RURAL northwest HEALTH
centred on you

# ANNUAL REPORT
# 2016 - 2017

RURAL northwest HEALTH
centred on you


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The annual report of Rural Northwest Health is prepared in accordance with all relevant Victorian legislations and pronouncements. 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 2017

Leo Casey

**Board Chairperson**

Warracknabeal

25th August 2017

# Vision, mission and strategic direction

**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**

1. Build business capacity
2. Respond bravely and innovatively to opportunities that improve local health outcomes

## This report:

- Covers the period 1 July 2016 to 30 June 2017
- 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
- Should also be read in conjunction with the Quality Account
- Will be presented to the community at the Rural Northwest Health Annual General Meeting on 28 November 2017
- 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 Chief Executive Officer report

**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 2017.**

Rural Northwest Health has experienced another exceptional year in 2016-2017. The results reflect the exceptional work undertaken by the Board of Management, team members, volunteers, including the Hopetoun Beulah Reference Group, auxiliaries and community members who work diligently, support our events and fundraising activities and attend the wide range of services that Rural Northwest Health offers.

We welcomed Associate Professor Amanda Kenny to the board in February and will farewell Mr Matt Richardson on 30 June 2017 after four years of service. Board members are all volunteers and provide their expertise and knowledge to the executive team with passion and gusto.

Walk for Yarri and Team Outpatients are key fundraisers for both campuses and have raised over $20,000 this year which has gone directly to supporting the residents at both campuses.

Our partners support our success and these include the Department of Health and Human Services, Wimmera Primary Care Partnership, the Wimmera Southern Mallee Health Alliance, Yarriambiack Shire, Western Victoria Primary Health Network, Woodbine, Ambulance Victoria, the Visiting Medical Officer, Dr Donald Liu, Dr Franklin Butuyuyu, Dr Amhed Rahim and a range of community groups including the community gardens, schools, kindergartens and community service groups.

Developing evidenced based best practice services continues to be a driving force in the organisation and our research partners, Latrobe University, Swinburne University and Deakin University assist us to research the innovative projects we develop and to demonstrate the success as we assist community members to improve their health and wellbeing.

The annual report includes updates on the 2016-2020 eight strategic goals. The outcomes we have achieved have assisted us to deliver our vision and strategic intent.

We are very pleased to demonstrate again our financial and business acumen to streamline processes, maximise funding and be as efficient and effective as we can be. This will hold us in good stead for the future. Betty Bartlett has worked with the team at both Yarriambiack Lodge and Hopetoun campus to allow us to be $450,000 above budget in ACFI funding which has contributed to our successful bottom line.

The Board of Management will continue to work with all stakeholders to ensure that we are accountable and deliver on our goals and our vision.

We look forward to working together through change to provide innovative rural health services.

**Leo Casey**

Board Chairperson
25th August 2017

**Catherine Morley**

Chief Executive Officer
25th August 2017

# Celebrations

## Betty Richardson Award

The award honours and recognises Betty Richardson's contributions to Rural Northwest Health and the passion for caring is her legacy that we are proud to carry on.

Betty Richardson loved nursing. She loved looking after people and loved the camaraderie she enjoyed with her colleagues. Her name is revered throughout the nursing fraternity of Rural Northwest Health and more broadly across the Wimmera. She epitomises the ideal of what we all grew up to believe a nurse should be.

Finalists of the Betty Richardson Award were Angie Cox, Kathy Poulton and Katie Ramsdale with Katie being presented the award.

The Betty Richardson awards night also celebrated 315 years of service to the organisation from 18 team members.

The BRIGHT (Brave and Resilient Individuals Getting Healthy Together) program was launched in 2016 to assist team members to improve their health and wellbeing. The BRIGHT award was presented for the first time in 2017 to the team member who assumed a leadership role inspiring others to follow their success and improve their own health and wellbeing.

Finalists for the award were Angie Cox and Kylie O'Connor with Angie being presented the award.

# Strategic plan update 2016-17

Rural Northwest Health released its strategic plan in March 2016 as we celebrated the opening of stage two and 125 years of health service delivery.

The plan includes two key areas – building business capability and responding bravely and innovatively to opportunities to improve health outcomes. By 2020 actions undertaken by Rural Northwest Health team members will achieve the strategic intent of improving the health and wellbeing of our community members and assisting us to all live a good life.

## 1. Support strong governance and leadership

The Board of Management and executive team have continued to undertake activities to enhance and develop their skills and decision making across clinical governance, communication, risk management, appetite and evidence based and next practice models of care. Time and energy was invested in understanding and developing a risk and quality plan that identifies key performance indicators across quality and safe care, team member health and engagement and financial areas of the organisation that need to be overseen and improved.

New reports developed included Venous Thrombus Embolism assessment and action, monitoring if team members feel respected at work, maximising radiology bookings and minimising vacancies and monitoring the correct number and required skill mix rostered for every shift.

Rural Northwest Health continues to take a leadership role in improving the health and wellbeing opportunities of all community members working with YCHANGe (Creating Healthy Active Nourished Generations); Deakin University; Yarriambiack Shire and community members; Southern Mallee Health Alliance; and implementing systems and activities to support community members to receive high quality and safe care at the right place and at the right time.

We continue to hear and include the voice of the community in our decision making, and are working on new partnerships and processes to recognise the diverse needs of the community and ensure that services provided reflect these needs.

International, national and interstate visitors continue to visit Rural Northwest Health to understand our model of care, the cultural change we have developed and continue to drive and improve, and we continue to ask questions and learn from these visitors.

## 2. Increase workforce capability and capacity

Time, energy and resources have continued to be invested into our biggest asset – our team members.

In March 2017, 35 team members were presented with service awards recognising 315 years of combined service.

The Betty Richardson Award was presented to Katie Ramsdale who demonstrates every day her leadership, her innovation, her team work and how humble she is as she works tirelessly to make a difference in people's lives.

Mindfulness at work, the essential training day, decision making days and groove train (compliance day) have allowed team members to develop and practice utilising new skills and being involved in operationalising new initiatives across the organisation which include:

- Development of the new model of care for community, district nursing and acute care.
- New education sessions held regularly to improve team member's computer skills.
- The implementation of new 8:8:10 roster so that residents, clients and team members benefit from the increased hours on the floor.
- Reviewing the orientation process and system for new team members.

Developing and implementing a new diversity plan has allowed the organisation to develop systems and processes to support everyone to feel valued and have opportunities to develop and grow and embrace differences.

## 3. Utilise preserve and enhance the infrastructure to maintain safe and efficient workplaces and residential services

The renovation was finalised at Hopetoun campus with an improved kitchenette and dining room enhancing the dining experience and access to the garden.

Housing was improved for team members with refurbishment of the old doctor's surgery into a three bedroom house. The independent living units were also refurbished and freshened up to allow a welcoming space for older community members to live independently at home but close to the health service.

New energy efficient lighting has been installed in both Warracknabeal and Hopetoun which will result in a saving of over $28,000 a year in energy costs as well as improved efficiency for the maintenance team.

We are continuing to work on finishing off the stage two building at Warracknabeal as we improve parts of the building. Soundproofing in the community health wing has been a priority and ensuring adequate draining in bathrooms in Yarriambiack Lodge. The new building and removal of the old acute wing has enhanced the experience for clients and residents and improved the efficiency of the team as well.

The wellbeing garden commenced in May which utilised a donation from a community member and savings from the stage two redevelopment. More work will be undertaken to find the funds to compete the garden.

Extensive painting and work has been undertaken in Yarriambiack Lodge as it approaches its tenth birthday. Bright pops of colour and art work have made the living spaces more inviting and intimate.

Toilets and storage was enhanced at Beulah and we continue to work with the community garden committee to enhance the outside space, which is looking inviting and has the added benefit of some healthy food as well.

The fleet of cars were replaced with energy efficient and safe transport for team members who continuously drive up and down the highway.

## 4. Maintain financial stability

Increasing our income at every opportunity and minimising our costs has continued in the 2016-17 financial year. The team have made significant gains with increasing our ACFI funding over the financial year and this has contributed to a very healthy bottom line. Occupancy at both Yarriambiack Lodge and Hopetoun campus has been tracking well above 99% with extra beds utilised at Hopetoun campus to meet community member's needs.

New Enterprise Agreements were introduced for all team members that were not fully funded and included significant back pays and one off payments which we have absorbed into salary and wages this financial year. Management focus has continued on the annual leave liability with all team members encouraged to take regular annual leave. Sick leave continues to impact on service safety and quality and the bottom line. Work has continued to support all team members to be fit for work and support work life balance and transitioning to retirement options when requested by team members.

This is the seventh successive year of an above budget result which has supported the board to make decisions on maintaining services despite a loss in funds for community health from the Primary Health Network tender and puts Rural Northwest Health in a great position for the future.

## 5. Develop and maintain productive partnerships

Rural Northwest Health continues to work with partners across the state to ensure that community members receive quality and safe services. Partners include the Wimmera Southern Mallee Health Alliance, Woodbine, Yarriambiack Shire, Ambulance Victoria, the local Medical Centres, Wimmera Primary Care Partnerships and the Western Victoria Primary Care Network along with the health services provided by organisations across the region.

Key work has been undertaken with Grampians Women's Health and Goolum Goolum to expand our knowledge and response for people living with violence or from Aboriginal and Torrens Strait Islander heritage.

Partnerships have been strengthened and enhanced with Swinburne, Latrobe and Deakin Universities with links now made to Canadian and interstate universities as we work on a significant number of research opportunities. These include obesity prevention, dementia, carer support, technology to support people living in the community, and working with vulnerable people to support them to access health services seamlessly across the continuum of care.

## 6. Identify and implement optimal models of care

In 2016-17 Rural Northwest Health has continued to listen to what the community members need, want and have worked with partners to expand services.

Volunteer drivers have allowed the Hopetoun to Horsham bus to be reinvigorated to allow community members to enjoy each other's company, visit health specialists in Horsham and enjoy life.

Rural Northwest Health were successful with a grant application with Cancer Victoria Wimmera Health care Group, Stawell Health Service and Goulburn Health to develop and implement a new telehealth model of oncology rehabilitation as requested by our community members. The first course commenced in May and was a huge success. This program is clearly focused on supporting people living with cancer to undertake a range of activities to assist them to improve their wellbeing.

The ABLE (Abilities and capabilities of the resident; Background of the resident; Leadership, cultural change and education; physical environment changes) model of care continues to be developed and improved with the team needing to develop innovative roles and activities for residents living with dementia who remain well while living in Wattle. Residents living with dementia went on a holiday to Ocean Grove and had an amazing time in the sea.

The team have introduced virtual reality to the residents that allows them to experience being at a circus, swimming with whales and travelling around the world.

In February the Primary Health Network requested Rural Northwest Health to tender to provide allied health services for people living with chronic disease based on the Wagner model of care. Extensive work has been undertaken by team and community members to develop a new model of care. All is ready to launch the new model in July 2017 and research will commence by Latrobe University to demonstrate that we are improving the health and wellbeing of community members.

The BRIGHT (Brave and Resilient Individuals Getting Healthy Together) program for team members was a huge success with 44 team members making the commitment to improve their health and wellbeing. A retreat was held in Halls Gap with team members sharing their learnings and an exercise challenge allowed the Pinnacle to be climbed by a significant number of participants. Interim results show that the majority of participants have significantly improved their health and wellbeing.

## 7. Establish transition models that enable community members to have a good experience when accessing services outside Rural Northwest Health

Rural Northwest Health has continued to work with a large number of partners to support community members to get access to the services they require as close to home as possible.

We have met with Ballarat Health Service, Wimmera Health Care Group and Ambulance Victoria to discuss the services they offer and raise some concerns that community members had raised with us. Outcomes were positive with Ambulance Victoria giving us information to share with community members, Ballarat Health Service inviting us to be part of the mental health services review and Wimmera Health Care Group working with us to allow our community members to be transferred back to our health service when they are well enough.

The Hopetoun Beulah Reference Group members continue to raise opportunities to improve access to local services and volunteers now drive the bus every month from Hopetoun to Horsham for community members.

The Community Action Research Group have continued to meet bi annually and the last 12 months have allowed us to focus on services for people living with chronic diseases. Feedback from the work was fed directly to the board of management and utilised in the development of our new community model of care ensuring that resources are allocated appropriately to support community members to maintain their wellbeing.

## 8. Increase health literacy about actions community members should undertake to keep well and living at home

BRIGHT (Brave and Resilient Individuals Getting Healthy Together) has continued in 2016-17 with 44 team members involved in a number of activities to improve their health and wellbeing. Expertise was provided from dietitians, exercise physiologist, mindfulness and life coaching to assist team members to understand what behaviours and actions were contributing to them not maintaining the necessary changes. Many team members shared what they were doing with family and friends and this allowed an expansion of the program to others in the community and supported team members to have someone assisting them at home as well.

YCHANGe (Creating Healthy Active Nourished Generations) has continued to go from strength to strength with Rural Northwest Health making sustained changes in providing healthy options only for team members in the workplace. On reflection significant changes have been made to food served across all campuses. Team members and visitors have accepted the changes and many presenters are clearly told when lollies are produced at training sessions that they are contraband. Fresh fruit Fridays continue and tea rooms are now healthier. Café YarriYak sales clearly demonstrate that if healthy options are available then 85% of the time we choose the healthy option.

With guidance from Deakin University and Jill Whelan we continue to engage with all community groups to ensure that a healthy option is available at every event held in the shire, and that all kindergartens and schools have healthy options at every meal and in canteens and for fund raisers.

Rural Northwest Health were very proud to be part of the Warracknabeal 150 year celebrations and contributed by holding open days, displaying some memorabilia, sharing healthy options from Café YarriYak and advertising the great work we do. Congratulations to the organising committee it was a wonderful celebration of the great success of the town.

The community gardens in all the towns are blooming and have a broad range of community members engaged and contributing to being active, growing healthy food, sharing knowledge and breaking down social barriers. Well done to Angie Cox who worked with the Men's shed and the community garden to open the community pantry.

The Board of Management and Rural Northwest Health team are looking forward to continuing to focus on our strategic intent and achieving brave and innovative goals and ultimately improving the health and wellbeing of our community members.

# About our organisation

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

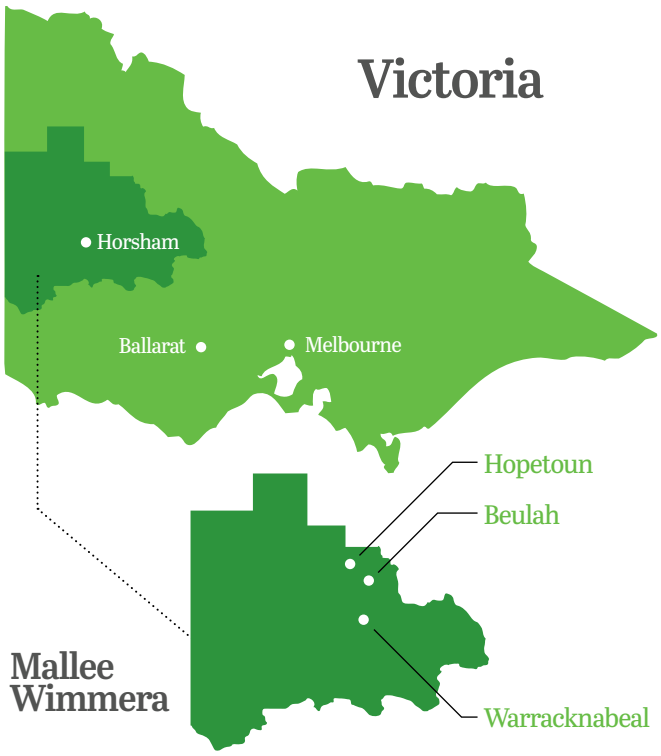
The population of the communities served by Rural Northwest Health is around 7000 people within the northern and southern areas of Yarriambiack Shire.

Three campuses are located at Warracknabeal, Beulah and Hopetoun.

The responsible Ministers during the reporting period were:

- The Honourable Jill Hennessy MP, Minister for Health, Minister for Ambulance Services
  1 July 2016 to 30 June 2017
- The Honourable Martin Foley MP, Minister for Mental Health, Minister for Housing, Disability and Ageing
  1 July 2016 to 30 June 2017

This annual report should be read in conjunction with our Quality Account 2017. Both documents are available on our website and at all our sites.




## Our 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.

# Services we provide

## Acute care

Warracknabeal and Hopetoun campuses provide urgent care services including:

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

## After hours service

General Practitioners and nursing team members provide an after hours on call service 24 hours 7 days per week at Warracknabeal and Hopetoun.

## Aged care

Warracknabeal and Hopetoun campuses provide aged care services including:

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

## Allied health

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

## Community health

Community and Allied Health services are provided across the three campuses at Warracknabeal, Beulah and Hopetoun:

- 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 and Beulah)
- Cancer Resource Nurse
- Community Health Nurse
- Memory Support Nurse
- District nursing services

## Medical imaging (Warracknabeal)

- X-ray and ultrasound

## Speciality services

- Ear, Nose and Throat
- Cardiology

## Support services

- Carer support services
- Volunteer program

# Statement of priorities

The Statement of Priorities is the key document of accountability between the Department of Health and Human Services and health services. The agreement is signed by the Minister for Health, Secretary or relevant Director of the health service and the health service Board Chairperson.

## SoP Part A: Strategic priorities for 2016-17

| | |
|---|---|
| **SoP PART A:** | identifies the Victorian Government's priorities and policy directions in the Victorian Health Priorities Framework 2012-22. |
| **PRIORITIES:** | each SoP identifies how the individual health service will contribute to the achievement of the Government's five key priorities in 2016-17 through the articulation of specific deliverables. |

## Priority 1: Quality and safety

| ACTION | DELIVERABLES | OUTCOME |
|---|---|---|
| **Implement systems and processes to recognise and support person-centred end of life care in all settings, with a focus on providing support for people who choose to die at home** | By June 2017, district nurses will have a documented process in place with hospice and palliative care services in the region regarding appropriate end of life care for people wishing to die at home | District Nurses and the team partners with Wimmera Hospice to provide appropriate End of Life care. The District Nurses work with the clients to ensure that they have advanced care directives in place to support all partners to be aware of the wishes of the community members. Wimmera Hospice share community members care plan and directives and work with the District Nurses to ensure that safe and high quality care is provided to community members. |
| | Rural Northwest Health will conduct audits to demonstrate that 90 per cent of people wishing to die at home will have an advanced care plan in place that has been extensively discussed and agreed by their family and general practitioner. | In Warracknabeal the District Nursing service had 17 palliative care clients of which 88 % (15) had an Advanced Care Plan directive in place.<br>In Hopetoun there was one client who died at home during this period and their Advanced Care Plan was in progress at the time of death. |

| ACTION | DELIVERABLES | OUTCOME |
|---|---|---|
| Advance care planning is included as a parameter in an assessment of outcomes including: mortality and morbidity review reports, patient experience and routine data collection | Data for Advance Care Plans in aged care will be collected by quality officer during mortality reviews, with a target of 90% compliance; reported at clinical governance committee | This outcome is reported monthly to the Board of Management and 95% of aged care residents have an active advanced care directive in place. The gap is related to their admission date and that some residents do not have family members available to document the advanced care directives of residents with a cognitive impairment.<br>On review of every resident death the audit results show that when the resident has an advanced care plan in place that it is followed 100%. |
| | By June 2017 Rural Northwest Health will document a process for ensuring that the Advance Care Plan travels with the person when they transfer to another facility 100% of the time | Rural Northwest Health has developed a process which details that the advanced care directives are included on the transfer information checklist and added to the daily 'safety scrum' worksheet to support all team members to highlight which clients have an existing Advanced Care Plan in place. |
| Progress implementation of a whole-of-hospital model for responding to family violence | By June 2017, Rural Northwest Health will have worked with partners to develop and implement protocols relating to violence or abuse | Rural Northwest Health have worked with the Australian Nursing and Midwifery Federation (ANMF) to introduce an action plan for Occupational violence and abuse.<br>Protocols have been developed and communicated with all team members<br>We have appointed and advertised a Family Violence Leader who has completed the two-day training.<br>Changes have been made in reception and urgent care to support team members to be safe and have a number of strategies in place to call a code grey if required. |
| | By October 2016, training for staff regarding recognising and referring people affected by family violence will be undertaken | We are the first health region in the Wimmera to run the ACT at Work program developed by Grampians Women's Health. We ran the sessions over five days and 85% of team members attended the training.<br>Family Violence protocols are in place with ongoing internal promotion of Family Violence referral options and promotion to all team members via the team member compliance and training day on internal contact and support offered. |

| ACTION | DELIVERABLES | OUTCOME |
|---|---|---|
| Develop a regional leadership culture that fosters multidisciplinary and multi organisational collaboration to promote learning and the provision of safe, quality care across rural and regional Victoria | The Board Chairperson and Chief Executive Officer of Rural Northwest Health will actively participate in the Wimmera Southern Mallee Health Alliance to develop and monitor programs and initiatives throughout the area, including health literacy, consumer engagement, cardiac rehabilitation and oncology telehealth to improve alternative services for clients to keep them as close to home as possible. | Rural Northwest Health are active participants of the Wimmera Southern Mallee Health Alliance.<br><br>The Chief Executive Officer is a key member of the consumer engagement group with team and executive members active in the Health Literacy community of practice and midwifery working group.<br><br>Rural Northwest Health has presented at the Nurse Manager meeting and the Better Practice Forum.<br><br>Team members are active contributors to the oncology telehealth steering and governance committees and Rural Northwest Health will be part of the first pilot program.<br><br>Rural Northwest Health's Chairperson is also the chairperson of the Wimmera Southern Mallee Alliance governance committee. |
| Use patient feedback, including the Victorian Healthcare Experience survey to drive improved health outcomes and experiences through a strong focus on person and family centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first | Continue bi monthly lunch meeting with past inpatients to discuss aspects of their experience, which will include any issues raised through Victorian Health Experience Survey, with actions to be added to Warracknabeal Acute Care and Hopetoun action plan. Suggestions for improvements will be recorded from each meeting and reported at Board of Management. | Community Action Research Group (CARG) sessions were held in October 2016 and March 2017, with reports discussed at Board of Management meetings, utilised for the development of the new model of care for community health, acute and district nursing.<br><br>Sessions are held with acute clients, community members, Yarriambiack Lodge residents, relatives, Hopetoun residents and community members as detailed in the updated community engagement protocol. All actions from the forums are documented with timelines and executive manager accountabilities listed and these are reported at the Board of Management. |
| Develop a whole of hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint | By March 2017, Rural Northwest Health will review current organisational restrictive practices policies for acute units including pharmacological management of acute behavioural disturbance in adults (sedation guidelines). Appropriate training and changes will be implemented by June 2017 | The Cognitive Impairment Action Group has developed a protocol in working with adults with acute behavioural disturbance. The group have used a range of resources including the delirium tools.<br><br>Training from Montessori Australia was undertaken in late June 2017 with a subsequent action plan developed to implement improved strategies for clients experiencing acute behavioural disturbance.<br><br>Rural Northwest Health is working with Wimmera Health Care Group to develop a regional approach to ensure high quality and safe care. |

# Priority 2: Access and timelines

| ACTION | DELIVERABLES | OUTCOME |
|---|---|---|
| **Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine)** | By June 2017, Rural Northwest Health will evaluate and strengthen the telehealth Cardiac Rehabilitation program to enable greater access, aiming for 75% participation for all eligible clients | Rural Northwest Health with Wimmera Southern Mallee Health Alliance has developed a service directory and brochure for the Smart Hearts (cardiac rehab programme) for General Practitioners and community.<br><br>Strong referral pathways from Wimmera Health Care Group Hospital Admission Risk Program ensures all Rural Northwest catchment clients are offered the Smart Hearts Program in Warracknabeal. All applicable Rural Northwest acute clients are referred via a multidisciplinary team. |
| | By December 2016, Rural Northwest Health will evaluate the Nurse Practitioner After Hours project currently underway with two other small rural health services.<br><br>By June 2017, have developed an ongoing improvement action plan | The project commenced in October 2016 with the Nurse Practitioner assisting three services.<br><br>Six month and final evaluation report submitted on time in June 2017.<br><br>A local nursing home used the service extensively with an ongoing partnership put in place for allied health and Nurse Practitioner support.<br><br>The sub regional health service is looking to put an emergency telehealth service in place and Rural Northwest Health will work with them to ensure its success. |
| **Develop and implement a strategy to ensure the preparedness of the organisation for the National Disability and Insurance Scheme and Home and Community Care program transition and reform, with particular consideration to service access, service expectations, workforce and financial management** | By November 2016, Rural Northwest Health will work with our local government area to develop a transition strategy for National Disability Insurance Scheme, Home, and Community Care with staged implementation to be completed by May 2017 | An executive is attending the sub regional planning group and along with the local disability providers, a working committee has developed an action plan with all actions to be completed in October 2017.<br><br>In June 2017 National Disability Insurance Scheme readiness forums were held for providers and community members.<br><br>Rural Northwest Health is part of the sub regional Home and Community Care implementation group with further work required across the region to ensure all services will remain in the region. |

# Priority 3 – Supporting healthy populations

| ACTION | DELIVERABLES | OUTCOME |
|---|---|---|
| **Support shared population health and wellbeing planning at a local level – aligning with the Local Government Municipal Public Health and Wellbeing plan and working with other local agencies and Primary Health Networks** | Rural Northwest Health will continue to provide leadership to the YCHANGe project with Deakin University and Yarriambiack Shire to introduce obesity prevention strategies across the shire. Data will be collated throughout the project to inform evidence based research projects | Rural Northwest Health has presented the work of Yarriambiack Creating Healthy Active Nourished Generations at the Department of Health and Human Services regional forum, Western Alliance conference and at World Organisation of National College Academics International Rural Health Conference.<br><br>In the local region we support all groups to always offer a healthy option at events. We do this by providing the healthy option or requesting a healthy option to be available.<br><br>Rural Northwest Health has successfully implemented a healthy eating protocol with the removal of all sugar drinks and the removal of bun Wednesday resulting in 27 kilos of sugar being removed from the workplace.<br><br>In partnership with Woodbine, Café YarriYak based on the traffic light standards and Health Eating Advisory Service has completed a case study on YarriYak café. Audit of sales at the YarriYak café indicate 74% of food and drinks purchased is green light and 68% of food only purchased is green light. |
| **Focus on primary prevention, including suicide prevention activities, and aim to impact on large numbers of people in the places where they spend their time adopting a place based, whole of population approach to tackle the multiple risk factors of poor health** | Team members involved in primary prevention work will continue to monitor and evaluate key projects including YCHANGe and Community Garden for levels of community engagement, collation of strategies, planning ideas and the development of annual plans | The key allied health team members of Dietitian, Community Nurse, and Exercise Physiologist and Community Health manager are engaged in a number of activities across the shire.<br><br>Activities offered included<br><br>• Healthy living on a budget program<br>• Rural Northwest Health led Active April activities with Steps across Yarri. This was very successful which has now resulted in community led walking groups<br>• Development of healthy snack recipes for Kindergartens<br>• Quarterly food audits of the Rural Northwest Health healthy eating protocol<br>• Monthly audits of the YarriYak café percentage of food that green is 65% amber 20% and red 15%.<br>• A six and twelve month review of the Brave Resilient Getting Healthy Together program for team members to see if they have maintained health changes. |

| ACTION | DELIVERABLES | OUTCOME |
|---|---|---|
| **Develop and implement strategies that encourage cultural diversity such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices** | By June 2017, Rural Northwest Health's diversity plan will be reviewed and updated based on feedback from team and community members | A diverse group of team members has developed the 2017-2019 Diversity Plan reflecting the diverse and individual needs of community members, covering Age, Gender, Cultural, and Abilities and Lesbian, Gay, Bi, Trans, Intersex (LGBTI).<br>The plan including responsibilities, time lines and actions to improve Rural Northwest Health's responses in all domains has commenced.<br>All team members were informed of the plan at the via the team member compliance and training day in May 2017. |
| **Improve the health outcomes of Aboriginal and Torres Strait Islander people by establishing culturally safe practices which recognise and respect their cultural identities and safely meets their needs, expectations and rights** | Rural Northwest team members will attend regional training opportunities through Wimmera Primary Care partnership to raise cultural awareness and work with the Goolum Goolum Aboriginal Co-operative to increase referrals for client health needs and treatment | The training was attended at Warracknabeal in October 2016 by team and executive members. The Board Chairperson attended training in December 2016.<br>Team members attended training at Goolum Goolum in April 2017. |
| | By May 2017, a cultural audit will be undertaken by Goolum Goolum of the health service site to improve its cultural appropriateness for Aboriginal and Torres Strait Islander people | The audit has been completed and actioned by the Diversity Action Group across all three campuses. |

| ACTION | DELIVERABLES | OUTCOME |
|---|---|---|
| **Drive improvements to Victoria's mental health system through focus and engagement in activity delivering on the 10 Year Plan for Mental Health and active input into consultations on the Design, Service and Infrastructure Plan for Victoria's Clinical mental health system** | Rural Northwest Health will review health service processes for supporting primary mental health and well-being for single mothers from socially disadvantaged backgrounds in order to strengthen access and social connection. The work will provide the foundation for exploring the possibility of a research project with Swinburne University | A new PhD candidate has been appointed from Swinburne University to work with Rural Northwest Health to develop a project at looking at boundary spanners in health. The project will look at:<br>• What are the characteristics of community based boundary spanners?<br>• How do boundary spanners use digital communications technologies in their boundary spanning activities in the community?<br>• What models of involving boundary spanners, boundary spanning as a concept and boundary spanning objects and technologies appear to be feasible to improve dialogue between health services and community members?<br>• What are the advantages and challenges of these models?<br>• Does boundary spanning offer potential in improving dialogue between health services and community members?<br>Nine team members attended a two-day Bridges Out of Poverty workshop run in the shire with partnership leaders. |
| **Using the Government's Rainbow eQuality Guide, identify and adopt 'actions for inclusive practices' and be more responsive to the health and wellbeing of lesbian, gay, bisexual, transgender and intersex individuals and communities** | By May 2017, Rural Northwest Health will have reviewed and implemented the lesbian, gay, bisexual, transgender and intersex persons inclusive practice guide for health and community services. | The Diversity Working Group has identified and commenced actions aligning with this guide.<br>Further actions, timelines and responsibilities are all identified on the 2017-2019 Diversity Plan. |

# Priority 4 – Governance and leadership

| ACTION | DELIVERABLES | OUTCOME |
|---|---|---|
| **Demonstrate implementation of the Victorian Clinical Governance Policy Framework: Governance for the provision of safe, quality healthcare at each level of the organisation, with clearly documented and understood roles and responsibilities. Ensure effective integrated systems, processes and leadership are in place to support the provision of safe, quality, accountable and person centred healthcare. It is an expectation that health services implement to best meet their employees and community needs, and that clinical governance arrangements undergo frequent and formal review, evaluation and amendment to drive continuous improvement** | Members of the Executive and Board will attend clinical governance information/ training sessions and utilise the knowledge gained to develop action plans to ensure compliance with the Clinical Governance Policy Framework. | Board members have attended the regional governance training which covered risk management, communication and clinical governance.<br><br>Board members have attended the National Rural Health Conference and Victoria Health Care Association (VHA) governance conference.<br><br>Executive members have attended the Victorian Managed Insurance Authority (VMIA) risk management training, the Australasian Association for Quality in Health Care (VHQA) Clinical Governance update in Bendigo, VHA and Public Sector Residential Aged Care Services (PRSACS) conferences.<br><br>Updates are provided to all board members at board meetings |
| | Managers and supervisors will undertake Mindfulness at Work training to enhance personal insight, reflection and person-centred focus for all work. | Mindfulness at Work continues to be run twice a year for all team members.<br><br>The executive group undertook the training with senior managers and a number of changes resulted. |
| | By June 2017, the Board of Management will prioritise and implement governance improvements identified by the review undertaken by external consultant in April 2016 | The Governance Committee and Board of Management have worked through 13 of the 15 recommendations with the five priorities achieved on time. |

| ACTION | DELIVERABLES | OUTCOME |
|---|---|---|
| **Contribute to the development and implementation of Local Region Action Plans under the series of statewide design, service and infrastructure plans being progressively released from 2016-17** | By June 2017, Rural Northwest Health will have actively contributed to the development and implementation of Local Regional Action Plans and work in partnership and collaboration to ensure the plan meet both regional and local service needs | Rural Northwest Health are active participants in regional working groups developing and implementing local and regional action plans to improve clinical governance, workforce capability and service improvements.<br><br>We are working with Ballarat Health Service and all the Grampians Health services to implement a region wide approach to implement Safer Care Victoria guidelines and practices. |
| **Ensure that an anti-bullying and harassment policy exists and includes identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal and the policy specifies a regular review schedule** | Rural Northwest Health will review their eliminating, minimising bullying protocol to ensure it meets all the requirements, and that processes are clearly documented. | The Eliminating Bullying and Harassment Protocol was reviewed and endorsed by the Board of Management in March 2017.<br><br>Rural Northwest Health has had two bullying incidents investigated independently and reported to the Board of Management as per the protocol. |
| | Team member education in regard to anti-bullying and harassment will be provided in essential training and orientation | Topics in 2017 Essential Training Program focus on identifying and naming unhealthy communication, unacceptable and bullying behaviours and strategies to support healthy communication minimising unacceptable and bullying behaviours. All new team members attend the Essential Training Program and existing team members attend annually. |
| | Rural Northwest Health will track results regarding bullying witnessed or experienced from the People Matters Survey to develop appropriate response pathways | All bullying incidents are reported to the Board of Management.<br><br>Managers continue to work with all team members to assist them to follow the protocol and address any concerns in a timely and effective manner. |

| ACTION | DELIVERABLES | OUTCOME |
|---|---|---|
| **Board and senior management ensure that an organisational wide occupational health and safety risk management approach is in place which includes: (1) A focus on prevention and the strategies used to manage risks, including the regular review of these controls; (2) Strategies to improve reporting of occupational health and safety incidents, risks and controls, with a particular focus on prevention of occupational violence and bullying and harassment, throughout all levels of the organisation, including the board; and (3) Mechanisms for consulting with, debriefing and communicating with all staff regarding outcomes of investigations and controls following occupational violence and bullying and harassment incidents** | By March 2017, Rural Northwest Health will continue work with Worksafe to implement strategies to minimise occupational violence incidents occurring in urgent care | Rural Northwest Health fully complied with an improvement notice provided by WorkSafe in the new urgent care unit before the required date.<br><br>The organisation is continuing to work with WorkSafe and the Department of Health and Human Services to implement further opportunities to improve safety of all team members.<br><br>We received and actioned a grant to improve the administration area.<br><br>An action plan is in place for occupational violence and aggression in line with the ANMF Regional 10 point plan. |
| | By March 2017, the Rural Northwest Health executive team will develop a new report to ensure all incidents and risks regarding occupational health and safety, occupational violence, and bullying and harassment are reported in a timely manner with risks and controls documented to the Board of Management, at team meetings and displayed on appropriate notice boards | The Board of Management have agreed to a new quality and risk framework and reporting schedule. This includes key clinical, health and wellbeing and financial monthly indicators.<br><br>Results are shared via team meetings and with appropriate committees and working groups. |

| ACTION | DELIVERABLES | OUTCOME |
|---|---|---|
| **Implement and monitor workforce plans that: improve industrial relations; promote a learning culture; align with the Best Practice Clinical Learning Environment Framework; promote effective succession planning; increase employment opportunities for Aboriginal and Torres Strait Islander people; ensure the workforce is appropriately qualified and skilled; and support the delivery of high-quality and safe person centred care** | By June 2017, Rural Northwest Health will undertake specific team development programs including Lean training (increase work effectiveness); mindfulness at work (reflective practice), customer service training; and change management strategies to enhance and support the delivery of high quality and safe person centred care | Rural Northwest Health is reviewing its annual training requirements for all team members by the Manager Education and Research and a skilled Clinical Support Nurse.<br><br>Team members have been offered the opportunity to attend the Mindfulness at Work program, customer service training and individual opportunities for the clinical team to upskill their expertise across infection control, diabetes, Rural and Isolated Practice Endorsed Register Nurse (RIPERN) and enhanced team and communication skills. |
| | Rural Northwest Health will annually review succession planning for specific positions | The Board of Management have identified a risk that needs to be managed being the development of succession planning for Executive Managers and Nurse Unit Managers.<br><br>A development plan is currently under development to support all the managers to undertake development opportunities.<br><br>Rural Northwest Health is participating in regional Enrolled Nurse graduate program with Wimmera Health Care Group as the regional fund holder and organiser.<br><br>The Education and Research Manager is exploring new opportunities to encourage and support existing team members to undertake further training as Enrolled Nurses or Registered Nurses. |

| ACTION | DELIVERABLES | OUTCOME |
|---|---|---|
| **Create a workforce culture that: (1) includes staff in decision making; (2) promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and (3) includes consumers and the community** | Rural Northwest Health will run four decision-making forums for team members throughout the year, with a focus on key areas identified by the team and board members. All team members will be invited to attend the sessions | Four decision making forums were held on, orientation and mandatory training, developing areas to prioritise from the People Matters Survey, the development of the new model of care for community health and implementing ideas generated at the via the team member compliance and training day discussing opportunities to deliver on Rural Northwest Health's strategic plan and intent.<br><br>A broad range of team members attended across departments and campuses and all days were highly evaluated by participants |
| | By June 2017, Rural Northwest Health will have reviewed and implemented any necessary changes to the comments, concerns and compliments protocol, open disclosure policy and grievance protocol | The Board of Management has reviewed and updated the Comments, Concerns and Compliments Protocol as part of their annual responsibilities to own and improve policies and protocols.<br><br>Education was undertaken and new locked letterboxes were placed around the campuses to support community and team members to drop off the forms easily. |
| | Community sessions held with acute clients, community health clients and aged care residents and their families will be attended by Board of Management, executive and team members. All outcomes will be recorded in the Board of Management minutes and reported in the newsletter | Community engagement sessions were held across all areas and campuses with excellent attendance, feedback and conversations achieved.<br><br>A new report was developed for executive managers to record all actions that occurred based on these conversations and this is reported at the Board of Management.<br><br>The Quality Account will share the actions undertaken by Rural Northwest Health based on this feedback.The Quality Account will share the actions undertaken by Rural Northwest Health based on this feedback. |

| ACTION | DELIVERABLES | OUTCOME |
|---|---|---|
| **Ensure that the Victorian Child Safe Standards are embedded in everyday thinking and practice to better protect children from abuse, which includes the implementation of: strategies to embed and organisational culture of child safety; a child safe policy or statement of commitment to child safety; a code of conduct that establishes clear expectations for appropriate behaviour with children; screening, supervision, training and other human resources practices that reduce the risk of child abuse; processes for responding to and reporting suspected abuse of children; strategies to identify and reduce or remove the risk of abuse and strategies to promote the participation and empowerment of children** | By April 2017, executive team will work with team members and the community to develop child safe strategies that include identifying and reporting suspected child abuse; processes for implementation strategies; and ongoing monitoring and review | The Child Safety Protocol and Child Safety Code of Conduct endorsed at February 2017 Clinical Governance meeting. All team members except those working exclusively in Aged Care are to undergo a Working With Children Check.<br><br>Department Health and Human Services action plan completed education provided via the team member compliance and training day held in May 2017.<br><br>Reminders and audit process in place to ensure all relevant team members have a Working With Children Check in place by 30 June 2017. |
| | By June 2017, appropriate team training on identifying signs of child abuse, reporting requirements and supports available for those affected by such abuse will be undertaken | This was completed via the team member compliance and training day in May 2017. |
| **Implement policies and procedures to ensure patient facing staff have access to vaccination programs and are appropriately vaccinated and/ or immunised to protect staff and prevent the transmission of infection to susceptible patients or people in their care** | Rural Northwest Health will conduct audits to demonstrate that all new team members have completed the staff immunisation questionnaire during the first three months of employment.<br><br>Fluvax clinics will be offered during the annual staff compliance event and additional vaccination clinics will be offered quarterly | The Infection Control Coordinator and Immunisation Nurse have been attending Orientation and Essential Training days to capture new team members.<br><br>Currently 83% of team members are vaccinated for influenza. To increase compliance the Infection Control Coordinator and Immunisation Nurse are targeting people specifically who have not had the fluvax and this is proving to be successful.<br><br>Audits are still to be introduced, the orientation process is currently under review and audits will be part of the process. |

# Priority 5 – Financial sustainability

| ACTION | DELIVERABLES | OUTCOME |
|---|---|---|
| Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due | By April 2017, Rural Northwest Health will have reviewed its Investment strategy re timing of maturity of investments, re-payments of aged care deposits/bonds to streamline efficiency for team members | A new Investment Protocol was developed and endorsed by the Finance Audit Compliance Committee in February 2017 |
| Actively contribute to the implementation of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measureable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling | By December 2017, all computers will be set on a power saving mode of shut down when not in use and overnight | This was completed in October 2016 |
| | Clinical waste audits will be undertaken quarterly to identify materials disposed of in this way and check the appropriateness of the disposal. Results will be presented back to team members and education initiatives implemented to support staff to meet waste targets and maximise appropriate disposal. | Waste audit completed in November 2016. Results distributed to relevant areas with key areas to target was medical waste in the General Practitioner clinics.<br>Education provided to team members from auditor and documented in the newsletter (the BUZZ).<br>A second audit was undertaken in May 2017 with medical clinical waste 40%, and the improvements noted were – medical clinic have decreased non clinical waste going into clinical waste by 20% and acute have reduced by 10%. |

# Statement of priorities

## SoP Part B: Performance priorities

### Quality and Safety

| KEY PERFORMANCE INDICATOR | TARGET | 2016-17 ACTUAL |
|---|---|---|
| **Accreditation** | | |
| Compliance with NSQHS Standards Accreditation | Full compliance | Full compliance |
| Compliance with the Commonwealth's Aged Care Accreditation Standards | Full compliance | Full compliance |
| **Infection prevention and control** | | |
| Compliance with cleaning standards | Full compliance | Full compliance |
| Submission of infections surveillance data to VICNISS1 | Full compliance | Full compliance |
| Compliance with the Hand Hygiene Australia program | 80% | 85.9% |
| Percentage of healthcare workers immunised for influenza | 75% | 76% |
| **Patient experience** | | |
| Victorian Healthcare Experience Survey – data submission | Full compliance | Full compliance |
| Victorian Healthcare Experience Survey – patient experience | 95% positive experience | Full compliance |
| Victorian Healthcare Experience Survey – discharge care | 75% very positive response | Full compliance |
| Victorian Healthcare Experience Survey – patient experience Q3 | 95% positive experience | Full compliance* |
| Victorian Healthcare Experience Survey – discharge care Q1 | 75% very positive response | Full compliance* |
| Victorian Healthcare Experience Survey – discharge care Q2 | 75% very positive response | Non-compliant |
| Victorian Healthcare Experience Survey – discharge care Q3 | 75% very positive response | Full compliance* |

*Less than 42 responses were received for the period due to the relative size of the health service.

### Governance and leadership

| KEY PERFORMANCE INDICATOR | TARGET | 2016-17 ACTUAL |
|---|---|---|
| People Matter Survey – percentage of staff with a positive response to safety culture questions | 80% | 95% |

# SoP Part B: Performance priorities

## Financial sustainability

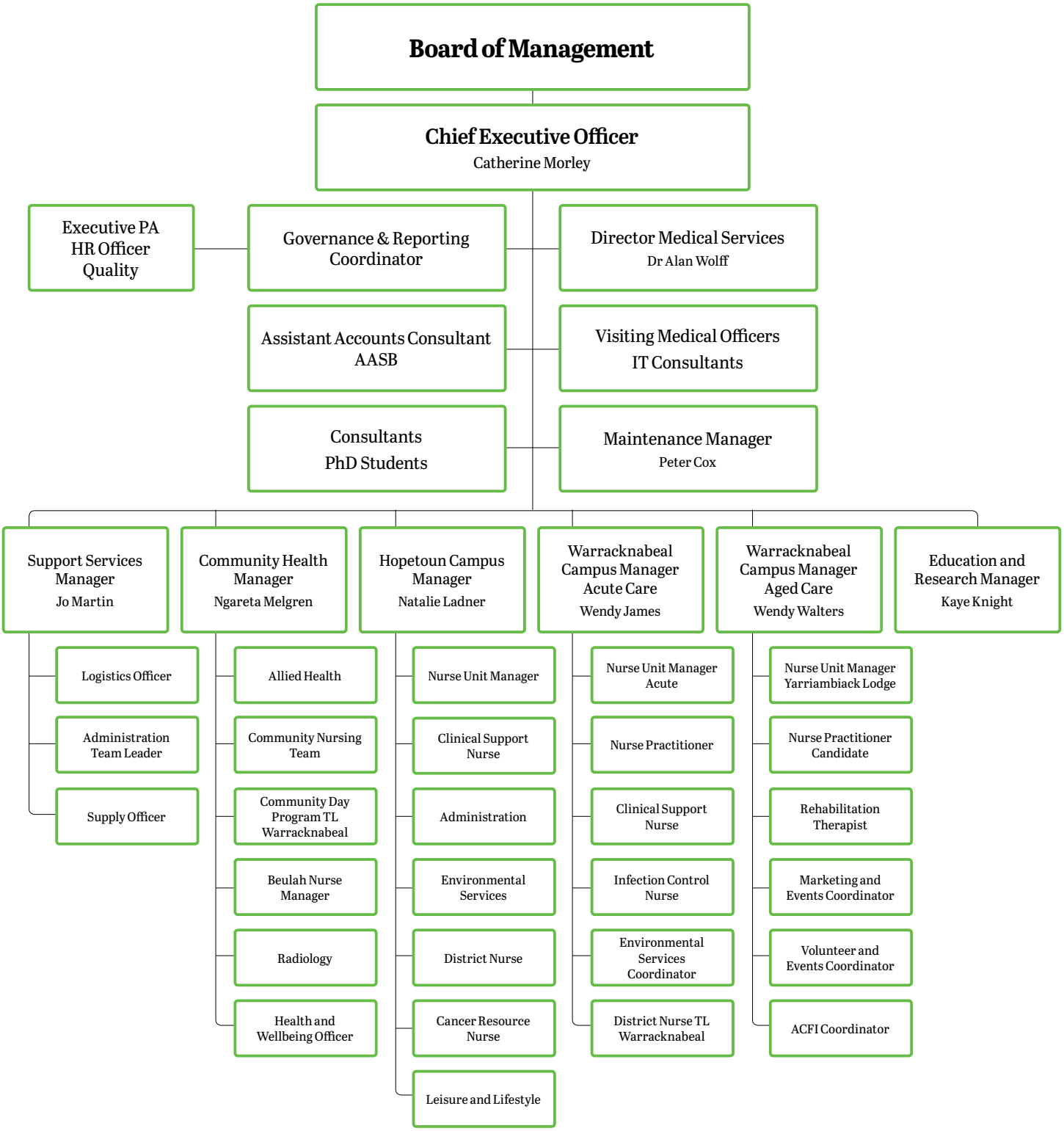
| KEY PERFORMANCE INDICATOR | TARGET | 2016-17 ACTUAL |
|---|---|---|
| **Finance** | | |
| Operating result ($m) | 0.20 | 0.93 |
| Trade creditors | 60 days | 37 |
| Patient fee debtors | 60 days | 21 |
| Adjusted current asset ratio | 0.7 | 1.66 |
| Number of days with available cash | 14 days | 179.9 |
| **Asset management** | | |
| Basic asset management plan | Full compliance | Full compliance |

[1]VICNISS is the Victorian Hospital Acquired Infection Surveillance System

# SoP Part C: Activity and funding

| FUNDING TYPE | ACTIVITY 2016-2017 | RESULT |
|---|---|---|
| Small Rural | | |
| **Small Rural Primary Health** | | |
| • Allied Health | hours of service | 4,522 |
| Small Rural Residential Care | bed days | 30,174 |
| **Small Rural HACC** | | |
| • Podiatry | hours of service | 161 |
| • Nursing | hours of service | 1,395 |
| • Planned Activity Group | hours of service | 318 |
| Health Workforce – Early Graduate Nurses Program | student placements | 4 |
| Other specified funding - Counselling | hours of service | 1,336 |

# Organisational structure 2017



# Board of management

The 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 function of the board of a public hospital are:

- To oversee the management of the health service
- To set the strategic plan and vision for the health service
- To ensure that the services provided by the hospital comply with the requirements of the Act and the objects of the hospital.

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 farewell Matthew Richardson who has resigned his position on the Board of Management but will remain as Chairperson of the Finance Audit and Compliance Committee for the remainder of 2017. We thank Matthew for his contribution to Rural Northwest Health over the past five and a half years.

We welcome new board member Professor Amanda Kenny who commenced her three year appointment on 7 March 2017

| | | |
|---|---|---|
| **Board Chairperson** | Leo Casey | First appointment: 25 September 2007 |
| **Deputy Chairperson** | Sally Gebert | First appointment: 1 July 2015 |
| **Members** | Glenda Hewitt | First appointment: 1 July 2010 |
| | Matthew Richardson | First appointment: 7 February 2012 |
| | Janette McCabe | First appointment: 1 July 2012 |
| | Carolyn Morcom | First appointment: 1 July 2012 |
| | Julia Hausler | First appointment: 1 July 2016 |
| | Amanda Kenny | First appointment: 7 March 2017 |


**Back row (from left):** Carolyn Morcom, Sally Gebert, Glenda Hewitt, Janette McCabe, Matthew Richardson, Julia Hausler

**Front row (from left):** Catherine Morley, Leo Casey

# Executive team

| | | |
|---|---|---|
| CHIEF EXECUTIVE OFFICER | **Catherine Morley** | governance and reporting, human resources, quality |
| SUPPORT SERVICES MANAGER | **Joanne Martin** | administration, payroll, supply |
| WARRACKNABEAL CAMPUS MANAGER ACUTE | **Wendy James** | acute, urgent care, district nursing, environmental services |
| WARRACKNABEAL CAMPUS MANAGER AGED | **Wendy Walters** | aged care, community memory support |
| HOPETOUN CAMPUS MANAGER | **Natalie Ladner** | Hopetoun acute care, aged care, district nursing, environmental services, administration |
| COMMUNITY HEALTH MANAGER | **Ngareta Melgren** | community health, radiology, Beulah primary care, day programs |

# 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 Matthew Richardson (Chairperson), Leo Casey and Sally Gebert.**

## 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 Leo Casey (Chairperson), Sally Gebert, Matthew Richardson and Glenda Hewitt.**

### 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), Julia Hausler and Alan Wolff (Director of Medical Services).**

### 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 Glenda Hewitt (Chairperson) and Sally Gebert.**

### 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 provided at the Hopetoun and Beulah campuses.

**Board representative of the group is Carolyn Morcom (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 Alan Wolff.

# Our team members

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 | |
|---|---|---|---|---|
| | 2017 | 2016 | 2017 | 2016 |
| Nursing | 68.24 | 70.96 | 70.44 | 73.49 |
| Administration and clerical | 16.52 | 23.77 | 20.60 | 24.68 |
| Medical support | 1.08 | 0.11 | 0.34 | 1.95 |
| Hotel and allied services | 77.46 | 57.90 | 70.29 | 60.12 |
| Medical officers | 0 | 0 | 0 | 0 |
| Hospital medical officers | 0 | 0 | 0 | 0 |
| Sessional clinicians | 0 | 0 | 0 | 0 |
| Ancillary staff (Allied Health) | 14.77 | 19.72 | 17.57 | 18.89 |

# 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

# Occupational Health and Safety Act 2004

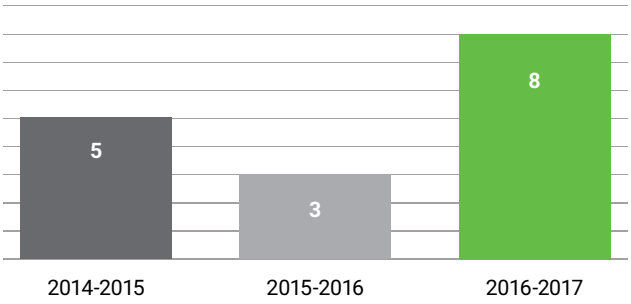
Rural Northwest Health is responsible for the health and safety of all team members in the work place. To fulfil this responsibility we have a duty to maintain a working environment that is safe and without risks to residents, clients, visitors and our team members' health.

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

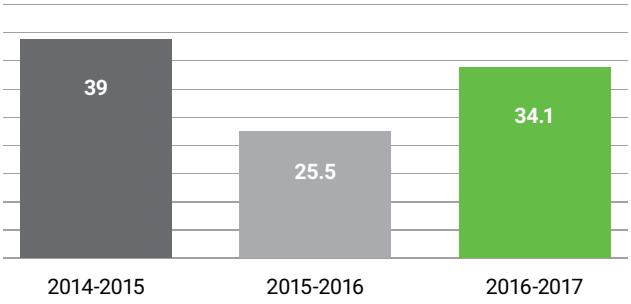
- Effective implementation of Occupational Health and Safety policy and protocols.
- Providing opportunities for regular discussion between the Board, leadership and management team and team members.
- Providing information, training and supervision for all team members in correct use of plant, equipment, 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:

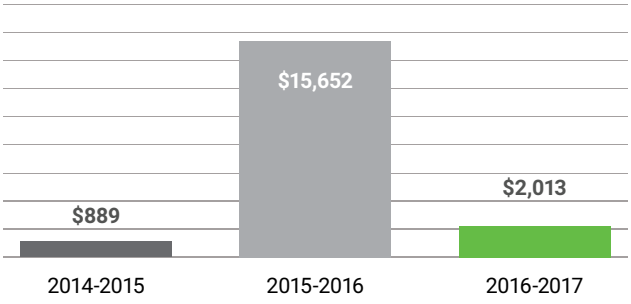
**WorkCover Claims**




**Hazards/Incidents per 100 FTE**




**Average Cost per claim**




| OCCUPATIONAL VIOLENCE STATISTICS | 2016-17 |
|---|---|
| WorkCover accepted claims with an occupational violence cause per 100 FTE | **1.6** |
| Number of acceptance WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 worked | **3** |
| Number of occupational violence incidents reported | **18** |
| Number of occupational violence incidents reported per 100 FTE | **10** |
| Percentage of occupational violence incidents resulting in a staff injury, illness or condition | **50%** |

# Rural Northwest Health financial overview 2016 - 17

Rural Northwest Health (RNH) is delighted to report a net surplus before capital and specific items of $930,000 and an entity deficit of $1,083,000 after capital and depreciation for the year ending 30 June 2017.

Revenue from operating activities increased by $1.06M compared to the previous financial year with an extra $499,000 received in Commonwealth residential aged care funding. All four residential facilities have achieved "significant refurbishment" status which leads to increased accommodation supplement rates. Occupancy of the facilities remained steady overall but the level of care for residents was greater which also increases the level of funding.

State funding also increased with $170,000 in growth and indexation, $140,000 to assist with the implementation of the 8:8:10 nursing rosters, $36,000 for graduate nurses and $185,000 to assist with revised Enterprise Bargaining Agreements (EBA's) for nurses and health/allied staff.

Private inpatient fees have reduced from $466,000 in 2014/15 to $440,000 in 2015/16 and down to $360,000 in 2016/17.

Donations received were $79,000 (2016/17 $54,000), RNH thanks the local community for their continued financial support and generous personal contributions such as volunteering and in kind goods/services that allows RNH to provide additional services, events and equipment for the benefit of the local community.

Expenditure wise employee benefits increased by 5.4% or $776,000 which was due to the new EBA's that included a component of back pay relating to 2015/16 and the increased casual/part time workforce which led to a $226,000 reduction in agency staff usage.

Expenditure for capital purpose income includes $85,000 in LED lighting upgrades at Warracknabeal and Hopetoun.

The major asset additions for the year include building improvements at Hopetoun $566,000, implementation of Kronos workforce management system $61,000, Elevating X-Ray Table $23,000, Pagewriter Cardiograph $10,000, Podiatry Chair $11,000, Floor Scrubber $10,000, ICT server upgrade $14,000, Warracknabeal Car Park $75,000, Catering Dishwashers $13,000, Catering Combi Oven $18,000, Residential Aged Care Television $10,000, Acoustic Panels $15,000 and $200,000 has been spent on the Well Being / Therapeutic Garden.

Investments and other financial assets have again increased with the receipt of additional "Refundable Accommodation Deposits" – see monies held in trust (liability) which has increased from $2.8M in 2014/15 to $6.3M in 2015/16 and is now $8.3M.

Two properties were on the market for sale at the end of the financial year therefore are treated as Non-Financial Assets Classified as Held for Sale $137,000 and are not included in the Property, Plant and Equipment note.

RNH's leave provisions have increased by $165,000 for the year, $149,000 of which relates to long service leave. This increase is due to a combination of pay rate increases and when staff elects to utilise their entitlement. Long service leave cash settled in 2016/17 was $185,000 compared to $191,000 in 2015/16.

Annual Leave increased by $11,000 (0.9%) keeping in line with RNH's objective of staff utilising their annual leave to maintain physical and mental well-being.

| FINANCE SUMMARY - 5 YEARS 2012-13 TO 2016-17 | 2017 $'000 | 2016 $'000 | 2015 $'000 | 2014 $'000 | 2013 $'000 |
|---|---|---|---|---|---|
| **Total revenue** | **21,667** | 20,341 | 19,260 | 18,843 | 19,169 |
| **Total expenses** | **(22,750)** | 19,563 | 19,033 | 18,608 | 18,139 |
| **Other operating flows included in the net result** | **38** | | | | |
| **Net result for the year** | **(1,083)** | **(1,630)** | **(1,715)** | **(1,715)** | **(737)** |
| *OPERATING RESULT | 930 | 778 | 227 | 235 | 1,030 |
| **Total assets** | **61,763** | 60,352 | 56,504 | 51,441 | 48,945 |
| **Total liabilities** | **13,622** | 11,361 | 7,441 | 6,963 | 6,733 |
| **Net assets** | **48,141** | **48,991** | **49,063** | **44,478** | **42,212** |
| TOTAL EQUITY | 48,141 | 48,991 | 49,063 | 44,478 | 42,212 |

*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.

# Service performance at a glance

| | 2016/17 | 2015/16 | 2014/15 | 2013/14 | 2012/13 |
|---|---|---|---|---|---|
| **Inpatient statistics (acute)** | | | | | |
| Inpatients treated | 632 | 622 | 625 | 662 | 728 |
| Average complexity (DRG weight) | 1.15 | 1.14 | 1.05 | 1.02 | 1.15 |
| Inpatient bed days | 3,444 | 3,649 | 3,435 | 4,030 | 4,542 |
| Average length of stay (days) | 5.43 | 5.87 | 5.50 | 5.72 | 6.59 |
| Nursing home type (NHT) bed days | 13 | 0 | 23 | 53 | 171 |
| Available bed days | 5,840 | 5,840 | 5,840 | 7,300 | 7,300 |
| Occupancy rate | 58% | 63% | 58% | 55% | 62.23% |
| **AGED CARE STATISTICS (AGED PROGRAM)** | | | | | |
| **High care permanent (residents at commencement of FY and new admissions)** | | | | | |
| Residents accommodated | 50 | 44 | 39 | 89 | 86 |
| Resident bed days | 12,987 | 11,588 | 10,445 | 12,050 | 12,792 |
| **Low care permanent (residents at commencement of FY and new admissions)** | | | | | |
| Residents accommodated | 53 | 60 | 60 | 18 | 20 |
| Resident bed days | 16,286 | 16,732 | 15,477 | 15,885 | 16,152 |
| **Respite high and low care** | | | | | |
| Residents accommodated | 46 | 60 | 64 | 48 | 30 |
| Respite resident bed days | 901 | 1,636 | 895 | 821 | 347 |
| **Aged care occupancy rate** | 91.64% | 90.88% | 83.8% | 87.22% | 89.17% |
| **OUTPATIENT (NON-ADMITTED) OCCASIONS OF SERVICE** | | | | | |
| Counsellor | 131 | 878 | 596 | 406 | 918 |
| Diabetic Educator | 604 | 409 | 505 | 465 | 739 |
| Dietician | 1,351 | 1,395 | 1,277 | 903 | 1,027 |
| Exercise Physiologist | 2,982 | 1,923 | 1,536 | 1,819 | 1,736 |
| Foot care | 1,526 | 1,381 | 674 | 379 | 337 |
| Massage Therapist | 792 | 770 | 659 | 399 | 446 |
| Occupational Therapist | 1,169 | 961 | 906 | 819 | 806 |
| Physiotherapy | 4,941 | 5,185 | 2,119 | 3,367 | 1,882 |
| Podiatry | 1,845 | 1,531 | 1,271 | 2,146 | 2,595 |
| Social Worker | 1,143 | 1,189 | 981 | 391 | |
| Speech Therapist | 1,280 | 1,221 | 1,277 | 1,165 | 799 |
| Emergency medicine | 2,470 | 2,152 | 2,322 | 2,306 | 2,138 |
| Meals on Wheels | 4094 | 5,011 | 5,620 | 6,486 | 5,481 |
| **No of emergency cases referred to other hospitals** | 181 | 131 | 154 | 122 | 135 |

# Legislative compliance

## Details of consultancies over $10,000

| CONSULTANT | PURPOSE OF CONSULTANCY | START DATE | END DATE | TOTAL APPROVED PROJECT FEE (EXCLUDING GST) | EXPENDITURE 2015-16 (EXCLUDING GST) | FUTURE EXPENDITURE (EXCLUDING GST) |
|---|---|---|---|---|---|---|
| Batman Discretionary Trust | Review and improve ACFI | 1 July 2016 | 30 June 2017 | $73,960 | $73,960 | $30,000 |
| Leading in Health | Building consultancy | 1 July 2016 | 30 June 2017 | $36,000 | $36,000 | 0 |

In 2016/17 Rural North West engaged one consultancy where the total fees payable to the consultants were less than $10,000 with a total expenditure of $4,725 (ex GST)

## Freedom of Information (FOI)

Rural Northwest Health has received five requests for information under the Freedom of Information Act (1982) during the 2016-17 financial year, a decrease on the previous financial year.

From the five requests, in all five 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

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

## Victorian Industry Participation policy

Rural Northwest Health complies with the requirements of the Victorian Industry Participation Act 2003. There were no reportable disclosures during the reporting period

## ICT expenditure

| BAU ICT EXPENDITURE TOTAL | NON-BAU ICTA EXPENDITURE TOTAL = A + B | OPERATIONAL EXPENDITURE A | CAPITAL EXPENDITURE B |
|---|---|---|---|
| $539,860 | $75,104 | $0 | $75,104 |

## Additional information available on request

Consistent with FRD 22H (Section 5:19) 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

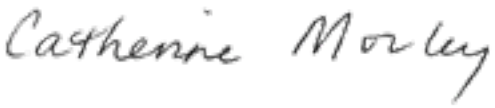
**j.** General statement on industrial relations within the health service and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the report of operations

**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.

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

I, Catherine Morley certify that Rural Northwest Health has complied with Ministerial Direction 3.7.1 – Risk Management Framework and Processes. The Rural Northwest Health Finance, Audit and Compliance committee has verified this

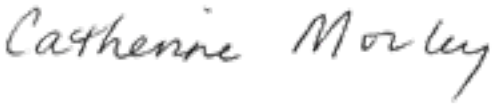


**Catherine Morley**

Accountable Officer
Warracknabeal
22nd August 2017

# Attestation on compliance with Health Purchasing Victoria (HPV) Health Purchasing policies

I, Catherine Morley 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



**Catherine Morley**

Accountable Officer
Warracknabeal
22nd August 2017

# Appendix A

## Alternative presentation of comprehensive operating statement

| | 2017 $'000 | 2016 $'000 |
|---|---|---|
| Interest | 401 | 399 |
| Sales of goods and services | 2,589 | 2,732 |
| Grants | 17,564 | 16,342 |
| Other | 1,113 | 1,250 |
| **Total Revenue** | **21,667** | **20,723** |
| Employee expenses | 15,080 | 14,304 |
| Depreciation | 2,139 | 2,300 |
| Other operating expenses | 5,569 | 5,749 |
| **Total Expenses** | **22,788** | **22,353** |
| **Net Result From Transactions – Net Operating Balance** | **(1,121)** | **(1,630)** |
| Net gain/(loss) on sale of non-financial assets | 0 | (171) |
| Other gains/(losses) from other economic flows included in net result | 38 | 1 |
| **Total Other Economic Flows included in Net Result** | **38** | **(170)** |
| **Net Result** | **(1,083)** | **(1,800)** |

Information contained in this page do not form part of the audited financial statements

# 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:<br>• balance sheet as at 30 June 2017<br>• comprehensive operating statement for the year then ended<br>• statement of changes in equity for the year then ended<br>• cash flow statement for the year then ended<br>• notes to the financial statements, including a summary of significant accounting policies<br>• board member's, accountable officers and chief finance and accounting officer's declaration.<br>In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2017 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards. |
| **Basis for Opinion** | I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. My responsibilities under the Act are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report.<br>My independence is established by the *Constitution Act 1975.* My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Australia. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code.<br>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.<br>In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, and using the going concern basis of accounting unless it is inappropriate to do so. |

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

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

MELBOURNE
28 August 2017

Ron Mak
*as delegate for the Auditor-General of Victoria*

**RURAL NORTHWEST HEALTH**
**COMPREHENSIVE OPERATING STATEMENT**
**FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017**

| | Note | 2017 $'000 | 2016 $'000 |
|---|---|---|---|
| Revenue from Operating Activities | 2.1 | 21,004 | 19,942 |
| Revenue from Non-Operating Activities | 2.1 | 401 | 399 |
| Employee Expenses | 3.1 | (15,080) | (14,304) |
| Non Salary Labour Costs | 3.1 | (440) | (666) |
| Supplies and Consumables | 3.1 | (1,308) | (1,172) |
| Other Expenses | 3.1 | (3,647) | (3,421) |
| **Net Result Before Capital and Specific Items** | | 930 | 778 |
| Capital Purpose Income | 2.1 | 262 | 382 |
| Depreciation | 4.4 | (2,139) | (2,300) |
| Expenditure for Capital Purposes | 3.1 | (174) | 0 |
| Specific Expenses | 3.2 | 0 | (490) |
| **Net Result After Capital and Specific Items** | | (1,121) | (1,630) |
| **Other Economic Flows Included in Net Result** | | | |
| Net Gain/(Loss) on Disposal of Non-Financial Assets | 7.2 | 0 | (171) |
| Revaluation of Long Service Leave | 3.1,3.3 | 38 | 1 |
| **Total Other Economic Flows Included in Net Result** | | 38 | (170) |
| **NET RESULT FOR THE YEAR** | | (1,083) | (1,800) |
| **Other Comprehensive Income** | | | |
| Changes in physical asset revaluation surplus | 8.1 | 0 | 0 |
| **Total Other Comprehensive Income** | | 0 | 0 |
| **COMPREHENSIVE RESULT** | | **(1,083)** | **(1,800)** |

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

**RURAL NORTHWEST HEALTH**
**BALANCE SHEET**
**AS AT 30 JUNE 2017**

| | Note | 2017 $'000 | 2016 $'000 |
|---|---|---|---|
| **Current Assets** | | | |
| Cash and Cash Equivalents | 6.1 | 1,646 | 1,859 |
| Receivables | 5.1 | 676 | 505 |
| Investments and Other Financial Assets | 4.1 | 16,485 | 14,295 |
| Inventories | 5.2 | 59 | 56 |
| Non-Financial Assets Classified as Held for Sale | 5.4 | 137 | 0 |
| Prepayments and Other Assets | 5.5 | 153 | 160 |
| **Total Current Assets** | | 19,156 | 16,875 |
| **Non-Current Assets** | | | |
| Property, Plant and Equipment | 4.3 | 42,607 | 43,477 |
| **Total Non-Current Assets** | | 42,607 | 43,477 |
| **TOTAL ASSETS** | | 61,763 | 60,352 |
| **Current Liabilities** | | | |
| Payables | 5.6 | 1,101 | 1,127 |
| Provisions | 3.3 | 3,638 | 3,473 |
| Other Liabilities | 5.3 | 8,518 | 6,426 |
| **Total Current Liabilities** | | 13,257 | 11,026 |
| **Non-Current Liabilities** | | | |
| Provisions | 3.3 | 365 | 335 |
| **Total Non-Current Liabilities** | | 365 | 335 |
| **TOTAL LIABILITIES** | | 13,622 | 11,361 |
| **NET ASSETS** | | 48,141 | 48,991 |
| **EQUITY** | | | |
| Property, Plant and Equipment Revaluation Surplus | 8.1a | 12,519 | 12,519 |
| Restricted Specific Purpose Surplus | 8.1b | 113 | 113 |
| Contributed Capital | 8.1b | 29,139 | 28,906 |
| Accumulated Surplus | 8.1c | 6,370 | 7,453 |
| **TOTAL EQUITY** | | 48,141 | 48,991 |
| Commitments | 6.2 | | |
| Contingent Assets and Contingent Liabilities | 7.3 | | |

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 2017**

| | Note | Property, Plant and Equipment Revaluation Reserve $'000 | Restricted Specific Purpose Reserve $'000 | Contributed Capital $'000 | Accumulated Surpluses/ (Deficits) $'000 | Total $'000 |
|---|---|---|---|---|---|---|
| **Balance at 1 July 2015** | | 12,519 | 113 | 27,178 | 9,253 | 49,063 |
| Net result for the year | 8.1c | 0 | 0 | 0 | (1,800) | (1,800) |
| Capital appropriation received from Victorian Government | 8.1b | 0 | 0 | 1,728 | 0 | 1,728 |
| **Balance at 30 June 2016** | | **12,519** | **113** | **28,906** | **7,453** | **48,991** |
| Net result for the year | 8.1c | 0 | 0 | 0 | (1,083) | (1,083) |
| Capital appropriation received from Victorian Government | 8.1b | 0 | 0 | 233 | 0 | 233 |
| **Balance at 30 June 2017** | | **12,519** | **113** | **29,139** | **6,370** | **48,141** |

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

**RURAL NORTHWEST HEALTH**
**CASH FLOW STATEMENT**
**FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017**

| | Note | 2017 $'000 Inflows / (Outflows) | 2016 $'000 Inflows / (Outflows) |
|---|---|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES** | | | |
| Operating Grants from Government | | 17,253 | 16,277 |
| Capital Grants from Government | | 46 | 110 |
| Patient and Resident Fees Received | | 2,640 | 2,758 |
| Donations and Bequests Received | | 79 | 54 |
| GST (Paid to)/received from ATO | | (25) | 235 |
| Interest Received | | 403 | 362 |
| Other Receipts | | 565 | 554 |
| ***Total Receipts*** | | ***20,961*** | ***20,350*** |
| Employee Expenses Paid | | (14,847) | (14,206) |
| Fee for Service Medical Officers | | (440) | (666) |
| Payments for Supplies and Consumables | | (903) | (1,266) |
| Other Payments | | (3,885) | (3,129) |
| ***Total Payments*** | | ***(20,075)*** | ***(19,267)*** |
| **NET CASH FLOW FROM OPERATING ACTIVITIES** | 8.2 | 886 | 1,083 |
| **CASH FLOWS FROM INVESTING ACTIVITIES** | | | |
| Proceeds from Redemption of Investments | | 0 | 823 |
| Purchase of Investments | | (207) | 0 |
| Payments for Non-Financial Assets | | (1,069) | (4,204) |
| Proceeds from Sale of Non-Financial Assets | | 0 | 155 |
| **NET CASH FLOW FROM /(USED IN) INVESTING ACTIVITIES** | | (1,276) | (3,226) |
| **CASH FLOWS FROM FINANCING ACTIVITIES** | | | |
| Contributed Capital from Government | | 0 | 1,728 |
| **NET CASH FLOW FROM /(USED IN) FINANCING ACTIVITIES** | | 0 | 1,728 |
| **NET DECREASE IN CASH AND CASH EQUIVALENTS HELD** | | (390) | (415) |
| **CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR** | | 1,618 | 2,033 |
| **CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR** | 6.1 | 1,228 | 1,618 |

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

**BASIS OF PRESENTATION**

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

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

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

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

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

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

Revisions to accounting estimates are recognised in the period in which the estimate is revised and also future periods that are affected by the revision. Judgements and assumptions made by management in applying the application of AASB that have significant effect on the financial statements and estimates are disclosed in the notes under the heading: 'Significant judgement or estimates'.

**NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

These annual financial statements represent the audited general purpose financial statements for Rural Northwest Health (ABN 23 976 871 636) for the period ending 30 June 2017. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

**(a) Statement of compliance**

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

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

The annual financial statements were authorised for issue by the Board of Rural Northwest Health on:
25th August 2017.

**(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)**

**(b) Reporting Entity (Continued)**

**Objectives and funding**

Rural Northwest Health's overall objective is to provide the highest standard of care and health related services that is responsive to community needs, as well as improve the quality of life to Victorians.

Rural Northwest Health is predominately funded by accrual based grant funding for the provision of outputs.

**(c) Basis of accounting preparation and measurement**

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

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

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

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

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

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

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

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

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

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

- The fair value of land, buildings, infrastructure, plant and equipment, (refer to Note 7.4);
- Superannuation expense (refer to Note 3.4);
- Actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.3); and

**(d) Principles of Consolidation**

**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 2: FUNDING DELIVERY OF OUR SERVICES

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

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

**Structure**
2.1 Analysis of revenue by source

| NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE | Admitted Patients 2017 $'000 | Residential Aged Care 2017 $'000 | Aged Care 2017 $'000 | Primary Health 2017 $'000 | Other 2017 $'000 | TOTAL 2017 $'000 |
|---|---|---|---|---|---|---|
| Government Grants | 8,683 | 7,196 | 289 | 1,371 | 0 | 17,539 |
| Indirect Contributions by Department of Health and Human Services | 10 | 14 | 1 | 0 | 0 | 25 |
| Patient and Resident Fees | 360 | 2,027 | 0 | 0 | 202 | 2,589 |
| Other Revenue from Operating Activities | 213 | 78 | 20 | 66 | 474 | 851 |
| **Total Revenue from Operating Activities** | **9,266** | **9,315** | **310** | **1,437** | **676** | **21,004** |
| Interest and Dividends | 152 | 236 | 13 | 0 | 0 | 401 |
| **Total Revenue from Non-Operating Activities** | **152** | **236** | **13** | **0** | **0** | **401** |
| Capital Purpose Income (excluding interest) | 46 | 0 | 0 | 0 | 216 | 262 |
| **Total Capital Purpose Income** | **46** | **0** | **0** | **0** | **216** | **262** |
| **TOTAL REVENUE** | **9,464** | **9,551** | **323** | **1,437** | **892** | **21,667** |

| | Admitted Patients 2016 $'000 | Residential Aged Care 2016 $'000 | Aged Care 2016 $'000 | Primary Health 2016 $'000 | Other 2016 $'000 | TOTAL 2016 $'000 |
|---|---|---|---|---|---|---|
| Government Grants | 7,882 | 6,697 | 279 | 1,456 | 0 | 16,314 |
| Indirect Contributions by Department of Health | 11 | 16 | 1 | 0 | 0 | 28 |
| Patient and Resident Fees | 440 | 2,092 | 0 | 0 | 200 | 2,732 |
| Other Revenue from Operating Activities | 244 | 116 | 26 | 91 | 391 | 868 |
| **Total Revenue from Operating Activities** | **8,577** | **8,921** | **306** | **1,547** | **591** | **19,942** |
| Interest and Dividends | 151 | 235 | 13 | 0 | 0 | 399 |
| **Total Revenue from Non-Operating Activities** | **151** | **235** | **13** | **0** | **0** | **399** |
| Capital Purpose Income (excluding interest) | 41 | 45 | 0 | 0 | 296 | 382 |
| **Total Capital Purpose Income** | **41** | **45** | **0** | **0** | **296** | **382** |
| **TOTAL REVENUE** | **8,769** | **9,201** | **319** | **1,547** | **887** | **20,723** |

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

**NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)**
Income is recognised in accordance with AASB 118 *Revenue* and is recognised as to the extent that it is probable that the economic benefits will flow to 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.

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

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

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

**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 reserve.

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

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

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

**Category Groups**
Rural Northwest Health has used the following category groups for reporting purposes for the current and previous financial years.

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

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

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

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

**NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)**
**Category Groups (Continued)**

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

## NOTE 3: THE COST OF DELIVERING SERVICES

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

**Structure**

3.1 Analysis of expenses by source
3.2 Specific expenses
3.3 Provisions
3.4 Superannuation

| NOTE 3.1: ANALYSIS OF EXPENSES BY SOURCE | Admitted Patients 2017 $'000 | Residential Aged Care 2017 $'000 | Aged Care 2017 $'000 | Primary Health 2017 $'000 | Other 2017 $'000 | TOTAL 2017 $'000 |
|---|---|---|---|---|---|---|
| Employee Expenses | 6,067 | 7,312 | 366 | 1,325 | 10 | 15,080 |
| Other Operating Expenses | | | | | | |
| Non Salary Labour Costs | 298 | 72 | 1 | 9 | 60 | 440 |
| Supplies and Consumables | 530 | 551 | 34 | 18 | 175 | 1,308 |
| Other Expenses | 1,372 | 1,544 | 93 | 263 | 375 | 3,647 |
| **Total Expenditure from Operating Activities** | **8,267** | **9,479** | **494** | **1,615** | **620** | **20,475** |
| Depreciation (refer note 4.4) | 0 | 0 | 0 | 0 | 2,139 | 2,139 |
| Expenditure for Capital Purposes | 0 | 0 | 0 | 0 | 174 | 174 |
| Revaluation of Long Service Leave | 0 | 0 | 0 | 0 | (38) | (38) |
| **Total Other Expenses** | **0** | **0** | **0** | **0** | **2,275** | **2,275** |
| **TOTAL EXPENSES** | **8,267** | **9,479** | **494** | **1,615** | **2,895** | **22,750** |

| | Admitted Patients 2016 $'000 | Residential Aged Care 2016 $'000 | Aged Care 2016 $'000 | Primary Health 2016 $'000 | Other 2016 $'000 | TOTAL 2016 $'000 |
|---|---|---|---|---|---|---|
| Employee Expenses | 5,736 | 6,980 | 348 | 1,221 | 19 | 14,304 |
| Other Operating Expenses | | | | | | |
| Non Salary Labour Costs | 306 | 300 | 0 | 0 | 60 | 666 |
| Supplies and Consumables | 483 | 474 | 25 | 15 | 175 | 1,172 |
| Other Expenses | 1,292 | 1,520 | 99 | 155 | 355 | 3,421 |
| **Total Expenditure from Operating Activities** | **7,817** | **9,274** | **472** | **1,391** | **609** | **19,563** |
| Depreciation (refer note 4.4) | 0 | 0 | 0 | 0 | 2,300 | 2,300 |
| Specific Expense (refer note 3.2) | 0 | 0 | 0 | 0 | 490 | 490 |
| Revaluation of Long Service Leave | 0 | 0 | 0 | 0 | (1) | (1) |
| **Total Other Expenses** | **0** | **0** | **0** | **0** | **2,789** | **2,789** |
| **TOTAL EXPENSES** | **7,817** | **9,274** | **472** | **1,391** | **3,398** | **22,352** |

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

**Employee expenses**
Employee expenses include:

- Wages and salaries;
- Fringe Benefits Tax;
- Leave Entitlements;
- Termination Payments;
- Workcover Premiums; and
- Superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

**NOTE 3.1: ANALYSIS OF EXPENSES BY SOURCE (Continued)**

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

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

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

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

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

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

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

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

**Net gain/ (loss) on financial instruments**
Net gain/ (loss) on financial instruments includes:

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

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

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

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

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

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

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

| NOTE 3.2: SPECIFIC EXPENSES | 2017 $'000 | 2016 $'000 |
|---|---|---|
| **Specific Expenses** | | |
| Write Down on Property, Plant and Equipment Stocktake | 0 | 490 |
| **Total Specific Expenses** | **0** | **490** |

| **NOTE 3.3: EMPLOYEE BENEFITS IN THE BALANCE SHEET** | 2017 $'000 | 2016 $'000 |
|---|---|---|
| **Current Provisions** | | |
| Employee Benefits (i) | | |
| Accrued Wages, Superannuation, ADO & Annual Leave | | |
| - unconditional and expected to be settled wholly within 12 months (ii) | 1,576 | 1,614 |
| - unconditional and expected to be settled wholly after 12 months (iii) | 94 | 13 |
| Long Service Leave | | |
| - unconditional and expected to be settled wholly within 12 months (ii) | 188 | 162 |
| - unconditional and expected to be settled wholly after 12 months (iii) | 1,436 | 1,355 |
| | 3,294 | 3,144 |
| Provisions related to employee benefit on-costs | | |
| - unconditional and expected to be settled wholly within 12 months (ii) | 173 | 178 |
| - unconditional and expected to be settled wholly after 12 months (iii) | 171 | 151 |
| | 344 | 329 |
| **Total Current Provisions** | 3,638 | 3,473 |
| | | |
| **Non-Current Provisions** | | |
| Employee Benefits (i) | | |
| Long Service Leave | | |
| - conditional and expected to be settled wholly after 12 months (iii) | 329 | 302 |
| Provisions related to employee benefit on-costs | | |
| - conditional and expected to be settled wholly after 12 months (iii) | 36 | 33 |
| **Total Non-Current Provisions** | 365 | 335 |
| | | |
| **Total Provisions** | 4,003 | 3,808 |
| | | |
| **(a) Employee Benefits and Related On-Costs** | | |
| **Current Employee Benefits and related on-costs** | | |
| Annual Leave Entitlements | 1,201 | 1,190 |
| Accrued Salaries and Wages | 426 | 403 |
| Accrued Days Off | 38 | 41 |
| Unconditional Long Service Leave Entitlements | 1,803 | 1,684 |
| Superannuation | 170 | 155 |
| | 3,638 | 3,473 |
| **Non-Current Employee Benefits and related on-costs** | | |
| Conditional Long Service Leave Entitlements (iii) | 365 | 335 |
| | | |
| **Total Employee Benefits and Related On-Costs** | 4,003 | 3,808 |

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

**(b) Movements in provisions**

| | | |
|---|---|---|
| **Movement in Long Service Leave** | | |
| **Balance at start of year** | 2,019 | 1,972 |
| Provision made during the year | | |
| - Revaluations | (38) | (1) |
| - Expense recognising Employee Service | 372 | 239 |
| Settlement made during the year | (185) | (191) |
| | | |
| **Balance at end of year** | 2,168 | 2,019 |

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

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

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

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

**Wages and Salaries, Annual Leave and Accrued Days Off**
Liabilities for wages and salaries, including non-monetary benefits, annual leave and accumulating sick leave are all recognised in the provision for employee benefits as 'current liabilities', because the Health Service does not have an unconditional right to defer settlements of these liabilities.

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

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

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

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

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

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

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

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

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

**NOTE 3.4: SUPERANNUATION**

| **Fund** | Paid Contributions for the Year | | Outstanding Contributions at Year End | |
|---|---|---|---|---|
| | **2017 $'000** | **2016 $'000** | **2017 $'000** | **2016 $'000** |
| Defined Contribution Plans: | | | | |
| Health Super | 922 | 955 | 143 | 129 |
| HESTA | 265 | 222 | 27 | 26 |
| Total | 1,187 | 1,177 | 170 | 155 |

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

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

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

**NOTE 3.4: SUPERANNUATION (Continued)**

***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.

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

The name and details of the major employee superannuation funds and contributions made by Rural Northwest Health are disclosed in the table above.

**Superannuation Liabilities**

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

**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 Jointly Controlled Operations and Assets
4.3 Property, plant & equipment
4.4 Depreciation

| **NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS** | 2017 $'000 | 2016 $'000 |
|---|---|---|
| **CURRENT** | | |
| **Loans and receivables** | | |
| Term Deposit | | |
| Aust. Dollar Term Deposits > 3 months (i) | 16,485 | 14,295 |
| **Total Current** | 16,485 | 14,295 |
| **TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS** | 16,485 | 14,295 |
| Represented by: | | |
| Health Service Investments | 8,200 | 7,993 |
| Accommodation Bonds (Refundable Entrance Fees) | 8,285 | 6,302 |
| **TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS** | 16,485 | 14,295 |

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

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

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

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

Investments are classified in the following categories:
- Loans and receivables.

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

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

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

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

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

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

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

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

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

## NOTE 4.2: JOINTLY CONTROLLED OPERATIONS AND ASSETS

| Name of Entity | Principal Activity | Ownership Interest 2017 % | Ownership Interest 2016 % |
|---|---|---|---|
| Grampians Rural Health Alliance | Information Systems | 5.71 | 5.52 |

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:

| | 2017 $'000 | 2016 $'000 |
|---|---|---|
| **Current Assets** | | |
| Cash and Cash Equivalents | 185 | 117 |
| Receivables | 25 | 71 |
| Prepayments | 2 | 10 |
| **Total Current Assets** | 212 | 198 |
| **Non Current Assets** | | |
| Property Plant and Equipment | 211 | 132 |
| **Total Non Current Assets** | 211 | 132 |
| **Total Assets** | 423 | 330 |
| **Current Liabilities** | | |
| Payables | 33 | 43 |
| **Total Current Liabilities** | 33 | 43 |
| **Total Liabilities** | 33 | 43 |
| **Net Assets** | 390 | 287 |

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

| | | |
|---|---|---|
| **Revenues** | | |
| Operating Revenue | 312 | 282 |
| Capital Income | 110 | 184 |
| **Total Revenue** | 422 | 466 |
| **Expenses** | | |
| Operating Expenditure | 304 | 271 |
| Depreciation | 25 | 17 |
| **Total Expenses** | 329 | 288 |
| **Net Result** | 93 | 178 |

**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 4.3: PROPERTY, PLANT AND EQUIPMENT**<br>**(a) Gross carrying amount and accumulated depreciation** | 2017<br>$'000 | 2016<br>$'000 |
|---|---|---|
| **Land** | | |
| - Land at Fair Value | 653 | 693 |
| **Total Land** | 653 | 693 |
| **Buildings** | | |
| - Buildings at Fair Value | 44,518 | 33,916 |
| Less Accumulated Depreciation | (4,896) | (3,165) |
| | 39,622 | 30,751 |
| - Land Improvements at Fair Value | 1,190 | 1,071 |
| Less Accumulated Depreciation | (524) | (344) |
| | 666 | 727 |
| **Assets Under Construction** | | |
| - Assets Under Construction at cost | 337 | 10,258 |
| **Total Assets Under Construction** | 337 | 10,258 |
| **Total Buildings** | 40,625 | 41,736 |
| **Plant and Equipment** | | |
| - Plant and Equipment at Fair Value | 892 | 828 |
| Less Accumulated Depreciation | (649) | (613) |
| - Grampians Rural Health Alliance | 269 | 166 |
| Less Accumulated Depreciation | (58) | (34) |
| **Total Plant and Equipment** | 454 | 347 |
| **Computers and Communications** | | |
| - Computers and Communications | 456 | 282 |
| Less Accumulated Depreciation | (193) | (132) |
| | 263 | 150 |
| **Medical Equipment** | | |
| - Medical Equipment | 805 | 723 |
| Less Accumulated Depreciation | (477) | (431) |
| | 328 | 292 |
| **Furniture and Fittings** | | |
| - Furniture and Fittings at Fair Value | 328 | 256 |
| Less Accumulated Depreciation | (164) | (142) |
| **Total Furniture and Fittings** | 164 | 114 |
| **Motor Vehicles** | | |
| - Motor Vehicles at Fair Value | 225 | 225 |
| Less Accumulated Depreciation | (105) | (80) |
| **Total Motor Vehicles** | 120 | 145 |
| **TOTAL** | 42,607 | 43,477 |

**NOTE 4.3: 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 2015** | **705** | **39,860** | **494** | **94** | **385** | **191** | **206** | **41,935** |
| Additions | 0 | 4,285 | 29 | 137 | 35 | 43 | 41 | 4,570 |
| Grampians Rural Health Alliance | 0 | 0 | 88 | 0 | 0 | 0 | 0 | 88 |
| Specific Expense Write Down | 0 | 0 | (213) | (40) | (86) | (102) | (49) | (490) |
| Disposals | (12) | (282) | 0 | 0 | 0 | 0 | (32) | (326) |
| Depreciation | 0 | (2,127) | (51) | (41) | (42) | (18) | (21) | (2,300) |
| **Balance at 1 July 2016** | **693** | **41,736** | **347** | **150** | **292** | **114** | **145** | **43,477** |
| Additions | 0 | 677 | 63 | 175 | 81 | 73 | 0 | 1,069 |
| Grampians Rural Health Alliance | 0 | 0 | 104 | 0 | 0 | 0 | 0 | 104 |
| Classified as Held for Sale | (40) | (97) | 0 | 0 | 0 | 0 | 0 | (137) |
| Capital Contributions | 0 | 233 | 0 | 0 | 0 | 0 | 0 | 233 |
| Disposals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Depreciation | 0 | (1,924) | (60) | (62) | (45) | (23) | (25) | (2,139) |
| **Balance at 30 June 2017** | **653** | **40,625** | **454** | **263** | **328** | **164** | **120** | **42,607** |

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

The effective date of the valuation is 30 June 2014.

**(c) Fair value measurement hierarchy for assets**

| | **Carrying amount as at 30 June 2017** | **Fair value measurement at end of reporting period using:** | | |
|---|---|---|---|---|
| | | Level 1 [(i)] | Level 2 [(i)] | Level 3 [(i)] |
| | $'000 | $'000 | $'000 | $'000 |
| **Land at fair value** | | | | |
| Specialised land | 392 | 0 | 0 | 392 |
| Non Specialised land | 261 | 0 | 261 | 0 |
| Total of land at fair value | 653 | 0 | 261 | 392 |
| **Buildings at fair value** | | | | |
| Specialised buildings | 38,643 | 0 | 0 | 38,643 |
| Non Specialised buildings | 979 | 0 | 979 | 0 |
| Specialised land improvements | 666 | 0 | 0 | 666 |
| Non Specialised land improvements | 0 | 0 | 0 | 0 |
| Total of building at fair value | 40,288 | 0 | 979 | 39,309 |
| **Plant and equipment at fair value** | | | | |
| Plant equipment and vehicles at fair value | | | | |
| - Vehicles (ii) | 120 | 0 | 120 | 0 |
| - Plant and equipment | 881 | 0 | 0 | 881 |
| Total of plant, equipment and vehicles at fair value | 1,001 | 0 | 120 | 881 |
| **Medical equipment at fair value** | 328 | 0 | 0 | 328 |
| Total medical equipment at fair value | 328 | 0 | 0 | 328 |
| **Assets under construction at cost** | 337 | 0 | 0 | 337 |
| Total assets under construction at cost | 337 | 0 | 0 | 337 |

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

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

There have been no transfers between levels during the period.

**Fair value measurement hierarchy for assets as at 30 June 2016**

| | Carrying amount as at 30 June 2016 | Fair value measurement at end of reporting period using: | | |
|---|---|---|---|---|
| | | Level 1 (1) | Level 2 (1) | Level 3 (1) |
| | $'000 | $'000 | $'000 | $'000 |
| **Land at fair value** | | | | |
| Specialised land | 392 | 0 | 0 | 392 |
| Non Specialised land | 301 | 0 | 301 | 0 |
| Total of land at fair value | 693 | 0 | 301 | 392 |
| **Buildings at fair value** | | | | |
| Specialised buildings | 29,619 | 0 | 0 | 29,619 |
| Non Specialised buildings | 1,132 | 0 | 1,132 | 0 |
| Specialised land improvements | 727 | 0 | 0 | 727 |
| Non Specialised land improvements | 0 | 0 | 0 | 0 |
| Total of building at fair value | 31,478 | 0 | 1,132 | 30,346 |
| **Plant and equipment at fair value** | | | | |
| Plant equipment and vehicles at fair value | | | | |
| - Vehicles (ii) | 145 | 0 | 145 | 0 |
| - Plant and equipment | 611 | 0 | 0 | 611 |
| Total of plant, equipment and vehicles at fair value | 756 | 0 | 145 | 611 |
| **Medical equipment at fair value** | 292 | 0 | 0 | 292 |
| Total medical equipment at fair value | 292 | 0 | 0 | 292 |
| **Assets under construction at cost** | 10,258 | 0 | 0 | 10,258 |
| Total assets under construction at cost | 10,258 | 0 | 0 | 10,258 |

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

There have been no transfers between levels during the period.

Consistent with AASB 13 Fair Value Measurement, Rural Northwest Health determines the policies and procedures for both recurring fair value measurements such as property, plant and equipment, investment properties and financial instruments, and for non-recurring fair value measurements such as non-financial physical assets held for sale, in accordance with the requirements of AASB 13 and the relevant FRDs.

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

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

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

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

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

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

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

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

- The fair value of land, buildings, infrastructure, plant and equipment (refer to Note 7.4);

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

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

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

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

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

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

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

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

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

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

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

**(d) Reconciliation of Level 3 fair value**

| **30 June 2017** | Land | Buildings | Plant and equipment | Medical equipment | Assets under construction |
|---|---|---|---|---|---|
| | $'000 | $'000 | $'000 | $'000 | $'000 |
| **Opening Balance** | 392 | 30,346 | 611 | 292 | 10,258 |
| **Purchases (sales)** | 0 | 910 | 415 | 81 | 0 |
| **Transfers in (out)** | 0 | 9,921 | 0 | 0 | (9,921) |
| Gains or losses recognised in net result | | | | | |
| - Depreciation | 0 | (1,868) | (145) | (45) | 0 |
| **Subtotal** | 392 | 39,309 | 881 | 328 | 337 |
| Items recognised in other comprehensive income | | | | | |
| - Revaluation | 0 | 0 | 0 | 0 | 0 |
| **Subtotal** | 0 | 0 | 0 | 0 | 0 |
| **Closing Balance** | 392 | 39,309 | 881 | 328 | 337 |
| Unrealised gains/(losses) on non-financial assets | 0 | 0 | 0 | 0 | 0 |
| | 392 | 39,309 | 881 | 328 | 337 |

There have been no transfers between levels during the period.

| **30 June 2016** | Land | Buildings | Plant and equipment | Medical equipment | Assets under construction |
|---|---|---|---|---|---|
| | $'000 | $'000 | $'000 | $'000 | $'000 |
| **Opening Balance** | 404 | 32,755 | 779 | 385 | 5,973 |
| **Purchases (sales)** | (12) | (282) | 297 | 35 | 4,285 |
| **Transfers in (out)** | 0 | 0 | (355) | (86) | 0 |
| Gains or losses recognised in net result | | | | | |
| - Depreciation | 0 | (2,127) | (110) | (42) | 0 |
| **Subtotal** | 392 | 30,346 | 611 | 292 | 10,258 |
| Items recognised in other comprehensive income | | | | | |
| - Revaluation | 0 | 0 | 0 | 0 | 0 |
| **Subtotal** | 0 | 0 | 0 | 0 | 0 |
| **Closing Balance** | 392 | 30,346 | 611 | 292 | 10,258 |
| Unrealised gains/(losses) on non-financial assets | 0 | 0 | 0 | 0 | 0 |
| | 392 | 30,346 | 611 | 292 | 10,258 |

There have been no transfers between levels during the period.

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

**Identifying unobservable inputs (level 3) fair value measurements**

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

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

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

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

**Non-specialised land and 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 independent valuers Valuer-General Victoria to determine the fair value using the market approach.

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

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

**Specialised land and specialised buildings**

The market approach is also used for specialised land and specialised buildings although 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 the Health Services, the depreciated replacement cost method is used for the majority of specialised buildings, adjusting for the associated depreciation. As depreciation adjustments are considered as significant and unobservable inputs in nature, specialised buildings are classified as Level 3 for fair value measurements.

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

**Vehicles**
The Health Service acquires new vehicles and at times disposes of them before completion of their economic life. The process of acquisition, use and disposal in the market is managed by the Health Service who set relevant depreciation rates during use to reflect the consumption of the vehicles. Where the fair value of vehicles differs materially from the carrying value (depreciated cost), the service revalues them based on current market value.

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

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

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

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

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

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

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

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

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed below.

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

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

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

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

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

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

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

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

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

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

In accordance with FRD 103F, Rural Northwest Health's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required. This assessment did not identify any significant movements that would require a revaluation.

**NOTE 4.4: DEPRECIATION**

| | 2017 $'000 | 2016 $'000 |
|---|---|---|
| **Depreciation** | | |
| Buildings | 1,744 | 1,963 |
| Land Improvements | 180 | 164 |
| Plant and Equipment | 35 | 34 |
| Medical Equipment | 45 | 42 |
| Computers and Communications | 62 | 41 |
| Furniture and Fittings | 23 | 18 |
| Motor Vehicles | 25 | 21 |
| Grampians Rural Health Alliance Depreciation | 25 | 17 |
| **TOTAL DEPRECIATION** | 2,139 | 2,300 |

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

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

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

| | 2017 | 2016 |
|---|---|---|
| Buildings | | |
| - Structure Shell Building Fabric | 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 |

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 Inventories
5.3 Other liabilities
5.4 Non-financial assets classified as held for sale
5.5 Prepayments and other assets
5.6 Payables

| **NOTE 5.1: RECEIVABLES** | 2017 $'000 | 2016 $'000 |
|---|---|---|
| **CURRENT** | | |
| **Contractual** | | |
| Patient Fees | 114 | 177 |
| Accrued Investment Income | 53 | 55 |
| Accrued Revenue - Other | 234 | 12 |
| Trade Debtors | 52 | 87 |
| Grampians Rural Health Alliance Receivables | 25 | 71 |
| Less Allowance for Doubtful Debts | (14) | (26) |
| | 464 | 376 |
| **Statutory** | | |
| Department of Health and Human Services | 58 | 0 |
| GST Receivable | 154 | 129 |
| | 212 | 129 |
| **TOTAL CURRENT RECEIVABLES** | 676 | 505 |
| **TOTAL RECEIVABLES** | 676 | 505 |
| **(a) Movement in the Allowance for doubtful debts** | | |
| Balance at beginning of the year | (26) | (9) |
| (Increase) / decrease in allowance recognised in net result | 12 | (17) |
| **Balance at end of the year** | (14) | (26) |

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

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

Receivables consist of:

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

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

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

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

| **NOTE 5.2: INVENTORIES** | 2017 $'000 | 2016 $'000 |
|---|---|---|
| Pharmaceuticals - at cost | 22 | 13 |
| Medical and Surgical Lines - at cost | 37 | 43 |
| **TOTAL INVENTORIES** | 59 | 56 |

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

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

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

**NOTE 5.2: INVENTORIES (Continued)**

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

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

**NOTE 5.3: OTHER LIABILITIES**

| | 2017 $'000 | 2016 $'000 |
|---|---|---|
| **CURRENT** | | |
| Monies Held in Trust* | | |
| - Patient Monies Held in Trust | 154 | 118 |
| - Accommodation Bonds (Refundable Entrance Fees) | 8,285 | 6,302 |
| - Other | 79 | 6 |
| | 8,518 | 6,426 |
| **TOTAL OTHER LIABILITIES** | 8,518 | 6,426 |

*** Total Monies Held in Trust**
**Represented by the following assets:**

| | | |
|---|---|---|
| Cash Assets (refer to Note 6.1) | 233 | 124 |
| Investment and Other Financial Assets (refer to Note 4.1) | 8,285 | 6,302 |
| **TOTAL** | 8,518 | 6,426 |

**NOTE 5.4: NON-FINANCIAL PHYSICAL ASSETS CLASSIFIED AS HELD FOR SALE**

| **(A) Non-financial physical assets including disposal groups classified as held for sale** | 2017 $'000 | 2016 $'000 |
|---|---|---|
| 26 McLean Street | 20 | 0 |
| 10 Gould Street | 117 | 0 |
| **TOTAL NON-FINANCIAL PHYSICAL ASSETS CLASSIFIED AS HELD FOR SALE** | 137 | 0 |

The Health Service has listed the above mentioned properties for sale with a local real estate agent.

**(B) Fair value measurement of non-financial physical assets held for sale**

| | **Carrying amount as at 30 June 2017** | **Fair value measurement at end of reporting period using:** Level 1 (i) | Level 2 (i) | Level 3 (i) |
|---|---|---|---|---|
| | **$** | **$** | **$** | **$** |
| 26 McLean Street (i) | 20 | 0 | 20 | 0 |
| 10 Gould Street (i) | 117 | 0 | 117 | 0 |
| | **137** | **0** | **137** | **0** |

Notes
(1) Classified in accordance with the fair value hierarchy, see Note 1
(i) Non-physical assets classified as held for sale are carried at fair value less cost to disposal.

**Non-financial physical assets classified as held for sale**
Non-financial physical assets and disposal groups and related liabilities are treated as current and are classified as held for sale if their carrying amount will be recovered through a sale transaction rather than through continuing use. This condition is regarded as met only when the sale is highly probable, the asset's sale (or disposal group) is expected to be completed within 12 months from the date of classification, and the asset is available for immediate use in the current condition.

Non-financial physical assets (including disposal groups) classified as held for sale are treated as current and are measured at the lower of carrying amount and fair value less costs of disposal, and are not subject to depreciation or amortisation.

| **NOTE 5.5: PREPAYMENTS AND OTHER NON-FINANCIAL ASSETS** | 2017 $'000 | 2016 $'000 |
|---|---|---|
| **CURRENT** | | |
| Prepayments | 151 | 150 |
| Grampians Rural Health Alliance Prepayments | 2 | 10 |
| **TOTAL OTHER ASSETS** | 153 | 160 |

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

| **NOTE 5.6: PAYABLES** | 2017 $'000 | 2016 $'000 |
|---|---|---|
| **CURRENT** | | |
| **Contractual** | | |
| Trade Creditors | 831 | 423 |
| Grampians Rural Health Alliance Payables | 33 | 43 |
| Accrued Expenses | 167 | 549 |
| Commonwealth Aged Care Funding | 27 | 71 |
| Accrued Audit Fees | 22 | 23 |
| | 1,080 | 1,109 |
| **Statutory** | | |
| Department of Health and Human Services - Accrued Grant Recall | 14 | 11 |
| Australian Taxation Office - Fringe Benefits Tax | 7 | 7 |
| | 21 | 18 |
| **TOTAL PAYABLES** | 1,101 | 1,127 |

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

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

Payables consist of:

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

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

## NOTE 6: HOW WE FINANCE OUR OPERATIONS

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

| | 2017 $'000 | 2016 $'000 |
|---|---|---|
| Cash on Hand | 2 | 3 |
| Cash at Bank | 1,644 | 1,856 |
| **TOTAL CASH AND CASH EQUIVALENTS** | 1,646 | 1,859 |
| **Represented by:** | | |
| Cash for Health Service Operations (as per cash flow statement) | 1,228 | 1,618 |
| Cash for Monies Held in Trust | | |
| - Cash at Bank | 233 | 124 |
| - Grampians Rural Health Alliance | 185 | 117 |
| **TOTAL CASH AND CASH EQUIVALENTS** | 1,646 | 1,859 |

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

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

**NOTE 6.2: COMMITMENTS FOR EXPENDITURE**

(a) Commitments other than public private partnerships

| | 2017 $'000 | 2016 $'000 |
|---|---|---|
| **Lease commitments** | | |
| Commitments for leases contracted for at reporting date: | | |
| Operating leases | 333 | 43 |
| **Total lease commitments** | **333** | **43** |
| ***Operating leases*** | | |
| Payable as follows: | | |
| Cancellable | | |
| Not later than one year | 130 | 43 |
| Later than 1 year and not later than 5 years | 203 | 0 |
| **Sub Total** | **333** | **43** |
| **Total lease commitments (inclusive of GST)** | 333 | 43 |
| less GST recoverable from the Australian Tax Office | (30) | (4) |
| **Total Commitments ( exclusive of GST)** | **303** | **39** |

**Lease and Renewal Terms Included in Lease Agreements**

Motor Vehicles: This lease is for 13 vehicles from Vic Fleet (Department of Treasury and Finance) at a cost of $6,905 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 Net gain/ (loss) on disposal of non-financial assets
7.3 Contingent assets and contingent liabilities
7.4 Fair value determination

**NOTE 7.1: FINANCIAL INSTRUMENTS**

**(a) Financial Risk Management Objectives and Policies**

Rural Northwest Health's principal financial instruments comprise of:
- Cash Assets
- Receivables (excluding statutory receivables)
- Payables (excluding statutory payables)
- Accommodation Bonds

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

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

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

The main purpose in holding financial instruments is to prudentially manage Rural Northwest Health financial risk within the government policy parameters.

**Categorisation of financial instruments**

| 2017 | Contractual financial assets - loans and receivables $'000 | Contractual financial liabilities at amortised cost $'000 | Total $'000 |
|---|---|---|---|
| **Contractual Financial Assets** | | | |
| Cash and cash equivalents | 1,646 | 0 | 1,646 |
| Receivables | | | |
| - Trade Debtors | 52 | 0 | 52 |
| - Other Receivables | 412 | 0 | 412 |
| Other Financial Assets | | | |
| - Term Deposits | 16,485 | 0 | 16,485 |
| Total Financial Assets (i) | 18,595 | 0 | 18,595 |
| **Financial Liabilities** | | | |
| Payables | 0 | 1,080 | 1,080 |
| Other Financial Liabilities | | | |
| - Monies Held in Trust | 0 | 8,518 | 8,518 |
| Total Financial Liabilities(ii) | 0 | 9,598 | 9,598 |

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

**NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)**
**(a) Financial Risk Management Objectives and Policies (Continued)**

| 2016 | Contractual financial assets - loans and receivables $'000 | Contractual financial liabilities at amortised cost $'000 | Total $'000 |
|---|---|---|---|
| **Contractual Financial Assets** | | | |
| Cash and cash equivalents | 1,859 | 0 | 1,859 |
| Receivables | | | |
| - Trade Debtors | 87 | 0 | 87 |
| - Other Receivables | 289 | 0 | 289 |
| Other Financial Assets | | | 0 |
| - Term Deposits | 14,295 | 0 | 14,295 |
| Total Financial Assets (i) | 16,530 | 0 | 16,530 |
| | | | |
| **Financial Liabilities** | | | |
| Payables | 0 | 1,109 | 1,109 |
| Other Financial Liabilities | | | |
| - Monies Held in Trust | 0 | 6,426 | 6,426 |
| Total Financial Liabilities(ii) | 0 | 7,535 | 7,535 |

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

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

| | Total interest income/ (expense) $'000 | Total $'000 |
|---|---|---|
| **2017** | | |
| **Financial Assets** | | |
| Loans and Receivables(i) | 401 | 401 |
| **Total Financial Assets** | 401 | 401 |
| | | |
| **2016** | | |
| **Financial Assets** | | |
| Loans and Receivables(i) | 399 | 399 |
| **Total Financial Assets** | 399 | 399 |

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

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

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

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

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

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

**NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)**
**(c) Credit Risk (Continued)**

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

| 2017 | Financial Institutions (Min AA credit rating) $000 | Government agencies (AAA credit rating) $000 | Government agencies (BBB credit rating) $000 | Other (Min BBB credit rating) $000 | Total $000 |
|---|---|---|---|---|---|
| **Financial Assets** | | | | | |
| Cash and Cash Equivalents | 1,346 | 300 | 0 | 0 | 1,646 |
| Loans and Receivables | | | | | |
| - Trade Debtors | 0 | 0 | 0 | 52 | 52 |
| - Other Receivables (i) | 0 | 0 | 0 | 412 | 412 |
| - Term Deposit | 8,285 | 8,200 | 0 | 0 | 16,485 |
| **Total Financial Assets** | 9,631 | 8,500 | 0 | 464 | 18,595 |
| | | | | | |
| **2016** | | | | | |
| **Financial Assets** | | | | | |
| Cash and Cash Equivalents | 1,509 | 350 | 0 | 0 | 1,859 |
| Loans and Receivables | | | | | |
| - Trade Debtors | 0 | 0 | 0 | 87 | 87 |
| - Other Receivables (i) | 0 | 0 | 0 | 289 | 289 |
| - Term Deposit | 6,295 | 8,000 | 0 | 0 | 14,295 |
| **Total Financial Assets** | 7,804 | 8,350 | 0 | 376 | 16,530 |

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

**Ageing analysis of financial asset as at 30 June**

| 2017 | Total Carrying Amount $'000 | Not Past due and not impaired $'000 | Less than 1 Month $'000 | 1 - 3 Months $'000 | 3 Months - 1 Year $'000 | 1 - 5 Years $'000 | Impaired Financial Assets $'000 |
|---|---|---|---|---|---|---|---|
| **Financial Assets** | | | | | | | |
| Cash and Cash Equivalents | 1,646 | 1,646 | 0 | 0 | 0 | 0 | 0 |
| Loans and Receivables (i) | | | | | | | |
| - Trade Debtors | 52 | 42 | 0 | 5 | 5 | 0 | 14 |
| - Other Receivables | 412 | 412 | 0 | 0 | 0 | 0 | 0 |
| - Term Deposits | 16,485 | 16,485 | 0 | 0 | 0 | 0 | 0 |
| **Total Financial Assets** | 18,595 | 18,585 | 0 | 5 | 5 | 0 | 14 |
| | | | | | | | |
| **2016** | | | | | | | |
| **Financial Assets** | | | | | | | |
| Cash and Cash Equivalents | 1,859 | 1,859 | 0 | 0 | 0 | 0 | 0 |
| Loans and Receivables (i) | | | | | | | |
| - Trade Debtors | 87 | 30 | 20 | 6 | 31 | 0 | 26 |
| - Other Receivables | 289 | 289 | 0 | 0 | 0 | 0 | 0 |
| - Term Deposits | 14,295 | 14,295 | 0 | 0 | 0 | 0 | 0 |
| **Total Financial Assets** | 16,530 | 16,473 | 20 | 6 | 31 | 0 | 26 |

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

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

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

**NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)**

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

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

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

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

**Maturity analysis of financial liabilities as at 30 June**

| | | | Maturity Dates | | | |
|---|---|---|---|---|---|---|
| | Total Carrying Amount | Nominal Amount | Less than 1 Month | 1 - 3 Months | 3 Months - 1 Year | 1 - 5 Years |
| **2017** | $'000 | $'000 | $'000 | $'000 | $'000 | $'000 |
| **Financial Liabilities** | | | | | | |
| *At amortised cost* | | | | | | |
| Payables | 1,080 | 1,080 | 1,080 | 0 | 0 | 0 |
| Other Financial Liabilities (i) | | | | | | |
| - Monies Held in Trust | 8,518 | 8,518 | 0 | 0 | 8,518 | 0 |
| **Total Financial Liabilities** | 9,598 | 9,598 | 1,080 | 0 | 8,518 | 0 |
| **2016** | | | | | | |
| **Financial Liabilities** | | | | | | |
| *At amortised cost* | | | | | | |
| Payables | 1,109 | 1,109 | 1,109 | 0 | 0 | 0 |
| Other Financial Liabilities (i) | | | | | | |
| - Monies Held in Trust | 6,426 | 6,426 | 0 | 0 | 6,426 | 0 |
| **Total Financial Liabilities** | 7,535 | 7,535 | 1,109 | 0 | 6,426 | 0 |

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

**(e) Market Risk**
Rural Northwest Health's exposures to market risk are primarily through interest rate risk with only insignificant exposure to foreign currency and other price risks. Objectives, policies and processes used to manage each of these risks are disclosed in the paragraphs below.

***Interest Rate Risk***
Exposure to interest rate risk's arise primarily through the Rural Northwest Health's' other financial assets. Minimisation of risk is achieved by mainly holding fixed rate or non-interest bearing financial instruments. For financial liabilities the Health Service mainly undertake financial liabilities with relatively even maturity profiles.

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

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

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

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

**NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)**
**(d) Liquidity Risk (Continued)**

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

| | Weighted Average Effective Interest Rate (%) | Carrying Amount $'000 | Interest Rate Exposure | | |
|---|---|---|---|---|---|
| **2017** | | | Fixed Interest Rate $'000 | Variable Interest Rate $'000 | Non - Interest Bearing $'000 |
| **Financial Assets** | | | | | |
| Cash and Cash Equivalents | 1.65 | 1,646 | 0 | 1,644 | 2 |
| Loans and Receivables (i) | | | | | |
| - Trade Debtors | 0.00 | 52 | 0 | 0 | 52 |
| - Other Receivables | 0.00 | 412 | 0 | 0 | 412 |
| - Term Deposits | 2.11 | 16,485 | 16,485 | 0 | 0 |
| **Total Financial Assets** | | 18,595 | 16,485 | 1,644 | 466 |
| **Financial Liabilities** | | | | | |
| *At amortised cost* | | | | | |
| Payables (i) | 0.00 | 1,080 | 0 | 0 | 1,080 |
| Other Financial Liabilities | | | | | |
| - Accommodation Bonds | 0.00 | 8,518 | 0 | 0 | 8,518 |
| **Total Financial Liabilities** | | 9,598 | 0 | 0 | 9,598 |
| **2016** | | | | | |
| **Financial Assets** | | | | | |
| Cash and Cash Equivalents | 1.90 | 1,859 | 0 | 1,856 | 3 |
| Loans and Receivables (i) | | | | | |
| - Trade Debtors | 0.00 | 87 | 0 | 0 | 87 |
| - Other Receivables | 0.00 | 289 | 0 | 0 | 289 |
| - Term Deposits | 2.51 | 14,295 | 14,295 | 0 | 0 |
| **Total Financial Assets** | | 16,530 | 14,295 | 1,856 | 379 |
| **Financial Liabilities** | | | | | |
| *At amortised cost* | | | | | |
| Payables (i) | 0.00 | 1,109 | 0 | 0 | 1,109 |
| Other Financial Liabilities | | | | | |
| - Accommodation Bonds | 0.00 | 6,426 | 0 | 0 | 6,426 |
| **Total Financial Liabilities** | | 7,535 | 0 | 0 | 7,535 |

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

**NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)**
**(e) Market Risk (Continued)**
**Sensitivity Disclosure Analysis**
Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, the Rural Northwest Health believes the following movements are 'reasonably possible' over the next 12 months (base rates are sourced from the Reserve Bank of Australia).
- A shift of 100 basis points up and down in market interest rates (AUD) from year-end rates of 2%; and
- A parallel shift of +1% and -1% in inflation rate from year-end rates of 2%.

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

| | Carrying Amount | Interest Rate Risk | | | | Other Price Risk | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | -1% | | +1% | | -1% | | +1% | |
| **2017** | $'000 | Profit $'000 | Equity $'000 | Profit $'000 | Equity $'000 | Profit $'000 | Equity $'000 | Profit $'000 | Equity $'000 |
| **Financial Assets** | | | | | | | | | |
| Cash and Cash Equivalents | 1,646 | (16) | (16) | 16 | 16 | 0 | 0 | 0 | 0 |
| Loans and Receivables | | | | | | | | | |
| - Trade Debtors | 52 | 0 | 0 | 0 | 0 | (1) | (1) | 1 | 1 |
| - Other Receivables | 412 | 0 | 0 | 0 | 0 | (4) | (4) | 4 | 4 |
| - Term Deposit | 16,485 | (165) | (165) | 165 | 165 | 0 | 0 | 0 | 0 |
| **Financial Liabilities** | | | | | | | | | |
| *At amortised cost* | | | | | | | | | |
| Payables | 1,080 | 0 | 0 | 0 | 0 | (11) | (11) | 11 | 11 |
| Other Financial Liabilities (i) | | | | | | | | | |
| - Accommodation Bonds | 8,518 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | (181) | (181) | 181 | 181 | (15) | (15) | 15 | 15 |
| **2016** | | | | | | | | | |
| **Financial Assets** | | | | | | | | | |
| Cash and Cash Equivalents | 1,859 | (19) | (19) | 19 | 19 | 0 | 0 | 0 | 0 |
| Loans and Receivables | | | | | | | | | |
| - Trade Debtors | 87 | 0 | 0 | 0 | 0 | (1) | (1) | 1 | 1 |
| - Other Receivables | 289 | 0 | 0 | 0 | 0 | (3) | (3) | 3 | 3 |
| - Term Deposit | 14,295 | (143) | (143) | 143 | 143 | | | | |
| **Financial Liabilities** | | | | | | 0 | 0 | 0 | 0 |
| *At amortised cost* | | | | | | | | | |
| Payables | 1,109 | 0 | 0 | 0 | 0 | (11) | (11) | 11 | 11 |
| Other Financial Liabilities (i) | | | | | | | | | |
| - Accommodation Bonds | 6,426 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | (162) | (162) | 162 | 162 | (15) | (15) | 15 | 15 |

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

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

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

**NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)**
**(f) Fair Value (Continued)**

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

**Comparison between carrying amount and fair value**

| | Total Carrying Amount 2017 $'000 | Fair Value 2017 $'000 | Total Carrying Amount 2016 $'000 | Fair Value 2016 $'000 |
|---|---|---|---|---|
| **Financial Assets** | | | | |
| Cash and Cash Equivalents | 1,646 | 1,646 | 1,859 | 1,859 |
| Loans and Receivables (i) | | | | |
| - Trade Debtors | 52 | 52 | 87 | 87 |
| - Other Receivables | 412 | 412 | 289 | 289 |
| - Term Deposits | 16,485 | 16,485 | 14,295 | 14,295 |
| **Total Financial Assets** | **18,595** | **18,595** | **16,530** | **16,530** |
| | | | | |
| **Financial Liabilities** | | | | |
| *At amortised cost* | | | | |
| Payables | 1,080 | 1,080 | 1,109 | 1,109 |
| Other Financial Liabilities (i) | | | | |
| - Accommodation Bonds | 8,518 | 8,518 | 6,426 | 6,426 |
| **Total Financial Liabilities** | **9,598** | **9,598** | **7,535** | **7,535** |

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

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of 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. For example, statutory receivables arising from taxes, fines and penalties do not meet the definition of financial instruments as they do not arise under contract.

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

The following refers to financial instruments unless otherwise stated.

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

Loans and receivables category includes cash and deposits (refer to Note 6.1), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

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

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

| NOTE 7.2: NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS | 2017 $'000 | 2016 $'000 |
|---|---|---|
| **Proceeds from Disposal of Non-Current Assets** | | |
| - Land & Buildings | 0 | 128 |
| - Motor Vehicles | 0 | 27 |
| **Total Proceeds from Disposal of Non-Current Assets** | 0 | 155 |
| | | |
| **Less: Written Down Value of Non-Current Assets Sold** | | |
| - Land & Buildings | 0 | 294 |
| - Motor Vehicles | 0 | 32 |
| **Total Written Down Value of Non-Current Assets Sold** | 0 | 326 |
| | | |
| **NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS** | 0 | (171) |

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

**Impairment of non-financial assets**
Goodwill and intangible assets with indefinite lives (and intangible assets not yet available for use) are tested annually for impairment (as described below) and whenever there is an indication that the asset may be impaired.

All other non-financial assets are assessed annually for indications of impairment, except for:
- inventories;
- non-current physical assets held for sale; and
- assets arising from construction contracts.

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

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

It is deemed that, in the event of the loss or destruction of an asset, the future economic benefits arising from the use of the asset will be replaced unless a specific decision to the contrary has been made. The recoverable amount for most assets is measured at the higher of depreciated replacement cost and fair value less costs of disposal. Recoverable amount for assets held primarily to generate net cash inflows is measured at the higher of the present value of future cash flows expected to be obtained from the asset and fair value less costs of disposal.

## NOTE 7.3: CONTINGENT 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.

**NOTE 7.4: FAIR VALUE DETERMINATION**

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

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

## NOTE 8: OTHER DISCLOSURES

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

**Structure**

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

| **NOTE 8.1: EQUITY** | 2017 | 2016 |
|---|---|---|
| **(a) Surpluses** | $'000 | $'000 |
| **Property, Plant and Equipment Revaluation Surplus** [1] | | |
| Balance at beginning of the reporting period | | |
| - Land | 468 | 468 |
| - Buildings | 12,051 | 12,051 |
| Revaluation Increment/(Decrement) | | |
| - Land | 0 | 0 |
| - Buildings | 0 | 0 |
| Balance at the end of the reporting period | 12,519 | 12,519 |
| | | |
| Represented by: | | |
| - Land | 468 | 468 |
| - Buildings | 12,051 | 12,051 |
| | 12,519 | 12,519 |

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

| | | |
|---|---|---|
| **(b) Specific Restricted Purpose Surplus** | | |
| Balance at the beginning of the reporting period | 113 | 113 |
| Balance at the end of the reporting period | 113 | 113 |
| **Total Surpluses** | 12,632 | 12,632 |
| **Contributed Capital** | | |
| Balance at the beginning of the reporting period | 28,906 | 27,178 |
| Capital Contribution received from Victorian Government | 233 | 1,728 |
| Balance at the end of the reporting period | 29,139 | 28,906 |
| **(c) Accumulated Surpluses** | | |
| Balance at the beginning of the reporting period | 7,453 | 9,253 |
| Net Result for the Year | (1,083) | (1,800) |
| Balance at the end of the reporting period | 6,370 | 7,453 |
| **Total Equity at end of financial year** | 48,141 | 48,991 |

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

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

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

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

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

| | 2017 $'000 | 2016 $'000 |
|---|---|---|
| **NET RESULT FOR THE PERIOD** | (1,083) | (1,800) |
| **Non-cash movements** | | |
| Depreciation | 2,114 | 2,283 |
| Provision for Doubtful Debts | (12) | 17 |
| Share of Net Result from Jointly Controlled Operations | (93) | (178) |
| Write Down on Property, Plant and Equipment Stocktake | 0 | 490 |
| **Movements included in investing and financing activities** | | |
| Net (Gain)/Loss from Sale of Non-Financial Physical Assets | 0 | 171 |
| **Movements in assets and liabilities** | | |
| Change in Operating Assets & Liabilities | | |
| (Increase)/Decrease in Receivables | (216) | 158 |
| (Increase)/Decrease in Prepayments | (1) | (1) |
| Increase/(Decrease) in Payables | (15) | (164) |
| Increase/(Decrease) in Provisions | 195 | 98 |
| Change in Inventories | (3) | 9 |
| **NET CASH INFLOW FROM OPERATING ACTIVITIES** | 886 | 1,083 |

## NOTE 8.3: OPERATING SEGMENTS

| | RACS | | ACUTE | | OTHER SERVICES | | TOTAL | |
|---|---|---|---|---|---|---|---|---|
| | 2017 **$'000** | 2016 **$'000** | 2017 **$'000** | 2016 **$'000** | 2017 **$'000** | 2016 **$'000** | 2017 **$'000** | 2016 **$'000** |
| **REVENUE** | | | | | | | | |
| External Segment Revenue | 9,315 | 8,966 | 9,312 | 8,618 | 2,639 | 2,740 | 21,266 | 20,324 |
| Total Revenue | 9,315 | 8,966 | 9,312 | 8,618 | 2,639 | 2,740 | 21,266 | 20,324 |
| External Segment Expenses | (9,479) | (9,274) | (8,267) | (7,817) | (5,004) | (5,432) | (22,750) | (22,523) |
| **Segment Result** | (164) | (308) | 1,045 | 801 | (2,365) | (2,692) | (1,484) | (2,199) |
| **Net Result from ordinary activities** | (164) | (308) | 1,045 | 801 | (2,365) | (2,692) | (1,484) | (2,199) |
| Interest Income | 236 | 235 | 152 | 151 | 13 | 13 | 401 | 399 |
| **Net Result for Year** | 72 | (73) | 1,197 | 952 | (2,352) | (2,679) | (1,083) | (1,800) |
| **OTHER INFORMATION** | | | | | | | | |
| Segment Assets | 38,877 | 37,988 | 13,849 | 13,533 | 9,037 | 8,831 | 61,763 | 60,352 |
| **Total Assets** | 38,877 | 37,988 | 13,849 | 13,533 | 9,037 | 8,831 | 61,763 | 60,352 |
| Segment Liabilities | 2,446 | 2,040 | 2,178 | 1,817 | 8,998 | 7,504 | 13,622 | 11,361 |
| **Total Liabilities** | 2,446 | 2,040 | 2,178 | 1,817 | 8,998 | 7,504 | 13,622 | 11,361 |
| Depreciation expense | 1,346 | 1,672 | 480 | 354 | 313 | 274 | 2,139 | 2,300 |
| Acquisition of Property, Plant & Equipment | 673 | 2,877 | 240 | 1,025 | 156 | 668 | 1,069 | 4,570 |
| Non cash expenses other than depreciation | 10 | 11 | 14 | 16 | 1 | 1 | 25 | 28 |

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

| **Business Segments** | **Services** |
|---|---|
| Acute | Warracknabeal and Hopetoun |
| | Aged Care Services |
| | Primary Health Services |
| Residential Aged Care | Nursing Home Facilities |
| | Hostel Facilities |
| Other Services | Allied Health Services |
| | Primary Health Services |
| | Yarriambiack Rural Health Alliance |
| | District & Community Nursing |
| | Meals on Wheels |

**NOTE 8.3: OPERATING SEGMENTS**

**Geographical Segment**
Rural Northwest Health operates predominantly in Warracknabeal, Victoria. More than 90% of revenue, net surplus from ordinary activities and segment assets related to operations in Warracknabeal-Hopetoun-Beulah, Victoria.

**NOTE 8.4: RESPONSIBLE PERSONS DISCLOSURES**
In accordance with the Ministerial Directions issued by the Minister for Finance under the Financial Management Act 1994, the following disclosures are made regarding responsible persons for the reporting period.

| | Period |
|---|---|
| **Responsible Ministers:** | |
| The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services | 01/07/2016 - 30/06/2017 |
| The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health | 01/07/2016 - 30/06/2017 |
| **Governing Boards** | |
| Leo Casey | 01/07/2016 - 30/06/2017 |
| Sally Gebert | 01/07/2016 - 30/06/2017 |
| Matthew Richardson | 01/07/2016 - 30/06/2017 |
| Janette McCabe | 01/07/2016 - 30/06/2017 |
| Glenda Hewitt | 01/07/2016 - 30/06/2017 |
| Carolyn Morcom | 01/07/2016 - 30/06/2017 |
| Julia Hausler | 01/07/2016 - 30/06/2017 |
| Amanda Kenny | 07/03/2017 - 30/06/2017 |
| **Accountable Officer** | |
| Catherine Morley | 01/07/2016 - 30/06/2017 |

**Remuneration of Responsible Persons**
Remuneration received or receivable by responsible persons was in the range: $220,000 - $229,999 ($210,000 - $219,999 in 2015-16).

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

**NOTE 8.5: EXECUTIVE OFFICER DISCLOSURES**
**Remuneration of executive officers**

| | **2017** |
|---|---|
| | **$** |
| Short-term employee benefits | 503 |
| Post-employment benefits | 56 |
| Other long-term benefits | 11 |
| Termination benefits | 0 |
| Share-based payments | 0 |
| **Total Remuneration (b)** | 570 |
| **Total Number of executives (c)** | 4 |
| **Total annualised employee equivalent (AEE) (d)** | 4 |

Notes:
(a) No comparatives have been reported because remuneration in the prior year was determined in line with the basis and definition under FRD 21B. Remuneration previously excluded non-monetary benefits and comprised any money, consideration or benefit received or receivable, excluding reimbursement of out-of-pocket expenses, including any amount received or receivable from a related party transaction. Refer to the prior year's financial statements for executive remuneration for the 2015-16 reporting period.
(b) Remuneration represents the expenses incurred by the entity in the current reporting period for the employee, in accordance with AASB 119 Employee benefits
(c) The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of the entity under AASB 124 Related Party Disclosures and are also reported within the related parties note disclosure (Note 8.6).
(d) Annualised employee equivalent is based on the time fraction worked over the reporting period. This is calculated as the total number of days the employee is engaged to work during the week by the total number of full-time working days per week (this is generally five full working days per week).

## NOTE 8.6: RELATED PARTIES

The 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; and
- all hospitals and public sector entities that are controlled and consolidated into the whole of state consolidated financial statements.

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

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

| COMPENSATION | 2017 $'000 |
|---|---|
| Short term employee benefits | 206 |
| Post-employment benefits | 16 |
| Other long-term benefits | 5 |
| Termination benefits | 0 |
| Share based payments | 0 |
| **Total** | **227** |

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

Procurement processes occur on terms and conditions consistent with the Victorian Government Procurement Board requirements. Outside of normal citizen type transactions with the department, there were no related party transactions that involved key management personnel and their close family members. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

| Key Management Personnel | Position Title |
|---|---|
| Catherine Morley | Chief Executive Officer |

**Significant transactions with government-related entities**
Rural North West Health received funding from the Department of Health and Human Services of $11,114,000 (2016: $10,558,000).

During the year, Rural North West Health had the following other government-related entity transactions:
- Commonwealth Government funding received for health related programs totalling $6,497,000 (2016 $5,894,000).

## NOTE 8.7: REMUNERATION OF AUDITORS

| | 2017 $'000 | 2016 $'000 |
|---|---|---|
| **Victorian Auditor-General's Office** | | |
| Audit or review of financial statements | 23 | 23 |
| | 23 | 23 |

**NOTE 8.8: AASBs ISSUED THAT ARE NOT YET EFFECTIVE**

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2017 reporting period.

As at 30 June 2017, the following standards and interpretations had been issued by the AASB but were not yet effective.
They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below.
Rural Northwest Health has not and does not intend to adopt these standards early.

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

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

| Standard / Interpretation | Summary | Applicable for reporting periods beginning on | Impact on Health Service's Annual Statements |
|---|---|---|---|
| *AASB 2014-5 Amendments* to Australian Accounting *Standards arising from AASB 15* | Amends the measurement of trade receivables and the recognition of dividends.<br>Trade receivables, that do not have a significant financing component, are to be measured at their transaction price, at initial recognition.<br>Dividends are recognised in the profit and loss only when:<br>- the entity's right to receive payment of the dividend is established;<br>- it is probable that the economic benefits associated with the dividend will flow to the entity; and the amount can be measured reliably. | 1 Jan 2017, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018 | The assessment has indicated that there will be no significant impact for the public sector. |
| *AASB 2015-8 Amendments to Australian Accounting Standards – Effective Date of AASB 15* | This Standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018. | 1 January 2018 | This amending standard will defer the application period of AASB 15 for for-profit entities to the 2018-19 reporting period in accordance with the transition requirements. |
| *AASB 2016-3 Amendments to* Australian Accounting Standards *– Clarifications to AASB 15* | This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require:<br>- A promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation;<br>- For items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer; and<br>- For licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access). | 1 January 2018 | The assessment has indicated that there will be no significant impact for the public sector, other than the impact identified for AASB 15 above. |
| *AASB 2016-7 Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities* | This Standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019. | 1 January 2019 | This amending standard will defer the application period of AASB 15 for not-for-profit entities to the 2019-20 reporting period. |
| *AASB 2016-8 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities* | This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events. The amendments<br>- require non-contractual receivables arising from statutory requirements (i.e. taxes, rates and fines) to be initially measured and recognised in accordance with AASB 9 as if those receivables are financial instruments; and<br>- clarifies circumstances when a contract with a customer is within the scope of AASB 15. | 1 January 2019 | The assessment has indicated that there will be no significant impact for the public sector, other than the impacts identified for AASB 9 and AASB 15 above. |

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

| **Standard / Interpretation** | **Summary** | **Applicable for reporting periods beginning on** | **Impact on Health Service's Annual Statements** |
|---|---|---|---|
| *AASB 16 Leases* | The key changes introduced by AASB 16 include the recognition of most operating leases (which are current not recognised) on balance sheet. | 1 January 2019 | The assessment has indicated that as most operating leases will come on balance sheet, recognition of the right-of -use assets and lease liabilities will cause net debt to increase.<br>Rather than expensing the lease payments, depreciation of right-of-use assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus.<br><br>No change for lessors. |
| *AASB 2016-4 Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities* | The standard amends AASB 136 Impairment of Assets to remove references to using depreciated replacement cost (DRC) as a measure of value in use for not-for-profit entities. | 1 January 2017 | The assessment has indicated that there is minimal impact. Given the specialised nature and restrictions of public sector assets, the existing use is presumed to be the highest and best use (HBU), hence current replacement cost under AASB 13 Fair Value Measurement is the same as the depreciated replacement cost concept under AASB 136. |
| **Standard / Interpretation** | **Summary** | **Applicable for reporting periods beginning on** | **Impact on Health Service's Annual Statements** |
| *AASB 1058 Income of Not-for-Profit Entities* | This standard replaces AASB 1004 Contributions and establishes revenue recognition principles for transactions where the consideration to acquire an asset is significantly less than fair value to enable to not-for-profit entity to further its objectives. | 1 January 2019 | The assessment has indicated that revenue from capital grants that are provided under an enforceable agreement that have sufficiently specific obligations, will now be deferred and recognised as performance obligations are satisfied. As a result, the timing recognition of revenue will change. |

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

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

**NOTE 8.9: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE**

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

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

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

**NOTE 8.10: ALTERNATIVE PRESENTATION OF COMPREHENSIVE OPERATING STATEMENT**

| | 2017 $'000 | 2016 $'000 |
|---|---|---|
| Grants | | |
| Operating | 17,518 | 16,232 |
| Capital | 46 | 110 |
| Interest | 401 | 399 |
| Sales of goods and services | 2,589 | 2,732 |
| Other | 1,113 | 1,250 |
| **Revenue from Transactions** | **21,667** | **20,723** |
| Employee expenses | 15,080 | 14,304 |
| Depreciation | 2,139 | 2,300 |
| Other operating expenses | 5,395 | 5,259 |
| Other non-operating expenses | 174 | 490 |
| **Expenses from Transactions** | **22,788** | **22,353** |
| **Net Result From Transactions - Net Operating Balance** | **(1,121)** | **(1,630)** |
| **Other economic flows included in net result** | | |
| Net gain/ (loss) on sale of non-financial assets | 0 | (171) |
| Other gains/ (losses) from other economic flows included in net result | 38 | 1 |
| **Total Other Economic Flows Included in Net Result** | **38** | **(170)** |
| **NET RESULT FOR THE YEAR** | **(1,083)** | **(1,800)** |
| **Other Comprehensive Income** | **0** | **0** |
| **COMPREHENSIVE RESULT** | **(1,083)** | **(1,800)** |

**RURAL NORTHWEST HEALTH**

**BOARD MEMBER'S, ACCOUNTABLE OFFICERS AND CHIEF FINANCE AND ACCOUNTING OFFICER'S 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.

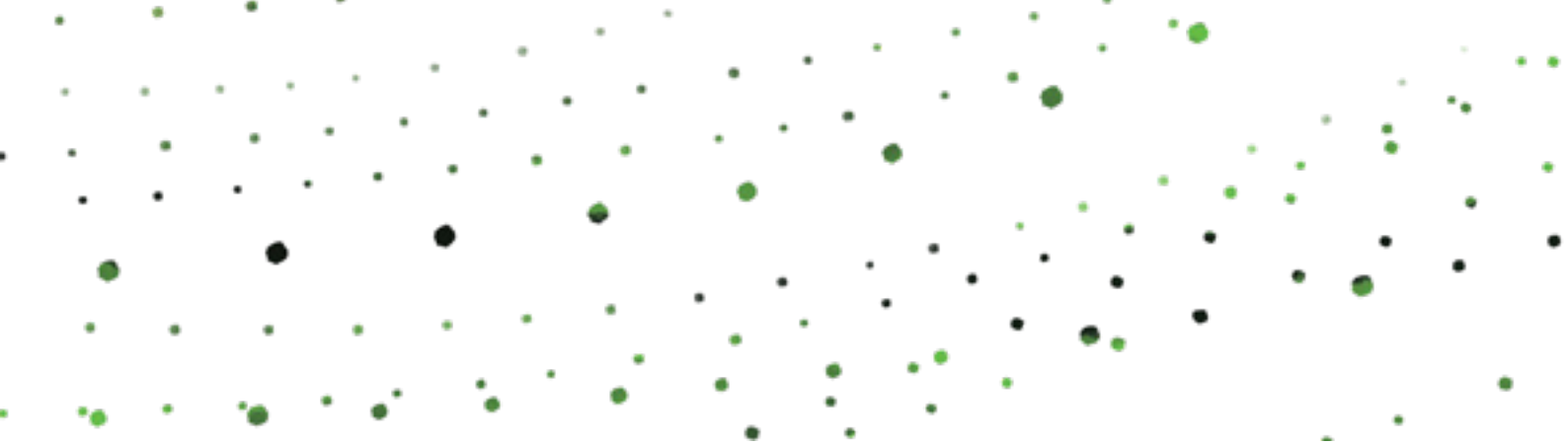
We further state that, in our opinion, the information set out in the Comprehensive Operating Statement, Balance Sheet, Statement of Changes in Equity, Cash Flow Statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2017 and financial position of Rural Northwest Health at 30 June 2017.

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

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

| | | |
|---|---|---|
| Leo Casey | Catherine Morley | Andrew Arundell |
| Board Member | Accountable Officer | Contract Finance & Accounting Officer |
| Warracknabeal | Warracknabeal | Warracknabeal |
| 25th August 2017 | 25th August 2017 | 25th August 2017 |

# Notes



RURAL northwest HEALTH
centred on you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