ANNUAL
REPORT

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Western Health

OUR VISION

Together, caring for the West
Our patients, staff, community and environment

OUR PURPOSE

Leading the delivery of a connected and consistent patient experience and providing the best care to save and improve the lives of those in our community most in need.

OUR VALUES

Compassion
Consistently acting with empathy and integrity

Accountability
Taking responsibility for our decisions and actions

Respect
Respect for the rights, beliefs and choice of every individual

Excellence
Inspiring and motivating, innovation and achievement

Safety
Prioritising safety as an essential part of everyday practice

OUR STRATEGIC AIMS

Growing & improving the delivery of safe, high quality care

Connecting the care provided to our community

Communicating with our patients, our partners and each other with transparency and purpose

Being socially responsible and using resources sustainably

Valuing and empowering our people

Acknowledgement of Traditional Owners:

Western Health respectfully acknowledges the traditional owners of the land on which its sites stand as the Boon Wurrung and the Wurundjeri people of the greater Kulin Nation.

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BOARD CHAIR AND CEO MESSAGE

WESTERN HEALTH HOLDS A VERY SIGNIFICANT RESPONSIBILITY TO RESPOND TO THE DEEP NEED WITHIN OUR COMMUNITIES FOR A HEALTH SERVICE THAT IS AS EFFICIENT AND INNOVATIVE AS IT CAN BE.

After an extensive consultation process that engaged more than 1,000 people, involved more than 120 hours of one-on-one meetings and focus groups with some 80 community partners, we have now set the direction and priorities for our health service through to 2020. Western Health's 2015-20 Strategic Plan was formally approved by the Minister for Health in November 2015.

Our strategic aims focus on: growing and improving care; better connecting care as patients move in and out of our service; communicating clearly with patients, our partners and our staff; having a broader commitment to be socially responsible and sustainable; and valuing and empowering our people. These priorities will be realised through a lot of hard work, commitment and innovation across Western Health and we are well underway.

GROWING AND IMPROVING CARE

Friday 11 March 2016 was a day of considerable pride for all of us at Western Health, when we achieved a great result after four days of intensive accreditation survey. This was a day when we could see the outcome of the continuous effort and commitment of so many staff and volunteers, on behalf of our patients, over many years to provide best care.

The survey involved nine Australian Council on Healthcare Standard Surveyors visiting patient areas and reviewing many aspects of our care and governance. The Surveyors' messages were clear – this is a health service which is very authentic in its commitment to the patients, families and communities we serve and this authenticity brings a great energy and enthusiasm to do the best for and with our patients. Surveyors felt our health service had demonstrated extraordinary improvements in a very short space of time.

As a strong reflection of our commitment to quality care, the accreditation survey confirmed compliance with externally set standards, with the additional award of "met with merit" status against patient care and service delivery aligned with six of the fifteen surveyed Standards.

One of many initiatives highlighted was our organisation-wide roll-out of a consistent patient assessment and care planning process. This has aided in the early identification of clinical risks and the implementation of strategies to prevent harm to patients. Nursing staff report that the initiative has improved the handover of key information about a patient's care needs and has led to a significant reduction in paperwork, allowing more time at the bedside for patient care.

In 2015 we once again demonstrated solid performance and commitment to the conduct of research to support the review and improvement of patient care. Western Health researchers had 453 ongoing and/or approved projects in 2015 and more than 390 journal articles published during the year. They delivered more than 344 seminar and conference presentations, in Australia and overseas and were contributors to 28 book chapters. Together with our university and other research partners, we were awarded or held a total of $30.5 million worth of research grants.

A new Western Health Research Roadmap was also developed in 2015. It sets out an ambitious yet practical plan to improve care for our patients through research. Further details about our research achievements can be found in our Annual Research Report located on our website (westernhealth.org.au)

CONNECTING CARE

In July 2015, we launched a whole-of-health service project to reduce the wait times for patients in Western Health's emergency departments. We called this approach 'It's About Time' and there has been extraordinary commitment to make a difference. Eleven months later, each day is a better day for our patients. More emergency department patients are now being seen within the appropriate triage time for their category and fewer patients are leaving without being seen.

At Sunshine Hospital, improvements in timely emergency care have been achieved in the context of a substantial increase in patient presentations and a steep rise in the numbers of much sicker patients, in line with the commencement of intensive care and coronary care services and an increase in specialist services and beds at the site.

Critical care services at Western Health received an additional boost within the last twelve months with the opening of four newly funded critical care beds. Our community has also provided great support for our critical care services. Under the leadership of the Association of Vietnamese Healthcare Professionals, the Sunshine Hospital Critical Care Appeal raised over $240,000 to enable additional valuable equipment for patient care in the critical care wards.

The drive to achieve reduced emergency care waiting times is one of the toughest challenges in a health service and we are striving to sustain these improvements. "It's About Time" is set to be expanded over the next twelve months to look at how we can improve timely care for patients using our outpatient services.

We are also set to enter a new phase in the care of those patients suffering from chronic disease. We will lead an innovative pilot, utilising a new model of care in pathways with community providers and general practitioners. We look forward to being able to provide an exceptional service to some of our sickest patients, enabling them to spend less time in hospital and more time in their homes, through this new service.

COMMUNICATING CLEARLY

Western Health's "First Impressions Program" focuses on building rapport with our patients and carers and involving them in care discussions. Over the past twelve months, we have launched the "Hello My Name Is Campaign" and promoted the five actions we can all take to improve communication with our patients: introducing yourself, explaining your role, explaining what you are going to do, answering any questions and checking in again. This has been very well received by our patients and their families.

Through the Maribyrnong Auxiliary and a Medicare Local grant, the Western Health Foundation supported the creation of a Patient Health Information Centre at Footscray Hospital in November 2015. The establishment of this centre follows on from the successful opening of a centre at Sunshine Hospital in September last year. Both centres are staffed by trained volunteers who help our patients find current and reliable information on a number of general health topics.

Given the significant cultural diversity of our patients, access to interpreter services is a key component of good communication. The past twelve months have seen an increase in the number of in-house interpreters across Western Health. We now have 18 interpreters covering 12 languages and continue to access interpreters from outside agencies for other languages or when our in house interpreters are not available.

Our Speech Pathology Team's CALD Assist App. won the award for Improving Health Equality and Closing the Gap at the 2015 Victorian Public Healthcare Awards. This innovative iPad application addresses the challenge of timely and effective initial allied health assessments for patients from non-English speaking backgrounds, when an interpreter is not available.

Engaging with patients along their journey also involves supporting their health care needs post discharge. In partnership with the Western Health Acute Stroke Unit, the Inpatient Rehabilitation Ward at Sunshine Hospital has been selected to participate in the National Stroke Foundation's StrokeConnect Follow Up program. This involves stroke survivors receiving a call from a health professional after hospital and being provided with information, advice, support and referral to assist them better manage their health and stroke recovery.

The past year saw Western Health reach a critical turning point in its move towards a fully electronic medical record. We will now progress towards developing and implementing a comprehensive record that will also support clinical decision making and electronic ordering of medications, pathology, imaging and more. This is a large scale project and one which will bring about great benefits for both our staff and our patients. In August 2015, the Department of Health and Human Services confirmed a capital funding contribution for Western Health to make this possible and by the end of 2016, a large team of staff will be in place to begin work on this project.

BEING SOCIALLY RESPONSIBLE

The West is a region with strong community linkages and a well-developed history of partnership to address the substantial challenges it faces. We have worked closely with community health service providers and general practitioners (GPs) over the past twelve months to improve continuity of patient care.

Our e-Health Gateway, an electronic data initiative that sends patients' care information automatically to each patient's GP, began in May 2015. Twelve months on, 81 practices and 581 GPs have signed up to the Gateway, with positive feedback on its usefulness.

We have also supported GPs to improve their early detection of patients suffering from chronic kidney disease (CKD), thanks to a new software tool funded by the state Department of Health and implemented by Western Health. Results from the program released recently reveal a 300 per cent increase in

BOARD CHAIR AND CEO MESSAGE

(CONTINUED)

the number of patients diagnosed with CKD and a large rise in those identified as having associated risk factors. General practitioners at 22 primary health care clinics in Melbourne's western suburbs used the software in an 18-month trial.

We continue to search for ways to improve our capacity to help patients receive care in their own homes and avoid hospital admissions.

Cardiology and aged-care specialists at Western Health have created a service to provide a better, co-ordinated approach to treating elderly heart patients in hospital and later, when they are discharged home. Nationally, about 25-35 per cent of elderly heart patients have multiple readmissions to hospital due to their complex needs, however, since Western Heath developed its service, hospital readmission rates among its elderly heart patients have dropped, with patients becoming more skilled at dealing with their chronic health conditions.

Support for patients' health needs following discharge has also been enhanced by the roll out of the Rapid Discharge Support Service (RDSS) at Footscray and Sunshine Hospitals. This service aims to break down social barriers preventing discharge home and bridge the gap between community services and inpatient units. The new service utilises trained carers through a local provider who, on short notice (under one hour) can provide care and transport for vulnerable adults upon discharge when they are needing more than just a driver.

Our partnership with the North Western Melbourne Primary Health Network (PHN) has also generated opportunities to work with community providers to enhance patient care. Over the past twelve months, we have collaborated with the PHN on program submission and development covering such areas as back pain management and assessment, cancer survivorship, and diabetes education and management.

Disadvantaged groups within and external to our community are a focus of our community outreach strategies. A visit to the dentist can be a confusing and frightening experience for intellectually disabled patients. This problem prompted Western Health and Dental Health Services Victoria (DHSV) to establish a specialist dental service for intellectually disabled patients and other patients with complex medical conditions. The new dental service at Williamstown Hospital provides additional care from nursing staff to reduce the anxiety often experienced by disabled patients when they visit a dentist. It is currently the only service of its kind in Victoria and has attracted some very heartfelt feedback from the carers of disabled patients on the high level of care and compassion of staff providing this service.

BEING SUSTAINABLE

The past 12 months have seen key milestones met for one of the most important developments in the west of Melbourne – the commencement of construction of the $200 million Joan Kirner Women's and Children's Hospital. Every step in this project brings us closer to being able to provide the services families of the west need, in a wonderful building closer to their homes. We have welcomed Lend Lease as the managing contractor and a wide range of staff from Western Health have been closely involved in planning for the hospital. As one of a range of community engagement initiatives, we ran an open Board meeting for the community on hospital design features, and Member for St Albans, Natalie Suleyman has been appointed as the chair of a community engagement panel. The next 12 months will see a great deal of action on site as the construction commences later in 2016.

We greatly appreciated welcome news in the 2016 Victorian Government budget, with the allocation of an additional $61.3 million for Western Health infrastructure. These funds include $17 million for urgent maintenance at Footscray Hospital and the next stage of planning for an eventual rebuild of the south block on that site. This is an important turning point for the future of Footscray Hospital.

With demands on our health service rapidly increasing, the State Budget funding will also enable us to eventually establish additional beds and upgrade supporting infrastructure at our Sunshine Hospital site.

Western Health takes a leadership role in reducing the environmental impact of its operations. This past year has seen the rollout of approximately 12,000 LED lights throughout Williamstown and Sunshine Hospital, a Single-use Metal Instruments Recycling Program, and the revitalisation of our Green Office Program. The amount of plastic waste we send to landfill has reduced by 35% per year through pioneering recycling programs that turn medical plastic into furniture, garden hoses and other objects. The PVC Recovery in Hospitals Program developed by Western Health has been adopted by more than 24 hospitals in the Asia Pacific region.

Our Environmental Management Strategy has also been updated in the last twelve months to set a clear sustainability roadmap and associated actions for the next five years. More details are available via the annual Sustainability Report on our website (westernhealth.org.au).

The high value we place on Western Health remaining financially responsible is once again evident in our financial results. We have recorded a surplus of $0.3m in the 2015/16 year in a budget of almost $650 million and we continue to have a strong cash position.

EMPOWERING OUR PEOPLE

In April 2016, the stories of trailblazing surgeons who worked at Footscray Hospital in its earliest days were revealed in a remarkable book published by Western Health called The People's Hospital – Tales from the surgeon's table. In the early 1900s, community and business leaders and workers in Melbourne's industrial west resolved to build an acute hospital. In 1953 they succeeded. More than 60 years later, the striking characteristic of this health service and its staff is still very closely aligned to the values and attitudes of its founders - the determination to provide the best possible care for communities in great need.

Over the past twelve months, we have conducted targeted recruitment campaigns for some of the hardest to recruit vacancies in healthcare worldwide, including midwives and neonatal intensive care nurses. An innovative approach was taken with a program called "Welcome Home" which yielded great results. This approach focuses on the sense of family and team spirit that makes employees feel 'at home' at Western Health.

We are also committed to increasing employment of Aboriginal staff and in the past year we have been able to attract funding for Aboriginal Administration trainee positions and Aboriginal Nursing Cadetships. We look forward to building on these opportunities.

Western Health's training programs support one of the most culturally diverse workforces of any health service in Australia. Our patients speak more than 110 different languages and our staff are broadly representative of our community – something that is enabled through our approaches to recruitment and training. One example is the successful path to jobs that has been forged in a training program run by Western Health and Djerriwarrh Community and Education Services. A lot of our trainees come from diverse cultural backgrounds, some were refugees and for many it's their first step into the workforce.

We are proud of our strong staff retention rate, with turnover in Western Health at 6.3% compared with 8.4% for our peers, based on the latest available data. An extraordinary 64% of our staff have a nationally recognised qualification through a Western Health program. We respond to a continually changing sector: advancement in clinical practices, growing population and continued demand for innovation. All of these factors have undoubtedly contributed to Western Health being a finalist, for the second year running, in the Large Employer of the Year category of the 2016 Victorian Training Awards.

The 600 members of our Western Health Volunteer Team play a crucial role in support patient-centred care. On one single day during the past 12 months, a count was made of the overall volunteer contribution on that day alone – it revealed more than 650 interactions between volunteers and patients, apart from the hundreds of other tasks carried out in that same 24 hour period. The volunteer visitor guide team at Sunshine were honoured with a Brimbank City Council Australia Day Award for their contribution to community wellbeing.

THANK YOU

Finally, we would like to thank Western Health's staff; volunteers; our many community stakeholders including our local members of parliament at both the State and Commonwealth levels; the Department of Health and Human Services and the Victorian Government; and financial donors, through the Western Health Foundation. Your support is greatly appreciated and makes an incredible difference to the care we are able to provide. We look forward to working with you over the next year.

In accordance with the Financial Management Act 1994, we are pleased to present the Report of Operations for Western Health for the year ending 30 June 2016.

The Hon Bronwyn Pike
Chair of the Board, Western Health
9 August 2016

Associate Professor Alex Cockram
Chief Executive, Western Health
9 August 2016

ABOUT WESTERN HEALTH

Western Health (WH) manages three acute public hospitals: Footscray Hospital, Sunshine Hospital and the Williamstown Hospital. It also operates the Sunbury Day Hospital and a Transition Care Program at Hazeldean in Williamstown. A wide range of community based services are also managed by Western Health, along with a large Health and Addiction Medicine Service.

Services are provided to the western region of Melbourne which has a population of approximately 800,000 people.

Western Health provides a comprehensive, integrated range of services from its various sites; ranging from acute tertiary services in areas of emergency medicine, intensive care, medical and surgical services, through to subacute care and specialist ambulatory clinics. Western Health provides a combination of hospital and community-based services to aged, adult and paediatric patients and newborn babies.

EMPLOYING MORE THAN 6,200 STAFF, WESTERN HEALTH HAS A STRONG PHILOSOPHY OF WORKING WITH ITS LOCAL COMMUNITY TO DELIVER EXCELLENCE IN PATIENT CARE.

Western Health has long-standing relationships with health providers in the western region of Melbourne and strong affiliations with numerous colleges and academic institutions. We have academic partnerships with the University of Melbourne, Victoria University and Deakin University.

OUR COMMUNITY:

- is growing at an unprecedented rate
- is among the fastest growth corridors in Australia
- covers a total catchment area of 1,569 square kilometres
- has a population of approximately 800,000 people
- is ageing, with frailty becoming an increasing challenge to independent healthy living
- has high levels of cancer, heart disease, stroke and mental illness, with diabetes and depression also significant population health issues
- has a diverse social and economic status
- is one of the most culturally diverse communities in the State
- speaks more than 110 different languages/dialects
- provides a significant number of our staff
- has a strong history of working collaboratively with Western Health to deliver excellence in patient care.

WESTERN HEALTH'S CATCHMENT INCLUDES THE FOLLOWING LOCAL GOVERNMENT MUNICIPALITIES:

- Brimbank
- Hobsons Bay
- Maribyrnong
- Melton
- Moonee Valley
- Moorabool
- Hume
- Wyndham

Western Health provides a range of higher level services to the patients who are also serviced by health services such as Werribee Mercy and Djerriwarrh at Bacchus Marsh.

OUR FACILITIES

FOOTSCRAY HOSPITAL

Footscray Hospital is an acute teaching hospital with approximately 300 beds. It provides acute elective and acute emergency services. Patients are provided with a range of inpatient and outpatient services including acute general medical and surgical, intensive and coronary care, sub-specialty medicine, surgical services, and related clinical support.

SUNSHINE HOSPITAL

Sunshine Hospital is an acute teaching hospital with approximately 600 beds. The hospital provides acute elective and acute emergency services with a range of inpatient and outpatient services including intensive care and coronary care, acute medical and surgical services and sub-specialty medicine and surgical services.

Sunshine Hospital's emergency department, incorporating a paediatric service, is one of the busiest general emergency departments in the state. Sunshine Hospital also has a comprehensive range of women's and children's services, with maternity services continuing to grow to meet the increasing demand within the community. Sunshine Hospital now has the third highest number of births of any hospital site in the state.

SUNSHINE HOSPITAL RADIATION THERAPY CENTRE

The Sunshine Hospital Radiation Therapy Centre, a partnership between Western Health and the Peter MacCallum Cancer Centre, provides a state-of-the-art radiation planning system and two linear accelerators to deliver treatment to patients with a range of cancers.

WILLIAMSTOWN HOSPITAL

Williamstown Hospital is a 90 bed facility providing emergency services, surgical services, rehabilitation and geriatric evaluation and management services, renal dialysis services and community rehabilitation and transition care services.

SUNBURY DAY HOSPITAL

The Sunbury Day Hospital provides day medical, day surgical, day chemotherapy and haemodialysis treatment and a number of specialist clinics.

DRUG HEALTH AND ADDICTION MEDICINE

Drug Health Services provide a diverse range of services for individuals and their families affected by drug and alcohol related problems. Drug Health Services is a community based program of Western Health and offers innovative client centered recovery programs that include specialist programs for Adults, Women and their Children, Adolescents and their Families. We also provide Residential Withdrawal Services for both adults and adolescents. Services are both office based and outreach. Office based services are provided from the Footscray and Sunbury Campuses. Access to Addiction Medicine Consultants and Nurse Practitioners is available to support seamless service delivery. Drug Health Services liaises with Addiction Medicine Services within Western Health.

WESTERN CENTRE FOR HEALTH RESEARCH AND EDUCATION

Located at Sunshine Hospital, the Western Centre for Health Research and Education provides a range of purpose built, state-of-the-art teaching and research facilities. The Centre is the result of the partnerships with the University of Melbourne and Victoria University and plays a pivotal role in staff and student education and research activities. Available within the Centre is a 200 seat auditorium, a 100 seat lecture theatre, library facilities, simulation centres and a number of seminar and tutorial rooms. The Centre is home to the Western Clinical School for Medicine and Allied Health in partnership with the University of Melbourne and also houses researchers, academics and educators from Western Health, Victoria University and the University of Melbourne. The Centre has enabled a number of collaborative projects and opportunities researching diseases that affect our local communities and has placed Western Health as a centre of excellence in academic and research fields.

Western Health maintains strong partnerships with a number of lead universities including the University of Melbourne, La Trobe, Monash, RMIT and Victoria Universities for medical, nursing and midwifery and allied health training.

HAZELDEAN TRANSITION CARE

Hazeldean Transition Care is located close to the Williamstown Hospital and provides Transition Care Program services to the people of the West. The Transition Care Program provides goal oriented, time limited and therapy focused care to help older people at the conclusion of their hospital stay.

STATEMENT OF PRIORITIES

Each year, Western Health identifies how it will contribute to the priorities in the Victorian Government's Health Priorities Framework 2012-2022. The following table lists outcomes against deliverables for 2015/16 agreed between our health service and the Minister for Health.

DOMAIN	ACTION	WESTERN HEALTH DELIVERABLES	OUTCOME
Patient experience and outcomes	Drive improved health outcomes through a strong focus on patient-centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first.	Western Health Elements of Care Policy implemented covering risk areas of nutrition, cognition, falls & pressure, and organisation roll-out completed of nutrition clinical practice strategy, and screening, assessment & care planning tool.	**ACHIEVED** Elements of care strategy implemented with improved clinical risk screening, assessment and care planning documentation supported by roll-out of organisation-wide tools, and implementation of audit tool. Nutrition programs implemented including communal dining & volunteer supported meal assistance.
	Strengthen the response of health services to family violence. This includes implementing interventions, processes and systems to prevent; identify and respond appropriately to family violence at an individual and community level.	Existing health service family violence protocols, pathways and partnership programs active and enhanced with introduction of an on-line family violence competency training module and pilot of an Advanced Scope of Practice Senior Social Work role to identify and work with at risk pregnant women, children and families in the emergency department setting.	**ACHIEVED** On-line family violence competency training module developed and Advanced Scope of Practice Senior Social Work role piloted and presented at the 2015 National Allied Health Conference. In addition, Western Health is a pilot site for the DHHS Strengthening Hospital Responses to Family Violence Project.
	Improve the health outcomes of Aboriginal and Torres Strait Islanders by increasing accessibility and cultural responsiveness of the Victorian health system.	Aboriginal Health Planning roadmap developed for 2015-18 and strategies implemented in the following targeted areas: patient identification, transition of patients through the Emergency Department to the community, employment opportunities.	**ACHIEVED** Aboriginal Health Roadmap 2015-18 developed with an electronic alert created to support Aboriginal patient identification in emergency departments and across the health service, and Western Health awarded Aboriginal Nursing Cadetships for 2016.
	Implement an organisation-wide approach to advance care planning including a system for identifying, documenting and/or receiving advance care plans in partnership with patients, carers and substitute decision makers so that people's wishes for future care can be activated when medical decisions need to be made.	Western Health End of Life Procedure actively implemented with Care of the Dying Observation Chart introduced and End of Life education rolled out to GPs and residential facilities.	**ACHIEVED** WH Advance Care Plan procedure and associated End of Life procedure completed, with trial of End of Life Observation Chart. Community partnership programs progressed, including training with Residential Aged Care Facility nurses. Marked increase noted in the recording of Advance Care Plans and end of life care conversations.
	Demonstrate an organisational commitment to quality cancer services through engagement with the local Integrated Cancer Service and implementation of the Optimal Care Pathways.	Western Health engaged in WCMICS & VCCC supported optimal care pathway development for the lung tumour stream.	**ACHIEVED** VCCC/WCMICS Lung Tumour Stream audit conducted at Western Health. Results released by WCMICS, with next steps being discussed with the WCMICS Clinical Management Advisory Committee.

DOMAIN	ACTION	WESTERN HEALTH DELIVERABLES	OUTCOME
Governance, leadership and culture	Demonstrate an organisational commitment to Occupational Health and Safety, including mental health and wellbeing in the workplace. Ensure accessible and affordable support services are available for employees experiencing mental ill health. Work collaboratively with the Department of Health and Human Services and professional bodies to identify and address systemic issues of mental ill health amongst the medical professions.	2015-2017 Western Health Staff Health and Wellbeing Plan implementation commenced, with a particular focus on mental health and wellbeing activity areas including stress awareness, psychological support and fatigue management.	**ACHIEVED** Staff Health & Wellbeing plan commenced, with processes supporting the management of workplace bullying and harassment and fatigue management updated against contemporary reviews and evidence based practice.
	Monitor and publically report incidents of occupational violence. Work collaboratively with the Department of Health and Human Services to develop systems to prevent the occurrence of occupational violence.	Western Health engaged in DHHS led design and implementation of a new streamlined Riskman OHS reporting module, and review completed of OV training against DHHS recommended training components and course effectiveness.	**ACHIEVED** Western Health involved in preliminary DHHS work to streamline OHS reporting, with appointment to an ongoing occupational violence prevention co-ordinator position supporting the review of OV training against recommended training components and review & enhancement of systems supporting OV management.
	Promote a positive workplace culture and implement strategies to prevent bullying and harassment in the workplace. Monitor trends of complaints of bullying and harassment and identify and address organisational units exhibiting poor workplace culture and morale.	"Custodians of Culture" training program expanded, a Registrars- In-Training Advisory Committee implemented and forums undertaken to engage Senior and Junior Medical staff in understanding the drivers for staff health and wellbeing and to address opportunities and gaps in Western Health's approach.	**ACHIEVED** "Custodians of Culture" training program expanded, with Registrars-In-Training Advisory Committee in place. Think Tanks have been undertaken with senior and junior medical staff and registrars, with a detailed Medical Wellbeing Program developed to outline a specific approach of education, communication and support for all medical professionals at Western Health.
	Undertake an annual board assessment to identify and develop board capability to ensure all board members are well equipped to effectively discharge their responsibilities.	Supported by the use of an online tool, annual board governance assessment undertaken and utilised to refresh a Board Governance Development Plan.	**ACHIEVED** Annual board governance assessment undertaken, with improved board director ratings on the maturity of systems supporting governance. Assessment results utilised to inform refresh of Board Governance Development Plan and focus areas for Board planning and development sessions.
	Build workforce capability and sustainability by supporting formal and informal clinical education and training for staff and health students, in particular inter-professional learning.	Organisation-wide Learning & Education enhanced with an Education Roadmap for 2015-2020 developed, the post graduate nursing partnership with the University of Melbourne strengthened, the Best Practice Learning Environment embedded and the Leadership Pathway Program for middle management continued.	**SIGNIFICANTLY PROGRESSED** Workshop and focus groups undertaken to refresh the Western Health Organisation Development and Education Roadmap. Post graduate nursing partnership with the University of Melbourne strengthened, with 16 postgraduates for ICU. Best Practice Learning Environment indicators implemented and progression of the Leadership Pathway Program and other nationally accredited programs has seen Western Health shortlisted for a Victorian Training Organisation of the Year Award.

STATEMENT OF PRIORITIES

(CONTINUED)

DOMAIN	ACTION	WESTERN HEALTH DELIVERABLES	OUTCOME
Safety and quality	Ensure management plans are in place to prevent, detect and contain Carbapenem Resistant Enterobacteriaceae as outlined in Hospital Circular 02/15 (issued 16 June 2015).	Existing health service standard & transmission based precautions processes active and enhanced with education and auditing processes expanded, and hospital circular 02/15 indications adopted.	**ACHIEVED** Standard & transmission based precautions active and enhanced with CPE Management Plan, staff education, and a screening tool and database established.
	Implement effective antimicrobial stewardship practices and increase awareness of antimicrobial resistance, its implications and actions to combat it, through effective communication, education, and training.	Existing health service antimicrobial stewardship protocols covering clinical practice, communication and education maintained and enhanced with introduction of a more detailed, in house analysis of quantity of antimicrobial use and engagement in an annual qualitative assessment of antimicrobial prescribing (benchmarked nationally).	**ACHIEVED** Antimicrobial stewardship practices maintained and enhanced with the introduction of a database for the comparison and benchmarking of restricted antibiotics.
	Develop perinatal mortality and morbidity review processes in alignment with the Clinical Practice Guideline for Perinatal Mortality.	In line with Clinical Practice Guideline for Perinatal Mortality, Perinatal Loss Review Committee introduced and oversighting improvements to perinatal loss support systems.	**ACHIEVED** Perinatal Loss Review Committee established, with partners from across the region.
	Improve cash management processes to ensure that financial obligations are met as they are due.	Existing systems supporting Western Health's strong cash position maintained and strengthened by engagement of the Victorian Financial Management Corporation to invest surplus funds and enhance interest returns.	**ACHIEVED** Western Health's strong cash position maintained, with surplus funds invested with the Victorian Funds Management Corporation and generating returns in-line with expectations.
	Identify opportunities for efficiency and better value service delivery.	Clinical Costing Program utilised to understand better efficiencies across targeted DRGs.	**ACHIEVED** Clinical Costing Program utilised successfully to identify savings initiatives against targeted DRGs.
	Work with Health Purchasing Victoria to implement procurement savings initiatives.	Savings realised for sutures and staples procurement following engagement with Health Purchasing Victoria and work progressed with HPV on procurement of non-emergency patient transport services.	**ACHIEVED** Suture and staples procurement reviewed, with implementation of the HPV framework and a change in suppliers as a result of product testing and evaluation. Western Health has also participated in and provided feedback on the State-wide pilot for non-emergency patient transport services.

DOMAIN	ACTION	WESTERN HEALTH DELIVERABLES	OUTCOME
Access	Implement integrated care approaches across health and community support services to improve access and responses for disadvantaged Victorians.	Fast tracking of patients with symptoms suggestive of a cancer diagnosis supported by full implementation and promotion of the integrated "RAGE" (Rapid Access Gastrointestinal Endoscopy) care pathway.	**ACHIEVED** Roll out of "RAGE" program progressed and supporting fast tracking, with ongoing work continuing between secondary and primary care. RAGE program shared with VCCC hospitals and informing state-wide work on Optimal Care Pathways for cancer patients and colonoscopy guidelines.
	Progress partnerships with other health services to ensure patients can access treatments as close to where they live when it is safe and effective to so, making the most efficient use of available resources across the system.	Collaborative work progressed with Western Metropolitan Regional work groups (Djerriwarrah Health, Mercy Health and Western Health) through the Regional Sustainable Hospitals Plan, with a particular focus on: addressing the co-ordination and operational efficiency of Maternity Services, Paediatric Services and Elective Surgery, and initiatives identified for improvement, including Phase 2 project of Emergency Transfer process.	**ACHIEVED** Collaborative work progressed with regional partners, including maternity service referral form standardisation, review of out of area paediatric patient flow to the Royal Children's Hospital and exploration of the addition of outpatient clinics for high volume paediatric ambulatory activity. Report to DHHS submitted, with next priorities identified.
	Optimise system capacity by ensuring that allocated points of care are implemented as per the Travis review recommendations.	Four points of care, inclusive of two acute coronary care beds and two intensive care beds opened as part of Travis review recommendations.	**ACHIEVED** Two acute coronary care beds and two intensive care beds opened.
	Develop and implement improvement strategies that optimise access, patient flow and system co-ordination of hospital services.	Organisation-wide "*It's About Time*" Action Plan implemented and supporting a whole of hospital response to improving care for emergency patients.	**PROGRESSED** Whole of health service "*It's About Time*" Action Plan implemented, with mid year targets for performance improvement achieved for length of stay less than 4 hours in the emergency department. Performance declined in the final 3 months of 2015/16, with work continuing to make improvement gains sustainable in 2016/17.

KEY PERFORMANCE STATISTICS

SAFETY AND QUALITY PERFORMANCE

KEY PERFORMANCE INDICATOR	TARGET	2015-16 ACTUALS
Safety and quality performance		
Compliance with NSQHS Standards accreditation	Full compliance	Achieved
Cleaning standards (Overall)	Full compliance	Achieved
Cleaning standards – very high risk (Category A)	90 points	Achieved
Cleaning standards – high risk (Category B)	85 points	Achieved
Cleaning standards – moderate risk (Category C)	85 points	Achieved
Compliance with the Hand Hygiene Australia program	80%	89%
Percentage of healthcare workers immunised for influenza	75%	77%
Patient experience and outcomes performance		
Victorian Healthcare Experience Survey - data submission	Full compliance	Achieved
Victorian Healthcare Experience Survey – patient experience Quarter 1	95% positive experience	87.6%
Victorian Healthcare Experience Survey – patient experience Quarter 2	95% positive experience	86.4%
Victorian Healthcare Experience Survey – patient experience Quarter 3	95% positive experience	92.8%
Number of patients with surgical site infection	No outliers	Achieved
ICU central line associated blood stream infection	No outliers	Not Achieved
SAB rate per occupied bed days	<2/10,000	0.8/10,000
Maternity – Percentage of women with prearranged postnatal home care	100%	99.3%
Governance, Leadership and Culture		
People Matter Survey – percentage of staff with a positive response to safety culture questions	80%	88%

FINANCIAL SUSTAINABILITY PERFORMANCE

KEY PERFORMANCE INDICATOR*	TARGET	2015-16 ACTUALS
Finance		
Public & private WIES performance to target	100	101.4
Asset Management		
Asset Management Plan	Full compliance	Full compliance

**for additional financial performance indicators, see page 16*

ACCESS PERFORMANCE

KEY PERFORMANCE INDICATOR	TARGET	FOOTSCRAY	SUNSHINE	WILLIAMSTOWN
Emergency Care				
Percentage of ambulance patients transferred within 40 minutes	90%	87%	79%	98%
Percentage of Triage Category 1 emergency patients seen immediately	100%	100%	100%	100%
Percentage of Triage Category 1 to 5 emergency patients seen within clinically recommended times	80%	80.9%	57.4%	86.0%
Percentage of emergency patients with a length of stay less than four hours	81%	68.2%	57.5%	91.1%
Number of patients with a length of stay in the emergency department greater than 24 hours	0	34	4	0

KEY PERFORMANCE INDICATOR	TARGET	2015-16 ACTUALS
Elective Surgery		
Percentage of elective patients removed within clinically recommended timeframes	94%	94.6%
Percentage of Urgency Category 1 elective patients removed within 30 days	100%	100%
10% longest waiting Category 2 and 3 removals from the elective surgery waiting list	100%	100%
Number of patients on the elective surgery waiting list	3,650	3,310
Number of hospital initiated postponements per 100 scheduled admissions	<8/100	7
Number of patients admitted from the elective surgery waiting list – annual total	14,606	14,597

KEY PERFORMANCE INDICATOR	TARGET	2015-16 ACTUALS
Critical Care		
Adult ICU number of days below the agreed minimum operating capacity – Footscray Hospital	0	5
Adult ICU number of days below the agreed minimum operating capacity – Sunshine Hospital	0	2

KEY PERFORMANCE STATISTICS

(CONTINUED)

ACTIVITY AND FUNDING

FUNDING TYPE	2015-16 ACTIVITY ACHIEVEMENT
Acute Admitted	
WIES Public	77,230
WIES Private	6,387
WIES (Public and Private)	83,617
WIES DVA	756
WIES TAC	189
WIES TOTAL	84,562
Acute Non-Admitted	
Renal Dialysis – Home ABF	88
Subacute & Non-Acute Admitted	
Rehab Public	17,893
Rehab Private	3,052
Rehab DVA	146
GEM Public	36,536
GEM Private	5,638
GEM DVA	1,378
Palliative Care Public	4,773
Palliative Care Private	648
Palliative Care DVA	88
Transition Care - Beddays	11,959
Transition Care - Homeday	10,116
Subacute non-admitted	
Health Independence Program	86,209
Mental Health and Drug Services	
Drug Services	2,497
Primary Health	
Community Health / Primary Care Programs	2,500

FINANCIAL SNAPSHOT

WORKFORCE FULL TIME EQUIVALENT (FTE) PER ANNUAL ACCOUNTS

LABOUR CATEGORY	JUNE CURRENT MONTH AVERAGE FTE		JUNE YTD AVERAGE FTE	
	2015	2016	2015	2016
Nursing	1914	1987	1815	1966
Administration and Clerical	605	640	568	618
Medical Support	352	359	318	357
Hotel and Allied Services	390	412	378	412
Medical Officers	115	121	107	116
Hospital Medical Officers	429	429	298	434
Sessional Clinicians	73	94	70	86
Ancillary Staff (Allied Health)	339	368	318	360
Total	**4218**	**4410**	**3873**	**4350**

FINANCIAL SNAPSHOT

$'000	2015/16	2014/15	2013/14	2012/13	2011/12
Total Revenue	686,303	644,174	607,881	571,686	585,579
Total Expenses	712,133	657,369	627,039	592,161	570,352
Net Result for the Year (inc. Capital and Specific Items)	**25,830**	**(13,195)**	**(19,158)**	**(20,475)**	**15,227**
Retained Surplus/(Accumulated Deficit)	**11,296**	**37,636**	**51,799**	**71,667**	**92,713**
Total Assets	684,212	679,764	684,698	640,413	658,515
Total Liabilities	164,166	142,636	134,359	122,814	120,441
Net Assets	**520,046**	**537,128**	**550,339**	**517,599**	**538,074**
TOTAL EQUITY	**520,046**	**537,128**	**550,339**	**517,599**	**538,074**

FINANCIAL SNAPSHOT

FINANCIAL PERFORMANCE

OPERATING RESULT	TARGET	2015/16 ACTUALS
Annual Operating result ($'m)	$0M	$0.3

CASH MANAGEMENT / LIQUIDITY	TARGET	2015/16 ACTUALS
Creditors (days)	<60	52
Debtors (days)	<60	48

ASSET MANAGEMENT	TARGET	2015/16 ACTUALS
Adjusted Current Asset Ratio	0.70	0.56
Days of Available Cash	14 days	23 days

CONSULTANCIES

OVER $10,000

NAME	PARTICULARS	START DATE	END DATE	TOTAL PROJECT FEES (EXCL GST)	AMOUNT INCURRED (EXCL GST)	FUTURE COMMITMENTS (EXCL GST)
Mary Whelan Food Services Pty Ltd	Operational review of current food services at sunshine hospital	May-16	May-16	$11,900	$11,900	N/A
Mercer Consulting (Australia) Pty Ltd	Workforce analysis and workforce plan for accreditation	Dec-15	Mar-16	$57,910	$57,910	N/A
Value Edge Consulting Pty Ltd	NUM role enhancement work group meeting, ECR assessment set-up, Operation manager questionnaires	Feb-16	Feb-16	$18,735	$18,735	N/A
Victoria University	Statistical consulting work on the AANZDEM data	Jul-15	Dec-15	$10,000	$10,000	N/A
Mercer Consulting (Australia) Pty Ltd	Strategic Workforce Plan for Joan Kirner Women's and Children's Hospital	May-16	Oct-16	$72,900	$72,900	N/A
	Totals			**$171,445**	**$171,445**	

UNDER $10,000

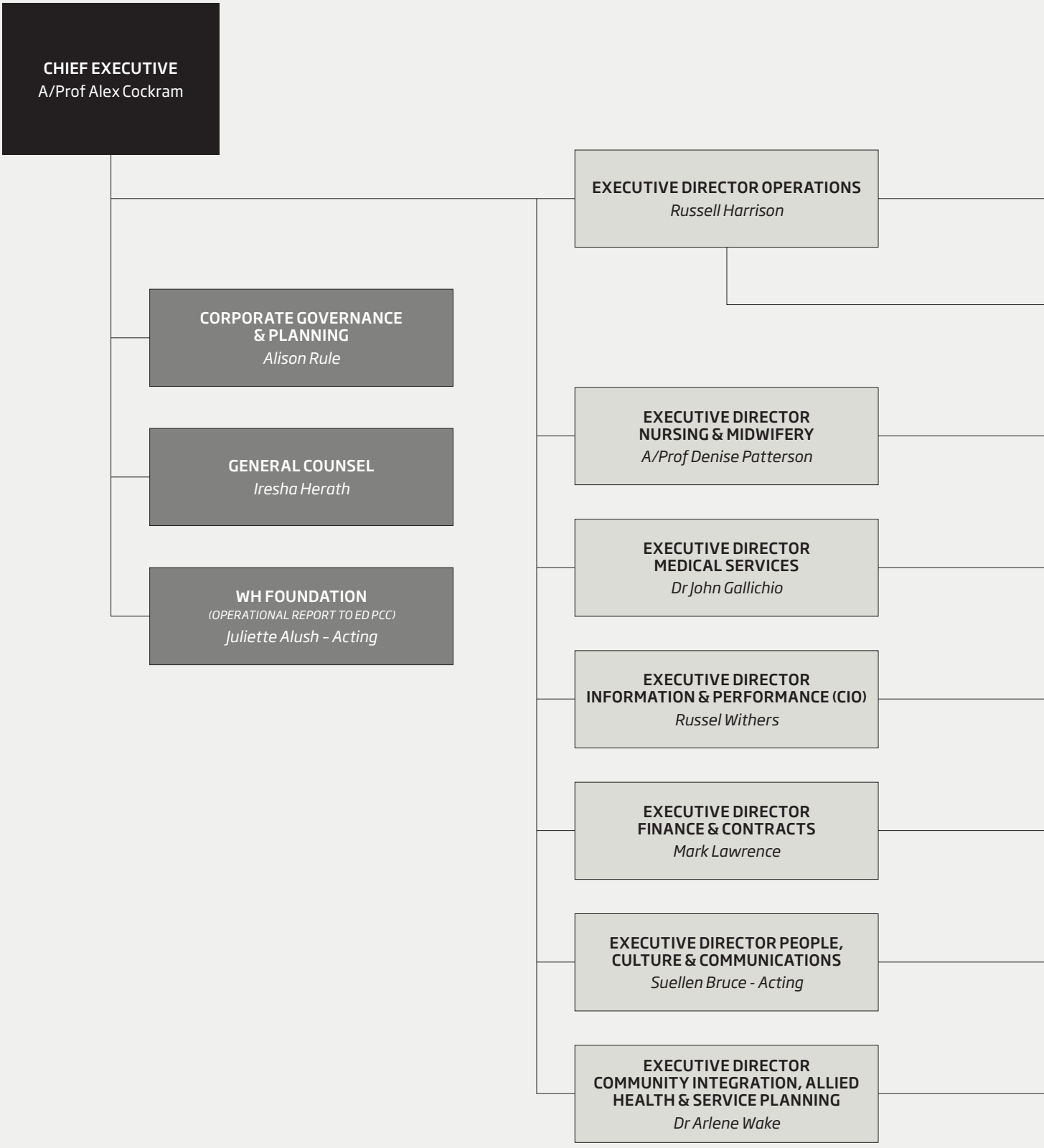
In 2015-16, Western Health engaged 11 consultants where the total fees payable to the consultants were less than $10,000, with total expenditure of $32,970 (excl. GST).

INFORMATION AND COMMUNICATION TECHNOLOGY (ICT) EXPENDITURE

BUSINESS AS USUAL (BAU) ICT EXPENDITURE (TOTAL) (EXCLUDING GST)	NON-BUSINESS AS USUAL (NON-BAU) ICT EXPENDITURE (TOTAL = OPERATIONAL EXPENDITURE AND CAPITAL EXPENDITURE) (EXCLUDING GST)	OPERATIONAL EXPENDITURE (EXCLUDING GST)	CAPITAL EXPENDITURE (EXCLUDING GST)
$7.01 million	$5.69 million	$0.19 million	$5.50 million

In 2015-16, depreciation and amortisation related to ICT amounted to $2.46 million, which is included in captial expenditure above.

ORGANISATIONAL STRUCTURE



Clinical Support & Specialist Clinics	Health Support
Sally Martin, Dr Andrew Jeffreys, Dr William Renwick	*Christine Neumann*

Emergency, Medicine & Cancer Services	Women's & Children's	Peri Operative & Critical Care Services	Sub Acute & Aged Care
Damian Gibney, A/Prof Garry Lane	*Adele Mollo, A/Prof Glyn Teale*	*Claire Culley, Dr Andrew Jeffreys*	*Natasha Toohey, Dr Kris Ghosh*

Director of Nursing & Midwifery Sunshine	Director of Nursing & Midwifery Footscray	Director of Nursing & Midwifery Sunbury	Director of Nursing & Midwifery Williamstown	Aboriginal Health
Wendy Watson	*Joy Turner*	*Deborah Clark*	*Douglas Mill*	*Jacqueline Watkins*

Medical Workforce	Medical Education	Quality, Safety, Patient Experience	Research & Development	Drug Health Services
Sally Watson	*Dr Stephen Lew*	*Louise McKinlay*	*Prof Edward Janus, Bill Karanatsios*	*Robyn Jackson*

Information & Communications Technology	Electronic Medical Record	Health Information & Performance
Andrew Leong	*TBA*	*Sean Downer*

Finance	Capital Planning & Redevelopment	Contracts & Commercial Relationships
Nicholas Russell	*Najla Sarkis*	*Arnold Roxas*

Public Affairs & Stakeholder Relations	Organisational Learning & Education: WCHRE	People & Culture	Employee Relations & Org-Wellbeing	Community Engagement & Volunteers	OHS & Wellbeing
Cathy Sommerville	*Michelle Noronha - Acting*	*Leonie Hall*	*Gillian Shedden*	*Jo Spence*	*Steve Parker*

Allied Health	Community Services	GP Integration	Cultural Diversity & Community Participation	Service Planning & Development
Sue Giles - Acting	*Lebe Malkoun*	*Bianca Bell*	*Assunta Morrone*	*Robert Rothnie*

WESTERN HEALTH SERVICES

EMERGENCY, MEDICINE AND CANCER SERVICES

Addiction Medicine
Dermatology
Endocrinology & Diabetes
Elective Booking Services
Emergency Medicine
Gastroenterology
General Medicine
Haematology
Hospital In The Home
Immunology
Infectious Diseases
Medical Acute Day Unit
Medical Oncology
Migrant Screening Program
Nephrology
Neurology
Renal Dialysis
Respiratory and Sleep Disorders
Rheumatology
Palliative Care
Stroke Service

PERIOPERATIVE AND CRITICAL CARE SERVICES

Anaesthetics and Pain Management
Cardiology Services
Central Sterilising Services
Colorectal and General Surgery
Elective Booking Service
General, Breast and Endocrine Surgery
Intensive Care Services (incorporating ICU Liaison)
Neurosurgery
Ophthalmology
Orthopaedic Surgery
Otolaryngology, Head, Neck Surgery
Paediatric Surgery
Plastic, Reconstructive and Facio-Maxillary Surgery
Preadmission Service
Thoracic Surgery
Upper Gastro Intestinal and General Surgery
Urology Surgery
Vascular Surgery

SUBACUTE AND AGED CARE SERVICES

Acute Aged Care
Cardio-Geriatric Service
Dementia Management Unit
Geriatric Evaluation and Management
Hazeldean Transition Care
Ortho- Geriatric Service
Palliative Care (inpatient service)
Rehabilitation
Subacute and Nonacute Assessment and Pathways Service
Wellcare Program

WOMEN'S AND CHILDREN'S SERVICES

Gynaecology
Obstetric Services
Maternal Fetal Medicine
Special Care Nursery
Paediatric Medicine

ALLIED HEALTH

Audiology
Exercise Physiology
Language Services
Neuropsychology
Nutrition and Dietetics
Occupational Therapy
Pastoral Care
Physiotherapy
Podiatry
Psychology
Social Work
Speech Pathology

CARE COORDINATION

Aged Care Assessment Service
Immediate Response Service
Hospital Admission Risk Program

CLINICAL SUPPORT AND SPECIALIST CLINIC SERVICES

Specialist Clinics (Adult)
Interventional Radiology
Medical Imaging
Pathology
Pharmacy

COMMUNITY SERVICES

Health Independence Programs (HIP)
- Immediate Response Service

Hospital Admission Risk Program
- Post Acute Care Program
- Community Based Rehabilitation

HIP Specialist Assessment Services
- Chronic Wound and Diabetic Foot Services, Cognition, Dementia and Memory Services
- Continence Clinic
- Falls Clinic
- GP Integration Unit
- Movement Disorders Service
- Parkinson's Disease Service

Community Transition Care Program

Aged Care Assessment Service

Children's Allied Health Service

DRUG HEALTH SERVICES

Youth and Family Services
Adult and Specialist Services
Community Residential Withdrawal Services

OTHER

Aboriginal Health, Policy and Planning

CORPORATE GOVERNANCE

THE BOARD OF WESTERN HEALTH CONSISTS OF INDEPENDENT NON-EXECUTIVE MEMBERS FROM A RANGE OF BACKGROUNDS AND WITH LOCAL TIES TO MELBOURNE'S WEST. THE BOARD CONSISTS OF TEN DIRECTORS. DIRECTORS ALSO HAVE A ROLE ON BOARD COMMITTEES.

Western Health is incorporated as a metropolitan health service pursuant to the Health Services Act 1988 (VIC). Western Health operates under the authority of the Act and its own by-laws.

Western Health is governed by the Board of Directors appointed by the Governor in Council on the recommendation of the Minister for Health. The Board's role is to govern the health service, consistent with applicable legislation and the terms and conditions attached to the funds provided to it.

The Board is responsible to the Minister for Health for setting the strategic direction of Western Health, within the framework of government policy, and ensuring that the health service:

- is effective and efficiently managed
- provides high quality care and service delivery
- meets the needs of the community; and
- meets financial and non-financial performance targets

Over the period 1 July 2015 to 30 June 2016, the Board comprised of ten members, including the Chair.

THE HON BRONWYN PIKE

BA, GRAD DIP EDUCATION, GAICD

CHAIR

The Hon Bronwyn Pike is a former Victorian Minister for Housing, Aged Care, Community Services, Health, Education, Skills and Workforce Participation. Her 13 year parliamentary career included 11 as a Minister.

Prior to entering parliament in 1999, Bronwyn headed up the Uniting Church welfare program in Victoria, now known as Uniting Care, which provided children, youth, family and aged care services. She trained as a secondary school teacher and taught in Adelaide and Darwin and at RMIT.

Having left Parliament in 2012, Bronwyn chairs the Renewal SA Board and the Uniting Care Victorian/Tasmania Board, and is a board member of Uniting Care NSW/ACT. Bronwyn is also the President of the Australian College of Educators.

The Hon Bronwyn Pike is a member of Western Health's Finance Committee, Governance and Remuneration Committee, Quality and Safety Committee and the Audit and Risk Committee.

Appointed July 2014

DR ROBERT MITCHELL

LLB, MPHIL, GRAD DIP TAX, MTHST, PhD

Robert (Bob) Mitchell has been a solicitor for 25 years, and was a Tax Partner at PricewaterhouseCoopers for 14 years. He has served on boards of several not-for-profit organisations including BlueCare, The Timor Children's Foundation, The PwC Foundation, World Relief Australia, and the Global Health and Development Network.

Dr Mitchell has a strong interest in international development work and justice issues. He has served in senior executive roles with World Vision Australia and is the CEO of Anglican Overseas Aid.

Bob is also an ordained Anglican Minister, and has served as a member of the Federal Attorney-General's International Pro Bono Advisory Group.

Dr Mitchell is Chair of the Audit and Risk Committee and Chair of the Governance and Remuneration Committee

Appointed July 2010

CORPORATE GOVERNANCE

(CONTINUED)

PROFESSOR COLIN CLARK

BBUS, DIP ED, MBA, PHD, FCPA, FCA, FIPAA, FAICD

Colin Clark is Dean of Business and Professor of Accounting at Victoria University.

He has been active within CPA Australia having been a member of the Victorian Council, including as State President, and also a member of the board of CPA Australia including serving as Vice President. He has undertaken a range of research and consulting projects in Australia and overseas. His area of specialisation is public sector accounting and corporate governance.

Professor Clark is Chair of the Finance and Resources Committee.

Appointed July 2010

MRS ELLENI BEREDED-SAMUEL

MED, GRAD DIP COUNSELLING, GRAD CERT IN MANAGEMENT, BA (FOREIGN LANGUAGES AND LITERATURE AND ENGLISH AS A SECOND LANGUAGE)

Elleni Bereded-Samuel was born in Ethiopia. Mrs Bereded-Samuel has focused her life's work on strengthening education, training and employment for Culturally and Linguistically Diverse communities in Australia. Her dynamic leadership has resulted in new solutions for community to access and participate in society. Mrs Bereded-Samuel is currently employed with Australian Unity as Strategic Development Manager. Mrs Bereded-Samuel is responsible for providing leadership & authoritative advice to internal and external stakeholders on how to effectively engage with communities particularly with Culturally & Linguistically Diverse Communities, NGO's, Government, Research Institutes and Aged Care providers.

For six years Mrs. Bereded–Samuel served as a Commissioner of Victorian Multicultural Commission and on the Board of Directors of The Women's Hospital. Mrs. Bereded-Samuel also served for three years as the inaugural member of the Australian Social Inclusion Board and for five years as a Director] of the SBS Board.

Mrs Bereded-Samuel is one of 40 Australian champions independently selected as the People of Australia Ambassadors appointed by the Prime Minster. Mrs. Bereded-Samuel has been recognized as one of the hundred most influential African Australians and inducted into the Hall of Fame for her exceptional work in assisting the Australian community. Mrs Bereded- Samuel was inducted into Westpac & Financial Review Award as one of 100 Women of Influence in Australia.

Mrs Bereded-Samuel is Chair of the Cultural Diversity and Community Advisory Committee and a Member of the Governance & Remuneration Committee

Appointed July 2011

MRS PATRICIA CAROLYN VEJBY

JP, CMC

Patricia (Trish) Vejby is a Full Member of Heritage Victoria and has previously held Board positions which include a member of the Board of Directors, Manor Court Aged Care Hostel for over 15 years (Life Governor), Commissioner to Board of the Legal Aid Commission of Victoria, and Director, Royal Victorian Association of Honorary Justices Board.

She is a long-time resident of the western suburbs and is currently a Justice of the Peace and a founding Chairperson of the Royal Victorian Association Honorary Justices, Wyndham Branch. Memberships include Biznet Wyndham, Women's Health Service Western Region, the Swedish Church Abroad, Melbourne and Trish is involved in various community activities.

Mrs Vejby enjoys her role as a Civil Celebrant/ Commonwealth Authorised Marriage Celebrant and has undertaken the AICD Company Director's Course to support her role as a Board Director.

Mrs Vejby is Chair of the Primary Care and Population Health Advisory Committee and a Member of the Quality and Safety Committee.

Appointed July 2011

MR GERARD BLOOD

BEng (Civil), MBA (London), MIEAust, MICE, CPEng, MAICD

Gerard Blood is a senior finance, investment and operational executive with 28 years success in creating, managing and restructuring infrastructure and development projects in Australia, UK, Canada, Middle East, North Africa and Asia. He was the Managing Director of Bilfinger Berger and delivered the new Royal Women's Hospital Public Private Partnership in Melbourne.

He has worked globally and more recently in 16 countries where he has gained exposure to a variety of different health systems. This experience has challenged his views on healthcare delivery and has led to his desire to contribute this knowledge and experience as a member of the Western Health Board.

Gerard has a strong sense of community and believes that a great healthcare system relies on trust between the people it serves and those delivering the care.

Mr Blood is a Member of the Finance and Resources Committee.

Appointed August 2013
Term Completed June 2016

DR VLADIMIR J VIZEC

MBBS (Monash)

Graduating MBBS from Monash University in 1975, Dr Vizec spent the first three years of his medical career at Prince Henry's Hospital, moving into General Practice in St. Albans in 1979. Now with over 40 years of experience across aged care, refugee health and family and industrial medicine, Dr Vizec has been providing medical services to the communities of the West for several generations. He has managed multi-disciplinary medical centres, worked in London under the NHS, and is now in part-time private practice in Williamstown.

Dr Vizec is on the Board of Australian Medical Association Victoria Services, the immediate past Chair of the Committee of Management of Australian Croatian Community Services, and was involved with Divisions of General Practice at Chair and Executive levels, and with Medicare Locals at an advisory level.

Dr Vizec's experience and continuing involvement with a range of organisations gives him a broad understanding of the needs and challenges faced by health service providers and community members in the West.

Dr Vizec is the Chair of the Quality and Safety Committee and a Member of the Cultural Diversity and Community Advisory Committee.

Appointed October 2013
Term Completed June 2016

DR MIMMIE CLAUDINE NGUM CHI WATTS

PhD (LaTrobe), MPH (UniMelb)

Dr Mimmie Ngum Chi Watts is a Public Health expert and an Academic at Victoria University, Melbourne Australia.

Dr Ngum Chi Watts has a PhD (Public Health) from La Trobe University and a Master's of Public Health from the University of Melbourne, Australia. Dr Ngum Chi Watts has a diverse range of skills and interests particularly in the areas of International/ Global Health; Gender and Health inequalities; Migrant Health; Advocacy, Health Policy; Chronic Disease Management and Prevention; Research and Curriculum Development. Dr Ngum Chi Watts has presented at many national and international conferences; has served on and continues to serve on several committees and Boards. Dr Ngum Chi Watts has been recognised at local and national level for her research and community engagement activities in Australia. Dr Ngum Chi Watts is the current Convener for the International Health Special Interest Group for the State of Victoria for the Public Health Association of Australia.

Dr Ngum Chi Watts is a Member of the Primary Care and Population Health Committee and a Member of the Audit and Risk Committee.

Appointed February 2014
Term Completed June 2016

DR PHUONG PHAM

DPhil, MA, BA, BSc

The son of Vietnamese immigrants, Dr Phuong Pham feels a strong connection to the community in the West.

Dr Pham has a background of public policy and financial governance with a wealth of experience in senior roles for the Commonwealth Government Department of Health and Department of Prime Minister and Cabinet.

In his current position as Principal Health Specialist in the Business Intelligence and Strategy division of Telstra Health, Dr Pham leads the development of strategies in telehealth and telemedicine, electronic medications management, and ehealth applications for the community and aged care sector.

Dr Pham is a member of the Quality and Safety Committee.

Appointed July 2015

CORPORATE GOVERNANCE

(CONTINUED)

MR KELVYN LAVELLE

Dip.YA, Grad.Dip. Urban Research and Policy, MA by Research, GAICD

Born and raised in the Western suburbs, Mr Lavelle sees being a Director of Western Health as an opportunity to contribute to the long-term development of health services in the West, including improving the environment for patient care.

Over the past 15 years, Mr Lavelle has had a distinguished career as a corporate and public affairs professional based in Melbourne. Firstly as a strategic advisor to senior executives at some of the nation's best known companies and now, as an Executive Director at leading international infrastructure company Plenary Group.

Mr Lavelle is a Director of Plenary Conventions Pty Ltd and is also on the Board of Western Chances, a not-for-profit organisation that helps talented and motivated young people in the West who face disadvantage to reach their potential through targeted scholarships.

Highly collaborative by nature, Mr Lavelle places great value on strategic and effective communications and has applied this focus to his positions on Boards and advisory committees.

Mr Lavelle is a member of the Audit and Risk Committee.

Appointed September 2015

BOARD COMMITTEES

The Board has established several standing committees to assist it in carrying out its responsibilities.

AUDIT AND RISK COMMITTEE

The Audit and Risk Committee is responsible for ensuring that the financial and related reporting systems produce timely, accurate and relevant reports on the financial operations of the health service and that sufficient resources are allocated to identifying and managing organisational risk.

2015/16 Committee Members:

- Dr Robert Mitchell (Chair)
- The Hon Bronwyn Pike
- Mr Kelvyn Lavelle
- Dr Mimmie Ngum Chi Watts

CULTURAL DIVERSITY AND COMMUNITY ADVISORY COMMITTEE

The role of the Cultural Diversity and Community Advisory Committee is to advise the Board on relevant structures, processes, key priority areas and issues to ensure effective consumer and community participation at all levels of service planning and delivery. It also advises the Board on matters involving access and equity for patients and their families from culturally and linguistically diverse backgrounds.

FINANCE AND RESOURCES COMMITTEE

The Finance and Resources Committee is responsible for advising the Board on matters relating to financial strategies and the financial performance, capital management and sustainability of Western Health.

GOVERNANCE AND REMUNERATION COMMITTEE

The role of the Governance and Remuneration Committee is to advise the Board and monitor matters involving organisational governance and administration, and executive and senior staff recruitment, remuneration and performance.

PRIMARY CARE AND POPULATION HEALTH ADVISORY COMMITTEE

The Primary Care and Population Health Advisory Committee provides advice and recommendations to the Board on health issues affecting the population served by Western Health.

QUALITY AND SAFETY COMMITTEE

The Quality and Safety Committee is responsible for ensuring that quality monitoring activities are systematically performed at all levels of the organisation and that deviations from quality standards are acted upon in a timely and effective manner.

BOARD MEETING ATTENDANCE 2015-16

DIRECTORS	MEETINGS ATTENDED/ MEETINGS HELD
Hon Bronwyn Pike	11/11
Dr Robert Mitchell	9/11
Professor Colin Clark	9/11
Patricia Vejby	11/11
Elleni Bereded-Samuel	10/11
Gerard Blood	11/11
Dr Vladimir Vizec	10/11
Dr Mimmie Ngum Chi Watts	10/11
Dr Phuong Pham	10/10
Kelvyn Lavelle	7/8

ATTESTATION ON DATA INTEGRITY

I, Alex Cockram, Chief Executive certify that Western Health has put in place appropriate internal controls and processes to ensure that reported data reasonably reflects actual performance. Western Health has critically reviewed these controls and processes during the year.

Associate Professor Alex Cockram
Chief Executive
9 August 2016

ATTESTATION FOR COMPLIANCE WITH MINISTERIAL STANDING DIRECTION 4.5.5. - RISK MANAGEMENT FRAMEWORK AND PROCESSES

I, Alex Cockram, Chief Executive certify that that Western Health has complied with Ministerial Direction 4.5.5 - Risk Management Framework and Processes. The Western Health Audit and Risk Committee has verified this.

Associate Professor Alex Cockram
Chief Executive
9 August 2016

THE FREEDOM OF INFORMATION ACT

The Freedom of Information (FOI) Act (Vic) 1982 grants the public a legally enforceable right to access documents in the possession of Government agencies, including clinical and non-clinical records. Western Health processes all requests for access to documents in accordance with the provisions of the FOI Act.

TOTAL REQUESTS 2015/16	1315
Full Access	880
Partial Access	3
Access Denied	8
Applications Withdrawn	83
No Documents	10
Applications Not Processed	331
VCAT Appeal	0
Appeal Withdrawn	0
Transfers received	3
Time of Births	11
Attendance letter	7

CORPORATE GOVERNANCE

(CONTINUED)

OCCUPATIONAL HEALTH AND SAFETY 2015/16

To minimise risk and promote staff health and wellbeing, the following programs and activities were provided:

- Regular reports provided to the Western Health Board of Directors, Executive and the Occupational Health and Safety Committee detailing OH&S and WorkCover performance.
- OH&S training courses for managers and supervisors – as part of a Diploma Unit - Manage Workplace Health and Safety (WHS) Processes.
- OH&S training provided to targeted staff groups.
- Efficient and effective staff rehabilitation and return to work processes embedded into organisational standard practice.
- Education and training provided to staff in relation to managing risks i.e. patient handling, general manual handling, occupational violence management, workstation ergonomics, gas cylinder storage and handling, hospital danger tags, chemical handling storage, ChemAlert chemical data base, and Hazstop chemical information.
- The ongoing maintenance and development of a comprehensive intranet site to facilitate an easy reference source for obtaining information on OH&S, wellbeing and emergency management for staff.
- A proactive approach adopted and maintained to minimise and control risks by management, in conjunction with staff Health and Safety representatives (HSRs).
- Ongoing support for staff Health and Safety Representatives including initial and annual refresher training and the use of a resource package to support newly elected representatives
- The use of a HSR monthly report card, which is designed to encourage a proactive risk management approach working with management to ensure a safe working environment for staff in designated work areas.
- Ensuring dangerous goods and hazardous substances manifests and information are readily available and up to date.
- Introduction and revision of OH&S related policies and procedures to ensure systematic standardised and effective processes.
- Annual OH&S Awards which acknowledge significant contributions in improving the health, safety or well-being by Health and Safety Representatives (HSR's), staff members, Back 4 Life trainers, management and groups.
- Psychological support made available to staff offering critical incident stress management, employee assistance programs and counselling services.
- Promotion of staff well-being and fitness.

WORKCOVER CLAIMS AND WORKSAFE NOTIFIABLE INCIDENTS

Twenty one (21) accepted Standard Claims (6 – Footscray Hospital, 11 – Sunshine Hospital, 3- Williamstown Hospital and 1 - Sunbury Day Hospital) and one (1) minor claim were recorded for the year.

Thirty standard claims (30) were registered by the WH's insurer, which were standard claims received for the year and minor claims converting to standard clams from the previous year. Ten (10) of these claims were rejected and some of these claims may undergo an appeal process which could affect the liability outcome.

The WorkCover Employer Performance Rating for 2016/17 indicates WH is performing 40.93% better than the industry average.

There were five (5) Notifiable Incidents [where either the injury or event is deemed as serious defined from section 38 (3) OH&S Act 2004 and regulation 904 Equipment (Public Safety) Regulations 2007] which resulted in two (2) Improvement Notices issued by WorkSafe Victoria.

OCCUPATIONAL VIOLENCE STATISTICS

MEASURE	2015/16 ACTUALS
1. Workcover accepted claims with an occupational violence cause per 100 FTE	0.092
2. Number of accepted claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	0.54
3. Number of occupational violence incidents reported	270
4. Number of occupational violence incidents reported per 100 FTE	6.3
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition	8.14

DEFINITIONS

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

Occupational violence – any incidence where an employee is abused, threatened or assualted in circumstances arising out of, or in the course of their employment.

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

Accepted Workcover claims – Accepted Workcover claims that were lodged in 2015-26.

Lost time – is defined as greater than one day.

OPEN ACCESS BOARD MEETING

Sixty-seven people joined Board Directors at Sunshine Hospital in December 2015 for a discussion on the design of the new Joan Kirner Women's & Children's Hospital.

The agenda for the open access event included:

- An introduction by the Board Chair
- A presentation on the hospital development
- Group discussions facilitated by Board Members on four questions related to the design of the hospital, covering way finding, amenities, waiting areas and patient surroundings
- General question and answer session

There was a positive response on the value of the meeting, with 100% of survey respondents (n=41) rating their opportunity to contribute to discussions or share their thoughts as good or excellent.

STATEMENT OF MERIT AND EQUITY

Further to the requirements of the Public Sector Administration Act 2004, Western Health has established that the organisational values of caring, accountability, respect, excellence and safety align with the public sector values of responsiveness, integrity, impartiality, accountability, respect, leadership and human rights.

Western Health is committed to the application of the public sector employment principles and has reviewed employment processes to ensure that employment decisions are based on merit. All employees are treated fairly and reasonably, equal employment opportunity is provided and employees are afforded a structured grievance procedure for redress against unfair or unreasonable treatment.

Western Health has an established Code of Conduct, which aligns with and supports the public sector employment principles.

BUILDING ACT 1993

Western Health fully complied with the building and maintenance provisions of the Building Act 1993 for the period 1 July 2015 to 30 June 2016. Where applicable, the appropriate Building Permits and Certificates of Occupancy were obtained in line with the requirements of the Building Act 1993.

CAR PARKING FEES

Western Health complies with the DHHS hospital circular on car parking fees effective 1 February 2016 and details of car parking fees and concession benefits can be viewed at www.westernhealth.org.au.

PROTECTED DISCLOSURE ACT

In accordance with Part 9 of the Protected Disclosure Act (Vic) 2012, Western Health has developed procedures and guidelines to facilitate the handling of a disclosure, the making of a disclosure and to ensure that the person making such disclosure is protected from detrimental action. To ensure awareness, the procedure and guidelines are available on the Western Health intranet.

In accordance with the provisions of section 21 (2) of the Act, no disclosures were received and notified to IBAC during the 2015/16 financial year.

CORPORATE GOVERNANCE

(CONTINUED)

VICTORIAN INDUSTRY PARTICIPATION POLICY

Western Health complies with the intent of the Victorian Industry Participation Policy Act (Vic) 2003 which is to encourage, where possible, local industry participation in the supply of goods and services to government agencies.

2015-16 – NEW/COMPLETED VICTORIAN INDUSTRY PARTICIPATION PROJECTS

PROCUREMENT NAME	SUNSHINE HOSPITAL STAFF CARPARK EXTENSION
Value of Procurement	$4m approximately
Project Location	Sunshine Hospital
Local Content (%)	98.89%
Commencement Date	June 2016
Completion Date	December 2016
Total Contracted Jobs	Contractor to Report against VIPP Plan as per ICN Requirements
Total Actual Jobs	Contractor to Report against VIPP Plan as per ICN Requirements
Total Contracted Apprentices/ trainees	Contractor to Report against VIPP Plan as per ICN Requirements
Total Actual Apprentices/ trainees	Contractor to Report against VIPP Plan as per ICN Requirements
Skill/technology transfer achieved	Contractor to Report against VIPP Plan as per ICN Requirements

NATIONAL COMPETITION POLICY

Western Health has implemented, and continues to comply with, the National Competition Policy and the requirements of the Victorian Government's Competitive Neutrality Policy.

ADDITIONAL INFORMATION

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

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

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

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

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

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

(f) Details of major research and development activities undertaken by Western Health 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 Western Health to develop community awareness of Western Health 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 Western Health 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 Western Health, the purposes 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.

DISCLOSURE INDEX

The annual report of Western 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 22G	Manner of establishment and the relevant Ministers	21-24
FRD 22G	Purpose, functions, powers and duties	21
FRD 22G	Initiatives and key achievements	2-5
FRD 22G	Nature and range of services provided	6-7, 20
Management and structure		
FRD 22G	Organisational Structure	18-19
Financial and other information		
FRD 10A	Disclosure index	29-30
FRD 11A	Disclosure of ex-gratia payments	N/A
FRD 21B	Responsible person and executive officer disclosures	88
FRD 22G	Application and operation of Protected Disclosure Act 2012	27
FRD 22G	Application and operation of Freedom of Information Act 1982	25
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FRD 22G	Details of consultancies over $10,000	16
FRD 22G	Details of consultancies under $10,000	16
FRD 22G	Employment and Conduct Principles	27
FRD 22G	Major changes or factors affecting performance	2-5
FRD 22G	Occupational health and safety	26-27
FRD 22G	Operational and budgetary objectives and performance against objectives	12-17
FRD 24C	Reporting of office-based environmental impacts	4
FRD 22G	Significant changes in financial position during the year	15-17
FRD 22G	Statement of availability of other information	28
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FRD 22G	Summary of the financial results for the year	15
FRD 22G	Workforce Data Disclosures including a statement on the application of employment and conduct principles	15, 27
FRD 25B	Victorian Industry Participation Policy disclosures	28

DISCLOSURE INDEX

(CONTINUED)

LEGISLATION	REQUIREMENT	PAGE
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SD 4.2(b)	Comprehensive operating statement	33
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SD 4.2(c)	Accountable officer's declaration	32
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FINANCIAL STATEMENTS & ACCOMPANYING NOTES

BOARD MEMBER'S, ACCOUNTABLE OFFICER'S AND CHIEF FINANCIAL OFFICER'S DECLARATION

The attached consolidated financial statements for Western Health have been prepared in accordance with Standing Direction 4.2 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 30th June 2016 and the financial position of Western Health as at 30th June 2016.

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

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

The Honourable Bronwyn Pike
Board Chairperson

Melbourne
9th August 2016

Associate Professor Alex Cockram
Chief Executive Officer

Melbourne
9th August 2016

Mark Lawrence
Chief Financial Officer

Melbourne
9th August 2016

COMPREHENSIVE OPERATING STATEMENT

	NOTE	2016 $'000	2015 $'000
Revenue from Operating Activities	2	669,468	615,962
Revenue from Non-operating Activities	2	2,072	2,630
Employee Expenses	3	(495,405)	(454,785)
Non Salary Labour Expenses	3	(10,216)	(8,599)
Supplies & Consumables	3	(101,698)	(86,993)
Other Expenses	3	(63,901)	(66,807)
Net Result Before Capital and Specific Items		**320**	**1,408**
Capital Purpose Income	2	14,763	25,582
Expenditure for Capital Purpose	3	(443)	(905)
Depreciation and Amortisation	4	(40,470)	(39,280)
NET RESULT FOR THE YEAR		**(25,830)**	**(13,195)**
Other Comprehensive Income			
Items that will not be reclassified to net result			
Changes in physical asset revaluation surplus		8,663	-
Items that may be reclassified subsequently to net result			
Changes to financial assets available-for-sale revaluation surplus	15a	101	-
Total Other Comprehensive Income		**8,764**	**-**
COMPREHENSIVE RESULT FOR THE YEAR		**(17,066)**	**(13,195)**

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

BALANCE SHEET

	NOTE	2016 $'000	2015 $'000
Current Assets			
Cash and Cash Equivalents	5	16,679	56,448
Receivables	6	13,895	11,922
Investments and Other Financial Assets	7	45,101	-
Inventories	8	2,105	2,404
Prepayments and Other Assets	9	404	1,123
Total Current Assets		**78,184**	**71,897**
Non-Current Assets			
Receivables	6	21,917	10,951
Investments and Other Financial Assets	7	1	-
Property, Plant and Equipment	10	582,479	595,290
Intangible Assets	11	1,631	1,626
Total Non-Current Assets		**606,028**	**607,867**
TOTAL ASSETS		**684,212**	**679,764**
Current Liabilities			
Payables	12	33,504	21,164
Provisions	13	107,047	108,808
Total Current Liabilities		**140,551**	**129,972**
Non-Current Liabilities			
Provisions	13	23,615	12,664
Total Non-Current Liabilities		**23,615**	**12,664**
TOTAL LIABILITIES		**164,166**	**142,636**
NET ASSETS		**520,046**	**537,128**
EQUITY			
Property, Plant & Equipment Revaluation Surplus	15a	302,777	294,114
Financial Asset Available for Sale Revaluation Surplus	15a	101	-
Restricted Specific Purpose Surplus	15a	2,892	2,398
Contributed Capital	15b	202,980	202,980
Accumulated Surplus	15c	11,296	37,636
TOTAL EQUITY	**15d**	**520,046**	**537,128**
Commitments For Expenditures	18		
Contingent Assets and Contingent Liabilities	19		

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

STATEMENT OF CHANGES IN EQUITY

	NOTE	PROPERTY, PLANT & EQUIPMENT REVAL-UATION SURPLUS	FINANCIAL ASSET AVAILABLE FOR SALE REVAL-UATION SURPLUS	RESTRICTED SPECIFIC PURPOSE SURPLUS	CONTRIB-UTED BY OWNERS	ACCUMU-LATED SUR-PLUSES/ (DEFICITS)	TOTAL
		$'000	$'000	$'000	$'000	$'000	$'000
Balance at July 1st 2014		**294,114**	**-**	**1,446**	**202,980**	**51,799**	**550,339**
Net result for the year	15c	-	-	-	-	(13,195)	(13,195)
Other comprehensive income for the year	15a	-	-	-	-	-	-
Share of decrements in surplus attributed to joint venture	15a	-	-	(16)	-	-	(16)
Transfer from accumulated surplus	15c	-	-	968	-	(968)	-
Balance at June 30th 2015		**294,114**	**-**	**2,398**	**202,980**	**37,636**	**537,128**
Net result for the year	15c	-	-	-	-	(25,830)	(25,830)
Other comprehensive income for the year	15a	8,663	101	-	-	-	8,764
Share of decrements in surplus attributed to joint venture	15a	-	-	(16)	-	-	(16)
Transfer from accumulated surplus	15c	-		510	-	(510)	-
Balance at June 30th 2016		**302,777**	**101**	**2,892**	**202,980**	**11,296**	**520,046**

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

STATEMENT OF CASH FLOWS

	NOTE	2016 $'000	2015 $'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating grants from government		586,527	548,752
Capital grants from government		14,514	25,964
Patient and resident fees received		19,454	15,919
Private practice fees received		20,991	19,407
Donations and bequests received		1,427	2,461
GST received from ATO		9,031	9,548
Recoupment from private practice for use of hospital facilities		726	604
Interest received		1,977	2,881
Other receipts		28,714	25,916
Total receipts		**683,361**	**651,452**
Employee expenses paid		(477,229)	(450,375)
Non salary labour costs		(10,788)	(9,119)
Payments for supplies & consumables		(102,505)	(93,031)
Other payments		(65,676)	(66,797)
Total payments		**(656,198)**	**(619,322)**
NET CASH INFLOW FROM/(USED IN) OPERATING ACTIVITIES	**16**	**27,163**	**32,130**
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of non-financial assets		(21,932)	(34,433)
Purchase of investments		(45,000)	-
Proceeds from sale of non-financial assets		-	(966)
NET CASH OUTFLOW FROM/(USED IN) INVESTING ACTIVITIES		**(66,932)**	**(35,399)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENT HELD		**(39,769)**	**(3,269)**
Cash and cash equivalents at beginning of financial year		**56,448**	**59,717**
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	**5**	**16,679**	**56,448**

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

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

These annual financial statements represent the audited general purpose financial statements for Western Health, (the "Health Service"), for the period ending 30th June 2016. The report provides users with information about the Health Service's stewardship of the resources entrusted to it.

(A) STATEMENT OF COMPLIANCE

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

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

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

The annual financial statements were authorised for issue by the Board of Western Health on the 9th August 2016.

(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 events are reported.

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30th June 2016 and the comparative information presented in these financial statements for the year ended 30th June 2015.

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

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

The financial statements, except for cash flow information, have been prepared using the accrual basis of accounting.

Under the accrual basis, items are recognised as assets, liabilities, equity, income or expenses when they satisfy the definitions and recognition criteria for those items, that is they are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

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

- Non-current physical assets which, subsequent to acquisition, are measured at the revalued amount being their fair value at the date of revaluation less any subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made and are reassessed when new indices are published by the Valuer-General to ensure that the carrying amounts do not materially differ from their fair 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.
- The fair value of assets, other than land and buildings, is the depreciated acquisition cost.

Judgements, estimates and assumptions are required to be made about the carrying amounts of assets and liabilties 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.

Consistent with AASB 13 *Fair Value Measurement*, the Health Service determines the policies and procedures for recurring fair value measurements such as property, plant and equipment and financial instruments.

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

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

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(CONTINUED)

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

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

The Valuer-General Victoria (VGV) is the Health Service's independent valuation agency in respect of land and buildings.

The Health Service, in conjunction with VGV, monitors the changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required. VGV supply land and building indices which the health service uses for fair value assesment, with adjustments made where applicable

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

- the fair value of land, buildings, infrastructure, plant and equipment (refer to Note 1(j));
- superannuation expense (refer to Note 1(g)); and
- actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 1(k)).

(C) REPORTING ENTITY

The financial statements include all the controlled entities of the Health Service. The only controlled entity is the Western Health Foundation Limited.

The principle address of Western Health is:

Gordon Street, Footscray
Victoria 3011

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

OBJECTIVES AND FUNDING

The Health Service's overall objective is the provision of health services, as well as to improve the quality of life of Victorians.

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

(D) PRINCIPLES OF CONSOLIDATION

In accordance with AASB 10 *Consolidated Financial Statements*, the consolidated financial statements of the Health Service includes all reporting entities controlled by the Health Service as at 30th June 2016. Control exists when the Health Service has the power to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable are taken into account. The consolidated financial statements include the audited financial statements of the controlled entities listed in note 24, namely the Western Health Foundation Limited.

In the process of preparing consolidated financial statements for the Health Service, all material transactions and balances between consolidated entities are eliminated.

JOINTLY CONTROLLED ASSETS AND OPERATIONS

Interests in jointly controlled assets or operations are not consolidated by the Health Service, but are accounted for in accordance with the policy outlined in Note 1(j) Financial Assets. The Victorian Comprehensive Cancer Care Centre (VCCC) is the only jointly controlled asset or operation.

(E) SCOPE AND PRESENTATION OF FINANCIAL STATEMENTS

FUND ACCOUNTING

The Health Service operates on a fund accounting basis and maintains three funds:

Operating, Specific Purpose and Capital Funds. The Health Service's Capital and Specific Purpose Funds include unspent capital donations and receipts from fund-raising activities conducted solely in respect of those funds.

SERVICES SUPPORTED BY HEALTH SERVICES AGREEMENT AND SERVICES SUPPORTED BY HOSPITAL AND COMMUNITY INITIATIVES

Activities classified as Services Supported by Health Services Agreement (HSA) are substantially funded by the Department

of Health and Human Services (DHHS) and are also funded from other sources such as the Commonwealth and patients. Services supported by Hospital and Community Initiatives (H&CI) are funded by the Health Service's own activities or local initiatives and/or the Commonwealth.

COMPREHENSIVE OPERATING STATEMENT

The comprehensive operating statement includes the subtotal titled 'Net Result Before Capital & Specific Items' to enhance the understanding of the financial performance of the Health Service. This subtotal reports the result excluding items such as capital grants, assets received or provided free of charge, depreciation, expenditure using capital purpose income and items of an unusual nature and amount such as specific income and expenses. The exclusion of these items is made to enhance matching of income and expenses so as to facilitate the comparability and consistency of results between years and Victorian Public Health Services. The 'Net Result Before Capital & Specific Items' is used by the management of the Health Service, the Department of Health and Human Services and the Victorian Government to measure the ongoing operating performance of health services.

Capital and specific items, which are excluded from this sub-total, comprise:

- Capital purpose income, which comprises all tied grants, donations and bequests received for the purpose of acquiring non-current assets, such as capital works, plant and equipment or intangible assets. It also includes donations of plant and equipment (refer Note 1 (f)). Consequently the recognition of revenue as capital purpose income is based on the intention of the provider of the revenue at the time the revenue is received.
- Specific income/expense, comprises the following items, where material:
  - Non-current asset revaluation increments/decrements
  - Diminution/impairment of investments
- Impairment of financial and non-financial assets, includes all impairment losses, (and reversal of previous impairment losses), which have been recognised in accordance with Note 1 (j).
- Depreciation and amortisation, as described in Note 1 (g).
- Expenditure using capital purpose income, comprises expenditure which either falls below the asset capitalisation threshold or does not meet asset recognition criteria and therefore does not result in the recognition of an asset in the balance sheet, where funding for that expenditure is from capital purpose income.

BALANCE SHEET

Assets and liabilities are categorised either as current or non-current, (non-current being those assets or liabilities expected to be recovered/settled more than twelve months after the reporting period), are separately disclosed in the notes where relevant.

STATEMENT OF CHANGES IN EQUITY

The statement of changes in equity presents reconciliations of each non-owner and owner changes in equity from opening balance at the beginning of the reporting period to the closing balance at the end of the reporting period. It also shows separately changes due to amounts recognised in the comprehensive result and amounts recognised in other comprehensive income.

CASH FLOW STATEMENT

Cash flows are classified according to whether or not they arise from operating activities, investing activities, or financing activities. This classification is consistent with requirements under AASB 107 *Statement of Cash Flow*s.

ROUNDING

All amounts shown in the financial statements are expressed to the nearest $1,000.

AASB 10 CONSOLIDATED FINANCIAL STATEMENTS

In accordance with the criteria prescribed in AASB 10, the Health Service management has reviewed the existing arrangements to determine entities that need to be consolidated into the group. An assessment of control was performed and it was concluded that the Health Service has control over the Western Health Foundation being the sole member controlling its total voting rights.

The objective of Western Health Foundation is the management of all fundraising and philanthropic activities for and on behalf of the Health Service.

AASB 11 JOINT ARRANGEMENTS

In accordance with AASB 11, there are two types of joint arrangements, i.e. joint operations and joint ventures. Joint operations arise where investors have rights to the assets and obligations for the liabilities of an arrangement. A joint operator accounts for its shares of the assets, liabilities, revenue and expenses. Joint ventures arise where the investors have rights to the net assets of the arrangement; joint ventures are accounted for under the equity method. Proportionate consolidation of joint ventures is no longer permitted.

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(CONTINUED)

The Health Service has reviewed its existing contractual arrangements with other entities to ensure they are aligned with the classifications under AASB 11 and has concluded that the Victorian Comprehensive Cancer Centre (VCCC) is a joint operation.

The Health Service as a member of the VCCC retains joint control over the arrangement which it has classified as a joint operation. The vision of the VCCC is to save lives through the integration of cancer research, education and patient care. The VCCC is a not-for-profit organisation and has been recognised by the Australian Taxation Office as a Health Promotion Charity.

All members of the VCCC hold an equal 10 percent (2015: 11 percent) share in the assets, liabilities, revenue and expenses of the VCCC. The members own the VCCC assets as tenants in common and are severally responsible for the joint operation costs in the same proportions as their interests. Accordingly, assets, liabilities, income and expenses are consolidated in proportion to the Health Service's contractually specified share.

Interests in the VCCC are not transferable and are forfeited on withdrawal from the joint operation. Distributions are not able to be paid to members and excess property, on winding up, will be distributed to other charitable organisations with objectives similar to those of the VCCC.

The VCCC member entities have created a company to conduct the affairs of the joint operation. The member entities have specifically, in their agreement, stated that they do not indemnify the company against any liabilities beyond their contribution to the joint assets of the joint operation. The member entities do not therefore bear any financial risk beyond their contribution to the joint assets. "Their contribution" means their share of the net assets. Reputational risk through membership is addressed through the appointment of representatives to the governing bodies of the VCCC. The risks associated with the VCCC have not changed from previous reporting periods.

The principal place of business for the VCCC is Level 10, 305 Grattan Street, Melbourne, Victoria.

(F) INCOME FROM TRANSACTIONS

Income is recognised in accordance with AASB 118 *Revenue* and is recognised to the extent that it is probable that economic benefits will flow to the Health Service and the income can be reliably measured at fair value. Unearned income at reporting date is reported as income received in advance.

Amounts disclosed as revenue are, where applicable, net of returns, allowances, 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 received are treated 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 (DHHS)

- Insurance premiums paid by DHHS on behalf of the Health Service are recognised as revenue following advice from the DHHS.
- Long Service Leave (LSL) grants are 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 05/2013. The grant is intended to partly reimburse the health service for LSL expenditure.

PATIENT FEES

Patient fees revenue is calculated by adding unbilled fees for patients not discharged at year end to fees billed to date less accrued fees in the previous year.

PRIVATE PRACTICE FEES

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

REVENUE FROM COMMERCIAL ACTIVITIES

Revenue from commercial activities is recognised at the time invoices are raised.

DONATIONS AND BEQUESTS

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

INTEREST REVENUE

Interest revenue is recognised on a time proportionate basis that takes into 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.

(G) EXPENSE RECOGNITION

Expenses are recognised as they are incurred and are 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

Employee expenses include:

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

Defined Contribution Superannuation Plans

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

Defined Benefit Superannuation Plans

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

Employees of the 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(s) provide benefits based on years of service and final average salary.

The names and details of the major employee superannuation funds and contributions made by the Health Service are disclosed in Note 14: Superannuation.

DEPRECIATION

All infrastructure assets, buildings, plant and equipment and other non-financial physical assets that have finite useful lives are depreciated, (this excludes land). 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 the manner intended by management.

Intangible produced assets with finite lives are depreciated as an expense from transactions on a systematic basis over the asset's useful life. Depreciation is 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 annually and adjustments are made where appropriate. The depreciation charge is not funded by the Department of Health and Human Services. Assets with a cost in excess of $2,500 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

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

	2016	2015
Buildings		
- Structures Shell Building Fabric	40-52 years	40-52 years
- Site Engineering Services and Central Plant	23-40 years	23-40 years
Central Plant		
- Fit Out	15-40 years	15-40 years
- Trunk Reticulated Building System	21-40 years	21-40 years
Plant and Equipment	10 Years	10 Years
Medical Equipment	7-10 Years	7-10 Years
Non Medical Equipment	10 Years	10 Years
Furniture and Fittings	10 Years	10 Years
Motor Vehicles	4 Years	4 Years
Computers and Communication	3 Years	3 Years

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(CONTINUED)

As part of building valuation, building values are separated into components and each component assessed for its useful life which is reported above.

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

AMORTISATION

Amortisation begins when the asset is available for use, that is, when it is in the location and condition necessary for it to be capable of operating in the manner intended by management.

The amortisation period and the amortisation method for an intangible asset with a finite useful life is reviewed annually. In addition, an assessment is made at each reporting date to determine whether there are indicators that the intangible asset concerned is impaired. If so, the asset concerned is tested as to whether its carrying value exceeds its recoverable amount. Any excess of the carrying amount over the recoverable amount is recognised as an impairment loss.

Intangible assets with finite useful lives are amortised over a 3 year period (2015: 3 years).

OTHER OPERATING EXPENSES

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

- **Supplies and consumables**
  Supplies and services costs which are recognised as an expense in the reporting period in which they are incurred. The carrying amounts of any inventories held for distribution are expensed when distributed.
- **Bad and doubtful debts**
  Refer to Note 1(j) Impairment of Financial Assets.
- **Fair value of assets, services and resources provided free of charge or for nominal consideration**
  Contributions of resources provided free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them, irrespective of whether restrictions or conditions are imposed over the use of the contributions, unless received from another agency as a consequence of a restructuring or administrative arrangements. In the latter case, such a transfer will be recognised at its carrying amount.

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

(H) OTHER COMPREHENSIVE INCOME

Other comprehensive income measures the change in 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) on non-financial physical assets**
  Refer to Note 1(j) Revaluations of non-financial physical assets.
- **Net gain/(loss) on financial instruments**
  Net gain/(loss) on financial instruments includes:
  - realised and unrealised gains and losses from revaluations of financial instruments at fair value;
  - impairment and reversal of impairment for financial instruments at amortised cost (refer to Note 1 (j); and
  - disposals of financial assets and derecognition of financial liabilities.
- **Revaluation of financial instrument at fair value**
  Refer to Note 1(i) Financial Instruments.

(I) 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 Health Service's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation*. For the Health Service, Goods and Services Tax ("GST") receivables and DHHS grants 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 financial assets and financial liabilities that meet the definition of financial instruments in accordance with AASB 132 and those that do not.

The following refers to financial instruments unless otherwise stated.

CATEGORIES OF NON-DERIVATIVE FINANCIAL INSTRUMENTS

Loans and Receivables

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

Loans and receivables includes cash and deposits (refer to Note 1(j)), trade receivables, loans and other receivables, but not statutory receivables.

Available-For-Sale Financial Assets

Available-for-sale financial instrument assets are those designated as available-for-sale or not classified in any other category of financial instrument asset. Such assets are initially recognised at fair value. Subsequent to initial recognition, gains and losses arising from changes in fair value are recognised in "other comprehensive income" until the investment is disposed of or is determined to be impaired, at which time the cumulative gain or loss previously recognised in equity is included in net result for the period. Fair value is determined in the manner described in Note 17.

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 and loss.

(J) ASSETS

CASH AND CASH EQUIVALENTS

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.

RECEIVABLES

Receivables consist of:

- contractual receivables, which includes mainly debtors in relation to goods and services and accrued investment income; and
- statutory receivables, which includes predominantly amounts owing from the Victorian Government and GST input tax credits recoverable.

Receivables that are contractual are classified as financial instruments and are 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. For the Health Service, GST receivables and certain DHHS Grants fall into this category.

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 not to be collectible 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.

INVESTMENTS AND OTHER FINANCIAL ASSETS

Hospital investments are made in accordance with Standing Direction 4.5.6 - Treasury Risk Management. Investments are recognised and derecognised on trade date where purchase or sale of an investment is under a contract whose terms require delivery of the investment within the timeframe established by the market concerned and are initially measured at fair value, net of transaction costs.

Investments are classified in the following categories:

- available-for-sale financial assets; and
- loans and receivables.

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

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(CONTINUED)

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

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

INVENTORIES

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 are measured at the lower of cost and net realisable value.

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

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

PROPERTY, PLANT AND EQUIPMENT

All non-current physical assets are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and accumulated impairment loss. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition.

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

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

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

REVALUATIONS OF NON-FINANCIAL PHYSICAL ASSETS

Non-financial physical assets are measured at fair value and are revalued in accordance with FRD 103F *Non-Financial Physical Assets*. This revaluation process for land and buildings 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 of land and buildings and any interim revaluations are determined in accordance with the requirements of the FRDs. Revaluation increments or decrements arise from differences between an asset's carrying amount and fair value.

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

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

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

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

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

INTANGIBLE ASSETS

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

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

Expenditure in research activities is recognised as an expense in the period in which it is incurred.

When the recognition criteria in AASB 138 *Intangible Assets* are met, internally generated intangible assets are recognised and measured at cost less accumulated amortisation and impairment.

An internally generated intangible asset arising from development, (or from the development phase of an

internal project) is recognised only if all of the following are demonstrated:

(a) the technical feasibility of completing the intangible asset so that it will be available for use or sale;

(b) an intention to complete the intangible asset and use or sell it;

(c) the ability to use or sell the intangible asset;

(d) the intangible asset will generate probable future economic benefits;

(e) the availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset; and

(f) the ability to measure reliably the expenditure attributable to the intangible asset during its development.

PREPAYMENTS

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

DISPOSAL OF NON-FINANCIAL ASSETS

Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement. Refer to note 1(h) - "comprehensive income".

IMPAIRMENT OF NON-FINANCIAL ASSETS

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

- inventories; 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 deducted from 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.

In the event of the loss or destruction of an asset, it is deemed that 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. The 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.

INVESTMENTS IN JOINT OPERATIONS

In respect of any interest in joint operations, the Health Service recognises in the financial statements:

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

DERECOGNITION OF FINANCIAL ASSETS

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

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

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

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

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

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(CONTINUED)

IMPAIRMENT OF FINANCIAL ASSETS

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

Receivables are assessed for bad and doubtful debts on a regular basis. Bad debts considered as written off and allowances for doubtful receivables are expensed.

The amount of 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 order to determine an appropriate fair value as at 30th June 2016 for its portfolio of financial assets, the Health Service obtained a valuation from the institution with which the investments are held.

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*.

(K) LIABILITIES

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 credit terms for accounts payable is usually Net 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.

PROVISIONS

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

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

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

EMPLOYEE BENEFITS

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

Wages and Salaries, Annual Leave and Accrued Days Off

Liabilities for wages and salaries, including non-monetary benefits, accrued days off and annual leave are all recognised in the provision for employee benefits as "current liabilities" because the Health Service does not have an unconditional right to defer settlements of these liabilities.

Depending on the expected timing of settlement, liabilities for wages and salaries, accrued days off and annual leave are measured at:

- undiscounted value - if the Health Service expects to wholly settle within 12 months; or
- present value - if the Health Service does not expect to wholly settle within 12 months.

Long Service Leave (LSL)

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

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

The components of this current LSL liability are measured at:

- undiscounted value - if the Health Service expects to wholly settle within 12 months; and
- discounted 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. This non-current LSL liability is measured at present, (discounted), value.

Any gain or loss followed revaluation of the present value of non-current LSL liability is recognised as a transaction.

Termination Benefits

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

The Health Service recognises termination benefits when it is demonstrably committed to either terminating the employment of an employee 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.

ON-COSTS RELATED TO EMPLOYEE EXPENSE

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

SUPERANNUATION LIABILITIES

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

DERECOGNITION OF FINANCIAL LIABILITIES

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

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

(L) LEASES

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

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

All other leases are classified as operating leases.

FINANCE LEASES

The Health Service does not hold any finance lease arrangements, either as a lessor or as a lessee.

OPERATING LEASES

Operating lease payments, including any contingent rentals, are recognised as an expense in the comprehensive operating statement on a straight line basis over the lease term, except where another systematic basis is more representative of the time pattern of the benefits derived from the use of the leased asset. The leased asset is not recognised in the balance sheet.

(M) EQUITY

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 to or distributions by owners that have been designated as contributed capital are also treated as contributed capital. Contributed capital consists of grants received from the owners i.e. the DHHS, no contributed capital was received in the 2015/16 financial year.

PROPERTY, PLANT & EQUIPMENT REVALUATION SURPLUS

The asset revaluation surplus is used to record increments and decrements on the revaluation of non-current physical assets.

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES
(CONTINUED)

FINANCIAL ASSET AVAILABLE-FOR-SALE REVALUATION SURPLUS

The available-for-sale revaluation surplus arises on the revaluation of available-for-sale financial assets. Where a revalued financial asset is sold that portion of the surplus which relates to that financial asset is effectively realised and is recognised in the comprehensive operating statement. Where a revalued financial asset is impaired that portion of the surplus which relates to that financial asset is recognised in the comprehensive operating statement.

SPECIFIC RESTRICTED PURPOSE FUND

A specific restricted purpose fund 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.

(N) COMMITMENTS

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed by way of a note (refer to Note 18) at their nominal value and are inclusive of the GST payable. In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant individual projects are stated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

(O) CONTINGENT ASSETS AND CONTINGENT LIABILITIES

Contingent assets and contingent liabilities are not recognised in the balance sheet, but are disclosed by way of note and, if quantifiable, are measured at nominal value. Contingent assets and contingent liabilities are presented inclusive of GST receivable or payable respectively (refer to Note 19).

(P) GOODS AND SERVICES TAX ("GST")

Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the taxation authority. In this case the GST payable is recognised as part of the cost of acquisition of the asset or as part of the expense.

Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the taxation authority is included with other receivables or payables in the balance sheet.

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

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

(Q) FOREIGN CURRENCY

All foreign currency transactions during the financial year are brought to account using the exchange rate in effect at the date of the transaction. Foreign monetary items existing at the end of the reporting period are translated at the closing rate at the date of the end of the reporting period. Non-monetary assets carried at fair value that are denominated in foreign currencies are translated to the functional currency at the rates prevailing at the date when the fair value was determined.

(R) AUSTRALIAN ACCOUNTING STANDARDS (AASs) ISSUED THAT ARE NOT YET EFFECTIVE

Certain new Australian accounting standards have been published that are not mandatory for the 30th June 2016 reporting period. The Department of Treasury and Finance assesses the impact of all these new standards and advises the Health Service of their applicability and early adoption where applicable.

As at 30th June 2016, 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. The Health Service has not and does not intend to adopt these standards early.

STANDARD / INTERPRETATION	SUMMARY	APPLICABLE FOR ANNUAL REPORTING PERIODS BEGINNING OR ENDING ON	IMPACT ON FINANCIAL STATEMENTS
AASB 9 *Financial instruments*	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1 Jan 2018	The assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss. While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.
AASB 10-7 *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 and loss, the effect of the changes in credit risk are also presented in profit or loss.	1 Jan 2018	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. Changes in own credit risk in respect of liabilities designated at fair value through profit and loss will now be presented within other comprehensive income (OCI). Hedge accounting will be more closely aligned with common risk management practices making it easier to have an effective hedge. For entities with significant lending activities, an overhaul of related systems and processses may be needed.
AASB 2014-1 *Amendments to Australian Accounting Standards [Part E Financial Instruments]*	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	1 Jan 2018	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2014-7 *Amendments to Australian Accounting Standards arising from AASB 9*	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1 Jan 2018	The assessment has indicated that there will be no impact for the public sector.

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(CONTINUED)

STANDARD / INTERPRETATION	SUMMARY	APPLICABLE FOR ANNUAL REPORTING PERIODS BEGINNING OR ENDING ON	IMPACT ON FINANCIAL STATEMENTS
AASB 15 *Revenue from Contracts with Customers*	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1 Jan 2018	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications. A potential impact will be the upfront recognition of revenue from licences that cover multiple reporting periods. Revenue that was deferred and amortised over a period may now need to be recognised immediately as a transitional adjustment against the opening returned earnings if there are no former performance obligations outstanding.
AASB 2014-15 *Amendments to Australian Accounting Standards arising from AASB 15*	Amends the measurement of trade receivables and the recognition of dividends. Trade receivables that do not have a significant financing component, are to be measured at their transaction price, at initial recognition. Dividends are recognised in the profit and loss only when: - the entity's right to receive payment of the dividend is established; - it is probable that the economic benefits associated with the dividend will flow to the entity; and - the amount can be measured reliably.	1 Jan 2017, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated that there will be no impact for the public sector.
AASB 2015-8 *Amendments to Australian Accounting Standards - Effective Date of AASB 15*	This Standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018	1 Jan 2018	This amending standard will defer the application period of AASB 15 to the 2018-19 reporting period in accordance with the transition requirements.

STANDARD / INTERPRETATION	SUMMARY	APPLICABLE FOR ANNUAL REPORTING PERIODS BEGINNING OR ENDING ON	IMPACT ON FINANCIAL STATEMENTS
AASB 2016-3 *Amendments to Australian Accounting Standards - Clarifications to AASB 15*	This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. the amendments require: – A promise to transfer to a customer a good or service that is ""distinct"" to be recognised as a separate performance obligation; – For items purchased online, the entity is a principal if it obtains control of the good or service prior to the transferring to the customer; and – For licences identified as being distinct from other foods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right of use) or at a point in time (right of access).	1 Jan 2018	This assessment has indicated that there will be no significant impact for the public sector, other than the impact identified in AASB 15.
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of most operating leases (which are currently not recognised) on balance sheet.	1 Jan 2019	The assessment has indicated that as most operating leases will come on balance sheet, recognition of lease assets and lease liabilities will cause net debt to increase. Depreciation of lease assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. The amounts of cash paid for the principal portion of the lease liability will be presented within financing activities and the amounts paid for the interest portion will be presented within operating activities in the cash flow statement. No change for lessors.
AASB 2016-4 *Amendments to Australian Accounting Standards - Recoverable Amount of Non-Cash Generating Specialised Assets of Not-for-Profit Entities*	The Standard amends AASB 136 *Impairment of Assets* to remove references to using depreciated replacement cost (DRC) as a meaure of value in use for not-for-profit entities.	1 Jan 2017	The assessment has indicated that there is minimal impact. Given the specialised nature and restrictions of public sector assets, the existing use is presumed to be the highest and best use (HBU), hence current replacement cost under AASB 13 *Fair Value Measurement* is the same as the depreciated replacement cost concept under AASB 136.

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(CONTINUED)

In addition to the new standards and amendments above, the AASB has issued a list of other amending standards that are not effective for the 2015-16 reporting period (as listed below). In general, these amending standards include editorial and references changes that are expected to have insignificant impacts on public sector reporting.

- AASB 1057 *Application of Australian Accounting Standard*
- AASB 2014-3 *Amendments to Australian Accounting Standards - Accounting for Acquisitions of Interests in Joint Operations [AASB 1 & AASB 11]*
- AASB 2015-2 *Amendments to Australian Accounting Standards - Disclosure Initiative: Amendments to AASB 101 [AASB 7, AASB 101, AASB 134 & AASB 1049*
- AASB 2015-5 *Amendments to Australian Accounting Standards - Investment Entities: Applying the Consolidation Exception [AASB 10, AASB 12 & AASB 128]*
- AASB 2015-9 *Amendments to Australian Accounting Standards - Scope and Application Paragraphs [AASB 8, AASB 133 & AASB 1057]*
- AASB 2015-10 *Amendments to Australian Accounting Standards - Effective Date of Amendments to AASB 10 and AASB 128*
- AASB 2016-2 *Amendments to Australian Accounting Standards - Disclosure Initiative: Amendments to AASB 107*

(S) CATEGORY GROUPS

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

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

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

Emergency Department Services (EDS) comprises all emergency department services.

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

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

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

NOTE 2: ANALYSIS OF REVENUE BY SOURCE

2016	ADMITTED PATIENTS $'000	NON ADMITTED $'000	EDS[1] $'000	AGED CARE $'000	OTHERS $'000	TOTAL $'000
Government Grants	467,997	46,057	56,053	10,101	7,258	587,466
Indirect contributions by Department of Health and Human Services	11,493	-	-	-	-	11,493
Patient Fees	18,938	93	1,300	395	-	20,726
Private Practice Fees	1,878	6,027	446	9	12,362	20,722
Commercial Activities	4,647	479	535	95	273	6,029
Other Revenue from Operating Activities	11,069	535	1,021	-	10,407	23,032
Total Revenue from Operating Activities	**516,022**	**53,191**	**59,355**	**10,600**	**30,300**	**669,468**
Interest	2,000				72	2,072
Other Revenue from Non-Operating Activities	-	-	-	-	-	-
Total Revenue from Non-Operating Activities	**2,000**	**-**	**-**	**-**	**72**	**2,072**
Capital Purpose Income	-	-	-	-	14,706	14,706
Capital Interest	-	61	-	-	-	61
Net Gain/(Loss) on Disposal of Non-Financial Assets (refer note 2a)	-	-	-	-	(4)	(4)
Total Capital Purpose Income	**-**	**61**	**-**	**-**	**14,702**	**14,763**
Total Revenue	**518,022**	**53,252**	**59,355**	**10,600**	**45,074**	**686,303**

(1) Emergency Department Services

NOTE 2: ANALYSIS OF REVENUE BY SOURCE

2015	ADMITTED PATIENTS $'000	NON ADMITTED $'000	EDS[1] $'000	AGED CARE $'000	OTHERS $'000	TOTAL $'000
Government Grants	435,403	42,766	53,116	9,823	6,621	547,729
Indirect contributions by Department of Health and Human Services	2,388	276	529	26	-	3,219
Patient Fees	15,779	1,019	1,105	409	-	18,312
Private Practice Fees	1,335	5,609	615	-	11,551	19,110
Commercial Activities	261	246	13	-	8,133	8,653
Other Revenue from Operating Activities	12,229	1,238	1,869	171	3,432	18,939
Total Revenue from Operating Activities	**467,395**	**51,154**	**57,247**	**10,429**	**29,737**	**615,962**
Interest	2,579	-	-	-	51	2,630
Other Revenue from Non-Operating Activities	-	-	-	-	-	-
Total Revenue from Non-Operating Activities	**2,579**	**-**	**-**	**-**	**51**	**2,630**
Capital Purpose Income	-	-	-	-	25,545	25,545
Capital Interest	-	53	-	-	-	53
Net Gain/(Loss) on Disposal of Non-Financial Assets (refer note 2a)	-	-	-	-	(16)	(16)
Total Capital Purpose Income	**-**	**53**	**-**	**-**	**25,529**	**25,582**
Total Revenue	**469,974**	**51,207**	**57,247**	**10,429**	**55,317**	**644,174**

Indirect contributions by Department of Health and Human Services: The Department of Health and Human Services makes certain payments on behalf of the Health Service, i.e. insurance paid on behalf of hospitals. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

(1) Emergency Department Services

NOTE 2A: NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS

	2016 $'000	2015 $'000
Proceeds from Disposal of Non-Current Assets		
Land	-	693
Building	-	224
Medical Equipment	-	49
Total Proceeds from Disposal of Non-Current Assets	**-**	**966**
Less: Written Down Value of Non-Current Assets Sold		
Land	-	693
Building	-	253
Medical Equipment	4	36
Total Written Down Value of Non-Current Assets Sold	**4**	**982**
Net loss on Disposal of Non-Financial Assets	**(4)**	**(16)**

NOTE 3: ANALYSIS OF EXPENSES BY SOURCE

2016	ADMITTED PATIENTS $'000	NON ADMITTED $'000	EDS[1] $'000	AGED CARE $'000	OTHERS $'000	TOTAL $'000
Employee Expenses	352,438	51,933	66,254	10,975	13,805	495,405
Non Salary Labour Expenses	8,296	977	716	94	133	10,216
Supplies & Consumables	78,711	9,692	11,404	1,034	857	101,698
Other Expenses	43,459	9,596	7,124	1,481	2,241	63,901
Total Expenditures from Operating Activities	**482,904**	**72,198**	**85,498**	**13,584**	**17,036**	**671,220**
Expenditure for Capital Purposes	-	-	-	-	443	443
Depreciation & Amortisation (refer note 4)	29,116	4,353	5,155	819	1,027	40,470
Total Other Expenses	**29,116**	**4,353**	**5,155**	**819**	**1,470**	**40,913**
Total Expenses	**512,020**	**76,551**	**90,653**	**14,403**	**18,506**	**712,133**

2015	ADMITTED PATIENTS $'000	NON ADMITTED $'000	EDS[1] $'000	AGED CARE $'000	OTHERS $'000	TOTAL $'000
Employee Expenses	340,944	30,191	54,867	9,310	19,473	454,785
Non Salary Labour Expenses	6,962	730	602	92	213	8,599
Supplies & Consumables	71,163	5,007	8,755	578	1,490	86,993
Other Expenses from Continuing Operations	49,138	4,763	7,962	1,466	3,478	66,807
Total Expenditures from Operating Activities	**468,207**	**40,691**	**72,186**	**11,446**	**24,654**	**617,184**
Expenditure for Capital Purposes	-	-	-	-	905	905
Depreciation & Amortisation (refer note 4)	28,627	3,056	3,480	814	3,303	39,280
Total Other Expenses	**28,627**	**3,056**	**3,480**	**814**	**4,208**	**40,185**
Total Expenses	**496,834**	**43,747**	**75,666**	**12,260**	**28,862**	**657,369**

(1) Emergency Department Services

NOTE 3A: ANALYSIS OF EXPENSE AND REVENUE BY INTERNALLY MANAGED AND RESTRICTED SPECIFIC PURPOSE FUNDS

	EXPENSE		REVENUE	
	2016 $'000	2015 $'000	2016 $'000	2015 $'000
Commercial Activities				
Diagnostic Imaging	6,126	14,910	12,508	11,511
Pharmacy Services (nominal - grouped under other)				
Car Parking	647	713	3,772	3,511
Property	6	1	181	178
Internal and Specific Purpose Funds	462	529	1,832	1,241
Other	145	146	245	231
Other Activities				
Fundraising and Community Support	460	420	1,427	2,461
Research	3,008	2,612	3,162	3,259
TOTAL	**10,854**	**19,331**	**23,127**	**22,392**

NOTE 4: DEPRECIATION AND AMORTISATION

	2016 $'000	2015 $'000
Depreciation		
Buildings	28,433	27,696
Plant and Equipment	1,701	1,597
Medical Equipment	6,710	6,501
Computers and Communication	1,166	1,343
Furniture and Fittings	687	598
Non Medical Equipment	482	419
Total Depreciation	**39,179**	**38,154**
Amortisation		
Intangibles Assets	1,291	1,126
Total Amortisation	**1,291**	**1,126**
Total Depreciation and Amortisation	**40,470**	**39,280**

NOTE 5: 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.

	2016 $'000	2015 $'000
Cash on Hand	13	14
Cash at Bank	14,507	56,261
Deposits at Call	2,159	173
Total Cash and Cash Equivalents	**16,679**	**56,448**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	16,679	56,448
Total Cash and Cash Equivalents	**16,679**	**56,448**

NOTE 6: RECEIVABLES

	2016 $'000	2015 $'000
CURRENT		
Contractual		
Inter Hospital Debtors	1,187	487
Trade Debtors	977	1,404
Patient Fees	5,742	4,932
Accrued Investment Income	161	5
Accrued Revenue	6,790	6,202
less Allowance for Doubtful Debts		
Trade Debtors	(146)	-
Patient Fees	(2,326)	(1,960)
	12,385	**11,070**
Statutory		
GST Receivable	865	852
Accrued Revenue - Department of Health and Human Services	645	-
	1,510	**852**
TOTAL CURRENT RECEIVABLES	**13,895**	**11,922**

NOTE 6: RECEIVABLES

(CONTINUED)

	2016 $'000	2015 $'000
NON CURRENT		
Statutory		
Long Service Leave - Department of Health and Human Services	21,917	10,951
TOTAL NON CURRENT RECEIVABLES	**21,917**	**10,951**
TOTAL RECEIVABLES	**35,812**	**22,873**

(A) MOVEMENT IN THE ALLOWANCE FOR DOUBTFUL DEBTS

	2016 $'000	2015 $'000
Balance at beginning of year	1,960	1,314
Amounts written off during the year	(1,315)	(748)
Increase/(decrease) in allowance recognised in net result	1,827	1,394
Balance at end of year	**2,472**	**1,960**

(B) AGEING ANALYSIS OF RECEIVABLES

Refer to note 17 (b) for the ageing analysis of contractual receivables.

(C) NATURE AND EXTENT OF RISK ARISING FROM RECEIVABLES

Refer to note 17 (b) for the nature and extent of credit risk arising from contractual receivables.

NOTE 7: INVESTMENTS AND OTHER FINANCIAL ASSETS

	OPERATING FUND		SPECIFIC PURPOSE FUND		CAPITAL FUND		TOTAL	
	2016 $'000	2015 $'000	2016 $'000	2015 $'000	2016 $'000	2015 $'000	2016 $'000	2015 $'000
CURRENT								
Available for sale								
Managed Investment								
- VFMC Multi Strategy Funds	36,934	-	8,167	-	-	-	45,101	-
Total Current	**36,934**	**-**	**8,167**	**-**	**-**	**-**	**45,101**	**-**

NOTE 7: INVESTMENTS AND OTHER FINANCIAL ASSETS

	OPERATING FUND		SPECIFIC PURPOSE FUND		CAPITAL FUND		TOTAL	
	2016 $'000	2015 $'000	2016 $'000	2015 $'000	2016 $'000	2015 $'000	2016 $'000	2015 $'000
NON CURRENT								
Investment								
- Cancer Therapeutics CRC	1	-	-	-	-	-	1	-
Total Non Current	**1**	**-**	**-**	**-**	**-**	**-**	**1**	**-**
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**36,935**	**-**	**8,167**	**-**	**-**	**-**	**45,102**	**-**
Represented by:								
Health Service Investments	36,935	-	8,167	-	-	-	45,102	-
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**36,935**	**-**	**8,167**	**-**	**-**	**-**	**45,102**	**-**

(A) AGEING ANALYSIS OF INVESTMENTS AND OTHER FINANCIAL ASSETS

Refer to note 17 (b) for the ageing analysis of investments and other financial assets.

(B) NATURE AND EXTENT OF RISK ARISING FROM INVESTMENTS AND OTHER FINANCIAL ASSETS

Refer to note 17 (b) for the nature and extent of credit risk arising from investments and other financial assets.

NOTE 8: INVENTORIES

	2016 $'000	2015 $'000
Pharmaceuticals		
- At cost	1,884	2,236
Radiology		
- At cost	221	168
TOTAL INVENTORIES	**2,105**	**2,404**

NOTE 9: PREPAYMENTS AND OTHER ASSETS

	2016 $'000	2015 $'000
CURRENT		
Prepayments	404	1,123
TOTAL OTHER ASSETS	**404**	**1,123**

NOTE 10: PROPERTY, PLANT & EQUIPMENT

(A) GROSS CARRYING AMOUNT AND ACCUMULATED DEPRECIATION

	2016 $'000	2015 $'000
Land		
Land at Fair Value	75,088	66,425
Total Land	**75,088**	**66,425**
Buildings		
Buildings under Construction at Cost	13,573	36,831
Buildings at Fair Value	494,203	469,685
- Less Accumulated Depreciation	(56,129)	(27,696)
Total Buildings	**451,647**	**478,820**
Plant and Equipment		
Plant and Equipment at Fair Value	26,902	22,269
- Less Accumulated Depreciation	(10,665)	(8,964)
Total Plant and Equipment	**16,237**	**13,305**
Medical Equipment		
Medical Equipment at Fair Value	90,674	81,424
- Less Accumulated Depreciation	(58,643)	(51,933)
Total Medical Equipment	**32,031**	**29,491**
Non Medical Equipment		
Non Medical Equipment at Fair Value	6,254	5,314
- Less Accumulated Depreciation	(3,681)	(3,199)
Total Non Medical Equipment	**2,573**	**2,115**
Computers and Communication		
Computers and Communication at Fair Value	16,736	16,041
- Less Accumulated Depreciation	(15,726)	(14,561)
Total Computers and Communications	**1,010**	**1,480**
Furniture and Fittings		
Furniture and Fittings at Fair Value	7,377	6,451
- Less Accumulated Depreciation	(3,484)	(2,797)
Total Furniture and Fittings	**3,893**	**3,654**
Motor Vehicles		
Motor Vehicles at Fair Value	93	93
- Less Accumulated Depreciation	(93)	(93)
Total Motor Vehicles	**-**	**-**
TOTAL PROPERTY, PLANT & EQUIPMENT	**582,479**	**595,290**

Share of jointly controlled assets included in property, plant and equipment are separately disclosed in Note 20 jointly controlled operations and assets.

NOTE 10: PROPERTY, PLANT & EQUIPMENT
(CONTINUED)

(B) RECONCILIATIONS OF THE CARRYING AMOUNTS OF EACH CLASS OF ASSET

	LAND	BUILDINGS	BUILDINGS UNDER CONSTR	PLANT AND EQUIPMENT	MEDICAL EQUIPMENT	NON MEDICAL EQUIPMENT	COMPUTER AND COMM	FURNITURE AND FITTINGS	MOTOR VEHICLES	TOTAL
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2014	**66,425**	**467,097**	**13,903**	**12,723**	**33,462**	**2,301**	**1,652**	**4,013**	**-**	**601,576**
Additions	-	769	18,754	9,158	2,566	233	205	219	-	31,904
Disposals	-	-	-	-	(36)	-	-	-	-	(36)
Revaluation increments/ (decrements)	-	-	-	-	-	-	-	-	-	-
Net transfer between classes	-	1,819	4,174	(6,979)	-	-	966	20	-	-
Depreciation and Amortisation (note 4)	-	(27,696)	-	(1,597)	(6,501)	(419)	(1,343)	(598)	-	(38,154)
Balance at 1 July 2015	**66,425**	**441,989**	**36,831**	**13,305**	**29,491**	**2,115**	**1,480**	**3,654**	**-**	**595,290**
Additions	-	1,357	6,438	4,077	4,854	404	367	212	-	17,709
Disposals	-				(4)	-	-	-	-	(4)
Revaluation increments/ (decrements)	8,663	-	-	-	-	-	-	-	-	8,663
Net transfer between classes	-	23,161	(29,696)	556	4,400	536	329	714	-	-
Depreciation and Amortisation (note 4)	-	(28,433)	-	(1,701)	(6,710)	(482)	(1,166)	(687)	-	(39,179)
Balance at 30 June 2016	**75,088**	**438,074**	**13,573**	**16,237**	**32,031**	**2,573**	**1,010**	**3,893**	**-**	**582,479**

LAND AND BUILDINGS CARRIED AT VALUATION

An independent valuation of the Health Service's land and buildings was performed by the Valuer-General Victoria to determine the fair value of the land and buildings. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments. The effective date of the valuation was 30th June 2014. Subsequent to this valuation, the Health Service assessed the carrying amounts of land and buildings based on indices made available by the Valuer-General Victoria to establish whether they materially approximate fair value at 30th June 2016. Indices (compounding) applied to the carrying amount of land and buildings since the last revaluation exercise indicated that land value had increased by 13 percent whereas buildings value remained relatively unchanged and approximate fair value.

A fair value assessment of plant and equipment was conducted by management as to whether the fair value of plant and equipment differs materially from its carrying amount at 30th June 2016. The outcome indicated that the carrying amount of plant and equipment does approximate fair value.

(C) FAIR VALUE MEASUREMENT HIERARCHY FOR ASSETS AS AT 30 JUNE 2016

	CARRYING AMOUNT AS AT 30TH JUNE 2016	FAIR VALUE MEASUREMENT AT END OF REPORTING PERIOD USING:		
	$'000	LEVEL 1 $'000	LEVEL 2 $'000	LEVEL 3 $'000
Land at fair value				
Land	75,088	-	6,159	68,929
Total Land at fair value	**75,088**	**-**	**6,159**	**68,929**
Buildings at fair value				
Buildings under Construction at fair value	13,573	-	-	13,573
Buildings at fair Value	494,203	-	484	493,719
– Less Accumulated Depreciation	(56,129)	-	(33)	(56,096)
Total Buildings at fair value	**451,647**	**-**	**451**	**451,196**
Plant and Equipment				
Plant and Equipment at Fair Value	26,902	-	-	26,902
– Less Accumulated Depreciation	(10,665)	-	-	(10,665)
Total Plant and Equipment at fair value	**16,237**	**-**	**-**	**16,237**
Medical Equipment				
Medical Equipment at Fair Value	90,674	-	-	90,674
– Less Accumulated Depreciation	(58,643)	-	-	(58,643)
Total Medical Equipment ar fair value	**32,031**	**-**	**-**	**32,031**
Non Medical Equipment				
Non Medical Equipment at Fair Value	6,254	-	6,254	-
– Less Accumulated Depreciation	(3,681)	-	(3,681)	-
Total Non Medical Equipment at fair value	**2,573**	**-**	**2,573**	**-**
Computers and Communication				
Computers and Communication at Fair Value	16,736	-	16,736	-
– Less Accumulated Depreciation	(15,726)	-	(15,726)	-
Total Computers and Communications at fair value	**1,010**	**-**	**1,010**	**-**
Furniture and Fittings				
Furniture and Fittings at Fair Value	7,377	-	7,377	-
– Less Accumulated Depreciation	(3,484)	-	(3,484)	-
Total Furniture and Fittings at fair value	**3,893**	**-**	**3,893**	**-**
Motor Vehicles				
Motor Vehicles at Fair Value	93	-	93	-
– Less Accumulated Depreciation	(93)	-	(93)	-
Total Motor Vehicles at fair value	**-**	**-**	**-**	**-**
TOTAL PROPERTY, PLANT & EQUIPMENT	**582,479**	**-**	**14,086**	**568,393**

NOTE 10: PROPERTY, PLANT & EQUIPMENT
(CONTINUED)

SPECIALISED LAND AND SPECIALISED BUILDINGS

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

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

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

An independent valuation of the Health Service's specialised land and specialised buildings was performed by the Valuer-General Victoria. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation is 30th June 2014. Subsequent to scheduled revaluation, land and buildings fair value assessment were carried out using VGV published indices.

PLANT AND EQUIPMENT

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

There were no changes in valuation techniques throughout the period to 30th June 2016.

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

(C) FAIR VALUE MEASUREMENT HIERARCHY FOR ASSETS AS AT 30 JUNE 2015

	CARRYING AMOUNT AS AT 30 JUNE 2015	FAIR VALUE MEASUREMENT AT END OF REPORTING PERIOD USING:		
	$'000	LEVEL 1 $'000	LEVEL 2 $'000	LEVEL 3 $'000
Land at Fair Value				
Specialised land	66,425	-	5,822	60,603
Total Land at fair value	**66,425**	**-**	**5,822**	**60,603**
Buildings at fair value				
Buildings under Construction at Cost	36,831	-	-	36,831
Buildings at fair Value	469,685	-	484	469,201
– Less Accumulated Depreciation	(27,696)	-	(33)	(27,663)

	CARRYING AMOUNT AS AT 30 JUNE 2015	FAIR VALUE MEASUREMENT AT END OF REPORTING PERIOD USING:		
	$'000	LEVEL 1 $'000	LEVEL 2 $'000	LEVEL 3 $'000
Total Buildings	**478,820**	**-**	**451**	**478,369**
Plant and Equipment				
Plant and Equipment at Fair Value	22,269	-	-	22,269
– Less Accumulated Depreciation	(8,964)	-	-	(8,964)
Total Plant and Equipment	**13,305**	**-**	**-**	**13,305**
Medical Equipment				
Medical Equipment at Fair Value	81,424	-	-	81,424
– Less Accumulated Depreciation	(51,933)	-	-	(51,933)
Total Medical Equipment	**29,491**	**-**	**-**	**29,491**
Non Medical Equipment				
Non Medical Equipment at Fair Value	5,314	-	5,314	-
– Less Accumulated Depreciation	(3,199)	-	(3,199)	-
Total Non Medical Equipment	**2,115**	**-**	**2,115**	**-**
Computers and Communication				
Computers and Communication at Fair Value	16,041	-	16,041	-
– Less Accumulated Depreciation	(14,561)	-	(14,561)	-
Total Computers and Communications	**1,480**	**-**	**1,480**	**-**
Furniture and Fittings				
Furniture and Fittings at Fair Value	6,451	-	6,451	-
– Less Accumulated Depreciation	(2,797)	-	(2,797)	-
Total Furniture and Fittings	**3,654**	**-**	**3,654**	**-**
Motor Vehicles				
Motor Vehicles at Fair Value	93	-	93	-
– Less Accumulated Depreciation	(93)	-	(93)	-
Total Motor Vehicles	**-**	**-**	**-**	**-**
TOTAL PROPERTY, PLANT & EQUIPMENT	**595,290**	**-**	**13,522**	**581,768**

NOTE 10: PROPERTY, PLANT & EQUIPMENT
(CONTINUED)

(D) RECONCILIATION OF LEVEL 3 FAIR VALUE

2016	LAND $'000	BUILDINGS $'000	ASSETS UNDER CONSTR $'000	PLANT AND EQUIPMENT $'000	MEDICAL EQUIPMENT $'000	TOTAL $'000
Opening Balance	**60,603**	**441,538**	**36,831**	**13,305**	**29,491**	**581,768**
Purchases (sales)	-	1,357	6,438	4,077	4,854	16,726
Transfers in (out) of Level 3		23,161	(29,696)	556	4,396	(1,583)
Gains/(losses) recognised in net result	-	-	-	-	-	-
Depreciation	-	(28,433)	-	(1,701)	(6,710)	(36,844)
	60,603	**437,623**	**13,573**	**16,237**	**32,031**	**560,067**
Unrealised gains/(losses) on non-financial assets revaluation	8,326	-	-	-	-	8,326
Balance at 30th June 2016	**68,929**	**437,623**	**13,573**	**16,237**	**32,031**	**568,393**

2015	LAND $'000	BUILDINGS $'000	ASSETS UNDER CONSTR $'000	PLANT AND EQUIPMENT $'000	MEDICAL EQUIPMENT $'000	TOTAL $'000
Opening Balance	**60,603**	**466,613**	**13,903**	**12,723**	**33,462**	**587,304**
Purchases (sales)	-	769	18,754	9,158	2,566	31,247
Transfers in (out) of Level 3		1,819	4,174	(6,979)	(36)	(1,022)
Gains/(losses) recognised in net result	-	-	-	-	-	-
Depreciation	-	(27,663)	-	(1,597)	(6,501)	(35,761)
	60,603	**441,538**	**36,831**	**13,305**	**29,491**	**581,768**
Unrealised gains/(losses) on non-financial assets revaluation	-	-	-	-	-	-
Balance at 30th June 2015	**60,603**	**441,538**	**36,831**	**13,305**	**29,491**	**581,768**

(E) DESCRIPTION OF SIGNIFICANT UNOBSERVABLE INPUTS TO LEVEL 3 VALUATIONS:

	VALUATION TECHNIQUE	SIGNIFICANT UNOBSERVABLE INPUTS	RANGE (WEIGHTED AVERAGE)	SENSITIVITY OF FAIR VALUE MEASUREMENT TO CHANGES IN SIGNIFICANT UNOBSERVABLE INPUTS
Specialised land				
- Western Hospital, Footscray	Market approach	Community Service Obligation (CSO) adjustment	20%	A significant increase or decrease in the CSO adjustment would result in a significantly lower or higher fair value.
- Sunshine Hospital			20%	
- Williamstown Hospital			20%	
- Sunbury Day Hospital			20%	
Specialised buildings				
- Western Hospital, Footscray	Depreciated replacement cost	Direct Cost per square metre	$893-$7517/m2 ($1902/m2)	A significant increase or decrease in direct cost per square meter adjustment would result in a significantly higher or lower fair value.
- Sunshine Hospital			$1000 - $5809/m2 ($1934/m2)	
- Williamstown Hospital			$893 - $6033/m2 ($1875/m2)	
- Sunbury Day Hospital			$940 - $2350/m2 ($1728/m2)	
- Hazeldean Transition Care, Williamstown			$610 - $1721/m2 ($1502/m2)	
- Western Hospital, Footscray		Useful life of specialised buildings	0 - 46 years (18 years)	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
- Sunshine Hospital			5 - 52 years (27 years)	
- Williamstown Hospital			2 - 46 years (24 years)	
- Sunbury Day Hospital			22 - 52 years (34 years)	
- Hazeldean Transition Care, Williamstown			3 - 13 years (8 years)	
Assets under construction at fair value	Depreciated replacement cost	Cost per unit	$4,327-$6,589/m2 ($5,458/m2)	A significant increase or decrease in direct cost per square meter adjustment would result in a significant higher or lower fair value
Plant and equipment at fair value	Depreciated replacement cost	Useful life of plant and equipment	10 years	Increase/(decrease) in the estimated useful life of the asset would result in a significantly higher/(lower) fair value.
Medical equipment at fair value	Depreciated replacement cost	Useful life of medical equipment	7 - 10 years	Increase/(decrease) in the estimated useful life of the asset would result in a significantly higher/(lower) fair value.

NOTE 11: INTANGIBLE ASSETS

	2016 $'000	2015 $'000
Software	12,455	11,159
- Less Accumulated Amortisation	(10,824)	(9,533)
Total Intangible Assets	**1,631**	**1,626**

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

	SOFTWARE $'000	TOTAL $'000
Balance at 1st July 2014	**1,130**	**1,130**
Additions	1,622	1,622
Disposals	-	-
Amortisation (note 4)	(1,126)	(1,126)
Balance at 1st July 2015	**1,626**	**1,626**
Additions	1,296	1,296
Disposals	-	-
Amortisation (note 4)	(1,291)	(1,291)
Balance at 30th June 2016	**1,631**	**1,631**

NOTE 12: PAYABLES

	2016 $'000	2015 $'000
CURRENT		
Contractual		
Trade Creditors	13,410	2,058
Accrued Expenses	10,911	9,593
Salary Packaging	2,776	1,620
Amounts payable to Governments and Agencies:		
- Melbourne Health	5,335	6,000
Other	1,072	1,524
	33,504	**20,795**
Statutory		
Repayable Grants - Department of Health and Human Services	-	369
	-	**369**
TOTAL PAYABLES	**33,504**	**21,164**

(A) MATURITY ANALYSIS OF PAYABLES

Refer to note 17 (c) for the ageing analysis of payables

(B) NATURE AND EXTENT OF RISK ARISING FROM PAYABLES

Refer to note 17 (d) for the nature and extent of risk arising from contractual payables

NOTE 13: PROVISIONS

	2016 $'000	2015 $'000
Current Provisions		
Employee Benefits[1]		
Annual Leave (Note 13 (a))		
- Unconditional and expected to be settled within 12 months	30,560	29,858
- Unconditional and expected to be settled after 12 months[2]	5,023	4,991
Long Service Leave (Note 13 (a))		
- Unconditional and expected to be settled within 12 months	6,649	5,542
- Unconditional and expected to be settled after 12 months[2]	43,189	39,923
Accrued salaries and wages	10,853	15,388
Other	1,894	2,527
	98,168	**98,229**
Provisions Related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months	3,911	4,740
- Unconditional and expected to be settled after 12 months[2]	4,968	5,839
Total Current Provisions	**107,047**	**108,808**
Non-Current Provisions		
Employee Benefits[1]	21,408	11,207
Provisions related to Employee Benefit On-Costs (Note 13 (a))	2,207	1,457
Total Non-Current Provisions	**23,615**	**12,664**
Total Provisions	**130,662**	**121,472**
(A) EMPLOYEE BENEFITS AND RELATED ON-COSTS		
Current Employee Benefits and related on-costs		
Annual Leave Entitlements	39,216	39,379
Accrued Wages and Salaries	10,853	15,388
Accrued Days Off	913	943
Unconditional Long Service Leave Entitlements	54,974	51,376
Superannuation	812	1,462
Other	279	260
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements[2]	23,615	12,664
Total Employee Benefits and Related On-Costs	**130,662**	**121,472**
(B) MOVEMENTS IN PROVISIONS		
Movement in Long Service Leave:		

	2016 $'000	2015 $'000
Balance at start of year	**64,039**	**57,877**
Provision made during the year		
- Revaluations	9,754	302
- Expense recognising Employee Service	11,294	12,099
Settlement made during the year	(6,498)	(6,239)
Balance at end of year	**78,589**	**64,039**

(1) Employee benefits consist of annual leave and long service leave accrued by employees. On-costs such as worker's compensation insurance are not employee benefits and are reflected as a separate provision.

(2) The amounts disclosed are at present values.

NOTE 14: SUPERANNUATION

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

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

	PAID CONTRIBUTION FOR THE YEAR		CONTRIBUTION OUTSTANDING AT YEAR END	
	2016 $'000	2015 $'000	2016 $'000	2015 $'000
Defined benefit plans[1]:				
State Superannuation Fund - revised and new	511	582	12	17
Defined contribution plans:				
First State Super	35,750	33,788	801	1,445
	36,261	**34,370**	**813**	**1,462**

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

NOTE 15: EQUITY

	2016 $'000	2015 $'000
(A) Surpluses		
Property, Plant and Equipment Revaluation Surplus[1]		
Balance at the beginning of the reporting period	294,114	294,114
Revaluation Increment/(Decrement)		
- Land	8,663	-
- Buildings	-	-
Balance at the end of the reporting period	**302,777**	**294,114**
Represented by:		
- Land	62,913	54,250
- Buildings	239,864	239,864
	302,777	**294,114**
Financial Assets Available-for-Sale Revaluation Surplus [2]		
Balance at the beginning of the reporting period	-	-
Valuation gain recognised	101	-
Balance at the end of the reporting period	**101**	**-**
Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	2,398	1,446
Share of decrements in surplus attributed to joint venture	(16)	(16)
Transfer from Accumulated Surplus	510	968
Balance at the end of the reporting period	**2,892**	**2,398**
Total Surpluses	**305,770**	**296,512**
(B) Contributed Capital		
Balance at the beginning of the reporting period	202,980	202,980
Balance at the end of the reporting period	**202,980**	**202,980**
(C) Accumulated Surplus		
Balance at the beginning of the reporting period	37,636	51,799
Net Result for the Year	(25,830)	(13,195)
Transfers to Restricted Specific Purpose Surplus	(510)	(968)
Balance at the end of the reporting period	**11,296**	**37,636**
(D) Total Equity at end of financial year	**520,046**	**537,128**

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

(2) The financial assets available-for-sale revaluation surplus arises on the revaluation of available-for-sale financial assets.

NOTE 16: RECONCILIATION OF NET RESULT FOR THE YEAR TO NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES

	2016 $'000	2015 $'000
Net Result For The Year	**(25,830)**	**(13,195)**
Non-cash movements:		
Depreciation and Amortisation	40,470	39,280
Revaluation of Long Service Leave	9,754	302
Provision for Doubtful Debts	1,827	1,394
Movements included in investing and financing activities:		
Net (Gain)/Loss from Disposal of Non Financial Physical Assets	4	16
Movements in assets and liabilities:		
Change in operating assets and liabilities		
(Increase)/Decrease in Receivables	(13,018)	(4,931)
(Increase)/Decrease in Other Assets	-	2,076
(Increase)/Decrease in Prepayments	719	(738)
Increase/(Decrease) in Payables	13,198	510
Increase/(Decrease) in Provisions	(262)	8,321
Change in Inventories	301	(905)
NET CASH INFLOW FROM OPERATING ACTIVITIES	**27,163**	**32,130**

NOTE 17: FINANCIAL INSTRUMENTS

(A) FINANCIAL RISK MANAGEMENT OBJECTIVES AND POLICIE

The Health Service's principal financial instruments comprises:

- Cash assets
- Term deposits
- Receivables (excluding statutory receivables)
- Investment in equities and managed investment schemes
- Payables (excluding statutory payables)

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

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

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

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

CATEGORISATION OF FINANCIAL INSTRUMENTS

2016	CONTRACTUAL FINANCIAL ASSETS - RECEIVABLES $'000	CONTRACTUAL FINANCIAL ASSETS - AVAILABLE FOR SALE $'000	CONTRACTUAL FINANCIAL LIABILITIES AT AMORTISED COST $'000	TOTAL $'000
Financial Assets				
Cash and Cash Equivalents	16,679	-	-	16,679
Receivables				
- Trade Debtors	2,164	-	-	2,164
- Patient Fees	5,742	-	-	5,742
- Other Receivables	6,951	-	-	6,951
Other Financial Assets				
- Managed Funds	-	45,101	-	45,101
- Shares in Other Entities	-	1	-	1
Total Financial Assets[1]	**31,536**	**45,102**	**-**	**76,638**
Financial Liabilities				
Payables	-	-	32,432	32,432
Other Financial Liabilities	-	-	1,072	1,072
Total Financial Liabilities[2]	**-**	**-**	**33,504**	**33,504**

2015	CONTRACTUAL FINANCIAL ASSETS - RECEIVABLES $'000	CONTRACTUAL FINANCIAL ASSETS - AVAILABLE FOR SALE $'000	CONTRACTUAL FINANCIAL LIABILITIES AT AMORTISED COST $'000	TOTAL $'000
Financial Assets				
Cash and Cash Equivalents	56,448	-	-	56,448
Receivables				
- Trade Debtors	1,891	-	-	1,891
- Patient Fees	4,932	-	-	4,932
- Other Receivables	6,207	-	-	6,207
Other Financial Assets				
- Managed Funds	-	-	-	-
- Shares in Other Entities	-	-	-	-
Total Financial Assets[1]	**69,478**	**-**	**-**	**69,478**
Financial Liabilities				
Payables	-	-	19,271	19,271
Other Financial Liabilities	-	-	1,524	1,524
Total Financial Liabilities[2]	**-**	**-**	**20,795**	**20,795**

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

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

(B) CREDIT RISK

Credit risk arises from the contractual financial assets of the Health Service, which comprise cash and deposits, non-statutory receivables and available-for-sale contractual financial assets. The Health 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 and patients, 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 financial institutions 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 long 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 the Health Service's maximum exposure to credit risk without taking account of the value of any collateral obtained.

NOTE 17: FINANCIAL INSTRUMENTS
(CONTINUED)

CREDIT QUALITY OF CONTRACTUAL FINANCIAL ASSETS THAT ARE NEITHER PAST DUE NOR IMPAIRED

2016	FINANCIAL INSTITUTIONS (AA CREDIT RATING) $'000	GOVERNEMENT AGENCIES (AA CREDIT RATING) $'000	OTHER $'000	TOTAL $'000
Financial Assets				
Cash and Cash Equivalents	16,679	-	-	16,679
Receivables				
- Trade Debtors	-	1,187	977	2,164
- Patient Fees	-	-	5,742	5,742
- Other Receivables[1]	-	-	6,951	6,951
Other Financial Assets				
- Managed Funds	-	45,101	-	45,101
- Shares in Other Entities	-	-	1	1
Total Financial Assets	**16,679**	**46,288**	**13,671**	**76,638**

2015				
Financial Assets				
Cash and Cash Equivalents	56,448	-	-	56,448
Receivables				
- Trade Debtors	-	487	1,404	1,891
- Patient Fees	-	-	4,932	4,932
- Other Receivables[1]	-	-	6,207	6,207
Other Financial Assets				
- Managed Funds	-	-	-	-
- Shares in Other Entities	-	-	-	-
Total Financial Assets	**56,448**	**487**	**12,543**	**69,478**

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

AGEING ANALYSIS OF FINANCIAL ASSETS AS AT 30 JUNE

2016	CARRYING AMOUNT $'000	NOT PAST DUE AND NOT IMPAIRED $'000	PAST DUE BUT NOT IMPAIRED				IMPAIRED FINANCIAL ASSETS $'000
			LESS THAN 1 MONTH $'000	1-3 MONTHS $'000	3 MONTHS - 1 YEAR $'000	1-5 YEARS $'000	
Financial Assets							
Cash and Cash Equivalents	16,679	16,679	-	-	-	-	-
Receivables[1]							
- Trade Debtors	2,164	1,118	518	259	123	-	146
- Patient Fees	5,742	1,384	936	790	306	-	2,326
- Other Receivables	6,951	6,951	-	-	-	-	-
Other Financial Assets							
- Managed Funds	45,101	45,101	-	-	-	-	-
- Shares in Other Entities	1	1	-	-	-	-	-
Total Financial Assets	**76,638**	**71,234**	**1,454**	**1,049**	**429**	**-**	**2,472**
2015							
Financial Assets							
Cash and Cash Equivalents	56,448	56,448	-	-	-	-	-
Receivables[1]							
- Trade Debtors	1,891	932	612	253	94	-	-
- Patient Fees	4,932	1,639	689	315	329	-	1,960
- Other Receivables	6,207	6,207	-	-	-	-	-
Other Financial Assets							
- Managed Funds	-	-	-	-	-	-	-
- Shares in Other Entities	-	-	-	-	-	-	-
Total Financial Assets	**69,478**	**65,226**	**1,301**	**568**	**423**	**-**	**1,960**

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

CONTRACTUAL FINANCIAL ASSETS THAT ARE EITHER PAST DUE OR IMPAIRED

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

There are no financial assets that have had their terms renegotiated so as to prevent them from being past due or impaired and they are stated at 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 17: FINANCIAL INSTRUMENTS
(CONTINUED)

(C) LIQUIDITY RISK

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

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

- maintaining an adequate level of uncommitted funds that can be drawn at short notice to meet its short term obligations;
- holding investments and other contractual financial assets that are readily tradeable in the financial markets; and
- careful maturity planning of its financial obligations based on forecasts of future cash flows.

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

MATURITY ANALYSIS OF FINANCIAL LIABILITIES AS AT 30TH JUNE

	CARRYING AMOUNT	NOMINAL AMOUNT	MATURITY DATES			
2016	$'000	$'000	LESS THAN 1 MONTH $'000	1-3 MONTHS $'000	3 MONTHS-1 YEAR $'000	1-5 YEARS $'000
Financial Liabilities						
At amortised cost						
Payables	32,432	32,432	31,020	1278	134	-
Other Financial Liabilities[1]	1,072	1,072	1,072	-	-	-
Total Financial Liabilities	**33,504**	**33,504**	**32,092**	**1,278**	**134**	**-**
2015						
Financial Liabilities						
At amortised cost						
Payables	19,271	19,271	18,570	659	42	-
Other Financial Liabilities[1]	1,524	1,524	1,524	-	-	-
Total Financial Liabilities	**20,795**	**20,795**	**20,094**	**659**	**42**	**-**

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

(D) MARKET RISK

The Health Service's exposures to market risk is 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

The 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 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 undertakes financial liabilities with relatively even maturity profiles.

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

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

The Health Service manages this risk by mainly undertaking fixed rate or non-interest bearing financial instruments with relatively even maturity profiles, with only insignificant amounts of financial instruments at floating rate. Management has concluded that cash at bank is a financial asset that can be left at floating rate without necessarily exposing the Health Service to significant risk.

In compliance with the requirements of the Victorian Public Sector Financial Management Compliance Framework, the Health Service invested with the Victorian Funds Management Corporation (VFMC) where interest rate risk is managed primarily in the physical market by observing the target portfolio composition.

OTHER PRICE RISK

Upon review of the risks related to financial instruments the Health Service has not identified other risks to exist which could potentially impair the carrying amounts of the financial assets or liabilities.

INTEREST RATE EXPOSURE OF FINANCIAL ASSETS AND LIABILITIES AS AT 30 JUNE

	WEIGHTED AVERAGE EFFECTIVE INTEREST RATE	CARRYING AMOUNT	INTEREST RATE EXPOSURE		
2016	RATE (%)	$'000	FIXED INTEREST RATE $'000	VARIABLE INTEREST RATE $'000	NON-INTEREST BEARING $'000
Financial Assets					
Cash and Cash Equivalents	2.6	16,679	-	16,666	13
Receivables					
- Trade Debtors	-	2,164	-	-	2,164
- Patient Fees	-	5,742	-	-	5,742
- Other Receivables[1]	-	6,951	-	-	6,951
Other Financial Assets					
- Managed Funds	2.4	45,101	-	45,101	-
- Shares in Other Entities	-	1	-	-	1
Total Financial Assets		**76,638**	**-**	**61,767**	**14,871**

NOTE 17: FINANCIAL INSTRUMENTS

(CONTINUED)

2016	WEIGHTED AVERAGE EFFECTIVE INTEREST RATE RATE (%)	CARRYING AMOUNT $'000	INTEREST RATE EXPOSURE FIXED INTEREST RATE $'000	VARIABLE INTEREST RATE $'000	NON-INTEREST BEARING $'000
Financial Liabilities					
At amortised cost					
Payables	-	32,432	-	-	32,432
Other Financial Liabilities[1]	-	1,072	-	-	1,072
Total Financial Liabilities	**-**	**33,504**	**-**	**-**	**33,504**
Net Financial Asset/Liabilities	**-**	**43,134**	**-**	**61,767**	**(18,633)**
2015					
Financial Assets					
Cash and Cash Equivalents	3.1	56,448	35,127	24,576	14
Receivables					
- Trade Debtors	-	1,891	-	-	1,891
- Patient Fees	-	4,932	-	-	4,932
- Other Receivables[1]	-	6,207	-	-	6,207
Other Financial Assets					
- Managed Funds	-	-	-	-	-
- Shares in Other Entities	-	-	-	-	-
Total Financial Assets		**69,478**	**35,127**	**24,576**	**13,044**
Financial Liabilities					
At amortised cost					
Payables	-	19,271	-	-	19,271
Other Financial Liabilities[1]	-	1,524	-	-	1,524
Total Financial Liabilities	**-**	**20,795**	**-**	**-**	**20,795**
Net Financial Asset/Liabilities	**-**	**48,683**	**35,127**	**24,576**	**(7,751)**

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

SENSITIVITY DISCLOSURE ANALYSIS

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

- A shift of 100 basis points up and down in market interest rates (AUD) from year-end rates
- A parallel shift of +1% and -1% in inflation rate from year-end rates
- A movement of 15% up and down (2015: 15%) for the top ASX 200 index

The following table discloses the impact on net operating result and equity for each category of financial instrument held by the 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%		-15%		+15%	
2016		PROFIT $'000	EQUITY $'000	PROFIT $'000	EQUITY $'000	PROFIT $'000	EQUITY $'000	PROFIT $'000	EQUITY $'000
Financial Assets									
Cash and Cash Equivalents	16,666	(167)	(167)	167	167	-	-	-	-
Receivables[1]									
– Trade Debtors	2,164	-	-	-	-	-	-	-	-
– Patient Fees	5,742	-	-	-	-	-	-	-	-
– Other Receivables[1]	6,951	-	-	-	-	-	-	-	-
Other Financial Assets									
– Managed Funds	45,101	-	-	-	-	(6,765)	(6,765)	6,765	6,765
– Shares in Other Entities	1	-	-	-	-	-	-	-	-
Total Financial Assets	**76,625**	**(167)**	**(167)**	**167**	**167**	**(6,765)**	**(6,765)**	**6,765**	**6,765**
Financial Liabilities									
Payables	32,432	-	-	-	-	-	-	-	-
Other Financial Liabilities[1]	1,072	-	-	-	-	-	-	-	-
Total Financial Liabilities	**33,504**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net Financial Asset/Liabilities	**43,121**	**(167)**	**(167)**	**167**	**167**	**(6,765)**	**(6,765)**	**6,765**	**6,765**
2015									
Financial Assets									
Cash and Cash Equivalents	56,434	(597)	(597)	597	597	-	-	-	-
Receivables[1]									
– Trade Debtors	1,891	-	-	-	-	-	-	-	-
– Patient Fees	4,932	-	-	-	-	-	-	-	-
– Other Receivables[1]	6,207	-	-	-	-	-	-	-	-
Other Financial Assets									
– Managed Funds	-	-	-	-	-	-	-	-	-
– Shares in Other Entities	-	-	-	-	-	-	-	-	-
Total Financial Assets	**69,464**	**(597)**	**(597)**	**597**	**597**	**-**	**-**	**-**	**-**
Financial Liabilities									
Payables	19,271	-	-	-	-	-	-	-	-
Other Financial Liabilities[1]	1,524	-	-	-	-	-	-	-	-
Total Financial Liabilities	**20,795**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net Financial Asset/Liabilities	**48,669**	**(597)**	**(597)**	**597**	**597**	**-**	**-**	**-**	**-**

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

NOTE 17: FINANCIAL INSTRUMENTS
(CONTINUED)

(E) FAIR VALUE

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

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

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

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

COMPARISON BETWEEN CARRYING AMOUNT AND FAIR VALUE

	CARRYING AMOUNT 2016 $'000	FAIR VALUE 2016 $'000	CARRYING AMOUNT 2016 $'000	FAIR VALUE 2016 $'000
Financial Assets				
Cash and Cash Equivalents	16,679	16,679	56,448	56,448
Receivables[1]				
- Trade Debtors	2,164	2,164	1,891	1,891
- Patient Fees	5,742	5,742	4,932	4,932
- Other Receivables	6,951	6,951	6,207	6,207
Other Financial Assets				
- Managed Funds	45,101	45,101	-	-
- Shares in Other Entities	1	1	-	-
Total Financial Assets	**76,638**	**76,638**	**69,478**	**69,478**
Financial Liabilities				
Payables	32,432	32,432	19,271	19,271
Other Financial Liabilities[1]	1,072	1,072	1,524	1,524
Total Financial Liabilities	**33,504**	**33,504**	**20,795**	**20,795**

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

NOTE 18: COMMITMENTS FOR EXPENDITURE

(A) COMMITMENTS

	2016 $'000	2015 $'000
Capital Expenditure Commitments		
Payable:		
- Buildings	40,348	2,328
- Plant and equipment	2,982	4,678
- Medical equipment	9,331	8,019
- Computer equipment	2,900	2,201
- Furniture and fittings	662	3,141
- Intangible assets	20,686	714
Total capital expenditure commitments	**76,909**	**21,081**
Other Expenditure Commitments		
Payable:		
- Supplies and consumables	131,167	21,240
- Service agreements	37,888	2,007
- Maintenance contracts	16,393	14,285
Total other expenditure commitments	**185,448**	**37,532**
Lease Commitments		
Commitments in relation to leases contracted for at the reporting date:		
- Operating leases	3,009	5,191
Total lease commitments	**3,009**	**5,191**
Operating Leases		
Cancellable	-	-
Sub-Total	**-**	**-**
Non-cancellable	*3,009*	*5,191*
Total operating lease commitments	**3,009**	**5,191**
Total lease commitments	**3,009**	**5,191**
Total Commitments (inclusive of GST)	**265,366**	**63,804**

Note: All amounts shown in the commitments note are nominal amounts inclusive of GST, where applicable

NOTE 18: COMMITMENTS FOR EXPENDITURE

(CONTINUED)

(B) COMMITMENTS PAYABLE

NOMINAL VALUES	2016 $'000	2015 $'000
Capital expenditure commitments payable		
Less than 1 year	65,003	20,696
Longer than 1 year but not longer than 5 years	11,906	385
Total capital expenditure commitments	**76,909**	**21,081**
Other expenditure commitments payable		
Less than 1 year	48,992	23,042
Longer than 1 year but not longer than 5 years	69,852	14,490
5 years or more	66,604	-
Total other expenditure commitments	**185,448**	**37,532**
Lease commitments payable		
Less than 1 year	538	219
Longer than 1 year but not longer than 5 years	2,471	4,972
Total lease commitments	**3,009**	**5,191**
Total commitments (inclusive of GST)	**265,366**	**63,804**
Less GST recoverable from the Australian Tax Office[1]	**11,985**	**5,800**
Total commitments (exclusive of GST)	**253,381**	**58,004**

(1) Supply of medical items, including drugs and diagnostic services, such as radiology and pathology are GST free

NOTE 19: CONTINGENT ASSETS & CONTINGENT LIABILITIES

Details of estimates of maximum amounts of Contingent Assets or Contingent Liabilities are as follows:

	2016 $'000	2015 $'000
Contingent Assets		
The Directors are not aware of any quantifiable or non quantifiable contingent assets	-	-
	-	**-**
Contingent Liabilities		
Quantifiable		
Recallable capital grant - Car Park System	520	780
Recallable capital grant - Medical Records Scanning System	-	500
Total Quantifiable Contingent Liabilities	**520**	**1,280**

NOTE 20: JOINTLY CONTROLLED ASSETS AND OPERATIONS

NAME OF ENTITY	PRINCIPAL ACTIVITY	OWNERSHIP INTEREST	
		2016 %	2015 %
Victorian Comprehensive Cancer Centre Joint Venture (VCCC)	Cancer research, education and training and patient care	10%	11%

Summarised financial information of the jointly controlled operations has been set out below.

	2016 $'000	2015 $'000
Current Assets	2,642	2,238
Non-Current Assets	48	40
Current Liabilities	959	798
Non-Current Liabilities	53	41
NET ASSETS	**1,678**	**1,439**
The following amounts have been included in the amounts above:		
Cash and cash equivalents	2,565	2,168
Current financial liabilities	155	455

	2016 $'000	2015 $'000
Revenue	3,166	3,202
Net Result From Continuing Operations	238	276
Other Comprehensive Income	-	-
Total Comprehensive Income	238	276
The following amounts have been included in the amounts above:		
Interest income	51	56
Depreciation	14	12
Commitments for Expenditure (inclusive of GST)	199	606
Contingent Assets and Contingent Liabilities	-	-

Note: Figures obtained from the unaudited VCCC joint venture annual report.

NOTE 21A: 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	1/07/2015 - 30/06/2016
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	1/07/2015 - 30/06/2016
Governing Board	
The Honourable Bronwyn Pike (Chair)	1/07/2015 - 30/06/2016
Professor Colin Clark	1/07/2015 - 30/06/2016
Mrs Elleni Bereded-Samuel	1/07/2015 - 30/06/2016
Mrs Patricia Carolyn Vejby	1/07/2015 - 30/06/2016
Dr Robert Mitchell	1/07/2015 - 30/06/2016
Dr Phuong Pham (appointed 1st July 2015)	1/07/2015 - 30/06/2016
Mr Kelvyn Lavelle (appointed 8th September 2015)	8/09/2015 - 30/06/2016
Mr Gerard Blood	1/07/2015 - 30/06/2016
Dr Vladimir J Vizec	1/07/2015 - 30/06/2016
Dr Mimmie Claudine Ngum Chi Watts	1/07/2015 - 30/06/2016
Accountable Officer	
Associate Professor Alex Cockram	1/07/2015 - 30/06/2016

	2016 NO.	2015 NO.
Remuneration of Responsible Persons		
The number of Responsible Persons are shown in their relevant income bands:		
Income Band		
$0 - $9,999	2	1
$10,000 - $19,999	1	1
$20,000 - $29,999	1	8
$30,000 - $39,999	7	0
$40,000 - $49,999	0	0
$50,000 - $59,999	0	1
$60,000 - $69,999	1	0
$450,000 - $459,999	0	1
$490,000 - $499,999	1	0
Total Numbers	**13**	**12**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**$836,461**	**$742,754**

Note: Remuneration includes payments made up to 30 June 2016 to Directors that have resigned as at 30 June 2015

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

OTHER TRANSACTIONS OF RESPONSIBLE PERSONS AND THEIR RELATED PARTIES

There were no other transactions paid by the Health Service in connection with the Responsible Persons of the Health Service.

There are no monies receivable from or payable to Responsible Persons and Responsible Persons' Related Parties.

RELATED PARTIES TRANSACTIONS

Transactions between the two entities relate to reimbursements made by Western Health Foundation to the Health Service for fundraising expenses incurred on behalf and transfer of funds by way of distributions to the Health Service. All dealings are carried out in the normal course of business and are based on commercial terms.

The following table provides the total transactions during the financial year with the controlled entity:

	2016	2015
Controlled entity distributions and reimbursements to the Health Service	998,071	1,567,316
Other receivables from and payables to the controlled entity	-	-

NOTE 21B: EXECUTIVE OFFICER DISCLOSURES

EXECUTIVE OFFICERS' REMUNERATION

The numbers of executive officers, other than Ministers and Accountable Officer, and their total remuneration during the reporting period are shown in the first two columns in the table below in their relevant income bands. The base remuneration of executive officers is shown in the third and fourth columns. Base remuneration is exclusive of bonus payments, long-service leave payments, redundancy payments and retirement benefits.

	TOTAL REMUNERATION		BASE REMUNERATION	
	2016	2015	2016	2015
$0 - $ 99,999	4	6	5	8
$100,000 - $109,999	0	0	0	0
$110,000 - $119,999	2	1	2	1
$120,000 - $129,999	0	0	0	0
$130,000 - $139,999	2	0	2	0
$140,000 - $149,999	2	1	2	3
$150,000 - $159,999	0	7	0	6
$160,000 - $169,999	5	8	7	7
$170,000 - $179,999	7	2	5	2
$180,000 - $189,999	3	6	3	5
$190,000 - $199,999	5	2	5	2
$200,000 - $209,999	3	1	2	2
$210,000 - $219,999	0	1	0	0
$220,000 - $229,999	1	1	1	2
$230,000 - $239,999	1	3	3	1
$240,000 - $249,999	0	0	0	1
$250,000 - $259,999	1	1	0	1
$260,000 - $269,999	0	0	1	0
$270,000 - $279,999	1	1	1	0
$280,000 - $289,999	1	0	0	0
$290,000 - $299,999	0	0	0	1
$300,000 - $309,999	0	0	1	0
$310,000 - $319,999	0	1	0	0
$320,000 - $329,999	1	0	0	0
$350,000 - $359,999	1	0	0	0
Total Numbers	**40**	**42**	**40**	**42**
Total annualised employee equivalent[1]	**33**	**35**	**33**	**35**
Total Remuneration	**$7,112,972**	**$7,105,515**	**$6,753,781**	**$6,780,837**

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

NOTE 22: REMUNERATION OF AUDITORS

	2016 $'000	2015 $'000
Victorian Auditor-General's Office		
Audit of financial statement	131	121
Acquittal audit - WHCRE and Cultural Key Phrases Project	7	6
Other Providers		
Internal Audit	198	150
	336	**277**

NOTE 23: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

At the time this report was being prepared the Directors were not aware of any events occurring after the reporting date that would have a material impact on the financial statements.

NOTE 24: CONTROLLED ENTITY

NAME OF ENTITY	PRINCIPAL ACTIVITY	COUNTR OF INCORPORATION	EQUITY HOLDING
Western Health Foundation Limited	Managing fundraising and philanthropic activities on behalf of the Health Service	Australia	Limited by Guarantee

AUDITOR-GENERAL'S REPORT

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INDEPENDENT AUDITOR'S REPORT

To the Board Members, Western Health

The Financial Report

I have audited the accompanying financial report for the year ended 30 June 2016 of Western Health which comprises comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement, notes comprising a summary of significant accounting policies and other explanatory information, and the Board Member's, Accountable Officer's and Chief Finance and Accounting Officer's declaration.

The Board Members' Responsibility for the Financial Report

The Board Members of Western Health are responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*, and for such internal control as the Board Members determine is necessary to enable the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

As required by the *Audit Act 1994*, my responsibility is to express an opinion on the financial report based on the audit, which has been conducted in accordance with Australian Auditing Standards. Those standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The audit procedures selected depend on judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, consideration is given to the internal control relevant to the entity's preparation and fair presentation of the financial report 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 entity's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Board Members, as well as evaluating the overall presentation of the financial report.

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

Independent Auditor's Report (continued)

Independence

The Auditor-General's independence is established by the *Constitution Act 1975*. The Auditor-General is not subject to direction by any person about the way in which his powers and responsibilities are to be exercised. In conducting the audit, I and my staff and delegates complied with all applicable independence requirements of the Australian accounting profession.

Opinion

In my opinion, the financial report presents fairly, in all material respects, the financial position of Western Health as at 30 June 2016 and of its financial performance and its cash flows for the year then ended in accordance with applicable Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*.

MELBOURNE
11 August 2016

Dr Peter Frost
Acting Auditor-General

NOTES

Western Health

Together, caring for the West

www.westernhealth.org.au

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WESTERN CENTRE FOR HEALTH RESEARCH AND EDUCATION

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