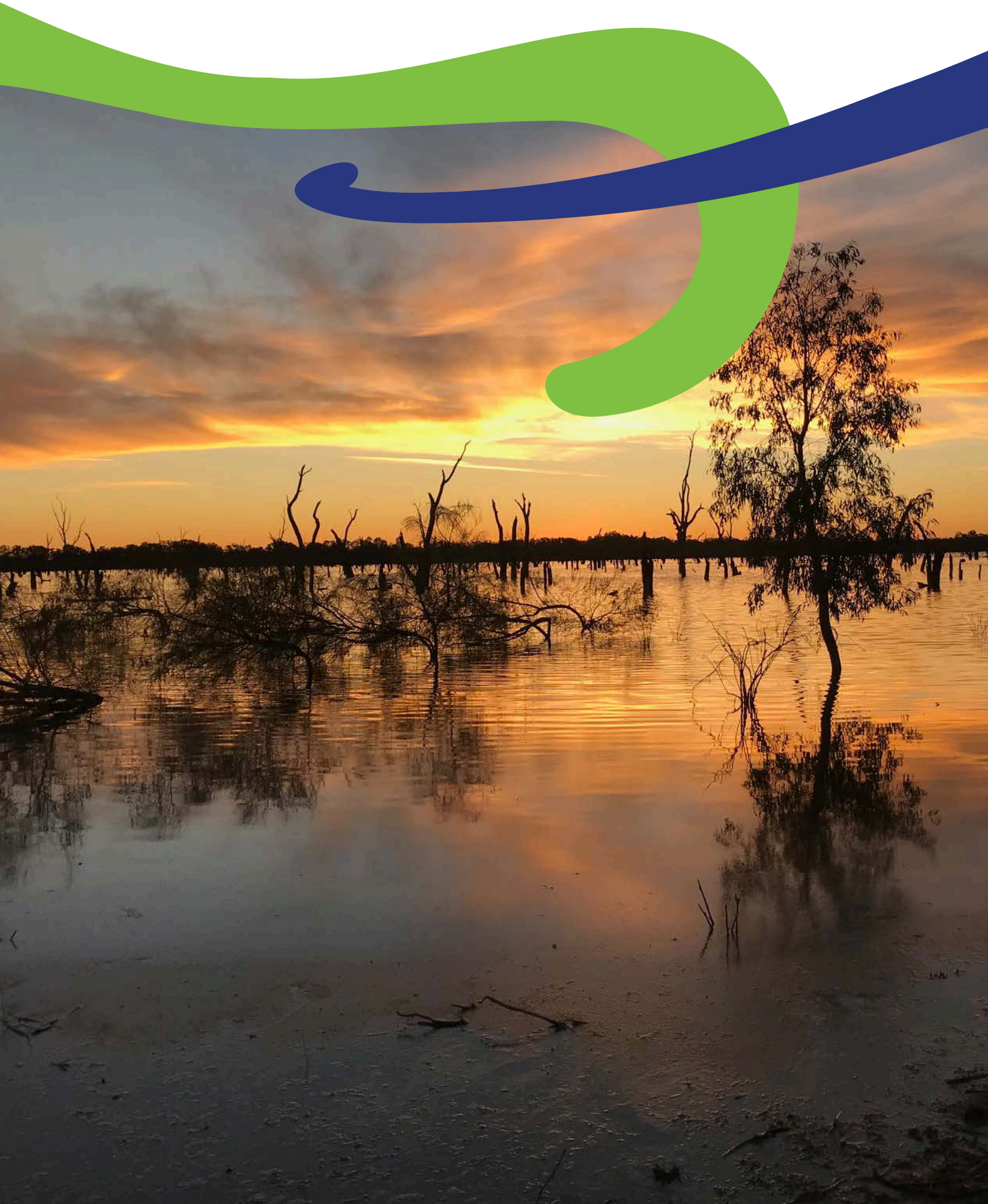
Annual Report 2025/26

Boort District Health





Acknowledging 16 days of activism at Boort District School - Kathryn Durie (BDH) & Sergeant Ben Huismann - Victoria Police

Our Values

Respect
We treat everyone with dignity, compassion, kindness and understanding.

Equity
We provide equitable access to health services, recognising the diversity of our community.

Quality
We strive for excellence in all that we do, we are committed to continuous improvement and proactively planning for the future.

Collaboration
We work in partnership with patients, families, the community and our stakeholders to achieve better health outcomes.

We will respect, protect and promote human rights in our decision-making and actions.

Cover photo credit – Loddon Shire Council

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Welcome / Acknowledgement of Traditional Owners

Djaara
BALAKI WUKA

Here in Boort, we stand on the sacred land marked by scar trees - symbols of indigenous culture, knowledge, and respectful relationship with the land. We acknowledge the Dja Dja Wurrung country and the Jarra people, Traditional Custodians of this land. We pay our respects to Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples. We recognise that sovereignty was never ceded.

Since **Boort District Health** was established on its current site in 1961 it has played a key role in the provision of public health services for the community of Boort and surrounding districts. The Annual Report 2025 –2026 is an important document that provides information to all stakeholders about the performance of the health service. The report highlights services provided as well as operational achievements and challenges during this financial year. Reporting period from 1 July 2025 to 30 June 2026.

This report is prepared for the Minister for Health, the Parliament of Victoria and the general public in accordance with relevant government and legislative requirements.

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.

About Boort District Health

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

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

Minister for Health:
The Hon Mary-Anne Thomas MP
(1 July 2025 – 15 April 2026)

Minister for Health:
Hon Harriet Shing MP
(15 April 2026 – 30 June 2026)

Minister for Ambulance Services:
Hon Harriet Shing MP
(15 April 2026 – 30 June 2026)

Minister for Water:
Hon Harriet Shing MP
(15 April 2026 – 30 June 2026)

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

Minister for Mental Health:
The Hon Ingrid Stitt MP
(1 July 2025 – 30 June 2026)

Minister for Ageing:
The Hon Ingrid Stitt MP
(1 July 2025 – 30 June 2026)

Minister for Disability/Minister for Children:
The Hon Lizzie Blandthorn MP
(1 July 2025 – 30 June 2026)

Boort District Health Urgent Care Centre (UCC) offers two (2) urgent care treatment trolleys and one (1) treatment room, 24 hours a day, 7 days a week. This service is supported by an on-call system.

Outreach community support programs are coordinated by Boort District Health. These include Meals on Wheels, District Nursing and Transitional Care Planning (TCP), Home Care, Home Maintenance and Personal Care

BDH Residential Aged Care LODDON PLACE, operates twenty-five (25) permanent residential aged care places, all single rooms with individual ensuite facilities.

Social Support Program operates weekly including outings, lunches, exercises, art and craft and community wellbeing programs.

BDH continue to offer placements for secondary school students for their years 9, 10 and 11 work experience programs, as well as VET students and and tertiary students for their placement studies.

Acute Services: 7 single, ensuite acute rooms are provided, including one Transitional Care Program bed-based bed and a family room with courtyard. Admission to our acute services is through the Visiting Medical Officers.

A number of Allied Health services are facilitated within Boort District Health including Physiotherapy, Podiatry, Health Education, Counselling and Health Promotion

108 Total Staff members. 99% of staff immunised for Influenza

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

The Spanner Café is the communal hub of the Health Service, a place for residents, patients, clients, visitors and community to catch up over a drink, or enjoy a delicious meal prepared by our Café staff.

Board Chair and Chief Executive Report

During 2025–26, Boort District Health (BDH) continued to deliver on its vision of providing high-quality, accessible, patient-centred care while demonstrating our core values of **Respect, Equity, Quality and Collaboration.**

Significant progress was achieved across all Statement of Priorities goals, strengthening clinical governance, workforce capability, financial sustainability, cultural safety and regional partnerships.

Respect and Equity

BDH strengthened consumer and community engagement through the Consumer Advisory Committee, resident forums, executive morning teas, consumer experience surveys and implementation of feedback-driven improvements. We proudly maintained a 5-star Aged Care Star Rating and progressed planning for the Aged Care Accommodation Project, ensuring residents' voices continue to inform our future service development. Cultural safety was enhanced through Aboriginal partnerships, the Healing Garden **DHELKUNYANG GARINGILANG** project, installation of Aboriginal artwork and signage, re-commencement of an Aboriginal Hospital Liaison Officer role, and ongoing cultural safety training initiatives.

Quality

BDH continued to strengthen clinical governance and quality systems through implementation of the Safer Care Victoria Clinical Governance Framework, compliance with legislative requirements, mandatory reporting processes, clinical governance maturity assessments and continuous improvement programs. Consumer feedback, quality-of-life measures and care experience reporting were actively used to guide service improvements and support safe, high-quality care.

Collaboration

Strong partnerships were maintained across the Loddon Mallee Local Health Service Network, Aboriginal community-controlled organisations, our partners and stakeholders and community leaders. BDH actively participated in regional planning, workforce initiatives, data-sharing arrangements, support-at-home reforms and collaborative clinical support models, demonstrating our commitment to an integrated and sustainable rural health system.

Statement of Priorities Achievements

Innovate and Improve Access and Care

BDH strengthened consumer participation in service design, maintained robust governance and risk management systems, and continued to build workforce capability through mandatory training, leadership development, graduate nurse programs and career progression opportunities. Workforce development initiatives included support for nurse practitioner pathways, rural urgent care training and expansion of our junior workforce programs.

Prudent, Sustainable and Effective Use of Resources

Disciplined financial management was maintained through delivery of Budget Action Plan initiatives, regular performance monitoring and evidence-based decision-making. Investments in sustainability included leadership in electric vehicle infrastructure, energy and water performance monitoring, and ongoing review of service efficiency and resource utilisation. Access to services was further supported through workforce recruitment initiatives and expanded clinical support arrangements with Inglewood and Districts Health Service.

A Stronger Workforce

BDH continued to invest in employee experience, leadership development, workforce planning and flexible work practices. Gender Equality Action Plan commitments were progressed, staff wellbeing supports enhanced, and workforce data used to inform future planning. Graduate recruitment and professional development opportunities strengthened workforce sustainability and succession planning.

Improving Aboriginal Health and Wellbeing

Key achievements included partnerships with local Aboriginal leaders and organisations, implementation of cultural safety initiatives, development of culturally appropriate environments and pathways, and improved identification and support mechanisms for Aboriginal and Torres Strait Islander consumers.

Moving from Competition to Collaboration

Through active participation in the Local Health Service Network and numerous regional working groups, BDH contributed to improved access, workforce capability, quality outcomes and sustainable service delivery across the region.

We are pleased to report the demonstrated strong performance against the Department of Health's Statement of Priorities, delivering measurable improvements in consumer engagement, clinical governance, workforce development, financial stewardship, cultural safety and regional collaboration. These achievements position our organisation well to continue providing safe, high-quality and sustainable healthcare services close to home for our community.

I was honoured to be asked to take over the role of Board Chair in 2026. I look forward to working with fellow Directors to implement our strategic plan and creating a culture reflective of our values of respect, equity, quality and collaboration. We will be focussed on positioning Boort District Health as a leading, sustainable small rural health service providing high quality, accessible, people-centred care to our community.

This year we farewell two long-serving Board Directors who have made significant contributions to the success of Boort District Health. Wendy Gladman has completed a term of nine years, all of them as Board Chair. Wendy's skilful leadership has been crucial to the capacity of the service to successfully navigate some difficult times. We are immensely grateful for her contribution and commitment to the community. Laurie Maxted leaves the Board after fifteen years of service, including as Deputy Board Chair and Chair of the Consumer Advisory Committee. Laurie's innovative and collaborative approach and his understanding of community have been of great benefit to Boort District Health. We thank these two retiring Directors for their strong commitment to the health of the community.

Responsible Bodies Declaration

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



Gregory Currie
Board Chair
30 June 2026

Resident Jenny Featherby and junior activity worker Anna Lanyon



Board of Directors

The Directors of the Board of Management are appointed by the Governor-in-Council, under section 33(7) of the Health Services Act 1988, and are responsible for helping to shape and influence government decisions and services.

There is a diverse representation of skills and experience within the Board of Management, it provides multiple perspectives which help make meaningful decisions.

Boort District Health Board of Management has the following sub-committees; Safety, Quality & Clinical Governance; Finance, Risk & Audit and Consumer Advisory.



Gregory Currie
Board Chair
from 21 January 2026,
Safety Quality & Clinical Governance (Chair)
up to 21 January 2026,
Finance Risk & Audit



Wendy Gladman
Board Chair
up to 21 January 2026,
Safety Quality & Clinical Governance



Brett Yates
Finance, Risk & Audit (Chair)



Gregory Kuchel
Finance Risk & Audit



John White
Safety Quality & Clinical Governance, Consumer Advisory



Cheree Schneider
Safety Quality & Clinical Governance



Amy Fay
Consumer Advisory (Chair)
from 21 January 2026



Laurie Maxted
Consumer Advisory (Chair)
up to 21 January 2026



Renee Harrison
Safety Quality & Clinical Governance (Chair)
from 21 January 2026,
Finance Risk & Audit

Name	Date Appointed to the Board	Meetings Attended
Wendy Gladman Director of Community Wellbeing	26 April 2017	9/12
Gregory Currie Teacher (retired)	1 July 2022	12/12
Laurie Maxted Primary Producer (retired)	26 April 2017	8/12
Brett Yates Business Director	1 July 2022	10/12
John White Solicitor/Prosecutor (retired)	1 July 2022	5/12
Renee Harrison Mental Health Clinician	1 July 2022	8/12
Amy Fay Agriculture Consultant	1 July 2022	10/12
Gregory Kuchel Farm Business Advisor	1 July 2025	10/12
Cheree Schneider Nurse Executive	1 July 2025	11/12

Committees

Finance, Risk and Audit Committee

The Finance, Risk & Audit Committee is an advisory committee to the Board of Directors appointed pursuant to the By-Laws of BDH and in accordance with the purpose of the Health Services Act 1988.

The purpose of the Finance, Risk & Audit Committee is to assist the Board in fulfilling its corporate governance responsibilities in regard to the integrity of financial reporting, risk management, the internal control environment, compliance with legal and regulatory obligations, oversight of the internal audit functions and other matters, within scope, referred by the Board.

Brett Yates (Chair) - board director

Gregory Currie – board director

Gregory Kuchel – board director

Renee Harrison – board director

Ray Stomann – external independent member

Grant Malone – external independent member

Samantha Anderson – external independent member

Report of Operations

Mubarak Meera Sahib
Director of Clinical and Community Services

The 2025–2026 year was one of significant achievement, growth and preparation for the future at Boort District Health. Across our acute, urgent care, aged care, community, primary health and support services, our teams remained committed to delivering safe, high-quality and person-centred care while ensuring that people living in Boort and surrounding communities could access healthcare services close to home. As a small rural health service, Boort District Health provides an integrated model of care spanning Urgent Care, Acute Care, Residential Aged Care, Transition Care, District Nursing, Community Services, Immunisation Programs, Primary Health, Day Centre programs and wellbeing initiatives. The dedication, professionalism and compassion of our staff, volunteers, visiting clinicians and community partners continue to be the foundation of our success.

Throughout the year, Boort District Health maintained excellent standards of clinical governance, patient safety and service performance. Urgent Care Centre triage compliance remained at 100%, ensuring timely assessment and treatment for all presentations. Urgent Care activity continued to grow, with approximately 650 presentations during 2025–2026, representing an increase of around 100 presentations compared to the previous financial year. Clinical incidents remained low, no Sentinel Events occurred, and hospital-acquired complications were minimal. Monthly Incident and Case Review Committees, Operational Management Meetings, Medical Staff Meetings, the Medication Advisory Committee and the Board's Safety, Quality and Clinical Governance Sub-Committee provided strong oversight and supported a culture of continuous quality improvement.

Loddon Place continued to provide high-quality residential aged care, achieving annual occupancy above 100% and maintaining a 5-Star Aged Care Rating across Compliance, Quality and Staffing measures. The Transition Care Program performed exceptionally well, achieving annual occupancy levels significantly above targets, while acute service occupancy remained below 50%, reflecting the rural demand profile of the service. Residents continued to report positive experiences through Quality of Life and Quality of Care surveys, Resident of the Day consultations and regular Resident–Family–Executive meetings, reinforcing our commitment to person-centred care and continuous improvement.

Boort District Health continued to strengthen clinical excellence through participation in Safer Care Victoria initiatives including the Adult Sepsis Collaborative, Delirium Collaborative and programs supporting early recognition and management of deteriorating patients. Significant preparation was also undertaken for implementation of the new Aged Care Act and strengthened Aged Care Quality Standards, including readiness planning, governance reviews, updated consumer information and agreements, strengthened documentation systems and ongoing staff education. These activities have positioned the organisation well for future regulatory requirements while maintaining a strong focus on resident rights, quality and safety.

The Aged Care Onsite Pharmacist Program delivered important improvements in medication safety, antimicrobial stewardship and clinical governance through regular medication reviews, education and monitoring. Boort District Health also strengthened its commitment to continuous quality improvement through a strategic partnership with Health Generation, supporting the validation, benchmarking and analysis of key aged care quality indicators, AN-ACC optimisation and evidence-based improvement initiatives. To support transparency and consumer engagement, a physical Quality and Safety Dashboard was introduced adjacent to the nursing station, providing residents, families, visitors and staff with visibility of key quality, safety and consumer experience indicators.

Aged care immunisation rates remained exceptional, with 100% coverage achieved for influenza, COVID-19 and RSV vaccinations. Immunisation services continued to be delivered across Boort, Pyramid Hill, Wedderburn, East Loddon and surrounding communities through our partnership with Loddon Shire Council. Mental Health and Wellbeing services also continued onsite through partnerships with local providers, helping improve access to care for community members.

Community Services continued to grow throughout the year, supporting local residents to remain independent, connected and healthy in their own homes. District Nursing, Home Care, Personal Care, Meals on Wheels, Social Support, Property Maintenance and Transport services provided vital support to older people and vulnerable community members, while primary health initiatives focused on prevention, chronic disease management, health promotion and wellbeing. The Day Centre remained a cornerstone of community wellbeing, providing social support activities, community outings,

educational opportunities and volunteer-led programs. Initiatives such as Men on the Move, community lunches, cultural celebrations and health promotion events helped reduce social isolation and strengthen community connection. The Day Centre also served as a valuable cooling and shelter-in-place facility during periods of extreme weather.

Boort District Health maintained a strong partnership with Ambulance Victoria through regular operational and clinical meetings that supported case review, service coordination, workforce development and shared learning. These collaborative sessions strengthened communication between services and delivered targeted education in key clinical areas, supporting ongoing improvements in urgent care delivery.

A key priority throughout 2025–2026 was improving access to healthcare closer to home. Boort District Health introduced and expanded a range of initiatives including High Sensitivity Troponin testing, a nurse-led limited rural X-ray service, Holter cardiac monitoring and 24-hour blood pressure monitoring through the District Nursing Service, a remote patient monitoring program, increased utilisation of the Victorian Virtual Emergency Department, free onsite optometry services through Raza Optical, expanded mental health and wellbeing services, and visiting Nurse Practitioner services through the Sustainable Rural Health Hub initiative. Access to specialised support was further strengthened through partnerships with The Orange Door, Northern District Community Health, Maternal and Child Health Services, the Resident In Reach Program, the IDHS Diabetes Educator, the onsite consultant pharmacist and Safer Care Victoria's Safer Together Program Leads. Together, these initiatives have enhanced access to timely, integrated and high-quality healthcare while reducing the need for travel. ,

Strong partnerships remained central to our success. Boort District Health worked closely with Boort District P–12 School, North Central LLEN, Northern District Community Health, Bendigo Health, Inglewood District Health Service, Kerang District Health, Boort Medical Practice, Loddon Shire Council, Ambulance Victoria, The Orange Door and numerous community organisations to support service innovation, workforce development and improved consumer outcomes. A Junior Weekend Activities Assistant Program was introduced, providing local young people with meaningful employment opportunities while supporting resident engagement and weekend activities in aged care. Intergenerational programs and school visits continued to flourish, while events such as Reconciliation Week, NAIDOC Week, Volunteer Week, R U OK? Day, the Biggest Morning Tea and the 16 Days of Activism Against Gender-Based Violence reinforced our commitment to community wellbeing. The appointment of Aboriginal Health and Liaison Officer Chris Cooper, development of the Dhelkunyang Garingilang Healing Garden and strengthened partnerships with First Nations organisations further demonstrated our commitment to cultural safety, inclusion and reconciliation.

Our staff continue to be our greatest asset. During the year we welcomed graduate nurses, internationally recruited nurses and Clinical Support Nurse support through Inglewood and Districts Health Service, while continuing to invest in workforce development. Staff participated in Advanced Life Support training, HiRAID education, Sepsis training, Rural Urgent Care Nursing programs, Ambulance Victoria education, leadership development and regional collaborative training opportunities. While workforce challenges remain a reality for rural health services, vacancy rates improved during the year and strong regional partnerships helped ensure service continuity.

As we move into 2026–2027, Boort District Health is well positioned to meet future opportunities and challenges. We enter the new year with strong clinical governance systems, a highly rated aged care service, growing community and primary health programs, innovative local healthcare solutions, strong partnerships and a workforce committed to delivering exceptional care. I sincerely thank our staff, volunteers, visiting clinicians, community partners, Executive Team, Board Directors, consumers, residents and families for their ongoing support. Their dedication, compassion and commitment continue to make Boort District Health a trusted and valued health service for our community

Key Service Areas

- Aged Care (Loddon Place)
- Workforce
- Acute & UCC Services
- Community Services
- Medical / Dental Services

Report of Operations

Social Support Programs

BDH Social Support programs operate weekly on Tuesdays and Thursdays, providing community members with the opportunity to enjoy a nutritious lunch, participate in meaningful activities, and connect with others in a welcoming environment.

Maree and Sally thoughtfully design the programs to be varied and engaging, with a focus on promoting social connection, enjoyment, and overall wellbeing. Activities are planned with client interests in mind and have included quizzes, games afternoons, themed events, dress-up days, guest speakers, friendship celebrations, as well as craft and photo days.

Outings are generally scheduled on a monthly basis, offering participants the chance to explore and experience different communities and local attractions. Over the past year, groups have visited Bendigo, Charlton, Kerang, Wycheproof, Cohuna and Donald, and enjoyed a train trip from Pyramid Hill to Swan Hill.

Participants have also taken part in a number of local excursions around Boort, including visits to Godfrey & Bear and the Spanner Sculptures, further strengthening connections within the local community.

The *Men on the Move* group, coordinated monthly by Sam Isaac, provides additional opportunities for social connection and exploration. Recent outings have included visits to Lake Boga, Barham and Nullawil, as well as a guided tour of Adam Wright's aircraft hangar.

These programs play an important role in fostering social connections, reducing isolation, and supporting participants to remain active and engaged within their community.

Clients also receive a quarterly newsletter featuring news, jokes, health information, and a calendar of upcoming social support programs, along with a variety of word puzzles. Feedback has been very positive, with many clients expressing how much they enjoy and look forward to receiving each edition.

Dental

BDH's dental service comprises a two-chair dental surgery led by Dentist Dr Diana Aio and supported by three Dental Assistants. To strengthen service capacity, two Dental Assistants are currently completing a Certificate IV qualification that includes Oral Health Education and Fluoride Varnish application. These additional skills will enable a broader range of preventive oral health services to be delivered within the clinic, supporting increased patient throughput and improved access to care in 2026.

In addition, one Dental Assistant and the Dental Manager are currently undertaking a Certificate IV in Sterilisation Services. This training will further strengthen infection prevention and control practices, support accreditation requirements, and enhance the quality and safety of dental service delivery.

These workforce development initiatives align with BDH's commitment to building a skilled and capable workforce, improving service efficiency, maintaining accreditation compliance, and achieving better oral health outcomes for the community.



Associate Nurse Unit Manager Neethu Ahamed

Occupational Health and Safety Data

Occupational Health and Safety Statistics	2023-24	2024-25	2025-26
The number or reported hazards/incidents for the year per 100FTE	284	367	163
The number of "lost time" standard WorkCover claims for the year per 100 FTE	1	5	3
The average cost per Work Cover claim for the year	55789.57	9391.84	55311.34

Occupational Violence Statistics

Occupational Violence Statistics	2025-26
Workcover accepted claims with an occupational violence cause per 100 FTE	0
Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	0
Number of occupational violence incidents reported	15
Number of occupational violence incidents reported per 100 FTE	23.44
Percentage of occupational violence incidents resulting in a staff injury, illness, or condition	0

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 rating must be included. Code Grey reporting is not included, however, if an incident occurs during a planned or unplanned Code Grey, it must be included.

Accepted WorkCover claims - claims accepted and lodged in 2025-26.

Lost time - defined as greater than one day.

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

Financial Overview

Financial Information

	2026 ($000)	2025 ($000)	2024 ($000)	2023 ($000)	2022 ($000)
OPERATING RESULT*	**$51**	**$218**	**$66**	**$66**	**$52**
Total revenue	$11,877	$10,922	$10,578	$8,949	$8,372
Total expenses	-$13,131	-$12,205	-$10,717	-$9,776	-$9,142
Net result from transactions	**-$1,254**	**-$1,283**	**-$139**	**-$827**	**-$770**
Total other economic flows	-$12	$56	$14	$5	-$31
Net result	**-$1,266**	**-$1,227**	**-$125**	**-$822**	**-$801**
Total assets	$38,396	$38,071	$38,452	$21,688	$22,061
Total liabilities	$7,943	$6,352	$5,506	$3,841	$4,596
Net assets/Total equity	**$30,453**	**$31,719**	**$32,946**	**$17,847**	**$17,465**

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

Significant changes in financial position

The current asset ration as at 30 June 2026 has decreased slightly to 1.14 (2024-25; 1.23). Despite this slight decrease, the ongoing positive operating results for Boort District Health continue to provide additional reserves, enabling us to meet our debts as and when they fall due.

Operational and budgetary objectives and performance against objectives and significant achievements

Each year the health service establishes an operational budget which is matched to the strategic objectives of the organisation and aims for a balanced budget outcome. In addition, the budget takes account of the service delivery profile which has been designed to meet community needs. For the 2025-2026 year the financial result was very close to the forecast budget.

The Operating Result for the year is a surplus of $51,000 compared to a budgeted result of29,000. Nursing Home occupancy remains high, creating a $235,000 surplus to budget revenue in federal grant funding. Employee expenses have grown by $129,000 on last year.

Reconciliation of Net Result from Transactions and Operating Result

	2025-26 ($000)
OPERATING RESULT	**$51**
Capital purpose income	$203
Specific income	$11
COVID 19 State Supply Arrangements - Assets received free of charge or for nil consideration under the State Supply	-
State supply items consumed up to 30 June 2026	-
Assets provided free of charge	-
Assets received free of charge	$29
Expenditure for capital purpose	-$27
Depreciation and amortisation	-$1,533
Impairment of non-financial assets	-
Finance costs (other)	-
Net result from transactions	**-$1,266**

Workforce Data

Hospitals Labour Category	JUNE Current Month FTE*		Average Monthly FTE	
	2025	2026	2025	2026
Nursing	21.93	24.35	21.19	22.28
Administration & Clerical	9.81	9.92	9.2	9.90
Medical Support	13.85	14.01	10.99	15.38
Hotel & Allied Services	18.17	16.00	16.88	17.76
Medical Officers	0.11	0.11	0.11	0.11
Hospital Medical Officers	0	0		0
Sessional Clinicians	0	0		0
Ancillary Staff (Allied Health)	1.90	0	2.07	0

*Employees have been correctly classified in workforce data collections

Employment Principles

Employment at BDH is open to all applicants without systemic, hidden or apparent bias on the grounds of gender, race, disability, sexuality, age, marital status, pregnancy, breastfeeding, parental or carer status, religious belief, political belief, medical record, irrelevant criminal record or trade union activity and reflects employment best practice. Appointments, employee conditions of employment and salary classifications are applied in accordance with the applicable Enterprise Agreement and the Victorian Government's Health Executive Employment Remuneration (HEER) Policy. Employees are correctly classified in workforce data collections.

Financial Overview

Social Procurement Framework

Social procurement provides an opportunity for Boort District Health (BDH) to deliver positive social, economic and sustainable outcomes that contribute to building a fair, inclusive and sustainable Victoria through all procurement activities undertaken by, or on behalf of, the Health Service.

BDH is committed to embedding the principles of the Victorian Social Procurement Framework within its procurement practices and decision-making processes. Through the implementation of this Social Procurement Strategy, BDH will leverage its purchasing power to advance social, environmental and local economic objectives while achieving value for money and supporting community wellbeing. BDH will meet the Strategy key objectives by:

1. Opportunities for Victorian Aboriginal People

Boort District Health (BDH) is committed to creating economic opportunities for Victorian Aboriginal people by increasing engagement with Aboriginal-owned businesses through its procurement activities. Consistent with the Victorian Social Procurement Framework, BDH will seek to strengthen Aboriginal economic participation by identifying and engaging Aboriginal suppliers, promoting supplier diversity, and fostering sustainable business relationships. Through these actions, BDH contributes to self-determination, economic inclusion, and improved social outcomes for Victorian Aboriginal communities.

2. Opportunities for Victorian Priority Jobseekers

BDH recognises the important role procurement can play in creating pathways to employment for people experiencing disadvantages or barriers to workforce participation. Through procurement planning and supplier engagement, BDH will encourage suppliers and contractors to create employment, training, apprenticeship, and skills development opportunities for Victorian priority jobseekers. These initiatives support social inclusion, workforce participation, and stronger community outcomes while delivering value through the procurement process.

3. Supporting Safe and Fair Workplaces

BDH is committed to promoting safe, ethical, diverse, and inclusive workplaces throughout its supply chain. Suppliers engaged by BDH are expected to comply with relevant workplace laws, industrial relations obligations, and the Victorian Government Supplier Code of Conduct. By incorporating fair employment practices into procurement decisions, BDH supports the protection of workers' rights, workplace safety, diversity, and employee wellbeing, ensuring procurement activities contribute to positive social outcomes beyond the delivery of goods and services.

4. Environmentally Sustainable Business Practices

BDH acknowledges that procurement decisions can significantly influence environmental outcomes. In line with the Social Procurement Framework, BDH seeks to engage suppliers that demonstrate environmentally sustainable business practices, reduce carbon emissions, minimise waste, improve resource efficiency, and support the transition to a more sustainable economy. By integrating environmental considerations into procurement planning and evaluation, BDH contributes to long-term environmental stewardship and sustainable health service operations.

Strategic Commitment Statement

BDH will use its purchasing power to generate social, economic, and environmental value for the communities it serves. Through implementation of the Victorian Social Procurement Framework, BDH aims to achieve value for money while creating opportunities for Victorian Aboriginal people, supporting priority jobseekers, promoting safe and fair workplaces, and encouraging environmentally sustainable business practices. These objectives will be embedded within procurement processes, supplier engagement activities, and contract management practices to deliver measurable and lasting community benefits.

Social procurement activities and commitments	
Reporting Period: 2025 – 2026 Reporting Entity: Boort District Health	
Overall social procurement activities	**2025-2026**
Number of suppliers engaged.	189
Total expenditure (excl. GST)	$1,946,054.37
Number of social benefit suppliers engaged	2
Total expenditure with social benefit suppliers (excl. GST)	$9,530.13
Number of Victorian Aboriginal businesses engaged	1
Total expenditure with Victorian Aboriginal businesses (excl. GST)	$1,822.73
Number of Victorian social enterprises led by a mission for people with disability and Australian Disability Enterprises engaged	0
Total expenditure with Victorian social enterprises led by a mission for people with disability and Australian Disability Enterprises (excl. GST)	$0.00
Number of Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers engaged	1
Total expenditure with Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers (excl. GST)	$7,707.40
Number of Victorian social enterprises engaged	1
Total expenditure with Victorian social enterprises (excl.GST)	$7,707.40
Number of Victorian Aboriginal businesses engaged	1
Total expenditure with Victorian Aboriginal businesses (excl. GST)	$1,822.73

Statement of Priorities

All data published in annual reports is accurate at the time of publishing.
Data may change following audit and data verification, which may not be finalised at the time of publishing.

Reporting against the Statement of Priorities – Part A

In 2025-2026 Boort District Health will contribute 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.

Goal	
Align with the Victorian Clinical Governance Framework to strengthen clinical governance systems, ensuring safe, high-quality care.	
Health service deliverables	**Achievements/Outcome**
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	**Achieved** **Commentary:** Boort District Health demonstrated its commitment to high quality, person-centred care by embedding consumer engagement across service planning, evaluation and quality improvement activities. Consumer feedback and lived experience were actively sought through multiple formal and informal mechanisms, ensuring consumers had meaningful opportunities to influence service delivery and organisational decision-making. The Consumer Advisory Committee continued to provide an important forum for consumer participation, enabling community members to contribute directly to discussions regarding service improvements and strategic priorities. Consumer perspectives were further captured through Quality of Life and Quality of Care Experience assessments, the Consumer Experience Survey, Residents' Experience Reports, resident forums, and regular Resident/Executive Morning Teas, which created opportunities for direct engagement between residents and executive leadership. Feedback gathered through these activities was systematically reviewed and reported through feedback reports and case review processes. Recommendations arising from consumer feedback were considered and implemented where appropriate, resulting in service improvements and strengthening the organisation's responsiveness to resident and patient needs. The patient experience survey was also revised to align with the Loddon Mallee Local Health Network Regional Strategy on Consumer Governance, ensuring contemporary and consistent approaches to measuring and responding to consumer experience. Consumer engagement informed several key organisational initiatives during the year. Consumers were represented in the newly established Aged Care Accommodation Project Control Group, ensuring resident and community perspectives were incorporated into planning for future accommodation developments. Recruitment efforts, including community advertising through About Boort media channels, supported the attraction of new consumer representatives, while a new consumer representative was successfully recruited to the Safety and Quality Committee Governance Committee to strengthen consumer participation in governance processes. Broader consultation and engagement activities were supported by the development of the Boort Demographic Health and Partnerships Overview and the Boort District Health Cultural Safety Report, which provided valuable insights into the needs and expectations of the community and priority population groups. These findings are informing future service planning and consumer engagement approaches. In addition, the Boort District Health Consumer Engagement Strategy underwent review to ensure ongoing alignment with best practice principles and emerging community needs. The organisation's commitment to quality and consumer-centred care was reflected in the achievement of a 5-Star Aged Care Star Rating and 100% implementation of the Healthy Choices Policy Directive, demonstrating strong performance in quality, safety and wellbeing outcomes. Collectively, these initiatives demonstrate that consumer engagement is actively embedded within organisational systems and is being effectively used to drive continuous improvement, enhance consumer experiences and achieve better outcomes for residents, patients and the broader community.

Health service deliverables	Achievements/Outcome
Ensure that health service reporting, reviews and decision-making are underpinned by a safety culture and systems that are transparent, accurate and fair for staff and consumers.	**Achieved** **Commentary:** Throughout the year, Boort District Health strengthened its governance, reporting and decision-making processes to ensure they were firmly grounded in a culture of safety, transparency, accountability and fairness for both staff and consumers. A strong focus was placed on equity and inclusion through the implementation and monitoring of the Gender Equality Action Plan and Gender Impact Assessments, ensuring organisational decisions considered their impact on all staff and community members. This commitment was further reinforced through engagement with the Victorian Gender Equality Commissioner, Dr Nikki Vincent, during her visit to the organisation, as well as the onsite support provided by gender equality consultant Genine Hook. The completion of the 2026 People Matter Survey and review of the 2025 survey results provided valuable staff feedback, enabling leadership to identify strengths and opportunities for improvement while promoting a culture of openness and continuous learning. Organisational integrity and transparency were strengthened through the ongoing management of declaration of interests processes and the completion of an updated Integrity Governance Framework assessment and accompanying action plan. These initiatives supported ethical decision-making and increased confidence that governance processes remained accountable, transparent and free from conflicts of interest. Clinical and organisational governance systems were further enhanced through a well-defined committee reporting structure that ensured risks, incidents, performance outcomes and strategic priorities were routinely reviewed and escalated appropriately. Alignment with the National Model for Clinical Governance and completion of the Clinical Governance Maturity Matrix provided assurance that governance systems reflected contemporary best practice and supported safe, high-quality care. The organisation continued to foster a just and learning culture through its commitment to the Statutory Duty of Candour and Open Disclosure requirements, ensuring consumers and families received honest, timely and compassionate communication when adverse events occurred. Staff capability and compliance were also strengthened through ongoing education and implementation of mandatory reporting requirements, Multi-Agency Risk Assessment Management, Family Violence Information Sharing Scheme, Child Information Sharing Scheme obligations, and the use of the Speaking Up For Safety framework to support safe and effective care delivery. Workplace culture initiatives, including the promotion of Above and Below the Line behaviours, reinforced expectations around respectful communication, accountability and psychological safety. These initiatives encouraged staff to openly identify concerns, participate in improvement activities and contribute to a positive and supportive workplace environment. Strategic decision-making was informed through regular engagement with the Department of Health, including the annual strategic meeting with Department of Health Hume Victoria representatives. Planning for the introduction of the Commonwealth Support at Home program also demonstrated proactive governance and risk management, with arrangements established for Boort District Health to remain an approved associate provider through Bendigo Health, ensuring continuity of services for consumers while maintaining compliance with evolving regulatory requirements. Collectively, these initiatives strengthened organisational governance, enhanced transparency and accountability, promoted equitable and evidence-based decision-making, and embedded a culture of safety and continuous improvement across the health service.

Statement of Priorities

Health service deliverables	Achievements/Outcome
Health services are able to show evidence of a comprehensive training program approach that includes performance management, accountability, and continuous improvement.	**Achieved** **Commentary:** Boort District Health has continued to demonstrate a comprehensive and structured approach to workforce development, incorporating performance management, accountability, professional development and continuous improvement across all service areas. Performance management processes were embedded through the ongoing implementation of Annual Performance Development Reviews, ensuring staff performance, professional goals and development needs were regularly reviewed and aligned with organisational objectives. Workplace trainer reports have provided oversight of workforce capability and development priorities, supporting accountability and informed decision-making. A strong commitment to compliance and workforce capability was maintained through the organisation's mandatory training program, with an outstanding 97% of staff attending face-to-face mandatory training sessions delivered across ten days. Continuing Professional Development compliance was actively monitored, ensuring clinicians maintained required competencies and professional registration standards. Continuous improvement principles underpin the organisation's approach to workforce development. Training priorities and workforce capability requirements are guided by both the Continuous Improvement Plan and Quality Plan, ensuring learning and development activities are directly linked to service quality, risk management and organisational performance outcomes. To support future workforce sustainability, a draft Workforce Planning document has been developed. This work is being strengthened through a comprehensive organisational training needs and aspirations analysis currently being undertaken by the Workforce Planning Team. The findings will be mapped against departmental workforce plans to identify capability gaps, succession planning opportunities and targeted development initiatives across the organisation. Leadership development has also remained a key focus. Senior executive staff participated in the Engaging People leadership development program, while four senior staff members attended the Women in Leadership Summit in Melbourne in February 2026. These initiatives have enhanced leadership capability and supported the development of future organisational leaders. Targeted workforce development opportunities have been provided across a range of disciplines. Catering staff commenced the Food Safety Supervisor course, while Maintenance and Gardening staff undertook Chemical Users training to strengthen compliance and workplace safety. Boort District Health also supported vocational training opportunities through work placements for students completing a Certificate II in Cookery. The organisation continues to invest in growing its future workforce through recruitment and career progression pathways. New staff have been recruited into the Junior Development Program, with ongoing recruitment supporting succession planning and workforce sustainability. Two Graduate Nurses commenced employment during the reporting period, while two Enrolled Nurses progressed to Registered Nurse training. In addition, one Registered Nurse commenced the Rural Urgent Care Nursing extended training program, further strengthening the organisation's clinical capability. Recognising the need to build advanced nursing practice capacity, a grant application was submitted to support Nurse Practitioner training requirements. Clinical workforce capability was further enhanced through an increase in contracted Clinical Support Nurse services provided by Inglewood District Health Service, offering additional mentoring, education and clinical support to nursing staff. Collectively, these initiatives demonstrate that Boort District Health has implemented a comprehensive and well-governed training and development framework that integrates performance management, accountability, workforce planning and continuous improvement to build a skilled, capable and sustainable workforce.

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.

Goal

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.

Health service deliverables	Achievements/Outcome
Deliver the key initiatives outlined in the Budget Action Plan within Government parameters.	**Achieved** **Commentary:** Throughout the reporting period, significant progress was made in delivering the key initiatives identified within the Budget Action Plan while maintaining compliance with Government requirements and financial management expectations. A strong focus was placed on financial stewardship, accountability, and transparent reporting to ensure organisational sustainability and alignment with Department of Health expectations. Compliance with both the Budget Action Plan and Financial Management Improvement Plan requirements was maintained through regular monitoring, reporting, and review of financial performance. Robust financial reporting processes ensured the Board, Executive and external stakeholders were provided with accurate and timely information to support decision-making and monitor progress against budget targets. Regular participation in Department of Health quarterly performance meetings provided opportunities to discuss financial performance, operational challenges and strategic priorities. These meetings enabled proactive engagement with the Department and ensured alignment with Government expectations and performance objectives. Following ongoing review and analysis of financial forecasts, the 2025-26 financial year budget was revised and reissued to reflect current operating conditions and organisational priorities. The updated budget was subsequently approved by Hospitals Victoria, providing assurance that financial planning remained realistic, achievable and aligned with Government funding parameters. Close oversight was maintained of Aged Care Grant funding requirements, including the achievement of grant milestones and monitoring of the health services co-contribution commitments against agreed timelines. This ensured grant obligations were met and funding opportunities were maximised in support of service delivery outcomes. Detailed expenditure reports were produced and reviewed regularly to monitor budget performance, identify variances, and support corrective actions where required. This disciplined financial management approach enabled the organisation to maintain control of expenditure, respond to emerging pressures, and deliver the Budget Action Plan objectives within the required Government framework. As a result, the organisation successfully met the key financial management and reporting obligations outlined in the Budget Action Plan, demonstrating sound governance, fiscal responsibility, and ongoing commitment to sustainable service delivery.

Resident Jan Lee with junior activity worker Milly Scott



Statement of Priorities

Health service deliverables	Achievements/Outcome
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.	**Achieved/Ongoing** **Commentary:** Throughout the reporting period, Boort District Health demonstrated a strong commitment to evidence-based decision-making by leveraging data analytics, performance reporting and benchmarking tools to identify inefficiencies, reduce waste and strengthen financial sustainability and operational performance. A range of environmental, clinical, financial and operational data sources were routinely analysed to inform organisational priorities and improvement activities. Comprehensive reporting through the Environmental Data Management System; Eden suite, and waste management reporting provided valuable insights into resource utilisation, compliance requirements and waste streams, enabling targeted actions to improve efficiency and support environmental sustainability objectives. Clinical Indicator Reports and trend analysis were regularly reviewed to monitor service quality, identify emerging risks and variations in performance, and drive continuous improvement initiatives. This data-informed approach supported timely decision-making and ensured resources were directed to areas of greatest need and impact. Similarly, finance reporting and budget monitoring processes provided ongoing visibility of organisational performance, enabling proactive management of expenditure and revenue while supporting financial sustainability. Workforce and activity data from Loddon Mallee Shared Services and Loddon Mallee Local Health Service Network reporting were utilised to monitor service demand, staffing trends and operational performance. Analysis of this information informed workforce planning, service delivery adjustments and resource allocation decisions, ensuring the organisation remained responsive to changing community needs while maintaining efficient operations. Environmental sustainability performance was monitored through the Environmental, Social and Governance framework and Eden suite, supported by National Australian Built Environment Rating System assessments. Boort District Health achieved an Energy rating of 3.5 stars and a Water rating of 1 star, providing measurable benchmarks for future improvement initiatives and helping identify opportunities to reduce energy consumption, water usage and associated costs. The organisation also demonstrated leadership in fleet sustainability through use of the VicFleet Transition Calculator to assess readiness for the Victorian Government's Zero Emission Vehicle transition. As a result of this proactive planning, Boort District Health was commended by VicFleet for being the first health service in our region to install electric vehicle charging infrastructure in preparation for future fleet transition requirements, positioning the organisation to achieve long-term environmental and financial benefits. Financial governance and accountability were further enhanced through a review and update of the Boort District Health and Bendigo Health Accounting Services Service Level Agreement, ensuring services remained aligned to organisational needs and delivered value for money. Detailed budget forecasting processes were also refined to incorporate additional expenditure pressures, providing a more accurate financial outlook and supporting informed executive decision-making. In addition, a comprehensive review and comparison of Commonwealth Home Support Program contracted services was undertaken to evaluate service costs, performance and value. The findings informed decisions regarding service delivery arrangements and opportunities to optimise resources while maintaining quality outcomes for consumers. Collectively, these initiatives demonstrate how the systematic use of performance metrics, benchmarking data and analytical reporting enabled Boort District Health to identify inefficiencies, minimise waste, improve resource utilisation and make informed decisions that strengthened both financial sustainability and operational performance.

Health service deliverables	Achievements/Outcome
Use funding efficiently and effectively to optimise patient facing services. Undertake programs to reduce the cost of service delivery, improve safety, capacity and reduce unnecessary waiting.	**Achieved/Ongoing** **Commentary:** Achieved/Ongoing Commentary: The organisation achieved this deliverable by maintaining a strong focus on the efficient and effective use of available funding to maximise patient-facing services while improving access, safety, capacity and service sustainability. Robust financial management and reporting processes ensured resources were allocated appropriately and transparently. Comprehensive internal and external reporting requirements were met through submissions to the Department of Health and other stakeholders, including Calumo, Data Exchange, Agency Information Management System, the Department Repository, Quarterly Financial Reports , Annual Certified Financial Reports, quarterly performance meetings, the Annual Report, and regular engagement with internal and external auditors and Victorian Auditor General Office. This disciplined approach enabled informed decision-making, supported accountability, and ensured funding was directed towards areas of greatest community need. Significant effort was directed towards reducing unnecessary waiting times and improving service accessibility. Performance against wait-time targets was closely monitored and managed across Dental Services, the Urgent Care Centre triage process, aged care services and community service waitlists. Active management of demand and service capacity supported timely access to care and contributed to improved patient experiences and outcomes. Workforce recruitment and retention initiatives remained a key priority to strengthen service delivery capacity and sustainability. The addition of a Clinical Support Nurse position through collaboration with Inglewood and Districts Health Service enhanced clinical leadership, workforce support and service quality. Workforce planning was further supported through the development of a business case for a part-time Dentist position, aimed at increasing dental service capacity and improving access to oral health services for the community. The organisation also leveraged innovative models of care to maximise service efficiency. Participation in the Virtual Care Office through the Loddon Mallee Shared Service Annual Work Plan supported exploration of technology-enabled and alternative service delivery approaches that could improve access and optimise the use of clinical resources. While participation in the Loddon Mallee Shared Service Wound Analytics Trial was initially considered, Boort District Health made the informed decision to withdraw when it became apparent that the organisation did not meet the required eligibility criteria, ensuring resources remained focused on initiatives that would deliver the greatest value. Data and performance monitoring continued to inform service planning and resource allocation. Regular review of the Dental Weighted Activity Unit Report provided valuable insights into activity levels, service demand and efficiency, supporting evidence-based decision-making and funding utilisation within dental services. Further enhancing local access to care, visiting Optometrist and Audiologist services were successfully established. These services expanded the range of specialist care available within the community, reducing the need for residents to travel elsewhere for assessment and treatment while improving access to timely, patient-centred healthcare close to home. Collectively, these initiatives demonstrate a strategic and disciplined approach to funding utilisation, enabling the organisation to optimise patient-facing services, strengthen workforce capacity, improve access and responsiveness, and deliver safe, efficient care that meets the evolving needs of the community.

Statement of Priorities

A stronger workforce

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

Goal
Position Victoria as a leader in employee experience, capability, and capacity by focusing on future roles and professional development in line with the Victorian Health Workforce Strategy to ensure a regenerative and sustainable workforce.

Health service deliverables	Achievements/Outcome
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.	**Achieved/Ongoing** **Commentary:** Boort District Health successfully implemented a range of strategic workforce initiatives to sustain workforce supply, meet legislative and industrial obligations, and enhance the employee experience across leadership, health and safety, flexibility, career development and organisational agility. These initiatives have strengthened our ability to deliver safe, high-quality care while building a capable, engaged and sustainable workforce. A strong focus was placed on advancing gender equality and creating an inclusive workplace through the implementation of the Gender Equality Action Plan. Gender Impact Assessments were undertaken as required, gender equality reporting obligations were met, and the Gender Equality Action Plan Progress Report was submitted, demonstrating ongoing commitment to addressing workplace gender equity and embedding gender-responsive decision-making across the organisation. Employee engagement and performance continued to be strengthened through the completion of Performance Development Reviews, providing staff with opportunities for feedback, goal setting, career planning and professional growth. Results from the People Matter Survey and associated workforce feedback processes were reviewed and used to inform workforce initiatives and organisational improvements aimed at enhancing employee experience, engagement and wellbeing. Workforce sustainability and compliance remained a key priority, with continued adherence to the Safe Patient Care Act ensuring appropriate staffing profiles and skill mix to support safe, high-quality patient care. Comprehensive workforce planning processes were undertaken to identify current and future workforce needs, enabling proactive recruitment, succession planning and workforce development activities. Significant effort was directed towards attracting and developing the future workforce. Partnerships Through the Workplace Trainer/Careers Advisor pathways into healthcare careers were strengthened, while the Clinical Support Nurse continued to support student placements and workforce pipelines. Graduate Nurse recruitment programs successfully attracted early-career clinicians, supporting workforce renewal and building future clinical capability within the organisation. Boort District Health continued to promote flexible work arrangements across the workforce, supporting improved work-life balance and helping to attract and retain staff in a competitive labour market. These arrangements contributed to employee wellbeing, workforce participation and organisational agility while ensuring service delivery requirements continued to be met. Staff wellbeing and psychological safety were further enhanced through the review and update of the Employee Assistance Program policy, ensuring employees had timely access to confidential support services. The implementation of RespectX training and reporting mechanisms reinforced BDH's commitment to a respectful, safe and inclusive workplace culture, supporting the prevention and management of inappropriate workplace behaviours. Leadership capability was strengthened through targeted leadership development programs that equipped managers and emerging leaders with the skills required to effectively lead teams, manage change and foster positive workplace cultures. These initiatives have supported greater workforce engagement, accountability and organisational resilience. Boort District Health also strengthened its commitment to cultural safety, inclusion and partnership through the Women's Health Loddon Mallee CARE partnership with Aunty Marilyn Nicholls and the health service. This collaboration has enhanced cultural awareness, understanding and responsiveness across the organisation, supporting a more inclusive workplace and contributing to culturally safe care for the communities served. Collectively, these initiatives have enhanced workforce capability, engagement and wellbeing while ensuring compliance with legislative requirements and workforce obligations. As a result, the health service has strengthened its ability to attract, retain and support a skilled workforce capable of delivering safe, high-quality care close to home for our community.

Health service deliverables	Achievements/Outcome
Collaborate with the department to improve workforce data analytics, generate actionable insights, and enhance strategic planning.	**Ongoing** **Commentary:** This deliverable was achieved through a strong focus on workforce data analysis, performance monitoring, and strategic collaboration with the Department and regional partners. Regular Full-Time Equivalent and vacancy reviews were undertaken to provide accurate workforce intelligence, enabling the identification of workforce gaps, recruitment priorities, and emerging service pressures. These reports informed operational decision-making and supported proactive workforce planning across the organisation. Workforce analytics and performance data were incorporated into the development and implementation of the Boort District Health Strategic Plan, ensuring future workforce requirements and service delivery objectives were aligned with organisational priorities. Ongoing engagement with the Department through quarterly performance meetings and Health Service Improvement Committee meetings provided opportunities to review workforce trends, benchmark performance, discuss emerging challenges, and identify opportunities for improvement. The organisation utilised data from the Victorian Agency for Health Information Monitor and HealthShare Victoria reporting frameworks to assess workforce-related performance indicators, monitor organisational outcomes, and support evidence-based decision-making. These analytics provided valuable insights into service demand, workforce utilisation, and areas requiring targeted action to improve efficiency and effectiveness. Collaboration extended beyond the organisation through active participation in the Loddon Mallee Local Health Service Network Clinical Services Planning process and the implementation of the Loddon Mallee Regional Data Sharing Agreement. These initiatives strengthened regional workforce intelligence capabilities, enhanced access to comparative data, and supported a coordinated approach to workforce and service planning across the region. Collectively, these activities improved the quality and accessibility of workforce data, generated actionable insights to inform strategic and operational decisions, and strengthened workforce planning processes, ensuring the organisation remained well positioned to meet current and future service delivery needs.

Improving Aboriginal health and wellbeing

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

Goal
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.

Health service deliverables	Achievements/Outcome
Deliver high-quality cultural safety training to all executives and staff using independent, expert, community-controlled organisations or a registered Aboriginal business.	**Not Achieved/Ongoing** **Commentary:** This deliverable was successfully achieved through a coordinated approach that combined expert guidance, culturally informed education, and strengthened First Nations engagement across the organisation. The LMHN First Nations Strategic Advisor played a key role in guiding the development and implementation of cultural safety initiatives, ensuring training content and organisational practices were aligned with the principles of cultural respect, self-determination, and improved outcomes for Aboriginal and Torres Strait Islander peoples. To deliver contemporary and impactful learning opportunities, the organisation implemented recommendations arising from the Blak Butterfly report, to provide culturally safe education and training. These sessions enhanced executives' and staff members' understanding of Aboriginal culture, history, lived experiences, and the importance of culturally responsive healthcare practices. The training fostered greater awareness, reflection, and accountability in supporting culturally safe environments for patients, families, communities, and colleagues. In addition, the organisation implemented the Kineo cultural safety training module, providing a consistent and accessible learning platform for all staff. This ensured cultural safety education was embedded across the workforce and enabled broad participation, supporting ongoing capability development and reinforcing key cultural safety principles. Further strengthening this work, a new shared Aboriginal Hospital Liaison Officer position was established and engaged. This role enhanced connections with Aboriginal patients and communities, improved access to culturally appropriate support, and provided staff with valuable guidance to strengthen culturally responsive care. The liaison officer also contributed practical insights that reinforced training outcomes and supported the translation of cultural safety principles into everyday practice. Collectively, these initiatives have strengthened organisational capability, increased cultural awareness and understanding across the workforce, and demonstrated a commitment to partnering with Aboriginal-led organisations and communities to deliver safe, respectful, and inclusive healthcare services.

Statement of Priorities

Health service deliverables	Achievements/Outcome
Health service executives and senior leaders establish 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-determined priorities, and cultural knowledge of Aboriginal communities in the design, delivery, and evaluation of health and wellbeing services.	**Ongoing** **Commentary:** Boort District Health executives and senior leaders have continued to build and strengthen meaningful partnerships with Aboriginal community-controlled organisations and respected Aboriginal leaders across the local catchment. Through regular engagement with organisations including Bendigo and District Aboriginal Co-operative, Mallee District Aboriginal Services, local Aboriginal community-controlled organisations and Dja Dja Wurrung Clans Aboriginal Corporation DJAARA, Boort District Health has sought to ensure that Aboriginal voices, cultural knowledge and community priorities inform the planning, delivery and evaluation of health and wellbeing services. A key focus during the reporting period has been fostering genuine relationships with Aboriginal community leaders including Aunty Marilyne Nichols, Jean McMahon and Dr Mishel McMahon, whose guidance and cultural expertise have contributed significantly to Boort District Health's understanding of community expectations and culturally safe service delivery. These relationships have enabled ongoing dialogue and strengthened the health services commitment to listening to and responding to Aboriginal perspectives. Boort District Health has demonstrated its commitment to cultural safety and recognition through several visible and enduring initiatives. The establishment of the Boort District Health Healing Garden has created a culturally meaningful space that acknowledges Aboriginal culture and promotes healing, reflection and connection. Official approval was sought and given by DJAARA to use traditional language to name the space Dhelkinyang Garingilang. This commitment was further reinforced through the installation of individually designed glass Acknowledgement of Country signage in the health service, and the commissioning and display of artwork by Jida Gulpilil, creating a more welcoming and culturally respectful environment for Aboriginal patients, visitors and staff. The appointment and support of an Aboriginal Health Liaison Officer has strengthened Boort District Health's ability to engage with Aboriginal consumers and communities and ensure culturally appropriate support and advocacy within the health service. The health service has also undertaken a comprehensive Cultural Safety Report, providing valuable insights into areas of strength and opportunities for continued improvement in the delivery of culturally safe care. Partnerships have extended beyond consultation to active collaboration and advocacy. The Board and Executive supported community-led discussions regarding the scar tree project outcome, with Paul Haw advocating alongside DJAARA to review and consider the project's future direction. In addition, the Board Chair and CEO have maintained direct engagement with DJAARA Director Jaran to progress discussions regarding cultural engagement opportunities and strengthen the strategic relationship between the organisations. Boort District Health has also sought to embed Aboriginal culture into everyday organisational practice. New staff polos and scrubs were developed in collaboration with YARN, ensuring Aboriginal artwork and cultural themes are visibly represented across the workforce and reinforcing the organisation's commitment to cultural inclusion and respect. Collectively, these initiatives demonstrate the health services proactive and ongoing approach to engaging with Aboriginal communities and organisations. Through relationship-building, visible cultural recognition, collaborative projects, governance engagement and continuous improvement activities, the health service has strengthened partnerships that support self-determination and ensure Aboriginal perspectives remain central to the design and delivery of healthcare services across the community.

Health service deliverables	Achievements/Outcome
Ensure culturally appropriate systems for identifying Aboriginal and Torres Strait Islander patients and implement responsive discharge plans and referral pathways.	**Ongoing** **Commentary:** Boort District Health strengthened its commitment to culturally safe and responsive care for Aboriginal and Torres Strait Islander peoples through a range of system, workforce and environmental initiatives. The organisation enhanced the visibility and recognition of Aboriginal and Torres Strait Islander identity across its services through the prominent display of Aboriginal and Torres Strait Islander flags, together with culturally significant artwork and artefacts throughout the health service. These initiatives created a more welcoming environment and demonstrated respect for culture, identity and connection to community. Significant improvements were made to patient identification processes, with admission documentation and associated workflows reviewed to ensure Aboriginal and Torres Strait Islander patients are appropriately identified at the point of care. This strengthened the ability of clinicians to implement culturally responsive care planning, discharge arrangements and referral pathways tailored to individual needs and circumstances. Implementation of the Blak Butterfly Action Plan provided a structured framework for embedding cultural safety initiatives across the organisation. The plan supported improvements in service delivery, staff awareness and organisational accountability, ensuring that Aboriginal and Torres Strait Islander consumers receive care that is respectful, culturally informed and responsive to their health and wellbeing needs. Boort District Health continued to leverage established partnerships with the Aboriginal Hospital Liaison Officers based in Bendigo and Swan Hill, ensuring both consumers and staff had access to expert cultural support, advocacy and referral assistance. These relationships strengthened continuity of care and facilitated more effective connections with community-based services following discharge. Further demonstrating its commitment to improving outcomes for Aboriginal and Torres Strait Islander consumers, Boort District Health established a local Aboriginal Hospital Liaison Officer position. Although unfunded, the organisation invested in a 0.2 Full-Time Equivalent Aboriginal Hospital Liaison Officer role to provide additional cultural guidance, support service navigation, enhance consumer engagement and strengthen culturally appropriate care pathways. This initiative has increased local capacity to support Aboriginal and Torres Strait Islander patients and their families throughout their healthcare journey, from admission through to discharge and ongoing community care.

Saying farewell to Sandra Poyner after almost 40 years' service



Statement of Priorities

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.

Goal
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.

Health service deliverables	Achievements/Outcome
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).	**Ongoing** **Commentary:** Strong engagement and leadership within the Local Mallee Loddon Health Service Network supported the successful achievement of the objectives outlined in the Statement of Expectations. Boort District Health Chief Executive Officer held the role of sponsor for two Loddon Mallee Local Health Service Network initiatives and four Project Control Groups. The Chief Executive Officer and Board Chair were active leaders supporting collaboration, accountability and strategic alignment across network partners. This sponsorship roles ensured progress against priority areas, promoted shared decision-making, and strengthened regional approaches to improving access, workforce sustainability, service integration, safety and quality outcomes. A significant contribution was also made to the review and refinement of the Joint Venture Agreement - Collaboration Agreement. Through active participation in consultation and review processes, opportunities were identified to strengthen governance arrangements, clarify roles and responsibilities, and enhance collaborative service delivery across member organisations. The revised agreement reinforced the foundations for effective regional partnerships and supported the achievement of shared network objectives. The successful completion of the Capability and Governance Maturity Model further demonstrated organisational commitment to continuous improvement and network excellence. The assessment process enabled the identification of strengths and development opportunities across governance, leadership and organisational capability domains, supporting the ongoing maturity of the health service and its contribution to network-wide priorities. In addition, meaningful contributions were made to the development and revision of the Clinical Services Plan, ensuring that local knowledge, community needs and service delivery priorities were reflected in future planning. This collaborative planning process supported the alignment of services across the network, strengthened pathways of care, and helped position the health service to meet current and emerging healthcare needs while improving equity of access and service sustainability. Collectively, these activities demonstrated a strong commitment to regional collaboration, strategic leadership and continuous improvement, contributing to the successful delivery of the Local Health Service Network Statement of Expectations across all priority areas.

Performance Priorities – Part B

High Quality And Safe Care

Key performance indicator	Target	2025 - 26 result
Infection prevention and control Percentage of healthcare workers immunised for influenza	94%	99%
Adverse events Percentage of reported 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	NA
Aged care Public Sector Residential Aged Care Services overall star rating	Minimum rating of 3 stars	Achieved
Patient experience Percentage of patients who reported positive experiences of their hospital stay	95%	NA
Aboriginal Health Difference between the percentage of Aboriginal patients and nor aboriginal patients who left against medical advice	0%	NA

NA - Less than 10 responses were received for the period due to the relative size of the Health Service

Strong Governance, Leadership and Culture

Key performance indicator	Target	2025 - 26 result
Organisational culture People matter survey – Percentage of staff with an overall positive response to safety culture survey questions	80%	86%

Changes to the 2025-26 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.

Effective Financial Management

Key performance indicator	Target	2025 - 26 result
Operating result ($m)	0.00	0.05
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	1.26
Variance between the 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

Activity and Funding – Part C

Boort District Health funding summary for 1 July 2025 - 30 June 2026

Funding Type	Activity
Aged Care	
Residential aged care	9,234
HACC	216

Volunteers

Boort District Health is fortunate to be supported by 34 dedicated volunteers who generously contributed their time, skills, and experience throughout the 2025-2026 year.

Collectively, our volunteers contribute between 20 and 50 hours each week, providing valuable support across a wide range of services.

Our volunteers play an invaluable role in both our aged care and community services.

In aged care, volunteers enrich the lives of residents by providing live music, playing games, assisting with themed activities and outings, and, most importantly, offering companionship through regular visits and meaningful conversations.

Within the community, volunteers assist with administrative tasks, deliver Meals on Wheels, provide transport to medical appointments and shopping, and support community social groups, helping people remain connected, engaged, and independent.

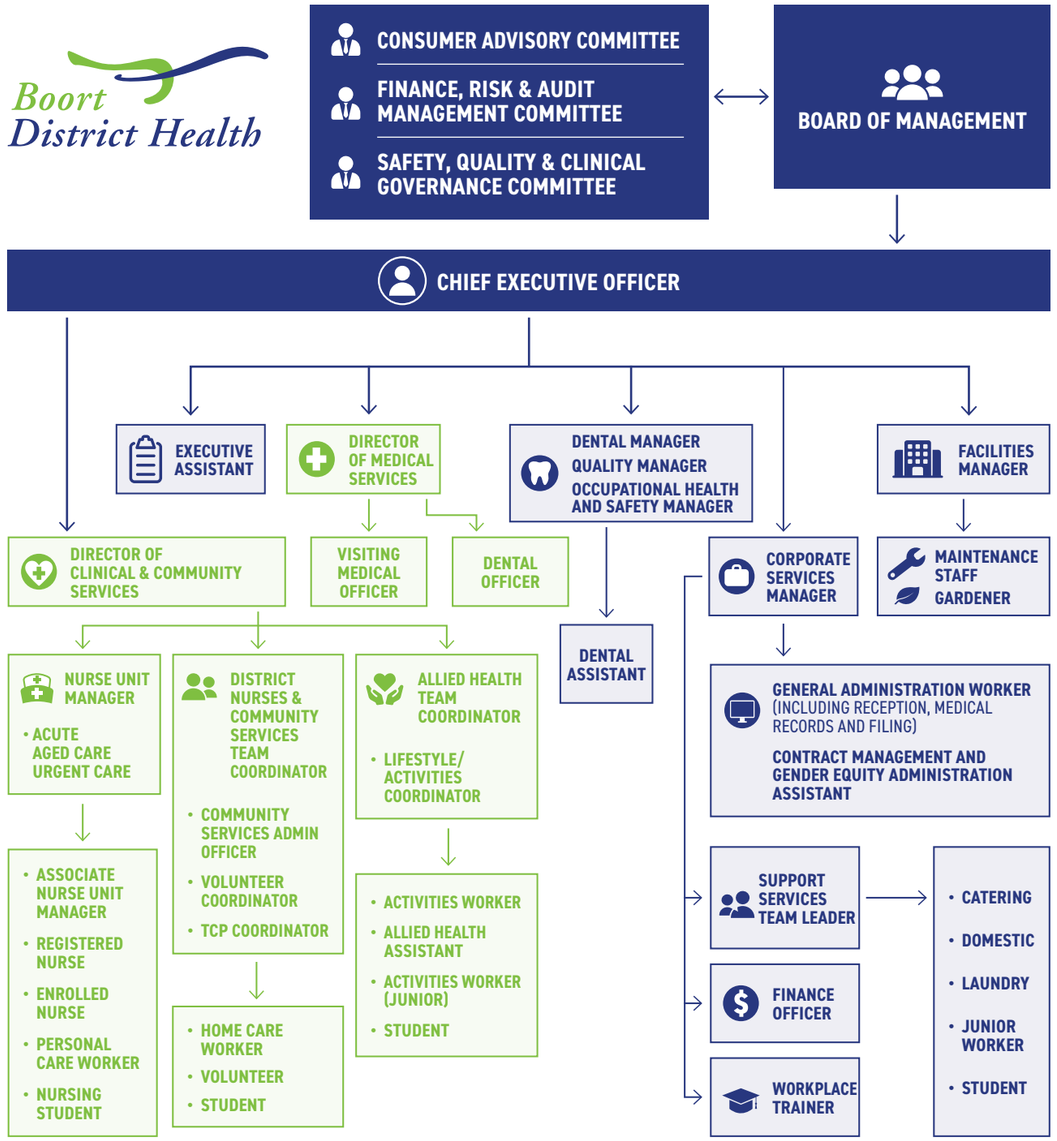
Our Hospital Auxiliary continues to make a significant contribution through the operation of the Op Shop, raising valuable funds that directly support Boort District Health and enhance services for our local community.

We sincerely thank each and every volunteer for their generosity, compassion, and commitment. Their contribution is invaluable, and the positive difference they make to the wellbeing of our residents, clients, and broader community is deeply appreciated.



Natarsha, Ros, Judilyn & Guessey - Environmental Services team

Organisational Chart



Statutory reporting requirements

Freedom of Information Act 1982

Boort District Health (BDH) is committed to transparency and accountability in accordance with the *Freedom of Information Act 1982 (Vic).*

Requests for access to documents held by BDH should be made in writing and accompanied by the prescribed application fee (unless waived under the Act). Requests should be directed to:

Freedom of Information Officer
Boort District Health
Mohammed.MeeraSahib@bdh.vic.gov.au
03 5451 5200

Access charges may apply depending on the nature and scope of the request.

FOI Statistics (2025–26)
During 2025–26, BDH received 3 applications:

- 0 from Members of Parliament
- 0 from media
- 3 from the general public

BDH finalised 3 requests during the reporting period:

- 3 granted in full
- 0 granted in part
- 0 denied

All requests were processed within statutory timeframes except where extensions were permitted under the Act.

Building Act 1993

BDH complies with the building and maintenance provisions of the *Building Act 1993 (Vic).*

BDH ensures:

- buildings are maintained in accordance with required standards
- appropriate inspection, reporting and maintenance systems are in place
- all applicable permits and certifications are obtained for building works

During 2025–26:

- Number of building permits issued: Nil
- Major capital works projects (> $50,000): Nil

Public Interest Disclosures Act 2012

BDH is committed to a culture of integrity and accountability. Procedures are in place for the protection of individuals who make disclosures under the P*ublic Interest Disclosures Act 2012 (Vic).*

These procedures are available on request and via the BDH website.

During 2025–26:

- Number of disclosures notified to IBAC: Nil

National Competition Policy

BDH has complied with the National Competition Principles and Victoria's Competitive Neutrality Policy.

BDH applies these principles to ensure that:

- services are delivered efficiently
- competitive neutrality is maintained where applicable

No formal competition neutrality complaints were received during 2025–26.

Carers Recognition Act 2012

BDH has taken all practical measures to comply with its obligations under the *Carers Recognition Act 2012 (Vic).*

These include:

- promoting awareness of the Act to staff and the community
- supporting staff understanding of carer relationships
- incorporating carer considerations into service delivery and policy development
- supporting initiatives aligned with the *Victorian Carer Strategy 2025–2035*

Environmental Performance (FRD 24)

BDH is committed to improving environmental sustainability and minimising its environmental impact.

Key initiatives during 2025–26 included:

- monitoring energy and water consumption
- improving waste management practices
- promoting environmentally sustainable procurement

Environmental performance data is included in the tables above. Variations between years are influenced by service demand and infrastructure usage.

FRD24 Report: Boort District Health Organisation Hierarchy (Jul-25 to Jun-26)

GREENHOUSE GAS EMISSIONS	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24	Notes
G1 Total Scope 1 (direct) greenhouse gas emissions (t CO2-e)				
Carbon Dioxide	62.10	58.46	60.71	
Methane	0.20	0.19	0.20	
Nitrous Oxide	0.21	0.19	0.20	
Total	**62.51**	**58.85**	**61.11**	
Scope 1 GHG emissions from stationary fuel (F2 Scope 1) (t CO2-e)	**59.04**	**58.85**	**61.11**	
Scope 1 GHG emissions from vehicle fleet (T3 Scope 1) (t CO2-e)	**3.47**			
Medical/Refrigerant gases				
Total Scope 1 (direct) greenhouse gas emissions (t CO2-e)	**62.51**	**58.85**	**61.11**	
G2 Total Scope 2 (indirect electricity) greenhouse gas emissions (t CO2-e) The emissions calculation for electricity-related activities uses the market-based method, as opposed to the location-based method used in previous FRD report versions.				
Electricity	271.45	293.77	281.32	
Total Scope 2 (indirect electricity) greenhouse gas emissions (t CO2-e)	**271.45**	**293.77**	**281.32**	
G3 Total Scope 3 (other indirect) greenhouse gas emissions associated with commercial air travel and waste disposal (t CO2-e)				
Commercial air travel	NA			
Waste emissions (WR5)	17.80	2.08	3.41	
Indirect emissions from Stationary Energy	56.54	59.51	55.10	
Indirect emissions from Transport Energy	0.87			
Paper emissions	0.00	0.00	0.00	
Water emissions	12.68	18.03	13.57	
Any other Scope 3 emissions	0.00	0.00	0.00	
Total Scope 3 greenhouse gas emissions (t CO2-e)	**87.88**	**79.62**	**72.08**	

Statutory reporting requirements

GREENHOUSE GAS EMISSIONS	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24	Notes
G(Opt) Net greenhouse gas emissions (t CO2-e)				
Gross greenhouse gas emissions (G1 + G2 + G3) (t CO2-e)	**421.84**	**432.24**	**414.50**	
Total gross reported greenhouse gas emissions per bed-day (t CO2-e/OBD)	0.04	0.05	0.05	
Carbon Neutral Electricity	0.00	0.00	0.00	
Green Power Electricity	0.00	0.00	0.00	
Purchased LGCs	-325.40	0.00	0.00	
Any Reduction Measures Offsets purchased (EL4-related)	**-308.32**			G(opt) EL4-related Reduction Measures Offsets capped to Scope2+3 Electricity
Any Offsets purchased	**-308.32**			G(opt) EL4-related Reduction Measures Offsets capped to Scope2+3 Electricity
Net greenhouse gas emissions (t CO2-e)	**113.53**	**432.24**	**414.50**	

ELECTRICITY USE	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24	Notes
EL1 Total electricity consumption segmented by source (MWh)				
Purchased	405.46	444.00	427.71	
Self-generated	-4.77	-2.02	-0.13	A system fault was identified during the reporting period and has since been rectified, resulting in improved system performance and data accuracy.
EL1 Total electricity consumption (MWh)	**400.69**	**441.98**	**427.58**	
EL2 On site-electricity generated (MWh) segmented by:				
Consumption behind-the-meter				
Solar Electricity	-4.77	-2.02	-0.13	
Total Consumption behind-the-meter (MWh)	-4.77	-2.02	-0.13	
Exports				
Solar Electricity	7.86	2.02	0.13	
Total Electricity exported (MWh)	**7.86**	**2.02**	**0.13**	
EL2 Total On site-electricity generated (MWh)	**3.10**	**0.00**	**0.00**	

ELECTRICITY USE	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24	Notes
EL3 On-site installed generation capacity (kW converted to MW) segmented by:				
Diesel Generator	0.28	0.28	0.28	
Solar System	0.17	0.10	0.10	
EL3 Total On-site installed generation capacity (MW)	**0.45**	**0.38**	**0.38**	
EL4 Total electricity offsets segmented by offset type (MWh)				
LGCs voluntarily retired on the entity's behalf	353.69			
RPP (Renewable Power Percentage in the grid)	70.33	81.29	80.23	
EL4 Total electricity offsets (MWh)	**405.46**	**81.29**	**80.23**	EL4 Total value capped to EL1 Purchased value

STATIONARY ENERGY	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24	Notes
F1 Total fuels used in buildings and machinery segmented by fuel type (MJ)				
LPG	974,215.00	971,120.80	1,008,406.30	
F1 Total fuels used in buildings (MJ)	**974,215.00**	**971,120.80**	**1,008,406.30**	
F2 Greenhouse gas emissions from stationary fuel consumption segmented by fuel type (t CO2-e)				
LPG	59.04	58.85	61.11	
F2 Greenhouse gas emissions from stationary fuel consumption (t CO2-e)	**59.04**	**58.85**	**61.11**	

TRANSPORTATION ENERGY	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24	Notes
T1 Total energy used in transportation (vehicle fleet) within the Entity, segmented by fuel type (MJ)				
Non-executive fleet - E10	26,605.30			data not collected in previous years
Petrol (E10)	**26,605.30**			
Executive fleet - Diesel	26,278.90			
Diesel	**26,278.90**			
Total energy used in transportation (vehicle fleet) (MJ)	**52,884.20**			

Statutory reporting requirements

TRANSPORTATION ENERGY	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24	Notes
T2 Number and proportion of vehicles in the organisational boundary segmented by engine/fuel type and vehicle category				
	NO OF VEHICLES			PROPORTION
Total Passenger Vehicles	8			
Fuel combustion engine	8			100%
Diesel	4			50%
Gasoline	1			13%
LPG	0			0%
Hybrid	3			38%
All electric	0			0%
T3 Greenhouse gas emissions from transportation (vehicle fleet) segmented by fuel type (t CO2-e)				
Non-executive fleet - E10	1.62			
Petrol (E10)	**1.62**			
Executive fleet - Diesel	1.85			
Diesel	**1.85**			
Total Greenhouse gas emissions from transportation (vehicle fleet) (t CO2-e)	**3.47**			
T4 Total distance travelled by commercial air travel (passenger km travelled for business purposes by entity staff on commercial or charter aircraft)				
Total distance travelled by commercial air travel	NA			

TOTAL ENERGY USE	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24	Notes
E1 Total energy usage from fuels, including stationary fuels (F1) and transport fuels (T1) (MJ)				
Total energy usage from stationary fuels (F1) (MJ)	974,215.00	971,120.80	1,008,406.30	
Total energy usage from transport (T1) (MJ)	52,884.20			
Total energy usage from fuels, including stationary fuels (F1) and transport fuels (T1) (MJ)	**1,027,099.20**	**971,120.80**	**1,008,406.30**	
E2 Total energy usage from electricity (MJ)				
Total energy usage from electricity (MJ)	1,442,495.86	1,591,129.15	1,539,297.25	
E3 Total energy usage segmented by renewable and non-renewable sources (MJ)				
Renewable	1,442,495.60	285,354.98	288,372.93	E3 Renewable value capped to EL1 Purchased value (consumed-behind-meter is never capped)
Non-renewable (E1 + E2 - E3 Renewable)	1,027,099.46	2,276,894.98	2,259,330.62	

TOTAL ENERGY USE	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24	Notes
E4 Units of Stationary Energy used normalised: (F1+E2)/normaliser				
Energy per unit of Aged Care OBD (MJ/Aged Care OBD)	267.87	289.72	288.33	
Energy per unit of LOS (MJ/LOS)	4,277.36	4,600.09	7,037.86	
Energy per unit of bed-day (LOS+Aged Care OBD) (MJ/OBD)	252.08	272.55	276.98	
Energy per unit of Separations (MJ/Separations)	42,398.44	50,240.20	67,044.83	
Energy per unit of floor space (MJ/m2)	641.55	680.18	676.32	

SUSTAINABLE BUILDINGS AND INFRASTRUCTURE	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24	Notes
B1 Discuss how environmentally sustainable design (ESD) is incorporated into newly completed entity-owned buildings				
NA				
B2 Discuss how new entity leases meet the requirement to preference higher-rated office buildings and those with a Green Lease Schedule				
NA				
B3 NABERS Energy (National Australian Built Environment Rating system) ratings of newly completed/occupied Entity-owned office buildings and substantial tenancy fit-outs (itemised)				
NA				
B4 Environmental performance ratings (eg. NABERS, Green Star, or ISCAIS rating scheme) of newly completed Entity-owned non-office building or infrastructure projects or upgrades with a value over $1 million				
NABERS Energy	NA			
B5 Environmental performance ratings achieved for Entity-owned assets portfolio segmented by rating scheme and building, facility, or infrastructure type, where these ratings have been conducted				
Rating scheme	NA			

SUSTAINABLE PROCUREMENT	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24	Notes

WATER USE	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24	Notes
W1 Total units of metered water consumed by water source (kL)				
Potable water (kL)	9,036.91	11,021.42	8,087.04	A wetter seasonal period throughout 2025-26 contributed to a reduction in water consumption, reflecting decreased reliance on supplementary water use across operations
Total units of water consumed (kL)	**9,036.91**	**11,021.42**	**8,087.04**	

Statutory reporting requirements

WATER USE	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24	Notes
W2 Units of metered water consumed normalised by FTE, headcount, floor area, or other entity or sector specific quantity				
Water per unit of Aged Care OBD (kL/ Aged Care OBD)	1.00	1.25	0.92	
Water per unit of LOS (kL/LOS)	15.99	19.79	22.34	
Water per unit of bed-day (LOS+Aged Care OBD) (kL/OBD)	0.94	1.17	0.88	
Water per unit of Separations (kL/ Separations)	158.54	216.11	212.82	
Water per unit of floor space (kL/m2)	2.40	2.93	2.15	

WASTE AND RECYCLING	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24	Notes
WR1 Total units of waste disposed of by waste stream and disposal method (kg)				
Landfill (total)				
General waste - bins	12,147.78	862.50	2,415.00	
General waste - skips	261.00			
Offsite treatment				
Clinical waste - incinerated		64.01	10.80	
Clinical waste - sharps	693.68	110.85	49.49	
Clinical waste - treated	587.81	583.33	149.26	
Recycling/recovery (disposal)				
Cardboard		3,208.97	3,217.50	
Commingled			16.50	
E-waste			27.60	
Grease traps		612.74	306.37	
Organics (garden)	1,569.75	341.25	1,205.75	Implement enhanced record management practices and integrate improved recycling processes into organisational systems to increase compliance, efficiency, and environmental sustainability.
Paper (confidential)	2,818.68	2,419.37		
Paper (recycling)	18.24			
Reused Beds and Furniture			40.00	
Wood		133.10	78.00	
Total units of waste disposed (kg)	**18,096.94**	**8,336.12**	**7,516.26**	

WASTE AND RECYCLING	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24	Notes
WR1 Total units of waste disposed of by waste stream and disposal method (%)				
Landfill (total)				
General waste	68.57%	10.35%	32.13%	
Offsite treatment				
Clinical waste - incinerated		0.77%	0.14%	
Clinical waste - sharps	3.83%	1.33%	0.66%	
Clinical waste - treated	3.25%	7.00%	1.99%	
Recycling/recovery (disposal)				
Cardboard		38.49%	42.81%	
Commingled			0.22%	
E-waste			0.37%	
Grease traps		7.35%	4.08%	
Organics (garden)	8.67%	4.09%	16.04%	
Paper (confidential)	15.58%	29.02%		
Paper (recycling)	0.10%			
Reused Beds and Furniture			0.53%	
Wood		1.60%	1.04%	
WR2 Percentage of office sites covered by dedicated collection services for each waste stream				Not reported
Printer cartridges				
Batteries				
e-waste				
Soft plastics				
WR3 Total units of waste disposed normalised by FTE, headcount, floor area, or other entity or sector specific quantity, by disposal method				
Total waste to landfill per patient treated ((kg general waste)/PPT)	1.29	0.09	0.26	
Total waste to offsite treatment per patient treated ((kg offsite treatment)/PPT)	0.13	0.08	0.02	
Total waste recycled and reused per patient treated ((kg recycled and reused)/PPT)	0.46	0.71	0.53	
WR4 Recycling rate (%)				
Weight of recyclable and organic materials (kg)	4,406.67	6,715.43	4,891.72	
Weight of total waste (kg)	18,096.94	8,336.12	7,516.26	
Recycling rate (%)	**24.35%**	**80.56%**	**65.08%**	
WR5 Greenhouse gas emissions associated with waste disposal (t CO2-e)				
Waste disposal emissions (t CO2-e)	17.80	2.08	3.41	

Statutory reporting requirements

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 the health service and are available on request to the relevant Ministers, Members of Parliament and the public, subject to the provisions of the Freedom of Information Act 1982.

The following information must be retained and made available upon request:

(a) a statement that declarations of pecuniary interests have been duly completed by all relevant officers;

(b) details of shares held by a senior officer as nominee or held beneficially in a statutory authority or subsidiary;

(c) details of publications produced by the entity about itself, and how these can be obtained;

(d) details of changes in prices, fees, charges, rates, and levies charged by the entity;

(e) details of any major external reviews carried out on the entity;

(f) details of major research and development activities undertaken by the entity;

(g) details of overseas visits undertaken including a summary of the objectives and outcomes of each visit;

(h) details of major promotional, public relations and marketing activities undertaken by the entity to develop community awareness of the entity and its services;

(i) details of assessments and measures undertaken to improve the occupational health and safety of employees;

(j) a general statement on industrial relations within the entity and details of time lost through industrial accidents and disputes;

(k) a list of major committees sponsored by the entity, the purposes of each committee and the extent to which the purposes have been achieved; and

(l) details of all consultancies and contractors including:

(i) consultants/contractors engaged;

(ii) services provided; and

(iii) expenditure committed to for each engagement

This information is available on request from:
Chief Executive Officer
Phone: 03 54515200
Email: Donna.Doyle@bdh.vic.gov.au

Local Jobs First Act 2003

No projects undertaken by BDH during 2025–26 met the threshold for Local Jobs First Policy application.

Accordingly, no Local Industry Development Plans were required.

Social Procurement

BDH is committed to supporting the Victorian Government's Social Procurement Framework.

During 2025–26, BDH:

- engaged local suppliers where possible
- supported social enterprises and regional businesses
- embedded social procurement considerations into procurement processes

Total social procurement spend: $1,946,054.37

Disclosure of Emergency Procurement

In 2025 - 2026 Boort District Health has nil reports where emergency procurement was not activated, resulting in nil spending for emergency procurements.

Disclosure of Procurement Complaints

In 2025 - 2026 Boort District Health has nil procurement complaints.

Consultancies

Consultancies under $10,000

In 2025–26, there were 1 consultancies valued at less than $10,000.
Total expenditure was $10,000 (excl. GST).

Consultancies over $10,000

In 2025–26, there were 2 consultancies valued at $10,000 or greater.
Total expenditure was $20,235.43 (excl. GST).

Consultant	Purpose of consultancy	Start date	End date	Total approved project fee (excluding GST)	Expenditure 2025 - 26 (excluding GST)	Future expenditure (excluding GST)
Health Generation Pty Ltd	AN_ACC review	23 June 2026	23 June 2026	$12,589.80	$1,144.53	$15,000.00
Gender Equality Regional Consultancy Co	Training, education, support for Action Plan and data reporting	09 October 2025	4 April 2026	$21,000.00	$19,090.90	$30,000.00

ICT Expenditure

Total ICT expenditure for 2025–26 was $330,000.00, comprising:

All operational ICT expenditure	ICT expenditure related to projects to create or enhance ICT capabilities		
Business as Usual (BAU) ICT expenditure	Non Business as Usual (BAU) ICT expenditure	Operational expenditure	Captial expenditure
(Total)	(Total = Operational expenditure and capital expenditure)		
$330,000	**0**	**0**	**$0.00**

Reviews and Studies

BDH did not undertake any reviews or studies during 2025–26.

Grants and Transfer Payments

BDH did not administer any grants or transfer payments during 2025–26.

Safe Patient Care Act 2015

BDH has no matters to report in relation to its obligations under the Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015.

Car Parking Fees

BDH does not operate fee-based car parking.

Subsequent Events

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

Attestations

Financial Management Compliance Attestation Statement

I, Gregory Currie, on behalf of the Responsible Body, certify that Boort District Health has no Material Compliance Deficiency with respect to the applicable Standing Directions under the *Financial Management Act 1994.*

Gregory Currie
Boort District Health
30 June 2026

Data Integrity Declaration

I Donna Doyle certify that BDH has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. **BDH has critically reviewed these controls and processes during the year.**

Donna Doyle
Boort District Health
30 June 2026

Conflict of Interest Declaration

I, Donna Doyle, certify that BDH 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 BDH and members of the board, and all declared conflicts have been addressed and are being managed. Conflict of interest is a standard agenda item for declaration and documenting at each executive board meeting.

Donna Doyle
Boort District Health
30 June 2026

Integrity, Fraud and Corruption Declaration

I Donna Doyle certify that BDH has put in place appropriate internal controls and processes to ensure that Integrity, fraud and corruption risks have been reviewed and addressed at BDH during the year.

Donna Doyle
Boort District Health
30 June 2026

Compliance with HealthShare Victoria (HSV) Purchasing Policies

I, Donna Doyle, on behalf of Boort District Health, certify that Boort District Health 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, Boort District Health 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. Boort District Health has implemented appropriate internal controls, which have been critically reviewed throughout the year.

Donna Doyle
Boort District Health
30 June 2026



Right: celebrating 100 years with Dot Poxon

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Notes: (a) Reference to FRDs have been removed from the Disclosure Index if the specific FRDs do not contain requirements that are in the nature of disclosure.
(b) Refer to the Model financial statements section (Part two) for further details.

Hospital ladies Auxiliary Report

It is with pleasure that I present my report to Chief Executive Officer Donna Doyle and Auxiliary members.

Once again, we had a great year. We had our two major raffles being easter eggs and Christmas cake. Thanks to IGA for donating some easter eggs and thanks to Lorraine for decorating our Christmas cake. And thank you to all volunteers who helped sell raffle tickets.

The Auxiliary have funded the following items for the hospital in the last 12 months;

Shower chair	$16,196.35
Tub chair	$5,034.65
Pressure mattresses	$8,162.00
Total	**$29,393.00**

Hopefully these items have been a help for the residents.

At the Op Shop this year, we have had new cement paths completed at the back of the shop- which are great thanks to BDH. We also purchased a blower vacuum for the shop.

We have had a new light installed in our back sheds and a new fan in our toilet-thanks to Guy (our favourite electrician) who has done a fantastic job and the lights are a great help.

We had our Christmas break up at Guy and Pam's this year, which was a great venue. Thanks to them for providing the venue and all the extras that they do. It was a lovely afternoon tea which was catered by L+J Catering, it was also a fun, filled afternoon to exchange Kris Kringle gifts and celebrate our Xmas break up.

The Op Shop has once again had a fantastic year thanks to all our members for doing all rostered shifts in the shop and to the ladies who come to do sorting etc. Many great thanks to the ladies doing window displays. They always look fantastic. To the ladies for ironing, washing, linen sorting etc. We couldn't do it without you all.

Thank you to the public for supplying our shop with all the donated goods that benefit our hospital.

Many thanks to Nicole, our organised secretary, Julie, for the rosters and newsletters and Robyn for managing our finances.

Thanks to the BDH catering staff for supplying our beautiful afternoon teas for our meetings, especially the scones!

Lastly, a huge THANK YOU to all members for all your help and support for the last year. All the best to the new incoming office bearers for the next year. I am sure you will enjoy your role as I have.

Judy Perryman
President



Boort District School student artwork

Our team

CEO
Doyle Donna

Director of Medical Services
Craig Winter

Director of Clinical and Community Services
Mohammed Mubarak Meera Sahib

Nurse Unit Manager
Michelle Lawrence
Abdul Afeel Srambikkal

Executive Assistant
Hannah Whitehouse

Clinical Services
Ancy Nadesan
Aniya Zuhra Narakkadan
Anoop Sathyadas
Barry Putman
Chrizelle Myr Andoy
Elisa Hender
Elodie McKenzie
Ena Green
Jaspal Singh
Jeanette Long
Jemimah Laurente
Jestin Joy
John Martin Dizon Yokoi
Judy Parker
Karan Gandhi
Karishma Shibin
Kerry Baker
Kim Griffiths
Lilima Pun
Linda Young
Madeleine Scott
Mary Loosley
Michelle Holland
Michelle Nisbet
Narelle Vernon
Neethu Ahamed
Pamela Griffiths
Pauline Cooper
Peter Jose
Philip Eddy
Rency Thomas
Robert Lahtz
Sarah McNally
Shabnampreet Kaur
Shruti Somanathan Pillai
Sini Joseph
Tanya Buchanan
Tracey Bird
Vincy Jacob
Zowie Brooks

Aged Care Activities Coordinator
Samantha Isaac

Maintenance / Gardening Team
Alister Lee
Ethan Rothacker
Joe Velleley
Natham Wright
Sinu Varghese

Allied Health
Deanne Smith

Community
Anne Gibson
Kelly Daniels
Loida Pacala
Maree Stringer
Maureen Ampeire
Michele Schmidt
Roslyn Stone
Sally Keeble
Shameem Pulakkal Shareef
Sibin Charly
Suzanne Varns

Quality, OH&S & Dental Manager
Nicole Fuller

Dentist
Diana Aio

Dental Staff
Guianne Ocaya
Nikki Lanyon
Stacey Streader

Corporate Services Manager
Kathryn Durie

Administration
Dylan Hatcher
Nyzelle Andoy
Ralph Beja
Sharyn O'Rourke

Workplace Trainer
Christopher Gray

Support Services Team Leader
Carmel Gillespie

Environmental Services Team
Alec Velleley
Amanda Mitchell
Anna Lanyon
Brian Foot
Eliana Haw
Emma Malone
Guessey Ocaya
Helen Absalom
Indie Koole
Irene Eigner
Isabella Quinn
Judilyn Ocaya
Julie Wilson
Kayla McPherson
Kirti Singh
Kristen Gooding
Laci Streader
Leanne Hodoras
Leona Nixon
Linda Ross
Madeleine Lanyon
Mason Young
Milly Scott
Natalie Hall
Natarsha Catherine
Rajwinder Kaur
Rhonna Jane Abon
Roslyn Wright
Sally Gillings
Sanil Lazar
Sarah Polack
Sheena Camille Diaz
Shibin Thomas Mannuzeril
Susan Dunne
Trishia Nicole Libardos

Life Governors

Mr. D.G. Coutts October 1964
Mrs. E.M. Wilson September 1972
Mrs. H.E. Lanyon September 1972
Mrs. N.M. Weaver September 1972
Mr. L.R. Meadows September 1972
Mr. L.F. Whitmore September 1972
Mr. G.A. Frost October 1974
Mr. W.N. Haw March 1976
Mr. H.D. Cable September 1980
Mr. W.A. Boyle April 1985
Mr. H.F. Slatter April 1985
Mr. K.I. McKay April 1985
Mr. E.L. Poxon October 1989
Miss A. Donnellon December 1989
Mr. F.L. Boyle December 1989
Mr. K.M. Weaver October 1992
Mrs. F.J. Meadows March 1995
Mr. K.M. Jeffery October 2000
Dr. G.C. Findlow May 2001
Dr. J.E. Findlow May 2001
Mr. M.J. Nolan October 2002
Mrs. M.A. Birt October 2003
Mr. G.E. Arundell October 2006
Mrs. P. Byrne December 2009
Mrs. M. Worland October 2011
Mrs. B. Jeffery October 2011
Mr. D Rees 2014
Mrs. E. Barnes October 2016
Mrs. J. Keath October 2016

Judy Parker with Broader Horizons student Anjanette Sanil - Boort District School



Boort District Health

Service AWARDS

CELEBRATING DEDICATION, COMMITMENT AND SERVICE

We proudly recognise and thank our Boort District Health staff, Hospital Ladies Auxiliary and volunteers for their outstanding years of service and contribution.

40 YEARS
Isabel Loader
Tanya Buchanan

30 YEARS
Judy Parker

20 YEARS
Joy DePiazza
Michelle Lawrence
Pauline Cooper

15 YEARS
Narelle Vernon
Natham Wright
Sharon Martin

10 YEARS
Carmel Allison
Craig Winter
Donna Doyle
Jennifer Allison
Jenny Stringer
Kathleen Lowrie
Pamela Contarino
Pamela Griffiths
Shirley McDonald
Susan Dunne
Wendy Mills

Thank you
FOR MAKING A DIFFERENCE!

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Boort District Health

Opinion

I have audited the financial report of Boort District Health (the health service) which comprises the:

- balance sheet as at 30 June 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 its 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.

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.



Simone Bohan
as delegate for the Auditor-General of Victoria

MELBOURNE
27 August 2026

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

Financial Statements
Financial Year ended 30 June 2026

Board member's, accountable officer's, and chief finance & accounting officer's declaration

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

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2026 and the financial position of Boort District Health 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 19 August 2026.

Board member	**Accountable Officer**	**Chief Finance & Accounting Officer**
Gregory Currie	Donna Doyle	Cameron Olsen
Board Chair	Chief Executive Officer	Chief Finance & Accounting Officer
Boort	Boort	Boort
19/08/2026	19/08/2026	19/08/2026

Boort District Health
Comprehensive Operating Statement
For the Financial Year Ended 30 June 2026

	Note	2026 $'000	2025 $'000
Revenue and income from transactions			
Revenue from contracts with customers	2.1 (a)	5,865	5,453
Government grants	2.1 (b)	4,405	4,000
Other sources of income	2.1 (c)	1,607	1,469
Total revenue and income from transactions		**11,877**	**10,922**
Expenses from transactions			
Employee expenses	3.1 (a)	(7,924)	(7,157)
Depreciation and amortisation	4.1(a), 4.2	(1,536)	(1,518)
Supplies and consumables	3.1 (c)	(964)	(831)
Other operating expenses	3.1 (d)	(2,707)	(2,699)
Total Expenses from transactions		**(13,131)**	**(12,205)**
Net result from transactions - net operating balance		**(1,254)**	**(1,283)**
Other economic flows included in net result			
Net (loss)/gain on sale of non-financial assets		(7)	26
Total Share of other economic flows from Joint Operations		(25)	29
Other gain from other economic flows		20	1
Total other economic flows included in net result		**(12)**	**56**
Net result		**(1,266)**	**(1,227)**
Other economic flows - other comprehensive income			
Items that will not be reclassified to net result			
Changes in property, plant and equipment revaluation surplus		-	-
Total other comprehensive income		**-**	**-**
Comprehensive result		**(1,266)**	**(1,227)**

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

Boort District Health
Balance Sheet
As at 30 June 2026

	Note	2026 $'000	2025 $'000
Financial assets			
Cash and cash equivalents	6.2	7,697	6,417
Receivables	5.1	892	840
Total financial assets		**8,589**	**7,257**
Non-financial assets			
Other assets		189	199
Property, plant and equipment	4.1	29,618	30,639
Total non-financial assets		**29,807**	**30,838**
Total assets		**38,396**	**38,095**
Liabilities			
Payables	5.2	1,452	1,357
Borrowings		224	306
Employee benefits	3.1(b)	1,498	1,444
Monies held in trust	5.3	4,769	3,269
Total liabilities		**7,943**	**6,376**
Net assets		**30,453**	**31,719**
Equity			
Reserves		24,839	24,839
Contributed capital		3,161	3,161
Accumulated surplus		2,453	3,719
Total equity		**30,453**	**31,719**

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

Boort District Health
Cash Flow Statement
For the Financial Year Ended 30 June 2026

	Note	2026 $'000	2025 $'000
Cash Flows from operating activities			
Government Grants		8,800	8,141
Patient and Resident Fees Received		1,315	1,123
Other Receipts		872	880
Total receipts		**10,987**	**10,144**
Payments to employees		(7,437)	(6,962)
Payments to suppliers and consumables		(1,277)	(1,049)
Other payments		(1,893)	(1,258)
Total payments		**(10,607)**	**(9,269)**
Net cash flows from operating activities		**380**	**875**
Cash Flows from investing activities			
Proceeds from sale of non-financial assets		39	26
Purchase of non-financial assets		(558)	(139)
Net cash flows used in investing activities		**(519)**	**(113)**
Cash flows from financing activities			
Repayment of borrowings and principal portion of lease liabilities		(81)	(38)
Repayment of accommodation deposits		(750)	(1,640)
Receipt of accommodation deposits		2,250	1,755
Net cash flows from financing activities		**1,419**	**77**
Net increase in cash and cash equivalents held		**1,280**	**839**
Cash and cash equivalents at beginning of year		6,417	5,578
Cash and cash equivalents at end of year	6.2	**7,697**	**6,417**

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

Boort District Health
Statement of Changes in Equity
For the Financial Year Ended 30 June 2026

	Property, Plant and Equipment Revaluation Surplus	Restricted Specific Purpose Reserve	Contributed Capital	Accumulated Surplus	Total
	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2024	**23,715**	**1,124**	**3,161**	**4,946**	**32,946**
Net result for the year	-	-	-	(1,227)	(1,227)
Other comprehensive income for the year	-	-	-	-	-
Balance at 30 June 2025	**23,715**	**1,124**	**3,161**	**3,719**	**31,719**
Net result for the year	-	-	-	(1,266)	(1,266)
Other comprehensive income for the year	-	-	-	-	-
Balance at 30 June 2026	**23,715**	**1,124**	**3,161**	**2,453**	**30,453**

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

Boort District Health
Notes to the Financial Statements
For the Financial Year Ended 30 June 2026

Structure
1.1 Basis of preparation
1.2 Material accounting estimates and judgements
1.3 Reporting entity
1.4 Economic dependency

Note 1 About this Report

These financial statements represent the financial statements of Boort District Health for the year ended 30 June 2026.

Boort District Health is a not-for-profit entity established as a public agency on 17 September 1961 under the *Health Services Act 1998 (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.

Note 1.1 Basis of preparation

These financial statements are 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 (Vic)* 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 Boort District Health.

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 Boort District Health on 19th August 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 Boort District Health.
Boort District Health's principal address is:
31 Kiniry Street
Boort, Victoria 3537

Note 1.4 Economic dependency

Boort District Health 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. Boort District Health 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 Boort District Health's operations and on that basis, the financial statements have been prepared on a going concern basis.

Note 2 Funding delivery of our services

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

Structure
2.1 Revenue and income from transactions

Note 2.1 Revenue and income from transactions

	Note	2026 $'000	2025 $'000
Revenue from contracts with customers	2.1(a)	5,865	5,453
Government grants	2.1(b)	4,405	4,000
Other sources of income	2.1(c)	1,607	1,469
Total revenue and income from transactions		**11,877**	**10,922**

Note 2.1(a) Revenue from contracts with customers

	2026 $'000	2025 $'000
Government grants (State) - Operating	572	626
Government grants (Commonwealth) - Operating	3,833	3,515
Patient and resident fees	1,344	1,191
Commercial activities	116	121
Total revenue from contracts with customers	**5,865**	**5,453**

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 Boort District Health's goods or services. Boort District Health's 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 Boort District Health's revenue streams, with information detailed below relating to Boort District Health's material revenue streams:

Government grant	Performance obligation
Commonwealth Aged Care Funding	The performance obligations for Commonwealth Aged Care Funding are the number and mix of residents in the Aged Care facilities. Revenue is recognised at a point in time, which is when AIMS (Agency Information Management System) data is submitted monthly.

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

	Note	2026 $'000	2025 $'000
Government grants (State) - Operating		4,202	3,951
Government grants (State) - Capital		203	49
Total government grants		**4,405**	**4,000**

How we recognise government grants

Government grants

Boort District Health 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 Boort District Health has an unconditional right to receive cash which usually coincides with receipt of cash. On initial recognition or the asset, Boort District Health 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:

- contributions by owners, in accordance with AASB 1004 *Contributions*
- 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 Boort District Health 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 Boort District Health'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 Department of Health makes some payments on behalf of Boort District Health as follows:

Supplier	Description
Victorian Managed Insurance Authority	The Department of Health purchases non-medical indemnity insurance for Boort District Health 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 Health Building Authority	The Department of Health made payments to the Victorian Health Building Authority to fund capital works projects during the year ended 30 June 2026, on behalf of Boort District Health.
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

	Note	2026 $'000	2025 $'000
Assets received free of charge or for nominal consideration		65	27
Other income from operating activities		444	564
Non-operating activities		295	295
Share of revenue from joint operations	8.6	803	583
Total other sources of income		**1,607**	**1,469**

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	2026 $'000	2025 $'000
Employee expenses	3.1(a)	7,924	7,157
Supplies and consumables	3.1(c)	964	831
Other operating expenses	3.1(d)	2,707	2,699
Total expenses incurred in the delivery of services		**11,595**	**10,687**

Note 3.1(a) Employee expenses

	2026 $'000	2025 $'000
Salaries and wages	6,078	5,417
Superannuation expense [(1)]	793	672
Other oncosts	690	709
Agency expenses	119	120
Fee for service medical officer expenses	141	152
Workcover Premium	103	87
Total employee expenses	**7,924**	**7,157**

[(1)] Defined contribution superannuation expense and defined benefits 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

	2026 $'000	2025 $'000
Current provisions for employee benefits		
Accrued days off	5	3
Annual leave	583	538
Long service leave	608	668
Provision for on-costs	151	165
Total current provisions for employee benefits	**1,347**	**1,374**
Non-current provisions for employee benefits		
Long service leave	136	62
Provision for on-costs	15	8
Total non-current provisions for employee benefits	**151**	**70**
Total provisions for employee benefits	**1,498**	**1,444**

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 Boort District Health 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 Boort District Health expects to wholly settle within 12 months or
- present value – if Boort District Health 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 Boort District Health 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 Boort District Health expects to wholly settle within 12 months or
- present value – if Boort District Health 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

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

	2026 $'000	2025 $'000
Drug supplies	67	59
Medical and surgical supplies (including Prostheses)	346	318
Other supplies and consumables	551	454
Total supplies and consumables	**964**	**831**

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

	2026 $'000	2025 $'000
Other operating expenses		
Low value lease expenses	6	11
Fuel, light, power and water	173	183
Repairs and maintenance	245	394
Maintenance contracts	118	136
Medical indemnity insurance	11	10
Finance costs	14	11
Other administration expenses	1,327	1,269
Share of expenses from joint operation	813	685
Total other operating expenses	**2,707**	**2,699**

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 Boort District Health. 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.

Note 4 Key assets to support service delivery

Boort District Health 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 Boort District Health 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

Note 4.1 Property, plant and equipment

	Gross carrying amount		Accumulated depreciation		Net carrying amount	
	2026 $'000	2025 $'000	2026 $'000	2025 $'000	2026 $'000	2025 $'000
Land at fair value	680	680	-	-	680	680
Landscaping at fair value	680	680	(36)	(16)	645	664
Buildings at fair value	29,973	29,626	(2,690)	(1,345)	27,283	28,281
Works in progress at cost	6	13	-	-	6	13
Plant, equipment and vehicles at fair value	2,487	2,313	(1,484)	(1,312)	1,004	1,001
Total property, plant and equipment	**33,826**	**33,312**	**(4,210)**	**(2,673)**	**29,618**	**30,639**

How we recognise property, plant and equipment

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 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) Reconciliations of the carrying amounts of each class of asset

	Land	Landscaping	Buildings	Works in progress	Plant, equipment and vehicles	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2025	**680**	**664**	**28,281**	**13**	**1,001**	**30,639**
Additions	-	-	-	340	210	551
Disposals	-	-	-		(36)	(36)
Net transfers between classes	-	-	347	(347)	-	-
Depreciation	-	(19)	(1,345)	-	(171)	(1,536)
Balance at 30 June 2026	**680**	**645**	**27,283**	**6**	**1,004**	**29,618**

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, Boort District Health 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 next scheduled independent revaluation, which is planned to be undertaken in 2029, in accordance with Boort District Health's revaluation cycle.

Note 4.1(b) Right-of-use assets

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

	Gross carrying amount		Accumulated depreciation		Net carrying amount	
	2026 $'000	2025 $'000	2026 $'000	2025 $'000	2026 $'000	2025 $'000
Plant, equipment and vehicles at fair value [1]	323	370	(99)	(65)	224	305
Total right-of-use assets	**323**	**370**	**(99)**	**(65)**	**224**	**305**

Reconciliations of the carrying amounts of each class of asset

	Plant, equipment and vehicles $'000	Total $'000
Balance at 1 July 2025 [1]	**305**	**305**
Additions	-	-
Disposals	(36)	(36)
Depreciation	(45)	(45)
Balance at 30 June 2026	**224**	**224**

(1) As a result of a change in FRD 104 *Leases* 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. For further information, refer to Note 7.3.

How we recognise right-of-use assets
Initial recognition

When Boort District Health 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 (refer to Note 6.1 for further information) 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 and
- 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.

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

Note 4.1(c) Impairment of property, plant and equipment

The recoverable amount of the primarily non-financial physical assets of Boort District Health, 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.

Boort District Health 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

How we recognise depreciation

All buildings, plant and equipment and other non-financial physical assets (excluding items under assets held for sale, land and investment properties) 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.

Useful lives of non-current assets

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

	2026	2025
Buildings	5 to 46 years	5 to 46 years
Landscaping	20 to 40 years	20 to 40 years
Plant & Equipment	3 to 25 years	3 to 25 years
Medical Equipment	3 to 20 years	3 to 20 years
Motor Vehicles	5 to 10 years	5 to 10 years
Computers and Communication	3 to 10 years	3 to 10 years
Furniture and Fittings	3 to 20 years	3 to 20 years

Boort District Health
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 Boort District Health's operations.

Structure

5.1 Receivables
5.2 Payables
5.3 Other liabilities

Note 5.1 Receivables

	Note	2026 $'000	2025 $'000
Current receivables			
Contractual			
Inter hospital debtors		8	40
Trade receivables		25	68
Trade receivables - joint operation		321	285
Patient fees		259	145
Allowance for impairment losses		(103)	(17)
Accrued revenue		23	17
Amounts receivable from governments and agencies		131	54
Total contractual receivables		**664**	**592**
Statutory			
GST receivable		63	98
Total statutory receivables		**63**	**98**
Total current receivables		**727**	**690**
Non-current receivables			
Contractual			
Long service leave - Department of Health		165	150
Total contractual receivables		**165**	**150**
Total non-current receivables		**165**	**150**
Total receivables		**892**	**840**
(i) Financial assets classified as receivables			
Total receivables		892	840
GST receivable		(63)	(98)
Total financial assets classified as receivables	7.1	**829**	**742**

How we recognise receivables

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.

Boort District Health
Notes to the Financial Statements
For the Financial Year Ended 30 June 2026

Note 5.2 Payables

	Note	2026 $'000	2025 $'000
Current payables			
Contractual			
Trade creditors		37	96
Trade creditors - joint operation		250	142
Accrued salaries and wages		664	366
Accrued expenses		85	50
Accrued expenses - joint operation		58	77
Deferred capital grant income	5.3(a)	-	177
Amounts payable to governments and agencies		121	97
Income in advance - joint operation		234	295
GST payable - joint operation		13	24
Other		(29)	8
Total contractual payables		**1,433**	**1,332**
Statutory			
GST payable		19	25
Total statutory payables		**19**	**25**
Total current payables		**1,452**	**1,357**
Total payables		**1,452**	**1,357**
(i) Financial liabilities classified as payables			
Total payables		1,452	1,357
Deferred grant income		-	(177)
GST payable		(19)	(25)
Total financial liabilities classified as payables	7.1	**1,433**	**1,155**

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 Boort District Health 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 5.2(a) Deferred capital grant income

	2026 $'000	2025 $'000
Opening balance of deferred capital grant income	177	25
Grant consideration for capital works received during the year	-	177
Deferred capital grant income recognised as income due to completion of capital works	(177)	(25)
Closing balance of deferred capital grant income	**-**	**177**

Note 5.3 Monies held in trust

	Note	2026 $'000	2025 $'000
Current monies held in trust			
Refundable accommodation deposits		4,769	3,269
Total current monies held in trust		**4,769**	**3,269**
Total other liabilities		**4,769**	**3,269**
*** Represented by:**			
- Cash assets	6.2	4,776	3,266
		4,776	**3,266**

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 Boort District Health 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* .

Note 6 How we finance our operations

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

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

Structure

6.1 Cash and cash equivalents

6.2 Commitments for expenditure

Note 6.1 Cash and Cash Equivalents

	Note	2026 $'000	2025 $'000
Cash at Bank - CBS (excluding monies held in trust)		2,564	2,728
Cash at Bank - joint operation		357	423
Total cash held for operations		**2,921**	**3,151**
Cash at Bank - CBS (Monies held in trust)	5.3	4,776	3,266
Total cash held as monies in trust		**4,776**	**3,266**
Total cash and cash equivalents	7.1	**7,697**	**6,417**

Note 6.2 Commitments

	Less than 1 year	1-5 Years	Over 5 years	Total
30 June 2026	**$'000**	**$'000**	**$'000**	**$'000**
Capital expenditure commitments	570	-	-	570
Total commitments (inclusive of GST)	**570**	**-**	**-**	**570**
Less GST recoverable	(52)	-	-	(52)
Total commitments (exclusive of GST)	**518**	**-**	**-**	**518**

	Less than 1 year	1-5 Years	Over 5 years	Total
30 June 2025	**$'000**	**$'000**	**$'000**	**$'000**
Capital expenditure commitments	115	-	-	115
Total commitments (inclusive of GST)	**115**	**-**	**-**	**115**
Less GST recoverable	(10)	-	-	(10)
Total commitments (exclusive of GST)	**105**	**-**	**-**	**105**

How we disclose our commitments

Our commitments relate to expenditure and short term and low value leases.

Expenditure commitments

Commitments for future expenditure include capital commitments 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.

Note 7 Financial instruments, contingencies and valuation judgements

Boort District Health 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 Boort District Health'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	Net gain/(loss) $'000	Total interest income/ $'000	Fee income/ (expense $'000	Impairment loss $'000
Financial assets at amortised cost						
Cash and cash equivalents	6.2	7,697	-	295	-	-
Receivables	5.1	829	-	-	-	-
Total financial assets [i]		**8,525**	**-**	**295**	**-**	**-**
Financial liabilities at amortised cost						
Payables	5.2	1,433	-	-	-	-
Borrowings		224	-	14	-	-
Monies held in Trust	5.3	4,769	-	-	-	-
Total financial liabilities [i]		**6,426**	**-**	**14**	**-**	**-**

30 June 2025	Note	Carrying amount $'000	Net gain/(loss) $'000	Total interest income/ $'000	Fee income/ (expense $'000	Impairment loss $'000
Financial assets at amortised cost						
Cash and cash equivalents	6.2	6,417	-	295	-	-
Receivables	5.1	742	-	-	-	-
Total financial assets [i]		**7,158**	**-**	**295**	**-**	**-**
Financial liabilities at amortised cost						
Payables	5.2	1,155	-	-	-	-
Borrowings		306	-	11	-	-
Monies held in Trust	5.3	3,269	-	-	-	-
Total financial liabilities [i]		**4,730**	**-**	**11**	**-**	**-**

[i] The carrying amount excludes statutory receivables (i.e. GST receivable) and statutory payables (i.e. GST payable) and deferred capital grant income.

Boort District Health
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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 Boort District Health solely to collect the contractual cash flows, and
- the assets' contractual terms give rise to cash flows that are solely payments of principal and interest on the principal amount outstanding on specific 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.

Boort District Health recognises the following assets in this category:
- cash and deposits; and
- 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.

Boort District Health recognises the following liabilities in this category:
- payables (excluding statutory payables and deferred capital grant income); and
- 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
- Boort District Health 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
- Boort District Health has transferred its rights to receive cash flows from the asset and either:
    - has transferred substantially all the risks and rewards of the asset, or
    - has neither transferred nor retained substantially all the risks and rewards of the asset but has transferred control of the asset.

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

- Property, plant and equipment, with the exception of right-of-use assets arising under AASB 16, which are measured using the cost model.

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

Boort District Health 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.

Boort District Health 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 Boort District Health's independent valuation agency for property, plant and equipment.

Fair value determination: non-financial physical assets

AASB 2010-10 *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 2025. 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 Boort District Health'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, Boort District Health 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, Boort District Health considers the current use as its highest and best use.

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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, Boort District Health 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 Boort District Health, 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. Boort District Health 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 Boort District Health who set relevant depreciation rates during use to reflect the utilisation of the vehicles.

Furniture, fittings, plant and equipment

Furniture, fittings, plant and equipment (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.

Significant assumptions

Asset class	Valuation technique	Significant assumption	Range (weighted average)[(i)]
Specialised land	Market approach	Community Service Obligations adjustment	20% (20%)[(ii)]
Specialised buildings	Current replacement cost approach	Cost per square metre	$380 - $10,740/m^2 ($8,740)
		Useful life	5-47 years (22 years)
Vehicles	Current replacement cost approach	Cost per unit	$17,000 - $67,000 ($32,000 per unit)
		Useful life	6 - 10 years (6 years)
Furniture, fittings, plant and equipment	Current replacement cost approach	Cost per unit	$1,000 - $172,000 ($5,000 per unit)
		Useful life	3 - 25 years (10 years)

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

[(ii)] CSO adjustments of 20% was applied to reduce the market approach value for Boort District Health's specialised land.

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 Responsible persons disclosures
8.2 Remuneration of executives
8.3 Related parties
8.4 Remuneration of auditors
8.5 Events occurring after the balance sheet date
8.6 Joint arrangements

Boort District Health
Notes to the Financial Statements
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Note 8.1 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
The Honourable Mary-Anne Thomas MP:	
Minister for Health	1 July 2025 - 15 April 2026
Minister for Ambulance Services	1 July 2025 - 15 April 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 Lizzy Blandthorn MP:	
Minister for Children	1 July 2025 - 30 June 2026
The Honourable Melissa Horne MP:	
Minister for Health Infrastructure	1 July 2025 - 30 June 2026
Honourable Harriet Shing MP:	
Minister for Health	15 April 2026 - 30 June 2026
Minister for Ambulance Services	15 April 2026 - 30 June 2026
Governing Boards	
Mr Gregory Currie (Board Chair from 21 January 2026)	1 July 2025 - 30 June 2026
Ms Wendy Gladman (Board Chair to 21 January 2026)	1 July 2025 - 30 June 2026
Ms Amy Fay	1 July 2025 - 30 June 2026
Ms Renée Harrison	1 July 2025 - 30 June 2026
Mr Laurie Maxted	1 July 2025 - 30 June 2026
Mr John White	1 July 2025 - 30 June 2026
Mr Brett Yates	1 July 2025 - 30 June 2026
Ms Cheree Schneider	1 July 2025 - 30 June 2026
Mr Gregory Kuchel	1 July 2025 - 30 June 2026
Accountable Officers	
Ms Donna Doyle	1 July 2025 - 30 June 2026

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

Income Band	2026 No	2025 No
$0-$9,999	9	8
$220,000-$229,999	-	1
$230,000-$239,999	1	-
Total Numbers	**10**	**9**

	2026 $'000	2025 $'000
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**279**	**260**

The remuneration of the Chief Executive Officer included a non-monetary benefit consisting of employer-provided accommodation in a health service-owned property. The estimated value of the accommodation provided during the financial year was $10,660, based on the property's market rental value.

The total remuneration disclosed in the income bands includes this non-monetary benefit.

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

Note 8.2 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 of executives officers
(including Key Management Personnel disclosed in Note 8.3)

	Total Remuneration	
	2026 $'000	2025 $'000
Total remuneration [i]	179	189
Total number of executives	1	1
Total annualised employee equivalent [ii]	1.0	1.0

i The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of Boort District Health's under AASB 124 *Related Party Disclosures* and are also reported within Note 8.3 Related Parties.
[ii] Annualised employee equivalent is based on working 38 ordinary hours per week over the reporting period.

Note 8.3 Related Parties

The Boort District Health 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 Loddon Mallee Rural Health Alliance; and
- 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
The Boort District Health received funding from government related entities of $4.7m (2025: $4.3m) and indirect contributions of $26k (2025: $189k). Balances outstanding as at 30 June 2026 are $nil (2025: $nil).

Expenses incurred by Boort District Health 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 Boort District Health 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 the Boort District Health, directly or indirectly.

The Board of Directors and the Executive Directors of the Boort District Health are deemed to be KMPs. This includes the following:

Entity	KMPs	Position Title
Boort District Health	Mr Gregory Currie (Board Chair from 21 January 2026)	Board Chair
Boort District Health	Ms Wendy Gladman (Board Chair to 21 January 2026)	Board Chair
Boort District Health	Mr Brett Yates	Chair of Audit & Risk
Boort District Health	Ms Amy Fay	Board Member
Boort District Health	Mr Laurie Maxted	Board Member
Boort District Health	Ms Renée Harrison	Board Member
Boort District Health	Mr John White	Board Member
Boort District Health	Ms Cheree Schneider	Board Member
Boort District Health	Mr Gregory Kuchel	Board Member
Boort District Health	Ms Donna Doyle	Chief Executive Officer
Boort District Health	Mr Mohammed Mubarak Meera Sahib	Director of Clinical & Community Services

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]	458	448

[i] KMPs are also reported in Note 8.1 Responsible Persons or Note 8.2 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.

Except for the transactions listed below, there were no other related party transactions required to be disclosed for Boort District Health's Board of Directors, Chief Executive Officer and Executive Directors in 2026. 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).

Boort District Health transacted with Loddon Shire Council during the financial year. Wendy Gladman, Chair of the Board of Directors of Boort District Health, is also the Director of Community Wellbeing at Loddon Shire Council. Transactions during the reporting period included council rates, shared service arrangements and contributions to local health and wellbeing programs. All transactions were conducted at arm's length and under standard commercial terms.

Total payments made by Boort District Health to Loddon Shire Council were $28,863 (2025: $27,635). No balances were outstanding at year end. Total revenue received by Boort District Health from Loddon Shire Council was $27,493 (2025: $18,353).

There were no further related party transactions required to be disclosed for the Boort District Health Board of Directors, Chief Executive Officer and Executive Directors in 2026 (2025: Nil).

Note 8.4 Remuneration of Auditors

	2026 $'000	2025 $'000
Victorian Auditor-General's Office		
Audit of the financial statements	29	28
Total remuneration of auditors	**29**	**28**

Note 8.5 Events occurring after the balance sheet date

There are no events occurring after the Balance Sheet date.

Note 8.6 Joint arrangements

	Principal Activity	Ownership Interest 2026 %	Ownership Interest 2025 %
Loddon Mallee Rural Health Alliance	Information Technology	3.02	3.28

For the year ended 30 June 2026, Boort District Health's share of the joint operations financials was:

	2026 $'000	2025 $'000
Total revenue and income	803	583
Total expenses	813	685
Total net result	(10)	(102)
Total other economic flows	-	-
Comprehensive result for the year	(10)	(102)
Total assets	744	725
Total liabilities	569	515
Total equity	175	210

Contingent liabilities and capital commitments

There are no known contingent liabilities or capital commitments held by the jointly controlled operations at balance date. Boort District Health is involved in joint arrangements where control and decision-making are shared with other parties. Boort District Health 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.


MAIN ENTRANCE
BOORT
DISTRICT
HOSPITAL
1961-2008
BOORT
DISTRICT
HEALTH
2008



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