RURAL northwest HEALTH

centred on you

Annual Report 2017-2018

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

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Responsible bodies declaration

In accordance with the Financial Management Act 1994 I am pleased to present the report of operations for Rural Northwest Health for the year ending 30 June 2018

Julia Hausler

BOARD CHAIRPERSON
WARRACKNABEAL

5 September 2018

Vision

MOVING TOGETHER THROUGH CHANGE TO PROVIDE INNOVATIVE RURAL HEALTH CARE

Mission

RURAL NORTHWEST HEALTH WILL PROVIDE ACCESSIBLE, EFFICIENT AND EXCELLENT CARE TO OUR COMMUNITY WITHIN THE WIMMERA MALLEE REGION

Strategic direction

BUILD BUSINESS CAPACITY

RESPOND BRAVELY AND INNOVATIVELY TO OPPORTUNITIES THAT IMPROVE LOCAL HEALTH OUTCOMES.

This report

Covers the period 1 July 2017 to 30 June 2018

Is prepared for the Minister for Health, the Parliament of Victoria and the community

- Is prepared in accordance with government and legislative requirements and FRD 30D guidelines
- Will be presented to the community at the Rural Northwest Health Annual General Meeting on 27 November 2018
- Should be read in conjunction with our Quality Account 2018 (both documents are available on our website and at all our sites)
- Acknowledges the support of our community
- Is printed with 100% recycled stock

Rural Northwest Health acknowledges the support of the Victorian Government

VICTORIA State Government

Board Chairperson & Chief Executive Officer report

It is with great pleasure that I present the 2017-18 Annual Board of Directors Report for Rural Northwest Health. Rural Northwest Health Directors are committed to improving local health outcomes for communities in the Northern Wimmera and Southern Mallee. The mission of providing accessible, efficient and excellent care to community members is front of mind when making Board decisions.

Rural Northwest Health has steadfastly delivered quality care for people who access services over the past year. This requires 290 team members to work together with a common purpose of meeting targets, whilst delivering high quality and safe care. The annual service awards highlight the dedication of team members with this years' award winners giving a combined 230 years of service.

To meet the strategic objective of building business capability the Board of Directors recognises that all team members make a valuable contribution to Rural Northwest Health. The executive team should be acknowledged for their leadership and successes in keeping the health service moving forward over the past year. Staff have completed extensive essential training delivered under the 'Twist of Oz' theme, and Directors are delighted with the impressive staff 90% flu immunisation result.

Rural Northwest Health proved very successful on the State and National stage last year collecting two prestigious awards. In the Victorian Healthcare Awards, Rural Northwest Health won the Excellence in public sector aged care award. At a national level Rural Northwest Health as a key partner in the Yarriambiack Shire YCHANGE initiative, were pleased when YCHANGE won the National Heart Foundation Recognising Healthy Communities Award.

The period 2017-18 has seen a multitude of changes at Rural Northwest Health. The introduction of Community Wellbeing Coordinators has made a substantial impact on the lives of community members living with chronic conditions. Kathy Poulton's work as a Wellbeing Coordinator was celebrated with a win at the annual Rural Northwest Health Betty Richardson Awards night. A new clinical information system BOSSNET, has been successfully introduced and there have been increased consultations using the Royal Flying Doctors Service Telehealth program.

Improving infrastructure to support health service delivery is an extremely important focus of the Rural Northwest Health Directors. Some of the infrastructure programs undertaken in 2017-18 included two new houses in Warracknabeal, signing a contract for two news houses in Hopetoun and ongoing maintenance of the existing real estate portfolio. Further infrastructure investment has been made to the multi-purpose therapeutic 'wellness' garden with the gazebo quickly taking the shape of the old hospital.

Maintaining quality infrastructure is an important strategic direction of the Board and is closely linked to recruiting and retaining high quality staff and ensuring the health and wellbeing of the community. Investing in housing in particular is an important support for staff transitioning into our region. The Board look forward to adding further infrastructure projects in 2018/19 whilst maintaining strong fiscal sustainability.

In February the Directors and members of the executive team were extremely fortunate to have a strategic thinking and planning day with Dr Stephen Duckett, Director of Health Programs at the Grattan Institute and author of the "Targeting Zero" report. Learnings from this day included - question more broadly, review practices and processes regularly, don't compromise governance and challenge ourselves towards continuous improvement.

Catherine Morley as Chief Executive Officer was farewelled after eight years in late 2017, and Director Sally Gebert after two and half years. On 30 June 2018, long term Director Leo Casey (10 years) will be farewelled. Leo is a former Board Chair and an outstanding contributor to the Board and all aspects of Rural Northwest Health, especially the garden. We welcomed Professor Amanda Kenny as a Director in 2017 and have valued her experience in rural health and governance.

All members of the Board are dedicated, putting in many hours of their own time to move Rural Northwest Health strategically forward. I thank my fellow Directors for their support as we build better health outcomes for the local communities.

Julia Hausler

GAICD

BOARD CHAIRPERSON

Craig Wilding

ACTING CHIEF EXECUTIVE OFFICER

Betty Richardson Award 2018

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 Kathleen Poulton, Wellbeing Coordinator; Jodie Malcolm, Activities Worker Hopetoun; Leonie Cheney, Environmental Services Warracknabeal; Gay Seebohm, Registered Nurse Hopetoun; Heath McGrath and Jamie Horton, Environmental Services Warracknabeal.

The Betty Richardson awards night also celebrated 230 years of service to the organisation from 11 team members.

Kathleen Poulton was announced as the recipient of the Betty Richardson Award for 2018.

Employer Excellence in Aged Care Award

Rural Northwest Health won the public sector excellence in aged care award for its exclusive ABLE model of care and the extension of its memory support nurse.

The award was open to every public aged care service in Victoria and it comes on the back of another state award. Rural Northwest Health was announced the winners of Employer Excellence in Aged Care at Victoria's Regional Achievement and Community Awards.

The aged care team has a wonderful understanding of the ABLE model that we created a few years ago and that's why it works so well for our residents, especially those living with dementia. The importance of the ABLE model is that it's not just about the care team. Environmental Services also play an important role, as do Community Health clinicians so it's a genuine team effort.

Rural Northwest Health's ABLE model focuses on the ability of each individual resident so they have continued capacity and the opportunity to keep doing things that they want to do. Its fundamental principles are Abilities, Background – focusing on the individual, Leadership and organisational culture and Environment – physically stimulating, welcoming and ability focused.

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

Our Strategic Goals are

a. Building Business Capability, and

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

STRATEGIC OBJECTIVE	ACTIONS	PROGRESS
Support strong governance and leadership	Rural Northwest Health continues to review and expand the capacity and capability of our Board Directors, our Executive and our key clinical roles. Our Board Directors and Executive undertake training and mentorship education enhancing our leadership capabilities and strengthening our regional relationships. Our governance structures are in place meeting the reporting and oversight requirements of the Rural Northwest Health Board of Directors	**Ongoing**
Increase workforce capability and capacity	The health and wellbeing of our team members is a priority. We work hard to ensure team members have a positive response to safety and culture and we endeavour to provide an environment that is free from bullying. We have introduced the principles of 'FISH' (Choose your attitude, be there in the moment, have fun and make someone's day) which has been successfully adopted by our team members across Rural Northwest Health. Management constantly seek feedback from our team members to improve our working environment	**Ongoing**
Utilise, preserve and enhance the infrastructure to maintain safe and efficient workplaces and residential services	We have enhanced our ICT systems through the introduction of a regional electronic patient information system. We continue to build accommodation to support our team members. Our preventative maintenance systems ensure compliance and efficient use of our existing infrastructure and resources. Our new community health wing is efficiently utilised by our health professionals and our community members	**Achieved**
Maintain financial stability	This is the eight successive year of an above budget result which supports our Board and Executive in maintaining and expanding our existing health care services to the Yarriambiack Community	**Achieved**
Develop and maintain productive partnerships	We are key stakeholders of the Wimmera and Southern Mallee Health Alliance, working together on initiatives that enhance health care services, quality and safety. Rural Northwest Health will continue to work closely with universities and specifically funded organisations on projects that demonstrate improved health and wellbeing outcomes for our community members	**Ongoing**
Identify and implement optimal models of care	Our Acute and Community health units have developed and implemented an ABLE model of care that is holistic, and demonstrates a focus on maintaining and improving the health and wellbeing of our community members with the aim of reducing our hospital admissions. We continue to achieve our targets and deliver the care required to address chronic illness within our region with the support of the Primary Health Network	**Ongoing**
Establish transition models that enable community members to have a good experience when accessing services outside of Rural Northwest Health	We have worked closely with our funding bodies and partners to develop innovative models of care that provide services as close to home as possible across a range of health conditions. We have developed hubs in our catchment area with our health care partners to utilise and support telehealth technology to assist in improving health outcomes for our community members	**Ongoing**
Increase health literacy about actions community members should undertake to keep well and living at home	We identified two local health priorities areas this year that have been actioned. Rural Northwest Health actively engaged with our community through forums on both Living with Dementia and Advanced Care Directives	**Achieved**

About Rural Northwest Health

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

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

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

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

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

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

Responsible Ministers

The responsible Ministers during the reporting period were:

- The Honourable Jill Hennessy MP, Minister for Health, Minister for Ambulance Services
  1 July 2017 to 30 June 2018
- The Honourable Martin Foley MP, Minister for Mental Health, Minister for Housing, Disability and Ageing, Minister for Creative Industries, Minister for Equality
  1 July 2017 to 30 June 2018

History

1999

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

2001

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

2008

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

2016

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

AFTER HOURS

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

ACUTE CARE

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

AGED CARE

Warracknabeal and Hopetoun campuses provide aged care services including:

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

SPECIALTY SERVICES

- Ear, nose and throat
- Cardiology

MEDICAL IMAGING

- X-ray and ultrasound (Warracknabeal)

SUPPORT SERVICES

- Carer support services
- Volunteer program

COMMUNITY HEALTH

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

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

ALLIED HEALTH

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

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

Part A: Strategic priorities 2017-18

In 2017-2018 Rural Northwest Health will contribute to the achievement of the Victorian Government's commitments by:

GOALS	STRATEGIES	DELIVERABLES	OUTCOMES
Better Health **A system geared to prevention as much as treatment** **Everyone understands their own health and risks** **Illness is detected and managed early** **Healthy neighbourhoods and communities encourage healthy lifestyles**	Better Health **Reduce statewide risks** **Build healthy neighbourhoods** **Help people to stay healthy** **Target health groups**	In partnership with Deakin University and the YCHANGe project, a fuelling your body program will be introduced at the local sporting clubs. Rural Northwest Health will provide a safe performance enhancing meal at training sessions along with education sessions and monitor the effectiveness of this strategy.	Successful ongoing partnership with Deakin University Yarriambiack Creating, Healthy, Active, Nourished Generations (YCHANGe) project introduced 'healthier choices' at local kindergartens, YarriYak Café, schools and Warracknabeal Eagles football/netball club and other community settings Evaluation to date shows improvements in the health of food brought to kindergarten, sales of and acceptance of healthier options in the café and sports club Further outcomes associated with education, training and the sustainability of healthy behaviour and environmental changes are being evaluated
		Rural Northwest Health's new community model of care for community members living with chronic disease will be introduced in July 2017. Research will be undertaken with Latrobe University and measure if community members have developed individual care plans and the satisfaction with the assistance provided by the Wellbeing Coordinators in managing and improving their wellbeing.	Primary Health Network targets associated with delivery of treatments and care for chronic illness have been achieved Ethics approval through La Trobe University has been completed Further research to be undertaken to collect and evaluate consumer satisfaction data
		Rural Northwest Health will engage with community groups and run information sessions throughout the year to support them to understand advanced care planning. Wellbeing Coordinators will be available to assist community members to document their personal advance care directives and share them with local health practitioners and personal stakeholders to ensure they are implemented as per their individual wishes.	Advance Care Planning community forums successfully completed throughout the last twelve months Trained Wellbeing Coordinators and District Nursing staff are in place to assist community members to document their personal advance care plans
		Rural Northwest Health will work in partnership with Ballarat Health Services, West Vic Primary Health Network, Grampians Community Health, Wimmera Uniting Care, Local Practitioners and community members to develop a responsive and timely mental health service system across the northern end of the Yarriambiack shire. The service system will be documented and be transferable across the shires in the Wimmera Southern Mallee region.	Wimmera Primary Care Partnership has appointed a Project Officer to lead the mental health pathway mapping for the region Rural Northwest Health remains a key stakeholder in the development of this work

Part A: Strategic priorities 2017-18

GOALS	STRATEGIES	DELIVERABLES	OUTCOMES
Better Access **Care is always there when people need it** **More access to care in the home and community** **People are connected to the full range of care and support they need** **There is equal access to care**	Better Access **Plan and invest** **Unlock innovation** **Provide easier access** **Ensure fair access**	In partnership with Ballarat Health Services, Wimmera Southern Mallee Health Alliance and Stawell Regional Health, Rural Northwest Health will develop and implement protocols based on clinical capability of each health service to provide safe and appropriate inter agency patient transfers.	Capability Framework developed in collaboration with Grampians Regional Health Services PROMPT document management system implemented providing access to protocols, policies and procedures of other health services in relation to clinical governance Three year project underway through Safer Care Victoria Emergency Clinical Care Network to review community to hospital and hospital to hospital transfer. Rural Northwest Health provides membership on this network Rural Northwest has ongoing representation on the Wimmera Southern Mallee Health Alliance partnership to address complex problems associated with 'hospital to hospital' transfer
		Rural Northwest Health will participate in the development of the rural and regional partnerships plan that includes developing and implementing a regional clinical governance model that involves cross agency clinical governance processes and articulates the clinical governance support to be led by Ballarat Health Services.	Rural Northwest Health participating in regional Chief Executive Officer forums and regional Clinical Governance forums Clinical audit tool has been developed and will be used to assess Rural Northwest Health against the Safer Care Victoria Clinical Governance Framework criteria
		Rural Northwest Health will work in partnership with Swinburne University and local community groups to undertake research on the role of boundary spanners in supporting marginalised community members to access health services. Rural Northwest Health will utilise this research to develop and implement strategies to support increased usage of health services by marginalised community members.	Rural Northwest Health has participated for the past 18 months of a continuing three year PhD research project into the role of boundary spanners supporting marginalised community members to access health services
		Rural Northwest Health in partnership with Royal Flying Doctors Service will expand a specialist telehealth service. Services will be expanded to support community members living with diabetes, cardiovascular respiratory, psychiatric, and gastroenterology disease to have timely and effective access to specialist care and expertise. Support will be provided by the Wellbeing Coordinators and the program will be evaluated by Latrobe university to measure uptake and satisfaction by community members of the service.	Royal Flying Doctors Service Telehealth pathways are utilised in assisting patients with health conditions such as diabetes, cardiovascular and respiratory disease and psychiatry consultations A Memorandum of Understanding continues with Royal Flying Doctors Service to further develop Telehealth services to our community

Part A: Strategic priorities 2017-18

GOALS	STRATEGIES	DELIVERABLES	OUTCOMES
Better Care Target zero avoidable harm Healthcare that focuses on outcomes Patients and carers are active partners in care Care fits together around people's needs	**3 mandatory actions against the 'Target zero avoidable harm' Goal:** **Establish agreements to involve external specialists in clinical governance processes for each major area of activity (including mortality and morbidity review)**	Rural Northwest Health in partnership with Ballarat Health Services and the Wimmera Southern Mallee Health alliance will introduce a new model of clinical governance. External specialists will be accessed to review the model of care provided in acute community and residential care. Review findings will be reported at the Clinical Governance meeting and resulting actions and KPI's will be reported to the Board of Management.	All service delivery models are focussed on providing quality and safe care. Key Performance Indicators developed and monitored through sub-board and Board of Management committees Health and Wellbeing Coordinators and District Nursing support those in the community with a chronic illness Primary Health network targets have been achieved Clinical audit tool developed to assess Rural Northwest Health against Safer Care Victoria clinical governance framework
	In partnership with consumers, identify 3 priority improvement areas using Victorian Healthcare Experience Survey data and establish an improvement plan for each. These should be reviewed every 6 months to reflect new areas for improvement in patient experience.	Rural Northwest Health will engage with clients accessing acute services bi monthly to identify opportunities to improve services. This will include reviewing the Victorian Healthcare Experience Survey Data if a report is available. Resulting actions will be documented on the continuous improvement plan and reported to the board of management bi monthly.	Bi-monthly feedback lunches are held in Warracknabeal with actions created, monitored, reported to Board of Management sub-committees and appropriate feedback provided: • Privacy curtains purchased and installed • Implementation of digital Patient Information System (BOSSnet) to assist in improvement of discharge information to support consumers upon discharge form Rural Northwest Health • Acute waiting room improvements made as per consumer feedback (Installation of a television and DVD player and the purchase of children's toys and activities)
	Develop and implement a plan to educate staff about obligations to report patient safety concerns	Rural Northwest Health will work in partnership with Wimmera Southern Mallee Alliance members to continue to educate team members about their obligations to report patient safety concerns. Training statistics will be reported to the clinical governance committee	Staff education on Safer Care Victoria and obligation to report delivered at Rural Northwest Health annual training event in May 2018 Obligation to report patient safety concerns is being promoted across Rural Northwest Health through the health services newsletter and in team meetings
	Better Care • **Put quality First** • **Align care** • **Partner with patients** • **Strengthen the workforce** • **Embed evidence into practice** • **Ensure equal care**	Rural Northwest Health's Board of Management will review the clinical Key Performance Indicators bi monthly to ensure that the operational team are improving health outcomes as identified by external clinical reviews, client feedback and audit results. These improvements will be noted in the Quality Account for 2017-18 and reported at the Annual General meeting	Clinical KPIs continue to be reviewed

Part B: Performance priorities

QUALITY AND SAFETY

Key performance indicator	Target	2017-18 results
Accreditation		
Accreditation against the National Safety and Quality Health Service Standards	Full compliance	**Achieved**
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	**Achieved**
Infection prevention and control		
Compliance with the Hand Hygiene Australia program	80%	**93.5%**
Percentage of healthcare workers immunised for influenza	75%	**84%**
Patient experience		
Data submission	Full compliance	**Achieved**
Patient experience – Quarter 1	95% positive experience	**Full compliance***
Patient experience – Quarter 2	95% positive experience	**Full compliance***
Patient experience – Quarter 3	95% positive experience	**Full compliance***
Discharge care – Quarter 1	75% very positive experience	**Full compliance***
Discharge care – Quarter 2	75% very positive experience	**Full compliance***
Discharge care – Quarter 3	75% very positive experience	**Full compliance***
Patients perception of cleanliness – Quarter 1	70%	**Full compliance***
Patients perception of cleanliness – Quarter 2	70%	**Full compliance***
Patients perception of cleanliness – Quarter 3	70%	**Full compliance***
*Less than 42 responses were received for the period due to the relative size of the health service		
Adverse events		
Number of sentinel events	Nil	**1**
Mortality – number of deaths in low mortality DRGs[1]	Nil	**N/A***
1 DRG is Diagnosis Related Group		

*This indicator was withdrawn during 2017/18 and is currently under review by the Victorian Agency for Health Information

STRONG GOVERNANCE AND LEADERSHIP

Key performance indicator	Target	2017-18 results
Organisational culture – People Matter Survey		
Percentage of staff with an overall positive response to safety and culture questions	80%	**95%**
Percentage of staff with an overall positive response to the question:		
'I am encouraged by my colleagues to report any patient safety concerns I may have'	80%	**98%**
'Patient care errors are handled appropriately in my work area'	80%	**97%**
'My suggestions about patient safety would be acted upon if I expressed them to my manager'	80%	**95%**
'The culture in my work area makes it easy to learn from the errors of others'	80%	**93%**
'Management is driving us to be a safety-centred organisation'	80%	**97%**
'This health service does a good job of training new and existing staff'	80%	**92%**
'Trainees in my discipline are adequately supervised'	80%	**88%**
'I would recommend a friend or relative to be treated as a patient here'	80%	**95%**

Part B: Performance priorities

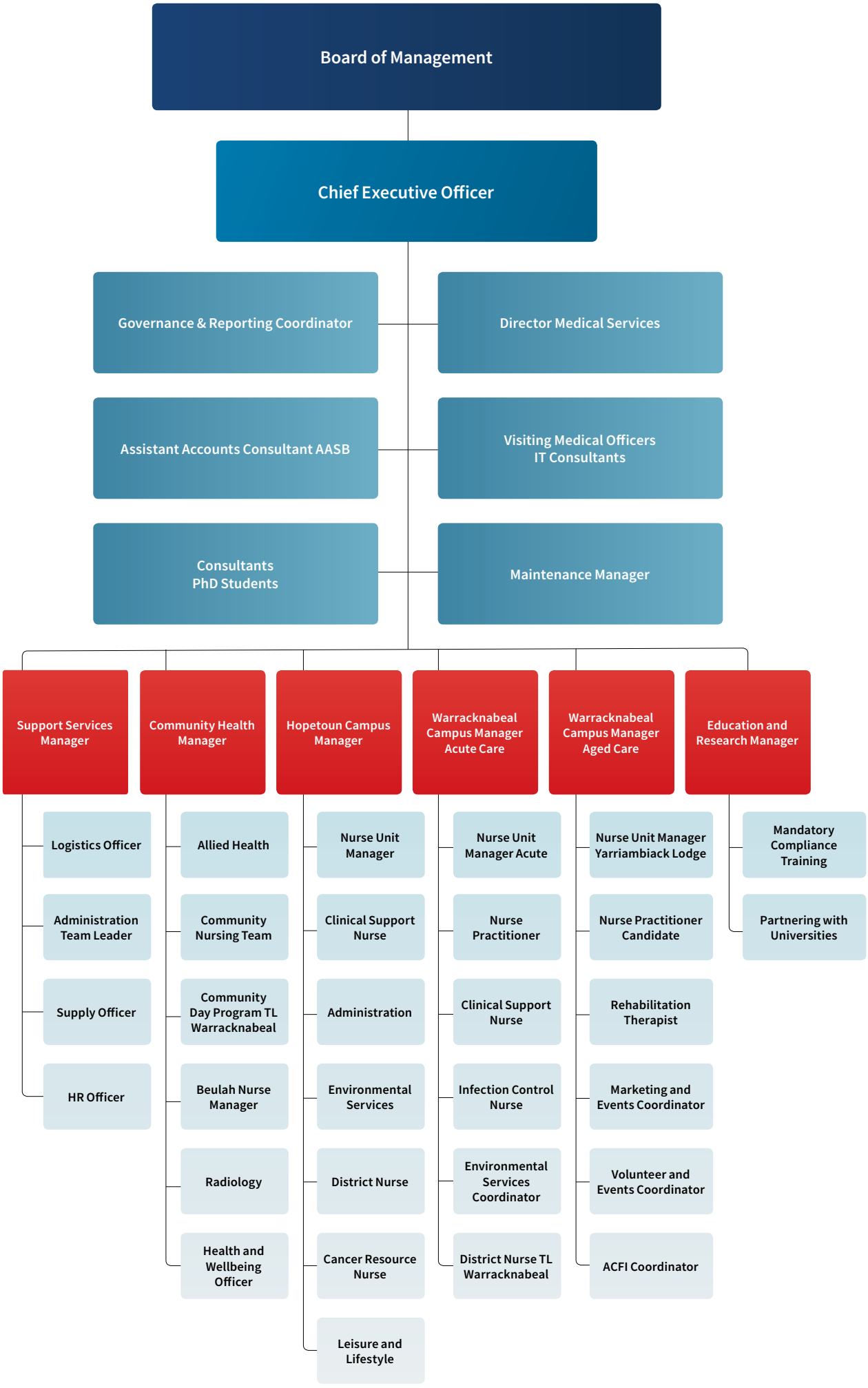
EFFECTIVE FINANCIAL MANAGEMENT

Key performance indicator	Target	2017-18 results
Finance		
Operating result ($m)	0.33	**2.11**
Average number of days to paying trade creditors	60 days	**51 days**
Average number of days to receiving patient fee debtors	60 days	**18 days**
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	**Achieved**
Number of days with available cash	14 days	**185 days**

Part C – Activity and funding

FUNDING TYPE	ACTIVITY	
Small Rural		
Small rural acute		**66**
Small rural primary health		
- Allied health	Allied health hours	**5560**
- Counselling	Contact hours	**1000**
Small rural HACC		
- Podiatry	Service hours	**121**
- Nursing	Service hours	**524**
- Planned Activity Group	Service hours	**365**
Small rural residential care	Bed days	**28313**
Health workforce	Number of students (T & D graduate)	**6**

Organisational Structure



The Rural Northwest Health Board of Management consists of persons appointed by the Minister for Health under the Act who are empowered to provide strategic direction for the organisation. While the board provides direction for the organisation and determines what must be done, the responsibility for determining how services are delivered is invested in the Chief Executive Officer.

The functions of the board of Rural Northwest Health are:

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

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

This year we farewelled Sally Gebert as Chairperson with Julia Hausler taking over as Chairperson to the end of the 2017-2018 financial year. We thank Sally for her contribution to Rural Northwest Health over the past two and a half years.

We also farewell Leo Casey who previously held the position of Chairperson for five years and has served on the Board of Management since 25 September 2007. We thank Leo for his contribution over the past 11 years.

Board Chairperson

Julia Hausler

First appointment: 1 July 2016

Board Member

Leo Casey

First appointment:
25 September 2007

End of term:
30 June 2018

Deputy Chairperson

Janette McCabe

First appointment:
1 July 2012

Board Member

Glenda Hewitt

First appointment:
1 July 2010

Board Member

Carolyn Morcom

First appointment:
1 July 2012

Board Member

Professor Amanda Kenny

First appointment:
7 March 2017

Board Member

Sally Gebert

First appointment:
1 July 2015

Resigned:
February 2018

Executive Team

Acting Chief Executive Officer

Craig Wilding

BOARD GOVERNANCE AND REPORTING, FINANCE

Support Services Manager

Joanne Martin

ADMINISTRATION, PAYROLL, SUPPLY, HUMAN RESOURCES

Warracknabeal Campus Manager Acute Care

Wendy James

ACUTE, URGENT CARE, DISTRICT NURSING, ENVIRONMENTAL SERVICES

Warracknabeal Campus Manager Aged Care

Wendy Walters

AGED CARE, COMMUNITY MEMORY SUPPORT, QUALITY

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, ALLIED HEALTH

Manager Education and Research

Dr Kaye Knight

EDUCATION, RESEARCH

Board of Management

Board committees

Finance Audit and Compliance Committee (FACC)

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

Board representatives of the committee are Julia Hausler (Chairperson), Leo Casey and Amanda Kenny.

Governance Committee

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

Members of the committee are Janette McCabe (Chairperson), Julia Hausler, Leo Casey, 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), Amanda Kenny 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 Leo Casey.

Hopetoun Beulah Reference Group (HBRG)

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

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

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.

Workforce data

Rural Northwest Health recruits high quality team members with the right skills to deliver the key objectives of the position, business unit and organisation an d 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	
	2018	**2017**	**2018**	**2017**
Nursing	67.99	68.24	69.80	70.44
Administration and clerical	20.79	16.52	20.02	20.6
Medical support	0.66	1.08	1.04	0.34
Hotel and allied services	70.3	77.46	73.51	70.29
Medical officers	0	0	0	0
Hospital medical officers	0	0	0	0
Sessional clinicians	0	0	0	0
Ancillary staff (Allied Health)	16.02	14.77	14.11	17.57

Life Governors

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

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

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

Rural Northwest Health Life Governors are:

Ken Healey

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

Leonard Shannon

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

Michael Lawlor

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

Alan Turnbull

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

Genevieve Lehmann

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

Alan Malcolm

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

Colin Natt

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

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

Max Gibson

Inaugural Rural Northwest Health Life Governor 2012

Marie Aitken

2014

Les Solly

2014

Jean Webster

2017

Occupational Health and Safety Act 2004

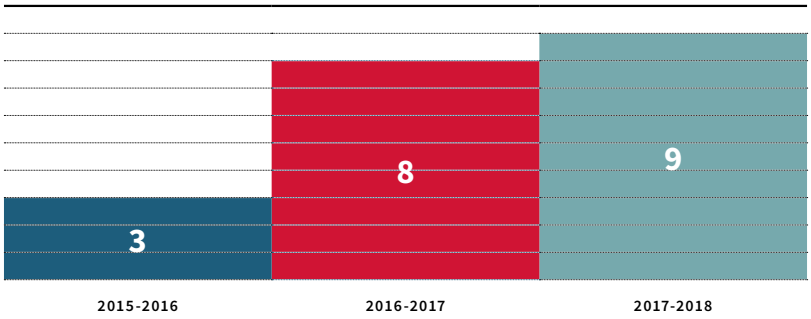
Rural Northwest Health is responsible for the health and safety of all team members in the work place. To fulfil this responsibility we have a duty to maintain a working environment that is safe and without risks to residents, clients, visitors and our team members' health.

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

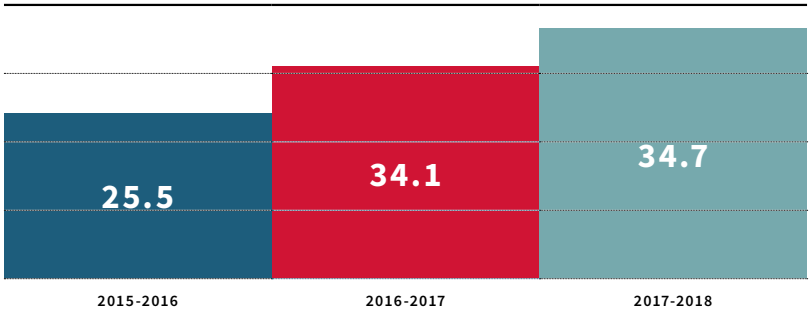
- Effective implementation of Occupational Health and Safety policy and protocols.
- Providing opportunities for regular discussion between the Board, leadership and management team and team members.
- Providing information, training and supervision for all team members in correct use of plant, equipment,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

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

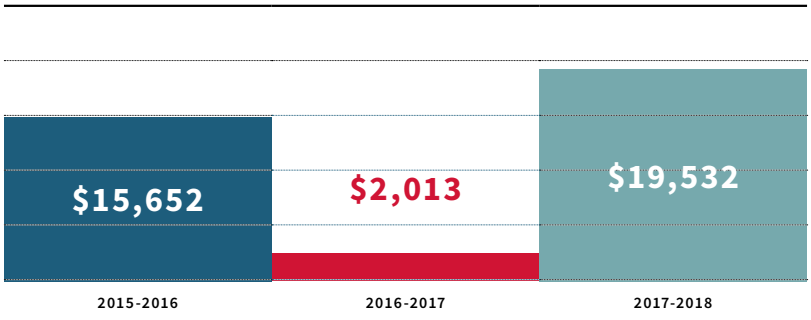
WorkCover claims



Hazards/incidents per 100 FTE



Average cost per claim



OCCUPATIONAL VIOLENCE STATISTICS	2017-18	2016-17
WorkCover accepted claims with an occupational violence cause per 100 FTE	1.5	1.6
Number of acceptance WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 worked	3	3
Number of occupational violence incidents reported	27	18
Number of occupational violence incidents reported per 100 FTE	9	10
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	33.30%	55.6%

Freedom of Information (FOI)

Rural Northwest Health has received three requests for information under the Freedom of Information Act (1982) during the 2017-18 financial year, a decrease on the previous financial year

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

Building and maintenance

All building works comply with the Building Act 1993

Protected Disclosure Act 2012

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

Competitive neutrality

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

Additional information available on request

Consistent with FRD 22H (Section 5:19) details in respect of the items listed below have been retained by Rural Northwest Health and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements, if applicable):

- **a.** Declaration of pecuniary interests have been duly completed by all relevant officers
- **b.** Details of shares held by senior officers as nominee or held beneficially
- **c.** Details of publications produced by the entity about itself, and how these can be obtained
- **d.** Details of changes in prices, fees, charges, rates and levies charged by the health service
- **e.** Details of any major external reviews carried out on the health service
- **f.** Details of major research and development activities undertaken by the health service that are not otherwise covered either in the report of operations or in a document that contains the financial statements and report of operations
- **g.** Details of overseas visits undertaken including a summary of the objectives and outcomes of each visit
- **h.** Details of major promotional, public relations and marketing activities undertaken by the health service to develop community awareness of the health service and its services
- **i.** Details of assessments and measures undertaken to improve the occupational health and safety of employees
- **j.** General statement on industrial relations within the health service and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the report of operations
- **k.** A list of major committees sponsored by the health service, the purposes of each committee and the extent to which those purposes have been achieved
- **l.** Details of all consultancies and contractors including consultants/contractors engaged, services provided and expenditure committed for each engagement.

Craig Wilding

ACCOUNTABLE OFFICER
WARRACKNABEAL

5 September 2018

Attestations

Data integrity

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

Craig Wilding

ACCOUNTABLE OFFICER
WARRACKNABEAL

5 September 2018

Conflict of interest

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

Craig Wilding

ACCOUNTABLE OFFICER
WARRACKNABEAL

5 September 2018

Compliance with Health Purchasing Victoria (HPV) Health Purchasing policies

I, Craig Wilding, 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

Craig Wilding

ACCOUNTABLE OFFICER
WARRACKNABEAL

5 September 2018

Compliance with financial management

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

Julia Hausler

CHAIRPERSON
WARRACKNABEAL

5 September 2018

Financial Overview

Rural Northwest Health is delighted to report a net surplus before capital and specific items of $2,099,000 and an entity surplus of $32,000 after capital depreciation for the year ending 30 June 2018

FINANCE SUMMARY - 5 YEARS 2013-14 TO 2017-18	2018 $'000	2017 $'000	2016 $'000	2015 $'000	2014 $'000
Total revenue	23,254	21,667	20,341	19,260	18,843
Total expenses	(23,353)	(22,788)	19,563	19,033	18,608
Other operating flows included in the net result	131	38	(1,630)	(1,715)	(1,355)
Net result for the year	32	(1,083)	778	227	235
***Operating result**	**2,099**	**930**	**60,352**	**56,504**	**51,441**
Total assets	61,128	61,763	11,361	7,441	6,963
Total liabilities	12,955	13,622	48,991	49,063	44,478
Net assets	**48,173**	**48,141**	**48,991**	**49,063**	**44,478**
Total equity	**48,173**	**48,141**	**48,991**	**49,063**	**44,478**

*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

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)
Hygenics P/L	Asbestos assessment	21/08/2017	25/08/2017	$16,680	$16,680	0

In 2017/18 Rural North West engaged four consultancies where the total fees payable to the consultants were less than $10,000 with a total expenditure of $10,828 (ex GST)

ICT expenditure

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

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

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

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

BAU ICT EXPENDITURE TOTAL	NON-BAU ICTA EXPENDITURE TOTAL = A + B	OPERATIONAL EXPENDITURE A	CAPITAL EXPENDITURE B
$620,422	$0	$0	$0

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

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

We further state that in our opinion the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes presents fairly the financial transactions during the year ended 30 June 2018 and the financial position of Rural Northwest Health at 30 June 2018

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

We authorise the attached financial statements for issue on this day

Julia Hausler

BOARD MEMBER
WARRACKNABEAL

5 September 2018

Craig Wilding

ACCOUNTABLE OFFICER
WARRACKNABEAL

5 September 2018

Andrew Arundell

CHIEF FINANCE AND ACCOUNTING OFFICER
WARRACKNABEAL

5 September 2018

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Rural Northwest Health

Opinion	I have audited the financial report of Rural Northwest Health (the health service) which comprises the: • balance sheet as at 30 June 2018 • comprehensive operating statement for the year then ended • statement of changes in equity for the year then ended • cash flow statement for the year then ended • notes to the financial statements, including significant accounting policies • board member's, accountable officer's and chief finance and accounting officer's declaration. In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2018 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.
Basis for Opinion	I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. I further describe my responsibilities under that Act and those standards in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report. My independence is established by the *Constitution Act 1975.* My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Victoria. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.
Board's responsibilities for the financial report	The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Financial Management Act 1994*, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error. In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.
Other Information	The Board of the health service is responsible for the Other Information, which comprises the information in health service's annual report for the year ended 30 June 2018, but does not include the financial report and my auditor's report thereon. My opinion on the financial report does not cover the Other Information and accordingly, I do not express any form of assurance conclusion on the Other Information. However, in connection with my audit of the financial report, my responsibility is to read the Other Information and in doing so, consider whether it is materially inconsistent with the financial report or the knowledge I obtained during the audit, or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude there is a material misstatement of the Other Information, I am required to report that fact. I have nothing to report in this regard.

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
10 September 2018

Ron Mak
as delegate for the Auditor-General of Victoria

RURAL NORTHWEST HEALTH
COMPREHENSIVE OPERATING STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2018

	Note	2018 $'000	2017 $'000
Revenue from Operating Activities	2.1	22,729	21,034
Revenue from Non-Operating Activities	2.1	407	401
Employee Expenses	3.1	(15,868)	(15,080)
Non Salary Labour Costs	3.1	(386)	(440)
Supplies and Consumables	3.1	(1,553)	(1,308)
Other Expenses	3.1	(3,230)	(3,647)
Net Result Before Capital and Specific Items		2,099	960
Capital Purpose Income	2.1	118	232
Depreciation	4.3	(2,222)	(2,139)
Expenditure for Capital Purposes	3.1	(94)	(174)
Net Result After Capital and Specific Items		(99)	(1,121)
Other Economic Flows Included in Net Result			
Net Gain/(Loss) on Disposal of Non-Financial Assets		25	0
Revaluation of Long Service Leave	3.1,3.2	106	38
Total Other Economic Flows Included in Net Result		131	38
NET RESULT FOR THE YEAR		32	(1,083)
Other Comprehensive Income			
Changes in physical asset revaluation surplus	8.1	0	0
Total Other Comprehensive Income		0	0
COMPREHENSIVE RESULT		**32**	**(1,083)**

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

RURAL NORTHWEST HEALTH
BALANCE SHEET
AS AT 30 JUNE 2018

	Note	2018 $'000	2017 $'000
Current Assets			
Cash and Cash Equivalents	6.1	8,130	1,646
Receivables	5.1	1,039	676
Investments and Other Financial Assets	4.1	10,404	16,485
Inventories	5.2	47	59
Non-Financial Assets Classified as Held for Sale	5.4	0	137
Prepayments and Other Assets	5.5	92	153
Total Current Assets		19,712	19,156
Non-Current Assets			
Receivables	5.1	72	0
Property, Plant and Equipment	4.2	41,344	42,607
Total Non-Current Assets		41,416	42,607
TOTAL ASSETS		61,128	61,763
Current Liabilities			
Payables	5.6	606	1,101
Provisions	3.2	3,840	3,638
Other Liabilities	5.3	8,107	8,518
Total Current Liabilities		12,553	13,257
Non-Current Liabilities			
Provisions	3.2	402	365
Total Non-Current Liabilities		402	365
TOTAL LIABILITIES		12,955	13,622
NET ASSETS		48,173	48,141
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	29,139
Accumulated Surplus	8.1c	6,402	6,370
TOTAL EQUITY		48,173	48,141
Commitments	6.2		
Contingent Assets and Contingent Liabilities	7.2		

RURAL NORTHWEST HEALTH
CASH FLOW STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2018

	Note	2018 $'000 Inflows / (Outflows)	2017 $'000 Inflows / (Outflows)
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		18,535	17,253
Capital Grants from Government		37	46
Patient and Resident Fees Received		2,738	2,640
Donations and Bequests Received		47	79
GST (Paid to)/received from ATO		49	(25)
Interest Received		388	403
Other Receipts		565	565
Total Receipts		***22,359***	***20,961***
Employee Expenses Paid		(15,523)	(14,847)
Fee for Service Medical Officers		(386)	(440)
Payments for Supplies and Consumables		(2,185)	(903)
Other Payments		(2,731)	(3,885)
Total Payments		***(20,825)***	***(20,075)***
NET CASH FLOW FROM OPERATING ACTIVITIES	8.2	1,534	886
CASH FLOWS FROM INVESTING ACTIVITIES			
Proceeds / (Purchase) of Investments		5,750	(207)
Payments for Non-Financial Assets		(899)	(1,069)
Proceeds from Sale of Non-Financial Assets		161	0
NET CASH FLOW FROM /(USED IN) INVESTING ACTIVITIES		5,012	(1,276)
NET DECREASE IN CASH AND CASH EQUIVALENTS HELD		6,546	(390)
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		1,228	1,618
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.1	7,774	1,228

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 2018

	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 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**
Net result for the year	8.1c	0	0	0	32	32
Capital appropriation received from Victorian Government	8.1b	0	0	0	0	0
Balance at 30 June 2018		**12,519**	**113**	**29,139**	**6,402**	**48,173**

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

BASIS OF PRESENTATION

The financial statements are prepared in accordance with Australian Accounting Standards and relevant FRDs.

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

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

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 year ending 30 June 2018. 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:
5th September 2018.

(b) Reporting Entity

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

Its principal address is:
Dimboola Road
Warracknabeal
Victoria 3393

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

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

(c) Basis of accounting preparation and measurement

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

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2018, and the comparative information presented in these financial statements for the year ended 30 June 2017.

The financial statements are prepared on a going concern basis.

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

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

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

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

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

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

- The fair value of land, buildings and plant and equipment (refer to Note 4.2 Property, Plant and Equipment);
- Superannuation expense (refer to Note 3.3 Superannuation);
- Employee benefit provisions are based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.2 Employee Benefits in the Balance Sheet); and
- Managed investment funds classified at level 2 of the fair value hierarchy.

Goods and Services Tax (GST)

Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the Australian Taxation Office (ATO). In this case the GST payable is recognised as part of the cost of acquisition of the asset or as part of the expense.

Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the ATO is included with other receivables or payables in the Balance Sheet.

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

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

(d) 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 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

(e) Jointly Controlled Operation

Joint control is the contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control.

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

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

Rural Northwest Health is a Member of the Grampians Alliance of Rural Health Joint Venture and retains joint control over the arrangement, which it has classified as a joint operation (refer to Note 4.2)

NOTE 2: FUNDING DELIVERY OF OUR SERVICES

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

Structure
2.1 Analysis of revenue by source

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE	Admitted Patients 2018 $'000	Residential Aged Care 2018 $'000	Aged Care 2018 $'000	Primary Health 2018 $'000	Other 2018 $'000	TOTAL 2018 $'000
Government Grants	9,603	7,561	227	1,536	0	18,927
Indirect Contributions by Department of Health and Human Services	39	55	3	0	0	97
Patient and Resident Fees	456	2,095	0	16	214	2,781
Other Revenue from Operating Activities	164	120	20	102	518	924
Total Revenue from Operating Activities	**10,262**	**9,831**	**250**	**1,654**	**732**	**22,729**
Interest	154	240	13	0	0	407
Total Revenue from Non-Operating Activities	**154**	**240**	**13**	**0**	**0**	**407**
Capital Purpose Income (excluding interest)	37	26	0	0	55	118
Total Capital Purpose Income	**37**	**26**	**0**	**0**	**55**	**118**
TOTAL REVENUE	**10,453**	**10,097**	**263**	**1,654**	**787**	**23,254**

	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	1,373	0	17,541
Indirect Contributions by Department of Health	10	14	0	0	0	24
Patient and Resident Fees	360	2,027	0	0	202	2,589
Other Revenue from Operating Activities	213	78	20	66	503	880
Total Revenue from Operating Activities	**9,266**	**9,315**	**309**	**1,439**	**705**	**21,034**
Interest	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	186	232
Total Capital Purpose Income	**46**	**0**	**0**	**0**	**186**	**232**
TOTAL REVENUE	**9,464**	**9,551**	**322**	**1,439**	**891**	**21,667**

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

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)

Revenue Recognition

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

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

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

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

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 on an accrual basis.

Private Practice Fees

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

Revenue from commercial activities

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

Donations and Other Bequests

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

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

- **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.

- **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 Provisions
3.3 Superannuation

NOTE 3.1: ANALYSIS OF EXPENSES BY SOURCE	Admitted Patients 2018 $'000	Residential Aged Care 2018 $'000	Aged Care 2018 $'000	Primary Health 2018 $'000	Other 2018 $'000	TOTAL 2018 $'000
Employee Expenses	6,236	7,941	377	1,304	10	15,868
Other Operating Expenses						
Non Salary Labour Costs	248	69	0	9	60	386
Supplies and Consumables	692	628	32	21	180	1,553
Other Expenses	1,275	1,421	85	80	369	3,230
Total Expenditure from Operating Activities	**8,451**	**10,059**	**494**	**1,414**	**619**	**21,037**
Depreciation (refer note 4.3)	0	0	0	0	2,222	2,222
Expenditure for Capital Purposes	0	0	0	0	94	94
Revaluation of Long Service Leave	0	0	0	0	(106)	(106)
Total Other Expenses	**0**	**0**	**0**	**0**	**2,210**	**2,210**
TOTAL EXPENSES	**8,451**	**10,059**	**494**	**1,414**	**2,829**	**23,247**

	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 4.3)	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**

Note 3.1 Expense Recognition
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

Grants and Other Transfers
These include transactions such as: grants, subsidies and personal benefit payments made in cash to individuals.

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 expensed when distributed.
- 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.

Net Gain / (Loss) on Non-Financial Assets

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

- Revaluation gain/ (losses) of non-financial physical assets (Refer to Note 4.3 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.

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

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.

NOTE 3.2: EMPLOYEE BENEFITS IN THE BALANCE SHEET	2018 $'000	2017 $'000
Current Provisions		
Employee Benefits (i)		
Accrued Wages, Superannuation, ADO & Annual Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	1,755	1,576
- unconditional and expected to be settled wholly after 12 months (iii)	61	94
Long Service Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	250	188
- unconditional and expected to be settled wholly after 12 months (iii)	1,411	1,436
	3,477	3,294
Provisions related to employee benefit on-costs		
- unconditional and expected to be settled wholly within 12 months (ii)	193	173
- unconditional and expected to be settled wholly after 12 months (iii)	170	171
	363	344
Total Current Provisions	3,840	3,638
Non-Current Provisions		
Employee Benefits (i)		
Long Service Leave		
- conditional and expected to be settled wholly after 12 months (iii)	362	329
Provisions related to employee benefit on-costs		
- conditional and expected to be settled wholly after 12 months (iii)	40	36
Total Non-Current Provisions	402	365
Total Provisions	4,242	4,003
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Annual Leave Entitlements	1,283	1,201
Accrued Salaries and Wages	489	426
Accrued Days Off	45	38
Unconditional Long Service Leave Entitlements	1,844	1,803
Superannuation	179	170
	3,840	3,638
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements (iii)	402	365
Total Employee Benefits and Related On-Costs	4,242	4,003

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	2,168	2,168
Provision made during the year		
- Revaluations	(106)	(38)
- Expense recognising Employee Service	499	223
Settlement made during the year	(315)	(185)
Balance at end of year	2,246	2,168

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

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

The amount recognised as a liability is the best estimate of the consideration required to settle the present obligation at reporting date, taking into account the risks and uncertainties surrounding the obligation.

NOTE 3.2: 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.

Salaries and Wages, Annual Leave and Accrued Days Off
Liabilities for wages and salaries, annual leave and accrued days off 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 accrued days off are measured at:
- Undiscounted value – if the health service expects to wholly settle within 12 months; or
- Present value – if the health service does not expect to wholly settle within 12 months.

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

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

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

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

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

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

NOTE 3.3: SUPERANNUATION

Fund	Paid Contributions for the Year		Outstanding Contributions at Year End	
	2018 $'000	**2017 $'000**	**2018 $'000**	**2017 $'000**
Defined Contribution Plans:				
Health Super	942	922	147	143
HESTA	334	265	32	27
Total	1,276	1,187	179	170

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

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

NOTE 3.3: 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.

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

However superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the comprehensive operating statement of the Health Service.

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY

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

Structure

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

NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS	2018 $'000	2017 $'000
CURRENT		
Loans and receivables		
Term Deposit		
Aust. Dollar Term Deposits > 3 months (i)	10,404	16,485
Total Current	10,404	16,485
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	10,404	16,485
Represented by:		
Health Service Investments	2,450	8,200
Accommodation Bonds (Refundable Entrance Fees)	7,954	8,285
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	10,404	16,485

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

Note 4.1 Investment Recognition
Investments are recognised and derecognised on trade date where purchase or sale of an investment is under a contract whose terms require delivery of the investment within the timeframe established by the market concerned, and are initially measured at fair value, net of transaction costs.

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

Rural Northwest Health investments must comply with Standing Direction 3.7.2 - Treasury and Investment Risk Management.

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

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

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

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

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

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

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

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

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

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT **(a) Gross carrying amount and accumulated depreciation**	2018 $'000	2017 $'000
Land		
- Land at Fair Value	653	653
Total Land	653	653
Buildings		
- Buildings at Fair Value	44,518	44,518
Less Accumulated Depreciation	(6,656)	(4,896)
	37,862	39,622
- Land Improvements at Fair Value	1,190	1,190
Less Accumulated Depreciation	(722)	(524)
	468	666
Assets Under Construction		
- Assets Under Construction at cost	984	337
Total Assets Under Construction	984	337
Total Buildings	39,314	40,625
Plant and Equipment		
- Plant and Equipment at Fair Value	980	892
Less Accumulated Depreciation	(691)	(649)
- Grampians Rural Health Alliance	326	269
Less Accumulated Depreciation	(81)	(58)
Total Plant and Equipment	534	454
Computers and Communications		
- Computers and Communications at Fair Value	506	456
Less Accumulated Depreciation	(285)	(193)
	221	263
Medical Equipment		
- Medical Equipment	878	805
Less Accumulated Depreciation	(531)	(477)
	347	328
Furniture and Fittings		
- Furniture and Fittings at Fair Value	370	328
Less Accumulated Depreciation	(190)	(164)
Total Furniture and Fittings	180	164
Motor Vehicles		
- Motor Vehicles at Fair Value	225	225
Less Accumulated Depreciation	(130)	(105)
Total Motor Vehicles	95	120
TOTAL	41,344	42,607

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

	Land	Buildings & Land Improv.	Plant & Equipment	Computers & Commun.	Medical Equipment	Furniture & Fittings	Motor Vehicles	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 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 1 July 2017	**653**	**40,625**	**454**	**263**	**328**	**164**	**120**	**42,607**
Additions	0	646	89	50	73	41	0	899
Grampians Rural Health Alliance	0	0	59	0	0	0	0	59
Classified as Held for Sale	40	97	0	0	0	0	0	137
Capital Contributions	0	0	0	0	0	0	0	0
Disposals	(40)	(96)	0	0	0	0	0	(136)
Depreciation	0	(1,958)	(68)	(92)	(54)	(25)	(25)	(2,222)
Balance at 30 June 2018	**653**	**39,314**	**534**	**221**	**347**	**180**	**95**	**41,344**

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.

In compliance with FRD 103F, in the year ended 30 June 2018, Rural Northwest Health management conducted an annual assessment of the fair value of land and buildings and leased buildings. To facilitate this, management obtained from the Department of Treasury and Finance the Valuer General Victoria indices for the financial year ended 30 June 2018. No change was made to the carrying value of land and buildings.

The effective date of the valuation is 30 June 2014.

(c) Fair value measurement hierarchy for assets

	Carrying amount as at 30 June 2018	**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	36,883	0	0	36,883
Non Specialised buildings	979	0	979	0
Specialised land improvements	468	0	0	468
Total of building at fair value	38,330	0	979	37,351
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	95	0	95	0
- Plant and equipment	935	0	0	935
Total of plant, equipment and vehicles at fair value	1,030	0	95	935
Medical equipment at fair value	347	0	0	347
Total medical equipment at fair value	347	0	0	347
Assets under construction at cost	984	0	0	984
Total assets under construction at cost	984	0	0	984

NOTE 4.2: 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 2017

	Carrying amount as at 30 June 2017	Fair value measurement at end of reporting period using:		
		Level 1 (1)	Level 2 (1)	Level 3 (1)
	$'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
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
(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.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)
(d) Reconciliation of Level 3 fair value

30-Jun-18	Land	Buildings	Plant and equipment	Medical equipment	Assets under construction
	$'000	$'000	$'000	$'000	$'000
Opening Balance	392	39,309	881	328	337
Purchases (sales)	0	647	239	73	0
Transfers in (out)	0	(647)	0	0	647
Gains or losses recognised in net result					
- Depreciation	0	(1,958)	(185)	(54)	0
Subtotal	392	37,351	935	347	984
Items recognised in other comprehensive income					
- Revaluation	0	0	0	0	0
Subtotal	0	0	0	0	0
Closing Balance	392	37,351	935	347	984
Unrealised gains/(losses) on non-financial assets	0	0	0	0	0
	392	37,351	935	347	984

There have been no transfers between levels during the period.

30-Jun-17	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.

(e) Fair Value Determination

Asset Class	Examples of types assets	Expected fair value level	Likely valuation approach	Significant inputs (Level 3 only)
Specialised land (Crown/Freehold)	- Land subject to restriction as to use and/or sale - Land in areas where there is not an active market	Level 3	Market approach	Community Service Obligation Adjustments
Specialised Buildings (a)	Specialised buildings with limited alternative uses and/or substantial customisation eg. Hospitals	Level 3	Depreciated replacement cost approach	- Cost per square metre - Useful life
Plant and equipment	Specialised items with limited alternative uses and/or substantial cutomisation	Level 3	Depreciated replacement cost approach	- Cost per square metre - Useful life

(a) AASB 13 Fair Value Measurement provides an exemption for not for profit public sector entities from disclosing the sensitivity analysis relating to 'unrealised gains/(losses) on non-financial assets' if the assets are held primarily for their current service potential rather than to generate net cash inflows.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

Initial Recognition

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

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

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

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

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

Subsequent Measure

Consistent with AASB 13 Fair Value Measurement, Rural Northwest Health determines the policies and procedures for both recurring property, plant and equipment fair value measurements, in accordance with the requirements of AASB 13 and the relevant FRDs.

All property, plant and equipment for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy.

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

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

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

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

The estimates and underlying assumptions are reviewed on an ongoing basis.

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.

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

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

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

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.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (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 4.2: PROPERTY, PLANT AND EQUIPMENT (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 2018.

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

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 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 4.3: DEPRECIATION	2018 $'000	2017 $'000
Depreciation		
Buildings	1,760	1,744
Land Improvements	198	180
Plant and Equipment	43	35
Medical Equipment	54	45
Computers and Communications	92	62
Furniture and Fittings	25	23
Motor Vehicles	25	25
Grampians Rural Health Alliance Depreciation	25	25
TOTAL DEPRECIATION	2,222	2,139

Depreciation
All 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 is generally calculated on a straight-line basis at rates that allocate the asset's value, less any estimated residual value over its estimated useful life

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

	2018	**2017**
Buildings		
- Structure Shell Building Fabric	2 to 50 years	2 to 50 years
- Site Engineering Services and Central Plant	2 to 50 years	2 to 50 years
Central Plant		
- Fit Out	2 to 50 years	2 to 50 years
- Trunk Reticulated Building Systems	2 to 50 years	2 to 50 years
Plant and Equipment	1 to 20 years	1 to 20 years
Medical Equipment	4 to 20 years	4 to 20 years
Computers and Communication	3 to 5 years	3 to 5 years
Furniture and Fittings	1 to 20 years	1 to 20 years
Motor Vehicles	8 years	8 years
Land Improvements	6 years	6 years

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

NOTE 5: OTHER ASSETS AND LIABILITIES

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

Structure

NOTE 5.1: RECEIVABLES	2018 $'000	2017 $'000
CURRENT		
Contractual		
Patient Fees	157	114
Accrued Investment Income	72	53
Accrued Revenue - Other	465	234
Trade Debtors	71	52
Grampians Rural Health Alliance Receivables	16	25
Less Allowance for Doubtful Debts	(14)	(14)
	767	464
Statutory		
Department of Health and Human Services (WIES)	167	58
GST Receivable	105	154
	272	212
TOTAL CURRENT RECEIVABLES	1,039	676
NON CURRENT		
Statutory		
Department of Health and Human Services (LSL Debtor)	72	0
TOTAL NON-CURRENT RECEIVABLES	72	0
TOTAL RECEIVABLES	1,111	676
(a) Movement in the Allowance for doubtful debts		
Balance at beginning of the year	(14)	(26)
(Increase) / decrease in allowance recognised in net result	0	12
Balance at end of the year	(14)	(14)

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.

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.

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

	2018 $'000	2017 $'000
Pharmaceuticals - at cost	18	22
Medical and Surgical Lines - at cost	29	37
TOTAL INVENTORIES	47	59

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

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

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

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

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

NOTE 5.3: OTHER LIABILITIES

	2018 $'000	2017 $'000
CURRENT		
Monies Held in Trust*		
- Patient Monies Held in Trust	123	154
- Accommodation Bonds (Refundable Entrance Fees)	7,954	8,285
- Other	30	79
	8,107	8,518
TOTAL OTHER LIABILITIES	8,107	8,518
*** Total Monies Held in Trust**		
Represented by the following assets:		
Cash Assets (refer to Note 6.1)	153	233
Investment and Other Financial Assets (refer to Note 4.1)	7,954	8,285
TOTAL	8,107	8,518

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	2018 $'000	2017 $'000
Freehold Land (i)	0	40
Buildings (i)	0	97
TOTAL NON-FINANCIAL PHYSICAL ASSETS CLASSIFIED AS HELD FOR SALE	0	137

(i) The health service disposed of freehold land and buildings it no longer utilised in 2018. No impairment loss was recognised on reclassification of the freehold land and buildings as held for sale at the end of the 2017 reporting period.

(B) Fair value measurement of non-financial physical asset held for sale	**Carrying amount**	**Fair value measurement at end of reporting period using:**		
	2017	**Level 1 (1)**	**Level 2 (1)**	**Level 3 (1)**
	$'000	**$'000**	**$'000**	**$'000**
Freehold Land (ii)	40	0	40	0
Buildings (ii)	97	0	97	0
TOTAL NON-FINANCIAL PHYSICAL ASSETS CLASSIFIED AS HELD FOR SALE	137	0	137	0

(1) Classified in accordance with the fair value hierarchy.
(ii) Freehold land and buildings held for sale is carried at fair value less costs to disposal.

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) 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 les costs of disposal, and are not subject to depreciation or amortisation.

NOTE 5.5: PREPAYMENTS AND OTHER NON-FINANCIAL ASSETS	2018 $'000	2017 $'000
CURRENT		
Prepayments	82	151
Grampians Rural Health Alliance Prepayments	10	2
TOTAL OTHER ASSETS	92	153

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	2018 $'000	2017 $'000
CURRENT		
Contractual		
Trade Creditors	187	831
Grampians Rural Health Alliance Payables	32	33
Accrued Expenses	349	167
Commonwealth Aged Care Funding	0	27
Accrued Audit Fees	23	22
	591	1,080
Statutory		
Department of Health and Human Services - Accrued Grant Recall	8	14
Australian Taxation Office - Fringe Benefits Tax	7	7
	15	21
TOTAL PAYABLES	606	1,101

Payables consist of:

- contractual payables, classified as financial instruments and measured at amortised cost. Accounts payable represents liabilities for goods and services provided to the Department prior to the end of the financial year that are unpaid; and
- statutory payables, that are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from contracts.

Note 5.4 (a): Maturity analysis of financial liabilities as at 30 June

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

			Maturity Dates			
2018	Total Carrying Amount $'000	Nominal Amount $'000	Less than 1 Month $'000	1 - 3 Months $'000	3 Months - 1 Year $'000	1 - 5 Years $'000
Financial Liabilities						
At amortised cost						
Payables	591	591	591	0	0	0
Other Financial Liabilities (i)						
- Monies Held in Trust	8,107	8,107	0	0	8,107	0
Total Financial Liabilities	8,698	8,698	591	0	8,107	0
2017						
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

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

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

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.

	2018 $'000	2017 $'000
Cash on Hand	2	2
Cash at Bank	8,128	1,644
TOTAL CASH AND CASH EQUIVALENTS	8,130	1,646
Represented by:		
Cash for Health Service Operations (as per cash flow statement)	7,774	1,228
Cash for Monies Held in Trust		
- Cash at Bank	153	233
- Grampians Rural Health Alliance	203	185
TOTAL CASH AND CASH EQUIVALENTS	8,130	1,646

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

	2018 $'000	2017 $'000
Lease commitments		
Commitments for leases contracted for at reporting date:		
Operating leases	201	333
Total lease commitments	**201**	**333**
Operating leases		
Payable as follows:		
Cancellable		
Not later than one year	130	130
Later than 1 year and not later than 5 years	71	203
Sub Total	**201**	**333**
Total lease commitments (inclusive of GST)	201	333
less GST recoverable from the Australian Tax Office	(18)	(30)
Total Commitments (exclusive of GST)	**183**	**303**

Lease and Renewal Terms Included in Lease Agreements

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

Motor Vehicles: This lease is for 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

NOTE 7.1: FINANCIAL INSTRUMENTS

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of Rural Northwest Health's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation.*

(a) Financial instruments: categorisation

2018	Contractual financial assets - loans and receivables $'000	Contractual financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets			
Cash and cash equivalents	8,130	0	8,130
Receivables			
- Trade Debtors	71	0	71
- Other Receivables	696	0	696
Other Financial Assets			
- Term Deposits	10,404	0	10,404
Total Financial Assets (i)	19,301	0	19,301
Financial Liabilities			
Payables	0	591	591
Other Financial Liabilities			
- Monies Held in Trust	0	8,107	8,107
Total Financial Liabilities(ii)	0	8,698	8,698

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			0
- 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 carrying amount excludes statutory receivables (i.e. GST Receivable and DHHS Receivable) and statutory payables (i.e. Revenue in advance and DHHS payable).

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

	Total interest income/ (expense) $'000	Total $'000
2018		
Financial Assets		
Loans and Receivables(i)	407	407
Total Financial Assets	407	407
2017		
Financial Assets		
Loans and Receivables(i)	401	401
Total Financial Assets	401	401

(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.

(ii) For financial liabilities measured at amortised cost, the net gain or loss is calculated by taking the interest expense measured at amortised cost.

Categories of 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 6.2), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

Financial Liabilities at Amortised Cost
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. The Health Service recognises the following liabilities in this category:

- payables (excluding statutory payables);
- borrowings (including finance lease liabilities).

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

- the rights to receive cash flows from the asset have expired; 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:
  - has transferred substantially all the risks and rewards of the asset; or
  - 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.*

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

Reclassification of financial instruments

Subsequent to initial recognition and under rare circumstances, non-derivative financial instruments assets that have not been designated at fair value through profit or loss upon recognition, may be reclassified out of the fair value through profit or loss category, if they are no longer held for the purpose of selling or repurchasing in the near term.

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

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

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 'other economic flow' in the comprehensive operating statement.

NOTE 7.2: CONTINGENT ASSETS AND CONTINGENT LIABILITIES

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

There are no known contingent assets or liabilities for Rural Northwest Health at the date of this report (2017: nil contingent assets or liabilities).

NOTE 8: OTHER DISCLOSURES

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

Structure

NOTE 8.1: EQUITY	2018	2017
(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
(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	29,139	28,906
Capital Contribution received from Victorian Government	0	233
Balance at the end of the reporting period	29,139	29,139
(c) Accumulated Surpluses		
Balance at the beginning of the reporting period	6,370	7,453
Net Result for the Year	32	(1,083)
Balance at the end of the reporting period	6,402	6,370
Total Equity at end of financial year	48,173	48,141

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

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

	2018 $'000	2017 $'000
NET RESULT FOR THE PERIOD	32	(1,083)
Non-cash movements		
Depreciation	2,197	2,114
Provision for Doubtful Debts	0	(12)
Share of Net Result from Jointly Controlled Operations	(52)	(93)
Movements included in investing and financing activities		
Net (Gain)/Loss from Sale of Non-Financial Physical Assets	(25)	0
Movements in assets and liabilities		
Change in Operating Assets & Liabilities		
(Increase)/Decrease in Receivables	(444)	(216)
(Increase)/Decrease in Prepayments	69	(1)
Increase/(Decrease) in Payables	(315)	(15)
Increase/(Decrease) in Provisions	60	195
Change in Inventories	12	(3)
NET CASH INFLOW FROM OPERATING ACTIVITIES	1,534	886

NOTE 8.3: 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	01/07/2017 - 30/06/2018
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health, Minister for Creative Industries, Minister for Equality.	01/07/2017 - 30/06/2018
Governing Boards	
Leo Casey	01/07/2017 - 30/06/2018
Sally Gebert	01/07/2017 - 28/02/2018
Janette McCabe	01/07/2017 - 30/06/2018
Glenda Hewitt	01/07/2017 - 30/06/2018
Carolyn Morcom	01/07/2017 - 30/06/2018
Julia Hausler	01/07/2017 - 30/06/2018
Amanda Kenny	01/07/2017 - 30/06/2018
Accountable Officer	
Catherine Morley	01/07/2017 - 07/09/2017
Joanne Martin (Acting)	08/09/2017 - 01/01/2018
Janet Feeny	02/01/2018 - 21/04/2018
Joanne Martin (Acting)	22/04/2018 - 27/05/2018
Craig Wilding (Acting)	28/05/2018 - 30/06/2018

Remuneration of Responsible Persons

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

Income Band	**2018 $**	**2017 $**
$10,000 - $19,999	7	8
$50,000 - $59,999	1	0
$60,000 - $69,999	1	0
$140,000 - $149,999	1	0
$220,000 - $229,999	0	1
Total Numbers	10	9
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	$257,912	$227,185

Amounts relating to Governing Board Members and Accountable Officer are disclosed in the Health Service's controlled entities financial statements.
Amounts relating to Responsible Ministers are reported within the Department of Parliamentary Services' Financial Report as disclosed in Note 8.6.

NOTE 8.4: EXECUTIVE OFFICER DISCLOSURES

Remuneration of executive officers

	2018 $'000	2017 $'000
Short-term employee benefits	613	503
Post-employment benefits	41	56
Other long-term benefits	14	11
Termination benefits	0	0
Share-based payments	0	0
Total Remuneration (b)	668	570
Total Number of executives (c)	5	4
Total annualised employee equivalent (AEE) (d)	5	4

Notes:
(i) 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 8.5).
(ii) 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 8.5: RELATED PARTIES

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

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

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

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

Entity	KMPs	Position Title
Rural Northwest Health	Julia Hausler	Chair of the Board
Rural Northwest Health	Leo Casey	Board Member
Rural Northwest Health	Sally Gebert	Board Member
Rural Northwest Health	Glenda Hewitt	Board Member
Rural Northwest Health	Amanda Kenny	Board Member
Rural Northwest Health	Janette McCabe	Board Member
Rural Northwest Health	Carolyn Morcom	Board Member
Rural Northwest Health	Catherine Morley	Chief Executive Officer
Rural Northwest Health	Joanne Martin	Chief Executive Officer (Acting)
Rural Northwest Health	Janet Feeny	Chief Executive Officer
Rural Northwest Health	Craig Wilding	Chief Executive Officer (Acting)

COMPENSATION	2018 $'000	2017 $'000
Short term employee benefits	208	206
Post-employment benefits	14	16
Other long-term benefits	0	5
Termination benefits	36	0
Share based payments	0	0
Total	**258**	**227**

(i)Total remuneration paid to KMPs employed as a contractor during the reporting period through accounts payable has been reported under short-term employee benefits.
(ii)KMPs are also reported in Note 8.3 Resposible Persons or Note 8.4 Remuneration of Executives.

NOTE 8.5: RELATED PARTIES (Continued)

Significant transactions with government-related entities

Rural Northwest Health received funding from the Department of Health and Human Services of $11,114,000 (2017: $10,558,000).

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

Professional medical indemnity insurance and other insurance products are obtained from a Victorian Public Financial Corporation.

Treasury Risk Management Directions require the Health Service to hold cash (in excess of working capital) and investments, and source all borrowings from Victorian Public Financial Corporations.

Transactions with key management personnel and other related parties

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

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

There were no related party transactions with Cabinet Ministers required to be disclosed in 2018.

There were no related party transactions required to be disclosed for Rural Northwest Health Board of Directors and Executive Directors in 2018.

NOTE 8.6: PAYMENTS TO OTHER PERSONNEL (i.e. contractors with significant management responsibilities)

Expense Band	2018 No.	2017 No.
$60,000-$69,999	1	-
	60,415	-

In accordance with FRD 21C the following disclosures are made in relation to other personnel of Rural Northwest Health, i.e. contractors charged with significant management responsibilities.

Payments have been made to a number of contractors with significant management responsibilities, which are disclosed within the $10,000 expense band. These contractors are responsible for planning, directing or controlling, directly or indirectly, of the Health Service's activities.

NOTE 8.7: REMUNERATION OF AUDITORS

	2018 $'000	2017 $'000
Victorian Auditor-General's Office		
Audit or review of financial statements	24	23
	24	23

NOTE 8.8: AASBs ISSUED THAT ARE NOT YET EFFECTIVE

Certain new Australian accounting standards and interpretations have been published that are not mandatory for 30 June 2018 reporting period. DTF assesses the impact of all these new standards and advises the Health Service of their applicability and early adoption where applicable.

As at 30 June 2018, 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.

Topic	Key Requirements	Effective date
AASB 9 *Financial Instruments*	The key changes introduced by AASB 9 include 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
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, and to amend Reduced Disclosure requirements.	1 January 2018
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
AASB 15 Revenue from Contracts with Customers	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer. Note that amending standard AASB 2015‑8 Amendments to Australian Accounting Standards – Effective Date of AASB 15 has deferred the effective date of AASB 15 to annual reporting periods beginning on or after 1 January 2018, instead of 1 January 2017.	1 January 2018
AASB 2014‑5 Amendments to Australian Accounting Standards arising from AASB 15	Amends the measurement of trade receivables and the recognition of dividends as follow: - Trade receivables, that do not have a significant financing component, are to be measured at their transaction price, at initial recognition. - Dividends are recognised in the profit and loss only when: • the entity's right to receive payment of the dividend is established; • it is probable that the economic benefits associated with the dividend will flow to the entity; and • the amount can be measured reliably.	1 January 2018, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply 1 January 2018
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
AASB 2016-3 Amendments to Australian Accounting Standards – Clarifications to AASB 15	This Standard amends AASB 15 to clarify requirements for identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: • a promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation; • for items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer; and • 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
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

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

Topic	Key Requirements	Effective date
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 and implementation guidance to assist not-for-profit entities in applying the respective standards to particular transactions and events. The amendments: • require non-contractual receivable 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 • clarifies circumstances when a contract with a customer is within the scope of AASB 15.	1 January 2019
AASB 16 Leases	The key changes introduced by AASB 16 include the recognition of most operating leases (which are currently not recognised) on balance sheet which has an impact on net debt.	1 January 2019
AASB 1058 Income of Not-for-Profit Entities	This standard will replace AASB 1004 Contributions and establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objectives. The restructure of administrative arrangement will remain under AASB 1004.	1 January 2019

The following accounting pronouncements are also issued but not effective for the 2017‑18 reporting period. At this stage, the preliminary assessment suggests they may have insignificant impacts on public sector reporting.

- AASB 2016-5 Amendments to Australian Accounting Standards – Classification and Measurement 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 2014-2016 Cycle and Other Amendments
- AASB 2017-3 Amendments to Australian Accounting Standards – Clarifications to AASB 4
- AASB 2017-4 Amendments to Australian Accounting Standards – Uncertainty over Income Tax Treatments
- AASB 2017-5 Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128 and Editorial Corrections
- AASB 2017-6 Amendments to Australian Accounting Standards – Prepayment Features with Negative Compensation
- AASB 2017-7 Amendments to Australian Accounting Standards – Long-term Interests in Associates and Joint Ventures
- AASB 2018-1 Amendments to Australian Accounting Standards – Annual Improvements 2015 – 2017 Cycle
- AASB 2018-2 Amendments to Australian Accounting Standards – Plan Amendments, Curtailment or Settlement

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 material events which have occurred subsequent to the reporting date which require further disclosure.

NOTE 8.10: JOINTLY CONTROLLED OPERATIONS

Name of Entity	Principal Activity	Ownership Interest 2018 %	Ownership Interest 2017 %
Grampians Rural Health Alliance	Information Systems	5.78	5.71

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:

	2018 $'000	2017 $'000
Current Assets		
Cash and Cash Equivalents	203	185
Receivables	16	25
Prepayments	10	2
Total Current Assets	229	212
Non Current Assets		
Property Plant and Equipment	245	211
Total Non Current Assets	245	211
Total Assets	474	423
Current Liabilities		
Payables	32	33
Total Current Liabilities	32	33
Total Liabilities	32	33
Net Assets	442	390

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

Revenues		
Operating Revenue	337	312
Capital Income	55	110
Total Revenue	392	422
Expenses		
Operating Expenditure	315	304
Depreciation	25	25
Total Expenses	340	329
Net Result	52	93

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

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

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

NOTE 8.11: ALTERNATIVE PRESENTATION OF COMPREHENSIVE OPERATING STATEMENT

	2018 $'000	2017 $'000
Grants		
Operating	18,987	17,519
Capital	37	46
Interest	407	401
Sales of goods and services	2,781	2,589
Other	1,042	1,112
Revenue from Transactions	**23,254**	**21,667**
Employee expenses	15,868	15,080
Depreciation	2,222	2,139
Other operating expenses	5,169	5,395
Other non-operating expenses	94	174
Expenses from Transactions	**23,353**	**22,788**
Net Result From Transactions - Net Operating Balance	**(99)**	**(1,121)**
Other economic flows included in net result		
Net gain/ (loss) on sale of non-financial assets	25	0
Other gains/ (losses) from other economic flows included in net result	106	38
Total Other Economic Flows Included in Net Result	**131**	**38**
NET RESULT FOR THE YEAR	**32**	**(1,083)**
Other Comprehensive Income	**0**	**0**
COMPREHENSIVE RESULT	**32**	**(1,083)**

This alternative presentation reflects the format required for reporting to the Department of Treasury and Finance, which differs to the disclosures of certain transactions, in particular revenue and expenses, in the hospital's annual report.

NOTE 8.12: ECONOMIC DEPENDENCY

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

Notes

RURAL northwest HEALTH
centred on you

Warracknabeal Campus

Dimboola Road
PO Box 386
Warracknabeal VIC 3393

Tel: (03) 5396 1200
Fax: (03) 5396 1210
Email: reception@rnh.net.au

Beulah Campus

Cnr Henty Hwy and Bell Street
PO Box 2
Beulah VIC 3395

Tel: (03) 5396 8200
Fax: (03) 5396 8201
Email: reception@rnh.net.au

Hopetoun Campus

12 Mitchell Place
Hopetoun VIC 3396

Tel: (03) 5083 2000
Fax: (03) 5083 2050
Email: reception@rnh.net.au

www.rnh.net.au