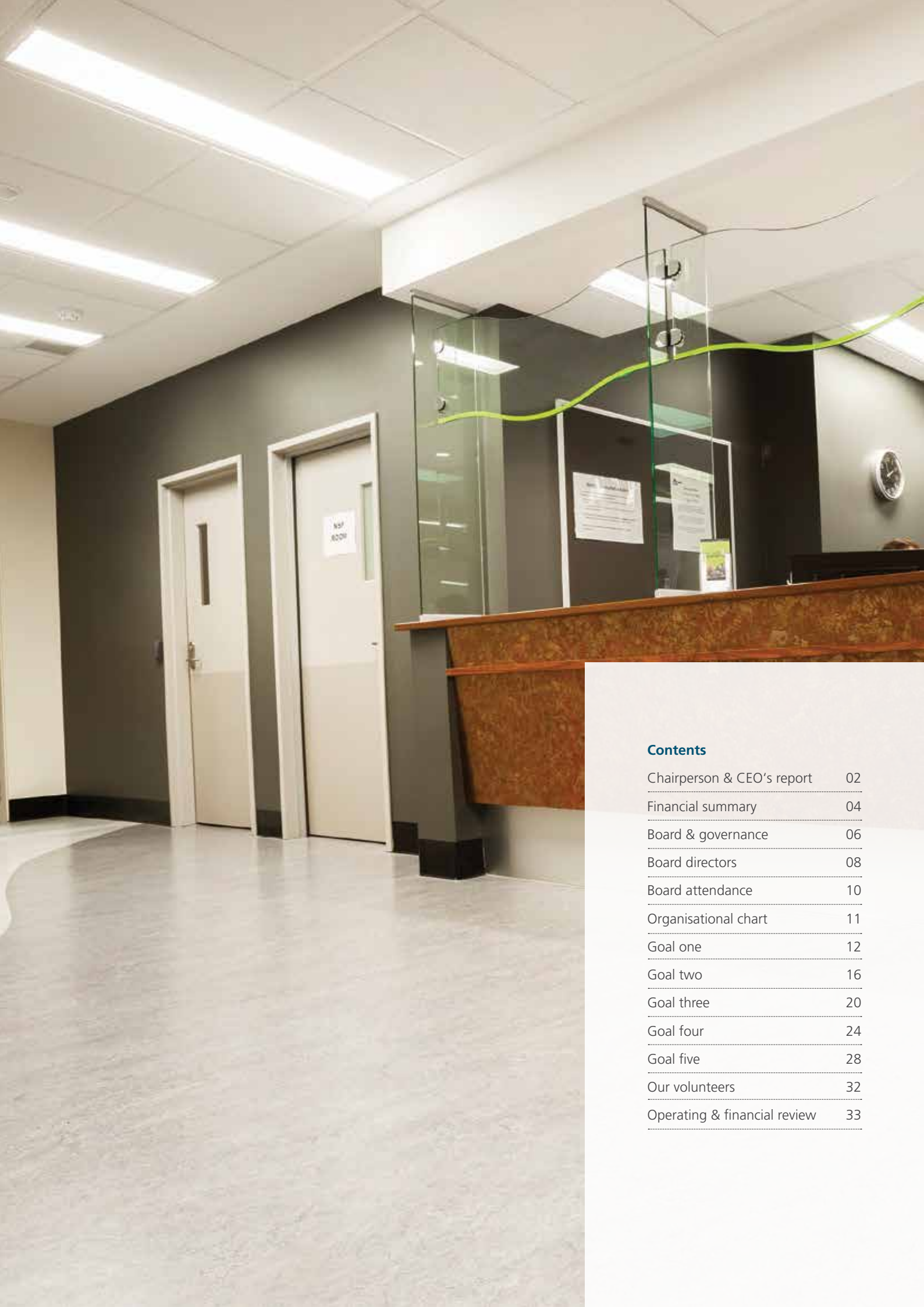
Latrobe Community Health Service

Annual Report

2014-2015

www.lchs.com.au



Contents

Better health
Better lifestyles
Stronger communities

Vision

Better health, Better lifestyles, Stronger communities.

Mission

Latrobe Community Health Service is a rapidly developing health service that has grown its people, its technology and infrastructure to offer more services to those who need them, along with a greater ability for people to look after their own health using a variety of fee-free and fee-based models.

Values

Providing excellent customer service

Actively assist our customers and clients to receive the quality services they require in a professional and courteous manner.

Always providing a personal best

Embrace a 'can do' attitude and go the extra distance when required.

Creating a successful environment

Contribute to making Latrobe Community Health Service a positive, respectful, innovative and healthy place to be.

Acting with the utmost integrity

Practice the highest ethical standards at all times.

Chairman and CEO's report

When the Latrobe Community Health Service 2012-17 Strategic Plan was launched in 2012, we said:

"We're inspired by a vision of strong, vibrant communities, where more people enjoy good health and healthy lifestyles. Improved access to healthcare and better information about healthy lifestyle choices are the building blocks of strong communities."

John Guy, Chairman

Ben Leigh, CEO

This year marks the halfway point of the five-year window to implement the strategic plan. Within Latrobe Community Health Service, the plan has provided a roadmap to ensure we remain focused on the activities that will help us meet the vision we outlined in 2012.

We have made strong progress. While there is much left to do, there is also much to celebrate.

To this end, 2015 marks a change in direction for the presentation of our annual report. Traditionally we have reported against the activities of each directorate.

From this year we will report against the goals outlined in the 2012-17 Strategic Plan. This offers two main benefits.

Firstly, this new approach gives the community and other stakeholders a greater sense of ownership and engagement with the plan. Internally we have monitored our progress against the strategic plan from day one. But ultimately we are a community health service, and it's important to us that the community feels connected with our progress.

Secondly, it further increases transparency and gives a better sense of our progress against the plan. While the report is not an exhaustive list of all of our activities, it does provide a good representation of our work during the year.

It is now far easier to draw connections between what we have done, and how that activity contributes to meeting our strategic goals. Similarly, it is clear where there is further work to be done.

In some ways 2014-15 was a year of consolidation, as a period of heavy investment in building infrastructure comes to fruition. The Newmason centre in Warragul is completed and will open in July 2015.

The new premises will combine our existing dental, aged, disability, counselling and carer services with a new GP clinic and allied health services, all under one roof.

The redevelopment of our Moe site is also nearing completion. The completed development adds GP and allied health suites, as well as community and training rooms. This building will provide valuable space for community members to meet or join in group activities.

2014-15 was also a period of innovation and investment in some of the new frontiers in health provision.

Perhaps the most exciting innovation in this area was the launch of 'Plan Your Care'.

This online portal allows our clients with a disability to log in and manage their package finances and mix of services. This is a clear demonstration of our progress towards providing services to people when and where they need them.

We also launched a brand new website that reflects the broader societal shift to 'digital first'.

The site provides clear and compelling descriptions of our services, and allows community members to book online for an appointment with a doctor. Traffic to the new site has grown steadily since its launch.

Online advertising has become an important third channel for providing information to the community, alongside print and broadcast.

Latrobe Community Health Service has invested in this area, with ads appearing next to online search results more than 50,000 times since commencing search advertising in May 2015.

The pivot away from traditional block funding models to consumer-directed care continued in 2014-15. This shift rightly positions clients as the primary driver of decisions about what care they should receive, and who should provide it.

All of our aged care clients have now moved to this new model, and we are preparing for a similar shift when the National Disability Insurance Scheme commences in Gippsland.

For Latrobe Community Health Service, this shift introduces a competitive, market-based driver to health decisions that community members make. This change requires a different sort of organisation.

Innovation and entrepreneurial spirit are no longer 'extras'. They are now basic organisational requirements, and will remain central to our plans not just to survive, but to flourish as a health service.

We are pleased to report Latrobe Community Health Service is already demonstrating these qualities. In the past year we launched 'Your Care Choice', a fee-for-service offering to provide direct care services within the home to the aged, people with a disability, and their carers.

Planned activity groups, pictured here at our Morwell site, help combat social isolation among older community members.

We also trialled a new health management model known as the 'guided care' or 'concierge' model, with the aim of providing holistic care through the appointment of a care coordinator for clients with complex health needs.

Our disability services team were able to slash waiting lists by introducing a new model of needs assessment.

It is this organisation-wide appetite for improvement that gives us confidence in our progress towards the goals of the strategic plan.

The broader funding environment for community health services remains fragile; the unfortunate challenge of doing more with less is ever-present. Nonetheless, the financial position of Latrobe Community Health Service remains strong. In 2014-15 our operating revenue, excluding capital grants, increased by 1.15%.

As an organisation we continue to look for opportunities to both grow revenue and diversify it. This will ensure we can re-invest in the health services that so many in our community rely upon.

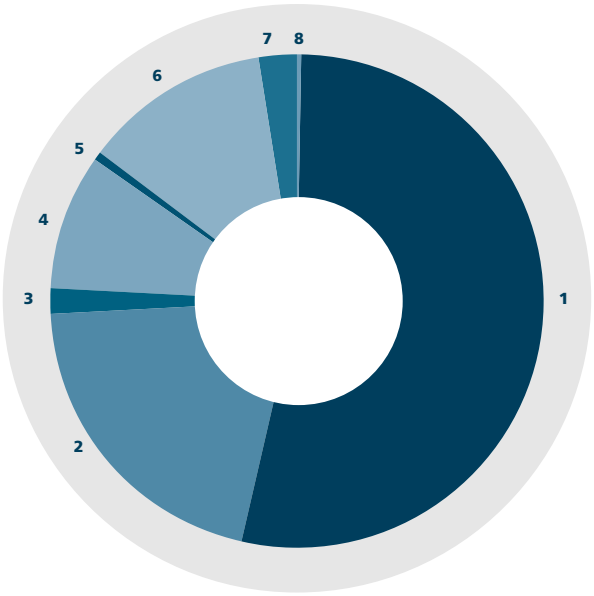
By any measure, our strategic plan is ambitious. At the halfway mark there remains significant work ahead of us, and the external landscape is constantly evolving. There will be new and unexpected challenges and opportunities in the coming years.

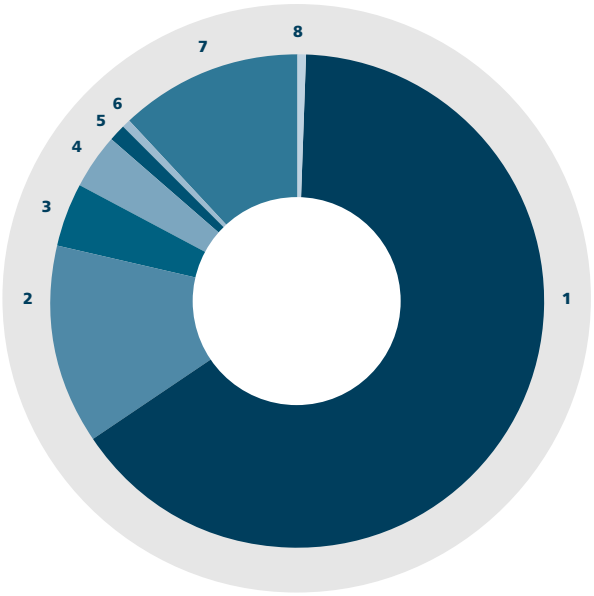
To date though, the plan has proved robust and our progress has been significant.

With the continued focus of our very committed staff and volunteers, there is no reason we cannot achieve similar success in coming years.

Financial summary

Latrobe Community Health Service delivered a net surplus of $4.02 million and retained a strong financial position in 2014-15. The financial ratios and cash position remained healthy and within financial strategy benchmarks during the year.





2014-15 Total revenue

1. Department of Health/ Department of Human Services **53.3%**
2. Commonwealth Government **20.7%**
3. Other **1.5%**
4. Client fees **8.9%**
5. Interest **0.7%**
6. Other government grants **12.0%**
7. Capital grants **2.5%**
8. Rental **0.4%**

2014-15 Total expenditure

1. Employee benefits **64.9%**
2. Brokerage clients **13.1%**
3. Contract labour **4.1%**
4. Depreciation **3.7%**
5. Motor vehicle costs **1.0%**
6. Operating leases **0.8%**
7. Program administration* costs **11.7%**
8. Utilities **0.7%**

** The main components making up 'Program Administration' costs are medical supplies, staff training, information technology, consortium payments and maintenance.*

Operating results

Our operating result for the year, excluding capital income, was a surplus of $2.9 million.

Operating revenue, excluding capital grants, increased by 1.15% to $44.1 million.

Funding from the Department of Health was again the major source of income, representing 53.3% of the total.

Client fees increased to 8.9% of total income (2014: 6.1%).

The increase in revenue is accompanied by a decrease in operating expenditure of 6.1% ($2.7 million) to $41.2 million.

This was principally due to a decrease of $2.0 million in 'contract labour' in line with the reduced funding to the dental voucher service.

Net results

After taking into consideration capital grants (primarily related to the Moe site redevelopment), Latrobe Community Health Service's overall net result for the 2014-15 financial year was a surplus of $4.02 million.

	2014-15 ($m)	2013-14 ($m)	2012-13 ($m)	2011-12 ($m)	2010-11 ($m)
NET RESULTS					
What we receive - Revenue	44.1	43.6	37.5	34.7	33.9
What we spent - Expenses	41.2	43.9	39.0	33.2	34.3
Operating result for the year	2.9	(0.3)	(1.6)	1.5	(0.4)
Plus capital grants received	1.1	2.4	4.2	0.2	0.5
Less building contractor payments	-	-	-	-	1.3
Net result for the year	**4.0**	**2.1**	**2.7**	**1.6**	**(1.2)**

Assets and liabilities

Latrobe Community Health Service's total assets increased by $4.1 million. This included an increase in current assets of $2.9 million due mostly to cash held from grants for capital works and community projects that will be completed in future years. These grants have been transferred to reserves. Non-current assets increased by $1.1 million for completed IT and construction works. Liabilities increased by $0.5 million primarily due to accrued client expenditure and outstanding payments to consortium members.

	2014-15 ($m)	2013-14 ($m)	2012-13 ($m)	2011-12 ($m)	2010-11 ($m)
ASSETS AND LIABILITIES					
What we own - Assets	31.1	27.0	27.1	21.2	19.0
What we owe - Liabilities	7.4	6.9	9.4	6.1	5.6
Net assets	**23.7**	**20.1**	**17.8**	**15.1**	**13.4**

The above mentioned changes in assets and liabilities result in an increase to the working capital ratio and a reduction to the debt ratio.

	2014-15	2013-14	2012-13	2011-12	2010-11
Working capital ratio					
Current assets/Current liabilities	1.93	1.59	1.75	1.90	1.94
Debt ratio					
Total liabilities/Total assets	23.75%	25.52%	34.50%	28.78%	29.67%

Cash flow

The cash position has increased by $3.97 million over the 2014-15 financial year due to cash held from grants for capital works and community projects. These grants have been transferred to reserves for planned expenditure in future years.

	2014-15 ($'000)	2013-14 ($'000)	2012-13 ($'000)	2011-12 ($'000)	2010-11 ($'000)
NET RESULTS					
Cash flow from operating activities	6,000	(218)	5,353	3,077	(1,002)
Cash flow from investing activities	(2,030)	(5,049)	(2,210)	(2,092)	(228)
Cash and cash equivalents at beginning of period	6,987	12,254	9,111	8,126	9,356
Cash and cash equivalents at end of period	**10,957**	**6,987**	**12,254**	**9,111**	**8,126**

Board and governance

Latrobe Community Health Service is incorporated under the Corporations Act 2001 as a Company Limited by Guarantee. It is governed by a skills-based board of up to nine directors. The membership of the company elects five directors and the board appoints four directors.

The work of the board is supported by three board committees:

- Audit and Risk
- Quality and Safety
- Governance.

Audit and Risk Committee

The purpose of the Audit and Risk Committee is to assist the Latrobe Community Health Service board to discharge its responsibility to exercise due care, diligence and skill.

The terms of reference relate to:

- Reporting financial information to users of financial reports
- applying accounting policies
- the independence of Latrobe Community Health Service's external auditors
- the effectiveness of the internal and external audit functions
- financial management
- internal control systems
- risk management
- organisational performance management
- Latrobe Community Health Service business policies and practices
- complying with Latrobe Community Health Service's constitutional documentation and material contracts
- complying with applicable laws and regulations, standards and best practice guidelines.

The committee includes two independent representatives:

Liz (Elizabeth) Collins

BBus, CPA, GAICD, Cert Bus.

Appointed April 2009

Liz is the Executive Manager Finance at East Gippsland Shire Council.

A former General Manager Governance at Wellington Shire Council for four years and a former Manager Finance at Latrobe City Council for ten years, Liz has experience with financial controls, risk assessments, legislative compliance, policy development, management accounting, procurement and asset management.

Ron Gowland

Dip Management, FCPA, Economics Degree

Appointed February 2012

Ron is semi-retired, has a Public Practice Certification from CPA Australia and is a director of public accounting practice Latrobe Business Solutions Pty Ltd.

Ron is a former Chair of Gippsland Water and Latrobe City Audit Committees. He has substantial experience in the finance sector spanning 50 years.

Quality and Safety Committee

The purpose of the Quality and Safety Committee is to assist the Latrobe Community Health Service board to maintain systems by which the board, managers and clinicians share responsibility and are held accountable for patient or client care, minimising risk to consumers and continuously monitoring and improving the quality of clinical care (Australian Council on Healthcare Standards).

The committee also ensures Latrobe Community Health Service quality and safety systems will support the implementation of the four key principles of clinical governance, which are:

- Build a culture of trust and honesty through open disclosure in partnership with consumers and community.
- Foster organisational commitment to continuous improvement.
- Establish rigorous monitoring, reporting and response systems.
- Evaluate and respond to key aspects of organisational performance.

Board Chairman John Guy.

Board member Melissa Bastian.

The Quality and Safety Committee is informed by the work of three staff committees:

- Occupational Health and Safety Committee
- Clinical Governance Advisory Committee
- Quality Implementation and Advisory Committee.

The committee includes a client representative:

Allison Higgins
Bachelor of Arts (Communications)
Appointed August 2009

Allison has cerebral palsy and requires the use of a mobility aid and paid personal care supports. She has a keen interest in disability advocacy and is actively involved in the management of her care in order to be as independent as possible.

As a client receiving care and support services, Allison is able to draw on her personal experiences within the healthcare system and provide her valuable insights to the Board Quality and Safety Committee.

Board Governance Committee

The role of the Governance Committee is to assist and advise the board on:

- composition, structure and operation of the board
- CEO selection and performance
- remuneration
- other matters as required.

Board directors

Latrobe Community Health Service board directors, left to right: Steven Porter, John Guy, Peter Starkey, Judith Walker, Stephen Howe, Carolyne Boothman, Mark Biggs, Melissa Bastian and Peter Wallace.

John V Guy, OAM JP

Grad. Dip. P.A.

Board Chairman

Board director since September 1997. Board Chair 2002-04 and 2008-14. Member Governance Committee, Board Recruitment Selection Panel, Former Chair Audit Committee.

John spent 35 years with the State Electricity Commission of Victoria, six years on the Morwell Shire/City Council; (three consecutive years as Mayor) was Chairman of the Latrobe Regional Commission; and Chairman of Commissioners of Wellington Shire during the amalgamation process.

He is currently Chair of Advance Morwell Inc. He is a Justice of the Peace, a volunteer with the Office of the Public Advocate, Independent Third Person Program and a volunteer with the Youth Referral and Independent Person Program.

John is a member of the Hazelwood Mine Fire Recovery Committee and represents Latrobe Community Health Service on the Hazelwood Mine Fire Health Study.

Mark Biggs

BA (SocSci), Grad Dip Counselling Psychology.

Board Deputy Chairman

Board director since February 2014. Member Quality & Safety Committee and Governance Committee.

Mark has an extensive management career in the primary health and human services sector including child protection, youth, disability, occupational rehabilitation, and project and business management.

He has expertise in strategic planning, policy, risk and business management. Mark is currently on the board of Gippsland Medicare Local and is Chair of the Clinical Governance Committee.

Mark was a board director of Latrobe Regional Hospital for nine years holding positions as Deputy Chair and Audit Chair. Mark is skilled in the area of governance, quality assurance and compliance.

Peter Wallace

BBus (Marketing), Post Graduate Diploma (Health Services Management), Master of Administration.

Board director since January 2007. Chair Quality & Safety Committee; previous member Governance Committee; previous member Audit Committee.

Peter's previous appointments have included Director Corporate Services at Latrobe Regional Hospital, Chief Executive Officer at Maroondah Hospital, Deputy Chief Executive Officer at Box Hill Hospital and Director of General Services at Monash Medical Centre.

Peter has also undertaken project and consulting assignments at Mercy Health

& Aged Care, Royal Children's Hospital, Barwon Health, Dental Health Services Victoria and the Department of Health. Peter completed the AICD Company Directors course in 2011.

Steven Porter

BA Eng (Civil), Masters Degree, GAICD.

Board director since November 2004. Member Audit & Risk Committee; previous Chair Audit & Risk Committee and Board Treasurer.

Steven is an alumni of Leadership Victoria and member of the Australian Institute of Company Directors. He completed his Masters in Organisation Dynamics at RMIT.

He has experience in senior management positions in asset planning, capital works, communications/public relations, business processes, change and resource management.

Steven is a committee member of the Victorian branch of the Australian Water Association (AWA).

Carolyne Boothman

Bachelor of Education (Primary), Graduate Certificate of Religious Education.

Board director since February 2010. Member Audit & Risk Committee; previous member Quality & Safety Committee.

Carolyne has been a member of the Gippsport Board of Management for 20 years, and many other sporting committees in the local area.

She is Chair of the Morwell and District Community Recovery Committee, which has worked closely with all levels of government following the bushfires and Hazelwood mine fire of 2014.

Carolyne is also president / publicity officer for the Gippsland Acoustic Music Club, member of the Latrobe Regional Hospital Foundation and appointed community representative to the community advisory committee for the Hazelwood Health Study.

Carolyne is currently teaching at local schools, and has a passionate interest in health, fitness and music. She has lectured at Monash University.

Melissa Bastian

LLB (Honours), BBus (Management), Grad Dip Legal Practice, GAICD.

Board director since January 2011. Chair of the Audit & Risk Committee.

Melissa has a diverse background and experience in a variety of industries including local and federal government, health, insurance, legal, banking and leadership development. She has advanced leadership and communication skills and extensive management, business planning, compliance, strategic development, financial management and corporate governance experience.

Melissa is a former State Registered Nurse and a 2011 graduate of the Gippsland Community Leadership Program. She is also a director of Bank Australia and a voluntary speaker on organ donation for DonateLife.

Judith (Judi) Walker

PhD, Grad Dip Ed, BA Hons, FACE & AFACHSE.

Board Director since July 2012. Member Audit & Risk Committee and Governance Committee.

Judi Walker took up the position of Professor and Head, School of Rural Health at Monash University in November 2010 to provide academic leadership across the seven departments that constitute the school, including four regional clinical training sites, the first year of the graduate entry MBBS program, a university department of rural health and a research office.

She is Vice President, Monash Academic Board, the recipient of the Dean's 2014 Award for Excellence in External Engagement and was nominee for the Vice Chancellor's Award for Excellence in Research Impact (Economic and Social Impact).

In 2014 Monash University responded to a competitive tender and was subsequently contracted by the Victorian Government to undertake a comprehensive study of the long-term health effects of exposure to the smoke from the Hazelwood mine fire in the Latrobe Valley. Judi is principal co-investigator of this study which has been funded for ten years.

Peter Starkey

Board director since June 2013. Member Quality & Safety Committee and Governance Committee.

Peter is General Manager of Worksafe Training Centre and has 15 years of experience in diverse roles focusing on business management and in the financial services industry.

Due to this experience he has developed leadership, management and communication skills. Peter has experience in human resources as well as strategic management, continuous quality improvement and risk management and financial management. Peter is also a board member of the Baw Baw Latrobe Learning and Employment Network and Advance Morwell.

Stephen Howe

BEng Civil (Hons), FIE Aust CP Eng.

Board director since February 2014. Member Audit & Risk Committee.

Stephen is currently the Regional Manager Gippsland for SMEC Australia.

He was previously the Independent Director for Greater Eastern Primary Health for many years and is a member, and former president and vice president of the Warragul Theatre Company.

Stephen has been a Chartered Professional Engineer with the Institute of Engineers Australia since 1992 and obtained his AICD Diploma of Company Directorship in 2006, with order of merit.

He has experience in management, business planning, strategic development, financial management, human resources and corporate governance. He also has expertise in the areas of asset planning, construction and capital works.

Board attendance

Details of attendance by Board Directors of Latrobe Community Health Service at Board, Board Audit & Risk Committee, Board Quality & Safety Committee and Board Governance Committee meetings held during the period 1 July 2014 – 30 June 2015, are as follows:

BOARD MEETINGS								
Board directors	Board		Audit & Risk Committee		Quality & Safety Committee		Governance Committee	
	A	B	A	B	A	B	A	B
John Guy (Board chairman)	11	10	--	1^	--	3^	4	4
Mark Biggs (Deputy chairman)	11	10	--	--	4	4	--	--
Peter Wallace	11	11	--	--	4	3	4	4
Steven Porter *	11	10	6	5	--	--	--	--
Judi Walker	11	10	1	--	3	2	4	4
Carolyne Boothman	11	11	5	4	1	1	--	--
Melissa Bastian	11	10	6	6	--	--	--	--
Peter Starkey	11	10	--	--	4	3	4	4
Stephen Howe	11	11	6	6	--	--	--	--

AUDIT & RISK COMMITTEE INDEPENDENT REPRESENTATIVES		
	A	B
Liz Collins	6	4
Ron Gowland	6	6

QUALITY & SAFETY COMMITTEE CLIENT MEMBER		
	A	B
Allison Higgins	4	2

Notes:

Column A – Indicates number of meetings held while Board Director/Committee Member was a member of the Board Committee.

Column B – Indicates number of meetings attended.

^ Board Chair will on occasion attend board committees ex-officio

* Steven Porter resigned effective the 30 June 2015 board meeting

Organisational chart

Ben Leigh
Chief Executive Officer

Elizabeth Meggetto
Executive Officer
Primary Care Partnership

Alison Skeldon
Executive Director
Community Support

Portfolio
- Koorie engagement

Site responsibility
Churchill & Bairnsdale

- Manager Drug Treatment Services
- Manager Counselling Services
- Manager Respite Services
- Manager Primary Prevention

Vince Massaro
Executive Director
Assessment, Aged
& Disability Services

Portfolio
- CALD & diversity
- GAIS (Interpreting Service)

Site responsibility
Wonthaggi & Warragul

- Manager Carer Programs
- Manager Aged Care Services
- Manager Disability Services
- Manager Gateway

Rachel Strauss
Executive Director
Primary Health

Portfolio
- Infection control
- GP & MBS Development

Site responsibility
Traralgon & Sale

- Manager Dental Services
- Manager Primary Intervention
- Medical Director
- Manager Ambulatory Care

Rick Davies
Executive Director
Corporate

Portfolio
- Chief Financial Officer
- Disaster recovery

Site responsibility
Morwell & Moe

- Manager Accounting Services, Sourcing & Procurement
- Manager Client Reporting & Records
- Manager Quality & Front Office, Fleet & Facilities
- Senior Manager People & Culture (Including Placement, Education & Research Unit)
- Manager Information & Communication Technology
- Manager Marketing & Communications

goal one

More people look after their own health

When it comes to people's health, getting in early delivers the best results.

We aim to help people to look after their own health and stay independent wherever possible.We're helping people to make healthy lifestyle choices, and want to reach more people than ever before.

We're doing this by:

- Making our services more youth friendly and working with young people in schools
- Helping people with high needs stay at home with support packages tailored to their specific circumstances
- Doing health assessments in workplaces and communities
- Improving the health information we provide online
- Helping you keep track of your health using internet-based tools.

Setting up good health habits

The foundations for life-long healthy habits are formed in childhood and adolescence.

One of the ways Latrobe Community Health Service is making sure the next generation continues to use health services into their adulthood is through Kids Connect. We deliver this service with the Victorian Aboriginal Child Care Agency to children experiencing an issue that may negatively impact on their mental health.

Last year, we reached out to almost 50 school children through a personal awareness program run through Kids Connect, called 'Rock and Water'. Through a variety of exercises, children in grades three and four from Elizabeth Street Primary School in Moe and grade five boys from Liddiard Road Primary School in Traralgon considered the ways they responded to life events through a 'rock' (inflexible) or 'water' (adaptable) attitude.

The exercise set the foundation for them to better articulate their emotions as well as learn how to set personal boundaries. This in turn gave the students a snapshot of their emotional and mental wellbeing.

We also expanded our dental outreach program into schools. Last year Latrobe Community Health Service visited 14 schools and preschools across Gippsland, including in the towns of Warragul, Morwell, Moe, Traralgon, Tyers and Hazelwood North. We conducted free dental screenings for 1,010 students and discussed the importance of good oral health and how it can help keep children out of hospital.

Following these screenings, we contacted all participating families to offer dental examinations for the child that was screened and any other children in the family. At each school, an average of 75% of students participated in the program.

We found from this cohort, approximately half then returned for follow up comprehensive dental examination and treatment with us or with another provider.

Latrobe Community Health Service's oral health screening program has resulted in more children accessing dental care. We know from experience that it is likely this would not have happened unless dental pain or trauma occurred.

Through our ongoing partnership with Latrobe City Council and the State and Federal Governments, Healthy Together Latrobe continued to take health prevention efforts to the grassroots level.

Through practical programs such as 'FOODCents', where people learned to shop for healthy food on a budget, to a 10,000 steps a day challenge called 'Think on Your Feet', we helped create better role models for children to look up to and model their future healthy behaviours on.

Through the FOODCents program, 94 community members learned the importance of a healthy diet. They developed cooking and food label reading skills, in addition to honing their shopping and budgeting skills for healthy meals.

More than 560 people participated in the Think on Your Feet program, which was run in five different workplaces, including Latrobe Community Health Service.

Evaluation of the program showed it contributed to a positive change for a number of employees.

These employees became more aware of their behaviours and proactive in their desire to adopt positive habits.

Recognising the high rates of smoking in the Latrobe Valley and Gippsland, we also brought Quit Smoking sessions to places where our community live, learn, work and play.

Latrobe Community Health Service conducted Quit educator training sessions so professionals could provide peer support within their workplaces. We also brought the program to two schools during the year to teach children about the harmful effects of smoking.

Latrobe Community Health Service staff pictured at the launch of Think on Your Feet.

By helping adults develop positive habits, we provide children with good role models who provide a healthy family environment and make them aware of the need to engage with health services.

Staying independent with support

The provision of home care packages remains Latrobe Community Health Service's main means of helping people with high needs to live at home.

After successfully tendering to provide home care packages in Hume and Grampians in 2014, we were able to secure an additional 16 packages in Hume in the past financial year. We also expanded our aged care services in Gippsland, securing an extra 20 packages. In total, Latrobe Community Health Service delivered 287 home care packages this financial year.

The transition to consumer-directed care continued in 2014-15. Consumer-directed care is a way of delivering services that allows consumers to have greater control over their own lives. They are allowed and encouraged to make choices about the types of care and services they access and how these services are delivered.

We successfully transitioned all 172 of our older packages in Gippsland to the new model by the end of the 2014-15 financial year.

In many cases, the simple acts of providing information and connecting community members with the right networks can have a profound impact on their ability to remain at home for longer.

For example, towards the end of the financial year we received funding to increase the provision of dementia services in the Sale and Yarram areas. Through a dementia access and support worker, we connect people with dementia and their carers to a host of relevant services, including counselling, respite and other aged care services.

In April 2015, Latrobe Community Health Service coordinated a financial forum for retirees in Wonthaggi. Speakers from First State Super, Centrelink, Consumer Affairs and the Financial and Consumer Rights Council all spoke about managing finances in retirement and planning for care in old age. More than 75 people attended this forum.

In June we ran an event in Traralgon on the government changes to Australia's aged care system. The forum provided information on how new home care packages work and how to access them. More than 70 frail and aged people, their carers, and service providers attended the event.

Many carers who attended the event subsequently joined our six-week course designed to improve their health and reduce social isolation.

We acknowledge the enormity of the role that carers play. One of the easiest ways to prevent people prematurely entering permanent residential care is to make sure their primary carer also receives care and support.

Taking control of our health

The internet has become one of the first places people turn to for health information and to search for services. We recognise there is much information available, but not all of it is accurate or locally relevant.

Over the past year Latrobe Community Health Service has introduced two online initiatives to ensure people access our services with maximum convenience and minimum delay.

The first of these initiatives is online booking for GP appointments. This allows clients to book a doctor's appointment at any of our clinics.

Disability support worker Mandy Smart visits a client in his home.

The online booking system works on desktop computers, tablets and smartphones. Clients can book, cancel, and reschedule their appointments at any time of day, from wherever they are.

The second of these initiatives was the launch of 'Plan Your Care'. Latrobe Community Health Service developed this website to provide an online portal to our clients with a disability, allowing them to view and manage their package finances. Clients can also request new services or cancel existing services.

Plan Your Care delivers new levels of responsiveness and transparency to our clients, and will become increasingly important with the imminent commencement of the National Disability Insurance Scheme in Gippsland. We continue to add more functionality to the site, making it an important management tool for clients.

These initiatives are a significant step forward. They dramatically improve our clients' experiences, and place Latrobe Community Health Service at the leading edge of technology use in healthcare provision.

goal two

People connect to services when and where they need them

We believe that people in rural and regional areas have a right to the same quality of healthcare as those who live in cities.

We know that better links between health providers will deliver the quality services people deserve. We're working to provide the services that are often missing in regional areas - and at the same time reduce the waiting times for all of our services.

We're doing this by:

- Improving our existing services and prioritising the areas of greatest need
- Working with other community and health agencies to plug service gaps
- Trialling 'virtual' clinics so you can contact health professionals and even get some services online
- Building systems so you track appointment times, get test results and referrals - from your phone or computer
- Developing a centralised call centre covering the Gippsland region, so you can get through to us easily and quickly
- Reaching out to people in isolated areas with mobile health services
- Making many more people aware of the services we provide and how they'll benefit them.

Meeting specific health needs

Last year saw the establishment of five area-based networks across Victoria that aim to increase the number of doctors who prescribe - and pharmacists who dispense - methadone and suboxone.

Latrobe Community Health Service is part of the pharmacotherapy area-based networks that cover the Gippsland and Hume regions.

In Gippsland, we work with Gippsland Lakes Community Health, while in the Hume region, we work with Primary Care Connect, Gateway Health and Nexus Primary Health.

Through these networks, last year we increased the number of methadone programs in local pharmacies in Gippsland to 32, and 34 in Hume.

There are now eight additional prescribing doctors in Gippsland and 12 in Hume, covering some areas that previously had no prescribers at all.

In the long run, this means clients with serious opioid addictions can receive the help they need within their communities. It also provides more opportunities for doctors and pharmacists to give people relevant information about seeking help for their addictions, from Latrobe Community Health Service or from other providers.

Natalie Troshen, front office staff member.

Ben Leigh, CEO of Latrobe Community Health Service, discusses Churchill development plans with Jaala Pulford, Victorian Minister for Regional Development.

Filling gaps in services

Part of the Latrobe Community Health Service strategy is to ensure gaps in healthcare in the community are met with high quality services. In 2014-15 several important infrastructure projects continued, laying the groundwork for new, improved facilities at our sites in Gippsland.

In Warragul, the Newmason development progressed from a vacant site to completion. The new site will house our existing Warragul services in dental, aged care, disability and carer services and counselling.

We are adding a general practice clinic, physiotherapy, podiatry, dietetics and other health services. The central location and growing population in Baw Baw place Latrobe Community Health Service in a strong position to flourish in West Gippsland.

The redevelopment of our Moe site is also nearing completion. Work has finished on the community and training area that now joins the main building and Moe After Hours Medical Service. This building will provide valuable space for community members to meet or join in group activities.

During the year Latrobe Community Health Service secured further State Government funding of $1 million to develop a dental prosthetics laboratory, training facility and expanded community health services at our existing site in Churchill. This brings the total State Government commitment to this project to $2 million.

Latrobe Community Health Service will contribute $665,000, and we are now seeking $2.66 million from the Federal Government.

A grant application was submitted to the National Stronger Regions Program during the year, however it was unsuccessful in the first round. We have further developed the application and we are hopeful of success in the second round of funding, due to be announced at the end of 2015.

Making it easy and fast to use services

We are always looking for ways to improve the way our health services are delivered.

Our central 1800 242 696 phone number remains the most common avenue for the community to access our services, and we have worked tirelessly to ensure the experience is fast and easy. Since 2012-13 the number of calls received each year has grown by more than 15,000, to 130,030 calls in the 2014-15 financial year.

Despite this growth, more than 96% of calls are answered within 20 seconds, meeting or exceeding call answer targets.

In the field of disability services we now provide a faster service for clients through the introduction of a more efficient service delivery model.

Previously clients with simple needs (for example, some basic equipment) were placed on the same waiting list as those with complex needs (such as ongoing case management and service coordination).

Under the new model, we asked clients more questions about their needs to determine the urgency of support they required.

We also stopped treating clients' needs as a single 'block'. By dividing up their needs into short-term and long-term, we were able to better deliver urgent, short-term support such as in-home equipment to clients.

At the end of the 2014-15 financial year, there were 13 people waiting for an average of 20 days to access services from us, down from 159 people waiting for an average of five months at the same time last year.

This meant we were able to respond to many clients' needs almost immediately, which they warmly welcomed. Similarly, we have worked with doctors in Gippsland to improve referral times through the establishment of e-referrals. Rather than faxing service referrals to Latrobe Community Health Service, GPs have been encouraged to use an online referral system that is significantly faster, easier and more secure than faxing.

In addition, there is far less manual entry of information than from faxes.

This releases staff from data entry and allows them to more quickly process referrals to our services.

Promoting relevant services to those who need them

It's important that people know what services Latrobe Community Health Service offers, and how those services are relevant to their needs.

Traditional channels such as print, broadcast and information brochures remain central to how Latrobe Community Health Service connects with the community. In the past year, we have produced more than 170 flyers, brochures, and advertisements.

We have shared more than 90 advertorial stories in six newspapers across Gippsland, and there were more than 100 news stories featuring Latrobe Community Health Service across print, radio and television.

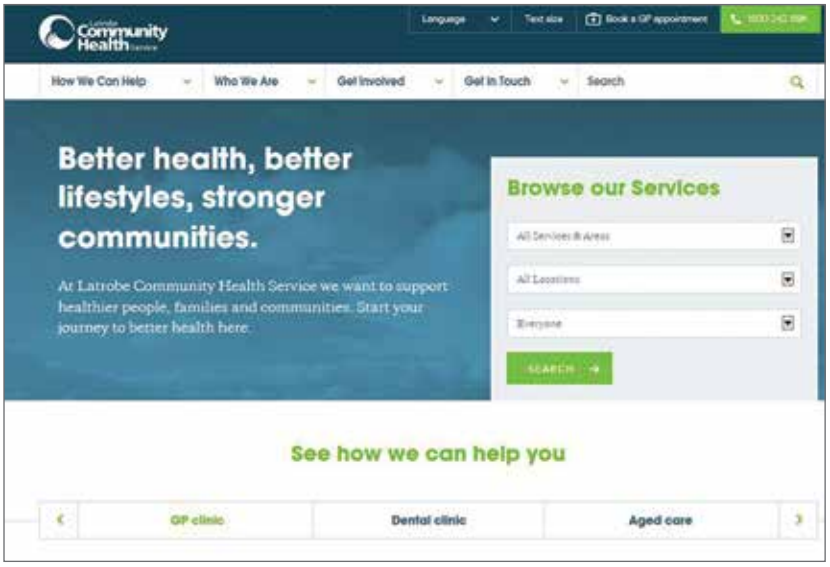
In February 2015 we also launched a new website aimed at increasing awareness of our services, and improving the quality of the health information we provide to the community.

The site works on desktop computers, smartphones and tablets. We have completely re-written all site content to ensure it is clear and easy to understand. Since its launch there have been more than 25,000 visits to the new site, and traffic continues to grow.

In April 2015 we secured up to $120,000 of in-kind advertising through a Google Adwords Grant.

This has allowed Latrobe Community Health Service to advertise online throughout Gippsland, targeting communities with information about services relevant to them. In the first two months of operation, the ads were served to the public more than 50,000 times.

More than 2,000 of those people clicked through to the new Latrobe Community Health Service website. These numbers will grow as the advertising campaign is further refined.



The new Latrobe Community Health Service website.

goal three

Those with multiple needs get holistic support

When people have more than one health issue it makes sense that they're not treated for each issue alone, but as part of a whole.

This means coordinating the care and support a person needs in a way that's highly customised to their particular situation.

At Latrobe Community Health Service, we're working to make sure that more of our clients are able to access the care and support they need, when they need it.

We're doing this by:

- Trialling new systems where one key worker coordinates all your needs, so you don't end up having to tell your story over and over
- Joining up different programs that logically go together, so you don't need to find your way around a complicated system - we'll do that for you
- Using the latest technology to coordinate client information and supports, so our people always know what they need to do next, for you
- Working out which combination of service supports have the greatest impact - and the best ways to pay for these with the least burden on clients.

Many services, one seamless experience

Recognising that many of our clients face multiple, complex health issues, in 2014-15 Latrobe Community Health Service trialled a new health management model known as the 'guided care' or 'concierge' model.

Through this approach, clients with a chronic disease were referred to a care coordinator who assessed their needs and then helped them set and achieve health goals.

Clients were then linked to other relevant services. For instance, a client with diabetes would set out a range of goals. Then the care coordinator would connect the client with other complementary services, including the diabetes nurse educator, dietitian or podiatrist.

The results of the pilot told us that of the 34 clients who completed the trial, most people achieved their goals as expected, or had their expectations exceeded.

An unexpected benefit of the pilot was that some of the carers of clients - who would have otherwise not sought our help - decided to be involved in the management of their own health conditions too. We are refining the model based on lessons from the pilot and will look to expand it in the near future. It is a promising step forward in our efforts to provide holistic support to those with multiple health needs.

A key consideration for Latrobe Community Health Service is ensuring we have business processes and systems that enable holistic support. In 2014-15 we completed an organisation-wide transition to client management software TCM7. This major undertaking, led by the client records team and information technology team, transferred thousands of appointments and data to the new system. This important development consolidates client appointments and client information for a range of services on one database. The result is a single, comprehensive view of a client's interactions across a range of services. This in turn means our health practitioners can quickly build a complete view of a client's journey at Latrobe Community Health Service, and provide health care in this context.

Treating the whole person, not the illness

Health issues don't usually happen in isolation from each other. Left unaddressed, a long-term health condition can amplify the effects of a newer and seemingly unrelated complaint.

We recognise that many of our clients have complex health issues and receive more than one service from us. These nuances mean it's our job to make sure everyone is on the same page to deliver the highest quality health services.

One indicator of our improved effort in this area is the number of referrals that our GPs make to other services at Latrobe Community Health Service.

Lindy Philip (right), planned activity group program leader, pictured with participants from Morwell.

In 2014-15 more than 400 referrals were made across nursing, podiatry, physiotherapy, dietetics, diabetes education and a host of other services.

We are building on this effort by integrating interprofessional collaborative practice into the way we deliver our services.

This ensures our staff communicate clearly and work together on each client's health management plans.

In the last 12 months, approximately 70 staff have attended interprofessional collaboration seminars. These seminars bring staff together from different services to better understand their respective skill sets, and to work on ways of better coordinating client care.

This increased awareness of each other's roles also means staff provide better referrals to other services at Latrobe Community Health Service. This in turn reduces access issues and brings us closer to delivering holistic support to clients.

One of the great strengths of our organisation is our ability to provide a range of services under one roof. However, the breadth of services means we have to be particularly diligent in sharing information and coordinating the care of clients.

Last year we merged our Primary Health and Ambulatory Care directorates to better meet community needs and put clients at the centre of their care.

The two directorates were merged to provide better integration of clinical services. A single unit now provides the full spectrum of care - from prevention, to intervention, to end-of-life care.

This is beneficial because all clinical managers now sit in a single team. Planning any services is much easier. Coordination of services is now the default starting point, rather than something that is done retrospectively.

As an organisation, there is still more to do to truly realise the goal of holistic support for clients. In the coming year we plan to develop improved case conferencing.

Dr James Bvirakare (right) and Registered Nurse Sue Whittle provide integrated health care to patients.

At the moment our doctors work individually with any other health care professionals assisting patients with complex health needs. Improved case conferencing will instead mean that all staff involved in a patient's care meet together regularly.

So for a patient with diabetes, this may mean a GP, diabetes nurse educator, podiatrist and wound care nurse meet to jointly map and review that patient's care. Using a similar philosophy, we are already trialling an allied health program for young children with developmental delays, after discovering serious gaps in services here in Gippsland. The program for children up to seven years of age also involves their families and operates in a group setting.

Each member of the team delivering the service has their own area of expertise - occupational therapy, speech therapy and physiotherapy - but work together to make sure children are assessed and treated as a whole person. Over the year, 219 children were assessed, and a total of 215 children participated in one of the 12 groups in the Latrobe Valley.

goal four

We use our resources for maximum impact, effectiveness and efficiency

We want to create the most skilled team we can. We know that when staff are well supported and united behind common goals, they will work hard for their clients and for the organisation they believe in.

Our productivity is testament to their passion. We also invest in technology and other systems to create better outcomes for our clients.

We're doing this by:

- Improving our technology so we collect better information about our results as well as link services much better
- Partnering more with other services with whom we have common aims
- Pioneering new ways to attract and retain staff so that we continue to be an 'employer of choice'
- Putting our volunteers in areas where they have greatest impact
- Telling individuals and communities about the areas in which we have great success.

Using evidence to gain support from funders and partners

The ability to capture and analyse meaningful data about our programs is essential to secure ongoing funding, and to inform improvements in the services we provide. Such mechanisms exist in all Latrobe Community Health Service programs.

For example, we offer a men's behaviour change program that offers group counselling to men who choose to use violence. The program aims to take 120 referrals every year. In 2014-15, we recorded 596 referrals.

Using this information, and working in conjunction with the Department of Health and Human Services, we were able to secure an additional $23,000 in 2014-15, and an additional $54,000 in 2015-16. Ultimately, taking this evidence-based approach to demonstrating demand resulted in more men accessing this program.

Making the most of available resources

Health services cannot be delivered effectively without partnerships and the sharing of resources. The vast geography of our service footprint, combined with finite funding, means Latrobe Community Health Service has had to be strategic in delivering necessary services. Where possible, we strive for strategic alliances where the sum of the whole is greater than the parts.

One such example during 2014-15 was our successful application to lead a partnership to deliver alcohol and drug treatment services in Victoria for the Gippsland catchment.

We now work in partnership with Gippsland Lakes Community Health, Gippsland Southern Health Service and Bass Coast Health to deliver these services.

This has several benefits for the community.

We have been able to join up some processes to provide more efficient service delivery. For example, the region-wide use of e-referral system S2S, and the shared use of client management system TCM7, will lead to improved data collection, reporting and analysis. Smaller services will also benefit from the scale and experience of the larger services. Most importantly, those who need help with alcohol and drug addiction will now have a better-coordinated treatment experience.

Another less conventional partnership for Latrobe Community Health Service was launched in March 2015, when we joined Gippsland Water to encourage the community to choose tap water ahead of sugary drinks. The partnership stems from shared interests in improving the oral health of the community, the health benefits of choosing tap water, and our similar service footprint in Gippsland.

The partnership will continue to grow, but in the early stages has focused on generating media interest and disseminating health information through the school networks that both organisations have developed.

The right people for the right job

We know the quality of our services is only as good as the people we have delivering them. As a result, Latrobe Community Health Service is focused on recruiting the right people for the job.

Over the past 12 months, we have grown our general practice at William Angliss Institute, Melbourne, adding three doctors.

This brings the total number of doctors there to five, to meet the demand for services in the city. In the Latrobe Valley, we also welcomed our first GP registrar and two medical students who were with us for 14 weeks.

These placements validate the quality of our clinics as an excellent place to learn best practises, and set a precedent for future student placements. In total, we now employ 13 doctors at Latrobe Community Health Service.

We also recently completed a workforce planning process to map what our workforce needs will be in the future, and put in place a strategy to meet that need.

Students from Commercial Road Primary School at the launch of the partnership between Latrobe Community Health Service and Gippsland Water.

Board deputy chairman Mark Biggs (centre) with the winners of the 2014 annual staff achievement awards.

Alongside this process we have introduced a renewed focus on behavioural interviewing techniques to ensure alignment with our organisational values when recruiting.

There is high demand for highly-skilled staff in regional areas, making this work vital to maintaining a skilled, motivated and stable workforce.

Beyond recruitment, we also value and want to retain the staff we currently have. We recognise the value of two-way communication.

Consequently last year we increased the frequency of collective and individual staff surveys.

An annual staff survey gives us a snapshot of issues important to our staff, including the value of reward and recognition, as well as occupational health and safety.

We are also committed to making sure our staff are satisfied with the work they do.

To improve the way we track this, surveys are conducted with new staff at the three, nine and 18-month mark.

Our People, Learning and Culture department, as well as the Chief Executive Officer, then review the survey results.

We know if new employees feel welcomed and valued, they are more confident early on in their careers with us.

All of this means a more consistent experience for our clients in terms of the staff they see, and the quality of the services they receive.

One of the outcomes we are seeking as part of goal four is that 'our people do a superb job'.

In 2014-15 there have been numerous examples of staff who consistently demonstrate excellence in their respective roles.

Latrobe Community Health Service recognises outstanding performance through a number of different means.

These include the annual staff achievement awards and service recognition awards.

EMPLOYEE OF THE YEAR

Megan Gray

ANNUAL ACHIEVEMENT AWARD WINNERS

Kate Mills
Assessment, Aged & Disability Services

Louise Murphy
Community Support

Megan Gray
Corporate

Debra Brighton
Primary Health

STAFF SERVICE RECOGNITION AWARDS

10 YEARS

Gerard Fraser
Rachel Buckley
Stephanie Borg
Natasha Hammond
Christine Howard
Danielle Daly

15 YEARS

Therese Jenkins
Janet Milne
Sonja Spehar
Penelope Silby
Leanne Crowe
Jean Murphy

30 YEARS

Janine Parise

goal five

We're increasing our scope and scale to assure long-term investment into the community

Adding to our range of services means smoother and more complete support, especially for people with multiple needs.

A mix of free and fee-paying services makes our services available to all, regardless of income. We think this is the fairest way to service our community.

We're doing this by:

- Securing extra funds from new sources, particularly for our coordinated support work, to support disadvantaged clients, and to reach new communities
- Collaborating with smaller providers for smoother client care
- Asking our clients (and the communities we operate in) for regular feedback, so we can continue to improve
- Expanding into new markets, across Gippsland and beyond
- Gathering evidence about what works and what doesn't and thinking about everything we do in this context.

Putting our money where it's needed

Securing extra funds to support disadvantaged clients and reach new communities is essential if we are to meet the growing need for health services in regional areas.

In 2014-15 Latrobe Community Health Service was successful in tendering for a range of projects that will help us increase our scope and scale.

In recognition of our ability to provide quality services to the community, we secured more than $3 million worth of new ongoing funding in the last financial year.

Notably, Latrobe Community Health Service won a tender valued at $2.6 million a year for the recommissioning of alcohol and drug services. We formed a consortium across Gippsland with other providers to help deliver these services.

We also secured $1.4 million in funding over three years from the Federal Government through the Department of Social Services.

Refugee health nurse Wendy Ruddell supports new arrivals to Gippsland.

The money will be allocated to emergency relief, financial counselling for people affected by problem gambling, a program for refugees and new arrivals, and a respite and education program for carer awareness.

Our Gambler's Help program also secured almost $112,000 in funding to run community expos across Gippsland with the aim of increasing financial literacy and improving budgeting skills.

Alongside securing new funds, it's important to Latrobe Community Health Service that in turn we support worthwhile community initiatives. To this end, the board has recently extended its ability to support communities through the establishment of the Latrobe Community Investment Fund.

This fund will be built up over coming years from any operational surpluses. The returns from the fund will be used to support otherwise unfunded Latrobe Community Health Service and community projects that will help achieve our vision of Better health, Better lifestyles, Stronger communities.

Broadening our client base

As part of our ongoing commitment to diversifying our revenue streams, Latrobe Community Health Service has undertaken significant work to broaden our client base to include private patients.

We have done this by expanding the offering of private services through the Medicare Benefits Schedule. Last year, podiatry was the most popular of the private services, with 2,441 Medicare Benefits Schedule consultations taking place, followed by psychology with 1,639 consultations and 923 consultations with a dietitian.

The rate of growth of private dental appointments, offered exclusively in Morwell presently, was steady from the previous year.

There is further work to be done to increase the number of private patients at Latrobe Community Health Service, and this will continue to be a priority in 2015-16.

Marketing of our private services has already increased significantly, with print advertising and direct mail to households throughout the year. This will continue in the next financial year, when private dental and allied health services are offered from our new clinic in Warragul.

We have also made changes to our employment arrangements to allow practitioners to undertake private work, including all allied health workers and nurse practitioners.

This arrangement allows us to offer clients appointments under schemes such as private health insurance, Medicare or the Department of Veterans' Affairs, opening up our services to more people who need them.

Growing with the community

Latrobe Community Health Service relies heavily on community support for success. We want to encourage the community to work with us, and to provide feedback.

This commitment to maintaining our community connections is reflected in the State Government's decision to fund us to re-open and run a Mine Fire Health Clinic. We see this as testament to our excellent health provision and standing in the community.

The clinic was established in 2015 so community members could seek professional, independent advice if they had health concerns in the wake of the 2014 Hazelwood mine fire.

Feedback and inclusion of all members of the community is an important part of the Latrobe Community Health Service Strategic Plan.

To this end, in May 2015 we joined with community members in Gippsland to acknowledge the International Day Against Homophobia and Transphobia.

To mark the day, Latrobe Community Health Service hosted a free sausage sizzle, raised the rainbow flag and had lesbian, gay, bisexual, transgender and intersex (LGBTI) speakers talk about their experiences. We also planted a tree as a symbol of our organisation's commitment to becoming a more inclusive workplace for LGBTI staff, and an inclusive health service for LGBTI members of the community.

We have encouraged members of the LGBTI community to complete an anonymous survey on their experiences of health provision in Gippsland. The findings of this survey will be used to improve our service provision to people who may identify as LGBTI.

Latrobe Community Health Service staff and community members celebrate the International Day Against Homophobia and Transphobia.

Expanding into new markets

In 2014-15, Latrobe Community Health Service continued to look for opportunities to provide services in new markets, and to expand our services in existing markets.

The GP clinic that Latrobe Community Health Service took over in February 2014 at William Angliss Institute in Melbourne continues to grow, with 4,292 appointments in the last financial year. This was a significant increase from 829 appointments in the six months after we took over the clinic in the first half of 2014.

The clinic now operates five days a week, from 9am to 5pm, and is seeing an increasing number of people accessing the service from William Angliss Institute and the surrounding area.

Our new health clinic in Warragul will also commence in the next financial year, providing GP services, private dental and private allied health. We also launched 'Your Care Choice', a program providing direct care services within the home to the aged, people with a disability, and their carers. These services include cleaning, home maintenance, personal care and respite.

Latrobe Community Health Service has traditionally used brokered agencies to provide these direct care services for clients. However we recognised demand for such services will only increase as a result of the frail and aged living longer, and the roll out of the National Disability Insurance Scheme.

This new in-house, fee-for-service business arm was launched in May 2014 with 15 staff. Both client numbers and revenue have grown month-on-month since its launch. The service will be reviewed in the coming financial year, with a view to expanding beyond the Latrobe Valley into other areas.

Research and evaluation

Our strategic plan demands that Latrobe Community Health Service gathers research about what works and what doesn't. Evidence is central to ensuring we are efficient and effective. To achieve this, we run the Placement, education and Research Unit (PERU), to coordinate research and evaluation.

The unit is a collaboration between Latrobe Community Health Service and Monash University.

There are more than ten research projects that are in progress or have been recently completed. Topics include:

- The role of carers in supporting care recipients in negotiating support through the consumer-directed care support packages.
- The influence that access to various types of health and wellbeing services has on the health of a rural community.
- Evaluating the impact of attending the children's services program at Latrobe Community Health Service.
- Evaluating the effectiveness of Latrobe Community Health Service self-management consultations for clients with a chronic condition.

These topics relate directly to the fields we work in, and their lessons will help inform our day-to-day work.

Our volunteers

The volunteer program at Latrobe Community Health Service has over 150 registered volunteers. Approximately 80 of those people provide active support across a number of program areas.

Our trained volunteers come from all walks of life. They play an integral role in ensuring the smooth running of programs and events by assisting with tasks such as:

- cooking and serving meals
- driving and transportation
- community visitors and individual support
- day trips and camps
- planned activity groups
- mental health and respite support
- palliative care
- health promotion
- community kitchens
- crafts and life skills
- peer-to-peer volunteers
- simulated patients
- travel training
- open days and special events
- administration and program support.

2015 Volunteer of the year

Michael Lancaster was our volunteer of the year for 2015. The staff nomination for Michael captures his contribution to Latrobe Community Health Service:

Michael has a caring nature, showing consideration and responsibility towards the clients he transports for the Planned Activity Group program.

Michael is friendly and happy, always with a helping hand on offer. He volunteers in the Planned Activity Group program at Moe, four days a week.

He works well as a team member, who gives and gains respect from staff, fellow volunteers and clients.

Michael has loads of patience, understanding the needs of the frail aged, people with dementia and those with special needs.

His cheerful, friendly manner and calming ways put everyone at ease. He is a much valued volunteer, and we'd be lost without him.

Ben Leigh, CEO, with Michael Lancaster, volunteer of the year and Mark Biggs, board deputy chairman.

VOLUNTEER SERVICE RECOGNITION AWARDS
5 YEARS OF SERVICE
Pam Atlee
Lyn Watts
Kaye Chester
Ken Findlay
Gwyneth Jones
Keith Luke
10 YEARS OF SERVICE
Annelie Roberts
20 YEARS OF SERVICE
Karen Cooper
25 YEARS OF SERVICE
Judy Tewierik
Pauline Prowse
30 YEARS OF SERVICE
Kathy Ljubinkovic
35 YEARS OF SERVICE
Joan Leister

Operating and financial review

Contents of the operating and financial review

AUDITOR'S INDEPENDENCE DECLARATION

UNDER SECTION 60-40 OF THE AUSTRALIAN CHARITIES AND NOT-FOR-PROFITS COMMISSION ACT 2012

To the Directors of Latrobe Community Health Service Ltd

We declare that, to the best of our knowledge and belief, during the year ended 30 June 2015, there have been:

(i) no contraventions of the auditor independence requirements as set out in the *Australian Charities and Not-for-profits Commission Act 2012* in relation to the audit; and

(ii) no contraventions of any applicable code of professional conduct in relation to the audit.

Rochelle Wrigglesworth
Director
GippsAudit Pty Ltd

Date: 29 September 2015
Place: Sale

Statement

OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME FOR THE YEAR ENDED 30 JUNE 2015

	Notes	2015 $	2014 (Restated) $
PROFIT OR LOSS			
Revenue	2	39,240,332	39,765,386
Other income	2	6,028,143	6,242,835
Employee provisions expense		(26,786,182)	(27,114,542)
Depreciation and amortisation expense	3	(1,529,136)	(1,194,758)
Bad and doubtful debts expense	3	(3,824)	(7,202)
Repairs, maintenance and vehicle running expenses		(397,179)	(489,098)
Fuel, light and power expense		(232,153)	(240,705)
Rental expense	3	(351,657)	(321,852)
Training expense		(118,365)	(284,617)
Audit, legal and consultancy fees		(371,783)	(635,027)
Marketing expenses		(179,796)	(181,253)
Client support services expenses		(5,381,451)	(5,807,042)
Service agreements		(925,680)	(834,269)
Contracts labour		(1,411,569)	(3,217,094)
Sundry expenses		(3,559,222)	(3,606,750)
Net current year surplus		**4,020,478**	**2,074,011**
OTHER COMPREHENSIVE INCOME			
Net gain/(loss) on revaluation of property, plant and equipment		(461,054)	-
Total other comprehensive income for the year		**(461,054)**	-
Total comprehensive income for the year		**3,559,424**	**2,074,011**
Net current year surplus attributed to members of the entity		3,559,424	2,074,011
Total comprehensive income attributable to members of the entity		**3,559,424**	**2,074,011**

The accompanying notes form part of these financial statements.

Statement

OF FINANCIAL POSITION AS AT 30 JUNE 2015

	Notes	2015 $	2014 (Restated) $
ASSETS			
CURRENT ASSETS			
Cash and cash equivalents	4	3,956,919	3,987,161
Trade and other receivables	5	199,922	402,863
Inventories	6	163,901	152,435
Other assets	7	647,568	1,502,505
Financial assets	8	7,000,000	3,000,000
Total current assets		**11,968,310**	**9,044,964**
NON-CURRENT ASSETS			
Property, plant and equipment	9	19,104,967	17,985,567
Total non-current assets		**19,104,967**	**17,985,567**
Total assets		**31,073,277**	**27,030,531**
LIABILITIES			
CURRENT LIABILITIES			
Trade and other payables	10	2,910,443	2,317,607
Provisions	11	3,279,317	3,374,227
Total current liabilities		**6,189,760**	**5,691,834**
NON-CURRENT LIABILITIES			
Provisions	11	1,191,204	1,205,808
Total non-current liabilities		**1,191,204**	**1,205,808**
Total liabilities		**7,380,964**	**6,897,642**
Net assets		**23,692,313**	**20,132,889**
EQUITY			
Retained surplus		20,154,392	15,666,306
Reserves		3,537,921	4,466,583
Total equity		**23,692,313**	**20,132,889**

The accompanying notes form part of these financial statements.

Statement

OF CHANGES IN EQUITY FOR THE YEAR ENDED 30 JUNE 2015

	Retained surplus $	Asset revaluation reserve $	Capital improvement reserve $	Community projects reserve $	General reserve $	Total $
Balance at 1 July 2013 (as reported)	**10,368,005**	**1,469,245**	**4,917,069**	**301,983**	**709,743**	**17,766,045**
Write down of property, plant and equipment	(800,000)					(800,000)
Correction of unearned revenue and grants in advance	1,368,761					1,368,761
Correction of provisions	(275,929)					(275,929)
Transfers to / (from) asset revaluation reserve	35,412	(35,412)				-
Restated balance at 1 July 2013	**10,696,249**	**1,433,833**	**4,917,069**	**301,983**	**709,743**	**18,058,877**
Comprehensive income **Surplus for the year attributable to members of the entity**	2,074,012					2,074,012
Total comprehensive income attributable to members of the entity	**2,074,012**	**-**	**-**	**-**	**-**	**2,074,012**
OTHER TRANSFERS						
Transfers to/(from) capital improvements reserve	2,177,036		(2,177,036)			-
Transfers to/(from) community projects reserve	109,266			(109,266)		-
Transfers to/(from) general reserve	609,743				(609,743)	-
Total other transfers	**2,896,045**	**-**	**(2,177,036)**	**(109,266)**	**(609,743)**	**-**
Balance at 30 June 2014	**15,666,306**	**1,433,833**	**2,740,033**	**192,717**	**100,000**	**20,132,889**
COMPREHENSIVE INCOME						
Surplus for the year attributable to members of the entity	4,020,478					4,020,478
Net gain on revaluation of property						-
Total comprehensive income attributable to members of the entity	**4,020,478**	**-**	**-**	**-**	**-**	**4,020,478**
OTHER TRANSFERS						
Cumulative revaluation surplus relating to sale of property, transferred to retained surplus						-
Transfers to/(from) asset revaluation reserve		(461,054)				(461,054)
Transfers to/(from) capital improvements reserve	1,735,025		(1,735,025)			-
Transfers to/(from) community projects reserve	(1,367,417)			1,367,417		
Transfers to/(from) general reserve	100,000				(100,000)	-
Total transactions with owners and other transfers	**467,607**	**(461,054)**	**(1,735,025)**	**1,367,417**	**(100,000)**	**(461,054)**
Balance at 30 June 2015	**20,154,392**	**972,779**	**1,005,008**	**1,560,134**	**-**	**23,692,313**

For a description of each reserve, refer to Note 19.

The accompanying notes form part of these financial statements.

Statement

OF CASH FLOWS FOR THE YEAR ENDED 30 JUNE 2015

	Notes	2015 $	2014 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts from grants and other income		44,973,731	43,897,857
Payments to suppliers and employees		(39,335,719)	(44,448,421)
Interest received		361,546	332,644
Net cash generated from operating activities	17	**5,999,558**	**(217,920)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Proceeds from sale of property, plant and equipment		298,245	333,113
Payment for property, plant and equipment		(3,464,159)	(7,761,588)
Payment for held-to-maturity investments		(4,000,000)	(3,000,000)
Receipts from capital grants		1,136,114	2,379,141
Net cash used in investing activities		**(6,029,800)**	**(8,049,333)**
Net increase in cash held		(30,242)	(8,267,253)
Cash on hand at beginning of the financial year		3,987,161	12,254,414
Cash on hand at end of the financial year	4	**3,956,919**	**3,987,161**

The accompanying notes form part of these financial statements.

Notes to the financial statements

FOR THE YEAR ENDED 30 JUNE 2015

Note 1 Summary of significant accounting policies

Basis of preparation

Latrobe Community Health Service Ltd. applies Australian Accounting Standards - Reduced Disclosure Requirements as set out in AASB 1053: Application of Tiers of Australian Accounting Standards and AASB 2010-2: Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements

The financial statements are general purpose financial statements that have been prepared in accordance with Australian Accounting Standards – Reduced Disclosure Requirements of the Australian Accounting Standards Board (AASB) and the *Australian Charities and Not-for-profit Commission Act 2012*.

The company is a not-for-profit entity for financial reporting purposes under Australian Accounting Standards Australian Accounting Standards set out accounting policies that the AASB has concluded would result in financial statements containing relevant and reliable information about transactions, events and conditions.

Material accounting policies adopted in the preparation of these financial statements are presented below and have been consistently applied unless otherwise stated. The financial statements, except for the cash flow information, have been prepared on an accruals basis and are based on historical costs, modified, where applicable, by the measurement at fair value of selected non-current assets, financial assets and financial liabilities.

The amounts presented in the financial statements have been rounded to the nearest dollar. The financial statements were authorised for issue on 29 September 2015 by the Directors of the Company.

Accounting policies

(a) Revenue

Non-reciprocal grant revenue is recognised in profit or loss when the entity obtains control of the grant and it is probable that the economic benefits gained from the grant will flow to the entity and the amount of the grant can be measured reliably.

When grant revenue is received whereby the entity incurs an obligation to deliver economic value directly back to the contributor, this is considered a reciprocal transaction and the grant revenue is recognised in the statement of financial position as a liability until the service has been delivered to the contributor, otherwise the grant is recognised as income on receipt.

Latrobe Community Health Service Ltd. receives non-reciprocal contributions of assets from the government and other parties for zero or a nominal value. These assets are recognised at fair value on the date of acquisition in the statement of financial position, with a corresponding amount of income recognised in profit or loss.

Donations and bequests are recognised as revenue when received. Interest revenue is recognised using the effective interest method, which for floating rate financial assets is the rate inherent in the instrument. Dividend revenue is recognised when the right to receive a dividend has been established.

Revenue from the rendering of a service is recognised upon the delivery of the service to the customers. All revenue is stated net of the amount of goods and services tax.

(b) Inventories

Inventories held for sale are measured at the lower of cost and net realisable value. Inventories held for distribution are measured at cost adjusted, when applicable, for any loss of service potential. Inventories acquired at no cost, or for nominal consideration, are valued at the current replacement cost as at the date of acquisition.

(c) Property, plant and equipment

Each class of property, plant and equipment is carried at cost or fair value as indicated, less, where applicable, accumulated depreciation and any impairment losses.

Freehold property

Freehold land and buildings are shown at their fair value based on periodic, but at least triennial, valuations by external independent valuers, less subsequent depreciation for buildings.

In periods when the freehold land and buildings are not subject to an independent valuation, the directors conduct directors' valuations to ensure the carrying amount for the land and buildings is not materially different to the fair value.

Increases in the carrying amount arising on revaluation of land and buildings are recognised in other comprehensive income and accumulated in the revaluation surplus in equity.

Revaluation decreases that offset previous increases of the same class of assets shall be recognised in other comprehensive income under the heading of revaluation surplus. All other decreases are recognised in profit or loss.

Any accumulated depreciation at the date of the revaluation is eliminated against the gross carrying amount of the asset and the net amount is restated to the revalued amount of the asset. Freehold land and buildings that have been contributed at no cost, or for nominal cost, are initially recognised and measured at the fair value of the asset at the date it is acquired.

Plant and equipment

Plant and equipment are measured on the cost basis and are therefore carried at cost less accumulated depreciation and any accumulated impairment losses.

In the event the carrying amount of plant and equipment is greater than

its estimated recoverable amount, the carrying amount is written down immediately to its estimated recoverable amount and impairment losses are recognised either in profit or loss or as a revaluation decrease if the impairment losses relate to a revalued asset.

A formal assessment of recoverable amount is made when impairment indicators are present (refer to Note 1(f) for details of impairment).

Plant and equipment that have been contributed at no cost, or for nominal cost, are valued and recognised at the fair value of the asset at the date it is acquired.

Depreciation

The depreciable amount of all fixed assets, including buildings and capitalised lease assets but excluding freehold land, is depreciated on a straight-line basis over the asset's useful life to the entity commencing from the time the asset is held ready for use.

Leasehold improvements are depreciated over the shorter of either the unexpired period of the lease including options to extend or the estimated useful lives of the improvements.

The depreciation rates used for each class of depreciable assets are:

Class of Fixed Asset	Depreciation Rate
Buildings	2.50%
Plant and equipment	5% to 33%
Motor vehicles	10% to 20%

The assets' residual values and useful lives are reviewed, and adjusted if appropriate, at the end of each reporting period.

Gains and losses on disposals are determined by comparing proceeds with the carrying amount. These gains or losses are recognised in profit or loss in the period in which they arise. When revalued assets are sold, amounts included in the revaluation surplus relating to that asset are transferred to retained earnings.

(d) Leases

Leases of fixed assets, where substantially all the risks and benefits incidental to the ownership of the asset (but not the legal ownership) are transferred to the entity, are classified as finance leases.

Finance leases are capitalised, recognising an asset and a liability equal to the present value of the minimum lease payments, including any guaranteed residual values.

Leased assets are depreciated on a straight-line basis over their estimated useful lives where it is likely that the entity will obtain ownership of the asset. Lease payments are allocated between the reduction of the lease liability and the lease interest expense for the period.

Lease payments for operating leases, where substantially all the risks and benefits remain with the lessor, are recognised as expenses on a straight-line basis over the lease term.

Lease incentives under operating leases are recognised as a liability and amortised on a straight-line basis over the life of the lease term.

(e) Financial instruments

Initial recognition and measurement

Financial assets and financial liabilities are recognised when the entity becomes a party to the contractual provisions to the instrument.

For financial assets, this is equivalent to the date that the company commits itself to either purchase or sell the asset (i.e. trade date accounting is adopted).

Financial instruments are initially measured at fair value plus transactions costs except where the instrument is classified 'at fair value through profit or loss' in which case transaction costs are recognised immediately as expenses in profit or loss.

Classification and subsequent measurement

Financial instruments are subsequently measured at fair value (refer to Note 1(q)), amortised cost using the effective interest method, or cost.

Amortised cost is calculated as the amount at which the financial asset or financial liability is measured at initial recognition less principal repayments and any reduction for impairment, and adjusted for any cumulative amortisation of the difference between that initial amount and the maturity amount calculated using the effective interest method.

The effective interest method is used to allocate interest income or interest expense over the relevant period and is equivalent to the rate that exactly discounts estimated future cash payments or receipts (including fees, transaction costs and other premiums or discounts) through the expected life (or when this cannot be reliably predicted, the contractual term) of the financial instrument to the net carrying amount of the financial asset or financial liability.

Revisions to expected future net cash flows will necessitate an adjustment to the carrying amount with a consequential recognition of an income or expense item in profit or loss.

(i) Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market and are subsequently measured at amortised cost.

Gains or losses are recognised in profit or loss through the amortisation process and when the financial asset is derecognised.

(ii) Held-to-maturity investments

Held-to-maturity investments are non-derivative financial assets that have fixed maturities and fixed or determinable payments, and it is the company's intention to hold these investments to maturity.

They are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial asset is derecognised.

(iii) Financial liabilities

Non-derivative financial liabilities other than financial guarantees are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial liability is derecognised.

Impairment

At the end of each reporting period, the company assesses whether there is objective evidence that a financial asset has been impaired.

A financial asset (or a group of financial assets) is deemed to be impaired if, and only if, there is objective evidence of impairment as a result of one or more events (a 'loss event') having occurred, which has an impact on the estimated future cash flows of the financial asset(s).

In the case of available-for-sale financial assets, a significant or prolonged decline in the market value of the instrument is considered to constitute a loss event.

Impairment losses are recognised in profit or loss immediately. Also, any cumulative decline in fair value previously recognised in other comprehensive income is reclassified to profit or loss at this point.

In the case of financial assets carried at amortised cost, loss events may include: indications that the debtors or a group of debtors are experiencing significant financial difficulty, default or delinquency in interest or principal payments; indications that they will enter bankruptcy or other financial reorganisation; and changes in arrears or economic conditions that correlate with defaults.

For financial assets carried at amortised cost (including loans and receivables), a separate allowance account is used to reduce the carrying amount of financial assets impaired by credit losses. After having taken all possible measures of recovery, if management establishes that the carrying amount cannot be recovered by any means, at that point the written-off amounts are charged to the allowance account or the carrying amount of impaired financial assets is reduced directly if no impairment amount was previously recognised in the allowance accounts.

When the terms of financial assets that would otherwise have been past due or impaired have been renegotiated, the company recognises the impairment for such financial assets by taking into account the original terms as if the terms have not been renegotiated so that the loss events that have occurred are duly considered.

Derecognition

Financial assets are derecognised where the contractual rights to receipt of cash flows expire or the asset is transferred to another party whereby the entity no longer has any significant continuing involvement in the risks and benefits associated with the asset.

Financial liabilities are derecognised when the related obligations are discharged, cancelled or have expired.

The difference between the carrying amount of the financial liability, which is extinguished or transferred to another party, and the fair value of consideration paid, including the transfer of non-cash assets or liabilities assumed, is recognised in profit or loss.

(f) Impairment of assets

At the end of each reporting period, the entity assesses whether there is any indication that an asset may be impaired. If such an indication exists, an impairment test is carried out on the asset by comparing the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, to the asset's carrying amount.

Any excess of the asset's carrying amount over its recoverable amount is recognised immediately in profit or loss, unless the asset is carried at a revalued amount in accordance with another Standard (e.g. in accordance with the revaluation model in AASB 116). Any impairment loss of a revalued asset is treated as a revaluation decrease in accordance with that other Standard.

Where it is not possible to estimate the recoverable amount of an individual asset, the entity estimates the recoverable amount of the cash-generating unit to which the asset belongs.

Impairment testing is performed annually for goodwill and intangible assets with indefinite lives.

(g) Employee benefits

Short-term employee benefits

Provision is made for the company's obligation for short-term employee benefits.

Short-term employee benefits are benefits (other than termination benefits) that are expected to be settled wholly within 12 months after the end of the annual reporting period in which the employees render the related service, including wages, salaries and sick leave.

Short-term employee benefits are measured at the (undiscounted) amounts expected to be paid when the obligation is settled.

The company's obligations for short-term employee benefits such as wages, salaries and sick leave are recognised as a part of

current trade and other payables in the statement of financial position.

Other long-term employee benefits

The company classifies employees' long service leave and annual leave entitlements as other long-term employee benefits as they are not expected to be settled wholly within 12 months after the end of the annual reporting period in which the employees render the related service. Provision is made for the company's obligation for other long-term employee benefits, which are measured at the present value of the expected future payments to be made to employees.

Expected future payments incorporate anticipated future wage and salary levels, durations of service and employee departures, and are discounted at rates determined by reference to market yields at the end of the reporting period on government bonds that have maturity dates that approximate the terms of the obligations.

Upon the remeasurement of obligations for other long-term employee benefits, the net change in the obligation is recognised in profit or loss classified under employee benefits expense.

The company's obligations for long-term employee benefits are presented as non-current liabilities in its statement of financial position, except where the company does not have an unconditional right to defer settlement for at least 12 months after the reporting date, in which case the obligations are presented as current liabilities.

(h) Cash and cash equivalents

Cash and cash equivalents include cash on hand, deposits held at-call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts.

Bank overdrafts are shown within short-term borrowings in current liabilities on the statement of financial position.

(i) Goods and Services Tax (GST)

Revenues, expenses and assets are recognised net of the amount of GST, except where the amount of GST incurred is not recoverable from the Australian Taxation Office (ATO).

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 statement of financial position. 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 flows included in receipts from customers or payments to suppliers.

(j) Income tax

No provision for income tax has been raised as the entity is exempt from income tax under Div 50 of the *income Tax Assessment Act 1997*.

(k) Provisions

Provisions are recognised when the entity has a legal or constructive obligation, as a result of past events, for which it is probable that an outflow of economic benefits will result and that outflow can be reliably measured. Provisions recognised represent the best estimate of the amounts required to settle the obligation at the end of reporting period.

(l) Comparative figures

Where required by Accounting Standards comparative figures have been adjusted to conform with changes in presentation for the current financial year. Certain comparative figures have been restated as a result of the changes discussed in Note 1(q).

(m) Trade and other payables

Trade and other payables represent the liabilities for goods and services received by the company during the reporting period that remain unpaid at the end of the reporting period. The balance is recognised as a current liability with the amounts normally paid within 30 days of recognition of the liability.

(n) Critical accounting estimates and judgements

The directors evaluate estimates and judgements incorporated into the financial statements based on historical knowledge and best available current information. Estimates assume a reasonable expectation of future events and are based on current trends and economic data, obtained both externally and within the company.

Key estimates

Valuation of freehold land and buildings

The freehold land and buildings were

independently valued at 30 April 2013 by CJALee property Valuers and Consultants. The valuation was based on the fair value less cost to sell. The critical assumptions adopted in determining the valuation included the location of the land and buildings, the current strong demand for land and buildings in the area and recent sales data for similar properties.

The valuation resulted in a revaluation increment of $36,898 being recognised for the year ended 30 June 2013.

Significant redevelopment works were undertaken on the Moe site and therefore CJALee Property Valuers and Consultants conducted a valuation at 30 June 2015 on the freehold land and buildings.

The valuation resulted in a decrement of $461,054 being recognised for the year ended 30 June 2015 and was written back to the asset revaluation reserve.

At 30 June 2015 the directors have performed a directors' valuation on freehold land and buildings.

The directors have reviewed the key assumptions adopted by the valuers in 2013 and 2015 and do no believe

there has been a significant change in the assumptions at 30 June 2015.They directors therefore believe the carrying amount of the land correctly reflects the fair value less cost to sell at 30 June 2015.

Key judgements

Employee benefits

For the purpose of measurement, AASB 119: Employee Benefits (September 2011) defines obligations for short-term employee benefits as obligations expected to be settled wholly before 12 months after the end of the annual reporting period in which the employees render the related services.

As the company expects that most employees will not use all of their annual leave entitlements in the same year in which they are earned or during the 12 month period that follows (despite an informal company policy that requires annual leave to be used within 18 months), the directors believe that obligations for annual leave entitlements satisfy the definition of other long-term employee benefits and, therefore, are required to be measured at the present value of the expected future payments to be made to employees.

(o) Economic dependence

Latrobe Community Health Service Ltd. is dependent on the Department of Health and Department Human Services for the majority of its revenue used to operate the business.

At the date of this report the Board of Directors has no reason to believe the Department of Health or Department Human Services will not continue to support Latrobe Community Health Service Ltd.

(p) Fair value of assets and liabilities

The company measures some of its assets and liabilities at fair value on either a recurring or non-recurring basis, depending on the requirements of the applicable Accounting Standard.

'Fair value' is the price the company would receive to sell an asset or would have to pay to transfer a liability in an orderly (i.e. unforced) transaction between independent, knowledgeable and willing market participants at the measurement date.

As fair value is a market-based measure, the closest equivalent observable market pricing information is used to determine fair value. Adjustments to market values may be made having regard to the characteristics of the specific asset or liability.

The fair values of assets and liabilities that are not traded in an active market are determined using one or more valuation techniques. These valuation techniques maximise, to the extent possible, the use of observable market data.

To the extent possible, market information is extracted from the principal market for the asset or liability (i.e. the market with the greatest volume and level of activity for the asset or liability).

In the absence of such a market, market information is extracted from the most advantageous market available to the entity at the end of the reporting period (i.e. the market that maximises the receipts from the sale of the asset or minimises the payments made to transfer the liability, after taking into account transaction costs and transport costs). For non-financial assets, the fair value measurement also takes into account a market participant's ability to use the asset in its highest and best use or to sell it to another market participant that would use the asset in its highest and best use.

The fair value of liabilities and the entity's own equity instruments (if any) may be valued, where there is no observable market price in relation to the transfer of such financial instrument, by reference to observable market information where such instruments are held as assets.

Where this information is not available, other valuation techniques are adopted and where significant, are detailed in the respective note to the financial statements

(q) Restatement of prior year comparatives

Statement of Profit or Loss and other comprehensive income (extract).

	30 June 2014 $	Increase/ (Decrease) $	June 30 2014 (Restated) $	30 June 2013 $	Increase/ (Decrease) $	June 30 2013 (Restated) $
Revenue (i)	40,320,614	(555,228)	39,765,386	34,990,739	1,368,761	36,359,500
Employee entitlements expense (ii)	(27,055,858)	58,684	(27,114,542)	(25,498,234)	275,929	(25,774,163)
Net current year surplus	2,687,923	(613,912)	2,074,011	2,689,452	1,092,833	3,782,285
Net gain/(Loss) on disposal of property (iii)			-	-	800,000	(800,000)
Total comprehensive income attributable to members of the entity	**2,687,923**	**(613,912)**	**2,074,011**	**2,689,452**	**292,833**	**2,982,285**

Statement of Financial Position (extract)

	30 June 2014 $	Increase/ (Decrease) $	June 30 2014 (Restated) $	30 June 2013 $	Increase/ (Decrease) $	June 30 2013 (Restated) $
Property, plant and equipment (iii)	13,485,930	-	13,485,930	11,522,741	(800,000)	10,722,741
Trade and other payables (i)	1,762,380	555,228	2,317,607	5,540,434	(1,368,761)	4,171,673
Employee provisions - Current (ii)	3,333,094	41,133	3,374,227	2,778,334	228,150	3,006,484
Employee provisions- Non Current (ii)	1,188,258	17,550	1,205,808	1,040,564	47,780	1,088,344
Net assets	**20,746,800**	**(613,911)**	**20,132,889**	**17,766,045**	**292,832**	**18,058,877**
Total equity	**20,746,800**	**(613,911)**	**20,132,889**	**17,766,045**	**292,832**	**18,058,877**

(i) Grants received in advance and unearned revenue have been re-assessed and adjusted to comply with AASB1004 Contributions.

(ii) On costs for employee leave such as leave loading, work cover premium and superannuation were not included in leave provisions. The leave provision has now been corrected to account for on costs.

(iii) In June 2013, demolition works were carried out at the Moe site in preparation for the site redevelopment. The value of the property demolished was not accounted for and therefore fixed assets were overstated. The error has been corrected in 2013 by recognising the loss on disposal of property and reducing fixed assets.

Note 2 Revenue and other income

	2015 $	2014 $
REVENUE		
Revenue from (non-reciprocal) government grants and other grants		
Commonwealth government grants – operating	9,375,173	7,309,027
State government grants	24,144,091	23,290,892
Other organisations	5,421,244	8,814,472
	38,940,508	**39,414,391**
OTHER REVENUE		
Interest received on investments in government and fixed interest securities	299,824	350,995
	299,824	350,995
Total revenue	**39,240,332**	**39,765,386**
OTHER INCOME		
Gain on disposal of property, plant and equipment	(56,324)	21,328
Charitable income and fundraising	4,575	14,643
Capital grants	1,136,114	2,379,141
Rental income	167,259	116,011
Other	748,509	907,263
Client fees	4,028,009	2,804,449
Total other income	**6,028,143**	**6,242,835**
Total revenue and other income	**45,268,475**	**46,008,221**

Note 3 Surplus for the year

	2015 $	2014 $
EXPENSES		
Depreciation and amortisation:		
Land and buildings	293,953	158,908
Motor vehicles	320,750	337,714
Furniture and equipment	914,433	698,136
Total depreciation and amortisation	**1,529,136**	**1,194,758**
Bad and doubtful debts		
Trade and other receivables	3,824	7,202
Rental expense on operating leases		
Minimum lease payments	351,657	321,852
Total rental expense	**351,657**	**321,852**
Total expenses	**41,247,997**	**43,934,209**

Note 4 Cash and cash equivalents

	2015 $	2014 $
CURRENT		
Cash at bank	131,728	1,982,281
Cash on hand	3,930	4,880
Cash at deposit	3,821,261	2,000,000
Total cash on hand as stated in the statement of financial position and statement of cash flows	**3,956,919**	**3,987,161**
Restricted cash for specific purposes	1,560,133	813,533

Note 5 Trade and other receivables

	Notes	2015 $	2014 $
CURRENT			
Accounts receivable		158,080	365,412
Provision for doubtful debts		(15,576)	(12,574)
		142,504	352,838
Other debtors			
Consumer fees		57,418	50,025
Total current accounts receivable and other debtors		**199,922**	**402,863**
(a) Provision for doubtful debts Movement in the provision for doubtful debts is as follows:			
Provision for doubtful debts as at 1 July 2013		11,262	
Charge for year		7,202	
Written off		(5,890)	
Provision for doubtful debts as at 30 June 2014		12,574	
Charge for year		3,824	
Written off		(822)	
Provision for doubtful debts as at 30 June 2015		15,576	

Note 6 Inventories

	2015 $	2014 $
CURRENT		
At cost		
Inventory	163,901	152,435
	163,901	**152,435**

Note 7 Other assets

	2015 $	2014 $
CURRENT		
Accrued income	320,857	1,275,975
Prepayments	326,711	226,530
	647,568	**1,502,505**

Note 8 Financial assets

	2015 $	2014 $
CURRENT		
Term deposits with original maturities greater than three months	7,000,000	3,000,000
	7,000,000	**3,000,000**

Note 9 Property, plant and equipment

	2015 $	2014 $
LAND AND BUILDINGS		
Freehold land at fair value	2,112,840	1,889,840
Total land	**2,112,840**	**1,889,840**
Buildings at fair value	8,370,586	4,441,926
Less accumulated depreciation	(112,537)	(322,765)
Total buildings	**8,258,049**	**4,119,161**
Leasehold improvements at cost	1,009,541	994,165
Less accumulated depreciation	(194,293)	(122,907)
Total leasehold improvements	**815,248**	**871,258**
Total land and buildings	**11,186,137**	**6,880,259**
PLANT AND EQUIPMENT		
Furniture and equipment at cost		
At cost	10,838,137	10,454,301
Less accumulated depreciation	(6,363,848)	(5,449,415)
	4,474,289	5,004,886
Motor vehicles		
At cost	2,234,251	2,247,317
Less accumulated depreciation	(696,183)	(646,533)
	1,538,068	1,600,785
Total plant and equipment	**6,012,357**	**6,605,671**
Capital work in progress	1,906,473	4,499,637
Total property, plant and equipment	**19,104,967**	**17,985,567**

Note 9 Property, plant and equipment *(CONTINUED)*

Movements in carrying amounts

Movement in the carrying amounts for each class of property, plant and equipment between the beginning and the end of the current financial year:

	Land and buildings $	Motor vehicles $	Furniture and equipment $	Total $
2014				
Balance at the beginning of the year	6,082,694	1,487,117	3,152,930	10,722,741
Additions at cost	956,473	763,916	2,550,093	4,270,482
Additions at fair value				-
Disposals		(312,534)		(312,534)
Revaluations				-
Depreciation expense	(158,908)	(337,714)	(698,136)	(1,194,758)
Carrying amount at the end of the year	**6,880,259**	**1,600,785**	**5,004,887**	**13,485,930**
2015				
Balance at the beginning of the year	6,880,259	1,600,785	5,004,887	13,485,930
Additions at cost	5,060,885	612,602	383,835	6,057,322
Additions at fair value				-
Disposals		(354,569)		(354,569)
Revaluations	(461,054)			(461,054)
Depreciation expense	(293,953)	(320,750)	(914,433)	(1,529,136
Carrying amount at the end of the year	**11,186,137**	**1,538,068**	**4,474,289**	**17,198,494**

Asset revaluations

The freehold land and buildings were independently valued at 30 April 2013 by CJALee Property valuers and consultants.

The valuation resulted in a revaluation increment of $36,898 being recognised in the revaluation surplus for the year ended 30 June 2013. Significant redevelopment works were undertaken on the Moe site and therefore CJALee Property Valuers and Consultants conducted a valuation at 30 June 2015 on the freehold land and buildings.

The valuation resulted in a decrement of $461,054 being recognised for the year ended 30 June 2015 and was written back to the asset revaluation reserve.

At 30 June 2015 the directors reviewed the key assumptions made by the valuers in 2013 and 2015. They have concluded that these assumptions remain materially unchanged, and are satisfied that the carrying amount does not exceed the recoverable amount of land and buildings at 30 June 2015.

Note 10 Trade and other payables

	Notes	2015 $	2014 $
CURRENT			
Trade and other payables		1,267,887	980,749
Monies held in trust		35,456	36,038
GST payable		133,157	188,610
Accrued expenses		833,976	571,181
Accrued salaries and wages		639,967	541,029
	10(a)	2,910,443	2,317,607
(a) Financial liabilities at amortised cost classified as trade and other payables			
Accounts payable and other payables:			
Total current		2,910,443	2,317,607
GST payable		(133,157)	(188,610)
Financial liabilities as trade and other payables	18	2,777,286	2,128,997

Note 11 Provisions

	Notes	2015 $	2014 $
CURRENT			
Provision for employee benefits: annual leave		1,936,044	2,014,486
Provision for employee benefits: long service leave		1,343,273	1,359,741
		3,279,317	**3,374,227**
NON-CURRENT			
Provision for employee benefits: long service leave		1,191,204	1,205,808
		1,191,204	1,205,808
		4,470,521	**4,580,035**

Note 12 Capital and leasing commitments

	2015 $	2014 $
(a) Operating lease commitments		
Payable – minimum lease payments:		
• Not later than 12 months	672,862	327,029
• Later than 12 months but not later than five years	1,943,179	2,108,220
• Later than five years	1,740,327	2,149,207
Minimum lease payments	4,356,368	4,584,456
(b) Capital commitments		
As at 30 June 2015 Latrobe Community Health Service has capital commitments with a construction contractor of $1,252,359 for the redevelopment of the Moe site.		

Note 13 Contingent liabilities and contingent assets

There were no contingent liabilities or assets as at 30 June 2015 (2014: Nil).

Note 14 Events after the reporting period

No material events occurred after the reporting date.

Note 15 Key management personnel compensation

Key management personnel

Any person(s) having authority and responsibility for planning, directing and controlling the activities of the company directly or indirectly, including any director (whether executive or otherwise) is considered key management personnel.

The totals of remuneration paid to key management personnel (KMP) of the company during the year are as follows:

	2015 $	2014 $
Key management personnel compensation	**1,292,403**	**915,696**

Note 16 Responsible persons disclosures

Board Member	Related Parties
Mark Biggs	Gippsland Primary Health Network
Melissa Bastian	Bank Australia
Executive Management	
Ben Leigh	Gippsland Primary Health Network

During the year revenue of $73,492 was received from Gippsland Primary Health Network. Investments were held with Bank Australia which earned interest revenue of $20,469 during the year. All transactions with related parties are per normal commercial terms and conditions.

Note 17 Cash flow information

	2015 $	2014 $
Reconciliation of cash flow from operating activities with current year surplus		
Net result from operating activities	4,020,478	2,074,012
Less capital income	(1,136,114)	(2,379,141)
Non-cash flows:		
Depreciation and amortisation expense	1,529,136	1,194,758
Gains on disposal of property, plant and equipment	56,324	(21,328)
Doubtful debts expense	3,824	7,202
Changes in assets and liabilities:		
(Increase)/decrease in trade and other receivables	199,117	872,695
Increase/(decrease) in trade and other payables	592,836	(1,854,065)
(Increase)/decrease in other assets	854,937	(518,857)
Increase/(decrease) in provisions	(109,514)	485,208
(Increase)/decrease in inventories	(11,466)	(78,403)
	5,999,558	**(217,920)**

Note 18 Financial risk management

The company's financial instruments consist mainly of deposits with banks, local money market instruments, short-term and long-term investments, receivables and payables. The carrying amounts for each category of financial instruments, measured in accordance with AASB 139 as detailed in the accounting policies to these financial statements, are as follows:

	Notes	2015 $	2014 $
FINANCIAL ASSETS			
Cash and cash equivalents	4	3,956,919	3,987,161
Loans and receivables	5	199,922	402,863
Held to maturity investments	8	7,000,000	3,000,000
Total financial assets		**11,156,841**	**7,390,024**
FINANCIAL LIABILITIES			
Financial liabilities at amortised cost:			
Accounts payable and other payables	10(a)	2,777,286	2,128,997
Total financial liabilities		**2,777,286**	**2,128,997**

Note 19 Reserves

(a) Asset Revaluation Reserve
The Asset Revaluation Reserve records the revaluations of non-current assets.

(b) Capital Improvements Reserve
The Capital Improvements Reserve records funds allocated to capital projects.

(c) Community Projects Reserve
The Community Projects Reserve records funds allocated to future board initiatives and community projects.

(d) General Reserve
The General Reserve records funds allocated to the replacement of IT equipment and other fixed assets.

Note 20 Entry details

The registered office of the entity is:
Latrobe Community Health Service Ltd.
81 - 87 Buckley Street
Morwell
Victoria

The principal place of business is:
Latrobe Community Health Service Ltd.
81 - 87 Buckley Street
Morwell
Victoria

Note 21 Members' guarantee

The entity is incorporated under the *Australian Charities and Not-for-profit Commission Act 2012* and is an entity limited by guarantee. If the entity is wound up, the constitution states that each member is required to contribute a maximum of $10 each towards meeting any outstanding's and obligations of the entity. At 30 June 2015 the number of members was 26.

LATROBE COMMUNITY HEALTH SERVICE LTD.
ABN: 74 136 502 022
DIRECTORS' DECLARATION

The directors have determined that the company is a reporting entity that does not have public accountability as defined in AASB 1053: Application of Tiers of Australian Accounting Standards and that these general purpose financial statements should be prepared in accordance with Australian Accounting Standards – Reduced Disclosure Requirements.

In accordance with a resolution of the directors of Latrobe Community Health Service Ltd., the directors declare that:

1. The financial statements and notes are in accordance with the Australian Charities and Not-for-profit Commission Act 2012 and:
   (a) comply with Australian Accounting Standards - Reduced Disclosure Requirements; and
   (b) give a true and fair view of the financial position of the company as at 30 June 2015 and of its performance for the year ended on that date.
2. In the directors' opinion there are reasonable grounds to believe that the entity will be able to pay its debts as and when they become due and payable.

This declaration is made in accordance with a resolution of the Board of Directors.

Director  ***John Guy***

Dated this 29th day of September 2015

INDEPENDENT AUDITOR'S REPORT

To the Members of Latrobe Community Health Service Ltd

We have audited the accompanying financial report of Latrobe Community Health Service Ltd, which comprises the statement of financial position as at 30 June 2015, the statement of profit or loss and comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and directors' declaration.

Director's Responsibility for the Financial Report

The directors of the company are responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards – Reduced Disclosure Requirements and the *Australian Charities and Not-for-profits Commission Act 2012,* and for such internal control as the directors determine 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.

Auditor's Responsibility

Our responsibility is to express an opinion on the financial report based on our audit. We conducted our audit in accordance with Australian Auditing Standards. Those standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the company's preparation of the financial report that gives a true and fair view 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 company's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the directors, as well as evaluating the overall presentation of the financial report.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Independence

In conducting our audit, we have complied with the independence requirements of the *Australian Charities and Not-for-profits Commission Act 2012.* We confirm that the independence declaration required by the *Australian Charities and Not-for-profits Commission Act 2012,* which has been given to the directors of the company, would be in the same terms if given to the directors at the time of this auditor's report.

Opinion

In our opinion, the financial report of Latrobe Community Health Service Ltd is in accordance with the *Australian Charities and Not-for-profits Commission Act 2012*, including:

(i) giving a true and fair view of the company's financial position as at 30 June 2015 and of its performance for the year ended on that date; and

(ii) complying with Australian Accounting Standards – Reduced Disclosure Requirements and the *Australian Charities and Not-for-profits Commission Regulation 2013*.

Rochelle Wrigglesworth
Director
GippsAudit Pty Ltd

Date: 29 September 2015
Place: Sale


Reception

1800 242 696 • www.lchs.com.au
Latrobe Community Health Service ABN: 74 136 502 022