Wimmera Health Care Group

ANNUAL REPORT 2015-2016

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.

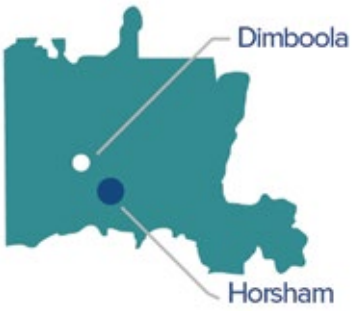
With an operating budget of approximately $81 million, Wimmera Health Care Group is the major specialist referral centre for the Wimmera and Southern Mallee region of Victoria. Our campuses in Horsham and Dimboola service an area of 61,000 square kilometres and a population of approximately 54,000.

We employ more than 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 11,700 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
- Aboriginal Liaison Office
- 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
- 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
- Stomal Therapy
- Stress Testing Clinic
- Stroke support
- Teleradiology
- Transition Care
- Ultrasound
- Urology
- Video Fluoroscopy
- Wound Care

HOW TO CONTACT US

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ABOUT THIS REPORT

This Annual Report provides performance and financial information for the 2015-16 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 of 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 and The Honourable Martin Foley MLA, Minister for Mental Health.

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STRATEGIC PLAN
2015 - 2018

Strategy: Align and further develop services to meet the changing needs of our community

COMMITMENT	MEASURE OF SUCCESS	FURTHER OPPORTUNITIES
Commitment 1 **Review and reset Subregional Service Plan** **Approach:** Review and reset in partnership with the Wimmera Southern-Mallee Health Alliance the subregional plan in the context of Wimmera Health Care Group's role in the subregion; determine community needs by engaging with our consumers (including strategic approach to aged care) and develop implementation pathways that adopt person centred principles, as agreed. **Complete Date: July 2015** **Success Measures:** Board of Management signs off on Subregional Service Plan reset and agreed implementation pathways.	• The Wimmera Southern-Mallee Health Alliance deferred a decision to reset the Subregional Service Plan until after the proposed Dunmunkle Health Services and West Wimmera Health Service amalgamation. • In the interim Wimmera Health Care Group has engaged Aspex Consulting to prepare a Service Plan for Wimmera Health Care Group. • Board of Management accepted and adopted an Aged Care Strategy - including service improvements. Infrastructure developed as part of that strategy has progressed in a timely manner to support the bed reduction program and facilities improvement. • Department of Health and Human Services will use the Wimmera Health Care Group Service Plan to inform a new Master Plan for the Wimmera Base Hospital site with a view to further securing the organisation's subregional role.	The Subregional Service Plan will guide future service developments, clinical expertise and match this to serve community needs.
Commitment 2 **Undertake regular review and update of existing services to ensure contemporary best practices** **Approach:** Develop a process and plan for annual review and update of existing services and systems to ensure contemporary best practices. Identify and agree what contemporary best practice means for each service and system and undertake relevant evaluation. Ensure this is an ongoing embedded process. Engage and utilise existing quality/ audit systems to assess contemporary best practice and gain the necessary knowledge as required. A key component of this action would be to identify how information technology could support and improve performance of both existing and future services and systems. **Complete Date: October 2015** **Success Measures:** At least 80% of annually reviewed services are formally (via external means) certified as best practice or contemporary.	• The Wimmera Health Care Group Service Plan review will support this process and underpins the Wimmera Cancer Centre Project. • Clinical System Review Plan; Some systems have been independently assessed with recommendations captured in the risk register. Three to date include Theatre, Emergency Department and Clinical Governance review. • Maternity services are to be independently reviewed in coming months. • Quality and Safety Plan is due to be reset which will also inform future service improvements. • The implementation of the Regional Digital Medical Record is underway which will substantially increase the visibility of clinical data.	Further develop our service models to deliver contemporary care, consistent with the plan and also monitor best practice and performance to deliver quality care.

STRATEGIC PLAN
2015 - 2018

COMMITMENT	MEASURE OF SUCCESS	FURTHER OPPORTUNITIES
Commitment 3 **Identify areas of sustainable collaborative and complementary service development** **Approach:** Utilise the reset of Subregional Service Plan, identify relevant business development opportunities and differentiate between collaborative and complementary opportunities. Develop prioritisation criteria and implementation plan and ensure this is an ongoing process. **Complete Date: June 2016** **Success Measures:** Plan formally approved by CEO.	• Ballarat Health Services have renewed their engagement within the region and this is providing opportunity for further service collaboration. • The securing of the Ballarat Regional Integrated Cancer Centre agreement for oncology services including a monthly operational teleconference between our two organisations will deliver sustainable services. • Royal Flying Doctor Service and Arthritis Victoria agreement on muscular skeletal/pain management. • Development of tele-oncology and other tele-health services. • Regional Digital Medical Record System. • Grampians Integrated Cancer Service – Wimmera Cancer Co-ordination Plan.	Further advance sub regional care models through personal delivery of e-health platforms in partnership with like-minded organisations.
Commitment 4 **Develop processes for acknowledging and promoting clinical and community leadership (e.g. Centres of Excellence)** **Approach:** Identify areas of existing and potential clinical and community leadership and implement a plan for acknowledging, developing and promoting (e.g. Centres of Excellence). **Complete Date: December 2016** **Success Measures:** Plan formally approved by CEO.	• Independent review of Clinical Governance. • Emergency Service collaborations with small rural health services' urgent care centres. • Engagement with the Dimboola community. • Wimmera Cancer Centre Project. • Aged Care Strategy and service reforms. • Reviewed our Clinical Governance Framework (Quality & Safety Plan) and made improvements. • Quarterly Clinical Reviews undertaken in partnership with West Wimmera Health Service to promote clinical leadership in the region.	Leverage off the key success stories and models of care to further strengthen the quality of care models and recognise/reward areas of excellence.

Strategy: Build Regional and Community Relations for the future

Commitment 5 **Build on community relationships** **Approach:** Build on community relationships by leveraging Community Advisory Committee and consumer engagement initiatives; develop systems for actively listening and responding to consumer feedback, test, amend as required. Embed and ensure ongoing process. **Complete Date: December 2016** **Success Measures:** At least 95% satisfaction rating on Victorian Healthcare Experience Survey.	• Wimmera Cancer Centre Project Steering Committee and Fundraising Sub-committee engagement with the Wimmera Southern-Mallee communities through the cancer centre appeal. • 3WM radio appeal and community support. • Dimboola community, including the provision of management services to Allambi Elderly Peoples Home.	Further progress engagement with our community, consumers and key stakeholders as we strengthen our service and leadership role in the region.

STRATEGIC PLAN
2015 - 2018

COMMITMENT	MEASURE OF SUCCESS	FURTHER OPPORTUNITIES
Commitment 6 **Develop formal strategic relationships with identified key agencies** **Approach:** Identify key agencies where we do not have formal relationship, agree required strategic outcomes of relationship, develop plan of engagement and timeframes; implement. **Complete Date: October 2017** **Success Measures:** At least 70% of identified new key agencies have a formal relationship with Wimmera Health Care Group.	• Ballarat Health Services – strengthen our relationship (including the Ballarat Regional Integrated Cancer Centre). • Wimmera Cancer Centre Project – strengthen our relationship with key stakeholders, Department of Health and Human Services and Grampians Integrated Cancer Service and sub-regional agencies through service models. • Royal Flying Doctor Service and Arthritis Victoria. • Emergency management via a number of organisations including Horsham Emergency Management Team and Emergency Services Liaison Committee (Ambulance Victoria and Victoria Police).	Engage in a more structured way with key stakeholders, agencies and organisations where benefits can be gained from such relationships.
Commitment 7 **Engage with key regional stakeholders** **Approach:** Identify key regional stakeholders to ensure strategic relevance in our region; develop partnering plans, timeframes and success measures. **Complete Date: December 2015** **Success Measures:** Board approval of Key Regional Stakeholders Engagement Plan.	• Ballarat Health Services: surgical services, information communication technology, digital medical records and mental health care. • Corporate service expansions with Stawell Regional Health, Goolum Goolum and potentially East Grampians Health Service and Ballan Community Health Centre. • West Wimmera Health Service on clinical quality improvements following their Surgical Services Review. • Sub-regional Training Programs. • Regional Project for Health Purchasing Victoria Reforms - Joint Tenders.	Focus on key stakeholders within the region to foster stronger relationships.

Strategy: Strengthen People and Culture

Commitment 8 **Align staff positions, capabilities and performance management systems to further support the vision and trademark culture and behaviours** **Approach:** Map staff positions, capabilities and performance management systems to further support the vision and culture/ behaviours. Set key targets for alignment with existing work force plans and ensure trademark behaviours and values are incorporated and embedded. Develop systems for actively listening and responding to staff feedback. Develop ongoing plan for implementation, including performance and success measures, and timeframes. **Complete Date: December 2015** **Success Measures:** At least 90% of agreed targets are achieved within the timelines.	• Cultural improvement following implementation of Trademark Behaviours. • Demonstrated improvement in staff responses to People Matters Survey. • Development of a staff 'Reward and Recognition' policy and progress in alignment with the Strategic Plan. • Implementation of Mercury E-Recruitment and Performance Appraisal software. • Trademark behaviours revitalisation program.	Further investment in our key asset; people. Re-align the culture of the organisation to be an employer of choice. To achieve an unwavering commitment to people, their wellbeing and true self.

STRATEGIC PLAN
2015 - 2018

COMMITMENT	MEASURE OF SUCCESS	FURTHER OPPORTUNITIES
Commitment 9 **Identify and implement innovative staff recruitment and retention strategies** **Approach:** Research innovative and alternative staff recruitment and retention strategies (including succession planning) and prepare preferred options, and develop implementation plans that encompass a positive education learning culture and are proactive regarding succession planning and future workforce needs. **Complete Date: December 2016** **Success Measures:** Plan formally approved by CEO.	• Investigating our own clinical skills centre to be more independent in securing nursing staff. • Health and Wellbeing Plan. • Reward and Recognition Program. • Revisit Workforce Plans. • Implement Kronos Advanced Scheduling. • Expansion of Employee Assistance Program to provide a 24 hours per day phone advisory service to complement services provided locally.	Cultivating our emerging leaders and strengthening the organisation through further people development, skills, education and knowledge.

Strategy: Redesign Organisational processes to meet future needs

Commitment 10 **Progress strengthening the implementation of redesign methodologies and principles** **Approach:** Investigate lean principles and process redesign to identify relevant process and information systems improvements. Incorporate the skills, experience and expertise of multidisciplinary performance team to develop a Performance Improvement Plan; that includes budget implications. Embed and ensure annualised process. **Complete Date: April 2016** **Success Measures:** CEO approves Performance Improvement Plan annually.	• Appointed a Director of Business Performance and Redesign. • Improved outcome on the Department of Health and Human Services Tollgate Health ICQ-tool performance to top of third quartile. • Senior staff undertaking Professional Certificate in Health Systems Management (of the three completed two received first class honours). • Process of establishing an Innovations Strategic Plan. • Two staff attended a two day Better Care Victoria 'Introduction to Process Improvement' training. • Completed sub-acute patient flow redesign project. • Undertaking payroll systems review to improve customer service. • Redesign principles presented to May 2016 Department Heads meeting. • Developing Redesign Methodologies Master Classes for staff. • Improvement Capability and Health ICQ feedback session for senior staff in June 2016.	Further development of our business capability to world's best practice and strengthen our corporate performance through embedded activities.

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 2016.

Angela Murphy
President
Horsham
23 August 2016

Wimmera Health Care Group has continued to provide a broad and comprehensive range of services commensurate with its capabilities and capacities, appropriate to the clinical needs of the people of the Wimmera and Southern-Mallee, and consistent with our subregional role.

During the year we delivered clinical services to 11,764 inpatients in our acute and sub-acute facilities. This was an increase 1.9% on the previous year which reflects the ongoing growth in demand for complex acute health care across the subregion. It was pleasing that the Department of Health and Human Services recognised the demand pressures and provided additional resources to meet the rising expectations of the expanded community which the Wimmera Health Care Group serves.

The combination of the traditional acute service models of care together with the maturing of our new sub-acute and rehabilitation capabilities has extended our reach into the community to deliver a comprehensive array of service types. The need for acute services at Dimboola rebounded following a change in the medical model which reaffirmed the importance of delivering the right services in the right location to meet the needs of the community. Our continued momentum to improve efficiency has witnessed a reduction in average length of stay for acute patients to 2.02 days, and similarly in our sub-acute service of 22.38 days. This has resulted in an average cost per separation almost a thousand dollars below the state average. The Department of Health and Human Services has again been very supportive of our expanded role in the subregion and with the additional growth funding received it is expected service expansion will continue in 2016-2017.

The critical nature of our Emergency Department to the region is demonstrated by the level of demand placed on it by the community. 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 13,925 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. Through resourcefulness and a whole of business approach; supported by our subregional partners, significant improvements have been made in patient outcomes both locally and in other communities. A unique feature of our emergency service is the collaborative work being undertaken across the subregion to improve patient flows and ensure care is provided as close to home as possible. The local agencies in the Wimmera Southern-Mallee have established a number of service improvements including the use of telehealth technology and weekly patient flow meetings to increase service access and reduce the pressures placed on patients and the health care system.

Demand for residential aged care accommodation was steady during the year with great emphasis placed on occupancy levels across the three aged care facilities. The constant demand for residential aged care services in all forms reflects our ongoing commitment to service quality and demonstrates areas of market growth outside the traditional forms. We have continued to progress our aged care strategy which includes the strengthening of the 'named nurse' care model, improved access to pain management, and advancements in our infrastructure redevelopment of the Wimmera Nursing Homes. The strategy underpins our commitment to deliver quality residential aged care services in contemporary facilities that has been recognised through the awarding of full accreditation by the Australian Aged Care Quality Agency.

Our investment into contemporary infrastructure has been hallmarked with the completion of the O'Brien Lane Car Park. The additional off-street parking capacity has allowed for improved traffic management around the hospital and facilitated improved access as demand for our services grows.

Further investments have been made in a number of capital renewal projects with an accumulated value of $2.07 million. The source of funds has been drawn from both state and federal government grants, fundraising activities and reserve funds with particular investments being made into our continued improvements to medical and surgical equipment, patient and employee security, air conditioning systems and operational infrastructure and technology. We acknowledge and thank the contributions of the Department of Health and Human Services, fundraising committees and individual benefactors in achieving these vital improvements and technological advancements.

Our commitment to continuous quality improvement and clinical governance was reconfirmed through a number of independent reviews and expansion of our internal audit program; the findings of which progressively strengthen our safety and quality of care. The group continues to maintain high levels of compliance to legislative requirements and standards within the industry as demonstrated by our success within the new National Safety and Quality Health Service Standards; and residential aged care accreditation and Home Care Standards formally

known as 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, safety and quality, and the application of innovative business practices as evidenced by our 40 plus years of unbroken achievement to these national requirements.

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 cooperation for sustainable health 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 relationships. The shared knowledge that such relationships bring to the organisation enriches the partnerships and builds a respectful trust on which to deliver tangible outcomes for the people of the region. Our commitment to working in partnership with other agencies is unwavering and evidenced by the support provided to the Allambi Elderly Peoples Home Inc in Dimboola, and to our long-time partner in Dunmunkle Health Services as they progressed their amalgamation within the region.

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 24 'Strategic Priorities' were agreed in 2015-2016 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 were also fully met. The headline result for 2015-2016 is an operating surplus of $591,404; which included treating an additional 4% of inpatients above our agreed target, which equates to over 400 more people receiving inpatient care. The calibre of these results placed Wimmera Health Care Group as one of the highest performing Regional and Subregional health services 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 strengthened through the alignment of employee behaviours with our values and direction as reflected through the People Matter Survey - leading to a greater focus on our workforce needs. The value of an engaged and empowered workforce cannot be underestimated and in response further investment is being made in leadership and personal development of our most important asset – our staff. Current results are providing value and are being reflected in 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 Wimmera Cancer Centre project has rallied and focused the community on this significant piece of infrastructure for the Wimmera and Southern-Mallee from which we will improve access to cancer treatments locally and improve the health and wellbeing of patients, families and friends. The Board of Management acknowledges and extends its appreciation to the Victorian State Government and in particular Minister for Health The Hon Jill Hennessey for the commitment of $1 million to the Wimmera Cancer Centre Project and her personal commitment to ensuring its coming to fruition. The respect and caring support for the people of the Wimmera and Southern-Mallee was most welcomed.

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 Mr Ted McCabe and Mr Mark Williams for their respective tenures on the Board. Both have made significant contributions over extended periods and their leadership is clearly acknowledged. We also welcome the reappointment of Ms Angela Murphy and Mrs Merryn Eagle and appointment of Mrs La Vergne Lehmann to the Board in 2016-2017; their contributions 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 maintain our financial sustainability; attract and keep a skilled and professional workforce; and safely deliver quality care as close to home as possible.

Angela Murphy
President

Chris Scott
Chief Executive

STATEMENT OF PRIORITIES

Part A - Strategic Priorities

DOMAIN	ACTION	DELIVERABLES	OUTCOME
Patient Experience and Outcomes	Drive improved health outcomes through a strong focus on patient-centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first.	By March 2016, prepare a report on health infrastructure and planning process for the development of the proposed oncology unit 'wellness centre' infrastructure renewal project.	Achieved. The new Service Plan (report) was received in May 2016 underpinning the planning for infrastructure renewal, including the proposed oncology unit 'wellness centre'. Department of Health and Human Services have confirmed master planning process is the next phase.
	Strengthen the response of health services to family violence. This includes implementing interventions, processes and systems to prevent; identify and respond appropriately to family violence at an individual and community level.	By June 2016 develop and implement a policy, including a staff education component, aimed at increasing the awareness of and appropriate response to suspected or actual incidents of elder abuse particularly in community settings.	Achieved. Draft policy and procedure for elder abuse in acute and community settings completed in March 2016. Family Violence Working Party established to implement staff education on the strengthening hospital responses to family violence model (including elder abuse). Policy and procedure for elder abuse launched and implemented in June 2016.
	Use consumer feedback and develop participation processes to improve person and family centred care, health service practice and patient experiences.	By June 2016 implement four key consumer driven feedback programs to improve health service practice and patient experience outcomes.	Achieved. Implemented the 'You Said. We Listened. We Did' program. A poster journey board developed in the acute wards corridor where we add improvements based on consumer feedback and input from each program of Wimmera Health Care Group. Health literacy resources made available for staff, patients and clients across the organisation. Education sessions provided regionally and at Wimmera Health Care Group. Implemented the 'Did we listen program?' across the organisation that ensures contact to a consumer who has made an informal complaint. 'How Was Your Stay?' program: Nurse in charge chats with the patient before they go home to see how their stay was. Post discharge follow-up in the acute care setting. A program whereby the nurse from the discharge lounge will call patients discharged to home post exit to gain feedback on their experience.

STATEMENT OF PRIORITIES

Part A - Strategic Priorities

DOMAIN	ACTION	DELIVERABLES	OUTCOME
Patient Experience and Outcomes (cont.)	Develop an organisational policy for the provision of safe, high quality end of life care in acute and subacute settings, with clear guidance about the role of, and access to, specialist palliative care.	By December 2015 implement a policy on the role of, and access to, specialist palliative care in the Wimmera Southern-Mallee.	Achieved. Policy finalised September 2015. Palliative Care Resource folders distributed throughout the region and included access to Wimmera Health Care Group services in September 2015. Communication with Regional Palliative Care Resource Nurses advising access to the resource.
	Identify service users who are marginalised or vulnerable to poor health, and develop interventions that improve their outcomes relative to other groups, for example, women, Aboriginal people, people affected by mental illness, people at risk of elder abuse, people with disability, homeless people, refugees and asylum seekers, people whose alcohol and other drug use is damaging their health or impacting on their recovery.	Work with local Aboriginal Co-operatives to identify enablers and barriers to accessing ophthalmology surgery in line with the Grampians Region Aboriginal Eye Health Project.	Achieved. Work plan established with local Aboriginal Co-operative (Goolum Goolum) to identify enablers. Implemented plan for 'fast track' ophthalmology referrals from community.
		By 30 June 2016 develop an action plan to assist with improving access to ophthalmology surgery for Aboriginal people in the Grampians region.	Achieved. Wimmera Health Care Group linked action plan into the Grampians Region Aboriginal Eye Health Project in March 2016. Wimmera Health Care Group representation on Wimmera Aboriginal Health Sub-Committee with Goolum Goolum and other stakeholders. Regional statistics show 50% of Aboriginal population in the Wimmera are undertaking annual retinal scans. Action plan in place to improve access.
	Demonstrate an organisational commitment to quality cancer services through engagement with the local Integrated Cancer Service and implementation of the Optimal Care Pathways.	In collaboration with the Grampians Integrated Cancer Service and other relevant health services progress implementation of optimal care pathways for colorectal and prostate cancer.	Achieved. Chemotherapy Working Group in consultation with the Patient Care Committee and Grampians Integrated Cancer Service integrated Optimal Care Pathways into care pathways for patients with colorectal and prostate cancer in June 2016.

STATEMENT OF PRIORITIES

Part A - Strategic Priorities

DOMAIN	ACTION	DELIVERABLES	OUTCOME
Governance, Leadership and Culture	Demonstrate an organisational commitment to Occupational Health and Safety, including mental health and wellbeing in the workplace. Ensure accessible and affordable support services are available for employees experiencing mental ill health. Work collaboratively with the Department of Health and Human Services and professional bodies to identify and address systemic issues of mental ill health amongst the medical professions.	By June 2016 review and further strengthen the staff wellbeing program to address any need for additional psychological and emotional support for employees, including engagement with professional bodies for systemic issues of mental illness.	Achieved. Conducted seven Beyond Blue training sessions from the National Workplace Program. This training is specifically for workplace settings and aims to increase the knowledge and skills of employees and managers to address mental health conditions in the workplace. This included two manager sessions and five employee sessions. In addition, two employee Beyond Blue sessions were held in June 2015. The Health and Wellbeing Working Party have developed: • Employee Health and Wellbeing Policy. • Workplace Wellness Program which is available to all staff and encompasses all areas of health – walking groups occurring weekly and trial of onsite yoga classes has commenced. • Staff Health and Wellbeing Intranet Page established. The People Matter Committee have implemented the following initiatives in regards to health and wellbeing: • Grievance Management Training sessions for all managers has been held. • Developed a checklist for managers for planning and conducting a meeting to discuss wellbeing and mental health issues. • Developed a Sexual Harassment presentation for all staff and following up with Sexual Harassment Guidelines. • Expanded Employee Assistance Program to be available by phone 24 hours a day and focused on communicating the procedure to staff. • Annual Wellbeing Session where wellbeing and monitoring mental health is promoted by having professional speakers, providing information for staff and communicating available support options. • Invested in staff becoming certified Health and Wellness Coaches to support staff in positive lifestyle choices and achieving health and wellness goals.

STATEMENT OF PRIORITIES

Part A - Strategic Priorities

DOMAIN	ACTION	DELIVERABLES	OUTCOME
Governance, Leadership and Culture (cont.)	Monitor and publicly report incidents of occupational violence. Work collaboratively with the Department of Health and Human Services to develop systems to prevent the occurrence of occupational violence.	By January 2016 review current Occupational Health and Safety, and emergency reporting procedures to ensure all incidents of occupational violence are reported, monitored and acted upon and to develop specific prevention strategies. Incidents will be reported in the 2015–2016 Annual Report.	Achieved. Incidents of Occupational Violence are reported in Victorian Health Incident Management System and monitored by the Health and Safe Practice Committee, Key Performance Indicators are reported through to Leadership and Management and Clinical Governance (Board of Management) Committees. Policies and procedures have been reviewed and updated. Training in Code Grey has been completed and an online video was produced which is mandatory for all staff to watch and then complete an assessment. Code Grey action cards have been developed and simulated exercises were undertaken in May and June 2016. Submission made under the Health Services Violence Prevention Fund was successful and has been used to upgrade security systems at both Dimboola and Horsham campuses. Planning for an upgrade to the Emergency Department to provide a 'safe' room has commenced.
	Promote a positive workplace culture and implement strategies to prevent bullying and harassment in the workplace. Monitor trends of complaints of bullying and harassment and identify and address organisational units exhibiting poor workplace culture and morale.	By June 2016 provide further education and training to improve employee cultural behaviour and monitor trends through annual participation in the People Matter Survey.	Achieved. Bullying and harassment training is part of our mandatory training program. Staff grievance training for all managers was completed in February 2016. Customer service training has been undertaken by front line administrative and nursing staff. WorkSafe reviewed policies and procedures during May 2016. Human Resources Committee is monitoring bullying statistics on a monthly basis. Organisation participates annually in the People Matter Survey and has established a committee in collaboration with staff to monitor and oversee actions identified.
	Apply existing capability frameworks and clinical guidelines to inform service system planning, giving consideration to the capability of neighbouring services and how best to allocate available resources so as to deliver the maximum benefit to the local community.	Continue to actively participate in the Grampians Regional Maternity and Newborn Reference Group to enhance partnerships across the region utilising an agreed framework for the delivery of safe patient care for the maternity and newborn cohort.	Achieved. Appointment of Clinical Operations Manager and Yandilla Nurse Unit Manager as Wimmera Health Care Group representatives on Grampians Regional Maternity and Newborn Reference Group. Meetings are being attended regularly and reports from this Reference Group are tabled at the monthly Obstetrics and Paediatrics Committee meetings.
	Adopt the Healthy Choices: Food and Drink Guidelines for Victorian Public Hospitals, to increase the availability of healthy food and drinks for purchase by staff, visitors and the general public.	By December 2015 undertake a produce assessment of onsite food vendors consistent with the Healthy Eating Advisory Service, and adopt the Healthy Choices: Food and Drink Guidelines for Victorian Public Hospitals.	Achieved. Completed the produce assessment of onsite food vendors and have received the audit from the Healthy Eating Advisory Service. We have adopted the Healthy Choices: Food and Drink Guidelines for Victorian Public Hospitals.

STATEMENT OF PRIORITIES

Part A - Strategic Priorities

DOMAIN	ACTION	DELIVERABLES	OUTCOME
Safety and Quality	Ensure management plans are in place to prevent, detect and contain Carbapenem Resistant Enterobacteriaceae as outlined in Hospital Circular 02/15 (issued 16 June 2015).	By November 2015 review the current infection control policy and procedures and implement changes to prevent, detect and contain Carbapenem Resistant Enterobacteriaceae.	Achieved. • Victorian guidelines received in November 2015. Change in process to identify patients at risk of contracting Carbapenem Resistant Enterobacteriaceae. • Policy and procedures to manage cases of Carbapenem Resistant Enterobacteriaceae at Wimmera Health Care Group completed and implemented in April 2016.
		By February 2016 and in collaboration with the Grampians Region Infection Control Group, facilitate preparedness for the management of Carbapenem Resistant Enterobacteriaceae through the development of a Carbapenem Resistant Enterobacteriaceae resource kit which will include personal protection training for staff, policy and procedure, flow chart for detection and management and Emergency Department signage.	Achieved. • Working with the Grampians Region Infection Control Group on Infectious Risk Screening Tool to include Carbapenem Resistant Enterobacteriaceae. • Education for all staff on multi-resistant organisms. • Resource kits including policy and procedure, and flow chart and signage in place, April 2016.
	Implement effective antimicrobial stewardship practices and increase awareness of antimicrobial resistance, its implications and actions to combat it, through effective communication, education, and training.	By January 2016 in collaboration with the Grampians Region Infection Control Group, reaffirm existing stewardship policies and practices through a planned education program to support improved antimicrobial awareness.	Achieved. • Active participation in Antibiotic Awareness Week promotion. • Participated in National Antimicrobial Prescribing Survey with assessment report December 2015. Results reported to Antimicrobial Stewardship working party. Action plan developed. • Improved processes to assist the auditing of compliance with the Antibiotic Therapeutic Guidelines implemented in June 2016.
	Develop perinatal mortality and morbidity review processes in alignment with the Clinical Practice Guideline for Perinatal Mortality.	Actively participate in the bi-annual Regional Mortality and Morbidity Forums.	Achieved. • Commitment from Medical and Nursing Divisions to participate in Mortality and Morbidity forums. • Attendance by Nurse Unit Manager and Obstetric Registrar at May 2016 forum.
		By 30 June 2016 review policies and procedures to ensure alignment with the Clinical Practice Guidelines for Maternity.	Achieved. • Review of policies and procedures for Maternity services completed in May 2016. • All policies and procedures are consistent with Clinical Practice Guidelines for Perinatal Mortality.

STATEMENT OF PRIORITIES

Part A - Strategic Priorities

DOMAIN	ACTION	DELIVERABLES	OUTCOME
Financial sustainability	Improve cash management processes to ensure that financial obligations are met as they are due.	By September 2015 implement cash flow forecasting and reporting systems to support the optimal management of cash resources including capital expenditure requirements.	Achieved. Forecasting systems and tools reviewed and improvements implemented. MAQIC software have been engaged to upgrade power budget software to incorporate identified improvements. System upgrade has been implemented and will be used for the 2016/17 financial year.
	Work with Health Purchasing Victoria to implement procurement savings initiatives.	By March 2016 implement the Health Purchasing Victoria Contract for Non-Emergency Transport and review all relevant consumable purchases to ensure compliance with Health Purchasing Victoria policy.	Achieved. All relevant consumable purchases have been reviewed and are compliant with Health Purchasing Victoria. Ongoing process with Health Purchasing Victoria and Royal Flying Doctor Service to implement Non-Emergency Transport Contract.
	Invest in revenue optimisation initiatives to ensure maximisation of revenue from both public and private sources.	By 30 June 2016 invest in three revenue optimisation initiatives, focused on residential aged care, private inpatients and sub-acute revenue strategies.	Achieved. Completed the business optimisation project within the three Residential Aged Care facilities through the Named Nurse Concept and the Pain Management Program. Process mapping completed for the patient journey from acute to sub-acute and developed a robust model for admission to either Geriatric Evaluation Management, Transition Care Program or Rehabilitation. Appointed a Patient Flow Co-ordinator to optimise revenue across the acute and sub-acute wards. The promotion of inpatients to use their private health insurance (currently 92%) through direct contact with the Private Patient Liaison Officer and through our external advertising campaign.
	Review and refine existing service agreements with providers.	By 30 June 2016 review existing service arrangements with a view to improve the financial sustainability of Dunmunkle Health Services in collaboration with the Dunmunkle Health Services Board of Management.	Achieved. Developed the 2015-16 Financial Management Improvement Program. Monthly reviews and presentations were provided to the Dunmunkle Health Services Board of Management and an operating surplus achieved.

STATEMENT OF PRIORITIES

Part A - Strategic Priorities

DOMAIN	ACTION	DELIVERABLES	OUTCOME
Access	Implement integrated care approaches across health and community support services to improve access and responses for disadvantaged Victorians.	By 30 June 2016 prepare shared resources and policies to support health literacy and consumer engagement across Wimmera Southern-Mallee in collaboration with Wimmera Southern-Mallee Health Alliance partners.	Achieved. A Health Literacy Community of Practice Group has been established with interested partners of the Wimmera Southern-Mallee Health Alliance. Wimmera Health Care Group is the lead in this project and all resources developed will be shared as a group.
	Progress partnerships with other health services to ensure patients can access treatments as close to where they live when it is safe and effective to so, making the most efficient use of available resources across the system.	In partnership with Ballarat Austin Radiation Oncology Centre Cancer Resource Nurses and Oncology Nurse Practitioners, progress a tele-oncology service for the Wimmera Southern-Mallee by June 2016.	Achieved. Regional Chemotherapy Project commenced and a Project Officer appointed. Project Steering Group formed and terms of reference completed. Development of a community of practice support network for the cancer resource nurses in April 2016. Virtual chat room for Oncology Nurse Practitioner to provide remote support to Cancer Resource Nurse Network established in May 2016.
	Reduce unplanned readmissions – with a focus on identifying high risk patients; delivering co-ordinated and integrated responses; and reducing the use of avoidable acute care services, where practicable and safe to do so.	By 30 June 2016 have active input into the development of shared guidelines and clinical pathways for patients accessing emergency, urgent care and acute care admissions through the Wimmera Southern-Mallee Health Alliance Unplanned Presentations Steering Group.	Achieved. The Wimmera Urgent Care e-Health Working Group formed with membership from the Wimmera Southern-Mallee Health Alliance. Wimmera Southern-Mallee Health Alliance Executive Committee confirmed Emergency Department Telehealth Project with the committee providing clinical governance oversight in June 2016.

STATEMENT OF PRIORITIES
Part B: Performance Priorities

Safety and quality performance

KEY PERFORMANCE INDICATOR	TARGET	2015–16 RESULT
SAFETY AND QUALITY		
Compliance with NSQHS Standards Accreditation	Full compliance	Achieved
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Achieved
Cleaning standards	Full compliance	Achieved
Very high risk (Category A)	90	96
High risk (Category B)	85	95
Moderate risk (Category C)	85	93
Compliance with the Hand Hygiene Australia program	80%	81%
Percentage of healthcare workers immunised for influenza	75%	90%
Submission of infection surveillance data to VICNISS	Full compliance	Achieved
PATIENT EXPERIENCE AND OUTCOMES		
Victorian Healthcare Experience Survey – data submission	Full compliance	Achieved
Victorian Healthcare Experience Survey – patient experience Quarter 1	95% positive experience	97.2%
Victorian Healthcare Experience Survey – patient experience Quarter 2	95% positive experience	97.0%
Victorian Healthcare Experience Survey – patient experience Quarter 3	95% positive experience	97.7%
ICU central line-associated blood stream infection	No outliers	Achieved
Maternity – Percentage of women with prearranged postnatal home care	100%	98%
GOVERNANCE, LEADERSHIP AND CULTURE		
People Matter Survey - percentage of staff with a positive response to safety culture questions	80%	91%

Financial Sustainability Performance

KEY PERFORMANCE INDICATOR	TARGET	2015–16 RESULT
FINANCE		
Operating result ($m)	0.05	0.59
Trade creditors	< 60 days	49
Patient fee debtors	< 60 days	37
Public & private WIES performance to target	100%	104%
ASSET MANAGEMENT		
Asset management plan	Full compliance	Achieved
Adjusted current asset ratio	0.7	0.85
Days of available cash	14 days	39

STATEMENT OF PRIORITIES

Part B: Performance Priorities

Access Performance

KEY PERFORMANCE INDICATOR	TARGET	2015-16 ACTUAL
EMERGENCY CARE		
Percentage of ambulance patients transferred within 40 minutes	90%	95%
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%	83%
Percentage of emergency patients with a length of stay less than four hours	81%	83%
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	*2015-16 ACTIVITY ACHIEVEMENT*
ACUTE ADMITTTED	
WIES Public	5,482
WIES Private	1,749
WIES (PUBLIC AND PRIVATE)	7,232
WIES DVA	233
WIES TAC	35
WIES TOTAL	7,500
SUBACUTE & NONACUTE ADMITTED	
Rehab Public	2,256
Rehab Private	1,092
GEM Public	1,938
GEM Private	1,081
GEM DVA	592
Palliative Care Public	314
Palliative Care Private	27
Palliative Care DVA	0
SUBACUTE NON-ADMITTED	
Health Independence Program (service events)	15,243
AGED CARE	
Residential Aged Care (bed days)	39,266
HACC	43,843
PRIMARY HEALTH	
Community Health / Primary Care Programs (hours)	8,698

CORPORATE GOVERNANCE 2015-2016
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
Resignation Date: 30 June 2016

DEPUTY CHAIR:

Ms A Murphy (Angela)

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

Profession/Occupation: Director Planning & Economic
Date Appointed: 1 July 2012

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
Appointment Expired: 30 June 2016

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

Mr W Winter (William)

MAICD, Chairman, Geelong Company Directors Forum

Director, Luv a Duck Pty Ltd, Chairman Enterprise Geelong Advisory Board

Board Member G21 Agribusiness forum

Profession/Occupation: Private Company Board Advisor
Date Appointed: 1 July 2011

Mrs M Aitken (Marie)

GAICD, MAPS, MAACBT

Profession/Occupation: Registered Psychologist and Supervisor
Date Appointed: 1 July 2014

Mrs M Eagle (Merryn)

Dip. Community Services, B. Biological Sciences (Hons), GAICD

Profession/Occupation: Self Employed Farmer
Date Appointed: 1 July 2015

Ms L Kwok (Linda)

BArch, MBA, PGDipUD, RAIA, MAICD

Profession/Occupation: Architect
Date Appointed: 1 July 2015

Board Committees

Remuneration Committee

Members: **M Williams (Chair), A Murphy, E McCabe, 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), L Kwok, M Eagle, 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, M Eagle, 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.

Performance Monitoring Committee

Members: **M Williams (Chair), A Murphy, M Aitken, P Campbell, M Eagle, R Goudie, L Kwok, E McCabe, W Winter**

Monitors and oversees the financial, clinical, quality and safety performance of the health care group and seeks expert advice where required. Receives annual financial reports and satisfies itself that they are prepared in accordance with the relevant accounting requirements and sound accounting principles and standards.

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 those for approval. Monitors research projects and maintains a register of all approved projects.

Community Advisory Committee

Members: **M Aitken, 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.

OUR EXECUTIVE TEAM

CHIEF EXECUTIVE:

Mr Christopher G Scott

BHSc (Mgt), MBA (CSU), Dip CDC, Prof Cert HSM, AFACHSM, CHE, FAICD.

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 & CORPORATE SERVICES/ DEPUTY CEO:

Mr Mark Knights

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

The Finance and Corporate Services Division encompasses the non-clinical areas of the service. 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, public relations, supply and engineering. A number of key business units are managed directly by the division including medical clinics, hospital coffee shop and Wimmera Group 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, MBA.

Primary Health Care Services at Wimmera Health Care Group provide a comprehensive range of health services that are delivered in community and centre-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 care services. Inpatient services include medical and surgical inpatient services, midwifery and obstetrics, operating suite, pre-admission and day procedure unit, emergency department, rehabilitation, geriatric evaluation and management, transition care, day oncology, and haemodialysis. Residential 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 and admission and discharge services.

DIRECTOR BUSINESS PERFORMANCE & REDESIGN

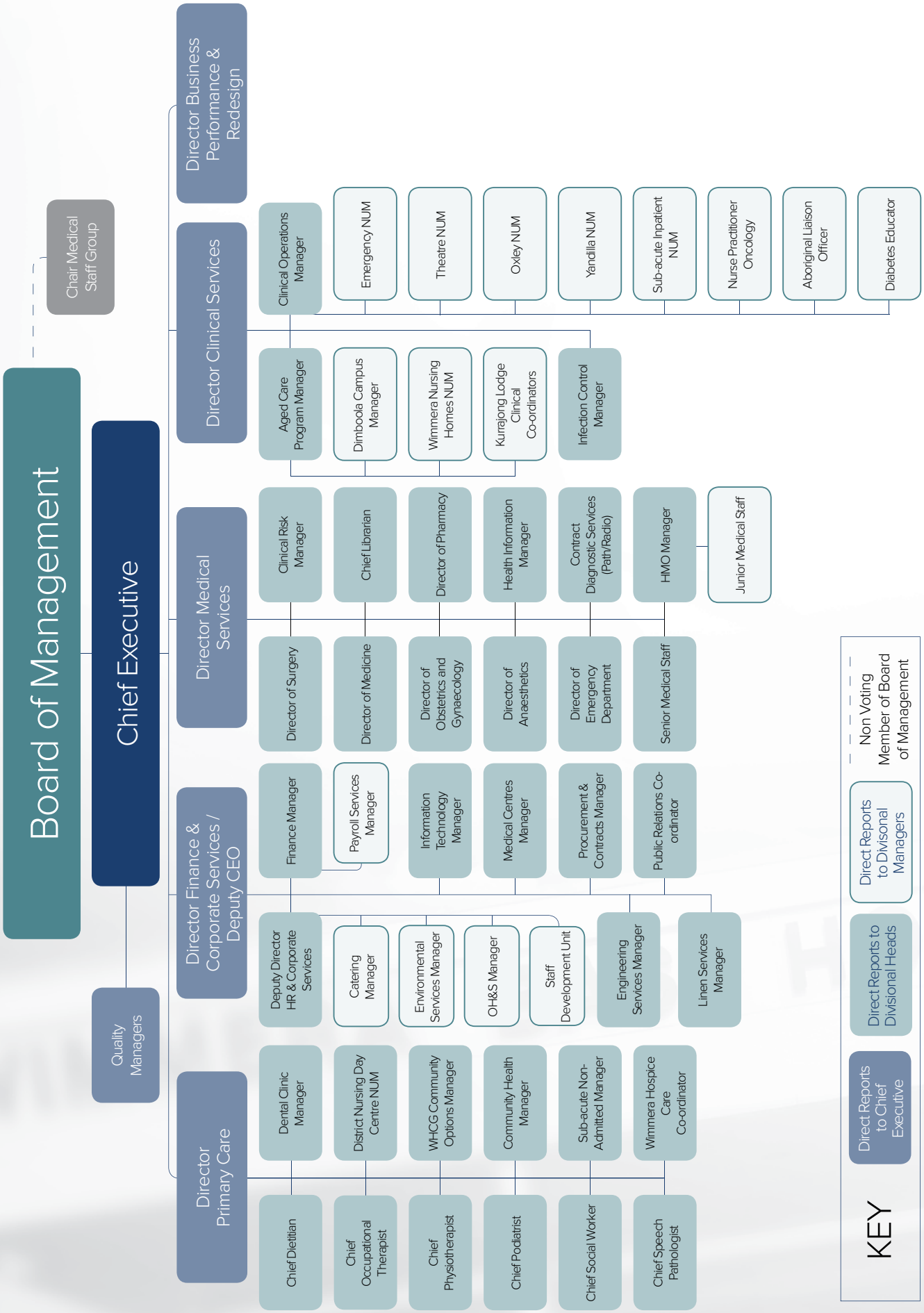
Mr Philip Sabien

B. App Science, MBA, Prof Cert HSM, FAICD

Business Performance and Redesign is responsible for monitoring the organisation's financial and clinical performance against internal and external key performance indicators. This includes developing and implementing financial and non-financial improvement strategies.

Redesign projects are identified and implemented across the whole organisation to increase the efficiency and quality of care delivered to our patients through improving work systems and processes. This incorporates the management of data through performance audits to ensure compliance and a systematic approach to improvement methodologies.

ORGANISATIONAL CHART



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.

HR INITIATIVES

This year the Human Resources department has implemented a number of initiatives to improve the organisation including introducing an online E-Recruitment program, significantly expanding our Employee Assistance Program and providing training to staff with a focus on mental health and wellbeing. We continue to review and develop our policies and procedures in line with legislative changes, improve our mandatory training and leave management compliance and develop initiatives to ensure Wimmera Health Care Group is an employer of choice in the region.

INDUSTRIAL RELATIONS

There were no industrial relations disputes.

Workforce Data Disclosures

LABOUR CATEGORY	JUNE Current Month - FTE		JUNE YTD FTE	
	2015	2016	2015	2016
Nursing	286.39	298.62	284.26	305.50
Administration and Clerical	103.45	105.97	101.64	105.64
Medical Support	22.38	22.03	22.98	23.01
Hotel and Allied Services	138.51	132.03	131.82	131.62
Medical Officers	4.21	5.82	5.18	4.75
Hospital Medical Officers	23.05	26.66	22.85	27.27
Ancillary Staff (Allied Health)	47.15	49.10	45.73	55.31

PRESENTATIONS

Mr Chris Scott, Chief Executive - Victorian Healthcare Association Rural and Regional Forum: Creswick, August 2015. Wimmera Cancer Centre Project 'Making it Happen Together'

Mr Chris Scott, Chief Executive - Engineers Australia Wimmera Professionals Evening: Horsham, November 2015. Wimmera Cancer Centre Project 'Making it Happen Together'

Mr Chris Scott, Chief Executive - Akolade Conference: Evaluating Success for the National Standards: Brisbane, February 2016. 'Demonstrating Compliance with the National Safety & Quality Health Service Standards 'Don't tell me.....show me!'

Mr Chris Scott, Chief Executive - Grampians Region CEO Forum: Stawell, February 2016. 'Clinical Governance Review 2015'

Mr Chris Scott, Chief Executive - Rural Health Services CEO Forum: Melbourne, February 2016. 'Clinical Governance Review 2015'

Ms Natalie Sutton, Dietitian - Rural Northwest Health: Regional Best Practice & Innovation Forum, Warracknabeal, March 2016. 'Eat Well, cooking group for carers and care recipients'

Ms Natalie Sutton, Dietitian - Barwon South Western and Grampians Region Allied Health Conference: Facing the future: innovation and collaboration in regional allied health, Horsham, April 2016. 'Collaborative development: Horsham cooking group for carers and care recipients'

Ms Natalie Sutton, Dietitian - DAA National Conference 2016: On track for the future, Melbourne, May 2016. Poster 'Community Eat Well Program Supporting Older Adults and Their Carers'

Mrs Pam Marshman, Dietitian- National Allied Health Conference 2015: Allied Health Front and Centre, Melbourne, November 2015. Poster: 'Delivering multi-disciplinary cardiac rehabilitation in the bush: The Wimmera Hub and Spoke Telehealth Model, improving access for rural people'.

Mrs Pam Marshman, Dietitian, Mrs J Carroll, CRC Nurse - Victorian Cardiac Clinical Network Symposium: A focus on data in the Victorian Cardiac Care System, Melbourne, October 2015. 'Hub and Spoke Cardiac Rehabilitation, model of care for rural patients'.

Mrs Pam Marshman, Dietitian - Wimmera PCP - End of year celebrations, Horsham, December 2015. 'Hub and Spoke Cardiac Rehabilitation, model of care for rural patients'

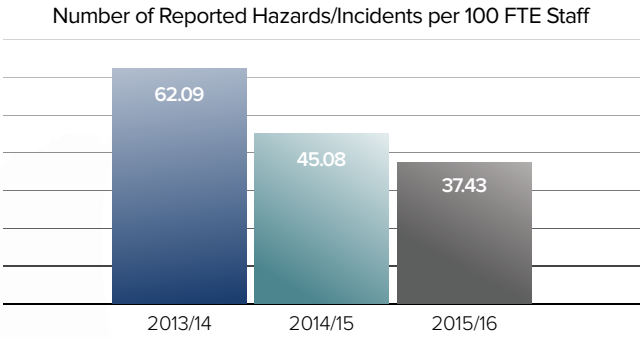
OCCUPATIONAL HEALTH AND SAFETY

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.

Through Wimmera Health Care Group's 'Safety Management Plan' the organisation's commitment to ensure that all activities carried out at all campuses are safe and in compliance with relevant legislative requirements. We promote a safe working culture that is enhanced by personal responsibility and ownership and supported by training, supervision and management.

Reported Hazards/Incidents

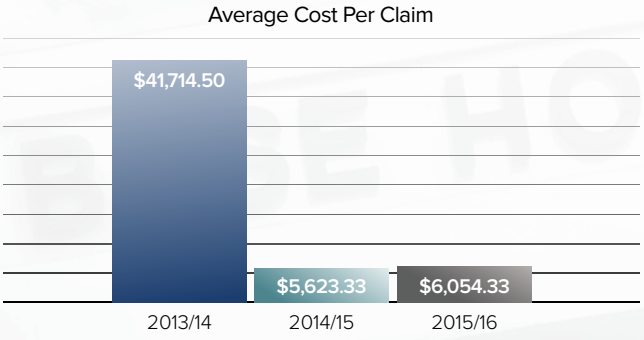
The number of reported incidents per 100 full-time equivalent staff members in 2015-2016 was 37.43.



OCCUPATIONAL VIOLENCE STATISTICS	2015-16
1. Workcover accepted claims with an occupational violence cause per 100 FTE	0.01
2. Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	.079
3. Number of occupational violence incidents reported	126
4. Number of occupational violence incidents reported per 100 FTE	1.26
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition	56.35%

Workers Compensation

All employees and other persons deemed to be employees will be provided with workers compensation insurance under the Occupational Health & Safety Act 2004 and Workplace Injury Rehabilitation and Compensation Act 2013. Wimmera Health Care Group recognises that 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. Wimmera Health Care Group has dramatically decreased the cost per claim for compensation in recent years. The 2013/14 year average cost per claim was significant due to the financial impact of one particular claim.



FINANCIAL OVERVIEW 2015/16

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 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 cash assets are available to meet liabilities as they fall due.
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 in excess of $590,000 which was significantly 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 plan focuses on the elimination of waste and the optimisation of funding and revenue streams whilst ensuring high quality care is delivered.

Demand for acute and sub-acute services exceeded our budgeted levels which saw a record number of patients treated, however, this also increased the pressure on our staff, infrastructure and equipment. Residential Aged Care Services operated in line with our budget expectations with consolidation of the Name Nurse Model of Care introduced in 2014/15 and the ongoing review of the funding instrument. Both Allied Health and Primary Care Divisions met their patient activity and financial targets.

Additional expenditure on staffing, medical consumables and patient transport was incurred as a result of the increased patient activity. In May 2016 the Department of Health and Human Services (DHHS) recognised this financial burden and allocated additional funding to offset these costs. We continue to work hard to ensure a full complement of specialist medical staff are available, however, this comes at a significant cost due to the ongoing reliance on locum medical staff to fill vacant positions.

During the year we have seen several additions to the fixed asset base of the organisation including the new 95 space car park in Arnott Street, implementation of electronic staff rostering software, replacement of the acute nurse call system, expansion of security systems at Horsham and Dimboola Campuses and the purchase of a number of items of medical and non-medical equipment.

Our cash position remains strong with day's available cash well above the DHHS requirement of 14 days and a current asset ratio well in excess of the DHHS requirement of 0.70 at June 30, 2016.

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

Note: Please see financial reports for exact figures.

Summary of Financial Results

	2016 $000	2015 $000	2014 $000	2013 $000	2012 $000
Total Revenue	85,253	82,535	93,051	79,541	75,064
Total Expenses	86,280	82,402	78,271	76,277	75,165
Net Result for the Year (inc. Capital and Specific Items)	(1,027)	133	14,780	3,264	(101)
Retained Surplus / (Accumulated Deficit)	(10,596)	(8,471)	(7,214)	(11,622)	(10,808)
Total Assets	81,996	81,475	80,287	63,186	60,728
Total Liabilities	23,458	22,187	22,382	20,061	20,867
Net Assets	58,538	59,288	57,905	43,125	39,861
Total Equity	58,538	59,288	57,905	43,125	39,861

Details of Information and Communication Technology (ICT) expenditure

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

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

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

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

The total ICT expenditure incurred during 2015-16 is $2,504,522 (excluding GST) with the details shown below.

OUTLINE OF EXPENDITURES	$000
Business As Usual (BAU) ICT expenditure (Total) (excluding GST)	2129
Non Business As Usual (non BAU) ICT expenditure (Total=Operational expenditure and Capital Expenditure) (excluding GST)	376
Operational expenditure (excluding GST)	-
Capital expenditure (excluding GST)	376

Major Equipment Purchases over $10,000

ITEM	PRICE	ITEM	PRICE
Drager Ventilators	49,000	Videoscopes	25,226
Bladder Scanner	11,500	Pan Sanitisers / Disinfectors	57,381
Birthing Simulator	11,957	Linen Wall Washer Extractors	319,212
Ultrasound System	41,950	Linen Tumble Dryers	33,800
Olympus Camera Heads	29,324	**TOTAL**	**579,350**

Consultancies

Consultant Individually > $10k	Purpose of Consultancy	Start Date	End Date	Total Approved project fee	Expenditure 2015-16	Future expenditure
Aspex Consulting Pty Ltd	Service Planning	1/11/2015	30/06/2016	59,000	59,000	-
Ernst & Young	Aged Care Consulting	1/06/2016	30/06/2016	23,000	23,000	-
HPA Consulting Pty Ltd	Clinical Governance	1/02/2016	30/06/2016	14,000	14,000	-
Inspiredhr	Leadership Program	1/09/2015	30/06/2016	15,000	15,000	-
LMS Human Resource Consulting	Strategic Planning	1/06/2016	30/06/2017	36,000	18,000	18,000
The Mordun Group	Leadership Program	1/07/2015	30/06/2016	18,000	18,000	-
Invertech Pty Ltd	Capital Projects	1/07/2015	30/06/2016	13,000	13,000	-
Total individually > $10k (GST exclusive)				**$178,000**	**$160,000**	**$18,000**

In 2015-16 there were 4 consultancies where the total fees payable to the consultants were less than $10,000. The total expenditure incurred during 2015-16 in relation to these consultancies is $4,000 (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 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 by implementing sound environmental practices in all areas of operation. Our Environmental Management Plan ensures we reduce our overall environmental impact now and into the future.

COMPLIANCE WITH DATAVIC ACCESS POLICY

The tables in the Annual Report will be submitted to Data Vic to be made available at

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

DISCLOSURE INDEX

Please refer to page 30 and 31.

FREEDOM OF INFORMATION

Wimmera Health Care Group has received 103 requests for information under *Freedom of Information Act (1982)* during the 2015/16 financial year, an increase of 20 on the previous financial year.

From the 103 requests:

- 91 cases access was granted in full
- 5 cases where there were no documents or the records were destroyed
- 1 request for access was denied
- 1 case was withdrawn
- 3 cases where the requests were not proceeded with
- 2 cases where 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 22a 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.

COMPLIANCE

ATTESTATION TO PARTIAL COMPLIANCE WITH THE MINISTERIAL STANDING DIRECTION 4.5.5 – RISK MANAGEMENT FRAMEWORK AND PROCESSES

I, Chris Scott certify that the Wimmera Health Care Group has partially complied with Ministerial Direction 4.5.5 – Risk Management Framework and Processes. Risk - specific requirements; Deficiencies in identifying and managing strategic and interagency risk. The Wimmera Health Care Group Audit Committee has verified this.

Chris Scott
Accountable Officer
Horsham

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

COMPLIANCE

OTHER INFORMATION

Consistent with FRD 22G (Section 6.19) Wimmera Health Care Group confirms that subject to the provisions of the FOI Act, the following information is retained by the Accountable Officer:

a. a statement that declarations of pecuniary interests have been duly completed by all relevant officers;
b. details of shares held by a senior officer as nominee or held beneficially in a statutory authority or subsidiary;
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 entity;
e. details of any major external reviews carried out on the entity;
f. details of major research and development activities undertaken by the entity;
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 entity to develop community awareness of the entity and its services;
i. details of assessments and measures undertaken to improve the occupational health and safety of employees;
j. a general statement on industrial relations within the entity and details of time lost through industrial accidents and disputes;
k. a list of major committees sponsored by the entity, the purposes of each committee and the extent to which the purposes have been achieved; and
l. details of all consultancies and contractors including:
    i. consultants/contractors engaged;
    ii. services provided;
    iii. expenditure committed to 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
Mr I Anderson
Mrs M Baker
Mrs J Blythe
Mr N Bothe
Mrs P Bothe
Mr P Brown
Mr I Campbell
Mrs F Carine
Mrs J Carter
Mr M Castellucio
Mrs P Corner
Mr M Cuddihy
Mr I Draffin
Mrs S Driscoll
Mrs U Faux
Dr P Haslau
Miss B Hill
Mr B Johansen
Rev A Johns
Mr D Johns
Mr J Kemfert
Mr G Kitchen
Mrs C Kroker
Prof R Larkins
Mr K Lehmann
Mr C Leith
Mr G Lind
Dr M Lloyd
Mr K Lovett
Mr J McCabe
Mr C McDonald
Mr D McFarlane
Mr W McGrath
Mrs L McKenzie
Mrs R McKenzie
Mrs J McRae
Miss M Menzel
Dr E Miller
Mrs E Mitchell
Mrs L Montgomery
Dr M O'Brien
Mr K O'Connor
Mr A Phillips
Mr J Pietsch
Mrs D Pilmore
Mr P Robertson
Mrs J Saxton
Mrs L Sharrock
Mr F Schultz
Miss N Schurmann
Ms M Smith
Miss L Stenhouse
Mrs V Stenhouse
Mr P Troeth
Mr P Wajszel
Mr A Walsgott
Prof R Webster
Mr A Wells
Mrs J Wells
Dr L Wong Shee
Mr A Wood

DONATIONS

Donations of $1000 or more

Adelphian Craft & Hobby Shop

Alan & Sandra Speirs

Alec & Coral Webb

Alex Goudie

Alison Driscoll

Anglican Op Shop

Bakers Delight

BC & AF Rogers

Bentley Group

Betty & Ian Cramer

Bill Ower Real Estate

Brenda Evans

Brim Hotel

Bruce Harberger

Caroline Ampt Cocks

Commonwealth Bank Horsham

Community Axis Enterprises Inc

Coral Sutherland

D S Meadows

David Emsile

Dawn Hobbs

Des Lardner Organic

Dimboola Pharmacy

Dodgshun Medlin

Donald Cameron

Ed & Joy Taig

Edenhope and District Memorial Hospital

Emmett Motors

Emily Farrugia

Enid King

Fred Hall

G C Astbury & Family

Gail Crane

Geoff & Helen Handbury Foundation

Gill Ballinger

Gwenda Bourchier

GWM Water

Hateley Reunion

Haven Recreation Reserve

Hillross Horsham

Hindmarsh Shire Council

Horsham Apex Club

Horsham Country Music Inc

Horsham Croquet Club

Horsham Football Netball Club

Horsham Islamic Welfare Association

Horsham Patchwork Quilters Group

Horsham Physiotherapy & Podiatry

Horsham Taxi Service

Hugh Delahunty

Janine Stergiopulos

Jason Wheaton

John & Ros Latimer

Juliana Antonoff

Kaniva Uniting Church Caterers

Kenneth Ley

Kerry & Wally Wade

Les Wills

Lighthouse Building Permits

Little Desert Rodders

Locks Construction

Lorna Schultz

Lorraine Ballinger

Luca Goudie

Lucas Hogan

M J P Charlton

Marie Dunlop

Marion Barber

Marlene Dickerson

McDonald Steel

Move4Life

National Hotel Charity Club

Olde Horsham Restaurant

Quota Wimmera

Rainbow Lions Club

Rebecca Cumming

Rednic Rock

Rhoni McIvor

Rotary Club

Rupanyup Football & Netball Club

Rural Northwest Health

Snap Fitness

Stephanie Latimer

Steven & Anne Clark

Stuart Hall

Tanya Barnes

Vonda Hamilton

Walter Fischer

WDEA Social Club

Wimmera Base Ladies Auxiliary

Wimmera Dry Cleaners

Wimmera Drytron

Wimmera Health Care Group Foundation

Wimmera Hospice Trust

Wimmera Spas & Pools

Wimmera Woodturners Guild Inc

DISCLOSURE INDEX

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

LEGISLATION	*REQUIREMENT*	*PAGE*
Charter and purpose		
FRD 22G	Manner of establishment and the relevant Ministers	*Inside front, 1*
FRD 22G	Purpose, functions, powers and duties	*2-14*
FRD 22G	Key initiatives and projects	*2-14*
FRD 22G	Nature and range of services provided	*Inside cover*
Management and structure		
FRD 22G	Organisational structure	*20*
Financial and other information		
FRD 10A	Disclosure index	*30-31*
FRD 22G	Employment and conduct principles	*21*
FRD 22G	Occupational health and safety policy	*22*
FRD 22G	Summary of the financial results for the year	*23-25*
FRD 22G	Significant changes in financial position during the year	*23, 24*
FRD 22G	Major changes or factors affecting performance	*23*
FRD 22G	Subsequent events	*23*
FRD 22G	Application and operation of Freedom of Information Act 1982	*26*
FRD 22G	Compliance with building and maintenance provisions of Building Act 1993	*26*
FRD 22G	Statement on National Competition Policy	*26*
FRD 22G	Application and operation of the Protected Disclosure 2012	*26*
FRD 22G	Application and operation of the Carers Recognition Act 2012	*26*
FRD 22G	Details of consultancies over $10 000	*25*
FRD 22G	Details of consultancies under $10 000	*25*
FRD 22G	Disclosure of ICT expenditure	*24*
FRD 22G	Statement of availability of other information	*28*
FRD 25B	Victorian Industry Participation Policy disclosures	*26*
Attestations		
SD 3.4.13	Attestation of Data Integrity	*27*

DISCLOSURE INDEX

SD 4.5.5	Attestation for compliance with Ministerial Standing Direction 4.5.5	*27*
	Occupation Violence Reporting	*22*
	Compliance with DataVic Access Policy	*26*

Ministerial Directions - Financial Report

Financial statements required under Part 7 of the FMA		
SD 4.2(a)	Statement of changes in equity	*FS 6*
SD 4.2(b)	Operating statement	*FS 4*
SD 4.2(b)	Balance sheet	*FS 5*
SD 4.2(b)	Cash flow statement	*FS 7*
Other requirements under Standing Directions 4.2		
SD 4.2(c)	Compliance with Australian accounting standards and other authoritative pronouncements	*FS 8*
SD 4.2(d)	Rounding of amounts	*FS 13*
SD 4.2(c)	Accountable officer's declaration	*FS 1*
Other disclosures as required by FRDs in notes to the financial statements		
FRD 11A	Disclosure of Ex gratia Expenses	*26*
FRD 21B	Disclosures of Responsible Persons, Executive Officers and other Personnel (Contractors with Significant Management Responsibilities) in the Financial Report	*FS 62, 63*
Legislation		
Freedom of Information Act 1982		*26*
Building Act 1993		*26*
Protected Disclosure Act 2012		*26*
Carers Recognition Act 2012		*26*
Victorian Industry Participation Policy Act 2003		*26*
Financial Management Act 1994		*26*

NOTES

Wimmera Health Care Group

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

The attached financial statements for the Wimmera Health Care Group have been prepared in accordance with Direction 4.2 of the Standing Directions of the Minister for Finance under the *Financial Management Act 1994,* applicable Financial Reporting Directions, Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2016 and the financial position of the Wimmera Health Care Group at 30 June 2016.

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.

Ms Angela Murphy
Chairperson

Horsham
19 August 2016

Mr Mark Knights
Acting Chief Executive Officer and Chief Finance & Accounting Officer

Horsham
19 August 2016

VAGO
Victorian Auditor-General's Office

Level 24, 35 Collins Street
Melbourne VIC 3000

Telephone 61 3 8601 7000
Facsimile 61 3 8601 7010

Website www.audit.vic.gov.au

INDEPENDENT AUDITOR'S REPORT

To the Board Members, Wimmera Health Care Group

The Financial Report

I have audited the accompanying financial report for the year ended 30 June 2016 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.

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, I and my staff and delegates complied with all applicable independence requirements of the Australian accounting profession.

Opinion

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

MELBOURNE
19 August 2016

Dr Peter Frost
Acting Auditor-General

Wimmera Health Care Group
Comprehensive Operating Statement
For the Year Ended 30 June 2016

	Note	2016 $'000	2015 $'000
Revenue from operating activities	2	81,379	77,837
Revenue from non-operating activities	2	662	876
Employee expenses	3	(55,224)	(52,849)
Non salary labour costs	3	(4,789)	(4,958)
Supplies and consumables	3	(10,096)	(9,616)
Other expenses	3	(11,342)	(10,718)
Net result before capital and specific items		**590**	**572**
Capital purpose income	2	3,212	3,825
Impairment of non-financial assets	3	(23)	-
Depreciation and Amortisation	4	(4,304)	(4,108)
Assets provided free of charge	2b	-	4
Expenditure for Capital Purpose	3	(360)	-
Net Result after capital and specific items		**(885)**	**293**
Other economic flows included in net result			
Net gain/(loss) on non-financial assets	2a	(10)	(7)
Revaluation of Long Service Leave		(132)	(153)
Total other economic flows included in net result		**(142)**	**(160)**
NET RESULT FOR THE YEAR		**(1,027)**	**133**
Comprehensive result		**(1,027)**	**133**

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

Wimmera Health Care Group
Balance Sheet
As at 30 June 2016

	Note	2016 $'000	2015 $'000
Current assets			
Cash and cash equivalents	5	14,468	11,909
Receivables	6	3,486	3,280
Inventories	7	346	334
Prepayments and Other assets		189	191
Total current assets		**18,489**	**15,714**
Non-current assets			
Receivables	6	1,449	1,665
Property, plant & equipment	8	61,802	64,096
Intangible assets	9	255	-
Total non-current assets		**63,506**	**65,761**
TOTAL ASSETS		**81,995**	**81,475**
Current liabilities			
Payables	10	3,957	4,081
Borrowings	11	5	10
Provisions	12	12,646	11,623
Other current liabilities	14	5,026	4,772
Total current liabilities		**21,634**	**20,486**
Non-current liabilities			
Borrowings	11	-	2
Provisions	12	1,824	1,699
Total non-current liabilities		**1,824**	**1,701**
TOTAL LIABILITIES		**23,458**	**22,187**
NET ASSETS		**58,537**	**59,288**
EQUITY			
Property, plant & equipment revaluation surplus	15a	36,537	36,537
Restricted specific purpose surplus	15b	5,115	4,016
Contributed capital	15c	27,482	27,206
Accumulated surpluses/(deficits)	15c	(10,597)	(8,471)
TOTAL EQUITY	15c	**58,537**	**59,288**
Contingent assets and contingent liabilities	19		
Commitments	18		

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 2016

	Note	Property, Plant & Equipment Revaluation Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributions by Owners $'000	Accumulated Surpluses/ (Deficits) $'000	Total $'000
Balance at 1 July 2014		**36,537**	**2,626**	**25,956**	**(7,214)**	**57,905**
Capital appropriation received from Victorian Government	15b	**-**	**-**	1,251	**-**	1,251
Net result for the year	15c	-	-	-	133	133
Transfer to restricted purpose surplus	15a,c	-	1,390	-	(1,390)	-
Balance at 30 June 2015		**36,537**	**4,016**	**27,207**	**(8,471)**	**59,289**
Capital appropriation received from Victorian Government	15b	-	-	275	-	275
Net result for the year	15c	-	-	-	(1,027)	(1,027)
Transfer to restricted purpose surplus	15a,c	-	1,099	-	(1,099)	-
Balance at 30 June 2016		**36,537**	**5,115**	**27,482**	**(10,597)**	**58,537**

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

Wimmera Health Care Group
Cash Flow Statement
For the Year Ended 30 June 2016

	Note	2016 $'000	2015 $'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating grants from government		69,487	65,353
Capital grants from government		1,049	3,261
Patient and resident fees received		6,717	6,712
Private practice fees received		633	897
GST received from/(paid to) ATO		1,753	1,736
Interest received		390	373
Other capital receipts		690	501
Other receipts		5,247	4,687
Total receipts		***85,966***	**83,520**
Employee expenses paid		(53,614)	(52,422)
Non salary labour costs		(4,679)	(4,858)
Payments for supplies & consumables		(13,268)	(12,573)
Other payments		(10,155)	(9,919)
Total payments		***(81,716)***	**(79,772)**
NET CASH FLOW FROM/(USED IN) OPERATING ACTIVITIES	16	**4,250**	**3,748**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for non-financial assets		(2,070)	(3,563)
Proceeds from sale of non-financial assets		10	4
NET CASH FLOW FROM/(USED IN) INVESTING ACTIVITIES		**(2,060)**	**(3,559)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of finance leases		(7)	(12)
Contributed capital from government		248	-
NET CASH FLOW FROM/(USED IN) FINANCING ACTIVITIES		**241**	**(12)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		**2,431**	**177**
Cash and cash equivalents at beginning of financial year		**7,243**	**7,066**
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	5	**9,674**	**7,243**

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 the Wimmera Health Care Group for the period ending 30 June 2016. The report provides 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 & 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 19 August 2016.

(b) Basis of accounting preparation and measurement

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

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

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

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

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

The financial statements are prepared in accordance with the historical cost convention, except 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 when new indices are published by the Valuer General 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 amounts 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, estimates and assumptions may be made with respect to lease commitments, impairment of non-current physical assets, 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, plant and equipment, (refer to Note 1(j));
- superannuation expense (refer to Note 1(g);
- actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 1(k)); and

Consistent with AASB 13 *Fair Value Measurement*, the 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, the 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, the 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 the 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 measured 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 impairment losses. Assets other than plant, equipment and vehicles are measured (after initial recognition at cost) at fair value at the date of the revaluation less any subsequent accumulated depreciation and 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.

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

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

(c) Reporting entity

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

Its principal address is:
Baillie Street
Horsham
Victoria 3400.

A description of the nature of the 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
The 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 improving the quality of life to Victorians.

The 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 the Wimmera Health Care Group, but are accounted for in accordance with the policy outlined in Note 1(j) 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) and 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 & 3 to the financial statements.

The Wimmera Health Care Group's Residential Aged Care Service is substantially funded from Commonwealth bed-day subsidies.

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 the 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 the 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 (f)). Consequently the recognition of revenue as capital purpose income is based on the intention of the provider of the revenue at the time the revenue is 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 (i)
- depreciation and amortisation, as described in Note 1 (g);
- assets provided or received free of charge (refer to Notes 1 (f) and (g)); 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 mainly those assets or liabilities expected to be recovered/settled more than 12 months after reporting period), are disclosed in the notes where relevant.

Statement of changes in equity

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

Cash flow statement

Cash flows are classified according to whether or not they arise from operating activities, investing activities, or financing activities. This classification is consistent with requirements under AASB 107 *Statement of Cash 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) 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 the 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 2014-15).

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 amount. 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.

(g) 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;

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

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 plans provide benefits based on years of service and final average salary.

The name and details of the major employee superannuation funds and contributions made by the Wimmera Health Care Group are disclosed in Note 13: *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.
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.

	2016	2015
Buildings		
- Structure Shell Building Fabric	1 to 50 years	1 to 50 years
- Fit Out	12 to 30 years	12 to 30 years
- Trunk Reticulated Building Systems	1 to 12 years	1 to 12 years
- Site Engineering Services and Site Works	6 to 40 years	6 to 40 years
Plant & Equipment	10 years	10 years
Medical Equipment	10 years	10 years
Computers and Communication	4 years	4 years
Furniture and Fittings	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.

Amortisation

Amortisation is allocated to intangible non-produced assets with finite useful lives on a systematic (typically straight-line) 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. The consumption of intangible non-produced assets with finite useful lives is classified as amortisation.

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

Intangible assets with indefinite useful lives are not amortised, but are tested for impairment annually or whenever there is an indication that the asset may be impaired. The useful lives of intangible assets that are not being amortised are reviewed each period to determine whether events and circumstances continue to support an indefinite useful life assessment for that asset. In addition, the Health Service tests all intangible assets with indefinite useful lives for impairment by comparing the recoverable amount for each asset with its carrying amount:

- annually; and
- whenever there is an indication that the intangible asset may be impaired

Any excess of the carrying amount over the recoverable amount is recognised as an impairment loss.

Intangible assets with finite useful lives are amortised over 4 years.

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 (j) *Impairment of financial assets.*

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

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

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

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.

(h) Other economic flows included in net result

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

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

Revaluation gains/ (losses) of non-financial physical assets
Refer to Note 1(j) *Revaluations of non-current 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 amount of the asset at the time.

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

a. the revaluation of the present value of the long service leave liability due to changes in the bond interest rates, this will also include the impact of changes to the long service leave model; and

b. transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

(i) Financial instruments

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of the 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.

Categories of non-derivative financial instruments

Loans and receivables

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

Loans and receivables category includes cash and deposits (refer to Note 1(j)), 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 or 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.

(j) Assets

Cash and Cash Equivalents

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

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

Investments are classified in the following categories:

- 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.

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

Property, plant and equipment

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

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

Revaluations of non-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 amount 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.

Intangible assets

Intangible assets represent identifiable non-monetary assets without physical substance such as patents, trademarks, and computer software and development costs (where applicable).

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

Prepayments

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

Disposal of non-financial assets

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

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;
- assets arising from construction contracts.

If there is an indication of impairment, the assets concerned are tested as to whether their carrying amount exceeds their possible recoverable amount. Where an asset's carrying amount exceeds its recoverable amount, the difference is written-off as an expense except to the extent that the write-down can be 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 of disposal. Recoverable amount for assets held primarily to generate net cash inflows is measured at the higher of the present value of future cash flows expected to be obtained from the asset and fair value less costs of disposal.

Investments in joint operations

In respect of any interest in joint operations, the 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:
  (a) has transferred substantially all the risks and rewards of the asset; or
  (b) has neither transferred nor retained substantially all the risks and rewards of the asset, but has transferred control of the asset.

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

Impairment of financial assets

At the end of each reporting period the 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.

(k) Liabilities

Payables

Payables consist of:

- contractual payables which consist predominantly of accounts payable representing liabilities for goods and services provided to the Health Service prior to the end of the financial year that are unpaid, and arise when the Health Service becomes obliged to make future payments in respect of the purchase of those goods and services. The 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(l) 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.

On-costs related to employee expense

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

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.

Derecognition of financial liabilities

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

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

(l) Leases

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

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

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

Entity as lessee

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

Entity as lessor

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.

Entity as lessee

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

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.

(m) Equity

Contributed capital

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

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.

(n) Commitments

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

(o) Contingent assets and contingent liabilities

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

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

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

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

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

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

(q) Foreign currency

All foreign currency transactions during the financial year are brought to account using the exchange rate in effect at the date of the transaction. Foreign monetary items existing at the end of the reporting period are translated at the closing rate at the date of the end of the reporting period.

(r) AASs issued that are not yet effective

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2016 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 2016, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. The Wimmera Health Care Group has not and does not intend to adopt these standards early.

Standard/ Interpretation[1]	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	While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.

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

Standard/ Interpretation[1]	Summary	Applicable for annual reporting periods beginning on	Impact on public sector entity financial statements
AASB 2015-8 *Amendments to Australian Accounting Standards – Effective Date of AASB 15*	This Standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1 Jan 2018	This amending standard will defer the application period of AASB 15 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of most operating leases (which are current not recognised) on balance sheet.	1 Jan 2019	The assessment has indicated that as most operating leases will come on balance sheet, recognition of lease assets and lease liabilities will cause net debt to increase. Depreciation of lease assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. The amounts of cash paid for the principal portion of the lease liability will be presented within financing activities and the amounts paid for the interest portion will be presented within operating activities in the cash flow statement. No change for lessors.
AASB 2014-4 *Amendments to Australian Accounting Standards – Clarification of Acceptable Methods of Depreciation and Amortisation* [AASB 116 & AASB 138]	Amends AASB 116 *Property, Plant and Equipment* and AASB 138 *Intangible Assets* to: – establish the principle for the basis of depreciation and amortisation as being the expected pattern of consumption of the future economic benefits of an asset; – prohibit the use of revenue-based methods to calculate the depreciation or amortisation of an asset, tangible or intangible, because revenue generally reflects the pattern of economic benefits that are generated from operating the business, rather than the consumption through the use of the asset.	1 Jan 2016	The assessment has indicated that there is no expected impact as the revenue-based method is not used for depreciation and amortisation.

Standard/ Interpretation[1]	Summary	Applicable for annual reporting periods beginning on	Impact on public sector entity financial statements
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. 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.
AASB 2016-4 *Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities*	The standard amends AASB 136 *Impairment of Assets* to remove references to using depreciated replacement cost (DRC) as a measure of value in use for not-for-profit entities.	1 Jan 2017	The assessment has indicated that there is minimal impact. Given the specialised nature and restrictions of public sector assets, the existing use is presumed to be the highest and best use (HBU), hence current replacement cost under AASB 13 Fair Value Measurement is the same as the depreciated replacement cost concept under AASB 136.

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

- AASB 1056 *Superannuation Entities*
- AASB 1057 *Application of Australian Accounting Standards*
- AASB 2014-1 *Amendments to Australian Accounting Standards [PART D – Consequential Amendments arising from AASB 14 Regulatory Deferral Accounts only]* [2]
- AASB 2014-3 *Amendments to Australian Accounting Standards – Accounting for Acquisitions of Interests in Joint Operations* [AASB 1 & AASB 11]
- 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 2015-2 Amendments to Australian Accounting Standards – *Disclosure Initiative: Amendments to AASB 101* [AASB 7, AASB 101, AASB 134 & AASB 1049]
- AASB 2015-5 *Amendments to Australian Accounting Standards – Investment Entities: Applying the Consolidation Exception [*AASB 10, AASB 12, AASB 128] [2]
- AASB 2015-9 *Amendments to Australian Accounting Standards – Scope and Application Paragraphs* [AASB 8, AASB 133 & AASB 1057]
- AASB 2015-10 *Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128*
- AASB 2016-1 *Amendments to Australian Accounting Standards – Recognition of Deferred Tax Assets for Unrealised Losses* [AASB 112]
- AASB 2016-2 *Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107*

(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.

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

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

Note 2: Analysis of Revenue by Source

	Admitted Patients 2016 $'000	EDs 2016 $'000	RAC 2016 $'000	HACC 2016 $'000	Primary Health 2016 $'000	Other 2016 $'000	Total 2016 $'000
Government Grant	46,799	3,439	8,876	2,039	1,213	6,719	69,085
Indirect contributions by Department of Health and Human Services	(28)	(20)	(71)	(7)	1	(41)	(166)
Patient & Resident Fees	3,687	-	2,390	61	197	437	6,772
Commerical Activities (refer note 3a)	-	-	-	-	-	2,692	2,692
Other Revenue from Operating Activities	470	33	147	6	43	2,297	2,996
Total Revenue from Operating Activities	**50,928**	**3,452**	**11,342**	**2,099**	**1,454**	**12,104**	**81,379**
Interest	-	-	-	-	-	154	154
Other Revenue from Non-Operating Activities	-	-	-	-	-	508	508
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**-**	**-**	**662**	**662**
Capital Purpose Income (excluding Interest)	-	-	-	-	-	3,212	3,212
Total Capital Purpose Income	**-**	**-**	**-**	**-**	**-**	**3,212**	**3,212**
Net gain/(loss) on disposal of Non-Current Assets (refer note 2a)	**-**	**-**	**-**	**-**	**-**	(10)	(10)
Total Income from Non-Current Assets	**-**	**-**	**-**	**-**	**-**	**(10)**	**(10)**
Total Revenue	**50,928**	**3,452**	**11,342**	**2,099**	**1,454**	**15,968**	**85,243**

	Admitted Patients 2015 $'000	EDs 2015 $'000	RAC 2015 $'000	HACC 2015 $'000	Primary Health 2015 $'000	Other 2015 $'000	Total 2015 $'000
Government Grant	43,269	3,363	8,409	2,487	1,192	6,899	65,619
Indirect contributions by Department of Health and Human Services	290	30	29	8	(31)	144	470
Patient & Resident Fees	3,159	-	2,345	84	224	370	6,182
Commerical Activities (refer note 3a)	-	-	-	-	-	3,001	3,001
Other Revenue from Operating Activities	455	10	73	6	31	1,990	2,565
Total Revenue from Operating Activities	**47,173**	**3,403**	**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**
Capital Purpose Income (excluding Interest)	-	-	-	-	-	3,475	3,475
Settlement funds void contract	-	-	-	-	-	350	350
Total Capital Purpose Income	**-**	**-**	**-**	**-**	**-**	**3,825**	**3,825**
Net gain/(loss) on disposal of Non-Current Assets (refer note 2a)	-	-	-	-	-	(7)	(7)
Assets received free of charge (refer note 2b)	-	-	-	-	-	4	4
Total Income from Non-Current Assets	**-**	**-**	**-**	**-**	**-**	**(3)**	**(3)**
Total Revenue	**47,173**	**3,403**	**10,856**	**2,585**	**1,416**	**17,102**	**82,535**

The Department of Health and Human Services makes certain payments on behalf of the Health Service (List). 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

	2016 $'000	2015 $'000
Proceeds from Disposals of Non-Current Assets		
Plant and Equipment	1	-
Medical Equipment	7	4
Motor Vehicles	2	-
Total Proceeds from Disposal of Non-Current Assets	**10**	**4**
Less: Written Down Value of Non-Current Assets Sold		
Plant and Equipment	10	-
Medical Equipment	5	6
Motor Vehicles	5	-
Other	-	5
Total Written Down Value of Non-Current Assets Sold	**20**	**11**
Net Gain/(Loss) on Disposal of Non-Financial Assets	**(10)**	**(7)**

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

	2016 $'000	2015 $'000
During the reporting period, the fair value of assets received free of charge, was as follows:		
Land (from Horsham Rural City Council)	-	4
TOTAL	**-**	**4**

Note 3: Analysis of Expenses by Source

	Admitted Patients 2016 $'000	EDs 2016 $'000	RAC 2016 $'000	HACC 2016 $'000	Primary Health 2016 $'000	Other 2016 $'000	Total 2016 $'000
Employee Expenses	16,058	2,717	8,440	1,690	3,182	23,137	55,224
Non Salary Labour Costs	3,948	-	15	-	26	800	4,789
Supplies & Consumables	5,689	229	621	(3)	154	3,406	10,096
Commercial Activities Expenses (refer note 3a)	-	-	-	-	-	3,811	3,811
Other Expenses	4,818	423	411	42	132	1,705	7,531
Total Expenditure from Operating Activities	**30,513**	**3,369**	**9,487**	**1,729**	**3,494**	**32,859**	**81,451**
Expenditure for Capital Purposes	**-**	**-**	**-**	**-**	**-**	360	360
Impairment of Non-Financial Assets	-	-	-	-	-	23	23
Depreciation & Amortisation (refer note 4)	-	-	-	-	-	4,304	4,304
Total Other Expenses	**-**	**-**	**-**	**-**	**-**	**4,687**	**4,687**
Total Expenses	**30,513**	**3,369**	**9,487**	**1,729**	**3,494**	**37,546**	**86,138**

	Admitted Patients 2015 $'000	EDs 2015 $'000	RAC 2015 $'000	HACC 2015 $'000	Primary Health 2015 $'000	Other 2015 $'000	Total 2015 $'000
Employee Expenses	14,716	2,678	8,392	1,867	2,829	22,367	52,849
Non Salary Labour Costs	3,782	-	7	-	22	1,147	4,958
Supplies & Consumables	5,553	237	477	51	191	3,107	9,616
Commercial Activities Expenses (refer note 3a)	-	-	-	-	-	3,371	3,371
Other Expenses	4,498	447	361	32	84	1,925	7,347
Total Expenditure from Operating Activities	**28,549**	**3,362**	**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	**28,549**	**3,362**	**9,237**	**1,950**	**3,126**	**36,025**	**82,249**

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	
	2016 $'000	2015 $'000	2016 $'000	2015 $'000
Commercial Activities				
Private Practice and Other Patient Activities	2,587	2,225	1,198	1,520
Laundry	812	793	1,067	1,047
Cafeteria	327	296	361	371
Accommodation	28	14	31	25
Stores	57	43	35	38
TOTAL	**3,811**	**3,371**	**2,692**	**3,001**

Note 4: Depreciation and Amortisation

	2016 $'000	2015 $'000
Depreciation		
Buildings	3,347	3,191
Plant	108	107
Vehicles	24	31
Medical Equipment	279	269
Computer and Communications	64	76
Furniture and Fittings	47	42
Other Equipment	268	265
Linen	121	118
Intangibles	41	-
Leased Assets	7	9
Total Depreciation	**4,304**	**4,108**

Note 5: Cash and Cash Equivalents

For the purposes of the cash flow statement, cash assets includes cash on hand and in banks, and

	2016 $'000	2015 $'000
Cash on Hand	6	8
Cash at Bank	3,916	7,401
Term Deposits	10,546	4,500
Total Cash and Cash Equivalents	**14,468**	**11,909**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	9,674	7,243
Cash for Monies Held in Trust		
- Cash at Bank	74	166
- Term Deposits	4,720	4,500
Total Cash and Cash Equivalents	**14,468**	**11,909**

Note 6: Receivables

	2016 $'000	2015 $'000
CURRENT		
Contractual		
Inter Hospital Debtors	1,446	1,320
Trade Debtors	1,021	1,057
Patient Fees	982	700
Less Allowance for Doubtful Debts		
Inter Hospital Debtors	(16)	-
Trade Debtors	(3)	-
Patient Fees	(142)	(7)
	3,288	**3,070**
Statutory		
GST Receivable	198	210
	198	**210**
TOTAL CURRENT RECEIVABLES	**3,486**	**3,280**
NON CURRENT		
Statutory		
Long Service Leave - Department of Health and Human Services	1,449	1,665
	1,449	**1,665**
TOTAL NON-CURRENT RECEIVABLES	**1,449**	**1,665**
TOTAL RECEIVABLES	**4,935**	**4,945**

(a) Movement in the Allowance for doubtful debts

	2016 $'000	2015 $'000
Balance at beginning of year	7	12
Amounts written off during the year	-	(11)
Increase/(decrease) in allowance recognised in net result	154	6
Balance at end of year	**161**	**7**

(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

	2016 $'000	2015 $'000
Pharmaceuticals		
At cost	128	131
Catering Supplies		
At cost	14	12
Housekeeping Supplies		
At cost	4	10
Medical and Surgical Lines		
At cost	157	139
Administration Stores		
At Cost	11	19
Linen		
At Cost	32	23
TOTAL INVENTORIES	**346**	**334**

Note 8: Property, plant & equipment

(a) Gross carrying amount and accumulated depreciation

	2016 $'000	2015 $'000
Land		
Land at Fair Value	5,310	5,310
Land at Cost	89	89
Total Land	**5,399**	**5,399**
Buildings		
Buildings Under Construction at Cost	315	400
Buildings at Cost	10,445	9,196
Less Acc'd Depreciation	(350)	(82)
Buildings at Fair Value	47,726	47,726
Less Acc'd Depreciation	(6,187)	(3,108)
Total Buildings	**51,949**	**54,132**
Plant		
Plant and Equipment Under Construction at Cost	338	419
Plant and Equipment at Fair Value	1,966	1,588
Less Acc'd Depreciation	(1,436)	(1,328)
Total Plant	**868**	**679**
Vehicles		
Vehicles at Fair Value	348	349
Less Acc'd Depreciation	(267)	(245)
Total Vehicles	**81**	**104**
Medical Equipment		
Medical Equipment at Fair Value	3,511	3,493
Less Acc'd Depreciation	(2,084)	(1,907)
Total Medical Equipment	**1,427**	**1,586**
Computers and Communications		
Computers and Communications at Fair Value	953	1,026
Less Acc'd Depreciation	(836)	(851)
Total Computers and Communications	**117**	**175**
Furniture and Fittings		
Furniture and Fittings at Fair Value	513	509
Less Acc'd Depreciation	(248)	(201)
Total Furniture and Fittings	**265**	**308**
Other Equipment		
Other Equipment at Fair Value	3,889	3,827
Less Acc'd Depreciation	(2,432)	(2,325)
Total Other Equipment	**1,457**	**1,502**
Total Plant and Equipment	**4,215**	**4,354**
Linen		
Linen at Fair Value	608	605
Less Acc'd Depreciation	(374)	(406)
Total Linen	**234**	**199**
Leased Assets		
Leased Assets	21	21
Less Acc'd Depreciation	(16)	(9)
Total Leased Assets	**5**	**12**
TOTAL	**61,802**	**64,096**

Note 8: Property, plant & equipment (continued)

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

	Land	Buildings	Plant & Equipment	Linen Assets	Leased Assets	Total
	$'000	$'000	$'000	$'000	$'000	$'000
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 (note 4)	-	(3,191)	(790)	(118)	(9)	(4,108)
Balance at 1 July 2015	**5,399**	**54,131**	**4,355**	**199**	**12**	**64,096**
Additions	-	492	1,364	157	-	2,013
Disposals	-	-	(21)	-	-	(21)
Impairment Losses (recognised)/reversed in Net Result	-	-	(23)	-	-	(23)
Net Transfers between Classes	-	673	(673)	-	-	-
Depreciation (note 4)	-	(3,347)	(789)	(121)	(7)	(4,263)
Balance at 30 June 2016	**5,399**	**51,950**	**4,214**	**235**	**5**	**61,802**

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

30 June 2016	Carrying amount as at 30 June 2016	Fair value measurement at end of reporting period using: Level 1 [i]	Level 2 [i]	Level 3 [i]
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	720		720	
Specialised buildings	50,914			50,914
Buildings under construction	315			315
Total of Buildings at fair value	**51,949**	**-**	**720**	**51,229**
Plant and Equipment at fair value				
Plant and equipment at fair value				
- Plant and equipment under construction	338			338
- Plant and equipment	530			530
- Vehicles [ii]	81			81
- Medical equipment	1,427			1,427
- Computers and communications	117			117
- Furniture and fittings	265			265
- Other equipment	1,457			1,457
Total of Plant and Equipment and vehicles at fair value	**4,215**	**-**	**-**	**4,215**
Leased Assets at fair value				
Leased assets at fair value	5			5
Total of Leased Assets at fair value	**5**	**-**	**-**	**5**
Linen at fair value				
Linen	234			234
Total of Linen at fair value	**234**	**-**	**-**	**234**
	61,802	**-**	**2,214**	**59,588**

30 June 2015	Carrying amount as at 30 June 2015	Fair value measurement at end of reporting period using: Level 1 [i]	Level 2 [i]	Level 3 [i]
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 Buildings at fair value	**54,132**	**-**	**772**	**53,360**
Plant and Equipment at fair value				
Plant and equipment at fair value				
- Plant and equipment under construction	419	-	-	419
- Plant and equipment	260	-	-	260
- Vehicles [ii]	104	-	-	104
- Medical equipment	1,586	-	-	1,586
- Computers and communications	175	-	-	175
- Furniture and fittings	308	-	-	308
- Other equipment	1,502	-	-	1,502
Total of Plant and Equipment and vehicles at fair value	**4,354**	**-**	**-**	**4,354**
Leased Assets at fair value				
Leased assets at fair value	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**

There have been no transfers between levels during the period.

[i] Classified in accordance with the fair value hierarchy, see Note 1.

[ii] Vehicles are categorised to Level 3 assets if the depreciated replacement cost is used in estimating the fair value. However, entities should consult with an independent valuer in determining whether a market approach is appropriate for vehicles with an active resale market available. If yes, a Level 2 categorisation for such vehicles would be appropriate.

Note 8: Property, plant & equipment (continued)

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

Non-specialised land and non-specialised buildings

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

For non-specialised land and non-specialised buildings, an independent valuation was performed by the Valuer-General Victoria to determine the fair value using the market approach. Valuation of the assets was determined by analysing comparable sales and allowing for share, size, topography, location and other relevant factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30 June 2014.

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

Specialised land and specialised buildings

The market approach is also used for specialised land and specialised buildings although 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 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 amount (depreciated cost).

Plant and equipment

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

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

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 2016	Land	Buildings	Plant and equipment	Linen assets	Leased assets
Opening Balance	3,905	53,360	4,354	199	12
Purchases (sales)	-	492	1,364	157	-
Transfers in (out) of Level 3	-	673	(673)	-	-
Gains or losses recognised in net result					
- Depreciation	-	(3,295)	(788)	(121)	(7)
- Impairment loss	-	-	(23)	-	-
- Disposals	-	-	(21)	-	-
Closing Balance	**3,905**	**51,230**	**4,213**	**235**	**5**

There have been no transfers between levels during the period.

30 June 2015	Land	Buildings	Plant and equipment	Linen assets	Leased assets
Opening Balance	3,905	53,590	4,289	193	21
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)	(9)
- Disposals	-	-	(11)	-	-
Closing Balance	**3,905**	**53,360**	**4,354**	**199**	**12**

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
Specialised land		
Land at fair value	Market approach	Community Service Obligation (CSO) adjustment
Specialised buildings		
Buildings at fair value	Depreciated replacement cost	Direct cost per square metre Useful life of specialised buildings
Buildings under construction	Depreciated replacement cost	Direct cost per square metre
Plant and equipment at fair value		
Plant and equipment	Depreciated replacement cost	Cost per unit Useful life of PPE
Plant and equipment under construction	Depreciated replacement cost	Cost per unit
Vehicles		
Vehicles	Depreciated replacement cost	Cost per unit Useful life of vehicles
Medical equipment at fair value		
Medical equipment	Depreciated replacement cost	Cost per unit Useful life of medical equipment
Computers and communications		
Computers and communications	Depreciated replacement cost	Cost per unit Useful life of cultural assets
Furniture and fittings		
Furniture and fittings	Depreciated replacement cost	Cost per unit Useful life of cultural assets
Other equipment		
Other equipment	Depreciated replacement cost	Cost per unit Useful life of cultural assets
Linen		
Linen	Depreciated replacement cost	Cost per unit Useful life of cultural assets
Leased assets		
Leased assets	Depreciated replacement cost	Cost per unit Useful life of cultural assets

(i) CSO adjustments ranging at 20% were applied to reduce the market approach value for the Department's specialised land, with the weighted average 60% reduction applied.

Note 9: Intangible Assets

	2016 $'000	2015 $'000
Computer Software	296	-
Less Acc'd Amortisation	(41)	-
	255	**-**
Total Intangible Assets	**255**	**-**

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

	Computer Software $'000	Total $'000
Balance at 1 July 2015	**-**	**-**
Additions	296	**296**
Disposals	-	**-**
Amortisation (note 4)	(41)	**(41)**
Balance at 30 June 2016	**255**	**255**

Note 10: Payables

	2016 $'000	2015 $'000
CURRENT		
Contractual		
Trade Creditors	1,922	1,933
Accrued Expenses	2,035	2,148
TOTAL CURRENT	**3,957**	**4,081**

(a) Maturity analysis of payables
Please refer to Note 17(c) for the ageing analysis of contractual payables

(b) Nature and extent of risk arising from payables
Please refer to Note 17(c) for the nature and extent of risks arising from contractual payables

Note 11: Borrowings

	2016 $'000	2015 $'000
CURRENT		
Australian Dollar Borrowings		
– Finance Lease Liability [(i)] (refer Note 11a)	5	10
Total Australian Dollars Borrowings	**5**	**10**
Total Current	**5**	**10**
NON CURRENT		
Australian Dollar Borrowings		
– Finance Lease Liability (refer Note 11a)	-	2
Total Australian Dollars Borrowings	**-**	**2**
Total Non-Current	**-**	**2**
Total Borrowings	**5**	**12**

(i) Secured by the assets leased. Finance leases are effectively secured as the rights to the leased assets revert to the lessor in the event of default.

Finance costs of the Health Service incurred during the year are accounted for as follows:

Amount of finance costs recognised as expenses	-	-

(a) Maturity analysis of borrowings
Please refer to Note 17(c) for the ageing analysis of borrowings.

(b) Nature and extent of risk arising from borrowings
Please refer to Note 17(c) for the nature and extent of risks arising from borrowings.

(c) Defaults and breaches
During the current and prior year, there were no defaults and breaches of any of the borrowings.

Note 11a: Leases

(a) 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 transaction converted the previous 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 obtained consent for the finance lease during the 2015/16 financial year.

($ thousand)	***Minimum future lease payments*** [(i)] **2016**	**2015**	***Present value of minimum future lease payments*** **2016**	**2015**
Other finance lease liabilities payable [(ii)]				
Not longer than one year	5	10	5	10
Longer than one year but not longer than five years	0	2	0	2
Minimum future lease payments	**5**	**12**	**5**	**12**
Present value of minimum lease payments	**5**	**12**	**5**	**12**
Included in the financial statements as:				
Current borrowings lease liabilities (Note 11)	5	10	5	10
Non-current borrowing lease liablities (Note 11)	0	2	0	2
	5	**12**	**5**	**12**

(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% (2015 - 1.8%)

Note 12: Provisions

	2016 $'000	2015 $'000
Current Provisions		
Employee Benefits (i)		
Accrued Salaries and Wages		
- Unconditional and expected to be settled within 12 months (ii)	759	236
Accrued Days Off		
- Unconditional and expected to be settled within 12 months (ii)	99	92
Annual Leave		
- Unconditional and expected to be settled wholly within 12 months (ii)	3,289	3,228
- Unconditional and expected to be settled wholly after 12 months (iii)	424	320
Long Service Leave		
- Unconditional and expected to be settled wholly within 12 months (ii)	620	813
- Unconditional and expected to be settled wholly after 12 months (iii)	6,051	5,643
	11,242	10,332
Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months (ii)	595	484
- Unconditional and expected to be settled after 12 months (iii)	809	807
	1,404	1,291
Total Current Provisions	**12,646**	**11,623**
Non-Current Provisions		
Employee Benefits (i) (Note 12(a))	1,619	1,510
Provisions related to Employee Benefit On-Costs	205	189
Total Non-Current Provisions	**1,824**	**1,699**
Total Provisions	**14,470**	**13,322**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and Related On-Costs		
Accrued Salaries and Wages	759	236
Accrued Days Off	99	92
Annual Leave Entitlements	3,713	3,548
Unconditional LSL Entitlement	6,671	6,456
Non-Current Employee Benefits and Related On-Costs		
Conditional Long Service Leave Entitlements (ii)	1,572	1,510
Conditional Sabbatical Leave Entitlements (ii)	46	-
Total Employee Benefits	**12,860**	**11,842**
On-Costs		
Current On-Costs	1,404	1,291
Non-Current On-Costs	205	189
Total On-Costs	**1,610**	**1,480**
Total Employee Benefits and Related On-Costs	**14,470**	**13,322**
(b) Movements in provisions		
Movement in Long Service Leave:		
Balance at start of year	**8,963**	**8,189**
Provision made during the year		
- Gain/(Loss) on revaluation of Long Service Leave liability due to change in bond rates	132	153
- Expense recognising Employee Service	854	1,434
Settlement made during the year	(675)	(813)
Balance at end of year	**9,274**	**8,963**

Notes:

(i) Provisions for employee benefits consist of amounts for accrued salaries and wages, accrued days off, annual leave, purchased leave, long service leave and sabbatical 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 13: Superannuation

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

The Health Service does not recognise any defined benefit liability in respect of the plans 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 & Finance discloses the State's defined benefits liabilities in its disclosure for administered items.

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

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

	Paid Contribution for the Year		Contribution Outstanding at Year End	
	2016 $'000	**2015 $'000**	**2016 $'000**	**2015 $'000**
Defined benefit plans (i)	**416**	**474**	**32**	**33**
First State Super	416	474	32	33
Defined contribution plans	**5,193**	**5,064**	**423**	**376**
First State Super	4,419	4,404	359	320
Hesta	774	660	64	56
Total	**5,609**	**5,538**	**455**	**409**

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

Note 14: Other Liabilities

	2016 $'000	**2015 $'000**
CURRENT		
Monies Held in Trust*		
- Patient Monies Held in Trust*	2	103
- Accommodation Bonds (Refundable Entrance Fees)*	4,792	4,565
Other	232	104
Total Current	**5,026**	**4,772**
*** Total Monies Held in Trust**		
Represented by the following assets:		
Cash Assets (refer to Note 5)	4,794	4,668
TOTAL	**4,794**	**4,668**

Note 15: Equity

	2016 $'000	2015 $'000
(a) Surpluses		
Property, Plant & Equipment Revaluation Surplus [1]		
Balance at the beginning of the reporting period	36,537	36,537
Balance at the end of the reporting period	**36,537**	**36,537**
Represented by:		
- Land	957	957
- Buildings	35,580	35,580
	36,537	**36,537**
Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	4,016	2,626
Transfer to and from Restricted Specific Purpose Surplus	1,099	1,390
Balance at the end of the reporting period	**5,115**	**4,016**
Total Surpluses	**41,652**	**40,553**
(b) Contributed Capital		
Balance at the beginning of the reporting period	27,207	25,956
Capital Contribution received from Victorian Government	275	1,251
Balance at the end of the reporting period	**27,482**	**27,207**
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	(8,471)	(7,214)
Net Result for the Year	(1,027)	133
Other Comprehensive Income	-	-
Transfers to Restricted Purpose Surplus	(1,099)	(1,390)
Balance at the end of the reporting period	**(10,597)**	**(8,471)**
Total Equity at end of financial year	**58,537**	**59,289**

[1] The property, plant & equipment asset revaluation surplus arises on the revaluation of property, plant & equipment.

Note 16: Reconciliation of Net Result for the Year to Net Cash Inflow/(Outflow) from Operating Activities

	2016 $'000	2015 $'000
Net result for the period	(1,027)	133
Non-cash movements:		
Depreciation and amortisation	4,304	4,108
Impairment of non-financial assets	23	-
Movement in Provision for doubtful debts	154	(6)
Resources/assets provided free of charge	-	(4)
Non-cash contributed capital	(27)	
Movement in LSL Liability due to change in bond rates	132	-
Insurance paid on our behalf	50	56
Movements included in investing and financing activities		
Net (gain)/loss from disposal of non financial physical assets	10	7
Movements in assets and liabilities:		
Change in operating assets and liabilities		
(Increase)/decrease in receivables	(144)	(1,244)
(Increase)/decrease in prepayments	2	60
Increase/(decrease) in payables	(124)	1,030
Increase/(decrease) in provisions	781	(514)
Increase/(decrease) in other liabilities	128	75
Change in inventories	(12)	47
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**4,250**	**3,748**

Note 17: Financial Instruments

(a) Financial risk management objectives and policies

The 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 and interest rate risk. The Health Service manages these financial risks in accordance with its financial risk management policy.

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

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

Categorisation of financial instruments

2016	Contractual financial assets - loans and receivables $'000	Contractual financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets			
Cash and cash equivalents	14,468	-	14,468
Receivables			
- Trade Debtors	1,018	-	1,018
- Other Receivables	2,270	-	2,270
Total Financial Assets [(i)]	**17,756**	**-**	**17,756**
Financial Liabilities			
Payables	-	4,166	4,166
Borrowings	-	5	5
Other Financial Liabilities			
- Accomodation bonds	-	4,792	4,792
- Other	-	25	25
Total Financial Liabilities [(ii)]	**-**	**8,988**	**8,988**

2015	Contractual financial assets - loans and receivables $'000	Contractual financial liabilities at amortised cost $'000	Total $'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**

(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
2016					
Financial Assets					
Cash and Cash Equivalents [(i)]	-	154	-	-	154
Total Financial Assets	**-**	**154**	**-**	**-**	**154**
Financial Liabilities					
At Amortised Cost [(ii)]	-	-	-	-	-
Total Financial Liabilities	**-**	**-**	**-**	**-**	**-**
2015					
Financial Assets					
Cash and Cash Equivalents [(i)]	-	391	-	-	391
Total Financial Assets	**-**	**391**	**-**	**-**	**391**
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

2016	Financial institutions (AA credit rating) $'000	Government agencies (AAA credit rating) $'000	Government agencies (BBB credit rating) $'000	Other (min BBB credit rating) $'000	Total $'000
Financial Assets					
Cash and Cash Equivalents	8,728	5,740	-	-	14,468
Loans and Receivables					
- Trade Debtors	-	-	1,430	1,018	2,448
- Other Receivables (i)	-			840	840
Total Financial Assets	**8,728**	**5,740**	**1,430**	**1,858**	**17,756**
2015					
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**

(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	
2016	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Financial Assets							
Cash and Cash Equivalents	14,468	14,468	-	-	-	-	-
Loans and Receivables							
- Trade Debtors	2,448	1,018	485	318	170	457	3
- Other Receivables (i)	840	349	166	109	58	158	158
Total Financial Assets	**17,756**	**15,835**	**651**	**427**	**228**	**615**	**161**
2015							
Financial Assets							
Cash and Cash Equivalents	11,909	11,909	-	-	-	-	-
Loans and Receivables							
- 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**

(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 Wimmera Health Care Group does not hold any collateral as security nor credit enhancements relating to any of its financial assets.

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

Note 17: Financial Instruments (continued)

(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

			Maturity Dates			
	Carrying Amount	Nominal Amount	Less than 1 Month	1-3 Months	3 months - 1 Year	1-5 Years
2016	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Financial Liabilities						
At amortised cost						
Payables	4,166	4,166	3,462	704	-	-
Borrowings	5	5	1	1	3	-
Other Financial Liabilities (i)						
- Accommodation Bonds	4,792	4,792	-	701	3,584	507
- Other	25	25	25	-	-	-
Total Financial Liabilities	**8,988**	**8,988**	**3,488**	**1,406**	**3,587**	**507**
2015						
Financial Liabilities						
At amortised cost						
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**

(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 undertakes financial liabilities with relatively even maturity profiles.

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

The Health Service has minimal exposure to cash flow interest rate risks through its cash and 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	Carrying Amount	Interest Rate Exposure		
			Fixed Interest Rate	Variable Interest Rate	Non-Interest Bearing
2016	**Rate (%)**	**$'000**	**$'000**	**$'000**	**$'000**
Financial Assets					
Cash and Cash Equivalents	2.14	14,468	-	14,462	6
Loans and Receivables [(i)]					
- Trade Debtors		2,448	-	-	2,448
- Other Receivables		840	-	-	840
		17,756	**-**	**14,462**	**3,294**
Financial Liabilities					
At amortised cost					
Payables[(i)]		4,166	-	-	4,166
Borrowings	1.8	5	5	-	-
Other Financial Liabilities					
- Accommodation Bonds		4,792	-	4,792	-
- Other		25	-	-	25
		8,988	**5**	**4,792**	**4,191**
2015					
Financial Assets					
Cash and Cash Equivalents	2.12	11,909	-	11,909	-
Loans and Receivables [(i)]					
- Trade Debtors		2,377	-	-	2,377
- Other Receivables		693	-	-	693
		14,979	**-**	**11,909**	**3,070**
Financial Liabilities					
At amortised cost					
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**

(i) The carrying amount excludes 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 the 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%		+1%	
2016		Profit $'000	Equity $'000	Profit $'000	Equity $'000
Financial Assets					
Cash and Cash Equivalents [(i)]	14,468	(145)	(145)	145	145
Loans and Receivables [(i)]					
- Trade Debtors	2,448	-	-	-	-
- Other Receivables	840	-	-	-	-
Financial Liabilities					
At amortised cost					
Payables	4,166	-	-	-	-
Borrowings	5	-	-	-	-
Other Financial Liabilities[(ii)]	-	-	-	-	-
- Accommodation Bonds	4,792	-	-	-	-
- Other	25	-	-	-	-
		(145)	**(145)**	**145**	**145**
2015					
Financial Assets					
Cash and Cash Equivalents [(i)]	11,909	(119)	(119)	119	119
Loans and Receivables [(i)]					
- Trade Debtors	2,377	-	-	-	-
- Other Receivables	693	-	-	-	-
Financial Liabilities					
At amortised cost					
Payables	4,081	-	-	-	-
Borrowings	12	-	-	-	-
Other Financial Liabilities[(ii)]					
- Accommodation Bonds	4,565	-	-	-	-
- Other	207	-	-	-	-
		(119)	**(119)**	**119**	**119**

(i) eg. Sensitivity of cash and cash equivalents to a +1% movement in interest rates: [$22,403k*0.07]-[$22,403k*0.06] = $224k. Similar for a -1% movement in interest rate, impact = $(224k).

(ii) The carrying amount excludes 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

	Consol'd Carrying Amount 2016 $'000	Fair value 2016 $'000	Consol'd Carrying Amount 2015 $'000	Fair value 2015 $'000
Financial Assets				
Cash and Cash Equivalents	14,468	14,468	11,909	11,909
Loans and Receivables [(i)]				
- Trade Debtors	2,448	2,448	2,377	2,377
- Other Receivables	840	840	693	693
Total Financial Assets	**17,756**	**17,756**	**14,979**	**14,979**
Financial Liabilities				
At amortised cost				
Payables	4,166	4,166	4,081	4,081
Borrowings	5	5	12	12
Other Financial Liabilities[(i)]				
- Accommodation Bonds	4,792	4,792	4,565	4,565
- Other	25	25	207	207
Total Financial Liabilities	**8,988**	**8,988**	**8,865**	**8,865**

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

Note 18: Commitments

	2016 $'000	2015 $'000
Capital expenditure commitments		
Payable:		
Land and buildings	-	34
Plant and equipment	-	409
Total capital expenditure commitments	**-**	**443**
Land and buildings		
Not later than one year	-	34
Total	**-**	**34**
Lease commitments		
Commitments in relation to leases contracted for at the reporting date:		
Property leases	123	109
Operating leases	783	767
Finance leases	5	14
Total lease commitments	**911**	**890**
Operating leases		
Cancellable		
Not later than one year	415	429
Later than 1 year and not later than 5 years	491	447
Total operating lease commitments	**906**	**876**
Finance Leases		
Commitments in relation to finance leases are payable as follows:		
Current	5	8
Non-current	-	6
Minimum Lease Payments	5	14
Less Future Finance Charges	-	-
Total finance lease commitments	**5**	**14**
Total lease commitments	**911**	**890**
Total Commitments (inclusive of GST)	**911**	**1,333**

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

Note 19: Contingent Assets and Contingent Liabilities

There were no contingent assets or liabilities at the reporting date.

Note 20: Operating Segments

	RAC		Acute		HACC		Primary Care		Other		Total	
	2016 $'000	2015 $'000	2016 $'000	2015 $'000	2016 $'000	2015 $'000	2016 $'000	2015 $'000	2016 $'000	2015 $'000	2016 $'000	2015 $'000
REVENUE												
External Segment Revenue	11,342	11,033	54,380	50,944	2,099	2,584	1,454	1,417	15,824	16,162	85,099	82,140
Total Revenue	**11,342**	**11,033**	**54,380**	**50,944**	**2,099**	**2,584**	**1,454**	**1,417**	**15,824**	**16,162**	**85,099**	**82,140**
EXPENSES												
External Segment Expenses	(12,953)	(12,392)	(50,675)	(49,402)	(2,168)	(2,387)	(2,393)	(1,884)	(17,949)	(16,173)	(86,138)	(82,238)
Total Expenses	**(12,953)**	**(12,392)**	**(50,675)**	**(49,402)**	**(2,168)**	**(2,387)**	**(2,393)**	**(1,884)**	**(17,949)**	**(16,173)**	**(86,138)**	**(82,238)**
Net Result from ordinary activities	**(1,611)**	**(1,359)**	**3,705**	**1,542**	**(69)**	**197**	**(939)**	**(467)**	**(2,125)**	**(11)**	**(1,039)**	**(98)**
Interest Income	-	-	-	-	-	-	-	-	154	391	154	391
Revaluation of Long Service Leave	-	-	-	-	-	-	-	-	(132)	(153)	(132)	(153)
Net gain/(loss) on disposal of Non-Current Assets (refer note 2a)	-	-	-	-	-	-	-	-	(10)	(7)	(10)	(7)
Net Result for Year	**(1,611)**	**(1,359)**	**3,705**	**1,542**	**(69)**	**197**	**(939)**	**(467)**	**(2,113)**	**220**	**(1,027)**	**133**
OTHER INFORMATION												
Segment Assets	17,681	20,676	48,946	44,484	2,448	2,687	7,771	8,687	5,150	4,941	81,996	81,475
Total Assets	**17,681**	**20,676**	**48,946**	**44,484**	**2,448**	**2,687**	**7,771**	**8,687**	**5,150**	**4,941**	**81,996**	**81,475**
Segment Liabilities	5,058	5,630	14,003	12,114	700	732	2,223	2,365	1,474	1,346	23,458	22,187
Total Liabilities	**5,058**	**5,630**	**14,003**	**12,114**	**700**	**732**	**2,223**	**2,365**	**1,474**	**1,346**	**23,458**	**22,187**
Depreciation & Amortisation Expense	928	1,043	2,569	2,243	128	135	408	438	271	249	4,304	4,108

This note is inclusive of transfer pricing figures.

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

Business Segments	**Services**
Residential Aged Care Services (RACS)	Residential aged care
Acute	Acute health care
HACC	Home and Community Care
Primary Care	Primary and allied health services
Other	Disabled and hospice health care, support services

Geographical Segment
The 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 21: Jointly Controlled Operations and Assets

Name of Entity	Principal Activity	Ownership Interest 2016 %	Ownership Interest 2015 %
Grampians Rural Health Alliance	Information Systems	11.06	11.06

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:

	2016 $'000	2015 $'000
Current Assets		
Cash and Cash Equivalents	235	65
Debtors	143	52
Prepayments	19	8
Total Current Assets	**397**	**125**
Non Current Assets		
Property, Plant and Equipment	299	122
Total Non Current Assets	**299**	**122**
Total Assets	**696**	**247**
Current Liabilities		
Creditors	121	28
Total Current Liabilities	**121**	**28**
Total Liabilities	**121**	**28**

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

	2016 $'000	2015 $'000
Revenues		
Other	933	543
Total Revenue	**933**	**543**
Expenses		
Information Technology and Administrative Expenses	577	545
Total Expenses	**577**	**545**
Net Result	**356**	**(2)**

Note 22a: Responsible Persons Disclosures

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

	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	1/7/2015 - 30/6/2016
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	1/7/2015 - 30/6/2016
Governing Boards	
Mr M A Williams (President and Chairperson)	1/7/2015 - 30/6/2016
Ms A Murphy (Deputy Chairperson)	1/7/2015 - 30/6/2016
Mr E McCabe	1/7/2015 - 30/6/2016
Mrs M Aitken	1/7/2015 - 30/6/2016
Mr P Campbell	1/7/2015 - 30/6/2016
Mrs M Eagle	1/7/2015 - 30/6/2016
Mr R Goudie	1/7/2015 - 30/6/2016
Ms L Kwok	1/7/2015 - 30/6/2016
Mr W Winter	1/7/2015 - 30/6/2016
Accountable Officer	
Mr C G Scott	1/7/2015 - 30/6/2016

Remuneration of Responsible Persons

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

Income Band	**2016 No.**	**2015 No.**
$0 - $9,999	9	9
$270,000 - $279,999	-	1
$280,000 - $289,999	1	-
Total Numbers	**10**	**10**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**$288,930**	**$270,571**

Amounts relating to Responsible Ministers are reported in the financial statements of the Department of Premier and Cabinet. For information regarding related party transactions of ministers, the register of members' interests is publicly available from: www.parliament.vic.gov.au/publications/register-of-interests.

Other Transactions of Responsible Persons and their Related Parties.

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

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

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.

Mrs M Aitken provides is a self-employed psychologist who transacts with the Health Service on normal terms and conditions.

Mr C G Scott is a director of Wimmera Uniting Care, who provide services to the community health service programs run by the Health Service on normal commercial terms and conditions. He is also the Chair of the Grampians Rural Health Alliance Executive Commitee who provide IT support services to the Health Service on normal commercial terms and conditions, and Chief Executive Officer to the Dunmunkle Health Service to whom the Health Service provides operational and management support services on normal commercial terms and conditions.

Mr W Winter is a consultant providing advice to owners and directors of private companies and is reimbursed by the Health Service for minor travel costs incurred to attend Board of Management meetings.

Note 22b: 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.

	Total Remuneration		Base Remuneration	
	2016 No.	2015 No.	2016 No.	2015 No.
$130,000 – $139,999	1	-	1	-
$140,000 – $149,999	-	-	-	1
$150,000 – $159,999	1	-	1	-
$160,000 – $169,999	-	1	-	1
$170,000 – $179,999	-	-	-	-
$180,000 – $189,999	-	1	-	1
$190,000 – $199,999	1	-	1	-
$200,000 – $209,999	-	1	-	-
$210,000 – $219,999	1	-	1	-
$300,000 – $309,999	-	-	-	1
$320,000 – $329,999	1	1	1	-
Total	5	4	5	4
Total annualised employee equivalents (AEE) [(i)]	5	4	5	4
Total Remuneration	**$ 1,012,003**	**$ 887,504**	**$ 1,012,003**	**$ 803,109**

(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 23: Remuneration of auditors

	2016 $'000	2015 $'000
Victorian Auditor-General's Office		
Audit or review of financial statement	44	43
Crowe Horwath		
Internal audit services	41	29
Other providers		
Internal audit services	9	17
TOTAL	**85**	**72**

Note 24: Events Occurring after the Balance Sheet Date

There were no significant events occurring after the reporting date which require further disclosure.

Note 25: Alternate Presentation of Comprehensive Operating Statement

	2016 $'000	2015 $'000
Interest	154	391
Fair Value of assets and services received free of charge or for norminal consideration	-	4
Sales of goods and services	9,464	9,055
Grants	68,919	66,089
Other Income	6,716	7,003
Total revenue	**85,253**	**82,542**
Employee expenses	55,224	52,849
Depreciation	4,304	4,108
Other operating expenses	26,587	25,292
Impairment of Non-Financial Assets	23	-
Total expenses	**86,138**	**82,249**
	-	-
Net result from transactions - Net operating balance	**(885)**	**293**
Net gain/ (loss) on disposal of non-financial assets	(10)	(7)
Other gains / (losses) from other economic flows	(132)	(153)
Total other economic flows included in net result	**(142)**	**(160)**
Net result	**(1,027)**	**133**

INCORPORATING

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

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Horsham, Victoria, 3400
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ABN: 21203855611

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