

Section 63 of the *Financial Accountability Act 2009* requires all agencies to prepare annual reports for tabling in the Legislative Assembly.

Annual reports are a key accountability document and the principal way agencies report on non-financial and financial performance.

The *Financial and Performance Management Standard 2009* mandates the disclosure of information detailed in the document *Annual report requirements for Queensland Government agencies* prepared by the Department of the Premier and Cabinet (DPC).

The Auditor-General notes that 'annual reports support transparency and can drive continuous improvement in performance. Where annual reports incorporate relevant and reliable performance information, they increase trust and confidence in government service delivery' (Auditor-General's Report to Parliament No. 4 for 2013–14 p.12).

The Gold Coast Health 2016–17 Annual Report is delivered in accordance with the above requirements and is compliant with the annual report requirements for Queensland Government agencies. Requirements can be found at www.forgov.qld.gov.au/manage-government-performance.

General information

Gold Coast Hospital and Health Service ('Gold Coast Health') is a statutory body established under the *Hospital and Health Boards Act 2011* and its registered trading name is Gold Coast Hospital and Health Service.

The head office and principal place of business of Gold Coast Health is Gold Coast University Hospital, 1 Hospital Boulevard, Southport QLD 4215.

A description of the nature of Gold Coast Health's operations and its principal activities is included in this Annual Report.

For information in relation to Gold Coast Health, please visit www.goldcoast.health.qld.gov.au.



Financial Statements

30 June 2017

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Gold Coast Hospital and Health Service

Statement of comprehensive income for the year ended 30 June 2017

	Note	2017 \$'000	2016 \$'000
Revenue			
Health service funding	5	1,234,756	1,166,779
User charges and fees	6	92,938	85,703
Grants and other contributions	7	19,439	19,276
Other revenue	8	5,821	5,946
Net revaluation increment	16	5,562	10,294
Total revenue		1,358,516	1,287,998
Expenses			
Employee expenses	9	(908,804)	(831,413)
Supplies and services	10	(354,894)	(358,204)
Grants and subsidies		(804)	(953)
Depreciation and amortisation	16/17	(79,165)	(77,553)
Impairment loss	11	(1,680)	(1,667)
Other expenses	12	(6,763)	(7,661)
Total expenses		(1,352,110)	(1,277,451)
Surplus for the year		6,406	10,547
Other comprehensive income for the year <i>Items that will not be reclassified subsequently to operating result:</i>			
– Increase in asset revaluation surplus	16	36,521	23,474
Total other comprehensive income		36,521	23,474
Total comprehensive income for the year		42,927	34,021

The above statement of comprehensive income should be read in conjunction with the accompanying notes.

Gold Coast Hospital and Health Service

Statement of financial position as at 30 June 2017

	Note	2017 \$'000	2016 \$'000
Assets			
Current assets			
Cash and cash equivalents	13	65,172	62,494
Receivables	14	28,136	20,987
Inventories	15	8,610	8,117
Prepayments		2,066	1,449
Total current assets		103,984	93,047
Non-current assets			
Property, plant and equipment	16	1,736,399	1,761,609
Intangibles	17	1,850	2,298
Total non-current assets		1,738,249	1,763,907
Total assets		1,842,233	1,856,954
Liabilities			
Current liabilities			
Payables	18	36,942	37,475
Accrued employee benefits	19	35,743	30,818
Unearned revenue	20	4,948	1,132
Total current liabilities		77,633	69,425
Total liabilities		77,633	69,425
Net assets		1,764,600	1,787,529
Equity			
Contributed equity		1,679,905	1,745,761
Accumulated surplus		16,019	9,613
Asset revaluation surplus	16	68,676	32,155
Total equity		1,764,600	1,787,529

The above statement of financial position should be read in conjunction with the accompanying notes.

Gold Coast Hospital and Health Service

Statement of changes in equity for the year ended 30 June 2017

	Note	Contributed Equity \$'000	Accumulated Surplus \$'000	Asset Revaluation Surplus \$'000	Total equity \$'000
Balance at 1 July 2015		1,801,445	(934)	8,681	1,809,192
Surplus for the year		-	10,547	-	10,547
<i>Other comprehensive income for the year</i>		-			
– Increase in asset revaluation surplus	16		-	23,474	23,474
Total comprehensive income for the year		-	10,547	23,474	34,021
<i>Transactions with owners in their capacity as owners:</i>					
Equity injections		20,582	-	-	20,582
Net non-current asset transfers	16	1,289	-	-	1,289
Equity withdrawals		(77,555)	-	-	(77,555)
Balance at 30 June 2016		1,745,761	9,613	32,155	1,787,529
Balance at 1 July 2016		1,745,761	9,613	32,155	1,787,529
Surplus for the year		-	6,406	-	6,406
<i>Other comprehensive income for the year</i>					
– Increase in asset revaluation surplus	16	-	-	36,521	36,521
Total comprehensive income for the year		-	6,406	36,521	42,927
<i>Transactions with owners in their capacity as owners:</i>					
Equity injections		13,316	-	-	13,316
Net non-current asset transfers	16	(7)	-	-	(7)
Equity withdrawals		(79,165)	-	-	(79,165)
Balance at 30 June 2017		1,679,905	16,019	68,676	1,764,600

The above statement of changes in equity should be read in conjunction with the accompanying notes.

Gold Coast Hospital and Health Service

Statement of cash flows for the year ended 30 June 2017

Note	2017 \$'000	2016 \$'000
Cash flows from operating activities		
Health service funding	1,153,633	1,114,149
User charges and fees	89,535	77,945
Grants and contributions	19,254	19,067
GST collected from customers	1,562	1,336
GST input tax credits from Australian Taxation Office	15,571	16,582
Other operating cash inflows	5,685	5,904
Employee expenses	(903,879)	(836,929)
Supplies and services	(356,511)	(354,818)
Grants and subsidies	(804)	(953)
GST paid to suppliers	(15,485)	(16,315)
GST remitted to Australian Taxation Office	(1,323)	(1,572)
Other operating cash outflows	(6,193)	(7,286)
Net cash from operating activities	13	1,045
Cash flows from investing activities		
Payments for property, plant and equipment	(12,614)	(17,451)
Payments for intangibles	-	(1,756)
Proceeds from sale of property, plant and equipment	931	65
Net cash used in investing activities		(19,142)
Cash flows from financing activities		
Equity injections	13,316	20,580
Net cash from financing activities		20,580
Net increase in cash and cash equivalents	2,678	18,548
Cash and cash equivalents at the beginning of the financial year	62,494	43,946
Cash and cash equivalents at the end of the financial year	13	62,494

The above statement of cash flows should be read in conjunction with the accompanying notes.

Gold Coast Hospital and Health Service

Notes to the financial statements

30 June 2017

Note 1. Significant accounting policies

The principal accounting policies adopted in the preparation of the financial statements are set out below. These policies have been consistently applied to all the years presented, unless otherwise stated.

(a) The reporting entity

Gold Coast Health is established under the *Hospital and Health Boards Act 2011*. Gold Coast Health is an independent statutory body and a reporting entity, which is domiciled in Australia. Accountable to the Minister for Health and to the Queensland Parliament, it is primarily responsible for providing quality and safe public hospital and health services and for the direct management of the facilities within the Gold Coast region. The ultimate parent entity is the State of Queensland.

These financial statements include the value of all revenue, expenses, assets, liabilities and equity of Gold Coast Health. Gold Coast Health does not have any controlled entities.

(b) Statement of compliance

Gold Coast Health has prepared these financial statements in compliance with section 62(1) of the *Financial Accountability Act 2009* and section 43 of the *Financial and Performance Management Standard 2009 (QLD)*. The financial statements are authorised for issue by the Board Chair and Chief Executive at the date of signing the management certificate.

These financial statements are general purpose financial statements and have been prepared on an accrual basis in accordance with Australian Accounting Standards and Interpretations. In addition, the financial statements comply with Queensland Treasury's Minimum Reporting Requirements for the year ended 30 June 2017, and other authoritative pronouncements.

With respect to compliance with Australian Accounting Standards and Interpretations, Gold Coast Health has applied those requirements applicable to not-for-profit entities. Except where stated, the historical cost convention is used.

Amounts in this report are in Australian dollars and have been rounded off to the nearest thousand dollars, or in certain cases, the nearest dollar.

There were no material restatements of the comparative information required to ensure consistency with current period disclosures.

(c) Basis of preparation

Gold Coast Health has prepared these financial statements on a going concern basis, which assumes that Gold Coast Health will be able to meet the payment terms of its financial obligations as and when they fall due. Gold Coast Health is economically dependent on funding received from its Service Agreement with the Department of Health ('the Department').

A Service Agreement Framework is in place in order to provide Gold Coast Health with a level of guidance regarding funding commitments and purchase activity for 2016–2017 to 2018–2019. The Board and management believe that the terms and conditions of its funding arrangements under the Service Agreement Framework will provide Gold Coast Health with sufficient cash resources to meet its financial obligations for at least the next year.

In addition to Gold Coast Health's funding arrangements under the Service Agreement Framework, Gold Coast Health has no intention to liquidate or to cease operations; and under section 18 of the *Hospital and Health Boards Act 2011*, Gold Coast Health represents the State of Queensland and has all the privileges and immunities of the State.

(d) Critical accounting estimates

The preparation of the financial statements necessarily requires the determination and use of certain critical accounting estimates, assumptions, and management judgements that have the potential to cause a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Such estimates, judgements and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised and in future periods as relevant.

Estimates and assumptions with the most significant effect on the financial statements are:

- Useful lives assessment – refer note 1(i)
- Land and building valuation assessment – refer note 1(j)
- Impairment of non-current assets – refer note 1(k)

(e) Health service funding

Health service funding is received as part of the Service Agreement between Gold Coast Health and the Department. The funding from the Department (excluding depreciation funding) is received in cash fortnightly in advance. Refer below for key types of funding and Gold Coast Health's revenue recognition policy.

Activity based funding (ABF)

ABF funding is provided according to the type and number of services purchased by the Department, based on a Queensland price for each type of service. ABF funding is received for acute inpatients, intensive care patients, sub-acute inpatients, emergency department presentations and outpatients. Revenue is recognised on the basis of purchased activity once delivered. Where actual activity exceeds purchased activity, additional funding is negotiated with the Department and accrued as an asset on the Statement of Financial Position where funding has been agreed to, but not yet received.

Non-activity based funding

Non-activity based funding is received for other services Gold Coast Health has agreed to provide per the Service Agreement with the Department. This funding has specific conditions attached that are not related to activity covered by ABF. This funding is recognised as revenue where the specific conditions have been met. Where conditions are not met, funding is renegotiated with the Department and may result in a deferral or return of revenue recognised as a liability on the Statement of Financial Position.

Depreciation and amortisation funding

The service agreement between the Department and Gold Coast Health specifies that the Department funds Gold Coast Health's depreciation and amortisation charges via non-cash revenue. The Department retains the cash to fund future major capital replacements. This transaction is shown in the Statement of Changes in Equity as a non-appropriated equity withdrawal.

(f) User charges and fees

User charges and fees are recognised as revenues when the revenue has been earned and can be measured reliably with a sufficient degree of certainty. Refer below for key types of user charges and revenue recognition policy.

Hospital fees and related services/goods

Hospital fees (mainly from private patients and patients ineligible for Medicare) are recognised as revenue when the services/goods have been provided, and cash is received or the invoice is raised. Where inpatients have not been discharged and therefore not invoiced, revenue is accrued on the Statement of Financial Position to the extent of services/goods provided. Revenue is recognised net of discounts provided in accordance with approved policies.

Granted private practice revenue

This revenue relates in part to fees generated by bulk billing services performed by doctors with an assignment private practice arrangement with Gold Coast Health. These fees are recognised as revenue when cash has been received by Gold Coast Health. In addition, service fees charged to doctors with a retention private practice arrangement with Gold Coast Health are recognised monthly based on a percentage of revenue which has been received by the practice in cash. See note 26.

Pharmaceutical Benefits Scheme

Reimbursements from the federal government under the Pharmaceutical Benefits Scheme are recognised when the revenue is received or accrued where a reliable estimate of the value of eligible drugs that have been distributed and claimed can be made, but the cash has not yet been received.

(g) Grants and contributions

Grants and contributions received that are non-reciprocal in nature are recognised in the year in which Gold Coast Health obtains control over them.

Contributed services are recognised only when a fair value can be measured reliably and the services would have been purchased if they had not been donated. Gold Coast Health receives corporate services support from the Department for no cost. Corporate services received include payroll services and accounts payable services. As the fair value of these services is unable to be estimated reliably, no associated revenue and expense is recognised.

(h) Employee expenses

Gold Coast Health is a prescribed employer (effective 1 July 2014) and as a result, all employees are deemed to be Gold Coast Health employees and related costs are recognised as employee expenses. Gold Coast Health also holds the liabilities for rostered days off, nurses' professional development and purchased leave entitlements for these employees.

Note 1. Significant accounting policies (continued)

The Director-General, Department of Health, is responsible for setting terms and conditions for employment, including remuneration and classification structures, and for negotiating enterprise agreements.

Classification of employee expenses

Employer superannuation contributions, annual leave levies and long service leave levies are regarded as employee benefits. Payroll tax and workers' compensation insurance are a consequence of employing employees, but are not counted in an employee's total remuneration package. They are not employee benefits and are recognised separately as employee related expenses.

Recoveries of costs associated with salaries and wages are offset against employee expenses.

Wages, Salaries and Sick Leave

Wages and salaries due but unpaid at reporting date are recognised in the Statement of Financial Position at the current salary rates. Unpaid entitlements are expected to be paid within 12 months and the liabilities are recognised at their undiscounted values.

Prior history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised. As sick leave is non-vesting, an expense is recognised for this leave as it is taken.

Annual Leave, Long Service Leave and Other Leave

Gold Coast Health participates in the Queensland Government's Annual Leave Central Scheme and Long Service Leave Scheme. Under the Annual Leave Central Scheme (established on 30 June 2008) and Long Service Leave Central Scheme (established on 1 July 1999), a levy is made on Gold Coast Health to cover the cost of employees' annual leave (including leave loading and on-costs) and long service leave. The levies are expensed in the period in which they are payable. Amounts paid to employees for annual leave and long service leave are claimed from the Schemes quarterly in arrears.

No provision for annual leave or long service leave is recognised as the liability is held on a whole-of-Government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting*.

Other leave relates to Rostered Days Off, Nurses Professional Development and Purchased leave entitlements. These liabilities are expected to be settled wholly within 12 months after the end of the period in which the employees render the related service. They are measured at the amounts expected to be paid when the liabilities are settled, and recognised at undiscounted values.

Superannuation

Employer superannuation contributions are paid to the employee's superannuation fund at rates prescribed by the government. Contributions are expensed in the period in which they are paid or payable. Gold Coast Health's obligation is limited to its contributions.

The superannuation schemes have defined benefit and contribution categories. The liability for defined benefits is held on a whole-of-Government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting*.

(i) Depreciation of non-current assets

Property, plant and equipment is depreciated on a straight-line basis. Annual depreciation is based on an assessment of the remaining useful life of individual assets. Land is not depreciated as it has an unlimited useful life. Assets under construction (work-in-progress) are not depreciated until they are ready for use as intended by management.

Any expenditure that increases the originally assessed capacity or service potential of an asset is capitalised and the new depreciable amount is depreciated over the remaining useful life of the asset. Where assets have separately identifiable components that are subject to regular replacement and these components have useful lives distinct from the asset to which they relate, they are separated into components and depreciated accordingly.

The estimated useful lives of assets are reviewed annually and where necessary, are adjusted to better reflect the pattern of consumption. The useful lives could change significantly as a result of events such as:

- the asset is technically obsolete; or
- non-strategic assets that have been abandoned or sold.

For each class of depreciable asset the following depreciation and amortisation rates are generally used:

Buildings	2.3%–6.3%
Leasehold improvements	6.7%–20.0%
Plant and equipment	
Computer Hardware and Motor Vehicles	20%
Engineering and Office Equipment	10%
Furniture and Fittings	5%
Medical equipment < \$200,000	6.7%–25%
Medical equipment > \$200,000	12.5%
Intangible Assets	20%

(j) Revaluations of non-current assets

Land and buildings are measured at fair value in accordance with AASB 116 *Property, Plant and Equipment*, AASB 13 *Fair Value Measurement* as well as Queensland Treasury's Non-Current Asset Policies for the Queensland Public Sector.

Gold Coast Health engage external valuers to determine fair value through either comprehensive revaluations and/or the indexation of the assets not subject to comprehensive revaluations. Comprehensive revaluations are undertaken at least once every five years. However, if a particular asset class experiences significant volatile changes in fair value, that class is subject to specific appraisal in the reporting period, where practicable, regardless of the timing of the last specific appraisal.

External valuers are selected based on market knowledge and reputation. Where there is a significant change in fair value of an asset or liability from one period to another, an analysis is undertaken, which includes a verification of the major inputs applied in the latest valuation and a comparison, where applicable, with external sources of data. Detailed disclosure of fair value methodology and inputs is included in Note 16.

Where indices are used, these are either publicly available, or are derived from market information available to the valuer. The valuer provides assurance of their robustness, validity and appropriateness for application to the relevant assets. Indices used are also tested for reasonableness by applying the indices to a sample of assets, comparing the results to similar assets that have been valued by the valuer, and analysing the trend of changes in values over time.

Any revaluation increment arising on the revaluation of an asset is credited to the asset revaluation surplus of the appropriate class, except to the extent it reverses a revaluation decrement for the class previously recognised as an expense. A decrease in the carrying amount on revaluation is charged as an expense, to the extent it exceeds the balance, if any, in the revaluation surplus relating to that asset class. On revaluation, for assets valued using a cost valuation approach, accumulated depreciation is restated proportionately with the change in the carrying amount of the asset and any change in the estimate of remaining useful life. On revaluation, for assets valued using a market approach, accumulated depreciation is eliminated against the gross amount of the asset prior to restating for valuation.

(k) Impairment of non-current assets

Property, plant and equipment and intangible assets are assessed for indicators of impairment on an annual basis in accordance with AASB 136 *Impairment of Assets*. If an indicator of impairment exists, Gold Coast Health determines the asset's recoverable amount (higher of value in use and fair value less costs to sell). Any amount by which the asset's carrying amount exceeds the recoverable amount is considered an impairment loss.

An impairment loss is recognised immediately in the Statement of Comprehensive Income, unless the asset is carried at a revalued amount. When the asset is measured at a revalued amount, the impairment loss is offset against the asset revaluation surplus of the relevant class to the extent available.

Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of its recoverable amount, so that the increased carrying amount does not exceed the carrying amount that would have been determined had no impairment loss been recognised for the asset in prior years. A reversal of an impairment loss is recognised as income, unless the asset is carried at a revalued amount, in which case the reversal of the impairment loss is treated as a revaluation increase to the carrying amount.

(l) Cash and cash equivalents

For the purposes of the Statement of Financial Position and the Statement of Cash Flows, cash assets include all cash and cheques receipted but not banked at 30 June.

Note 1. Significant accounting policies (continued)

(m) Receivables

Receivables comprise trade receivables, GST net receivables and other accrued revenue. Trade receivables are recognised at the amounts due at the time of sale or service delivery. Settlement of these amounts is required within 30 days from the invoice date.

The collectability of receivables is assessed periodically with provisions made for impairment. Increases in the allowance for impairment are based on loss events as disclosed in Note 14. All known bad debts are written off when identified.

The provision for impairment of receivables assessment requires a degree of estimation and judgement.

(n) Inventories

Inventories consist mainly of pharmaceutical supplies and clinical supplies held in wards for use throughout the hospitals. Inventories are measured at the lower of cost and net realisable value based on periodic assessments for obsolescence. Where damaged or expired items have been identified, provisions are made for impairment. Refer Note 15.

Consignment stock is held but is not recognised as inventory as it remains the property of the supplier until consumption. Upon consumption it is expensed as clinical supplies.

(o) Property, plant and equipment

Items of property, plant and equipment with a cost or other value equal to or more than the following thresholds are recognised for financial reporting purposes in the year of acquisition:

Buildings – \$10,000

Land – \$1

Plant and Equipment – \$5,000

Property, plant and equipment are initially recorded at consideration plus any other costs directly incurred in ensuring the asset is ready for use.

Assets acquired at no cost or for nominal consideration, other than from an involuntary transfer from another Queensland Government entity, are recognised at their fair value at date of acquisition in accordance with AASB 116 *Property, Plant and Equipment*.

(p) Intangible assets

Intangible assets with a cost or other value equal to or greater than \$100,000 are recognised in the financial statements. Items with a lesser value are expensed. Each intangible asset is amortised over its estimated useful life, currently 5 years. It has

been determined that there is not an active market for any of Gold Coast Health's intangible assets. As such, the assets are recognised and carried at cost less accumulated amortisation and accumulated impairment losses. Work in progress is for software developed in-house but not yet in use and will be amortised in the same way as purchased software.

(q) Payables

Trade creditors are recognised on receipt of the goods or services ordered and are measured at the agreed purchase or contract price, net of applicable trade and other discounts. Amounts owing are unsecured and are generally settled on 30 to 60 day terms.

(r) Provisions

Provisions are recorded when there is a present obligation, either legal or constructive as a result of a past event. They are recognised at the amount expected at reporting date for which the obligation will be settled in a future period. Where the settlement of the obligation is expected after 12 or more months, the obligation is discounted to the present value using an appropriate discount rate.

(s) Financial Instruments

Recognition

Financial assets and financial liabilities are recognised in the Statement of Financial Position when Gold Coast Health becomes party to the contractual provisions of the financial instrument.

Classification

Financial instruments are classified and measured as follows:

- cash and cash equivalents – held at fair value
- receivables – held at amortised cost
- payables – held at amortised cost.

Gold Coast Health does not enter into derivative and other financial instrument transactions for speculative purposes nor for hedging. Apart from cash and cash equivalents, Gold Coast Health holds no financial assets classified at fair value through profit and loss.

All other disclosures relating to the measurement and financial risk management of financial instruments are included in Note 21.

(t) Taxation

Gold Coast Health is a State body as defined under the *Income Tax Assessment Act 1936* and is exempt from Commonwealth taxation with the exception of Fringe Benefits Tax (FBT) and Goods and Services Tax (GST). All Queensland Hospital and Health

Services and the Department are grouped for the purposes of Section 149–25 *A New Tax System (Goods and Services Tax) Act 1999*.

Therefore all transactions made between the entities in the tax group do not attract GST, and all transactions external to the group are required to be accounted for GST where applicable. GST credits receivable from, and GST payable to the Australian Taxation Office are recognised.

(u) Leases

A distinction is made in the financial statements between finance leases that effectively transfer from the lessor to the lessee substantially all risks and benefits incidental to ownership, and operating leases, under which the lessor retains substantially all risks and benefits.

Operating lease payments are representative of the pattern of benefits derived from the leased assets and are expensed in the periods in which they are incurred.

(v) Trust transactions and balances

Gold Coast Health manages patient trust accounts transactions (fiduciary funds) as trustee. As Gold Coast Health acts only in a custodial role in respect of these transactions and balances, they are not recognised in the financial statements. Trust activities are included in the annual audit performed by the Auditor-General of Queensland and disclosed in Note 25.

(w) Private practice arrangements

Gold Coast Health administers the Private Practice arrangements. As Gold Coast Health acts only in an agency role in respect of these transactions and balances, they are not recognised in the financial statements. Fees collected under the scheme must be deposited initially into the private practice bank accounts and later distributed in accordance with the policy governing the private practice scheme. Private Practice funds are not controlled but the activities are included in the annual audit performed by the Auditor-General of Queensland and disclosed in Note 26.

(x) New, revised or amending Accounting Standards and Interpretations adopted

One Australian Accounting Standard has been adopted for the 2016–17 year as required by Queensland Treasury.

AASB 124 Related Party Disclosures

AASB 124 *Related Party Disclosures* became effective for the first time in 2016–17 for not-for-profit public sector entities. The amendments are of a disclosure nature only and have no impact on the line items in the financial statements. This standard requires disclosure about the key management personnel (KMP) remuneration and other related party transactions. As Queensland Treasury already required disclosure of KMP remuneration expenses, AASB 124 itself had minimal impact on the KMP disclosure compared to 2015–16. However, the standard has resulted in the responsible Minister being identified as part of Gold Coast Health's KMP from 2016–17. Remuneration details (including comparatives) have been disclosed in note 3 for KMP identified in 2016–2017. Material related party transaction information now required for 2016–17 is disclosed in Note 4. As this is the first year of application, comparative information is not required.

(y) New Accounting Standards and Interpretations not yet mandatory or early adopted

Australian Accounting Standards and Interpretations that have recently been issued or amended but are not yet mandatory, have not been early adopted by Gold Coast Health. Gold Coast Health's assessment of the impact of these new or amended Accounting Standards and Interpretations where applicable, are set out below.

AASB 1058 Income of Not-for-Profit Entities and AASB 15 Revenue from Contracts with Customers

These standards will first apply in Gold Coast Health's financial statements from 2019–20. AASB 15 *Revenue from Contracts* requires much more detailed requirements for the accounting for certain types of revenue from customers. Depending on the specific contractual terms, the new requirements may potentially result in a change to the timing of revenue from sales of Gold Coast Health's goods and services, such that some revenue may need to be deferred to a later reporting period to the extent that the service has not met its associated obligations. Further, under the new standards, grants presently recognised as revenue upfront may be eligible to be recognised as revenue progressively as the associated performance obligations are satisfied, but only if the associated performance obligations are enforceable and sufficiently specific.

Gold Coast Health is yet to complete its analysis of current arrangements for sale of its goods and services, but at this stage does not expect a significant impact on its present accounting practices.

Note 1. Significant accounting policies (continued)

AASB 9 Financial Instruments and AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)

AASB 9 *Financial Instruments* and AASB 2014-7 *Amendments to Australian Accounting Standards* arising from AASB 9 (December 2014) will become effective from reporting periods beginning on or after 1 January 2018. The main impacts of these standards on Gold Coast Health are that they will change the requirements for the classification, measurement, impairment and disclosures associated with financial assets. AASB 9 will introduce different criteria for whether financial assets can be measured at amortised cost or fair value.

The most likely ongoing disclosure impacts are expected to relate to the credit risk of financial assets subject to impairment. Gold Coast Health's receivables do not include a significant financing component and therefore impairment losses will be determined according to the amount of lifetime expected credit losses. As Gold Coast Health's receivables are short-term in nature, it is not expected that there will be a significant impact.

AASB 16 Leases

AASB 16 *Leases* will be effective for annual periods beginning on or after 1 January 2019. It supersedes:

- (a) AASB 117 *Leases*;
- (b) Interpretation 4 *Determining whether an Arrangement contains a Lease*;
- (c) SIC-15 *Operating Leases—Incentives*; and
- (d) SIC-27 *Evaluating the Substance of Transactions Involving the Legal Form of a Lease*.

This standard introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases (both operating and finance) with a term of more than 12 months, unless the underlying asset is of low value. A lessee is required to recognise a right-of-use asset representing its right to use the underlying asset and a lease liability representing its obligations to make lease payments. Lessors continue to classify leases as operating or finance. Presently Gold Coast Health has minimal non-cancellable operating leases with a term exceeding 12 months and as such it is not anticipated that the impact of changes to the accounting standards for leases will have a material impact.

Note 2. Budget vs Actual Comparison

This note provides an explanation for major variances between the original budget and actual performance for 2016–2017. An explanation has also been provided for health service funding revenue due to its significance.

The original budget is the budget part of the Queensland Health Service Delivery Statement which was published prior to the completion of service agreement negotiations.

Statement of Comprehensive Income

	Variance Notes	Original Budget 2017 \$'000	Actual 2017 \$'000	Variance \$'000
Revenue				
Health service funding	A	1,183,696	1,234,756	51,060
User charges and fees	B	86,345	92,938	6,593
Grants and other contributions	C	12,656	19,439	6,783
Other revenue	B	740	5,821	5,081
Net revaluation increment	F	-	5,562	5,562
Total revenue		1,283,437	1,358,516	75,079
Expenses				
Employee expenses	D	(865,404)	(908,804)	(43,400)
Supplies and services	E	(332,939)	(354,894)	(21,955)
Grants and subsidies		(1,323)	(804)	519
Depreciation and amortisation		(79,458)	(79,165)	293
Impairment loss		(950)	(1,680)	(730)
Other expenses		(3,363)	(6,763)	(3,400)
Total expenses		(1,283,437)	(1,352,110)	(68,673)
Surplus for the year		-	6,406	6,406
Other comprehensive income for the year <i>Items that will not be reclassified subsequently to operating result:</i>				
– Increase in asset revaluation surplus	F	-	36,521	36,521
Total other comprehensive income		-	36,521	36,521
Total comprehensive income for the year		-	42,927	42,927

Note 2. Budget vs Actual Comparison (continued)

Statement of Financial Position

	Variance Notes	Original Budget 2017 \$'000	Actual 2017 \$'000	Variance \$'000
Assets				
Current assets				
Cash and cash equivalents	G	20,309	65,172	44,863
Receivables	H	44,893	28,136	(16,757)
Inventories		8,106	8,610	504
Prepayments		1,537	2,066	529
Total current assets		74,845	103,984	29,139
Non-current assets				
Property, plant and equipment	I	1,761,957	1,736,399	(25,558)
Intangibles		727	1,850	1,123
Total non-current assets		1,762,684	1,738,249	(24,435)
Total assets		1,837,529	1,842,233	4,704
Liabilities				
Current Liabilities				
Payables	J	27,331	36,942	9,611
Accrued employee benefits	K	23,170	35,743	12,573
Unearned revenue		5,047	4,948	(99)
Total current liabilities		55,548	77,633	22,085
Net assets		1,781,981	1,764,600	(17,381)
Equity				
Contributed equity	L	1,669,505	1,679,905	10,400
Accumulated surplus/(deficit)		(933)	16,019	16,952
Asset revaluation surplus	F	113,409	68,676	(44,733)
Total equity		1,781,981	1,764,600	(17,381)

Statement of cash flows

	Variance Notes	Original Budget 2017 \$'000	Actual 2017 \$'000	Variance \$'000
Cash flows from operating activities				
Health service funding	A	1,104,239	1,153,633	49,394
User charges and fees	B	85,043	89,535	4,492
Grants and contributions	C	12,656	19,254	6,598
GST collected from customers	N	-	1,562	1,562
GST input tax credits from Australian Taxation Office	N	8,050	15,571	7,521
Other operating cash inflows	B	740	5,685	4,945
Employee expenses	D	(865,398)	(903,879)	(38,481)
Supplies and services	E	(330,907)	(356,511)	(25,604)
Grants and subsidies		(1,323)	(804)	519
GST paid to suppliers	N	(8,055)	(15,485)	(7,430)
GST remitted to Australian Taxation Office	N	-	(1,323)	(1,323)
Other operating cash outflows		(3,128)	(6,193)	(3,065)
Net cash from operating activities		1,917	1,045	(872)
Cash flows from investing activities				
Payments for property, plant and equipment	M	(6,389)	(12,614)	(6,225)
Payments for intangibles		-	-	-
Proceeds from sale of property, plant and equipment		(85)	931	1,016
Net cash used in investing activities		(6,474)	(11,683)	(5,209)
Cash flows from financing activities				
Equity injection	L	6,389	13,316	6,927
Net cash from financing activities		6,389	13,316	6,927
Net increase in cash and cash equivalents		1,832	2,678	846
Cash and cash equivalents at the beginning of the financial year		18,477	62,494	44,017
Cash and cash equivalents at the end of the financial year	G	20,309	65,172	44,863

Note 2. Budget vs Actual Comparison (continued)

Explanations of major variances

A. Health service funding variance

Health service funding revenue has increased by \$51.1 million due to additional patient activity (estimated actual weighted activity units are 212,284 compared with budgeted activity of 198,182) and additional funding for new enterprise bargaining agreements which took effect during 2016–2017 (\$22.0 million). This caused the corresponding increase in statement of cash flows of \$49.4 million.

B. User charges and fees variance

The combined user charges revenue and other revenue is higher than budget by \$11.7 million. Additional patient activity led to additional revenue from chargeable services. This also caused the corresponding combined increase in the statement of cash flows of \$9.4 million.

C. Grants and contributions variance

Grants revenue of \$19.4 million aligns to the funding agreements negotiated by Gold Coast Health with various State and Commonwealth government bodies for 2016–2017. The difference to budget relates to funding arrangements that were not confirmed before the finalisation of the budget. This also caused the corresponding increase in statement of cash flows of \$6.6 million.

D. Employee expenses variance

Employee expenses is \$43.4 million higher than budget due to the additional staff required to service the growth in demand for healthcare services, along with new enterprise bargaining agreements which took effect during 2016–2017 (\$22.0 million). The average number of full time equivalent staff for 2016–2017 is 7,360 compared to budget of 7,108. This also caused the corresponding increase in statement of cash flows of \$38.4 million.

E. Supplies and services variance

Supplies and services is \$22.0 million higher than budget due to the costs of external contractors (mainly nursing staff) not included in the supplies and services budget (\$17.7 million), additional costs related to the growth in demand for healthcare services (\$1.9 million) and costs associated with outsourcing services to ensure patients are treated within clinically recommended timeframes (\$2.4 million). This also caused the corresponding increase in statement of cash flows of \$25.6 million.

F. Net revaluation increment variance

The net revaluation increment totalling \$42.0 million (\$5.5 million in revenue and \$36.5m in other comprehensive income) is a result of land and building revaluation programs. The impact of

revaluations is different to the budgeted movement of \$53.0 million due to the unforeseen nature of market forces affecting revaluation calculations. The budget assumed the full impact would increase the asset revaluation reserve, resulting in a variance in other comprehensive income and asset revaluation reserve.

G. Cash and cash equivalents variance

The cash balance fluctuates due to the timing of receivables and payables. Refer to cash flow notes for more information.

H. Receivables variance

The receivables balance is lower than budget by \$16.7 million. The majority of this variance is caused by the unforeseeable nature of final amendments to funding in the Service Agreement with the Department.

I. Property, Plant and equipment variance

The property, plant and equipment balance is lower than budget by \$25.6 million. The majority of this variance is caused by lower than budget revaluation increment (see note F).

J. Payables variance

The variance to budget of payables is \$9.6 million and is due to a difference in the assumed impact of timing of payments to suppliers at the time of preparing the budget.

K. Accrued employee benefits variance

The variance to budget of accrued employee benefits is \$12.6 million and is due primarily to the impact of increased employee expenses (refer note D) and timing of payroll payment run.

L. Equity injection variance

The variance to budget in contributed equity of \$10.4 million was primarily due to equity injections. The equity injection of \$13.3 million reflects the Department of Health capital funding connected with the establishment of the Gold Coast University Hospital and replacement of critical medical equipment. This increased by \$6.9 million compared to budget due to the increased capital requirements arising from provision of new and/or expanded health care services.

M. Payments for property plant and equipment variance

Payments for property, plant and equipment (\$12.6 million) predominantly reflects the expenditure of the equity injection funding of \$13.3 million (see note L).

N. GST variance

Per Queensland Treasury Financial Reporting Requirements, GST inflows and outflows are reported separately in the financial statements. The net impact of the GST variance in the cash flow is only \$0.3 million.

Note 3. Key Management Personnel

The following details for key management personnel include those positions that had the authority and responsibility for planning, directing and controlling the major activities of the Gold Coast Health.

Minister

As from 2016–2017, the responsible Minister is identified as part of Gold Coast Health Key Management Personnel. The Honourable Cameron Dick is the Minister for Health and the Minister for Ambulance Services. No associated remuneration figures will be disclosed for the Minister, as Gold Coast Health does not provide the Minister’s remuneration.

Board

The Board members of Gold Coast Health as at 30 June 2017 and their positions are outlined below.

Name and position of current incumbents	Appointment authority	Appointment date
Board Chair – Mr Ian Langdon	Section 25(1)(a), HHB Act	01/07/2012 (Reappointed 18/05/2016)
Deputy Board Chair – Ms Teresa Dyson	Section 23, HHB Act	18/05/2016
Board Members		
Professor Allan Cripps	Section 23, HHB Act	01/07/2012 (Reappointed 17/05/2014)
Ms Colette McCool	Section 23, HHB Act	01/07/2012 (Reappointed 17/05/2014)
Dr Andrew Weissenberger	Section 23, HHB Act	01/09/2012 (Reappointed 17/05/2014)
Dr Cherrell Hirst	Section 23, HHB Act	17/05/2014 (Reappointed 26/06/2015)
Mr Robert Buker	Section 23, HHB Act	18/05/2016 (Reappointed 17/05/2017)
Professor Helen Chenery	Section 23, HHB Act	18/05/2016 (Reappointed 17/05/2017)
Professor Judy Searle	Section 23, HHB Act	18/05/2016 (Reappointed 17/05/2017)

The Board members perform the duties of the Board as prescribed in the HHB Act.

Membership of board committees as at 30 June 2017 is as follows:

Name and position of current incumbents	Executive Committee	Finance and Performance Committee	Audit and Risk Committee	Safety, Quality and Clinical Engagement Committee	Research Committee
Board Chair – Mr Ian Langdon	Chair	-	-	-	-
Deputy Board Chair – Ms Teresa Dyson	Member	Chair	Member	-	-
Professor Allan Cripps	-	Member	-	-	Chair
Ms Colette McCool	Member	-	Member	Chair	-
Dr Andrew Weissenberger	Member	-	-	Member	Member
Dr Cherrell Hirst	Member	-	Member	Member	-
Mr Robert Buker	-	Member	Chair	-	-
Professor Helen Chenery	-	Member	Member	-	Member
Professor Judy Searle	-	-	-	Member	Member

Note 3. Key Management Personnel (continued)

Executives

The Key Management Personnel – Executive level includes those positions that have responsibility for planning, directing and controlling the agency as a whole. Each member holds responsibility for their divisional, financial, operational and clinical performance.

Name and position of current incumbents	Appointment authority	Appointment date
Chief Executive – Mr Ron Calvert	SESL Contract – Section 33, HHB Act.	01/10/2012*
Chief Operations Officer – Ms Kimberley Pierce (previously named Executive Director, Operations)	HES3 Contract – Section 67, HHB Act.	15/08/2016
Executive Director, Finance and Business Services – Mr Ian Moody	HES3 Contract – Section 67, HHB Act.	04/12/2013
Executive Director, Clinical Governance, Education and Research – Professor Marianne Vonau	Medical Officer (Queensland Health) Certified Agreement (No. 4) 2015	01/09/2014
Executive Director, Digital Transformation Services – Mr Damian Green (previously named Executive Director, People, Systems and Performance up to 18/09/2016)	HES3 Contract – Section 67, HHB Act.	07/01/2013
Executive Director, People and Engagement – Ms Hannah Bloch (new position from 19/09/2016)	HES2 Contract – Section 67, HHB Act.	19/09/2016
Executive Director, Strategy and Planning – Ms Toni Peggrem	HES3 Contract – Section 67, HHB Act.	29/09/2014
Executive Director, Governance, Risk and Commercial Services – Ms Rebecca Freath	HES2 Contract – Section 67, HHB Act.	01/08/2014

* reappointed 20 June 2016

a) Remuneration

Remuneration policy for the Gold Coast Health Board are approved by the Governor in Council and the Chair, Deputy Chair and members are paid an annual fee consistent with the government procedures titled 'Remuneration procedures for part-time chairs and members of Queensland Government bodies'. Remuneration policy for Gold Coast Health Executive is set by the Director-General of the Department as provided for under the HHB Act. The remuneration and other terms of employment for are specified in individual employment contracts. Remuneration packages for key management personnel comprise the following components:

- Short term employee benefits which include: base salary, allowances and annual leave entitlements expensed for the entire year or for that part of the year during which the employee occupied the specified position. Non-monetary benefits consist of provision of vehicle together with fringe benefits tax applicable to the benefit.
- Long term employee benefits include amounts expensed in respect of long service leave.
- Post-employment benefits include amounts expensed in respect of employer superannuation obligations.
- Redundancy payments are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu of notice on termination, regardless of the reason for termination.
- Performance bonuses are not paid under the contracts in place.

Total fixed remuneration is calculated on a 'total cost' basis and includes the base and non-monetary benefits, long term employee benefits and post-employment benefits.

Due to a change in assessment of which positions constitutes Key Management Personal per Queensland Treasury Financial Reporting Requirements, there are additional positions published for the prior year that have not met the definition in the current year.

2017

	Short-term employee expenses		Post-employment expenses \$'000	Long-term employee expenses \$'000	Termination benefits \$'000	Total Expenses \$'000
	Monetary \$'000	Non-monetary \$'000				
Board						
Board Chair – Mr Ian Langdon	98	-	9	-	-	107
Board Chair – Ms Teresa Dyson	61	-	6	-	-	67
Board Members						
Professor Allan Cripps	51	-	5	-	-	56
Ms Colette McCool	55	-	5	-	-	60
Dr Andrew Weissenberger	53	-	5	-	-	58
Dr Cherrell Hirst	56	-	6	-	-	62
Mr Robert Buker	53	-	5	-	-	58
Professor Helen Chenery	54	-	5	-	-	59
Professor Judy Searle	50	-	5	-	-	55
Executive Management						
Chief Executive – Mr Ron Calvert	469	11	39	9	-	528
Chief Operations Officer (previously Executive Director, Operations) – Kimberley Pierce (from 15/08/16)	201	-	20	4	-	225
Executive Director, Finance and Business Services – Mr Ian Moody	237	-	24	5	-	266
Executive Director, Clinical Governance, Education and Research – Professor Marianne Vonau	424	-	32	8	-	464
Executive Director, Digital Transformation Service (previously Executive Director, People, Systems and Performance) – Mr Damian Green	234	-	18	4	-	256
Executive Director, People and Engagement – Ms Hannah Bloch (from 19/09/16)	158	-	16	3	-	177
Executive Director, Strategy and Planning – Ms Toni Peggrem	210	-	20	4	-	234
Executive Director, Governance, Risk and Commercial Services – Ms Rebecca Freath	188	-	19	4	-	211

Note 3. Key Management Personnel (continued)

2016

	Short-term employee expenses		Post-employment expenses \$'000	Long-term employee expenses \$'000	Termination benefits \$'000	Total Expenses \$'000
	Monetary \$'000	Non-monetary \$'000				
Board						
Board Chair – Mr Ian Langdon	96	-	8	-	-	104
Deputy Board Chair – Mr Kenneth Brown (To 17/05/2016)	49	-	5	-	-	54
Deputy Board Chair – Ms Teresa Dyson (From 18/05/2016)	6	-	-	-	-	6
Board Members						
Professor Allan Cripps	51	-	5	-	-	56
Ms Colette McCool	52	-	6	-	-	58
Ms Pauline Ross (To 17/05/2016)	43	-	5	-	-	48
Dr Andrew Weissenberger	48	-	4	-	-	52
Dr Cherrell Hirst	53	-	5	-	-	58
Mr Robert Buker (From 18/05/2016)	5	-	1	-	-	6
Professor Helen Chenery (From 18/05/2016)	4	-	-	-	-	4
Professor Judy Searle (From 18/05/2016)	3	-	-	-	-	3

2016

	Short-term employee expenses		Post-employment expenses \$'000	Long-term employee expenses \$'000	Termination benefits \$'000	Total Expenses \$'000
	Monetary \$'000	Non-monetary \$'000				
Executive Management Team						
Chief Executive – Mr Ron Calvert	362	10	30	7	-	409
Executive Director, Operations – Ms Jane Hancock	208	-	21	4	-	233
Executive Director, Finance and Business Services – Mr Ian Moody	229	-	23	4	-	256
Executive Director, Clinical Governance, Education and Research – Professor Marianne Vonau	434	-	31	8	-	473
Executive Director, People, Systems and Performance – Mr Damian Green	223	-	22	4	-	249
Executive Director, Strategy & Planning – Ms Toni Peggrem	204	-	15	4	-	223
Executive Director, Governance, Risk and Commercial Services – Ms Rebecca Freath	191	-	19	4	-	214
General Manager, Specialty and Procedural Services – Mr Brendan Docherty (To 21/02/2016)	118	-	11	2	-	131
A/General Manager, Specialty and Procedural Services – Mr Colin Dawson (From 22/02/2016)	50	-	6	1	-	57
Clinical Director, Specialty and Procedural Services – Dr Deborah Bailey	439	-	30	9	-	478
General Manager, Diagnostic, Emergency and Medical Services – Ms Kimberley Pierce	196	-	19	4	-	219
Clinical Director, Diagnostic, Emergency and Medical Services – Dr Mark Forbes	449	1	30	9	-	489

Note 3. Key Management Personnel (continued)

2016

	Short-term employee expenses		Post-employment expenses \$'000	Long-term employee expenses \$'000	Termination benefits \$'000	Total Expenses \$'000
	Monetary \$'000	Non-monetary \$'000				
General Manager, Mental Health and Specialist Services – Ms Karlyn Chettleburgh	210	1	21	4	-	236
Clinical Director, Mental Health and Specialist Services – Dr Kathryn Turner	397	2	25	8	-	432
General Manager, Cancer, Access and Support Services – Ms Alison Ewens	200	-	20	4	-	224
Clinical Director, Cancer, Access and Support Services – Dr Jeremy Wellwood	443	-	31	9	-	483
Senior Director, Clinical Governance and Community Partnerships – Ms Morven Gemmill (To 28/08/2015)	35	-	2	-	83	120
Senior Director, Clinical Governance and Community Partnerships – Ms Erin Finn (From 11/01/2016)	136	-	15	3	-	154
Professor Nursing and Midwifery – Professor Anita Bamford-Wade	186	-	18	4	-	208
Professor Allied Health – Professor Sharon Mickan	179	-	18	3	-	200
Director of Nursing, Diagnostic, Emergency and Medical Services – Ms Paula Duffy	159	-	18	3	-	180
Director of Nursing, Cancer, Access and Support Services – Mr Matthew Lunn	154	-	17	3	-	174
Director of Nursing, Mental Health and Specialist Services – Ms Diana Grice	162	-	18	3	-	183
Director of Nursing, Specialty and Procedural Services – Mr Paul Nieuwenhoven	118	-	13	2	-	133

Note 4. Related Parties

Gold Coast Health is controlled by its ultimate parent entity, the State of Queensland. All State of Queensland controlled entities meet the definition of a related party in AASB 124 *Related Party Disclosures*.

Transactions with other Queensland Government-controlled entities

Department of Health

Gold Coast Health receives funding in accordance with a service agreement with the Department. The Department receives its revenue from the Queensland Government (majority of funding) and the Commonwealth. The signed service agreements are published on the Queensland Government website and publically available. The original 2016–17 service agreement was for \$1,289,624,770.

In addition, the Department provides free of charge a number of services including accounts payable, procurement, payroll and information technology infrastructure and support services.

Queensland Treasury Corporation

Gold Coast Health has accounts with the Queensland Treasury Corporation (QTC) for general trust monies. The amount held by QTC is disclosed in Note 13.

Department of Housing and Public Works

Gold Coast Health pays rent to the Department of Housing and Public Works (DHPW) for a number of properties. In addition, the Department of Housing and Public Works provides fleet management services (Qfleet) to Gold Coast Health. The amount paid to DHPW in 2016–2017 was \$3.1m.

Other Hospital and Health Service entities

Payments to and receipts from other Hospital and Health service entities in Queensland occur to facilitate the transfer of patients, drugs, staff and other services shared. Payments in 2016–2017 approximated \$1.2m.

Transactions with people/entities related to Key Management Personnel

A member of the Gold Coast Health Board is also a Board member of the Gold Coast Hospital Foundation (a separate entity to Gold Coast Health), which has provided free equipment, resources and services to Gold Coast Health in accordance with their objectives identified in the *Hospitals Foundations Act 1982 (Qld)*.

All other transactions in the year ended 30 June 2017 between Gold Coast Health and key management personnel, including their related parties were on normal commercial terms and conditions and were immaterial in nature.

Note 5. Health service funding

	2017 \$'000	2016 \$'000
Activity based funding	942,965	924,654
Non-activity based funding	212,626	164,572
Depreciation funding	79,165	77,553
Total health service funding	1,234,756	1,166,779

Note 6. User charges and fees

	2017 \$'000	2016 \$'000
Hospital fees and related services/goods	33,022	29,234
Private practice revenue	13,854	13,561
Pharmaceutical benefits scheme	37,435	35,744
Other goods and services	8,627	7,164
Total user charges and fees	92,938	85,703

Note 7. Grants and other contributions

	2017 \$'000	2016 \$'000
Commonwealth grants and contributions	13,355	13,723
Other grants and contributions	4,484	4,206
Donations other	1,415	1,137
Donations non-current physical assets	185	210
Total grants and contributions	19,439	19,276

Note 8. Other revenue

	2017 \$'000	2016 \$'000
Interest	198	224
Minor capital recoveries	983	2,000
Rental income	2,196	2,073
Gain on sale of property plant and equipment	135	42
Other	2,309	1,607
Total other revenue	5,821	5,946

Note 9. Employee expenses

	2017 \$'000	2016 \$'000
Employee expenses		
<i>Employee benefits</i>		
Wages and salaries	717,904	657,294
Annual Leave	86,362	77,113
Superannuation	75,450	69,040
Long Service Leave	15,256	14,008
Termination payments	612	380
<i>Employee related expenses</i>		
Other employee related expenses	7,019	7,401
Workers compensation premium	6,198	6,174
Payroll tax	3	3
Total employee expenses	908,804	831,413

The number of employees of Gold Coast Health at 30 June 2017 measured on a full-time equivalent basis (reflecting Minimum Obligatory Human Resource Information) is 7,436 (30 June 2016: 7,279).

Note 10. Supplies and services

	2017 \$'000	2016 \$'000
Building services	418	482
Catering and domestic supplies	10,160	12,992
Clinical supplies and services	99,816	98,665
Communications	13,304	12,650
Computer services	13,198	7,399
Consultants	1,051	1,690
Contractors and external labour	17,653	21,765
Drugs	54,020	51,423
Expenses relating to capital works	1,915	4,149
Insurance premiums (Queensland Government Insurance Fund) *	12,766	11,469
Interstate patient expenses	49,240	49,014
Motor vehicles	1,271	1,177
Operating lease rentals	4,041	3,887
Outsourced service delivery	24,333	27,273
Repairs and maintenance	24,885	32,051
Travel – patients	4,697	4,799
Travel – staff	1,145	1,252
Utilities	14,363	10,583
Other	6,618	5,484
Total supplies and services	354,894	358,204

* Gold Coast Health is covered by the Department's insurance policy with the Queensland Government Insurance Fund (QGIF). Gold Coast Health pays a fee to the Department as part of a fee-for-service arrangement.

Note 11. Impairment loss

	2017 \$'000	2016 \$'000
Impairment on receivables	(1,680)	(1,400)
Impairment on intangibles	-	(267)
Total impairment loss	(1,680)	(1,667)

Note 12. Other expenses

	2017 \$'000	2016 \$'000
Advertising	369	560
Ex-gratia payments*	140	19
External audit fees**	237	229
Insurance – other	125	200
Internal audit fees	340	251
Interpreter fees	908	952
Inventory written off	167	170
Legal Fees	581	798
Losses from the disposal of non-current assets	569	373
Other expenses	3,327	4,109
Total other expenses	6,763	7,661

*Ex-gratia payments are special payments that Gold Coast Health is not contractually or legally obligated to make to other parties and include payments to patients and staff for damaged or lost property. In compliance with the *Financial and Performance Management Standard 2009*, Gold Coast Health maintains a register setting out details of all special payments greater than \$5,000. Three payments for patient and employee related matters exceeded the \$5,000 threshold in 2016–2017.

**Total audit fees paid or accrued to the Queensland Audit Office for the financial statement audit were \$237,000 (2016: \$240,000). There are no non-audit services included in this amount.

Note 13. Current assets – Cash and cash equivalents

	2017 \$'000	2016 \$'000
Cash on hand	23	33
Cash at bank	57,842	55,316
QTC Cash Fund	7,307	7,145
Total cash	65,172	62,494

a) Restricted Cash

Gold Coast Health receives cash contributions from private practice arrangements (refer to Note 26) for education, study and research in clinical areas, and from external parties in the form of gifts, donations and bequests for stipulated purposes. This money is retained separately and payments are only made from the General Trust Fund for the specific purposes upon which contributions were received.

b) Effective Interest Rate

Cash deposited with the Queensland Treasury Corporation earns interest at a rate of 2.43% per annum (2016: 2.78%). No interest is earned on other bank accounts.

c) Reconciliation of surplus to net cash from operating activities

	2017 \$'000	2016 \$'000
Surplus for the year	6,406	10,547
Adjustments for:		
Depreciation and amortisation	79,165	77,553
Net loss on disposal of property, plant and equipment	569	373
Net revaluation (increment)	(5,562)	(10,294)
Impairment loss on intangibles	-	267
Depreciation and amortisation funding	(79,165)	(77,553)
Other	(317)	(249)
Change in operating assets and liabilities:		
(Increase)/Decrease in receivables	(7,149)	22,912
(Increase) in inventories	(493)	(189)
(Increase) in prepayments	(617)	(447)
(Decrease)/Increase in payables	(533)	3,622
Increase/(Decrease) in other employee benefits	4,925	(5,516)
Increase/(Decrease) in unearned revenue	3,816	(3,916)
Net cash from operating activities	1,045	17,110

Note 14. Current assets – Receivables

	2017 \$'000	2016 \$'000
Trade receivables	13,370	11,732
Less: Provision for impairment of receivables	(4,133)	(4,228)
	9,237	7,504
GST input tax credits receivable	1,683	1,769
GST payable	(325)	(86)
	1,358	1,683
Health service funding accrued	11,960	6,020
Other accrued revenue	5,581	5,780
Total receivables	28,136	20,987

a) Impaired trade receivables

Impairment is based on a specific review of individual trade debtors at risk for either actual loss events or past experiences in relation to these loss events. These loss events mainly relate to unrecoverable debts from individuals ineligible for Medicare. Total impairment loss recognised in the operating result was:

	2017 \$'000	2016 \$'000
Impairment losses on receivables	1,331	1,183
Bad debts written off	349	217
Total impairment loss	1,680	1,400

Movements in the provision for impairment of receivables are as follows:

	2017 \$'000	2016 \$'000
Opening balance	4,228	3,928
Additional provisions recognised	1,331	1,183
Receivables written off during the year as uncollectable	(1,426)	(883)
Closing balance	4,133	4,228

The aging of the impaired receivables provided for above is as follows:

	2017 \$'000	2016 \$'000
0–30 days	127	112
31–60 days	132	139
61–90 days	147	387
More than 90 days	3,727	3,590
Total impaired receivables	4,133	4,228

b) Past due but not impaired

The aging of the past due but not impaired receivables is as follows:

	2017 \$'000	2016 \$'000
0–30 days	-	-
31–60 days	2,231	2,337
61–90 days	798	750
More than 90 days	439	135
Total past due but not impaired	3,468	3,222

Based on credit history and other information, it is expected that these amounts will be received.

Note 15. Current assets – Inventories

	2017 \$'000	2016 \$'000
Pharmaceutical and clinical supplies	8,302	8,000
Less: Provision for impairment	(109)	(109)
Catering and domestic supplies	347	188
Other Supplies	70	38
Total inventories	8,610	8,117

Note 16. Non-current assets – Property, plant and equipment

	2017 \$'000	2016 \$'000
Land – at independent valuation	86,008	81,200
Buildings – at independent valuation	1,848,621	1,793,136
Less: Accumulated depreciation	(291,005)	(214,306)
	1,557,616	1,578,830
Plant and equipment – at cost	180,839	175,027
Less: Accumulated depreciation	(89,016)	(74,464)
	91,823	100,563
Capital works in progress – at cost	952	1,016
Total property, plant and equipment	1,736,399	1,761,609

Note 16. Non-current assets – Property, plant and equipment (continued)

a) Movement reconciliation

Reconciliations of the written down values at the beginning and end of the current and previous financial year are set out below:

	Land \$'000	Buildings \$'000	Plant and Equipment \$'000	Work-in- Progress \$'000	Total \$'000
Balance at 30 June 2015	70,906	1,609,979	104,819	527	1,786,231
Additions	-	461	9,052	7,938	17,451
Disposals	-	-	(373)	-	(373)
Revaluation increments	10,294	23,474	-	-	33,768
Donations received	-	-	184	-	184
Net transfers from the Department	-	1,289	-	-	1,289
Transfers in/(out)	-	2,312	5,137	(7,449)	-
Depreciation expense	-	(58,685)	(18,256)	-	(76,941)
Balance at 30 June 2016	81,200	1,578,830	100,563	1,016	1,761,609
Additions	-	-	7,642	4,972	12,614
Disposals	(754)	(35)	(579)	-	(1,368)
Revaluation increments	5,562	36,521	-	-	42,083
Donations received/made	-	-	185	-	185
Net transfers from the Department	-	-	(7)	-	(7)
Transfers in/(out)	-	2,071	2,965	(5,036)	-
Depreciation expense	-	(59,771)	(18,946)	-	(78,717)
Balance at 30 June 2017	86,008	1,557,616	91,823	952	1,763,399

b) Valuations of land and buildings

Fair value is the price that would be received by using assets in their highest and best use or by selling it to another market participant that would use the assets in their highest and best use, regardless of whether that price is directly derived from observable inputs or estimated using another valuation technique. All Gold Coast Health assets are currently used in line with their highest and best use.

Observable inputs are publicly available data that are relevant to the characteristics of the asset being valued. Examples for Gold Coast Health include, but are not limited to, published sales data for land and general buildings. Unobservable inputs are data, assumptions and judgements that are not publicly available, but are relevant to the characteristics of the asset being valued. Examples for Gold Coast Health include, but are not limited to, internal records of construction costs, assessment of physical condition and remaining useful life. Unobservable inputs are used to the extent that sufficient relevant and reliable observable inputs are not available for similar assets.

Land

The State Valuation Service performed a comprehensive valuation of all land holdings, with an effective valuation date of 30 June 2017. The valuation is based on a market approach. Key inputs into the valuation include publicly available data on sales of similar land in nearby localities in the 12 months prior to the date of revaluation. Adjustments were made to the sales data to take into account the location, size, street/road frontage and access, and any significant restrictions for each individual parcel of land.

Previously, the State Valuation Service had performed a comprehensive valuation of all land holdings in 2013–14 with an index applied in 2014–2015 and 2015–2016. The indices provided by the State Valuation Service were derived from data on land sales in respective areas.

Buildings

AECOM Australia Pty Ltd performed a comprehensive valuation of all buildings measured on a current replacement cost basis (effective valuation date of 30 June 2017), except one building held at market value which was not revalued due to immateriality in 2016–2017. Key inputs into the valuation on replacement cost basis included internal records of the original cost of the specialised fit out and more contemporary design/construction costs published for various standard components of buildings. Significant judgement was also used to assess the remaining service potential of the buildings given local environmental conditions and the records of the current condition of the building.

Previously, Davis Langdon (now part of AECOM Australia Pty Ltd) had performed comprehensive valuations for 84 percent of the gross value of the building portfolio in 2013–2014. This included valuations of Gold Coast University Hospital and the Southport Health Precinct. In 2015–2016 (and 2014–2015 except for one property which was comprehensively revalued) an indexation rate determined by Davis Langdon was applied to the building portfolio.

The revaluation increment/decrement is shown below:

	2017 \$'000	2016 \$'000
Recognised in operating result:		
Land revaluation increment	5,562	10,294
Net building revaluation increment	-	-
Net revaluation increment	5,562	10,294
Recognised in other comprehensive income:		
Land revaluation increment	-	-
Net building revaluation increment	36,521	23,474
Net revaluation increment	36,521	23,474

The asset revaluation surplus in the statement of financial position as at 30 June 2017 (\$68.7 million) relates solely to the building revaluation increments.

Note 16. Non-current assets – Property, plant and equipment (continued)

c) Fair value hierarchy classification

The fair value hierarchy classification is based on the lowest level of input that is significant to the entire fair value measurement, being:

- Level 1: Quoted prices (unadjusted) in active markets for identical assets or liabilities at the measurement date
- Level 2: Inputs other than quoted prices included within Level 1 that are observable, either directly or indirectly
- Level 3: Unobservable inputs for the asset or liability

Land valued with reference to an active market is classified as Level 2. Buildings valued with reference to an active market are classified as Level 2. Purpose-built hospital buildings valued without reference to an active market are valued using the depreciated replacement cost methodology and classified as Level 3.

	Level 1 \$'000	Level 2 \$'000	Level 3 \$'000	Total \$'000
2017				
<i>Assets</i>				
Land	-	86,008	-	86,008
Buildings	-	1,914	1,555,702	1,557,616
Total assets	-	87,922	1,555,702	1,643,624
2016				
<i>Assets</i>				
Land	-	81,200	-	81,200
Buildings	-	1,615	1,577,215	1,578,830
Total assets	-	82,815	1,577,215	1,660,030

The movements associated with Level 3 assets are shown below:

	2017 \$'000	2016 \$'000
Balance at 30 June 2016	1,577,215	1,608,312
Transfers into Level 3 from Level 2	426	-
Additions	-	461
Disposals	(18)	-
Revaluation increments	36,388	23,472
Net transfers from the Department	-	1,289
Transfers in/(out)	1,334	2,312
Depreciation	(59,643)	(58,631)
Balance at 30 June 2017	1,555,702	1,577,215

Note 17. Non-current assets – Intangibles

	2017 \$'000	2016 \$'000
Software purchased – at cost	939	3,794
Less: Accumulated amortisation	(627)	(3,373)
	312	421
Software developed	2,091	428
Less: Accumulated amortisation	(553)	(214)
	1,538	214
Software work in progress – at cost	-	1,663
Total intangibles	1,850	2,298

a) Movement reconciliation

Reconciliations of the written down values at the beginning and end of the current and previous financial year are set out below:

	Work-in-Progress \$'000	Purchased \$'000	Developed \$'000	Total \$'000
Balance at 30 June 2015	267	833	321	1,421
Additions	1,663	93	-	1,756
Transfers In/(out)	-	-	-	-
Amortisation expense	-	(505)	(107)	(612)
Impairment	(267)	-	-	(267)
Balance at 30 June 2016	1,663	421	214	2,298
Additions	-	-	-	-
Disposals	-	-	-	-
Transfers In/(out)	(1,663)	-	1,663	-
Amortisation expense	-	(109)	(339)	(448)
Impairment	-	-	-	-
Balance at 30 June 2017	-	312	1,538	1,850

Note 18. Current liabilities – Payables

	2017 \$'000	2016 \$'000
Trade and other payables	8,680	9,914
Payables to the Department	2,057	2,921
Accrued expenses	26,205	24,640
Total payable	36,942	37,475

Note 19. Current liabilities – Accrued employee benefits

	2017 \$'000	2016 \$'000
Wages and salaries payables	32,109	27,977
Superannuation payable	3,634	2,841
Total accrued employee benefits	35,743	30,818

Note 20. Current liabilities – Unearned revenue

	2017 \$'000	2016 \$'000
Health service funding unearned revenue	4,926	1,073
Other unearned revenue	22	59
Total unearned revenue	4,948	1,132

Note 21. Financial instruments

Gold Coast Health's activities expose it to a variety of financial risks – interest risk, credit risk and liquidity risk. Financial risk management is implemented pursuant to Gold Coast Health's Financial Management Practice Manual. Overall financial risk is managed in accordance with written principles of Gold Coast Health for overall risk management, as well as policies covering specific areas.

The carrying amounts of cash, trade and other receivables and trade and other payables are assumed to approximate their fair values as disclosed on the Statement of Financial Position due to their short-term nature.

Interest Risk

Gold Coast Health is exposed to interest rate risk through its cash deposited in interest bearing accounts. Changes in interest rates have had a minimal impact on the operating result.

Credit risk

Credit risk exposure refers to the situation where Gold Coast Health may incur financial loss as a result of another party to a financial instrument failing to discharge their obligation. The maximum exposure to credit risk at balance date is equal to the gross carrying amount of the financial asset, inclusive of any provisions for impairment. As such, the gross carrying amount of cash and cash equivalents as well as receivables represents the maximum exposure to credit risk. See Note 14 for further information on impairment of receivables.

Liquidity risk

Liquidity risk refers to the situation where Gold Coast Health may encounter difficulty in meeting obligations associated with financial liabilities that are settled by delivering cash or another financial asset.

Gold Coast Health is exposed to liquidity risk in respect of its payables. Exposure to liquidity risk is reduced by ensuring that sufficient funds are available to meet employee and supplier obligations as they fall due. This is achieved by ensuring that minimum levels of cash are held within the various bank accounts so as to match the expected incidence and duration of the various employee and supplier liabilities. Gold Coast Health has an approved overdraft facility of \$7.5 million under whole-of-Government banking arrangements to manage any unexpected short term cash shortfalls. This facility has not been drawn down as at 30 June 2017.

Gold Coast Health's trade and other payables are expected to be settled within 30–60 days.

Note 22. Contingent liabilities

The following cases were filed in the courts naming the State of Queensland acting through Gold Coast Health as the defendant:

	2017 cases	2016 cases
Supreme Court	3	3
District Court	4	6
Magistrates Court	1	1
Tribunals, commissions and boards	2	0
Total cases	10	10

It is not possible to make a reliable estimate of the final amount payable, if any, in respect of litigations before the courts at this time. Any amount payable would be covered by the Queensland Government Insurance Fund (QGIF). Gold Coast Health's maximum exposure under the QGIF policy is \$20,000 excess for each insurable event. Tribunals, commissions and boards include matters that may never be litigated or result in payments to claims.

Note 23. Commitments

Non-cancellable operating leases

Commitments at the reporting date under non-cancellable operating leases are inclusive of GST and payable as follows:

	2017 \$'000	2016 \$'000
Within one year	2,523	2,712
One to five years	2,509	4,319
	5,032	7,031

Operating leases are entered into as a means of acquiring access to office accommodation and fleet vehicles and contain no restrictions on cancellation. Lease payments are generally fixed, but with standard inflation escalation clauses.

Consistent with prior year, there are no capital expenditure (property, plant and equipment and intangible), other expenditure or grants and subsidies commitments.

Lessor Commitments

Minimum lease commitments receivable but not recognised in the financial statements:

	2017 \$'000	2016 \$'000
Within one year	1,547	1,477
One to five years	657	2,083
	2,204	3,560

Gold Coast Health is the beneficiary of rental income arising from the sub-lease of clinical, retail and office accommodation to third parties. Lease receipts are generally fixed, but with inflation escalation clauses.

Note 24. Service Concession Arrangements

SurePark Pty Ltd was appointed in July 2010 to build, own, operate and transfer the Gold Coast University Hospital western car park (land owned by Gold Coast Health). The arrangement is for a period of 31 years. There was no revenue received from SurePark Pty Ltd and no upfront payments were made. Gold Coast Health does not control the facility and therefore it is not recognised as an asset of Gold Coast Health.

Healthscope Ltd was appointed in February 2012 to build, own, operate and transfer a private hospital facility in the southeast corner of the Gold Coast University Hospital campus (land owned by Gold Coast Health). The arrangement is from 12 March 2016 for a period of 50 years with possible extensions. No upfront payments were made. Gold Coast Health has a right to rental payments based on a percentage of revenue from March 2020. A reliable estimate of the rental amount cannot yet be determined. Gold Coast Health does not control the facility and therefore it is not recognised as an asset of Gold Coast Health.

Note 25. Trust transactions and balances

Patient trust receipts and payments	2017 \$'000	2016 \$'000
<i>Receipts</i>		
Amounts received on behalf of patients	265	240
<i>Payments</i>		
Amounts paid to or on behalf of patients	259	235
<i>Assets</i>		
Cash held and bank deposits on behalf of patients	24	18

Note 26. Granted private practice arrangements

Gold Coast Health performs a custodial role in respect of private practice transactions and balances, and as such these are not recognised in the financial statements but are disclosed in these notes for information purposes.

Trust receipts and payments	2017 \$'000	2016 \$'000
<i>Receipts</i>		
Private practice revenue	21,062	19,487
Private practice interest revenue	33	32
Total receipts	21,095	19,519
<i>Payments</i>		
Payments to private practice doctors under retention arrangements	6,623	4,524
Payments to Gold Coast Health for service fees	6,347	6,908
Payments to Gold Coast Health for assignment arrangements	6,209	7,354
Payments to Gold Coast Health Private Practice Trust Fund*	1,352	940
Total payments	20,531	19,726
<i>Assets</i>		
Cash held and bank deposits for private practice	2,376	1,812

The cash balance above represents timing differences between cash receipts and payments in relation to the private practice arrangements.

* Private Practice Trust funds are generated by doctors reaching the ceiling allowable under the retention option arrangements. These funds are included in the General Trust Fund and the allocation of these funds is managed by an advisory committee.

Note 27. Events after the reporting period

No events have occurred after the reporting period that have an impact on the financial statements.

Certificate of Gold Coast Hospital and Health Service

These general purpose financial statements have been prepared pursuant to s.62(1) of the *Financial Accountability Act 2009* (the Act), section 43 of the *Financial and Performance Management Standard 2009* and other prescribed requirements. In accordance with s.62(1)(b) of the Act we certify that in our opinion:

(a) the prescribed requirements for establishing and keeping the accounts have been complied with in all material respects; and

(b) the financial statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of the Gold Coast Hospital and Health Service for the financial year ended 30 June 2017 and of the financial position of the Gold Coast Hospital and Health Service at the end of that year; and

(c) these assertions are based on an appropriate system of internal controls and risk management processes being effective, in all material respects, with respect to financial reporting throughout the reporting period.



Ian Langdon
Board Chair

15 August 2017



Ron Calvert
Chief Executive

15 August 2017

Independent auditor's report

INDEPENDENT AUDITOR'S REPORT

To the Board of Gold Coast Hospital and Health Service

Report on the audit of the financial report

Opinion

I have audited the accompanying financial report of Gold Coast Hospital and Health Service. The financial report comprises the statement of financial position as at 30 June 2017, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including summaries of significant accounting policies and other explanatory information, and the management certificate.

In my opinion, the financial report:

- a) gives a true and fair view of the entity's financial position as at 30 June 2017, and its financial performance and cash flows for the year then ended
- b) complies with the *Financial Accountability Act 2009*, the *Financial and Performance Management Standard 2009* and Australian Accounting Standards.

Basis for opinion

I conducted my audit in accordance with the *Auditor-General of Queensland Auditing Standards*, which incorporate the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report.

I am independent of the entity in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's *APES 110 Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Australia. I have also fulfilled my other ethical responsibilities in accordance with the Code and the *Auditor-General of Queensland Auditing Standards*.

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

Key audit matters

Key audit matters are those matters that, in my professional judgement, were of most significance in my audit of the financial report of the current period. I addressed these matters in the context of my audit of the financial report as a whole, and in forming my opinion thereon, and I do not provide a separate opinion on these matters.

Independent auditor's report (continued)

Specialised buildings valuation (\$1,557.6M)

Key audit matter	How my audit addressed the key audit matter
<p>Buildings were material to Gold Coast Hospital and Health Service at balance date, and were measured at fair value using the current replacement cost method. Gold Coast Hospital and Health Service performed a comprehensive revaluation of all of its buildings this year.</p> <p>The current replacement cost method comprises:</p> <ul style="list-style-type: none"> • Gross replacement cost, less • Accumulated depreciation <p>Gold Coast Hospital and Health Service derived the gross replacement cost of its buildings at balance date using unit prices that required significant judgements for:</p> <ul style="list-style-type: none"> • identifying the components of buildings with separately identifiable replacement costs • developing a unit rate for each of these components, including: <ul style="list-style-type: none"> ○ estimating the current cost for a modern substitute (including locality factors and oncosts), expressed as a rate per unit (e.g. \$/square metre) ○ identifying whether the existing building contains obsolescence or less utility compared to the modern substitute, and if so estimating the adjustment to the unit rate required to reflect this difference. • The measurement of accumulated depreciation involved significant judgements for forecasting the remaining useful lives of building components. <p>The significant judgements required for gross replacement cost and useful lives are also significant for calculating annual depreciation expense.</p>	<p>My procedures included, but were not limited to:</p> <ul style="list-style-type: none"> • Assessing the adequacy of management's review of the valuation process. • Assessing the appropriateness of the components of buildings used for measuring gross replacement cost with reference to common industry practices • Engaging a real estate specialist to review the valuation methodology and the underlying assumptions for a sample of the buildings being comprehensively revalued • For unit rates associated with buildings that were comprehensively revalued this year: <ul style="list-style-type: none"> ○ Assessing the competence, capabilities and objectivity of the experts used to develop the models ○ Reviewing the scope and instructions provided to the valuer, and obtaining an understanding of the methodology used and assessing its appropriateness with reference to common industry practices. ○ On a sample basis, evaluating the relevance, completeness and accuracy of source data used to derive the unit rate of the: <ul style="list-style-type: none"> ▪ modern substitute (including locality factors and oncosts) ▪ adjustment for excess quality or obsolescence. • Evaluating useful life estimates for reasonableness by: <ul style="list-style-type: none"> ○ Reviewing management's annual assessment of useful lives. ○ Ensuring that no asset still in use has reached or exceeded its useful life. ○ Enquiring of management about their plans for assets that are nearing the end of their useful life. ○ Reviewing assets with an inconsistent relationship between condition and remaining useful life. • Where changes in useful lives were identified, evaluating whether the effective dates of the changes applied for depreciation expense were supported by appropriate evidence.

Refer to Note 16 in the financial report.

Responsibilities of the entity for the financial report

The Board is responsible for the preparation of the financial report that gives a true and fair view in accordance with the *Financial Accountability Act 2009*, the *Financial and Performance Management Standard 2009* and Australian Accounting Standards, and for such internal control as the Board determines is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

The Board is also responsible for assessing the entity's ability to continue as a going concern, disclosing, as applicable, matters relating to going concern and using the going concern basis of accounting unless it is intended to abolish the entity or to otherwise cease operations.

Auditor's responsibilities for the audit of the financial report

My objectives 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 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 expressing an opinion on the effectiveness of the entity's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the entity.
- Conclude on the appropriateness of the entity'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 entity'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. I base my conclusions on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity 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.

Independent auditor's report (continued)

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.

From the matters communicated with the Board, I determine those matters that were of most significance in the audit of the financial report of the current period and are therefore the key audit matters. I describe these matters in my auditor's report unless law or regulation precludes public disclosure about the matter or when, in extremely rare circumstances, I determine that a matter should not be communicated in my report because the adverse consequences of doing so would reasonably be expected to outweigh the public interest benefits of such communication.

Report on other legal and regulatory requirements

In accordance with s.40 of the *Auditor-General Act 2009*, for the year ended 30 June 2017:

- a) I received all the information and explanations I required.
- b) In my opinion, the prescribed requirements in relation to the establishment and keeping of accounts were complied with in all material respects.



D. J. OLIVE
as delegate of the Auditor-General



Queensland Audit Office
Brisbane

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Appendix 1

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Glossary of acronyms

Appendix 2

AASB Australian Accounting Standards Board

ABF Activity-based Funding

ACHS The Australian Council on Healthcare Standards

AODS Alcohol and Other Drugs Service

ATOD Alcohol, Tobacco and Other Drugs

BYOD Bring Your Own Device

CAG Consumer Advisory Group

CALD Culturally and Linguistically Diverse

CCC Crime and Corruption Commission

CCF Core Capability Framework

CDU Clinical Decision Unit

DHPW Department of Housing and Public Works

DPC Department Premier and Cabinet

DSO District Senior Officer

DTS Digital Transformation Services

EBP Evidence Based Practice

ECGO Executive Control Group: Operations

ED Emergency Department

EEO Equal Employment Opportunity

EMR Electronic Medical Record

EMT Executive Management Team

ENT Ear, nose, throat

EQuIP Evaluation and Quality Improvement Program

FBT Fringe Benefits Tax

FPMS Finance and Performance Management Standard 2009

FRR Financial Reporting Requirements

FTE Full-time Equivalent

GC2018 2018 Commonwealth Games

GCHKP Gold Coast Health and Knowledge Precinct

GCIC Gold Coast Integrated Care

GPUH Gold Coast University Hospital

GOLDOC Gold Coast 2018 Commonwealth Games Corporation

GP General Practitioner

GST Goods and Services Tax

HES Health Executive Service

HHB Hospital and Health Board

HHOT Homeless Health Outreach Team

HHS Hospital and Health Service

HR Human Resources

HSC Haemopoietic Stem Cell

ICT Information Communication Technology

ICU Intensive Care Unit

IHPA Independent Hospital Pricing Authority

IMT Information Management and Technology

KMP Key Management Personnel

KPI Key Performance Indicators

MGP Midwifery Group Practice

MHSS Mental Health and Specialist Services

MIS Management Information System

MOHRI Minimum Obligatory Human Resource Information

NAIDOC National Aborigines and Islanders Day Observance Committee

NATA National Association of Testing Authorities

NEAT	National Emergency Access Target
NED	Neurodevelopment Exposure Disorder
NEST	National Elective Surgery Target
NHHNA	National Health and Hospitals Network Agreement
NHMRC	National Health and Medical Research Council
NHS	National Health Service
NICU	Neonatal Intensive Care Unit
NPA	National Partnership Agreement
NSQHS	National Safety and Quality Health Service
PID	Public Interest Disclosure
PLS	Patient Liaison Service
PPH	Potentially Preventable Hospitalisations
PPM	Professional Practice Model
QAO	Queensland Audit Office
QAS	Queensland Ambulance Service
QGIF	Queensland Government Insurance Fund
QPS	Queensland Police Service
QTC	Queensland Treasury Corporation
QWAU	Queensland Weighted Activity Units
RACS	Royal Australasian College of Surgeons
SCC	Statutory Compliance and Conduct
SDS	Service Delivery Statement
SNAP	Sub- and Non-acute Patients
SRAC	Strategic Research Advisory Committee
VMO	Visiting Medical Officer
WAU	Weighted Activity Units

Accessible	Accessible healthcare is characterised by the ability of people to obtain appropriate healthcare at the right place and right time, irrespective of income, cultural background or geography.
Activity-based funding	<p>A management tool with the potential to enhance public accountability and drive technical efficiency in the delivery of health services by:</p> <ul style="list-style-type: none">• capturing consistent and detailed information on hospital sector activity and accurately measuring the costs of delivery• creating an explicit relationship between funds allocated and services provided• strengthening management’s focus on outputs, outcomes and quality• encouraging clinicians and managers to identify variations in costs and practices so they can be managed at a local level• in the context of improving efficiency and effectiveness• providing mechanisms to reward good practice and support quality initiatives.
Acute	Having a short and relatively severe course.
Acute care	<p>Care in which the clinical intent or treatment goal is to:</p> <ul style="list-style-type: none">• manage labour (obstetric)• cure illness or provide definitive treatment of injury• perform surgery• relieve symptoms of illness or injury (excluding palliative care)• reduce severity of an illness or injury• protect against exacerbation and/or complication of an illness and/or injury that could threaten life or normal function• perform diagnostic or therapeutic procedures.
Admission	The process whereby a hospital accepts responsibility for a patient’s care and/or treatment. It follows a clinical decision, based on specified criteria, that a patient requires same-day or overnight care or treatment, which can occur in hospital and/or in the patient’s home (for hospital-in-the-home patients).
Allied health	Professional staff who meet mandatory qualifications and regulatory requirements in the following areas: audiology; clinical measurement sciences; dietetics and nutrition; exercise physiology; leisure therapy; medical imaging; music therapy; nuclear medicine technology; occupational therapy; orthoptics; pharmacy; physiotherapy; podiatry; prosthetics and orthotics; psychology; radiation therapy; sonography; speech pathology and social work.
Best practice	Cooperative way in which organisations and their employees undertake business activities in all key processes, and use benchmarking that can be expected to lead sustainable world-class positive outcomes.

Clinical governance	A framework by which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Clinical practice	Professional activity undertaken by health professionals to investigate patient symptoms and prevent and/or manage illness, together with associated professional activities for patient care.
Full-time equivalent (FTE)	Refers to full-time equivalent staff currently working in a position.
Department of Health	Refers to Queensland Health.
Health reform	Response to the National Health and Hospitals Reform Commission Report (2009) that outlined recommendations for transforming the Australian health system, the National Health and Hospitals Network Agreement (NHHNA) signed by the Commonwealth and states and territories, other than Western Australia, in April 2010 and the National Health Reform Heads of Agreement (HoA) signed in February 2010 by the Commonwealth and all states and territories amending the NHHNA.
Hospital	Healthcare facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day-procedure unit and authorised to provide treatment and/or care to patients.
Hospital and Health Boards	The Hospital and Health Boards are made up of a mix of members with expert skills and knowledge relevant to managing a complex health care organisation.
Hospital and Health Service	Hospital and Health Service (HHS) is a separate legal entity established by Queensland Government to deliver public hospital services.
Immunisation	Process of inducing immunity to an infectious agency by administering a vaccine.
Incidence	Number of new cases of a condition occurring within a given population, over a certain period of time.
Indigenous health worker	An Aboriginal and/or Torres Strait Islander person who holds the specified qualification and works within a primary healthcare framework to improve health outcomes for Indigenous Australians.
Long wait	A 'long wait' elective surgery patient is one who has waited longer than the clinically recommended time for their surgery, according to the clinical urgency category assigned. That is, more than 30 days for a category 1 patient, more than 90 days for a category 2 patient and more than 365 days for a category 3 patient.

Glossary of terms (continued)

Nurse Navigator	Highly experienced nurses who have an in-depth understanding of the health system and who will assist patients with complex healthcare needs to navigate to and from their referring general practitioner and/or other primary care providers, through hospital, the community and back home again.
Nurse practitioner	A registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessing and managing clients using nursing knowledge and skills and may include, but is not limited to, direct referral of clients to other healthcare professionals, prescribing medications, and ordering diagnostic investigations.
Outpatient	Non-admitted health service provided or accessed by an individual at a hospital or health service facility.
Outpatient service	Examination, consultation, treatment or other service provided to non-admitted non-emergency patients in a speciality unit or under an organisational arrangement administered by a hospital.
Patient flow	Optimal patient flow means the patient's journey through the hospital system, be it planned or unplanned, happens in the safest, most streamlined and timely way to deliver good patient care.
Performance indicator	A measure that provides an 'indication' of progress towards achieving the organisation's objectives and usually has targets that define the level of performance expected against the performance indicator.
Private hospital	A private hospital or free-standing day hospital, and either a hospital owned by a for-profit company or a non-profit organisation and privately funded through payment for medical services by patients or insurers. Patients admitted to private hospitals are treated by a doctor of their choice.
Public patient	A public patient is one who elects to be treated as a public patient, so cannot choose the doctor who treats them, or is receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority.

Public hospital

Public hospitals offer free diagnostic services, treatment, care and accommodation to eligible patients.

Registered nurse

An individual registered under national law to practice in the nursing profession as a nurse, other than as a student.

Statutory bodies

A non-departmental government body, established under an Act of Parliament. Statutory bodies can include corporations, regulatory authorities and advisory committees/councils.

Sustainable

A health system that provides infrastructure, such as workforce, facilities and equipment, and is innovative and responsive to emerging needs, for example, research and monitoring within available resources.

Weighted Activity Unit

A standard unit used to measure all patient care activity consistently. The more resource intensive an activity is, the higher the weighted activity unit. This is multiplied by the standard unit cost to create the 'price' for the episode of care.



Compliance checklist

Appendix 4

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	<ul style="list-style-type: none"> A letter of compliance from the accountable officer or statutory body to the relevant Minister/s 	ARRs – section 7	3
Accessibility	<ul style="list-style-type: none"> Table of contents Glossary 	ARRs – section 9.1	3 104–109
	<ul style="list-style-type: none"> Public availability 	ARRs – section 9.2	2
	<ul style="list-style-type: none"> Interpreter service statement 	Queensland Government Language Services Policy ARRs – section 9.3	2
	<ul style="list-style-type: none"> Copyright notice 	Copyright Act 1968 ARRs – section 9.4	2
	<ul style="list-style-type: none"> Information Licensing 	QGEA – Information Licensing ARRs – section 9.5	2
General information	<ul style="list-style-type: none"> Introductory Information 	ARRs – section 10.1	4
	<ul style="list-style-type: none"> Agency role and main functions 	ARRs – section 10.2	4
	<ul style="list-style-type: none"> Operating environment 	ARRs – section 10.3	7
Non-financial performance	<ul style="list-style-type: none"> Government's objectives for the community 	ARRs – section 11.1	10
	<ul style="list-style-type: none"> Other whole-of-government plans / specific initiatives 	ARRs – section 11.2	10
	<ul style="list-style-type: none"> Agency objectives and performance indicators 	ARRs – section 11.3	11
	<ul style="list-style-type: none"> Agency service areas and service standards 	ARRs – section 11.4	21
Financial performance	<ul style="list-style-type: none"> Summary of financial performance 	ARRs – section 12.1	18–20
Governance – management and structure	<ul style="list-style-type: none"> Organisational structure 	ARRs – section 13.1	48–49
	<ul style="list-style-type: none"> Executive management 	ARRs – section 13.2	50–54
	<ul style="list-style-type: none"> Government bodies (statutory bodies and other entities) 	ARRs – section 13.3	N/A
	<ul style="list-style-type: none"> Public Sector Ethics Act 1994 	Public Sector Ethics Act 1994 ARRs – section 13.4	59
	<ul style="list-style-type: none"> Queensland public service values 	ARRs – section 13.5	10
Governance – risk management and accountability	<ul style="list-style-type: none"> Risk management 	ARRs – section 14.1	56
	<ul style="list-style-type: none"> Audit committee 	ARRs – section 14.2	46
	<ul style="list-style-type: none"> Internal audit 	ARRs – section 14.3	57

Summary of requirement		Basis for requirement	Annual report reference
	<ul style="list-style-type: none"> External scrutiny 	ARRs – section 14.4	56
	<ul style="list-style-type: none"> Information systems and recordkeeping 	ARRs – section 14.5	58
Governance – human resources	<ul style="list-style-type: none"> Workforce planning and performance 	ARRs – section 15.1	30–37
	<ul style="list-style-type: none"> Early retirement, redundancy and retrenchment 	Directive No.11/12 <i>Early Retirement, Redundancy and Retrenchment</i> Directive No.16/16 <i>Early Retirement, Redundancy and Retrenchment</i> (from 20 May 2016) ARRs – section 15.2	34
Open Data	<ul style="list-style-type: none"> Statement advising publication of information 	ARRs – section 16	59
	<ul style="list-style-type: none"> Consultancies 	ARRs – section 33.1	59
	<ul style="list-style-type: none"> Overseas travel 	ARRs – section 33.2	59
	<ul style="list-style-type: none"> Queensland Language Services Policy 	ARRs – section 33.3	59
Financial statements	<ul style="list-style-type: none"> Certification of financial statements 	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 17.1	98
	<ul style="list-style-type: none"> Independent Auditor's Report 	FAA – section 62 FPMS – section 50 ARRs – section 17.2	99–102

FAA *Financial Accountability Act 2009*

FPMS *Financial and Performance Management Standard 2009*

ARRs *Annual report requirements for Queensland Government agencies*

Notes to Service Performance Statement

Appendix 5

1. The 2016–17 Estimated Actual figures are based on actual performance from 1 July 2016 to 30 April 2017. A Target/Estimate for percentage of emergency department patients seen within recommended timeframes is not included in the 'All Categories' as there is no national benchmark. Queensland public hospital emergency departments face ongoing increases in demand, with an average 1.3 per cent annual increase in emergency department attendances, which has an effect on emergency department performance.
2. This is a measure of access and timeliness of emergency department services. The 2016–17 Estimated Actual figures are based on actual performance from 1 July 2016 to 30 April 2017.
3. This is a measure of effectiveness that shows how hospitals perform in providing elective surgery services within the recommended timeframe for each urgency category. The 2016–17 Estimated Actual figures are based on actual performance from 1 July 2016 to 30 April 2017.
4. This is a National Performance Agreement indicator and a measure of effectiveness of infection control programs and services in hospitals. *Staphylococcus aureus* are bacteria commonly found on around 30 per cent of people's skin and noses and often cause no adverse effects. Infections with this organism can be serious, particularly so when they infect the bloodstream. The data reported for this service standard are for bloodstream infections with *Staphylococcus aureus* (including methicillin resistant *Staphylococcus aureus*) and are reported as a rate of infection per 10,000 patient days. The Target/Estimate for this measure aligns with the national benchmark of 2 cases per 10,000 acute public hospital patient days for each jurisdiction. The 2016–17 Estimated Actual figures are based on actual performance from 1 July 2016 to 31 March 2017.
5. This is a measure of access to, and timeliness of the community support system that is in place for persons who have experienced an acute psychiatric episode requiring hospitalisation. The 2016–17 Estimated Actual is for the period 1 July 2016 to 31 January 2017. Queensland has made significant progress in improving the rate of community follow up over the past five years. Increased pressure on community and inpatient mental health services has seen increases in readmission rates and is impacting the rate of follow up.
6. This is a measure of effectiveness that shows the percentage of patients who are waiting to have their first appointment (from the time of referral) with the health professional in an outpatient clinic, within the clinically recommended time. The 2016–17 Estimated Actual figure is based on patients waiting as at 30 April 2017.
7. This is a measure of effectiveness that indicates the percentage of patients seen within clinically recommended times during the reporting period. The 2016–17 Estimated Actual figures are based on actual performance from 1 July 2016 to 30 April 2017.
8. This measure indicates the amount of time for which half of all people waited in the emergency department (for all categories), from the time of presentation to being seen by a nurse or doctor (whichever was first). The 2016–17 Estimated Actual figure is based on actual performance from 1 July 2016 to 30 April 2017.
9. This is a measure of effectiveness that reports on the number of days for which half of all patients wait before undergoing elective surgery. The 2016–17 Estimated Actual figure is based on actual performance from 1 July 2016 to 30 April 2017.
10. A WAU is a measure of activity and provides a common unit of comparison so that all activity can be measured consistently. Service agreements between the Department of Health and HHSs and other organisations specify the activity to be provided in WAUs by service type. Refer to Box 1, page 12.
11. The 2016–17 Estimated Actual figure reflects 1 July to 31 December 2016 activity based costs and actual activity based funded activity. The 2017-18 Target/Estimate reflects the activity based funding less Clinical Education and Training and Specified Grants and activity within the finance and activity schedules of the 2017-18 Final Round Service Agreements Contract Offers. 2017-18 Target/Estimate for cost per Queensland

WAU includes HHS activity forecast over delivery in 2016–17, funded by the Commonwealth at a marginal rate of 45 per cent. As a result, funding per Queensland WAU in 2017-18 is generally lower than the 2016–17 Target/Est cost per Queensland WAU. The impact of this is partially offset in some HHSs due to changes in Own Source Revenue classification between 2016–17 and 2017-18, and non-Queensland WAU investments. 2016–17 Est Actual cost per Queensland WAU is a point in time measure which includes the first 6 months of HHS expenditure and activity. It includes the impact of one-off investments in 2016–17.

12. This is a measure of activity. The 2016–17 Estimated Actual figures are based on 10 months of actual performance from 1 July 2016 to 30 April 2017.
13. This measure tracks the growth in occasions of service for Telehealth enabled outpatient services. These services support timely access to contemporary specialist services for patients from regional, rural and remote communities, supporting the reduction in wait times and costs associated with patient travel. The 2016–17 Estimated Actual figure is based on actual performance from 1 July 2016 to 30 April 2017 forecast out over 12 months.
14. The 2016–17 Estimated Actual figures are based on 2016–17 Queensland WAU forecasts as provided by HHSs. 2017-18 Target/Estimate figures are based on the 2017-18 Final Round Service Agreements Contract Offers. All activity is reported in the same phase - Activity Based Funding (ABF) model Q19. 'Total WAUs – Interventions and procedures' has been reallocated to 'Total WAUs – Acute Inpatient Care' and 'Total WAUs – Outpatient Care' service standards. 'Total WAUs – Prevention and Primary Care' is comprised of BreastScreen and Dental WAUs. Total WAUS - Prevention and Primary Care' is a new measure for the Service Delivery Statement, however, it has been included in the HHS Service Agreements since 2016–17. Purchased Queensland WAUs in 2017-18 for Prevention and Primary Care are lower due to one off investments in Oral Health in 2016–17 and National Partnership Agreement (NPA) funding not yet allocated.
15. This measure counts the number of in-scope service contact hours attributable to each HHS, based on the national definition and calculation of service contacts and duration. The Estimated Actuals for 2016–17 are for the period 1 July 2016 to 31 March 2017. It is important to note that not all activity of ambulatory clinicians is in-scope for this measure, with most review and some service coordination activities excluded. In addition, improvements in data quality have contributed to the result, with the data more accurately reflecting way in which services are delivered. The Target/Estimate for this measure is determined using a standard formula based upon available clinical staffing, HHS rurality, and historical performance. The targets for these measures have been set to be consistently calculated and are considered a stretch for many services.

