COHUNA DISTRICT HOSPITAL



74th Annual Report of Operations and Financials

C A R E
Care Accountability Respect Equality

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Acknowledgement of Country

Cohuna District Hospital acknowledges the Yorta Yorta and Barapa Barapa people as the Traditional Custodians of the land and waters that the health service occupies. We pay our respects to their Elders past, present and emerging.





INTRODUCTION

Purpose

Cohuna District Hospital (CDH) will report on annual operational and financial performance in this document. The Annual Report complies with statutory reporting requirements.

Manner of Establishment

Cohuna District Hospital was established as a public hospital in 1952. Prior to this, the hospital had operated as a private hospital and was purchased from its owner, Dr Stewart, in that year.

Since the 1950s, there have been many significant changes to health services and hospital facilities, reflecting the evolving needs of the Cohuna community. In 1983, a community appeal successfully raised funds to establish a nursing home. A 14-bed nursing home wing was subsequently built adjacent to the hospital and officially opened in 1985. A further two beds were added in 1994, bringing the nursing home capacity to 16 beds.

Tuesday, 24 March 2026, marked another significant milestone in the history of Cohuna District Hospital and the local community. The $41.1 million redevelopment was completed, delivering a new 16-bed Residential Aged Care Facility and an 8-bed Acute Care Hospital.

The new state-of-the-art facility has been designed to promote dignity, privacy and independence, with modern single rooms and private ensuite bathrooms. It provides contemporary aged care and acute medical services, ensuring that residents of Cohuna and the surrounding communities can continue to access high-quality care close to home, both now and into the future.

Our Belief - We believe that every person in our rural community deserves access to high quality, excellent, compassionate, and person-centred care, through every stage of life.

Our Purpose - Our purpose is to deliver quality care locally, through skilled workforce, collaboration, cultural safety and trusted relationships.

Our Values - Care, Accountability, Respect and Equality





RESPONSIBLE MINISTERS

The responsible Minister(s) for the reporting period was/were:

Minister for Health:
Minister for Ambulance Services:
The Hon Mary-Anne Thomas MP (01 July 2025 to 15 April 2026)

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

Minister for Health Infrastructure:
The Hon Melissa Horne MP (01 July 2025 to 30 June 2026)

Minister for Mental Health
Minister for Ageing
The Hon Ingrid Stitt MP (01 July 2025 to 30 June 2026)



Bernadette Loughnane (CEO) and John Tesoriero, (Board Chair) launched the Strategic Plan and Service Plan at the Annual General Meeting in December 2025.

OUR HEALTH SERVICE

Cohuna is a vibrant township located on the Murray Valley Highway, approximately 274 kilometers north of Melbourne in northern Victoria. Surrounded by productive dairy farms and situated on the banks of the Gunbower Creek, Cohuna is a welcoming community and a popular destination for visitors seeking to enjoy the region's natural environment and lifestyle.

Cohuna District Hospital is an important part of the local community and employs people from Cohuna and the surrounding areas. As a locally focused health service, we play an important role in supporting the health and wellbeing of individuals, families and communities across the Gannawarra Shire and surrounding region.

Cohuna District Hospital is committed to providing high-quality healthcare that is responsive, efficient and person-centred. We are determined to ensure that people remain at the heart of everything we do and that our community has access to safe, high-quality healthcare close to home.

Meeting the changing health needs and expectations of our community requires strong collaboration. We recognise that our success depends on working closely with our community, our workforce and our strategic partners across the health and broader sectors.

Building and strengthening these partnerships enables us to better understand local needs, respond to emerging challenges and identify opportunities to improve the way healthcare is delivered. Through collaboration, shared knowledge and a commitment to continuous improvement, we can strengthen the services available to our community.

Our people are one of our greatest strengths. Together with our infrastructure and available resources, our workforce provides a strong foundation for the future of Cohuna District Hospital.

We have significant opportunities to build our clinical capability and capacity, strengthen and expand our workforce, and increase self-sufficiency in healthcare across the Gannawarra Shire and surrounding communities.



Realising these opportunities will require thoughtful planning, investment and a willingness to embrace change. Changing Together and smart investment are important elements in achieving our purpose and ensuring that our health service is well positioned to meet the needs of our community into the future.

As we look to the future, Cohuna District Hospital remains focused on putting people first. We will continue to strengthen our partnerships, invest in our people and capabilities, and identify innovative and sustainable ways to improve healthcare delivery.

By working together with our community, our staff and our strategic partners, we can build on our strengths and create opportunities for better health outcomes.

NATURE AND RANGE OF SERVICES

ACUTE HOSPITAL

Medical, Day Surgery, Midwifery Group Care, Palliative Care, Urgent Care,

RESIDENTIAL AGED CARE - (Five Star Rating)

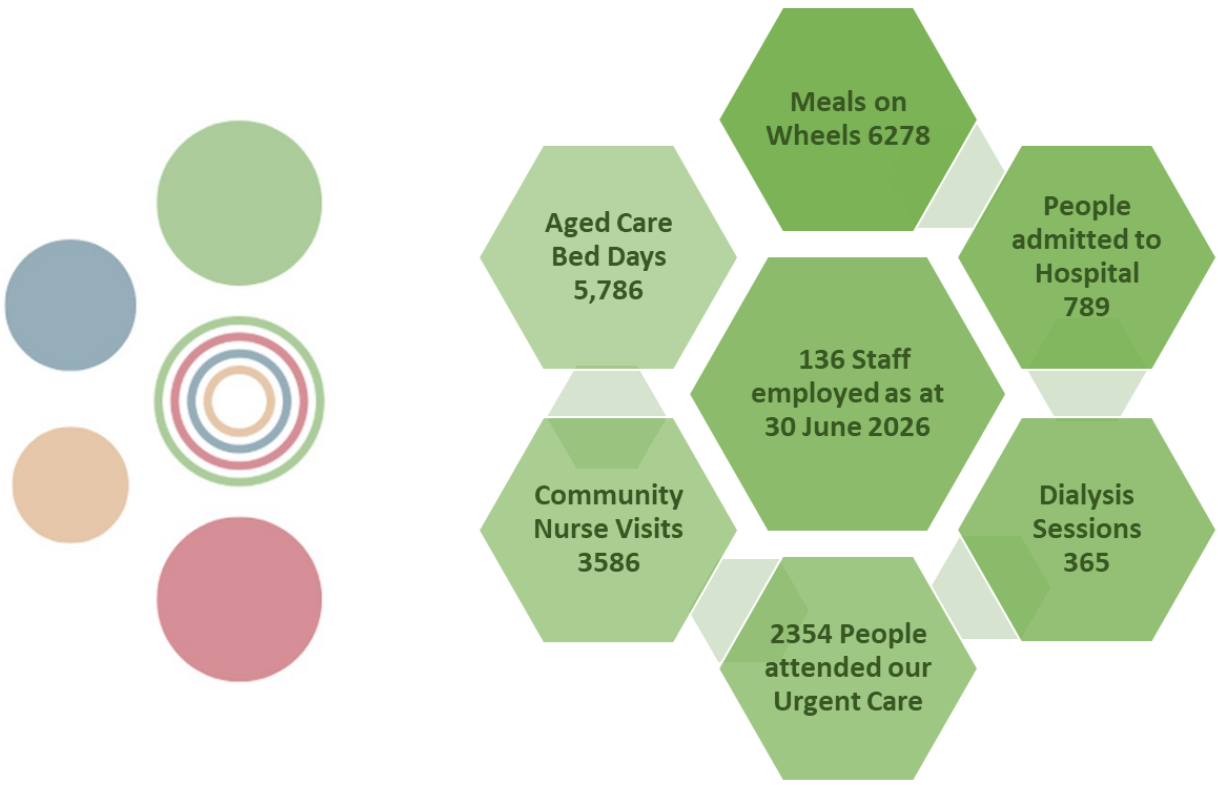
The overall rating is based on a provider's performance across the 4 key areas of Compliance, Quality Measures, Residents' Experience, and Staffing

COMMUNITY BASED SERVICES

Community Health Nursing, Renal Dialysis, Hospital in the Home, Physiotherapy, Transition Care Program, Midwifery Home Care, Social Support

OTHER SERVICES

Rich River Physiotherapy, Meals on Wheels, Royal Flying Dental Service



BOARD CHAIR & CHIEF EXECUTIVE OFFICER REPORT 2025-26

The 2025-2026 year has been an unprecedented year for Cohuna District Hospital (CDH). We acknowledge the support of many teams in contributing to all our achievements.

Firstly, the major capital works program delivered a generational investment in Cohuna District Hospital. $41.1 million was invested from the Public Sector Residential Aged Care Fund. This has delivered sixteen aged care ensuite rooms plus eight acute care ensuite rooms. The aged care is designed to create two households. There are quiet rooms overlooking the aged friendly landscaped garden with raised garden beds and plants that flower on rotation throughout the four seasons. The dining room is designed to improve the food and dining experience and the café style area is designed to enable local community to visit and share this space. The acute care unit has a special purpose palliative care suite with large single patient ensuite room, a family room and separate outdoor court yard.

The colour scheme of the new building reflects the nearby Gunbower region. The art work is bespoke to emulate the flora and fauna of the region. Included is some beautiful local Aboriginal art work.

Strategic Plan
The launch of the CDH Strategic Plan 2026-29, Services Plan 2026-29 and Workforce Plan 2024 has set the direction for CDH over coming years. The Board approved the development of the Services Plan to ensure the Strategic Plan was well informed. There was a particular focus on Community demographics and social determinants of health. Included in this was our key service drivers of health needs and projections. Importantly the voice of our community was compelling and welcomed.

The plans were informed by increased ageing population (Gannawarra median age is 51 vs 38 for VIC). The ageing trend is accelerating and it is estimated there will be a 43% increase in people aged 75+ from 2021 to 2030. Other significant trends include:

- Growing burden of chronic disease (39.4% of population report long-term health conditions vs 37.2% in regional Victoria and 31.4% for VIC).
- Increased mental health issues (10% report long term mental health conditions vs 8.8% for VIC). Suicide and alcohol deaths higher than VIC average. 54.6% of Gannawarra residents report poor access to mental health services vs 21.5% for VIC.
- Growing cancer incidence (cancer is one of the leading causes of avoidable death in Gannawarra). There was a 37.5% increase in cancer diagnoses from 2021-2022. Need highlighted for overall women's care not just maternity. Sexually Transmitted Infections (STIs) in young women higher than state average.

BOARD CHAIR & CHIEF EXECUTIVE OFFICER REPORT

The CDH belief is that every person in our community deserves access to high quality excellent compassionate and person-centred care, through every stage of life. Our purpose is to deliver quality care locally, through skilled workforce, collaboration, cultural safety and trusted relationships. Our CARE values of care, accountability, respect and equality underpin everything we do every day.

Our key priorities are to improve health outcomes across the lifespan:
Equity, community engagement and trust;
Digital transformation for connected care;
Workforce capability, culture and wellbeing and
Organisational sustainability.

All of these priorities are enabled through strong governance, collaborative partnership and community engagement and experience.

Workforce
CDH continues to attract a skilled workforce. We partner with Dhelkaya Health to appoint a multiskilled Human Resources team. Our community has backed us to enable stronger local recruitment and retention. Special effort has been to continue strong local recruitment. We continue to partner with our peers in procuring shared services to achieve purchasing power and better efficiency and standardisation. This includes Echuca Regional Health, Bendigo Health and Loddon Mallee Shared Services. We look forward to the development of local childcare currently in the delivery stage. Our employee value proposition includes benefits, wellbeing, values, opportunities, meaning and purpose. CDH has focused on ensuring clinicians are enabled to work to the top of their scope of practice. This is evident through CDH inaugural Nurse Practitioners and Authorised Midwives, X-ray nurses and a team of vaccination nurses. Many staff are currently working towards advanced studies. Work continues on ensuring a health care pipeline though development of a unique certified health care worker role, enrolled nurse diploma pathway, through to registered nurse degree pathway. We continue to welcome students from many universities and colleges.

Gender Equality Action Plan
CDH has advanced our Gender Equality Action Plan (GEAP). We welcomed a visit from the Commissioner for Gender Equality Dr Niki Vincent. CDH has a high rate of female workforce, gender balance on Board of Directors, flexible work arrangements with >90% part-time staff, and training on diversity, equity and inclusion. Staff have access to an Employee Assistance Program and family violence leave. Sexual Harassment is benchmarked through the People Matter Survey, and is measured through performance reviews and exit interviews. CDH conducted a gender impact assessment of the operating theatre. The CDH Board has approved the development of GEAP Project Officer.

BOARD CHAIR & CHIEF EXECUTIVE OFFICER REPORT

Aged Care
As a result of the Royal Commission into Aged Care, the new Australian Strengthened Aged Care Quality Standards were launched in 2025. CDH is progressing implementation of these standards with Board Governance and oversight. The standards focus on person centred care, dignity of risk, and shared decision making. There has been a big uplift in quality safety inclusion culture to enable our aged care team to deliver quality care. CDH has rolled out electronic medication management in the aged care service. The state-of-the-art new building optimises the delivery of the strengthened aged care standards. The most exciting part of the new standards is changes to food and dining experience. While this has been a paradigm shift for CDH this continues to be work in progress. The exciting part has been the whole of hospital approach to this change in partnership with our residents.

Home Care
Not all of our care is delivered within our four walls. CDH has a large cohort of clients receiving care at home as well as virtual care. Added to this is our role in provision of meals on wheels to our community. All meals are cooked fresh on site by our in-house chefs with dietician input. CDH is a partner in research with La Trobe University to explore the impacts of extreme temperatures on in-home aged care provision in rural and regional areas. CDH was selected as a partner given our locality and volume of older people in our community. CDH is well established in the Virtual Emergency Department initiative.

Theatre and maternity upgrade
The delivery of operating theatre and midwifery space is completed and currently undergoing fine detailed compliance testing. This includes an operating theatre, unit for reprocessing surgical instruments, post anaesthetic recovery area and staff facilities. We look forward to re-commencing day only surgery in the near future. Co-located with this is our pregnancy care centre.

Digital transformation
Digital transformation has had some remarkable changes this year. The upgrade of the nurse call bell results in earlier notification to nurses Remote monitoring of home care patients is being rolled out. The upgrade of electronic medication system in aged care improves safety. CDH uses an electronic auditing system and this gives clinicians real time feedback on findings. All meetings are now supported through Convene, paperless agenda and meeting platform. Laptops and ipads are provided for point of care documentation.

First Nations
Welcoming our First Nations community to be cared for by CDH team in a culturally safe way is of paramount importance. We live and work on Yorta Yorta and Barapa Barapa country where 1.9% of our community identify as Indigenous. This is similar to the rate presenting to Urgent Care as well as the rate of our workforce identifying as Indigenous. During design of the new building the importance of creating a welcome space for First Nations people was included. We incorporated much loved aboriginal art work. The availability of a reflection room and access to outdoor garden and space is remarkable. Our single bed rooms enable open visiting hours. CDH has partnered with Kerang Hospital to appoint a local Aboriginal Health Liaison officer to ensure we deliver on our First Nations commitment. Training of our workforce in providing welcome and culturally safe place for our First Nations people is mandatory.

BOARD CHAIR & CHIEF EXECUTIVE OFFICER REPORT

Accreditation
CDH was accredited to the National Safety and Quality Health Care standards by the Australian Council for Health Care Standards in 2025 and was awarded four years accreditation. CDH is proud to have a track record of continuous accreditation. CDH has sustained five-star rating in Aged Care. This year we have made no reports to Australian Health Practitioners Regulation Agency (AHPRA) and have nil listings on the Aged Care Banning Order register. There have been no sentinel events.

Budget
Financially, after six years of delivering a budget surplus, CDH is posting a small deficit this year. This is driven by a reduction in use of private health insurance, a drop in interest rates both impacting on revenue as well as some premium labour costs of specialist agency nurses. One of the biggest impacts was the cost of commissioning the new buildings and increased operational costs through contracted services and supplies. Cash reserves remain healthy. CDH Board and executive team are mindful of our financial stewardship responsibilities and commit to return a better budget outcome in 2026/27.

Loddon Mallee Health Service Network (LMHSN)
CDH is a key partner in the re-formed Loddon Mallee Health Service Network. Both CDH Board Chair and Chief Executive Officer (CEO) are executive members. The reforms are articulated in the annual statement of expectations and Loddon Mallee is progressing to target. The Health Services Plan 2024 underpins all of the strategic directions. The fundamental principles of the reform include care closer to home, role delineation, access to care, health equity, workforce strategies, research and development, streamlined access to care for patients requiring higher complexity care and very high specialised care. Importantly, the plan is committed to governing a connected health services system for all Victorians. CDH is represented on all governance committees. CDH CEO is co-chair of the LMHSN Clinical Services Plan Committee and co-chair of Maternity Committee and oversight of recommendations from Victorian Maternity Taskforce.

Sustainability
CDH launched our Sustainability Strategy in 2024 and this year saw significant progress through the delivery of capital works. Sustainability is a key driver for CDH. Upgrade of LED lighting and fire systems was completed this year with a special grant. Key features of the design of the new building focused on a reduction in energy consumption and carbon emission, and improved indoor environment quality to reduce operational cost. Sustainable initiatives include enhanced passive building design, openable windows, circadian lighting, better internal access to daylight, external shading for outdoor comfort and increased local vegetation and biodiversity. Water sensitive urban design strategies were adopted to reduce storm water runoff and decrease pollutants. CDH uses chemical free cleaning. Modern eco technology includes the seismic proof pendant in theatre. Reprocessing medical devices in theatre is a key sustainability feature and meets industry standards.

BOARD CHAIR & CHIEF EXECUTIVE OFFICER REPORT

Midwifery Group Practice (MGP)
Our Midwifery Group Practice established in 2023 continues to make a difference. CDH MGP is seen as an exemplar model of care and has attracted much positive attention and showcasing. This is a great example of how a rural community, skilled midwives and executive leadership came together with statewide leaders to develop a bespoke safe model of care, closer to home. CDH remains a non-birthing service, however our midwives can attend Echuca Regional Health (ERH) to care for their mothers. CDH is well progressed in delivering the recommendations of the Victorian Maternity Taskforce report launched by the Minister of Health. The CDH model of midwifery lead care is contemporary. Care of the mother is personalised to prioritise her choice and experience. CDH uses standardised clinical guidelines and escalation pathways. CDH has appointed the inaugural midwife to the Clinical Governance Board sub-committee. CDH Board has committed to development of midwifery services within a tight risk management framework. CDH welcomes the appointment of the inaugural Victorian Chief Midwife. CDH was awarded $50k from the prestigious La Trobe Violet Vines Marshman research fund and has appointed an experienced midwifery researcher to conduct this study to evaluate the midwifery model of care.

Partnering with Community
CDH is only as strong as the community we serve; we value the trusting relationship with our community and their enduring support through donations and in-kind support. The high level of community engagement was evident during the open day when so many viewed the new building. Their feedback is welcomed and nudges us to continue to learn how we can be better. Our Partnering with Consumers Committee has kept us on our toes this year. They continue to meet regularly and focus on community access to care and services closer to home. They had an active role in community open day for new building. They provide us with unsolicited feedback from our community and adopt an ambassadorial role in our community. Our Ladies Auxiliary meet monthly and continue to provide community feedback. Importantly, their fund-raising drives are very successful with cake stalls, raffles and an annual golf day. They funded the purchase of cardiac equipment this year as well as items to improve patient experience for patients attending renal dialysis.

Board of Directors
CDH Board farewelled three long serving Board Directors at the completion of their tenure. Sam Manduskar, Rick Henery and Margot Henty have been exemplar governors during unprecedented generational change. We thank them for their governance and stewardship and commend their enduring legacy to CDH.

BOARD CHAIR & CHIEF EXECUTIVE OFFICER REPORT

Thank you
As Board Chair and Chief Executive Officer we express our gratitude to be chosen to serve our loyal community. It is a privilege to lead this year of unprecedent change and improvements. We thank wholeheartedly our workforce whom endeavor to advocate for the care needs of our community while juggling their own family commitments and studies.

John Tesoriero
Board Chair
Cohuna District Hospital
09/10/2026

Bernadette Loughnane
Chief Executive Officer
Cohuna District Hospital
09/10/2026

Standing Directions 2018

(5.2.3 Declaration in the Report of Operations - Responsible Body's Declaration

In accordance with the *Financial Management Act 1994*, I am pleased to present the Report of Operations for Cohuna District Hospital for the year ending 30 June 2026.

John Tesoriero
Board Chair
Cohuna District Hospital
09/10/2026



MANAGEMENT AND STRUCTURE
BOARD OF DIRECTORS



Board Chair
John Tesoriero
Appointed 01/07/2022



Senior Vice Chair
Anthea Toma
Appointed 01/07/2018



Junior Vice Chair
Margot Henty
Appointed 01/07/2023
Resigned 30/06/2026



Finance Chairperson
Sam Manduskar
Appointed 01/07/2017
Retired 30/06/2026



Clinical Governance Chairperson
Kate Fuller
Appointed 01/07/2023



Board Director
Rick Henery
Appointed 01/07/2017
Retired 30/06/2026



Board Director
Kerri Sidorow
Appointed 01/07/2023



Board Director
Suzanne Gundry
Appointed 01/07/2024



Board Director
Cara van der Zande
Appointed 01/07/2025

AUDIT & RISK

The purpose of the Audit and Risk Committee is to assist, oversee and advise the Board of Directors on:

- operating and asset budgets and performance;
- financial management and control systems; and
- compliance with the Standing Directions and the Instructions issued by the Department of Treasury and Finance (the Instructions) that support the Standing Directions.

The Committee plays a key role in ensuring the credibility and objectivity of the organisation's accountability processes, including financial reporting and risk management processes.
Members: Margot Henty (Chair), Cara van der Zande (Deputy Chairperson), Sam Manduskar, Rick Henery, Suzanne Gundry, Rob Johns (Community Representative)

CLINICAL GOVERNANCE COMMITTEE

The purpose of the Clinical Governance Committee is to ensure that the impact on patient and resident safety and the quality of care is appropriately considered in decision-making and organisational governance.
The strategic objective of the Committee is to provide effective clinical governance in accordance with the National Model Clinical Governance Framework (2017), the National Safety and Quality Health Service Standards (2nd Edition), and the Aged Care Quality and Safety Commission Standards.
The Committee supports the organisation's commitment to safety and quality in healthcare by providing oversight, assurance and advice on clinical governance, patient and resident safety, quality of care, and continuous improvement.

PARTNERING WITH CONSUMERS

The purpose of the Consumer Advisory Committee is to support the Cohuna District Hospital (CDH) Board and Executive by providing consumer input into the strategic and service planning of the Hospital.
The Committee provides consumer, carer and community perspectives to inform CDH's planning and implementation of safety, quality and service improvements. It also supports the development and implementation of effective approaches to community participation and engagement in the health service's activities.



CARE
Care Accountability Respect Equality

MANAGEMENT AND STRUCTURE

Executive Leadership Team

Chief Executive Officer, Bernadette Loughnane



The Chief Executive Officer is responsible to the Board of Directors for the efficient and effective management of Cohuna District Hospital. This position provides leadership on workforce and culture matters and includes the development and implementation of operational and strategic planning, maximising service efficiency, quality improvement and minimisation of risk.

Director of Clinical Services, Wendy Lunghusen



The Director of Clinical Services has a professional responsibility for nursing across clinical streams and executive responsibility for Acute nursing services including, Urgent Care, Renal Dialysis, General Medical, General Surgical, Midwifery and Residential Aged Care Services, Community Nursing, and Social Support Group. Major areas of responsibility include Clinical Leadership and Standards of Practice, Nursing credentialing and resource management, service and strategic planning, clinical risk management and quality improvement.

Director of Medical Services, Dr Craig Winter



The Director of Medical Services is responsible for leadership of the Cohuna District Hospital Medical workforce. This position chairs Medical Management meetings and represents medical staff on Quality and Safety Board sub-committees. The Director of Medical Services provides clinical governance, planning and resource management to the organisation.

Chief Finance Officer, Steve Jackel



The Chief Finance Officer is responsible for the oversight of accounting practices and ensures compliance with industry standards, capital and operational budgets.

Corporate Services Manager, Allison Peace (Resigned 28/03/2026)



The Corporate Services Manager is responsible for the efficient and effective management of the non-clinical day-to-day operations of the Organisation. Key responsibilities include Support Services, Infrastructure & Facilities Maintenance, Finance, Administration, Human Resources, Occupational Health & Safety, Emergency Management, Contracts and Procurement.

Capital Projects Manager, Peter Jones



The Capital Projects Manager is responsible for the planning and delivery phase of the organisation's Capital Works. This position works collaboratively with internal and external stakeholders. This position is a member of the Project Control Group.

LIFE GOVERNORS AND DONORS

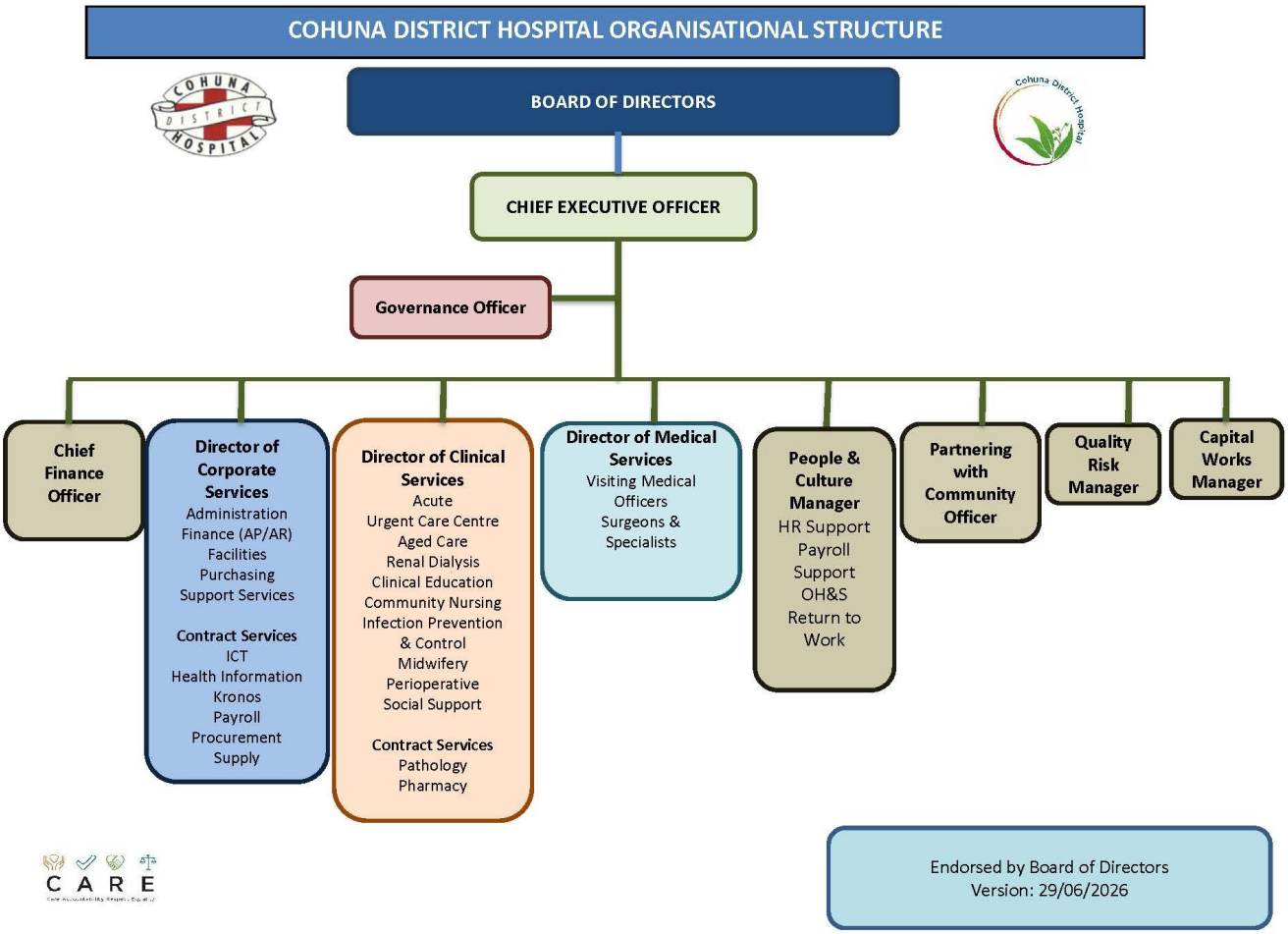
DONATIONS (OVER $500.00) received during the period 01/07/2025—30/06/2026

Charlie Bartelson Estate
Kerang Agricultural Research Farm
B P Kervin
The Alfred & Jean Dickson Foundation
Ladies Auxiliary
Jill North



LIFE GOVERNORS OF COHUNA DISTRICT HOSPITAL

C. MUES	C. OTTREY	V. ROWLANDS
C. SCHIER	E. FERRIS	G. SMITH
R. OTTREY	DR P. GRAHAM, OAM	G. MUNZEL
T. EVANS	T. CLEAVE	E. TURNOUR
E. HEINRICH	A. LEE	DR P. BARKER, OAM
M. FLANNERY	A. LESTER	J. GRANT
F. FARRANT	T. MACKENZIE	R. DYE
T. FARRANT	K. MAWSON	A. RICKEY
M. GARNER	R. TOLL	G. HALL
J. TREACY	I. BARR	A. GRAHAM
L. NORMAN	M. BERRY	G. PAYNE
T. MAJOR	D. HEWITT	R. STANTON
H. LITHGOW	R. HINDHAUGH	L. DRUMMOND
E. WINTERBOTTOM	H. ROBERTSON	E. LAKE
A. LEE	R. FARRANT	J. CASSIDY
DR. K TELLESSON	A. FRY, OAM	H. SPENCE, OAM
R. HAWKEN	E. LUNGHUSEN	J. HOLDERHEAD
A. GOW	G. HILL	



STAFF SERVICE AWARDS - presented at the 73rd Annual General Meeting

Clinical Staff

Robyn Gladman - 40 years
Heather Spence - 40 years
Sherryn Bond - 40 years
Kay Tuohey - 35 years
Sally McCahon - 30 years
Glenda Crichton - 20 years
Clifford Dwyer - 15 years
Daniella Mathers - 15 years



Corporate Staff

Maxine Rush - 40 years
Gabriel Dunne - 25 years
Michelle Gladman - 20 years
Caitlin Taylor-Irvin - 15 years
Helen Cramer - 15 years
Derrie Cherry - 10 years

WORKFORCE DATA, EMPLOYMENT AND CONDUCT PRINCIPLES

The FTE figures required in the table are those excluding overtime. These do not include contracted staff (e.g. Agency nurses, Fee-for-Service, Visiting Medical Officers) who are not regarded as employees for this purpose.

HOSPITAL Labour Category	JUNE Current Month FTE		AVERAGE Monthly FTE	
	2024-25	2025-26	2024-25	2025-26
Nursing	45.42	48.82	42.93	46.08
Administration and Clerical	10.19	10.12	8.85	10.66
Hotel and Allied Services	16.80	16.81	18.19	15.99

At the Annual General Meeting held in December 2025 Jan Holderhead was nominated and received a Life Governorship after leading the auxiliary during a very successful period. The leadership she provided to her colleagues was exemplary. The funds raised under her stewardship continue to grow and include the annual golf day, bi-annual raffles and cake stalls.



OCCUPATIONAL HEALTH AND SAFETY STATISTICS			
	2023-24	**2024-25**	**2025-26**
The number of reported hazards/incidents for the year per 100 FTE	46	72	72
The number of 'lost time' standard Workcover claims for the year per 100 FTE	2	1.42	4.0
The average cost per Workcover claim for the year ($'000)	0.426	0.133	0.259

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	8
Number of occupational violence incidents reported per 100 FTE	10.6
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	0

OCCUPATIONAL VIOLENCE

Victorian public health services are required to monitor and publicly report incidents of occupational violence in the health service. To ensure consistency in reporting, Cohuna District Hospital is required, as a minimum, to report the following occupational violence statistics in the following format.

For the purposes of the Occupational Violence Statistics, the following definitions apply:
Occupational violence – any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment.

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

Accepted Workcover claims – Accepted Workcover claims that were lodged in 2025-26.

Lost time – is defined as greater than one day.

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

FINANCIAL INFORMATION

	2026 $000	2025 $000	2024 $000	2023 $000	2022 $000
OPERATING RESULT	(434)	169	292	150	386
Total Revenue	34,491	25,086	15,707	13,316	12,105
Total Expenses	16,366	15,002	14,473	13,705	12,065
Net Result from Transactions	18,125	10,084	1,234	(389)	40
Total other economic flows	32	(52)	15	(6)	27
NET RESULT	**18,157**	**10,032**	**1,249**	**(395)**	**67**
Total Assets	53,852	35,965	24,536	15,132	15,450
Total Liabilities	7,251	7,521	6,124	5,568	5,491
NET ASSETS / TOTAL EQUITY	**46,601**	**28,444**	**18,412**	**9,564**	**9,959**

Operational and budgetary objectives and performance against objectives

The Health Service reported an operating deficit of $434K, which was negative against our target of breakeven in our Statement of Priorities (SOP). Despite achieving our overall revenue targets, expenditure has been impacted by the ongoing need to engage agency staffing, plus increased utility costs and information technology expenditure.

Significant changes in financial position

The comprehensive net result for 2026 is a significant surplus and a further improvement over 2025. This result is impacted by the recognition of capital funding for our building projects which provided $19.52m in revenue which has been fully expended against the building projects.

This compares with $11.19m recorded for 2025 and is the main contributing factor to our $8m improvement in results over the previous financial year.

Activity levels for renal patients has continued at high levels and our aged care facilities have improved with occupancy and funding levels.

As we have moved into our new facilities during the year, occupancy costs have increased which has contributed to our operating deficit. Our current year budget remains tight, however we have instigated further cost saving plans in an effort to return to breakeven for 2026-27.

There were no subsequent events to balance date which required adjustment or disclosure in the financial report at year-end.

	2025 - 2026 ($000)
Operating Result	**(434)**
Capital purpose income	20,001
Specific Income	0
COVID 19 State Supply Arrangements - Assets received free of charge or for nil consideration under the State Supply	0
State supply items consumed up to 30 June 2026	0
Assets provided free of charge	0
Assets received free of charge	0
Expenditure for capital purpose	(219)
Depreciation and amortisation	(1223)
Impairment of non-financial assets	0
Finance costs (other)	0
Net result from transactions	**18,125**



CONSULTANCIES INFORMATION

Details of consultancies (under $10,000)

In 2025-2026, there was one (1) consultancy where the total fees payable to the consultant was less than $10,000. The total expenditure incurred during 2025-2026 in relation to this consultancy was $1,000 (excl. gst).

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

In 2025-2026, there were zero (0) consultancies where the total fees payable to the consultants were $10,000 or greater.

INFORMATION AND COMMUNICATION TECHNOLOGY (ICT) EXPENDITURE

The total ICT expenditure incurred during 2025-2026 was $506,340 (excl gst) with the details shown below.

All operational ICT expenditure	ICT expenditure related to projects To create or enhance ICT capabilities		
Business as Usual (BAU) ICT expenditure (Total)	Non-Business as Usual (non-BAU) ICT expenditure (total = Operational expenditure and capital expenditure)	Operational expenditure	Capital expenditure
$506,340	$0	$0	$0

ASSET MANAGEMENT ACCOUNTABILITY FRAMEWORK

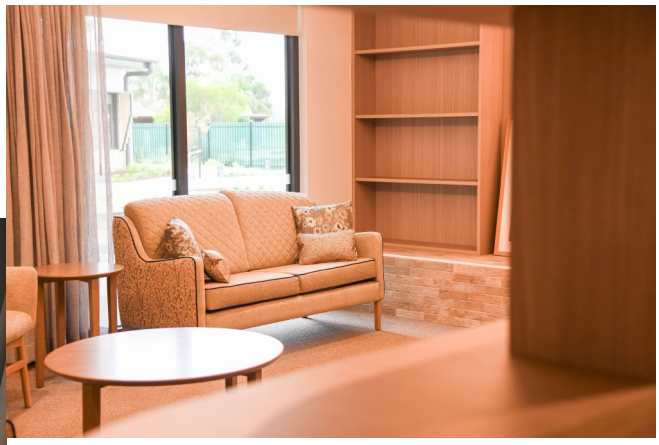
Leadership and Accountability (requirements 1 to 19)
CDH met the target maturity level for more than half of the requirements within this category. CDH did not comply with the requirements for monitoring contractor performance and qualifications, monitoring asset performance and establishing an Asset Information Management System which provides relevant asset information.

Planning (requirements 20 to 23)
CDH met the target maturity level for more than half of the requirements within this category. CDH did not comply with the areas relating to Asset Risk Management.

Acquisition (requirements 24 and 25)
CDH partially complies with both elements within the acquisition area. Full compliance will be achieved by further documentation of considerations during the asset acquisition process to evidence compliance with AMAF requirements.

Operation (requirements (26 to 41)
CDH met the target maturity level for less than half of the requirements within this category. CDH did not comply within the requirements relating to recording asset performance and condition, performing asset stocktakes and recording complete, accurate and timely information in an Asset Information Management System.

Disposal (requirement 47)
CDH met the target maturity in this category.







SOCIAL PROCUREMENT

Cohuna District Hospital considers procurement to be a core business and strategic function. Social procurement creates an opportunity for Cohuna District Hospital to use our buying power to deliver social and sustainable outcomes that help to build a fair, inclusive and sustainable Victoria.

Social procurement will also deliver benefits to the organisation which include:

- Employee empowerment and satisfaction through staff to pursue social and/or sustainable outcomes that benefit the State of Victoria, the economy and/or the planet for every individual procurement activity;
- Understanding suppliers better and their commitment to corporate social responsibility.
- Better support and improvements within the local community.

Cohuna District Hospital's Social Procurement Strategy is committed to advancing social and sustainable procurement objectives through procurement in accordance with the Social Procurement Framework.

Through the development and implementation of this strategy, Cohuna District Hospital can be strategic about the social and sustainable outcomes pursued for the organisation and the State. This supports the strategic commitment of organisational management to identify and pursue opportunities to enhance Cohuna District Hospital's role as a good corporate citizen and an employer of choice.

Direct Spend Metrics	**2025-2026**	**2024-2025**	**2023-2024**
Total Number of suppliers	213	222	217
Total Spend with suppliers	$6,146,553	$6,840,279	$3,544,357
Social Benefit suppliers	2	2	1
Total spent with social benefit suppliers	$22,948	$23,630	$800
Number of Aboriginal businesses engaged	0	0	1
Total expenditure with Victorian Aboriginal business (excl GST)	$0	$0	$800
Opportunities for Victorians with disability	1	1	
Total expenditure for Victorians with disability	$1,349	$450	
Opportunities for Victorian priority jobseekers	1	1	
Total expenditure for Victorian priority jobseekers	$21,598	$23,180	
Sustainable Victorian Social enterprises and Aboriginal businesses			
Number of Victorian social enterprises engaged	2		
Total expenditure with Victorian social enterprises (excl. GST)	$22,948		
Number of Victorian Aboriginal businesses engaged	0		
Total expenditure with Victorian Aboriginal businesses (excl GST)	$0		

ENVIRONMENTAL PERFORMANCE

GREENHOUSE GAS EMISSIONS			
G1 Total; Scope 1 (direct) greenhouse gas emissions (t CO2-e)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Carbon Dioxide	60.35	56.87	59.32
Methane	0.17	0.16	0.17
Nitrous Oxide	0.22	0.20	0.21
Total	**60.74**	**57.23**	**59.69**
Scope 1 GHG emissions from stationary fuel (F2 Scope 1) (t CO2-e)	**52.06**	**58.09**	**5.38**
Scope 1 GHG emissions from vehicle fleet (T3 Scope 1) (t CO2-e)	**8.68**	**9.14**	**9.32**
Medical/Refigerant gases			
Nitrous oxide	15.11	5.02	
Total Scope 1 (direct) greenhouse gas emissions (t CO2-e)	75.86	62.25	59.69
G2 Total; Scope 12 (indirect electricity) greenhouse gas emissions (t CO2-e)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Electricity	366.65	222.95	259.68
Total Scope 2 (indirect electricity) greenhouse gas emissions (t CO2-e)	366.65	222.95	269.68
G3 Total Scope 3 (other indirect) greenhouse gas emissions associated with commercial air travel and waste disposal	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Commercial air travel			
Waste emissions (WR5)	38.98	38.98	39.08
Indirect emissions from Stationary Energy	67.15	46.31	48.85
Indirect emissions from Transport Energy	2.17	2.29	2.34
Paper emissions			
Water emissions	4.24	5.11	4.71
Any other Scope 3 emissions		0.00	0.00
Total Scope 3 greenhouse gas emissions (t CO2-e)	**112.53**	**92.69**	**94.97**

ENVIRONMENTAL PERFORMANCE

GREENHOUSE GAS EMISSIONS continued			
G(Opt) Net greenhouse gas emissions (t CO2-e)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Gross greenhouse gas emissions (G1 + G2 + G3) (tCO2-e)	**555.04**	**377.89**	**414.35**
Total gross reported greenhouse gas emissions per bed-day (t CO2-e/OBD)	0.07	0.06	0.06
Carbon Neutral Electricity	0.00	0.00	0.00
Green Power Electricity	0.00	0.00	0.00
Purchased LGCs	-465.03	0.00	0.00
Any Reduction Measures Offsets purchased (EL4-related)	**-416.45**		
Any offsets purchased	**-416.45**		
Net greenhouse gas emissions (t C02-e)	**138.59**	**377.89**	**414.35**

ELECTRICTY USE			
EL1 Total electricity consumption segmented by source (MWh)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Purchased	545.71	338.11	394.82
Self-generated			
EL1 Total electricity consumption (MWh)	**545.71**	**338.11**	**394.82**
EL3 On-site installed generation capacity (kW converted to MW) segmented by:	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Diesel Generator	0.28	0.28	0.28
Solar System	0.10		
EL3 Total On-site installed generation capacity (MW)	**0.37**	**0.28**	**0.28**
EL4 Total Electricity offsets segmented by offset type (MWh)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
LGCs voluntarily retired on the entity's behalf	505.46		
RPP (Renewable Power Percentage in the grid)	93.06	62.05	74.07
EL4 Total Electricity offsets (MWh)	**545.71**	**62.05**	**74.07**

ENVIRONMENTAL PERFORMANCE

STATIONARY ENERGY			
F1 Total fuels used in buildings and machinery segmented by fuel type (MJ)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
LPG	859,112.30	793,590.20	831,305.20
F1 Total fuels used in buildings	**859,112.30**	**793,590.20**	**831,305.20**
F2 Greenhouse gas emissions from stationary fuel consumption segmented by fuel type (tCO2-e)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
LPG	52.06	48.09	50.38
F2 Greenhouse gas emissions from stationary fuel consumption (tCO2-e)	**52.06**	**48.09**	**50.38**

TRANSPORTATION ENERGY			
T1 Total energy used in transportation (vehicle fleet) within the Entity, segmented by fuel type (MJ)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Non-executive fleet - Gasoline	62,815.00	81,765.30	81,266.00
Petrol	**62,815.00**	**81,765.30**	**81,266.00**
Non-executive fleet - Diesel	62,979.80	51,241.50	54,2873.20
Diesel	62,979.80	51,241.50	54,2873.20
Total energy used in transportation used in transportation (vehicle fleet) (MJ)	125,794.80	133,006.80	135,549.20
T3 Greenhouse gas emissions from transportation (vehicle fleet) segmented by fuel type (t CO2-e)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Non-executive fleet - Gasoline	4.25	5.53	5.50
Petrol	**4.25**	**5.53**	**5.50**
Non-executive fleet - Diesel	4.43	3.61	3.82
Diesel	**4.43**	**3.61**	**3.82**
Total Greenhouse gas emissions from transportation (vehicle fleet) (t CO2-e)	**8.68**	**9.14**	**9.32**

ENVIRONMENTAL PERFORMANCE

TOTAL ENERGY USE			
E1 Total energy usage from fuels, including stationary fuels (F1) and transport fuels (T1) (MJ)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Total; energy usage from stationary fuels (F1) (MJ)	859,112.30	793,590.20	831,305.20
Total energy usage from transport (T1) (MJ)	125,794.80	133,006.80	135,549.20
Total energy usage from fuels, including stationary fuels (F1) and transport fuels (T1) (MJ)	**984,907.10**	**926,597.00**	**966,854.40**
E2 Total energy usage from electricity (MJ)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Total energy usage from electricity (MJ)	1,964,572.45	1,217,191.07	1,421,334.90
E3 Total energy usage segmented by renewable and non-renewable sources (MJ)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Renewable	1,964,572.40	223,372.19	266,636.44
Non-renewable (E1 + E2 - E3 Renewable)	984,907.15	1,920,415.87	2,121,552.86
E4 Units of Stationary Energy used normalised (F1 + E2)/normaliser	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Energy per unit of Aged Care OBD (MJ/Aged Care OBD)	524.75	415.97	483.30
Energy per unit of LOS (MJ/LOS)	1,378.08	1,028.53	982.83
Energy per unit of bed-day (LOS+Aged Care OBD) (MJ/OBD)	380.04	296.18	323.98
Energy per unit of Separations (MJ/Separations)	3,597.05	2,287.58	2,551.12
Energy per unit of floor space (MJ/m2)	676.72	755.93	846.86

ENVIRONMENTAL PERFORMANCE

WATER USE			
W1 Total Units of metered water consumed by water source (kL)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Potable water (kL)	3,021.85	3,123.07	2,806.87
Total units of water consumer (kL)	**3,021.85**	**3,123.07**	**2,806.87**
W2 Units of metered water consumed normalised by FTE, headcount, floor area, or other entity or sector specific quantity	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Water per unit of Aged Care OBD (kL/Aged Care OBD)	0.56	0.65	0.60
Water per unit of LOS (kL/LOS)	1.47	1.60	1.22
Water per unit of bed-day (LOS+Aged CareOBD) (kL/OBD)	0.41	0.46	0.40
Water per unit of Separations (kL/Separations	3.85	3.55	3.18
Water per unit of floor space (kL/m2)	0.72	1.17	1.06

WASTE AND RECYCLING			
WR1 Total units of waste disposal of by waste stream and disposal method (kg)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Landfill (total)			
General waste - skips	28,638.00	28,638.00	28,710.00
Offsite treatment			
Clinical waste - sharps	176.14	176.14	176.88
Clinical waste - treated	1,168.01	1,168.01	1,171.40
Recycling/recovery (disposal)			
Cardboard		4,113.62	4,125.00
Total units of waste disposed (kg)	**29,982.15**	**34,095.77**	**34,183.28**

ENVIRONMENTAL PERFORMANCE

WASTE AND RECYCLING continued			
WR2 Total units of waste disposed of by waste stream and disposal method (%)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Landfill (total)			
General waste	95.52%	83.99%	83.99%
Offsite treatment			
Clinical waste - sharps	0.59%	0.52%	0.52%
Clinical waste - treated	3.90%	3.43%	3.43%
Recycling/recovery (disposal)			
Cardboard		12.06%	12.07%
WR3 Total units of waste disposed normalised by FTE, headcount, floor area, or other entity or sector specific quantity, by disposal method	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Total waste to landfill per patient treated ((kg general waste (/PPT)	3.49	3.73	3.66
Total waste to offsite treatment per patient treated ((kg offsite treatment)/PPT)	0.16	0.18	0.17
Total waste recycled and reused per patient treated ((kg recycled and reused)/PPT)		0.54	0.53
WR4 Recycling rate (%)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
Weight of recyclable and organic materials (kg)		4,113.62	4,125.00
Weight of total waste (kg)	29,982.15	34,095.77	34,183.28
Recycling rate)%)		**12.06%**	**12.07%**
WR5 Greenhouse gas emissions associated with waste disposal (t CO2-e)	**Jul 25 - Jun 26**	**Jul 24 - Jun 25**	**Jul 23 - Jun 24**
t CO2-e	38.98	38.98	39.08

ENVIRONMENTAL PERFORMANCE CONTINUED

SUSTAINABLE BUILDINGS AND INFRASTRUCTURE

Under the guidance of the Victorian Health Building Authority, 2.5% of the total construction cost was allocated to implementing enhanced sustainability features, with a focus on:

- Improving the indoor environment quality
- Reducing energy consumption and carbon emissions
- Reducing operation costs

The top four preferred sustainability opportunities identified were:

- Enhanced passive design - including insulation, high-performance glazing, external shading , and airtightness testing
- Maximising solar PV
- Openable windows - interlocked with air-conditioning operation
- Circadian lighting - provided in suitable areas

These sustainability opportunities were achieved through the following measures:

- A minimum of 60% of the total roof area has been dedicated to solar panels
- Recycled and natural materials have been incorporated throughout the project
- Universal design principles have been applied to ensure ease of access for all users
- Water-efficient fixtures and fittings have been installed to reduce water consumption

Cohuna District Hospital achieved a 4-star NABERS rating for Energy.

Cohuna District Hospital achieved a 5-star NABERS rating for Water.





DISCLOSURES REQUIRED UNDER LEGISLATION

Freedom of Information Act 1982

During 2025-26, Cohuna District Hospital received 20 applications. Of these requests 0 were from Members of Parliament, 0 from media, and the remainder from the general public.
Cohuna District Hospital made 20 FOI decisions during the 12 months ended 30 June 2026.
There were 20 decisions made within the statutory time periods. Of the decisions made outside time, 0 were made within a further 45 days and 0 decisions were made in greater than 45 days. A total of 20 FOI access decisions were made where access to documents was granted in full, granted in part or denied in full. 0 decisions were made after mandatory extensions has been applied or extensions were agreed upon by the applicant. Of requests finalised, the average number of days over / under the statutory time (including extended timeframes) to decide the request was 4 days.
During 2025-26, 0 requests were subject to a complaint/internal review by Office of the Victorian Information Commissioner. 0 requests progressed to the Victorian Civil and Administrative Tribunal (VCAT). To access your Health Record information, please visit the website https://cdh.vic.gov.au/patient/health-information/

Building Act 1993

Cohuna District Hospital does not own or control any government buildings and consequently is exempt from notifying its compliance with the building and maintenance provisions of the Building Act 1993.

Public Interest Disclosure Act 2012

Cohuna District Hospital has policies and procedures consistent with the requirements of the Public Interest Disclosure Act 2012, which supports staff to disclose improper or corrupt conduct within the health service. There were no disclosures notified to Independent Broad-based Anti-Corruption Committee (IBAC) under section 21(2) during the financial year.

Emergency Procurement and Procurement Complaints Disclosure

Cohuna District Hospital did not receive any complaints during the reported period.
Cohuna District Hospital did not activate the Emergency Procurement during the reported period.

Safe Patient Care Act 2015

The hospital has no matters to report in relation to its obligations under section 40 of the Safe Patient Care Act 2015.

DISCLOSURES REQUIRED UNDER LEGISLATION - Continued

Statement on National Competition Policy

Cohuna District Hospital is compliant with the National Competition Policy and applies competitive neutral costing and pricing arrangement to significant business units within its operations. These arrangements are in line with the Government policy and the model principles applicable to the health sector.

Carers Recognition Act 2012

Cohuna District Hospital has taken all practical measures to comply with its obligations under the Carers Recognition Act 2012 (the Act). These include;

- Promoting the principles of the Act to people in care relationships who receive our services and to the wider community (e.g. distributing printed material about the Act at community events or services points; providing links to state government resource materials on our website; providing digital and/or printed information about the Act to our partner organisations)
- Ensuring our staff have an awareness and understanding of the care relationship principles set out in the Act (e.g. developing and implementing a staff awareness strategy about the principles in the Act and what they mean for staff; induction and training programs offered by the organisation include discussion of the Act and the statement of principles therein)
- Considering the care relationships principles set out in the Act when setting policies and providing services (e.g. reviewing our employment policies such as flexible working arrangements and leave provisions to ensure that these comply with the statement of principles in the Act; developing a satisfaction survey for distribution at assessment and review meetings between workers, carers and those receiving care)
- Implementing priority actions in Victorian Carer Strategy 2025—2035.

Environmental Performance

Cohuna District Hospital is committed to protecting the environment. When developing changes or making improvements, consideration is given to conserving energy and water, reducing greenhouse emissions and improving waste management.

Local Jobs First Act 2003

No projects undertaken by Cohuna District Hospital during 2025-26 met the threshold for Local Jobs First Policy application. As such, no Local Industry Development Plans were required or submitted.

Gender Equality Act 2020

Cohuna District Hospital's inaugural Gender Equality Action Plan 2022-2026 was developed and it is our intention to build on the workforce initiatives and safety matters consistent with the Gender Equality Act 2020.

The work includes strategies and actions which we have already made good progress on, with the development of the Cohuna District Hospital Workforce Strategy 2024-2027 which is available on our website: Cohuna-District-Hospital-Workforce-Strategy-2024.pdf (cdh.vic.gov.au)

Government Advertising Campaign

Cohuna District Hospital did not have any reports of activities or circumstances that triggered the disclosure threshold of $100,000 on government advertising expenditure.

Grants and Transfer Payments

Cohuna District Hospital did not administer any grants, transfer payments or Commercial-in-Confidence grants in 2025-26.

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 developmental 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 purpose 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 committee to for each engagement

This information is available on request from:

Helen Cramer
Governance Officer
Cohuna District Hospital

Phone: (03) 54 565 302

Email: info@cdh.vic.gov.au

Attestations and Declarations

Standing Directions 2018 (5.1.4 Financial Management Compliance attestation)

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



John Tesoriero
Responsible Officer
Cohuna District Hospital
09/10/2026

Data Integrity Declaration

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



Bernadette Loughnane
Accountable Officer
Cohuna District Hospital
09/10/2026

Integrity, Fraud and Corruption Declaration

I, Bernadette Loughnane, certify that Cohuna District Hospital has put in place appropriate internal controls and processes to ensure that Integrity, fraud and corruption risks have been reviewed and addressed at Cohuna District Hospital during the year.



Bernadette Loughnane
Accountable Officer
Cohuna District Hospital
09/10/2026

Conflict of Interest Declaration

I, Bernadette Loughnane, 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 Cohuna District Hospital and members of the board, and all declared conflicts have been addressed and are being managed. Conflict of interest is a standard agenda item for declaration and documenting at each executive board meeting.



Bernadette Loughnane
Accountable Officer
Cohuna District Hospital
09/10/2026

Health Share Victoria Attestation

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



Bernadette Loughnane
Accountable Officer
Cohuna District Hospital
09/10/2026

DISCLOSURE INDEX

The annual report of the Cohuna District Hospital is prepared in accordance with all relevant Victorian legislation. This index has been prepared to facilitate identification of the Department's compliance with statutory disclosure requirements.

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REPORTING AGAINST THE STATEMENT OF PRIORITIES

Part A—System Priorities

In 2025-26 Cohuna District Hospital 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	Deliverable
Align with the Victorian Clinical Governance Framework to strengthen clinical governance systems, ensuring safe, high-quality care.	Demonstrate high quality care in which consumer engagement and input is actively sought, facilitated and used to drive system change to improve consumer experience and outcomes. 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. Health services are able to show evidence of a comprehensive training program approach that includes performance management, accountability , and continuous improvement.

Status: Achieved

Cohuna District Hospital (CDH) was awarded 100% accreditation against the National Standards by the Australian Council on Healthcare Standards (ACHS) in December 2025, demonstrating a strong commitment to quality, safety and continuous improvement.

There have been no sentinel events or ISR 1 events during the reporting period. One unplanned birth occurred within 11 minutes of arrival at the Health Service in July 2025; the event was monitored through the relevant clinical governance processes.

(MGP) continues to operate in accordance with the agreed model of care, with midwives attending Echuca Hospital to provide continuity and support for women accessing birthing services. The MGP model has also been showcased at national conferences, demonstrating CDH's contribution to innovation and the delivery of contemporary maternity care in a rural setting.

The Clinical Governance Subcommittee meets bi-monthly and is chaired by a Board Director, with a Regional Midwife appointed to the committee to support oversight and implementation of recommendations arising from the Victorian Maternity Taskforce.

The Midwifery Governance Meeting meets quarterly and remains robust to ensure the model of care remains compliant with relevant requirements and is aligned with state-wide policy.

Mandatory training requirements continue to be monitored, with training provided to support workforce competency and compliance. Annual performance appraisal is mandated by the Board of Directors, reinforcing individual accountability and professional development.

Performance against the Statement of Priorities (SoP) is monitored through monthly Board meetings, ensuring appropriate oversight of organisational performance and accountability. Quarterly meetings with the Department of Health are also in place to monitor performance, alignment with the SoP and Monitor reporting requirements. CDH remains in the green zone, reflecting ongoing financial and organisational performance stability.

CDH continues to identify and promote innovative models of care and service delivery. Two submissions were made to the 2025–26 Victorian Premier's Awards, recognising the Midwifery Group Practice and CDH as a Small Rural Health Service of the Year.

REPORTING AGAINST THE STATEMENT OF PRIORITIES

Part A—System Priorities

In 2025-26 Cohuna District Hospital will contribute to the achievement of the Victorian Government's commitments by:

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	Deliverable
Develop and implement initiatives to strengthen financial sustainability. By delivering sustainable, responsible budgets, we can ensure a well-managed, viable, and sustainable health system for the future.	Deliver the key initiatives outlined in the Budget Action Plan within Government parameters. 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. 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.

Status: Achieved & Ongoing

2025–26 has been a unique and demanding year in the management of CDH's operational budget and capital programs, requiring strong financial stewardship, sound fiduciary oversight and disciplined decision-making by both the executive team and Board.

Targets established under the Financial Management Improvement Plan have been exceeded, reflecting effective leadership and proactive management of key cost drivers. Strong financial controls and ongoing monitoring have supported the organisation to maintain focus on financial sustainability while continuing to deliver strategic priorities.

The end-of-financial-year result reflects a small deficit, primarily attributable to reduced private health insurance utilisation, lower interest income, and increased expenditure associated with power, fuel and utilities. These pressures have been actively monitored and managed throughout the year.

Workforce expenditure remains well controlled, with nil medical locum expenditure and the rate of agency nursing utilisation having plateaued, supporting greater predictability and sustainability of workforce costs.

CDH continues to demonstrate strong community support, attracting bequests and donations that contribute to the organisation's capacity to invest in services, equipment and initiatives that benefit the local community.

Overall, financial performance during 2025–26 reflects strong governance, disciplined cost management and continued focus on financial sustainability, despite a challenging operating environment and significant capital investment program.

REPORTING AGAINST THE STATEMENT OF PRIORITIES

Part A—System Priorities

In 2025-26 Cohuna District Hospital will contribute to the achievement of the Victorian Government's commitments by:

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

Goal	Deliverable
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.	Implement process 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. Collaborate with the department to improve workforce data analytics, generate actionable insights, and enhance strategic planning.

Status - Achieved & Ongoing

CDH continues to implement the strategies outlined in the Workforce Plan 2024, with a strong focus on attracting, developing and retaining a skilled workforce and strengthening local recruitment pathways. The organisation continues to build a sustainable workforce through stronger local recruitment and retention strategies. CDH has also partnered with Dhelkaya Health to establish a multiskilled Human Resources team, strengthening workforce capability and access to specialist HR expertise.

Partnerships with peer health services continue to support the procurement of shared services, providing opportunities to leverage collective purchasing power, improve efficiency and promote greater standardisation across services.

The CDH Employee Value Proposition focuses on the key elements of benefits, wellbeing, organisational values, career opportunities, meaning and purpose. A particular priority has been enabling clinicians to work to the top of their scope of practice. This is demonstrated through the introduction of inaugural Nurse Practitioners and Eligible Midwives, the development of x-ray nursing roles and establishment of a dedicated vaccination nursing team.

Workforce pipeline development remains a key strategic priority. CDH is progressing development of a unique certified healthcare worker role, together with an enrolled nurse diploma pathway that provides a supported progression through to a Registered Nurse degree pathway. These initiatives are designed to strengthen local workforce supply and create sustainable career pathways within the health service. CDH continues to support the development of the future health workforce by welcoming students from universities and colleges across a range of health disciplines, providing valuable clinical placement opportunities and supporting local workforce attraction.

The Gender Equality Action Plan (GEAP) has been updated and is progressing well, with continued focus on embedding gender equality principles across organisational planning, workforce practices and decision-making.

CDH welcomed a visit from the Commissioner for Gender Equality, Dr Niki Vincent, providing an opportunity to demonstrate the organisation's progress and commitment to gender equality.

Key achievements include a high proportion of female employees, gender balance on the Board of Directors, flexible working arrangements supporting more than 90% of staff who work part-time, and training in diversity, equity and inclusion. Staff continue to have access to an Employee Assistance Program and family violence leave, supporting employee wellbeing, safety and participation in the workforce.

CDH has undertaken a gender impact assessment of the operating theatre, demonstrating the application of gender equality principles to service planning and operational decision-making. The CDH Board has also approved investment in a GEAP Project Officer, providing dedicated capacity to progress implementation and strengthen accountability for gender equality initiatives.

Overall, CDH continues to demonstrate a strong commitment to workforce sustainability, professional development, flexible employment, diversity and inclusion, and the development of local workforce pipelines, aligned with the organisation's strategic workforce priorities.

REPORTING AGAINST THE STATEMENT OF PRIORITIES

Part A—System Priorities

In 2025-26 Cohuna District Hospital will contribute to the achievement of the Victorian Government's commitments by:

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	Deliverable
Enhance Delivery and Access to Culturally Safe Services, fostering strong connections to culture. Address racism and provide Aboriginal people with culturally safe healthcare and referral pathways between mainstream and community-controlled health services.	Deliver high-quality cultural safety training to all executives and staff using independent, expert, community-controlled organisation's or a registered Aboriginal business. 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. Ensure culturally appropriate systems for identifying Aboriginal and Torres Strait Islander patients and implement responsive discharge plans and referral pathways.

Status - Achieved & Ongoing

We welcome our First Nations community to be cared for by the CDH team in a culturally safe, respectful and inclusive environment.

We live and work on Yorta Yorta and Barapa Barapa country and recognise the deep connection First Nations peoples have to Country, culture, community and place.

Approximately 1.9% of our community identify as First Nations people. This is similar to the proportion of First Nations people presenting to our Urgent Care service, as well as the proportion of our workforce who identify as First Nations.

During the design of our new building, the importance of creating a welcoming and culturally safe space for First Nations people was recognised and intentionally incorporated into the environment.

The space incorporates much-loved Aboriginal artwork, providing a strong connection to culture and Country. The availability of a dedicated reflection room, together with access to an outdoor garden and open spaces, provides opportunities for quiet reflection, connection and healing.

Our single-bed rooms and open visiting hours support family and community connection, recognising the important role of family and kinship in wellbeing and care.

CDH has partnered with Kerang District Health to appoint a local Aboriginal Health Liaison Officer to support the delivery of our commitment to First Nations people and help ensure culturally safe and responsive care.

Mandatory training for our workforce supports staff to understand and provide culturally safe care and to create an environment where First Nations people feel welcomed, respected, heard and valued.

Through our environment, partnerships, workforce and commitment, we aim to ensure that every First Nations person who enters CDH feels a genuine sense of welcome, belonging and cultural safety.

REPORTING AGAINST THE STATEMENT OF PRIORITIES

Part A—System Priorities

In 2025-26 Cohuna District Hospital will contribute to the achievement of the Victorian Government's commitments by:

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	Deliverable
Collaborate within the Local Health Service Network to build a more integrated health system, with better access and experience for patients, strengthened workforce, consistently high-quality care, and more sustainable healthcare delivery.	Meet all objectives agreed to in the Local Health Service Network Statement of Expectations across priority areas (access, equity and flow, workforce, safety and quality and shared services).

Status – Achieved & Ongoing

CDH is a key partner in the re-formed Loddon Mallee Health Service Network (LMHSN), with both the CDH Board Chair and CEO serving as executive members of the Network.

The reforms are articulated through the Annual Statement of Expectations, with the Loddon Mallee region progressing towards its identified targets. The Health Services Plan 2024 provides the foundation for the strategic direction of the reforms and supports the development of a connected, equitable and sustainable health service system.

The fundamental principles of the reform include:

- Care closer to home
- Clear role delineation across health services
- Improved access to care
- Health equity
- Workforce strategies and sustainability
- Research and development
- Streamlined access to higher-complexity and highly specialised care

A connected health services system that supports the needs of all Victorians

CDH is strongly represented across the Network's governance structures and is a member of all key governance committees. This ensures that the needs of our local community are reflected in regional planning and decision-making.

The CDH CEO provides leadership across the Loddon Mallee Health Service Network as Co-Chair of the Clinical Services Plan Committee and Co-Chair of the Maternity Taskforce Committee. Through these roles, CDH is actively contributing to the development of integrated clinical services, regional planning and improved access to care across the Loddon Mallee.

Our active participation in the Network reflects our commitment to working collaboratively across the health system, strengthening local services and ensuring patients can access the right care, in the right place, at the right time.

Part B - PERFORMANCE PRIORITIES

HIGH QUALITY AND SAFE CARE Key Performance Measure	Target	Result
Infection prevention and control		
Percentage of healthcare workers immunised for influenza	94%	100%
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 *Less than 10 responses were received for the period due to the relative size of the Health Service.*
Aboriginal Health		
Difference between the percentage of Aboriginal patients and non-Aboriginal patients who left against medical advice	0%	NA *No Aboriginal and/or Torres Strait Islander patients during the reported period, or the number less than 10*

STRONG GOVERNANCE, LEADERSHIP AND CULTURE Key Performance Measure		
Organisational Culture	**Target**	**Result**
People matter survey - Percentage of staff with an overall positive response to safety culture survey questions	80%	69%

* 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 Measure	**Target**	**Result**
Operating result ($m)	$0.00	**$-0.43**
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	**1.18**
Variance between forecast and actual operating result (OR) as a percentage of the forecast OR for the current financial year ending 30 June	5% movement in forecast revenue and expenditure forecasts	**Not Achieved**

Part C - ACTIVITY AND FUNDING

COHUNA DISTRICT HOSPITAL FUNDING SUMMARY FOR 1 JULY 2025 - 30 JUNE 2026	
Funding Type	**2025 –2026 Activity Achievement**
Aged Care	
Residential Aged Care	5,786
HACC	747
Small Rural	
Small rural acute	35

2025 - 2026 ACTIVITY REPORTING

SERVICE	TYPE OF ACTIVITY	ACTIVITY 2025-26	ACTIVITY 2024-25
Acute Inpatients	Number of admissions (excl. Dialysis and Unqualified Newborns)	423	450
Acute Bed Days	Total Bed Days (excl. Dialysis and Unqualified Newborns)	1,738	1,952
ALOS (Avg length of Stay)	(excl. Dialysis and Unqualified Newborns)	2.61	3.38
Urgent Care	Total Presentations	2,354	2,248
District Nursing	Occasions of Service	3,586	4,118
Births	Number of Births	1	0
Renal Dialysis	Number of sessions held (three chairs)	365	428
Aged Care	% Bed Occupancy	97.3%	82.4%
Meals on Wheels	Total Number of Meals delivered (Entrée, Main & Sweet)	6,278	6,912
Transitional Care	Bed Based	105	54
Transitional Care	Community Based	581	581

Note: All data published in this annual report was accurate at the time of publication.
Data may be subject to change following audit and data verification processes that may not have been finalised at the time of publication.

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Cohuna District Hospital

Opinion	I have audited the financial report of Cohuna District Hospital (the health service) which comprises the: • balance sheet as at 30 June 2026 • comprehensive operating statement for the year then ended • statement of changes in equity for the year then ended • cash flow statement for the year then ended • notes to the financial statements, including material accounting policy information • Board member's, accountable officer's and chief finance & accounting officer's declaration. In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2026 and 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.



MELBOURNE
8 October 2026

Simone Bohan
as delegate for the Auditor-General of Victoria

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

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

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

We authorise the attached financial statements for issue on 7th October, 2026.

Board member	**Accountable Officer**	**Chief Finance & Accounting Officer**
		
John Tesoriero	Bernadette Loughnane	Steven Jackel
Chair	Chief Executive Officer	Chief Financial Officer
Cohuna 7th October, 2026	Cohuna 7th October, 2026	Cohuna 7th October, 2026

Comprehensive Operating Statement
Cohuna District Hospital
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)	3,854	3,498
Government Grants	2.1 (b)	28,635	19,758
Other sources of income	2.1 (c)	2,002	1,830
Total revenue and income from transactions		**34,491**	**25,086**
Expenses from transactions			
Employee expenses	3.1 (a)	(11,298)	(10,279)
Supplies and consumables	3.1 (c)	(1,033)	(930)
Depreciation	4.1(a)	(1,223)	(1,248)
Other operating expenses	3.1 (d)	(2,812)	(2,545)
Total expenses from transactions		**(16,366)**	**(15,002)**
Net result from transactions - net operating balance		**18,125**	**10,084**
Other economic flows included in net result			
Net loss on sale of non-financial assets		-	(54)
Other gain from other economic flows		32	2
Total other economic flows included in net result		**32**	**(52)**
Net result		**18,157**	**10,032**
Comprehensive result		**18,157**	**10,032**

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

Balance Sheet
Cohuna District Hospital
As at 30 June 2026

	Note	2026 $'000	2025 $'000
Financial assets			
Cash and cash equivalents	6.1	6,205	6,736
Receivables	5.1	1,444	1,430
Contract assets		69	41
Total financial assets		**7,718**	**8,207**
Non-financial assets			
Prepayments		171	187
Inventories		85	93
Property, plant and equipment	4.1	45,868	27,478
Other assets		10	-
Total non-financial assets		**46,134**	**27,758**
Total assets		**53,852**	**35,965**
Liabilities			
Payables	5.2	2,124	3,193
Borrowings		91	157
Employee benefits	3.1(b)	2,562	2,269
Monies held in trust	5.3	2,474	1,902
Total liabilities		**7,251**	**7,521**
Net assets		**46,601**	**28,444**
Equity			
Reserves		18,483	18,483
Contributed capital		2,688	2,688
Accumulated surplus		25,430	7,273
Total equity		**46,601**	**28,444**

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

Cash Flow Statement
Cohuna District Hospital
For the Financial Year Ended 30 June 2026

	Note	2026 $'000	2025 $'000
Cash flows from operating activities			
Receipts from Government		30,608	14,799
GST received from ATO		226	-
Other receipts		2,207	1,840
Total receipts		**33,041**	**16,639**
Payments to employees		(10,936)	(9,855)
Payments to suppliers and consumables		(1,189)	(680)
GST paid to ATO		-	(258)
Other payments		(2,626)	(2,512)
Total payments		**(14,751)**	**(13,305)**
Net cash flows from operating activities		**18,290**	**3,334**
Cash flows from investing activities			
Proceeds from sale of non-financial assets		-	26
Purchase of non-financial assets		(19,613)	(4,294)
Capital donations and bequests received		276	204
Net cash flows used in investing activities		**(19,337)**	**(4,064)**
Cash flows from financing activities			
Repayment of borrowings and principal portion of lease liabilities		(66)	(80)
Repayment of accommodation deposits		(775)	(264)
Receipt of accommodation deposits		1,357	1,565
Net cash flows from financing activities		**516**	**1,221**
Net increase/(decrease) in cash and cash equivalents held		**(531)**	**491**
Cash and cash equivalents at beginning of year		6,736	6,245
Cash and cash equivalents at end of year	6.1	**6,205**	**6,736**

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

Statement of Changes in Equity
Cohuna District Hospital
For the Financial Year Ended 30 June 2026

	Property, Plant and Equipment Revaluation Surplus	Contributed Capital	Accumulated Surplus	Total
	$'000	$'000	$'000	$'000
Balance at 1 July 2024	**18,483**	**2,688**	**(2,759)**	**18,412**
Net result for the year	-	-	10,032	10,032
Balance at 30 June 2025	**18,483**	**2,688**	**7,273**	**28,444**
Net result for the year	-	-	18,157	18,157
Balance at 30 June 2026	**18,483**	**2,688**	**25,430**	**46,601**

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

Notes to the Financial Statements
Cohuna District Hospital
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 Cohuna District Hospital for the year ended 30 June 2026.

Cohuna District Hospital is a not-for-profit entity established as a public agency on 1 July 1988 under the *Health Services Act 1988* (Vic). A description of the nature of its operations and its principal activities is included in the Report of Operations, which does not form part of these financial statements.

This section explains the basis of preparing the financial statements.

Note 1.1 Basis of preparation

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

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

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

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

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

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

The financial statements are presented in Australian dollars.

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

The annual financial statements were authorised for issue by the Board of Cohuna District Hospital on 7th October, 2026.

Note 1.2 Material accounting estimates and judgements

Management makes estimates and judgements when preparing the financial statements.

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

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

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

Note 1.3 Reporting Entity

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

Cohuna District Hospital's principal address is:

King George Street
Cohuna, Victoria 3568

Note 1.4 Economic dependency

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

Note 2 Funding delivery of our services

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

Significant judgement - Grant revenue

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

Structure

2.1 Revenue and income from transactions

Note 2.1 Revenue and income from transactions

	Note	2026 $'000	2025 $'000
Revenue from contracts with customers	2.1(a)	3,854	3,498
Government Grants	2.1(b)	28,635	19,758
Other sources of income	2.1(c)	2,002	1,830
Total revenue and income from transactions		**34,491**	**25,086**

Note 2.1(a) Revenue from contracts with customers

	2026 $'000	2025 $'000
Government grants (State) - Operating	337	232
Government grants (Commonwealth) - Operating	2,713	2,563
Patient and resident fees	685	580
Commercial activities	119	123
Total revenue from contracts with customers	**3,854**	**3,498**

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

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

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

Patient and resident fees

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

Note 2.1(b) Government Grants

	2026 $'000	2025 $'000
Government grants (State) - Operating	9,068	8,759
Government grants (State) - Capital	19,526	10,955
Government grants (Commonwealth) - Capital	41	44
Total Government grants	**28,635**	**19,758**

How we recognise Government grants

Government grants

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

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

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

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

Cohuna District Hospital is currently completing a redevelopment project across our aged care and acute facilities. The project is funded and managed by the State Government, with a total budget of $41.1M and is expected to be completed in the 2026-27 financial year.

Non-cash contributions from the Department of Health

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

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

Note 2.1(c) Other sources of income

	Note	2026 $'000	2025 $'000
Other capital purpose income		121	120
Capital donations		165	84
Assets received free of charge or for nominal consideration		165	237
Other income from operating activities		1,331	1,035
Income from non-operating activities		220	354
Total other sources of income		**2,002**	**1,830**

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)	11,298	10,279
Supplies & Consumables	3.1(c)	1,033	930
Other operating expenses	3.1(d)	2,812	2,545
Total expenses incurred in the delivery of services		**15,143**	**13,754**

Note 3.1(a) Employee expenses

	2026 $'000	2025 $'000
Salaries and wages	9,086	8,371
Superannuation expense [(1)]	1,026	895
Agency expenses	662	693
Fee for service medical officer expenses	524	320
Total employee expenses	**11,298**	**10,279**

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

How we recognise employee expenses

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

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

Note 3.1(b) Employee related provisions

	2026 $'000	2025 $'000
Current provisions for employee benefits		
Accrued days off	1	2
Annual leave	904	846
Long service leave	1,117	1,040
Provision for on-costs	283	209
Total current provisions for employee benefits	**2,305**	**2,097**
Non-current provisions for employee benefits		
Long service leave	226	151
Provision for on-costs	31	21
Total non-current provisions for employee benefits	**257**	**172**
Total provisions for employee benefits	**2,562**	**2,269**

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 Cohuna District Hospital does not have an unconditional right to defer settlement of these liabilities.

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

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

Long service leave

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

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

The components of this current LSL liability are measured at:

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

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

Provisions

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	85	87
Medical and surgical supplies (including Prostheses)	116	99
Diagnostic and radiology supplies	60	58
Other supplies and consumables	772	686
Total supplies and consumables	**1,033**	**930**

How we recognise supplies and consumables

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

Note 3.1(d) Other operating expenses

	2026 $'000	2025 $'000
Fuel, light, power and water	162	115
Repairs and maintenance	92	62
Maintenance contracts	93	71
Medical indemnity insurance	80	81
Other administration expenses	2,380	2,208
Finance costs	5	8
Total other operating expenses	**2,812**	**2,545**

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 Cohuna District Hospital. These amounts have been brought to account in determining the operating result for the year, by recording them as revenue (Refer to Note 2.1(b)) and recording a corresponding expense.

Note 4 Key assets to support service delivery

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

Significant judgement - Fair value measurement

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

Structure

4.1 Property, plant and equipment
4.2 Depreciation

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 - Crown	470	470	-	-	470	470
Buildings at fair value	13,761	13,742	(1,933)	(970)	11,828	12,772
Works in progress at cost	31,944	13,097	-	-	31,944	13,097
Plant, equipment and vehicles at fair value	3,349	2,957	(1,723)	(1,818)	1,626	1,139
Total property, plant and equipment	**49,524**	**30,266**	**(3,656)**	**(2,788)**	**45,868**	**27,478**

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 change are transferred at their carrying amounts.

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

Note 4.1(a) Reconciliation of the carrying amounts of each class of asset

	Land $'000	Buildings $'000	Works in progress $'000	Plant, equipment and vehicles $'000	Total $'000
Balance at 1 July 2025	**470**	**12,772**	**13,097**	**1,139**	**27,478**
Additions	-	-	19,510	103	19,613
Net transfers between classes	-	19	(663)	644	-
Depreciation	-	(963)	-	(260)	(1,223)
Balance at 30 June 2026	**470**	**11,828**	**31,944**	**1,626**	**45,868**

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, Cohuna District Hospital has elected to apply the practical expedient in FRD 103 Non-Financial Physical Assets and has therefore not applied the amendments to AASB 13 Fair Value Measurement. The amendments to AASB 13 will be applied at the earlier of the interim revaluation or next scheduled independent revaluation in 2029, in accordance with Cohuna District Hospital's revaluation cycle.

4.1(b) Impairment of property, plant and equipment

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

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

Note 4.2 Depreciation

How we recognise depreciation

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

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

Useful lives of non-current assets

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

	2026	2025
Buildings	5 - 40 years	5 - 40 years
Plant, equipment and vehicles	3 - 20 years	3 - 20 years

Note 5 Other assets and liabilities

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

Structure

5.1 Receivables
5.2 Payables
5.3 Monies held in trust

Note 5.1 Receivables

	Note	2026 $'000	2025 $'000
Current receivables			
Contractual			
Inter hospital debtors		25	53
Trade receivables		507	380
Patient fees		71	56
Allowance for impairment losses		(28)	(27)
Other receivable		142	68
Total contractual receivables		**717**	**530**
Statutory			
GST receivable		101	327
Total statutory receivables		**101**	**327**
Total current receivables		**818**	**857**
Non-current receivables			
Contractual			
Long service leave - Department of Health		626	573
Total contractual receivables		**626**	**573**
Total non-current receivables		**626**	**573**
Total receivables		**1,444**	**1,430**
(i) Financial assets classified as receivables			
Total receivables		1,444	1,430
GST receivable		(101)	(327)
Total financial assets classified as receivables	7.1	**1,343**	**1,103**

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.

Note 5.2 Payables

	Note	2026 $'000	2025 $'000
Current payables			
Contractual			
Trade creditors		767	439
Accrued salaries and wages		423	386
Accrued expenses		205	746
Deferred capital grant income	5.2(a)	134	1,081
Other		595	541
Total contractual payables		**2,124**	**3,193**
Total current payables		**2,124**	**3,193**
Total payables		**2,124**	**3,193**
(i) Financial liabilities classified as payables			
Total payables		2,124	3,193
Deferred capital grant income		(134)	(1,081)
Total financial liabilities classified as payables	7.1	**1,990**	**2,112**

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 Cohuna District Hospital prior to the end of the financial year that are unpaid.

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

Note 5.2(a) Movement in deferred capital grant income

	2026 $'000	2025 $'000
Opening balance of deferred capital grant income	1,081	1,970
Grant consideration for capital works received during the year	17,123	2,667
Deferred capital grant income recognised as income due to completion of capital works	(18,070)	(3,556)
Closing balance of deferred capital grant income	**134**	**1,081**

How we recognise deferred capital grant income

Grant consideration was received from the Department of Health to support the upgrade of our theatre and fire systems.

Capital grant income is recognised progressively as the asset is constructed, since this is the time when Cohuna District Hospital satisfies its obligations. The progressive percentage of costs incurred is used to recognise income because this most closely reflects the percentage of completion of the building works. As a result, Cohuna District Hospital has deferred recognition of a portion of the grant consideration received as a liability for the outstanding obligations.

Note 5.3 Monies held in trust

	Note	2026 $'000	2025 $'000
Current monies held in trust			
Patient monies		1	11
Refundable accommodation deposits		2,473	1,891
Total current monies held in trust		**2,474**	**1,902**
Total other liabilities		**2,474**	**1,902**
*** Represented by:**			
- Cash assets	6.1	2,474	1,902
		2,474	**1,902**

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 Cohuna District Hospital upon admission. These deposits are liabilities which fall due and payable when the resident leaves the home.

RAD/accommodation bond liabilities are recorded at an amount equal to the proceeds received, net of retention and any other amounts deducted from the RAD/accommodation bond in accordance with the *Aged Care Act 1997* .

Note 6 How we finance our operations

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

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

Structure

6.1 Cash and cash equivalents
6.2 Commitments for expenditure

Notes to the Financial Statements
Cohuna District Hospital
For the Financial Year Ended 30 June 2026

Note 6.1 Cash and Cash Equivalents

	Note	2026 $'000	2025 $'000
Cash on hand (excluding monies held in trust)		-	1
Cash at bank (excluding monies held in trust)		3,731	4,833
Total cash held for operations		**3,731**	**4,834**
Cash on hand (monies held in trust)		1	13
Cash at bank (monies held in trust)		2,473	1,889
Total cash held as monies in trust	5.3	**2,474**	**1,902**
Total cash and cash equivalents	7.1	**6,205**	**6,736**

Note 6.2 Commitments for expenditure

30 June 2026	Less than 1 year $'000	1-5 Years $'000	Over 5 years $'000	Total $'000
Capital expenditure commitments[1]	15,595	-	-	15,595
Total commitments (inclusive of GST)	**15,595**	**-**	**-**	**15,595**
Less GST recoverable				-
Total commitments (exclusive of GST)				**15,595**

30 June 2025	Less than 1 year $'000	1-5 Years $'000	Over 5 years $'000	Total $'000
Capital expenditure commitments	38,687	-	-	38,687
Total commitments (inclusive of GST)	**38,687**	**-**	**-**	**38,687**
Less GST recoverable				-
Total commitments (exclusive of GST)				**38,687**

[1] Capital expenditure commitments include the redevelopment of aged care and acute facilities, which are being undertaken and managed by VHBA. The commitments relating to this project total $15.448M and will be fully funded by VHBA.

How we disclose our commitments

Our commitments relate to capital expenditure.

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

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

Structure

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

Note 7.1 Financial instruments

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

30 June 2026	Note	Carrying amount $'000	Net gain/(loss) $'000	Total interest income/ (expense) $'000	Fee income/ (expense) $'000	Impairment loss $'000
Financial assets at amortised cost						
Cash and cash equivalents	6.1	6,205	-	220	-	-
Receivables	5.1	1,343	-	-	-	-
Total financial assets [i]		**7,548**	**-**	**220**	**-**	**-**
Financial liabilities at amortised cost						
Payables	5.2	1,990	-	-	-	-
Borrowings		91	-	-	-	-
Other financial liabilities - Refundable Accommodation Deposits	5.3	2,473	-	(5)	-	-
Other financial liabilities - patient monies held in trust	5.3	1	-	(2)	-	-
Total financial liabilities [i]		**4,555**	**-**	**(7)**	**-**	**-**

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

30 June 2025	Note	Carrying amount $'000	Net gain/(loss) $'000	Total interest income/ (expense) $'000	Fee income/ (expense) $'000	Impairment loss $'000
Financial assets at amortised cost						
Cash and cash equivalents	6.1	6,736	-	354	-	-
Receivables	5.1	1,103	-	-	-	-
Total financial assets [i]		**7,839**	**-**	**354**	**-**	**-**
Financial liabilities at amortised cost						
Payables	5.2	2,112	-	-	-	-
Borrowings	6.1	157	-	-	-	-
Other financial liabilities - Refundable Accommodation Deposits	5.3	1,891	-	(8)	-	-
Other financial liabilities - patient monies held in trust	5.3	11		(2)		
Total financial liabilities [i]		**4,171**	**-**	**(10)**	**-**	**-**

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

How we categorise financial instruments

Financial assets at amortised cost

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

- the assets are held by Cohuna District Hospital 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.

Cohuna District Hospital 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.

Cohuna District Hospital recognises the following liabilities in this category:

- payables (excluding statutory payables and contract liabilities)
- borrowings 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
- Cohuna District Hospital retains the right to receive cash flows from the asset, but has assumed an obligation to pay them in full without material delay to a third party under a 'pass through' arrangement or
- Cohuna District Hospital has transferred its rights to receive cash flows from the asset and either:
  - has transferred substantially all the risks and rewards of the asset, or
  - has neither transferred nor retained substantially all the risks and rewards of the asset but has transferred control of the asset.

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

Derecognition of financial liabilities

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

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

Reclassification of financial instruments

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

A financial liability reclassification is not permitted.

Note 7.2 Contingent assets and contingent liabilities

At balance date, the Board is 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
- Lease liabilities.

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

Valuation hierarchy

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

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

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

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

Fair value determination: non-financial physical assets

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

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

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

Non-specialised land and non-specialised buildings

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

Specialised land and specialised buildings

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

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

Vehicles

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

Plant and equipment, furniture, fittings

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

Significant assumptions

Asset class	Valuation technique	Significant assumption	Range (weighted average)[(i)]
Specialised land	Market approach	Community Service Obligations adjustment	20% [(ii)]
Specialised buildings	Current replacement cost approach	Cost per square metre Useful life	$100 - $8,250/m^2 ($4,500) 5 - 40 years (15 years)
Plant, equipment and vehicles	Current replacement cost approach	Cost per unit Useful life	$1,000 - $235,000 ($24,500 per unit) 3 - 20 years (8.5 years)

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

[(ii)] CSO adjustments of 20% was applied to reduce the market approach value for Cohuna District Hospital'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 Ex-gratia expenses
8.2 Responsible persons disclosures
8.3 Remuneration of executives
8.4 Related parties
8.5 Remuneration of auditors
8.6 Events occurring after the balance date
8.7 Joint arrangements

Note 8.1 Ex gratia payments

There were no Ex gratia payments made during the current financial year. (2025: Nil)

Note 8.2 Responsible persons disclosures

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

	Period
The Honourable Mary-Anne Thomas MP:	
Minister for Health	1 Jul 2025 - 14 April 2026
Minister for Ambulance Services	1 Jul 2025 - 14 April 2026
The Honourable Harriet Shing MP:	
Minister for Health	15 April 2026 - 30 June 2026
Minister for Ambulance Services	15 April 2026 - 30 June 2026
The Honourable Melissa Horne MP:	
Minister for Health Infrastructure	1 Jul 2025 - 30 June 2026
Minister for Prevention of Family Violence	15 April 2026 - 30 June 2026
The Honourable Ingrid Stitt MP:	
Minister for Mental Health	1 Jul 2025 - 30 June 2026
Minister for Ageing	1 Jul 2025 - 30 June 2026
The Honourable Lizzie Blandthorn MP:	
Minister for Children	1 Jul 2025 - 30 June 2026
Minister for Disability	1 Jul 2025 - 30 June 2026
Governing Board	
Mr J. Tesoriero (Board Chair)	1 Jul 2025 - 30 Jun 2026
Mr R.Henery	1 Jul 2025 - 30 Jun 2026
Mr S. Manduskar	1 Jul 2025 - 30 Jun 2026
Ms A. Toma	1 Jul 2025 - 30 Jun 2026
Ms M. Henty	1 Jul 2025 - 30 Jun 2026
Ms K. Fuller	1 Jul 2025 - 30 Jun 2026
Ms K. Sidorow	1 Jul 2025 - 30 Jun 2026
Ms S. Gundry	1 Jul 2025 - 30 Jun 2026
Ms C. Van der Zande	1 Jul 2025 - 30 Jun 2026
Accountable Officers	
Ms B. Loughnane (Chief Executive Officer)	1 Jul 2025 - 30 Jun 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	8	8
$10,000 - $19,999	1	1
$250,000 - $259,999	-	1
$260,000 - $269,999	1	-
Total Numbers	**10**	**10**

	2026 $'000	2025 $'000
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**318**	**307**

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

Note 8.3 Remuneration of executives

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

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

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

	Total Remuneration	
	2026 $'000	2025 $'000
Total remuneration [i]	182	188
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 Cohuna District Hospital under AASB 124 Related Party Disclosures and are also reported within Note 8.4 Related Parties.
[ii] Annualised employee equivalent is based on working 38 ordinary hours per week over the reporting period.

Note 8.4 Related parties

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

- all key management personnel (KMP) and their close family members and personal business interests
- cabinet ministers (where applicable) and their close family members
- jointly controlled operations –the 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

Cohuna District Hospital received operating funding from government related entities of $9.4m (2025: $9.00m) and indirect contributions of $0.16m (2025: $0.22m). Balances outstanding as at 30 June 2026 are $0.69m receivable, (2025: $0.41m payable).

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

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

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

Key management personnel

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

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

Entity	KMPs	Position Title
Cohuna District Hospital	Mr J. Tesoriero	Chair of the Board
Cohuna District Hospital	Mr R.Henery	Board Member
Cohuna District Hospital	Mr S. Manduskar	Board Member
Cohuna District Hospital	Ms A. Toma	Board Member
Cohuna District Hospital	Ms M. Henty	Board Member
Cohuna District Hospital	Ms K. Fuller	Board Member
Cohuna District Hospital	Ms K. Sidorow	Board Member
Cohuna District Hospital	Ms S. Gundry	Board Member
Cohuna District Hospital	Ms C. Van der Zande	Board Member
Cohuna District Hospital	Ms B. Loughnane	Chief Executive Officer
Cohuna District Hospital	Ms W. Lunghusen	Director of Clinical 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]	500	495

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

Transactions with KMPs and other related parties

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

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

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

Note 8.5 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 8.6 Events occurring after the balance sheet date

There are no events occurring after the Balance Sheet date.

Note 8.7 Joint arrangements

	Principal Activity	Ownership Interest 2026 %	Ownership Interest 2025 %
Loddon Mallee Rural Health Alliance (LMRHA)	Information Technology Services	3.81	4.17

	2026 $'000	2025 $'000
Total revenue and income	1,012	748
Total expenses	(1,026)	(870)
Total net result	(14)	(122)
Total other economic flows	-	-
Comprehensive result for the year	(14)	(122)
Total assets	939	964
Total liabilities	718	697
Total equity	221	267

Contingent liabilities and capital commitments

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