Boort District Health

ANNUAL REPORT 2017 / 2018

TABLE OF CONTENTS

Since Boort District Health was established on its current site in 1961 it has played a key role in the provision of public health services for the community of Boort and surrounding districts. The Annual Report 2017 - 2018 is an important document that provides information to all stakeholders about the performance of the health service. The report will highlight services provided as well as operational achievements and challenges during this financial year.

The Annual Report should be read in conjunction with Boort District Health's Quality of Care Report. The document details Boort District Health's achievements in many clinical, community and operational areas. The Quality of Care Report is produced in a calendar format to make it a useful document that will be read throughout the year.

Report specifications: Reporting period from 1 July 2017 to 30 June 2018. This report is prepared for the Minister for Health, the Parliament of Victoria and the general public in accordance with relevant government and legislative requirements.

Dja Dja Wurrung Enterprises Pty Ltd

Acknowledgment of Country
We acknowledge the Dja Dja Wurrung Country of the Jaara people and we pay our respects to their elders past, present and emerging. We acknowledge their living culture and the unique role they play in the life of this region.

Boort
District Health

ABOUT BOORT DISTRICT HEALTH

Boort District Health provides a comprehensive range of multidisciplinary health care services to Boort and the wider community.

BOORT DISTRICT HEALTH is a public hospital established in 1961 and is an incorporated body listed under Schedule 1 of the Health Services Act (1988).

The responsible Minister is the Honourable Jill Hennessy, M.P. The activities of the Boort District Health are directed by the Board of Management, which meets regularly with its Executive staff to determine policy and planning direction.

RESIDENTIAL AGED CARE
Boort District Health operates twenty five (25) permanent residential aged care places, all single rooms with individual ensuite facilities to residents with both low and high care needs.

URGENT CARE CENTRE
Boort District Health Urgent Care Centre offers two (2) urgent care treatment trolleys and one (1) treatment room, 24 hours a day, 7 days a week. This service is supported by an on call system coordinated by St Anthony Family Medical Practice.

ACUTE SERVICES
7 single, ensuite acute beds are provided, including one Transitional Care Program (TCP) bed based bed and a family room with courtyard. Admission to our acute services is through the Visiting Medical Officers.

PRIMARY CARE SERVICES
A number of Allied Health services are facilitated within Boort District Health including Physiotherapy, Podiatry, Health Education and Health Promotion.

SPANNER CAFÉ
The Spanner Café operates in a small area located between reception, urgent care and the hospital kitchen. The spanner café is the communal hub of the Health Service a place for residents, patients, clients, visitors and community to catch up over a cup of tea or coffee, or enjoy a delicious lunch prepared by our Café staff.

ORAL HEALTH SERVICES
Public and private oral health services are offered to the community. Within the public program, outreach services are offered to other towns. The service includes a preventative program to children and schools as well as oral health service to residents in care.

COMMUNITY AND HOME BASED CARE
Outreach community support programs are coordinated by Boort District Health. They include Meals on Wheels, District Nursing, TCP and Planned Activity Groups including exercises, craft and art and community wellbeing programs.

OUR BOARD CHAIR AND CHIEF EXECUTIVE

On behalf of the Board, we are pleased to present the Annual Report of Boort District Health (BDH) for the twelve months ended 30 June 2018.

During this past year our health service has actively embraced new opportunities and responded flexibly to ensure that the highest outcomes are consistently achieved and sustained. At BDH we are committed to providing an inclusive organisational culture where all our staff are valued and recognised for their unique qualities, ideas and perspectives. We are committed to providing a working environment that values diversity and inclusion, which supports everyone to achieve their full potential and excel.

Throughout the course of the year, the Board has regularly reviewed the objectives of the BDH Strategic Plan 2015-2018 and monitored our progress. To inform the development of our new Strategic Plan for 2019-2021 broad consultation will occur in late 2018.

BDH is committed to improved health outcomes for all through the provision of culturally appropriate health services. We take great pride in our ability to remain focused on delivering safe, high-quality, person-centred care, ensuring a positive healthcare experience. We are continuing to develop and implement new models of care to innovatively transform our practice.

In November 2017 we celebrated a major milestone with the official opening of our recently extensively redeveloped facilities. Following a submission to the Department of Health and Human Services (DHHS) Rural Health Infrastructure Fund – Round 2, in February 2018 we were advised of a successful application for $992,691 which will enable relocation of the dental clinic and creation of two additional consulting rooms. The project will also expand our capacity from the current single dental chair to two dental chairs, which will enhance workflow between patients, provide better privacy and increase overall operational efficiency. Planning is well advanced, with construction set to commence in the latter part of 2018.

In June 2018 a partial refurbishment of our primary care facilities in Boort, funded through a DHHS 2016-17 Health Service Violence Prevention Fund grant, was also completed and this has significantly enhanced the accessibility and security of these premises.

We are extremely proud of the high level of commitment and care consistently displayed by our staff and volunteers in providing services for the community. Throughout the past year, we have participated in a broad range of external review processes, with each of the respective services being awarded ongoing accreditation for a corresponding further three year period. In September 2017, our sub-acute facilities were assessed as being fully compliant with the National Safety and Quality Health Service (NSQHS) Standards. Our Commonwealth Home Support Program (CHSP) funded District Nursing and Social Support services were reviewed in October 2017, under the Home Care Common Standards. Most recently, in May 2018, the Australian Aged Care Quality Agency reviewed and re-accredited both of our residential aged care facilities in Loddon Place (Boort District Health Low and Boort District Health High Care), which were each deemed to be fully compliant with all 44 expected outcomes of the Residential Aged Care Accreditation Standards.

While the demand for entry into our residential aged care places remains relatively constant, further scope exists to expand our local service provision within the Home Care sphere. In June 2018 Boort District Health received formal confirmation from the Commonwealth Department of Health that it is approved to provide Home Care and work is now underway to progress this initiative.

We value our numerous partnerships with stakeholders, who all add value to our organisation and community. We have been a key partner in collaborating with other health services within the Buloke, Loddon and Gannawarra area in establishing a partnership approach to look at ways to address the issues that have the most impact on our services collectively. BDH is working collaboratively with other health care providers to address priority areas for action.

Our achievements would not have been possible without the combined efforts of so many people. We thank all members of our local community for the high level of support. The Board also acknowledges the tremendous efforts of everyone involved either directly or indirectly with the health service, including our staff, volunteers, visiting medical officers, contractors and all levels of government. We appreciate the support and assistance of the Victorian Department of Health and Human Services and the Commonwealth Department of Health. We remain grateful for the combined assistance that has been given to of our health service over the past year, in our endeavour to continually improve the health and well-being of our local community.

The guidance and direction provided by the Board is greatly appreciated. Indeed, it has been another very positive year for our organisation and we look forward to further developing and enhancing our services over the coming year.

Mrs Wendy Gladman
Board Chair

Dr Darren Clarke
Chief Executive Officer

Board of MANAGEMENT

The Board of Management at Boort District Health follows the strategic framework for boards developed by the Victorian Department of Health and Human Services. It is acknowledged that the board is the cornerstone of our health system, and the performance of health services depends on the quality of members who work on the board. The actions of boards and individual directors can positively influence the lives of all in our community. It is for this reason that the Board of Management actively undertakes training and annually evaluates its performance.

The three priority areas for training and development that the board has focused on during the year are:

- Clinical Governance
- Leadership
- Financial Management

The Board has established four sub-committees that meet at least quarterly and provide advice. These committees are:

- Finance, Audit and Risk Management Committee
- Board Excellence in Governance Committee
- Community Advisory Committee
- Safety, Quality & Clinical Governance Committee

Role of the EXECUTIVE

The role of the Executive is to enact the decisions of the Board of Management, provide leadership and management to the BDH staff, approve and oversee the implementation of the strategic, business and quality plans and to ensure the organisation operates within the various statutory requirements set for it by government and statutory bodies.

OFFICE BEARERS

Board Chair

Mrs Wendy Gladman
(First elected: 26.04.2017)
Board Chair from 27.11.2017
(Board Excellence in Governance Committee)

Mrs Marlies Eicher
(First elected: 01.07.2012)
Board Chair until 27.11.2017
(Board Excellence in Governance Committee) (Finance, Audit & Risk Committee) (Safety, Quality & Clinical Governance Committee)

Members

Mrs Gayle Smith
(First elected: 01.06.2013)
(Safety, Quality & Clinical Governance Committee)

Mr Chris Harrison
(First elected: 01.07.2016)
(Safety, Quality & Clinical Governance Committee)

Mrs Bronwyn Simpson
(First elected: 01.07.2016)
(Community Advisory Committee)

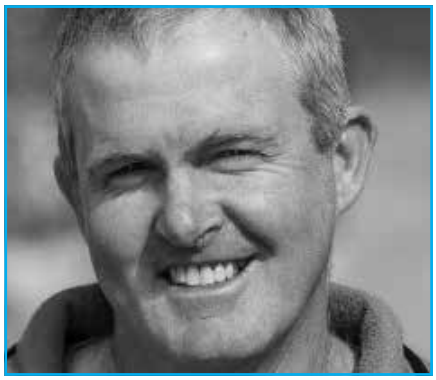
Mr Laurie Maxted
(First elected: 26.04.2017)
(Community Advisory Committee)

Ms Donna Sherringham
(First elected: 26.04.2017)
(Safety, Quality & Clinical Governance Committee)

Mr Neal Beattie
(First elected: 26.04.2017)
(Finance, Audit & Risk Committee)

Mrs Kathryn Lanyon
(First elected 26.04.2017)
(Board Excellence in Governance Committee)

OFFICE BEARERS



Mr Grant Malone
(First elected: 01.07.2014)
(Finance, Audit & Risk Committee)

Mrs Jo Haw
(First elected: 01.07.2017)
(Board Excellence in Governance Committee)

Mr Alister Ferguson
(First elected: 01.07.2017)
(Board Excellence in Governance Committee)

BOARD MEETING ATTENDANCE 2017/18

BOARD MEETINGS													AGM NOV-17	TOTAL ATTENDED
	2017						2018							
Board members	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**		
Wendy Gladman	A	A	√	√	√	NA	√	√	√	√	√	√	√	10/12
Marlies Eicher	√	A	√	√	√	NA	A	√	√	√	√	√	√	10/12
Gayle Smith	A	√	√	√	√	NA	√	√	√	√	√	A	√	10/12
Laurie Maxted	√	√	√	√	√	NA	A	√	√	√	√	√	√	11/12
Grant Malone	√	√	A	√	A	NA	A	√	√	√	√	√	√	9/12
Chris Harrison	√	√	A	√	ABS	NA	ABS	ABS	ABS	ABS	ABS	ABS	√	4/12
Bronwyn Simpson	A	A	ABS	ABS	ABS	NA	ABS	ABS	ABS	ABS	ABS	ABS	ABS	0/12
Neil Beattie	√	√	√	A	√	NA	A	√	A	ABS	ABS	A	A	5/12
Donna Sherringham	√	A	TC	√	√	NA	A	√	TC	A	√	TC	A	8/12
Alister Ferguson	√	√	√	√	√	NA	√	√	A	√	A	√	A	9/12
Kathryn Lanyon	A	√	ABS	ABS	ABS	NA	ABS	ABS	ABS	ABS	ABS	ABS	ABS	1/12
Jo Haw	A	√	√	√	√	NA	√	√	√	A	ABS	ABS	A	7/12

A apology **ABS** absent **TC** via Teleconference

COMMITTEE PARTICIPATION 2017/18

Board members	Community Advisory	Finance, Audit & Risk	Quality, Safety & Clinical Governance	Board Excellence in Governance
Wendy Gladman	1/1			3/3
Marlies Eicher		4/5	6/6	1/1
Gayle Smith			3/5	
Laurie Maxted	4/4			
Grant Malone		4/5		1/2
Chris Harrison				
Bronwyn Simpson				
Neil Beattie		2/5		
Donna Sherringham			2/3	
Alister Ferguson				2/3
Kathryn Lanyon				
Jo Haw				2/3

REPORT OF OPERATIONS

Safety and Quality

Boort District Health (BDH) is committed to the provision of person-centred care and the delivery of quality, safe, flexible and responsive health care to the community. Under the governance of the Board of Management and in line with the 10 National Safety and Quality Health Service Standards, BDH is focused on delivering health care using systems that as well as protecting the public from harm, continuously improve the quality of care as it is provided. In particular BDH supports the goals of governing for safety and quality in health services and partnering with consumers.

We strive to do this through recognising that, in order to achieve our goals, we must work consistently at developing and maintaining our partnerships with the community. In defining this link BDH encourages community representation on a number of our committees, opening channels of communication with our consumers to ensure our community is confident they receive the highest standard of care in a safe environment and offering opportunities for feedback and input into delivery and planning.

Boort District Health's principle to deliver person-centred care means that we are focused on delivering care, support and services that are personalised and focused on individual needs and preferences. Via our regular forums, meetings, feedback forms, surveys and day-to-day communication we have worked to ensure there is ongoing consultation and collaboration.

Following re-accreditation surveys in 2017, our organisation has maintained all requirements for ongoing accreditation under the National Safety and Quality Health Services Standards and the Home Care Common Standards. In May 2018, Boort District Health also met all requirements for re-accreditation under the Residential Aged Care Accreditation Standards. We are very proud of these results as they demonstrate the strong commitment of all staff towards consistently delivering a high level of care to our patients, residents and wider community.

Our organisation is committed to working in partnership with our consumers, patients, residents and clients to continuously improve our services, and engage with the community about safety and quality, in order to create and sustain an organisation where people are at the centre of everything we do. In particular BDH seeks to actively support our consumers as partners in planning, designing, and evaluating our systems and services that we provide.

Financial Management

During the past year Boort District Health met all expectations of the Financial Management Compliance Framework. We have welcomed the ongoing support from our independent Finance, Audit and Risk Committee members and internal and external auditors. The Finance and Audit Committee has been reviewing and implementing the Standing Directions of the Minister for Finance that details health services compliance requirements. These standing directions are reviewed annually and Boort District Health has been assessed during the past year to ensure that full adherence to all compliance-related criteria is achieved and maintained, including meeting all Health Purchasing Victoria requirements.

Community Partnerships

BDH believes in a strong relationship with Boort and the surrounding community. Our ability to partner effectively with the community means we ensure a strong consumer focus is instrumental in our service planning, designing of care and importantly in our service measurement and evaluation.

As well as maintaining very positive working relationships with neighbouring rural health services, including Kerang, Cohuna, Inglewood, Rochester, Bendigo and Heathcote, BDH has valuable partnerships with a wide range of entities, including:

• Ladies Auxiliary

The Boort District Health Ladies Auxiliary continue to meet monthly with the CEO and/or Director of Clinical Services and their volunteer efforts in raising funds through the Boort District Health Opportunity Shop has enabled the donation of a range of items to BDH, including new portable lifting machine for our aged care area. In addition, the Ladies Auxiliary have very generously contributed $50,000 during this past year towards the purchase of an Orthopantomogram (OPG) dental x-ray machine and dental equipment, as part of the redevelopment of the dental facilities. An OPG provides a panoramic view of the mouth, teeth and bones of the upper and lower jaws. We are extremely grateful for the enormous support that the Ladies Auxiliary provide.

• Boort District School P-12

Students of the Boort District School are regular visitors and participants in our aged care activity program. The children's enthusiasm and energy brightens any day by sharing their day with our residents, patients and clients. The students have been involved in a number of specific activities at BDH including the making of Easter bonnets and colourful drawings for display in the Op Shop window. BDH has engaged with the school to also offer a number of work experience placements and a school based traineeship within the hospitality area.

• Boort Men's Shed

The Men's Shed is co-located with the health service and provides an important service; encouraging men to come together to share information and resources, develop new skills and complete community projects. The men meet each Tuesday and Thursday and their skills are always in demand. A number of our male residents of Loddon Place visit the Men's Shed to participate in their work and collaborate with the men to remain engaged in the community.

• Primary Care Partnerships

BDH is an active member of the Bendigo Loddon Primary Care Partnership (BLPCP). This group has a role in building sustainability across the health care services in our region. Within the BLPCP there are a number of working groups that focus on areas such as diabetes, women's health, physical activity, mental health and aged care projects. This partnership has again been extremely important in supporting our staff by providing skills based workshops (including on Health Literacy), a network for accessibility to services and a broad variety of health care options.

• Murray Primary Health Network

The Murray PHN works together with BDH to strategise solutions to promote service access across our region. One of the major focus areas BDH are directly involved in is improving access to cancer services with the aim to improve survivorship. The cancer survivorship project is ongoing and the partnership has developed pathways of care for the key forms of cancer affecting our region that are being utilised currently prior to review and regional roll out. The Murray PHN also extended the trial of the Telehealth model and BDH now confidently use this equipment to connect with health care professionals across a range of specialities such as Gerontology, Palliative Care, Specialists clinics, Cardiology and Aged Care Assessment Services.

During the past year, the Murray PHN have also supported a BDH Registered Nurse, Mohammed Mubarak Meera Sahib, to undertake postgraduate training through the provision of a $10,000 RIPERN Scholarship Grant. A rural and isolated practice endorsed registered nurse (RIPERN) is a nurse who has undertaken additional training and is able to provide a wider range of primary care and emergency services from rural health services. RIPERNs are able to help fill the gap in rural medical settings.

Clinical Governance

Our Safety, Quality and Clinical Governance Committee, chaired by Board member Donna Sherringham, monitors a range of core quality-related activities and reports directly to the Board. The key aim is ensuring accountability for the quality of care that we deliver throughout BDH, facilitating continuous improvement

and minimisation of risk through fostering an environment of excellence in care. This year the committee has reviewed and revised the reporting model for clinical indicators, including trending of BDH-specific data.

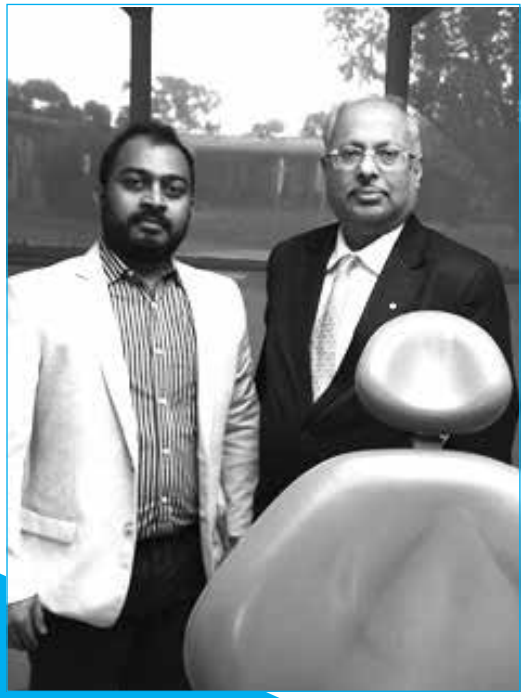
Dr Sajeev Koshy, Director of Dental Services, continues to support the Dental Clinic by providing clinical excellence and oversight across our dental program.

Primary Care
St Anthony Family Medical Practice provide support to BDH through the provision of general practitioner services for Boort.

Monthly podiatry services are provided by Nicole Hocking and Ryan Evans (Loddon Valley Physiotherapy) continues to deliver a comprehensive physiotherapy program to our aged care residents four days per week, and as required to our acute and Transitional Care Program patients.

Dental Services
BDH continues to offer dental services to both public and private patients. Our Dentist, Dr Manoj Mogilisetty, provides the following: Emergency dental Care; Preventative oral health treatments; Prosthodontics (e.g. Dentures, Crown and Bridge); Orthodontic referrals; Children's dental health care (Medicare, public and private).

The BDH Dental clinic has a strong commitment to our region and during the year the dental service provided outreach services to nearby towns. These outreach services are very popular and patients are encouraged to make an appointment at the dental clinic in Boort for more extensive treatment. The dental clinic also provides dental services to Mallee District Aboriginal Services (MDAS). This has been an important relationship. The Mallee District Aboriginal Service provides transport to the dental clinic to Boort for more specific services when required. The total dental attendances over the past year as of end of June 2018 was 1,736.



Above:
Dr Manoj Mogilisetty and
Dr Sajeev Koshy OAM

Students
Each year BDH endorses the student training program from a number of tertiary and registered training organisations. A planned student placement program runs annually for nurses both registered and enrolled. In addition, at BDH, we host medical students, pharmacy students, health service assistant students and allied health trainees for placement times throughout the course of their education.

BDH is part of the Northern Districts Post Graduate Nursing Program also employs graduate nurses to undertake graduate nursing experience in our small rural health services and in collaboration with St Anthony's Family Medical Practice.

Support Services
Food Services
Boort District Health is committed to providing high quality and nutritious meals that reflect patient and resident's dietary needs. During the year the food services team produced, delivered and served 23,714 meals. The Spanner Café continues to provide a special place for community, clients, residents and

patients to catch up, share lunch, a snack, cup of tea or coffee prepared by our friendly Café staff.

This year saw the establishment of a Nutrition and Hydration working group at BDH. The group is looking at ways to further improve food service practices and improve nutrition and hydration for residents of Loddon Place based on current best available evidence. An outcome from the Nutrition and Hydration working group has seen the establishment of a new position of Ward Assistant. This new role works in collaboration with the residents, clinical staff and kitchen staff to ensure that the resident's nutritional needs and food preferences are being implemented. Northern District Community Health Service dietitian Leesa van Ruiswyk and speech pathologist Melanie Read-Wishart provided training in dietetics and texture modified food preparation for support and clinical services staff.

Laundry Services

This year BDH commenced laundering all linen internally. BDH had previously outsourced all non-resident linen to a commercial linen service. The establishment of BDH's own linen service has provided an increase in work hours available for staff. Support staff have worked in partnership with the clinical services to implement the new laundry service into BDH.

Cleaning

Domestic Services staff continue to work diligently to maintain a clean environment. BDH cleaning results are consistently over 90%. The annual external cleaning audit was conducted in 2017 with an outcome of 98%. Fantastic Results!

Grounds & Buildings

BDH completed renovation works at Boort Primary Care as part of 2016-17 Health Service Violence Prevention Fund – Round 2. The new works included renovation of reception, waiting area, improved lighting, security and new furnishings.

New access paths have been installed connecting the primary care service to the health service allowing safer access for the community. All emergency evacuation points have been upgraded with new easy access concrete paths installed. A new driveway has been installed at the delivery dock to allow meals on wheels volunteers' easy access to meal pickup and deliveries.

Murray to Moyne

The Boort District Health cycling team has been participating in the Murray to Moyne bicycle relay event since 2007. 2018 saw the 32nd year of this event. Over the past years, the Boort Team has raised over $170,000 for Boort District Health. The funds raised have helped to purchase Urgent Care Centre (UCC) procedure lights, i-STAT machine, pocH blood analyser, diagnostic sets, AED electrodes, ultrasound machine, patient trolleys, blood pressure cuff and various other items for the UCC. All proceeds from this year's event will be used towards the purchase of a new Dental Chair as part of the redevelopment of the Dental Clinic. This will provide the Dental Clinic with two dental chairs and ensure less waiting time and provide extra services to Boort and the surrounding communities.

QUALITY OVERVIEW

Boort District Health continues to have a strong focus on our commitment to providing excellence in service delivery. The Director of Clinical Services, Donna Doyle, and the Director of Medical Services, Dr Craig Winter, are active members of the Loddon Mallee Regional Clinical Council.

We are working collaboratively across BDH to ensure that all people accessing our services obtain the most effective care at the right time in the most appropriate setting. We are committed to being an innovative and transformational organisation.

Safety is the foundation of everything we do. We take pride in our ability to provide high quality care and services. We are continually seeking ways to further improve by developing new, evidence-based models of care. We remain focused on delivering person centred care, ensuring every care recipient has a positive experience. Our clinical staff have access to a comprehensive range of clinical guidelines. These are available electronically and are used to guide practice and to facilitate comprehensive care delivery.

There is an organisation-wide risk register which is informed from the Victorian Health Incident Management (VHIMS) electronic reporting system and regularly reviewed by the Operational Management Group and reported up to the Board of Management through the Safety, Quality and Clinical Governance Committee.

Dedicated Standards Champions on our staff work with us to continuously look for ways to improve our delivery of health care and in doing so help us to ensure we deliver best practice.

At BDH we are committed to providing an inclusive organisational culture where all our staff are valued and recognised for their unique qualities, ideas and perspectives. All staff continue to attend annual mandatory training days each year. As well as providing an overview of standard requirements such as fire and evacuation processes, basic life support assessment, Occupational Health and Safety updates and person centred care education.

Within our quality program we welcome feedback regarding the quality of our service. Feedback forms are available throughout our health service and also via our website.

OVERVIEW OF CLINICAL SERVICES

Residential Aged Care ~ LODDON PLACE

Loddon Place offers 25 permanent aged care beds to residents with scope to flex an additional 3 beds for respite, Transition Care Program or permanent care as needed. Our facility offers single rooms with individual ensuites, temperature control, televisions, direct line telephones, ceiling hoists for mobility, call bell access and outlook into one of our many, now well established courtyards and garden areas.
Winter and summer courtyards with raised garden beds, water features, shade and shelter as well as BBQ and vegetable garden give our residents much to interact with. Loddon Place also offers a secure gopher parking bay with automatic gate access.

Families and visitors to Loddon Place utilise any of a number of small sitting areas for private time with loved ones. Our activity room is fully equipped with kitchen facilities, television, bathroom and a range of activities for use for regular activities or by families for small gatherings or sharing a meal.
Our integrated activity program run by Sandra Poyner includes scheduled activities for our aged care residents across 5 days of the week. It includes a regular program with the local Boort District School and other community groups and events such as the Boort Show, Men's Shed, visiting entertainers and church services, the RSL, senior citizens and Apex. Residents enjoy regular outings to the main street, the library, the lake surrounding sights as well as the in-house program of cooked breakfasts, bingo, pet therapy, music, craft and cooking.

Workforce Review and Design

Boort District Health continues to evolve its workforce to recruit and retain employees across all areas of service delivery. Staffing is in accordance with the Safe Patient Care Act 2015 and varied according to level of need, patient numbers as well as acute and UCC throughput. Upskilling of staff through successful grant applications sees BDH staff now being trained in limited radiology, RIPERN and Advanced Life Support.

A close working relationship with Ambulance Victoria has introduced new skills to our clinical team and along with clinical support provided by the St Anthony Medical Group and our Director of Medical Services, Dr Craig Winter, our knowledge, skills and ability to triage and treat many and varied presentations continues to grow.

Acute and UCC Services

With an average of over 500 presentations annually our UCC is supported by the St Anthony Medical Group on call system with VMO's providing both on site and telephone medical advice. Boort has successfully embedded the use of Telehealth to ensure patients are not disadvantaged due to our rural location in accessing professional services including but not limited to eye and ear specialist, emergency physician review, geriatrician and aged care assessments.

Medical Services

Dr Craig Winter, provides expertise as our Director of Medical Services. Dr Winter visits BDH monthly to participate as chair of the Medical Staff Committee, attend the Safety, Quality and Clinical Governance board subcommittee, our Medication Advisory committee, undertake case reviews and assist in training and education for clinical staff. The Boort Medical Practice provides VMO services with St Anthony's principals Dr Adel Asaid and Dr Poate Radrekusa along with Dr Michelle Medenilla delivering medical services to acute, urgent care, aged and community residents.

Dental Services

BDH continues to operate a single chair clinic to both public and private dental patients. Our dentist Dr Manoj Mogilisetty provides exceptional emergency dental care, preventative oral treatments, prosthodontics, children dental health and orthodontic referrals. The exciting redevelopment of dental at Boort will see the dental clinic relocate onsite with the health service and increase service scope to include 2 dental chairs as well as OPG facilities and sterilisation.

Community Services
Boort District Health District Nursing delivers registered nurse services to Boort and surrounding district community clients 5 days a week with provision to weekend services through our Urgent Care Centre as required. The service includes, medication management, complex wound care, post-acute care, infusion pump and pain management as well as general health monitoring.

Planned Activity Groups run 4 days a week in our Day Centre. Often the groups are out and about in the community or neighbouring towns enjoying meals, seeing shows, participating in community events or doing craft and other activities in-house. Maree and Carmel make a great team delivering the following regular programs;

- Down the street
- Creative living
- Talk and tucker
- Ladies and laughs
- Film club and
- Men on the move

Allied Health assistant Dee Smith works with Ryan Evans of Loddon Valley Physiotherapy to offer weekly hydrotherapy sessions in Kerang, Staying Strong exercise groups twice a week, low impact exercise in our aged care facility as well as regular walking groups and remedial therapies as required.

Transitional Care is offered by Boort District Health to both bed based and home based clients. Occupancy has increased this year and it is rewarding to see our community clients rehabilitated with our assistance to optimal independence. The program facilitates allied health and home based services as well as assessment for and purchase of aids and equipment to assist clients work towards agreed health care goals.

Volunteers form an invaluable part of the BDH team. Mr and Mrs Everall go above and beyond to tend to our beautiful gardens and surrounds. Our current suite of volunteers assist across the following BDH run programs;

- Transport both locally and regionally to medical appointments.
- Escorting aged care residents on outings
- Assist with day centre programs
- Run our Monday movie afternoon and
- Deliver Meals On Wheels

Support Services staff are now well set up in the new kitchen and commercial laundry. Laundry services moved to a full in-house service this year which saw increase in positions offered at BDH and all acute as well as aged care linen being laundered onsite.

Staff received training and education by our visiting Dietician and Speech Pathologist in diet modifications, texture modified foods, fortified menu planning and menu review.

Domestic and maintenance services continue to set the standard high and BDH boast exceptional results with cleaning audits and feedback from community regarding our building and facilities.
The Spanner Café is now a well-known communal hub for not just the health service but the community in general. The collaboration of patients, residents, visitors and staff at the café gives a wonderful atmosphere to the health service. BDH are working towards achieving the HEAS (Healthy Eating Advisory Service) tick of approval in providing healthy options.

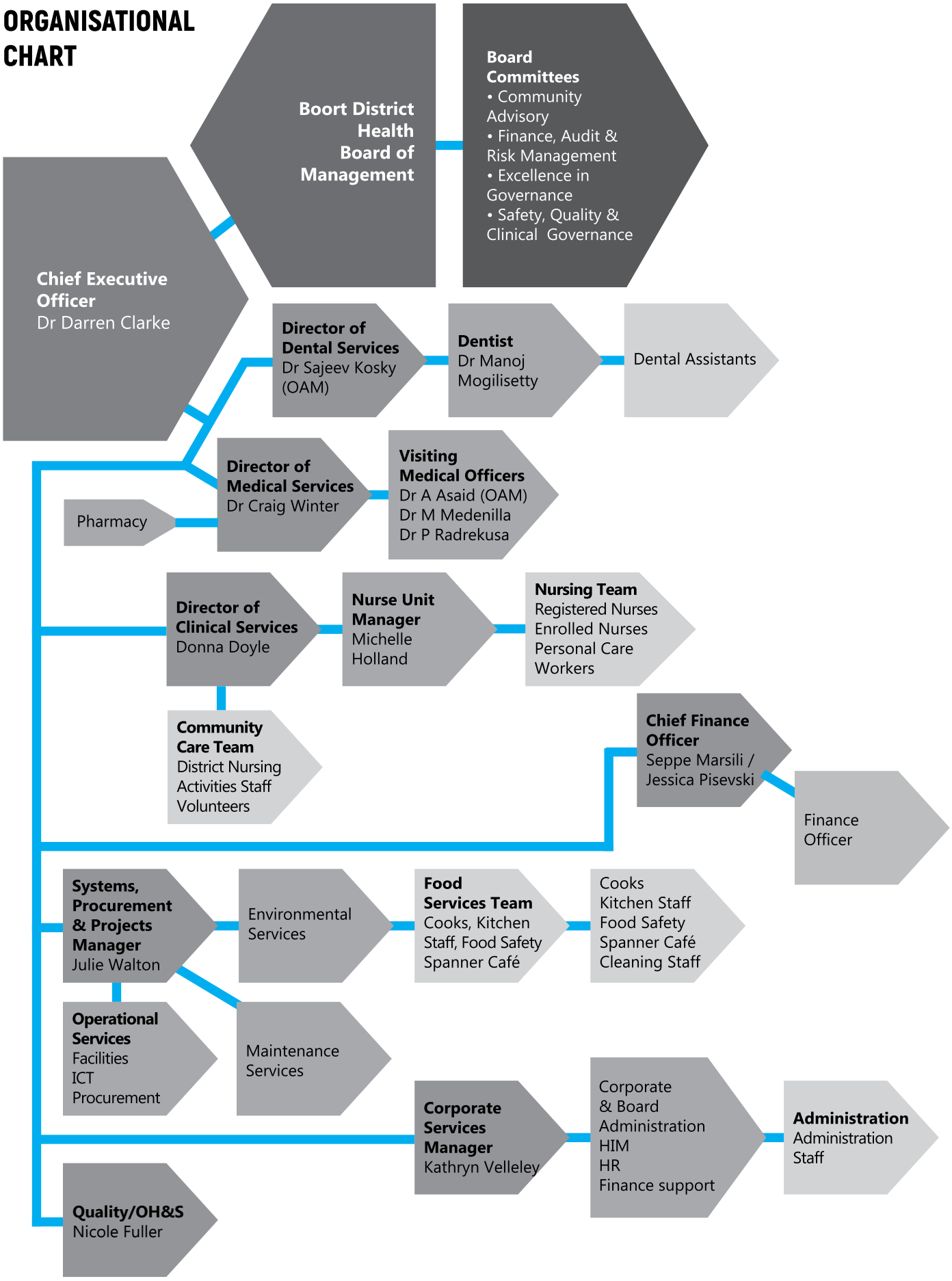
Aged Care Activities
The Aged Care Activities program is delivered by coordinator Sandra Poyner five days per week. There are additional scheduled activities offered to residents for example, bingo on Thursday night. Activities are provided in the evening and weekends. The types of activities include but are not limited to: one on one therapies/activities, pet therapy, cooked breakfasts, games, music, craft, cooking, movies and visiting services such as church and entertainers. The RSL held a moving and valued Anzac service in the aged care facility, which enabled our returned servicemen to be honoured.

District Nursing Services
The District Nursing Service is provided by Registered Nurses. The nurses care for clients in the community five days each week. The nurses have cared for 54 clients over 1300 visits in the 12 month period. Our dedicated team attend to multiple health needs which include wound dressings, complex medication therapies as well as assessments and support. Within the District Nursing Service there are additional hours provided for clients who are involved with the Transitional Care Program. The Transitional Care Program was delivered to 9 clients and involved 70 contact visits.

Volunteers
BDH currently has 32 volunteers registered. The assistance provided by volunteers is invaluable. They are involved in community activity groups as well as residential aged care. They also provide a range of support services including transporting community members both locally and out of town to appointments. In the 12 month period to date they have assisted 21 clients with long distance transport to various appointments.

Planned Activity Group and Social Support	80 clients	2,019 points of contact
Allied Health Assistant	4 programs	3 days per week
ACTIVITIES	26 residents	Staffed 5 days/week
District Nurse Service	54 clients	1,300 points of contact
Transition Care Program	9 clients	70 points of contact
VOLUNTEERS	32 volunteers	Assisted with 11 programs

ORGANISATIONAL CHART



ENVIRONMENTAL PERFORMANCE

Boort District Health is committed to improving the environmental sustainability of our operations and minimise the environmental effects associated with our operations to the greatest extent possible. We do this by, minimising waste, being responsible with our purchasing practices and monitoring BDH's environmental impacts.

To date Boort District Health has:

- ✓ Continued use of electronic meeting program enabling us to be paperless at all meetings
- ✓ Participation in environmental friendly processes within Boort District Health; such as printer cartridge and battery recycling, separation of comingled wastes (composting, bricks, pipes, plastics etc.) and regular waste audits
- ✓ Bicycle parking and scooter facilities for staff and visitors to BDH
- ✓ Installation of Solar Power to reduce dependency on the power
- ✓ Installation of Solar Hot Water for all patient/resident showers with gas boost when required
- ✓ All external windows are double glazed on the new facilities
- ✓ Energy efficient individual heating and cooling for all rooms
- ✓ Underground water tank to collect water for use in grey water system and garden areas
- ✓ Installation of water saving devices in all showers and toilets
- ✓ Garden planting – drought friendly selection watered with grey water when possible. Automatic watering installed
- ✓ Installation of energy efficient generator to power hospital during power outages
- ✓ All Lighting is set on timing system to regulate external lighting. Lighting is LED fluorescent tubing

SERVICE PERFORMANCE REPORTING 2017-18

	Acute Health	Aged Care	Primary Health	Total
Admitted Patient				
1. Separations Same Day	2			2
Multi Day: Acute + TCP	97			97
Total Separations				
2. Bed Days				
i. Acute	810			810
ii. Nursing Home type	76			76
iii. Residential Care		9,727		9,727
iv.				
Non Admitted Patients				
3. Urgent Care	464			464
4. Non-admitted patients				
5. Ambulatory Services (Community)				
District Nursing			1,399	1,399
Transitional Care			79	79
Planned Activity			1,553	1,553
Meals on Wheels	1,741			1,741
Dental				
Pathology Collection	61			61
Total (Items 3,4,& 5)				
Total Occasions of Service	3,251	9,727	3,031	16,009

PERFORMANCE PRIORITIES

Quality and safety

Key performance indicator	Target	Result
Health service accreditation	Full compliance	Full compliance
Compliance with cleaning standards	Full compliance	Full compliance
Compliance with the Hand Hygiene Australia program	80%	96%
Percentage of healthcare workers immunised for influenza	75%	94%
Victorian Healthcare Experience Survey – positive patient experience – Quarter 1	95% positive experience	Full Compliance*
Victorian Healthcare Experience Survey – positive patient experience – Quarter 2	95% positive experience	Full Compliance*
Victorian Healthcare Experience Survey – positive patient experience – Quarter 3	95% positive experience	Full Compliance*
Victorian Healthcare Experience Survey – discharge care – Quarter 1	75% very positive experience	Full Compliance*
Victorian Healthcare Experience Survey – discharge care – Quarter 2	75% very positive experience	Full Compliance*
Victorian Healthcare Experience Survey – discharge care – Quarter 3	75% very positive experience	Full Compliance*

*Less than 42 responses received for the period due to relative size of the Health Service

Financial sustainability

Key performance indicator	Target	Result
Operating result ($m)	0.00	- 0.27
Trade creditors	60 days	35 days
Patient fee debtors	60 days	11 days

Strong governance, leadership and culture

Key performance indicator	Target	Actual
People matter survey – percentage of staff with an overall positive response to safety and culture questions	80%	91%
People matter survey – percentage of staff with a positive response to the question, "I am encouraged by my colleagues to report any patient safety concerns I may have"	80%	100%
People matter survey – percentage of staff with a positive response to the question, "Patient care errors are handled appropriately in my work area"	80%	94%
People matter survey – percentage of staff with a positive response to the question, "My suggestions about patient safety would be acted upon if I expressed them to my manager"	80%	84%
People matter survey – percentage of staff with a positive response to the question, "The culture in my work area makes it easy to learn from the errors of others"	80%	91%
People matter survey – percentage of staff with a positive response to the question, "Management is driving us to be a safety-centred organisation"	80%	93%
People matter survey – percentage of staff with a positive response to the question, "This health service does a good job of training new and existing staff"	80%	89%
People matter survey – percentage of staff with a positive response to the question, "Trainees in my discipline are adequately supervised"	80%	86%
People matter survey – percentage of staff with a positive response to the question, "I would recommend a friend or relative to be treated as a patient here"	80%	94%

PERFORMANCE PRIORITIES

Reporting against Priorities Part C – Activity and Funding

Funding type	Activity
Small Rural	
Other specified funding	N/A
Small Rural Acute	4
Small Rural HACC	334
Small Rural Residential Care	21,334
Health Workforce	2
Total	21,674

Primary health care

Service	Actual Activity 2017-18
Speech Pathology	43.6 hours of service
Community health nursing	N/A
District nursing	1300 visits
Dietetics	74 hours of service
Podiatry	237 hours of service

STATEMENT OF PRIORITIES

Service Profile

Boort District Health is a small rural health service located in central Victoria, providing a diverse range of health services to Boort and neighbouring communities.

Boort District health has a catchment population of approximately 3,455 people.

Boort District Health has been providing health services to the community since 1961. Services provided include: medical inpatient care; palliative care; aged care; ambulatory care through the urgent care centre, general nursing and diagnostic monitoring services; physiotherapy services in acute, aged care and community settings; podiatry services in aged care and community settings; community outreach including district nursing, planned activity and social support services; and a dental chair that provides services to public and private patients and a children's dental service.

A substantial redevelopment of the acute and residential care facilities at Boort District Health was completed in early 2017.

Goals	Strategies	Health Service Deliverables	Health Service Deliverables
Better Health A system geared to prevention as much as treatment Everyone understands their own health and risks Illness is detected and managed early Healthy neighborhoods and communities encourage healthy lifestyles	**Better Health** Reduce Statewide Risks Build Healthy Neighborhoods Help people to stay healthy Target health gaps	Participate in the design and pilot of integrated, innovative models of care to improve health outcomes in collaboration with the Loddon and Gannawarra Health Services Executive Network (LGHSEN).	ACHIEVED · Working collaboratively with LGHSEN colleagues to implement Loddon Gannawarra Healthy Hearts and Lungs Program (funded through Murray PHN). Aim to develop and embed best practice local referral. To monitor % increase of uptake on assessment and rehabilitation services from commencement of the program in March 2018 and % clients completing cardiac and pulmonary rehabilitation program(s). · Supported Loddon Gannawarra Buloke Primary Mental Health submission to the Murray Primary Health Network (advised successful in Feb 2018). To develop a Local Community Multi-Disciplinary Health Team model to support people with Mental illness.
		Actively promote a better understanding and ownership of health issues by the community, by advocating healthy lifestyle choices. To address the disproportionately high rates of smoking in the Loddon Shire, BDH will build community awareness about smoking cessation by encouraging our health professionals to raise the topic of smoking status with patients and offer referral to relevant supports such as Quitline and General Practitioners.	ACHIEVED · Ongoing Health promotion focus across BDH. · Health Literacy Workshop conducted at BDH in April 2018 · Engaging with Community Advisory Committee to promote awareness in the community.
		Achieve a 15% increase in referrals from the previous year for the Smiles 4 Miles program, which aims to improve the oral health of children and their families.	ACHIEVED · Increasing focus on provision of oral health initiatives specifically targeting children.
		Pursue discussions for the co-location on site of locally delivered services provided by the Northern Districts Community Health Service (NDCHS).	ACHIEVED · RHIF (Round 2) $993K funding received Feb 2018 for relocation of Dental Clinic. This will also enable construction of two consulting rooms to facilitate co-location of NDCHS on BDH site. Architect has been engaged and completing final specifications in preparation for tender process (June 2018).

Goals	Strategies	Health Service Deliverables	Health Service Deliverables
Better Access Care is always there when people need it More access to care in the home and community People are connected to the full range of care and support they need There is equal access to care	**Better Access** Plan and invest Unlock innovation Provide easier access Ensure fair access	Work collaboratively to ensure that all people accessing our services obtain the most effective care at the right time in the most appropriate setting. Boort District Health will actively promote access to care in the home and community.	ACHIEVED · Ongoing
		Apply for approval to be a provider for the Commonwealth Home Care Packages.	ACHIEVED · Limited scope exists to cost-effectively provide district nursing services to support expanded Home Care across 7 days / week.
		Collaborate with Murray Primary Health Network and Boort Medical Practice to increase access to external services and specialists as required through telehealth	ACHIEVED · Actively promoting use of telehealth services. · Also exploring potential additional access opportunities through Flying Doctor Telehealth (RFDS).
		Consult with consumers to identify particular access strategies to ensure that our services remain responsive to the changing needs of the community.	ACHIEVED · Consumer Advisory Committee are actively engaged. · BDH Strategic Plan 2015-2018 to be reviewed and new plan developed in conjunction with BLPCP Executive Officer (Public Consultation proposed for September November 2018)

Goals	Strategies	Health Service Deliverables	Health Service Deliverables
Better Care Target zero avoidable harm Healthcare that focusses on outcomes Patients and carers are active partners in care Care fits together around people's needs	**Better Care** Put Quality First Join up care Partner with patients Strengthen the workforce Embed evidence Ensure equal care	Review the 2017 People Matters survey results and establish action plans in conjunction with staff by December 2017.	ACHIEVED · BDH People Matter Working Party established and meeting regularly. · Action Plan developed in consultation with staff

Goals	Strategies	Health Service Deliverables	Health Service Deliverables
	Mandatory deliverables against 'Target zero avoidable harm';		
	Develop and implement a plan to educate staff about obligations to report patient safety concerns	Develop and implement a plan to ensure that all staff are fully aware of their obligations to report safety concerns by November 2017	ACHIEVED · Incorporated into People Matter Working Party · Incorporated into Mandatory Training sessions for all staff. · Reviewed 'Above and Below the Line Behaviours' in consultation with all staff (June 2018).
	Establish agreements to involve with external specialists in clinical governance processes for each major area of activity (including mortality and morbidity review)	Work with the Loddon Mallee Regional Clinical Council (LMRCC) to review the role of the Director of Medical Services and establish roles of external specialists in clinical reviews.	ACHIEVED · DMS and DCS participating on LMRCC
	In partnership with consumers, identify 3 priority improvement areas using Victorian Healthcare Experience Survey data and establish an improvement plan for each. These should be reviewed every 6 months to reflect new areas for improvement in patient experience.	Utilise patient/client feedback data to identify three priority areas for improving patient experience, and develop an implementation plan.	ACHIEVED BDH Priority Areas are: · Hydration/Nutrition (Working Party established) · Members of Community Advisory Committee and Board to interact regularly with patients / residents / clients – document & feedback de-identified data to staff for improvement · Reassuring community that patients who attend the Urgent Care Centre are able to access appropriate care without a doctor necessarily physically present on site (consult via telehealth).

OCCUPATIONAL VIOLENCE

Occupational violence statistics	Activity
Workcover accepted claims with an occupational violence cause per 100 FTE	0
Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	0
Number of occupational violence incidents reported	0
Number of occupational violence incidents reported per 100 FTE	0
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	0

For the purposes of the above statistics the following definitions apply:

Occupational violence
any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment.

Incident
any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment.

Accepted Workcover claims
Accepted Workcover claims that were lodged in 2017-18.

Lost time
is defined as greater than one day.

Injury, illness or condition
This includes all reported harm as a result of the incident, regardless of whether the employee required time off work or submitted a claim.

Responsible Bodies Declaration as at 30 June 2018
In accordance with the Financial Management Act 1994, I am pleased to present the report of operations for Boort District Health for the year ending 30 June 2018.

Mrs Wendy Gladman
Board Chair
BOORT
30 June 2018

WORKFORCE RESOURCES

As at 30 June 2018 Boort District Health employed 87 staff equating to 54.1 persons in full-time equivalent units (FTE).

Hospitals Labour Category	June Current Month 2018	June 2018 YTD	June 2017	June YTD 2017
Nursing	22.94	19.82	19.44	19.92
Administration/Clerical	5.38	6.94	6.26	7.13
Medical Support	4.05	4.07	3.08	3.23
Hotel/Allied Services	19.92	19.61	17.81	19.49
Medical Officers	0.17	0.18	0.17	0.15
Ancilliary Support	1.68	1.68	1.68	1.73
Grand Total	**54.14**	**52.30**	**48.45**	**51.66**

Application of employment and conduct principles

Boort District Health is committed to upholding the principles of merit and equity in all aspects of the employment relationship. To this end, we have policies and practices in place to ensure all employment related decisions, including recruitment, promotion, training and retention, are based on merit.

Any complaints, allegations or incidents involving discrimination, vilification, bullying or harassment are taken seriously and addressed. All staff are provided with education and training on their rights and responsibilities and are provided with the necessary resources to ensure equal opportunity principles are upheld.

STATUTORY REPORTING REQUIREMENTS

Additional Information Available on Request
Consistent with FRD 22H (Section 5.19) Boort District Health Service confirms that subject to the provisions of the FOI Act, the following information is retained by the Accountable Officer:

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

Health Services Act
Boort District Health does not administer any Acts directly. The Health Services Act 1988 is the vehicle by which the Boort District Health is incorporated, and prescribes the manner in which BDH is regulated.

Building Act 1993
This Act sets standards for the construction of new buildings and for the maintenance of existing buildings. It includes provisions to protect the safety and health of building users, and cost effective construction is encouraged.

During the year the following works and maintenance were undertaken to ensure conformity with the relevant standards:

Building Works	
Buildings certified for approval	Nil
Works in construction and the subject of Mandatory inspections	Nil
Occupancy Permits issued	Nil
Maintenance	
Notices issued for rectification of substandard	Nil
Buildings requiring urgent attention	Nil
Involving major expenditure and urgent attention	Nil
Conformity	Nil
Number of buildings conforming with standards	1
Number brought into conformity this year	1

Carers Recognition Act 2012

Boort District Health takes all practicable measures to ensure;

- its employees and agents have an awareness and understanding of the care relationship principles
- all practicable measures to ensure that persons who are in care relationships and who are receiving services in relation to the care relationship from the care support organisation have an awareness and understanding of the care relationship principles; and
- all practicable measures to ensure that the care support organisation and its employees and agents reflect the care relationship principles in developing, providing or evaluating support and assistance for persons in care relationships.

Freedom of Information Act 1982

The Freedom of Information Act provides members of the public with a means of obtaining information held by Boort District Health. In the majority of cases, a Freedom of Information (FOI) request is to gain access to a patient's own medical record. In accordance with the Act an application fee is payable upon request and administrative charges apply.

Protected Disclosure Act 2012

The Protected Disclosure Act is designed to protect people who disclose information about serious wrongdoing within the Victorian public sector and to provide a framework for the investigation of these matters.

The Act's key objectives are to:

- Promote a culture in which people feel safe to make disclosures;
- Protect these people from recrimination;
- Provide a clear process for investigating allegations; and
- Ensure that investigated matters are properly dealt with.

Boort District Health has a prescribed procedure in place for dealing with disclosures made under the Act. A copy of the procedures are available from the BDH Privacy Officer (Protected Disclosure Officer) to whom all enquiries on this matter should be directed. In the year ended 30 June 2018 there were no disclosures made to Boort District Health under the Protected Disclosure Act.

Privacy

Boort District Health is committed to the protection of privacy for all patients, residents, clients and staff.

Consultancies

Details of consultancies (individually valued at less than $10,000)

In 2017-18, there were no consultancies individually valued at less than $10,000 (exclusive of GST).

Details of consultancies (valued at $10,000 or greater)

In 2017-18, there was 1 consultancy where the total fees payable to the consultants were $10,000 or greater. The total expenditure incurred during 2017-18 in relation to these consultancies is $13931.82 (excl. GST). Details of individual consultancies can be viewed at www.bdh.vic.gov.au .

Consultant	Purpose of consultancy	Start date	End date	Total approved project fee (excluding GST)	Expenditure 2017-18 (excluding GST)	Future expenditure (excluding GST)
Applied Aged Care Solutions	Review of Aged Care Funding Instrument subsidies	Sept 2017	Review June 2019	15,000.00	13,931.82	10,000.00

Information and communication technology (ICT) expenditure
The total ICT expenditure incurred during 2017-18 is $134,083 (excluding GST) with the details shown below:

Business As Usual (BAU) ICT expenditure		Non-Business As Usual (non-BAU) ICT expenditure	
Total (excluding GST)	**Total=Operational expenditure and Capital Expenditure (excluding GST) (a) + (b)**	**Operational expenditure (excluding GST) (a)**	**Capital expenditure (excluding GST) (b)**
$124,793.87	$124,793.87	$ 9,289.71	$0

Ex-Gratia Payments
There were no Ex-Gratia payments made by Boort District Health during the 2017/2018 reporting period.

Victorian Industry Participation Policy Act 2003
During the 2017/2018 financial year there were zero contracts which met the specified criteria under this policy.

Pecuniary Interest
Boort District Health subscribes to Government principle and practice, that appointees to Government bodies should have records of personal, professional and commercial integrity. As such all Board Members are required to complete a Declaration of Private Interest prior to their appointment to the Board of Management. This provides for disclosure of private interests or other interests, which would conflict with the proper performance of their Board member duties. In addition all new Board members are required to consent to the conduct of formal probity checks.

Industrial Relations
Industrial relations within Boort District Health have been harmonious and no time was lost due to industrial disputes during the reporting period.

Overseas Visits
During 2017-18 there were no overseas visits undertaken on behalf of BDH by a paid member of the staff.

Publications
Boort District Health produces the following publications annually:
- Annual Report of Boort District Health
- Quality of Care Report of Boort District Health

Workcover and Work Safety
The Occupational Health and Safety Committee as established under the Occupational Health and Safety Act 2004 includes staff representation, plays a major role in investigating unsafe work practices and managing staff welfare issues and safety concerns. Under the prescribed criteria, there were three claims submitted to the Insurer.

Factors Affecting Performance
During 2017-18 there were no major changes or factors which affected the achievements or performance of Boort District Health.

Competitive Neutrality
Boort District Health supports the Victorian Government's Competitive Neutrality Policy as outlined in the Guide to Implementing Competitively Neutral Pricing Principles. We see competitive neutrality as a complementary mechanism to the ongoing quest to increase operating efficiencies by way of benchmarking and embracing better work practices.

Therefore we will continue to comply with Victorian Legislation as it is introduced to reflect the objectives of the National Competition Policy.

Risk Management
The BDH Risk Management Program is regularly reviewed to ensure that all risks are appropriately prioritised and appropriate actions for mitigation of our risks are developed. Boort District Health has risk management processes in place consistent with the Australian/New Zealand Risk Management Standard AS/NZS ISO 31000:2009 and an internal control system is in place that enables the executives to understand, manage and satisfactorily control risk exposures. The Safety and Quality Committee verifies this assurance and that the risk profile of Boort District Health has been critically reviewed within the last 12 months.

Equal Employment Opportunity
Boort District Health is subject to the provisions of the Public Authorities (Equal Employment Opportunity) Act 1990. As such, it wishes to report the following information in respect of equal employment opportunity. Boort District Health is committed to providing an equal employment opportunity workplace free from discrimination for existing and prospective employees.

In promoting an equal employment opportunity workplace the Boort District Health acknowledges and abides by following principles:

- BDH shall obtain through the merit system the best employees possible to deliver its services;
- It shall realise the potential contribution of each employee; and
- Ensure that all employees can pursue their duties free from discrimination and harassment.

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

Occupational Health and Safety
Boort District Health is committed to providing a safe working environment and promoting staff health. Boort District Health Occupational and Safety Committee (OH&S) members completed relevant Occupational Health and Safety Representative training as required during 2017/2018.

OCCUPATIONAL HEALTH AND SAFETY – PERFORMANCE INDICATORS

Health and Safety Indicators	Details	2017-18	2016-17	2015-16
Number of reported OHS hazards/ incidents	Per 100 FTE Employees	72	130	66
Number of 'lost time' standard claims	Per 100 FTE Employees	1.85	11.68	3.23
Average cost per claim for the year*		$62,639.14	$54,564.31	$77,607.06

*including payments to date and an estimate of outstanding claim costs as advised by WorkSafe

Subsequent Events
As at the time of writing this report there were no events subsequent of the reporting date which by their nature and/or amount will have or may have a financial effect on the financial position of the entity.

Attestations:

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

Darren Clarke
CEO
BOORT
30 June 2018

Data Integrity Attestation
I, Darren Clarke, certify that the Boort District Health has put it place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. Boort District Health has critically reviewed these controls and processes during the year.

Darren Clarke
CEO
BOORT
30 June 2018

Conflict of Interest Attestation

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

Darren Clarke
CEO
BOORT
30 June 2018

Financial Management Compliance Attestation

I, Wendy Gladman, on behalf of the Responsible Body, certify that Boort District Health has complied with the applicable Standing Directions of the Minister for Finance under the Financial Management Act 1994 and Instructions.

Mrs Wendy Gladman
Board Chair
BOORT
30 June 2018

COMPLIANCE DISCLOSURE INDEX

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

Legislation	Requirement	Page Reference
Ministerial Directions		
Report of Operations		
Charter and purpose		
FRD 22H	Manner of establishment and the relevant Ministers	2-3
FRD 22H	Purpose, functions, powers and duties	18
FRD 22H	Initiatives and key achievements	23-26
FRD 22H	Nature and range of services provided	3
Management and structure		
FRD 22H	Organisational structure	18
Financial and other information		
FRD 10A	Disclosure index	35
FRD 11A	Disclosure of ex gratia expenses	31
FRD 21C	Responsible person and executive officer disclosures	27
FRD 22H	Application and operation of Protected Disclosure 2012	30
FRD 22H	Application and operation of Carers Recognition Act 2012	30
FRD 22H	Application and operation of Freedom of Information Act 1982	30
FRD 22H	Compliance with building and maintenance provisions of Building Act 1993	29
FRD 22H	Details of consultancies over $10,000	See Financial Report
FRD 22H	Details of consultancies under $10,000	See Financial Report
FRD 22H	Employment and conduct principles	28
FRD 22H	Information and Communication Technology Expenditure	See Financial Report
FRD 22H	Major changes or factors affecting performance	31
FRD 22H	Occupational violence	27
FRD 22H	Operational and budgetary objectives and performance against objectives	See Financial Report
FRD 24C	Reporting of office-based environmental impacts	19
FRD 22H	Significant changes in financial position during the year	See Financial Report
FRD 22H	Statement on National Competition Policy	32
FRD 22H	Subsequent events	33
FRD 22H	Summary of the financial results for the year	See Financial Report
FRD 22H	Additional information available on request	29
FRD 22H	Workforce Data Disclosures including a statement on the application of employment and conduct principles	28
FRD 25C	Victorian Industry Participation Policy disclosures	31
FRD 29B	Workforce Data disclosures	28
FRD 103F	Non-Financial Physical Assets	See Financial Report
FRD 110A	Cash flow Statements	See Financial Report
FRD 112D	Defined Benefit Superannuation Obligations	See Financial Report
SD 5.2.3	Declaration in report of operations	27
Other requirements under Standing Directions 5.2		
SD 5.2.2	Declaration in financial statements	27
SD 5.2.1(a)	Compliance with Australian accounting standards and other authoritative pronouncements	See Financial Report
SD 5.2.1(a)	Compliance with Ministerial Directions	See Financial Report
Legislation		
Freedom of Information Act 1982		30
Protected Disclosure Act 2012		30
Carers Recognition Act 2012		30
Victorian Industry Participation Policy Act 2003		31
Building Act 1993		29
Financial Management Act 1994		27/34
Safe Patient Care Act 2015		32

OUR TEAM

CEO
Dr Darren Clarke

CORPORATE SERVICES
Kathryn Velleley

ADMINISTRATION
Sharyn O'Rourke
Emily Grining
Stacey Streader

FINANCE
Stacey Fernee
Wendy Last

QUALITY
Nicole Fuller

SYSTEMS PROCUREMENT & PROJECTS MANAGER
Julie Walton

SUPPORT SERVICES
Helen Absalom
Jodie Curtis
Susan Dunne
Lindee Frost
Kristen Gooding
Jane Gould
Sally Keeble
Shaji Kurian
Margaret Lanyon
Kelly Malone
Sharon Martin
Robyn McConnell
Amanda Mitchell
Leona Nixon
Judith Perryman
Binu Varghese
Sinu Varghese
Julie Wilson
Natham Wright
Roslyn Wright

DIRECTOR OF MEDICAL SERVICES
Dr Craig Winter

DIRECTOR OF CLINICAL SERVICES
Donna Doyle

NURSE UNIT MANAGER
Michelle Holland

DISTRICT NURSING SERVICES
Tanya Buchanan
Michelle Lawrence

CLINICAL SERVICES
Neethu Ahamed
Carmen Cauchi
Nadine Chalmers
Suwattana Chulakathappa
Pauline Cooper
Ebony Ford
June Gardner
Syamkumar Gopalakrishnan
Ena Green
Kim Griffiths
Madeline Hawke
Janesa Holland
Samantha Isaac
Vincy Jacob
Joyana Jose
Jeanette Long
Yvonne Mannix
Jaclyn McDougall
Mohammed Meerasahib
Denise Murphy
Mary Noonan
Judy Parker
Elizabeth Pashley
Catherine Patching
Licymol Payyamthadathil Scaria
Tanya Pickering
Ann Pink
Kathryn Robson
Saritha Sajan
Kristina Sanders
Lois Seipolt
Beverley Taylor
Susan Taylor
Amber Thamm
Richard Tierney
Narelle Vernon
Lois Whykes
Jennifer Withington
Sharon Wright

DIRECTOR OF DENTAL SERVICES
Dr Sajeev Koshy (OAM)

DENTIST
Dr Manoj Mogilisetty

DENTAL ASSISTANT
Vicki Peiffer
Helen Tular
Brigitte Yetman
Katrina Roy

ALLIED HEALTH
Deanne Smith

ACTIVITIES
Carmel Allison
Sandra Poyner
Maree Stringer

STAFF - YEARS OF SERVICE

10 Years	15Years	20 Years	25 Years	30 Years
Kathryn Velleley	Margaret Lanyon	Carmen Cauchi	Mary Noonan	Judy Perryman
Julie Wilson				
Lynette Clark				
Vicki Peiffer				
Sajeev Koshy				
Deanne Smith				

LADIES AUXILIARY

BOORT DISTRICT HEALTH LADIES AUXILIARY REPORT 2017/2018

It is with pleasure I present my annual report to CEO Darren Clarke and members of the Hospital Board of Management.

Ken Streader repaired the large cracks in the walls of the shop early this year, which has made it look safer, neater and cleaner. He also replaced the roof on the back store room and installed an air vent. This has given better protection for the clothes being stored there.

We paid for the OPG machine for the proposed new dental clinic, which is now in storage, waiting for the new clinic to be completed.

Again we catered for the BDH Annual meeting, serving 58 meals. This followed the official opening of the new hospital and residential area. Margaret Allison did a beautiful job with followers to decorate the tables. Thank you Margaret. Honi Tweedle made and donated a patchwork quilt for a raffle which was drawn at the meeting. Thank you Honi.

The Op Shop stayed open extra hours again for the annual Christmas party and was deemed worthwhile.

A huge thankyou to Rod Leversha for repairing our display trolleys, so the wheels have been fixed and the trolleys are easy to move. It is such simple things as this that makes our volunteer jobs much easier. Special thanks again to IGA for once again providing Easter eggs for our raffle.

Our Boomerang Bags have been selling constantly, mainly to visitors. It is a good way to utilise the material donated to the shop. Thanks to Dawn Cooper for coming on board to help with making them.

It is pleasing to have CEO Darren Clarke attend our meetings so regularly. We are all more aware of what is happening in our hospital, as well as keeping up to date in areas where we can assist with purchasing items needed, but which are not always funded by external sources.

We have funded a portable lifter, so should a resident have a fall outside their room, this is available for staff to bring them up from the floor to a chair. This was $2,950.

We have also supplied funds totaling $2,506 for the purchase of a new toaster for the kitchen; a lawn mower and chain saw for Natham; and 4 sensor pads for the hospital.

Thanks go to Julie and Robyn for opening the shop especially for the Charlton Probus Club. It proved worthwhile, and the visitors were not only grateful, but most impressed with the cleanliness and neatness of it all.

I wish to say a personal thank you to my secretary Isabel, without whom I could not have managed this year. To Robyn, another great year as treasurer. To all the Auxiliary girls for their untiring efforts in the shop, and for help in setting up and catering for the AGM. All this would not work without you. To Isabel for the making and decorating the wonderful Christmas cake for our raffle. Julie, you are a genius with our windows. Thank you Sue, as Vice President, I knew you would be there should you be required.

It is with Pride that I present this report on behalf of the Boort District Health Ladies Auxiliary, and thank all our hard-working members for their continued support.

Nerrida Major
President

AUXILIARY - YEARS OF SERVICE

Name	Year Commenced	Years
Dorothy Wellard	2003	15
Margaret Rothacker	2008	10
Joy De Piazza	2008	10
Gwen Parker	2008	10
Lorraine Stringer	2008	10
Doris Gawne	2008	10

DONATIONS RECEIVED 2017-18

Mens Shed	$27.00
NorthWest Ag	$50.00
Innocence and Attitude	$70.00
Jennie Weaver	$100.00
Goulburn Murray Water	$100.00
Boort IGA	$150.00
Grain Corp	$150.00
Wendy Pollard Tupperware	$164.00
Boort Amity Club	$200.00
Wycheproof Lions Club	$250.00
Rubicon Systems Australia	$500.00
Salute Oliva	$500.00
Neil Beattie/Windarra	$1000.00
Barnes Family	$1500.00
Murray to Moyne	$2626.20
Pethard Tarax Charitable Trust	$3000.00
Boort Debutant Ball	$4479.00
Estate M. Crombie	$4000.00
Estate E. Poxon	$5000.00
Ladies Auxiliary	$55,456.00
Total Donations 2017-2018	**$79,072.20**

LIFE GOVERNORS

NAME	MONTH	YEAR
Mr. D.G. Coutts	October	1964
Mrs. E.M. Wilson	September	1972
Mrs H.E. Lanyon	September	1972
Mrs. N.M. Weaver	September	1972
Mr. L.R. Meadows	September	1972
Mr. L.F. Whitmore	September	1972
Mr. G.A. Frost	October	1974
Mr. W.N. Haw	March	1976
Mr. H.D. Cable	September	1980
Mr. W.A. Boyle	April	1985
Mr. H.F. Slatter	April	1985
Mr. K.I McKay	April	1985
Mr. E.L. Poxon	October	1989
Miss. A. Donnellon	December	1989
Mr. F.L. Boyle	December	1989
Mr. K.M. Weaver	October	1992
Mrs. F.J. Meadows	March	1995
Mr. K.M. Jeffrey	October	2000
Dr. G.C. Findlow	May	2001
Dr. J.E. Findlow	May	2001
Mr M.J.Nolan	October	2002
Mrs M.A.Birt	October	2003
Mr G.E. Arundell	October	2005
Mrs P Byrne	December	2009
Mrs M Worland	October	2011
Mrs B Jeffery	October	2011
Mr D Rees	October	2014
Mrs E. Barnes	October	2016
Mrs J Keath	October	2016

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Boort District Health

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

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
6 September 2018

Ron Mak
as delegate for the Auditor-General of Victoria

Boort District Health

PO Box 2, Boort 3537
Phone: (03)5451 5200
Fax: (03)5455 2502
reception@bdh.vic.gov.au

BOORT DISTRICT HEALTH
Financial Statements Year Ended 30 June 2018

BOARD MEMBER'S AND ACCOUNTABLE OFFICER'S DECLARATION

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

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

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.

Wendy Gladman
Board Chair
Boort
Date: 3 September 2018

Darren Clarke
Chief Executive Officer
Boort
Date: 3 September 2018

Boort District Health

Comprehensive Operating Statement for the financial year ended 30 June 2018

	NOTE	2018 $	2017 $
Revenue from Operating Activities	2.1	6,129,111	6,110,895
Revenue from Non-operating Activities	2.1	132,795	86,144
Employee Expenses	3.1	(4,706,089)	(4,639,572)
Non Salary Labour Costs	3.1	(265,213)	(291,394)
Supplies and Consumables	3.1	(743,913)	(719,172)
Other Expenses	3.1	(819,857)	(1,056,996)
Net Result Before Capital and Specific Items		**(273,166)**	**(510,095)**
Capital Purpose Income	2.1	1,171,064	3,312,989
Depreciation	4.3	(895,106)	(886,344)
Expenditure for Capital Purpose	3.1	(57,117)	(231,867)
Net result after capital and specific items		**(54,325)**	**1,684,683**
Other Economic flows included in net result			
Net gain/(loss) on non-financial assets		27,619	10,580
Revaluation of Long Service Leave	3.1	2,505	(8,351)
Total other economic flows included in net result		**30,124**	**2,229**
NET RESULT FOR THE YEAR		**(24,201)**	**1,686,912**
Other comprehensive income			
Items that will not be reclassified subsequently to net result			
Changes to Property, Plant and Equipment Revaluation Surplus	8.1	1,705,860	-
COMPREHENSIVE RESULT		**1,681,659**	**1,686,912**

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

Boort District Health

Balance Sheet as at 30 June 2018

	NOTE	2018 $	2017 $
Current Assets			
Cash and Cash Equivalents	6.1	3,311,965	1,008,681
Receivables	5.1	373,762	324,108
Investments and other financial assets	4.1	2,839,714	2,600,000
Inventories	5.2	53,737	66,744
Prepayments and Other Assets	5.4	68,067	68,024
Total Current Assets		**6,647,245**	**4,067,557**
Non-Current Assets			
Receivables	5.1	29,902	35,460
Property, Plant & Equipment	4.2	16,607,096	15,366,057
Total Non-Current Assets		**16,636,998**	**15,401,517**
TOTAL ASSETS		**23,284,243**	**19,469,074**
Current Liabilities			
Payables	5.5	617,798	275,354
Provisions	3.3	822,827	764,199
Other Current Liabilities	5.3	3,051,061	1,283,066
Total Current Liabilities		**4,491,686**	**2,322,619**
Non-Current Liabilities			
Provisions	3.3	92,622	128,179
Total Non-Current Liabilities		**92,622**	**128,179**
TOTAL LIABILITIES		**4,584,308**	**2,450,798**
NET ASSETS		**18,699,935**	**17,018,276**
EQUITY			
Property, Plant & Equipment Revaluation Surplus	8.1	5,831,404	4,125,544
Restricted Specific Purpose Surplus	8.1	1,124,049	1,124,049
Contributed Capital	8.1	3,160,907	3,160,907
Accumulated Surpluses	8.1	8,583,575	8,607,776
TOTAL EQUITY		**18,699,935**	**17,018,276**
Contingent Assets and Contingent Liabilities	7.2		
Commitments	6.2		

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

Boort District Health

Statement of Changes in Equity for the financial year ended 30 June 2018

	Note	Property, Plant and Equipment Revaluation Surplus	Restricted Special Purpose Surplus	Contribution by Owners	Accumulated Surpluses / (Deficits)	Total
		$	$	$	$	$
Balance at 1 July 2016		**4,125,544**	**139,300**	**3,160,907**	**7,905,613**	**15,331,364**
Net result for the year	8.1	-	-	-	1,686,912	1,686,912
Transfers	8.1	-	984,749	-	(984,749)	-
Other comprehensive income for the year	8.1	-	-	-	-	-
Balance at 30 June 2017		**4,125,544**	**1,124,049**	**3,160,907**	**8,607,776**	**17,018,276**
Net result for the year	8.1	-	-	-	(24,201)	(24,201)
Transfers	8.1	-	-	-	-	-
Other comprehensive income for the year	8.1	1,705,860	-	-	-	1,705,860
Balance at 30 June 2018		**5,831,404**	**1,124,049**	**3,160,907**	**8,583,575**	**18,699,935**

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

Boort District Health

Cash Flow Statement for the financial year ended 30 June 2018

	NOTE	2018 $	2017 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		4,791,924	4,584,254
Capital Grants from Government		1,071,860	2,330,636
Patient and Resident Fees Received		1,211,973	1,201,397
Donations and Bequests Received		77,070	44,245
GST Received from/(paid to) ATO		155,452	507,877
Interest Received		110,643	86,465
Other Capital Receipts		92,815	752,698
Other Receipts		18,753	352,188
Total Receipts		**7,530,490**	**9,859,760**
Employee Expenses Paid		(4,773,939)	(4,809,935)
Non Salary Labour Costs		(168,707)	(162,750)
Payments for Supplies & Consumables		(839,539)	(725,329)
Other Payments		(604,165)	(1,912,967)
Total Payments		**(6,386,350)**	**(7,610,981)**
NET CASH FLOW FROM OPERATING ACTIVITIES	8.2	**1,144,140**	**2,248,779**
CASH FLOWS FROM INVESTING ACTIVITIES			
Proceeds from Sale of Investments		1,316,934	234,271
Payments for Non-Financial Assets		(384,701)	(2,486,176)
Proceeds from sale of Non-Financial Assets		27,619	27,610
NET CASH FLOW FROM/(USED IN) INVESTING ACTIVITIES		**959,852**	**(2,224,295)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		**2,103,992**	**24,484**
Cash and Cash Equivalents at beginning of financial year		870,580	846,096
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.1	**2,974,572**	**870,580**

This Statement should be read in conjunction with the accompanying notes

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Basis of preparation

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

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

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

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

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

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

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 applying AAS that have significant effects on the financial statements and estimates are disclosed in the notes under the heading: 'Significant judgement or estimates'.

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 1 – Summary of Significant Accounting Policies

These annual financial statements represent the audited general purpose financial statements for Boort District Health and its controlled entities for the year ended 30 June 2018. The report provides users with information about the Health Service's 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 AASBs, which include interpretations issued by the Australian Accounting Standards Board (AASB). They are presented in a manner consistent with the requirements of AASB 101 Presentation of Financial Statements.

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

The annual financial statements were authorised for issue by the Board of Boort District Health on 3rd September 2018.

(b) Reporting Entity

The financial statements include all the controlled activities of Boort District Health.
Its principal address is:
Kiniry Street
Boort VIC 3537.

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

(c) Basis of Accounting Preparation and Measurement

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

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

The financial statements are prepared on a going concern basis.

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

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

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

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

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

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

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

Goods and Services Tax (GST)
Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the Australian Taxation Office (ATO). In this case the GST payable is recognised as part of the cost of acquisition of the asset or as part of the expense.
Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the ATO is included with other receivables or payables in the Balance Sheet.

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

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

(d) Jointly Controlled Operation

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

In respect of any interest in joint operations, Boort District Health recognises in the financial statements:

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

Boort District Health is a Member of the Loddon Mallee Rural Health Alliance Joint Venture and retains joint control over the arrangement, which it has classified as a joint operation (refer to Note 8.9 Jointly Controlled Operations).

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 2 – Funding delivery of our services

Boort District Health's overall objective is to provide quality health services that supports and enhances the wellbeing of the community and surround districts. Boort District Health is predominantly funded by accrual based grant funding for the provision of outputs. The hospital also receives income from the supply of services.

Structure

2.1 Analysis of Revenue by Source

Boort District Health
Notes to the financial statements for the year ended 30 June 2018

Note 2.1: Analysis of Revenue by Source

	Admitted Patients 2018 $	Residential Aged Care 2018 $	Aged Care 2018 $	Primary Health 2018 $	Other 2018 $	Total 2018 $
Government Grants	2,227,693	1,700,214	343,819	-	526,262	4,799,988
Indirect contributions by Department of Health and Human Services	(400)	(400)	(77)	-	-	(877)
Patient & Resident Fees	277,834	626,917	43,449	-	226,883	1,175,083
Commerical Activites	-	-	-	-	95,079	95,079
Other Revenue from Operating Activities	30,650	-	1,696	-	27,492	59,838
Total Revenue from Operating Activities	**2,535,777**	**2,326,731**	**388,887**	**-**	**877,716**	**6,129,111**
Interest	-	3,625	-	-	110,643	114,268
Other Revenue from Non-Operating Activities	-	-	-	-	18,527	18,527
Total Revenue from Non-Operating Activities	**-**	**3,625**	**-**	**-**	**129,170**	**132,795**
Capital Purpose Income (Excluding Interest)	-	-	-	-	1,171,064	1,171,064
Gain/(Loss) on Sale of Assets	-	-	-	-	27,619	27,619
Total Capital Purpose Income	**-**	**-**	**-**	**-**	**1,198,683**	**1,198,683**
Total Revenue	**2,535,777**	**2,330,356**	**388,887**	**-**	**2,205,569**	**7,460,589**

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

	Admitted Patients 2017 $	Residential Aged Care 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	Total 2017 $
Government Grants	2,271,333	1,689,268	206,778	31,880	437,241	4,636,500
Indirect contributions by Department of Health and Human Services	(12,485)	(13,770)	(7,480)	-	(9,314)	(43,049)
Patient and Resident Fees	358,357	599,538	32,036	-	232,684	1,222,615
Commercial Activities	-	-	-	-	60,865	60,865
Other Revenue from Operating Activites	32,623	38,987	2,064	-	160,290	233,964
Total Revenue from Operating Activities	**2,649,828**	**2,314,023**	**233,398**	**31,880**	**881,766**	**6,110,895**
Interest	-	2,372	-	-	76,963	79,335
Other Revenue from Non-Operating Activities	-	-	-	-	6,809	6,809
Total Revenue from Non - Operating Activities	**-**	**2,372**	**-**	**-**	**83,772**	**86,144**
Capital Purpose Income (excluding Interest)	-	-	-	-	3,305,859	3,305,859
Capital Interest	-	7,130	-	-	-	7,130
Gain/(Loss) on Sale of Assets	-	-	-	-	10,580	10,580
Total Capital Purpose Income	**-**	**7,130**	**-**	**-**	**3,316,439**	**3,323,569**
Total Revenue	2,649,828	2,323,525	233,398	31,880	4,281,977	9,520,606

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

Revenue Recognition

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

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

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

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

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

Indirect Contributions from the Department of Health and Human Services

-Insurance is recognised as revenue following advice from the Department of Health and Human Services.

-Long Service Leave (LSL) - Revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Department of Health and Human Services Hospital Circular 04/2017.

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 the Medical Clinic is recognised at the time invoices are raised.

Donations and Other Bequests

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

Interest Revenue

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

Sale of Investments

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

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

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

Other Income

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

Category Groups

Boort District Health has used the following category groups for reporting purposes for the current and previous financial year:

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

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

Primary Health comprises revenue/expenditure for Community Health Services including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy.

Other Services comprises services not separately classified above, including: sexually transmitted infections clinical services, Koori liaison officers, immunisation and screening services, drugs services and community care programs including sexual assault support, early parenting services and parenting assessment and skills development.

Boort District Health
Notes to the financial statements for the year ended 30 June 2018

Note 3: The cost of delivering our services

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

Structure
3.1 Analysis of expenses by source
3.2 Analysis of expense and revenue by internally managed and restricted specific purpose funds
3.3 Provisions
3.4 Superannuation

Boort District Health
Notes to the financial statements for the year ended 30 June 2018

Note 3.1: Analysis of Expenses by Source

	Admitted Patients 2018 $	Residential Aged Care 2018 $	Aged Care 2018 $	Primary Health 2018 $	Other 2018 $	Total 2018 $
Employee Expenses	1,243,907	1,312,404	312,751	-	1,837,027	4,706,089
Non Salary Labour Costs	117,501	4,455	-	-	143,257	265,213
Supplies & Consumables	224,020	324,293	2,399	-	193,201	743,913
Other Expenses	191,230	325,395	23,553	-	279,679	819,857
Total Expenditure from Operating Activities	**1,776,658**	**1,966,547**	**338,703**	**-**	**2,453,164**	**6,535,072**
Expenditure for Capital Purpose	-	-	-	-	57,117	57,117
Revaluation of Long Service Leave	-	-	-	-	(2,505)	(2,505)
Depreciation (refer Note 4.3)	-	-	-	-	895,106	895,106
Total Other Expenses	**-**	**-**	**-**	**-**	**949,718**	**949,718**
Total Expenses	**1,776,658**	**1,966,547**	**338,703**	**-**	**3,402,882**	**7,484,790**

	Admitted Patients 2017 $	Residential Aged Care 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	Total 2017 $
Employee Expenses	1,602,233	1,880,234	687,200	-	469,905	4,639,572
Non Salary Labour Costs	104,865	2,834	-	-	183,695	291,394
Supplies & Consumables	282,772	364,999	1,058	2,343	68,000	719,172
Other Expenses	396,359	463,575	23,705	51,020	122,337	1,056,996
Total Expenditure from Operating Activities	**2,386,229**	**2,711,642**	**711,963**	**53,363**	**843,937**	**6,707,134**
Expenditure for Capital Purpose	-	-	-	-	231,867	231,867
Revaluation of Long Service Leave	-	-	-	-	8,351	8,351
Depreciation (refer Note 4.3)	-	-	-	-	886,344	886,344
Total Other Expenses	**-**	**-**	**-**	**-**	**1,126,562**	**1,126,562**
Total Expenses	**2,386,229**	**2,711,642**	**711,963**	**53,363**	**1,970,499**	**7,833,696**

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

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

Employee expenses
Employee expenses include:

- wages and salaries;
- annual leave;
- sick leave;
- long service leave;
- workcover premiums;
- termination payments;
- fringe benefits tax; and
- superannuation expenses

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

- Supplies and consumables - Supplies and service costs which are recognised as an expense in the reporting period in which they are incurred. The carrying amounts of any inventories held for distribution are expensed when distributed.
- Fair value 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.

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

- Revaluation gains/ (losses) of non-financial physical assets (Refer to Note 4.2 Property, Plant and Equipment)
- Net gain/ (loss) on disposal of non-financial assets

Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal.

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

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

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

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

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

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 3.2: Analysis of expense and revenue by internally managed and restricted specific purpose funds

	Expense		Revenue	
	2018	2017	2018	2017
Commercial Activities	$	$	$	$
Medical Clinic	74,365	51,272	33,729	48,138
Cafeteria	6,653	1,507	19,904	12,727
Total	**81,018**	**52,779**	**53,633**	**60,865**

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 3.3: Employee Benefits in the Balance Sheet

	2018 $	2017 $
Current Provisions		
Employee Benefits (i)		
Annual Leave		
- Unconditional and expected to be settled within 12 months (ii)	306,871	312,808
- Unconditional and expected to be settled after 12 months (iii)	54,810	53,038
Accrued Day Off		
- Unconditional and expected to be settled within 12 months (ii)	6,797	8,003
- Unconditional and expected to be settled after 12 months (iii)	1,155	1,340
Long Service Leave		
- Unconditional and expected to be settled within 12 months (ii)	94,753	36,260
- Unconditional and expected to be settled after 12 months (iii)	214,669	255,127
Provisions related to employee benefit on-costs		
- Unconditional and expected to be settled within 12 months (ii)	43,694	32,735
- Unconditional and expected to be settled after 12 months (iii)	30,251	5,872
Salaries and Wages	69,827	59,016
Total Current Provisions	**822,827**	**764,199**
Non-Current Provisions		
Employee Benefits (i)	83,178	94,437
Provisions related to employee benefits on-costs	9,444	33,742
Total Non-Current Provisions	**92,622**	**128,179**
Total Provisions	**915,449**	**892,378**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and Related On-Costs		
Annual Leave Entitlements	399,657	385,846
Accrued Wages and Salaries	69,827	59,016
Accrued Days Off	8,787	9,543
Unconditional Long Service Leave Entitlements	344,555	309,794
Non-Current Employee Benefits and Related On-Costs		
Conditional Long Service Leave Entitlements (iii)	92,622	128,179
Total Employee Benefits and Related On-Costs	**915,448**	**892,378**
(b) Movements in Provisions		
Movement in Long Service Leave:		
Balance at start of year	437,973	505,088
Provision made during the year		
- Revaluations	(2,505)	8,351
- Expense Recognising Employee Service	85,016	44,170
Settlement made during the year	(83,307)	(119,636)
Balance at end of year	**437,177**	**437,973**

(i) Employee benefits consist of amounts for accrued days off, annual leave and long service leave accrued by employees, not including on-costs.

(ii) The amounts disclosed are at nominal amount.

(iii) The amounts disclosed are at present values.

Employee Benefit Recognition

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

Provisions

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

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

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, sick leave and accrued days off

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

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

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

Long service leave (LSL)

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

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

The components of this current LSL liability are measured at:

- Undiscounted value – if the health service expects to wholly settle within 12 months; and
- Present value – where the entity does not expect to settle a component of this current liability within

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

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

Termination benefits

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

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.

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 3.4: Superannuation

		Paid Contributions for the year		Outstanding Contributions at Year End	
		2018 $	2017 $	2018 $	2017 $
Defined Benefits Plans:	FIRST State	14,520	12,268	0	0
Defined Contribution Plans:	FIRST State/HESTA	384,497	365,707	0	0
TOTAL		**399,017**	**377,975**	**0**	**0**

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 plan provides benefits based on years of service and final average salary.

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.

The Health Service does not recognise any unfunded defined benfit liability in respect of the 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. The Department of Treasury and Finance discloses the State's defined benefits liabilities in its disclosure for administered items.

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

Boort District Health
Notes to the financial statements for the year ended 30 June 2018

Note 4: Key Assets to support service delivery

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

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

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 4.1: Investments and Other Financial Assets

	Operating Fund		Total	
	2018 $	2017 $	2018 $	2017 $
CURRENT				
Loans and Receivables				
Aust. Dollar Term Deposits(i)	2,839,714	2,600,000	2,839,714	2,600,000
Available for Sale	**2,839,714**	**2,600,000**	**2,839,714**	**2,600,000**
Represented by:				
Health Services Investments	-	1,316,934	-	1,316,934
Accommodation Bonds (Refundable Entrance Fees)	2,839,714	1,182,221	2,839,714	1,182,221
Victorian Cancer Survivorship Program	-	100,845	-	100,845
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**2,839,714**	**2,600,000**	**2,839,714**	**2,600,000**

Notes:

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

Investment Recognition

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

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

Boort District Health manages their investments in accordance with their own investment policy as approved by their Board.

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

Derecognition of financial assets

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

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

Where Boort District 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, Boort District Health Service 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.
Where the fair value of an investment in an equity instrument at balance date has reduced by 20 percent or more than its cost price or where its fair value has been less than its cost price for a period of 12 or more months, the financial asset is treated as impaired.
In order to determine an appropriate fair value as at 30 June 2018 for its portfolio of financial assets, Boort District Health used the market value of investments held provided by the portfolio managers.
The above valuation process was used to quantity the level of impairment (if any) on the porfolio of financial assets as at year end.

Doubtful debts

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

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 4.2: Property, Plant and Equipment

(a) Gross carrying amount and accummulated depreciation

	2018 $	2017 $
Land		
- Land at Fair Value	343,000	343,000
- Landscaping at Fair Value	11,964	11,964
Less Accumulated Depreciation	(1,082)	(604)
Total Land	**353,882**	**354,360**
Buildings		
- Buildings at Fair Value	15,126,037	4,565,000
Less Accumulated Depreciation	-	(1,532,580)
- Buildings at Cost	-	8,819,473
Less Accumulated Depreciation	-	(266,266)
Total Buildings	**15,126,037**	**11,585,627**
Plant and Equipment		
- Plant and Equipment at Fair Value	1,377,946	1,323,230
Less Accumulated Depreciation	(690,141)	(577,959)
- Loddon Mallee Rural Health Alliance at Fair Value	31,311	19,267
Less Accumulated Depreciation	(17,740)	(15,728)
Total Plant and Equipment	**701,376**	**748,810**
Computers and Communication		
- Computers and Communication at Fair Value	79,103	79,103
Less Accumulated Depreciation	(34,690)	(11,957)
Total Computers and Communications	**44,413**	**67,146**
Furniture and Fittings		
- Furniture and Fittings at Fair Value	173,161	170,894
Less Accumulated Depreciation	(70,015)	(53,344)
Total Furniture and Fittings	**103,146**	**117,550**
Motor Vehicles		
- Motor Vehicles at Fair Value	210,016	250,204
Less Accumulated Depreciation	(142,835)	(214,261)
Total Motor Vehicles	**67,181**	**35,943**
Under Construction		
- Work in Progress	211,061	2,456,621
Total Assets under construction	**211,061**	**2,456,621**
TOTAL	**16,607,096**	**15,366,057**

Boort District Health
Notes to the financial statements for the year ended 30 June 2018

Note 4.2: Property, Plant and Equipment (Continued)

(b) Reconciliations of the carrying amounts of each class of asset at the beginning and end of the previous and current financial year is set out below.

	Land	Buildings	Plant & Equipment	Furniture & Fittings	Computer Equip	Motor Vehicles	Under Construction	Total
	$	$	$	$	$	$	$	$
Balance at 1 July 2016	354,839	12,303,957	746,676	102,983	-	82,853	-	13,591,308
Additions	-	-	111,440	29,285	79,103	-	2,264,724	2,484,552
Indirect Contribution from Government	-	-	-	-	-	-	191,897	191,897
Loddon Mallee Rural Health Alliance	-	-	1,674	-	-	-	-	1,674
Disposals	-	-	-	-	-	(17,030)	-	(17,030)
Depreciation (see Note 4.3)	(479)	(718,330)	(110,980)	(14,718)	(11,957)	(29,880)	-	(886,344)
Balance at 30 June 2017	354,360	11,585,627	748,810	117,550	67,146	35,943	2,456,621	15,366,057
Additions	-	-	54,715	2,267	-	50,453	277,266	384,701
Net Transfers between classes	-	2,563,486					(2,563,486)	-
Indirect Contribution from Government	-	-	-	-	-	-	40,660	40,660
Loddon Mallee Rural Health Alliance	-	-	11,576	-	-	-	-	11,576
Revaluation increments/(decrements)	-	1,705,860	-	-	-	-	-	1,705,860
Disposals	-	-	-	-	-	(6,652)	-	(6,652)
Depreciation (see Note 4.3)	(478)	(728,936)	(113,725)	(16,671)	(22,733)	(12,563)	-	(895,106)
Balance at 30 June 2018	353,882	15,126,037	701,376	103,146	44,413	67,181	211,061	16,607,096

Land and buildings carried at valuation

An independent valuation of the Health Service's land was performed by the Valuer-General Victoria to determine the fair value of the land. 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.

In compliance with FRD 103F, in the year ended 30 June 2018, Boort District Health's management conducted an annual assessment of the fair value of land and buildings and leased buildings. To facilitate this, management obtained from the Department of Treasury and Finance the Valuer General Victoria indices for the financial year ended 30 June 2018.

The latest indices required a managerial revaluation for buildings in 2018. The indexed value was then compared to individual assets written down book value as at 30 June 2018 to determine the change in their fair values. The Department of Health and Human Services approved a managerial revaluation of the building asset class of $15.1m ($11.6m in 2017).

There was no material financial impact on change in fair value of Land.

Fair value of plant and equipment has been assessed by management in accordance with Financial Reporting Direction 103F. Management have obtained second-hand values for equipment where possible, or completed an assessment of value based on depreciated replacement cost.

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 4.2: Property, plant & equipment (continued)

(c) Fair value measurement hierarchy for assets as at 30 June 2018

	Carrying amount as at 30 June 2018	Fair value measurement at end of reporting period using: Level 1 [1]	Level 2 [1]	Level 3 [1]
	$	$	$	$
Land at fair value				
Specialised land	353,882	-	-	353,882
Total of land at fair value	**353,882**	-	-	**353,882**
Buildings at fair value				
Specialised buildings	15,126,037	-	-	15,126,037
Total of building at fair value	**15,126,037**	-	-	**15,126,037**
Plant and Equipment at fair value				
Plant and Equipment	701,376	-	-	701,376
Total of plant and equipment at fair value	**701,376**	-	-	**701,376**
Computer and Communitcation at fair value				
Computers and Communication	44,413	-	-	44,413
Total Computer and communication at fair value	**44,413**	-	-	**44,413**
Furniture and Fittings at fair value				
Furniture and Fittings	103,146	-	-	103,146
Total Furniture and Fittings at fair value	**103,146**	-	-	**103,146**
Motor Vehicles at fair value				
Motor Vehicles	67,181	-	67,181	-
Total Motor Vehicles at fair value	**67,181**	-	**67,181**	-
Under Construction				
Work in Progress	211,061	-	-	211,061
Total Motor Vehicles at fair value	**211,061**	-	-	**211,061**
	16,607,096	-	**67,181**	**16,539,915**

Note

[1] Classified in accordance with the fair value hierarchy. There have been no transfers between levels during the period.

(c) Fair value measurement hierarchy for assets as at 30 June 2017

	Carrying amount as at 30 June 2017	Fair value measurement at end of reporting period using: Level 1 [1]	Level 2 [1]	Level 3 [1]
	$	$	$	$
Land at fair value				
Specialised land	354,360	-	-	354,360
Total of land at fair value	**354,360**	-	-	**354,360**
Buildings at fair value				
Specialised buildings	11,585,626	-	-	11,585,626
Total of building at fair value	**11,585,626**	-	-	**11,585,626**
Plant and Equipment at fair value				
Plant and Equipment	748,811	-	-	748,811
Total of plant and equipment at fair value	**748,811**	-	-	**748,811**
Computer and Communitcation at fair value				
Computers and Communication	67,146	-	-	67,146
Total Computer and communication at fair value	**67,146**	-	-	**67,146**
Furniture and Fittings at fair value				
Furniture and Fittings	117,550	-	-	117,550
Total Furniture and Fittings at fair value	**117,550**	-	-	**117,550**
Motor Vehicles at fair value				
Motor Vehicles	35,942	-	35,942	-
Total Motor Vehicles at fair value	**35,942**	-	**35,942**	-
Under Construction				
Work in Progress	2,456,621	-	-	2,456,621
Total Motor Vehicles at fair value	**2,456,621**	-	-	**2,456,621**
	15,366,056	-	**35,942**	**15,330,114**

Note

[1] Classified in accordance with the fair value hierarchy. There have been no transfers between levels during the period.

Boort District Health
Notes to the financial statements for the year ended 30 June 2018

Note 4.2: Property, plant & equipment (continued)

(d) Reconciliation of Level 3 fair value 2018

	Land	Buildings	Plant and Equipment	Computers & Communication	Furniture & Fittings	Assets under construction
	$	$	$	$	$	$
Opening Balance	354,360	11,585,627	748,810	67,146	117,550	2,456,621
Additions	-	-	66,291	-	2,267	317,926
Net transfers between classes		2,563,486				(2,563,486)
Gains or losses recognised in net result						
- Depreciation	(478)	(728,936)	(113,725)	(22,733)	(16,671)	-
Subtotal	353,882	13,420,177	701,376	44,413	103,146	211,061
Items recognised in other comprehensive income						
- Revaluation	-	1,705,860	-	-	-	-
Subtotal	-	1,705,860	-	-	-	-
Closing Balance	353,882	15,126,037	701,376	44,413	103,146	211,061
	353,882	15,126,037	701,376	44,413	103,146	211,061

Note
There have been no transfers between levels during the period.

(d) Reconciliation of Level 3 fair value 2017

	Land	Buildings	Plant and Equipment	Computers & Communication	Furniture & Fittings	Assets under construction
	$	$	$	$	$	$
Opening Balance	354,839	12,303,957	746,676	-	102,983	-
Additions	-	-	113,114	79,103	29,285	2,456,621
Gains or losses recognised in net result						
- Depreciation	(479)	(718,330)	(110,980)	(11,957)	(14,718)	-
Subtotal	354,360	11,585,627	748,810	67,146	117,550	2,456,621
Items recognised in other comprehensive income						
- Revaluation	-	-	-	-	-	-
Subtotal	-	-	-	-	-	-
Closing Balance	354,360	11,585,627	748,810	67,146	117,550	2,456,621
	354,360	11,585,627	748,810	67,146	117,550	2,456,621

Note
There have been no transfers between levels during the period.

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

	Valuation technique (i)	Significant unobservable inputs (i)
Specialised land	Market approach	Community Service Obligation (CSO) adjustment
Specialised buildings	Depreciated replacement cost	Direct cost per square metre Useful life of specialised buildings
Landscaping & Grounds	Depreciated replacement cost	Direct replacement cost Useful life of Landscaping & Grounds
Plant & Equipment	Depreciated replacement cost	Cost per unit Useful life of PPE
Computers and Communication	*Depreciated replacement cost*	Cost per unit Useful life of furniture & fittings
Furniture & Fittings at fair value	*Depreciated replacement cost*	Cost per unit Useful life of furniture & fittings

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 4.2: Property, plant & equipment (continued)

Initial Recognition

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

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

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

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

Subsequent Measurement

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

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

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

In addition, Boort District Healthdetermines whether transfers have occurred between levels in the hierarchy by reassessing 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.

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

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

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

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

Fair value measurement

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

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

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

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

Therefore, an assessment of the HBU will be required when the indicators are triggered within a reporting period, which suggest the market participants would have perceived an alternative use of an asset that can generate maximum value. Once identified, Health Services are required to engage with VGV or other independent valuers for formal HBU assessment.

These indicators, as a minimum, include:

External factors:

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

Valuation hierarchy

Health Services need to use valuation techniques that are appropriate for the circumstances and where there is sufficient data available to measure fair value, maximising the use of relevant observable inputs and minimising the use of unobservable inputs.

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy.

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 4.2: Property, plant & equipment (continued)

Identifying unobservable inputs (level 3) fair value measurements

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

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

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

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

Specialised Land and Specialised Buildings

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

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

The market approach is also used for specialised land and specialised buildings although it is adjusted for the community service obligation (CSO) to reflect the specialised nature of the assets being valued. Specialised assets contain significant, unobservable adjustments; therefore these assets are classified as Level 3 under the market based direct comparison approach.

The CSO adjustment is a reflection of the valuer's assessment of the impact of restrictions associated with an asset to the extent that is also equally applicable to market participants. This approach is in light of the highest and best use consideration required for fair value measurement, and takes into account the use of the asset that is physically possible, legally permissible and financially feasible. As adjustments of CSO are considered as significant unobservable inputs, specialised land would be classified as Level 3 assets.

For Boort District Healths, 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 Boort District Health's specialised land and specialised buildings was performed by the Valuer-General Victoria. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation is 30 June 2014.

In June 2018 a managerial valuation was carried out in accordance with FRD 103F to revalue the Buildings to its fair value.

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

There were no changes in valuation techniques throughout the period to 30 June 2018.

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

Boort District Health
Notes to the financial statements for the year ended 30 June 2018

Note 4.2: Property, plant & equipment (continued)
Revaluations of Non-Current Physical Assets

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

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

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

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

Revaluation surplus is not transferred to accumulated funds on de-recognition of the relevant asset, except where an asset is transferred via contributed capital.

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

Note 4.3: Depreciation	**2018 $**	**2017 $**
Buildings	728,936	718,330
Plant & Equipment	112,181	108,008
Motor Vehicles	12,563	29,880
Furniture and Fittings	16,671	14,718
Computer and Communications	22,733	11,957
Landscaping	478	479
Loddon Mallee Rural Health Alliance	1,544	2,972
Total Depreciation	**895,106**	**886,344**

All buildings, plant and equipment and other non-financial physical assets (excluding items under operating leases and land) that have finite useful lives are depreciated. Depreciation is generally calculated on a straight-line basis at rates that allocate the asset's value, less any estimated residual value over its estimated useful life (refer AASB 116 *Property, Plant and Equipment*).

The useful lives illustrated in the guidelines are for illustrative purposes only. Health Services should determine the useful lives of assets by consideration of the nature and characteristics of specific assets. The estimated useful lives, residual values and depreciation method are reviewed at the end of each annual reporting period, and adjustments made where appropriate.

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

	2018	**2017**
Buildings		
- Structure Shell Building Fabric	5 to 50 years	5 to 50 years
- Site Engineering Services and Central Plant	5 to 50 years	5 to 50 years
Central Plant		
- Fit Out	2 to 50 years	2 to 50 years
- Trunk Reticulated Building Systems	2 to 50 years	2 to 50 years
Plant & Equipment	5 to 25 years	5 to 25 years
Medical Equipment	5 to 15 years	5 to 15 years
Computers and Communication	3 years	3 years
Furniture and Fitting	6 to 20 years	6 to 20 years
Motor Vehicles	5 years	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.

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 5: Other assets and liabilities

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

Structure

5.1 Receivables
5.2 Inventories
5.3 Other liabilities
5.4 Prepayments and other assets
5.5 Payables

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 5.1: Receivables

	2018 $	2017 $
CURRENT		
Contractual		
Trade Debtors	147,908	172,077
Patient Fees	41,596	52,150
Accrued Investment Income	26,650	26,016
Accrued Revenue - Other	54,467	15,075
Loddon Mallee Rural Health Alliance Receivables	10,195	4,397
Less Allowance for Doubtful Debts Patient Fees	-	(52,941)
	280,816	**216,774**
Statutory		
Accrued Revenue- Dental Health Services Victoria	29,599	50,907
GST Receivable	59,425	53,512
Loddon Mallee Rural Health Alliance GST Receivables	3,922	2,915
	92,946	**107,334**
TOTAL CURRENT RECEIVABLES	**373,762**	**324,108**
NON CURRENT		
Statutory		
Long Service Leave - Department of Health and Human Services	29,902	35,460
	29,902	**35,460**
TOTAL NON-CURRENT RECEIVABLES	**29,902**	**35,460**
TOTAL RECEIVABLES	**403,664**	**359,568**

(a) Movement in the Allowance for doubtful debts	2018 $	2017 $
Balance at the beginning of year	52,941	-
Increase/(decrease) in allowance recognised in net result	(52,941)	52,941
Balance at end of year	**-**	**52,941**

Receivables Recognition

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 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.

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 5.2: Inventories

	2018 $	2017 $
CURRENT		
Domestic - at cost	10,986	6,505
Medical Supplies - at cost	5,563	14,999
Pharmacy - at cost	6,797	13,353
Catering - at cost	3,361	3,171
Dental - at cost	16,023	20,605
Engineering Stores - at cost	8,604	7,086
LMRHA	2,403	1,025
TOTAL INVENTORIES	**53,737**	**66,744**

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

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

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

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

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

Note 5.3: Other Liabilities

	2018 $	2017 $
CURRENT		
Monies Held in Trust*		
- Accommodation Bonds (Refundable Entrance Fees)	3,051,061	1,182,221
- Victorian Cancer Survivorship Program	-	100,845
TOTAL CURRENT	**3,051,061**	**1,283,066**
*** Total Monies Held in Trust**		
Represented by the following assets:		
Cash Assets (refer to Note 6.1)	211,347	-
Investment and other Financial Assets (refer to Note 4.1)	2,839,714	1,283,066
TOTAL	**3,051,061**	**1,283,066**

Note 5.4: Prepayments and Other Assets

	2018 $	2017 $
Current:		
Prepayments	55,042	52,910
Loddon Mallee Rural Health Alliance	13,025	15,114
TOTAL CURRENT OTHER ASSETS	**68,067**	**68,024**
TOTAL OTHER ASSETS	**68,067**	**68,024**

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.

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 5.5: Payables

	2018 $	2017 $
CURRENT		
Contractual		
Trade Creditors	484,865	126,561
Accrued Expenses	5,950	2,320
Accrued Audit Fees	12,030	15,000
Other Payable	8,844	34,716
Loddon Mallee Rural Health Alliance	37,019	29,382
	548,708	**207,979**
Statutory		
GST Payable	8,788	10,123
PAYG Payable	60,302	57,252
TOTAL CURRENT	**69,090**	**67,375**
TOTAL PAYABLES	**617,798**	**275,354**

Payables consist of:

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

Note 5.5: Payables and Borrowings Maturity Analysis

The following table discloses the contractual maturity analysis for Boort District Health'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 18

			Maturity Dates			
2018	**Carrying Amount $**	**Nominal Amount $**	**Less than 1 Month $**	**1-3 Months $**	**3 months - 1 Year $**	**1-5 Years $**
Financial Liabilities						
At amortised cost						
Payables	548,708	548,708	548,708	-	-	-
Other Financial Liabilities (i)						
- Accommodation Bonds	3,051,061	3,051,061	-	-	3,051,061	-
Total Financial Liabilities	**3,599,769**	**3,599,769**	**548,708**	**-**	**3,051,061**	**-**
2017						
Financial Liabilities						
At amortised cost						
Payables	207,979	207,979	207,979	-	-	-
Other Financial Liabilities (i)						
- Accommodation Bonds	1,182,221	1,182,221	-	-	1,182,211	-
- Other	100,845	100,845	-	-	100,845	-
Total Financial Liabilities	**1,491,045**	**1,491,045**	**207,979**	**-**	**1,283,056**	**-**

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

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 6: How we finance our operations

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

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

Structure

6.1 Cash and Cash Equivalents
6.2 Commitments for expenditure

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 6.1: Cash and Cash Equivalents

	2018 $	2017 $
Cash on Hand	205	205
Cash at Bank	3,311,760	1,008,476
Total Cash and Cash Equivalents	**3,311,965**	**1,008,681**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	2,974,572	870,580
Cash for Monies Held in Trust		
- Accommodation Bonds (Refundable Entrance Fees)	211,347	-
- Loddon Mallee Rural Health Alliance	126,046	138,101
Total Cash and Cash Equivalents	**3,311,965**	**1,008,681**

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.

Note 6.2: Commitments for Expenditure

Boort District Health Service does not have any commitments for expenditure as at 30 June, 2018

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

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 7: Risks, contingencies & valuation uncertainties

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

Structure

7.1 Financial instruments
7.2 Contingent assets and contingent liabilities

Boort District Health
Notes to the financial statements for the year ended 30 June 2018

Note 7.1: Financial Instruments

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

(a) Financial instruments: categorisation

2018	Contractual financial assets - loans and receivables $	Contractual financial assets - available for sale $	Contractual financial liabilities at amortised cost $	Total $
Contractual Financial Assets				
Cash and cash equivalents	3,311,965	-	-	3,311,965
Receivables				
- Trade Debtors	189,504	-	-	189,504
- Other Receivables	120,911	-	-	120,911
Other Financial Assets				
- Term Deposit	2,839,714	-	-	2,839,714
Total Financial Assets [(i)]	**6,462,094**	**-**	**-**	**6,462,094**
Financial Liabilities				
Payables	-	-	548,708	548,708
Other Financial Liabilities				
- Accommodation bonds	-	-	3,051,061	3,051,061
- Other	-	-	-	-
Total Financial Liabilities [(i)]	**-**	**-**	**3,599,769**	**3,599,769**

2017	Contractual financial assets - loans and receivables $	Contractual financial assets - available for sale $	Contractual financial liabilities at amortised cost $	Total $
Contractual Financial Assets				
Cash and cash equivalents	1,008,681	-	-	1,008,681
Receivables				
- Trade Debtors	224,227	-	-	224,227
- Other Receivables	43,454	-	-	43,454
Other Financial Assets				
- Term Deposit	2,600,000	-	-	2,600,000
Total Financial Assets [(i)]	**3,876,362**	**-**	**-**	**3,876,362**
Financial Liabilities				
Payables	-	-	207,979	207,979
Other Financial Liabilities				
- Accommodation bonds	-	-	1,182,221	1,182,221
- Other	-	-	100,845	100,845
Total Financial Liabilities [(i)]	**-**	**-**	**1,491,045**	**1,491,045**

(i) The carrying amount excludes statutory receivables (i.e GST receivable and DHHS receivable) and statutory paybales (i.e Revenue in Advance and DHHS Payables)

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

	Net holding gain/(loss) $	Total interest income / (expense) $	Fee income / (expense) $	Impairment loss $	Total $
2018					
Financial Assets					
Loans and Receivables	-	114,268	-	-	114,268
Total Financial Assets	**-**	**114,268**	**-**	**-**	**114,268**
2017					
Financial Assets					
Loans and Receivables	-	86,465	-	-	86,465
Total Financial Assets	**-**	**86,465**	**-**	**-**	**86,465**

' For cash and cash equivalents, loans or receivables and financial assets available-for-sale, the net gain or loss is calculated by taking the movement in the fair value of the asset, the 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.

Boort District Health
Notes to the financial statements for the year ended 30 June 2018

Note 7.1: Financial Instruments (continued)

Categories of financial instruments

Loans and receivables and cash 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.

Boort District Health's principal financial instruments comprise of:
- Cash Assets
- Term Deposits
- Receivables (excluding statutory receivables)
- Payables (excluding statutory payables)
- Accommodation Bonds

Available-for-sale financial instrument assets are those designated as available-for-sale or not classified in any other category of financial instrument asset. Such assets are initially recognised at fair value. Subsequent to initial recognition, they are measured at fair value with gains and losses arising from changes in fair value, recognised in 'Other economic flows – other comprehensive income' until the investment is disposed. Movements resulting from impairment and foreign currency changes are recognised in the net result as other economic flows. On disposal, the cumulative gain or loss previously recognised in 'Other economic flows – other comprehensive income' is transferred to other economic flows in the net result.

Financial assets and liabilities at fair value through net result are categorised as such at trade date, or if they are classified as held for trading or designated as such upon initial recognition. Financial instrument assets are designated at fair value through profit or loss on the basis that the financial assets form part of a group of financial assets that are managed based on their fair values and have their performance evaluated in accordance with documented risk management and investment strategies. Financial instruments at fair value through net result are initially measured at fair value; attributable transaction costs are expensed as incurred. Subsequently, any changes in fair value are recognised in the net result as other economic flows. Boort District Health recognises certain debt securities in this category.

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

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

Derivative financial instruments are classified as held for trading financial assets and liabilities. They are initially recognised at fair value on the date on which a derivative contract is entered into. Derivatives are carried as assets when their fair value is positive and as liabilities when their fair value is negative. Any gains or losses arising from changes in the fair value of derivatives after initial recognition are recognised in the consolidated comprehensive operating statement as an 'other economic flow' included in the net result.

Offsetting financial instruments: Financial instrument assets and liabilities are offset and the net amount presented in the consolidated balance sheet when, and only when, Boort District Health concerned has a legal right to offset the amounts and intend either to settle on a net basis or to realise the asset and settle the liability simultaneously.

Some master netting arrangements do not result in an offset of balance sheet assets and liabilities. Where the Boort District Health does not have a legally enforceable right to offset recognised amounts, because the right to offset is enforceable only on the occurrence of future events such as default, insolvency or bankruptcy, they are reported on a gross basis.

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 Boort District Health retains the right to receive cash flows from the asset, but has assumed an obligation to pay them in full
- the Boort District Health has transferred its rights to receive cash flows from the asset and either:
  - has transferred substantially all the risks and rewards of the asset; or
  - has neither transferred nor retained substantially all the risks and rewards of the asset, but has transferred control of the asset.

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

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

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

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

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

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

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

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

Note 7.2: Contingent Assets & Contingent Liabilities

Boort District Health Service does not have any known contingent assets or liabilities at 30 June, 2018 (2017: Nil)

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

Boort District Health
Notes to the financial statements for the year ended 30 June 2018

Note 8: Other disclosures

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

Structure

8.1 Equity
8.2 Reconciliation of net result for the year to net cash inflow/(outflow) from operating activities
8.3 Responsible persons
8.4 Remuneration of Executives
8.5 Related parties
8.6 Remuneration of auditors
8.7 AASBs issued that are not yet effective
8.8 Events occurring after the balance sheet date
8.9 Jointly Controlled Operations

Boort District Health
Notes to the financial statements for the year ended 30 June 2018

Note 8.1: Equity

	2018 $	2017 $
(a) Surpluses		
Property, Plant and Equipment Revaluation Surplus		
Balance at the beginning of the reporting period		
- Land	82,000	82,000
- Buildings	4,043,544	4,043,544
Revaluation Increment		
- Buildings (refer to Note 4.2)	1,705,860	-
Balance at the end of the reporting period	**5,831,404**	**4,125,544**
Balance at the end of the reporting period*		
***Represented by:**		
- Land	82,000	82,000
- Buildings	5,749,404	4,043,544
	5,831,404	**4,125,544**
Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	1,124,049	139,300
Transfer to and from Restricted Purpose Surplus	-	984,749
Balance at the end of the reporting period	**1,124,049**	**1,124,049**
TOTAL SURPLUSES	**6,955,453**	**5,249,593**
(b) Contributed Capital		
Balance at the beginning of the reporting period	3,160,907	3,160,907
Balance at the end of the reporting period	**3,160,907**	**3,160,907**
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	8,607,776	7,905,613
Net Result for the year	(24,201)	1,686,912
Transfer to and from Restricted Purpose Surplus	-	(984,749)
Balance at the end of the reporting period	**8,583,575**	**8,607,776**
TOTAL EQUITY AT END OF FINANCIAL YEAR	**18,699,935**	**17,018,276**

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.

Note 8.2: Reconciliation of the net result for the year to net cash inflow/(outflow) from operating activities

	2018 $	2017 $
Net result for the period	(24,201)	1,686,912
Non-cash movements:		
Depreciation	895,106	886,344
Share of Net Result from LMRHA	7,131	(605)
Indirect Capital Grants from DHHS	(40,660)	(191,897)
Movements included in investing and financing activites:		
Net (Gain)/Loss from Sale of Motor Vehicles	(27,619)	(10,580)
Movements in assets and liabilities:		
Change in operating assets and liabilities		
(Increase)/Decrease in Receivables	(44,096)	174,315
(Increase)/Decrease in Prepayments	(43)	(16,369)
Change in Inventories	13,007	979
Increase/(Decrease) in Payables	342,444	(178,030)
Increase/(Decrease) in Provisions	23,071	(102,290)
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**1,144,140**	**2,248,779**

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 8.3: Responsible Persons Disclosures

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

Responsible Ministers:	**Period**
The Honourable Jill Hennessy, MLC, Minster for Health, Minister for Ambulance Services	01/07/2017-30/06/2018
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	01/07/2017-30/06/2018
Governing Boards	
Mrs M Eicher - Chair (01/07/2017-28/11/2017)	01/07/2017-30/06/2018
Mrs W Gladman - Chair (29/11/2017-30/06/2018)	01/07/2017-30/06/2018
Mr C Harrison	01/07/2017-30/06/2018
Mr G Malone	01/07/2017-30/06/2018
Mrs J Haw	01/07/2017-30/06/2018
Mr A Ferguson	01/07/2017-30/06/2018
Mrs B Simpson	01/07/2017-30/06/2018
Mrs G Smith	01/07/2017-30/06/2018
Mr N Beattie	01/07/2017-30/06/2018
Ms K Lanyon	01/07/2017-30/06/2018
Mr M Maxted	01/07/2017-30/06/2018
Ms D Sherringham	01/07/2017-30/06/2018
No remumeration was paid to any Governing Board Members for the Financial Year ended 30 June 2018	
Accountable Officers	
Mr Darren Clarke	01/07/2017-30/06/2018

Remuneration of Responsible Persons

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

	2018	**2017**
Income Band	**No.**	**No.**
$110,000 - $119,999	0	1
$120,000 - $129,999	0	1
$140,000 - $149,999	1	0
Total Number	1	2
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**$ 144,275**	**$ 243,111**

Amounts relating to Governing Board Members and Accountable Officer are disclosed in Boort District Health's controlled entities financial statements.

Amounts relating to Responsible Ministers are reported within the Department of Parliamentary Service's financial report as disclosed in Note 8.5 Related Parties.

Note 8.4: Executive Officer Disclosures

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

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

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

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

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

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

Share-based payments are cash or other assets paid or payable as agreed between the health service and the employee, provided specific vesting conditions, if any, are met.

	TOTAL REMUNERATION	
	2018	**2017**
Compensation	**$**	**$**
Short term employee benefits	110,368	102,552
Post-employment benefits	8,846	-
Other long-term benefits	-	-
Termination benefits	-	14,058
Share based payments	-	-
Total	**$119,213**	**$116,610**
Total number of executives	**1**	**2**
Total annualised employee equivalent (AEE)	**1**	**2**

Notes:

(i) The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of the entity under AASB 124 Related Party Disclosures and are also reported within the related parties note disclosure (Note 8.5).

(ii) Annualised employee equivalent is based on the time fraction worked over the reporting period. This is calculated as the total number of days the employee is engaged to work during the week by the total number of full-time working days per week (this is generally five full working days per week).

Boort District Health
Notes to the financial statements for the year ended 30 June 2018

Note 8.5: Related Parties

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

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

Key management personnel (KMP) are those people with the authority and responsibility for planning, directing and controlling the activities of Boort District Health, directly or indirectly.

The Board of Directors and the Executive Directors of Boort District Health are deemed to be KMP's.

Entity	KMPs	Position Title
Boort District Health	Mrs M Eicher	Chair of the Board
Boort District Health	Mrs W Gladman	Chair of the Board
Boort District Health	Mr C Harrison	Board Member
Boort District Health	Mr G Malone	Board Member
Boort District Health	Mrs J Haw	Board Member
Boort District Health	Mr A Ferguson	Board Member
Boort District Health	Mrs B Simpson	Board Member
Boort District Health	Mrs G Smith	Board Member
Boort District Health	Mr N Beattie	Board Member
Boort District Health	Ms K Lanyon	Board Member
Boort District Health	Mr M Maxted	Board Member
Boort District Health	Ms D Sherringham	Board Member
Boort District Health	Mr D Clarke	Chief Executive Officer

The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The ministers remuneration and allowances is set by the Parliamentary Salaries and Superannuation Act 1998, and is reported within the Department of Parliamentary Services' Financial Report.

Compensation	2018 $	2017 $
Short term employee benefits (i)	243,623	325,822
Post-employment benefits	19,866	33,899
Termination benefits	-	-
Total (ii)	**263,489**	**359,721**

(i) Total remuneration paid to KMPs employed as a contractor during the reporting period through accounts payable has been reported under short-term employee benefits.

(ii) KMPs are also reported in Note 8.4 Responsible Persons or Note 8.5 Remuneration of Executives

Significant transactions with government related entities

The Boort District Health received funding from the Department of Health and Human Services of $5.91 million ($6.913 million in 2017-18)

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

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

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

Transactions with KMPs and Other Related Parties

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

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

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

Boort District Health
Notes to the financial statements for the year ended 30 June 2018

Note 8.6: Remuneration of auditors

Victorian Auditor-General's Office	2018 $	2017 $
Audit of review of financial statements	16,500	15,400
TOTAL	**16,500**	**16,500**

Note 8.7: AASBs issued that are not yet effective

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

The table below lists all the standards and interpretations that have been issued by the AASB but were not yet effective at at 30 June 2018. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. Boort District Health 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 hedge accounting model and a revised impairment loss model to recognise expected impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1-Jan-18	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. The initial application of AASB 9 is not expected to significantly impact the financial positon however there will be a change to the way financial instruments are classified and new disclosure requirements.
AASB 2014-1 *Amendments to Australian Accounting Standards [Part E Financial Instruments]*	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018, and to amend reduced disclosure requirements.	1-Jan-18	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-18	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. Note that amending standard AASB 2015-8 *Amendments to Australian Accounting Standards – Effective Date of AASB 15* has deferred the effective date of AASB 15 to annual reporting periods beginning on or after 1 January 2018, instead of 1 January 2017.	1-Jan-18	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.
AASB 2014-5 *Amendments to Australian Accounting Standards arising from AASB 15*	Amends the measurement of trade receivables and the recognition of dividends as follows: • Trade receivables that do not have a significant financing component, are to be measured at their transaction price, at initial recognition. • Dividends are recognised in the profit and loss only when: – the entity's right to receive payment of the dividend is established;	1 Jan 2018, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

	– it is probable that the economic benefits associated with the dividend will flow to the entity; and – the amount can be measured reliably.		
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-18	This amending standard will defer the application period of AASB 15 for for-profit entities to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2016-3 *Amendments to Australian Accounting Standards – Clarifications to AASB 15*	This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: • a promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation; • for items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer, and • for licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access).	1-Jan-18	The assessment has indicated that there will be no significant impact for the public sector, other than the impact identified for AASB 15 above.
AASB 2016-7 *Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities*	This Standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019.	1-Jan-19	This amending standard will defer the application period of AASB 15 for not-for-profit entities to the 2019-20 reporting period.
AASB 2016-8 *Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities*	AASB 2016-8 inserts Australian requirements and authoritative implementation guidance for not-for-profit entities into AASB 9 and AASB 15. This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events.	1-Jan-19	This standard clarifies the application of AASB 15 and AASB 9 in a not-for-profit context. The areas within these standards that are amended for not-for-profit application include: *AASB 9* • Statutory receivables are recognised and measured similarly to financial assets *AASB 15* • The 'customer' does not need to be the recipient of goods and/or services; • The 'contract' could include an arrangement entered into under the direction of another party; • Contracts are enforceable if they are enforceable by legal or 'equivalent means'; • Contracts do not have to have commercial substance, only economic substance; and • Performance obligations need to be 'sufficiently specific' to be able to apply AASB 15 to these transactions.
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of operating leases (which are currently not recognised) on balance sheet.	1-Jan-19	The assessment has indicated that most operating leases, with the exception of short term and low value leases will come on to the balance sheet and will be recognised as right of use assets with a corresponding lease liability. In the operating statement, the operating lease expense will be replaced by depreciation expense of the asset and an interest charge.

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

			There will be no change for lessors as the classification of operating and finance leases remains unchanged.
AASB 1058 *Income of Not-for-Profit Entities*	AASB 1058 standard will replace the majority of income recognition in relation to government grants and other types of contributions requirements relating to public sector not-for-profit entities, previously in AASB 1004 *Contributions*. The restructure of administrative arrangement will remain under AASB 1004 and will be restricted to government entities and contributions by owners in a public sector context. AASB 1058 establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objective.	1-Jan-19	The current revenue recognition for grants is to recognise revenue up front upon receipt of the funds. This may change under AASB 1058, as capital grants for the construction of assets will need to be deferred. Income will be recognised over time, upon completion and satisfaction of performance obligations for assets being constructed, or income will be recognised at a point in time for acquisition of assets. The revenue recognition for operating grants will need to be analysed to establish whether the requirements under other applicable standards need to be considered for recognition of liabilities (which will have the effect of deferring the income associated with these grants). Only after that analysis would it be possible to conclude whether there are any changes to operating grants. The impact on current revenue recognition of the changes is the phasing and timing of revenue recorded in the profit and loss statement.

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 2017-18 reporting period (as listed below). In general, these amending standards include editorial and references changes that are expected to have insignificant impacts on public sector reporting.

- AASB 2016-5 *Amendments to Australian Accounting Standards – Classification and Measurements of Share-based Payment Transactions*
- AASB 2016-6 *Amendments to Australian Accounting Standards – Applying AASB 9 Financial Instruments with AASB 4 Insurance Contracts*
- AASB 2017-1 *Amendments to Australian Accounting Standards – Transfers of Investment Property, Annual Improvements 2014-16 Cycle and Other Amendments*
- AASB 2017-3 *Amendments to Australian Accounting Standards – Clarifications to AASB 4*
- AASB 2017-4 Amendments to Australian Accounting Standards – Uncertainty over Income Tax Treatments
- AASB 2017-5 Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128 and Editorial Corrections
- AASB 2017-6 Amendments to Australian Accounting Standards – Prepayment Features with Negative Compensation
- AASB 2017-7 Amendments to Australian Accounting Standards – Long-term Interests in Associates and Joint Ventures
- AASB 2018-1 Amendments to Australian Accounting Standards – Annual Improvements 2015 – 2017 Cycle
- AASB 2018-2 Amendments to Australian Accounting Standards – Plan Amendments, Curtailment or Settlement

Note:

1. For the current year, given the number of consequential amendments to AASB 9 Financial Instruments AASB 15 Revenue from Contracts with Customers, and AASB 16 Leases, the standards/interpretations have been grouped together to provide a more relevant view of the upcoming changes.

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 8.8: Events occuring after the Balance Sheet Date.

No events occured after Balance Date.

Note 8.9: Jointly controlled operations and assets

Name of entity	Principal Activity	Ownership Interest 2018 %	Ownership Interest 2017 %
Loddon Mallee Rural Health Alliance	Information Technology	2.41	2.34

Boort District Health's interest in assets employed in the above jointly controlled operations and assets in detail below. The amounts are included in the financial statements under their respective asset categories:

	2018 $	2017 $
CURRENT ASSETS		
Cash and Cash Equivalents	126,046	138,101
Receivables	16,520	8,336
Prepayments	13,024	15,114
TOTAL CURRENT ASSETS	**155,590**	**161,551**
NON-CURRENT ASSETS		
Property, Plant and Equipment	13,571	3,539
TOTAL NON-CURRENT ASSETS	**13,571**	**3,539**
TOTAL ASSETS	**169,161**	**165,090**
CURRENT LIABILITIES		
Payables	31,898	25,949
Accrued Expenses	5,120	3,433
TOTAL CURRENT LIABILITIES	**37,018**	**29,382**
NET ASSETS	**132,143**	**135,708**

Boort District Health's interest in revenue and expenses resulting from jointly controlled operations and assets is detailed below:

Revenue from Continuing Operations	179,263	178,675
Capital Purpose Income	-	(3,990)
Total Revenue	**179,263**	**174,685**
Information Technology and Administrative Expenditure	182,738	161,304
Capital Purpose Expenditure	5,725	(265)
Depreciation	1,544	2,972
Total Expenses	**190,007**	**164,011**
Net Result	**(10,744)**	**10,674**

Contingent Assets and Liabilities

The joint venture does not have any known contingent assets or contingent liabilities as at 30 June 2018.

Investments in jointly controlled assets and operations

In respect of any interest in joint operations, Boort District Health recognises in the financial statements:

- its assets, including its share of any assets held jointly;
- any liabilities including its share of liabilities that it had incurred;
- its revenue from the sale of its share pf 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.

Boort District Health

Notes to the financial statements for the year ended 30 June 2018

Note 8.10: Economic Dependancy

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

Note 8.11: Alternative Presentation of Comprehensive Operating Statement

	2018 $	2017 $
Interest	114,268	79,335
Sales of Goods and Services	1,175,083	1,222,615
Grants	4,799,988	4,636,500
Other Current Revenue	1,343,631	3,571,578
Total Revenue	**7,432,970**	**9,510,028**
Employee Expenses	(4,706,089)	(4,639,572)
Depreciation	(895,106)	(886,344)
Other Operating Expenses	(1,886,100)	(2,299,429)
Total Expenses	**(7,487,295)**	**(7,825,345)**
Net Result from Transactions - Net Operating Balance	**(54,325)**	**1,684,683**
Gain/(Loss) on non-financial assets	27,619	10,580
Gain/(Loss) from other economic flows	2,505	(8,351)
Total Other Economic Flows Included in the Net Result	**30,124**	**2,229**
Items That Will Not be Reclassified to Net Result		
Changes in Property, Plant and Equipment Revaluation Surplus	1,705,860	-
Net Result	**1,681,659**	**1,686,912**

Boort District Health

PO Box 2, Boort Victoria, 3537
Phone: (03) 5451 5200
Fax: (03) 5455 2502
www.bdh.vic.gov.au