

KERANG DISTRICT HEALTH

Annual Report 2025-2026

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Acknowledgement to Country

Kerang District Health acknowledges the traditional custodians of the land on which this facility stands, the Barapa Barapa people, and pay our respect to their Elders past and present.

We acknowledge their significant cultural heritage, their fundamental spiritual connection to the country, and value their contributions to our diverse community.

We are proud to embrace the spirit of truth telling, and learn from First Nations people's 'lived experiences' which in turn guides us to better improve our organisation to improve their health, wellbeing and safety.

We will do this with open attitudes addressing the issues impacting Aboriginal and Torres Strait Islander peoples.

REPORT OF OPERATIONS

OUR PURPOSE

Kerang District Health exists to Protect, Restore and Enhance Health

For us this means:

- We deliver the best services aligned to community needs
- We measure and make adjustments to enhance health outcomes
- We create environments where our staff and community can thrive
- We work together for collective impact

OUR VALUES



MANNER OF ESTABLISHMENT

Kerang District Health is a public hospital listed in Schedule 1 of the Health Services Act 1988.

The purpose of this Act is to make provision for the development of health services in Victoria, for the carrying on of hospitals, nursing homes and other health care agencies and related matters.

The health service reports to the Department of Health, through its Loddon Mallee regional office which is located in Bendigo.

RESPONSIBLE MINISTERS

Minister for Health/Minister for Ambulance Services:

The Hon Mary-Anne Thomas MP (1 July 2025 to 15 April 2026)

Minister for Health/Minister for Ambulance Services/Minister for Water

Hon Harriet Shing MP (15 April 2026 to 30 June 2026)

Minister for Health Infrastructure

The Hon Melissa Horne MP (From 1 July 2025 to 30 June 2026)

Minister for Mental Health/Minister for Ageing

The Hon Ingrid Stitt MP (1 July 2025 to 30 June 2026)

Minister for Disability/Minister for Children

The Hon Lizzie Blandthorn MP (1 July 2025 to 30 June 2026)

RANGE OF SERVICES

Kerang District Health (KDH) is one of two district health services in the Gannawarra Shire. KDH provides an integrated range of services consisting of acute, residential aged care, community and primary care services, to a population of 10,549 people across the Shire.

The health service delivers the following acute health services: general medicine; urgent care centre; transition care program, oncology, theatre and palliative care services. KDH has one operating theatre and offers a pre-anaesthetic clinic and elective surgery modalities for general surgery, gynaecology, urology and dental.

Glenarm is a 30-bed residential aged care service under the Public Sector Residential Care Service (PSRACS) and is situated in the main hospital building.

KDH community services include the district nursing service who also provide HITH and post-acute care. Over in the WD Thomas Centre there are planned activity groups both centre-based and mobile; the Allied Health team provide adult exercise groups, hydrotherapy classes and exercise physiology and physiotherapy outpatient clinics. KDH also run a Lymphoedema Clinic and Cancer Survivorship Program.

The Men's Shed and Rita Hall Opportunity Shop are offsite but form an integral part of KDH services.

The health service owns and operates one of the two primary care clinics in Kerang with General Practitioner's and Surgical Specialists consulting at the Kerang Medical Clinic in Patchell Plaza, Victoria Street, Kerang.

The Austin Pathology Collection Centre and Bendigo Radiology Imaging Services are provided on site at KDH Monday to Friday with the Radiology Service owned and operated by KDH since October 2025.

KDH is fortunate to have visiting specialists such as Oncology, Breast Care Nurse, General Surgery, Urology, Infant Hearing, Palliative Care and the Bendigo Central Victorian Cardiology service providing services closer to home for our community members.

KDH use telehealth services including but not limited to Geri Connect, Aged Care Assessment Service (ACAS), Adult Retrieval Services (ARV), Paediatric Infant Perinatal Emergency Retrieval (PIPER), Bendigo Health ED, Stroke Network, and a range of other speciality services.

KDH uses the Victorian Virtual Emergency Department (VVED) especially after hours and on weekends for urgent care presentations requiring medical support.

RESPONSIBLE BODIES DECLARATION

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



Andrew Jeffreys, Board Chair, Kerang District Health, 30th June 2026

BOARD CHAIR & CEO REPORT

THE YEAR IN REVIEW:

On behalf of the Board of Directors and staff of Kerang District Health (KDH), it is our pleasure to present the 75th Annual Report for the year ending 30 June 2026.

The year was marked by several significant achievements, including the launch of the Kerang Radiology Service as a public service model; the official unveiling of the First Nations Acknowledgement to Country Plaque at the main entrance of the hospital; the development of three new accommodation units for key workers; development of a Community Telehealth Room; the development of a new Strategic Plan 2026–2029 and SOAR values; the commencement of a Lymphoedema Clinic and a continued strengthening of regional partnerships and integrated models of care.

The transition of the **Kerang Radiology Service** to KDH operational management was a significant achievement, ensuring the continuation of local diagnostic imaging services following Bendigo Radiology's departure after 25 years. The service now provides local X-ray and ultrasound services, improving access to care, reducing travel for patients and supporting timely clinical decision-making. Future plans include expanded capability to further support urgent care and reduce avoidable patient transfers.

A significant milestone during the year was the commencement of the Shadforth Street Worker Accommodation Project, supported through the **Victorian Government's Regional Worker Accommodation Fund.** Construction of three new staff townhouses commenced in August 2025 and will provide modern accommodation for healthcare professionals and their families, supporting KDH's ongoing efforts to attract, recruit and retain a sustainable workforce for the future. Designed by local firm McKnight & Bray Building Design and constructed using local trades and suppliers; the project demonstrates KDH's commitment to strengthening workforce capacity while investing in the long-term health and wellbeing of our community.

During 2025–26, KDH secured **Regional Health Infrastructure Funding** for the Glenarm Aged Care Facility, to deliver important upgrades including two new family meeting rooms and an enclosed walkway connecting the two residential wings. Tender preparations were completed during the year, with construction scheduled to commence in August 2026.

KDH's **Community Telehealth Room** model was co-designed with the Consumer Advisory Committee with resource support from the Loddon Mallee Virtual Care Unit. The service provides local access for community members who may otherwise face barriers, lengthy travel and time away from work, to attend telehealth appointments locally. Recent discussions with Bendigo Health regarding a specialist telehealth clinic pilot project will be continued in the new financial year.

KDH is also one of two Loddon Mallee health services participating in a **Tissue Analytics Research Project**, introducing innovative AI telehealth technology to enhance wound care services within the District Nursing Service.

During the first half of 2026, KDH engaged external consultants to undertake comprehensive strategic planning with the Board, Executive, staff, consumers, community members, partners and stakeholders to guide the development of the **Kerang District Health Strategic Plan 2026–2029.** The Plan reinforces our vision of being a trusted, high-performing rural health service delivering high quality and safe care to the community and we look forward to the plan coming to life over the next three years.

Equally significant was the introduction of our new organisational values, **SOAR – Seek Joy, Own It, Always Connected and Reach Higher**. These values reflect the culture we aspire to create and the behaviours that support exceptional care, strong teamwork and meaningful community connections. The SOAR Values were developed by the leadership team and launched internally with staff during the month of June. We look forward to staff embracing the values and embedding them into everyday practice.

KDH remains an active partner within the **Loddon Mallee Local Health Service Network (LMLHSN)**, working collaboratively with regional health services on clinical governance, workforce initiatives and service planning. These partnerships strengthen healthcare access, quality and sustainability while supporting shared services and more connected models of care for rural communities.

EXPECTATIONS FOR THE FUTURE:

KDH continues to play an active role in strengthening community resilience and addressing health inequities by working collaboratively with local organisations, community groups and regional partners to improve access to healthcare, support vulnerable populations and respond to the evolving needs of our community.

Workforce wellbeing, leadership development and cultural safety have remained key priorities. Results from staff engagement surveys continue to demonstrate strong organisational pride, purpose and commitment. We are particularly encouraged by the high proportion of staff who report feeling that their work makes a meaningful contribution to the community. At the same time, we recognise ongoing challenges relating to workload pressures and staff wellbeing and remain committed to investing in programs, resources and supports that help our people thrive.

The commitment and compassion of our staff, volunteers, visiting medical officers and Board Directors continue to be the foundation of our success. Every day, our teams demonstrate professionalism, resilience and a genuine dedication to delivering safe, person-centred care. We are deeply grateful for the contribution each person makes to improving the health and wellbeing of our community.

We acknowledge the invaluable support of our community members, volunteers, consumer representatives, partner organisations and funding bodies. Through strong relationships and shared purpose, we continue to strengthen healthcare services for current and future generations. While rural healthcare continues to face challenges including workforce shortages, increasing demand and financial pressures, KDH is well positioned to embrace new opportunities through innovation, partnership and integration.

Together, guided by our new values and strategic direction, we remain committed to improving health and wellbeing outcomes for our community and ensuring Kerang District Health continues to thrive as a trusted and sustainable rural health service.

ACCREDITATION UPDATE

KDH is fully compliant with all accreditation bodies across acute, aged care, community and primary care services.

During 2025–2026, KDH continued preparations for the commencement of the new Aged Care Act, strengthening systems, processes and practices across the Glenarm Aged Care Facility. This work has focused on further embedding person-centred care, supporting resident choice and dignity, enhancing governance and quality systems, and ensuring compliance with the evolving legislative and regulatory requirements.

FIRST NATIONS CULTURAL SAFETY

KDH remains committed to creating a culturally safe, welcoming and inclusive environment for First Nations people. During the year, KDH worked closely with the Aboriginal Health Liaison, community Elders and staff to co-design an Acknowledgement to Country plaque which is now proudly displayed at the main entrance of KDH. This acknowledgement is a visible sign of respect and recognition of First Nations peoples and the important role Aboriginal Health Liaisons play within our community.

First Nations artwork holds significance across the organisation. Recent artworks have been displayed in the Acute and Radiology waiting areas, with plans underway to develop a dedicated multicultural room. The Aboriginal Health Liaison role is shared across three small rural health services as a strong collaborative partnership – KDH, Cohuna District Hospital and Boort District Health.

Ongoing Cultural Awareness and Cultural Safety training continues across the organisation, including at Board level, reinforcing KDH's commitment to culturally responsive care and improved health outcomes for Aboriginal and Torres Strait Islander peoples.

STRATEGIC PLANNING

During the 2025-2026 financial year, KDH embarked on a 6-month strategic planning process engaging Ian MacDonald and Kylie Vos, Australian Health Service Group (AHSG) as strategic planning consultants. The new three-year strategic plan was comprehensive and well-informed with extensive staff, community and stakeholder engagement.

The KDH Department Heads and leadership team were fortunate to receive valuable education on the strategic planning process.

CONSUMER ADVISORY COMMITTEE

The KDH Consumer Advisory Committee meets bi-monthly and welcomed several new members throughout the year. The Committee plays a vital role in ensuring the voices of consumers, carers and the community are reflected in health service planning, policy development and service improvement activities, bringing valuable lived experience and community perspectives to all levels of the organisation.

We also farewelled Jenny Kelly who stepped down from chairperson role and the committee after many years of dedicated service.

DONATIONS

During 2025-2026 year, **$310,553.00** was received in donations. Major contributions received were from the KDH Ladies Auxiliary, A McCallum, M Jobling, K Fowler and the Kerang Agricultural Research Farm however there are many more wonderful donors that we personally acknowledge, who are simply too many to list.

We are incredibly grateful for the generosity of all the community donors. Donations support safe patient care by ensuring state-of-the-art patient equipment and maintenance to the hospital buildings and gardens.

LADIES AUXILIARY

The Ladies Auxiliary, under the leadership of Mrs. Wilma Ellis, Mrs. Edith Wishart and the committee continue their loyal support to the health service through the Rita Hall Opportunity Shop. The donation of $110,000 received by the CEO and Executive following the Annual General Meeting in December 2025, was an absolute credit to the hard work and commitment of the Auxiliary.

We appreciate the spirit and generosity of the Auxiliary. Provision of ongoing donations go to state-of-the-art equipment and modern infrastructure and furnishings.

We were also sad to accept Wilma's resignation as President of the Ladies Auxiliary in late 2025 after many years of dedicated service to KDH.

VOLUNTEERS

Kerang District Health acknowledges the commitment and dedication that the Volunteers provide for our patients, residents and community clients. Volunteers play an important role in the day-to-day operations of our health service by providing support and entertainment to residents and clients, particularly in Glenarm and the WD Thomas Activity Centre, the Men's Shed and the Rita Hall Opportunity Shop.

KDH are a proud sponsor for Cycling without Age, Kerang who provide a wonderful service, fund and outdoor enjoyment to the Glenarm aged care residents.

KDH celebrated National Volunteers Week in May 2026 for a lovely afternoon tea. Each volunteer was presented with a gift bag and certificate of appreciation from the KDH CEO and staff, acknowledging their valuable services to KDH.

MASONIC LODGE AND KDH OP SHOP SCHOLARSHIP

2025 was the first year that the Masonic Lodge has officially partnered with the KDH Op Shop to provide $7000 towards staff scholarships. Kerang District Health appreciates the strong relationship with the local members of the Cohuna Masonic Lodge and the former Kerang Masonic Lodge, along with the Freemasons Foundation and the Kerang District Health Ladies Auxiliary, who provide generous scholarships on an annual basis so that KDH staff can seek opportunities for ongoing professional development and training.

ANNUAL GENERAL MEETING (AGM)

KDH held its 74th Annual General Meeting at the WD Thomas Activity Centre on 13th November 2025 with 32 staff and community members in attendance. The presentation for the meeting was the official launch of the new KDH Recruitment video by local videographer Mitchell Barkman.

The following staff members received Recognition of Service badges:

10 years	15 years	20 years	25 years	30 years	45 years
Jessica O'Brien	Allan Reid	Gregory Price	Annette Ritchie	Debra O'Brien	Jill Bennett
Nicole Sanders	Megan Simmonds				
Haylee Wellard					

KDH Ladies Auxiliary – Certificates of Service	
10 years	**25 years**
Ellen Bortolotto	Edith Wishart
Jill Marshall	
Irene Martin	
Vivien McClung	
April O'Neill	
Dianne Parker	
Russell Parker	
Jane Starr	

Kerang Masonic Lodge Scholarship recipients	
Taylor Dicinoski	Bachelor of Nursing studies
Deaniee Henderson	Benchmarque Ear Wax Removal Irrigation course
Codie Laursen	Graduate Certificate of Image Interpretation
Kate Matthews	Leadership courses (ERH) High Performing Teams & Managing Difficult Conversations
Angela Toma	Benchmarque Ear Wax Removal Irrigation course



Photo: Russell Sincock, Cohuna Masonic Lodge, Marlene Rawson - President, Ladies Auxiliary and Deaniee Henderson (KMC enrolled nurse) receiving her scholarship award.

We would like to extend our sincere appreciation to all Kerang District Health staff for their dedication in delivering safe, high-quality care to our patients, residents, clients and the wider Kerang community. We also gratefully acknowledge the invaluable contribution of our volunteers and contractors, whose support enhances the care and services provided to our patients, residents and clients.

We look forward to further strengthening and enhancing services for our community in the years ahead through continued improvements to patient care, equipment and infrastructure. We will also focus on building and maintaining strong collaborative partnerships across the region to enhance the patient experience, address ongoing workforce challenges, and strengthen clinical service delivery to ensure more people can access quality care closer to home.

Andrew Jeffreys
Board Chair

Kellie Byron-Gray
Chief Executive Officer



Photo: KDH Executives, Department Heads and Leadership team, along with Strategic Consultants Kylie Vos (far left) and Ian MacDonald (third from the left) during the Strategic Planning workshop.

DIRECTOR OF CLINICAL SERVICES REPORT

This year we have seen growth in nearly all services and have commenced several new services.

The Allied Health team were supported through funding from the Masonic Lodge and KDH Ladies Auxiliary Scholarship to train a Physiotherapist in Lymphoedema Management. Through an equipment grant funded by the Victorian Integrated Cancer Services (VICS), we commenced an outpatient clinic treating people with lymphoedema. This program commenced in October 2025 and has supported local people to have their care provided closer to home.

Additionally, we also commenced a public Radiology Service onsite following a planned withdrawal of the Bendigo Radiology private provider. This service has enabled x-ray services four days per week and ultrasound services two days per week with the bonus of extended hours. The intent of taking on this vital service was to ensure the wider Kerang and district community receive more care close to home, whilst supporting locally skilled staff with employment opportunities.

ACUTE

The Acute Ward has seen a significant increase in presentations to the Urgent Care Centre this year with figures increasing by over 200 presentations. Last financial year we treated 2,754 people in the Urgent Care Centre. The significant increase meant that staffing levels have had to increase accordingly to meet obligations under the Safe Patient Care Act. We have been busy recruiting new staff and are in the process of implementing additional nursing staff on evening and night duty shifts, and across the weekend.

We currently have a Nurse Practitioner (NP) candidate studying. Once qualified this NP will significantly strengthen the nursing staff skill mix, which in turn will further support the Visiting Medical Officers who provide services in Urgent Care and the Acute Ward.

We are really proud of all of the nursing team who constantly seek further education and training to grow and develop their skills. Our team provides exceptional high-quality care to our local community, ensuring people can receive treatment close to home within our capabilities as a small rural hospital.

We have purchased a new 12 lead ECG machine to ensure accurate identification of cardiac conditions and timey treatment. The implementation of High Sensitivity Troponin testing in the Urgent Care Centre assists with timely diagnosis of cardiac conditions, potentially decreasing the length of time spent in Urgent Care, or potentially avoiding the need for transfer to Bendigo. KDH is also fortunate to have a helipad on site for any urgent transfers.

We work closely with Ambulance Victoria, and virtual care services such as the Victorian Virtual Emergency Department (VVED) and more recently My Emergency Doctor, to complement our highly skilled GP VMOs and ensure our nurses are well-supported.

ONCOLOGY

The KDH Oncology Service continues to provide high quality care to consumers with cancer or chronic conditions requiring ongoing infusions. The Oncology service has been in operation for 33 years, and the demand for this vital service continues to grow. Attendance numbers now hover around 850 patients per year. The complexity of treatments and meeting the needs of rural consumers is increasing. The way in which we manage the roles in coordination of holistic care has a big impact on how consumers experience not only their care at KDH, but also their disease journey. KDH is a satellite service under the auspice of Bendigo Health Cancer Services.

Quality improvements for the year include an upgrade of the Telehealth room with a new soundbar and TV unit for enhanced quality during specialist reviews; and the development of a lymphoedema clinic.

We continue to have a strong sustainable workforce keen to engage in ongoing education and have successfully obtained support to train two additional oncology nurses this year, making a total of 14 trained oncology staff who work at KDH.

OPERATING SUITE

Significant quality improvements and equipment upgrades have been achieved since the completion of the Central Sterile Supply Department (CSSD) and Post Anaesthesia Care Unit (PACU) in May 2025. KDH has a state-of-the-art theatre complex of which we are very proud.

We continue to be compliant with current Australian Standards (AS5369) and relevant clinical guidelines, while supporting safe and efficient surgical care.

We have implemented an admission and discharge lounge in Bays 1 and 2 of the Day Surgery Unit, which has allowed us to improve bed turnover and patient throughput during our lists.

We also welcomed the arrival of a new anaesthetic machine to replace the previous one which was at end of serviceable life. This was thanks to donation money from the Ladies Auxiliary.

Our surgical services continue to include:

1. General Surgery – Mr Joshi and Mr Nair
2. Endoscopy – Mr Joshi and Mr Nair
3. Urology – Dr Lindsay
4. Dental Surgery (private) – Dr Behroz

KDH are very lucky to have a two local GP Anaesthetists – Dr Gerry Guimaraes who also works at Kerang Medical Clinic and Dr Peter Barker, Ochre Medical Clinic, Cohuna. We also welcomed Dr Gaith Al Timimi and Dr Nathan Sturgess to the GP Anaesthetist casual pool.

We have been successful in obtaining several 'procedures by exception' from Safer Care Victoria and the Department of Health. These include numerous gynaecological procedures, paediatric procedures (within our scope), laparoscopic hernia repairs, and laparoscopic cholecystectomies.

Our year-to-date surgical numbers are 576, of which 436 are minor cases and 140 are major cases.

We have seen 489 patients through the pre-anaesthetic clinic.

AGED CARE

Aged Care Services have undergone significant reform throughout 2025/2026 with the introduction of the new Strengthened Aged Care Quality Standards and Aged Care Act. This has involved substantial work across Glenarm to ensure processes, systems, and care delivery align with the new standards, alongside the implementation of many continuous improvement initiatives.

This year, Glenarm welcomed Kerang Optical to provide on-site optometry services for individuals unable to access local appointments. A new 100-inch television was purchased, thanks to donations from the wonderful Glenarm Family and Friends Committee. The Treat Trolley has also been a great success, offering individuals access to treats, useful items, and personal supplies.

Glenarm proudly celebrated its first-ever Kerang Technical High School student successfully completing a School-Based Apprenticeship and Traineeship (SBAT), with another SBAT who commenced in January 2026. Over the past financial year, Glenarm also farewelled several long-term nursing staff members whose years of dedication and experience will be greatly missed.

Despite ongoing sector reform, Glenarm maintained a strong occupancy rate of 98.3% throughout the year and is looking forward to some aged care construction upgrades commencing in August 2026. KDH remains committed to delivering safe, high-quality aged care services that place individuals, families and carers at the centre of care and decision-making.

ACTIVITY CENTRE

The Day Activity Centre based in the W.D. Thomas center is a vibrant and inclusive space for older people in the community to attend where they are encouraged to stay active, connect to our community and enjoy social connections and interactions.

This past year they have had many outings on the hospital buses including attending Normy Rowe and Winter Wonderland, both in Swan Hill, and regular shopping groups supporting local businesses. Some of our onsite celebration days included Miss Coad's 100th birthday and Easter celebrations. The popular mystery flight day included staff dressed as flight attendants and airport staff, industry guest speaker, scanning in on arrival, tickets and food presented as you would receive on a flight.

We currently have 45 registered participants who attend one or more days each week.



Photo: Winter Wonderland in Swan Hill



Photo: Mystery Flight Day

EXERCISE PHYSIOLOGY (EP)

Exercise Physiology services and the gym have continued to grow the intensive, small group, time limited rehabilitation programs, with a high uptake in Falls and Balance, Heart and Lung and Orthopedic groups. The outpatients attending for group sessions continues to be strong, especially in the over 65-year age group.

PHYSIOTHERAPY

Kerang District Health provides physiotherapy services to inpatients admitted to the Acute Ward, Transitional Care and older people living in Glenarm. KDH physiotherapist also runs outpatient services including Cancer Rehabilitation and Survivorship Program together with limited outpatient clinics for acute physiotherapy presentations. The new Lymphoedema Service is delivered by our Lymphoedema trained Physiotherapist and is very well attended.

MEN'S SHED

The Men's Shed is a Commonwealth Home Support Program and continues to provide a space for older men in our community to gather and contribute to local community projects whilst enjoying social connection and enjoying their various hobbies. This has also been ongoing opportunities for local health and wellbeing presenters meeting with the men and sharing their knowledge and expertise. Kerang Medical Clinic Doctors - Dr Gerry, Dr Brendan, Dr Jonan & Dr Ned discuss all things men's health. Registered Nurse Rebecca Benkovic provided Basic Life Support training and the men had a visit from a representative from Meering West Solar Farm.

There are 43 men registered in the 3 day per week program.

The Men's Shed Coordinator also assists the local community to enjoy a community garden where produce is grown, shared and donated.

RITA HALL OPPORTUNITY SHOP

The KDH Ladies Auxiliary continue to dedicate much time and effort running the Rita Hall Opportunity Shop where they tirelessly work to provide vital clothes and furnishings to the community, with all proceeds going to Kerang District Health. This year has seen the implementation of an Eftpos machine, improving the service delivery and supporting the volunteers working in the shop to manage finances more efficiently. This past year has seen a record amount raised of $110,000.00. The donations are absolutely vital to support capital equipment purchasing to ensure patients are cared for with state-of-the-art equipment. We are so very grateful for the work the Ladies Auxiliary do to support the community and our health service.



Photo: Members of the Ladies Auxiliary at the Rita Hall Opportunity Shop, Helen Reilly, Marlene Rawson, and Edith Wishart.

DISTRICT NURSING SERVICES

The District Nurse service have been busy delivering person centered care to the community in their home to ensure they are meeting their health care journey goals. The District Nursing department have successfully implemented a software program RCP which digitalizes client's documentation and scheduling, this has improved our work flow and impacting positively on client's outcomes. The KDH service have commenced a pilot wound management program, Tissue Analytics. This

program is designed with the assistance of AI to assess, monitor and treat wounds. This program is due to go live in July 2026.

On average the District Nursing service conduct over 700 visits per month throughout the Gannawarra shire catchment area which includes Kerang, Koondrook and Murrabit.

KERANG MEDICAL CLINIC

Kerang Medical Clinic maintained a strong complement of five General Practitioners throughout the year, providing essential primary care services together with GP Anesthetic support for theatre services, the Urgent Care Centre, Emergency Department and Acute Ward. This integrated model strengthens medical service delivery across the district, enhances patient safety and continuity of care, and ensures local residents can access high-quality healthcare closer to home whenever clinically appropriate.

The offices and treatment rooms were also upgraded and refurbished in June 2026, to ensure we had additional space for increasing number of skin procedures and a larger team to support outpatient care. The new spaces are bright & fresh, adding a more modern look to the clinic.

The General Practitioners continue to expand their knowledge and skill set by attending events such as the Rural Medicine Australia Annual conference in Perth & the SARGA conference specifically for Rural Generalist (RG) Anesthetists in the Barossa Valley. Our doctors have also attended a variety of education sessions including advanced life support & skin cancer treatment training.

The nursing staff has grown to ensure that our doctors have experienced & capable nursing assistance with wound management, procedures & immunisations, as well as ensuring care plans & health assessments are continually available for our patients with chronic health conditions.

KMC has also added a further visiting general surgeon to the team over the past 12 months.

Mr. Radha Nair has joined Mr. Kaushik Joshi to provide specialist care for the local community. Both surgeons consult regularly from the Kerang Medical Clinic rooms.

Over the past 12 months, Kerang Medical Clinic has accepted over 1000 new patients, taking our active patient total to in excess of 4,500 patients. Our GPs, nurses & administration staff are constantly busy, but continue to strive to provide the highest quality primary health care to the community.

KERANG RADIOLOGY SERVICE

KDH fully transitioned to a public operational model on 1st October 2025. KDH is very thankful to Bendigo Radiology for providing 25 years of service to Kerang and wider community and for their ongoing support. KDH worked closely with both Bendigo Health and Bendigo Radiology during this important transition. The ongoing partnerships and support have been greatly appreciated and really encapsulate the strength of ongoing collaborative partnerships to gain the best for the community we serve.

During September 2025, KDH employed the following staff compliment:

- Tutor Sonographer
- Medical Imaging Technician (MIT) and,
- two Reception staff.

All staff live within the local region and have worked enthusiastically to establish the service.

KDH continue to offer x-rays as a walk-in service, and ultrasounds as a booked service. Bendigo health have provided excellent support with Radiologist work off site where x rays are read and

reports provided. The consumer survey following the first 6 months indicated a 94% overall satisfaction rate.

KDH already owned the infrastructure including all equipment and the modern and accessible space. This transition also ensured Kerang District Health has transitional accreditation with NATA. During the year, KDH partnered with Bendigo Health in a tender process to purchase new ultrasound machine across both health services, of which KDH will purchase one. The money for the ultrasound machine has been kindly donated by the Kerang Agricultural Research Farm (KARF) and will ensure state of the art equipment and reporting of diagnostic images.

Katrina Sparrow
Director of Clinical Services



Photo: Cycling without Age member Brian Pope with Glenarm individuals Geoff and Brian.



Photo: Graduate Nurses 2025 from left back row – Emmer Harwood, Jo Thompson, Tahlia Butters, Rebecca Benkovic (Clinical Nurse Educator). Front Row from left – Nicole Sanders and Cassandra Stone.



Photo: Official unveiling of the new KDH Acknowledgement to Country Plaque.
Pictured left to right – Cree Clayton (Aboriginal Hospital Liaison, SHDH), Charmaine Anton (Aboriginal Health Manager, SHDH), Pearl Dunn (Aboriginal Health Liaison, KDH) and Deb Chaplin (Aboriginal Hospital Liaison, SHDH).

BOARD OF DIRECTORS

Name	Date appointed to Board	Meetings attended
Dr Andrew Jeffreys Anaesthetist	Appointed July 2018	12/12
Melissa Iskov Legal Practitioner	Appointed July 2019	12/12
Jonathan Norton Counselling Psychologist	Appointed July 2022	11/12
Edward (Ted) Rayment Semi-Retired Health Service CEO	Appointed July 2023	11/12
Tory Gruen Acting Financial Controller at South East Water	Appointed July 2023	10/12
Paul Fernee Local Government Executive	Appointed July 2024	12/12
Renee Harrison Registered Nurse	Appointed July 2024	7/12
Peter Koetsveld Retired Project Manager	Appointed July 2024	10/12
Linda Jungwirth Regional Coordinator for Down Syndrome Victoria	Appointed July 2025	3/12

SUB-COMMITTEE MEMBERSHIP BY BOARD DIRECTORS

Finance, Audit & Risk Committee

The Finance, Audit and Risk Committee is an advisory committee to the Board of Directors appointed pursuant to the By- Laws of KDH and in accordance with the purpose of the *Health Services Act 1988*. The purpose of the Audit and Risk Committee is to assist the Board in fulfilling its corporate governance responsibilities in regards to the integrity of financial reporting, risk management, the internal control environment, compliance with legal and regulatory obligations, oversight of the internal and external audit functions and other matters, within scope, referred by the Board.

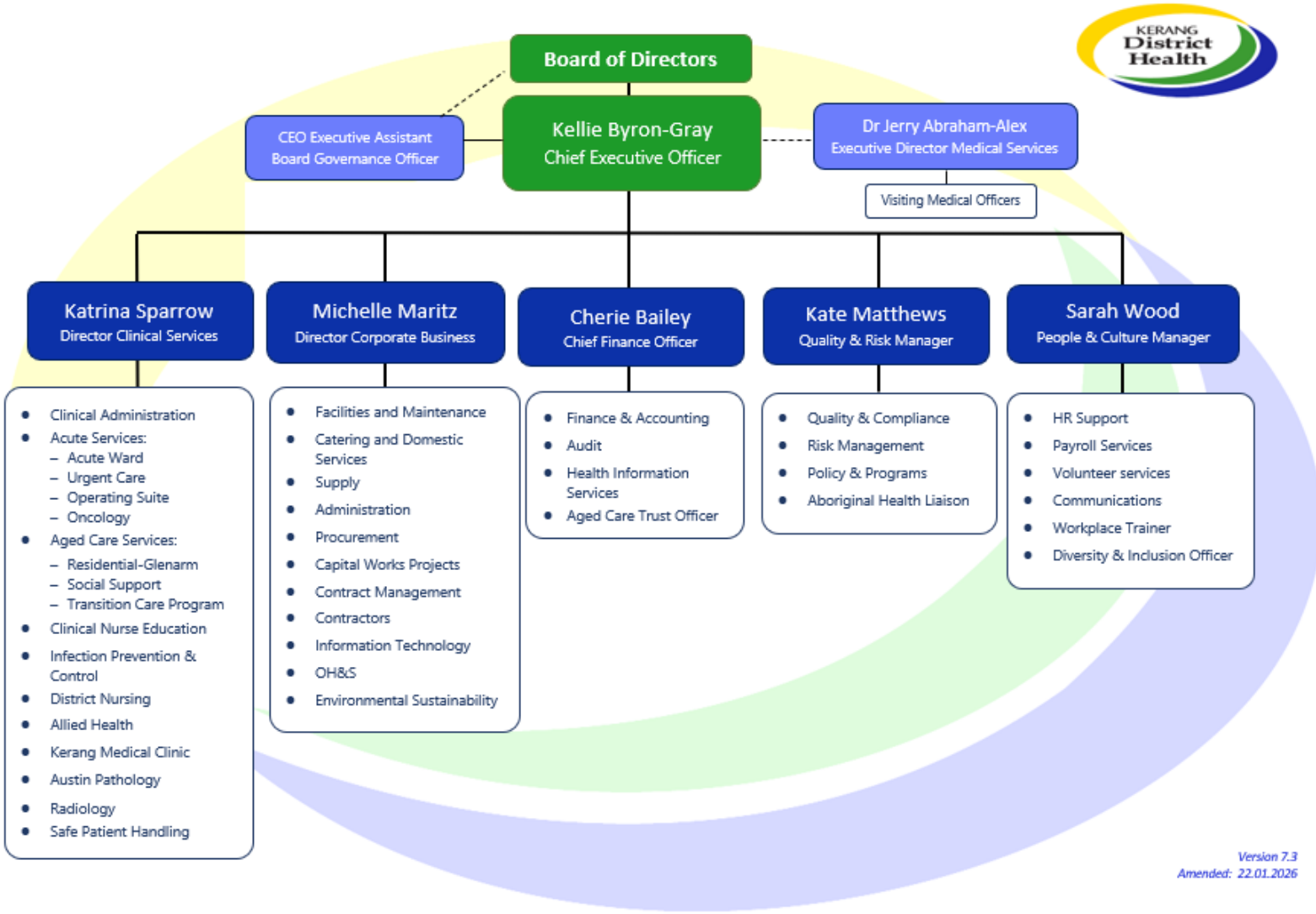
Members of all sub-committees for the 2025-2026 financial year were:

KDH Finance, Audit & Risk Committee	Melissa Iskov (Chair and Board Director), Tory Gruen (Board Director), Jonathan Norton (Board Director) and, Paul Fernee (Board Director)	**KDH Credentialing Committee**	Dr Andrew Jeffreys (Chair and Board Chair/Director), and Jonathan Norton (Board Director)
Safety and Quality Committee	Ted Rayment (Quality Board Chair/Director) and Peter Koetsveld (Board Director)	**Consumer Advisory Committee**	Ted Rayment (Board Director), and Renee Harrison (Board Director)

EXECUTIVE MANAGEMENT

KELLIE BYRON-GRAY **CHIEF EXECUTIVE OFFICER** Registered Nurse (RN); Diploma of Health Science (Nursing); Intensive Care Certificate; Master of Public Health (MPH); Master of Health Administration (MHA); Certificate in Advanced Leadership (Women & Leadership Australia); Member, Australian College of Nursing (MACN); Australian Institute of Clinical Governance Graduate (AICGG)	Kellie officially commenced her role as CEO on 18/12/2021. The Chief Executive Officer is accountable to the Board for delivering the strategic direction, performance and sustainability of Kerang District Health. Through visible and effective leadership, the CEO drives organisational excellence, fosters a high-performing and values-led culture, and builds strong partnerships across health and local community. The CEO provides leadership, guidance and support ensuring the organisation remains focused on safe, high-quality care, continuous improvement and future growth.
MICHELLE MARITZ **DIRECTOR OF CORPORATE BUSINESS** Adv Dip Business Legal Studies, Dip Human Resources Management, Certificate IV in Procurement and Contracting.	Michelle commenced the role of DCB in November 2023, after 10 years in the People and Culture department. The Director, Corporate Business is responsible for the day-to-day provision of non-clinical support services including Information and Communication Technology, Maintenance, Health Information Services, Capital Works, Catering and Domestics, Fleet, Procurement, Supply, OHS, and Environmental.
KATRINA SPARROW **DIRECTOR OF CLINICAL SERVICES** Bachelor of Nursing (RN), Graduate Diploma in Healthcare Leadership	Katrina commenced 30 November 2023 as the Director of Clinical Services. Katrina is responsible for the operational running of the clinical services at KDH with a focus on a positive consumer experience and providing leadership for clinical staff to provide high quality care close to home.
CHERIE BAILEY **CHIEF FINANCIAL OFFICER** Bachelor of Commerce (BCom) and a CPA	The Chief Finance Officer is responsible for Planning, Coordinating, Managing and Monitoring the effective delivery of all finance activities across Kerang District Health. Providing strategic leadership for the corporate and financial governance.
DR JERRY ABRAHAM-ALEX **EXECUTIVE DIRECTOR OF MEDICAL SERVICES** FACRRM, ARANZCOG, MBBS, BEng (Hons), MEng, Grad DipEd, Med	The Executive Director, Medical Services provides high level medical advice and support, with responsibility for clinical governance, professional standards, continuous improvement, and patient safety across Swan Hill District Health and Kerang District Health.

KDH ORGANISATIONAL STRUCTURE



WORKFORCE DATA

Labour Category	JUNE – Current Month *FTE		Average Monthly *FTE	
	2025	2026	2025	2026
Nursing	61.78	**59.45**	**57.39**	**58.23**
Administration & Clerical	17.12	**19.48**	**16.82**	**18.73**
Medical Support	0.00	**0.00**	**0.00**	**0.00**
Hotel & Allied Services	27.02	**24.75**	**25.60**	**25.44**
Medical Officers	1.09	**0.00**	**0.55**	**0.33**
Hospital Medical Officers	0.00	**0.00**	**0.00**	**0.00**
Sessional Clinicians	0.00	**0.00**	**0.00**	**0.00**
Ancillary Staff (Allied Health)	10.03	**12.06**	**10.33**	**10.59**
Total *FTE	**115.04**	**115.74**	**110.69**	**113.32**

"Employees have been correctly classified in workforce data collections." *FTE stands for full-time equivalent positions.

WORKFORCE INCLUSION POLICY

At present, our health service does not have a formal workforce inclusion policy with measurable targets in place. However, we are committed to advancing workforce inclusion and are actively exploring initiatives aligned with the Gender Equality Act, 2020.

As part of our ongoing efforts, we are considering the development of measurable targets and reporting mechanisms to support transparency and continuous improvement.

We acknowledge the importance of tracking progress and will provide updates as our initiatives evolve. In the interim, we welcome feedback and remain committed to fostering an inclusive and equitable workplace.

KDH is committed to fairness, respect and diversity in all aspects of employment and service delivery. We promote equitable employment practices based on merit and provide a workplace that is inclusive, respectful and free from discrimination, harassment and bullying.

KDH values the diversity of its workforce and the community it serves. Employees are expected to demonstrate behaviours consistent with the organisation's values and Code of Conduct, fostering a culture where all people are treated with dignity, respect and inclusion.

OCCUPATIONAL HEALTH & SAFETY

Kerang District Health maintains a strong commitment to the health, safety, and wellbeing of all staff, volunteers, contractors, and visitors. The organisation promotes a proactive safety culture guided by the KDH Risk Management Framework, in full compliance with the Occupational Health and Safety Act 2004 and WorkSafe Victoria requirements.

Key activities during 2025 – 2026 included refinement of simplified auditing processes, the incident management system, and user-friendly Hazard/Risk Assessment tools that integrate into the Quality and Risk Management system. A monthly staff safety focus is produced for staff to be discussed at staff forums to improve communication flow and dissemination of pertinent safety information. A strong focus was maintained on upskilling Health and Safety representatives and staff to improve hazard identification and control implementation, supporting the goal of an injury-free workplace and a self-sustaining organisational safety culture.

In line with the new requirements relating to psychosocial hazards under Victorian occupational health and safety legislation, the organisation has strengthened its systems for identifying and managing psychosocial risks, including work-related stress, bullying, aggression, and other psychosocial hazards. Preventative controls and support measures have been embedded into existing policies and practices, with ongoing focus on early intervention and staff wellbeing.

Njeghiska Johnson
Occupational Health and Safety Officer

Occupational Health and Safety Statistics	2023-2024	2024-2025	2025-2026
Number of reported hazards/incidents for the year per 100 FTE	32	11	61
The number of 'lost time' standard WorkCover claims for the year per 100 FTE	0.01	0	0.88
The average cost per WorkCover claim for the year	$7,314.00	$0	$22,799.40

Occupational Violence Statistics	2025-2026
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.	11
Number of occupational violence incidents reported per 100 FTE	10.2
Percentage of occupational violence incidents resulting in a staff injury, illness or condition.	0

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, 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 2025-2026.

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.

STATEMENT OF PRIORITIES 2025-2026

Part A: Strategic Priorities

Goals/Strategies	Collaborative Regional Deliverables	Local KDH Outcomes and Progress
Specific 2025-2026 Priorities		
INNOVATE AND IMPROVE ACCESS AND CARE		
Align with the Victorian Clinical Governance Framework to strengthen clinical governance systems, ensuring safe, high-quality care.	Demonstrate high quality care in which consumer engagement and input is actively sought, facilitated and used to drive system change to improve consumer experience and outcomes.	**Status: Achieved** KDH delivers person-centred care by embedding consumer voices in governance, service planning and quality improvement. In 2025, consumers helped co-design the new public Radiology Service, the Community Telehealth Room project and advised KDH on other key initiatives. Consumer engagement was central to the 2026 strategic planning process, which ensured community priorities drive service delivery, quality improvements, patient experience and health outcomes. Consumer stories are presented to the highest level of governance.
	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.	**Status: Achieved** KDH fosters a culture of safety and continuous improvement through strong clinical governance, regular Mortality and Morbidity/Clinical Review meetings with both medical and nursing staff participation to increase learning; and Safety and Quality Committee oversight based on SCV frameworks. Participation in the Loddon Mallee Local Health Service Network (LMLHSN) Statement of Expectation key priorities that supports collaborative improvement, streamlining processes, improve consistency, and enhanced patient safety and care quality across health services.
	Health services are able to show evidence of a comprehensive training program approach that includes performance management, accountability, and continuous improvement.	**Status: Achieved and Ongoing** KDH supports comprehensive training through regular policy reviews, mandatory training, and a regular, comprehensive staff orientation program. The organisation is also reinvigorating the Leadership Development Series, with education in workforce management, performance development, grievance management and staff supervision to strengthen leadership capability, accountability and organisational performance. These processes are reflected in the new staff led SOAR values. Mandatory online education reporting is provided to the highest level of governance. Staff are regularly engaged with change management initiaitves and KDH is well known for implementation of new systems and processes and embracing change.

Maintain a commitment to delivering equitable access to planned surgery and drive reform in alignment with the Planned Surgery Reform Blueprint.	Implement and scale theatre optimisation initiatives in planned surgery, for example same-day surgery and same-day surgery by default models of care, criteria-led discharge, monitoring of theatre measures, and high-throughput approaches such as high-intensity theatre lists.	**Status: Achieved** KDH manages planned surgery services within the constraints of a rural, block-funded health service and limited visiting surgeon workforce. Surgical services are delivered in line with KDH's Capability Framework, with a focus on patient safety, quality and equitable access. Regular reviews of theatre utilisation, together with investment in enhanced surgical equipment, support increased day surgery activity, reduced post-operative pain and improved health experience.
	Proactively manage planned surgery and specialist clinics (or outpatients) waitlists, for example validating and supporting patients into optimal care pathways such as evidence-based alternatives to surgery and optimisation pathways. A particular focus should be applied to long-waiting patients and priority population groups (for example, Aboriginal and Torres Strait Islander patients and under-18 patients).	**Status: Achieved** KDH actively manages surgery and specialist clinic waitlists through regular review, validation and prioritisation based on clinical need. Long-waiting patients are monitored and supported through collaboration with specialists, GPs and regional services. Additional support for Aboriginal and Torres Strait Islander patients and children helps ensure equitable, timely access to care.
PRUDENT, SUSTAINABLE AND EFFECTIVE USE OF RESOURCES		
Develop and implement initiatives to strengthen financial sustainability. By delivering sustainable, responsible budgets, we can ensure a well-managed, viable, and sustainable health system for the future.	Deliver the key initiatives outlined in the Budget Action Plan within Government parameters.	**Status: Achieved** KDH provided a break even budget to the DOH; KDH continues to explore opportunities to improve finanical performance collaborativel with the department.
	Utilise data analytics and performance metrics to identify areas of inefficiency and waste and make evidence-based decisions to improve financial sustainability and operational performance.	**Status: Achieved** KDH's growth in utilising data and analytics, continue to improve efficiency and sustainability through targeted cost-saving initiatives and strengthened asset management. The implementation of FMI Asset Management Software enhances data collection, reporting, maintenance planning, contractor compliance and lifecycle management, supporting evidence-based decision-making, risk management, operational efficiency and long-term financial sustainability.
	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** KDH is progressing a new Strategic Plan informed by data analysis, service planning and community priorities. Key achievements include establishing a local Radiology Service, commencing a Lymphoedema Clinic, and advancing Clinical Services Planning through the Loddon Mallee Local

		Health Service Network. Ongoing service reviews support efficiency improvement and care closer to home.
A STRONGER WORKFORCE		
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 processes to sustain workforce supply and fulfill obligations, including those under the Gender Equality Act 2020 by improving employee experience in leadership, health and safety, flexibility, career development, and agility to ensure safe, high-quality care.	**Status: Achieved** KDH continues to strengthen its workforce through leadership development, education and succession planning. Key initiatives include implementation of the Workforce Plan, appointment of a Diversity and Inclusion Officer, delivery of the Gender Equality Action Plan, and flexible work arrangements that support staff wellbeing, inclusion, engagement and organisational capability. KDH also welcomed the Gender Equity Commissioner in November 2025.
	Collaborate with the department to improve workforce data analytics, generate actionable insights, and enhance strategic planning.	**Status: Achieved** KDH continues to strengthen digital capability through the implementation of RCP in community programs, FMI Asset Management Software, Karisma in Radiology and Cubiko in Kerang Medical Clinic, with SuccessFactors underway across the region. These systems enhance data quality, reporting, workforce planning and service performance, supporting evidence-based decision-making, operational efficiency, workforce sustainability and current and future strategic planning.
IMPROVING ABORIGINAL HEALTH AND WELLBEING		
Enhance Delivery and Access to Culturally Safe Services, fostering strong connections to culture. Address racism and provide Aboriginal people with culturally safe healthcare and referral pathways between mainstream and community-controlled health services.	Deliver high-quality cultural safety training to all executives and staff using independent, expert, community-controlled organisations or a registered Aboriginal business.	**Status: Achieved and Ongoing** KDH is committed to strengthening cultural safety through organisation-wide training, including Board training CATOnline Cultural Awareness training. Executive and Department Heads staff have almost all completed Weenthunga Critical Consciousness and Cultural Safety training. The Aboriginal Health Liaison has updated brochures and information for First Nations people, developed a power point presentation for new staff explaining Cultural Awareness and Cultural Safety, along with the role of the AHL in a health service and the community. The unveiling of the KDH Acknowledgement to Country plaque was a very pivitol and powerful message to First Nations community providing: • A commitment that KDH will continue working to create a culturally safe environment; • A commitment that we will keep learning from First Nations voices; • A commitment that we will embed respect and inclusion in all that we do.
	Health service executives and senior leaders establish and maintain	**Status: Achieved and Ongoing** KDH continues to strengthen partnerships with Aboriginal and Torres Strait Islander

	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.	communities through regular engagement with the local Kerang Elders and Emerging Leaders group, along with strong collaboration with MDAS and Swan Hill District Health Aboriginal Health Service. KDH has developed an Aboriginal Employment Plan with First Nations community engagement to better understand barriers to employment pathways and to strengthen equity and inclusion. Cultural inclusion initiatives and community consultation support culturally safe, respectful and responsive care.
	Ensure culturally appropriate systems for identifying Aboriginal and Torres Strait Islander patients and implement responsive discharge plans and referral pathways.	**Status: Achieved and Ongoing** KDH is improving support for Aboriginal and Torres Strait Islander patients through stronger partnerships with MDAS, enhanced identification processes for admitted patients and urgent care presentations, onging staff education and coordinated discharge planning. Development of a Memorandum of Understanding (MoU) with MDAS remains in progress to strengthen referral pathways, ensure patient confidentiality and consent processes are strengthened, supports culturally safe care, improved service access and better coordination between hospital and community services.
MOVING FROM COMPETITION TO COLLABORATION		
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** KDH successfully delivered on the Local Health Service Network Statement of Expectations through collaboration, shared services and continuous improvement initiatives. Working closely with network partners strengthened access, patient flow, workforce sustainability, safety and quality, supporting coordinated care pathways, efficient resource utilisation and improved health outcomes for the local community.

Part B: Performance Priorities

High Quality and Safe Care

Key Performance Measure	Target	Actual
Infection Prevention and Control		
Percentage of healthcare workers immunised for influenza	94%	97%
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	Met
Aged Care		
Public sector residential aged care services overall star rating (> 3)	100%	100%
Patient Experience		
Percentage of patients who reported positive experiences of their hospital stay	95%	98%
Aboriginal Health		
Difference between the percentage of Aboriginal and/or Torres Strait Islander patients and non-Aboriginal and/or non-Torres Strait Islander patients who left against medical advice	0%	0%

Strong governance, leadership, and culture

Key Performance Measure	Target	Actual
Organisational culture		
People matter survey – Percentage of staff with an overall positive response to safety culture survey questions	80%	79%
Percentage of workers reporting nil or low/mild work-related stress	61%	47%

***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	2025-2026
Finance		
Operating result ($m)	0.00	-0.352
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	1.07
Variance between forecast and actual operating result (OR) for the current financial year ending 30 June	5% movement in forecast revenue and expenditure forecasts	Not Achieved

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

Part C: Activity & Funding

Kerang District Health funding summary for 2025-2026

Funding Type	2025-2026 Activity achievement
Small rural acute	20.45
Small rural primary health & HACC	4,232
Small rural residential care	10,781

FINANCIAL INFORMATION

KDH's financial and strategic objective is to provide the necessary resources to achieve activity levels, address essential capital needs and ensure cash sustainability.

Kerang District Health achieved an operating deficit of $352k for the 2025-26 financial year. Key changes throughout the year included capital expenditure in relation to completion of our CSSD Theatre Equipment Upgrade project. Kerang District Health remained focused on delivering safe, high quality and accessible healthcare services to its rural community while maintaining financial sustainability and meeting its operational and budgetary objectives. Performance against these objectives was supported by sound governance, effective resource management and continued progress against strategic and operational priorities. There were no significant events occurring after the balance date that have materially affected, or may materially affect, the operations or financial position.

SUMMARY OF FINANCIAL RESULTS

	2026	2025	2024	2023	2022
	$000	$000	$000	$000	$000
OPERATING RESULT	-352	235	100	310	113
Total revenue	22,911	22,609	19,761	18,249	16,704
Total expenses	24,381	21,755	20,039	18,883	17,662
Net results from transactions	-1,470	854	-278	-636	-956
Total other economic flows	149	187	259	-80	128
Net results	-1,321	1,041	-19	-716	-828
Total assets	82,903	83,347	78,964	41,492	43,007
Total liabilities	12,469	11,592	8,250	6,708	7,507
Net assets/Total equity	70,434	71,755	70,714	34,784	35,500

RECONCILIATION OF NET RESULT FROM TRANSACTIONS AND OPERATING RESULT

	2025-2026
	$000
Net operating result	-352
Capital purpose income	4,743
Specific income	-
COVID 19 State Supply Arrangements – Assets received free of charge or for nil consideration under the State Supply	-
State supply items consumed up to 30 June 2026	-

Assets provided free of charge	-
Assets received free of charge	-
Expenditure for capital purpose	-
Depreciation and amortisation	-2,921
Impairment of non-financial assets	-
Finance costs (other)	-
Net result from transactions	-1,470

CONSULTANCIES

Details of consultancies (under $10,000)
In 2025-2026, there were ten consultancies where the total fees payable to the consultants were less than $10,000. The total expenditure incurred during 2025-2026 in relation to these Consultancies is $19,992 (excl. GST).

Details of consultancies (valued at $10,000 or greater)
In 2025-2026, there was one consultancy where the total fees payable to the consultant was $10,000 or greater. The total expenditure incurred during 2025-2026 in relation to this consultancy is $54,005 (excl. GST).

Consultant	Purpose of Consultant	Start Date	End Date	Total approved project fee (excluding GST)	Expenditure 2025-2026 (excluding GST)	Future expenditure (excluding GST)
Australian Health Services Group (AHSG)	Development of Strategic Plan, Department Heads Strategic Plan education along with development of Values and behaviours	Jan 2026	June 2026	$54,005	$54,005	0

INFORMATION AND COMMUNICATION TECHNOLOGY (ICT) DISCLOSURE

Total ICT expenditure incurred during 2025-2026 is $982,448 (excluding GST) with details shown below:

Business as Usual (BAU) ICT Expenditure	Non-Business as Usual (non-BAU) ICT Expenditure		
Total (excluding GST)	Total = Operational expenditure and Capital Expenditure (excluding GST) (a)+(b)	Operational expenditure (excluding GST) (a)	Capital expenditure (excluding GST) (b)
$982,448	$0	$0	$0

SOCIAL PROCUREMENT

Kerang District Health (KDH) recognises social procurement as an important mechanism for delivering positive social, economic and environmental outcomes through its purchasing activities. By embedding social procurement principles into procurement practices, KDH contributes to building a fairer, more inclusive and sustainable Victoria.

KDH is committed to advancing social and sustainable procurement objectives in alignment with the Victorian Government's Social Procurement Framework. Through its procurement processes, KDH seeks to maximise opportunities that generate broader community benefits while maintaining value for money and supporting organisational objectives.

All procurement activities undertaken by, or on behalf of, KDH aim to support regional Small and Medium Enterprises (SMEs), acknowledging their vital contribution to the strength, sustainability and prosperity of the local economy and community. KDH continues to incorporate government social procurement objectives into routine procurement practices and actively engages with suppliers that deliver social benefits.

KDH remains committed to identifying and pursuing opportunities to increase its engagement and expenditure with social benefit suppliers, further enhancing the positive impact of its procurement activities on the communities it serves.

Social Procurement Activity

	2025-2026	2024-2025	2023-2024
Total Number of suppliers	465	395	409
Total Spend with suppliers (excl. GST)	$13,800,791	$8,252,408	$6,649,000
Social Benefit suppliers	4	3	2
Total spent with social benefit suppliers (excl. GST)	$19,686	$15,568	$6,649
Number of Aboriginal businesses engaged	2	1	1
Total expenditure with Victorian Aboriginal businesses (excl. GST)	$3,576	$2,031	$3,828

GRANTS AND TRANSFER PAYMENTS

Kerang District Health has provided assistance to certain companies and organisations. Financial assistance provided in 2025-2026 was as follows:

Organisation	Payment $
Kerang Technical High School Bursary Award	$ 500.00
Cycling Without Age Kerang	$1,100.00

DISCLOSURES

FREEDOM OF INFORMATION (FOI)

The Freedom of Information (FOI) Act gives you the right to request information and access your medical record and, in certain cases, our activities.

FOI requests from the public can be made on a KDH FOI application form available from our website. FOI requests are to be forward to foi@kdh.org.au. FOI fees apply, application fee $33.60 and photocopying of 20 cents per page.

The Chief Executive Officer is the Principal Officer to whom all requests should be forwarded.

During 2025-2026, Kerang District Health received 10 applications. Of these requests, 0 were from Members of Parliament, 0 from the media and the remainder from the general public.

Kerang District Health made 10 FOI decisions during the 12 months ended 30 June 2026

There were 10 decisions made within the statutory time periods. Of the decisions made outside time, 0 was made within a further 45 days and 0 decisions were made in greater than 45 days.

Of the total decision made, 10 granted access to documents in full, 0 granted access in part and 0 denied access in full. 0 decisions were made after mandatory extensions had been applied or extensions were agreed upon by the applicant.

Of requests finalised, the average number of days under the statutory time (including extended timeframes) to decide the request was 6 days.

During 2025-2026, no requests were subject to a complaint/internal review by Office of the Victorian Information Commissioner. No requests progressed to the Victorian Civil and Administrative Tribunal (VCAT).

Further information regarding FOI can be found on the Office of Victorian Information Commissioners Website www.foi.vic.gov.au or email enquiries@ovic.vic.gov.au

BUILDING ACT 1993

This Act sets standards for the construction of new buildings and for the maintenance of existing buildings. It includes provisions to protect the safety and health of building users, and cost-effective construction is encouraged. All building work carried out during 2025-2026 complies with current Building Standards and to the best of our knowledge, the Health Service complies with building and maintenance provisions as per the Act. Kerang District Health does not own or control any government buildings and is exempt from notifying its compliance with the building and maintenance provisions of the Act.

PUBLIC INTEREST DISCLOSURES ACT 2012

Kerang District Health has policies and procedures consistent with the requirements of the Public Interest Disclosures Act 2012 which supports staff to disclose improper or corrupt conduct within the health service. During 2025-2026 there were no disclosures made to Kerang District Health under the Act.

NATIONAL COMPETITION POLICY

Kerang District Health complies with the requirements of the National Competition Policy and the Victorian Government policy statement, Competitive Neutrality Policy Victoria and subsequent reforms.

CARERS RECOGNITION ACT 2012

Kerang District Health has taken all practical measures to comply with its obligations under the Act. These include:

- 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 Recognising and supporting Victoria's carers: Victorian carer strategy 2018-22.

LOCAL JOBS FIRST ACT 2003

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

REVIEW AND STUDY EXPENSES

In 2025-2026 there were no reviews or study expenses that were required to be disclosed.

SAFE PATIENT CARE ACT 2015

Kerang District Health has no matters to report in relation to its obligations under section 40 of the Safe Patient Care Act 2015 for the year.

GENDER EQUALITY ACT 2020

Kerang District Health continues to make progress around the actions outlined in the KDH Gender Equality Plan and as per the legislative requirements. Work is progressing with Gender Impact Assessments for all new services, alterations and changes across the organisation to case a 'gender lens'.

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

  (i) consultants/contractors engaged;
  (ii) services provided; and
  (iii) expenditure committed to for each engagement

This information is available on request from:
Chief Executive Officer
Phone: (03) 5450 9200
Email: contact@kdh.org.au

ENVIRONMENTAL PERFORMANCE

All Victorians have a role to play in making Victoria a more sustainable state for future generations and protecting our reputation as one of the world's most liveable places.

Responding to this challenge, Kerang District Health has made a commitment to making the environment central to our planning, operations and policy decisions and reducing our environmental impacts by adopting an environmental policy, and monitoring and reporting our achievements.

Kerang District Health aims to minimise the environmental impacts associated with our operations to the greatest extent possible and seek continual improvement in the management of our environmental effects. In addition, we continue to integrate the concept of sustainable development into all our business operations and to pursue a vision of sustainability to achieve a fairer, safer and healthier world.

The environmental data presented below has been prepared using a revised reporting approach and is therefore presented in a different format to previous years. This change reflects Kerang District Health's ongoing commitment to improving the quality, consistency and transparency of environmental reporting. We will continue to review and refine our data collection and reporting processes to further enhance the accuracy, completeness and reliability of future reporting.

FRD24 Report: Kerang District Health Organisation Hierarchy (Jul-25 to Jun-26)			
ELECTRICITY USE	**Jul-25 to Jun-26**	**Jul-24 to Jun-25**	**Jul-23 to Jun-24**
EL1 Total electricity consumption segmented by source (MWh)			
Purchased	1,142.02	1,055.99	1,127.75
Self-generated	126.17	90.02	66.05
EL1 Total electricity consumption (MWh)	**1,268.19**	**1,146.01**	**1,193.80**
EL2 On site-electricity generated (MWh) segmented by:			
Consumption behind-the-meter			
Solar Electricity	126.17	90.02	66.05
Total Consumption behind-the-meter (MWh)	**126.17**	**90.02**	**66.05**
Exports			
Solar Electricity	0.03		
Total Electricity exported (MWh)	**0.03**		
EL2 Total On site-electricity generated (MWh)	**126.20**	**90.02**	**66.05**
EL3 On-site installed generation capacity (kW converted to MW) segmented by:			
Diesel Generator	0.45	0.45	0.45
Solar System	0.12	0.09	0.09
EL3 Total On-site installed generation capacity (MW)	**0.57**	**0.54**	**0.54**

EL4 Total electricity offsets segmented by offset type (MWh)			
LGCs voluntarily retired on the entity's behalf	969.98		
RPP (Renewable Power Percentage in the grid)	197.44	193.30	211.56
EL4 Total electricity offsets (MWh)	**1,142.02**	**193.30**	**211.56**
STATIONARY ENERGY	**Jul-25 to Jun-26**	**Jul-24 to Jun-25**	**Jul-23 to Jun-24**
F1 Total fuels used in buildings and machinery segmented by fuel type (MJ)			
LPG	1,659,449.00	1,226,452.80	960,537.40
F1 Total fuels used in buildings (MJ)	**1,659,449.00**	**1,226,452.80**	**960,537.40**
F2 Greenhouse gas emissions from stationary fuel consumption segmented by fuel type (t CO2-e)			
LPG	100.56	74.32	58.21
F2 Greenhouse gas emissions from stationary fuel consumption (t CO2-e)	**100.56**	**74.32**	**58.21**
TRANSPORTATION ENERGY	**Jul-25 to Jun-26**	**Jul-24 to Jun-25**	**Jul-23 to Jun-24**
T1 Total energy used in transportation (vehicle fleet) within the Entity, segmented by fuel type (MJ)			
Non-executive fleet - Gasoline	65,277.50	123,215.70	310,655.80
Petrol	**65,277.50**	**123,215.70**	**310,655.80**
Non-executive fleet - E10		1,483.90	1,487.20
Petrol (E10)		**1,483.90**	**1,487.20**
Non-executive fleet - Diesel	48,408.40	75,756.30	127,056.00
Diesel	**48,408.40**	**75,756.30**	**127,056.00**
Total energy used in transportation (vehicle fleet) (MJ)	**113,685.90**	**200,455.90**	**439,199.00**
T2 Number and proportion of vehicles in the organisational boundary segmented by engine/fuel type and vehicle category			
Unleaded Electric	3		
Premium Unleaded Electric	6		
Diesel	4		
T3 Greenhouse gas emissions from transportation (vehicle fleet) segmented by fuel type (t CO2-e)			
Non-executive fleet - Gasoline	4.41	8.33	21.01
Petrol	**4.41**	**8.33**	**21.01**
Non-executive fleet - E10		0.09	0.09
Petrol (E10)		**0.09**	**0.09**

Non-executive fleet - Diesel	3.41	5.33	8.95
Diesel	**3.41**	**5.33**	**8.95**
Total Greenhouse gas emissions from transportation (vehicle fleet) (t CO2-e)	**7.82**	**13.76**	**30.04**
T4 Total distance travelled by commercial air travel (passenger km travelled for business purposes by entity staff on commercial or charter aircraft)			
Total distance travelled by commercial air travel			
TOTAL ENERGY USE	**Jul-25 to Jun-26**	**Jul-24 to Jun-25**	**Jul-23 to Jun-24**
E1 Total energy usage from fuels, including stationary fuels (F1) and transport fuels (T1) (MJ)			
Total energy usage from stationary fuels (F1) (MJ)	1,659,449.00	1,226,452.80	960,537.40
Total energy usage from transport (T1) (MJ)	113,685.90	200,455.90	439,199.00
Total energy usage from fuels, including stationary fuels (F1) and transport fuels (T1) (MJ)	**1,773,134.90**	**1,426,908.70**	**1,399,736.40**
E2 Total energy usage from electricity (MJ)			
Total energy usage from electricity (MJ)	4,565,494.99	4,125,622.25	4,297,675.54
E3 Total energy usage segmented by renewable and non-renewable sources (MJ)			
Renewable	4,565,495.00	1,020,103.05	999,528.76
Non-renewable (E1 + E2 - E3 Renewable)	1,773,134.89	4,532,427.90	4,697,883.17
E4 Units of Stationary Energy used normalised: (F1+E2)/normaliser			
Energy per unit of Aged Care OBD (MJ/Aged Care OBD)	579.17	496.76	483.69
Energy per unit of LOS (MJ/LOS)	2,145.05	2,151.16	1,839.18
Energy per unit of bed-day (LOS+Aged Care OBD) (MJ/OBD)	456.04	403.56	382.97
Energy per unit of Separations (MJ/Separations)	4,510.83	5,006.62	4,179.82
Energy per unit of floor space (MJ/m2)	1,158.34	995.92	978.45

SUSTAINABLE BUILDINGS AND INFRASTRUCTURE	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24
B1 Discuss how environmentally sustainable design (ESD) is incorporated into newly completed entity-owned buildings			
During FY 25-26, three newly constructed townhouses (worker accommodation) were equipped with 6KW Solar PV systems and battery backups, achieving a Whole of Home performance rating of 60 out of 100			
B2 Discuss how new entity leases meet the requirement to preference higher-rated office buildings and those with a Green Lease Schedule			
B3 NABERS Energy (National Australian Built Environment Rating system) ratings of newly completed/occupied Entity-owned office buildings and substantial tenancy fit-outs (itemised)			
B4 Environmental performance ratings (eg. NABERS, Green Star, or ISCAIS rating scheme) of newly completed Entity-owned non-office building or infrastructure projects or upgrades with a value over $1 million			
NatHERS for Workers Accommodation	7 stars		
B5 Environmental performance ratings achieved for Entity-owned assets portfolio segmented by rating scheme and building, facility, or infrastructure type, where these ratings have been conducted			
NABERS - Water	2 stars	2 stars	2 stars
NABERS - Energy	3 stars	3 stars	3 stars
WATER USE	**Jul-25 to Jun-26**	**Jul-24 to Jun-25**	**Jul-23 to Jun-24**
W1 Total units of metered water consumed by water source (kL)			
Potable water (kL)	14,140.13	17,656.35	11,401.19
Total units of water consumed (kL)	**14,140.13**	**17,656.35**	**11,401.19**
W2 Units of metered water consumed normalised by FTE, headcount, floor area, or other entity or sector specific quantity			
Water per unit of Aged Care OBD (kL/Aged Care OBD)	1.32	1.64	1.05
Water per unit of LOS (kL/LOS)	4.87	7.10	3.99
Water per unit of bed-day (LOS+Aged Care OBD) (kL/OBD)	1.04	1.33	0.83
Water per unit of Separations (kL/Separations)	10.25	16.52	9.06
Water per unit of floor space (kL/m2)	2.63	3.29	2.12

WASTE AND RECYCLING	Jul-25 to Jun-26	Jul-24 to Jun-25	Jul-23 to Jun-24
WR1 Total units of waste disposed of by waste stream and disposal method (kg)			
Landfill (total)			
General waste - bins	280.30	257.51	26.31
General waste - skips	98,658.00	122,931.01	57,831.34
Offsite treatment			
Clinical waste - incinerated	149.56	149.56	149.82
Clinical waste - sharps	321.27	321.27	322.34
Clinical waste - treated	1,191.00	1,191.00	1,194.10
Recycling/recovery (disposal)			
Cardboard	7,195.60	4,145.33	4,602.92
Commingled	3,886.08	3,928.32	3,843.84
Grease traps	684.00	342.00	342.00
Paper (confidential)	1,278.00	1,707.00	1,178.00
Total units of waste disposed (kg)	**113,643.81**	**134,973.00**	**69,490.67**
WR1 Total units of waste disposed of by waste stream and disposal method (%)			
Landfill (total)			
General waste	87.06%	91.27%	83.26%
Offsite treatment			
Clinical waste - incinerated	0.13%	0.11%	0.22%
Clinical waste - sharps	0.28%	0.24%	0.46%
Clinical waste - treated	1.05%	0.88%	1.72%
Recycling/recovery (disposal)			
Cardboard	6.33%	3.07%	6.62%
Commingled	3.42%	2.91%	5.53%
Grease traps	0.60%	0.25%	0.49%
Paper (confidential)	1.12%	1.26%	1.70%
WR3 Total units of waste disposed normalised by FTE, headcount, floor area, or other entity or sector specific quantity, by disposal method			
Total waste to landfill per patient treated ((kg general waste)/PPT)	6.58	8.60	3.86
Total waste to offsite treatment per patient treated ((kg offsite treatment)/PPT)	0.11	0.12	0.11
Total waste recycled and reused per patient treated ((kg recycled and reused)/PPT)	0.87	0.71	0.66
WR4 Recycling rate (%)			
Weight of recyclable and organic materials (kg)	13,043.68	10,122.65	9,966.76
Weight of total waste (kg)	113,643.81	134,973.00	69,490.67
Recycling rate (%)	**11.48%**	**7.50%**	**14.34%**

WR5 Greenhouse gas emissions associated with waste disposal (t CO2-e)			
t CO2-e	130.72	162.24	77.32
GREENHOUSE GAS EMISSIONS	**Jul-25 to Jun-26**	**Jul-24 to Jun-25**	**Jul-23 to Jun-24**
G1 Total Scope 1 (direct) greenhouse gas emissions (t CO2-e)			
Carbon Dioxide	107.68	87.52	87.73
Methane	0.33	0.25	0.20
Nitrous Oxide	0.37	0.31	0.32
Total	**108.39**	**88.08**	**88.25**
Scope 1 GHG emissions from stationary fuel (F2 Scope 1) (t CO2-e)	**100.56**	**74.32**	**58.21**
Scope 1 GHG emissions from vehicle fleet (T3 Scope 1) (t CO2-e)	**7.82**	**13.76**	**30.04**
Medical/Refrigerant gases			
Total Scope 1 (direct) greenhouse gas emissions (t CO2-e)	**108.39**	**88.08**	**88.25**
G2 Total Scope 2 (indirect electricity) greenhouse gas emissions (t CO2-e)			
Electricity	765.10	696.91	741.74
Total Scope 2 (indirect electricity) greenhouse gas emissions (t CO2-e)	**765.10**	**696.91**	**741.74**
G3 Total Scope 3 (other indirect) greenhouse gas emissions associated with commercial air travel and waste disposal (t CO2-e)			
Commercial air travel			
Waste emissions (WR5)	130.72	162.24	77.32
Indirect emissions from Stationary Energy	137.42	119.42	110.98
Indirect emissions from Transport Energy	1.96	3.45	7.56
Paper emissions			
Water emissions	19.84	28.88	19.13
Any other Scope 3 emissions	0.00	0.00	0.00
Total Scope 3 greenhouse gas emissions (t CO2-e)	**289.94**	**313.99**	**214.99**
G(Opt) Net greenhouse gas emissions (t CO2-e)			
Gross greenhouse gas emissions (G1 + G2 + G3) (t CO2-e)	**1,163.43**	**1,098.98**	**1,044.99**
Total gross reported greenhouse gas emissions per bed-day (t CO2-e/OBD)	0.09	0.08	0.08
Carbon Neutral Electricity	0.00	0.00	0.00
Green Power Electricity	0.00	0.00	0.00
Purchased LGCs	-892.38	0.00	0.00

Any Reduction Measures Offsets purchased (EL4-related)	**-869.01**		
Any Offsets purchased	**-869.01**		
Net greenhouse gas emissions (t CO2-e)	**294.42**	**1,098.98**	**1,044.99**
NORMALISATION FACTORS	**Jul-25 to Jun-26**	**Jul-24 to Jun-25**	**Jul-23 to Jun-24**
1000km (Corporate)			
1000km (Non-emergency)			
Aged Care OBD	10,748.00	10,774.00	10,871.00
ED Departures	0.00	0.00	0.00
FTE	113.00	109.00	103.00
LOS	2,902.00	2,488.00	2,859.00
OBD	13,650.00	13,262.00	13,730.00
PPT	15,030.00	14,331.00	14,988.00
Separations	1,380.00	1,069.00	1,258.00
TotalAreaM2	5,374.00	5,374.00	5,374.00
NOTE: Indicators are not reported where data is unavailable or an indicator is not relevant to the organisation's operations			

ATTESTATIONS

Financial Management Compliance

I, Andrew Jeffreys, on behalf of the Responsible body, certify that Kerang District Health has no Material Compliance Deficiency with respect to the applicable Standing Directions under the Financial Management Act 1994 and Instructions.



Andrew Jeffreys, Board Chair, Kerang District Health, 30th June 2026

Data Integrity

I, Kellie Byron-Gray, certify that Kerang District Health has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. Kerang District Health has critically reviewed these controls and processes during the year.



Kellie Byron-Gray, Chief Executive Officer, Kerang District Health, 30th June 2026

Conflict of Interest

I, Kellie Byron-Gray, certify that Kerang District Health 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 Kerang District Health and members of the board, and all declared conflicts have been addressed and are being managed. Conflict of interest is a standard agenda item for declaration and documenting at each executive board meeting.



Kellie Byron-Gray, Chief Executive Officer, Kerang District Health, 30th June 2026

Integrity, Fraud and Corruption

I, Kellie Byron-Gray, certify that Kerang District Health has put in place appropriate internal controls and processes to ensure that Integrity, fraud and corruption risks have been reviewed and addressed at Kerang District Health during the year.



Kellie Byron-Gray, Chief Executive Officer, Kerang District Health, 30th June 2026

Compliance with Health Share Victoria (HSV) Purchasing Policies

I, Kellie Byron-Gray, certify that Kerang District Health is fully compliant with respect to the HSV Purchasing Policies as required by the Health Services Act 1988 (Vic). Kerang District Health has implemented appropriate internal controls, which have been critically reviewed throughout the year.



Kellie Byron-Gray, Chief Executive Officer, Kerang District Health, 30th June 2026

DISCLOSURE INDEX

The Annual Report of Kerang District Health 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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Declaration

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FINANCIAL

STATEMENTS

For the year ended

30th June 2026

Kerang District Health

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

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

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

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

We authorise the attached financial statements for issue on Monday, 28th September 2026

Board member	**Accountable Officer**	**Chief Finance & Accounting Officer**
		
Andrew Jeffreys	Kellie Byron-Gray	Cherie Bailey
Board Chair	Chief Executive Officer	Chief Finance and Accounting Officer
Kerang	Kerang	Kerang
28 September 2026	28 September 2026	28 September 2026

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Kerang District Health

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
30 September 2026

Simone Bohan
as delegate for the Auditor-General of Victoria

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

	Note	2026 $	2025 $
Revenue and income from transactions			
Revenue from contracts with customers	2.1(a)	5,136,466	4,369,788
Government Grants	2.1(b)	15,596,377	16,833,120
Other sources of income	2.1(c)	2,178,345	1,406,255
Total revenue and income from transactions		**22,911,188**	**22,609,163**
Expenses from transactions			
Employee expenses	3.1(a)	15,660,418	14,664,526
Supplies and consumables	3.1(c)	611,467	385,393
Depreciation	4.1(a,b)	2,921,470	2,782,211
Other operating expenses	3.1(d)	5,187,436	3,923,180
Total Expenses from transactions		**24,380,791**	**21,755,310**
Net result from transactions - net operating balance		**(1,469,603)**	**853,853**
Other economic flows included in net result			
Net gain on sale of non financial assets		12,868	62,356
Net gain/(loss) on financial instruments		(48,057)	2,630
Other gain/(loss) from other economic flows		184,180	121,875
Total other economic flows included in net result		**148,991**	**186,861**
Net result for the year		**(1,320,612)**	**1,040,714**
Other economic flows - other comprehensive income			
		-	-
Total other comprehensive income		**-**	**-**
Comprehensive result for the year		**(1,320,612)**	**1,040,714**

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

Kerang District Health
Balance Sheet
As at 30 June 2026

	Note	2026 $	2025 $
Financial Assets			
Cash and cash equivalents	6.2	9,737,951	9,372,409
Receivables and Contract assets	5.1	2,621,210	2,695,805
Total financial assets		**12,359,161**	**12,068,214**
Non-financial assets			
Prepayments		44,363	50,014
Inventories		85,334	87,190
Property, plant and equipment	4.1(a,b)	70,414,303	71,141,438
Total non-financial assets		**70,544,000**	**71,278,642**
Total assets		**82,903,161**	**83,346,856**
Liabilities			
Payables	5.2	1,884,056	1,923,436
Borrowings	6.1	764,027	909,125
Employee benefits	3.1(b)	3,665,288	3,845,855
Monies held in trust	5.3	6,155,863	4,913,901
Total liabilities		**12,469,234**	**11,592,318**
Net assets		**70,433,927**	**71,754,539**
Equity			
Revaluation surplus	SCE	50,173,357	50,173,357
Restricted specific purpose reserve	SCE	105,000	105,000
Contributed capital	SCE	19,456,003	19,456,003
Accumulated surplus	SCE	699,567	2,020,179
Total equity		**70,433,927**	**71,754,539**

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

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

	Property, Plant and Equipment Revaluation Surplus	Restricted Specific Purpose Reserve	Contributed Capital	Accumulated Surplus	Total
	$	$	$	$	$
Balance at 1 July 2024	**50,173,357**	**105,000**	**19,456,003**	**979,465**	**70,713,825**
Net result for the year	-	-	-	1,040,714	1,040,714
Balance at 30 June 2025	**50,173,357**	**105,000**	**19,456,003**	**2,020,179**	**71,754,539**
Net result for the year	-	-	-	(1,320,612)	(1,320,612)
Balance at 30 June 2026	**50,173,357**	**105,000**	**19,456,003**	**699,567**	**70,433,927**

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

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

	Note	2026 $	2025 $
Cash Flows from operating activities			
Receipts from Government		16,566,418	17,769,337
Patient and resident fees received		3,271,808	2,816,927
Donations and bequests received		16,070	15,070
Interest and investment income received		375,220	372,292
Other receipts received		1,262,587	762,619
Total receipts		**21,492,104**	**21,736,245**
Employee expenses		(13,027,537)	(12,654,267)
Non salary labour costs		(2,769,004)	(2,134,764)
Payments for supplies and consumables		(1,532,388)	(686,064)
Other payments		(2,807,566)	(1,374,865)
GST received from/(paid to) ATO		33,148	(39,052)
Total payments		**(20,103,347)**	**(16,889,012)**
Net cash flows from/(used in) operating activities		**1,388,758**	**4,847,233**
Cash Flows from investing activities			
Purchase of non-financial assets		(2,276,410)	(4,068,025)
Proceeds from sale of property, plant and equipment		11,231	62,356
Net cash flows from/(used in) investing activities		**(2,265,179)**	**(4,005,669)**
Cash flows from financing activities			
Repayment of borrowings		-	(27,119)
Repayment of accommodation deposits		(1,586,824)	(785,633)
Receipt of accommodation deposits		2,828,787	2,287,999
Net cash flows from/(used in) financing activities		**1,241,963**	**1,475,247**
Net increase/(decrease) in cash and cash equivalents held		**365,542**	**2,316,809**
Cash and cash equivalents at beginning of year		9,372,409	7,055,600
Cash and cash equivalents at end of year	6.2	**9,737,951**	**9,372,409**

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

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 Kerang District Health for the year ended 30 June 2026.

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

This section explains the basis of preparing the financial statements.

Note 1.1: Basis of preparation

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

These general purpose financial statements have been prepared in accordance with the *Financial Management Act 1994* (FMA) 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 Kerang District Health.
The financial statements have been prepared on a going concern basis (refer to Note 1.4 Economic Dependency).

The financial statements are in Australian dollars.

The amounts presented in the financial statements have been rounded to the nearest dollar. 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 Kerang District Health on Monday, 28th September 2026.

Note 1.2: Material accounting estimates and judgements

Management make estimates and judgements when preparing the financial statements.

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

Revisions to key 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 Kerang District Health.

Its principal address is:

Burgoyne Street
Kerang, Victoria 3579

Note 1.4 Economic dependency

Kerang District Health is a public health service governed and managed in accordance with the *Health Services Act 1988* and its results form part of the Victorian General Government consolidated financial position. Kerang District Health 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 Kerang District Health operations and on that basis, the financial statements have been prepared on a going concern basis.

Note 2: Funding delivery of our services

Kerang District Health's overall objective is to provide quality health services in the right setting by dedicated people with and for our community, as well as improve the quality of life to Victorians. Kerang District Health predominantly receives income (grants) for the provision of health service outputs. Kerang District Health also receives income from the supply of services.

Significant judgement – Grants revenue

Kerang District Health has determined that funding received under the Commonwealth Home Support Program (CHSP) is within the scope of AASB 15 as the funding agreement is legally enforceable and contains sufficiently specific performance obligations. The agreement requires the delivery of specified home support services over a defined period and includes acquittal and reporting requirements, enabling revenue to be recognised as the services are provided.

Structure:

2.1 Revenue and income from transactions

Note 2.1 Revenue and income from transactions

	Note	2026 $	2025 $
Revenue from contracts with customers	2.1(a)	5,136,466	4,369,788
Government grants	2.1(b)	15,596,377	16,833,120
Other sources of income	2.1(c)	2,178,345	1,406,255
Total revenue and income from transactions		**22,911,188**	**22,609,163**

Note 2.1(a) Revenue from contracts with customers

	2026 $	2025 $
Revenue from contracts with customers		
Government grants (State) - Operating	72,855	84,278
Government grants (Commonwealth) - Operating	897,186	851,939
Patient and resident fees	1,463,997	1,239,202
Private practice fees	2,031,184	1,695,137
Commercial activities	671,244	499,232
Total revenue from contracts with customers	**5,136,466**	**4,369,788**

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

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

Government grant	Performance obligation
Commonwealth Residential Aged Care Grants	Funding is provided for the provision of care for aged care residents within facilities at Kerang District Health. 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 facilities.

Patient and resident fees

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

Note 2.1(b) Government grants

	Note	2026 $	2025 $
Government grants (State) - Operating		10,095,928	9,656,628
Government grants (Commonwealth) - Operating		4,002,604	3,836,309
Government grants (State) - Capital		1,497,845	3,340,183
Total Government grants		**15,596,377**	**16,833,120**

How we recognise Government grants

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

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

- contributions by owners, in accordance with AASB 1004 *Contributions*
- revenue or contract liability arising from a contract with a customer, in accordance with AASB 15
- a lease liability in accordance with AASB 16 *Leases*
- a financial instrument, in accordance with AASB 9 *Financial Instruments*
- a provision, in accordance with AASB 137 *Provisions, Contingent Liabilities and Contingent Assets.*

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

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

Non-cash contributions from the Department of Health

The DH makes some payments on behalf of Kerang District Health as follows:

Key judgements and estimates	Description
Victorian Managed Insurance Authority	The Department of Health purchases non-medical indemnity insurance for Kerang District Health which is paid directly to the Victorian Managed Insurance Authority. To record this contribution, such payments are recognised as income with a matching expense in the net result from transactions.
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

	2026 $	2025 $
Non-cash contributions by Department of Health	96,851	59,278
Other capital purpose income	270,500	101,994
Other revenue from operating activities (inc. non-capital donations)	1,435,774	872,691
Interest	375,220	372,292
Total other sources of income	**2,178,345**	**1,406,255**

Note 3: The cost of delivering our services

This section provides an account of the expenses incurred by Kerang District Health in delivering services and outputs. In Section 2, the funds that enable the provision of services were disclosed and in this note the cost associated with 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 $	2025 $
Employee expenses	3.1(a)	15,660,418	14,664,526
Supplies and consumables	3.1(c)	611,467	385,393
Other operating expenses	3.1(d)	5,187,436	3,923,180
Total expenses incurred in the delivery of services		**21,459,321**	**18,973,099**

Note 3.1(a) Employee Expenses

	2026 $	2025 $
Salaries and wages	11,481,777	11,299,907
Defined contribution/benefit superannuation expense	1,409,637	1,229,855
Agency expenses	961,998	859,506
Fee for service medical officer expenses	1,807,006	1,275,258
Total	**15,660,418**	**14,664,526**

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 $	2025 $
Current provisions for employee benefits		
Accrued days off	26,439	21,676
Annual leave	1,452,246	1,576,700
Long service leave	1,486,441	1,512,194
Provisions for on-costs	381,631	411,839
Total current employee benefits and related on-costs	**3,346,757**	**3,522,409**
Non-current provisions for employee benefits		
Long service leave	282,931	284,523
Provisions for on-costs	35,600	38,923
Total non-current provisions for employee benefits	**318,531**	**323,446**
Total provisions for employee benefits	**3,665,288**	**3,845,855**

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 Kerang District Health does not have an unconditional right to defer settlement of these liabilities.

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

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

Long service leave

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

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

Note 3.1(b) Employee-related provisions continued

The components of this current LSL liability are measured at:

- nominal value – if Kerang District Health expects to wholly settle within 12 months; or
- present value – if Kerang District Health does not expect to wholly settle within 12 months.

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

Provisions

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

Note 3.1(c) Supplies and consumables

	2026 $	2025 $
Drug supplies	67,202	51,763
Medical and surgical supplies (including Prostheses)	356,699	221,783
Diagnostic and radiology supplies	116,770	73,536
Other supplies and consumables	70,796	38,311
Total supplies and consumables	**611,467**	**385,393**

How we recognise supplies and consumables

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

Note 3.1(d) Other operating expenses

	Note	2026 $	2025 $
Food supplies		309,285	295,145
Low value lease expenses		47,164	45,677
Fuel, light, power and water		332,348	342,216
Domestic charges & linen		332,024	301,005
Repairs and maintenance		387,046	275,600
Maintenance contracts		2,338,753	1,560,804
Motor vehicle expenses		48,074	41,944
Medical indemnity insurance		128,597	101,683
Other administrative expenses		1,264,145	959,106
Total other operating expenses		**5,187,436**	**3,923,180**

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.

The following lease payments are recognised on a straight-line basis:

- low value leases – leases with the underlying asset's fair value (when new, regardless of the age of the asset being leased) is no more than $10,000.

Other operating expenses

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

The DoH also makes certain payments on behalf of Kerang District Health. These amounts have been brought to account as grants 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

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

Significant judgement – Fair value measurement

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

Structure:

- ***4.1 Property, plant & equipment***
- ***4.2 Depreciation***

Note 4.1 Property, plant and equipment

	Gross carrying amount		Accumulated depreciation		Net carrying amount	
	2026	2025	2026	2025	2026	2025
	$	$	$	$	$	$
Land at fair value	1,365,000	1,365,000	-	-	1,365,000	1,365,000
Buildings at fair value	69,884,922	67,022,500	(4,957,303)	(2,457,903)	64,927,619	64,564,597
Works in progress at cost	1,300,680	2,780,152	-	-	1,300,680	2,780,152
Plant, equipment at fair value	1,427,174	1,382,770	(1,108,367)	(1,050,828)	318,807	331,942
Motor vehicles at fair value	747,834	829,910	(366,370)	(315,329)	381,465	514,581
Medical equipment at fair value	2,946,470	2,577,243	(1,520,556)	(1,355,344)	1,425,914	1,221,899
Non Medical equipment at fair value	856,067	796,655	(661,807)	(583,294)	194,260	213,361
Furniture and fittings at fair value	680,941	288,392	(180,383)	(138,486)	500,558	149,906
Total property, plant and equipment	**79,209,088**	**77,042,622**	**(8,794,786)**	**(5,901,184)**	**70,414,303**	**71,141,438**

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) Reconciliations of the carrying amounts of each class of asset

	Land	Buildings	Works in progress	Plant & equipment	Motor vehicles	Medical Equipment	Non Medical Equipment	Furniture & Fittings	Total
	$	$	$	$	$	$	$	$	$
Balance at 30 June 2025	**1,365,000**	**64,564,597**	**2,780,152**	**331,942**	**514,582**	**1,221,899**	**213,361**	**149,906**	**71,141,438**
Additions	-	-	1,867,623	44,405	26,032	245,841	61,669	30,839	2,276,410
Disposals	-	-	-	-	(82,074)	-	-	-	(82,074)
Net Transfers between classes	-	2,862,422	(3,347,095)	-	-	122,963	-	361,710	-
Depreciation	-	(2,499,400)	-	(57,540)	(77,074)	(164,789)	(80,770)	(41,897)	(2,921,470)
Balance at 30 June 2026	**1,365,000**	**64,927,619**	**1,300,680**	**318,807**	**381,466**	**1,425,914**	**194,260**	**500,558**	**70,414,303**

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

Note 4.1(b) Right-of-use assets included in property, plant and equipment

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

	Gross carrying amount		Accumulated depreciation		Net carrying amount	
	2026	2025	2026	2025	2026	2025
	$	$	$	$	$	$
Buildings	418,500	418,500	(92,900)	(46,385)	325,600	372,115
Plant, equipment and vehicles	553,030	635,104	(171,565)	(120,525)	381,465	514,579
Total right-of-use assets	**971,530**	**1,053,604**	**(264,465)**	**(166,910)**	**707,065**	**886,694**

Reconciliations of the carrying amounts of each class of asset

	Buildings	Plant, equipment and vehicles	Total
	$	$	$
Balance at 1 July 2025 [(1)]	**372,115**	**514,579**	**886,694**
Additions	-	-	-
Disposals	-	(82,074)	(82,074)
Depreciation	(46,514)	(51,040)	(97,554)
Balance at 30 June 2026	**325,600**	**381,465**	**707,065**

(1) As a result of a change in FRD 104 Leases effective for reporting periods from 30 June 2026, right-of-use assets are measured at cost for reporting period 2026. The comparative information for reporting period 2025 is not restated and is reported at the previously determined fair value. For further information, refer to Note 7.3.

Note 4.1 (b): Reconciliations of the carrying amount by class of asset (continued)

How we recognise right-of use-assets

Initial recognition

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

Unless the lease is considered a short-term lease or a lease of a low-value asset (refer to Note 6.1 for further information) the contract gives rise to a right-of-use asset and corresponding lease liability.

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

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

Subsequent measurement

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

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

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

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

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

Note 4.2 Depreciation

How we recognise depreciation

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

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

Useful lives of non-current assets

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

	2026	2025
Buildings		
- Structure Shell Building Fabric	50 years	50 years
- Site Engineering Services and Central Plant	40 years	33 years
Central Plant		
- Fit out	20 to 25 years	20 to 25 years
- Trunk Reticulated Building Systems	25 years	25 years
Plant and Equipment	4 to 25 years	4 to 25 years
Medical Equipment	7 to 10 years	4 to 10 years
Computer and Communication	4 years	2.5 to 10 years
Furniture and Fittings	10 to 20 years	4 to 20 years
Motor Vehicles	5 to 10 Years	5 to 10 Years

Note 5: Other Assets and Liabilities

This section set out those assets and liabilities that arose from Kerang District Health's operations.

Structure:

- ***5.1 Receivables***
- ***5.2 Payables and contract liabilities***
- ***5.3 Monies held in trust***

Note 5.1 Receivables

	Notes	2026 $	2025 $
Current receivables			
Contractual			
Inter hospital debtors		35,239	420,749
Trade receivables		578,226	428,564
Patient fees		491,177	267,805
Amounts receivable from governments and agencies		-	82,182
Less allowance for impairment losses of contractual receivables		(16,428)	(4,465)
Total contractual receivables		**1,088,214**	**1,194,835**
Statutory			
GST receivable		82,317	115,465
Total statutory receivables		**82,317**	**115,465**
Total current receivables		**1,170,531**	**1,310,300**
Non-current receivables			
Contractual			
Long service leave - Department of Health		1,450,679	1,385,505
Total non-current receivables		**1,450,679**	**1,385,505**
Total receivables		**2,621,210**	**2,695,805**
(i) Financial assets classified as receivables			
Total receivables		2,621,210	2,695,805
GST receivable		82,317	115,464
Total financial assets classified as receivables	7.1	**2,538,893**	**2,580,341**

Note 5.1 Receivables (continued)

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 the 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 $	2025 $
Current payables			
Trade creditors		741,182	800,624
Trade creditors - Department of Health		-	42,072
Accrued salaries and wages		516,783	448,325
Accrued expenses		248,609	181,594
Inter hospital creditors		377,482	450,823
Total payables		**1,884,056**	**1,923,436**
Total current payables		**1,884,056**	**1,923,436**
(i) Financial liabilities classified as payables (Note 7.1)			
Total payables		1,884,056	1,923,436
Total financial liabilties classified as payables	7.1	**1,884,056**	**1,923,436**

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 Kerang District Health prior to the end of the financial year that are unpaid.
- **Statutory payables**, including Goods and Services Tax (GST) payable. Statutory payables are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from contracts.

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

Note 5.3 Monies held in trust

	Note	2026 $	2025 $
Current monies held in trust			
- Accommodation Bonds		6,155,863	4,913,901
Total current monies held in trust		**6,155,863**	**4,913,901**
Total monies held in trust		**6,155,863**	**4,913,901**
*** Represented by:**			
- Cash assets	6.2	6,155,863	4,913,901
		6,155,863	**4,913,901**

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

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

Note 6: How we finance our operations

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

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

Structure:

6.1 Borrowings

6.2 Cash and cash equivalents

Note 6.1 Borrowings

	Note	2026 $	2025 $
Current borrowings			
Lease liability [(i)]	6.1(a)	290,730	172,546
Total current borrowings		**290,730**	**172,546**
Non-current borrowings			
Lease liability [(i)]	6.1(a)	473,297	736,579
Total non-current borrowings		**473,297**	**736,579**
Total borrowings	7.1	**764,027**	**909,125**

[i] Secured by the assets leased.

How we recognise borrowings

Borrowings refer to interest bearing liabilities raised from motor vehicle and medical equipment leases.

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

Note 6.1 Borrowings (continued)

Terms and conditions of borrowings

	Weighted Average Interest Rate	Maturity Dates						
		Carrying Amount	Nominal Amount	Less than 1 Month	1-3 Months	3 months - 1 Year	1-5 Years	Over 5 years
30 June 2026	**(%)**	**$**	**$**	**$**	**$**	**$**	**$**	**$**
Lease liability	3.32%	764,027	790,228	8,734	17,467	244,230	426,797	93,000
Total Financial Liabilities		**764,027**	**790,228**	**8,734**	**17,467**	**244,230**	**426,797**	**93,000**

	Weighted Average Interest Rate	Maturity Dates						
		Carrying Amount	Nominal Amount	Less than 1 Month	1-3 Months	3 months - 1 Year	1-5 Years	Over 5 years
30 June 2025	**(%)**	**$**	**$**	**$**	**$**	**$**	**$**	**$**
Lease liability	3.20%	909,125	939,167	10,014	20,028	79,546	643,579	186,000
Total Financial Liabilities		**909,125**	**939,167**	**10,014**	**20,028**	**79,546**	**643,579**	**186,000**

Note 6.1(a) Lease liabilities

Kerang District Health's lease liabilities are summarised below:

	2026 $	2025 $
Total undiscounted lease liabilities	790,228	939,167
Net lease liabilities	**790,228**	**939,167**

How we recognise lease liabilities

A lease is defined as a contract, or part of a contract, that conveys the right for Kerang District Health to use an asset for a period of time in exchange for payment.

To apply this definition, Kerang District Health ensures the contract meets the following criteria:

- the contract contains an identified asset, which is either explicitly identified in the contract or implicitly specified by being identified at the time the asset is made available to Kerang District Health and for which the supplier does not have substantive substitution rights;
- Kerang District Health has the right to obtain substantially all of the economic benefits from use of the identified asset throughout the period of use, considering its rights within the defined scope of the contract and Kerang District Health has the right to direct the use of the identified asset throughout the period of use; and
- Kerang District Health has the right to take decisions in respect of 'how and for what purpose' the asset is used throughout the period of use.

Kerang District Health's lease arrangements consist of the following:

Type of asset leased	Lease term
Leased property	9 years
Leased vehicles	3 years

Note 6.1(a) Lease liabilities (continued)

All leases are recognised on the balance sheet, with the exception of low value leases (less than $10,000 AUD) and short-term leases of less than 12 months. Kerang District Health has elected to apply the practical expedients for short-term leases and leases of low-value assets. As a result, no right-of-use asset or lease liability is recognised for these leases; rather, lease payments are recognised as an expense on a straight-line basis over the lease term, within “other operating expenses” (refer to Note 3.1c).

The following low value and short term lease payments are recognised in profit or loss:

	2026 $	2025 $
Expenses relating to leases of low-value assets	47,164	45,677
Total amounts recognised as expense	**47,164**	**45,677**

Initial measurement

The lease liabilities have been initially measured at the present value of the lease payments unpaid at the commencement date, discounted using the interest rate implicit in the lease if that rate is readily determinable or Kerang District Health's incremental borrowing rate. Our lease liability has been discounted by rates of between 1.25% and 5.25%.

Lease payments included in the measurement of the lease liability comprise the following:

- fixed payments (including in-substance fixed payments) less any lease incentive receivable;
- variable payments based on an index or rate, initially measured using the index or rate as at the commencement date;
- amounts expected to be payable under a residual value guarantee; and
- payments arising from purchase and termination options reasonably certain to be exercised.

Subsequent measurement

Subsequent to initial measurement, the liability will be reduced for payments made and increased for interest. It is remeasured to reflect any reassessment or modification, or if there are changes in the substance of fixed payments.

When the lease liability is remeasured, the corresponding adjustment is reflected in the right-of-use asset, or profit and loss if the right of use asset is already reduced to zero.

Note 6.1(a) Lease liabilities (continued)

Leases with significantly below market terms and conditions

Kerang District Health holds lease arrangements which contain significantly below-market terms and conditions, which are principally to enable the health service to further its objectives. These are commonly referred to as concessionary lease arrangements. Kerang District Health measures its concessionary lease arrangements at cost, both initially and subsequently.

The nature and terms of such lease arrangements, including Kerang District Health's dependency on such lease arrangements is described below:

Description of lease	Our dependence on lease	Nature and terms of lease
Part of the land and buildings situated at 13-15 Burgoyne Street, Kerang, Vic 3579	The leased land and buildings is used by Austin Health to conduct its pathology laboratory. Kerang District Health's dependence on this lease is considered low. The land and buildings is recognised in Kerang District Health's property, plant and equipment at cost.	Lease payments of $1.00 are required per annum. The lease was renewed in February 2024 and has a lease term of 3 years with an option to extend Austin Health must use the leased area for its permitted use only. Kerang District Health retains the risk and rewards of the land and buildings.
The land and buildings situated at 78 Victoria Street, Kerang, Vic, 3579	The leased land and buildings is used by Kerang District Health. Kerang District Health's dependence on this lease is considered low.	Lease payments of $104.00 are required per annum. The lease was renewed in May 2025 and has a lease term of 20 years. Kerang District Health must use the leased area for its permitted use only.

Note 6.2 Cash and Cash Equivalents

	Note	2026 $	2025 $
Cash on hand (excluding monies held in trust)		1,200	1,100
Cash at bank (excluding monies held in trust)		3,580,888	4,457,408
Total cash held for operations		**3,582,088**	**4,458,508**
Cash at bank (monies held in trust)		6,155,863	4,913,901
Total cash held as monies in trust		**6,155,863**	**4,913,901**
Total cash and cash equivalents	5.3	**9,737,951**	**9,372,409**

Note 7: Risks, Contingencies & Valuation Judgements

Kerang District Health is exposed to risk from its activities and outside factors. In addition, it is often necessary to make judgements and estimates associated with recognition and measurement of items in the financial statements. This section sets out financial instrument specific information, (including exposures to financial risks) as well as those items that are contingent in nature or require a higher level of judgement to be applied, which for the hospital 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 Kerang District Health's activities, certain financial assets and financial liabilities arise under statute rather than a contract (for example, taxes, fines and penalties). Such financial assets and financial liabilities do not meet the definition of financial instruments in *AASB 132 Financial Instruments: Presentation.*

30 June 2026	Note	Carrying amount $	Net gain/ (loss) $	Total interest income/ (expense) $	Fee income/ (expense) $	Impairment loss $
Financial assets at amortised cost						
Cash and cash equivalents	6.2	9,737,951	-	375,220	-	-
Receivables	5.1	2,538,893	-	-	-	(16,428)
Total financial assets [i]		**12,276,844**	**-**	**375,220**	**-**	**(16,428)**
Financial liabilities at amortised cost						
Payables	5.2	1,884,056	-	-	-	-
Borrowings	6.1	764,027	-	(23,450)	-	-
Monies held in trust	5.3	6,155,863	-	-	-	-
Total financial liabilities [i]		**8,803,946**	**-**	**(23,450)**	**-**	**-**

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

Note 7.1 Financial Instruments (continued)

30 June 2025	Note	Carrying amount $	Net gain/(loss) $	Total interest income/ (expense) $	Fee income/ (expense) $	Impairment loss $
Financial assets at amortised cost						
Cash and cash equivalents	6.2	9,372,409	-	372,292	-	-
Receivables	5.1	2,580,341	-	-	-	(4,465)
Total financial assets [i]		**11,952,749**	**-**	**372,292**	**-**	**(4,465)**
Financial liabilities at amortised cost						
Payables	5.2	1,923,436	-	-	-	-
Borrowings	6.1	909,125	-	(17,167)	-	-
Other financial liabilities - Refundable Accommodation Deposits	5.3	4,913,901	-	-	-	-
Total financial liabilities [i]		**7,746,463**	**-**	**(17,167)**	**-**	**-**

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

Note 7.1 Financial Instruments (continued)

How we categorise financial instruments

Financial assets at amortised cost

Financial assets are measured at amortised costs 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 Kerang District Health to collect the contractual cash flows; and
- the assets' contractual terms give rise to cash flows that are solely payments of principal and interests on the principle amount outstanding on specific dates.

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

Kerang District Health recognises the following assets in this category:

- cash and deposits; and
- receivables (excluding statutory receivables).

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.

Kerang District Health recognises the following liabilities in this category:

- payables (excluding statutory payables);
- borrowings (including lease liabilities); and
- 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

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

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

Note 7.1 Financial Instruments (continued)

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 fair value, amortised cost, fair value through net result and fair value through other comprehensive income when, and only when, Kerang District Health's business model for managing its financial assets has changed such that its previous model would no longer apply.

A financial liability reclassification is not permitted.

Note 7.2 Contingent Assets and Contingent Liabilities

At the date of this report the Board are not aware of any contingent assets or liabilities.

Note 7.3 Fair value determination

How we measure fair value

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

The following assets and liabilities are carried at fair value:

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

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

Valuation hierarchy

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

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

Kerang District Health determines whether transfers have occurred between levels in the hierarchy by reassessing categorisation (based on the lowest level input that is significant to the fair value measurement as a whole) at the end of each reporting period.

Kerang District Health monitors changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required. The Valuer-General Victoria (VGV) is Kerang District Health'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).

Note 7.3 Fair value determination (continued)

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

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

Non-specialised land and non-specialised buildings

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

Specialised land and specialised buildings

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

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

The market approach is also used for specialised land and specialised buildings 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 Kerang District Health, the current replacement cost method is used for the majority of specialised buildings, adjusting for the associated depreciation.

Note 7.3 Fair value determination (continued)

Vehicles

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

Furniture, fittings, plant and equipment

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

There were no changes in valuation techniques throughout the period to 30 June 2026.

Significant assumptions

Description of significant assumptions applied to fair value measurement:

Asset class	Valuation technique	Significant assumption	Range (weighted average) [(i)]
Specialised Land	Market approach	Community Service Obligations Adjustments [(ii)]	20%
Specialised Buildings	Current replacement cost approach	- Cost per square metre - Useful life	$8,217 - $10,814/m2 40 - 50 Years
Vehicles	Current replacement cost approach	- Cost per unit - Useful life	$35,000 - $43,000 ($38,900 per unit) 5 - 10 Years
Furniture, fittings, plant and equipment	Depreciated replacement cost approach	- Cost per unit - Useful life	$5,200 - $6,200 ($5,700 per unit) 4 - 25 Years

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

[(ii)] A community service obligation (CSO) of 20% was applied to the Kerang District Health's specialised land.

Note 8: Other Disclosures

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

Structure:

8.1 Responsible persons disclosures

8.2 Remuneration of executives

8.3 Related parties

8.4 Remuneration of auditors

8.5 Events occurring after the balance sheet date

8.6 Joint arrangements

Note 8.1 Responsible persons disclosures

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

	Period
The Honourable Mary Anne Thomas MP:	
Minister for Health	1 Jul 2025 - 14 Apr 2026
Minister for Ambulance Services	1 Jul 2025 - 14 Apr 2026
The Honourable Harriet Shing MP:	
Minister for Health	15 Apr 2026 - 30 Jun 2026
Minister for Ambulance Services	15 Apr 2026 - 30 Jun 2026
The Honourable Melissa Horne MP:	
Minister for Health Infrastructure	1 Jul 2025 - 30 Jun 2026
Minister for Prevention of Family Violence	15 Apr 2026 - 30 Jun 2026
The Honourable Ingrid Stitt MP:	
Minister for Mental Health	1 Jul 2025 - 30 Jun 2026
Minister for Ageing	1 Jul 2025 - 30 Jun 2026
Minister for Multicultural Affairs	1 Jul 2025 - 30 Jun 2026
The Honourable Lizzy Blandthorn MP:	
Minister for Children	1 Jul 2025 - 30 Jun 2026
Minister for Disability	1 Jul 2025 - 30 Jun 2026
Governing Boards	
A. Jeffreys (Chair of the Board)	1 Jul 2025 - 30 Jun 2026
M. Iskov	1 Jul 2025 - 30 Jun 2026
J. Norton	1 Jul 2025 - 30 Jun 2026
E. Rayment	1 Jul 2025 - 30 Jun 2026
T. Gruen	1 Jul 2025 - 30 Jun 2026
P. Fernee	1 Jul 2025 - 30 Jun 2026
R. Harrison	1 Jul 2025 - 30 Jun 2026
P. Koetsveld	1 Jul 2025 - 30 Jun 2026
L. Jungwirth	1 Jul 2025 - 23 Oct 2025
Accountable Officer	
K. Byron-Gray (Chief Executive Officer)	1 Jul 2025 - 30 Jun 2026

Note 8.1 Responsible persons (continued)

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

	Total Remuneration	
	2026	2025
Income Band	**No**	**No**
$0 - $9,999	9	9
$210,000 - $219,999	-	1
$240,000 - $249,999	1	-
Total Numbers	**10**	**10**

	2026	2025
	$	**$**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**289,050**	**255,556**

Amounts relating to Responsible Ministers are reported within the State's Annual Financial Report as disclosed in Note 8.3 Related Parties.

Note 8.2 Remuneration of executives

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

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

Total remuneration payable to executives was impacted by executive vacancies during the 2025-26 financial year, resulting in lower executive staffing levels and remuneration compared to the previous year.

Remuneration of executive officers (including Key Management Personnel disclosed in Note 8.3)	**Total Remuneration**	
	2026	**2025**
	$	**$**
Total remuneration [i]	415,294	571,276
Total number of executives	3	5
Total annualised employee equivalent [ii]	2.2	3.2

[i] The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of Kerang District Healths under *AASB 124 Related Party Disclosures* and are also reported within Note 8.3 Related Parties.

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

Note 8.3 Related parties

Kerang District Health is a wholly owned and controlled entity of the State of Victoria. Related parties of the Health Service include:

- All key management personnel (KMP) and their close family members and personal business interests;
- Cabinet ministers (where applicable) and their close family members;
- Jointly controlled operation - A member of 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

Kerang District Health received funding from the Department of Health of $10,321,746 (2025: $9,793,082) and indirect contributions of $425,125 (2025: $59,277). Balances outstanding as at 30 June 2026 are $0 owing to the Department of Health (2025: $42,072 owing to the Department of Health).

Expenses incurred by Kerang District Health in delivering services and outputs 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 Kerang District Health to hold cash (in excess of working capital) in accordance with the State of Victoria's centralised banking arrangements. All borrowings are required to be sourced from Treasury Corporation Victoria unless an exemption has been approved by the Minister for Health and the Treasurer.

Key management personnel

KMPs are those people with the authority and responsibility for planning, directing and controlling the activities of Kerang District Health, directly or indirectly.

The Board of Directors, Chief Executive Officer and the Executive Directors of Kerang District Health are deemed to be KMPs. This includes the following:

Entity	KMPs	Position Title
Kerang District Health	Andrew Jeffreys	Chair of the Board
Kerang District Health	Melissa Iskov	Board Member
Kerang District Health	Jonathan Norton	Board Member
Kerang District Health	Edward Rayment	Board Member
Kerang District Health	Tory Gruen	Board Member
Kerang District Health	Paul Fernee	Board Member
Kerang District Health	Renee Harrison	Board Member
Kerang District Health	Peter Koetsveld	Board Member
Kerang District Health	Linda Jungwirth	Board Member
Kerang District Health	Kellie Byron-Gray	CEO
Kerang District Health	Michelle Maritz	Director of Corporate Business
Kerang District Health	Katrina Sparrow	Director of Clinical Services
Kerang District Health	Cherie Bailey	Director of Finance (CFO)

Note 8.3 Related parties (continued)

	2026 $	2025 $
Compensation - KMPs [i]	**704,344**	**826,832**

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

Transactions with KMPs and other related parties

Given the breadth and depth of State government activities, related parties transact with the Victorian public sector in a manner consistent with other members of the public e.g. stamp duty and other government fees and charges. Further employment of processes within the Victorian public sector occur on terms and conditions consistent with the *Public Administration Act 2004* and Codes of Conduct and Standards issued by the Victorian Public Sector Commission. 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 Kerang District Health, 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 the Kerang District Health Board of Directors, Chief Executive Officer and Executive Directors in 2026 (2025: none).

Note 8.4 Remuneration of auditors

	2026 $	2025 $
Victorian Auditor-General's Office		
Audit of the financial statements	35,200	33,500
Total remuneration of auditors	**35,200**	**33,500**

Note 8.5 Events occurring after the balance sheet date

There are no events occurring after the Balance Sheet date.

Note 8.6 Joint arrangements

	Principal Activity	Ownership Interest 2026 %	Ownership Interest 2025 %
Loddon Mallee Rural Health Alliance	Information Technology Services	4.45	4.57

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

	2026 $	2025 $
Total revenue and income	1,182,572	812,515
Total expenses	(1,197,942)	(953,939)
Total net result	(15,370)	(141,424)
Total other economic flows	-	-
Comprehensive result for the year	**(15,370)**	**(141,424)**
Total assets	1,087,834	1,040,457
Total liabilities	(838,291)	(763,936)
Total equity	**249,543**	**276,521**

Contingent liabilities and capital commitments

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