Annual Report

2015–16

the royal victorian eye and ear hospital

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Vision, Mission and Values

The Royal Victorian Eye and Ear Hospital (the Eye and Ear) is Australia's leading provider of eye and ear health care. In 2015–16, the Eye and Ear cared for 250,000 patients throughout Victoria and continued to improve its operational and financial performance.

Vision
Improving quality of life through caring for the senses.

Mission
We aspire to be the world's leading eye and ear hospital by:

- Excelling in specialist services
- Integrating teaching and research with clinical services
- Leading workforce capability
- Partnering with consumers and communities
- Building a sustainable future

Values

Integrity
We act ethically, accept personal accountability, communicate openly and honestly and treat everyone with trust and respect.

Care
We treat patients with respect, are compassionate, thoughtful and responsive to their needs and sensitive to diversity.

Teamwork
We communicate openly, respect diversity of views and skills and work effectively with partners and in multi-disciplinary teams to deliver the best outcomes for patients.

Excellence
We give our personal best at all times, deliver exemplary customer service, monitor performance and seek leading edge ways to improve it.

Chair and CEO Report

It has been a busy and exciting year for the Royal Victorian Eye and Ear Hospital (the Eye and Ear) as we continue to progress our redevelopment project and meet the challenge of ongoing growth through collaboration, innovation and redesign.

It was with great pleasure that I assumed the role of Chief Executive Officer from Ann Clark in August 2015. Ann retired after seven years as CEO, leaving an indelible mark at the hospital. I would like to thank all the staff, volunteers and patients who have made me feel welcome in my new role.

Caring for all Victorians

The Eye and Ear is the largest provider of specialist eye, ear, nose and throat care services in Victoria. Our clinical services are delivered in partnership with patients, carers, the community and other health care providers across all metropolitan, regional and rural areas.

We continued to experience high demand on our services, with the hospital caring for 195,188 outpatients, 14,495 inpatients and 39,837 emergency patients this year.

As demand for our specialist services continues to increase, we must look to the future to ensure the hospital is equipped to meet the growing and changing needs of our community.

Redevelopment

Our redevelopment project is well underway and due for completion at the end of 2018. On 24 May 2016, the doors to our new Emergency Department were opened to patients and visitors. A week earlier, the Minister for Health, The Hon Jill Hennessy MP, officially unveiled the department, which is the first clinical area to be developed as part of the hospital's overall redevelopment project. The new area is filled with natural light, the waiting area and staff base are much larger, there are more consulting rooms and the patient flow is more streamlined; this will support our clinicians, nursing and clerical staff to provide dedicated patient centred care that will enhance the patient's experience.

Other key milestones in our redevelopment over the past 12 months include the successful relocation of our Medical Photography Imaging Centre – the first outpatient clinic area to relocate. We also moved a number of our departments into the new Lower Ground Floor, Smorgon Family Wing.

Earlier this year, we were excited by the announcement of an additional $31.4M funding for our redevelopment project to help meet the increases in costs the project has faced due to the unanticipated extensive removal of hazardous material. There was also an agreement made that we would temporarily relocate our outpatient and some of our day surgical services to the former Peter MacCallum Cancer Centre site, in St Andrews Place. This relocation will allow the builders to complete our redevelopment faster and in a less disruptive manner to our patients, consumers, staff and volunteers. The move involves a large amount of planning and consultation with patients, staff and the community prior to us being operational at our new site on the 29 August 2016.

Research

Last October our Board held a reception to celebrate the 80th birthday of Professor Graeme Clark AC. It was at the Eye and Ear that Professor Clark carried out the world's first cochlear implant operation in 1978. That success was the catalyst for the development of the bionic ear. Such events are a great reminder of the ground breaking research that is undertaken at the Eye and Ear that has led to us becoming an international centre of excellence and innovation.

We are currently involved with over 200 active research projects, all working towards improving outcomes for our patients. A critical factor in our research success is the strength of the relationships we have with partners such the Centre for Eye Research Australia, The University of Melbourne, the Bionics Institute, Bionic Vision Australia and the HEARing CRC. We acknowledge our research partners and the generosity of our patients who take part in ground-breaking research that will benefit future generations.

Affiliation Agreement with the Australian College of Optometry

In late 2015, the Eye and Ear signed an Affiliation Agreement with the Australian College of Optometry. This affiliation is a continuation of the partnership between our two organisations and demonstrates the integration of primary and secondary care services, which is being achieved by ophthalmology and optometry. By working together we are able to provide innovative care models for those patients needing both ophthalmological and optometric management.

Patient Centred Care

At the Eye and Ear, we are always looking for new ways to improve our patients' journey and ensure patients receive the best possible care in a timely and safe manner. This year our Community Advisory Committee led the introduction of a new initiative called the "Hello, my name is ..." campaign. All Eye and Ear staff wear name badges and introduce themselves and

their role at the beginning of every care conversation. The campaign demonstrates our commitment to personalised care and creates a welcoming and inclusive environment for our patients, their families and carers. The campaign also demonstrates our ongoing commitment to the National Safety and Quality Health Service Standards, as the campaign is intrinsically linked to Standard 2, Partnering with Consumers.

Aboriginal Eye and Ear Health

The eye and ear health of the Aboriginal and Torres Strait Islander community is an important issue at our hospital. In late 2015, we signed a Memorandum of Understanding with our neighbours, St Vincent's Health, aimed at improving access and promoting better health and wellbeing for Aboriginal and Torres Strait Islander people. By working with St Vincent's and sharing our expertise, knowledge, passion and resources, we can continue to make a difference to Aboriginal healthcare not only in East Melbourne, but the state of Victoria.

During the year we held the official launch of the Eye and Ear's art collection. We are building a quality art collection for the newly redeveloped hospital to improve the patient journey, reduce anxiety, assist with healing and provide a welcoming environment. The first five pieces in the hospital's collections, all from local Indigenous artists, were unveiled last August.

Staff Awards and Recognition

The Eye and Ear Excellence Awards recognise individuals and specialist groups who have contributed to achieving organisational excellence. The award categories acknowledge creative and original thinking that results in positive outcomes for our patients, an improved working environment or improved hospital systems. The winners of the 2015 Excellence Awards were:

- Board Chair's Medal – Associate Professor Michael Coote
- CEO's Team Award – Surgical Ophthalmology Clinical Leads: Dr John Manolopoulos, Dr Peter Meagher, Dr Christine Tangas, Dr Anton van Heerden and Associate Professor Diane Webster
- Aubrey Bowen Medal – Mr David Marty, Head of Rhinology
- Nursing Excellence Award – Elizabeth Wilson, Nurse Unit Manager, Ward 8
- Allied Health Excellence Award – Valerie Judge, Manager Social Services
- Administrative Excellence Award – Kathryn Day, Outpatients Booking Unit Coordinator

Acknowledgements

The Board Chair and CEO would like to thank Board Members, clinicians, volunteers and all staff for their continued dedication and passion throughout the year, particularly with the redevelopment process. This commitment ensures that we continue to provide world class care to our patients and the broader Victorian community.

We would like to extend a special thank you to Peter Buzzard and Jenny Taing for their contribution during their time on the Board of Directors, which ended in June 2015. We also welcome Ms Llewellyn Prain and Mr David Anderson to the Board.

Thank you

The Eye and Ear is most grateful for the generosity of its supporters. Financial support from our loyal donors and philanthropic Trusts and Foundations help the hospital to continue its work in improving quality of life through caring for the senses.

We are also sincerely grateful to our volunteers and community advisory members who offer their time to help others and make the patient experience a more positive and memorable one.

In accordance with the *Financial Management Act 1994*, the hospital is pleased to present the Report of Operations for The Royal Victorian Eye and Ear Hospital for the year ending 30 June 2016.

Sherene Devanesen
Chair, Board of Directors

Mark Petty
Chief Executive Officer

Board of Directors and Board Committees

The Board of Directors is appointed by the Governor in Council on the recommendation of the Victorian Minister for Health and is governed by the principles contained within the *Health Services Act 1988* (as amended).

The Board provides governance of The Royal Victorian Eye and Ear Hospital and is responsible for its financial performance, strategic directions, the quality of its health care services and strengthening community involvement through greater partnerships.

The 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.

Dr Sherene Devanesen MBBS; DIP(OBS)RACOG; FRACMA; FACHSM; FAIM; FHKCCM; GAICD

Appointed 14 April 2015
Chair Board of Directors
Member Finance Committee, Redevelopment Committee, Remuneration Committee

Dr Sherene Devanesen is the Chief Executive Officer of Yooralla. Before joining Yooralla in January 2014, Dr Devanesen was Chief Executive Officer of Peninsula Health. With over 30 years' experience in the management of health services and medical administration, her experience has provided her with a strong reputation in consumer consultation and engagement and in achieving quality outcomes for human and community services.

Mr David Anderson BCOM, MCOM (FINANCE)

Appointed 26 April 2016

Mr Anderson brings a wealth of experience in finance and audit. He has held senior finance positions within the Victorian Government over the past 20 years and has been Executive Director, Finance at Peninsula Health since 2002. David has a demonstrated commitment to the wider community and roles include being a current Fellow and Board member of Australian Health Services Financial Management Association (AHSFMA) and previously Treasurer of the Statewide Autistic Society (Vic).

Dr Malcolm Brown MBBS, DOH, FAFOEM (RACP)

Appointed 1 July 2011, reappointed 1 July 2014
Chair Audit Committee, Primary Care and Population Health Advisory Committee
Member Quality Committee

Dr Brown is an occupational physician in private practice and has many years' corporate experience, working primarily in the oil and gas and mining industries in Australia, the Middle East and Europe. He has sat on government expert committees, mainly on environmental health matters. Dr Brown is a Director of the Centre for Eye Research Australia (CERA) and is also an adjunct lecturer at the School of Public Health and Preventative Medicine at Monash University.

Mr Roger Greenman AM

Appointed 1 July 2009, reappointed 30 June 2012, 1 July 2015.
Chair Quality Committee, Redevelopment Committee
Member Finance Committee, Remuneration Committee

Mr 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. In March 2015, Mr Greenman was appointed Chair of the Snowdome Foundation.

Sandra Mercer Moore AM, DBA, M PHYSIOTHERAPY

Appointed 1 July 2011, reappointed 1 July 2014
Chair Community Advisory Committee
Member Quality Committee, Redevelopment Committee

Dr Mercer Moore has extensive experience in the Australian and the International Health Care industry, covering both private and public sectors. She is the immediate past president of the World Confederation for Physical Therapy, an alternate Director of the Centre for Eye Research Australia (CERA) and a Fellow of the Australian Institute of Company Directors. Dr Mercer Moore, an independent management and training consultant, serves as a Board Member for a range of organisations.

Mr Andrew Porter MA (HONS), FCA, MAICD

Appointed 1 July 2009, reappointed 1 July 2011, 1 July 2014
Chair Finance Committee
Member Redevelopment Committee, Remuneration Committee

Mr Porter is a Chartered Accountant and has had over 21 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.

Ms Llewellyn Prain BA(HONS), LLB(HONS), GAICD

Appointed 1 July 2015
Member Audit Committee, Community Advisory Committee

Ms Prain has worked as a commercial litigation lawyer and in senior roles at a number of Victorian government agencies. She is a past chair of the Western Region Health Centre and was an inaugural director of cohealth, one of the largest community health organisations in Australia. She is currently a director of Western Water and the Public Transport Ombudsman of Victoria. Ms Prain has a vision impairment and brings a strong consumer focus to the Board.

Mr Derek Skues DIP. ARCH., REG. ARCH., MAICD

Appointed 3 December 2013
Member Finance Committee, Quality Committee, Redevelopment Committee

Mr Skues is qualified and practiced as an architect and campus planner in Australia and internationally for many years prior to becoming a director of Atkinson Project Management in 1989, which merged with Aurecon in 2006. He has undertaken executive client management roles in Victoria, New South Wales and Hong Kong for a variety of health and university capital works projects. Mr Skues is currently a director of two not-for-profit foundations, and previously a director of City West Water and President and Camp Chief of the youth development organisation Lord Somers Camp and Power House.

Ms Sue Smethurst MAICD

Appointed 3 December 2013
Member Audit Committee, Community Advisory Committee, Primary Care and Population Health Advisory Committee

Ms Smethurst is a journalist who has held senior roles with Australia's leading media organisations for more than 20 years, enjoying prominent roles across magazines, television and radio. She is a best-selling author and is currently employed by Bauer Media's flagship title, The Australian Women's Weekly. She has extensive experience in the fields of media, communications and marketing and currently serves on a number of boards and committees for a wide range of organisations.

Board Committees

Audit Committee

The Audit Committee membership comprises the following non-executive directors: Dr Malcolm Brown (Chair), Ms Llewellyn Prain (from 10 September 2015) and Ms Sue Smethurst. Advisor: Ms Amanda Bond.

The Audit Committee meets at least four times per year and assists the Board in monitoring compliance with laws, regulations, standards and internal controls.

Key responsibilities for the Audit Committee include monitoring the hospital's strategic and operational risks, developing the hospital's strategic internal audit plan, oversight of the Internal Audit Program, review of the Draft Annual Accounts and review of the relevant risk policies and procedures. All the Audit Committee members are independent of Management.

Finance Committee

The Finance Committee membership comprises the following non-executive directors: Mr Andrew Porter (Chair), Dr Sherene Devanesen, Mr Roger Greenman AM and Mr Derek Skues. Advisor: Mr Grant Cashin.

The Finance Committee meets at least seven times per year and assists the Board to fulfil its duties relating to the effective financial management of the Eye and Ear.

Key responsibilities for the Finance Committee include oversight of the hospital's annual operating and capital budget, review of the financial management reports, advising the Board on the financial implications associated with major projects and reviewing the relevant financial policies and procedures. All the Finance Committee members are independent of Management.

Redevelopment Committee

The Redevelopment Committee membership comprises the following non-executive directors: Mr Roger Greenman AM (Chair), Dr Sherene Devanesen, Dr Sandra Mercer Moore AM, Mr Andrew Porter and Mr Derek Skues.

The Redevelopment Committee meets ad hoc to consider redevelopment issues as determined by the Board and to recommend a course of action(s) for consideration by the Board.

Remuneration Committee

The Remuneration Committee membership comprises the following non-executive directors: Dr Sherene Devanesen, Dr Malcolm Brown (from September 2015), Mr Roger Greenman AM and Mr Andrew Porter.

The Remuneration Committee meets at least annually and makes assessments and recommendations to the Board concerning the performance against the agreed Performance Plan, remuneration and bonus awards (if applicable) and terms and conditions of employment for the Chief Executive Officer. It also provides oversight of the remuneration and bonus arrangements (if applicable) of the Executive Directors of the hospital.

Quality Committee

The Quality Committee membership comprises the following non-executive directors: Mr Roger Greenman AM (Chair), Dr Malcolm Brown, Dr Sandra Mercer Moore AM and Mr Derek Skues.

The Quality Committee meets quarterly and provides leadership and strategic direction on issues regarding the quality of services at the Eye and Ear. The Committee's focus is the delivery of the highest level of quality and safety to patients, family and staff, and to ensure that all relevant standards are met. Innovation to improve quality and safety systems is a priority. The committee works in conjunction with the Community Advisory Committee to develop the annual Quality of Care Report which highlights patient and family-centred care service improvements.

Community Advisory Committee

The Community Advisory Committee membership includes the following non-executive directors: Dr Sandra Mercer Moore AM (Chair), Ms Llewellyn Prain (from September 2015) and Ms Sue Smethurst.

The Community Advisory Committee advises the Board on consumer and community participation in the development and delivery of services. The committee meets bi-monthly and members include community, consumer and carer representatives.

Primary Care and Population Health Advisory Committee

The Primary Care and Population Health Advisory Committee membership includes the following non-executive directors: Dr Malcolm Brown (Chair) and Ms Sue Smethurst.

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 at least annually.

Executive Management

Chief Executive Officer

Mark Petty MHA, GDIP COMP SCI, BAPPSCI ADV NSG, RN, GAICD

The Chief Executive Officer is accountable to the Board for executive leadership and management 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 Health

Executive Director Medical Services and Chief Medical Officer

Dr Christine Bessell MBBS, MPH, FRANZCOG, FRACMA (UNTIL DECEMBER 2015)

Dr Caroline Clarke MD, FRACP, MRCP, FRACMA

The Executive Director Medical Services and Chief Medical Officer is responsible for professional leadership of the medical workforce. The role also has executive responsibility for the medical workforce, medical training and education and the research strategy of the hospital, as well as responsibility for the leadership of clinical governance and improvement initiatives, including those related to the redevelopment and the introduction of the Electronic Medical Record. The role also manages Health Information Services and provides oversight of the Data Integrity Framework and management of clinical datasets.

Clinical Director Ophthalmology Services

Dr Mark McCombe MBBS, FRANZCO

The Clinical Director Ophthalmology Services is responsible for ophthalmic medical leadership. The role advises on strategy and models of care in ophthalmology that are sustainable and lead to excellence.

Executive Director Chief Operating Officer and Chief Nursing Officer

Ms Jenni Bliss GENERAL NURSING, GRAD DIP, ADVANCED CLINICAL PRACTICE PAEDIATRICS AND PROFESSIONAL CERTIFICATE IN HEALTH SYSTEMS MANAGEMENT, ACHS EXECUTIVE LEADERSHIP PROGRAM

The Chief Operating Officer (COO) is responsible for overseeing all clinical operations for the organisation including surgical and inpatient services, the Emergency Department, and ambulatory service delivery. As Chief Nursing Officer, the role also has professional responsibility and leadership for all nursing staff, the clinical competence framework and nurse education.

Clinical Director ENT Services

Mr Robert Briggs MBBS, FRACS, FACS

The Clinical Director ENT Services provides clinical and medical leadership, advice on models of care to support clinical excellence in ear, nose and throat and surgical support services.

Executive Director Redevelopment, Planning and Infrastructure

Ms Jenni Gratton-Vaughan BAPPSC, GRADDIPREHABSTUD, MBUS, DIP PROJECT MGT, MAICD (UNTIL SEPTEMBER 2015)

Mr Alex Campbell B.EC, MHA, CPA, AFCHSM , GAICD (FROM SEPTEMBER 2015 TO DECEMBER 2015)

Mr Ian Leong BACH BLDG (QS) (HONS), GRAD DIP COMP SC, MBA (DECEMBER 2015, ONGOING)

The Executive Director Redevelopment, Planning and Infrastructure has overarching responsibility for capital redevelopment of the Eye and Ear, future health service delivery strategy, facility maintenance and security services. The role has oversight of the 5 year redevelopment program, the model of care and physical works associated with the redevelopment and service planning.

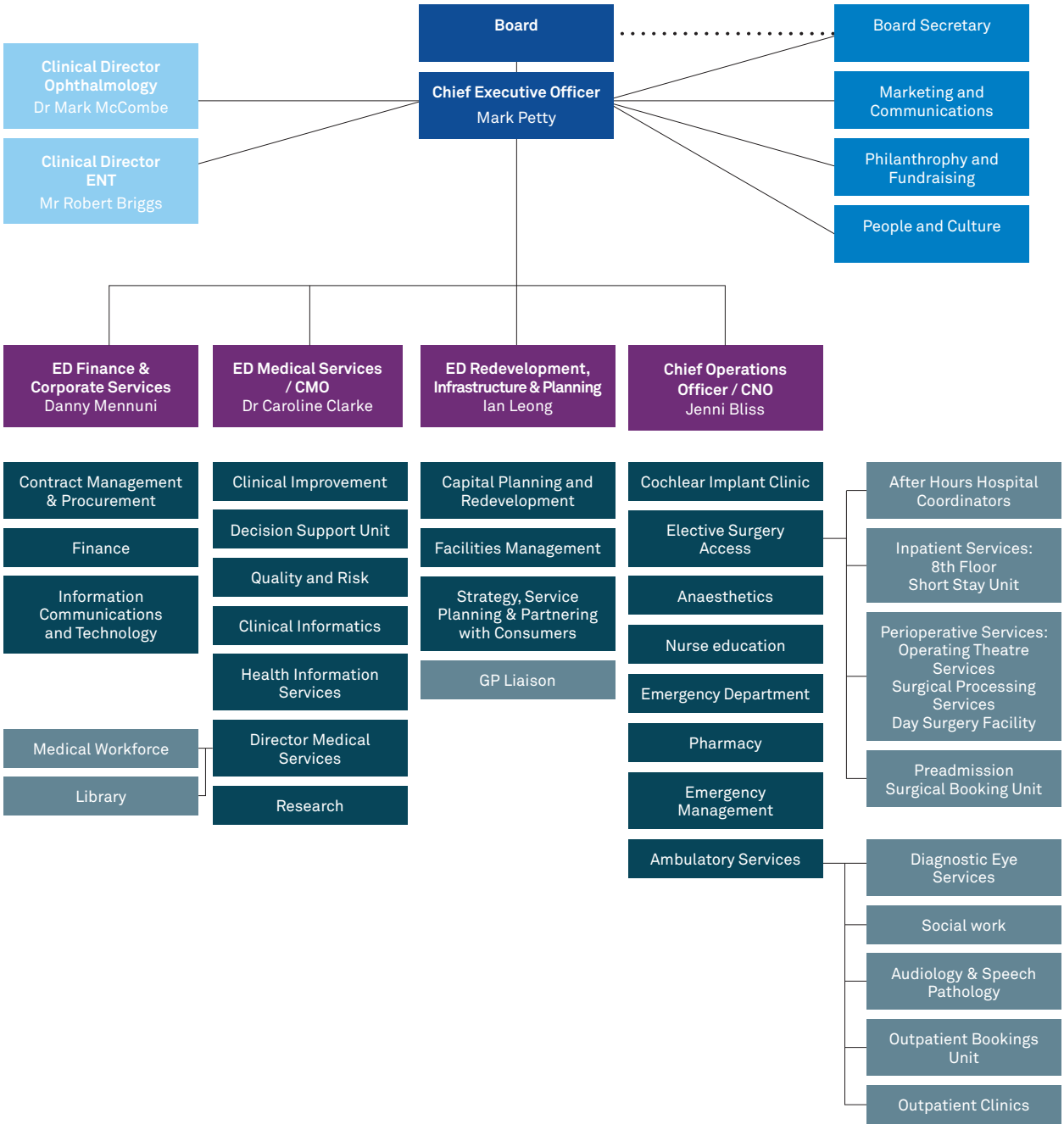
Executive Director Finance & Corporate Services

Mr Peter Gould BBUS, PGRADDIPSIA, FCPA, FFIN (UNTIL NOVEMBER 2015)

Mr Danny Mennuni B.BUS, CPA (FROM NOVEMBER 2015, ONGOING)

The Executive Director Finance and Corporate Services is the Chief Financial Officer and is responsible for providing leadership in financial management, reporting and controls. The position is also responsible for leading and managing efficient and effective information technology, contracts and procurement services.

Organisational Chart



Donors and Supporters

The Eye and Ear is most appreciative of the continued support of our donors, ambassadors and volunteers. The financial donations and funding we receive enables us to improve our services to patients through the purchase of state-of-the-art equipment, new treatment options and continued research into new diagnostic techniques and treatments.

We also gratefully acknowledge our supporters who have expressed their intent to leave a bequest and those who have left a bequest to the Eye and Ear to help us continue to improve care and treatment for those living with vision and hearing loss in the future.

Patron

His Honour Judge Anthony Howard QC
(11 August 2015 – present)

Wagstaff Fellowships 2015–16

This significant bequest from Ernest Wagstaff was received in 1996 to support research and fellowships. In 2015–16 funds from this bequest were used to fund major research fellowships in ophthalmology and otolaryngology as follows:

Wagstaff Fellow in Ophthalmology

Associate Professor Ian Trounce (PhD) completed his fellowship term studying improvements to ocular health in ageing by optimising mitochondrial function.

Wagstaff Fellow in Otolaryngology

In 2015–16 Dr Karina Needham (PhD) continued her study on functional outcomes of novel treatments for hearing loss. Dr Needham's Fellowship continues until April 2017.

Peter Howson Deafness Fellowship 2015–16

A joint venture between The Royal Victorian Eye and Ear Hospital and the Deafness Foundation funds a two year Fellowship in the field of hearing science and is now in its fifth year. The Peter Howson Research Fellow during 2015–16 were as follows:

Dr Jessica Vitkovic (PhD) completed her Fellowship researching the contribution of hearing to balance control.

Dr Kerryn Saunders (MB BS, FRACP) was appointed as the third Peter Howson Deafness Fellow researching a new clinical model for early identification and management of congenital CMV hearing loss.

Zoran Georgievski Memorial Research Scholarship 2015–16

The late Associate Professor Zoran Georgievski was Manager of Diagnostic Eye Services at the Eye and Ear and in 2012, in conjunction with La Trobe University, a scholarship was established in his memory.

Ms Jane Scheetz is the inaugural recipient of the Scholarship and her PhD research project is entitled 'The Validity and Reliability of Orthoptists in Classifying or Measuring Glaucoma Progression'.

Our Major Donors, Bequestors, Corporate and Community Supporters

Trusts and Foundations

Collier Charitable Fund
Lord Mayor's Charitable Foundation
Louis and Lesley Nelken Trust Fund
Joe White Bequest
L.E.W. Carty Charitable Fund
John and Thirza Daley Charitable Trust

Bequests

Estate of Alwyn George Riordan
Estate of Alfred Heller
Estate of Anne Murray
Estate of Betty Lesley Manning
Estate of Bruce L Powell
Estate of Cornelis Teeuwen
Estate of David Brian Draffin
Estate of Doris Annie Layton
Estate of Edwin Erasmus Hinde
Estate of Helena Nolan
Estate of John Alexander Anderson
Estate of Joan Frances Norris
Estate of John F Wright
Estate of Kim-Thoa Tran
Estate of Lena Weysenfeld
The Elizabeth & Alexander Reddan Memorial Foundation
The Estate of the late Frank Berra

Estates

The Orloff Family Charitable Trust
The Elizabeth and Alexander Reddan Memorial Foundation
The Harry Yoffa Charitable Bequest

Managed by Perpetual
Estate of John Alexander Anderson
Estate of Alfred H W Dehnert
The Joseph and Kate Levi Charitable Trust
The Rudolph Hally and Pia Martin Memorial Trust

Managed by Equity Trustees
The Erica Cromwell Trust
Estate of Heather Sybil Smith
Estate of John F Wright
George T and Lockyer Potter Trust
Estate of Ernest and Letitia Wears
Joseph Kronheimer Charitable Fund
Eliza Wallis Charitable Trust
Betty Brenda Spinks Charitable Trust
William Hall Russell Trust Fund

Managed by State Trustees
Estate of Bruce L Powell
Estate of Jessie Ross

Major Donors
Anonymous donor
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Mr Brian Goddard
Mr Leon Goldman and the late Mrs Judith Goldman
Mr Philip Hammond
Mr Bruce Howells
Mr and Mrs Harold and Margaret Jarvis
Mr and Mrs Peter and Lesley James and family
Mr Con Kalfadellis
Mr Boo Tsan Khoo
Mr Brian Loton
Mr Minh Ly
Miss Jules McLean in memory of the late Mr Douglas McLean
Miss Carolyn Maddy
Mr Alan McKay
Mrs Diep Nguyen
Mrs Dorothy NowellMrs Nirmala Pandey
Mr Herbert Palmer
Mr John Phillips
Mr Michael Sandor
Mr Arthur Tsilibakis and Ms Janet Sickinger
Ms Kirsty Smith
Mt Harry Soultanidis
The late Ms Robyn Swanson
Mrs Marjorie Todd
Ms Ngoc Chau Tran
Mrs Thi Joan Vu
Mr John Waddington
Mr Michael Whelan
Mrs Joan Whiting
Mr Lloyd Williams
Mr Robert A Young

Community Supporters
Lions Club of Melbourne Chinese
Charity and Multi Art
Camcare Charity Card Shop
Ritchies Stores
United Way
Uniting Church in Australia
Zouki Catering

Volunteers
The hospital is home to a dedicated and growing group of volunteers who assist in a range of roles, offer a welcoming smile and a bit of extra help to reassure patients in need. This year we were fortunate to welcome 30 new volunteers to the Eye and Ear.

In the past year our volunteers have given close to 8,000 hours of their time and provided direct assistance to over 65,000 patients. The Concierge volunteers provide an important personal touch to our patients' experience as they help patients and their carers throughout their journey from arrival at our front door to arranging a taxi ride home. Volunteers also support patients in our Outpatient Clinics and have been instrumental in making the transition to our new Emergency Department a smooth one for our patients and visitors. We sincerely thank all our volunteers for their hard work and continued commitment.

We would like to take the opportunity to thank our Auxiliary members who are often one of the first people in the hospital of a morning and continue to raise vital funds both within the hospital and the wider community.

We also appreciate the contributions made by consumers who kindly provide their time to participate in our advisory and research committees, hospital working groups, focus groups and committees, act as patient ambassadors and are members of our consumer register. Our consumers make up a very special workforce who represent the voices of our patients. We currently have just over 100 consumers on our register who have partnered with the hospital to provide their feedback and help us work towards ensuring that our hospital meets the needs of all our patients and visitors.

Service Overview

The Royal Victorian Eye and Ear Hospital has provided state-wide eye, ear, nose and throat health care since it was founded in 1863. The hospital is accountable to the people of Victoria, through the Minister for Health.

Manner of Establishment and Relevant Minister

The Eye and Ear was founded in 1863 by the pioneer surgeon, Dr Andrew Sexton Gray. The hospital is a public health service and is established under the Health Services Act 1988 (as amended). The responsible Minister during the reporting period was The Hon Jill Hennessy MP.

Powers and Duties

The power and duties of The Royal Victorian Eye and Ear Hospital are prescribed by the *Health Services Act 1988*.

Nature and Range of Services

The Royal Victorian Eye and Ear Hospital provides a state-wide specialist tertiary and emergency eye and ear health care service. It is internationally recognised as a leader in clinical service delivery, teaching and research in both ophthalmology and otolaryngology.

The hospital operates from a central hub at East Melbourne to ensure ease of access to eye and ear specialists. Services are provided in outpatient and community settings.

As the largest public provider of ophthalmology and ENT services in Victoria, the hospital delivers more than half of Victoria's public eye surgery and all of Victoria's public cochlear implants. The Eye and Ear has over 50 different outpatient clinics for the diagnosis, monitoring and treatment of vision and hearing loss and provides a 24-hour emergency eye and ENT health service. The majority of services provided at the Eye and Ear are on an outpatient or same-day basis. In 2015–16 we cared for 250,000 patients throughout Victoria:

- 195,188 outpatients
- 14,495 inpatients
- 39,837 emergency patients.

There were also 19,250 pharmacy occasions of service, which are not included as part of our total number of patients in 2015-26.

The hospital is a teaching and research centre and has key partnerships with the Centre for Eye Research Australia, The University of Melbourne, the Bionics Institute, Bionic Vision Australia and The HEARing CRC.

Disability Action Plan

The Eye and Ear is committed to providing an inclusive and accessible environment for staff, patients and visitors to the hospital; regardless of ability or capacity.

The Disability Action Plan (DAP) has been updated and merged into the Partnering with Consumers and Community Plan, following extensive community consultation. A new governance model has been established to ensure organisational wide engagement in the key deliverables and objectives of the plan.

The DAP reflects the strategic priorities of the Eye and Ear, whilst meeting the requirements of the *Federal Disability Discrimination Act 2006*. Major DAP achievements implemented in 2015–16 include collaboration in the development of the language line project, an accessibility audit of our web site, contribution to the 'Hello, my name is ...' campaign and input into strategic and operational planning processes.

Privacy

Privacy is an important part of the culture at the Eye and Ear. Since the *Health Records Act 2001* became legally binding in 2002, the hospital has aimed to ensure all staff are aware of the Act and its implications in the workplace. The hospital also aims to ensure compliance with the *Privacy and Data Protection Bill 2014*.

The Eye and Ear's Privacy Officer is the Executive Director Medical Services and Chief Medical Officer.

Protected Disclosures Act 2012

Under the *Protected Disclosures Act 2012* (the Act), complaints about certain serious misconduct or corruption involving public health services in Victoria should be made directly to the Independent Broadbased Anti-corruption Commission (IBAC) in order to remain protected under the Act. The Eye and Ear encourages individuals to make any disclosures which are protected disclosures within the meaning of the Act with IBAC. The hospital also has a range of procedures in place to ensure no detrimental action is taken against anyone who makes a protected disclosure, including an overarching procedure available through the hospital's website.

Carers Recognition Act 2012

The *Carers Recognition Act 2012* recognises, promotes and values the role of carers. The Eye and Ear understands the different needs of carers and the value they provide to the community. The Eye and Ear takes practical measures to ensure that our staff have an awareness and understanding of the care relationship principles and this is reflected in our commitment to a model of patient and family-centred care and to involving carers in the development and delivery of our services.

Workforce Data by Labour Category

Labour Category	June 2015 Current Month	June 2016 Current Month	June 2015 YTD FTE	June 2016 YTD FTE
Nursing	153	155	157	156
Administration and Clerical	159	155	160	157
Medical Support	41	45	45	44
Hotel and Allied Services	13	11	12	11
Medical Officers	5	6	5	6
Hospital Medical Officers	59	52	60	60
Sessional Clinicians	31	32	31	31
Ancillary Staff (Allied Health)	37	40	37	37
	498	**496**	**507**	**502**

Freedom of Information

The Victorian *Freedom of Information (FOI) Act 1982* provides members of the public with the right to apply, in writing, to the Eye and Ear for access to information held by the hospital. The hospital provides an annual report of all FOI requests to the Victorian Department of Justice.

Freedom of Information Applications 2015–16	
Total requests	193
Fully granted	190
Completed	190

Of the 190 applications, 38 were from the general public. Of the total requests received by the hospital (193 received, 3 were withdrawn), all were acceded to.

The requirements for making a request are:

- it should be in writing
- it should identify as clearly as possible which document is being requested
- it should be accompanied by the appropriate application fee.

People and Culture

The Eye and Ear continued to develop the workforce and engage with staff to deliver patient care that aims to be the world's best. We do this through practices that are underpinned by behaviours which align to our organisational values of integrity, team, care and excellence. We measure the uptake of these through the Victorian Public Sector People Matter staff survey. The organisation's Values and Code of Conduct are widely promoted and form the basis of how we work together.

The Strategic Workforce Plan continued to be implemented to ensure our people initiatives effectively build workforce capability to meet current and future demand.

Recruiting Staff

In 2015–16 the Eye and Ear workforce comprised of approximately 883 staff; we recruited 155 new staff, all of whom attended an orientation program.

Our orientation program transitioned into a blended delivery approach with a new online orientation course that combines with a face-to-face welcome event.

Merit, fairness and reasonable treatment, equal opportunity and avenues of redress are reinforced in our policies and procedures to support our decision making processes.

Pre-employment Safety Screening

The organisation continues to apply thorough credentialing and pre-employment verification checks to ensure we sustain safety and quality of health care provision. Applicable clinical staff are required to hold and maintain current registration with the relevant National Board in conjunction with the Australian Health Practitioner Regulation Agency (AHPRA) or equivalent. All staff are required to maintain a satisfactory Criminal Record Check and clinical staff are required to hold a valid Working With Children Check.

Aboriginal Employment Plan

The organisation continued activities to support the Aboriginal Employment Plan which is designed to provide practical steps to achieve increased workforce participation under Karreeta Yirramboi. The hospital is working towards setting strong foundations and developing greater cultural awareness and understanding of the Victorian Aboriginal community's needs and requirements. We are implementing attraction and retention strategies to ensure Aboriginal employees are engaged in sustainable and rewarding employment, both now and well into the future.

Employee Recognition Programs

Our staff are recognised for their contribution to eye, ear nose and throat treatment, research and patient care through our Employee Recognition Programs. The winners of our 2015 Excellence Awards are listed in our Chair and CEO Report on page 3. Our quarterly *'I see you, I hear you, Values in Action'* staff reward and recognition program is well supported and receives many worthy nominations throughout the year. The program aims to recognise and retain staff who contribute to the organisation's vision of improving quality of life through caring for the senses, through practical demonstration of our values.

The following were the recipients of the *'I see you, I hear you, Values in Action'* Award for 2015–16:

- Glenda Prewett, Contracts and Procurement Manager
- Damien Curran, Registered Nurse Ward 4
- Janki Solanki, Pharmacist Grade 1
- PIMS Project Team - Owen Thistlethwaite, George Suluk, Diane Kempen, Caroline McClelland, Marc Hand, Farzan Farnoodfar, Fiona Jessett, Jason Yap and Stefan Orzes.

In 2015, the Length of Service Awards were held and we awarded 128 staff acknowledging either 10, 15, 20, 25, 30, 35 and one outstanding 40 years of service.

Employee Counselling and Support Program

The Employee Assistance Program is a confidential external counselling service available to staff, their family and household members. The service provides assisting in addressing personal concerns or work related issues that have an impact on wellbeing and quality of life. The service also offers managers support and post incident debriefing in the workplace.

Developing Our Workforce

The Eye and Ear recognises ongoing education is integral to increasing capacity and maximising performance. Education programs are provided for nursing, medical, allied health and administrative staff.

The Eye and Ear continued to sponsor leadership development programs to build the effectiveness of our managers. In line with our organisational priorities, we have placed an emphasis on building successful change leadership and management skills. This gave rise to the development of key resources namely, a practical toolkit to support managers before, during and after change.

The 'Leading with Impact' leadership program was held for operational leaders with a focus on leadership communication, change management, a coaching leadership style, quality decision making and executive strategy at the frontline.

The mandatory training matrix continues to guide our requirements in line with the Australian Council on Health Care Standards. The matrix outlines training requirements by professional groups.

The MyLearning system profiles individual training schedules of mandatory and professionally recommenced education courses for staff to ensure they maintain the knowledge and skills to perform their role safely.

People managers conduct annual performance and development reviews for their team members. This provides a formal framework to ensure performance discussions are held to review past achievements and set work and development goals for the next 12 months. Managers are provided with tools and support from People and Culture to facilitate meaningful conversations and outcomes. This process provides for the review of: individual clinical scope of practice; mandatory training compliance; expectations about quality and safety responsibilities; upward feedback; and, feedback on quality and safety processes.

Payroll

In consultation with Melbourne Health (our external payroll provider), a survey was created seeking feedback on the knowledge, professionalism and responsiveness of the service provider. There was a 12.5% response rate, with satisfaction rates of over 80% in respect to the responsiveness and over 70% in respect to the knowledge and professionalism of the provider. A large number of employees indicated a preference for a self-service function where employees could view their leave balances on line. Process improvement activities are underway to increase the use of online systems.

Health and Wellbeing Initiatives

The Eye and Ear recognises the important link between employee wellbeing and the delivery of high quality patient care.

During the year our wellness@work program focused on building a foundation of staff wellbeing with initiatives such as:

- forming a Health and Wellbeing Committee with staff members who have an interest in this area
- taking part in the State Governments' Healthy Together Victoria Achievement Programs for Workplaces
- providing information about healthy eating and food choices
- free sunscreen
- introductory mindfulness sessions
- building links for staff to access a local gym which provides yoga and fitness classes.

The program's future priority areas are: mental health, physical activity, nutrition, smoking, alcohol and financial health.

Occupational Health and Safety

The Eye and Ear continues to drive initiatives that maintain a safe environment for employees, patients, visitors, volunteers and contractors. We operate in accordance with the Victorian *OHS Act 2004*, *OHS Regulations 2007*, the *Workplace Injury Rehabilitation and Compensation Act 2013* and other relevant legislation.

Our culture of staff safety continued to be a priority during 2015-16, our approach included:

- zero tolerance for inappropriate behaviour at work including bullying and harassment
- developing a wellbeing strategy
- raising awareness of appropriate behaviours and encouraging staff to report concerns through online education and staff forums
- ensuring People and Culture are able to respond to complaints and are adequately skilled in conducting workplace investigations.

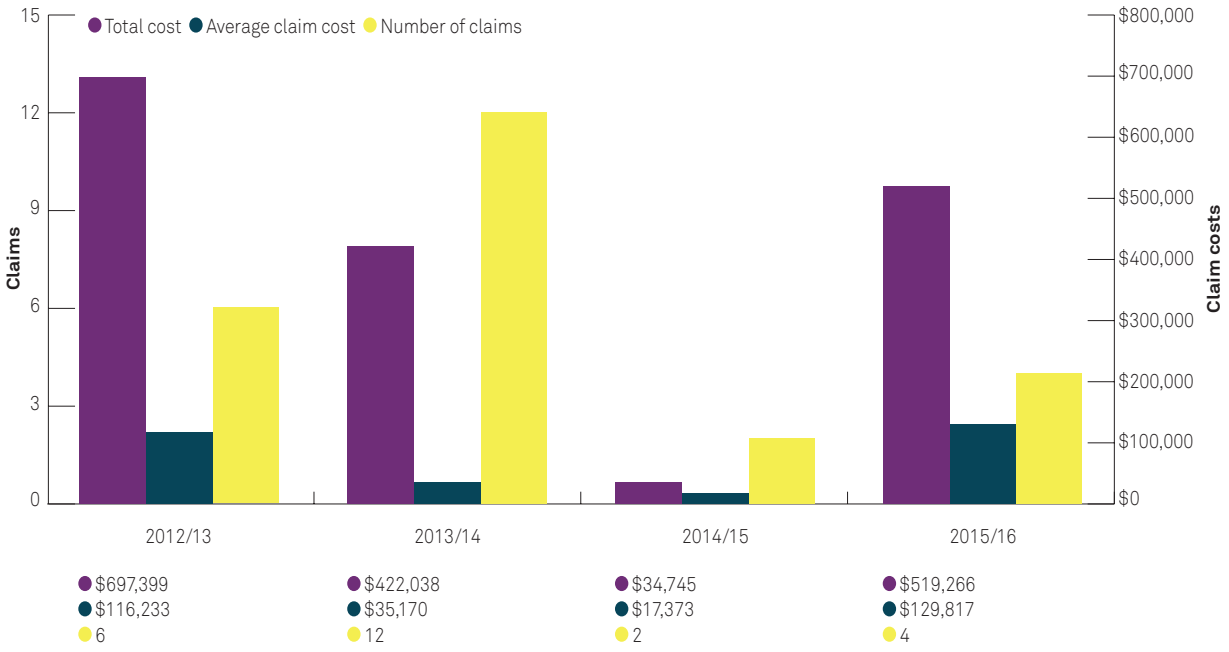
In 2015-16, the Health, Safety and Environment Committee met regularly during the year to discuss and address safety issues. Other committees with key roles in addressing safety include the Laser and Radiation Safety and Emergency Management Committees. Staff and safety representatives were involved in health and safety decisions through regular meetings.

Our designated work group structure was reviewed to align with the department changes due to the redevelopment. This followed extensive consultation with staff, and ensures all staff are represented by an elected health and safety representative.

Our OHS training includes: bullying prevention training for all managers, aggression management for clinical staff, manual handling 'train the trainer' training for Allied Health staff, OHS education at orientation and local induction, laser and radiation safety for clinical staff, and emergency response training for emergency coordinators and area wardens.

Workers Compensation

The total number of WorkCover claims lodged increased in 2015–16 (from 2 to 4). There were four standard claims reported, with three resulting in time lost from work during the year. The table below summarises workers' compensation claims lodged over the last four years. It shows a comparison of total claims costs and the average cost per claim.



Occupational Violence

Occupational violence is any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment. The Eye and Ear can report the following occupational violence statistics for 2015–16:

Occupational violence statistics	
Workcover accepted claims with an occupational violence per 100 FTE	0
Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	0
Number of occupational violence incidents reported	18
Number of occupational violence incidents reported per 100 FTE	3.59
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	0%

Building and Maintenance Compliance

During the financial year, it has been practice to obtain building permits for building projects and certificates of occupancy or certificates of final inspection for all completed projects. Registered building practitioners have been engaged for all building projects, new or major refurbishments.
To ensure buildings are maintained in a safe and functional condition, ongoing maintenance programs are in place. There is a requirement under the *Building Act 1993* (*Building Regulations 2006*, rr. 1209, 1215) for the hospital to establish comprehensive management of the Essential Safety Measures (ESM). In 2016, the hospital once again achieved 100% compliance with mandatory ESM inspections, testing, maintenance and documentation in relation to building safety.
The hospital has established a comprehensive management of the Essential Safety Measures (ESM). All ESM are annually audited and identified on the Certificate of Occupancy issued by the building surveyor with each ESM maintained as per certified maintenance agreements at the specified time intervals. The ESM compliance certificates can be located on display at the main entrance of the hospital.

Information and Communication Technology (ICT) expenditure

The total ICT expenditure incurred during 2015-16 is $4,323,000 (excluding GST) with the details shown below.

($ millions)

Business As Usual (BAU) ICT expenditure	(Total) (excluding GST)	**$3.07**
NonBusiness As Usual (nonBAU) ICT expenditure	(Total=Operational expenditure and Capital Expenditure) (excluding GST)	**$1.25**
Operational expenditure (excluding GST)		**$0**
Capital expenditure (excluding GST)		**$1.25**

Environmental Achievements

In 2015–16 the Eye and Ear has continued its commitment to monitoring and improving its environmental performance and managing environmental risks that affect our patients, visitor, staff, community and assets by integrating considerations of environmental sustainability into all business operations, especially during the hospital's redevelopment project.

In the past 12 months the Eye and Ear has:

- Publicly reported and disclosed hospital environmental performance.
- Continued with recycling program.
- During redevelopment assessed redundant and obsolete goods and worked with other partners such as: recyclers, universities, other health services and charity organisations including the Marsh Foundation.
- Promoted World Environmental Day.
- Implementation project commenced for the new Environmental Date Management system for reporting performance and data.

Victorian Industry Participation Policy Disclosure

The Eye and Ear complies with the *Victorian Industry Participation Policy Act 2003*. The Act requires, wherever possible, local industry participation in supplies, taking into consideration the principle of value for money and transparent tendering processes.

National Competition Policy

In accordance with the Competition Principles Agreement (CPA), Victoria is obliged to apply competitive neutrality policy and principles to all significant business activities undertaken by government agencies and local authorities.

The Victorian Government's competitive neutrality policy commits public health services to apply this policy to 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.

Competitive Neutrality Policy Victoria 2000 sets out the Victorian approach to competitive neutrality. The Eye and Ear complies with this policy in all relevant business activities.

Compliance

The Eye and Ear has complied substantially with the requirements of the Victorian Public Sector Financial Management Compliance Framework for the year ended 30 June 2016.

Consultancies less than $10k

In 2015–16, the Eye and Ear engaged one consultant where the total fees payable to the consultant were less than $10,000, with a total expenditure of $5,571 (excluding GST).

Consultancies more than $10k

In 2015–16, there was one consultant where the total fees payable to the consultant was $10,000 or greater. The total expenditure incurred during 2015-16 in relation to this consultancy was $13,000 (excl. GST).

($ thousand)

Consultant	PharmConsult
Purpose of consultancy	Professional Fees to investigate options regarding medication management systems
Start date	January 2015
End date	September 2015
Total approved project fee (excluding GST)	$18
Expenditure 2015-16 (excluding GST)	$13
Future expenditure (excluding GST)	0

Disclosure of Ex-Gratia Payments

The Eye and Ear made no ex-gratia payments for the year ending 30 June 2016.

Additional Information Available on Request (FRD 22G Appendix)

In compliance with the requirements of FRD 22G Standard Disclosures in the Report of Operations, details in respect of the items listed below have been retained by The Royal Victorian Eye and Ear Hospital and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements, if applicable):

- Declarations of pecuniary interests have been duly completed by all relevant officers.
- Details of shares held by senior officers as nominee or held beneficially;
- Details of publications produced by The Royal Victorian Eye and Ear Hospital can be obtained upon request.
- Details of changes in prices, fees, charges, rates and levies charged by the Health Service.
- Details of any major external reviews carried out.
- Details of major research and development activities undertaken that are not otherwise covered either in the Report of Operations or in a document that contains the financial statements and Report of Operations.
- Details of overseas visits undertaken including a summary of the objectives and outcomes of each visit.
- Details of major promotional, public relations and marketing activities undertaken by the entity to develop community awareness of The Royal Victorian Eye and Ear Hospital.
- Details of assessments and measures undertaken to improve the occupational health and safety of employees.
- General statement on industrial relations within The Royal Victorian Eye and Ear Hospital and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the Report of Operations.
- A list of major committees sponsored by The Royal Victorian Eye and Ear Hospital, the purposes of each committee and the extent to which those purposes have been achieved.
- Details of all consultancies and contractors including consultants/contractors engaged, services provided, and expenditure committed for each engagement.

Key Financial and Service Performing Reporting

Part A: Strategic Priorities

Domain	Action	Deliverables	Outcomes
Patient experience and outcomes	Drive improved health outcomes through a strong focus on patient-centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first.	A new model of care will be implemented for new and for reviewing outpatient appointments to increase discharge to community care, decrease waiting times and optimally manage waiting list.	**Achieved** implementation of new model of care within medical retina clinic. Otology clinic review currently in progress.
		Continued to participate in the DHHS redevelopment project and construct and commission a new Emergency Department.	**Achieved** Emergency Department construction complete and redeveloped Emergency Department opened May 2016.
	Strengthen the response of health services to family violence. This includes implementing interventions, processes and systems to prevent; identify and respond appropriately to family violence at an individual and community level.	Update policies, procedures and guidelines to support staff to identify family violence, provide timely and appropriate support, and facilitate community referrals and follow up.	**Achieved** Family Violence Procedure updated. **In progress** Social Work trialling a new referral process which reflects best practice.
	Use consumer feedback and develop participation processes to improve person and family centred care, health service practice and patient experiences.	Community consultation will be undertaken to develop a partnering with consumers plan. Once the plan is ratified it will be implemented.	**Achieved** Community consultation undertaken and new Partnering with Consumers and Community Plan published.
	Improve the health outcomes of Aboriginal and Torres Strait Islanders by increasing accessibility and cultural responsiveness of the Victorian health system.	Actions of Aboriginal Health Strategy will be implemented including the Aboriginal employment plan and Aboriginal health plan.	**Achieved** implementation of key initiatives within the Aboriginal Health Strategy, including full recruitment to Aboriginal patient support roles, purchase of Aboriginal artwork and participation in pathway projects with community providers.
Governance, leadership and culture	Demonstrate an organisational commitment to Occupational Health and Safety, including mental health and wellbeing in the workplace. Ensure accessible and affordable support services are available for employees experiencing mental ill health. Work collaboratively with the Department of Health and Human Services and professional bodies to identify and address systemic issues of mental ill health amongst the medical professions.	Participate in consultation process with peak professional bodies (RACS & others). The recommendations of this consultation process will contribute to the development of an appropriate wellbeing plan for medical professionals and other hospital staff.	**Achieved** Health and wellbeing plan developed and implemented. Supporting governance structure implemented to progress the plan.
	Monitor and publically report incidents of occupational violence. Work collaboratively with the Department of Health and Human Services to develop systems to prevent the occurrence of occupational violence.	Continued identification and reporting of incidents of occupational violence through VHIMS and quality scorecards.	**Achieved** Implemented procedure to support tracking and case review of all emergency codes, overseen by the Emergency Management and Planning Committee
		Continued implementation of preventative strategies aligned with VAGO recommendations including training of managers, public reporting and dedicated response teams.	**In progress** Occupational violence plan reflecting VAGO recommendations in progress.

	Promote a positive workplace culture and implement strategies to prevent bullying and harassment in the workplace. Monitor trends of complaints of bullying and harassment and identify and address organisational units exhibiting poor workplace culture and morale.	Utilise staff recognition program to promote hospital values and support a culture that aims to facilitate early intervention and minimise bullying and harassment incidents	**Achieved** Staff recognition program supporting values driven care implemented.
		Promote current bullying and harassment reporting mechanisms across all levels of the organisation.	**Achieved** Bullying reporting mechanisms gap analysis completed based on the nine Auditor General recommendations.
		Ensure all substantiated bullying and harassment complaints are reported to Executive and brought to attention of Board where appropriate.	**Achieved** OHS score card developed to monitor OHS issues and reviewed by Executive and Board quarterly.
	Improve data reporting systems to increase accountability and transparency, consistent with the Transparency in Government Bill.	Continued enhancement of the Business Intelligence Tool/ standardised reporting to ensure applicability to heads of clinical units and inform decision making.	**Achieved** Patient Administration System upgraded; Finance budgeting tools implemented; Balanced Scorecard reporting reviewed and refreshed; waiting list management tools enhanced; patient demographic analysis implemented and theatre utilisation analysis enhanced.
	Undertake an annual board assessment to identify and develop board capability to ensure all board members are well equipped to effectively discharge their responsibilities.	An annual Board assessment will be conducted. Any outcomes or recommendations of this assessment to enhance Board capability will be actioned.	**Achieved** Annual Board assessment completed and Board planning day undertaken in April 2016.
Safety and quality	Ensure management plans are in place to prevent, detect and contain Carbapenem Resistant Enterobacteriaceae as outlined in Hospital Circular 02/15 (issued 16 June 2015).	Coordinated and planned approach to CRE management developed and implemented in conjunction with St Vincent's Health.	**Achieved** Relevant processes and procedures updated in conjunction with St Vincent's Health Infectious Diseases Department.
	Implement effective antimicrobial stewardship practices and increase awareness of antimicrobial resistance, its implications and actions to combat it, through effective communication, education, and training.	Continued achievement of National Standard 3.14.1: An Antimicrobial Stewardship Program is in place in order to increase awareness of antimicrobial resistance, its implications and actions to combat it.	**Achieved** Antimicrobial stewardship program in place. Initial staff survey undertaken in July 2015, followed by awareness week promotions in November 2015. Survey will be repeated in July 2016 to measure effectiveness of the awareness week.
	Ensure that emergency response management plans are in place, regularly exercised and updated, including trigger activation and communication arrangements.	Business Continuity Plan is reviewed and updated. The plan will be regularly tested and updated, including trigger activation and communication arrangements.	**Achieved** Business Continuity Plan reviewed and updated. Oversight provided by the Emergency Management and Planning Committee, with the plan continuously refined in response to incidents, and benchmarking.

Financial sustainability	Improve cash management processes to ensure that financial obligations are met as they are due.	The current cash management plan has been implemented to meet DHHS creditor KPI of < 60 days.	**Achieved**
	Identify opportunities for efficiency and better value service delivery.	The current delivery of day surgery for ENT will be remodelled to increase the number of ENT same-day admissions.	**Achieved** Total ENT day case procedures have increased by 30%.
	Invest in revenue optimisation initiatives to ensure maximisation of revenue from both public and private sources.	The current shared care Australian College of Optometry clinic will be converted to MBS model.	**Achieved** Partnership with ACO implemented to support shared care for patients with Glaucoma using a MBS model.
Access	Implement integrated care approaches across health and community support services to improve access and responses for disadvantaged Victorians.	Develop and implement a MOU with St Vincent's Health to support a partnership approach to building capacity across the health services in regard to Aboriginal health.	**Achieved** MOU signed between St Vincent's Health and the Eye and Ear Hospital, supporting a capacity building across both health services.
	Progress partnerships with other health services to ensure patients can access treatments as close to where they live when it is safe and effective to do so, making the most efficient use of available resources across the system.	Continue to support the Geelong Cochlear Centre that was opened in conjunction with Cochlear Ltd and local primary care health services.	**Not achieved** Pilot model undertaken with Geelong but not progressed at this time.
	Develop tele-health service models to facilitate the delivery of high quality and equitable specialist services to patients across regional Victoria.	Develop the Remote Ophthalmic Devices (eyeConnect) program and implement in designated rural health services.	**Achieved** Trial of eyeConnect service completed. First device installed into Peninsula Health.

Part B: Performance Priorities

Key performance indicator	Target	Result
Safety and Quality Performance		
Compliance with NSQHS Standards accreditation	Full compliance	Achieved
Overall compliance with cleaning standards	Full compliance	Achieved
Very high risk (Category A)	90%	Achieved
High risk (Category B)	85%	Achieved
Moderate risk (Category C)	85%	Achieved
Compliance with the Hand Hygiene Australia Program	80%	87%
Percentage of health care workers immunised for influenza	75%	75%
Patient experience and outcomes performance		
Victorian Healthcare Experience Survey – data submission	Full compliance	Achieved
Victorian Healthcare Experience Survey – patient experience Quarter 1	95% positive experience	94.3%
Victorian Healthcare Experience Survey – patient experience Quarter 2	95% positive experience	94.5%
Victorian Healthcare Experience Survey – patient experience Quarter 3	95% positive experience	95.4%
SAB rate per occupied bed days	<2/10,000	Achieved
Governance, leadership and culture performance		
People Matter Survey – percentage of staff with a positive response to safety culture questions	80%	91%

Financial sustainability performance

Key performance indicator	Target	Result
Operating Result		
Operating Result ($m)	0	0.086
Cash Management/Liquidity		
Trade creditors	<60 days	39 days
Patient fee debtors	<60 days	30 days
WIES activity performance		
Public and private WIES performance to target	100%	101.41%
Asset management		
Asset management plan	Full compliance	Full compliance
Adjusted current asset ratio	0.70	3.63
Days of available cash	14 days	33 days

Access performance

Key performance indicator	Target	Actuals
Emergency care		
Percentage of ambulance patients transferred within 40 minutes	90	98.8%
Percentage of Triage Category 1 emergency patients seen immediately	100	100%
Percentage of Triage Category 1 to 5 emergency patients seen within clinically recommended times	80	79.4%
Percentage of emergency patients with a length of stay less than four hours	81	84.8%
Number of patients with length of stay in the Emergency Department greater than 24 hours	0	0
Elective surgery		
Percentage of elective patients removed within clinically recommended timeframes	94	90.4
Percentage of Urgency Category 1 elective patients removed within 30 days	100	100
10% longest waiting Category 2 and 3 removals from the elective surgery waiting list	100	97.5
Number of patients on the elective surgery waiting list	3,185	2,845
Number of hospital initiated postponements per 100 scheduled admissions	8	2.84
Number of patients admitted from the elective surgery waiting list – annual total	11,727	11,796

Part C: Activity and Funding

Funding type	Activity achievement
Acute Admitted	
WIES Public	7,629
WIES Private	2,845
Total PPWIES (Public and Private)	**10,474**
WIES DVA	61
WIES TAC	5
WIES TOTAL	**10,540**

Summary of Financial Results

For the year ended 30 June 2016 compared with the last five financial years

	2016 $'000	2015 $'000	2014 $'000	2013 $'000	2012 $'000
Operating Revenue	94,509	91,933	86,537	81,605	81,874
Operating Expense	(94,423)	(91,876)	(86,465)	(81,568)	(81,779)
Net Result Before Capital and Specific Items	**86**	**57**	**72**	**37**	**95**
Total Revenue	118,625	122,087*	99,088	85,797	89,252
Total Expense	(104,644)	(100,638)	(94,225)	(91,005)	(89,250)
Net Result for the Year, including Capital and Specific Items	**13,981**	**21,449***	**4,863**	**(5,208)**	**2**
Retained Surplus / (Accumulated Deficit)	62,763	19,237*	(13,325)	(10,750)	(7,370)
Total Assets	245,951	226,102	194,700	184,623	183,053
Total Liabilities	(21,576)	(20,209)	(21,082)	(19,334)	(19,534)
Net Assets	224,375	205,893	173,618	165,289	163,519
Total Equity	**224,375**	**205,893**	**173,618**	**165,289**	**163,519**

* A prior year adjustment of $26,346,000 in 2015 relates to Capital Purpose Income that was incorrectly reported as Contributed Capital; Total Revenue, Net Result for the Year including Capital and Specific Items and Retained Surplus /(Accumulated Deficit) have been adjusted accordingly.

Significant Changes in Financial Position During 2015–16

There were no significant changes in the financial position during 2015-16.

Summary of Major Changes or Factors which have Affected the Achievement of Operational Objectives for the Year

There were no major changes or factors that affected the achievement of operational objectives for 2015-16.

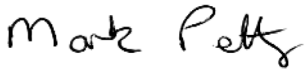
Events Subsequent to Balance Date, which may have a Significant Effect on the Operations of the Entity in Subsequent Years

There have been no significant events subsequent to balance date affecting the operations of the hospital.

Attestations

Attestation on Data Integrity

I, Mark Petty, certify that The Royal Victorian Eye and Ear Hospital has put in place appropriate internal controls and processes to ensure that reported data reasonably reflects actual performance. The Royal Victorian Eye and Ear Hospital has critically reviewed these controls and processes during the year.



Mark Petty
Accountable Officer
The Royal Victorian Eye and Ear Hospital
30 August, 2016

Attestation for compliance with the Ministerial Standing Direction 4.5.5– Risk Management Framework and Processes

I, Mark Petty certify that The Royal Victorian Eye and Ear Hospital has complied with Ministerial Direction 4.5.5 – Risk Management Framework and Processes. The Royal Victorian Eye and Ear Hospital Audit Committee has verified this.

Mark Petty
Accountable Officer
The Royal Victorian Eye and Ear Hospital
30 August, 2016

Responsible Bodies Declaration

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 2016.

Dr Sherene Devanesen
Chair, Board of Directors
30 August, 2016

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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Financial Statements

The Royal Victorian Eye and Ear Hospital
Comprehensive Operating Statement
For the Year Ended 30 June 2016

	Note	2016 $'000	2015 * $'000
Revenue from Operating Activities	2	92,243	88,869
Revenue from Non-Operating Activities	2	2,266	3,064
Employee Expenses	3	(57,563)	(57,381)
Non Salary Labour Costs	3	(1,590)	(1,740)
Supplies and Consumables	3	(25,352)	(23,238)
Administrative Costs	3	(4,715)	(5,048)
Other Expenses	3	(5,203)	(4,469)
Net Result Before Capital and Specific Items		**86**	**57**
Capital Purpose Income	2	18,277	30,115
Net Gain/(Loss) on Disposal of Non-Financial Assets	2a	(124)	(30)
Impairment of Financial Assets	3	(352)	-
Net Gain/(Loss) on Sale of Financial Instruments	2	5,832	-
Depreciation and Amortisation	4	(9,867)	(8,525)
Expenditure for Capital Purpose	3	(2)	(237)
Available-for-Sale Revaluation Surplus Gain/(Loss) Recognised	2	-	69
Specific income	2b	131	-
Net Result For The Year		**13,981**	**21,449**
Other Comprehensive Income:			
Items that Will Not Be Reclassified to Net Result			
Changes in Physical Asset Revaluation Surplus	17a	10,255	-
Items that May Be Reclassifed Subsequently to Net Result			
Gain/(Loss) on Available-for-Sale Financial Assets taken to Equity	17a	78	1,105
Cumulative (Gain)/Loss Reclassified to Profit or Loss on Sale of Available for Sale Financial Assets	17a	-	(69)
Total Other Comprehensive Income		**10,333**	**1,036**
Comprehensive Result		**24,314**	**22,485**

* Due to a prior period error the 2015 figures have been restated (refer Note 25).

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

The Royal Victorian Eye and Ear Hospital
Balance Sheet
As at 30 June 2016

	Note	2016 $'000	2015 * $'000
Current Assets			
Cash and Cash Equivalents	5	1,606	2,953
Receivables	6	2,129	3,097
Investments and Other Financial Assets	7	63,647	69,359
Inventories	8	151	594
Prepayments and Other Assets	9	918	2,401
Total Current Assets		**68,451**	**78,404**
Non-Current Assets			
Receivables	6	1,801	1,618
Property, Plant & Equipment	10	172,773	143,068
Intangible Assets	11	1,690	1,907
Investment Properties	12	1,236	1,105
Total Non-Current Assets		**177,500**	**147,698**
Total Assets		**245,951**	**226,102**
Current Liabilities			
Payables	13	4,809	3,727
Provisions	14	13,928	12,986
Other Current Liabilities	16	116	653
Total Current Liabilities		**18,853**	**17,366**
Non-Current Liabilities			
Provisions	14	2,723	2,843
Total Non-Current Liabilities		**2,723**	**2,843**
Total Liabilities		**21,576**	**20,209**
Net Assets		**224,375**	**205,893**
Equity			
Property, Plant & Equipment Revaluation Surplus	17a	80,402	70,147
Financial Asset Available for Sale Revaluation Surplus	17a	-	5,754
General Purpose Surplus	17a	1,734	22,252
Restricted Specific Purpose Surplus	17a	27,908	36,935
Contributed Capital	17b	51,568	51,568
Accumulated Surpluses/(Deficits)	17c	62,763	19,237
Total Equity	17c	**224,375**	**205,893**

Commitments	20
Contingent Assets and Contingent Liabilities	21

* Due to a prior period error the 2015 figures have been restated (refer Note 25).

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

The Royal Victorian Eye and Ear Hospital
Statement of Changes in Equity
For the Year Ended 30 June 2016

	Note	Property, Plant & Equipment Revaluation Surplus $'000	Financial Asset Available for Sale Revaluation Surplus $'000	General Purpose Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributions by Owners $'000	Accumulated Surpluses/ (Deficits) $'000	Total $'000
Balance at 1 July 2014		**70,147**	**4,718**	**21,918**	**38,592**	**51,568**	**(13,325)**	**173,618**
Net Result for the Year		-	-	-	-	-	21,449	21,449
Other Comprehensive Income for the Year	17a	-	1,036	-	-	-	-	1,036
Prior Year Adjustment from understatement / (overstatement) of Capital Purpose Income	17a,c	-	-	-	(2,326)	-	12,116	9,790
Transfer to / (from) Accumulated Surplus	17a,c	-	-	334	669	-	(1,003)	-
Balance at 30 June 2015 *		**70,147**	**5,754**	**22,252**	**36,935**	**51,568**	**19,237**	**205,893**
Net Result for the Year		-	-	-	-	-	13,981	13,981
Other Comprehensive Income for the Year	17a	10,255	78	-	-	-	-	10,333
Net (gain) / loss transferred to Operating Statement	17a	-	(5,832)	-	-	-	-	(5,832)
Transfer to / (from) Accumulated Surplus	17a,c	-	-	(20,518)	(9,027)	-	29,545	-
Balance at 30 June 2016		**80,402**	**-**	**1,734**	**27,908**	**51,568**	**62,763**	**224,375**

* Due to a prior period error the 2015 figures have been restated (refer Note 25).

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

The Royal Victorian Eye and Ear Hospital
Cash Flow Statement
For the Year Ended 30 June 2016

	Note	2016 $'000	2015 $'000
Cash Flows From Operating Activities			
Operating Grants from Government		78,950	73,996
Patient Fees Received		4,837	4,877
Private Practice Fees Received		1,496	1,587
Donations and Bequests Received		1,133	547
GST Received from / (Paid to) ATO		2,698	2,697
Interest Received		980	1,937
Dividend Received		153	163
Other Receipts		7,616	6,589
Total Receipts		**97,863**	**92,393**
Employee Expenses Paid		(56,742)	(56,167)
Non Salary Labour Costs		(1,750)	(1,740)
Payments for Supplies & Consumables		(26,597)	(38,467)
Other Payments		(10,503)	-
Total Payments		**(95,592)**	**(96,374)**
Cash Generated from Operations		**2,271**	**(3,981)**
Capital Grants from Government		1,735	1,057
Capital Donations and Bequests Received		886	-
Capital Interest Received		2,743	-
Capital Dividend Received		97	-
Other Capital Receipts		85	2,712
Capital Expenses		(2)	-
Net Cash Flow From/(Used In) Operating Activities	18	**7,815**	**(212)**
Cash Flows From Investing Activities			
Purchase of Investments		(174,550)	(1,800)
Proceeds from Sale of Investments		179,987	5,803
Payments for Non-Financial Assets		(14,606)	(7,992)
Proceeds from Sale of Non-Financial Assets		7	3
Net Cash Flow From/(Used In) Investing Activities		**(9,162)**	**(3,986)**
Net Increase/(Decrease) In Cash And Cash Equivalents Held		**(1,347)**	**(4,198)**
Cash and Cash Equivalents at Beginning of Financial Year		**2,953**	**7,151**
Cash And Cash Equivalents At End Of Financial Year	5	**1,606**	**2,953**

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

Note 1: Summary of Significant Accounting Policies

These annual financial statements represent the audited general purpose financial statements for The Royal Victorian Eye and Ear Hospital ("the hospital") for the period ending 30 June 2016. The report provides users with information about the hospital's stewardship of resources entrusted to it.

(a) Statement of Compliance

These financial statements are general purpose financial statements which have been prepared in accordance with the Financial Management Act 1994 and applicable AASs, which include interpretations issued by the Australian Accounting Standards Board (AASB). They are presented in a manner consistent with the requirements of AASB 101 *Presentation of Financial Statements.*

The financial statements also comply with relevant Financial Reporting Directions (FRDs) issued by the Department of Treasury & Finance, and relevant Standing Directions (SDs) authorised by the Minister for Finance.

The Royal Victorian Eye and Ear Hospital is a not-for profit entity and therefore applies the additional Aus paragraphs applicable to "not-for-profit" hospitals under the AASs.

The annual financial statements were authorised for issue by the Board of The Royal Victorian Eye and Ear Hospital on 30 August 2016.

(b) Basis of Accounting Preparation and Measurement

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 statements for the year ended 30 June 2016, and the comparative information presented in these financial statements for the year ended 30 June 2015.

The going concern basis was used to prepare the financial statements.

These financial statements are presented in Australian dollars, the functional and presentation currency of the hospital.

The financial statements, except for cash flow information, have been prepared using the accrual basis of accounting. Under the accrual basis, items are recognised as assets, liabilities, equity, income or expenses when they satisfy the definitions and recognition criteria for those items, that is they are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

The financial statements are prepared in accordance with the historical cost convention, except for:

- non-current physical assets, which subsequent to acquisition, are measured at a revalued amount being their fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made and are re-assessed when new indices are published by the Valuer General to ensure that the carrying amounts do not materially differ from their fair values;
- derivative financial instruments, managed investment schemes, certain debt securities, and investment properties after initial recognition, which are measured at fair value with changes reflected in the comprehensive operating statement (fair value through profit or loss);
- available-for-sale investments which are measured at fair value with movements reflected in equity until the asset is derecognised (i.e. other comprehensive income – items that may be reclassified subsequent to net result); and
- the fair value of assets other than land is generally based on their depreciated replacement value.

Judgements, estimates and assumptions are required to be made about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

Revisions to accounting estimates are recognised in the period in which the estimate is revised and also in future periods that are affected by the revision. Judgements and assumptions made by management in the application of AASs that have significant effects on the financial statements and estimates relate to:

- the fair value of land, buildings, infrastructure, plant and equipment, (refer to Note 1(i));
- superannuation expense (refer to Note 1(f));
- actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 1(j)); and
- equities and management investment schemes classified at level 3 of the fair value hierarchy.

Consistent with AASB 13 *Fair Value Measurement* , the hospital determines the policies and procedures for both recurring fair value measurements such as property, plant and equipment, investment properties and financial instruments, and for non-recurring fair value measurements such as non-financial physical assets held for sale, in accordance with the requirements of AASB 13 and the relevant FRDs.

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy, described as follows, based on the lowest level input that is significant to the fair value measurement as a whole:

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

For the purpose of fair value disclosures, the hospital has determined classes of assets and liabilities on the basis of the nature, characteristics and risks of the asset or liability and the level of the fair value hierarchy as explained above.

In addition, the hospital determines whether transfers have occurred between levels in the hierarchy by re-assessing categorisation (based on the lowest level input that is significant to the fair value measurement as a whole) at the end of each reporting period.

The Valuer-General Victoria (VGV) is the hospital's independent valuation agency.

The hospital, in conjunction with VGV monitors the changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required.

For key assumptions used in the determination of fair value, refer to Note 10(e).

(c) Reporting Entity

The financial statements include all the controlled activities of The Royal Victorian Eye and Ear Hospital.

Its principal address is:
32 Gisborne Street
East Melbourne
Victoria 3002

A description of the nature of the hospital's operations and its principal activities is included in the report of operations, which does not form part of these financial statements.

Objectives and Funding

The Royal Victorian Eye and Ear Hospital's overall objective is to improve the quality of life to Victorians through caring for the senses.

The Royal Victorian Eye and Ear Hospital is predominantly funded by accrual based grant funding for the provision of outputs.

(d) Scope and Presentation of Financial Statements

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.

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 Health and Human Services and are also funded from other sources such as the Commonwealth and patients, while S*ervices Supported by Hospital and Community Initiatives* (H&CI) are funded by the hospital's own activities or local initiatives.

Comprehensive Operating Statement

The Comprehensive Operating Statement includes the subtotal entitled 'Net Result before Capital & Specific Items' 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, expenditure using capital purpose income and items of an unusual nature and amount such as specific income 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 hospitals. The 'Net Result before Capital & Specific Items' is used by the management of the hospital, the Department of Health and Human Services and the Victorian Government to measure the ongoing operating performance of hospitals.

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. 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:
  - non-current asset revaluation increments/decrements
- depreciation and amortisation, as described in Note 1(f);
- expenditure using capital purpose income, comprises expenditure which either falls below the asset capitalisation threshold 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.

Other economic flows; are changes arising from market re-measurements. They include:

- gains and losses from disposals of non-financial assets;
- revaluations and impairments of non-financial physical and intangible assets; and
- fair value changes of financial instruments.

Balance Sheet

Assets and liabilities are categorised either as current or non-current (non-current being mainly those assets or liabilities expected to be recovered/settled more than 12 months after reporting period), are disclosed in the notes where relevant.

Statement of Changes in Equity

The Statement of Changes in Equity presents reconciliations of each non-owner and owner changes in equity from opening balance at the beginning of the reporting period to the closing balance at the end of the reporting period. It also shows separately changes due to amounts recognised in the comprehensive result and amounts recognised in other comprehensive income.

Cash Flow Statement

Cash flows are classified according to whether or not they arise from operating activities, investing activities, or financing activities. This classification is consistent with requirements under AASB 107 *Statement of Cash Flows.*

For the cash flow statement presentation purposes, cash and cash equivalents includes bank overdrafts, which are included as current borrowings in the balance sheet.

Rounding

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

Minor discrepancies in tables between totals and sum of components are due to rounding.

(e) Income from Transactions

Income is recognised in accordance with AASB 118 *Revenue* and is recognised as to the extent that it is probable that the economic benefits will flow to the hospital and the income can be reliably measured at fair value. 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.

Government Grants and Other Transfers of Income (other than Contributions by Owners)

In accordance with AASB1004 *Contributions* , government grants and other transfers of income (other than contributions by owners) are recognised as income when the hospital gains control of the underlying assets irrespective of whether conditions are imposed on the hospital's use of the contributions.

Contributions are deferred as income in advance when the hospital has a present obligation to repay them and the present obligation can be reliably measured.

Indirect Contributions from the Department of Health and Human Services

- Insurance is recognised as revenue following advice from the Department of Health and 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 05/2013 (update for 2014-15).

Patient 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.

Revenue from Commercial Activities

Revenue from commercial activities such as private pharmacy sales is recognised 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 surplus, such as the specific restricted purpose surplus.

Dividend Revenue

Dividend revenue is recognised when the right to receive payment is established. Dividends represent the income arising from the hospital's investments in financial assets.

Interest Revenue

Interest revenue is recognised on a time proportionate basis that takes in account the effective yield of the financial asset, which allocates interest over the relevant period.

Sale of Investments

The gain/loss on the sale of investments is recognised when the investment is realised.

(f) Expense Recognition

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

Cost of Goods Sold

Costs of goods sold are recognised when the sale of an item occurs by transferring the cost or value of the item/s from inventories.

Employee Expenses

Employee expenses include:

- wages and salaries;
- leave entitlements;
- termination payments;
- workcover premiums; and
- superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

Defined Contribution Superannuation Plans

In relation to defined contribution (ie. accumulation) superannuation plans, the associated expense is simply the employer contributions that are paid or payable in respect of employees who are members of these plans during the reporting period. Contributions to defined contribution superannuation plans are expensed when incurred.

Defined Benefit Superannuation Plans

The amount charged to the Comprehensive Operating Statement in respect of defined benefit superannuation plans represents the contributions made by the hospital to the superannuation plans in respect of the services of current hospital staff during the reporting period. Superannuation contributions are made to the plans based on the relevant rules of each plan, and are based upon actuarial advice.

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 disclosed in Note 15: Superannuation.

Depreciation

All infrastructure assets, buildings, plant and equipment and other non-financial physical assets that have finite useful lives are depreciated (ie. investment properties). Depreciation begins when the asset is available for use, which is when it is in the location and condition necessary for it to be capable of operating in a manner intended by management.

Intangible produced assets with finite lives are depreciated as an expense from transactions on a systematic basis over the asset's useful life. Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives, residual value and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health and Human Services. Assets with a cost in excess of $1,000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

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

	2016	2015
Buildings		
- Structure Shell Building Fabric	2 to 60 years	2 to 40 years
- Site Engineering Services and Central Plant	2 to 15 years	2 to 15 years
Central Plant		
- Fit Out	2 to 15 years	2 to 15 years
- Trunk Reticulated Building Systems	2 to 15 years	2 to 15 years
Plant & Equipment	5 to 20 years	5 to 20 years
Medical Equipment	4 to 10 years	4 to 10 years
Computers and Communication	3 to 10 years	3 to 10 years
Furniture and Fitting	10 to 13 years	10 to 13 years
Motor Vehicles	4 years	4 years

As part of the buildings valuation, building values were separated into components and each component assessed for its useful life which is represented above.

Intangible produced assets with finite lives are depreciated as an expense on a systematic basis over the asset's useful life.

Amortisation

Amortisation is allocated to intangible non-produced 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 consumption of intangible non-produced assets with finite useful lives is classified as amortisation.

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 asset concerned is tested as to whether its carrying amount exceeds its recoverable amount.

Any excess of the carrying amount over the recoverable amount is recognised as an impairment loss.

Intangible assets with finite useful lives are amortised between 2 and 10 years (2015: 2 and 10 years).

Other Operating Expenses

Other operating expenses generally represent the day-to-day running costs incurred in normal operations and include:

Supplies and Consumables

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

Bad and Doubtful Debts

Refer to Note 1(i) Impairment of Financial Assets.

(g) Other Comprehensive Income

Other Comprehensive Income measures the change in volume or value of assets or liabilities that do not result from transactions.

Net Gain/(Loss) on Non-Financial Assets

Net gain/(loss) on non-financial assets and liabilities includes realised and unrealised gains and losses as follows:

- Revaluation gains/(losses) on Non-Financial Physical Assets
  - Refer to Note 1(i) Revaluations of Non-Financial Physical Assets.
- Net gain/(loss) on Disposal of Non-Financial Assets
  - Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal and is the difference between the proceeds and the carrying amount of the asset at the time.
- Net gain/(loss) on Financial Instruments
  Net gain/(loss) on financial instruments includes:
  - realised and unrealised gains and losses from revaluations of financial instruments at fair value;
  - impairment and reversal of impairment for financial instruments at amortised cost (refer to Note 1(h)); and
  - disposals of financial assets and derecognition of financial liabilities

Revaluations of Financial Instrument at Fair Value

Refer to Note 1(h) Financial Instruments.

Other Gains/(Losses) from Other Comprehensive Income

Other gains /(losses) include:

- transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

(h) Financial Instruments

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of the hospital's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation* . For example, statutory receivables arising from taxes do not meet the definition of financial instruments as they do not arise under contract.

Where relevant, for note disclosure purposes, a distinction is made between those financial assets and financial liabilities that meet the definition of financial instruments in accordance with AASB 132 and those that do not.

The following refers to financial instruments unless otherwise stated.

Categories of Non-Derivative Financial Instruments

Financial Assets and Liabilities at Fair Value through Profit or Loss

Financial assets are categorised as fair value through profit or loss at trade date if they are classified as held for trading or designated as such upon initial recognition. Financial instrument assets are designated at fair value through profit or loss on the basis that the financial assets form part of a group of financial assets that are managed by the hospital based on their fair values, and have their performance evaluated in accordance with documented risk management and investment strategies.

Financial instruments at fair value through profit or loss are initially measured at fair value and attributable transaction costs are expensed as incurred. Subsequently, any changes in fair value are recognised in the net result as other comprehensive income, as required by AASB 139 para 55. Any dividend or interest on a financial asset is recognised in the net result for the year.

Loans and Receivables

Loans and receivables are financial instrument assets with fixed and determinable payments that are not quoted on an active market. These assets are initially recognised at fair value plus any directly attributable transaction costs. Subsequent to initial measurement, loans and receivables are measured at amortised cost using the effective interest method, less any impairment.

Loans and receivables category includes cash and deposits (refer to Note 1(i)), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

Held-to-Maturity Investments

If the hospital has the positive intent and ability to hold nominated investments to maturity, then such financial assets may be classified as held-to-maturity. Held-to-maturity financial assets are recognised initially at fair value plus any directly attributable transaction costs. Subsequent to initial recognition held-to-maturity financial assets are measured at amortised cost using the effective interest method, less any impairment losses.

The hospital makes limited use of this classification because any sale or reclassification of more than an insignificant amount of held-to-maturity investments not close to their maturity, would result in the whole category being reclassified as available-for-sale. The hospital would also be prevented from classifying investment securities as held-to-maturity for the current and the following two financial years.

The held-to-maturity category includes certain term deposits.

Available-for-Sale Financial Assets

Available-for-sale financial instrument assets are those designated as available-for-sale or not classified in any other category of financial instrument asset. Such assets are initially recognised at fair value. Subsequent to initial recognition, gains and losses arising from changes in fair value are recognised in 'Other Comprehensive Income' 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 net result for the period. Fair value is determined in the manner described in Note 19.

Financial Liabilities at Amortised Cost

Financial instrument liabilities are initially recognised on the date they are originated. They are initially measured at fair value plus any directly attributable transaction costs. Subsequent to initial recognition, these financial instruments are measured at amortised cost with any difference between the initial recognised amount and the redemption value being recognised in profit or loss over the period of the interest-bearing liability, using the effective interest rate method.

Financial instrument liabilities measured at amortised cost include all of the hospital's contractual payables, deposits held and advances received.

(i) Assets

Cash and Cash Equivalents

Cash and cash equivalents recognised on the balance sheet comprise cash on hand and cash at bank, deposits at call and highly liquid investments (with an original maturity of three months or less), which are held for the purpose of meeting short term cash commitments rather than for investment purposes, which are readily convertible to known amounts of cash with an insignificant risk of changes in value.

Receivables

Receivables consist of:

- contractual receivables, which includes mainly debtors in relation to goods and services and accrued investment income; and
- statutory receivables, which includes predominantly amounts owing from the Victorian Government and Goods and Services Tax ("GST") input tax credits recoverable.

Receivables that are contractual are classified as financial instruments and categorised as loans and receivables. Statutory receivables are recognised and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments because they do not arise from a contract.

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

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 recognised when there is objective evidence that the debts may not be collected and bad debts are written off when identified.

Investments and Other Financial Assets

Hospital investments must be in accordance in Standing Direction 4.5.6 – Treasury Risk Management. Investments 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.

Investments are classified in the following categories:

- financial assets at fair value through profit or loss;
- held-to-maturity;
- loans and receivables; and
- available-for-sale financial assets.

The 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 hospital assesses at each balance sheet date whether a financial asset or group of financial assets is impaired.

All financial assets, except those measured at fair value through profit or loss are subject to annual review for impairment.

Inventories

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

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.

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

The 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.

Non-Financial Physical Assets Classified as Held for Sale

Non-financial physical assets and disposal groups and related liabilities are treated as current and are classified as held for sale if their carrying amount will be recovered through a sale transaction rather than through continuing use. This condition is regarded as met only when the sale is highly probable, the asset's sale (or disposal group) is expected to be completed within 12 months from the date of classification, and the asset is available for immediate use in the current condition.

Non-financial physical assets (including disposal groups) classified as held for sale are treated as current and are measured at the lower of carrying amount and fair value less costs of disposal, and are not subject to depreciation or amortisation.

Property, Plant and Equipment

All non-current physical assets are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and accumulated impairment loss. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. Assets transferred as part of a merger/machinery of government are transferred at their carrying amount.

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 10 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 physical 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. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best uses.

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

Plant, Equipment and Vehicles are recognised initially at cost and subsequently measured at fair value less accumulated depreciation and accumulated impairment loss. Depreciated historical cost is generally a reasonable proxy for fair value because of the short lives of the assets concerned.

Revaluations of Non-Current Physical Assets

Non-current physical assets are measured at fair value and are revalued in accordance with FRD 103F *Non-current physical assets*. This revaluation process normally occurs at least 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. Independent valuers are used to conduct these scheduled revaluations and any interim revaluations are determined in accordance with the requirements of the FRDs. Revaluation increments or decrements arise from differences between an asset's carrying amount and fair value.

Revaluation increments are recognised in 'other comprehensive income' and are credited directly in equity to the asset revaluation surplus, except that, to the extent that an increment reverses a revaluation decrement in respect of that same class of asset previously recognised as an expense in net result, the increment is recognised as income in the net result.

Revaluation decrements are recognised in 'other comprehensive income' to the extent that a credit balance exists in the asset revaluation surplus in respect of the same class of property, plant and equipment.

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 surplus is not normally transferred to accumulated funds on derecognition of the relevant asset.

In accordance with FRD 103F, the hospital's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

Intangible Assets

Intangible assets represent identifiable non-monetary assets without physical substance such as patents, trademarks, and 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.

Expenditure on research activities is recognised as an expense in the period on which it is incurred.

When the recognition criteria in AASB 138 *Intangible Assets* are met, internally generated intangible assets are recognised and measured at cost less accumulated depreciation/amortisation and impairment.

An internally-generated intangible asset arising from development (or from the development phase of an internal project) is recognised if, and only if, all of the following are demonstrated:

a. the technical feasibility of completing the intangible asset so that it will be available for use or sale;
b. an intention to complete the intangible asset and use or sell it;
c. the ability to use or sell the intangible asset;
d. the intangible asset will generate probable future economic benefits;
e. the availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset; and
f. the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Investment Properties

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

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, determined annually by independent valuers and/or reference to VGV indices. Fair values are determined based on a market comparable approach that reflects recent transaction prices for similar properties. Investment properties are neither depreciated nor tested for impairment.

Rental revenue from leasing of investment properties is recognised in the comprehensive operating statement in the periods in which it is receivable on a straight line basis over the lease term.

Prepayments

Other non-financial assets include prepayments which represent payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period.

Disposal of Non-Financial Assets

Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement. Refer to Note 1(g) 'Other Comprehensive Income'.

Impairment of Non-Financial Assets

Intangible assets with indefinite lives (and intangible assets not yet available for use) are tested annually for impairment (as described below) and whenever there is an indication that the asset may be impaired.

All other non-financial assets are assessed annually for indications of impairment, except for:

- inventories; and
- investment properties that are measured at fair value.

If there is an indication of impairment, the assets concerned are tested as to whether their carrying amount exceeds their possible recoverable amount. Where an asset's carrying amount 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 surplus amount applicable to that same class of asset.

If there is an indication that there has been a reversal in the estimate of an asset's recoverable amount since the last impairment loss was recognised, the carrying amount shall be increased to its recoverable amount. This reversal of the impairment loss occurs only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised in prior years.

It is deemed that, in the event of the loss or destruction 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 of disposal. 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 of disposal.

Investments in Joint Operations

In respect of any interest in joint operations, the hospital recognises in the financial statements:

- its assets, including its share of any assets held jointly;
- any liabilities including its share of liabilities that it had incurred;
- its revenue from the sale of its share of the output from the joint operation;
- its share of the revenue from the sale of the output by the operation; and
- its expenses, including its share of any expenses incurred jointly.

Derecognition of Financial Assets

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

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

Impairment of Financial Assets

At the end of each reporting period the hospital assesses whether there is objective evidence that a financial asset or group of financial asset is impaired. All financial instrument assets, except those measured at fair value through profit or loss, are subject to annual review for impairment.

Receivables are assessed for bad and doubtful debts on a regular basis. Bad debts considered as written off and allowances for doubtful receivables are expensed.

The amount of the allowance is the difference between the financial asset's carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate.

Where the fair value of an investment in an equity instrument at balance date has reduced by 20 percent 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 asset is treated as impaired.

In order to determine an appropriate fair value as at 30 June 2016 for its portfolio of financial assets, the hospital obtained a valuation based on the best available advice using an estimated 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 2016. These methodologies were critiqued and considered to be consistent with standard market valuation techniques.

In assessing impairment of statutory (non-contractual) financial assets, which are not financial instruments, professional judgement is applied in assessing materiality using estimates, averages and other computational methods in accordance with AASB 136 *Impairment of Assets.*

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 and derecognition of financial liabilities.

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.

(j) Liabilities

Payables

Payables consist of:

- contractual payables which consist predominantly of accounts payable representing 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 those goods and services. The normal credit terms for accounts payable are usually nett 30 days.
- statutory payables, such as goods and services tax and fringe benefits tax payables.

Contractual payables are classified as financial instruments and are initially recognised at fair value, and then subsequently carried at amortised cost. Statutory payables are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from a contract.

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 liability 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, using a discount rate that reflects the time value of money and risks specific to the provision.

When some or all of the economic benefits required to settle a provision are expected to be received from a third party, the receivable is recognised as an asset if it is virtually certain that recovery will be received and the amount of the receivable can be measured reliably.

Employee Benefits

This provision arises for benefits accruing to employees in respect of wages and salaries, annual leave and long service leave for services rendered to the reporting date.

Wages and Salaries, Annual Leave, Sick Leave and Accrued Days Off

Liabilities for wages and salaries, including non-monetary benefits, annual leave and accrued days off are all recognised in the provision for employee benefits as 'current liabilities', because the hospital does not have an unconditional right to defer settlements of these liabilities.

Depending on the expectation of the timing of settlement, liabilities for wages and salaries and annual leave are measured at:

- Undiscounted value – if the liability is expected to wholly settle within 12 months; or
- Present value – if the liability is not expected to wholly settle within 12 months.

Long Service Leave (LSL)

Liability for LSL is recognised in the provision for employee benefits.

Unconditional LSL is disclosed in the notes to the financial statements as a current liability, even where the 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:

- Undiscounted value – if the liability is expected to wholly settle within 12 months; or
- Present value – if the liability is not expected to wholly settle within 12 months.

Conditional LSL 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. This non-current LSL liability is measured at present value.

Any gain or loss following revaluation of the present value of non-current LSL liability is recognised as a transaction.

Termination Benefits

Termination benefits are payable when employment is terminated before the normal retirement date or when an employee decides to accept an offer of benefits in exchange for the termination of employment.

The hospital recognises termination benefits when it is demonstrably committed to either terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

On-Costs Related to Employee Expense

Provision for on-costs, such as workers compensation and superannuation are recognised together with provisions for employee benefits.

Superannuation Liabilities

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.

Derecognition of Financial Liabilities

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

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

(k) Leases

A lease is a right to use an asset for an agreed period of time in exchange for payment. Leases are classified at their inception as either operating or finance leases based on the economic substance of the agreement so as to reflect the risks and rewards incidental to ownership.

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 Leases

Entity as Lessor

Rental income from operating lease is recognised on a straight-line basis over the term of the relevant lease.

All incentives for the agreement of a new or renewed operating lease are recognised as an integral part of the net consideration agreed for the use of the leased asset, irrespective of the incentive's nature or form or the timing of payments.

In the event that lease incentives are given to the lessee, the aggregate cost of incentives are recognised as a reduction of rental income over the lease term, on a straight-line basis unless another systematic basis is more appropriate of the time pattern over which the economic benefit of the leased asset is diminished.

(l) Equity

Contributed Capital

Consistent with Australian Accounting Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities* and FRD 119A *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 to or distributions by owners that have been designated as contributed capital are also treated as contributed capital.

Property, Plant & Equipment Revaluation Surplus

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

Financial Asset Available-for-Sale Revaluation Surplus

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

Specific Restricted Purpose Surplus

A specific restricted purpose surplus 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.

(m) Commitments

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed by way of a note (refer to Note 20) at their nominal value and are inclusive of the GST payable. In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant individual projects are stated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

(n) Contingent Assets and Contingent Liabilities

Contingent assets and contingent liabilities are not recognised in the balance sheet, but are disclosed by way of note and, if quantifiable, are measured at nominal value. Contingent assets and contingent liabilities are presented inclusive of GST receivable or payable respectively.

(o) 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, the GST payable 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 an operating cash flow.

Commitments for expenditure and contingent assets and liabilities are presented on a gross basis.

(p) AASs Issued that are Not Yet Effective

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2016 reporting period. DTF assesses the impact of all these new standards and advises the hospital of their applicability and early adoption where applicable.

As at 30 June 2016, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. The hospital has not and does not intend to adopt these standards early.

Standard/ Interpretation	Summary	Applicable for Annual Reporting Periods Beginning	Impact on Financial Statements
AASB 9 Financial Instruments	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	01 Jan 2018	The assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss. While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.

AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)	The requirements for classifying and measuring financial liabilities were added to AASB 9. The existing requirements for the classification of financial liabilities and the ability to use the fair value option have been retained. However, where the fair value option is used for financial liabilities the change in fair value is accounted for as follows: • The change in fair value attributable to changes in credit risk is presented in other comprehensive income (OCI); and • Other fair value changes are presented in profit and loss. If this approach creates or enlarges an accounting mismatch in the profit or loss, the effect of the changes in credit risk are also presented in profit or loss.	01 Jan 2018	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. Changes in own credit risk in respect of liabilities designated at fair value through profit and loss will now be presented within other comprehensive income (OCI). Hedge accounting will be more closely aligned with common risk management practices making it easier to have an effective hedge. For entities with significant lending activities, an overhaul of related systems and processes may be needed.
AASB 2014-1 *Amendments to Australian Accounting Standards [Part E Financial Instruments]*	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	01 Jan 2018	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements
AASB 15 Revenue from Contracts with Customers	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	01 Jan 2018	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications. A potential impact will be the upfront recognition of revenue from licenses that cover multiple reporting periods. Revenue that was deferred and amortised over a period may now need to be recognised immediately as a transitional adjustment against the opening returned earnings if there are no former performance obligations outstanding.
AASB 2015-8 Amendments to Australian Accounting Standards – Effective Date of AASB 15	This Standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	01 Jan 2018	This amending standard will defer the application period of AASB 15 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 16 Leases	The key changes introduced by AASB 16 include the recognition of most operating leases (which are current not recognised) on balance sheet.	01 Jan 2019	The assessment has indicated that as most operating leases will come on balance sheet, recognition of lease assets and lease liabilities will cause net debt to increase. Depreciation of lease assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. The amounts of cash paid for the principal portion of the lease liability will be presented within financing activities and the amounts paid for the interest portion will be presented within operating activities in the cash flow statement. No change for lessors.

AASB 2015 6 Amendments to Australian Accounting Standards – Extending Related Party Disclosures to Not-for-Profit Public Sector Entities [AASB 10, AASB 124 & AASB 1049]	The Amendments extend the scope of AASB 124 Related Party Disclosures to not-for-profit public sector entities. A guidance has been included to assist the application of the Standard by not-for-profit public sector entities.	01 Jan 2016	The amending standard will result in extended disclosures on the entity's key management personnel (KMP), and the related party transactions.
AASB 2016-4 Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities	The standard amends AASB 136 Impairment of Assets to remove references to using depreciated replacement cost (DRC) as a measure of value in use for not-for-profit entities.	1 Jan 2017	The assessment has indicated that there is minimal impact. Given the specialised nature and restrictions of public sector assets, the existing use is presumed to be the highest and best use (HBU), hence current replacement cost under AASB 13 Fair Value Measurement is the same as the depreciated replacement cost concept under AASB 136.

(q) Accounting Error

Funding from the Department of Health and Human Services for the hospital redevelopment project in the 2015 financial year was incorrectly reported as Contributed Capital rather than Capital Purpose Income.

The error caused the Net Result For The Year and Comprehensive Result to be understated for the 2015 financial year and Accumulated Surpluses/(Deficits) to be understated and Contributed Capital to be overstated at 30 June 2015.

The error has been corrected by increasing the Capital Purpose Income reported for 2015 (refer Note 2) and reducing Contributed Capital at 30 June 2015 (refer Note 25).

(r) 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 acute and subacute admitted patient services, where services are delivered in public hospitals.

Non Admitted Services (Non-Admitted) comprises acute and subacute non admitted services, where services are delivered in public hospital clinics and provide models of integrated community care, which significantly reduces the demand for hospital beds and supports the transition from hospital to home in a safe and timely manner.

Emergency Department Services (EDs) comprises all emergency department services.

Other Services not reported elsewhere - (Other) comprises services not separately classified above, including diagnostic services. Health and Community Initiatives also falls in this category group.

Note 2: Analysis of Revenue by Source

	Admitted Patients	Non-Admitted	EDs	Other	Total
	2016 $'000	2016 $'000	2016 $'000	2016 $'000	2016 $'000
Government Grants	47,602	26,048	5,623	-	79,273
Indirect Contributions by Department of Health and Human Services	161	75	32	-	268
Patient Fees	2,806	1,911	31	69	4,817
Recoupment from Private Practice for Use of Hospital Facilities	-	497	-	1,000	1,497
Other Revenue from Operating Activities	1,781	3,795	348	464	6,388
Total Revenue from Operating Activities	**52,350**	**32,326**	**6,034**	**1,533**	**92,243**
Interest	44	20	9	907	980
Dividends	92	43	18	-	153
Donations & Bequests	-	-	-	1,133	1,133
Total Revenue from Non-Operating Activities	**136**	**63**	**27**	**2,040**	**2,266**
Capital Purpose Income	-	-	-	17,330	17,330
Capital Interest	-	-	-	850	850
Capital Dividends	-	-	-	97	97
Net Gain/(Loss) on Disposal of Non-Financial Assets (refer Note 2a)	-	-	-	(124)	(124)
Net Gain/(Loss) on Sale of Financial Instruments	-	-	-	5,832	5,832
Total Capital Purpose Income	**-**	**-**	**-**	**23,985**	**23,985**
Specific Income (refer Note 2b)	-	-	-	131	131
Total Revenue	**52,486**	**32,389**	**6,061**	**27,689**	**118,625**

Indirect contributions by Department of Health and Human Service: Department of Health and Human Services makes certain payments on behalf 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.

Revenues and expenses of Support Services are distributed to source categories using a number of allocation bases including estimated usage, percentage of total revenue and full time equivalent (FTE) staff.

Note 2: Analysis of Revenue by Source (continued)

	Admitted Patients	Non-Admitted	EDs	Other	Total
	2015 $'000	2015 $'000	2015 $'000	2015 $'000	2015 $'000
Government Grants	43,853	25,628	5,916	-	75,397
Indirect Contributions by Department of Health and Human Services	617	361	84	-	1,062
Patient Fees	3,716	618	479	64	4,877
Recoupment from Private Practice for Use of Hospital Facilities	303	177	41	1,066	1,587
Other Revenue from Operating Activities	5,370	59	-	517	5,946
Total Revenue from Operating Activities	**53,859**	**26,843**	**6,520**	**1,647**	**88,869**
Interest	9	297	59	1,989	2,354
Dividends	4	133	26	-	163
Donations & Bequests	-	-	-	547	547
Total Revenue from Non-Operating Activities	**13**	**430**	**85**	**2,536**	**3,064**
Capital Purpose Income	-	-	-	27,902	27,902
Capital Interest	-	-	-	2,159	2,159
Capital Dividends	-	-	-	54	54
Net Gain/(Loss) on Disposal of Non-Financial Assets (refer Note 2a)	-	-	-	(30)	(30)
Total Capital Purpose Income	**-**	**-**	**-**	**30,085**	**30,085**
Available-for-Sale Revaluation Surplus Gain/(Loss) Recognised (refer Note 17a)	-	-	-	69	69
Total Revenue	**53,872**	**27,273**	**6,605**	**34,337**	**122,087**

Indirect contributions by Department of Health and Human Service: Department of Health and Human Services makes certain payments on behalf 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.

Revenues and expenses of Support Services are distributed to source categories using a number of allocation bases including estimated usage, percentage of total revenue and full time equivalent (FTE) staff.

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

	2016 $'000	2015 $'000
Proceeds from Disposals of Non-Current Assets		
Medical Equipment	7	3
Less: Written Down Value of Non-Current Assets Sold		
Plant and Equipment	(5)	-
Medical Equipment	(126)	(33)
Net gain/(loss) on Disposal of Non-Financial Assets	**(124)**	**(30)**

Note 2b: Specific Income

	2016 $'000	2015 $'000
Specific Income		
Revaluation Increment/(Decrement) on Investment Properties	131	-
TOTAL	**131**	**-**

Note 3: Analysis of Expenses by Source

	Admitted Patients 2016 $'000	Non-Admitted 2016 $'000	EDs 2016 $'000	Other 2016 $'000	Total 2016 $'000
Employee Expenses	35,262	14,500	6,737	1,064	57,563
Non Salary Labour Costs	1,160	275	136	19	1,590
Supplies & Consumables	12,111	11,826	1,371	44	25,352
Administrative Costs	2,485	1,194	523	513	4,715
Other Expenses	3,081	1,462	557	103	5,203
Total Expenditure from Operating Activities	**54,099**	**29,257**	**9,324**	**1,743**	**94,423**
Expenditure for Capital Purposes	-	-	-	2	2
Impairment of Financial Assets	-	-	-	352	352
Depreciation & Amortisation (refer Note 4)	-	-	-	9,867	9,867
Total Other Expenses	**-**	**-**	**-**	**10,221**	**10,221**
Total Expenses	**54,099**	**29,257**	**9,324**	**11,964**	**104,644**

	Admitted Patients 2015 $'000	Non-Admitted 2015 $'000	EDs 2015 $'000	Other 2015 $'000	Total 2015 $'000
Employee Expenses	37,630	11,911	6,694	1,146	57,381
Non Salary Labour Costs	1,445	32	245	18	1,740
Supplies & Consumables	9,496	13,239	358	145	23,238
Administrative Costs	1,703	2,033	865	447	5,048
Other Expenses	2,097	2,137	143	92	4,469
Total Expenditure from Operating Activities	**52,371**	**29,352**	**8,305**	**1,848**	**91,876**
Expenditure for Capital Purposes	-	-	-	237	237
Depreciation & Amortisation (refer Note 4)	-	-	-	8,525	8,525
Total Other Expenses	**-**	**-**	**-**	**8,762**	**8,762**
Total Expenses	**52,371**	**29,352**	**8,305**	**10,610**	**100,638**

Revenues and expenses of Support Services are distributed to source categories using a number of allocation bases including estimated usage, percentage of total revenue and full time equivalent (FTE) staff.

Note 3a: Analysis of Expense and Revenue by Internally Managed and Restricted Specific Purpose Funds

	Expense		Revenue	
	2016 $'000	2015 $'000	2016 $'000	2015 $'000
Commercial Activities				
Private Practice and Other Patient Activities	988	1,102	1,000	1,068
Pharmacy Services	88	102	176	187
Property	-	-	261	253
Other	38	58	32	92
Other Activities				
Fundraising and Community Support	471	514	1,948	2,320
Research and Scholarship	158	72	153	256
Other	-	-	3	7
Total Expense / Revenue	**1,743**	**1,848**	**3,573**	**4,183**

Note 4: Depreciation and Amortisation

	2016 $'000	2015 $'000
Depreciation		
Buildings	7,915	5,976
Plant & Equipment	445	507
Medical Equipment	966	1,008
Total Depreciation	**9,326**	**7,491**
Amortisation		
Intangible Assets	541	1,034
Total Depreciation and Amortisation	**9,867**	**8,525**

Note 5: 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.

	2016 $'000	2015 $'000
Cash on Hand	2	2
Cash at Bank	110	156
Deposits at Call	1,494	2,795
Total Cash and Cash Equivalents	**1,606**	**2,953**
Represented by:		
Cash for Hospital Operations (per Cash Flow Statement)	1,606	2,953
Total Cash and Cash Equivalents	**1,606**	**2,953**

Note 6: Receivables

	2016 $'000	2015 $'000
Current		
Contractual		
Inter Hospital Debtors	131	1,186
Trade Debtors	853	813
Patient Fees	382	420
Accrued Revenue - Other	563	558
Less Allowance for Doubtful Debts		
Trade Debtors	(43)	(28)
Patient Fees	(40)	(58)
Total Contractual	**1,846**	**2,891**
Statutory		
GST Receivable	283	206
Total Statutory	**283**	**206**
Total Current Receivables	**2,129**	**3,097**
Non-Current		
Statutory		
Long Service Leave - Department of Health and Human Services	1,801	1,618
Total Non-Current Receivables	**1,801**	**1,618**
Total Receivables	**3,930**	**4,715**
(a) Movement in the Allowance for Doubtful Debts		
Balance at Beginning of Year	85	86
Amounts Written Off During the Year	(52)	46
Amounts Recovered During the Year	(33)	-
Increase/(Decrease) in Allowance Recognised in Net Result	83	(47)
Balance at End of Year	**83**	**85**

(b) Ageing analysis of receivables
Please refer to Note 19(c) for the ageing analysis of contractual receivables.

(c) Nature and extent of risk arising from receivables
Please refer to Note 19(c) for the nature and extent of credit risk arising from contractual receivables.

Note 7: Investments and Other Financial Assets

	Specific Purpose Fund	
	2016 $'000	**2015 $'000**
Current		
Loans and Receivables		
Term Deposit		
Aust. Dollar Term Deposits > 3 months [(i)]	22,000	41,500
Available for Sale		
Equities and Managed Investment Schemes		
Managed Investment Schemes [(ii)]	41,647	27,859
Total Current	63,647	69,359
Total Investments And Other Financial Assets	**63,647**	**69,359**
Represented by:		
Hospital Investments	63,647	69,359
Total Investments And Other Financial Assets	**63,647**	**69,359**

[(i)] Term deposits under 'investments and other financial assets' class include only term deposits with maturity greater than 90 days.

[(ii)] The hospital designates all of its managed investment schemes at fair value through profit or loss. Therefore, unless they are part of a disposal group held for sale, all managed investment schemes are classified as non-current.

(a) Ageing analysis of investments and other financial assets

Please refer to Note 19(c) for the ageing analysis of investments and other financial assets.

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

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

Note 8: Inventories

	2016 $'000	**2015 $'000**
Pharmaceuticals At Cost	151	177
Medical and Surgical Lines At Cost	-	410
Gift Shop At Cost	-	7
Total Inventories	**151**	**594**

Note 9: Prepayments and Other Assets

	2016 $'000	2015 $'000
Current		
Prepayments	818	408
Accrued Investment Interest	100	1,993
Total Current Other Assets	**918**	**2,401**
Total Other Assets	**918**	**2,401**

Note 10: Property, Plant & Equipment

(a) Gross carrying amount and accumulated depreciation

	2016 $'000	2015 $'000
Land		
Land at Fair Value	47,959	37,704
Total Land	**47,959**	**37,704**
Buildings		
Buildings at Fair Value	72,871	58,293
less Accumulated Depreciation	(13,891)	(5,976)
Total Buildings	**58,980**	**52,317**
Plant and Equipment		
Plant and Equipment at Fair Value	7,356	6,949
less Accumulated Depreciation	(4,985)	(4,543)
Total Plant and Equipment	**2,371**	**2,406**
Medical Equipment		
Medical Equipment at Fair Value	18,211	18,233
less Accumulated Depreciation	(12,957)	(13,277)
Total Medical Equipment	**5,254**	**4,956**
Assets Under Construction		
Assets Under Construction	58,209	45,685
Total Assets Under Construction	**58,209**	**45,685**
Total Property, Plant & Equipment	**172,773**	**143,068**

Note 10: Property, Plant & Equipment (continued)

(b) Reconciliations of the carrying amounts of each class of asset

	Land $'000	Buildings $'000	Plant & Equipment $'000	Medical Equipment $'000	Assets Under Construction $'000	Total $'000
Balance at 1 July 2014	**37,704**	**58,282**	**2,812**	**4,880**	**3,273**	**106,951**
Additions	-	11	95	800	46,514	47,420
Disposals	-	-		(33)	-	(33)
Assets Written Back and Transferred to Expense	-	-	-	-	(3,765)	(3,765)
Net Transfers between Classes	-	-	6	317	(337)	(14)
Depreciation (Note 4)	-	(5,976)	(507)	(1,008)	-	(7,491)
Balance at 1 July 2015	**37,704**	**52,317**	**2,406**	**4,956**	**45,685**	**143,068**
Additions	-	-	400	1,355	27,144	28,899
Disposals	-	-	(7)	(119)	-	(126)
Assets Written Back and Transferred to Expense	-	1	2	-	-	3
Revaluation Increments/(Decrements)	10,255	-	-	-	-	10,255
Net Transfers between Classes	-	14,577	15	28	(14,620)	-
Depreciation (Note 4)	-	(7,915)	(445)	(966)	-	(9,326)
Balance at 30 June 2016	**47,959**	**58,980**	**2,371**	**5,254**	**58,209**	**172,773**

Land and Buildings Carried at Valuation

An independent valuation of the hospital's land and buildings 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 2014. Indices provide by the Valuer-General Victoria led to a management revaluation of land effective 30 June 2016.

Note 10: Property, Plant & Equipment (continued)

(c) Fair value measurement hierarchy for assets

	Carrying Amount as at 30 June 2016 $'000	Fair Value Measurement at End of Reportin Period using:		
		Level 1 [(i)] $'000	Level 2 [(i)] $'000	Level 3 [(i)] $'000
Land				
Land at Fair Value	47,959	-	10,532	37,42
Total Land at Fair Value	**47,959**	-	10,532	37,42
Buildings				
Buildings at Fair Value	58,980	-	6,871	52,10
Total Buildings at Fair Value	**58,980**	-	6,871	52,10
Plant and Equipment				
Plant and Equipment at Fair Value	2,371	-	-	2,37
Total Plant and Equipment at Fair Value	**2,371**	-	-	2,37
Medical Equipment				
Medical Equipment at Fair Value	5,254	-	-	5,25
Total Medical Equipment at Fair Value	**5,254**	-	-	5,25
Assets Under Construction				
Assets Under Construction	58,209	-	-	58,20
Total Assets Under Construction at Fair Value	**58,209**	-	-	58,20
Total Property, Plant & Equipment At Fair Value	**172,773**	**-**	**17,403**	**155,37**

	Carrying Amount as at 30 June 2015 $'000	Fair Value Measurement at End of Reportin Period using:		
		Level 1 [(i)] $'000	Level 2 [(i)] $'000	Level 3 [(i)] $'000
Land				
Land at Fair Value	37,704	-	12,660	25,04
Total Land at Fair Value	**37,704**	-	12,660	25,04
Buildings				
Buildings at Fair Value	52,317	-	6,605	45,71
Total Buildings at Fair Value	**52,317**	-	6,605	45,71
Plant and Equipment				
Plant and Equipment at Fair Value	2,406	-	-	2,40
Total Plant and Equipment at Fair Value	**2,406**	-	-	2,40
Medical Equipment				
Medical Equipment at Fair Value	4,956	-	-	4,95
Total Medical Equipment at Fair Value	**4,956**	-	-	4,95
Assets Under Construction				
Assets Under Construction	45,685	-	-	45,68
Total Assets Under Construction at Fair Value	**45,685**	-	-	45,68
Total Property, Plant & Equipment At Fair Value	**143,068**	**-**	**19,265**	**123,80**

[(i)] Classified in accordance with the fair value hierarchy, refer Note 1

Note 10: Property, Plant & Equipment (continued)

(d) Reconciliation of Level 3 fair value

	Land	Buildings	Plant and Equipment	Medical Equipment	Assets Under Construction	Total
	$'000	$'000	$'000	$'000	$'000	$'000
30 June 2016						
Opening Balance	25,044	45,712	2,406	4,956	45,685	123,803
Purchases (Sales)	-	-	395	1,236	27,144	28,775
Transfers In (Out) of Level 3	4,380	(265)	-	-	-	4,115
Transfers In (Out) of Asset Classes	-	14,577	15	28	(14,620)	-
Gains or Losses Recognised in Net Result						
- Depreciation	-	(7,915)	(445)	(966)	-	(9,326)
Subtotal	29,424	52,109	2,371	5,254	58,209	147,367
Items Recognised in Other Comprehensive Income						
- Revaluation	8,003	-	-	-	-	8,003
Subtotal	8,003	-	-	-	-	8,003
Closing Balance	**37,427**	**52,109**	**2,371**	**5,254**	**58,209**	**155,370**
30 June 2015						
Opening Balance	25,044	51,677	2,812	4,880	3,273	87,686
Purchases (Sales)	-	11	101	767	46,514	47,393
Transfers In (Out) of Level 3	-	-	-	317	-	317
Transfers In (Out) of Asset Classes					(337)	(337)
Assets Written Back and Transferred to Expense					(3,765)	(3,765)
Gains or Losses Recognised in Net Result						
- Depreciation	-	(5,976)	(507)	(1,008)	-	(7,491)
Subtotal	25,044	45,712	2,406	4,956	45,685	123,803
Closing Balance	**25,044**	**45,712**	**2,406**	**4,956**	**45,685**	**123,803**

Note 10: Property, Plant & Equipment (continued)

(e) Description of significant unobservable inputs to Level 3 valuations:

	Valuation technique	Significant unobservable inputs	Range (weighted average)	Sensitivity of fair value measurement to changes in significant unobservable inputs
Specialised Land				
	Market approach	Community Service Obligation (CSO) adjustment	50 - 70% (60%)	A significant increase or decrease in the CSO adjustment would result in a significantly lower (higher) fair value.
Specialised Buildings				
	Depreciated replacement cost	Direct cost per square metre	$1,000 - $1,500/m2 ($1,300)	A significant increase or decrease in direct cost per square meter adjustment would result in a significantly higher or lower fair value.
		Useful life of specialised buildings	30 - 60 years (45 years)	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Plant and Equipment at Fair Value				
	Depreciated replacement cost	Cost per unit	$9,000 - $10,000 ($9,500)	A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value.
		Useful life of PPE	5-10 years (7 years)	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Medical Equipment at Fair Value				
	Depreciated replacement cost	Cost per unit	$6,000 - $7,000 ($6,500)	Increase (decrease) in gross replacement cost would result in a significantly higher (lower) fair value.
		Useful life of medical equipment	10-15 years (12 years)	Increase (decrease) in useful life would result in a significantly higher (lower) fair value.
Assets Under Construction at Fair Value				
	Depreciated replacement cost	Cost per unit	$500 - $600 ($550)	A significant increase or decrease in direct cost per unit adjustment would result in a significantly higher or lower fair value.

Note 11: Intangible Assets

	2016 $'000	2015 $'000
Computer Software	7,055	6,773
Less Acc'd Amortisation	(5,627)	(5,086)
	1,428	**1,687**
Computer Software - Work in Progress	262	220
Total Intangible Assets	**1,690**	**1,907**

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

	Computer Software $'000	Computer Software Work in Progress $'000	Total $'000
Balance at 1 July 2014	**1,653**	**801**	**2,454**
Additions	253	220	473
Assets transferred between Classes	815	(801)	14
Amortisation (Note 4) (i)	(1,034)	-	(1,034)
Balance at 1 July 2015	**1,687**	**220**	**1,907**
Additions	59	265	324
Assets transferred between Classes	223	(223)	-
Amortisation (Note 4) (i)	(541)	-	(541)
Balance at 30 June 2016	**1,428**	**262**	**1,690**

(i) The consumption of separately acquired intangible assets is included in the 'amortisation' line item, where the consumption of the internally generated intangible assets is included in 'net gain/(loss) on non-financial assets' line item on the comprehensive operating statement.

Note 12: Investment Properties

(a) Movements in carrying value for investment properties as at 30 June 2016

	2016 $'000	2015 $'000
Balance at Beginning of Period	1,105	1,105
Net Gain/(Loss) from Fair Value Adjustments	131	-
Balance at End of Period	**1,236**	**1,105**

Note 12: Investment Properties

(b) Fair value measurement hierarchy for investment properties

	Carrying amount as at 30 June 2016	Fair Value Measurement at End of Reporting Period using:		
		Level 1 [(i)]	Level 2 [(i)]	Level 3 [(i)]
Investment properties	1,236	-	1,236	-
	1,236	**-**	**1,236**	**-**

	Carrying amount as at 30 June 2015	Fair Value Measurement at End of Reporting Period using:		
		Level 1 [(i)]	Level 2 [(i)]	Level 3 [(i)]
Investment properties	1,105	-	1,105	-
	1,105	**-**	**1,105**	**-**

[(i)] classified in accordance with the fair value hierarchy.

Note 13: Payables

	2016 $'000	2015 $'000
CURRENT		
Contractual		
Trade Creditors [(i)]	1,627	2,314
Accrued Expenses	3,051	1,413
	4,678	**3,727**
Statutory		
Department of Health and Human Services [(ii)]	131	-
	131	**-**
Total Current	**4,809**	**3,727**
Total Payables	**4,809**	**3,727**

[(i)] The average credit period is 30 days. No interest is charged on payables.

[(ii)] Terms and conditions of amounts payable to the Department of Health and Human Services vary according to the particular agreement with the Department.

(a) Maturity analysis of payables
Please refer to Note 19c for the ageing analysis of contractual payables.

(b) Nature and extent of risk arising from payables
Please refer to Note 19c for the nature and extent of risks arising from contractual payables.

Note 14: Provisions

	2016 $'000	2015 $'000
Current Provisions		
Employee Benefits [(i)]		
Annual Leave		
- Unconditional and expected to be settled wholly within 12 months [(ii)]	3,590	3,436
- Unconditional and expected to be settled wholly after 12 months [(iii)]	570	578
Long Service Leave		
- Unconditional and expected to be settled wholly within 12 months [(ii)]	566	814
- Unconditional and expected to be settled wholly after 12 months [(iii)]	5,745	4,802
Employee Benefits		
- Unconditional and expected to be settled wholly within 12 months [(ii)]	2,352	2,226
	12,823	11,856
Provisions related to Employee Benefit On-Costs for Annual Leave		
- Unconditional and expected to be settled within 12 months (ii)	390	403
- Unconditional and expected to be settled after 12 months (iii)	53	68
Provisions related to Employee Benefit On-Costs for Long Service leave		
- Unconditional and expected to be settled within 12 months (ii)	138	96
- Unconditional and expected to be settled after 12 months (iii)	525	563
	1,105	1,130
Total Current Provisions	**13,928**	**12,986**
Non-Current Provisions		
Employee Benefits (i)	2,464	2,843
Provisions related to Employee Benefit On-Costs	259	-
Total Non-Current Provisions	**2,723**	**2,843**
Total Provisions	**16,651**	**15,829**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits including Related On-Costs		
Unconditional LSL Entitlement	6,974	6,275
Annual Leave Entitlements	4,602	4,485
Accrued Wages and Salaries	2,228	2,129
Accrued Days Off	124	97
Non-Current Employee Benefits including Related On-Costs		
Conditional Long Service Leave Entitlements (ii)	2,723	2,843
Total Employee Benefits	**16,651**	**15,829**
On-Costs included in Total Employee Benefits above		
Current On-Costs	1,105	1,130
Non-Current On-Costs	259	-
Total On-Costs	**1,364**	**1,130**
Total Employee Benefits and Related On-Costs	**16,651**	**15,829**

[(i)] Provisions for employee benefits consist of amounts for annual leave and long service leave accrued by employees, not including on-costs.
[(ii)] The amounts disclosed are nominal amounts.
[(iii)] The amounts disclosed are discounted to present values.

Note 14: Provisions (continued)

	2016 $'000	2015 $'000
(b) Movements in provisions		
Movement in Long Service Leave:		
Balance at Start of Year	**9,118**	**7,738**
Provision made during the year		
- Revaluations	248	593
- Expense recognising Employee Service	1,201	1,680
Settlement made during the year	(870)	(893)
Balance at End of Year	**9,697**	**9,118**

Note 15: Superannuation

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 hospital does not recognise any defined benefit liability in respect of the plan(s) because the entity 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 discloses the State's defined benefit liabilities in its disclosure for administered items.

The superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the comprehensive operating statement of the hospital. The name, details and amounts expensed in relation to the major employee superannuation funds and contributions made by the hospital are as follows:

	Paid Contribution for the Year		Contribution Outstanding at Year End	
	2016 $'000	2015 $'000	2016 $'000	2015 $'000
[(i)] Defined benefit plans:				
Health Super Pty Ltd	109	112	2	2
Defined contribution plans:				
Health Super Pty Ltd	3,145	3,100	37	37
HESTA	1,121	1,030	91	19
Other	118	225	22	19
Total Superannuation	4,493	4,467	152	77

[(i)] The bases for determining the level of contributions is determined by the various actuaries of the defined benefit superannuation plans.

Note 16: Other Liabilities

	2016 $'000	2015 $'000
Current		
Income in Advance	59	117
Bond Money	9	9
Patient Fees	48	50
Income in Advance - Department of Health and Human Services	-	477
Total Current	**116**	**653**
Total Other Liabilities	**116**	**653**

Note 17: Equity

	2016 $'000	2015 $'000
(a) Surpluses		
Property, Plant & Equipment Revaluation Surplus [1]		
Balance at the beginning of the reporting period	70,147	70,147
Revaluation Increment/(Decrements)		
- Land	10,255	-
Balance at the End of the Reporting Period *	**80,402**	**70,147**
* Represented by:		
- Land	37,870	27,615
- Buildings	42,532	42,532
	80,402	**70,147**
Financial Assets Available-for-Sale Revaluation Surplus [2]		
Balance at the Beginning of the Reporting Period	5,754	4,718
Valuation Gain / (Loss) Recognised	78	1,105
Cumulative (Gain) / Loss transferred to Operating Statement on Sale of Financial Assets	(5,832)	(69)
Balance at the End of the Reporting Period	**-**	**5,754**
General Purpose Surplus [3]		
Balance at the Beginning of the Reporting Period	22,252	21,918
Transfer To and From General Surplus:		
- Restricted Specific Purpose Surplus	1,734	334
- Accumulated Surplus / (Deficits)	(22,252)	-
Balance at the End of the Reporting Period	**1,734**	**22,252**
Restricted Specific Purpose Surplus [3]		
Balance at the Beginning of the Reporting Period	36,935	38,592
Transfer To and From Restricted Surplus:		
- General Purpose Surplus	(1,734)	669
- Accumulated Surplus / (Deficits)	(7,293)	-
Prior Year Adjustment from Overstatement of Capital Purpose Income	-	(2,326)
Balance at the End of the Reporting Period	**27,908**	**36,935**
Total Surpluses	**110,044**	**135,088**
(b) Contributed Capital		
Balance at the Beginning of the Reporting Period	51,568	51,568
Balance at the End of the Reporting Period	**51,568**	**51,568**

Note 17: Equity (continued)

	2016 $'000	2015 $'000
(c) Accumulated Surpluses/(Deficits)		
Balance at the Beginning of the Reporting Period	19,237	(13,325)
Net Result for the Year	13,981	21,449
Transfers (To) and From:		
- General Purpose Surplus Reserve	22,252	(334)
- Restricted Specific Purpose Surplus Reserve	7,293	(669)
Prior Year Adjustment from Understatement of Capital Purpose Income	-	12,116
Balance at the End of the Reporting Period	**62,763**	**19,237**
Total Equity at End of the Financial Year	**224,375**	**205,893**

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

(2) The financial assets available-for-sale revaluation surplus 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 net result. Where a revalued financial asset is impaired that portion of the reserve which relates to that financial asset is recognised in net result.

(3) Refer Note 1 for explanation on nature of reserve.

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

	2016 $'000	2015 $'000
Net Result for the Period	13,981	21,449
Non-Cash Movements:		
Depreciation and Amortisation	9,867	8,525
Impairment of Financial and Non-Financial Assets	352	-
Valuation of Investment Properties	(131)	-
Provision for Doubtful Debts	(2)	(1)
Non-Cash DHHS Government Grants	(14,625)	(26,346)
Movements Included in Investing and Financing Activities		
Net (Gain)/Loss from Disposal of Non-Financial Physical Assets	124	30
Net (Gain)/Loss from Disposal of Financial Assets	(5,832)	(69)
Movements in Assets and Liabilities:		
Change in Operating Assets and Liabilities		
(Increase)/Decrease in Receivables	2,680	(2,811)
(Increase)/Decrease in Prepayments	(409)	(201)
Increase/(Decrease) in Payables	1,083	(2,132)
Increase/(Decrease) in Provisions	821	1,214
Increase/(Decrease) in Other Liabilities	(537)	83
Change in Inventories	443	47
Net Cash Inflow / (Outflow) from Operating Activities	**7,815**	**(212)**

Note 19: Financial Instruments

(a) Financial risk management objectives and policies

The hospital's principal financial instruments comprise of:

- cash assets
- term deposits
- receivables (excluding statutory receivables)
- investment in 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 hospital's main financial risks include credit risk, liquidity risk, interest rate risk, foreign currency risk and equity price risk. The hospital manages these financial risks in accordance with its financial risk management policy.

The hospital uses different methods to measure and manage the different risks to which it is exposed. Primary responsibility for the identification and management of financial risks rests with the financial risk management committee of the hospital.

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

Categorisation of Financial Instruments

	Contractual Financial Assets - Loans and Receivables $'000	Contractual Financial Assets - Available for Sale $'000	Contractual Financial Liabilities at Amortised Cost $'000	Total $'000
2016				
Contractual Financial Assets				
Cash and cash equivalents	1,606	-	-	1,606
Receivables				
- Trade Debtors	984	-	-	984
- Other Receivables	945	-	-	945
Other Financial Assets				
- Term Deposit	22,000	-	-	22,000
- Managed Investment Schemes	-	41,647	-	41,647
Total Financial Assets [(i)]	**25,535**	**41,647**	**-**	**67,182**
Financial Liabilities				
Payables	-	-	4,678	4,678
Other Financial Liabilities				
- Other	-	-	116	116
Total Financial Liabilities [(ii)]	**-**	**-**	**4,794**	**4,794**

Note 19: Financial Instruments (Continued)

(a) Financial risk management objectives and policies (continued)

	Contractual Financial Assets - Loans and Receivables $'000	Contractual Financial Assets - Available for Sale $'000	Contractual Financial Liabilities at Amortised Cost $'000	Total $'000
2015				
Contractual Financial Assets				
Cash and cash equivalents	2,953	-	-	2,953
Receivables				
- Trade Debtors	1,999	-	-	1,999
- Other Receivables	978	-	-	978
Other Financial Assets				
- Term Deposit	41,500	-	-	41,500
- Managed Investment Schemes	-	27,859	-	27,859
Total Financial Assets [(i)]	**47,430**	**27,859**	**-**	**75,289**
Financial Liabilities				
Payables	-	-	3,727	3,727
Other Financial Liabilities				
- Other	-	-	653	653
Total Financial Liabilities [(ii)]	**-**	**-**	**4,380**	**4,380**

[(i)] The total amount of financial assets disclosed here excludes statutory receivables.
[(ii)] The total amount of financial liabilities disclosed here excludes statutory payables (ie. Department of Health and Human Services payable).

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

	Total Interest Income / (Expense) $'000	Total $'000
2016		
Financial Assets		
Cash and Cash Equivalents [(i)]	65	65
Loans and Receivables [(i)]	1,765	1,765
Total Financial Assets	**1,830**	**1,830**
2015		
Financial Assets		
Cash and Cash Equivalents [(i)]	71	71
Loans and Receivables [(i)]	4,443	4,443
Total Financial Assets	**4,514**	**4,514**

[(i)] For cash and cash equivalents, loans or receivables and available-for-sale financial assets, the net gain or loss is calculated by taking the movement in the fair value of the asset, interest revenue, plus or minus foreign exchange gains or losses arising from revaluation of the financial assets, and minus any impairment recognised in the net result.

Note 19: Financial Instruments (continued)

(c) Credit risk

Credit risk arises from the contractual financial assets of the hospital, which comprise cash and deposits, non-statutory receivables and available for sale contractual financial assets. The hospital's exposure to credit risk arises from the potential default of a counter party on their contractual obligations resulting in financial loss to the hospital. Credit risk is measured at fair value and is monitored on a regular basis.

Credit risk associated with the hospital's contractual financial assets is minimal because the main debtor is the Victorian Government. For debtors other than the Government, it is the hospital's policy to only deal with entities with high credit ratings of a minimum Triple-B rating and to obtain sufficient collateral or credit enhancements, where appropriate.

In addition, the hospital does not engage in hedging for its contractual financial assets and mainly obtains contractual financial assets that are on fixed interest, except for cash assets, which are mainly cash at bank. As with the policy for debtors, the hospital's policy is to only deal with banks with high credit ratings.

Provision of impairment for contractual financial assets is recognised when there is objective evidence that the hospital will not be able to collect a receivable. Objective evidence includes financial difficulties of the debtor, default payments, debts which are more than 60 days overdue, and changes in debtor credit ratings.

Except as otherwise detailed in the following table, the carrying amount of contractual financial assets recorded in the financial statements, net of any allowances for losses, represents hospital's maximum exposure to credit risk without taking account of the value of any collateral obtained.

Credit quality of contractual financial assets that are neither past due nor impaired

	Financial institutions (AA credit rating) $'000	Other (min BBB credit rating) $'000	Total $'000
2016			
Financial Assets			
Cash and Cash Equivalents	1,606	-	1,606
Loans and Receivables			
- Trade Debtors	-	984	984
- Other Receivables [(i)]	-	945	945
- Term Deposits	22,000	-	22,000
Available for Sale			
- Managed Investment Schemes	41,647	-	41,647
Total Financial Assets	**65,253**	**1,929**	**67,182**
2015			
Financial Assets			
Cash and Cash Equivalents	2,953	-	2,953
Loans and Receivables			
- Trade Debtors	-	1,999	1,999
- Other Receivables [(i)]	-	978	978
- Term Deposits	41,500	-	41,500
Available for sale			
- Managed Investment Schemes	27,859	-	27,859
Total Financial Assets	**72,312**	**2,977**	**75,289**

[(i)] The total amounts disclosed here exclude statutory amounts (eg. amounts owing from GST input tax credit recoverable).

Note 19: Financial Instruments (continued)

(c) Credit risk (continued)

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 Assets as at 30 June

	Carrying Amount	Not Past Due and Not Impaired	Past Due But Not Impaired			Impaired Financial Assets
			Less than 1 Month	1 to 3 Months	3 months to 1 Year	
	$'000	$'000	$'000	$'000	$'000	$'000
2016						
Financial Assets						
Cash and Cash Equivalents	1,606	1,606	-	-	-	-
Loans and Receivables						
- Trade Debtors	984	853	69	18	1	43
- Other Receivables	945	818	46	36	5	40
- Term Deposits	22,000	22,000	-	-	-	-
Available for Sale						
- Managed Investment Schemes	41,647	41,647	-	-	-	-
Total Financial Assets	**67,182**	**66,924**	**115**	**54**	**6**	**83**
2015						
Cash and Cash Equivalents	2,953	2,953	-	-	-	-
Loans and Receivables						
- Trade Debtors	1,999	1,746	178	44	3	28
- Other Receivables	978	834	33	29	24	58
- Term Deposits	41,500	41,500	-	-	-	-
Available for Sale						
- Managed Investment Schemes	27,859	27,859	-	-	-	-
Total Financial Assets	**75,289**	**74,892**	**211**	**73**	**27**	**86**

Note 19: Financial Instruments (continued)

(d) Liquidity risk

Liquidity risk is the risk that the hospital would be unable to meet its financial obligations as and when they fall due. The hospital operates under the Government's fair payments policy of settling financial obligations within 30 days and in the event of a dispute, making payments within 30 days from the date of resolution.

The hospital's maximum exposure to liquidity risk is the carrying amounts of financial liabilities as disclosed in the face of the balance sheet.

The following table discloses the contractual maturity analysis for the 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

	Carrying Amount	Nominal Amount	Maturity Dates			
			Less than 1 Month	1 to 3 Months	3 months to 1 Year	1-5 Years
	$'000	$'000	$'000	$'000	$'000	$'000
2016						
Financial Liabilities						
At Amortised Cost						
Payables	4,678	4,678	4,629	49	-	-
Other Financial Liabilities [(i)]						
- Other	116	116	69	14	24	9
Total Financial Liabilities	**4,794**	**4,794**	**4,698**	**63**	**24**	**9**
2015						
Financial Liabilities						
At Amortised Cost						
Payables	3,727	3,727	3,652	32	43	-
Other Financial Liabilities [(i)]						
- Other	653	653	653	-	-	-
Total Financial Liabilities	**4,380**	**4,380**	**4,305**	**32**	**43**	**-**

[(i)] Ageing analysis of financial liabilities excludes the types of statutory financial liabilities (ie. Department of Health and Human Services payable).

Note 19: Financial Instruments (continued)

(e) Market Risk

The hospital's exposures to market risk are primarily through interest rate risk with only insignificant exposure to foreign currency and other price risks. 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 interest bearing liabilities. Minimisation of risk is achieved by mainly undertaking fixed rate or non-interest bearing financial instruments. For financial liabilities, the health service mainly undertake financial liabilities with relatively even maturity profiles.

Cash flow interest rate risk is the risk that the future cash flows of a financial instrument will fluctuate because of changes in market interest rates.

The hospital has minimal exposure to cash flow interest rate risks through its cash and deposits, term deposits and bank overdrafts that are at floating rate.

The hospital manages this risk by mainly undertaking fixed rate or non-interest bearing financial instruments with relatively even maturity profiles, with only insignificant amounts of financial instruments at floating rate. Management has concluded for cash at bank and bank overdraft, as financial assets that can be left at floating rate without necessarily exposing the Health Service to significant bad risk, management monitors movement in interest rates on a daily basis.

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
2016					
Financial Assets					
Cash and Cash Equivalents	1.70	1,606	-	1,606	-
Loans and Receivables [(i)]					
- Trade Debtors	-	984	-	-	984
- Other Receivables	-	945	-	-	945
- Term Deposit	2.70	22,000	22,000	-	-
Available for Sale					
- Managed Investment Schemes	-	41,647	-	-	41,647
		67,182	**22,000**	**1,606**	**43,576**
Financial Liabilities					
At Amortised Cost					
Payables[(i)]	-	4,678	-	-	4,678
Other Financial Liabilities					
- Other	-	116	-	-	116
		4,794	**-**	**-**	**4,794**

[(i)] The carrying amount disclosed excludes statutory financial assets and liabilities (ie. GST input tax credit and Department of Health and Human Services payable).

Note 19: Financial Instruments (continued)

(e) Market Risk (continued)

	Weighted Average Effective Interest Rate (%)	Carrying Amount $'000	Interest Rate Exposure		
			Fixed Interest Rate $'000	Variable Interest Rate $'000	Non-Interest Bearing $'000
2015					
Financial Assets					
Cash and Cash Equivalents	2.10	2,953	-	2,953	-
Loans and Receivables [(i)]					
- Trade Debtors	-	1,999	-	-	1,999
- Other Receivables	-	978	-	-	978
- Term Deposit	3.44	41,500	41,500	-	-
Available for Sale					
- Managed Investment Schemes	-	27,859	-	-	27,859
		75,289	**41,500**	**2,953**	**30,836**
Financial Liabilities					
At Amortised Cost					
Payables[(i)]	-	3,727	-	-	3,727
Other Financial Liabilities					
- Other	-	653	-	-	653
		4,380	**-**	**-**	**4,380**

[(i)] The carrying amount disclosed excludes statutory financial assets and liabilities (ie. GST input tax credit and Department of Health and Human Services payable).

Note 19: Financial Instruments (continued)

(e) Market risk (continued)

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 100 basis points up and down in market interest rates (AUD) from year-end rates of 1.75% (2015: 200 basis points);
- A parallel shift of +1% and -1% in inflation rate from year-end rates of 1% (2015: +2% and -2%)

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.

	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-1%		+1%		-1%		+1%	
		Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000
2016									
Financial Assets									
Cash and Cash Equivalents	1,606	(16)	(16)	16	16	-	-	-	-
Loans and Receivables [(i)]									
- Trade Debtors	984	-	-	-	-	-	-	-	-
- Other Receivables	945	-	-	-	-	-	-	-	-
- Term Deposit	22,000	(220)	(220)	220	220	-	-	-	-
Available for Sale									
- Managed Investment Schemes	41,647	-	-	-	-	(416)	(416)	416	416
	67,182	**(236)**	**(236)**	**236**	**236**	**(416)**	**(416)**	**416**	**416**
Financial Liabilities									
At Amortised Cost									
Payables	4,678	-	-	-	-	(47)	(47)	47	47
Other Financial Liabilities[(i)]									
- Other	116	-	-	-	-	-	-	-	-
	4,794	**-**	**-**	**-**	**-**	**(47)**	**(47)**	**47**	**47**

[(i)] The carrying amount disclosed excludes statutory financial assets and liabilities (ie. GST input tax credit and Department of Health and Human Services payable).

Note 19: Financial Instruments (continued)

(e) Market risk (continued)

	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-2%		+2%		-2%		+2%	
		Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000
2015									
Financial Assets									
Cash and Cash Equivalents	2,953	(59)	(59)	59	59	-	-	-	-
Loans and Receivables [(i)]									
- Trade Debtors	1,999	-	-	-	-	-	-	-	-
- Other Receivables	978	-	-	-	-	-	-	-	-
- Term Deposit	41,500	(830)	(830)	830	830	-	-	-	-
Available for Sale									
- Managed Investment Schemes	27,859	-	-	-	-	(557)	(557)	557	557
	75,289	**(889)**	**(889)**	**889**	**889**	**(557)**	**(557)**	**557**	**557**
Financial Liabilities									
At Amortised Cost									
Payables	3,727	-	-	-	-	(75)	(75)	75	75
Other Financial Liabilities[(i)]									
- Other	653	-	-	-	-	(13)	(13)	13	13
	4,380	**-**	**-**	**-**	**-**	**(88)**	**(88)**	**88**	**88**

[(i)] The carrying amount disclosed excludes statutory financial assets and liabilities (ie. GST input tax credit and Department of Health and Human Services payable).

Note 19: Financial Instruments (continued)

(f) Fair value

The fair values and net fair values of financial instrument assets and liabilities are determined as follows:
• Level 1 - the fair value of financial instrument with standard terms and conditions and traded in active liquid markets are determined with reference to quoted market prices;
• Level 2 - the fair value is determined using inputs other than quoted prices that are observable for the financial asset or liability, either directly or indirectly; and
• Level 3 - the fair value is determined in accordance with generally accepted pricing models based on discounted cash flow analysis using unobservable market inputs.

The hospital considers that the carrying amount of financial instrument assets and liabilities recorded in the financial statements to be a fair approximation of their fair values, because of the short-term nature of the financial instruments and the expectation that they will be paid in full.

The following table shows that the fair values of most of the contractual financial assets and liabilities are the same as the carrying amounts.

Comparison between carrying amount and fair value

	Carrying Amount 2016 $'000	Fair value 2016 $'000	Carrying Amount 2015 $'000	Fair value 2015 $'000
Financial Assets				
Cash and Cash Equivalents	1,606	1,606	2,953	2,953
Loans and Receivables [(i)]				
- Trade Debtors	984	984	1,999	1,999
- Other Receivables	945	945	978	978
- Term Deposit	22,000	22,000	41,500	41,500
Available for Sale				
- Managed Investment Schemes	41,647	41,647	27,859	27,859
Total Financial Assets	**67,182**	**67,182**	**75,289**	**75,289**
Financial Liabilities				
At Amortised Cost				
Payables	4,678	4,678	3,727	3,727
Other Financial Liabilities[(i)]				
- Other	116	116	653	653
Total Financial Liabilities	**4,794**	**4,794**	**4,380**	**4,380**

[(i)] The carrying amount disclosed excludes statutory financial assets and liabilities (ie. GST input tax credit and Department of Health and Human Services payable).

Note 19: Financial Instruments (continued)

(f) Fair value (continued)

Financial assets measured at fair value

	Carrying Amount as at 30 June	Fair value measurement at end of reporting period using:		
		Level 1*	Level 2*	Level 3
	$'000	$'000	$'000	$'000
2016				
Financial assets at fair value through profit or loss				
Available for Sale Securities				
- Managed Investment Schemes	41,647	41,647	-	-
Total Financial Assets	**41,647**	**41,647**	**-**	**-**
2015				
Financial assets at fair value through profit or loss				
Available for sale securities				
- Managed Investment Schemes	27,859	27,859	-	-
Total Financial Assets	**27,859**	**27,859**	**-**	**-**

*There is no significant transfer between level 1 and level 2

Note 20: Commitments

	2016 $'000	2015 $'000
Capital Expenditure Commitments		
Payable:		
Land and Buildings	26,977	24,000
Total Capital Expenditure Commitments	**26,977**	**24,000**
Land and buildings*		
Not later than one year	8,388	6,000
Later than 1 year and not later than 5 years	18,589	18,000
Total	**26,977**	**24,000**
Other Expenditure Commitments		
Payable:		
Consumables/Supplies	12,962	16,674
Maintenance	286	702
Total Other Expenditure Commitments	**13,248**	**17,376**
Not later than one year	8,994	13,486
Later than 1 year and not later than 5 years	4,254	3,890
TOTAL	**13,248**	**17,376**
Total Commitments (inclusive of GST)	**40,225**	**41,376**
less GST Recoverable from the Australian Tax Office	(1,240)	(1,580)
Total Commitments (exclusive of GST)	**38,985**	**39,796**

All amounts shown in the commitments note are nominal amounts inclusive of GST.

Note 21: Contingent Assets and Contingent Liabilities

The Royal Victorian Eye and Ear Hospital has Nil contingent assets or contingent liabilities at 30 June 2016. (30 June 2015: Nil).

Note 22: Operating Segments

The Royal Victorian Eye and Ear Hospital derives all its revenue from the Acute Health Programs 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 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 Jill Hennessy, Minister for Health, Minister for Ambulance Services	1/7/2015 - 30/6/2016
Governing Boards	
Dr Malcolm Brown	1/7/2015 - 30/6/2016
Dr Sherene Devanesen	1/7/2015 - 30/6/2016
Mr Roger Greenman AM	1/7/2015 - 30/6/2016
Dr Sandra Mercer Moore AM	1/7/2015 - 30/6/2016
Mr Andrew Porter	1/7/2015 - 30/6/2016
Ms Llewellyn Prain	1/7/2015 - 30/6/2016
Mr Derek Skues	1/7/2015 - 30/6/2016
Ms Sue Smethurst	1/7/2015 - 30/6/2016
Mr David Anderson	26/04/2016 - 30/6/2016
Accountable Officers	
Ms Ann Clark	1/7/2015 - 7/8/2015
Mr Mark Petty	27/7/2015 - 30/6/2016

Remuneration of Responsible Persons

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

Income Band	2016 Number	2015 Number
$0 - $9,999	1	1
$10,000 - $19,999	-	8
$20,000 - $29,999	7	-
$30,000 - $39,999	-	1
$40,000 - $49,999	1	-
$190,000 - $199,999	1	-
$240,000 - $249,999	1	-
$360,000 - $369,999	-	1
Total Numbers	**11**	**11**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**$650,297**	**$572,841***

* The 2015 total remuneration was misreported as $554,695 in the 2015 financial statements; this figure excluded superannuation benefits received or due and receivable by Responsible Persons.

Amounts relating to Responsible Ministers are reported in the financial statements of the Department of Premier and Cabinet. For information regarding related party transactions of ministers, the register of members' interests is publicly available from: www.parliament.vic.gov.au/publications/register of interests.

Other Transactions of Responsible Persons and their Related Parties.

There were no other transactions with Responsible Persons or their related parties in 2016; Nil 2015.

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.

Several factors affected total remuneration payable to executives over the year. A number of employment contracts were completed during the year and negotiated and a number of executives received bonus payments during the year. These bonus payments depend on the terms of individual employment contracts. Some contracts provide for an annual bonus payment whereas other contracts only include the payment of bonuses on the successful completion of the full term of the contract. A number of these contract completion bonuses became payable during the year.

A number of executive officers retired, resigned or were retrenched in the past year. This has had a significant impact on total remuneration figures due to the inclusion of annual leave, long-service leave and retrenchment payments.

	Total Remuneration		Base Remuneration	
	2016 No.	2015 No.	2016 No.	2015 No.
$40,000 - $49,999	-	-	1	-
$50,000 - $59,999	1	-	1	1
$60,000 - $69,999	-	1	-	-
$80,000 - $89,999	-	-	2	-
$90,000 – $99,999	2	-	-	-
$100,000 - $109,999	-	-	1	-
$110,000 – $119,999	-	-	1	-
$120,000 – $129,999	2	-	-	-
$130,000 – $139,999	1	-	-	-
$150,000 – $159,999	-	-	-	1
$160,000 – $169,999	-	-	1	-
$180,000 – $189,999	-	1	-	2
$190,000 – $199,999	1	-	-	-
$200,000 – $209,999	-	1	-	-
$210,000 – $219,999	-	1	-	-
$220,000 – $229,999	-	-	1	1
$250,000 - $259,999	1	-	-	-
$260,000 - $269,999	-	1	-	-
Total	8.00	5.00	8.00	5.00
Total Annualised Employee Equivalents (AEE) [(i)]	5.67	3.65	5.54	4.00
Total Remuneration	**$ 1,086,392**	**$ 921,631**	**$ 887,326**	**$ 805,097**

[(i)] Annualised employee equivalent is based on paid working hours of 38 ordinary hours per week over the 52 weeks for a reporting period.

Note 24: Remuneration of Auditors

	2016 $'000	2015 $'000
Victorian Auditor-General's Office		
Audit of Financial Statements	49	49
Fees Paid to Ernst & Young		
Internal Audits	100	133
Total Auditor Remuneration	**149**	**182**

Note 25: Correction of a Prior Period Error

There was an error in the reporting of funding from the Department of Health and Human Services for the hospital redevelopment project in the 2015 financial year. $26,346,000 in funding was incorrectly reported as Contributed Capital; this funding should have been reported as Capital Purpose Income.

As a result of this error, Capital Purpose Income and the Net Result For The Year and Comprehensive Result were understated by $26,346,000 for the 2015 financial year. Accumulated Surpluses/(Deficits) was understated and Contributed Capital was overstated by $26,346,000 at 30 June 2015.

The error has been corrected by increasing the amount of Capital Purpose Income reported for the 2015 financial year by $26,346,000 (refer Note 2) and decreasing Contributed Capital by the same amount (Note 17).

Board Member's, Accountable Officer's and Chief Finance and Account Officer's Declaration

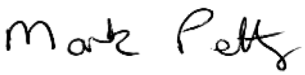
The attached financial statements for The Royal Victorian Eye and Ear Hospital have been prepared in accordance with Standing Directions 4.2 of the *Financial Management Act 1994*, applicable Financial Reporting Directions, Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2016 and financial position of The Royal Victorian Eye and Ear Hospital at 30 June 2016.

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

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

Dr Sherene Devanesen
Chair, Board of Directors
30 August, 2016



Mark Petty
Accountable Officer
30 August, 2016

Danny Mennuni
Chief Finance and Accounting Officer
30 August, 2016

VAGO
Victorian Auditor-General's Office

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INDEPENDENT AUDITOR'S REPORT

To the Board Members, The Royal Victorian Eye and Ear Hospital

The Financial Report

I have audited the accompanying financial report for the year ended 30 June 2016 of The Royal Victorian Eye and Ear Hospital which comprises comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement, notes comprising a summary of significant accounting policies and other explanatory information, and the Board Member's, Accountable Officer's and Chief Finance and Account Officer's Declaration.

The Board Members' Responsibility for the Financial Report

The Board Members of The Royal Victorian Eye and Ear Hospital are responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*, and for such internal control as the Board Members determine is necessary to enable the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error.

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. Those standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance about 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 Board Members, 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.

Independent Auditor's Report (continued)

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, I and my staff and delegates complied with all applicable independence requirements of the Australian accounting profession.

Opinion

In my opinion, the financial report presents fairly, in all material respects, the financial position of The Royal Victorian Eye and Ear Hospital as at 30 June 2016 and of its financial performance and its cash flows for the year then ended in accordance with applicable Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*.

MELBOURNE
1 September 2016

Dr Peter Frost
Acting Auditor-General

Affiliations and Memberships

The Royal Victorian Eye and Ear Hospital is affiliated with:

Bionic Vision Australia
Lions Eye Donations Service Melbourne
The HEARing CRC
The Bionics Institute
The Centre for Eye Research Australia
The University of Melbourne

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

The World Association of Eye Hospitals

Members: Tun Hussein On National Eye Hospital, Kuala Lumpur, Malaysia; The Department of Ophthalmology of the University Hospital Leuven, Belgium; Singapore National Eye Centre, Singapore; Moorfields Eye Hospital, London, UK; The Royal Victorian Eye and Ear Hospital, Melbourne, Australia; Rutnin Eye Hospital, Bangkok, Thailand; St Eriks Eye Hospital, Stockholm, Sweden; The Rotterdam Eye Hospital, The Netherlands; The Royal Victoria Eye and Ear Hospital, Dublin, Ireland; Jakarta Eye Center, Jakarta, Indonesia; Tianjin Medical University Eye Centre, China; Sydney Eye Hospital, Sydney, Australia; Kim's Eye Hospital, Seoul, South Korea; Aditya Jyot Eye Hospital, Maharashtra, India; St John Eye Hospital, Jerusalem, Israel; Kellogg Eye Center, Ann Arbor, USA; Fondation Asile des Aveugles, Lausanne, Switzerland; The Metta Eye Hospital (Mettapracharak (Wat Rai Khing) Hospital), Bangkok, Thailand; Ispahani Islamia Eye Institute and Hospital, Bangladesh; Bascom Palmer Eye Institute, USA; Massachusetts Eye and Ear Infirmary, USA; Phillips Eye Institute, USA; Wilmer Eye Institute at Johns Hopkins, USA; Emory Eye Center, USA; New York Eye and Ear Infirmary, USA; Wills Eye Hospital, USA; The Eye Hospital from Turino, Italy; Hoftalon Eye Hospital, Brasil.

The American Association of Eye and Ear Centers of Excellence

Members: Bascom Palmer Eye Institute, Florida, USA; Emory Eye Centre, Georgia, USA; Massachusetts Eye and Ear Infirmary, Massachusetts, USA; Moorfields Eye Hospital, London, UK; New York Eye and Ear Infirmary, New York, USA; Phillips Eye Institute, Minnesota, USA; The Royal Victorian Eye and Ear Hospital, Melbourne, Australia; Rutnin Eye Hospital, Bangkok, Thailand; Show Chwan Health Care System, Taiwan; Singapore National Eye Centre, Singapore; St Eriks Eye Hospital, Stockholm, Sweden; Wills Eye Hospital, Pennsylvania, USA; Wilmer Eye Institute, Maryland, USA; King Khaled Eye Specialist Hospital, Riyadh, Saudi Arabia.

Victorian Healthcare Association

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