Omeo District Health

125th Annual Report for the year ended 30th June 2017 incorporating the Consolidated Financial Statements

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Our History

When gold was discovered in Omeo in 1851, the isolated communities of Omeo, Swifts Creek, Ensay and Benambra changed dramatically with the influx of visitors. The need to build a hospital was identified in November 1891 with incorporation of the Omeo District Hospital. Provision of care for the sick and injured commenced in August 1894 until the devastating 1939 bushfires that destroyed the original building. A new 19 bed hospital was built in 1940 on the Easton Street site and continues to be utilised to provide acute and residential aged care, medical, community and allied health services. Services delivered by Omeo District Health (name change occurred in 2004) have been regularly reviewed to meet the changing needs of the community. In 1990, the acute service was reduced to twelve beds, following further reviews and funding changes in September 1993 the number was further reduced to four registered acute beds plus an emergency room and ten nursing home places. In July 1997, the construction of a purpose built four-bed hostel was completed. On the 9th December 2005 the full redevelopment of the existing hospital buildings and service areas was completed and officially opened. In 2011 Omeo became part of the Transitional Care Program (TCP) with one residential bed and one community based bed. 2015 further sees the completion of our Aged care redevelopment. All residents now have single rooms each with ensuite. The Board of Management has continued to review service provision and explore innovative ways of meeting the community's needs. The growth in community care, allied health services, and the establishment of the Medical Centre, Dental Clinic, Community Gym, the lead partner in construction of a men's shed and an in-venue Day care centre are a testament to this. The introduction of Harvest Fest during 2016, a produce sharing initiative, is yet another example of innovative programs developed to meet the community need.

Omeo District Health is established under the Health Services Act 1988. The responsible Ministers during the reporting period were:

The Honorable Jill Hennessy MP, Minister for Health and Minister for Ambulance Services

The Honorable Martin Foley MP, Minister for Housing, Disability and Ageing, Minister for Mental Health, Minister for Equality and Minister for Creative Industries.

Our Objective

Mission

To promote and enhance the health and wellbeing of the people of Omeo and district.

Aim

To provide the most effective and efficient physical, emotional and social care possible through the delivery of services that are accountable to individual and community's needs.

Objectives

To ensure the Health Service is accessible to all and continues to develop within a Best Practice model in response to the community's identified need.

To provide a coordinated continuum of health care to the communities of Omeo and district, encompassing aged and residential care, community care and appropriate acute services.

To maximise the health and wellbeing for all community members.

To provide a well-maintained, safe and pleasant environment for patients, residents, staff and visitors.

Attestations

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

I, Alison Burston certify that Omeo District Health has complied with Ministerial Direction 3.7.1 – Risk Management Framework and Processes. Omeo District Health's Audit Committee has verified this.

Alison Burston
Board of Management Chair
Omeo District Health

Date: 12 September 2017

Reece Newcomen
Chair, Audit Committee
Omeo District Health

Date: 12 SEPTEMBER 2017

Attestation on Compliance with Health Purchasing Victoria (HPV) Health Purchasing Policies

I, Ward Steet certify that *Omeo 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.

Ward Steet
Chief Executive Officer
Omeo District Health

Date: 12 SEPTEMBER 2017

Our Services

Omeo District Health provides broad-based health and support services to Omeo, Benambra, Swifts Creek, Ensay, Dinner Plain and surrounding districts.

Acute Care
4 Acute beds for general medical care
Urgent Care Centre

Residential Aged Care
10 High Level Care Beds
4 Low Level Care Beds
Diversional Therapy
Respite Care
Virtual Visiting program for Residents
Gentle exercise program for Residents

District Nursing Services
Equipment Hire
Home Visiting
Post-Acute Care Program
Respite Care
Post Discharge Support
Transitional Care program in the community

Home and Community Care
Domestic Assistance
Home Maintenance
Home Respite
Meals on Wheels
Personal Care
Social Support Group

Medical Services
Omeo Medical Centre

Dental Services
Public Dental Services
Private Dental Service

Use of the Facilities
Community Group Meetings
Optometry Services
Swifts Creek Community Centre

Ancillary Services
Radiology
Pathology

Sub-Acute Care
Rehabilitation
Transitional Care Programme

Visiting Services
Maternal & Child Health
Continence Service
Wound Consultant
Cardiologist

Allied Health & Community Services
Chronic Disease Management,
Diabetes Education
Counselling / Social Work
Dietetics
Podiatry
Foot Care
Health Promotion and Education
Information and Referral
Kindy Gym
Occupational Therapy
Physiotherapy
Speech Pathology
Youth Program
Allied Health Assistant
Community Transport
Volunteer Program
Community Gym and Exercise Classes
Pre-employment physical testing program service
In-venue child day care program

Supporting Portfolios
Administration
Environmental & Food Services
Infection Control
Maintenance & Gardens
Occupational Health & Safety
Pathology
Quality & Safety

Governance Overview

Board of Management

Mrs Alison Burston – President
Self Employed Farmer, Benambra,
Appointed 01/07/2008
Member of the Finance, Credentialing, Remuneration & Nomination Committees
Appointment Expires 30/06/2018
Board Meetings attended – 12/12

Mrs Sandra Crisp – Treasurer
Pharmacy Assistant, Omeo,
Appointed 01/07/2010
Member of the Finance and Audit Committee
Appointment Expires 30/06/2019
Board Meetings attended – 11/12

Mr David Foster
Ranger in Charge, Parks Victoria, Dinner Plain
Member of Finance and Credentialing Committee
Appointed 1/7/2016
Appointment expires 30/6/2020
Board meetings attended 9/12

Mr Alastair McKenzie - Jrn Vice President
CPA, Finance Manager. Murray Goulburn Co-operative. Omeo
Member of Finance and Audit Committees
Appointed 23/03/2017
Appointment Expires 30/06/2019
Board Meetings attended 3/3

Mr Simon Lawlor
Self Employed Farmer, Omeo
Member of Finance, Quality & Safety and Community Advisory Committees
Appointed 23/03/2017
Appointment expires 30/6/2019
Board meetings attended 3/3

Mrs Cindy Joffee
Physiotherapist, Richmond
Member of Finance & Credentialing Committees
Appointed 23/03/2017
Appointment expires 30/6/2019
Board meetings attended 1/3

Mrs Liza Newby
Ministerial Delegate, (DHHS), Mallacoota
Board meetings attended 8/9

Mr Russell Pendergast – Interim President
Self Employed Farmer, Benambra,
Board member since 1987
Member of the Finance, Quality & Safety, Credentialing & Nomination & Remuneration Committees
Appointment Expires 30/06/2017
Board Meetings attended – 12/12

Mrs Kate Commins – Vice President
Director, Merino Pastoral, Swifts Creek,
Appointed 1/07/2012
Member of Quality & Safety and Finance Committees
Appointment Expires 30/06/2018
Board Meetings attended – 11/12

Ms Suzanne Malcolm
Primary Schoolteacher, Dept. Education, Dinner Plain
Appointed 01/03/2007
Member of Finance Committee
Appointment expires 30/06/2018
Board Meetings attended – 8/12

Mrs Ann Ferguson
Commercial Manager, Sale
Member of Finance & Remuneration & Nomination Committees
Appointed 23/03/2017
Appointment expires 30/6/2018
Board meetings attended 3/3

Mrs Penny Barry
Director, Bindi Pty Ltd, Swifts Creek
Member of Finance, Quality & Safety and Community Advisory Committees
Appointed 23/03/2017
Appointment expires 30/6/2018
Board meetings attended 3/3

Mr Graeme Dear
CEO, East Gippsland Catchment Management Authority
Member of Finance and Nomination & Remuneration Committees
Appointed 23/03/2017
Appointment Expires 30/06/2019
Board Meetings attended 3/3

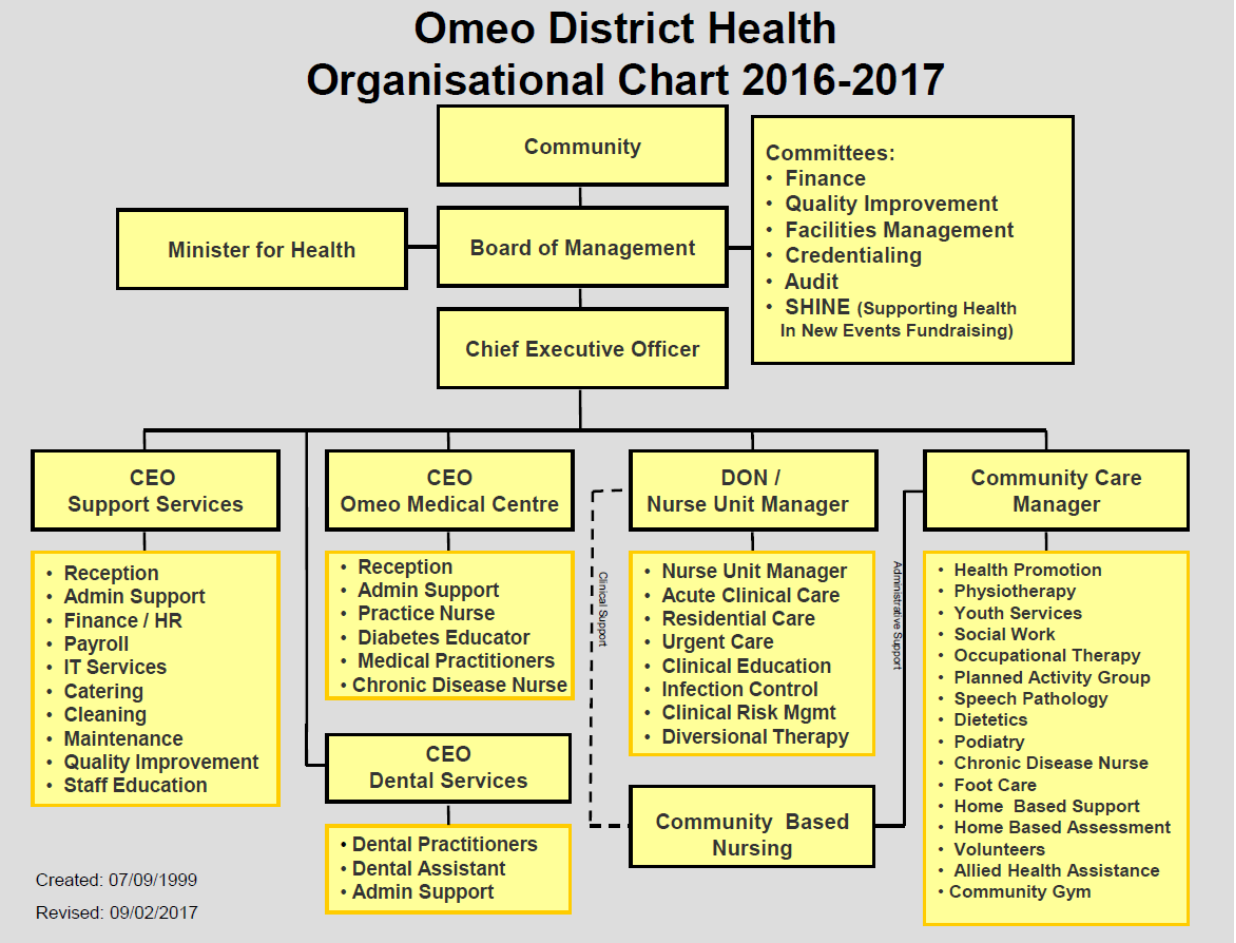
Mr Ormond Pearson
Ministerial Delegate, (DHHS), Warragul
Board meetings attended 8/11

Audit Committee

Reece Newcomen – Audit Chair
Self Employed, Farmer, Ensay
Appointed 2013

Caroline Mildenhall
Ensay Community Health Service-Employee
Appointed 2015

Lyn Bevans
Semi – Retired, Omeo
Appointed 2016



Role of the Board of Management

The Board of a public health service is responsible for its governance. It is accountable to both Government and the community that it serves for ensuring the provision of agreed services within the resources provided. Board of Management directors are appointed by the Governor-in-Council, upon the recommendations of the Minister for Health. Directors of the Board of Management act in a voluntary capacity and have not received fees in the 2016-2017 financial year. To fulfil its role, the Board should have directors with a range of appropriate expertise and experience. The functions of the Board of Management as determined by the Health Services Act 1988 are:

- To oversee the management of the hospital; and
- To ensure the services provided by the Hospital comply with the requirements of the Act and the aims of the organisation.

The goal of the board is to ensure the provision of excellent care for our residents, patients and clients as well as ensuring a safe working environment for our staff. The Board is assisted in delivering these goals by receiving regular reports on the organisations operations including Quality, Safety, Risk and Financial activities at monthly Board meetings and through Board director representation on various committees.

Resignations and New Appointments

Mr. Ward Steet was appointed as the Chief Executive Officer as at 9 January 2017. We thank Mr. Darren Fitzpatrick who held the role of Acting CEO/DON during the extended recruitment process following the resignation of the previous CEO/DON in May 2016. Ms. Ann Walker was appointed to fill the Nurse Unit Manager role vacated by Darren.

The role of CEO/DON was restructured and the role split into two distinct roles in recognition of the workload and increased reporting and accountability required of the position. Following a comprehensive recruitment process Mr. Fitzpatrick was subsequently appointed to the DON position.

Clinical governance was strengthened at ODH with the appointment of a new Director of Medical Services, Dr. Kaushik Banerjea, in a joint collaborative arrangement with Bairnsdale Regional Health Service.

During 2016-17 the Board also received the resignation of one Board member who has served the community tirelessly for over 30 years. We acknowledge the contribution Mr. Russell Pendergast has made to Omeo District

Health. Over the 30-year tenure Russell served several times as Chair of the Board of Management and sat on numerous of the Board Committees, his measured input will be missed by the Board.

ODH welcomes to the Board of Management six new directors: Mr. Graeme Dear, Mr. Simon Lawler, Ms. Ann Ferguson, Mr. Alastair McKenzie, Ms. Cindy Joffe and Ms. Penny Barry.

Also during the year ODH had the honour of having two Board delegates appointed by the Minister for Health. We would like to acknowledge and thank Mr. Ormond Pearson and Ms. Liza Newby for their wisdom and guidance over the last nine months.

GOVERNANCE

Pecuniary Interest

It is an obligation for Board directors to declare a pecuniary interest when Board discussions include matters in which they have a direct, or indirect, financial or other interest. The Conflict of Interest Register is current and can be viewed on request. There were no occasions during the year when Board directors declared a pecuniary interest in connection with Board deliberations.

Finance / Audit Committee

The Board endorses plans and strategies, and monitors the performance of ODH through appropriate budgetary processes to ensure compliance with Financial Framework requirements. The Audit committee continued meeting quarterly and reporting directly to the Board of Management, led by Reece Newcomen as independent Chairperson.

Quality & Safety Committee

The Quality & Safety committee is responsible for oversight of the clinical governance framework and the Quality Improvement Program, meeting on a monthly basis with three Board members and a range of staff from across the organisation attending. A quality improvement schedule informs the agenda and ensures the timely completion and evaluation of quality improvement activities.

Facilities Committee

This Committee was dissolved as it was felt management could adequately fulfil the functions overseen by this Committee. Board directors will instead attend to an annual 'walk-around' to review the facility infrastructure. A facility report is provided to the Board of Management regularly in the executive management report.

Credentialing Committee

Ensuring the medical and dental practitioners are appropriately qualified and experienced is an important role for this committee. Dr. Kaushick Banerjea, Director of Medical Services, supported by Ms. Kelly Greenland (Executive PA), reviewed all Medical and Dental Officer positions again this year ensuring ODH is compliant with all credentialing requirements. Reaccreditation of current staff was attended to and recommendations for appointments of new locums or visiting GP's were made to the Board of Management for approval.

Safe Patient Care

The Safe Patient Care (Nurse / Midwife to Patient Ratios) Bill 2015 was introduced to Parliament on 1 September 2015 and took effect from 23 December 2015 It delivers on the Government's commitment to enshrine in law minimum numbers of nurses and midwives to care for patients. Omeo District Health has consulted with DHHS and VHIA to ensure we comply Safe Patient Care requirements.

Statement of Priorities

The 2016-17 financial year again saw Omeo District Health commit to a framework that captured key strategic priorities and again achieve considerable advances.

The Statement of Priorities provides key actions and deliverables as the organisation travels through the year. The framework ensures key local and regional objectives are met while aligning the organisation with the direction of government policy.

See following pages for achievments.

STRATEGIC PRIORITIES

Agreement between Secretary Department of Health and Human Services and Omeo District Health

The Victorian Government's priorities and policy directions are outlined in the *Victorian Health Priorities Framework 2012–2022*.

In 2016–17 Omeo District Health contributed to the achievement of these priorities by:

Domain	Action	Deliverables	Outcome
Quality and safety	Implement systems and processes to recognise and support person-centred end of life care in all settings, with a focus on providing support for people who choose to die at home.	Ensure end of life pathways and procedures are embedded within acute and aged care areas.	*Palliative Care* and *Death and Dying with Dignity* policies in place; *palliative care pathways* in place; all Aged Care residents have advanced directives in place; All outpatients attending the Medical Centre with chronic conditions are encouraged to complete advanced care planning.
		Review current practices with Gippsland region Palliative Care Consortia in relation to care planning and additional support for community members.	Regular contact with the regional Consortia representative established and palliative care training has been delivered at ODH. The DON is a member of the GRPCC alliance. Discussions have also been held with Gippsland Lakes Community Health (GLCH) regarding home-based palliative care to ensure contemporary practice.
		Review current practice by seeking feedback from bereaved families.	Feedback has been sought from a number of bereaved families who have received support services from the ODH palliative care team. The feedback was overwhelmingly positive and complimentary of the services provided.
		Investigate availability of services and the ability to offer greater support to provide increased assistance to families to assist individuals remain in the home environment during terminal stages of care.	Meeting held with the regional consortia representative is planned to establish the range of services available to the Omeo and District region. Two nurses within ODH have had up-skilling in Palliative care. General training in Palliative Care has been provided to ODH staff. ODH provide afterhours nurse call support.
	Advance care planning is included as a parameter in an assessment of outcomes including: mortality and morbidity review reports, patient experience and routine data collection.	Review admission forms to include Advance Care Planning as an item to be assessed and followed up as part of acute admissions.	Admission forms revised to include Advanced care Planning assessment questions to encourage patients to consider their end of life wishes and commence discussions with their families
		Review chronic disease management plans and medical assessments for those over 75 years of age to ensure Advance Care Planning is discussed and offered	The ODH Chronic Disease Management Practice Nurse raises the matter of management plans and assists in the development of the plans with 75+ year old clients attending the Omeo Medical Centre

Domain	Action	Deliverables	Outcome
		to individuals. Monitor outcomes of palliative clients to ensure adherence to advanced care planning wishes.	 ODH has in place a standard practice to follow up with bereaved families following the passing of their loved one to ensure the advanced care planning wishes were followed Introduction of patient / resident death screening tool to assist in reviewing care delivery, identify any areas of concern and implement improvement plans as required
	Progress implementation of a whole-of-hospital model for responding to family violence.	Collaborate with East Gippsland Primary Care Partnership (EGPCP) and Gippsland Women's Health Service to provide local access to regional family violence initiatives. Utilise the "Strengthening Hospital responses to family violence toolkit" to ensure consistency of staff response to family violence.	ODH provided a letter of support for the EGPCP funding application related to Women's Health and Family Violence. The ODH CEO and Social Worker have attended family violence consultations and forums providing updates on available resources. All ODH staff informed about the toolkit and encouraged to familiarise themselves with it.
	Develop a regional leadership culture that fosters multidisciplinary and multi-organisational collaboration to promote learning and the provision of safe, quality care across rural and regional Victoria.	Participate with subregional partners to finalise and implement the East Gippsland Capability and Clinical Service Plan outcomes.	The East Gippsland Strategic Services Plan has been finalised and endorsed by the Boards of all four health services. An implementation plan is under development.
	Use patient feedback, including the Victorian Healthcare Experience Survey to drive improved health outcomes and experiences through a strong focus on person and family centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first.	Continue to invite receivers of care to forums to seek feedback and to enable improvement of services and the health experience.	ODH participated in the most recent VHES. The July 2015 – June 2016 results were tabled at the January 2017 Board meeting. Due to a low response rate the results, while overwhelmingly positive, were not statistically valid. ODH is developing a new Strategic Plan 2017-2020 which, as part of the process, includes community consultations in Omeo, Swifts Creek, Ensay, Benambra and Dinner Plain, encouraging input and feedback from consumers. Clients who have attended the ODH Urgent Care Centre are sent invitations to participate in a focus group to glean consumer feedback.

Domain	Action	Deliverables	Outcome
		Encourage participation of individual clients to provide feedback to our community advisory committee.	All clients are encouraged to provide feedback on the services they receive. Complaints/ Feedback form has been reviewed to make it easier for clients to provide feedback. We are also implementing an electronic feedback process on website. ODH also has social media Facebook sites for a number of its programs where feedback may be provided.
		Participate in Victorian Health Experience Survey community experience survey.	ODH participated in the Community Victorian Health Experience Survey during November/ December 2016. The results again were overwhelmingly positive.
Access and timeliness	Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine).	Review District Nursing Service (DNS) in relation to service delivery and time allocation by December 2016.	Review was completed and the day of the week the DNS was provided were changed to enhance response to community need.
		Review chronic disease programs and explore opportunities to improve service delivery to the community and integrate the two services to maintain continuity of care, refine and identify roles and interactions.	The review of the Chronic Disease Management program and the DNS revealed synergies in the two programs that that complement each other and the staff are working more closely together to ensure improved case management, especially for the more complex clients.
		Investigate and implement new technologies such as the National Broadband Network and improved videoconferencing capacity to provide support and monitoring for community members.	A telemedicine link between ODH Urgent Care and BRHS ED has been implemented and an MoU drawn up to reflect the arrangement. NBN is still not available in Omeo while the placement of the tower is being finalised. Telemedicine to outreach areas such as Benambra may be made possible once the NBN is available. A telemedicine Dietetic service model of care is being negotiated with BRHS.
		Improve access to community programs by developing a new gym in Benambra.	A partnership between the Benambra Neighbourhood house and ODH was agreed to facilitate the establishment of the Benambra Community Gym that was launched in May 2017. Total Care Gym has been appointed to perform annual equipment safety checks on all three gyms, the other two gyms being in Swifts Creek and Omeo.

Domain	Action	Deliverables	Outcome
	Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine).	Finalise Memorandum of Understanding (MoU) with Ensay Bush Nursing Centre.	The ODH CEO and the Ensay Bush Nurse have met and discussed the issues in the existing draft MoU. The MoU has been revised addressing the issues and this process is near completion.
	Develop and implement a strategy to ensure the preparedness of the organisation for the National Disability and Insurance Scheme and Home and Community Care program transition and reform, with particular consideration to service access, service expectations, workforce and financial management.	Maintain established networks to ensure awareness of proposed changes and implementation dates to assist the planning of service provision.	Key ODH staff have attended multiple NDIS and HACC transition information sessions. We have established relationships with the key program liaison contacts. ODH is also a participant in the Gippsland Region tactical response advisory group tasked with preparing health services with the transition to NDIS.
		Communicate endorsed changes to community members on a regular basis utilising local news-sheet and website to provide updates.	ODH has a regular article in the Local news-sheet that keeps the Community informed of any changes. New Commonwealth information brochure was ordered and distributed to community-based clients.
		Monitor workforce requirements and budget on a regular basis.	ODH has established two short fixed-term positions to facilitate ODH becoming a registered NDIS provider and enable assessment of the actual EFT requirement to meet service needs once the new services are in place and demand is identified.
		In partnership with staff implement identified actions to ensure Omeo District Health is positioned to respond to the National Disability and Insurance Scheme and Home and Community Care transition.	Position descriptions and organisation chart have been reviewed in context of management, staffing and program changes. The Community Services team is responding with changes as new information is made available
		Assist the community in understanding My Aged Care services and develop and share pathways to enable individuals to access services.	My Aged Care website information revised. ODH website has link to the My Aged Care website to facilitate exchange of information. ODH Community Care staff are available to assist clients to register for My Aged Care and answer any related questions.

Domain	Action	Deliverables	Outcome
Supporting healthy populations	Support shared population health and wellbeing planning at a local level - aligning with the Local Government Municipal Public Health and Wellbeing plan and working with other local agencies and Primary Health Networks.	Maintain partnerships with Gippsland Primary Health Network (GPHN) and East Gippsland Primary Care Partnership. In partnership with other health providers actively engage in East Gippsland Shire Council's planning cycle for a new East Gippsland Municipal Public Health and Wellbeing Plan (MPHWBP) 2017-21.	The ODH CEO has met with the GPHN CEO and maintains a close relationship with the Gippsland PHN. The ODH CEO now chairs the EGPCP Steering committee. The ODH CEO and Community Care Manager have been engaged in the development of the MPHWBP 2017-21. The CEO remains engaged in the Partnership Advisory Group.
	Focus on primary prevention, including suicide prevention activities, and aim to impact on large numbers of people in the places where they spend their time adopting a place based, whole of population approach to tackle the multiple risk factors of poor health.	Complete an evaluation of actions implemented in response to the 2015 community survey by November 2016. Participate in suicide prevention initiatives generated through Gippsland Primary Health Network. Set and implement strategies to address identified priority areas in the Omeo District Health Workplace Achievement Program.	An evaluation of the community survey has been completed and an action plan developed. Many actions stemming from the feedback have already been completed. ODH Social Worker has been in contact with the GPHN. ODH has commenced the delivery of the GPHN funded Access to Allied Health Psychological Service (ATAPS) focused on adult mental health interventions. The Workplace Achievement framework has been embraced by ODH with the organisation successfully achieving Level One in the program. Further initiatives are planned to see further advancement of this program within the workplace.
	Develop and implement strategies that encourage cultural diversity such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.	Review the Omeo District Health diversity plan by March 2017 and implement identified strategies to ensure Omeo District Health has inclusive practices.	The 2016-17 Diversity Plan has been completed and submitted December 2016. A working party was convened and the Gippsland Cultural Safety toolkit has been completed
	Improve the health outcomes of Aboriginal and Torres Strait Islander people by establishing culturally safe practices which	Improve access to and understanding of the "Gippsland BLACK PAGES" to enable appropriate supports are implemented to assist Aboriginal and	An electronic version of the document was distributed to staff as well as a hard copy circulated for staff review. ODH Social Worker holds the resource in her office.

Domain	Action	Deliverables	Outcome
	recognise and respect their cultural identities and safely meets their needs, expectations and rights.	Torres Strait Islander people. Complete the Gippsland Aboriginal Health Cultural Competence Framework Quality Improvement Tool and develop action plan to support implementation.	A working party was convened and the Gippsland Cultural Safety toolkit has been completed and action plan developed. Implementation of the action plan is well underway and will continue into 2017-18.
	Drive improvements to Victoria's mental health system through focus and engagement in activity delivering on the 10 Year Plan for Mental Health and active input into consultations on the Design, Service and infrastructure Plan for Victoria's Clinical mental health system.	Improve networking and understanding in relation to Victoria's 10 Year Plan for Mental Health. Identify capability to contribute to the required services and education needed in order to assist safe consistent care delivery. Explore opportunities with Latrobe Regional Hospital to support health service professionals in the area of mental health.	The ODH Social Worker has a good working knowledge of the 10-year plan and is linked into the LRH Mental Health Service and now also delivers the ATAPS program. ODH has two staff with the required competency to enable the organisation to deliver safe consistent care in relation to mental health. ODH triggers outward referral as appropriate. ODH has an established communication channel with LRH and have opened dialogue on improved care pathways between the two organisations with regard mental health clients.
	Using the Government's Rainbow eQuality Guide, identify and adopt 'actions for inclusive practices' and be more responsive to the health and wellbeing of lesbian, gay, bisexual, transgender and intersex individuals and communities.	Review current admission documentation to ensure transgender people are addressed by their preferred gender. Provide assistance and education to staff working with Lesbian, Gay, Bisexual, Transgender, or Intersex people to assist recognition and understanding the individual's specific needs and sensitivities. Undertake a gap analysis against the eQuality guide and develop an action plan to respond to identified gaps.	Documentation has been reviewed and updated to ensure that all patients have the option to state their preferred gender identification. LGBTQI preference is included in the categories available. On-line training is available to staff on LGBTQI-inclusive practice. On-line GBLTQI training is available to staff. Staff support and assistance is provided at and during admission of GBLTQI clients to ensure LGBTQI-inclusive practice. Communication strategies are discussed at case management. Information brochures and posters have been distributed around the organisation. The gap analysis has been completed and an action plan developed. Implementation of the action plan will continue into 2017-18.
Governance and leadership	Demonstrate implementation of the Victorian Clinical Governance Policy	Refine the Omeo District Health Clinical Governance Framework to assist each level of	In recognition of the importance of quality, safety, clinical governance and risk management a 0.63 EFT Manager, Quality, Safety & Risk Management

Domain	Action	Deliverables	Outcome
	Framework: Governance for the provision of safe, quality healthcare at each level of the organisation, with clearly documented and understood roles and responsibilities. Ensure effective integrated systems, processes and leadership are in place to support the provision of safe, quality, accountable and person centred healthcare. It is an expectation that health services implement to best meet their employees' and community's needs, and that clinical governance arrangements undergo frequent and formal review, evaluation and amendment to drive continuous improvement.	the organisation understand their roles and responsibilities in order to demonstrate compliance. In partnership with Bairnsdale Regional Health Service, investigate a model to increase Director of Medical Services (DMS) presence and refine role to assist in improving consistent practices. Review position descriptions further to define roles and responsibilities in line with Clinical Governance Framework.	position has been established replacing the 0.3 EFT Quality & Safety Coordinator position. This person has been developing a new clinical governance framework and a new suite of clinical and quality indicators monitored by the Board. The new ODH DMS role in partnership with BRHS has been established and is working very well. As part of the agreement ODH has access to the BRHS Mortality and Morbidity Committee for medical peer review should the need arise. The DMS is actively engaged with the ODH Quality and Safety Committee and the Credentialing Committee and performs a range of medical audits to ensure best practise is provided. Revision of position descriptions is ongoing on an annual basis during the performance review process. Quality, safety and risk management have been identified as core functions for inclusion in all position descriptions.
	Contribute to the development and implementation of Local Region Action Plans under the series of statewide design, service and infrastructure plans being progressively released from 2016 17. Development of Local Region Action Plans will require partnerships and active collaboration across regions to ensure plans meet both regional and local service needs, as articulated in the statewide design, service and infrastructure plans.	Participate in capability and service planning activity for the East Gippsland region which is expected to be completed in October 2016. Further refine strategies to ensure local relevance as part of the development of a new strategic plan for Omeo District Health from February 2017. Review health service capabilities in conjunction with strategic goals.	East Gippsland Health Services Strategic Services Plan has been finalised and endorsed by the boards of the four participating health services in East Gippsland. The implementation plan is under development and will be carried on into 2017-18. The East Gippsland Health Services Strategic Services Plan is a key document informing the ODH Strategic Plan 2017-2020 process. The strategic planning process has included numerous community consultations to ensure the Plan is inclusive of expressed community need. The plan also considers current and emerging health needs for the region based on available demographic data and health care policy change. Health Service capabilities have been reviewed but these need further alignment to the Strategic Goals that will come from the Strategic Planning process once finalised.

Domain	Action	Deliverables	Outcome
	Ensure that an anti-bullying and harassment policy exists and includes the identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal and the policy specifies a regular review schedule.	Review our current bullying and harassment policy and ensure support people are clearly identified and investigate access to counselling and support services external to Omeo District Health to assist staff in maintaining privacy and obtaining independent feedback and direction. Undertake local case studies to identify current deficiencies.	Bullying and harassment policy has been reviewed. ODH has a peer support program in place and staff also have the option of an Employee assistance Program (EAP). The People Matters Survey indicated that there were no active instances of Bullying or Harassment at the time of the survey with the data exhibiting marked improvement compared to the previous survey twelve months earlier. No cases of Bullying and Harassment have been identified to facilitate the implementation of a case study.
	Board and senior management ensure that an organisational wide occupational health and safety risk management approach is in place which includes: (1) A focus on prevention and the strategies used to manage risks, including the regular review of these controls; (2) Strategies to improve reporting of occupational health and safety incidents, risks and controls, with a particular focus on prevention of occupational violence and bullying and harassment, throughout all levels of the organisation, including to the board; and (3) Mechanisms for consulting with, debriefing and communicating with all staff regarding outcomes of investigations and controls following occupational violence and bullying and harassment incidents.	Implement the recommendations of HLB Mann Judd, internal auditors of the Omeo District Health Risk Management Framework. Increase access to the risk register to improve understanding of risks and interventions and of planning undertaken in order to minimise risk. Investigate avenues to reconfigure system to allocate risks to specific areas within the health service. Maintain a suite of key indicators to ensure regular reporting of Occupational Health & Safety, bullying, harassment and violence incident(s) are presented to staff and to the Board. Refine procedures to ensure processes for consultation, debriefing, investigation	Riskman access has been enabled for all staff and the risk register is reviewed and updated on a monthly basis. Riskman access has been enabled and the risk register is reviewed on a monthly basis by management and reported to Board level monthly. Audit Committee have undertaken and review of the full risk register. The Risk Register has risk categories to identify local and enterprise risks, further work is being undertaken to further refine the categories to separate out governance risk from operational risk and also clearly define clinical risk. The Board receives a monthly OH&S and WorkCover report. Any incidents of bullying & harassment or workplace violence are captured through the Riskman incident reporting system and reported the Quality & Safety Committee. The ODH Quality, Safety and Risk Manager is developing a new suite of quality indicators aligned to the National safety and Quality Health Service standards for reporting to the Quality & safety Committee Incident reporting authorities have been updated within Riskman. Investigation and feedback by responsible manager is part on the Riskman requirement.

Domain	Action	Deliverables	Outcome
		and feedback are consistent and undertaken in a timely manner. Implement recommendations arising from KPMG Board review and embrace direction and learnings from appointed Board delegates to ensure consistency of reporting and embed good governance principles at Omeo District Health.	KPMG Board governance Review Action Plan document developed and endorsed by the Board. Progress against the required actions are reported monthly to the Board.
	Implement and monitor workforce plans that: improve industrial relations; promote a learning culture; align with the Best Practice Clinical Learning Environment Framework; promote effective succession planning; increase employment opportunities for Aboriginal and Torres Strait Islander people; ensure the workforce is appropriately qualified and skilled; and support the delivery of high-quality and safe person centred care.	Identify and encourage individual staff members who demonstrate skills, knowledge and abilities to be integral in introducing new ideas, techniques and technologies. Maintain an educator position, and evaluate contribution and broaden scope where necessary to assist local health services like the bush nursing services to have access to learning opportunities available to Omeo District Health staff. Maintain network with East Gippsland clinical educators and continue participation and contribution to the Best Practice Clinical Learning Environment Framework.	A new revised mandatory competency framework has been implemented. NSQHS staff portfolios established. E3 Learning RHSEN online education platform introduced. Career pathway support in place for EN to RN qualification Investigating career pathway to establish Nurse Practitioner role within ODH. Discussions held with Rural Workforce Agency Victoria (RWAV) regarding possible funding sources. Lifestyle & Leisure coordinator has revamped the Aged care lifestyle activities program Educator position increased from 0.10 EFT to 0.20 EFT and the Ensay and Swifts Creek Bush Nursing Centres have been offered access to ODH resources CRANA, the peak professional body for the remote and isolated workforce of Australia, has delivered several on-site training courses at ODH in plastering, suturing, eyes and ear/nose/throat assessment and nutrition. ODH Educator is engaged and actively networking with the EG Clinical Educators Group and has been reporting against the BPCLEF requirements.

Domain	Action	Deliverables	Outcome
		Review / evaluate the educator role and introduce annual plan incorporating identified priority areas.	Review of Educator role completed and the value of the role recognised. Role increased to 0.20 EFT to enable an increased focus on identified educational opportunities.
	Create a workforce culture that: (1) includes staff in decision making; (2) promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and (3) includes consumers and the community.	Review policies and position descriptions to ensure that appropriate behaviours are identified. Ensure behaviour is one of the key selection criteria when appointing new personnel. Reinforce expected behaviour on induction to the facility and maintain awareness during training activities. Develop and encourage attendance to staff forums and meetings by enabling staff to contribute in decision making processes and offer timely feedback any concerns raised. Continue chit chat newsletter as a less formal staff communication tool.	Position descriptions refer to the organisation's Code of Conduct. The Code of Conduct and Child Safe Code of Conduct have both been reviewed. Child Safe Policy developed. Position Descriptions have been updated as positions become vacant and are recruited to. As the performance review process is undertaken the remaining position descriptions will be revised to include behaviour as a key selection criterion. Code of Conduct, Child Safe Code of Conduct, Bullying and Harassment Policy, Privacy and Confidentiality polices and are included in the Induction package. All departments hold regular staff meetings and All Staff Forums delivered by the CEO and Board Chair are held bi-monthly to provide staff with an opportunity to receive information, provide input and voice concerns. Newsletter has been reinstated.
	Ensure that the Victorian Child Safe Standards are embedded in everyday thinking and practice to better protect children from abuse, which includes the implementation of: strategies to embed an organisational culture of child safety; a child safe policy or statement of commitment to child safety; a code of conduct that establishes clear expectations for	Review the Victorian Child Safe Standards and ensure staffs are aware of their responsibilities in relation to the protection of children and their roles in responding to and reporting suspected abuse and appropriate referrals to be undertaken. Incorporate child safety responsibilities in our Vulnerable Children policy	Child Safe policy, Child Safe Staff Code of Conduct Agreement are in place. Staff have been made aware of the obligations under this legislation. The Child Safe policy and the Vulnerable Children/ Child At risk/ Failure To Disclose polices are interfaced and cross-referenced.

Domain	Action	Deliverables	Outcome
	appropriate behaviour with children; screening, supervision, training and other human resources practices that reduce the risk of child abuse; processes for responding to and reporting suspected abuse of children; strategies to identify and reduce or remove the risk of abuse and strategies to promote the participation and empowerment of children.		
	Implement policies and procedures to ensure patient facing staff have access to vaccination programs and are appropriately vaccinated and/or immunised to protect staff and prevent the transmission of infection to susceptible patients or people in their care.	Support the infection control officer in refining the program, to improve processes and the maintenance of staff immunisation information. Offer vaccinations and screening to staff to ensure their protection, other staff protection and the protection of susceptible patients. Review staff vaccination exposure record and vaccinations received to ensure accuracy of records.	The Infection Control officer has been supported with education and refinement of the position description. Further training to other staff members has been undertaken to support the infection control office position. Staff immunisation process implemented with high levels of staff uptake. A new Immunisation checklist has been developed and implemented to make accurate recording of staff immunisation status easier and to create efficiency in identifying required actions to be undertaken. Screening checklist developed as above. All new staff complete a vaccination history checklist.
Financial sustainability	Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	Monitor and review areas that are underperforming and investigate and implement improvements to improve financial position. Complete the four recommendations from HLB Mann Judd Financial Management	The two key underperforming areas identified during 2016-17 were the Community Dental Service and Residential Aged Care Service (RACS). Strategies were developed to address these areas and improve their performance and financial sustainability. The Transition Care Program community-based bed that was experiencing low throughput has been operating at over 100% capacity through a targeted response to improve admissions to the program. All four recommendations were completed and reported back to the Audit Committee.

Domain	Action	Deliverables	Outcome
		Compliance Framework audit by November 2016.	
	Actively contribute to the implementation of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measureable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling.	Introduce waste monitoring reporting by the end of September 2016 and include in monthly reporting to Quality committee. Maintain monitoring of electrical usage, review anomalies. Replace both internal and external lighting with energy efficient products as part of the Victorian Energy Efficiency Target scheme by December 2016. Review practices to ascertain correct use of clinical waste to be introduced as part of infection control role by April 2017.	Waste monitor reporting included in the 2016-17 ODH Annual Report. Waste monitor report including trend data is also reported monthly to the Quality & Safety Committee. Monthly electrical usage data is maintained by the Maintenance Manager. 70% of organisation lighting has been changed over to LED lighting to date, process ongoing. The Clinical Waste policy has been reviewed. Education to Staff has been provided on the correct methodology for waste disposal.

Part B: Performance Priorities

a) Safety and Quality Performance

Key performance indicator	Target	Actual
Accreditation		
Compliance with NSQHS Standards accreditation	Full compliance	Achieved
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Achieved
Infection prevention and control		
Compliance with cleaning standards	Full compliance	Achieved
Submission of infection surveillance data to VICNISS	Full compliance	Achieved
Compliance with the Hand Hygiene Australia program	80%	87%
Percentage of healthcare workers immunised for influenza	75%	76%
Patient experience		
Victorian Health Experience Survey – data submission	Full Compliance	Achieved
Victorian Healthcare Experience Survey – patient experience Quarter 1	95% positive experience	Full Compliance* Jul to Sep Result - Taken from Q2 Monitor
Victorian Healthcare Experience Survey – patient experience Quarter 2	95% positive experience	Full Compliance* Oct to Dec Result -Taken from Q3 Monitor

Victorian Healthcare Experience Survey – patient experience Quarter 3	95% positive experience	Full Compliance* Jan to March Result - Taken from Q4 Monitor
Victorian Healthcare Experience Survey – discharge care Quarter 1	75% very positive response	Full Compliance* Jul to Sep Result - Taken from Q2 Monitor
Victorian Healthcare Experience Survey – discharge care Quarter 2	75% very positive response	Full Compliance* Oct to Dec Result -Taken from Q3 Monitor
Victorian Healthcare Experience Survey – discharge care Quarter 3	75% very positive response	Full Compliance* Jan to March Result - Taken from Q4 Monitor

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

b) Governance, leadership and culture performance

Key performance indicator	Target	Actual
People Matter Survey - percentage of staff with a positive response to safety culture questions	80%	97%

c) Financial sustainability performance

Key performance indicator	Target	Actual
Operating Result ($m)	0.00	0.03
Creditors avg. days	<60 days	47
Debtors avg. days	<60 days	37
Adjusted current asset ratio	0.07	2.43
Days of available cash	14 Days	159.5
Asset management		
Basic asset management plan	Full compliance	Full compliance

Part C: Activity and funding

Service	Activity 2016-17
Volunteer Coordination – Community Transport	52
HACC Assessment	118
Counselling	110.5
Occupational Therapy	54.12
Health Physiotherapy	53.53
HACC Respite	72
Delivered Meals	72
Domestic Assistance	103
HACC Property Maintenance	7
HACC Nursing	146
Personal Care	231
HACC Planned Activity Group - Core	157

Board President & Chief Executive Officers Report

It is with pleasure we present the 125th Annual Report of operations for Omeo District Health (ODH), in accordance with the *Financial Management Act 1994* for the year ending 30th June 2017.

The board of directors and management recognise the important role of ODH in the region, not only as the region's primary healthcare provider but also its social responsibility as the region's largest employer. ODH is consistently reviewing its strategic direction and practices to ensure safe, quality and sustainable service provision that is compliant with State and Federal legislative obligations and health priorities while ensuring relevance to community needs.

The Strategic Plan 2014-2017 has provided the road map and outlined the key priority areas for ODH. The board has commenced the development of a new Strategic Plan 2017-2020 to align our Strategic Plan with those of our neighboring health services and guide our organisation over the coming years.

STRATEGIC INITIATIVES:

During the year progress continued to be made on meeting our Strategic Goals.

Strategic Goal 1: *To provide services that promote health and wellbeing for the community*

- Community Survey Action plan outcomes evaluated;
- ODH participated in the development of the East Gippsland Municipal Public Health and Wellbeing Plan and engaged as a member of the Advisory Group;
- Community Advisory Committee established as a committee of the board of Management;
- Strategic relationships maintained with Primary Care Partnerships (PCP), Gippsland Primary Health Network (PHN) and regional health services;
- ODH CEO appointed as Chair of the East Gippsland PCP; and
- East Gippsland Strategic Health Services Plan completed in collaboration with Bairnsdale Regional Health Service, Orbost Regional Health and Gippsland Lakes Community Health.

Strategic Goal 2: *To deliver safe, best practice care and services to the community*

- Nurse Led x-ray project implemented; four nurses trained in the use of the x-ray equipment. Diagnostic x-ray and care provided closer to home for some conditions previously requiring transfer;
- Telemedicine link established with Bairnsdale Regional Health Service for emergency services. Existing telemedicine links with Ambulance Retrieval Victoria and Royal Children's Hospital tested;
- Successful unannounced Residential Aged Care survey in May 2017;
- Manager of Food & Environmental Services upskilled to surveyor level in Cleaning Standards Auditing;
- Successful external Food Safety Survey;
- Launch in Benambra of a third Community Gym for the Omeo and District Region; and
- Establishment of an innovative produce sharing initiative, Harvest Fest.

Strategic Goal 3: *To effectively recruit, retain and build a quality workforce*

- Restructure of the CEO/DON role and successful appointments to the new positions of Chief Executive Officer and Director of Nursing;
- CEO succession plan established;
- Director of Medical Services position negotiated with Bairnsdale Regional Health Service to improve clinical governance;

- Continuation of Rural Workforce Agency Victoria (RWAV) relationship for medical recruitment and discussions commenced to establish a career pathway for registered nurses to gain a Nurse Practitioner qualification;
- Recruitment of additional General Practitioners to the Omeo Medical Centre roster
- ODH Educator position expanded;
- Restructure and streamlining of the mandatory competency professional development process;
- Commencement of 6-weekly on-site visits of Gippsland Health Alliance IT Support staff;
- Participation in Victorian Healthcare Experience Survey and the Community Victorian Healthcare Experience Survey;
- Achievement of level one in the "Healthy Together Achievement Program";
- Participation in 2017 People Matter Survey; and
- Infection Control consultant engaged to assist portfolio holder in relation to reporting and monitoring requirements and review systems.

Strategic Goal 4: *To provide services that are financially sustainable*

- Review of the Dental Service model of care including staffing structure, documentation, billing practices and quality of care;
- Restructure of Dental Services to ensure the delivery of services within available funding;
- Restructure of Finance and Administration teams to create efficiency savings and facilitate the dental restructure;
- Private Patient Initiative implemented to capture private patient revenue;
- Focus of Respite and Transition Care Program's to maximize bed occupancy and revenue capture;
- Implementation of Aged Care reforms; and
- Ongoing monitoring, review and planning in relation to HACC and National Disability Insurance Scheme (NDIS) changes. Funding secured to appoint a fixed term project worker to roll out the NDIS registration process.

Strategic Goal 5: *To review future capital asset and infrastructure requirements*

- Basic asset management plan implemented;
- Quarterly survey of facility infrastructure;
- 3-year rolling capital maintenance plan established; and
- 3-year rolling capital budget established.

Strategic Goal 6: *To actively promote partnerships and engage with the community*

- Joint board meeting held between ODH and the three neighboring health services: Bairnsdale Regional Health, Orbost Regional Health and Gippsland Lakes Community Health;
- Completion of the East Gippsland Health Service Strategic Services Plan in collaboration with Bairnsdale regional Health Service, Orbost Regional health and Gippsland Community Health Service;
- Community Advisory Committee restructured to become a board committee chaired by a board director to emphasize to importance of the Committee;
- Participation in the development of the East Gippsland Municipal Public Health and Wellbeing Plan. The ODH CEO remains on the Advisory Group;
- Active engagement in the Gippsland Health Alliance;
- The ODH CEO appointed to the Chair of the East Gippsland Primary Care Partnership; and
- Meetings held with the Ensay and Swifts Creek Bush Nursing Centres.

Strategic Goal 7: *To strengthen governance, performance, transparency and accountability*

- Restructure of the board Remuneration Committee to establish the Nomination and Remuneration Committee to address board succession planning, board training requirements, in addition to CEO succession planning, professional development and performance review requirements;
- Appointment of a Director of Medical Services to strengthen clinical governance;
- Review of key performance indicators reported to Quality Committee;
- Health legal legislative compliance tool reviewed and additional modules subscribed;
- Internal audit of the Financial Management Compliance Framework obligations and ODH VMO billing practices;
- Monthly review of the organisation's Risk Register added to the board agenda as a standing agenda item; and
- Action plan developed to implement recommendations stemming from the KPMG governance review.

Strategic Goal 8: *To promote the use of available technologies*

- Telemedicine capability enhanced through an MoU with Bairnsdale Regional Health Service;
- Digital radiology agreement reached with Bairnsdale Regional Health Service for the reading of digital x-rays taken at Omeo District Health;
- Adoption of e3learning platform to improve access to learning opportunities and to facilitate on-line competency mandatories;
- Secure password-protected board portal for electronic board papers established;
- Secure password-protected Volunteer portal for access to Induction documents, PROMPT policies and procedures and on-line training links established; and
- Cisco Jabber videoconferencing capability introduced to select computers and the Boardroom.

OPERATIONS REPORT

Enhancing the Services Available to the Community

2016-17 has been a challenging year for ODH from both governance and staffing perspectives. Changes to policy regarding board director tenure resulted in significant renewal of board director membership which presented together opportunity and loss. The appointment of six new board directors brings with it fresh eyes and a variety of valuable skills that ODH may capitalise on while equally it meant the departure of a very competent and knowledgeable board director who had selflessly served ODH for over thirty years. ODH would like to acknowledge and thank Russell Pendergast for his dedication and commitment to the community of Omeo and district during his years of service to ODH. During his tenure Russell never failed to attend any board meetings, not missing even one over the thirty year period. He served several terms as board chair overseeing some of the more significant capital developments and service expansions undertaken by ODH, in particular the development of the new Residential Aged Care facility and the introduction of the dental service to Omeo. His insight, determination, loyalty to the community is valued and will be sorely missed.

An extended recruitment process for the new CEO saw Darren Fitzpatrick perform the acting CEO role for nearly 11 months. Darren did a stellar job and the board wishes to extend its gratitude for the exemplary work and dedication demonstrated by Darren during this period. The CEO recruitment process was successful with the final outcome being a restructure of the combined CEO/Director of Nursing (DON) role, splitting the role into separate CEO and DON positions with Ward Steet being appointed to the CEO position and Darren Fitzpatrick to the newly created DON position.

The board renewal process facilitated the Ministerial appointment of two board delegates to the ODH Board for a period of twelve months. ODH welcomed Mr. Ormond Pearson and Ms. Liza Newby to the board and would like to thank them for the invaluable counsel and advice they have provided over the ensuing period. Equally the board welcomed new board director appointees Mr. Graeme Dear, Ms. Anne Ferguson, Ms. Penny Barry, Mr. Simon Lawlor, Mr. Alastair McKenzie and Ms. Cindy Joffe, all of whom brought a variety of skills and knowledge to round out and complement the existing board of directors and further strengthen stewardship and governance of ODH.

The release of Duckett review *"Targeting Zero"* brought with it many recommendations to improve the manner in which health services are managed, in particular the clinical governance surrounding the delivery of multiple and varied complex clinical services. In response ODH has appointed Dr. Kaushik Banerjea to the Director of Medical Services position at ODH. The appointment is a collaborative agreement with Bairnsdale Regional Health Service and greatly enhances ODH's clinical governance arrangements. Dr. Banerjea participates in the monthly board Quality Committee meetings, oversees the organisation's clinical governance framework, audits and processes as well as chairing the Medical & Dental Credentialing Committee.

Delivering Quality, Accessible and Coordinated Care

Omeo District Health (ODH) offers a broad suite of healthcare services to support the communities of the Omeo and District region. Our mission to promote and enhance the health and wellbeing of the people of Omeo and district remains as relevant today as when it was first coined.

ODH continually reviews the current and emerging healthcare needs of the communities we serve and strives for continuous improvement in the quality and safety of our services while keeping a focus on access and responsiveness.

ODH is an integrated healthcare service providing Acute inpatient and Urgent Care services, an inpatient and community-based Transition Care Program, respite and palliative care services, residential aged care services, a

public dental service, primary care services delivered from the Omeo Medical Centre as well as a comprehensive range of community and home-based allied health and support services.

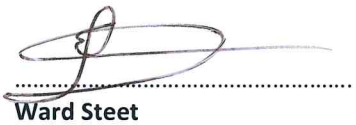
The challenge for the ODH board of directors and management is to maintain and expand the range of services available while continuing to meet all the organisation's legislative compliance obligations in a financially sustainable manner.

A key to thriving in the changing healthcare environment is the development of strong strategic partnerships and there is and will continue to be an emphasis on developing and working collaboratively with all the key stakeholders in our region, our neighboring health services, the East Gippsland Shire Council, the Primary Care Partnership, the Gippsland Primary Health Network and our funding bodies to name but a few. We will continue to lobby for additional funding and resources to meet the needs of our community.

The ODH board of directors and management would like to thank Rural Workforce Agency Victoria (RWAV) and the numerous General Practitioners that continue to support ODH, Omeo and the surrounding district for without their support the health service would cease to exist. Warm thanks is also extended to the Gippsland Primary Health Network, the Victorian Department of Health and Human Services and the Commonwealth Department of Health who provide the bulk of ODH's funding that allows us to deliver the services required to keep our communities healthy.

Recognition and appreciation must also be extended to all our board directors, the executive and management and all the past and present members of staff, including the nurses, food and environmental services staff, maintenance, administration support, ancillary staff as well as all the community care staff and contractors for without each and every one of you working together as a team we would not be able to achieve the great outcomes for our community that we do. Finally we would like to acknowledge all of our wonderful Volunteers who give up their valuable time to provide assistance in a range of ways from contributing on Committees to driving community members to medical appointments and everything in between. Omeo District Health and the community thank each and every one of you.

Alison Burston
Board of Management, Chair



Ward Steet
Chief Executive Officer

CLINICAL SERVICES REPORT

2016 – 2017 has seen a very challenging and successful year for Omeo District Health's Clinical Service's area. Whilst maintaining a broad range of clinical services to the community by a dedicated and caring team.

Our Aged Care permanent occupancy has been lower than in many other years. Despite having community members utilizing respite the next step of moving into permanent care has not been forthcoming. This is reflection of other services provided by ODH being in place to assist and support the care needs of these individuals and our Transitional Care services working well to recuperate individuals from an acute stay in hospital and support them back into the community.
The appointment of a standalone CEO in January saw the Nurse Unit Manager position split between myself and Anne Walker. Anne had done a remarkable job essentially doing the role independently whilst I was interim CEO/DON. Anne's consistency, dedication and support to ODH during this period was exceptional.

Our Educator role has continued to be successful with many sessions held throughout the year locally which have been well attended and supported. The attendance of CRANAplus onsite delivering education to our nursing staff is but one example of the addition of this role to Omeo. Maintaining relationships and support with Ambulance Victoria has also been a bonus of this role with the engagement of the local MICA officer in delivering education directly to nursing staff. e3 learning has been reviewed and provides a complete learning platform to all our staff, its coordination is maintained by the efforts of our educator as well. Our educator's enthusiasm flows to our nursing staff. Congratulations and thanks to Jackie Hughes for making this role produce opportunities to staff and thanks also to our local Ambulance Victoria MICA officer, Kerryn Wratt, for the provision of educational opportunities locally for our staff.

Our infection control practitioner has done a remarkable job in reviewing multiple aspects of the facility in relation to infection control, the provision of direction to staff and reviewing auditing practices and reporting. The ability to share this important area beyond the hidden realm of nursing has been a fantastic achievement, a fantastic effort Penny Geyle.
Nursing staff personnel numbers have been relatively stable this year with Helen Goudie resigning from her nursing role as Nurse in Charge on night duty after seven years. We wish Helen the best in her future adventures. Our Graduate nurse from last year, Josie Anderson, developed her skills and confidence. Josie continues in a casual role with ODH.

Our Diversional Therapy team of Leanne Appleby and Arielle Dickson have provided wonderful opportunities to maintain our resident's interest. The enthusiasm and diversity offered have been extensive and the multiple decorations to the residential area have ensured a more homely and at times an educational environment to not only the residents, but staff and visitors alike. Arielle resigned from the role due to the need to relocate and we wish her well in her life pursuits.

It has been a challenging year for many reasons but the first six months of this financial year sitting in as acting CEO/DON has been one of the greatest challenges. We successfully achieved our Aged Care accreditation in September. Christa Thompson as our Quality Coordinator did a remarkable job of preparation in maintaining quality activities to ensure the accreditation site visit went smoothly. Individuals also associated with this wonderful outcome who also should be acknowledged include Marijs Last, Penny Geyle, Jackie Hughes, Margaret Worcester, Anne Walker and representatives from our Board of management ensured that we achieved a successful outcome.

Standing in as Acting CEO/DON also put pressure on our nursing staff. Much appreciation is extended to the all nursing staff for their support and especially to Anne Walker for providing direction and continuity in aged and acute care and Margaret Worcester for maintaining rostering.

I wish to extend my gratitude and sincere appreciation for the support, encouragement and commitment of all our staff, Board of Management, Volunteers and the Community. All have contributed to ongoing achievements at Omeo District Health during 2016-17.

Darren Fitzpatrick –*Director of Nursing / Nurse Unit Manager*

COMMUNITY SERVICES REPORT

Changes in the 2016-2017 year

July 2016 saw the introduction of the My Aged Care platform - an initiative introduced Australia wide to provide streamlined services to older people through Home Support, Home Care Packages and Residential Aged Care. As part of this transition, services formerly provided through the State funded Home and Community Care program moved to the Commonwealth funded Commonwealth Home Support Program. Whilst clients did not see a lot of change in the services they received through ODH; there was a considerable administrative effort behind the scenes in adapting to the new program.
Home and Community Care is still the program providing support services for younger people with disabilities; however this will also undertake transition as the National Disability insurance Scheme (NDIS) is introduced in the East Gippsland region (expected from July 2018 onwards).

Some positive Health Promotion initiatives took shape in the 2016-2017 year with a new Community Gym site being opened in Benambra in partnership with the Benambra Neighbourhood House. The Harvest Exchange initiative which provides an opportunity for local fruit and vegetable gardeners to meet and swap produce moved from strength to strength and is now cemented as a regular monthly event across the year. The program attracts many participants from across the whole of the ODH catchment area.

A new fortnightly nurse-led Chronic Conditions Clinic was piloted in 2016. This clinic is targeted to support people with diagnosed chronic disease conditions. Clients are enabled to better manage their condition by improving their knowledge and understanding and making lifestyle changes that can positively impact their health.

Results from the Victorian Health Experience Survey (VHES) carried out in December 2016 showed consistent support and appreciation by consumers of the range of community based services available through Omeo District Health.

Funding Sources:

Omeo District Health Community Health Services receives funding from three main sources:

- Commonwealth funding through Gippsland Primary Health Network Place Based Flexible Funding program (Allied Health Services)
- Commonwealth funding through The Department of Health for the Commonwealth Home Support Programme
- State funding through The Department of Health and Human Services Home and Community Care Program for Younger People
- State funding through The Department of Health and Human Services Flexible Care Packages program (Disability Support)
- Local Government funding through East Gippsland Shire Council to supplement the Home and Community Care program

Services Provided:

Allied Health:

- Allied Health Assistant
- Dietetics
- Health Promotion
- Occupational Therapy
- Physiotherapy
- Podiatry/ Foot Care
- Social Work
- Speech Pathology
- Youth Services

Home Support Services:

The Commonwealth Home Support programme provides a range of entry-level aged care services for older people who need assistance with daily tasks to continue keep living independently at home and in their community.

The Home and Community Care program (program For Younger People) is aimed at assisting people with disabilities to remain living independently at home in a community setting. Monitoring of clients' health status and providing a care coordination role form an important part of the service provision for both these services.

- Domestic Assistance
- Personal care
- Respite care
- Home Maintenance/Home Modification
- Meals on Wheels and assistance with meal preparation
- Planned Activity/Social Support Group
- Home Based Nursing

In order to support these services, Omeo District Health provides independent assessment for clients through the Regional Assessment Service.

Other Services:

- Chronic Disease Management / Practice Nurse
- Community Transport
- Transitional Housing
- Omeo Kindy Gym
- High Country Men's Shed
- Community Gyms- Swifts Creek, Omeo and Benambra

Volunteers:

Omeo District Health has a small but dedicated pool of volunteers. The Commonwealth Home Support Program and the Home and Community Care program provides coordination funding to enable volunteer support and assistance in the following areas:

- Volunteer driving as part of the Community Transport program
- Assistance to the resident's Lifestyle and Leisure program
- Volunteer Supervisors for the Men's Shed program
- Delivery of meals in the Meals on Wheels program.
- Volunteer exercise program facilitators.

The contribution our volunteers make is greatly appreciated and significantly supports and extends access to programs in the community.

Flexible Care Package funding

This program, funded through Department of Health and Human Services allows younger people with disabilities to access funding for a wide range of applications to enhance independence and support.

Partnerships:

ODH Community Health Services has strong links with the East Gippsland Primary Care Partnership and East Gippsland Shire at a regional level, and at a local level works in collaboration with such organisations as Swifts Creek Bush Nursing Centre, Ensay Bush Nursing Centre, Community Centre Swifts Creek, Benambra Neighbourhood House, Ambulance Victoria, Victoria Police and local schools and early childhood centres.

Outreach services are provided out of the Swifts Creek Bush Nursing Centre on a regular basis. Services operating from this location include: Social Work, Physiotherapy and Foot Care.

Client care coordination is greatly improved through fortnightly case conferencing meetings with input from community health direct care staff, ODH acute nursing staff and medical practitioners from Omeo Medical Centre. These meetings have led to improved referral processes and streamlined care coordination for community based clients.

Marijs Last
Manager – Community Care

SHINE

ODH again thanks the ongoing support enjoyed by the organisation from the SHINE committee.
This committee meets regularly through the year and plans social and fundraising events that benefit the residents and patients of Omeo District Health.
The committee membership is open to all community members however special mention is required for our long time members including Roma Lumsden, Coleen Thomas and Thelma Langshaw.
ODH thanks these committed volunteers for their knowledge, dedication and support.

SUPPORT SERVICES

Public & Private Dental Services

The ODH Dental service was restructured during 2016-17 to ensure it remained a viable and financially sustainable service into the future. Due to an illness in the family Dr. Lex Bertrand, who provided the private component of the dental services, went on extended leave and the opportunity was taken during this time to reassess the affordability of this component of the service. The dental service had been losing considerable money for an extended period of time and the decision was taken to suspend the private component while a review was undertaken. The outcome of the review was to cease providing private dental services until a more financially sustainable model can be identified. ODH would like to thank Dr. Lex Bertrand for his years of loyal service to the community of Omeo and district and we wish him and his family all the best for a speedy recovery.

Dr. Daniel Wong, with the assistance of Mrs. Rowena Ssemwanga as Dental Assistant, has continued to provide skilled public dental services throughout the year. Rowena also provided exceptional supervision of the Dental Assistant Trainee who unfortunately resigned almost immediately upon completion of her course. Fortunately Rowena was able to continue on to provide the necessary dental assisting so the Dental Clinic could remain operating. ODH would like to thank Bairnsdale Regional Health Service for their support with the provision of Dr. Wong for without that collaborative arrangement dental services in Omeo may not be possible.

The Commonwealth Child Dental Benefits Scheme CDBS has been well received by the community and ODH continues to promote this as an important care option. The dental service will continue into 2017-18 under the current model of delivering only public dental services. ODH remains actively engaged in the Gippsland Oral Health Consortia which works hard to support dental services right across Gippsland.

Omeo Medical Centre

The practice has prospered well this year continuing to deliver General Practice services to the community of Omeo and surrounding towns/areas for the majority of weeks in the year.

We are extremely fortunate to have a large number of dedicated and experienced General Practitioners making up the medical officer team at the Medical Centre. Demand for medical services continues to increase, a testimony to the skill and knowledge our doctors bring to the role, but also a sign of the increasing needs of our ageing community. We are extremely grateful to our new and existing cohort and to those that have joined the team of “returnees” over the year. The service to ODH, Swifts creek and Ensay is well highly regarded by the communities.

Feedback from the doctors is that they value their time in Omeo and enjoy the experience and challenges of providing medical support to remote rural patients. Without exception medical staff acknowledges the success of the model.

We also wish to acknowledge the contribution to the success of this service by our clinic staff of Practice Nurse, Ms. Annie Kissane, and Practice Manager, Ms. Tracey AhSam.

The practice has continued to be popular with Medical Students from Monash Gippsland School of Medicine, Melbourne University, and James Cook University in Queensland. Students comment on this rotation as a popular placement which provides valuable rural GP clinic experience.

Food & Environmental Services

Our external food audit was conducted in April this year with favorable results, clearly demonstrating the continued delivery of excellent catering services and compliance with regulations. It is a requirement to conduct two external audits per calendar year. A Further three internal audits were also conducted indicating full compliance with food safety requirements. Catering staff, under the supervision of the Food & Environmental Services Manager, Ms. Grace Elford, maintain a continuous quality improvement approach to all aspects of operations, as evidenced by food quality and safety initiatives.

This year the Food Services staff provided innovative themes to resident meals providing enjoyment and variation in our meals service.

Department	Number of meals provided
Meals On Wheels	496
Residents and Patients	12714

It is a government requirement that external cleaning audits be conducted at least annually. The latest result of 90.2% organisational wide average on 15th July 2016 and demonstrates a continued very high standard of cleanliness. The clean environment is obvious to all entering the facility and a testament to the domestic staff hard work.

Occupational Health and Safety

Occupational Health & Safety (OH&S) is monitored through the Quality, Safety & Risk program. Regular OH&S management meetings are held with minutes of the meeting reported up through the Quality & Safety committee to the Board. Review of incidents and identified risks from across the organisation result in changes, upgrades or education as appropriate. This process is assisted by the electronic 'Riskman' incident reporting program. Each work discipline has the opportunity to escalate any concerns to one of the two duly elected OH&S representatives. This year OH&S representatives were Ms. Lisa Airs and Ms. Lisa Mitchell who were available to provide representation for staff with OHS concerns. The Community Care Manager, Ms. Marijs Last remains the OH&S management representative and the teams have worked effectively together to initiate OH&S improvements and continue to monitor issues in the workplace.

Reception / Administration / Finance / Payroll /Human Resources

The current team of Ms. Kelly Greenland, Ms. Katie VanHeek (Maternity Leave), and Ms. Merinda Sedgman work together to deliver a wide range of administrative services. It was with regret that ODH accepted the resignation of Ms. BJ Thorburn after seven years of dedicated service.

This team has been impacted significantly by the dental restructure, with dental reception moving across to the health service front reception, but true to form the team just got on with it and continued to deliver exemplary services without missing a beat.

Katie has taken on the Human Resources functions in addition to the accounts payable/receivable finance role, Merinda has moved from dental reception to take over payroll and banking and Kelly continues with her EA and front reception roles as well as assuming the dental reception function. ODH maintains clear policies on performance and behaviour for all staff and contractors and the successful maintenance of the data base "PROMPT" which holds all ODH Policies and procedure has assisted the health service in accessing these documents more easily and facilitated in the process of a number of accreditation processes.

Maintenance / Facilities / Grounds

Our hospital continues to be well serviced in our maintenance requirements through the skilled efforts of Mr. Stephen Disney and Maintenance Manager, Mr. Darryl Shepherd.

There continue to be significant improvements in the grounds and infrastructure upgrades and maintenance across the whole health service. The comprehensive preventative maintenance program for both general and essential services continues, meeting fire safety requirements and the ongoing repair needs of the organisation. Our team also provides home maintenance under the Home and Community Care (HACC) service which continues to be a valuable service to support residents in their home.

ODH has an Environmental Management Plan that is monitored and implemented by the maintenance team. During the year the team also developed a three-year rolling capital maintenance plan that will act as the roadmap for ensuring the infrastructure is maintained at an acceptable standard and the funds are available to meet the maintenance needs.

Donations:

ODH gratefully acknowledges the kind donations made by the community towards the purchase of equipment and items for residents and patients.

Hugh McMillan Estate	High Country Mens Shed	Jane Fleming
Lou Armit		

Ward Steet *Chief Executive Officer*

WORKFORCE DATA – OUR PEOPLE

Chief Executive Officer
Mr Ward Steet
B.App SC (Pysiotherapist), Grad Dip (Business Administration), MBA (Strategic Ops), MAICD

Community Services Manager
Ms M Last *B. App Sc (Occupational Therapy)*

Quality & Safety Manager
Mrs C Thompson RN
Leanne Stedman *BA(Hons), LLB(Hons), GAICD*

Director of Medical Services
Dr K. Banerjea
MBBS, FACRRM,

General Practitioners
Dr T Watford, *MB.BS, L.R.C.P. (Lond), MRCS (Eng), D. Obst. RCOG, Dip. Anaes. (Eng)*
Dr J Schlager, *MB.BS, CSCT RACGP, FACRRM, Dip. PallMed., Dip. Skin Cancer*
Dr D Appleton*, MB.BS, FACRRM*
Dr B Moore, *MB.BS, RCOG,*
Dr J Young, *MB.BS, RACGP,*

Registered Nurses
Mr D Fitzpatrick *(DON)*
Ms J Anderson(Grad RN to Jan 2017)
Mrs B Flannagan
Ms P Geyle
Mrs H Goudie
Mrs J Hughes *(Educator)*
Ms A Kissane
Mrs S O'Keefe *(Casual)*
Ms K Parker *(Casual)*
Mrs T Sedgman
Mr P Somerville
Mrs C Thompson
Mrs A Walker *(O'Brien) (NUM)*

Lifestyle Program
Ms A. Dickson
MS L. Appleby

Omeo Medical Centre
Mrs T AhSam *(Medical Centre Receptionist)*
Ms M Sedgman *(Casual Receptionist)*
Ms M Machtolf *(Casual Receptionist)*
Ms A Kissane , Practice Nurse *(incorporating Chronic Disease Management)*
Mrs A Walker (O'Brien), *Diabetes Educator*

Home Care Coordinator
Mrs N Boucher (Retired)
Mrs L Airs *(Admin assistant)*
Ms T Crisp *(Admin assistant)*
Mrs M Armstrong *(Home Support Assessor)*

Social Support Group
Mrs L Airs
Miss A Dickson
Mrs K. Weaver

Director of Nursing / Nurse Unit Manager
Mr D Fitzpatrick
Acting CEO/DON from February 2016 – 15th January, RN, RIPERN

Finance
Mr S Jackel, and Mr B. Dowsey *(CA) Accounting & Audit Solutions Bendigo*

Dental Practitioners
Dr L Bertrand, *BDSc, LDS*
Dr D. Wong, BDSc

Dr M Barson, MB.BS, RACGP
Dr R Weates, MB.BS, FACRRM
Dr J Findlow, MB.BS, FACRRM
Dr M Higgs, MB.BS, FACRRM
Dr M Chapman, MB.BS, FACRRM
Dr E Boyd, MB.BS, FACRRM

Enrolled Nurses
Miss S Anderson
Mrs J Connley
Ms K DeVisser
Ms R Fletcher
Mrs C Johnson
Mrs S Johnson
Mrs L Mitchell
Ms S O'Brien
Mrs A Richards
Mrs M Worcester

District Nursing Service
Mrs C Thompson RN

Dental Nurses / Assistants
Ms R. Ssemwanga
Ms S. Stirling-Hustler *(Trainee Dental Assistant)*
Ms M Sedgman *(Receptionist)*

Administrative Assistants
Mrs K Greenland *(Executive PA)*
Mrs B Thorburn *(Payroll/HR Officer)*
Mrs K Van Heek *(Finance Officer)*
Ms M Sedgman *(Payroll)*
Mrs T. Pendergast *(Finance Officer, Maternity Relief)*

Allied Health Staff
Ms M. Last, *Occupational Therapist (Manager)*
Mrs E Anthony, *Allied Health Assistant*
Ms L Wards, *Social Worker/Counsellor*
Ms A Seiler, *Speech Pathologist (Brokered service)*
Mrs Jill Hill, *Physiotherapist*
Mrs D Rebeiro, *Foot care services (Brokered Service)*
Mr S Learhinan*, Podiatrist (Brokered service)*
Ms L Mooney, *Health Promotion (Maternity Leave)*
Mrs C Hall, *Youth Worker*
Ms M. Smith, Youth Worker

Maintenance / Engineering
Mr D Shepherd (Manager)
Mr S Disney

Home & Community Care Workers
Mrs L Airs
Mr John Arnott *(Casual)*
Ms D Baker *(Casual)*
Ms T Crisp
Ms L Froud *(Casual)*
Mrs J Kennedy *(Casual)*
Mr Peter Matthews *(Casual)*
Ms J Miles *(Casual)*
Ms S Watts *(Casual)*
Ms K Weaver *(Casual)*

Food & Domestic Services
Ms G Elford *(Food & Environmental Services Manager)*
Ms L Appleby
Mr T Cameron
Ms P Craig
Ms L Leighton
Ms M Machtolf
Mrs M Pendergast
Ms M Sedgman
Ms P Simm
Mrs C Thomas

Volunteers
Mr John Arnott
Mrs Roma Lumsden
Mrs Joyce Lee
Mr Ron Grinter
Mr Peter Matthews
Mrs A Thorburn

Equal Employment Opportunity (EEO)

Omeo District Health is subject to the requirements of the Equal Opportunity Act 1995 and applies appropriate merit and equity principles in its management of staff. The Health Service expects all staff to take responsibility for fair, non-discriminatory behaviour.

Recognition of Service

Omeo District Health recognises staff as its greatest asset and acknowledges the dedication and commitment of all staff to residents, patients and the community. Their loyalty to the health service is highly valued.

Full Time Equivalent (FTE) for Omeo District Health:

Hospitals	**June 2017**	**June 2017**
Labour Category	**Current Month FTE**	**YTD FTE**
Nursing	15.79	16.20
Admin & Clerical	4.34	2.82
Medical Support	1.58	1.57
Hotel & Allied Services	8.33	8.42
Medical Officers	1.0	1.0
Hospital Medical Officers	N/A	N/A
Sessional Clinicians	N/A	N/A
Ancillary Staff (Allied Health)	11.58	11.29

Application of Employment and Conduct Principles

The Omeo District Health is an equal employment opportunity employer and promotes and applies the public sector principles, developed by the former Victorian State Services Authority (SSA), to its employment practices. ODH supports the Victorian Public Sector Commission's (formerly SSA) Code of Conduct for public sector employees and expects all employees to abide by this Code. All new employees receive a copy of the Code of Conduct on commencement of employment.

ABN: 24 479 149 504

Financial	2017 $,000	2016 $,000	2015 $,000	2014 $,000	2013 $,000
Total Revenue	5,219	5,323	5,060	5,295	4,718
Total Expenses	5,710	5,619	5,409	5,223	5,038
Surplus / (Deficit)	(491)	(295)	(349)	72	(320)
Retained Surplus / (Accumulated Deficit)	1,532	2,023	2,318	2,668	2,597
Total Assets	8,024	8,497	8,728	9,102	8,329
Total Liabilities	1,544	1,525	1,460	1,458	1,464
Net Assets	6,480	6,972	7,267	7,617	6,865
Total Equity	6,480	6,972	7,267	7,617	6,865

Operational and Budgetary Objectives of Omeo District Health for the Financial Year

Omeo District Health projected an operating surplus of $169,645 for the year and an overall deficit after depreciation of $416,272. The Health Service is operating under tight monetary constraints but continues to provide a broad range of services to the community.

Audited Financial Results

The financial results for 2017 reflect a net surplus before capital and specific items of $28,011 (2016 $51,915) and an overall deficit before asset revaluation movements of $491,053 (2016 deficit $295,436). The results are unfavorable against budget however the Health Service remains positive in key areas such as cash flow.

Summary of Major Changes or Factors Affecting Achievement of Operational Objectives

Decreased occupancy with Residential Aged Care has reflected unfavorably on overall financial results for Omeo District Health. The dental unit operating result has come in on budget. However, the Medical Clinic produced a negative variance on operations of $35k.

Events Subsequent to Balance Day, which may have significant effect on Operations in Subsequent Years

There have been no events subsequent to balance day which may have a significant effect on operations in subsequent years.

Consultancies costing in excess of $10,000 (ex GST)

There were no consultancies costing in excess of $10,000 during the financial year.

Consultancies costing less than $10,000 (ex GST)

There were no consultancies costing less than $10,000 during the financial year.

Fees Charged by Omeo District Health

Aged Care

ODH is bound by the Schedule of Resident Fees as set down by the Commonwealth Department of Health & Ageing on a bi-annual basis. Fees for clients include daily care fees, accommodation charges, income tested fees and accommodation bonds.

From the 1st July 2014 Aged Care underwent significant change under the Living Longer Living Better Commonwealth reforms.

Changes included a broader means tested requirement for all residents entering aged care facilities. Information regarding the changes can be accessed through the “MyAgedCare” website and staff at ODH attended training sessions to assist future residents and family with navigating the system.

Dental

ODH is bound by the fee structure set down by Dental Health Services Victoria. Fees are applicable for public and private patients.

Admitted & Non-Admitted Patients

ODH is bound by the Victorian Department of Health and Human Services Fees Manual for admitted public, private, DVA, WorkCover and TAC patients. The DHS Fees Manual also provides information on charges for non-admitted patients, referred to by ODH for Physiotherapy and Outpatient Facility Fees. Facilitated exercise programs attract a nominal fee.

Home and Community Care

ODH refers to the 'Schedule of Costs for Services provided' as set down by the Victorian Department of Health and Human Services. Fees to other health agencies include post acute care, home care for DVA clients, home care and respite for supported clients. Fees to clients include home care, home maintenance and District Nursing Service visits.

Other

ODH also charges a small fee to clients for items that are not directly funded, nor specified in the Fees Manual, by the Victorian Department of Health and Human Services or the Commonwealth Department of Health & Ageing. Fees to clients include rental of Health Service equipment, rental of Health Service buildings, and outpatient charges for procedures, starter packs and interventions

Occupational Health & Safety

Omeo District Health observes and abides by the *Occupational Health and Safety Act 2004* and seeks to secure the health, safety and welfare of employees and other persons at work by eliminating or minimizing risks at the source when possible. Omeo District Health has an Occupational Health and Safety plan that is reviewed annually. Management and OH&S staff representatives have participated in further education and have been involved in the formulation and implementation of health, safety and welfare standards. OH&S work area assessments are conducted annually to determine areas in need of improvement. Occupational Health and safety activity is documented through quarterly OH&S meetings and through the ODH Quality Management meetings.

Building & Maintenance Compliance

In the year ended 30 June 2017, all buildings of Omeo District Health were fully compliant with the *Building Act 1993*.

Freedom of Information Requests

Omeo District Health is subject to the *Freedom of Information Act (Victoria) 1982*. All health service records are accessible to the limitations imposed by the Act. The public may seek access to such records by making a written request to the Chief Executive Officer. In the year ended 30 June 2017, four (4) applications for access to documents under the Freedom of Information Act were received.

Implementation and Compliance with National Competition Policy

In accordance with the national competition principles agreed by the Federal and State Governments in April 1995, Omeo District Health has implemented policies and procedures to ensure compliance with the National Competition Policy. These programs and policies include tendering for the provision of goods and services, and a number of services are already outsourced on a competitive basis including the supply of dairy, bakery and fresh meat and vegetable produce.

ODH is compliant with Health Purchasing Victoria procurement policies and procedures.

External Reviews Undertaken in 2016-17

Quality & Safety

National Standards:

1 May 2017: Omeo District Health submitted its Progress Report 1 to the Australian Council on Healthcare Standards. This included addressing the six recommendations of the previous Survey, updating ODH's response to each of the 10 National Standards and submitting a new 2016/17 Quality Improvement Plan.

Aged Care Standards:

13 & 14 September 2016: The Australian Aged Care Quality Agency conducted a re-accreditation audit against the 44 Aged Care Standards. All Standards were met and Omeo District Health is currently accredited to 4 December 2019.

16 May 2017: The Australian Aged Care Quality Agency conducted an unannounced Assessment Contact visit to Omeo District Health. All assessed Aged Care Standards were met.

September 2016 - Food safety inspection, Gippsland Shire. External Consultant
April 2017 Food Safety Audit/Inspection, Paul Maggs. External Consultant
May 2017 – VMO Billing, HLB Mann Judd Auditors.
May 2017 – Review of Financial Management Compliance Framework (FMCF) completed, HLB Mann Judd Auditors.
15th & 16th June 2016 Crowe Horwath External Financial Audit.

Details of Major Promotional, Public Relations and Marketing Activities to Develop Community Awareness of ODH

Articles and advertisements of interest to the local community and beyond are regularly placed in the Omeo Region News Sheet, published on a weekly basis. Bairnsdale newspapers are also utilised as required. ODH produces "Healthmatters" newsletter on a quarterly basis, distributed to all local residents providing relevant health and activity information. Community health promotional activities included health checks at the Omeo Show and initiatives in response to youth issues. ODH in conjunction with Alps Link Communities Development Association supports an annual fund raising event for Motor Neurone Disease.

Details of overseas visits

No overseas visits occurred during the reporting period.

Details of Assessments and Measures Undertaken to improve OH&S of Employees

The ODH OH&S plan outlines the occupational health framework within the organisation. The Board receives a monthly OH&S report.
Influenza vaccination – offered to all staff and residents with documented uptake.
Home and Community Care (HACC) – pre-visit telephone home safety assessments conducted for HACC workers and District Nurses. On-site risk assessments also performed for HACC workers prior to commencement of service.
Organisation wide mandatory training days for all staff covering Manual Handling/No Lift, Infection Control, Fire Safety training and Emergency Response scheduled on a regular basis.
Work area OH&S inspections conducted.
ODH is a member of the Victorian Network of Smokefree Health Services.

General Statement on Industrial Relations & Details of Time Lost through Industrial Accidents & Disputes

ODH management meets regularly with employee Australian Nursing & Midwifery Federation representatives, the regional Industrial Officer and the Health Workers Union representative.
There have been 0 days lost through an industrial accident.

Protecting Your Privacy

ODH complies with the provisions of the Health Services Act 1988 (No.49/1988), the Health Records Act 2001 (No.2/2001) and the Information Privacy Act 2000 (No.98/2000) relating to confidentiality and privacy by ensuring that all employees do not disclose any information or records concerning Omeo District Health's patients, clients, staff and customers acquired in the course of their employment, other than for any authorised or lawful purpose.

Protected Disclosure Act 2012

Omeo District Health has in place appropriate procedures for disclosure in accordance with the Protected Disclosure Act 2012. No protected disclosures were made under the Act in 2016-2017.

Carers Recognition Act 2012 Statement

The Carers Recognition Act 2012 recognises, promotes and values the role of people in care relationships. Omeo District health service understands the different needs of persons in care relationships and that care relationships bring benefits to the patients, their carers and to the community. Omeo District health service takes all practicable measures to ensure that its employees, agents and carers have an awareness and understanding of the care relationship principles and this is reflected in our commitment to a model of patient and family centred care and to involving carers in the development and delivery of our services.

Details of Information and Communication Technology (ICT) expenditure

The total ICT expenditure incurred during 2016-17 is $221,770 (excluding GST) with the details shown below. ($ million)

Business As Usual (BAU) ICT Expenditure	Non – Business As Usual (non BAU) ICT expenditure	Operational expenditure (excluding GST)	Capital Expenditure (excluding GST)
Total $0.213	$0.00	$0.208	$0.05

Occupational Violence

Occupational violence statistics	2016-17
1. Workcover accepted claims with an occupational violence cause per 100 FTE	0
2. Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	0
3. Number of occupational violence incidents reported	0
4. Number of occupational violence incidents reported per 100 FTE	0
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition	0

Office Based Environmental Statement

ODH remains committed to environmental sustainability and improving environmental performance through the implementation of organisation-wide strategies in environmental sustainability and climate change adaptation.

The organisation actively strives to integrate environmental design into new and existing facilities with the aim of saving energy and reduce greenhouse gas emissions. We achieve this through reducing natural resource usage such as water, power and gas and minimising waste generation.

Redevelopment of facilities focuses on engineered environmental solutions whereby energy saving opportunities are sought through the installation of efficient insulation and double glazing in all reconstruction works. The use of solar panels for energy generation is currently being investigated.

Total energy consumption by energy type (GJ)	2014-15	2015-16	2016-17
Electricity	728	817	730
Natural gas and LPG	1,723	1,686	1,919

Normalised water consumption	2014-15	2015-16	2016-17
Water per unit of floor space (kL/m2)	0.33	0.51	0.50

Normalised greenhouse gas emissions	2014-15	2015-16	2016-17
Emissions per unit of floor space (kgCO2e/m2)	81	88	84
Emissions per unit of activity (kgCO2e/bed-day)	81	85	77

Additional information (FRD 22H)

Consistent with FRD 22H (Section 6.19) the Report of Operations should confirm that details in respect of the items listed below have been retained by Omeo District Health and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements, if applicable):

Declarations of pecuniary interests have been duly completed by all relevant officers

Details of shares held by senior officers as nominee or held beneficially;

Details of publications produced by the entity about itself, and how these can be obtained

Details of changes in prices, fees, charges, rates and levies charged by the Health Service;

Details of any major external reviews carried out on the Health Service;

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;

Details of overseas visits undertaken including a summary of the objectives and outcomes of each visit;

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;

Details of assessments and measures undertaken to improve the occupational health and safety of employees;

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;

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;

Details of all consultancies and contractors including consultants/contractors engaged, services provided, and expenditure committed for each engagement.

Victorian Industry Participation Policy

Omeo did not commence or complete any contracts to which the VIPP Act 2003 would apply.

Disclosure Index

The Annual report of the Omeo 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 requirements.

Legislation	Requirement	Page Reference
Ministerial Directions		
Report of operations – FRD Guidance		
Charter and purpose		
FRD 22H	Manner of establishment and the relevant Ministers	2
FRD 22H	Objectives, functions, powers and duties	2
FRD 22H	Nature and range of services provided	3
FRD 22H	Initiatives and Key achievements	21
Management and structure		
FRD 22H	Organisational structure	6
Financial and other information		
FRD 22H	Operational and budgetary objectives and performance against objectives	32
FRD 29B	Workforce Data Disclosures	30
FRD 22H	Workforce Data Disclosures – including a statement on application of employment and conduct principles	31
FRD 22H	Summary of the financial results for the year	32
FRD 22H	Significant changes in financial position during the year	32
FRD 22H	Major changes or factors affecting performance	32
FRD 22H	Subsequent events	n/a
FRD 22H	Compliance with building and maintenance provisions of Building *Act 1993*	33
FRD 25C	Victorian Industry Participation Policy disclosures	36
FRD 22H	Statement of National Competition Policy	33
FRD 22H	Details of consultancies over $10,000	32
FRD 22H	Details of consultancies under $10,000	32
FRD 22H	Statement of availability of other information	36
FRD 10A	Disclosure index	37
FRD 11A	Disclosure of ex-gratia expenses	n/a
FRD 12A	Disclosure of major contracts	n/a
FRD 21C	Responsible person and executive officer disclosures	42(FS)
FRD 22H	Application and operation of protected disclosure 2012	34
FRD 22H	Application and operation of Careers Recognition Act 2012	34
FRD 22H	Application and operation of Freedom of Information Act 1982	33
FRD 22H	Information and Communication Technology (ICT) Expenditure	34
FRD 22H	Ocupational Violence	35
FRD 22H	Employment conduct principles	31
FRD 24C	Reporting of office based environmental impacts	35
FRD 103F	Non-Financial Physical Assests	25(FS)

Legislation	Requirement	Page Reference
FRD 110A	Cash Flow Statements	29(FS)
FRD 112D	Defined Benefit Superannuation Obligations	15(FS)
SD 5.2.3	Declaration in Report of Operations	38
SD 3.7.1	Risk management framework and processes	4
Other requirements under Standing Directions 5.2		
SD 5.2.2	Declaration in Financial Statements	44(FS)
SD 5.2.1 (a)	Compliance with Australian accounting standards and other authoritative Pronouncements	5(FS)
SD 5.2.1 (a)	Compliance with Ministerial Directions	5(FS)
Legislation		
Freedom of Information Act 1982		33
Protected Disclosure Act 2012		34
Victorian Industry Protection Policy Act 2003		36
Careers Recognition Act 2012		34
Building Act 1993		33
Financial Management Act 1994		5(FS)
Safe Patient Care Act 2015		7

FS = Financial Statements

Responsible Bodies Declaration

In accordance with the *Financial management Act 1994,* I am pleased to present the Report of Operations for Omeo District Health for the year ending 30 June 2017.

Alison J. Burston

Alison Burston
Board of Management Chair
Omeo District Health

Date: 12 September 2017

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Omeo District Health

Opinion	I have audited the financial report of Omeo District Health (the health service) which comprises the: • balance sheet as at 30 June 2017 • 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 a summary of significant accounting policies • board member's, accountable officer's and chief finance and accounting officer's declaration. In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2017 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.
Basis for Opinion	I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. My responsibilities under the Act are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report. My independence is established by the *Constitution Act 1975.* My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Australia. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.
Board's responsibilities for the financial report	The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Financial Management Act 1994*, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error. In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, and using the going concern basis of accounting unless it is inappropriate to do so.

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
13 September 2017

Ron Mak
as delegate for the Auditor-General of Victoria

OMEO DISTRICT HEALTH
COMPREHENSIVE OPERATING STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017

	Note	2017 $	2016 $
Revenue from Operating Activities	2.1	5,031,652	4,945,960
Revenue from Non-Operating Activities	2.1	61,363	86,892
Employee Expenses	3.1	(3,472,750)	(3,305,588)
Non Salary Labour Costs	3.1	(534,363)	(581,546)
Supplies and Consumables	3.1	(129,968)	(142,208)
Other Expenses	3.1	(927,923)	(951,595)
Net Result Before Capital and Specific Items		28,011	51,915
Capital Purpose Income	2.1	126,477	290,098
Depreciation	4.4	(644,421)	(638,282)
Net Result After Capital and Specific Items		(489,933)	(296,269)
Other Economic Flows Included in Net Result			
Revaluation of Long Service Leave	3.2	(1,120)	833
Total Other Economic Flows Included in Net Result		(1,120)	833
NET RESULT FOR THE YEAR		(491,053)	(295,436)
Other Comprehensive Income			
Items that will not be reclassified to net result			
Changes in physical asset revaluation surplus	8.1	-	-
Total Other Comprehensive Income		-	-
COMPREHENSIVE RESULT		**(491,053)**	**(295,436)**

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

OMEO DISTRICT HEALTH
BALANCE SHEET
AS AT 30 JUNE 2017

	Note	2017 $	2016 $
Current Assets			
Cash and Cash Equivalents	6.1	697,270	378,122
Receivables	5.1	335,198	138,066
Investments and other Financial Assets	4.1	1,951,737	2,374,044
Prepayments and Other Assets		33,858	32,831
Total Current Assets		**3,018,063**	**2,923,063**
Non-Current Assets			
Receivables	5.1	49,364	40,319
Property, Plant & Equipment	4.3	4,956,824	5,533,382
Total Non-Current Assets		**5,006,188**	**5,573,701**
TOTAL ASSETS		**8,024,251**	**8,496,764**
Current Liabilities			
Payables	5.3	395,063	297,300
Provisions	3.2	621,793	598,595
Other Liabilities	5.2	412,132	519,233
Total Current Liabilities		**1,428,988**	**1,415,128**
Non-Current Liabilities			
Provisions	3.2	114,514	109,834
Total Non-Current Liabilities		**114,514**	**109,834**
TOTAL LIABILITIES		**1,543,502**	**1,524,962**
NET ASSETS		**6,480,749**	**6,971,802**
EQUITY			
Property, Plant and Equipment Revaluation Reserve	8.1a	3,049,328	3,049,328
Restricted Specific Purpose Reserve	8.1b	106,508	106,508
Contributed Capital	8.1b	1,793,235	1,793,235
Accumulated Surpluses	8.1c	1,531,678	2,022,731
TOTAL EQUITY		**6,480,749**	**6,971,802**
Commitments	6.2		
Contingent Assets and Contingent Liabilities	7.2		

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

OMEO DISTRICT HEALTH
STATEMENT OF CHANGES IN EQUITY
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017

	Note	Property, Plant and Equipment Revaluation Reserve $	Restricted Specific Purpose Reserve $	Contributed Capital $	Accumulated Surpluses/ (Deficits) $	Total $
Balance at 1 July 2015		3,049,328	106,508	1,793,235	2,318,167	7,267,238
Net result for the year	8.1c	-	-	-	(295,436)	(295,436)
Other comprehensive income for the year	8.1a	-	-	-	-	-
Balance at 30 June 2016		**3,049,328**	**106,508**	**1,793,235**	**2,022,731**	**6,971,802**
Net result for the year	8.1c	-	-	-	(491,053)	(491,053)
Other comprehensive income for the year	8.1a	-	-	-	-	-
Balance at 30 June 2017		**3,049,328**	**106,508**	**1,793,235**	**1,531,678**	**6,480,749**

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

OMEO DISTRICT HEALTH
CASH FLOW STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2017

	Note	2017 $	2016 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		3,876,490	3,838,754
Capital Grants from Government		20,522	66,462
Patient and Resident Fees Received		437,449	471,057
Donations and Bequests Received		24,292	125,770
GST (Paid to)/received from ATO		3,941	8,012
Interest Received		58,370	108,843
Other Receipts		616,868	584,648
Total Receipts		***5,037,932***	***5,203,546***
Employee Expenses Paid		(3,400,123)	(3,327,203)
Fee for Service Medical Officers		(534,363)	(581,546)
Payments for Supplies and Consumables		(107,010)	(56,312)
Other Payments		(1,021,768)	(731,519)
Total Payments		***(5,063,264)***	***(4,696,580)***
NET CASH FLOW (USED IN) / FROM OPERATING ACTIVITIES	8.2	(25,332)	506,966
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for Property, Plant and Equipment		(67,863)	(266,533)
Purchase of Investments		344,789	(467,401)
NET CASH FLOW FROM / (USED IN) INVESTING ACTIVITIES		276,926	(733,934)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		251,594	(226,968)
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		332,170	559,138
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.1	583,764	332,170

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

BASIS OF PRESENTATION

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

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

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

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

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

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

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

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

These annual financial statements represent the audited general purpose financial statements for Omeo District Health for the period ended 30 June 2017. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

These financial statements are general purpose financial statements which have been prepared in accordance with the *Financial Management Act* 1994, and applicable Australian Accounting Standards (AASs), which include interpretations issued by the Australian Accounting Standards Board (AASB). They are presented in a manner consistent with the requirements of AASB101 *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 AASB's.

The annual financial statements were authorised for issue by the Board of Omeo District Health on 12 September, 2017.

(b) Reporting Entity

The financial statements includes all the controlled activities of Omeo District Health.

Its principal address is:
Easton Street
Omeo, Victoria 3898

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

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

(b) Reporting Entity (Continued)

Objectives and funding

Omeo District Health's overall objective is to promote and enhance the health and wellbeing of to people of Omeo and district, as well as improve the quality of life to Victorians.

Omeo District Health is predominantly funded by accrual based grant funding for the provision of outputs.

(c) Basis of accounting preparation and measurement

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

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

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

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

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

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

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

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

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

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

- The fair value of land, buildings, infrastructure, plant and equipment, (refer to Note 7.1);
- Superannuation expense (refer to Note 3.3); and
- Actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.2).

(d) Principles of Consolidation

Intersegment Transactions

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

NOTE 2: FUNDING DELIVERY OF OUR SERVICES

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

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

Structure
2.1 Analysis of revenue by source

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE

	Admitted Patients 2017 $	Residential Aged Care 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	TOTAL 2017 $
Government Grants	1,732,297	840,842	366,179	635,423	286,116	3,860,857
Indirect Contributions by Department of Health and Human Services	2,176	6,093	1,998	3,146	856	14,269
Patient and Resident Fees	51,981	243,443	113,999	53,793	-	463,216
Commercial Activities and Specific Purpose Funds	-	-	-	-	343,475	343,475
Other Revenue from Operating Activities	15,130	18,438	49,744	29,715	236,808	349,835
Total Revenue from Operating Activities	**1,801,584**	**1,108,816**	**531,920**	**722,077**	**867,255**	**5,031,652**
Property Income	-	-	-	-	2,993	2,993
Bank and Investment Income	-	-	-	-	58,370	58,370
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**-**	**61,363**	**61,363**
Capital Purpose Income	-	-	-	-	126,477	126,477
Total Capital Purpose Income	**-**	**-**	**-**	**-**	**126,477**	**126,477**
Total Revenue	**1,801,584**	**1,108,816**	**531,920**	**722,077**	**1,055,095**	**5,219,492**

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)

	Admitted Patients 2016 $	Residential Aged Care 2016 $	Aged Care 2016 $	Primary Health 2016 $	Other 2016 $	TOTAL 2016 $
Government Grants	1,634,029	932,170	390,821	628,614	247,083	3,832,717
Indirect Contributions by Department of Health and Human Services	(1,042)	(2,919)	(957)	(1,507)	(410)	(6,835)
Patient and Resident Fees	12,184	248,510	104,548	105,815	-	471,057
Commercial Activities and Specific Purpose Funds	-	-	-	-	354,575	354,575
Other Revenue from Operating Activities	7,253	15,894	28,367	25,156	217,776	294,446
Total Revenue from Operating Activities	**1,652,424**	**1,193,655**	**522,779**	**758,078**	**819,024**	**4,945,960**
Property Income	-	-	-	-	4,995	4,995
Bank and Investment Income	-	-	-	-	81,897	81,897
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**-**	**86,892**	**86,892**
Capital Purpose Income	-	-	-	-	290,098	290,098
Total Capital Purpose Income	**-**	**-**	**-**	**-**	**290,098**	**290,098**
Total Revenue	**1,652,424**	**1,193,655**	**522,779**	**758,078**	**1,196,014**	**5,322,950**

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

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 Omeo 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 Metropolitan Health and Aged Care Services Division Hospital Circular 04/2017.

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)

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 provision of meals to external users is recognised at the time the 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 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.

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

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

Category Groups
Omeo District Health has used the following category groups for reporting purposes for the current and previous financial years.

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

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

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

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

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

NOTE 3: THE COST OF DELIVERING SERVICES

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

Structure

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

NOTE 3.1: ANALYSIS OF EXPENSE BY SOURCE

	Admitted Patients 2017 $	Residential Aged Care 2017 $	Aged Care 2017 $	Primary Health 2017 $	Other 2017 $	TOTAL 2017 $
Employee Expenses	607,946	1,685,665	399,878	608,577	170,684	3,472,750
Other Operating Expenses						
Non Salary Labour Costs	25,309	5,228	357	144,848	358,621	534,363
Supplies and Consumables	31,951	68,465	5,416	18,873	5,263	129,968
Other Expenses	107,056	261,337	88,912	198,522	272,096	927,923
Total Expenditure from Operating Activities	**772,262**	**2,020,695**	**494,563**	**970,820**	**806,664**	**5,065,004**
Depreciation (refer note 4)	-	-	-	-	644,421	644,421
Total Other Expenses	**-**	**-**	**-**	**-**	**644,421**	**644,421**
Total Expenses	**772,262**	**2,020,695**	**494,563**	**970,820**	**1,451,085**	**5,709,425**

	Admitted Patients 2016 $	Residential Aged Care 2016 $	Aged Care 2016 $	Primary Health 2016 $	Other 2016 $	TOTAL 2016 $
Employee Expenses	573,614	1,618,674	410,131	558,334	144,835	3,305,588
Other Operating Expenses						
Non Salary Labour Costs	23,834	2,566	838	174,240	380,068	581,546
Supplies and Consumables	51,112	57,990	4,382	22,548	6,176	142,208
Other Expenses	100,780	202,383	69,689	136,575	442,168	951,595
Total Expenditure from Operating Activities	**749,340**	**1,881,613**	**485,040**	**891,697**	**973,247**	**4,980,937**
Depreciation (refer note 4)	-	-	-	-	638,282	638,282
Total Other Expenses	**-**	**-**	**-**	**-**	**638,282**	**638,282**
Total Expenses	**749,340**	**1,881,613**	**485,040**	**891,697**	**1,611,529**	**5,619,219**

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

NOTE 3.1: ANALYSIS OF EXPENSE BY SOURCE (Continued)

Employee expenses

Employee expenses include:

- Wages and salaries;
- Annual leave;
- Sick leave;
- Long service leave; and
- Superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

Grants and Other Transfers

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

Other operating expenses

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

Supplies and Consumables

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

Bad and Doubtful Debts

Refer to Note 4.1 *Investments and other financial assets.*

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

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

Other Economic Flows Included in Net Result

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

Net Gain / (Loss) on Non-Financial Assets

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

Net Gain / (Loss) on Disposal of Non-Financial Assets

Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal and is determined after deducting from the proceeds the carrying value of the asset at that time.

Other gains/(losses) from Other Economic Flows

Other gains/(losses) include:

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

Derecognition of financial liabilities

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

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

NOTE 3.2: EMPLOYEE BENEFITS IN THE BALANCE SHEET	2017 $	2016 $
Current Provisions		
Employee Benefits (i)		
Accrued Wages, ADO & Annual Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	291,489	242,798
- unconditional and expected to be settled wholly after 12 months (iii)	-	-
Long Service Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	90,000	90,000
- unconditional and expected to be settled wholly after 12 months (iii)	180,609	208,329
Provisions related to employee benefit on-costs		
- unconditional and expected to be settled wholly within 12 months (ii)	40,514	35,343
- unconditional and expected to be settled wholly after 12 months (iii)	19,181	22,125
Total Current Provisions	621,793	598,595
Non-Current Provisions		
Employee Benefits (i)	103,520	99,289
Provisions related to employee benefit on-costs	10,994	10,545
Total Non-Current Provisions	114,514	109,834
Total Provisions	736,307	708,429
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Unconditional Long Service Leave Entitlements	299,348	330,012
Annual Leave Entitlements	272,886	233,366
Accrued Salaries and Wages	38,408	31,028
Accrued Days Off	11,151	4,189
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements (iii)	114,514	109,834
Total Employee Benefits and Related On-Costs	736,307	708,429

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

	2017 $	2016 $
Movements in provisions		
Movement in Long Service Leave:		
Balance at start of year	439,846	426,112
Provision made during the year		
- revaluations	1,120	(833)
- expense recognising employee service	76,759	65,775
Settlement made during the year	(103,863)	(51,208)
Balance at end of year	413,862	439,846

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

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

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

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.

NOTE 3.2: EMPLOYEE BENEFITS IN THE BALANCE SHEET (Continued)

Wages and salaries, annual leave and accrued days off

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

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

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

Long service leave (LSL)

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

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

The components of this current LSL liability are measured at:

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

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

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

Termination benefits

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

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

On-Costs related to employee expense

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

NOTE 3.3: SUPERANNUATION

Fund		Paid Contributions for the Year		Outstanding Contributions at Year End	
		2017 $	**2016 $**	**2017 $**	**2016 $**
Defined Benefit Plans:	Health Super	-	11,422	-	-
Defined Contribution Plans:	Health Super	243,780	235,309	36,720	10,900
	HESTA	36,132	31,946	-	-
Total		**279,912**	**278,677**	**36,720**	**10,900**

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

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

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

Defined contribution superannuation plans

In relation to defined contributions (i.e. accumulation) superannuation plans, the associated expense is simply the employer contributions that are paid or payable in respect of employees who are members of these plans during the reporting period. Contributions to defined contribution superannuation plans are expensed when incurred.

NOTE 3.3: SUPERANNUATION (Continued)

Defined benefit superannuation plans

The amount charged to the Comprehensive Operating Statement in respect of defined benefit superannuation plans represents the contributions made by the Health Service to the superannuation plans in respect of the services of current Health Service staff during the reporting period. Superannuation contributions are made to the plans based on the relevant rules of each plan, and are based upon actuarial advice.

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

The name and details of the major employee superannuation funds and contributions made by Omeo District Health are disclosed in Note 11: Superannuation.

Superannuation liabilities

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

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY

The hospital 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 Jointly controlled operations and assets
4.3 Property, plant & equipment
4.4 Depreciation and amortisation

NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS	Total	
	2017	2016
CURRENT	$	$
Loans and Receivable		
Term Deposit		
Aust. Dollar Term Deposits >3 months (i)	1,951,737	2,374,044
TOTAL CURRENT	1,951,737	2,374,044
TOTAL	1,951,737	2,374,044
Represented by:		
Health Service Investments	1,539,605	1,854,811
Monies Held in Trust		
- Accommodation Bonds (Refundable Entrance Fees)	412,132	519,233
TOTAL	1,951,737	2,374,044

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

(b) Ageing analysis of other investments and financial assets
Please refer to Note 7.1 for the ageing analysis of investments and other financial assets.

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

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

Investments are classified in the following categories:
- financial assets at fair value through profit or loss;
- held-to-maturity;
- loans and receivables; and
- available-for-sale financial assets.

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

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

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

NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS (Continued)

Derecognition of financial assets

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

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

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

Impairment of financial assets

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

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

Doubtful debts

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

NOTE 4.2: JOINTLY CONTROLLED OPERATIONS AND ASSETS

Name of Entity	Principal Activity	Ownership Interest 2017 %	Ownership Interest 2016 %
Gippsland Health Alliance	Information Technology	2.24	2.22

The amounts included within each respective asset and liability line item of the Hospital's financial statements at 30 June 2017 is disclosed below:

	2017 $	2016 $
Current Assets		
Cash and Cash Equivalents	113,506	45,951
Receivables and Other	66,172	31,536
Total Current Assets	179,678	77,487
Non Current Assets		
Plant and Equipment	1,199	294
Total Non Current Assets	1,199	294
Total Assets	180,877	77,781
Current Liabilities		
Payables	24,301	15,251
Total Current Liabilities	24,301	15,251
Net Assets	156,576	62,530

Omeo District Hospitals interest in revenues and expenses resulting from jointly controlled operations and assets is detailed below:

Revenue from Operating Activities	234,590	216,093
Expenditure	217,201	220,807
Surplus/(Deficit) before Capital and Depreciation	17,389	(4,714)
Capital Purpose Income	76,727	-
Depreciation	70	26
Total	76,657	(26)
Current Year Surplus/(Deficit)	94,046	(4,740)

NOTE 4.2: JOINTLY CONTROLLED OPERATIONS AND ASSETS (Continued)

Contingent Liabilities and Capital Commitments

There are no known contingent liabilities or commitments for expenditure for Gippsland Health Alliance as at the date of this report.

Investments in joint operations

In respect of any interest in joint operations, Alexandra 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.

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT **(a) Gross carrying amount and accumulated depreciation**	2017 $	2016 $
Land		
- Land at Fair Value	338,000	338,000
Less Impairment	-	-
Total Land	338,000	338,000
Buildings		
- Buildings under Construction	-	-
- Buildings at Cost	351,901	351,901
Less Accumulated Depreciation	8,798	-
	343,103	351,901
- Buildings at Fair Value	5,462,000	5,462,000
Less Accumulated Depreciation	1,548,918	1,032,612
	3,913,082	4,429,388
- Leasehold Improvements at Cost	23,918	23,918
Less Accumulated Depreciation	23,918	17,938
	-	5,980
Total Buildings	4,256,185	4,787,269
Plant and Equipment		
- Plant - Gippsland Health Alliance (refer note 4.2)	1,269	371
- Plant and Equipment at Fair Value	1,060,107	1,054,384
Less Accumulated Depreciation	835,435	773,820
Total Plant and Equipment	225,941	280,935
Furniture and Fittings		
- Furniture and Fittings at Fair Value	546,535	485,293
Less Accumulated Depreciation	451,140	433,472
Total Furniture and Fittings	95,395	51,821
Motor Vehicles		
- Motor Vehicles at Fair Value	259,423	259,423
Less Accumulated Depreciation	218,120	184,066
Total Motor Vehicles	41,303	75,357
TOTAL	4,956,824	5,533,382

Share of jointly controlled assets included in property, plant and equipment are separately disclosed in Note 4.2 Jointly Controlled Operations and Assets.

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)
(b) Reconciliation of the carrying amounts of each class of asset

	Land	Buildings	Leasehold Improvements	Plant and Equipment	Furniture & Fittings	Motor Vehicle	Total
	$	$	$	$	$	$	$
Balance at 1 July 2015	338,000	5,097,209	11,958	296,131	71,477	90,356	5,905,131
Additions	-	200,386	-	46,662	-	19,485	266,533
Disposals	-	-	-	-	-	-	-
Depreciation (note 4)	-	(516,306)	(5,978)	(61,858)	(19,656)	(34,484)	(638,282)
Balance at 1 July 2016	338,000	4,781,289	5,980	280,935	51,821	75,357	5,533,382
Additions	-	-	-	6,621	61,242	-	67,863
Disposals	-	-	-	-	-	-	-
Depreciation (note 4)	-	(525,104)	(5,980)	(61,615)	(17,668)	(34,054)	(644,421)
Balance at 30 June 2017	338,000	4,256,185	-	225,941	95,395	41,303	4,956,824

Land and buildings carried at valuation

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

The effective date of the valuation is 30 June 2014.

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

	Carrying amount as at 30 June 2017	Fair value measurement at end of reporting period using: Level 1 (1)	Level 2 (1)	Level 3 (1)
Land at fair value				
Non-specialised land	148,000	-	148,000	-
Specialised land	190,000	-	-	190,000
Total of land at fair value	338,000	-	148,000	190,000
Buildings & Leasehold Improvements at fair value				
Non-specialised buildings	230,000	-	230,000	-
Specialised buildings & leasehold improvements	4,026,185	-	-	4,026,185
Total of building at fair value	4,256,185	-	230,000	4,026,185
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles	41,303	-	41,303	-
- Plant and equipment	225,941	-	-	225,941
- Furniture and Fittings	95,395	-	-	95,395
Total of plant, equipment and vehicles at fair value	362,639	-	41,303	321,336
Assets Under Construction at fair value				
- Buildings under Construction	-	-	-	-
Total assets under construction at fair value	-	-	-	-
TOTAL	4,956,824	-	419,303	4,537,521

(i) Classified in accordance with the fair value hierarchy,
There have been no transfers between levels during the period.

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

	Carrying amount as at 30 June 2016	Fair value measurement at end of reporting period using: Level 1 (1)	Level 2 (1)	Level 3 (1)
Land at fair value				
Non-specialised land	148,000	-	148,000	-
Specialised land	190,000	-	-	190,000
Total of land at fair value	338,000	-	148,000	190,000
Buildings & Leasehold Improvements at fair value				
Non-specialised buildings	230,000	-	230,000	-
Specialised buildings & leasehold improvements	4,557,269	-	-	4,557,269
Total of building at fair value	4,787,269	-	230,000	4,557,269
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles	75,357	-	75,357	-
- Plant and equipment	280,935	-	-	280,935
- Furniture and Fittings	51,821	-	-	51,821
Total of plant, equipment and vehicles at fair value	408,113	-	75,357	332,756
Assets Under Construction at fair value				
- Buildings under Construction	-	-	-	-
Total assets under construction at fair value	-	-	-	-
TOTAL	5,533,382	-	453,357	5,080,025

(i) Classified in accordance with the fair value hierarchy,
There have been no transfers between levels during the period.

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

- The fair value of land, buildings, infrastructure, plant and equipment, (refer to Note 7.1);
- Superannuation expense (refer to Note 3.3);
- Actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.2); and
- Equities and management investment schemes classified at level 3 of the fair value hierarchy.

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

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

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

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

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

For the purpose of fair value disclosures, Omeo 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, Omeo 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 Omeo District Health's independent valuation agency.

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

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

- the fair value of land, buildings, infrastructure, plant and equipment (refer to Note 7.1);
- superannuation expense (refer to Note 3.3); and
- actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.2).

Fair value measurement

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

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

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

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

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

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

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

In considering the HBU for non-financial physical assets, valuers are probably best placed to determine highest and best use (HBU) in consultation with Health Services. Health Services and their valuers therefore need to have a shared understanding of the circumstances of the assets. A Health Service has to form its own view about a valuer's determination, as it is ultimately responsible for what is presented in its audited financial statements.

In accordance with 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.

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

Valuation hierarchy

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

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

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

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

30 June 2017	Land	Buildings & Leasehold Improvements	Plant and equipment
Opening Balance	190,000	4,557,269	332,756
Purchases (sales)	-	-	67,863
Gains or losses recognised in net result			
- Depreciation	-	(531,084)	(79,283)
Subtotal	190,000	4,026,185	321,336
Closing Balance	190,000	4,026,185	321,336

30 June 2016	Land	Buildings & Leasehold Improvements	Plant and equipment
Opening Balance	190,000	4,716,592	367,608
Purchases (sales)	-	-	46,662
Transfers in (out) of Level 3	-	351,901	-
Gains or losses recognised in net result			
- Depreciation	-	(511,224)	(81,514)
Subtotal	190,000	4,557,269	332,756
Closing Balance	190,000	4,557,269	332,756

There have been no transfers between levels during the period.

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.

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)
(d) Reconciliation of Level 3 fair value (Continued)
Identifying unobservable inputs (level 3) fair value measurements (Continued)
A Health Service shall develop unobservable inputs using the best information available in the circumstances, which might include the Health Service's own data. In developing unobservable inputs, a Health Service may begin with its own data, but it shall adjust this data if reasonably available information indicates that other market participants would use different data or there is something particular to the Health Service that is not available to other market participants. A Health Service need not undertake exhaustive efforts to obtain information about other market participant assumptions. However, a Health Service shall take into account all information about market participant assumptions that is reasonably available. Unobservable inputs developed in the manner described above are considered market participant assumptions and meet the object of a fair value measurement.

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

For non-specialised land and non-specialised buildings, an independent valuation was performed by independent valuers Valuer-General Victoria to determine the fair value using the market approach.

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

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

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

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

For the health services, the depreciated replacement cost method is used for the majority of specialised buildings, adjusting for the associated depreciation. As depreciation adjustments are considered as significant and unobservable inputs in nature, specialised buildings are classified as Level 3 for fair value measurements.

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

Vehicles
The Health Service acquires new vehicles and at times disposes of them before completion of their economic life. The process of acquisition, use and disposal in the market is managed by the Health Service who set relevant depreciation rates during use to reflect the consumption of the vehicles. As a result, the fair value of vehicles does not differ materially from the carrying value (depreciated cost).

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

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

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

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

	Valuation technique	Significant unobservable inputs	Range (weighted average)	Sensitivity of fair value measurement to changes in significant unobservable inputs.
Specialised land	Market Approach	Community Service Obligation (CSO)	20%	A significant increase or decrease in the CSO adjustment would result in a significantly lower (higher) fair value.
Specialised Buildings	Depreciated Replacement Cost	Direct cost per square metre	$669 - $2625 ($1,489)	A significant increase or decrease in direct cost per square metre adjustment would result in a significantly higher or lower fair value.
		Useful life of specialised buildings	20 - 40 Years	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Plant and equipment at fair value	Depreciated Replacement Cost	Cost per Unit	$108 - $47,500 ($4,055)	A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value.
		Useful life of PP	3-13 Years (9 Years)	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Vehicles	Depreciated Replacement Cost	Cost per Unit	$6,445 - $23,558 ($16,480)	A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value.
		Useful life of vehicles	7 Years (4.5 Years)	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.

Refer to Note 7.3 for guidance on fair value measurement indicative expectations.

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

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 4.3 Property, plant and equipment.

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

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

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

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

NOTE 4.3: PROPERTY, PLANT AND EQUIPMENT (Continued)

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

Revaluations of non-current physical assets

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

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

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

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

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

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

NOTE 4.4: DEPRECIATION	2017 $	2016 $
Depreciation		
Buildings	525,104	516,306
Leasehold Improvements	5,980	5,978
Plant and Equipment	61,545	61,832
Furniture and Fittings	17,668	19,656
Motor Vehicles	34,054	34,484
Gippsland Health Alliance (refer note 4.2)	70	26
TOTAL DEPRECIATION	644,421	638,282

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

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

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

	2017	**2016**
Buildings		
- Structure Shell Building Fabric	20 to 40 years	20 to 40 years
- Site Engineering Services and Central Plant	20 to 37 years	20 to 37 years
Central Plant		
- Fit Out	10 to 21 years	10 to 21 years
- Trunk Reticulated Building Systems	10 to 21 years	10 to 21 years
Plant and Equipment	3 to 13 years	3 to 13 years
Medical Equipment	6 to 10 years	6 to 10 years
Computers and Communication	3 years	3 years
Furniture and Fittings	3 to 13 years	3 to 13 years
Motor Vehicles	3 to 7 years	3 to 7 years

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

NOTE 5: OTHER ASSETS AND LIABILITIES

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

Structure
5.1 Receivables
5.2 Other liabilities

NOTE 5.1: RECEIVABLES	2017 $	2016 $
CURRENT		
Contractual		
Trade Debtors	197,389	87,223
Accrued Revenue	59,370	7,206
Gippsland Health Alliance Receivables (refer note 4.2)	66,172	31,858
less provision for doubtful debts	-	(176)
	322,931	126,111
Statutory		
GST Receivable	12,267	11,955
	12,267	11,955
TOTAL CURRENT RECEIVABLES	335,198	138,066
NON CURRENT		
Statutory		
Long Service Leave - Department of Health and Human Services	49,364	40,319
TOTAL NON-CURRENT RECEIVABLES	49,364	40,319
TOTAL RECEIVABLES	384,562	178,385
(a) Movement in the Allowance for doubtful debts		
Balance at beginning of the year	(176)	(176)
Decrease in allowance recognised in net result	176	-
Balance at end of the year	-	(176)

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

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

Receivables consist of:

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

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

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

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

NOTE 5.2: OTHER LIABILITIES	2017 $	2016 $
CURRENT		
Monies Held in Trust*		
- Accommodation Bonds (Refundable Entrance Fees)	412,132	519,233
TOTAL CURRENT	412,132	519,233
*** Total Monies Held in Trust**		
Represented by the following assets:		
Investments and Other Financial Assets (refer to Note 4.1)	412,132	519,233
TOTAL	412,132	519,233

NOTE 5.3: PAYABLES	2017 $	2016 $
CURRENT		
Contractual		
Trade Creditors	157,688	134,730
Accrued Audit Fees	14,400	14,400
Gippsland Health Alliance Payables (refer note 4.2)	24,301	15,251
Other	11,646	9,798
	208,035	174,179
Statutory		
PAYG Payable	80,671	34,802
GST Payable - Health Service	12,549	8,296
Department of Health and Human Services	93,808	80,023
	187,028	123,121
TOTAL PAYABLES	395,063	297,300

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

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

Payables consist of:

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

- statutory payables, such as goods and services tax and fringe benefits tax payables.

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

NOTE 6: HOW WE FINANCE OUR OPERATIONS

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

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

NOTE 6.1: CASH AND CASH EQUIVALENTS	2017	2016
For the purposes of the cash flow statement, cash assets includes cash on hand and in banks, and short-term deposits which are readily convertible to cash on hand, and are subject to an insignificant risk of change in value, net of outstanding bank overdrafts.	$	$
Cash at Bank and on Hand	104,386	116,893
Cash Management Account	479,378	215,277
Cash at Gippsland Health Alliance (refer note 4.2)	113,506	45,952
TOTAL CASH AND CASH EQUIVALENTS	697,270	378,122
Represented by:		
Cash for Health Service Operations (as per cash flow statement)	583,764	332,170
Cash for Monies Held in Trust		
- Cash for Gippsland Health Alliance (refer note 4.2)	113,506	45,952
TOTAL CASH AND CASH EQUIVALENTS	697,270	378,122

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

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

NOTE 6.2: COMMITMENTS FOR EXPENDITURE

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

There are no known capital or leasing commitments as at the date of this report, at 30 June 2017 (30 June 2016: $Nil)

NOTE 7: RISKS, CONTINGENCIES & VALUATION UNCERTAINTIES

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

Structure

7.1 Financial instruments
7.2 Contingent assets and contingent liabilities
7.3 Fair value determination

NOTE 7.1: FINANCIAL INSTRUMENTS

Financial risk management objectives and policies

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

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

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

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

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

Categorisation of financial instruments

	Carrying Amount 2017 $	Carrying Amount 2016 $
Financial Assets		
Cash and cash equivalents	697,270	378,122
Loans and Receivables	2,274,668	2,500,155
Total Financial Assets (i)	2,971,938	2,878,277
Financial Liabilities		
At amortised cost	620,167	693,412
Total Financial Liabilities (ii)	620,167	693,412

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

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

	Net holding gain/(loss) 2017 $	Net holding gain/(loss) 2016 $
Financial Assets		
Cash and Cash Equivalents (i)	(34,663)	(4,567)
Loans and Receivables	93,033	62,937
Total Financial Assets	58,370	58,370
Financial Liabilities		
At amortised cost (ii)	-	-
Total Financial Liabilities	-	-

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

(ii) For financial liabilities measured at amortised cost, the net gain or loss is calculated by taking the interest expense, plus or minus foreign exchange gains or losses arising from the revaluation of financial liabilities measured at amortised cost.

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(c) Credit Risk

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

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

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

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

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

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

2017	Financial Institutions (min. BBB credit rating) $	Government agencies (AAA credit rating) $	Other (Unrated) $	Total $
Financial Assets				
Cash and Cash Equivalents	697,270	-	-	697,270
Receivables				
- Trade Debtors	-	-	322,931	322,931
Other Financial Assets				
- Term Deposit	1,951,737	-	-	1,951,737
Total Financial Assets	2,649,007	-	322,931	2,971,938
2016				
Financial Assets				
Cash and Cash Equivalents	378,122	-	-	378,122
Receivables				
- Trade Debtors	-	-	126,111	126,111
Other Financial Assets				
- Term Deposit	2,374,044	-	-	2,374,044
Total Financial Assets	2,752,166	-	126,111	2,878,277

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
(c) Credit Risk (Continued)
Ageing analysis of financial asset as at 30 June

			Past Due But Not Impaired				
2017	Carrying Amount $	Not Past due and not impaired $	Less than 1 Month $	1 - 3 Months $	3 Months - 1 Year $	1 - 5 Years $	Impaired Financial Assets $
Financial Assets							
Cash and Cash Equivalents	697,270	697,270	-	-	-	-	-
Receivables							
- Trade & Patient Debtors	322,931	276,114	1,285	10,555	34,977	-	-
Other Financial Assets							
- Term Deposits	1,951,737	1,951,737	-	-	-	-	-
Total Financial Assets	2,971,938	2,925,121	1,285	10,555	34,977	-	-
2016							
Financial Assets							
Cash and Cash Equivalents	378,122	378,122	-	-	-	-	-
Receivables							
- Trade & Patient Debtors	126,111	82,413	5,180	6,660	31,682	-	176
Other Financial Assets							
- Term Deposits	2,374,044	2,374,044	-	-	-	-	-
Total Financial Assets	2,878,277	2,834,579	5,180	6,660	31,682	-	176

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

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

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

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

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

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
(d) Liquidity Risk (Continued)
Maturity analysis of financial liabilities as at 30 June

			Maturity Dates			
	Total Carrying Amount	Nominal Amount	Less than 1 Month	1 - 3 Months	3 Months - 1 Year	1 - 5 Years
2017	$	$	$	$	$	$
Financial Liabilities						
Payables	208,035	208,035	208,035	-	-	-
Other Financial Liabilities						
- Accommodation Bonds	412,132	412,132	-	-	412,132	-
Total Financial Liabilities	620,167	620,167	208,035	-	412,132	-
2016						
Financial Liabilities						
Payables	174,179	174,179	174,179	-	-	-
Other Financial Liabilities						
- Accommodation Bonds	519,233	519,233	-	-	519,233	-
Total Financial Liabilities	693,412	693,412	174,179	-	519,233	-

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

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

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

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

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

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

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

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
(e) Market Risk (Continued)
Interest Rate Exposure of Financial Assets and Liabilities as at 30 June

2017	Weighted Average Effective Interest Rate (%)	Carrying Amount	Interest Rate Exposure		
			Fixed Interest Rate $	Variable Interest Rate $	Non - Interest Bearing $
Financial Assets					
Cash and Cash Equivalents	1.61	697,270	-	697,065	205
Receivables					
- Trade Debtors	-	322,931	-	-	322,931
Other Financial Assets					
- Term Deposit	2.26	1,951,737	1,951,737	-	-
Total Financial Assets		2,971,938	1,951,737	697,065	323,136
Financial Liabilities					
Payables	-	208,035	-	-	208,035
Other Financial Liabilities					
- Accommodation Bonds	-	412,132	-	-	412,132
Total Financial Liabilities		620,167	-	-	620,167

2016	Weighted Average Effective Interest Rate (%)	Carrying Amount	Interest Rate Exposure		
			Fixed Interest Rate $	Variable Interest Rate $	Non - Interest Bearing $
Financial Assets					
Cash and Cash Equivalents	0.67	378,122	-	377,917	205
Receivables					
- Trade Debtors	-	126,111	-	-	126,111
Other Financial Assets					
- Term Deposit	2.86	2,374,044	2,374,044	-	-
Total Financial Assets		2,878,277	2,374,044	377,917	126,316
Financial Liabilities					
Payables	-	174,179	-	-	174,179
Other Financial Liabilities					
- Accommodation Bonds	-	519,233	-	-	519,233
Total Financial Liabilities		693,412	-	-	693,412

Sensitivity Disclosure Analysis
Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, the Omeo District Health believes the following movements are 'reasonably possible' over the next 12 months (base rates are sourced from the Westpac Banking Corporation).
- A parallel shift of +1% and -1% in market interest rates (AUD) from year-end rates of 3.22%.

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
(e) Market Risk (Continued)
Sensitivity Disclosure Analysis (Continued)
The following table discloses the impact on net operating result and equity for each category of interest bearing financial instrument held by Omeo District Health at year end as presented to key management personnel, if changes in the relevant risk occur.

	Carrying Amount	Interest Rate Risk			
		-1%		+1%	
		Profit	Equity	Profit	Equity
2017	$	$	$	$	$
Financial Assets					
Cash and Cash Equivalents	697,270	(6,973)	(6,973)	6,973	6,973
		(6,973)	(6,973)	6,973	6,973
2016					
Financial Assets					
Cash and Cash Equivalents	378,122	(3,781)	(3,781)	3,781	3,781
		(3,781)	(3,781)	3,781	3,781

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

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

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

Comparison between carrying amount and fair value

	Carrying Amount 2017 $	Fair Value 2017 $	Carrying Amount 2016 $	Fair Value 2016 $
Financial Assets				
Cash and Cash Equivalents	697,270	697,270	378,122	378,122
Receivables				
- Trade Debtors	322,931	322,931	126,111	126,111
Other Financial Assets				
-Term Deposits	0	0	2,374,044	2,374,044
Total Financial Assets	**1,020,201**	**1,020,201**	**2,878,277**	**2,878,277**
Financial Liabilities				
Payables	208,035	208,035	174,179	174,179
Other Financial Liabilities				
-Accommodation Bonds	412,132	412,132	519,233	519,233
Total Financial Liabilities	**620,167**	**620,167**	**693,412**	**693,412**

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 Health Service. Due to the nature of Omeo 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. For example, statutory receivables arising from taxes, fines and penalties do not meet the definition of financial instruments as they do not arise under contract.

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

The following refers to financial instruments unless otherwise stated.

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
(e) Market Risk (Continued)
Categories of non-derivative financial instruments
Loans and receivables
Loans and receivables are financial instrument assets with fixed and determinable payments that are not quoted on an active market. These assets are initially recognised at fair value plus any directly attributable transaction costs. Subsequent to initial measurement, loans and receivables are measured at amortised cost using the effective interest method, less any impairment.

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

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

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

NOTE 7.2: CONTINGENT ASSETS AND CONTINGENT LIABILITIES
Contingent assets and contingent liabilities are not recognised in the Balance Sheet, but are disclosed by way of note and, if quantifiable, are measured at nominal value. Contingent assets and contingent liabilities are presented inclusive of GST receivable or payable respectively.

There are no known contingent assets or liabilities for Omeo District Health as at the date of this report (30 June 2016: $Nil)

NOTE 7.3: FAIR VALUE DETERMINATION

Asset Class	Examples of types of assets	Expected fair value level	Likely valuation approach	Significant inputs (Level 3 only)
Non-specialised land	In areas where there is an active market: - vacant land - land not subject to restrictions as to use or sale	Level 2	Market approach	N/A
Specialised land	Land subject to restrictions as to use and/or sale Land in areas where there is not an active market	Level 3	Market approach	CSO adjustments
Non-specialised buildings	For general/commercial buildings that are just built	Level 2	Market approach	N/A
Specialised buildings [(i)]	Specialised buildings with limited alternative uses and/or substantial customisation e.g. prisons, hospitals, and schools	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Plant and equipment [(i)]	Specialised items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Vehicles	If there is an active resale market available;	Level 2	Market approach	N/A
	If there is no active resale market available	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life

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

NOTE 8: OTHER DISCLOSURES

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

Structure

NOTE 8.1: EQUITY	2017 $	2016 $
(a) Surpluses		
Property, Plant and Equipment Revaluation Reserve [1]		
Balance at beginning of the reporting period		
- Land	336,000	336,000
- Buildings	2,713,328	2,713,328
Revaluation Increment/(Decrement)		
- Land	-	-
- Buildings	-	-
Balance at the end of the reporting period	3,049,328	3,049,328
Represented by:		
- Land	336,000	336,000
- Buildings	2,713,328	2,713,328
	3,049,328	3,049,328

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

(b) Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	106,508	106,508
Balance at the end of the reporting period	106,508	106,508
Total Surpluses	3,155,836	3,155,836
Contributed Capital		
Balance at the beginning of the reporting period	1,793,235	1,793,235
Balance at the end of the reporting period	1,793,235	1,793,235
(c) Accumulated Surpluses		
Balance at the beginning of the reporting period	2,022,731	2,318,167
Net Result for the Year	(491,053)	(295,436)
Balance at the end of the reporting period	1,531,678	2,022,731
Total Equity at end of financial year	6,480,749	6,971,802

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

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

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

General purpose surplus
No General purpose surpluses are in existence at the date of this report.

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

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

	2017 $	2016 $
NET RESULT FOR THE YEAR	(491,053)	(295,436)
Non-cash movements		
Depreciation	644,351	638,256
Share of Net Result from Joint Operations	13,222	(4,740)
Movements included in investing and financing activities		
Net (Gain)/Loss from Sale of Plant and Equipment	-	-
Movements in assets and liabilities		
Change in Operating Assets and Liabilities		
(Increase)/Decrease in Receivables	(307,416)	90,625
(Increase)/Decrease in Prepayments	(1,027)	(8,664)
Increase/(Decrease) in Payables	88,713	78,334
Increase/(Decrease) in Provisions	27,878	8,591
NET CASH INFLOW FROM OPERATING ACTIVITIES	(25,332)	506,966

NOTE 8.3: OPERATING SEGMENTS

	ACUTE		RACS		OTHER SERVICES		CONSOLIDATED	
	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $
REVENUE								
External Segment Revenue	1,801,584	1,652,424	1,108,816	1,193,655	2,250,722	2,394,974	5,161,122	5,241,053
Total Revenue	**1,801,584**	**1,652,424**	**1,108,816**	**1,193,655**	**2,250,722**	**2,394,974**	**5,161,122**	**5,241,053**
EXPENSES								
External Segment Expenses	773,382	748,507	2,020,695	1,881,613	2,916,468	2,988,266	5,710,545	5,618,386
Total Expenses	**773,382**	**748,507**	**2,020,695**	**1,881,613**	**2,916,468**	**2,988,266**	**5,710,545**	**5,618,386**
Net Result from ordinary activities	**1,028,202**	**903,917**	**(911,879)**	**(687,958)**	**(665,746)**	**(593,292)**	**(549,423)**	**(377,333)**
Interest Income	-	-	-	-	58,370	81,897	58,370	81,897
Net Result for Year	**1,028,202**	**903,917**	**(911,879)**	**(687,958)**	**(607,376)**	**(511,395)**	**(491,053)**	**(295,436)**
OTHER INFORMATION								
Segment Assets	4,722,386	4,905,482	2,934,991	3,192,250	366,874	399,032	8,024,251	8,496,764
Total Assets	**4,722,386**	**4,905,482**	**2,934,991**	**3,192,250**	**366,874**	**399,032**	**8,024,251**	**8,496,764**
Segment Liabilities	664,660	693,460	821,398	777,152	57,444	54,350	1,543,502	1,524,962
Total Liabilities	**664,660**	**693,460**	**821,398**	**777,152**	**57,444**	**54,350**	**1,543,502**	**1,524,962**
Acquisition of property, plant and equipment and intangible assets	50,618	214,121	3,000	9,118	14,245	43,294	67,863	266,533
Depreciation expense	380,791	375,082	234,338	233,956	29,292	29,244	644,421	638,282
Non cash expenses other than depreciation	648	8,984	-	-	-	-	648	8,984

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

Business Segments	**Services**
Acute	Acute Hospital services
Residential Aged Care	Nursing Home facilities Hostel facilities
Other	Primary Health services

Geographical Segment
Omeo District Health operates predominantly in Omeo, Victoria. More than 90% of revenue, net surplus from ordinary activities and segment assets relate to operations in Omeo, Victoria.

NOTE 8.4: RESPONSIBLE PERSON DISCLOSURES

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

	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	01/07/2016 - 30/06/2017
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health, Minister for Equality and Minister for Creative Industries	01/07/2016 - 30/06/2017
Governing Boards	
Mr. R. Pendergast	01/07/2016 - 30/06/2017
Mrs. A. Burston	01/07/2016 - 30/06/2017
Ms. S. Malcolm	01/07/2016 - 30/06/2017
Mrs. S. Crisp	01/07/2016 - 30/06/2017
Mrs. K. Commins	01/07/2016 - 30/06/2017
Mr. D. Foster	01/07/2016 - 30/06/2017
Mr. A. McKenzie	23/03/2017 - 30/06/2017
Mrs. M. Ferguson	23/03/2017 - 30/06/2017
Mrs. C. Joffee	23/03/2017 - 30/06/2017
Mr. G. Dear	23/03/2017 - 30/06/2017
Mr. S. Lawlor	23/03/2017 - 30/06/2017
Mrs. P. Barry	23/03/2017 - 30/06/2017
Accountable Officer	
Mr Darren Fitzpatrick	01/07/2016 - 08/01/2017
Mr Ward Steet	09/01/2017 - 30/06/2017

Remuneration of Responsible Persons

Remuneration received or receivable by responsible persons was in the range: $140,000 - $149,999 ($270,000 - $279,999 in 2015-16).

Amounts relating to Responsible Ministers are reported in the financial statements of the Department of Premier and Cabinet.

NOTE 8.5: EXECUTIVE OFFICER DISCLOSURES

Remuneration of executive officers	**Total Remuneration**	
	2017	**2016(a)**
	$	**$**
Short-term employee benefits	100,248	
Post-employment benefits	9,239	
Other long-term benefits	2,514	
Termination benefits	0	
Share-based payments	0	
Total Remuneration (b)	112,001	
Total Number of executives (c)	2	
Total annualised employee equivalent (AEE) (d)	1	

Notes:

(a) No comparatives have been reported because remuneration in the prior year was determined in line with the basis and definition under FRD 21B. Remuneration previously excluded non-monetary benefits and comprised any money, consideration or benefit received or receivable, excluding reimbursement of out-of-pocket expenses, including any amount received or receivable from a related party transaction. Refer to the prior year's financial statements for executive remuneration for the 2015-16 reporting period.

(b) Remuneration represents the expenses incurred by the entity in the current reporting period for the employee, in accordance with AASB 119 Employee benefits

(c) The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of the entity under AASB 124 Related Party Disclosures and are also reported within the related parties note disclosure (Note 8.6).

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

NOTE 8.6: RELATED PARTIES

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

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

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

Key management personnel consist of the board of management and accountable officers as detailed in Note 8.4.

COMPENSATION	
Short term employee benefits	126,653
Post-employment benefits	11,251
Other long-term benefits	4,198
Termination benefits	0
Share based payments	0
Total	**142,102**

Transactions with key management personnel and other related parties

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

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

Significant transactions with government-related entities

Omeo District Health received funding from the Department of Health and Human Services of $2,381,473 (2016: $2,386,523).

During the year, Omeo District Health had the following other government-related entity transactions:
- Commonwealth Government funding received for health related programs totalling $1,218,235 (2016 $1,253,436).
- Dental Health Services Victoria funding received for dental health related programs totalling $80,400 (2016 $69,614).
- Latrobe Regional Hospital funding received for HACC related programs totalling $157,562 (2016 $96,324).

Note 8.7: REMUNERATION OF AUDITORS

	2017	2016
Victorian Auditor-General's Office	**$**	**$**
Audit or review of financial statement	14,400	14,400
	14,400	14,400

NOTE 8.8: AASBs ISSUED THAT ARE NOT YET EFFECTIVE

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2017 reporting period. DTF assesses the impact of all these new standards and advises the Health Service of their applicability and early adoption where applicable.

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

Standard / Interpretation	**Summary**	**Applicable for reporting periods beginning on**	**Impact on Health Service's Annual Statements**
AASB 9 *Financial Instruments*	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1 January 2018	The assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss. While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.
AASB 2010-7 *Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)*	The requirements for classifying and measuring financial liabilities were added to AASB 9. The existing requirements for the classification of financial liabilities and the ability to use the fair value option have been retained. However, where the fair value option is used for financial liabilities the change in fair value is accounted for as follows: - The change in fair value attributable to changes in credit risk is presented in other comprehensive income (OCI); and - Other fair value changes are presented in profit and loss. If this approach creates or enlarges an accounting mismatch in the profit or loss, the effect of the changes in credit risk are also presented in profit or loss.	1 January 2018	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. Changes in own credit risk in respect of liabilities designated at fair value through profit and loss will now be presented within other comprehensive income (OCI). Hedge accounting will be more closely aligned with common risk management practices making it easier to have an effective hedge. For entities with significant lending activities, an overhaul of related systems and processes may be needed.
AASB 15 *Revenue from Contracts with Customers*	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1 January 2018	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications. A potential impact will be the upfront recognition of revenue from licenses that cover multiple reporting periods. Revenue that was deferred and amortised over a period may now need to be recognised immediately as a transitional adjustment against the opening returned earnings if there are no former performance obligations outstanding.
AASB 2015-1 Amendments to Australian Accounting Standards *[Part E Financial Instruments]*	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	1 January 2018	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.

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

Standard / Interpretation	**Summary**	**Applicable for reporting periods beginning on**	**Impact on Health Service's Annual Statements**
AASB 2015-4 Amendments to Australian Accounting *Standards – Clarification of Acceptable Methods of Depreciation and Amortisation [AASB 116 & AASB 138]*	Amends AASB 116 Property, Plant and Equipment and AASB 138 Intangible Assets to: - establish the principle for the basis of depreciation and amortisation as being the expected pattern of consumption of the future economic benefits of an asset; - prohibit the use of revenue-based methods to calculate the depreciation or amortisation of an asset, tangible or intangible, because revenue generally reflects the pattern of economic benefits that are generated from operating the business, rather than the consumption through the use of the asset.	1 January 2017	The assessment has indicated that there is no expected impact as the revenue-based method is not used for depreciation and amortisation.
AASB 2015-7 *Amendments to Australian Accounting Standards arising from AASB 9*	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1 January 2018	The assessment has indicated there will be no significant impact for the public sector.
AASB 2015-9 Amendments to Australian Accounting *Standards – Equity Method in Separate Financial Statements [AASB 1, 127 & 128]*	Amends AASB 127 Separate Financial Statements to allow entities to use the equity method of accounting for investments in subsidiaries, joint ventures and associates in their separate financial statements.	1 January 2017	The assessment indicates that there is no expected impact as the entity will continue to account for the investments in subsidiaries, joint ventures and associates using the cost method as mandated if separate financial statements are presented in accordance with FRD 113A.
AASB 2015-10 Amendments to Australian Accounting Standards – Sale or Contribution of Assets between an Investor and its Associate or Joint Venture [AASB 10 & AASB 128]	AASB 2015-10 amends AASB 10 *Consolidated Financial Statements and AASB 128 Investments in Associates* to ensure consistent treatment in dealing with the sale or contribution of assets between an investor and its associate or joint venture. The amendments require that: - a full gain or loss to be recognised by the investor when a transaction involves a business (whether it is housed in a subsidiary or not); and - a partial gain or loss to be recognised by the parent when a transaction involves assets that do not constitute a business, even if these assets are housed in a subsidiary.	1 January 2017	The assessment has indicated that there is limited impact, as the revisions to AASB 10 and AASB 128 are guidance in nature.
AASB 2016-6 Amendments to Australian Accounting *Standards – Extending Related Party Disclosures to Not-for-Profit Public Sector Entities [AASB 10, AASB 124 & AASB 1049]*	The Amendments extend the scope of AASB 124 Related Party Disclosures to not-for-profit public sector entities. A guidance has been included to assist the application of the Standard by not-for-profit public sector entities.	1 January 2017	The amending standard will result in extended disclosures on the entity's key management personnel (KMP), and the related party transactions.
AASB 2016-8 Amendments to Australian Accounting Standards - Effective Date of AASB 15	This standards defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1 January 2018	This amending standard will defer the application period of AASB 15 to the 2018-19 reporting period in accordance with the transition requirements.

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

Standard / Interpretation	Summary	Applicable for reporting periods beginning on	Impact on Health Service's Annual Statements
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of most operating leases (which are currently not recognised) on balance sheet.	1 January 2019	The assessment has indicated that as most operating leases will come on balance sheet, recognition of lease assets and lease liabilities will cause net debt to increase. Depreciation of lease assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. The amounts of cash paid for the principal portion of the lease liability will be presented within financing activities and the amounts paid for the interest portion will be presented within operating activities in the cash flow statement. No change for lessors.

NOTE 8.9: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

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

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

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

NOTE 8.10: ALTERNATIVE PRESENTATION OF COMPREHENSIVE OPERATING STATEMENT

	Note	2017 $	2016 $
Grants			
Operating	2.1	3,875,126	3,825,882
Capital	2.1	-	-
Interest	2.1	58,370	81,897
Sales of goods and services	2.1	463,216	471,057
Other income	2.1	822,780	944,114
Revenue from Transactions		**5,219,492**	**5,322,950**
Employee expenses	3.1	3,472,750	3,305,588
Depreciation	4.4	644,421	638,282
Other operating expenses	3.1	1,592,254	1,675,349
Expenses from Transactions		**5,709,425**	**5,619,219**
Net Result From Transactions		**(489,933)**	**(296,269)**
Other economic flows included in net result			
Net gain/ (loss) on sale of non-financial assets		-	-
Other gains/ (losses) from other economic flows included in net result	3.2	(1,120)	833
Total Other Economic flows included in Net Result		**(1,120)**	**833**
NET RESULT FOR THE YEAR		**(491,053)**	**(295,436)**

OMEO DISTRICT HEALTH

BOARD MEMBER'S, ACCOUNTABLE OFFICER'S AND CHIEF FINANCE AND ACCOUNTING OFFICER'S DECLARATION

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

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

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

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

Mrs Alison Burston Board President	Mr Ward Steet Chief Executive Officer	Mr Steven Jackel Chief Finance Officer
Omeo	Omeo	Omeo
12 September, 2017	12 September, 2017	12 September, 2017