eye&ear

Annual Report 2008 – 2009

Jack Aston was diagnosed with hearing loss at 11 months and referred to the Eye and Ear. Bilateral cochlear implants were recommended to ensure Jack's speech and language could develop optimally. ENT surgeon, Mr Robert Briggs performed the 5 hour surgery. Jack, now 22 months, understands everything his mum, Sarah says to him and is able to communicate and express himself with ease.

The Royal Victorian Eye & Ear Hospital
caring in every sense

CONTENTS

Tribute to our community
At the Eye and Ear we recognise the valuable contribution the community makes to improve our services. The Eye and Ear acknowledges the tragic loss of life in Victoria's worst bushfires in February, 2009. The Eye and Ear responded by providing emergency care to a number of Victorians who were affected and we are humbled by the resilience and fortitude of our community. We especially honour the memory of Mark Butler, a member of the Eye and Ear nursing staff who sadly lost his life in the tragedy.

The Patron of the Royal Victorian Eye and Ear Hospital is Mrs Jan de Kretser

The Royal Victorian Eye and Ear Hospital is Australia's leading provider of eye and ear health care.

The Eye and Ear approach integrates eye and ear clinical care, research and education to optimise innovation and produce the most advanced treatments for vision and hearing loss.

By sharing knowledge and expertise throughout the community, the Eye and Ear helps make world-quality eye and ear health care available to all.

BIONIC EAR TO BIONIC EYE AT THE EYE AND EAR

1978 — World's first cochlear implant performed at the Royal Victorian Eye & Ear Hospital

1982 — The first device for world-wide clinical trial was implemented at the Royal Victorian Eye & Ear Hospital

1986 — The Eye & Ear opened the world's first public hospital-based cochlear implant clinic

1990 — First paediatric implantation performed at the Eye & Ear, with ground-breaking implications for speech development in deaf children. Children can now be fitted with cochlear implants as young as two weeks of age

1994 — The cochlear implant was approved by the US Food and Drug Administration, the first multiple electrode bionic ear to be approved by a world regulatory body

1998

Comparison of Eye attendance type, by age group[1]

0-19	4.8%
20-39	14.0%
40-59	21.3%
60-79	44.5%
80 +	15.4%

Comparison of ENT attendance type, by age group[1]

0-19	17.9%
20-39	24.2%
40-59	29.3%
60-79	24.6%
80 +	4.0%

2002

Bilateral cochlear implantation is offered to deaf children after research from the Eye & Ear and the University of Melbourne showed that it produces better language and developmental outcomes

2006

30th anniversary of the first cochlear implantation

Eye and Ear retinal specialists are part of the team developing an Australian model of the bionic eye

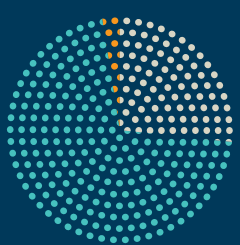
2008 – 2009

Prime Minister Kevin Rudd announced funding of $50.7 million over four years to support the development of an advanced bionic eye

2013

1st prototype bionic eye expected

The Eye & Ear will be the location for the implantation of the first advanced bionic eye when trials commence



Attendance types of Victorian patients by speciality[1]

ENT	27.32%
Eye	72.33%
Both	0.35%

CHAIR'S REPORT

A great invention of the twentieth century, the cochlear implant turned thirty in August, and it was one of my first tasks as Chair of the Eye and Ear to celebrate this milestone.

In the company of bionic ear founder, Professor Graeme Clark and cochlear implant recipients we acknowledged all who brought the world of hearing to the profoundly deaf.

The Eye and Ear was the site of the first cochlear implant, and today is poised to play a leading role in one of the twenty-first century's anticipated great medical advances – a bionic eye.

This year I have written to the Chair of Bionic Vision Australia, Professor Anthony Burkitt in support of the quest to develop an Australian bionic eye. I am delighted that the Eye and Ear is to be the site for the implantation of the first advanced bionic eye.

Advances in medical science and our community's increasing longevity bring increasing demand for eye and ear health care.

With Victorian government support, the Eye and Ear is conducting service planning to inform capital redevelopment. It is with confidence that we proceed to the next phase of growth and redevelopment of the Eye and Ear's services.

To support innovative models of care, this year the Board endorsed a patient focused reorganisation of the Eye and Ear's leadership and management. Clustered around our two specialities of ophthalmology and otolaryngology, our organisation offers improved avenues for clinical and management leadership.

Chief Executive Officer, Ms Ann Clark, who commenced in August, has successfully completed this reshaping of the Eye and Ear organisation and is developing business planning frameworks to guide our growth.

I thank the Chairs of our valued research partners for their support and recognition of the Eye and Ear's significant role. Our partnerships with the University of Melbourne, the Centre for Eye Research Australia and the Bionic Ear Institute provide the optimum hub for eye and ear clinical care, research and teaching.

I welcome newly appointed Managing Director of the Centre for Eye Research Australia, Professor Jonathon Crowston, leading glaucoma specialist and head of the Eye and Ear's Glaucoma unit.

I thank all Board members and advisory committees for their contribution, in particular Ms Catherine Brown, Dr Nicolas Radford, Mr Chris Randell and Ms Jill Rossouw who completed their term of service this year. We welcome new Board members Mr John Wilson, Mr Roger Greenman, Mr Andrew Porter and Ms Natalie Savin.

The Board expresses its appreciation to the Minister for Health, Hon. Daniel Andrews MP and the Department of Human Services for their support.

I sincerely thank our leadership team, clinicians and staff for their skill and resourcefulness in delivering life-changing eye and ear treatments.

It is pleasing to see the increase in community members offering their service to the Eye and Ear as trained volunteers. We were delighted Eye and Ear volunteer, Mrs Natalina Paganoni received special commendation in the inaugural 2009 Minister for Health Volunteer Awards.

I wish to thank our financial donors, and to honour the contribution of two benefactors and great Victorians who sadly passed away this year: the Honourable Peter Howson CMG and Mr Victor Smorgon AC.

The Eye and Ear continues to improve the quality of life of the Victorian community through its excellence in clinical services and research which promptly informs clinical care, teaching and training.

In accordance with the Financial Management Act 1994, I am pleased to present the Report of Operations for the Royal Victorian Eye and Ear Hospital for the year ending 30 June 2009.

Ms Jan Boxall
Chair, Board of Directors
Melbourne
3 September 2009

"It is with confidence that we proceed to the next phase of growth and redevelopment of the Eye and Ear's services."

CEO'S REPORT

It has been an exciting and fulfilling year at the Eye and Ear, with more Victorians accessing our specialist eye and ear health care service.

The implementation of initiatives to function more efficiently are enabling the Eye and Ear to be more responsive to the needs of patients. Clinicians continue to integrate world-quality research and teaching into their clinical care to prevent and treat vision and hearing impairment. With an emphasis on early intervention, the Eye and Ear has increased access to services in the community and continues to play an important role in meeting Victorian elective surgery waiting list objectives.

Alongside this work, the Eye and Ear has undertaken extensive work to reshape its future in order to better respond to the needs of Victorians. A major focus of my first year as CEO has been to establish five service based divisions. This reorganisation is delivering a patient-centred model of care bringing improved patient outcomes, providing clinical leadership and ensuring that Directorates achieve performance goals within agreed targets. Importantly, we have increased our emphasis on forward planning and innovation.

The Eye and Ear achieved excellent results in the Australian Council on Healthcare Standards assessment in December, gaining seven commendations for exemplary performance in patient assessment, care delivery in partnership with patients, consent processes, discharge processes, health records management and documentation, infection control management and incident and complaint management. Congratulations to staff who have achieved these outstanding results.

From a centralised hub at East Melbourne, the Eye and Ear provides State-wide specialist eye and ear health services in partnership with Victorian hospitals. Several initiatives this year are extending specialist eye and ENT care throughout the community:

- During the year, as part of the Victorian government's multi-million dollar HealthSMART initiative, the Eye and Ear continued its lead agency role in implementing the Cerner Clinical systems.
- In partnership with Western District Health, the Eye and Ear trialled a new tele-ophthalmology service with Hamilton Hospital, to extend specialist care to regional Victorians.
- In partnership with Yarra Ranges Health, the Eye and Ear commenced day surgery at the new Lilydale super clinic facility in February. This provides access to specialised eye services for patients in the outer eastern metropolitan growth corridor.
- The Community Eye Care Partnership, with funding support from the Victorian and Australian governments, benefits patients who require monitoring rather than treatment and enables them to be seen at regular intervals by community eye care practitioners in locations closer to the patient's home.
- The Eye and Ear trains all of Victoria's ophthalmologists and most of Victoria's ENT surgeons and in 2009, we commenced a specialist eye service at Canberra Hospital.
- The Eye and Ear signed a Memorandum of Association with Alice Springs Hospital to provide a coordinated ENT service to the Central Australia region.

The Eye and Ear continues to lead in the field of cochlear implantation. In the last thirty years, cochlear implants have provided more than 1,000 severely and profoundly deaf Victorians with enhanced hearing ability, giving them increased social independence and improved quality of life.

The Eye and Ear has been selected to host the 2010 meeting of the World Association of Eye Hospitals and this will further facilitate the sharing of expertise internationally between centres of excellence.

Bionics expertise developed through cochlear implantation is now being used in world class research to produce a 'bionic eye'. When the first clinical trials of the bionic eye are conducted in Australia at the Eye and Ear, Victorians will be some of the first in the world to benefit.

Ann Clark
Chief Executive Officer
Melbourne
3 September 2009

"From its hub at East Melbourne, the Eye and Ear provides State-wide specialist eye and ear health services in partnership with Victorian hospitals."

eye and ear to the world

The first Cochlear Implant occurred at the Royal Victorian Eye and Ear Hospital in 1978 and the technology is one of Victoria's most successful exports. Today there are cochlear implant clinics in 78 countries.

Argentina, Armenia, Australia, Austria, Belgium, Bolivia, Bosnia, Brazil, Bulgaria, Canada, Chile, China, Colombia, Costa Rica, Croatia, Czech Republic, Denmark, Dominican Republic, Ecuador, Estonia, Egypt, Finland, France, Germany, Greece, Guatemala, Herzegovina, Hungary, Iceland, India, Indonesia, Iran, Ireland, Italy, Israel, Japan, Jordan, Korea, Kuwait, Latvia, Lithuania, Lebanon, Malaysia, Mexico, Montenegro, Morocco, Nepal, Netherlands, New Zealand, Pakistan, Panama, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Romania, Russian Federation, Saudi Arabia, Serbia, Singapore, Slovakia, Slovenia, Spain, South Africa, Sweden, Switzerland, Syrian Arab Republic, Thailand, Tunisia, Turkey, Ukraine, United Arab Emirates, United Kingdom, United States, Uruguay, Venezuela.

The Royal Victorian Eye and Ear Hospital is a member of:

World Association of Eye Hospitals
- Tun Hussein On National Eye Hospital, Kuala Lumpur, Malaysia
- The Department of Ophthalmology of the University Hospital Leuven, Belgium
- Singapore National Eye Centre
- Moorfields Eye Hospital, London, UK
- Royal Victorian Eye and Ear Hospital
- Rutnin Eye Hospital, Bangkok, Thailand
- St Erik Eye Hospital, Stockholm, Sweden
- The Rotterdam Eye Hospital, Netherlands

European Association of Eye Hospitals
- 37 Military Hospital, Ghana
- VISSUM Instituto Oftalmologico de Alicante, Spain
- Department of Ophthalmology, University of Helsinki, Finland
- Royal Victorian Eye and Ear Hospital
- The Department of Ophthalmology of the University Hospital Leuven, Belgium
- Singapore National Eye Centre
- Moorfields Eye Hospital, London, UK
- St Erik Eye Hospital, Stockholm, Sweden
- The Rotterdam Eye Hospital, Netherlands

American Association of Eye and Ear Hospitals
- Bascom Palmer Eye Institute, Florida, USA
- Callahan Eye Foundation Hospital, Alabama
- Manhattan Eye, Ear and Throat Hospital, USA
- Massachusetts Eye and Ear Infirmary, Massachusetts, USA
- Moorfields Eye Hospital, London, UK
- New York Eye and Ear Infirmary, USA
- Phillips Eye Institute, Minnesota, USA
- Rotterdam Eye Hospital
- Royal Victorian Eye and Ear Hospital
- St. Erik's Eye Hospital, Stockholm, Sweden
- Wills Eye Hospital, Pennsylvania, USA
- Wilmer Eye Institute, Maryland, USA

Eye and ENT (ear, nose and throat) fellowships and registrar placements at the Eye and Ear Hospital are sought from around the globe. In the last 10 years ophthalmology and otolaryngology fellows and registrars from 22 countries have studied at the Eye and Ear.

Australia, Canada, China, Denmark, Germany, India, Iran, Ireland, Israel, Japan, Mexico, Netherlands, New Zealand, Nigeria, Papua New Guinea, Philippines, Singapore, South Africa, Switzerland, Thailand, United Kingdom, United States.

Eye and Ear registrars offer specialist care in Victoria, NSW, ACT and Tasmania.

- Royal Victorian Eye and Ear Hospital – East Melbourne
- Royal Melbourne Hospital – Parkville
- Alfred Hospital – Prahran
- Western Hospital – Sunshine and Footscray
- Northern Hospital – Epping
- Austin Hospital – Heidelberg
- Southern Health – Cranbourne, Dandenong, Clayton
- Geelong Hospital
- Ballarat Hospital
- Albury Eye Clinic
- Albury Base Hospital
- Launceston General Hospital
- Canberra Hospital
- Wodonga Hospital
- Royal Children's Hospital – Parkville

Through the Community Eye Care Partnership, the Eye and Ear shares care with general practitioners and optometrists.

Mill Park, Bairnsdale, East Keilor, Springvale, Traralgon and The Victorian College of Optometry at Carlton, Doveton, Braybrook, and Broadmeadows.

The Eye and Ear Hospital operates from a central hub at East Melbourne, with spoke services located at:

Yarra Ranges Health, Lilydale, Broadmeadows Health Service and Taralye Oral Language Centre, Blackburn. The Eye and Ear also delivers cochlear care services at the Royal Children's Hospital, Parkville.

advancing eye health

The Eye and Ear is saving sight. Each year, we undertake 90% of Victoria's specialist eye surgery, and deliver eye care to around 80,000 people through specialist outpatient clinics.

The Eye and Ear is helping to detect, prevent and cure the leading causes of blindness and vision impairment – age related macular degeneration, glaucoma, diabetes related eye disease, cataract and refractive error.

Age-related macular degeneration (AMD) affects one in seven people over the age of 50. AMD is a degenerative condition, affecting central vision. As close and distance vision is impaired, activities such as reading and driving can be virtually impossible.

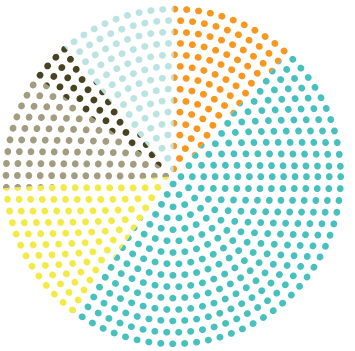
The first clinical trial for the Lucentis treatment for AMD was conducted at the Eye and Ear in 2004. With treatment proven and widely available since 2007, demand is growing and now thousands of Australians have access to this vision-saving treatment.

The Lucentis treatment inhibits the proliferation of the abnormal blood vessels leaking into the retina and causing vision loss. The results have revolutionised the outcomes for patients, with close to 25% of patients with AMD experiencing an improvement in vision.

This year, the Eye and Ear established two purpose built treatment rooms where patients receive their regular Lucentis intravitreal injection and have their vision monitored by our specialist, multi-disciplinary team.

In 2004 vision disorders cost Australia $9.85 billion. The cost is predicted to more than double by 2020

PROFESSOR ROBYN GUYMER AND PATIENT MR ALBERT RAESIDE



Main conditions causing blindness which are preventable or treatable[2]

Cataract	12%
Macular Degeneration	48%
Glaucoma	14%
Diabetic & Other Retinal Disease	11%
Refractive Error	4%
Not Treatable or Preventable	11%

Eye and Ear patients may soon benefit from a trial using the latest retinal laser treatment to restore vision lost through AMD.

Eye patients with a high risk of early AMD are currently being recruited for a trial to determine if a novel laser treatment can slow progression of the disease to vision loss.

The retinal laser, designed in Australia by Ellex Medical Lasers, can emit very short pulses, over nanoseconds, to the retina. The treatment induces a small pulse which causes a reaction and clears debris from the retina, potentially reducing the risk of lost vision.

Significantly, the Eye and Ear is the first in the world to use this novel laser for high risk early AMD.

Identifying genetic and lifestyle risks for AMD.

Together with research partner Centre for Eye Research Australia, the Eye and Ear is seeking to better understand the role of genetic and lifestyle factors to develop a means of early detection and new treatments to prevent, and even cure AMD.

Identifying modifiable risks has enormous implications for public health.

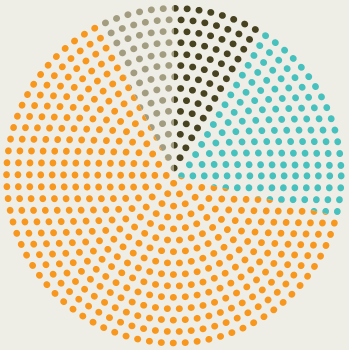
Links between AMD and cholesterol pathway genes are the focus of Professor Guymer's three year statins trial which is nearing completion. Results are expected in 2010. If long term use of statins (cholesterol lowering drugs) is found to have a protective effect, it will be a feasible treatment to adopt to delay the progression of AMD.

The anti-inflammatory actions of statins may also be relevant to AMD, and samples taken from Eye and Ear patients participating in trials are tested for inflammatory and other biomarkers.

A study of the association between red meat and chicken consumption positively associated a higher red meat intake with early AMD. Undertaken by a team of researchers from Centre for Eye Research Australia, including Dr Elaine Chong who undertook her PhD in this work, the findings suggest that intakes of specific meats may have different effects on the risk of AMD.

Dr Chong's study proposed that a high level of meat consumption may be a novel risk factor for early AMD, or it may act as a marker for people with an increased risk from other lifestyle factors.

advancing glaucoma care



Visual impairment from glaucoma by age (est. 2010)[3]

60-69	9%
70-79	20%
80-89	64%
90+	7%

Improved early detection and diagnosis of the sometimes subtle signs of glaucoma are being achieved through multi-disciplinary approaches to care, improving professional practice and utilising online learning tools to share Eye and Ear expertise throughout the community.

The Eye and Ear continues to develop multi-disciplinary expertise in the management of the diagnosis and treatment of glaucoma–a disease which causes damage to the fine nerves connecting the eye to the brain. Untreated glaucoma can lead to blindness.

In a dedicated glaucoma monitoring clinic, patients whose condition has stabilised benefit from regular monitoring of their condition. A team, led by a consultant ophthalmologist and comprising orthoptists, optometrists and ophthalmic nurses share their knowledge and expertise so that all aspects of living with glaucoma can be addressed. This approach is enabling the Eye and Ear to respond to increasing demand.

Glaucoma causes no discomfort, and as vision is initially lost from the side, it is estimated that half of those affected are unaware they have the disease. Glaucoma can be diagnosed by testing the pressure of the eye, but half the people tested do not initially present with raised eye pressure. This makes the condition difficult to detect.

The Eye and Ear, in partnership with the Centre for Eye Research Australia has developed the world's first internet educational tool in glaucoma diagnosis – the optic disc examination. Developed by Professor Jonathan Crowston and Dr Michael Coote, this interactive test can be accessed conveniently online.

The Glaucomatous Optic Neuropathy Evaluation (GONE) project tests recognition of the more subtle signs of glaucoma. In a series of 42 photographs of optic discs, practitioners are asked to describe many of the characteristics, and to determine whether glaucoma is present. The program then identifies characteristics of the nerve missed in diagnosis.

Tailored teaching packages are being developed to address specific learning needs, and over 600 eye care providers have already completed the test.

Glaucoma affects 1 in 10 Australians, but half of those affected are unaware that they have the condition.

LEFT TO RIGHT: OPTOMETRIST LEANNE NGUYEN, ASSOCIATE PROFESSOR ZORAN GEORGIEVSKI, NURSE TRACEY HO AND OPHTHALMOLOGIST DR CATHY GREEN

DR MICHAEL COOTE AND PATIENT MRS LORRAINE MOXON

SHARED EYE CARE IN THE COMMUNITY

The Eye and Ear has developed a new model of shared eye care in the community, partnering with thirteen community based optometrists and general practitioners to focus on improving care for patients, closer to home.

With Victorian and Australian government funding support, the project focuses on preventing the major causes of vision loss: diabetic related eye disease, age related macular degeneration (AMD) and glaucoma.

In this innovative national pilot project, patients invited to participate may have a risk of developing a chronic condition, or have a stable or mild eye condition which can be managed safely and effectively by community-based practitioners.

Importantly, because patients are seen regularly in the appropriate setting, any developments in their condition can be identified at the earliest possible time. If the eye condition progresses the patient can be referred to the Eye and Ear Hospital.

Individualised web-learning packages have been developed by Eye and Ear eye specialists, and through regular forums, community practitioners explore and share learnings, discussing eye diseases, diagnosis and forms of treatment. All participating practitioners are now certified to monitor diabetic eye disease, AMD and glaucoma.

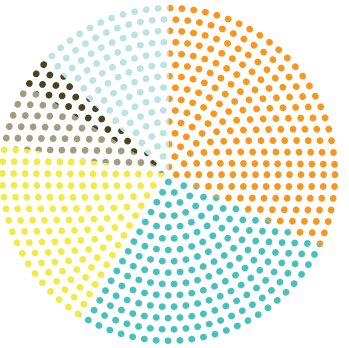
In recognition of the potential for this model of care to be widely adopted, the Victorian Department of Human Services has committed additional funding to enable the project to move to the sustainability phase. The project has potential to be adopted nationally.

advancing keratoconus treatment

Keratoconus is a debilitating condition which currently affects around 50,000 Australians. Many of them are adolescents.

ORTHOPTIST TONY NG AND PATIENT DR KATHERINE ARMOUR

DR CHRISTINE WITTIG-SILVA AND PATIENT DR KATHERINE ARMOUR



Indications for Corneal Transplantation

Keratoconus	32%
Bullous keratopathy	27%
Failed graft	19%
Dystrophies	6%
Scars	3%
Other	13%

Keratoconus is a debilitating condition which currently affects around 50,000 Australians. Many of them are adolescents.

The Eye and Ear, in partnership with Centre for Eye Research Australia, has been conducting the first clinical trial of corneal cross-linking technology (CXL), led by Dr Christine Wittig-Silva and Associate Professor Grant Snibson.

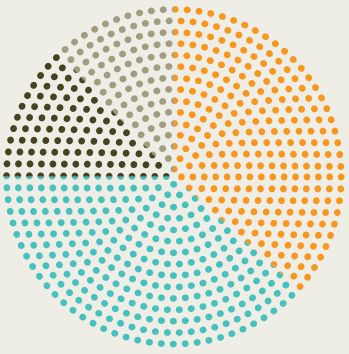
Recruitment of 100 participants was completed this year. The randomised controlled trial is designed to evaluate and investigate the efficacy and safety of the treatment over a prolonged period. Primary results are already promising, with the condition stabilising after twelve months, and even improving in some cases.

These encouraging early observations have brought an increased demand to make CXL treatment more widely available and further trials are in preparation.

Keratoconus causes a generally bilateral progressive thinning and steepening of the cornea, the eye's outermost focussing system. Early symptoms of blurred and distorted vision can progress to significant vision impairment. In its early stages, it is commonly treated with glasses or rigid contact lenses, while more severe cases often require a corneal transplant. Keratoconus is the most common reason for corneal transplants in Australia.

Keratoconus corneas are weaker than normal and it is widely believed that there are some connections of fibres missing which would normally hold them in place. Corneal collagen cross-linking involves treating underlying corneal structural weakness using a chemical reaction similar to the hardening of tooth fillings and polymers. To trigger this process in the cornea, the cornea is saturated with Vitamin B2 (Riboflavin). Exposure to a defined dose of UVA light (370nm wavelength) excites the vitamin molecules which then promote the linking of the collagen fibres. The enhanced number of connections, or cross-links, firms and stabilises the cornea.

If current promising results can be maintained and confirmed, the researchers believe that the treatment will substantially benefit those living with the condition, and reduce the need for corneal transplants for patients with keratoconus. The equipment required for this one hour-long procedure is also easily transportable and this has positive implications for patients in rural and remote locations of Australia.



Prevalence of hearing loss in children under 15 years[4]

Mild	36.7%
Moderate	38.3%
Severe	13.3%
Profound	11.7%

advancing ear health

In 2005 hearing loss cost Australia $11.75 billion. The prevalence of hearing loss is estimated to double by 2050, from 1 in 6 to 1 in 3.

The Royal Victorian Eye and Ear Hospital is committed to preserving, restoring and even creating hearing, to improve the lives of hearing impaired children and adults.

Eye and Ear surgeons and researchers, together with our partners at the University of Melbourne are working towards preserving inner ear function during and after surgery and learning more to prevent and treat sudden loss of inner ear function.

At the Eye and Ear, patients participate in clinical ENT and hearing trials, with resulting treatments a direct application of rigorous ear, nose and throat and hearing research.

The Eye and Ear, in conjunction with the University of Melbourne, performs pioneering cochlear implant research and in 2009, over 100 ENT surgeons, audiologists and speech pathologists from the Asia Pacific region participated in our internationally renowned training program.

Increasing access to cochlear support services in the community

The Eye and Ear cochlear implant clinic, the world's first, was established in 1983 in partnership with the University of Melbourne. The clinic remains the most prestigious and brings together ear, nose and throat (ENT) surgeons, audiologists and speech therapists in a centralised state-wide service to optimise hearing outcomes for profoundly deaf children and adults.

The cochlear implant system consists of the internal implant and an external speech processor which must be programmed post-surgery to make it functional. Intensive rehabilitative post-implant care is crucial to maximise the developmental outcomes for the cochlear recipient. Speech processors are generally replaced or upgraded every three to five years. A young child with a cochlear implant also requires intensive speech therapy and specialised education.

The centralised state-wide service currently in place has served Victoria well. It has enabled the development of a world-class specialist service of critical mass with a highly experienced team. However, with a 67% increase in demand in the last three years, and with demand predicted to grow by

MS DEBORAH AMOTT,
ENT REGISTRAR

another 60% in the next 5 years, we are reviewing our current service model to determine the most appropriate ways to meet the needs of children and adults into the future.

A role in developing cochlear technologies

Clinical research conducted at the Eye and Ear in conjunction with the University of Melbourne, Cochlear Limited and the HEARing CRC has ensured that the Australian designed cochlear implant, which is used in around 70% of all cochlear implant procedures, leads the world in cochlear technology. The Eye and Ear clinical research team plays a special role in the development of cochlear technology, trialling updated cochlear components, such as the new slimline implants, before they are made available to the market.

PATIENT JACK ASTON & MRS SARAH ASTON

ENT surgical precision

The delicate sinus passages form the mask of the face. With close proximity to the eyes and the brain, surgical skill for operations on the sinus is paramount.

Real time virtual/GPS capabilities empower the surgeon to know exactly how far they are from the eye and the brain at any one time. Image guided surgery accurately and vividly maps a patient's unique cranio-facial features and further complements the use of CT scans to provide surgeons with the utmost in anatomical information. The LandmarX image guided technology represents an investment in patient safety and surgical innovation for Victoria.

Improving vestibular health

Specialist ENT medical staff and allied therapists seek to better understand the workings of the inner ear and how it affects balance.

The Eye and Ear vestibular service continues to grow with the introduction of the ocular Vestibular Evoked Myogenic Potential (oVEMP) test to measure balance impairment. The oVEMP test is the very latest technology and has been made available first in Victoria at the Eye and Ear.

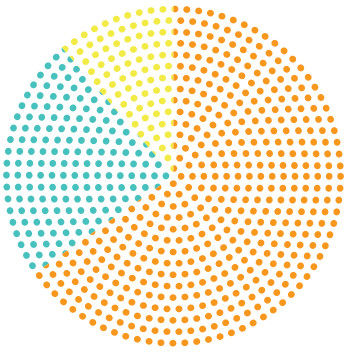
The oVEMP test measures eye muscle responses to stimulation applied through electrodes on the patient's forehead. The test causes no discomfort and clinical trials, Led by Professor Stephen O'Leary are showing it to be extremely effective. Data will be used to investigate results from groups of patients, including cochlear implant recipients, pre- and post- surgery.

The Eye and Ear is conducting clinical research to investigate the relationship between headaches, migraines and dizziness. Also under investigation are possible links between balance, glaucoma and

advanced ENT surgical techniques

Image guided ENT surgery provides surgeons with the utmost in anatomical information.

MR CHRIS BROWN,
ENT SURGEON



Hearing loss in adults by severity – 2005[4]

Mild	65.54%
Moderate	23.13%
Severe	11.33%

auditory neuropathy. Interaction of vision and hearing disciplines to enable cross-discipline study is a unique feature of the Eye and Ear.

Diagnosis of permanent hearing loss in newborn babies

In partnership with the University of Melbourne Department of Otolaryngology, the Eye and Ear is supporting research to further improve the diagnosis and treatment of hearing loss in children.

Associate Professor Gary Rance and his team are working on ways to measure hearing in newborns so that management strategies, such as fitting hearing aids, can be undertaken in the first weeks of life.

Approximately 70-100 babies are born in Victoria each year with permanent hearing loss. Early detection and intervention is vital for these children to optimise their potential for long-term speech, language, educational and social development.

In the course of this work, a previously unrecognised form of hearing loss called auditory neuropathy has been discovered in babies. Affected children show normal cochlear (inner ear) function but disrupted neural transmission in the auditory pathway. Auditory neuropathy does not necessarily affect detection of sound, but the quality of the signal reaching the brain. As such, management of this form of auditory deficit, which we now know affects around 10% of children with permanent hearing problems, is challenging and the Eye and Ear Hospital has become a tertiary referral centre for every affected child in Victoria.

Professor Rance's work is supported by the Eye and Ear through a Wagstaff Research Fellowship.

Most commonly reported long term health conditions among Aboriginal and Torres Strait Islander people in 2004-05[5]

Eye/sight	30%
Asthma	15%
Back and disc disorders	13%
Heart and circulatory diseases	12%
Ear/hearing problems	12%
Other	18%

sharing ENT expertise

Since February 2009, the Eye and Ear has been sharing its ear, nose and throat expertise further afield with communities in central Australia.

Specialist ENT teams have now made five scheduled monthly visits to Alice Springs and surrounding communities.

With a population of 28,000, Alice Springs is one of the most remote towns on earth. Up to 20% of the population is indigenous.

The Eye and Ear was approached by Alice Springs Hospital to provide a planned and co-ordinated ENT service to the region. Each month an Eye and Ear team, including ENT surgeon, theatre nurse and audiologist, visit Alice Springs for up to a week.

The Eye and Ear ENT team provides additional clinical resources and expertise, runs a consultative clinic, manages chronic ear conditions and performs specialist ear surgery such as repairing eardrums.

One patient travelled 2,000 kilometres from Warburton in Western Australia to Alice Springs for surgery by our team.

In rural and remote areas beyond Alice Springs there are many small, predominantly indigenous communities with limited access to medical care.

An exciting feature of the Eye and Ear partnership with Alice Springs Hospital is the outreach to remote communities. Recently, the Eye and Ear team visited Titjikala, a community located 120 kilometres, or 30 minutes flying time, south of Alice Springs.

Remote areas of Australia continue to have poorer health than the rest of the community. It is recognised that health services need to address barriers of distance, communication and culture to build a sustainable multidisciplinary framework to deliver regular primary health care to remote areas of Australia.

The Eye and Ear Hospital accepted the invitation from Australia's first Aboriginal ENT surgeon, Kelvin Kong to help address ENT health in remote communities.

We are using our hands on experience in Central Australia to inform proposals for improved models of ENT care for indigenous communities, locally and nationally.

An exciting feature of a new ENT partnership with Alice Springs Hospital is the outreach to remote communities.

TITJIKALA COMMUNITY, FROM THE AIR

ABOVE: ALICE SPRINGS HOSPITAL NURSE GENEVIEVE MURRAY, WITH EYE AND EAR STAFF – NURSE ELIZABETH BELL, AUDIOLOGIST BROOKE PAISLEY AND ENT SURGEON MR MICHAEL DOBSON

a future eye and ear workforce

All of Victoria's ophthalmologists and most of Victoria's ENT surgeons train at the Eye and Ear.

Specialist eye and ENT trainees can access the most advanced technologies and models of care, and these opportunities attract specialist eye and ENT trainees from Australia and around the world.

Ophthalmology and ENT registrars attend outpatient clinics and operating theatres under the supervision of a consultant. Registrars complete a rotation to hospitals and clinics throughout Victoria, and also to Launceston, Albury and Canberra. They provide essential specialist eye and ear health care, including to some communities with otherwise limited access to these services.

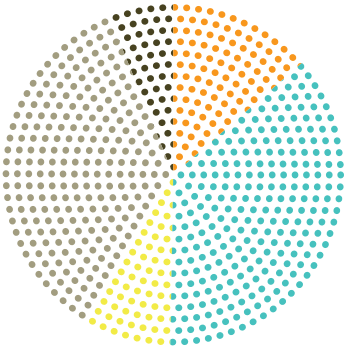
The Eye and Ear clinical school also offers undergraduate and postgraduate training and placements for general practice, emergency medicine and optometry disciplines.

Innovation in ENT surgical learning techniques

Trials of an Australian-first virtual reality surgery simulator, led by Professor Stephen O'Leary have proven successful and the surgical training tool now complements ENT training provided in the operating theatre. The surgical simulator offers anatomical and practical surgical procedural teaching and practice at low cost, building trainee confidence and at no risk to patients.

The Eye and Ear provides the optimal teaching environment dedicated exclusively to specialist eye and ENT care, integrated with research and education.

DR CHING NG,
EYE REGISTRAR



Visual impairment from diabetic retinopathy by age (est. 2010)[3]

50-59	14%
60-69	37%
70-79	8%
80-89	36%
90+	6%

The simulator allows the student to interact with a three dimensional model of the temporal bone through sight, sound and touch. The student can manipulate the model for enhanced anatomical study and practice surgery without utilising theatre resources or involving patients. Oral assessments made before and after training sessions support use of the simulator as an effective teaching tool, and it is well accepted by users of all levels of expertise.

The technology can distinguish skill levels and track improvements, and the team is working towards real-time feedback to enable students to learn effectively outside the operating theatre.

Instilling best clinical practice

In July, the Eye and Ear commenced an orthoptist-led review clinic for patients who require a twelve month review following their previous attendance at the Eye and Ear general clinics. Patients with non-acute eye conditions, particularly cataract, glaucoma and diabetic retinopathy, can be seen in the orthoptic clinic at the time advised, reducing waiting times and freeing up appointments for new patients with an ophthalmologist in the other Eye and Ear clinics.

Orthoptists assess a patient's vision status, review their medical record, and in consultation with each person, develop a suitable plan for ongoing eye care, in conjunction with the patient and their general practitioner.

The Eye and Ear, in partnership with La Trobe University is the largest provider of orthoptic clinical education in Victoria. The partnership plays a significant role in workforce development and optimising patient care, and the partnership model has extended to include St Vincent's Health and Ballarat Hospital.

DR CHING NG WITH DR EHUD ZAMIR

BOARD OF DIRECTORS

THE DIRECTORS FOR 2008/09 WERE:

Ms Jan Boxall
LLB, FAICD
Appointed 1 July 2008,
term expires 30 June 2011

Ms Boxall is an independent legal consultant, having been a partner at the national law firm, Corrs Chambers Westgarth where she advised clients in the property and infrastructure, health, statutory corporations and government sectors. She is a member of the Board of Directors of City West Water, Queen Victoria Market, and the Melbourne Wholesale Fish Market. Ms Boxall is a Fellow of the Australian Institute of Company Directors and she is the immediate past Chair of the Board of Cabrini Hospital Group.

Ms Katerina Angelopoulos
BSw, Dip Wel Studies
Appointed 28 March 2006, reappointed 1 July 2008, term expires 30 June 2011

Ms Angelopoulos is President of Merri Community Health Service which has a reputation for leadership and innovation in the area of community health. She is also represented on a number of community committees contributing to the promotion of health and wellbeing, including the local YMCA and Ethnic Communities Council. Ms Angelopoulos was recently appointed to the University of Notre Dame School of Medicine Advisory Committee.

Ms Catherine Brown
LLB, BA, Grad Dip Bus Admin, FAICD
Appointed 1 July 2000, re-appointed 1 July 2003 and 1 July 2006, term expires 30 June 2009

Ms Brown is a lawyer and management consultant with extensive experience in the fields of human services and philanthropy, including three years as Chief Executive Officer of the Brain Foundation. Ms Brown has been director of her own consulting business, Catherine Brown & Associates Pty Ltd, since 1999 and is Chair of the Queen Victorian Women's Centre Trust. Ms Brown has been a director or company secretary of a diverse group of not for profit organisations over the last 20 years. She consults to leading philanthropic foundations including the Foundation for Rural and Regional Renewal (Community Foundation Program), The Myer Foundation, The Ian Potter Foundation and ANZ Trustees.

Mr Timothy O'Leary
Welfare Officer – Family Therapy, MBA
Appointed 1 July 2003, reappointed 1 July 2006, term expires 30 June 2009

Mr O'Leary is Director and Principal Consultant with management consulting firm Strategos Australia. He has extensive experience in health and human services as chief executive officer, senior executive, program, policy and project manager and consultant in acute, community, aged and mental health, local government and education. He has been a board member and chair of a range of organisations and is currently a Director of the Victorian Healthcare Association.

Mr Ian Pollerd
B.Ed (Bus Studies), B.Ed (Administration), Grad Dip Ed Admin, Dip Crim, MAICD
Appointed 1 July 2007,
term expires 30 June 2010

Mr Pollerd has extensive experience in rural health, disability services, aged care, palliative care and family and community services. He is currently Director of a health and community services consultancy business–Eureka Solutions and is a member of the Australian Institute of Company Directors. Mr Pollerd is also a member of the Board of Governance Connections Uniting Care and the Chinese Medicine Registration Board. Mr Pollerd has been appointed as the Health Services Commissioner nominee to the Investigation Review Panel in accordance with the Health Professions Registration Act 2005.

Dr Nicolas Radford
MBBS, FRACP, FAICD
Appointed 1 July 2000, reappointed 1 July 2002 and 1 July 2005, term expires 30 June 2009

Dr Radford is a Consultant Physician at the Royal Women's Hospital. He is in private consultant practice in East Melbourne specialising in internal medicine, nephrology and obstetric medicine. Dr Radford has held office

in the Royal Australasian College of Physicians and the Australian Medical Association. He is Chairman of the Determining Authority, Commonwealth Professional Services Review.

Mr Chris Randell
BAppSc Appointed 1 July 2000, re-appointed 1 July 2002 and 1 July 2005, term expires 30 June 2009

Mr Randell is a Training Consultant for the Australian Institute of Superannuation Trustees (AIST). He is a Chair of the AIST Accreditation Committee, as well as being a member of the Policy and Professional Development Committees. Mr Randell is also a company director and fitness instructor. He was formerly the National Secretary of the Health Services Union of Australia.

Ms Jill Rossouw
BCom, MPhil (Finance), Grad Dip App Fin & Investment
Appointed 1 July 2005, reappointed 1 July 2007, resigned March 2009

Ms Rossouw is an Investment Director (Infrastructure) at Industry Funds Management. She has experience in corporate and project finance, project management and consulting, investment management, and evaluation and structuring of infrastructure investments. Ms Rossouw has previously worked for PricewaterhouseCoopers as Associate Director in its Project Finance group and for GE Capital as Manager Direct Equity Investments, in Australia.

Mr John Wilson
BCom(Hons), CA, CPA, F Fin
Appointed March 2009, term expires 30 June 2010

Mr Wilson has extensive experience in management, securities, accountancy and corporate risk. He was formerly a senior executive and Board member at Potter Warburg and from 2003 to 2005 he was the Managing Director of Tolhurst Group Limited. Mr Wilson has worked for Pricewaterhouse Coopers as a director in corporate finance and lectured in accountancy at the University of Melbourne.

Mr Mike Zafiropoulos
BAppSc, AssDip Computer Science
Appointed 1 July 2003, reappointed 1 July 2006, term expires 30 June 2009

Mr Zafiropoulos has extensive experience in the areas of community development, local government, philanthropy, arts and culture, and media. He has previously held executive positions at the Bureau of Immigration and Population Research, at the Department of Immigration and between 1995 and 2007 was the General Manager of SBS in Melbourne. Mr Zafiropoulos serves on the boards of The Lord Mayor's Charitable Foundation and the Melbourne Community Foundation and chairs Regional Arts Victoria and the Multicultural Arts Policy Advisory Committee. He is a former mayor of Fitzroy.

CHANGES TO THE BOARD SINCE 30 JUNE 2009:

Mr Roger Greenman
Appointed 1 July 2009 to 30 June 2012

Mr Roger Greenman is the immediate past Chief Executive Officer and former Board Member of Cabrini Health. He has an acute health background with considerable experience in hospital construction and redevelopment.

Mr Andrew Porter
Appointed 1 July 2009 to 30 June 2012

Mr Porter is a Chartered Accountant and has had over 17 years experience in accounting and financial management. He is currently Chief Financial Officer of the ASX-listed companies Australian Foundation Investment Company Ltd, Djerriwarrh Investments Ltd, Mirrabooka Investments Ltd and AMCIL Ltd, and is a member of the User Focus Group of the Australian Accounting Standards Board.

Ms Natalie Savin
Appointed 1 July 2009 to 30 June 2012

From 2000 until June 2009, Ms Savin was a member of the Board of Dental Health Services Victoria, and Chair from 2006. She has worked extensively in human services management within local and State government and the community sector. Ms Savin is currently the Chief Executive Officer of Arthritis Victoria.

From left to right:
Ms Jan Boxall
Mr Andrew Porter
Ms Katerina Angelopoulos
Mr Ian Pollerd
Mr John Wilson
Mr Timothy O'Leary
Ms Natalie Savin
Mr Roger Greenman
Mr Mike Zafiropoulos

BOARD OF DIRECTORS AND BOARD COMMITTEES

The Board of Directors is appointed by the Governor in Council on the recommendation of the Victorian Health Minister, and is governed by the principles contained within the Health Services Act 1988 (as amended). The Board provides governance of the Eye and Ear and is responsible for its financial performance, strategic directions, the quality of its healthcare services and strengthening community involvement through greater partnerships. Eye and Ear by-laws enable the Board to delegate certain responsibilities. The by-laws are supported by the delegations of executive and operational responsibility enabling designated executives and staff to perform their duties through the exercise of specified authority. The Board meets monthly during the year, excluding January.

FINANCE COMMITTEE

Board Membership:
Mr Chris Randell (Chair)
Ms Jan Boxall
Mr Timothy O'Leary
Ms Jill Rossouw
Mr John Wilson

The Finance Committee assists the Board to fulfil its duties relating to the financial management of the Eye and Ear and regularly advises the Board about the financial position of the Eye and Ear and major projects. It reviews the annual operating and capital budgets and makes recommendations on financial policy. The committee meets monthly and all of its members are independent.

AUDIT COMMITTEE

Board Membership:
Mr John Wilson (Chair)
Ms Jill Rossouw (Chair to March 2009)
Ms Jan Boxall
Ms Catherine Brown
Mr Chris Randell

The purpose of the Audit Committee is to ensure the integrity of financial reports and review the Eye and Ear's process for monitoring compliance with laws, regulation, internal standards, policies, best practice guidelines and expectations of relevant authorities, patients, employees and the community. During 2008/9 the Audit Committee oversaw further development of the Eye and Ear's risk management framework and processes which were independently reviewed by the Victorian Managed Insurance Authority and found to be consistent with the Australian and New Zealand standard for risk management.

INVESTMENT MANAGEMENT ADVISORY COMMITTEE

Board Membership:
Mr Chris Randell (Chair)
Ms Jan Boxall
Mr Timothy O'Leary
Ms Jill Rossouw
Mr John Wilson

The Investment Management Advisory Committee supports the Finance Committee by advising it on investment strategy and recommending arrangements for the investment of Eye and Ear funds. The committee meets quarterly.

REDEVELOPMENT COMMITTEE

Board Membership:
Ms Jan Boxall (Chair)
Ms Catherine Brown
Mr Timothy O'Leary
Mr Chris Randell
Ms Jill Rossouw
Mr John Wilson

The Redevelopment Committee provides ongoing advice to the Board on the capital redevelopment of the Eye and Ear Hospital. The committee comprises six members of the Board and meets monthly.

REMUNERATION COMMITTEE

Board Membership:
Ms Jan Boxall (Chair)
Ms Catherine Brown
Mr Chris Randell
Ms Jill Rossouw
Mr John Wilson

The Remuneration Committee comprises four members consisting of the Board Chair and Chairs of the Finance, Audit and Quality Committees. The committee recommends remuneration levels to the Board for the Chief Executive Officer.

QUALITY COMMITTEE

Board Membership:
Ms Catherine Brown (Chair)
Ms Jan Boxall
Mr Ian Pollerd
Dr Nicolas Radford

The Quality Committee meets four times a year to promote and support hospital-wide improvements in the areas of: patient outcomes measurement, patient feedback, safety and quality process improvement, risk management, patient information and involvement and effective and efficient patient flow. The committee in conjunction with the Community Advisory Committee develops the Quality of Care Report annually.

COMMUNITY ADVISORY COMMITTEE

Board Membership:
Mr Mike Zafiropoulos (Chair)
Ms Katerina Angelopoulos
Mr Ian Pollerd

The Community Advisory Committee advises the Board on consumer and community participation in development and delivery of services. The committee meets bimonthly and members are appointed for a two-year term. In 2008/2009 the committee comprised community, consumer and carer representatives. In 2008 the development and implementation of the Community Participation Plan 2009-11 commenced which aims to create a welcoming, inclusive environment to engage the community and encourage patients to be involved in their own health care.

PRIMARY CARE AND POPULATION HEALTH ADVISORY COMMITTEE

Board Membership:
Dr Nicolas Radford (Chair)
Mr Timothy O'Leary
Mr Chris Randell

The Primary Care and Population Health Advisory Committee provides advice to the Board on working with primary health services and responding to population health issues. The committee meets quarterly and in 2008/2009 membership included representatives from community groups and partner organisations. This year's highlights were the development of a Primary Care and Population Health Advisory Committee Plan and involvement in the South East Healthy Communities Partnership, Make a Move Project, in partnership with Vision Australia, Victorian College of Optometry and Vision 2020 Australia.

CULTURAL DIVERSITY COMMITTEE

Board Membership:
Ms Katerina Angelopoulos (Chair)
Mr Mike Zafiropoulos

The Cultural Diversity Committee advises the Board on the Eye and Ear's services from a culturally and linguistically diverse (CALD) perspective. The committee's role is to promote involvement from the hospital's CALD communities, help the Eye and Ear communicate with its CALD communities and advocate on behalf of CALD communities in planning how services are developed and run. The committee meets quarterly. Highlights included the development of cultural diversity intranet and internet sites and input into the translation of patient information.

EXECUTIVE MANAGEMENT

CHIEF EXECUTIVE OFFICER

Ms Ann Clark
BCom, CA, GAICD
from August 2008

Mr Graeme Houghton
to August 2008

The Chief Executive Officer is accountable to the Board for executive leadership and management to support the attainment of operational, policy, and strategic goals agreed with the Board and in accordance with the funding, planning and regulatory framework of the Victorian Government Department of Human Services.

EXECUTIVE DIRECTOR OPHTHALMOLOGY SERVICES

Ms Tanya McPharlane
acting in role from April 2009

Mr Stephen Vale
resigned April 2009

The Executive Director Ophthalmology Services is responsible for the co-ordination of ophthalmic care, specialist ophthalmology outpatients clinics and diabetes education and support services for non-inpatient services. These include interpreting, translating and transcultural functions, medical photography and imaging, orthoptics and the orthoptics clinical school, patient representation and transport, pharmacy and social work. The role is also responsible for Eye and Ear spoke services at Broadmeadows, Lilydale and the Royal Children's Hospital.

CLINICAL DIRECTOR OPHTHALMOLOGY SERVICES

Dr Michael Coote
MBBS, FRANZCO, GAICD
from February 2009

The Clinical Director Ophthalmology Services is responsible for ophthalmic clinical and medical leadership. The role advises on models of care in Ophthalmology that provide excellence and which are sustainable. The role works in close partnership with the Executive Director Ophthalmology Services, engaging with clinicians, executive and staff.

EXECUTIVE DIRECTOR ENT SERVICES AND CLINICAL SUPPORT, CHIEF NURSING OFFICER

Ms Angela Scarlett
MaHSM, BEdStudies, GradDipHealthEd, RN, RM, AssACHSE

The Executive Director ENT Services and Clinical Support is responsible for the ear, nose and throat and clinical services of the Eye and Ear including surgical services and inpatient services. As Chief Nursing Officer, the role also has professional responsibility for nursing staff.

CLINICAL DIRECTOR ENT SERVICES AND CLINICAL SUPPORT

Dr Peter J Read
MBBS(Lon), FFARCS
from February 2009

The Clinical Director ENT Services and Clinical Support provides clinical and medical leadership and advice on models of care to support clinical excellence in ear, nose and throat and surgical support services. The role works in close partnership with the Executive Director ENT and Surgical Support Services. The role maintains close communication with ENT clinicians and initiates and fosters a culture that encourages sound patient care, financial responsibility, innovation, and productivity.

EXECUTIVE DIRECTOR MEDICAL SERVICES, CHIEF MEDICAL OFFICER

Dr Elizabeth Hallam
BMedSc, MBBS, FRACP, MBA(Melb), GAICD
from March 2008

Dr Simrat Sachdev
acting in role from December 2008 to March 2009

Dr Robyn Mason
acting in role to December 2008

The Executive Director Medical Services leads the development and implementation of a central framework for clinical governance and medical administration. As Chief Medical Officer, the role requires key involvement in the recruitment and selection of senior medical staff and provides leadership in medical staff relations and clinical policy implementation.

EXECUTIVE DIRECTOR CORPORATE SERVICES, CHIEF FINANCIAL OFFICER

Mr David Gerrard
BBus (Accounting), CPA, MBA, GAICD

The Executive Director Corporate Services is responsible for the management of corporate services, financial reporting, analysis, controls, budgeting and treasury. The role provides leadership in financial and business strategies and manages the functions of human resources, contracts and engineering, information technology, marketing, media relations and fundraising.

EXECUTIVE DIRECTOR PLANNING AND INNOVATION

Ms Jenni Gratton-Vaughan
BAppSc, GradDipRehabStud, MBus
from May 2008

The Executive Director Planning and Innovation has overarching responsibility for capital redevelopment of the Eye and Ear and future strategy regarding health service delivery. The role also involves establishing and implementing a comprehensive organisation wide performance monitoring system and redesigning care principles across all systems and processes to enable efficiencies in patient care.

ORGANISATIONAL STRUCTURE

BOARD OF DIRECTORS

CHIEF EXECUTIVE OFFICER

OPHTHALMOLOGY SERVICES	ENT SERVICES AND CLINICAL SUPPORT	CLINICAL GOVERNANCE AND RESEARCH	CORPORATE SERVICES	PLANNING AND INNOVATION
• Executive Director • Clinical Director	• Executive Director and Chief Nursing Officer • Clinical Director	• Executive Director Medical Services and Chief Medical Officer	• Executive Director and Chief Financial Officer	• Executive Director
Outpatients – Administration and Bookings – Spoke Services – Diabetes Education	Inpatient	Clinical Governance – Quality and Risk	Finance	Innovation and Redesign
Medical Photography	MediHotel	Senior Medical Workforce Management	Human Resources – Occupational Health and Safety – Payroll	Organisational Performance
Orthoptics	Audiology	Junior Medical Workforce Management	Building and Engineering Services	Service Planning
Pharmacy	Speech Pathology	Community Liaison	Bio Medical Engineering	Redevelopment
Interpreting Services	Cochlear	Infection Control	Security Services	
Transport	Surgical Bookings	Research	Contracts and Procurement	
Social Work	Pre-Admission Clinic	Medical Training and Education	Marketing and Community Relations	
Eye and Ear Emergency	Perioperative Services		Information Communications Technology	
	Anaesthetics		Health Information	
	Nurse Education			

BENEFACTORS AND SUPPORTERS

The Board, management and staff of the Eye and Ear wish to thank all donors for their generosity.

The Royal Victorian Eye and Ear Hospital is especially grateful for support from members of the community, business and philanthropic trusts whose generosity affirms confidence in our ability to lead the world in eye and ENT research, training and clinical care. The unique integrated approach at the Eye and Ear provides the community with the best in eye and ear health, and investing in the Eye and Ear improves the quality of life for all Victorians.

Maintaining the highest level of eye and ear care requires continual upgrading of equipment, facilities and technology. Gifts received this year have assisted the Eye and Ear to purchase specialised equipment, to upgrade capital works for improved safety and patient support, to upgrade treatment rooms, and to initiate new research studies into eye and ear health conditions.

WAGSTAFF RESEARCH FELLOWSHIPS

With a significant bequest from Ernest Wagstaff received in 1996, the Eye and Ear established major research fellowships, in Ophthalmology and Otolaryngology. Wagstaff Fellows during 2008/09 are:

Wagstaff Fellows in Ophthalmology:
Professor Jill Keefe OAM PhD for the epidemiology of vision impairment

Dr Luba Robman for inflammatory markers of AMD progression

Wagstaff Fellows in Otolaryngology:
Associate Professor Gary Rance PhD for auditory neuropathy and hearing screening in infants

Dr Bryony Nayagam for stem cells and regeneration of the auditory nerve.

The Ronald Churches Bequest Award for research into the treatment and prevention of eye conditions recognises projects of originality and significance. In 2008, Dr Christine Wittig-Silva was the first recipient for her leadership role in the ground-breaking Keratoconus cross-linking treatment. In 2009 recipients were Dr Carmel Crock, Director of Emergency and colleagues Dr Atul Shah, Dr Anita Ng and Ms Pat Usher for their clinical study to determine the effectiveness of a point of care test to diagnose viral conjunctivitis.

VOLUNTEERS

We are grateful for the services of trained concierge volunteers, and those volunteers who perform retail and administrative duties at the Eye and Ear. To the members of former Auxiliaries throughout Victoria, we express our continued gratitude for your support over many years.

BENEFACTORS

In special honour

Hon Peter Howson CMG (1913 – 2009) is a former Chairman of the Board, whose service to the hospital was recognised by naming the Peter Howson Wing in his memory.

Mr Victor Smorgon AC (1919 – 2009) was an industrialist, innovator and philanthropist whose support of the hospital was recognised in the naming of the Smorgon Family Wing.

Major Corporate Partner
Advanced Medical Optics

Major Donors
Mr Malcolm Anderson
Mr Glen Annetts
Mr Keith Bailey
Ms Judith Balding
Mr & Mrs WR & LL Brewer
Mrs Elizabeth Donovan
Mr Z Elton
Ms Miriam Faine
Mr Brian Goddard
Mr Petar Kolakovic
Mr Laurence McLaren
Mr & Mrs B Mildenhall
Mr Robert Morsillo
Mr Rudolph Pollio
Mr Maxwell Roberts
Mr John Schotkamp
Mr Greg Shalit
Mrs Janet Stonier
Stylevibe
Mr David Walker
Ms Jill A Whitford
Mr Matthew Zanos

We thank those who included the Eye and Ear in their wills and those who have expressed their intent to support us through a bequest. Bequests were received from the following estates in 2008/09:

Estates and Bequests
Vera Clarice Adams
John Alexander Anderson
Dr Mark Ashkenasy
Erica Wareham Cromwell
Thelma Rose Davis
Alfred HW Dehnert
Helen Fleurette Finnie
Rudolph Hally & Pia Martin
Jane Loveday Hammill
William & Mary Ievers & Sons
Malcolm Stuart Johnston
Edna May Kerr
Joseph Kronheimer
Joseph & Kate Levi Charitable Trust
Martha Miranda Livingstone
Norman H McKenzie
Louise Mair
Sheila V Paxton
George T & Lockyer Potter
Bruce Leslie Powell
Frank Wilton Prewett
Maurice & Winifred Redding
Isabella M Richardson
William Hall Russell
Heather Sybil Smith
Ian S Wallace
Eliza Wallis
Ernest & Letitia Wears
Joe White
John Frederick Wright
Henry Herbert Yoffa
Nina Zyk

Trusts and Foundations
John & Thirza Daley Charitable Trust
Louis & Lesley Nelken Trust Fund

Corporate Supporters
Alcon
ANZ Trustees
Bausch & Lomb
Device Technologies
E. P. Johnson & Davies
Equity Trustees Limited
Novartis Ophthalmics
Optimed
Perpetual Trustees
Pfizer Ophthalmics
State Trustees Limited
Trust Company of Australia

Community Supporters
Banyule Support & Information Centre Inc
Blepharospasm Support Group
Box Hill Lions Club
Camcare Charity Shop
Ethnic Chinese Happy Age Association Vic Inc
Frankston Auxiliary
Giovanni & Beatrice Iacobucci
Lions Club of Karingal
Lions Club of Wantirna
Malta Star of the Sea Inc
Mornington Community Centre
Ritchies Stores
Strathmerton Lioness Club

SERVICE OVERVIEW

NATURE AND RANGE OF SERVICES PROVIDED

The Royal Victorian Eye and Ear Hospital is a Victorian teaching, training and research health service that specialises in the area of eye and ear, nose and throat (ENT) health.

The Eye and Ear has over 50 different outpatient clinics for the diagnosis, monitoring and treatment of eye and ear, nose and throat conditions. In addition, the Eye and Ear undertakes half of Victoria's public general eye surgery, up to 90 percent of specialised eye surgery and nearly all of Victoria's public cochlear implant surgery. The Eye and Ear also provides primary care to our community through a 24 hour, 7 days-a-week emergency eye and ear health service.

In addition to services provided from East Melbourne, the Hospital also provides services at Broadmeadows Health Service, Royal Childrens Hospital, Taralye Oral Language Centre and Yarra Ranges Health.

Inpatients:	13,434
Outpatients:	173,568
Emergency patients:	41,766

MANNER OF ESTABLISHMENT AND RELEVANT MINISTER

The Royal Victorian Eye and Ear Hospital was founded in 1863 by pioneering surgeon Dr Andrew Sexton Gray, and his charitable services merged with those provided by ophthalmologist, Dr Aubrey Bowen in 1870. The Royal Victorian Eye and Ear Hospital is a public health service and is established under the Health Services Act 1988. The responsible Minister during the reporting period was the Hon Daniel Andrews MP.

BUILDING AND MAINTENANCE COMPLIANCE

The Minister for Finance has issued instructions in accordance with the Building Act 1993 stating that all public entities are to ensure that buildings under their control are: safe and fit for occupation, comply with statutory requirements and are maintained to a standard where they remain fit for occupancy. The Hospital reports annually on the measures taken to comply with the provision of the Act. In February 2009, the hospital once again achieved 100% compliance with mandatory Essential Safety Measures Inspections, testing, maintenance and documentation in relation to building safety.

FREEDOM OF INFORMATION

The Victorian Freedom of Information (FOI) Act 1982 provides members of the public with the right to apply to the Royal Victorian Eye and Ear Hospital for access to information held by the Eye and Ear. The Eye and Ear provides an annual report of all FOI requests to the Victorian Department of Justice as prescribed by legislation and associated regulations. Requests for access to a medical file under the Act should be directed to:

The Freedom of Information Officer
The Royal Victorian Eye and Ear Hospital
Locked Bag 8
East Melbourne Vic 8002

Freedom of Information Applications 2008/2009:

Total requests	111
Fully granted	111
Completed	111
Fees waived	$1228.10

MERIT AND EQUITY

All appointments are made based on merit. Decisions are guided by the Hospital's Code of Conduct and supported by the Equal Opportunity Policy.

WHISTLEBLOWERS PROTECTION ACT 2001

The Royal Victorian Eye and Ear Hospital has a number of policies and procedures for employees wishing to raise complaints within or about the Hospital. These are outlined in the Hospital's Code of Conduct. There were no reports made under the Whistleblowers Protection Act 2001 this year.

STATEMENT OF COMPETITIVE NEUTRALITY

The Victorian Government's Competitive Neutrality policy commits public health services to apply this policy on all dealings. This includes the adoption of pricing principles to take account of the full cost attribution for net competitive advantages conferred by government ownership. The policy gives direction that where the Government's business activities involve it in competition with private sector business activities, the net advantages that accrue to a government business are offset.

FURTHER INFORMATION

Other relevant information in relation to the financial year is retained by the accountable officer and made available to the relevant Minister, Member of Parliament and the public on request.

For more general information on the Royal Victorian Eye and Ear Hospital, visit our website www.eyeandear.org.au.

CONSULTANCIES DISCLOSURE

Consultancies totalling $490,329 were engaged during the year, with $107,500 paid to Health IQ Pty Ltd to support the implementation of the Cerner Clinical System.

OCCUPATIONAL HEALTH AND SAFETY

The Royal Victorian Eye and Ear Hospital is committed to providing a safe environment for patients, visitors, contractors, volunteers and employees.

In 2008/2009 the hospital undertook a number of safety programs including the identification and review of hazardous materials throughout the hospital, implementation of new manual handling equipment for clinical areas and increasing the safety controls

for laser use throughout theatres and specialist outpatient clinics.

The Board and Executive continued the endorsement of health and safety projects by successfully implementing a Totally Smoke Free workplace policy. Volunteers participated in safety training and information programs, assisting staff to maintain a friendly and safe environment for all.

Support Services staff safety was improved with the implementation of new equipment including an upgrade to the loading bay area and the addition of various engineering equipment such as safe access and Lock-out Tag-out equipment.

Consultation with staff remained strong through continued support and training provided to approximately 20 health and safety representatives. Eye and Ear Hospital safety systems, emergency procedures and other safety related initiatives were audited and maintained compliance during a periodic review by the Australian Council for Healthcare Standards.

Workforce data by labour category

Labour category	June 09 [FTE]	June 08 [FTE]
Nursing	169	160
Administration and Clerical	128	124
Medical Support	45	42
Hotel and Allied Services	15	9
Medical Officers	1	2
Hospital Medical Officers	36	53
Sessional Clinicians	32	30
Ancillary Health (Allied Health)	32	26
	458	**446**

1. Full Time Equivalent

VICTORIAN GOVERNMENT RISK MANAGEMENT FRAMEWORK ATTESTATION

I, Ann Clark, certify that the Royal Victorian Eye and Ear Hospital has risk management processes in place consistent with the *Australian/New Zealand Risk Management Standard* and an internal control system is in place that enables the executive to understand, manage and satisfactorily control risk exposures. The Board verifies this assurance and that the risk profile of the Royal Victorian Eye and Ear Hospital has been critically reviewed within the last 12 months.

Ann Clark
Accountable Officer
Melbourne
3 September 2009

ATTESTATION ON DATA ACCURACY

I, Ann Clark, certify that the Royal Victorian Eye and Ear Hospital has put in place appropriate internal controls and processes to ensure that the Department of Human Services is provided with data that reflects actual performance. The Royal Victorian Eye and Ear Hospital has critically reviewed these controls and processes during the year.

Ann Clark
Accountable Officer
Melbourne
3 September 2009

SERVICE ACTIVITY AND EFFICIENCY MEASURES

For the year ended 30 June 2009

Elective Surgery

	2009	2008
Elective Surgery admissions	**11,514**	**11,717**
Elective Surgery Performance		
Category 1 - proportion of patients admitted within 30 days (%)	100	100
Category 2 - proportion of patients admitted within 90 days (%)	97.5	100
Category 3 - proportion of patients admitted within 365 days (%)	99	100
Number of patients on the elective surgery waiting list	3,391	2,905
Number of Hospital Initiated postponements (HIPs) per 100 scheduled admissions	4.7	3.4

Service Performance

	2009	2008
Admitted Patients		
Separations		
Same Day	9,157	9,321
Multi Day	4,277	4,180
Total Separations	**13,434**	**13,501**
Emergency	1,734	1,678
Elective	11,700	11,823
Total Separations	**13,434**	**13,501**
Total WIES	**9,697**	**9,909**
WIES performance to target (%)	**1.04**	**1.03**
Total Bed Days	**16,038**	**16,860**
Non Admitted Patients		
Emergency Department presentations	41,766	40,998
Outpatients services - Occasions of service (VACS and Non VACS clinics)	173,568	173,739
Total Occasions of Service	**215,334**	**214,737**
Victorian Ambulatory Classification System (Number of encounters)	83,894	81,122

SUMMARY OF FINANCIAL RESULTS

For the year 30 June, 2009 compared with last 4 financial years

	2009* $000's	2008* $'000	2007* $'000	2006* $'000	2005* $'000
Total Revenue	**73,662**	**72,517**	**66,209**	**65,777**	**60,487**
Total Expenses	(78,489)	(71,970)	(63,606)	(60,671)	(56,082)
Operating Surplus / (Deficit)	**(4,827)**	**547**	**2,603**	**5,106**	**4,405**
Retained Surplus / (Accumulated Deficit)	(2,848)	(1,790)	(355)	1,202	(2,196)
Total Assets	181,909	133,167	131,752	121,064	111,576
Total Liabilities	(18,563)	(15,748)	(14,150)	(11,453)	(12,418)
Net Assets	**163,346**	**117,419**	**117,602**	**109,611**	**99,158**
Total Equity	**163,346**	**117,419**	**117,602**	**109,611**	**99,158**

* Prepared in accordance with Australian Accounting Standards which include A-IFRS

SIGNIFICANT CHANGES IN FINANCIAL POSITION DURING 2008/09

There were no significant changes in financial position during 2008/09.

Summary of Major Changes or Factors, which have Affected the Achievement of the Operational Objectives for the Year.
There were no major changes or factors, which affected the achievement of the Hospital's operational objectives during 2008/09.

Events Subsequent to Balance Date, which may have a Significant Effect on the Operations of the Entity in Subsequent Years.
There have been no events subsequent to balance date effecting the operations of the Hospital.

REVENUE INDICATORS

For the year ended 30 June 2009

Average Collection Days

	2009	2008
Private	34.40	43.03
Transport Accident Commission	n/a	n/a
Victorian WorkCover Authority	62.81	37.38
Other Compensable	26.84	48.00

n/a = not applicable

Inpatient Debtors Outstanding as at 30 June, 2009

	Under 30 Days $'000	31-60 days $'000	61-90 days $'000	Over 90 days $'000	Total 30/06/09 $'000	Total 30/06/08 $'000
Private	192	10	3	6	211	372
Transport Accident Commission	0	0	0	0	0	0
Victorian WorkCover Authority	20	4	0	0	24	29
Other Compensable	7	2	2	0	11	4

FINANCIAL ANALYSIS OF OPERATING REVENUE AND EXPENSES

	2009 $'000	2008 $'000
REVENUE		
Services supported by Health Service Agreement		
Government Grants	57,745	54,322
Indirect contributions by Human Services	1,154	1,369
Patient Fees	4,079	3,248
Other Revenue	2,971	2,437
	65,949	**61,376**
Services supported by Hospital and Community Initiatives		
Government Grants	1,304	713
Donations and Bequests	1,456	3,233
Investment Income	2,942	5,365
Property Income	235	225
Other Revenue	1,776	1,605
	7,713	**11,141**
TOTAL REVENUE FROM ORDINARY ACTIVITIES	**73,662**	**72,517**
EXPENSES FROM ORDINARY ACTIVITIES		
Services supported by Health Service Agreement		
Salaries and Related Expenses	41,709	39,630
Supplies and Consumables	14,938	12,610
Other	10,359	10,570
	67,006	**62,810**
Services supported by Hospital and Community Initiatives		
Salaries and Related Expenses	1,175	1,928
Supplies and Consumables	190	183
Other	10,118	7,049
	11,483	**9,160**
TOTAL EXPENSES FROM ORDINARY ACTIVITIES	**78,489**	**71,970**
NET RESULT FROM ORDINARY ACTIVITIES	**(4,827)**	**547**
Extraordinary Items	0	0
NET RESULT FOR THE YEAR	**(4,827)**	**547**

financial statements

OPERATING STATEMENT

For the year ended 30 June 2009

	Note	2009 $'000	2008 $'000
Revenue from Operating Activities	2	68,930	66,323
Revenue from Non-operating Activities	2	832	1,432
Employee Benefits	3	(41,866)	(40,666)
Non Salary Labour Costs	3	(714)	(674)
Supplies and Consumables	3	(15,128)	(12,793)
Other Expenses From Continuing Operations	3	(11,755)	(11,285)
Net Result Before Capital & Specific Items		**299**	**2,337**
Capital Purpose Income	2	3,900	4,762
Depreciation and Amortisation	4	(2,863)	(2,817)
Impairment of Financial Assets	3c	(5,548)	(3,512)
Expenditure using Capital Purpose Income	3	(615)	(223)
NET RESULT FOR THE YEAR	**17c**	**(4,827)**	**547**

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

BALANCE SHEET

As at 30 June 2009

	Note	2009 $'000	2008 $'000
Current Assets			
Cash and Cash Equivalents	6	6,990	5,490
Receivables	7	1,007	973
Other Financial Assets	8	3,000	3,000
Inventories	9	887	1,179
Other Current Assets	10	201	300
Total Current Assets		**12,085**	**10,942**
Non-Current Assets			
Receivables	7	198	258
Other Financial Assets	8	53,773	56,792
Property, Plant & Equipment	11	114,786	64,344
Intangible Assets	12	427	191
Investment Properties	13	640	640
Total Non-Current Assets		**169,824**	**122,225**
TOTAL ASSETS		**181,909**	**133,167**
Current Liabilities			
Payables	14	4,657	5,090
Employee Benefits and Related On-Costs Provisions	15	10,925	9,918
Other Liabilities	16	2,768	467
Total Current Liabilities		**18,350**	**15,475**
Non-Current Liabilities			
Employee Benefits and Related On-Costs Provisions	15	213	273
Total Non-Current Liabilities		**213**	**273**
TOTAL LIABILITIES		**18,563**	**15,748**
NET ASSETS		**163,346**	**117,419**
EQUITY			
Property, Plant & Equipment Revaluation Reserve	17a	62,462	11,708
General Purpose Reserve	17a	35,978	37,218
Restricted Specific Purpose Reserve	17a	16,186	18,713
Contributed Capital	17b	51,568	51,568
Accumulated Surpluses/(Deficits)	17c	(2,848)	(1,788)
TOTAL EQUITY	**17d**	**163,346**	**117,419**
Contingent Liabilities and Contingent Assets	21		
Commitments for Expenditure	20		

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

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2009

	Note	2009 $'000	2008 $'000
Total equity at beginning of financial year		**117,419**	**117,602**
Effects of changes in accounting policy		–	–
Restated total equity at beginning of financial year		**117,419**	**117,602**
Gain/(loss) on Asset Revaluation of Land and Buildings taken to equity	17a	50,754	–
Gain/(Loss) on Revaluation of Financial Assets taken to equity	17a	–	(1,258)
NET INCOME RECOGNISED DIRECTLY IN EQUITY		**50,754**	**(1,258)**
Net result for the year		(4,827)	547
TOTAL RECOGNISED INCOME AND EXPENSE FOR THE YEAR		**45,927**	**(711)**
Transactions with the State in its capacity as owner	17b	–	528
TOTAL EQUITY AT THE END OF THE FINANCIAL YEAR		**163,346**	**117,419**

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

CASH FLOW STATEMENT

For the year ended 30 June 2009

	Note	2009 $'000	2008 $'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		61,243	55,751
Patient and Resident Fees Received		3,871	3,128
Private Practice Fees Received		1,216	1,552
Donations and Bequests Received		1,028	2,667
GST Received from/(paid to) ATO		2,348	1,853
Realised Investment Returns		–	1,206
Property Rental Received		198	248
Other Receipts		4,331	3,970
Employee Benefits Paid		(42,066)	(41,303)
Payments for Supplies and Consumables		(29,628)	(24,966)
Other Payments		–	(209)
Cash Generated from Operations		**2,541**	**3,897**
Capital Grants from Government		1,157	664
Realised Investment Returns		2,963	4,257
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	18	**6,661**	**8,818**
CASH FLOWS FROM INVESTING ACTIVITIES			
Net (Purchase) / Redemption of Investments		(2,529)	(2,896)
Payments for Property, Plant and Equipment		(2,632)	(2,212)
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES		**(5,161)**	**(5,108)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Contributed Capital from Government		–	528
NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES		**–**	**528**
NET INCREASE/(DECREASE) IN CASH HELD		**1,500**	**4,238**
CASH AND CASH EQUIVALENTS AT BEGINNING OF PERIOD		5,490	1,252
CASH AND CASH EQUIVALENTS AT END OF PERIOD	6	**6,990**	**5,490**

This Statement should be read in conjunction with the accompanying notes

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the year ended 30 June 2009

Contents

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the year ended 30 June 2009

Note 1: Statement of Significant Accounting Policies

(a) Statement of Compliance

The financial report is a general purpose financial report which has been prepared on an accrual basis in accordance with the *Financial Management Act* 1994, applicable Australian Accounting Standards (AASs) and Australian Accounting Interpretation.

AASs includes Australian equivalents to International Financial Reporting Standards.

The entity is a not-for-profit entity and therefore applies the additional Aus paragraphs applicable to "not-for-profit" entities under the AASs.

(b) Basis of Preparation

The financial report is prepared in accordance with the historical cost convention, except for the revaluation of certain non-financial assets and financial instruments, as noted. Cost is based on the fair values of the consideration given in exchange for assets.

In the application of AASs management is required to make judgments, estimates and assumptions about carrying values of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgments. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision, and future periods if the revision affects both current and future periods.

Accounting policies are selected and applied in a manner which ensures that 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 accounting policies set out below have been applied in preparing the financial report for the year ended 30 June 2009, and the comparative information presented in these financial statements for the year ended 30 June 2008.

(c) Reporting Entity

The financial report includes all the controlled activities of The Royal Victorian Eye & Ear Hospital ("the hospital").

(d) Rounding Of Amounts

All amounts shown in the financial report are expressed to the nearest $1,000 unless otherwise stated.

(e) Cash and Cash Equivalents

Cash and cash equivalents comprise cash on hand and cash at bank, deposits at call and highly liquid investments with an original maturity of 3 months or less, which are readily convertible to known amounts of cash and are subject to insignificant risk of changes in value.

(f) Receivables

Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition. Collectability of debts is reviewed on an ongoing basis, and debts which are known to be uncollectible are written off. A provision for doubtful debts is raised where doubt as to collection exists. Bad debts are written off when identified.

Receivables are recognised initially at fair value and subsequently measured at amortised cost, using the effective interest rate method, less any accumulated impairment.

(g) Inventories

Inventories include goods and other property held either for sale or for distribution at no or nominal cost in the ordinary course of business operations.

Inventories held for distribution are measured at cost, adjusted for any loss of service potential. All other inventories are measured at the lower of cost and net realisable value.

Bases used in assessing loss of service potential for inventories held for distribution include current replacement cost and technical or functional obsolescence. Technical obsolescence occurs when an item still functions for some or all of the tasks it was originally acquired to do, but no longer matches existing technologies. Functional obsolescence occurs when an item no longer functions the way it did when it was first acquired.

Cost for all other inventory is measured on the basis of weighted average cost.

Inventories acquired for no cost or nominal considerations are measured at current replacement cost at the date of acquisition.

Note 1: Statement of Significant Accounting Policies (continued)

(h) Other Financial Assets

Other financial assets are recognised and derecognised on trade date where purchase or sale of an investment is under a contract whose terms require delivery of the investment within the timeframe established by the market concerned, and are initially measured at fair value, net of transaction costs.

The Royal Victorian Eye & Ear Hospital classifies its other financial assets between current and non-current assets based on the purpose for which the assets were acquired. Management determines the classification of its other financial assets at initial recognition.

The Royal Victorian Eye & Ear Hospital assesses at each balance sheet date whether a financial asset or group of financial assets is impaired

Available-for-sale financial assets
All of the other financial assets held by the hospital are classified as being available-for-sale and are stated at fair value. Gains and losses arising from changes in fair value are recognised directly in equity until the investment is disposed of or is determined to be impaired, at which time the cumulative gain or loss previously recognised in equity is included in profit or loss for the period. Fair value is determined in the manner described in Note 3c.

(i) Intangible Assets

Intangible assets represent identifiable non-monetary assets without physical substance such as patents, trademarks, computer software and development costs (where applicable).

Intangible assets are initially recognised at cost. Subsequently, intangible assets with finite useful lives are carried at cost less accumulated amortisation and accumulated impairment losses. Costs incurred subsequent to initial acquisition are capitalised when it is expected that additional future economic benefits will flow to the hospital.

Amortisation is allocated to intangible assets with finite useful lives on a systematic (typically straight-line) basis over the asset's useful life. Amortisation begins when the asset is available for use, that is, when it is in the location and condition necessary for it to be capable of operating in the manner intended by management. The amortisation period and the amortisation method for an intangible asset with a finite useful life are reviewed at least at the end of each annual reporting period. In addition, an assessment is made at each reporting date to determine whether there are indicators that the intangible asset concerned is impaired. If so, the assets concerned are tested as to whether their carrying value exceeds their recoverable amount.

Intangible assets with finite useful lives are amortised over a 3 to 10 year period (2008: 3 to 10 years).

(j) Property, Plant and Equipment

Crown Land is measured at fair value with regard to the property's highest and best use after due consideration is made for any legal or constructive restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset. Theoretical opportunities that may be available in relation to the asset(s) are not taken into account until it is virtually certain that any restrictions will no longer apply.

Land and Buildings are recognised initially at cost and subsequently measured at fair value less accumulated depreciation and impairment.

Plant, Equipment and Vehicles are recognised initially at cost and subsequently measured at fair value less accumulated depreciation and impairment.

(k) Revaluations of Non-current Physical Assets

Non-current physical assets measured at fair value are revalued in accordance with FRD 103D. This revaluation process normally occurs every five years, based upon the asset's Government Purpose Classification, but may occur more frequently if fair value assessments indicate material changes in values. Revaluation increments or decrements arise from differences between an asset's carrying value and fair value.

Revaluation increments are credited directly to the asset revaluation reserve, except that, to the extent that an increment reverses a revaluation decrement in respect of that class of asset previously recognised at an expense in net result, the increment is recognised as income in the net result.

Revaluation decrements are recognised immediately as expenses in the net result, except that, to the extent that a credit balance exists in the asset revaluation reserve in respect of the same class of assets, they are debited directly to the asset revaluation reserve.

Revaluation increases and revaluation decreases relating to individual assets within an asset class are offset against one another within that class but are not offset in respect of assets in different classes.

Revaluation reserves are not transferred to accumulated funds on derecognition of the relevant asset.

In accordance with FRD 103D, the Royal Victorian Eye and Ear Hospital's non-current physical assets were subjected to a detailed valuation in the current financial year.

Note 1: Statement of Significant Accounting Policies (continued)

(l) Investment Property

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

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

Subsequent to initial recognition at cost, investment properties are revalued to fair value with changes in the fair value recognised as income or expenses in the period that they arise. The properties are not depreciated.

Rental revenue from the leasing of investment properties is recognised in the Operating Statement in the periods in which it is receivable, as this represents the pattern of service rendered through the provision of the properties.

(m) Depreciation and Amortisation

Assets with a cost in excess of $1,000 (2007-8 and 2008-9) are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives using the straight-line method. Estimates of the remaining useful lives and depreciation method for all assets are reviewed at least annually. This depreciation charge is not funded by the Department of Human Services (DHS).

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

	2009	2008
Buildings	Up to 40 Years	Up to 40 Years
Plant & Equipment	From 5 to 20 Years	From 5 to 20 Years
Medical Equipment	From 3 to 10 Years	From 3 to 10 Years
Computers & Communications	From 3 to 10 Years	From 3 to 10 Years
Furniture & fittings	From 3 to 15 Years	From 3 to 15 Years
Motor vehicles	From 4 Years	From 4 Years

(n) Net Gain/(Loss) on Non-Financial Assets

Net gain/(loss) on non-financial assets includes realised and unrealised gains and losses from revaluations, impairments and disposals of all physical assets and intangible assets.

Disposal of Non-Financial Assets
Any gain or loss on the sale of non-financial assets is recognised at the date that control of the asset is passed to the buyer and is determined after deducting from the proceeds the carrying value of the asset at that time.

Impairment of Non-Financial Assets
Intangible assets with indefinite useful lives (and intangible assets not yet available for use) are tested annually for impairment (i.e. as to whether their carrying value exceeds their recoverable amount, and so require write-downs) and whenever there is an indication that the asset may be impaired. All of the hospital's other assets are assessed annually for indications of impairment, except for:

- inventories;
- financial assets; and
- investment property that is measured at fair value

If there is an indication of impairment, the assets concerned are tested as to whether their carrying value exceeds their possible recoverable amount. Where an asset's carrying value exceeds its recoverable amount, the difference is written-off as an expense except to the extent that the write-down can be debited to an asset revaluation reserve amount applicable to that class of asset.

It is deemed that, in the event of the loss of an asset, the future economic benefits arising from the use of the asset will be replaced unless a specific decision to the contrary has been made. The recoverable amount for most assets is measured at the higher of depreciated replacement cost and fair value less costs to sell. Recoverable amount for assets held primarily to generate net cash inflows is measured at the higher of the present value of future cash flows expected to be obtained from the asset and fair value less costs to sell.

(o) Net Gain/(Loss) on Financial Instruments

Net gain/(loss) on financial instruments includes realised and unrealised gains and losses from revaluations of financial instruments that are designated at fair value through profit or loss or held-for-trading, impairment and reversal of impairment for financial instruments at amortised cost, and disposals of financial assets.

Revaluations of Financial Instruments at Fair Value
The revaluation gain/(loss) on financial instruments at fair value excludes dividends or interest earned on financial assets, which is reported as part of income from transactions.

Impairment of Financial Instruments
Bad and doubtful debts are assessed on a regular basis. Those bad debts considered as written off are classified as an expense.

Note 1: Statement of Significant Accounting Policies (continued)

Financial Assets have been assessed for impairment in accordance with Australian Accounting Standards. Where a financial asset's fair value at balance date has reduced by 20 per cent or more than its cost price; or where its fair value has been less than its cost price for a period of 12 or more months, the financial instrument is treated as impaired.

In order to determine an appropriate fair value as at 30 June 2009 for its portfolio of financial assets, the hospital obtained a valuation based on the best available advice using a fair value based on market value through a reputable financial institution. This value was compared against valuation methodologies provided by the issuer as at 30 June 2009. These methodologies were critiqued and considered to be consistent with standard market valuation techniques.

Prices obtained from both sources were compared and were generally consistent with the full portfolio. The above valuation process was used to quantify the level of impairment on the portfolio of financial assets as at year end.

(p) Payables

These amounts consist predominantly of liabilities for goods and services.

Payables are initially recognised at fair value, then subsequently carried at amortised cost and represent liabilities for goods and services provided to the hospital prior to the end of the financial year that are unpaid, and arise when the hospital becomes obliged to make future payments in respect of the purchase of these goods and services.

The normal credit terms are usually Net 30 days.

(q) Provisions

Provisions are recognised when the hospital has a present obligation, the future sacrifice of economic benefits is probable, and the amount of the provision can be measured reliably.

The amount recognised as a provision is the best estimate of the consideration required to settle the present obligation at reporting date, taking into account the risks and uncertainties surrounding the obligation. Where a provision is measured using the cash flows estimated to settle the present obligation, its carrying amount is the present value of those cash flows.

(r) Functional and Presentation Currency

The presentation currency of the hospital is the Australian dollar, which has also been identified as the functional currency of the hospital.

(s) Goods and Services Tax (GST)

Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the taxation authority. In this case it is recognised as part of the cost of acquisition of the asset or as part of the expense.

Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the taxation authority is included with other receivables or payables in the Balance Sheet.

Cash flows are presented on a gross basis. The GST components of cash flows arising from investing or financing activities which are recoverable from, or payable to the taxation authority, are presented as operating cash flow.

Commitments are presented on a gross basis.

(t) Employee Benefits

Wages and Salaries, Annual Leave, Sick Leave and Accrued Days Off
Liabilities for wages and salaries, including non-monetary benefits, annual leave, accumulating sick leave and accrued days off expected to be settled within 12 months of the reporting date are recognised in the provision for employee benefits in respect of employee's services up to the reporting date, classified as current liabilities and measured at nominal values.

Those liabilities that the hospital does not expect to be settled within 12 months are recognised in the provision for employee benefits as current liabilities, measured at present value of the amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

Long Service Leave (LSL)
Current Liability – unconditional LSL (representing 10 or more years of continuous service) is disclosed as a current liability even where the hospital does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months.

The components of this current LSL liability are measured at:
- present value – component that the hospital does not expect to settle within 12 months; and
- nominal value – component that the hospital expects to settle within 12 months.

Note 1: Statement of Significant Accounting Policies (continued)

Non-Current Liability – conditional LSL (representing less than 10 years of continuous service) is disclosed as a non-current liability. There is an unconditional right to defer the settlement of the entitlement until the employee has completed the requisite years of service. Conditional LSL is required to be measured at present value.

Consideration is given to expected future wage and salary levels, experience of employee departures and periods of service. Expected future payments are discounted using interest rates of Commonwealth Government guaranteed securities in Australia.

Superannuation

Defined contribution plans

Contributions to defined contribution superannuation plans are expensed when incurred.

Defined benefit plans

The amount charged to the Operating Statement in respect of defined benefit superannuation plans represents the contributions made by the hospital to the superannuation plan in respect of the services of current hospital staff. Superannuation contributions are made to the plans based on the relevant rules of each plan.

Employees of the hospital are entitled to receive superannuation benefits and the hospital contributes to both the defined benefit and defined contribution plans. The defined benefit plan(s) provide benefits based on years of service and final average salary.

The name and details of the major employee superannuation funds and contributions made by the hospital are as follows:

Fund	Contributions Paid or Payable for the year	
	2009 $'000	2008 $'000
Defined benefit plans:		
Health Super Pty Ltd	191	198
Defined contribution plans:		
Health Super Pty Ltd	2,389	2,378
Hesta	502	397
Other	112	125
Total	**3,194**	**3,098**

The hospital does not recognise any unfunded defined benefit liability in respect of the superannuation plans because the hospital has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due. The Department of Treasury and Finance administers and discloses the State's defined benefit liabilities in its financial report.

Termination Benefits

Liabilities for termination benefits are recognised when a detailed plan for the termination has been developed and a valid expectation has been raised with those employees affected that the terminations will be carried out. The liabilities for termination benefits are recognised in other creditors unless the amount or timing of the payments is uncertain, in which case they are recognised as a provision.

On-Costs

Employee benefits on-costs (workers compensation, superannuation, annual leave and LSL accrued while on LSL taken in service) are recognised separately from provision for employee benefits.

(u) Intersegment Transactions

Transactions between segments within the hospital have been eliminated to reflect the extent of the hospital's operations as a group.

(v) Leases

Leases of property, plant and equipment are classified as finance leases whenever the terms of the lease transfer substantially all the risks and rewards of ownership to the lessee. All other leases are classified as operating leases.

Operating lease payments, including any contingent rentals, are recognised as an expense in the Operating Statement on a straight line basis over the lease term, except where another systematic basis is more representative of the time pattern of the benefits derived from the use of the leased asset.

(w) Income Recognition

Income is recognised in accordance with AASB 118 *Revenue* and is recognised as to the extent it is earned. Unearned income at reporting date is reported as income received in advance.

Amounts disclosed as revenue are, where applicable, net of returns, allowances and duties and taxes. If conditions are attached to a grant the recognition of the grant as revenue will be deferred until the conditions have been satisfied.

Note 1: Statement of Significant Accounting Policies (continued)

Government Grants
Grants are recognised as income when the hospital gains control of the underlying assets in accordance with AASB 1004 *Contributions*. For reciprocal grants, the hospital is deemed to have assumed control when the performance has occurred under the grant. For non-reciprocal grants, the hospital is deemed to have assumed control when the grant is received or receivable. Conditional grants may be reciprocal or non-reciprocal depending on the terms of the grant.

Indirect Contributions
Insurance is recognised as revenue following advice from the Department of Human Services.

Long Service Leave (LSL) – Revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Metropolitan Health and Aged Care Services Division Hospital Circular 34/2008.

Patient and Resident Fees
Patient fees are recognised as revenue at the time invoices are raised.

Private Practice Fees
Private practice fees are recognised as revenue at the time invoices are raised.

Donations and Other Bequests
Donations and bequests are recognised as revenue when received. If donations are for a special purpose, they may be appropriated to a reserve, such as specific restricted purpose reserve.

Dividend Revenue
Dividend revenue is recognised on a receivable basis.

Interest Revenue
Interest revenue is recognised on a time proportionate basis that takes in account the effective yield of the financial asset.

(x) Fund Accounting

The hospital operates on a fund accounting basis and maintains three funds: Operating, Specific Purpose and Capital Funds. The hospital's Capital and Specific Purpose Funds include unspent capital donations and receipts from fund-raising activities conducted solely in respect of these funds.

(y) Services Supported By Health Services Agreement and Services Supported By Hospital And Community Initiatives

Activities classified as *Services Supported by Health Services Agreement* (HSA) are substantially funded by the Department of Human Services and includes Residential Aged Care Services (RACS) and are also funded from other sources such as the Commonwealth, patients and residents, while *Services Supported by Hospital and Community Initiatives* (Non HSA) are funded by the hospital's own activities or local initiatives and/or the Commonwealth

(z) Comparative Information

Where necessary the previous year's figures have been reclassified to facilitate comparisons.

(aa) Property, Plant and Equipment Revaluation Reserve

The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets.

(ab) Financial Asset Available-for-Sale Revaluation Reserve

The available-for-sale revaluation reserve arises on the revaluation of available-for-sale financial assets. Where a revalued financial asset is sold that portion of the reserve which relates to that financial asset is effectively realised, and is recognised in the Operating Statement. Where a revalued financial asset is impaired that portion of the reserve which relates to that financial asset is recognised in the Operating Statement.

(ac) General Reserves

In the 2001-02 year, the hospital undertook a detailed review of its specific purpose funds, following the issue by the Department of Human Services of the Guidelines for the identification and establishment of Specific Purpose Funds during that year. This review identified various funds over which the hospital has discretion in terms of changing/amending the conditions under which the funds have been established and used. These funds have been designated as Specific Purpose Fund (Internal) for accounting purposes and were transferred from the Restricted Specific Purpose Reserve to a General Reserve at 30 June 2002.

Note 1: Statement of Significant Accounting Policies (continued)

(ad) Specific Restricted Purpose Reserve

A specific restricted purpose reserve is established where the hospital has possession or title to the funds but has no discretion to amend or vary the restriction and/or condition underlying the funds received.

(ae) Contributed Capital

Consistent with Australian Accounting Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities* and FRD 119 *Contributions by Owners*, appropriations for additions to the net asset base have been designated as contributed capital. Other transfers that are in the nature of contributions or distributions that have been designated as contributed capital are also treated as contributed capital.

(af) Net Result Before Capital and Specific Items

The subtotal entitled 'Net result Before Capital and Specific Items' is included in the Operating Statement to enhance the understanding of the financial performance of the hospital. This subtotal reports the result excluding items such as capital grants, assets received or provided free of charge, depreciation, and items of unusual nature and amount such as specific revenues and expenses. The exclusion of these items is made to enhance matching of income and expenses so as to facilitate the comparability and consistency of results between years and Victorian Public Health Services. The Net result Before Capital and Specific Items is used by the management of the hospital, the Department of Human Services and the Victorian Government to measure the ongoing result of Health Services in operating hospital services.

Capital and specific items, which are excluded from this sub-total, comprise:

- Capital purpose income, which comprises all tied grants, donations and bequests received for the purpose of acquiring non-current assets, such as capital works, plant and equipment or intangible assets. It also includes donations of plant and equipment. Consequently the recognition of revenue as capital purpose income is based on the intention of the provider of the revenue at the time the revenue is provided.
- Specific income/expense, comprises the following items, where material:
  - Voluntary departure packages
  - Write-down of inventories
  - Non-current asset revaluation increments/decrements
  - Diminution in investments
  - Restructuring of operations (disaggregation/ aggregation of health services)
  - Litigation settlements
  - Non-current assets lost or found
  - Forgiveness of loans
  - Reversals of provisions
  - Voluntary changes in accounting policies (which are not required by an accounting standard or other authoritative pronouncement of the Australian Accounting Standards Board);
- Impairment of financial and non-financial assets, includes all impairment losses (and reversal of previous impairment losses), which have been recognised in accordance with note 1 (n) and (o);
- Depreciation and amortisation, as described in note 1 (j) and (m);
- Assets provided or received free of charge; and
- Expenditure using capital purpose income, comprises expenditure which either falls below the asset capitalisation threshold (note 1 (i) and (m)), or doesn't meet asset recognition criteria and therefore does not result in the recognition of an asset in the Balance Sheet, where funding for that expenditure is from capital purpose income.

(ag) Category Groups

The hospital has used the following category groups for reporting purposes for the current and previous financial years.

Admitted Patient Services (Admitted Patients) comprises all recurrent health revenue/expenditure on admitted patient services, where services are delivered in public hospitals, or free standing day hospital facilities, or alcohol and drug treatment units or hospitals specialising in dental services, hearing and ophthalmic aids.

Outpatient Services (Outpatients) comprises all recurrent health revenue/expenditure on public hospital type outpatient services, where services are delivered in public hospital outpatient clinics, or free standing day hospital facilities, or rehabilitation facilities, or alcohol and drug treatment units, or outpatient clinics specialising in ophthalmic aids or palliative care.

Note 1: Statement of Significant Accounting Policies (continued)

Emergency Department Services (EDS) comprises all recurrent health revenue/expenditure on emergency department services that are available free of charge to public patients.

Other Services excluded from Australian Health Care Agreement (AHCA) (Other) comprises revenue/expenditure for services not separately classified above, including: Public health services including Laboratory testing, Blood Borne Viruses / Sexually Transmitted Infections clinical services, Kooris liaison officers, immunisation and screening services, Drugs services including drug withdrawal, counselling and the needle and syringe program, Dental Health services including general and specialist dental care, school dental services and clinical education, Disability services including aids and equipment and flexible support packages to people with a disability, Community Care programs including sexual assault support, early parenting services, parenting assessment and skills development, and various support services. Health and Community Initiatives also falls in this category group.

(ah) New Accounting Standards and Interpretations

Certain new accounting standards and interpretations have been published that are not mandatory for 30 June 2009 reporting period. As at 30 June 2009, the following standards and interpretations had been issued but were not mandatory for financial years ended 30 June 2009. The Royal Victorian Eye and Ear Hospital has not and does not intend to adopt these standards early.

Standard / Interpretation	Summary	Applicable for reporting periods beginning on or ending on	Impact on Entities Annual Statements
AASB 8 Operating Segments.	Supersedes AASB 114 Segment Reporting.	Beginning 1 January 2009	Not applicable.
AASB 2007-3 Amendments to Australian Accounting Standards arising from AASB 8 [AASB 5, AASB 6, AASB 102, AASB 107, AASB 119, AASB 127, AASB 134, AASB 136, AASB 1023 and AASB 1038]	An accompanying amending standard, also introduced consequential amendments into other Standards.	Beginning 1 January 2009	Impact expected to be not significant.
AASB 2007-6 Amendments to Australian Accounting Standards arising from AASB 123 [AASB 1, AASB 101, AASB 107, AASB 111, AASB 116 & AASB 138 and Interpretations 1 & 12]	An accompanying amending standard, also introduced consequential amendments into other Standards	Beginning 1 January 2009	All Australian government jurisdictions are currently still actively pursuing an exemption for government from capitalising borrowing costs.
AASB 2008-3 Amendments to AAS arising from AASB 3 & AASB 127 [AASB 1, 2, 4, 5, 7, 101, 107, 112, 114, 116, 121, 128, 131, 132, 133, 134, 136, 137, 138 &139 and Interpretation 9 & 107]	This Standard gives effect to consequential changes arising from revised AASB 3 and amended AASB 127. The Prefaces to those Standards summarise the main requirements of those Standards.	Beginning 1 January 2009	Impact expected to be insignificant.
AASB 2008-5 Amendments to AASs arising from Annual Improvements Projects [AASBs 5, 7, 101, 102, 107, 108, 110, 116, 118, 119, 120, 123, 127, 128, 129, 131, 132, 134, 136, 140, 141, 1023 & 1308]	A suite of amendments to existing standards following issuance of IASB Standard Improvements to IFRSs in May, 2008. Some amendments result in accounting changes for presentation, recognition and measurement purposes.	Beginning 1 January 2009	Impact is expected to be insignificant.

Note 1: Statement of Significant Accounting Policies (continued)

Standard / Interpretation	Summary	Applicable for reporting periods beginning on or ending on	Impact on Entities Annual Statements
AASB 2008-6 Further Amendments to Australian Accounting Standards arising from the Annual Improvements project [AASB 1 & AASB 5]	The amendments require all the assets and liabilities of a for-sale subsidiary to be classified as held for sale and clarify the disclosures required when the subsidiary is part of a disposal group that meets the definition of a discontinued operation.	Beginning 1 January 2009	Impact expected to be insignificant.
AASB 2008-7 Amendments to AAS Cost of An Investment in a Subsidiary, Jointly Controlled Entity or Associate [AASB 1, AASB 118, AASB 121, AASB 127 & AASB 136]	Changes mainly relate to treatment of dividends from subsidiaries or controlled entities.	Beginning 1 January 2009	Impact expected to be insignificant.
AASB 2008-8 Amendments to Australian Accounting Standards – Eligible Hedged Items [AASB 139]	The amendments to AASB 139 clarify how the principles that determine whether a hedged risk or portion of cash flows is eligible for designation as a hedged item, should be applied in particular situations.	Beginning 1 January 2009	Impact is expected to be insignificant.
AASB 2008-9 Amendments to AASB 1049 for Consistency with AASB 101	Amendments to AASB 1049 for consistency with AASB 101 (September 2007) version.	Beginning 1 January 2009	Impact expected to be insignificant.
AASB 2009-1 Amendments to Australian Accounting Standards – Borrowing Costs for Non-for-Profit Public Sector Entities [AASB 1, AASB 111 & AASB 123]	Amendments to Australian Accounting Standards to allow borrowing costs of Not-for-Profit Public Sector Entities to be expensed.	Beginning 1 January 2009	Impact expected to be insignificant.
AASB 2009-2 Amendments to Australian Accounting Standards – Improving Disclosures about Financial Instruments [AASB 4, AASB 7, AASB 1023 & AASB 1038]	Amendments to AASB 7 to enhance disclosures about fair value measurements and liquidity risk. Editorial amendments to AASB 4, AASB 1023 and AASB 1038 resulting from the amendments to AASB 7.	Beginning 1 January 2009	Impact expected to be insignificant.

Note 2: Revenue

	HSA 2009 $'000	HSA 2008 $'000	Non HSA 2009 $'000	Non HSA 2008 $'000	Total 2009 $'000	Total 2008 $'000
Revenue from Operating Activities						
Government Grants						
– Department of Human Services	57,087	53,888	147	109	57,234	53,997
– State Government – Other	–	–	–	–	–	–
– Equipment and Infrastructure Maintenance	658	434	–	–	658	434
Total Government Grants	**57,745**	**54,322**	**147**	**109**	**57,892**	**54,431**
Indirect Contributions by Department of Human Services						
– Insurance	1,214	1,222	–	–	1,214	1,222
– Long Service Leave	(60)	147	–	–	(60)	147
Total Indirect Contributions by Department of Human Services	**1,154**	**1,369**	**–**	**–**	**1,154**	**1,369**
Patient and Resident Fees						
– Patient and Resident Fees (refer note 2b)	4,079	3,248	–	–	4,079	3,248
Total Patient and Resident Fees	**4,079**	**3,248**	**–**	**–**	**4,079**	**3,248**
Donations and Bequests	–	–	561	2,667	561	2,667
Recoupment from Private Practice for Use of Hospital Facilities	–	–	1,216	983	1,216	983
Other Revenue from Operating Activities	2,971	2,437	1,057	1,188	4,028	3,625
Sub-Total Revenue from Operating Activities	**65,949**	**61,376**	**2,981**	**4,947**	**68,930**	**66,323**
Revenue from Non-Operating Activities						
Interest and Dividends	–	–	463	832	463	832
Net Gain/(Loss) on Disposal of Financial Assets	–	–	134	375	134	375
Other Revenue from Non-Operating Activities	–	–	235	225	235	225
Sub-Total Revenue from Non-Operating Activities	**–**	**–**	**832**	**1,432**	**832**	**1,432**

Note 2: Revenue (continued)

	HSA 2009 $'000	HSA 2008 $'000	Non HSA 2009 $'000	Non HSA 2008 $'000	Total 2009 $'000	Total 2008 $'000
Revenue from Capital Purpose Income						
State Government Capital Grants						
– Targeted Capital Works and Equipment	–	–	1,157	604	1,157	604
Net Gain/(Loss) on Disposal of Financial Assets	–	–	457	1,274	457	1,274
Net Gain/(Loss) on Disposal of Non-Financial Assets (note 2c)	–	–	–	–	–	–
Capital Interest	–	–	1,756	2,758	1,756	2,758
Capital Dividends	–	–	132	126	132	126
Donations and Bequests	–	–	397	–	397	–
Other Capital Purpose Income	–	–	1	–	1	–
Sub-Total Revenue from Capital Purpose Income	**–**	**–**	**3,900**	**4,762**	**3,900**	**4,762**
Total Revenue (refer to note 2a)	**65,949**	**61,376**	**7,713**	**11,141**	**73,662**	**72,517**

Indirect contributions by Department of Human Services: Department of Human Services makes certain payments on behalf of the hospital. These amounts relate to (a) Insurances, and (b) reimbursement of long service leave payments made by the hospital over and above 1.8% funding allowed in the DHS's annual funding of the hospital. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

Note 2a: Analysis of Revenue by Source

	Admitted Patients 2009 $'000	Outpatients 2009 $'000	EDS 2009 $'000	Other 2009 $'000	Total 2009 $'000
Revenue from Services Supported by Health Services Agreement					
Government Grants					
– Department of Human Services	35,178	18,831	3,078	–	57,087
– State Government – Other	405	217	36	–	658
Indirect contributions by Department of Human Services					
– Insurance	748	401	65	–	1,214
– Long Service Leave	(37)	(20)	(3)	–	(60)
Patient and Resident Fees (refer note 2b)	3,538	171	370	–	4,079
Other Revenue from Operating Activities	532	2,192	247	–	2,971
Sub-Total Revenue from Services Supported by Health Services Agreement	**40,364**	**21,792**	**3,793**	**–**	**65,949**
Revenue from Services Supported by Hospital and Community Initiatives					
Government Grants					
– Department of Human Services	–	–	–	147	147
Donations and Bequests (non capital)	–	–	–	561	561
Other					
– Private Practice and Other Patient Activities	–	–	–	1,215	1,215
– Pharmacy Fees	–	–	–	269	269
– Car Park	–	–	–	82	82
– Property Income	–	–	–	235	235
– Research	–	–	–	498	498
– Investment Returns	–	–	–	597	597
– Other	–	–	–	209	209
Capital Purpose Income (refer note 2)	–	–	–	3,900	3,900
Sub-Total Revenue from Services Supported by Hospital and Community Initiatives	**–**	**–**	**–**	**7,713**	**7,713**
Total Revenue	**40,364**	**21,792**	**3,793**	**7,713**	**73,662**

Indirect contributions by Department of Human Services: Department of Human Services makes certain payments on behalf of the hospital. These amounts relate to (a) Insurances, and (b) reimbursement of long service leave payments made by the hospital over and above 1.8% funding allowed in the DHS's annual funding of the hospital. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

Note 2a: Analysis of Revenue by Source (continued)

	Admitted Patients 2008 $'000	Outpatients 2008 $'000	EDS 2008 $'000	Other 2008 $'000	Total 2008 $'000
Revenue from Services Supported by Health Services Agreement					
Government Grants					
– Department of Human Services	33,629	17,063	3,196	–	53,888
– State Government – Other	271	137	26	–	434
Indirect contributions by Department of Human Services					
– Insurance	763	387	72	–	1,222
– Long Service Leave	92	46	9	–	147
Patient and Resident Fees (refer note 2b)	2,734	166	348	–	3,248
Other Revenue from Operating Activities	954	970	513	–	2,437
Sub-Total Revenue from Services Supported by Health Services Agreement	**38,443**	**18,769**	**4,164**	**–**	**61,376**
Revenue from Services Supported by Hospital and Community Initiatives					
Government Grants					
– Department of Human Services	–	–	–	109	109
Donations and Bequests (non capital)	–	–	–	2,667	2,667
Other					
– Private Practice and Other Patient Activities	–	–	–	983	983
– Pharmacy Fees	–	–	–	229	229
– Car Park	–	–	–	94	94
– Property Income	–	–	–	225	225
– Research	–	–	–	566	566
– Investment Returns	–	–	–	1,207	1,207
– Other	–	–	–	299	299
Capital Purpose Income (refer note 2)	–	–	–	4,762	4,762
Sub-Total Revenue from Services Supported by Hospital and Community Initiatives	**–**	**–**	**–**	**11,141**	**11,141**
Total Revenue	**38,443**	**18,769**	**4,164**	**11,141**	**72,517**

Indirect contributions by Department of Human Services: Department of Human Services makes certain payments on behalf of the hospital. These amounts relate to (a) Insurances, and (b) reimbursement of long service leave payments made by the hospital over and above 1.8% funding allowed in the DHS's annual funding of the hospital. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

Note 2b: Patient and Resident Fees

	2009 $'000	2008 $'000
Patient and Resident Fees Raised		
Recurrent:		
Acute		
– Inpatients	3,349	2,548
– Outpatients	730	700
Total Recurrent	**4,079**	**3,248**

Patient and Resident Fees exclude recoupment from private practice and Pharmaceutical Benefits Scheme (PBS) co-payments.

Note 2c: Net Gain/(Loss) on Disposal of Non-Financial Assets

	2009 $'000	2008 $'000
Proceeds from Disposals of Non-Current Assets		
Medical Equipment	6	–
Total Proceeds from Disposal of Non-Current Assets	**6**	**–**
Less: Written Down Value of Non-Current Assets Sold		
Medical Equipment	6	–
Total Written Down Value of Non-Current Assets Sold	**6**	**–**
Net gains/(losses) on Disposal of Non-Current Assets	**-**	**-**

Note 2d: Specific Income

	2009 $'000	2008 $'000
Specific Income		
Revaluation Increment on Non Current Assets	–	–
TOTAL	**–**	**–**

The hospital assessed the fair value of Non-Current Assets and the movement was considered immaterial.

Note 3: Expenses

	HSA 2009 $'000	HSA 2008 $'000	Non HSA 2009 $'000	Non HSA 2008 $'000	Total 2009 $'000	Total 2008 $'000
Employee Benefits						
Salaries and Wages	36,714	34,769	842	1,682	37,556	36,451
WorkCover Premium	224	160	3	2	227	162
Long Service Leave	937	978	(2)	(7)	935	971
Superannuation	3,123	3,064	25	18	3,148	3,082
Total Employee Benefits	**40,998**	**38,971**	**868**	**1,695**	**41,866**	**40,666**
Non Salary Labour Costs						
Agency Costs – Nursing	520	577	–	–	520	577
Agency Costs – Other	191	82	3	15	194	97
Total Non Salary Labour Costs	**711**	**659**	**3**	**15**	**714**	**674**
Supplies & Consumables						
Drug Supplies	4,147	3,505	130	115	4,277	3,620
Medical, Surgical Supplies and Prosthesis	9,686	7,999	24	52	9,710	8,051
Pathology Supplies	582	575	–	–	582	575
Food Supplies	523	531	36	16	559	547
Total Supplies & Consumables	**14,938**	**12,610**	**190**	**183**	**15,128**	**12,793**
Other Expenses from Continuing Operations						
Domestic Services and Supplies	2,098	2,267	1	1	2,099	2,268
Fuel, Light, Power and Water	585	571	–	–	585	571
Insurance costs funded by DHS	1,214	1,222	–	–	1,214	1,222
Motor Vehicle Expenses	138	68	–	–	138	68
Postal and Telephone	411	371	45	23	456	394
Repairs and Maintenance	678	579	10	66	688	645
Maintenance Contracts	309	405	–	–	309	405
Patient Transport	192	155	–	–	192	155
Bad and Doubtful Debts	12	43	3	(1)	15	42
Lease Expenses	531	525	–	9	531	534
Other Administrative Expenses	4,095	4,235	1,337	509	5,432	4,744
Car Park Expenses	–	–	–	108	–	108
Audit Fees						
– Victorian Audit Government Office – Audit of Financial Statements	38	36	–	–	38	36
– Other	58	93	–	–	58	93
Total Other Expenses from Continuing Operations	**10,359**	**10,570**	**1,396**	**715**	**11,755**	**11,285**

Note 3: Expenses (continued)

	HSA 2009 $'000	HSA 2008 $'000	Non HSA 2009 $'000	Non HSA 2008 $'000	Total 2009 $'000	Total 2008 $'000
Expenditure using Capital Purpose Income						
Employee Benefits						
– Salaries and Wages	–	–	276	199	276	199
– WorkCover Premium	–	–	1	2	1	2
– Superannuation	–	–	11	16	11	16
– Long Service Leave	–	–	16	1	16	1
Total Employee Benefits	**–**	**–**	**304**	**218**	**304**	**218**
Other Expenses						
– Repairs and Maintenance	–	–	2	–	2	–
– Administrative Expenses	–	–	307	5	307	5
– Other	–	–	2	–	2	–
Total Other Expenses	**–**	**–**	**311**	**5**	**311**	**5**
Total Expenditure using Capital Purpose Income	**–**	**–**	**615**	**223**	**615**	**223**
Impairment of Non-Financial Assets						
– Available-for-Sale Financial Assets	–	–	5,548	3,512	5,548	3,512
Total Impairment of Financial Assets	**–**	**–**	**5,548**	**3,512**	**5,548**	**3,512**
Depreciation and Amortisation	–	–	2,863	2,817	2,863	2,817
Total	**–**	**–**	**8,411**	**6,329**	**8,411**	**6,329**
Total Expenses	**67,006**	**62,810**	**11,483**	**9,160**	**78,489**	**71,970**

Note 3a: Analysis of Expenses by Source

	Admitted Patients 2009 $'000	Outpatients 2009 $'000	EDS 2009 $'000	Other 2009 $'000	Total 2009 $'000
Services Supported by Health Services Agreement					
Employee Benefits	19,559	17,604	3,835	–	40,998
Non Salary Labour Costs	518	176	17	–	711
Supplies and Consumables	7,499	6,843	596	–	14,938
Other Expenses from Continuing Operations	6,515	3,476	368	–	10,359
Sub-Total Expenses from Services Supported by Health Services Agreement	**34,091**	**28,099**	**4,816**	**–**	**67,006**
Services Supported by Hospital and Community Initiatives					
Employee Benefits	–	–	–	868	868
Non Salary Labour Costs	–	–	–	3	3
Supplies and Consumables	–	–	–	190	190
Other Expenses from Continuing Operations	–	–	–	1,396	1,396
Depreciation and Amortisation (refer note 4)	–	–	–	2,863	2,863
Sub-Total Expense from Services Supported by Hospital and Community Initiatives	**–**	**–**	**–**	**5,320**	**5,320**
Services Supported by Capital Sources					
Employee Benefits	–	–	–	304	304
Other Expenses	–	–	–	311	311
Sub-Total Expenses from Services Supported by Capital Resources	**–**	**–**	**–**	**615**	**615**
Impairment of Financial Assets (refer Note 3c)	–	–	–	5,548	5,548
Total Expenses	**34,091**	**28,099**	**4,816**	**11,483**	**78,489**

Note 3a: Analysis of Expenses by Source (continued)

	Admitted Patients 2008 $'000	Outpatients 2008 $'000	EDS 2008 $'000	Other 2008 $'000	Total 2008 $'000
Services Supported by Health Services Agreement					
Employee Benefits	20,567	15,431	2,973	–	38,971
Non Salary Labour Costs	580	77	2	–	659
Supplies and Consumables	9,753	2,350	507	–	12,610
Other Expenses from Continuing Operations	7,516	2,672	382	–	10,570
Impairment of Non-Financial Assets (refer note 3)	–	–	–	–	–
Sub-Total Expenses from Services Supported by Health Services Agreement	**38,416**	**20,530**	**3,864**	**–**	**62,810**
Services Supported by Hospital and Community Initiatives					
Employee Benefits	–	–	–	1,695	1,695
Non Salary Labour Costs	–	–	–	15	15
Supplies and Consumables	–	–	–	183	183
Other Expenses from Continuing Operations	–	–	–	715	715
Impairment of Non-Financial Assets (refer note 3)	–	–	–	–	–
Depreciation and Amortisation (refer note 4)	–	–	–	2,817	2,817
Sub-Total Expense from Services Supported by Hospital and Community Initiatives	**–**	**–**	**–**	**5,425**	**5,425**
Services Supported by Capital Sources					
Employee Benefits	–	–	–	218	218
Other Expenses	–	–	–	5	5
Sub-Total Expenses from Services Supported by Capital Resources	**–**	**–**	**–**	**223**	**223**
Impairment of Financial Assets (refer note 3c)	–	–	–	3,512	3,512
Total Expenses	**38,416**	**20,530**	**3,864**	**9,160**	**71,970**

Note 3b: Analysis of Expenses by Internal and Restricted Specific Purpose Funds for Services Supported by Hospital and Community Initiatives

	2009 $'000	2008 $'000
Private Practice and Other Patient Activities	1,006	779
Pharmacy Services	154	139
Car Park	–	108
Property Expenses	15	10
Computer Implementation	352	17
Impairment of Financial Assets (refer note 3c)	5,548	3,512
Other	362	505
Other Activities		
Fundraising and Community Support	251	345
Research and Scholarship	909	928
Education and Training	8	–
TOTAL	**8,605**	**6,343**

Note 3c: Specific Expenses

	2009 $'000	2008 $'000
Specific Expenses		
Impairment of Financial Assets (refer note 3)	5,548	3,512
TOTAL	**5,548**	**3,512**

The strategic investment portfolio of the hospital returned a negative 9.28% for 2008-09 compared with a negative 5.70% in 2007-08. However, when investment earnings are taken into consideration the hospital returned a net negative of 4.69% for 2008-09 (compared with a net positive 0.58% for 2007-08). Components of the asset allocations provided negative returns which accumulated in available-for-sale financial assets. For the year ended 30 June 2009 and 30 June, 2008, the hospital made a significant judgement about the impairment of its available-for-sale financial assets. The hospital followed the guidance of *AASB 139 Financial Instruments: Recognition and Measurement* on determining whether and when an available-for-sale financial asset is impaired. This determination required significant judgement. In making this judgement, the hospital evaluated, among other factors, the duration and extent to which fair value of an investment is less than its cost and the financial performance, changes in technology and operational and financing cash flows. As at 30 June 2009, it was decided to impair $5.548m ($3.512m in 2008) at this point in time after considering the recent negative returns and the expected future performance of these non-cash portfolio assets.

Note 4: Depreciation and Amortisation

	2009 $'000	2008 $'000
Depreciation		
Buildings	892	862
Plant and Equipment	150	157
Medical Equipment	1,492	1,530
Computers and Communication	208	157
Non-Medical Equipment	13	13
Furniture and Fittings	31	32
Total Depreciation	**2,786**	**2,751**
Amortisation		
Intangible Assets	77	66
Total Amortisation	**77**	**66**
Total Depreciation and Amortisation	**2,863**	**2,817**

Note 5: Finance Costs

The Royal Victorian Eye and Ear Hospital did not incur any finance costs arising from borrowings during the year.

Note 6: Cash and Cash Equivalents

For the purposes of the Cash Flow Statement, cash assets includes cash on hand and in banks, and short-term deposits which are readily convertible to cash on hand, and are subject to an insignificant risk of change in value, net of outstanding bank overdrafts.

	2009 $'000	2008 $'000
Cash on Hand	41	22
Cash at Bank	814	(112)
Deposits at Call	6,135	5,580
TOTAL	**6,990**	**5,490**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	6,990	5,490
TOTAL	**6,990**	**5,490**

Note 7: Receivables

	2009 $'000	2008 $'000
CURRENT		
Contractual		
Inter Hospital Debtors	266	132
Trade Debtors	175	161
Patient Fees	268	441
Accrued Investment Income	18	38
Accrued Revenue – Other	45	15
Less Allowance for Doubtful Debts		
Trade Debtors	(25)	(23)
Patient Fees	(32)	(55)
	715	**709**
Statutory		
GST Receivable	292	264
	292	**264**
TOTAL CURRENT RECEIVABLES	**1,007**	**973**
NON CURRENT		
Statutory		
Long Service Leave – DHS	198	258
TOTAL NON-CURRENT RECEIVABLES	**198**	**258**
TOTAL RECEIVABLES	**1,205**	**1,231**

(a) Movement in the Allowance for Doubtful Debts

	2009 $'000	2008 $'000
Balance at beginning of year	78	75
Amounts written off during the year	37	37
Amounts recovered during the year	–	–
Increase/(decrease) in allowance recognised in profit or loss	(58)	(34)
Balance at end of year	**57**	**78**

(b) Ageing analysis of receivables

Please refer to note 19(b) for the ageing analysis of receivables.

(c) Nature and extent of risk arising from receivables

Please refer to note 19(b) for the nature and extent of credit risk arising from receivables.

Note 8: Other Financial Assets

	Operating Fund		Specific Purpose Fund		Capital Fund		Total	
	2009 $'000	2008 $'000	2009 $'000	2008 $'000	2009 $'000	2008 $'000	2009 $'000	2008 $'000
CURRENT								
Available-for-Sale Financial Assets								
Cash Management Account	–	–	3,000	3,000	–	–	3,000	3,000
Total Current	**–**	**–**	**3,000**	**3,000**	**–**	**–**	**3,000**	**3,000**
NON CURRENT								
Available-for-Sale Financial Assets								
Cash Management Account	–	–	24,424	20,548	9,896	10,430	34,320	30,978
Units in Managed Funds	–	–	19,453	25,814	–	–	19,453	25,814
Total Non Current	**–**	**–**	**43,877**	**46,362**	**9,896**	**10,430**	**53,773**	**56,792**
TOTAL	**–**	**–**	**46,877**	**49,362**	**9,896**	**10,430**	**56,773**	**59,792**
Represented by:								
Health Service Investments	–	–	46,877	49,362	9,896	10,430	56,773	59,792
TOTAL	**–**	**–**	**46,877**	**49,362**	**9,896**	**10,430**	**56,773**	**59,792**

(b) Ageing analysis of other financial assets

Please refer to note 19(b) for the ageing analysis of other financial assets.

(c) Nature and extent of risk arising from other financial assets

Please refer to note 19(b) for the nature and extent of credit risk arising from other financial assets.

Note 9: Inventories

	2009 $'000	2008 $'000
Pharmaceuticals		
At cost	333	345
Medical and Surgical Lines		
At cost	391	409
Administration Stores		
At Cost	5	9
Other		
Cochlear Implants – At Cost	150	401
Gift Shop – At Cost	8	15
TOTAL INVENTORIES	**887**	**1,179**

Note 10: Other Assets

	2009 $'000	2008 $'000
Prepayments	201	300
CURRENT	**201**	**300**
NON CURRENT	**–**	**–**
TOTAL	**201**	**300**

Note 11: Property, Plant and Equipment

	2009 $'000	2008 $'000
Land		
Land at fair value – 2009	27,160	–
Land at fair value – 2007	–	20,070
Total Land	**27,160**	**20,070**
Buildings		
Buildings Under Construction at cost	680	564
Buildings at fair value – 2009	77,757	–
Buildings at fair value – 2007	–	34,480
Buildings at cost	–	1,060
Less Accumulated Depreciation	–	(862)
Total Buildings	**78,437**	**35,242**
Plant and Equipment		
Plant and Equipment at fair value	1,911	–
Plant and Equipment at cost	–	2,598
Less Accumulated Depreciation	–	(652)
Total Plant and Equipment – at cost	**1,911**	**1,946**
Total Plant and Equipment	**1,911**	**1,946**
Medical Equipment		
Medical Equipment at fair value	6,434	–
Medical Equipment at cost	–	14,574
Less Accumulated Depreciation	–	(8,461)
Total Medical Equipment – at cost	**6,434**	**6,113**
Total Medical Equipment	**6,434**	**6,113**

Note 11: Property, Plant and Equipment (continued)

	2009 $'000	2008 $'000
Computers and Communications		
Computers and communications at fair value	546	–
Computers and communications at cost	–	1,343
Less Accumulated Depreciation	–	(694)
Total Computers and Communications	**546**	**649**
Non-Medical Equipment		
Non-Medical Equipment at fair value	72	–
Non-Medical Equipment at cost	–	135
Less Accumulated Depreciation	–	(67)
Total Non-Medical Equipment	**72**	**68**
Furniture and Fittings		
Furniture and fittings at fair value	226	–
Furniture and fittings at cost	–	357
Less Accumulated Depreciation	–	(101)
Total Furniture and Fittings	**226**	**256**
Motor Vehicles		
Motor Vehicles at fair value	–	–
Motor Vehicles at cost	–	25
Less Accumulated Depreciation	–	(25)
Total Motor Vehicles	**–**	**–**
TOTAL	**114,786**	**64,344**

Note 11: Property, Plant and Equipment (continued)

Reconciliations of the carrying amounts of each class of asset for the consolidated entity at the beginning and end of the previous and current financial year are set out below.

	Land $'000	Buildings $'000	Construction in Progress $'000	Plant & Equipment $'000	Medical Equipment $'000	Computers & Comm'ns $'000	Non-Medical Equipment $'000	Furniture & Fittings $'000	Motor Vehicles $'000	Total $'000
Balance at 1 July 2007	**20,070**	**34,480**	**1,182**	**1,873**	**6,304**	**459**	**423**	**174**	**–**	**64,965**
Additions	–	374	68	21	1,252	382	–	2	–	2,099
Fixed assets discovered from stocktake	–	–	–	209	87	(35)	(342)	112	–	31
Capitalisation of Construction-in-Progress upon project completion	–	686	(686)	–	–	–	–	–	–	–
Depreciation and Amortisation (note 4)	–	(862)	–	(157)	(1,530)	(157)	(13)	(32)	–	(2,751)
Balance at 1 July 2008	**20,070**	**34,678**	**564**	**1,946**	**6,113**	**649**	**68**	**256**	**–**	**64,344**
Additions	–	307	116	115	1,819	105	17	1	–	2,480
Disposals	–	–	–	–	(6)	–	–	–	–	(6)
Revaluation increments/ (decrements)	7,090	43,664	–	–	–	–	–	–	–	50,754
Depreciation and Amortisation (note 4)	–	(892)	–	(150)	(1,492)	(208)	(13)	(31)	–	(2,786)
Balance at 30 June 2009	**27,160**	**77,757**	**680**	**1,911**	**6,434**	**546**	**72**	**226**	**–**	**114,786**

Note 11: Property, Plant and Equipment (continued)

Land and buildings carried at valuation

(a) Freehold Land and Buildings on Freehold Land – 2009

An independent valuation of the hospital's property, plant and equipment was performed by the Valuer-General Victoria to determine the fair value of the land and buildings. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments.

The effective date of the valuation is 30 June 2009.

Freehold land owned by the hospital was valued at 30 June, 2009 on the basis of its Fair (Market) Value.

Buildings situated on the freehold land were valued at 30 June, 2009 on the basis of their fair value based using the depreciated replacement cost.

As a result of the valuation undertaken in June, 2009, the hospital's Asset Revaluation Reserve was increased by $50.754 million to $62.462 million. The increase of $50.754 million comprised an increase in the Land component of the Asset Revaluation Reserve of $7.090 million, and an increase in the Buildings component of the Asset Revaluation Reserve of $43.564 million.

(b) Freehold Land and Buildings on Freehold Land – 2007

An independent kerb-side valuation of the hospital's land and buildings was performed by Mr. Gary Longden, AVLE (Val) of Jones Lang LaSalle Advisory Services Pty Ltd to determine the fair value of the land and buildings. The valuation, which conformed to Australian Valuation Standards, was determined with reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments. The effective date of the valuation was 30 June, 2007.

Freehold land owned by the hospital was valued at 30 June, 2007 on the basis of its Fair (Market) Value.

Buildings situated on the freehold land were valued at 30 June, 2007 on the basis of their fair value based using the depreciated replacement cost.

Plant, Equipment, Furniture and Fittings

In 2009, the hospital used the fair value to measure all these asset groups, while in 2008 it used the cost basis for measuring all of its plant, equipment, furniture and fittings. The fair value did not materially differ from the current value and, as such, no adjustment was recorded.

Note 12: Intangible Assets

	2009 $'000	2008 $'000
Computer Software	907	594
Less Accumulated Amortisation	(480)	(403)
	427	**191**
Total Written Down Value	**427**	**191**

Reconciliation of the carrying amounts of intangible assets at the beginning and end of the previous and current financial year:

	Total $'000
Balance at 1 July 2007	**176**
Additions	28
Fixed assets discovered from stocktake	53
Amortisation (note 4)	(66)
Balance at 1 July 2008	**191**
Additions	313
Amortisation (note 4)	(77)
Balance at 30 June 2009	**427**

Note 13: Investment Properties

	2009 $'000	2008 $'000
Balance at Beginning of Period	**640**	**640**
Net Gain/(Loss) from Fair Value Adjustments	–	–
Balance at End of Period	**640**	**640**

Valuation of Investment Properties

(a) Valuation – 2009

An independent valuation of the hospital's investment properties was performed by the Valuer-General Victoria to determine their fair value. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments.

The effective date of the valuation is 30 June 2009. The basis of the valuation was at Fair (Market) Value subject to lease. The Fair (Market) Value utilised the Depreciated Replacement Cost method.

(b) Valuation – 2007

An independent kerb-side valuation of the hospital's investment properties was performed by Mr Gary Longden AVLE (Val) of Jones Lang LaSalle Advisory Services Pty Ltd to determine their fair value. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments.

The effective date of the valuation is 30 June 2007. The basis of the valuation was at Fair (Market) Value subject to lease.

Note 14: Payables

	2009 $'000	2008 $'000
CURRENT		
Contractual		
Trade Creditors	1,090	1,357
Accrued Expenses	3,548	3,711
	4,638	5,068
Statutory		
GST Payable	17	18
Fringe Benefits Tax Payable	2	4
TOTAL CURRENT	**4,657**	**5,090**
TOTAL PAYABLES	**4,657**	**5,090**

(a) Maturity analysis of payables

Please refer to Note 19c for the ageing analysis of payables.

(b) Nature and extent of risk arising from payables

Please refer to note 19c for the nature and extent of risks arising from payables.

Note 15: Employee Benefits and Related On-Costs Provisions

	2009 $'000	2008 $'000
CURRENT PROVISIONS		
Employee Benefits		
- Unconditional and expected to be settled within 12 months	6,262	5,728
- Unconditional and expected to be settled after 12 months	4,393	3,929
	10,655	9,657
Provisions related to employee benefit on-costs		
- Unconditional and expected to be settled within 12 months (nominal value)	270	261
	270	261
Total Current Provisions	**10,925**	**9,918**
NON-CURRENT PROVISIONS		
Employee Benefits	213	273
Total Non-Current Provisions	**213**	**273**
Total Provisions	**11,138**	**10,191**
CURRENT EMPLOYEE BENEFITS		
Unconditional long service leave entitlement	5,069	4,693
Annual leave entitlements	2,697	2,570
Accrued Wages and Salaries	2,517	2,012
Accrued Days Off	137	121
Other :		
– Superannuation	209	246
– Workcover	26	15
Total Current Employee Benefits	**10,655**	**9,657**

Note 15: Employee Benefits and Related On-Costs Provisions (continued)

	2009 $'000	2008 $'000
NON-CURRENT EMPLOYEE BENEFITS		
Conditional long service leave entitlements (present value)	213	273
Total Non-Current Employee Benefits	**213**	**273**
Total Employee Benefits	**10,868**	**9,930**
ON-COSTS		
Current On-Costs – Annual Leave	270	261
Total On-Costs	**270**	**261**
Total Employee Benefits and Related On-Costs	**11,138**	**10,191**
Movement in Long Service Leave:		
Balance at start of year	**4,966**	**4,722**
Provision made during the year		
Revaluations	378	–
Expense recognising employee service	573	972
Settlement made during the year	(635)	(728)
Balance at end of year	**5,282**	**4,966**

Note 16: Other Liabilities

	2009 $'000	2008 $'000
CURRENT		
Rental in Advance	15	1
Bond Money	9	9
Patient Fees	6	2
Income in Advance – DHS	2,738	455
Total Current	**2,768**	**467**
Total Other Liabilities	**2,768**	**467**

Note 17: Equity

	2009 $'000	2008 $'000
(a) Reserves		
Property, Plant and Equipment Revaluation Reserve[1]	**11,708**	**11,708**
Revaluation Increment/(Decrements)		
– Land	7,090	–
– Buildings	43,664	–
Balance at the end of the reporting period	**62,462**	**11,708**
Represented by:		
– Land	17,071	9,981
– Buildings	45,391	1,727
	62,462	**11,708**
Financial Assets Available-for-Sale Revaluation Reserve[2]		
Balance at the beginning of the reporting period	–	1,258
Valuation gain/(loss) recognised	(5,548)	(4,770)
Cumulative (gain)/loss transferred to Operating Statement on impairment of financial assets	5,548	3,512
Balance at end of the reporting period	**–**	**–**

Note 17: Equity (continued)

	2009 $'000	2008 $'000
General Purpose Reserve		
Balance at the beginning of the reporting period	37,218	34,947
Transfer to and from General Reserve:		
– Restricted Specific Purpose Reserve	–	2
– Accumulated Surplus / (Deficits)	(1,240)	2,269
Balance at the end of the reporting period	**35,978**	**37,218**
Restricted Specific Purpose Reserve		
Balance at the beginning of the reporting period	18,713	19,004
– Accumulated Surpluses / (Deficits)	(2,527)	(291)
Balance at the end of the reporting period	**16,186**	**18,713**
Total Reserves	**114,626**	**67,639**
(b) Contributed Capital		
Balance at the beginning of the reporting period	51,568	51,040
Capital contribution received from Victorian Government	–	528
Balance at the end of the reporting period	**51,568**	**51,568**
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	(1,788)	(355)
Net Result for the Year	(4,827)	547
Transfers to and from Reserve:		
– General Purpose Reserve	1,240	(2,269)
– Restricted Specific Purpose Reserve	2,527	289
Balance at the end of the reporting period	**(2,848)**	**(1,788)**
(d) Total Equity at end of financial year	**163,346**	**117,419**

(1) The property, plant and equipment asset revaluation reserve arises on the revaluation of property, plant and equipment.

(2) The financial assets available-for-sale revaluation reserve arises on the revaluation of available-for-sale financial assets. Where a revalued financial asset is sold, that portion of the reserve which relates to the financial asset, and is effectively realised, is recognised in the profit and loss. Where a revalued financial asset is impaired that portion of the reserve which relates to that financial asset is recognised in profit and loss.

Note 18: Reconciliation of Net Result for the Year to Net Cash Inflow/(Outflow) from Operating Activities

	2009 $'000	2008 $'000
Net Result for the Year	**(4,827)**	**547**
Depreciation and Amortisation	2,787	2,751
Amortisation of Intangibles	76	66
Impairment of Non-Current Assets	5,548	3,512
Provision for Doubtful Debts	(21)	3
Fixed assets discovered from stocktake	–	(85)
Change in Operating Assets and Liabilities		
(Increase)/Decrease in Debtors	(64)	635
(Increase)/Decrease in Patient Fees	173	(249)
(Increase)/Decrease in Accrued Income	(30)	284
(Increase)/Decrease in Prepayments	99	(14)
(Increase)/Decrease in GST Debtor/Creditor	(14)	(15)
(Increase)/Decrease in Inventories	292	(214)
Increase/(Decrease) in Payables/Creditors	(267)	1,673
Increase/(Decrease) in Accruals	1,965	(570)
Increase/(Decrease) in Employee Benefits	944	494
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**6,661**	**8,818**

Note 19: Financial Instruments

(a) Financial Risk Management Objectives and Policies

The Royal Victorian Eye and Ear Hospital's principal financial instruments comprise of:
– Cash Assets
– Term Deposits
– Receivables (excluding statutory receivables)
– Investment in Equities and Managed Investment Schemes
– Payables (excluding statutory payables)

Details of the significant accounting policies and methods adopted, including the criteria for recognition, the basis of measurement and the basis on which income and expenses are recognised, with respect to each class of financial asset, financial liability and equity instrument are disclosed in note 1 to the financial statements.

The main purpose in holding financial instruments is to prudentially manage the hospital's financial risks within the government policy parameters.

Note 19: Financial Instruments (continued)

(b) Risk management policies

The Board of Directors has responsibility for the establishment and oversight of the risk management framework. The framework guides the Board in identifying and analysing the risks faced by the hospital.

These other financial assets are invested by the hospital based on advice received from appointed financial advisers. The Investment Management Advisory Committee is responsible for setting the hospital's investment mandate based on advice received from the financial advisors and within the parameters set out in the Financial Management Act 1994. The committee meets quarterly to review the performance of the portfolio and provides advice to the Finance Committee. The other financial assets are predominately units held in managed funds of Colonial First State. The Board of Directors evaluates the performance of its portfolio based on reports received from the external financial advisor.

The hospital's activities expose it primarily to the financial risks of changes in interest rates, price risk, liquidity risk and credit risk. The hospital does not enter into or trade financial instruments including derivative financial instruments for speculative purposes. The Board reviews and agrees policies for managing each of these risks and undertakes regular monitoring of the performance of its financial assets and liabilities.

(c) Categorisation of financial instruments

	Carrying Amount 2009 $'000	Carrying Amount 2008 $'000
Financial Assets		
Cash and cash equivalents	6,990	5,490
Receivables	1,205	1,231
Available-for-sale financial assets (at fair value)	56,773	59,792
Total Financial Assets	**64,968**	**66,513**
Financial Liabilities		
Financial Liabilities measured at amortised cost	4,657	5,090
Other Liabilities at amortised cost	2,768	467
Total Financial Liabilities	**7,425**	**5,557**

(d) Net holding gain/(loss) on financial instruments by category

	Carrying Amount 2009 $'000	Carrying Amount 2008 $'000
Financial Assets		
Available for sale	(3,197)	204
Total Financial Assets	**(3,197)**	**204**
Financial Liabilities		
At amortised cost	–	–
Total Financial Liabilities	**–**	**–**

Note 19: Financial Instruments (continued)

(e) Credit Risk

Credit risk represents the loss that would be recognised if counterparties fail to meet their obligations under the respective contracts at maturity. The credit risk on financial assets of the hospital has been recognised on the Balance Sheet, as the carrying amount, net of any provisions for doubtful debts.

There is no significant exposure to any individual debtor except to the Department of Human Services.

The hospital's exposure to credit risk and effective weighted average interest rate by ageing periods is set out in the following table. For interest rates applicable to each class of asset, refer to individual notes to the financial statements.

Ageing analysis of financial asset as at 30 June

	Carrying Amount $'000	Not Past Due and Not Impaired $'000	Past Due But Not Impaired				Impaired Financial Assets $'000
			Less than 1 Month $'000	1–3 Months $'000	3 months – 1 Year $'000	1–5 Years $'000	
2009							
Financial Assets							
Cash and Cash Equivalents	6,990	6,990	–	–	–	–	–
Receivables							
– Trade debtors	416	339	76	–	1	–	–
– Other receivables	789	560	15	48	166	–	–
Other Financial Assets							
– Other Financial Assets	56,773	56,773	–	–	–	–	–
Total Financial Assets	**64,968**	**64,662**	**91**	**48**	**167**	**–**	**–**
2008							
Financial Assets							
Cash and Cash Equivalents	5,490	5,490	–	–	–	–	–
Receivables							
– Trade debtors	270	151	70	49	–	–	–
– Other receivables	961	595	20	263	83	–	–
Other financial assets							
– Other Financial Assets	59,792	59,792	–	–	–	–	–
Total Financial Assets	**66,513**	**66,028**	**90**	**312**	**83**	**–**	**–**

Note 19: Financial Instruments (continued)

(f) Liquidity Risk

Liquidity risk arises from the possibility that the hospital may encounter difficulty in settling its debts or otherwise meeting its obligations to financial liabilities. This risk is managed by monitoring monthly cash flow in relation to the hospital's operational, investing and financing activities, managing credit risk related to financial assets and investing any surplus cash with major financial institutions.

The following table discloses the contractual maturity analysis for Hospital's financial liabilities. For interest rates applicable to each class of liability, refer to individual notes to the financial statements.

Maturity analysis of financial liabilities as at 30 June

			Maturity Dates			
	Carrying Amount $'000	Contractual Cash Flows $'000	Less than 1 Month $'000	1–3 Months $'000	3 months – 1 Year $'000	1–5 Years $'000
2009						
Financial Liabilities						
Payables	4,657	4,657	3,686	972	–	(1)
Other Financial Liabilities						
– Other	2,768	2,768	2,756	3	–	9
Total Financial Liabilities	**7,425**	**7,425**	**6,442**	**975**	**–**	**8**
2008						
Financial Liabilities						
Payables	5,090	5,090	2,595	665	1,830	–
Other Financial Liabilities						
– Other	467	467	458	–	–	9
Total Financial Liabilities	**5,557**	**5,557**	**3,053**	**665**	**1,830**	**9**

(g) Market Risk

The hospital's exposures to market risk are primarily through interest rate risk and price risk with only insignificant exposure to foreign currency risk. Objectives, policies and processes used to manage each of these risks are disclosed in the paragraph below.

Currency Risk

The hospital is exposed to insignificant foreign currency risk through its payables relating to purchases of supplies and consumables from overseas. This is because of a limited amount of purchases denominated in foreign currencies and a short timeframe between commitment and settlement.

Interest Rate Risk

Exposure to interest rate risk might arise primarily through the hospital's financial liabilities and assets with variable interest rates whereby a future change in rates will affect future cash flows or the fair value of fixed rate financial instruments. Minimisation of risk is achieved by mainly undertaking fixed rate financial instruments. For financial liabilities, the hospital mainly undertakes financial liabilities with relatively even maturity profiles.

Other Price Risk

Market price risk is the risk that the value of a financial instrument will fluctuate due to factors specific to the individual instrument or factors affecting all instruments traded in the market. The hospital is exposed to securities price risk and this is managed by an asset allocation strategy of diversification of investments across Industries and geographic locations.

Note 19: Financial Instruments (continued)

(d) Market Risk (continued)

Interest Rate Exposure of Financial Assets and Liabilities as at 30 June

	Weighted Average Effective Interest Rate (%)	Carrying Amount $'000	Interest Rate Exposure		
			Fixed Interest Rate $'000	Variable Interest Rate $'000	Non-Interest Bearing $'000
2009					
Financial Assets					
Cash and Cash Equivalents	5.82	6,990	–	6,990	–
Receivables					
– Trade debtors	–	416	–	–	416
– Other receivables	–	789	–	–	789
Other financial assets					
– Other Financial Assets	(4.69)	56,773	–	37,320	19,453
		64,968	**–**	**44,310**	**20,658**
Financial Liabilities					
Payables	–	4,657	–	–	4,657
Other Liabilities	–	2,768	–	–	2,768
	–	**7,425**	**–**	**–**	**7,425**
2008					
Financial Assets					
Cash and Cash Equivalents	7.46	5,490	–	5,490	–
Receivables					
– Trade debtors	–	270	–	–	270
– Other receivables	–	961	–	–	961
Other financial assets					
– Other Financial Assets	0.58	59,792	–	33,978	25,814
		66,513	**–**	**39,468**	**27,045**
Financial Liabilities					
Payables	–	5,090	–	–	5,090
Other Liabilities	–	467	–	–	467
		5,557	**–**	**–**	**5,557**

Sensitivity Disclosure Analysis

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, the hospital believes the following movements are 'reasonably possible' over the next 12 months (Base rates are sourced from the Reserve Bank of Australia):

– A shift of +5% and -5% in market interest rates (AUD) from year-end rates of 4%;

– A parallel shift of +5% and -5% in inflation rate from year-end rates of 2%.

Note 19: Financial Instruments (continued)

The following table discloses the impact on net operating result and equity for each category of financial instrument held by the hospital at year end as presented to key management personnel, if changes in the relevant risk occur.

		Interest Rate Risk				Other Price Risk			
		-2%		+2%		-10%		+10%	
	Carrying Amount $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000
2009									
Financial Assets									
Cash and Cash Equivalents	6,990	(140)	(140)	140	140	–	–	–	–
Receivables									
– Trade debtors	416	–	–	–	–	–	–	–	–
– Other receivables	789	–	–	–	–	–	–	–	–
Other financial assets	56,773	(746)	(746)	746	746	(1,945)	(1,945)	1,945	1,945
Financial Liabilities									
Payables	4,657	–	–	–	–	–	–	–	–
Other Liabilities	2,768	–	–	–	–	–	–	–	–
	57,543	**(886)**	**(886)**	**886**	**886**	**(1,945)**	**(1,945)**	**1,945**	**1,945**

		Interest Rate Risk				Other Price Risk			
		-1%		+1%		-1%		+1%	
	Carrying Amount $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000
2008									
Financial Assets									
Cash and Cash Equivalents	5,490	(55)	(55)	55	55	–	–	–	–
Receivables									
– Trade debtors	270	–	–	–	–	–	–	–	–
– Other receivables	961	–	–	–	–	–	–	–	–
Other financial assets	59,792	(340)	(340)	340	340	(258)	(258)	258	258
Financial Liabilities									
Payables	5,090	–	–	–	–	–	–	–	–
Other Liabilities	467	(5)	(5)	5	5	–	–	–	–
	60,956	**(399)**	**(399)**	**400**	**399**	**(258)**	**(258)**	**258**	**258**

Note 20: Commitments for Expenditure

	2009 $'000	2008 $'000
Capital Expenditure Commitments		
Payable:		
Land and Buildings	964	139
Plant and Equipment	569	1,172
Furniture and Fittings	–	6
Computer Equipment	6	42
Total Capital Commitments	**1,539**	**1,359**
Land and Buildings		
Not later than one year	1,539	1,359
Total	**1,539**	**1,359**
Other Expenditure Commitments		
Payable:		
Consumables/Supplies	2,821	1,751
Maintenance	46	107
Total Other Commitments	**2,867**	**1,858**
Not later than one year	2,301	1,813
Later than 1 year and not later than 5 years	566	45
TOTAL	**2,867**	**1,858**
Lease Commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating Leases	572	861
Total Lease Commitments	**572**	**861**
Operating Leases		
These operating leases relate to the provision of computers, photocopiers/facsimiles and printers for general hospital use		
Cancellable		
Not later than one year	440	511
Later than 1 year and not later than 5 years	132	350
TOTAL	**572**	**861**
Total Commitments for expenditure (inclusive of GST)	**4,978**	**4,078**
less GST recoverable from the Australian Tax Office	(306)	(371)
Total commitments for expenditure (exclusive of GST)	**4,672**	**3,707**

Note 21: Contingent Assets and Contingent Liabilities

The Royal Victorian Eye and Ear Hospital does not have any contingent assets or contingent liabilities.

Note 22: Segment Reporting

The Royal Victorian Eye and Ear Hospital derives all its revenue from within the Acute Health Program services.

Geographical Segment

The Royal Victorian Eye and Ear Hospital operates predominantly in Melbourne, Victoria. More than 90% of revenue, net surplus from ordinary activities and assets relate to operations in Melbourne, Victoria. The hospital has spoke services at Broadmeadows, Lilydale and Blackburn.

Note 23a: Responsible Persons Disclosures

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

	Period
Responsible Ministers:	
The Honourable Daniel Andrews, MP, Minister for Health	1/7/2008 – 30/06/2009
Governing Boards	
Ms Jan Boxall	1/07/2008 – 30/06/2009
Ms Katerina Angelopoulos	1/07/2008 – 30/06/2009
Ms Catherine Brown	1/07/2008 – 30/06/2009
Mr Tim O'Leary	1/07/2008 – 30/06/2009
Mr Ian Pollerd	1/07/2008 – 30/06/2009
Dr Nicolas Radford	1/07/2008 – 30/06/2009
Ms Jill Rossouw	1/07/2008 – 04/03/2009
Mr Chris Randell	1/07/2008 – 30/06/2009
Mr John Wilson	5/03/2009 – 30/06/2009
Mr Mike Zafiropoulos	1/07/2008 – 30/06/2009
Accountable Officers	
Mr Graeme Houghton	1/07/2008 – 07/08/2008
Ms Ann Clark	8/08/2008 – 30/06/2009

Note 23a: Responsible Persons Disclosures (continued)

Remuneration of Responsible Persons

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

	2009 No.	2008 No.
Income Band		
$0 – $9,999	1	–
$10,000 – $19,999	7	8
$20,000 – $29,999	1	–
$30,000 – $39,999	–	1
$40,000 – $49,999	1	–
$100,000 – $109,999	1	–
$190,000 – $199,999	1	–
$240,000 – $249,999	–	1
Total Numbers	**12**	**10**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**$501,521**	**$447,967**

Amounts relating to Responsible Ministers are reported in the financial statements of the Department of Premier and Cabinet.

Other Transactions of Responsible Persons and their Related Parties.

There were no other transactions with Responsible Persons and their Related Parties.

Note 23b: Executive Officer Disclosures

Executive Officers' Remuneration

The numbers of executive officers, other than Ministers and Accountable Officers, and their total remuneration during the reporting period are shown in the first two columns in the table below in their relevant income bands. The base remuneration of executive officers is shown in the third and fourth columns. Base remuneration is exclusive of bonus payments, long-service leave payments, redundancy payments and retirement benefits.

	Total Remuneration		Base Remuneration	
	2009	2008	2009	2008
$100,000 – $109,999	–	–	–	–
$110,000 – $119,999	–	–	–	–
$120,000 – $129,999	–	2	–	3
$130,000 – $139,999	2	–	2	–
$140,000 – $149,999	–	–	–	–
$150,000 – $159,999	–	–	–	–
$160,000 – $169,999	1	2	1	1
$170,000 – $179,999	–	–	–	–
$180,000 – $189,999	–	–	–	–
$190,000 – $199,999	–	–	–	–
$200,000 – $209,999	–	–	–	–
$210,000 – $219,999	–	–	–	–
$220,000 – $229,999	–	–	–	–
$230,000 – $239,999	–	–	–	–
Total	**3**	**4**	**3**	**4**
Total Remuneration	**$439,192**	**$582,844**	**$439,192**	**$536,889**

Note 24: Remuneration of Auditors

	2009 $'000	2008 $'000
Audit fees paid or payable to the Victorian Auditor-General's Office for audit of the hospital's current financial report	38	36
Internal audit	58	93
Total Paid and Payable	**96**	**129**

Note 25: Events Occurring after the Balance Sheet Date

The Royal Victorian Eye and Ear Hospital had the following changes to responsible persons after 30 June 2009:
– Ms Catherine Brown – Term as Board Director expired on 30 June 2009
– Dr Nicolas Radford – Term as Board Director expired on 30 June 2009
– Mr Chris Randell – Term as Board Director expired on 30 June 2009
– Mr Roger Greenman – Appointed to the Board of Directors as of 1 July 2009
– Mr Andrew Porter – Appointed to the Board of Directors as of 1 July 2009
– Ms Natalie Savin – Appointed to the Board of Directors as of 1 July 2009

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

We certify that the attached financial report for the Royal Victorian Eye and Ear Hospital has been prepared in accordance with Standing Direction 4.2 of the *Financial Management Act* 1994, applicable *Financial Reporting Directions,* Australian Accounting Standards, Interpretations and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the Operating Statement, Balance Sheet, Statement of Changes in Equity, Cash Flow Statement and Notes forming part of the financial report, presents fairly the financial transactions during the year ended 30 June 2009 and financial position of the Royal Victorian Eye and Ear Hospital at 30 June 2009.

We are not aware of any circumstance which would render any particulars included in the financial statements to be misleading or inaccurate.

We authorise the attached financial report for issue on this day.

Jan Boxall
Chair, Board of Directors
Melbourne
3 September 2009

Ann Clark
Chief Executive Officer
Melbourne
3 September 2009

David Gerrard
Chief Finance and Accounting Officer
Melbourne
3 September 2009

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Victorian Auditor-General's Office

INDEPENDENT AUDITOR'S REPORT

To the Members of the Board, The Royal Victorian Eye & Ear Hospital

The Financial Report

The accompanying financial report for the year ended 30 June 2009 of The Royal Victorian Eye & Ear Hospital which comprises the operating statement, balance sheet, statement of changes in equity and cash flow statement, a summary of significant accounting policies and other explanatory notes to and forming part of the financial report, and the board member's, accountable officer's and chief finance and accounting officer's declaration has been audited.

The Members of the Board's Responsibility for the Financial Report

The Members of the Board of The Royal Victorian Eye & Ear Hospital are responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the financial reporting requirements of the *Financial Management Act 1994*. This responsibility includes:

- establishing and maintaining internal controls relevant to the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error
- selecting and applying appropriate accounting policies
- making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

As required by the *Audit Act 1994*, my responsibility is to express an opinion on the financial report based on the audit, which has been conducted in accordance with Australian Auditing Standards. These Standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance whether the financial report is free from material misstatement.

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

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Level 24, 35 Collins Street, Melbourne Vic. 3000
Telephone 61 3 8601 7000 Facsimile 61 3 8601 7010 Email comments@audit.vic.gov.au Website www.audit.vic.gov.au

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Victorian Auditor-General's Office

Independent Auditor's Report (continued)

Matters Relating to the Electronic Presentation of the Audited Financial Report

This auditor's report relates to the financial report published in both the annual report and on the website of The Royal Victorian Eye & Ear Hospital for the year ended 30 June 2009. The Members of the Board of The Royal Victorian Eye & Ear Hospital are responsible for the integrity of the website. I have not been engaged to report on the integrity of the website. The auditor's report refers only to the statements named above. An opinion is not provided on any other information which may have been hyperlinked to or from these statements. If users of this report are concerned with the inherent risks arising from electronic data communications, they are advised to refer to the hard copy of the audited financial report to confirm the information included in the audited financial report presented on The Royal Victorian Eye & Ear Hospital website.

Independence

The Auditor-General's independence is established by the *Constitution Act 1975*. The Auditor-General is not subject to direction by any person about the way in which his powers and responsibilities are to be exercised. In conducting the audit, the Auditor-General, his staff and delegates complied with all applicable independence requirements of the Australian accounting profession.

Auditor's Opinion

In my opinion, the financial report presents fairly, in all material respects, the financial position of The Royal Victorian Eye & Ear Hospital as at 30 June 2009 and its financial performance and cash flows for the year then ended in accordance with applicable Australian Accounting Standards (including the Australian Accounting Interpretations), and the financial reporting requirements of the *Financial Management Act 1994*.

MELBOURNE
3 September 2009

D D R Pearson
Auditor-General

Level 24, 35 Collins Street, Melbourne Vic. 3000
Telephone 61 3 8601 7000 Facsimile 61 3 8601 7010 Email comments@audit.vic.gov.au Website www.audit.vic.gov.au

DISCLOSURE INDEX

The Annual Report of the Royal Victorian Eye and Ear Hospital is prepared in accordance with all relevant Victorian legislation. This index has been prepared to facilitate identification of the Department's compliance with statutory disclosure requirements.

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Data references

1. Community Mapping Project Report, Royal Victorian Eye and Ear Hospital 2008

2. Clear Insight – the economic impact and cost of vision loss in Australia, A Report prepared by Access Economics, 2004

3. Access Economics Pty Ltd from VIP, BMES and ABS population data in Clear Insight – the economic impact and cost of vision loss in Australia, A Report prepared by Access Economics, 2004

4. Australian Hearing 2005 data in Listen Hear! The economic impact and cost of hearing loss in Australia, Access Economics, 2006

5. Australian Bureau of Statistics from www.abs.gov.au

Royal Victorian Eye and Ear Hospital

Annual Report 2008 – 09

Production: Marketing and Community Relations, Royal Victorian Eye and Ear Hospital

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Front cover – Master Jack Aston & Mrs Sarah Aston
Back cover – Rainer Haycraft

The Eye and Ear thanks the patients who have shared their stories in this Annual Report.

Cover and editorial printed on paper that contains 55% recycled fibre (25% post consumer and 30% pre consumer) and FSC Certified pulp, which ensures that all virgin pulp is derived from well-managed forests and controlled sources. Financials printed on FSC Mixed Source Certified paper.

Rainer Haycraft, a 21 year old apprentice metal worker felt something go in his eye at work. At Eye and Ear Emergency, he was found to have a corneal lesion which was treated and managed in Emergency, overseen by Dr Peter van Wijngaarden. A few days off work allowed the eye to heal, and Rainer's eyesight has not been affected.

The Royal Victorian Eye and Ear Hospital
32 Gisborne Street East Melbourne
Victoria 3002 Australia
T +61 3 9929 8666
F +61 3 9663 7203
E info@eyeandear.org.au
www.eyeandear.org.au