of building at fair value	6,462,817	0	0	6,462,817
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	340,700	0	340,700	0
- Plant and equipment	851,253	0	0	851,253
Total of plant, equipment and vehicles at fair value	1,191,953	0	340,700	851,253

Note
(i) Classified in accordance with the fair value hierarchy
(ii) Vehicles are categorised to Level 3 assets if the depreciated replacement cost is used in estimating the fair value. However entities should consult with independent valuers in determining whether a market approach is appropriate for vehicles with an active resale market available. If yes, a Level 2 categorisation for such vehicles would be appropriate.

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				
Specialised land	949,671	0	0	949,671
Total of land at fair value	949,671	0	0	949,671
Buildings at fair value				
Specialised buildings	5,869,352	0	0	5,869,352
Total of building at fair value	5,869,352	0	0	5,869,352
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	316,714	0	316,714	0
- Plant and equipment	1,011,388	0	0	1,011,388
Total of plant, equipment and vehicles at fair value	1,328,102	0	316,714	1,011,388

Note
(i) Classified in accordance with the fair value hierarchy
(ii) Vehicles are categorised to Level 3 assets if the depreciated replacement cost is used in estimating the fair value. However entities should consult with independent valuers in determining whether a market approach is appropriate for vehicles with an active resale market available. If yes, a Level 2 categorisation for such vehicles would be appropriate.

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

- The fair value of land, buildings, infrastructure, plant and equipment, (refer to Note 7.1);
- Superannuation expense (refer to Note 3.5);
- Actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.4); and
- Equities and management investment schemes classified at level 3 of the fair value hierarchy.

Consistent with AASB 13 Fair Value Measurement, Terang & Mortlake Health Service 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.

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

The Valuer-General Victoria (VGV) is Terang & Mortlake Health Service's independent valuation agency.

Terang & Mortlake Health Service, 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)
Plant and equipment at fair value (Continued)

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

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

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

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

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

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

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

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

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

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

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

30 June 2017	Land	Buildings	Plant and equipment
Opening Balance	949,671	5,869,352	1,011,388
Purchases (sales)	0	1,111,891	60,244
Transfers in (out) of Level 3	0	0	0
Gains or losses recognised in net result			
- Disposals	0	0	0
- Depreciation	(1,748)	(537,813)	(200,992)
Subtotal	947,923	6,443,430	870,640
Items recognised in other comprehensive income			
- Revaluation	0	19,387	(19,387)
Subtotal	0	19,387	(19,387)
Closing Balance	947,923	6,462,817	851,253
Unrealised gains/(losses) on non-financial assets	0	0	0
	947,923	6,462,817	851,253

30 June 2016	Land	Buildings	Plant and equipment
Opening Balance	951,419	5,439,713	1,093,854
Purchases (sales)	0	942,664	120,992
Transfers in (out) of Level 3	0	0	0
Gains or losses recognised in net result			
- Disposals	0	0	0
- Depreciation	(1,748)	(513,025)	(203,458)
Subtotal	949,671	5,869,352	1,011,388
Items recognised in other comprehensive income			
- Revaluation	0	0	0
Subtotal	0	0	0
Closing Balance	949,671	5,869,352	1,011,388
Unrealised gains/(losses) on non-financial assets	0	0	0
	949,671	5,869,352	1,011,388

There have been no transfers between levels during the period.

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

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

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

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)
(d) Reconciliation of Level 3 fair value (Continued)
Identifying unobservable inputs (level 3) fair value measurements (Continued)
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.

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 [i]	Significant unobservable inputs [i]	Range (weighted average) [i]	Sensitivity of fair value measurement to changes in significant unobservable inputs
Specialised land	Market Approach	Community Service Obligation (CSO)	20%	A significant increase or decrease in the CSO adjustment would result in a significantly lower (higher) fair value
Specialised Buildings	Depreciated Replacement Cost	Direct cost per square metre	$792 - $2450 ($1,565)	A significant increase or decrease in direct cost per square metre adjustment would result in a signficantly higher or lower fair value
		Useful life of specialised buildings	25 - 60 Years	A significant increase or decrease in the estimated useful life of the asset would result in a signficantly higher or lower valuation
Plant and equipment at fair value	Depreciated Replacement Cost	Cost per Unit	$10 - $40,000 ($2,300)	A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value.
		Useful life of PPE	2-20 Years (7 Years)	A significant increase or decrease in the estimated useful life of the asset would result in a signficantly higher or lower valuation

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

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

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 10 *Property, plant and equipment* .

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

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.

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

Revaluations of non-current physical assets

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

NOTE 4.4: DEPRECIATION	2017 $	2016 $
Depreciation		
Buildings	539,561	514,773
Plant and Equipment		
- Plant	200,992	201,263
- Motor Vehicles	81,205	75,308
Plant - South West Alliance of Rural Health	0	2,195
Leased Assets - South West Alliance of Rural Health	181,808	162,122
TOTAL DEPRECIATION	1,003,566	955,661

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

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

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

	2017	**2016**
Buildings		
- Structure Shell Building Fabric	10 to 47 years	10 to 47 years
- Site Engineering Services and Central Plant	10 to 12 years	10 to 12 years
Central Plant		
- Fit Out	5 to 10 years	5 to 10 years
- Trunk Reticulated Building Systems	6 to 7 years	6 to 7 years
Plant and Equipment	3 to 7 years	3 to 7 years
Medical Equipment	7 to 10 years	7 to 10 years
Computers and Communication	3 years	3 years
Furniture and Fittings	13 years	13 years
Motor Vehicles	10 years	10 years
Intangible Assets	3 years	3 years
Leasehold Improvements	6 to 7 years	6 to 7 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.

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

NOTE 5: OTHER ASSETS AND LIABILITIES

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

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

NOTE 5.1: RECEIVABLES	2017 $	2016 $
CURRENT		
Contractual		
Trade Debtors	21,277	25,625
Patient Fees	86,721	100,384
Accrued Investment Income	20,969	14,279
Other Accrued Income	0	2,211
Receivables - South West Alliance of Rural Health	912,192	715,223
Less allowance for Doubtful Debts	0	0
	1,041,159	857,722
Statutory		
GST Receivable - Health Service	51,232	120,118
	51,232	120,118
TOTAL CURRENT RECEIVABLES	1,092,391	977,840
NON CURRENT		
Statutory		
Long Service Leave - Department of Health and Human Services	353,179	334,245
TOTAL NON-CURRENT RECEIVABLES	353,179	334,245
TOTAL RECEIVABLES	1,445,570	1,312,085
(a) Movement in the allowance for doubtful debts		
Balance at beginning of year	0	0
Increase/(Decrease) in allowance recognised in net result	0	0
Balance at end of year	0	0

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

(c) Nature and extent of risk arising from receivables
Please refer to note 7.1 for the nature and extent of credit risk arising from 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 debt is recognised when there is objective evidence that the debts may not be collected and bad debts are written off when identified.

NOTE 5.2: INVENTORIES

	2017 $	2016 $
CURRENT		
Pharmaceuticals - at cost	11,045	12,558
Catering Supplies - at cost	1,685	3,036
Housekeeping Supplies - at cost	4,270	4,832
Medical and Surgical Lines - at cost	20,490	19,010
Administration Stores - at cost	3,599	4,260
South West Alliance of Rural Health - at Cost	921	3,447
TOTAL INVENTORIES	42,010	47,143

Inventories held by the Health Service are held for short periods of time with regular turnover. There is no material loss of service potential in inventories held at the end of the year.

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

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

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

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

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

NOTE 5.3: OTHER LIABILITIES

	2017 $	2016 $
Monies Held in Trust*		
- Accommodation Bonds (Refundable Entrance Fees)	300,000	0
Other Monies Held on Behalf of Others	45,000	135,000
TOTAL OTHER LIABILITIES	345,000	135,000
*** Total Monies Held in Trust**		
Represented by the followings assets:		
Investments and other Financial Assets (refer to Note 4.1)	300,000	0
TOTAL	300,000	0

NOTE 5.4: PREPAYMENTS AND OTHER NON-FINANCIAL ASSETS

	2017 $	2016 $
Prepaid Expenses	53,035	41,048
Prepayments - South West Alliance of Rural Health	0	13,769
TOTAL	53,035	54,817

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

NOTE 5.5: PAYABLES	2017 $	2016 $
CURRENT		
Contractual		
Trade Creditors	169,530	410,993
Accrued Expenses	62,302	54,619
Payables - South West Alliance of Rural Health	1,044,362	714,508
Accrued Audit Fees	9,000	9,000
	1,285,194	1,189,120
Statutory		
Amounts payable to Government - PAYG	84,660	69,250
Superannuation Obligations Payable	64,239	0
Aged Care Funding - Department of Health & Ageing	10,325	0
Department of Health and Human Services	0	55,200
	159,224	124,450
TOTAL	1,444,418	1,313,570

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

Payables consist of:

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

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

NOTE 6: HOW WE FINANCE OUR OPERATIONS

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

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

Structure

6.1 Borrowings
6.2 Cash and cash equivalents
6.3 Commitments for expenditure

NOTE 6.1: BORROWINGS	2017	2016
CURRENT	$	$
Australian Dollar Borrowings		
- Finance Lease Liability (South West Alliance of Rural Health)	130,697	146,603
TOTAL CURRENT	130,697	146,603
NON CURRENT		
Australian Dollar Borrowings		
- Finance Lease Liability (South West Alliance of Rural Health)	158,527	199,567
TOTAL NON CURRENT	158,527	199,567
TOTAL BORROWINGS	289,224	346,170

Finance leases are held by the South West Alliance of Rural Health and are secured by the rights to the leased assets being held by the lessor.

(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 risks arising from borrowings

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

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 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. Contingent rentals associated with finance leases are recognised as an expense in the period in which they are incurred.

Finance leases are regarded as a financial accommodation and under Section 30 of the Health Services Act 1988, the Minister for Health and the Treasurer must declare a registered funded agency to be an approved borrower for the purposes of this section.

Terang & Mortlake Health Service has received such approval prior to 30 June 2017, in a joint letter for all Health Services impacted by finance leases either directly or via a Jointly Controlled entity. The specific values approved for Terang & Mortlake Health Service total $527,737.

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 the 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 it's borrowing at initial recognition.

NOTE 6.2: CASH AND CASH EQUIVALENTS

For the purposes of the cash flow statement, cash assets includes cash on hand and in banks, and short-term deposits which are readily convertible to cash on hand, and are subject to an insignificant risk of change in value, net of outstanding bank overdrafts.

	2017 $	2016 $
Cash on Hand	270	270
Cash at Bank	430,689	982,713
Cash at Bank - South West Alliance of Rural Health	259,342	99,933
TOTAL CASH AND CASH EQUIVALENTS	690,301	1,082,916
Represented by:		
Cash for Health Service Operations (as per cash flow statement)	690,301	1,082,916
TOTAL	690,301	1,082,916

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

	2017 $	2016 $
Capital Expenditure Commitments		
Kronos Capital Cost	34,072	0
Total Capital Expenditure Commitments	34,072	
Lease commitments		
Commitments in relation to leases contracted for at the reporting date:		
Finance Leases (South West Alliance of Rural Health)	289,224	346,170
Total lease commitments	289,224	346,170
Finance Leases		
Commitments in relation to finance leases are payable as follows:		
Current	109,822	109,822
Non-current	280,137	280,137
Minimum lease payments	389,959	389,959
Less future finance charges	100,735	43,789
Total finance lease commitments	289,224	346,170
Total lease commitments	289,224	346,170

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

NOTE 7: RISKS, CONTINGENCIES & 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
Terang & Mortlake Healthcare Service's principal financial instruments comprise of:
- Cash Assets
- Term Deposits
- Receivables (excluding statutory receivables)
- Payables (excluding statutory payables)

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

The Health Service's main financial risks include credit risk, liquidity risk 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 Terang and Mortlake Health Service financial risk within the government policy parameters.

Categorisation of financial instruments

2017	Contractual financial assets/liabilities designated at fair value through profit/loss $	Contractual financial assets/liabilities held-for-trading at fair value through profit/loss $	Contractual financial assets - loans and receivables $	Contractual financial assets - available for sale $	Contractual financial liabilities at amortised cost $	Total $
Contractual Financial Assets						
Cash and cash equivalents	0	0	690,301	0	0	690,301
Receivables	0	0	1,041,159	0	0	1,041,159
Investments	0	0	3,150,000	0	0	3,150,000
Total Financial Assets (i)	0	0	4,881,460	0	0	4,881,460
Financial Liabilities						
Payables	0	0	0	0	1,285,194	1,285,194
Borrowings	0	0	0	0	289,224	289,224
Total Financial Liabilities(ii)	0	0	0	0	1,574,418	1,574,418

Categorisation of financial instruments

2016	Contractual financial assets/liabilities designated at fair value through profit/loss $	Contractual financial assets/liabilities held-for-trading at fair value through profit/loss $	Contractual financial assets - loans and receivables $	Contractual financial assets - available for sale $	Contractual financial liabilities at amortised cost $	Total $
Contractual Financial Assets						
Cash and cash equivalents	0	0	1,082,916	0	0	1,082,916
Receivables	0	0	857,722	0	0	857,722
Investments	0	0	3,350,000	0	0	3,350,000
Total Financial Assets (i)	0	0	5,290,638	0	0	5,290,638
Financial Liabilities						
Payables	0	0	0	0	1,189,120	1,189,120
Borrowings	0	0	0	0	346,170	346,170
Total Financial Liabilities(ii)	0	0	0	0	1,535,290	1,535,290

(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 payables)

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

	Net holding gain/(loss) $'000	Total interest income/ (expense) $'000	Fee income / (expense) $'000	Impairment loss $'000	Total $'000
2017					
Financial Assets					
Cash and cash equivalents(i)	0	0	0	0	0
Loans and Receivables(i)	0	94,452	0	0	94,452
Total Financial Assets	0	94,452	0	0	94,452
Financial Liabilities					
At amortised cost (ii)	0	40,704	0	0	40,704
Total Financial Liabilities	0	40,704	0	0	40,704
2016					
Financial Assets					
Cash and cash equivalents(i)	0	0	0	0	0
Loans and Receivables(i)	0	117,179	0	0	117,179
Total Financial Assets	0	117,179	0	0	117,179
Financial Liabilities					
At amortised cost (ii)	0	19,919	0	0	19,919
Total Financial Liabilities	0	19,919	0	0	19,919

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

(ii) For financial liabilities measured at amortised cost, the net gain or loss is calculated by taking the interest expense, plus or minus foreign exchange gains or losses arising from the revaluation of financial liabilities measured at amortised cost.

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

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

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

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

Except as otherwise detailed in the following table, the carrying amount of contractual financial assets recorded in the financial statements, net of any allowances for losses, represents Terang & Mortlake Health Service'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 (Min BBB credit rating) $	Government Agencies (Min AA credit rating) $	Other $	Total $
Financial Assets				
Cash and Cash Equivalents	690,301	0	0	690,301
Loans and Receivables				
- Trade Debtors	0	0	107,998	107,998
- Other Receivables	0	0	933,161	933,161
- Term Deposit	1,550,000	1,600,000	0	3,150,000
Total Financial Assets	2,240,301	1,600,000	1,041,159	4,881,460
2016				
Financial Assets				
Cash and Cash Equivalents	1,082,916	0	0	1,082,916
Loans and Receivables				
- Trade Debtors	0	0	126,009	126,009
- Other Receivables	0	0	731,713	731,713
- Term Deposit	1,750,000	1,600,000	0	3,350,000
Total Financial Assets	2,832,916	1,600,000	857,722	5,290,638

(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 asset as at 30 June

			Past due and not impaired				
2017	Carrying Amount $	Not Past due and not impaired $	Less than 1 Month $	1 - 3 Months $	3 Months - 1 Year $	1 - 5 Years $	Impaired Financial Assets $
Financial Assets							
Cash and Cash Equivalents	690,301	690,301	0	0	0	0	0
Loans and Receivables (i)							
- Trade Debtors	107,998	69,023	31,671	4,398	2,906	0	0
- Other Receivables	933,161	933,161	0	0	0	0	0
- Term Deposit	3,150,000	3,150,000	0	0	0	0	0
Total Financial Assets	4,881,460	4,842,485	31,671	4,398	2,906	0	0
2016							
Financial Assets							
Cash and Cash Equivalents	1,082,916	1,082,916	0	0	0	0	0
Loans and Receivables							
- Trade Debtors	126,009	70,739	22,776	22,846	9,648	0	0
- Other Receivables	731,713	731,713	0	0	0	0	0
- Term Deposit	3,350,000	3,350,000	0	0	0	0	0
Total Financial Assets	5,290,638	5,235,368	22,776	22,846	9,648	0	0

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

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.

(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 cashflow requirements of the Health Service from month to month.

The following table discloses the contractual maturity analysis for Terang and Mortlake Health Service'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			
	Total 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 (i)	1,285,194	1,285,194	1,285,194	0	0	0
Borrowings	289,224	289,224	0	0	0	289,224
Total Financial Liabilities	1,574,418	1,574,418	1,285,194	0	0	289,224
2016						
Financial Liabilities						
At amortised cost						
Payables (i)	1,189,120	1,189,120	1,189,120	0	0	0
Borrowings	346,170	346,170	0	0	0	346,170
Total Financial Liabilities	1,535,290	1,535,290	1,189,120	0	0	346,170

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

(e) Market Risk

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

Currency Risk

Terang and Mortlake Health Service is exposed to insignificant foreign currency risk through its payables relating to purchases of supplies and consumables from overseas. This is because of a limited amount of purchases denominated in foreign currencies and a short timeframe between commitment and settlement.

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
(e) Market Risk (Continued)
Interest Rate Risk
Exposure to interest rate risk is insignificant. Minimisation of risk is achieved by mainly holding fixed rate or non-interest bearing financial instruments. For financial liabilities the Health Service mainly undertake financial liabilities with relatively even maturity profiles.

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

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

The Health Service manages this risk by mainly undertaking fixed rate or non-interest bearing financial instruments with relatively even maturity profiles, with only insignificant amounts of financial instruments at floating rate. Management has concluded for cash at bank and bank overdraft, as financial assets that can be left at floating rate without necessarily exposing the Health Service to significant bad risk, management monitors 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 Hospital on a monthly basis. These contracts have set price arrangements and are reviewed on a regular basis.

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

	Weighted Average Effective Interest Rate (%)	Carrying Amount	Interest Rate Exposure		
2017			Fixed Interest Rate $	Variable Interest Rate $	Non - Interest Bearing $
Financial Assets					
Cash and Cash Equivalents	1.65	690,301	0	690,301	0
Loans and Receivables (i)					
- Trade Debtors		107,998	0	0	107,998
- Other Receivables		933,161	0	0	933,161
- Term Deposit	2.32	3,150,000	3,150,000	0	0
Total Financial Assets		4,881,460	3,150,000	690,301	1,041,159
Financial Liabilities					
At amortised cost					
Payables (i)		1,285,194	0	0	1,285,194
Borrowings	9.40	289,224	289,224	0	0
Total Financial Liabilities		1,574,418	289,224	0	1,285,194
2016					
Financial Assets					
Cash and Cash Equivalents	1.90	1,082,916	0	1,082,916	0
Loans and Receivables (i)					
- Trade Debtors		126,009	0	0	126,009
- Other Receivables		731,713	0	0	731,713
- Term Deposit	2.61	3,350,000	3,350,000	0	0
Total Financial Assets		5,290,638	3,350,000	1,082,916	857,722
Financial Liabilities					
At amortised cost					
Payables (i)		1,189,120	0	0	1,189,120
Borrowings	9.40	346,170	346,170	0	0
Total Financial Liabilities		1,535,290	346,170	0	1,189,120

(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)
(e) Market Risk (Continued)
Sensitivity Disclosure Analysis
Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, the Terang and Mortlake Health Service believes the following movements are 'reasonably possible' over the next 12 months (base rates are sourced from the Reserve Bank of Australia).
- A shift of 100 basis points up and down in market interest rates (AUD) from year-end rates of 1.65%; and
- A parallel shift of +1% and -1% in inflation rate from year-end rates of 2.5%.

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

	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-1%		+1%		-1%		+1%	
		Profit	Equity	Profit	Equity	Profit	Equity	Profit	Equity
2017	$	$	$	$	$	$	$	$	$
Financial Assets									
Cash and Cash Equivalents	690,301	(6,903)	(6,903)	6,903	6,903	0	0	0	0
Loans and Receivables (i)									
- Trade Debtors	107,998	0	0	0	0	0	0	0	0
- Other Receivables	933,161	0	0	0	0	0	0	0	0
- Term Deposit	3,150,000	0	0	0	0	0	0	0	0
Financial Liabilities									
At amortised cost									
Payables (i)	1,285,194	0	0	0	0	0	0	0	0
Borrowings	289,224	0	0	0	0	0	0	0	0
		(6,903)	(6,903)	6,903	6,903	0	0	0	0
2016									
Financial Assets									
Cash and Cash Equivalents	1,082,916	(10,829)	(10,829)	10,829	10,829	0	0	0	0
Loans and Receivables (i)									
- Trade Debtors	126,009	0	0	0	0	0	0	0	0
- Other Receivables	731,713	0	0	0	0	0	0	0	0
Other Financial Assets									
- Term Deposit	3,350,000	0	0	0	0	0	0	0	0
Financial Liabilities									
At amortised cost									
Payables (i)	1,189,120	0	0	0	0	0	0	0	0
Borrowings	346,170	0	0	0	0	0	0	0	0
		(10,829)	(10,829)	10,829	10,829	0	0	0	0

(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

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 financial assets include holdings in unlisted shares. Fair value of these is determined by projecting future cash inflows from expected future dividends and subsequent disposals of the securities.

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

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

Comparison between carrying amount and fair value

	Carrying Amount 2017 $	Fair Value 2017 $	Carrying Amount 2016 $	Fair Value 2016 $
Financial Assets				
Cash and Cash Equivalents	690,301	690,301	1,082,916	1,082,916
Loans and Receivables (i)				
- Trade Debtors	107,998	107,998	126,009	126,009
- Other Receivables	933,161	933,161	731,713	731,713
-Term Deposits	3,150,000	3,150,000	3,350,000	3,350,000
Total Financial Assets	**4,881,460**	**4,881,460**	**5,290,638**	**5,290,638**
Financial Liabilities				
At amortised cost				
Payables (i)	1,285,194	1,285,194	1,189,120	1,189,120
Borrowings	289,224	289,224	346,170	346,170
Total Financial Liabilities	**1,574,418**	**1,574,418**	**1,535,290**	**1,535,290**

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

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

Reclassification of financial instruments at fair value through profit or loss

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
(f) Fair Value (Continued)
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 (refer to Note 6.2), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

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

NOTE 7.2: NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS	2017 $	2016 $
Proceeds from Disposal of Non Financial Assets		
- Motor Vehicles	46,182	43,099
Total Proceeds from Disposal of Non-Financial Assets	46,182	43,099
Less: Written Down Value of Non Financial Assets Sold		
- Motor Vehicles	(39,321)	(47,780)
Total Written Down Value of Non-Financial Assets Sold	(39,321)	(47,780)
NET GAINS/(LOSSES) ON DISPOSAL OF NON FINANCIAL ASSETS	6,861	(4,681)

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

Impairment of non-financial assets
All non-financial assets are assessed annually for indications of impairment, except for:
- inventories;
- investment properties that are measured at fair value,
- non-current physical assets held for sale; and
- assets arising from construction contracts.

If there is an indication of impairment, the assets concerned are tested as to whether their carrying value exceeds their possible recoverable amount. Where an asset's carrying value exceeds its recoverable amount, the difference is written-off as 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.

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 LIABILITIES AND CONTINGENT ASSETS
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 liabilities for Terang and Mortlake Health Service at the date of this report.

NOTE 7.4: FAIR VALUE DETERMINATION

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

[(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	6,367,935	6,367,935
- Revaluation increment for land	0	0
- Revaluation increment for Buildings	0	0
Balance at the end of the reporting period	6,367,935	6,367,935
Represented by:		
- Land	938,215	938,215
- Buildings	5,429,720	5,429,720
	6,367,935	6,367,935
(1) The property, plant & equipment asset revaluation reserve arises on the revaluation of property, plant & equipment.		
Total Surpluses	6,367,935	6,367,935
(b) Contributed Capital		
Balance at the beginning of the reporting period	3,328,769	3,328,769
Capital Contribution received from Victorian Government	0	0
Balance at the end of the reporting period	3,328,769	3,328,769
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	772,846	982,180
Net Result for the Year	(378,478)	(209,334)
Balance at the end of the reporting period	394,368	772,846
Total Equity at end of financial year	10,091,072	10,469,550

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

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.

NOTE 8.2: RECONCILIATION OF NET RESULT FOR THE YEAR TO NET CASH FLOWS FROM OPERATING ACTIVITIES	2017 $	2016 $
NET RESULT FOR THE PERIOD	(378,478)	(209,334)
Non-cash movements		
Depreciation	1,003,566	955,661
Movements included in investing and financing activities		
Net (Gain)/Loss from Sale of Plant and Equipment	(6,861)	4,681
Movements in assets and liabilities		
Change in Operating Assets & Liabilities		
(Increase)/Decrease in Receivables	(133,485)	(682,612)
(Increase)/Decrease in Prepayments	1,782	(21,171)
(Increase)/Decrease in Stores	5,133	(5,445)
Increase/(Decrease) in Payables	66,609	914,661
Increase/(Decrease) in Employee Benefits	98,974	82,194
Increase/(Decrease) in Other Liabilities	(90,000)	133,092
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	567,240	1,171,727

NOTE 8.3: OPERATING SEGMENTS

	HEALTH SERVICES		RACS		OTHER SERVICES		TOTAL	
	2017	2016	2017	2016	2017	2016	2017	2016
	$	$	$	$	$	$	$	$
REVENUE								
External Segment Revenue	9,279,862	8,695,873	1,859,724	1,706,873	0	0	11,139,586	10,402,746
Total Revenue	**9,279,862**	**8,695,873**	**1,859,724**	**1,706,873**	**0**	**0**	**11,139,586**	**10,402,746**
EXPENSES								
External Segment Expenses	(8,672,760)	(8,082,598)	(2,939,756)	(2,670,311)	0	0	(11,612,516)	(10,752,909)
Total Expenses	(8,672,760)	(8,082,598)	(2,939,756)	(2,670,311)	0	0	(11,612,516)	(10,752,909)
Net Result from ordinary activities	607,102	613,275	(1,080,032)	(963,438)	0	0	(472,930)	(350,163)
Interest Income	0	0	0	0	94,452	140,829	94,452	140,829
Net Result for Year	**607,102**	**613,275**	**(1,080,032)**	**(963,438)**	**94,452**	**140,829**	**(378,478)**	**(209,334)**
OTHER INFORMATION								
Segment Assets	8,448,099	8,772,346	4,363,976	1,781,578	0	0	12,812,075	10,553,924
Unallocated Assets	0	0	0	0	1,468,340	3,786,332	1,468,340	3,786,332
Total Assets	**8,448,099**	**8,772,346**	**4,363,976**	**1,781,578**	**1,468,340**	**3,786,332**	**14,280,415**	**14,340,256**
Segment Liabilities	2,170,801	3,353,575	585,361	318,435	0	0	2,756,162	3,672,010
Unallocated Liabilities	0	0	0	0	1,433,181	198,696	1,433,181	198,696
Total Liabilities	**0**	**0**	**0**	**0**	**1,433,181**	**198,696**	**4,189,343**	**3,870,706**
Acquisition of property, plant and equipment and intangible assets	344,389	255,400	1,104,702	892,674	0	0	1,449,091	1,148,074
Depreciation	(844,703)	(823,350)	(158,863)	(132,311)	0	0	(1,003,566)	(955,661)
Non cash expenses other than depreciation	8,752	11,929	0	0	0	0	8,752	11,929

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

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

Geographical Segment

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

NOTE 8.4: RESPONSIBLE PERSON DISCLOSURES

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

	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	01/07/2016 - 30/06/2017
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	01/07/2016 - 30/06/2017
Governing Boards	
Mr Geoff Barby	01/07/2016 - 30/06/2017
Mrs Elizabeth Clarke	01/07/2016 - 30/06/2017
Mr Ashley Eccles	01/07/2016 - 30/06/2017
Ms Erin Guiney	01/07/2016 - 30/06/2017
Mrs Helen Kenna	01/07/2016 - 30/06/2017
Mr Colin Long	01/07/2016 - 30/06/2017
Mr Barry Philp	01/07/2016 - 30/06/2017
Mr David Selman	01/07/2016 - 30/06/2017
Mr Murray Whiting	01/07/2016 - 30/06/2017
Accountable Officers	
Ms Julia Ogdin-Gubbins (Chief Executive Officer - Maternity Leave)	01/07/2016 - 25/09/2016
Ms Margaret White (Acting Chief Executive Officer)	26/09/2016 - 30/06/2017

Remuneration of Responsible Persons

Remuneration received or receivable by responsible persons was in the range: $240,000 - $249,999 ($150,000 - 159,999 in 2015-16).

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

NOTE 8.5: EXECUTIVE OFFICER DISCLOSURES

Remuneration of executive officers	**Total Remuneration**	
	2017	**2016(a)**
	$	**$**
Short-term employee benefits	212,519	
Post-employment benefits	21,196	
Other long-term benefits	5,877	
Termination benefits	0	
Share-based payments	0	
Total Remuneration (b)	239,592	
Total Number of executives (c)	2	
Total annualised employee equivalent (AEE) (d)	2	

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 responsible ministers, the board of management and accountable officers as detailed in Note 8.4.

COMPENSATION	2017 $
Short term employee benefits	218,601
Post-employment benefits	17,164
Other long-term benefits	7,351
Termination benefits	0
Share based payments	0
Total	**243,116**

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

Terang & Mortlake Health Service received funding from the Department of Health and Human Services of $7,339,332 (2016: $7,590,164).

During the year, Terang & Mortlake Health Service had the following other government-related entity transactions:
- Commonwealth Government funding received for health related programs totalling $1,526,783 (2016 $842,081).

Note 8.7: REMUNERATION OF AUDITORS

	2017	2016
	$	$
Victorian Auditor-General's Office		
Audit or review of financial statement	9,000	9,000
	9,000	9,000

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. Terang and Mortlake Health Service has not and does not intend to adopt these standards early.

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

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

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

NOTE 8.9: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

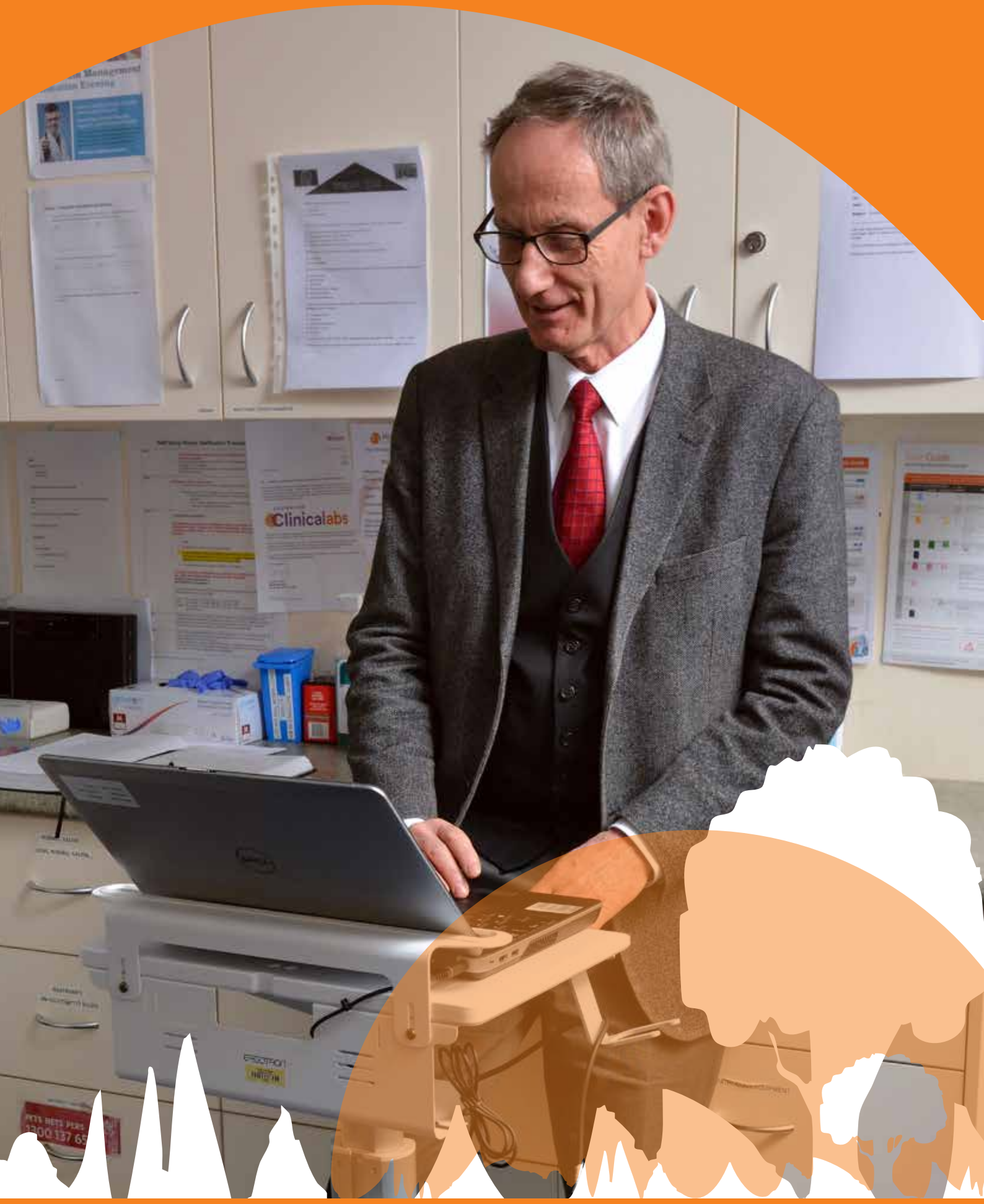
Assets, liabilities, income or expenses arise from past transactions or other past events. Where the transactions result from an agreement between the Health Service and other parties, the transactions are only recognised when the agreement is irrevocable at or before the end of the reporting period.

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	**2017 $**	**2016 $**
Grants		
Operating	8,686,411	8,267,733
Capital	89,852	82,256
Interest	94,452	117,179
Sales of goods and services	723,426	1,046,172
Other	1,633,036	1,034,916
Revenue from Transactions	**11,227,177**	**10,548,256**
Employee expenses	7,655,887	7,163,423
Depreciation	1,003,566	955,661
Other operating expenses	2,974,885	2,629,947
Expenses from Transactions	**11,634,338**	**10,749,031**
Net result from transactions - Net Operating Balance	**(407,161)**	**(200,775)**
Other economic flows included in net result		
Net gain/ (loss) on sale of non-financial assets	6,861	(4,681)
Other gains/ (losses) from other economic flows included in net result	21,822	(3,878)
Total Other Economic flows included in Net Result	**28,683**	**(8,559)**
NET RESULT FOR THE YEAR	**(378,478)**	**(209,334)**

NOTES


Clinicalabs

TERANG & MORTLAKE
HEALTH
SERVICE

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