AlfredHealth

Annual Report 2013–14

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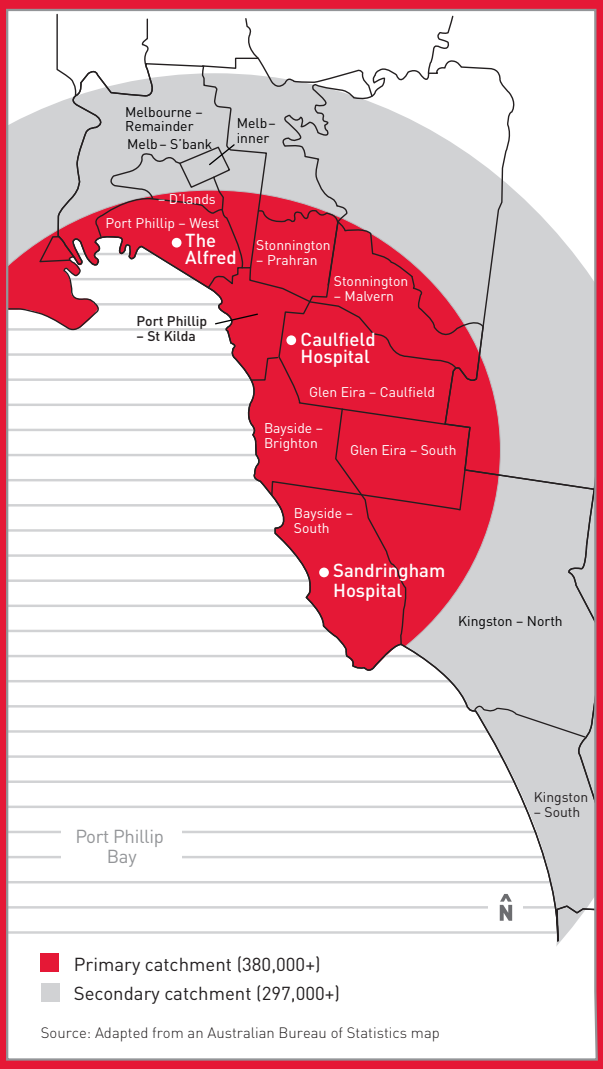
Alfred Health's primary and secondary catchments



About the cover:

The Hospital @ Night team was introduced in 2013. Led by an After Hours Clinical Lead, the team ensures medical and nursing staff have access to high-level clinical leadership and decision making at all hours (see page 7). From left: Janine Shiels, Hospital @ Night Nurse; Carmel Lackey, After Hours Clinical Operations Manager; Dr Jessica O'Brien, General Medicine registrar; and Dr Owen Roodenburg, Deputy Director, Intensive Care.

Our vision

Trusted to deliver outstanding care

Our mission

Highest-quality clinical practice:

> Delivered in partnership with patients, carers, the community and other healthcare providers.

> Enabled through innovation, research and education.

Our values

Integrity

We engage others in a respectful, fair and ethical manner, fulfilling our commitments as professionals and employees. We ensure the highest degree of dignity, equity, honesty and trust.

Accountability

We show pride, enthusiasm and dedication in everything that we do. We ensure quality patient care and use resources appropriately. We accept professional responsibility for all our decisions and actions.

Collaboration

We consult and collaborate with others and respect the diverse knowledge and skills of our partners; working as a team, we ensure the best inter-professional patient care.

Knowledge

We create opportunities for education and are committed to continuous development. We enable everyone to make knowledge-based decisions.

About this report

This annual report outlines the operational and financial performance for Alfred Health from 1 July 2013 to 30 June 2014. Alfred Health is a multi-site health service provider, with three hospital campuses – The Alfred, Caulfield Hospital and Sandringham Hospital – as well as several clinics and a range of community-based services.

The relevant ministers for the period were the Minister for Health and the Minister for Ageing, the Hon. David Davis MLC and the Minister for Mental Health, the Hon. Mary Wooldridge MLA.

Alfred Health is a metropolitan health service established under section 181 of the *Health Services Act 1988* (Vic) in June 2000. Established as Bayside Health, the name was changed to Alfred Health from 10 September 2008, by order of the Governor in Council.

This report is available online at: www.alfredhealth.org.au/publications

About Alfred Health

Alfred Health is a leading major metropolitan health service, serving more than 680,000 people living in Melbourne's bayside and inner southeast areas. We have three hospital campuses – The Alfred, Caulfield Hospital and Sandringham Hospital – as well as clinics and a range of community-based services.

We provide the most comprehensive range of specialist medical and surgical services in Victoria and deliver 12 statewide services. Our aim is to provide the best possible health outcomes for our patients and community by integrating clinical practice with research and education.

Partnerships are integral to realising our vision, *trusted to deliver outstanding care*, and Alfred Health actively seeks opportunities for innovation through strategic partnerships.

We have a strong commitment to research, especially to undergraduate and postgraduate training for medical, nursing, allied health and other support staff. This is facilitated through partnerships with Monash University and La Trobe University. We also have important research and development links with the Baker IDI, the Burnet Institute and Monash University – our partners in the Alfred Medical Research and Education Precinct (AMREP).

Recognised as a national pacesetter, Alfred Health is consistently linked to progressive developments in healthcare services, medical research and healthcare teaching. We strive to deliver tomorrow's care today through understanding, anticipating and addressing our community's health needs now and in the future.

Our three hospital campuses:

The Alfred, a major tertiary referral hospital, is best known as one of Australia's busiest emergency and trauma centres and home to the largest and most advanced intensive care unit in the region.

Caulfield Hospital specialises in community services, rehabilitation, aged care, residential care and aged mental health. Many services are delivered through outpatient and community-based programs. The hospital plays a statewide role in providing rehabilitation services.

Sandringham Hospital is community focused, meeting hospital healthcare needs for the local area through emergency, maternity, special care nursery, paediatrics, general medicine and outpatient services. The hospital works closely with local community healthcare providers.

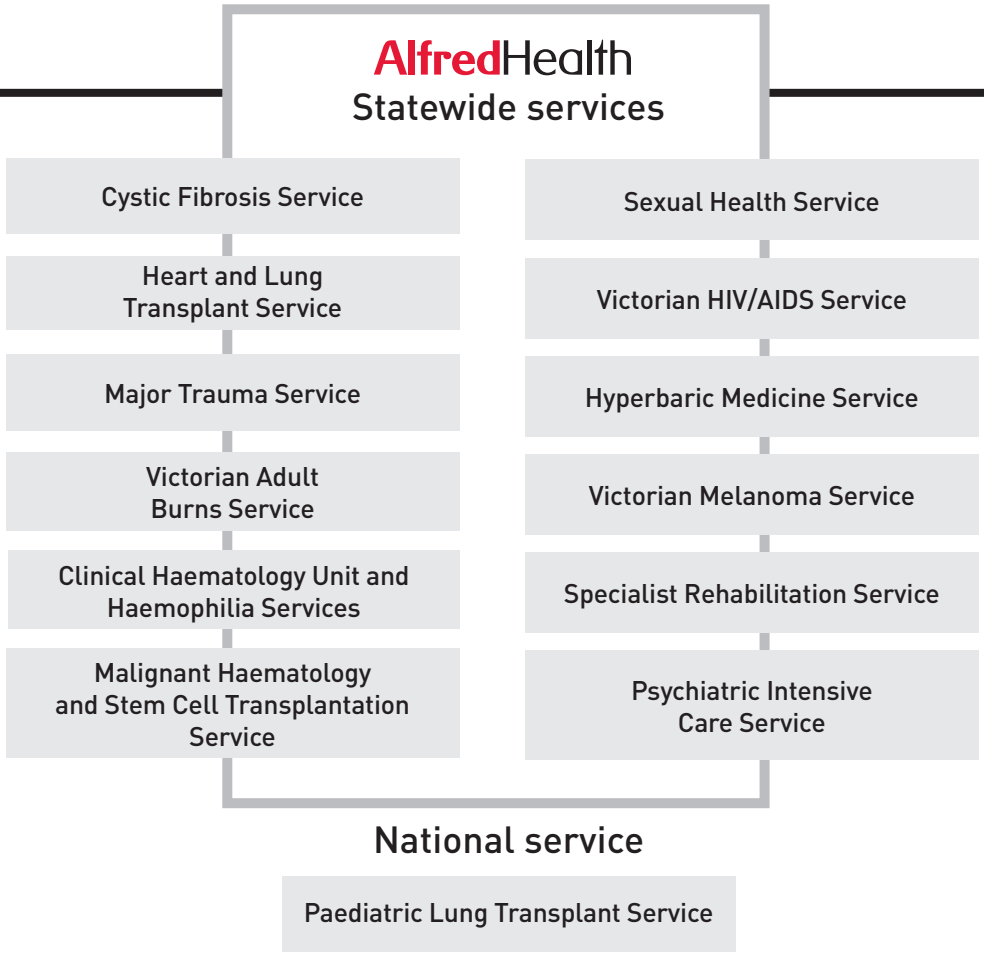
98,262
EPISODES OF INPATIENT CARE

94,535
EMERGENCY DEPARTMENT PRESENTATIONS
(admitted and non-admitted)

498
ALFRED HEALTH VOLUNTEERS

6,986
TRAUMA PATIENTS TREATED

11,756
ELECTIVE SURGERIES PERFORMED



Clinical services

We provide the most comprehensive range of specialist medical and surgical services in Victoria. We offer almost every form of medical treatment across our multiple sites and three hospital campuses.

> **Cancer Services**
- Bone Marrow Transplantation
- Radiotherapy
- Oncology
- Cancer Surgery
- Palliative Care

> **Cardiothoracic Services**
- Heart and Lung Transplantation
- Cardiology
- Cardiac Surgery
- Cardiac Rehabilitation
- Respiratory Medicine
- Thoracic Surgery
- Adult Cystic Fibrosis

> **Emergency Medicine**
- Intensive Care
- Burns
- Adult Major Trauma

> **Eye and Ear, Nose & Throat**
- Head and Neck Surgery

> **Gastrointestinal Services**
- Gastroenterology
- Gastrointestinal Surgery

> **General Medicine**

> **General Surgery**
- Breast
- Endocrine
- Colorectal Surgery

> **Infectious Diseases treatment services**

> **Neurosciences**
- Neurology
- Neurosurgery

> **Obstetrics and Gynaecology**
- *(in October 2013 services were transferred to The Royal Women's Hospital)*

> **Special Care Nursery**

> **Orthopaedics**

> **Renal Services**
- Nephrology
- Urology
- Haemodialysis
- Renal Transplantation

> **Specialist Medicine**
- Clinical Immunology
- Clinical Pharmacology
- Dermatology
- Endocrinology/Diabetes
- Hyperbaric
- Infectious Diseases
- Rheumatology

> **Specialist Surgery**
- Dental Surgery
- Faciomaxillary Surgery
- Plastic Surgery
- Vascular Surgery

> **Psychiatry**
- Adult
- Child
- Adolescent
- Youth
- Aged

> **Residential Aged Care, Geriatric Evaluation and Management**

> **Rehabilitation**

> **Community Programs**
- Melbourne Sexual Health Centre
- Community Medicine
- Alcohol and Drug Services
- Carer Support
- Community Health

Chairman and Chief Executive's review

The year focused on delivering quality healthcare and improving access while meeting increased demand within a sound financial framework.

Providing excellence in care

Alfred Health started 2013–14 as the first major metropolitan health service in Victoria to achieve accreditation under the new National Safety and Quality Heath Service Standards. We ended the year with The Alfred consistently meeting and exceeding state and federal targets for emergency access.

Demand for emergency services grew by 2.5 per cent with 94,535 presentations at The Alfred and Sandringham Hospital. Trauma care remained a priority, with 6,986 people requiring treatment, a 6 per cent increase from 2012–13.

Inpatient care grew to 98,262 episodes and, encouragingly, waiting times for surgery continued to reduce. Our financial operating result of a $0.22 million surplus was in line with expectations and a positive outcome in a rapidly changing environment.

The needs of patients come first

Satisfying both quality and demand requires flexibility and responsiveness. Over the past two years we have been building such capacity into our hospitals through the Timely Quality Care (TQC) initiative, which redesigns care around the needs of patients.

TQC places senior decision makers at the front of service delivery. Patient treatment starts at the point of arrival, so the hospital stay is only as long as is clinically required. During the year, we extended TQC from The Alfred to Caulfield Hospital's sub-acute services and planned its rollout at Sandringham Hospital for early in 2014–15.

Innovation through partnership

The cornerstone of healthcare partnership is the all-important relationship between clinicians, patients, their families and carers.

Last year, we launched our *Patients Come First* strategy to support this relationship. This year it was implemented through a variety of programs such as *Let me know*, which encourages patients and their families to escalate their concerns directly if they notice a worrying change in a patient's condition.

In terms of innovative healthcare partnerships, in October 2013 Alfred Health successfully transferred maternity and gynaecology services at Sandringham Hospital to the Royal Women's Hospital. Working effectively as a 'hospital within a hospital', this initiative responded to the increasing demand for local maternity services, ensuring that more women in the bayside area have access to local, safe, high-quality maternity and gynaecology care.

In May 2014, following the HIV Services Review and the subsequent community consultation process and report, we announced a new advisory group to help plan future HIV services, identify community needs and recognise future trends in HIV care. The HIV Service Advisory Group (HSAG) represents a significant development in direct community participation, and its membership will include people living with HIV, community agencies and representatives, and specialist clinicians. It will commence in 2014–15.

Research changing practice

Research continued to inform and develop clinical practice. In 2013–14, one of the largest ever anaesthetic drug studies confirmed nitrous oxide to be safe for major surgery. The six-year multi-centre research study, led by Alfred Health's Director of Anaesthesia & Peri-operative Medicine, Professor Paul Myles, has the potential to change clinical practice worldwide.

Funded by the National Health and Medical Research Council, the study also gives confidence to parents of children having surgery, and to women using nitrous oxide for labour pain relief.

The Monash Partners Academic Health Science Centre (AHSC), which includes Alfred Health as a founding member, continued to make strides in 2013–14. With $540,000 invested in new translational health projects, eight innovative projects will now receive seed funding. The AHSC aims to enhance the health and well-being of our community by integrating healthcare, education and research.

Chairman and Chief Executive's review

Stronger staff engagement

One of the year's most significant outcomes was increased engagement with our 8,000-strong workforce. Initiatives such as TQC and *Patients Come First* have fostered staff involvement in redesigning the care that staff are responsible for delivering. This has been further supported by employee leadership and education programs, which are well received.

Increased engagement levels were evidenced by two significant indicators: 46 per cent of staff completed the *2014 People Matters Survey*, and more than 80 per cent of staff participated in the 2014 influenza vaccination program. These are substantial increases from previous years.

Building the future

Progress continued on large-scale projects that will help shape our future healthcare service.

The building of the $36 million Acquired Brain Injury (ABI) Rehabilitation Centre at Caulfield Hospital progressed substantially during the year, with commissioning activities on track for an opening in September 2014. The ABI Centre will provide leading care and treatment for patients with moderate to severe brain injury resulting from traumatic accidents, illness or stroke.

In 2013–14, we delivered two significant programs at Sandringham Hospital: the $6.8 million refurbished Emergency Department was completed in December 2013 and its co-located Urgent Care Centre opened in May 2014, providing a new model for emergency care.

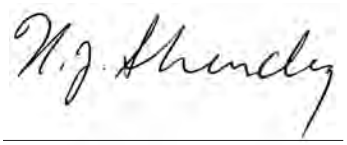
Appreciation and acknowledgement

Gratitude and thanks go to our donors and volunteers for their constant support and tireless efforts to make a difference to our patients' health and well-being.

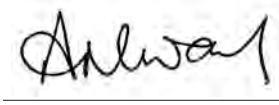
During the year, we welcomed two new Board members, Carl Putt and James Turcato, and at the end of the year farewelled David Menadue, Anthony Starkins and Tim Wilson. We thank them for their service and commitment.

Finally, to our employees and many partners, thank you for the skill and dedication that you demonstrate every day.

Looking to the future, our focus will remain on providing excellent health services through the power of innovative thinking, clinical excellence and collaborative action.



Helen Shardey
Chairman, Board of Directors



Andrew Way
Chief Executive

14 August 2014

CEO Scorecard: 2013–14

Emergency Indicators	Target	Result*
The Alfred		
< 4 Hr in ED (Jul to Dec)	75%	78%
< 4 Hr in ED (Jan to Jun)	81%	83%
> 24 Hr in ED	0	0
Attendances	N/A	60,345
Triage Seen in Time	80%	83%
Sandringham Hospital		
< 4 Hr in ED (Jul to Dec)	75%	75%
< 4 Hr in ED (Jan to Jun)	81%	76%
> 24 Hr in ED	0	0
Attendances	N/A	34,190
Triage Seen in Time	80%	78%

*Alfred Health results. They are checked and referenced to equivalent Department of Health results for accuracy and consistency.

Elective Indicators	Target	Result*
The Alfred		
Cat 1 Admit < 30 Days	100%	100%
Cat 2 Admit < 90 Days (Jul to Dec)	80%	82.1%
Cat 2 Admit < 90 Days (Jan to Jun)	88%	83.5%
Cat 3 Admit < 365 Days (Jul to Dec)	94.5%	99.3%
Cat 3 Admit < 365 Days (Jan to Jun)	97%	99.5%
HiPs	8	4.9
Alfred Health		
Waiting List	1,966	1,891
Sandringham Hospital		
Cat 1 Admit < 30 Days	100%	100%
Cat 2 Admit < 90 Days (Jul to Dec)	80%	99.3%
Cat 2 Admit < 90 Days (Jan to Jun)	88%	99.4%
Cat 3 Admit < 365 Days (Jul to Dec)	94.5%	100%
Cat 3 Admit < 365 Days (Jan to Jun)	97%	100%
HiPs	8	2.8

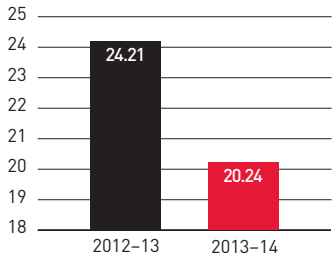
Helen Shardey
Chairman

Andrew Way
Chief Executive

Key indicators 2013–14

Innovation and new clinical practices drove improved patient outcomes during the year.

Avg LOS – Rehab

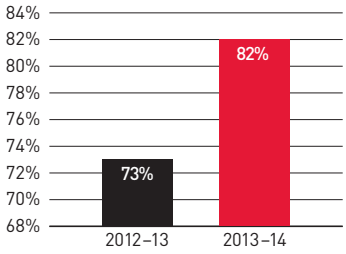


↓16%

AVG. LENGTH OF STAY (REHABILITATION)

Improvement through simplified processes, better workforce allocation and teamwork centred around patients.

ED Treated in Time – The Alfred

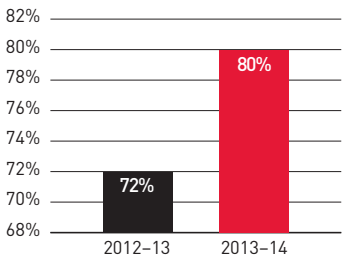


↑9.0%

ED TREATED IN TIME – THE ALFRED

Placing senior clinicians at the front of service delivery has improved patient experience.

ED 4 hour – The Alfred

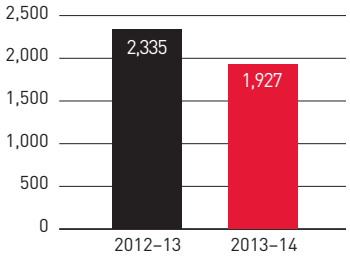


↑8%

ED TREATED WITHIN 4 HOURS (ALFRED)

Improvement driven by new emergency patient pathways.

Elective waiting list size

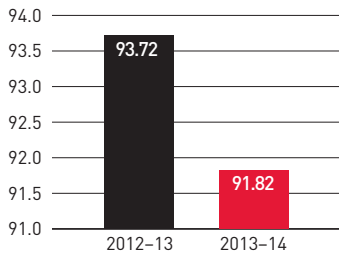


↓17.0%

ELECTIVE WAITING LIST SIZE

Improvement through increased bed and theatre capacity.

30 Day re-admission rate



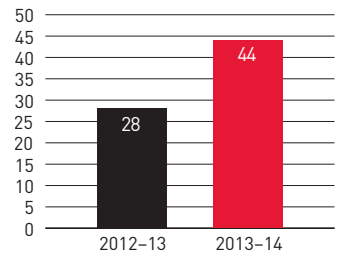
↓2%

30 DAY RE-ADMISSION RATE*

Improvement through ongoing strategies such as GP liaison and effective disease management.

*Standardised readmission rate. Risk-adjusted observed rates of re-admission versus expected rates.

Number of ECMO episodes



↑57.0%

ECMO EPISODES

ICU has built considerable expertise in this life-saving technique which has extended this service to patients in critical conditions.

Employees

Engaging with staff to redesign patient care through the Timely Quality Care initiative and building internal capacity through innovative learning experiences were key drivers for the year. The results were an increasingly engaged workforce with an even stronger commitment to delivering leading healthcare.

7,989

EMPLOYEES

1,326

NEW STARTS

3,278

STAFF PARTICIPATED IN WORKHEALTH CHECKS

470

EMPLOYEES RECEIVED LENGTH OF SERVICE AWARDS

$1.5m

SAVED IN WORKCOVER NET CLAIM COSTS

Recruiting and rewarding long service

In 2013–14, Alfred Health employed 7,989 staff. We welcomed 1,326 new recruits, 83 per cent of whom attended an orientation program within their first six weeks. We continued to be an employer of choice, typically attracting high-calibre applicants for all roles. During the year, we employed 141 international candidates, with 65 new recruits holding a 457 visa.

Headcount

	2014				2013			
	Casual	Full Time	Part Time	**Grand Total**	Casual	Full Time	Part Time	**Grand Total**
Caulfield	177	460	691	1,328	158	476	680	1,314
Sandringham	117	90	329	536	147	96	400	643
The Alfred	779	2,851	2,495	6,125	651	2,797	2,336	5,784
Grand Total	**1,073**	**3,401**	**3,510**	**7,989**	**956**	**3,369**	**3,416**	**7,741**

Workforce

		As at 30 June		Average*	
		2013	**2014**	Jun-13	**Jun-14**
1	Nursing	2,276	2,324	2,262	2,275
2	Administration/Clerical	745	741	758	740
3	Medical Support	766	769	782	768
4	Hotel/Allied	204	202	198	200
5	Medical	180	187	176	181
6	HMO	461	485	458	469
7	Sessional Clinical	129	130	133	128
8	Allied Health	493	501	468	495

* The average EFT is calculated based on the weighted average of employees in each category for the 26 pay-fortnights paid in the 2013–14 year.

Alfred Health is proud to recognise longevity of service and we conduct presentation ceremonies to acknowledge 10, 20, 25, 30, 35, 40, 45 and 50 years of service. In 2013–14, we recognised 470 employees for long service.

Staff redesigning care

Alfred Health continued to transform the way we work and provide care across our three main hospital campuses.

The Timely Quality Care (TQC) initiative, which started two years ago, involves staff at all levels in redesigning the care that they are responsible for delivering. While TQC has improved patient experiences, it has also re-engaged staff and lifted work satisfaction.

During the year, Alfred Health – using the TQC framework – changed the way in which patient care happened at night. A new model to progress 'after hours' care evolved through feedback from medical and nursing staff. This included introducing a new specialist Hospital at Night Support Team (HANST), which works closely with the medical team to help with patient admissions, provide expert coaching during procedures and offer staff relief.

The HANST ensures that medical and nursing staff have onsite clinical leadership providing high-level decision making, support and mentorship. Nursing staff satisfaction increased 34 per cent from the baseline survey undertaken during a six-month period, while night-time staff reported a 71 per cent improvement with regard to clinical supervision.

2014 *People Matter Survey*

Participation increased in the State Government's 2014 *People Matter Survey*, with more than 46 per cent of staff responding to the questionnaire, up from 11.6 per cent in 2011.

The survey demonstrated a strong team culture focused on safety and quality patient outcomes. Significantly, 95 per cent of staff would recommend a friend or relative to be treated as a patient at Alfred Health. Areas for ongoing improvement were to increase staff involvement in change initiatives and provide feedback.

Staff development and education

Alfred Health's education program develops the capacity, performance and capability of our employees. Education programs delivered across Alfred Health in 2013–14 were:

Education programs	Attendees
Nursing education	2,762
Allied Health	540
Medical	1,119
Psychiatry	1,963
Pharmacy	200

Specialist training units provided essential core and mandatory programs, while a substantial leadership and capacity-building program continued across Alfred Health

Innovative ICU education: In 2013–14, an innovative web-based education model was created by The Alfred's Intensive Care Unit (ICU) team to translate research on the care of critically ill patients into clinical practice. Launched in May 2014, INTENSIVE is a free-to-access online educational resource that integrates with The Alfred's education program. Within the four weeks following its launch, the site recorded 16,733 page views by 2,645 individuals – 33 per cent from Australia and 67 per cent from 79 other countries.

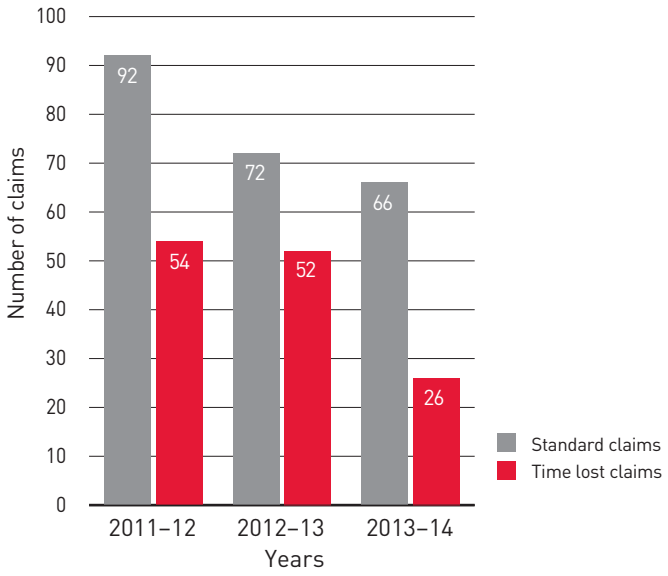
Occupational health and safety

In 2013–14, staff were involved in health and safety decisions through regular meetings, health and safety committees and regular consultations with health and safety representatives. Importantly, they contributed to risk assessments, health-promotion initiatives and training and mentoring programs, further building safety culture into work practice.

During the year, quarterly progress reports to the Alfred Health Executive and Board were introduced to help identify trends and reduce risk. Key achievements included projections by WorkCover insurer, Allianz, showing a premium reduction of approximately 10 per cent for 2014–15 due to lower claims costs. Our Employer Performance Rate decreased to 0.79, indicating that Alfred Health is performing 21 per cent better than comparable health services.

WorkCover claims continue to decrease

We focused on early intervention to ensure that all injured employees were supported in their return to work in a timely and safe manner. Claims continued to fall in 2013–14, with an 8 per cent decrease in the number of standard claims lodged. Also, the average time lost per claim was greatly reduced.



Employees

Manual handling strategy

Manual handling remained a central driver to health and safety initiatives, building on the successful implementation of the 2011–13 Manual Handling Strategy. This strategy resulted in a 17.5 per cent reduction in manual handling claims in its first two years. In 2013–14, the reduction in claims continued, equating to a $1.5 million saving in net claim costs. The strategy was updated for 2014–16 to ensure that Alfred Health continues to reduce manual handling claims.

Well-being initiatives

Alfred Health worked to understand and mitigate the workplace's impact on the health of individual employees. Continuing to act on the evidence of health issues associated with prolonged sitting, more than 200 employees now spend increased time on their feet – with an extra 100 standing workstations added during the year.

Average sitting times among these employees reduced from 91 per cent of working time to 53 per cent, with benefits reported by 98 per cent of staff who would recommend the setup to colleagues. The major benefits cited are increased comfort, energy, ability to focus and greater productivity. Alfred Health's efforts to reduce prolonged sitting were published and shared nationally and internationally.

We continued to involve staff in a range of health-related programs, including WorkHealth Checks, which were taken up by 3,278 employees. The innovative *Break 4 Health* program enabled staff to participate in outdoor group fitness training during their lunch breaks, while '*Health 4 Life*' saw 25 participants receive a funded six-month gym membership, weekly personal training and nutrition counselling as intensive support to achieve their health goals.

We instigated a program aimed at encouraging an active travel culture among staff and upgrading the end-of-trip facilities. The program will focus on improving the experience for those who cycle and will aim to engage more staff in active forms of travel to and from work.

RECOGNITION FOR EXCELLENCE

ALFRED HEALTH STAFF WERE AWARDED FOR A RANGE OF OUTSTANDING ACHIEVEMENTS IN 2013–14.

PEOPLE IN HEALTH AWARDS

The *Out of Hours Workforce Model and Training Program* was named winner in the Victorian Government's inaugural People in Health Awards.

VICTORIAN PUBLIC HEALTHCARE AWARDS

Alfred Health was recognised with six significant awards in the 2013 Victorian Public Healthcare Awards. TQC's Hospital at Night program was again acknowledged with the Premier's Award for Advancing Healthcare – Putting Patients First.

Awards for Healthcare Innovation included:

- *'Antimicrobial Stewardship; Improving the quality of antimicrobial prescribing'* program (Gold);
- *'Bridging the patient specimen labelling gap using postline patient identification collection'* (Silver);
- Allied Health Assistant Leadership team (Highly commended);
- Advanced Musculoskeletal Physiotherapy Competency team (Highly commended).

The Minister's highest honour for an individual, The Health Lifetime Achievement Award, was awarded to Associate Professor Alison Street AO, recognising her outstanding contribution to haematology and her career in public health.

Delivering quality care

In 2013–14, we continued to innovate for, and with, our patients – developing new models of care, nurturing partnerships, investing in research and embracing technology to deliver sustained improvement.

1st

VICTORIAN METROPOLITAN HEALTHCARE SERVICE TO MEET AND EXCEED NATIONAL EMERGENCY ACCESS TARGET

83%

OF ALFRED PATIENTS EXPERIENCED A LENGTH OF STAY OF LESS THAN FOUR HOURS AT THE ALFRED IN THE EMERGENCY DEPARTMENT*

*January to June 2014 results.

98,262

EPISODES OF INPATIENT CARE PROVIDED

11,756

ELECTIVE SURGERIES PERFORMED

Driving quality and safety

Sustaining national standards

In June 2013, Alfred Health became the first major metropolitan healthcare service to regularly achieve accreditation under the new national standards (NSQHS) set by the Australian Commission on Safety and Quality in Healthcare. All services at The Alfred, Caulfield Hospital and Sandringham Hospital were surveyed and achieved full accreditation status for three years.

The year saw a concerted effort to embed these standards across Alfred Health locations. We developed and implemented a sustainable model to ensure that safety and quality are overseen by high-level governance and that standards are applied consistently in clinical settings.

The model included:

> an NSQHS action plan, which reported on progress and formulated recommendations for improvement

> regular audits of safety and quality systems, which included 'point of care' delivery

> staff education and training, which focused on 'a standard a month', promoted through newsletters, displays, competitions and executive briefings

> detailed scorecards for programs and wards, encouraging local clinical areas to review their data and audit results, and take corrective action where necessary.

Using benchmarking data

In 2013–14, Alfred Health participated in four different benchmarking systems to further clinical diagnosis and improvement initiatives. These included:

1) Health Roundtable (benchmarked with 10 Australian health services)

2) Healthcare Evaluation Data (UK system with a Victorian component)

3) Dr Foster Quality Investigator (all Victorian hospitals)

4) Dr Foster Global Comparators (collaboration with 41 health organisations from nine countries).

The focus for the year was on further improving unplanned readmissions. The Dr Foster QI data analysed from October 2012 to September 2013 indicated a favourable performance compared to other health services.

Redesigning care around patient experiences

Timely Quality Care (TQC) requires a whole-of-hospital response to redesign care and improve patient experiences. It places senior decision makers at the front of service delivery, allowing treatment to start when patients first arrive. This means that their hospital stay is only as long as clinically required and involves the highest quality care.

This transformational approach generated quality improvements across Alfred Health. During the year, the model was extended from The Alfred to Caulfield Hospital, where the focus was on improving sub-acute care. Preparation was undertaken to introduce TQC to Sandringham Hospital in July 2014.

Key TQC achievements during the year included:

> The Alfred as the first Victorian major metropolitan hospital to meet and then exceed the Federal Government's National Emergency Access Target (NEAT)

> the length of stay in sub-acute care at Caulfield Hospital reducing 16 per cent since TQC's implementation in October 2013.

Infection prevention

Research into VRE: In 2013, Alfred Health changed infection prevention management of patients with *vancomycin-resistant enterococci* (VRE), bacterial strains of the genus *Enterococcus* that are resistant to many antibiotics. These changes followed a study into VRE to better understand the length of time that patients carry the bacteria, and associated factors with the length of carriage.

The results suggested that, in many circumstances, patients with a history of colonisation of more than four years no longer required contact isolation when admitted to hospital. Consequently, fewer patients need to be placed in isolation, leading to increased patient satisfaction and improved access to tests performed outside ward areas. These changes were supported by a broad staff engagement and education program.

Patient safety initiatives: Continuous monitoring and dynamic feedback to staff on performance resulted in sustained improvements in hand hygiene, *Staphylococcus aureus* bacteraemia rates and influenza vaccination rates. Efforts also included staff awareness programs that focused on patient safety. The outcomes were:

> raised influenza vaccination compliance among staff from 56 per cent at June 2013 to 80.3 per cent in June 2014, with **94.9** per cent of staff reporting their vaccination status

> increased hand hygiene compliance from 45 per cent in 2009 to 80 per cent in 2014.

Patients come first

High-quality healthcare relies on the partnership between clinicians and our patients, their families and carers. We continued to implement our *Patients Come First* strategy, which was initiated last year.

A new team, Patient Experience and Consumer Participation Program (PECPP), was established in November 2013 with a clear focus on cultural diversity, Aboriginal involvement, disability access and supporting volunteer participation. Key achievements included:

> signing the Statement of Intent with the Boon Wurrung people of the Kulin Nation and initiating the development of a Reconciliation Action Plan

> establishing a new disability working group that reviews our physical environment and access to information

> conducting focus groups with culturally diverse communities to identify specific healthcare needs.

Several initiatives were undertaken to engage patients and their families in their own care, furthering the approach of putting patients at the centre of care.

Let me know

Recognising the integral role played by families and carers in supporting patients, Alfred Health developed the *Let me know* program. It encourages patients and their families to raise their concerns directly with nurses and doctors, as well as through a dedicated hotline, if they are observing concerning changes in a patient's condition. The *Let me know* program will be piloted at The Alfred from July to September 2014 and, following a review, it will be implemented across the health service.

Medical care goes mobile with a new desktop and mobile phone application that allows medical staff and nurses to log requests during the day that are then actioned by the Hospital @ Night team.

Innovations in General Medicine

Alfred Health's General Medicine team introduced two innovative approaches to increase patient involvement in their own care.

SIBR: In December 2013, the bedside rounds process changed to ensure that the multidisciplinary team, patient and relatives remain 'on the same page'. Structured Interdisciplinary Bedside Rounds (SIBR) formalised the processes and involved a scheduled checklist presentation with standardised, auditable documentation. Families were invited to attend. SIBR has proved highly effective with the whole care team, and enabled patients and their families to contribute to the round.

CareTV: To simplify discharge without reducing the quality of the information provided to patients, *CareTV* was launched in late 2013. It comprises three-minute videos, filmed at the patient's bedside with the interdisciplinary team prior to discharge.

The patient is given a diagnosis summary, response to treatment, follow-up plan and contact details for the medical team on DVD or USB, to review later. This is provided to the GP, family members and carers, facilitating a broad understanding of the patient's post-hospital treatment plan.

Patient feedback

Victorian Healthcare Experience Survey: Survey methods changed from January 2014, as the health system moved from the Victorian Patient Satisfaction Monitor (VPSM) to the new Victorian Healthcare Experience Survey. (Consequently, results data is not available for that period.) The new survey focuses on individual patient experience rather than on measuring satisfaction, resulting in richer and more actionable data.

Victorian Patient Satisfaction Monitor results: From July to December 2013, Alfred Health met its major targets regarding patient satisfaction – except for the 'Patient experience admitted overnight', which measured 74 per cent. This indicator related to patients' experience of the restfulness of the hospital and privacy of rooms at Caulfield Hospital and reflected the impact of ageing facilities and mixed wards. Early in 2014, a Patient Experience Working Group was established at Caulfield Hospital to focus on improvements and to better understand complaints data.

Alfred Health Patient Healthcare Experience Survey: Alfred Health's own patient measurement tool aims to provide program and unit-specific information at a local level. For the September to December 2013 period, results indicated that 84 per cent of patients who took part in the survey were happy with the overall quality of care received at Alfred Health. Work continued on developing the tool to provide real-time information to better support patients and staff.

Patient feedback summary

Indicator	Target	Score
Percentage of patients who rate very good to excellent on Patient Experience Survey (September–December 2013)	75%	84%
Consumer involvement in decision making and care (VPSM Consumer Participation Indicator score July–December 2013)	75%	76.5%
Measurement of patient experience admitted overnight (VPSM overall care index July–December 2013)	75%	74%
Number of consumers formally recruited to consumer register (July 2013–June 2014)	30	50
Number of orientated/trained consumer representatives (July 2013–June 2014)	30	50

Significant operational activities

The Alfred

The Alfred *is a major tertiary referral hospital providing a comprehensive range of acute and mental health services to local residents. It is also a teaching hospital with strong roots in integrating clinical practice with research discoveries, and provides 12 statewide services.*

Significant developments in 2013–14:

Leading ECMO treatment: Over the last two years, the Intensive Care Unit (ICU) has introduced ECMO-CPR, in which an arrested patient is fully supported on a heart–lung machine, allowing a cardiologist to treat the blocked coronary artery. This is the first such model of care in Australasia.

The Alfred's ICU has built considerable expertise in developing extra-corporeal membrane oxygenation (ECMO), a life-saving intervention for patients with severe heart and/or lung disease. ICU has been acknowledged as an international centre of excellence by the Extracorporeal Life Support Organisation and awarded an 'Excellence in Healthcare Outcomes' in the Victorian Public Healthcare Awards for its work.

Over this two-year period, 40 people with an average age of 47 have been treated with ECMO-CPR, with a 42.5 per cent survival rate. This patient group previously had a 100 per cent mortality rate.

Faster ICU patient recovery: Continued improvements in ICU practice further reduced duration of ventilation and ICU length of stay, irrespective of illness severity. While clearly better for patients, this has resulted in reduced revenue associated with the ventilator co-payment for critically ill patients. However, this has been offset by increased patient flow through the unit and increased numbers of patients on ECMO.

Preparation for the new Mental Health Act: Mental health services are an important component of Alfred Health, where we provide psychiatric intensive care on a statewide level, as well as services delivered through our psychiatry unit and community-based programs.

In preparation for changes to Victoria's *Mental Health Act 2014* from 1 July, a significant awareness program was undertaken with the Department of Health, to educate staff about forthcoming changes and their practical impacts. The key changes relate to procedures for initiating compulsory assessment and compulsory mental health treatment.

Providing self-care opportunities for dialysis patients: In July 2012, Alfred Health's home therapy dialysis prevalence rate was 15.75 per cent, one of the lowest in Victoria. To lift home therapy rates to the state target (35 per cent), we:

1) redesigned the service around a home therapy centric model and improved access to dialysis catheter insertion in radiology
2) introduced a nurse outreach program that linked nephrologists and patients within the region at an early stage to improve patient education and decision making
3) offered innovative hybrid dialysis for patients who had been previously assessed as not suitable for home therapies.

The program has increased prevalence rates from 15 to 28 per cent, the highest growth rate in Victoria in 2013. Rates of new home therapy dialysis patients increased from 21 per cent in June 2012 to an average of 52 per cent for the 2013 calendar year.

HIV Services Review: Through advances in antiretrovirals, people with HIV are living longer and presenting new challenges for healthcare services. To address changing clinical needs, Alfred Health outlined a plan to develop services in October 2013. When this proposal was released, the HIV community requested broader consultation on the proposed changes.

Following this process, in May 2014 we announced a new HIV Service Advisory Group (HSAG) to help plan for future services, as well as identify community needs and future trends in care. Current services, including Fairfield House, will continue as the group is established and work gets underway to support Alfred Health in providing world-leading HIV services.

HSAG membership will include service users, community representatives and HIV specialists. The group will report to the Board's Consumer Advisory Committee, chaired by Alfred Health's Chief Executive.

HeLP Clinic: A free legal clinic for patients, the first of its kind in Australia, was established within The Alfred as a six-month pilot project in March 2014. In line with our approach to treating the whole patient through innovative partnerships, HeLP (Health Legal Partnership) is an alliance between law firm Maurice Blackburn (which provides legal advice pro bono); the Michael Kirby Centre for Public Health and Human Rights at Monash University; Justice Connect; and Alfred Health.

The service is available to any hospital patient (and their families) with a health-related legal problem. There has been substantial demand for such help, with cases ranging from assisting patients to prepare a power of attorney or plan for end-of-life issues, to advising on immigration, tax, domestic violence, asbestos exposure and family law.

Caulfield Hospital

Caulfield Hospital *specialises in community services, rehabilitation, aged care, residential care and aged mental health. In addition, the hospital plays a statewide role in providing rehabilitation services. Many of these services are provided through outpatient and community-based programs that focus on enhancing the health, independence and overall well-being of people residing in the community.*

Significant developments in 2013–14:

Targeting brain injury: The building of the $36 million Acquired Brain Injury (ABI) Rehabilitation Centre at Caulfield Hospital progressed well during the year, with commissioning activities ready to start early in 2014–15. As Victoria's first purpose-built centre of excellence in brain injury rehabilitation, the ABI Centre will give patients referred from across Victoria every opportunity to return to independent living.

The new facility is jointly funded by Commonwealth and State Governments, along with the Transport Accident Commission (TAC). Due to open in September 2014, it will provide specialist care to patients with moderate to severe brain injuries.

The new statewide service will comprise:

> a 42-bed inpatient rehabilitation service

> a community and ambulatory rehabilitation service

> a four-bed transitional living service.

Redeveloping residential aged care: In December 2013, we announced our intention for the upgrade and modernisation of residential facilities at Caulfield Hospital. Our preference was for this to be undertaken by a specialist residential aged care provider, who would run residential services on a daily basis. During the year we actively sought an expert provider with a reputation for leadership, quality and care in the residential care sector. The aim is to ensure residential aged care continues at Caulfield Hospital, with high-quality service levels maintained and needs of current and future residents met.

Residents and their families and carers have been kept informed through forums, newsletters and personal visits. Also, staff have been engaged about the project's potential impact on their roles. The intention is for residential care staff to continue working for Alfred Health.

The outcome will be announced in 2014–15.

Carer recognition: The *Carer Recognition Act 2012* (Vic) promotes and values the role of people in care relationships and recognises the contribution that carers and people in carer relationships make to the social and economic fabric of the Victorian community. We have taken measures to comply with our obligations under the Act. This includes developing guidelines designed to ensure that the needs of carers are recognised and responded to when the person for whom they care is admitted to Alfred Health or when the carer is admitted to Alfred Health.

Victoria's first purpose-built Acquired Brain Injury Centre will extend the rehabilitation services already offered at Caulfield Hospital.

Carer respite: Using TQC principles, Alfred Health's Carer Services redesigned the frontline telephone service to improve our response to carers. This has resulted in a service restructure, with two separate teams (the Aged Care team and the Disability, Mental Health and Young Carers team) now providing support. The restructure also involves placing senior decision makers at the front of the service to enable appropriate assessment and problem solving, so that responses to carers are made directly and appropriately.

Since the change was introduced, over 90 per cent of calls have been responded to on the same or next day. There has been a 27 per cent increase in referrals to internal programs at the initial point of contact, indicating that carers receive services in a more timely manner.

Community Rehabilitation program: Over the past 12 months, the Community Rehabilitation program has undergone significant redesign, supported by a project grant from the Department of Health. The redesign aims to increase the capacity within Community Rehabilitation so clients receive timely care.

While the project will continue, initial results include:

> a 44 per cent reduction (compared to the previous year) in waiting time before clients receive community rehabilitation services

> a 52 per cent increase (compared to the previous year) in the number of clients who are referred directly from The Alfred to Community Rehabilitation, avoiding an inpatient rehabilitation admission and providing rehabilitation in a community setting.

Delivering quality care

Sandringham Hospital

Sandringham Hospital *is a community hospital focused on meeting the hospital healthcare needs of the local area through emergency, maternity, special care nursery, paediatrics, general medicine and outpatient services. The hospital works closely with local community healthcare providers.*

Significant developments in 2013–14:

The Women's @Sandringham: An innovative partnership between the Royal Women's Hospital (the Women's) and Alfred Health saw the successful transfer of maternity and gynaecology services to The Women's in October 2013.

This initiative responded to the increasing demand for maternity services in the area, ensuring that women in bayside Melbourne had access to safe, high-quality maternity and gynaecology care locally, supported by a tertiary specialised maternity service.

Refurbished Emergency Department: The $6.8 million improvement program to the Sandringham Hospital Emergency Department was fully completed in December 2013. The refurbished facility was expanded to include new waiting areas, reception, six new short stay beds and an improved entry.

The new Emergency Department saw more than 34,000 patient visits during the year and supported growing demand from the local bayside community, as well as that of south east Melbourne.

Urgent Care Centre opening: The Urgent Care Centre opened its doors in May 2014. Located within Sandringham Hospital's Emergency Department, the centre is staffed by general practitioners skilled at caring for people with non-life-threatening conditions. In line with TQC practices, this GP-styled clinic ensures that patients are seen by the most relevant staff, with correct care and treatment provided as quickly as possible, eliminating long waiting periods.

Since opening, the Urgent Care Centre team has treated burns, wounds, rashes, infections, simple fractures and viruses, while the emergency team has continued to focus on conditions such as chest and abdominal pain, allergic reactions, breathing difficulties and head injuries.

Sandringham Hospital turned 50: In 2014, Sandringham Hospital celebrated its 50th birthday. Originally developed as an 88-bed emergency and maternity care hospital in 1964, the Bluff Road hospital was designed to eliminate the need for local residents to seek care in the city. With initial funding for the hospital gathered by the community, local families, groups and individuals have continued to play an invaluable role in supporting the hospital.

Several events were planned during the calendar year to celebrate the 50th milestone, providing something for everyone, ranging from a primary school art competition to cocktail events, a Mothers' Day raffle, past staff reunion lunch, golf days and a formal ball.

At Sandringham Hospital one in four emergency presentations is a child.

Activity

Admitted Patients	Acute	Subacute	Mental Health	Other	Total
Separations					
Same Day	53,970	8	22	0	54,000
Multi Day	39,031	3,948	1,283	0	44,262
Total Separations	**93,001**	**3,956**	**1,305**	**0**	**98,262**
Emergency	36,175	9	956	0	37,140
Elective	55,374	3,947	349	0	59,670
Other, inc. Maternity	1,452	0	0	0	1,452
Total separations	**93,001**	**3,956**	**1,305**	**0**	**98,262**
Other					
Total bed days	**258,641**	**131,846**	**23,717**	**0**	**414,204**
Total WIES	**90,582**	**0**	**0**	**0**	**90,582**
Major trauma admissions	**1,130**	**0**	**0**	**0**	**1,130**

Non-Admitted Patients	Alfred	Caulfield	Sandringham	Other	Total
Emergency Department presentations	60,345	0	34,190	0	94,535
Specialist outpatient appointments	127,483	3,204	11,621	0	142,308
Allied Health outpatient appointments	39,758	0	3,447	0	43,205
Diagnostic outpatient events	130,774	2,685	22,172	0	155,631
Radiotherapy occasions of service	36,205	0	0	20,053	56,258
Other services – occasions of service	98,739	126,217	0	40,014	264,970
Total occasions of service	**493,304**	**132,106**	**71,430**	**60,067**	**756,907**

Report of Operations Responsible Body Declaration

In accordance with the *Financial Management Act 1994* (Vic), I am pleased to present the Report of Operations for Alfred Health for the year ending 30 June 2014.

Helen Shardey
Chairman, Board of Directors

14 August 2014

Performance

STRATEGIC PERFORMANCE

Accountability for Alfred Health's operational performance is set by the Minister for Health through the Statement of Priorities (SOP) agreement. This annual agreement tracks our progress towards three important objectives:

1) access to healthcare services
2) quality of services to our community
3) financial viability.

Part A: Performance against strategic priorities 2013–14

Victorian Government's Priorities	Actions	Alfred Health Deliverables	Progress as at 30 June 2014
Developing a system that is responsive to people's needs	Implement formal Advance Care Planning structures and processes that provide patients with opportunities to develop, review and have their expressed preferences for future treatment and care enacted.	Continue to expand Advance Care Planning throughout Alfred Health and increase referrals from the catchment through direct contact with patients and clients and through partnership with Bayside Medicare Local and other providers.	**Complete** Advance Care Plan referrals and number of plans significantly expanded through direct contacts with patients and through workshops, seminars and education inside and outside Alfred Health including with Bayside Medicare Local.
	In partnership with other local providers, apply existing service capability frameworks to maximise the use of available resources across the catchment.	In partnership with The Royal Women's Hospital, successfully implement 'Women's @ Sandringham' and thereby continue to strengthen maternity and gynaecology services in Alfred Health's catchment.	**Complete** Maternity and gynaecology at Sandringham successfully transferred from 1 October 2013.
Improving every Victorian's health status and experience	Improve thirty-day unplanned readmission rates.	Reduce readmission rates in a selected area through delivery of evidenced-based care.	**Good progress** Alfred Health has participated in global, national and local benchmarking exercises that have shown favourable readmission rates at hospital level. Further work is focussing on drilling down to procedure and diagnosis level.
	Identify service users who are marginalised or vulnerable to poor health, and develop interventions that improve their outcomes relative to other groups, for example, Aboriginal people, people affected by mental illness, people at risk of elder abuse, refugees and asylum seekers.	Complete construction of Acquired Brain Injury facility at Caulfield; implement statewide rehabilitation model of care for patients with moderate to severe/catastrophic acquired brain injury and establish a research program.	**Good progress** Caulfield Acquired Brain Injury service will be ready to take patients from September 2014 with approved model of care, workforce and research program. Handover of the facility was slightly extended due to inclement weather conditions and building contractor-based delays.

Victorian Government's Priorities	Actions	Alfred Health Deliverables	Progress as at 30 June 2014
	Optimise alternatives to hospital admission.	Establish Integrated Urgent Care Centre model at Sandringham Hospital.	**Complete** New Sandringham Integrated Urgent Care Centre and Emergency Department facility completed and operational from May 2014.
	Ensure service coordination, discharge planning and referral processes support effective care transition.	Patients' community providers receive discharge summaries in 48 hours, providing clinical information that facilitates safe handover of care.	**Good progress** Alfred Health has completed significant work to optimise discharge summary timeliness and quality. Standardised medical discharge summaries that focus on providing key GP information have now been introduced. Work is continuing to ensure that, where possible, patients take a copy of the discharge summary with them and to deliver discharge summaries securely into GP practice software.
Expanding service, workforce and system capacity	Build workforce capability and sustainability by supporting formal and informal clinical education and training for staff and health students – in particular, inter-professional learning.	Continue to develop the role of Monash Partners Academic Health Science Centre in south east Melbourne to improve translational research and improved health outcomes.	**Good progress** Monash Partners increasingly recognised as platform for system development, including, for example, funding of cancer research.
	Optimise workforce productivity through identification and implementation of workforce models that enhance individual and team capacity and support flexibility.	Continue to expand the use of advanced physiotherapy practitioners, pharmacy technicians, nurse practitioners, allied health assistants and enrolled nurses. > Embed online performance management system to significantly increase proportion of staff having annual performance reviews.	**Good progress** Good progress on extended scope in allied health assistants, nurse practitioners, nurse endoscopy and pharmacy technicians, and advanced scope in physiotherapy; implementation of online performance system well underway, supported by tools and training.
	Implement the Credentialing and Scope of Practice policy and '*Partnering for Performance*' framework for senior clinicians.	Implement electronic credentialing for all Alfred Health medical staff.	**Complete** Electronic credentialing system implemented as planned in November 2013.
Increasing the system's financial sustainability and productivity	Reduce variation in health service administrative costs.	Identify best-practice benchmarks against the Department's administrative costs framework to support continued reduction of administrative expenses as proportion of revenue.	**Complete** Operating within benchmarks in 2013–14 and further reductions targeted for 2014–15.
Implementing continuous improvements and innovation	Develop and implement improvement strategies that optimise access, patient flow, system coordination, and the quality and safety of hospital services.	Participate in Global Comparators project, leading to improved length of stay and clinical outcomes in two identified areas.	**Good progress** Alfred Health participating in global benchmarking projects; data sets being refined to allow identification of appropriate clinical areas.

Victorian Government's Priorities	Actions	Alfred Health Deliverables	Progress as at 30 June 2014
Increasing accountability and transparency	Prepare for commencement of proposed new mental health legislation in 2014.	Implement changes to Alfred and Caulfield Psychiatry to comply with new Mental Health Act.	**Complete** Processes and procedures implemented, and supported by training and development to ensure compliance with new Act from 1 July 2014.
	Increase transparency and accountability in reporting of accurate and relevant information about the organisation's performance.	Publish two additional scorecards on the Alfred Health internet, including the National Safety and Quality Health Service Standards Indicators.	**Complete** National Safety and Quality Health Service standards scorecard and inpatient mortality scorecard published in addition to CEO daily scorecard.
Utilising e-health and communication technology	Maximise the use of health ICT infrastructure.	> Complete core system implementations/ initiatives: pathology; clinical electronic task management; Acquired Brain Injury clinical documentation; online performance management > Plan response to Health Information and Communication Technology Review	**Complete** Core system implementation initiatives completed and Health ICT Review responded to with approval of Alfred Health ICT Strategic Plan.
	Trial, implement and evaluate strategies that use e-health as an enabler of better patient care.	Investigate feasibility and strategy to offer all discharge summaries for inclusion in Personally Controlled Electronic Health Record.	**Some progress** Rationalising and standardising discharge summaries is well progressed. System for electronic distribution of discharge summaries has been developed and will be trialled and implemented more broadly across Alfred Health in 2014–15.

Part B: Performance priorities

Financial Performance

Operating Result	Target	2013–14 actuals
Annual Operating Result ($m)	$0	$0.22m
WIES Activity Performance		
Percentage of WIES (Public and Private) Performance to Target	100%	-2.22%
Cash Management		
Creditors	← 60 days	43
Debtors	← 60 days	58

Access Performance (Note: Emergency Indicators are to be reported at campus/hospital level)

Emergency Care	Target	2013–14 actuals The Alfred	2013–14 actuals Sandringham
Percentage of operating time on hospital bypass	3%	0.9%	Not applicable
Percentage of ambulance transfers within 40 minutes*	90%	81.70%	86.40%
NEAT** (July–December 2013)	75%	78%	75%
NEAT** (January–June 2014)	81%	83%	76%
Number of patients with length of stay in the Emergency Department greater than 24 hours	0	0	0
Percentage of Triage Category 1 emergency patients seen immediately	100%	100%	100%
Percentage of Triage Category 1 to 5 emergency patients seen within clinically recommended times	80%	83%	78%

**Ambulance data as at 10 July 2014.*

**Percentage of emergency presentations to physically leave the Emergency Department for admissions to hospital, be referred to another hospital for treatment or be discharged within four hours.

Elective Surgery	Target	Jul–Dec 2013	Jan–June 2014
Percentage of Urgency Category 1 elective patients treated within 30 minutes	100%	100%	100%
NEST – Percentage of Urgency Category 2 elective surgery patients treated within 90 days	80%	86.6%	86.2%
NEST – Percentage of Urgency Category 3 elective surgery patients treated within 365 days	94.5%	99.6%	99.9%
Number of Hospital Initiated Postponements per 100 scheduled admissions	8	5.2	4.1

Elective Surgery Waiting list	Target	Actual 2013–14
Number of patients on the elective surgery waiting list	1,966	1,891

Service Performance

Elective Surgery	Target	2013–14 actuals
Number of patients admitted from the elective surgery waiting list – quarter 1	2,914	3,054
Number of patients admitted from the elective surgery waiting list – quarter 2	2,649	2,732
Number of patients admitted from the elective surgery waiting list – quarter 3	2,737	2,813
Number of patients admitted from the elective surgery waiting list – quarter 4	2,980	3,157
Critical Care	**Target**	**2013–14 actuals**
Number of days operating below agreed Adult ICU minimum operating capacity	0	0
Quality and Safety	**Target**	**2013–14 actuals**
Health service accreditation	Full Compliance	Full Compliance
Residential aged care accreditation	Full Compliance	Full Compliance
Cleaning standards (Overall)	Full Compliance	Full Compliance
Cleaning standards (AQL – A)	90%	96.20%
Cleaning standards (AQL – B)	85%	97.20%
Cleaning standards (AQL – C)	85%	97.20%
Healthcare worker immunisation – influenza (1 March 2013–31 July 2013)	60%	56%
Healthcare worker immunisation – influenza (1 March 2014–30 June 2014)	75%	80.3%
Hospital acquired infection surveillance	No Outliers	No Outliers
Hand hygiene (rate)	70%	Achieved (80.4%)
SAB rate per occupied bed days	← 2/10,000	0.85/10,000
Victorian Patient Satisfaction Monitor: (OCI) (July to December 2013)	73	Not Achieved
Consumer Participation Indicator (July to December 2013)	75	Not Achieved
Victorian Hospital Experience Measurement Instrument (January to June 2014)	Full Compliance	Achieved
People Matter Survey	Full Compliance	Achieved
Mental Health	**Target**	**2013–14 actuals**
28-day readmission rate (%)	14%	13.40%
Post-discharge follow-up rate (%)	75%	79.30%
Seclusion rate per occupied bed days	← 15/1,000	16.4/1000

Part C: Activity and funding

	2013–14 activity
Acute Admitted	
WIES Public	71,710
WIES Private	11,976
WIES (Public and Private)	83,685
WIES DVA	1,069
WIES TAC	5,828
WIES Total	90,582
Acute Non-admitted	
Radiotherapy WAUs Public	70,020
Radiotherapy WAUs DVA	1,840
Mental Health and Drug Services	
Mental Health Inpatient	22,276
Mental Health Ambulatory	63,808
Mental Health Residential	10,950

	2013–14 activity
Sub-acute and Non-acute Admitted	
Rehab Public	28,289
Rehab Private	10,803
Rehab DVA	597
GEM Public	27,761
GEM Private	14,801
GEM DVA	2,411
Transition Care – Beddays	24,114
Transition Care – Homedays	6,551
Aged Care	
Residential Aged Care	29,026
HACC	13,306
Primary Health	
Community Health/Primary Care Programs	15,091

The Alfred Health's Emergency and Trauma Centre is one of the busiest in Australia, treating more than 60,300 patients in 2013–14.

Financial summary 2013–14

The operating result* – the key financial result for 2013–14 – was a $0.22 million surplus. This is a solid result compared with a breakeven budget target and the $0.11 million result for the prior year. Revenue increased by $21 million, which included increases in government funding relating to elective surgery. This saw a reduction in Alfred Health's waiting list from 2,335 to 1,891, an improvement on the State Government's target of 1,966.

The comprehensive result for 2013–14 was a profit of $261.8 million, including Capital Donations/Revenue of $7.6 million. This capital revenue is designated for specific capital purchases, including the Emergency Department Redevelopment Project and various IT, surgical, ICU and other capital equipment. This is an increase of $4.5 million from the last financial year.

The comprehensive result also includes the asset revaluation of $285 million. This revaluation is also reflected in the increase in total assets to $1,086 million. Total liabilities increased by $17.3 million, which included the addition of a loan from the Department of Health.

Alfred Health provides excellent patient care while continuing to find financial savings through efficiency improvements. A savings value program managed by McKinsey & Co. identified $10 million of potential savings, which will be implemented over the next five years.

Financial summary

	2014	2013	2012	2011	2010
Total Revenue	$M	$M	$M	$M	$M
Total Revenue	915.7	894.5	868.9	821.0	758.9
Total Expenses	**915.5**	**894.4**	**868.9**	**821.0**	**762.7**
Operating Result	0.2	0.1	–	–	(3.8)
Capital and Specific Items	(25.1)	(25.3)	(18.5)	(43.7)	(26.9)
Comprehensive Result	261.8	(17.3)	(18.5)	(43.7)	(30.7)
Transfers to Reserves	7.1	(8.4)	(10.8)	(11.7)	(15.3)
Retained Surplus/Deficit	(159.4)	(141.5)	(159.1)	(129.8)	(74.4)
Total Assets	1,086.2	808.2	763.0	826.1	844.8
Total Liabilities	265.1	248.9	237.6	275.0	273.7
Net Assets	821.1	559.3	525.4	551.1	571.1

*Operating result (net result before capital and specific items).

Attestation on Data Accuracy

I, Andrew Way, certify that Alfred Health put in place appropriate internal controls and processes to ensure that reported data reasonably reflects actual performance. Alfred Health has critically reviewed these controls and processes during the year.

Andrew Way
Chief Executive
Melbourne

14 August 2014

Research through partnership

Achievements in 2013–14 included strengthened research partnerships through the Monash Partners Academic Health Science Centre, a new ethics application management system, and findings from a major international research project, which may change clinical practice.

$100.8m

IN EXTERNAL RESEARCH FUNDING

1,856

PUBLICATIONS, UP 14% FROM LAST YEAR

GLOBAL NITROUS OXIDE RESEARCH STUDY COMPLETED

$540k

INVESTED IN NEW TRANSLATIONAL HEALTH RESEARCH PROJECTS BY MONASH PARTNERS

Alfred Medical Research and Education Precinct (AMREP)

Alfred Health is a collaborative partner in AMREP with Monash University, Baker IDI Heart and Diabetes Institute, the Burnet Institute, La Trobe University and Deakin University.

This successful partnership, established more than 12 years ago, has facilitated major building projects – including research and education facilities. It has also led to increased research collaborations and shared research platforms, such as state-of-the-art imaging and microscopy modalities. The linking of health and medical research with education and healthcare delivery at AMREP continued to provide the ideal environment for rapid translation of research findings into improved health policy and clinical practice.

AMREP research outputs

In 2013–14, AMREP's external competitive research revenue of $100.8 million continued at similar levels to that of last year; 65 per cent of this funding was received from the National Health and Medical Research Council (NHMRC) and the US National Institutes of Health. The number of publications (refereed journal articles, book chapters and books) rose by 14 per cent from the previous year to 1,856.

Research Poster Display and Research Day

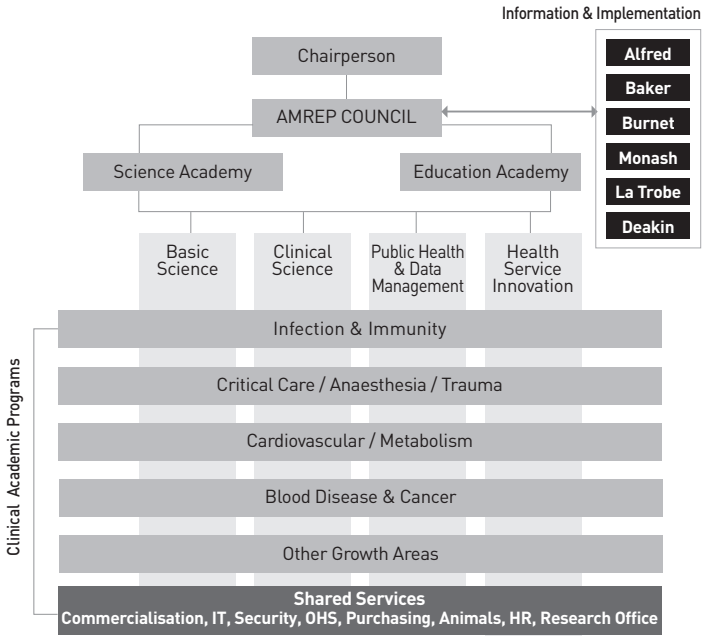
The 2013 Alfred Week Research Poster Display attracted 184 research posters from AMREP. Generous prizes were awarded for the posters judged to be the best in their category.

Research Day, held during Alfred Week, featured a keynote address by Professor Kathryn North AM, Director of the Murdoch Children's Research Institute, titled 'Next generation sequencing in action, with a focus on neuromuscular disorders'.

Following the address, Professor North presented the AMREP Research Prizes for 2013 to Professor John Dixon, Dr Tin Soe Kyaw and Dr Xiaowei Wang, all from Baker IDI, in recognition of their high-impact original research articles published in *Journal of the American Medical Association* and *Circulation*, respectively. The Research Day session concluded with brief presentations from the three prize winners.

Research through partnership

Alfred Medical Research and Education Precinct, Academic Health Centre Working Model



New NHMRC funding awarded

Alfred Health staff secured several new NHMRC grants commencing in 2013–14.

Professor Jeffrey Rosenfeld (Director, Department of Neurosurgery) was awarded a $1.5 million Development Grant for 'Restoring vision with a wireless multi-electrode cortical device: towards commercialisation'.

Professor Jamie Cooper (Director of Research, Intensive Care Unit) and team were awarded a two-year NHMRC-European Union Collaborative Research Grant for OZENTER-TBI, the Australia–Europe NeuroTrauma Effectiveness Research in TBI collaboration ($358,347). Professor Cooper also received a Partnership Project Grant aimed at improving outcomes for patients with critical bleeding who require massive transfusion ($861,706).

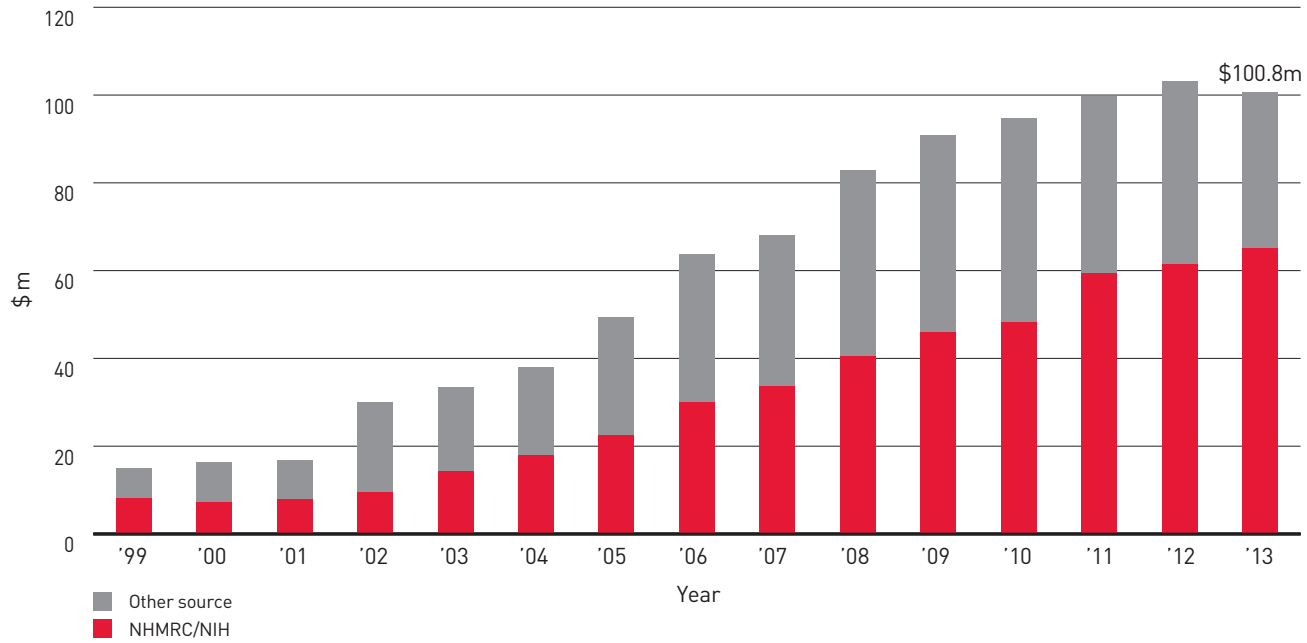
Among the numerous staff members who were recipients of research grants, two Alfred Health researchers were directly awarded with new Project Grants in their capacity as clinical lead investigators:

> Professor Stephen Jane (Director of Research, The Alfred) – Towards a cure for the beta-haemoglobinopathies: $617,562;

> Associate Professor Paul Cameron (Infectious Diseases Unit) – The impact of HIV integration sites on eliminating HIV latency: $752,950.

Associate Professor Allen Cheng (Infectious Diseases Unit) was awarded a four-year Career Development Fellowship to prevent and treat significant infections in the community and in hospitals, focusing on influenza, hospital-acquired infections and use of antibiotics, and clinical infectious diseases. At the NHMRC's 200th Council Dinner in June 2014, Associate Professor Cheng was presented with an NHMRC Research Excellence Award for the highest-ranked Career Development Fellowship Level 2 applicant in the year.

External research funding 1999–2013



Launch of new ethics application management system

The increasing complexity of ethics and governance applications has necessitated the development of more efficient documentation-handling and communication processes. In April 2014, an online ethics application management system named ERA (Ethics Research Administration) was launched at The Alfred. The secure system provides researchers, Ethics Committee members and administration staff with access to applications. It also serves as a document repository and allows for tracking of applications through the review process. ERA enables direct communication between the various user groups, removing the need for email correspondence.

The new system aims to reduce the time to ethics approval and governance authorisation. Future system development will include governance functionality, reporting capabilities and linkage with other IT platforms.

Laughing gas study completed

Nitrous oxide, better known as 'laughing gas', was first used as an anaesthetic more than 160 years ago; however, during the past decade there has been concern about possible side-effects. Small nitrous oxide studies led to conflicting findings, creating uncertainty about its use. In 2013–14, one of the largest ever anaesthetic drug studies confirmed nitrous oxide to be safe, with the potential to change clinical practice worldwide.

Alfred Health's Professor Paul Myles, Director Anaesthesia & Peri-operative Medicine, led the six-year 45-hospital study that monitored more than 7,000 surgical patients across Australia, Asia, North America and Europe. Results showed that there was no greater risk of complication with nitrous oxide over another drug and that the risk of heart attack, stroke or infection was very low and unaffected by the anaesthetic.

Monash Partners Academic Health Science Centre

The Monash Partners Academic Health Science Centre (AHSC) brings together Alfred Health, Baker IDI, the Burnet Institute, MIMR-PHI, Cabrini Health, Epworth Healthcare and Monash University.

Formed in 2011, Monash Partners was officially launched last year by the Minister for Health as one of only two such centres in Melbourne. The AHSC aims to enhance the health and well-being of the community by integrating healthcare, education and research.

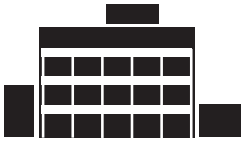
In 2013–14, Monash Partners and its member organisations invested $540,000 in new translational health research projects – projects that wouldn't have been possible without the collaborations encouraged by the AHSC. Funding came from Monash Partners funds, but also from separate investments by member organisations, including the Monash Health Foundation. This has allowed eight innovative clinical translation projects to receive seed funding, including exploring pathways for stroke patients, a biobank for understanding major surgery and trauma, and measuring post-discharge intensive care patient outcomes.

Also during the year, Monash Partners:

1) developed a draft Memorandum of Understanding with Manchester AHSC (one of only six AHSCs in the UK) to foster collaboration between our clinicians, to pursue joint research and clinical trials activity – and to support the exchange of commercialisation experience Monash Partners and Manchester have jointly funded a $100,000 research innovation fund
2) awarded two part-time Clinician Researcher Fellowships in Cancer, supported by the Victorian Cancer Agency – one to Dr Andrew Wei from Alfred Health and one to Dr Sue Evans from Monash University
3) worked with University College London Partners to formalise clinical links – especially in the fields of critical care and stroke – to support joint research projects and clinician exchange
4) discussed membership opportunities with primary health providers with a shared catchment population.

Projects

Significant capital projects were undertaken during the year, supported by government funding for new facilities and equipment.



6 MAJOR PROJECTS COMPLETED

$36m

NEW ABI CENTRE READY FOR COMPLETION IN SEPTEMBER 2014

$6.4m

IN MEDICAL EQUIPMENT FUNDING FROM STATE GOVERNMENT

Major projects

Acquired Brain Injury Centre (ABI)

Building works on the new ABI Centre progressed well during the year. Following commissioning, the facility will be handed over to Alfred Health in July, with first patients scheduled for September 2014.

The new facility is jointly funded by Commonwealth and State Governments, along with the Transport Accident Commission. Its focus is providing specialist care to patients with moderate to severe brain injuries.

Sandringham Hospital Emergency Department Expansion Project

As part of the National Health Reform Agreement on Improving Public Hospital Services, Alfred Health was allocated $6.8 million to provide an additional point of care to the Sandringham Emergency Department. The expansion included new waiting areas, a reception, an urgent care facility and an improved entry to the Emergency Department. It was completed and fully operational in December 2013.

Caulfield Hospital Inpatient Unit feasibility study

During the year Alfred Health, in conjunction with the Department of Health, completed a feasibility study for the construction of a new Inpatient Patient Unit (IPU) to replace the ageing assets associated with the 'breezeway'.

MEIRP funding

In 2013–14, Alfred Health received $6.4 million in funding from the Department of Health's Medical Equipment Infrastructure Replacement Program (MEIRP) to undertake the following works:

Equipment	Funding ($m)
Gamma camera – SPECT CT	1.2
CT scanner (The Alfred's Emergency Department)	1.0
Two Cardiac Catheter Laboratories	2.1
Emergency lighting and exit signs	0.5
New chiller infrastructure (Philip Block)	0.3
Patient lift (Main Ward Block)	0.4
Nurse call system	0.5
X-ray system (Sandringham)	0.4

Building project status

Alfred Health obtains building permits for new projects where required and certificates of occupancy or certificates of final inspection for all completed projects.

2013–14 building projects status

Projects completed *(with certificates of final completion)*

Alfred Centre – Ground Floor Outpatients

Alfred Centre – MRI Development

Alfred Hospital, Main Ward Block (Level 4) – Refurbishment

Alfred Hospital – Hyperbaric, Service Expansion

Sandringham Hospital, Emergency Department Development

AMREP Library Upgrade

Projects completed *(with building permits)*

Caulfield – Acquired Brain Injury Centre

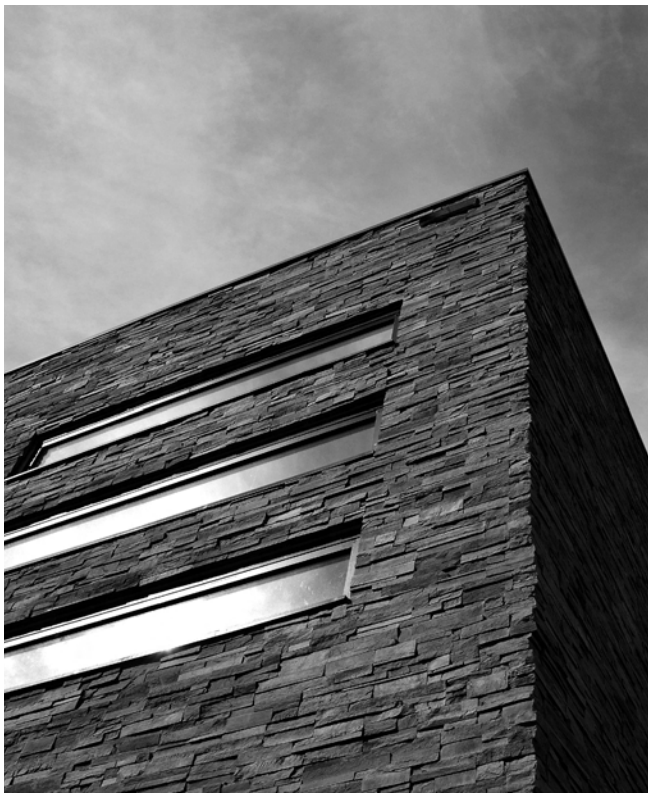
Caulfield – Transitional Living Centre

Headspace fit-out, Nepean Hwy, Frankston

Gamma camera – SPECT CT installation

Cardiac Catheter Laboratory Redevelopment

In line with requirements, registered building practitioners were used on all building projects, with maintenance of their registered status for the duration of the works a condition of their contract. All buildings are maintained in a safe and serviceable condition, with routine inspections and scheduled maintenance programs undertaken. All building essential services were inspected for compliance as required by legislation.



The building of the $36 million Acquired Brain Injury (ABI) Rehabilitation Centre at Caulfield Hospital progressed substantially, with commissioning activities on track for opening in September 2014.

Community and environment

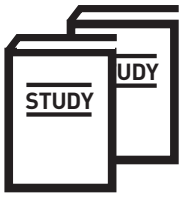
Promoting community health understanding through new research and healthy living initiatives was a focus during the year, as was progressing our environmental sustainability. Community support continued, with almost 500 volunteers giving their time and many more helping through generous donations and fundraising.

498

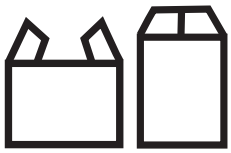
VOLUNTEERS PROVIDE THOUSANDS OF HOURS TO SUPPORT PATIENTS AND FAMILIES

14th

FATHER'S DAY APPEAL FOR THE ALFRED



2 GROUND-BREAKING STUDIES ON EDUCATE LOCAL COMMUNITY



90 TONNES OF CARDBOARD WERE RECYCLED IN THE YEAR

5 TONNES OF CLEAN PLASTICS WERE DIVERTED FROM LANDFILL SINCE 2012

Promoting better community health

Alfred Health researchers provided ground-breaking insights for improved community health in 2013–14. Professor Robyn O'Hehir published research about the risks associated with applying products containing food allergens to eczematous skin, which generated significant national media coverage.

Professor O'Hehir noted that application of natural food products to broken skin may lead to a severe allergic reaction when the food is eaten subsequently. It is the first time that laboratory tests have been used to confirm that a skin cream was the cause of the sensitisation.

In another world-first, Alfred Health and Monash University researchers found that reducing the intake of short chain carbohydrates – and not gluten – is central to lessening the symptoms of irritable bowel syndrome (IBS).

Professor Peter Gibson noted that reducing intake of short-chain carbohydrates, known collectively as FODMAPs, has proven to be the key to greater physical/bowel comfort. FODMAPs – the acronym for fermentable oligosaccharides, disaccharides, monosaccharides and polyols – are collectively found in dozens of foods, including apples, dairy, wheat, garlic and onions.

With one-in-five people thought to be affected by IBS, this important research has successfully measured the beneficial impact of this change for the first time.

Healthy living

Alfred Health plays an important part in promoting and supporting better health in the community and, in 2013–14, conducted a range of health promotion programs:

1) **Totally Smokefree**: Our campaign to manage and address nicotine dependency continued, with Alfred Health leading a pilot project with seven other hospitals to increase support for patients to quit smoking. A 'stop before the op' initiative and a new outpatient-based smoke-free clinic saw smoking cessation efforts applied before planned admissions and following discharge.

   We hosted two visits from Dr Hayden McRobbie, an international expert in this area to further build our organisational capacity and understanding.

2) **Healthy Choices**: We continued to take a public leadership role in nutrition. Using colour coding to indicate the nutritional value in food available across our sites, we have increased the availability of healthy food choices.

Nutritional value	2010 (baseline) % food in retail outlets	2014% food in retail outlets
Green (healthy)	30 per cent	48 per cent
Red (least healthy)	42 per cent	31 per cent

Vending foods and drinks achieved the government target of 50 per cent 'green' and no more than 20 per cent 'red'. Catering for meetings and events include no 'red' rated items.

Support for social enterprise catering is now valued as standard practice. Alfred Health was appointed to the Ministerial Victorian Healthy Eating Enterprise in 2014 in direct recognition of our achievement in this area of public health practice.

Environmental sustainability

As an energy-intensive organisation, Alfred Health measures and manages the environmental impact of our operational activities. (Victorian health services are required to develop a whole-of-organisation Environmental Management Plan (EMP) focusing on energy, carbon, water and waste across all locations.)

During the year, we progressed our 2012 Environmental Sustainability Strategy and revised the EMP for 2014. An online environmental report will be published in 2014–15.

Waste management: As a member of the Victorian Green Round Table Waste Committee, Alfred Health meets bi-monthly with waste/sustainability representatives from the Victorian public health services to discuss and promote new initiatives. The Alfred Health Waste Day is held every September, with contractors providing interactive displays about the various waste streams, and encouraging feedback and questions from staff and the general public.

An audit of waste disposal patterns resulted in significant action to improve our waste management. In 2014, an external audit of clinical waste checked compliance and segregation levels, prompting an internal education campaign and trials of new products in various units.

Recycling: More than 90 tonnes of cardboard were recycled during the year. An initiative between Alfred Health and Carranballac College in Point Cook prevented more than 1.5 tonnes of plastic waste collected by The Alfred's theatres team, and 100 kilograms of rubbish collected by students, from going to landfill. The plastic was transformed into two school-yard benches, now in use at the college. Since the plastic recycling program began in 2012, more than 5 tonnes of clean plastic has been diverted from landfill.

Other environmental initiatives in 2013–14 included:

> developing a database to record energy, water, waste and carbon use by function and by site, supported by a reporting tool to analyse usage and trend data

> participating in the State Government Greening Better Buildings Program, which provides an independent audit of energy consumption and strategies for reducing demand and greenhouse gas emissions

> initiating pilots for installing LED lighting and reconfiguring the central chilled water system

> replacing condensation heat exchangers on The Alfred site, resulting in significant energy savings and water consumption reduction

> collecting water from the reverse osmosis plant, associated with renal dialysis, to use for watering gardens within The Alfred.

Community involvement

Alfred Health volunteers

During the year, nearly 500 volunteers supported patients, carers, families and staff across Alfred Health, generously giving their time, interest and care. In 2013–14, volunteers assisted with patient care as well as administration, business and support services, providing:

> patient and family support in Emergency Departments and Intensive Care

> archiving, courier and admissions support

> library trolley service

> knitted dolls for children

> kiosk management

> concierge services

> Pink Ladies (flowers)

> gardening assistance

> consumer participation in service-improvement activities.

Importantly, 50 specially trained volunteers worked as part of our consumer register, providing support on service improvements and ensuring that the patient, carer and consumer perspective is well considered. Some examples of consumer involvement this year include administration of the service-wide patient experience survey, the *Let me know* program and a variety of infection prevention initiatives.

Alfred Health benefited from several corporate volunteering opportunities during the year, including the Radisson Hotel and Crowne Plaza, which supply volunteer staff. In 2013–14, there was a noticeable increase in student volunteering, with information partnerships from many universities, including the University of Melbourne, Monash University and Deakin University.

Gifts and donations

The generous gifts from our growing list of loyal and valued supporters helped fund equipment, facilities and research to improve the quality of patient care.

During the year, significant gifts were received from:

THE ALFRED

- Estate of Sylvia Lesley Gleeson
- Estate of Stella McDonald
- Estate of Adolf Haas
- Mr John & Mrs Betty Laidlaw
- Estate of Ruth Leiser
- Estate of Imelda Francis Foster
- The Kefford Family
- Num Pon Soon Charitable Trust
- Estate of Mary Sylvia Joyce Jones
- Estate of Jeffrey Gordon Coles
- Estate of Doreen Mavis Williams
- James and Elsie Borrowman Trust
- AAMI
- Merrin Foundation
- The Margaret Pratt Foundation
- Estate of Barbara Whilton Shearer
- John Swire & Sons
- Swiss Concept Australia
- Estate of Beryl Whitfield
- Gras Foundation

CAULFIELD HOSPITAL

- Helmsmen Kiosk Auxiliary
- Collier Charitable Fund
- Ms Deborah Reich
- Aged Persons Welfare Foundation
- Mr Wilfrid Omer-Cooper
- Estate of Henry Herbet Yoffa

SANDRINGHAM HOSPITAL

- The Alfred & Jean Dickson Foundation
- Bayside Companion Dog Training School
- Mrs Florence Rosier
- Sunrise Foundation
- The William Angliss Charitable Fund
- Collier Charitable Fund
- Cybec Foundation
- Rotary Club Cheltenham
- Black Rock Sports Auxiliary

The Alfred Foundation

The Alfred Foundation raised more than $12 million in 2013–14 for The Alfred, with contributions coming from individuals and community groups, organisations and trusts.

Activities

Following the successful implementation of the Timely Quality Care initiative, The Alfred Foundation's fundraising focus for 2013–14 was redeveloping The Alfred's Emergency and Trauma Centre to support this new improved way of delivering emergency care. Fundraising efforts for this ongoing campaign attracted a wide range of donations.

Other activities for the year included:

Women @ The Alfred: We hosted 500 guests at the 11th annual Chairman's Lunch, raising funds for stereotactic imaging equipment for the William Buckland Radiotherapy Centre to improve treatment of prostate cancer patients.

Community fundraising: Activities included a number of 'In Celebration' events, where people can ask their loved ones to support The Alfred through donations instead of buying presents. Patient-inspired community groups, such as Kate's Table, also continued to grow. Kate's Table raised money for neurology research through a series of events, including a fashion show, a fundraising lunch and a bi-annual bridge tournament.

The Alfred Men's Health Father's Day Appeal 2013: This year, we concentrated on men's heart health, with more than 300,000 copies of the publication *Healthy Men* distributed through corporate and sponsor partners. Proceeds went to redeveloping our Cardiac Unit.

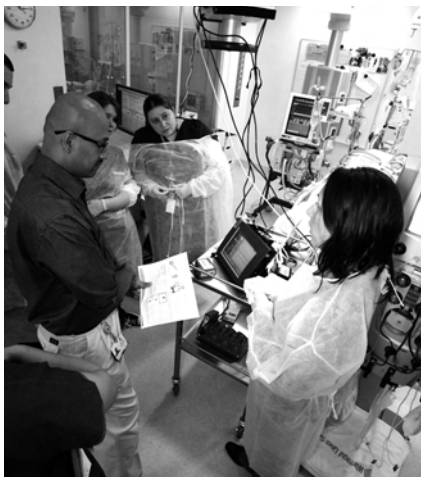
Life Support Committee: A new chairman and several new members introduced a program of unique events for 2014–15 to grow and maintain the supporter base.

In 2013–14 The Alfred Foundation Board comprised:

- Sir Rod Eddington (Chairman)
- Mr Ian Cootes (Deputy Chairman)
- Mr Peter Barnett
- Mr Ravi Bhatia
- Mr Anthony Charles
- Mr Didier Elzinga
- Mr Peter Fox AM
- Mr Ian Johnson
- Mr Michael Kiely
- Mr Eddie McGuire AM
- Ms Angela Mihelcic (Director, The Alfred Foundation)
- Mr Chris Nolan
- Mr Nicholas O'Donohue
- Mr Tony Phillips
- Mr George Richards
- Mr Rob Sayer
- Mr Paul Sheahan AM
- Mrs Carolyn Stubbs
- Associate Professor Andrew Way (Chief Executive, Alfred Health)
- Mr Alan Williams
- Sir Donald Trescowthick AC KBE (Patron)

Governance

Transparency and accountability are fundamental to Alfred Health's governance.



The Alfred's Intensive Care Unit is the largest in the region.

Alfred Health's Board is accountable to the Minister for Health.

Its role is to exercise good governance in achieving the objectives as outlined in Alfred Health's Strategic Plan 2012–15 and the Annual Statement of Priorities.

The Board comprises nine independent non-executive directors who are elected for a period of up to three years and can be re-elected to serve for up to nine years.

Objectives, functions, power and duties

The core object of the service is to provide public health services in accordance with the principles established as guidelines for the delivery of public hospital services in Victoria under section 17AA of the *Health Services Act 1988* (VIC) ('the Act').

The other objects of the service as a public health service are to:

1) provide high-quality health services to the community, which aim to meet community needs effectively and efficiently;
2) integrate care as needed across service boundaries in order to achieve continuity of care and promote the most appropriate level of care to meet the needs of individuals;
3) ensure that health services are aimed at improvements in individual health outcomes and population health status by allocating resources according to best-practice healthcare approaches;
4) ensure that the service strives to continuously improve quality and foster innovation;
5) support a broad range of high-quality health research to contribute to new knowledge and to take advantage of knowledge gained elsewhere;
6) operate in a business-like manner, which maximises efficiency, effectiveness and cost-effectiveness and ensures the financial viability of the service;
7) ensure that mechanisms are available to inform consumers and protect their rights and to facilitate consultation with the community;
8) operate a public health service as authorised by or under the Act; and
9) carry out any other activities that may be conveniently carried out in connection with the operation of a public health service or calculated to make more efficient any of the service's assets or activities.

The powers and duties of Alfred Health are as prescribed by the Act.

Board of Directors as at 30 June 2014

Ms Helen Shardey BComm TSTC MAICD (Chairman)

Chair: Remuneration Committee. Member: Audit, Finance and Quality committees

Ms Shardey was a Member of the Victorian Parliament for 14 years until her retirement in 2010, including five years as the Shadow Minister for Health. She also served as the Shadow Minister for Aged Care; Community Services; Housing; and Multicultural Affairs. Ms Shardey has an in-depth understanding of the health portfolio, the structure and governance of the health system, both state and federal, as well as the development of strategy and health policy. She has previously worked as a corporate consultant and senior policy adviser (Commonwealth Parliament), and was recently appointed Ambassador at Large for the Jewish National Fund of Australia. Ms Shardey is a member of the Australian Institute of Company Directors and a board member of the Assisted Victorian Reproductive Treatment Authority.

Mr Julian Gardner BA LLB FIPAA

Chair: Primary Care & Population Health Advisory Committee. Member: Quality Committee

Mr Gardner is a lawyer whose consultancy has included law reform, advance care planning and public administration. He is the Chair of the Board of Mind Australia Ltd, an NGO providing community mental health services, Chair of the National Reference Group of the Respecting Patient Choices program, and the Vice-Chair of the Australian Press Council. He has previously held positions as Victoria's Public Advocate, President of the Mental Health Review Board, National Convenor of the Social Security Appeals Tribunal, Chairperson of the WorkCare Appeals Board and Director of the Victorian Legal Aid Commission. He is a Fellow of the Institute of Public Administration Australia (Victoria) and a Fellow of International House, University of Melbourne where he was the Council Chair.

Mr David Menadue OAM BA BEd
(retired on 30 June 2014)

Member: Primary Care & Population Health Advisory, Community Advisory and Quality committees

Mr Menadue is a former teacher and editor. He was a founding member of People Living with HIV/AIDS Victoria, holding a variety of roles between 1989 and 2008, including President and Vice President. He was also a founding member of the National Association of People Living with HIV/AIDS. Mr Menadue has held board positions with the Victorian AIDS Council/Gay Men's Health Centre, where he is currently a board member. He was a Director of the AIDS Trust of Australia from 2002 to 2008, a member of the Disability Caucus of Australia from 1998 to 2002 and a Board Member of the Consumer Health Forum between 2001 and 2003. He was made a member of the Order of Australia in 1995 for services to community health.

Associate Professor Jillian Sewell
AM MBBS FRACP FAICD

Chair: Quality Committee

Associate Professor Sewell is a consultant paediatrician and Deputy Director of the Centre for Community Child Health at the Royal Children's Hospital. She is responsible for clinical services in developmental/behavioural paediatrics and runs the Victorian Training Program in Community Child Health for advanced paediatric trainees. Her special interests are in learning difficulties, language delay, attention deficit disorder and other behavioural problems. She is a past President of the Royal Australasian College of Physicians, and was previously President of the Paediatrics and Child Health Division of the College. She has also served on the Australian Council for Safety and Quality in Health Care, the Victorian Quality Council and the National Health and Medical Research Council. Assoc. Prof. Sewell was made a Member of the Order of Australia in January 2005, for services to child health.

Mr Tim Wilson DipBus BA MDiplomacy&Trade (term ended 30 June 2014)

Member: Primary Care & Population Health Advisory and Quality committees

Mr Wilson is an international public policy analyst specialising in trade, public health, intellectual property and climate change policy, and has a particular interest in policy implementation and delivery. He is currently the Federal Human Rights Commissioner, having previously been the Director of Climate Change Policy and the IP and Free Trade Unit at the Institute of Public Affairs, and regularly contributes to public debate. He is also a Senior Fellow at New York's Center for Medicine in the Public Interest. Mr Wilson has previously served on the Council of Monash University and the board of a commercial retail and food services company.

Mr Damien Kenny BCom BBus Systems

Chair: Community Advisory. Member: Quality Committee

Mr Kenny is a commercialisation specialist in IT and digital communications. His experience includes launching and managing the Australian businesses of a number of UK and US software and internet-based companies addressing sectors as diverse as social housing, Allied Health Practice Management and industry-wide data collection and analysis in the performing arts.

Mr Carl Putt BSc MHA (appointed July 2013)

Chair: Finance Committee. Member: Remuneration and Audit committees

Mr Putt has extensive experience in hospital management, financing and redevelopment. During his career he has held senior executive positions in a number of Victorian teaching hospitals. He was involved in the redevelopment and relocation of the Queen Victoria Medical Centre to Clayton; its amalgamation with Prince Henry's and Moorabbin Hospitals in 1987 to form Monash Medical Centre; the establishment of Jessie McPherson Private Hospital; and the subsequent creation of the Southern Health Care Network in 1996. Mr Putt was a Director and subsequent Managing Director of the Victorian Hospital's Association from 1999 to 2002 before taking on the role of Director of Hospital Services in the Northern Territory Department of Health and Community Services. He returned to Melbourne to lead the redevelopment and relocation of the Royal Women's Hospital to Parkville. Since retiring at the end of 2013, Mr Putt has served as Ministerial Delegate to a rural hospital board and has undertaken a number of management reviews in the public hospital sector.

Mr James Turcato CPA, GAICD, AIMM (appointed October 2013)

Chair: Audit Committee. Member: Finance and Remuneration committees

Mr Turcato is a CPA, business consultant and professional facilitator with extensive corporate experience in financial performance, strategic financial decision making and business case development. He has facilitated finance programs for some of Australia's leading organisations from the private, public and non-for-profit sectors, including healthcare organisations such as Medibank, Mercy Health, The Australian Centre for Healthcare Governance, Baptcare and The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Mr Turcato is an accredited facilitator of the Australian Institute of Company Directors and has presented programs for the Loddon Mallee and Albury regional health boards. His experience as a director includes more than five years as a Non-Executive Director of South East Water, including service as a Chair of the Finance, Audit and Risk Committee. He is currently a Director of Gippsland Medicare Local Ltd and Chair of that organisation's Audit and Risk Committee.

Board changes

Board member Anthony Starkins resigned as a director on 4 February 2014.

Board committees

The Alfred Health Board established a number of committees and advisory committees in accordance with sections 65S and 65ZA of the Act and Government Sector Remuneration Panel (GSERP) Policy.

Audit Committee

The Audit Committee assists the Board to fulfil its statutory and fiduciary duties relating to the financial management of Alfred Health with respect to internal controls, accounting and reporting practices. It aims to ensure that those duties are carried out in accordance with the Act, the Financial Management Compliance Framework, the Risk Management Framework and any other relevant legislation. This committee is responsible for overseeing the internal audit function and developing and reviewing the Alfred Health Internal Audit Plan. Also, it is responsible for:

> overseeing the maintenance of an effective system of internal monitoring and control of data integrity risk management

> reviewing the implications of external audit findings for internal controls

> reviewing the annual accounts for recommendation to the Board.

Community Advisory Committee

The Community Advisory Committee (CAC) provides advice to the Board on consumer, carer and community participation and other Alfred Health community initiatives. It advises on priority areas and issues requiring consumer and carer participation. This includes matters of community interest and concern to culturally, religiously and linguistically diverse (CALD) communities. It is a forum through which members of the community can work in partnership with Alfred Health as consumer representatives to improve patient experiences.

Finance Committee

The Finance Committee assists the Board to fulfil its financial responsibilities. This includes reporting to the Board on Alfred Health's financial position and the appropriateness of the financial information prepared by management, receiving and reviewing the annual budget and key budget strategies, and overseeing and supervising the management and implementation of actions to address financial management risks. In addition, the committee considers and recommends to the Board financial commitments that require approval.

Primary Care & Population Health Advisory Committee

The Primary Care & Population Health Advisory Committee assists the Board in ensuring that:

> the health services provided meet the needs of our communities

> the views of users and providers are taken into account

> arrangements are put in place with other relevant agencies and service providers to enable effective and efficient service delivery and continuity of care.

Quality Committee

The Quality Committee was established to ensure that effective and accountable systems are in place to monitor and improve the quality and effectiveness of health services. This involves making certain that:

> any systemic problems identified with the quality and effectiveness of health services are addressed

> continuous improvement and innovation are fostered within Alfred Health.

Remuneration Committee

The Remuneration Committee provides advice to the Board on executive remuneration matters and monitors the implementation of an executive remuneration policy that is consistent with the business objectives and human resources needs of Alfred Health, GSERP policies and prevailing legislation.

Committee membership as at 30 June 2014

Audit Committee

> Mr James Turcato (Chair, appointed October 2013)

> Ms Helen Shardey

> Mr Carl Putt (appointed August 2013)

Finance Committee

> Mr Carl Putt (Chair, appointed August 2013)

> Ms Helen Shardey

> Mr James Turcato (appointed October 2013)

> Mr Andrew Way

Community Advisory Committee

> Mr Damien Kenny (Chair and Board Representative)
> Mr David Menadue (Board Representative)
> Dr Caroline Spencer

Community representatives

> Ms Val Johnstone
> Ms Sarah Gray
> Mr Steve Barrand
> Dr Chan Cheah
> Ms Natalie Ross
> Mrs Lynn Stanton
> Ms Melissa Lowrie
> Dr Lindsay McMillan
> Ms Estie Teller

Primary Care & Population Health Advisory Committee

> Mr Julian Gardner (Chair)
> Mr Tim Wilson
> Mr David Menadue
> Mr Andrew Way

Quality Committee

> Assoc. Prof. Jill Sewell (Chair)
> Mr Julian Gardner
> Mr David Menadue
> Ms Helen Shardey
> Mr Damien Kenny
> Mr Tim Wilson

Remuneration Committee

> Ms Helen Shardey (Chair)
> Mr Carl Putt (appointed August 2013)
> Mr James Turcato (appointed October 2013)

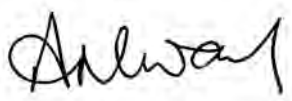
Risk management

The incident reporting system, RiskMan, is an integral component of Alfred Health's risk management system. Regular training and information for staff on the use of RiskMan were provided during the year. Incidents are routinely analysed and trends are reported to the Executive Committee, the Quality Committee and the Audit Committee. Serious incidents are subject to a formal review.

There are several high and extreme risk issues that are addressed by specific committees, including falls prevention, pressure injuries, medication safety and behaviours of concern. This ensures focus and coordination of effort on the important issues for Alfred Health.

Attestation on compliance with Australian/New Zealand Risk Management Standard

I, Andrew Way, certify that Alfred Health has risk management processes in place consistent with the Australian/New Zealand Risk Management Standard and an internal control system is in place that enables the executives to understand, manage and satisfactorily control risk exposures. The Audit Committee verifies this assurance and that the risk profile of Alfred Health has been critically reviewed within the last 12 months.

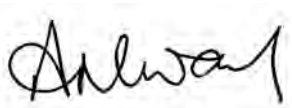


Andrew Way
Chief Executive

Melbourne
14 August 2014

Attestation for compliance with the Ministerial Standing Direction 4.5.5.1 – Insurance

I, Andrew Way, certify that Alfred Health has complied with Ministerial Direction 4.5.5.1 – Insurance.



Andrew Way
Chief Executive

Melbourne
14 August 2014

Senior officers

Chief Executive

Associate Professor Andrew Way *RN BSc(Hons) MBA FAICD*

Responsible to the Board of Directors for the overall effective and efficient performance of Alfred Health and the attainment of strategic directions, Associate Professor Way has been Chief Executive at Alfred Health since July 2009.

During this time Assoc. Prof. Way has concentrated on improving access, ensuring high-quality and safe services with low mortality, and engaging with patient experiences, all within a strong financial framework. He holds several board directorships, including Baker IDI, and has led the development of Victoria's first Academic Health Science Centre – Monash Partners.

Prior to Assoc. Prof. Way's relocation to Melbourne, he had an extensive career in the UK's National Health Service, including his last appointment as the CEO of the Royal Free Hampstead NHS Trust, a major London teaching hospital associated with University College London.

Chief Operating Officer and Deputy Chief Executive

Mr Andrew Stripp *BBSc(Hons) MSc*

Responsible for the leadership of the Operations Division across Alfred Health, including Cardio-respiratory and Intensive Care; Cancer and Medical Specialties; Surgical Services and Outpatients; Emergency and Acute Medicine; Rehabilitation, Aged and Community Care Services; Sandringham Hospital Medical and Surgical Services and Psychiatry.

Mr Stripp has worked in a variety of hospitals and healthcare settings. He has also held roles within the State Government's Department of Human Services as the Director for the state's mental health system, Regional Director for Health, Housing and Community Services, and as Director of Strategy.

Chief Medical Officer

Dr Lee Hamley *MBBS MBA FRACMA*

Responsible for clinical governance, quality and patient safety, the development of the clinical workforce across Alfred Health, professional medical issues, Investigative Services (Pathology and Radiology), Pharmacy and the National Trauma Research Institute.

Dr Hamley's external appointments include membership of the Postgraduate Medical Council of Victoria, Accreditation Sub-Committee and Chair of the Melbourne Metropolitan Medical Executives Committee.

Executive Director Nursing Services, Chief Nursing Officer

Ms Janet Weir-Phyland *RN BScN MBA*

Responsible for Allied Health, the Women and Children's Program, and Sandringham Hospital site management, Caulfield Hospital residential care and site management. Professionally responsible for nursing practice standards, quality and clinical risk, workforce planning and education.

Ms Weir-Phyland has a track record of implementing clinical and quality care initiatives, and developing nursing strategies; she has a particular interest in interdisciplinary practice development.

Executive Director Finance

Mr Peter Joyce *BCom CPA*

Responsible for the preparation of budgets, financial analysis and review, monthly and annual financial results and KPI monitoring. The Supply Chain department and Payroll also form part of the Finance division.

Following a diverse career, including roles as a senior financial executive and general manager, Mr Joyce spent much of the last 12 years as a consultant, small-business owner in the IT industry and serving as a Chief Financial Officer for a company servicing the financial products industry.

Executive Director People and Culture

Ms Chris McLoughlin *BSW*

Responsible for developing and implementing strategies and processes to improve organisational effectiveness, enhancing Alfred Health's role as a centre of excellence for teamwork, leadership, innovation and improvement. Also accountable for building a positive culture that is supported by Alfred Health's values, with teamwork as the basis for service excellence.

Ms McLoughlin is currently on the Board of the Victorian Hospitals' Industrial Association (VHIA) and, in her personal time, sits on the Board of Sacred Heart Mission.

Executive Director Information Development

Dr Ethan Gershon *MD* (resigned May 2014)

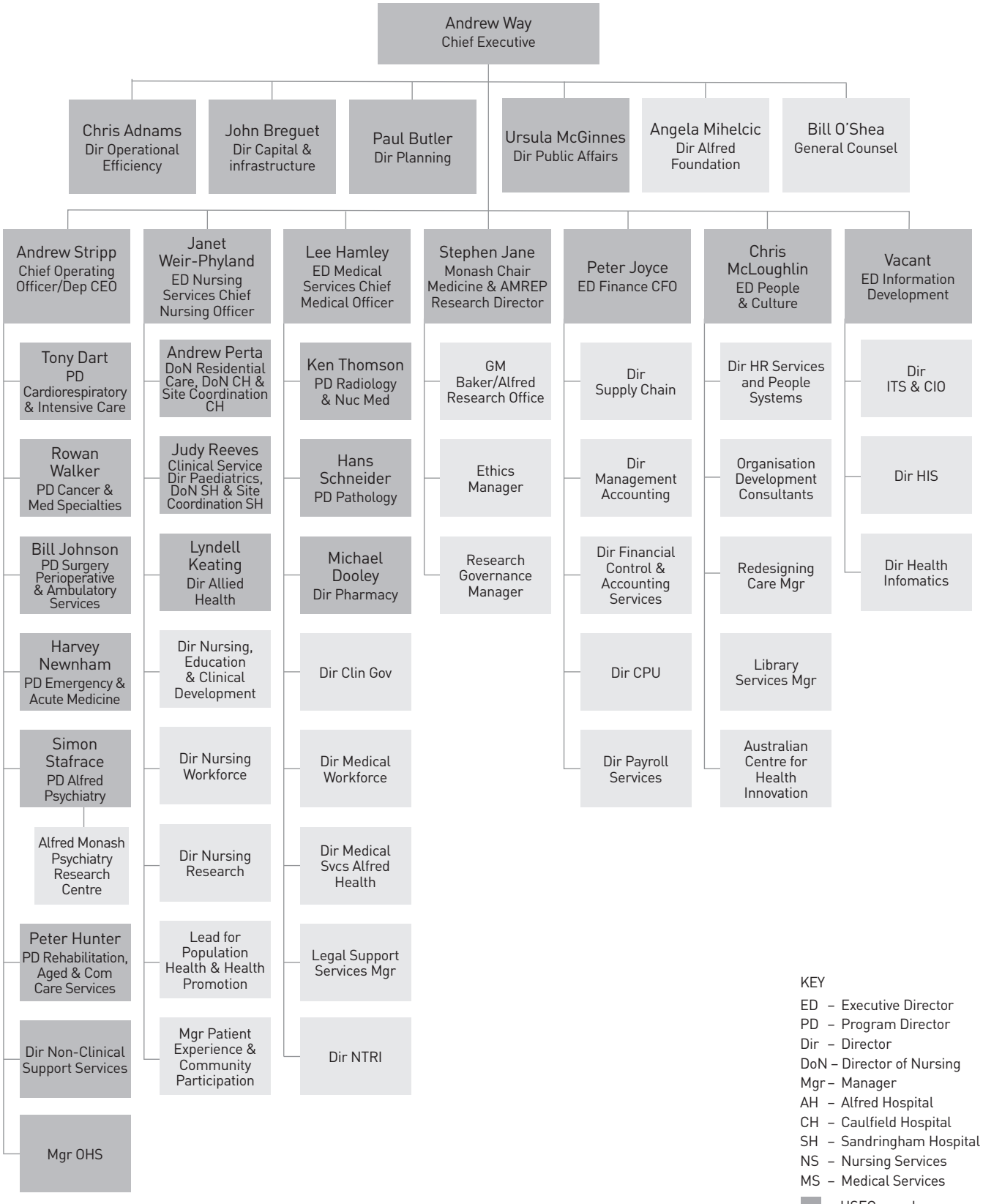
Responsible for managing health service information systems and continuous developing information management that advances quality of care, operational efficiency, and performance in research and education.

General Counsel

Mr Bill O'Shea *BSc DipEd LLB(Hons)*

Responsible for providing legal advice across Alfred Health.

Alfred Health
Organisational Structure
June 2014



General information

Directions of the Minister for Finance

All the information described in the directions of the Minister for Finance is available to the relevant Minister, Members of Parliament or the public on request.

Competitive neutrality

Alfred Health continues to comply with government policy on competitive neutrality.

Alignment with public administration values

Alfred Health assists staff to identify desired behaviours and ensures that policy and practice are underpinned by core public sector values through its Code of Conduct and Financial Code of Practice. These are approved by the Board of Directors and are consistent with the Public Sector Code of Conduct for Victorian Public Sector Employees issued by the Public Sector Standards Commissioner. Principles of equal opportunity and fair and reasonable treatment of others are included in the Code of Conduct and the range of policies and guidelines. This includes a policy and guideline on conflicts of interest. We ensure that policy and practice are consistent with the *Charter of Human Rights and Responsibilities Act 2006* (Vic).

Freedom of Information Act 1982 (Vic)

Freedom of Information Decisions 2013–14

Applications received	2,791
Applications granted (full)	2,501
Applications granted (part)	5
Access denied	3
No documents	28
Other	71
Not finalised	183
Not finalised 2012–13	114
Access granted in full	113
Access granted in part	1

Privacy legislation

During the year, *The Privacy Act 1988* (Cth) was amended by the *Privacy Amendment* (Enhancing Privacy Protection) *Act 2012* (Cth) (Amending Act). The Amending Act replaces the National Privacy Principles (NPPs) with the Australian Privacy Principles (APPs).

While these amendments apply only to Commonwealth Government departments and the private sector, there may be occasions when Alfred Health is required to comply – for example, when undertaking a contract with a Commonwealth entity.

Other relevant legislation that commenced during the year included:

> *Fair Work Amendment Act 2013* No. 73 (Cth), Fair Work Commission Rules 2013 (Cth) and Fair Work Amendment Regulation 2013 (No. 2) (Cth)

> *Fair Work Amendment Act 2013* No. 73 (Cth) and Fair Work Commission Amendment (Anti-bullying and Other Measures) Rules 2013 (Cth).

Summary of procedures

Statement of support

Alfred Health does not tolerate improper conduct by its employees or reprisals being taken against those who disclose such conduct, including under the *Protected Disclosure Act 2012* (Vic). Alfred Health supports the disclosure of corrupt conduct, and of conduct involving a substantial mismanagement of public resources or a substantial risk to public health and safety or the environment.

Corrupt conduct

Corrupt conduct means:

> conduct that adversely affects the honest performance of functions

> the dishonest performance of functions or performance with inappropriate partiality

> conduct that amounts to a breach of public trust

> conduct that amounts to the misuse of information/ material acquired in the course of one's duties

> a conspiracy or attempt to engage in the above conduct.

Complaints about certain serious misconduct or corruption involving public health services in Victoria can be made by individuals directly to the Independent Broad-based Anticorruption Commission (IBAC).

Alfred Health encourages individuals to raise their concerns with IBAC if they are uncomfortable raising their concerns directly with Alfred Health or if they feel some detrimental action has been, or may be, taken against them if they make a complaint.

Preventing detrimental action

Alfred Health is committed to extend the protections under the *Protected Disclosure Act 2012* (Vic) to individuals who make protected disclosures under that Act, or who cooperate with investigations into protected disclosures. Under the Act, it is an offence for a person to take, incite or threaten detrimental action against any person because of, or because of a substantial belief that:

1) the other person or anyone else has made, or intends to make, a protected disclosure; or
2) the other person or anyone else has cooperated, or intends to cooperate, with an investigation of a protected disclosure.

Detrimental action includes:

1) action causing injury, loss or damage
2) intimidation or harassment
3) discrimination, disadvantage or adverse treatment in relation to a person's employment, career, profession, trade or business, including the taking of disciplinary action.

The penalties under the Act for taking or threatening to take detrimental action include fines and imprisonment for up to two years. Civil action may also be taken, in which case compensation may be ordered. If an officer or employee suspects that detrimental action may have been taken or has been threatened, they should raise their concerns with the Alfred Health Chief Executive immediately.

Alfred Health will take all reasonable steps to protect the identity of a whistleblower.

Consultancies

Consultancy Fees 2013–14

Consultant	Purpose of Consultancy	Start Date	End Date	Total Approved Project Fee (excl. GST)	Expenditure 2013–14 (excl. GST)	Future Expenditure (excl. GST)
Bridge Advisory	Caulfield Residential Aged Care Commercial Advisory	Apr 2014	Oct 2014	$199,000	$58,000	$141,000
Ernst & Young	Western Tower Block Feasibility Study	Apr 2013	Sep 2014	$98,500**	$68,500	0
PWC	Western Tower Block Preliminary Business Case	Nov 2013	May 2014	$100,000	$54,978	$45,022
McKinsey	Savings Value Program	Nov 2014	Jun 2014	$2.2m	$2.2m	0

Notes: There were no consultancies under $10,000 during the year.
**Ernst & Young was paid $30,000 of its project fee in 2012–13.

Additional information

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

a. a statement of pecuniary interest has been completed;

b. details of shares held by senior officers as nominee or held beneficially;

c. details of publications produced by the Department about the activities of Alfred Health and where they can be obtained;

d. details of changes in prices, fees, charges, rates and levies charged by Alfred Health;

e. details of any major external reviews carried out on Alfred Health;

f. details of major research and development activities undertaken by Alfred Health that are not otherwise covered either in the Report of Operations or in a document that contains the financial statements and Report of Operations;

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 Alfred Health to develop community awareness of Alfred Health and its services;

i. details of assessments and measures undertaken to improve the occupational health and safety of employees;

j. general statement on industrial relations within Alfred Health and details of time lost through industrial accidents and disputes that are not otherwise detailed in the Report of Operations;

k. a list of major committees sponsored by Alfred Health, the purposes of each committee and the extent to which those purposes have been achieved;

l. details of all consultancies and contractors, including consultants/contractors engaged, services provided and expenditure committed for each engagement.

Disclosure index

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

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F – Financial Statements

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Management and structure		
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Financial and other information		
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FRD 11A	Disclosure of ex gratia payments	N/A
FRD 12A	Disclosure of major contracts	N/A
FRD 21B	Responsible person and executive officer disclosures	100
FRD 22E	Application and operation of Protected Disclosure Act 2012 (Vic)	39
FRD 22E	Application and operation of Carers Recognition Act 2012 (Vic)	13
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FRD 22E	Compliance with building and maintenance provision of Building Act 1993 (Vic)	27
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Legislation	Requirement	Page
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Carers Recognition Act 2012 (Vic)		13
Victorian Industry Participation Act 2003 (Vic)		N/A
Building Act 1993 (Vic)		27
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N/A – Not Applicable

Financial Statements

30 June 2014

Established as Bayside Health, the name of the health service was changed to Alfred Health from 10 September 2008, by order of the Governor in Council.

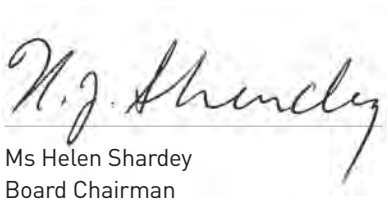
Board member's, accountable officer's and chief finance & accounting officer's declaration

We certify that the attached financial statements for Alfred Health and the Consolidated Entity have been prepared in accordance with Standing Directions 4.2 of the *Financial Management Act* 1994, applicable Financial Reporting Directions, Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2014 and financial position of Alfred Health and the Consolidated Entity at 30 June 2014.

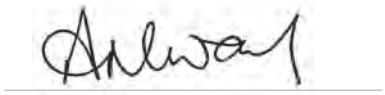
At the time of signing, we are not aware of any circumstance which would render any particulars included in the financial statements to be misleading or inaccurate.

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



Ms Helen Shardey
Board Chairman

Melbourne
14 August 2014



Mr Andrew Way
Accountable Officer

Melbourne
14 August 2014

Mr Peter Joyce
Chief Finance & Accounting Officer

Melbourne
14 August 2014

VAGO
Victorian Auditor-General's Office

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

INDEPENDENT AUDITOR'S REPORT

To the Board Members, Alfred Health

The Financial Report

The accompanying financial report for the year ended 30 June 2014 of Alfred Health which comprises comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement, notes comprising a summary of significant accounting policies and other explanatory information, and the Board member's, accountable officer's and chief finance and accounting officer's declaration has been audited. The financial report is the consolidated financial statements of the economic entity, comprising the Alfred Health and the entities it controlled at the year's end or from time to time during the financial year as disclosed in note 26 to the financial statements.

The Board Members' Responsibility for the Financial Report

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

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The audit procedures selected depend on judgment, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, consideration is given to the internal control relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Alfred Health and the consolidated entity's internal control. An audit also includes evaluating the appropriateness of the accounting policies used, and the reasonableness of accounting estimates made by the Board Members, as well as evaluating the overall presentation of the financial report.

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

Independent Auditor's Report (continued)

Independence

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

Opinion

In my opinion, the financial report presents fairly, in all material respects, the financial position of Alfred Health and the consolidated entity as at 30 June 2014 and of their financial performance and cash flows for the year then ended in accordance with applicable Australian Accounting Standards, and the financial reporting requirements of the Financial Management Act 1994.

Matters Relating to the Electronic Publication of the Audited Financial Report

This auditor's report relates to the financial report of the Alfred Health for the year ended 30 June 2014 included both in Alfred Health's annual report and on the website. The Board Members of Alfred Health are responsible for the integrity of Alfred Health's website. I have not been engaged to report on the integrity of Alfred Health's website. The auditor's report refers only to the subject matter described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these statements. If users of the financial report are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial report to confirm the information contained in the website version of the financial report.

MELBOURNE
15 August 2014

John Doyle
Auditor-General

Comprehensive Operating Statement for the Financial Year Ended 30 June 2014

	Note	Parent Entity 2014	Parent Entity 2013	Consol'd 2014	Consol'd 2013
		$'000	$'000	$'000	$'000
Revenue from operating activities	2	909,264	884,459	909,264	884,459
Revenue from non-operating activities	2	4,899	4,626	6,472	5,950
Employee expenses	3	(603,879)	(582,457)	(603,879)	(582,457)
Non salary labour costs	3	(11,757)	(14,734)	(11,757)	(14,734)
Supplies and consumables	3	(189,237)	(184,974)	(189,237)	(184,974)
Other expenses	3	(110,313)	(107,682)	(110,636)	(108,133)
Net Result Before Capital & Specific Items		**(1,023)**	**(762)**	**227**	**111**
Capital purpose income	2	21,865	23,990	21,865	23,990
Other capital expenses	3	(685)	(616)	(685)	(616)
Depreciation and amortisation	3	(46,117)	(47,179)	(46,117)	(47,179)
Finance costs	3	(240)	(1,478)	(240)	(1,478)
Net Result For the Year		**(26,200)**	**(26,045)**	**(24,950)**	**(25,172)**
Other Comprehensive Income					
Items that will not be reclassified to net result					
Changes in Physical Asset Revaluation Surplus		284,997	–	284,997	–
Items that may be reclassified subsequently to net result					
Changes to financial assets available-for-sale revaluation surplus		1,043	6,695	1,767	7,869
Total Other Comprehensive Income	**17**	**286,040**	**6,695**	**286,764**	**7,869**
COMPREHENSIVE RESULT		**259,840**	**(19,350)**	**261,814**	**(17,303)**

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

Balance Sheet as at 30 June 2014

	Note	Parent Entity 2014	Parent Entity 2013	Consol'd 2014	Consol'd 2013
		$'000	$'000	$'000	$'000
Current Assets					
Cash and cash equivalents	6	13,493	18,775	13,702	18,795
Receivables	7	33,645	31,754	33,843	31,754
Inventories	9	7,282	7,259	7,282	7,259
Other current assets	10	2,184	2,069	2,184	2,069
Total Current Assets		**56,604**	**59,857**	**57,011**	**59,877**
Non-Current Assets					
Receivables	7	4,500	14,238	4,500	14,238
Investments and other financial assets	8	41,904	40,189	56,880	53,656
Property, plant & equipment	11	962,875	674,817	962,875	674,817
Intangible assets	12	4,924	5,596	4,924	5,596
Total Non–Current Assets		**1,014,203**	**734,840**	**1,029,179**	**748,307**
TOTAL ASSETS		**1,070,807**	**794,697**	**1,086,190**	**808,184**
Current Liabilities					
Payables	13	56,005	62,797	56,023	62,893
Interest bearing liabilities	14	1,241	1,093	1,241	1,093
Provisions	15	158,093	144,001	158,093	144,001
Other current liabilities	16	98	76	98	76
Total Current Liabilities		**215,437**	**207,967**	**215,455**	**208,063**
Non-Current Liabilities					
Interest bearing liabilities	14	28,878	21,357	28,878	21,357
Provisions	15	20,730	19,452	20,730	19,452
Total Non–Current Liabilities		**49,608**	**40,809**	**49,608**	**40,809**
TOTAL LIABILITIES		**265,045**	**248,776**	**265,063**	**248,872**
NET ASSETS		**805,762**	**545,921**	**821,127**	**559,312**
EQUITY					
Property, plant & equipment revaluation surplus	17	511,301	226,303	511,301	226,303
Financial assets available for sale revaluation surplus	17	16,717	15,674	18,916	17,149
General purpose surplus	17	58,721	63,220	58,721	63,220
Restricted specific purpose surplus	17	52,889	55,445	67,428	69,984
Contributed capital	17	324,134	324,134	324,134	324,134
Accumulated deficits	17	(158,000)	(138,855)	(159,373)	(141,478)
TOTAL EQUITY		**805,762**	**545,921**	**821,127**	**559,312**
Commitments	20				
Contingent assets and contingent liabilities	21				

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

Statement of Changes in Equity for the Financial Year Ended 30 June 2014

Parent	Note	Property, Plant & Equipment Revaluation Surplus	Financial Assets Available for Sale Revaluation Surplus	General Purpose Surplus	Restricted Specific Purpose Surplus	Contributions by Owners	Accumulated Surpluses/ (Deficits)	Total
		$'000	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 30 June 2012		**226,303**	**8,979**	**59,121**	**51,109**	**324,134**	**(155,588)**	**514,058**
Effect of correction of errors		–	–	–	–	–	51,213	51,213
Restated Balance at 30 June 2012		**226,303**	**8,979**	**59,121**	**51,109**	**324,134**	**(104,375)**	**565,271**
Net result for the year as restated		–	–	–	–	–	(26,045)	(26,045)
Other comprehensive income for the year		–	6,695	–	–	–	–	6,695
Transfer from accumulated surplus		–	–	4,099	4,336	–	(8,435)	–
Balance at 30 June 2013		**226,303**	**15,674**	**63,220**	**55,445**	**324,134**	**(138,855)**	**545,921**
Net result for the year		–	–	–	–	–	(26,200)	(26,200)
Other comprehensive income for the year		–	1,043	–	–	–	–	1,043
Revaluation of land and buildings		284,998	–	–	–	–	–	284,998
Transfer from accumulated surplus		–	–	(4,499)	(2,556)	–	7,055	–
Balance at 30 June 2014		**511,301**	**16,717**	**58,721**	**52,889**	**324,134**	**(158,000)**	**805,762**

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

Statement of Changes in Equity for the Financial Year Ended 30 June 2014

Consolidated	Note	Property, Plant & Equipment Revaluation Surplus	Financial Assets Available for Sale Revaluation Surplus	General Purpose Surplus	Restricted Specific Purpose Surplus	Contributions by Owners	Accumulated Surpluses/ (Deficits)	Total
		$'000	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 30 June 2012		**226,303**	**9,280**	**59,121**	**65,648**	**324,134**	**(159,084)**	**525,402**
Effect of correction of errors		–	–	–	–	–	51,213	51,213
Restated Balance at 30 June 2012		**226,303**	**9,280**	**59,121**	**65,648**	**324,134**	**(107,871)**	**576,615**
Net result for the year as restated		–	–	–	–	–	(25,172)	(25,172)
Other comprehensive income for the year		–	7,869	–	–	–	–	7,869
Transfer from accumulated surplus		–	–	4,099	4,336	–	(8,435)	–
Balance at 30 June 2013		**226,303**	**17,149**	**63,220**	**69,984**	**324,134**	**(141,478)**	**559,312**
Net result for the year		–	–	–	–	–	(24,950)	(24,950)
Other comprehensive income for the year		–	1,767	–	–	–	–	1,767
Revaluation of land and buildings		284,998	–	–	–	–	–	284,998
Transfer from accumulated surplus		–	–	(4,499)	(2,556)	–	7,055	–
Balance at 30 June 2014		**511,301**	**18,916**	**58,721**	**67,428**	**324,134**	**(159,373)**	**821,127**

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

Cash Flow Statement for the Financial Year Ended 30 June 2014

	Note	Parent Entity 2014	Parent Entity 2013	Consol'd 2014	Consol'd 2013
		$'000	$'000	$'000	$'000
CASH FLOWS FROM OPERATING ACTIVITIES					
Operating grants from government		779,342	753,533	779,342	753,533
Patient and resident fees received		34,880	36,335	34,880	36,335
Private practice fees received		43,663	42,651	43,663	42,651
Donations and bequests received		15,933	13,850	15,933	13,850
GST received from / (paid to) ATO		30,104	26,279	30,132	26,333
Other receipts		50,079	45,559	50,241	45,435
Total Receipts		**954,001**	**918,207**	**954,191**	**918,137**
Employee expenses paid		(590,817)	(581,912)	(590,817)	(581,912)
Non salary labour costs		(9,488)	(12,004)	(9,488)	(12,004)
Payments for supplies and consumables		(333,511)	(315,558)	(333,940)	(315,960)
Finance costs		(1,407)	(1,478)	(1,407)	(1,478)
Total Payments		**(935,223)**	**(910,952)**	**(935,652)**	**(911,354)**
Cash Generated from Operations		**18,778**	**7,255**	**18,539**	**6,783**
Capital grants from government		14,097	20,707	14,097	20,707
NET CASH FLOW FROM OPERATING ACTIVITIES	**18**	**32,875**	**27,962**	**32,636**	**27,490**
Cash flows from investing activities					
Purchase of property, plant and equipment		(49,190)	(37,083)	(49,190)	(37,083)
Proceeds from sale of non-financial assets		–	616	–	616
Proceeds from sale of investments		2,158	3,741	2,586	3,741
NET CASH USED IN INVESTING ACTIVITIES		**(47,032)**	**(32,726)**	**(46,604)**	**(32,726)**
Cash flows from financing activities					
Proceeds from borrowings		10,000	–	10,000	–
Repayment of borrowings		(1,164)	(1,093)	(1,164)	(1,093)
Net cash used in financing activities		**8,836**	**(1,093)**	**8,836**	**(1,093)**
Net increase/(decrease) in cash and cash equivalents held		**(5,321)**	**(5,857)**	**(5,132)**	**(6,329)**
Cash and cash equivalents at beginning of financial year		18,703	24,560	18,723	25,052
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	**6**	**13,382**	**18,703**	**13,591**	**18,723**

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

Notes to the Financial Statements

30 June 2014

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Note 1: Summary of Significant Accounting Policies

These annual financial statements represent the audited general purpose financial statements for Alfred Health and the Consolidated Entity for the period ended 30 June 2014. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

These Financial Statements are general purpose financial statements which have been prepared in accordance with the *Financial Management Act 1994* and applicable Australian Accounting Standards (AASs), which include interpretations issued by the Australian Accounting Standards Board (AASB). They are presented in a manner consistent with the requirements of AASB101 *Presentation of Financial Statements*.

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

Alfred Health is a not-for profit entity and therefore applies the additional AUS paragraphs applicable to "not-for-profit" Health Services under the AASs.

The annual financial statements were authorised for issue by the Board of Alfred Health on 14 August 2014.

(b) Basis of accounting preparation and measurement

Accounting policies are selected and applied in a manner which ensures that the resulting financial information satisfies the concepts of relevance and reliability, thereby ensuring that the substance of the underlying transactions or other events is reported.

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2014, and the comparative information presented in these financial statements for the year ended 30 June 2013.

The going concern basis was used to prepare the financial statements. Alfred Health contemplates the continuity of normal trading operations and the realisation of assets and settlement of liabilities in the ordinary course of business. The Department of Health (DH) has confirmed in writing its intention to continue to provide financial support to Alfred Health up until September 2015.

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

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

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

> Non-current physical assets, which subsequent to acquisition, are measured at a revalued amount being their fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made and are reassessed with sufficient regularity to ensure that the carrying amounts do not materially differ from their fair values;

> Available-for-sale investments which are measured at fair value with movements reflected in equity until the asset is derecognised (i.e. other comprehensive income – items that may be reclassified subsequent to net result); and

> The fair value o f assets other than land is generally based on their depreciated replacement value.

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

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

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

> Level 1 – Quoted (unadjusted) market prices in active markets for identical assets or liabilities

> Level 2 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable

> Level 3 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

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

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

The Valuer-General Victoria (VGV) is Alfred Health's independent valuation agency. Alfred Health, in conjunction with VGV monitors the changes in the fair value of each asset and liability through relevant data sources to determine whether a revaluation is required.

For the financial year ending 30 June 2014 VGV performed formal valuations on Alfred Health's land and buildings in accordance with FRD103E. These valuations were confirmed by VGV to be compliant with AASB 13. Fair values of land and buildings have been adjusted to the fair values specified in the formal valuations as at 30 June 2014.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision, and future periods if the revision affects both current and future periods. Judgements made by management in the application of AASs that have significant effects on the financial statements and estimates, with a risk of material adjustments in the subsequent reporting period, are disclosed throughout the notes to the financial statements.

(c) Reporting Entity

The financial statements include all the controlled activities of Alfred Health. Its principal address is:

55 Commercial Road
Melbourne
Victoria 3004

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

(d) Principles of Consolidation

In accordance with AASB127 *Consolidated and Separate Financial Statements*, the consolidated financial statements of Alfred Health incorporate the assets and liabilities of all entities controlled by Alfred Health as at 30 June 2014, and their income and expenses for that part of the reporting period in which control existed. Control exists when Alfred Health has the power to govern the financial and operating policies of an entity so as to obtain benefits from its activities.

In assessing control, potential voting rights that presently are exercisable are taken into account. The consolidated financial statements include the audited financial statements of the controlled entities listed in Note 26.

In the process of preparing consolidated financial statements for Alfred Health, all material transactions and balances between consolidated entities are eliminated.

INTERSEGMENT TRANSACTIONS

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

(e) Scope and presentation of financial statements

FUND ACCOUNTING

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

SERVICES SUPPORTED BY HEALTH SERVICES AGREEMENT AND SERVICES SUPPORTED BY HOSPITAL AND COMMUNITY INITIATIVES

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

RESIDENTIAL AGED CARE SERVICE

The Caulfield Residential Aged Care Service operations are an integral part of Alfred Health and share some of its resources. Where separately identified, property, plant and equipment has been allocated to these operations. Where not separately identified, assets and liabilities have been apportioned on the basis of revenue generated, expenses incurred and staff employed. The results of the two operations have been segregated based on actual revenue earned and expenditure incurred by each operation in Note 2b to the financial statements.

The Caulfield Residential Aged Care Service is substantially funded from Commonwealth bed-day subsidies.

Note 1 – Summary of Significant Accounting Policies (continued)

COMPREHENSIVE OPERATING STATEMENT

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

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

> Capital purpose income, which comprises all tied grants, donations and bequests received for the purpose of acquiring non-current assets, such as capital works, plant and equipment or intangible assets. It also includes donations of plant and equipment (refer Note 1(g)). Consequently the recognition of revenue as capital purpose income is based on the intention of the provider of the revenue at the time the revenue is provided.

> Impairment of financial and non-financial assets, includes all impairment losses (and reversal of previous impairment losses) which have been recognised in accordance with Notes 1 (j) and (k)

> Depreciation and amortisation, as described in Note 1 (h)

> Assets provided or received free of charge (refer to Notes 1 (g) and (h))

> Expenditure using capital purpose income, comprises expenditure which either falls below the asset capitalisation threshold or does not meet asset recognition criteria and therefore does not result in the recognition of an asset in the balance sheet, where funding for that expenditure is from capital purpose income.

BALANCE SHEET

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

STATEMENT OF CHANGES IN EQUITY

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

CASH FLOW STATEMENT

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

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

(f) Change in Accounting Policies

The following new and revised accounting standards were adopted by Alfred Health.

AASB 13 FAIR VALUE MEASUREMENT

AASB 13 establishes a single source of guidance for all fair value measurements. AASB 13 does not change when a health service is required to use fair value, but rather provides guidance on how to measure fair value under Australian Accounting Standards when fair value is required or permitted. Alfred Health has considered the specific requirements relating to highest and best use, valuation premise, and principal (or most advantageous) market. The methods, assumptions, processes and procedures for determining fair value were revised and adjusted where applicable. In light of AASB 13, the health service has reviewed the fair value principles as well as its current valuation methodologies in assessing the fair value, and the assessment has not materially changed the fair values recognised.

AASB 13 has predominantly impacted the disclosures of the health service. It requires specific disclosures about fair value measurements and disclosures of fair values, some of which replace existing disclosure requirements in other standards, including AASB 7 *Financial Instruments: Disclosures*.

The disclosure requirements of AASB 13 apply prospectively and need not to be provided for comparative periods, before initial application. Consequently, comparatives of these disclosures have not been provided for 2012-13, except for financial instruments, of which the fair value disclosures are required under AASB 7 *Financial Instruments Disclosures*.

AASB 119 EMPLOYEE BENEFITS

In 2013-14, Alfred Health has applied AASB 119 *Employee Benefits (Sep 2011, as amended)*, and related consequential amendments for the first time.

The revised AASB 119 changes the accounting for defined benefit plans and termination benefits. The most significant change relates to the accounting for changes in defined benefit obligation and plan assets. As the current accounting policy is for the Department of Treasury and Finance to recognise and disclose the State's defined benefit liabilities in its financial statements, changes in defined benefit obligations and plan assets will have limited impact on the health service.

The revised standard also changes the definition of short-term employee benefits. These were previously benefits that were expected to be settled within 12 months after the end of the reporting period in which the employees render the related service, however, short-term employee benefits are now defined as benefits expected to be settled wholly within 12 months after the end of the reporting period in which the employees render the related service. As a result, accrued annual leave balances which were previously classified as short-term employee benefits no longer meet this definition and are now classified as long-term employee benefits. This has resulted in a change of measurement for the annual leave provision from an undiscounted to discounted basis.

This change has not materially altered Alfred Health's measurement of the annual leave provision. As such no change has been made to comparative amounts for 2012-13.

(g) Income from Transactions

Income is recognised in accordance with AASB 118 *Revenue* and is recognised as to the extent that it is probable that the economic benefits will flow to Alfred Health and the income can be reliably measured at fair value. Unearned income at reporting date is reported as income received in advance.

Amounts disclosed as revenue are, where applicable, net of returns, allowances and duties and taxes.

GOVERNMENT GRANTS AND OTHER TRANSFERS OF INCOME (OTHER THAN CONTRIBUTIONS BY OWNERS)

In accordance with AASB 1004 *Contributions*, government grants and other transfers of income (other than contributions by owners) are recognised as income when Alfred Health gains control of the underlying assets irrespective of whether conditions are imposed on Alfred Health's use of the contributions.

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

INDIRECT CONTRIBUTIONS FROM THE DEPARTMENT OF HEALTH

> Insurance is recognised as revenue following advice from the Department of Health.

> Long Service Leave (LSL) - Revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Metropolitan Health and Aged Care Services Division Hospital Circular 05/2013 (update for 2012-13).

PATIENT AND RESIDENT FEES

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

PRIVATE PRACTICE FEES

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

DONATIONS AND OTHER BEQUESTS

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

DIVIDEND REVENUE

Dividend revenue is recognised when the right to receive payment is established.

INTEREST REVENUE

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

SALE OF INVESTMENTS

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

FAIR VALUE OF ASSETS AND SERVICES RECEIVED FREE OF CHARGE OR FOR NOMINAL CONSIDERATION

Resources received free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them, irrespective of whether restrictions or conditions are imposed over the use of the contributions, unless received from another Health Service or agency as a consequence of a restructuring of administrative arrangements. In the latter case, such transfer will be recognised at carrying value. Contributions in the form of services are only recognised when a fair value can be reliably determined and the services would have been purchased if not received as a donation.

Note 1 – Summary of Significant Accounting Policies (continued)

(h) Expense Recognition

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

COST OF GOODS SOLD

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

EMPLOYEE EXPENSES

Employee expenses include:

> Wages and salaries;

> Annual leave;

> Sick leave;

> Long service leave;

> Workcover; and

> Superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

Defined contribution superannuation plans

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

Defined benefit superannuation plans

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

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

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

	Fund	Contributions Paid or Payable for the year	
		2014	2013
		$'000	$'000
Defined benefit plans:	Health Super	1,092	1,101
	ESSC	–	–
Defined contribution plans:	First State	27,678	26,936
	Vic Super	143	151
	HESTA	15,114	14,098
	Other	3,612	3,069
	Total	**47,639**	**45,355**

DEPRECIATION

Assets with a cost in excess of $2,500 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives. Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health.

Depreciation is provided on property, plant and equipment, including freehold buildings, but excluding land and investment properties. Depreciation begins when the asset is available for use, which is when it is in the location and condition necessary for it to be capable of operating in a manner intended by management.

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

	2013/14	2012/13
Buildings	25–56 years	25–40 years
Plant & Equipment	10–20 years	10–20 years
Medical Equipment	8–10 years	8–10 years
Computers	3 years	3 years
Furniture and Fittings	10–15 years	10–15 years
Motor Vehicles	8 years	8 years
Intangible Assets	3–4 years	3–4 years
Leasehold Improvements	40 years	40 years

AMORTISATION

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

Alfred Health does not have any intangible assets with indefinite useful lives.

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

Intangible assets with finite lives are amortised over a 3 to 4 year period (2013: 3 to 4 years)

FINANCE COSTS

Finance costs are recognised as expenses in the period in which they are incurred.

Finance costs include:

> interest on bank overdrafts and short-term and long-term borrowings;

> amortisation of discounts or premiums relating to borrowings;

> amortisation of ancillary costs incurred in connection with the arrangement of borrowings; and

> finance charges in respect of finance leases recognised in accordance with AASB 117 *Leases*.

GRANTS AND OTHER TRANSFERS

Grants and other transfers to third parties (other than contribution to owners) are recognised as an expense in the reporting period in which they are paid or payable. They include transactions such as: grants, subsidies and personal benefit payments made in cash to individuals.

OTHER OPERATING EXPENSES

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

SUPPLIES AND CONSUMABLES

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

BAD AND DOUBTFUL DEBTS

Refer to Note 1 (k) Impairment of financial assets.

FAIR VALUE OF ASSETS, SERVICES AND RESOURCES PROVIDED FREE OF CHARGE OR FOR NOMINAL CONSIDERATION

Contributions of resources provided free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them, irrespective of whether restrictions or conditions are imposed over the use of the contributions, unless received from another agency as a consequence of a restructuring of administrative arrangements. In the latter case, such a transfer will be recognised at its carrying value. Contributions in the form of services are only recognised when a fair value can be reliably determined and the services would have been purchased if not donated.

BORROWING COSTS OF QUALIFYING ASSETS

In accordance with the paragraphs of AASB 123 Borrowing Costs applicable to not-for-profit public sector entities, the Health Services continues to recognise borrowing costs immediately as an expense, to the extent that they are directly attributable to the acquisition, construction or production of a qualifying asset.

(i) Other comprehensive income

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

NET GAIN/(LOSS) ON NON-FINANCIAL ASSETS

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

REVALUATION GAINS/(LOSSES) OF NON-FINANCIAL PHYSICAL ASSETS

Refer to Note 1(l) Revaluations of non-financial physical assets.

NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS

Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal and is the difference between the proceeds and the carrying value of the asset at the time.

Note 1 – Summary of Significant Accounting Policies (continued)

NET GAIN/(LOSS) ON FINANCIAL INSTRUMENTS

Net gain/(loss) on financial instruments includes:

> realised and unrealised gains and losses from revaluations of financial instruments at fair value;

> impairment and reversal of impairment for financial instruments at amortised cost (refer to Note 1 (k)); and

> disposals of financial assets and derecognition of financial liabilities

REVALUATIONS OF FINANCIAL INSTRUMENT AT FAIR VALUE

Refer to Note 1 (j) Financial instruments.

OTHER GAINS/(LOSSES) FROM OTHER COMPREHENSIVE INCOME

Other gains/(losses) include:

> the revaluation of the present value of the long service leave liability due to changes in the bond interest rates; and

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

(j) 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 Alfred Health's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation*. For example, statutory receivables arising from taxes, fines and penalties do not meet the definition of financial instruments as they do not arise under contract.

Where relevant, for note disclosure purposes, a distinction is made between those financial assets and financial liabilities that meet the definition of financial instruments in accordance with AASB132 and those that do not.

The following refers to financial instruments unless otherwise stated.

LOANS AND RECEIVABLES

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

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

AVAILABLE-FOR-SALE FINANCIAL ASSETS

Available-for-sale financial instrument assets are those designated as available-for-sale or not classified in any other category of financial instrument asset. Such assets are initially recognised at fair value. Subsequent to initial recognition, gains and losses arising from changes in fair value are recognised in 'other comprehensive income' until the investment is disposed of or is determined to be impaired, at which time the cumulative gain or loss previously recognised in equity is included in the net result for the period. Fair value is determined in the manner described in Note 19.

FINANCIAL LIABILITIES AT AMORTISED COST

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

Financial instrument liabilities measured at amortised cost include all of Alfred Health's contractual payables, deposits held and advances received, and interest-bearing arrangements other than those designated at fair value through profit and loss.

(k) Assets

CASH AND CASH EQUIVALENTS

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

RECEIVABLES

Receivables consist of:

> Contractual receivables, which includes mainly debtors in relation to goods and services, loans to third parties, accrued investment income, and finance lease receivables; and

> Statutory receivables, which includes predominantly amounts owing from the Victorian Government and Goods and Services Tax (GST) input tax credits recoverable.

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

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

Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition. Collectability of debts is reviewed on an ongoing basis, and debts which are known to be uncollectible are written off. A provision for doubtful debts is recognised when there is objective evidence that the debts may not be collected and bad debts are written off when identified.

INVESTMENTS AND OTHER FINANCIAL ASSETS

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

Investments are classified in the following categories:

> Loans and Receivables; and

> Available-for-Sale financial assets.

These assets currently include Alfred Health's trustee investments, the income of which Alfred Health is wholly entitled to and, on a consolidated basis, the Whole Time Medical Specialists' Private Practice Scheme and Trust Fund.

Alfred Health classifies its other financial assets between current and non-current assets based on the purpose for which the assets were acquired. Management determines the classification of its other financial assets at initial recognition.

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

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

IMPAIRMENT OF FINANCIAL ASSETS

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

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

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

Where the fair value of an investment in an equity instrument at balance date has reduced by 20 per cent or more than its cost price or where its fair value was less than its cost price for a period of 12 or more months, the financial asset is treated as impaired.

In order to determine an appropriate fair value as at 30 June 2014 for its portfolio of financial assets, Alfred Health obtained a valuation based on the best available advice using market values through reputable financial institutions. This value was compared against the valuation methodologies provided by the issuer as at 30 June 2014. These methodologies were critiqued and considered to be consistent with standard market valuation techniques.

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

NET GAIN / (LOSS) ON FINANCIAL INSTRUMENTS

Net gain / (loss) on financial instruments includes:

> realised and unrealised gains and losses from revaluations of financial instruments that are designated at fair value through profit or loss or held-for-trading;

> impairment and reversal of impairment for financial instruments at amortised cost; and

> disposals of financial assets.

Note 1 – Summary of Significant Accounting Policies (continued)

REVALUATIONS OF FINANCIAL INSTRUMENTS AT FAIR VALUE

The revaluation gain/(loss) on financial instruments at fair value excludes dividends or interest earned on financial assets.

(l) Non-Financial Assets

INVENTORIES

Inventories include goods and other property held either for sale, consumption or for distribution at no or nominal cost in the ordinary course of business operations. It excludes depreciable assets. Inventories held for distribution are measured at cost, adjusted for any loss of service potential. All other inventories, including land held for sale, are measured at the lower of cost and net realisable value.

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

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

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

NON-FINANCIAL PHYSICAL ASSETS CLASSIFIED AS HELD FOR SALE

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

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

PROPERTY, PLANT AND EQUIPMENT

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

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 11 Property, plant and equipment.

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

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

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

REVALUATIONS OF NON-CURRENT ASSETS

Non-current physical assets are measured at fair value and are revalued in accordance with FRD 103E *Non-current physical assets*. This revaluation process normally occurs at least every five years, based upon the asset's Government Purpose Classification, but may occur more frequently if fair value assessments indicate material changes in values. Independent valuers are used to conduct these scheduled revaluations and any interim revaluations are determined in accordance with the requirements of the FRD. Revaluation increments or decrements arise from differences between an asset's carrying value and fair value.

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

Revaluation decrements are recognised in 'other comprehensive income' to the extent that a credit balance exists in the asset revaluation surplus in respect of the same class of property, plant and equipment. Revaluation increases and revaluation decreases relating to individual assets within an asset class are offset against one another within that class but are not offset in respect of assets in different classes. Revaluation surplus is not transferred to accumulated funds on derecognition of the relevant asset.

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

INTANGIBLE ASSETS

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

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

PREPAYMENTS

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

DISPOSAL OF NON-FINANCIAL ASSETS

Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement. Refer to note 1(i) – 'other comprehensive income'.

IMPAIRMENT OF NON-FINANCIAL ASSETS

Apart from intangible assets with indefinite useful lives, all other non-financial assets are assessed annually for indications of impairment.

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

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

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

(m) Liabilities

PAYABLES

Payables consist of:

> contractual payables which consist predominantly of accounts payable representing liabilities for goods and services provided to the health service prior to the end of the financial year that are unpaid, and arise when the health service becomes obliged to make future payments in respect of the purchase of those goods and services.

  The normal credit terms are usually Nett 30 days.

> statutory payables, such as goods and services tax and fringe benefits tax payables.

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

BORROWINGS

All borrowings are initially recognised at fair value of consideration received, less directly attributable transaction costs. The measurement basis subsequent to initial recognition is at amortised cost. Any difference between the initial recognised amount and the redemption value is recognised in net result over the period of the borrowing using the effective interest method.

The classification depends on the nature and purpose of the borrowing. Alfred Health determines the classification of its borrowing at initial recognition.

Note 1 – Summary of Significant Accounting Policies (continued)

PROVISIONS

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

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

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

EMPLOYEE BENEFITS

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

Wages and Salaries, Annual Leave, and Accrued Days Off

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

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

> undiscounted value – if the Health Service expects to wholly settle within 12 months; and

> present value – if the Health Service 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.

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

The components of this current LSL liability are measured at:

> present value – the component that Alfred Health does not expect to settle within 12 months; and

> nominal value – the component that Alfred Health expects to settle within 12 months.

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

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

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 bond interest rates for which it is then recognised another economic flow.

Termination Benefits

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

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

ON-COSTS

Employee benefit on-costs, such as payroll tax, workers compensation and superannuation are recognised together with provisions for employee benefits.

SUPERANNUATION LIABILITIES

Alfred Health does not recognise any unfunded defined benefit liability in respect of the superannuation plans because Alfred Health 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.

(n) Leases

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

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

OPERATING LEASES

Entity as Lessee

Operating lease payments, including any contingent rentals, are recognised as an expense in the comprehensive operating statement on a straight line basis over the lease term, except where another systematic basis is more representative of the time pattern of the benefits derived from the use of the leased asset. The leased asset is not recognised in the balance sheet.

LEASE INCENTIVES

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

In the event that lease incentives are received by the lessee to enter into operating leases, such incentives are recognised as a liability. The aggregate benefits of incentives are recognised as a reduction of rental expense on a straight-line basis, except where another systematic basis is more representative of the time pattern in which economic benefits from the leased asset are diminished.

LEASEHOLD IMPROVEMENTS

The cost of leasehold improvements are capitalised as an asset and depreciated over the remaining term of the lease or the estimated useful life of the improvements, whichever is the shorter.

(o) Equity

CONTRIBUTED CAPITAL

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

PROPERTY, PLANT & EQUIPMENT REVALUATION SURPLUS

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

FINANCIAL ASSET AVAILABLE-FOR-SALE REVALUATION SURPLUS

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

GENERAL PURPOSE SURPLUS

General purpose surpluses represent specific purpose funds over which Alfred Health has management control as well as discretion on the ultimate usage of these funds.

SPECIFIC RESTRICTED PURPOSE SURPLUSES

Specific restricted purpose surpluses are established where Alfred Health has possession or title to the funds but has no discretion to amend or vary the restriction and/or condition underlying the funds received.

(p) Commitments

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

(q) Contingent assets and contingent liabilities

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

(r) Goods and Services Tax ("GST")

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

Note 1 – Summary of Significant Accounting Policies (continued)

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

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

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

(s) Rounding

All amounts shown in the financial statements are expressed to the nearest $1,000 unless otherwise stated. Minor discrepancies in tables between totals and sum of components are due to rounding.

(t) AASs issued that are not yet effective

Certain new Australian accounting standards and interpretations have been published that are not mandatory for 30 June 2014 reporting period. DTF assesses the impact of all these new standards and advises Alfred Health of their applicability and early adoption where applicable.

As at 30 June 2014, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. Alfred Health has not and does not intend to adopt these standards early.

Standard/Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on Alfred Health financial statements
AASB 9 *Financial instruments*	This standard simplifies requirements for the classification and measurement of financial assets resulting from Phase 1 of the IASB's project to replace IAS 39 *Financial Instruments: Recognition and Measurement* (AASB 139 *Financial Instruments: Recognition and Measurement*).	1 Jan 2017	The preliminary assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss. While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.
AASB 10 *Consolidated Financial Statements*	This Standard forms the basis for determining which entities should be consolidated into an entity's financial statements. AASB 10 defines 'control' as requiring exposure or rights to variable returns and the ability to affect those returns through power over an investee, which may broaden the concept of control for public sector entities. The AASB has issued an Australian Implementation Guidance for Not-for-Profit Entities – Control and Structured Entities that explains and illustrates how the principles in the Standard apply from the perspective of not-for-profit entities in the private and public sectors.	1 Jan 2014 (not-for-profit entities)	For the public sector, AASB 10 builds on the control guidance that existed in AASB 127 and Interpretation 112 and is not expected to change which entities need to be consolidated. Ongoing work is being done to monitor and assess the impact of this standard.
AASB 11 *Joint Arrangements*	This Standard deals with the concept of joint control, and sets out a new principles-based approach for determining the type of joint arrangement that exists and the corresponding accounting treatment. The new categories of joint arrangements under AASB 11 are more aligned to the actual rights and obligations of the parties to the arrangement.	1 Jan 2014 (not-for-profit entities)	No material impact anticipated from this standard.

Standard/Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on Alfred Health financial statements
AASB 12 *Disclosure of Interests in Other Entities*	This Standard requires disclosure of information that enables users of financial statements to evaluate the nature of, and risks associated with, interests in other entities and the effects of those interests on the financial statements. This Standard replaces the disclosure requirements in AASB 127 Separate Financial Statements and AASB 131 Interests in Joint Ventures.	1 Jan 2014 (not-for-profit entities)	No material impact anticipated from this standard.
AASB 127 *Separate Financial Statements*	This revised Standard prescribes the accounting and disclosure requirements for investments in subsidiaries, joint ventures and associates when an entity prepares separate financial statements.	1 Jan 2014 (not-for-profit entities)	Current assessment indicates that there is limited impact on Victorian Public Sector entities. Ongoing work is being done to monitor and assess the impact of this standard.
AASB 128 *Investments in Associates and Joint Ventures*	This revised Standard sets out the requirements for the application of the equity method when accounting for investments in associates and joint ventures.	1 Jan 2014 (not-for-profit entities)	Current assessment indicates that there is limited impact on Victorian Public Sector entities. Ongoing work is being done to monitor and assess the impact of this standard.

Note 1 – Summary of Significant Accounting Policies (continued)

(u) Category Groups

Alfred Health has used the following category groups for reporting purposes for the current and previous financial years.

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

Mental Health Services (Mental Health) comprises all recurrent health revenue/expenditure on specialised mental health services (child and adolescent, general and adult, community and forensic) managed or funded by the state or territory health administrations, and includes: Admitted patient services (including forensic mental health), outpatient services, emergency department services (where it is possible to separate emergency department mental health services), community-based services, residential and ambulatory services.

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

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

Aged Care comprises revenue/expenditure from Home and Community Care (HACC) programs, Allied Health, Aged Care Assessment and support services.

Primary Health comprises revenue/expenditure for Community Health Services including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy.

Off Campus, Ambulatory Services (Ambulatory) comprises all recurrent health revenue/expenditure on public hospital type services including palliative care facilities and rehabilitation facilities as well as services provided under the following agreements: Services that are provided or received by hospitals (or area health services) but are delivered/ received outside a hospital campus, services which have moved from a hospital to a community setting since June 1998, services which fall within the agreed scope of inclusions under the new system, services which have been delivered within hospitals i.e. in rural/remote areas.

Residential Aged Care including Mental Health (RAC incl. Mental Health) referred to in the past as psychogeriatric residential services, comprises those Commonwealth-licensed residential aged care services in receipt of supplementary funding from DH under the mental health program. It excludes all other residential services funded under the mental health program, such as mental health-funded community care units (CCUs) and secure extended care units (SECs).

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

Note 2 – Revenue (Parent Entity)

	Note	Health Services Agreement	Health Services Agreement	Hospital & Community Initiatives	Hospital & Community Initiatives	Total	Total
		2014	2013	**2014**	2013	**2014**	2013
Revenue from Operating Activities		$'000	$'000	$'000	$'000	$'000	$'000
Government Grants:							
> Department of Health		140,427	355,271	–	–	140,427	355,271
> Victorian Health Funding Pool		528,144	288,517	–	–	528,144	288,517
> Commonwealth Government							
– Residential Aged Care Subsidy		8,468	7,143			8,468	7,143
– Other		93,011	95,811	–	–	93,011	95,811
Total Government Grants		**770,050**	**746,742**	**–**	**–**	**770,050**	**746,742**
Indirect contributions by Department of Health:							
> Insurance		778	1,014	–	–	778	1,014
> Long Service Leave		1,262	1,450	–	–	1,262	1,450
Total Indirect Contributions by Department of Health		**2,040**	**2,464**	**–**	**–**	**2,040**	**2,464**
Patient and Resident Fees:							
> Patient and Resident Fees		31,805	29,622	–	–	31,805	29,622
> Residential Aged Care		3,324	3,135	–	–	3,324	3,135
Total Patient and Resident Fees	2b	**35,129**	**32,757**	**–**	**–**	**35,129**	**32,757**
Business Units & Specific Purpose Funds: -							
> Diagnostic Imaging		2,633	2,719	–	–	2,633	2,719
> Pharmacy Services		2,038	3,501	–	–	2,038	3,501
> Car Park		–	–	9,099	8,639	9,099	8,639
> Research		–	–	9,621	9,109	9,621	9,109
Total Business Units & Specific Purpose Funds		**4,671**	**6,220**	**18,720**	**17,748**	**23,391**	**23,968**
Donations & Bequests		–	–	8,165	10,852	8,165	10,852
Recoupment from Private Practice for Use of Hospital Facilities		30,365	30,220	13,300	12,431	43,665	42,651
Other		15,333	13,252	11,491	11,773	26,824	25,025
Total Revenue from Operating Activities		**857,588**	**831,655**	**51,676**	**52,804**	**909,264**	**884,459**
Revenue from Non-Operating Activities:							
> Interest & Dividends		–	–	4,049	3,853	4,049	3,853
> Rental / Property Income		–	–	850	773	850	773
Total Revenue from Non–Operating Activities		**–**	**–**	**4,899**	**4,626**	**4,899**	**4,626**
Capital Purpose Revenue							
State Government Capital Grants:							
– Medical Equipment and Infrastructure Replacement program		–	–	8,676	4,313	8,676	4,313
– Other		–	–	4,791	16,181	4,791	16,181
Commonwealth Government Capital Grants		–	–	–	–	–	–
Residential and Accommodation Payments	2b	–	–	630	498	630	498
Donations & Bequests		–	–	7,768	2,998	7,768	2,998
Total Revenue from Capital Purpose Income		**–**	**–**	**21,865**	**23,990**	**21,865**	**23,990**
TOTAL REVENUE		**857,588**	**831,655**	**78,440**	**81,420**	**936,028**	**913,075**

Indirect contributions by Department of Health: Department of Health makes certain payments on behalf of Alfred Health. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

This note relates to revenues above the net result line only, and does not reconcile to comprehensive income.

Note 2 – Revenue (Consolidated)

	Note	Health Services Agreement	Health Services Agreement	Hospital & Community Initiatives	Hospital & Community Initiatives	Total	Total
		2014	2013	**2014**	2013	**2014**	2013
Revenue from Operating Activities		$'000	$'000	$'000	$'000	$'000	$'000
Government Grants:							
> Department of Health		140,427	355,271	–	–	140,427	355,271
> Victorian Health Funding Pool		528,144	288,517	–	–	528,144	288,517
> Commonwealth Government							
– Residential Aged Care Subsidy		8,468	7,143	–	–	8,468	7,143
– Other		93,011	95,811	–	–	93,011	95,811
Total Government Grants		**770,050**	**746,742**	**–**	**–**	**770,050**	**746,742**
Indirect contributions by Department of Health:							
> Insurance		778	1,014	–	–	778	1,014
> Long Service Leave		1,262	1,450	–	–	1,262	1,450
Total Indirect Contributions by Department of Health		**2,040**	**2,464**	**–**	**–**	**2,040**	**2,464**
Patient and Resident Fees:							
> Patient and Resident Fees		31,805	29,622	–	–	31,805	29,622
> Residential Aged Care		3,324	3,135	–	–	3,324	3,135
Total Patient and Resident Fees	2b	**35,129**	**32,757**	**–**	**–**	**35,129**	**32,757**
Business Units & Specific Purpose Funds: -							
> Diagnostic Imaging		2,633	2,719	–	–	2,633	2,719
> Pharmacy Services		2,038	3,501	–	–	2,038	3,501
> Car Park		–	–	9,099	8,639	9,099	8,639
> Research		–	–	9,621	9,109	9,621	9,109
Total Business Units & Specific Purpose Funds		**4,671**	**6,220**	**18,720**	**17,748**	**23,391**	**23,968**
Donations & Bequests		–	–	8,165	10,852	8,165	10,852
Recoupment from Private Practice for Use of Hospital Facilities		30,365	30,220	13,300	12,431	43,665	42,651
Other		15,333	13,252	11,491	11,773	26,824	25,025
Total Revenue from Operating Activities		**857,588**	**831,655**	**51,676**	**52,804**	**909,264**	**884,459**
Revenue from Non-Operating Activities:							
> Interest & Dividends		–	–	5,622	5,177	5,622	5,177
> Rental / Property Income		–	–	850	773	850	773
Total Revenue from Non–Operating Activities		**–**	**–**	**6,472**	**5,950**	**6,472**	**5,950**
Capital Purpose Revenue							
State Government Capital Grants:							
– Medical Equipment and Infrastructure Replacement program		–	–	8,676	4,313	8,676	4,313
– Other		–	–	4,791	16,181	4,791	16,181
Commonwealth Government Capital Grants		–	–	–	–	–	–
Residential and Accommodation Payments	2b	–	–	630	498	630	498
Donations & Bequests		–	–	7,768	2,998	7,768	2,998
Total Revenue from Capital Purpose Income		**–**	**–**	**21,865**	**23,990**	**21,865**	**23,990**
TOTAL REVENUE		**857,588**	**831,655**	**80,013**	**82,744**	**937,601**	**914,399**

Indirect contributions by Department of Health: Department of Health makes certain payments on behalf of Alfred Health. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

This note relates to revenues above the net result line only, and does not reconcile to comprehensive income.

Note 2a – Analysis of Revenue by Source – 2014

(Based on consolidated view)

	Admitted Patients	Out-patients	ED Services	Ambu-latory	Mental Health	RAC incl. Mental Health	Aged Care	Primary Health	Other	Total 2014
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Revenue from Services Supported by Health Services Agreement										
Government Grants	429,184	62,328	36,394	77,146	47,396	12,302	2,148	10,093	93,059	770,050
Indirect Contributions by Department of Health	2,040	–	–	–	–	–	–	–	–	2,040
Patient and Resident Fees (Note 2b)	21,107	360	–	8,147	318	–	64	337	1,472	31,805
Residential Aged Care (Note 2b)	–	–	–	1,029	–	2,295	–	–	–	3,324
Recoupment from Private Practice for Use of Hospital Facilities	8,850	–	491	71	114	–	110	–	20,729	30,365
Business Units & Specific Purpose Funds	–	–	–	–	–	–	–	–	4,671	4,671
Other Revenue from Operating Activities	3,232	18	180	143	1,971	–	2	–	9,787	15,333
Sub–Total Revenue from Services Supported by Health Services Agreement	**464,413**	**62,706**	**37,065**	**86,536**	**49,799**	**14,597**	**2,324**	**10,430**	**129,718**	**857,588**
Revenue from Services Supported by Hospital and Community Initiatives										
Donation and Bequests (non capital)	–	–	–	–	–	–	–	–	8,165	8,165
Private Practice and Other Patient Activities	–	–	–	–	–	–	–	–	–	–
Recoupment from Private Practice for Use of Hospital Facilities	–	–	–	–	–	–	–	–	13,300	13,300
Interest Income	–	–	–	–	–	–	–	–	5,622	5,622
Business Units & Specific Purpose Funds	–	–	–	–	–	–	–	–	18,720	18,720
Capital Purpose Income	–	–	–	–	–	–	–	–	21,865	21,865
Other Revenue from Non-Operating Activities (Rental / Property Income)	–	–	–	–	–	–	–	–	850	850
Other	–	–	–	–	–	–	–	–	11,491	11,491
Sub–Total Revenue from Services Supported by Hospital and Community Initiatives	–	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**80,013**	**80,013**
TOTAL REVENUE	**464,413**	**62,706**	**37,065**	**86,536**	**49,799**	**14,597**	**2,324**	**10,430**	**209,731**	**937,601**

Indirect contributions by Department of Health: Department of Health makes certain payments on behalf of Alfred Health. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

Note 2a – Analysis of Revenue by Source – 2013

(Based on consolidated view)

	Admitted Patients	Out-patients	ED Services	Ambu-latory	Mental Health	RAC incl. Mental Health	Aged Care	Primary Health	Other	Total 2013
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Revenue from Services Supported by Health Services Agreement										
Government Grants	423,453	60,832	35,059	72,455	45,875	10,941	2,182	9,294	86,651	746,742
Indirect Contributions by Department of Health	2,464	–	–	–	–	–	–	–	–	2,464
Patient and Resident Fees (Note 2b)	18,625	59	–	8,735	386	–	73	324	1,420	29,622
Residential Aged Care (Note 2b)	–	–	–	993	–	2,142	–	–	–	3,135
Recoupment from Private Practice for Use of Hospital Facilities	12,681	–	124	101	148	–	89	–	17,077	30,220
Business Units & Specific Purpose Funds	622	–	–	–	–	–	–	–	5,598	6,220
Other Revenue from Operating Activities	3,752	4	352	437	1,206	1	–	–	7,500	13,252
Sub–Total Revenue from Services Supported by Health Services Agreement	**461,597**	**60,895**	**35,535**	**82,721**	**47,615**	**13,084**	**2,344**	**9,618**	**118,246**	**831,655**
Revenue from Services Supported by Hospital and Community Initiatives										
Donation and Bequests (non capital)	–	–	–	–	–	–	–	–	10,852	10,852
Private Practice and Other Patient Activities	–	–	–	–	–	–	–	–	–	–
Recoupment from Private Practice for Use of Hospital Facilities	–	–	–	–	–	–	–	–	12,431	12,431
Interest Income	–	–	–	–	–	–	–	–	5,177	5,177
Business Units & Specific Purpose Funds	–	–	–	–	–	–	–	–	17,748	17,748
Capital Purpose Income	–	–	–	–	–	–	–	–	23,990	23,990
Other Revenue from Non-Operating Activities (Rental / Property Income)	–	–	–	–	–	–	–	–	773	773
Other	–	–	–	–	–	–	–	–	11,773	11,773
Sub–Total Revenue from Services Supported by Hospital and Community Initiatives	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**82,744**	**82,744**
TOTAL REVENUE	**461,597**	**60,895**	**35,535**	**82,721**	**47,615**	**13,084**	**2,344**	**9,618**	**200,990**	**914,399**

Indirect contributions by Department of Health: Department of Health makes certain payments on behalf of Alfred Health. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

Note 2b – Patient & Resident Fees

	Parent Entity 2014	Parent Entity 2013	Consol'd 2014	Consol'd 2013
	$'000	$'000	$'000	$'000
Patient & Resident Fees Raised				
Acute				
> Inpatients	30,026	27,318	30,026	27,318
> Outpatients	1,360	1,895	1,360	1,895
Residential Aged Care				
> Aged Nursing Home	2,757	2,635	2,757	2,635
> Mental Health	566	501	566	501
	34,709	**32,349**	**34,709**	**32,349**
Other	420	408	420	408
TOTAL PATIENT & RESIDENT FEES	**35,129**	**32,757**	**35,129**	**32,757**
Capital Purpose Income:				
Residential Accommodation Payments	630	498	630	498
TOTAL CAPITAL PURPOSE INCOME	**630**	**498**	**630**	**498**

Commonwealth Nursing Home inpatient benefits are included in patient fees revenue.

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

	Parent Entity 2014	Parent Entity 2013	Consol'd 2014	Consol'd 2013
	$'000	$'000	$'000	$'000
Proceeds from Disposals of Non-Current Assets				
Plant & Equipment	–	–	–	–
Less: Written Down Value of Non-Current Assets Sold				
Building	–	–	–	–
Plant & Equipment	–	(29)	–	(29)
Medical equipment	(680)	(585)	(680)	(585)
Other equipment	(5)	(2)	(5)	(2)
NET GAIN/(LOSS) ON DISPOSAL OF NON–FINANCIAL ASSETS	**(685)**	**(616)**	**(685)**	**(616)**

Note 3 – Expenses (Parent Entity)

	Health Services Agreement	Health Services Agreement	Hospital & Community Initiatives	Hospital & Community Initiatives	Total	Total
	2014	2013	**2014**	2013	**2014**	2013
Employee Expenses	$'000	$'000	$'000	$'000	$'000	$'000
Salaries and Wages	510,184	492,460	26,254	22,557	536,438	515,017
Workcover Premium	3,342	4,798	245	309	3,587	5,107
Departure Packages	340	841	–	–	340	841
Long Service Leave	15,287	15,602	588	511	15,875	16,113
Superannuation	45,758	43,794	1,881	1,585	47,639	45,379
Total Employee Expenses	**574,911**	**557,495**	**28,968**	**24,962**	**603,879**	**582,457**
Non Salary Labour Costs						
Fees for Visiting Medical Officers	2,037	2,368	232	502	2,269	2,870
Agency Costs – Nursing	4,512	6,823	1	2	4,513	6,825
Agency Costs – Other	4,487	4,842	488	197	4,975	5,039
Total Non Salary Labour Costs	**11,036**	**14,033**	**721**	**701**	**11,757**	**14,734**
Supplies and Consumables						
Drug Supplies	31,393	32,133	–	111	31,393	32,244
Highly Specialised Drugs	71,567	68,976	–	–	71,567	68,976
Medical, Surgical Supplies and Prostheses	68,429	66,043	858	884	69,287	66,927
Pathology Supplies	6,532	6,442	119	138	6,651	6,580
Food Supplies	10,023	9,997	316	250	10,339	10,247
Total Supplies and Consumables	**187,944**	**183,591**	**1,293**	**1,383**	**189,237**	**184,974**
Other Expenses						
Domestic Services and Supplies	27,212	26,391	194	176	27,406	26,567
Fuel, Light, Power and Water	6,984	6,461	45	56	7,029	6,517
Insurance Costs Funded by DH	8,102	9,240	–	–	8,102	9,240
Motor Vehicle Expenses	633	761	–	–	633	761
Repairs & Maintenance	7,218	5,961	1,404	457	8,622	6,418
Maintenance Contracts	12,490	11,360	108	2,483	12,598	13,843
Patient Transport	2,804	2,924	13	1	2,817	2,925
Bad and Doubtful Debts	85	2,785	–	–	85	2,785
Lease Expenses	6,893	6,381	768	766	7,661	7,147
Administrative Expenses	24,897	22,829	7,101	5,080	31,998	27,909
Audit Fees – VAGO – Audit of Financial Statements	226	220	–	–	226	220
Other	142	370	–	–	142	370
Other Expenses	–	–	2,994	2,980	2,994	2,980
Total Other Expenses	**97,686**	**95,683**	**12,627**	**11,999**	**110,313**	**107,682**
Other Expenditure						
Disposal of Non-Financial Assets	–	–	480	616	480	616
Assets Provided Free of Charge	–	–	205	–	205	–
Depreciation and Amortisation (Note 4)	46,117	47,179	–	–	46,117	47,179
Finance Costs (Note 5)	–	–	240	1,478	240	1,478
Total Other Expenditure	**46,117**	**47,179**	**925**	**2,094**	**47,042**	**49,273**
Total Expenses	**917,694**	**897,981**	**44,534**	**41,139**	**962,228**	**939,120**

Note 3 – Expenses (Consolidated)

	Health Services Agreement	Health Services Agreement	Hospital & Community Initiatives	Hospital & Community Initiatives	Total	Total
	2014	2013	**2014**	2013	**2014**	2013
Employee Expenses	$'000	$'000	$'000	$'000	$'000	$'000
Salaries and Wages	510,184	492,460	26,254	22,557	536,438	515,017
Work Cover Premium	3,342	4,798	245	309	3,587	5,107
Departure Packages	340	841	–	–	340	841
Long Service Leave	15,287	15,602	588	511	15,875	16,113
Superannuation	45,758	43,794	1,881	1,585	47,639	45,379
Total Employee Expenses	**574,911**	**557,495**	**28,968**	**24,962**	**603,879**	**582,457**
Non Salary Labour Costs						
Fees for Visiting Medical Officers	2,037	2,368	232	502	2,269	2,870
Agency Costs – Nursing	4,512	6,823	1	2	4,513	6,825
Agency Costs – Other	4,487	4,842	488	197	4,975	5,039
Total Non Salary Labour Costs	**11,036**	**14,033**	**721**	**701**	**11,757**	**14,734**
Supplies and Consumables						
Drug Supplies	31,393	32,133	–	111	31,393	32,244
Highly Specialised Drugs	71,567	68,976	–	–	71,567	68,976
Medical, Surgical Supplies and Prostheses	68,429	66,043	858	884	69,287	66,927
Pathology Supplies	6,532	6,442	119	138	6,651	6,580
Food Supplies	10,023	9,997	316	250	10,339	10,247
Total Supplies and Consumables	**187,944**	**183,591**	**1,293**	**1,383**	**189,237**	**184,974**
Other Expenses						
Domestic Services and Supplies	27,212	26,391	194	176	27,406	26,567
Fuel, Light, Power and Water	6,984	6,461	45	56	7,029	6,517
Insurance Costs Funded by DH	8,102	9,240	–	–	8,102	9,240
Motor Vehicle Expenses	633	761	–	–	633	761
Repairs & Maintenance	7,218	5,961	1,404	457	8,622	6,418
Maintenance Contracts	12,490	11,360	108	2,483	12,598	13,843
Patient Transport	2,804	2,924	13	1	2,817	2,925
Bad and Doubtful Debts	85	2,785	–	–	85	2,785
Lease Expenses	6,893	6,381	768	766	7,661	7,147
Administrative Expenses	25,220	23,272	7,101	5,080	32,321	28,352
Audit Fees – VAGO – Audit of Financial Statements	234	228	–	–	234	228
Other	134	370	–	–	134	370
Other Expenses	–	–	2,994	2,980	2,994	2,980
Total Other Expenses	**98,009**	**96,134**	**12,627**	**11,999**	**110,636**	**108,133**
Other Expenditure						
Disposal of Non-Financial Assets	–	–	480	616	480	616
Assets Provided Free of Charge	–	–	205	–	205	–
Depreciation and Amortisation (Note 4)	46,117	47,179	–	–	46,117	47,179
Finance Costs (Note 5)	–	–	240	1,478	240	1,478
Total Other Expenditure	**46,117**	**47,179**	**925**	**2,094**	**47,042**	**49,273**
Total Expenses	**918,017**	**898,432**	**44,534**	**41,139**	**962,551**	**939,571**

Note 3a – Analysis of Expense by Source (Consolidated) 2014

	Admitted Patients	Out-patients	EDS	Ambu-latory	Mental Health	RAC Incl. Mental Health	Aged Care	Primary Health	Other	Total 2014
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Services Supported by Health Services Agreement										
Employee Expenses	272,060	11,449	38,254	39,025	39,758	11,992	4,333	2,523	155,517	574,911
Non Salary Labour Costs	4,209	19	861	978	1,411	175	–	–	3,383	11,036
Supplies & Consumables	85,072	36,865	1,793	2,823	424	1,168	163	29	59,607	187,944
Other Expenses from Continuing Operations	17,920	2,412	2,165	11,203	4,043	896	1,904	21	57,445	98,009
Medical Support Costs (Allied Health, Diagnostics, etc)	169,160	22,634	19,211	24,098	20,355	3,010	2,852	1,147	(262,467)	–
Total Expenses from Services Supported by Health Service Agreement	**548,421**	**73,379**	**62,284**	**78,127**	**65,991**	**17,241**	**9,252**	**3,720**	**13,485**	**871,900**
Services Supported by Hospital and Community Initiatives										
Employee Expenses	–	–	–	–	–	–	–	–	28,968	28,968
Non Salary Labour Costs	–	–	–	–	–	–	–	–	721	721
Supplies & Consumables	–	–	–	–	–	–	–	–	1,293	1,293
Other Expenses from Continuing Operations	–	–	–	–	–	–	–	–	12,627	12,627
Total Expenses from Services Supported by Hospital and Community Initiatives	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**43,609**	**43,609**
Depreciation & Amortisation (Note 4)	–	–	–	–	–	–	–	–	46,117	46,117
Disposal of Non-Financial Assets	–	–	–	–	–	–	–	–	480	480
Assets Provided Free of Charge	–	–	–	–	–	–	–	–	205	205
Finance Costs (Note 5)	–	–	–	–	–	–	–	–	240	240
TOTAL EXPENSES	**548,421**	**3,379**	**62,284**	**78,127**	**65,991**	**17,241**	**9,252**	**3,720**	**104,136**	**962,551**

Note 3a – Analysis of Expense by Source (Consolidated) (Continued) 2013

	Admitted Patients	Out-patients	EDS	Ambu-latory	Mental Health	RAC Incl Mental Health	Aged Care	Primary Health	Other	Total 2013
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Services Supported by Health Services Agreement										
Employee Expenses	259,506	11,126	34,645	38,181	39,943	11,427	4,852	2,426	155,389	557,495
Non Salary Labour Costs	8,857	34	855	964	1,977	153	39	–	1,154	14,033
Supplies & Consumables	73,575	34,470	1,631	3,389	499	1,087	995	38	67,907	183,591
Other Expenses from Continuing Operations	22,847	2,535	1,786	11,186	3,300	802	2,521	17	51,140	96,134
Medical Support Costs (Allied Health, Diagnostics, etc)	161,510	21,210	17,137	23,656	20,144	2,818	3,711	1,092	(251,278)	–
Total Expenses from Services Supported by Health Service Agreement	**526,295**	**69,375**	**56,054**	**77,376**	**65,863**	**16,287**	**12,118**	**3,573**	**24,312**	**851,253**
Services Supported by Hospital and Community Initiatives										
Employee Expenses	–	–	–	–	–	–	–	–	24,962	24,962
Non Salary Labour Costs	–	–	–	–	–	–	–	–	701	701
Supplies & Consumables	–	–	–	–	–	–	–	–	1,383	1,383
Other Expenses from Continuing Operations	–	–	–	–	–	–	–	–	11,999	11,999
Total Expenses from Services Supported by Hospital and Community Initiatives	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**39,045**	**39,045**
Depreciation & Amortisation (Note 4)	–	–	–	–	–	–	–	–	47,179	47,179
Disposal of Non-Financial Assets	–	–	–	–	–	–	–	–	616	616
Finance Costs (Note 5)	–	–	–	–	–	–	–	–	1,478	1,478
TOTAL EXPENSES	**526,295**	**69,375**	**56,054**	**77,376**	**65,863**	**16,287**	**12,118**	**3,573**	**112,630**	**939,571**

Note 3b – Analysis of Expenses by Internally Managed and Restricted Specific Purpose Funds for Services Supported by Hospital & Community Initiatives

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
Commercial Activities	$'000	$'000	$'000	$'000
Private Practice and Other Patient Activities	4,870	4,335	4,870	4,335
Car Park	2,370	2,434	2,370	2,434
Property Expenses	95	106	95	106
Other Activities				
Fundraising and Community Support	2,639	2,618	2,639	2,618
Research and Scholarships	13,545	12,961	13,545	12,961
Other	18,302	16,725	18,302	16,725
TOTAL	**41,821**	**39,179**	**41,821**	**39,179**

Note 4 – Depreciation and Amortisation

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
Depreciation	$'000	$'000	$'000	$'000
Buildings	27,393	28,622	27,393	28,622
Plant, Equipment, Furniture and Fittings				
Medical	10,571	10,404	10,571	10,404
Computers	2,162	2,729	2,162	2,729
Furniture and Fittings	389	406	389	406
Other Plant and Equipment	3,488	3,157	3,488	3,157
Motor Vehicles	2	1	2	1
TOTAL DEPRECIATION	**44,005**	**45,319**	**44,005**	**45,319**
Amortisation				
Leasehold Improvements	132	128	132	128
Computer Software	1,980	1,732	1,980	1,732
TOTAL AMORTISATION	**2,112**	**1,860**	**2,112**	**1,860**
TOTAL DEPRECIATION AND AMORTISATION	**46,117**	**47,179**	**46,117**	**47,179**

Note 5 – Finance Costs

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
	$'000	$'000	$'000	$'000
Interest on Long Term Borrowings (Note 14)	240	1,478	240	1,478
TOTAL	**240**	**1,478**	**240**	**1,478**

Note 6 – Cash and Cash Equivalents

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

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
	$'000	$'000	$'000	$'000
Cash on Hand	43	37	43	37
Cash at Bank	13,450	18,738	13,659	18,758
TOTAL	**13,493**	**18,775**	**13,702**	**18,795**
Represented by				
Cash held for:				
Health Service Operations	(10,457)	(28,168)	(10,248)	(28,148)
Pre-funded Capital Projects	20,256	38,609	20,256	38,609
Employee Salary Packaging*	3,583	8,262	3,583	8,262
Total	**13,382**	**18,703**	**13,591**	**18,723**
Monies held in Trust on behalf of patients*	111	72	111	72
Total	**111**	**72**	**111**	**72**
TOTAL	**13,493**	**18,775**	**13,702**	**18,795**

Alfred Health has an overdraft facility of $1,808,000 with Westpac Banking Corporation.

* Not available for cash flow statement presentation purposes as the cash is not available to be used for day to day operating activities of Alfred Health.

Note 7 – Receivables

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
	$'000	$'000	$'000	$'000
Current				
Contractual				
Inter Hospital Debtors	2,466	1,470	2,466	1,470
Trade Debtors	9,188	8,939	9,188	8,939
Patient Fees Receivable	15,782	10,283	15,782	10,283
Accrued Revenue – Other	9,097	10,201	9,282	10,201
Less Allowance for Doubtful Debts (a)				
Trade Debtors	(3,771)	(2,818)	(3,771)	(2,818)
Patient Fees	(2,213)	(2,046)	(2,213)	(2,046)
Subtotal	**30,549**	**26,029**	**30,734**	**26,029**
Statutory				
GST Receivable	3,096	5,725	3,109	5,725
Total current receivables	**33,645**	**31,754**	**33,843**	**31,754**
Non-Current				
Statutory				
Long Service Leave – Department of Health	4,500	14,238	4,500	14,238
Total non–current receivables	**4,500**	**14,238**	**4,500**	**14,238**
TOTAL RECEIVABLES	**38,145**	**45,992**	**38,343**	**45,992**
(a) Movement in the Allowance for Doubtful Debts				
Balance at beginning of year	(4,864)	(2,510)	(4,864)	(2,510)
Amounts written off/(on) during the year	(1,035)	805	(1,035)	805
Increase in allowance recognised in net result	(85)	(3,159)	(85)	(3,159)
BALANCE AT END OF YEAR	**(5,984)**	**(4,864)**	**(5,984)**	**(4,864)**

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

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

Note 8 – Investments and Other Financial Assets

	Parent Entity Specific Purpose Fund		Consolidated Specific Purpose Fund	
	2014	2013	**2014**	2013
Non-Current Assets	$'000	$'000	$'000	$'000
Available for sale				
Australian Listed Equity Securities	–	1,935	–	1,935
Managed Investment Schemes	41,904	38,254	56,880	51,721
TOTAL NON–CURRENT	**41,904**	**40,189**	**56,880**	**53,656**
Represented by:				
Investments Held in Trust	41,904	38,254	56,880	51,721
Australian Health Service Investments	–	1,935	–	1,935
TOTAL	**41,904**	**40,189**	**56,880**	**53,656**

(a) Refer to Note 19(b) for the ageing analysis of, and for the nature and extent of credit risk arising from, other financial assets.

Note 9 – Inventories

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
Pharmaceuticals	$'000	$'000	$'000	$'000
At cost	3,756	3,754	3,756	3,754
Medical and Surgical Lines				
At cost	1,600	1,539	1,600	1,539
Radiology Stores				
At cost	467	507	467	507
Theatre Stores				
At cost	1,459	1,459	1,459	1,459
TOTAL INVENTORIES	**7,282**	**7,259**	**7,282**	**7,259**

Note 10 – Other Assets

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
Current	$'000	$'000	$'000	$'000
Prepayments	2,184	2,069	2,184	2,069
TOTAL	**2,184**	**2,069**	**2,184**	**2,069**

Note 11 – Property, Plant and Equipment

a) Gross carrrying amount and accumulated depreciation

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
Land	$'000	$'000	$'000	$'000
Crown Land at Fair Value	176,327	159,912	176,327	159,912
Total Land	**176,327**	**159,912**	**176,327**	**159,912**
Buildings				
Buildings Under Construction at cost	38,398	14,063	38,398	14,063
Buildings at Fair Value	676,098	440,331	676,098	440,331
Less Accumulated Depreciation	–	(102,225)	–	(102,225)
Total Building at Fair Value	714,496	352,169	714,496	352,169
Buildings at Cost	–	98,307	–	98,307
Less Accumulated Depreciation	–	(7,617)	–	(7,617)
Total Building at Cost	–	90,690	–	90,690
Total Buildings	**714,496**	**442,859**	**714,496**	**442,859**
Leasehold Improvements at Fair Value				
Leasehold Improvements	4,385	4,333	4,385	4,333
Less Accumulated Amortisation	(844)	(712)	(844)	(712)
Total Leasehold Improvements	**3,541**	**3,621**	**3,541**	**3,621**
Plant & Equipment, Furniture & Fittings at Fair Value				
Medical Equipment	113,536	106,164	113,536	106,164
Less Accumulated Depreciation	(76,144)	(67,132)	(76,144)	(67,132)
Total Medical Equipment	37,392	39,032	37,392	39,032
Computers & Communication Equipment	45,854	44,106	45,854	44,106
Less Accumulated Depreciation	(42,432)	(40,373)	(42,432)	(40,373)
Total Computers & Communication Equipment	3,422	3,733	3,422	3,733
Furniture & Fittings	7,346	8,027	7,346	8,027
Less Accumulated Depreciation	(5,143)	(5,436)	(5,143)	(5,436)
Total Furniture & Fittings	2,203	2,591	2,203	2,591
Other Equipment	48,922	44,746	48,922	44,746
Less Accumulated Depreciation	(26,448)	(23,740)	(26,448)	(23,740)
Total Other Equipment	22,474	21,006	22,474	21,006
Plant & Equipment – Work in Progress	3,018	2,059	3,018	2,059
Total Plant & Equipment and Furniture & Fittings	**68,509**	**68,421**	**68,509**	**68,421**
Motor Vehicles				
Motor Vehicles at Fair Value	119	119	119	119
Less Accumulated Depreciation	(117)	(115)	(117)	(115)
Total Motor Vehicles	**2**	**4**	**2**	**4**
TOTAL	**962,875**	**674,817**	**962,875**	**674,817**

Land and buildings carried at valuation: An independent valuation of Alfred Health's land and buildings was performed by the *Valuer-General Victoria* to determine the fair value of the land and buildings as at 30 June 2014. The valuation, which conforms to Australian Valuations Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments. The effective date of the valuation is 30 June 2014.

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

	Land	Buildings	Leasehold Improve-ments	Medical Equipment	Computers	Furniture & Fittings	Other Plant & Equipment	Motor Vehicles	Totals
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Restated Balance at 1 July 2012	**159,912**	**451,815**	**2,991**	**42,350**	**5,254**	**2,123**	**23,661**	**5**	**688,111**
Net additions and transfers between classes	–	19,666	758	7,671	1,209	875	2,590	–	32,769
Disposals (WDV)	–	–	–	(585)	(1)	(1)	(29)	–	(616)
Depreciation	–	(40,843)	(128)	(10,404)	(2,729)	(406)	(3,157)	(1)	(57,668)
Restatement of depreciation*	–	12,221	–	–	–	–	–	–	12,221
Restated Balance at 1 July 2013	**159,912**	**442,859**	**3,621**	**39,032**	**3,733**	**2,591**	**23,065**	**4**	**674,817**
Net additions and transfers between classes	200	30,204	52	9,526	1,847	10	6,044	–	47,883
Disposals (WDV)	–	44	–	(595)	4	(9)	(129)	–	(685)
Revaluation Increments	16,215	268,782	–	–	–	–	–	–	284,997
Depreciation	–	(27,393)	(132)	(10,571)	(2,162)	(389)	(3,488)	(2)	(44,137)
Balance at 30 June 2014	**176,327**	**714,496**	**3,541**	**37,392**	**3,422**	**2,203**	**25,492**	**2**	**962,875**

*Refer to Note 28 for further information.

Note 11 – Property, Plant and Equipment (continued)

c) Fair Value Measurement Hierarchy for Assets as at 30 June 2014

	Carrying Amount As At 30 June 2014	Fair Value Measurement at End of Reporting Period Using		
Land at Fair Value	$'000	Level 1	Level 2	Level 3
Non-Specialised Land	200	–	–	200
Specialised Land	176,127	–	–	176,127
Total Land at Fair Value	**176,327**	**–**	**–**	**176,327**
Buildings at Fair Value				
Non-Specialised Buildings	–	–	–	–
Specialised Buildings	714,496	–	–	714,496
Total Buildings at Fair Value	**714,496**	**–**	**–**	**714,496**
Leasehold Improvements at Fair Value				
Leasehold Improvements	3,541	–	–	3,541
Total Leasehold Improvements Fair Value	**3,541**	**–**	**–**	**3,541**
Plant & Equipment, Furniture & Fittings at Fair Value				
Medical Equipment	37,392	–	–	37,392
Computers & Communication Equipment	3,422	–	–	3,422
Furniture & Fittings	2,203	–	–	2,203
Other Equipment	22,474	–	–	22,474
Plant & Equipment – Work in Progress	3,018	–	–	3,018
Total Plant & Equipment and Furniture & Fittings Fair Value	**68,509**	**–**	**–**	**68,509**
Motor Vehicles Fair Value				
Motor Vehicles at fair value	2	–	–	2
Total Motor Vehicles Fair Value	**2**	**–**	**–**	**2**
TOTAL ASSETS AT FAIR VALUE	**962,875**	**–**	**–**	**962,875**

There have been no transfers between levels during the period

Non-specialised land and non-specialised buildings

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

For non-specialised land and non-specialised buildings, an independent valuation was performed by independent valuers Opteon as agent for the Valuer-General Victoria, and Value It Property Valuers 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 2014.

To the extent that non-specialised land and non-specialised buildings do not contain significant, unobservable adjustments, these assets are classified as Level 2 under the market approach.

Specialised land and specialised buildings

The market approach is also used for specialised land and specialised buildings although 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 is a reflection of 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 takes into account 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 health services, the depreciated 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 Health Service's specialised land and specialised buildings was performed by the Valuer-General Victoria. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation is 30 June 2014.

Plant and Equipment and Furniture and Fittings

Plant and equipment and furniture and fittings are held at carrying value (depreciated cost). When plant and equipment and furniture and fittings are specialised in use, such that it is rarely sold other than as part of a going concern, the depreciated replacement cost is used to estimate the fair value. Unless there is market evidence that current replacement costs are significantly different from the original acquisition cost, it is considered unlikely that depreciated replacement cost will be materially different from the existing carrying value.

Motor Vehicles

Alfred Health acquires new vehicles and at times disposes of them before completion of their economic life. The process of acquisition, use and disposal in the market is managed by Alfred Health 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 value (depreciated cost).

There were no changes in valuation techniques throughout the period to 30 June 2014.

For all assets measured at fair value, the current use is considered the highest and best use.

Note 11 – Property, Plant and Equipment (continued)

d) Reconciliation of Level 3 Fair Value

	Land	Buildings	Leasehold Improvements	Plant & Equipment, Furniture & Fittings	Motor Vehicles	Totals
	$'000	$'000	$'000	$'000	$'000	$'000
Opening Balance	**159,912**	**442,859**	**3,621**	**68,421**	**4**	**674,817**
Purchases / (Sales)	200	30,248	52	16,698	–	47,198
Transfers in / (out) of Level 3	–	–		–	–	–
Gains or losses recognised in net result				–	–	–
> Depreciation	–	(27,393)	(132)	(16,610)	(2)	(44,137)
Subtotal	**160,112**	**445,714**	**3,541**	**68,509**	**2**	**677,878**
Items recognised in other comprehensive income						
> Revaluation	16,215	268,782	–	–	–	284,997
Subtotal	**16,215**	**268,782**	**–**	**–**	**–**	**284,997**
Closing Balance	**176,327**	**714,496**	**3,541**	**68,509**	**2**	**962,875**

There have been no transfers between levels during the period.

e) Description of Significant Unobservable Inputs to Level 3 Valuations

	Valuation Technique	Significant Unobservable Inputs	Range (Weighted Average)	Sensitivity of Fair Value Measurement to Changes in Significant Unobservable Inputs
Specialised Land	Market Approach	Community Service Obligation (CSO) adjustment	50%	A significant increase or decrease in the CSO adjustment would result in a significantly lower (higher) fair value
Specialised Buildings	Depreciated Replacement Cost	Useful life of specialised buildings	30–60 Years	A significant increase or decrease or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation
Leasehold Improvements	Depreciated Replacement Cost	Useful life of leasehold improvements	20–40 Years	A significant increase or decrease or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation
Plant & Equipment, Furniture & Fittings	Depreciated Replacement Cost	Useful life of plant, equipment, furniture & fittings	5–10 Years	A significant increase or decrease or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation
Motor Vehicles	Depreciated Replacement Cost	Useful life of motor vehicles	3–4 Years	A significant increase or decrease or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation

Note 12 – Intangible Assets

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
	$'000	$'000	$'000	$'000
Computer Software at cost	14,790	13,449	14,790	13,449
Less Accumulated Amortisation	(9,866)	(7,853)	(9,866)	(7,853)
TOTAL	**4,924**	**5,596**	**4,924**	**5,596**

Reconciliations of the carrying amounts of intangible assets at the beginning and end of the previous and current financial years are set out below.

	Computer Software
	$'000
Balance at 1 July 2012	**3,014**
Additions	4,314
Amortisation (Note 4)	(1,732)
Balance at 1 July 2013	**5,596**
Additions	1,308
Amortisation (Note 4)	(1,980)
Balance at 30 June 2014	**4,924**

Note 13 – Payables

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
	$'000	$'000	$'000	$'000
Current				
Contractual				
Trade Creditors [i]	24,124	27,408	24,124	27,408
Accrued Expenses	17,348	13,031	17,366	13,127
Salary Packaging	3,583	10,247	3,583	10,247
Superannuation	4,472	4,260	4,472	4,260
	49,527	54,946	49,545	55,042
Statutory				
Department of Health [ii]	6,478	7,851	6,478	7,851
	6,478	**7,851**	**6,478**	**7,851**
TOTAL	**56,005**	**62,797**	**56,023**	**62,893**

(i) The average credit period is 43 days. No interest is charged on payables.

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

(a) Maturity analysis of payables – refer to Note 19(c) for the maturity analysis of payables

(b) Nature and extent of risk arising from payables – please refer to Note 19(c) for the nature and extent of risk arising from payables

Note 14 – Borrowings

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
	$'000	$'000	$'000	$'000
Current				
Australian Dollar Borrowings				
> Treasury Corporation Victoria Loan	1,241	1,093	1,241	1,093
Total Current	**1,241**	**1,093**	**1,241**	**1,093**
Non-Current				
Australian Dollar Borrowings				
> Department of Health	8,833	–	8,833	–
> Treasury Corporation Victoria Loan	20,045	21,357	20,045	21,357
Total Non–Current	**28,878**	**21,357**	**28,878**	**21,357**
TOTAL	**30,119**	**22,450**	**30,119**	**22,450**

Terms and conditions of Borrowings

Treasury Corporation Victoria

a) Repayments for the Multi Storey Car Park are quarterly with the final instalment due on 22 March 2024. The principal outstanding for this loan at 30 June 2014 is $5.55m.

b) Average interest rate applied during 2013/14 was 6.39% (2012/13: 6.39%). Interest rate is fixed for the life of the loans.

c) Repayments for the Alfred Centre Car Park are quarterly starting September 2007 and with the final instalment due on 15 June 2027. The principal outstanding for this loan at 30 June 2014 is $14.50m.

d) Repayment of these loans has been guaranteed in writing by the Treasurer.

Department of Health

e) Department of Health has provided an interest free loan to Alfred Health for the amount of $10m. Repayments for this loan are not due to commence until year ended 30 June 2017.

Amount of Borrowing Costs Recognised as Expense (Note 5)	**240**	**1,478**

(a) Maturity analysis of Borrowings – refer to Note 19(c) for the maturity analysis of Borrowings

(b) Nature and extent of risk arising from Borrowings – refer to Note 19(c) for the nature and extent of risk arising from Borrowings

(c) Defaults and breaches – there were no defaults and breaches of any loan during the current and prior year

Note 15 – Provisions

	Parent Entity	Parent Entity	Consol'	Consol'd
	2014	2013	**2014**	2013
Current Provisions	$'000	$'000	$'000	$'000
Employee Benefits (Note 15(a))				
Annual Leave (Note 15(a))				
> Unconditional and expected to be settled within 12 months (ii)	45,129	43,343	45,129	43,343
> Unconditional and expected to be settled after 12 months (iii)	7,174	6,843	7,174	6,843
Long Service Leave (Note 15(a))				
> Unconditional and expected to be settled within 12 months (ii)	79,236	72,716	79,236	72,716
> Unconditional and expected to be settled after 12 months (iii)	–	–	–	–
Employee Termination Benefits				
> Unconditional and expected to be settled within 12 months (ii)	–	237	–	237
> Unconditional and expected to be settled after 12 months (iii)	–	–	–	–
Other	26,554	20,862	26,554	20,862
Total Current Provisions	**158,093**	**144,001**	**158,093**	**144,001**
Non-Current Provisions				
Employee Benefits (ii)	20,730	19,452	20,730	19,452
Total Non–Current Provisions	**20,730**	**19,452**	**20,730**	**19,452**
TOTAL PROVISIONS	**178,823**	**163,453**	**178,823**	**163,453**
(a) Employee Benefits and Related On-Costs				
Current Employee Benefits and Related On-Costs				
Unconditional LSL Entitlements	79,236	72,716	79,236	72,716
Annual Leave Entitlements	52,303	50,186	52,303	50,186
Accrued Wages and Salaries	24,586	18,893	24,586	18,893
Accrued Days Off	1,968	1,969	1,968	1,969
Other	–	237	–	237
Non-Current Employee Benefits and related on-costs				
Conditional Long Service Leave Entitlements (iii)	20,730	19,452	20,730	19,452
Other	–	–	–	–
Total Employee Benefits & Related On–Costs	**178,823**	**163,453**	**178,823**	**163,453**
(b) Movement in Provisions				
Movement in Long Service Leave:				
Balance at start of year	92,128	84,858	92,128	84,858
Provision made during the year	14,295	15,185	14,295	15,185
Settlement made during the year	(6,457)	(7,915)	(6,457)	(7,915)
Balance at end of year	**99,966**	**92,128**	**99,966**	**92,128**

(i) Employee benefit provisions are reported as current liabilities where Alfred Health does not have an unconditional right to defer settlement for at least 12 months. Consequently, the current portion of the employee benefit provision includes both short-term benefits that are measured at nominal values and long-term benefits that are measured at present values.

(ii) Employee benefit provisions that are reported as non-current liabilities also include long-term benefits such as non- vested long service leave (i.e. where the employee does not have a present entitlement to the benefit) that do not qualify for recognition as a current liability, and are measured at present values.

(iii) The present value determination of the non-current long service leave liability has been based on a forecast inflation rate of 4.438% p.a. (2013 – 2.40% p.a.) discounted by the future bond rate as at 30 June 2014.

Note 16 – Other Liabilities

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
	$'000	$'000	$'000	$'000
Current				
Patient Monies held in Trust	98	76	98	76
TOTAL	**98**	**76**	**98**	**76**
Total Monies held in Trust				
Represented by the following assets:				
Cash Assets (Note 6)	111	72	111	72

Note 17 – Equity

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
	$'000	$'000	$'000	$'000
(a) Surpluses				
(i) Property, Plant & Equipment Revaluation Surplus (1)				
Balance at the Beginning of the Reporting Period	226,303	226,303	226,303	226,303
Revaluation Increment				
Land	16,215	–	16,215	–
Buildings	268,782	–	268,782	–
Balance at the End of the Reporting Period	**511,301**	**226,303**	**511,301**	**226,303**
Represented by: Land	125,663	109,448	125,663	109,448
Buildings	385,638	116,855	385,638	116,855
	511,301	**226,303**	**511,301**	**226,303**
(ii) Financial Assets Available-for-Sale Revaluation Surplus (2)				
Balance at the Beginning of the Reporting Period	15,674	8,979	17,149	9,280
Cumulative gain/(loss) transferred to Operating Statement on sale of financial assets.	–	–	–	–
Valuation gain/loss recognised	1,043	6,695	1,767	7,869
Balance at the End of the Reporting Period	**16,717**	**15,674**	**18,916**	**17,149**
(iii) General Purpose Surplus				
Balance at the Beginning of the Reporting Period	63,220	59,121	63,220	59,121
Transfers (to)/from Accumulated Deficit	(4,499)	4,099	(4,499)	4,099
Balance at the End of the Reporting Period	**58,721**	**63,220**	**58,721**	**63,220**
(iv) Restricted Specific Purpose Surplus				
Balance at the Beginning of the Reporting Period	55,445	51,109	69,984	65,648
Transfers (to)/from Accumulated Deficit	(2,556)	4,336	(2,556)	4,336
Balance at the End of the Reporting Period	**52,889**	**55,445**	**67,428**	**69,984**
Total Surpluses	**639,628**	**360,642**	**656,366**	**376,656**
(b) Contributed Capital				
Balance at the Beginning of the Reporting Period	324,134	324,134	324,134	324,134
Balance at the End of the Reporting Period	**324,134**	**324,134**	**324,134**	**324,134**
(c) Accumulated Deficit				
Balance at the Beginning of the Reporting Period	(138,855)	(104,375)	(141,478)	(107,871)
Net Result for the Year	(26,200)	(26,045)	(24,950)	(25,172)
Transfers to General Purpose Surplus	4,499	(4,099)	4,499	(4,099)
Transfers to Restricted Specific Purpose Surplus	2,556	(4,336)	2,556	(4,336)
Balance at the End of the Reporting Period	**(158,000)**	**(138,855)**	**(159,373)**	**(141,478)**
TOTAL EQUITY AT END OF FINANCIAL YEAR	**805,762**	**545,921**	**821,127**	**559,312**

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

(2) The financial assets available-for-sale revaluation surplus arises on the revaluation of available-for-sale financial assets. Where a revalued financial asset is sold, that portion of the surplus which relates to the financial asset, and is effectively realised, is recognised in the net result. Where a revalued financial asset is impaired (to a value less than cost), that portion of the surplus which relates to that financial asset is recognised in net result.

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

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
	$'000	$'000	$'000	$'000
Net Result for the Year	**(26,200)**	**(26,045)**	**(24,950)**	**(25,172)**
Non-cash movements:				
Depreciation and Amortisation	46,117	47,179	46,117	47,179
Provision for Doubtful Debts	1,120	2,354	1,120	2,354
DH Loan Discount	(1,167)	–	(1,167)	–
Non-cash Investment Income	(2,830)	(3,362)	(4,043)	(5,050)
Movements Included in Investing and Financing Activities				
Net (Gain)/Loss from Disposal of Non-Financial Assets	685	–	685	–
Movements in Assets & Liabilities				
> Increase/(Decrease) in Employee Benefits	15,370	3,273	15,370	3,273
> Increase/(Decrease) in Payables	(6,831)	9,024	(6,909)	9,101
> Increase/(Decrease) in Other Liabilities	22	5	22	5
> Decrease/(Increase) in Receivables	6,727	(3,795)	6,529	(3,529)
> Decrease/(Increase) in Prepayments	(115)	(622)	(115)	(622)
> Decrease/(Increase) in Inventories	(23)	(49)	(23)	(49)
NET CASH INFLOWS/(OUTFLOWS) FROM OPERATING ACTIVITIES	**32,875**	**27,962**	**32,636**	**27,490**

Note 19 – Financial Instruments

(a) Financial Risk Management Objectives and Policies

Alfred Health's principal financial instruments comprise of:

> Cash Assets

> Term Deposits

> Receivables (excluding statutory receivables)

> Investment in Equities and Managed Investment Schemes

> Payables

> Borrowings

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

Alfred Health's main financial risks include credit risk, liquidity risk and market risk. Alfred Health manages these financial risks in accordance with its financial risk management policy.

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

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

CATEGORISATION OF FINANCIAL INSTRUMENTS

Details of each category of financial instrument, in accordance with AASB 139, is disclosed either on the face of the balance sheet or in these notes.

	Contractual Financial Assets – Available for Sale	Contractual Financial Assets – Loans and Receivables	Contractual Financial Liabilities at Amortised Cost	Total
	2014	2014	2014	2014
	$'000	$'000	$'000	$'000
Financial Assets				
Cash and Cash equivalents	–	13,702	–	13,702
Receivables	–	36,718	–	36,718
Other Financial Assets	56,880	–	–	56,880
Total Financial Assets (i)	**56,880**	**50,420**	**–**	**107,300**
Financial Liabilities				
Payables	–	–	49,545	49,545
Borrowings	–	–	30,119	30,119
Other Liabilities	–	–	98	98
Total Financial Liabilities (ii)	**–**	**–**	**79,762**	**79,762**

	Contractual Financial Assets – Available for Sale	Contractual Financial Assets – Loans and Receivables	Contractual Financial Liabilities at Amortised Cost	Total
	2013	2013	2013	2013
	$'000	$'000	$'000	$'000
Financial Assets				
Cash and Cash equivalents	–	18,795	–	18,795
Receivables	–	30,893	–	30,893
Other Financial Assets	53,656	–	–	53,656
Total Financial Assets (i)	**53,656**	**49,688**	**–**	**103,344**
Financial Liabilities				
Payables	–	–	55,042	55,042
Borrowings	–	–	22,450	22,450
Other Liabilities	–	–	76	76
Total Financial Liabilities (ii)	**–**	**–**	**77,568**	**77,568**

(i) The total amount of financial assets disclosed here excludes statutory receivables (i.e. GST input tax credit recoverable)

(ii) The total amount of financial liabilities disclosed here excludes statutory receivables (i.e. Taxes payables)

Note 19 – Financial Instruments (continued)

NET HOLDING GAIN/(LOSS) ON FINANCIAL INSTRUMENT BY CATEGORY

	Net Holding gain/(loss)	Net Holding gain/(loss)
	2014	2013
	$'000	$'000
Financial Assets		
Cash and Cash equivalents	5,622	5,177
Available for Sale Investments	1,767	7,869
Total Financial Assets	**7,389**	**13,046**
Financial Liabilities		
Borrowings	(240)	(1,478)
Total Financial Liabilities	**(240)**	**(1,478)**

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

(ii) For financial liabilities measured at amortised cost, the net gain or loss is calculated by taking the interest expense, plus or minus foreign exchange gains or losses from revaluation of the financial liabilities measured at amortised cost.

(b) Credit Risk

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

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

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

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

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

CREDIT QUALITY OF CONTRACTUAL FINANCIAL ASSETS THAT ARE NEITHER PAST DUE NOR IMPAIRED

	Financial institutions (AAA credit rating)	Government agencies (AAA credit rating)	Government agencies (BBB credit rating)	Other (min BBB credit rating)	Total
2014	$'000	$'000	$'000	$'000	$'000
Financial Assets					
Cash and Cash Equivalents	13,702	–	–	–	13,702
Trade debtors	–	9,188	–	–	9,188
Other receivables	–	2,813	–	24,717	27,530
Other Financial Assets (i)	56,880	–	–	–	56,880
Total Financial Assets	**70,582**	**12,001**	**–**	**24,717**	**107,300**
2013					
Financial Assets					
Cash and Cash Equivalents	18,795	–	–	–	18,795
Trade debtors	–	8,939	–	–	8,939
Other receivables	–	1,470	–	20,484	21,954
Other Financial Assets (i)	53,656	–	–	–	53,656
Total Financial Assets	**72,451**	**10,409**	**–**	**20,484**	**103,344**

(i) The total amounts disclosed here exclude statutory amounts (e.g. amounts owing from Victorian State Government and GST input tax credits recoverable).

AGEING ANALYSIS OF FINANCIAL ASSET AS AT 30 JUNE 2014

	Consol'd Carrying Amount	Not Past Due and Not Impaired	Past Due but Not Impaired				Impaired Financial Assets
			Less than 1 Month	1 – 3 Months	3 Months – 1 Year	1 – 5 Years	
2014	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Financial Assets							
Cash and Cash Equivalents	13,702	13,702	–	–	–	–	–
Receivables	36,718	9,299	6,628	8,245	6,562	–	5,984
Other Financial Assets	56,880	56,880	–	–	–	–	–
Total Financial Assets	**107,300**	**79,881**	**6,628**	**8,245**	**6,562**	**–**	**5,984**
2013							
Financial Assets							
Cash and Cash Equivalents	18,795	18,795	–	–	–	–	–
Receivables	30,893	16,206	7,057	5,540	2,090	–	4,864
Other Financial Assets	53,656	53,656	–	–	–	–	–
Total Financial Assets	**103,344**	**88,657**	**7,057**	**5,540**	**2,090**	**–**	**4,864**

Note 19 – Financial Instruments (continued)

(c) Liquidity Risk

Liquidity risk is the risk that Alfred Health would be unable to meet its financial obligations as and when they fall due.

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

Alfred Health manages its liquidity risk by a number of avenues. Cash assets are held with more than one financial institution, and a reasonable amount of cash is held at call to enable access as required.

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

MATURITY ANALYSIS OF FINANCIAL LIABILITIES AS AT 30 JUNE 2014

	Consol'd Carrying Amount	Consol'd Nominal Amount	Maturity Dates				
			Less than 1 Month	1 – 3 Months	3 Months – 1 Year	1 – 5 Years	Over 5 Years
2014	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Financial Liabilities							
Payables	49,545	49,545	31,920	16,888	737	–	–
Borrowings	30,119	31,286	–	310	931	13,326	16,719
Other Financial Liabilities	98	98	98	–	–	–	–
Total Financial Liabilities	**79,762**	**80,929**	**32,018**	**17,198**	**1,668**	**13,326**	**16,719**
2013							
Financial Liabilities							
Payables	55,042	55,042	31,894	21,739	1,409	–	–
Borrowings	22,450	22,450	–	273	820	4,372	16,985
Other Financial Liabilities	76	76	76	–	–	–	–
Total Financial Liabilities	**77,568**	**77,568**	**31,970**	**22,012**	**2,229**	**4,372**	**16,985**

(d) Market Risk

CURRENCY RISK

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

INTEREST RATE RISK

Exposure to interest rate risk may arise primarily through Alfred Health's interest bearing liabilities and its investment of surplus cash resources. Minimisation of risk is achieved by mainly undertaking fixed rate interest bearing financial instruments and investing in short-term financial instruments.

INFLATION RATE RISK

Exposure to inflation rate risk arises through Alfred Health's interest bearing liabilities and its investment of surplus cash resources. Minimisation of risk is achieved by mainly undertaking fixed rate interest bearing financial instruments and investing in short term financial instruments.

INTEREST RATE EXPOSURE OF FINANCIAL ASSETS AND LIABILITIES AS AT 30 JUNE 2014

	Weighted Average Effective Interest Rate (%)	Carrying Amount	Interest Rate Exposure		
			Fixed Interest Rate	Variable Interest Rate	Non Interest Bearing
2014		$'000	$'000	$'000	$'000
Financial Assets					
Cash and Cash Equivalents	2.50	13,702	1,526	12,133	43
Receivables:					
Trade Debtors	–	9,188	–	–	9,188
Other Receivables	–	27,530	–	–	27,530
Other Financial Assets	–	56,880	–	–	56,880
Total Financial Assets		**107,300**	**1,526**	**12,133**	**93,641**
2014					
Financial Liabilities					
Payables	–	49,545	–	–	49,545
Borrowings	6.39	30,119	30,119	–	–
Other Financial Liabilities	2.50	98	98	–	–
Total Financial Liabilities		**79,762**	**30,217**	**–**	**49,545**
2013					
Financial Assets					
Cash and Cash Equivalents	2.75	18,795	1,475	17,283	37
Receivables:					
Trade Debtors	–	8,939	–	–	8,939
Other Receivables	–	21,954	–	–	21,954
Other Financial Assets	–	53,656	–	–	53,656
Total Financial Assets		**103,344**	**1,475**	**17,283**	**84,586**
2013					
Financial Liabilities					
Payables	–	55,042	–	–	55,042
Borrowings	6.39	22,450	22,450	–	–
Other Financial Liabilities	2.75	76	76	–	–
Total Financial Liabilities		**77,568**	**22,526**	**–**	**55,042**

Note 19 – Financial Instruments (continued)

SENSITIVITY DISCLOSURE ANALYSIS

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

- A parallel shift of +0.5% and -0.5% in market interest rates (AUD) from year-end rates of 2.5%;
- A parallel shift of +0.5% and -0.5% in inflation rate from year-end rates of 3.0%
- A parallel shift of +10% and -10% in prices of Australian equities.

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

		Interest Rate Risk				Other Price Risk			
		-0.5%		+0.5%		-10%		+10%	
	Carrying Amount	Profit	Equity	Profit	Equity	Profit	Equity	Profit	Equity
2014	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Financial Assets									
Cash and Cash Equivalents	13,702	(69)	(69)	69	69	–	–	–	–
Receivables:									
Trade Debtors	9,188	–	–	–	–	–	–	–	–
Other Receivables	27,530	–	–	–	–	–	–	–	–
Other Financial Assets	56,880	–	–	–	–	–	(5,688)	–	5,688
Total Financial Assets	**107,300**	**(69)**	**(69)**	**69**	**69**	**–**	**(5,688)**	**–**	**5,688**
2014									
Financial Liabilities									
Payables	49,545	–	–	–	–	–	–	–	–
Borrowings	30,119	–	–	–	–	–	–	–	–
Other Financial Liabilities	98	–	–	–	–	–	–	–	–
Total Financial Liabilities	**79,762**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
2013									
Financial Assets									
Cash and Cash Equivalents	18,795	(94)	(94)	94	94	–	–	–	–
Receivables:									
Trade Debtors	8,939	–	–	–	–	–	–	–	–
Other Receivables	21,954	–	–	–	–	–	–	–	–
Other Financial Assets	53,656	–	–	–	–	–	(5,366)	–	5,366
Total Financial Assets	**103,344**	**(94)**	**(94)**	**94**	**94**	**–**	**(5,366)**	**–**	**5,366**
2013									
Financial Liabilities									
Payables	55,042	–	–	–	–	–	–	–	–
Borrowings	22,450	–	–	–	–	–	–	–	–
Other Financial Liabilities	76	–	–	–	–	–	–	–	–
Total Financial Liabilities	**77,568**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**

Please note that a change in interest rates will not affect the borrowings balance above due to the interest rate in relation to these loans being fixed for the length of their term.

(e) Fair Value

The fair values and net fair values of financial instrument assets and liabilities are determined as follows:

> Level 1 – the fair value of financial instrument with standard terms and conditions and traded in active liquid markets are determined with reference to quoted market prices;

> Level 2 – the fair value is determined using inputs other than quoted prices that are observable for the financial asset or liability, either directly or indirectly; and

> Level 3 – the fair value is determined in accordance with generally accepted pricing models based on discounted cash flow analysis using unobservable market inputs.

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

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

COMPARISON BETWEEN CARRYING AMOUNT AND FAIR VALUE

	Consol'd Carrying Amount	Fair value	Consol'd Carrying Amount	Fair value
	2014	**2014**	2013	2013
	$'000	$'000	$'000	$'000
Financial Assets				
Cash and Cash Equivalents	13,702	13,702	18,795	18,795
Receivables (i)				
> Trade Debtors	9,188	9,188	8,939	8,939
> Other Receivables	27,530	27,530	21,954	21,954
Other Financial Assets (i)	56,880	56,880	53,656	53,656
Total Financial Assets	**107,300**	**107,300**	**103,344**	**103,344**
Financial Liabilities				
Payables	49,545	49,545	55,042	55,042
Borrowings	30,119	30,119	22,450	22,450
Other Financial Liabilities (i)	98	98	76	76
Total Financial Assets	**79,762**	**79,762**	**77,568**	**77,568**

(i) The carrying amounts exclude statutory financial assets and liabilities (i.e. GST input tax credit and GST Payable)

FINANCIAL ASSETS MEASURED AT FAIR VALUE

	Carrying Amount as at 30 June	Fair value measurement at end of reporting period using:		
		Level 1	Level 2	Level 3
2014	$'000	$'000	$'000	$'000
Available for sale financial assets				
> Equities and managed funds	56,880	56,880	–	–
Total Financial Assets	**56,880**	**56,880**	**–**	**–**
2013				
Available for sale financial assets				
> Equities and managed funds	53,656	53,656	–	–
Total Financial Assets	**53,656**	**53,656**	**–**	**–**

Note 19 – Financial Instruments (continued)

(e) Fair Value (continued)

There have been no transfers between levels during the period.

The fair value of the financial assets and liabilities is included at the amount at which the instrument could be exchanged in a current transaction between willing parties, other than in a forced or liquidation sale. The following methods and assumptions were used to estimate fair value:

LISTED SECURITIES

The listed share assets are valued at fair value with reference to a quoted (unadjusted) market price from an active market. Alfred Health categorises these instruments as Level 1.

DEBT SECURITIES

In the absence of an active market, the fair value of Alfred Health's debt securities and government bonds are valued using observable inputs such as recently executed transaction prices in securities of the issuer or comparable issuers and yield curves. Adjustments are made to the valuations when necessary to recognise differences in the instrument's terms. To the extent that the significant inputs are observable, Alfred Health categorises these investments as Level 2.

UNLISTED SECURITIES

The fair value of unlisted securities is based on the discounted cash flow method. Significant inputs in applying this technique include growth rates applied for future cash flows and discount rates utilised. To the extent that the significant inputs are unobservable, Alfred Health categorises these investments as Level 3.

The fair value of unlisted investments is based on the discounted cash flow technique. Significant inputs in applying this technique include growth rates applied for cash flows and discount rates used.

Alfred Health does not have unlisted securities as at 30 June 2014.

Note 20 – Commitments for Expenditure

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
	$'000	$'000	$'000	$'000
Capital Expenditure Commitments:				
Payable:				
Building Works	21,778	42,792	21,778	42,792
Plant & Equipment				
> Medical Equipment	1,122	3,542	1,122	3,542
> Computer Equipment	224	41	224	41
> Other Equipment	–	386	–	386
Furniture and Fittings	–	6	–	6
Total Capital Expenditure Commitments	**23,124**	**46,767**	**23,124**	**46,767**
Capital Expenditure Commitments:				
Not later than one year	23,124	21,037	23,124	21,037
Later than one year but not later than five years	–	25,730	–	25,730
Total Capital Expenditure Commitments	**23,124**	**46,767**	**23,124**	**46,767**
Other Expenditure Commitments				
Payable:				
Supplies and Consumables				
> Medical	1,050	499	1,050	499
> Other	82,221	109,048	82,221	109,048
Maintenance Contracts				
> Medical	4,260	3,806	4,260	3,806
> Information Technology	11,924	14,696	11,924	14,696
Total Other Expenditure Commitments	**99,455**	**128,049**	**99,455**	**128,049**
Other Expenditure Commitments:				
Not later than one year	38,238	37,124	38,238	37,124
Later than one year but not later than five years	60,327	89,133	60,327	89,133
Later than 5 years	890	1,792	890	1,792
Total Other Expenditure Commitments	**99,455**	**128,049**	**99,455**	**128,049**
Operating Leases Commitments				
Commitments in relation to leases contracted for at the reporting date:				
Operating leases				
> Property	6,436	6,581	6,436	6,581
> Medical Equipment	299	320	299	320
> Motor Vehicle	1,923	653	1,923	653
Total Operating Leases Commitments	**8,658**	**7,554**	**8,658**	**7,554**
Operating Leases Commitments Payable as Follows:				
Cancellable				

Note 20 – Commitments for Expenditure (continued)

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
	$'000	$'000	$'000	$'000
Not later than one year	–	71	–	71
Later than one year but not later than five years	–	3	–	3
Non-Cancellable				
Not later than one year	2,620	4,046	2,620	4,046
Later than one year but not later than five years	4,475	2,575	4,475	2,575
Later than 5 years	1,563	859	1,563	859
Total Operating Leases Commitments	**8,658**	**7,554**	**8,658**	**7,554**
Total Commitments for Expenditure (inclusive of GST)	**131,237**	**182,370**	**131,237**	**182,370**
Less GST recoverable from the Australian Tax Office	**(11,931)**	**(16,579)**	**(11,931)**	**(16,579)**
Total Commitments for Expenditure (exclusive of GST)	**119,306**	**165,791**	**119,306**	**165,791**

Other Supplies and Consumables commitments are inclusive of the contract to provide non-clinical support services.

Alfred Health has operating lease arrangements for motor vehicles, office and medical equipment and property (including a car park). There are no contingent rental payments. Payments are determined within the terms of agreement and do not contain purchase options. There are no significant restrictions imposed by the lease agreements such as additional debt or further financing.

Note 21 – Contingent Assets and Contingent Liabilities

No contingent assets or liabilities are present for the year ending 30 June 2014

Note 22 – Operating Segments

	Residential Aged Care Services		Other		Consol'd Total	
	2014	2013	**2014**	2013	**2014**	2013
	$'000	$'000	$'000	$'000	$'000	$'000
Revenue						
External Segment Revenue	14,597	13,084	917,382	896,138	931,979	909,222
Total Revenue	**14,597**	**13,084**	**917,382**	**896,138**	**931,979**	**909,222**
Expenses						
External Segment Expenses	(17,241)	(16,384)	(945,070)	(921,709)	(962,311)	(938,093)
Total Expenses	**(17,241)**	**(16,384)**	**(945,070)**	**(921,709)**	**(962,311)**	**(938,093)**
Net Result from ordinary activities	**(2,644)**	**(3,300)**	**(27,688)**	**(25,571)**	**(30,332)**	**(28,871)**
Interest Expense	–	–	(240)	(1,478)	(240)	(1,478)
Interest Income	–	–	5,622	5,177	5,622	5,177
Net result for the year	**(2,644)**	**(3,300)**	**(22,306)**	**(21,872)**	**(24,950)**	**(25,172)**
Other information						
Segment Assets	8,896	9,119	1,077,170	735,631	1,086,066	744,750
Total Assets	**8,896**	**9,119**	**1,077,170**	**735,631**	**1,086,066**	**744,750**
Segment Liabilities	–	–	265,063	248,872	265,063	248,872
Total Liabilities	**–**	**–**	**265,063**	**248,872**	**265,063**	**248,872**
Depreciation & Amortisation Expense	–	(1,575)	(46,117)	(45,604)	(46,117)	(47,179)

The major products/services from which the above segments derive revenue are:

Business Segments	**Types of Services Provided**
Residential Aged Care Services	Residential Aged Care and Mental Health for Aged Care Services
Other	Other includes Admitted Patients, Outpatients, Emergency Department Services, Ambulatory, Primary Health and clinical support such as Pharmacy, Imaging, Pathology

Alfred Health operates predominantly in Metropolitan Melbourne, Victoria. More than 90% of revenue, net surplus from ordinary activities and segment assets relate to operations in Metropolitan Melbourne, Victoria.

Note 23a – Responsible Persons Disclosures

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

RESPONSIBLE MINISTERS

The Honourable David Davis, MLC, Minister for Health, Minister for Ageing (1 July 2013 to 30 June 2014)

The Honourable Mary Wooldridge, MLA, Minister for Mental Health (1 July 2013 to 30 June 2014)

Responsible persons are as follows (all are Directors of Alfred Health and except where noted held their office for the period 1 July 2013 to 30 June 2014)

Ms Helen Shardey BComm TSTC MAICD

Mr Julian Gardner BA LLB FIPAA

Mr David Menadue OAM BA BEd (Resigned 30 June 2014)

Associate Professor Jillian Sewell AM MBBS FRACP FAICD

Mr Anthony Starkins LLB BEc FFin MAICD (Resigned 4 February 2014)

Mr Tim Wilson DipBus BA MDiplomacy&Trade (Resigned 30 June 2014)

Mr Damien Kenny BCom BBus Systems

Mr Carl Putt BSc MHA (Commenced 30 July 2013)

Mr James Turcato CPA GAICD AIMM (Commenced 2 October 2013)

ACCOUNTABLE OFFICER

Mr Andrew Way (Chief Executive) RN BSc (Hons) MBA

RESPONSIBLE PERSONS' REMUNERATION

The number of responsible persons are shown in their relevant income bands:

Income Band	Parent		Consolidated	
	2014	2013	**2014**	2013
$10,000–$19,999	1	–	1	–
$20,000–$29,999	2	1	2	1
$30,000–$39,999	5	7	5	7
$60,000–$69,999	1	1	1	1
$450,000–$459,999	1	–	1	–
$500,000–$509,999	–	1	–	1
Total Number	**10**	**10**	**10**	**10**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**$733,766**	**$803,407**	**$733,766**	**$803,407**

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

OTHER TRANSACTIONS OF RESPONSIBLE PERSONS AND THEIR RELATED ENTITIES

The following Directors of Alfred Health are also directors of the organisations noted. Alfred Health has, or has had in the past, ongoing business dealings with these organisations. All transactions were under normal commercial conditions and at arms' length.

Board Member	Organisation	Year to 30 June 2014		At 30 June 2014		Year to 30 June 2013		At 30 June 2013	
		Sales	Purchases	Receivable	Payable	Sales	Purchases	Receivable	Payable
		$	$	$	$	$	$	$	$
Julian Gardner	Mind Australia Ltd	–	1,247	–	–	–	4,789	–	–
David Menadue	Victorian AIDS Council	13,111	–	8,741	–	13,000	2,000	4,370	–

There were no other transactions with responsible persons or their related entities other than those within normal employee relationships on terms and conditions no more favourable than those available in similar arms length dealings.

Note 23b – Executive Officer Disclosures

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

Range	Parent				Consolidated			
	Total Remuneration Number		Base Remuneration Number		Total Remuneration Number		Base Remuneration Number	
	2014	2013	2014	2013	2014	2013	2014	2013
$ 190,000–$ 199,999	–	–	–	1	–	–	–	1
$ 200,000–$ 209,999	–	–	1	2	–	–	1	2
$ 210,000–$ 219,999	–	3	–	–	–	3	–	–
$ 220,000–$ 229,999	1	–	–	1	1	–	–	1
$ 230,000–$ 239,999	–	1	1	–	–	1	1	–
$ 240,000–$ 249,999	1	–	1	–	1	–	1	–
$ 250,000–$ 259,999	1	–	–	–	1	–	–	–
$ 270,000–$ 279,999	–	–	1	–	–	–	1	–
$ 280,000–$ 289,999	1	–	–	–	1	–	–	–
$ 290,000–$ 299,999	–	–	–	2	–	–	–	2
$ 300,000–$ 309,999	–	–	1	–	–	–	1	–
$ 320,000–$ 329,999	1	1	1	–	1	1	1	–
$ 340,000–$ 349,999	–	1	–	–	–	1	–	–
$ 350,000–$ 359,999	1	–	–	–	1	–	–	–
Total Number of Staff	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**
Total Annualised Employee Equivalents (AEE) [i]	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**
Total Remuneration ($)	**1,684,479**	**1,950,393**	**1,584,032**	**1,835,180**	**1,684,479**	**1,950,393**	**1,584,032**	**1,835,180**

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

Note 23c – Payments to Other Personnel (Contractors with Significant Management Responsibilities)

Expense Band	Parent		Consolidated	
	2014	2013	**2014**	2013
$110,000–$119,999	–	1	–	1
Total expenses (exclusive of GST)	**–**	**$116,844**	**–**	**$116,844**

Payments have been made to a number of contractors with significant management responsibilities, which are disclosed within the $110,000 expense band. This contractor was responsible for planning, directing or controlling, directly or indirectly, of Alfred Health's activities.

Note 24 – Events Occurring after the Balance Sheet Date

No events after the Balance Sheet date which may have a material impact on these financial statements have occurred.

Note 25 – Remuneration of Auditors

	Parent Entity	Parent Entity	Consol'd	Consol'd
	2014	2013	**2014**	2013
	$'000	$'000	$'000	$'000
Victorian Auditor-General's Office				
Audit or review of financial statements	226	220	234	228
Total Auditor Remuneration	**226**	**220**	**234**	**228**

Note 26 – Controlled Entities

Name of Entity	Country of Residence
Whole Time Medical Specialists' Private Practice Scheme and Trust Fund	Australia

The Whole Time Medical Specialists' Private Practice Scheme and Trust Fund is a charitable trust set up, principally, for the benefit of the Alfred Hospital.

AASB 127 (Consolidated and Separate Financial Statements) is to be applied in the preparation and presentation of consolidated financial statements for a group of entities under the control of the parent. Per AASB 127, control is constituted by the parent's power to govern the financial and operational policies of an entity so as to obtain benefit from its activities.

Control can be presumed to exist when the parent has:

(a) power over more than half of the voting rights by virtue of an agreement with other investors;

(b) power to govern the financial and operating policies of the entity under a statute or an agreement;

(c) power to appoint or remove the majority of the members of the board of directors or equivalent governing body and control of the entity is by that board or body; or

(d) power to cast the majority of votes at meetings of the board of directors or equivalent governing body and control of the entity is by that board or body.

In the case of the Trust, Alfred Health has the powers noted above due to its ability to appoint and remove the majority of the trustees.

Control was deemed to have occurred on 31 May 2009, when Alfred Health appointed the trustees. At that time, the Trust had net assets of $13.197m and under AASB 3 *Business Combinations*, this amount was recognised in Alfred Health's revenue.

At 30 June 2014, the Trust had net assets of $15.366m (2013: $13.393m) which have been included in the financial statements of the consolidated entity.

Note 27 – Economic Dependency

Alfred Health is wholly dependent on the continued financial support of the State Government and in particular, the Department of Health. The Department of Health has provided confirmation that it will continue to provide Alfred Health adequate cash flow support to meet its current and future obligations as and when they fall due for a period up to September 2015.

Note 28 – Correction of Error and Revision of Estimates

Alfred Health has performed a review of useful lives pertaining to its buildings at valuation. This review has indicated that an understatement of useful lives for a limited number of buildings at valuation has occurred in prior years. The error has been corrected by restating each of the affected financial statement line items for the prior periods as follows:

> Overstatement of accumulated deficit and accumulated depreciation balances as at 30 June 2012 in relation to 2009–10, 2010–11, and 2011–12 financial years of $51.21m, leading to understatement of net assets and overstatement of accumulated deficit of $51.21m.

> Overstatement of depreciation expense and accumulated depreciation for 2012–13 financial year by $12.22m, leading to an understatement of the net result for the year and net assets for the 2012–13 year of $12.22m.

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