Omeo District Health

WE CARE
about creating a healthy community

ANNUAL REPORT 2018

Our Journey

1851 Gold was discovered in Omeo, dramatically changing the isolated communities of Omeo, Swifts Creek, Ensay and Benambra bringing an influx of new residents and visitors.

1891 The Omeo District Hospital was incorporated in November to service a growing community.

1894 Provision of care for the sick and injured commenced in August 1894 until the devastating 1939 bushfires that destroyed the original building.

1939 Bushfires that devastated the surrounding towns and landscape also destroyed the original building

1940 A new 19 bed hospital was built on the Easton Street site.

1990 The acute service was reduced to twelve beds.

1993 Following further reviews and funding changes in September, the number of beds were reduced to 4 acute beds, 1 emergency room and 10 nursing home places.

1997 In July, the construction of a purpose built four-bed hostel was completed.

2005 On the 9th December the full redevelopment of the existing hospital buildings and service areas was completed and officially opened.

2011 2005 -2011 Omeo became part of the Transitional Care Program (TCP) with 1 residential bed and 1 community based bed.

2015 The Aged Care redevelopment is completed with all residents having ensuite single rooms.

2016 The introduction of Harvest Fest, a produce sharing initiative, is yet another example of innovative programs developed to meet community needs.

Omeo District Health

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Omeo District Health is established under the Health Services Act 1988.

The responsible Ministers during the reporting period were The Honorable Jill Hennessy MP, Minster for Health and Minister for Ambulance Services and The Honorable Martin Foley MP, Minister for Housing, Disability and Ageing, Minister for Mental Health, Minister for Equality and Minister for Creative Industries.

Cover image:

Resident Hilda Burnham with her daughter and son in law Judy and John Arnott

Our Vision

WE CARE about creating a healthy community

Our Mission

To promote and enhance the health and wellbeing of the people of the East Gippsland High Country

Acknowledgement of Country

Omeo District Health acknowledges the traditional owners of the lands on which we operate. We recognise and respect their cultural heritage, beliefs and relationship with the lands. We pay our respects to Elders both past and present and thank them for their contribution to our health service.

Diversity

Omeo District Health is committed to diversity in the workplace and to culturally safe and LGBTQI-inclusive practice. Omeo District Health fosters an inclusive environment that accepts each individual's differences, embraces their strengths and provides opportunities for all staff to achieve their full potential. Our staff understand and respect the differences in religion, race, ethnicity, cultural values, gender and thinking styles and embrace this in all aspects of the care we provide.

Omeo District Health

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PO Box 42
OMEO VIC 3898

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ABN: 24 479 149 504

Our Values – WE CARE

Wellbeing	Maintain a healthy balance of work, rest and play
Empathy	Show compassion and understanding for the perspectives and experiences of others
Creativity	Encourage new ideas, explore ways to innovate
Accountability	Act with integrity. Take responsibility for our decisions and actions
Resourcefulness	Be responsive in overcoming challenges and changing circumstances
Excellence	Expect, recognise and reward excellence

Our Strategic Plan

Every three years we develop a Strategic Plan that reflects our vision, defines our mission, encapsulates our values and details how we will deliver our objectives. Our Strategic Plan for 2018 to 2023 contains six pillars which each contain Key Objectives.

Healthy Community

Reach out to our local rural community in the planning and delivery of our services.

- Formal & simple structures are established to seek broader community consultation, engagement, volunteering & participation;
- Plan services around existing & emerging community needs & demands, participate in community events & introduce regular periodic assessments of performance;
- Targeted promotion of available services through the use of print & online platforms.

Quality Care & Safety

Deliver first class care to our clients, community and key stakeholders.

- Evidence based models of care are in place to ensure excellent client outcomes;
- A person centred approach underpins our models of care aligned with our rural context;
- Consistent and safe delivery of all services at a level that meets government & community standards;

People & Culture

Build a highly engaged and skilled team of health care professionals and volunteers with a commitment to creating a culture of achievement and service excellence.

- Recruit, retain & develop key talent;
- A structured program for the reward & recognition of excellence in achievement & behaviour is in place;
- Create a constructive culture reflective & demonstrative of our core values where safety is paramount.

Sustainable Services

Develop a fully sustainable health care service model to fund future growth & investment in new markets & emerging technologies.

- A structured & considered prioritisation processes in place to assist in the best utilisation of resources;
- Adopt a diversified & agile funding approach;
- Fund new & alternate models of care to meet the needs of our community.

Effective Governance

Create a comprehensive & accessible governance framework that ensures compliance with our legislative, ethical & statutory obligations.

- Effective corporate & clinical governance frameworks are in place;
- Integrated systems & frameworks are in place to support effective decision making across all functions;
- Formalised assessments in place to review performance of Board & its committees.

Collaborative Partnerships

Invest in strategic partnerships & alliances that allow us to achieve better outcomes for our service.

- Seek & nurture alliances where common objectives exist;
- Promote a reputation of collaboration with organisations & individuals; including community groups, who wish to assist us in achieving our strategic goals;
- Review & ensure all formal agreements are relevant & in place.

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
- Gerontology Nurse Practitioner

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
- Food & Environmental Services
- Infection Control
- Maintenance & Gardens
- Occupational Health & Safety
- Pathology
- Quality & Safety

Our Board

The goal of the Board is to ensure, through robust governance and a clear strategic direction, the provision of excellent care for our residents, patients and clients as well as ensuring a safe working environment for our staff

Role of the Board of Management

The Board of a public health service is responsible for its own 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 2017-18 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 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.

Board of Management Attendance

Member	# meetings attended / 11
Alison Burston	11
Graeme Dear	10
Ann Ferguson	10
Alastair McKenzie	10
Suzanne Malcolm	10
Simon Lawler	9
Kate Commins	8
Penny Barry	8
Sandra Crisp	7
David Foster	5

President

Simon Lawler

Farmer, Omeo

Simon was appointed to the Board in March 2017 and was elected President in November 2017. His appointment expires on 30 June 2019.

Committee Membership
Finance, Quality & Safety & Credentialing

Vice President

Kate Commins

Director, Meringo Pastoral, Swifts Creek

Kate was appointed to the Board in July 2012 and was elected Vice President in November 2017. Her appointment expires on 30 June 2018.

Committee Membership
Finance, Quality & Safety & Credentialing

Treasurer

Alastair McKenzie, CPA

Finance Manager, Murray Goulburn Co-operative, Omeo

Alastair was appointed to the Board in March 2017 and was elected Treasurer in November 2017. His appointment expires on 30 June 2019.

Committee Membership
Finance, Audit & Risk & Nomination & Remuneration

Directors

Alison Burston

Farmer,
Benambra

Alison was appointed to the Board in July 2008. Her appointment expires on 30 June 2018.

Committee Membership
Finance & Community Advisory

Sandra Crisp

Pharmacy Assistant,
Omeo

Sandra was appointed to the Board in July 2010. Her appointment expires on 30 June 2019.

Committee Membership
Finance, Quality & Safety & Community Advisory

Graeme Dear

CEO, East Gippsland Catchment Management Authority,
Bairnsdale

Graeme was appointed to the Board in March 2017. His appointment expires on 30 June 2019.

Committee Membership
Finance, Nomination & Remuneration and Quality & Safety

Ann Ferguson

Commercial Manager,
Sale

Ann was appointed in March 2017. Her appointment expires on 30 June 2018.

Committee Membership
Finance and Nomination & Remuneration

Suzanne Malcolm

Primary School Teacher,
Dept of . Education,
Dinner Plain

Susan was appointed in March 2007. Her appointment expires 30 June 2018.

Committee Membership
Finance & Community Advisory

Penny Barry

Director, Bindi Pty Ltd
Swifts Creek

Penny was appointed to the Board in March 2017. Her appointment expires on 30 June 2018.

Committee Membership
Finance, Audit & Community Advisory

David Foster

Ranger in Charge,
Parks Victoria,
Dinner Plain

David was appointed in July 2016 and resigned on 20 June 2018.

Committee Membership
Finance & Credentialing Committee

Resignations and New Appointments

There were no new appointments in the period. Mr. David Foster resigned his position as at 20th June 2018.

Board Committees

Audit & Risk 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.

Chair – Independent Member

Reece Newcomen, CA

Farmer,
Ensay

Appointed 2013

Independent Members

Caroline Mildenhall

Ensay Community Health Service

Appointed 2015

Lyn Bevans

Semi-retired – Omeo - Appointed 2016

Nomination, Remuneration Committee

This committee was established in 2017 to assist in ensuring robust governance for ODH.

The primary focus is to ensure appropriate diversity and skills mix is considered in board director succession planning and ongoing training.

Ensuring appropriate oversight and recommendation to the board regarding the ongoing professional development and strategic focus of the Executive Team and the recruitment, succession planning and performance review of Chief Executive Officer position.

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.

Community Advisory Committee

Members of the community participate in an innovative and creative continuing Community Advisory Committee.

The Committee is an expansion on current initiatives in place at ODH that act as an advocate to the Board of Management on behalf of the community, consumers and carers.

The Committee plays an essential role in conveying the community member's perspective to the development of priority areas and strengthen effective consumer and community participation at all levels of service planning and delivery.

Credentialing Committee

Ensuring the medical and dental practitioners are appropriately qualified and experienced is an important role for this committee. Dr. David McConachy, 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.

Our Year in Review

The past year has brought new opportunities and new challenges. Some key achievements include:

- Strategic Plan 2018-2023 developed
- New Clinical Governance Framework developed
- ODH Medical Centre achieved full 3-year AGPAL accreditation
- X-year Commonwealth Home Support Program accreditation
- Achieved DHS Disability Services accreditation
- An enhanced reporting culture
- Introduction of a new sustainable public dental service model of care operated by the Royal Flying Doctors Service
- Successful funding submissions for:
    - A new integrated nurse call, duress, pager, phone and fire system ($140k)
    - A new community bus ($69k)
    - Replacement carpet throughout Community Care ($18k)10 kW Solar Panel initiative for the two staff residences ($16k)
- Interest free loan for 40 kW of solar panels for the hospital campus
- Successful Expression of Interest to be one of 5 Victorian pilot sites for a 2-year Leadership Development program
- Successful Expression of Interest to secure a donation of gym equipment (value ~$100k) from the East Gippsland Shire Council for our Community Gyms
- ODH participation of the Omeo Mountain Bike Park Steering Committee assisted in a successful submission securing $3.0M
- Retrofit of LED lighting throughout the health service to reduce our environmental footprint
- Refurbished student nurse accommodation
- Refurbished the Community Dental Service Clinic3-year appointment of RSM Australia as the ODH internal auditors
- Celebration for 2 aged care residents who achieved the benchmark 100 years old
- Introduction of All Staff Forums to enhance communication
- Implementation of the electronic web-based KRONUS time and attendance payroll software and system

Report of the Chair of the Board and Chief Executive

Welcome to our 2017-18 Annual Report

It is with pleasure we present the 126th Annual Report of operations for Omeo District Health (ODH), in accordance with the Financial Management Act 1994 for the year ending 30th June 2018.

The past year has been a challenging one for ODH with significant impact broadly across the organisation. It has been a year of high highs and low lows, most notably two of our long term residents in our aged care facility becoming centurions, turning 100 years old, and receiving letters from the Queen.

Sadly, we also lost three cherished residents over the year and on behalf of the Board of Management, Executive team and staff we would like to express our sincerest condolences to their family and friends. Our staff develop strong bonds with the people they care for, especially our aged care residents, and their passing impacts us all greatly.

On a positive note we have also welcomed a number of new residents to our Aged Care Facility and look forward to developing close long-term relationships with them into the future.

We finished the year in a deficit position, the key contributing factor in our financial result was the impact of lower bed occupancy in our Residential Aged Care Service. To ensure the financial sustainability of our health service attracting more permanent residents will be a priority for the coming year.

It has been a busy and constructive year for the Board. After extensive community, staff and key stakeholder consultations the Board finalised the new Strategic Plan 2018-2023.

The newly developed WE CARE Values underpin all behaviours and decision making processes to achieve the new ODH Vision that "WE CARE about creating a healthy community".

The six strategic pillars of Healthy Community, Quality Care & Safety, People & Culture, Sustainable Services, Effective Governance and Collaborative Partnerships that set the direction and position the organisation well to achieve its Mission to promote and enhance the health and wellbeing of the East Gippsland High Country.

There has been a significant focus on quality and safety culminating in the production of a Clinical Governance Framework to guide our staff in the delivery of safe, quality care. This was a huge body of work for which our Quality & Safety Coordinator must be recognized and commended.

As an adjunct to this work, significant advancements have been achieved in the reporting of quality indicators and key performance indicators to the Board Quality & Safety Committee ensuring robust governance and stewardship exists surrounding clinical care.

The ODH Medical Centre successfully achieved full 3-year AGPAL accreditation. The Community Care team undertook the Commonwealth Home Support Program and the Department of Human Services Disability Services accreditation process achieving successful outcomes in each. Our Aged Care team went through an unannounced survey with flying colours achieving fully met outcomes without any recommendations.

Our community consultations revealed our community wished for greater continuity of care regarding access to doctors. We responded by reducing the number of rotating doctors from 17 in

2016-17 to only 8 during the past year.

We continued to develop our close working relationships with our neighboring health services, bush nursing centres and other key partners such as Benambra Neighborhood House, Ambulance Victoria and the East Gippsland Shire Council and thank them for the valuable input they have had in assisting us in the provision of excellent care to our local community.

We have also focused on both Board director and staff development and our Educator has done a sensational job at attracting numerous professional education opportunities delivered on-site at ODH so the staff have not had the inconvenience of having to travel to maintain their skill and knowledge.

Throughout the year our Business Continuity Plan has been tested through multiple power and telecommunications outages. We are proud that our services continued seamlessly in the face of this adversity and while inconvenient that quality of care was not compromised.

We would like to acknowledge and thank our wonderful staff, our cleaners, our kitchen staff, maintenance staff, administration, finance and payroll staff, community care team, medical centre team, lifestyle activities, enrolled nurses and registered nurses alike for without each and every one of you we could not serve our community as well as we do. You are appreciated and acknowledged for your dedication and hard work.

We also thank all the Board directors for their strong guidance and direction over the year but would like to especially acknowledge the services of three Board directors that have completed their terms on the Board.

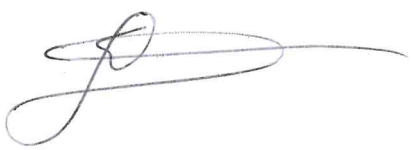
Suzie Grinter (12 years), Alison Burston (10 years) and David Foster (3 years) have all provided valued wisdom, knowledge and stewardship for ODH over many tears and their input will be sorely missed.

The support we have received from our various funding bodies is essential to the future of healthcare for our region and we especially note and acknowledge the Victorian Department of Health and Human Services, The Commonwealth Department of Health, the East Gippsland Shire Council and the Gippsland Primary Health Network for their ongoing support of Omeo District Health and the East Gippsland High Country.

Thank you

Simon Lawler

Board Chair



Ward Steet

Chief Executive

Clinical Services Report

Omeo District Health continues to provide a broad range of excellent clinical services to promote and enhance the wellbeing of the people of the East Gippsland High Country.

Aged Care

Our Aged Care permanent occupancy remains our greatest challenge as we have struggled to maintain and increase the number of our permanent residents. While admitting three new residents during the financial year we were saddened by the loss of 3 of our permanent residents during the same period.

A further 2 residents were admitted into respite in poor health whilst preparing to move into permanent care and also progressed to a palliative pathway instead.

Community members are utilising respite regularly which saw us increasing the number of days that we are able to offer residential respite services.

The inability to have community members taking up the offer of permanent placement is a 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.

Our Diversional Therapist / activities coordinator Leanne Appleby has provided wonderful opportunities to maintain our resident's interest. The enthusiasm and diversity offered has 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.

We celebrated a first for Omeo with two of our residents celebrating their 100th birthday within a week of each other.

Education

This has been a high priority again this year and interest in nursing has grown from within the Hospital. This year we saw three of our staff and one community member all successfully complete their enrolled nurse training, a welcome boost to our nursing team.

The Nurse Educator role has continued to be successful with many sessions held throughout the year which have been well attended and supported.

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.

A key improvement has been the development of an education room within the hospital so access can be easily achieved. A bonus of the room is the integration of nurse training with ambulance officers and the increased utilisation of the equipment that we have been fortunate enough to obtain.

Congratulations and thanks to Jackie Hughes for making this role provide opportunities for staff and thanks also to our local Ambulance Victoria MICA officer, Kerryn Wratt, for the provision of educational opportunities locally for our staff.

Nursing

Nursing staff personnel numbers have been relatively stable this year with Sarah Anderson resigning from her nursing role as enrolled nurse after two years in nursing and nine years in catering services. We wish Sarah the best in her future adventures.

Christa Thompson also resigned from a permanent part time role as a registered nurse in August. In

her role as Quality Coordinator Christa was instrumental in achieving multiple accreditations Hospital wide, she has since returned to our casual bank and taken up a role in Quality at Orbost Regional Health.

Ian McKenzie has moved from a casual RN position to a permanent part time role. Lisa Airs and Tania Crisp have moved from community health to permanent part time positions as enrolled nurses. Lee McAlpine has also taken up a permanent part time role as an enrolled nurse.

Our casual bank has grown with the welcome additions of Leonie Brammall, Kerry Leclerc and Yvonne Symons joining our team as registered nurses and Marijs Last joining us as an enrolled nurse on a casual basis in addition to her Manager – Community care role.

It has been a challenging year for many reasons in addition to our low aged care bed occupancy. Our Transitional Care Program occupancy decreased by 26% due to decreased opportunities. Urgent Care Centre presentations increased by 23% increasing our time in attendance by 12%, whilst the waiting time to be assessed for all presentations was under four minutes. Transfers from UCC was a significant number at 65 compared to admissions (15) indicative of the acuity of the presentations and ensuring the appropriate care was available.

Much appreciation is extended to the all nursing staff for their support and especially to Anne Walker (NUM) for providing direction consistency and continuity in aged and acute care, Penny Geyle (infection Control), Jackie Hughes (Educator) and Margaret Worcester for maintaining rostering.

It would be remiss of me not to mention SHINE, our volunteer fundraising group as they have been extremely supportive this year and contributed greatly to the purchase of essential medical equipment which has been most welcomed and will be well utilised.

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.

Darren Fitzpatrick
Director of Nursing / Nurse Unit Manager

Community Services Report

Changes in the 2017-2018 year

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 continues to impact Home Based Services. 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. These changes continue to be embedded, with staff becoming more proficient at navigating the My Aged Care on line platform which is used for client data management.

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. The Outer Gippsland NDIS rollout is anticipated to commence in January 2019. ODH employed a full time project worker for a 3-week period in April 2018 to enable ODH to carry out the necessary preparations to be NDIS ready.

Health Promotion programs including the Harvest Exchange and the Community Gymnasiums located at Omeo, Swifts Creek, and Benambra continue to provide positive preventative health activities for the wider community.

Results from the Victorian Health Experience Survey (VHES) carried out in December 2017 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

- Gippsland Primary Health Network Place Based Flexible Funding program (Allied Health Services)
- Department of Health for the Commonwealth Home Support Programme

State

- Department of Health and Human Services Home and Community Care Program for Younger People
- Department of Health and Human Services Flexible Care Packages program (Disability Support)

Local

- East Gippsland Shire Council supplements 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 Program 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.

This year ODH nominated the Community Transport team for the Health Ministers Volunteers award. Whilst our team did not carry off the major prize, the nomination process was a great opportunity to acknowledge the great work that our dedicated drivers have done over the years.

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

Support Services Report

Public & Private Dental Services

The existing model of dental services was proving financially unsustainable and a new model of care was trialed having the Royal Flying Doctor Service (RFDS) provide dental services in our region from the ODH dental clinic.

The pilot proved to be very successful and the RFDS clinic was well-received by the local community. Subsequently a successful business case to have the RFDS assume responsibility for dental services was submitted to DHHS and Dental Health Services Victoria by ODH.

The RFDS commences a monthly public and private dental service from the ODH dental clinic in July 2018.

The clean environment is obvious to all entering the facility and a testament to the domestic staff hard work.

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	# of meals provided
Meals on Wheels	475
Residents and patients	13,190

It is a government requirement that external cleaning audits be conducted at least annually. The latest result of 90.2% organizational wide average in July 2018 and demonstrates a continued very high standard of cleanliness.

Facilities & Maintenance Services

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 continues 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.

Administrative Services

The restructure of the Administrative team performed last financial year has proven to be very successful. The three team members, Kelly Greenland, Katie Van Heek and Merinda Sedgman have pulled together to form a close-knit, competent and high performing team.

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 this year has purchased items identified by staff that make a positive impact on the care needs of our clientele.

The committee membership is open to all

ODH thanks these committed volunteers for their knowledge, dedication and support.

Donations

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

- Lex Bertrand
- Eddie Rockzy
- David Bock
- CWA
- Roma Lumsden
- Heather Mumford
- Mitch Kennedy
- Monica Morgan
- Thelma Langshaw
- Steve Disney
- Bicycle Network

Ward Steet
Chief Executive Officer

Medical Centre Report

This year the Medical Centre undertook its 7th round in Accreditation, we were pleased to be awarded full accreditation on 9th March 2018, taking us through until the 4th May 2021.

Thank you to Dr Bernie Moore, Annie Kissane & Leanne Stedman for all their support in the accreditation process, we had 2 standards out of 138 both relating to the recording of vaccine fridge temperatures, these were actioned straight away & processes have been altered to meet both standards.

In the 16 & a half years I have been at the Medical Centre it was the first time we were able to have our survey visit well before our expiry in May and very pleasing to be awarded it 2 months prior to it lapsing, thus avoiding the process of applying for an extension.

We say goodbye to Dr Tim Watford from our roster. Tim joined us 10 years ago and in June 2018 announced his retirement from the Omeo Medical Centre, Tim has been cutting back his work load over the last 6 months also working in Bairnsdale at GEGAC & Bairnsdale Medical Group, Thank you Tim for your contribution to the Omeo Medical Centre & Omeo District Health.

At the end of January 2018 our Medical Student Christoph Hammans from Melbourne University joined us for his 6-week placement. Christoph was also present during our accreditation survey visit, which gave him some insight to the process of accreditation in general practice.

Christoph thoroughly enjoyed his time at Omeo, as well as consulting with patients in the Medical Centre, he went on Ambulance call outs with our local Mica Paramedic & attended emergency presentations at the hospital. Christoph made the most of his weekends hiking from Mt Hotham to Falls Creek with a fellow Medical Student on his placement. I ask Christoph about his experience at the end of his time at Omeo and I was pleased to hear him say "I thought I'd be bored, but it's been quite the opposite, it's been really busy and it has been a fantastic experience" it was great hear he had a positive experience.

I would also like to thank Doctors Jenny Schlager, Bernie Moore & David Appleton for the supervision of Christoph.

If it wasn't for our dedicated team of Doctors, we wouldn't be able to maintain fulltime cover and deliver a high standard of health care to our community.

Thank you, Dr Timothy Watford, Dr Jennifer Schlager, Dr David Appleton, Dr Bernard Moore, Dr Murray Barson, Dr Elizabeth Boyd, Dr Myles Chapman & Angela Phillips from Rural Workforce Agency (RWAV) for the GP's that come to us through the agency for your commitment to the roster each year.

And on an end note I would like to Thank our Chronic Disease/Practice Nurse Annie Kissane, Annie is well regarded by our patients as well as her colleagues.

Tracey AhSam
Practice Manager

Our People

Omeo District Health recognises staff as its greatest asset and acknowledges the dedication and commitment of all staff to residents, patients and the community.

Staff Numbers

HOSPITALS Labour Category	JUNE Current Month FTE		JUNE YTD FTE	
	2018	2017	2018	2017
Nursing	15.79	15.79	16.25	16.20
Admin & Clerical	4.37	4.34	3.48	2.82
Medical Support	1.58	1.58	1.62	1.57
Hotel & Allied Services	6.97	8.33	7.08	8.42
Medical Officers	1.0	1.0	1.0	1.0
Hospital Medical Officers	N/A	N/A	N/A	N/A
Sessional Clinicians	N/A	N/A	N/A	N/A
Ancillary Staff (Allied Health)	12.35	11.58	11.34	11.29

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.

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.

Occupational Health & 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 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 elected OH&S representatives.

This year OH&S representatives were Ms Lisa Airs, Ms Lisa Mitchell and Ms Margie Worcester 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.

Assessments and Measures Undertaken to improve Employee OH&S

The ODH OH&S plan outlines the occupational health framework within the organisation, reporting to the Board monthly.

- **Influenza vaccination** – offered to all staff and residents with documented uptake.
- **Home Based Services** – pre-visit telephone home safety assessments conducted for Home Support workers and District Nurses. On-site risk assessments also performed for Home Support 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

	2017 / 18	2016 / 17	2015 / 16
Number of reported hazards / incidents for the year per 100 FTE staff	0/ 12.9	21.8/ 26.9	43.6 / 31.5
Number of 'lost time' standard claims for the year per 100 FTE staff	0	2.4	2.6
Average cost per claim for the year	$0	$24,787	$42,320

The organisation had one ongoing claim that ceased in the 2016/17 financial year.

Occupational Violence Statistics

	2017-18
WorkCover Accepted claims with an occupational violence cause per 100FTE	Nil
Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	Nil
Number of occupational violence incidents reported	4
Number of occupational violence incidents reported per 100FTE	11.4
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	Nil

Definitions

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

Incident - An event or circumstance that could have resulted in, or did result in, harm to an employee.

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

Lost time - is defined as greater than one day.

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

Our Executive Team

Chief Executive Officer

Ward Steet

The Chief Executive Officer (CEO) is responsible for the executive leadership, operational and clinical management of Omeo District Health in accordance with the health service's Statement of Priorities and Board of Management directions. Responsible for implementing the Strategic Plan including setting the culture of the organisation to achieve the Mission and Vision of ODH. Oversight of risk management, and quality and safety and is also accountable for implementing internal controls to prevent, detect and report fraud, corruption and other losses.

Director of Nursing

Darren Fitzpatrick

The Director of Nursing Services (DON) / Nurse Unit Manager (NUM) is a combined administrative and clinical role, directly responsible to the Chief Executive Officer.

Responsible for the provision and delivery of leadership and quality clinical care services to patients/residents/clients within primary care, acute care, aged care, urgent care and community care at ODH

Community Care Manager

Marijs Last

The role of Community Care Manager encompasses the management of the community and home based services across the multi-disciplinary health team.

The position is responsible for facilitating and co-ordinating a range of allied health and support services including the co-ordination of specific health education and health promotion programs.

Monitoring target populations, providing care advice and advocacy as appropriate and co-ordinating referrals across the health care continuum are important aspects of the role. Additionally, this position actively carries out executive functions and incorporates a broader organisational management responsibility.

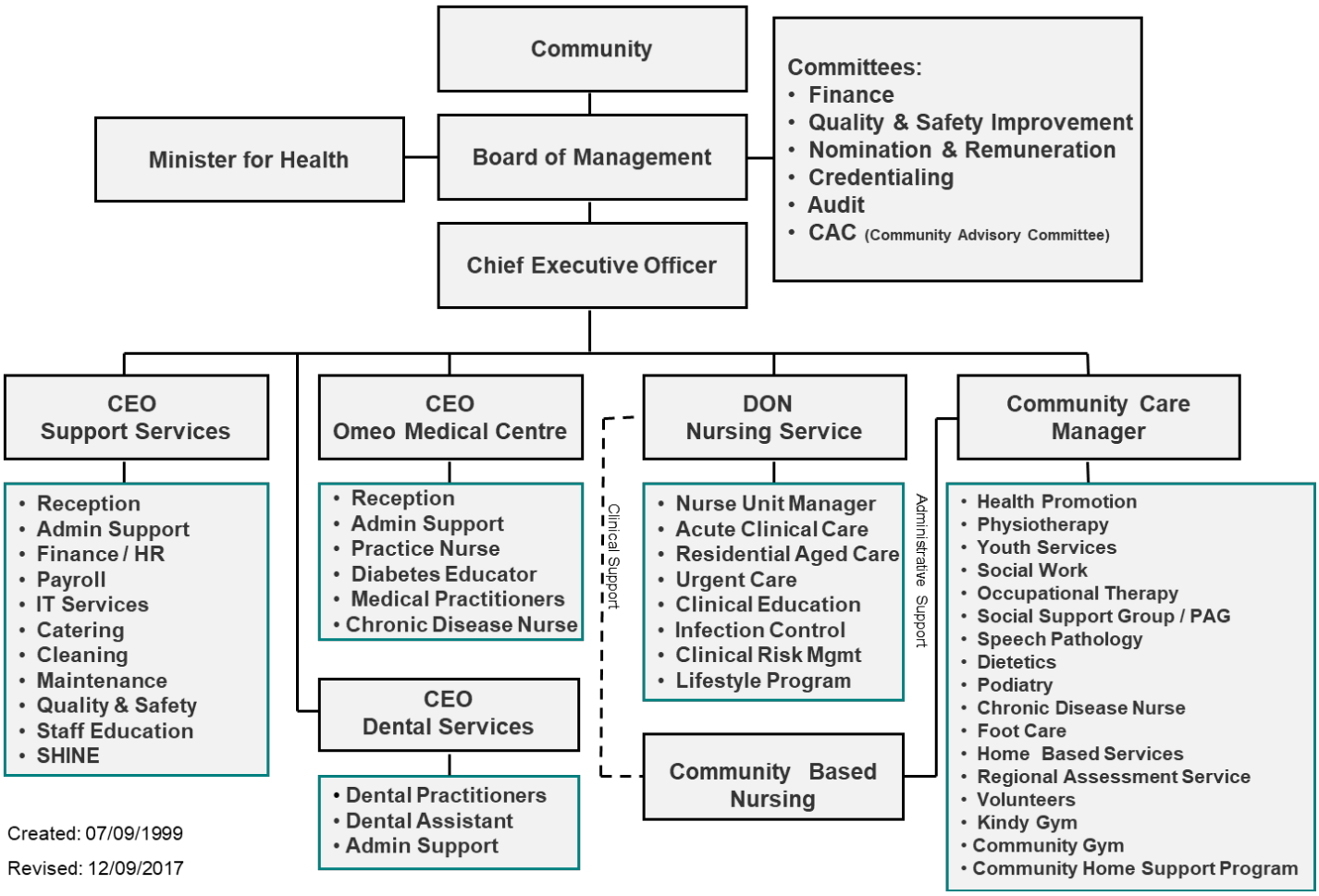
Quality Manager

Leanne Stedman

The Quality Manager oversees and co-ordinates the efforts of all staff toward meeting and maintaining the five sets of accreditation standards that apply to ODH activities.

As well as collating all evidence required to support each accreditation review, the role includes monitoring, collating and presenting monthly quality data, maintaining audit and improvement schedules, delivering staff education, managing the Riskman incident reporting portal and the PROMPT document management portal and preparing the annual Quality Account.

Organisational Chart



Created: 07/09/1999

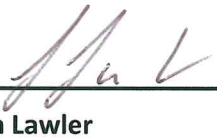
Revised: 12/09/2017

Attestations

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 2018.

Signed:



Simon Lawler
Chair, Board of Management
Omeo, 20th September 2018

Financial Management Compliance

I, Simon Lawler, on behalf of the Responsible Body, certify that Omeo District Health has complied with the applicable Standing Directions of the Minister for Finance under the Financial Management Act 1994 and Instructions. The Audit Committee has reviewed this attestation.

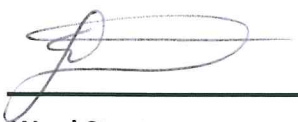
Signed:

Simon Lawler
Chair, Board of Management
Omeo, 20th September 2018

Data Integrity

I, Ward Steet, certify that Omeo District health has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. Omeo District Health has critically reviewed these controls and processes during the year.

Signed:



Ward Steet,
Chief Executive Officer
Omeo, 20th September 2018

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.

Signed:

Ward Steet
Chief Executive Officer
Omeo, 20th September 2018

Conflict of Interest

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

Signed:

Ward Steet,
Chief Executive Officer
Omeo, 20th September 2018

Statement of Priorities - Part A

Agreement between the 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*.

The 2017-18 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.

Strategic Priorities

Goals	Strategies	Health Service Deliverables	Outcome
Better Health A system geared to prevention as much as treatment Everyone understands their own health and risks Illness is detected and managed early Healthy neighborhoods and communities encourage healthy lifestyles	**Better Health** Reduce Statewide Risks Build Healthy Neighborhoods Help people to stay healthy Target health gaps	Work towards achieving White Ribbon accreditation to promote respectful relationships and gender equality in the workplace	**ONGOING** White Ribbon accreditation requirements investigated. Resourcing opportunities discussed with East Gippsland Shire Council.
		In partnership with Bairnsdale Regional Health Service and Orbost Regional Health implement the Strengthening Hospital Responses to Family Violence initiative.	**ACHIEVED** The ODH Social Worker has been appointed as lead for ODH, is engaged in the process with the BRHS lead and has completed training. The ODH Social Worker attended Train the Trainer "MATE" training in May 2018 The ODH Health Promotion Worker role includes a special focus on family violence Gender equality and family violence posters displayed throughout the organisation
		In partnership with early years organisations throughout the catchment (childcare, kindergartens, primary schools) commence implementation of the Achievement Program framework to create healthy learning environments.	**ACHIEVED** Consultations with Early Years services, including Primary schools has commenced, with agreement to focus the achievement program across services in the area of Mental Health (social and emotional resilience) Several of the local Early Years agencies have registered as participants in the Achievement Program
		Implement the Access To Allied Psychological Services (ATAPS) adult mental health service.	**ACHIEVED** The ATAPS program has been revamped as the Psychological Services Program and the RFDS has assumed responsibility for delivery of the service for East Gippsland.

Goals	Strategies	Health Service Deliverables	Outcome
		Participate on the East Gippsland Shire Mountain Bike Trail Steering Committee to develop a mountain bike park in Omeo to engage the local youth/adults in physical activity and drive economic development for the community.	**ACHIEVED** $3.0M if funding for the Omeo Mountain Bike Park was announced in July 2018 ($1.5M through the Building Better Regions Fund application and $1.5M matching contribution from the East Gippsland Shire). The tender process for the design and build phase is expected to commence September/October 2018 with Stage 1 of the project to be delivered by the end of 2020.
Better Access Care is always there when people need it More access to care in the home and community People are connected to the full range of care and support they need There is equal access to care	**Better Access** Plan and invest Unlock innovation Provide easier access Ensure fair access	Develop and implement an LGBTQI-inclusive practice action plan from the gap analysis results of the Rainbow eQuality Guide Standards.	**ACHIEVED** The ODH RAS assessor has participated in the LGBTI Equality Roadshow when it visited Bairnsdale, and has made connections with the Gippsland Rainbow Collective Positive feedback regarding inclusiveness has been received and logged by ODH from a transgender client E-mail tag identifying ODH as an LGBTQI-inclusive practice health service developed Flag poles have been purchased so that the Rainbow flag may be flown outside the organisation The CEO attend the inaugural LGBTQI+ forum held at the Alfred Hospital
		Investigate the potential of a Nurse Practitioner Primary Care career pathway in primary care to complement the existing general practitioner and nurse- models to enable progression towards a seven day per week primary care model for Omeo District Health	**ACHIEVED** Discussions for potential funding underway with RWAV. Two RN's have expressed interest in the NP career pathway Participate in the University of Melbourne role and implementation of older persons NP research in March 2018 NP model of care and career pathway included in the East Gippsland Health Services Strategic Service Plan and the Action Plan stemming from the report
		In partnership with Bairnsdale Regional Health Service implement a face-to-face and telemedicine Dietetics model of care	**ACHIEVED** The initial consultation using the telehealth dietetics model was conducted in March 2018, with positive feedback at this stage. Model now embedded as routine practice

Goals	Strategies	Health Service Deliverables	Outcome
		Partner with Gippsland Lakes Community Health to facilitate a regular alcohol and other drugs (AOD) service in the Omeo area.	**ACHIEVED** AOD services raised at the East Gippsland Health Services Executive meeting and included in the Action Plan stemming from the East Gippsland Health Services Strategic Service Plan Referral pathways for AOD with GLCH have been established
		Implement digital reading of Holter monitor recordings utilising secure web-based technology to facilitate improved access to remote cardiology diagnostic services.	**ACHIEVED** This arrangement has been implemented and is in use providing access to cardiology services for local residents without the need to drive to Bairnsdale
		Investigate ways to enhance the Volunteer Transport program to facilitate improved access to care and reduce the impact of rural isolation.	**ACHIEVED** Existing demand is currently being serviced; recruitment processes for additional drivers undertaken Improvements to volunteer program underway including- revision of Volunteers Recruitment Kit Improved HR records, in line with other staff members Promote recognition of Volunteers through nomination of Community Transport Team for the Minister of Health Volunteer awards. The Team have been recognised as Finalists A reward & recognition program for volunteers is under development A volunteer portal has been added to the ODH website to assist volunteers with information and training
Better Care Target zero avoidable harm Healthcare that focusses on outcomes Patients and carers are active partners in care Care fits together around people's needs	**Better Care** Put Quality First Join up care Partner with patients Strengthen the workforce Embed evidence Ensure equal care	Revise and develop new Terms of Reference for the Community Advisory Group to improve clarity and ensure the community has greater input into, and awareness of, service planning and service delivery.	**ACHIEVED** The Community Advisory Group TOR have been revised and endorsed by the ODH Board of Management
	Mandatory actions against the 'Target zero avoidable harm' Goal:		

Goals	Strategies	Health Service Deliverables	Outcome
	Develop and implement a plan to educate staff about obligations to report patient safety concerns	Develop and implement a plan to educate staff about obligations to report patient safety concerns	**ACHIEVED** Education on staff obligations regarding reporting patient safety concerns has been included in ODH annual mandatory training. A policy on staff reporting of patient safety concerns has been developed
	Establish agreements to involve with external specialists in clinical governance processes for each major area of activity (including mortality and morbidity review)	Finalise the Agreement with Bairnsdale Regional Health Service regarding clinical governance support through the provision of a Director of Medical Services and associated services, including credentialing and access to mortality and morbidity review.	**ACHIEVED** The third iteration of the Agreement is currently being considered by Management The CEO of ODH and the new CEO of BRHS, Robyn Hales, have met and discussed the ODH requirements of the position. Interim arrangements have been put in place and BRHS is finalising a restructure at the Executive level. Once this structure is finalised and the available resources known the Agreement between ODH and BRHS can be finalised.
	In partnership with consumers, identify 3 priority improvement areas using Victorian Healthcare Experience Survey data and establish an improvement plan for each. These should be reviewed every 6 months to reflect new areas for improvement in patient experience.	Utilising the Victorian Healthcare Experience Survey and other community consultations and feedback Omeo District Health will focus on:	
		1 Strengthen the admission and discharge planning processes with Ensay Bush Nursing Centre and Swifts Creek Bush Nursing Centre;	**ACHIEVED** The ODH daily admission/ discharge spreadsheet is now distributed to the BNC's providing more timely information on admissions and discharges of patients from their communities. There are ODH staff members on the BNC Committees of Management to improve communications and address any issues as they arise The ODH Clinical Governance Framework has been made available to both BNC's ODH has offered the BNC's support of the ODH Quality & Safety Coordinator to assist them as they undertake the NSQHS accreditation process MoU's between ODH and the BNC's have been revised
		2 Develop social media communication channels to improve engagement with local youth; and	ODH has developed a Facebook page dedicated to the Youth program overseen by the ODH Youth Worker. The Facebook page has gathered over 100 followers.

Goals	Strategies	Health Service Deliverables	Outcome
			ODH have recruited a young local female to the Youth Worker role who has been very well received by the Youth as well as the key stakeholder organisations in the region
		3 Redevelop the health service website to make it more user friendly and provide more assistance in navigating the changes associated with aged Care reforms.	**ACHIEVED** Simplified information regarding aged care has been developed in lay person terms which has been uploaded to the Aged Care page of ODH website Information regarding ODH Community Health Services has been updated on the ODH website, including links to key sites such as My Aged Care A totally new website is under development that will enhance navigation and consumer-friendly use of the website.

Statement of Priorities - Part B

Performance Priorities

a) Safety and Quality Performance

Key Performance Indicator	2017/18 Target	2017/18 Actual
Accreditation		
Accreditation against the National Safety and Quality Health Service Standards.	Full Compliance	Achieved
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full Compliance	Achieved
Infection prevention and control		
Compliance with the Hand Hygiene Australia program	80%	81%
Percentage of healthcare workers immunised for influenza	75%	88%
Patient experience		
Victorian Healthcare Experience Survey – positive patient experience - Quarter 1, Quarter 2 and Quarter 3	95% positive experience	Full Compliance*
Victorian Healthcare Experience Survey – positive discharge care – Quarter 1, Quarter 2 and Quarter 3	75% very positive experience	Full Compliance*
Victorian Healthcare Experience Survey – patients perception of cleanliness – Quarter 1, Quarter2 and Quarter 3	70%	Full Compliance*
Adverse events		
Number of sentinel events	Nil	Nil
Mortality – number of deaths in low mortality DRG's	Nil	Nil

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

b) Strong governance, leadership and culture

Key Performance Indicator	Target	Actual	Actual
Organisational culture	**2017/18**	**2017/18**	**2016/17**
People Matter Survey - percentage of staff with an overall positive response to safety and culture questions	80%	97%	87%
People matter survey – percentage of staff with a positive response to the question, **"I am encouraged by my colleagues to report any patient safety concerns I may have"**	80%	100%	95%
People matter survey – percentage of staff with a positive response to the question, **"Patient care errors are handled appropriately in my work area"**	80%	97%	79%
People matter survey – percentage of staff with a positive response to the question, **"My suggestions about patient safety would be acted upon if I expressed them to my manager"**	80%	95%	90%
People matter survey – percentage of staff with a positive response to the question, **"The culture in my work area makes it easy to learn from the errors of others"**	80%	94%	79%
People matter survey – percentage of staff with a positive response to the question, **"Management is driving us to be a safety-centred organisation"**	80%	100%	92%
People matter survey – percentage of staff with a positive response to the question, **"This health service does a good job of training new and existing staff"**	80%	97%	85%
People matter survey – percentage of staff with a positive response to the question, **"Trainees in my discipline are adequately supervised"**	80%	97%	74%
People matter survey – percentage of staff with a positive response to the question, **"I would recommend a friend or relative to be treated as a patient here"**	80%	100%	95%

c) Effective Financial Management

Key Performance Indicator	Target	Actual
Funding		
Operating Result ($m)	0.00	-0.097
Average number of days to paying trade creditors	60 days	50 days
Average number of days to receiving patient fee debtors	60 days	45 days
Adjusted current asset ratio * or 3% improvement from health service base target	0.7*	2.22
Number of days of available cash	14 days	26 days

Statement of Priorities - Part C

Activity and funding

Funding Type	Activity	Budget ($'000)
Small Rural		
Small rural Acute		1,622
Small Rural Primary Health		$0
Small Rural Residential Care	5,062	328
Small Rural HACC	1,691	120
Health Workforce	1	25
Other specified funding		114
Total Funding		**2,210**

Primary Health Care	
Service	**Actual Activity**
Volunteer Coordination – Community Transport	127
HACC Assessment	158
Counselling	123.75
Occupational Therapy	63.08
Health Physiotherapy	57.15
HACC Respite	78
Delivered Meals	475
Domestic Assistance	146.5
HACC Property Maintenance	26
HACC Nursing	168.75
Personal Care	283.58
HACC Social Support Group	170.5

Summary of Financial Results

	2018 $,000	2017 $,000	2016 $,000	2015 $,000	2014 $,000
Total Revenue	5,465	5,219	5,323	5,060	5,295
Total Expenses	5,832	5,710	5,619	5,409	5,223
Surplus / (Deficit)	(367)	(491)	(295)	(349)	72
Retained Surplus / (Accumulated Deficit)	1,165	1,532	2,023	2,318	2,668
Total Assets	7,642	8,024	8,497	8,728	9,102
Total Liabilities	1,528	1,544	1,525	1,460	1,458
Net Assets	6,114	6,480	6,972	7,267	7,617
Total Equity	6,114	6,480	6,972	7,267	7,617

Operational and Budgetary Objectives

Omeo District Health projected an operating surplus of $26,187 for the year and an overall deficit after depreciation of $552,849 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 2018 reflect a net surplus before capital and specific items of $97,177 (2017 $28,011) and an overall deficit before asset revaluation movements of $366,486 (2017 deficit $491,053). 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 Medical Clinic produced a surplus of $51k for the year, slightly down on the projected surplus of $62k. The Dental unit was closed during the year, prior to this is achieved a surplus of $1k.

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.

ICT Expenditure

Expenditure	$,000 2018	$,000 2017
Business as Usual ICT	248	0.213
Non Business as Usual ICT	0.00	0.00
Operational Expenditure	192	0.208
Capital Expenditure	0.33	0.05

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 may also charge 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. ODH does not charge fees for afterhours urgent care services to eligible clients

Statutory Compliance

Building Act 1993

In the year ended 30 June 2018, all buildings of Omeo District Health were fully compliant with the *Building Act 1993*.

Freedom of Information Act 1982

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 2018, four (5) 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.

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 2017-2018.

Carers Recognition Act 2012 Statement

The Carers Recognition Act 2012 recognises, promotes and values the role of people in care relationships. Omeo District Health 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.

Safe Patient Care Act 2015

Omeo District Health has no matters to report in relation to its obligations under the Safe Patient Care Act 2015.

Victorian Industry Participation Policy

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

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. ODH has successfully acquired a 60kW system as part of the Gippsland Region Solar Program bulk procurement and are awaiting instillation. All external sensor, security and flood lights have been upgraded to LED.

	2017 /18	2016 /17	2015 /16	2014 /15
Total energy consumption by energy type (GJ)				
Electricity	688	730	817	728
Natural gas & LPG	1,995	1,919	1,686	1,723
Normalised water consumption				
Water per unit of floor space (kL/m^2)	0.56	0.50	0.51	0.33
Normalised greenhouse gas emissions				
Emissions per unit of floor space ($kgCO^2e/m^2$)	72	84	88	81
Emissions per unit of activity ($kgCO^2e$/bed-day)	139	77	85	81

External Reviews Undertaken in 2017/18

Home Care Common Standards (Home Based Services, District Nursing, Allied Health):

25 October 2017: The Australian Aged Care Quality Agency conducted an accreditation audit of Omeo District Health Home Based Services, District Nursing and Allied Health. ODH received confirmation on 7 December 2017 that all Standards had been assessed as Met.

Human Services Standards (Disability Services):

10 November 2017: Omeo District Health is required to provide DHHS with a self-assessment under these Standards every 18 months. The last Self-Assessment was submitted on 10 November 2017 and feedback from DHHS received 15 December 2017. The feedback received was very positive, describing our self-assessment as "comprehensive and thorough" and noting that our quality improvement plan "demonstrates a commitment by Omeo District Health to continuous quality improvement".

Royal Australian College of General Practitioners (RACGP) Standards (Medical Centre):

12 February 2018: Australian General Practice Accreditation Limited (AGPAL) conducted an accreditation audit of Omeo District Health's Medical Centre under the RACGP Standards. ODH

received confirmation on 12 March 2018 that all Standards had been assessed as Met.

National Standards (Hospital):

1 May 2018: Omeo District Health submitted its Progress Report 2 to the Australian Council on Healthcare Standards. This included updating ODH's response to each of the 10 National Standards and submitting a new 2017/18 Quality Improvement Plan.

Aged Care Standards (Residential Aged Care):

29 May 2018: The Australian Aged Care Quality Agency conducted an unannounced Assessment Contact visit to Omeo District Health. All Aged Care Standards under assessment were assessed as Met.

Additional Information

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.

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.

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FS = Financial Statements

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
20 September 2018

Ron Mak
as delegate for the Auditor-General of Victoria

OMEO DISTRICT HEALTH
COMPREHENSIVE OPERATING STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2018

	Note	2018 $	2017 $
Revenue from Operating Activities	2.1	5,000,159	5,031,652
Revenue from Non-Operating Activities	2.1	58,280	61,363
Employee Expenses	3.1	(3,593,363)	(3,472,750)
Non Salary Labour Costs	3.1	(377,439)	(534,363)
Supplies and Consumables	3.1	(122,356)	(129,968)
Medical Indemnity Insurance	3.1	(4,348)	(4,944)
Fuel, Light, Power and Water	3.1	(109,507)	(83,511)
Repairs and Maintenance	3.1	(65,697)	(47,404)
Other Expenses	3.1	(882,906)	(792,064)
Net Result Before Capital and Specific Items		(97,177)	28,011
Capital Purpose Income	2.1	365,554	126,477
Depreciation	4.3	(674,650)	(644,421)
Net Result After Capital and Specific Items		(406,273)	(489,933)
Other Economic Flows Included in Net Result			
Net Gain on Disposal of Non-Financial Assets		41,584	-
Revaluation of Long Service Leave	3.2	(1,797)	(1,120)
Total Other Economic Flows Included in Net Result		39,787	(1,120)
NET RESULT FOR THE YEAR		(366,486)	(491,053)
COMPREHENSIVE RESULT		**(366,486)**	**(491,053)**

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

OMEO DISTRICT HEALTH
BALANCE SHEET
AS AT 30 JUNE 2018

	Note	2018 $	2017 $
Current Assets			
Cash and Cash Equivalents	6.2	1,056,054	697,270
Receivables	5.1	487,510	335,198
Investments and other Financial Assets	4.1	1,453,236	1,951,737
Prepayments and Other Assets		43,092	33,858
Total Current Assets		**3,039,892**	**3,018,063**
Non-Current Assets			
Receivables	5.1	27,403	49,364
Property, Plant & Equipment	4.2	4,575,449	4,956,824
Total Non-Current Assets		**4,602,852**	**5,006,188**
TOTAL ASSETS		**7,642,744**	**8,024,251**
Current Liabilities			
Payables	5.3	248,841	395,063
Borrowings	6.1	12,930	-
Provisions	3.2	687,874	621,793
Other Liabilities	5.2	393,707	412,132
Total Current Liabilities		**1,343,352**	**1,428,988**
Non-Current Liabilities			
Borrowings	6.1	36,558	-
Provisions	3.2	148,571	114,514
Total Non-Current Liabilities		**185,129**	**114,514**
TOTAL LIABILITIES		**1,528,481**	**1,543,502**
NET ASSETS		**6,114,263**	**6,480,749**
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	1,165,192	1,531,678
TOTAL EQUITY		**6,114,263**	**6,480,749**
Commitments for expenditure	6.3		
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 2018

	Note	Property, Plant and Equipment Revaluation Reserve $	Restricted Specific Purpose Reserve $	Contributed Capital $	Accumulated Surpluses/ (Deficits) $	Total $
Balance at 1 July 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)
Balance at 30 June 2017		**3,049,328**	**106,508**	**1,793,235**	**1,531,678**	**6,480,749**
Net result for the year	8.1c	-	-	-	(366,486)	(366,486)
Balance at 30 June 2018		**3,049,328**	**106,508**	**1,793,235**	**1,165,192**	**6,114,263**

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

OMEO DISTRICT HEALTH
CASH FLOW STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2018

	Note	2018 $	2017 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		3,840,370	3,876,490
Capital Grants from Government		250,573	20,522
Patient and Resident Fees Received		454,006	437,449
Donations and Bequests Received		29,791	24,292
GST (Paid to)/received from ATO		(8,255)	3,941
Interest Received		54,615	58,370
Other Receipts		658,774	616,868
Total Receipts		***5,279,874***	***5,037,932***
Employee Expenses Paid		(3,563,042)	(3,400,123)
Fee for Service Medical Officers		(377,439)	(534,363)
Payments for Supplies and Consumables		(218,871)	(107,010)
Other Payments		(1,135,644)	(1,021,768)
Total Payments		***(5,294,996)***	***(5,063,264)***
NET CASH FLOW (USED IN) / FROM OPERATING ACTIVITIES	8.2	(15,122)	(25,332)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for Property, Plant and Equipment		(300,762)	(67,863)
Proceeds from Sale of Non-Financial Assets		49,071	-
(Purchase of)/Proceeds from Investments		498,501	344,789
NET CASH FLOW FROM / (USED IN) INVESTING ACTIVITIES		246,810	276,926
CASH FLOWS FROM FINANCING ACTIVITIES			
Proceeds from Borrowings		49,488	-
NET CASH INFLOW FROM FINANCING ACTIVITIES		49,488	-
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		281,176	251,594
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		583,764	332,170
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.2	864,940	583,764

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

BASIS OF PRESENTATION

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

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

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

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

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 AASs 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 year ended 30 June 2018. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

These financial statements are 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 12th September, 2018.

(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)

(c) Basis of accounting preparation and measurement

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

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

The financial statements are prepared on a going concern basis (refer note 8.10 Economic Dependency).

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

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

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

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

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

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

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

Goods and Services Tax (GST)

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

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

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

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

(d) Principles of Consolidation

Intersegment Transactions

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

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

(e) Jointly Controlled Operation

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

In respect of any interest in joint operations, Omeo 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.

Omeo District Health is a Member of the Gipsland Health Alliance Joint Venture and retains joint control over the arrangement, which it has classified as a joint operation (refer to Note 8.9)

NOTE 2: FUNDING DELIVERY OF OUR SERVICES

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

Structure
2.1 Analysis of revenue by source

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE

	Admitted Patients 2018 $	Residential Aged Care 2018 $	Aged Care 2018 $	Primary Health 2018 $	Other 2018 $	TOTAL 2018 $
Government Grants	1,852,229	783,588	375,364	587,449	236,961	3,835,591
Indirect Contributions by Department of Health and Human Services	(2,575)	(7,379)	(2,364)	(3,554)	(1,013)	(16,885)
Patient and Resident Fees	47,687	246,798	154,106	20,024	-	468,615
Commercial Activities and Specific Purpose Funds	-	-	-	-	337,686	337,686
Other Revenue from Operating Activities	7,854	25,009	50,234	27,945	264,110	375,152
Total Revenue from Operating Activities	**1,905,195**	**1,048,016**	**577,340**	**631,864**	**837,744**	**5,000,159**
Property Income	-	-	-	-	3,665	3,665
Bank and Investment Income	-	-	-	-	54,615	54,615
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**-**	**58,280**	**58,280**
Capital Purpose Income	-	-	-	-	365,554	365,554
Total Capital Purpose Income	**-**	**-**	**-**	**-**	**365,554**	**365,554**
Total Revenue	**1,905,195**	**1,048,016**	**577,340**	**631,864**	**1,261,578**	**5,423,993**

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)

	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**

The 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.

Revenue Recognition
Income is recognised in accordance with AASB 118 *Revenue* and is recognised as to the extent that it is probable that the economic benefits will flow to 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 Department of Health and Human Services Hospital Circular 04/2017.

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (Continued)

Patient and Resident Fees
Patient fees are recognised as revenue on an accrual basis.

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

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

Donations and Other Bequests
Donations and bequests are recognised as revenue when received. If donations are for a special purpose, they may be appropriated to a 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 Note 2, the funds that enable the provision of services were disclosed and in this note the cost associated with provision of services are recorded.

Structure

3.1 Analysis of expenses by source
3.2 Employee Benefits in the Balance Sheet
3.3 Superannuation

NOTE 3.1: ANALYSIS OF EXPENSE BY SOURCE

	Admitted Patients 2018 $	Residential Aged Care 2018 $	Aged Care 2018 $	Primary Health 2018 $	Other 2018 $	TOTAL 2018 $
Employee Expenses	589,479	1,754,702	439,332	545,713	264,137	3,593,363
Other Operating Expenses						
Non Salary Labour Costs	40,492	1,179	328	56,819	278,621	377,439
Supplies and Consumables	48,243	55,190	4,213	8,221	6,489	122,356
Medical Indemnity Insurance	663	1,900	609	915	261	4,348
Fuel, Light, Power and Water	16,172	46,308	14,653	22,189	10,185	109,507
Repairs and Maintenance	15,431	23,541	5,410	18,197	3,118	65,697
Other Expenses	57,201	136,460	48,118	115,355	525,772	882,906
Total Expenditure from Operating Activities	**767,681**	**2,019,280**	**512,663**	**767,409**	**1,088,583**	**5,155,616**
Depreciation (refer note 4.3)	-	-	-	-	674,650	674,650
Total Other Expenses	**-**	**-**	**-**	**-**	**674,650**	**674,650**
Total Expenses	**767,681**	**2,019,280**	**512,663**	**767,409**	**1,763,233**	**5,830,266**

	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
Medical Indemnity Insurance	754	2,111	692	1,090	297	4,944
Fuel, Light, Power and Water	11,827	32,769	12,428	17,691	8,796	83,511
Repairs and Maintenance	12,882	17,807	3,140	11,242	2,333	47,404
Other Expenses	81,593	208,650	72,652	168,499	260,670	792,064
Total Expenditure from Operating Activities	**772,262**	**2,020,695**	**494,563**	**970,820**	**806,664**	**5,065,004**
Depreciation (refer note 4.3)	-	-	-	-	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**

Note 3.1 Expense Recognition
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;
- Fringe Benefits Tax;
- Leave Entitlements;
- Termination Payments;
- Workcover Premiums; and
- Superannuation expenses

Grants and Other Transfers

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

Other operating expenses

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

- Supplies and Consumables - Supplies and service costs which are recognised as an expense in the reporting period in which they are incurred. The carrying amounts of any inventories held for distribution are expensed when distributed.
- Fair value of assets, services and resources provided free of charge or for nominal consideration - Contributions of resources provided free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them.

Net Gain / (Loss) on Non-Financial Assets

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

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

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

Net gain/ (loss) on financial instruments

Net gain/ (loss) on financial instruments includes:

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

Other gains/(losses) from other economic flows

Other gains/(losses) include:

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

Derecognition of financial liabilities

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

NOTE 3.1A: ANALYSIS OF EXPENSES AND REVENUE BY INTERNALLY MANAGED AND RESTRICTED SPECIFIC PURPOSE FUNDS

	Expense		Revenue	
	Consol'd 2018 $	Consol'd 2017 $	Consol'd 2018 $	Consol'd 2017 $
Medical Clinic	605,437	589,463	573,634	630,447
TOTAL	605,437	589,463	573,634	630,447

NOTE 3.2: EMPLOYEE BENEFITS IN THE BALANCE SHEET	2018 $	2017 $
Current Provisions		
Employee Benefits (i)		
Accrued Wages, ADO & Annual Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	344,911	291,489
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)	186,925	180,609
Provisions related to employee benefit on-costs		
- unconditional and expected to be settled wholly within 12 months (ii)	46,187	40,514
- unconditional and expected to be settled wholly after 12 months (iii)	19,851	19,181
Total Current Provisions	687,874	621,793
Non-Current Provisions		
Employee Benefits (i)	134,308	103,520
Provisions related to employee benefit on-costs	14,263	10,994
Total Non-Current Provisions	148,571	114,514
Total Provisions	836,445	736,307
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Unconditional Long Service Leave Entitlements	306,334	299,348
Annual Leave Entitlements	326,188	272,886
Accrued Salaries and Wages	48,507	38,408
Accrued Days Off	6,845	11,151
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements (iii)	148,571	114,514
Total Employee Benefits and Related On-Costs	836,445	736,307

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

Movements in provisions	2018 $	2017 $
Movement in Long Service Leave:		
Balance at start of year	413,862	439,846
Provision made during the year		
- revaluations	1,797	1,120
- expense recognising employee service	41,642	76,759
Settlement made during the year	(2,396)	(103,863)
Balance at end of year	454,905	413,862

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

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

The amount recognised as a 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.

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)

Salaries and Wages, Annual Leave and Accrued Days Off

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

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

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

Long Service Leave (LSL)

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

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

The components of this current LSL liability are measured at:

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

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

Termination Benefits

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

On-Costs related to employee expense

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

NOTE 3.3: SUPERANNUATION

Fund		Paid Contributions for the Year		Outstanding Contributions at Year End	
		2018 $	**2017 $**	**2018 $**	**2017 $**
Defined Contribution Plans:	Health Super	240,029	243,780	-	36,720
	HESTA	45,709	36,132	-	-
Total		**285,738**	**279,912**	**-**	**36,720**

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.

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.

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

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 that have been expensed in relation to the major employee superannuation funds and contributions made by Omeo District Health are disclosed above.

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY

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

Structure

NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS	Total	
	2018	2017
CURRENT	$	$
Loans and Receivable		
Term Deposit		
Aust. Dollar Term Deposits >3 months (i)	1,453,236	1,951,737
TOTAL CURRENT	1,453,236	1,951,737
TOTAL	1,453,236	1,951,737
Represented by:		
Health Service Investments	1,059,529	1,539,605
Monies Held in Trust		
- Accommodation Bonds (Refundable Entrance Fees)	393,707	412,132
TOTAL	1,453,236	1,951,737

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

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

Investments are classified in the following categories:
- Loans and receivables.

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

Omeo District Health investments must comply with Standing Direction 3.7.2 - Treasury and Investment Risk Management.

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

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

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

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

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

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

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

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT **(a) Gross carrying amount and accumulated depreciation**	2018 $	2017 $
Land		
- Land at Fair Value	338,000	338,000
Total Land	338,000	338,000
Buildings		
- Buildings at Cost	351,901	351,901
Less Accumulated Depreciation	(17,595)	(8,798)
	334,306	343,103
- Buildings at Fair Value	5,462,000	5,462,000
Less Accumulated Depreciation	(2,065,224)	(1,548,918)
	3,396,776	3,913,082
- Leasehold Improvements at Cost	23,918	23,918
Less Accumulated Depreciation	(23,918)	(23,918)
	-	-
Total Buildings	3,731,082	4,256,185
Plant and Equipment		
- Plant - Gippsland Health Alliance (refer note 8.9)	2,640	1,269
- Plant and Equipment at Fair Value	956,177	1,060,107
Less Accumulated Depreciation	(733,940)	(835,435)
Total Plant and Equipment	224,877	225,941
Furniture and Fittings		
- Furniture and Fittings at Fair Value	554,938	546,535
Less Accumulated Depreciation	(407,890)	(451,140)
Total Furniture and Fittings	147,048	95,395
Motor Vehicles		
- Motor Vehicles at Fair Value	251,367	259,423
Less Accumulated Depreciation	(116,925)	(218,120)
Total Motor Vehicles	134,442	41,303
TOTAL	4,575,449	4,956,824

Share of jointly controlled assets included in property, plant and equipment are separately disclosed in Note 8.9 Jointly Controlled Operations and Assets.

NOTE 4.2: 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 2016	338,000	4,781,289	5,980	280,935	51,821	75,357	5,533,382
Additions	-	-	-	6,621	61,242	-	67,863
Depreciation (note 4)	-	(525,104)	(5,980)	(61,615)	(17,668)	(34,054)	(644,421)
Balance at 1 July 2017	338,000	4,256,185	-	225,941	95,395	41,303	4,956,824
Additions	-	-	-	73,490	75,229	152,043	300,762
Disposals	-	-	-	-	-	(7,487)	(7,487)
Depreciation (note 4)	-	(525,103)	-	(74,554)	(23,576)	(51,417)	(674,650)
Balance at 30 June 2018	338,000	3,731,082	-	224,877	147,048	134,442	4,575,449

Land and buildings carried at valuation

The Valuer-General Victoria undertook to re-value all of Omeo District Health's owned and leased land and buildings to determine their fair value. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments. The effective date of the valuation is 30 June 2014.

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

There were no material impact on change in fair value of land or buildings for the year ended 30 June 2018.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)
(c) Fair value measurement hierarchy for assets

	Carrying amount as at 30 June 2018	Fair value measurement at end of reporting period using: Level 1 (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	3,166,776	-	-	3,166,776
Total of building at fair value	3,396,776	-	230,000	3,166,776
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles	134,442	-	134,442	-
- Plant and equipment	224,877	-	-	224,877
- Furniture and Fittings	147,048	-	-	147,048
Total of plant, equipment and vehicles at fair value	506,367	-	134,442	371,925
TOTAL	4,241,143	-	512,442	3,728,701

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

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)
(c) Fair value measurement hierarchy for assets (Continued)

	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	3,683,082	-	-	3,683,082
Total of building at fair value	3,913,082	-	230,000	3,683,082
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
TOTAL	4,613,721	-	419,303	4,194,418

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

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

30-Jun-18	Land	Buildings & Leasehold Improvements	Plant and equipment
Opening Balance	190,000	3,683,082	321,336
Purchases (sales)	-	-	148,719
Gains or losses recognised in net result			
- Depreciation	-	(516,305)	(98,130)
Subtotal	190,000	3,166,777	371,925
Closing Balance	190,000	3,166,777	371,925

30-Jun-17	Land	Buildings & Leasehold Improvements	Plant and equipment
Opening Balance	190,000	4,205,368	332,756
Purchases (sales)	-	-	67,863
Transfers in (out) of Level 3			
Gains or losses recognised in net result			
- Depreciation	-	(522,286)	(79,283)
Subtotal	190,000	3,683,082	321,336
Closing Balance	190,000	3,683,082	321,336

There have been no transfers between levels during the period.

(e) Fair Value Determination

Asset Class	Examples of types assets	Expected fair value level	Likely valuation approach	Significant inputs (Level 3 only)
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 (Crown/Freehold)	- Land subject to restriction as to use and/or sale - Land in areas where there is not an active market	Level 3	Market approach	Community Service Obligation Adjustments (b)
Specialised Buildings (a)	Specialised buildings with limited alternative uses and/or substantial customisation eg. Hospitals	Level 3	Depreciated replacement cost approach	- Cost per square metre - Useful life
Vehicles	If there is no active resale market	Level 3	Market approach	n.a.
Plant and equipment	Specialised items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	- Cost per square metre - Useful life

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

(b) CSO adjustment of 20% was applied to reduce market approach value for Omeo District Health's specialised land.

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

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

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.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

Initial Recognition (Continued)

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

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

Subsequent Measure

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

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

For the purpose of fair value disclosures, 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.

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

Fair value measurement

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

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

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

In accordance with paragraph AASB 13.29, Health Services can assume the current use of a non-financial physical asset is its HBU unless market or other factors suggest that a different use by market participants would maximise the value of the asset. Therefore, an assessment of the HBU will be required when the indicators are triggered within a reporting period, which suggest the market participants would have perceived an alternative use of an asset that can generate maximum value. Once identified, Health Services are required to engage with VGV or other independent valuers for formal HBU assessment.

These indicators, as a minimum, include:
External factors:

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

Valuation hierarchy

Health Services need to use valuation techniques that are appropriate for the circumstances and where there is sufficient data available to measure fair value, maximising the use of relevant observable inputs and minimising the use of unobservable inputs.
All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy.

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.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

Identifying unobservable inputs (level 3) fair value measurements (Continued)

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

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

Specialised land and specialised buildings

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

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

The market approach is also used for specialised land and specialised buildings although 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 Service, 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 2018.

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

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

Revaluations of non-current physical assets

Non-Current physical assets are measured at fair value and are revalued in accordance with FRD 103F *Non-current physical assets*. This revaluation process normally occurs 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, except where an asset is transferred via contributed capital.

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 4.3: DEPRECIATION

	2018 $	2017 $
Depreciation		
Buildings	525,103	525,104
Leasehold Improvements	-	5,980
Plant and Equipment	74,121	61,545
Furniture and Fittings	23,576	17,668
Motor Vehicles	51,417	34,054
Gippsland Health Alliance (refer note 8.9)	433	70
TOTAL DEPRECIATION	674,650	644,421

Depreciation

All infrastructure assets, buildings, plant and equipment and other non-financial physical assets that have finite useful lives are depreciated (i.e. excludes land assets held for sale, and investment properties). Depreciation is generally calculated on a straight-line basis at rates that allocate the asset's value, less any estimated residual value over its estimated useful life (refer AASB 116 *Property, Plant and Equipment*).

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

	2018	2017
Buildings		
- Structure Shell Building Fabric	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
5.3 Payables

NOTE 5.1: RECEIVABLES	2018 $	2017 $
CURRENT		
Contractual		
Trade Debtors	139,977	197,389
Accrued Revenue	255,885	59,370
Gippsland Health Alliance Receivables (refer note 8.9)	73,473	66,172
	469,335	322,931
Statutory		
GST Receivable	18,175	12,267
	18,175	12,267
TOTAL CURRENT RECEIVABLES	487,510	335,198
NON CURRENT		
Statutory		
Long Service Leave - Department of Health and Human Services	27,403	49,364
TOTAL NON-CURRENT RECEIVABLES	27,403	49,364
TOTAL RECEIVABLES	514,913	384,562
(a) Movement in the Allowance for doubtful debts		
Balance at beginning of the year	-	(176)
Decrease in allowance recognised in net result	-	176
Balance at end of the year	-	-

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.

(b) Nature and extent of 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.

In assessing impairment of statutory (non-contractual) financial assets, which are not financial instruments, professional judgement is applied in assessing materiality using estimates, averages and other computational methods in accordance with AASB 136 Impairment of Assets.

Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition. Collectability of debts is reviewed on an ongoing basis, and debts which are known to be uncollectible are written off. A provision for doubtful 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	2018 $	2017 $
CURRENT		
Monies Held in Trust*		
- Accommodation Bonds (Refundable Entrance Fees)	393,707	412,132
TOTAL CURRENT	393,707	412,132
*** Total Monies Held in Trust**		
Represented by the following assets:		
Investments and Other Financial Assets (refer to Note 4.1)	393,707	412,132
TOTAL	393,707	412,132

NOTE 5.3: PAYABLES	2018 $	2017 $
CURRENT		
Contractual		
Trade Creditors	66,073	157,688
Accrued Audit Fees	9,500	14,400
Gippsland Health Alliance Payables (refer note 8.9)	12,998	24,301
Other	11,775	11,646
	100,346	208,035
Statutory		
PAYG Payable	44,911	80,671
GST Payable - Health Service	10,202	12,549
Department of Health and Human Services	93,382	93,808
	148,495	187,028
TOTAL PAYABLES	248,841	395,063

Payables consist of:

- contractual payables, classified as financial instruments and measured at amortised cost. Accounts payable represents liabilities for goods and services provided to the Department prior to the end of the financial year that are unpaid; and

- statutory payables, that are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from contracts.

Note 5.3 (a): Maturity analysis of financial liabilities as at 30 June

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

			Maturity Dates			
2018	Total Carrying Amount $	Nominal Amount $	Less than 1 Month $	1 - 3 Months $	3 Months - 1 Year $	1 - 5 Years $
Financial Liabilities						
Payables	100,346	100,346	100,346	-	-	-
Borrowings	49,488	49,488	-	-	12,930	36,558
Other Financial Liabilities						
- Accommodation Bonds	393,707	393,707	-	-	393,707	-
Total Financial Liabilities	543,541	543,541	100,346	-	406,637	36,558
2017						
Financial Liabilities						
Payables	208,035	208,035	208,035	-	-	-
Borrowings	-	-	-	-	-	-
Other Financial Liabilities						
- Accommodation Bonds	412,132	412,132	-	-	412,132	-
Total Financial Liabilities	620,167	620,167	208,035	-	412,132	-

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

NOTE 6: HOW WE FINANCE OUR OPERATIONS

This section provides information on the sources of finance utilised by the hospital during its operations, along with interest expenses (the cost of borrowings) and other information related to financing activities of the 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: BORROWINGS	2018 $	2017 $
CURRENT		
Department of Health and Human Services - Loan	12,930	-
TOTAL CURRENT BORROWINGS	12,930	-
NON CURRENT		
Department of Health and Human Services - Loan	36,558	-
TOTAL NON CURRENT BORROWINGS	36,558	-
TOTAL BORROWINGS	49,488	-

A loan has been provided by the Department of Health and Human Services in order to provide cash flow to fund a solar array at the Health Service. The loan is provided on an interest free basis and is repayable over a term of 4 years, commencing in June 2018.

(a) Maturity analysis of borrowings
Please refer to Note 5.3a for the ageing analysis of contractual payables.

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

Borrowing Recognition
All borrowings are initially recognised at fair value of the consideration received, less directly attributable transactions costs. Subsequent to initial recognition, borrowings are measured at amortised cost with any difference between the initial recognised amount and the redemption value being recognised in the net result over the period of the borrowing using the effective interest method. Fair value is determined in the manner described in Note 7.1.

NOTE 6.2: CASH AND CASH EQUIVALENTS For the purposes of the cash flow statement, cash assets includes cash on hand and in banks, and short-term deposits which are readily convertible to cash on hand, and are subject to an insignificant risk of change in value, net of outstanding bank overdrafts.	2018 $	2017 $
Cash at Bank and on Hand	613,915	104,386
Cash Management Account	251,025	479,378
Cash at Gippsland Health Alliance (refer note 8.9)	191,114	113,506
TOTAL CASH AND CASH EQUIVALENTS	1,056,054	697,270
Represented by:		
Cash for Health Service Operations (as per cash flow statement)	864,940	583,764
Cash for Monies Held in Trust		
- Cash for Gippsland Health Alliance (refer note 8.9)	191,114	113,506
TOTAL CASH AND CASH EQUIVALENTS	1,056,054	697,270

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 6.3: 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 2018 (30 June 2017: $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

NOTE 7.1: FINANCIAL INSTRUMENTS
Financial risk management objectives and policies

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

Categorisation of financial instruments

	Carrying Amount 2018 $	Carrying Amount 2017 $
Financial Assets		
Cash and cash equivalents	1,056,054	697,270
Loans and Receivables	469,335	322,931
Investments	1,453,236	1,951,737
Total Financial Assets (i)	2,978,625	2,971,938
Financial Liabilities		
At amortised cost	543,541	620,167
Total Financial Liabilities (ii)	543,541	620,167

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

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

	Net holding gain/(loss) 2018 $	Net holding gain/(loss) 2017 $
Financial Assets		
Cash and Cash Equivalents (i)	54,615	58,370
Total Financial Assets	54,615	58,370

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

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

Categories of financial instruments
Loans and receivables and cash
are financial instrument assets with fixed and determinable payments that are not quoted on an active market. These assets are initially recognised at fair value plus any directly attributable transaction costs. Subsequent to initial measurement, loans and receivables are measured at amortised cost using the effective interest method (and for assets, less and impairment). The Health Service recognises the following assets in this category:
- cash and deposits;
- receivables (excluding statutory receivables); and
- term deposits

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

NOTE 7.1: FINANCIAL INSTRUMENTS (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:
  - (i) has transferred substantially all the risks and rewards of the asset; or
  - (ii) has neither transferred nor retained substantially all the risks and rewards of the asset, but has transferred control of the asset.

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

Impairment of financial assets

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

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

Reclassification of financial instruments:

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

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

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

Derecognition of financial liabilities

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

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

NOTE 7.2: CONTINGENT ASSETS AND CONTINGENT LIABILITIES

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

There are no known contingent assets or liabilities for Omeo District Health as at the date of this report (30 June 2017: $Nil)

NOTE 8: OTHER DISCLOSURES

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

Structure

NOTE 8.1: EQUITY	2018 $	2017 $
(a) Surpluses		
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	1,531,678	2,022,731
Net Result for the Year	(366,486)	(491,053)
Balance at the end of the reporting period	1,165,192	1,531,678
Total Equity at end of financial year	6,114,263	6,480,749

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.

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

	2018 $	2017 $
NET RESULT FOR THE YEAR	(366,486)	(491,053)
Non-cash movements		
Depreciation	674,650	644,351
Movements included in investing and financing activities		
Net (Gain)/Loss from Sale of Plant and Equipment	(41,584)	-
Movements in assets and liabilities		
Change in Operating Assets and Liabilities		
(Increase) in Receivables	(207,959)	(264,611)
(Increase) in Prepayments	(9,234)	(1,027)
Increase/(Decrease) in Payables	(146,222)	88,713
Increase in Provisions	100,138	27,878
(Decrease) in Other Liabilities	(18,425)	(29,583)
NET CASH INFLOW FROM OPERATING ACTIVITIES	(15,122)	(25,332)

NOTE 8.3: 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	01/07/2017 - 30/06/2018
The Honourable Martin Foley, Minister for Housing, Disability and Ageing and Minister for Mental Health	01/07/2017 - 30/06/2018
Governing Boards	
Mrs. A. Burston	01/07/2017 - 30/06/2018
Ms. S. Malcolm	01/07/2017 - 30/06/2018
Mrs. S. Crisp	01/07/2017 - 30/06/2018
Mrs. K. Commins	01/07/2017 - 30/06/2018
Mr. D. Foster	01/07/2017 - 30/06/2018
Mr. A. McKenzie	01/07/2017 - 30/06/2018
Mrs. M. Ferguson	01/07/2017 - 30/06/2018
Mr. G. Dear	01/07/2017 - 30/06/2018
Mr. S. Lawlor	01/07/2017 - 30/06/2018
Mrs. P. Barry	01/07/2017 - 30/06/2018
Accountable Officer	
Mr Ward Steet	01/07/2017 - 30/06/2018

Remuneration of Responsible Persons

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

	2018	**2017**
Income Band	**$**	**$**
$0 - $10,000	10	10
$110,000 - $119,999	0	1
$130,000 - $139,999	1	0
Total Numbers	11	11
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	$139,580	$112,001

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

NOTE 8.4: EXECUTIVE OFFICER DISCLOSURES

Remuneration of executives

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

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

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

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

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

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

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

Remuneration of executive officers	**Total Remuneration**	
	2018	**2017**
	$	**$**
Short-term employee benefits	124,990	100,248
Post-employment benefits	11,671	9,239
Other long-term benefits	2,919	2,514
Total Remuneration (b)	139,580	112,001
Total Number of executives (c)	1	2
Total annualised employee equivalent (AEE) (d)	1	1

Notes:

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

(b) Annualised employee equivalent is based on working 38 ordinary hours per week over the reporting period.

NOTE 8.5: RELATED PARTIES

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

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

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

The Board of Directors and the Executive Directors of Omeo District Health and it's controlled entities are deemed to be KMPs.

Entity	KMPs	Position Title
Omeo District Health	Mrs. A. Burston	Board Chair
Omeo District Health	Ms. S. Malcolm	Board Member
Omeo District Health	Mrs. S. Crisp	Board Member
Omeo District Health	Mrs. K. Commins	Board Member
Omeo District Health	Mr. D. Foster	Board Member
Omeo District Health	Mr. A. McKenzie	Board Member
Omeo District Health	Mrs. M. Ferguson	Board Member
Omeo District Health	Mr. G. Dear	Board Member
Omeo District Health	Mr. S. Lawlor	Board Member
Omeo District Health	Mrs. P. Barry	Board Member
Omeo District Health	Mr. Ward Steet	CEO

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.

COMPENSATION	2018 $	2017 $
Short term employee benefits	124,990	126,653
Post-employment benefits	11,671	11,251
Other long-term benefits	2,919	4,198
Termination benefits	0	0
Share based payments	0	0
Total	**139,580**	**142,102**

(i)Total remuneration paid to KMPs employed as a contractor during the reporting period through accounts payable has been reported under short-term employee benefits.
(ii)KMPs are also reported in Note 8.4 Responsible Persons or Note 8.5 Remuneration of Executives.

Significant transactions with government-related entities

Omeo District Health received funding from the Department of Health and Human Services of $2,519,132 (2017: $2,381,483).

During the year, Omeo District Health had the following other government-related entity transactions:
- Commonwealth Government funding received for health related programs totalling $1,358,574 (2017 $1,218,235).
- Latrobe Regional Hospital funding received for HACC related programs totalling $125,248 (2017 $157,562).

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

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

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

Transactions with key management personnel and other related parties

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

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

There were no related party transactions with Cabinet Ministers required to be disclosed in 2018.
There were no related party transactions required to be disclosed for Omeo District Health Board of Directors and Executive Directors in 2018.

Note 8.6: REMUNERATION OF AUDITORS

	2018	2017
Victorian Auditor-General's Office	**$**	**$**
Audit or review of financial statement	15,500	14,400
	15,500	14,400

NOTE 8.7: AASBs ISSUED THAT ARE NOT YET EFFECTIVE

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

As at 30 June 2018, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. Omeo District Health has not and does not intend to adopt these standards early.

Topic	Key Requirements	Effective date
AASB 9 *Financial Instruments*	The key changes introduced by AASB 9 include simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1 January 2018
AASB 2014-1 *Amendments to Australian Accounting Standards [Part E Financial Instruments]*	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018, and to amend Reduced Disclosure requirements.	1 January 2018
AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1 January 2018
AASB 15 Revenue from Contracts with Customers	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer. Note that amending standard AASB 2015-8 Amendments to Australian Accounting Standards – Effective Date of AASB 15 has deferred the effective date of AASB 15 to annual reporting periods beginning on or after 1 January 2018, instead of 1 January 2017.	1 January 2018
AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15	Amends the measurement of trade receivables and the recognition of dividends as follow: - Trade receivables, that do not have a significant financing component, are to be measured at their transaction price, at initial recognition. - Dividends are recognised in the profit and loss only when: • the entity's right to receive payment of the dividend is established; • it is probable that the economic benefits associated with the dividend will flow to the entity; and • the amount can be measured reliably.	1 January 2018, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply 1 January 2018
AASB 2015-8 Amendments to Australian Accounting Standards – Effective Date of AASB 15	This standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1 January 2018
AASB 2016-3 Amendments to Australian Accounting Standards – Clarifications to AASB 15	This Standard amends AASB 15 to clarify requirements for identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: • a promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation; • for items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer; and • for licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access).	1 January 2018
AASB 2016-7 Amendments to Australian Accounting Standards Deferral of AASB 15 for Not-for-Profit Entities	This standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019	1 January 2019
AASB 2016-8 Amendments to Australian Accounting Standards Australian Implementation Guidance for Not-for-Profit Entities	This Standard amends AASB 9 and AASB 15 to include requirements and implementation guidance to assist not-for-profit entities in applying the respective standards to particular transactions and events. The amendments: • require non-contractual receivable arising from statutory requirements (i.e. taxes, rates and fines) to be initially measured and recognised in accordance with AASB 9 as if those receivables are financial instruments; and • clarifies circumstances when a contract with a customer is within the scope of AASB 15.	1 January 2019

NOTE 8.7: AASBs ISSUED THAT ARE NOT YET EFFECTIVE (Continued)

Topic	Key Requirements	Effective date
AASB 16 Leases	The key changes introduced by AASB 16 include the recognition of most operating leases (which are currently not recognised) on balance sheet which has an impact on net debt.	1 January 2019
AASB 1058 Income of Not-for-Profit Entities	This standard will replace AASB 1004 Contributions and establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objectives. The restructure of administrative arrangement will remain under AASB 1004.	1 January 2019
AASB 1059 Service Concession Arrangements: Grantor	This standard prescribes the accounting treatment of Public Private Partnership (PPP) arrangements involving a private sector operator providing public services related to a service concession asset on behalf of the State, for a specified period of time. For social infrastructure PPP arrangements, this would result in an earlier recognition of financial liabilities progressively over the construction period rather than at completion date. For economic infrastructure PPP arrangements, that were previously not on balance sheet, the standard will require recognition of these arrangements on-balance sheet.	1 January 2019

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

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

NOTE 8.8: 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 8.9: JOINTLY CONTROLLED OPERATIONS

Name of Entity	Principal Activity	Ownership Interest 2018 %	Ownership Interest 2017 %
Gippsland Health Alliance	Information Technology	2.29	2.24

The Health Service's interest in the above jointly controlled operations are detailed below. The amounts are included in the consolidated financial statements under their respective categories:

	2018 $	2017 $
Current Assets		
Cash and Cash Equivalents	191,114	113,506
Receivables and Other	73,473	66,172
Total Current Assets	264,587	179,678
Non Current Assets		
Plant and Equipment	2,640	1,199
Total Non Current Assets	2,640	1,199
Total Assets	267,227	180,877
Current Liabilities		
Payables	12,998	24,301
Total Current Liabilities	12,998	24,301
Net Assets	254,229	156,576

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

Revenue from Operating Activities	260,944	234,590
Expenditure	255,464	217,201
Surplus/(Deficit) before Capital and Depreciation	5,480	17,389
Capital Purpose Income	92,606	76,727
Depreciation	433	70
Total	92,173	76,657
Current Year Surplus/(Deficit)	97,653	94,046

Contingent Liabilities and Capital Commitments
There are no known contingent liabilities or capital commitments held by the jointly controlled operations at balance date.

NOTE 8.10: ECONOMIC DEPENDENCY
Omer District Health is dependent on the Department of Health and Human services for the majority of its revenue used to operate the entity. A the date of this report, the Board of Directors has no reason to believe the Department will not continue to support Omeo District Health.

NOTE 8.11: ALTERNATIVE PRESENTATION OF COMPREHENSIVE OPERATING STATEMENT

	Note	2018 $	2017 $
Grants			
Operating	2.1	3,818,706	3,875,126
Capital	2.1	-	-
Interest	2.1	54,615	58,370
Sales of goods and services	2.1	468,615	463,216
Other income	2.1	1,082,057	822,780
Revenue from Transactions		**5,423,993**	**5,219,492**
Employee expenses	3.1	3,593,363	3,472,750
Depreciation	4.3	674,650	644,421
Other operating expenses	3.1	1,562,253	1,592,254
Expenses from Transactions		**5,830,266**	**5,709,425**
Net Result From Transactions		**(406,273)**	**(489,933)**
Other economic flows included in net result			
Net gain/ (loss) on sale of non-financial assets		41,584	-
Other gains/ (losses) from other economic flows included in net result	3.2	(1,797)	(1,120)
Total Other Economic flows included in Net Result		**39,787**	**(1,120)**
NET RESULT FOR THE YEAR		**(366,486)**	**(491,053)**

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

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 2018 and the financial position of Omeo District Health at 30 June 2018.

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

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

Mr Simon Lawlor Board President	Mr Ward Steet Chief Executive Officer	Mr Steven Jackel Chief Finance Officer
Omeo	Omeo	Omeo
12th September, 2018	12th September, 2018	12th September, 2018