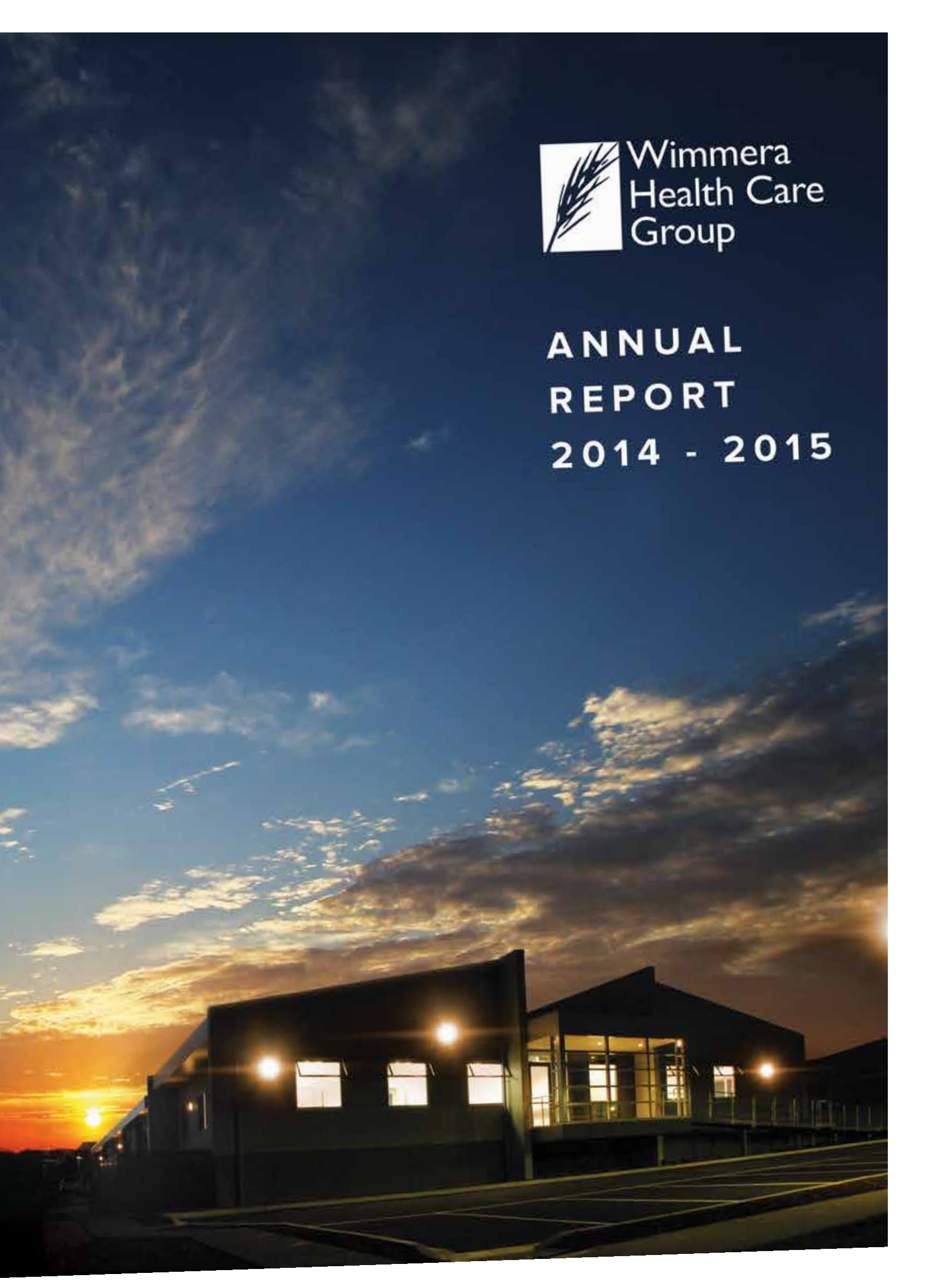




ANNUAL REPORT 2014 - 2015



OUR PROFILE

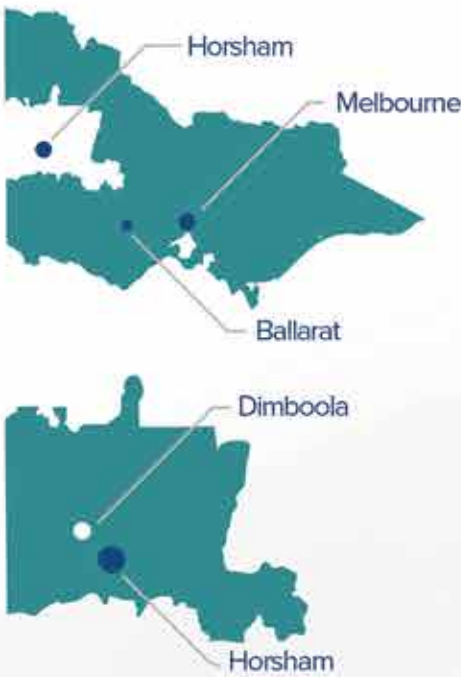
Wimmera Health Care Group is based in the Wimmera sub-region of the Grampians, 310 km west of Melbourne and in close proximity to the Grampians National Park. With an operating budget of approximately \$77 million, Wimmera Health Care Group is the major specialist referral centre for the Wimmera and Southern Mallee region of Victoria. Our campuses in Horsham and Dimboola service an area of 61,000 square kilometres and a population of approximately 54,000.

We employ approximately 800 staff who provide a range of acute, sub-acute, residential aged care, allied health and primary care services to our community.

This year we treated more than 11,500 acute inpatients.

The Wimmera Health Service was established in 1874 as the Horsham Hospital and was incorporated by the authority of the Hospitals and Charities Act (No. 5300) on 27th August 1877.

In 1950, the name was changed to Wimmera Base Hospital and, following a formal amalgamation with Dimboola District Hospital on 1st November 1995, became officially known as Wimmera Health Care Group.



OUR SERVICES AND PROGRAMS

- Acquired Brain Injury Support
- Anticoagulant Clinic
- Antenatal Classes
- Audiology
- Breast Care Nurse
- Breast Prosthetics
- Breast Screening
- Cancer Support
- Cardiac Rehabilitation
- Case Management
- Cognitive Dementia and Memory
- Colposcopy Clinic
- Community Rehabilitation
- Computerised Tomography
- Continence
- Day Oncology
- Day Surgery
- Dental and Prosthetic Clinic
- Dermatology
- Dementia support and respite
- Diabetes Education
- Dietetics
- District Nursing
- Domiciliary Midwife
- Ear, Nose and Throat
- Echocardiography
- Emergency Department
- Endoscopy
- Fracture Clinic
- Gait and Balance Clinic
- Geriatric Evaluation Management
- General Medicine
- General Surgery
- Haemodialysis
- Hospital Admissions Risk Program
- Health Promotion
- Hospice Care
- Hospital in the Home
- Infection Control
- Intensive Care Unit
- Koori Hospital Liaison Officer
- Lactation Consultant
- Low Vision Clinic
- Living At Home Assessment Service
- Magnetic Resonance Imaging
- Medical Imaging
- Medical Library
- Midwifery
- Neonatal Nursing
- Obstetrics and Gynaecology
- Occupational Therapy
- Oncology
- Ophthalmology
- Oral Surgery
- Orthopaedics
- Orthotics Laboratory
- Pacemaker Clinic
- Paediatric Care
- Pathology
- Pharmacy
- Physiotherapy
- Planned Activity Group
- Podiatry
- Post-Acute Care
- Pre-Admission Clinic
- Pulmonary Rehabilitation
- Radiology
- Rehabilitation Assessment
- Residential Aged Care Services
- Residential In Reach Service
- Respite for Carers
- Respiratory services (asthma/COPD education and management)
- Safety Link
- Social Work
- Speech Pathology
- Spinal Clinic
- Stomal Therapy
- Stress Testing Clinic
- Stroke support
- Teleradiology
- Transition Care
- Ultrasound
- Urology
- Video Fluoroscopy
- Wound Care

ABOUT THIS REPORT

This Annual Report provides performance and financial information for the 2014-15 financial year.

It is a legal document prepared in accordance with the *Financial Management Act 1994* and the Department of Health and Human Services annual reporting guidelines for the Minister for Health, the Parliament of Victoria and the community. The contents were prepared to meet compliance with statutory disclosure and other requirements.

The responsible Ministers during the reporting period are The Honourable Jill Hennessy MLA, Minister for Health, Minister for Ambulance Services, 4 December 2014 to 30 June 2015; Martin Foley MLA, Minister for Mental Health, 4 December 2014 to 30 June 2015; The Honourable David Davis MLC, Minister for Health, Minister for Ageing, 1 July 2014 to 3 December 2014 and The Honourable Mary Wooldridge MLA, Minister for Mental Health, 1 July 2014 to 3 December 2014.

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STRATEGIC PLAN

2012 - 2015

The Strategic Plan is a core business tool in defining a clear direction for decision making in planning, governance and management over any given period. The plan is a demonstration of our commitment to planning health services, monitoring progress and ensuring accountability toward meeting the needs of our various stakeholders. The 2012-2015 strategic plan has provided this structure across the chosen five essential management pillars to achieve eight over-arching objectives. During the latter half of 2014-2015 the Board of Management commenced a process to reset the strategic direction of the business as it responds to the changing economic, corporate and clinical environment.

Vision

To be the leader in Australian rural health, delivering caring services with respect, reliability and integrity.

Mission

To build a sustainable health service in our region that meets the health care needs of our community now and into the future.

Values

We believe that together, we are accountable for delivering high quality person-centred care.

OUR STRATEGIC DIRECTIONS

Our Strategic Goals

Quality and Safe Care

STRATEGY

1. To create and deliver high quality care and services that are:
 - Person-centred
 - Safe
 - Effective and appropriate
 - Integrated and co-ordinated

OUTCOME

- 1.1. Our health service delivering measurable high quality and safe care
- 1.2. Expanded use of 'best practice' that delivers integrated and co-ordinated care
- 1.3. Our health service delivering person-centred care
- 1.4. Improved local self-sufficiency and capability in the provision of sub-acute services

STRATEGY

2. To develop consumer knowledge in health across the Wimmera region

OUTCOME

- 2.1. Enhanced community knowledge and understanding of our services
- 2.2. Increased role of Wimmera Health Care Group in health promotion in our community

Financial Sustainability

STRATEGY

3. To achieve a sustainable operating surplus

OUTCOME

- 3.1. Consistently demonstrated financial viability

Contemporary Infrastructure

STRATEGY

4. To develop our infrastructure to meet current standards and changes in service delivery requirements

OUTCOME

- 4.1. Infrastructure and equipment renewal program to meet contemporary standards

STRATEGY

5. To advance our use of technology to improve service delivery

OUTCOME

- 5.1. To be a health service that uses technology effectively to enhance high quality patient care

Engaged Workforce

STRATEGY

6. To attract, retain and support highly skilled people committed to providing excellent healthcare services

OUTCOME

- 6.1. Sustainable workforce to meet our needs
- 6.2. A supportive culture engaging our staff to provide excellent health care services
- 6.3. An environment supportive of training and people development
- 6.4. That occupational health and safety standards are established and maintained to protect individuals in the workplace

STRATEGY

7. To progressively develop teaching and training as a core function

OUTCOME

- 7.1. Increased capacity to deliver training programs

Constructive Partnerships

STRATEGY

8. To build effective relationships with strategic partners

OUTCOME

- 8.1. Consolidated Wimmera Southern-Mallee Health Alliance
- 8.2. Effective collaborative partnerships that add value to the organisation

REPORT OF OPERATIONS

President and Chief Executive's Report

RESPONSIBLE BODIES DECLARATION

In accordance with the Financial Management Act 1994, I am pleased to present the Report of Operations for Wimmera Health Care Group for the year ending 30 June 2015.



Mark Williams
President
Horsham
25 August 2015

Wimmera Health Care Group has continued to provide a range of health services and expanded its service profile appropriate to the clinical needs of the people of the Wimmera and Southern-Mallee, and consistent with our sub-regional role.

During the year we delivered clinical services to 11,543 inpatients in our acute and sub-acute facilities. This was a 6.2% increase on the previous year which reflects growth in community demand across the sub-region. It was also a consequence of our expanded bed capacity with the new sub-acute unit opening mid-year.

The formal consolidation of sub-acute and rehabilitation models of care in their own dedicated facility has significantly broadened our role in the region and allows people who have received treatment elsewhere to return home sooner.

These increases in sub-acute activity, in what is traditionally more complex care types and longer acuity periods, has extended the average length of stay to 2.43 days; however our acute inpatient length of stay remains below the state average at just over two days. These increases in headline indicators have been expected and support the expansion of our service role in the sub-region. Further increases in our patient throughput numbers during

2015-2016 is anticipated as the new sub-acute unit reaches full operating capacity.

Demand for residential aged care accommodation rebounded from the decline in the prior year recording an additional 579 bed days or 1.5% growth. The increase reflects our ongoing commitment to service improvement and the need for casual or respite care. We have progressed our aged care strategy which includes the implementation of the 'named nurse' care model, improved access to pain management, and commencement of planning for redevelopment of the Wimmera Nursing Homes. The strategy articulates our aspirations and provides a well-constructed plan for our direction in aged care to enhance care, build better facilities and deliver a sustainable business model well into the future.

Our investment into contemporary infrastructure with the finalisation of the sub-acute unit building has extended our bed capacity. We acknowledge Fairbrother Construction Pty Ltd and Balcombe Griffith Architects for their roles, and extend our appreciation to the Department of Health and Human Services for their support and leadership in bringing the project to fruition.

We have made a number of significant capital investments including the expansion of public dental facilities, upgrading air-conditioning systems and replacement of various items of medical equipment and information technology. We acknowledge and thank the contributions of the Department of Health and Human Services, fundraising committees and individual benefactors in achieving these vital investments.

Our commitment to continuous quality improvement as measured through the accreditation process, and combined with our skilled and experienced staff, has resulted in achieving full accreditation under all external agencies that measure our performance. These include the new National Safety and Quality Health Service Standards; and residential

aged care accreditation and Community Common Care Standards through the Australian Aged Care Quality Agency. It is important to acknowledge that Wimmera Health Care Group is committed to the ethos of continuous improvement and application of innovative business practices as evidenced by our 40 years of unbroken achievement to these national requirements. It is also significant to this achievement that Mr Ian Campbell was awarded an 'Outstanding Service to the Community Award' presented by the Royal Australasian College of Surgeons at a Horsham Rural City Council civic reception.

The critical nature of our Emergency Department to the region is demonstrated by the level of demand placed on it by the community, and the collaborative work being undertaken across the sub-region to improve patient flows and ensure care is provided as close to home as possible. Being the only emergency department between Ballarat and the South Australian border, our rural remoteness brings a high level of complexity and variety, evidenced through the 13,600 attendances this year. Our priority is to address patient needs first and through the dedication of our staff we have exceeded all access targets for Emergency Care across all patient categories. With resourcefulness and a whole of business approach; supported by our sub-regional partners, significant improvements have been made in patient outcomes both locally and in other communities.

A key element of our business and underpinned by our strategic direction, is the development and maintenance of effective relationships. We believe the Wimmera Southern-Mallee Health Alliance is an important coalition in fostering these relationships, and facilitates co-operative service planning and innovative business services. Just as important, are our relationships with other key regional service providers and government agencies; local, state and federal.

Our ongoing association with Ballarat Health Services continues to deliver enhanced clinical models of care, and builds on corporate and governance collaborations. The 'Building Board Capability Program' is well supported by all local agencies and has demonstrated tangible governance outcomes in the region. Our commitment to working in partnership with other agencies is unwavering and was rewarded by being selected as a finalist in the Australian Centre for Healthcare Governance Awards.

Our Statement of Priorities agreement with the Department of Health and Human Services provides a framework for shared goals and activity targets. The Board of Management has ensured the appropriation and application of resources to achieve the key elements of the Statement of Priorities; and support its own strategic objectives in meeting the needs of our community.

In collaboration with the Department of Health and Human Services 14 'Strategic Priorities' were agreed for 2014-2015 with all the objectives being accomplished. Complementary to these outcomes, our performance against the key priorities as measured in the Victorian Health Services Performance Monitor Report; we met all the designated targets. The headline result for 2014-2015 is an operating surplus of \$572,000; which included treating an additional 3.1% of inpatients above our agreed target, which equates to an additional 210 people receiving inpatient care. The calibre of these results placed Wimmera Health Care Group as the equal highest performing Regional and Sub-regional health service in rural Victoria as measured against the Victorian Health Services Performance Monitor. This recognises the extensive strategies undertaken through the Hospital Redesign Program and Health Improvement Capability Quotient Tool which facilitates the assessment and monitoring of our capability to drive and sustain continuous improvement and approach operational excellence. The operational environment

has been further strengthening through the alignment of employee behaviours with our values and direction as reflected through the People Matters Survey - leading to a greater focus on our workforce needs. Current results are highly valued by the Board of Management and staff, and are reflective of our improved service capability, strategic planning execution and ongoing commitment to building a sustainable health service for all the Wimmera and Southern-Mallee.

The Wimmera Health Care Group fundraising committees have again proven to be significant contributors as they promote and market their activities in our community. The initiation by Wimmera Health Care Group Foundation Trustees to support a redeveloped oncology unit is testimony to the enthusiasm and commitment of our fundraising committees. The proposed Wimmera Cancer Centre project has rallied and focused the community on this significant piece of infrastructure for the Wimmera and Southern-Mallee from which our poor five year cancer survival rates can be addressed. The collaboration between the Foundation and Federal Member for Mallee Andrew Broad culminated in a Commonwealth Government contribution of \$1 million towards the project; and was further supplemented with a fundraising breakfast held at the Wimmera Base Hospital site to highlight the occasion. The Foundation and their supporter groups were the driving force behind this significant community event and made this exceptional outcome possible.

In thanking the individual Board of Management members for their ongoing support and commitment to the values and strategic direction of Wimmera Health Care Group and the region as a whole, the Board acknowledges the contribution made by Mr Dean Luciani and Mr Robert Pyers for their respective tenures on the Board. We also welcome Mrs Merryn Eagle and Ms Linda Kwok to the Board in 2015-2016, their

contribution will further strengthen the Boards skills and capabilities.

The Wimmera Health Care Group has had a successful year in positioning itself for the future and we will continue to work collaboratively with our partners across the region to develop and promote the best of care that is available. We are committed to the efficient and effective operation of our business and have an absolute commitment to the community and government to meet the changing needs of our population. Primary to our vision is to ensure we continue to build our financial sustainability; attract and maintain a skilled and professional workforce; and safely deliver the best quality of care as close to home as possible.

Mark Williams
President

Chris Scott
Chief Executive

STATEMENT OF PRIORITIES

Part A - Strategic Priorities

PRIORITY	ACTION	DELIVERABLE	OUTCOME
Developing a system that is responsive to people's needs.	Develop an organisational policy for the provision of safe, high quality end of life care in acute and sub-acute settings with clear guidance about the role of, and access to, specialist palliative care.	By March 2015 Wimmera Health Care Group will appoint a palliative care medical physician. By June 2015 Wimmera Health Care Group will demonstrate full utilisation of the 'Care of the Dying' pathway for all inpatient services.	Achieved. Palliative care physician appointed for services at Wimmera Health Care Group. 'Care of the Dying' pathway is utilised in all inpatient services. This pathway has been reviewed and updated by the Wimmera Health Care Group Palliative Care Approach in Aged Care Working Party. Ongoing staff education is provided. Protocols have been developed and implemented to ensure all clients have the opportunity to develop an Advance Care Plan. This has included the preparation of an information brochure and the implementation of relevant policies, procedures and guidelines. Respecting Patient Choices facilitators continue to be trained across the organisation, and Advance Care Planning education is now mandatory for all clinical staff. The 'Refusal of Treatment' certificate recently developed has an associated checklist to assist clients and staff.
	Implement an organisation-wide policy for responding to clinical and non-clinical violence and aggression by patients, staff and visitors (including code grey) that aligns with department guidance (2014).	By December 2014 Wimmera Health Care Group will establish a 'Code Grey Team' and expand on it's policy development and formal training program; then by May 2015 have conducted an evaluation to measure alignment to the Department of Health and Human Services guidelines.	Achieved. The Code Grey Policy and Procedures are complete and available to all staff. 'Code Grey Team' members and frontline support staff have been identified, with education programs and workplace strategies implemented. A training DVD has been developed and implemented. An evaluation of the program conducted in June 2015 reported a strong alignment with the Department of Health and Human Service's guidelines.
	Progress partnerships with other services to improve outcomes for regional and rural patients.	Following completion of the new sub-acute facility and in collaboration with key stakeholders, Wimmera Health Care Group will advance the sub-acute model of care and implement the inpatient rehabilitation service for the Wimmera Southern-Mallee region by May 2015.	Achieved. Sub-acute unit was completed and received its first patients in December 2014. Promotional material for local General Practitioners and health services is widely distributed. Model of Care for Rehabilitation service is supported by medical teams and multidisciplinary meetings established; with support from Ballarat Health Services to provide both additional rehabilitation consultant support and deliver a regional referral network. Support for the service across the sub-region was reflected in demand with occupancy rates exceeding 2014-2015 service targets.

STATEMENT OF PRIORITIES

Part A - Strategic Priorities

PRIORITY	ACTION	DELIVERABLE	OUTCOME
Improving every Victorian's health status and experiences	Use consumer feedback to improve person and family centred care, health service practice and patient experience.	By December 2014 Wimmera Health Care Group will identify three patient experience improvement strategies in response to feedback from the Victorian Healthcare Experience Survey.	Achieved. Three programs identified and implemented as a consequence of feedback in the Victorian Healthcare Experience Survey: Customer service education and training for front line, clinical and non-clinical staff that work in the Emergency Department. Subsequent results demonstrate consumer experience improvement. Review the handover process in the acute care setting to improve communication and systems. Develop a system to check bathroom amenities cleanliness.
	Apply existing capability frameworks and clinical guidelines to inform service system planning.	Wimmera Health Care Group will actively participate in two of the innovation projects recognised by the Wimmera Southern-Mallee 'Unplanned Presentations' steering committee in 2014-15.	Achieved. The Wimmera Southern-Mallee 'Unplanned Presentations' steering committee selected the following two projects, which Wimmera Health Care Group actively participated in: Assessment Squad - additional urgent care patients receive the care they need in the home; and Virtual Hub - supporting urgent care decision making in the Wimmera Southern-Mallee – that is, transfers to Wimmera Health Care Group Emergency Department from other hospitals. The Wimmera Health Care Group is an active participant in the steering committee; which is evidenced by attending meetings, implementing strategies and providing resources to underpin the progressive outcomes.
	Progress improvements to the health and wellbeing status of the indigenous population consistent with Victorian Aboriginal Affairs Framework 2013-2018.	By June 2015 Wimmera Health Care Group will build on the Koolin Balit strategy by developing a program specific to the Aboriginal community that delivers improved access to primary and acute health services.	Achieved. In support of making a significant and measurable impact on improving the length and quality of the lives of Aboriginals in Victoria an access audit was completed and recommendations formulated. In support of the key enabler of cultural responsiveness: Cultural awareness training programs specific to the Wimmera area have been provided to staff. An Aboriginal culture specific service directory has been developed and distributed to community members to improve access and health literacy.

STATEMENT OF PRIORITIES

Part A - Strategic Priorities

PRIORITY	ACTION	DELIVERABLE	OUTCOME
Expanding service, workforce and system capacity	Develop and implement a workforce immunisation plan that includes pre-employment screening and immunisation assessment for existing staff that work in high risk areas in order to align with Australian infection control and immunisation guidelines.	By December 2014 Wimmera Health Care Group will develop a workforce immunisation plan that effectively aligns with the Australian immunisation guidelines.	Achieved. Workforce immunisation plan submitted in December 2014 to the Department of Health (Commonwealth). Immunisation plan incorporated into induction for all new staff, with an 89.5% immunisation rate for all staff being achieved in 2014-2015.
	Support excellence in clinical training through productive engagement in clinical training networks and developing health education partnerships across the continuum of learning.	By May 2015 Wimmera Health Care Group will increase access to weekly contact for medical students' tutorials, case presentations and online discussion through the Deakin University: Integrated Model of Medical Education in Rural Settings (IMMERSe) program.	Achieved. Commenced 2015 intake of the Integrated Model of Medical Education in Rural Settings (IMMERSe) students by increasing the number of tutorials and case studies by 50%. Now includes all specialities in clinical training and provides a substantial increase in student contact and access to training. The IMMERSe 2015 training program implemented with four weekly clinical training sessions across all medical specialities.
Increasing the system's financial sustainability and productivity	Identify and implement practice change to enhance asset management.	By December 2014 Wimmera Health Care Group will establish a Plant and Equipment Planning Committee with accompanying policies and procedures to support Asset Management Plans and End of Life details.	Achieved. Plant and Equipment Planning Committee established; Terms of Reference adopted and committee takes responsibility for monitoring the Basic Asset Management Plan. All major assets have end of life information documented in asset management software. The information informs the 2015-2018 Basic Asset Management Plan and organisation's ongoing Capital Renewal Plan.
	Reduce health service administrative costs.	By June 2015 Wimmera Health Care Group will develop and implement three innovative programs on workforce and process redesign; and the application of new technologies to improve administration efficiency as part of the Redesigning Hospital Care Program (Commission for Hospital Improvement).	Achieved. In support of the Commission for Hospital Improvement, Redesigning Hospital Care Program, Wimmera Health Care Group undertook a number of service changes in workforce and process redesign. The following represent just three of these strategies; Completed a 'Primary Care Department Review' to develop and implement a more sustainable management structure and service delivery model. Commenced a 'Chemotherapy Service Redesign Project' to increase the capability of our Chemotherapy Day Unit team in 'Lean' business improvement techniques; promoting locally led service improvements, and completed a 'Workforce and Process Redesign Project in Residential Aged Care' as a key part of the implementation of the Resident Centred Model of Care focus.

STATEMENT OF PRIORITIES

Part A - Strategic Priorities

PRIORITY	ACTION	DELIVERABLE	OUTCOME
Implementing continuous improvements and innovation	Develop a focus on 'systems thinking' to drive improved integration and networking across health care settings.	By June 2015 Wimmera Health Care Group will develop and implement an innovative system improvement strategy for discharge planning and patient flow across the emergency, acute and sub-acute clinical areas as part of the Redesigning Hospital Care Program (Commission for Hospital Improvement).	Achieved. In support of the Commission for Hospital Improvement, Redesigning Hospital Care Program, Wimmera Health Care Group undertook a number of system improvement changes, the most predominant being in patient flow. The 'Discharge Planning and Patient Flow' project identified a number of activities for improvement, namely: Discharge metrics developed and monitored; A daily pre-discharge checklist; A review of morning and afternoon ward rounds; Developing a Transit Lounge for patient discharge; Standardised process for admission to Ward from Emergency Department by After Hours Co-ordinators; and a Discharge Planning and Patient Flow Working Group established. A further significant initiative implemented has included a 'fast track' bay in the Emergency Department for Triage 4 and 5 patients during peak times. An investment in medical resources has provided greater coverage; with all initiatives leading to all Access Targets in the Emergency Department being met.
Increasing accountability and transparency	Undertake an annual board assessment to identify and develop board capability to ensure all board members are well equipped to effectively discharge their responsibilities.	By February 2015 Wimmera Health Care Group will undertake the annual board member assessment program using an appropriate framework for assessing the effectiveness of the board and its committee structures. In 2014–15 the Wimmera Health Care Group Board will continue to participate in and share learnings from the regional and state-wide Building Board Capability Network and professional development opportunities.	Achieved. Annual Board member assessments were completed using the Australian Centre for Healthcare Governance -Governance Evaluator Tool. Feedback from survey/review is used to build Board capability and assess effectiveness of the Board and committee structure. The Board of Management Chair is a member of the state-wide Building Board Capability Network. Board members regularly attend the regional Building Board Capability Network meetings and share their experiences and learnings back into the board. Network meetings were hosted in Horsham in October 2014 and February 2015, with a site visit to the new Wimmera Health Care Group Sub-acute facility being provided at the October meeting.

STATEMENT OF PRIORITIES

Part A - Strategic Priorities

PRIORITY	ACTION	DELIVERABLE	OUTCOME
	Demonstrate a strategic focus and commitment to aged care by responding to community needs as well as the Commonwealth Living Longer Living Better reforms.	By December 2014 Wimmera Health Care Group will have received and considered the second phase of the Aged Care Strategy for the appropriate long term delivery of high quality aged care services to the local community.	Achieved. The Board received and adopted the second phase of the Aged Care Strategy at its November 2014 meeting. The local community stakeholder engagement underpinned the formulation of the strategy whilst interpreting state and federal policy environments. The Aged Care Strategy was accepted by the Department of Health and Human Services.
Improving utilisation of e-health and communications technology.	Trial, implement and evaluate strategies that use e-health as an enabler of better patient care.	By March 2015 Wimmera Health Care Group will establish a communications framework to monitor patient flow between Wimmera Base Hospital and Rural Northwest Health.	Achieved. A video link was established between the Wimmera Health Care Group acute wards and Rural Northwest Health to develop timely communication and promote improved patient flow between the agencies.

STATEMENT OF PRIORITIES

Part B: Performance Priorities

Safety and quality performance		
KEY PERFORMANCE INDICATOR	TARGET	2014-15 ACTUAL
PATIENT EXPERIENCE AND OUTCOMES		
Victorian Healthcare Experience Survey	Full compliance	Full compliance
Healthcare associated infection surveillance	No outliers	No outliers
ICU central line associated blood stream infections (ICU CLABSI)	No outliers	N/A
SAB rate per occupied bed days	< 2/10,000	N/A
Maternity - Percentage of women with prearranged postnatal home care	100	100
GOVERNANCE, LEADERSHIP AND CULTURE		
Patient safety culture	80	86
SAFETY AND QUALITY		
Health Service accreditation	Full compliance	Full compliance
Residential aged care accreditation	Full compliance	Full compliance
Cleaning standards	Full compliance	Full compliance
Cleaning standards (AQL-A)	90	98
Cleaning standards (AQL-B)	85	98
Cleaning standards (AQL-C)	85	96
Submission of data to VICNISS	Full compliance	Full compliance
Hand hygiene (rate) – quarter 2	75	79
Hand hygiene (rate) – quarter 3	77	78
Hand hygiene (rate) – quarter 4	80	82
Health care worker immunisation – influenza	75	76

Financial Sustainability Performance		
KEY PERFORMANCE INDICATOR	TARGET	2014-15 ACTUAL
FINANCE		
Annual Operating result (\$m)	0.03	0.57
Creditors	<60 days	57
Debtors	<60 days	30
Percentage of WIES (public & private) performance to target	100%	103%
ASSET MANAGEMENT		
Basic asset management plan	Full compliance	Full compliance

STATEMENT OF PRIORITIES

Part B: Performance Priorities

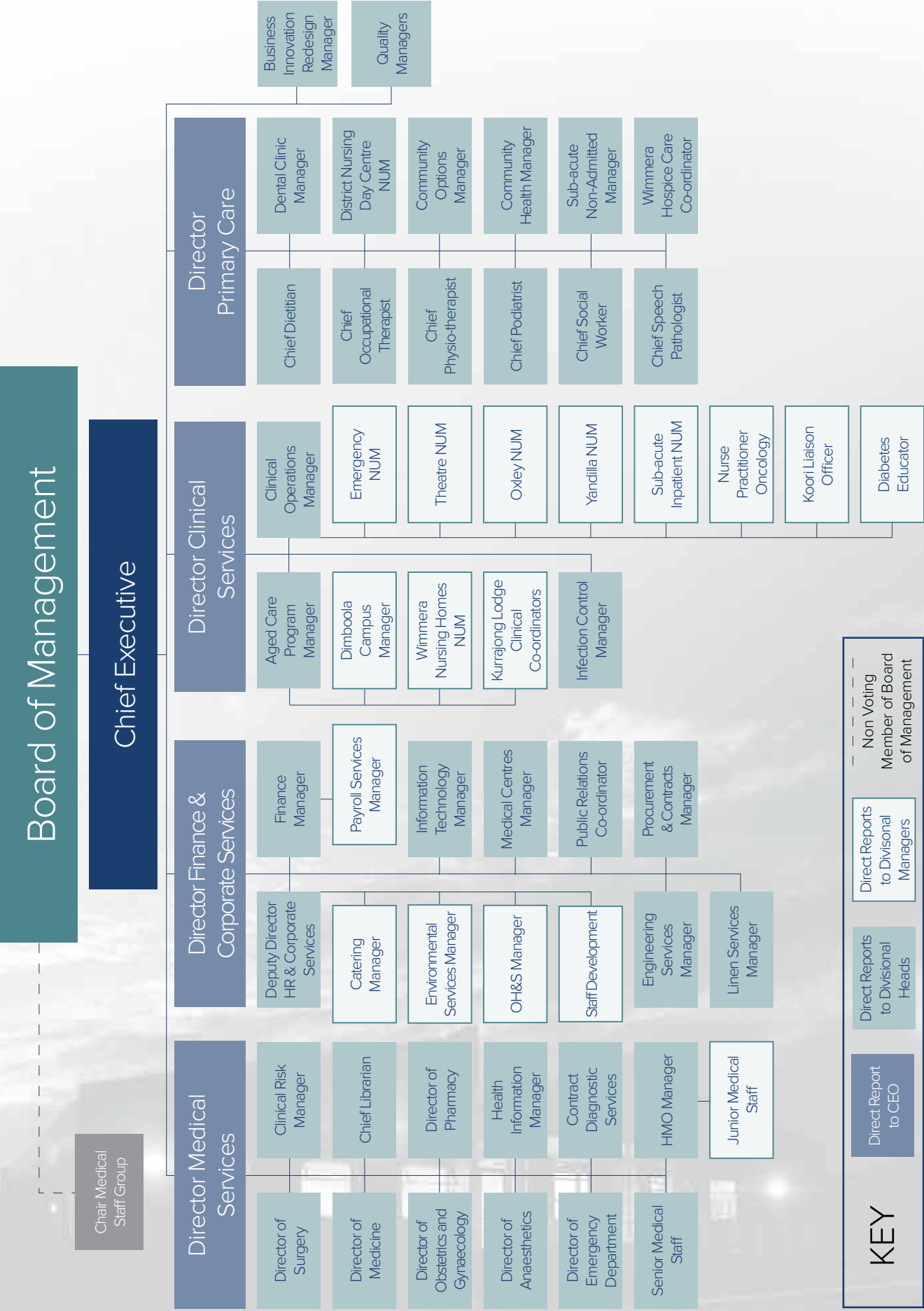
Access Performance

KEY PERFORMANCE INDICATOR	TARGET	2014-15 ACTUAL
EMERGENCY CARE		
Percentage of ambulance transfers within 40 minutes	90	96
Percentage of Triage Category 1 emergency patients seen immediately	100	100
Percentage of Triage Category 1 to 5 emergency patients seen within clinically recommended times	80	84
NEAT - Percentage of emergency presentations to physically leave the emergency department for admission to hospital, be referred to another hospital for treatment, or be discharged within four hours	81	81
Number of patients with a length of stay in the emergency department greater than 24 hours	0	0

Part C: Activity and Funding

FUNDING TYPE	2014-15 ACTIVITY ACHIEVEMENT
ACUTE ADMITTED	
WIES Public	5,266
WIES Private	1,684
WIES (PUBLIC AND PRIVATE)	
WIES DVA	229
WIES TAC	54
WIES TOTAL	7,233
SUBACUTE & NONACUTE ADMITTED	
Rehab Public	1,270
Rehab Private	344
GEM Public	2,839
GEM Private	1,012
GEM DVA	660
Palliative Care Public	229
Palliative Care Private	107
Palliative Care DVA	0
SUBACUTE NON-ADMITTED	
Health Independence Program (service events)	14,234
AGED CARE	
Residential Aged Care (bed days)	39,783
HACC	43,816
PRIMARY HEALTH	
Community Health / Primary Care Programs (hours)	8,044

ORGANISATIONAL CHART



CORPORATE GOVERNANCE 2014-2015

Board of Management

PRESIDENT AND CHAIRMAN:

Mr M A Williams (Mark)

*B Bus (Accounting and Data Processing),
MBA, CPA, ACS, IWA*

Profession/Occupation: Managing Director

Date Appointed: 1 November 2001

MEMBERS:

Mr E J McCabe (Ted)

Barrister and Solicitor of the Supreme Court of Victoria

Profession/Occupation: Lawyer

Date Appointed: 1990 -1997

Date Re-appointed: 1 November 2006

Mr R Pyers (Robert)

M Ed, B Letters, BA, Dip Ed

Profession/Occupation: Secondary College Principal

Date Appointed: 1 July 2010

Date Retired: 30 November 2014

Mr P Campbell (Phillip)

B.Com, MBA, FCPA, GAICD

Profession/Occupation: Chief Financial Officer

Date Appointed: 1 July 2011

Mr R Goudie (Richard)

Dip Fin Planning, CFP

Profession/Occupation: Senior Financial Planner

Date Appointed: 1 July 2011

DEPUTY CHAIRMAN:

Mr D Luciani (Dean)

Adv Dip Bus, Adv Dip Bus/HR, Grad Cert Mgt, FAICD

Profession/Occupation: Chief Executive

Date Appointed: 1 July 2009

Mr W Winter (William)

*MAICD, Chairman, Geelong Company Directors
Forum*

Profession/Occupation: Private Company Board
Advisor

Date Appointed: 1 July 2011

Ms A Murphy (Angela)

B.Bus (Acc), B.Bus (Local Govt)

Profession/Occupation: Director Community Services

Date Appointed: 1 July 2012

Mrs M Aitken (Marie)

GAICD, MAPS, MAACBT

Profession/Occupation: Registered Psychologist
and Supervisor

Date Appointed: 1 July 2014

Board of Management Committees

Remuneration Committee

Members: M Williams (Chair), D Luciani, R Pyers, W Winter

Reviews performance of the Chief Executive and contractual requirements of the executive staff on an annual basis and makes recommendations on remuneration levels.

Audit and Risk Committee

Members: P Campbell (Chair), E McCabe, W Winter, M Williams (ex-officio)

Reviews the external auditor's draft management letters and final report and sets the internal audit program. The committee meets quarterly to monitor performance against audit and risk. The members are independent.

Clinical Governance Committee

Members: R Goudie (Chair), A Murphy, M Aitken, R Pyers, M Williams (ex officio)

Develops a comprehensive program to monitor, review and continually improve all the activities and services relevant to the quality of care provided for all patients. To assess the health care group's level of compliance with formal accreditation guidelines and oversee preparations for all accreditation and standards compliance. The Clinical Governance Committee provides a forum to consolidate the various elements of the Quality Improvement System.

Finance Committee

Members: M Williams (Chair), D Luciani, E McCabe, R Pyers, R Goudie, P Campbell, W Winter, M Aitken, A Murphy

Monitors and oversees the financial performance of the health care group and business units in detail. Recommends policies and procedures to ensure resources of the health care group are used in an efficient and effective manner and to maintain management procedures and systems to achieve this. Approve and monitor progress of major capital expenditure, capital management, acquisitions and divestitures making recommendation to the Board of Management on bad debts to be written off and any other matter related to finance as appropriate.

Medical Advisory Committee

Members: M Williams (Chair), E McCabe, R Goudie, M Aitken

Makes recommendations to the Board of Management relating to medical staff appointments and the delineation of clinical privileges.

Committees with Board Representation

Clinical Research Committee

Members: E McCabe, M Williams (ex officio)

Assesses all submissions for clinical research within Wimmera Health Care Group and recommends to the Board of Management those for approval. Monitors research projects and maintains a register of all approved projects.

Community Advisory Committee

Members: A Murphy, M Williams (ex officio)

Has a primary role in commenting on the service needs of local communities, the development of strategic plans and making recommendations on health service delivery to the Board of Management through the Chief Executive.

Nursing and Midwifery Advisory Committee

Members: M Aitken (Chair), M Williams (ex officio)

Provides a centralised representative forum for discussion and making recommendations to the Board of Management on matters related to nursing resources, education and practice.

OUR EXECUTIVE TEAM

CHIEF EXECUTIVE:

Mr Christopher G Scott

BHSc (Mgt), MBA (CSU), Dip CDC, AFACHSM, AIMM, CHE, GAICD.

The Chief Executive is responsible for leadership in the area of policy and strategic direction and provides the Board of Management with comprehensive information, analysis and timely advice on all Corporate and Clinical Governance matters affecting the organisation. The Chief Executive also leads and manages the day to day operations of the business to achieve optimum health outcomes and ensure the effective and efficient use of human resources and business assets. The Chief Executive leads a team of Executive Directors.

DIRECTOR FINANCE AND CORPORATE SERVICES:

Mr Mark Knights

B Bus, Grad Dip Bus (Acc), CPA.

The Finance and Corporate Services Division encompasses the non-clinical areas of the business. A number of these departments work directly with the clinical operations such as the catering and environmental services teams whilst other areas provide business and administrative support and maintenance of our facilities. These areas include finance, information technology, human resources, procurement, public relations and engineering. A number of key business units are managed directly by the Division including medical clinics, hospital coffee shop and linen service.

DIRECTOR MEDICAL SERVICES:

Professor Alan Wolff

MB, BS, MD, MBA, Dip RACOG, FRACGP, FRACMA, FACHSM.

The Medical Division provides medical services to inpatients, emergency department patients and outpatients. Specialist medical services are provided in anaesthetics, general medicine, general surgery, and obstetrics and gynaecology as well as visiting services in ENT, ophthalmology, oncology, psychiatry, geriatrics and rehabilitation, urology, oral surgery, orthopaedics, respiratory medicine, cardiology, neurosurgery and dermatology. General practitioners provide services in general medicine, obstetrics, anaesthetics, paediatrics, geriatrics and psychiatry. Visiting medical officers, staff specialists and hospital medical officers provide medical services. These doctors also provide teaching to medical students from Deakin University and the University of Melbourne. On-site pathology and radiology services are available from private providers. The Division also provides pharmacy, health information, library and clinical risk management services.

DIRECTOR PRIMARY CARE:

Ms Denise Hooper

RN, RM, Grad Dip OH&S, B.Bus.

Primary Health Care Services at Wimmera Health Care Group provide a comprehensive range of health services that are delivered in community and center-based settings. All services are provided in partnership with our consumers and seek to maximise individual abilities in order to enhance independence, self-management and general wellbeing. Our team comprises of a number of highly trained professional staff including specialist medical staff, allied health professionals, nursing and administrative support staff. A well-developed range of aged care outreach services are provided by our Community Options team, which resides in the Wimmera Uniting Care Building in Baillie Street and services Hindmarsh, Horsham Rural City, West Wimmera and Yarriambiack shires.

DIRECTOR CLINICAL SERVICES

Mr Don McRae

RN, M H Mgt, RM, Grad Dip Crit Care, CC Cert.

The Clinical Services Division comprises all inpatient and residential aged care services. This includes medical and surgical inpatient services, midwifery and obstetrics, operating suite, pre-admission and day procedure unit, emergency department, day oncology, and haemodialysis. The residential aged care services are provided through the Wimmera Nursing Homes, Kurrajong Lodge and Dimboola Hospital. The Division is also responsible for clinical support services such as infection control, diabetes education, central sterilising and supply department, Aboriginal liaison, admission and discharge and staff development.

OUR STAFF

MERIT AND EQUITY

Wimmera Health Care Group is an equal opportunity employer. Appointments are based on merit, without regard to race, gender, religious belief or any other factor not related to the pursuit of excellence in patient care.

HUMAN RESOURCES INITIATIVES

This year the Human Resources (HR) department has focused on streamlining HR processes and procedures across all areas of the organisation. This included reviewing and improving recruitment, performance management and training and

development practices as well as updating and developing our policies and procedures. We will also be developing further initiatives to become an employer of choice and expand our professional development opportunities. These include training in areas such as cultural diversity and mental health issues.

INDUSTRIAL RELATIONS

There were no industrial relations disputes.

Workforce Data Disclosures

LABOUR CATEGORY	JUNE Current Month - FTE		JUNE YTD FTE	
	2014	2015	2014	2015
Nursing	273.93	286.39	279.67	284.26
Administration and Clerical	97.63	103.45	101.28	101.64
Medical Support	22.20	22.38	22.47	22.98
Hotel and Allied Services	126.85	138.51	135.38	131.82
Medical Officers	6.28	4.21	7.41	5.18
Hospital Medical Officers	22.35	23.05	22.76	22.85
Sessional Clinicians	0.00	0.00	0.00	0.00
Ancillary Staff (Allied Health)	46.31	47.15	43.72	45.73

PRESENTATIONS

Mrs Melanie Hahne

Wimmera Hospice Care Co-ordinator, July 2014

Palliative Care Victoria State-wide Conference: Living, dying and grieving well, Melbourne

“Palliative Care orientation training program for overseas trained nurses”

Mrs Gay Baker

Continence Nurse Consultant, November 2014

Building Blocks for the Future Forum, Halls Gap

“Managing Continence Care in the HACC Community”

Mrs Anne Richards

Sub-acute Services Manager, Mrs Cathy Newell - Complex Care Team Leader, April 2015

Health Independence Program, Community of Practice Forum, Department of Health and Human Services, Melbourne

“Community of Practice Complex Care - Strengthening a Working Relationship in Complex Care”

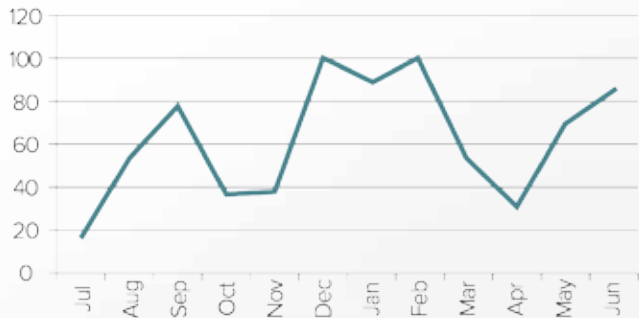
OCCUPATIONAL HEALTH AND SAFETY

Wimmera Health Care Group recognises that it is our moral and legal responsibility to provide a safe and healthy environment for employees, contractors and visitors. This commitment extends to ensuring the organisation's operations do not place the local community at risk of injury, illness or damage to property and/or the environment. Wimmera Health Care Group's 'Safety Management Plan' ensures the organisation's commitment that activities carried out at all campuses are safe and in compliance with regulatory requirements. We promote a safe working culture that is enhanced by personal responsibility and ownership and supported by training, supervision and management.

Security

Wimmera Health Care Group's security team has responded to 503 requests to attend security related duties which equated to 752.25 hours. Of the 503 requests for security there were 94 recorded incidents where police attended. There were 72.32 reported security incidents/hazards per 100 full time staff in the reporting year.

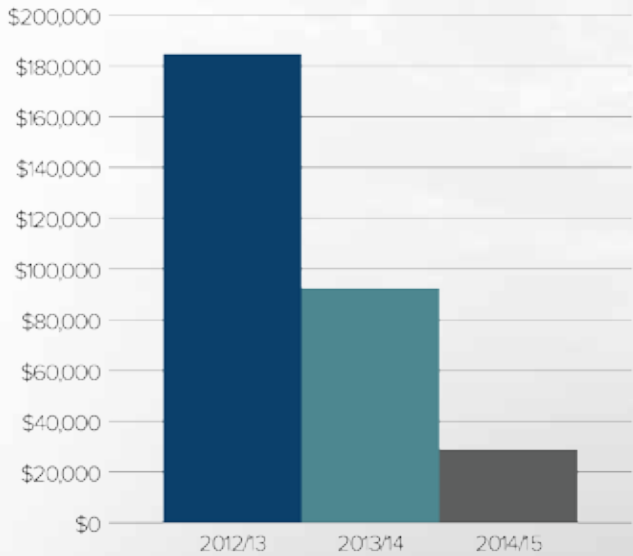
2014/15 Security Hours Monthly Total



Workers Compensation

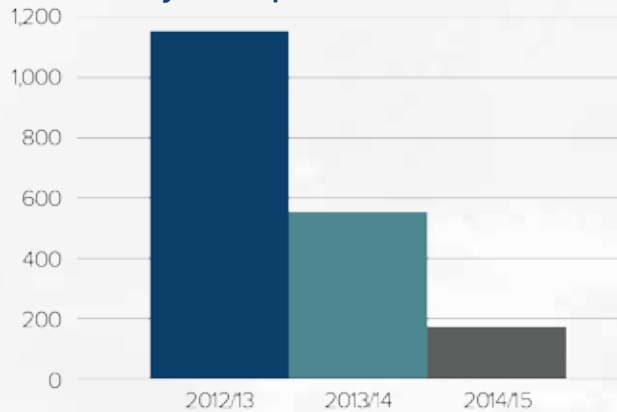
All employees and other persons deemed to be employees will be provided with Workers Compensation Insurance under the *Occupational Health and Safety Act 2004* and *Workplace Injury Rehabilitation and Compensation Act 2013*. Wimmera Health Care Group recognises the wellbeing of their staff is of the utmost importance. Wimmera Health Care Group is committed to the treatment and rehabilitation of any injured employee.

Claims Costs Paid



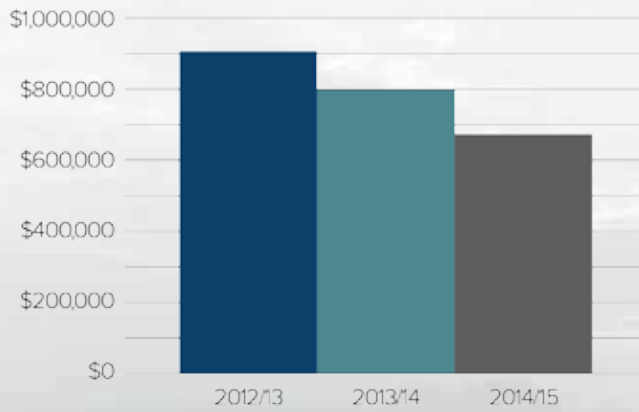
Wimmera Health Care Group has reduced claims costs paid from \$94,723 in the 2013/14 year to \$29,092 in the 2014/15 year.

Days Compensation Paid



Wimmera Health Care Group has reduced days of compensation paid from 560 for 2013/14 to 185 for the 2014/15 year.

Premium Paid



Wimmera Health Care Group has reduced the premium paid from \$793,706 in the 2013/14 year to \$680,413 in the 2014/15 year.

FINANCIAL OVERVIEW 2014/15

Wimmera Health Care Group's long-term financial objectives are to continue to improve financial performance, provide funds to reinvest into the organisation, allocate our limited resources to maximise patient, resident and client outcomes and to address strategic priorities. We use a number of Key Performance Indicators to monitor our financial viability including:

1. Operating performance – achieving activity targets and a surplus from operations.
2. Liquidity – ensuring sufficient assets are available to meet liabilities as they fall due. The Department of Health and Human Services' (DHHS) expectation is a ratio in excess of 0.7.
3. Asset Management – ensuring that sufficient levels of investment are undertaken to maintain the asset base.

Operating Performance

The operating result (prior to capital and specific items) was a surplus of \$572,000 which was \$542,000 ahead of budget. The result reflects the commitment of staff across all areas of the organisation to achieve the goals set in our Financial Management Improvement Plan (FMIP). The FMIP focused on elimination of waste and the optimisation of funding and revenue streams whilst ensuring high quality care was delivered.

The major activities for the year included the introduction of a new model of care in residential aged care, increased occupancy levels in residential aged care, the opening of the Wyuna sub-acute facility and increased patient activity across the acute, allied health and primary care divisions.

Offsetting the positive outcomes of the FMIP was the ongoing challenge of maintaining a full complement of specialist medical staff, which relied heavily on costly locum services and the impact of changes to the charging arrangements for emergency transport.

During the year we have seen significant additions to the fixed asset base of the organisation including the new sub-acute facility, redevelopment of our dental clinic, replacement of both chiller units, renovation of a number of administrative and patient areas and the purchase of a number of items of medical and non-medical equipment.

Liquidity levels have improved during the year with the current asset ratio of 0.77 at June 30, 2015.

The combination of the above achievements has resulted in the Victorian Auditor General's Office recognising our improved financial position. As a result we were not required to obtain a letter of comfort from the Department of Health and Human Services to underwrite our debts for the 2015/16 year which has been required in prior years.

Wimmera Health Care Group is unaware of any events subsequent to balance date that may have a significant effect on operations of the entity in future years.

Summary of Financial Results

	2015 \$000	2014 \$000	2013 \$000	2012 \$000	2011 \$000
Total Revenue	82,535	93,051	79,541	75,064	72,009
Total Expenses	82,402	78,271	76,277	75,165	71,555
Net Result for the Year (inc. Capital and Specific Items)	133	14,780	3,264	(101)	494
Retained Surplus / (Accumulated Deficit)	(8,471)	(7,214)	(11,622)	(10,808)	(9,244)
Total Assets	81,475	80,287	63,186	60,728	58,022
Total Liabilities	22,187	22,382	20,061	20,867	18,060
Net Assets	59,288	57,905	43,125	39,861	39,962
Total Equity	59,288	57,905	43,125	39,861	39,962

Major Equipment Purchases over \$10,000 2014-2015

ITEM	PRICE \$000	ITEM	PRICE \$000
Colonoscopes	164	Patient Intellivue Monitors	34
Air Conditioning – Day Centre	149	Urocap IV Wireless Uroflowmeter	33
Dental Chairs	52	Force Triad Energy Platforms	31
Anaesthesia Machines	50	Patient Journey Board	18
Avalon Fetal Monitor	44	Thermal Disinfectors	18
Convotherm Boiler	44	Digital X-Ray	13
Dental Hand Piece Kits	34		
		Total	\$684

Consultancies

Consultant Individually > \$10k	Purpose of Consultancy	Start Date	End Date	Total Approved project fee \$'000	Expenditure 2014-15 \$'000	Future expenditure \$'000
Syris Consulting	Clinical Costing	1/07/2014	30/06/2015	15	15	-
Foresight Lane Pty Ltd	Aged Care Consulting	1/07/2014	30/06/2015	50	50	-
Promentor Pty Ltd	Acute Care Consulting	1/07/2014	30/06/2015	36	36	-
HF Legal Services Pty Ltd	Review Medical Centre	1/07/2014	31/01/2015	11	11	-
Lifemastery (Aust) Pty Ltd	Strategic Planning	1/09/2014	31/03/2015	11	11	-
The Mordun Group	Leadership Program	1/07/2014	30/06/2015	33	33	-
Balcombe Griffiths Pty Ltd	Dental Redevelopment	1/08/2014	30/06/2015	46	46	-
Invertech Pty Ltd	Capital Projects	1/07/2014	30/06/2015	25	25	-
Ernst & Young	Aged Care Consulting	1/04/2015	30/06/2015	150	150	-
Total individually > \$10k (GST exclusive)				\$377		

In 2014-15 there were 7 consultancies where the total fees payable to the consultants were less than \$10,000. The total expenditure incurred during 2014-15 in relation to these consultancies is \$16,000 (GST exclusive).

COMPLIANCE

FINANCIAL MANAGEMENT ACT 1994

In accordance with the direction of the Minister for Finance, Part 9.1.3 (IV), information requirements have been prepared and are available to the relevant Minister, Members of Parliament and the public on request.

OCCUPATIONAL HEALTH AND SAFETY

In accordance with the *Occupational Health and Safety Act 2004*, responsibility is accepted to be proactive and take reasonable practical measures to ensure health and safety, exchange information and ideas with staff about risks to health and safety and take measures to eliminate or reduce occupational risk.

BUILDING AND MAINTENANCE

All building works have been designed in accordance with DHHS Capital Development Guidelines and comply with the *Building Act 1993*, *Building Regulations 2006* and the *Building Code of Australia*.

CARERS RECOGNITION ACT 2012

Wimmera Health Care Group has taken measures to ensure awareness and understanding of care relationship principles, in line with Section 11 of the *Carer's Recognition Act 2012*.

EX-GRATIA PAYMENTS

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

ENVIRONMENTAL PERFORMANCE

Wimmera Health Care Group continues our commitment to sustainability and has developed an Environmental Management Program. New and ongoing energy saving initiatives include the installation of a 20KVA solar panel system, introduction of hybrid vehicles into the fleet and significantly reduced the use of polystyrene and office waste bins.

COMPLIANCE WITH DATAVIC ACCESS POLICY

The tables in the Annual Report will be submitted to DataVic to be made available at:

<http://www.data.vic.gov.au/category/health>

FREEDOM OF INFORMATION

Wimmera Health Care Group has received 83 requests for information under the *Freedom of Information Act 1982* during the 2014/15 financial year, a decrease of 15 on the previous financial year.

From the 83 requests:

- 64 cases access was granted in full
- No cases where the records were destroyed
- 1 request for access was denied
- 3 cases where no documents were available
- 6 cases the requests were not proceeded with
- 9 cases the requests were not yet finalised at time of reporting

Using discretion, Wimmera Health Care Group continues to promote a policy of giving staff, patients and the general public access to information.

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.

VICTORIAN INDUSTRY PARTICIPATION POLICY

Wimmera Health Care Group complies with the requirements of the *Victorian Industry Participation Policy Act 2003*.

DECLARATIONS OF PECUNIARY INTEREST

All necessary declarations have been completed and duly noted at the time of occurrence. Refer to note 21 (a) of the financial statements.

APPLICATION AND OPERATION OF THE PROTECTED DISCLOSURE ACT 2012

Wimmera Health Care Group is committed to the aims and objectives of the *Protected Disclosure Act 2012*. Wimmera Health Care Group will not tolerate improper conduct by its employees, executives, officers or members nor detrimental action against those who come forward to disclose such conduct.

DISCLOSURE INDEX

Please refer to page 25.

COMPLIANCE

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

I, Chris Scott certify that the Wimmera Health Care Group has complied with the Ministerial Standing Direction 4.5.5 - Risk Management Framework and Processes. The Wimmera Health Care Group Audit and Risk Committee verifies this.



Chris Scott
Accountable Officer
Horsham
25 August 2015

ATTESTATION ON DATA INTEGRITY

I, Chris Scott certify that the Wimmera Health Care Group has put in place appropriate internal controls and processes to ensure that reported data reasonably reflects actual performance. The Wimmera Health Care Group has critically reviewed these controls and processes during the year.



Chris Scott
Accountable Officer
Horsham
25 August 2015

COMPLIANCE

OTHER INFORMATION

Consistent with FRD 22F (Section 6.18) the items listed below have been retained by Wimmera Health Care Group and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements):

- (a) Declarations of pecuniary interests have been duly completed by all relevant officers
- (b) Details of shares held by senior officers as nominee or held beneficially;
- (c) Details of publications produced by 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.

Life Governors

Wimmera Health Care Group values the significant contribution that many individuals make to our health service. Life Governorships are awarded to people whose actions or contributions have changed the organisation. See below for a full list of life governors.

Dr R Abud	Dr P Haslau	Mr D McFarlane	Mr F Schultz
Mr I Anderson	Miss B Hill	Mr W McGrath	Miss N Schurmann
Mrs M Baker	Mr B Johansen	Mrs L McKenzie	Mrs L Sharrock
Mrs J Blythe	Rev A Johns	Mrs R McKenzie	Ms M Smith
Mr N Bothe	Mr D Johns	Mrs J McRae	Miss L Stenhouse
Mrs P Bothe	Mr J Kemfert	Miss M Menzel	Mrs V Stenhouse
Mr P Brown	Mr G Kitchen	Dr E Miller	Mr P Troeth
Mr I Campbell	Mrs C Kroker	Mrs E Mitchell	Mr P Wajszel
Mrs F Carine	Prof R Larkins	Mrs L Montgomery	Mr A Walsgott
Mrs J Carter	Mr K Lehmann	Dr M O'Brien	Mr A Walsgott
Mr M Castellucio	Mr C Leith	Mr K O'Connor	Prof R Webster
Mrs P Corner	Mr G Lind	Mr A Phillips	Mr A Wells
Mr M Cuddihy	Dr M Lloyd	Mr J Pietsch	Mrs J Wells
Mr I Draffin	Mr K Lovett	Mrs D Pilmore	Dr L Wong Shee
Mrs S Driscoll	Mr J McCabe	Mr P Robertson	Mr A Wood
Mrs U Faux	Mr C McDonald	Mrs J Saxton	

DONATIONS

Donations of \$100 or more

100 Chicks Chase 100 Clicks	Horsham & District Orchid Society	Outdoor Timber Treatment
A & G Vanderwaal	Horsham Charity Events	Patrick Ryan
Alex Goudie	Horsham Church Of Christ	Patrick, Kayla, Hannah & Nadia White
Andrew Broad MP	Horsham Doors & Glass	Peter & Denise Ralph
Apex Club	Horsham Golf Club	Peter Fedke
Basil Nowotna	Horsham Post Office	Rebecca Dunlop
BCH Accountants	Horsham Sports & Community Club	Rednic Rock
Betty Cook	Hotondo Homes Horsham	RJ & GM Schneider
Bill McGrath	Iluka Resources Ltd	Robert Goudie
Bruce Harberger	Jean Anderson	Robyn & Des Lardner
Carol Smithett	John Mott	Ronald Angley
Chris & Julie Scott	Justin Rethusglen Huntly	Rural Northwest Health
Conundrum Holdings	K & S Gibbs	Sadie Krelle
Country Fire Authority Horsham	Kaniva Branch of the Cancer Council	Simon McNamara
Craig O'Connor	Ken Curzon	Smallaire Pty Ltd
Culturally and Linguistically Diverse Committee	Kerryn Shade	Steve Wik
Denise K Wallis	L Crouch	The Hon. Tony Abbott, MP Prime Minister of Australia
Dimboola East Ladies Auxiliary	Laser Electrical Horsham	Tony Schneider
Doreen J Galvin	Lester & Robyn Maybery & Family	Tracey & Peter Daffy
Driscoll, Mcillrey & Dickinson	Lighthouse Building Permits	Uniting Church Bible Study Group
EB Jones	Lions Club Of Horsham	Val Baum
Estate Late Doris Evelyn Burkhart	Lions Club of the City of Horsham	Wayne Watkins
Gavin Marshman	Luca Goudie	Wendy Mitchell, Brian Watts
Geoff Lord	Lynette Crittenden	Wimmera Base Hospital Ladies Auxiliary
Gill Mibus	Mark Williams	Wimmera Base Hospital Past Trainees Association
Glenis Reading	Marylou & John Spehr	Wimmera Health Care Group Foundation
Graham & Barbara Hair	Max & Elaine Cuddihy	Wimmera Hospice Care Auxiliary
Grant & Katherine Hollaway	Michael Georgeallis	Wimmera Hospice Care Trust
Grassflat Uniting Ladies Guild	Mink Hair	Woomelang & District Bush Nursing Centre
Greg Speirs	MJ & P Charlton	
Grosser Family	Old Time Dance & Social Club	
Gwen Bouchier		
Gwen Bouchier		
Hillross Horsham		

DISCLOSURE INDEX

The annual report of the Wimmera Health Care Group is prepared in accordance with all relevant Victorian legislation. This index has been prepared to facilitate identification of the Department’s compliance with statutory disclosure requirements.

LEGISLATION	DISCLOSURE REQUIRED	PAGE
Financial Management Act		
SD 4.2(a)	Compliance with Australian accounting standards (AAS and AASB standards) and other mandatory professional reporting requirements.	FS8
SD 4.2(b)	Financial Statements: <ul style="list-style-type: none"> income statement balance sheet statement of changes in equity cash flows statement notes to the financial statements. 	FS4 FS5 FS6 FS7 FS8
SD 4.2(c)	Accountable Officer, Chief Financial Officer and Responsible Body declaration and sign off.	FS1
SD 4.2(d)	Rounding of amounts	FS12
SD 4.2(j)	Responsible Bodies Declaration	4
Financial Reporting Directions		
FRD 10	Disclosure Index	25-26
FRD 11A	Disclosure of ex-gratia payments	21
FRD 21B	Responsible Persons Disclosure	FS57
FRD 22F	Manner of establishment and the relevant Ministers	Inside Cover, 1
FRD 22F	Purpose, functions, powers and duties	2-12
FRD 22F	Nature and range of services provided	Inside Cover
FRD 22F	Key initiatives, programs and achievements	4-12
FRD 22F	Organisational Structure	13
FRD 22F	Workforce data	17
FRD 22F	Statement on employment and conduct principles	17
FRD 22F	Occupational Health and Safety	18
FRD 22F	Financial information: <ul style="list-style-type: none"> summary of the financial results for past five years summary of the significant changes in financial position summary of the entity’s operational and budgetary objectives subsequent events Significant factors affecting performance 	20 19 19 19 4-5, 19

DISCLOSURE INDEX

FRD 22F	Details of consultancies over \$10,000	20
FRD 22F	Details of consultancies under \$10,000	20
FRD 22F	Application and compliance <ul style="list-style-type: none">summary of the application and operation of the Freedom of Information Act 1982 (FOI Act);statement on compliance with the building and maintenance provisions of the Building Act 1993;summary of the application and operation of the Protected Disclosure Act 2012;statement on the implementation and compliance with National Competition Policy;statement on the application and operation of the Carers Recognition Act 2012 (Carers Act).summary of an entity's environmental performance.	21 21 21 21 21 21
FRD 22F	Additional information available on request	23
FRD 25B	Disclosures under the Victorian Industry Participation Policy 2003.	21
Attestations		
SD 3.4.13	Attestation of Data Integrity	22
SD 4.5.5	Attestation of Risk Management Framework and Processes	22
	Compliance with DataVic Access Policy	21
Key Financial and Service Performance Reporting		
	Statement of Priorities: Part A Part B Part C	6-10 11-12 12

Wimmera Health Care Group

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

The attached financial statements for Wimmera Health Care Group have been prepared in accordance with Standing Directions 4.2 of 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 2015 and the financial position of the Wimmera Health Care Group at 30 June 2015.

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

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



Mr M. Williams
Chairperson

Horsham
25 August 2015



Mr C. G. Scott
Chief Executive

Horsham
25 August 2015



Mr M. Knights
Director of Finance &
Corporate Services

Horsham
25 August 2015

VAGO

Victorian Auditor-General's Office

Level 24, 35 Collins Street
Melbourne VIC 3000
Telephone 61 3 8601 7000
Facsimile 61 3 8601 7010
Email comments@audit.vic.gov.au
Website www.audit.vic.gov.au

INDEPENDENT AUDITOR'S REPORT

To the Board Members, Wimmera Health Care Group

The Financial Report

The accompanying financial report for the year ended 30 June 2015 of the Wimmera Health Care Group which comprises comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement, notes comprising a summary of significant accounting policies and other explanatory information, and the Board member's, accountable officer's and chief finance & accounting officer's declaration has been audited.

The Board Members' Responsibility for the Financial Report

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

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The audit procedures selected depend on judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, consideration is given to the internal control relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Board Members, as well as evaluating the overall presentation of the financial report.

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

Independent Auditor's Report (continued)

Independence

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

Opinion

In my opinion, the financial report presents fairly, in all material respects, the financial position of the Wimmera Health Care Group as at 30 June 2015 and of its financial performance and its cash flows for the year then ended in accordance with applicable Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*.

MELBOURNE
26 August 2015


John Doyle
Auditor-General

Wimmera Health Care Group Comprehensive Operating Statement For the Year Ended 30 June 2015

	Note	2015 \$'000	2014 \$'000
Revenue from operating activities	2	77,837	74,109
Revenue from non-operating activities	2	876	928
Employee expenses	3	(52,849)	(51,583)
Non salary labour costs	3	(4,958)	(4,066)
Supplies and consumables	3	(9,616)	(8,752)
Other expenses	3	(10,718)	(11,020)
Net result before capital and specific items		572	(384)
Capital purpose income	2	3,825	8,052
Net Gain/(loss) on disposal of Non-Current Assets	2(a)	(7)	(8)
Assets provided free of charge	2(b)	4	-
Impairment of financial assets		-	(67)
Depreciation and Amortisation	4	(4,108)	(2,853)
NET RESULT FOR THE YEAR		286	4,740
Other gains/(losses) from other comprehensive income			
Other gains/(losses) included: the revaluation of the present value of the long service leave liability due to changes in the bond interest rates	14	(153)	70
Items that will not be reclassified to net result			
Changes in physical asset revaluation surplus	14	-	9,970
Total other comprehensive income		(153)	10,040
Comprehensive result		133	14,780

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

Wimmera Health Care Group
Balance Sheet
As at 30 June 2015

	Note	2015 \$'000	2014 \$'000
Current assets			
Cash and cash equivalents	5	11,909	11,698
Receivables	6	3,280	2,446
Inventories	7	334	381
Prepayments		191	251
Total current assets		15,714	14,776
Non-current assets			
Receivables	6	1,665	1,249
Property, plant & equipment	8	64,096	64,262
Total non-current assets		65,761	65,511
TOTAL ASSETS		81,475	80,287
Current liabilities			
Payables	9	4,081	3,799
Borrowings	10	10	8
Provisions	11	11,623	12,374
Other current liabilities	13	4,772	4,726
Total current liabilities		20,486	20,907
Non-current liabilities			
Borrowings	10	2	13
Provisions	11	1,699	1,462
Total non-current liabilities		1,701	1,475
TOTAL LIABILITIES		22,187	22,382
NET ASSETS		59,288	57,905
EQUITY			
Property, plant & equipment revaluation surplus	14a	36,537	36,537
Restricted specific purpose surplus	14b	4,016	2,626
Contributed capital	14c	27,206	25,956
Accumulated surpluses/(deficits)	14c	(8,471)	(7,214)
TOTAL EQUITY	14c	59,288	57,905
Commitments	18		
Contingent Assets and Liabilities	24		

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

Wimmera Health Care Group
Statement of Changes in Equity
For the Year Ended 30 June 2015

		Property, Plant & Equipment Revaluation Surplus	Restricted Specific Purpose Surplus	Contributions by Owners	Accumulated Surpluses/ (Deficits)	Total
	Note	\$'000	\$'000	\$'000	\$'000	\$'000
Balance at 1 July 2013		26,567	2,224	25,956	(11,622)	43,125
Net result for the year		-	-	-	4,740	4,740
Other comprehensive income for the year	14a,c	9,970	-	-	70	10,040
Transfer to accumulated surplus	14a,c	-	402	-	(402)	-
Balance at 30 June 2014		36,537	2,626	25,956	(7,214)	57,905
Net result for the year		-	-	-	286	286
Other comprehensive income for the year	14c	-	-	-	(153)	(153)
Transfer to accumulated surplus	14a,c	-	1,390	-	(1,390)	-
Contributed capital from government	14b	-	-	1,251	-	1,251
Balance at 30 June 2015		36,537	4,016	27,206	(8,471)	59,288

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

Wimmera Health Care Group
Cash Flow Statement
For the Year Ended 30 June 2015

	Note	2015 \$'000	2014 \$'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating grants from government		65,353	60,827
Patient and resident fees received		7,609	5,759
GST received from/(paid to) ATO		1,736	1,975
Interest received		373	420
Other receipts (<i>disclose material items</i>)		4,687	6,328
Total receipts		79,758	75,309
Employee expenses paid		(52,422)	(50,169)
Non salary labour costs		(4,858)	(3,953)
Payments for supplies & consumables		(12,573)	(11,650)
Other payments		(9,919)	(9,764)
Total payments		(79,772)	(75,536)
Cash generated from operations		(14)	(227)
Capital grants from government		3,261	7,687
Capital donations and bequests received		501	223
NET CASH FLOW FROM/(USED IN) OPERATING ACTIVITIES	15	3,748	7,683
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for non-financial assets		(3,563)	(7,889)
Proceeds from sale of non-financial assets		4	7
NET CASH FLOW FROM/(USED IN) INVESTING ACTIVITIES		(3,559)	(7,882)
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of borrowings		(12)	21
NET CASH FLOW FROM/(USED IN) FINANCING ACTIVITIES		(12)	21
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		177	(178)
Cash and cash equivalents at beginning of financial year		7,066	7,244
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	5	7,243	7,066

This Statement should be read in conjunction with the accompanying notes

Note 1: Summary of significant accounting policies

These annual financial statements represent the audited general purpose financial statements for Wimmera Health Care Group for the period ending 30 June 2015. 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 general purpose financial statements which have been prepared in accordance with the *Financial Management Act 1994* and applicable 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 AASs.

The annual financial statements were authorised for issue by the Board of the Wimmera Health Care Group on 25 August 2015.

(b) Basis of accounting preparation and measurement

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

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2015, and the comparative information presented in these financial statements for the year ended 30 June 2014.

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

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

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

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

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

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

results may differ from these estimates. Judgements, estimated and assumptions may be made with respect to lease commitments, impairment of PPE's, accruals and provisions.

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 AASs that have significant effects on the financial statements and estimates relate to:

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

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

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

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

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

In addition, Wimmera Health Care Group 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 Wimmera Health Care Group's independent valuation agency.

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

Land and buildings are measure at the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. Plant, equipment and vehicles are measured at cost and are carried at cost less any accumulated depreciation and any accumulated impairment losses. Assets other than plant, equipment and vehicles are measured (after initial recognition at cost) at fair value at the date of revaluation less any subsequent accumulated depreciated and any subsequent accumulated impairment losses. These assets must be revalued every five years as at June 30 following the revaluation date. Land may need to be revalued where significant changes are brought about by certain market conditions. The decision to revalue this class outside of the five year cycle is made in conjunction with the Department of Treasury and Finance's reporting team and the VGV.

(c) Reporting entity

The financial statements include all the controlled activities of the Wimmera Health Care Group.

Its principal address is:

Baillie Street

Horsham

Victoria 3400.

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

Objectives and funding

Wimmera Health Care Group's overall objective is to be the leader in Australian rural health, delivering caring services with respect, reliability and integrity, as well as improve the quality of life to Victorians.

Wimmera Health Care Group is predominantly funded by accrual based grant funding for the provision of outputs.

(d) Principles of consolidation

Intersegment Transactions

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

Jointly controlled assets or operations

Interests in jointly controlled assets or operations are not consolidated by Wimmera Health Care Group, but are accounted for in accordance with the policy outlined in Note 1(k) Financial Assets.

(e) Scope and presentation of financial statements

Fund Accounting

The Wimmera Health Care Group operates on a fund accounting basis and maintains three funds: Operating, Specific Purpose and Capital Funds. The Wimmera Health Care Group's Capital and Specific Purpose Funds include unspent capital donations and receipts from fund-raising activities conducted solely in respect of these funds.

Services Supported By Health Services Agreement and Services Supported By Hospital and Community Initiatives

Activities classified as Services Supported by Health Services Agreement (HSA) are substantially funded by the Department of Health and Human Services and includes Residential Aged Care Services (RACS) which are also funded from other sources such as the Commonwealth, patients and residents, while Services Supported by Hospital and Community Initiatives (H&CI) are funded by the Health Service's own activities or local initiatives and/or the Commonwealth.

Residential Aged Care Service

The Wimmera Health Care Group's Residential Aged Care Service operations are an integral part of the Wimmera Health Care Group and shares its resources. An apportionment of land and buildings has been made based on floor space. The results of the two operations have been segregated based on actual revenue earned and expenditure incurred by each operation in Note 2 to the financial statements.

Comprehensive operating statement

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

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

- capital purpose income, which comprises all tied grants, donations and bequests received for the purpose of acquiring non-current assets, such as capital works, plant and equipment or intangible assets. It also includes donations of plant and equipment [refer Note 1 (g)]. Consequently the recognition of revenue as capital purpose income is based on the intention of the provider of the revenue at the time the revenue is provided.
- specific income/expense, comprises the following items, where material:
 - Voluntary departure packages
 - Write-down of inventories
 - Non-current asset revaluation increments/decrements
 - Reversals of provisions
- impairment of financial and non-financial assets, includes all impairment losses (and reversal of previous impairment losses), which have been recognised in accordance with Notes 1 (k);
- depreciation and amortisation, as described in Note 1 (h);
- assets provided or received free of charge [refer to Notes 1 (g) and (h)]; and
- expenditure using capital purpose income, comprises expenditure which either falls below the asset capitalisation threshold or doesn't meet asset recognition criteria and therefore does not result in the recognition of an asset in the balance sheet, where funding for that expenditure is from capital purpose income.

'Other economic flows; are changes arising from market re-measurements. They include:

- gains and losses from disposals of non-financial assets;
- revaluations and impairments of non-financial physical and intangible assets;
- re-measurement arising from defined benefit superannuation plans; and
- fair value changes of financial instruments.

Balance sheet

Assets and liabilities are categorised either as current or non-current (non-current being those assets or liabilities expected to be recovered/settled more than 12 months after reporting period), are disclosed in the notes where relevant.

The net result is equivalent to profit or loss derived in accordance with AASs.

Statement of changes in equity

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

Cash flow statement

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

For the cash flow statement presentation purposes, cash and cash equivalents includes bank overdrafts, which are included as current borrowings in the balance sheet.

Rounding

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

Minor discrepancies in tables between totals and sum of components are due to rounding.

(f) Change in accounting policies

AASB 10 Consolidated financial statements

AASB 10 provides a new approach to determine whether an entity has control over another entity, and therefore must present consolidated financial statements. The new approach requires the satisfaction of all three criteria for control to exist over an entity for financial reporting purposes:

- The investor has power over the investee;
- The investor has exposure, or rights to variable returns from its involvement with the investee; and
- The investor has the ability to use its power over the investee to affect the amount of investor's returns.

Based on the new criteria prescribed in AASB 10, Wimmera Health Care Group has reviewed the existing arrangements to determine if there are any additional entities that need to be consolidated into the group.

There were no additional entities requiring consolidation into the financial results of Wimmera Health Care Group.

AASB 11 Joint Arrangements

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

Wimmera Health Care Group has reviewed its existing contractual arrangements with other entities to ensure they are aligned with the new classifications under AASB 11.

Wimmera Health Care Group has accounted for the Grampians Regional Health Alliance interests as a joint operation.

AASB 12 Disclosure of Interests in Other Entities

AASB 12 Disclosure of Interests in Other Entities prescribes the disclosure requirements for an entity's interests in subsidiaries, associates and joint arrangements; and extends to the entity's association with unconsolidated structured entities.

Wimmera Health Care Group has disclosed information about its interests in associates and joint ventures, including any significant judgement and assumptions used in determining the type of joint arrangement in which it has an interest.

(g) Income from transactions

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 Wimmera Health Care Group 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 05/2013 (update for 2013-14).

Patient and Resident Fees

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

Private Practice Fees

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

Revenue from commercial activities

Revenue from commercial activities such as commercial laboratory medicine is recognised at the time invoices are raised.

Donations and Other Bequests

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

Interest Revenue

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

Sale of investments

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

Fair value of assets and services received free of charge or for nominal consideration

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

Other income

Other income includes non-property rental, dividends, forgiveness of liabilities, and bad debt reversals.

(h) Expense recognition

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

Cost of goods sold

Costs of goods sold are recognised when the sale of an item occurs by transferring the cost or value of the item/s from inventories.

Employee expenses

Employee expenses include:

- wages and salaries;
- annual leave;
- sick leave;
- long service leave; and
- superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

- Defined contribution superannuation plans

In relation to defined contribution (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 contribution superannuation plans are expensed when incurred.

- Defined benefit superannuation plans

The amount charged to the comprehensive operating statement in respect of defined benefit superannuation plans represents the contributions made by the Health Service to the superannuation plans in respect of the services of current Health Service staff during

the reporting period. Superannuation contributions are made to the plans based on the relevant rules of each plan, and are based upon actuarial advice.

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

The name and details of the major employee superannuation funds and contributions made by the Wimmera Health Care Group are disclosed in Note 12: *Superannuation*.

Depreciation

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

Intangible produced assets with finite lives are depreciated as an expense from transactions on a systematic basis over the asset's useful life. Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives, residual value and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health and Human Services. Assets with a cost in excess of \$2,000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

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

	2015	2014
Building - Structure, Shell & Building Fabric	1-50 years	1-50 years
- Fit out	12-30 years	12-30 years
- Combined Fit out/Trunk Retic Systems	1-12 years	1-12 years
- Site Engineering and site works	6-40 years	6-40 years
Plant & Equipment	10 years	10 years
Medical Equipment	10 years	10 years
Computers and Communication	4 years	4 years
Furniture and Fitting	10 years	10 years
Motor Vehicles	8 years	8 years
Linen in use	4.5 Years	4.5 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.

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

Finance costs

Finance costs are recognised as expenses in the period in which they are incurred.

Finance costs include:

- interest on bank overdrafts and short-term and long-term borrowings (Interest expense is recognised in the period in which it is incurred);

- amortisation of discounts or premiums relating to borrowings;
- amortisation of ancillary costs incurred in connection with the arrangement of borrowings; and
- finance charges in respect of finance leases recognised in accordance with AASB 117 *Leases*.

Grants and other transfers

Grants and other transfers to third parties (other than contribution to owners) are recognised as an expense in the reporting period in which they are paid or payable. They include transactions such as: grants, subsidies and personal benefit payments made in cash to individuals.

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 services costs which are recognised as an expense in the reporting period in which they are incurred. The carrying amounts of any inventories held for distribution are expensed when distributed.

• Bad and doubtful debts

Refer to Note 1 (k) *Impairment of financial assets*.

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

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

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

• Borrowing costs of qualifying assets

In accordance with the paragraphs of AASB 123 *Borrowing Costs* applicable to not-for-profit public sector entities, the Health Services continues to recognise borrowing costs immediately as an expense, to the extent that they are directly attributable to the acquisition, construction or production of a qualifying asset.

(i) Other comprehensive income

Other comprehensive income measures the change in volume or value of assets or liabilities that do not result from transactions.

Net gain/ (loss) on non-financial assets

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

• Revaluation gains/ (losses) of non-financial physical assets

Refer to Note 1(k) *Revaluations of non-financial physical assets*.

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

Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal and is the difference between the proceeds and the carrying value of the asset at the time.

- **Net gain/ (loss) on financial instruments**

Net gain/ (loss) on financial instruments includes:

- realised and unrealised gains and losses from revaluations of financial instruments at fair value;
- impairment and reversal of impairment for financial instruments at amortised cost [refer to Note 1 (k)]; and
- disposals of financial assets and derecognition of financial liabilities

- **Amortisation of non-produced intangible assets**

Intangible non-produced assets with finite lives are amortised as an 'other economic flow' on a systematic basis over the asset's useful life. Amortisation begins when the asset is available for use that is when it is in the location and condition necessary for it to be capable of operating in the manner intended by management.

- **Impairment of non-financial assets**

Goodwill and intangible assets with indefinite useful lives (and intangible assets not available for use) are tested annually for impairment and whenever there is an indication that the asset may be impaired. Refer to Note 1 (k) *Assets*.

- **Revaluations of financial instrument at fair value**

Refer to Note 1 (j) *Financial instruments*.

- **Share of net profits/ (losses) of associates and jointly controlled entities, excluding dividends.**

Refer to Note 1 (d) *Basis of consolidation*.

- **Other gains/ (losses) from other comprehensive income**

Other gains/ (losses) include:

- the revaluation of the present value of the long service leave liability due to changes in the bond interest rates; and
- transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

(j) Financial instruments

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of the Wimmera Health Care Group's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation*. For example, statutory receivables arising from taxes, fines and penalties do not meet the definition of financial instruments as they do not arise under contract.

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

The following refers to financial instruments unless otherwise stated.

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 1(k)], term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

Held-to-maturity investments

If the Health Service has the positive intent and ability to hold nominated investments to maturity, then such financial assets may be classified as held-to-maturity. Held-to-maturity financial assets are recognised initially at fair value plus any directly attributable transaction costs. Subsequent to initial recognition held-to-maturity financial assets are measured at amortised cost using the effective interest method, less any impairment losses.

The Health Service makes limited use of this classification because any sale or reclassification of more than an insignificant amount of held-to-maturity investments not close to their maturity, would result in the whole category being reclassified as available-for-sale. The Health Service would also be prevented from classifying investment securities as held-to-maturity for the current and the following two financial years.

The held-to-maturity category includes certain term deposits and debt securities for which the Health Service concerned intends to hold to maturity.

Financial liabilities at amortised cost

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

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

(k) Assets

Cash and Cash Equivalents

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

Receivables

Receivables consist of:

- contractual receivables, which includes mainly debtors in relation to goods and services, loans to third parties, accrued investment income, and finance lease receivables; and

- statutory receivables, which includes predominantly amounts owing from the Victorian Government and Goods and Services Tax ("GST") input tax credits recoverable.

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

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

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

Investments and other financial assets

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

Investments are classified in the following categories:

- financial assets at fair value through profit or loss;
- held-to-maturity;
- loans and receivables; and
- available-for-sale financial assets.

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

Wimmera Health Care Group assesses at each balance sheet date whether a financial asset or group of financial assets is impaired.

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

Inventories

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

Inventories held for distribution are measured at cost, adjusted for any loss of service potential. All other inventories, 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 is assigned to land for sale (undeveloped, under development and developed) and to other high value, low volume inventory items on a specific identification of cost basis (*identify classes*).

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

Property, plant and equipment

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

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 8 *Property, plant and equipment*.

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

Crown land is measured at fair value with regard to the property's highest and best use after due consideration is made for any legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset. Theoretical opportunities that may be available in relation to the asset(s) are not taken into account until it is virtually certain that any 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 impairment.

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

Revaluations of non-current physical assets

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

Revaluation increments are recognised in 'other comprehensive income' and are credited directly in equity to the asset revaluation surplus, except that, to the extent that an increment reverses a revaluation decrement in respect of that same class of asset previously recognised as an expense in net 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 normally transferred to accumulated funds on derecognition of the relevant asset.

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

Prepayments

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

Disposal of non-financial assets

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

Impairment of non-financial assets

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

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

- inventories; and
- assets arising from construction contracts.

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

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

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

Investments in joint operations

In respect of any interest in joint operations, Wimmera Health Care Group recognises in the financial statements:

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

Derecognition of financial assets

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

- the rights to receive cash flows from the asset have expired; or
- the Health Service retains the right to receive cash flows from the asset, but has assumed an obligation to pay them in full without material delay to a third party under a 'pass through' arrangement; or
- the Health Service has transferred its rights to receive cash flows from the asset and either:
 - 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 Wimmera Health Care Group assesses whether there is objective evidence that a financial asset or group of financial asset is impaired. All financial instrument assets, except those measured at fair value through profit or loss, are subject to annual review for impairment.

Receivables are assessed for bad and doubtful debts on a regular basis. Bad debts considered as written off and allowances for doubtful receivables are expensed. Bad debt written off by mutual consent and the allowance for doubtful debts are classified as 'other comprehensive income' in the net result.

The amount of the allowance is the difference between the financial asset's carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate.

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 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*.

Net gain/(loss) on financial instruments

Net gain/(loss) on financial instruments includes:

- realised and unrealised gains and losses from revaluations of financial instruments that are designated at fair value through profit or loss or held-for-trading;
- impairment and reversal of impairment for financial instruments at amortised cost; and
- disposals of financial assets and derecognition of financial liabilities.

Revaluations of financial instruments at fair value

The revaluation gain/(loss) on financial instruments at fair value excludes dividends or interest earned on financial assets.

(l) Liabilities

Payables

Payables consist of:

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

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

Borrowings

All borrowings are initially recognised at fair value of the consideration received, less directly attributable transaction costs [refer also to note 1(m) Leases] The measurement basis subsequent to initial recognition depends on whether the Health Service has categorised its borrowings as either, financial liabilities designated at fair value through profit or loss, or financial liabilities at amortised cost. Any difference between the initial recognised amount and the redemption value is recognised in net result over the period of the borrowings using the effective interest method.

The classification depends on the nature and purpose of the borrowing. The Health Service determines the classification of its borrowing at initial recognition.

Provisions

Provisions are recognised when the Health Service has a present obligation, the future sacrifice of economic benefits is probable, and the amount of the provision can be measured reliably. The amount recognised as a liability is the best estimate of the consideration required to settle the present obligation at reporting date, taking into account the risks and uncertainties surrounding the obligation. Where a provision is measured using the cash flows estimated to settle the present obligation, its carrying amount is the present value of those cash flows, using a discount rate that reflects the time value of money and risks specific to the provision.

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

Employee benefits

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

Wages and salaries, annual leave and accrued days off

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

Depending on the expectation of the timing of settlement, liabilities for wages and salaries and annual leave are measured at:

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

Long service leave (LSL)

Liability for LSL is recognised in the provision for employee benefits.

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

The components of this current LSL liability are measured at:

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

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

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

Termination benefits

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

The health service recognises termination benefits when it is demonstrably committed to either terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

Employee benefit on-costs

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

Superannuation liabilities

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

(m) Leases

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

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

For service concession arrangements, the commencement of the lease term is deemed to be the date the asset is commissioned.

All other leases are classified as operating leases.

Finance leases

Finance leases are recognised as assets and liabilities at amounts equal to the fair value of the lease property or, if lower, the present value of the minimum lease payment, each determined at the inception of the lease. The lease asset is accounted for as a non-financial physical asset and is depreciated over the shorter of the estimated useful life of the asset or the term of the lease. If there is certainty that the health service will obtain the ownership of the lease asset by the end of the lease term, the asset shall be depreciated over the useful life of the asset. If there is no reasonable certainty that the lessee will obtain ownership by the end of the lease term, the asset shall be fully depreciated over the shorter of the lease term and its useful life. Minimum lease payments are apportioned between reduction of the outstanding lease liability, and the periodic finance expense which is calculated using the interest rate implicit in the lease, and charged directly to the comprehensive operating statement. Contingent rentals associated with finance leases are recognised as an expense in the period in which they are incurred.

Operating leases

Rental income from operating lease is recognised on a straight-line basis over the term of the relevant lease.

All incentives for the agreement of a new or renewed operating lease are recognised as an integral part of the net consideration agreed for the use of the leased asset, irrespective of the incentive's nature or form or the timing of payments.

In the event that lease incentives are given to the lessee, the aggregate cost of incentives are recognised as a reduction of rental income over the lease term, on a straight-line basis unless another systematic basis is more appropriate of the time pattern over which the economic benefit of the leased asset is diminished.

Lease Incentives

All incentives for the agreement of a new or renewed operating lease are recognised as an integral part of the net consideration agreed for the use of the leased asset, irrespective of the incentive's nature or form or the timing of payments.

In the event that lease incentives are received by the lessee to enter into operating leases, such incentives are recognised as a liability. The aggregate benefits of incentives are recognised as a reduction of rental expense on a straight-line basis, except where another systematic basis is more representative of the time pattern in which economic benefits from the leased asset is diminished.

Leasehold Improvements

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

(n) Equity

Contributed capital

Consistent with Australian Accounting Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities* and FRD 119A *Contributions by Owners*, appropriations for additions to the net asset base have been designated as contributed capital. Other transfers that

are in the nature of contributions to or distributions by owners that have been designated as contributed capital are also treated as contributed capital.

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 & 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.

(o) Commitments

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

(p) 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.

(q) Goods and Services Tax ("GST")

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

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

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

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

(r) AASs issued that are not yet effective

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2015 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 2015, 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. Wimmera Health Care Group has not and does not intend to adopt these standards early.

Standard/ Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on public sector entity financial statements
AASB 9 Financial Instruments	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1 Jan 2018	<p>The assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss.</p> <p>While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.</p>
AASB 15 Revenue from Contracts with Customers	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1 Jan 2017 (Exposure Draft 263 – potential deferral to 1 Jan 2018)	<p>The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications.</p> <p>A potential impact will be the upfront recognition of revenue from licenses that cover multiple reporting periods. Revenue that was deferred and amortised over a period may now need to be recognised immediately as a transitional adjustment against the opening returned earnings if there are no former performance obligations outstanding.</p>
AASB 2014-1 Amendments to Australian Accounting Standards [Part E Financial Instruments]	Amends various AASBs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	1 Jan 2018	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.

AASB 2014-9 Amendments to Australian Accounting Standards – Equity Method in Separate Financial Statements [AASB 1, 127 & 128]	Amends AASB 127 Separate Financial Statements to allow entities to use the equity method of accounting for investments in subsidiaries, joint ventures and associates in their separate financial statements.	1 Jan 2016	The assessment indicates that there is no expected impact as the entity will continue to account for the investments in subsidiaries, joint ventures and associates using the cost method as mandated if separate financial statements are presented in accordance with FRD 113A.
AASB 2014-10 Amendments to Australian Accounting Standards – Sale or Contribution of Assets between an Investor and its Associate or Joint Venture [AASB 10 & AASB 128]	<p>AASB 2014-10 amends AASB 10 Consolidated Financial Statements and AASB 128 Investments in Associates to ensure consistent treatment in dealing with the sale or contribution of assets between an investor and its associate or joint venture. The amendments require that:</p> <ul style="list-style-type: none"> a full gain or loss to be recognised by the investor when a transaction involves a business (whether it is housed in a subsidiary or not); and a partial gain or loss to be recognised by the parent when a transaction involves assets that do not constitute a business, even if these assets are housed in a subsidiary. 	1 Jan 2016	The assessment has indicated that there is limited impact, as the revisions to AASB 10 and AASB 128 are guidance in nature.
AASB 2015-6 Amendments to Australian Accounting Standards – Extending Related Party Disclosures to Not-for-Profit Public Sector Entities [AASB 10, AASB 124 & AASB 1049]	The Amendments extend the scope of AASB 124 Related Party Disclosures to not-for-profit public sector entities. A guidance has been included to assist the application of the Standard by not-for-profit public sector entities.	1 Jan 2016	The amending standard will result in extended disclosures on the entity's key management personnel (KMP), and the related party transactions.

In addition to the new standards and amendments above, the AASB has issued a list of other amending standards that are not effective for the 2014-15 reporting period (as listed below). In general, these amending standards include editorial and references changes that are expected to have insignificant impacts on public sector reporting.

AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010).

AASB 2013-9 Amendments to Australian Accounting Standards – Conceptual Framework, Materiality and Financial Instruments

AASB 2014-1 Amendments to Australian Accounting Standards [PART D – Consequential Amendments arising from AASB 14 Regulatory Deferral Accounts only] #

AASB 2014-3 Amendments to Australian Accounting Standards – Accounting for Acquisitions of Interests in Joint Operations [AASB 1 & AASB 11]

AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15

AASB 2014-6 Amendments to Australian Accounting Standards – Agriculture: Bearer Plants [AASB 101, AASB 116, AASB 117, AASB 123, AASB 136, AASB 140 & AASB 141]

AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)

AASB 2014-8 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014) – Application of AASB 9 (December 2009) and AASB 9 (December 2010) [AASB 9 (2009 & 2010)]

AASB 2015-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 101 [AASB 7, AASB 101, AASB 134 & AASB 1049]

AASB 2015-3 Amendments to Australian Accounting Standards arising from the Withdrawal of AASB 1031 Materiality

AASB 2015-4 Amendments to Australian Accounting Standards – Financial Reporting Requirements for Australian Groups with a Foreign Parent [AASB 127, AASB 128] #

AASB 2015-5 Amendments to Australian Accounting Standards – Investment Entities: Applying the Consolidation Exception [AASB 10, AASB 12, AASB 128] #

Note:

This Standard or Amendment may not be relevant to Victorian not-for-profit entities when operative.

(s) Category groups

The Wimmera Health Care Group has used the following category groups for reporting purposes for the current and previous financial years:

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

Outpatient Services (Outpatients) comprises all recurrent health revenue/expenditure on public hospital type outpatient services, where services are delivered in public hospital outpatient clinics, or free standing day hospital facilities, or rehabilitation facilities, or alcohol and drug treatment units, or outpatient clinics specialising in ophthalmic aids or palliative care.

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

Ambulatory Services (Ambulatory) comprises all recurrent health revenue/expenditure on public hospital type services including palliative care facilities and rehabilitation facilities, as well as services provided under the following agreements: Services that are provided or received by hospitals (or area Health Services) but are delivered/received outside a hospital campus, services which have moved from a hospital to a community setting since June 1998, services which fall within the agreed scope of inclusions under the new system, which have been delivered within hospital's i.e. in rural/remote areas.

Residential Aged Care (RAC) 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.

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

Primary, Community and Dental Health (Primary 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.

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 early parenting services, parenting assessment and skills development, and various support services. Health and Community Initiatives also falls in this category group.

Note 2: Analysis of Revenue by Source

	Admitted Patients 2015 \$'000	Outpatients 2015 \$'000	EDs 2015 \$'000	Ambulatory 2015 \$'000	RAC 2015 \$'000	HACC 2015 \$'000	Primary Health 2015 \$'000	Other 2015 \$'000	Total 2015 \$'000
Government Grant	37,689	-	3,363	5,580	8,409	2,487	1,192	6,899	65,619
Indirect contributions by Department of Health and Human Services	268	-	30	22	29	8	(31)	144	470
Patient & Resident Fees	2,559	-	-	600	2,345	84	224	370	6,182
Commerical Activities (refer note 3a)	-	-	-	-	-	-	-	2,873	2,873
Other Revenue from Operating Activities	412	-	10	43	73	6	31	2,118	2,693
Total Revenue from Operating Activities	40,928	-	3,403	6,245	10,856	2,585	1,416	12,404	77,837
Interest	-	-	-	-	-	-	-	391	391
Other Revenue from Non-Operating Activities	-	-	-	-	-	-	-	485	485
Total Revenue from Non-Operating Activities	-	-	-	-	-	-	-	876	876
Settlement funds void contract	-	-	-	-	-	-	-	350	350
Capital Purpose Income (excluding Interest)	-	-	-	-	-	-	-	3,475	3,475
Total Capital Purpose Income	-	-	-	-	-	-	-	3,825	3,825
Assets received free of charge (refer note 2b)	-	-	-	-	-	-	-	4	4
Net Gain/(loss) on disposal of Non-Current Assets (refer note 2a)	-	-	-	-	-	-	-	(7)	(7)
Total Revenue	40,928	-	3,403	6,245	10,856	2,585	1,416	17,102	82,535

	Admitted Patients 2014 \$'000	Outpatients 2014 \$'000	EDs 2014 \$'000	Ambulatory 2014 \$'000	RAC 2014 \$'000	HACC 2014 \$'000	Primary Health 2014 \$'000	Other 2014 \$'000	Total 2014 \$'000
Government Grant	37,030	-	3,159	4,233	7,845	2,039	1,123	6,565	61,994
Indirect contributions by Department of Health and Human Services	(56)	-	18	(20)	26	29	31	27	55
Patient & Resident Fees	2,076	-	-	531	2,162	188	250	328	5,535
Commerical Activities (refer note 3a)	-	-	-	-	-	-	-	3,045	3,045
Other Revenue from Operating Activities	452	12	2	105	149	40	32	2,688	3,480
Total Revenue from Operating Activities	39,502	12	3,179	4,849	10,182	2,296	1,436	12,653	74,109
Interest	-	-	-	-	-	-	-	460	460
Other Revenue from Non-Operating Activities	-	-	-	-	-	-	-	468	468
Total Revenue from Non-Operating Activities	-	-	-	-	-	-	-	928	928
Capital Purpose Income (excluding Interest)	-	-	-	-	-	-	-	8,052	8,052
Total Capital Purpose Income	-	-	-	-	-	-	-	8,052	8,052
Net Gain/(loss) on disposal of Non-Current Assets (refer note 2a)	-	-	-	-	-	-	-	(8)	(8)
Total Revenue	39,502	12	3,179	4,849	10,182	2,296	1,436	21,633	83,081

Indirect contributions by Department of Health (1 July 2014 - 31 Dec 2014) / Department of Health and Human Services (1 Jan 2015 - 30 June 2015)
Department of Health / Department of Health and Human Services makes certain payments on behalf of the Health Service including capital construction costs and insurance payments. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

Note 2a: Net Gain/(Loss) on Disposal of Non-Financial Assets

Proceeds from Disposals of Non-Current Assets

Plant and Equipment

Medical Equipment

Total Proceeds from Disposal of Non-Current Assets

Less: Written Down Value of Non-Current Assets Sold

Plant and Equipment

Medical Equipment

Other

Total Written Down Value of Non-Current Assets Sold

Net gain/(loss) on Disposal of Non-Financial Assets

2015 \$'000	2014 \$'000
-	2
4	4
4	6
-	8
6	6
5	-
11	14
(7)	(8)

Note 2b: Assets Received Free of Charge or For Nominal

During the reporting period, the fair value of assets received free of charge, was as follows:

Land

TOTAL

2015 \$'000	2014 \$'000
4	-
4	-

Note 3: Analysis of Expenses by Source

	Admitted Patients 2015 \$'000	Outpatients 2015 \$'000	EDs 2015 \$'000	Ambulatory 2015 \$'000	RAC 2015 \$'000	HACC 2015 \$'000	Primary Health 2015 \$'000	Other 2015 \$'000	Total 2015 \$'000
Employee Expenses	11,173	-	2,678	3,543	8,392	1,867	2,829	22,367	52,849
Non Salary Labour Costs	3,782	-	-	-	7	-	22	1,147	4,958
Supplies & Consumables	5,044	-	237	509	477	51	191	3,107	9,616
Commercial Activities Expenses (refer note 3a)	-	-	-	-	-	-	-	3,357	3,357
Other Expenses	4,348	1	447	149	361	32	84	1,939	7,361
Total Expenditure from Operating Activities	24,347	1	3,362	4,201	9,237	1,950	3,126	31,917	78,141
Depreciation & Amortisation (refer note 4)	-	-	-	-	-	-	-	4,108	4,108
Total other expenses	-	-	-	-	-	-	-	4,108	4,108
Total Expenses	24,347	1	3,362	4,201	9,237	1,950	3,126	36,025	82,249

	Admitted Patients 2014 \$'000	Outpatients 2014 \$'000	EDs 2014 \$'000	Ambulatory 2014 \$'000	RAC 2014 \$'000	HACC 2014 \$'000	Primary Health 2014 \$'000	Other 2014 \$'000	Total 2014 \$'000
Employee Expenses	11,192	4	2,545	2,448	8,610	1,754	2,625	22,405	51,583
Non Salary Labour Costs	2,834	-	-	-	-	-	22	1,210	4,066
Supplies & Consumables	4,577	1	219	236	318	33	181	3,187	8,752
Commercial Activities Expenses (refer note 3a)	-	-	-	-	-	-	-	4,228	4,228
Other Expenses	4,555	5	372	124	370	38	72	1,256	6,792
Total Expenditure from Operating Activities	23,158	10	3,136	2,808	9,298	1,825	2,900	32,286	75,421
Impairment of Non-Financial Assets	-	-	-	-	-	-	-	67	67
Depreciation & Amortisation (refer note 4)	-	-	-	-	-	-	-	2,853	2,853
Total other expenses	-	-	-	-	-	-	-	2,920	2,920
Total Expenses	23,158	10	3,136	2,808	9,298	1,825	2,900	35,206	78,341

Note 3a: Analysis of Expense and Revenue by Internally Managed and Restricted Specific Purpose Funds for Services Supported by Hospital and Community Initiatives

	Expense		Revenue	
	2015 \$'000	2014 \$'000	2015 \$'000	2014 \$'000
Commercial Activities				
Private Practice and Other Patient Activities	2,268	3,156	1,497	1,471
Laundry	793	794	1,008	1,253
Cafeteria	296	278	368	321
TOTAL	3,357	4,228	2,873	3,045

Note 4: Depreciation and Amortisation

	2015 \$'000	2014 \$'000
Depreciation		
Buildings	3,191	1,899
Plant & Equipment	107	134
Medical Equipment	269	265
Leased Assets	9	-
Transport	31	32
Computer and Communications	76	142
Furniture and Fittings	42	27
Linen	118	129
Other	265	225
Total Depreciation	4,108	2,853

Note 5: Cash and Cash Equivalents

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

	2015 \$'000	2014 \$'000
Cash on hand	8	6
Cash at bank	11,901	11,692
Total Cash and Cash Equivalents	11,909	11,698
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	7,243	7,066
Cash for Monies Held in Trust		
- Cash at Bank	166	62
- Short Term Money Market	4,500	4,570
Total Cash and Cash Equivalents	11,909	11,698

Wimmera Health Care Group are compliant with Standing Direction 4.5.6

Note 6: Receivables

CURRENT

Contractual

Inter Hospital Debtors
Trade Debtors
Patient Fees
Less Allowance for Doubtful Debts
Patient Fees

Statutory

GST Receivable

TOTAL CURRENT RECEIVABLES

NON CURRENT

Statutory

Long Service Leave - Department of
Health / Department of Health and Human Services

TOTAL NON-CURRENT RECEIVABLES

TOTAL RECEIVABLES

2015 \$'000	2014 \$'000
1,320	436
1,057	1,290
700	528
(7)	(12)
3,070	2,242
210	204
210	204
3,280	2,446
1,665	1,249
1,665	1,249
4,945	3,695

(a) Movement in the Allowance for doubtful debts

Balance at beginning of year
Amounts written off during the year
Increase/(decrease) in allowance recognised in net result
Balance at end of year

2015 \$'000	2014 \$'000
12	32
(11)	(35)
6	15
7	12

(b) Ageing analysis of receivables

Please refer to note 17(c) for the ageing analysis of contractual receivables

(c) Nature and extent of risk arising from receivables

Please refer to note 17(c) for the nature and extent of credit risk arising from contractual receivables

Note 7: Inventories

Pharmaceuticals

At cost

Catering Supplies

At cost

Housekeeping Supplies

At cost

Medical and Surgical Lines

At cost

Administration Stores

At Cost

Linen

At Cost

TOTAL INVENTORIES

2015 \$'000	2014 \$'000
131	169
12	10
10	9
139	136
19	11
23	46
334	381

Note 8: Property, plant & equipment

(a) Gross carrying amount and accumulated depreciation

	2015 \$'000	2014 \$'000
Land		
Land at Fair Value	5,310	5,310
Land at Cost	89	-
Total Land	5,399	5,310
Buildings		
Buildings Under Construction at cost	400	6,723
Buildings at Cost	9,196	-
Less Acc'd Depreciation	82	-
Buildings at Fair Value	47,726	47,726
Less Acc'd Depreciation	3,108	-
Total Buildings	54,132	54,449
Plant and Equipment		
Plant & Equipment Under Construction	419	1,199
Plant and Equipment at Fair Value	1,588	1,594
Less Acc'd Depreciation	1,328	1,227
Total Plant and Equipment	679	1,566
Transport		
Transport at Fair Value	349	349
Less Acc'd Depreciation	245	215
Total Plant and Equipment	104	134
Medical Equipment		
Medical Equipment at Fair Value	3,493	3,167
Less Acc'd Depreciation	1,907	1,771
Total Medical Equipment	1,586	1,396
Computers and Communications		
Computers and Communications at Fair Value	1,026	876
Less Acc'd Depreciation	851	806
Total Computers and Communications	175	70
Other Equipment		
Other Equipment at Fair Value	3,827	3,104
Less Acc'd Depreciation	2,325	2,120
Total Other Assets	1,502	984
Furniture and Fittings		
Furniture and Fittings at Fair Value	509	299
Less Acc'd Depreciation	201	160
Total Other Assets	308	139
Total Plant and Equipment	4,354	4,289
Linen		
Linen at Fair Value	605	639
Less Acc'd Depreciation	406	446
Total Linen	199	193
Leased Assets		
Leased Assets	21	21
Less Acc'd Depreciation	9	-
Total Leased Assets	12	21
TOTAL	64,096	64,262

Note 8: Property, plant & equipment (continued)

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

	Land \$'000	Buildings \$'000	Plant & Equipment \$'000	Linen Assets \$'000	Leased Assets \$'000	Total \$'000
Balance at 1 July 2013	4,573	39,593	4,698	246	-	49,110
Additions	252	5,670	2,096	76	21	8,115
Disposals	-	-	(14)	-	-	(14)
Impairment Losses (recognised)/reversed in Net Result	-	-	(67)	-	-	(67)
Revaluation Increments/(Decrements)	485	9,485	-	-	-	9,970
Net Transfers between Classes	-	1,600	(1,600)	-	-	-
Depreciation and Amortisation (note 4)	-	(1,899)	(824)	(129)	-	(2,852)
Balance at 1 July 2014	5,310	54,449	4,289	193	21	64,262
Additions	89	1,781	1,959	124	-	3,953
Disposals	-	-	(11)	-	-	(11)
Net Transfers between Classes	-	1,092	(1,092)	-	-	-
Depreciation and Amortisation (note 4)	-	(3,190)	(791)	(118)	(9)	(4,108)
Balance at 30 June 2015	5,399	54,132	4,354	199	12	64,096

Land and buildings carried at valuation

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

The effective date of the valuation is *30 June 2014*.

Note 8: Property, plant & equipment (continued)

(c) Fair value measurement hierarchy for assets as at 30 June 2015

	Carrying amount as at 30 June 2015	Fair value measurement at end of reporting period using:		
		Level 1 ⁽¹⁾	Level 2 ⁽¹⁾	Level 3 ⁽¹⁾
Land at fair value				
Non-specialised land	1,494	-	1,494	
Specialised land	3,905	-	-	3,905
Total of land at fair value	5,399	-	1,494	3,905
Buildings at fair value				
Non-specialised buildings	772	-	772	-
Specialised buildings	52,960	-	-	52,960
Buildings under construction	400	-	-	400
Total of building at fair value	54,132	-	772	53,360
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	104	-	-	104
- Plant and equipment	2,245	-	-	2,245
- Plant and equipment under construction	419	-	-	419
- Medical Equipment	1,586	-	-	1,586
Total of plant, equipment and vehicles at fair value	4,354	-	-	4,354
Leased Assets at Fair value				
Leased Assets	12	-	-	12
Total of Leased Assets at fair value	12	-	-	12
Linen at fair value				
Linen	199	-	-	199
Total of Linen at fair value	199	-	-	199
	64,096	-	2,266	61,830

Fair value measurement hierarchy for assets as at 30 June 2014

	Carrying amount as at 30 June 2014	Fair value measurement at end of reporting period using:		
		Level 1 ⁽¹⁾	Level 2 ⁽¹⁾	Level 3 ⁽¹⁾
Land at fair value				
Non-specialised land	1,405	-	1,405	
Specialised land	3,905	-	-	3,905
Total of land at fair value	5,310	-	1,405	3,905
Buildings at fair value				
Non-specialised buildings	859	-	859	-
Specialised buildings	46,867	-	-	46,867
Buildings under construction	6,723	-	-	6,723
Total of building at fair value	54,449	-	859	53,590
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles	134	-	-	134
- Plant and equipment	1,573	-	-	1,573
- Plant and equipment under construction	1,186	-	-	1,186
- Medical Equipment	1,396	-	-	1,396
Total of plant, equipment and vehicles at fair value	4,289	-	-	4,289
Medical equipment at fair value				
Total medical equipment at fair value				
Leased Assets at Fair value				
Leased Assets	21	-	-	21
Total of Leased Assets at fair value	21	-	-	21
Linen at fair value				
Linen	193	-	-	193
Total of Linen at fair value	193	-	-	193
	64,262	-	2,264	61,998

Note 8: Property, plant & equipment (continued)

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

Specialised land and specialised buildings

The market approach is also used for specialised land and specialised buildings although 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. As a result, the fair value of vehicles does not differ materially from the carrying value (depreciated cost).

Plant and equipment

Plant and equipment is held at carrying value (depreciated cost). When plant and equipment is specialised in use, such that it is rarely sold other than as part of a going concern, the depreciated replacement cost is used to estimate the fair value. Unless there is market evidence that 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 2015.

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

(d) Reconciliation of Level 3 fair value

30 June 2015

Land	Buildings	Plant and equipment	Linen Assets	Leased assets
2015 \$'000	2015 \$'000	2015 \$'000	2015 \$'000	2015 \$'000
Opening Balance	3,905	53,590	4,289	193
Purchases (sales)	-	1,781	1,959	124
Transfers in (out) of Level 3	-	1,092	(1,092)	-
Gains or losses recognised in net result				
- Depreciation	-	(3,103)	(791)	(118)
- Disposals	-	-	(11)	-
Closing Balance	3,905	53,360	4,354	199

There have been no transfers between levels during the period.

30 June 2014

Land	Buildings	Plant and equipment	Linen Assets	Leased assets
2014 \$'000	2014 \$'000	2014 \$'000	2014 \$'000	2014 \$'000
Opening Balance	3,681	37,337	4,698	246
Purchases (sales)	-	5,671	2,082	76
Transfers in (out) of Level 3	-	1,600	(1,600)	-
Gains or losses recognised in net result	-	-	-	-
- Depreciation	-	(1,820)	(824)	(129)
- Impairment loss	-	-	(67)	-
Subtotal	3,681	42,788	4,289	193
Items recognised in other comprehensive income	-			
- Revaluation	224	10,802	-	-
Subtotal	224	10,802	-	-
Closing Balance	3,681	42,788	4,289	21

There have been no transfers between levels during the period.

Note 8: Property, plant & equipment (continued)

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

	Valuation technique	Significant unobservable inputs	Range (weighted average) 2015	Range (weighted average) 2014	Sensitivity of fair value measurement to changes in significant unobservable inputs
Specialised land Land at Fair Value	Market approach	Community Service Obligation (CSO) adjustment	20% (I)	20% (I)	A significant increase or decrease in the CSO adjustment would result in a significantly lower (higher) fair value.
Specialised buildings Buildings at Fair Value	Depreciated replacement cost	Direct cost per square metre Useful life of specialised buildings	\$337 - \$2,763/m2 (\$1,546) 30 - 50 years (40 years)	\$1,000 - \$2,719/m2 (\$1,190) 30 - 50 years (40 years)	A significant increase or decrease in direct cost per square meter adjustment would result in a significantly higher or lower fair value. A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Plant and equipment at fair value Plant and Equipment	Depreciated replacement cost	Cost per unit Useful life of PPE	\$2,000 - \$78,000 (\$6,000) 4-10 years (7 years)	\$2,000 - \$78,000 (\$6,000) 4-10 years (7 years)	A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value. A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Vehicles	Depreciated replacement cost	Cost per unit Useful life of vehicles	\$86,000-\$129,000 per unit (\$107,500 per unit) 8 years	\$86,000-\$129,000 per unit (\$107,500 per unit) 8 years	A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value. A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Medical equipment at fair value	Depreciated replacement cost	Cost per unit Useful life of medical equipment	\$2,000 - \$104,000 (\$10,500) 10 years	\$2,000 - \$104,000 (\$10,500) 10 years	Increase (decrease) in gross replacement cost would result in a significantly higher (lower) fair value. Increase (decrease) in useful life would result in a significantly higher (lower) fair value.
Assets under construction at fair value Buildings under Construction	Depreciated replacement cost	Cost per unit	\$100 - \$295,000 (\$40,000)	\$49,000 - \$6,725,000 (\$2,293,000)	A significant increase or decrease in direct cost per unit meter adjustment would result in a significantly higher or lower fair value.
Plant and Equipment under Construction	Depreciated replacement cost	Cost per unit	\$1,000 - \$160,000 (\$67,000)	\$1,500 - \$686,000 (\$97,000)	A significant increase or decrease in direct cost per unit meter adjustment would result in a significantly higher or lower fair value.
Leased assets Leased assets	Depreciated replacement cost	Cost per unit Useful life of leased assets	\$12,000 2 years	\$21,000 3 years	A significant increase or decrease in direct cost per unit adjustment would result in a significantly higher or lower fair value. A significant increase or decrease in direct cost per unit adjustment would result in a significantly higher or lower fair value.

(ii) CSO adjustments at 20% were applied to reduce the market approach value for the Wimmera Health Care Group's specialised land, with the weighted average 60% reduction applied.

Note 9: Payables

CURRENT
Contractual

Trade Creditors
Accrued Expenses

Statutory

Department of Health and Human Services

TOTAL CURRENT

(a) Maturity analysis of payables

Please refer to Note 17c for the ageing analysis of contractual payables

(b) Nature and extent of risk arising from payables

Please refer to note 17c for the nature and extent of risks arising from contractual payables

2015 \$'000	2014 \$'000
1,933 2,148	2,298 1,499
4,081	3,797
-	2
-	2
4,081	3,799

Note 10 Leases

Finance lease liabilities

Wimmera Health Care Group entered into a finance lease with BOQ Finance in April 2014 after electing to roll over the residual on a previous lease into a new lease. Ownership of the computers and server covered by the previous lease transferred to Wimmera Health Care Group at that time.

This converted the operating lease into a finance lease which requires approval of the Minister for Finance under section 30 of the Health Services Act 1988. Wimmera Health Care Group will obtain consent during the 2015/16 financial year.

Other finance lease liabilities payable (ii)

Not longer than one year
Longer than one year but not longer than five years

Minimum future lease payments

Present value of minimum lease payments

Included in the financial statements as:

Current borrowings lease liabilities (Note 17)
Non-current borrowing lease liabilities (Note 17)

Minimum future lease payments (i)		Present value of minimum future lease payments	
2015 \$'000	2014 \$'000	2015 \$'000	2014 \$'000
10 2	8 13	10 2	8 13
12	21	12	21
12	21	12	21
10 2	8 13	10 2	8 13
12	21	12	21

- (i) Minimum future lease payments include the aggregate of all base payments and any guaranteed residual
- (ii) Other finance lease liabilities include obligations that are recognised on the balance sheet; the future payments related to operating and lease commitments are disclosed in Note 18

The weighted average interest rate implicit in leases is 1.8% (2014 - 1.8%)

Note 11: Provisions

Current Provisions

Employee Benefits (i)		
Long service leave		
- Unconditional and expected to be settled wholly within 12 months (ii)	813	760
- Unconditional and expected to be settled wholly after 12 months (iii)	5,643	5,219
Annual leave		
- Unconditional and expected to be settled wholly within 12 months (ii)	3,228	3,338
- Unconditional and expected to be settled wholly after 12 months (iii)	320	-
Accrued Wages and Salaries		
- Unconditional and expected to be settled within 12 months (ii)	236	1,597
Accrued Days Off		
- Unconditional and expected to be settled within 12 months (ii)	92	85

Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months (ii)	484	628
- Unconditional and expected to be settled after 12 months (iii)	807	747

Total Current Provisions

Non-Current Provisions

Employee Benefits (i)	1,510	1,300
Provisions related to Employee Benefit On-Costs	189	162

Total Non-Current Provisions

Total Provisions

(a) Employee Benefits and Related On-Costs

Current Employee Benefits and related on-costs

Unconditional LSL Entitlement	6,456	5,979
Annual Leave Entitlements	3,548	3,338
Accrued Wages and Salaries	236	1,597
Accrued Days Off	92	85

Non-Current Employee Benefits and related on-costs

Conditional Long Service Leave Entitlements (ii)	1,510	1,300
Total Employee Benefits	11,842	12,299

On-Costs

Current On-Costs	1,291	1,375
Non-Current On-Costs	189	162

Total On-Costs

Total Employee Benefits and Related On-Costs	13,322	13,836
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(b) Movements in provisions

Movement in Long Service Leave:

Balance at start of year*	8,189	7,826
Provision made during the year		
- Gain / (Loss) on revaluation of long service leave liability due to change in bond rates	153	(70)
- Expense recognising Employee Service	1,434	1,195
Settlement made during the year	(813)	(762)
Balance at end of year*	8,963	8,189

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

Note 12: Superannuation

Employees of the Health Service are entitled to receive superannuation benefits and the Health Service contributes to both defined benefits and defined contrubution plans.

The Health Service does not recognise any defined benefit liability in respect of the plan because the entity has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due. The Department of Treasury and Finance discloses the State's defined benefits liabilities in its disclosure for administered items. However superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the comprehensive operating statement of the Health Service.

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

The name, details and amounts expense in relation to the major employee superannuation funds and contributions made by the Health Service are as follows:

Defined benefit plans:

First State Super	
Defined contribution plans:	
First State Super	
Hesta	
Total	

Paid Contribution for the Year		Contribution Outstanding at Year End	
2015 \$'000	2014 \$'000	2015 \$'000	2014 \$'000
270	280	8	10
270	280	8	10
3,667	3,544	348	361
3,195	3,145	305	318
472	399	43	43
3,937	3,824	356	371

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

Note 13: Other Liabilities

CURRENT

Monies Held in Trust	
- Patient Monies Held in Trust	
- Accommodation Bonds (Refundable Entrance Fees)	
Other	
Total Current	

Total Monies Held in Trust Represented by the following assets:

Cash Assets (refer to Note 5)	
TOTAL	

2015 \$'000	2014 \$'000
103	36
4,565	4,596
104	94
4,772	4,726
4,668	4,632
4,668	4,632

Note 14: Equity

(a) Surpluses

Property, Plant & Equipment Revaluation Surplus ¹

Balance at the beginning of the reporting period

Revaluation Increment/(Decrements)

- Land

- Buildings

Balance at the end of the reporting period

Represented by:

- Land

- Buildings

Restricted Specific Purpose Surplus

Balance at the beginning of the reporting period

Transfer to and from Restricted Specific Purpose Surplus

Balance at the end of the reporting period

Total Surpluses

(b) Contributed Capital

Balance at the beginning of the reporting period

Capital Contribution received from Victorian Government

Balance at the end of the reporting period

(c) Accumulated Surpluses/(Deficits)

Balance at the beginning of the reporting period

Net Result for the Year

Other comprehensive income

Transfers to and from Surplus

Adjustments Resulting from correction of errors

Balance at the end of the reporting period

2015 \$'000	2014 \$'000
36,537	26,567
-	485
-	9,485
36,537	36,537
957	957
35,580	35,580
36,537	36,537
2,626	2,224
1,390	402
4,016	2,626
40,553	39,163
25,956	25,956
1,251	-
27,207	25,956
(7,214)	(11,622)
286	4,740
(153)	70
(1,390)	(402)
-	-
(8,471)	(7,214)

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

Note 15: Reconciliation of Net Result for the Year to Net Cash Inflow/(Outflow) from Operating Activities

Net result for the period

Non-cash movements:

Depreciation and amortisation

Impairment of financial and non financial assets

Provision for doubtful debts

Resources/assets provided free of charge

Movement in LSL Liability due to change in bond rates

Insurance Paid on our Behalf

Movements included in investing and financing activities

Net (gain)/loss from disposal of non financial physical assets

Movements in assets and liabilities:

Change in operating assets and liabilities

(Increase)/decrease in receivables

(Increase)/decrease in other assets

(Increase)/decrease in prepayments

Increase/(decrease) in payables

Increase/(decrease) in provisions

Increase/(decrease) in other liabilities

Change in inventories

NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES

2015 \$'000	2014 \$'000
286	4,740
4,108	2,853
-	67
(6)	(15)
(4)	-
(153)	70
56	44
7	8
(1,244)	(217)
-	-
60	(15)
1,030	(580)
(514)	575
75	175
47	(22)
3,748	7,683

Note 16: Non-Cash Financing and Investing Activities

Acquisition of plant and equipment by means of Finance Leases

Total Non-Cash Financing and Investing Activities

2015 \$'000	2014 \$'000
-	21
-	21

Note 17: Financial Instruments

(a) Financial risk management objectives and policies

Wimmera Health Care Group's principal financial instruments comprise of:

- cash assets
- term deposits
- receivables (excluding statutory receivables)
- payables (excluding statutory payables)
- finance lease payables
- accommodation bonds

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

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

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

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

Categorisation of financial instruments

	Contractual financial assets - loans and receivables	Contractual financial liabilities at amortised cost	Total
2015	\$'000	\$'000	\$'000
Contractual Financial Assets			
Cash and cash equivalents	11,909	-	11,909
Receivables			
- Trade Debtors	1,057	-	1,057
- Other Receivables	2,013	-	2,013
Total Financial Assets ⁽ⁱ⁾	14,979	-	14,979
Financial Liabilities			
Payables	-	4,081	4,081
Borrowings	-	12	12
Other Financial Liabilities			
- Accomodation bonds	-	4,565	4,565
- Other	-	207	207
Total Financial Liabilities ⁽ⁱⁱ⁾	-	8,865	8,865

	Contractual financial assets - loans and receivables	Contractual financial liabilities at amortised cost	Total
2014	\$'000	\$'000	\$'000
Contractual Financial Assets			
Cash and cash equivalents	11,698	-	11,698
Receivables			
- Trade Debtors	1,290	-	1,290
- Other Receivables	952	-	952
Total Financial Assets ⁽ⁱ⁾	13,940	-	13,940
Financial Liabilities			
Payables	-	3,797	3,797
Borrowings	-	21	21
Other Financial Liabilities			
- Accomodation bonds	-	4,596	4,596
- Other	-	130	130
Total Financial Liabilities ⁽ⁱⁱ⁾	-	8,544	8,544

(i) The total amount of financial assets disclosed here excludes statutory receivables

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

Note 17: Financial Instruments (Continued)

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

	Net holding gain/(loss) \$'000	Total interest income / (expense) \$'000	Fee income / (expense) \$'000	Impairment loss \$'000	Total \$'000
2015					
Financial Assets					
Cash and Cash Equivalents ⁽ⁱ⁾	-	391	-	-	391
Total Financial Assets	-	391	-	-	391
Financial Liabilities					
At Amortised Cost ⁽ⁱⁱ⁾	-	-	-	-	-
Total Financial Liabilities	-	-	-	-	-
2014					
Financial Assets					
Cash and Cash Equivalents ⁽ⁱ⁾	-	420	-	-	420
Total Financial Assets	-	420	-	-	420
Financial Liabilities					
At Amortised Cost ⁽ⁱⁱ⁾	-	-	-	-	-
Total Financial Liabilities	-	-	-	-	-

(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, plus or minus foreign exchange gains or losses arising from the revaluation of financial liabilities measured at amortised cost.

(c) Credit risk

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

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

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

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

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

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

	Financial institutions (AA credit rating)	Government agencies (AAA credit rating)	Government agencies (BBB credit rating)	Other (min BBB credit rating)	Total
2015	\$'000	\$'000	\$'000	\$'000	\$'000
Financial Assets					
Cash and Cash Equivalents	8,388	3,521	-	-	11,909
Loans and Receivables					
- Trade Debtors	-	-	1,320	1,057	2,377
- Other Receivables (i)	-	-	-	693	693
Total Financial Assets	8,388	3,521	1,320	1,750	14,979
2014					
Financial Assets					
Cash and Cash Equivalents	11,698	-	-	-	11,698
Loans and Receivables					
- Trade Debtors	-	-	436	1,290	1,726
- Other Receivables	-	-	-	516	516
Total Financial Assets	11,698	-	436	1,806	13,940

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

Note 17: Financial Instruments (continued)

(c) Credit Risk (continued)

Ageing analysis of Financial Assets as at 30 June

	Consol'd Carrying Amount	Not Past Due and Not Impaired	Past Due But Not Impaired				Impaired Financial Assets
			Less than 1 Month	1-3 Months	3 months - 1 Year	1-5 Years	
2015	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Financial Assets							
<i>Cash and Cash Equivalents</i>	11,909	11,909	-	-	-	-	-
<i>Loans and Receivables</i>							
- Trade Debtors	2,377	1,342	566	186	166	110	7
- Other Receivables (i)	693	399	157	55	50	32	-
Total Financial Assets	14,979	13,650	723	241	216	142	7
2014							
Financial Assets							
<i>Cash and Cash Equivalents</i>	11,698	11,698	-	-	-	-	-
<i>Loans and Receivables</i>							
- Trade Debtors	1,726	1,163	146	166	147	92	12
- Other Receivables (i)	516	350	44	50	44	28	-
Total Financial Assets	13,940	13,211	190	216	191	120	12

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

Contractual financial assets that are either past due or impaired

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

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

Note 17: Financial Instruments (continued)

(d) Liquidity risk

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

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

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

Trade creditors are paid in accordance with their trading terms. Accommodation bonds are refunded when the resident departs the aged care facility.

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

Maturity analysis of Financial Liabilities as at 30 June

	Carrying Amount	Nominal Amount	Maturity Dates			
			Less than 1 Month	1-3 Months	3 months - 1 Year	1-5 Years
2015	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Financial Liabilities						
<i>At amortised cost</i>						
Payables	4,081	4,081	1,242	2,839	-	-
Borrowings	12	12	1	1	5	5
Other Financial Liabilities (i)						
- Accommodation Bonds	4,565	4,565	97	1,250	1,854	1,364
- Other	207	207	207	-	-	-
Total Financial Liabilities	8,865	8,865	1,547	4,090	1,859	1,369
2014						
Financial Liabilities						
<i>At amortised cost</i>						
Payables	3,797	3,797	1,140	2,657	-	-
Borrowings	21	21	1	1	6	13
Other Financial Liabilities (i)						
- Accommodation Bonds	4,596	4,596	98	1,258	1,867	1,373
- Other	130	130	130	-	-	-
Total Financial Liabilities	8,544	8,544	1,369	3,916	1,873	1,386

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

Note 17: Financial Instruments (continued)

(e) Market risk

The Wimmera Health Care Group's exposures to market risk are primarily through interest rate risk with only insignificant exposure to foreign currency and other price risks. Objectives, policies and processes used to manage each of these risks are disclosed in the paragraph below.

Currency risk

The Wimmera Health Care Group is exposed to insignificant foreign currency risk through its payables relating to purchases of supplies and consumables from overseas. This is because of a limited amount of purchases denominated in foreign currencies and a short timeframe between commitment and settlement.

Interest rate risk

Exposure to interest rate risk might arise primarily through the Wimmera Health Care Group's interest bearing liabilities. Minimisation of risk is achieved by mainly undertaking fixed rate or non-interest bearing financial instruments. For financial liabilities, the health service mainly undertake financial liabilities with relatively even maturity profiles.

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

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

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

Other price risk

Wimmera Health Care Group is exposed to normal price fluctuations from time to time through market forces.

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

	Weighted Average Effective Interest Rate (%)	Carrying Amount \$'000	Interest Rate Exposure		
			Fixed Interest Rate \$'000	Variable Interest Rate \$'000	Non- Interest Bearing \$'000
2015					
Financial Assets					
<i>Cash and Cash Equivalents</i>	2.12	11,909	-	11,909	-
<i>Loans and Receivables⁽ⁱ⁾</i>					
- Trade Debtors		2,377	-	-	2,377
- Other Receivables		693	-	-	693
		14,979	-	11,909	3,070
Financial Liabilities					
<i>At amortised cost</i>					
Payables ⁽ⁱ⁾		4,081	-	-	4,081
Borrowings	1.8	12	12	-	-
Other Financial Liabilities					
- Accommodation Bonds		4,565	-	4,565	-
- Other		207	-	-	207
		8,865	12	4,565	4,288
2014					
Financial Assets					
<i>Cash and Cash Equivalents</i>	2.8	11,698	-	11,698	-
<i>Loans and Receivables⁽ⁱ⁾</i>					
- Trade Debtors		1,726	-	-	1,726
- Other Receivables		516	-	-	516
		13,940	-	11,698	2,242
Financial Liabilities					
<i>At amortised cost</i>					
Payables ⁽ⁱ⁾		3,797	-	-	3,797
Borrowings	1.8	21	21	-	-
Other Financial Liabilities					
- Accommodation Bonds		4,596	-	4,596	-
- Other		130	-	-	130
		8,544	21	4,596	3,927

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

Note 17: Financial Instruments (continued)

(e) Market risk (continued)

Sensitivity disclosure analysis

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

A shift of 100 basis points up and down in market interest rates (AUD) from year-end rates of 3%.

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

	Carrying Amount	Interest Rate Risk			
		-1% Profit \$'000	Equity \$'000	+1% Profit \$'000	Equity \$'000
2015					
Financial Assets					
<i>Cash and Cash Equivalents</i>	11,909	(119)	(119)	119	119
<i>Loans and Receivables</i>					
- Trade Debtors	2,377	-	-	-	-
- Other Receivables	693	-	-	-	-
Financial Liabilities					
<i>At amortised cost</i>					
Payables	4,081	-	-	-	-
Borrowings	12	-	-	-	-
Other Financial Liabilities ⁽ⁱ⁾					
- Accommodation Bonds	4,565	-	-	-	-
- Other	207	-	-	-	-
		(119)	(119)	119	119
2014					
Financial Assets					
<i>Cash and Cash Equivalents</i>	11,698	(117)	(117)	117	117
<i>Loans and Receivables</i>					
- Trade Debtors	1,726	-	-	-	-
- Other Receivables	516	-	-	-	-
Financial Liabilities					
<i>At amortised cost</i>					
Payables	3,797	-	-	-	-
Borrowings	21	-	-	-	-
Other Financial Liabilities ⁽ⁱ⁾					
- Accommodation Bonds	4,596	-	-	-	-
- Other	130	-	-	-	-
		(117)	(117)	117	117

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

Note 17: Financial Instruments (continued)

(f) Fair value

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

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

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

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

Comparison between carrying amount and fair value

	Carrying Amount	Fair value	Carrying Amount	Fair value
	2015 \$'000	2015 \$'000	2014 \$'000	2014 \$'000
Financial Assets				
<i>Cash and Cash Equivalents</i>	11,909	11,909	11,698	11,698
<i>Loans and Receivables ⁽ⁱ⁾</i>				
- Trade Debtors	2,377	2,377	1,726	1,726
- Other Receivables	693	693	516	516
Total Financial Assets	14,979	14,979	13,940	13,940
Financial Liabilities				
<i>At amortised cost</i>				
Payables	4,081	4,081	3,797	3,797
Borrowings	12	12	21	21
Other Financial Liabilities ⁽ⁱ⁾				
- Accommodation Bonds	4,565	4,565	4,596	4,596
- Other	207	207	130	130
Total Financial Liabilities	8,865	8,865	8,544	8,544

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

Note 18: Commitments

a) Commitments other than public private partnerships

Capital expenditure commitments

Payable:

Land and buildings

Plant and equipment

Total capital expenditure commitments

Land and buildings

Not later than one year

Total

Plant and Equipment

Not later than one year

Total

Other expenditure commitments

Payable:

General

Total other expenditure commitments

Not later than one year

TOTAL

Lease commitments

Commitments in relation to leases contracted for at the reporting date:

Property lease

Operating leases

Finance leases

Total lease commitments

Operating leases

Not later than one year

Later than 1 year and not later than 5 years

Sub Total

Total operating lease commitments

Finance Leases

Commitments in relation to finance leases are payable as follows:

Current

Non-current

Minimum Lease Payments

Total finance lease commitments

Total lease commitments

Total Commitments (inclusive of GST) other than public private partnerships

2015 \$'000	2014 \$'000
34	501
409	233
443	734
34	501
34	501
409	233
409	233
-	18
-	18
-	18
-	18
109	50
767	746
14	23
890	819
429	400
447	396
876	796
876	796
8	8
6	15
14	23
14	23
890	819
1,333	1,571

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

Note 19: Operating Segments

	RAC		Acute		HACC		Primary Care		Other		Total	
	2015 \$'000	2014 \$'000	2015 \$'000	2014 \$'000	2015 \$'000	2014 \$'000	2015 \$'000	2014 \$'000	2015 \$'000	2014 \$'000	2015 \$'000	2014 \$'000
REVENUE												
External Segment Revenue	11,033	10,398	50,944	48,135	2,584	2,296	1,417	1,436	16,162	20,354	82,140	82,619
Total Revenue	11,033	10,398	50,944	48,135	2,584	2,296	1,417	1,436	16,162	20,354	82,140	82,619
EXPENSES												
External Segment Expenses	(12,392)	(12,182)	(49,402)	(45,557)	(2,387)	(2,260)	(1,884)	(2,257)	(16,180)	(16,083)	(82,245)	(78,339)
Total Expenses	(12,392)	(12,182)	(49,402)	(45,557)	(2,387)	(2,260)	(1,884)	(2,257)	(16,180)	(16,083)	(82,245)	(78,339)
Net Result from ordinary activities	(1,359)	(1,784)	1,542	2,578	197	36	(467)	(821)	(18)	4,271	(105)	4,280
Interest Income	-	-	-	-	-	-	-	-	391	460	391	460
Net Result for Year	(1,359)	(1,784)	1,542	2,578	197	36	(467)	(821)	373	4,731	286	4,740
OTHER INFORMATION												
Segment Assets	20,676	17,134	44,484	43,100	2,687	2,501	8,687	8,094	4,941	9,460	81,475	80,289
Total Assets	20,676	17,134	44,484	43,100	2,687	2,501	8,687	8,094	4,941	9,460	81,475	80,289
Segment Liabilities	5,630	4,777	12,114	12,016	732	697	2,365	2,257	1,346	2,637	22,187	22,384
Total Liabilities	5,630	4,777	12,114	12,016	732	697	2,365	2,257	1,346	2,637	22,187	22,384
Depreciation & Amortisation Expense	1,043	609	2,243	1,532	135	89	438	288	249	335	4,108	2,853
Net Gain/(loss) on disposal of Non-Current Assets (refer note 2a)	-	-	-	-	-	-	-	-	-	67	-	67

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

Business Segments	Services
Residential Aged Care Services (RACS)	Aged Health Care
Acute	Acute Health Care
HACC	Home and Community Care
Primary Care	Allied Health Services
Other	Disabled and Hospice Health Care

Geographical Segment

Wimmera Health Care Group operates predominantly in Horsham, Victoria. More than 90% of revenue, net surplus from ordinary activities and segment assets relate to operations in Horsham, Victoria.

Note 20: Jointly Controlled Operations and Assets

Name of Entity	Principal Activity	Ownership Interest	
		2015 %	2014 %
Grampians Rural Health Alliance	Information Systems	11.06	11.71

Wimmera Health Care Group's interest in assets employed in the above jointly controlled operations and assets is detailed below. The amounts are included in the financial statements and consolidated financial statements under their respective asset categories:

	2015 \$'000	2014 \$'000
Current Assets		
Cash and Cash Equivalents	65	94
Debtors	52	72
Prepayments	8	5
Total Current Assets	125	171
Non Current Assets		
Property, Plant and Equipment	122	134
Total Non Current Assets	122	134
Total Assets	247	305
Current Liabilities		
Creditors	28	71
Total Current Liabilities	28	71
Total Liabilities	28	71

Wimmera Health Care Group's interest in revenues and expenses resulting from jointly controlled operations and assets is detailed below:

	2015 \$'000	2014 \$'000
Revenues		
Other	543	568
Total Revenue	543	568
Expenses		
Information Technology and Administrative Expenses	545	545
Total Expenses	545	545
Net result	(2)	23

Note 21a: Responsible Persons Disclosures

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

Responsible Ministers:

The Honourable David Davis, MLC, Minister for Health and Minister for Ageing
The Honourable Mary Wooldridge, MP, Minister for Disability Services and Reform
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services
The Honourable Jenny Mikakos, MLC, Minister for Families and Children
The Honourable Martin Foley, Minister for Housing, Disability and Ageing

Governing Boards

Mr E McCabe
Mr R Pyers
Mr R Goudie
Mr P Campbell
Mr W Winter
Mr D Luciani (Deputy Chairman)
Mr M A Williams (Chairman)
Ms A Murphy
Mrs M Aitken

Accountable Officers

Mr C G Scott

Remuneration of Responsible Persons

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

Income Band

\$0 - \$9,999
\$260,000 - \$269,999
\$270,000 - \$279,999

Total Numbers

Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:

All Board of Management members undertake their duties on an honorary basis for no payment.

Other Transactions of Responsible Persons and their Related Parties.

Mr E McCabe is a partner of Brown & Proudfoot, a law firm which provides legal advice to the Health Service on normal commercial terms and conditions.

Mr M Williams is the Managing Director of Grampians Wimmera Malle Water Corporation. Any transaction between the Health Service and Grampians Wimmera Malle Water Corporation occur based on normal commercial terms and conditions.

Mr D Luciani was the General Manager of Workco Ltd. Any transactions between the Health Service and Workco Ltd occur based on normal commercial terms and conditions.

Ms A Murphy is the Director of Community Services at Horsham Rural City Council. Any transactions between the Health Service and Horsham Rural City Council occur based on normal commercial terms and conditions.

Mrs M Aitken provides consultative services to Wimmera Health Care Group staff through the employee assistance program.

Mr C Scott is a Director of Wimmera Uniting Care, who provide services to the community health services programs run by the Health Service on normal terms & conditions.

Note 21b: Executive Officer Disclosures

Executive Officers' Remuneration

The numbers of executive officers, other than Ministers and Accountable Officers, and their total remuneration during the reporting period are shown in the first two columns in the table below in their relevant income bands.

The base remuneration of executive officers is shown in the third and fourth columns. Base remuneration is exclusive of bonus payments, long-service leave payments, redundancy payments and retirement benefits.

Several factors affected total remuneration payable to executives over the year. A number of employment contracts were completed during the year and negotiated and a number of executives received bonus payments during the year. These bonus payments depend on the terms of individual employment contracts. Some contracts provide for an annual bonus payment whereas other contracts only include the payment of bonuses on the successful completion of the full term of the contract. A number of these contract completion bonuses became payable during the year.

A number of executive officers retired, resigned or were retrenched in the past year. This has had a significant impact on total remuneration figures due to the inclusion of annual leave, long-service leave and retrenchment payments.

	Total Remuneration 2015 No.	2014 No.	Base Remuneration 2015 No.	2014 No.
\$130,000 - \$139,999	-	-	-	1
\$140,000 - \$149,999	-	1	1	-
\$160,000 - \$169,999	1	-	1	2
\$170,000 - \$179,999	-	1	-	-
\$180,000 - \$189,999	1	-	1	-
\$190,000 - \$199,999	-	1	-	-
\$200,000 - \$209,999	1	-	-	-
\$290,000 - \$299,999	-	-	-	1
\$300,000 - \$309,999	-	-	1	-
\$320,000 - \$329,999	1	-	-	-
\$340,000 - \$349,999	-	1	-	-
Total	4	4	4	4
Total annualised employee equivalents (AEE) ⁽ⁱ⁾	4	4	4	4
Total Remuneration	\$ 887,504	\$ 868,734	\$ 803,109	\$ 756,169

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

Note 21c: Payments to other personnel

Expense Band

\$310,000 - 319,999

Total expenses (exclusive of GST)

In accordance with FRD 21B the following disclosures are made in relation to other personnel of Wimmera Health Care Group, 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 22: Remuneration of auditors

Victorian Auditor-General's Office

Audit or review of financial statements

Note 23: Events Occurring after the Balance Sheet Date

There were no significant events occurring after reporting date.

Note 24: Contingent Assets and Contingent Liabilities

There were no Contingent Assets or Liabilities at reporting date.

Appendix A - Alternative presentation of comprehensive operating statement

	2015 \$'000	2014 \$'000
Interest	391	460
Fair Value of assets and services received free of charge or for nominal consideration	4	-
Sales of goods and services	9,055	8,580
Grants	66,089	62,049
Other Income	7,003	12,000
Total revenue	82,542	83,089
Employee expenses	52,849	51,583
Depreciation	4,108	2,853
Other operating expenses	25,292	23,838
Impairment of Non-Financial Assets	-	67
Total expenses	82,249	78,341
Net result from transactions - Net operating balance	293	4,748
Net gain/ (loss) on disposal of non-financial assets	(7)	(8)
Other gains/(losses) from other comprehensive income	(153)	70
Total other economic flows included in net result	(160)	62
Items that may be reclassified subsequently to net result		
Changes to financial assets available-for-sale revaluation surplus	-	9,970
Total other economic flows included in net result	-	9,970
Net result	133	14,780



INCORPORATING

Wimmera Base Hospital
Dimboola Hospital
Wimmera Nursing Homes
Kurrajong Lodge
Wimmera Medical Centre
John Pickering Medical Centre, Dimboola

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At Wimmera Health Care Group our
trademark culture and behaviour is:
United and Cohesive;
Open, Honest, Trusting;
Respectful, Caring, Supportive;
Accountable and Effective.