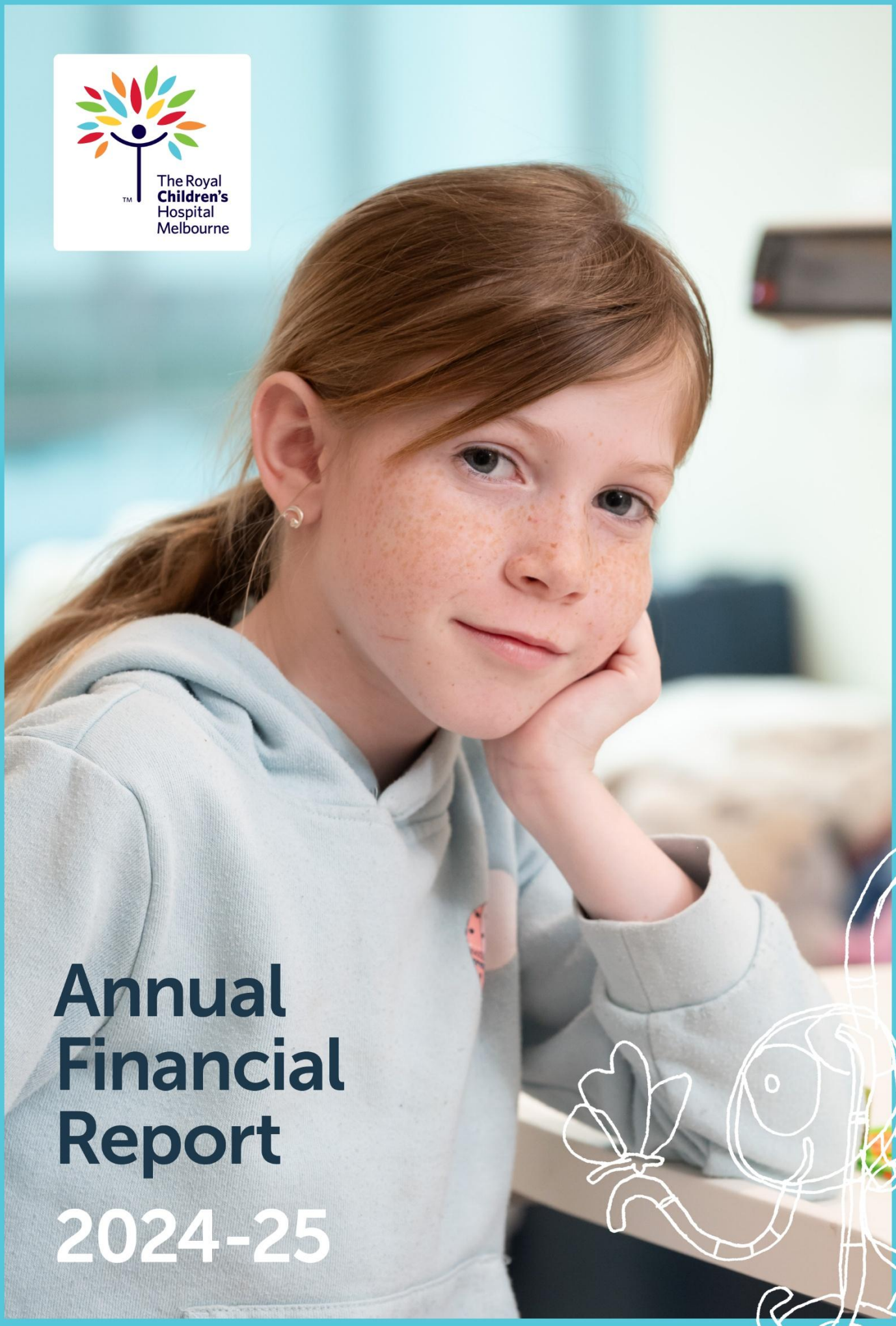
The Royal Children's Hospital Melbourne



Annual Financial Report 2024-25

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Acknowledgement of Country

The Royal Children's Hospital (RCH) acknowledges the traditional owners of the land on which the RCH is situated, the land of the Wurundjeri people of the Kulin nation, and we pay our respects to their Elders past and present.

General Information

The Royal Children's Hospital (RCH) acknowledges the traditional owners of the land on which the RCH is situated, the land of the Wurundjeri people of the Kulin Nation, and we pay our respects to their Elders past and present.

Our Vision

A world where all kids thrive.

We believe all children and young people should have the same opportunity to realise their potential.

Our Role

We work together to put children and young people at the heart of our care, research and learning.

Our Values

Our values help us achieve a world where all kids thrive.

Curious
We are creative, playful and collaborative.

Courageous
We pursue our goals with determination, ambition and confidence.

Inclusive
We embrace diversity, communicate well, build connections and celebrate our successes together.

Kind
We are generous, warm and understanding.

The RCH is a public health service and is incorporated pursuant to the provisions of the *Health Services Act 1988* (as amended). The RCH has cared for the children of Victoria since it was founded in 1870 and is internationally recognised as a leading centre for paediatric treatment, teaching and research.

Chief Executive Officer and Board Chair Report

It has been a great honour to join The Royal Children's Hospital (RCH) as Chief Executive Officer (CEO) in March 2025. In the months since stepping into this role, I've seen first-hand the exceptional care, deep compassion, and unwavering dedication of our staff. The RCH is a truly special place, built on the trust of children, young people, and families – trust that has been hard earned over 155 years.

This year also marks a new chapter in leadership with Professor Christine Kilpatrick AO commencing as Chair of the RCH Board in July 2025. I extend my sincere thanks to our outgoing Board Chair Dr Rowena Coutts for her outstanding service and strong leadership during a period of significant transformation and growth. I would also like to acknowledge Professor Ed Oakley, who served as Interim CEO prior to my commencement and Bernadette McDonald who concluded her time as CEO in September 2024. We all share a commitment to excellence and stability during an important time for the organisation.

Bringing our vision to life – every day

Our Strategic Plan 2024–26 reflects the aspirations of more than half of our 6,500 staff who helped develop and create our three bold, interconnected goals:

1. Our Hospital: A leading academic paediatric hospital
2. Our Health System: An integrated paediatric service
3. Our Community: Healthy children and young people

These goals guide our daily work and decisions, representing a whole-of-system approach to paediatric care grounded in excellence, equity and collaboration across Victoria and beyond.

We're also pleased to share that work has recommenced on the expansion of our Emergency Department – an essential redevelopment to meet growing demand and continue delivering timely, high-quality care in a modern, purpose-built environment.

Caring at scale

Throughout 2024–25, we provided care at extraordinary levels:

- 85,415 Emergency Department presentations
- 456,070 ambulatory (outpatient) appointments
- 15,106 surgeries
- 53,450 inpatient admissions

While these numbers reflect the scale of our work, it's the quality of care and the experience of families that remains our greatest focus. This includes more than 600,000 separate contacts with patients in the community – a testament to both our reach and commitment to compassionate, person-centred care.

Hospital in the Home – 20 year anniversary

This year, the RCH celebrated 20 years of our Wallaby ward – Australia's largest paediatric Hospital in the Home (HITH) program.

Wallaby delivers hospital-level care in the comfort of a home, reducing stress and disruption for families. Over two decades, the program has:

- Saved patients a collective 538 years of hospital stays
- Collectively travelled the equivalent of seven return journeys to the moon, reaching patients in every corner of the state.
- Received positive feedback from nearly 49,000 children and families.

Operating as a 61-bed virtual ward, Wallaby provides acute care across Victoria, including services like IV antibiotics, chemotherapy, wound care, diabetes education, oxygen therapy, sleep studies, and allied health support. The team continues to innovate, ensuring high-quality care through strong partnerships and new technologies.

Immigrant Health Service – 25 year anniversary
This year, we also celebrated 25 years of the Immigrant Health Service – a vital initiative that delivers free, multidisciplinary care to children and young people who have arrived as refugees or are seeking asylum.Through weekly clinics, the teams have provided integrated medical, developmental, and mental health support, ensuring families are seen together and care is coordinated – with over 35,000 attendances since conception. Beyond clinical excellence, the service has played a key role in shaping education, policy and guidelines to advance equitable healthcare across our community.

Sleep Medicine Service – 10 year anniversary
The Sleep Medicine Service also celebrated a decade of being a nationally accredited, internationally recognised program that has helped thousands of children with complex sleep and respiratory needs. Through gold-standard care, research leadership and global collaboration, the service has continued to set benchmarks in paediatric sleep medicine and improve outcomes for families across Victoria and beyond.

Victorian Infant Hearing Screening Program – 20 year anniversary
The Victorian Infant Hearing Screening Program (VIHSP) reached a significant milestone in its mission to ensure that every newborn has the best start in life. In February 2025, the state-wide program celebrated its 20th anniversary, commemorating two decades of dedication to the early detection of reduced hearing levels in infants across Victoria.

The program is delivered by the Centre for Community Child Health, a department of the RCH and a research group of the Murdoch Children's Research Institute (MCRI). Since VIHSP's establishment, it has been screening the hearing of newborns, enabling timely diagnosis and intervention. This early detection plays a crucial role in helping babies develop critical speech, language, and cognitive skills, which ultimately improves their long-term outcomes. The program has screened over 1.3 million babies, a remarkable achievement that has had an enduring impact on countless families.

Paediatric Liver Transplant Service – Celebrating 250 liver transplants
The RCH and Austin Health reached a major milestone as well, completing over 250 liver transplants and 30 years of the Paediatric Liver Transplant Service.

This collaborative service provides liver transplants for children with end-stage liver disease and other conditions across Victoria, Tasmania and South Australia.

Transplants are performed at the RCH by specialist surgeons from Austin Health. The RCH delivers all other aspects of care, from pre-surgery to long-term follow-up, often beginning from birth.

Around half of the transplants are for children with biliary atresia, a progressive liver disease present from birth. Today, it is a highly specialised, protocol-driven service supported by expert transplant coordinators and a multidisciplinary team.

Good Friday Appeal – Supporting regional Victoria

A record $23.45 million was raised through the Good Friday Appeal, with nearly $3 million invested in regional health services – building on last year's $2.5 million investment. This funding has supported equipment upgrades, specialised education and training programs across regional Victoria:

- **Barwon**: Faster blood test processing for neonatal babies at local hospitals.
- **Grampians**: Upgraded spaces and equipment for families, plus emergency paediatric training.
- **Gippsland**: Emergency resuscitation tools, mobile x-ray machines and ultrasound equipment for newborn care.
- **Hume**: Enhanced education in maternity services, anaesthesia and emergency births.
- **Loddon Mallee**: Coordinated care for children with developmental delays and neurodiverse characteristics, including a new clinic and culturally safe birthing experiences for First Nations families in Echuca.

More highlights from the year

This year we launched the the RCH Nursing Excellence Awards, opened the Banksia Mental Health Intensive Care Area, and our role as a trusted voice in family health through the National Child Health Poll, was honoured with the Kidsafe Community Award.

Looking ahead

I want thank our staff, volunteers, and partners for their dedication and excellence. To our partners at the RCH Foundation, Murdoch Children's Research Institute, Good Friday Appeal and the University of Melbourne – thank you for your continued collaboration in driving research, innovation and patient-centred care. As we look to the future, we do so with optimism and determination. The year ahead offers us the opportunity to build on our strengths, continue innovating, and ensure that every child, wherever they are, receives the best possible care.

In accordance with the *Financial Management Act 1994*, I am pleased to present the report of operations for The Royal Children's Hospital (RCH) for the year ending 30 June 2025.

Dr Peter Steer
Chief Executive Officer
The Royal Children's Hospital
Melbourne

25 September 2025

Professor Christine Kilpatrick AO
Board Chair
The Royal Children's Hospital
Melbourne

25 September 2025

Powers and duties

The powers and duties of the RCH are prescribed by the *Health Services Act 1988*. The hospital is accountable to the people of Victoria through the Minister for Health and Minster for Ambulance Services, the Honourable Mary-Anne Thomas from 1 July 2024 to 30 June 2025, the Minister for Mental Health, the Honourable Ingrid Stitt from 1 July 2024 to 30 June 2025 as well as the Minister for Disability and Minister for Children, the Honourable Lizzie Blandthorn from 1 July 2024 to 30 June 2025.

Our services

The RCH is a major specialist paediatric hospital in Victoria and provides specialist care for children from Tasmania, southern New South Wales, and other states around Australia. It is also Victoria's designated major trauma centre for paediatrics.

The hospital delivers the statewide Paediatric, Infant, and Perinatal Emergency Retrieval (PIPER) service and is a Nationally Funded Centre for paediatric heart transplantation, paediatric liver transplantation (in collaboration with Austin Health), and paediatric lung transplantation (in collaboration with Alfred Health). The RCH delivers forensic medicine services, treatment for complex congenital heart disease (including hypoplastic left heart syndrome) and provides an internationally recognised Gender Service.

The RCH is part of the Melbourne Children's Campus and collaborates with its campus partners, the Murdoch Children's Research Institute and the University of Melbourne, Department of Paediatrics to provide global leadership in integrated clinical care, research and education.

The RCH leads a number of statewide services, including:

- Victorian Paediatric Rehabilitation Service (with Monash Health, Ballarat Health Services, Barwon Health, Bendigo Health, Eastern Health and Goulburn Valley Health).
- Victorian Paediatric Palliative Care Program (with Monash Health and Very Special Kids).
- Victorian Forensic Paediatric Medical Service (with Monash Health and Victorian Institute of Forensic Medicine).
- Victorian Infant Hearing Screening Program.

The RCH is a Nationally Funded Centre for:

- paediatric heart transplants
- paediatric liver transplants (in collaboration with Austin Health)
- paediatric lung transplants (in collaboration with Alfred Health).

Staff Excellence Awards

At our 2024 Staff Excellence Awards celebration, we recognised the incredible work of team members across the organisation.

The recipients of the 2024 awards were:

Chairs' Medal – Bradley Carter

Integrated Access Award – Transition Support Services Team

Quality, Innovation and Improvement Award – Apheresis Service Team

People Award – Adrienne Fosang

Sustainable Healthcare Award – Andrei Kononov

Dr William Snowball Award – Alyce Horstman

Mary Patten Award – Brendan Cusack

Bernadette O'Connor Award – Complex Feeding Service Team

Yvonne Wagner Award – Nicole Bellino

Health, Safety and Wellbeing Award – Code Grey Team

Newcomer Impact Award (clinical) – Siew-Lian Crossley

Newcomer Impact Award (non-clinical) – Jacqueline Davey

2024-25 Board member profiles

Board Chair
Dr Rowena Coutts
LLB and BJuris (Monash University), Doctor FedUni (Hon).

Dr Rowena Coutts is the Chair of the Board, Melbourne Institute of Technology; and is a partner in her family's primary production business.She is the past Chair and Director of Ballarat Health Services and former Chair of the Grampians Regional Board Network. As former Senior Deputy Vice-Chancellor, University of Ballarat/Federation University Australia she had responsibility for Corporate Services including Finance, Legal, Governance, HR, Technology Park, Commercial, International Education and PR. She is also a former Chair and member of Board of Directors, Ballarat Clarendon College. Rowena commenced her career as a lawyer, holding an LLB and BJuris from Monash University and a Doctor FedUni (Hon).

Board Deputy Chair
Professor Richard Doherty
MBBS (Hons), DObstRCOG, FRACP

Professor Richard Doherty trained in paediatrics and in paediatric infectious diseases in Brisbane and Boston and is a consultant physician in Paediatric Infectious Diseases at Monash Children's Hospital and Professor in the Monash University Department of Paediatrics. He is also a former staff member of the RCH. He has held previous appointments as Dean of the Royal Australasian College of Physicians, Head of the Department of Paediatrics and Associate Dean for Teaching Hospitals at Monash, Medical Director of the Southern Health Children's Program, Deputy Director of the Macfarlane Burnet Centre for Medical Research and consultant physician at the RCH. He has served as a Director of the Australian Medical Council and on national committees including NHMRC panels, the 2016 Intern Review, the National Medical Training Advisory Network and several Victorian Department of Health advisory committees. Richard was a member of the Medical Board of Australia from 2018 to 2021.

Board Deputy Chair
Pallavi Khanna
CA, GAICD

Pallavi Khanna is an experienced risk management and governance advisor. She has worked both in South Africa and Australia across the corporate and not-for-profit sectors. For more than 35 years, Pallavi has worked with organisations to develop strategies to address strategic risks, undertaken independent evaluation of governance frameworks and managed projects to deliver strategic objectives. She has also undertaken assessments pertaining to privacy (Australia and International), IT controls, procurement (probity) and customer experience. Pallavi is currently the Head of internal Audit and Enterprise Risk at Metro Trains. Pallavi is also an independent member of the Finance and Risk Committee at the City of Stonnington. Her prior board roles include Avet Health, Public Galleries Association of Victoria, Common Equity Housing Ltd and Ballarat Health Services. She is a Chartered Accountant (Australia and South Africa), Prince 2 certified, and a graduate of the Australian Institute of Company Directors.

Elleni Bereded–Samuel AM
MED, GradDip (Couns), GradCert (Mgt), BA

Elleni Bereded–Samuel AM is a highly respected senior executive, board director, and community engagement leader with extensive experience in advancing the interests of culturally and linguistically diverse (CALD) communities across Australia. Recognised nationally for her impactful work with migrant and refugee communities, Elleni was appointed a Member of the Order of Australia (AM) in 2019 for her outstanding service to the community. She was honoured by receiving multiple awards for her leadership and advocacy, including being named one of Australia's 100 Women of Influence by Westpac and The Australian Financial Review, and the Diversity@Work Individual National Champion Award for her commitment to diversity and inclusion. Elleni brings deep expertise in enhancing access to education, training, employment, and essential services for CALD communities. She is known for her strategic mindset in designing and implementing programs that foster social inclusion and equity.

Currently, Elleni is the Executive Manager of Diversity and Inclusion at Great Care Pty Ltd, where she provides strategic leadership and expertise on equity, inclusion, and community engagement. Her previous leadership roles include Director positions at SBS, The Royal Women's Hospital, Western Health, BreastScreen Victoria, and the Australian Social Inclusion Board. She also contributes her expertise through several governance and advisory roles. Elleni is a Board Director of The Royal Children's Hospital, the inaugural Co-Chair of the Growing Minds Australia (GMA) Community Engagement Advisory Committee, a member of the GMA Scientific Advisory Committee, and a Director of Wellways Australia. In 2025, she was appointed to the Clinical Governance Advisory Committee of the Australian Commission on Safety and Quality in Health Care.

Sammy Kumar
B. Bus, FCA

Sammy Kumar is the Co-Founder and CEO of Tenet Advisory & Investments. Sammy is a business leader with over 35 years' experience in management consulting, mergers and acquisitions, risk management, strategy, technology and ventures. Sammy's work includes significant experience in many overseas markets including the US, Canada, South America and Asia Pacific. He has advised companies in a number of different sectors including financial services, telecommunications, technology services, private equity and venture capital. During his time at PwC he started, led and grew businesses both in Australia and the Asia-Pacific region, managing revenues of over $1 billion. Sammy is a thought leader on a range of topics including revenue risk management, mega trends impacting economies, and the impact of technology on business strategy. Sammy is a committed member of the broader community, serving on the Boards of the RCH and the RCH Foundation. He is also a Board member of Melbourne and Olympic Park Trust and Member of the Advisory Board for the Centre for Australia-India Relations.

Jude Munro AO
BA Hons (Uni of Melbourne), Grad Dip Public Policy (Uni of Melbourne), Grad Dip Business Administration (University of Swinburne)

Jude Munro AO is experienced in guiding large complex organisations both as a Non-Executive Director and CEO. She has been Board Chair of Australia's fourth largest water utility, a state planning authority and one of Victoria's largest not-for-profits with services directed to children, young people and families. She has also been a Chair of a not-for-profit company with oversight

of four major hospitals. She has been a Director of a national aviation business, an airport, a state transit authority, a bus company, a development company, and chair of Australia's first Pride Centre for the LGBTQI+ community. She provides advice to organisations on strategic planning, governance and leadership. Jude mentors CEOs and assists organisations in selection and CEO performance reviews. She has been CEO of two capital city Councils – Adelaide and Brisbane. Her last CEO position was as CEO of Brisbane City Council for 10 years. She led the Council with its $2.6B annual budget, 9,000 employees on planning and delivering infrastructure projects, bus and ferry services, regulatory and other municipal services for more than 1.2 million people. The infrastructure projects included the $2.7 billion Clem7 tunnel, the steering committee chair for the feasibility stage of Airport Link, the Green Bridge, and Go Between bridge. She served three Lord Mayors in that time.

Dr Michael Wildenauer
PhD MBA(Computing), GDipCommLaw BSc(MathSc), MACS(Snr), CP, MAICD

After 30 years of technology leadership experience in Australia, the US, UK and Europe, Dr Michael Wildenauer transitioned into academia. At La Trobe Business School, he was appointed a Professor of Practice in Management, teaching MBA and Master's courses on the social and ethical issues around technology and business, as well as in corporate governance. Subsequently, Michael was an academic at the Centre for AI and Digital Ethics (CAIDE), and the Melbourne Law School at the University of Melbourne, where he is currently an Honorary Senior Fellow. In addition to his professional and governance roles, Michael was previously the Chair of the Professional Ethics Committee of the Australian Computer Society (ACS) and a Member of the ACS Professional Standards Board, and is a current member of the Expert Advisory Committee on Neurotechnology for the Australian Human Rights Commission.

In the health sector, Michael was previously a Non-Executive Director of Kyneton District Health, where he was at various times the Chair of its Governance and Remuneration Committee and a member of the Clinical Governance and Audit and Risk Committees and was also an external member of the Audit and Risk Committee of Central Highlands Rural Health. Michael was awarded a PhD in Corporate Governance for research into board effectiveness, an MBA with a concentration in computing, a Grad Diploma in Communications Law, and a BSc in Pure Mathematics and Computing. His academic interests are at the intersection of health, ethics, technology, law and governance, and to this end he is currently undertaking a Master's degree in Practical Ethics at the University of Oxford.

Mark Rogers
B.Eng (Hons), B.Sc

Mark is the Group Executive – Chief Financial Officer & Group Strategy of Medibank. Mark is a director of Myhealth Medical Group, East Sydney Private Hospital and Integrated Mental Health. He has more than 25 years of global finance, strategic and operational experience across the financial services, insurance and health care (including primary care, diagnostics, pharmaceuticals, and tertiary care) sectors. Mark commenced his career as Chemical Engineer.

Andrew Chan
B.Comm, LLB (Honours)

Andrew Chan is a partner at Mills Oakley, a national corporate law firm and has over 17 years' legal experience in Australia and the UK. As a parent of a regular patient, Andrew is particularly interested in improving the consumer and patient experience at RCH.

Board appointments

Jude Munro AO concluded her duties with the Board on 31 July 2024.

Dr Rowena Coutts concluded her duties with the Board on 30 June 2025. Professor Christine Kilpatrick AO was then appointed as the new Chair of the RCH Board, effective 1 July 2025.

Julie Green was appointed as a member of the RCH board on 1 July 2025.

The RCH Board Committee membership 2024-25 financial year

Audit and Corporate Risk Management Committee

Pallavi Khanna (Chair)
Dr Michael Wildenauer
Sammy Kumar
Michelle Bendschneider (External member)

Community Advisory Committee

Elleni Bereded-Samuel AM (co-Chair)
Andrew Symes (External Community member) (co-Chair)
Dr Rowena Coutts
Andrew Chan

Finance Committee

Mark Rogers (Chair)
Pallavi Khanna
Andrew Chan

Quality and Population Health Committee

Professor Richard Doherty (Chair)
Pallavi Khanna
Andrew Chan

Remuneration and Governance Committee

Dr Rowena Coutts (Chair)
Prof Richard Doherty
Pallavi Khanna

People and Culture Committee (previously named Workplace Culture Committee)

Dr Michael Wildenauer (Chair)
Elleni Bereded-Samuel AM
Dr Rowena Coutts

Executive staff

Peter Steer
Chief Executive Officer
MBBS, FRACP (Paediatrics), FRCPC (Paediatrics), FAAP, GAICD

Sandy Bell
Executive Director Strategy, Planning and Performance
BA (Hons), MPPM, GAICD

Tom Connell
Executive Director Medical Services and Chief Medical Officer
MB BAO BCH B Med Science MRCPI FRACP PhD FRACMA

Frank Vosnidis
Acting Chief Financial Officer
BComm, MBA, FCPA

Doug McCaskie
Executive Director of Ambulatory Services and Chief Allied Health Officer
Adjunct Associate Professor, Speech Pathologist, Grad Dip (Research), MHA, GAICD

Ed Oakley
Chief of Critical Care
MBBS FACEM

Clive Peter
Executive Director, People and Culture
Bsc. Hons, MPhil, MAICD

Kathryn Riddell
Executive Director Nursing and Chief Nursing Officer
Adjunct Professor, RN, CCRN, MN (Research), MACN

Kog Ravindran
Executive Director Communications
Bachelor of Journalism, Specialist Certificate in Public Administration (Advanced)

Michelle Telfer
Chief of Medicine
MBBS (Hons.), FRACP, GAICD

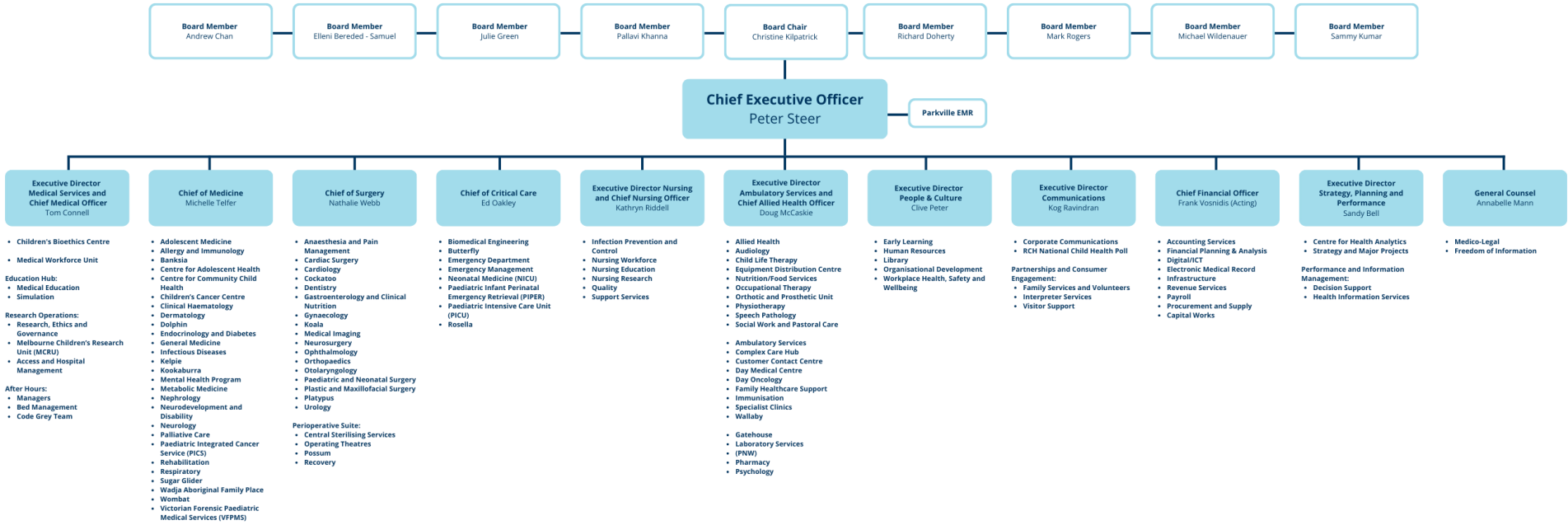
Nathalie Webb
Chief of Surgery
MB BS (Hons) FRACS (Urol) FFSTEd MSurgEd GAICD

Bernadette McDonald concluded her duties as Chief Executive Officer on 13 September 2024. Ed Oakley assumed duties as Interim Chief Executive Officer from 14 September 2024 to 2 March 2025. Peter Steer was appointed as Chief Executive Officer on 3 March 2025.

Tom Rozen was Acting Chief of Critical Care from 14 September 2024 to 2 March 2025. Ed Oakley resumed duties as Chief of Critical Care from 3 March 2025.

Andrew Gay concluded his duties as Chief Financial Officer on Monday 26 May 2025. Frank Vosnidis assumed duties as Acting Chief Financial Officer from Tuesday 27 May 2025.

Organisational structure



Workforce data

Hospitals Labour Category	June FTE		Average Monthly FTE	
	2023-24	*2024-25*	*2023-24*	*2024-25*
Nursing	1,592	1,522	1,524	1,512
Administration and Clerical	861	793	854	804
Medical Support	442	434	439	434
Hotel and Allied Services	284	269	277	276
Medical Officers	145	145	145	143
Hospital Medical Officers	401	387	398	399
Sessional Clinicians	181	182	176	179
Ancillary Staff (Allied Health)	425	407	423	411

Code of Conduct

The RCH Code of Conduct is founded on four organisational values; being curious, courageous, inclusive and kind. Our role is that we work together to put children and young people at the heart of our care, research and learning.

In the pursuit of this role, we aim to grow and nurture a safe and positive workplace culture that is underpinned by our values. We recognise the rights and the diverse needs of children and young people and encourage their participation wherever practicable. The Code of Conduct sets out our behavioural expectations and the way we conduct ourselves at the RCH. This Code applies to all RCH Board members, managers and employees, prospective employees, contractors, honorary employees, students, volunteers and affiliates. Our campus partners and contractors acknowledge and observe the Code.

In addition, all employees and volunteers are required to comply and abide by the Victorian Public Sector Code of Conduct, the National Safety and Quality Health Service Standards, and any applicable Code of Conduct of their relevant professional membership body.

The RCH promotes a culture of diversity, inclusion and belonging. Grievance and dispute resolution processes are in place that provide fairness and protect employees from the negative consequences of accessing formal dispute processes. This ensures employment decisions at the RCH are based on merit and reflect equal employment opportunities for all team members.

Occupational Health and Safety

The RCH is committed to providing a healthy and safe environment for all employees, volunteers, patients, visitors, contractors and suppliers. In 2024-25, we continued to implement measures to mature a positive safety culture and minimise risk at work. The hospital continued to demonstrate its commitment to prioritising the wellbeing of each individual, strategically targeting physical and psychosocial hazards in the workplace.

Health and Wellbeing Strategy

The RCH continued to support and strengthen its proactive approach to the health and wellbeing of staff in 2024-25. In April 2025, the RCH appointed a Health and Wellbeing Manager to develop and deliver *The RCH Health and Wellbeing Strategy 2026-2029* to continue to support its goal of meeting the health and wellbeing challenges of our workforce. Extensive consultation and collaboration across the organisation is underway to develop a contemporary roadmap that aligns with our strategic priorities and will increase health and wellbeing literacy while encouraging a safety culture of responsibility.

Mental Health First Aid Training

Mental Health First Aid training is now in its fourth year at the RCH. In 2024-25, an additional 200 RCH staff were trained, with a total of 700 staff members now trained. Five accredited in-house instructors provide monthly training sessions. The organisation has continued to actively increase its capacity to respond effectively to mental health challenges within its workforce. The RCH is proud to continue to be recognised as a *Mental Health First Aid Australia Skilled Workplace*, showcasing its commitment to positive change through mental health literacy and action.

Peer Support Program

The RCH made significant efforts to broaden the reach of Peer Supporters in 2024-25, in recognition of their critical role in providing essential support to colleagues during times of distress. A recruitment drive in October and November 2024 resulted in 11 new peers undertaking the role. To standardise and bolster the skills of peers, the essential training prerequisites were defined as Mental Health First Aid and Suicide Prevention training in September 2024.

The profile of Peer Supporters at the RCH was increased through a targeted communication plan incorporating new posters, peer support badges and email signatures. Supporting staff to identifying their peer supporters was further enhanced through an internal engagement campaign. Supporting the 35 peer volunteers in their own health and wellbeing is undertaken by offering monthly reflective practice. The monthly sessions provide a safe and supportive environment for peers to discuss challenges they face, collaborate and develop strategies to better support their colleagues.

Employee Assistance Program

Converge International, the RCH's EAP provider, has continued to provide free and confidential counselling, coaching and additional services to support employees and their family members. The following benchmarking data was provided by Converge International for the 2024-25 period:

Annual EAP utilisation rate 2024- 25*	
RCH	7.1%
Industry Average (healthcare and social assistance)	5.0%

Consultation and Health and Safety Representatives Engagement

The RCH recognises the vital role that Health and Safety Representatives (HSRs) play in advocating for and promoting a safe workplace. In 2024-25, we reaffirmed our commitment to cultivating a strong safety culture by facilitating WorkSafe approved HSR training programs. As a result, 39 HSRs were trained, bringing the total number of active HSRs across the organisation to 120.

To support ongoing engagement, we maintained regular consultation with HSRs to assess risks, implement control measures, ensuring health and safety decisions are informed and employee - centred. As part of this commitment, a Central Building Consultative Committee (CBCC) was established in response to significant redevelopment works in our Emergency Department and the Banksia mental health inpatient ward. This commitment brings together HSRs, union representatives, and other key stakeholders to ensure transparent and inclusive consultation throughout the construction process, further demonstrating our dedication to supporting the voices of HSRs in workplace safety matters.

In March 2025, WorkSafe commenced a new inspection approach for hospitals with healthcare specific inspectors. This pilot has seen an increase in entries by the Authority to the RCH and provided the opportunity to seek collaboration and guidance on managing risk complexity. The approach has continued to support the strong culture of collaboration and consultation at the RCH and provided HSRs with a direct opportunity to engage with the Authority.

Building Manager Capability in Safety and Injury Management

The RCH continues to invest in strengthening safety leadership across the organisation with targeted training workshops delivered in 2024-25. These sessions equipped people leaders with the knowledge and practical tools needed to manage safety risks, ensure compliance with legislative requirements, and foster a proactive safety culture. A total of 96 people leaders participated in formal safety training during the year. This included 32 people leaders who increased their capability to manage WHS issues through the foundational workshop on legislative requirements and risk management processes, further embedding safety as a cornerstone of our organisational culture. The Injury Management team facilitated training for 64 people leaders through their injury management workshops. The workshops enhanced leadership capability on contemporary injury management processes to support staff injured in the workplace or who require reasonable adjustments to thrive in their role. Program evaluation showed strong outcomes, with all participants reporting increased confidence in supporting staff with injuries, illnesses or medical conditions.

Injury Management and WorkCover

The Early Intervention Program continued to be well utilised in the management of staff injuries. Throughout 2024-25, the RCH supported 144 staff who sustained an injury in the workplace. Early Intervention was accessed by 118 staff who received support for their workplace injury.

A total of 18 standard WorkCover claims were accepted during 2024-25. The number and duration of workers' compensation claims remained low when benchmarked against industry averages. As a result, the RCH performed (approximately) 38% better when compared with peer organisations.

The RCH Injury Management team completed an onboarding project for a new case management system to strengthen recovery at work practices. This system will be utilised across the organisation to improve timely recovery at work programs and foster collaboration with all stakeholders supporting injured staff with their recovery.

Occupational Health and Safety data

Occupational Health and Safety Statistics	2022-23	2023-24	2024-25
The number of reported hazards/ incidents for the year per 100FTE	14.6	11.5	14.2
The number of 'lost time' standard WorkCover claims for the year per 100FTE	0.41	0.32	0.43
The average cost per WorkCover claim for the year	$179,117	$110,110	$101,859

Staff family violence support

The RCH took positive steps to support our staff who experienced family violence. In 2024-25, managers and staff continued to seek support and guidance via Family Violence Contact Officers. The culture of support continued to be fostered via campus and precinct events, including the 16 Days of Activism in November-December 2024 and "Are you Safe at Home?" day in May 2025. Recognising the need to continue to build manager capability, bite-size learning modules were developed and delivered throughout the year to increase knowledge and provide practical skills to support our leaders. Enhanced cultural safety has resulted in greater disclosures of family violence among staff.

To support the increased disclosures and staff seeking support, an additional five Contact Officers were recruited. The organisation now has 13 Contact Officers to support our staff with a catalogue of over 50 different support modalities. In recognition of the challenges of this work, Contact Officers are in turn supported through monthly supervision. The sessions, known as Thriving Together, provide a space for staff to share and problem solve challenges. Thriving Together is run as a supportive internal discussion, with the alternate session facilitated by an external family violence specialist to support the ongoing work of this important role.

Respiratory Protection Program

To strengthen its focus in 2024–25, the Respiratory Protection Program (RPP) team upskilled high-risk teams to perform intra-departmental fit tests using our mobile fit testing units. This approach has been particularly effective for capturing night duty and weekend staff and has resulted in improved compliance rates in these work groups. In 2024-25, a total of 1,949 staff members, students and volunteers were fit tested.

In July 2024, the RCH launched the bespoke *MaskFit* program to enhance respiratory protection compliance. The integrated *MaskFit* testing database and booking system platform has significantly streamlined fit testing processes by offering a unified platform for appointment scheduling, test result access and compliance tracking. This system has simplified reporting and provided managers with clearer oversight of workforce compliance, supporting a safer and more efficient environment.

Smart Move Smart Lift Program

The RCH continues to promote safe patient handling through the Smart Move Smart Lift (SMSL) Program. During the 2024-25 period, an additional 13 trainers were credentialed. The program now has a total of 207 trainers who provide local assessment, training and support to staff across a variety of clinical roles at the RCH. Several nursing and allied health trainers enhanced their skills in the care of bariatric patients to improve patient outcomes and decrease the risk of staff injuries when caring for patients of size.

To improve the sustainability of the program, an additional master trainer was credentialled. The additional master trainer is focused on supporting the Ambulatory stream. The RCH now has three master trainers who can support the ongoing sustainability of the program.

The RCH continued to progress and support the Western Metro Health Service Partnership with consultation and review of manual handling training and education across the Parkville Precinct. The health services are working towards recognition of prior learning to support efficiencies for staff who work across the precinct or move between services. Strategic and informal collaboration will continue to identify opportunities to streamline activities.

Occupational Violence

The RCH continues to progress the implementation of our three-year occupational violence and aggression (OVA) Strategy. Year two of the OVA strategy has a key focus on the prevention and management of OVA. Staff training numbers in *Paediatric Approaches to Understanding Safe de-escalation* (P.A.U.S.E) continued to enhance the workforce's ability to effectively manage OVA. The full-day training was offered to staff across all high-risk patient-facing areas, in alignment with our strategic objectives. To accelerate progress towards training targets, sessions were offered fortnightly.

Ten newly recruited P.A.U.S.E associate trainers commenced delivery of the training, doubling our credentialed trainers from 10 to 20, significantly increasing training capacity. In total, 441 staff completed the training during 2024-25, with over 625 staff now having completed the program. A pre- and post-training participant survey showed staff's confidence, understanding and skills in de-escalation increased after completion.

The message is clear across the RCH; we have a zero tolerance to violence and aggression towards our staff. In support of our message, visuals are now featured across the organisation, including lifts, digital screens and reception areas. The development of this message is the culmination of extensive consultation with stakeholders, outlining the expected conduct towards our staff from all consumers, including children, young people, parents and carers. The high-visibility messaging supports RCH's stance on supporting a respectful and safe environment for all.

As we progress into the next phase of our three-year strategy, we remain committed to strengthening post-incident support for staff. A key initiative in this phase is the development of a support tool for managers, designed to assist managers in providing care, psychological support to staff and access to resources following an OVA incident. This actionable plan for the immediate support of staff will ensure contributing factors are captured to inform learning and further refine the training offering. This initiative is underpinned by our continued emphasis on reporting all incidents of OVA, including verbal, physical and technology-based, to capture critical data which ensures resources are directed to areas of greatest need.

Occupational violence statistics	2024-25
WorkCover accepted claims with an occupational violence cause per 100 FTE	0.5
Number of accepted WorkCover claims with lost time injury with occupational violence cause per 1,000,000 hours worked	0.22
Number of occupational violence incidents reported	157
Number of occupational violence incidents reported per 100 FTE	3.78
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	17%

Corporate Health Partnerships

Corporate Health Partner

In September 2024, the RCH took part in the *Healthy Cities* program with 270 staff registering. Healthy Cities was a creative step-challenge that focused on building the link between people's health and the environment. In acknowledgement of the RCH's participation, the organisation planted 771 native trees and shrubs for the *Western Plains Grassland's Living Ark Project* and donated $2,000 to mutually agreed, registered charities.

The RCH takes a proactive approach to wellbeing, undertaking a range of preventative health initiatives. In recognition of sun exposure as the main cause of skin cancer, skin checks were provided for 120 staff in October 2024. The preventative healthcare offering included a range of assessments offered to staff utilising a risk management approach; these screenings served as a crucial step towards fostering a safe and health-conscious workplace culture. Notably, 76% of staff members screened were identified as being at high risk of developing melanoma in their lifetime. Furthermore, 6% of staff members receiving skin checks were recommended to follow up with a medical practitioner based on assessment findings.

Financial Fitness

Supporting the financial health and literacy of the workforce, the RCH partnered with a superannuation provider to deliver targeted educational initiatives in October 2024 and February 2025 with a number of staff engaging with the programs. These sessions included tailored seminars focused on *Better Money Habits* and *Preparing for Retirement*, equipping staff with practical tools to make informed financial decisions and plans.

In continued effort to support the wellbeing of our workforce, the RCH welcomed a new collaboration between the super provider and a virtual healthcare service. This partnership offers members and their families access to a suite of health and wellbeing services, including mental health, nutrition and fitness guidance, and menopause care. These programs are designed to empower individuals to lead healthier, more balanced lives. The free and confidential services are available to members, their partners and adult children. The RCH is proud to promote this initiative as part of our broader commitment to holistic staff wellbeing.

Fitness Passport

Fitness Passport is a corporate health and fitness program providing its members and their families with access to a wide choice of fitness facilities close to their home and work. Use by RCH staff continued to grow in 2024-25 with an increase in membership of 12%. Staff continue to experience the benefit of reduced cost Fitness Passport membership to support the physical health benefits for themselves and their families. Membership has continued to steadily increase since launching the partnership in 2022, with 839 staff now enjoying access to more than 200 fitness facilities across Melbourne.

Australian Red Cross LifeBlood

In April 2025, the RCH proudly relaunched its partnership with LifeBlood as part of the Health Services Blood Drive. The newly formed RCH Melbourne team has seen remarkable growth in just a few short months, expanding to 232 members. Together, the team's generous blood donations have made a profound impact, collectively helping to save more than 450 lives.

Staff Massages

Throughout 2024-25, more than 1,000 employees benefited from the monthly massage program. Delivered by students from the Melbourne Institute of Massage Therapy and Myotherapy undergoing professional training, the seated massages offer an opportunity for relaxation and rejuvenation amidst busy work schedules. Staff consistently express their appreciation of the program. For the student practitioner, the program has been equally rewarding – working with grateful staff has enriched their learning journey and supported their skill development in a supportive environment. The anticipation of the monthly sessions remains high, highlighting the program's positive impact on staff morale and student development.

Financial information

Summary of the financial results for the year

The full year result for FY25 reflects a deficit of $19.4 million. NWAU activity achieved target, however the acute admitted category was challenged with operational theatre impacts in the first half of the year as well as lower mental health community hours achieved. The organisational savings plan realised over $28 million in benefits with vacancy management, reduced overtime and lower medical and surgical supplies, however the high instances of sick leave coupled with low annual leave utilisation during the year adversely impacted the cost base.

Significant changes in financial position during the year

As of 30 June 2025, the RCH reported net assets of $864 million, primarily attributable to the significant value of its non-current assets. This includes the main hospital building, held under a Public Private Partnership (PPP) arrangement, and other property assets. The combined value of these assets exceeds the corresponding PPP related liabilities, contributing substantially to the positive net asset position.

Significant events occurring after balance date/ subsequent events

Professor Christine Kilpatrick AO has been appointed as the new Board Chair of the RCH, effective 1 July 2025.

	2025	2024	2023	2022	2021
	$000	**$000**	**$000**	**$000**	**$000**
OPERATING RESULT	(19,360)	(12,679)	501	183	25
Total revenue	1,148,789	1,126,176	1,132,140	994,687	913,672
Total expenses	(1,177,812)	(1,133,405)	(1,104,776)	(1,009,085)	(927,649)
Net result from transactions	(29,023)	(7,229)	27,365	(14,398)	(13,977)
Total other economic flows	(620)	(472)	(6,894)	6,139	6,353
Net result	(29,643)	(7,701)	20,471	(8,260)	(7,624)
Total assets	1,920,833	1,997,190	1,716,061	1,588,893	1,600,907
Total liabilities	1,056,441	1,103,155	1,130,468	1,163,071	1,192,469
Net assets/Total equity	864,392	894,035	585,593	425,822	408,438

Reconciliation between the Net Result from Transactions to the Statement of Priorities Operating Result

	2024-25 ($000)
Operating result	**(19,360)**
Capital purpose income	108,775
COVID 19 State Supply Arrangements – Assets received free of charge or for nil consideration under the State Supply	106
State supply items consumed up to 30 June 2024	(106)
Expenditure for capital purpose	(1)
Depreciation and amortisation	(82,147)
Finance costs (other)	(36,290)
Net result from transactions	**(29,023)**

Consultancies information

Details of consultancies (under $10,000)

In 2024-25, there was one consultancy where the total fee payable to the consultant was less than $10,000. The total expenditure incurred during 2024-25 in relation to this consultancy is $560 (excl. GST).

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

In 2024-25, there were two consultancies where the total fees payable to the consultants were $10,000 or greater. The total expenditure incurred during 2024-25 in relation to these consultancies is $22,375 (excl. GST).

Consultancies over $10,000						
Consultant	**Purpose of consultancy**	**Start date**	**End date**	**Total approved project fee** (excl. GST)	**Expenditure 2024-25** (excl. GST)	**Future expenditure** (excl. GST)
Insync Surveys	Board Effectiveness	August 2024	August 2024	$10,700	$10,700	$0
Insync Surveys	Board Effectiveness	March 2025	March 2025	$11,675	$11,675	$0

Government advertising campaign

The RCH did not undertake any government advertising campaigns for the 2024-25 period.

Information and communication technology (ICT) expenditure

The total ICT expenditure incurred during 2024-25 is $33.64 million (excluding GST).

Business as Usual (BAU) ICT expenditure	Non-Business as Usual (non-BAU) ICT expenditure		
Total (excl. GST)	**Total=Operational expenditure and Capital Expenditure** (excl. GST) (a) + (b)	**Operational expenditure** (excl. GST) (a)	**Capital expenditure** (excl. GST) (b)
$32.2 million	$1.44 million	$0.01 million	$1.43 million

Disclosure of review and study expenses

The RCH has no review or study expenses to report for the 2024-25 period.

Social procurement framework

The RCH is committed to social and sustainable outcomes for the community of Victoria. RCH has developed a Social Procurement Strategy in alignment with the Victorian Social Procurement Framework (SPF) to document the commitment, processes, mechanisms and communication approaches to ensure social value benefits and outcomes are a focus for procuring goods and/or services.

All procurement activities at the RCH apply the most appropriate SPF objective as relevant to the goods and/or services being procured at the time. The three prioritised SPF objectives for financial year 2024-25 (*Opportunities for Victorians with disability*; *Supporting safe and fair workplaces* and *Environmentally sustainable business practices)*, are those which the RCH can directly influence through strategic procurements.

Analysis of the RCH's spend profile and activities undertaken in 2024-25 has yielded the following results:

Reporting period: 2024–25	
All suppliers	
Number of suppliers engaged	1,437
Total expenditure (excluding GST)	$169,857,417.96
Social benefit suppliers	
Number of social benefit suppliers engaged	11
Total expenditure with social benefit suppliers (excluding GST)	$94,470.38
SPF Objective: Opportunities for Victorian Aboriginal people	
SPF Outcome: Purchasing from Victorian Aboriginal businesses	
Metric 1. Number of Victorian Aboriginal businesses engaged.	7
Metric 2. Total expenditure with Victorian Aboriginal businesses (excluding GST)	$90,250.30
SPF Objective: Opportunities for Victorians with disability	
SPF Outcome: Purchasing from Victorian Social Enterprises led by a mission for people with disability and Australian Disability Enterprises	
Metric 3. Number of Victorian social enterprises led by a mission for people with disability and Australian Disability Enterprises engaged	0
Metric 4. Total expenditure with Victorian social enterprises led by a mission for people with disability and Australian Disability Enterprises (excluding GST)	$0
SPF Objective: Opportunities for Victorian priority jobseekers	
Objective: Opportunities for disadvantaged Victorians	
SPF Outcome: Purchasing from Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers	

Metric 5. Number of Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers engaged	0
Metric 6. Total expenditure with Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers (excluding GST)	$0
SPF Objective: Sustainable Victorian social enterprises and Aboriginal businesses	
SPF Outcome: Purchasing from Victorian social enterprises and Aboriginal businesses	
Metric 7. Number of Victorian social enterprises engaged	4
Metric 8. Total expenditure with Victorian social enterprises (excl.GST)	$4,220.08
Metric 9. Number of Victorian Aboriginal businesses engaged	7
Metric 10. Total expenditure with Victorian Aboriginal businesses (excl. GST)	$90,250.30

Procurement complaints

In 2024-25 there were no procurement complaints made to the RCH.

Disclosures required under legislation

Freedom of Information Act 1982

The *Victorian Freedom of Information (FOI) Act 1982* provides a legally enforceable right of access to information held by government agencies.

FOI requests to the RCH should be made in writing. Detailed instructions on how to make an application can be found on the RCH website together with information regarding associated costs and timeframes.

For more information, the Freedom of Information staff at the RCH can be reached on (03) 9345 5132 / (03) 9345 9464. Alternatively, inquiries can be sent to foi@rch.org.au.

General information regarding the *Freedom of Information Act* can be found on the Victorian Government Website on www.ovic.vic.gov.au.

Nominated FOI Officers

Annabelle Mann, General Counsel
Liz Morgan, Senior Legal Counsel
Tanya Dargaville, Senior Legal Counsel
May Low, Senior Legal Counsel
Judith Smith, Freedom of Information Officer and Reviewer
Kylie Borlase, Freedom of Information Admin Officer
Ricky Huynh, FOI Reviewer
Angela Wood, FOI Reviewer

Requests received	2023-24	2024-25
Total requests	945	895
Access granted in full	449	434
No information available	58	38
Application withdrawn	67	78

Requests made came primarily from patients and their families (approximately 57.5%), legal representatives (35%) and the Transport Accident Commission (approximately 6%). The remaining 1.5% was for non-patient related information.

All FOI applications received by the RCH were processed in accordance with the provisions of the *Freedom of Information Act*. The RCH provides an annual report on FOI applications to the Office of the Victorian Information Commissioner.

Building Act 1993

As required under the Building Act 1993, all RCH infrastructure projects were delivered with the required building permits for new projects and Certificates of Occupancy or Certificates of Final Inspection, where applicable, for all completed projects.

All RCH capital works are compliant with requirements of regulatory bodies and codes, such as the Australasian Health Facility Design Guidelines; the Victorian Department of Health Fire Risk Management Guidelines; Disability Discrimination Act regulations; Cladding Safety Victoria, and Victorian Health Building Authority.

The current RCH building was delivered as a Public Private Partnership (PPP) project, in accordance with the State Government's Partnerships Victoria policy. Children's Health Partnership (CHP) is the state's private sector partner and is responsible for maintaining the hospital facility through Downer.

Downer provides a comprehensive maintenance and asset management program for the facility, incorporating maintenance of essential safety measures. All construction works/projects delivered under the PPP arrangements adhered to the requirements of relevant regulatory bodies and codes, ensuring compliance with building standards, safety regulations, and other applicable laws.

An annual report is issued by Downer to certify testing, and maintenance is compliant with the *Building Act 1993*. Fire Safety Systems, Emergency Warning and Intercommunication System (EWIS) audits.

Public Interest Disclosures Act 2012

The RCH supports the objectives of the *Public Interest Disclosures Act 2012* (Vic) and has policies and procedures in place to support disclosure of known or suspected incidences of improper conduct that involve the RCH or its employees by reporting such conduct to IBAC in accordance with Part 2 of the *Act.*

The RCH encourages individuals to make any disclosures, which are public interest disclosures within the meaning of the Act directly to IBAC in accordance with s51 of the *Independent Broad-Based Anti-Corruption Commission Act 2011*. The RCH is not aware of any disclosures reported to IBAC for the year ending 30 June 2025.

National Competition Policy

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

Carers Recognition Act 2012

The Carers Recognition Act 2012 promotes and values the role of people in care relationships. The RCH understands the different needs of people in care relationships and that care relationships bring benefits to patients, their carers and the community. The RCH takes all practicable measures to ensure that its employees, agents and carers have an awareness and understanding of the care principles. This is reflected in our commitment to a model of patient and family-centered care and to involving carers in the development and delivery of our services.

Environmental performance

At the RCH, sustainability is embedded into our vision of a world where all kids thrive. Guided by our Sustainability Plan 2023–25 we are working to reduce our environmental impact across key areas including energy, water, waste, procurement and clinical care. This section outlines our environmental performance and progress, reflecting our dedication to creating a healthier future for kids, families and our community.

In the 2024-25 financial year, the RCH has adopted the **Financial Reporting Direction 24 (FRD24)** guidelines for the first time. This marks a significant step forward in our environmental reporting practices and reflects our commitment to greater transparency and accountability in tracking our environmental performance.

As a result of this transition, the structure, scope and content of this section differ notably from previous annual reports. Key changes include:

- **Organisation-specific reporting:** Data now reflects the environmental performance of the RCH as a standalone entity, rather than being aggregated across the wider Melbourne Children's Campus.
- **Expanded reporting activities:** This year's report captures a broader range of emissions sources and environmental impacts, including medical gases, air travel, fleet vehicles, refrigerants, waste and recycling.
- **Contextual commentary:** For the first time, the report includes narrative analysis to explore key trends, changes, and considerations in our environmental performance.

This shift aligns our approach with best practice standards and sets a strong foundation for future improvements.

Reporting boundary for environmental data

The environmental data presented in this report pertains to the following RCH facilities:

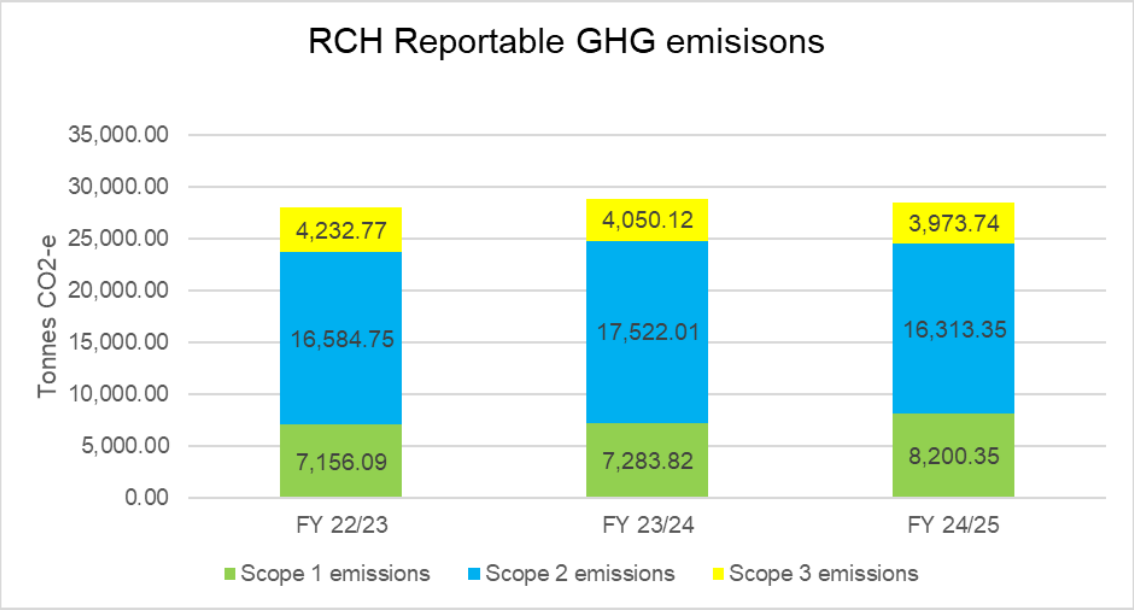
- RCH Parkville
- RCH Travancore
- RCH St Albans (Midwest Mental Health)
- RCH William Buckland House

In accordance with FRD 24 reporting requirements, the following entities are excluded from the reporting boundary: the University of Melbourne (UoM), Murdoch Children's Research Institute (MCRI), associated foundations, and retail operations.

Greenhouse Gas Emissions

The graph below shows the RCH's greenhouse gas (GHG) emissions from the past three consecutive financial years, from 1 July 2022 to 30 June 2025.

*note that this does not represent the full extent of RCHs scope 3 emissions, only those reportable under FRD24.



The RCH reports its greenhouse gas emissions in alignment with both national and international standards, categorised under Scope 1, Scope 2 and Scope 3 emissions.

- **Scope 1** emissions are direct emissions from sources that the RCH owns or controls, such as fuel combustion in vehicles or onsite machinery.
- **Scope 2** emissions are indirect emissions resulting from the RCH's consumption of purchased electricity.
- **Scope 3** emissions are other indirect emissions that occur outside of the RCH's direct control but arise from activities the hospital influences – such as air travel, waste disposal and supply chain operations. Due to the complexity and breadth of Scope 3 emissions, current reporting requirements do not mandate full disclosure of all Scope 3 categories. As such, only selected Scope 3 emissions that can be reliably measured are included in this year's report.

Scope 1

The RCH Scope 1 emissions increased 12.58% from FY 23/24 to FY 24/25. This increase is likely attributable to an increase in natural gas use, which increased by 34.4%, as a result of operating our trigeneration plant more than the previous financial year.

Greenhouse gas emissions (CO2-e(t))				
Scope 1 (direct) GHG emissions	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Carbon Dioxide	5,313.22	4,403.39	5845.36	32.75%
Methane	10.21	8.41	11.23	33.57%
Nitrous Oxide	3.45	2.97	3.88	30.57%
Stationary fuel	5,283.40	4,350.02	5,810.08	33.56%

Vehicle fleet	43.48	64.75	50.39	-22.19%
Isoflurane	8.20	9.54	4.44	-53.50%
Sevoflurane	92.72	84.97	115.89	36.40%
Nitrous oxide	901.48	1,120.95	1,205.06	7.50%
Refrigerant - R134A (HFC-134A)	826.80	1,653.60	973.08	-41.15%
Refrigerant - R32 (HFC-32)			1.23	
Refrigerant - R404A (HFC-404A)			40.19	
Total Scope 1 (direct) greenhouse gas emissions	**7,156.09**	**7,283.82**	**8,200.35**	**12.58%**

Scope 2 (indirect electricity) GHG emissions	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Electricity	16,584.75	17,522.01	16,313.46	-6.90%
Total Scope 2 (indirect electricity) GHG emissions	16,584.75	17,522.01	16,313.46	-6.90%

Scope 3 (other indirect) GHG emissions	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Commercial air travel	296.02	255.58	177.80	-30.43%
Waste emissions (WR5)	1,064.45	1,003.32	926.77	-7.63%
Indirect emissions from Stationary Energy	2,565.23	2,519.18	2,684.71	6.57%
Indirect emissions from Transport Energy	307.08	272.05	190.40	-30.01%
Water emissions	199.01	209.02	194.12	-7.13%
Any other Scope 3 emissions				
Total Scope 3 GHG emissions	**4,232.77**	**4,050.12**	**4173.81**	**-2.00%**
Total GHG Emissions	**27,973.60**	**28,855.95**	**28,463.36**	**-1.36%**
Total gross reported GHG emissions per bed-day	0.21	0.20	0.20	2.5%

Scope 2

The RCH's scope 2 emissions have decreased by 6.9% from FY23/24 to FY24/25. This reduction in electricity use is also a result of the increased use of the trigeneration plant which provided an alternate energy supply.

Scope 3

The RCH currently only reports limited scope 3 emissions. Between FY23/24 and FY24/25 we realised a 2.0% reduction in scope 3 emissions. This is likely a result of an increased focus on waste reduction and recycling, and a reduction in corporate air travel in preference to local and/or remote conference attendance.

Energy use

Energy use at the RCH is made up of electricity produces and consumed, fuel use and energy used for transportation (i.e. air travel and fleet vehicle use). The table below shows a summary of our energy use, with the following sections providing deeper insight.

Total energy use				
Total energy usage from fuels, including stationary fuels, and transport fuels	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Total energy usage from stationary fuels (F1) (MJ)	101,971,244.20	83,857,728.00	112,191,995.80	33.79%
Total energy usage from transport (T1) (MJ)	642,956.10	957,606.60	730,947.30	-23.67%
Total energy usage from fuels, including stationary fuels (F1) and transport fuels (T1) (MJ)	102,614,200.30	84,815,334.60	112,579,403.40	32.73%
Total energy usage from electricity (MJ)	86,913,051.95	95,860,229.65	88,766,233.34	-7.40%
Total energy usage segmented by renewable and non-renewable sources (MJ)	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Renewable	16,339,653.83	17,984,330.35	16,260,084.79	-9.59%
Non-renewable (E1 + E2 - E3 Renewable)	173,187,598.42	162,691,233.90	185,429,091.65	13.98%
Units of Stationary Energy used normalised: (F1+E2)/normaliser	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Energy per unit of LOS (MJ/LOS)	1,383.13	1,266.02	1,471.01	16.19%
Energy per unit of bed-day (LOS+Aged Care OBD) (MJ/OBD)	1,383.13	1,266.02	1,471.01	16.19%

Energy per unit of Separations (MJ/Separations)	3,758.89	3,384.84	3,740.85	10.52%
Energy per unit of floor space (MJ/m2)	1,623.78	1,535.32	1,716.77	11.82%

Electricity

Electricity is a key resource in the operation of the RCH, supporting a wide range of clinical, research, administrative and facility functions across our sites. As part of our ongoing commitment to environmental sustainability and energy efficiency, we closely monitor electricity consumption to identify opportunities for improvement and support the health and wellbeing of our community and environment.

Electricity Usage Overview

In the last financial year, total electricity consumption across all of the RCH reporting sites was 24,657MWh, representing a decrease of 7.4% compared to the previous financial year. This change is attributed to an increase in the use of our trigeneration plant compared to the previous financial year as it was down for significant periods of maintenance.

Transition to 100% Renewable Electricity

In alignment with the Victorian Government's energy policy and our organisational sustainability goals, the RCH will transition to a 100% renewable electricity supply from 1 July 2025. This significant milestone supports our goal of reducing greenhouse gas emissions and promoting a low-carbon future in the healthcare sector.

ELECTRICITY USE				
Total electricity consumption segmented by source (MWh)	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Purchased	24,142.51	26,627.84	24,657.29	-7.40%
Self-generated				
Total electricity consumption (MWh)	**24,142.51**	**26,627.84**	**24,657.29**	**-7.40%**
On-site installed generation capacity (kW converted to MW) segmented by:	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Cogeneration Plant	2.32	2.32	2.32	0.00%
Diesel Generator	6.75	6.75	6.75	0.00%
Total On-site installed generation capacity (MW)	**9.07**	**9.07**	**9.07**	**0.00%**

Total electricity offsets segmented by offset type (MWh)	2022-23	2023-24	2024-25	% change previous year
RPP (Renewable Power Percentage in the grid)	4,538.79	4,995.65	4,516.69	-9.59%
Total electricity offsets (MWh)	4,538.79	4,995.65	4,516.69	-9.59%

Stationary Fuel

Natural gas is used across several RCH facilities, primarily for powering our trigeneration system, boilers, steam generators and kitchens. Our Facilities Management Partner, Downer, are responsible for monitoring gas consumption and seeking opportunities to reduce reliance on fossil fuels where feasible.

Usage overview

During FY 24/25, the RCH recorded a total gas consumption of 100,427,229 MJ, reflecting an increase of 34.2% compared to the previous financial year. This change is due to an increase in hours that the trigeneration system was operating compared to the previous financial year where it underwent significant downtime due to maintenance. Diesel consumption remained stable as it is the hospitals back-up system and was not required, consumption was due to routine generator testing.

Stationary energy				
F1 Total fuels used in buildings and machinery segmented by fuel type (MJ)	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Natural gas	100,427,228.70	82,313,720.40	110,647,980.30	34.42%
Diesel	1,544,015.50	1,544,007.60	1,544,015.50	0%
F1 Total fuels used in buildings (MJ)	101,971,244.20	83,857,728.00	112,191,995.80	33.79%
F2 GHG emissions from stationary fuel consumption segmented by fuel type (CO2-e(t))	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Natural gas	5,175.02	4,241.63	5,701.69	34.42%
Diesel	108.39	108.39	108.39	0%
F2 GHG emissions from stationary fuel consumption	5,283.40	4,350.02	5,810.08	33.56%

Transportation energy

Emissions associated with business related travel include the use of fleet vehicles and corporate air travel to conferences and continuous education opportunities.

Fleet

The RCH fleet vehicles are leased by VicFleet and usage data is provided by StreetFleet. In December 2023, StreetFleet acquired Alliance Fleet Data, the previous manager of the RCH fleet vehicles. Following this transition, StreetFleet undertook the task of integrating two separate reporting systems to compile the data required under FRD24. While every effort was made to ensure data accuracy, some historical data was unavailable, and the system merge introduced a degree of uncertainty in the final figures reported. As such, we cannot accurately verify that data reported in FY 22/23 and FY 23/24 is accurate. Looking ahead, StreetFleet will serve as the sole agency responsible for managing and reporting RCH's fleet data. This consolidation is expected to enhance the accuracy and reliability of fleet emissions data in future reporting periods.

The RCH leased fleet currently comprises of 46 vehicles, of which 41 are hybrid and five are petrol. We also own and operate four diesel vans to support the work of our PIPER service. We are required to begin transitioning our fleet to Zero Emission Vehicles in line with the State Net Zero roadmap, and this work will commence in FY 25/26.

Flights

At the RCH, staff air travel can be arranged either through our corporate travel partner, FCM, or by individual staff members who then seek reimbursement. Currently, we are only able to capture and report environmental data for flights booked through FCM. This data has been included in the current year's reporting.

Transportation energy				
T1 Total energy used in transportation (vehicle fleet) within the Entity, segmented by fuel type (MJ)	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Non-executive fleet - Gasoline	642,956.10	957,606.60	387,407.60	-59.54%
Petrol	642,956.10	957,606.60	387,407.60	-59.54%
Non-executive fleet - Diesel			343,539.70	
Diesel			343,539.70	
Total energy used in transportation (vehicle fleet) (MJ)	**642,956.10**	**957,606.60**	**730,947.30**	**-23.67%**
T2 Number and proportion of vehicles in the organisational boundary segmented by engine/fuel type and vehicle category	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Internal combustion engine				

Petrol	**6**	**6**	**6**	
Diesel	**4**	**4**	**4**	
Hybrid	**43**	**43**	**43**	
T3 Greenhouse gas emissions from transportation (vehicle fleet) segmented by fuel type (CO2-e(t))	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Non-executive fleet - Gasoline	43.48	64.75	26.20	-59.54%
Petrol	43.48	64.75	26.20	-59.54%
Non-executive fleet - Diesel			24.19	
Diesel			24.19	
Total Greenhouse gas emissions from transportation (vehicle fleet) (CO2-e(t))	**43.48**	**64.75**	**50.39**	**-22.19%**
T4 Total distance travelled by commercial air travel (passenger km travelled for business purposes by entity staff on commercial or charter aircraft)	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Total distance travelled by commercial air travel	1,540,047.00	1,606,171.00	1,026,385.00	-36.10%
T(opt1) Total vehicle travel associated with entity operations (1,000 km)	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Total vehicle travel associated with entity operations (1,000 km)	602.09	606.78	572.01	-5.89%
T(opt2) Greenhouse gas emissions from vehicle fleet (CO2-e(t) per 1,000 km)	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
CO2-e(t) per 1,000 km	0.07	0.11	0.09	-20%

Waste and recycling

The total waste generated by the RCH decreased by 9.2% in FY 24/25 compared to the previous year. During this time, we saw a reduction in waste sent to landfill and clinical waste streams, likely a result of further education around correct waste disposal, and increased emphasis on reusable products over disposable. We also introduced a number of new recycling streams which has resulted in increased awareness of and engagement in correct waste management processes.

Waste and recycling				
Total waste disposed by waste stream and disposal method (kg)	**2022-23**	**2023-24**	**2024-25**	**% change previous year**

Landfill (total)				
General waste – compactors	565,544.00	556,902.00	542,790.40	-2.53%
General waste – skips	47,310.00	46,505.00	22,391.00	-51.85%[i]
Offsite treatment				
Clinical waste – incinerated	32,198.00	28,491.00	26,242.50	-7.89%
Clinical waste – sharps	10,532.18	10,730.47	TBC	TBC
Clinical waste – treated	173,642.00	138,372.00	129,972.00	-6.07%
Recycling/recovery (disposal)				
Batteries			1,232.00	
Cardboard	75,312.00	81,888.00	54,288.00	-33.70%[ii]
Commingled	23,683.00	46,116.00	36,288.90	-21.31%
Fluorescent tubes	337.00			
Grease traps	53,000.00	80,000.00	62,510.00	-21.86%
Organics (food)			7,028.00	
Other recycling		43.88	54.56	24.34%
Paper (confidential)	13,344.00	12,300.00	18,912.00	53.76%
PVC	1,269.00	427.00	1,848.00	332.79%
Sterilisation wraps	466.00	602.00	6,638.00	1002.66%[iii]
Total units of waste disposed (kg)	996,637.18	1,002,377.36	910,195.37	-9.20%
Percentage waste disposed of by waste stream and disposal method (%)	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Landfill (total)				
General waste	61.49%	60.20%	62.09%	3.15%
Offsite treatment				
Clinical waste – incinerated	3.23%	2.84%	2.88%	1.44%
Clinical waste – sharps	1.06%	1.07%		
Clinical waste – treated	17.42%	13.80%	14.28%	3.44%
Recycling/recovery (disposal)				
Batteries			0.14%	

Cardboard	7.56%	8.17%	5.96%	-26.99%
Commingled	2.38%	4.60%	3.99%	-13.34%
Fluorescent tubes	0.03%			
Grease traps	5.32%	7.98%	6.87%	-13.95%
Organics (food)			0.77%[iv]	
Other recycling		0.00%	0.01%	36.93%
Paper (confidential)	1.34%	1.23%	2.08%	69.33%
PVC	0.13%	0.04%	0.20%	376.62%
Sterilisation wraps	0.05%	0.06%	0.73%	1114.33%
Total units of waste disposed normalised	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Total waste to landfill per patient treated ((kg general waste)/PPT)	2.22	2.22	2.09	-6.09%
Total waste to offsite treatment per patient treated ((kg offsite treatment)/PPT)	0.78	0.65	0.58	-11.81%
Total waste recycled and reused per patient treated ((kg recycled and reused)/PPT)	0.61	0.82	0.70	-14.50%
Recycling rate (%)	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
Weight of recyclable and organic materials (kg)	167,411.00	221,376.88	188,799.46	-14.72%
Weight of total waste (kg)	996,637.18	1,002,377.36	910,195.37	-9.20%
Recycling rate (%)	16.80%	22.09%	20.74%	-6.08%
GHG emissions associated with waste disposal (CO2-e(t))	**2022-23**	**2023-24**	**2024-25**	**% change previous year**
CO2-e(t)	1,064.45	1,003.32	926.77	-7.63%

[i]The RCH and MCRI share access to the general waste skip bin. Historically we have not reflected this shared use in our annual reporting and therefore the figures for the previous two financial years are included. Going forward only the RCH use of this skip bin will be reported.
[ii] Our general waste compactor has encountered a number of breakdowns which has unfortunately necessitated us disposing of general waste in the cardboard compactor. This has meant that the cardboard has been contaminated and sent to general waste, resulting in a reduction of our cardboard recycling rate.
[iii] We introduced a recyclable cocoon blanket in theatre and recovery which can be recycled via the sterilisation wrap waste stream. This initiative has likely increased the volume of this waste stream recycled.

[iv] In April 2025 we partnered with a local social enterprise called Bardee to recycle food waste from our kitchens. Food returned from the patient rooms is collected and converted into animal feed and soil conditioner, keeping food waste out of landfill and giving it a second life.

Additional information available on request

In compliance with the requirements of the Standing Directions 2018 under the Financial Management Act 1994, details in respect of the items listed below have been retained by the health service and are available on request to the relevant Ministers, Members of Parliament and the public, subject to the provisions of the Freedom of Information Act 1982.

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

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

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

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

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

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

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

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

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

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

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

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

(l) details of all consultancies and contractors including:

(i) consultants/contractors engaged

(ii) services provided

(iii) expenditure committed to for each engagement.

Contact rch.communications@rch.org.au to request further information.

Local Jobs First Act 2003

The RCH complies with the intent of the *Local Jobs First Act 2003 (Vic)*, promoted through the Local Jobs First Policy (LJFP). The Local Jobs First Policy encompasses both Victorian Industry Participation Policy and Major Projects Skills Guarantee. Part of this policy requires, wherever possible, local industry development through the improvement of opportunities for local suppliers while taking into consideration the principle of value for money and transparency in procurement processes.

During 2024-25, the RCH undertook one project which required disclosure under the *Local Jobs First Act 2003 (Vic)*.

Gender Equality Act 2020

The RCH continues its commitment to fostering a supportive, expansive, and accepting workplace environment where staff feel that they can bring their whole self to work. This is underpinned by our vision to build a world where *all* kids thrive; and our values of being kind, courageous, curious and inclusive.

Committed to meeting our obligations under the Gender Equality Act, the RCH continues to implement initiatives defined in its Gender Equality Action Plan 2022-2025 (GEAP). Of the 16 actions, ten have been completed and embedded as ongoing practices, four are in progress, and the two remaining actions related to workforce data integrity will be implemented over longer timeframes as they are larger, complex, systems-driven items embedded in enterprise wide projects.

One of the ways we focus on enabling gender equity is by building a safe, responsive and empowering environment for patients, families and staff members alike. We are proud to have an even gender balance on our Executive team with six men and five women (and one vacancy at the time of writing); and similarly, our Board is well balanced with four women (including our Chair) and five men.

The importance of applying a lens of intersectionality reflects our commitment to every child and young person needing our services. We appreciate that anyone who accesses our services should be able to do so freely and safely, regardless of gender, cultural background, sexuality, or any other minoritised characteristic. As our services evolve and develop, we want to take that opportunity to ensure that safety. Over the past year, the Organisational Development team has developed an Equity Impact Assessment (EIA) tool. This tool is currently being piloted as part of the redevelopment of RCH's Emergency Services and will help to ensure more positive outcomes and experiences for all RCH consumers.

Intersectionality is also the cornerstone of planned co-design of a new Diversity, Equity, Inclusion and Belonging (DEIB) Strategic Plan. Once developed, it will integrate our continuing and developing work across gender, disability, reconciliation and LGBTQIA+. A highly valued aspect of the culture at the RCH is our continued recognition of communities and identities through our celebrations of International Women's Day, Aboriginal days of cultural significance such as Sorry Day and NAIDOC week, and pride events such as Midsumma, IDAHOBIT Day and Wear it Purple.

The LGBTQIA+ Campus Collective, a partnership between the RCH, Murdoch Children's Research Institute, the University of Melbourne, and the RCH Foundation, continued its work on developing a shared LGBTQIA+ Strategy. In September 2024, the Melbourne Children's LGBTQIA+ Coordinator, one of the Campus's first inter-organisational roles, commenced. Their focus included updating inclusive systems, processes and policies, embedding LGBTIQA+

safety in the patient EMR, and developing inclusive signage, messaging and resources for patients and families.

Looking to the future, the RCH is currently planning the delivery of three key compliance documents required by the Act. These are: the Gender Equality Workplace Audit (due December 2025); the Progress Report against our current GEAP; and the creation and submission of a new Gender Equality Action Plan for 2026-2028 (both due May 2026). The work is ongoing and is well supported by the Board and Executive, senior leaders and staff from across the organisation. It is enabled by committed teams such as Organisational Development, Human Resources, Decision Support, Finance and Payroll, among others. Importantly, we seek and value the voices of community members, as their lived experience guides and inspires our work.

Safe Patient Care Act 2015

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

Car parking fees

The RCH is committed to reducing the burden of car parking fees for vulnerable patients who frequently attend health services. The RCH works with stakeholders to make sure that users can access car parks as safely, conveniently and economically as possible.

The RCH complies with the Department of Health hospital circular on car parking fees. Details of car parking fees and concession benefits can be viewed on the RCH website: Car_parking_official_visitors_and_off_site_staff

Attestations and Declarations

Financial Management Compliance Attestation Statement

I Christine Kilpatrick, on behalf of the Responsible Body, certify that The Royal Children's Hospital has no Material Compliance Deficiency with respect to the applicable Standing Directions under the *Financial Management Act 1994* and Instructions.

Professor Christine Kilpatrick AO

Board Chair
The Royal Children's Hospital
Melbourne

25 September 2025

Data Integrity Declaration

I, Peter Steer, certify that The Royal Children's Hospital has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. The Royal Children's Hospital has critically reviewed these controls and processes during the year.

Dr Peter Steer

Chief Executive Officer
The Royal Children's Hospital
Melbourne

25 September 2025

Conflict of Interest Declaration

I, Peter Steer, certify that The Royal Children's Hospital has put in place appropriate internal controls and processes to ensure that it has implemented a 'Conflict of Interest' policy consistent with the minimum accountabilities required by the VPSC. Declaration of private interest forms have been completed by all executive staff within The Royal Children's Hospital and members of the board, and all declared conflicts have been addressed and are being managed. Conflict of interest is a standard agenda item for declaration and documenting at each executive board meeting.

Dr Peter Steer

Chief Executive Officer
The Royal Children's Hospital
Melbourne

25 September 2025

Integrity, Fraud and Corruption Declaration

I, Peter Steer, certify that The Royal Children's Hospital has put in place appropriate internal controls and processes to ensure that integrity, fraud and corruption risks have been reviewed and addressed at The Royal Children's Hospital during the year.

Dr Peter Steer

Chief Executive Officer
The Royal Children's Hospital
Melbourne

25 September 2025

Compliance with Health Share Victoria (HSV) Purchasing Policies

I, Peter Steer, certify that The Royal Children's Hospital has put in place appropriate internal controls and processes to ensure that it has materially complied with all requirements set out in the HSV Purchasing Policies including mandatory HSV collective agreements as required by the *Health Services Act 1988 (Vic)* and has critically reviewed these controls and processes during the year.

Dr Peter Steer

Chief Executive Officer
The Royal Children's Hospital
Melbourne

25 September 2025

Disclosure index

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

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Reporting of outcome from Statement of Priorities (SOP) 2024-25

Reporting against the Statement of Priorities – Part A

Focus Priorities	2024-25 Deliverables	2024-25 Updates
Excellence in clinical governance We aim for the best patient experience and care outcomes by assuring safe practice, leadership of safety, an engaged and capable workforce, and continuing to improve and innovate care.		
MA2 Strengthen all clinical governance systems, as per the Victorian Clinical Governance Framework, to ensure safe, high-quality care, with a focus on building and maintaining a strong safety culture, identifying, reporting, and learning from adverse events, and early, accurate recognition and management of clinical risk to and deterioration of all patients.	• MA2 Improved paediatric patient outcomes by implementing the Victorian Children's Tools for Observation and Response (ViCTOR) track and trigger observation chart and escalation system whenever children have observations taken.	• The RCH has achieved this target and continues to support the Victorian Paediatric Clinical Network (VPCN) as required.
MA3 Work with Safer Care Victoria (SCV) to reduce hospital acquired complications, including minimising COVID-19 transmission into and within the	• MA3 Work with SCV to submit an annual quality account report to provide transparency of the health services safety	• SCV confirmed they do not require the RCH to deliver a quality account. The RCH will work with the Department of Health (DH) to have this requirement removed from our SOP.

Focus Priorities	2024-25 Deliverables	2024-25 Updates
health service, including to staff and patients.	performance and improvement strategies. • MA3 RCH to work with SCV, Monash Health and the Victorian Paediatric Clinical Network to determine meaningful paediatric HAC indicators. This work is currently contingent of access to data held by the VAHI.	• The RCH has provided written advice to SCV and DH, recommending exemption for six HAC categories that are not relevant for paediatric patients. • The RCH is currently engaged with SCV, Monash Health and the VPCN, in addition to interstate paediatric partners to develop and propose a paediatric sensitive suite of HAC's to the Commission. The goal of this work is the creation of a National Paediatric HAC suite. This work is currently contingent on access to data held by VAHI.
MA7 Improve mental health and wellbeing outcomes by implementing Victoria's new and expanded Mental Health and Wellbeing system architecture and services.	• MA7 Engage in one or more mental health improvement programs of Safer Care Victoria – elimination of restrictive intervention, improving sexual safety, implementation of the zero-suicide framework and reducing compulsory treatment.	Zero Suicide Framework: • The service has an active implementation plan to build a tool within our EMR for clinicians to write risk formulations and Safety Plans. • A mandatory training package is currently being built for all Mental Health staff and will be available in our online learning platform. • Both action items are envisaged to be completed by November 2025. Intensive Care Area (ICA) refurbishments: • The newly refurbished space is complete and has been well received by both staff and patients. Elimination of Restrictive Interventions: • The period April to June 2025 (Q4) relates to the period between non-ICA availability and when the refurbished space became available. Thus, while restrictive interventions have seemingly increased compared to previous periods, they must be read in this context. In Q4 there were: 20 Physical restraints; one Mechanical restraint; six Seclusion episodes; and nine Chemical restraints. Most of these are attributable to three patients. Eating Disorders Model of Care: • A workshop was held in early July with attendance from HACSU, the Australian Nursing and Midwifery Federation, the Banksia User Group, and the RCH/Downer Project Team to finalise the design for the new construction. The formal Change Impact Statement (CIS) relating to the construction work has been drafted

Focus Priorities	2024-25 Deliverables	2024-25 Updates
		• Updated quotes for the construction work have been requested and will be shared with the RCH Foundation.
MA9 Maintain commitment to driving planned surgery reform in alignment with the Surgery Recovery and Reform Program, as well as identify and implement local report priorities.	• MA9 Implement and scale high throughout approaches to planned surgery in line with SCV's targeted high throughput approaches to theatre list management recommendations. • MA9 Proactively manage preparation lists including validation and support of patients into optimal care pathways.	• The Division of Surgery implemented a High Throughput List initiative, optimising the use of in-hours theatre sessions, which has contributed to closing the gap in admission targets. • The Division of Surgery met its planned admission targets for six consecutive months across Q3 and Q4. This sustained performance further reduced the activity shortfall; however, the program concluded the year 103 cases short of the annual target of 7,900 admissions. Contributing factors included the temporary closure of two theatres for eight weeks during the construction of the Rapid Access Hub. • Continued funding for the Patient Support Unit has enabled the RCH to build upon prior initiatives aimed at evaluating and enhancing the health service system and the planned surgery waitlist. This funding supports the Elective Surgery Access Unit's model of care, including a dedicated team of nurses and administrative officers who screen, refer and optimise patients for surgery. The Planned Surgery Access Policy 2025 remains a guiding framework for equitable care delivery, list standardisation, active waitlist management, and improved regional coordination. • The transition of adult patients from the RCH planned surgery waitlist to appropriate adult health services has commenced, ensuring age-appropriate and timely care. • As part of the routine waitlist validation audit, 794 patients were removed from the planned surgery waitlist from January 2025. Audit outcomes are reported quarterly to DH. • The RCH provides quarterly reports to DH on extremely long waiting patients. In Q3 and Q4, 17 children were treated or appropriately removed from this category. As of the April 2023 DH report, a total of 489 children have been treated or removed from the list. Two children remain, with surgery scheduled early in Q1 of the 2025-26 financial year.

Working to achieve long term financial sustainability – operating within budget		
MB1 Develop and implement a health service Budget Action Plan (BAP) in partnership with the Department to manage cost growth effectively to ensure the efficient operation of the health service.	• MB1 Deliver key initiatives as outlined in the Budget Action Plan. • MB1 Utilise data analytics and performance metrices to identify areas of inefficiency and waste and make evidence-based decisions to improve financial sustainability and operational performance.	• The RCH continues delivering on key initiatives as outlined in the BAP as well as identifying additional savings ideas to offset any delayed realisation of benefits. • Q4 resulted in the RCH contributing a further $3.5M BAP and $3.4M FMIP savings. From a full year perspective, the RCH has achieved 76% of the yearly target. • The recurring nature of key initiatives as well as new commitments identified enable RCH to achieve a pathway towards financial sustainability (break even SOP) for FY26.
Improving equitable access to healthcare and wellbeing Ensure that Aboriginal people have access to a health, wellbeing and care system that is holistic, culturally safe, accessible and empowering. Ensure that communities in rural and regional areas have equitable health outcomes irrespective of locality.		

MC2, MC3 Enhance the provision of appropriate and culturally safe services, programs and clinical trials for and as determined by Aboriginal people, embedding the principles of self-determination.	• MC3 Partner with Aboriginal community-controlled health organisations, respected Aboriginal leaders and Elders, and Aboriginal communities to deliver healthcare improvements.
	• MC3 Promote a culturally safe welcoming environment with Aboriginal cultural symbols and spaces demonstrating, recognising, celebrating, and respecting Aboriginal communities and culture.
		• The RCH Wadja Aboriginal Family Place continues to play a critical role in the provision of culturally safe services and programs for Aboriginal and Torres Strait Islander children, young people, and families accessing care at the RCH including:
		  • Clinical Care: Provides culturally safe paediatric services for Aboriginal and Torres Strait Islander children with complex health and social needs, many affected by trauma and intergenerational challenges.
		  • Partnerships: Collaborates with Aboriginal organisations across health, education, welfare, and legal sectors. Strengthens ties with VACCA through secondment of the Wadja Fellow, expanding clinical support and cultural learning.
		  • Cultural Engagement: Hosted Sorry Day and NAIDOC Week events, including Smoking Ceremonies, performances, and the Wadja Walkthrough video to support families navigating hospital care.
		  • Mental Health Integration: Established new collaboration with the RCH Mental Health service and secured a 0.4 FTE Clinical Psychologist to provide therapeutic support.

		• Strategic Alignment: Supports the RCH's priorities by delivering innovative care, advocating for equity, and promoting cultural knowledge through education and research. • From April 2024 to March 2025, the Wadja Health Clinic achieved an 84% outpatient attendance rate, with 501 of 596 appointments attended. Aboriginal outpatient attendance remained consistent at 82%, with 8,271 appointments booked and 6,781 attended. • The team delivered 5,804 occasions of service to Aboriginal patients and families, addressing complex behavioural, mental health and developmental needs. • Wadja contributed significantly to knowledge, creation and dissemination within the RCH and the broader medical community by developing a Clinical Practice Guidelines to support culturally informed care and contributed to a trauma-informed care eLearning package. • Wadja presented at the RCH Grand Round on Aboriginal child health and Out-of-Home Care (OOHC), highlighting health needs, systemic challenges and the link between OOHC and youth justice involvement. This presentation encouraged reflection on how clinical care can positively influence outcomes for vulnerable children.
MC4 Expand the delivery of high-quality cultural safety training for all staff to align with the Aboriginal and Torres Strait Islander cultural safety framework. This training should be delivered by independent, expert, community-controlled organisations or a Kinaway or Supply Nation certified Aboriginal business.	• MC4 Implement mandatory cultural safety training and assessment for all staff in alignment with the Aboriginal and Torres Strait Islander cultural safety framework, and developed and/or delivered by independent, expert, and community-controlled organisations, Kinaway or Supply Nation certified Aboriginal businesses.	• Wadja Aboriginal Family Place delivers a culturally sensitive service at the RCH for Aboriginal and Torres Strait Islander children, young people and their families. The service ensures equitable access to healthcare services and seeks to increase the cultural awareness and sensitivity of care delivered by RCH staff. • The Cultural awareness program currently in place at the RCH includes: • Mandatory online training for all new starters – 100% compliance since commencement. The online training package was developed in consultation with over 100 Aboriginal health liaison officers from health services across Victoria plus two Aboriginal people on the RCH project team. Narration and animation included in the online training package is by First Nations people. • Face to face Aboriginal awareness workshop run by independent Aboriginal Elder.

A stronger workforce There is increased supply of critical roles, which supports safe, high-quality care. Victoria is a world leader in employee experience, with a focus on future roles, capabilities and professional development. The workforce is regenerative and sustainable, bringing a diversity of skills and experience that reflect the people and communities it serves. As a result of a stronger workforce, Victorians receive the right care at the right time closer to home.		
MD1 Improve employee experience across four initial focus areas to assure safe, high-quality care: leadership, health and safety, flexibility and career development and agility.	• MD1 Implement and/or evaluate new/expanded programs that uplift workforce flexibility such as a flexibility policy for work arrangements. • MD1 Implement and/or evaluate new/expanded wellbeing and safety program and its improvement on workforce wellbeing.	• Flexible work arrangements policy updated and active formal and informal work flexibility arrangements in place and working well. This is reflected by a strong People Matter Survey result for 2024 of 73.1%, which is favourable against the comparator group by 3% (CG 70.2%). • Wellbeing initiatives have been refreshed and a new wellbeing strategy is currently in development. Evaluation is underway for the previous suite of strategic initiatives. Initial results from the People Matter Survey 2024 indicate: 1) a reduction in stress of 1% from prior year 2) staff experiencing at least one symptom of burnout has also reduced by 2% (from 34% to 32%) 3) Happiness scores have improved from 65.3% to 65.6%, this is significantly above the average score of the comparator group of 57.6% 4) Enthusiasm scores have increased from 55.9 to 56.6% and are also significantly higher than our comparator group (50.0%) 5) Our Safety Climate score (59.6%) is 2.4% above the comparator group at 57.2%.
MD2 Explore new and contemporary models of care and practice, including future roles and capabilities.	• MD2 Continuing to support the implementation of medium and long-term priorities of the Mental Health Workforce Strategy.	• The RCH community based Mental Health teams to complete development of new and contemporary models of care for the ICY AMHWS for 0–4-year-olds and 5–11-year-olds and implement service-wide training and professional development to improve capability and capacity for the Infant, Child and Family service stream (0-11 years). • First draft of community services models of care completed and expected to be operational by November 2025 following completion of consultation process.

Moving from competition to collaboration Share knowledge, information and resources with partner health and wellbeing services and care providers. This will allow patients to experience one health, wellbeing and care system through connected digital health information, evidence and data flows, enabled by advanced interoperable platforms.		
ME2 Engage in integrated planning and service design approaches, whilst assuring consistent and strong clinical governance, with partners to join up the system to deliver seamless and sustainable care pathways and build sector collaboration.	• ME2 RCH together with the Victorian Paediatric Clinical Network will develop a statewide paediatric plan. • ME2 Partner with mental health and wellbeing services in the local region to implement mental health reform.	• Work continues with DH, Monash Children's Hospital and the VPCN to explore opportunities to implement the statewide paediatric services plan. • Orygen Specialist Program transitioned to the newly established Parkville Youth Mental Health and Wellbeing Service (PYMHWS) on 1 July 2025. The draft interservice level agreement will continue to progress between the RCH Mental Health service and the new leadership team of PYMHWS. • Monthly Senior Leadership meetings are now established with the terms of reference agreed to by the clinical leadership of both organisations.

Reporting against the Statement of Priorities – Part B Performance Priorities

High quality and safe care

Key Performance Measure	Target	Result
Infection prevention and control		
Percentage of healthcare workers immunised for influenza	94%	97%
Adverse events		
Percentage of reported sentinel events for which a root cause analysis (RCA) report was submitted within 30 business days from notification of the event	100%	100%
Patient experience		
Percentage of patients who reported positive experiences of their hospital stay	95%	97%
Aboriginal Health		
The gap between the number of Aboriginal patients who discharged against medical advice compared to non-Aboriginal patients	0%	0%
The gap between the number of Aboriginal patients who 'did not wait' presenting to hospital emergency departments non-Aboriginal patients	0%	0%
Mental Health		
Mental Health Patient Experience		
Percentage of consumers/families/carers reporting a 'very good' or 'excellent' overall experience of the service	80%	NA – Statewide Survey did not take place in 2024-25
Percentage of families/carers who report they 'always' or 'usually' felt their opinions as a carer were respected	90%	NA – Statewide Survey did not take place in 2024-25
Percentage of mental health consumers reporting they 'usually' or 'always' felt safe using this service	90%	NA – Statewide Survey did not take place in 2024-25
Mental Health follow-ups, readmissions, and seclusions		
Percentage of consumers followed up within 7 days of separation – Inpatient	88%	77%
Percentage of consumers re-admitted within 28 days of separation - inpatient.	<14%	25%
Rate of seclusion episodes per 1,000 occupied bed days - inpatient	≤ 6	6

Strong governance, leadership and culture

Key Performance Measure	Target	Result
Organisational culture		
People matter survey – Percentage of staff with an overall positive response to safety culture survey questions	80%	78%

Timely access to care

Key Performance Measure	Target	Result
Planned Surgery		
Percentage of urgency category 1 planned surgery patients admitted within 30 days	100%	100%
Percentage of all planned surgery patients admitted within the clinically recommended time	94%	65.2%
Number of patients admitted from the planned surgery waiting list	7,900	7,792
Percentage of patients on the waiting list who have waited longer than the clinically recommended time for their respective triage category	29.1%	38.8%
Optimisation of surgical inpatient length of stay (LOS), including through the use of virtual and home-based pre- and post-operative models of care	1.62%	1.67%
Emergency Care		
Percentage of patients transferred from ambulance to emergency department within 40 minutes	80%	100%
Number of emergency patients with a length of stay in the ED greater than 24 hours	Zero	13
Mean ED length of stay (admitted) in minutes	306	263
Mean ED length of stay (non-admitted) in minutes	240	167
Inpatient length of stay in minutes	2276	2276
Mental Health		
Percentage of mental health-related emergency department presentations with a length of stay of less than 4 hours	65%	58%
Percentage of departures from emergency departments to a mental health bed within 8 hours	80%	80%
Number of admitted mental health occupied bed days	4,672	3,203
Specialist Clinics		
Percentage of patients referred by a GP or external specialist who attended a first appointment within the recommended timeframe	95%	78%
Home based care		

Key Performance Measure	Target	Result
Percentage of admitted bed days delivered at home	12.1%	10.1%

Effective financial management

Key Performance Measure	Target	Result
Operating result ($m)	0.00	-19.4
Adjusted current asset ratio	0.7	0.35
Variance between forecast and actual Net result from transactions (NRFT) for the current financial year ending 30 June.	5% movement in forecast revenue and expenditure forecasts	Not achieved

Reporting against the Statement of Priorities – Part C

Funding Type	2024-25 Activity Achievement
Consolidated activity funding	
Acute admitted, subacute admitted, emergency services, non-admitted NWAU	95,936
Acute admitted mental health NWAU	1,695
Acute Admitted	
Acute admitted TAC	550
Acute Non-Admitted	
Mental Health and drug services	
Mental Health ambulatory	41,201
Community health/ primary care programs	2,546
NFC – Paediatric heart no VAD	2
NFC – Paediatric heart VAD	5
NFC – Paediatric heart lung transplantation	
NFC – transplants – paediatric liver	9

Financial statements

Board Member's, Accountable Officer's and Chief Finance and Accounting Officer's declaration

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

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2025 and the financial position of The Royal Children's Hospital at 30 June 2025.

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.

Professor Christine Kilpatrick
Chair
The Royal Children's Hospital
Melbourne
25 August 2025

Dr Peter Steer
Chief Executive Officer
The Royal Children's Hospital
Melbourne
25 August 2025

Frank Vosnidis
Acting Chief Financial Officer
The Royal Children's Hospital
Melbourne
25 August 2025

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of the Royal Children's Hospital

Opinion	I have audited the financial report of the Royal Children's Hospital (the health service) which comprises the: • balance sheet as at 30 June 2025 • comprehensive operating statement for the year then ended • statement of changes in equity for the year then ended • cash flow statement for the year then ended • notes to the financial statements, including material accounting policy information • board member's, accountable officer's and chief finance and accounting officer's declaration. In my opinion, the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2025 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.
Basis for Opinion	I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. I further describe my responsibilities under that Act and those standards in the Auditor's Responsibilities for the Audit of the Financial Report section of my report. My independence is established by the *Constitution Act 1975*. My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants (including Independence Standards)* (the Code) that are relevant to my audit of the financial report in Victoria. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.
Key audit matters	Key audit matters are those matters that, in my professional judgement, were of most significance in my audit of the financial report of the current period. The following matter was addressed in the context of my audit of the financial report as a whole, and in forming my opinion thereon, and I do not provide a separate opinion on this matter.

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T 03 8601 7000 enquiries@audit.vic.gov.au www.audit.vic.gov.au

Key audit matter	How I addressed the matter
Control over The Royal Children's Hospital Foundation Limited *Refer to Note 1.2 Principles of consolidation*	

In Note 1.2 the Royal Children's Hospital (RCH) disclosed that it no longer controls the Royal Children's Hospital Foundation Limited (the Foundation)
 	
During 2024–25, RCH and the Foundation amended the trust deed and signed a new relationship agreement. These changes clarified that the two entities now collaborate to achieve a shared vision rather than RCH having control over the Foundation.
 	
After reviewing these amendments RCH made a significant management judgement that it no longer had control over the Foundation. As a result, RCH deconsolidated the Foundation's assets, liabilities and results of operations on 22 August 2024.
 	
I considered the RCH's control assessment to be a key audit matter because:
• the Foundation manages financially significant funds and investments
• evaluating control is complex and applying AASB 10 *Consolidated Financial Statements* (AASB 10) required significant management judgement. Determining control involved assessing whether RCH had:
  ○ power over the Foundation
  ○ exposure or rights to variable returns from its involvement
  ○ the ability to use that power to affect returns.
• the audit team spent considerable time, including consulting technical experts, to evaluate management's judgement on this matter.
	My key procedures included:
	• reviewing all relevant documentation that define and support the relationship between RCH and the Foundation
	• engaging with management of RCH and the Foundation to understand how the two entities operate and collaborate
	• reviewing technical accounting papers prepared by the management of RCH that support their judgement and conclusions
	• assessing whether management's accounting treatment aligned with AASB 10 and evaluating the reasonableness of management's judgements in applying the standard
	• assessing the adequacy of financial report disclosures against the requirements of applicable Australian Accounting Standards.

Other information	The Board of the health service is responsible for the other information, which comprises the information in the health service's annual report for the year ended 30 June 2025, but does not include the financial report and my auditor's report thereon. My opinion on the financial report does not cover the other information and accordingly, I do not express any form of assurance conclusion on the other information. However, in connection with my audit of the financial report, my responsibility is to read the other information and in doing so, consider whether it is materially inconsistent with the financial report or the knowledge I obtained during the audit, or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude there is a material misstatement of the other information, I am required to report that fact. I have nothing to report in this regard.
The Board's responsibilities for the financial report	The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Financial Management Act 1994*, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error. In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.
Auditor's responsibilities for the audit of the financial report	As required by the *Audit Act 1994*, my responsibility is to express an opinion on the financial report based on the audit. My objectives for the audit are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

Auditor's responsibilities for the audit of the financial report (continued)	As part of an audit in accordance with the Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also: • identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. • obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the health service's internal control • evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board • conclude on the appropriateness of the Board's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the health service's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the health service to cease to continue as a going concern. • evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation I communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

MELBOURNE
29 August 2025

Simone Bohan
as delegate for the Auditor-General of Victoria

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The Royal Children's Hospital
Comprehensive operating statement

For the financial year ended 30 June 2025

	Note	2025 $'000	2024 $'000
Revenue and income from transactions			
Revenue from contracts with customers	2.1	850,906	661,839
Other source of income	2.1	297,883	448,355
Total revenue and income from transactions		**1,148,789**	**1,110,194**
Expenses from transactions			
Employee expenses	3.1 (a)	(739,445)	(724,424)
Supplies and consumables	3.1 (d)	(146,985)	(130,186)
Public/private partnership operating expenses	3.1 (d)	(76,838)	(71,868)
Finance costs	3.1 (d)	(37,290)	(39,584)
Other operating expenses	3.1 (d)	(95,107)	(101,134)
Depreciation and amortisation	3.1 (d)	(82,147)	(68,799)
Total expenses from transactions		**(1,177,812)**	**(1,135,994)**
NET RESULT FROM TRANSACTIONS		**(29,023)**	**(25,800)**
Other economic flows included in net result			
Net gain/(loss) on sale of non-financial assets		(1,504)	(2,480)
Net gain/(loss) on financial instruments		-	6,826
Other gains/(losses) from other economic flows		883	2,366
Total other economic flows included in net result		**(621)**	**6,712**
NET RESULT FOR THE YEAR		**(29,643)**	**(19,088)**
Other comprehensive income			
Items that will not be reclassified to net result			
Changes in property, plant and equipment revaluation surplus		-	316,033
Total other comprehensive income		**-**	**316,033**
COMPREHENSIVE RESULT FOR THE YEAR		**(29,643)**	**296,945**

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

Only Parent entity results are required to be reported in FY25. The details are set out in Note 1.2

The Royal Children's Hospital
Balance sheet

As at 30 June 2025

	Note	2025 $'000	2024 $'000
ASSETS			
Financial assets			
Cash and cash equivalents	6.2	61,448	90,059
Receivables	5.1	94,546	90,022
Other financial assets	5.2	-	95,960
Total financial assets		**155,994**	**276,040**
Non-financial assets			
Prepayments		7,641	5,898
Inventories		3,196	3,279
Property, plant and equipment	4.1	1,727,600	1,783,411
Intangible assets	4.2	18,939	24,951
Investment properties		7,463	9,262
Total non-financial assets		**1,764,839**	**1,826,801**
TOTAL ASSETS		**1,920,833**	**2,102,841**
LIABILITIES			
Payables	5.4	56,232	65,720
Contract liabilities	5.5	28,576	27,666
Borrowings	6.1	740,536	787,759
Employee benefits	3.1(b)	229,601	218,215
Other liabilities		1,496	1,699
Total liabilities		**1,056,441**	**1,101,059**
NET ASSETS		**864,392**	**1,001,782**
EQUITY			
Property, plant and equipment revaluation surplus		1,054,873	1,059,573
Restricted specific purpose reserve		12,042	50,873
Contributed capital		91,314	91,314
Accumulated deficit		(293,837)	(199,977)
TOTAL EQUITY		**864,392**	**1,001,782**

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

Only Parent entity results are required to be reported in FY25. The details are set out in Note 1.2

The Royal Children's Hospital
Statement of changes in equity

For the financial year ended 30 June 2025

	Property, plant and equipment revaluation surplus	Restricted specific purpose reserve	Contributed capital	Accumulated surplus/ (deficit)	Total
	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2023	**743,540**	**72,291**	**91,314**	**(201,486)**	**705,659**
Net result for the year	-	-	-	(19,088)	(19,088)
Other comprehensive income for the year	316,033	-	-	-	316,033
Derecognition of joint arrangement	-	-	-	(822)	(822)
Transfer to accumulated surplus/(deficit)	-	(21,418)	-	21,418	-
Balance at 30 June 2024	**1,059,573**	**50,873**	**91,314**	**(199,977)**	**1,001,782**
Net result for the year	-	-	-	(29,643)	(29,643)
Derecognition of controlled entity	(4,700)	(40,305)	-	(62,742)	(107,747)
Transfer from/(to) accumulated surplus/(deficit)	-	1,474	-	(1,474)	-
Balance at 30 June 2025	**1,054,873**	**12,042**	**91,314**	**(293,837)**	**864,392**

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

Only Parent entity results are required to be reported in FY25. The details are set out in Note 1.2

The Royal Children's Hospital
Cash flow statement

For the financial year ended 30 June 2025.

	Note	2025 $'000	2024 $'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating grants from State Government		703,554	705,717
Operating grants from Commonwealth Government		50,874	57,538
Capital grants from State Government		4,730	7,739
Commercial activities, patient and private practice fees received		65,399	67,252
Donations and bequests received		50,423	30,507
GST received from ATO		10,115	9,725
Interest and dividends received		6,632	8,309
Other receipts		67,748	70,960
Total receipts		**959,476**	**957,746**
Payments to employees		(733,972)	(711,828)
Payments for supplies and consumables		(147,116)	(157,706)
Finance cost		(1,000)	(1,059)
GST paid to ATO		(4,161)	(2,468)
Payment for medical indemnity insurance		(10,864)	(8,035)
Other payments		(72,456)	(76,220)
Total payments		**(969,570)**	**(957,317)**
NET CASH FLOW FROM/(USED IN) OPERATING ACTIVITIES	8.1	**(10,094)**	**429**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for non-financial assets		(14,928)	(24,670)
Capital donations and bequests received		435	5,313
Proceeds from sale of non-financial assets		36	625
Purchase of investments		(38)	(8,414)
Proceeds from disposal of investments		-	27,804
NET CASH FLOW FROM/(USED IN) INVESTING ACTIVITIES		**(14,495)**	**657**
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of borrowings		(1,337)	(1,077)
Cash outflow for leases		(1,286)	(773)
NET CASH FLOW FROM/(USED IN) FINANCING ACTIVITIES		**(2,623)**	**(1,851)**
Net increase/(decrease) in cash and cash equivalents held		(27,212)	(765)
Derecognition of controlled entity		(1,398)	-
Cash and cash equivalents at the beginning of financial year		90,059	90,823
CASH AND CASH EQUIVALENTS AT THE END OF FINANCIAL YEAR	6.2	**61,448**	**90,059**

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

Only Parent entity results are required to be reported in FY25. The details are set out in Note 1.2

Notes to the Financial Statements 30 June 2025

Note 1: About this report

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These financial statements represent the financial statements for The Royal Children's Hospital (the RCH) for the year ended 30 June 2025.

This section explains the basis of preparing the financial statements.

Note 1.1: Basis of preparation

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

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

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

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

The financial statements have been prepared on a going concern basis (refer to Note 1.6 Economic Dependency).

The financial statements are presented in Australian dollars.

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

The annual financial statements were authorised for issue by the Board of the RCH on 25 August 2025.

Note 1.2: Principles of consolidation

Derecognition of Controlled Entity – The Royal Children's Hospital Foundation Limited

An entity is considered a controlled entity when the RCH has the power to govern its financial and operating policies to obtain benefits from its activities. Assessment of control under AASB 10 considers both exercisable potential voting rights and the application of significant management judgement.

On 22 August 2024, the RCH Foundation Limited lodged a revised trust deed with the Australian Charities and Not-for-profits Commission (ACNC). The amendments removed the RCH Committee of Management's power to appoint new or additional trustees. This authority now resides with the Board of the Trustee. Furthermore, changes to the trust deed no longer require the written consent of the RCH.

Based on these changes, significant management judgment has determined that the RCH no longer controls the RCH Foundation Limited under AASB 10. The current governance structure and the level of discretion exercised by the Foundation's Board indicate that the RCH no longer has the ability to direct the relevant activities of the Foundation or power to obtain benefits from these activities.

As a result of derecognition, the assets, liabilities and results of operations of the RCH Foundation Limited are no longer consolidated into the financial statements of the RCH. The material financial impacts are as follows:

1. Derecognition of Net Assets:
   Removal of $108 million in net assets from the balance sheet, including $96 million relating to the RCH Foundation's investment fund.
2. Exclusion of Net Results:
   Net results from untied public donations and investment income are no longer recognised. These include:
   – Dividend income (2024: $4.7 million)
   – Unrealised investment gains (2024: $7.1 million)
   – Public donations to the RCH Foundation (2024: $2.0 million)
3. Recognition of Foundation Distributions:
   Inter-entity eliminations are no longer required. Distributions from the RCH Foundation are now recognised as revenue when received (2025: $16.5 million; 2024: $25.77 million).

Further information is provided in Note 8.8.

Under AASB 12 Disclosure of Interests in Other Entities, the RCH is required to disclose its interests in other entities. While the RCH no longer meets the control criteria under AASB 10, it is assessed to have significant influence over the RCH Foundation Limited in accordance with AASB 128 Investments in Associates.

However, as the RCH has no equity or economic interest in the RCH Foundation Limited, no investments in associates has been recognised as at 30 June 2025. Distributions and funding received from the Foundation are instead recognised as revenue.

Note 1.3: Material accounting estimates and judgements

Management makes estimates and judgements when preparing the financial statements.

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

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

The material accounting judgements and estimates used, and any changes thereto, are identified at the beginning of each section where applicable and relate to the following disclosures:

- Note 2.1: Revenue and income from transactions
- Note 3.1: Expenses incurred in the delivery of services
- Note 4.1: Property, plant and equipment
- Note 4.2: Intangible assets
- Note 4.3: Depreciation and amortisation
- Note 4.4: Impairment of assets
- Note 5.4: Payables
- Note 5.5: Contract liabilities
- Note 6.1(a): Lease liabilities
- Note 6.1(b): Public Private Partnership (PPP) lease liabilities
- Note 7.4: Fair value determination

Note 1.4: Accounting standards issued but not yet effective

An assessment of accounting standards and interpretations issued by the AASB that are not yet mandatorily applicable to the RCH has been carried out and their potential impact is not material.

Note 1.5: Reporting entity

The financial statements include all the controlled activities of the RCH.

The RCH’s principal address is:

50 Flemington Road
Parkville Victoria 3052

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

Note 1.6: Economic dependency

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

Note 2: Funding delivery of our services

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

Structure

Note 2.1: Revenue and income from transactions 78

Material judgements and estimates

This section contains the following material judgements and estimates:

Material judgements and estimates	*Description*
Identifying performance obligations	The RCH applies material judgement when reviewing the terms and conditions of funding agreements and contracts to determine whether they contain sufficiently specific and enforceable performance obligations. If this criterion is met, the contract/funding agreement is treated as a contract with a customer, requiring the RCH to recognise revenue as or when the health service transfers promised goods or services to beneficiaries. If this criterion is not met, funding is recognised immediately in the net results from operations.
Determining timing of revenue recognition	The RCH applies material judgement to determine when a performance obligation has been satisfied and the transaction price that is to be allocated to each performance obligation. A performance obligation is either satisfied at a point in time or over time.
Determining timing of capital grant income recognition	The RCH applies material judgement to determine when its obligation to construct an asset is satisfied. Costs incurred is used to measure the RCH's progress as this is deemed to be the most accurate reflection of the stage of completion.
Assets and services received free of charge or for nominal consideration	The RCH applies material judgement to determine the fair value of assets and services provided free of charge or for nominal value. When the items are delivered, the RCH recognises revenue at that point in time based on the agreed value of the arrangement, or the cost that would incur if the RCH were to acquire the asset.

Note 2.1: Revenue and income from transactions

		2025 $'000	2024 $'000
Revenue from contracts with customers	2.1(a)	850,906	661,839
Other source of income	2.1(b)	297,883	448,355
Total revenue and income from transactions		**1,148,789**	**1,110,194**

Note 2.1(a) Revenue from contracts with customers

	2025 $'000	2024 $'000
Government grants (State) - operating	640,008	455,379
Government grants (Commonwealth) - operating	51,726	58,078
RCH Foundation grants - operating	48,448	30,128
Patient fees	31,315	28,969
Private practice fees	27,186	24,805
Commercial activities [1]	15,585	15,442
Other revenue from operating activities	36,638	49,038
Total revenue from contracts with customers	**850,906**	**661,839**

[1] Commercial activities represent business activities which the RCH enters to support its operations.

Revenue recognition from contracts with customers

Government operating grants

Revenue from government operating grants that are enforceable and contain sufficiently specific performance obligations are accounted for as revenue from contracts with customers under AASB 15.

In contracts with customers, the 'customer' is typically a funding body, who is the party that promises funding in exchange for the RCH's goods or services. The RCH funding bodies often direct that goods or services are to be provided to third party beneficiaries, including individuals or the community at large. In such instances, the customer remains the funding body that has funded the program or activity, however the delivery of goods or services to third party beneficiaries is a characteristic of the promised good or service being transferred to the funding body.

The policy applies to each of the RCH's revenue streams, with information detailed below relating to the RCH's significant revenue streams:

Government grant	Performance obligation
Activity Based Funding (ABF) paid as National Weighted Activity Unit (NWAU)	NWAU is a measure of health service activity expressed as a common unit against which the Victorian efficient price (VEP) is paid. The performance obligations for NWAU are the number and mix of admissions, emergency department presentations and outpatient episodes, and is weighted for clinical complexity. Revenue is recognised at point in time, which is when a patient is discharged.
Funding as Nationally Funded Centre (NFC)	RCH is funded for the following procedures:

- paediatric heart transplants
- paediatric liver transplants (in collaboration with Austin Health)
- paediatric lung transplants (in collaboration with Alfred Health)

Revenue is recognised at a point in time when a qualifying procedure has been completed.

RCH Foundation grants

Donations to the RCH predominantly come from The Royal Children's Hospital Foundation Limited. Distributions are used to fund various program and activity with revenue recognised when sufficiently specific performance obligations are met.

Note 2.1(b) Other sources of income

	2025 $'000	2024 $'000
Operating activities		
Government grants (State) - operating	144,134	321,120
Government grants (State) - capital	99,959	96,411
RCH Foundation grants - capital	411	5,389
Salary and wages recoveries	20,517	16,129
Donations and bequests	-	1,988
Assets received free of charge	26,151	2,459
Total other sources of income	**291,171**	**443,496**
Non-operating activities		
Interest revenue	6,712	4,859
Total other sources of income	**6,712**	**4,859**
Total other sources of income	**297,883**	**448,355**

Revenue recognition from other sources of income

Government operating grants

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

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

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

Capital grants

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

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

Interest income

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

Assets received free of charge

Personal protective equipment

Under the State Supply Arrangement, Health Share Victoria supplies personal protective equipment to the RCH for nil consideration.

Compassionate drug

From time to time, the RCH receives compassionate drugs from pharmaceutical companies for nil consideration. Due to materiality, the RCH has updated its accounting policy to recognise the revenue and the corresponding expense of $26m in this financial year.

Non-cash contributions from the Department of Health (DH)

The DH makes some payments on behalf of the RCH as follows:

Supplier	Description
Victorian Managed Insurance Authority	The Department of Health purchases non-medical indemnity insurance for the RCH which is paid directly to the Victorian Managed Insurance Authority. To record this contribution, such payments are recognised as income with a matching expense in the net result from transactions.
Victorian Health Building Authority	The Department of Health made payments to the Victorian Health Building Authority to fund capital works projects during the year ended 30 June 2025, on behalf of the RCH.
Department of Health	Long Service Leave (LSL) revenue is recognised upon finalisation of movements in LSL liability in line with the long service leave funding arrangements with the DH.
PPP Consortium	The DH has entered into lease arrangements and services which are paid directly to PPP Consortium. To record this contribution, such payments are recognised as income with a matching reduction in the lease liability and expense in the net result from transactions, in accordance with the nature and timing of the monthly or quarterly payment.

Note 3: The cost of delivering our services

This section provides an account of the expenses incurred by the RCH in delivering services and outputs. In section 2, the funds that enable the provision of services were disclosed and in this note the cost associated with the provision of services are disclosed.

Structure

Note 3.1: Expenses incurred in the delivery of services 83

Material judgements and estimates

Key judgements and estimates	*Description*
Classifying employee benefit liabilities	The RCH applies material judgement when classifying its employee benefit liabilities. Employee benefit liabilities are classified as a current liability if the RCH does not have an unconditional right to defer payment beyond 12 months. Annual leave accrued days off and long service leave entitlements (for staff who have exceeded the minimum vesting period) fall into this category. Employee benefit liabilities are classified as a non-current liability if the RCH has a conditional right to defer payment beyond 12 months. Long service leave entitlements (for staff who have not yet exceeded the minimum vesting period) fall into this category.
Measuring employee benefit liabilities	The RCH applies material judgement when measuring its employee benefit liabilities. The health service applies judgement to determine when it expects its employee entitlements to be paid. With reference to historical data, if the health service does not expect entitlements to be paid within 12 months, the entitlement is measured at its present value, being the expected future payments to employees. Expected future payments incorporate: • an inflation rate of 4.25%, reflecting the future wage and salary levels • durations of service and employee departures, which are used to determine the estimated value of long service leave that will be taken in the future, for employees who have not yet reached the vesting period. The estimated rates are between 30.76% and 84.50%

- discounting at the rate of 4.203%, as determined with reference to market yields on government bonds at the end of the reporting period.

All other entitlements are measured at their nominal value

Note 3.1: Expenses incurred in the delivery of services

Note 3.1: **Expenses incurred in the delivery of services**

	Note	2025 $'000	2024 $'000
Employee expenses	3.1(a)	739,445	724,424
Other operating expenses	3.1(d)	438,367	411,570
Total expenses incurred in the delivery of services		**1,177,812**	**1,135,994**

Note 3.1(a) Employee expenses

Note 3.1(a) Employee expenses

	Note	2025 $'000	2024 $'000
Salaries and wages		651,125	639,903
On-costs		66,905	63,307
Agency expenses		12,686	12,377
Fee for service medical officers expenses		2,450	3,244
Workcover premium		6,280	5,593
Total employee expenses		**739,445**	**724,424**

Expense recognition

Employee expenses

Employee expenses include:

- Salaries and wages (including fringe benefits tax, leave entitlements, termination payments)
- On-costs
- Agency expenses
- Fee for service medical officer expenses
- Work cover premiums

Note 3.1(b) Employee benefits in the balance sheet

Note 3.1(b) Employee benefits in the balance sheet

	2025 $'000	2024 $'000
Current employee benefits and related on-costs		
Accrued days off		
Unconditional and expected to be settled wholly within 12 months [i]	1,267	1,471
Annual leave		
Unconditional and expected to be settled wholly within 12 months [i]	60,669	54,864
Unconditional and expected to be settled wholly after 12 months [ii]	7,888	8,751
Long service leave		
Unconditional and expected to be settled wholly within 12 months [i]	11,951	10,994
Unconditional and expected to be settled wholly after 12 months [ii]	106,563	102,345
Provisions related to employee benefit on-costs		
Unconditional and expected to be settled within 12 months [i]	9,540	8,274
Unconditional and expected to be settled after 12 months [ii]	14,777	14,169
Total current employee benefits and related on-costs	**212,645**	**200,868**
Non-current employee benefits and related on-costs		
Conditional long service leave	15,017	15,380
Provisions related to employee benefit on-costs	1,939	1,967
Total non-current employee benefits and related on-costs	**16,956**	**17,348**
Total employee benefits and related on-costs	**229,601**	**218,215**

i The amounts disclosed are nominal amounts.
ii The amounts disclosed are discounted to present values.

Provision for related on-costs movement schedule

Provision for related on-costs movement schedule

	2025 $'000	2024 $'000
Carrying amount at start of the year	**24,411**	**22,087**
Additional provision recognised	11,042	10,757
Amounts incurred during the year	(8,394)	(7,708)
Net (gain)/loss from revaluation of long service leave liability	(801)	(725)
Carrying amount at end of year	**26,257**	**24,411**

Employee benefit recognition

Employee benefits are accrued for employees in respect of accrued days off, annual leave and long service leave, for services rendered to the reporting date.

No provision has been made for sick leave as all sick leave is non-vesting and it is not considered probable that the average sick leave taken in the future will be greater than the benefits accrued in the future. As sick leave is non-vesting, an expense is recognised in the Statement of Comprehensive Income as sick leave is taken.

Annual leave and accrued days off

Liabilities for annual leave and accrued days off are recognised in the provision for employee benefits as current liabilities because the RCH does not have an unconditional right to defer settlements of these liabilities.

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

- nominal value – if the RCH expects to wholly settle within 12 months; or

- present value – if the RCH does not expect to wholly settle within 12 months.

Long Service Leave

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

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

The components of this current LSL liability are measured at:

- nominal value – if the RCH expects to wholly settle within 12 months; and
- present value – if the RCH does not expect to wholly settle within 12 months.

Conditional LSL is measured at present value and is disclosed as a non-current liability. Any gain or loss following revaluation of the present value of non-current LSL liability is recognised as a transaction, except to the extent that a gain or loss arises due to changes in estimations e.g. bond rate movements, inflation rate movements and changes in probability factors which are then recognised as other economic flows.

Provisions

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

Note 3.1(c) Superannuation

Note 3.1(c) Superannuation

	Paid contributions for the year		Contribution outstanding at year end	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000
Defined benefit plans [i]				
Aware Super Scheme	143	352	5	25
Defined contribution plans				
Aware Super Scheme	32,887	31,723	2,341	2,223
Hesta	19,772	18,260	1,501	1,388
Other	14,488	12,446	1,092	952
Total	67,290	62,781	4,939	4,588

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

i. The basis for determining the level of contributions is determined by the various actuaries of the defined benefit superannuation plans.

Superannuation recognition

Employees of the RCH are entitled to receive superannuation benefits and it contributes to both defined benefit and defined contribution plans.

Defined benefit superannuation plans

A defined benefit plan provides benefits based on years of service and final average salary. The amount charged to the Comprehensive Operating Statement in respect of defined benefit superannuation plans represents the contributions made by the RCH to the superannuation plans in respect of the services of current RCH's 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.

The RCH does not recognise any unfunded defined benefit liability in respect of the plans because the health service 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 DTF discloses the State's defined benefits liabilities in its disclosure for administered items. Superannuation contributions paid or payable for the reporting period, however, are included as part of employee benefits in the Comprehensive Operating Statement of the RCH.

The name, details and amounts that have been expensed in relation to the major employee superannuation funds and contributions made by the RCH are disclosed above.

Defined contribution superannuation plans

Defined contribution (i.e. accumulation) superannuation plan expenditure 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.

The name, details and amounts that have been expensed in relation to the major employee superannuation funds and contributions made by the RCH are disclosed above.

Note 3.1(d) Other operating expenses

Note 3.1(d) Other operating expenses

	Note	2025 $'000	2024 $'000
Drug supplies		97,118	79,229
Medical and surgical supplies		35,440	35,939
Diagnostic and radiology supplies		11,169	11,525
Other supplies and consumables		3,258	3,493
Total supplies and consumables		**146,985**	**130,186**
Contingent rent		47,514	44,039
Recurrent charges		18,652	17,949
Lifecycle maintenance		9,699	8,935
Community partnership payments		598	582
Minor works		375	362
Total public/private partnership operating expenses		**76,838**	**71,868**
Finance costs		1,067	1,106
Finance costs - PPP arrangements		36,222	38,477
Total finance costs		**37,290**	**39,584**
Fuel, light, power and water		7,404	7,593
Repairs and maintenance		2,427	3,770
Maintenance contracts		17,353	17,383
Medical indemnity insurance		12,684	8,830
Distributions to Murdoch Children's Research Institute		18,248	21,356
Other administrative expenses		35,583	39,425
Expenses related to short term leases		155	121
Expenses related to leases of low value assets		619	988
Expenditure for capital purposes		634	1,669
Total other operating expenses		**95,107**	**101,134**
Depreciation and amortisation	4.3	82,147	68,799
Total non-operating expenses		**82,147**	**68,799**
Total expenses from transactions		**438,367**	**411,570**

Expense recognition

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

Supplies and consumables

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

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

- short term leases – leases with a term of twelve months or less, and
- low value leases – leases with the underlying asset's fair value (when new, regardless of the age of the asset being leased) is no more than $10,000.

Variable lease payments that are not included in the measurement of the lease liability, i.e. variable lease payments that do not depend on an index or a rate such as those based on performance or usage of the underlying asset, are recognised in the Comprehensive Operating Statement (except for payments which have been included in the carrying amount of another asset) in the period in which the event or condition that triggers those payments occurs. The RCH's variable lease payments during the year ended 30 June 2025 was nil.

Other operating expenses

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

The DH also makes certain payments on behalf of the RCH. These amounts have been brought to account in determining the operating result for the year, by recording them as revenue and recording a corresponding expense.

Note 4: Key assets to support service delivery

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

Structure

Note 4.1: Property, plant and equipment 89

Note 4.2: Intangible assets 90

Note 4.3: Depreciation and amortisation 92

Note 4.4: Impairment of assets 93

Material judgements and estimates

Material judgements and estimates	*Description*
Estimating useful life of property, plant and equipment	The RCH assigns an estimated useful life to each item of property, plant and equipment. This is used to calculate depreciation of the asset. The health service reviews the useful life and depreciation rates of all assets at the end of each financial year and where necessary, records a change in accounting estimate.
Classifying land with no lease agreement in place	The RCH utilises some land owned by the Department of Health, which is classified as property, plant and equipment. In the absence of a lease agreement, the following points have been considered to conclude on the classification: • The RCH is responsible for maintenance, insurance, and other holding costs. • The RCH has the right to use the land indefinitely unless a ministerial change happens. • The land is held and used as property, plant and equipment in substance. This classification is subject to material judgement.
Estimating useful life of intangible assets	The RCH assigns an estimated useful life to each intangible asset with a finite useful life, which is used to calculate amortisation of the asset.

Note 4.1: Property, plant and equipment

Note 4.1: **Property, plant and equipment**

	Gross carrying amount		Accumulated depreciation		Net carrying amount	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000
Land at fair value - Crown	144,884	144,884	-	-	144,884	144,884
Land at fair value - Freehold	15,850	17,950	-	-	15,850	17,950
Buildings - right of use at fair value	511	624	(224)	(587)	288	37
Buildings at fair value	9,669	11,769	(848)	-	8,821	11,769
Leasehold improvements	-	1,405	-	(771)	-	634
Plant and equipment	2,218	2,052	(1,582)	(1,474)	636	578
Medical equipment	103,203	101,705	(66,621)	(62,763)	36,582	38,942
Computers and communication	17,884	18,703	(12,963)	(13,259)	4,921	5,444
Furniture and fittings	4,163	2,519	(1,383)	(1,246)	2,780	1,274
Motor vehicles	801	621	(215)	(117)	586	504
Cultural assets	607	607	-	-	607	607
Right of use - plant, equipment, furniture, fittings and vehicles	3,905	6,061	(2,200)	(4,068)	1,705	1,993
PPP assets						
Buildings at fair value	1,495,668	1,494,125	(63,052)	-	1,432,617	1,494,125
Leasehold improvements at cost	32,368	16,953	-	-	32,368	16,953
Fittings	45,531	45,531	(19,956)	(18,408)	25,574	27,124
Equipment at fair value	34,518	34,518	(15,135)	(13,924)	19,383	20,594
Total right of use PPP assets	**1,508,085**	**1,591,128**	**(98,145)**	**(32,332)**	**1,509,941**	**1,558,796**
Total property, plant and equipment	**1,911,781**	**1,900,027**	**(184,181)**	**(116,617)**	**1,727,600**	**1,783,411**

Property, plant and equipment recognition

Items of property, plant and equipment are initially measured at cost and are subsequently measured at fair value less accumulated depreciation and impairment. Where an asset is acquired for no or nominal cost, being far below the fair value of the asset, the deemed cost is its fair value at the date of acquisition.

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

Further information regarding fair value measurement is disclosed in Note 7.4.

Note 4.1(a) Reconciliations of the carrying amounts by class of assets

	Land	Right of use - buildings	Buildings	Plant and equipment	Medical equipment	Computers and communicatio	Furniture and fittings	Motor vehicles	Cultural Assets	Right of use - PP&E, F and V	PPP assets	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2023	**172,024**	**74**	**22,062**	**814**	**26,526**	**5,963**	**2,934**	**34**	**604**	**1,451**	**1,269,319**	**1,501,796**
Additions	-	-	-	67	19,799	1,559	660	521	32	1,252	5,508	29,397
Disposals	-	-	-	-	(158)	(2)	-	-	(66)	-	-	(224)
Revaluation increments/ (decrements)	(9,191)	-	(9,106)	-	-	-	-	-	37	-	334,292	316,033
Net transfers between classes	-	-	14	(119)	-	69	(1,802)	-	-	-	1,794	(45)
Derecognition of joint arrangement	-	-	(4)	-	-	(7)	(0)	-	-	-	-	(11)
Depreciation and amortisation (note 4.3)	-	(36)	(564)	(184)	(7,227)	(2,138)	(518)	(51)	-	(710)	(52,117)	(63,535)
Balance at 30 June 2024	**162,834**	**37**	**12,403**	**578**	**38,942**	**5,444**	**1,274**	**504**	**607**	**1,993**	**1,558,796**	**1,783,411**
Additions	-	482	-	186	5,474	1,191	1,748	254	-	354	16,781	26,470
Disposals	-	-	-	(5)	(247)	0	(12)	(3)	-	36	-	(232)
Net transfers between classes	-	(175)	-	-	-	0	-	-	-	-	175	-
Derecognition of controlled entity	(2,100)	-	(2,734)	0	-	(14)	0	(0)	-	-	-	(4,850)
Depreciation and amortisation (note 4.3)	-	(56)	(648)	(124)	(7,567)	(1,700)	(229)	(161)	-	(678)	(65,811)	(77,193)
Balance at 30 June 2025	**160,734**	**288**	**8,821**	**636**	**36,582**	**4,921**	**2,780**	**595**	**607**	**1,705**	**1,509,941**	**1,727,600**

Note that intangible assets are not included in this schedule, refer note 4.2.

The RCH on behalf of the State of Victoria records the PPP assets and any other additions and improvement to the PPP assets.

Land and Buildings Carried at Valuation

Fair value assessments have been performed for all classes of assets in this purpose group and the decision was made that the movements were not material (less than or equal to 10%). As such, an independent revaluation was not required per FRD 108. In accordance with FRD 103, the RCH has elected to apply the practical expedient in FRD 103 Non-Financial Physical Assets and has therefore not applied the amendments to AASB 13 Fair Value Measurement. The amendments AASB 13 will be applied at the next scheduled independent revaluation, which is

planned to be undertaken in 2029, in accordance with the RCH's revaluation cycle, or at the next interim revaluation (whichever is earlier).

Right of use assets recognition

Initial recognition

Where the RCH enters a contract, which provides the health service with the right to control the use of an identified asset for a period of time in exchange for payment, this contract is considered a lease.

Unless the lease is considered a short-term lease or a lease of a low-value asset (refer to note 6.1 for further information) the contract gives rise to a right-of-use asset and a corresponding lease liability, which is recognised at the lease commencement date.

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

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

Subsequent measurement

Right-of-use assets are subsequently measured at fair value, with the exception of right-of-use assets arising from leases with significantly below-market terms and conditions, which are subsequently measured at cost, less accumulated depreciation and accumulated impairment losses where applicable.

Right-of-use assets are also adjusted for certain remeasurements of the lease liability (for example, when a variable lease payment based on an index or rate becomes effective).

Further information regarding fair value measurement is disclosed in Note 7.4.

Note 4.2: Intangible assets

	Gross carrying amount		Accumulated depreciation		Net carrying amount	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000
Software	60,510	60,966	(56,340)	(52,049)	4,170	8,917
Car park revenue rights (i)	30,000	30,000	(15,370)	(14,097)	14,630	15,903
Intangible work in progress	138	131	-	-	138	131
Total intangible assets	**90,649**	**91,098**	**(71,710)**	**(66,146)**	**18,939**	**24,951**

Note 4.2(a) Reconciliations of the carrying amounts by class of assets

	Software	Car park revenue rights	Intangible WIP	Total
	$'000	$'000	$'000	$'000
Balance at 1 July 2023	**13,988**	**17,175**	**78**	**31,240**
Additions	114	-	54	168
Net transfers between classes	45	-	-	45
Amortisation (note 4.3)	(5,186)	-	-	(5,186)
Other economic flows	-	(1,272)	-	(1,272)
Derecognition of joint arrangement	(44)	-	-	(44)
Balance at 30 June 2024	**8,917**	**15,903**	**131**	**24,951**
Additions	375	-	7	382
Amortisation (note 4.3)	(4,954)	-	-	(4,954)
Other economic flows	-	(1,272)	-	(1,272)
Derecognition of controlled entity	(169)	(0)	-	(169)
Balance 30 June 2025	**4,170**	**14,630**	**138**	**18,939**

i. As part of the RCH project, the revenue stream associated with the three-level underground car park (stage 1 and stage 2) is retained by the RCH. The rights for this revenue are financed by way of a long-term loan from the Treasury Corporation of Victoria (TCV).

Intangible assets recognition

Intangible assets represent identifiable non-monetary assets without physical substance such as computer software and car park revenue recognition rights.

Initial recognition

Purchased intangible assets are initially recognised at cost.

An internally generated intangible asset arising from development (or from the development phase of an internal project) is also recognised at cost if, and only if, all of the following can be demonstrated:

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

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

Subsequent measurement

Intangible assets with finite useful lives are carried at cost less accumulated amortisation and accumulated impairment losses.

Note 4.3: Depreciation and amortisation

	2025 $'000	2024 $'000
Depreciation		
Buildings	848	554
Plant and equipment	124	184
Motor vehicles	161	51
Medical equipment	7,587	7,227
Computers and communication equipment	1,700	2,138
Furniture and fittings	229	518
Leased fittings	1,550	1,596
Leased equipment	1,209	1,153
Right of use assets		
- Right of use PPP buildings	63,052	49,368
- Right of use buildings	56	38
- Right of use plant, equipment and vehicles	678	710
Total depreciation	**77,193**	**63,535**
Amortisation		
Software	4,954	5,186
Total depreciation and amortisation	**82,147**	**68,721**

Depreciation

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

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

Amortisation

Amortisation is the systematic allocation of the depreciable amount of an asset over its useful life.

Useful life of non-current assets

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

	2025	2024
Non PPP assets		
Buildings	50 years	50 years
Plant, equipment and vehicles (including leased assets)	3 to 50 years	3 to 50 years
Intangible assets	3 to 25 years	3 to 25 years
PPP assets		
Buildings	25 to 60 years	25 to 60 years
Plant, equipment and vehicles	30 years	30 years

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

Note 4.4: Impairment of assets

Impairment recognition

At the end of each reporting period, the RCH reviews the carrying amount of its tangible and intangible assets that have a finite useful life, to determine whether there is any indication that an asset may be impaired. The assessment will include consideration of external sources of information and internal sources of information.

If such an indication exists, an impairment test is carried out. Assets with indefinite useful lives (and assets not yet available for use) are tested annually for impairment, in addition to where there is an indication that the asset may be impaired.

When performing an impairment test, the RCH compares the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, to the asset's carrying amount. Any excess of the asset's carrying amount over its recoverable amount is recognised immediately in net result, unless the asset is carried at a revalued amount.

Where an impairment loss on a revalued asset is identified, this is recognised against the asset revaluation surplus in respect of the same class of asset to the extent that the impairment loss does not exceed the cumulative balance recorded in the asset revaluation surplus for that class of asset.

Where it is not possible to estimate the recoverable amount of an individual asset, the RCH estimates the recoverable amount of the cash-generating unit to which the asset belongs.

The RCH performed an impairment assessment and there was no indication of impairment losses for the year ended 30 June 2025 (30 June 2024: $339k).

Note 5: Other assets and liabilities

This section sets out those assets and liabilities that arose from the RCH's operations.

Structure

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Note 5.2: Investments and other financial assets 95

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Material judgements and estimates

Key judgements and estimates	*Description*
Measuring contract liabilities	The RCH applies material judgement to measure its progress towards satisfying a performance obligation as detailed in Note 2. Where a performance obligation is yet to be satisfied, the health service assigns funds to the outstanding obligation and records this as a contract liability until the promised good or service is transferred to the customer.

Note 5.1: Receivables

		2025 $'000	2024 $'000
CURRENT			
Contractual			
Inter hospital debtors		6,190	2,043
Trade debtors		6,852	11,393
Patient fees		11,037	7,348
Accrued investment income		-	3,610
Diagnostic and pathology debtors		3,190	2,150
Accrued revenue - Department of Health		3	50
Accrued revenue - Others		7,185	6,618
Less allowance for impairment losses			
Trade debtors		(410)	(419)
Patient fees		(1,184)	(973)
Diagnostic and pathology debtors		(762)	(367)
	7.1 (a)	**32,102**	**31,453**
Statutory			
GST receivable		831	815
Total current receivables		**32,933**	**32,268**
NON-CURRENT			
Contractual			
Accrued LSL revenue Department of Health		61,613	57,753
Total non-current receivables		**61,613**	**57,753**

Receivables recognition

Receivables consist of:

- Contractual receivables include debtors that relate to the provision of goods and services. These receivables are classified as financial instruments and are categorised as 'financial assets at amortised cost'. They are initially recognised at fair value plus any directly attributable transaction costs. The health service holds the contractual receivables with the

objective to collect the contractual cash flows and therefore subsequently measured at amortised cost using the effective interest method, less any impairment.

- Statutory receivables include Goods and Services Tax (GST) input tax credits that are recoverable. Statutory receivables do not arise from contracts and are recognised and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments for disclosure purposes. The health service applies AASB 9 for initial measurement of the statutory receivables and as a result, statutory receivables are initially recognised at fair value plus any directly attributable transaction cost.

Trade receivables are carried at the nominal amounts due for settlement within 30 days from the date of recognition.

Note 5.1(a) Movements in allowance for impairment losses on contractual receivables

	2025 $'000	2024 $'000
Balance at the beginning of the reporting period	1,759	1,487
Amounts written off during the year	(736)	(152)
Increase/(decrease) in allowance recognised in net result	1,333	424
Balance at the end of the reporting period	**2,356**	**1,759**

Impairment losses of contractual receivables

Refer to note 7.2 (a) for the RCH's contractual impairment losses.

Note 5.2: Investments and other financial assets

	2025 $'000	2024 $'000
CURRENT		
Financial assets - at fair value through profit or loss		
Managed funds [i]	-	95,960
Total current	**-**	**95,960**
Represented by:		
Investments held by The Royal Children's Hospital Foundation	-	95,960
	-	95,960

i. *The managed funds consist of investments held by The Royal Children's Hospital Foundation Limited which was derecognised on 22 August 2024. Refer to Note 1.2*

Note 5.3: Investments in Associates

Investment in an associate is recognised when the RCH has significant influence to participate in the financial and operating policy discussions of the investee but is not control or joint control of those policies. If the RCH holds, directly or indirectly, 20 per cent or more of the voting power of the investee, it is presumed that the RCH has significant influence.

Initial recognition

On initial recognition the investment in an associate is recognised at cost, and the carrying amount is increased or decreased to recognise the RCH's share of the profit or loss of the investee after the date of acquisition. The RCH's share of the investee's profit or loss is recognised in the RCH's profit or loss.

Subsequent measurement

The carrying amount is increased or decreased to account for the RCH's share of the profit or loss of the investee subsequent to the initial recognition. Distributions received from an investee reduce the carrying amount of the investment. Adjustments to the carrying amount may also be

necessary for changes in the RCH's proportionate interest in the investee arising from changes in the investee's other comprehensive income. Such changes include those arising from the revaluation of property, plant and equipment.

Investment in Transcendomics

The RCH has classified its equity interests in Transcendomics as an Investment in Associates, with the RCH holding 20% voting right contributes to a significant influence of Transcendomics. The RCH's share of the profit of Transcendomics for 2024-25 is not material to the RCH and has not been reflected in the financial statements.

The Royal Children's Hospital Foundation Limited

The RCH has classified its interests in the RCH Foundation Limited as an Investment in Associates. While the RCH no longer meets the control criteria under AASB 10 (refer to Note 1.2), it is assessed to have significant influence over the RCH Foundation Limited.

However, as the RCH has no equity or economic interest in the RCH Foundation Limited, no investments in associates has been recognised as at 30 June 2025. Distributions and funding received from the Foundation are instead recognised as revenue.

Note 5.4: Payables

Note 5.4(a) Payables

	2025 $'000	2024 $'000
CURRENT		
Contractual		
Trade creditors	11,071	17,886
Accrued salaries and wages	21,719	22,893
Accrued expenses	8,853	10,234
Deposits	24	33
Department of Health - deferred capital grant income[i]	6,424	7,669
Superannuation and workcover	7,140	6,463
Sundry creditors	1,202	542
Total current payables	**56,232**	**65,720**
Financial liabilities classified as payables in note 7.1 (a)		
Total payables	56,232	65,720
Deferred grant income	(6,424)	(7,669)
Total financial liabilities	**49,808**	**58,051**

i. Deferred grant income includes deferred capital grant income as shown in note 5.4 (b) below.

Payables recognition

Payables consist of:

- Contractual payables include payables that relate to the purchase of goods and services. These payables are classified as financial instruments and measured at amortised cost. Accounts payable and salaries and wages payable represent liabilities for goods and services provided to the RCH prior to the end of the financial year that are unpaid.
- Statutory payables include goods and services tax (GST) and fringe benefits tax (FBT) payables. Statutory payables are recognised and measured similarly to contractual payables but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from contracts.

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

Note 5.4(b) Movement in deferred capital grant income

	2025 $'000	2024 $'000
Opening balance of deferred capital grants income	7,669	10,862
Grant consideration for capital works received during the year	4,679	7,642
Deferred captial grant income recognised as income due to completion of capital works	(5,924)	(10,835)
Closing balance of deferred capital grant income	**6,424**	**7,669**

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

Note 5.5: Contract liabilities

	2025 $'000	2024 $'000
Opening balance of contract liabilities	27,666	18,196
Add: payments received for performance obligations yet to be completed during the peirod	11,388	14,812
Add: grant consideration for sufficiently specific performance obligations received during the year	741,074	742,903
Less: revenue recognised in the reporting period for the completion of a performance obligation	(13,454)	(15,577)
Less: grant revenue for sufficiently specific performance obligations work recognised consistent with the performance obligations met duirng the year	(740,487)	(730,668)
Derecognition of controlled entity	2,388	-
Total current contract liabilties	**28,576**	**27,666**

Contract liabilities recognition

Contract liabilities include consideration received in advance from customers for various services or projects before a related performance obligation is satisfied. This mainly consists of grants from the Department of Health and the RCH Foundation.

Contract liabilities are derecognised and recorded as revenue when promised goods and services are transferred to the customer. Refer to Note 2.1.

Note 6: How we finance our operations

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

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

Structure

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Material judgements and estimates

Key judgements and estimates	*Description*
Determining if a contract is or contains a lease	The RCH applies material judgement to determine if a contract is or contains a lease by considering if the health service: • has the right to use and identified asset • has the right to obtain substantially all economic benefits from the use of the leased asset and • can decide how and for what purpose the asset is used throughout the lease.
Determining if a lease meets the short-term or low value asset lease exemption	The RCH applies material judgement when determining if a lease meets the short-term or low value lease exemption criteria. The health service estimates the fair value of leased assets when new. Where the estimated fair value is less than $10,000, the health service applies the low-value lease exemption. The health service also estimates the lease term with reference to remaining lease term and period that the lease remains enforceable. Where the enforceable lease period is less than 12 months the health service applies the short-term lease exemption.
Discount rate applied to future lease payments	The RCH discounts its lease payments using the interest rate implicit in the lease. If this rate cannot be readily determined, which is generally the case for the health service's lease arrangements, the RCH uses its incremental borrowing rate, which is the amount the health service would have to pay to borrow funds necessary to obtain an asset of similar value to the right-of-use asset in a similar economic environment with similar terms, security and conditions.

Assessing the lease term	The lease term represents the non-cancellable period of a lease, combined with periods covered by an option to extend or terminate the lease if the RCH is reasonably certain to exercise such options. The RCH determines the likelihood of exercising such options on a lease-by-lease basis through consideration of various factors including: • If there are significant penalties to terminate (or not extend), the health service is typically reasonably certain to extend (or not terminate) the lease. • If any leasehold improvements are expected to have a significant remaining value, the health service is typically reasonably certain to extend (or not terminate) the lease. • The health service considers historical lease durations and the costs and business disruption to replace such leased assets.

Note 6.1: Borrowings

	2025 $'000	2024 $'000
CURRENT		
TCV loan [i]	1,299	1,337
Finance lease liability [ii]	49,006	46,728
Total current	**50,306**	**48,066**
NON-CURRENT		
TCV loan [i]	18,305	19,604
Finance lease liability [ii]	671,925	720,089
Total non-current	**690,230**	**739,693**
Total borrowings	**740,536**	**787,759**

i. The TCV loan is an unsecured loan with an interest rate of 4.93% (2024: 4.93%). The maturity date of the loan is 31 December 2036.

ii. Secured by the assets leased. Finance leases are effectively secured as the rights to the leased assets revert to the lessor in the event of default. Note that the obligation of fulfilling PPP interest and principal payments over the PPP term rests with the DH. The RCH records on behalf of the DH according to the information provided.

Borrowings recognition

Borrowings refer to interest bearing liabilities mainly raised from advances from the Treasury Corporation of Victoria (TCV) and other funds raised through lease liabilities.

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

Maturity analysis

Please refer to note 7.2 (b) for a maturity analysis of borrowings.

Interest expense

Interest expense includes costs incurred in connection with the borrowing of funds and includes interest on short term and long-term borrowings, interest component of lease repayments and the increase in financial liabilities.

Interest expense is recognised in the period in which it is incurred.

The RCH recognises borrowing costs immediately as an expense.

	2025 $'000	2024 $'000
Interest on TCV loan	1,000	1,059
Interest on Finance lease liability	36,290	38,524
Total interest expense	**37,290**	**39,584**

Defaults and breaches

During the current and prior year, there were no defaults of any of the loans.

Note 6.1(a) Lease liabilities

The RCH's lease liabilities are summarised below:

	2025 $'000	2024 $'000
Current lease liabilities		
Lease liability	49,006	46,728
Total current lease liabilities	**49,006**	**46,728**
Non-current lease liabilities		
Lease liability	671,925	720,089
Total non-current lease liabilities	**671,925**	**720,089**
Total lease liabilities	**720,932**	**766,817**

The following table sets out the maturity analysis of lease liabilities, showing the undiscounted lease payments to be made after the reporting date.

	2025 $'000	2024 $'000
Not longer than one year	83,030	83,000
Longer than one year but not later than five years	329,381	329,435
Longer than five years	531,304	613,352
Minimum future lease liability	943,715	1,025,787
- Less unexpired finance expenses	(222,783)	(258,970)
Present value of lease liability	**720,932**	**766,817**

Lease liabilities recognition

The RCH has entered into leases related to buildings, motor vehicles, medical equipment and office equipment.

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

To apply this definition, the RCH ensures the contract meets the following criteria:

- the contract contains an identified asset, which is either explicitly identified in the contract or implicitly specified by being identified at the time the asset is made available to the RCH and for which the supplier does not have substantive substitution rights
- The RCH has the right to obtain substantially all of the economic benefits from use of the identified asset throughout the period of use, considering its rights within the defined scope

of the contract and the RCH has the right to direct the use of the identified asset throughout the period of use and

- the RCH has the right to take decisions in respect of 'how and for what purpose' the asset is used throughout the period of use.

The RCH's lease arrangements consist of the following:

Type of asset leased	Lease term
Leased buildings	3 to 4 years
Leased motor vehicles, medical equipment and office equipment	3 to 7 years

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

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

Type of payment	Description	Type of leases captured
Low value lease payments	Leases where the underlying asset, when new, is no more than $10,000	Computers
Short-term lease payments	Leases with a term less than 12 months	Buildings

Initial measurement

The lease liability is initially measured at the present value of the lease payments unpaid at the commencement date, discounted using the interest rate implicit in the lease if that rate is readily determinable or the RCH incremental borrowing rate. Our lease liability has been discounted by rates of between 1.11% to 5.63%.

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

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

The following types of lease agreements contain extension and termination options:

- Motor Vehicles
- Medical Equipment

- Buildings

These terms are used to maximise operational flexibility in terms of managing contracts. Extension and termination options held are exercisable only by the health service and not by the respective lessor.

In determining the lease term, management considers all facts and circumstances that create an economic incentive to exercise an extension option, or not exercise a termination option. Extension options (or periods after termination options) are only included in the lease term and lease liability if the lease is reasonably certain to be extended (or not terminated).

The assessment is reviewed if a significant event or a significant change in circumstances occurs which affects this assessment and that is within the control of the lessee.

During the current financial year, the financial effect of revising lease terms to reflect the effect of exercising extension and termination options was an increase in recognised lease liabilities and right-of-use assets of $52k.

Subsequent measurement

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

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

Note 6.1(b) Commissioned PPP related lease liabilities

	2025 $'000	2024 $'000
Current lease liabilities		
Lease liability	48,086	45,825
Total current lease liabilities	**48,086**	**45,825**
Non-current lease liabilities		
Lease liability	670,805	718,890
Total non-current lease liabilities	**670,805**	**718,890**
Total lease liabilities	**718,890**	**764,716**

The following table sets out the maturity analysis of lease liabilities, showing the undiscounted lease payments to be made after the reporting date.

	2025 $'000	2024 $'000
Not longer than one year	82,048	82,048
Longer than one year but not later than five years	328,191	328,191
Longer than five years	531,304	613,352
Minimum future lease liability	941,543	1,023,591
- Less unexpired finance expenses	(222,653)	(258,875)
Present value of lease liability	**718,890**	**764,716**

Public private partnerships (PPP)

Construction and fit out of the RCH main hospital building was funded through Public Private Partnership arrangement. The RCH is responsible for operating the hospital and has recognised the leased asset and associated interest-bearing liability on behalf of the State of Victoria.

The PPP is not accounted for as a Service Concession Arrangement within the scope of AASB 1059 *Service Concession Arrangements: Grantors* as the required criteria are not satisfied.

The hospital building is maintained by Children's Health Partnership (CHP) through Downer, as part of the PPP arrangement. Under the agreement between CHP and the State of Victoria, CHP is responsible for the maintenance of the building for a 25-year period ending in December 2036. The State of Victoria pays CHP a quarterly service payment for the delivery of maintenance and ancillary services. The service charges have been brought to account in the operating result by recognising them as non-cash revenue and expenditure.

The portion of total payments to CHP that relates to the RCH's right to use the hospital building is accounted for as a finance lease liability. The lease asset is accounted for as a non-financial physical asset and is depreciated over the shorter of the estimated useful life of the asset or the term of the lease.

Initial measurement

PPP leases are recognised as assets and liabilities at amounts equal to the fair value of the leased property or, if lower, the present value of the minimum lease payments, each determined at the inception of the PPP lease.

Subsequent measurement

The leased assets under the PPP arrangement are accounted for as a non-financial physical asset and is depreciated over the term of the lease. If there is certainty that the RCH will obtain ownership of the lease asset by the end of the lease term, the asset shall be depreciated over the useful life of the asset.

Minimum lease payments are apportioned between reduction of the outstanding lease liability and the periodic finance expense which is calculated using the interest rate implicit in the lease and charged directly to the comprehensive operating statement. Contingent rentals associated with finance leases are recognised as an expense in the period in which they are incurred.

Note 6.2: Cash and cash equivalents

	2025 $'000	2024 $'000
Deposit held on behalf of employees (salary packaging)	1,488	1,437
Cash at bank	-	846
Cash at bank - CBS (excluding monies held in trust)	57,903	85,335
Cash at bank - CBS (monies held in trust)	2,057	1,888
Fixed deposits	-	552
	61,448	**90,059**
Represented by:		
Monies held in trust	2,057	1,888
Cash for health service operations [i]	59,391	88,170
	61,448	**90,059**

i. Cash for health service operations includes cash held for capital commitments, operating commitments and salary packaging monies held on behalf of employees.

Note 6.3: Commitments for expenditure

Note 6.3(a) Commitments for expenditure

2024	Less than 1 year	1-5 years	Over 5 years	Total
	$'000	$'000	$'000	$'000
Capital expenditure commitments	3,662	-	-	3,662
Operating expenditure commitments	6,890	4,072	-	10,962
Public private partnership commitments	85,604	414,244	1,023,754	1,523,602
Total commitments (inclusive of GST)	**96,155**	**418,316**	**1,023,754**	**1,538,226**
Less GST recoverable				(139,839)
Total commitments (exclusive of GST)				**1,398,387**

2025	Less than 1 year	1-5 years	Over 5 years	Total
	$'000	$'000	$'000	$'000
Capital expenditure commitments	681	-	-	681
Operating expenditure commitments	12,499	12,128	-	24,627
Public private partnership commitments	94,740	426,942	891,900	1,413,582
Total commitments (inclusive of GST)	**107,920**	**439,070**	**891,900**	**1,438,890**
Less GST recoverable				(130,808)
Total commitments (exclusive of GST)				**1,308,082**

Expenditure commitments

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed at their nominal value and are inclusive of GST payable. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

Operating commitments largely comprise software maintenance and service delivery agreements, professional services agreements and consumables contracts.

Short term and low value leases

The RCH discloses short term and low value lease commitments which are excluded from the measurement of right-of-use assets and lease liabilities. Refer to note 6.1 for further information.

Commissioned public private partnerships (PPP)

Pursuant to the requirements of the Operating Deed signed by the State of Victoria and the RCH, the Department of Health agrees to meet all payments (including leasing and operating) for which the State of Victoria is liable, and which are associated with the project. The RCH records and reports all of the obligations of the State of Victoria reflecting the RCH's position as the government agency that controls the assets.

Note 7: Risks, contingencies and valuation uncertainties

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

Structure

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Material judgements and estimates

Material judgements and estimates	*Description*
Measuring fair value of non-financial assets	Fair value is measured with reference to highest and best use, that is, the use of the asset by a market participant that is physically possible, legally permissible, financially feasible, and which results in the highest value, or to sell it to another market participant that would use the same asset in its highest and best use. In determining the highest and best use, the RCH has assumed the current use is its highest and best use. Accordingly, characteristics of the health service's assets are considered, including condition, location and any restrictions on the use and disposal of such assets. The RCH uses a range of valuation techniques to estimate fair value, which include the following: ▪ Market approach, which uses prices and other relevant information generated by market transactions involving identical or comparable assets and liabilities. The fair value of the RCH's specialised land is measured using this approach. Where assets are held to meet Community Service Obligations (CSOs), such as the delivery of public health services, adjustments may be made to reflect the reduced marketability or alternative use of these assets, in recognition of the operational restrictions and obligations attached to them. ▪ Cost approach, which reflects the amount that would be required to replace the service capacity of the asset (referred to as current replacement cost). The fair value of the RCH's specialised buildings, furniture, fittings, plant, equipment and vehicles are measured using this approach.

- Income approach, which converts future cash flows or income and expenses to a single undiscounted amount. The RCH does not this use approach to measure fair value.

The health service selects a valuation technique which is considered most appropriate, and for which there is sufficient data available to measure fair value, maximising the use of relevant observable inputs and minimising the use of unobservable inputs.

Subsequently, the health service applies material judgement to categorise and disclose such assets within a fair value hierarchy, which includes:

- Level 1, using quoted prices (unadjusted) in active markets for identical assets that the health service can access at measurement date. The RCH does not categorise any fair values within this level.
- Level 2, inputs other than quoted prices included within Level 1 that are observable for the asset, either directly or indirectly. The RCH categorises non-specialised land & building, cultural assets and right-of-use plant & equipment, furniture & fitting and vehicles in this level.
- Level 3, where inputs are unobservable. The RCH categorises specialised land & buildings, plant & equipment, furniture & fittings in this level.

Note 7.1: Financial instruments

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

Note 7.1(a) Categorisation of financial instruments

Note 7.1(a) Categorisation of financial instruments

2024	Note	Financial assets at amortised cost	Financial assets at fair value through net result	Financial assets at fair value through other comprehensive income	Financial liabilities at amortised cost	Total
		$'000	$'000	$'000	$'000	$'000
Contractual financial assets						
Cash and cash equivalents	6.2	90,059	-	-	-	90,059
Receivables	5.1	31,453	-	-	-	31,453
Other financial assets						
- Managed funds	5.2	-	95,960	-	-	95,960
Total financial assets [i]		**121,511**	**95,960**	**-**	**-**	**217,471**
Financial liabilities						
Payables	5.4	-	-	-	58,051	58,051
TCV loan	6.1	-	-	-	20,942	20,942
Lease liability	6.1	-	-	-	766,817	766,817
Total financial liabilities [ii]		**-**	**-**	**-**	**845,810**	**845,810**

2025	Note	Financial assets at amortised cost	Financial assets at fair value through net result	Financial assets at fair value through other comprehensive income	Financial liabilities at amortised cost	Total
		$'000	$'000	$'000	$'000	$'000
Contractual financial assets						
Cash and cash equivalents	6.2	61,448	-	-	-	61,448
Receivables	5.1	32,102	-	-	-	32,102
Total financial assets [i]		**93,550**	**-**	**-**	**-**	**93,550**
Financial liabilities						
Payables	5.4	-	-	-	49,808	49,808
TCV loan	6.1	-	-	-	19,604	19,604
Lease liability	6.1	-	-	-	720,932	720,932
Total financial liabilities [ii]		**-**	**-**	**-**	**790,344**	**790,344**

i. The total amount of the financial assets disclosed here excludes statutory receivables (i.e. GST input tax credit recoverable and accrued LSL revenue from the Department of Health).

ii. The total amount of the financial liabilities disclosed includes loans from the Treasury Corporation of Victoria and PPP finance liabilities, and excludes deferred income and statutory payables (i.e. taxes payable).

The obligation of fulfilling the PPP interest payment over the PPP term rests with the Department of Health.

Financial instruments categorisation

Categories of financial assets

Financial assets are recognised when the RCH becomes party to the contractual provisions to the instrument. For financial assets, this is at the date the RCH commits itself to either the purchase or sale of the asset (i.e. trade date accounting is adopted).

Financial instruments (except trade receivables) are initially measured at fair value plus transaction costs, except where the instrument is classified at fair value through net result, in which case transaction costs are expensed to profit or loss immediately.

Where available, quoted prices in an active market are used to determine fair value. In other circumstances, valuation techniques are adopted.

Trade receivables are initially measured at the transaction price if the trade receivables do not contain a significant financing component or if the practical expedient has been applied in AASB 15 paragraph 63.

Financial assets at amortised cost

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

- the assets are held by the RCH solely to collect the contractual cash flows, and

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

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

The RCH recognises the following assets in this category:

- cash and deposits
- receivables (excluding statutory receivables) and
- term deposits

Financial assets at fair value through net result

The RCH initially designates a financial instrument as measured at fair value through net result if:

- it eliminates or significantly reduces a measurement or recognition inconsistency (often referred to as an "accounting mismatch") that would otherwise arise from measuring assets or recognising the gains and losses on them, on a different basis
- it is in accordance with the documented risk management or investment strategy and information about the groupings was documented appropriately, so the performance of the financial asset can be managed and evaluated consistently on a fair value basis, or
- it is a hybrid contract that contains an embedded derivative that significantly modifies the cash flows otherwise required by the contract.

The initial designation of the financial instruments to measure at fair value through net result is a one-time option on initial classification and is irrevocable until the financial asset is derecognised.

The RCH recognises listed equity securities as mandatorily measured at fair value through net result and has designated all managed investment schemes as well as certain 5-year government bonds as fair value through net result.

Categories of financial liabilities

Financial liabilities are recognised when the RCH becomes a party to the contractual provisions to the instrument. Financial instruments are initially measured at fair value plus transaction costs, except where the instrument is classified at fair value through profit or loss, in which case transaction costs are expensed to profit or loss immediately.

Financial liabilities at amortised cost

Financial liabilities are measured at amortised cost using the effective interest method, where they are not held at fair value through net result.

The effective interest method is a method of calculating the amortised cost of a debt instrument and of allocating interest expense in net result over the relevant period. The effective interest is the internal rate of return of the financial asset or liability. That is, it is the rate that exactly discounts the estimated future cash flows through the expected life of the instrument to the net carrying amount at initial recognition.

The RCH recognises the following liabilities in this category:

- payables (excluding statutory payables and contract liabilities)
- borrowings and

- other liabilities (including monies held in trust)

Offsetting financial instruments

Financial instrument assets and liabilities are offset and the net amount presented in the consolidated balance sheet when, and only when, the RCH has a legal right to offset the amounts and intend wither to settle on a net basis or to realise the asset and settle the liability simultaneously.

Some master netting arrangements do not result in an offset of balance sheet assets and liabilities. Where the RCH does not have a legally enforceable right to offset recognised amounts, because the right to offset is enforceable only on the occurrence of future events such as default, insolvency or bankruptcy, they are reported on a gross basis.

Derecognition of financial assets

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

- the rights to receive cash flows from the asset have expired, or
- the RCH 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 RCH has transferred its rights to receive cash flows from the asset and either:
    - has transferred substantially all the risks and rewards of the asset, or
    - has neither transferred nor retained substantially all the risks and rewards of the asset but has transferred control of the asset

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

Derecognition of financial liabilities

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

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 'other economic flows' in the comprehensive operating statement.

Reclassification of financial instruments

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

A financial liability reclassification is not permitted.

Note 7.2: Financial risk management objectives and policies

As a whole, the RCH's financial risk management program seeks to manage the risks and the associated volatility of its financial performance.

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 above are disclosed throughout the financial statements.

The RCH's main financial risks include credit risk, liquidity risk, foreign currency risk and interest rate risk. RCH manages these financial risks in accordance with its financial risk management policy.

Primary responsibility for the identification and management of financial risks rests with the Accountable Officer.

Note 7.2(a) Credit risk

Credit risk refers to the possibility that a borrower will default on its financial obligations as and when they fall due. The RCH's exposure to credit risk arises from the potential default of a counter party on their contractual obligations resulting in financial loss to the RCH. Credit risk is measured at fair value and is monitored on a regular basis.

Credit risk associated with the RCH's contractual financial assets is minimal because the main debtor is the Victorian Government. For debtors other than the Victorian Government, the RCH is exposed to credit risk associated with patient debtors and sundry debtors.

In addition, the RCH does not engage in hedging for its contractual financial assets and mainly obtains contractual financial assets that are on fixed interest, except for cash and deposits, which are mainly cash at bank. As with the policy for debtors, the RCH's policy is to only deal with bank approved by the Victorian Government under Central Banking System (CBS) arrangements.

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

Contractual financial assets are written off against the carrying amount when there is no reasonable expectation of recovery. Bad debt written off by mutual consent is classified as a transaction expense. Bad debt written off following a unilateral decision is recognised as other economic flows in the net result.

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 the RCH's maximum exposure to credit risk without taking account of the value of any collateral obtained.

There has been no material change to the RCH's credit risk profile in 2024-25.

Impairment of financial assets under AASB 9

The RCH records the allowance for expected credit loss for the relevant financial instruments applying AASB 9's expected credit loss approach. Subject to AASB 9, the impairment assessment includes the health service's contractual receivables.

The credit loss allowance is classified as other economic flows in the net result.

Contractual receivables at amortised cost

The RCH applies AASB 9's simplified approach for all contractual receivables to measure expected credit losses using a lifetime expected loss allowance based on the assumptions about risk of default and expected loss rates. The RCH has grouped contractual receivables on shared credit risk characteristics and days past due and select the expected credit loss rate based on the RCH's past history, existing market conditions, as well as forward looking estimates at the end of the financial year.

On this basis, the RCH determines the closing loss allowance at the end of the financial year as follows:

2024	Less than 1 month	1-3 months	3-12 months	1-5 years	Total
Expected loss rate	0.1%	0.8%	38.3%	99.7%	5.3%
Gross carrying amount of contractual receivables ($'000)	20,212	10,034	2,024	892	33,162
Loss allowance ($'000)	(15)	(80)	(776)	(889)	(1,759)

2025	Less than 1 month	1-3 months	3-12 months	1-5 years	Total
Expected loss rate	0.1%	0.2%	16.3%	89.5%	6.8%
Gross carrying amount of contractual receivables ($'000)	17,939	11,536	2,932	2,048	34,455
Loss allowance ($'000)	(19)	(24)	(479)	(1,834)	(2,356)

Statutory receivables at amortised cost

The RCH's non-contractual receivables arising from statutory requirements are not financial instruments. However, they are nevertheless recognised and measured in accordance with AASB 9 requirements as if those receivables are financial instruments.

Statutory receivables are considered to have low credit risk, considering the counterparty's credit rating, risk of default and capacity to meet contractual cash flow obligations in the near term. As a result, no loss allowance has been recognised.

Note 7.2(b) Liquidity risk

Liquidity risk arises from being unable to meet financial obligations as they fall due.

The RCH is exposed to liquidity risk mainly through the financial liabilities as disclosed in the balance sheet and the amounts related to financial guarantees. The health service manages its liquidity risk by:

- close monitoring of its short-term and long-term borrowings by senior management, including monthly reviews on current and future borrowing levels and requirements
- maintaining an adequate level of uncommitted funds that can be drawn at short notice to meet its short-term obligations
- careful maturity planning of its financial obligations based on forecasts of future cash flows.

The RCH's exposure to liquidity risk is deemed insignificant based on prior period data and current assessment of risk. The RCH, deemed as essential service, relies on Victorian Government funding to meet its liquidity needs

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

2024	Note	Carrying amount as at 30 June 2024 $'000	Nominal amount as at 30 June 2024 $'000	Maturity dates: Less than 1 month $'000	1-3 months $'000	3-12 months $'000	1-5 years $'000	More than 5 years $'000
Financial liabilities								
Payables	5.4	58,051	58,051	48,525	9,426	100	-	-
TCV loan	6.1	20,942	20,942	201	203	933	5,476	14,129
Lease liability	6.1	766,817	766,817	58	11,293	35,175	208,364	511,928
		845,810	**845,810**	**48,785**	**20,922**	**36,208**	**213,839**	**526,056**

2025	Note	Carrying amount as at 30 June 2025 $'000	Nominal amount as at 30 June 2025 $'000	Maturity dates: Less than 1 month $'000	1-3 months $'000	3-12 months $'000	1-5 years $'000	More than 5 years $'000
Financial liabilities								
Payables	5.4	49,808	49,808	39,313	10,429	67	-	-
TCV loan	6.1	19,604	19,604	106	213	981	5,752	12,553
Lease liability	6.1	720,932	720,932	108	11,951	37,321	217,918	453,634
		790,344	**790,344**	**39,527**	**22,593**	**38,368**	**223,670**	**466,187**

Note 7.2(c) Market risk

The RCH's exposure to market risk is primarily through interest rate risk. Objectives, policies and processes used to manage this risk is disclosed below.

Interest rate risk

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate because of changes in market interest rates. The RCH does not hold any interest-bearing financial instruments that are measured at fair value, and therefore has no exposure to fair value interest rate risk.

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 RCH has minimal exposure to cash flow interest rate risks through cash and deposits that are at floating rate.

Note 7.3: Contingent assets and contingent liabilities

Contingent assets and contingent liabilities are not recognised in the balance sheet, but are disclosed and, if quantifiable, are measured at nominal value.

Contingent assets and contingent liabilities are presented inclusive of GST receivable or payable respectively.

Contingent assets

Contingent assets are possible assets that arise from past events, whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the health service.

These are classified as either quantifiable, where the potential economic benefit is known, or non-quantifiable.

Contingent liabilities

Contingent liabilities are:

- possible obligations that arise from past events, whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the health service, or
- present obligations that arise from past events but are not recognised because:

- It is not probable that an outflow of resources embodying economic benefits will be required to settle the obligations or
- the amount of the obligations cannot be measured with sufficient reliability.

Contingent liabilities are also classified as either quantifiable or non-quantifiable.

As of 30 June 2025, the RCH is not aware of any contingent assets or liabilities.

Note 7.4: Fair value determination

Fair value measurement

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

The following assets and liabilities are carried at fair value:

- Financial assets and liabilities at fair value through net result
- Property, plant and equipment
- Right-of-use assets
- Investment properties

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

Valuation hierarchy

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

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

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

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

Identifying unobservable inputs (level 3) fair value measurements

Level 3 fair value inputs are unobservable valuation inputs for an asset or liability. These inputs require significant judgement and assumptions in deriving fair value for both financial and non-financial assets.

Unobservable inputs are used to measure fair value to the extent that relevant observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity for the asset or liability at the measurement date. However, the fair value measurement

objective remains the same, i.e., an exit price at the measurement date from the perspective of a market participant that holds the asset or owes the liability. Therefore, unobservable inputs shall reflect the assumptions that market participants would use when pricing the asset or liability, including assumptions about risk.

Note 7.4(a) Fair value determination of investments and other financial assets

2024	Note	Carrying amount as at 30 June 2024 $'000	Fair value measurement at end of reporting period using: Level 1 [(i)] $'000	Level 2 [(i)] $'000	Level 3 [(i)] $'000
Other financial assets					
Managed funds	5.2	95,960	7,734	71,521	16,705
Total financial assets held at feir value through profit or loss		**95,960**	**7,734**	**71,521**	**16,705**
Total		**95,960**	**7,734**	**71,521**	**16,705**

2025	Note	Carrying amount as at 30 June 2025 $'000	Fair value measurement at end of reporting period using: Level 1 [(i)] $'000	Level 2 [(i)] $'000	Level 3 [(i)] $'000
Other financial assets					
Managed funds	5.2	-	-	-	-
Total financial assets held at feir value through profit or loss		**-**	**-**	**-**	**-**
Total		**-**	**-**	**-**	**-**

The managed funds consist of investments held by The Royal Children's Hospital Foundation Limited which was derecognised on 22 August 2024. Refer to Note 1.2

Note 7.4(b) Fair value determination of non-financial physical assets

2024	Note	Carrying amount as at 30 June 2024 $'000	Fair value measurement at end of reporting period using: Level 1 [(i)] $'000	Level 2 [(i)] $'000	Level 3 [(i)] $'000
Land at fair value					
Non-specialised land		17,950	-	17,950	-
Specialised land		144,884	-	-	144,884
Total land at fair value	4.1	**162,834**	-	**17,950**	**144,884**
Buildings at fair value					
Non-specialised buildings		6,320	-	6,320	
Specialised buildings		6,119	-		6,119
Total buildings at fair value	4.1	**12,439**	-	**6,320**	**6,119**
Investment properties			-		
Investment properties		9,262	-	9,262	-
Total investment properties		**9,262**	-	**9,262**	-
Other plant and equipment at fair value					
Plant and equipment		578	-	-	578
Motor vehicles		504	-	-	504
Medical equipment		38,942	-	-	38,942
Computers and communication equipment		5,444	-	-	5,444
Furniture and fittings		1,274	-	-	1,274
Cultural assets		607	-	607	-
Right of use - PP&E, furniture & fittings and vehicles		1,993	-	1,993	-
Total other plant and equipment at fair value	4.1	**49,342**	-	**2,600**	**46,742**
PPP assets at fair value					
PPP - specialised leased buildings		1,511,078	-	-	1,511,078
PPP - other leased assets		47,718	-	-	47,718
Total right of use PPP assets at fair value	4.1	**1,558,796**	-	-	**1,558,796**
Total		**1,792,673**	-	**36,132**	**1,756,541**

2025	Note	Carrying amount as at 30 June 2025 $'000	Fair value measurement at end of reporting period using: Level 1 (i) $'000	Level 2 (i) $'000	Level 3 (i) $'000
Land at fair value					
Non-specialised land		15,850	-	15,850	-
Specialised land		144,884	-	-	144,884
Total land at fair value	4.1	**160,734**	-	**15,850**	**144,884**
Buildings at fair value					
Non-specialised buildings		3,416	-	3,416	-
Specialised buildings		5,693	-	-	5,693
Total buildings at fair value	4.1	**9,109**	-	**3,416**	**5,693**
Investment properties					
Investment properties		7,463	-	7,463	-
Total investment properties		**7,463**	-	**7,463**	-
Other plant and equipment at fair value					
Plant and equipment		636	-	-	636
Motor vehicles		586	-	-	586
Medical equipment		36,582	-	-	36,582
Computers and communication equipment		4,921	-	-	4,921
Furniture and fittings		2,780	-	-	2,780
Cultural assets		607	-	607	-
Right of use - PP&E, furniture & fittings and vehicles		1,705	-	1,705	-
Total other plant and equipment at fair value	4.1	**47,816**	-	**2,312**	**45,504**
PPP assets at fair value					
PPP - specialised leased buildings		1,464,984	-	-	1,464,984
PPP - other leased assets		44,957	-	-	44,957
Total right of use PPP assets at fair value	4.1	**1,509,941**	-	-	**1,509,941**
Total		**1,735,063**	-	**29,041**	**1,706,022**

(i) Classified in accordance with the fair value hierarchy.

Non-financial physical assets fair value measurements

The fair value of non-financial physical assets reflects their highest and best use, considering whether market participants would use the asset similarly or sell it for that purpose. This assessment takes into account the asset's characteristics and any physical, legal, or contractual restrictions.

The RCH assumes the current use reflects highest and best use unless market or other factors indicate otherwise. Potential alternative uses are only considered when it is virtually certain that restrictions will no longer apply.

Fair value is based on periodic valuations by independent valuers, which normally occur once every five years, based upon the asset's Government Purpose Classification, but may occur more frequently if fair value assessments indicate a material change in fair value has occurred.

Where an independent valuation has not been undertaken at balance date, the RCH perform a fair value assessment to estimate possible changes in value since the date of the last independent valuation with reference to Valuer-General of Victoria (VGV) indices.

An adjustment is recognised if the assessment concludes that the fair value of non-financial physical assets has changed by 10% or more since the last revaluation (whether that be the most recent independent valuation or fair value assessment). Any estimated change in fair value of less than 10% is deemed immaterial to the financial statements and no adjustment is recorded. Where the assessment indicates there has been an exceptionally material movement in the fair value since the last independent valuation, being equal to or in excess of 40%, the RCH would obtain an interim independent valuation prior to the next scheduled independent valuation.

AASB 2022-10 Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities amended AASB 13 by adding Appendix F Australian implementation guidance for not-for-profit public sector entities. Appendix F explains and illustrates the application of the principles in AASB 13 on developing unobservable inputs and the application of the cost approach. These clarifications are mandatorily applicable annual reporting periods beginning on or after 1 January 2024. FRD 103

permits Victorian public sector entities to apply Appendix F of AASB 13 in their next scheduled formal asset revaluation or interim revaluation (whichever is earlier).

An independent valuation of the RCH's non-financial physical assets was performed by the VGV on 30 June 2024. Fair value assessments have therefore been performed for all classes of assets in this purpose group at 30 June 2025 and the decision was made that the movements were not material (less than or equal to 10%). As such, an independent revaluation was not required per FRD 103. In accordance with FRD 103, the RCH will apply Appendix F of AASB 13 prospectively in its next scheduled formal revaluation in 2029 or interim revaluation process (whichever is earlier). The RCH does not expect the impact to be material to the financial statements.

There were no changes in valuation techniques throughout the period to 30 June 2025.

Non-specialised land, non-specialised buildings and cultural assets

Non- specialised land, non-specialised buildings and cultural assets are valued using the market approach. Under this valuation method, the assets are compared to recent comparable sales or sales of comparable assets which are considered to have nominal or no added improvement value.

For non-specialised land and non-specialised buildings, an independent valuation was performed by the Valuer-General Victoria to determine the fair value using the market approach. Valuation of the assets was determined by analysing comparable sales and allowing for share, size, topography, location and other relevant factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30 June 2024.

For cultural assets, the Valuer-General Victoria is the RCH's independent valuer.

Specialised land and specialised buildings

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

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

The market approach is also used for specialised land although it is adjusted for the community service obligation (CSO) to reflect the specialised nature of the assets being valued. Specialised assets contain significant, unobservable adjustments; therefore, these assets are classified as Level 3 under the market based direct comparison approach.

The CSO adjustment reflects the valuer's assessment of the impact of restrictions associated with an asset to the extent that is also equally applicable to market participants. This approach is in light of the highest and best use consideration required for fair value measurement and considers the use of the asset that is physically possible, legally permissible and financially feasible. As adjustments of CSO are considered as significant unobservable inputs, specialised land would be classified as Level 3 assets.

For the RCH, the current replacement cost method is used for the majority of specialised buildings, adjusting for the associated depreciation. As depreciation adjustments are considered as significant and unobservable inputs in nature, specialised buildings are classified as Level 3 for fair value measurements.

An independent valuation of the RCH's specialised land and specialised buildings was performed by the Valuer-General Victoria. The effective date of the valuation is 30 June 2024.

Vehicles

The RCH acquires new vehicles and at times disposes of them before completion of their economic life. The process of acquisition, use and disposal in the market is managed by the health service who set relevant depreciation rates during use to reflect the consumption of the vehicles. As a result, the fair value of vehicles does not differ materially from the carrying amount (depreciated cost).

Furniture, fittings, plant and equipment

Furniture, fittings, plant and equipment (including medical equipment, computers and communication equipment) are held at fair value. When plant and equipment is specialised in use, such that it is rarely sold other than as part of a going concern, the current replacement cost is used to estimate the fair value.

Note 7.4(c) Reconciliation of level 3 fair value[(i)]

2024	Land $'000	Buildings $'000	Plant and equipment $'000	Motor vehicles $'000	Medical equipment $'000	Computers and comm. $'000	Furniture and fittings $'000	PPP assets[(ii)] $'000
Balance at 1 July 2023	**152,913**	**2,856**	**814**	**34**	**26,526**	**5,963**	**2,934**	**1,269,319**
Additions/(disposals)	-	-	67	521	19,643	1,557	660	5,508
Reclassification	-	12,694	-	-	-	-	-	-
Net transfers between classes	-	-	(119)	-	-	69	(1,802)	1,794
Depreciation and amortisation	-	(379)	(184)	(51)	(7,227)	(2,138)	(518)	(52,117)
Derecognition of joint arrangement	-	-	-	-	-	(7)	(0)	-
Revaluation	(8,030)	(9,052)	-	-	-	-	-	334,292
Balance at 30 June 2024	**144,884**	**6,119**	**578**	**504**	**38,942**	**5,444**	**1,274**	**1,558,796**
Additions/(disposals)	-	-	181	251	5,227	1,191	1,736	16,781
Net transfers between classes	-	-	-	-	-	-	-	175
Depreciation and amortisation	-	(426)	(124)	(161)	(7,587)	(1,700)	(229)	(65,811)
Derecognition of controlled entity	-	-	-	(8)	-	(14)	-	-
Balance at 30 June 2025	**144,884**	**5,693**	**636**	**585**	**36,582**	**4,921**	**2,780**	**1,509,941**

i. Classified in accordance with the fair value hierarchy, refer Note 7.4.

Note 7.4(d) Description of significant unobservable inputs to level 3 valuations

Asset class	Valuation technique	Significant unobservable inputs
Specialised land	Market approach	Community service obligations adjustments[(i)]
Specialised buildings	Current replacement cost approach	Direct cost per square meter Useful life of specialised buildings
Plant and equipment	Current replacement cost approach	Useful life
Motor vehicles	Current replacement cost approach	Useful life
Medical equipment	Current replacement cost approach	Useful life
Computers and communication equipment	Current replacement cost approach	Useful life
Furniture and fittings	Current replacement cost approach	Useful life
PPP assets	Current replacement cost approach	Building cost per square meter Useful life

i. A community service obligations (CSO) discount of 30% was applied to the RCH's specialised land.

Note 8: Other disclosure

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

Structure

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Note 8.1: Reconciliation of net result for the year to net cash inflow/(outflow) from operating activities

	Note	2025 $'000	2024 $'000
Net result for the year		**(29,643)**	**(19,088)**
Non-cash movements			
Depreciation and amortisation	4.3	82,147	68,721
Assets and services received free of charge		(25)	(2,161)
Amortisation of non-produced intangible assets	4.2(a)	1,272	1,272
DH - indirect contribution on repayment of finance lease liabilities		(82,048)	(82,048)
DH - indirect contribution on building improvement		(12,064)	(4,766)
PPP non-cash finance lease interest expense		36,222	38,477
Revaluation of financial instruments through profit or loss		-	(7,098)
Revaluation of investment properties		-	1,609
Gain/(loss) on derecognition of joint arrangement		-	(86)
Written down value of assets disposed		232	224
Non-cash accounting adjustments in accordance with AASB 16		703	543
Movements included in investing and financing activities			
(Increase)/decrease in payables for capital items		(733)	627
GST paid for capital items		1,367	2,257
Capital donations received		(471)	(6,782)
Movements in assets and liabilities			
Change in operating assets and liabilities			
- (increase)/decrease in receivables		(5,911)	(3,229)
- (increase)/decrease in inventories		47	(510)
- (increase)/decrease in prepayments		(1,753)	3
- increase/(decrease) in payables		(10,620)	2,164
- increase/(decrease) in employee entitlements		11,386	10,607
- increase/(decrease) in other liabilities		(203)	(307)
Net cash inflow/(outflow) from operating activities		**(10,094)**	**429**

Note 8.2: Responsible persons disclosures

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

	Period	
Responsible Ministers		
The Honourable Mary-Anne Thomas MP:		
Minister for Health	1 July 2024	30 June 2025
Former Minister for Health Infrastructure	1 July 2024	18 December 2024
Minister for Ambulance Services	1 July 2024	30 June 2025
The Honourable Ingrid Stitt MP:		
Minister for Mental Health	1 July 2024	30 June 2025
Minister for Ageing	1 July 2024	30 June 2025
The Honourable Lizzy Blandthorn MP:		
Minister for Children	1 July 2024	30 June 2025
Minister for Disability	1 July 2024	30 June 2025
The Honourable Melissa Horne MP:		
Minster for Health Infrastructure	19 December 2024	30 June 2025
Governing Board		
Dr Rowena Coutts (Chairman)	1 July 2024	30 June 2025
Ms Elleni Bereded-Samuel AM	1 July 2024	30 June 2025
Mr Andrew Chan	1 July 2024	30 June 2025
Prof Richard Doherty	1 July 2024	30 June 2025
Ms Pallavi Khanna	1 July 2024	30 June 2025
Mr Sammy Kumar	1 July 2024	30 June 2025
Ms Judith Munro AO	1 July 2024	31 July 2024
Mr Mark Rogers	1 July 2024	30 June 2025
Dr Michael Wildenauer	1 July 2024	30 June 2025
Accountable Officer		
Ms Bernadette McDonald (Former Chief Executive Officer)	1 July 2024	13 September 2024
Prof Edward Oakley (Interim Chief Executive Officer)	14 September 2024	28 February 2025
Dr Peter Steer (Chief Executive Officer)	1 March 2025	30 June 2025

Remuneration of Responsible Persons

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

Income band	2025 No.	2024 No.
$0 - $9,999	1	-
$40,000 - $49,999	7	8
$90,000 - $99,999	1	1
$250,000 - $259,999	1	-
$270,000 - $279,999	1	-
$280,000 - $289,999	1	-
$490,000 - $499,999	-	1
Total	**12**	**10**

	Total remuneration	
	2025 $'000	2024 $'000
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**1,237**	**940**

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

Note 8.3: Remuneration of executives

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

	Total remuneration	
	2025 $'000	2024 $'000
Short term employee benefits	2,224	2,138
Post employment benefits	221	199
Other long term benefits	123	139
Total remuneration	**2,569**	**2,475**
Total number of executives	**9**	**10**
Total annualised employee equivalent (AEE)	**7.00**	**7.00**

(i) Annualised employee equivalent is based on working 38 ordinary hours per week over the reporting period.

Remuneration comprises employee benefits in all forms of consideration paid, payable or provided in exchange for services rendered, and is disclosed in the following categories.

Short-term employee benefits

Salaries and wages, annual leave or sick leave that is usually paid or payable on a regular basis, as well as non-monetary benefits such as allowances and free or subsidised goods or services

Post-employment benefits

Pensions and other retirement benefits (such as superannuation guarantee contributions) paid or payable on a discrete basis when employment has ceased

Other long-term benefits

Long service leave

Note 8.4: Related parties

The RCH is a wholly owned and controlled entity of the State of Victoria. Related parties of the RCH include:

- all key management personnel (KMP) and their close family members and personal business interests
- cabinet ministers (where applicable) and their close family members
- all health services and public sector entities that are controlled and consolidated into the State of Victoria financial statements.

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

All related party transactions have been entered into on an arm's length basis.

Key management personnel

Significant management judgment is applied when determining KMPs of the RCH. Under AASB 124, the RCH has determined that the Board of Directors and the CEO of the RCH are deemed to be KMPs, as they have the authority and responsibility for planning, directing and controlling the RCH activities and direction as a whole.

KMPs of the RCH includes the following:

	Period	
Governing Board		
Dr Rowena Coutts (Chairman)	1 July 2024	30 June 2025
Ms Elleni Bereded-Samuel AM	1 July 2024	30 June 2025
Mr Andrew Chan	1 July 2024	30 June 2025
Prof Richard Doherty	1 July 2024	30 June 2025
Ms Pallavi Khanna	1 July 2024	30 June 2025
Mr Sammy Kumar	1 July 2024	30 June 2025
Ms Judith Munro AO	1 July 2024	31 July 2024
Mr Mark Rogers	1 July 2024	30 June 2025
Dr Michael Wildenauer	1 July 2024	30 June 2025
Accountable Officer		
Ms Bernadette McDonald (Former Chief Executive Officer)	1 July 2024	13 September 2024
Prof Edward Oakley (Interim Chief Executive Officer)	14 September 2024	28 February 2025
Dr Peter Steer (Chief Executive Officer)	1 March 2025	30 June 2025

The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The Minister's remuneration and allowances is set by the *Parliamentary Salaries and Superannuation Act 1968*, and is reported within the State's Annual Financial Report.

	Total compensation	
	2025 $'000	2024 $'000
Short term employee benefits	955	848
Post employment benefits	79	75
Other long term benefits	(38)	17
Termination benefits	240	-
Total compensation	**1,237**	**940**

i. KMP are also reported in note 8.2 Responsible persons disclosures.

Significant transactions with government-related parties

The RCH received funding from the Department of Health of $701 million (2024: $707 million) and indirect contributions of $176 million (2024: $165 million).

The RCH also received funding from the Department of Education and Training of $0.9 million (2024: $4.8million) and Department of Families, Fairness and Housing of $6.4 million (2024: $6.9 million)

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

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

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

Transactions with KMPs and other related parties

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

Outside of normal citizen type transactions with the RCH, there were no related party transactions that involved key management personnel, their close family members or their personal business interests. No provision has been required, nor any expense recognised, for impairment of receivables from related parties. There were no related party transactions with Cabinet Ministers required to be disclosed in 2025 (2024: none).

All other transactions that have occurred with KMP and their related parties are outlined below. In this context, transactions are only disclosed when they are considered of interest to users of the financial report in making and evaluation decisions about the allocation of scarce resources.

The Royal Children's Hospital Foundation

One Board member and the CEO of the RCH was a Director of the RCH Foundation during 2024-25 financial year

The transactions between the two entities relate to reimbursements made by the RCH Foundation to the RCH for goods and services and the transfer of funds by way of distributions made to the hospital. All dealings are in the normal course of business and are on normal commercial terms and conditions.

	2025 $'000	2024 $'000
Distributions and reimbursements by The Royal Children's Hospital Foundation	50,858	31,328
Payments to The Royal Children's Hospital Foundation	-	262
Receivable from The Royal Children's Hospital Foundation	2,561	5,576

Murdoch Children's Research Institute

The CEO of the RCH was a Director of Murdoch Children's Research Institute (MCRI) during 2024-25 financial year.

The transactions between the two entities relate to reimbursements made by MCRI to the RCH for salaries, goods and services paid on its behalf. In addition, the transactions relate to general research funding, clinical supplies and support provided to MCRI. All dealings are in the normal course of business and are on normal commercial terms and conditions.

	2025 $'000	2024 $'000
Reimbursements by Murdoch Children's Research Institute	7,990	7,261
Payments to Murdoch Children's Research Institute	35,524	26,904
Receivable from Murdoch Children's Research Institute	476	351
Payable to Murdoch Children's Research Institute	1,293	-

Victorian Clinical Genetics Services

Victorian Clinical Genetics Services (VCGS) is a wholly owned subsidiary of MCRI of which the CEO of the RCH was a Director during 2024-25 financial year.

The transactions between the two entities relate to reimbursements made by VCGS to the RCH for goods and services paid on its behalf. In addition, the transactions relate to general research funding, clinical supplies and support provided to VCGS. All dealings are in the normal course of business and are on normal commercial terms and conditions.

	2025 $'000	2024 $'000
Reimbursements by Victorian Clinical Genetics Services	88	72
Payments to Victorian Clinical Genetics Services	1,631	1,355
Receivable from Victorian Clinical Genetics Services	3	3
Payable to Victorian Clinical Genetics Services	-	9

Melbourne Genomics

The CEO of the RCH was a Director of Melbourne Genomics during 2024-25 financial year.

The transactions between the two entities relate to reimbursements made by Melbourne Genomics to the RCH for salaries, and research costs associated with the genomic immersion. All dealings are in the normal course of business and are on normal commercial terms and conditions.

	2025 $'000	2024 $'000
Reimbursements by Melbourne Genomics Health Alliance	138	204

Medibank Private

One Board member of the RCH was an employee of the Medibank Private during 2024-25 financial year.

The transactions between the RCH and Medibank Private consist of patient insurance claims. All dealings are in the normal course of business and are on normal commercial terms and conditions.

	2025 $'000	2024 $'000
Reimbursements by Medibank Private	5,359	4,446
Receivable from Medibank Private	427	1,039

Australian Health Management (AHM)

AHM is a wholly owned subsidiary of Medibank Private of which one Board member of the RCH was an employee during 2024-25 financial year.

The transactions between the RCH and AHM consist of patient insurance claims. All dealings are in the normal course of business and are on normal commercial terms and conditions.

	2025 $'000	2024 $'000
Reimbursements by Australian Health Management	849	775
Receivable from Australian Health Management	127	133

Uniting Victoria Tasmania Limited

One former Board member of the RCH was the Chair of Uniting Victoria Tasmania Limited. The transactions between the RCH and Uniting Victoria Tasmania consist of various workforce training services. All dealings are in the normal course of business and are on normal commercial terms and conditions.

	2025 $'000	2024 $'000
Reimbursements by Uniting Victoria Tasmania Limited	8	23
Receivable from Uniting Victoria Tasmania Limited	1	4

Australian Catholic University

The CEO of the RCH was the Senate Member of Australian Catholic University (ACU) during 2024-25 financial year. The transactions between the RCH and ACU consist of student placement for medical courses and delivery of workshop. All dealings are in the normal course of business and are on normal commercial terms and conditions.

	2025 $'000	2024 $'000
Reimbursements by Australian Catholic University	77	82

Note 8.5: Remuneration of auditors

	2025 $'000	2024 $'000
Victorian Auditor-General's Office		
Audit of financial statements	254	239
Other service providers		
Audit of financial statements	-	32
Compilation of financial statements & financial reporting advice	-	10
	254	**281**

Note 8.6: Ex-gratia payments

	2025 $'000	2024 $'000
The RCH has made the following ex gratia expenses:		
Forgiveness or waiver of debt	11	-
Compensation for economic loss	6	44
Total ex-gratia expenses	**16**	**44**

Includes ex-gratia for both individual items and in aggregate that are greater than or equal to $5,000.

Ex gratia expenses are the voluntary payments of money or other non-monetary benefit (e.g. a write off) that are not made either to acquire goods, services or other benefits for the entity or to meet a legal liability, or to settle or resolve a possible legal liability of or claim against the entity.

Note 8.7: Events occurring after the balance sheet date

Professor Christine Kilpatrick has been appointed as the new Board Chair of the RCH, effective 1 July 2025.

Note 8.8: Controlled entity

	Country of incorporation/ establishment	Equity holding
Name of entity		
The Royal Children's Hospital Foundation Limited	Australia	N/A

	2025 $'000	2024 $'000
Net result for the year		
The Royal Children's Hospital Foundation Limited	-	(12,112)
	-	**(12,112)**

The Royal Children's Hospital Foundation Limited has been derecognised on 22 August 2024. Details of the principles of consolidation are set out in Note 1.2.

Note 8.9: Equity

Contributed capital

Contributions by owners (that is, contributed capital and its repayment) are treated as equity transactions and, therefore, do not form part of the income and expenses of the RCH.

Transfers of net assets arising from administrative restructurings are treated as distributions to or contributions by owners. Transfers of net liabilities arising from administrative restructurings are treated as distributions to owners.

Other transfers that are in the nature of contributions or distributions or the have been designated as contributed capital are also treated as contributed capital.

Property, plant and equipment revaluation surplus

The property, plant and equipment revaluation surplus arises on the revaluation of infrastructure, land and buildings. The revaluation surplus is not normally transferred to the accumulated surpluses/(deficits) on derecognise of the relevant assets.

Restricted specific purpose reserves

The specific restricted purpose reserves are funds where the RCH has possession or title to the funds but has no discretion to amend or vary the restriction and/or condition underlying the funds received.

The Royal Children's Hospital Melbourne

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