Our Vision

Kerang District Health seeks to improve the health and wellbeing of the community.

Our Values

CARING

We will be person centered, show compassion and empathy.

ACCOUNTABILITY

We will be transparent, trustworthy and responsible for our actions.

RESPECT

We will embrace and be considerate of the differences between all people.

EXCELLENCE

We will be dedicated to every person, every time.

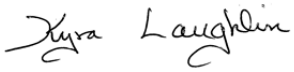
Contents

Introduction

This Annual Report and Report of Operations details the activities and achievements of Kerang District Health for the year ended 30 June 2017. The Report is required under the provisions of the Financial Management Act 1994. Additional requirements are contained in Standing Directions of the Minister for Finance and Financial Reporting Directions issued by the Department of Treasury and Finance.

Responsible Bodies Declaration

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



Kyra Laughlin, Board President, Kerang.
9th August 2017

Location & Contact Details

Hospital
13-15 Burgoyne Street, KERANG, 3579.
Postal Address: PO Box 179, KERANG, 3579.
Email: contact@kerhosp.vic.gov.au
Website: www.kerangdistricthealth.com.au
Phone: 03 5450 9200
Fax: 03 5450 9209

Glenarm
13 Burgoyne Street, KERANG, 3579.
Phone: 03 5450 9278
Fax: 03 5450 9220

WD Thomas Activity Centre
15 Burgoyne Street, KERANG, 3579.
Phone: 03 5450 9284
Fax: 03 5450 9678

District Nursing Service
13 Burgoyne Street, KERANG, 3579.
Phone: 03 5450 9292
Fax: 03 5450 9289

Responsible Ministers

The Honourable Jill Hennessy MP,
Minster for Health
Minister for Ambulance Services

Martin Foley MP,
Minister for Mental Health
Minister for Housing, Disability and Ageing
Minister for Equality
Minister for Creative Industries

Jenny Mikakos MLC,
Minister for Families and Children
Minister for Youth Affairs

The Hon John Eren MP,
Minister for Sport
Minister for Tourism and Major Events
Minister for Veterans' Affairs

Profile

Established
3 September 1954

Registered Beds
20 Acute
30 Residential Aged Care

Accreditation Status
Accredited with the Australian Council on Healthcare Standards (ACHS) until November 2017
Accredited with The Australian Aged Care Quality Agency until March 2018

Bankers
National Australia Bank

Insurers
Victorian Managed Insurance Agency (VMIA)

Auditor
Auditor General Victoria – Agent – Richmond Sinnott & Delahunty, Bendigo.

Internal Auditor & Accountants
Accounting and Auditing Solutions Bendigo (AASB), Bendigo.

Solicitors
Basile & Co., Kerang
Workplace Legal

Memberships
The Victorian Healthcare Association
The Victorian Hospitals' Industrial Association
Leading Age Services Australia

Service Directory

Visiting Medical Officers

Local General Practitioners

Dr. R. Banskota
Dr. N. Darko
Dr. F. Hussain
Dr. P. Keppel
Dr. K. Ojo
Dr. H. Van Rensburg
Dr. G. Wood

Visiting Surgeons

General Surgery
Mr. P. Modak

Obstetrics and Gynaecology
Dr. M. Jalland
Dr. G. Dennerstein

Ophthalmology
Dr. A. Gibson

Urology
Dr. S. Lindsay

Dental
Dr. G. Gin
Dr. S Amiri

Dr. J. Gorey

Oncology
Dr. M. Warren

Urgent Care Centre
24 hours

Glenarm
30 Residential Aged Care Beds

Transitional Care Program
(2 inpatient beds, 1 community bed)

Community/Allied Health Services

Pathology
Australian Clinical Labs

Radiology
Bendigo Radiology

Primary Care and Community Services including:

- District Nursing
- Hospital in the Home
- Health Promotion
- Domiciliary Midwifery
- Palliative Care
- Centre Based Planned Activity Groups
- Men's Shed
- Mobile Planned Activity Group
- Adult Exercise Program
- Welfare
- Physiotherapy
- Occupational Therapy
- Community Garden

Attestation for Compliance with the Ministerial Standing Direction 3.7.1 – Risk Management Framework & Processes.

I, Robert Jarman, certify that Kerang District Health has complied with Ministerial Direction 3.7.1 – Risk Management Framework and Processes. The Kerang District Health Board of Management has verified this.

Robert Jarman,
Chief Executive Officer, Kerang
9th August 2017

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

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

Robert Jarman,
Chief Executive Officer, Kerang
9th August 2017

History

The Kerang & District Hospital building in Burgoyne Street, Kerang was officially opened on the 21st September 1954, by His Excellency the Governor of Victoria Sir Dallas Brooks.

The two storey Hospital was built as a 46 bed acute hospital providing medical, surgical, obstetric, and accident & emergency services.

In 1974 the Board of Management launched a major fundraising appeal to build a twenty bed nursing home adjacent to the hospital and after several years of fundraising, His Excellency Sir Henry Winneke, Governor of Victoria officially opened "Glenarm" on 26 April 1979.

In 1979, a day activity centre was established in Nolan Street, in a building owned by the Catholic Church and day activity services operated from this site until May 1991. During 1990/91 completion and occupation of a purpose built day activity centre was realised. The building was named the W D Thomas Day Centre in honour of a former Board Member Mr Des Thomas.
The last 25 years has seen the introduction of services such as; pathology, radiology, welfare, physiotherapy and district nursing and health promotion.
The completion of a Master Plan in November 1991 and acceptance of concept plans developed from this process formed the basis of future strategic planning for Kerang & District Hospital.

Stage one of the re-development in 1993 saw the addition of ten beds to "Glenarm", four being allocated by the Commonwealth Government and six being relocated from the Hospital.

Stage two involved the relocation of all beds and services from the first floor of the hospital building to the ground floor and this work was completed in 1992 with the building of a new operating theatre. During the project the physiotherapy service was relocated from the main hospital building to the nurse's home.

Stage three in 1993 saw a refurbishment of the midwifery area and the creation of a conference room on the first floor.

In late 1999 after several years of discussions the Gannawarra Neighbourhood House in Kerang and Cohuna became part of Kerang & District Hospital.

In April 2002 two shops were purchased in Fitzroy Street. One to be used by the Kerang & District Hospital Ladies Auxiliary for their Opportunity Shop and the other to be used by the District Nursing Service and Health Promotion. The District Nursing Centre was officially opened by Mr Peter Walsh, State Member of Parliament for Swan Hill, in October 2003.

On 18 June 2002 the Governor in Council amended Schedule 1 of the Health Services Act to amend the name of Kerang & District Hospital to Kerang District Health. Although there were no major changes made to services offered at Kerang, the Board of Management believed that the organisation offers much more than hospital services to the community.

In August 2005 work was completed on a Day Surgery Recovery Room, built adjacent to Theatre at a cost of $372,322.00. Also in August 2005 the Department of Human Services announced that it would fund the completion of a Capital Master Plan for Kerang District Health. The Capital Master Planning process was completed in June 2010.

In May 2011 the State and Federal Governments announced combined capital funding of $36.25 million for the redevelopment of acute and aged care facilities.

The first stage of the building program, the "Early Works" commenced in June 2012 and was completed in June 2013. The second stage of the building program, the "Main Works" commenced in July 2013 and was completed mid-2016.

In April 2016 hospital patients moved into the refurbished acute ward and Glenarm residents moved into the new Glenarm building.

In December 2016 works commenced to extend the W D Thomas Activity Centre and in April 2017 the refurbishment of the Administration area on the first floor commenced. Both projects are nearing completion at the end of the financial year.

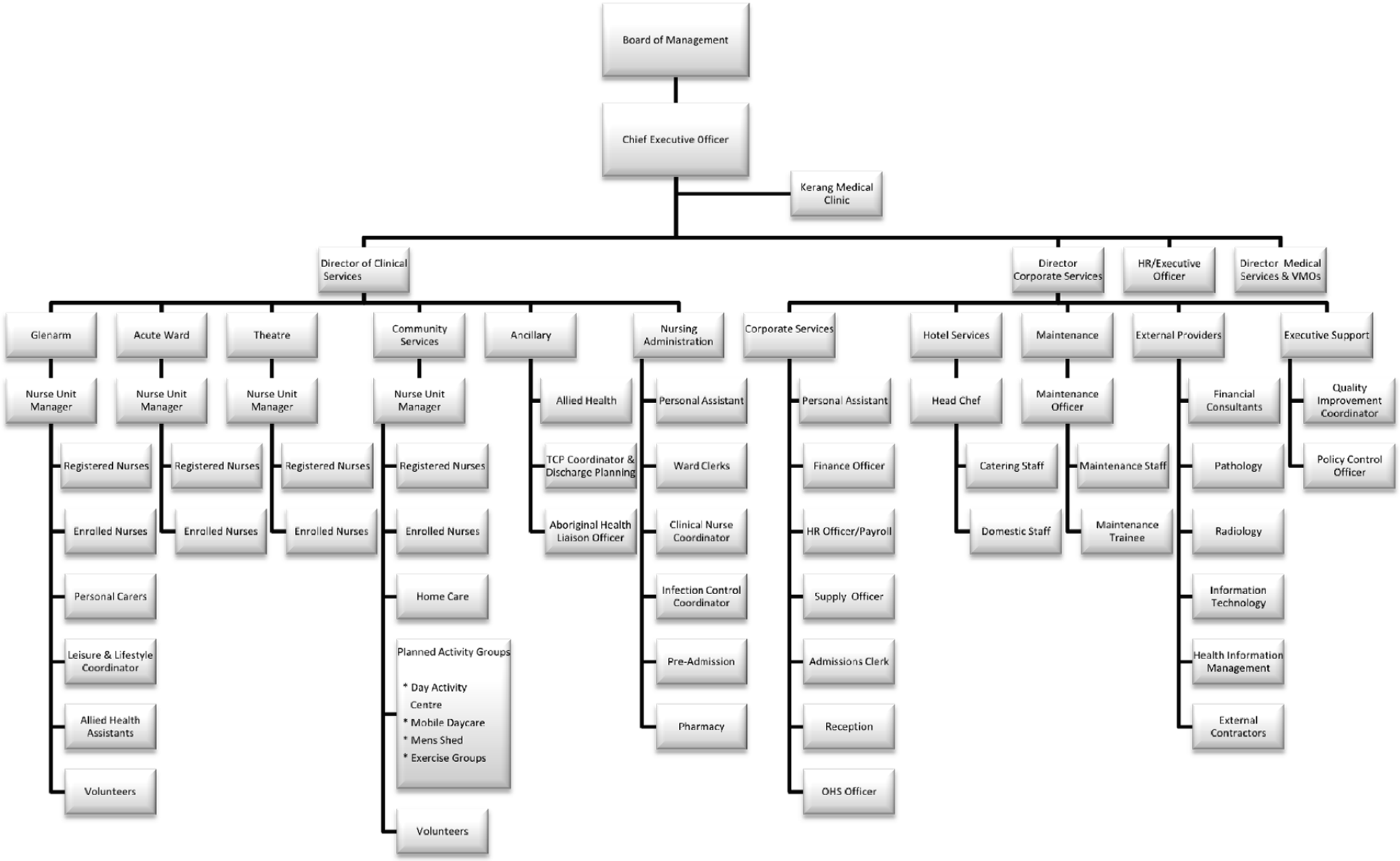
Board of Management

Name	Date appointed to Board and current term	Meetings attended
Trevor Adams Funeral Celebrant	Appointed February 2008 01/07/2016-30/06/2019	17/19
Lauren Edwards Physiotherapist	Appointed July 2016 01/07/2016-30/06/2019	17/19
John Ginnivan Environmental Consultant	Appointed July 2015 01/07/2015-30/06/2018	15/19
Simon Hall, B Ag Econ **(President)** Primary Producer	Appointed November 1993 01/07/2014-30/06/2017	16/19
Ken Jenkins Managing Editor	Appointed November 2003 01/07/2014-30/06/2017	15/19
Melonie Lane Senior ATSI Coordinator	Appointed July 2016 01/07/2016-30/06/2019	14/19
Kyra Laughlin Primary School Teacher	Appointed November 2002 01/07/2015-30/06/2018	16/19
Kylie Liebmann Scientist	Appointed July 2015 01/07/2015-30/06/2018	12/19
Lorraine Morris Primary Producer	Appointed November 1996 01/07/2014-30/06/2017	12/19

Executive Management

Name	Responsibilities
Robert Jarman Chief Executive Officer	Robert is responsible to the Board of Management for strategic leadership and management. He is responsible for implementing policy and direction as determined by the Board of Management. Robert has served as Chief Executive Officer since December 2001 and has many years' experience as an Executive Officer within the Public Health Sector in rural Australia.
Chloe Keogh Director of Clinical Services	Chloe commenced her role as Director of Clinical Services in 2015. She has responsibility for Acute Nursing, Residential Aged Care, District Nursing, Day Activity Centre, and Community and Allied Health Services.
Peter Jones Director Corporate Services	Peter is responsible for the management of Corporate Services such as Administration, Payroll, Information Technology, Catering & Domestic Services, Maintenance and External Contractors, Procurement, Risk Management and OHS. Peter has extensive experience as an Executive Officer within the Public Health Sector in Victoria.
Dr Craig Winter Director of Medical Services	Craig started with KDH in November 2015 is responsible for ensuring visiting medical officers are credentialed and have the appropriate experience for the privileges they have applied for at KDH. This position provides support, advice and guidance for clinical risk and medication management.

Kerang District Health Organisational Structure



President and Chief Executive Officer Report

We have much pleasure in providing this President and Chief Executive Officer's report, the organisation's 66th for the year ending 30 June 2017.

Capital Redevelopment

In last year's report, reference was made to the final stages of the Main Works Stage of the capital redevelopment by Nicholson Construction valued at $20.53M. Work on the new entry road, carpark and new canopy was completed in August 2016. The final stage of the project which is the refurbishment of Administration on the first floor commenced in April 2017 and is being carried out by CJ & BT McLoughlan. In December 2016 the Board of Management accepted a tender from David Knight Building Services to extend the W D Thomas Activity Centre at a cost of $403,260.

Accreditation

In December 2016, the Australian Aged Care Quality Agency carried out an assessment contact visit of "Glenarm", our residential aged care home. The home was assessed against Standard 1, 2 and 4. No major recommendations were made by the surveyor. Our next re-accreditation for Glenarm is scheduled for December 2017.

In June 2017 an organisation wide accreditation survey was carried out by The Australian Council on Healthcare Standards against the new National Safety and Quality Health Service Standards. Kerang District Health complied with all 10 Standards and no major recommendations were identified.

On behalf of the Board of Management we would like to express our appreciation of the valuable contribution of management and staff in contributing to the quality improvement process at Kerang District Health and the work of Karen Transton our Quality Improvement Coordinator.

We would also like to acknowledge the contribution of Wendy Van der heiden our Supervisor, Catering & Domestic Services and her staff in meeting the requirements of the Food Safety Audit and Cleaning Audit.

Loddon Gannawarra Health Services Executive Network

During the last twelve months, Kerang District Health joined with other health service providers in the Loddon and Gannawarra Shire's to establish a collaborative partnership to proactively address existing and emerging health needs that impact on the communities we serve.

One of the key projects already completed by the Network was to undertake a Loddon and Gannawarra communities health gap needs analysis, which provided us with localized evidence based research on the needs of our community.

The Network has developed a submission "Loddon Gannawarra Healthy Hearts & Lungs Program" which will deliver a local community multidisciplinary health team for people with Chronic Obstructive Pulmonary Disease and/or Cardio-vascular disease.

Partnering with Consumers Committee

During the past twelve months under the guidance of Karen Transton, our Quality Improvement Coordinator the Partnering with Consumers Committee has become more active with monthly meetings taking place. Kerang District Health currently has a consumer representative on the Board of Management and the Quality Management & Risk Committee.

Building & Equipment Program

As in previous years, the Board of Management is committed to replacing and maintaining buildings, plant and equipment at Kerang District Health and as part of the capital redevelopment at Kerang District Health, buildings, plant and equipment have been upgraded and replaced where necessary.

Donations & Bequests

As in previous years, Kerang District Health continues to receive very valuable financial support from residents and service clubs from the local community and surrounding district.

In 2016/17 $124,037 was received in donations and bequests with major contributions received from Kerang District Health Ladies Auxiliary $81,000, Kerang Murray to Moyne Committee $12,000, Kerang Masonic Lodge $7,000 for nursing scholarships, Murrabit Lions Club $1750,

Lions Club of Kerang $1,000, Estate of the Late Eva Brimacombe, Mr Franklin Cross, Mr Allan & Mrs Christine McCallum and Mr Hendrick Bos.

Ladies Auxiliary
The Ladies Auxiliary under the chairmanship of Mrs Wilma Ellis continue their loyal support to the health service and their donation of $81,000 to the Board of Management in December 2016 confirms their dedication and commitment to improving facilities for patients, residents and clients at Kerang District Health. The Rita Hall Opportunity Shop in Fitzroy Street remains their main source of income.

Volunteers
A health care organization such as Kerang District Health cannot function without the dedication, support and commitment it receives from its many volunteers. Volunteers play a valuable role in the day to day operations of our health service in areas such as “Glenarm” our residential aged care home, the W D Thomas Activity Centre and the Men’s Shed.

Medical Officers
In December 2016 Dr Divina Del Rosario left Kerang to relocate to Bendigo. Dr Erin Hawkey joined the Kerang Medical Clinic in December 2016 along with Dr Kolade Ojo in February 2017.

In August 2016 Dr Muhammad Tufail returned to Melbourne and Dr Farah Hussain joined the Fitzroy Street Medical Clinic in February 2017.

In April 2017 Dr Erin Hawkey returned to work at Swan Hill Hospital and Dr Abhishek Singh relocated to Melbourne.

Kerang is currently served by the following Medical Officers who provide vital medical, urgent care and anaesthetic services to our local community 24 hours a day, 7 days a week and their dedication and commitment to both the health service and the community cannot be under-estimated; Dr Graeme Wood, Dr Harry van Rensburg, Dr Reshma Banskota, Dr Farah Hussain, Dr Peter Keppel, Dr Nii Darko, and Dr Kolade Ojo.

Executive Managers, Department Heads & Staff
An organisation such as Kerang District Health with an operating budget of just over $12M providing acute, residential aged care and community services, a major capital redevelopment and 160 staff cannot function without the dedication and contribution of its Executive Managers, Department Heads and Staff.

We would like to take this opportunity in thanking Dr Craig Winter in his role as Director of Medical Services, Mrs Chloe Keogh, Director of Clinical Services, Mr Peter Jones, Director Corporate Services, Department Heads and Staff for their dedication and valuable contribution during 2016/17.

The following staff members received service badges at the annual general meeting in November 2016;

10 Years	Ian Hastie
	Deaniee Henderson
	Melissa Hunter
	Tricia Kinsey
	Kim Marsh
	Linda Oram
	Lesley Stacey
	Clare Steed
15 Years	Jeecinta Lightbody
	Noeleen Opie
	Rosie Pearce
	Judy Teasdale
20 Years	Cheryl Dear
	Pam Walsh
	Kathryn Wilson
25 Years	Cheryl Algie
	Maree Neville
	Teena Steains
30 Years	Kerryn Bradshaw
35 Years	Lyn Mann

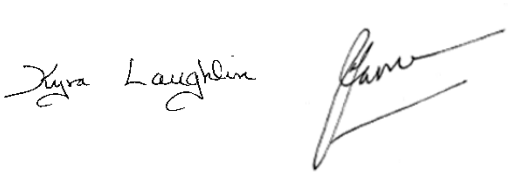
Congratulations also to the following nursing staff who received a Kerang Masonic Lodge Nursing Scholarship for 2016;

Chloe Keogh

Board of Management
On 1 July 2016 Mrs Kyra Laughlin, Mrs Lorraine Morris, Mr Trevor Adams, Mr John Ginnivan and Ms Kylie Liebmann, were re-

elected to the Board along with new Board members Mrs Melanie Lane and Mrs Lauren Edwards. Other remaining Board Members are Mr Simon Hall and Mr Ken Jenkins.

The contribution of Board Members needs to be acknowledged as they voluntarily attend board meetings, sub-committee meetings, conferences and workshops and represent the health service at various industry and community meetings and forums, meetings with the Department of Health and Human Services and both Local and Commonwealth Government. In addition, they contribute to the development of health service by providing policy and strategic direction.



President Kyra Laughlin

Chief Executive Officer Robert Jarman

Director of Clinical Services

In partnership with other local services Kerang District Health are part of the GLAM group (Gannawarra Local Agency). Some GLAM highlights for the year include the reconciliation walk and celebration, the LGBTI discussions and planning, the Family Violence awareness campaign, and the Walk to School program among others. This collaboration allows our health service and other service providers to come together and address the health needs of the community.

Dr Craig Winter our Director of Medical Services visits the health service once a month, and provides a lot of support and service throughout the year, and he coordinates the breakfast meetings with the VMO's. Craig's service is invaluable and he is generous with his knowledge of rural hospitals and health care.

I would also like to thank all the KDH VMO's for their work and dedication, and our visiting specialists and surgeons for the service they provide to our community.

The nursing and nursing administration staff have continued to show their dedication and commitment to their jobs, the organisation and the community they care for, throughout the year always maintaining a high standard of care, and being open to change and striving for Best Practice.

Our Ladies Auxiliary Opportunity Shop volunteers settled into their newly carpeted shop, with the extended space and have gone from strength to strength with more shed space out the back to work in, and climate control, and storage systems. Their support and generosity towards the hospital is remarkable, and the district nurses are now offering them health checks, to repay some of their generosity of spirit.

Education

Our clinical placement program for student nurses and clinical support staff has been a busy one, and this has been an avenue for prospective employees to do a placement at Kerang and apply when they have graduated for work. We have expanded our education equipment to a family of resuscitation dolls for staff and students to attend simulation exercises on which has had fabulous learning potential.

The appointment of a nurse educator, Sally Evans has been a highlight for many of the clinical staff with that bed side opportunity to have ongoing education on the floor in a timely manner.

Aboriginal liaison

Our work with the Indigenous members of our community continues to be in partnership wherever possible with (Murray District Aboriginal Services) MDAS, Shire of Gannawarra and Northern District Community health, and our ALO continues to work at supporting the Indigenous on discharge or when navigating the health system for appointments and visits.

District services

Men's Shed continues to be well attended and has benefited from Men's Health education sessions being provided by the Men's Health Worker from Northern District Community Health.

W D Thomas Activity Centre

The expansion of the W D Thomas activity centre to include a purpose built Exercise area dedicated to the programs offered in this space has been a very exciting project for the year, and will be completed early in the new financial year. This new area provides a lot

more space around the equipment and an outdoor exercise area too. We are eagerly awaiting the completion of this area, and the Activity Group will be thrilled to have a dedicated space for their activities, programs and entertainment.

We welcomed Tracey den Houting, a new Coordinator W D Thomas Activity Centre and this has provided some new and different activities, including a highly successful senior karaoke afternoon in the Kerang Memorial Hall, attended by various groups and individuals from around the region.

District nursing
District Nurses now visit the op-shop volunteers and do health checks regularly for this service. They have also expanded their services to include routine ECG's and 24/24 Halter monitors. They are also now attending to the post-op phone checks from theatre, which allows them the opportunity to follow up promptly if required.

In keeping with the safety theme this service introduced a door bell outside the Office to be rung for Nurses attention and office door is kept locked.

Theatre
This area has received comprehensive services from their visiting surgeons. Mr. Modak, Mr. Lindsay, Dr. Jalland, Dr. Dennerstein and Dr. Gibson. Also, anaesthetic services from Dr. Wood, Dr. Keppel and Dr. McCarthy.

The availability of colonoscopy procedures at KDH is greatly appreciated by our local community. Also, the waiting list for this procedure has decreased to 2-3 months.

The teamwork in DSU and theatre is respectful, caring, reliable, and efficient. This is reflected in customer feedback surveys. eg. Quote from theatre survey in June " the care was very good, staff kind and understanding, surroundings beautiful, quiet and relaxing. I commend you all. Thank you"

Glenarm
The year has been spent settling into their new home, and making it their own space. Vegetables were produced within a short time from the garden, and chutney was made, amongst other produce.

The home had a successful unannounced visit from the aged care quality agency in January 2017, where the surveyor was complimentary about the new Aged Care space and commented on the happy residents.

The residents are kept busy with a full social activity calendar, including various outings and entertainers.

Glenarm have also welcomed a number of new staff to their team who bring new ideas and enthusiasm

Acute Ward
National Standards accreditation in early June 2017, through National Safety and Quality Health Service Standards was a positive experience with staff, patients, and consumers contributing to the discussions about the quality of services provided by the organisation. All involved are to be complimented on their positive approach over the last 3 years towards provision of safe and quality care, and during the survey in their championing of their processes to show case all the work that had been done.
A focus on staff security within the newly developed building occurred throughout the year with fob access to staff only areas has been an excellent project.

Further refinement of our Graduate Nurse Program under the guiding arm of the nurse educator has seen some further improvements in this area focussing how we support and mould the nurses of the future.

Transitional Care has been consistently over capacity throughout the year with a huge demand for this goal focussed program, with a large proportion of our clients reaching their goals within the program time frame.

Oncology has seen the introduction of 2 oncology nurses on one day, and another day for dressings and flushes. The hospital was delighted to receive a generous donation of oncology chairs for this space, and is eagerly awaiting their arrival.

Chloe Keogh
Director of Clinical Services

Occupational Health and Safety Report

Kerang District Health is committed to the safety and wellbeing of all employees, patients, residents, clients, contractors and visitors with a safe and healthy environment. This is achieved through complying with the Occupational Health & Safety Act 2004 (Vic) and OHS Regulations 2017, incident reporting & data collection, Health and Safety Representatives consultation, staff suggestions, OHS meetings, policies and actions that are undertaken to eliminate or manage the risk.

The OH&S Committee meets bi-monthly to discuss incidents, data, policies and procedures with an emphasis for individual representatives to nominate continuous improvements for their workgroup areas with a focus on consultation and collaboration of all staff in relation to safety processes, hazards and equipment.

Health and Safety Representatives (HSR) election for designated work areas were held in November 2016 as a result 8 HSRs were elected for a 3 year term. Worksafe approved HSR 5 day training sessions have been arranged to be held at KDH. This will assist with providing the appropriate skills, knowledge and confidence to represent staff in their work area.

A VHIA one day training program for Managers in occupational health and safety was conducted at KDH in November 2016. It was a valuable day with 12 staff attending. Information provided included risk identification & management, safe work systems and practices, OHS legislation, acts and regulations.

2017 Compulsory OH&S Training for all staff provided at Professional Development Days includes:

- Fire extinguisher and evacuation training
- Overview of OH&S
- Code grey- Occupational Violence & Aggression
- No lift training – clinical staff
- Manual Handling
- Chemical Safety Training

KDH has adopted the Worksafe Prevention of Occupational Violence and Aggression against health workers campaign that “IT IS NEVER OK” and has taken a number of steps to create a strong safety culture where violence and aggression is not tolerated encouraging staff to report incidents. Polices and Worksafe Victoria guidelines have been implemented providing a resilient process in preventing and managing OVA incidences across all work areas.

The OH&S Benchmarking Group for the Loddon Mallee resumed this year with meetings being held bimonthly incorporating 5 health services. These meeting provide an opportunity to bench mark OH&S incidents, compare data and discuss strategies & programs with an emphasis on compliance and improvement to safety systems.

OHS incidents across the organisation have reduced by 29% over the past twelve months. This has been achieved through consultation, ongoing education and training, upgrading of equipment and improved safe work practices, together with the commitment of the Board of Management, executives and staff to safety in the workplace.

Cathie Trewin
Occupational Health & Safety Coordinator

Health and Safety Indicators	Details	**2016-2017**	2015-2016	2014-2015
No. of WorkCover Claims	Claims made during year	**5**	1	1
No. Lost Time Claims		**4**	1	1
No. OHS Incidents	Staff Incidents	**29**	66	32
Hazards/Incidents per 100 FTE Employees		**28**	63	30
Lost Time Standard Claims	Per 100 FTE Employees	**0.9**	.9	.9

Current Authority

Kerang District Health is established under and operates in accordance with the Health Services Act 1988. The purpose of this Act is to make provision for the development of health services in Victoria, for the carrying on of hospitals, nursing homes and other health care agencies and related matters.

The health service reports to the Department of Health and Human Services, through its Loddon Mallee Regional Office located in Bendigo. The Minister for Health is the Honourable Jill Hennessy MLA.

Governance

Kerang District Health is governed by a Board of Management, members of which are appointed by the Governor-in-Council. The Board of Management comprises nine (9) members who meet twice monthly.

The objectives of Kerang District Health are detailed in its By Laws as follows:

- To organise for and provide health care services in the Kerang district, including regional services and services provided jointly with other agencies in accordance with the Health Services Act 1988 and other relevant Acts and Regulations.
- To utilise appropriate physical and personnel resources, knowledge and technologies available to promote health and to prevent, treat and alleviate disease, injury and suffering so far as possible in the prevailing conditions.
- To set and achieve standards consistent with prevailing principles of quality patient care and community health needs.
- To foster continuing improvement in standards through education, research and training.
- To arrange, manage, and provide programs and services designed to reduce social isolation.
- To arrange, manage, provide opportunities for social interaction including an integrated range of services for the diverse needs of individuals and families.

Kerang District Health has the following Board of Management sub-committees:

- Management Quality & Risk Committee
- Finance Committee
- Audit Committee
- Clinical Review Committee
- Occupational Health & Safety Committee.

Reports & Publications

The following reports and publications dealing with the functions and activities of the health service are available from the office of the Chief Executive Officer;

- By-Laws
- Annual Report
- Quality Account (Calendar)
- Department of Health and Human Services Annual Report

The current regulations of Kerang District Health are incorporated in the By-Laws of Kerang District Health dated January 2005, and approved by the Department of Health and Human Services.

Pecuniary Interest

Members of the Board of Management are required to lodge a declaration of pecuniary interest.

Fees

Kerang District Health charges fees as directed and published in circulars issued by the Department of Health and Human Services.

Industrial Relations

Industrial relations within the Health Service have been harmonious and no time was lost in 2016/17 due to industrial disputes.

Overseas Visits

No member of staff travelled overseas on business during 2016/2017.

Freedom of Information

During 2016/2017 there were nine (9) requests for access to documents under the Freedom of Information Act compared with ten (10) in 2015/2016 and all of these requests were for access to medical records.

All nine (9) of these requests were approved. The Chief Executive Officer is the Principal Officer to whom all requests should be forwarded.

Consultancies

In 2016/17, there were no (0) consultancies where the total fees payable to consultants was $10,000 or greater.

There were six (6) other consultancies totalling $7,279.76. Each of these consultancies was valued at less than $10,000.

Building Act 1993

This Act sets standards for the construction of new buildings and for the maintenance of existing buildings. It includes provisions to protect the safety and health of building users, and cost effective construction is encouraged.

All building work carried out during 2016/2017 complies with current Building Standards and to the best of our knowledge, the Health Service complies with building and maintenance provisions as per the Act.

Occupational Health & Safety

The Health Service has an active Occupational Health & Safety Program to ensure the health & safety of employees, patients and visitors to the Health Service.

National Competition Policy

Kerang District Health complies with the requirements of the National Competition Policy and the Victorian Government policy statement, Competitive Neutrality Policy Victoria and subsequent reforms.

Comments & Complaints

Kerang District Health encourages comments and complaints from patients, residents, their families and visitors so that this feedback can be used to look at ways of making improvements. All comment and complaint forms are forwarded to the Chief Executive Officer. Each form is registered and a brief summary, whilst maintaining confidentiality, is provided at the monthly Management Quality and Risk Committee meeting.
All persons lodging comment and complaint forms receive feedback via telephone, letter or interview.

In 2016/2017 Kerang District Health received sixty-four (64) complaints compared to sixty-nine (69) in 2015/2016.

Victorian Industry Participation Policy Act 2003

Kerang District Health has not entered into or completed any contracts during 2016/17 which required disclosure under the above Act.

Ex-Gratia Payments

No ex-gratia payments were made during 2016/17.

Financial Reporting

Kerang District Health has provided a statement to the Victorian Auditor general indicating that;

- No events have occurred subsequent to balance date which would require adjustment to or disclosure in the financial report:
- There are no contingent liabilities which have been bought to the entity's attention since balance day which should be included in the financial statements in 2016/17
- There are no plans or intentions that may materially affect the carrying values or classification, of assets or liabilities in the financial statements in 2016/17.

Merit & Equity

Kerang District Health is committed to applying merit and equity principles when appointing staff. Selection processes ensure that applicants are assessed and evaluated fairly and equitably on the basis of key selection criteria and other accountabilities without discrimination.

Kerang District Health acknowledges its obligations under the Public Administration Act 2004 and promotes and supports adherence to the public sector values prescribed in the Act. All employees model their behaviour in accordance with the Code of Conduct for Victorian Public Sector Employees and the specific public sector values of Responsiveness, Integrity, Impartiality, Accountability, Respect, Leadership and Human Rights, with particular reference to the *Victorian Charter of Human Rights and Responsibilities.*

Environmental Performance

Kerang District Health strives to continually improve the health of the people in our community by endeavouring to provide health care in an environmentally sound and sustainable manner. We commit to continual improvement in energy saving initiatives to reduce our carbon foot print.

We progressively establish and maintain environmental standards in compliance with all applicable regulations and standards.

Kerang District Health's environmental management strategy covers elements of energy reduction and sustainability from water, gas, electricity, waste and recycling to transport, procurement and service delivery.

Our performance is reported to the Department of Health and Human Services in the Victorian Public Healthcare Services Reporting Tool quarterly.

Carers Recognition Act 2012

Kerang District Health recognises its obligations under the Carers Recognition Act 2012 by ensuring that;

a. Its employees and agents have an awareness and understanding of the care relationship principles;
b. All practicable measures are taken to ensure that persons who are in care relationships and who are receiving services in relation to the care relationships from the care support organisation have an awareness and understanding of the care relationship principles;
c. All practicable measures are taken to ensure that the care support organisation and its employees and agents reflect the care relationship principles in developing, providing or evaluating support and assistance for persons in care relationships.

Protected Disclosure Act 2012

Kerang District Health has policies and procedures consistent with the requirements of the Protected Disclosure Act 2012 which supports staff to disclose improper or corrupt conduct within the health service.

In 2016/2017 there were no disclosures made to Kerang District Health under the Act.

Safe Patient Care Act 2015

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

Occupational Violence

Occupational Violence Statistics	2016/17
WorkCover accepted claims with an occupational violence cause per 100 FTE.	**0**
Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	**0**
Number of occupational violence incidents reported.	**34**
Number of occupational violence incidents reported per 100 FTE.	**32**
Percentage of occupational violence incidents resulting in a staff injury, illness or condition.	**0**

Definitions

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

Occupational Violence:
Any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment.

Incident:
Occupational health and safety incidents reported in the health services incident reporting system. Code Grey reporting is not included.

Accepted WorkCover Claims:
Accepted WorkCover claims that were lodged in 2016-2017.

Lost Time:
Is defined as greater than one day.

Car Parking Fees

Kerang District Health complies with DHHS Circular on Car Parking Fees, and does not charge car parking fees

Strategic Planning

The table below provides an overview of the progress towards the achievement of the Strategic Objectives contained in the 2016-2018 Strategic Plan.

STRATEGY	OUTCOME
Strategic Objective 1 – Our People ***Secure an agile workforce where safety is paramount, learning and education opportunities are provided, and our staff and consumers have access to timely information.***	
Recruitment	
• GP Anaesthetist • GP Obstetrician • Director of Medical Services • Surgeons/Visiting specialists • Replacement GPs.	• Ongoing advertising via RWAV website and also using external recruitment consultants. • DMS appointed in Jan 2016. • Replacement surgeons being recruited for orthopaedics and ENT. • Currently advertising via RWAV website and also using external recruitment consultants.
Communication	
• We will communicate with the community to ensure they are aware of services offered, including any changes to our service provision.	• Partnering with Consumers Committee established and meeting regularly. • Monthly advertising feature in the Gannawarra Times.
• We will communicate with staff across the health service in regard to governance and workplace issues.	• Weekly department heads huddle introduced. • Monthly organisation wide staff meetings introduced. • 2017 People Matter Survey conducted.
Strategic Objective 2 – Service Provision & Partnerships ***Actively participate in the design of integrated and coordinated delivery of services, and enhance affiliations with providers to avoid duplication, optimize service availability and continually.***	
Mental Health & Wellbeing	
• Explore and implement collaborative prevention and early intervention initiatives to address mental health and wellbeing, including alcohol dependence, drug dependence and domestic violence in the community.	• Regular meetings held with SMPCP, GLAM and Murray Primary Health Network.
Midwifery Service	
• Make a decision regarding the continuation of maternity services to ensure that they safely meet the needs of the community and communicate the outcome to the community.	• Low Risk Maternity Care agreement between KDH and SDHS. • No action to date.
Primary Health	
• Explore opportunities to work collaboratively with other service providers to support the community, especially the low socio economic sector with nutrition/ healthy eating strategies and support around issues of obesity and diabetes.	• Regular meetings held with SMPCP, GLAM and Murray Primary Health Network.
Allied Health	
• Explore possibilities to share Allied Health services with other health services.	• No action to date.

Residential Aged Care	
• In the relocation of the Residential Aged Care facility ensure an enhanced homelike environment is complemented by the introduction of additional daily activities for residents.	• Additional daily activities have been introduced for residents with the new kitchen, living area, and garden. • Monitored by Aged Care NUM.
Information Technology	
• Utilise video conferencing and eHealth technologies to enhance service provision.	• New video conferencing units purchased and installed with training provided. – July 2016. • Steady take up of video conferencing to deliver clinical consultations.
Strategic Objective 3* – *Leadership & Governance ***Ensure our governance systems support best care for our people***	
Financial	
• Maintain financial viability	• Surplus budget achieved in 2015/16. • 2016/17 Financial results pending finalisation of audit.
Quality & Safety	
• Continue work on developing a sound quality system across the organisation to ensure that the four pillars of quality and safety are embedded in aged care, acute services and community services.	• Full accreditation maintained with: • National Standards until November 2017 • Aged Care Standards until March 2018 • HACC Standards until August 2017 • Food Safety - Successful audits 2016 and 2017 • Cleaning Standards – excellent results obtained
• Ensure good clinical leadership/supervision/governance is in place.	• Currently reviewing the organisations clinical governance policy and structure. KDH representatives appointed to Loddon Mallee Clinical Governance Council.
• Develop strategies to improve health literacy with patients and carers, (both written and verbal) especially in regard to medications.	• Target a 10% increase in satisfaction to questions for health literacy as per the VHES.
Strategic Objective 4* – *Infrastructure ***Ensure our facilities support best care for our people***	
Infrastructure	
• Completion of the $36.3 million capital redevelopment program.	• Projected completion date 15 August 2016.
• Complete a refurbishment of the first floor administration area.	• Works commenced April 2017 and due for completion July 2017.
• Refurbish and extend the WD Thomas Activity Centre.	• Works commenced December 2016 and due for completion August 2017.
• Seek support from Bendigo Radiology for the provision of a CT scanner and operator to enhance service provision.	• No action to date

Statement of Priorities 2016/2017

Access and timeliness		
Action	**Deliverable**	**Outcome**
Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine).	Increase the use of Video Conferencing Equipment at KDH for telehealth by 20% involving nursing staff and local GP's by June 2017.	**Achieved:** Telemedicine with Gericonnect to ACAS patients for permanent and respite care is being explored with LMRHA. Nursing staff and GP's prefer a system of telephone contact and telephone orders than telemedicine within the township of Kerang, however the infrastructure is in place for telehealth to be used between KDH and regional centres as required.
Develop and implement a strategy to ensure the preparedness of the organisation for the NDIS and HACC transition and reform, with particular consideration to service access, service expectations, workforce and financial management.	Establish a sub-committee involving NUM Community Services, TCP Co-ordinator and Finance Officer to develop and Action Plan to identify opportunities service growth with NDIS and assist with the planned transition and reform of HACC services by March 2017.	**Achieved:** Subcommittee established to ensure preparedness of NDIS transition. Issues being addressed and worked through.
Governance and leadership		
Action	**Deliverable**	**Outcome**
Demonstrate implementation of the Victorian Clinical Governance Policy Framework: Governance for the provision of safe, quality healthcare at each level of the organisation, with clearly documented and understood roles and responsibilities. Ensure effective integrated systems, processes, 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.	Develop and Clinical Governance Framework at KDH which includes policy development, a clinical governance committee and participate in the Loddon Mallee Clinical Governance Council by March 2017.	**Achieved:** Clinical Governance policy due for EMT approval before going to the KDH BOM for endorsement in march 2017. Policy is outlining what is already occurring in practice with effective quality systems in place to ensure that person centred healthcare is delivered in an accountable manner. KDH has awareness of the Loddon Mallee Clinical Council and its role within the region, and DMS Craig Winter and Deputy DMS Ken Cheng have been part of these discussions. KDH contribute perinatal data for the quarterly M and M committee meetings established in 2016.
Contribute to the development and implementation of Local Region Action Plans under the series of state-wide design, service and infrastructure plans being progressively released from 2016-17. This will require partnerships and active collaboration across regions to ensure plans meet both regional and local service needs.	Support the establishment of the Gannawarra & Loddon Health Services Executive Network by working in a partnership with other health service providers and the Murray Primary Health Network to progress health prevention initiatives by March 2017.	**Achieved:** See above the information regarding the release for the LGHNA data and the relationship with the Murray PHN will be further strengthened with this data to direct where best energy needs to be focussed. CEO participating in these Regional Leadership Forums. Regional Action Plans being developed.
Ensure that an anti-bullying and harassment policy exists and includes the identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal and the policy specifies a regular review schedule.	Review the current KDH policy on Bullying and Harassment and ensure the policy is in line with the DHHS guidelines by Dec 2016. Implement Above and Below the Line behaviours at KDH by Dec 2016.	**Achieved:** Policy in place and consequence and management of staff who do not follow the policy is followed in practice.

Board and senior management ensure that an organisational wide occupational health and safety risk management approach is in place which includes: A focus on prevention and the strategies used to manage risks, including the regular review of these controls; and Strategies to improve reporting of OHS 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 Mechanisms for consulting with, debriefing and communicating with all staff regarding outcomes of investigations and controls following occupational violence and bullying and harassment incidents.	Review the KDH OH&S policy and program at KDH to ensure it has a focus on prevention of occupational injury by March 2017. Review the reporting of incidents at KDH with the view of implementing VHIMS 2 by March 2017. Establish a reporting process where staff receive feedback regarding occupational violence and bullying and harassment incidents at KDH by Dec 2016.	**Achieved:** Gap analysis undertaken with VHIA education day for Heads of Department. Action Plan to be formulated and submitted to OH and S committee after Executive endorsement.
Implement and monitor workforce plans that: improve industrial relations; promote a learning culture; align with the Best Practice Clinical Learning Environment Framework; promote effective succession planning; increase employment opportunities for Aboriginal and Torres Strait Islander people; ensure the workforce is appropriately qualified and skilled; and support the delivery of high-quality and safe person centred care.	Review the KDH Workforce Plan and Staffing Profile for 2016/17 to ensure compliance with DHHS workforce planning and policy by Dec 2016.	**Achieved:** Workforce Plan and Staffing profile on HR plan for implementation however this has not yet been fully implemented. Staff appointment and learning and education needs aligns with BPCLE. The workforce is appropriately qualified, skilled and supported to provide the care needed.
Create a workforce culture that: includes staff in decision making; promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and includes consumers and the community.	Implement some of the Studer Group Australia initiatives such as weekly huddles, organisation wide staff meetings and above and below the line initiatives by Sept 2016.	**Achieved:** CEO maintaining weekly huddles for improved communication. Monthly All staff meetings also continue. Above the Line behaviours to be fully implemented with the six point plan commencing late Feb 2017
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 to children; strategies to identify and reduce or remove the risk of abuse and strategies to promote the participation and empowerment of children.	Develop a Child Safe framework at KDH that includes the imp[lamentation of policy based on the Victorian Child Safe Standards thereby ensuring that child safety and mandatory reporting is embedded in every day thanking and practice at KDH by Dec 2016.	**Achieved:** See attached action plan, or if required KDH organisational plan can be forwarded to DHHS.
Implement policies and procedures to ensure clinical 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.	Continue to promote the vaccination program at KDH to ensure that staff are appropriately vaccinated and/or immunised and aim to achieve a vaccination rate of 75% by March 2017.	**Achieved:** Policy in place and consequence and management of staff who do not follow the policy is followed in practice. Policy to be further developed to include students.

Quality & Safety		
Action	**Deliverable**	**Outcome**
Implement systems and processes to recognise and support person-centred end of life care in all settings, with a focus on providing support for people who chose to die at home.	Improve the capability of clinical staff to support person-centered end of life discussions with a focus on people who choose to die at home by June 2017.	**Achieved:** Kerang District Health has 35 completed advanced care plans in place. Referrals to Swan Hill Palliative Care Service in place. June2016- December 2016- 32 Discussions held, and 17- completed. January 2017- 22 May 2017- 43 Discussions held, 14 completed
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.		**Achieved:** DMS reviews all mortality cases and advanced care plans are part of the admission and discharge process.
Progress implementation of a whole-of-hospital model for responding to family violence	Work in partnership with other local health providers to develop an Action Plan to respond to family violence by June 2017.	**Achieved:** Family Violence questions introduced in the admissions process at KDH, contact made with the SHRFV regional worker and Board education has been arranged with staff education completed on 27 March 2017.
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.	Actively participate in the Loddon Mallee Clinical Governance structure by Sept 2016.	**Achieved:** Health service CEO participates in Regional Leadership Group which monitors the performance of the Loddon Clinical Governance Council.
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.	KDH currently has a policy in place that ensures midwives undertake foetal surveillance competency on an annual basis.	**Achieved:** Kerang District Health has a fetal surveillance policy in place that has been updated. Annual education and competency is included in this policy, however whilst the health service is not birthing all fetal surveillance is forwarded to the requesting practitioner and reviewed by this external provider before the woman is discharged. VHES results and the CQI that result from improvements made to our system are to be placed onto our webpage for the community to see. We have also updated our complaints policy and process to make this more robust and responses timely and more transparent in an effort to focus on consumer experience and person centre care in our services. Complaints and VHES are monitored through indicators to the BOM.
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.	Further develop the Tea for Ten program at KDH which will provide additional patient feedback to KDH by March 2017.	
Develop a whole of hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint.	Review the seclusion and restraint policy at KDH to ensure KDH has a whole of health service approach to seclusion and restraint by Dec 2016.	**Achieved:** Organisational wide policy in place and Aged care indicators are carefully monitored to ensure minimal restraint measures are in place. Acute patients require a consent for the use of cot sides.

Supporting healthy populations		
Action	**Deliverable**	**Outcome**
Health services support shared population health and wellbeing planning at a local level - aligning with the Local Government Municipal Public Health and Wellbeing plan and working with other local agencies and Primary Health Networks.	KDH is currently participating in the Gannawarra & Loddon Health Services Executive Network to develop a whole of population approach to providing a number of primary health initiatives in consultation with the Murray PHN by Dec 2016.	**Achieved:** Health Needs analysis released for Loddon Gannawarra Feb 2017 at Dingee. This report being used to apply for funding to address identified issues.
That health services focus on primary prevention, including suicide prevention, 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.	This process will focus on primary health prevention initiatives and aim to impact on large numbers of people by adopting a whole of population approach to tackle multiple risk factors of poor health by March 2017.	**Achieved:** To now further advance initiatives to improve population eHealth in identified areas through local partnerships and opportunities.
Develop and implement strategies that encourage a culturally diverse environment such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.	Develop a formal agreement with MDAS, NDCHS and the Gannawarra Shire to assist in the development of strategies that encourages a culturally diverse environment within our community by March 2017.	**Achieved:** Priority are of LGHNA were diabetes, heart health, mental health and oral health. GLAM partnerships submission for DV project in the region was submitted in Feb 2017. GLAM have a formal partnership between all agencies and shared goals and objectives that are reviewed annually against the local data and needs analysis. KDH submit an annual diversity plan and staff are educated about cultural diversity and what that means within our community. Adverse events in this area are addressed with individuals or as a group of staff, to ensure that inclusive practice is the standard expected of all KDH staff. Liaison between the KDH ALO and MDAS workers has increased and the KDH ALO prepares a weekly summary of feedback reporting to DoCS with issues outstanding and impacts of these issues. ALO feedback informally evaluated to ensure community are getting the assistance required.
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.	With the assistance of the KDH Aboriginal Health Liaison Officer establish culturally safe practices which recognise and respect the cultural differences of Aboriginal & Torres Strait Islander people by March 2017.	
Drive improvements to Victoria's mental health system through focus and engagement in activity delivering on the 10 Year Plan for Mental Health and active input into consultations on the Design, Service and infrastructure Plan for Victoria's Clinical mental health system.	In partnership with other health service providers in the Gannawarra Shire, develop a Mental Health Action Plan to drive improvements in design, service and infrastructure for Victoria's Clinical Mental Health system by March 2017.	**Achieved:** Through the Loddon Gannawarra health needs analysis survey mental health is one of the key priority areas that needs addressing. This will be further expanded after the committee meet to determine the best next steps for the whole of community approach.
Using the Government's Rainbow eQuality Guide, identify and adopt 'actions for inclusive practices' and be more responsive to the health and wellbeing of lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals and communities.	Further progress the Rainbow Tick accreditation process at KDH by Dec 2016.	**Achieved:** LGBTI policy developed and implemented along with a LGBTI staff education program.

Financial sustainability		
Action	**Deliverable**	**Outcome**
Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	Undertake an internal audit process at KDH that makes recommendations for improvements to cash management strategies at KDH by March 2017.	**Achieved:** An ongoing "substantial improvement subsidy" has been received from the Commonwealth Government as a result of improved facilities offered by Glenarm aged care facility. TCP activity and funding has also increased.
Actively contribute to the development 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.	Continue to promote the recycling program at KDH which is confirmed by an increase in the waste management data by Dec 2016.	**Achieved:** Recent capital works have seen the addition of solar panels to KDH. Environmental waste management is now a regular reporting item on monthly OH&S meetings.

Part B: Performance Priorities

Key performance indicator Targets	Target	Actual
Safety and quality performance		
Compliance with NSQHS Standards accreditation	Full compliance	Achieved
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Achieved
Cleaning standards	Full compliance	Achieved
Compliance with the Hand Hygiene Australia program	80%	96.1%
Percentage of healthcare workers immunised for influenza	75%	80%
Submission of infection surveillance data to VICNISS1	Full compliance	Achieved
[1] VICNISS is the Victorian Hospital Acquired Infection Surveillance System		
Patient experience and outcomes performance		
Maternity – Percentage of women with prearranged postnatal home care	100%	100%
Governance, leadership and culture performance		
People Matter Survey - percentage of staff with a positive response to Safety culture questions	80%	77% Not achieved

Victorian Healthcare Experience Survey reporting

Key performance indicator	Target	2016-17 Result
Victorian Healthcare Experience Survey - data submission	Full compliance	**Achieved**
Victorian Healthcare Experience Survey – **patient experience** Quarter 1	95% positive experience	**94%** **Not achieved**
Victorian Healthcare Experience Survey – **patient experience** Quarter 2	95% positive experience	**94.5%** **Not achieved**
Victorian Healthcare Experience Survey – **patient experience** Quarter 3	95% positive experience	**Full compliance***
Victorian Healthcare Experience Survey – **discharge care** Quarter 1	75% very positive response	**93.9%** **Achieved**
Victorian Healthcare Experience Survey – **discharge care** Quarter 2	75% very positive response	**96.2%** **Achieved**
Victorian Healthcare Experience Survey – **discharge care** Quarter 3	75% very positive response	**Full compliance***
** Less than 42 responses were received for the period due to relative size of the Health Service*		

Workforce Statistics

Labour Category	JUNE Current Month FTE*		JUNE YTD FTE**	
	2016	**2017**	**2016**	**2017**
Nursing	58.66	53.52	**55.60**	**53.98**
Administration & Clerical	18.20	20.24	**18.01**	**20.66**
Hotel & Allied Services	24.26	18.28	**23.12**	**19.35**
Ancillary Staff (Allied Health)	9.63	11.39	**8.48**	**11.28**
Total FTE	**110.85**	**103.43**	**105.36**	**105.27**

Employment Status by Gender at 30 June 2017					
	Full Time	Part Time	Casual	**Total**	Percentage
Females	15	114	19	**148**	86%
Males	7	11	7	**25**	14%
Total	**22**	**125**	**26**	**173**	**100%**

Disclosure Index

The Annual Report of Kerang District Health is prepared in accordance with all relevant Victorian legislation. This index has been prepared to facilitate identification of the Department's compliance with statutory disclosure requirements.

Legislation	Requirement	Page
Ministerial Directions		
Report of Operations		
Charter and purpose		
FRD 22H	Manner of establishment and the relevant ministers	2
FRD 22H	Purpose, functions, powers and duties	12
FRD 22H	Initiatives and key achievements	7-9
FRD 22H	Nature and range of services provided	3
Management and structure		
FRD 22H	Organisation structure	6
Financial and other information		
FRD 10A	Disclosure index	23
FRD 11A	Disclosure of ex-gratia payments	13
FRD 21B	Responsible person and executive officer disclosures	Appendix I
FRD 22H	Application and operation of *Protected Disclosure Act 2012*	14
FRD 22H	Application and operation of *Carers Recognition Act 2012*	14
FRD 22H	Application and operation of *Freedom of Information Act 1982*	12
FRD 22H	Compliance with building and maintenance provisions of *Building Act 1993*	13
FRD 22H	Details of consultancies over $10,000	12
FRD 22H	Details of consultancies under $10,000	13
FRD 22H	Employment and conduct principles	13
FRD22H	Information and Communication Technology expenditure	Appendix I
FRD 22H	Major changes or factors affecting performance	7-9
FRD22H	Occupational Violence	14
FRD 22H	Operational and budgetary objectives and performance against objectives	17-22
FRD 24C	Reporting of office-based environmental impacts	13
FRD 22H	Significant changes in financial position during the year	Appendix I
FRD 22H	Statement on National Competition Policy	13
FRD 22H	Subsequent events	Appendix I
FRD 22H	Summary of the financial results for the year	Appendix I
FRD22H	Additional information available on request	24
FRD 22H	Workforce Data Disclosures including a statement on the application of employment and conduct principles	13, 22
FRD 25C	Victorian Industry Participation Policy disclosures	13
FRD103F	Non-Financial Physical Assets	Appendix I
FRD110A	Cash flow Statements	Appendix I
FRD112D	Defined Benefit Superannuation Obligations	Appendix I
SD5.2.3	Declaration in report of operations	2
SD 3.7.1	Risk management framework and processes	3
Other requirements under Standing Directions 5.2		
SD 5.2.2	Declaration in financial statements	Appendix I
SD 5.2.1 (a)	Compliance with Australian accounting standards and other authoritative pronouncements	Appendix I
SD 5.2.1 (a)	Compliance with Ministerial Directions	Appendix I

Legislation

Freedom of Information Act 1982
Protected Disclosure Act 2012
Carers Recognition Act 2012
Victorian Industry Participation Policy Act 2003
Building Act 1993
Financial Management Act 1994
Safe Patient Care Act 2015

Additional Information

In compliance with the requirements of FRD 22H Standard Disclosures in the Report of Operations, details in respect of the items listed below have been retained by Kerang District Health and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements, if applicable):

(a) Declarations of pecuniary interest have been duly completed by all relevant officers.

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

(c) Details of publications produced by the Health Service and how these can be obtained.

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

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

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

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

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

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

(j) General Statement on industrial relations within the Health Service and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the Report of Operations.

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

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

Annual Report 2016/2017

Appendix 1

FINANCIAL STATEMENTS

For the year ended 30th June 2017

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Kerang District Health

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
15 September 2017

Ron Mak
as delegate for the Auditor-General of Victoria

Kerang District Health

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

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

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

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

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

.....	.....	.....
Ken Jenkins Board Member	Robert Jarman Chief Executive Officer	Tony Pearson Chief Finance & Accounting Officer
Kerang 6/9/2017	Kerang 6/9/2017	Kerang 6/9/2017

Kerang District Health Service
Comprehensive Operating Statement
For the Financial Year Ended 30 June 2017

	Note	2017 $	2016 $
Revenue from Operating Activities	2.1	12,570,649	12,198,553
Revenue from Non-Operating Activities	2.1	225,888	216,048
Employee Expenses	3.1	(9,178,368)	(8,624,817)
Non Salary Labour Costs	3.1	(772,381)	(812,999)
Computer Services	3.1	(618,696)	(659,027)
Administrative Costs	3.1	(508,066)	(539,100)
Supplies and Consumables	3.1	(710,198)	(662,309)
Other Expenses	3.1	(1,075,112)	(1,023,589)
Net Result Before Capital and Specific Items		**(66,284)**	**92,760**
Capital Purpose Income	2.1	205,262	1,409,479
Depreciation	4.3	(2,053,239)	(1,775,686)
Expenditure using Capital Purpose Income	3.1	(42,996)	(367,716)
Net Result after capital and specific items		**(1,957,257)**	**(641,163)**
Other economic flows included in the net result			
Revaluation of long service leave	2.1	10,415	-
Total other economic flows included in net result		**10,415**	**-**
Items that will not be reclassified to net result			
Changes in physical asset revaluation surplus	8.1(a)	-	-
COMPREHENSIVE RESULT		**(1,946,842)**	**(641,163)**

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

Kerang District Health Service
Balance Sheet
As at 30 June 2017

	Note	2017 $	2016 $
Current Assets			
Cash and Cash Equivalents	6.1	2,434,654	1,884,447
Receivables	5.1	351,125	351,925
Investments and Other Financial Assets	4.1	2,145,242	2,208,798
Inventories	5.2	121,217	83,358
Prepayments and Other Assets	5.4	234,585	233,553
Total Current Assets		**5,286,823**	**4,762,081**
Non-Current Assets			
Receivables	5.1	430,902	355,270
Property, Plant and Equipment	4.2	32,797,088	32,617,481
Total Non-Current Assets		**33,227,990**	**32,972,751**
TOTAL ASSETS		**38,514,813**	**37,734,832**
Current Liabilities			
Payables	5.5	717,222	522,335
Provisions	3.3	2,594,964	2,562,496
Other Liabilities	5.3	1,810,205	942,540
Total Current Liabilities		**5,122,391**	**4,027,371**
Non-Current Liabilities			
Provisions	3.3	328,328	278,463
Total Non-Current Liabilities		**328,328**	**278,463**
TOTAL LIABILITIES		**5,450,719**	**4,305,834**
NET ASSETS		**33,064,094**	**33,428,998**
EQUITY			
Property, Plant and Equipment Revaluation Surplus	8.1(a)	5,112,575	5,112,575
Restricted Specific Purpose Surplus	8.1(a)	105,000	105,000
Contributed Capital	8.1(b)	18,428,646	16,846,707
Accumulated Surpluses	8.1(c)	9,417,872	11,364,716
TOTAL EQUITY	8.1(c)	**33,064,094**	**33,428,998**
Commitments	6.2		
Contingent Assets and Contingent Liabilities	7.3		

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

Kerang District Health Service
Statement of Changes in Equity
For the Financial Year Ended 30 June 2017

	Note	Property, Plant & Equipment Revaluation Surplus	Restricted Specific Purpose Surplus	Contributions by owners	Accumulated Surpluses/ (Deficits)	Total
		$	$	$	$	$
Balance at 1 July 2015		**5,112,575**	**105,000**	**12,216,722**	**12,005,878**	**29,440,175**
Net result for the year	8.1	-	-	-	(641,163)	(641,163)
Other Comprehensive Income	8.1	-	-	4,629,985	-	4,629,985
Balance at 30 June 2016		**5,112,575**	**105,000**	**16,846,707**	**11,364,715**	**33,428,997**
Net result for the year	8.1	-	-	1,581,939	(1,946,842)	(364,903)
Other Comprehensive Income		-	-	-	-	-
Balance at 30 June 2017		**5,112,575**	**105,000**	**18,428,646**	**9,417,873**	**33,064,094**

This Statement should be read in conjunction with the accompanying notes

Kerang District Health Service
Cash Flow Statement
For the Financial Year Ended 30 June 2017

	Note	2017 $	2016 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		9,609,819	9,273,637
Capital Grants from Government		69,945	807,620
Patient and Resident Fees Received		2,276,328	2,365,103
Donations and Bequests Received		124,038	303,085
GST Received from/(paid to) ATO		5,815	(651)
Interest Received		97,957	75,174
Other Receipts		410,032	343,402
Total Receipts		**12,593,934**	**13,167,370**
Employee Expenses Paid		(9,085,620)	(8,533,853)
Non Salary Labour Costs		(772,381)	(812,999)
Payments for Supplies & Consumables		(518,982)	(878,345)
Capital Purpose		(36,082)	(305,062)
Other Payments		(1,944,672)	(1,910,047)
Total Payments		**(12,357,737)**	**(12,440,306)**
NET CASH FLOW FROM OPERATING ACTIVITIES	8.2	**236,197**	**727,064**
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of Investments		18,831	(13,453)
Payments for Non-Financial Assets	4.2(b)	(2,044,900)	(4,847,724)
Proceeds from sale of Non-Financial Assets		12,727	42,964
NET CASH USED IN INVESTING ACTIVITIES		**(2,013,342)**	**(4,818,213)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Contributed capital from government		1,395,897	4,629,984
NET CASH USED IN FINANCING ACTIVITIES		**1,395,897**	**4,629,984**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		**(381,248)**	**538,835**
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		**933,627**	**394,792**
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.1	**552,379**	**933,627**

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 basis.

The accrual bais 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 repayments) 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 contributed by owners.

Transfers of net assets arising from administrative restructurings are treated as distributions to or contributed by owners. Transfers of net liabilities arising from administrative restructurings are treated as distributions 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 beleived 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 diclosed inthe notes under the heading: 'Significant judgement or estimate'

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

(a) Statement of compliance

These financial statements are general purpose financial statements which have bwwn 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 prepared in a manner consistent with the requirements od AASB 101 Presentation of Financial Statements.

The financial statemsnts also comlpy with relevant Financial Reporting Directions (FRDs) issued by the Department of Treasury and Finanace, and relevant Standing Orders (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 Kerang District Health on 22nd August 2017

(b) 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 funtional and presentation currency of the Health Service.

The financial statements, except for cash inflows informatiom, have been prepared using the accrual basis of accouting. Under the accrual basis, items are recognised as assets, liabilities, equity, income and expenses when they satisfy the definitions and recognition criteria for those itmes, 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 revaluation less any subsequent accumulated depreciation and subsequent impairment value. Revaluations are made and are re-assessed when new indices are published by the ValuerGeneral to ensure that the carrying amounts do not materially differ from their values;

- available-for sale investments which are measured at fair value with movements reflected in equity until the asset is derecognised (i.e. other comprehensive income-items that may be reclassified subsequent to net result); and

(b) Basis of accounting preparation and measurement (continued)

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

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

Revisions to accounting estimates are recognised in the period in which the estimate is revised and also in future periods affected by the revision. Judgements and assumptions made by management in the application of AAS's 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); and
- superannuation expense (refer to note 3.4).
- employee benefits based on likely tenure of existing staff, patterns of leave, future salary movements and future discount rates (refer to Note 3.3).

(c) Reporting Entity

The financial statements represent the activities of Kerang District Health as a single entity.

Its principal address is:
Burgoyne Street
Kerang VIC 3579

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

Objectives and Funding

Kerang District Health's overall objective is to improve the health and wellbeing of the community as well as improve the quality of life in Victorians.

Kerang District Health is predominantly funded by block grant funding for the provision of outputs.

(d) Principles of Consolidation

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

Jointly controlled assets

Interest in jointly controlled assets are not consolidated by Kerang District Health but are accounted for in accordance with policy in Note 4 Financial Assets.

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 objectives it receives income based on parliamentary appropriations. The hospital also receives income from the supply of services

Structure

2.1 Analysis of revenue by source

Note 2.1: Analysis of Revenue by Source

	Admitted Patients 2017 $	Residential Aged care 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	Total 2017 $
Revenue from Operating Activities						
Government Grants	6,122,802	2,622,385	763,144	-	101,488	9,609,819
Indirect contributions by Department of Health	54,321	25,171	7,238	1,069	-	87,799
Patient and Resident Fees	717,257	737,430	118,164	-	646,091	2,218,942
Interest	60,249	27,918	8,028	1,186	-	97,381
Donations	-	-	1,190	-	-	1,190
Loddon Mallee Rural Health Alliance	309,604	-	-	-	-	309,604
Other Revenue from Operating Activities	189,433	23,541	31,894	1,046	-	245,914
Total Revenue from Operating Activities	**7,453,666**	**3,436,445**	**929,658**	**3,301**	**747,579**	**12,570,649**
Revenue from Non-Operating Activities						
Catering	-	-	-	-	110,534	110,534
Property Income	-	-	-	-	105,167	105,167
Other	-	-	-	-	10,187	10,187
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**-**	**225,888**	**225,888**
Revenue from Capital Purpose Income						
Capital Redevelopment Funding	69,945	-	-	-	-	69,945
Donations	-	-	-	-	122,848	122,848
Long Service Leave Gain/Loss on Revaluation	-	-	-	-	10,415	10,415
Net Gain/(Loss) on Disposal of Non-Financial Assets (refer note 7.2)	-	-	-	-	12,469	12,469
Total Revenue from Capital Purpose Income	**69,945**	**-**	**-**	**-**	**145,732**	**215,677**
Total Revenue	**7,523,611**	**3,436,445**	**929,658**	**3,301**	**1,119,199**	**13,012,214**

	Admitted Patients 2016 $	Residential Aged care 2016 $	Aged Care 2016 $	Primary Health 2016 $	Other 2016 $	Total 2016 $
Revenue from Operating Activities						
Government Grants	6,011,166	2,447,733	729,350	2,290	92,846	9,283,385
Indirect contributions by Department of Health	(7,971)	822	236	35	-	(6,878)
Patient & Resident Fees	796,553	698,432	211,523	-	717,131	2,423,639
Interest	51,569	23,896	6,871	1,015	-	83,351
Donations	-	-	1,988	-	-	1,988
Loddon Mallee Rural Health Alliance	347,314	-	-	-	-	347,314
Other Revenue from Operating Activities	49,750	8,038	7,883	83	-	65,754
Total Revenue from Operating Activities	**7,248,381**	**3,178,921**	**957,851**	**3,423**	**809,977**	**12,198,553**
Revenue from Non-Operating Activities						
Catering	-	-	-	-	108,111	108,111
Property Income	-	-	-	-	101,819	101,819
Other	-	-	-	-	6,118	6,118
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**-**	**216,048**	**216,048**
Revenue from Capital Purpose Income						
Capital Redevelopment Funding	1,105,095	-	-	-	-	1,105,095
Donations	-	-	-	-	301,097	301,097
Long Service Leave Gain/Loss on Revaluation	-	-	-	-	-	-
Net Gain/(Loss) on Disposal of Non-Financial Assets (refer note 7.2)	-	-	-	-	3,287	3,287
Total Revenue from Capital Purpose Income	**1,105,095**	**-**	**-**	**-**	**304,384**	**1,409,479**
Total Revenue	**8,353,476**	**3,178,921**	**957,851**	**3,423**	**1,330,409**	**13,824,080**

Indirect contributions by Department of Health and Human Services:

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

Note 2: Services Supported by Health Services Agreement and Services Supported by Hospital Community Initiatives

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

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

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

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

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

Indirect Contributions from the Department of Health and Human Services

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

Patient and Resident Fees

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

Private Practice Fees

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

Revenue from commercial activities

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

Donations and Other Bequests

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

Interest Revenue

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

Sale of investments

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

Note 2: Services Supported by Health Services Agreement and Services Supported by Hospital Community Initiatives (continued)

Category Groups

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

Admitted Patient Services (Admitted Patients) comprises all acute and subacute admitted 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, such as Home and Community Care (HACC) that are targeted to older people, people with a disability, and

Primary and Community Health comprises a range of home based, community care, counselling, physiotherapy, speech therapy, podiatry and

Residential Aged Care 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. Ie excludes all other residential services funded under the mental health program, such as mental health funded community care.

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 our services

This section provides an account of the expenses incurred by the hospital in delivering services and outputs. In Section 2, the funds that anable 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 expenses and revenue by internally managed and restricted specific purpose funds
3.3 Provisions
3.4 Superannuation

Note 3.1: Analysis of Expenses by Source

	Admitted Patients 2017 $	Residential Aged Care 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	Total 2017 $
Expenses from Operating Expenses						
Employee Expenses	4,594,900	3,071,422	955,968	89,100	466,978	9,178,368
Non Salary Labour Costs	772,381	-	-	-	-	772,381
Computer Services	483,087	94,338	27,126	4,008	10,137	618,696
Administrative Costs	225,089	117,201	50,035	14,121	101,620	508,066
Supplies and Consumables	359,792	167,466	27,172	3,050	152,718	710,198
Other Expenses from Continuing Operations	204,989	265,902	74,674	13,447	516,100	1,075,112
Total Expenses from Operating Expenses	**6,640,238**	**3,716,329**	**1,134,975**	**123,726**	**1,247,553**	**12,862,821**
Expenses from Non-Operating Expenses						
Depreciation	-	-	-	-	2,053,239	2,053,239
Loddon Mallee Rural Health Alliance	-	-	-	-	6,914	6,914
Plant purchased for Redevelopment Costing less than $1000	36,082	-	-	-	-	36,082
Total Expenses from Non Operating Expenses	**36,082**	**-**	**-**	**-**	**2,060,153**	**2,096,235**
Total Expenses	**6,676,320**	**3,716,329**	**1,134,975**	**123,726**	**3,307,706**	**14,959,056**

	Admitted Patients 2016 $	Residential Aged Care 2016 $	Aged Care 2016 $	Primary Health 2016 $	Other 2016 $	Total 2016 $
Expenses from Operating Expenses						
Employee Expenses	4,236,395	2,936,715	889,459	91,049	471,199	8,624,817
Non Salary Labour Costs	812,999	-	-	-	-	812,999
Computer Services	517,147	100,146	28,797	4,255	8,682	659,027
Administrative Costs	257,845	129,000	41,805	14,594	95,856	539,100
Supplies and Consumables	331,686	165,607	27,445	3,035	134,536	662,309
Other Expenses from Continuing Operations	122,123	264,894	80,561	15,060	540,951	1,023,589
Total Expenses from Operating Expenses	**6,278,195**	**3,596,362**	**1,068,067**	**127,993**	**1,251,224**	**12,321,841**
Expenses from Non-Operating Expenses						
Depreciation	-	-	-	-	1,775,686	1,775,686
Loddon Mallee Rural Health Alliance	-	-	-	-	62,654	62,654
Plant purchased for Redevelopment Costing less than $1000	305,062	-	-	-	-	305,062
Total Expenses from Non Operating Expenses	**305,062**	**-**	**-**	**-**	**1,838,340**	**2,143,402**
Total Expenses	**6,583,257**	**3,596,362**	**1,068,067**	**127,993**	**3,089,564**	**14,465,243**

Note 3: The cost of delivering our services.

Expense Recognition

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

Cost of Goods Sold

Cost 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 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.

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 are recognised as an expense in the reporting period in which they are incurred.

Bad and Doubtful Debts

Refer to Note 4 Impairment of financial assets.

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

Contributions of resources provided or received free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them, irrespective of whether restrictions or conditions are imposed over the use of the contributions, unless received from another entity or agency as a consequence of a restructuring of administrative arrangements. In the latter case, such transfer will be recognised at carrying value.

Contributions in the form of services are only recognised when a fair value can be reliably determined and the services would have been purchased if not donated.

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:

Revaluation gains/(losses) of non financial physical assets

Refer Note 4 Revaluations of non financial physical assets.

Note 3: The cost of delivering our services.

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

Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal and is the difference between the proceeds and the carrying value of the asset at that 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 Note 4); and
- disposals of financial assets and derecognition of financial liabilities

Revaluations of financial instrument at fair value

Refer Note 7.1 Financial Instruments.

Share of net profits/(losses) of associates and joint entities, excluding dividends

Refer Note 1 (d) Principles on consolidation.

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

	2017 $	2016 $
Commercial Activities		
Property Expenses	176,864	143,671
Provision of Accommodation	29,705	30,452
Catering Services	162,963	160,445
TOTAL	**369,532**	**334,568**

Note 3.3: Employee benefits in the balance sheet

	2017 $	2016 $
Current Provisions		
Employee Benefits (i)		
Annual Leave		
- Unconditional and expected to be settled within 12 months (ii)	752,807	681,628
- Unconditional and expected to be settled after 12 months (iii)	116,579	197,140
Long Service Leave		
- Unconditional and expected to be settled within 12 months (ii)	159,985	143,037
- Unconditional and expected to be settled after 12 months (iii)	989,768	994,899
Accrued Salary and Wages/ADO's		
- Unconditional and expected to be settled within 12 months (ii)	333,824	299,926
- Unconditional and expected to be settled after 12 months (iii)	-	-
	2,352,963	2,316,630
Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months (ii)	128,261	130,310
- Unconditional and expected to be settled after 12 months (iii)	113,740	115,556
	242,001	245,866
Total Current Provisions	**2,594,964**	**2,562,496**
Non-Current Provisions		
Employee Benefits (iii)	297,264	252,117
Provisions related to Employee Benefit On-Costs	31,064	26,346
Total Non-Current Provisions	**328,328**	**278,463**
Total Provisions	**2,923,292**	**2,840,959**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Unconditional LSL Entitlements	1,269,902	1,256,850
Annual Leave Entitlements	990,418	1,004,591
Accrued Wages and Salaries	326,088	289,666
Accrued Days Off	8,556	11,389
	2,594,964	**2,562,496**
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements (iii)	328,328	278,463
Total Employee Benefits and Related On-Costs	**2,923,292**	**2,840,959**

(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.

(b) Movements in provisions	2017 $'000	2016 $'000
Movement in Long Service Leave:		
Balance at start of year	**1,535,313**	**1,477,433**
Provision made during the year	200,480	180,733
Revaluations made during the year	10,415	-
Settlement made during the year	(147,978)	(122,853)
Balance at end of year	**1,598,230**	**1,535,313**

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 is the time value of money and risks specific to the provision.

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

Employee Benefits

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

Wages and Salaries, Annual Leave, Sick Leave and Accrued Days Off

Liabilities for wages and salaries, including non-monetary benefits, annual leave, accumulating sick leave and accrued days off which are expected to be settled within 12 months of the reporting date are 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)

The liability for LSL is recognised in the provision for employee benefits.

Unconditional LSL (representing 10 or more years of continuous service) is disclosed in the notes to the financial statements as a current liability even where Kerang District Health 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.

The components of this current LSL liability are measured at:

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

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

Any gain or loss following revaluation of the present value of non-current LSL liability is recognised as a transaction, except to the extent that a gain or loss arises due to changes in bond interest rates for which it is then recognised as an other economic flow.

Termination Benefits

Termination benefits are payable when employment is terminated before the normal retirement date or when an employee accepts voluntary redundancy in exchange for these benefits.

Provisions (continued)

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. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

Employee benefit on-costs

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

Note 3.4: Superannuation

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

The Health Service does not recognise any defined benefit liability in respect of the plan 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 items.

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

Defined contribution superannuation plans
In relation to odefined contributions (i.e. accumulation) superannuation plan, 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 contribution made by the Health Service to the superannuation plans in respect of 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 Kerang District Health are entitled to receive superannuation benefits and Kerang District Health contributes to both the defined benefit and defined contribution plans. The defined benefit plans provide benefits based on years of service and final average salary.

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

	Paid Contribution for the Year		Contributions outstanding at Year End	
	2017 $	**2016 $**	**2017 $**	**2016 $**
(i) Defined benefit plans:				
Health Super	18,923	20,739	1,474	1,534
Defined contribution plans:				
Health Super	654,907	631,395	50,650	35,557
Hesta	102,000	98,269	7,007	8,005
Total	**775,830**	**750,403**	**59,131**	**45,096**

(i) The bases for determining the level of contributions is determined by the actuary of the defined benefit superannuation plan.

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 the delivery of those outputs.

Structure

4.1 Investments
4.2Property, plant and equipment
4.3 Depreciation

Note 4.1: Investments and other Financial Assets

	Operating Fund		Total	
	2017 $	**2016 $**	**2017 $**	**2016 $**
CURRENT				
Loans and Receivables				
Aust. Dollar Term Deposits > 3 months	2,145,242	2,208,798	2,145,242	2,208,798
Total Current	2,145,242	2,208,798	2,145,242	2,208,798
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**2,145,242**	**2,208,798**	**2,145,242**	**2,208,798**
Represented by:				
Investments - Health service	1,980,785	1,999,616	1,980,785	1,999,616
Investments - Loddon Mallee Rural Health Alliance	164,457	209,182	164,457	209,182
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**2,145,242**	**2,208,798**	**2,145,242**	**2,208,798**

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

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

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 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:

- Loans and receivables; and
- Available for sale financial assets.

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

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 flow 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 as transferred control of the asset.

Impairment of Financial Assets

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

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

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: Property, Plant and Equipment

(a) Gross carrying amount and accumulated depreciation

	2017 $	2016 $
Land		
Land at Fair Value	780,000	780,000
Total Land	**780,000**	**780,000**
Buildings		
Buildings Under Construction at cost	2,599,555	631,794
Buildings at Fair Value	31,710,542	31,688,853
Less Accumulated Depreciation	3,782,018	2,166,893
Total Buildings	**30,528,079**	**30,153,754**
Plant and Equipment		
Plant and Equipment at Fair Value	861,498	815,508
Less Accumulated Depreciation	493,891	386,930
Total Plant and Equipment	**367,607**	**428,578**
Medical Equipment		
Medical Equipment at Fair Value	1,542,888	1,470,906
Less Accumulated Depreciation	796,022	632,334
Total Medical Equipment	**746,866**	**838,572**
Computers and Communications		
Loddon Mallee Rural Health Alliance Assets at Fair Value	33,386	36,734
Less Accumulated Depreciation	27,254	28,071
Computers and Communication at Fair Value	372,174	314,109
Less Accumulated Depreciation	268,999	226,830
Total Computers and Communications Assets	**109,307**	**95,942**
Motor Vehicles		
Motor Vehicles at Fair Value	589,492	589,242
Less Accumulated Depreciation	373,001	333,320
Total Motor Vehicles	**216,491**	**255,922**
Furniture and fittings		
Furniture and fittings at Fair value	244,924	244,924
Less Accumulated Depreciation	196,186	180,211
Total Furniture & Fittings	**48,738**	**64,713**
TOTAL	**32,797,088**	**32,617,481**

Note 4.2: Property, Plant and Equipment (cont)

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

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

	Land	Buildings	Plant & Equipment	Computers	Medical Equipment	Motor Vehicles	Furniture & Fittings	Work in Progress	Total
	$	$	$	$	$	$	$	$	$
Balance at 1 July 2015	**780,000**	**10,402,551**	**519,363**	**79,124**	**595,043**	**234,403**	**62,946**	**16,613,391**	**29,286,821**
Additions	-	-	19,211	54,914	389,063	142,483	21,125	4,518,403	5,145,199
Assets Transferred from Work in Progress	-	20,500,000	-	-	-	-	-	(20,500,000)	-
Disposals	-	-	-	-	-	(39,677)	-	-	(39,677)
Loddon Mallee Rural Health Alliance	-	-	-	(10,392)	-	-	-	-	(10,392)
Revaluation Increments/(Decrements)	-	-	-	-	-	-	-	-	-
Depreciation (note 4.3)	-	(1,380,591)	(109,996)	(27,704)	(145,534)	(81,287)	(19,358)	-	(1,764,470)
Balance at 1 July 2016	**780,000**	**29,521,960**	**428,578**	**95,942**	**838,572**	**255,922**	**64,713**	**631,794**	**32,617,481**
Additions	-	21,689	45,991	58,065	98,882	38,555	-	1,781,718	2,044,900
Assets Transferred as Capital Contributed	-	-	-	-	-	-	-	186,043	186,043
Assets Transferred from Work in Progress	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(257)	-	-	-	(257)
Loddon Mallee Rural Health Alliance	-	-	-	(2,531)	-	-	-	-	(2,531)
Revaluation Increments/(Decrements)	-	-	-	-	-	-	-	-	-
Depreciation (note 4.3)	-	(1,615,125)	(106,962)	(42,169)	(190,331)	(77,986)	(15,975)	-	(2,048,548)
Balance at 30 June 2017	**780,000**	**27,928,524**	**367,607**	**109,307**	**746,866**	**216,491**	**48,738**	**2,599,555**	**32,797,088**

Land and buildings carried at valuation

An independent valuation of Kerang District Health Service's land and buildings was performed by *the Valuer-General Victoria* to determine the fair value of the land and buildings as at 30 June 2014. 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.

Note 4.2: Property, Plant and Equipment (cont)

(c) Fair value measurement hierarchy for assets as at 30 June 2017

	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	780,000	-	-	780,000
Total of land at fair value	**780,000**	**-**	**-**	**780,000**
Buildings at fair value				
Specialised buildings	27,928,524	-	-	27,928,524
Total of building at fair value	**27,928,524**	**-**	**-**	**27,928,524**
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles	216,491	-	216,491	-
- Plant and equipment	525,652	-	-	525,652
- Medical Equipment	746,866	-	-	746,866
Total of plant, equipment and vehicles at fair value	**1,489,009**	**-**	**216,491**	**1,272,518**
Assets under construction at fair value				
Redevelopment	2,599,555	-	-	2,599,555
Total assets under construction at fair value	**2,599,555**	**-**	**-**	**2,599,555**
	32,797,088	**-**	**216,491**	**32,580,597**

	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	780,000	-	-	780,000
Total of land at fair value	**780,000**	**-**	**-**	**780,000**
Buildings at fair value				
Specialised buildings	29,521,960	-	-	29,521,960
Total of building at fair value	**29,521,960**	**-**	**-**	**29,521,960**
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles	255,922	-	255,922	-
- Plant and equipment	589,233	-	-	589,233
- Medical Equipment	838,572	-	-	838,572
Total of plant, equipment and vehicles at fair v	**1,683,727**	**-**	**255,922**	**1,427,805**
Assets under construction at fair value				
Redevelopment	631,794	-	-	631,794
Total assets under construction at fair value	**631,794**	**-**	**-**	**631,794**
	32,617,481	**-**	**255,922**	**32,361,559**

Note
[1] Classified in accordance with the fair value hierarchy.

There have been no transfers between levels during the period.

Specialised land and specialised buildings

The market approach is used for specialised land and specialised buildings although 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

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.

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

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

Vehicles

The Health Service acquires new vehicles and at times disposes of them before completion of their economic life. The process of acquistion, 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 the vehicle 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 the current replacement costs are significantly different from the original acquisiton 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.

Property, plant and equipment

Consistent with AASB 13 *Fair Value Measurement* , Kerang District Health determines the ploicies 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 relevant FRD's.

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

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

For the purposes of fair value, Kerang District Health has determined classes of assets and liabilities on the basis of the nature, characteristics and risks of the asset or liability and the level of the fair value hierarchy as explained above.

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

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

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

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.

Note 4.2: Property, Plant and Equipment (cont)

(d) Reconciliation of Level 3 fair value 2017

	Land	Buildings	Plant and equipment	Computers	Furniture & Fittings	Medical equipment	Assets under construction
	$	$	$	$	$	$	$
Opening Balance	780,000	29,521,960	428,578	95,942	64,713	838,572	631,794
Purchases	-	21,689	45,991	58,065	-	98,882	1,967,761
Transfers in (out)	-	-	-	-	-	-	-
Gains or losses recognised in net result							
- Loddon Mallee Rural Health Alliance			-	(2,531)	-	-	-
- Disposals	-	-	-	-	-	(257)	-
- Depreciation	-	(1,615,125)	(106,962)	(42,169)	(15,975)	(190,331)	-
Subtotal	**780,000**	**27,928,524**	**367,607**	**109,307**	**48,738**	**746,866**	**2,599,555**
Items recognised in other comprehensive income							
- Revaluation	-	-	-	-	-	-	-
Subtotal	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Closing Balance	**780,000**	**27,928,524**	**367,607**	**109,307**	**48,738**	**746,866**	**2,599,555**

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

(d) Reconciliation of Level 3 fair value 2016

	Land	Buildings	Plant and equipment	Computers	Furniture & Fittings	Medical equipment	Assets under construction
	$	$	$	$	$	$	$
Opening Balance	780,000	10,402,551	519,363	79,124	62,946	595,043	16,613,391
Purchases	-	-	19,211	54,914	21,125	389,063	4,518,403
Transfers in (out)	-	20,500,000	-	-	-	-	(20,500,000)
Gains or losses recognised in net result							
- Loddon Mallee Rural Health Alliance			-	(10,392)	-	-	-
- Disposals	-	-	-	-	-	-	-
- Depreciation	-	(1,380,591)	(109,996)	(27,704)	(19,358)	(145,534)	-
Subtotal	**780,000**	**29,521,960**	**428,578**	**95,942**	**64,713**	**838,572**	**631,794**
Items recognised in other comprehensive income							
- Revaluation	-	-	-	-	-	-	-
Subtotal	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Closing Balance	**780,000**	**29,521,960**	**428,578**	**95,942**	**64,713**	**838,572**	**631,794**

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

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.

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.

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.

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 in equity to the asset revaluation surplus, except that, to the extent that an increment reverses a revaluation decrement in respect of that same class of asset previously recognised as an expense in net the 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 are not normally transferred to accumulated funds on derecognition of the relevant asset.

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

Property, plant and equipment (continued)

Assets with a cost in excess of $1,000 ($1000 in 2015-2016) 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 usefule lives of non-current assets on which the depreciation charges are based.

	2017	2016
Buildings		
- Structure Shell Building Fabric	5 to 33 years	5 to 33 years
- Site Engineering Services and Central Plant	5 to 30 years	5 to 30 years
- Fit Out	8 to 40 years	8 to 40 years
- Trunk Reticulated Building Systems	30 to 40years	30 to 40years
Plant & Equipment	3 to 7 years	3 to 7 years
Medical Equipment	7 to 10 years	7 to 10 years
Computers and Communication	4 years	4 years
Furniture & Fittings	13 years	13 years
Motor Vehicles	2 to 10 years	2 to 10 years

The estimated useful lives, residual values and depreciation methods are reviewed at the end of each annual reporting period, and adjustments made where appropriate.

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

Note 4.2: Property, Plant and Equipment (cont)

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

	Valuation technique	Significant unobservable inputs
Specialised land	Market approach	Community Service Obligation (CSO) adjustment
Specialised buildings including buildings under construction.	Depreciated replacement cost	Direct cost per square metre Useful life of specialised buildings
Furniture, computer, plant and equipment at fair value	Depreciated replacement cost	Cost per unit Useful life of PPE
Medical equipment at fair value	Depreciated replacement cost	Cost per unit Useful life of cultural assets

The significant unobservable inputs remain unchanged from 2016.

Note 4.3: Depreciation

	2017 $	2016 $
Depreciation		
Buildings	1,615,125	1,380,592
Plant and equipment	106,962	109,996
LMRHA Assets	4,691	11,215
Computers and Communication	42,169	27,704
Medical Equipment	190,331	145,534
Motor Vehicles	77,986	81,287
Furniture and Fittings	15,975	19,358
Total Depreciation	**2,053,239**	**1,775,686**

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

Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives, residual value and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health and Human Services. Assets with a cost in excess of $1000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

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 Othe liabilities
5.4 Prepayments and other assets
5.5 Payables

Note 5.1: Receivables

	2017 $	2016 $
CURRENT		
Contractual		
Trade Debtors - Health Service	176,968	123,485
Less Allowance for Doubtful Debts	(5,000)	(5,000)
Patient Fees	68,588	125,974
Accrued Investment Income	18,211	18,787
Accrued Revenue - Other	16,748	8,463
Receivables - Loddon Mallee Rural Health Alliance	7,620	7,054
	283,135	**278,763**
Statutory		
GST Receivable - Health Service	62,940	68,755
GST Receivable - Loddon Mallee Rural Health Alliance	5,050	4,407
	67,990	**73,162**
TOTAL CURRENT RECEIVABLES	**351,125**	**351,925**
NON CURRENT		
Statutory		
Long Service Leave - Department of Health	430,902	355,270
	430,902	**355,270**
TOTAL NON-CURRENT RECEIVABLES	**430,902**	**355,270**
TOTAL RECEIVABLES	**782,027**	**707,195**

(a) Movement in the Allowance for doubtful debts

	2017 $'000	2016 $'000
Balance at beginning of year	5,000	5,000
Balance at end of year	**5,000**	**5,000**

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

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

Receivables

Receivables consist of:

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

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

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

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

Note 5.2: Inventories

	2017 $	2016 $
Pharmaceuticals		
At cost	50,525	54,570
Catering Supplies		
At cost	6,892	2,792
Housekeeping Supplies		
At cost	10,337	4,189
Medical and Surgical Lines		
At cost	38,592	15,637
Engineering Stores		
At Cost	2,067	838
Administration Stores		
At Cost	11,027	4,468
Loddon Mallee Rural Health Alliance		
At Cost	1,777	863
TOTAL INVENTORIES	**121,217**	**83,357**

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 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.

Note 5.3: Other Liabilities

	2017 $	2016 $
CURRENT		
Monies Held in Trust		
- Patient Monies Held in Trust	500	500
- refundable Accommodation Deposits	1,809,705	942,040
Total Current	**1,810,205**	**942,540**
Total Monies Held in Trust		
Represented by the following assets:		
Cash Assets (refer to Note 6.1)	1,810,205	942,540
TOTAL	**1,810,205**	**942,540**

Note 5.4: Prepayments and Other Assets

	2017	2016
CURRENT	**$**	**$**
Prepayments - Health Service	208,398	210,875
Prepayments - Loddon Mallee Rural Health Alliance	26,187	22,678
TOTAL CURRENT OTHER ASSETS	**234,585**	**233,553**
TOTAL OTHER ASSETS	**234,585**	**233,553**

Note 5.5: Payables

	2017 $	2016 $
CURRENT		
Contractual		
Trade Creditors - Health Service	630,402	417,727
Payables - Loddon Mallee Rural Health Alliance	50,912	47,241
Accrued Audit Fees	15,100	14,700
Accrued Expenses	20,808	42,667
Other	-	-
	717,222	**522,335**
Statutory		
FBT Payable	-	-
Department of Health	-	-
	-	**-**
TOTAL CURRENT	**717,222**	**522,335**

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

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

Payables consist of:

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

- statutory payables, such as goods and services tax and fringe benefits tax payables.

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

Note 6: How we finance our operations

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

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

Structure

Note 6.1: Cash and Cash Equivalents

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

		2017 $	2016 $
Cash on Hand		1,100	900
Cash at Bank		2,432,394	1,882,387
Bond held on Rental properties		1,160	1,160
Total Cash and Cash Equivalents		**2,434,654**	**1,884,447**
Represented by:			
Cash for Health Service Operations (as per Cash Flow Statement)		552,379	933,627
Cash for Loddon Mallee Rural Health Alliance		72,070	8,280
Cash for Monies Held in Trust			
- Cash at Bank	5.3	1,810,205	942,540
Total Cash and Cash Equivalents		**2,434,654**	**1,884,447**

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

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

Note 6.2: Commitments

Kerang District Health currently has a capital commitment of approximately $500,000 to complete the redevelopment project. The funds for this project are held by the Department of Health and not Kerang District Health.

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

Note 7: Risks, contingencies and valuation uncertanties

The hospital in exposed to riskfrom 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 exposure to financial risks) as well as those that are contingent in nature or require a higher level of judgement to be applied, which for the hospital is related mainly to fair value determination.

Structure

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

Note 7.1: Financial Instruments

(a) Financial risk management objectives and policies

Kerang District Health 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 these notes to the financial statements.

The Health Service's main financial risks include credit 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 finance committee of the Health Service.

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

Categorisation of financial instruments
Details of each categories in accordance with AASB 139, is disclosed either on the face of the balance sheet or in the notes.

2017	Contractual financial assets - loans and receivables	Contractual financial liabilities at amortised cost	Total
	$	$	$
Contractual Financial Assets			
Cash and cash equivalents	2,434,654	-	2,434,654
Receivables			
- Trade Debtors	245,556	-	245,556
- Other Receivables	37,579	-	37,579
Other Financial Assets			-
- Term Deposits	2,145,242	-	2,145,242
Total Financial Assets [(i)]	**4,863,031**	**-**	**4,863,031**
Financial Liabilities			
Payables	-	717,222	717,222
Other financial liabilities			
- Monies held in trust	-	1,810,205	1,810,205
Total Financial Liabilities [(ii)]	**-**	**2,527,427**	**2,527,427**

Note 7.1: Financial Instruments

2016	Contractual financial assets - loans and receivables	Contractual financial liabilities at amortised cost	Total
	$	$	$
Contractual Financial Assets			
Cash and cash equivalents	1,884,447	-	1,884,447
Receivables			
- Trade Debtors	249,459	-	249,459
- Other Receivables	29,304	-	29,304
Other Financial Assets			
- Term Deposits	2,208,798	-	2,208,798
Total Financial Assets [(i)]	**4,372,008**	**-**	**4,372,008**
Financial Liabilities			
Payables	-	522,335	522,335
Other financial liabilities			
- Monies held in trust	-	942,540	942,540
Total Financial Liabilities [(ii)]	**-**	**1,464,875**	**1,464,875**

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

(ii) The total amount of financial liabilities disclosed here excludes statutory payables (i.e. Taxes payable).

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

	Net holding gain/(loss) 2017 $	Net holding gain/(loss) 2016 $
Financial Assets		
Cash and Cash Equivalents [(i)]	-	**-**
Loans and Receivables [(i)]	97,381	83,352
Total Financial Assets	**97,381**	**83,352**
Financial Liabilities		
At Amortised Cost	-	-
Total Financial Liabilities	**-**	**-**

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

Note 7.1: Financial Instruments (continued)

(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 *Kerang District Health Service*'s maximum exposure to credit risk without taking account of the value of any collateral obtained.

Credit quality of contractual financial assets that are neither past due nor impaired

	Financial Institutions (BBB credit rating)	Other	Total
2017	**$**	**$**	**$**
Financial Assets			
Cash and Cash Equivalents	2,434,654	-	2,434,654
Receivables			
- Trade Debtors	-	245,556	245,556
- Other Receivables (i)	-	37,579	37,579
Other Financial Assets			
- Term Deposit	2,145,242	-	2,145,242
Total Financial Assets	**4,579,896**	**283,135**	**4,863,031**
2016			
Financial Assets			
Cash and Cash Equivalents	1,884,447	-	1,884,447
Receivables			
- Trade Debtors	-	249,459	249,459
- Other Receivables	-	29,304	29,304
Other Financial Assets			
- Term Deposit	2,208,798	-	2,208,798
Total Financial Assets	**4,093,245**	**278,763**	**4,372,008**

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

Note 7.1: Financial Instruments (continued)

(c) Credit Risk (continued)

Ageing analysis of Financial Assets as at 30 June

	Carrying Amount	Not Past Due and Not Impaired	Past Due But Not Impaired				Impaired Financial Assets
			Less than 1 Month	1-3 Months	3 months - 1 Year	1-5 Years	
2017	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Financial Assets							
Cash and Cash Equivalents	2,434,654	2,434,654	-	-	-	-	-
Receivables (i)							
- Trade Debtors	245,556	178,968	17,984	6,661	41,943	-	5,000
- Other Receivables	37,579	37,579	-	-	-	-	-
Other Financial Assets							
- Term Deposit	2,145,242	2,145,242	-	-	-	-	-
Total Financial Assets	**4,863,031**	**4,796,443**	**17,984**	**6,661**	**41,943**	**-**	**5,000**
2016							
Financial Assets							
Cash and Cash Equivalents	1,884,447	1,884,447	-	-	-	-	-
Receivables (i)							
- Trade Debtors	249,459	219,298	12,769	15,443	1,948	-	5,000
- Other Receivables	29,304	29,304	-	-	-	-	-
Other Financial Assets							
- Term Deposit	2,208,798	2,208,798	-	-	-	-	-
Total Financial Assets	**4,372,008**	**4,341,847**	**12,769**	**15,443**	**1,948**	**-**	**5,000**

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

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

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

Note 7.1: Financial Instruments (continued)

(d) Liquidity risk

Liquidity risk is the risk that the Health Service would be unable to meet its financial obligations as and when they fall due. The Health Service operates under the Government's fair payment policy of settling financial obligations within 30 days and in the event of a dispute 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 Kerang District Health's financial liabilities. For interest rates applicable to each class of liability refer to individual notes to the financial statements.

Maturity analysis of Financial Liabilities as at 30 June 2017

	Carrying Amount	Nominal Amount	Maturity Dates			
			Less than 1 Month	1-3 Months	3 months - 1 Year	1-5 Years
2017	**$**	**$**	**$**	**$**	**$**	**$**
Financial Liabilities						
Payables	717,222	717,222	717,222	-	-	-
Other Financial Liabilities (i)						
- Monies Held in Trust	1,810,205	1,810,205	-	-	1,810,205	-
Total Financial Liabilities	**2,527,427**	**2,527,427**	**717,222**	**-**	**1,810,205**	**-**
2016						
Financial Liabilities						
Payables	522,335	522,335	522,335	-	-	-
Other Financial Liabilities (i)						
- Monies Held in Trust	942,540	942,540	-	-	942,540	-
Total Financial Liabilities	**1,464,875**	**1,464,875**	**522,335**	**-**	**942,540**	**-**

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

Note 7.1: Financial Instruments (continued)

(e) Market risk

Kerang District 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

Kerang District 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.

Interest rate risk

Exposure to interest rate risk might arise primarily through the *Kerang District Health Service's* interest bearing liabilities. Minimisation of risk is achieved by mainly undertaking 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 rates 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 realtively 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 movement in rates as required.

Interest rate exposure of financial assets and liabilities as at 30 June 2017

	Weighted Average Effective Interest	Carrying Amount	Interest Rate Exposure		
			Fixed Interest Rate	Variable Interest Rate	Non-Interest Bearing
2017	**Rate (%)**	**$**	**$**	**$**	**$**
Financial Assets					
Cash and Cash Equivalents	1.00	2,434,654	-	2,433,754	900
Receivables[(i)]					
- Trade Debtors		245,556	-	-	245,556
- Other Receivables		37,579	-	-	37,579
Other Financial Assets					
- Term Deposit	2.45	2,145,242	2,145,242	-	-
Total Financial Assets		**4,863,031**	**2,145,242**	**2,433,754**	**284,035**
Financial Liabilities					
Payables[(i)]		717,222	-	-	717,222
Other Financial Liabilities					
- Monies Held in Trust		1,810,205	-	-	1,810,205
Total Financial Liabilities		**2,527,427**	**-**	**-**	**2,527,427**
2016					
Financial Assets					
Cash and Cash Equivalents	1.00	1,884,447	-	1,883,547	900
Receivables[(i)]					
- Trade Debtors		249,459	-	-	249,459
- Other Receivables		29,304	-	-	29,304
Other Financial Assets					
- Term Deposit	2.86	2,208,798	2,208,798	-	-
Total Financial Assets		**4,372,008**	**2,208,798**	**1,883,547**	**279,663**
Financial Liabilities					
Payables[(i)]		522,335	-	-	522,335
Other Financial Liabilities					
- Monies Held in Trust		942,540	-	-	942,540
Total Financial Liabilities		**1,464,875**	**-**	**-**	**1,464,875**

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

Note 7.1: Financial Instruments (continued)

(e) Market risk (continued)

Sensitivity disclosure analysis

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, the *Kerang District 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 +1% and -1% in market interest rates (AUD) from year-end rates of 2.5%;
- A parallel shift of +1% and -1% in inflation rate from year-end rates of 2%

The following table discloses the impact on net operating result and equity for each category of financial instrument held by *Kerang District 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%	-1%	-1%	+1%	+1%
		Profit	Equity	Profit	Equity	Profit	Equity	Profit	Equity
2017	**$**	**$**	**$**	**$**	**$**	**$**	**$**	**$**	**$**
Financial Assets									
Cash and Cash Equivalents	2,434,654	(24,347)	(24,347)	24,347	24,347	-	-	-	-
Receivables									
- Trade Debtors	245,556	-	-	-	-	-	-	-	-
- Other Receivables	37,579	-	-	-	-	-	-	-	-
Other Financial Assets									
- Term Deposit	2,145,242	(21,452)	(21,452)	21,452	21,452	-	-	-	-
Financial Liabilities									
Payables	717,222	-	-	-	-	-	-	-	-
Other Financial Liabilities	-	-	-	-	-	-	-	-	-
- Monies Held in Trust	1,810,205	-	-	-	-	-	-	-	-
		(45,799)	**(45,799)**	**45,799**	**45,799**	**-**	**-**	**-**	**-**
2016									
Financial Assets									
Cash and Cash Equivalents	1,884,447	(18,844)	(18,844)	18,844	18,844	-	-	-	-
Receivables									
- Trade Debtors	249,459	-	-	-	-	-	-	-	-
- Other Receivables	29,304	-	-	-	-	-	-	-	-
Other Financial Assets									
- Term Deposit	2,208,798	(22,088)	(22,088)	22,088	22,088	-	-	-	-
Financial Liabilities									
Payables	522,335	-	-	-	-	-	-	-	-
Other Financial Liabilities									
- Monies Held in Trust	942,540	-	-	-	-	-	-	-	-
		(40,932)	**(40,932)**	**40,932**	**40,932**	**-**	**-**	**-**	**-**

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

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

Comparison between carrying amount and fair value

	Total Carrying Amount	Fair value	Total Carrying Amount	Fair value
	2017 $	2017 $	2016 $	2016 $
Financial Assets				
Cash and Cash Equivalents	2,434,654	2,434,654	1,884,447	1,884,447
Receivables[(i)]				
- Trade Debtors	245,556	245,556	249,459	249,459
- Other Receivables	37,579	37,579	29,304	29,304
Other Financial Assets				
- Term Deposit	2,145,242	2,145,242	2,208,798	2,208,798
Total Financial Assets	**4,863,031**	**4,863,031**	**4,372,008**	**4,372,008**
Financial Liabilities				
Payables	717,222	717,222	522,335	522,335
Other Financial Liabilities (i)				
- Monies Held in Trust	1,810,205	1,810,205	942,540	942,540
- Other	-	-	-	-
Total Financial Liabilities	**2,527,427**	**2,527,427**	**1,464,875**	**1,464,875**

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

Financial Instruments

Financial Instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of the Kerang District Health's activities, certain financial assets and financial liabilities arise under statue 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.

Categorised non-derivative financial instruments

Loans and Receivables

Loans and receivables are financial instrument assets with fixed and determinable payments that are not quoted on an active market. These assets are initially recognised at fair value plus any directly attributable transactions 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 1(j)), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

Financial Liabilities at amortised cost

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

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

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

	2017 $	2016 $
Proceeds from Disposals of Non-Current Assets		
Medical Equipment	3,636	-
Motor Vehicles	9,091	42,964
Total Proceeds from Disposal of Non-Current Assets	**12,727**	**42,964**
Less: Written Down Value of Non-Current Assets Sold		
Medical Equipment	258	-
Motor Vehicles	-	39,677
Total Written Down Value of Non-Current Assets Sold	**258**	**39,677**
Net gain on Disposal of Non-Financial Assets	**12,469**	**3,287**

Disposal of non-financial assets

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

Impairment of non-financial assets

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

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

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

There are no known contingent assets or liabilities as at the date of this report.

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

Note 7.4: Fair vaue determination

Asset class	Examples of types of assets	Expected fair value level	Likely valuation approach	Significant inputs (level 3 only)
Non-specialised land	In areas where there is an active market: - Vacant land - land not subject to restrictions as to use or sale	Level 2	Market approach	N/A
Specialised land	Land subject to restrictions as to use and/or sale Land in areas where there is not an active market	Level 3	Market approach	CSO adjustments
Non specialsed buildings	For general/commercial buildings that are just built	Level 2	Market approach	N/A
Specialised buildings	Specialised buildings with limited alternative uses and/or substantial customisation e.g. hospitals & schools	Level 3	Depreciated replacement cost approach	Useful life
Dwellings	social/public housing/ employee housing	Level 2	Market approach	N/A
Infrastructure	Any type	Level 3	Depreciated replacement cost approach	Useful life
Plant & Equipment	Specialised items with limited alternative uses and/or substantial customisaton	Level 3	Depreciated replacement cost approach	Useful life
Vehicles	motor vehicles	Level 2	Depreciated replacement cost approach	N/A

Note 8: Other disclosures

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

Structure

Note 8.1: Equity

	2017 $	2016 $
(a) Surpluses		
Property, Plant and Equipment Revaluation Surplus		
Balance at the beginning of the reporting period	5,112,575	5,112,575
Revaluation Increment		
- Land	-	-
- Buildings	-	-
Balance at the end of the reporting period*	**5,112,575**	**5,112,575**
* Represented by:		
- Land	367,826	367,826
- Buildings	4,744,749	4,744,749
	5,112,575	**5,112,575**
Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	105,000	105,000
Balance at the end of the reporting period	**105,000**	**105,000**
Total Surpluses	**5,217,575**	**5,217,575**
(b) Contributed Capital		
Balance at the beginning of the reporting period	16,846,707	12,216,722
Capital Contrinbution received from Victorian Government	1,581,939	4,629,985
Balance at the end of the reporting period	**18,428,646**	**16,846,707**
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	11,364,716	12,005,879
Net Result for the Year	(1,946,842)	(641,163)
Balance at the end of the reporting period	**9,417,873**	**11,364,716**
Total Equity at end of financial year	**33,064,094**	**33,428,998**

Contributed Capital

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

Specific Restricted Purpose Surplus

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

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

	2017 $	2016 $
Net Result for the Year	(1,946,842)	(641,163)
Non Cash Movements:		
Depreciation	2,053,239	1,775,686
Share of Joint Venture	(23,186)	-
Resources/Assets Provided by the Department of Health	-	(297,475)
Movements included in Investing and Financing Activities:		
Net (Gain)/Loss from Disposal of Non Financial Physical Assets	(12,469)	(3,287)
Movements in Assets and Liabilities:		
(Increase)/Decrease in Receivables	(73,623)	20,997
(Increase)/Decrease in Prepayments	2,477	3,672
Increase/(Decrease) in Payables	191,216	(216,689)
Increase/(Decrease) in Provisions	82,333	90,964
Increase/(Decrease) in Inventories	(36,947)	(5,641)
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**236,198**	**727,064**

Note 8.3: Operating Segments

	HEALTH SERVICES		RACS		OTHER SERVICES		TOTAL	
	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $
REVENUE								
External Segment Revenue	8,758,727	9,775,727	3,408,527	3,155,025	747,579	809,977	12,914,833	13,740,729
Intersegment Revenue	-	-	-	-	-	-	-	-
Total Revenue	**8,758,727**	**9,775,727**	**3,408,527**	**3,155,025**	**747,579**	**809,977**	**12,914,833**	**13,740,729**
EXPENSES								
External Segment Expenses	(9,837,533)	(9,408,967)	(3,828,839)	(3,708,872)	(1,287,993)	(1,347,404)	(14,954,365)	(14,465,243)
Total Expenses	**(9,837,533)**	**(9,408,967)**	**(3,828,839)**	**(3,708,872)**	**(1,287,993)**	**(1,347,404)**	**(14,954,365)**	**(14,465,243)**
Net Result from ordinary activities	**(1,078,806)**	**366,760**	**(420,312)**	**(553,847)**	**(540,414)**	**(537,427)**	**(2,039,532)**	**(724,514)**
Interest Expense	-	-	-	-	-	-	-	-
Interest Income	69,463	59,455	27,918	23,896	-	-	97,381	83,351
Net Result for Year	**(1,009,343)**	**426,215**	**(392,394)**	**(529,951)**	**(540,414)**	**(537,427)**	**(1,942,151)**	**(641,163)**
OTHER INFORMATION								
Segment Assets	17,256,113	17,107,124	4,987,562	4,949,770	-	-	22,243,675	22,056,894
Unallocated Assets	-	-	-		16,271,138	15,677,938	16,271,138	15,677,938
Total Assets	**17,256,113**	**17,107,124**	**4,987,562**	**4,949,770**	**16,271,138**	**15,677,938**	**38,514,813**	**37,734,832**
Segment Liabilities	874,062	858,260	676,875	665,114	-	-	1,550,937	1,523,374
Unallocated Liabilities			-	-	3,899,782	2,782,460	3,899,782	2,782,460
Total Liabilities	**874,062**	**858,260**	**676,875**	**665,114**	**3,899,782**	**2,782,460**	**5,450,719**	**4,305,834**
Acquisition of Property, Plant and Equipment and Intangible Assets	2,039,988	5,140,287	1,895	1,895	3,017	3,017	2,044,900	5,145,199
Depreciation & Amortisation Expense	**(1,902,512)**	**(1,629,650)**	**(112,510)**	**(112,510)**	**(33,526)**	**(33,526)**	**(2,048,548)**	**(1,764,470)**
Non Cash Expenses other than Depreciation	**62,628**	**(7,700)**	**25,171**	**822**	**(6,914)**	**(62,654)**	**80,885**	**(69,532)**

Note 8.3: Operating segments (continued)

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

Business Segments	**Services**
Health Services	Acute Hospital services Aged Care Services Primary Health Services
Residential Aged Care	Nursing Home Facility
Other	Medical Clinic

Geographical Segment

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

Note 8.4: Responsible Persons Disclosures

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

	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	1/7/2016-30/6/2017
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	1/7/2016-30/6/2017
Governing Boards	
S. Hall	1/7/2016 - 30/6/2017
L. Morris	1/7/2016 - 30/6/2017
K. Laughlin	1/7/2016 - 30/6/2017
k. Jenkins	1/7/2016 - 30/6/2017
T. Adams	1/7/2016 - 30/6/2017
J Ginnivan	1/7/2016 - 30/6/2017
K Liebmann	1/7/2016 - 30/6-2017
L Edwards	1/7/2016 - 30/6 2017
M Lane	1/7/2016 - 30/6/2017
Accountable Officer	
Mr R. Jarman	1/7/2016 - 30/6/2017

Remuneration

Remuneration received or receivable by responsible persons was in the range $0-$9,999 and $160,000 and $169,000

Responsible persons remuneration	**Total Remuneration**	
	2017	**2016 (i)**
	$	**$**
Short-term employee benefits	186,816	
Post-employment benefits	16,931	
Other long-term benefits	3,983	
Total remuneration (i) (ii)	207,730	
Total number of executives	1	
Total annualised employee equivalent (AEE) (iii)	**1**	

Note 8.5: Remuneration of executive officers

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

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

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

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

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

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

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

Remuneration of executive officers	**Total Remuneration**	
	2017	**2016 (i)**
	$	**$**
Short-term employee benefits	222,278	
Post-employment benefits	19,544	
Other long-term benefits	5,117	
Total remuneration (i) (ii)	246,939	
Total number of executives	2	
Total annualised employee equivalent (AEE) (iii)	**2**	

Notes:
(i) No comparatives have been reported because remuneration in the prior year was determined in line with the basis and definition under FRD 21B. Remuneraton previously excluded non-monetary benefits and comprised any money, consideration or benefit received or receivable, excluding reimbursement of out-of-pocket from a related party transaction. Refer to prior year's financial statements for executive remuneration for the 2015-16 reporting period.
(ii) 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 realted parties notes disclosure.
(iii) Annualised employee equivalent is based on the time fraction worked over the reporting period.

Note 8.6: Related Parties

The hospital is a wholly owned and controlled entity of the State of Victoria. Related parties of the hospital include:
- all key management personnel and their close family members;
- all cabinet ministers and their close family members; and
- all hospitals and public sector entities that are controlled and consolidated into the whole of state consolidated financial statements.

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

Key management personnel (KMP) of the hospital include the Portfolio Ministers, the board and Chief Executive Officer. The compensation detailed in note 8.4 excludes the salaries and benefits the Portfolio Ministers receive. The Ministers remuneration and allowances is set by the Parliamentary Salaries and Superannuation Act 1968, and is reported within the Department of Parliamentary Services' Financial Report.

Transactions with key management personnel and other realted 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 prcesses within the Victorian public sector occur on terms and conditions consistent with the Public Administratin 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. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

During the year, related parties of key management personnel transacted with the hospital, on terms and conditions that prevail on arm's length transactions under the hospital's procurement practices.

Entity	Key Management Personnel	Position Title	$
Northern Times	Ken Jenkins	Board member	14,993
Clinical Laboratories/St John of God Pathology	Kylie Liebmann	Board member	53,107

Significant transactions with government-related entities
Kerang District Health received funding from the Department of Health and Human Services of $7,304,995 (2016: $7,704,040).

Note 8.7: Remuneration of auditors

	2017	2016
Victorian Auditor-General's Office	**$**	**$**
Audit or review of financial statements	15,100	14,700
	15,100	**14,700**

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. Kerang District Health has not and does not intend to adopt these standards early.

Standard / Interpretation	**Summary**	**Applicable for reporting periods beginning on**	**Impact on Health Service's Annual Statements**
AASB 9 Financial Instruments	This standard simplifies Requirements for the classification and measurement of financial asset, a 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	Beginning 1-Jan-2018	The preliminary assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss. While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.
AASB 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.	Beginning 1-Jan-2018	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. Changes in own credit risk in respect of liabilities designated at fair value through profit and loss will now be presented within other comprehensive income (OCI).

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 15 Revenue from Contracts with Customers	The core principal of AASB requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	Beginning 1-Jan-2018	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications.
AASB 16 Leases	The key changes introduced by AASB 16 include the recognition of most operating leases (which are current not recognised) on balance sheet	Beginning 1-Jan-2019	The assessment has indicated that as most operating leases will come on balance sheet, recognition of the right-of-use assets and lease liabilities will cause net debt to increase. Rather than expensing the lease payments, depreciation of right-of-use assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. No change for lessors.
AASB 1058 Income of Not-for-Profit Entities	This standard replaces AASB 1004 Contributions and establishes revenue recognition principles for transactions where the consideration to acquire an asset is significantly less than fair value to enable the not-for-profit entity to further its objectives	Beginning 1-Jan-2019	The assessment has indicated that revenue from capital grants that are provided under an enforceable agreement that have sufficiently specific obligations, will now be deferred and recognised as performance obligations are satisfied. As a result, the timing recogonition or revenue will change.

Note 8.9: Events occurring after the Balance Sheet Date

There are no known events occurring after the balance sheet date as at the date of this report.

Note 8.10: Jointly Controlled Operations and Assets

Name of Entity	Principal Activitv	Ownership Interest 2017 %	Ownership Interest 2016 %
Loddon Mallee Rural Health Alliance	Information Systems	4.06	4.09

Kerang and District Health interest in assets employed in the above jointly controlled operatons and assets is detailed below. The amountsare included in the financial statements and consolidated financial statements under their respective asset categories:

	2017 $	2016 $
Current Assets		
Cash and Cash Equivalents	72,070	8,280
Other Financial Assets	164,457	209,182
Receivables	12,670	11,461
Inventory	1,777	863
Prepayments	26,187	22,678
Total Current Assets	**277,161**	**252,464**
Non Current Assets		
Property, Plant and Equipment	6,132	8,663
Total Non Current Assets	**6,132**	**8,663**
Total Assets	**283,293**	**261,127**
Current Liabilities		
Payables	44,963	42,845
Accrued Liabilities	5,949	4,396
Total Current Liabilities	**50,912**	**47,241**
Total Liabilities	**50,912**	**47,241**
Net Assets	**232,381**	**213,886**

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

	2017 $	2016 $
Revenues		
Grants	309,604	347,314
Total Revenue	**309,604**	**347,314**
Expenses		
Information Technology and Administrative Expenses	279,504	301,027
Capital Expenses	6,914	62,654
Depreciation	4,691	11,215
Total Expenses	**291,109**	**374,896**
Net Result	**18,495**	**(27,582)**

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

Note 8.11: Alternative presentation of comprehensive operating statement

	2017 $	2016 $
Interest	97,381	83,351
Sales of Goods and Services	2,449,830	2,644,687
Grants	9,767,563	10,381,602
Other current revenue	689,971	716,153
Total Revenue	**13,004,745**	**13,825,793**
Employee Expenses	9,178,368	8,624,817
Depreciation	2,053,239	1,775,686
Other Operating Expenses	3,727,449	4,064,740
Total Expenses	**14,959,056**	**14,465,243**
Net Results from transactions	**(1,954,311)**	**(639,450)**
Net Gain on sale of non-financial assets	12,469	3,287
Other gains/losses from economic flows	(5,000)	(5,000)
Total other economic flows included in net result	**7,469**	**(1,713)**
TOTAL RECEIVABLES	**(1,946,842)**	**(641,163)**

Note 8.12: Glossary of terms and style conventions

Actuarial gains or losses on superannuation defined benefit plans
Actuarial gains or losses are changes in the present value of the superannuation defined benefit liability resulting from

(a) experience adjustments (the effects of differences between the previous actuarial assumptions and what has actually occurred); and
(b) the effects of changes in actuarial assumptions.

Amortisation
Amortisation is the expense which results from the consumption, extraction or use over time of a non-produced physical or intangible asset.

Associates
Associates are all entities over which an entity has significant influence but not control, generally accompanying a shareholding and voting rights of between 20 per cent and 50 per cent.

Comprehensive result
The net result of all items of income and expense recognised for the period. It is the aggregate of operating result and other comprehensive income.

Commitments
Commitments include those operating, capital and other outsourcing commitments arising from non-cancellable contractual or statutory sources.

Current grants
Amounts payable or receivable for current purposes for which no economic benefits of equal value are receivable or payable in return.

Depreciation
Depreciation is an expense that arises from the consumption through wear or time of a produced physical or intangible asset. This expense reduces the 'net result for the year'.

Effective interest method
The effective interest method is used to calculate the amortised cost of a financial asset or liability and of allocating interest income over the relevant period. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial instrument, or, where appropriate, a shorter period

Employee benefits expenses
Employee benefits expenses include all costs related to employment including wages and salaries, fringe benefits tax, leave entitlements, redundancy payments, defined benefits superannuation plans, and defined contribution superannuation plans.

Ex gratia expenses
Ex-gratia expenses mean the voluntary payment of money or other non-monetary benefit (e.g. a write off) that is not made either to acquire goods, services or other benefits for the entity or to meet a legal liability, or to settle or resolve a possible legal liability, or claim against the entity.

Financial asset
A financial asset is any asset that is:

(a) cash;
(b) an equity instrument of another entity;
(c) a contractual or statutory right:
- to receive cash or another financial asset from another entity; or
- to exchange financial assets or financial liabilities with another entity under conditions that are potentially favorable to the entity; or

Note 8.12: Glossary of terms and style conventions (continued)

(d) a contract that will or may be settled in the entity's own equity instruments and is:
- a non-derivative for which the entity is or may be obliged to receive a variable number of the entity's own equity instruments; or
- a derivative that will or may be settled other than by the exchange of a fixed amount of cash or another financial asset for a fixed number of the entity's own equity instruments.

Financial instrument

A financial instrument is any contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Financial assets or liabilities that are not contractual (such as statutory receivables or payables that arise as a result of statutory requirements imposed by governments) are not financial instruments.

Financial liability
A financial liability is any liability that is:
(a) A contractual obligation:
(i) to deliver cash or another financial asset to another entity; or
(ii) to exchange financial assets or financial liabilities with another entity under conditions that are potentially unfavorable to the entity; or
(b) A contract that will or may be settled in the entity's own equity instruments and is:
(i) a non-derivative for which the entity is or may be obliged to deliver a variable number of the entity's own equity instruments; or
(ii) a derivative that will or may be settled other than by the exchange of a fixed amount of cash or another financial asset for a fixed number of the entity's own equity instruments. For this purpose the entity's own equity instruments do not include instruments that are themselves contracts for the future receipt or delivery of the entity's own equity instruments.

Financial statements
A complete set of financial statements comprises:
(a) Balance sheet as at the end of the period;
(b) Comprehensive operating statement for the period;
(c) A statement of changes in equity for the period;
(d) Cash flow statement for the period;
(e) Notes, comprising a summary of significant accounting policies and other explanatory information;
(f) Comparative information in respect of the preceding period as specified in paragraph 38 of AASB 101 Presentation of Financial Statements; and
(g) A statement of financial position at the beginning of the preceding period when an entity applies an accounting policy retrospectively or makes a retrospective restatement of items in its financial statements, or when it reclassifies items in its financial statements in accordance with paragraphs 41 of AASB 101.

Grants and other transfers
Transactions in which one unit provides goods, services, assets (or extinguishes a liability) or labour to another unit without receiving approximately equal value in return. Grants can either be operating or capital in nature.

While grants to governments may result in the provision of some goods or services to the transferor, they do not give the transferor a claim to receive directly benefits of approximately equal value. For this reason, grants are referred to by the AASB as involuntary transfers and are termed non-reciprocal transfers. Receipt and sacrifice of approximately equal value may occur, but only by coincidence. For example, governments are not obliged to provide

Note 8.12: Glossary of terms and style conventions (continued)

commensurate benefits, in the form of goods or services, to particular taxpayers in return for their taxes. Grants can be paid as general purpose grants which refer to grants that are not subject to conditions regarding their use. Alternatively, they may be paid as specific purpose grants which are paid for a particular purpose and/or have conditions attached regarding their use.

General government sector
The general government sector comprises all government departments, offices and other bodies engaged in providing services free of charge or at prices significantly below their cost of production. General government services include those which are mainly non-market in nature, those which are largely for collective consumption by the community and those which involve the transfer or redistribution of income. These services are financed mainly through taxes, or other compulsory levies and user charges.

Intangible produced assets
Refer to produced assets in this glossary.

Intangible non-produced assets
Refer to non-produced asset in this glossary.

Interest expense
Costs incurred in connection with the borrowing of funds includes interest on bank overdrafts and short-term and long-term liabilities, amortisation of discounts or premiums relating to liabilities, interest component of finance leases repayments, and the increase in financial liabilities and non-employee provisions due to the unwinding of discounts to reflect the passage of time.

Interest income
Interest income includes unwinding over time of discounts on financial assets and interest received on bank term deposits and other investments.

Joint Arrangements
A joint arrangement is an arrangement of which two or more parties have joint control. A joint arrangement has the following characteristics:

(a) The parties are bound by a contractual arrangement.
(b) The contractual arrangement gives two or more of those parties joint control of the arrangement

A joint arrangement is either a joint operation or a joint venture.

Liabilities
Liabilities refers to interest-bearing liabilities mainly raised from public liabilities raised through the Treasury Corporation of Victoria, finance leases and other interest-bearing arrangements. Liabilities also include non-interest-bearing advances from government that are acquired for policy purposes.

Net acquisition of non-financial assets (from transactions)
Purchases (and other acquisitions) of non-financial assets less sales (or disposals) of non-financial assets less depreciation plus changes in inventories and other movements in non-financial assets. It includes only those increases or decreases in non-financial assets resulting from transactions and therefore excludes write-offs, impairment write-downs and revaluations.

Note 8.12: Glossary of terms and style conventions (continued)

Net result
Net result is a measure of financial performance of the operations for the period. It is the net result of items of income, gains and expenses (including losses) recognised for the period, excluding those that are classified as 'other comprehensive income'.
Net result from transactions/net operating balance Net result from transactions or net operating balance is a key fiscal aggregate and is income from transactions minus expenses from transactions. It is a summary measure of the ongoing sustainability of operations. It excludes gains and losses resulting from changes in price levels and other changes in the volume of assets.

Net worth
Assets less liabilities, which is an economic measure of wealth.

Non-financial assets
Non-financial assets are all assets that are not 'financial assets'. It includes inventories, land, buildings, infrastructure, road networks, land under roads, plant and equipment, investment properties, cultural and heritage assets, intangible and biological assets.

Non-produced assets
Non-produced assets are assets needed for production that have not themselves been produced. They include land, subsoil assets, and certain intangible assets. Non-produced intangibles are intangible assets needed for production that have not themselves been produced. They include constructs of society such as patents.

Non-profit institution
A legal or social entity that is created for the purpose of producing or distributing goods and services but is not permitted to be a source of income, profit or other financial gain for the units that establish, control or finance it.

Payables
Includes short and long term trade debt and accounts payable, grants, taxes and interest payable.

Produced assets
Produced assets include buildings, plant and equipment, inventories, cultivated assets and certain intangible assets. Intangible produced assets may include computer software, motion picture films, and research and development costs (which does not include the startup costs associated with capital projects).

Public financial corporation sector
Public financial corporations (PFCs) are bodies primarily engaged in the provision of financial intermediation services or auxiliary financial services. They are able to incur financial liabilities on their own account (e.g. taking deposits, issuing securities or providing insurance services). Estimates are not published for the public financial corporation sector.

Public non-financial corporation sector
The public non-financial corporation (PNFC) sector comprises bodies mainly engaged in the production of goods and services (of a non-financial nature) for sale in the market place at prices that aim to recover most of the costs involved (e.g. water and port authorities). In general, PNFCs are legally distinguishable from the governments which own them.

Receivables
Includes amounts owing from government through appropriation receivable, short and long term trade credit and accounts receivable, accrued investment income, grants, taxes and interest receivable.

Note 8.12: Glossary of terms and style conventions (continued)

Sales of goods and services
Refers to income from the direct provision of goods and services and includes fees and charges for services rendered, sales of goods and services, fees from regulatory services and work done as an agent for private enterprises. It also includes rental income under operating leases and on produced assets such as buildings and entertainment, but excludes rent income from the use of non-produced assets such as land. User charges includes sale of goods and services income.

Supplies and services
Supplies and services generally represent cost of goods sold and the day-to-day running costs, including maintenance costs, incurred in the normal operations of the Department.

FINANCIAL DATA

Cash Management / Liquidity Indicators	**2016-17 actuals**
Cash Management / Liquidity	
Creditors (days)	44.42
Debtors (patient fees) (days)	38.99

SUMMARY OF FINANCIAL RESULTS

	2016 $	**2016** $	**2015** $	**2014** $	**2013** $
Total Expenses	14,959,056	14,465,243	13,871,582	14,010,244	13,860,850
Total Revenue	13,012,214	13,824,080	15,309,263	19,682,331	20,010,292
Net Result for Period Surplus/(Deficit)	(1,946,842)	(641,163)	1,437,681	5,672,087	6,149,442
Operating Result for Period Surplus/(Deficit)	(66,284)	92,760	(535,484)	(433,516)	($359,200)
Accumulated Deficits	9,417,876	11,364,718	12,005,881	10,568,200	4,896,113
Total Assets	38,514,813	37,734,831	33,278,507	24,737,021	17,809,475
Total Liabilites	5,450,719	4,305,834	3,838,332	4,170,195	3,122,847
Net Assets	33,064,094	33,428,997	29,440,175	20,566,826	14,686,628
Total Equity	33,064,094	33,428,997	29,440,175	20,566,826	14,686,628

Kerang District Health's 2016/2017 full year net result was a deficit of $1,946,842, compared with a surplus of $641,163 for the previous financial year.
The operating result was a deficit of $67,474 compared with a suplus of $92,760 for 2015/2016
The operating result excludes capital purpose income of $205,262 and depreciation/amortisation $2,053,239