RURAL northwest HEALTH

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Annual Report 2018-2019

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The annual report of Rural Northwest Health is prepared in accordance with all relevant Victorian legislation. This index has been prepared to facilitate identification of Rural Northwest Health's compliance with statutory disclosure requirements

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Responsible bodies declaration

In accordance with the Financial Management Act 1994 I am pleased to present the report of operations for Rural Northwest Health for the year ending 30 June 2019.

Julia Hausler

BOARD CHAIRPERSON
WARRACKNABEAL

6 September 2019

Vision

Moving together through change to provide innovative rural health care.

Mission

Rural Northwest Health will provide accessible, efficient and excellent care to our community within the Wimmera Mallee Region.

Strategic direction

Build business capacity.

Respond bravely and innovatively to opportunities that improve local health outcomes.

This report

Covers the period 1 July 2018 to 30 June 2019

- Is prepared for the Minister for Health, the Parliament of Victoria and the community
- Is prepared in accordance with government and legislative requirements and FRD 30D guidelines
- Will be presented to the community at the Rural Northwest Health Annual General Meeting on 19 November 2019
- Should be read in conjunction with our Quality Account 2019 (both documents are available on our website and at all our sites)
- Acknowledges the support of our community
- Is printed with 100% recycled stock

Rural Northwest Health acknowledges the support of the Victorian Government

VICTORIA State Government

Board Chairperson and CEO Annual Report 2018-19

The board of Rural Northwest Health were pleased to appoint Mr Kevin Mills to the role of CEO in October 2018. Kevin has settled quickly into the role and also importantly settled well with his family into our community.

With the appointment of a new CEO, the board and senior management took the opportunity to undertake a structural review of our health service and reset the organisation chart.

The board's primary role as appointed by the Minister for Health, is to be accountable for the provision of high quality, safe clinical care. To ensure we are meeting this requirement the Board has a clinical governance committee and a Hopetoun Beulah reference group who meet with staff / community members quarterly and report regularly to the full board. We also attend consumer feedback luncheons and other forums to interact with our residents, short stay visitors and allied health clients. In the coming year the Board will be establishing a new committee to further enhance our opportunity to learn about our community needs. This committee will be the Warracknabeal reference group.

A second significant role for a health service board is to set the strategic direction and goals for the organisation. The board and senior management had a successful strategic planning day in February with a thought provoking "governance and legal requirements of a health board" workshop provided by Dr. Heather Wellington, consultant at Clayton Utz. We also took the opportunity to reflect on the current strategic plan, have we delivered the strategies and how do we ensure our organisation operates effectively. We will be writing our new strategic plan this coming year, ready for implementation 1st July 2020.

Our strategic direction has two main components – to build business capability and to find opportunities that improve local health outcomes. Some exciting outcomes in these objectives include an expanded partnering with the Royal Flying Doctor Service to deliver further mental health services, lobbying with PHN to achieve greater flexibility in delivering allied health services, exploring shared service opportunities throughout our Grampians region alliance with other health services and at a board level meeting with other health service boards to learn and improve health advocacy.

We continue to add to the aesthetic capacity of our three campuses to ensure our community members have a positive interaction with Rural Northwest Health as well helping to attract and retain quality staff. We have increased our housing portfolio with the addition of two new houses in Hopetoun, garden improvements in Hopetoun, the ongoing maintenance of community gardens in Hopetoun and Beulah and the exiting addition of specialist exercise equipment to complete the wellbeing garden in Warracknabeal.

Monitoring and managing risks to our organisation is another important function the board constantly consider. We acknowledge Rural Northwest Health has been through a period of extreme personnel change including a new CEO, departing staff, changing roles and a new organisation structure. The board have also farewelled Glenda Hewitt after 9 years of being a valued director. We remain mindful of the health and wellbeing effects this change has on our staff and thank them for their professionalism throughout. It is important that we acknowledge recognition of service years, continue with the Betty Richardson awards, excitedly launched the new Leo Casey education scholarship and introduced a "stickers and stayers" event to demonstrate our commitment to staff.

Challenges moving forward include continuing to fill all employment positions available, ensuring our workplace culture has good expectations and motivations and ensuring rural health services are adequately funded for ever increasing complex care needs. The board of Rural Northwest Health are dedicated, well researched and considerate in their efforts to strategically deliver the best health care service we can for our community. I thank my fellow directors for their support as we build better health outcomes for our local communities.

Julia Hausler
GAICD
BOARD CHAIRPERSON

Kevin Mills
CHIEF EXECUTIVE OFFICER

RNH Life Governor Jean Webster checks out the living area during an Open Day for the units.

Stylish homes for our best asset

The erection of two modular units on the same block as Rural Northwest Health's Hopetoun campus has proved to be great success.

The two-bedroom, two bathroom units have been fully occupied by nursing staff since their completion last Christmas. RNH Community Health manager Jo Martin said the absolute occupancy justified the investment made by the board of directors.

"When I was acting CEO early last year, I saw there was a need for these units," Jo said.

"The accommodation for visiting nurses at Hopetoun was looking very tired and just wasn't inviting enough to attract clinical staff to our furthest placed campus," she said.

"I pointed out the urgency of the situation to the board and they realised we had to make sure it happened and as soon as possible.

"We put a planning committee together which included community members and nurses using accommodation and it all happened very quickly from there."

The beautifully appointed units have been built to provide accommodation flexibility. They can be occupied by a couple with a child or by two single people.

Jo said RNH wanted units that would support people to move to Hopetoun.

"The accommodation we wanted was to reflect that our staff are the most valuable asset we have and this investment is an extension of that," she said.

"You would not find more stylish and comfortable accommodation anywhere.

"We've had great feedback on the standard of the accommodation already. It certainly enhances the experience of working on the edge of the Mallee."

The two units were built in Melbourne and transported to Hopetoun. They were completed there and made fully operational within budget, including landscaping around both units.

Our Strategic Goals 2016-2020 builds on Our Vision, Moving together through change to provide innovative rural health care.

Our Strategic Goals are:

a. Building Business Capability, and

b. Responding bravely and with innovation to opportunities that improve our local health outcomes

STRATEGIC OBJECTIVE	ACTIONS	PROGRESS
Support strong governance and leadership	Our Board of Directors and executive undertake training and mentorship education to enhance our leadership capabilities and strengthen our partnerships. The DHHS Directors toolkit is also resourced as a tool to ensure adequate policies and protocols are in place for good governance	**Ongoing**
Increase workforce capability and capacity	All team members completed essential training which reinforced our FISH principles (Choose your attitude, be there in the moment, have fun and make someone's day). Management also utilizes the "Opportunities for Improvement" system for team feedback and a new Leo Casey scholarship to assist team members with further learning.	**Ongoing**
Utilise, preserve and enhance the infrastructure to maintain safe and efficient workplaces and residential services	Rural Northwest Health (RNH) is committed to ensuring we maintain modern facilities for our community care needs. We proudly added two new accommodation houses to our portfolio this year, completed our wellbeing garden with specialist aged exercise equipment and have also undertaken community and general gardening improvements. Our ongoing preventative maintenance systems and routine scenario testing ensure compliance and efficient use of our infrastructure and resources.	**Achieved**
Maintain financial stability	This is the ninth successive year of above budget results and allows our Board and executive to expand and improve our health care services.	**Achieved**
Develop and maintain productive partnerships	RNH again had a productive year as a member of the Wimmera Southern Mallee Health Alliance (WSMHA). Our ongoing partnership with disability support provider Woodbine enables the YarriYak café to operate. We have established community gardens at our facilities for Hopetoun and Beulah communities.	**Ongoing**
Identify and implement optimal models of care	Our Acute and Community health units have developed and implemented an ABLE model of care that is holistic, and demonstrates a focus on maintaining and improving the health and wellbeing of our community members with the aim of reducing our hospital admissions. We continue to achieve our targets and deliver the care required to address chronic illness within our region with the support of the Primary Health Network	**Ongoing**
Establish transition models that enable community members to have a good experience when accessing services outside of Rural Northwest Health	We have partnered with Royal Flying Doctor Service to meet a gap in mental health access across our community. Our work with the WSMHA has also strengthened the health needs within our catchment area.	**Ongoing**
Increase health literacy about actions community members should undertake to keep well and living at home	We have engaged the local community in a range of activities to promote healthy eating, physical activity and social connection. These activities have included 'The Hardest Kick' mental health forum, 'Pain Train' pain management education, dementia awareness education, free fruit offerings, engagement with community at local field days, health screens and presentations to multiple community groups.	**Achieved**

About Rural Northwest Health

Rural Northwest Health is a public health service located in the Wimmera Mallee Region of Victoria established in 1999 under the Health Services Act 1994 and responsible to the Minister for Health.

Rural Northwest Health is funded by State and Commonwealth Government and supported by local community members.

Rural Northwest Health provides responsive quality care and community services by empowering a vibrant and committed group of staff working across three campuses; Warracknabeal, Beulah and Hopetoun. Services are also provided in the community at local halls, parks and in community members own homes.

The key focus of Rural Northwest Health is caring and supporting people to be healthy and living a full life. Our logo represents this by the carer reaching out and embracing its community over the broad horizon.

Rural Northwest Health works in partnership with regional and subregional service providers to support community members to access high quality and safe care as close to home as possible. Key partners include the Wimmera Southern Mallee Health Alliance, Wimmera Primary Care Partnership, West Vic Primary Health Network, Ballarat Health Services, Woodbine, Yarriambiack Shire, Ambulance Victoria, local general practitioners, Royal Flying Doctors Service and the Department of Health and Human services.

Rural Northwest Health acknowledges the traditional owners of the lands of the Wotjobaluk, Jaadwa, Jadawadjali, Wergaia and Japagulk people.

Responsible Ministers

The responsible Ministers during the reporting period were:

- The Honourable Jill Hennessy, Minister for Health and Minister for Ambulance Services
  01/07/2018 - 29/11/2018
- Jenny Mikakos, Minister for Health and Minister for Ambulance Services
  29/11/2018 - 30/06/2019
- Martin Foley, Minister for Mental Health
  01/07/2018 - 30/06/2019

History

1999

Rural Northwest Health was created from the amalgamation of Warracknabeal District Hospital (including JR & AE Landt Nursing Home), Hopetoun Bush Nursing Hospital (including Cumming House) and Beulah Pioneers Bush Nursing Hospital.

2001

The two low care facilities – Corrong Village at Hopetoun and Landt Hostel at Warracknabeal were subsequently amalgamated with Rural Northwest Health.

2008

To modernise Rural Northwest Health facilities new campuses were constructed at Hopetoun and Warracknabeal. Hopetoun's new campus and ambulance station were officially opened in July 2008. Stage one of Warracknabeal's redevelopment including new integrated care facilities was officially opened by the Victorian Premier in October 2008.

2016

Stage two of Warracknabeal's redevelopment including Community Health and Medical Clinic wings was officially opened by Member for Lowan, Emma Kealy in March 2016.

AFTER HOURS

General Practitioners, Nurse Practitioner and nursing team members provide an after-hours on call service 24 hours seven days per week at Warracknabeal and Hopetoun campuses

ACUTE CARE

- Acute medical
- Palliative care
- Pharmacy
- Pathology services
- Urgent care

AGED CARE

Warracknabeal and Hopetoun campuses provide aged care services including:

- High and low care accommodation
- Lifestyle program
- Respite care
- Memory support (Warracknabeal)
- Cognitive Rehabilitative Therapist

SPECIALTY SERVICES

- Ear, nose and throat
- Cardiology

MEDICAL IMAGING

- X-ray and ultrasound (Warracknabeal)

SUPPORT SERVICES

- Carer support services
- Volunteer program

COMMUNITY HEALTH

Community health services are provided across the three campuses at Warracknabeal, Hopetoun and Beulah

- Ante natal and domiciliary midwifery services
- Asthma education and health plan development
- Diabetes education and health plan development
- Health education and promotion
- Post-acute care
- Hospital to home
- Day program (Warracknabeal & Beulah)
- Cancer Resource Nurse
- Memory Support Nurse
- District Nursing
- Community Health Nurse
- Wellbeing Coordinators
- YarriYak Café healthy choice options

ALLIED HEALTH

Allied health services are provided across the three campuses at Warracknabeal, Hopetoun and Beulah

- Counselling
- Occupational therapy
- Dietetics
- Podiatry
- Exercise physiology
- Social work
- Massage therapy
- Speech pathology
- Physiotherapy

Part A: Strategic priorities 2018-19

In 2018-2019 Rural Northwest Health will contribute to the achievement of the Victorian Government's commitments by:

GOALS	STRATEGIES	DELIVERABLES	OUTCOMES
Better Health **A system geared to prevention as much as treatment** **Everyone understands their own health and risks** **Illness is detected and managed early** **Healthy neighbourhoods and communities encourage healthy lifestyles**	**Better Health** **Build Healthy Neighbourhoods**	Work with the Wimmera Southern Mallee Health Alliance member agencies and East Wimmera Health Service to enhance our whole of health service response to family violence, including strengthening local partnerships, improving referral pathways, advocating for support service improvements and enhancing staff competence in being able to recognise, refer and respond appropriately.	Bi-monthly Executive sponsored meetings continue, with 100% meeting attendance. Training of all RNH staff completed and training all new staff ongoing as part of corporate orientation. Training of all staff in partner organisation ongoing and to be completed in 2019. New SHRFV Project Worker appointed in partnership with Grampians Community Health. New Family Violence Management policies for clinicians and Family Violence Workplace Support policies drafted. Rural Northwest Health Strengthening Hospital Response to Family Violence (SHRFV) working group convened. Financial year reporting completed and now in planning for the new financial year.
Better Access **Care is always there when people need it** **More access to care in the home and community** **People are connected to the full range of care and support they need** **There is equal access to care**	**Better Access** **Unlock innovation**	Partner with the Wimmera Southern Mallee Health Alliance on Safer Care Victoria sponsored Leadership training for Healthcare Executive. Implement the actions of the Wimmera Southern Mallee Health Alliance on the transfer of care (hospital to hospital) project work.	The Safer Care Victoria / Department of Health and Human Services sponsored Leadership training is now complete. Transfer of Care work has commenced within the alliance. Rural Northwest Health has an executive on this committee. To assist with this work, Rural Northwest Health is benchmarking average length of stay and acuity within our acute service with other like size services. Collaboration with Royal Flying Doctor Service to provide low to moderate mental health under the Primary Health Network STEP model of care. 2 1/2 days a week Warracknabeal and 1 day per week Hopetoun Campus.
Better Care **Target zero avoidable harm** **Healthcare that focusses on outcomes** **Patients and carers are active partners in care** **Care fits together around people's needs**	**Better Care** **Put Quality First**	Participate in the regional Clinical Governance Committee to identify clinical governance gaps, build capability, identify and prioritise regional strategies for improvement.	Rural Northwest Health has representation on the regional Clinical Governance Committee. Rollout of audit tool is now complete. RNH representative involved in 2 audits in other health services. Final reports completed. Representation on Safer Care Victoria ECCN INSIGHT committee and numerous working groups to reduce variation across region, reducing harm, and incorporate consumers as active partners. Participated in Safer Care Victoria Delirium Project. Participation in Safer Care Victoria are Implementing a sepsis bundle of care in emergency departments and urgent care centres and End PJ paralysis.

Part A: Strategic priorities 2018-19

GOALS	STRATEGIES	DELIVERABLES	OUTCOMES
Specific 2018-19 priorities (mandatory)	**Disability Action Plans** **Draft disability action plans are completed in 2018-19. Note: Guidance on developing disability action plans can be found at https://providers.dhhs.vic.gov.au/disability-action-plans. Queries can be directed to the Office for Disability by phone on 1300 880 043 or by email at ofd@dhhs.vic.gov.au.**	Engage with Woodbine Disability Support Services to assist in audits and development of a disability action plan. Embed this plan into the current Rural Northwest Health Equity Plan. Submit the draft disability action plan to the department by 30 June 2019. The draft plan will outline the approach to full implementation within three years of publication.	Rural Northwest health has an active Diversity Action Group responsible for developing and enacting the Diversity Action Plan. A new plan for 2019-2021 is under development and the Department of Health and Human Services Disability Action plan is the foundation for the 'All Abilities' element of the Rural Northwest Health Diversity Action Plan. First action is to seek expressions of interest from suitability qualified people with a disability and, representative from Woodbine to join the Diversity Action Group to assist with the All Abilities element. Further investigation has identified the need for organisational wide service provision elements to be added to the local Action Plan and is in progress.
	Volunteer engagement **Ensure that the health service executives have appropriate measures to engage and recognise volunteers.**	Develop a clear and defined system for the orientation, support, recognition and management of volunteers ensuring that volunteering remains a mutually beneficial activity and that all programs and involvement are governed appropriately.	A clear and defined system for the orientation, support and recognition of volunteers is complete. Rural Northwest Health Explored partnership opportunities with the Local Shire who will not be engaging in volunteer coordinators. Volunteer coordination role has been realigned with the Leisure & Lifestyle team leader role. Recruitment in progress.
	Bullying and harassment **Actively promote positive workplace behaviours and encourage reporting. Utilise staff surveys, incident reporting data, outcomes of investigations and claims to regularly monitor and identify risks related to bullying and harassment, in particular include as a regular item in Board and Executive meetings. Appropriately investigate all reports of bullying and harassment and ensure there is a feedback mechanism to staff involved and the broader health service staff.**	Address, as is reasonably practicable, all forms of workplace bullying or harassment by maintaining a culture of openness, support and accountability. Handle complaints in a confidential and procedurally fair manner. Monitor risks and incidents through the Health and Well-being (sub-board) Committee. Develop an action plan based on People Matters survey findings associated with potential risks of Bullying and Harassment.	Training for all staff as part of annual mandatory training commenced in February and has been completed. This training is in line with Know Better Be Better Campaign. Mapping of activities and organisational systems against The Know Better Be Better Framework has commenced. During Q3 Rural Northwest Health has experienced change of several senior roles. Executive team have been meeting with impacted teams, individual team members weekly and/or as required to listen to, inform and support impacted team members proactively to minimise uncertainty and promote a positive communication culture during an unsettling period. Quarterly reporting to the Heath & Wellbeing Committee ongoing. Wimmera Southern Mallee Health Alliance leadership program with all executive staff has been completed. First round of, leadership training for line managers has now been completed and the second round commenced in May 2019. A key action item from the 2018 People Matters survey was to establish agreed team behaviours. 80% of team members engaged in face to face team behaviour/cultural development activities in May and provided ideas for behaviours that we want to see more of and behaviours we won't tolerate. Data on display for consideration and feedback as part of the consultative process to finalise an Agreed Team Behaviours statement.

Part A: Strategic priorities 2018-19

GOALS	STRATEGIES	DELIVERABLES	OUTCOMES
Specific 2018-19 priorities (mandatory)	**Occupational violence** **Ensure all staff who have contact with patients and visitors have undertaken core occupational violence training, annually. Ensure the department's occupational violence and aggression training principles are implemented.**	Work with the Grampians region Occupational Health and Safety Committee to design and implement training for staff in occupational violence and aggression that reflects the unique environment of rural health and the principles of the department.	P3 training for new team members and those requiring refresher training included in 2019 Education Plan. Rural Northwest Health is a member of the SMArt Research Partnership, which has engaged Swinburne University to conduct a research project related to Code Grey in small rural health service context. A Rural Northwest Health Executive member is a co-researcher and Rural Northwest Health has been the pilot for the telephone interviews. Data gathered through the research project has identified that current training options do not meet the needs of the small rural health service context. Further work in the areas is required to ensure training is relevant and meaningful for the context and promotes safety.
	Environmental Sustainability **Actively contribute to the development of the Victorian Government's:** • **policy to be net zero carbon by 2050 and improve environmental** • **sustainability by identifying and implementing projects, including** • **workforce education, to reduce material environmental impacts with** • **particular consideration of procurement and waste management, and** • **publicly reporting environmental performance data, including** • **measureable targets related to reduction of clinical, sharps and landfill** • **waste, water and energy use and improved recycling.**	In partnership with the Wimmera Health Care Group Environmental Management Committee implement shared priorities related to reducing paper usage and water and energy consumption through investment in solar panels, LED replacement and water saving initiatives. Provide environmental sustainability training and education programs for staff.	Second meeting chaired by Wimmera Health Care Group has been held. Further LED replacement for one further Rural Northwest Health property was completed in May 2019. An organisational wide environmental sustainability education program has been conducted. The associated activity generated 56 ideas from team members for consideration.
	LGBTI **Develop and promulgate service level policies and protocols, in partnership with LGBTI communities, to avoid discrimination against LGBTI patients, ensure appropriate data collection, and actively promote rights to free expression of gender and sexuality in healthcare settings. Where relevant, services should offer leading practice approaches to trans and intersex related interventions. Note: deliverables should be in accordance with the DHHS Rainbow eQuality Guide (see at www2.health.vic.gov.au/about/populations/lgbti-health/rainbow-equality) and the Rainbow Tick Accreditation Guide (see at www.glhv.org.au)**	Update the equity plan and policies to reflect the deliverables of the department's Rainbow eQuality guide. In partnership with the Wimmera and Southern Mallee Health Alliance, recognise and celebrate international Day against Homophobia, Transphobia and Biphobia (IDAHOBIT) on May 17, 2019 and in liaison with the LGBTI community educate our health care services workforce on the rights of gender, trans and intersex equality.	Rural Northwest health has an active Diversity Action Plan, which specifically references LGBTI. A new plan for 2019-2021 is under development and includes review of the Actions for Inclusive Practice as a first action of the working group. 5 team members registered to attend further training in LGBTI inclusive services for aged care. Rainbow eQuality guide deliverables have been included in the action plan and this work continues to ensure an inclusive approach. A local celebration IDAHOBIT day was held at Rural Northwest Health on 17 May 2019.

Part B: Performance priorities

QUALITY AND SAFETY

Key performance indicator	Target	2018-19 results
Accreditation		
Accreditation against the National Safety and Quality Health Service Standards	Full compliance	**Achieved**
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	**Achieved**
Infection prevention and control		
Compliance with the Hand Hygiene Australia program	80%	**86.77%**
Percentage of healthcare workers immunised for influenza	80%	**91%**
Patient experience		
Data submission	Full compliance	**Achieved**
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – Quarter 1	95% positive experience	**Full compliance***
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – Quarter 2	95% positive experience	**Full compliance***
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – Quarter 3	95% positive experience	**Full compliance***
Victorian Healthcare Experience Survey – percentage of very positive responses to questions on discharge care - Quarter 1	75% very positive experience	**Full compliance***
Victorian Healthcare Experience Survey – percentage of very positive responses to questions on discharge care - Quarter 2	75% very positive experience	**Full compliance***
Victorian Healthcare Experience Survey – percentage of very positive responses to questions on discharge care - Quarter 3	75% very positive experience	**Full compliance***
Patients perception of cleanliness – Quarter 1	70%	**Full compliance***
Patients perception of cleanliness – Quarter 2	70%	**Full compliance***
Patients perception of cleanliness – Quarter 3	70%	**Full compliance***
*Less than 42 responses were received for the period due to the relative size of the health service		
Adverse events		
Sentinel events – root cause analysis (RCA) reporting	All RCA reports submitted within 30 business days	**Achieved**

STRONG GOVERNANCE AND LEADERSHIP

Key performance indicator	Target	2018-19 results
Organisational culture – People Matter Survey		
Percentage of staff with an overall positive response to safety and culture questions	80%	**94%**
Percentage of staff with an overall positive response to the question:		
'I am encouraged by my colleagues to report any patient safety concerns I may have'	80%	**95%**
'Patient care errors are handled appropriately in my work area'	80%	**96%**
'My suggestions about patient safety would be acted upon if I expressed them to my manager'	80%	**95%**
'The culture in my work area makes it easy to learn from the errors of others'	80%	**94%**
'Management is driving us to be a safety-centred organisation'	80%	**98%**
'This health service does a good job of training new and existing staff'	80%	**94%**
'Trainees in my discipline are adequately supervised'	80%	**87%**
'I would recommend a friend or relative to be treated as a patient here'	80%	**96%**

Part B: Performance priorities

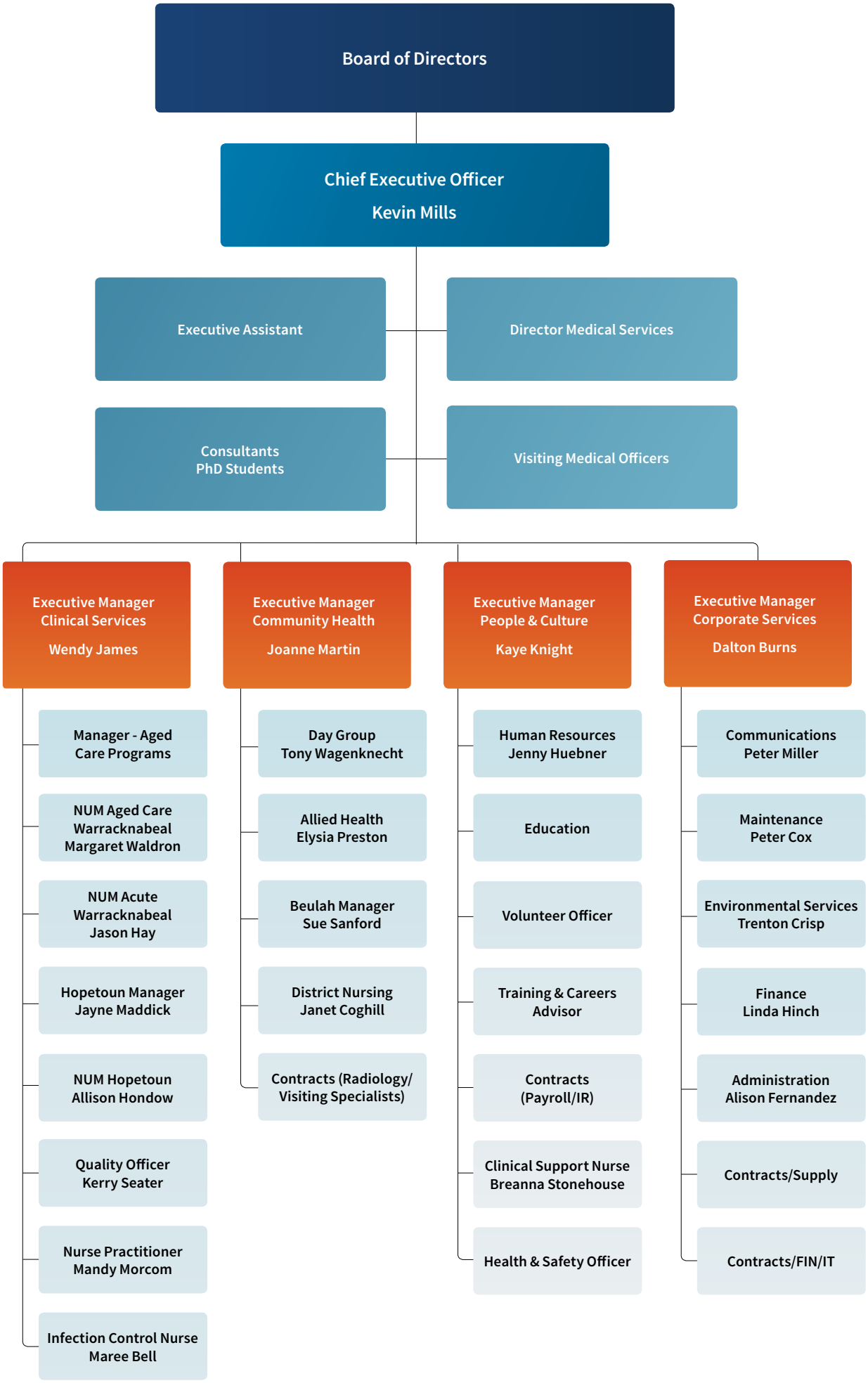
EFFECTIVE FINANCIAL MANAGEMENT

Key performance indicator	Target	2018-19 results
Finance		
Operating result ($m)	0.00	**0.79**
Average number of days to paying trade creditors	60 days	**43 days**
Average number of days to receiving patient fee debtors	60 days	**23 days**
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	**1.44**
Number of days with available cash	14 days	**192.4 days**
Actual number of days a health service can maintain its operations with unrestricted available cash, measured on the last day of each month.	14 days	**192.4 days**
Measures the accuracy of forecasting the Net result from transactions (NRFT) for the current financial year ending 30 June.	Variance ≤ $250,000	**-$150,000**

Part C – Activity and funding

FUNDING TYPE		RESULT
Small Rural		
Small rural acute inpatients	inpatients	**650**
Small rural primary health & HACC		
• Counselling/Casework	hours or service	**234**
• Dietetics	hours of service	**103**
• Occupational Therapy	hours of service	**350**
• Physiotherapy	hours of service	**718**
• Podiatry	hours of service	**327**
• Speech Therapy	hours of service	**472**
Small Rural Residential Care	bed days	**29,452**
Health Workforce	students	**5**

Organisational Structure



The Rural Northwest Health Board of Management consists of persons appointed by the Minister for Health under the Act who are empowered to provide strategic direction for the organisation.

While the board provides direction for the organisation and determines what must be done, the responsibility for determining how services are delivered is invested in the Chief Executive Officer.

The functions of the board of Rural Northwest Health are:

- To oversee and guide the management of the health service.
- To set the mission, vision and strategic direction of the health service.
- To ensure that the services provided by the hospital comply with the requirements of this Act and the objects of the hospital.
- Set a values based culture.

The board of a public hospital has such powers as are necessary to enable it to carry out its functions, including the power to make, amend or revoke by-laws.

This year we welcomed three new Board Members to Rural Northwest Health.

Dr John Aitken was Warracknabeal's local pharmacist for 20 years. John has recently completed a PhD with La Trobe University Rural Health School, studying community participation strategies to improve health outcomes in Yarriambiack Shire.

Hugh Molenaar, was born and raised in country Victoria in a family heavily involved in rural health. Hugh currently resides in Melbourne where he works as an accountant, having completed a Bachelor of Business - Professional Accountancy (BBus(ProfAcc)) and has commenced a Graduate Diploma of Chartered Accounting (GradDipCA).

Genevieve O'Sullivan is an Occupational Therapist with extensive experience working in rural and metropolitan settings as well as overseas. In recent years she has managed community services for people who are older and/or have a disability in local government settings through a period of unprecedented government reforms. Genevieve and her young family recently moved to Patchewollock. She joins the RNH Board and we are very excited to utilise her diverse experience and passion to improve the health and wellbeing outcomes of clients, staff and communities.

Board Chairperson

Julia Hausler

First appointment:
1 July 2016

Board Member

Genevieve O'Sullivan

First appointment:
1 July 2018

Deputy Chairperson

Janette McCabe

First appointment:
1 July 2012

Board Member

Glenda Hewitt

First appointment:
1 July 2010

Board Member

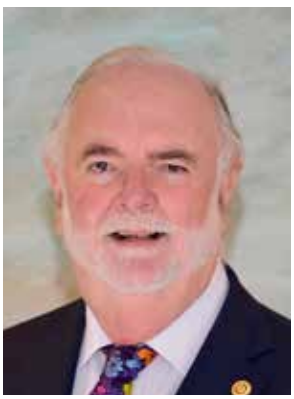
Carolyn Morcom

First appointment:
1 July 2012

Board Member

Professor Amanda Kenny

First appointment:
7 March 2017



Board Member

Dr John Aitken

First appointment:
1 July 2018

Board Member

Hugh Molenaar

First appointment:
1 July 2018

Executive Team

Chief Executive Officer

Kevin Mills

Executive Manager Community Health

Joanne Martin

Executive Manager Clinical Services

Wendy James

Executive Manager Corporate Services

Dalton Burns

Executive Manager People & Culture

Dr Kaye Knight

Board of Management

Board committees

Finance Audit and Compliance Committee (FACC)

Ensures that Rural Northwest Health reviews and evaluates a range of financial, legislative and compliance data and information collected across the organisation. The committee meets quarterly to monitor performance against audit and risk.

Board representatives of the committee are Julia Hausler, Hugh Molenaar (Chairperson) and Genevieve O'Sullivan.

Governance Committee

Reviews performance of the Chief Executive Officer and contractual requirements on an annual basis and makes recommendations on remuneration levels. The committee meets quarterly with the Chief Executive Officer to review the Chief Executive Officer's performance and provide support.

Members of the committee are Janette McCabe (Chairperson), Julia Hausler, John Aitken and Amanda Kenny.

Clinical Governance Committee

Aims to ensure that the community receives high quality and safe care close to home and that Rural Northwest Health is committed to the constant improvement of all clinical and care services. The committee meets quarterly to review and analyse information detailing the clinical care activities undertaken at Rural Northwest Health.

Board representatives of the committee are Janette McCabe (Chairperson), Amanda Kenny, Dr Amir Rahami (Director of Medical Services) and John Aitken.

Health and Wellbeing Committee

Rural Northwest Health aims to provide a safe, fair and happy workplace for all that work and visit our workplace. The committee meets quarterly to review and evaluate a range of data, ideas and information collected across the organisation strategically regarding team member health and wellbeing and to develop and improve Rural Northwest Health organisational culture.

Board representatives of the committee are Genevieve O'Sullivan (Chairperson),

Hopetoun Beulah Reference Group (HBRG)

The group meets quarterly to review comments, suggestions and concerns from the community members about access and improving the availability and quality of the service, program or facility provide at the Hopetoun and Beulah campuses.

Board representative of the group is Carolyn Morcom (Chairperson).

Warracknabeal Reference Group (WRG)

The group meets quarterly to review comments, suggestions and concerns from the community members about access and improving the availability and quality of the service, program or facility provide at the Warracknabeal campus.

Board representative of the group is John Aitken (Chairperson).

Other relevant committees

Medication Advisory Committee (MAC)

Reviews and analyses information detailing the prescribing, dispensing, administrating and monitoring of medication management at Rural Northwest Health. When service gaps and risks are identified the committee ensures appropriate actions are undertaken. The committee reports to the Clinical Governance Committee via the Chairperson, the Director of Medical Services Dr Amir Rahami .

Workforce data

Rural Northwest Health recruits high quality team members with the right skills to deliver the key objectives of the position, business unit and organisation and will comply with all legislated requirements and reflect a fair and open process with an appointment made based on merit. Rural Northwest Health is an equal opportunity employer.

LABOUR CATEGORY	JUNE CURRENT MONTH FTE		JUNE YTD FTE	
	2019	**2018**	**2019**	**2018**
Nursing	78.71	67.99	78.71	69.80
Administration and clerical	24.23	20.79	24.23	20.02
Medical support	0	0.66	0	1.04
Hotel and allied services	70.83	70.3	70.83	73.51
Medical officers	0	0	0	0
Hospital medical officers	0	0	0	0
Sessional clinicians	0	0	0	0
Ancillary staff (Allied Health)	16.69	16.02	16.69	14.11

Life Governors

An award of Life Governor may be conferred upon a person to recognise a significant contribution through voluntary, philanthropic or professional service to Rural Northwest Health.

Service worth of note may include: excellence or length of service as a volunteer; significant philanthropy; outstanding professional service; an exceptional contribution in years of service or effort; initiating a new or innovative idea; or making a contribution significantly above and beyond expectations of their role.

The purpose of the award is to recognise and honour people whose service has resulted in a significant benefit to Rural Northwest Health. Awards will be issued in accordance with Rural Northwest Health's Service Standing Orders Section 18, and every appointed Life Governor shall be enrolled on the books of the service. The award comprises a framed certificate of appointment presented at the Annual General Meeting usually held in the month of November.

Rural Northwest Health Life Governors are:

Ken Healey

Originally awarded by the Hopetoun Bush Nursing Hospital and transferred to Rural Northwest Health in 2012.

Leonard Shannon

Originally awarded by the Beulah Pioneers and Bush Nursing Hospital and transferred to Rural Northwest Health in 2012.

Michael Lawlor

Originally awarded by the Beulah Pioneers and Bush Nursing Hospital and transferred to Rural Northwest Health in 2012.

Alan Turnbull

Originally awarded by the Beulah Pioneers and Bush Nursing Hospital and transferred to Rural Northwest Health in 2012.

Genevieve Lehmann

Originally awarded by the Beulah Pioneers and Bush Nursing Hospital and transferred to Rural Northwest Health in 2012.

Alan Malcolm

Originally awarded by the Hopetoun Bush Nursing Hospital and transferred to Rural Northwest Health in 2012.

Colin Natt

Original awarded by the Beulah Pioneers and Bush Nursing Hospital and transferred to Rural Northwest Health in 2012.

Rural Northwest Health commenced the Life Governor Award process in 2012 and the following Life Governor Awards have been presented:

Max Gibson

Inaugural Rural Northwest Health Life Governor 2012.

Marie Aitken

2014

Les Solly

2014

Jean Webster

2017

Leo Casey

2018

Occupational Health and Safety Act 2004

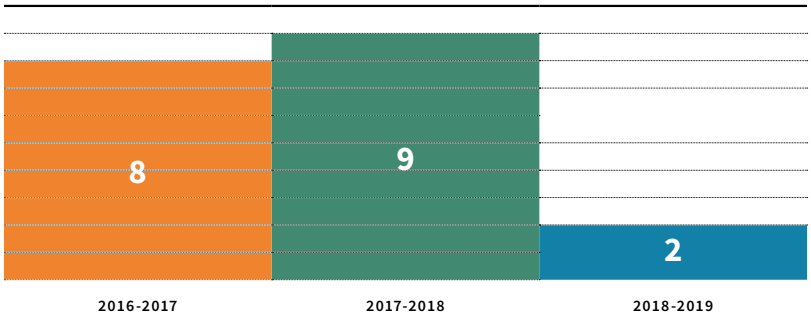
Rural Northwest Health is responsible for the health and safety of all team members in the work place. To fulfil this responsibility we have a duty to maintain a working environment that is safe and without risks to residents, clients, visitors and our team members' health.

Rural Northwest Health have ensured compliance with the Occupational Health and Safety Act 2004 by:

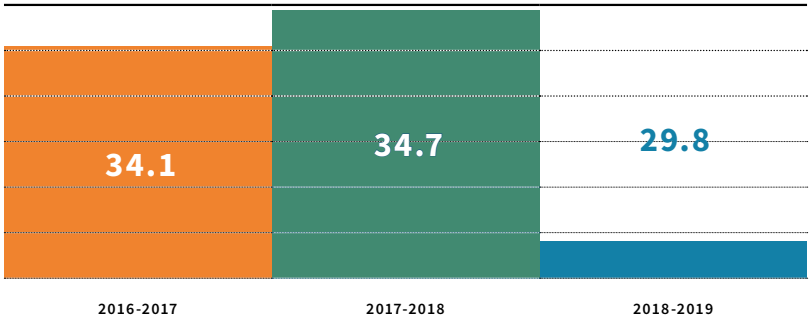
- Effective implementation of Occupational Health and Safety policy and protocols.
- Providing opportunities for regular discussion between the Board, leadership and management team and team members.
- Providing information, training and supervision for all team members in correct use of plant, equipment, chemical and other substances used.
- Maintaining regular reporting on Occupational Health and Safety statistics and data.

The following indicators for Occupational Health and Safety performance for Rural Northwest Health are:

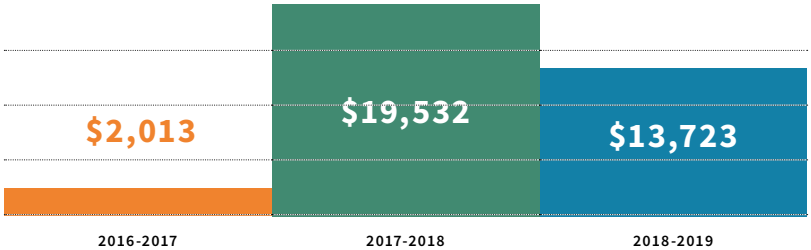
WorkCover claims



Hazards/incidents per 100 FTE



Average cost per claim



OCCUPATIONAL VIOLENCE STATISTICS	2017-18	2018-19
WorkCover accepted claims with an occupational violence cause per 100 FTE	1.5	0
Number of acceptance WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 worked	3	0
Number of occupational violence incidents reported	27	30
Number of occupational violence incidents reported per 100 FTE	9	16
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	33.30%	0%

Freedom of Information (FOI)

Rural Northwest Health has received three requests for information under the Freedom of Information Act (1982) during the 2018-19 financial year, a decrease on the previous financial year.

From the three requests, in all three cases access was granted in full.

Building and maintenance

All building works comply with the Building Act 1993.

Protected Disclosure Act 2012

Rural Northwest Health facilitates the making of disclosures of improper conduct by employees, provides a system of investigation of such disclosures and protects employees making disclosures from retribution in accordance with the provisions of the Protected Disclosure Act 2012.

Competitive neutrality/National Competition Policy

All competitive neutrality requirements were met in accordance with the requirements of the Government policy statement, Competitive Neutrality Policy Victoria and subsequent reforms.

Carers Recognition Act 2012

Rural Northwest Health has taken measures to ensure awareness and understanding of care relationship principles in line with Section 11 of the Carer's Recognition Act 2012.

Safe Patient Care Act 2015

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

Environmental performance

Rural Northwest Health is committed to sustainability and reducing its carbon footprint. New and ongoing energy saving initiatives include commitment to protecting our limited resources by:

- Turning computers and monitors off automatically when not in use and overnight
- Replacing all existing lighting in Hopetoun and Warracknabeal with LED lighting
- Using a building maintenance system to automatically turn off air conditioning and lighting
- Restricting use of bottled water and utilising a water filtration system.

Ex-gratia payments

No ex-gratia payments have been incurred and written off during the reporting period.

Local Jobs Act 2003

Rural Northwest Health complies with the requirements of the Local Jobs Act 2003. There were no reportable disclosures during the reporting period.

Additional information available on request

Consistent with FRD 22H (Section 5:19) details in respect of the items listed below have been retained by Rural Northwest 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.** Declaration 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 the entity about itself, and how these can be obtained
- **d.** Details of changes in prices, fees, charges, rates and levies charged by the health service
- **e.** Details of any major external reviews carried out on the health service
- **f.** Details of major research and development activities undertaken by the health service that are not otherwise covered either in the report of operations or in a document that contains the financial statements and report of operations
- **g.** Details of overseas visits undertaken including a summary of the objectives and outcomes of each visit
- **h.** Details of major promotional, public relations and marketing activities undertaken by the health service to develop community awareness of the health service and its services
- **i.** Details of assessments and measures undertaken to improve the occupational health and safety of employees
- **j.** General statement on industrial relations within the health service and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the report of operations
- **k.** A list of major committees sponsored by the health service, the purposes of each committee and the extent to which those purposes have been achieved
- **l.** Details of all consultancies and contractors including consultants/contractors engaged, services provided and expenditure committed for each engagement.

Kevin Mills

ACCOUNTABLE OFFICER
WARRACKNABEAL

6 September 2019

Attestations

Data integrity

I, Kevin Mills, certify that Rural Northwest Health has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. Rural Northwest health has critically reviewed these controls and processes during the year.

Kevin Mills

ACCOUNTABLE OFFICER
WARRACKNABEAL

6 September 2019

Compliance with Health Purchasing Victoria (HPV) Health Purchasing policies

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

Kevin Mills

ACCOUNTABLE OFFICER
WARRACKNABEAL

6 September 2019

Compliance with Integrity, fraud and corruption

I , Kevin Mills , certify that Rural Northwest Health has put in place appropriate internal controls and processes to ensure that Integrity, fraud and corruption risks have been reviewed and addressed at Rural Northwest Health during the year.

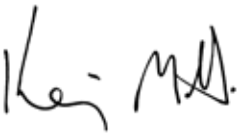
Kevin Mills

ACCOUNTABLE OFFICER
WARRACKNABEAL

6 September 2019

Conflict of interest

I, Kevin Mills, certify that Rural Northwest Health has put in place appropriate internal controls and processes to ensure that it has complied with the requirements of hospital circular 07/2017 Compliance reporting in health portfolio entities (Revised) and has implemented a 'Conflict of Interest' policy consistent with the minimum accountabilities required by the VPSC. Declaration of private interest forms have been completed by all executive staff within Rural Northwest Health and members of the board, and all declared conflicts have been addressed and are being managed. Conflict of interest is a standard agenda item for declaration and documenting at each executive board meeting.



Kevin Mills

ACCOUNTABLE OFFICER
WARRACKNABEAL

6 September 2019

Compliance with financial management

I, Julia Hausler, on behalf of the Responsible Body, certify that Rural Northwest Health has complied with the applicable Standing Directions 2018 under the Financial Management Act 1994 and instructions.

Julia Hausler

CHAIRPERSON
WARRACKNABEAL

6 September 2019

Financial Overview

Rural Northwest Health is delighted to report a net surplus operating result of $794,014 and an entity deficit from transactions of $1,329,924 after capital depreciation for the year ending 30 June 2019.

FINANCE SUMMARY - 5 YEARS 2014-15 TO 2018-19	2019 $'000	2018 $'000	2017 $'000	2016 $'000	2015 $'000
Total revenue	23,934	23,254	21,667	20,723	19,838
Total expenses	(25,264)	(23,353)	(22,788)	(22,353)	(21,553)
Other operating flows included in the net result	121	131	38	(170)	56
Net result for the year	(1,209)	32	(1,083)	(1,800)	(1,659)
***Operating result**	**794**	**2,099**	**960**	**778**	**176**
Total assets	88,860	61,128	61,763	60,352	56,504
Total liabilities	16,108	12,955	13,622	11,361	7,441
Net assets	**72,572**	**48,173**	**48,141**	**48,991**	**49,063**
Total equity	**72,572**	**48,173**	**48,141**	**48,991**	**49,063**

*The operating result is the result for which the hospital is monitored in its Statement of Priorities also referred to as the Net result before Capital and Specific items

RECONCILIATION NET RESULT FROM OPERATING TO TRANSACTION RESULT	2019 $'000	2018 $'000	2017 $'000	2016 $'000	2015 $'000
Net operating result *	**794**	**2,099**	**960**	**778**	**176**
Capital and specific items					
Capital purpose income	210	118	232	382	578
Specific income	-	-	-	-	-
Assets provided free of charge	-	-	-	-	-
Assets received free of charge	-	-	-	-	-
Expenditure for capital purpose	(84)	(95)	(174)	-	(66)
Depreciation and amortisation	(2,250)	(2,222)	(2,139)	(2,300)	(2,403)
Impairment of non financial assets	-	-	-	(490)	-
Finance costs (other)	-	-	-	-	-
Net result from transactions	**(1,330)**	**(99)**	**(1,121)**	**(1,630)**	**(1,715)**

*The Net operating result is the result which the health service is monitored against in its Statement of Priorities

Details of consultancies over $10,000

CONSULTANT	PURPOSE OF CONSULTANCY	START DATE	END DATE	TOTAL APPROVED PROJECT FEE (EXCLUDING GST)	EXPENDITURE 2018-19 (EXCLUDING GST)	FUTURE EXPENDITURE (EXCLUDING GST)
Andrew Collins	Financial Governance Review	7/5/18	31/8/18	18,565	18,565	0
Clare Dewan & Associates	Provision of advice regarding human resources	1/7/18	30/6/19	10,352.5	10,352.5	0
National Ageing Research Institute	Publication of research model	1/8/18	30/6/19	18,345.91	18,345.91	0
Loss Prevention Group Australia	Security Audit	1/6/19	30/6/19	14,950	14,950	0
Batman Discressionary Trust	Funding advice and training	15/4/19	3/5/19	32,965.9	32,965.9	0

In 2018/19 Rural North West engaged five consultancies where the total fees payable to the consultants were less than $10,000 with a total expenditure of $8,705 (ex GST).

ICT expenditure

ICT expenditure represents an entity's costs in providing business enabling ICT services and consists of the following cost elements:

- Operating and capital expenditure (including depreciation)
- ICT services – internally and externally sourced
- Cost in providing ICT services (including personnel and facilities) across the agency, whether funded through a central ICT budget or through other budgets, and
- Cost in providing ICT services to other organisations.

Non-Business As Usual (Non-BAU) expenditure – is a subset of ICT expenditure that relates to extending or enhancing current ICT capabilities and are usually run as projects.

Business AS Usual (BAU) expenditure – includes all remaining ICT expenditure other than Non-BAU ICT expenditure and typically relates to ongoing activities to operate and maintain the current ICT capability.

Statement

The total ICT expenditure incurred during 2018-19 is $0.76 million (exclusing GST) with the details shown below:

BAU ICT EXPENDITURE TOTAL	NON-BAU ICTA EXPENDITURE TOTAL = A + B	OPERATIONAL EXPENDITURE A	CAPITAL EXPENDITURE B
$669,515	$93,515	$0	$93,565

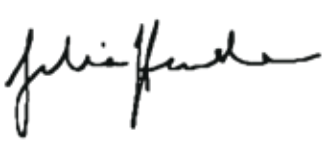
Board Member, Accountable Officer and Chief Finance and Accounting Officer declaration

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

We further state that in our opinion the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes presents fairly the financial transactions during the year ended 30 June 2019 and the financial position of Rural Northwest Health at 30 June 2019.

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

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



Julia Hausler

BOARD MEMBER
WARRACKNABEAL

6 September 2019

Kevin Mills

ACCOUNTABLE OFFICER
WARRACKNABEAL

6 September 2019

Dalton Burns

CHIEF FINANCE AND ACCOUNTING OFFICER
WARRACKNABEAL

6 September 2019

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Rural Northwest Health

Opinion	I have audited the financial report of Rural Northwest Health (the health service) which comprises the: • balance sheet as at 30 June 2019 • comprehensive operating statement for the year then ended • statement of changes in equity for the year then ended • cash flow statement for the year then ended • notes to the financial statements, including significant accounting policies • board member's, accountable officer's and chief finance & accounting officer's declaration. In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2019 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.
Basis for Opinion	I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. I further describe my responsibilities under that Act and those standards in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report. My independence is established by the *Constitution Act 1975.* My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Victoria. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.
Board's responsibilities for the financial report	The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Financial Management Act 1994*, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error. In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
10 September 2019

Travis Derricott
as delegate for the Auditor-General of Victoria

RURAL NORTHWEST HEALTH
COMPREHENSIVE OPERATING STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2019

	Note	2019 $'000	2018 $'000
Income from Transactions			
Operating Activities	2.1	23,495	22,846
Non-operating Activities	2.1	439	407
Total Income from Transactions		**23,934**	**23,253**
Expenses from Transactions			
Employee Expenses	3.1	(17,981)	(16,254)
Supplies and Consumables	3.1	(1,779)	(1,644)
Depreciation	3.1	(2,250)	(2,222)
Other Operating Expenses	3.1	(3,254)	(3,232)
Total Expenses from Transactions		**(25,264)**	**(23,352)**
Net Result from Transactions - Net Operating Balance		**(1,330)**	**(99)**
Other Economic Flows Included in Net Result			
Net Gain/(Loss) on Non-Financial Assets	3.2	1	25
Other Gain/(Loss) from Other Economic Flows	3.2	120	106
Total Other Economic Flows Included in Net Result		**121**	**131**
Net Result for the year		**(1,209)**	**32**
Other Comprehensive Income			
Items that will not be classified to Net Result			
Changes in Property, Plant & Equipment Revaluation Surplus	4.2b	25,608	-
Total Other Comprehensive Income		25,608	-
Comprehensive Result for the year		**24,399**	**32**

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

RURAL NORTHWEST HEALTH
BALANCE SHEET
AS AT 30 JUNE 2019

	Note	2019 $'000	2018 $'000
Current Assets			
Cash and Cash Equivalents	6.1	21,841	8,130
Receivables	5.1	519	1,039
Investments and Other Financial Assets	4.1	-	10,404
Inventories		33	47
Prepayments and Other Assets		93	92
Total Current Assets		22,486	19,712
Non-Current Assets			
Receivables	5.1	287	72
Property, Plant and Equipment	4.2	65,907	41,344
Total Non-Current Assets		66,194	41,416
TOTAL ASSETS		88,680	61,128
Current Liabilities			
Payables	5.2	1,439	1,095
Provisions	3.3	3,676	3,351
Other Liabilities	5.3	10,471	8,107
Total Current Liabilities		15,586	12,553
Non-Current Liabilities			
Provisions	3.3	522	402
Total Non-Current Liabilities		522	402
TOTAL LIABILITIES		16,108	12,955
NET ASSETS		72,572	48,173
EQUITY			
Property, Plant and Equipment Revaluation Surplus		38,127	12,519
Restricted Specific Purpose Surplus		113	113
Contributed Capital		29,139	29,139
Accumulated Surplus		5,193	6,402
TOTAL EQUITY		72,572	48,173

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

RURAL NORTHWEST HEALTH
CASH FLOW STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2019

	Note	2019 $'000 Inflows / (Outflows)	2018 $'000 Inflows / (Outflows)
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		19,772	18,535
Capital Grants from Government		192	37
Patient Fees Received		2,640	2,738
Donations and Bequests Received		-	47
GST Received from/(paid to) from ATO		109	49
Interest Received		511	388
Other Receipts		657	565
Total Receipts		***23,881***	***22,359***
Employee Expenses Paid		(16,610)	(15,523)
Fee for Service Medical Officers		(722)	(386)
Payments for Supplies and Consumables		(1,793)	(2,185)
Other Payments		(2,621)	(2,731)
Total Payments		***(21,746)***	***(20,825)***
NET CASH FLOW FROM OPERATING ACTIVITIES	8.1	2,135	1,534
CASH FLOWS FROM INVESTING ACTIVITIES			
Proceeds / (Purchase) of Investments		10,404	6,081
Payments for Non-Financial Assets		(1,123)	(899)
Payment for share of Rural Health Alliance		(70)	18
Proceeds from Sale of Non-Financial Assets		1	161
NET CASH FLOW FROM /(USED IN) INVESTING ACTIVITIES		9,212	5,361
CASH FLOWS FROM FINANCING ACTIVITIES			
Receipt of Monies Held in Trust		2,364	(411)
NET CASH FLOW FROM / (USED IN) FINANCING ACTIVITIES		2,364	(411)
NET INCREASE / (DECREASE) IN CASH AND CASH EQUIVALENTS HELD		13,711	6,484
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		8,130	1,646
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.1	21,841	8,130

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

RURAL NORTHWEST HEALTH
STATEMENT OF CHANGES IN EQUITY
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2019

	Property, Plant and Equipment Revaluation Reserve	Restricted Specific Purpose Reserve	Contributed Capital	Accumulated Surpluses/ (Deficits)	Total
	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2017	12,519	113	29,139	6,370	48,141
Net result for the year	-	-	-	32	32
Other comprehensive income for the year	-	-	-	-	-
Balance at 30 June 2018	**12,519**	**113**	**29,139**	**6,402**	**48,173**
Net result for the year	-	-	-	(1,209)	(1,209)
Other comprehensive income for the year	25,608	-	-	-	25,608
Balance at 30 June 2019	**38,127**	**113**	**29,139**	**5,193**	**72,572**

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

BASIS OF PRESENTATION

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

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

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

These annual financial statements represent the audited general purpose financial statements for Rural Northwest Health (ABN 23 976 871 636) for the year ending 30 June 2019. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

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

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

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

(b) Reporting Entity

The financial statements includes all the controlled activities of Rural Northwest Health.

Its principal address is:
Dimboola Road
Warracknabeal
Victoria 3393

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

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

(c) Basis of accounting preparation and measurement

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

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2019, and the comparative information presented in these financial statements for the year ended 30 June 2018.

The financial statements are prepared on a going concern basis.

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

All amounts shown in the financial statements have been rounded to the nearest thousand dollars, unless otherwise stated. Minor discrepancies in tables between totals and sum of components are due to rounding.

The Health Service operates on a fund accounting basis and maintains three funds: Operating, Specific Purpose and Capital Funds.

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.

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

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

- The fair value of land, buildings and plant and equipment (refer to Note 4.2 Property, Plant and Equipment);
- Superannuation expense (refer to Note 3.4 Superannuation);
- Employee benefit provisions are based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.3 Employee Benefits in the Balance Sheet)

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 Australian Taxation Office (ATO). 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 ATO 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 ATO, are presented as operating cash flow.

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

(d) Intersegment Transactions

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

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

(e) Jointly Controlled Operation

Joint control is the contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control.
In respect of any interest in joint operations, Rural Northwest Health recognises in the financial statements:

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

Rural Northwest Health is a Member of the Grampians Alliance of Rural Health Joint Venture and retains joint control over the arrangement, which it has classified as a joint operation (refer to Note 8.7)

(f) Equity

Contributed Capital

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

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

Other transfers that are in the nature of contributions or distributions or that have been designated as contributed capital are also treated as contributed capital.

Specific Restricted Purpose Surplus

The Specific Restricted Purpose Surplus is established where Rural Northwest Health has possession or title to the funds but has no discreation to amend or vary the restriction and/or condition underlying the funds received.

NOTE 2: FUNDING DELIVERY OF OUR SERVICES

Rural Northwest Health's overall objective is to provide quality health services that support and enhance the wellbeing of all Victorians. Rural Northwest Health is predominantly funded by accrual based grant funding for the provision of outputs. The hospital also receives income from the supply of services.

Structure

2.1 Income from Transactions

NOTE 2.1: INCOME FROM TRANSACTIONS	2019 $'000	2018 $'000
Government Grants - Operating	19,372	18,927
Government Grants - Capital	192	37
Indirect Contributions by Department of Health and Human Services	239	97
Patient and Resident Fees	2,664	2,798
Commercial Activities 1	281	595
Other Revenue from Operating Activities (including non-capital donations)	747	392
Total Income from Operating Activities	**23,495**	**22,846**
Capital Interest	439	407
Total Income from Non-Operating Activities	**439**	**407**
Total Income from Transactions	**23,934**	**23,253**

1. Commercial activities represent business activities which health services enter into to support their operations.

NOTE 2.1: INCOME FROM TRANSACTIONS (CONTINUED)

Revenue Recognition

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

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

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

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

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

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

Non-cash contributions from the Department of Health and Human Services

The Department of Health and Human Services makes some payments on behalf of health services as follows:

- The Victorian Managed Insurance Authority non-medical indemnity insurance payments are recognised as revenue following advice from the Department of Health and Human Services
- Long Service Leave (LSL) - revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Metropolitan Health and Aged Care Services Division Hospital Circular

Patient and Resident Fees

Patient and resident fees are recognised as revenue on an accrual basis.

Revenue from commercial activities

Revenue from commercial activities such as provision of meals to external users is recognised on an accrual basis.

Donations and Other Bequests

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

Interest revenue

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

Sale of investments

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

Other Income

Other income includes recoveries, sundry sales and minor facility charges.

NOTE 3: THE COST OF DELIVERING SERVICES

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

Structure

3.1 Expenses from Transactions
3.2 Other Economic Flows included in Net Result
3.3 Employee benefits in the Balance Sheet
3.4 Superannuation

NOTE 3.1: EXPENSES FROM TRANSACTIONS	2019 $'000	2018 $'000
Salaries and Wages	15,704	14,453
On-costs	1,402	1,311
Agency Expenses	407	136
Fee for Service Medical Officer Expenses	315	250
Workcover Premium	153	104
Total Employee Expenses	**17,981**	**16,254**
Drug Supplies	148	259
Medical & Surgical Supplies (including Prosthesis)	250	144
Diagnostic and Radiology Supplies	221	211
Other Supplies and Consumables	1,160	1,030
Total Supplies and Consumables	**1,779**	**1,644**
Fuel, Light, Power and Water	472	484
Repairs and Maintenance	434	449
Maintenance Contracts	111	122
Medical Indemnity Insurance	96	89
Other Administration Expenses	2,057	1,993
Expenditure for Capital Purposes	84	95
Total Other Operating Expenses	**3,254**	**3,232**
Depreciation (refer note 4.3)	2,250	2,222
Total Other Non-Operating Expenses	**2,250**	**2,222**
Total Expenses from Transactions	**25,264**	**23,352**

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

Employee expenses
Employee expenses include:

- Salaries and wages (including fringe benefits tax, leave entitlements, termination payments);
- On-costs;
- Agency expenses;
- Fee for service medical officer expenses;
- Work cover premium.

Supplies and consumables
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.

Finance costs
Finance costs include:

- finance charges in respect of finance leases which are recognised in accordance with AASB 117 Leases.

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

- Fuel, light and power
- Repairs and maintencance
- Other administrative expenses
- Expenditure for capital purposes (represents expenditure related to the purchase of assets that are below the capitalisation threshold).

The Department of Health and Human Services also makes certain payments on behalf of Rural Northwest Health. These amounts have been brought to account as grants in determining the operating result for the year by recording them as revenue and also recording the related expense.

Non-operating expenses
Other non-operating expenses generally represent expenditure for outside the normal operations such as depreciation and amortisation, and assets and services provided free of charge or for nominal consideration.

NOTE 3.2: Other Economic Flows included in net result	2019 $'000	2018 $'000
Net gain/(loss) on sale of non-financial assets		
Net gain on disposal of property plant and equipment	1	25
Total net gain/(loss) on non-financial assets	1	25
Other gains/(losses) from other economic flows		
Net gain/(loss) arising from revaluation of long service liability	120	106
Total other gains/(losses) from other economic flows	120	106
Total other gains/(losses) from economic flows	121	131

Other economic flows are changes in the volume or value of an asset or liability that do not result from transactions.
Other gains/(losses) from other economic flows include the gains or losses from:

- the revaluation of the present value of the long service leave liability due to changes in the bond interest rates; and
- reclassified amounts relating to available-for-sale financial instruments from the reserves to net result due to a disposal or derecognition of the financial instrument. This does not include reclassification between equity accounts due to machinery of government changes or 'other transfers' of assets.

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 gain/ (losses) of non-financial physical assets (Refer to Note 4.2 Property, Plant and Equipment)
- Net gain/(loss) on disposal of Non-Financial Assets
- Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal.

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

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

NOTE 3.3: EMPLOYEE BENEFITS IN THE BALANCE SHEET	2019 $'000	2018 $'000
Current Provisions		
Employee Benefits (i)		
ADO & Annual Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	1,447	1,314
- unconditional and expected to be settled wholly after 12 months (iii)	46	61
Long Service Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	250	250
- unconditional and expected to be settled wholly after 12 months (iii)	1,588	1,411
	3,331	3,036
Provisions related to employee benefit on-costs		
- unconditional and expected to be settled wholly within 12 months (ii)	159	145
- unconditional and expected to be settled wholly after 12 months (iii)	186	170
	345	315
Total Current Provisions	3,676	3,351
Non-Current Provisions		
Employee Benefits (i)		
Long Service Leave		
- conditional and expected to be settled wholly after 12 months (iii)	470	362
Provisions related to employee benefit on-costs		
- conditional and expected to be settled wholly after 12 months (iii)	52	40
Total Non-Current Provisions	522	402
Total Provisions	4,198	3,753

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

(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Annual Leave Entitlements	1,389	1,283
Accrued Days Off	56	45
Unconditional Long Service Leave Entitlements	2,040	1,844
Superannuation	191	179
	3,676	3,351
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements (iii)	522	402
Total Employee Benefits and Related On-Costs	4,198	3,753
(b) Movements in provisions		
Movement in Long Service Leave		
Balance at start of year	2,246	2,168
Provision made during the year		
- Revaluations	(120)	(106)
- Expense recognising Employee Service	624	499
Settlement made during the year	(188)	(315)
Balance at end of year	2,562	2,246

Employee Benefit Recognition
Provision is made for benefits accruing to employees in respect of annual leave, ADO's and long service leave for services rendered to the reporting date as an expense during the period the services are delivered.

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.

NOTE 3.3: EMPLOYEE BENEFITS IN THE BALANCE SHEET (Continued)

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

Annual Leave and Accrued Days Off
Liabilities for annual leave and accrued days off are recognised in the provision for employee benefits as 'current liabilities', because the health service does not have an unconditional right to defer settlements of these liabilities.

Depending on the expectation of the timing of settlement, liabilities for wages and salaries, annual leave and accrued days off are measured at:
- Undiscounted value – if the health service expects to wholly settle within 12 months; or
- Present value – if the health service does not expect to wholly settle within 12 months.

Long Service Leave (LSL)
Liability for LSL is recognised in the provision for employee benefits.

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

The components of this current LSL liability are measured at:
- Undiscounted value – if the Health Service expects to wholly settle within 12 months; or
- Present value – where the entity does not expect to settle a component of this current liability within 12 months.

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

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

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

NOTE 3.4: SUPERANNUATION

Fund	Paid Contributions for the Year		Outstanding Contributions at Year End	
	2019 $'000	**2018 $'000**	**2019 $'000**	**2018 $'000**
Defined Contribution Plans:				
First State Super	927	942	161	147
HESTA	395	334	30	32
Total	**1,322**	**1,276**	**191**	**179**

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

The name, details and amounts that have been expensed in relation to the major employee superannuation funds and contributions made by Rural Northwest Health are disclosed above.

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.

Defined contribution superannuation plans
In relation to defined contributions (i.e. accumulation) superannuation plans, the associated expense is simply the employer contributions that are paid or payable in respect of employees who are members of these plans during the reporting period. Contributions to defined 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 reporting period. Superannuation contributions are made to the plans based on the relevant rules of each plan, and are based upon actuarial advice.

Rural Northwest Health 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.

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY

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

Structure

4.1 Investments and other financial assets
4.2 Property, plant & equipment
4.3 Depreciation and amortisation

NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS	2019 $'000	2018 $'000
CURRENT		
Loans and receivables		
Aust. Dollar Term Deposits > 3 Months (i)	-	10,404
Total Current	-	10,404
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	-	10,404
Represented by:		
Health Service Investments	-	2,297
Accommodation Bonds (Refundable Entrance Fees)	-	8,107
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	-	10,404

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

Investment Recognition
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.

Rural Northwest Health classifies its other financial assets between current and non-current assets based on the Board of Management's intention at balance date with respect to the timing of disposal of each asset. The Health Service assesses at each balance sheet date whether a financial asset or group of financial assets is impaired.

Rural Northwest Health investments must comply with Standing Direction 3.7.2 - Treasury Management, including Central Banking System.

All financial assets, except those measured at fair value through the Comprehensive Operating Statement are subject to annual review for impairment.

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

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

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

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

Where the fair value of an investment in an equity instrument at balance date has reduced by 20 percent or more than its cost price or where its fair value has been less than its cost price for a period of 12 or more months, the financial asset is treated as impaired.

In order to determine an appropriate fair value as at 30 June 2018 for its portfolio of financial assets, the Health Service used the market value of investments held provided by the portfolio managers.

The above valuation process was used to quantify the level of impairment (if any) on the portfolio of financial assets as at year end.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT

Initial Recognition

Items of property, plant and equipment are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and impairment loss. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. Assets transferred as part of a merger/machinery of government change are transferred at their carrying amounts.

The cost of a leasehold improvement is capitalised as an asset and depreciated over the shorter of the remaining term of the lease or the estimated useful life of the improvements.

Crown land is measured at fair value with regard to the property's highest and best use after due consideration is made for any legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset.

Theoretical opportunities that may be available in relation to the asset(s) are not taken into account until it is virtually certain that any restrictions will no longer apply. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best uses.

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

Revaluations of Non-current Physical Assets

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

Revaluation increments are recognised in 'Other Comprehensive Income' and are credited directly to the asset revaluation surplus except that, to the extent that an increment reverses a revaluation decrement in respect of that same class of asset previously recognised as an expense in 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 de-recognition of the relevant asset, except where an asset is transferred via contributed capital.

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

Fair value measurement

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

Valuation hierarchy

In determining fair values a number of inputs are used. To increase consistency and comparability in the financial statements, these inputs are categorised into three levels, also known as the fair value hierarchy. The levels are as follows:

- 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.

Identifying unobservable inputs (level 3) fair value measurements

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

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

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

Judgements about highest and best use must take into account the characteristics of the assets concerned, including restrictions on the use and disposal of assets arising from the asset's physical nature and any applicable legislative/contractual arrangements.

In accordance with paragraph AASB 13.29, Health Services can assume the current use of a non-financial physical asset is its HBU unless market or other factors suggest that a different use by market participants would maximise the value of the asset.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)
Non-Specialised Land, Non-Specialised Buildings

Non-specialised land and non-specialised buildings are valued using the market approach. Under this valuation method, the assets are compared to recent comparable sales or sales of comparable assets which are considered to have nominal or no added improvement value.

For non-specialised land and non-specialised buildings, an independent valuation was performed by the Valuer-General Victoria to determine the fair value using the market approach. Valuation of the assets was determined by analysing comparable sales and allowing for share, size, topography, location and other relevant factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30 June 2019.

Specialised Land and Specialised Buildings

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

During the reporting period, Rural Northwest Health held Crown Land. The nature of this asset means that there are certain limitations and restrictions imposed on its use and/or disposal that may impact their fair value.

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 would be classified as Level 3 assets.

For Rural Northwest Health, 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 Rural Northwest Health's specialised land and specialised buildings was performed by the Valuer-General Victoria. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation is 30 June 2019.

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

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

There were no changes in valuation techniques throughout the period to 30 June 2019.

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

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued) (a) Gross carrying amount and accumulated depreciation	2019 $'000	2018 $'000
Land		
- Land at Fair Value	888	653
Total Land	**888**	**653**
Buildings		
- Buildings at Fair Value	62,434	44,518
Less Accumulated Depreciation	-	(6,656)
	62,434	**37,862**
- Land Improvements at Fair Value	918	1,190
Less Accumulated Depreciation	-	(722)
	918	**468**
Assets Under Construction		
- Assets Under Construction at cost	175	984
Total Assets Under Construction	**175**	**984**
Total Buildings	**63,527**	**39,314**
Plant and Equipment		
- Plant and Equipment at Fair Value	1,083	980
Less Accumulated Depreciation	(753)	(691)
- Grampians Rural Health Alliance	388	326
Less Accumulated Depreciation	(79)	(81)
Total Plant and Equipment	**639**	**534**
Computers and Communications		
- Computers and Communications at Fair Value	599	506
Less Accumulated Depreciation	(387)	(285)
	212	**221**
Medical Equipment		
- Medical Equipment	943	878
Less Accumulated Depreciation	(592)	(531)
	351	**347**
Furniture and Fittings		
- Furniture and Fittings at Fair Value	435	370
Less Accumulated Depreciation	(215)	(190)
Total Furniture and Fittings	**220**	**180**
Motor Vehicles		
- Motor Vehicles at Fair Value	225	225
Less Accumulated Depreciation	(155)	(130)
Total Motor Vehicles	**70**	**95**
TOTAL	**65,907**	**41,344**

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)
(b) Reconciliation of the carrying amounts of each class of asset

	Land	Buildings & Land Improv.	Plant & Equipment	Computers & Commun.	Medical Equipment	Furniture & Fittings	Motor Vehicles	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2017	**653**	**40,625**	**454**	**263**	**328**	**164**	**120**	**42,607**
Additions	-	646	89	50	73	41	-	899
Grampians Rural Health Alliance	-	-	59	-	-	-	-	59
Classified as Held for Sale	40	97	-	-	-	-	-	137
Revaluation Increments/(Decrements)	-	-	-	-	-	-	-	-
Disposals	(40)	(96)	-	-	-	-	-	(136)
Depreciation	-	(1,958)	(68)	(92)	(54)	(25)	(25)	(2,222)
Balance at 1 July 2018	**653**	**39,314**	**534**	**221**	**347**	**180**	**95**	**41,344**
Additions	-	797	103	93	65	65	-	1,123
Grampians Rural Health Alliance	-	-	82	-	-	-	-	82
Classified as Held for Sale	-	-	-	-	-	-	-	-
Revaluation Increments/(Decrements)	235	25,373	-	-	-	-	-	25,608
Disposals	-	-	-	-	-	-	-	-
Depreciation	-	(1,957)	(80)	(102)	(61)	(25)	(25)	(2,250)
Balance at 30 June 2019	**888**	**63,527**	**639**	**212**	**351**	**220**	**70**	**65,907**

Land and buildings carried at valuation

The Valuer-General Victoria undertook to re-value all of Rural Northwest Health's owned and leased land and buildings to determine their fair value. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments. The effective date of the valuation is 30 June 2019.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)
(c) Fair value measurement hierarchy for assets

	Carrying amount as at 30 June 2019	Fair value measurement at end of reporting period using:		
		Level 1 [(i)]	Level 2 [(i)]	Level 3 [(i)]
Balance at 30 June 2019	$'000	$'000	$'000	$'000
Land at fair value				
Specialised land	577	-	-	577
Non Specialised land	311	-	311	-
Total of land at fair value	888	-	311	577
Buildings at fair value				
Specialised buildings	61,177	-	-	61,177
Non Specialised buildings	1,257	-	1,257	-
Specialised land improvements	918	-	-	918
Total of building at fair value	63,352	-	1,257	62,095
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	70	-	70	-
- Plant and equipment	1,071	-	-	1,071
Total of plant, equipment and vehicles at fair value	1,141	-	70	1,071
Medical equipment at fair value	351	-	-	351
Total medical equipment at fair value	351	-	-	351

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

There have been no transfers between levels during the period.

	Carrying amount as at 30 June 2018	Fair value measurement at end of reporting period using:		
		Level 1 [(1)]	Level 2 [(1)]	Level 3 [(1)]
Balance at 30 June 2018	$'000	$'000	$'000	$'000
Land at fair value				
Specialised land	392	-	-	392
Non Specialised land	261	-	261	-
Total of land at fair value	653	-	261	392
Buildings at fair value				
Specialised buildings	36,883	-	-	36,883
Non Specialised buildings	979	-	979	-
Specialised land improvements	468	-	-	468
Total of building at fair value	38,330	-	979	37,351
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	95	-	95	-
- Plant and equipment	935	-	-	935
Total of plant, equipment and vehicles at fair value	1,030	-	95	935
Medical equipment at fair value	347	-	-	347
Total medical equipment at fair value	347	-	-	347

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

There have been no transfers between levels during the period.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

(d) Reconciliation of Level 3 fair value

30-Jun-19	Land	Buildings	Plant and equipment	Medical equipment
	$'000	$'000	$'000	$'000
Opening Balance	392	37,351	935	347
Purchases (sales)	-	797	343	65
Transfers in (out)	-	809	-	-
Gains or losses recognised in net result				
- Depreciation	-	(1,957)	(207)	(61)
Subtotal	392	37,000	1,071	351
Items recognised in other comprehensive income				
- Revaluation	185	25,095	-	-
Subtotal	185	25,095	-	-
Closing Balance	577	62,095	1,071	351

There have been no transfers between levels during the period.

30-Jun-18	Land	Buildings	Plant and equipment	Medical equipment
	$'000	$'000	$'000	$'000
Opening Balance	392	39,309	881	328
Purchases (sales)	-	647	239	73
Transfers in (out)	-	(647)	-	-
Gains or losses recognised in net result				
- Depreciation	-	(1,958)	(185)	(54)
Subtotal	392	37,351	935	347
Items recognised in other comprehensive income				
- Revaluation	-	-	-	-
Subtotal	-	-	-	-
Closing Balance	392	37,351	935	347

There have been no transfers between levels during the period.

(e) Fair Value Determination

Asset Class	Likely valuation approach	Significant inputs (Level 3 only)
Non-specialised land	Market approach	n.a.
Specialised Land (Crown / Freehold)	Market approach	Community Service Obligations Adjustments - 20%
Non-specialised buildings	Market approach	n.a.
Specialised buildings	Depreciated replacement cost approach	- Cost per square metre - Useful life
Vehicles	Market approach	n.a.
	Depreciated replacement cost approach	- Cost per unit - Useful life
Plant and equipment	Depreciated replacement cost approach	- Cost per unit - Useful life

(f) Property, Plant and Equipment Revaluation Surplus

	2019 $'000	2018 $'000
Property, Plant and Equipment Revaluation Surplus		
Balance at the beginning of the reporting period	12,519	12,519
Transfer to Accumulated Deficits		
- Land	-	-
Revaluation Increment		
- Land	235	-
- Buildings	25,373	-
Balance at the end of the reporting period*	38,127	12,519
***Represented by:**		
- Land	703	468
- Buildings	37,424	12,051
	38,127	12,519

NOTE 4.3: DEPRECIATION

	2019 $'000	2018 $'000
Depreciation		
Buildings	1,778	1,760
Land Improvements	179	198
Plant and Equipment	62	43
Medical Equipment	61	54
Computers and Communications	102	92
Furniture and Fittings	25	25
Motor Vehicles	25	25
Grampians Rural Health Alliance Depreciation	18	25
TOTAL DEPRECIATION	2,250	2,222

Depreciation
All infrastructure assets, buildings, plant and equipment and other non-financial physical assets (excluding items under operating leases, assets held for sale, land and investment properties) that have finite useful lives are depreciated. Depreciation is generally calculated on a straight-line basis at rates that allocate the asset's value, less any estimated residual value over its estimated useful life.

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

	2019	2018
Buildings		
- Structure Shell Building Fabric	2 to 50 years	2 to 50 years
- Site Engineering Services and Central Plant	2 to 50 years	2 to 50 years
Central Plant		
- Fit Out	2 to 50 years	2 to 50 years
- Trunk Reticulated Building Systems	2 to 50 years	2 to 50 years
Plant and Equipment	1 to 20 years	1 to 20 years
Medical Equipment	4 to 20 years	4 to 20 years
Computers and Communication	3 to 5 years	3 to 5 years
Furniture and Fittings	1 to 20 years	1 to 20 years
Motor Vehicles	8 years	8 years
Land Improvements	6 years	6 years

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

NOTE 5: OTHER ASSETS AND LIABILITIES

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

Structure
5.1 Receivables
5.2 Payables
5.3 Other liabilities

NOTE 5.1: RECEIVABLES	2019 $'000	2018 $'000
CURRENT		
Contractual		
Patient Fees	181	157
Accrued Investment Income	-	72
Accrued Revenue - Other	313	465
Trade Debtors	29	71
Grampians Rural Health Alliance Receivables	14	16
Less: Allowance for Impairment Losses of Contractual Receivables	(14)	(14)
	523	767
Statutory		
Department of Health and Human Services (WIES)	-	167
GST Receivable	(4)	105
	(4)	272
TOTAL CURRENT RECEIVABLES	519	1,039
NON CURRENT		
Statutory		
Department of Health and Human Services (LSL Debtor)	287	72
TOTAL NON-CURRENT RECEIVABLES	287	72
TOTAL RECEIVABLES	806	1,111
(a) Movement in the Allowance for Impairment Losses of Contractual Receivables		
Balance at beginning of the year	(14)	(14)
(Increase) / decrease in allowance recognised in net result	-	-
Balance at end of the year	(14)	(14)

Receivables recognition
Receivables consist of:

- Contractual receivables, which consists of debtors in relation to goods and services and accrued investment income. These receivables are classified as financial instruments and categorised as 'financial assets at amortised costs'. They are initially recognised at fair value plus any directly attributable transaction costs. Rural Northwest Health holds the contractual receivables with the objective to collect the contractual cash flows and therefore subsequently measured at amortised cost using the effective interest method, less any impairment.
- Statutory receivables, which predominantly includes amounts owing from the Victorian Government and Goods and Services Tax (GST) input tax credits recoverable. Statutory receivables do not arise from contracts and are recognised and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments for disclosure purposes. Rural Northwest Health applies AASB 9 for initial measurement of the statutory receivables and as a result statutory receivables are initially recognised at fair value plus any directly attributable transaction cost.

Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition.

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.

Rural Northwest Health is not exposed to any significant credit risk exposure to any single counterparty or any group of counterparties having similar characteristics. Trade receivables consist of a large number of customers in various geographical areas. Based on historical information about customer default rates, management consider the credit quality of trade receivables that are not past due or impaired to be good.

Receivables are subject to impairment loss assessment in accordance with AASB 9's expected credit loss model and the impairment loss allowance is increased accordingly with the impairment expense recognised in the net result as an 'other economic flow'. However, when it becomes mutually agreed between debtor and creditor that the receivable has become uncollectible, the carrying amount of the receivable needs to be reduced, and a bad debt expense for the write-off recognised in the net result as a transaction. Accordingly at the same time, the amount in the provision together with its related impairment expense initially recognised as an 'other economic flow' will need to be reversed.

Where the bad debt is written off following a unilateral decision, the carrying amount of the receivable needs to be reduced, and a bad debt expense for the write-off recognised in the net result as an 'other economic flow'. Accordingly at the same time, the amount in the provision together with its related impairment expense will need to be reversed.

Impairment losses of contractual receivables:
Refer to Note 7.1(c) Contractual receivables at amortised costs for Rural Northwest Health's contractual impairment losses.

Statutory receivables:
Assets that are not contractual (such as assets that arise as a result of statutory requirements), are not financial assets. However, the initial fair value measurement requirements of AASB 9 are the most appropriate for the types of receivables under consideration as the economic substance of contractual receivables and receivables arising from statutory requirements is similar at initial recognition and therefore AASB 9 is applied for the initial measurement of such receivables.

NOTE 5.2: PAYABLES	2019 $'000	2018 $'000
CURRENT		
Contractual		
Trade Creditors	159	187
Accrued Salaries and Wages	573	489
Grampians Rural Health Alliance Payables	47	32
Accrued Expenses	587	349
Accrued Audit Fees	26	23
	1,392	1,080
Statutory		
Department of Health and Human Services - Accrued Grant Recall	47	8
Australian Taxation Office - Fringe Benefits Tax	-	7
	47	15
TOTAL PAYABLES	1,439	1,095

Payables recognition

Payables consist of:

- contractual payables, classified as financial instruments and measured at amortised cost. Accounts payable and salaries and wages payable represent liabilities for goods and services provided to Rural Northwest Health prior to the end of the financial year that are unpaid; and
- statutory payables, that 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 contracts.

Maturity analysis of payables

Please refer to Note 7.1(b) for the ageing analysis of payables.

NOTE 5.3: OTHER LIABILITIES	2019 $'000	2018 $'000
CURRENT		
Monies Held in Trust*		
- Patient Monies Held in Trust	168	123
- Accommodation Bonds (Refundable Entrance Fees)	10,262	7,954
- Other	41	30
	10,471	8,107
TOTAL OTHER LIABILITIES	10,471	8,107
*** Total Monies Held in Trust**		
Represented by the following assets:		
Cash Assets (refer to Note 6.1)	10,471	8,107
TOTAL	10,471	8,107

NOTE 6: HOW WE FINANCE OUR OPERATIONS

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

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

Structure

6.1 Cash and cash equivalents
6.2 Commitments for expenditure

NOTE 6.1: CASH AND CASH EQUIVALENTS

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

	2019 $'000	2018 $'000
Cash on Hand	2	2
Cash at Bank	21,839	8,128
TOTAL CASH AND CASH EQUIVALENTS	21,841	8,130
Represented by:		
Cash for Health Service Operations	11,237	7,774
Grampians Rural Health Alliance Cash	133	203
Cash for Monies Held in Trust		
- Cash at Bank	209	153
- Accommodation Bonds (Refundable Entrance Fees)	10,262	-
TOTAL CASH AND CASH EQUIVALENTS	21,841	8,130

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

For cash flow statement presentation purposes, cash and cash equivalents include bank overdrafts, which are included as liabilities on the balance sheet. The cash flow statement includes monies held in trust.

NOTE 6.2: COMMITMENTS FOR EXPENDITURE

(a) Commitments

	2019 $'000	2018 $'000
Lease commitments		
Commitments for leases contracted for at reporting date:		
Operating leases	141	201
Total lease commitments	**141**	**201**
Operating leases		
Payable as follows:		
Cancellable		
Not later than one year	120	130
Later than 1 year and not later than 5 years	21	71
Sub Total	**141**	**201**
Total lease commitments (inclusive of GST)	141	201
less GST recoverable from the Australian Tax Office	(13)	(18)
Total Commitments (exclusive of GST)	**128**	**183**

Lease and Renewal Terms Included in Lease Agreements

All amounts shown in the commitments note are nominal amounts inclusive of GST.

Motor Vehicles: This lease is for 17 vehicles from Vic Fleet (Department of Treasury and Finance) at a cost of $10,816 per month over 36 months. The Health Service is under no obligation to renew the lease upon expiry.

Photocopiers / Printers: This lease is for 7 photocopiers / printers from Viatek at a cost of $3,955 per month. The Health Service is under no obligation to renew the lease upon expiry.

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

NOTE 7: RISKS, CONTINGENCIES & VALUATION UNCERTAINTIES

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

Structure

7.1 Financial instruments
7.2 Contingent assets and contingent liabilities

NOTE 7.1: 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 Rural Northwest Health's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation.*

NOTE 7.1 (a): Financial instruments: categorisation

2019	Financial Assets at Amortised Cost $'000	Financial Liabilities at Amortised Cost $'000	Total $'000
Contractual Financial Assets			
Cash and cash equivalents	21,841	-	21,841
Receivables			
- Trade Debtors	29	-	29
- Other Receivables	494	-	494
Total Financial Assets (i)	22,364	-	22,364
Financial Liabilities			
Payables	-	1,392	1,392
Other Financial Liabilities			
- Monies Held in Trust	-	10,471	10,471
Total Financial Liabilities(ii)	-	11,863	11,863

2018	Contractual Financial Assets - Loans and Receivables $'000	Contractual Financial Liabilities at Amortised Cost $'000	Total $'000
Contractual Financial Assets			
Cash and cash equivalents	8,130	-	8,130
Receivables			
- Trade Debtors	71	-	71
- Other Receivables	696	-	696
Other Financial Assets			
- Term Deposits	10,404	-	10,404
Total Financial Assets (i)	19,301	-	19,301
Financial Liabilities			
Payables	-	1,080	1,080
Other Financial Liabilities			
- Monies Held in Trust	-	8,107	8,107
Total Financial Liabilities(ii)	-	9,187	9,187

(i) The carrying amount excludes statutory receivables (i.e. GST Receivable and DHHS Receivable) and statutory payables (i.e. Revenue in advance and DHHS payable).

From 1 July 2018, Rural Northwest Health applies AASB 9 and classifies all of its financial assets based on the business model for managing the assets and the asset's contractual terms.

Categories of financial assets under AASB 9

Financial assets at amortised cost

Financial assets are measured at amortised costs if both of the following criteria are met and the assets are not designated as fair value through net result:

- the assets are held by Rural Northwest Health to collect the contractual cash flows, and
- the assets' contractual terms give rise to cash flows that are solely payments of principal and interests.

These assets are initially recognised at fair value plus any directly attributable transaction costs and subsequently measured at amortised cost using the effective interest method less any impairment.

The Department recognises the following assets in this category:

- cash and deposits;
- receivables (excluding statutory receivables);
- term deposits; and
- certain debt securities.

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
NOTE 7.1 (a): Financial instruments: categorisation (Continued)
Categories of financial assets previously under AASB 139
Loans and receivables and cash are financial instrument assets with fixed and determinable payments that are not quoted on an active market. These assets and liabilities 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 (and for assets, less any impairment).

Rural Northwest Health recognises the following assets in this category:
- cash and deposits; and
- receivables (excluding statutory receivables).

Financial liabilities at amortised cost 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. Rural Northwest Health recognises the following liabilities in this category:
- payables (excluding statutory payables); and
- borrowings (including finance lease liabilities).

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.

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

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

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

NOTE 7.1 (b): Maturity analysis of Financial Liabilities as at 30 June

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 Dates			
	Total Carrying Amount	Nominal Amount	Less than 1 Month	1 - 3 Months	3 Months - 1 Year	1 - 5 Years
2019	$'000	$'000	$'000	$'000	$'000	$'000
Financial Liabilities						
At amortised cost						
Payables	1,392	1,392	1,392	-	-	-
Other Financial Liabilities (i)						
- Monies Held in Trust	10,471	10,471	-	-	10,471	-
Total Financial Liabilities	11,863	11,863	1,392	-	10,471	-
2018						
Financial Liabilities						
At amortised cost						
Payables	1,080	1,080	1,080	-	-	-
Other Financial Liabilities (i)						
- Monies Held in Trust	8,107	8,107	-	-	8,107	-
Total Financial Liabilities	9,187	9,187	1,080	-	8,107	-

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
NOTE 7.1 (c): Contractual receivables at amortised costs

01-Jul-18	Current	Less than 1 month	1-3 months	3 months - 1 year	1-5 years	Total
Expected loss rate	0%	0%	0%	100%	0%	
Gross carrying amount of contractual receivables	611	128	14	14	-	767
Loss allowance	-	-	-	14	-	14

30-Jun-19	Current	Less than 1 month	1-3 months	3 months - 1 year	1-5 years	Total
Expected loss rate	0%	0%	0%	0%	100%	
Gross carrying amount of contractual receivables	347	154	8	-	14	523
Loss allowance	-	-	-	-	14	14

Impairment of financial assets under AASB 9 – applicable from 1 July 2018
From 1 July 2018, the Health Service has been recording the allowance for expected credit loss for the relevant financial instruments, replacing AASB 139's incurred loss approach with AASB 9's Expected Credit Loss approach. Subject to AASB 9 impairment assessment include the Health Service's contractual receivables, statutory receivables and its investment in debt instruments.

Equity instruments are not subject to impairment under AASB 9. Other financial assets mandatorily measured or designated at fair value through net result are not subject to impairment assessment under AASB 9. While cash and cash equivalents are also subject to the impairment requirements of AASB 9, the identified impairment loss was immaterial.

Contractual receivables at amortised cost
The Health Service applies AASB 9 simplified approach for all contractual receivables to measure expected credit losses using a lifetime expected loss allowance based on the assumptions about risk of default and expected loss rates. The Health Service has grouped contractual receivables on shared credit risk characteristics and days past due and select the expected credit loss rate based on the Health Service's past history, existing market conditions, as well as forward‑looking estimates at the end of the financial year.

On this basis, the Health Service determines the opening loss allowance on initial application date of AASB 9 and the closing loss allowance at end of the financial year as disclosed above.

Reconciliation of the movement in the loss allowance for contractual receivables

	2019	*2018*
Balance at the beginning of the year	14	14
Opening retained earnings adjustment on adoption of AASB 9	-	-
Opening Loss Allowance	14	14
Modification of contractual cash flows on financial assets	-	-
Increase in provision recognised in the net result	-	-
Reversal of provision of receivables written off during the year as uncollectible	-	-
Reversal of unused provision recognised in the net result	-	-
Balance at end of the year	14	14

Credit loss allowance is classified as other economic flows in the net result. Contractual receivables are written off when there is no reasonable expectation of recovery and impairment losses are classified as a transaction expense. Subsequent recoveries of amounts previously written off are credited against the same line item.

In prior years, 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. A provision is made for estimated irrecoverable amounts from the sale of goods when there is objective evidence that an individual receivable is impaired. Bad debts considered as written off by mutual consent.

Statutory receivables and debt investments at amortised cost
The Health Service's non-contractual receivables arising from statutory requirements are not financial instruments. However, they are nevertheless recognised and measured in accordance with AASB 9 requirements as if those receivables are financial instruments.

Both the statutory receivables and investments in debt instruments are considered to have low credit risk, taking into account the counterparty's credit rating, risk of default and capacity to meet contractual cash flow obligations in the near term. As the result, the loss allowance recognised for these financial assets during the period was limited to 12 months expected losses. No loss allowance recognised at 30 June 2018 under AASB 139. No additional loss allowance required upon transition into AASB 9 on 1 July 2018.

NOTE 7.2: CONTINGENT ASSETS AND CONTINGENT LIABILITIES

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

There are no known contingent assets or liabilities for Rural Northwest Health at the date of this report (2018: nil contingent assets or liabilities).

NOTE 8: OTHER DISCLOSURES

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

Structure

8.1 Reconciliation of Net Result for the Year to Net Cash Flow from Operating Activities
8.2 Responsible Persons
8.3 Remuneration of Executives
8.4 Related Parties
8.5 Remuneration of Auditors
8.6 Events Occurring after the Balance Sheet Date
8.7 Jointly Contolled Operations
8.8 AASBs issued that are not yet effective
8.9 Economic Dependency

NOTE 8.1: RECONCILIATION OF NET RESULT FOR THE YEAR TO NET CASH INFLOW / (OUTFLOW) FROM OPERATING ACTIVITIES	2019 $'000	2018 $'000
NET RESULT FOR THE PERIOD	(1,209)	32
Non-cash movements		
Depreciation	2,232	2,197
Share of Net Result from Jointly Controlled Operations	16	(52)
Movements included in investing and financing activities		
Net (Gain)/Loss from Sale of Non-Financial Physical Assets	(1)	(25)
Movements in assets and liabilities		
Change in Operating Assets & Liabilities		
(Increase)/Decrease in Receivables	303	(444)
(Increase)/Decrease in Prepayments	6	69
Increase/(Decrease) in Payables	329	(315)
Increase/(Decrease) in Provisions	445	60
Change in Inventories	14	12
NET CASH INFLOW FROM OPERATING ACTIVITIES	2,135	1,534

NOTE 8.2: RESPONSIBLE PERSONS DISCLOSURES

In accordance with the Ministerial Directions issued by the Assistant Treasurer 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 and Minister for Ambulance Services	01/07/2018 - 29/11/2018
Jenny Mikakos, Minister for Health and Minister for Ambulance Services	29/11/2018 - 30/06/2019
Martin Foley, Minister for Mental Health,	01/07/2018 - 30/06/2019
Martin Foley, Minister for Housing, Disability and Ageing	01/07/2018 - 29/11/2018
Luke Donnellan, Minister for Child Protection, Minister for Disability, Ageing and Carers	29/11/2018 - 30/06/2019
Governing Boards	
Julia Hausler	01/07/2018 - 30/06/2019
Janette McCabe	01/07/2018 - 30/06/2019
Carolyn Morcom	01/07/2018 - 30/06/2019
Amanda Kenny	01/07/2018 - 30/06/2019
John Aitken	01/07/2018 - 30/06/2019
Glenda Hewitt	01/07/2018 - 30/06/2019
Genevieve O'Sullivan	01/10/2018 - 30/06/2019
Hugh Molenaar	01/10/2018 - 30/06/2019
Accountable Officer	
Craig Wilding (Acting)	01/07/2018 - 16/09/2018
Joanne Martin (Acting)	17/09/2018 - 30/09/2018
Kevin Mills	01/10/2018 - 30/06/2019

Remuneration of Responsible Persons

The number of Responsible Persons are shown in their relevant income bands:

Income Band	2019 $'000	2018 $'000
$0 - $9,999	10	8
$50,000 - $59,999	-	1
$60,000 - $69,999	-	1
$130,000 - $139,999	1	-
$140,000 - $149,999	-	1
Total Numbers	11	11
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	159	258

Ballarat Health Services provided the services of Craig Wilding to act as Accountable Officer of Rural Northwest Health in the period 28/05/2018 - 14/09/2018. A fee of $54,699 was paid to Ballarat Health Services for this service in 2019 (2018: $23,751).

Amounts relating to Responsible Ministers are reported within the Department of Parliamentary Services' Financial Report.

NOTE 8.3: REMUNERATION OF EXECUTIVES

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

Remuneration of executive officers	Consolidated Total Remuneration	
	2019 $'000	2018 $'000
Short-term employee benefits	658	613
Post-employment benefits	56	41
Other long-term benefits	13	14
Termination benefits	-	-
Share-based payments	-	-
Total Remuneration (i)	727	668
Total Number of Executives	7	5
Total Annualised Employee Equivalent (AEE) (ii)	6.75	5

i The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of Rural Northwest Health under AASB 124 Related Party Disclosures and are also reported within Note 8.4 Related Parties.

ii Annualised employee equivalent is based on working 38 ordinary hours per week over the reporting period

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

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

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

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

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

NOTE 8.4: RELATED PARTIES

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

- all key management personnel and their close family members;
- all cabinet ministers and their close family members;
- Jointly Controlled Operation - A member of the Grampians Rural Health Alliance; and
- all hospitals and public sector entities that are controlled and consolidated into the whole of state consolidated financial statements.

KMPs are those people with the authority and responsibility for planning, directing and controlling the activities of the Health Service and its controlled entities, directly or indirectly.

The Board of Directors and the Executive Directors of Rural Northwest Health are deemed to be KMPs.

Entity	KMPs	Position Title
Rural Northwest Health	Julia Hausler	Chair of the Board
Rural Northwest Health	Janette McCabe	Board Member
Rural Northwest Health	Amanda Kenny	Board Member
Rural Northwest Health	John Aitken	Board Member
Rural Northwest Health	Glenda Hewitt	Board Member
Rural Northwest Health	Genevieve O'Sullivan	Board Member
Rural Northwest Health	Carolyn Morcom	Board Member
Rural Northwest Health	Hugh Molenaar	Board Member
Rural Northwest Health	Craig Wilding	Chief Executive Officer (Acting)
Rural Northwest Health	Joanne Martin	Chief Executive Officer (Acting)
Rural Northwest Health	Kevin Mills	Chief Executive Officer
Rural Northwest Health	Dalton Burns	Executive Manager Corporate Services
Rural Northwest Health	Wendy James	Executive Manager Clinical Services
Rural Northwest Health	Kaye Knight	Executive Manager People & Culture
Rural Northwest Health	Joanne Martin	Executive Manager Community Health
Rural Northwest Health	Natalie Ladner	Hopetoun Campus Manager
Rural Northwest Health	Ngaraeta Melgren	Community Health Manager
Rural Northwest Health	Wendy Walters	Warracknabeal Campus Manager - Aged

COMPENSATION	2019 $'000	2018 $'000
Short term employee benefits (i)	803	821
Post-employment benefits	66	55
Other long-term benefits	17	14
Termination benefits	-	36
Share based payments	-	-
Total (ii)	**886**	**926**

(i)Total remuneration paid to KMPs employed as a contractor during the reporting period through accounts payable has been reported under short-term employee benefits.
(ii)KMPs are also reported in Note 8.2 Responsible Persons or Note 8.3 Remuneration of Executives.

Significant transactions with government-related entities

Rural Northwest Health received funding from the Department of Health and Human Services of $12,118,524 (2017: $11,114,000).

Expenses incurred by the Health Service in delivering services and outputs are in accordance with Health Purchasing Victoria requirements. Goods and services including procurement, diagnostics, patient meals and multi-site operational support are provided by other Victorian Health Service Providers on commercial terms.

Professional medical indemnity insurance and other insurance products are obtained from the Victorian Managed Insurance Authority.

The Standing Directions of the Assistant Treasurer require the Health Service to hold cash (in excess of working capital) in accordance with the State's centralised banking arrangements. All borrowings are required to be sourced from Treasury Corporation Victorian unless an exemption has been approved by the Minister for Health and Human Services and the Treasurer.

Transactions with key management personnel and other related parties

Given the breadth and depth of State government activities, related parties transact with the Victorian public sector in a manner consistent with other members of the public e.g. stamp duty and other government fees and charges. Further employment of processes within the Victorian public sector occur on terms and conditions consistent with the Public Administration Act 2004 and Codes of Conduct and Standards issued by the Victorian Public Sector Commission. Procurement processes occur on terms and conditions consistent with the Victorian Government Procurement Board requirements.

Outside of normal citizen type transactions with the Department of Health and Human Services, all other related party transactions that involved KMPs and their close family members have been entered into on an arm's length basis. Transactions are disclosed when they are considered material to the users of the financial report in making and evaluation decisions about the allocation of scare resources.

There were no related party transactions with Cabinet Ministers required to be disclosed in 2019.

There were no related party transactions required to be disclosed for Rural Northwest Health Board of Directors and Executive Directors in 2019.

NOTE 8.5: REMUNERATION OF AUDITORS

	2019 $'000	2018 $'000
Victorian Auditor-General's Office		
Audit of the Financial Statements	25	24
Total Remuneration of auditors	25	24

NOTE 8.6: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

There are no events occurring after the Balance Sheet Date.

NOTE 8.7: JOINTLY CONTROLLED OPERATIONS

Name of Entity	Principal Activity	Ownership Interest 2019 %	Ownership Interest 2018 %
Grampians Rural Health Alliance	Information Systems	5.81	5.78

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

	2019 $'000	2018 $'000
Current Assets		
Cash and Cash Equivalents	133	203
Receivables	14	16
Prepayments	17	10
Total Current Assets	164	229
Non Current Assets		
Property Plant and Equipment	309	245
Total Non Current Assets	309	245
Total Assets	473	474
Current Liabilities		
Payables	47	32
Total Current Liabilities	47	32
Total Liabilities	47	32
Net Assets	426	442

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

Revenues		
Operating Revenue	364	337
Capital Income	7	55
Total Revenue	371	392
Expenses		
Operating Expenditure	341	315
Depreciation	46	25
Total Expenses	387	340
Net Result	(16)	52

Contingent Liabilities and Capital Commitments

There are no known contingent assets or liabilities for Grampians Rural Health Alliance as at the date of this report.

Investments in joint operations

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

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

NOTE 8.8: AASBs ISSUED THAT ARE NOT YET EFFECTIVE

Certain new Australian accounting standards and interpretations have been published that are not mandatory for 30 June 2019 reporting period. DTF assesses the impact of all these new standards and advises the Health Service of their applicability and early adoption where applicable.

As at 30 June 2019, 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. Rural Northwest Health has not and does not intend to adopt these standards early.

Standard/Interpretation	Summary	Applicable for annual reporting periods beginning 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. Note that amending standard AASB 2015 8 Amendments to Australian Accounting Standards – Effective Date of AASB 15 has deferred the effective date of AASB 15 to annual reporting periods beginning on or after 1 January 2018, instead of 1 January 2017 for Not-for-Profit entities.	1 January 2019	There is an expectation this will impact capital grant funding, however it is not possible to quantify the impact until such time as funding is received and projects are commenced.
AASB 2018-4 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Public-Sector Licensors	AASB 2018-4 amends AASB 15 and AASB 16 to provide guidance for revenue recognition in connection with taxes and Non-IP licences for Not-for-Profit entities.	1 January 2019	There is no material financial impact expected.
AASB 2016-8 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities	AASB 2016-8 inserts Australian requirements and authoritative implementation guidance for not-for-profit-entities into AASB 9 and AASB 15. This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events.	1 January 2019	The impact on reporting capital funding has potential to result in material change, however this is not able to be quantified prior to receipt of capital grants and commencement of projects.
AASB 16 Leases	The key changes introduced by AASB 16 include the recognition of most operating leases (which are currently not recognised) on balance sheet.	1 January 2019	As at 30 June 2019 Rural Northwest Health has 17 Motor Vehicle Leases with future Assets of $336,272 and Liabilities of $337,363 to be recognised on the Balance Sheet in 2019/20.
AASB 2018-8 Amendments to Australian Accounting Standards – Right of Use Assets of Not-for-Profit entities	This standard amends various other accounting standards to provide an option for not-for-profit entities to not apply the fair value initial measurement requirements to a class or classes of right of use assets arising under leases with significantly below-market terms and conditions principally to enable the entity to further its objectives. This Standard also adds additional disclosure requirements to AASB 16 for not-for-profit entities that elect to apply this option.	1 January 2019	There is no material financial impact expected.
AASB 1058 Income of Not-for-Profit Entities	AASB 1058 will replace the majority of income recognition in relation to government grants and other types of contributions requirements relating to public sector not-for-profit entities, previously in AASB 1004 Contributions. The restructure of administrative arrangement will remain under AASB 1004 and will be restricted to government entities and contributions by owners in a public sector context, AASB 1058 establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objective	1 January 2019	Grant revenue is currently recognised up front upon receipt of the funds under AASB 1004 Contributions. The impact on current revenue recognition of the changes is the potential phasing and deferral of revenue recorded in the operating statement.
AASB 2018-7 Amendments to Australian Accounting Standards – Definition of Material	This Standard principally amends AASB 101 Presentation of Financial Statements and AASB 108 Accounting Policies, Changes in Accounting Estimates and Errors. The amendments refine and clarify the definition of material in AASB 101 and its application by improving the wording and aligning the definition across AASB Standards and other publications. The amendments also include some supporting requirements in AASB 101 in the definition to give it more prominence and clarify the explanation accompanying the definition of material.	1 January 2020	The standard is not expected to have a significant impact on the public sector. No material impact is expected.

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

Standard/Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on financial statements
AASB 2018-5 Amendments to Australian Accounting Standards – Deferral of AASB 1059	This standard defers the mandatory effective date of AASB 1059 from 1 January 2019 to 1 January 2020.	1 January 2020	As the State has elected to early adopt AASB 1059, the financial impact will be reported in the financial year ending 30 June 2019, rather than the following year.

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 2018-19 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 2017-1 Amendments to Australian Accounting Standards – Transfers of Investment Property, Annual Improvements 2014-16 Cycle and Other Amendments
- AASB 2017-6 Amendments to Australian Accounting Standards – Prepayment Features with Negative Compensation
- AASB 2017-7 Amendments to Australian Accounting Standards – Long-term Interests in Associates and Joint Ventures

NOTE 8.9: ECONOMIC DEPENDENCY

Rural Northwest Health is dependent on the Department of Health and Human Services for the majority of its revenue used to operate the entity.
At the date of this report, the Board of Directors has no reason to believe the Department of Health and Human Services will not continue to support Rural Northwest Health Service.

Notes

Notes

THE WELLNESS GARDEN AT WARRACKNABEAL

RURAL northwest HEALTH

centred on you

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