MANSFIELD
DISTRICT HOSPITAL



ANNUAL REPORT
2025 - 2026

Mansfield District Hospital would like to acknowledge the Taungurung people, Traditional Custodians of the land on which we provide care, and pay our respects to their Elders past, present and emerging. Respect is extended to any Aboriginal and Torres Strait Islander peoples in our care, amongst our staff and those who live in our community.

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SD 5.2.1 (a)	Compliance with Standing Directions
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MANSFIELD DISTRICT HOSPITAL ANNUAL REPORT

MANNER IN WHICH THE HEALTH SERVICE WAS ESTABLISHED

Mansfield District Hospital is a public health service established under the Health Services Act 1988 (Vic)

RESPONSIBLE MINISTERS

Minister for Health: Minister for Ambulance Services:
The Hon Mary-Anne Thomas MP 1 July 2025 to 15 April 2026

Minister for Health: Minister for Ambulance Services: Minister for Water:
Hon Harriet Shing MP 15 April 2026 to 30 June 2026

Minister for Mental Health: Minister for Ageing:
The Hon Ingrid Stitt MLC 1 July 2025 to 30 June 2026

Minister for Disability: Minister for Children:
The Hon Lizzie Blandthorn MP 1 July 2025 to 30 June 2026

Minister for Health Infrastructure:
The Hon Melissa Horne MP 1 July 2025 to 30 June 2026

PURPOSE, FUNCTION, POWERS AND DUTIES

In accordance with Mansfield District Hospital By-Laws Section 3:

3.1 The objects of the Health Service are to:

3.1.1 operate a public hospital in accordance with the Act, and any enabling Commonwealth or Victorian legislation, including the provision of the following services:

(a) public hospital services;

(b) primary health services;

(c) aged care services; and

(d) community health services.

3.1.2 provide a range of health and related services ancillary to those services described in clause 3.1.1;

3.1.3 carry on any other activity or business that it is convenient to carry on in connection with providing the services described in clauses 3.1.1 and 3.1.2, or which are intended or calculated to make any of the Health Service's assets or activities more efficient and effective; and

3.1.4 to do all things that are conducive or incidental to achieving the Health Service's objects.

3.1.5 to ensure the accountable and efficient provision of health services and the long-term financial viability of the Health Service;

3.1.6 to ensure effective and accountable systems are in place to monitor and improve the quality, safety and effectiveness of the health services provided by the Health Service;

3.1.7 to strive to improve continuously the quality and safety of the health services provided and to foster innovation;

3.1.8 to ensure the effective and efficient use of the Health Service's resources;

3.1.9 to develop arrangements with other agencies and service providers to enable effective and efficient service delivery and continuity of care;

3.1.10 to facilitate health education to improve the training and knowledge of staff;

3.1.11 to establish and maintain effective systems to ensure:

1. that health services meet the needs of the community served by the Health Service; and

2. effective consultation with the community to take account of the views of users of the health services.

3.2 The Health Service must not do or permit anything to be done that is inconsistent with its objects or is not otherwise authorised by or under the Act.

VISION

Healthy communities, trusted healthcare

MISSION

We deliver healthcare locally for our rural communities. We lead and advocate for the healthcare needs of the people of Mansfield and surrounding communities. In addition to providing safe and clinical best practice care, we focus on health promotion and preventative care to deliver the best possible outcomes for our consumers.

NATURE AND RANGE OF SERVICES PROVIDED

Mansfield District Hospital provides acute, primary and aged services. Acute services include medical, surgical and obstetric care. Emergency care is provided in the Urgent Care Centre. Buckland House Nursing Home provides 30 beds for high level residential aged care while Bindaree Retirement Centre provides 42 residential aged care beds. Primary Care comprises a visiting nursing service, community health nursing, home support and social inclusion programs along with a wide range of allied health services and health promotion and prevention services to the community. Community nurses visit Jamieson and Woods Point on a weekly basis. The health service also operated a medical clinic on Mt Buller during the alpine ski season 2024.

Services offered by Mansfield District Hospital are:

- General Medicine
- Elective Surgery
- Obstetrics
- Haemodialysis
- Urgent Care
- Community Health
- Health Promotion
- Residential Aged Care
- Visiting Nursing
- Home Support
- Social Inclusion
- Medical Imaging

The health service serves the catchment of Mansfield Shire with a population of approximately 10,000 permanent residents. In holiday seasons this population increases three-fold. For obstetric services the catchment extends to include part of Murrindindi Shire.

ORGANISATIONAL STRUCTURE

BOARD OF DIRECTORS

Dr. Karen Bennetts (Chair)	Chair to 07.10.2025
Mr. Matthew Hoskin (Chair)	Chair from 07.10.2026
Ms. Amanda Vogt	
Ms. Catherine Easton	
Mr. Darren Taylor	to 15.09.2025
Ms. Kristy Aldridge	
Ms. Lisa Morgan	
Ms. Rachel Paulus	
Mr. Richard Ray	
Mr. Stephen Bendle	

AUDIT & RISK MANAGEMENT COMMITTEE

Mr. Darren Taylor (Chair)	Chair to 15.09.2025
Dr. Karen Bennetts (Chair)	Chair from 15.09.2025
Ms. Amanda Vogt	
Ms. Kristy Aldridge	
Mr. Richard Ray	

Community Members

Mr. David Roff
Ms. Leeanne Darmanin
Mr. Mark Evans

COMMUNITY ADVISORY COMMITTEE

Ms. Rachel Paulus (Chair)
Ms. Catherine Easton
Mr. Stephen Bendle

Community/Consumer Representatives

Aunty Ann-Marie Fletcher
Prof. Brenda Happell
Ms. Candice Martin
Ms. Di Bergelin
Ms. Jill O'Halloran
Mr. John Saggers
Ms. Joyce Isbester
Ms Nola Andrews
Ms. Sharon Howie

FINANCE COMMITTEE

Mr. Richard Ray (Chair)	
Mr. Darren Taylor	to 15.09.2025
Ms. Catherine Easton	
Dr. Karen Bennetts	from 01.11.2025

GOVERNANCE, NOMINATIONS AND EXECUTIVE PERFORMANCE

Ms. Amanda Vogt (Chair)	
Dr. Karen Bennetts	to 01.11.2025
Mrs. Lisa Morgan	
Mr. Matthew Hoskin	from 01.11.2025

SAFETY AND QUALITY COMMITTEE

Mr. Matthew Hoskin (Chair)	Chair to 01.11.2025
Mr. Stephen Bendle (Chair)	Chair from 01.11.2025
Ms. Lisa Morgan	
Ms. Rachel Paulus	
Mrs. Kristy Aldridge	
Ms. Debra Worrall	

Consumer Representatives

Ms. Kristina Zlatic
Ms. Nola Andrews

EXECUTIVE

Chief Executive Officer: to 13.07.2025
Mr. Cameron Butler, RN B. Bus
Responsibilities; setting the strategic vision, ensure operational efficiency, and maintaining regulatory compliance, while fostering a positive culture and driving innovation.

Chief Executive Officer: from 14.07.2025
Ms. Michelle Spence, RN PGDip CritCareNsg
Responsibilities; setting the strategic vision, ensure operational efficiency, and maintaining regulatory compliance, while fostering a positive culture and driving innovation. Represent the organisation within the Hume Local Health Service Network, supporting the vision and delivery of Statement of Expectations setting out the common and local initiatives to be delivered, supported by an annual implementation plan.

Director of Clinical Services: to 13.07.2025
Ms. Michelle Spence, RN PGDip CritCareNsg
Responsibilities; leading and managing all aspects of clinical operations to ensure high-quality, safe, and efficient patient care.

Director of Clinical Services: from 3.11.2025
Ms. Sarah Lieber, RN BN
Responsibilities; leading and managing all aspects of clinical operations to ensure high-quality, safe, and efficient patient care. Including strategic planning, operational management and clinical governance.

Director of Medical Services:
Prof. Louis Irving, MBBS FRACGP FRACP FThor Soc
Responsibilities; providing strategic and operational leadership for all medical services, ensuring high-quality patient care, and promoting a culture of safety and continuous improvement.

Director of Quality & Safety:
Mrs. Kate Les, RN BN Gr Dip Neuroscience
Responsibilities; overseeing and improving the quality and safety of patient care, Develop, Implement and enhance clinical governance, risk management and patient safety systems while ensuring compliance and regulations.

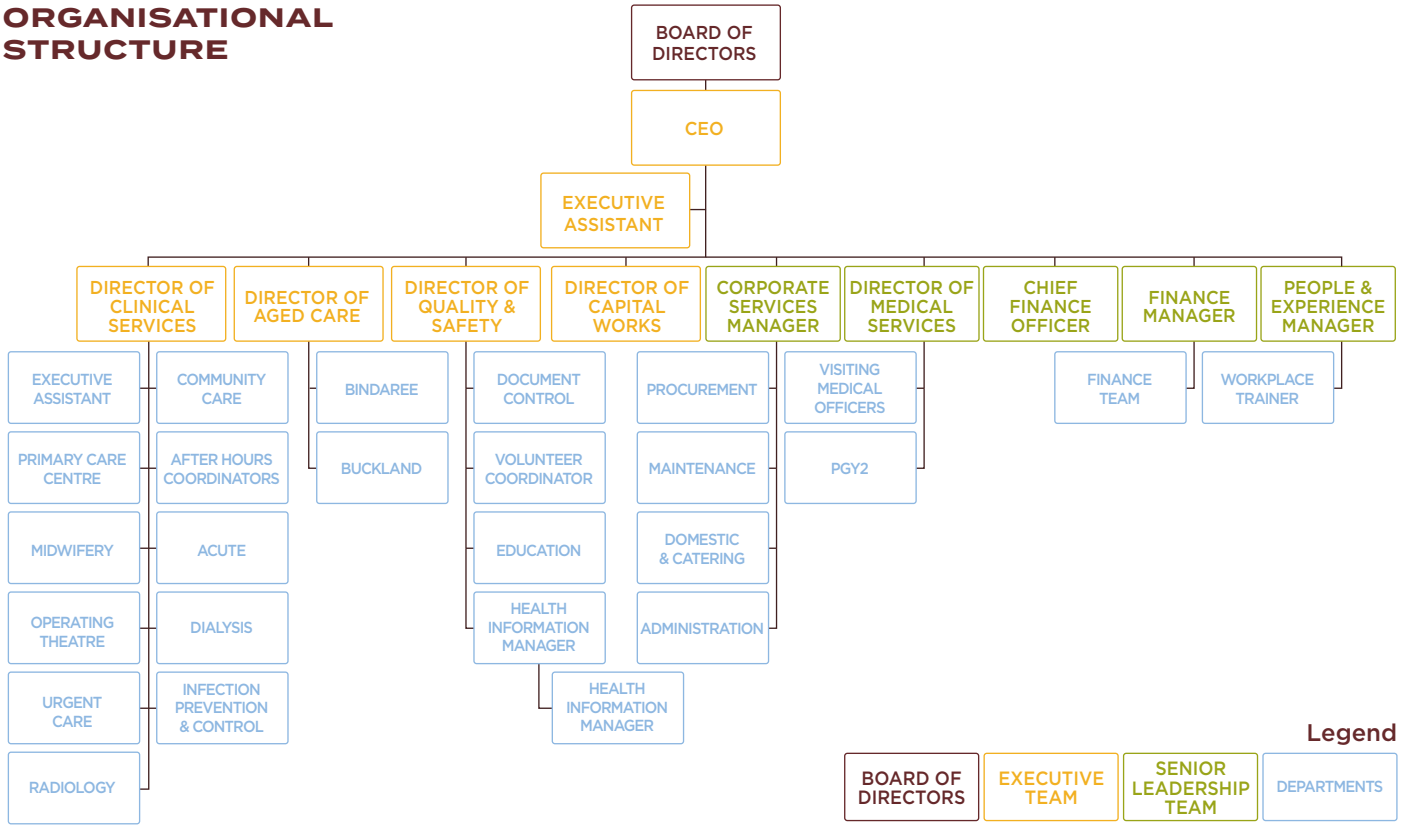
Director of Finance & Corporate Services: to 02.12.2025
Dr. Vijen Reddy, DBA, JP Accredited, AFCHSM, CHM, AIPA, IFA
Responsibilities; overseeing all financial operational and corporate functions. Include strategic financial planning, budgeting, reporting and ensuring compliance and regulation.

Director of Aged Care:
Ms. Anne Jewitt, RN RM, IBCLC
Responsibilities; overall clinical leadership, coordination of care services, ensuring high-quality care delivered to residents in accordance with Aged Care standards, legislation and policies.

Director of Capital Projects:
Ms. Melanie Green, BSci (Speech Pathology) MHHSM GradDIP Risk & Bus Continuity
Responsibilities; primary responsible for the planning, execution, and oversite of all capital projects within a healthcare organisation. Ensuring projects are on time, within budget, and meet quality care standards.

Personal Assistant to CEO:
Ms. Tracy Rekers
Responsibilities; manages CEO and Board schedule, correspondence, communication, and providing strategic support for the CEO's and Boards various roles and responsibilities.

ORGANISATIONAL STRUCTURE



As as May 2026

VISITING MEDICAL OFFICERS

Dr. R. Bennetts, MBBS (Hons)
Dr. L. Carter, MBBS Bsc(Hons) FRACGP FACRRM JCCA
Dr. D Chakraborty, MBBS FRACGP RANZCOG DRANZCOG
Dr. P. Daniel. MBBS, BSc Hons Orthopaedic Science
Dr. E. Dirksen, MBBS (Hons), DRANZCOG
Dr. D. Friday, MBBS DRANZCOG FRACGP
Dr. J. Harper, MBBS, FACRRM
Dr. K. Hudson, BMedSc(Hons) MD DRANZCOG
Dr. H. Jennens, MBBS, FRACGP
Dr. K. Lardner, MBBS
Dr. D. Le Brocque, BAppSc MSc MBBS
Dr. C. Lewis, MBChB
Dr. B. Nally, MBBS, B.Nursing
Dr. J. Penate, MBBS, FRACGP, AACEM
Dr. L. Plant, MBBS, BBiomed
Dr. R. Radford, MBBS, FRACGP
Dr. M. Reed, MBBS, FRACGP, FACRRM
Dr. S. Richards, MBBS (Hons), DipRGA, BA
Dr. D. Ross, MD, BParamedic
Dr. M Sathveegarajah, MD, BSc, ACD Dermoscopy
Dr. G Slaney, MBBS, MPH DA DRCOG FACRRM
Dr. S. Slater, MD
Dr. W. Twycross, MBBS DTPH, DRCOG, DRANZCOG
Dr. B. Weatherhead, MBBS, BMedSci FRACGP JCCA
Dr. C. Weatherhead, BMedSci (Hons) MBBS DCH DRANZCOG FRACGP
Dr. A. Wettenhall, MBBS, FRACGP, FACRRM
Dr. S. Wiles, MBBS, FRACGP, JCCA DipRGA

VISITING SPECIALISTS

Mr. M Forbes, MBBS FRACS
Dr. P MacLeish, MBBS FRACP
Dr. S Pearce, MBBS FRANZCOG
Mr. P Ruljancich, MBBS FRACS
Mr. M Shears, MBBS (Hons) BBiomedSc PGDipAnat FRACS
Dr. John Stuchbery, MBBS, FRACS, BMedSc
Dr. Katrina Gelhaar, MBBS, FANZCA

VISITING DENTAL PRACTITIONER

Dr D Kohli B.D Sc

RESPONSIBLE BODIES DECLARATION

In accordance with the Financial Management Act 1994, I am pleased to present the report of operations for Mansfield District Hospital for the year ending 30 June 2026.



Mr. Matthew Hoskin
Chair, Board of Directors
Mansfield District Hospital

MANSFIELD DISTRICT HOSPITAL

A YEAR IN REVIEW

INTRODUCTION

Mansfield District Hospital (MDH) and its Board of Directors are pleased to present the 2025–2026 Annual Report to our community. The past year has been one of significant achievement, and this report highlights the many ways in which our health service has continued to deliver high-quality care and improve health outcomes for our community.

The outstanding commitment and expertise of our staff, supported by the leadership of our dedicated Executive team, have enabled MDH to continue providing safe, compassionate and person-centred care to a growing population. Equally, our medical workforce has demonstrated exceptional professionalism, clinical expertise and commitment, underpinning the high standard of care for which MDH is recognised.

On behalf of the Board of Directors, I extend my sincere thanks and congratulations to everyone across our organisation. Your dedication, professionalism and commitment to our patients and community are the foundation of MDH's continued success.

STRATEGY

In the past year, Mansfield District Hospital completed its Strategic Plan for 2026–2029 and commenced implementation of the accompanying action plan, establishing a clear direction for the organisation over the next four years.

At the heart of the Strategic Plan is our mission to deliver trusted, inclusive, high-quality healthcare that improves lives and strengthens our communities, supported by our vision of healthy communities and trusted healthcare.

The Strategic Plan is guided by five strategic pillars that will shape our priorities and decision-making:

1 OUR PEOPLE, OUR FUTURE

Build a skilled, inclusive and resilient workforce aligned to future service needs.

To be a rural health service of choice, where people feel proud to work, grow, and belong.

2 LOCAL, HIGH-QUALITY CARE

Deliver timely, person-centred care closer to home through innovative service models.

Uphold our excellent standards for quality and clinical governance and expand local service models.

3 STRONGER TOGETHER: REGIONAL PARTNERSHIPS & LEADERSHIP

Lead and collaborate across the region to strengthen system-wide impact.

Strengthen regional collaboration and strategic partnerships that improve care expand service capacity.

4 CONNECTED SYSTEMS, SMARTER CARE

Develop and build reliable, integrated digital and physical systems that support safe, efficient, and coordinated care.

5 WORKING WITH OUR COMMUNITY

Build trust and visibility through transparent, inclusive, and proactive communication.

Supporting these strategic priorities are the values that underpin everything we do:

1 CARE – We lead with care, always

2 RESPECT – We create a respectful and inclusive environment

3 COLLABORATE – We collaborate to achieve better outcomes

4 EMPOWER – We empower people to make a difference

Further information about the MDH Strategic Plan 2026–2029, including the full plan document, is available on the MDH website.

Additionally, each year, Mansfield District Hospital enters into a Statement of Priorities with the Victorian Department of Health. This agreement outlines the key strategic priorities, service delivery expectations and performance measures that guide the organisation throughout the year. Our performance against these priorities is reported later in this Annual Report.

For the 2025–2026 reporting period, the Department's strategic priorities were:

- Innovate and improve access and care
- Prudent, sustainable and effective use of resources
- A stronger workforce
- Improving Aboriginal health and wellbeing
- Moving from Competition to Collaboration

Together, the MDH Strategic Plan and the annual Statement of Priorities provide a strong foundation for organisational planning, ensuring that our strategic ambitions are supported by clear operational priorities, measurable performance objectives and a continued focus on delivering outstanding care for our community.

PEOPLE

Our staff, Visiting Medical Officers (VMOs) and volunteers are the foundation of Mansfield District Hospital. Their expertise, dedication and compassion are reflected in the exceptional care they provide to our patients, residents and the wider community every day. Their commitment to delivering safe, high-quality care is one of MDH's greatest strengths, and I sincerely thank each of them for their outstanding contribution.

Our volunteers and donors continue to make an invaluable contribution to the life of MDH, helping to enhance the care we provide and strengthening the connection between our health service and the community we serve.

This year also marked an important leadership transition, with Michelle Spence appointed as Chief Executive Officer after previously serving as Director of Clinical Services. Michelle has brought energy, vision and strong clinical and operational leadership to the role, and I congratulate Michelle on a highly successful first year as Chief Executive Officer. Under her leadership, MDH has continued to strengthen its services, culture and strategic direction.

I also acknowledge the Executive Leadership Team for its professionalism, commitment and collaborative leadership throughout the year. Together, they have demonstrated resilience and a shared focus on delivering excellent care while fostering a positive organisational culture and upholding the values that define MDH.

From a governance perspective, we were pleased to welcome Kristy Aldridge, Stephen Bendle and Catherine Easton to the Board of Directors, further strengthening the breadth of skills and experience around the Board table. As a small rural health service, MDH benefits greatly from a Board whose members bring diverse expertise and a strong commitment to good governance. Collectively, the Board provides strategic oversight, sound governance and ongoing support to the Chief Executive Officer and Executive Leadership Team as they continue to guide the organisation into the future.

SAFETY AND QUALITY

Delivering safe, high-quality care remains at the heart of everything we do at MDH. Our commitment to excellence is reflected in the care we provide to our patients, residents and the wider community, with a strong focus on achieving the best possible outcomes through evidence-based practice, effective clinical governance and continuous quality improvement.

As a rural health service, MDH delivers a broad range of services including urgent care, surgery, acute care, maternity services, aged care, Visiting Nursing Service, palliative care, primary care, renal dialysis, community health services and a range of medical imaging services.

Each of these services is supported by robust governance and quality systems, with regular internal and external audits undertaken to ensure compliance with regulatory requirements while identifying opportunities for ongoing improvement.

MDH once again successfully maintained accreditation against a range of nationally and internationally recognised quality standards, including:

- National Safety and Quality Health Service (NSQHS) Standards
- Aged Care Quality Standards
- ISO 9001:2015 – Quality Management Systems

The Board remains firmly committed to strong clinical governance and patient safety, recognising that a strong culture of quality underpins every aspect of our health service.

INFRASTRUCTURE AND CAPITAL INVESTMENT

This year marked the beginning of the most significant infrastructure renewal program undertaken by MDH in decades. Through a combined investment of $62.8 million in aged care redevelopment, together with upgrades to our Primary Care facilities, MDH is reshaping its campus to better meet the needs of our community for decades to come.

Construction of the new residential aged care facility commenced during the year, representing the first stage of the redevelopment of Bindaree Retirement Centre, to be followed by Buckland House. Phase One of the project is complete, and we are part way through Stage Two, marking an important milestone in the delivery of contemporary, purpose-built facilities for older members of our community.

The redevelopment will provide modern, dementia-friendly accommodation featuring single bedrooms with private ensuites, welcoming communal living areas and landscaped outdoor spaces designed to promote independence, dignity, wellbeing and social connection. The project also includes the refurbishment and repurposing of Buckland House for Primary Care and community use, ensuring the campus continues to evolve to meet the changing needs of our region, and further strengthening our ability to provide integrated, multidisciplinary healthcare close to home. Together, these investments will enhance the experience of patients, residents, families and staff while supporting the delivery of high-quality healthcare for many years to come.

The Board acknowledges the Victorian Government for its significant investment in the future of healthcare in Mansfield, together with the Victorian Health Building Authority, our project partners and the many staff including Melanie Green in particular, who have worked diligently to ensure these projects have progressed while minimising any interruption to the delivery of services to our community.

COMMUNITY HEALTH AND WELLBEING

Mansfield District Hospital is committed to improving the health and wellbeing of our community through a broad range of programs that extend well beyond the traditional hospital setting. By focusing on prevention, early intervention, rehabilitation, health promotion and community education, we are helping people to stay healthier, maintain their independence and access the support they need closer to home.

These initiatives complement our acute and residential aged care services by addressing the broader factors that influence health and wellbeing, while supporting people to manage their health throughout every stage of life.

Examples of these programs include:

- Restart: supporting community members on their recovery journey from substance dependence.
- Dietetics programs, including education and support for healthy eating across the community.
- Community movement and exercise programs that promote healthy ageing and physical wellbeing.
- RESPOND – a community-led, place-based initiative focused on improving the health and wellbeing of local children, including Chop and Chat, Fresh Food Drive, Active for Kids, Soups for School, Chop and Chat for Men
- Chronic disease management programs, including cardiac and pulmonary rehabilitation.
- Community health promotion initiatives, including the annual Health Expo.
- Women's Health Physio outpatient clinic
- Alcohol and Other Drugs, education for teens program

STRENGTHENING ABORIGINAL CULTURAL SAFETY

MDH continues to strengthen Aboriginal and Torres Strait Islander cultural safety through face-to-face education and engagement sessions for Board Directors, the Executive Leadership Team and organisational leaders.

These sessions are facilitated by Aunty Robynne Nelson, Mulana Kaalinya – Strong Spirit. In addition, all staff have access to Aboriginal Cultural Awareness training through the MDH Learning Management System.

HUME LOCAL HEALTH SERVICES NETWORK

Throughout the year, Mansfield District Hospital continued to play an active role in the Hume Local Health Service Network, working collaboratively with health services across the region to strengthen healthcare delivery for our local community and the broader Hume region.

The Network has been established to improve access to care, enhance patient flow, strengthen workforce capability, improve quality and safety, and deliver more coordinated services across the region. By working together, member health services are developing innovative models of care that enable more patients to receive the right care, in the right place, at the right time, and as close to home as clinically appropriate.

Importantly, participation in the Hume Local Health Service Network enables MDH to benefit from stronger regional collaboration while retaining its independent Board, local leadership and unwavering focus on meeting the healthcare needs of the Mansfield community. This model allows us to preserve local decision-making and accountability while drawing on the collective expertise, capability and resources of our regional partners.

By working together, we are creating opportunities to improve patient access, strengthen clinical pathways, enhance workforce sustainability and deliver better health outcomes for our community and the wider Hume region. The Board strongly supports this collaborative approach and is committed to ensuring Mansfield District Hospital remains a strong, independent rural health service that is both locally led and regionally connected.

FINANCE

The full financial statements for the year ended 30 June 2026 are included in this Annual Report.

Despite a challenging operating environment characterised by rising costs, workforce pressures and increasing demand for services, Mansfield District Hospital continued to demonstrate strong financial stewardship throughout the year.

Through disciplined financial management and a continued focus on delivering high-quality, sustainable healthcare, MDH achieved the financial outcome agreed with the Victorian Department of Health while maintaining the high standard of care our community expects.

The Board acknowledges the efforts of the Executive Leadership Team and staff in carefully balancing financial sustainability with the ongoing delivery of safe, high-quality healthcare. Their commitment has ensured that MDH remains well positioned to meet both its current obligations and the future needs of our community.

CLOSING ACKNOWLEDGEMENTS

As I conclude, I would like to acknowledge the outstanding contribution of everyone who makes Mansfield District Hospital the organisation it is today—our dedicated staff, Visiting Medical Officers (VMOs), volunteers, donors and valued partners. Your commitment to delivering safe, compassionate, high-quality care and supporting those who depend on our services is deeply appreciated.

On behalf of the Board of Directors, I extend my sincere thanks to everyone who has contributed throughout the year. Your professionalism, compassion, resilience and unwavering commitment in the face of an ever-changing healthcare environment have enabled MDH to continue providing outstanding care to our community.

Together with my fellow Board directors, I offer our heartfelt appreciation for your dedication, service and support. We are proud of what has been achieved over the past year and remain confident that, by continuing to work together, MDH will build on these achievements and continue to provide trusted, high-quality healthcare for our community into the future.



Matthew Hoskin
Board Chair

MANSFIELD DISTRICT HOSPITAL AUXILIARY REPORT

The Auxiliary continues to move forward in a most positive way. We have a healthy membership of about 30 which means more hands-on support for all our activities. We continue to support the general Hospital, Bindaree and Buckland House and for our May meeting we were taken on a personal tour of the wonderful new Bindaree facility.

We have continued with our two major fund-raising events. The annual Cup Weekend Art Show was again most successful, raising over $18,000. The show was judged by internationally renowned local artist Tony Pridham with the major awards going to Ray Winspear (Rotary Award) and Judy Ciancio (Friday Foundation Award). Over 200 paintings were exhibited, including works from 20 artists new to our Show and we sold 51 paintings.

Many thanks to the Art Show committee which has always been a well-oiled machine, but special thanks go to Jan Bedford who has coordinated the show again this year.

Our second major fund-raising event is the Annual Golf Day every February. This was our 19th year for the event and it was again highly successful, raising over $40,000. That makes well over $550,000 raised in total over those 19 years. We continue to receive wonderful community support for our golf day with corporate support from local businesses and generous major sponsorships from Mansfield Motor Group, DPG property group, Vacuum Trucks, Spargo Group, Delatite Winery, Foodworks and the Mansfield Golf Club. Special thanks to the organising committee for their tireless efforts again this year.

Bindaree Auxiliary members have worked hard again during the year to raise extra funds through the Golf Club Cash Cow and we thank them for the regular effort in organising this.

We were most pleased to have Michelle Spence, Julie Duncan and Eileen Wettenhall visit our meetings during the year. We heard about general needs for the hospital, the RESTART program and the work in the Occupational Therapy area, especially the valuable addition of the lymphoedema scanner that we funded during the year.

Our major purchases for 2026 have been:

- I-pads and noise cancelling headphones to enhance treatment time for dialysis patients.
- Dementia clocks for Buckland
- Lymphoedema scanner
- A second X-ray plate for small scale X-rays e.g. Paediatric (($60,000)
- We have also earmarked $100,000 for the purchase of a bone density scanner which is expected to be on-line in the second half of this year.

Future purchases are now dependent on several pending decisions related to any new expansion plans. But the auxiliary is well placed to provide some major purchases for new requirements.

The Auxiliary can only continue to provide such valuable support to the Hospital, Bindaree and Buckland because of the dedication of all our wonderful members. They work tirelessly to make our key events a success and thanks go to every single one of them. We also express our thanks to the hospital administration for their invaluable support of our activities and the open access that we have with them.

Val Doyle

President
Mansfield District Hospital Auxiliary

WORKFORCE

Mansfield District Hospital adheres to the public sector employment principles. These align to our health service's values and shape our working environment. We aim for a culture where there are productive working relationships, employees are treated with respect, treat each other with respect, can safely raise concerns and have career opportunities.

The Mansfield District Hospital Strategic workforce plan 2026 – 2029 will continue to develop recruitment strategies for local, national and international recruitment, individual staff skill set with the needs of our community shaping the workforce for the future.

Mansfield District Hospital Values:

CONSUMERS ARE AT THE CENTRE OF OUR CARE

WE DELIVER GREAT CARE

We strive for the best health outcomes for our consumers and communities every time. Consumers are at the centre and we consistently provide high-quality, safe and personalised care. We demonstrate empathy and kindness in every aspect of our care.

WE WORK TOGETHER

We work as a cohesive team and feel connected to the work we do together. We maintain strong connections to our diverse communities in and outside of Mansfield. We work in collaboration with our partners to deliver exceptional care. We have honest and open conversations with our staff, consumers and the community.

WE RESPECT EACH OTHER

We respect our peers, our consumers, our hospital and our environment. Care is delivered thoughtfully and with compassion. We are considerate of our consumers' dignity and privacy, and our consumers trust and have confidence in our quality of care. We actively listen and act fairly, impartially and without judgement.

WE EMPOWER EACH OTHER

We support and trust each other to deliver an exceptional consumer experience. We give our consumers the information and resources they need to make considered and informed decisions about their health care. We continuously support our staff in their development and empower them to make decisions based on their best judgement.

All employees have been correctly classified in workforce data collections.

Hospitals Labour Category	JUNE current month FTE*		Average Monthly FTE**	
	2025	2026	2025	2026
Nursing	75.70	90.08	78.01	84.59
Administration and Clerical	23.86	21.38	22.73	21.74
Medical Support	3.73	4.34	3.21	4.17
Hotel and Allied Services	44.38	45.95	43.94	43.67
Medical Officers	-	-	-	-
Hospital Medical Officers	-	-	-	-
Sessional Clinicians	0.21	0.21	0.20	0.21
Ancillary Staff (Allied Health)	14.37	13.56	14.10	13.44
Other (Health Promotion)		0.42		0.42
TOTAL	**162.25**	**175.94**	**162.19**	**168.24**

The FTE figures required in the table above are those excluding overtime. These do not include contracted staff (e.g. agency nurses and fee-for-service visiting Medical Officers) who are not regarded as employees for this purpose.

WORKFORCE INCLUSION POLICY

At Mansfield District Hospital (MDH), we are committed to fostering a workplace that values diversity, promotes equity, and creates a culture of inclusion.

As part of our obligations under the Gender Equality Act 2020, we continue to report transparently on our progress against gender equality targets.

Our Gender Equality Action Plan is focused on:

- Holding our leaders accountable for championing gender equality;
- Increasing intersectional gender representation and inclusion across all levels;
- Normalising and formalising flexible work and supporting staff with caring responsibilities
- Improving support and processes for staff who experience unacceptable behaviours; and
- Reducing gender pay gaps toward eventual elimination.

The Mansfield District Hospital Diversity and Inclusion Committee is key in embedding inclusive leadership and continuous improvement across the organisation. These initiatives are part of a longer-term cultural transformation. Over time, we are seeing positive shifts in leadership representation, staff engagement, and flexibility—laying the foundation for a more respectful, equitable workplace.

OCCUPATIONAL HEALTH AND SAFETY

Mansfield District Hospital is committed to providing a safe environment for employees, consumers and members of the public.

The Health Service complies with the requirements of the Occupational Health and Safety Act (Vic) 2004 and the Victorian Occupational Health and Safety Regulations 2017.

Health and Safety Representatives seek to find ways to eliminate or mitigate the risk of injury within the workplace. We aim for a workplace culture where people identify and report issues early. Where injury has occurred, the health service seeks to achieve the safe, appropriate, supportive and timely return to work of employees.

The recent inclusion of Occupational Violence and Aggression train the trainer program at Mansfield District Hospital will endeavour to improve staff education, staff awareness and overall improved staff safety.

Reported Incidents

Occupational Health and Safety Statistics	2023-24	2024-25	2025-26
The number of reported hazards/incidents for the year per 100 FTE	36.1	47.4	54.08
The number of 'lost time' standard Workcover claims for the year per 100 FTE	2.6	1.4	0.0
The average cost per Workcover claim for the year	$8,690	$3,900	$2,695

OCCUPATIONAL VIOLENCE

Occupational Violence statistics	2025-26
Workcover accepted claims with an occupational violence cause per 100 FTE	0.0
Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	0.0
Number of occupational violence incidents reported	26
Number of occupational violence incidents reported per 100 FTE	15.45
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	0%

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

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

Incident – an event or circumstance that could have resulted in, or did result in, harm to an employee. Incidents of all severity ratings are included. Code Grey reporting is not included, however, if an incident occurred during the course of a planned or unplanned Code Grey it is included.

Accepted Workcover claims - accepted Workcover claims that were lodged in 2024-25

Lost time - lost time is defined as greater than one day.

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

FINANCIAL INFORMATION

Summary of Financial Results for last five years

	2026 $000	2025 $000	2024 $000	2023 $000	2022 $000
Operating result*	**(172)**	**(310)**	**(1,581)**	**15**	**5**
Total revenue	54,350	51,455	27,162	27,692	26,021
Total expenses	35,783	33,484	29,779	28,872	27,477
Net result from transactions	**18,567**	**17,971**	**(2,617)**	**(1,180)**	**(1,456)**
Total other economic flows	(38)	21	19	(19)	177
Net result	**18,529**	**17,992**	**(2,598)**	**(1,199)**	**(1,279)**
Total assets	97,370	76,274	58,075	49,023	48,439
Total liabilities	22,393	19,826	19,619	18,837	17,054
Net assets/Total equity	**74,977**	**56,448**	**38,456**	**30,186**	**31,385**

* The Operating result is the result for which the heath service is monitored in its Statement of Priorities

Mansfield District Hospital's net result for 2025-26 is a $18,529 million surplus, which considers other economic flows (such as Long Service Leave liability revalued for changed bond rates), capital purpose income and depreciation and amortisation costs. The Operating Result, of $0.172m deficit for the year, was unfavourable to the target included in the Statement of Priorities of $0 that is breakeven.

Reconciliation between the Net Result from Transactions reported in the Financial Statements to the Operating Result as agreed in the Statement of Priorities

	2025-26 ($000)
Operating result	**(172)**
Capital purpose income	22,073
Expenditure for capital purpose	-256
Depreciation and amortisation	-3,078
Finance costs (other)	0
Net results from transactions	**18,567**

CONSULTANCIES

Details of consultancies (under $10,000)

In 2025-2026 there were zero consultancies where the total fees payable to the consultants were less than $10,000.

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

In 2025-2026 there was three consultancies where the total fees payable to the consultants were $10,000 or greater (exc. GST). The total expenditure during 2025 -2026 in relation to this consultancy was $215,447.95 (exc. GST).

Consultant	Purpose of consultancy	Start date	End date	Total approved project fee (excl. GST)	Expenditure 2025-26 (excl. GST)	Future expenditure (excl. GST)
JWP Architects	Architecture support in the development of Theatre and Urgent Care RHIF funding submission - design development and documentation - Urgent Care and Theatre compliance upgrade	Jul-24	Ongoing	Estimated $100,000	$48,591.40	$100,000
Healthcare Australia	Allied Health agency for Physiotherapy, vacant position unable to recruit to	Jul-25	Jun-26	$0.0	$144,031.55	$0.0
Health Generation	ANNAC Aged Care review and education	Jul-25	Ongoing	$3'500 Monthly	$22,825.00	$3,500 Monthly

INFORMATION AND COMMUNICATION TECHNOLOGY (ICT) EXPENDITURE

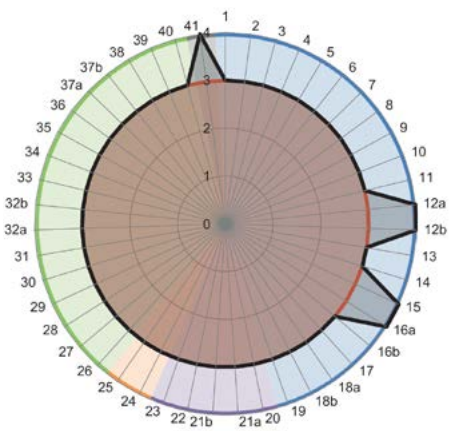
The total ICT expenditure incurred during 2025-2026 is $1,796,482.00 (excluding GST) with the details shown below.

Business as Usual (BAU) ICT expenditure	Non-Business as Usual (non-BAU) ICT expenditure		
Total (excl. GST)	Total = Operational expenditure and capital expenditure (excl. GST)	Operational expenditure (excl. GST)	Capital expenditure (excl. GST)
$1,796,482.00	$0	$0	$0

ASSET MANAGEMENT ACCOUNTABILITY FRAMEWORK

The following sections summarise Mansfield District Hospital's assessment of maturity against the requirements of the Asset Management Accountability Framework (AMAF). The AMAF is a non-prescriptive, devolved accountability model of asset management that requires compliance with 41 mandatory requirements. These requirements can be found on the DTF website https://www.dtf.vic.gov.au/infrastructure-investment/asset-management-accountability-framework.

Mansfield District Hospital's target maturity rating is 'competence', meaning systems and processes are fully in place, consistently applied and systematically meeting the AMAF requirement, including a continuous improvement process to expand system performance above AMAF minimum requirements.



Status	Scale
Not Applicable	N/A
Innocence	0
Awareness	1
Developing	2
Competence	3
Optimising	4
Unassessed	U/A

Target

Overall

DISCLOSURE OF SOCIAL PROCUREMENT ACTIVITIES UNDER THE SOCIAL PROCUREMENT FRAMEWORK

FY25-26 SPF Direct Spend Metrics - Mansfield District Hospital

All suppliers	
Number of suppliers engaged	364
Total expenditure (excl. GST)	$8,840,932.48

Social benefit suppliers	
Number of social benefit suppliers engaged	1
Total expenditure with social benefit suppliers (excl. GST)	$0.00

SPF Objective: Opportunities for Victorian Aboriginal people	
SPF Outcome: Purchasing from Victorian Aboriginal businesses	
Metric 1. Number of Victorian Aboriginal businesses engaged	1
Metric 2. Total expenditure with Victorian Aboriginal businesses (excl. GST)	$0.00

SPF Objective: Opportunities for Victorians with disability	
SPF Outcome: Purchasing from Victorian Social Enterprises led by a mission for people with disability and Australian Disability Enterprises	
Metric 3. Number of Victorian social enterprises led by a mission for people with disability and Australian Disability Enterprises engaged	0
Metric 4. Total expenditure with Victorian social enterprises led by a mission for people with disability and Australian Disability Enterprises (excl. GST)	$0.00

SPF Objective: Opportunities for Victorian priority jobseekers	
SPF Outcome: Purchasing from Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers	
Metric 5. Number of Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers engaged	0
Metric 6. Total expenditure with Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers (excl. GST)	$0.00

SPF Objective: Sustainable Victorian social enterprises and Aboriginal businesses	
SPF Outcome: Purchasing from Victorian social enterprises and Aboriginal businesses	
Metric 7. Number of Victorian social enterprises engaged	0
Metric 8. Total expenditure with Victorian social enterprises (excl.GST)	$0.00
Metric 9. Number of Victorian Aboriginal businesses engaged	1
Metric 10. Total expenditure with Victorian Aboriginal businesses (excl. GST)	$0.00

DISCLOSURE OF EMERGENCY PROCUREMENT AND EMERGENCY COMPLAINTS

No emergency procurements were undertaken during the 2025-2026 financial year, resulting in nil emergency procurement expenditure. No procurement complaints were received during the year.

DISCLOSURE OF REVIEW AND STUDY EXPENSES

There were no reviews or studies undertaken in 2025-26. These include:

1. Feasibility studies
2. Scoping studies
3. Audits/reviews
4. Research and development
5. Inquiries and investigations; and
6. Impact/evaluation studies

DISCLOSURES REQUIRED UNDER LEGISLATION

Freedom of Information Act 1982

During 2025-26, Mansfield District Hospital received 19 applications. Of these requests, 0 were carried over from 2024-25. All requests were made by members of the general public.

Mansfield District Hospital made 19 FOI decisions during the 12 months ended 30 June 2026.

There were 19 decisions made within the statutory time periods without delay. A total; of 18 FOI access decisions were made where access to documents was granted in full or granted in part. 1 application was incomplete. Nil decisions were made after mandatory extensions had been applied or extensions were agreed upon by the applicant. Of requests finalised, the average number of days over/ under the statutory time (including extended timeframes) to decide the request was 16.5 days.

During 2025-26 0 requests were subject to a complaint/ internal review by Office of the Victorian Information Commissioner. No requests progressed to the Victorian Civil and Administrative Tribunal (VCAT).

Freedom of Information applications are made to the Freedom of Information Officer and are dealt with in accordance with the Act. Any charges applied are in accordance with the Act and Regulations.

Information on making a Freedom of Information request can be found at https://mdh.org.au/freedom-information-requests.html. Applications may be submitted by post or in person.

Building Act 1993

Mansfield District Hospital has complied with building and maintenance provisions of the Building Act 1993 guidelines for publicly owned buildings. Mansfield District Hospital also complied with the relevant provisions of the National Construction Code.

Mansfield District Hospital received two occupancy permits for the Mansfield PSRACS building works being undertaken by the Victorian Infrastructure Delivery Authority – Health. The first was for a stage 1a Back of House Kitchen area granted on 9/12/2025 and the second a 42 bed, 3 household aged care facility on 25/02/2026. Stage 2 will be completed in 2027.

Public Interest Disclosure Act 2012

Complaints about certain serious misconduct or corruption involving public health services in Victoria can be made by individuals directly to the Independent Broad-based Anti-Corruption Commission (IBAC). Individuals with concerns about corrupt or improper conduct are encouraged to raise the matter directly with IBAC.

Mansfield District Hospital is committed to extending the protections under the Public Interest Disclosure Act 2012 (Vic) to individuals who make protected disclosures under that Act, or who cooperate with investigations into protected disclosures. Websites of interest for complaint procedures regarding this Act are: http://www.ibac.vic.gov.au and http://www.ombudsman.vic.gov.au

Statement of National Competition Policy

Mansfield District Hospital complied with government policies regarding competitive neutrality including Competitive Neutrality Policy Victoria.

Careers Recognition Act 2012

Mansfield District Hospital has complied with its obligations under Section 11 of the Carers Recognition Act 2012 (the Act) for the reporting period 1 July 2025 to 30 June 2026.

The Health Service has taken practical measures to comply with its obligations under the Act.

These include:

- ensuring our staff have an awareness and understanding of the care relationship principles set out in the Act
- considering the care relationships principles set out in the Act when setting policies and providing services. We have employment policies allowing for flexible working arrangements and leave provisions that promote and facilitate a work life balance.
- implementing priority actions in Recognising and supporting Victoria's carers; Victorian carer strategy 2025-2035.

FRD24 ENVIRONMENTAL DATA REPORTING

MANSFIELD DISTRICT HOSPITAL ORGANISATION HIERARCHY (JUL-25 TO JUN 26)

Greenhouse Gas Emissions

G1 Total Scope 1 (direct) greenhouse gas emissions (t CO2-e)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Carbon Dioxide	229.97	178.44	146.42
Methane	0.75	0.59	0.48
Nitrous Oxide	0.76	0.59	0.49
Total	**231.49**	**179.62**	**147.39**
Scope 1 GHG emissions from stationary fuel (F2 Scope 1) (t CO2-e)	**227.77**	**178.57**	**146.81**
Scope 1 GHG emissions from vehicle fleet (T3 Scope 1) (t CO2-e)	**3.71**	**1.05**	**0.58**
Medical/Refrigerant gases - Nitrous oxide		4.91	14.79
Total Scope 1 (direct) greenhouse gas emissions (t CO2-e)	**231.49**	**184.53**	**162.18**

G2 Total Scope 2 (indirect electricity) greenhouse gas emissions (t CO2-e)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Electricity	510.30	552.01	832.71
Total Scope 2 (indirect electricity) greenhouse gas emissions (t CO2-e)	**510.30**	**552.01**	**832.71**

G3 Total Scope 3 (other indirect) greenhouse gas emissions associated with commercial air travel and waste disposal (t CO2-e)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Commercial air travel			
Waste emissions (WR5)	56.20	56.02	56.02
Indirect emissions from Stationary Energy	138.92	134.49	162.02
Indirect emissions from Transport Energy	0.94	0.27	0.15
Water emissions	12.37	15.31	20.79
Total Scope 3 greenhouse gas emissions (t CO2-e)	**208.44**	**206.09**	**238.98**

G(Opt) Net greenhouse gas emissions (t CO2-e)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Gross greenhouse gas emissions (G1 + G2 + G3) (t CO2-e)	**950.23**	**942.63**	**1,233.88**
Total gross reported greenhouse gas emissions per bed-day (t CO2-e/OBD)	0.03	0.04	0.05
Purchased LGCs	0	0	-1,040.15
Any Reduction Measures Offsets purchased (EL4-related)			-945.80
Any Offsets purchased			**-945.80**
Net greenhouse gas emissions (t CO2-e)	**950.23**	**942.63**	**288.08**

Electricity Use

EL1 Total electricity consumption segmented by source (MWh)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Purchased	775.87	836.55	1,240.96
Self-generated	-0.20	-0.21	-0.29
EL1 Total electricity consumption (MWh)	**775.67**	**836.33**	**1,240.66**

Electricity Use Continued

EL2 On site-electricity generated (MWh) segmented by:	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Consumption behind-the-meter			
Solar Electricity	-0.20	-0.21	-0.29
Total Consumption behind-the-meter (MWh)	**-0.20**	**-0.21**	**-0.29**
Exports			
Solar Electricity	0.29	0.21	0.20
Total Electricity exported (MWh)	**0.29**	**0.21**	**0.20**
EL2 Total On site-electricity generated (MWh)	**0.00**	**0.00**	**0.00**

EL3 On-site installed generation capacity (kW converted to MW) segmented by:	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Diesel Generator	0.35	0.35	0.35
Solar System	0.07	0.07	0.15
EL3 Total On-site installed generation capacity (MW)	**0.42**	**0.42**	**0.50**

EL4 Total electricity offsets segmented by offset type (MWh)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
LGCs voluntarily retired on the entity's behalf			1,130.60
RPP (Renewable Power Percentage in the grid)	145.55	153.13	212.91
EL4 Total electricity offsets (MWh)	**145.55**	**153.13**	**1,240.96**

Stationary Energy

F1 Total fuels used in buildings and machinery segmented by fuel type (MJ)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
LPG	3,758,617.40	2,946,754.10	2,422,641.30
F1 Total fuels used in buildings (MJ)	**3,758,617.40**	**2,946,754.10**	**2,422,641.30**

F2 Greenhouse gas emissions from stationary fuel consumption segmented by fuel type (t CO2-e)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
LPG	227.77	178.57	146.81
F2 Greenhouse gas emissions from stationary fuel consumption (tCO2-e)	**227.77**	**178.57**	**146.81**

Transport Energy

T1 Total energy used in transportation (vehicle fleet) within the Entity, segmented by fuel type (MJ)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Non-executive fleet - Gasoline	54,911.40	15,495.90	8,577.60
Petrol	**54,911.40**	**15,495.90**	**8,577.60**
Total energy used in transportation (vehicle fleet) (MJ)	**54,911.40**	**15,495.90**	**8,577.60**

T3 Greenhouse gas emissions from transportation (vehicle fleet) segmented by fuel type (t CO2-e)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Non-executive fleet - Gasoline	3.71	1.05	0.58
Petrol	**3.71**	**1.05**	**0.58**
Non-executive fleet - Diesel		0.00	0.00
Diesel		**0.00**	**0.00**
Total Greenhouse gas emissions from transportation (vehicle fleet) (t CO2-e)	**3.71**	**1.05**	**0.58**

Total Energy Use

E1 Total energy usage from fuels, including stationary fuels (F1) and transport fuels (T1) (MJ)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Total energy usage from stationary fuels (F1) (MJ)	3,758,617.40	2,946,754.10	2,422,641.30
Total energy usage from transport (T1) (MJ)	54,911.40	15,495.90	8,577.60
Total energy usage from fuels, including stationary fuels (F1) and transport fuels (T1) (MJ)	**3,813,528.80**	**2,962,250.00**	**2,431,218.90**

E2 Total energy usage from electricity (MJ)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Total energy usage from electricity (MJ)	2,792,399.87	3,010,804.70	4,466,392.96

E3 Total energy usage segmented by renewable and non-renewable sources (MJ)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Renewable	523,258.69	550,510.53	4,466,393.10
Non-renewable (E1 + E2 - E3 Renewable)	6,082,669.98	5,422,544.17	2,431,218.76

E4 Units of Stationary Energy used normalised: (F1+E2)/normaliser	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Energy per unit of Aged Care OBD (MJ/Aged Care OBD)	285.21	280.01	317.97
Energy per unit of LOS (MJ/LOS)	1,323.71	1,130.90	1,232.61
Energy per unit of bed-day (LOS+Aged Care OBD) (MJ/OBD)	234.65	224.44	252.76
Energy per unit of Separations (MJ/Separations)	3,623.35	2,601.55	3,186.42
Energy per unit of floor space (MJ/m2)	988.98	899.39	795.01

Water Use

W1 Total units of metered water consumed by water source (kL)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Potable water (kL)	7,370.85	9,359.80	14,822.14
Total units of water consumed (kL)	**7,370.85**	**9,359.80**	**14,822.14**

W2 Units of metered water consumed normalised by FTE, headcount, floor area, or other entity or sector specific quantity	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Water per unit of Aged Care OBD (kL/Aged Care OBD)	0.32	0.44	0.68
Water per unit of LOS (kL/LOS)	1.49	1.78	2.65
Water per unit of bed-day (LOS+Aged Care OBD) (kL/OBD)	0.26	0.35	0.54
Water per unit of Separations (kL/Separations)	4.08	4.09	6.86
Water per unit of floor space (kL/m2)	1.11	1.41	1.71

Waste and Recycling

WR1 Total units of waste disposed of by waste stream and disposal method (kg)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Landfill (total)			
General waste - skips	40,716.00	40,594.50	40,594.50
Offsite treatment			
Clinical waste - incinerated	19.38		
Clinical waste - sharps	254.06	253.02	253.02
Clinical waste - treated	2,249.56	2,245.28	2,245.28
Recycling/recovery (disposal)			
Cardboard	4,290.00	4,275.78	
Commingled	8,580.00	8,557.24	
Total units of waste disposed (kg)	**56,109.00**	**55,925.82**	**43,092.80**

WR1 Total units of waste disposed of by waste stream and disposal method (%)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Landfill (total)			
General waste - skips	72.57%	72.59%	94.20%
Offsite treatment			
Clinical waste - incinerated	0.03%		
Clinical waste - sharps	0.45%	0.45%	0.59%
Clinical waste - treated	4.01%	4.01%	5.21%
Recycling/recovery (disposal)			
Cardboard	7.65%	7.65%	
Commingled	15.29%	15.30%	

WR3 Total units of waste disposed normalised by FTE, headcount, floor area, or other entity or sector specific quantity, by disposal method	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Total waste to landfill per patient treated ((kg general waste)/PPT)	1.37	1.41	1.38
Total waste to offsite treatment per patient treated ((kg offsite treatment)/PPT)	0.08	0.09	0.08
Total waste recycled and reused per patient treated ((kg recycled and reused)/PPT)	0.43	0.45	

WR4 Recycling rate (%)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
Weight of recyclable and organic materials (kg)	12,870.00	12,833.02	
Weight of total waste (kg)	56,109.00	55,925.82	43,092.80
Recycling rate (%)	**22.94%**	**22.95%**	

WR5 Greenhouse gas emissions associated with waste disposal (t CO2-e)	Jul 23- Jun 24	Jul 24- Jun 25	Jul 25 - Jun 26
t CO2-e	56.20	56.02	56.02

Note: Indicators are not reported where data is unavailable or an indicator is not relevant to the organisation's operations

ADDITIONAL INFORMATION AVAILABLE ON REQUEST

In compliance with the requirements of the Standing Directions 2018 under the Financial Management Act 1994, details in respect of the items listed below have been retained by Mansfield District Hospital and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the provisions of the Freedom of Information Act 1982,

- a statement that declarations of pecuniary interests have been duly completed by all relevant officers
- details of shares held by senior officers as nominee or held beneficially in a statutory authority or subsidiary;
- details of publications produced by Mansfield District Hospital about itself, and how these can be obtained;
- details of changes in prices, fees, charges, rates and levies charged by Mansfield District Hospital;
- details of any major external reviews carried out on the health service;
- details of major research and development activities undertaken by Mansfield District Hospital;
- details of overseas visits undertaken including a summary of the objectives and outcomes of each visit;
- details of major promotional, public relations and marketing activities undertaken by Mansfield District Hospital to develop community awareness of the health service;
- details of assessments and measures undertaken to improve the occupational health and safety of employees;
- a general statement on industrial relations within the health service and details of time lost through industrial accidents and disputes;
- a list of major committees sponsored by Mansfield District Hospital, the purposes of each committee and the extent to which those purposes have been achieved; and
- details of all consultancies and contractors including consultants/contractors engaged, services provided, and expenditure committed for each engagement.

This information is available on request from;

Freedom of Information officer
Mansfield District Hospital
PO Box 139, Mansfield, VIC 3722

Phone: **(03) 5775 8800**

Email: **foi@mdh.org.au**

LOCAL JOBS FIRST ACT 2003

No projects undertaken by Mansfield District Hospital during 2025-2026 met the threshold for Local Jobs First Policy application. As such, no local Industry Development Plans were required or submitted.

COMPLIANCE ATTESTATIONS AND DECLARATIONS

FINANCIAL MANAGEMENT COMPLIANCE ATTESTATION

I, Matthew Hoskin, on behalf of the Responsible Body, certify that Mansfield District Hospital has no Material Compliance Deficiency with respect to the applicable Standing Directions under the Financial Management Act 1994 and Instructions.



Mr. Matthew Hoskin 5 October 2026

Chair, Board of Directors
Mansfield District Hospital

DATA INTEGRITY DECLARATION

I, Michelle Spence, certify that Mansfield District Hospital has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. Mansfield District Hospital has critically reviewed these controls and processes during the year.



Michelle Spence 5 October 2026

Accountable Officer
Mansfield District Hospital

INTEGRITY, FRAUD AND CORRUPTION DECLARATION

I, Michelle Spence, certify that Mansfield District Hospital has put in place appropriate internal controls and processes to ensure that integrity, fraud and corruption risks have been reviewed and addressed at Mansfield District Hospital during the year.



Michelle Spence 5 October 2026

Accountable Officer
Mansfield District Hospital

CONFLICT OF INTEREST DECLARATION

I, Michelle Spence, certify that Mansfield District Hospital has put in place appropriate internal controls and processes to ensure that it has implemented a Conflict-of-Interest policy consistent with the minimum accountabilities required by the VPSC. Declaration of private interest forms have been completed by all executive staff within Mansfield District Hospital and members of the Board, and all declared conflicts have been addressed and are being managed. Conflict of interest is a standard agenda item for declaration and documentation at each executive board meeting.



Michelle Spence 5 October 2026

Accountable Officer
Mansfield District Hospital

COMPLIANCE WITH HEALTH SHARE VICTORIA (HSV) PURCHASING POLICIES

I, Michelle Spence, on behalf of Mansfield District Hospital certify that Mansfield District Hospital has no material compliance deficiency with respect to the HSV Purchasing Policies as required by the Health Services Act 1988 (Vic). While instances of non-material non-compliance have been identified during the reporting period, Mansfield District Hospital has an agreement in place with HealthShare Victoria to address and rectify these issues. These instances do not constitute material non-compliance and have not had a significant impact on procurement governance or operational integrity. Mansfield District Hospital has implemented appropriate internal controls, which have been critically reviewed throughout the year.



Michelle Spence 5 October 2026

Accountable Officer
Mansfield District Hospital

STATEMENT OF PRIORITIES – PART A: DEPARTMENT OF HEALTH STRATEGIC PLAN

In 2025-26 Mansfield District Hospital contributed to the achievement of the Victorian Government's commitments by:

INNOVATE AND IMPROVE ACCESS AND CARE

We aim for the best patient experience and care outcomes by assuring safe practice, leadership of safety, an engaged and capable workforce, and continuing to improve and innovate care

Goals	Health Service Deliverables	Achievements/Outcome
Align with the Victorian Clinical Governance Framework to strengthen clinical governance systems, ensuring safe, high-quality care.	Demonstrate high quality care in which consumer engagement and input is actively sought, facilitated and used to drive system change to improve consumer experience and outcomes.	Status: Ongoing Consumer representatives on Board level Safety and Quality meeting, Community Advisory committee and Audit and Risk Committee. Consumer involvement in Residential Aged Care meetings and Older Person Advisory group.
	Ensure that health service reporting, reviews and decision-making are underpinned by a safety culture and systems that are transparent, accurate and fair to staff and consumers.	Status: Ongoing Mansfield District Hospital (MDH) maintains transparent incident reporting processes, undertaking multidisciplinary reviews of adverse events, involving consumers in governance and improvement activities, and using reliable data to inform decision-making. MDH ensures incident investigations focus on learning and system improvement while treating staff and consumers fairly and respectfully. MDH maintains regular reporting to governance committees to ensure accountability and continuous improvement
	Health services can show evidence of a comprehensive training program approach that includes performance management, accountability, and continuous improvement.	Status: Ongoing MDH maintains a comprehensive training and development framework that supports workforce capability, performance management, and accountability. Training compliance and competency data are monitored through governance structures. Incident reviews, audit outcomes, consumer feedback, and workforce needs assessments inform continuous improvement activities. Education programs are regularly evaluated to ensure they remain effective, relevant, and aligned with health service priorities and safety objectives.
Maintain a commitment to delivering equitable and timely access to planned care and drive reform in alignment with the Planned Surgery Reform Blueprint.	Implement and scale theatre optimisation initiatives in planned surgery, for example same-day surgery by default models of care, criteria-led discharge, monitoring of theatre measures, and high-throughput approaches such as high-intensity theatre lists.	Status: Ongoing MDH maintains clear surgical optimisation planning with all visiting surgeons and local medical practitioners. Local review of surgical efficiencies and data led planning.
	Proactively manage planned surgery and specialist clinics (or outpatients) waitlist, for example, validating and supporting patients into optimal care pathways such as evidence-based alternatives to surgery and optimisation pathways. A particular focus should be applied to long-waiting patients and priority population groups (for example, Aboriginal and Torres Strait Islander patients and under-18 patients).	Status: Ongoing MDH works in collaboration with all visiting surgeons and specialists to support and optimism individual care pathways within the HUME region, this includes considering the individual needs of minority groups including Aboriginal and Torres strait islander community members.

PRUDENT, SUSTAINABLE AND EFFECTIVE USE OF RESOURCES

We are innovative and resourceful in balancing improved patient care, operational performance, and system management to ensure a financially secure health system. We invest in a skilled and future-ready workforce, maintaining a modern, safe, and resilient healthcare system for all Victorians.

Goals	Health Service Deliverables	Achievements/Outcome
Develop and implement initiatives to strengthen financial sustainability. By delivering sustainable, responsible budgets, we can ensure a well-managed, viable, and sustainable health system for the future.	Deliver the key initiatives outlined in the Budget Action Plan within Government parameters.	Status: Achieved Key deliverables were implemented as part of financial savings plan. Nursing recruitment strategy, nil use of agency since July 2024, reduction in staff overtime and reduction in medical staff recall.
	Utilise data analytics and performance metrics to identify areas of inefficiency and waste and make evidence-based decisions to improve financial sustainability and operational performance.	Status: Ongoing Continuous reporting of financial results and data to management via internal performance meetings. Support in interpretation of results to engage management in the identification of areas of efficiency improvement. Utilisation of information provided by management to inform budgeting and forecasting, supporting financial sustainability. Implementation of plans developed in collaboration with management and executive for improvement of operational performance.
	Use funding efficiently and effectively to optimise patient facing services. Undertake program to reduce the cost-of-service delivery, improve safety, capacity and reduce unnecessary waiting.	Status: Ongoing Key deliverables were implemented as part of financial savings plan with no change to operational activity and organisational growth.

A STRONGER WORKFORCE

We strive to foster an equitable, skilled and supported workforce that builds professional capabilities to meet current and future roles.

Goals	Health Service Deliverables	Achievements/Outcome
Position Victoria as a leader in employee experience, capability, and capacity by focusing on future roles and professional development in line with the Victorian Workforce Strategy to ensure a regenerative and sustainable workforce.	Implement processes to sustain workforce supply and fulfill obligations, including those under the Gender Equality Act 2020 by improving employee experience in leadership, health and safety, flexibility, career development, and agility to ensure safe, high-quality care.	Status: Ongoing Organisationally imbedded wellbeing initiatives throughout the year, via the Employee Engagement committee. Includes but not limited to, the development of the Workplace trainer role, Nurse Practitioner candidate program and local Leadership development programs. Development of the Hume Ruralist Post Graduate Year 2 Program promoting Rural generalist medical workforce for the future. Enhancement of residential aged care workforce allowing for multidisciplinary practice to enhance the experience of residents through the establishment of a stimulating, safe and homelike environment. Ongoing collaboration and partnering with regional and metropolitan health services to provide secondment opportunities for speciality nursing staff will continue.

Goals	Health Service Deliverables	Achievements/Outcome
		Urgent Care Nurse Practitioner education collaboration with Alfred Health Emergency Department has been successful. Ongoing development of Obstetric surgical exposure training in partnership with Northeast Health Wangaratta and Albury Wodonga Health. Development of Mansfield District Hospital multi-disciplinary education and simulation training program; a medical, Nursing, Allied Health and Ambulance Victoria collaboration. Mansfield District Hospital Workforce Strategic plan 2026-2029.
	Collaborate with the department to improve workforce data analytics, generate actionable insights, and enhance strategic planning.	Status: Ongoing Workforce data reviewed via Hume Local Health Service Network, Clinical Service planning workshops. Data supporting the development of the Mansfield District Hospital Workforce Strategic plan 2026-2029.

IMPROVING ABORIGINAL HEALTH AND WELLBEING

Strengthen cultural safety in Victoria's health system by fostering strong connections to Aboriginal culture, creating holistic, accessible, and empowering health system.

Goals	Health Service Deliverables	Achievements/Outcome
Enhance Delivery and Access to Culturally Safe Services, fostering strong connections to culture. Address racism and provide Aboriginal people with culturally safe healthcare and referral pathways between mainstream and community-controlled health services.	Deliver high-quality cultural safety training to all executives and staff using independent expert, community-controlled organisations or a registered Aboriginal business.	Status: Achieved Mansfield District Hospital continues to grow its Aboriginal and Torres Strait inlander cultural safety and inclusion training through face-to-face education and engagement sessions for all Board members, Executive and Leaders, all sessions are facilitated by Aunty Robynne Nelson, Mulana Kaalinya "Strong Spirit". All staff have access to Cultural Awareness training through the MDH Learning Management System.
	Health service executives and senior leaders stablish and maintain strong, ongoing partnerships with Aboriginal community -controlled organisations and/or recognised Aboriginal leaders within their local catchments. These partnerships must be based on regular, proactive engagement that prioritises the voices, self-determination priorities, and cultural knowledge of Aboriginal communities in the design, delivery, and evaluation of health and wellbeing services.	Status: Ongoing Continue to engage, link and attend meetings with Gadhaba Local Indigenous Network where discussions take place regarding MDH services, barriers to access and future service redesign. Gadhaba representative on MDH Community Advisory and engagement committee (COMAD). Chief Executive Officer representation on the Ovens & Murray Aboriginal Health Forum and committee. Aboriginal cultural safety enhanced through use of artwork acknowledging the traditional owners throughout MDH. Collaborating with Gadhaba Local Indigenous Network has led to identifying culturally sensitive place names and art which will be is included in the aged care redevelopment.
	Ensure culturally appropriate systems for identifying Aboriginal and Torres Strait Islander patients and implement responsive discharge plans and referral pathways.	Status: Achieved/Ongoing As a member of the Aboriginal Health Innovation Initiative Steering Committee, we have reviewed Admission and Discharge policies, Work Instructions and Risk Assessment tools to strengthen Aboriginal and Torres Strait Islander patient identification, risk and clinical assessment including cultural needs. We have embedded the Hume Aboriginal persons patient journey booklet.

MOVING FROM COMPETITION TO COLLABORATION

We are committed to transforming Victoria's health system by partnering with care providers and health services to share knowledge, information, and resources.

Goals	Health Service Deliverables	Achievements/Outcome
Collaborate within the Local Health Service Network to build a more integrated health system, with better access and experience for patients, strengthened workforce, consistently high-quality care, and more sustainable healthcare delivery.	Meet all objectives agreed to in the Local Health Service Network Statement of Expectations across priority areas (access, equity and flow, workforce, safety and quality, and shared services).	Status: Ongoing The Hume Local Health Service Network has successfully met all objectives outlined in its Statement of Expectations, demonstrating strong performance across access, equity and flow; workforce; safety and quality; and shared services. Overall, targets have been achieved, supported by the successful recruitment of key Network staff. Where delays have occurred, these have been appropriately communicated to, and endorsed by, the Department of Health. The Hume Network has established robust collaboration and governance arrangements through a comprehensive foundation process, shaped by active contributions from all member health service Chief Executive Officers and Board Chairs. Broad Health Service representation across committees supports collective, system-focused decision-making, strengthening the Network's ability to respond to challenges and improve health outcomes across Hume. This work has positioned the Network to enable genuine, sustained collaboration. The Network finalised its Strategy 2026–2028 following extensive consultation with members. The Strategy provides a clear three-year roadmap to strengthen collaboration, improve equitable access, and enhance the quality and sustainability of health services across the Network. Bringing together twelve public health services, the Network is focused on improving system effectiveness and efficiency through coordinated planning, shared expertise, and reduced duplication.

STATEMENT OF PRIORITIES – PART B: PERFORMANCE PRIORITIES*

HIGH QUALITY AND SAFE CARE

Key Performance Measure	Target	Result
Infection prevention and control		
Percentage of healthcare workers immunised for influenza	94%	99%
Adverse events		
Percentage of reporting sentinel events for which a root cause analysis (RCA) report was submitted within 30 business days from notification of the event	All RCA reports submitted within 30 business days	100%
Aged Care		
Public sector residential aged care services overall star rating	Minimum rating of 3 stars	100%
Patient experience		
Percentage of patients who reported positive experience of their hospital stay	95%	100%
Aboriginal Health		
Difference between the percentage of Aboriginal patients and non-Aboriginal patients who left against medical advice	0%	0%

STRONG GOVERNANCE, LEADERSHIP AND CULTURE

Key Performance Measure	Target	Result
Organisational culture		
People matter survey – Percentage of staff with an overall positive response to safety culture survey questions**	80%	78%

EFFECTIVE FINANCIAL MANAGEMENT

Key Performance Measure	Target	Result
Operating result ($m)	0.00	-$0.172
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	1.17
Variance between forecast and actual operating result (OR) as a percentage of the forecast OR for the current financial year ending 30 June	5% movement in forecast revenue and expenditure forecasts	Achieved

* The data included in this annual report was accurate at the time of publication and is subject to validation by official sources from the Department of Health

**Changes to the 2025-2026 Health Sector People Matter Survey has affected the Percentage of staff with an overall positive response to safety culture survey questions' measure. Historical results are not directly comparable and should be interpreted with consideration of a break in the time series.

STATEMENT OF PRIORITIES – PART C: ACTIVITY AND FUNDING

Funding type	2025-26 Activity Achievement
Consolidated Activity Funding	
Acute admitted, subacute admitted, emergency services, non-admitted NWAU	359
Aged Care	
Residential aged care	21,909
HACC	1,827
Primary Health	
Community health/primary care programs	3,094
Small Rural	
Small Rural Acute	89

*The data included in this annual report was accurate at the time of publication and is subject to validation by official sources from the Department of Health

FINANCIAL STATEMENTS

FOR THE FINANCIAL YEAR ENDED 30 JUNE 2026

ABN 65 866 548 895

MANSFIELD DISTRICT HOSPITAL

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FINANCIAL STATEMENTS
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2026

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

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

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2026 and the financial position of Mansfield District Hospital at 30 June 2026.

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

We authorise the attached financial statements for issue on 5 October, 2026.

Mr. Matthew Hoskin
Board Chair

Mansfield
5 October, 2026

Ms. M. Spence
Chief Executive Officer

Mansfield
5 October, 2026

Ms. Rita Ruyters
Chief Financial and Accounting Officer (Contract)

Mansfield
5 October, 2026

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Mansfield District Hospital

Opinion	I have audited the financial report of Mansfield District Hospital (the health service) which comprises the: • balance sheet as at 30 June 2026 • comprehensive operating statement for the year then ended • statement of changes in equity for the year then ended • cash flow statement for the year then ended • notes to the financial statements, including material accounting policy information • board member's, accountable officer's and chief finance & accounting officer's declaration. In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2026 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and Australian Accounting Standards – Simplified Disclosures.
Basis for Opinion	I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. I further describe my responsibilities under that Act and those standards in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report. My independence is established by the *Constitution Act 1975.* My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants (including Independence Standards)* (the Code) that are relevant to my audit of the financial report in Victoria. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.
Board's responsibilities for the financial report	The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards – Simplified Disclosures and the *Financial Management Act 1994*, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error. In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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



MELBOURNE
6 October 2026

Simone Bohan
as delegate for the Auditor-General of Victoria

COMPREHENSIVE OPERATING STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2026

	Note	Total 2026 $'000	Total 2025 $'000
Revenue and income from transactions			**5**
Revenue from contracts with customers	2.1 (a)	12,830	10,931
Government Grants	2.1 (b)	38,126	36,935
Other sources of income	2.1 (c)	3,394	3,589
Total revenue and income from transactions		**54,350**	**51,455**
Expenses from transactions			
Employee expenses	3.1 (a)	(25,736)	(24,459)
Supplies and consumables	3.1 (c)	(2,697)	(2,108)
Depreciation and amortisation	4.1 (a)	(3,078)	(2,788)
Other operating expenses	3.1 (d)	(4,272)	(4,129)
Total expenses from transactions		**(35,783)**	**(33,484)**
Net result from transactions - net operating balance		**18,567**	**17,971**
Other economic flows included in net result			
Net gain/(loss) on sale of non-financial assets		38	-
Other gain/(loss) from other economic flows		43	21
Total other economic flows included in net result		**81**	**21**
Net result		**18,648**	**17,992**
Comprehensive result		**18,648**	**17,992**

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

BALANCE SHEET
AS AT 30 JUNE 2026

	Note	Total 2026 $'000	Total 2025 $'000
Financial asset			
Cash and cash equivalents	6.2	21,458	19,306
Receivables	5.1	2,104	2,578
Contract assets		81	-
Total financial assets		**23,643**	**21,884**
Non-financial assets			
Prepayments		294	138
Inventories		142	139
Property, plant and equipment	4.1	72,570	53,399
Investment property	4.3	721	714
Total non-financial assets		**73,727**	**54,390**
Total assets		**97,370**	**76,274**
Liabilities			
Payables	5.2	3,416	1,913
Contract liabilities	5.3	489	849
Borrowings	6.1	481	320
Employee benefits	3.1(b)	5,962	6,060
Monies held in trust	5.4	11,916	10,684
Total liabilities		**22,274**	**19,826**
Net assets		**75,096**	**56,448**
Equity			
Reserves		38,800	38,800
Contributed capital		10,853	10,853
Accumulated surplus/(deficit)		25,443	6,795
Total equity		**75,096**	**56,448**

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

CASH FLOW STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2026

	Note	Total 2026 $'000	Total 2025 $'000
Cash flows from operating activities			
Receipts from Government		28,073	24,166
Commercial activity revenue received		2,751	2,546
Donations and bequests received		317	388
Interest and investment income received		963	1,078
Other receipts		2,524	1,588
Total receipts		**34,628**	**29,766**
Payments to employees		(26,254)	(21,694)
Payments to suppliers and consumables		(2,890)	(5,495)
GST received / (paid) to ATO		810	637
Other payments		(3,667)	(2,424)
Total payments		**(32,001)**	**(28,976)**
Net cash flows from/(used in) operating activities		**2,627**	**790**
Cash flows from investing activities			
Proceeds from sale of non-financial assets		38	58
Purchase of non-financial assets		(1,828)	(1,349)
Other capital receipts		144	52
Net cash flows from/(used in) investing activities		**(1,646)**	**(1,239)**
Cash flows from financing activities			
Repayment of borrowings and principal portion of lease liabilities		(61)	(32)
Receipt of accommodation deposits		4,779	(3,793)
Repayment of accommodation deposits		(3,547)	3,157
Net cash flows from/(used in) financing activities		**1,171**	**(668)**
Net increase/(decrease) in cash and cash equivalents held		**2,152**	**(1,117)**
Cash and cash equivalents at beginning of year		19,306	20,423
Cash and cash equivalents at end of year	**6.2**	**21,458**	**19,306**

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

STATEMENT OF CHANGES IN EQUITY
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2026

	Property, Plant and Equipment Revaluation Surplus $'000	Contributed Capital $'000	Accumulated Surplus/ (Deficit) $'000	Total $'000
Balance at 1 July 2024	**38,800**	**10,853**	**(11,197)**	**38,456**
Net result for the year	-	-	17,992	17,992
Balance at 30 June 2025	**38,800**	**10,853**	**6,795**	**56,448**
Net result for the year	-	-	18,648	18,648
Balance at 30 June 2026	**38,800**	**10,853**	**25,443**	**75,096**

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

NOTES TO THE FINANCIAL STATEMENTS
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2026

NOTE 1: ABOUT THIS REPORT

These financial statements represent the financial statements of Mansfield District Hospital for the year ended 30 June 2026.

Mansfield District Hospital is a not-for-profit entity established as a public agency under the Health Services Act 1988 (Vic). A description of the nature of its operations and its principal activities is included in the Report of Operations, which does not form part of these financial statements.

This section explains the basis of preparing the financial statements.

Structure

1.1 BASIS OF PREPARATION
1.2 MATERIAL ACCOUNTING ESTIMATES AND JUDGEMENTS
1.3 REPORTING ENTITY
1.4 ECONOMIC DEPENDENCY

NOTE 1.1 BASIS OF PREPARATION

These financial statements are Tier 2 general purpose financial statements which have been prepared in accordance with AASB 1060 General Purpose Financial Statements – Simplified Disclosures for For-Profit and Not-for-Profit Tier 2 Entities (AASB 1060) and Financial Reporting Direction 101 Application of Tiers of Australian Accounting Standards (FRD 101).

These general purpose financial statements have been prepared in accordance with the Financial Management Act 1994 and applicable Australian Accounting Standards (AASs), which include interpretations, issued by the Australian Accounting Standards Board (AASB).

Where appropriate, those AASs paragraphs applicable to not-for-profit entities have been applied. Accounting policies selected and applied in these financial statements ensure the resulting financial information satisfies the concepts of relevance and reliability, thereby ensuring that the substance of the underlying transactions or other events is reported.

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

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

The financial statements have been prepared on a going concern basis (refer to Note 1.4 Economic Dependency).

The financial statements are presented in Australian dollars.

The amounts presented in the financial statements have been rounded to the nearest thousand dollars. Minor discrepancies in tables between totals and sum of components are due to rounding.

The annual financial statements were authorised for issue by the Board of Mansfield District Hospital on 5th October 2026.

NOTE 1.2 MATERIAL ACCOUNTING ESTIMATES AND JUDGEMENTS

Management makes estimates and judgements when preparing the financial statements.

These estimates and judgements are based on historical knowledge and the best available current information and assume any reasonable expectation of future events. Actual results may differ.

Revisions to estimates are recognised in the period in which the estimate is revised and also in future periods that are affected by the revision.

The material accounting judgements and estimates used, and any changes thereto, are disclosed within the relevant accounting policy.

NOTE 1.3 REPORTING ENTITY

The financial statements include all the controlled activities of Mansfield District Hospital.

Mansfield District Hospital's principal address is:

53 Highett Street
Mansfield, Victoria 3722

NOTE 1.4 ECONOMIC DEPENDENCY

Mansfield District Hospital is a public health service governed and managed in accordance with the Health Services Act 1988 and its results form part of the Victorian General Government consolidated financial position. Mansfield District Hospital provides essential services and is predominantly dependent on the continued financial support of the State Government, particularly the Department of Health, and the Commonwealth funding via the National Health Reform Agreement (NHRA). The State of Victoria plans to continue Mansfield District Hospital operations and on that basis, the financial statements have been prepared on a going concern basis.

NOTES TO THE FINANCIAL STATEMENTS
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2026

NOTE 2: FUNDING DELIVERY OF OUR SERVICES

Mansfield District Hospital's overall objective is to provide quality health service that support and enhance the wellbeing of the local community. Mansfield District Hospital is predominantly funded by grant funding for the provision of outputs. Mansfield District Hospital also receives income from the supply of services.

Significant judgement – Grant revenue

Mansfield District Hospital has made the judgement that amounts received in relation to activity based funding should be recognised under AASB 15 on the basis where the Health Service does not achieve the relevant target or occupancy levels, funding will be recallable.

Structure

2.1 REVENUE AND INCOME FROM TRANSACTIONS

NOTE 2.1 REVENUE AND INCOME FROM TRANSACTIONS

	Note	Total 2026 $'000	Total 2025 $'000
Revenue from contracts with customers	2.1 (a)	12,830	10,931
Government Grants	2.1 (b)	38,126	36,935
Other sources of income	2.1 (c)	3,394	3,589
Total revenue and income from transactions		**54,350**	**51,455**

NOTE 2.1(A) REVENUE FROM CONTRACTS WITH CUSTOMERS

	Total 2026 $'000	Total 2025 $'000
Government grants (State) - Operating	758	440
Government grants (Commonwealth) - Operating	9,073	7,717
Patient and resident fees	2,602	2,447
Commercial activities	397	327
Total revenue from contracts with customers	**12,830**	**10,931**

How we recognise revenue from contracts with customers

Government grants

Revenue from government operating grants that are enforceable and contain sufficiently specific performance obligations are accounted for as revenue from contracts with customers under AASB 15.

In contracts with customers, the 'customer' is the funding body, who is the party that promises funding in exchange for Mansfield District Hospital's goods or services. Mansfield District Hospital funding bodies often direct that goods or services are to be provided to third party beneficiaries, including individuals or the community at large. In such instances, the customer remains the funding body that has funded the program or activity, however the delivery of goods or services to third party beneficiaries is a characteristic of the promised good or service being transferred to the funding body.

This policy applies to each of Mansfield District Hospital's revenue streams, with information detailed below relating to Mansfield District Hospital's material revenue streams:

Government grant	Performance obligation
Activity Based Funding (ABF) paid as National Weighted Activity Unit (NWAU)	NWAU is a measure of health service activity expressed as a common unit against which the national efficient price (NEP) is paid. The performance obligations for NWAU are the number and mix of admissions, emergency department presentations and outpatient episodes, and is weighted for clinical complexity. Revenue is recognised at point in time, which is when a patient is discharged.
Commonwealth Residential Aged Care Grants	Funding is provided for the provision of care for aged care residents within facilities at Mansfield District Hospital. The performance obligations include provision of residential accommodation and care from nursing staff and personal care workers. Revenue is recognised at the point in time when the service is provided within the residential aged care facility.

Patient and resident fees

Patient and resident fees are charges incurred by patients for services they receive. Patient and resident fees are recognised under AASB 15 at a point in time when the performance obligation, the provision of services, is satisfied, except where the patient and resident fees relate to accommodation charges. Accommodation charges are calculated daily and are recognised over time, to reflect the period accommodation is provided.

NOTE 2.1(B) GOVERNMENT GRANTS

	Total 2026 $'000	Total 2025 $'000
Government grants (State) - Operating	16,513	16,040
Government grants (State) - Capital	21,613	20,895
Total Government grants	**38,126**	**36,935**

How we recognise Government grants

Government grants

Mansfield District Hospital recognises income of not-for-profit entities under AASB 1058 where it has been earned under arrangements that are either not enforceable or linked to sufficiently specific performance obligations.

Income from grants without any sufficiently specific performance obligations or that are not enforceable, is recognised when Mansfield District Hospital has an unconditional right to receive cash which usually coincides with receipt of cash. On initial recognition of the asset, Mansfield District Hospital recognises any related contributions by owners, increases in liabilities, decreases in assets or revenue (related amounts) in accordance with other Australian Accounting Standards.

Related amounts may take the form of:

- revenue or contract liability arising from a contract with a customer, in accordance with AASB 15
- a lease liability in accordance with AASB 16 Leases
- a financial instrument, in accordance with AASB 9 Financial Instruments
- a provision, in accordance with AASB 137 Provisions, Contingent Liabilities and Contingent Assets

Capital grants

Where Mansfield District Hospital receives a capital grant it recognises a liability, equal to the financial asset received less amounts recognised under other Australian Accounting Standards.

Income is recognised in accordance with AASB 1058 progressively as the asset is constructed which aligns with Mansfield District Hospital's obligation to construct the asset. The progressive percentage of costs incurred is used to recognise income, as this most accurately reflects the stage of completion.

Non-cash contributions from the Department of Health

The DH makes some payments on behalf of Mansfield District Hospital as follows:

Supplier	Description
Victorian Managed Insurance Authority	The Department of Health purchases non- medical indemnity insurance for Mansfield District Hospital which is paid directly to the Victorian Managed Insurance Authority. To record this contribution, such payments are recognised as income with a matching expense in the net result from transactions
Victorian Infrastructure Delivery Authority	The Department of Health made payments to the Victorian Infrastructure Delivery Authority to fund capital works projects during the year ended 30 June 2026, on behalf of Mansfield District Hospital
Department of Health	Long Service Leave (LSL) revenue is recognised upon finalisation of movements in LSL liability in line with the long service leave funding arrangements with the DH

NOTE 2.1(C) OTHER SOURCES OF INCOME

	Total 2026 $'000	Total 2025 $'000
Other capital purpose income	144	21
Capital donations	317	440
Other income from operating activities	1,970	1,745
Income from non-operating activities	963	1,383
Total other sources of income	**3,394**	**3,589**

NOTES TO THE FINANCIAL STATEMENTS
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2026

NOTE 3: THE COST OF DELIVERING OUR SERVICES

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

Structure

3.1 EXPENSES INCURRED IN THE DELIVERY OF SERVICES

NOTE 3.1 EXPENSES INCURRED IN THE DELIVERY OF SERVICES

	Note	Total 2026 $'000	Total 2025 $'000
Employee expenses	3.1 (a)	25,736	24,459
Supplies & Consumables	3.1 (b)	2,697	2,108
Other operating expenses	3.1 (c)	4,272	4,129
Total expenses incurred in the delivery of services		**32,705**	**30,696**

NOTE 3.1(A) EMPLOYEE EXPENSES

	Total 2026 $'000	Total 2025 $'000
Salaries and wages	20,945	19,253
Superannuation expense [1]	2,302	2,069
Agency expenses	23	396
Fee for service medical officer expenses	2,466	2,741
Total employee expenses	**25,736**	**24,459**

(1) Defined contribution superannuation expense and defined benefit superannuation expense have been combined.

How we recognise employee expenses

Employee expenses include salaries and wages, fringe benefits tax, leave entitlements, termination payments, WorkCover payments and agency expenses.

The amount recognised in relation to superannuation is employer contributions for members of both defined benefit and defined contribution superannuation plans that are paid or payable during the reporting period.

NOTE 3.1(B) EMPLOYEE RELATED PROVISIONS

	Total 2026 $'000	Total 2025 $'000
Current provisions for employee benefits		
Annual leave	2,744	2,637
Long service leave	2,115	2,352
Provision for on-costs	667	649
Total current provisions for employee benefits	**5,526**	**5,638**
Non-current provisions for employee benefits		
Long service leave	386	372
Provision for on-costs	50	50
Total non-current provisions for employee benefits	**436**	**422**
Total provisions for employee benefits	**5,962**	**6,060**

How we recognise employee-related provisions

Employee related provisions are accrued for employees in respect of accrued days off, annual leave and long service leave, for services rendered to the reporting date.

No provision has been made for sick leave as all sick leave is non-vesting and it is not considered probable that the average sick leave taken in the future will be greater than the benefits accrued in the future. As sick leave is non-vesting, an expense is recognised in the Statement of Comprehensive Income as sick leave is taken.

Annual leave and accrued days off

Liabilities for annual leave and accrued days off are recognised in the provision for employee benefits as current liabilities because Mansfield District Hospital does not have an unconditional right to defer settlement of these liabilities.

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

- nominal value – if Mansfield District Hospital expects to wholly settle within 12 months or
- present value – if Mansfield District Hospital does not expect to wholly settle within 12 months

Long service leave

The liability for long service leave (LSL) is recognised in the provision for employee benefits.

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

The components of this current LSL liability are measured at:

- nominal value – if Mansfield District Hospital expects to wholly settle within 12 months or
- present value – if Mansfield District Hospital does not expect to wholly settle within 12 months

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

Provisions for on-costs

Employment on-costs such as payroll tax, workers compensation and superannuation are not employee benefits. They are disclosed separately as a component of the provision for employee benefits when the employment to which they relate has occurred. The on-costs provision is immaterial in 2026.

NOTE 3.1(C) SUPPLIES AND CONSUMABLES

	Total 2026 $'000	Total 2025 $'000
Drug supplies	192	168
Medical and surgical supplies (including Prostheses)	478	588
Diagnostic and radiology supplies	464	326
Other supplies and consumables	1,563	1,026
Total supplies and consumables	**2,697**	**2,108**

How we recognise supplies and consumables

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

NOTE 3.1(D) OTHER OPERATING EXPENSES

	Total 2026 $'000	Total 2025 $'000
Fuel, light, power and water	441	368
Repairs and maintenance	206	223
Maintenance contracts	233	252
Medical indemnity insurance	203	166
Other administration expenses	3,189	3,120
Total other operating expenses	**4,272**	**4,129**

How we recognise other operating expenses

Expense recognition

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

Other operating expenses

Other operating expenses generally represent the day-to-day running costs incurred in normal operations.

The DH also makes certain payments on behalf of Mansfield District Hospital. These amounts have been brought to account in determining the operating result for the year, by recording them as revenue (Refer to Note 2.1(b)) and recording a corresponding expense.

NOTES TO THE FINANCIAL STATEMENTS
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2026

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY

Mansfield District Hospital controls infrastructure and other investments that are utilised in fulfilling its objectives and conducting its activities. They represent the key resources that have been entrusted to Mansfield District Hospital to be utilised for delivery of services.

Significant judgement – Fair value measurement

Where the assets included in this section are carried at fair value, additional information is disclosed in Note 7.3 in connection with how those fair values were determined.

Structure

4.1 PROPERTY, PLANT AND EQUIPMENT
4.2 DEPRECIATION AND AMORTISATION
4.3 INVESTMENT PROPERTY

NOTE 4.1 PROPERTY, PLANT AND EQUIPMENT

	Gross carrying amount		Accumulate depreciation		Net carrying amount	
	2026 $'000	2025 $'000	2026 $'000	2025 $'000	2026 $'000	2025 $'000
Land at fair value - Crown	1,060	1,060	-	-	1,060	1,060
Land at fair value - Freehold	1,785	1,785	-	-	1,785	1,785
Buildings at fair value	63,701	29,721	(4,974)	(2,341)	58,727	27,380
Works in progress at cost	7,401	20,947	-	-	7,401	20,947
Plant, equipment and vehicles at fair value	9,595	7,871	(5,998)	(5,644)	3,597	2,227
Total property, plant and equipment	**83,542**	**61,384**	**(10,972)**	**(7,985)**	**72,570**	**53,399**

How we recognise other operating expenses

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

The cost of constructed non-financial physical assets includes the cost of all materials used in construction, direct labour on the project and an appropriate proportion of variable and fixed overheads.

NOTE 4.1(A) RECONCILIATION OF THE CARRYING AMOUNTS OF EACH CLASS OF ASSET

	Land $'000	Buildings $'000	Works in progress $'000	Plant, equipment and vehicles $'000	Total $'000
Balance at 1 July 2025	**2,845**	**27,380**	**20,947**	**2,227**	**53,399**
Additions	-	-	22,021	228	22,249
Net transfers between classes	-	33,979	(35,567)	1,588	-
Depreciation	-	(2,632)	-	(446)	(3,078)
Balance at 30 June 2026	**2,845**	**58,727**	**7,401**	**3,597**	**72,570**

Fair value assessments have been performed for all classes of assets in this purpose group and the decision was made that the movements were not material (less than or equal to 10%). As such, an independent revaluation was not required per FRD 103. In accordance with FRD 103, Mansfield District Hospital has elected to apply the practical expedient in FRD 103 Non-Financial Physical Assets and has therefore not applied the amendments to AASB 13 Fair Value Measurement. The amendments to AASB 13 will be applied at the earlier of the interim revaluation or next scheduled independent revaluation in 2029, in accordance with Mansfield District Hospital's revaluation cycle.

NOTE 4.1(B) RIGHT-OF-USE ASSETS INCLUDED IN PROPERTY, PLANT AND EQUIPMENT

The following tables are right-of-use assets included in the property, plant and equipment balance, presented by subsets of buildings and plant and equipment.

	Gross carrying amount		Accumulate depreciation		Net carrying amount	
	2026 $'000	2025 $'000	2026 $'000	2025 $'000	2026 $'000	2025 $'000
Plant, equipment and vehicles at fair value [1]	605	373	(129)	(55)	476	318
Total right-of-use assets	**605**	**373**	**(129)**	**(55)**	**476**	**318**

	Plant, equipment and vehicles $'000	Total $'000
Balance at 1 July 2025 [1]	**318**	**318**
Additions	228	228
Depreciation	(70)	(70)
Balance at 30 June 2026	**476**	**476**

(1) As a result of changes in FRD 104 effective for reporting periods from 30 June 2026, right-of-use assets are measured at cost for reporting period 2026. The comparative information for reporting period 2025 is not restated and is reported at the previously determined fair value.

NOTE 4.1(B) RIGHT-OF-USE ASSETS INCLUDED IN PROPERTY, PLANT AND EQUIPMENT (CONTINUED)

How we recognise right-of-use assets

Initial recognition

When Mansfield District Hospital enters a contract, which provides the health services with the right to control the use of an identified asset for a period of time in exchange for payment, this contract is considered a lease.

Unless the lease is considered a short-term lease or a lease of a low-value asset the contract gives rise to a right-of-use asset and corresponding lease liability.

The right-of-use asset is initially measured at cost and comprises the initial measurement of the corresponding lease liability, adjusted for:

- any lease payments made at or before the commencement date
- any initial direct costs incurred
- an estimate of costs to dismantle and remove the underlying asset or to restore the underlying asset or the site on which it is located, less any lease incentive received

Subsequent measurement

Right-of-use assets are subsequently measured at cost less accumulated depreciation, impairment and any adjustments for remeasurement of the lease liability.

NOTE 4.1(C) IMPAIRMENT OF PROPERTY, PLANT AND EQUIPMENT

The recoverable amount of the primarily non-financial physical assets of Mansfield District Hospital, which are typically specialised in nature and held for continuing use of their service capacity, is expected to be materially the same as fair value determined under AASB 13 Fair Value Measurement, with the consequence that AASB 136 Impairment of Assets does not apply to such assets that are regularly revalued.

Mansfield District Hospital Service has assessed all right-of-use assets for impairment, and no indicators of impairment are identified as at 30 June 2026.

NOTE 4.2 DEPRECIATION AND AMORTISATION

How we recognise depreciation

All buildings, plant and equipment and other non-financial physical assets that have finite useful lives are depreciated. Depreciation is generally calculated on a straight-line basis at rates that allocate the asset's value, less any estimated residual value over its estimated useful life.

Right-of-use assets are depreciated over the lease term or useful life of the underlying asset, whichever is the shortest. Where a lease transfers ownership of the underlying asset or the cost of the right-of-use asset reflects that the health service anticipates exercising a purchase option, the specific right-of-use asset is depreciated over the useful life of the underlying asset.

How we recognise amortisation

Amortisation is the systematic allocation of the depreciable amount of an asset over its useful life.

Useful lives of non-current assets

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

	2026	2025
Buildings	6 to 46 Years	6 to 46 Years
Plant, equipment and vehicles (including leased assets)	3 to 25 Years	3 to 25 Years

NOTE 4.3 INVESTMENT PROPERTY

	2026 $'000	2025 $'000
Investment property	721	714
Total non-financial physical assets classified as held for sale	**721**	**714**

How we recognise investment properties

Investment properties represent properties held to earn rentals or for capital appreciation or both. Investment properties exclude properties held to meet service delivery objectives of the health services.

Initial recognition

Investment properties are initially recognised at cost. Costs incurred subsequent to initial acquisition are capitalised when it is probable that future economic benefits in excess of the originally assessed performance of the asset will flow to the health service.

Subsequent measurement

Subsequently investment properties are measured at fair value, determined annually by independent valuers. Fair values are determined based on a market comparable approach that reflects recent transaction prices for similar properties. Investment properties are neither depreciated nor tested for impairment.

For investment properties measured at fair value, the current use of the asset is considered the highest and best use.

Further information regarding fair value measurement is disclosed in Note 7.3.

NOTES TO THE FINANCIAL STATEMENTS
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2026

NOTE 5: OTHER ASSETS AND LIABILITIES

This section sets out those assets and liabilities that arose from Mansfield District Hospital's operations.

Structure

5.1 RECEIVABLES
5.2 PAYABLES
5.3 CONTRACT LIABILITIES
5.4 MONIES HELD IN TRUST

NOTE 5.1 RECEIVABLES

	Note	Total 2026 $'000	Total 2025 $'000
Current receivables Contractual			
Inter hospital debtors		1	1
Trade receivables		380	864
Patient fees		408	160
Allowance for impairment losses		(25)	(25)
Other receivable		36	99
Total contractual receivables		**800**	**1,106**
Statutory			
GST receivable		90	57
Total statutory receivables		**90**	**57**
Total current receivables		**890**	**1163**
Non-current receivables Contractual			
Long service leave - Department of Health		1,214	1,415
Total contractual receivables		**1,214**	**1,415**
Total non-contractual receivables		**1,214**	**1,415**
Total receivables		**2,104**	**2,578**
(i) Financial assets classified as receivables			
Total receivables		2,104	2,578
GST receivable		(90)	(57)
Total financial assets classified as receivables	**7.1**	**2,014**	**2,521**

How we recognise depreciation

Receivables consist of:

- **Contractual receivables**, including debtors that relate to goods and services. These receivables are classified as financial instruments and are categorised as 'financial assets at amortised cost'. They are initially recognised at fair value plus any directly attributable transaction costs. The health service holds contractual receivables with the objective to collect the contractual cash flows and therefore they are subsequently measured at amortised cost using the effective interest method, less any impairment.
- **Statutory receivables**, including Goods and Services Tax (GST) input tax credits that are recoverable. Statutory receivables do not arise from contracts and are recognised and measured similarly to contractual receivables (except for impairment) but are not classified as financial instruments for disclosure purposes. The health service applies AASB 9 for initial measurement of the statutory receivables and as a result, statutory receivables are initially recognised at fair value plus any directly attributable transaction cost.

NOTE 5.2 PAYABLES

	Note	Total 2026 $'000	Total 2025 $'000
Current payables Contractual			
Trade creditors		1,394	576
Accrued salaries and wages		431	890
Accrued expenses		719	429
Deferred capital grant income		721	-
Other		161	14
Total contractual payables		**3,426**	**1,909**
Statutory			
GST Payable		-	4
Total statutory payables		**-**	**4**
Total current payables		**3,426**	**1,913**
Total payables		**3,426**	**1,913**
(i) Financial assets classified as payables			
Total payables		3,426	1,913
Deferred capital grant income		(721)	-
GST payable		-	(4)
Total financial liabilities classified as payables	**7.1**	**2,705**	**1,909**

How we recognise payables

Payables consist of:

- **Contractual payables**, including payables that relate to the purchase of goods and services. These payables are classified as financial instruments and measured at amortised cost. Accounts payable and salaries and wages payable represent liabilities for goods and services provided to Mansfield District Hospital prior to the end of the financial year that are unpaid.
- **Statutory payables**, including Goods and Services Tax (GST) payable are recognised and measured similarly to contractual payables but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from contracts.

The normal credit terms for accounts payable are usually Net 60 days.

NOTE 5.3 CONTRACT LIABILITIES

	Note	Total 2026 $'000	Total 2025 $'000
Current			
Contract liabilities		489	489
Total current contract liabilities		**489**	**489**
Total contract liabilities		**489**	**489**

How we recognise contract liabilities

Contract liabilities include consideration received in advance from customers in respect of capital projects. The balance of contract liabilities was significantly lower than the previous reporting period due to the project nearing completion.

Contract liabilities are derecognised and recorded as revenue when promised goods and services are transferred to the customer. Refer to Note 2.1.

NOTE 5.4 MONIES HELD IN TRUST

	Note	Total 2026 $'000	Total 2025 $'000
Current monies held in trust			
Refundable accommodation deposits		11,916	10,684
Total current monies held in trust		**11,916**	**10,684**
Total other liabilities		**11,916**	**10,684**
* **Represented by:**			
- Cash assets	6.2	11,916	10,778
		11,916	**10,778**

How we recognise monies held in trust

Refundable Accommodation Deposit (RAD)/Accommodation Bond liabilities

RADs/accommodation bonds are non-interest-bearing deposits made by some aged care residents to Mansfield District Hospital upon admission. These deposits are liabilities which fall due and payable when the resident leaves the home.

RAD/accommodation bond liabilities are recorded at an amount equal to the proceeds received, net of retention and any other amounts deducted from the RAD/accommodation bond in accordance with the Aged Care Act 2024.

NOTES TO THE FINANCIAL STATEMENTS
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2026

NOTE 6: HOW WE FINANCE OUR OPERATIONS

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

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

Structure

6.1 BORROWINGS
6.2 CASH AND CASH EQUIVALENTS
6.3 COMMITMENTS FOR EXPENDITURE

NOTE 6.1 BORROWINGS

	Note	Total 2026 $'000	Total 2025 $'000
Current borrowings			
Lease liability		193	50
Total current borrowings		**193**	**50**
Non-current borrowings			
Lease liability		288	270
Total non-current borrowings		**288**	**270**
Total borrowings	7.1	**481**	**320**

How we recognise monies held in trust

Borrowings refer to interesting bearing liabilities mainly raised from advances from the Treasury Corporation of Victoria (TCV) and other funds raised through lease liabilities and other interest-bearing arrangements.

Borrowings are classified as financial instruments. Interest bearing liabilities are classified at amortised cost and recognised at the fair value of the consideration received directly attributable to transaction costs and subsequently measured at amortised cost using the effective interest method.

					Maturity Dates			
30 June 2026	**Note**	**Weighted avg.interest rate (%)**	**Carrying Amount $'000**	**Nominal Amount $'000**	**Less than 1 Month $'000**	**1-3 Months $'000**	**3 months - 1 Year $'000**	**1-5 Years $'000**
Lease liabilities	6.1	3.06%	481	525	18	36	160	311
Total Financial Liabilities			**481**	**525**	18	36	**160**	**311**
30 June 2025								
Lease liabilities	6.1	3.87%	320	320	5	10	35	270
Total Financial Liabilities			**320**	**320**	**5**	**10**	**35**	**270**

NOTE 6.2 CASH AND CASH EQUIVALENTS

	Note	Total 2026 $'000	Total 2025 $'000
Cash on hand (excluding monies held in trust)		1	1
Cash at bank (excluding monies held in trust)		9,541	8,527
Total cash held for operations		**9,542**	**8,527**
Cash at bank (monies held in trust)		11,916	10,778
Total cash held as monies in trust	5.4	**11,916**	**10,778**
Total cash and cash equivalents	**7.1**	**21,458**	**19,306**

NOTE 6.3 COMMITMENTS FOR EXPENDITURE

30 June 2026	Less than 1 year $'000	Total $'000
Operating expenditure commitments	1,048	1,048
Total commitments (inclusive of GST)	**1,048**	**1,048**
Less GST recoverable	(95)	(95)
Total commitments (exclusive of GST)	**953**	**953**

30 June 2025	Less than 1 year $'000	Total $'000
Operating expenditure commitments	871	871
Total commitments (inclusive of GST)	**871**	**871**
Less GST recoverable	(79)	(79)
Total commitments (exclusive of GST)	**792**	**792**

How we disclose our commitments

Our commitments relate to expenditure for ICT related services.

Expenditure commitments

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

Short term and low value leases

Mansfield District Health discloses short term and low value lease commitments which are excluded from the measurement of right-of-use assets and lease liabilities. Refer to Note 6.1 for further information.

NOTES TO THE FINANCIAL STATEMENTS
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2026

NOTE 7: FINANCIAL INSTRUMENTS, CONTINGENCIES AND VALUATION JUDGEMENTS

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

Structure

7.1 FINANCIAL INSTRUMENTS
7.2 CONTINGENT ASSETS AND CONTINGENT LIABILITIES
7.3 FAIR VALUE DETERMINATION

NOTE 7.1 FINANCIAL INSTRUMENTS

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

30 June 2026	Note	Carrying Amount $'000	Total interest income/ (expense) $'000
Financial assets at amortised cost			
Cash and cash equivalents	6.2	21,458	810
Receivables	5.1	2,014	-
Total financial assets (i)		**23,472**	**810**
Financial liabilities at amortised cost			
Payables	5.2	2,705	-
Borrowings	6.1	481	(23)
Other financial liabilities - Refundable Accommodation Deposits	5.4	11,916	-
Total Financial Liabilities (i)		**15,102**	**(23)**

(i) The carrying amount excludes statutory receivables (i.e. GST receivable) and statutory payables (i.e. GST payable).

30 June 2025	Note	Carrying Amount $'000	Total interest income/ (expense) $'000
Financial assets at amortised cost			
Cash and cash equivalents	6.2	19,306	963
Receivables	5.1	2,521	-
Total financial assets (i)		**21,827**	**963**
Financial liabilities at amortised cost			
Payables	5.2	1,909	-
Borrowings	6.1	320	(13)
Other financial liabilities - Refundable Accommodation Deposits	5.4	10,684	-
Total Financial Liabilities (i)		**12,913**	**(13)**

(i) The carrying amount excludes statutory receivables (i.e. GST receivable) and statutory payables (i.e. GST payable).

How we categorise financial instruments

Financial assets at amortised cost

Financial assets are measured at amortised cost if both of the following criteria are met and the assets are not designated as fair value through net result:

- the assets are held by Mansfield District Hospital solely to collect the contractual cash flows
- the assets' contractual terms give rise to cash flows that are solely payments of principal and interest on the principal amount outstanding onspecific dates

These assets are initially recognised at fair value plus any directly attributable transaction costs and are subsequently measured at amortised cost using the effective interest method less any impairment.

Mansfield District Hospital recognises the following assets in this category:

- cash and deposits
- receivables (excluding statutory receivables)

Categories of financial liabilities

Financial liabilities at amortised cost

Financial liabilities are measured at amortised cost using the effective interest method, where they are not held at fair value through net result.

The effective interest method is a method of calculating the amortised cost of a debt instrument and of allocating interest expense in net result over the relevant period. The effective interest is the internal rate of return of the financial asset or liability. That is, it is the rate that exactly discounts the estimated future cash flows through the expected life of the instrument to the net carrying amount at initial recognition.

Mansfield District Hospital recognises the following liabilities in this category:

- payables (excluding statutory payables and contract liabilities)
- borrowings
- other liabilities (including monies held in trust)

Derecognition of financial assets

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

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

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

Derecognition of financial liabilities

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

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

Reclassification of financial instruments

A financial asset is required to be reclassified between amortised cost, fair value through net result and fair value through other comprehensive income when, and only when, Mansfield District Hospital's business model for managing its financial assets has changed such that its previous model would no longer apply.

A financial liability reclassification is not permitted.

NOTE 7.2: CONTINGENT ASSETS AND CONTINGENT LIABILITIES

At balance date, the Board are not aware of any contingent assets or liabilities.

NOTE 7.3 FAIR VALUE DETERMINATION

How we measure fair value

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

The following assets and liabilities are carried at fair value:

- Financial assets and liabilities at fair value through net result
- Financial assets and liabilities at fair value through other comprehensive income
- Property, plant and equipment, with the exception of right-of-use assets arising under AASB 16, which are measured using the cost model
- Lease liabilities

In addition, the fair value of other assets and liabilities that are carried at amortised cost, also need to be determined for disclosure.

Valuation hierarchy

In determining fair values, a number of inputs are used. To increase consistency and comparability in the financial statements, these inputs are categorised into three levels, also known as the fair value hierarchy. The levels are as follows:

Level 1 – quoted (unadjusted) market prices in active markets for identical assets or liabilities

Level 2 – valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable

Level 3 – valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable

Mansfield District Hospital determines whether transfers have occurred between levels in the hierarchy by reassessing categorisation (based on the lowest level input that is significant to the fair value measurement as a whole) at the end of each reporting period. There have been no transfers between levels during the period.

Mansfield District Hospital monitors changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required. The Valuer-General Victoria (VGV) is Mansfield District Hospital's independent valuation agency for property, plant and equipment.

Fair value determination: non-financial physical assets

AASB 2022-10 Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities amended AASB 13 Fair Value Measurement by adding Appendix F Australian Implementation Guidance for Not-for-Profit Public Sector Entities. Appendix F explains and illustrates the application of the principals in AASB 13 on developing unobservable inputs and the application of the cost approach. These clarifications are mandatorily applicable annual reporting periods beginning on or after 1 January 2024. FRD 103 permits Victorian public sector entities to apply Appendix F of AASB 13 in their next scheduled formal asset revaluation or interim revaluation process (whichever is earlier).

The last scheduled full independent valuation of all of Mansfield District Hospital's non-financial physical assets was performed by VGV on 30 June 2024. The annual fair value assessment for 30 June 2026 using VGV indices does not identify material changes in value. In accordance with FRD 103, Mansfield District Hospital will reflect Appendix F in its next scheduled formal revaluation on 30 June 2029 or interim revaluation process (whichever is earlier). All annual fair value assessments thereafter will continue compliance with Appendix F.

For all assets measured at fair value, Mansfield District Hospital considers the current use as its highest and best use.

Non-specialised land and non-specialised buildings

Non-specialised land, non-specialised buildings are valued using the market approach. Under this valuation method, the assets are compared to recent comparable sales or sales of comparable assets which are considered to have nominal or no added improvement value. From this analysis, an appropriate rate per square metre has been applied to the asset.

Specialised land and specialised buildings

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

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

The market approach is also used for specialised land although it is adjusted for the community service obligation (CSO) to reflect the specialised nature of the assets being valued.

The CSO adjustment reflects the valuer's assessment of the impact of restrictions associated with an asset to the extent that is also equally applicable to market participants. This approach is in light of the highest and best use consideration required for fair value measurement and considers the use of the asset that is physically possible, legally permissible and financially feasible.

For Mansfield District Hospital, the current replacement cost method is used for the majority of specialised buildings, adjusting for the associated depreciation.

Vehicles

Vehicles are valued using the current replacement cost method. Mansfield District Hospital acquires new vehicles and at times disposes of them before completion of their economic life. The process of acquisition, use and disposal in the market is managed by experienced fleet managers in Mansfield District Hospital who set relevant depreciation rates during use to reflect the utilisation of the vehicles.

Plant and equipment, furniture, fittings

Plant and equipment, furniture, fittings, (including medical equipment, computers and communication equipment) are held at fair value. When plant and equipment is specialised in use, such that it is rarely sold, fair value is determined using the current replacement cost method.

Asset class	Valuation technique	Significant assumption	Range (weighted average)[i]
Specialised land	Market approach	Community Service Obligations adjustment	(20%)[ii]
Specialised buildings	Current replacement cost approach	Cost per square metre	$1,000 - $1,500/m2 ($1,300)
		Useful life	6 - 46 years (17 years)
Vehicles	Current replacement cost approach	Cost per unit	-$32,000 - $90,000 ($53,000 per unit)
		Useful life	3 - 5 years (3 years)
Plant, equipment, furniture and fittings	Current replacement cost approach	Cost per unit	$3,000 - $4,000 ($3,500 per unit)
		Useful life	3 - 25 years (9 years)

(i) Illustrations on the valuation techniques and significant assumptions and unobservable inputs are and indicator and should not be directly used without consultation with the health services independent valuer.

(ii) A CSO adjustments of 20% has been applied to reduce the market approach value for Mansfield District Hospital's specialised land.

NOTES TO THE FINANCIAL STATEMENTS
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2026

NOTE 8: OTHER DISCLOSURES

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

Structure

8.1 EX-GRATIA EXPENSES
8.2 RESPONSIBLE PERSONS DISCLOSURES
8.3 REMUNERATION OF EXECUTIVES
8.4 RELATED PARTIES
8.5 REMUNERATION OF AUDITORS
8.6 EVENTS OCCURRING AFTER THE BALANCE DATE
8.7 JOINT ARRANGEMENTS

NOTE 8.1: EX GRATIA PAYMENTS

There were no ex gratia payments made during the year ended 30 June 2026 (2025: $Nil).

NOTE 8.2: RESPONSIBLE PERSONS DISCLOSURES

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

	Period
Responsible Ministers:	
The Honourable Mary-Anne Thomas MP:	
Minister for Health	1 Jul 2025 - 14 April 2026
Minister for Ambulance Services	1 Jul 2025 - 14 April 2026
The Honourable Harriet Shing MP:	
Minister for Health	15 April 2026 - 30 June 2026
Minister for Ambulance Services	15 April 2026 - 30 June 2026
The Honourable Melissa Horne MP:	
Minister for Health Infrastructure	1 July 2025 - 30 June 2026
Minister for Prevention of Family Violence	15 April 2026 - 30 June 2026
The Honourable Ingrid Stitt MP:	
Minister for Mental Health	1 July 2025 - 30 June 2026
Minister for Ageing	1 July 2025 - 30 June 2026
The Honourable Lizzie Blandthorn MP:	
Minister for Children	1 July 2025 - 30 June 2026
Minister for Disability	1 July 2025 - 30 June 2026

	Period
Governing Boards	
Mr. Matthew Hoskin	1 Jul 2025 - 30 Jun 2026
Ms. Lisa Morgan	1 Jul 2025 - 30 Jun 2026
Ms. Karen Bennetts	1 Jul 2025 - 30 Jun 2026
Mr. Richard Ray	1 Jul 2025 - 30 Jun 2026
Ms. Amanda Vogt	1 Jul 2025 - 30 Jun 2026
Ms. Rachel Paulus	1 Jul 2025 - 30 Jun 2026
Mr. Darren Taylor	1 Jul 2025 - 30 Jun 2026
Ms. Catherine Easton	1 Jul 2025 - 30 Jun 2026
Ms. Kristy Aldridge	1 Jul 2025 - 30 Jun 2026
Mr. Stephen Bendle	1 Jul 2025 - 30 Jun 2026
Accountable Officers	
Ms. Michelle Spence (Chief Executive Officer)	14 Jul 2025 - 30 Jun 2026
Mr. Cameron Butler (Chief Executive Officer)	1 Jul 2025 - 13 Jul 2025

Remuneration of Responsible Persons

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

Income Band	2026 No.	2025 No.
$0,000 - $9,999	11	9
$200,000 - $209,999	-	1
$250,000 - $259,999	1	-
Total Numbers	**12**	**10**

	2026 $'000	2025 $'000
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to*:	**304**	**545**

* Total remuneration decreased substantially from the previous financial year due to the CEO role being held predominantly by one person. The previous financial year included long term leave coverage which resulted in remuneration being reported for two responsible persons.

Amounts relating to Responsible Ministers are reported within the State's Annual Financial Report.

NOTE 8.3: REMUNERATION OF EXECUTIVES

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

Remuneration comprises employee benefits in all forms of consideration paid, payable or provided in exchange for services rendered. Accordingly, remuneration is determined on an accrual basis.

Remuneration comprises employee benefits in all forms of consideration paid, payable or provided in exchange for services rendered. Accordingly, remuneration is determined on an accrual basis.

Remuneration of executives officers *(including Key Management Personnel disclosed in Note 8.4)*

	Total Remuneration	
	2026 $'000	**2025 $'000**
Total remuneration [(i)]	816	929
Total number of executives	4	4
Total annualised employee equivalent [(ii)]	3.4	4.0

i The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of Mansfield District Hospital under AASB 124 Related Party Disclosures and are also reported within Note 8.4 Related Parties.

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

NOTE 8.4: RELATED PARTIES

Mansfield District Hospital is a wholly owned and controlled entity of the State of Victoria. Related parties of the health service include:

- all key management personnel (KMP) and their close family members and personal business interests
- cabinet ministers (where applicable) and their close family members
- jointly controlled operations –the Hume Rural Health Alliance
- all health services and public sector entities that are controlled and consolidated into the State of Victoria financial statements

Significant transactions with government related entities

Mansfield District Hospital received funding from government related entities of $18.721 m (2025: $16.793 m) and indirect contributions of $20.163 m (2025: $20.803 m).

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

Professional medical indemnity insurance and other insurance products are obtained from the Victorian Managed Insurance Authority.

The Standing Directions of the Minister for Finance require Mansfield District Hospital to hold cash (in excess of working capital) in accordance with the State of Victoria's centralised banking arrangements. All borrowings are required to be sourced from Treasury Corporation Victoria unless an exemption has been approved by the Minister for Health and the Treasurer.

Key management personnel

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

The Board of Directors and the Executive Directors of Mansfield District Hospital and its controlled entities are deemed to be KMPs. This includes the following:

Entity	KMPs	Position Title
Mansfield District Hospital	Mr. Matthew Hoskin	Board Chair
Mansfield District Hospital	Ms. Lisa Morgan	Board Director
Mansfield District Hospital	Ms. Karen Bennetts	Board Director
Mansfield District Hospital	Mr. Richard Ray	Board Director
Mansfield District Hospital	Ms. Amanda Vogt	Board Director
Mansfield District Hospital	Ms. Rachel Paulus	Board Director
Mansfield District Hospital	Mr. Darren Taylor	Board Director
Mansfield District Hospital	Ms. Catherine Easton	Board Director
Mansfield District Hospital	Ms. Kristy Aldridge	Board Director
Mansfield District Hospital	Mr .Stephen Bendle	Board Director
Mansfield District Hospital	Ms. Michelle Spence	Chief Executive Officer (from 14/07/2025)
Mansfield District Hospital	Mr. Cameron Butler	Chief Executive Officer (to 13/07/2025)
Mansfield District Hospital	Ms. Sarah Lieber	Director of Clinical Services
Mansfield District Hospital	Ms. Anne Jewitt	Director of Aged Care
Mansfield District Hospital	Ms. Kate Les	Director of Quality & Safety
Mansfield District Hospital	Mr. Vijendran Reddy	Director of Finance & Corporate Services (to Nov 25)

Remuneration of key management personnel

The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The Minister's remuneration and allowances is set by the Parliamentary Salaries and Superannuation Act 1968 and is reported within the State's Annual Report.

	2026 $'000	2025 $'000
Total compensation - KMPs (i)	1,120	1,474

(i) KMPs are also reported in Note 8.2 Responsible Persons or Note 8.3 Remuneration of Executives.

Transactions with KMPs and other related parties

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

Outside of normal citizen type transactions with Mansfield District Hospital, there were no related party transactions that involved key management personnel, their close family members or their personal business interests. No provision has been required, nor any expense recognised, for impairment of receivables from related parties. There were no related party transactions with Cabinet Ministers required to be disclosed in 2026 (2025: none).

There were no related party transactions required to be disclosed for Mansfield District Hospital Board of Directors, Chief Executive Officer and Executive Directors in 2026 (2025: none).

NOTE 8.5: REMUNERATION OF AUDITORS

	Total 2026 $'000	Total 2025 $'000
Victorian Auditor-General's Office		
Audit of the financial statements	56	39
Total remuneration of auditors	**56**	**39**

NOTE 8.6 EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

There are no events occurring after the Balance Sheet date.

NOTE 8.7 JOINT ARRANGEMENTS

Entity Name	Principal Activity	2026 %	2025 %
Hume Rural Health Alliance (HRHA)	Provision of Information Technology Services	5.76	5.3

	2026 $'000	2025 $'000
Total revenue and income	1,407	832
Total expenses	(1,495)	(953)
Total net result	(88)	(121)
Comprehensive result for the year	(88)	(121)
Total assets	832	913
Total liabilities	702	695
Total equity	130	218

Contingent liabilities and capital commitments

There are no known contingent liabilities or capital commitments held by the jointly controlled operations at balance date. Mansfield District Hospital is involved in joint arrangements where control and decision-making are shared with other parties. Mansfield District Hospital has determined the entities detailed in the above table are joint operations and therefore recognises its share of assets, liabilities, revenues and expenses in accordance with its rights and obligations under the arrangement.

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