

Annual Financial Report 2025-26

Contents

Our vision, role and values 1
Chief Executive Officer and Board Chair report 2
Staff Excellence Awards 6
RCH Board member profiles 7
RCH Board Committee membership 11
Executive staff 12
Organisational structure 14
Workforce data 15
Occupational Health and Safety 16
Occupational Violence 20
Statutory statements 22
Attestations and Declarations 46
Disclosure index 48
Statement of Priorities 50
Financial statements 62

Acknowledgement of Country

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

General Information

Our Vision

A world where all kids thrive.

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

Our Role

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

Our Values

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

Curious
We are creative, playful and collaborative.

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

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

Kind
We are generous, warm and understanding.

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

Chief Executive Officer and Board Chair Report

It's been another rewarding year at The Royal Children's Hospital, as we've embraced new opportunities, strengthened partnerships and explored new ways of working across the health system. By connecting with teams across our community, we're building a shared understanding of how we can work together to achieve even better outcomes for children and their families.

Caring at scale

Throughout 2025–26, we provided care at extraordinary levels:

- 85,865 Emergency Department presentations
- 420,619 ambulatory (outpatient) appointments
- 16,224 surgeries
- 53,299 inpatient admissions

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

RCH TV hits 100 million viewers

Now in its 35th year of production, the RCH YouTube channel has amassed over 100 million video views, almost entirely driven by RCH TV content. RCH TV aims to turn negative expectations about healthcare and hospital into a positive experience, empowering children for their visit to a hospital or healthcare provider. RCH TV depicts medical procedures, health professionals and medical equipment in an informative, relatable and truthful way, using knowledge and understanding as a way of overcoming fear and anxiety about hospital.

Kids Health Info Fact Sheets – 20 years

For 20 years, the RCH has been producing Kids Health Info – helping parents and caregivers support their children to thrive. What started as handouts, has now flourished into a plethora of digital fact sheets, videos, podcasts and social media posts, shared across different online platforms to maximise its reach. The aim of Kids Health Info is to provide helpful, trustworthy and clear information to guide parents and caregivers through the health and wellbeing changes their children may face – from croup to burns and everything in between.

Victorian Forensic Paediatric Medical Service (VFPMS) – 20 years

This year marked 20 years of the Victorian Forensic Paediatric Medical Service (VFPMS), a centre of excellence providing specialist forensic medical assessment and care for children and young people who have experienced abuse, assault or neglect. Through a statewide network led by The Royal Children's Hospital, VFPMS delivers expert care close to home, supports early intervention, and works across health, child protection and justice systems to strengthen Victoria's response to child maltreatment.

RCH Volunteers service – 65 years

This year we celebrated more than six decades of service from our incredible volunteer workforce. Through their time, compassion and generosity, volunteers help create a welcoming and supportive environment for patients, families and staff. Whether greeting visitors, supporting children through play, assisting families in waiting areas or helping behind the scenes, they make a meaningful difference every day. We thank all our volunteers for their dedication and the lasting contribution they make to our hospital community.

95 years of the Good Friday Appeal – Supporting regional Victoria

A record $25,268,485 million was raised through the Good Friday Appeal, with nearly $3 million invested in regional health services.

Marking the Appeal's 95th year, the result will help fund equipment upgrades, specialised education and training programs across regional Victoria:

- **Barwon**: Funded essential neonatal and specialist equipment and expanded training programs, strengthening high-acuity care at Barwon Women's and Children's and building workforce capability across the region.
- **Gippsland**: Enhanced neonatal and emergency paediatric care, established a multidisciplinary eating disorder clinic, expanded culturally safe resources for Aboriginal families and strengthened regional clinical partnerships to deliver consistent, high-quality care.
- **Hume**: Expanded paediatric outpatient services, upgraded newborn and maternity equipment and supported advanced emergency training, improving access to timely, high-quality care closer to home.
- **Grampians**: Contributions improved family accommodation, upgraded allied health technology, enabled cutting-edge paediatric equipment and delivered multidisciplinary skills-uplift programs to support safer, more efficient care.
- **Loddon Mallee**: Strengthened early-assessment and navigation services, expanded paediatric clinics, improved family-friendly maternity spaces, established a Mildura Outreach Hub and enhanced telehealth services to ensure coordinated care closer to home.

More highlights from the year

This year, we celebrated the remarkable contribution of our nursing workforce on International Nurses Day, commenced our Innovate Reconciliation Action Plan, and welcomed the Duke and Duchess of Sussex, who spent time with young people receiving care in our Adolescent Medicine ward. These moments reflect the breadth of our work and the strong culture of compassion, excellence and inclusion that defines the RCH.

Looking ahead

We want to thank our staff, volunteers and partners for the dedication, compassion and expertise you bring every day. Together, you make an extraordinary difference to the lives of children, young people and their families. To our partners at the RCH Foundation, Murdoch Children's Research Institute, the Good Friday Appeal and the University of Melbourne, thank you for your continued collaboration and shared commitment to advancing child health through exceptional care, research, education and innovation.

As we look to the future, we do so with confidence and purpose. We will build on our strengths, embrace new opportunities and continue shaping a healthier future for children and young people. We look forward to what we will achieve together as we continue to improve the health and wellbeing of children and young people, now and into the future.

In accordance with the *Financial Management Act 1994*, I am pleased to present the report of operations for The Royal Children's Hospital (RCH) for the year ending 30 June 2026.

Peter Steer

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

31 August 2026

Christine Kilpatrick

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

31 August 2026

Powers and duties

The powers and duties of the RCH are prescribed by the *Health Services Act 1988*. The hospital is accountable to the people of Victoria through the Minister for Health and Minister for Ambulance Services, the Hon Harriet Shing MP from 15 April 2026 to June 30 2026 (the Hon Mary-Anne Thomas MP (1 July 2025 to 15 April 2026)), the Minister for Mental Health, the Hon Ingrid Stitt MP from 1 July 2025 to 30 June 2026 as well as the Minister for Disability and Minister for Children, the Hon Lizzie Blandthorn MP from 1 July 2025 to 30 June 2026.

Our services

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

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

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

The RCH leads a number of statewide services, including:

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

Staff Excellence Awards

At our 2025 Staff Excellence Awards celebration, we recognised the incredible work of team members across the organisation.

The recipients of the 2025 awards were:

Chairs' Medal – Annette Gaulton

Integrated Access Award – Charlotte Peak

Quality, Innovation and Improvement Award – Kate Harley

People Award – Jayne Hughan

Sustainable Healthcare Award – Kate Wadsworth

Dr William Snowball Award – Justin Lee

Mary Patten Award – Bronwyn Mahoney

Bernadette O'Connor Award – Daniella Tassoni

Yvonne Wagner Award – Katina Borg

Health, Safety and Wellbeing Award – Stefanie Davis

Newcomer Impact Award (clinical) – Kieran Walsh

Newcomer Impact Award (non-clinical) – Marit Van Zonneveld

2025-26 Board member profiles

Board Chair

Professor Christine Kilpatrick AO
Professor Kilpatrick is a highly renowned leader with a track-record of shaping and strengthening health services in Victoria with deep experience across clinical, academic medicine and hospital administration.

Previously, Professor Kilpatrick was CEO of the Royal Melbourne Hospital (2017–2023), and CEO of The Royal Children's Hospital (RCH) (2008–2017). In her clinical career Professor Kilpatrick trained in neurology, specialising in epilepsy, working in both public and private practice. Professor Kilpatrick continues to work actively across the health sector serving on several boards, including Chair of Healthdirect Australia and Chair of The Australian Commission on Safety and Quality in Health Care and Board Director of Victorian Managed Insurance Authority (VMIA) and Central Adelaide Local Health Network (CALHN). Professor Kilpatrick was awarded a Centenary Medal in 2003 and appointed an Officer of the Order of Australia in 2019.

Board Deputy Chair

Professor Richard Doherty
MBBS (Hons), DObstRCOG, FRACP

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

Board Deputy Chair

Pallavi Khanna
CA, GAICD

Pallavi Khanna is an experienced risk management and governance advisor. She has worked both in South Africa and Australia across the corporate and not-for-profit sectors. For more than 20 years she has worked with organisations to develop strategies to address strategic risks, undertaken independent evaluation of governance frameworks and managed projects to deliver strategic objectives. She has also undertaken assessments pertaining to privacy (Australia and International), IT controls, procurement (probity) and customer experience. Pallavi is an independent member of the Finance and Risk Committee at the City of Stonnington and a Director on AVet Health. Her prior board roles include Public Galleries Association of Victoria, Common Equity Housing Ltd and Ballarat Health Services. She is a Chartered Accountant (Australia and South Africa), Prince 2 certified and a Graduate of the Australian Institute of Company Directors.

Board Members

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

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

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

Sammy Kumar
B. Bus, FCA

Sammy Kumar is the Co-Founder and Executive Director of Tenet Group. Sammy is a business leader with over 37 years' experience in management consulting, mergers and acquisitions, risk management, strategy, technology and ventures. He has advised companies across several different sectors including financial services, telecommunications, technology services, private equity and venture capital. Prior to Tenet Group, Sammy spent over 30 years at PwC in a number of senior roles, gaining significant experience across many overseas markets including the US, Canada, South America, and Asia Pacific. During his time at PwC he started, led and grew businesses both in Australia and the Asia-Pacific region, managing revenues of over $1 billion. Sammy is a thought leader on a range of topics including revenue risk management, megatrends impacting economies, and the impact of technology on business strategy. He is a committed member of the broader community, serving on the Boards of the RCH and the RCH Foundation. He is also a Board member of Melbourne and Olympic Park Trust and Board Director of Volaro Group. Sammy also served on the Advisory Board for the Centre for Australia-India Relations until 30 June 2026.

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

After 30 years of technology leadership experience in Australia, the US, UK and Europe, Dr Michael Wildenauer transitioned into academia. At La Trobe Business School, he was appointed a Professor of Practice in Management, teaching MBA and Master's courses on the social and ethical issues around technology and business, as well as in corporate governance.

Following this, Michael was an academic at the Centre for AI and Digital Ethics (CAIDE), and the Melbourne Law School at the University of Melbourne, where he was subsequently an Honorary Senior Fellow. In addition to his professional and governance roles, Michael was previously the Chair of the Professional Ethics Committee of the Australian Computer Society (ACS) and a Member of the ACS Professional Standards Board and was a member of the Expert Advisory Committee on Neurotechnology for the Australian Human Rights Commission.

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

Mark Rogers

B.Eng (Hons), B.Sc

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

Andrew Chan

B.Comm, LLB (Honours)

Andrew Chan is a partner at Mills Oakley, a national corporate law firm and has over 18 years' legal experience in Australia and the UK. As a parent of a regular patient, Andrew is particularly interested in improving the consumer and patient experience at RCH and health outcomes for children.

Julie Green

Julie Green has been a passionate, professional Company Director for 13 years, who advocates for people, planet and profit. Current directorships include Bendigo Health, Zero Emissions Australia, NatureCo and NatureCo GRP. Formerly, Julie served on RACV - a mobility, leisure and insurance company with 2.3M members, Greening Australia - a large environmental enterprise, Maldon Hospital, Shepparton Villages - a large, aged care provider, Loddon Mallee Waste and Resource Recovery, and a Cooperative startup. In addition, Julie served on Advisory Boards for Symphony 7 – a member organisation for SMEs to uplift profit, humanity and the planet, Redgrid - a software startup in the energy sector, ClimateWise Associations and charities Food Bank and Oxfam Australia.

Over 23 years, Julie was a Senior Executive (Operational General Management and CFO roles) reporting to various Boards, prior to being a portfolio Director. She is an experienced change manager and strategist, in the public and private sectors, across diverse industries, including healthcare, transport and infrastructure. Julie started her career as a business advisor for 10 years with chartered firms in the UK and Australia, including Ernst & Young. Julie is a Fellow of

the Institute of Chartered Accountant in England and Wales, Fellow of Australian Institute of Company Directors and Fellow Williamson Leadership Community Program.

Board appointments

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

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

The RCH Board Committee membership 2025-26 financial year

Audit and Corporate Risk Committee

Pallavi Khanna (Chair)
Prof Christine Kilpatrick AO
Sammy Kumar
Prof Richard Doherty
Julie Green
Michelle Bendschneider (External member)

Community Advisory Committee

Elleni Bereded-Samuel AM (co-Chair)
Andrew Symes (External Community member) (co-Chair)
Dr Michael Wildenauer
Prof Christine Kilpatrick AO – Ex Officio

Finance Committee

Mark Rogers (Chair)
Pallavi Khanna
Andrew Chan
Julie Green
Prof Christine Kilpatrick AO – Ex Officio

Quality Committee

Professor Richard Doherty (Chair)
Pallavi Khanna
Andrew Chan
Prof Christine Kilpatrick AO – Ex Officio

People and Culture Committee

Dr Michael Wildenauer (Chair)
Elleni Bereded-Samuel AM
Mark Rogers
Julie Green

Remuneration and Governance Committee

The Committee was disestablished on 25 October 2025, with the Board resolving that items previously handled by the Remuneration and Governance Committee would become whole of Board matters,

Prof Christine Kilpatrick (Chair) – Ex Officio
Prof Richard Doherty
Pallavi Khana

Executive staff

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

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

Claire Hare
Chief Financial Officer
BBus (Acctg), BIT (IS), CA

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

Ed Oakley
Executive Director Strategy, Planning and Improvement and Chief of Critical Care
MBBS, FACEM

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

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

Kog Ravindran
Chief of Staff to the CEO and Executive Director Communications
BJ, SC-PAADV

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

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

Kim O'Sullivan
Executive Director Access and Clinical Operations
RN, Post Grad (Critical Care), MBA

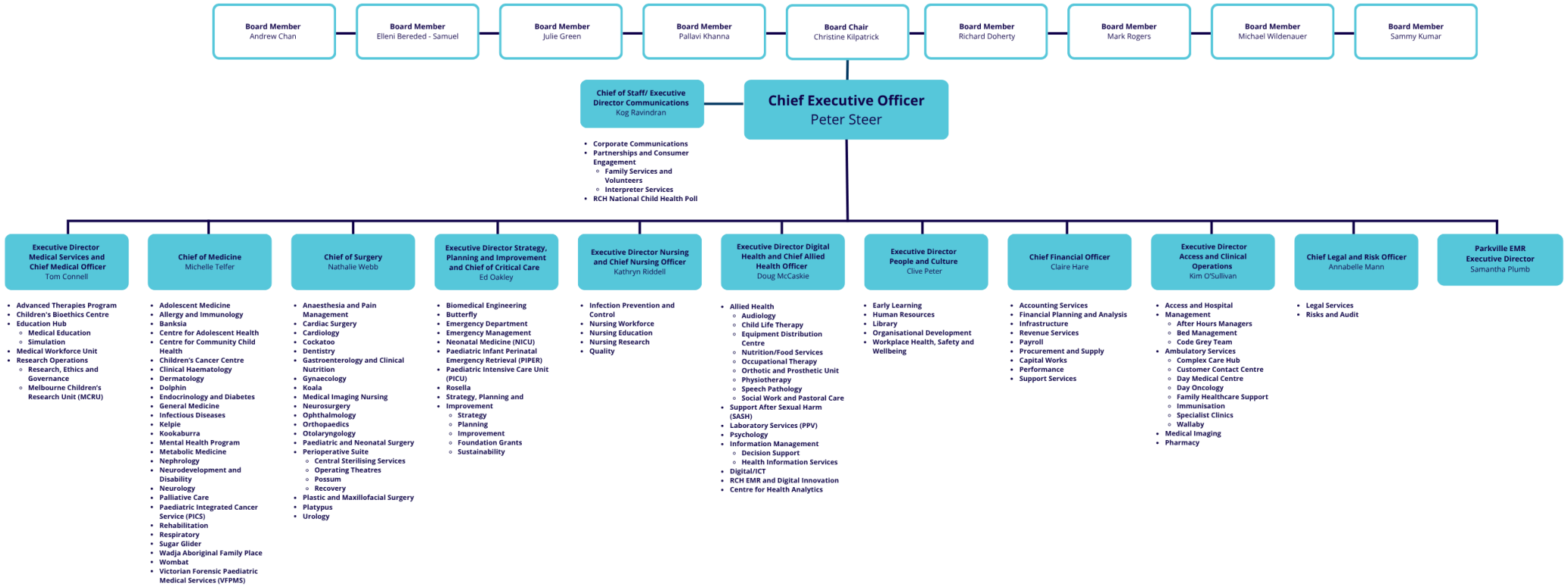
Annabelle Mann
Chief Legal and Risk Officer
BSc LLB LLM MBioeth MAICD

Jo Miller assumed duties as Interim Executive Director of Access and Clinical Operations from 1 December 2025 to 17 May 2026. Kim O'Sullivan was appointed as Executive Director of Access and Clinical Operations on 18 May 2026.

Frank Vosnidis was Interim Chief Financial Officer from 1 July 2025 to 14 December 2025. Claire Hare was appointed Chief Financial Officer on 15 December 2025.

Changes to the executive structure were implemented on 1 December 2025. At this time, Ed Oakley's role changed to Executive Director Strategy, Planning and Improvement and Chief of Critical Care. Doug McCaskie's role changed to Executive Director Digital Health and Chief Allied Health Officer. Annabelle Mann's role changed to Chief Legal and Risk Officer.

Organisational structure



Workforce data

Hospitals Labour Category	June FTE		Average Monthly FTE	
	2024/25	2025/26	2024/25	2025/26
Nursing	1,522	1,461	1,512	1,490
Administration and Clerical	792	812	804	804
Medical Support	434	449	434	441
Hotel and Allied Services	269	276	276	275
Medical Officers	145	146	143	146
Hospital Medical Officers	388	400	399	394
Sessional Clinicians	183	187	179	183
Ancillary Staff (Allied Health)	407	441	411	425

Code of Conduct

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

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

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

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

Occupational Health and Safety

Workplace Health, Safety and Wellbeing

In 2025-26, the Workplace Health, Safety and Wellbeing team focused on strengthening its safety management systems and delivering strategic initiatives across occupational violence and aggression, workplace wellbeing literacy, safety through design, and psychosocial hazard assessment and control. The RCH remains committed to providing a healthy and safe environment for all employees, volunteers, patients, visitors and contractors. Building on progress from 2024-25, the organisation continued to implement measures to proactively foster a positive and safe culture.

A key focus for the year was building people leader capability to better support the workforce. Targeted initiatives included enhanced post-incident follow-up, strengthened support for injured workers and a proactive, evidence-informed approach to risk management, including psychosocial hazards. These initiatives have strengthened preventative practices, embedded regulatory changes and enhanced our workforce capability, agility and resilience. The progress of this approach is evidenced through improved risk management practices, increased leadership capability, and a measurable uplift in organisational safety performance.

Psychosocial hazards

A key priority in 2025-26 has been organisational readiness following the implementation of the new Occupational Health and Safety (Psychological Health) Regulations on 1 December 2025. The RCH has continued to strengthen its positive safety culture through the implementation of these regulations, embedding an integrated framework to identify, assess and control psychosocial risks across the workplace. This work reflects a proactive commitment to ensuring psychological health is managed with the same rigour as physical safety and aligns with evolving regulatory expectations and best practice approaches.

To support the implementation of the new regulations, the organisation developed a suite of practical tools and resources to build capability and drive consistency. This included the introduction of a psychosocial risk assessment tool, a dedicated SharePoint platform to centralise information and resources, targeted fact sheets outlining hazard and controls, and a formal procedure (May 2026) to guide application across the business. Looking forward, the RCH has developed an education package for managers to support the identification, management and review of psychosocial hazards. Together, these initiatives support leaders and employees to better understand psychosocial hazards, implement effective risk management strategies and review their effectiveness.

Health and wellbeing

During 2025-26, the RCH undertook a comprehensive review of its workforce health and wellbeing supports to inform the development of a Health and Wellbeing Strategy. This work included mapping existing health and wellbeing offerings across the organisation, identifying gaps and opportunities, and evaluating key supports including the Employee Assistance Program, Peer Support Program and Mental Health First Aid training.

Building on these insights, the RCH is progressing the development of a contemporary roadmap to strengthen health and wellbeing literacy, supporting a culture of shared responsibility for wellbeing, aligned to the organisation's strategic priorities. The foundational work has incorporated workforce co-design, building on existing organisational strengths and placing staff voices at the centre of change. While work on the strategy is being finalised, it is grounded in shared knowledge and capabilities that will support RCH to move beyond individual wellness programs toward an integrated framework enabling staff to thrive at work. Support for the workforce has continued with targeted proactive programs and reactive support at times of need. It has continued over the year with a focus on integrating proactive and responsive supports within a cohesive wellbeing framework.

Mental Health First Aid Training

The RCH continued to strengthen its mental health literacy in its sixth year of delivering the Mental Health First Aid (MHFA) program. The program equips individuals with the knowledge and skills to provide initial support, promote early intervention and improve outcomes. In 2025-26, a further 131 staff were trained. The RCH now has 787 staff trained in MHFA.

Ongoing support and development of MHFA-trained staff remained a focus during the year. Trained staff were supported with the development of a dedicated online resource platform with ready access to resources and referral pathways within the RCH and the broader community. The reach of the MHFA program was further extended through the delivery of training to RCH employees based in offsite locations in May 2026. Additionally, the RCH maintained recognition as a Mental Health First Aid Skilled Workplace.

Peer Support program

Throughout 2025-26, the RCH strengthened its Peer Support framework. Trained staff provide confidential peer support and assist colleagues to access appropriate services for a range of concerns. In April 2026, a tiered Peer Support model was introduced, recognising the diverse roles that trained staff perform, from informal day-to-day support within teams through to an organisational-wide formal on-call response. On-call Peer Supporters continued to receive monthly reflective practice sessions, providing a structured opportunity to debrief, build capability, navigate complex situations and maintain their own wellbeing while supporting others.

Health and wellbeing initiatives

The RCH is committed to a proactive and preventative approach to staff wellbeing, delivering a range of evidence-informed initiatives focused on early detection, risk reduction and supporting long-term health outcomes.

The RCH continued to promote staff health and wellbeing through a range of initiatives. In partnership with Bupa, 168 staff accessed skin check screenings, with outcomes highlighting the importance of early detection and follow-up care. The monthly staff massage program continued to support staff recovery and wellbeing during the workday, with expanded capacity and scheduling improving access across diverse work groups and rosters. Fitness Passport also remained a valued benefit, providing subsidised access to fitness facilities for staff and their families, supporting 800 active members during 2025-26.

Employee Assistance Program

The RCH's Employee Assistance Program (EAP), delivered by Converge International, continued to provide free and confidential counselling, coaching and wellbeing services to employees. Program offerings were expanded in October 2025. Immediate family members of RCH employees have ongoing access to family counselling, and access was expanded to include career coaching, legal support and financial coaching.

Neurodivergent Support is now offered through the EAP. This offering provides bespoke support for staff and managers, enhancing tailored care for individuals and building manager capability to support diversity and inclusion within the workforce. In 2025-26, the EAP utilisation rate reached 8.7% exceeding the industry benchmark of 5.8% and representing a 2.9% increase from the prior year. This represents a total of 1,246 meaningful engagements with the service to support staff and their families.

Annual EAP utilisation rate 2025-26*	
RCH	8.7%
Industry average (healthcare and social assistance)	5.8%

EAP Partner Program

In April 2026, the RCH launched the onsite EAP Partner Program supported by Converge International, strengthening the integration of wellbeing support across the organisation. The EAP Partner Program adopted a proactive, organisation focused approach on promoting wellbeing, preventing harm, and supporting recovery from ill health or injury. The pilot has moved away from a traditional model centred on individual crisis response and therapeutic intervention to strategically engaging where organisational need arises. The embedded EAP Partner is onsite working as a strategic resource within the Health and Wellbeing team to address organisational psychosocial challenges.

Corporate partnerships

The RCH continued to maintain active corporate partnerships with Bupa, HESTA and Aware Super, providing staff with access to preventative health resources, wellbeing education and superannuation support services. The RCH promotes a monthly calendar of health and wellbeing webinars provided by these partners, covering a variety of topics including financial wellbeing, nutrition and physical health.

Staff and community engagement

The RCH maintained a dedicated Australian Red Cross Lifeblood team, growing to 291 staff members in 2025-26. The RCH team, now in its second year, recruited an additional 39 members, representing a 17% growth. Additionally, donations increased by approximately 12%, helping to save an estimated 1,206 lives.

Consultation and Health and Safety Representatives engagement

Active engagement and consultation remained a focus to support the vital role that Health and Safety Representatives (HSR) perform in identifying hazards, developing solutions and advocating for a safe workplace. The RCH continued to have a strong and engaged HSR group, with the workforce currently having more than 150 HSRs appointed. Committees remain active, with members working proactively both within formal structures and in response to emerging issues. In 2025-26, an additional 36 HSRs were trained in the WorkSafe approved HSR training program. Formal engagement with HSRs continued through structures including the Central Building Consultative Committee (CBCC).

Staff family violence support

During 2025-2026, the RCH continued to strengthen its organisational response to family violence and support for impacted staff. The Family Violence Contact Officer network remained a key support mechanism, with managers and staff continuing to seek guidance and assistance. Cultural awareness and engagement were reinforced through key initiatives, including *16 Days of Activism* and *Are You Safe at Home?* Day. A key focus of the year was the development of senior leader capability in May 2026. Enhanced cultural safety continued to support increased disclosures among staff. The organisation is supported by 12 trained Contact Officers who provide direct support to impacted staff and advice to people leaders.

Risk management through design

During 2025-26, design principles were actively applied to support safe systems of work, with a focus on reducing both harm and the potential for harm through the physical work environment. Emphasis was placed on creating spaces that were not only safe but also adaptable, ensuring they could respond to current operational needs while remaining flexible to support future models of care and innovation. This approach reinforced the organisation's commitment to integrating safety into design from the outset. Collaborative partnerships with managers, Health and Safety Representatives, unions and other key stakeholders were central to the process, ensuring that redevelopment initiatives reflected best practice in clinical care while also supporting a safe and effective working environment for staff.

Three high-risk clinical areas were redeveloped during the reporting period, including the Intensive Care area of Banksia ward, Stage 2 of the Emergency Department redevelopment, and the South West Metro Community site. Each of these areas presented elevated occupational violence and aggression (OVA) risks, requiring careful and deliberate design consideration. The outcome of these projects is improved clinical environments, workforce engaged through the design process and enduring collaborative partnerships with participants, supporting improved safety and service outcomes.

Injury management and WorkCover

The RCH WorkCover claims profile continued to demonstrate strong performance, with measures reflecting results 45% better than industry average benchmarks. This result highlights the effectiveness of a proactive injury management approach and an ongoing focus on early intervention, employee support and timely return-to-work strategies. Across the reporting period,

a total of 14 standard WorkCover claims were accepted. Both the frequency and duration of these claims tracked consistently below industry benchmarks. Additionally, the Early Intervention program was used to effectively manage workplace injuries. Throughout 2025-26 the RCH supported 113 staff access recovery supports for their workplace injuries.

Outcomes across both WorkCover claims and Early Intervention reinforce RCH's commitment to maintaining a safe and supportive work environment, while also ensuring that employees who experience injury or illness are provided with appropriate care, structured recovery support, and meaningful pathways to remain or recover at work. The RCH Injury Management team advanced several key initiatives during the reporting period to strengthen early intervention and recovery at work practices across the organisation.

Occupational Health and Safety data

Occupational Health and Safety Statistics	2023-24	2024-25	2025-26
The number of reported hazards/ incidents for the year per 100FTE	11.5	14.2	13.39
The number of 'lost time' standard WorkCover claims for the year per 100FTE	0.32	0.43	0.34
The average cost per WorkCover claim for the year	$110,110	$101,859	$164,195

Occupational Violence and Aggression (OVA) Strategy

The RCH entered the final year of its three-year Occupational Violence and Aggression (OVA) Strategy, with a focus on evaluation, monitoring, reporting and sustainability. The organisation continued to build and communicate a clear, consistent position of zero tolerance toward violence and aggression. CCTV signage was installed across entry points, public areas and the car park to increase awareness of surveillance and strengthen deterrence. Data-driven improvement remained a key focus, with incident reporting informing targeted interventions, resource allocation, and the ongoing refinement of prevention and response strategies.

In February 2026, the Paediatric Approaches to Understanding Safe de-Escalation (P.A.U.S.E) program was expanded with the introduction of. P.A.U.S.E 1, an annual all staff mandatory e-learning module, strengthened staff capability in recognising and responding to early signs of aggression. 4,706 staff completed the training. The advanced P.A.U.S.E hands on skills, launched in February 2024, continues to support staff employed within high-risk wards or roles.

The RCH strengthened its procedural response through the introduction of the Addressing Threatening and Hateful Communication Procedure and the Limitation of Engagement Procedure. These procedures established a consistent approach to managing unacceptable behaviour by patients, families and visitors, supporting the organisation's zero-tolerance position. In February 2026, a Post Incident Checklist was launched to assist managers in providing timely support following OVA incidents, including access to psychological support, incident review and follow-up actions.

Occupational violence statistics	2025-26
WorkCover accepted claims with an occupational violence cause per 100 FTE	0.02
Number of accepted WorkCover claims with lost time injury with occupational violence cause per 1,000,000 hours worked	0.11
Number of occupational violence incidents reported	182
Number of occupational violence incidents reported per 100 FTE	4.38
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	11.5%

Financial information

Summary of the financial results for the year

The RCH recorded an operating result of $5.2 million for 2025-26. Financial performance throughout most of the year reflected sustained cost pressures, including higher employee costs resulting from lower vacancy levels than anticipated, persistently high overtime and allowance expenditure and continued growth in medical supply costs.

The financial position improved significantly in June 2026 when the Department of Health confirmed a one-off $12.6 million increase. This additional funding contributed to revenue growth and supported the RCH achieving a year-end operating surplus.

Significant changes in financial position during the year

At 30 June 2026, the RCH reported net assets of $872 million, an increase of $8 million from the prior year (30 June 2025: $864 million). The increase was primarily driven by the net surplus recorded for the year.

The RCH's financial position continues to be underpinned by its non-current physical assets, principally the main hospital building which was constructed under a Public Private Partnership (PPP) arrangement. The related financial obligation reduced by $50 million during the year as a result of quarterly service payments made by the Department of Health to the PPP consortium on the RCH's behalf. This reduction was largely offset by depreciation expense of property, plant and equipment.

Significant events occurring after balance date/ subsequent events

There were no events after the balance sheet date that had a significant effect on the operations of the RCH.

	2026	2025	2024	2023	2022
	$000	**$000**	**$000**	**$000**	**$000**
OPERATING RESULT	5,166	(19,360)	(12,679)	501	183
Total revenue	1,249,871	1,148,789	1,126,176	1,132,140	994,687
Total expenses	(1,235,928)	(1,177,812)	(1,133,405)	(1,104,776)	(1,009,085)
Net result from transactions	13,943	(29,023)	(7,229)	27,365	(14,398)

Total other economic flows	(4,970)	(620)	(472)	(6,894)	6,139
Net result	8,973	(29,643)	(7,701)	20,471	(8,260)
Total assets	1,887,849	1,920,833	1,997,190	1,716,061	1,588,893
Total liabilities	1,016,182	1,056,441	1,103,155	1,130,468	1,163,071
Net assets/Total equity	871,667	864,392	894,035	585,593	425,822

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

	2025-26 ($000)
Operating result	**5,166**
Capital purpose income	126,397
COVID 19 State Supply Arrangements – Assets received free of charge or for nil consideration under the State Supply	34
State supply items consumed up to 30 June 2026	(34)
Expenditure for capital purpose	(243)
Depreciation and amortisation	(83,306)
Finance costs (other)	(34,070)
Net result from transactions	**13,943**

Consultancies information

Details of consultancies (under $10,000)

In 2025-26, there was no consultancy where the total fee payable to the consultant was less than $10,000.

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

In 2025-26, there was one consultancy where the total fees payable to the consultant was $10,000 or greater. The total expenditure incurred during 2025-26 in relation to the consultancy is $12,400 (excl. GST).

Consultancies over $10,000						
Consultant	**Purpose of consultancy**	**Start date**	**End date**	**Total approved project fee** (excl. GST)	**Expenditure 2025-26** (excl. GST)	**Future expenditure** (excl. GST)
Prensa Pty Ltd	Assess Risk Controls for Liquid Nitrogen Use	Nov 25	Nov 25	$12,400	$12,400	$0

Government advertising campaign

The RCH did not undertake any government advertising campaigns for the 2025-26 period.

Information and communication technology (ICT) expenditure

The total ICT expenditure incurred during 2025-26 is $33.60 million (excluding GST).

Business as Usual (BAU) ICT expenditure	Non-Business as Usual (non-BAU) ICT expenditure		
Total (excl. GST)	**Total=Operational expenditure and Capital Expenditure** (excl. GST) (a) + (b)	**Operational expenditure** (excl. GST) (a)	**Capital expenditure** (excl. GST) (b)
$32.7 million	$0.90 million	$0.01 million	$0.89 million

Disclosure of review and study expenses

The RCH has no review or study expenses to report for the 2025-26 period.

Social procurement framework

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

All procurement activities at the RCH apply the most appropriate SPF objective as relevant to the goods and/or services being procured at the time. The three prioritised SPF objectives for financial year 2025-26 (*Opportunities for Victorians with disability*; *Supporting safe and fair workplaces* and *Environmentally sustainable business practices)*, are those which the RCH can directly influence through strategic procurements.

Analysis of the RCH's spend profile and activities undertaken in 2025-26 has yielded the following results:

Reporting period: 2025–26	
All suppliers	
Number of suppliers engaged	15
Total expenditure (excluding GST)	$72,538.44
Social benefit suppliers	
Number of social benefit suppliers engaged	15
Total expenditure with social benefit suppliers (excluding GST)	$72,538.44
SPF Objective: Opportunities for Victorian Aboriginal people	
SPF Outcome: Purchasing from Victorian Aboriginal businesses	
Metric 1. Number of Victorian Aboriginal businesses engaged.	8
Metric 2. Total expenditure with Victorian Aboriginal businesses (excluding GST)	$49,470.39
SPF Objective: Opportunities for Victorians with disability	
SPF Outcome: Purchasing from Victorian Social Enterprises led by a mission for people with disability and Australian Disability Enterprises	
Metric 3. Number of Victorian social enterprises led by a mission for people with disability and Australian Disability Enterprises engaged	1
Metric 4. Total expenditure with Victorian social enterprises led by a mission for people with disability and Australian Disability Enterprises (excluding GST)	$6,377.50
SPF Objective: Opportunities for Victorian priority jobseekers	
Objective: Opportunities for disadvantaged Victorians	
SPF Outcome: Purchasing from Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers	

Metric 5. Number of Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers engaged	0
Metric 6. Total expenditure with Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers (excluding GST)	$0.00
SPF Objective: Sustainable Victorian social enterprises and Aboriginal businesses	
SPF Outcome: Purchasing from Victorian social enterprises and Aboriginal businesses	
Metric 7. Number of Victorian social enterprises engaged	8
Metric 8. Total expenditure with Victorian social enterprises (excluding GST)	$24,089.42
Metric 9. Number of Victorian Aboriginal businesses engaged	8
Metric 10. Total expenditure with Victorian Aboriginal businesses (excluding GST)	$49,470.39

There have been no procurement complaints FY25/26.

Emergency procurement

The RCH had no emergency procurement to report for the 2025-26 period.

Disclosures required under legislation

Freedom of Information Act 1982

The *Freedom of Information Act 1982* (Vic) provides a legally enforceable right of access to information held by government agencies. General information regarding the *Freedom of Information Act* can be found on the Victorian Government Website on www.ovic.vic.gov.au.

FOI requests for documents held by the RCH should be made in writing. Detailed instructions on how to make an application can be found on the RCH website (rch.org.au/foi/), together with information regarding associated costs and timeframes. For more information, the Freedom of Information staff at the RCH can be reached on (03) 9345 5132 / (03) 9345 9464. Alternatively, inquiries can be sent to foi@rch.org.au.

Nominated FOI Officers

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

Requests received	2024-25	2025-26
Total requests	895	1,048
Access granted in full	434	503
No information available	38	41
Application withdrawn	78	56

Requests made came primarily from patients and their families (approximately 43.3 per cent), legal representatives (44.6 per cent) and the Transport Accident Commission (approximately 6.3 per cent). The remaining 5.8 per cent were for non-patient related information.

Of the decisions made, 184 were made outside the statutory timeframes. All applications received were otherwise processed in accordance with the provisions of the Freedom of Information Act. The RCH provides an annual report on FOI applications to the Office of the Victorian Information Commissioner.

Building Act 1993

All RCH building designs and completed works meet the National Construction Code and Victorian regulations.

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

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

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

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

An annual report is issued by Downer to certify testing, and maintenance is compliant with the Building Act 1993. Fire Safety System testing, Emergency Warning and Intercommunication System (EWIS) audits are regularly undertaken and reported to ensure the maintenance of specific building safety features.

Public Interest Disclosures Act 2012

The RCH supports the objectives of the *Public Interest Disclosures Act 2012* (Vic) and has policies and procedures in place to support disclosure of known or suspected incidences of improper conduct that involve the RCH or its employees. The RCH cannot receive a public interest disclosure but encourages staff to report such conduct to IBAC in accordance with Part 2 of the *Act.*

The RCH encourages individuals to make any disclosures which are public interest disclosures within the meaning of the Act directly to IBAC in accordance with s51 of the *Independent Broad-Based Anti-Corruption Commission Act 2011*. The RCH is not aware of any disclosures reported to IBAC for the year ending 30 June 2026.

National Competition Policy

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

Carers Recognition Act 2012

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

Environmental performance

At the RCH, sustainability is a key enabler of our vision of a world where all kids thrive. Guided by our Sustainability Plan we are working to reduce our environmental impact across the organisation to achieve net zero emissions by 2045. This section outlines our environmental performance and progress, reflecting our dedication to creating a healthier future for kids, families and our community.

Reporting boundary for environmental data

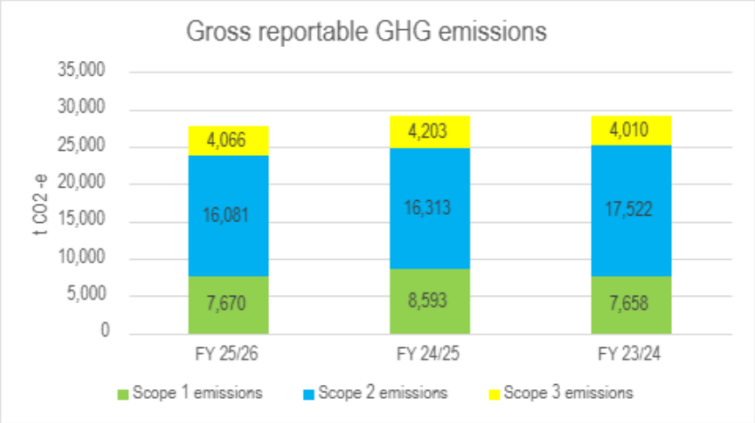
The environmental data presented in this report pertains to the following RCH facilities:

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

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

Greenhouse gas emissions

The graph below shows the RCH's greenhouse gas (GHG) emissions from the past three consecutive financial years, from 1 July 2023 to 30 June 2026. Note that this does not represent the full extent of the RCH's scope 3 emissions, only those reportable under FRD24.



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

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

Scope 1

The RCH's Scope 1 emissions decreased by 9.40% between FY24/25 and FY25/26. This reduction was primarily driven by lower corporate air travel emissions, reduced diesel consumption from emergency generators, and the absence of refrigerant leaks requiring replacement during the reporting period.

Scope 2

Gross Scope 2 emissions from electricity consumption decreased by 0.64**%** during FY25/26. In July 2025, RCH transitioned to renewable electricity supplied through the State Electricity Commission. The State Electricity Commission purchases Large-scale Generation Certificates (LGCs) on the RCH's behalf, effectively making the electricity purchased by the hospital carbon neutral.

While the RCH's electricity supply is now considered carbon neutral for reporting purposes, reducing electricity consumption remains an important priority. Continued improvements in energy efficiency will lower operating costs, reduce demand on the electricity grid and support broader sustainability objectives. The reduction in gross electricity consumption during the reporting period is therefore a positive outcome.

Scope 3

In accordance with the FRD 24 reporting requirements, only selected Scope 3 emissions are included in this report. Between FY24/25 and FY25/26, reported Scope 3 emissions decreased by 3.43%.

This improvement was driven by a range of initiatives and operational changes. Emissions from corporate air travel fell by more than 33%, while emissions associated with water consumption decreased by 10%. The introduction of food organics recycling, together with increased recovery of metals and batteries through recycling programs, also contributed to the overall reduction in Scope 3 emissions.

Greenhouse gas emissions				
Scope 1 (direct) GHG emissions (t CO2-e)	**2023-24**	**2024-25**	**2025-26**	**% change previous FY**
Carbon Dioxide	4,776.76	6,383.56	6,348.44	0.55%
Methane	9.07	12.20	12.13	0.57%
Nitrous Oxide	3.12	4.30	4.30	0.03%
Isoflurane	9.54	4.55	5.58	22.63%
Nitrous oxide	1,120.95	1,306.88	1,525.33	16.72%
Refrigerant – R134A (HFC-134A)	1,653.60	973.08	-	-
Refrigerant – R32 (HFC-32)		1.23	-	-
Refrigerant – R404A (HFC-404A)		40.19	-	-
Sevoflurane	84.97	115.55	114.57	- 0.85%
Total Scope 1	**7,658.01**	**8,841.54**	**8,010.35**	**- 9.40%**

Scope 2 (indirect electricity) GHG emissions (t CO2-e)	**2023-24**	**2024-25**	**2025-26**	**% change**
Electricity	17,522.01	16,313.46	16,208.56	- 0.64%
Total Scope 2	**17,522.01**	**16,313.46**	**16,208.56**	**- 0.64%**

Total Scope 3 (other indirect) GHG emissions (t CO2-e)	**2023-24**	**2024-25**	**2025-26**	**% change**
Commercial air travel	255.58	353.79	233.54	- 33.99%
Waste emissions (WR5)	1,003.32	940.44	952.36	1.27%
Indirect emissions from Stationary Energy	2,526.73	2,723.15	2,703.23	- 0.73%
Indirect emissions from Transport Energy	32.94	23.88	24.95	4.44%
Water emissions	191.14	173.10	155.54	-10.14%
Total Scope 3	**4,009.70**	4,214.36	4,069.61	- 3.43%

Net greenhouse gas emissions (t CO2-e)	2023-24	2024-25	2025-26	% change
Gross greenhouse gas emissions (G1 + G2 + G3) (t CO2-e)	29,189.72	29,369.36	28,288.52	- 3.69%
Total gross reported greenhouse gas emissions per bed-day (t CO2-e/OBD)	0.21	0.21	0.21	- 4.36%
Any Offsets purchased			-18,264.8	
Net greenhouse gas emissions (t CO2-e)	**29,189.72**	**29,109.80**	9,878.80	- 66.36%

Energy use

Energy consumption at the RCH comprises purchased electricity, fuel used to operate emergency generators and the tri-generation plant, and energy associated with transportation, including corporate air travel and the hospital fleet. A summary of energy use across these sources is provided in the table below.

Total energy use				
Total energy usage from fuels, including stationary fuels (F1) and transport fuels (T1) (MJ)	**2023-24**	**2024-25**	**2025-26**	**% change previous year**
Total energy usage from stationary fuels (F1) (MJ)	90,366,124.1	118,958,407.9	119,610,327.7	0.01
Total energy usage from transport (T1) (MJ)	1,915,213.2	1,386,629.7	1,447,444.8	0.04
Total energy usage	**92,281,337.3**	**120,345,037.6**	**121,057,772.5**	0.01

Total energy usage from electricity (MJ)	2023-24	2024-25	2025-26	% change
Total energy usage from electricity (MJ)	**95,860,229.7**	**88,766,233.3**	**87,064,134.7**	**-0.02**

Total energy usage segmented by renewable and non-renewable sources (MJ)	2023-24	2024-25	2025-26	% change
Renewable	17,984,330.4	16,260,084.8	87,064,134.7	4.35
Non-renewable (E1 + E2 - E3 Renewable)	170,157,236.6	192,851,186.1	121,057,772.5	-0.37

Units of Stationary Energy used normalised: (F1+E2)/normaliser	2023-24	2024-25	2025-26	% change
Energy per unit of LOS (MJ/LOS)	1,311.9	1,520.5	1,502.3	-0.01
Energy per unit of bed-day (LOS+Aged Care OBD) (MJ/OBD)	1,311.9	1,520.5	1,502.3	-0.01
Energy per unit of Separations (MJ/Separations)	3,507.4	3,866.8	3,875.5	0.00
Energy per unit of floor space (MJ/m2)	1,577.6	1,759.7	1,737.8	-0.01

Electricity

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

Electricity Usage Overview

In the 25/26 financial year, total electricity consumption across all RCH reporting sites was 24,184 MWh, representing a 1.92% decrease compared with the previous financial year.

During the reporting period, the RCH also transitioned to a new electricity provider that purchases Large-scale Generation Certificates (LGCs) to offset the organisation's electricity consumption. As a result, the electricity supplied to RCH is now carbon neutral.

ELECTRICITY USE				
Total electricity consumption segmented by source (MWh)	**2023-24**	**2024-25**	**2025-26**	**% change previous year**
Purchased	26,627.8	24,657.3	24,184.5	-1.92%
Total electricity consumption (MWh)	**26,627.8**	**24,657.3**	**24,184.5**	-1.92%

On-site installed generation capacity (kW converted to MW) segmented by:	2023-24	2024-25	2025-26	% change
Cogeneration Plant	2.3	2.3	2.3	0.00%
Diesel Generator	6.8	6.8	6.8	0.00%

Total On-site installed generation capacity (MW)	**9.1**	**9.1**	**9.1**	**0.00%**

Total electricity offsets segmented by offset type (MWh)	**2023-24**	**2024-25**	**2025-26**	**% change**
LGCs voluntarily retired on the entity's behalf			20,341.9	
RPP (Renewable Power Percentage in the grid)	4,995.6	4,516.7	4,331.4	-4.10%
Total electricity offsets (MWh)	**4,995.6**	**4,516.7**	**24,184.5**	**435.45%**

Stationary fuel

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

Usage overview

During FY 25/26, RCH recorded a total gas consumption of 119,610,327 MJ, which is an insignificant increase from the previous year compared to the previous financial year.

Stationary energy				
F1 Total fuels used in buildings and machinery segmented by fuel type (MJ)	**2023-24**	**2024-25**	**2025-26**	**% change**
Natural gas	90,211,720.3	117,414,392.4	118,285,961.7	0.74%
Diesel	154,403.8	1,544,015.5	1,324,366.0	-14.23%
F1 Total fuels used in buildings (MJ)	**90,366,124.1**	**118,958,407.9**	**119,610,327.7**	**0.55%**

F2 GHG emissions from stationary fuel consumption segmented by fuel type (CO2-e(t))	**2023-24**	**2024-25**	**2025-26**	**% change**
Natural gas	4,648.6	6,050.4	6,095.3	0.74%
Diesel	10.8	108.4	93.0	-14.23%
F2 GHG emissions from stationary fuel consumption	**4,659.5**	**6,158.8**	**6,188.3**	**0.48%**

Transportation energy

Emissions associated with business travel include fuel consumption from the RCH fleet vehicles, and corporate air travel undertaken for conferences, training and professional development.

Fleet

The RCH vehicle fleet currently comprises 47 vehicles, including 40 hybrid vehicles, three petrol vehicles and four diesel vans that support our PIPER (Paediatric Infant Perinatal Emergency Retrieval) program. As part of our fleet optimisation and decarbonisation program, three vehicles were removed from the fleet during the 25/26 financial year. In addition, the RCH introduced its first four electric vehicles, which were added to the shared fleet pool in June 2026. This marks an important milestone in the transition to a lower-emissions fleet.

Flights

At the RCH, business air travel can be booked either through our corporate travel provider, FCM, or independently by staff members who subsequently claim reimbursement. At present, environmental reporting is limited to flights booked through FCM, as emissions data is not available for travel arranged through the reimbursement process. Accordingly, this report includes emissions associated with FCM-booked flights only.

Transportation energy				
T1 Total energy used in transportation (vehicle fleet) within the Entity, segmented by fuel type (MJ)	**2023-24**	**2024-25**	**2025-26**	**% change previous year**
Non-executive fleet – Gasoline	1,915,213.2	1,043,090.0	957,606.8	-8.20%
Petrol	1,915,213.2	1,043,090.0	957,606.8	-8.20%
Non-executive fleet – Diesel		343,539.7	489,838.0	42.59%
Diesel		343,539.7	489,838.0	42.59%
Total energy used in transportation (vehicle fleet) (MJ)	**1,915,213.2**	**1,386,629.7**	**1,447,444.8**	**4.39%**

T3 Greenhouse gas emissions from transportation (vehicle fleet) segmented by fuel type (t CO2-e)	**2023-24**	**2024-25**	**2025-26**	**% change**
Non-executive fleet - Gasoline	129.5	70.5	64.8	-8.20%
Petrol	129.5	70.5	64.8	-8.20%
Non-executive fleet - Diesel		24.2	34.5	42.59%
Diesel		24.2	34.5	42.59%

Total Greenhouse gas emissions from transportation (vehicle fleet) (CO2-e(t))	**129.5**	**94.7**	**99.2**	**4.77%**

T4 Total distance travelled by commercial air travel (passenger km travelled for business purposes by entity staff on commercial or charter aircraft)	**2023-24**	**2024-25**	**2025-26**	**% change**
Total distance travelled by commercial air travel	1,606,171.0	582,809.0	456,291.0	-21.71%

T(opt1) Total vehicle travel associated with entity operations (1,000 km)	**2023-24**	**2024-25**	**2025-26**	**% change**
Total vehicle travel associated with entity operations (1,000 km)	606.8	572.0	582.4	1.81%

T(opt2) Greenhouse gas emissions from vehicle fleet (CO2-e(t) per 1,000 km)	**2023-24**	**2024-25**	**2025-26**	**% change**
CO2-e(t) per 1,000 km	0.2	0.2	0.2	2.91%

Waste and recycling

The total waste generated by the RCH decreased by 11% in FY 25/26 compared to the previous year. During this time, we saw an increase in project based general waste but decreases in clinical waste and recycling which is reflective of our heightened focus on correct waste separation.

Waste and recycling				
Total waste disposed by waste stream and disposal method (kg)	**2023-24**	**2024-25**	**2025-26**	**% change previous year**
Landfill (total)				
General waste – compactors	556,902.000	542,790.400	565,318.000	4.15%
General waste – skips	46,505.000	22,391.000	44,399.000	98.29%
Offsite treatment				
Clinical waste – incinerated	28,491.000	26,242.500	25,381.000	-3.28%
Clinical waste – sharps	10,730.472	10,516.000	10,301.000	-2.04%
Clinical waste – treated	138,372.000	129,972.000	118,518.000	-8.81%

Recycling/recovery (disposal)				
Batteries		1,232.000	2,322.000	88.47%
Cardboard	81,887.999	54,288.000	87,310.190	60.83%
Commingled	46,116.000	36,288.900	47,374.000	30.55%
Grease traps	80,000.000	62,510.000	53,480.000	-14.45%
Metals			13,000.000	
Organics (food)		7,028.000	30,126.000	328.66%
Other recycling	43.885	54.565	206.600	278.63%
Paper (confidential)	12,300.000	18,912.000	15,424.000	-18.44%
PVC	427.000	1,848.000	748.000	-59.52%
Sterilisation wraps	602.000	6,638.000	7,950.000	19.76%
Total units of waste disposed (kg)	**1,002,377.357**	**920,711.365**	**1,021,857.790**	**10.99%**

Percentage waste disposed of by waste stream and disposal method (%)	**2023-24**	**2024-25**	**2025-26**	**% change**
Landfill (total)				
General waste	0.602	0.614	0.597	-2.80%
Offsite treatment				
Clinical waste – incinerated	0.028	0.029	0.025	-12.86%
Clinical waste – sharps	0.011	0.011	0.010	-11.74%
Clinical waste – treated	0.138	0.141	0.116	-17.84%
Recycling/recovery (disposal)				
Batteries		0.001	0.002	69.82%
Cardboard	0.082	0.059	0.085	44.91%
Commingled	0.046	0.039	0.046	17.62%
Fluorescent tubes	0.080	0.068	0.052	-22.91%
Grease traps			0.013	
Organics (food)		0.008	0.029	286.23%
Other recycling	0.000	0.000	0.000	241.15%

Paper (confidential)	0.012	0.021	0.015	-26.52%
PVC	0.000	0.002	0.001	-63.53%
Sterilisation wraps	0.001	0.007	0.008	7.91%

Total units of waste disposed normalised	**2023-24**	**2024-25**	**2025-26**	**% change**
Total waste to landfill per patient treated ((kg general waste)/PPT)	2.223	2.087	2.240	7.30%
Total waste to offsite treatment per patient treated ((kg offsite treatment)/PPT)	0.654	0.616	0.566	-8.02%
Total waste recycled and reused per patient treated ((kg recycled and reused)/PPT)	**0.816**	**0.697**	**0.948**	**35.88%**

Recycling rate (%)	**2023-24**	**2024-25**	**2025-26**	**% change**
Weight of recyclable and organic materials (kg)	221,376.884	188,799.465	257,940.791	36.62%
Weight of total waste (kg)	1,002,377.357	920,711.365	1,021,857.790	10.99%
Recycling rate (%)	**0.221**	**0.205**	**0.252**	**23.10%**

GHG emissions associated with waste disposal (CO2-e(t))	**2023-24**	**2024-25**	**2025-26**	**% change**
t CO2-e	1,003.316	940.437	982.406	4.46%

Additional information available on request

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

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

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

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

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

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

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

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

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

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

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

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

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

(l) details of all consultancies and contractors including:

(i) consultants/contractors engaged

(ii) services provided

(iii) expenditure committed to for each engagement.

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

Local Jobs First Act 2003

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

During 2025-26, the RCH undertook one project which required disclosure under the *Local Jobs First Act 2003 (Vic)*.

Gender Equality Act 2020

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

Committed to meeting our obligations under the Gender Equality Act, the RCH recently completed a review of its first Gender Equality Action Plan (2022-25) and submitted its second Gender Equality Action Plan (2026-30) for consideration by the Commission for Gender Equality in the Public Service. This review included a comprehensive audit against the seven compulsory gender equality indicators and provided descriptions of equity impact assessments undertaken.

The RCH made positive progress against five of the seven indicators, was stable on one, and declined slightly on the other. With respect to progress against our inaugural Gender Equality Action Plan, of the 16 actions outlined the RCH reported only two actions as incomplete. The remainder have been completed and embedded as ongoing practices. The two incomplete actions related to workforce data integrity which will be implemented over longer timeframes as they are larger, complex, system dependent items embedded in enterprise-wide projects.

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

The importance of applying a lens of intersectionality reflects our commitment to every child and young person needing our services. We appreciate that anyone who accesses our services should be able to do so freely and safely, regardless of gender, cultural background, sexuality, or any other minoritised characteristic. In our progress report, the RCH was able to conduct several equity impact assessments on significant patient service projects, including the RSV Immunisation Clinic, Banksia ward redesign and the Immigrant Health Service Clinic. We continue to assess for impact on intersectional groups to ensure more positive outcomes and experiences for all RCH consumers.

A highly valued aspect of the culture at the RCH is our continued recognition of communities and identities through our celebrations of International Women's Day, Aboriginal days of cultural significance such as National Sorry Day and NAIDOC week, and pride events such as Midsumma, IDAHOBIT Day and Wear it Purple.

The LGBTQIA+ Campus Collective, a partnership between the RCH, Murdoch Children's Research Institute, the University of Melbourne and the RCH Foundation, is currently finalising a shared LGBTQIA+ Strategy. The RCH looks forward to further impact in this area by building its own inhouse capability to create impact and change.

Looking to the future, the RCH is setting out its aspirations and agenda with the development of a Diversity, Equity, Inclusion and Belonging Strategic Plan that will overarch the strong work being completed in gender equality and LGBTIQA+. It will also expand to include disability and neurodivergent communities. The work is ongoing and is well supported by the Board and Executive, senior leaders and staff from across the organisation. It is enabled by committed teams such as Organisational Development, Human Resources, Decision Support, Finance and Payroll, among others. Importantly, we seek and value the voices of community members, as their lived experience guides and inspires our work.

Safe Patient Care Act 2015

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

Car parking fees

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

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

Attestations and Declarations

Financial Management Compliance Attestation Statement

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

Christine Kilpatrick

Professor Christine Kilpatrick AO

Board Chair
The Royal Children's Hospital
Melbourne

31 August 2026

Data Integrity Declaration

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

Peter Steer

Dr Peter Steer

Chief Executive Officer
The Royal Children's Hospital
Melbourne

31 August 2026

Conflict of Interest Declaration

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

Peter Steer

Dr Peter Steer

Chief Executive Officer
The Royal Children's Hospital
Melbourne

31 August 2026

Integrity, Fraud and Corruption Declaration

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

Peter Steer

Dr Peter Steer

Chief Executive Officer
The Royal Children's Hospital
Melbourne

31 August 2026

Compliance with Health Share Victoria (HSV) Purchasing Policies

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

Peter Steer

Dr Peter Steer

Chief Executive Officer
The Royal Children's Hospital
Melbourne

31 August 2026

Disclosure index

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

Legislation	Requirement	Page reference
Standing Directions and Financial Reporting Directions		
Report of Operations		
Charter and purpose		
FRD 22	Manner of establishment and the relevant Ministers	5
FRD 22	Purpose, functions, powers, and duties	1,5
FRD 22	Nature and range of services provided	5
FRD 22	Activities, programs and achievements for the reporting period	2-4,6
FRD 22	Significant changes in key initiatives and expectations for the future	4
Management and Structure		
FRD 22	Organisational structure	13
FRD 22	Workforce data/employment and conduct principles	14
FRD22	Workforce inclusion policy	45-46
FRD 22	Occupational Health and Safety	15-19
Financial and other information		
FRD 22	Summary of the financial results for the year	21
FRD 22	Significant changes in financial position during the year	21
FRD 22	Operational and budgetary objectives and performance against objectives	51-66
FRD 22	Subsequent events	22
FRD 22	Details of consultancies under $10,000	24
FRD 22	Details of consultancies over $10,000	24
FRD 22	Disclosure of government advertising expenditure	25
FRD 22	Disclosure of ICT expenditure	26
FRD 22	Asset Management Accountability Framework	N/A
FRD 22	Disclosure of social procurement activities under the Social Procurement Framework	28-29
FRD 22	Disclosure of reviews and study expenses	27
FRD 22	Disclosure of grants and transfer payments	N/A
FRD 22	Application and operation of *Freedom of Information Act 1982*	31
FRD 22	Compliance with building and maintenance provisions of *Building Act 1993*	32
FRD 22	Application and operation of *Public Interest Disclosure Act 2012*	32
FRD 22	Statement on National Competition Policy	32
FRD 22	Application and operation of *Carers Recognition Act 2012*	33
FRD 22	Additional information available on request	44
FRD 24	Environmental data reporting	33-43
FRD 25	*Local Jobs First Act 2003* disclosures	45

Compliance attestation and declaration		
SD5.1.4	Financial Management Compliance attestation	49
SD5.2.3	Declaration in Report of Operations	49-50
	Attestation on Data Integrity	49
	Attestation on Managing Conflicts of Interest	49
	Attestation on Integrity, Fraud and Corruption	50
	Compliance of Health Share Victoria (HSV) Purchasing Policies	50
Other reporting requirements		
	Reporting of outcomes from the Statement of Priorities 2024-25	49-66
	Occupational Violence reporting	19-20
	Reporting obligations under the *Safe Patient Care Act 2015*	46
	Reporting compliance regarding the Car Parking Fees	46
Financial statements		
Declaration		
SD5.2.2	Declaration in financial statements	65
Other requirements under Standing Directions 5.2		
SD 5.2.1 (a)	Compliance with Australian accounting standards and other authoritative pronouncements	65,75
SD 5.2.1 (a)	Compliance with Standing Directions	65
SD 5.2.1 (b)	Compliance with Model Financial Report	65-140
Other disclosures as required by FRDs in notes to the financial statements [(a)(b)]		
FRD 11	Disclosure of Ex gratia Expenses	138
FRD 103	Non-Financial Physical Assets	90-126
FRD 110	Cash Flow Statements	74
FRD 112	Defined Benefit Superannuation Obligations	87
FRD 114	Financial Instruments – general government entities and public non-financial corporations	114-119
Legislation		
Freedom of Information Act 1982 (Vic) (FOI Act)		31
Building Act 1993		32
Public Interest Disclosures Act 2012		32
Carers Recognition Act 2012		33
Local Jobs Act 2003		45
Financial Management Act 1994 [(b)]		65-140

Reporting of outcome from Statement of Priorities (SOP) 2025-26

Reporting against the Statement of Priorities – Part A

Focus priorities	2025-26 deliverables	2025-26 updates
Innovate and improve access to care *We aim for the best patient experience and care outcomes by assuring safe practice, leadership of safety, an engaged and capable workforce, and continuing to improve and innovate care.*		
Goal Align with the Victorian Clinical Governance Framework to strengthen clinical governance systems, ensuring safe, high-quality care.	Demonstrate high-quality care in which consumer engagement and input is actively sought, facilitated and used to drive system change to improve consumer experience and outcomes.	**Status**: Ongoing **Commentary:** • Partnering with consumers is a cornerstone of service delivery at the RCH, reflected in key consumer committees, including a Consumer Advisory Committee, Family Advisory Council, and condition-specific advisory groups (e.g., Colorectal Care Consumer Advisory Group). • The RCH Partnering With Consumers Framework, developed in consultation with more than 120 consumers and staff, guides the development, delivery and monitoring of actions to improve patient care and experience. • The RCH National Child Health Poll is a national survey of Australian households shedding new light on the big issues in contemporary child and adolescent health – as told by the Australian public. The poll delivers significant new knowledge about the health, wellbeing and lives of children and young people, and is a vital input to fact sheets and resources developed by the RCH.

Focus priorities	2025-26 deliverables	2025-26 updates
		• The RCH Health Literacy Youth Advisory Committee brings together 14 young people with diverse lived experiences to contribute to the development of health resources for teens and their promotion via social media channels. • The RCH Interpreter Services function has been repositioned to enhance supports available to children, their family members and carers, from culturally and linguistically diverse backgrounds as well as those from deaf or hard of hearing communities and from Aboriginal and Torres Strait Islander backgrounds.
	Ensure that health service reporting, reviews and decision-making are underpinned by a safety culture and systems that are transparent, accurate and fair for staff and consumers.	**Status**: Ongoing **Commentary:** • The RCH has further developed its response to feedback from patients and families, ensuring thorough review and timely responses to concerns raised including system changes required. • The RCH continues to mature processes for managing Serious Adverse Patient Safety Events (SAPSE) and Statutory Duty of Candour (SDC) obligations, to learn from and make improvements focusing on system changes that will prevent further harm occurring. • The morbidity and mortality (M&M) at the RCH project has delivered a standardised, best-practice approach to M&M review. It includes a suite of practical resources to support a consistent, best-practice approach to M&M review meetings across RCH.
	Health services can show evidence of a comprehensive training program approach that includes performance management, accountability, and continuous improvement.	**Status**: Ongoing **Commentary:** • The RCH Leadership Academy is a key initiative of the RCH's Leadership Development Strategy. The programs offered by the Leadership Academy are underpinned by several leadership competencies, including Developing capability, Holding to account, and Influencing for results. • The RCH annual Performance and Development Appraisal and Planning (PDAP) process underpins performance discussions to support growth individually and as an organisation. The PDAP process invites reflection on performance, safety and quality improvements, and learning and development.

Focus priorities	2025-26 deliverables	2025-26 updates
		• The RCH implemented a new approach to education and training with the introduction of three tiers – 'My Org', 'My Role' and 'My Area' that allows staff better visibility of the training they are required to do and training that is available for them to do. • The RCH annual People Matter Survey process requires all teams to create an action plan focused on key safety and culture goals.

Goal
Improve access to timely emergency care by implementing system-wide patient flow strategies that reduce emergency department wait times and improve ambulance-to-hospital transfer times.
	Implement initiatives that support early discharge of patients to appropriate settings to improve timely patient access to care.	**Status**: Ongoing
		Commentary:
		• The RCH is expanding and upgrading its infrastructure to keep pace with increasing demand. The first stage of the expansion is an additional 30-bed inpatient ward launched in 2023 which treats patients with a range of different illnesses. The second stage will deliver a bigger Emergency Department, boosting capacity by an additional 20 treatment spaces. This second stage of works is in progress.
		• The RCH continues to mature the Daily Operating System (DOS), bringing key leaders together to deliver timely care accountability.
		• An Access Governance structure supports the improvement trajectory and access performance framework, components of which are further supported by Department of Health access reform agenda.
		• The RCH has contributed as part of the Timely Emergency Care (TEC2) program, with a dedicated improvement project dedicated to improving patient flow through the ED. The RCH is on track to deliver against TEC2 performance outcomes including:
		  • increasing number of patients admitted to ED short stay and express short stay
		  • reducing time spent in ED for all patients.
		• The RCH is an active contributor to Victorian Paediatric Clinical Network and CHRIS database to support care closer to home for all Victorian children and young people. This will remain a targeted access initiative with further digital enhancements offering reduced length of stay alongside improved consumer and partnership experience.
		• An Independent review of Access and Flow was undertaken in Q3 2025 indicating recommendations to improve timely access and coordination across RCH. Early actions have included establishing a dedicated Executive Director, Access and Clinical Operations role which will lead the implementation plan.

Focus priorities	2025-26 deliverables	2025-26 updates
Goal Maintain a commitment to delivering equitable and timely access to planned care and drive reform in alignment with the Planned Surgery Reform Blueprint.	• Implement and scale theatre optimisation initiatives in planned surgery, for example same-day surgery and same-day surgery by default models of care, criteria-led discharge, monitoring of theatre measures, and high-throughput approaches such as high-intensity theatre lists. • Proactively manage planned surgery and specialist clinics (or outpatients) waitlists, for example validating and supporting patients into optimal care pathways such as evidence-based alternatives to surgery and optimisation pathways. A particular focus should be applied to long-waiting patients and priority population groups (for example, Aboriginal and Torres Strait Islander patients and under-18 patients).	**Status**: Ongoing **Commentary:** • The Division of Surgery has continued to optimise theatre utilisation for planned surgery, which has contributed to meeting or exceeding planned admission targets each month in 2025-26. • Implementation of a new model of care for procedural oncology has improved patient access and increased available theatre capacity for planned and in-hours emergency work. Additional ENT planned surgery sessions have been established in the newly freed capacity. • Continued funding for the Patient Support Unit has enabled the RCH to build prior initiatives aimed at evaluating and enhancing the health service system and the planned surgery waitlist. Particular focus has been brought to enhance access for priority populations. • The RCH has implemented the statewide Customer Relationship Management (CRM) platform (VicKey) to enhance waitlist auditing, aligned with reporting obligations.
Goal Support the implementation of the “Next Phase of Reform” to deliver inclusive, personalised, compassionate, integrated mental health and wellbeing care in the community.	• Progress mental health reform: Implement mental health services per department guidelines, and engage in reform related initiatives to improve access to community mental health services, crisis reforms, headspace integration, youth and adolescent inpatient care, catchment removal as well as infant, child and youth age streaming.	**Status**: Ongoing **Commentary:** • The RCH is creating models of care for 0-4 years, 5-11 years, Child and Youth HOPE and hospital-based consultation-liaison mental health services. This includes initiatives to improve access and crisis management. • The RCH is expanding the role of the acute adolescent mental health unit to include planned assessment and treatment admissions and improved services for adolescents aged 13 to 18 years with severe eating disorders. The RCH continues to implement Royal Commission Reforms including:

Focus priorities	2025-26 deliverables	2025-26 updates
		• Healthcare award winning COMPASS program, which connects mental health paediatric specialists and community services providing community of practice consultations to GPs, allied health clinicians and paediatricians. • Multidisciplinary early intervention services established for infants and children at Brimbank Melton Children's Health and Wellbeing Local. • The RCH delivered the final phase of the RCH Campus Mental Health Strategy, focusing on translating latest evidence into practice, leveraging newly developed digital tools within EMR: • Behaviour Support Profile Tool to document communication and sensory sensitivities and ensure trauma-informed, patient-centred care. • SAPHER Tool to support risk formulations and safety planning for identified risks of suicide or self-harm.
	• Partner with Safer Care Victoria in one or more mental health improvement programs: elimination of restrictive intervention, improving sexual safety, implementation of the zero suicide framework and reducing compulsory treatment.	**Status**: Ongoing **Commentary:** • RCH Mental Health is working with Safer Care Victoria to eliminate restrictive interventions, reducing compulsory treatment, and to improve sexual safety. • RCH Mental Health's community arm (for children aged 0-11 years) is supporting a zero suicide, zero aggression project that also includes the reduction of developmental risks, family and psychosocial risks.
	• Progress partnerships, whether through a formal partnership, MoU or exchange of letters, with local community based mental health services (including Mental Health and Wellbeing Locals, Headspace and other local non-profit (NGO) providers) and deliver initiatives that align with the objectives of the Mental Health and Wellbeing Act 2022, and in accordance with the priorities outlined in Victoria's	**Status**: Ongoing Commentary: • The RCH and Parkville Youth MHS have entered into an interservice agreement which provides community mental health support to 12-18 years old consumers. • The RCH has a service agreement with IPC Health (IPC) and Western Health to deliver the Brimbank Melton Children's Health and Wellbeing Local. This is a relatively new Tier 4 mental health and wellbeing service for children up to 11 years and their families. • The RCH has an MoU with Foundation House to work together to improve the mental health and wellbeing of children and their families from refugee backgrounds. This

Focus priorities	2025-26 deliverables	2025-26 updates
	next phase of reform for Mental Health and Wellbeing.	includes opportunities for collaborative service and practice development and for enhanced operational and clinical partnership. • The RCH, Monash Health and Austin Health have entered into an interservice agreement for provision of care for 3-12-year-olds transitioning across inpatient and outpatient settings.

Focus priorities	2025-26 deliverables	2025-26 updates
Prudent, sustainable and effective use of resources *We are innovative and resourceful in balancing improved patient care, operational performance, and system management to ensure a financially secure health system. We invest in a skilled and future-ready workforce, maintaining a modern, safe, and resilient healthcare system for all Victorians.*		

Goal
Develop and implement initiatives to strengthen financial sustainability. By delivering sustainable, responsible budgets, we can ensure a well-managed, viable, and sustainable health system for the future.
	• Deliver the key initiatives outlined in the Budget Action Plan (BAP) within Government parameters.
	• Utilise data analytics and performance metrics to identify areas of inefficiency and waste and make evidence-based decisions to improve financial sustainability and operational performance.
	• Use funding efficiently and effectively to optimise patient facing services. Undertake programs to reduce the cost of service delivery, improve safety, capacity and reduce unnecessary waiting.
		Status: Ongoing
		Commentary:
		• The RCH continues delivering on key initiatives as outlined in the BAP and FMIP (financial management improvement plan) savings plan.
		• The RCH continues to lead:
		  • monthly performance reviews across Divisions
		  • periodic forecasting of financial and activity targets
		  • capital management planning and cash flow forecasting.

Focus priorities	2025-26 deliverables	2025-26 updates
A stronger workforce *We strive to foster an equitable, skilled and supported workforce that builds professional capabilities to meet current and future roles.*		
Goal Position Victoria as a leader in employee experience, capability, and capacity by focusing on future roles and professional development in line with the Victorian Health Workforce Strategy to ensure a regenerative and sustainable workforce.	Implement processes to sustain workforce supply and fulfill obligations, including those under the Gender Equality Act 2020 by improving employee experience in leadership, health and safety, flexibility, career development, and agility to ensure safe, high-quality care.	**Status**: Ongoing **Commentary:** • The RCH Leadership Academy provides customised leadership development to multiple levels of management across the organisation supporting all aspects of a stronger workforce, sustained engagement and psychosocial safety. • The RCH is up to date with all elements related to the *Gender Equality Act* reporting, having made progress against more than half the indicators. An updated Gender Equality Action Plan was developed and submitted to ensure ongoing and sustainable progress. • The career development of staff is supported through RCH annual Performance and Development Appraisal and Planning (PDAP) process and also enabled via multiple educational opportunities. • The RCH actively ensures appropriate education and learning via a multidisciplinary Education and Learning Committee that has oversight of the full breadth of clinical and non-clinical learning and provides guidance and support to ensure early career to mature career learning. • The Selection and Recruitment Policy ensures that all career opportunities are offered via a competitive merit-based process so they are made available to all staff as well as new to service talent pools. • The RCH places great value on the feedback provided by employees via the annual People Matter survey, with a focus on improving engagement, safety, development and quality through action planning at the organisational and team level. • The RCH continues to evolve its safety, health and wellbeing initiatives to ensure both the physical and psychosocial safety of its staff.
	• Collaborate with the department to improve workforce data analytics, generate actionable	**Status**: Ongoing **Commentary:**

Focus priorities	2025-26 deliverables	2025-26 updates
	insights, and enhance strategic planning.	• Work continues with the Parkville LHSN to understand data reporting requirements, challenges and required improvements to generate standardised, high quality and comprehensive workforce data and insights.

Focus priorities	2025-26 deliverables	2025-26 updates
Improving Aboriginal health and wellbeing *Strengthen cultural safety in Victoria's health service system by fostering strong connections to Aboriginal culture, creating a holistic, accessible, and empowering health system.*		
Goal Enhance Delivery and Access to Culturally Safe Services, fostering strong connections to culture. Address racism and provide Aboriginal people with culturally safe healthcare and referral pathways between mainstream and community-controlled health services.	• Deliver high-quality cultural safety training to all executives and staff using independent, expert, community-controlled organisations or a registered Aboriginal business. • Health service executives and senior leaders establish and maintain strong, ongoing partnerships with Aboriginal community-controlled organisations and/or recognised Aboriginal leaders within their local catchments. These partnerships must be based on regular, proactive engagement that prioritises the voices, self-determined priorities, and cultural knowledge of Aboriginal communities in the design, delivery, and evaluation of health and wellbeing services.	**Status**: Ongoing **Commentary:** • The RCH is progressing an Innovate Reconciliation Action Plan (RAP) through a process of truth-telling, examination and acknowledgement of historical harms, Aboriginal empowerment and self-determination. • The RCH led the development of the widely used Aboriginal Cultural Awareness eLearning package and has implemented a customised version focused on paediatric care. • The RCH provides in person workshops to all staff inclusive of the Board and Executive teams to deepen Aboriginal Cultural Competence, responsiveness and sensitivity from an external Aboriginal consultancy. • The RCH has a Reconciliation Action Steering Committee with representatives from state level Aboriginal Community Controlled Health Organisations *(*ACCHOs), such as VACCHO and VAHS, and Aboriginal Elders. • Wadja Aboriginal Family Place delivers a culturally safe service at the RCH for Aboriginal and Torres Strait Islander children, young people and their families. The service ensures equitable access to health care services and seeks to increase the cultural awareness and sensitivity of care delivered by RCH staff.

Focus priorities	2025-26 deliverables	2025-26 updates
	• Ensure culturally appropriate systems for identifying Aboriginal and Torres Strait Islander patients and implement responsive discharge plans and referral pathways.	• Completion of the West Metro Health Service Partnership project: Improving Cultural Safety and Access in Emergency Departments for First Nations Patients and Families with improvement in Aboriginal and Torres Strait Islander patient identification and care. • The RCH hosted Sorry Day and NAIDOC Week events, including Smoking Ceremonies and performances led by members of the Aboriginal community.
Moving from competition to collaboration *We are committed to transforming Victoria's health system by partnering with care providers and health services to share knowledge, information, and resources.*		
Goal Collaborate within the Local Health Service Network to build a more integrated health system, with better access and experience for patients, strengthened workforce, consistently high-quality care, and more sustainable healthcare delivery.	Meet all objectives agreed to in the Local Health Service Network *Statement of Expectations* across priority areas (access, equity and flow, workforce, safety and quality, and shared services).	**Status**: Ongoing Commentary: • The RCH continues collaborative efforts to embed governance arrangements for the Parkville Local Health Service Network (LHSN) to meet the objectives of the *Statement of Expectations* across all priority areas. • Key deliverables include the development of the LHSN Clinical Service Plan. The RCH is leading the paediatric component of the plan, including the development of an RCH specific Clinical Service Plan.

Reporting against the Statement of Priorities – Part B Performance Priorities

High quality and safe care

Key Performance Measure	Target	Result
Infection prevention and control		
Percentage of healthcare workers immunised for influenza	94%	96%
Adverse events		
Percentage of reported sentinel events for which a root cause analysis (RCA) report was submitted within 30 business days from notification of the event	100%	100%
Patient experience		
Percentage of patients who reported positive experiences of their hospital stay	95%	97%
Aboriginal Health		
Difference between the percentage of Aboriginal patients and non Aboriginal patients who left against medical advice	0%	0%
Difference between the percentage of Aboriginal patients and non Aboriginal patients presenting to ED who did not wait to be treated	0%	1%
Mental Health		
Mental Health Patient Experience		
Percentage of consumers who rated their overall experience with a service in the last three months as positive.	80%	73.2%
Percentage of consumers/families/carers reporting a 'very good' or 'excellent' overall experience of the service	80%	64.4%
Percentage of families/carers who report they 'always' or 'usually' felt their opinions as a carer were respected	90%	86.2%
Percentage of mental health consumers reporting they 'usually' or 'always' felt safe using this service	90%	78%
Mental Health follow-ups, readmissions, and seclusions		
Percentage of consumers followed up within 7 days of separation – Inpatient	88%	76%
Percentage of consumers re-admitted within 28 days of separation – Inpatient.	<14%	24%
Rate of seclusion episodes per 1,000 occupied bed days – inpatient	≤ 6	92.5

Strong governance, leadership and culture

Key Performance Measure	Target	Result
Organisational culture		
People Matter survey – Percentage of staff with an overall positive response to safety culture survey questions	80%	82%

Timely access to care

Key Performance Measure	Target	Result
Planned Surgery		
Percentage of urgency category 1 planned surgery patients admitted within 30 days	100%	100%
Percentage of all planned surgery patients admitted within the clinically recommended time	94%	69.2%
Number of patients admitted from the planned surgery waiting list	7,933	8,101
Percentage of patients on the waiting list who have waited longer than the clinically recommended time for their respective triage category	25%	32.9%
Optimisation of surgical inpatient length of stay (LOS), including through the use of virtual and home-based pre- and post-operative models of care	<=1.64%	1.62%
Emergency Care		
Percentage of patients transferred from ambulance to emergency department within 40 minutes	80%	99%
Number of emergency patients with a length of stay in the ED greater than 24 hours	Zero	20
Average ED length of stay (LOS) for admitted patients, in minutes	414	396
Average ED length of stay (LOS) for non-admitted patients, in minutes	240	180
Mental Health		
Percentage of mental health-related emergency department presentations with a length of stay of less than 4 hours	65%	53%
Percentage of departures from emergency departments to a mental health bed within 8 hours	80%	67%
Number of admitted mental health occupied bed days	3,592	4,111
Number of community mental health service hours	39,116	43.313
Specialist Clinics		
Percentage of patients referred by a GP or external specialist who attended a first appointment within the recommended timeframe	95%	78.8%
Home based care		
Percentage of admitted bed days delivered at home	12.1%	10.6%

Effective financial management

Key Performance Measure	Target	Result
Operating result ($m)	0.00	5.17
Adjusted current asset ratio	0.7	0.52%
Variance between the forecast and actual operating result (OR) as a percentage of the forecast OR for the current financial year ending 30 June 2026	5% movement in forecast revenue and expenditure forecasts	Not achieved

Reporting against the Statement of Priorities – Part C

Funding type	Activity achievement
Consolidated activity funding	
Acute admitted, subacute admitted, emergency services, non-admitted NWAU	97,786
Community mental health NWAU	4,473
Acute Admitted	
Acute admitted TAC	627
Acute Non-Admitted	
Mental Health and drug services	
Mental Health ambulatory	841
Community health/ primary care programs	2,381
NFC – Paediatric heart no VAD	3
NFC – Paediatric heart VAD	7
NFC – Paediatric heart lung transplantation	N/A
NFC – transplants – paediatric liver	15

Financial statements

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

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

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2025 and the financial position of The Royal Children's Hospital at 30 June 2026.

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

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



Professor Christine Kilpatrick
Chair
The Royal Children's Hospital
Melbourne
31 August 2026



Dr Peter Steer
Chief Executive Officer
The Royal Children's Hospital
Melbourne
31 August 2026



Claire Hare
Chief Financial Officer
The Royal Children's Hospital
Melbourne
31 August 2026

VAGO Report

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of the Royal Children's Hospital

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
2 September 2026

Simone Bohan
as delegate for the Auditor-General of Victoria

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The Royal Children's Hospital Financial statements contents

The Royal Children's Hospital Comprehensive operating statement 66
The Royal Children's Hospital Balance sheet 67
The Royal Children's Hospital Statement of changes in equity 68
The Royal Children's Hospital Cash flow statement 69
Notes to the Financial Statements 30 June 2026 700
Note 1: About this report 700
Note 1.1: Basis of preparation 700
Note 1.2: Material accounting estimates and judgements 711
Note 1.3: Accounting standards issued but not yet effective 71
Note 1.4: Changes in accounting policy 71
Note 1.5: Reporting entity 72
Note 1.6: Economic dependency 72
Note 2: Funding delivery of our services 73
Note 2.1: Revenue and income from transactions 73
Note 3: The cost of delivering our services 77
Note 3.1: Expenses incurred in the delivery of services 78
Note 4: Key assets to support service delivery 83
Note 4.1: Property, plant and equipment 83
Note 4.2: Depreciation and amortisation 86
Note 4.3: Impairment of assets 87
Note 5: Other assets and liabilities 88
Note 5.1: Receivables 88
Note 5.2: Investments in Associates 89
Note 5.3: Payables 90
Note 5.4: Contract liabilities 91
Note 6: How we finance our operations 93
Note 6.1: Borrowings 94
Note 6.2: Cash and cash equivalents 98
Note 6.3: Commitments for expenditure 98
Note 7: Risks, contingencies and valuation uncertainties 100
Note 7.1: Financial instruments 101
Note 7.2: Financial risk management objectives and policies 104
Note 7.3: Contingent assets and contingent liabilities 106
Note 7.4: Fair value determination 106
Note 8: Other disclosure 113
Note 8.1: Reconciliation of net result to net cash flows from operating activities 113
Note 8.2: Responsible persons disclosures 114
Note 8.3: Remuneration of executives 115
Note 8.4: Related parties 116
Note 8.5: Remuneration of auditors 121
Note 8.6: Ex-gratia payments 121
Note 8.7: Events occurring after the balance sheet date 121
Note 8.8: Equity 121

The Royal Children's Hospital Comprehensive operating statement

For the financial year ended 30 June 2026

	Note	2026	2025
		$'000	$'000
Revenue and income from transactions			
Revenue from contracts with customers	2.1	897,834	850,906
Government grants	2.1	294,889	244,092
Other income	2.1	57,149	53,791
Total revenue and income from transactions		**1,249,872**	**1,148,789**
Expenses from transactions			
Employee expenses	3.1 (a)	(772,199)	(739,445)
Supplies and consumables	3.1 (d)	(150,916)	(146,985)
Public/private partnership operating expenses	3.1 (e)	(88,288)	(76,838)
Finance costs	3.1 (e)	(35,007)	(37,290)
Other operating expenses	3.1 (e)	(106,213)	(95,107)
Depreciation and amortisation	4.2	(83,306)	(82,147)
Total expenses from transactions		**(1,235,928)**	**(1,177,812)**
NET RESULT FROM TRANSACTIONS – NET OPERATING BALANCE		**13,943**	**(29,023)**
Other economic flows included in net result			
Net gain/(loss) from non-financial assets		(10,538)	(1,504)
Other gain/(loss) from other economic flows		5,567	883
Total other economic flows included in net result		**(4,971)**	**(621)**
NET RESULT		**8,973**	**(29,643)**
Other comprehensive income			
Items that will not be reclassified to net result			
Changes in property, plant and equipment revaluation surplus		(1,698)	-
Total other comprehensive income		**(1,698)**	**-**
COMPREHENSIVE RESULT FOR THE YEAR		**7,275**	**(29,643)**

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

The Royal Children's Hospital
Balance sheet

As at 30 June 2026

	Note	2026	2025
		$'000	$'000
ASSETS			
Financial assets			
Cash and cash equivalents	6.2	91,555	61,448
Receivables	5.1	93,814	94,546
Total financial assets		**185,369**	**155,994**
Non-financial assets			
Property, plant and equipment	4.1	1,668,832	1,727,600
Other non-financial assets		33,647	37,239
Total non-financial assets		**1,702,479**	**1,764,839**
TOTAL ASSETS		**1,887,849**	**1,920,833**
LIABILITIES			
Payables	5.3	64,565	56,209
Contract liabilities	5.4	20,031	26,526
Borrowings	6.1	691,038	740,536
Employee benefits	3.1(b)	238,698	229,601
Monies held in trust		1,850	3,568
Total liabilities		**1,016,182**	**1,056,441**
NET ASSETS		**871,667**	**864,392**
EQUITY			
Property, plant and equipment revaluation surplus		1,053,175	1,054,873
Restricted specific purpose reserve		11,871	12,042
Contributed capital		91,314	91,314
Accumulated deficit		(284,693)	(293,837)
TOTAL EQUITY		**871,667**	**864,392**

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

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The Royal Children's Hospital
Statement of changes in equity

For the financial year ended 30 June 2026

	Property, plant and equipment revaluation surplus	Restricted specific purpose reserve	Contributed capital	Accumulated surplus/ (deficit)	Total
	$'000	**$'000**	**$'000**	**$'000**	**$'000**
Balance at 1 July 2024	**1,059,573**	**50,873**	**91,314**	**(199,977)**	**1,001,782**
Net result for the year	-	-	-	(29,643)	(29,643)
Derecognition of controlled entity	(4,700)	(40,305)	-	(62,742)	(107,747)
Transfer from/(to) accumulated surplus/(deficit)	-	1,474	-	(1,474)	-
Balance at 30 June 2025	**1,054,873**	**12,042**	**91,314**	**(293,837)**	**864,392**
Net result for the year	-	-	-	8,973	8,973
Other comprehensive income for the year	(1,698)	-	-	-	(1,698)
Transfer from/(to) accumulated surplus/(deficit)	-	(171)	-	171	-
Balance at 30 June 2026	**1,053,175**	**11,871**	**91,314**	**(284,693)**	**871,667**

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

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The Royal Children's Hospital Cash flow statement

For the financial year ended 30 June 2026

	Note	2026	2025
		$'000	$'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts from Government		826,905	759,158
Commercial activities, patient and private practice fees received		78,015	65,399
Donations and bequests received		45,241	50,423
GST received from ATO		5,006	5,954
Other receipts		89,021	74,381
Total receipts		**1,044,187**	**955,314**
Payments to employees		(766,679)	(733,972)
Payments for supplies and consumables		(131,680)	(147,116)
Other payments		(105,285)	(84,319)
Total payments		**(1,003,644)**	**(965,408)**
NET CASH FLOW FROM/(USED IN) OPERATING ACTIVITIES	8.1	**40,544**	**(10,094)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of non-financial assets		(9,082)	(14,928)
Capital donations and bequests received		352	435
Proceeds from sale of non-financial assets		200	36
Purchase of financial assets		-	(38)
NET CASH FLOW FROM/(USED IN) INVESTING ACTIVITIES		**(8,531)**	**(14,495)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of borrowings		(1,299)	(1,337)
Cash outflow for leases		(606)	(1,286)
NET CASH FLOW FROM/(USED IN) FINANCING ACTIVITIES		**(1,905)**	**(2,623)**
Net increase/(decrease) in cash and cash equivalents held		30,107	(27,212)
Derecognition of controlled entity		-	(1,398)
Cash and cash equivalents at the beginning of financial year		61,448	90,059
CASH AND CASH EQUIVALENTS AT THE END OF FINANCIAL YEAR	6.2	**91,555**	**61,448**

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

Notes to the Financial Statements 30 June 2026

Note 1: About this report

Structure

Note 1.1: Basis of preparation 700
Note 1.2: Material accounting estimates and judgements 711
Note 1.3: Accounting standards issued but not yet effective 71
Note 1.4: Changes in accounting policy 71
Note 1.5: Reporting entity 72
Note 1.6: Economic dependency 72

These financial statements represent the financial statements of The Royal Children's Hospital (the RCH) for the year ended 30 June 2026.

This section explains the basis of preparing the financial statements.

Note 1.1: Basis of preparation

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

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

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

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

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

The financial statements are presented in Australian dollars.

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

The annual financial statements were authorised for issue by the Board of the RCH on 31 August 2026.

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Note 1.2: Material accounting estimates and judgements

Management makes estimates and judgements when preparing the financial statements.

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

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

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

- Note 2.1: Revenue and income from transactions
- Note 3.1: Expenses incurred in the delivery of services
- Note 4.1: Property, plant and equipment
- Note 5.4: Contract liabilities
- Note 6.1(a): Lease liabilities
- Note 7.4: Fair value determination

Note 1.3: Accounting standards issued but not yet effective

An assessment of accounting standards and interpretations issued by the AASB that are not yet mandatorily applicable to the RCH is not expected to have material impact on the financial statements.

There are no other accounting standards and interpretations issued by the AASB that are not yet mandatorily applicable to the RCH in future periods.

Note 1.4: Changes in accounting policy

In the current year, the RCH changed its accounting policy for the subsequent measurement of right-of-use (ROU) assets, including the PPP hospital building, from the revaluation model to the cost model, in line with updated FRD 104 requirements.

Under the cost model, ROU assets are measured at cost less accumulated depreciation, impairment and lease remeasurements. Previously, these assets were measured at fair value determined using the current replacement cost approach.

The change has been applied using the modified retrospective approach. Comparative information has not been restated. The carrying amount of each ROU asset at 30 June 2025 has been adopted as its deemed cost and recognised as the opening balance under the new policy from 1 July 2025.

Impact of the change in accounting policy

As the 30 June 2025 carrying amounts have been carried forward as opening balances under the cost model, there was no adjustment recognised on transition. No impairment was identified for ROU assets as at 30 June 2026.

Note 1.5: Reporting entity

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

The RCH's principal address is:

50 Flemington Road
Parkville Victoria 3052

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

Note 1.6: Economic dependency

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

Note 2: Funding delivery of our services

The RCH's overall objective is to provide quality health services that support and enhance the wellbeing of all Victorians. The RCH predominantly receives income (grants) for the provision of health services. The RCH also receives income from the supply of services.

Structure

Note 2.1: Revenue and income from transactions 73

Material judgements and estimates

This section contains the following material judgements and estimates:

Material judgements and estimates	Description
Identifying performance obligations	The RCH applies material judgement when reviewing the terms and conditions of funding agreements and contracts to determine whether they contain sufficiently specific and enforceable performance obligations. If this criterion is met, the contract/funding agreement is treated as a contract with a customer, requiring the RCH to recognise revenue as or when the health service transfers promised goods or services to the beneficiaries. If this criterion is not met, funding is recognised immediately in the net results from operations.
Determining timing of revenue recognition	The RCH applies material judgement to determine when a performance obligation has been satisfied and the transaction price that is to be allocated to each performance obligation. A performance obligation is either satisfied at a point in time or over time.
Determining timing of capital grant income recognition	The RCH applies material judgement to determine when its obligation to construct an asset is satisfied. Costs incurred is used to measure the RCH's progress as this is deemed to be the most accurate reflection of the stage of completion.

Note 2.1: Revenue and income from transactions

		2026	2025
	Note	**$'000**	**$'000**
Revenue from contracts with customers	2.1(a)	897,834	850,906
Government grants	2.1(b)	294,889	244,092
Other income	2.1(c)	57,149	53,791
Total revenue and income from transactions		**1,249,872**	**1,148,789**

Note 2.1(a) Revenue from contracts with customers

	2026	2025
	$'000	**$'000**
Government grants (State) – operating	678,602	640,008
Government grants (Commonwealth) – operating	53,801	51,726
RCH Foundation grants – operating	44,824	48,448
Patient fees	30,341	31,315
Private practice fees	26,645	27,186
Commercial activities (i)	16,303	15,585
Other revenue from operating activities	47,317	36,638
Total revenue from contracts with customers	**897,834**	**850,906**

(i) Commercial activities primarily comprise car park revenue and crèche fees, representing business activities which the RCH enters to support its operations.

How we recognise revenue from contracts with customers

Government operating grants

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

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

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

Government grant	Performance obligation
Activity Based Funding (ABF) paid as National Weighted Activity Unit (NWAU)	NWAU is a measure of health service activity expressed as a common unit against which the Victorian efficient price (VEP) is paid. The performance obligations for NWAU are the number and mix of admissions, emergency department presentations and outpatient episodes, and is weighted for clinical complexity. Revenue is recognised at a point in time upon separation, up to the NWAU target agreed with the Department of Health (DH). Activity above this target is not funded.
Funding as Nationally Funded Centre (NFC)	The RCH is funded for the following procedures: • paediatric heart transplants • paediatric liver transplants (in collaboration with Austin Health) • paediatric lung transplants (in collaboration with Alfred Health) Revenue is recognised at a point in time when a qualifying procedure has been completed.

RCH Foundation grants

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

Note 2.1(b) Government grants

	2026	2025
	$'000	$'000
Operating activities		
Government grants (State) – operating	188,227	144,134
Government grants (State) – capital	106,662	99,959
Total Government grants	**294,889**	**244,092**

How we recognise Government grants

Government operating grants

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

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

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

Capital grants

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

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

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

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

Supplier	Description
Victorian Infrastructure Delivery Authority	The Department of Health made payments to the Victorian Infrastructure Delivery Authority (VIDA) to fund capital works projects during the year ended 30 June 2026, on behalf of the RCH.
Department of Health	Long Service Leave (LSL) revenue is recognised upon finalisation of movements in LSL liability in line with the long service leave funding arrangements with the DH.
PPP Consortium	In 2011 DH entered lease arrangements and services which are paid directly to PPP Consortium. To record this contribution, such payments are recognised as income with a matching reduction in the lease liability and expense in the net result from transactions, in accordance with the nature and timing of the monthly or quarterly payment.

Note 2.1(c) Other sources of income

	2026	2025
	$'000	$'000
Operating activities		
RCH Foundation grants – capital	439	411
Assets received free of charge	27,798	26,151
Other income from operating activities	23,816	20,517
Total from operating activities	**52,053**	**47,079**
Non-operating activities		
Interest income	5,096	6,712
Total from non-operating activities	**5,096**	**6,712**
Total other income	**57,149**	**53,791**

Income from operating activities

Assets received free of charge represent compassionate drugs received from pharmaceutical companies at no cost.

Other income includes salary and non-salary recoveries recognised upon receipt.

Note 3: The cost of delivering our services

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

Structure

Note 3.1: Expenses incurred in the delivery of services 78

Material judgements and estimates

Key judgements and estimates	Description
Classifying employee benefit liabilities	The RCH applies material judgement when classifying its employee benefit liabilities. Employee benefit liabilities are classified as a current liability if the RCH does not have an unconditional right to defer payment beyond 12 months. Annual leave, accrued days off and long service leave entitlements (for staff who have exceeded the minimum vesting period) fall into this category. Employee benefit liabilities are classified as a non-current liability if the RCH has a conditional right to defer payment beyond 12 months. Long service leave entitlements (for staff who have not yet exceeded the minimum vesting period) fall into this category.
Measuring employee benefit liabilities	The RCH applies material judgement when measuring its employee benefit liabilities. The health service applies judgement to determine when it expects its employee entitlements to be paid. With reference to historical data, if the health service does not expect entitlements to be paid within 12 months, the entitlement is measured at its present value, being the expected future payments to employees. Expected future payments incorporate: • an inflation rate of 4.15%, reflecting the future wage and salary levels • durations of service and employee departures, which are used to determine the estimated value of long service leave that will be taken in the future, for employees who have not yet reached the vesting period. The estimated rates are between 27.93% and 83.34% • discounting at the rate of 4.736%, as determined with reference to market yields on government bonds at the end of the reporting period. All other entitlements are measured at their nominal value.

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Note 3.1: Expenses incurred in the delivery of services

	Note	2026	2025
		$'000	$'000
Employee expenses	3.1(a)	772,199	739,445
Supplies and consumables	3.1(d)	150,916	146,985
Other operating expenses	3.1(e)	229,508	209,235
Total expenses incurred in the delivery of services		**1,152,623**	**1,095,665**

Note 3.1(a) Employee expenses

	2026	2025
	$'000	$'000
Salaries and wages	674,836	651,125
On-costs	72,335	66,905
Agency expenses	13,173	12,686
Fee for service medical officer expenses	4,530	2,450
Workcover premium	7,325	6,280
Total employee expenses	**772,199**	**739,445**

How we recognise employee expenses

Employee expenses

Employee expenses include salaries and wages, fringe benefits tax, leave entitlements, termination payments, WorkCover payments and agency expenses.

Note 3.1(b) Employee benefits in the balance sheet

	2026	2025
	$'000	$'000
Current employee benefits and related on-costs		
Accrued days off		
Unconditional and expected to be settled wholly within 12 months i	1,387	1,267
Annual leave		
Unconditional and expected to be settled wholly within 12 months i	67,791	60,669
Unconditional and expected to be settled wholly after 12 months ii	7,180	7,888
Long service leave		
Unconditional and expected to be settled wholly within 12 months i	13,388	11,951

Unconditional and expected to be settled wholly after 12 months ii	108,188	106,553
Provisions related to employee benefit on-costs		
Unconditional and expected to be settled within 12 months i	10,490	9,540
Unconditional and expected to be settled after 12 months ii	15,132	14,777
Total current employee benefits and related on-costs	**223,556**	**212,645**
Non-current employee benefits and related on-costs		
Conditional long service leave	13,386	15,017
Provisions related to employee benefit on-costs	1,756	1,939
Total non-current employee benefits and related on-costs	**15,142**	**16,956**
Total employee benefits and related on-costs	**238,698**	**229,601**

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

Provision for related on-costs movement schedule

	2026	2025
	$'000	$'000
Carrying amount at start of the year	**26,257**	**24,411**
Additional provision recognised	10,701	11,042
Amounts incurred during the year	(8,911)	(8,394)
Net (gain)/loss from revaluation of long service leave liability	(670)	(801)
Carrying amount at end of year	**27,377**	**26,257**

How we recognise employee benefits

Employee benefit recognition

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

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

Annual leave and accrued days off

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

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

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

Long Service Leave

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

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

The components of this current LSL liability are measured at:

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

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

Provisions

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

Note 3.1(c) Superannuation

	Paid contributions for the year		Contribution outstanding at year end	
	2026	**2025**	**2026**	**2025**
	$'000	**$'000**	**$'000**	**$'000**
Defined benefit plans (i)				
Aware Super Scheme	93	143	7	5
Defined contribution plans				
Aware Super Scheme	33,764	32,887	2,465	2,341
Hesta	20,812	19,772	1,653	1,501
Other	17,048	14,488	1,340	1,092
Total	**71,717**	**67,290**	**5,466**	**4,939**

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

How we recognise superannuation

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

Defined contribution superannuation plans

Defined contribution (i.e. accumulation) superannuation plan expenditure is simply the employer contributions that are paid or payable in respect of employees who are members of these plans

during the reporting period. Contributions to defined contribution superannuation plans are expensed when incurred.

Note 3.1(d) Supplies and consumables

	2026	2025
	$'000	$'000
Drug supplies	98,794	97,118
Medical and surgical supplies	37,734	35,440
Diagnostic and radiology supplies	10,817	11,169
Other supplies and consumables	3,572	3,258
Total supplies and consumables	**150,916**	**146,985**

Supplies and consumables

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

Note 3.1(e) Other operating expenses

	2026	2025
	$'000	$'000
PPP operating expenses	88,288	76,838
Total public/private partnership operating expenses	**88,288**	**76,838**
Finance costs	1,045	1,067
Finance costs – PPP arrangements	33,962	36,222
Total finance costs	**35,007**	**37,290**
Fuel, light, power and water	7,485	7,404
Repairs, maintenance and maintenance contracts	23,088	19,780
Medical indemnity insurance	15,518	12,684
Distributions to Murdoch Children's Research Institute	18,610	18,248
Other administrative expenses	41,511	36,991
Total other expenses	**106,213**	**95,107**
Total other operating expenses	**229,508**	**209,235**

How we recognise expenses from transactions

Expense recognition

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

Other operating expenses

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

The DH also makes certain payments on behalf of the RCH. These amounts have been brought into account in determining the operating result for the year, by recording them as non-cash revenue and a corresponding expense, representing facility management, maintenance services and finance costs under the PPP arrangement.

Note 4: Key assets to support service delivery

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

Structure

Note 4.1: Property, plant and equipment 83
Note 4.2: Depreciation and amortisation 86
Note 4.3: Impairment of assets 87

Material judgements and estimates

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

Note 4.1: Property, plant and equipment

	Gross carrying amount		Accumulated depreciation		Net carrying amount	
	2026	2025	2026	2025	2026	2025
	$'000	$'000	$'000	$'000	$'000	$'000
Land at fair value – Crown	144,884	144,884	-	-	144,884	144,884
Land at fair value – Freehold	15,850	15,850	-	-	15,850	15,850

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Buildings at cost – right of use	585	511	(330)	(224)	255	288
Buildings at fair value	9,669	9,669	(1,695)	(848)	7,974	8,821
Plant and equipment	2,036	2,218	(1,628)	(1,582)	408	636
Medical equipment	106,329	103,203	(70,134)	(66,621)	36,195	36,582
Computers and communication	18,913	17,884	(13,949)	(12,963)	4,964	4,921
Furniture and fittings	2,416	4,163	(1,240)	(1,383)	1,177	2,780
Motor vehicles	801	801	(315)	(215)	486	586
Cultural assets	607	607	-	-	607	607
Plant, equipment, furniture, fittings and vehicles at cost – right of use	4,130	3,905	(2,532)	(2,200)	1,598	1,705
PPP assets						
Buildings at cost	1,520,352	1,495,668	(128,046)	(63,052)	1,392,306	1,432,617
Leasehold Improvements at cost	17,622	32,368	-	-	17,622	32,368
Fittings	45,531	45,531	(21,508)	(19,958)	24,024	25,574
Equipment at cost	37,099	34,518	(16,616)	(15,135)	20,483	19,383
Total right of use PPP assets	**1,620,604**	**1,608,085**	**(166,170)**	**(98,145)**	**1,454,435**	**1,509,941**
Total property, plant and equipment	**1,926,825**	**1,911,781**	**(257,993)**	**(184,181)**	**1,668,832**	**1,727,600**

How we recognise property, plant and equipment

Items of property, plant and equipment are initially measured at cost and are subsequently measured at fair value less accumulated depreciation and impairment, with the exception of right-of-use assets, which are subsequently measured at cost (Refer Note 1.4). Where an asset is acquired for no or nominal cost, being far below the fair value of the asset, the deemed cost is its fair value at the date of acquisition.

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

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

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

	Land	Right of use - buildings	Buildings	Plant and equipment	Medical equipment	Computers and Comm.	Furniture and fittings	Motor vehicles	Cultural Assets	Right of use - PP&E, F and V	PPP assets	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2024	**162,834**	**37**	**12,403**	**578**	**38,942**	**5,444**	**1,274**	**504**	**607**	**1,993**	**1,558,796**	**1,783,411**
Additions	-	482	-	186	5,474	1,191	1,748	254	-	354	16,781	26,470
Disposals	-	-	-	(5)	(247)	-	(12)	(3)	-	36	-	(232)
Net transfers between classes	-	(175)	-	-	-	-	-	-	-	-	175	-
Derecognition of controlled entity	(2,100)	-	(2,734)	-	-	(14)	-	(8)	-	-	-	(4,855)
Depreciation and amortisation (note 4.2)	-	(56)	(848)	(124)	(7,587)	(1,700)	(229)	(161)	-	(678)	(65,811)	(77,193)
Balance at 30 June 2025	**160,734**	**288**	**8,821**	**636**	**36,582**	**4,921**	**2,780**	**585**	**607**	**1,705**	**1,509,941**	**1,727,600**
Additions	-	74	-	369	6,822	1,434	325	-	-	829	21,996	31,849
Disposals (i)	-	-	-	(3)	(320)	-	(10)	-	-	(216)	(9,132)	(9,681)
Revaluation increments/ (decrements) (ii)	-	-	-	-	-	-	-	-	-	-	(1,698)	(1,698)
Net transfers between classes	-	-	-	(478)	928	159	(1,770)	-	-	23	1,138	-
Depreciation and amortisation (note 4.2)	-	(106)	(848)	(116)	(7,817)	(1,550)	(149)	(99)	-	(743)	(67,809)	(79,238)
Balance at 30 June 2026	**160,734**	**255**	**7,974**	**408**	**36,195**	**4,964**	**1,177**	**486**	**607**	**1,598**	**1,454,435**	**1,668,832**

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

(i) Disposals for 2025–26 include $9.13m of costs incurred on the Emergency Department Expansion project prior to its suspension in March 2023, when the original design was identified as not fit for purpose. The project recommenced in November 2023 under a revised design. Following a review of the value able to be retained or repurposed from the pre-suspension works, the balance of costs which could not be carried forward was derecognised and expensed in the 2025–26 year.

Land and Buildings Carried at Valuation

Fair value assessments have been performed for all classes of assets in this purpose group, and the decision was made that the movements were not material (less than or equal to 10%). As such, an independent revaluation was not required per FRD 103. In accordance with FRD 103, the RCH has elected to apply the practical expedient in FRD 103 Non-Financial Physical Assets and has therefore not applied the amendments to AASB 13 Fair Value Measurement. The amendments to AASB 13 will be applied at the earlier of the interim revaluation or next scheduled independent revaluation in 2029, in accordance with the RCH's revaluation cycle.

(ii) No revaluation of property, plant and equipment was undertaken in 2025–26. The $1.7 million decrement shown in the revaluation line is an accounting entry correction to the PPP asset revaluation previously recognised at 30 June 2024.

How we recognise right of use assets

Initial recognition

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

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

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

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

Subsequent measurement

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

Note 4.2: Depreciation and amortisation

	2026	2025
	$'000	**$'000**
Depreciation		
Buildings	848	848
Plant and equipment	116	124
Motor vehicles	99	161
Medical equipment	7,817	7,587
Computers and communication equipment	1,550	1,700
Furniture and fittings	149	229
Leased fittings	1,550	1,550
Leased equipment	1,265	1,209
Right of use assets		
- Right of use PPP buildings	64,994	63,052
- Right of use buildings	106	56
- Right of use plant, equipment and vehicles	743	678
Total depreciation	**79,238**	**77,193**
Amortisation		
Software	4,068	4,954
Total depreciation and amortisation	**83,306**	**82,147**

How we recognise depreciation

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

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

How we recognise amortisation

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

Useful life of non-current assets

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

	2026	2025
Non-PPP assets		
Buildings	50 years	50 years
Right-of-use buildings	3 to 5 years	3 to 5 years
Plant and equipment (non-medical)	3 to 25 years	3 to 25 years
Medical equipment	5 to 15 years	5 to 15 years
Computers and communication equipment	3 to 5 years	3 to 5 years
Furniture and fittings	3 to 50 years	10 to 50 years
Motor vehicles	7 to 10 years	7 to 10 years
Intangible assets	3 to 25 years	3 to 25 years
PPP assets		
Buildings	25 to 60 years	25 to 60 years
Plant and equipment, furniture and fittings	7 to 30 years	7 to 30 years

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

Note 4.3: Impairment of assets

Impairment of property, plant and equipment

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

Impairment of intangible assets

Intangible assets with finite useful lives are tested for impairment whenever an indication of impairment is identified.

The RCH did not record any impairment losses for the year ended 30 June 2026 (30 June 2025: Nil).

Note 5: Other assets and liabilities

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

Structure

Note 5.1: Receivables 88
Note 5.2: Investments in Associates 89
Note 5.3: Payables 90
Note 5.4: Contract liabilities 91

Material judgements and estimates

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

Note 5.1: Receivables

		2026	2025
	Note	$'000	$'000
CURRENT			
Contractual			
Inter hospital debtors		1,189	6,190
Trade debtors		5,048	6,852
Patient fees		4,516	11,037
Allowance for impairment losses		(808)	(2,356)
Other receivables		15,532	10,379
	7.1 (a)	**25,478**	**32,102**
Statutory			
GST receivable		1,606	831
Total current receivables		**27,083**	**32,933**
NON-CURRENT			
Contractual			
Long service leave – Department of Health		66,731	61,613
Total non-current receivables		**66,731**	**61,613**

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How we recognise receivables

Receivables consist of:

- Contractual receivables include debtors that relate to the provision of goods and services. These receivables are classified as financial instruments and are categorised as 'financial assets at amortised cost'. They are initially recognised at fair value plus any directly attributable transaction costs. The health service holds the contractual receivables with the objective to collect the contractual cash flows and therefore subsequently measured at amortised cost using the effective interest method, less any impairment.

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

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

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

	2026	2025
	$'000	**$'000**
Balance at the beginning of the reporting period	2,356	1,759
Amounts written off during the year	(1,620)	(736)
Increase/(decrease) in allowance recognised in net result	71	1,333
Balance at the end of the reporting period	**808**	**2,356**

Impairment losses of contractual receivables

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

Note 5.2: Investments in Associates

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

Initial recognition

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

investee after the date of acquisition. The RCH's share of the investee's profit or loss is recognised in the RCH's profit or loss.

Subsequent measurement

The carrying amount is increased or decreased to account for the RCH's share of the profit or loss of the investee subsequent to the initial recognition. Distributions received from an investee reduce the carrying amount of the investment. Adjustments to the carrying amount may also be necessary for changes in the RCH's proportionate interest in the investee arising from changes in the investee's other comprehensive income. Such changes include those arising from the revaluation of property, plant and equipment.

Investment in Transcendomics

The RCH has classified its equity interests in Transcendomics as an Investment in Associates as the RCH's 20% voting interest gives it significant influence over Transcendomics. The RCH's share of the profit of Transcendomics for 2025-26 is not material to the RCH and has not been reflected in the financial statements.

The Royal Children's Hospital Foundation

The RCH has classified its interests in the RCH Foundation as an Investment in Associates. It is assessed to have significant influence over the RCH Foundation.

However, as the RCH has no equity or economic interest in the RCH Foundation, no investments in associates have been recognised as at 30 June 2026. Distributions and funding received from the Foundation are instead recognised as revenue.

Note 5.3: Payables

Note 5.3(a) Payables

	2026	2025
	$'000	**$'000**
CURRENT		
Contractual		
Payables	21,052	12,273
Accrued employee costs	26,673	28,859
Accrued expenses	10,608	8,653
Department of Health - deferred capital grant income (i)	6,232	6,424
Total current payables	**64,565**	**56,209**
Financial liabilities classified as payables in note 7.1 (a)		
Total payables	64,565	56,209
Deferred grant income	(6,232)	(6,424)
Total financial liabilities	**58,333**	**49,785**

(i) Deferred grant income includes deferred capital grant income as shown in note 5.3 (b) below.

How we recognise payables

Payables consist of:

- Contractual payables include payables that relate to the purchase of goods and services. These payables are classified as financial instruments and measured at amortised cost. Accounts payable and salaries and wages payable represent liabilities for goods and services provided to the RCH prior to the end of the financial year that are unpaid.

- Statutory payables include goods and services tax (GST) and fringe benefits tax (FBT) payables. Statutory payables are recognised and measured similarly to contractual payables but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from contracts.

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

Note 5.3(b) Movement in deferred capital grant income

	2026	2025
	$'000	**$'000**
Opening balance of deferred capital grants income	6,424	7,669
Grant consideration for capital works received during the year	4,491	4,679
Deferred capital grant income recognised as income due to completion of capital works	(4,683)	(5,924)
Closing balance of deferred capital grant income	**6,232**	**6,424**

How we recognise deferred capital grant income

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

Note 5.4: Contract liabilities

	2026	2025
	$'000	**$'000**
Opening balance of contract liabilities	26,526	25,778
Add: payments received for performance obligations yet to be completed during the period	15,153	10,768
Add: grant consideration for sufficiently specific performance obligations received during the year	809,548	741,074

Less: revenue recognised in the reporting period for the completion of a performance obligation	(15,854)	(12,994)
Less: grant revenue for sufficiently specific performance obligations work recognised consistent with the performance obligations met during the year	(815,342)	(740,487)
Derecognition of controlled entity	-	2,388
Total current contract liabilities	**20,031**	**26,526**

How we recognise contract liabilities

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

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

Note 6: How we finance our operations

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

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

Structure

Note 6.1: Borrowings 94
Note 6.2: Cash and cash equivalents 98
Note 6.3: Commitments for expenditure 98

Material judgements and estimates

Key judgements and estimates	Description
Determining if a contract is or contains a lease	The RCH applies material judgement to determine if a contract is or contains a lease by considering if the health service: • has the right to use and identified asset • has the right to obtain substantially all economic benefits from the use of the leased asset and • can decide how and for what purpose the asset is used throughout the lease
Discount rate applied to future lease payments	The RCH discounts its lease payments using the interest rate implicit in the lease. If this rate cannot be readily determined, which is generally the case for the health service's lease arrangements, the RCH uses its incremental borrowing rate, which is the amount the health service would have to pay to borrow funds necessary to obtain an asset of similar value to the right-of-use asset in a similar economic environment with similar terms, security and conditions.
Assessing the lease term	The lease term represents the non-cancellable period of a lease, combined with periods covered by an option to extend or terminate the lease if the RCH is reasonably certain to exercise such options. The RCH determines the likelihood of exercising such options on a lease-by-lease basis through consideration of various factors including: • If there are significant penalties to terminate (or not extend), the health service is typically reasonably certain to extend (or not terminate) the lease • If any leasehold improvements are expected to have a significant remaining value, the health service is typically reasonably certain to extend (or not terminate) the lease • The health service considers historical lease durations and the costs and business disruption to replace such leased assets

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Note 6.1: Borrowings

	2026	2025
	$'000	$'000
CURRENT		
TCV loan	1,365	1,299
Finance lease liability	978	921
Finance lease liability (PPP)	50,457	48,086
Total current	**52,800**	**50,306**
NON-CURRENT		
TCV loan	16,940	18,305
Finance lease liability	950	1,121
Finance lease liability (PPP)	620,347	670,805
Total non-current	**638,237**	**690,230**
Total borrowings	**691,038**	**740,536**
Represented by:		
TCV loan (i)	18,305	19,604
Finance lease liability (ii)	1,928	2,041
Finance lease liability (PPP) (iii)	670,805	718,890
Total borrowings	**691,038**	**740,536**

(i) The TCV loan is an unsecured loan with an interest rate of 4.93% (2025: 4.93%). The maturity date of the loan is 31 December 2036.
(ii) Secured by the assets leased. Finance leases are effectively secured as the rights to the leased assets revert to the lessor in the event of default.
(iii) Note that the obligation of fulfilling PPP interest and principal payments over the PPP term rests with the DH. The RCH records on behalf of the DH according to the information provided.

Note 6.1(a) Maturity analysis of lease liabilities

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

Lease liabilities

	2026	2025
	$'000	$'000
Not longer than one year	1,042	982
Longer than one year but not later than five years	998	1,190
Minimum future lease liability	2,040	2,172
- Less unexpired finance expenses	(112)	(131)
Present value of lease liability	**1,928**	**2,041**

Lease liabilities (PPP)

	2026	2025
	$'000	$'000
Not longer than one year	82,048	82,048
Longer than one year but not later than five years	328,191	328,191
Longer than five years	449,256	531,304
Minimum future lease liability	859,495	941,543
- Less unexpired finance expenses	(188,690)	(222,653)
Present value of lease liability	**670,805**	**718,890**

How we recognise borrowings

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

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

Maturity analysis

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

Interest expense

	2026	2025
	$'000	$'000
Interest on TCV loan	937	1,000
Interest on Finance lease liability	108	68
Interest on Finance lease liability (PPP)	33,962	36,222
Total interest expense	**35,007**	**37,290**

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

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

The RCH recognises borrowing costs immediately as an expense.

Defaults and breaches

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

How we recognise Non-PPP lease liabilities

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

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

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

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

The RCH's lease arrangements consist of the following:

Type of asset leased	Lease term
Leased buildings	3 to 5 years
Leased motor vehicles, medical equipment and office equipment	3 to 7 years

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

Initial measurement

The lease liability is initially measured at the present value of the lease payments unpaid at the commencement date, discounted using the interest rate implicit in the lease if that rate is readily determinable or the RCH incremental borrowing rate. Our lease liability has been discounted by rates of between 4.53% to 5.72%

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

- fixed payments (including in-substance fixed payments) less any lease incentive receivable
- amounts expected to be payable under a residual value guarantee
- payments arising from purchase and termination options reasonably certain to be exercised

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

- Motor Vehicles
- Medical Equipment
- Buildings

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

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

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

During the current financial year, the financial effect of revising lease terms to reflect the effect of exercising extension and termination options was an increase in recognised lease liabilities and right-of-use assets of $744k.

Subsequent measurement

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

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

How we recognise Public Private Partnerships (PPP) lease liabilities

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

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

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

The portion of total payments to CHP that relates to the RCH's right to use the hospital building is accounted for as a finance lease liability. The lease asset is accounted for as a non-financial physical asset and is depreciated over its estimated useful life, on the basis that RCH is expected to obtain ownership of the hospital building beyond the term of the PPP arrangement.

Initial measurement

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

Subsequent measurement

The leased assets under the PPP arrangement are accounted for as a non-financial physical asset and are depreciated over the estimated useful life.

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

Note 6.2: Cash and cash equivalents

	2026	2025
	$'000	**$'000**
Cash at bank - CBS (excluding monies held in trust)	89,705	57,880
Cash at bank - CBS (monies held in trust)	1,850	3,568
	91,555	**61,448**
Represented by:		
Monies held in trust	1,850	3,568
Cash for health service operations (i)	89,705	57,880
	91,555	**61,448**

(i) Cash for health service operations includes cash held for capital commitments and operating commitments.

Note 6.3: Commitments for expenditure

Note 6.3(a) Commitments for expenditure

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

2026	Less than 1 year	1-5 years	Over 5 years	Total
	$'000	$'000	$'000	$'000
Capital expenditure commitments	396	-	-	396
Operating expenditure commitments	16,472	7,768	6	24,245
Public private partnership commitments	105,552	460,496	773,079	1,339,127
Total commitments (inclusive of GST)	**122,419**	**468,263**	**773,085**	**1,363,768**
Less GST recoverable				(123,979)
Total commitments (exclusive of GST)				**1,239,789**

How we disclose our commitments

Our commitments relate to expenditure and short term and low value leases.

Expenditure commitments

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

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

Short term and low value leases

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

Commissioned public private partnerships (PPP)

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

The commitments disclosed above relate only to contingent rental, lifecycle costs and recurrent maintenance charges under the PPP arrangement. Lease payments associated with the RCH's right to use the hospital building are recognised as finance lease liabilities on the balance sheet (refer Note 6.1(a)) and are excluded from the above commitments.

Note 7: Risks, contingencies and valuation uncertainties

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

Structure

Note 7.1: Financial instruments 101
Note 7.2: Financial risk management objectives and policies 104
Note 7.3: Contingent assets and contingent liabilities 106
Note 7.4: Fair value determination 106

Material judgements and estimates

Material judgements and estimates	Description
Measuring fair value of non-financial assets	Fair value is measured with reference to highest and best use, that is, the use of the asset by a market participant that is physically possible, legally permissible, financially feasible, and which results in the highest value, or to sell it to another market participant that would use the same asset in its highest and best use. In determining the highest and best use, the RCH has assumed the current use is its highest and best use. The RCH uses a range of valuation techniques to estimate fair value. The health service selects a valuation technique which is considered most appropriate, and for which there is sufficient data available to measure fair value, maximising the use of relevant observable inputs and minimising the use of unobservable inputs. Subsequently, the health service applies material judgement to categorise and disclose such assets within a fair value hierarchy, which includes: ▪ Level 1, using quoted prices (unadjusted) in active markets for identical assets that the health service can access at measurement date. The RCH does not categorise any fair values within this level ▪ Level 2, inputs other than quoted prices included within Level 1 that are observable for the asset, either directly or indirectly. The RCH categorises non-specialised land & building, cultural assets and right-of-use plant & equipment, furniture & fitting and vehicles in this level ▪ Level 3, where inputs are unobservable. The RCH categorises specialised land & buildings, plant & equipment, furniture & fittings in this level

Note 7.1: Financial instruments

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

Note 7.1(a) Categorisation of financial instruments

2025	Note	Financial assets at amortised cost	Financial liabilities at amortised cost	Total
		$'000	**$'000**	**$'000**
Contractual financial assets				
Cash and cash equivalents	6.2	61,448	-	61,448
Receivables	5.1	32,102	-	32,102
Total financial assets (i)		**93,550**	**-**	**93,550**
Financial liabilities				
Payables	5.3	-	49,785	49,785
TCV loan	6.1	-	19,604	19,604
Lease liability	6.1	-	720,932	720,932
Monies held in trust		-	3,568	3,568
Total financial liabilities (ii)		**-**	**793,889**	**793,889**

2026	Note	Financial assets at amortised cost	Financial liabilities at amortised cost	Total
		$'000	**$'000**	**$'000**
Contractual financial assets				
Cash and cash equivalents	6.2	91,555	-	91,555
Receivables	5.1	25,478	-	25,478
Total financial assets (i)		**117,033**	**-**	**117,033**
Financial liabilities				
Payables	5.3	-	58,333	58,333
TCV loan	6.1	-	18,305	18,305
Lease liability	6.1	-	672,733	672,733
Monies held in trust		-	1,850	1,850
Total financial liabilities (ii)		**-**	**751,221**	**751,221**

(i) The total amount of the financial assets disclosed here excludes statutory receivables (i.e. GST input tax credit recoverable) and accrued LSL revenue from the Department of Health.
(ii) The total amount of the financial liabilities disclosed includes loans from the Treasury Corporation of Victoria and PPP finance liabilities, and excludes deferred income and statutory payables (i.e. taxes payable).

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

How we recognise financial instruments

Categories of financial assets

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

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

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

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

Financial assets at amortised cost

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

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

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

The RCH recognises the following assets in this category:

- cash and deposits
- receivables (excluding statutory receivables)

Categories of financial liabilities

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

Financial liabilities at amortised cost

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

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

The RCH recognises the following liabilities in this category:

- payables (excluding statutory payables and contract liabilities)

- borrowings and
- other liabilities (including monies held in trust)

Offsetting financial instruments

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

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

Derecognition of financial assets

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

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

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

Derecognition of financial liabilities

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

When an existing financial liability is replaced by another from the same lender on substantially different terms, or the terms of an existing liability are substantially modified, such an exchange or modification is treated as a derecognition of the original liability and the recognition of a new liability.

The difference in the respective carrying amounts is recognised as 'other economic flows' in the comprehensive operating statement.

Reclassification of financial instruments

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

A financial liability reclassification is not permitted.

Note 7.2: Financial risk management objectives and policies

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

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

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

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

Note 7.2(a) Credit risk

The RCH has assessed there is no material credit risk.

Impairment of financial assets under AASB 9

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

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

Contractual receivables at amortised cost

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

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

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

2026	Less than 1 month	1-3 months	3-12 months	1-5 years	Total
Expected loss rate	0.2%	1.0%	27.2%	80.4%	3.5%
Gross carrying amount of contractual receivables ($'000)	13,224	8,160	1,061	504	22,949
Loss allowance ($'000)	(31)	(82)	(289)	(405)	(808)

Statutory receivables at amortised cost

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

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

Note 7.2(b) Liquidity risk

The RCH's exposure to liquidity risk is deemed insignificant based on prior periods' data and current assessment of risk in that the RCH provides essential services to the Victorian health system and it is highly likely that the State of Victoria will continue providing ongoing financial support to the entity.

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

2025	Note	Carrying amount as at	Nominal amount as at	Maturity dates				
		30 June 2025	**30 June 2025**	**Less than 1 month**	**1-3 months**	**3-12 months**	**1-5 years**	**More than 5 years**
		$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Financial liabilities								
Payables	5.3	49,785	49,785	39,306	10,416	63	-	-
TCV loan	6.1	19,604	19,604	106	213	981	5,752	12,553
Lease liability	6.1	720,932	720,932	108	11,951	37,321	217,918	453,634
Monies held in trust	6.2	3,568	3,568	40	87	1,793	1,648	-
		793,889	**793,889**	**39,560**	**22,667**	**40,157**	**225,318**	**466,187**

2026	Note	Carrying amount as at	Nominal amount as at	Maturity dates				
		30 June 2026	30 June 2026	Less than 1 month	1-3 months	3-12 months	1-5 years	More than 5 years
		$'000	$'000	$'000	$'000	$'000	$'000	$'000
Financial liabilities								
Payables	5.3	58,333	58,333	46,834	10,612	886	-	-
TCV loan	6.1	18,305	18,305	111	224	1,030	6,042	10,898
Lease liability	6.1	672,733	672,733	108	12,538	39,106	228,515	392,466
Monies held in trust	6.2	1,850	1,850	56	118	454	1,222	-
		751,221	**751,221**	**47,109**	**23,492**	**41,476**	**235,780**	**403,364**

Note 7.2(c) Market risk

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

Interest rate risk

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

Cash flow interest rate risk is the risk that the future cash flows of a financial instrument will fluctuate because of changes in market interest rates. The RCH has minimal exposure to cash flow interest rate risks through cash and deposits that are at floating rate.

Note 7.3: Contingent assets and contingent liabilities

As at 30 June 2026, the Board is not aware of any contingent assets or contingent liabilities.

Note 7.4: Fair value determination

How we measure fair value

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

The following assets and liabilities are carried at fair value:

- Financial assets and liabilities at fair value through net result

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

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

Valuation hierarchy

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

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

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

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

Identifying unobservable inputs (level 3) fair value measurements

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

Unobservable inputs are used to measure fair value to the extent that relevant observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity for the asset or liability at the measurement date. However, the fair value measurement objective remains the same, i.e., an exit price at the measurement date from the perspective of a market participant that holds the asset or owes the liability. Therefore, unobservable inputs shall reflect the assumptions that market participants would use when pricing the asset or liability, including assumptions about risk.

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

2025	Carrying amount as at	Fair value measurement at end of reporting period using		
	30 June 2025	Level 1 (i)	Level 2 (i)	Level 3 (i)

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

2026		Carrying amount as at	Fair value measurement at end of reporting period using		
		30 June 2026	Level 1 (i)	Level 2 (i)	Level 3 (i)
	Note	$'000	$'000	$'000	$'000
Land at fair value					
Non-specialised land		15,850	-	15,850	-
Specialised land		144,884	-	-	144,884
Total land at fair value	4.1	**160,734**	**-**	**15,850**	**144,884**
Buildings at fair value					
Non-specialised buildings		2,708	-	2,708	-

Specialised buildings		5,266	-	-	5,266
Total buildings at fair value	4.1	**7,974**	**-**	**2,708**	**5,266**
Investment properties					
Investment properties		7,463	-	7,463	-
Total investment properties		**7,463**	**-**	**7,463**	**-**
Other plant and equipment at fair value					
Plant and equipment		408	-	-	408
Motor vehicles		486	-	-	486
Medical equipment		36,195	-	-	36,195
Computers and communication equipment		4,964	-	-	4,964
Furniture and fittings		1,177	-	-	1,177
Cultural assets		607	-	607	-
Total other plant and equipment at fair value	4.1	**43,837**	**-**	**607**	**43,230**
Total (ii)		**220,007**	**-**	**26,628**	**193,380**

(i) Classified in accordance with the fair value hierarchy.
(ii) The 2026 balances exclude right-of-use assets which are measured at cost in accordance with AASB 16 and are not subject to fair value measurement (refer Note 1.4).

How we measure fair value of non-financial physical assets

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

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

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

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

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

AASB 2022-10 Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities amended AASB 13 by adding

Appendix F Australian implementation guidance for not-for-profit public sector entities. Appendix F explains and illustrates the application of the principles in AASB 13 on developing unobservable inputs and the application of the cost approach. These clarifications are mandatorily applicable to annual reporting periods beginning on or after 1 January 2024. FRD 103 permits Victorian public sector entities to apply Appendix F of AASB 13 in their next scheduled formal asset revaluation or interim revaluation (whichever is earlier).

An independent valuation of the RCH's non-financial physical assets was performed by the VGV on 30 June 2024. Fair value assessments have therefore been performed for all classes of assets in this purpose group at 30 June 2026 and the decision was made that the movements were not material (less than or equal to 10%). As such, an independent revaluation was not required per FRD 103. In accordance with FRD 103, the RCH will apply Appendix F of AASB 13 prospectively in its next scheduled formal revaluation in 2029 or interim revaluation process (whichever is earlier). The RCH does not expect the impact to be material to the financial statements.

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

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

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

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

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

Specialised land and specialised buildings

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

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

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

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

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

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

Medical equipment

Medical equipment is measured using the current replacement cost approach. It is classified as Level 3 in the fair value hierarchy as the significant inputs used in the valuation are unobservable. There is no active secondary market for specialised medical equipment of this nature as quoted prices for identical or comparable assets are not readily available in observable markets.

Replacement costs are determined with reference to biomedical engineering assessments and manufacturer specifications, which require significant management judgement. The accumulated depreciation component reflects both physical deterioration and technological obsolescence, assessed with reference to the estimated useful life of each item ranging from 5 to 15 years. The degree of obsolescence applied involves judgement that is not directly observable from market data.

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

	Land	Buildings	Plant and equipment	Motor vehicles	Medical equipment	Computers and comms	Furniture and fittings	PPP assets
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2024	**144,884**	**6,119**	**578**	**504**	**38,942**	**5,444**	**1,274**	**1,558,796**
Additions/ (disposals)	-	-	181	251	5,227	1,191	1,736	16,781
Net transfers between classes	-	-	-	-	-	-	-	175
Depreciation and amortisation	-	(426)	(124)	(161)	(7,587)	(1,700)	(229)	(65,811)
Derecognition of controlled entity	-	-	-	(8)	-	(14)	-	-
Balance at 30 June 2025	**144,884**	**5,693**	**636**	**585**	**36,582**	**4,921**	**2,780**	**1,509,941**
Additions/ (disposals)	-	-	(199)	-	6,938	1,434	(2,983)	-
Net transfers between classes	-	-	88	-	493	159	1,528	-
Depreciation and amortisation	-	(426)	(116)	(99)	(7,817)	(1,550)	(149)	-
Transfer out of fair value hierarchy on transition to cost model (ii)	-	-	-	-	-	-	-	(1,509,941)
Balance at 30 June 2026	**144,884**	**5,266**	**408**	**486**	**36,195**	**4,964**	**1,177**	**-**

(i) Classified in accordance with the fair value hierarchy, refer Note 7.4.
(ii) PPP right-of-use assets are measured at cost from 1 July 2025 and are therefore no longer included within the fair value hierarchy.

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

Asset class	Valuation technique	Significant unobservable inputs
Specialised land	Market approach	Community service obligations adjustments(i)
Specialised buildings	Current replacement cost approach	Direct cost per square metre useful life of specialised buildings
Plant, equipment, furniture, fittings and vehicles	Current replacement cost approach	Useful life

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

Note 8: Other disclosure

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

Structure

Note 8.1: Reconciliation of net result to net cash flows from operating activities 113
Note 8.2: Responsible persons disclosures 114
Note 8.3: Remuneration of executives 115
Note 8.4: Related parties 116
Note 8.5: Remuneration of auditors 121
Note 8.6: Ex-gratia payments 121
Note 8.7: Events occurring after the balance sheet date 121
Note 8.8: Equity 121

Note 8.1: Reconciliation of net result to net cash flows from operating activities

	Note	2026	2025
		$'000	$'000
Net result for the year		**8,973**	**(29,643)**
Non-cash movements			
Depreciation and amortisation	4.2	83,306	82,147
Assets and services received free of charge		(1,693)	(25)
Amortisation of non-produced intangible assets		1,272	1,272
DH - indirect contribution on repayment of finance lease liabilities		(82,048)	(82,048)
DH - indirect contribution on building improvement		(20,206)	(12,064)
PPP non-cash finance lease interest expense		33,962	36,222
Written down value of assets disposed		9,681	232
Non-cash accounting adjustments in accordance with AASB 16		(1,037)	703
Movements included in investing and financing activities			
(Increase)/decrease in payables for capital items		(505)	(733)
GST paid for capital items		823	1,367
Capital donations received		(551)	(471)
Movements in assets and liabilities			
Change in operating assets and liabilities			
- (increase)/decrease in receivables		731	(5,911)
- (increase)/decrease in inventories		(7)	47
- (increase)/decrease in prepayments		(1,398)	(1,753)
- increase/(decrease) in payables		373	(10,620)
- increase/(decrease) in employee entitlements		9,097	11,386
- increase/(decrease) in other liabilities		(230)	(203)
Net cash inflow/(outflow) from operating activities		**40,544**	**(10,094)**

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Note 8.2: Responsible persons disclosures

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

	Period	
Responsible Ministers		
The Honourable Mary-Anne Thomas MP		
Minister for Health	1 July 2025	15 April 2026
Minister for Ambulance Services	1 July 2025	15 April 2026
The Honourable Harriet Shing MP		
Minister for Health	15 April 2026	30 June 2026
Minister for Ambulance Services	15 April 2026	30 June 2026
The Honourable Melissa Horne MP		
Minister for Health Infrastructure	1 July 2025	30 June 2026
The Honourable Ingrid Stitt MP		
Minister for Mental Health	1 July 2025	30 June 2026
Minister for Ageing	1 July 2025	30 June 2026
The Honourable Lizzy Blandthorn MP		
Minister for Children	1 July 2025	30 June 2026
Governing Board		
Prof Christine Kilpatrick AO (Chair)	1 July 2025	30 June 2026
Ms Elleni Bereded-Samuel AM	1 July 2025	30 June 2026
Mr Andrew Chan	1 July 2025	30 June 2026
A/Prof Richard Doherty	1 July 2025	30 June 2026
Ms Julie Green	1 July 2025	30 June 2026
Ms Pallavi Khanna	1 July 2025	30 June 2026
Mr Sameer Kumar	1 July 2025	30 June 2026
Mr Mark Rogers	1 July 2025	30 June 2026
Dr Michael Wildenauer	1 July 2025	30 June 2026
Accountable Officer		
Dr Peter Steer (Chief Executive Officer)	1 July 2025	30 June 2026

Remuneration of Responsible Persons

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

Income band	2026	2025
	No.	No.
$0 - $9,999	-	1
$40,000 - $49,999	8	7
$90,000 - $99,999	1	1

$250,000 - $259,999	-	1
$270,000 - $279,999	-	1
$280,000 - $289,999	-	1
$720,000 - $729,999	1	-
Total	**10**	**12**

Total remuneration		
	2026	**2025**
	$'000	**$'000**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to	1,194	1,237

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

Note 8.3: Remuneration of executives

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

	Total remuneration	
	2026	**2025**
	$'000	**$'000**
Short term employee benefits	2,700	2,224
Post employment benefits	258	221
Other long term benefits	319	123
Total remuneration	**3,277**	**2,569**
Total number of executives	**11**	**9**
Total annualised employee equivalent (AEE) (i)	**8.41**	**7.00**

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

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

Short-term employee benefits

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

Post-employment benefits

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

Other long-term benefits

Long service leave

Note 8.4: Related parties

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

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

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

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

Key management personnel

The Board of Directors and Executive Directors of the RCH are deemed to be KMPs.

This includes the following:

	Period	
Governing Board		
Prof Christine Kilpatrick AO (Chair)	1 July 2025	30 June 2026
Ms Elleni Bereded-Samuel AM	1 July 2025	30 June 2026
Mr Andrew Chan	1 July 2025	30 June 2026
A/Prof Richard Doherty	1 July 2025	30 June 2026
Ms Julie Green	1 July 2025	30 June 2026
Ms Pallavi Khanna	1 July 2025	30 June 2026
Mr Sameer Kumar	1 July 2025	30 June 2026
Mr Mark Rogers	1 July 2025	30 June 2026
Dr Michael Wildenauer	1 July 2025	30 June 2026
Accountable Officer		
Dr Peter Steer (Chief Executive Officer)	1 July 2025	30 June 2026
Executives		
A/Prof Thomas Connell (Executive Director Medical Service and Chief Medical Officer)	1 July 2025	30 June 2026
Mr Frank Vosnidis (Interim Chief Financial Officer)	1 July 2025	12 December 2025
Ms Claire Hare (Chief Financial Officer)	15 December 2025	30 June 2026
Ms Annabelle Mann (Chief Legal and Risk Officer)	1 July 2025	30 June 2026
Mr Douglas McCaskie (Executive Director Digital Health and Chief Allied Health Officer)	1 July 2025	30 June 2026
Ms Sandra Bell (Executive Director Strategy)	1 July 2025	30 November 2025
Dr Edward Oakley (Executive Director Strategy, Planning and Improvement and Chief of Critical Care)	1 July 2025	30 June 2026
Ms Joanne Miller (Interim Executive Director Access and Clinical Operations)	1 December 2025	17 May 2026
Ms Kim O'Sullivan (Executive Director Access and Clinical Operations)	18 May 2026	30 June 2026

Mr Clive Peter (Executive Director, People and Culture)	1 July 2025	30 June 2026
Mr Kogulan Ravindran (Chief of Staff and Executive Director Communications)	1 July 2025	30 June 2026
Ms Kathryn Riddell (Executive Director Nursing and Chief Nursing Officer)	1 July 2025	30 June 2026
Dr Michelle Telfer (Chief of Medicine) **Dr Nathalie Webb (Chief of Surgery)**	1 July 2025 1 July 2025	30 June 2026 30 June 2026

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

	Total compensation	
	2026	**2025**
	$'000	**$'000**
Short term employee benefits	5,493	4,790
Post employment benefits	461	427
Other long term benefits	414	139
Termination benefits	-	240
Total compensation	**6,368**	**5,596**

(i) KMP are also reported in note 8.2 Responsible persons or Note 8.3 Remuneration of Executives.
(ii) During 2025–26, the RCH expanded its assessment of KMP to include executives meeting the definition under AASB 124. The comparative has been updated to reflect the current assessment.

Significant transactions with government-related parties

The RCH received funding from government related entities of $775.5m (2025: $708.3m) and indirect contributions of $198.8m (2025: $176m).

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

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

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

Transactions with KMPs and other related parties

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

conditions consistent with the HealthShare Victoria and Victorian Government Procurement Board requirements.

Outside of normal citizen type transactions with the RCH, there were no related party transactions that involved key management personnel, their close family members or their personal business interests. No provision has been required, nor any expense recognised, for impairment of receivables from related parties. There were no related party transactions with Cabinet Ministers required to be disclosed in 2026 (2025: none).

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

The Royal Children's Hospital Foundation

One Board member, the Board Chair and the CEO of the RCH were Directors of the RCH Foundation during the 2025-26 financial year.

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

	2026	2025
	$'000	$'000
Distributions and reimbursements by The Royal Children's Hospital Foundation	45,592	50,858
Payments to The Royal Children's Hospital Foundation	251	-
Receivable from The Royal Children's Hospital Foundation	2,948	2,561

Murdoch Children's Research Institute

The Board Chair and the CEO of the RCH were Directors of Murdoch Children's Research Institute (MCRI) during the 2025-26 financial year.

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

	2026	2025
	$'000	$'000
Reimbursements by Murdoch Children's Research Institute	6,629	7,990
Payments to Murdoch Children's Research Institute	22,634	35,524
Receivable from Murdoch Children's Research Institute	443	476
Payable to Murdoch Children's Research Institute	1,797	1,293

Victorian Clinical Genetics Services

Victorian Clinical Genetics Services (VCGS) is a wholly owned subsidiary of MCRI of which the Board Chair and the CEO of the RCH were Directors during the 2025-26 financial year.

The transactions between the two entities relate to reimbursements made by VCGS to the RCH for goods and services paid on its behalf, as well as transactions relating to general research

funding, clinical supplies and support provided to VCGS. All dealings are in the normal course of business and are on normal commercial terms and conditions.

	2026	2025
	$'000	$'000
Reimbursements by Victorian Clinical Genetics Services	71	88
Payments to Victorian Clinical Genetics Services	1,369	1,631
Receivable from Victorian Clinical Genetics Services	2	3
Payable to Victorian Clinical Genetics Services	12	-

Victorian Managed Insurance Authority

The Board Chair was a Director of Victorian Managed Insurance Authority (VMIA) during the 2025-26 financial year. The transactions between the two entities relate to premiums paid for the RCH medical indemnity insurance. All dealings are in the normal course of business and are on normal commercial terms and conditions.

	2026	2025
	$'000	$'000
Payment to Victorian Managed Insurance Authority	13,490	-

(i) No comparative transactions are disclosed as the related party was newly appointed as KMP of the RCH during the 2025–26 financial year.

Melbourne Genomics

The CEO of the RCH was a Director of Melbourne Genomics during the 2025-26 financial year.

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

	2026	2025
	$'000	$'000
Reimbursements by Melbourne Genomics Health Alliance	-	138

Medibank Private

One Board member of the RCH was an employee of Medibank Private during the 2025-26 financial year.

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

	2026	2025
	$'000	$'000
Reimbursements by Medibank Private	5,288	5,359
Payments to Medibank Private	45	-
Receivable from Medibank Private	181	427

Australian Health Management (AHM)

AHM is a wholly owned subsidiary of Medibank Private of which one Board member of the RCH was an employee during the 2025-26 financial year.

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

	2026	2025
	$'000	$'000
Reimbursements by Australian Health Management	1,095	849
Receivable from Australian Health Management	39	127

Australian Catholic University

The CEO of the RCH was the Senate Member of Australian Catholic University (ACU) during the 2025-26 financial year. The transactions between the RCH and ACU consist of student placement for medical courses and delivery of workshop. All dealings are in the normal course of business and are on normal commercial terms and conditions.

	2026	2025
	$'000	$'000
Reimbursements by Australian Catholic University	168	77

Child and Adolescent Health Service

The CEO of the RCH was a Director of the Child and Adolescent Health Service during the 2025-26 financial year. The transactions between the RCH and the Child and Adolescent Health Service consist of license and services agreement to access neonatal resuscitation teaching resources and training materials. All dealings are in the normal course of business and are on normal commercial terms and conditions.

	2026	2025
	$'000	$'000
Reimbursements by Child and Adolescent Health Service	18	-

Children's Healthcare Australasia

The CEO of the RCH was a Director of Children's Healthcare Australasia during the 2025-26 financial year. The transactions between the RCH and Children's Healthcare Australasia consist of registrations for conferences, workshops and forums. All dealings are in the normal course of business and are on normal commercial terms and conditions.

	2026	2025
	$'000	$'000
Payment to Children's Healthcare Australasia	99	-
Payable to Children's Healthcare Australasia	7	-

Bendigo Health

One Board member was a Director of Bendigo Health during the 2025-26 financial year. The transactions between the two entities relate to reimbursements for paediatric surgery services provided by the RCH, and transactions relating to general research funding program. All dealings are in the normal course of business and are on normal commercial terms and conditions.

	2026	2025
	$'000	$'000
Reimbursement by Bendigo Health	191	-
Payment to Bendigo Health	508	-

(i) No comparative transactions are disclosed as the related party was newly appointed as KMP of the RCH during the 2025–26 financial year.

Note 8.5: Remuneration of auditors

	2026	2025
	$'000	$'000
Victorian Auditor-General's Office		
Audit of financial statements	292	254
	292	**254**

Note 8.6: Ex-gratia payments

	2026	2025
	$'000	$'000
The RCH has made the following ex gratia expenses:		
Forgiveness or waiver of debt	-	11
Compensation for economic loss	27	6
Total ex-gratia expenses	**27**	**16**

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

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

Note 8.7: Events occurring after the balance sheet date

There are no events occurring after the Balance Sheet date.

Note 8.8: Equity

Contributed capital

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

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

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

Property, plant and equipment revaluation surplus

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

Restricted specific purpose reserves

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



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